SOUTH AFRICAN HEALTH REVIEW 1996

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1996

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Information presented in this Review is based on best available data derived from numerous sources. Discrepancies between different sources, even for important indicators like the infant mortality rate, reflect the current quality of data. All data should thus be interpreted carefully, and with recognition of potential inaccuracy.

Published jointly by the Health Systems Trust and the Henry J. Kaiser Family Foundation

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FOREWORD

Publication of the first South African Health Review in October 1995 provided a solid basis for assessing progress in health systems reform. At that time, newly appointed health administrations were struggling to find their feet, and grappling with major policy options. Progress was assessed primarily in terms of the definition and clarity of policy intentions.

A year later, national and provincial health managers are well established and have already considerable experience under their belts. In many respects, the yardsticks for gauging success are different from last year. Change should be measured in terms of its impact on health care provision - if not on health outcome itself.

The South African Health Review 1996 chronicles and critiques policy developments over the past year. Inevitably, the scorecard is mixed. In some areas, progress has been excellent. In others, there appears to have been little movement. This is the nature of health care reform.

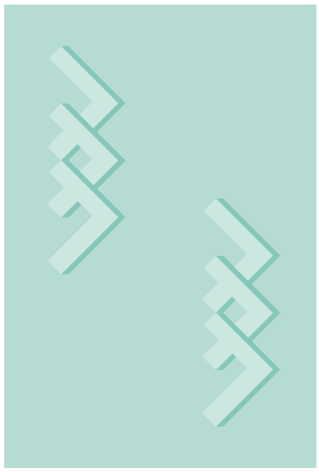
What is most important is that the momentum for change is sustained, and does not falter. This Review helps to identify areas of energy and activity which serve as the vanguard of health reform, and bottlenecks which impede progress.

On behalf of the Board of the Health Systems Trust, I would like to thank all authors and reviewers who contributed freely of their time and expertise. Our thanks to the Editorial Board who shaped and guided this Review, and to Gcinile Buthelezi and Thokozile Nkabinde who have driven the process from conception to publication.

Finally, a word of acknowledgement to all health service managers and health workers striving to improve health care. This Review is testimony to your efforts. Sometimes critical, sometimes laudatory, it is always supportive of your goal of better health for all South Africans.

JAIRAM REDDY

CHAIRPERSON: HEALTH SYSTEMS TRUST



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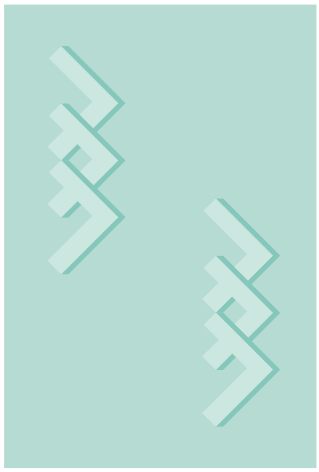

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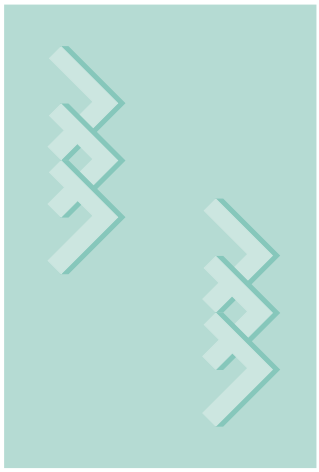


PREFACE

CONTEXT OF REVIEW

The South African Health Review 1996 will find its way into a variety of health care settings over the course of the next year. In a dilapidated rural clinic in the former Transkei, the book may be read by a nurse completing a course assignment, before becoming sodden by a downpour of rain which floods through the holes in the corrugated iron roof. The Professor of Medicine at an academic hospital might enjoy the Review as bedtime reading, before storing it amongst weightier tomes on his office bookshelf. The co-ordinator of a small non-government organisation, always hungry for information, will use the information in her motivation for funding to foreign donors. In the waiting room of a private practitioner, a client may thumb through the publication before becoming more absorbed by the antics of Asterix and Obelix. The spokesperson for the striking health workers may quote from the Review to back up her assertion that conditions are bad and workers demoralised. The community representative on the district health forum may read the book avidly to develop a better understanding of health care. The doctor in an isolated district hospital will appreciate the information, but wonder vaguely whether it has any real relevance for his daily work. In Maputaland, the Review may have pride of place on the gleaming new bookshelf in the newly built clinic.

All of the above provide the context for the South African Health Review 1996. In other words, its context is the day-to-day realities of health service delivery in South Africa. Health sector transformation should be seen through the eyes of those working right at the site of service delivery. And changes should increasingly be measured in terms of outcome, rather than processes of restructuring and policy formulation.

In other words:

- What has changed for the poor, rural woman or child who presents to the clinic?
- Is the academic hospital closer to its goal of an appropriate, cost-effective training and service institution than it was a year ago?
- Are community-based and non-government organisations now regarded as partners in service provision, and is this borne out in practice?
- Do private general practitioners and hospitals participate more in the management of people who cannot afford to pay than in 1995?
- Do health workers feel more supported, less demoralised?
- Is there now real community representation in health care management and governance?
- Have primary health care (PHC) services been developed to the extent that people use PHC facilities in preference to hospitals?

These are the types of questions which this Review seeks to answer. More systematically, the questions which serve as the implicit framework for each chapter of the South African Health Review 1996 are the following:

- Has structural reform and policy formulation translated into real improvements in *health outcome*?
- Have efforts made a difference to the *adequacy of health care provision*?
- Are better *health management systems* in place?
- Are *policies and plans* clear?

The sequence of these questions illustrates an emphasis on action, rather than words, in the analysis of progress.

Some may argue that it is unfair to attempt to measure health care reform on the basis of health outcome, especially in the short term. But we need to keep in mind constantly the purpose of health care restructuring, so that reform does not become bogged down at an administrative level, but actually improves the quality of people's lives.

PURPOSE OF REVIEW

This Review seeks to serve three purposes: First, it serves as an independent and comprehensive source of information about health and health care in South Africa, by collating, interpreting and presenting available data. Second, it provides a critique of policy developments and trends, linked to the analysis of data. Third, it helps clarify an agenda for health systems research at national, provincial and local levels.

PROCESS OF REVIEW

The South African Health Review 1996 is a joint publication of the Health Systems Trust and the Henry J. Kaiser Family Foundation (USA). An Editorial Board designed and refined the structure of the Review, and provided support throughout the process of commissioning and editing. The Project for Health Information Dissemination of the Health Systems Trust invited selected people to contribute to specific chapters of the Review. A number of authors chose to co-opt additional co-authors. Each chapter was reviewed internally, and referred back to authors. The composite draft was sent to a number of external reviewers, and revised prior to publication.

REVIEW FRAMEWORK

The Review consists of three main parts. The first describes the imperatives for health systems reform by documenting demographic and socio-economic patterns and health status. Part II describes and critiques crucial elements in the transformation of health care in South Africa. For each, the corresponding chapter in the South African Health Review 1995 serves as the basis for evaluating progress. Part III highlights a number of areas which have been identified as priorities for the Department of Health. This Review concludes with an agenda for health systems research which will help bring about improvements in health service delivery, and ultimately, people's health.

YEAR IN REVIEW

INTRODUCTION

Health was never far from the headlines in 1995/6. During the year, much happened that was positive and the Health Department was one of the government departments which was seen to be active and getting on with the job. Unfortunately all the positive achievements were somewhat overshadowed in the media by the controversies surrounding the Sarafina 2 AIDS project and other controversial issues. In this chapter, both positive achievements and negative events are described.

HUMAN RESOURCES

Ethos of caring

Health is essentially a service sector - and the most important factor in health service delivery are the people working in the services. During the year, there were a number of positive developments in this crucially important component of health services delivery.

Many observers have concluded that the attitudes of health many workers in South Africa do not reflect commitment, caring and dedication. The Minister of Health, Dr Zuma, has called for an "Ethos of Caring" amongst all health workers with a view to improving the quality of care rendered.

Nurses' strikes

Against this call must be placed the wave of crippling countrywide nurses' strikes during late 1995. Nurses were frustrated by the slow pace of change in their working conditions and by their low salaries. They embarked on a strike and brought many hospitals to a standstill. The strike caused a public outcry as patients had to be rerouted to private hospitals or turned away. The worst hit province was the Eastern Cape, and the strike there resulted in thousands of nurses being dismissed and having to reapply for their old jobs, forfeiting many of their hard-earned benefits.

Salary increases

During the first half of 1996 massive increases in nurses' and doctors' salaries were announced, which should do much to alleviate the grievances of these two professional groups. The introduction of these increases in July 1996 was met with mixed reaction, as doctors and nurses tried to understand the full implications of reorganised salary packages.

Abolition of posts and severance packages

In general, posts continued to be frozen and abolished across the board, instead of through carefully planned pruning. This indiscriminate abolition of posts, coupled

Authors : Peter Barron and Kathy Strachan

with the offer of severance packages, placed severe burden on hospitals, particularly in the Western Cape and Gauteng.

Shortage of doctors

Not only rural areas, but also primary level facilities such as Day Hospitals in the Western Cape, experienced a shortage of medical personnel during the past year. A moratorium was placed on the registration of foreign doctors, outside of bilateral government agreements, to achieve a higher degree of quality control. Arguably a necessary step, this move exacerbated the shortage in areas not designated as priorities for Cuban doctors.

Medical interns

Intern posts, in which newly graduated doctors spend a year gaining practical experience, were more evenly spread through the country, with neglected areas benefiting from this policy at the expense of larger metropolitan areas.

Servicing the outlying areas - Cuban and other foreign doctors

In an attempt to combat the shortage of skilled medical personnel in poor and remote areas, Cuban doctors were imported on a government to government agreement. Local doctors working in the public sector, especially those in outlying areas, felt threatened by the plan, saying it eroded their base for negotiating better salaries as they would now be replaceable. The Department of Health countered that local doctors would remain the "first prize" and in order to keep the few local doctors still in these remote areas, it was necessary to urgently bring in foreign doctors to share their heavy workload. It was calculated that there were about 800 doctors' posts in outlying areas which needed to be filled immediately.

Five months after the arrival of the 96 Cuban doctors in January 1996, health authorities in various provinces said that these doctors had already made an immense difference to health services in rural areas. However, there were also reports of discontent amongst the Cuban doctors in some areas. A further 110 Cuban doctors arrived in South Africa in August 1996.

Further plans are being made to bring over young doctors from Europe to work in neglected areas of South Africa on two year contracts under the framework of the European Union's newly launched European Voluntary Service Programme.

While implementing these short term plans for recruitment of foreign doctors, the Health Department worked on longer term plans to change the way health workers were trained in order to encourage them to work in rural areas, as well as to play a more meaningful role once they were there. Other incentives were also being investigated to draw doctors to rural areas such as awarding rural working experience with academic status by accrediting it for postgraduate studies, and setting up networks to connect rural hospitals with consultants in larger areas.

But Minister Zuma believes it will take time before all these improvements and incentives lead to a marked increase in the number of doctors in outlying areas. "It would be naive to think that we will see doctors rushing to the public sector. It will be a gradual change, and we will be relying on foreign doctors for quite a while because we will never be able to offer private sector salaries", she said.

Primary health care

For the foreseeable future, the delivery of the primary level care will rely on the skills of clinically trained nurses. Dr Zuma has stated that the basic building block for primary health care is the nurse working at the clinic. During 1995, a crash course to train 50 primary health care nurse trainers was embarked upon, with a view to these trainers each training 10 nurses themselves in 1996 and subsequent years. In addition, many of the training institutions which have been training nurse clinicians for many years have intensified their efforts and increased their capacity. These courses will help to alleviate the acute shortage of competent clinically skilled nurses and the fruits of these efforts will be seen over the next few years.

Training programmes for managers

Many training programmes for managers were introduced. These included the Oliver Tambo Fellowship training programme funded by the Henry J. Kaiser Family Foundation for top and very senior health managers. A systematic countrywide training programme for district managers was funded by the Overseas Development Association (ODA). This programme will get going in earnest in the second half of 1996 in addition to a general organisational development programme in the Northern Cape, Northern and North West Provinces also funded by the ODA. The Health Systems Trust supported a management training programme in KwaZulu-Natal and North West, adapted from the District Team Problem-Solving Programme promoted by the World Health Organisation.

The future of Community Health Workers

At the community level, community health workers (CHW) face an uncertain future. Dr Zuma said, "No health service could be built on CHW's. They can supplement the nurse but under no circumstances could they replace her." There is a debate as to where community-based health workers will be located in the new health system, who should fund them and how much they should be paid. There was no resolution to these problems. At the same time, the non-governmental organisations that employ these workers face an increasingly difficult task in obtaining funds to pay the salaries, while there is considerable ambivalence about continued support for existing state-run programmes.

Higher education

The long term future of the higher education training of health workers was brought into focus through a draft report of the Working Group of the National Commission of Higher Education. This Working Group, chaired by Prof David Sanders, made a number of wide ranging recommendations. These included:

- a closer, more formalised relationship between the Health and Education Ministries regarding health higher education and its funding and control
- a review of curricula
- a review of access to educational facilities
- a review of admission criteria
- the rationalisation and relocation of nursing training, with this training being linked to universities and technikons
- a system of continuing education for health professionals.

RESTRUCTURING THE HEALTH SERVICES

Policy making at national and provincial levels

During the year, the focus fell on changing the structure of health services and getting new integrated organograms in place. At national and provincial level most senior management posts were filled and previously fragmented structures were integrated into a single rational entity. Joint policy decisions were made by the national and provincial departments in monthly meetings of the Minister of Health and the provincial Members of the Executive Council (MEC's). The Director-General of Health and the top provincial health civil servants were in attendance at these meetings. These meetings ensured that there was no conflict between the policy making function of the national department and the implementation function of the provinces.

Structure of health services at provincial levels

Provinces have introduced different permutations for combining Departments of Health and Welfare. For example, in the Eastern Cape, down to district level health and welfare personnel are fully integrated into a single department. In Gauteng, KwaZulu-Natal and the Western Cape, these departments are completely separate. Only the future will tell which is the better route to follow.

At the time of publication, the Free State had split their previously combined department and the Eastern Cape was talking about a similar move.

The district system

The district is the foundation on which the future health service is being built. However, the movement to a functional district health system is being hampered by a number of key policy issues which have not been adequately resolved. The most important of these issues are:

- the governance of the district system
- the relationship between state and local authorities
- the form of representation of local communities
- the disparity of salaries and conditions of service between large metropolitan local authorities and the provincial (state) sector salaries
- the relationship between districts and community hospitals in metropolitan areas.

Despite these obstacles significant progress was made towards establishing districts, with some provinces having district boundaries and district managers in place and district plans being made.

National Health Information System (NHIS/SA)

The process for implementing four modules of the planned National Health Information System of South Africa in facilities throughout the country ran into difficulty with the Tender Board, European Union (as donor) and the media. As a start, it was decided to identify pilot sites in all nine provinces, but these have yet to be implemented. It has now been decided to opt for separate provincial tenders, rather than a single national one.

FINANCING AND RESOURCE ALLOCATION

The National Health Insurance System

The national Health Department has recognised the obvious inequality in health expenditure in the country. The private sector accounts for approximately 60% of the resources spent on health for about 20% of the population. Within the public sector, there is gross inequity in the per capita spending among the provinces. There is also a disproportionate amount spent on tertiary care as opposed to primary health care.

In an attempt to start to tackle these inequities, the Health Ministry initiated a Committee of Inquiry into a National Health Insurance System. The report of this committee was tabled in Parliament in July 1995 and made a number of wide-ranging recommendations. These dealt less with health insurance and more with the mechanics of delivering primary care. One of the recommendations to improve primary health care envisaged some of the required resources for primary care being derived from the spin-offs of a mandatory health insurance coverage for a defined hospital benefit package for all employees. It was expected that savings in efficiency in public hospitals and income from private patients would go towards funding the expansion of primary care services. However, most of this recommendations of the report have not yet been implemented.

Equity in public health spending among provinces

Resources were shifted from better resourced provinces such as Gauteng and Western Cape to the less well resourced provinces such as the Northern and North West Provinces. This was part of a five year plan to obtain equity in the public health spending among the provinces. Doubts were expressed about the capacity of the poorer provinces to spend the extra resources whilst the better resourced provinces protested that the pace of change was too quick, that the cuts would be unsustainable and that services would close.

The redistribution of resources were largely obtained through a shift away from the major academic hospitals in Gauteng and the Western Cape, and channelled towards the primary level care. This has led to the creation of 700 additional primary care posts which are mainly in the poorer provinces, but has placed considerable strain on services in these two provinces.

During 1996, the allocation formula was refined and a more gradual approach was adopted, with Dr Zuma saying that it would probably take closer to 10 years than the original five years to achieve equity. The refined formula also recognised that the Eastern Cape had been short-changed in the original allocation and, with health services in the former Transkei area falling further into a state of decay, the province later obtained a significant increase.

Hospital management

Hospitals have been under scrutiny and research commissioned by the national Department of Health indicated that increased autonomy for hospital managers will allow them to make decisions which will lead to savings and improved quality. By allowing hospitals to retain some of the revenue collected through fees they will be given the incentive to operate more cost efficiently. A policy on these issues regarding improving hospital efficiency still needs to be taken. This research and policy development is being spearheaded by the Hospital Strategy Project, an amalgam of research partners, and is making a major contribution to improvements in hospital management in South Africa.

National health facilities audit

Results of a national audit to assess the maintenance and state of disrepair of public health facilities were released in August 1996. The poor state of many facilities in provinces such as KwaZulu-Natal and the Eastern Cape was highlighted. Urgent repair and rebuilding will have significant implications for allocations for capital expenditure over the next five years.

OTHER DEVELOPMENTS

Free health care for children and pregnant women

A number of positive steps were taken to improve delivery of services and access to these. A policy of free care for children under 6 and pregnant women was announced by the State President in mid 1994 in conjunction with a Primary School Nutrition Programme.

An evaluation of the free care policy commissioned by the Health Systems Trust (HST) was generally very favourable. It showed that utilisation of services, especially for the rural poor, increased dramatically after the introduction of the policy. It also showed that pregnant women tended to initiate attendance at antenatal clinics earlier in their pregnancy. Both providers and users of health services felt the policy was good in principle, but they also thought that primary level services needed strengthening in order to improve the quality.

The free care policy at primary level was extended to all patients with effect from 1 April 1996, although implementation was staggered across provinces. Clinics appeared more prepared for the policy this time and the introduction of the extended free care policy went more smoothly in many provinces.

However, concern has been expressed that the increased workload will continue to undermine health worker morale unless additional resources are provided, and that state-subsidised hospitals have been particularly hard-hit by a substantial reduction in revenue.

Construction and upgrading of facilities

There was a large scale attempt to improve the physical access to primary level care through a clinic building and upgrading programme. By June 1996, R190 million of the Reconstruction and Development Plan (RDP) funds had been used to build 60 new clinics, to upgrade 47 more and to equip a further 73. In addition, 142 mobile units have been purchased and general improvements made to a large number of clinics around the country.

The Essential Drugs Programme

On 1 April 1996, the Health Department took arguably the most significant practical step in its entire restructuring programme by introducing an essential drugs list for state primary health clinics. Through setting up an essential drugs list (EDL) the cost of medicines in primary clinics will be greatly reduced, and outlying centres will be ensured of a reliable supply of effective and safe drugs. The use of this list will be supported by an Essential Drugs Programme aimed at promoting proper and safe use of the selected drugs. The Department has shelved its earlier proposal to extend the list into the private sector - and whether it eventually gets extended will depend on the private sector's ability to demonstrate control of spiralling medicine costs.

Immunisation campaign

During August 1996, an immunisation campaign was launched, focusing particularly on polio.

Health service reviews conducted by various provincial health departments in conjunction with the Health Systems Trust, indicate that many opportunities for immunisation are still being missed by the failure to integrate immunisations into all child health activities at both hospitals and clinics.

Tuberculosis review

A review of the extent and management of tuberculosis was conducted in all provinces in South Africa. This highlighted both the growing magnitude of the problem, as well as the failure of health services to implement effective management systems for its prevention and control.

Tobacco control

New tobacco regulations were introduced. These place stricter control on the advertising of tobacco products and improve the visibility of the warning of the harmful effects of smoking.

Donor funding

The European Union (EU) continued to be the single biggest donor within the health sector. However, this funding has been jeopardised by events around the Sarafina 2 AIDS play. The extent of further support by the EU to the health sector remains to be seen.

After considerable delay, United States Agency for International Development (USAID) released a tender for the implementation of the EQUITY project in the Eastern Cape, aimed at improving primary health care services. There has been some scepticism about the degree to which South Africans will have discretion over this project, and the Eastern Cape government has made satisfactory control by South Africans a condition for accepting funds.

Other significant bilateral donors included the Overseas Development Administration and Scandinavian countries. The Henry J. Kaiser Family Foundation (USA) and the Kellogg Foundation remain significant funders of non-government organisations, in addition to selective support for academic institutions and/or public sector restructuring or training.

PROBLEMS

Health services in the Eastern Cape

The health services in the former Transkei were brought to attention after a provincial delegation described Umtata Hospital as “an affront to humanity”. It said that the terrible conditions in the hospital were a health risk and it should be condemned. In the paediatric ward there were five babies to a cot and two babies to an incubator. Half way through 1996, many clinics in the former Transkei area still did not have medicines on the shelves and they lacked the most basic equipment. The gravity of the situation has been acknowledged by the provincial department, which is seeking to address these problems urgently.

The country's psychiatric institutions

A ministerial report lifted the lid on the country's psychiatric institutions, disclosing a picture of widespread abuse and malpractice. The report concluded that conditions in most prisons were better than those existing in some psychiatric hospitals, where there were claims of sexual abuse, assaults and deaths caused by neglect.

HIV/AIDS scenario

Despite efforts to raise awareness, the HIV infection trend generally continued along the trajectory of the "worst case scenario". The 1995 survey of women attending antenatal clinics showed that 10.4% were HIV positive, with the figure rising to 18% in KwaZulu-Natal. The survey also showed an average of 10% of teenage girls visiting antenatal clinics across the country were infected with the HIV.

The Primary School Nutrition Programme

The Primary School Nutrition Programme came under the spotlight when widespread corruption in the programme was discovered in the Eastern Cape. Corruption was also found in nutrition programme management in KwaZulu-Natal and Mpumalanga. While these were the worst cases, reports of lesser cases of fraud and abuse were reported from around the country.

Non-government organisations

Non-government organisations have experienced mounting difficulty in securing funding, as many traditional donors have now chosen to direct funds straight to government. This funding squeeze has seriously undermined their ability to respond the needs of their communities, many of which have yet to experience the fruits of government plans for development.

Efforts to channel donor funding through government have, by and large, proved unsuccessful. This was due as much to the different perspectives and priorities of government and non-government sector, as to cumbersome and bureaucratic processes which frustrated - and in some instances, undermined the capacity of non-government organisations. This was illustrated most vividly within the Primary School Nutrition Programme, where delays in payment to non-government organisations (NGOs) operating on a shoestring budget often harmed their credit-worthiness and community credibility.

CONTROVERSY

The Sarafina controversy

The Health Department became embroiled in a controversy over the funding of Sarafina 2 - the R14 million AIDS awareness musical created by the playwright Mbongeni Ngema. The tender process which saw him win the contract raised protest and the issue was widely reported in the media. The European Union, whose funds were ostensibly used to pay Ngema, was angered that it had not been informed of the project.

A report by the public protector, Selby Baqwa, was tabled in Parliament in early June 1996. It found that the tendering process was incorrect, that the musical in its present form was ineffectual and that various officials of the department were guilty of serious maladministration and negligence. He recommended that the play should be scrapped as a funded project of the HIV/AIDS Directorate of the Department of Health.

This recommendation was accepted by the department, but its failure to disclose the play's new sponsor has drew widespread criticism, and lead eventually to the withdrawal of the anonymous donor who was to have bailed the Department out. The Minister of Health subsequently announced that the play's funding would be regarded as unauthorised expenditure.

The controversy also highlighted underlying tensions between the National Portfolio Committee on Health and the national Health Department, with accusations of poor communication between these two arms of government.

Organ transplants versus PHC

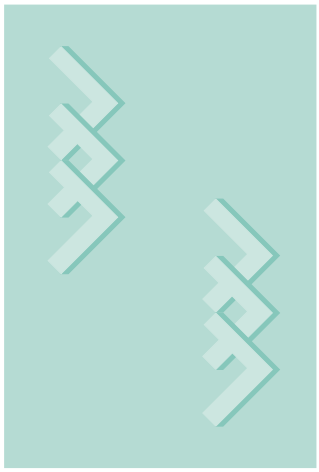
A furore erupted around heart transplants which highlighted South Africa's unique position of falling at the interface of First and Third World realities. While the Health Department was concentrating on spreading resources from specialised high level care to primary care, a Pretoria surgeon broke a provincial moratorium and went ahead with a heart transplant. The cost of a single heart transplant was equated with the costs of saving the lives of thousands of children through immunisation campaigns. There was a realisation that balance had to be struck between both ends of the health care spectrum and that, even in the wealthiest nations, priorities have to be made.

Vocational training for doctors

The Junior Doctors Association of South Africa (JUDASA) slammed the July 1996 announcement of the introduction of two years' vocational training for all doctors completing their internship, labelling it compulsory service in disguise. The Interim Medical and Dental Council maintains that the rationale is to equip doctors for health care practice in South Africa. Minister Zuma has lauded the Council's "progressive step", and reiterated that the training period will be introduced.

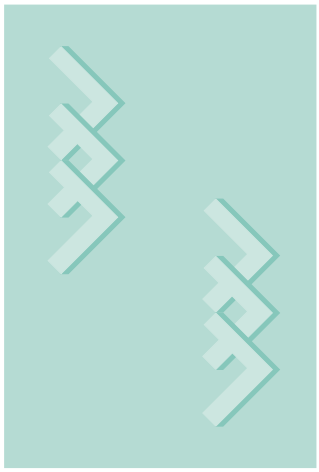
CONCLUSION

These highlights represent most of the health policy matters which grabbed media attention during the latter part of 1995 and most of 1996. Much change did not hit the headlines, as national and provincial health departments seemed to consolidate their activities and efforts during this period. Frequent policy announcements gave way to recognition that they were now settling in for the long haul, just as the euphoria of democracy in South Africa has been replaced by sombre recognition of the challenges of delivery.



PART 1

Imperatives for Health Systems Reform



1 DEMOGRAPHICS AND POPULATION POLICY

INFORMATION, DATA COLLECTION AND ANALYSIS

The assessment of demographic patterns carried in the South African Health Review of 1995 presented a number of key recommendations. The first was "to improve demographic data in South Africa"; the second to "establish a population policy which integrates population structures and trends into a wider framework for national development".[1] This chapter considers developments in relation to these two areas over the past year. Although there is hardly any new data, a synopsis of the most significant demographic characteristics is presented.

The recurrent theme in considering demographic trends is the lack of accurate and comprehensive data. Effective systems for ongoing demographic data collection, analysis and dissemination have yet to be developed. During 1995, preparation for both the 1996 census and a Demographic and Health Survey began, while the annual October Household Survey was in its second year. These are intended to lay the foundation for the collection of national statistics and for ongoing demographic monitoring. A number of additional processes sought to address the problem of poor information, including: a national consultative process on population policy facilitated by the Department of Welfare and Population Development; a national and provincial government co-ordinating process to develop a National Information Programme, facilitated by the RDP; and a series of national meetings amongst academic departments to develop a process for building demographic training and research capacity in South Africa.

The census

Process

As a result of questionable methodologies and suspicions towards previous censuses, 1995 saw substantial consultation and preparation for the 1996 census. Much of 1995 was spent trying not only to resolve the content of the census, but the mechanisms which will be used for data gathering and analysis, in order to ensure that the census meets the needs of the provinces and that they have the capacity to conduct and to use the census effectively.

Content

One of the most complex questions was the role of the provinces in identifying information needs, and in conducting the census. Provinces seek more involvement in this process compared to previous censuses, in which the national Central Statistical Services (CSS) took full responsibility.

Matters arising

The 1996 census poses a challenge to government to ensure that people get involved in the census, and fill in the forms! This done, the second challenge is to make the data accessible. This applies not only to the raw data, but to its interpretation. In the past, the CSS has not presented the data in a manner that can be used by departments, or civil society, for planning purposes. Whether this is their role, or that of a separate unit responsible for data interpretation and policy analysis is unclear. This begs the question of the role of population units presently in the departments responsible for welfare and population, in analysing this data - an issue at the heart of the population policy debate.

Author : Barbara Klugman

The demographic and health survey

Process

A Demographic and Health Survey (DHS) is being planned for 1997. It is being spearheaded by the Department of Health who have asked the Medical Research Council to co-ordinate the process. They, in turn have approached the Human Sciences Research Council to become involved. The possibility of linking the DHS to the October Household Survey by using the same sample every five years is under discussion. There is already agreement to ensure shared definitions across all of these surveys so that the data is mutually comparable.

Content

The DHS will be based on the standard DHS used in many developing countries and funded by USAID. The intention, however, is to ensure that the findings meet South African needs - in particular, to provide a data base for health services and population-related development planning.[2] To this end, Provincial Health and Welfare Departments are being visited and a technical committee has been established to formulate the questions through extensive consultation with government, academic and NGO sectors. A decision has already been made to incorporate a range of adolescent and adult health and sexuality questions.[3] Additional questions related to chronic diseases, injury and violence will be added to the DHS.[2]

Matters arising

One of the criticisms of the conventional DHS is its focus on women. This issue is starting to emerge in debate in South Africa.[4] For example, the Green Paper on population policy asks the question, "Should South Africa set goals and time frames specifically in relation to fertility levels, that is, the average number of children a woman or man should have?"[5] Definition of fertility on the basis of women's behaviour and women's ideal family size, tends to direct interventions towards influencing women's behaviour. This can obscure the fundamentally gendered nature of fertility behaviour. For example, the oppression of women requires interventions which improve women's socio-economic status and encourage men to take greater domestic responsibility, rather than exclusive reliance on the provision of contraception. The possibility of interviewing men is under discussion, and should certainly be encouraged.[2]

Another positive decision is the intention to disaggregate information in terms of the old 'population groups', since they have served as proxies for socio-economic status. In the short- to medium-term, it is essential to maintain these categories so that changes in key indicators of quality of life can be measured. At the same time, more accurate measures of socio-economic status need to be developed.

National Information Programme

Process

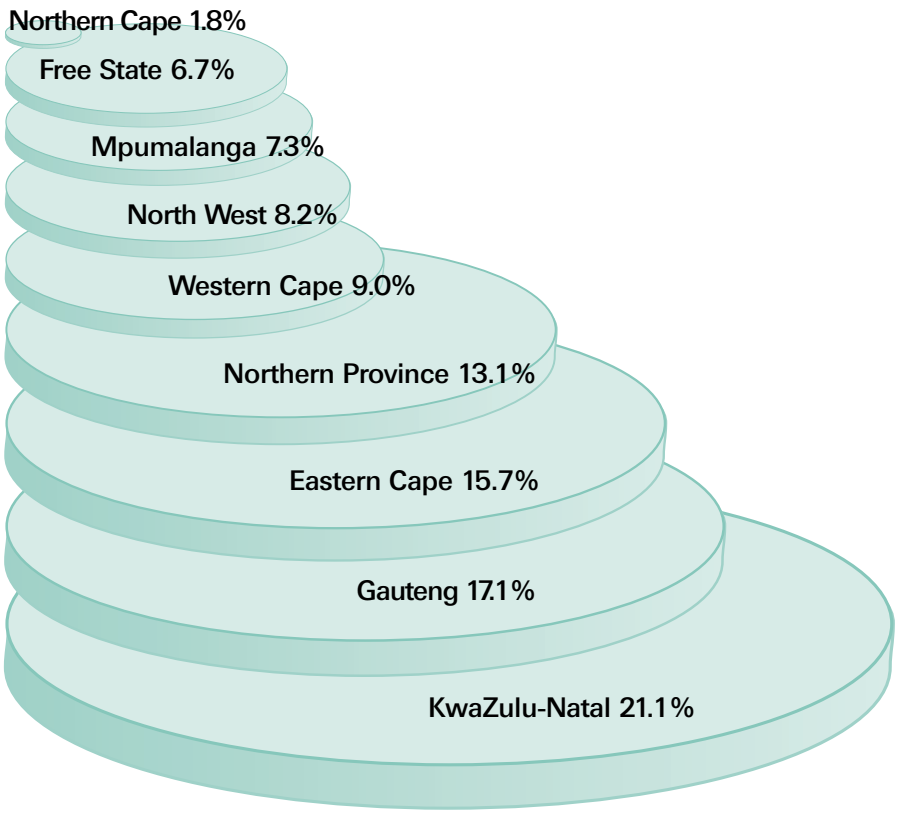
The RDP spearheaded the development of a National Information Programme. During 1995, programme personnel worked with departments in developing data models for their strategic planning. The next stage is to determine the point at which these different models can be integrated to support the delivery of development programmes, particularly at the local level. For example, access to coherent, quick and reliable information at local level for crime prevention requires that the data systems of the departments of justice, welfare, correctional services and safety and security communicate with each other; and the departments of health, housing and water affairs should be able to interlink to ensure effective planning, delivery and monitoring of safe water supply.

Matters arising

The RDP had defined its role as facilitating this process of ensuring interlinkages. They did not, however, have their own technical staff, and were reliant on consultants for this purpose. Problems thus arose not out of inefficiency, but rather the contested role of the RDP. The Public Service Commission (PSC) is mandated to provide standard definitions and guidelines for systems development within government departments. The Department of Arts, Culture, Science and Technology has set up an interdepartmental committee known as 'Networking 2000', also to ensure effective systems of interlinking. Since the PSC has never managed to ensure effective systems of data collection and communication, and is widely recognised as limiting rather than facilitating the development of new

and efficient approaches to governance, it would be more appropriate to redirect this role to another department. With the closure of the RDP ministry, and unresolved debate about the merits of a separate planning ministry, this issue has yet to be adequately addressed. Until this issue is resolved, there remains no body mandated to ensure intersectoral collaboration in order to have an effective national information programme.

FIGURE 1.1 POPULATION BY PROVINCE (as a percentage of total population)



Source: CSS. RSA Statistics in brief. Pretoria 1995

POPULATION POLICY

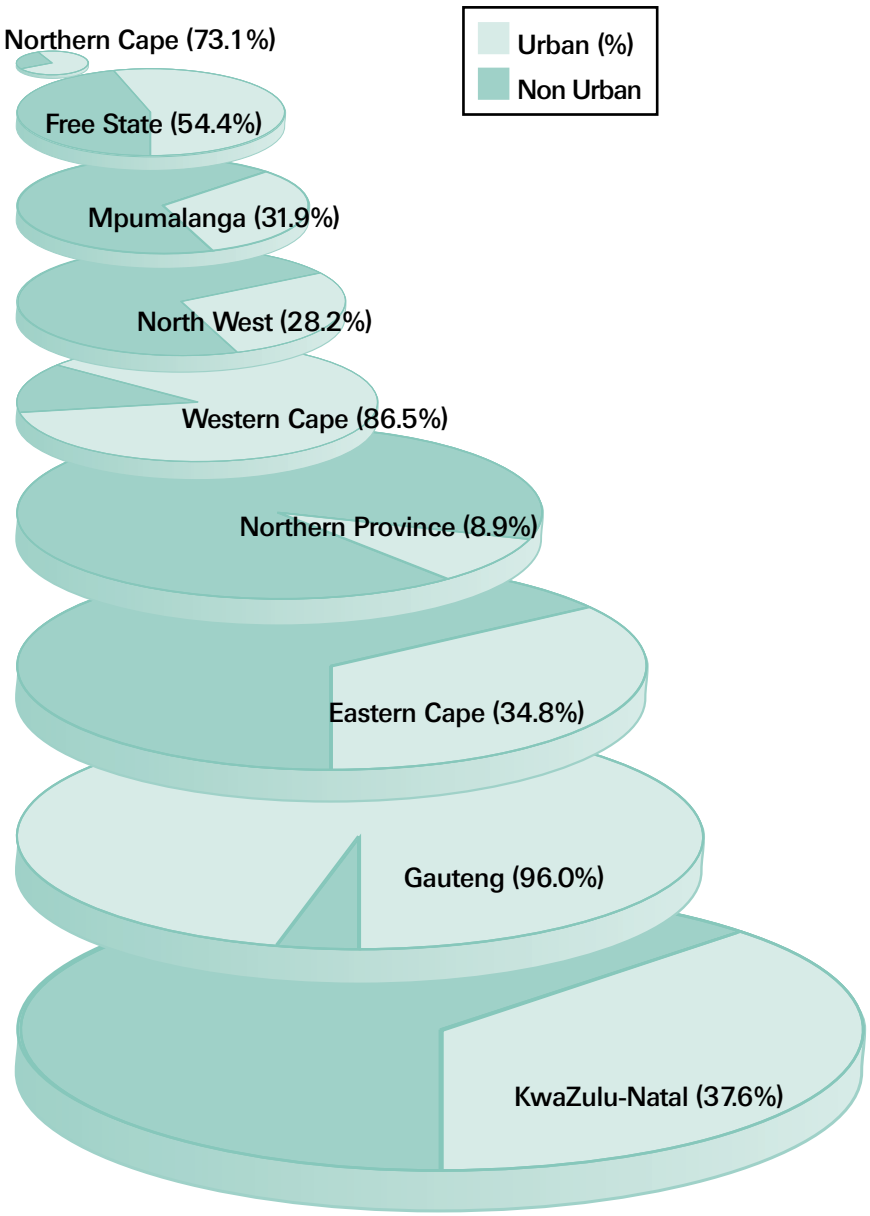
Population policies during the apartheid era were reflective of the racist policies of that government. The focus was on controlling the movement of the population, and reducing the fertility rate of the black population. Motivation for both policies stemmed from the promotion of quality of life and access to resources for whites at the expense of black South Africans. This highly ideological approach to demographic processes makes it imperative to develop a completely new approach.

Process

The Ministry of Welfare and Population Development took up this challenge in early 1995 by publishing "A Green Paper for Public Discussion: A Population Policy for South Africa?" to elicit public opinion on the question of population policy.

The process of consultation, using the Green Paper as a basis, was extensive. Workshops were advertised in every province, and over 34 000 copies were distributed to NGOs, community organisations, the private sector, academic institutions and government. The Green Papers were made available in six South African languages. The 739 submissions on the Green Paper reflected a wide diversity of responses, some of which were from group workshops rather than individuals.

FIGURE 1.2 URBAN AND NON-URBAN POPULATION BY PROVINCE, 1993



Source: CSS. RSA Statistics in brief. Pretoria 1995

A working group, comprising experts from civil society, and representatives of the population units at provincial and national levels, analysed the submissions to the Green Paper and presented a report of the findings to the national and provincial ministers responsible for welfare and population. They also presented an outline of their approach to population policy. The Ministry of Welfare and Population Development accepted this approach, since it was consistent with the inputs from the public submissions, the Chief Directorate Population Development, and international consensus on population policy, as reflected in the Programme of Action of the International Conference on Population and Development. This approach was then presented to all cabinet ministers; they and the policy directorates of all relevant government departments were asked to give input into the development of a white paper. On the basis of these findings, and an assessment of demographic trends in South Africa, the working group developed a draft discussion document, which was to form the substance of a white paper.

This document was reviewed in a national workshop including representatives of most government departments, the health and welfare parliamentary portfolio committees, experts from civil society, including academics and NGOs, and representatives from World Health Organisation (WHO) and United Nations Fund for Population Activities (UNFPA). From this meeting, and ongoing consultations with demographers, a white paper was developed and was to have gone for Cabinet approval as a draft for public input at the time of publication.

FIGURE 1.3 GENDER STRUCTURE OF THE POPULATION, 1993

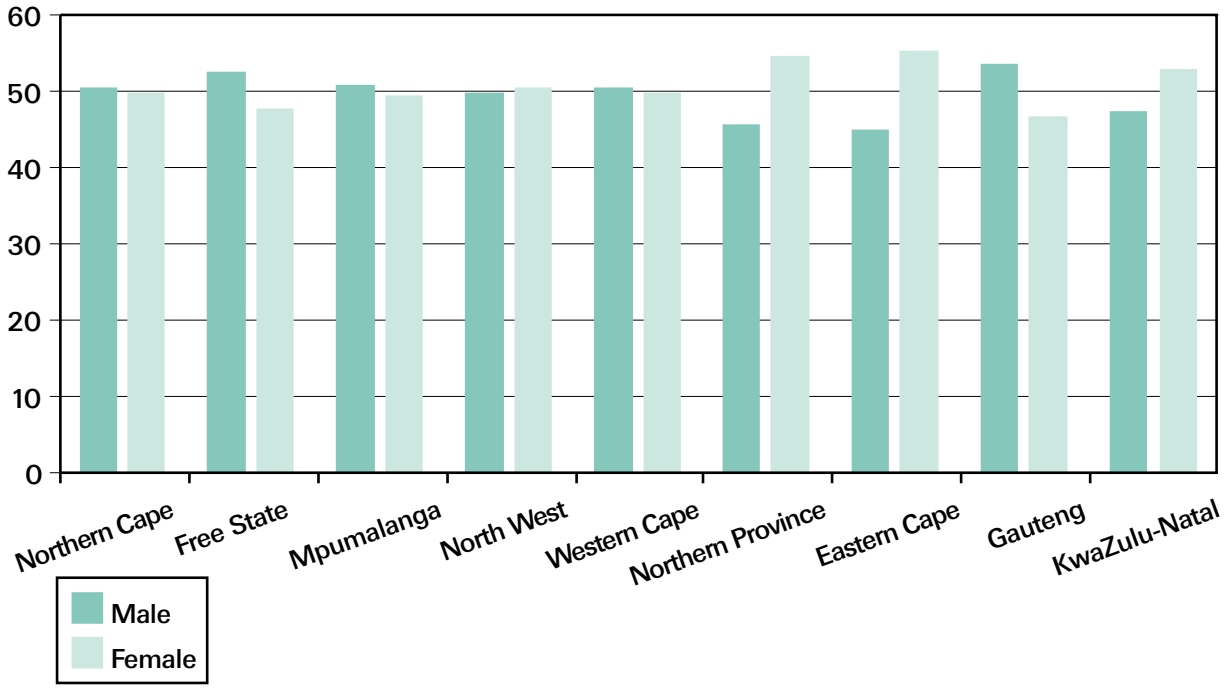


TABLE 1.1 THE RACIAL COMPOSITION OF THE SOUTH AFRICAN POPULATION AND GROWTH RATES, 1995

Racial Group	Number (000s)	% of SA population	1991-95 rate of growth Average annual %
African	31 461	76.3	2.4
Coloured	3 508	8.5	1.4
Indian	1 051	2.5	1.4
Whites	5 224	12.7	0.7
Total	**41 244**	**100**	**2.1**

Source: CSS. RSA Statistics in brief. Pretoria 1995

Matters arising

The Green Paper drew heavily on the Programme of Action of the International Conference on Population and Development (ICDP) in order to provide a stamp of international and technical authority on the process. This approach, developed by a working group set up by the Ministry, was no doubt considered a 'safe' option in the context of a politically divided Ministry (with a Minister from the National Party and a Deputy Minister from the ANC), to avoid getting trapped within the ideological arguments which had informed previous policy. The Ministry has, however, been criticised for using international conventions rather than the RDP and interim constitution as its base.[6] Although the Green Paper did ask whether a distinct population policy was necessary, this was almost a foregone conclusion. This may not have been the case had the Ministry itself not been politically divided. At the time, the ANC's own position on population policy was for an entirely integrated approach with demographic trends used as indicators of improvements resulting from the national development programme in all sectors, rather than setting up an additional population policy with programmes and indicators re-articulated in relation to demographic trends.[7]

The discussion document on population policy represents the triumph of logic over conventional wisdom. Despite the fact that the emphasis on fertility reduction as the primary means of addressing poverty arose out of an imperialist and racist agenda, adherence to this viewpoint is widespread in South Africa. Just as pervasive is the view, not corroborated by national or international experience, that family planning programmes can, on their own, lower the fertility rate. These perspectives have long been challenged by demographers, and have now been dispelled in the Programme of Action

FIGURE 1.4 AGE - SEX COMPOSITION OF THE POPULATION

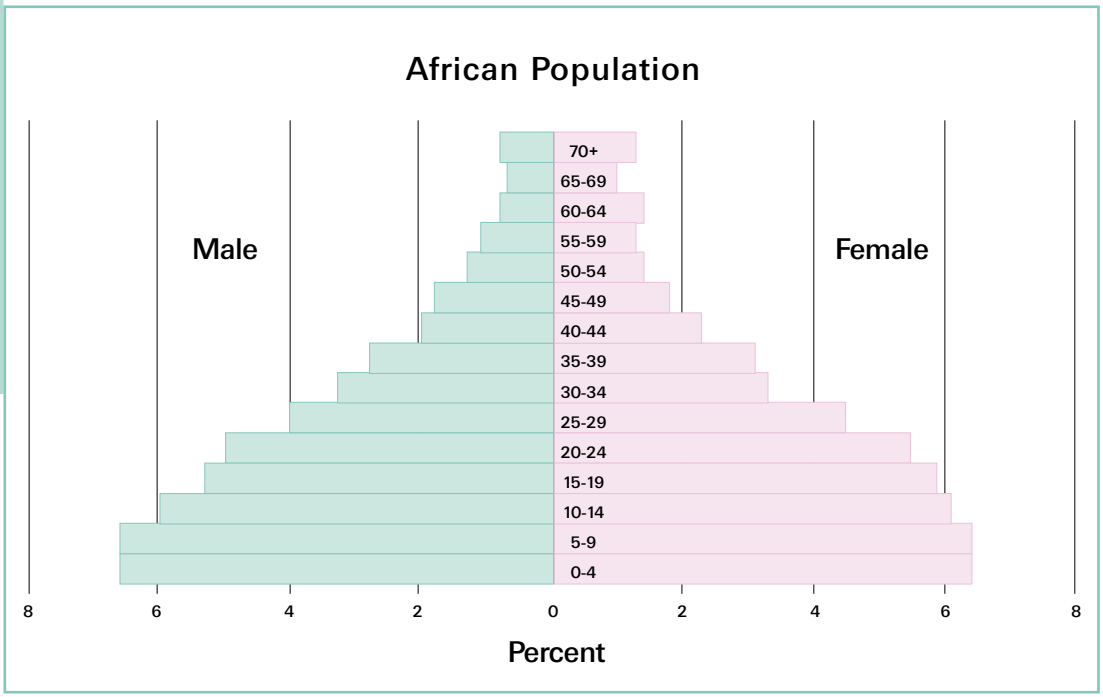


FIGURE 1.5 AGE - SEX COMPOSITION OF THE POPULATION

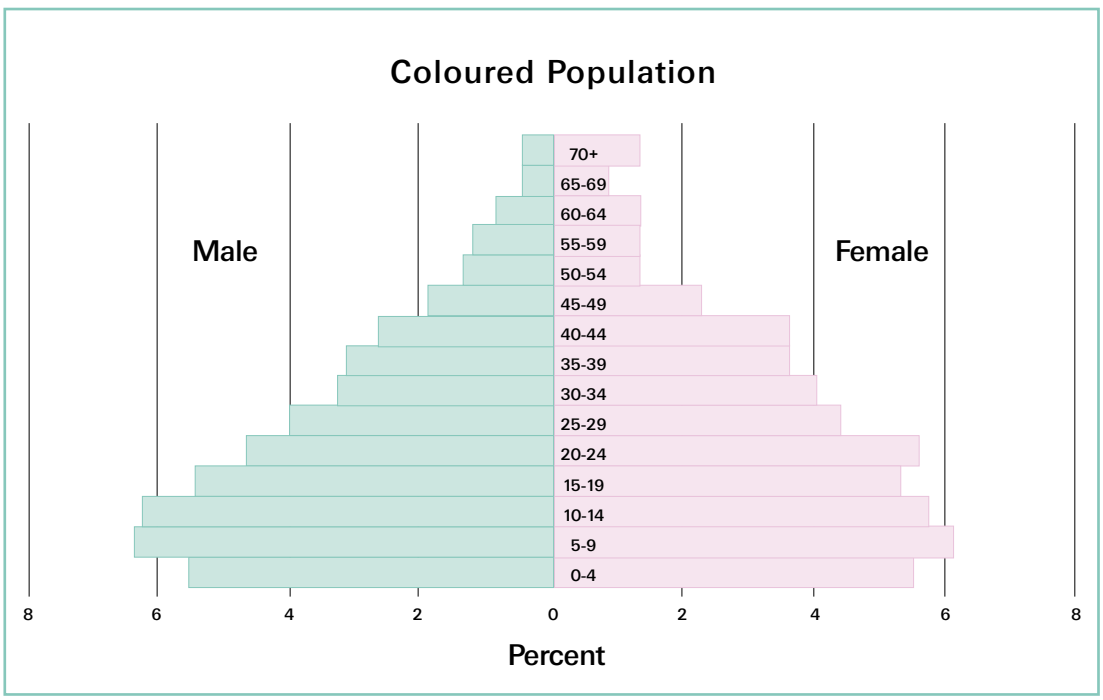


FIGURE 1.6 AGE - SEX COMPOSITION OF THE POPULATION

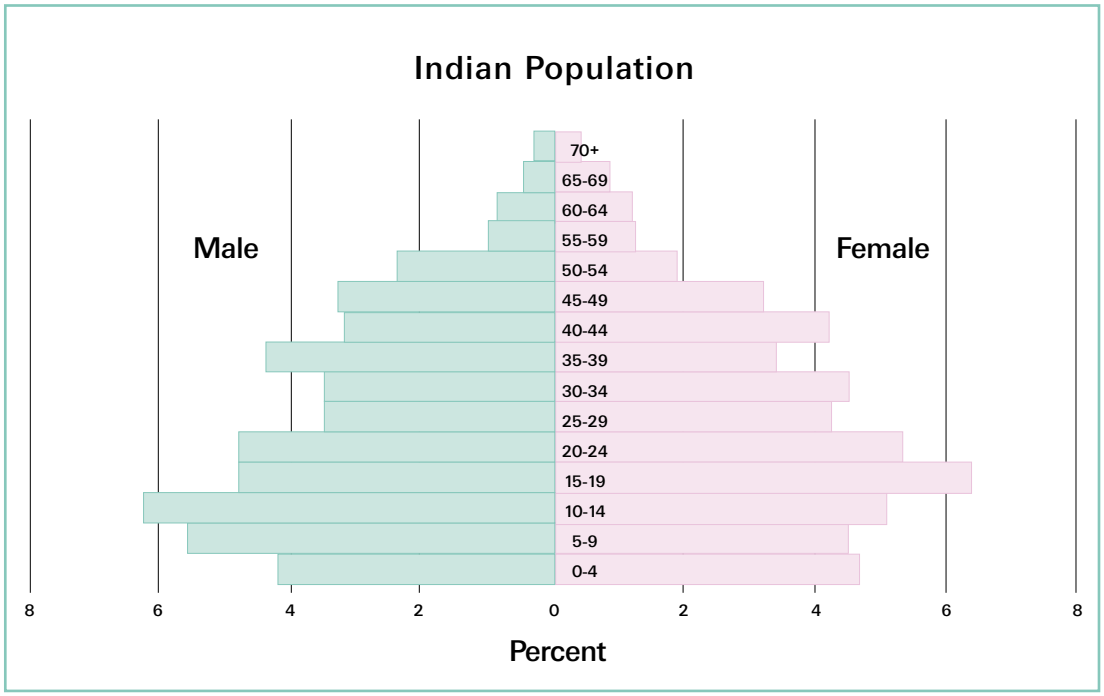
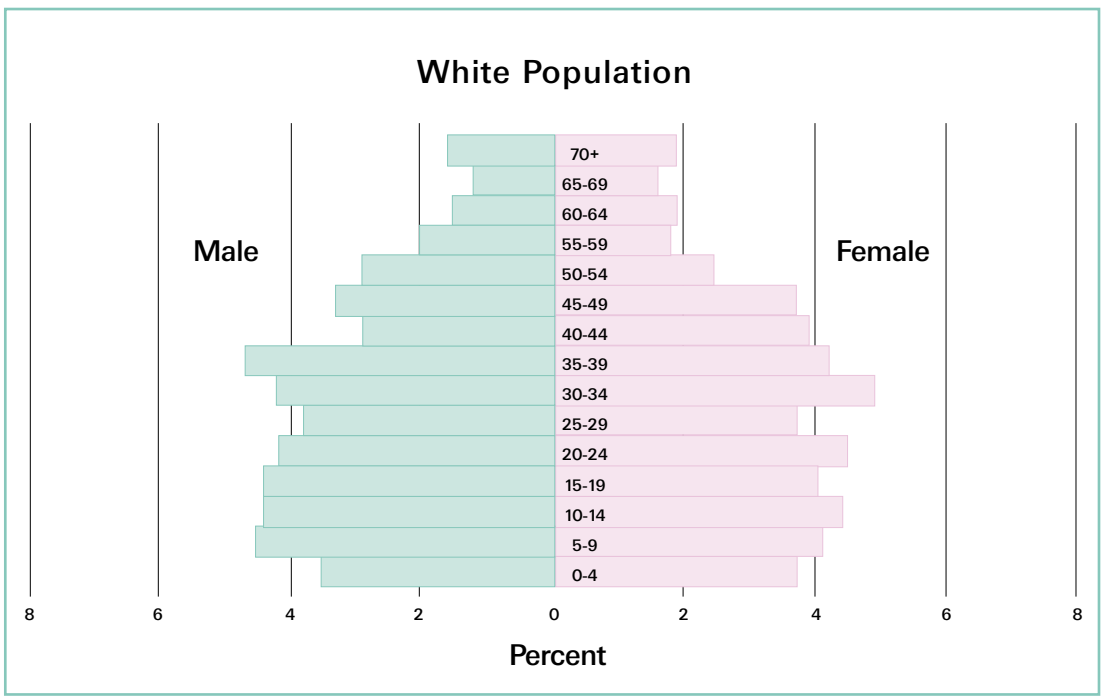


FIGURE 1.7 AGE - SEX COMPOSITION OF THE POPULATION



Source: Mazur R. Population structure, fertility and childhood mortality in South Africa: Lessons to be learnt from analysis of the poverty survey. MRC, Tygerberg. 1995

of the ICDP. Discussions around the Green Paper have enabled people in South Africa to develop a new understanding of population dynamics. The new policy will be derived from an analysis of the underlying causes of all three demographic variables: fertility, mortality and migration. Programmes to address the identified problems will include promotion of sexual and reproductive rights and health, as well as other equally critical programmes such as promotion of education, employment and gender equity.

The only unresolved question is the actual location of the population units which would monitor the implementation of the population policy. The most logical step would be to move the units from the Department of Welfare, which is only one actor in the population scenario, and set them up in a planning division, probably in the President's office - whether independently or parallel to the CSS and Central Economic Advisory Services. This seems to be the optimal placement for a unit responsible for analysing and interpreting demographic data, and using this to monitor population policy as part of monitoring the overall development programme.

BUILDING TRAINING AND RESEARCH CAPACITY

The issue

One of the most striking problems in the population policy debate is the absence of credible research on the issues. The absence of good data is the first stumbling block, since it is only possible to describe broad trends. Priorities are based on a combination of weak data and self-evident problems, such as teenage pregnancy or impoverished environments as a result of the 'homeland' policies. Solutions to these problems, that is the best possible policy options, must again be posited from international experience and self-evident actions. There is, however, very little local research identifying the nature of interventions which have the greatest impact on demographic trends, or, indeed, on quality of life. For example, while we know that women's employment is a key factor in improving family health and overall well-being and fostering reproductive choices, we do not know whether specific kinds of employment make differential impacts. It is this kind of information which should be informing education, training and job creation programmes. This is symptomatic of the lack of an overall research framework related to gender and development - an issue which should be seriously considered in processes of prioritising new research.

Process

The absence of adequate research for use in planning and monitoring partly reflects historical agendas, but more substantially a lack of research expertise in demography and related fields in South Africa. During 1995, two meetings were held by demographers and other academics from different universities to strategise how best to build research capacity in the field of 'population'. This rather odd terminology is used internationally to refer to the wide range of disciplines and issues which relate to demographic trends. A steering committee was established to ascertain the need for people with 'population' specialisations particularly in government, but also in educational institutions and the private sector. The outcome of this research will be used to identify and plan strategies to ensure that training in the relevant disciplines is available, drawing on the wide range of existing expertise in the country.

One of the explicit objectives of the Demographic and Health Survey, is "to build research capacity of the organisations involved eg. provincial departments of health . . . in planning and implementing a survey". This may be an appropriate focal point for not only conducting and analysing the DHS, but for developing mechanisms for monitoring demographic changes and using this information to plan and assess programmes.

CONCLUSION

The past year has been a time of preparation - for new population policy, for the census and the DHS, and for increasing population-related research and training capacity. To some extent, progress has been trapped by political and bureaucratic processes. The year ahead should reveal far greater clarity with regard to population policy. Certainly, the Census and Demographic and Health Survey will add enormously to our knowledge of the people of South Africa.

2 SOCIO-ECONOMIC CONTEXT OF HEALTH

INTRODUCTION

The status of health among South Africans today, is both a product of development of the past and an input into development effort for the future. For this reason, the level of health, and the ensuing quality and longevity of life, is as much an outcome of development efforts as it is an ingredient necessary for the implementation of sustainable development programmes.

Internationally, the world community has devised frameworks for sustainable development which place health at the centre of development. Recent United Nations' Plans of Action and Declarations emanating out of development conferences have highlighted the interrelationship between health and other socio-economic factors.[1]These include the International Conference on Population and Population (ICPD) which brought about the Cairo Plan of Action, and the Social Development Summit.[2] Since the installation of the Government of National Unity in 1994, operating with a general policy framework of the Reconstruction and Development Programme, policies and programmes with positive implications for the health status of the country, have been put in place. This has reinforced the nexus between health and other factors in development, but has also highlighted areas of eminent policy discord. For example, the government has committed itself to equity in the development of health policy and the delivery of services. But the closure of the RDP office has been seen by many as an abandonment of the integrated development approach.

Despite these apparent contradictions, clarity regarding the government's macro-economic, labour market, and social development policies has began to emerge. The release of the government's Growth, Employment and Redistribution Strategy, the Labour Market Commission Report and even the closure of the RDP office represent significant consolidation of the government's policy direction. This chapter reviews significant developments in the economy, poverty, water and sanitation, education, welfare, and housing sectors - all of which affect health services and the health status of people in South Africa.

The White Paper on Reconstruction and Development highlighted the centrality of developing and collecting appropriate information to monitor effectiveness of government policies and programmes in the battle against poverty and deprivation.[3] More South African researchers, research organisations, and policy institutes are taking up the challenge of providing comprehensive information and policy proposals to the government and the country. The revamped Central Statistical Services (CSS) has introduced new surveys and reports, while also improving on old reports.

Government efforts to improve the quality of available data are evidenced in reports such as the October Household Survey of 1994 and that of 1995; the Human Development Index Report of 1995; and Key Indicators of Poverty in South Africa.[4, 5, 6] Non-governmental and parastatal research organisations have made strides in this effort, with the release of publications such as the National Household Survey of Health Inequalities in South Africa.[7]

ECONOMIC FACTORS

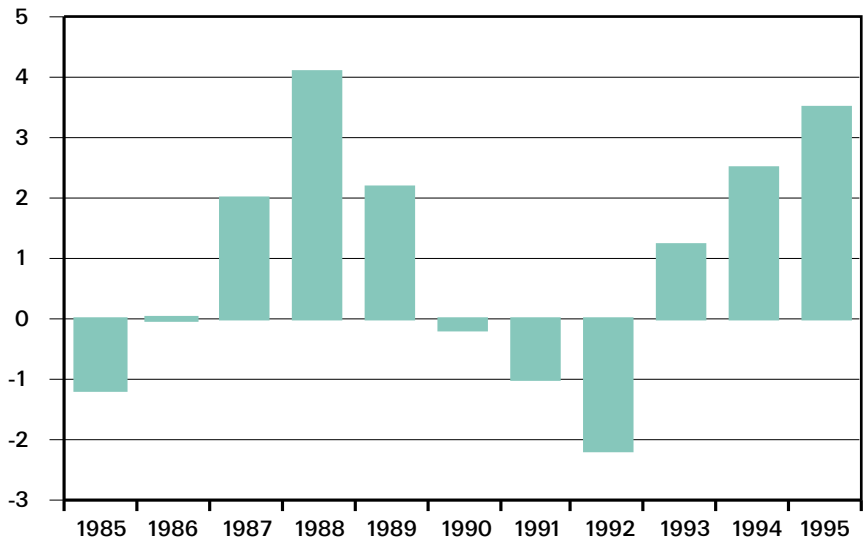
The United Nations' Human Development Report of 1996, which adopted the theme "Growth and Human Development" states that "economic growth has the potential to enhance human capabilities and enlarge people's choices."[8] It further argues that for this potential to be realised, there must be a steady expansion of opportunities to enable people to make improved choices.

Authors : Benny Mokaba and Mmankgabe Bambo

Economic growth

The prospect and onset of democratic government in South Africa brought about a reversal of the negative real economic growth that had characterised the country's economy for much of the last decade. The growth in real Gross Domestic Product in 1995 was estimated at between 2.5% and 3.5% - the highest since 1988.[9]

FIGURE 2.1 ECONOMIC GROWTH 1985 - 1995



Source: Republic of South Africa 1996 Budget

This remarkable change in economic growth is primarily a result of higher demand in the manufacturing sector both locally and abroad, with real value added by manufacturing increasing by 7.5% in 1995 as compared with 2.5% the year before.

The Government's Growth, Employment and Redistribution Macro-economic Strategy (GEARS), released during June 1996, has clarified government policy, and was heralded as the solution that the country needed. It projected a GDP growth rate of 3.5% in 1996, dipping to 2.9% in 1997, but rising constantly to a targeted 6.1% in 2000.[10] These estimates have been challenged by various stakeholders such as the Congress of South African Trade Unions (COSATU), which argue that the strategy of reducing inflation through lower wage increases and public expenditure, shortchanges the poor.

Fluctuation of the value of the Rand

These positive changes are tempered primarily by the fluctuations in the value of the Rand compared to other currencies beginning in February 1996 and continuing up until the time of publication. The initial decline in the value of the Rand from its pre-February 1996 value of R3.90 to the American Dollar demonstrated the vulnerability of the post-1994 economic boomlet. This decline is likely to have negative effects on the growth rate of the economy and on the quality of health services that the country can afford. The GEARS acknowledges that "the recent exchange rate instability presents further complication. There is a danger of a further capital outflow and a balance of payment crisis".[10] This could lead to an abrupt curtailment of economic growth expectations.

Income and poverty

As a result of many years of apartheid policies, racial income disparities among South Africa are among the highest in the world. Even with a government committed to redressing past imbalances, such disparities will remain for years to come. The RDP's primary purpose was to jump-start government effort to alleviate such disparities.

TABLE 2.1. INEQUALITY: SOUTH AFRICA AND COMPARABLE COUNTRIES

Measure	Middle Income Countries					
	Tunisia	Thailand	Poland	Chile	South Africa	Brazil
GNP per capita[1] ($)	1 720	1 840	1 910	2 730	2 670	2 770
Gini co-efficient[2]	0.04	0.43	0.27	0.58	0.61	0.63
% Poor[1,2]	2.9	10.4	9.3	15.6	22.1	31.1

Sources: 1 Adapted from South African Health Review 1995
2 RDP Office. South Africa Key Indicators of Poverty in South Africa, 1995

To achieve this task, the government required extensive data to determine the magnitude and causes of poverty and the location of poor people in the country. Momentum towards quality information was enhanced in 1995, with the release by the RDP Office of "Key Indicators of Poverty in South Africa", and the Human Sciences Research Council's profile of "Poverty, Inequality and Human Development". These studies confirm the following:

- Among middle income countries, South Africa has the highest income inequalities in the world, comparable only to Chile and Brazil, both of which were former dictatorships (see Table 2.1).
- Africans carry the most burden of poverty, bearing the highest negative (or undesirable) indicators and the lowest desirable indicators. For example, Africans and African households have the lowest income of all race groups in the country and the highest percentage of households and individuals in poverty (Table 2.2).
- Women bear much of the brunt of inequality and poverty. Women constitute a larger and larger proportion of people in poverty.
- There are serious disparities among provinces and between rural and urban areas of the country, with rural areas and provinces with larger percentages of rural settlements faring worse than urban provinces.[7]

TABLE 2.2. RACE COMPARISON ON KEY POVERTY AND HUMAN DEVELOPMENT INDICATORS

Poverty Indicators	Race Group				
	Whites	Coloureds	Indians	African	Total
% Household income (ZAR)[1]	3 544	1 474	2 679	679	1 359
% Household in poverty[2]	2.1	18.5	6.2	47.2	35.2
% Individuals in poverty[3]	2.1	19.8	6.8	57.2	45.7
Human Development Index[2,3]	0.897	0.663	0.836	0.500	0.677

Sources: 1 CASE/Kaiser Family Foundation. A National Household Survey of Health Inequalities in South Africa 1995
2 Whitehead et al. A Profile of Poverty, Inequality and Human Development 1995
3 SALDRU/World Bank Project for Statistics on Living Standards and Development 1993

Employment

While the economy experienced real growth in 1995, employment conditions remain less responsive to such changes. The estimated 55 500 new jobs that were created in the formal non-agricultural sectors did not alleviate the chronic unemployment experienced by this country. An unemployment rate of about 40% of Economically Active Persons (EAP) was sustained despite government intervention in the form of public works and the implementation of the RDP.[11] Employment figures remain most controversial, largely as a result of varying definitions of "employment". A recent International Labour Organisation (ILO) report indicated that South Africa's unemployment may be as low as 20%. Suffice it to note President Mandela's conclusion that "despite the welcome growth, very few jobs have been created. In fact, against the backdrop of new entrants into the job market, there has been a shrinkage in work opportunities."[12]

SOCIAL WELFARE SERVICES AND SOCIAL SECURITY

Two years after the establishment of the RDP office, it is apparent that the primary task of social development and the redress of past imbalances demands far more resources. High levels of unemployment continue to jeopardise the Unemployment Insurance Fund, even with shrewd management by the new Department of Labour. New legislation in this regard is expected to revolutionise unemployment insurance. Nevertheless, non-contributory social welfare services and social pensions remain central mechanisms for poverty alleviation and sound development.

There have been substantial increases in the welfare budget in recent years, due largely to the achievement of parity in payments of social grants. In 1995/96, the national welfare budget amounted to R13.4 billion, which is 8.7% of the consolidated national budget and 2.7% of Gross Domestic Product. The welfare budget has two main components, social security and welfare services. Social security is dominant, while welfare services are underfunded - amounting to only 8%. Eighty seven percent of the social welfare services budget is spent on institutional care which is costly and not always appropriate.

Social welfare services

The new Welfare Policy aims to promote human capacity and self-reliance among all people in a caring and enabling society. The primary focus will be on development and the building of institutional capacity where required. The national and provincial departments of welfare are working on a five year national plan of action to implement the Draft White Paper. The plan will target the 40% of the population who are the poorest and most in need of assistance and social support. Its priorities will include a National Plan of Action to rebuild families, children and youth; poverty reduction programmes; tackling the abuse of women and empowering them economically; fighting alcohol and drug abuse; addressing the impact of chronic illnesses and HIV/AIDS; and promoting the needs and rights of the elderly, and people with physical and mental disabilities. Concerted effort will be made to develop community-based care programmes, and institutional care will only be used where appropriate.

Family and child welfare services will seek to preserve and strengthen families so that they can provide a suitable environment for the physical, emotional and social development of children. Families in need of special support will be offered the necessary assistance and family-centred community-based programmes will be developed in rural areas and under-serviced urban settlements.

A National Programme of Action for South African families, children and youth is being developed. Programmes will be developed in partnership with all stakeholders and will address the need for life skills training, families life enrichment, parenting and other appropriate programmes. Recognising the crisis in the child and youth care system, and the need for fundamental overhaul, the Cabinet agreed to set up an Interministerial Committee (IMC) on young people at risk. The committee is made up of seven national non-governmental organisations and eight government ministries. The Minister for Welfare and Population Development, Ms Geraldine Fraser-Moleketi, chairs the committee nationally and the respective welfare departments chair the provincial committees.

The Department of Welfare announced a flagship programme targeted at unemployed women with children under five years of age. The pilot programme is intended to provide disadvantaged women with jobs and job-related training, while their children receive appropriate education to give them a head start in learning.

Social security

The non-contributory social pension which includes, among others, Old Age Pensions, Disability Pensions (or Grants), and Veterans Pensions recently received a long-awaited boost with the promulgation of new regulation in March 1996.[13] These regulations, made in the spirit of the draft white paper on social welfare, sought to increase access to those that qualify and to reduce fraud and waste through a more stringent means test.[14]

A committee was established by the Department of Welfare under the leadership of Ms Francie Lund to investigate the child maintenance system. This committee undertook a critical appraisal of the existing system of state support to children and families, in all government departments. It was also tasked with investigating the feasibility of increased parental financial support through the private maintenance system; identifying alternative policy options in relation to social security for

children and families as well as other anti-poverty, economic empowerment and capacity building strategies; and developing approaches for effective targeting of programmes for children and families. The report was released publicly on 18 September 1996.[15]

EDUCATION AND TRAINING

Education, especially primary and secondary level education is recognised world-wide as a prerequisite for sustainable development.[1,2] The CASE/Kaiser Family Foundation study found that 92% of persons responsible for household health care were women. Among Africans, 57% had attained standard five education or less, compared with 50% among coloureds, 22% among Indians, and one percent among whites. One in five caregivers in African households had received no formal education whatsoever.[7]

The budget for the national Department of Education for 1996/7 amounted to R5.5 billion, compared with a revised estimate of R4.3 billion last year. This provides for significant increases in the subsidies to universities and technikons, which should help stabilise their financial circumstances. Amounts of R100 million for universities and R50 million for technikons have been earmarked for the erection of new buildings. In addition, an amount of R300 million has been set aside for a national student financial assistance scheme. This allocation is intended to relieve the plight of financially disadvantaged students.

INFRASTRUCTURE AND SERVICES

Access to infrastructure and services such as water and sanitation, electricity and land have direct effects on health. The RDP focuses on such services and has kick-started implementation in various areas. The Municipal Infrastructure Investment Framework (MIIF) estimates the service backlog for all municipal areas throughout South Africa, considers the affordability of overcoming the backlogs and proposes the financial mechanisms that should be used for this purpose. It also recommends the institutional arrangements necessary to improve the delivery of services.

The significance of the MIIF arises from three inter-related facts. First, 65% of the population is located in cities and towns, but these cities and towns embody all the vestiges of apartheid. Areas previously designated for Africans, Indians and coloureds generally have inadequate services and housing, and are isolated from economic opportunities. Second, 80% of the country's economic output originates in the cities, but the inefficiencies of the 'apartheid city' mean that economic growth is impeded. Third, improved infrastructure will make a positive contribution to the environment, and to the health of the poor. It is the poor who lack clean water and who live in unsanitary surroundings, which means that they have more health problems and fewer employment opportunities. In sum, the delivery of services will improve access to basic needs, enhance the health profile of the poor and their access to employment opportunities, and contribute to both employment creation and government revenue (which in turn can be used for delivering additional infrastructure and social services).

The MIIF reports that, in respect of all people living in formal and informal urban areas:

- approximately 4 million people (15%) have access only to water which is untreated and not reticulated
- about 8 million people (30%) only have access to minimal sanitation (i.e. either shared toilet facilities and/or unimproved pit latrines)
- an estimated 17 million people (65%) do not have access to electricity
- another 8 million people do not have formal road access to their residence, nor any form of storm water runoff.

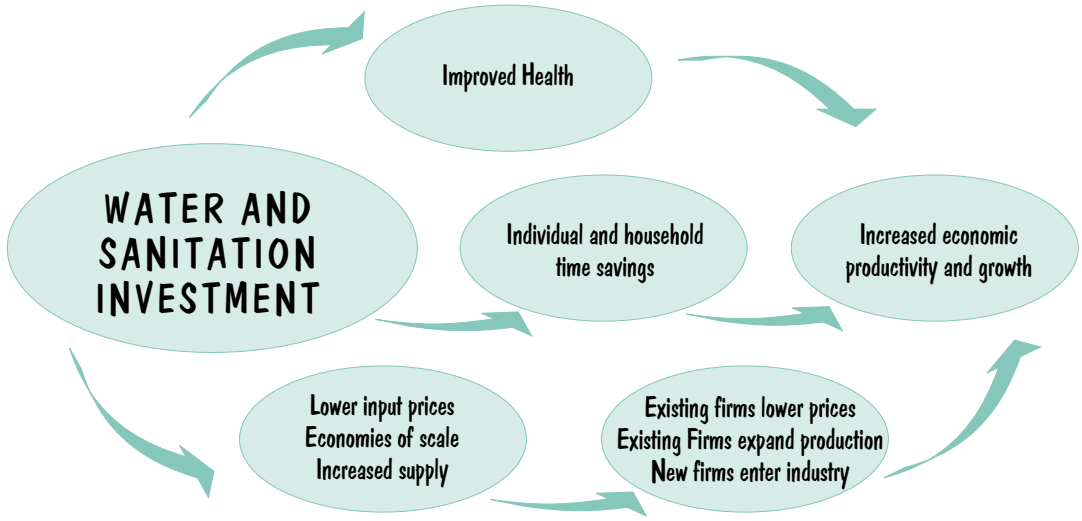
The MIIF further estimates that new demands for services arising from the growth in the urban population constitute an additional 150 000 new households a year - and in a decade's time will be adding 190 000 households a year. In ten years' time, the number of new households will equal about a third of the present population.

Water, Sanitation and Health

Clean and sufficient quantity of water together with the adequate disposal of human excreta is a necessary but not sufficient condition for health in the home environment. The minimum amount of water regarded as necessary for the maintenance of health is 20 litres per capita per day.[16] Many diseases may result from poor sanitation and/or hygienic practice, for example, diarrhoea, intestinal helminth infestation, poliomyelitis, typhoid, schistosomiasis and cholera.

Provision of clean water to communities has been one of the most visible and evidently successful activities of the Reconstruction and Development Programme.[17] Figure 2.2 below illustrates a simplified representation of the effects of investment in water and sanitation on health and economic growth.

FIGURE 2.2 A PATH MODEL OF THE EFFECTS OF INVESTMENT IN WATER AND SANITATION



Source: Palmer Development Group. "Water Supply and Sanitation in South Africa". 25 year vision and costs. Draft 1: June 1994.

Housing

Housing is a vital element in the improvement of the status of health in South Africa. The type and quality of housing contributes to the household's quality and access to other health promoting services such as water and sanitation, and electricity.

Since May 1994 progress has been made in establishing the basis of a new national housing programme and moving towards implementation. A national housing strategy which was formulated, negotiated with the nine provincial governments and relevant non-government constituencies and formally accepted by all relevant stakeholders at the Botshabelo Housing Summit, has been under review to ensure that it is 'implementable'.

New statutory housing boards have been appointed in each province and legislative changes have brought housing policies in line with the new constitutional dispensation. By September 1995, the Provincial Housing Boards had approximately 160 projects (in excess of 200 000 subsidies) country-wide. By December 1995 subsidies worth R122 million were available compared to R47 million in July 1995. Various refinements to subsidy policies were introduced to enable wider application, and an extra (higher) subsidy band of R15 000 per household was implemented for householders earning less than R800 per month.

A Mortgage Indemnity Fund was established and has since assessed over 300 areas and granted indemnity cover of approximately 80% of these areas to participating banks, to facilitate their early re-entry into housing finance in these areas. Furthermore, an agreement was reached with the home-building industry to introduce self-regulation of the industry, standard product warranties and a national warranty fund to back individual warranties issued by accredited home builders who default on such guarantees. The National Home Builders Registration Council is established and has commenced its work.

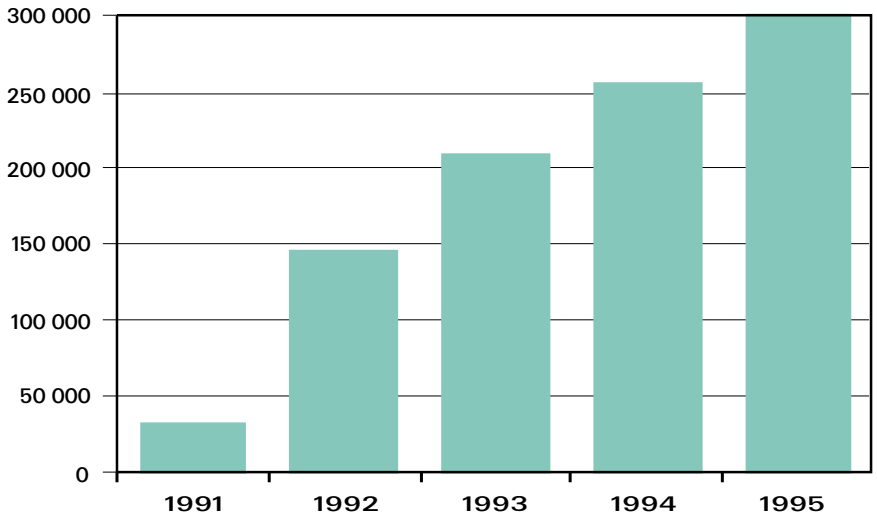
A payment normalisation programme to improve the relationship between lenders and borrowers in instances where borrowers had been living in houses without paying has been negotiated with the banking sector. It is presently targeting 35 to 40 000 cases country-wide.

The Masakhane campaign to improve service delivery and the billing system of local authorities on one hand, and payment for services rendered on the other, has had mixed success. The campaign has been successful in towns such as Butterworth in the Eastern Cape where the payment levels and services delivery have improved drastically.

Electrification

Eskom's electrification programme commenced towards the end of 1990. In 1991, some 31 000 connections were made. At the end of 1994, 44% of the estimated 8.4 million houses in South Africa were electrified. Provided that the electricity supply industry can meet the Reconstruction and Development Programme's electrification targets, 65% of the households in South Africa will have electricity by the year 2000. The 1995 target of 300 000 represents a tenfold increase over the four year period.

FIGURE 2.3 ESKOM'S ANNUAL ELECTRIFICATION PROGRESS



Source: Theron D. Journal of Energy in Southern Africa. November 1995

Given the substantial increase in the number of connections over time, as well as the drive to reduce the costs of electrification, thorough up-front planning has become essential to ensure that the programme is implemented in an effective and efficient manner.

CONCLUSION

Two and a half years after the election of a democratic government, evidence of progress in the implementation of new policies has begun to emerge. For most sectors, the phase of developing new frameworks is gradually being replaced by implementation and service delivery. Policies and programmes put in place in the early months of democratic government are being fine-tuned. The closure of the RDP office is perhaps one of the key indications of this process. But such modification cannot be viewed as an indication of either an abandonment of the RDP nor its failure, but rather a targeting of its objectives.

Major developments during this period, include continued but low economic growth, an adoption of a new macro-economic framework and unstable rand foreign exchange rates. Infrastructural improvements for social development, utility and economic activities have been accepted as crucial for human development. But human development will be affected by the government policy framework on economic growth and redistribution which seeks to reduce real expenditure in social services over time. The challenge for the government will be to maintain acceptable levels of social services such as education, health and welfare despite a declining budget. It still remains to be seen how the implementation of the Growth, Economic and Redistribution Strategy will fulfil the expectations of poor people, whose patience for better services continues to be tried.

The success of social welfare reform should help alleviate poverty. The Lund Committee on Family and Child Support has provided some clarity on poverty reduction among the truly needy. But inevitably , some poor people, especially those that received benefits during the previous dispensation, will get less assistance than they received during the apartheid era.

Improvements in the quality of socio-economic data, especially those relating to the monitoring of poverty and deprivation will facilitate programme targeting. Nonetheless, the country's national data sources are still inadequate to monitor its massive development programme.

The centrality of democracy within the new constitution makes the current development agenda more likely to bring about stability and total human development than ever before. But the magnitude of disparities between rich and poor in South Africa creates special responsibility to ensure that development policies and programmes promote equity, and not just economic growth.

HEALTH STATUS 3

INTRODUCTION

South Africa is going through profound social and political change. The continuing restructuring of the South African health system presents an opportunity to consider new approaches towards a more effective health system. Last year's review of health status illustrated that much of the burden of disease is due to preventable causes of mortality, morbidity and disability.[1] Improvement in these aspects will come about once the inequalities in health care provision are adequately addressed. In this chapter, we keep track on some of the progress that has been made in this regard, and highlight the areas that still need to be addressed.

A prerequisite for a review of the health status of any population is the availability of high quality data. Mortality data are an important source of health information. Though notorious for significantly underestimating the incidence of diseases, notifications data, compiled by the Directorate of Epidemiology of the Department of Health, provide an important source of morbidity data. It is also important to note that all the changes that accompany the process of restructuring and reorganisation of health services have an inevitable effect on the notification process.

Household surveys provide useful supplementary information about the health status of the population. In the past year, these have included the October Household Survey conducted by Central Statistical Services and the National Household Survey of Health Inequalities in South Africa by the Community Agency for Social Enquiry.[2, 3]

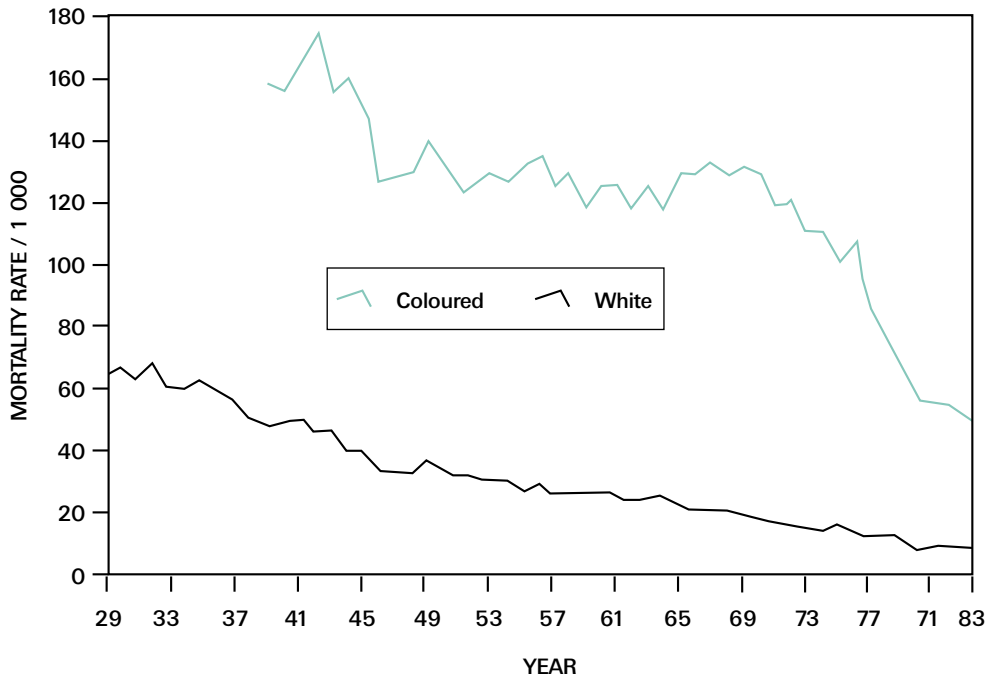
HEALTH TRANSITION

South African society - like many other developing societies, is pre-eminently a society in transition, and this is reflected in its disease and death profiles. During the last century, both childhood and adult mortality declined dramatically (Figure 3.1 and 3.2)[4] Generally, mortality rates have declined as a result of improved incomes, food and living conditions, and access to medical technology. The effects of HIV and tobacco are the only two factors which are expected to oppose this trend.

Typical of the demographic transition, fertility rates have also declined and South Africa can expect to begin to experience an ageing population i.e. proportionally more elderly. However, development is accompanied by an unhealthy lifestyle. In the words of Frenk *et al*, "Many of the emerging illnesses are a result of a defective process of industrialisation that has placed more value on economic growth than on human welfare."[5] Yet the pace of this transition in the different sectors of the population varies significantly. Consequently a mixed profile displaying pre-and post-transitional extremes and intermediate types is evident. Apartheid policies have resulted in a correlation between socio-economic status and population groups and in certain respects, the morbidity and mortality profile of whites and Indians is characteristic of more developed societies as degenerative diseases gain prominence. On the other hand, the disease and death profiles of Africans and coloureds reflect the situation of less developed societies, with a prominence of "social diseases" (deficiency diseases, tuberculosis, gastro intestinal diseases and measles). As in many other middle-income countries, we can expect a co-existence of the poverty related diseases and the diseases related to social development. We can expect a protracted polarised transition with the co-existence of the diseases of the rich and poor.[5] Despite the paucity of the data, analyses of the South African mortality data of 1990 reflected the bi-polar nature of the mortality patterns.[6] In addition, it is evident that injury also plays a disproportionately large role in the burden of disease in South Africa.

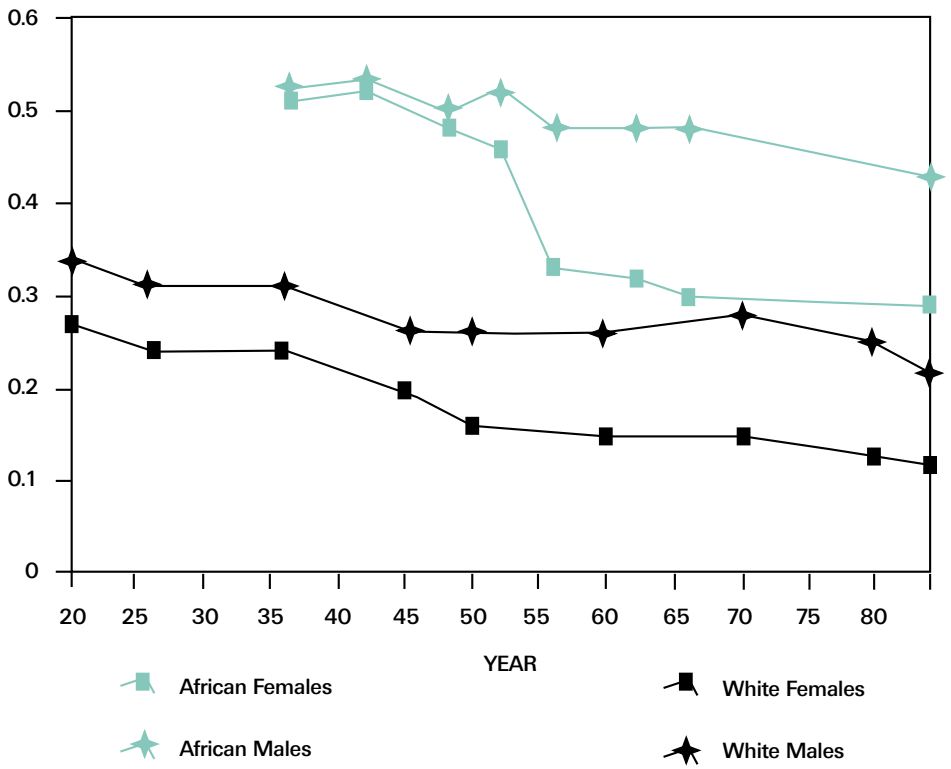
Authors : Debbie Bradshaw and Gcinile Buthelezi

FIGURE 3.1 SECULAR TRENDS OF THE IMR FOR WHITES AND COLOUREDS



Source: Rip, 1988. (Reproduced with permission)

FIGURE 3.2 ESTIMATES OF ADULT MORTALITY IN SOUTH AFRICA



Source: Bradshaw D *et al.* Trends in adult mortality in South Africa 1920-1985.1994

DETERMINANTS OF HEALTH

Reduction of morbidity and mortality of populations is influenced by a wide range of factors. Some of these have had, and continue to have a profound effect on the health status of South Africans. A discussion of the determinants of mortality and morbidity highlights the range of measures that need to be implemented in order to bring about a sustainable decline in the inequalities and thus an overall improvement in the health of everyone.

Economy and population growth

Low economic growth and per capita income accompanied by relatively high population growth has resulted in inadequate provision of social services, and the private sector being unable to generate much needed jobs for a significant portion of the population entering the labour market each year. In turn, unemployment and poverty impacts negatively on health status. Typically, in a recent household survey, those living in conditions of impoverishment rated their health status as worse than those living in more affluent circumstances.[3]

Water, sanitation and housing

The provision of adequate water, sanitation and housing is associated with a substantial decline in death and illness rates. Investments in water and sanitation is therefore crucial for public health; and yet again, the CASE Household Survey indicates inequities in all these aspects, with rural Africans being worse off.

Urbanisation and urban development

Although urbanisation is generally associated with improvement in health, it also carries with it many potential risks. Such is the case in the squalid, overcrowded conditions in shacks and other informal settlements at the fringes of the major cities, which are characterised by inadequate water and sanitation services and high crime and violence rates.

Immunisation coverage

Nine out of 10 one year old children in the country had an immunisation card; and 6 out of 10 had a visible BCG scar; 7 out of 10 were considered to be fully immunised. Again, children in the rural areas were less likely to be fully immunised, to possess an immunisation card or to have a visible BCG scar.[3]

Breast feeding

A greater proportion of rural children were breast fed (91%) compared with urban children (83%); in general, a greater percentage of rural children were also breast fed for longer periods. A high percentage of children of well educated mothers were breast fed for less than 3 months.[3]

Unhealthy lifestyle and risk factors related to chronic diseases

The **tobacco** related epidemic will be second only to HIV in its negative effect on mortality. The latest Medical Research Council/Human Sciences Research Council survey conducted in 1995 indicates that 34% of the adult population smoke, up 3% from 1992.[7] The prevalence is higher among men (52%) than women (17%). The rate is highest for coloured South Africans (59%), followed by Indians (36%), whites (35%) and Africans (31%). The province with the highest smoking rate is the Northern Cape (55%) which is followed by the Western Cape (48%) and North West (46%).

Obesity is known to be related to a range of chronic illnesses. Despite extensive under-nutrition, over-nutrition co-exists in South Africa. While there is no national data on the extent of obesity, past studies suggest that there are large variations by race and sex. These studies have recently been reviewed and an overview is shown in Table 3.1.

TABLE 3.1 THE PREVALENCE OF OBESITY (BMI ›30) IN SOUTH AFRICAN ADULTS AGE 15-64

Population group	Male	Female
White	14.7%	18.0%
Coloured	6.1%	25.9%
Indian	3.2%	21.6%
African	7.9%	34.4%

Source: Walker ARP. Epidemiology and health implications of obesity in Southern Africa. MRC Technical Report 1995.

Physical inactivity is also known to be related to ill-health. There is a lack of information regarding the habitual physical activity levels in the country. This is partly as a result of the difficulties in measurement.

In the MRC report, it was estimated that 56.5% of adults age 15-64 years need to change to a healthy lifestyle and that 16.5% fall into a high risk category that need to be diagnosed and managed. These determinants demonstrate the many factors affecting health, and help clarify the bi-polar nature of the epidemiological transition in South Africa.

THE UNFINISHED AGENDA : INFECTIOUS DISEASES, MATERNAL AND PERINATAL MORTALITY

Many of the infectious diseases are preventable and access to primary health care during pregnancy and childbirth is known to reduce maternal and perinatal morbidity and mortality. In many respects, these conditions can be considered as the unfinished agenda which could have been virtually eliminated with the appropriate provision of services.

Of all the notifiable diseases, tuberculosis (TB), measles, malaria, viral hepatitis and typhoid have the highest crude morbidity rates in the country. Incidence rates of the leading groups of illnesses reported by the Department of Health for 1993 are shown on Table 3.2.[8]

TABLE 3.2 INCIDENCE OF NOTIFIABLE CONDITIONS IN SOUTH AFRICA, 1993 PER 100 000 POPULATION

Disease / Condition	Incidence per 100 000 population
Tuberculosis	224
Measles	32
Malaria	29
Viral Hepatitis	4.2
Typhoid Fever	4.1
Congenital syphilis	2.5
Meningococcal infection	1.2
Food poisoning	0.9
Trachoma	0.6
Pesticide poisoning	0.3
Cholera	0.2
Tetanus	0.1
Rheumatic fever	0.1
Brucellosis	0.1

Source: Department of Health. Health Trends in South Africa. Pretoria 1994.

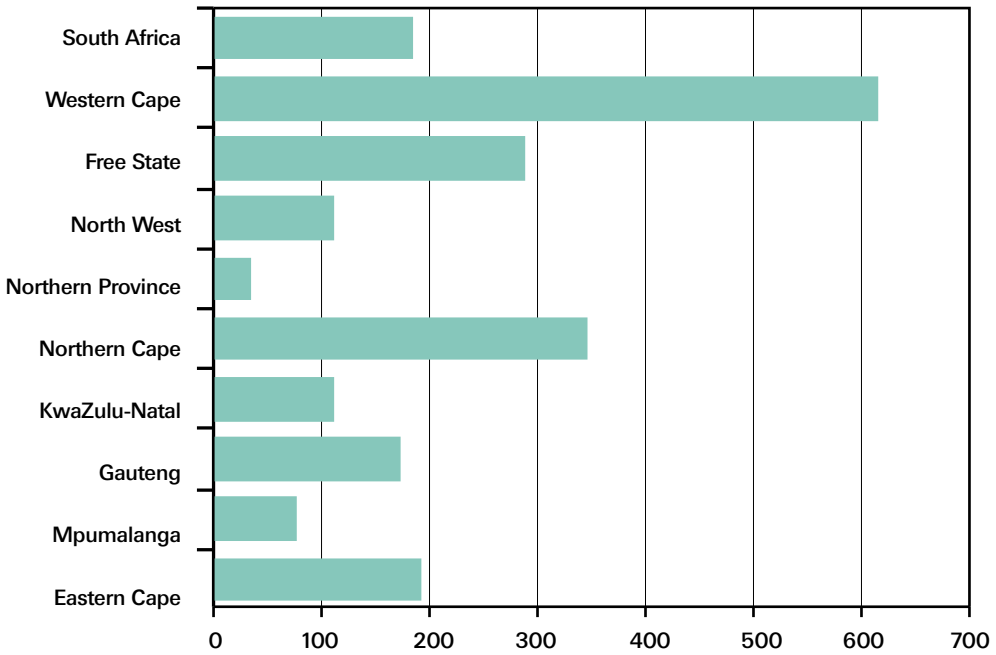
Tuberculosis

Despite the availability of effective drugs, TB remains a serious public health problem and the most frequently notified diseases, with 74 650 cases notified in 1995 (accounting for over 80% of all notifiable diseases) in South Africa.[9] Although South Africa's tuberculosis rates rank among the highest in the world, it is still likely that poor notification and undetected cases in rural areas significantly underestimate the extent of the problem. It is estimated that there are over 10 million people infected with TB in South Africa. About 90 000 new cases and 3 000 deaths due to TB were expected to be notified in 1995.[10] The incidence of TB is rising, due in part to the interaction between TB and AIDS and in part to a breakdown in surveillance and management of cases. The World Health Organisation has declared tuberculosis an emergency.

A national TB register has been introduced by the South African Tuberculosis Programme, and it emphasises the management of the infectious (sputum positive) TB patient. Focus will now be on establishing the bacteriological status of patients (diagnosis of TB by bacteriological evidence).

The distribution of TB in South Africa reflects strong geographical and racial disparities. The Western Cape region continues to have the highest incidence (notification rate of 612 cases per 100 000 population in 1995).[9] Over 20 000 people, of whom some 900 later died, were treated for tuberculosis in the Western Cape Province, according to Western Cape AIDS and communicable diseases programme sources.[11]

FIGURE 3.3 TB NOTIFICATION RATES 1995 (PER 100 000 POPULATION)



Source: Department of Health. RSA. Epidemiological Comments. Vol 22 (10) 1995

Similarly, the various ethnic groups find themselves at different positions on the TB graphs. The disease is largely under control in whites and Indians, but is alarmingly high in coloureds followed by Africans (Table3.3).

TABLE 3.3 NOTIFICATION RATES (PER 100 000 POPULATION) OF TUBERCULOSIS BY POPULATION GROUP

Population Group	Notification rates per 100 000 population (1995)
White	14
Coloured	612
Indian	64
African	159

Source: Department of Health. Epidemiological Comments. Vol 22 (10) 1995

The TB situation in South Africa is very serious. The factors contributing to this situation include:

- the emergence of multi-drug resistant TB
- inadequate or poorly implemented control programmes, resulting in poor management of cases
- socio-economic (and socio-political) circumstances, including the effect of drought on the nutritional status of those affected; indirect effects of violence (mass movement of people into squatter settlements and temporal shelters which are often overcrowded)
- increase in HIV infection.

In a person dually infected with the tubercle bacillus and HIV, the development of both TB and AIDS are enhanced. Meanwhile, HIV is a strong risk factor for TB and other mycobacteria infection. The same group is also at high risk for developing multi-drug resistant TB. The proportion of persons dually infected with TB and HIV in South Africa is not known.

Measles

Although preventable through effective immunisation programmes, measles was still the second most important notifiable disease in 1995. The highest notification was amongst coloureds and Africans (17 and 12 per 100 000 population respectively).

TABLE 3.4 MEASLES NOTIFICATION RATES BY POPULATION GROUP - 1995

Population Group	Notification Rate (per 100 0000)
White	4.8
Coloured	16.9
Indian	4.5
African	12.4
Total	**12.2**

Source: Department of Health. Epidemiological Comments. Vol 22 (10) 1995

TABLE 3.5 MEASLES NOTIFICATION RATES BY AGE GROUP - 1995

Population Group	Notification Rate (per 100 0000)
‹ 1 year	56.2
1-4 years	41.1
5-14 years	24.6
15+ years	1.1

Source: Department of Health. Epidemiological Comments. Vol 22 (10) 1995

Following the 1992 measles epidemic, Schoub *et al* described two patterns of measles infection as characteristic of the South African situation. The most common patterns affects young infants and children; especially the disadvantaged, living in crowded, poor socio-economic conditions. Accumulation of a sufficient number of susceptible older children and adults - due to a combination of non-vaccination, incorrect documentation of vaccination status and vaccine failure- accounts for the second pattern of infection, and was largely responsible for the 1992 epidemic.[12] Future campaigns for combatting measles must therefore take into account the possible existence of both patterns.

Malaria

Despite being situated at the tip of the distribution of the disease in Africa, the number of malaria cases notified in South Africa has been rising steadily over the past decade, especially in the low altitude areas of KwaZulu-Natal, Mpumalanga and Northern Province. The resurgence of endemicity has been exacerbated by the emergence of drug resistant *Plasmodium falciparum*; and agricultural development in malarious areas.

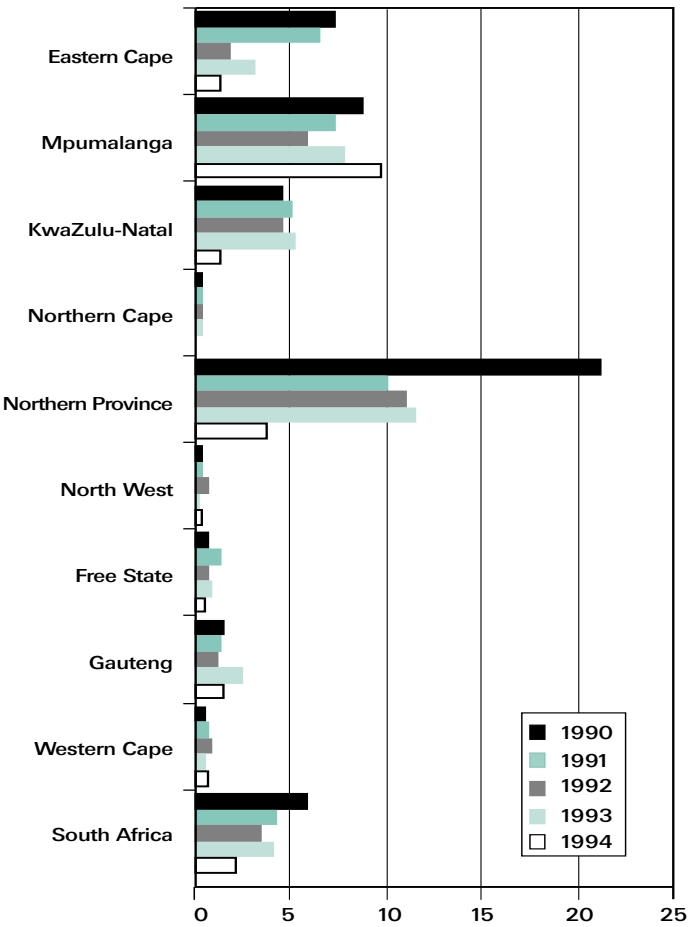
Approximately 38% of all malaria cases were classified as imported from neighbouring countries between 1987 and 1990.[13] Control measures therefore need to take this into account and collaboration with neighbouring countries is necessary.

Being a typical seasonal disease, the good rainy season in 1995/6, accompanied by hot weather encouraged mosquito breeding and resulted in an outbreak of malaria in the endemic areas and neighbouring countries (Mozambique, Zimbabwe and Swaziland) during this period. Over 20 000 cases and about 124 deaths were recorded in South Africa. Zimbabwe had more than 1.4 million cases and more than 2 000 deaths.[14] Under normal circumstances, the malaria season usually peaks in April and May and rarely exceeds 10 000 cases per annum.[12] The outbreak has also been attributed to the large number of imported cases from Mozambicans coming into the country to get treatment.[15]

Typhoid

Typhoid still ranks among the five most notified diseases in the country, although notification rates have dropped considerably over the years (Notified incidence rates of 17 in 1985, 11 in 1989 and 2 in 1994).

FIGURE 3.4 INCIDENCE RATES FOR TYPHOID BY PROVINCE (PER 100 000)



Source: Department of Health. Epidermiological Comments. Vol 22 (2) 1995

Even though the available data indicates a decline of the disease in all population groups, the concentration of the disease among the African population relative to the other population groups is noticeable. Similarly, the data shows prominence of the disease in provinces that generally lack adequate infrastructure. Whatever remains of the problem of typhoid, affects Africans residing in under-serviced areas. This of course is to be expected given the strong correlation between typhoid and availability of clean water supplies and adequate sanitation, and points to the need for continued monitoring of the disease and improvement in infrastructure in the affected areas.

Maternal mortality

Maternal mortality is a good indicator of the health status of women and has an impact on family and especially child health. It also provides a general picture of the availability, accessibility and quality of maternal services for the particular population. The reported maternal mortality rate per 100 000 births in 1990 was 3 for white, 15 for Indian, 30 for coloured and 23 for African women.[8] Indirect demographic techniques estimated that the rate for African women was in the order of 250 in 1991.[16]

Improvement of maternal health features prominently in the Department of Health's vision of improved health status by the year 2000.

Nutrition

Malnutrition in South Africa has two major components. Poor nutrition especially in mothers is associated with a high incidence of low birth weight babies (about 16%) whose subsequent growth and development are poor. Available nutritional status data indicate that the prevalence of stunting in children may be up to 30%.[17] At the same time, young children and pregnant and lactating women suffer from micro-nutrient deficiency, especially iron, iodine and vitamin A. Iron deficiency anaemia is thought to affect up to 25% of women in South Africa.[18]

Findings of the survey on the anthropometric, vitamin A, iron and immunisation coverage status of children aged 6-71 months in South Africa revealed the following:

- Children's nutritional status was found to be a good indicator of overall social development/social well-being.
- 1 in 3 children had a marginal vitamin A status. Children living in the rural areas and whose mothers were poorly educated were the most disadvantaged; signifying a serious public health problem of Vitamin A deficiency, by international standards.
- 1 in 5 children in the country was anaemic, 1 in 15 moderately anaemic and 1 in 500 severely anaemic. In terms of iron status, 1 in 10 children was iron deficient; 1 in 20 was severely iron deficient. 1 in 20 had iron deficiency anaemia. Anaemia and poor iron status were more prevalent in urban areas. Children in the 6-23 month age group were the most severely affected.
- Almost 1 in 4 children was stunted and 1 in 10 underweight. This translates into approximately 660 000 pre-school children being identifiably malnourished and 1 520 000 being stunted because of long term malnutrition. According to international criteria, stunting is a major problem in the country especially in rural communities and children whose mothers are less well educated.
- 1 out of 100 children had a visible goitre.[19]

The second component comprises diseases of lifestyle which manifests typically in adulthood as obesity-related disease such as ischaemic heart diseases, hypertension, diabetes and certain cancers.

A National Nutrition Surveillance System will be implemented as part of the National Health Information System of South Africa to monitor the nutritional status of pregnant and lactating women, pre-school children, and levels of micro-nutrient deficiency. Nutritional status, especially that of young children will be a key indicator of social well-being and an outcome measure of Reconstruction and Development Programme (RDP) projects.[17] The problems of undernutrition and hunger constitute a priority for the government, and are discussed more fully in Chapter 13.

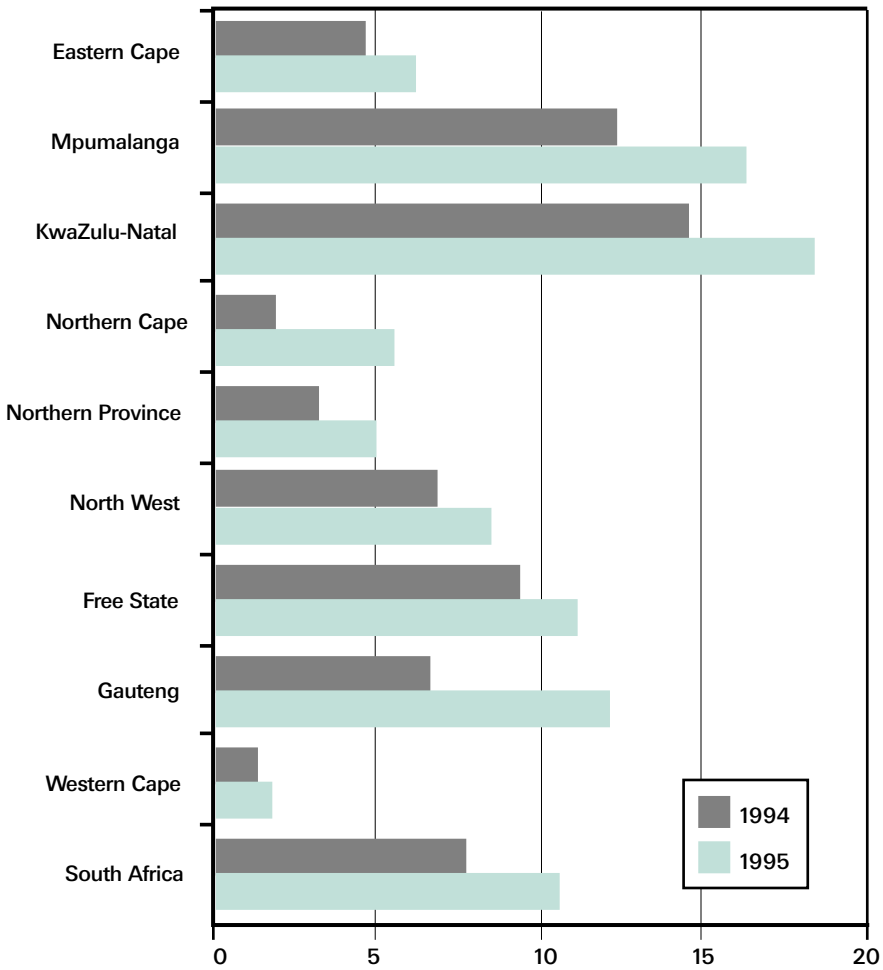
EMERGING PROBLEMS: CHRONIC DISEASES, HIV/AIDS, INJURY, MENTAL HEALTH AND SUBSTANCE ABUSE

HIV/AIDS and Sexually Transmitted Diseases

The HIV epidemic is well established in South Africa, with an estimated 1.8 million people (4.3% of the population) already infected by the end of 1995.[20]

Available data from the national annual antenatal clinic surveys indicate that the epidemic has increased tenfold in the last five years. At present, the doubling rate of infection is estimated to be between 13 and 15 months. The results of the annual survey conducted in October/November 1995 demonstrated that 10.44% of women attending antenatal clinics of the public health services were infected. Figure 3.5 illustrates the prevalence by province.

FIGURE 3.5 HIV PREVALENCE RATES AMONGST WOMEN ATTENDING ANTENATAL CLINICS IN SOUTH AFRICA- 1994 AND 1995



Source: Department of Health media release. Sixth national HIV survey of pregnant women attending antenatal clinics. 1996

Based on the antenatal findings, it has been estimated that there were 10 500 HIV infected babies born in 1994. In 1992, there were 211 paediatric AIDS cases.

HIV infection has increased in all age groups. Of teenagers attending antenatal clinics, 9.5% tested HIV positive. As in the previous year, the highest rates of HIV infection are in the 20-24 year age group (13.1%) closely followed by the 25-29 year age group (11.0%).

The national HIV/AIDS and Sexually Transmitted Diseases Control Programme has adopted various mechanisms for the control of HIV, which include behavioural strategies; early detection and treatment of classical sexually transmitted diseases (STDs); the maintenance of safe blood supplies; and the use of barrier methods.[18] The shrinking budgets in the health service faced with many other pressing issues has made it imperative to focus on interventions to slow down the spread of HIV. The government's response to HIV/AIDS is discussed more fully in Chapter 15.

Besides the critical role that sexually transmitted diseases play in the transmission of HIV, all forms of sexually transmitted diseases are still a significant cause of ill health in South Africa. For example, syphilis, which can be treated successfully, is still a major problem. Where special surveys have been conducted, such as in KwaZulu-Natal, sero-positive prevalence rates of 30.7% have been recorded in unbooked women presenting for delivery in Durban in 1990.[1] A high prevalence of STDs in Khayelitsha, a peri-urban informal settlement in Cape Town, is evidenced in that 12% of antenatal clinic attenders have syphilis.[21]

Chronic Diseases

The Medical Research Council (MRC) released a technical report on Chronic Diseases of Lifestyle in 1995.[7] It presented an empirical model of the complex relationships between unhealthy lifestyle, the development of risk factors and the onset of chronic diseases, as well as the high toll on mortality.

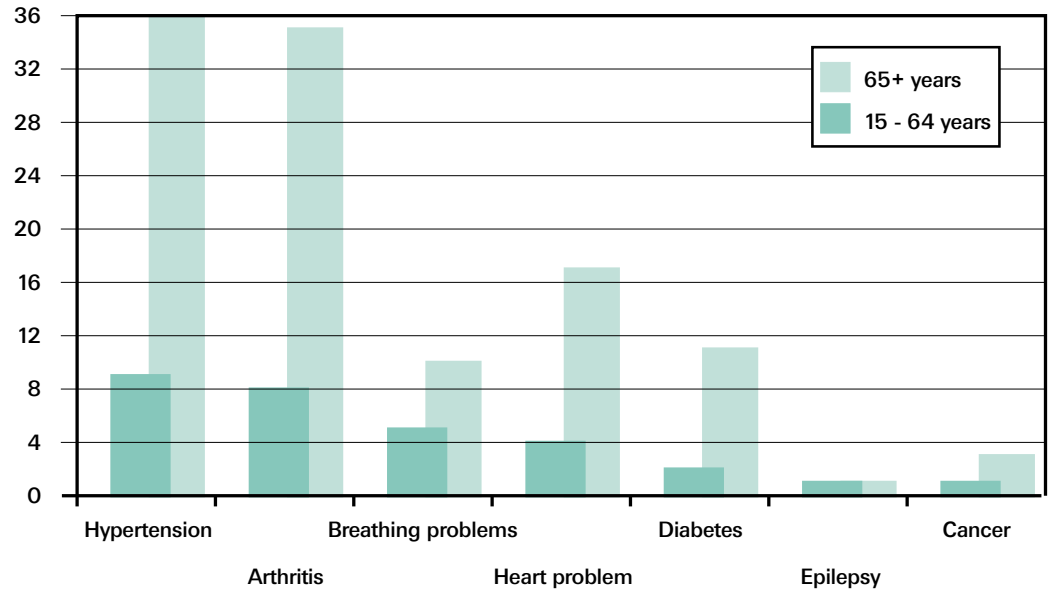
It is estimated that 24.5% of all deaths in 1988 were due to chronic diseases. Details of the mortality rates are shown in Table 3.6. The recent household survey on health inequalities included questions on the prevalence of chronic diseases amongst adults. Twenty five percent of adults aged 15-64 and 70% of those over 65 years reported that they were suffering from a chronic disease. The details of the diseases are shown in Figure3.6.

TABLE 3.6 AGE-STANDARDISED MORTALITY RATES (1984-86) PER 100 000 POPULATION PER ANNUM

Cause of death	White Urban	White Rural	Coloured Urban	Coloured Rural	Indian Urban	Indian Rural	African Urban
Hypertension	12.1	12.7	35.5	34.1	53.2	59.8	28.3
Diabetes	15.3	17.2	43.1	26.4	90.0	73.9	28.1
Stroke	68.7	71.4	139.7	176.4	123.9	141.7	96.4
Ischaemic heart disease	162.7	187.9	118.7	101.0	206.9	194.6	13.1
Lung Cancer	30.8	23.8	47.1	36.7	13.5	11.6	18.1
Cervical Cancer	3.8	3.5	18.0	24.5	8.9	6.0	23.1
Breast Cancer	26.0	21.8	26.4	15.7	14.6	9.2	9.6
Ill-defined	53.8	41.3	123.3	107.8	96.4	64.6	306.1

Source: Bradshaw D *et al.* Mortality patterns of chronic diseases of lifestyle in South Africa. MRC Technical Report 1995

FIGURE 3.6 PREVALENCE OF CHRONIC DISEASE AND DISABILITY (%)



Source: A National Household Survey of Health Inequalities in South Africa. CASE/Kaiser Family Foundation. 1995

Hypertension

Hypertension is the most prevalent reported chronic disease (Figure3.6). The levels vary between race and sex groups as can be seen from the Table 3.6, which shows the findings from a series of studies. The mortality due to hypertension also reflects these differences.

Diabetes

National data are not available. A review of local studies has suggested increases in the prevalence of late onset diabetes and particularly amongst Africans.[22] Recent studies have revealed prevalences of 6% in Bloemfontein, 4.8% in Qwa-Qwa, 8% in Cape Town and 5.3% in Umlazi amongst African adults. These are similar to levels experienced by the Indians some 30 years ago. The prevalence among Indians is now of the order of 11-13%. Related to obesity and urbanisation, the extent of this disease can be expected to rise. Mortality data reflects the urban/rural differences.

Hyperlipidaemia

National data are not known. Review of the available studies suggests large variations between race groups.[23] The levels of total cholesterol is lowest amongst Africans and the protective ratio of high density lipoprotein cholesterol (HDLC) to total cholesterol is best for Africans.

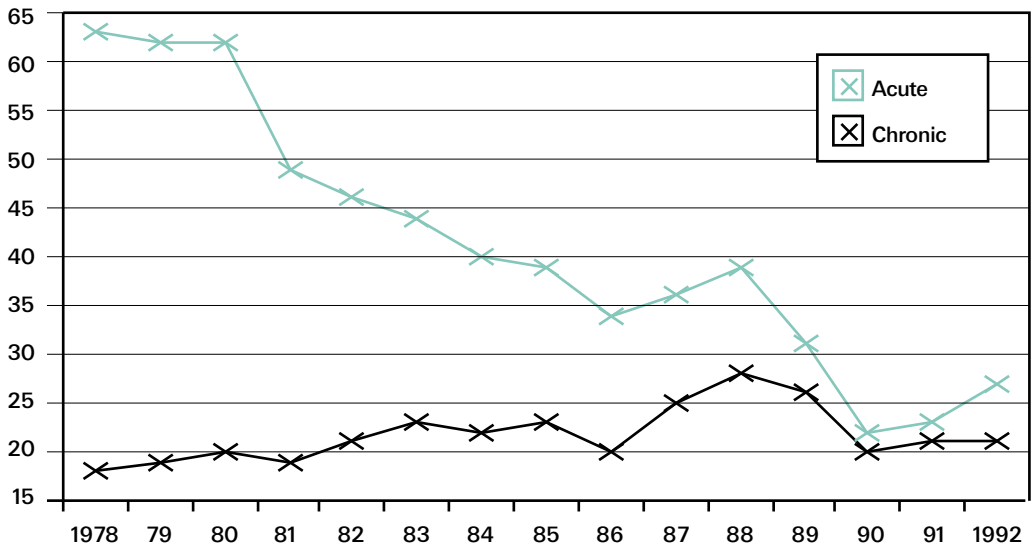
Stroke and Ischaemic Heart Disease

Mortality due to stroke and ischaemic heart disease varies for different population groups (see Table 3.6). The mortality rate reflects the different combinations of risk factors exhibited by the different groups.

Chronic obstructive airways disease

It has been estimated that 2.5% of all deaths are due to chronic obstructive airways diseases. The crude rate for chronic respiratory mortality in 1992 was 21 per 100 000. While the proportion of deaths due to acute respiratory diseases has declined, the proportion of deaths due to chronic respiratory diseases has increased.

FIGURE 3.7 RESPIRATORY DISEASE MORTALITY (PER 100 000 POPULATION)



Source: Department of Health. Health Trends. 1994

Rheumatic diseases

The actual prevalence of these diseases is unknown. However, the Household Survey of Health Inequalities suggests that these debilitating diseases are extensive. Eight percent of the 15-64 year olds and 35% of the 65+ age group reported that they had arthritis.

Cancer

The age standardised incidence rate per 100 000 population for cancer in 1988 was 146 for women and 163 for men.[24] In the case of women, the most common cancers were cervix, breast and basal cell skin cancer. In the case of men, the most common cancers were basal cell skin cancer, prostate, oesophagus and lung. The mortality pattern is not identical and the most common fatal cancers were lung, oesophagus and breast. The mortality rates differ by race group and gender (see Table 3.6).

Mental heath and substance abuse

In general, mental health promotion and the provision of services to South African communities have been neglected in the past. Common manifestations are interpersonal violence, trauma, neurosis of living under continuous stress, post-traumatic stress reactions and disorders, substance abuse, suicide, adjustment related reactions and disturbances in children and the elderly.

In the Household Survey of Health Inequalities, almost two thirds (65%) of the adult sample claimed to be teetotallers. The highest proportion was among the Indians (83%), followed by Africans (72%), coloureds (59%) and then whites (37%). Nearly one quarter (28% of men and 19% of women) of the adult sample had experienced one or more traumatic event in their lives. The most common type of event was having been physically attacked, having witnessed and attack, a life threatening event or a home burning.

Mental health is one of the priorities listed in the Reconstruction and Development Programme. South Africa's unfortunate history of apartheid has resulted in many South Africans experiencing psychological trauma (post-traumatic stress disorder) irrespective of race, gender, age or social class.[25] A study in Khayelitsha found that 19% of children and adolescents in informal settlements had diagnosable psychiatric disorders, predominantly mood or anxiety related.[26] For the most part, severe psychiatric illnesses are dealt with through long term institutionalisation of patients, far removed from family and community support, while less severe problems are not dealt with at all. Recent trends however attempt to integrate mental health as part of primary health care and to engage community members in mental health care.[27]

Injuries

Since 1992, medical practitioners have not been required to give details of the underlying cause of death when certifying a death due to an external cause. Injury mortality surveillance has become completely problematic and the law must be changed to facilitate a national surveillance system that includes the underlying cause of death. A local system was set up for the metropolitan area of Cape Town. The first report has shown that in 1994, nearly 30% of the Cape Town deaths were due to injuries.[28] The homicide rates were exceedingly high with an average of 44 homicides per 100 000 people. This rate was six times higher than the average homicide rate in the United States of America (USA). The traffic injury rate was approximately double the rate in the USA with 24 traffic deaths per 100 000 population. The suicide rate in Cape Town was comparable to that in the USA with 11 per 100 000 population. While there was no comparative data, high proportions of blood alcohol levels were observed in many of the injury deaths, suggesting the potential role of alcohol in injury mortality. The report highlighted the variations in these rates between the districts within Cape Town and illustrated the need for district level information to enable the district health service to serve its community.

Approximately R300 million is spent by the public hospitals in the Cape Metropole in treating people admitted with traffic trauma.[29] In comparative terms, this represents 80% of the annual budget of Groote Schuur Hospital. A study in 1995 of the medico-legal autopsies performed in Durban revealed a high proportion of assault deaths due to firearms (50.5%) and sharp instruments (39.6%).[30] The study also revealed a relatively high proportion of suicides, the majority of which were due to firearm injuries. A study undertaken by the Medical Research Council in collaboration with the University of Natal showed that in the decade up to 1992, there has been a more than eightfold increase in penetrating wounds arising from gunshots.[31]

Prevention of alcohol abuse, improved firearm control and community level initiatives to develop 'safe communities' are all required to reduce the heavy social and economic burden of injuries.

DISABILITY

Included in the Household Survey of Health Inequalities were questions about disability and the extent of restrictions on daily living activities. Seventeen percent of adults aged 16-64 years and 55% of those aged 65 years and over, reported at least one disability. In young adults, disabilities were reported by 18% of Africans and 17% of coloureds compared to 12% of whites and 7% of Indians. In the elderly, most Africans (61%) and coloureds (52%) reported disability compared to 46% of Indians and 41% of whites. The nature of the disability is summarised in Table3.7.

TABLE 3.7 PROPORTION OF ADULTS WITH A DISABILITY, 1995

Type of disability	16-64 years	65+ years
Difficulty in seeing	11%	36%
Difficulty in hearing	4%	20%
Difficulty with speech	1%	3%
Difficulty walking/moving	3%	20%
Difficulty in learning	2%	12%

Source: A National Household Survey of Health Inequalities in South Africa. CASE/Kaiser Family Foundation. 1995

The extent to which people have difficulties with daily living activities are shown in Table3.8.

TABLE 3.8 PROPORTION OF ADULTS WITH LIMITATIONS WITH ACTIVITIES OF DAILY LIVING, 1995

Daily living activity	16-64 years	65+ years
Getting in and out of bed	4%	18%
Bathing/showering/cleaning	1%	11%
Eating/feeding oneself	1%	3%
Toilet	1%	5%
Getting around outside	1%	11%
Shopping	2%	23%

Source: A National Household Survey of Health Inequalities in South Africa. CASE/Kaiser Family Foundation. 1995

ORAL HEALTH

National oral health surveys from the late 1980s have provided sufficient information to indicate that the oral health status in South Africa is that of a mixed developing industrialised community. The results of the surveys suggest that increasing primary preventive measures will be necessary to improve oral health status.

Caries and Periodontal disease

In the Report of the Oral Health Committee appointed by the Minister of Health, evidence is presented that reflects extensive dental caries.[32] The committee reports that in disadvantaged groups, 67% of children aged between 2-5 years had at least one or more tooth decayed with an average of 30% of their primary teeth decayed. In adolescents aged 12-15 years, only 31% had caries free mouths and had on average 4-5 decayed or missing teeth. They also reported that at least 37% of adults aged 35-44 years and more than 65% of adults over 65 years of age were completely edentulous. Evidence of extensive periodontal disease is also presented. For example, 23% of children under 5 years suffer from acute ulcerative gingivitis.

Oral Cancer

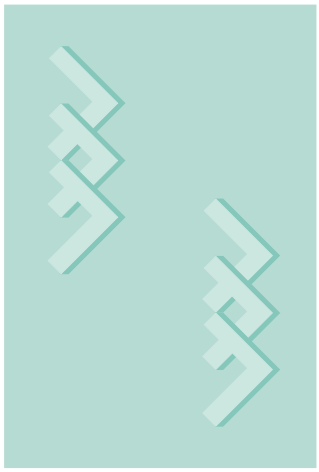
Data from the National Cancer Registry for 1989 showed high age standardised incidence rates for mouth cancer in coloured men (8.2 per 100 000), Indian women (6.5 per 100 000), African men (4.5 per 100 000) and white men (4.3 per 100 000).[33] Lip cancer was high in white men (7.7 per 100 000). Tongue cancer was high in coloured men (5.6 per 100 000), African men (3.4 per 100 000) and white men (3.4 per 100 000). These gender and racial differences have been observed previously and point to dietary and other habits which have persisted despite public awareness efforts relating to tobacco use and betel nut chewing.

POLICY IMPLICATIONS

The disparities in health status and the presence of diseases related to poor living conditions make a shift in health services towards a primary care approach imperative. Universal access to primary care will contribute towards overcoming the unfinished agenda of infectious diseases and morbidity and mortality related to reproduction. Finding effective ways to limit the impact of the HIV epidemic are critically important. At the same time the primary health care approach needs to be adapted for the health transition and must address the tobacco epidemic and other chronic diseases as the population ages. The health sector also needs to find ways in which to contribute to the physical safety of communities to reduce the level of violence and injury. Reliable surveillance systems are essential foundations to obtain the data necessary to monitor progress towards meeting goals.

PART II

Health Systems Reform in South Africa



4 ORGANISATION AND MANAGEMENT

PUBLIC SECTOR

INTRODUCTION

The essence of health care reform in South Africa is an attempt to shift away from a curative-based and urban-centred health system to one based on a primary health care (PHC) approach. The rationale for this change is obvious. Huge variations in the quality and accessibility of health care in the past need to be rectified by redistributing resources and replacing a top-down managerial approach with far greater decentralisation and community participation in health care governance.

However, there are several major obstacles to the transformation process. Some of these obstacles concern the way in which the provinces are reorganising their health services and the management structures necessary to administer them. This chapter looks at the management structures as a key component in the transformation process.

The first obstacle is felt most keenly in those provinces which include the old homelands (Eastern Cape, KwaZulu-Natal, Mpumalanga, Northern Province and the North West). Along with these homeland areas, most of which are in pressing need of improved health care, have come entire bureaucracies which have needed to be incorporated into the new structures. This has seriously complicated the work of re-organisation taking place in health departments in these provinces.

Secondly, re-organisation has been further bedevilled by the fragmentation of the services which the new provincial health authorities have inherited. In the past, some aspects of the health service had been administered by local authorities, most by the provincial health departments and others by the national health department. Now provinces are charged with the task of taking on the whole responsibility of planning and co-ordinating health services. How to draw these separate segments (often with their own staff salary scales and other features which prevent easy fusion) into a unified service has become a major problem in all provinces.

Finally, the uncertainties contained in the existing situation have been hugely magnified by the policy of district health, a policy which sees power going to the lowest possible level and draws heavily on community involvement. Having been charged with overall responsibility, and having painstakingly gathered the reins of overall control into the provincial fist, the next step has been to give a lot of it away again to the regions and districts (and in many areas, local authorities) into which the provinces have all now more or less been divided.

The complexity of the task has been enormous, and it has not been eased by the definite political need to force the pace of structural transformation of the provincial health services to dovetail with other health reforms being hurried through at the national level. Chief among these have been:

- the commencement of the redistribution of financial resources between the well and poorly served provinces
- the redistribution of some resources from tertiary hospitals to secondary and primary level
- the clinic upgrading programme which is rapidly developing infrastructure in previously under-served areas
- the introduction of free primary health care (PHC) nationwide in April 1996.

Authors : David Power and David Robbins

All this has placed mounting pressure on the provinces to deliver a new type and quality of health care. And the inevitable first step in this direction has been the re-organisation of the entire service and the establishment of appropriate management structures.

The underlying framework for this mammoth exercise was originally contained in the ANC's health plan developed in the early 1990s, with more detailed guidelines subsequently emerging from the national department and the Reconstruction and Development Programme. All this was given substance through the early work of the Strategic Management Teams established in 1994 in all nine of the newly delineated provinces; and not least by the energy and insights of new personnel drawn into the civil service from non-governmental organisations and the progressive health movement generally.

But what sort of new management structures have been built through this process? How suitable are they to fulfilling the new philosophy of delivering PHC via the district model? Who is staffing these structures? And what sort of management training support is being provided? In an attempt to find answers, a set of basic questions was sent to all provincial Health (or Health and Welfare) departments.

All nine provinces responded, but with varying degrees of detail and efficiency. It is in itself a comment on the pressures being experienced by the various provincial health authorities that 97 telephone calls and facsimile messages were required to elicit the replies. The Northern Province responded immediately after a single telephone call and fax. At the other end of the accessibility scale, Mpumalanga needed 24 calls and the North West 19 calls before their responses could be extracted.

After an initial examination of the responses, and especially the organograms, further sets of clarifying questions were directed to the various provinces. Once more Northern Province responded immediately, followed by the Northern Cape, Eastern Cape, Gauteng and Western Cape. Other provinces responded only after prompting, and KwaZulu-Natal did not respond at all.

Nevertheless, sufficient information has been gathered to throw considerable light on our central questions: What sort of new management structures have been built? How suitable are they to fulfilling the new philosophy of delivering PHC via the district model? Who's staffing these new structures? And what sort of management training is being provided?

During the second contact with provinces, the following specific question was asked: Does the province have a mission statement and strategic plan available for all health managers to study? Four of the seven responding provinces replied in the affirmative on both counts. The Northern Province has a health and welfare mission statement which the managers themselves helped to draw up, while the department is currently engaged with the design of an integrated strategic plan. The Free State and Western Cape also have mission statements and the strategic management team reports serve as their strategic plans. In Gauteng, mission statements are being developed for each programme, and each region will have its own strategic plan.

THE STRUCTURE OF THE PROVINCIAL DEPARTMENTS

The rationale behind the creation of new organisational structures for provincial health departments is the need to amalgamate and take full control of all health services in the province, and then to deliver them via the district health model. But what is this model?

According to general guidelines issued by the national Department of Health, a district health system is defined as comprising:

- ✧ a well-defined population living within a clearly delineated administrative and geographical area
- ✧ and all institutions and individuals providing health care within this district, including all health workers and facilities, up to and including hospitals at the first referral level, and the appropriate laboratory, other diagnostic, and logistic support services.

All provinces have already been divided into regions, while the work of delimiting districts still continues in some of them. In response to specific questions - Are districts as defined for health also applicable to welfare? Do districts geographically correspond to local authority delimitations? - provinces have provided a variety of answers. In some provinces, but not in all, there is correspondence between health and welfare districts and local authority boundaries, although in most provinces health and welfare districts comprise more than one local authority. In other provinces, there is no correspondence at this stage, although authorities say they are working towards this as an ideal. However, only one

The Set of Basic Questions sent to all Provincial Health Authorities

a: Structures:

Describe new organisational structures at provincial level, preferably to be expressed as an organogram.

The organogram should be accompanied by brief descriptions of the function of each directorate and sub-directorate.

Incumbents of directorships and sub-directorships should be classified as:

(1) previously occupying the position, or new to the position?;

(2) if new to the position, are they from within the civil service or new to the civil service?

b: District health reform:

Have regional structures within the province been established with a view to managing district health?

How has regional management been organised?

c: Management training:

What steps are being taken to develop and improve managerial capacity?

Describe content and intent of in-house training programmes.

Describe how European Union, Oliver Tambo, and other training initiatives are being used at provincial and regional level.

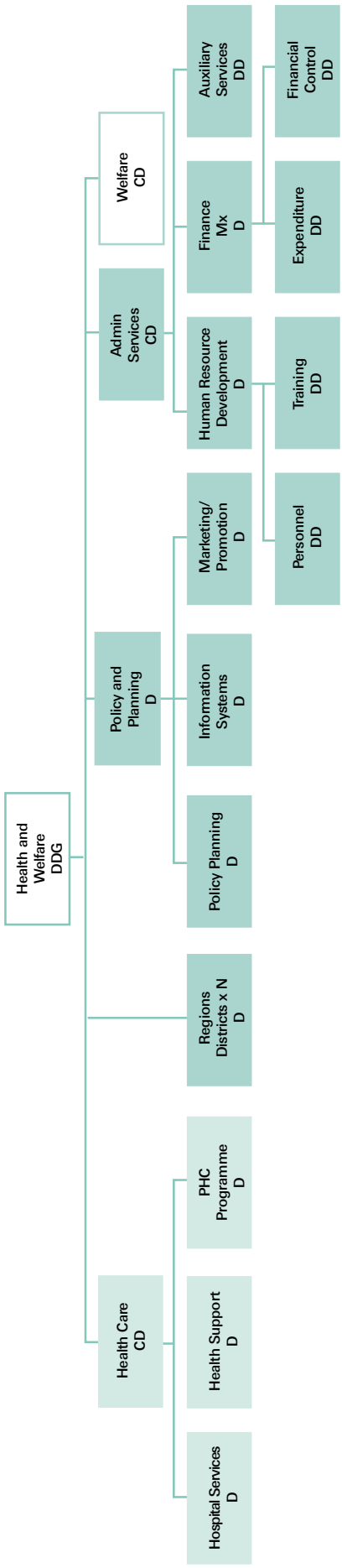
province (Gauteng) has a dedicated "local authority co-ordination" function at the regional level.

These considerations provide a convenient background against which to identify the general rationale which appears to underlie the new structures being adopted by the health departments in South Africa's nine provinces. Although there are considerable variations between departments, it is nevertheless possible to establish a generic organogram against which these variations can be more fruitfully examined.

Most provincial departments were originally established to administer both health and welfare. It needs to be stated, however, that moves are afoot in some provinces to split the two service functions. In the large provinces (Gauteng, KwaZulu-Natal, Western Cape) the functions are already split, or held together only by an MEC responsible for both. Now the Free State and the Eastern Cape are also considering splits.

Nevertheless, it is useful to bear in mind the original need to pair off the two services, and to this end Figure 4.1. shows the generic model of a dual arrangement. As can be seen, responsibilities on the health side are usually divided into directorates of Hospital Services, Health Support, and PHC Programmes. Welfare no doubt has similar sub-divisions, but these are beyond the scope of this chapter. Between these two basic service-support departments (welfare and health) stands a central column of policy, planning and administrative infrastructure shared by the service departments. Also located in this shared central column is the directorate responsible for the line management of actual service provision which reaches down to the regions within the province and thence to the districts within each region.

FIGURE 4.1 GENERIC PROVINCIAL ORGANOGRAM: HEALTH AND WELFARE SHARING COMMON RESOURCES



Key:

SG	superintendent-general
DDG	deputy director-general
CD	chief director
D	director
DD	deputy director
AD	assistant director
CNSM	chief nursing services manager
SNSM	senior nursing services manager
SMS	senior medical superintendent

The variations between provinces are clearly evidenced by examining the simplified organograms published here without comment, except on issues of clarity. Organograms have been checked by seven of the provinces concerned. No organograms were supplied by KwaZulu-Natal where officials could not be persuaded to respond. Nevertheless, organograms were obtained from another source and simplified, but unchecked, versions are published as Figures 4.2 and 4.3 for comparison purposes. Mpumalanga provided insufficient information with which to construct a regional organogram.

KwaZulu-Natal

FIGURE 4.2 PROVINCIAL ORGANOGRAM FOR KWAZULU-NATAL

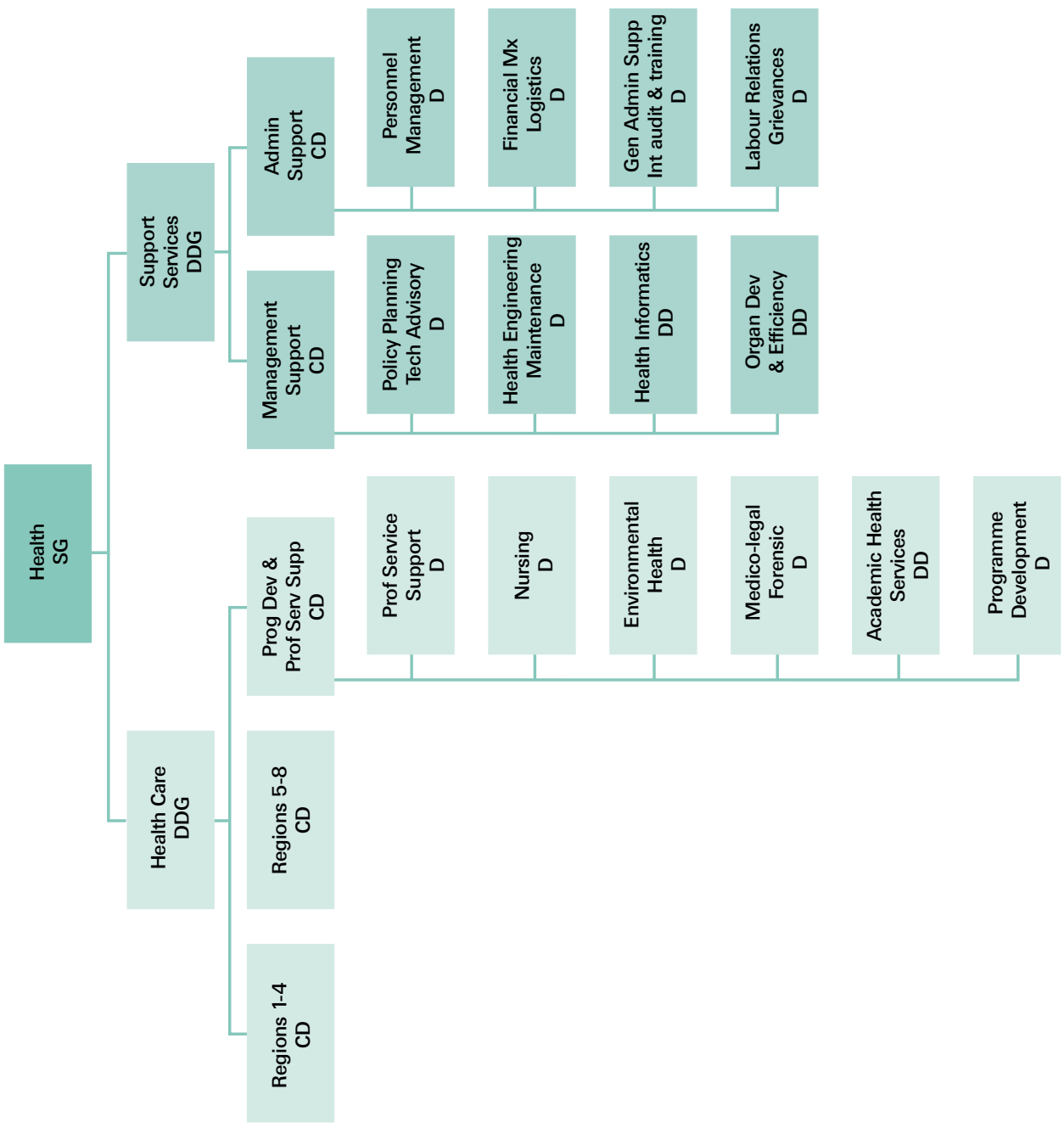
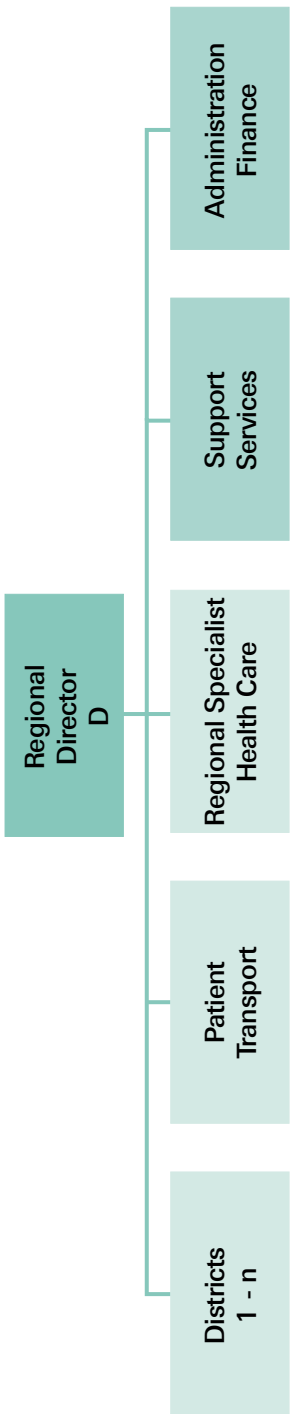


FIGURE 4.3 REGIONAL ORGANOGRAM FOR KWAZULU-NATAL



Northern Province

FIGURE 4.4 PROVINCIAL ORGANOGRAM FOR THE NORTHERN PROVINCE

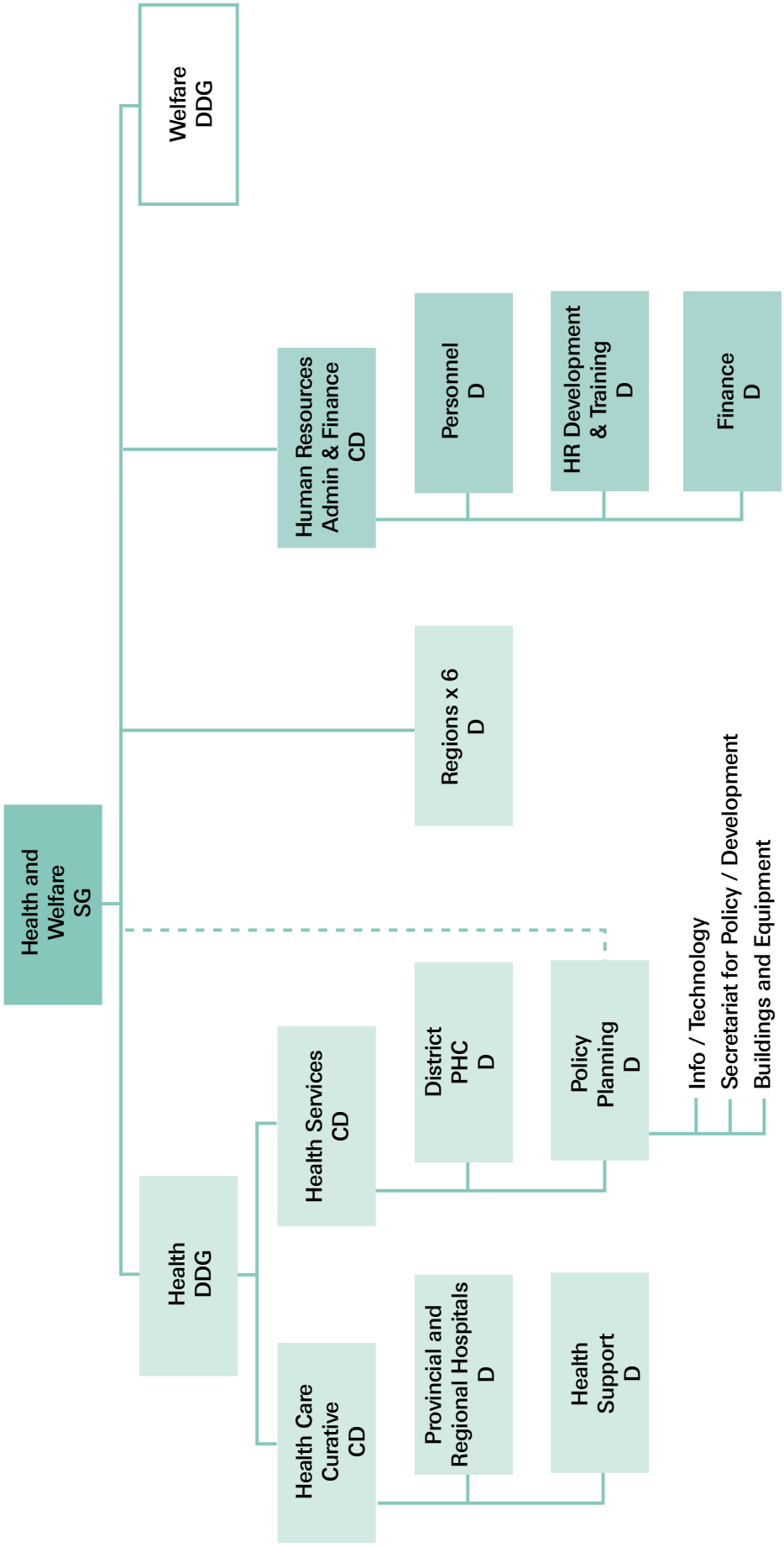
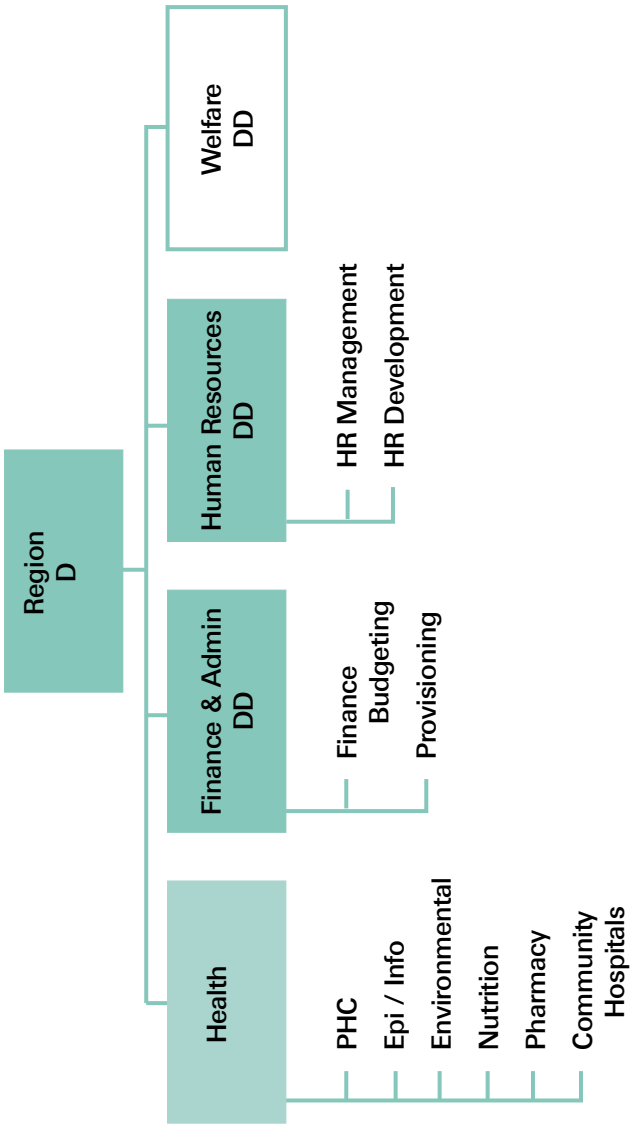


FIGURE 4.5 REGIONAL ORGANOGRAM FOR THE NORTHERN PROVINCE



The dotted line in Figure 4.4 indicates a proposed change which will allow the Policy and Planning directorate to report directly to the Health and Welfare superintendent-general rather than to the Health Services chief directorate as at present. Line management responsibility for the regions (see Figure 4.5) is from the regional directorates direct to the superintendent-general, an arrangement which involves a triple jump up the reporting chain. It is also proposed to merge the regional deputy directorates for Finance and Administration and Human Resources into a single department.

North West

FIGURE 4.6 PROVINCIAL ORGANOGRAM FOR THE NORTH WEST

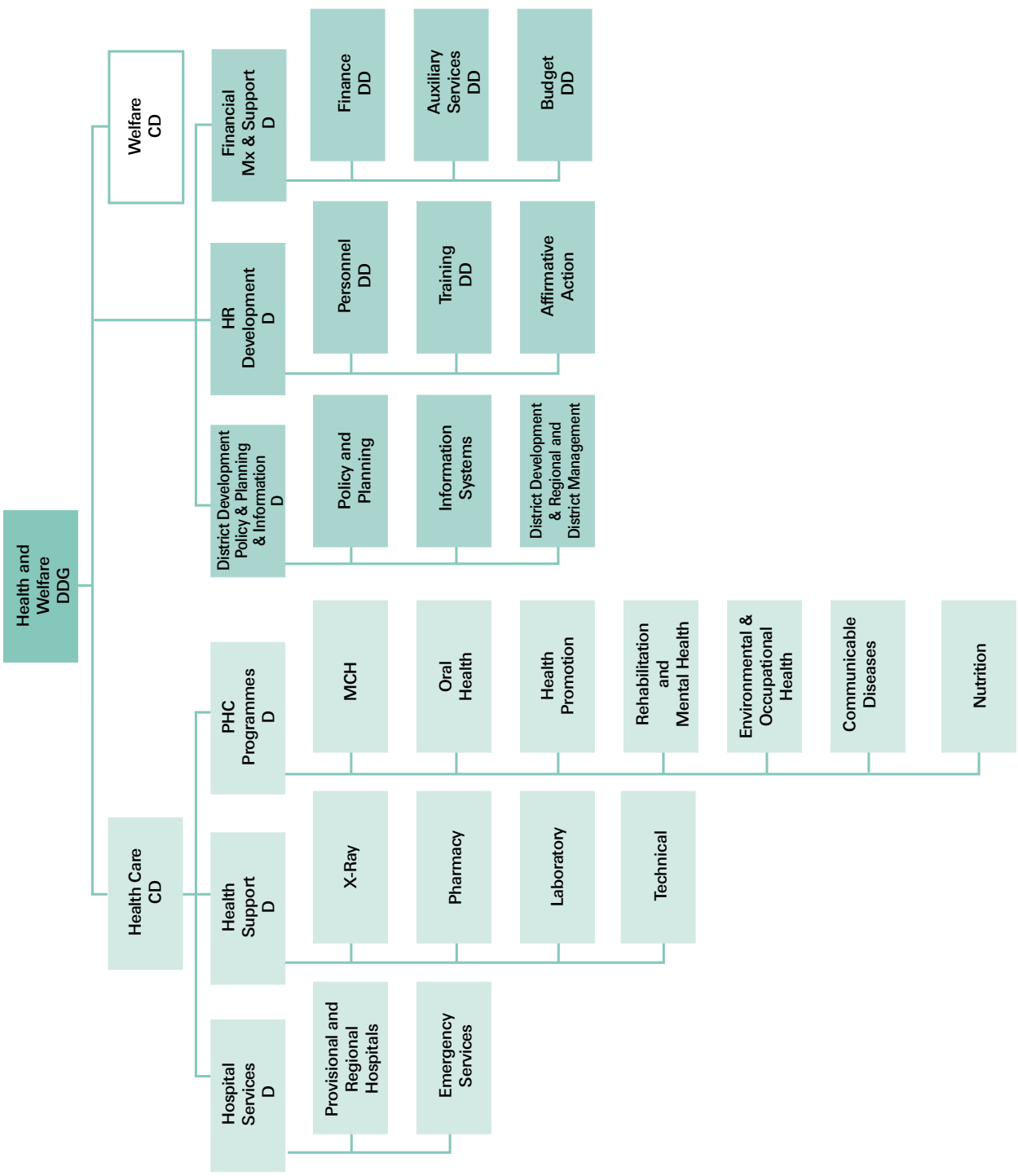
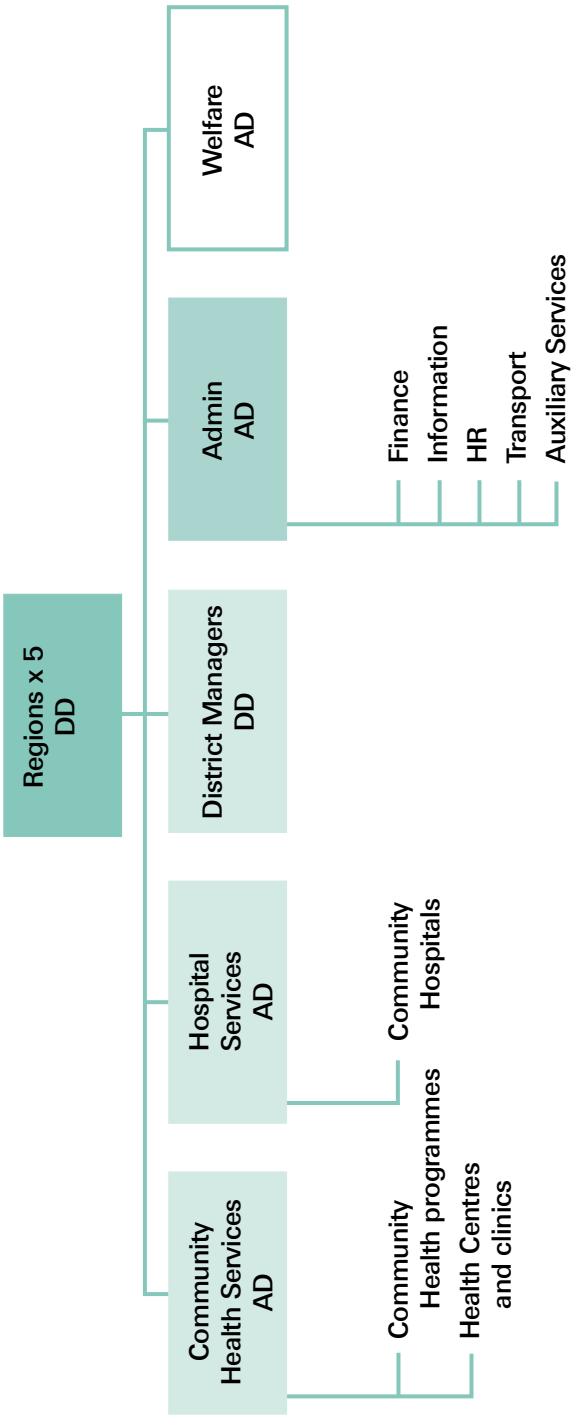


FIGURE 4.7 REGIONAL ORGANOGRAM FOR THE NORTH WEST



Line management of the regions and districts emanates from the directorate of District Development, Planning and Policy, and Information. Community (or district) hospitals will be controlled by the district deputy directors, while all other hospitals will be controlled at the provincial level. Also controlled at the provincial level will be emergency services (ambulances). On the other hand, the Health Support directorate offers functional guidance only on such specialised services as X-ray and laboratories. The line management for these services has been devolved right down to the district level.

Gauteng

FIGURE 4.8 PROVINCIAL ORGANOGRAM FOR GAUTENG

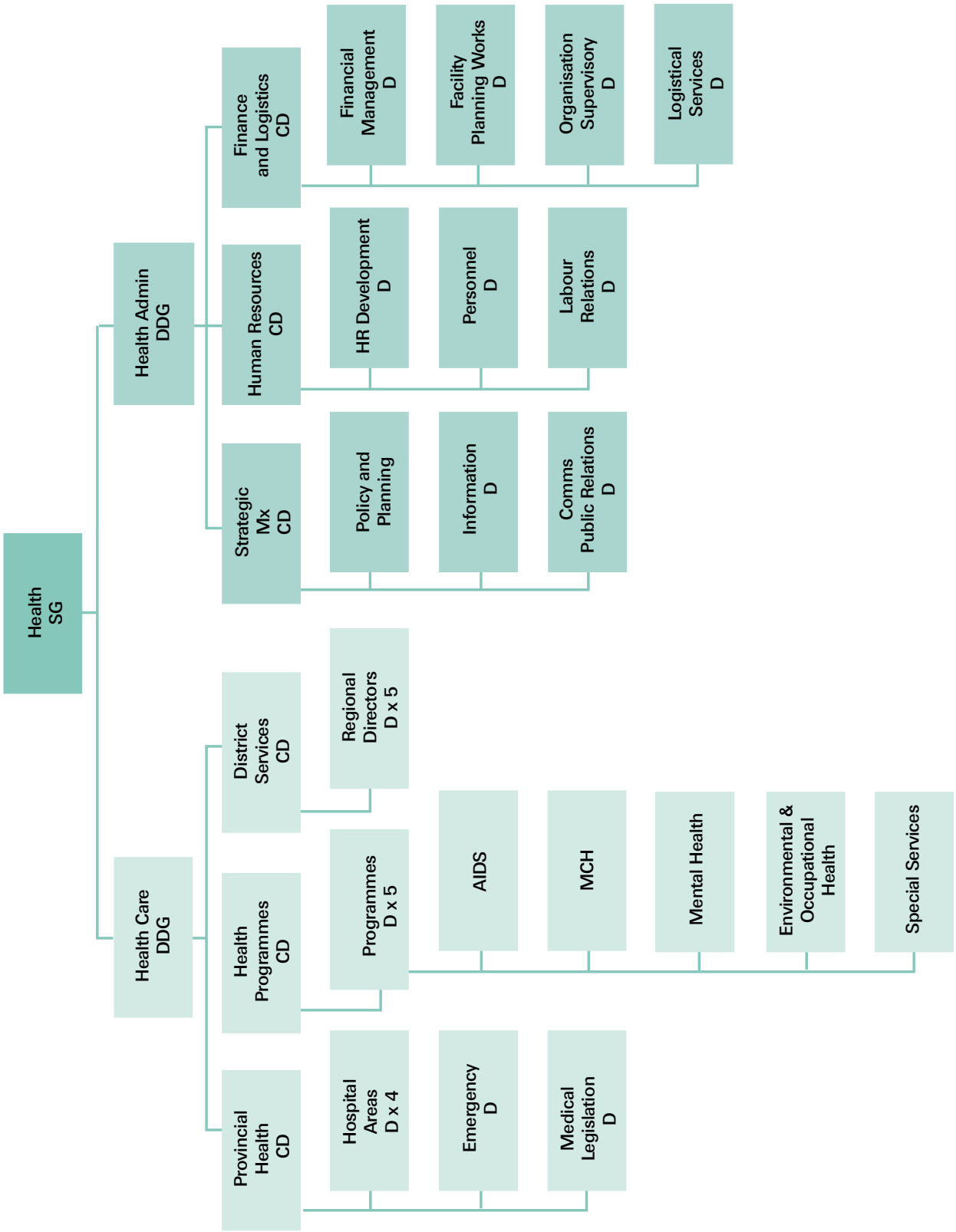
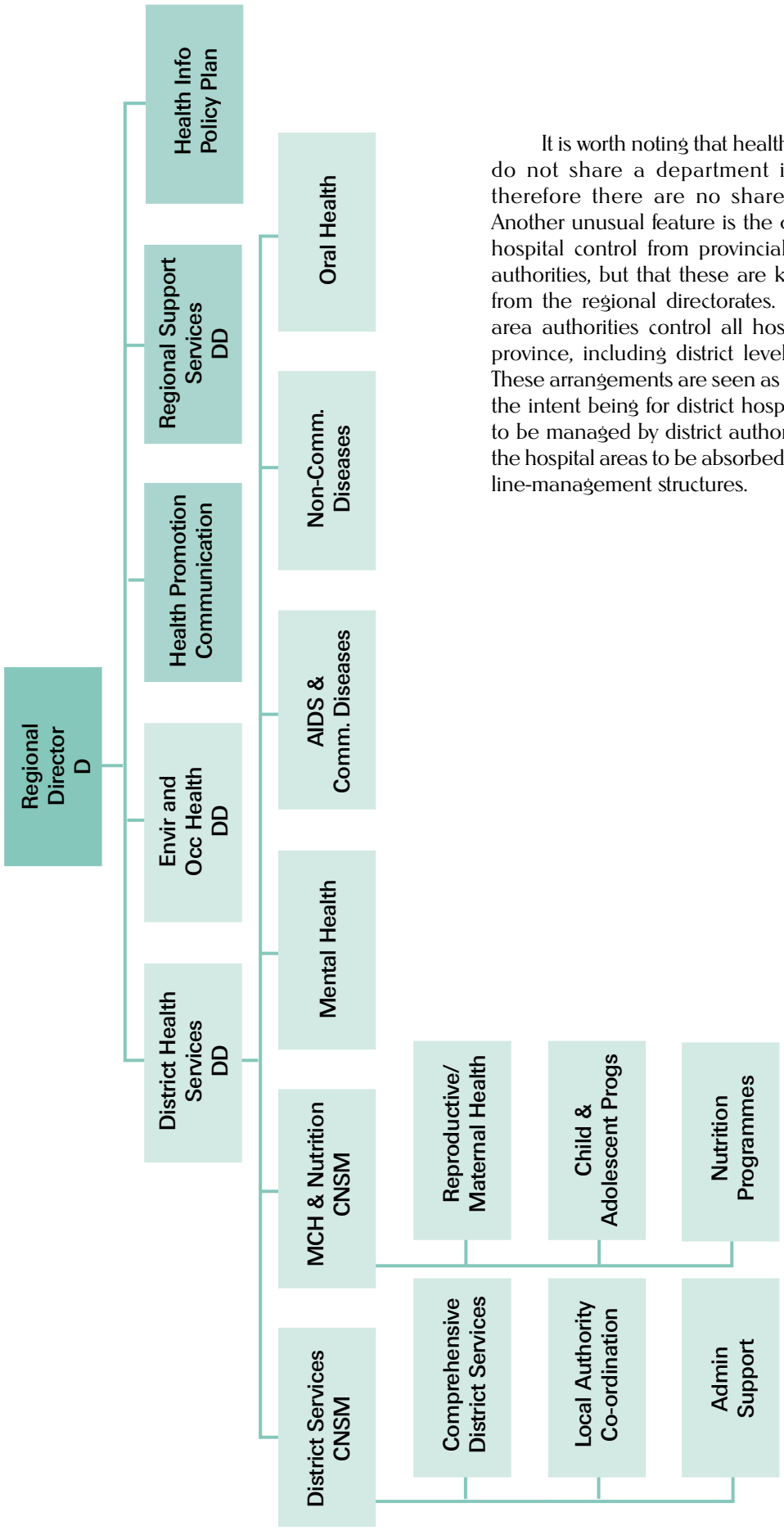


FIGURE 4.9 REGIONAL ORGANOGRAM FOR GAUTENG



It is worth noting that health and welfare do not share a department in Gauteng: therefore there are no shared functions. Another unusual feature is the devolution of hospital control from provincial to regional authorities, but that these are kept separate from the regional directorates. The hospital area authorities control all hospitals in the province, including district level institutions. These arrangements are seen as interim ones, the intent being for district hospitals, in time, to be managed by district authorities, and for the hospital areas to be absorbed into regional line-management structures.

Free State

FIGURE 4.10 PROVINCIAL ORGANOGRAM FOR THE FREE STATE

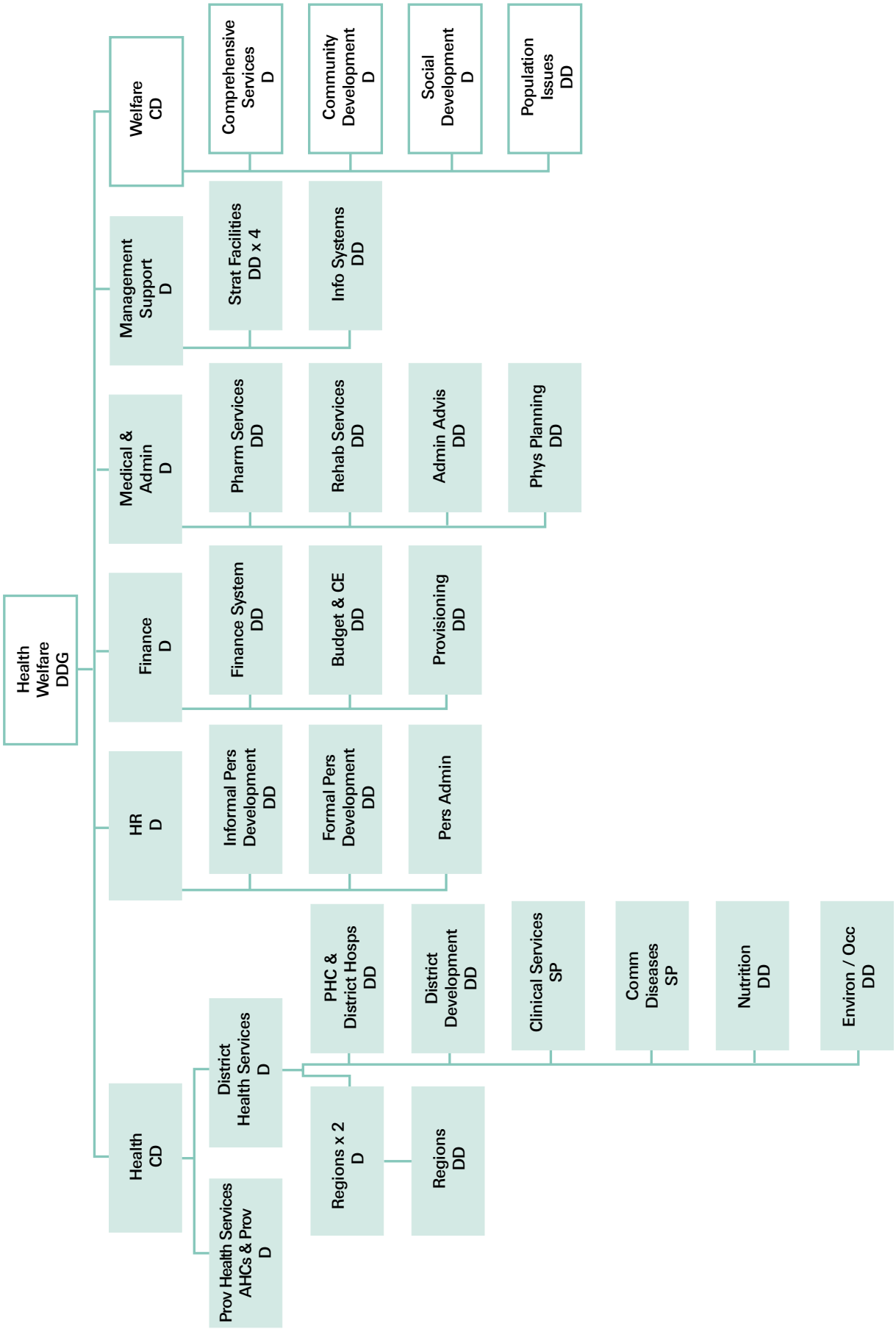
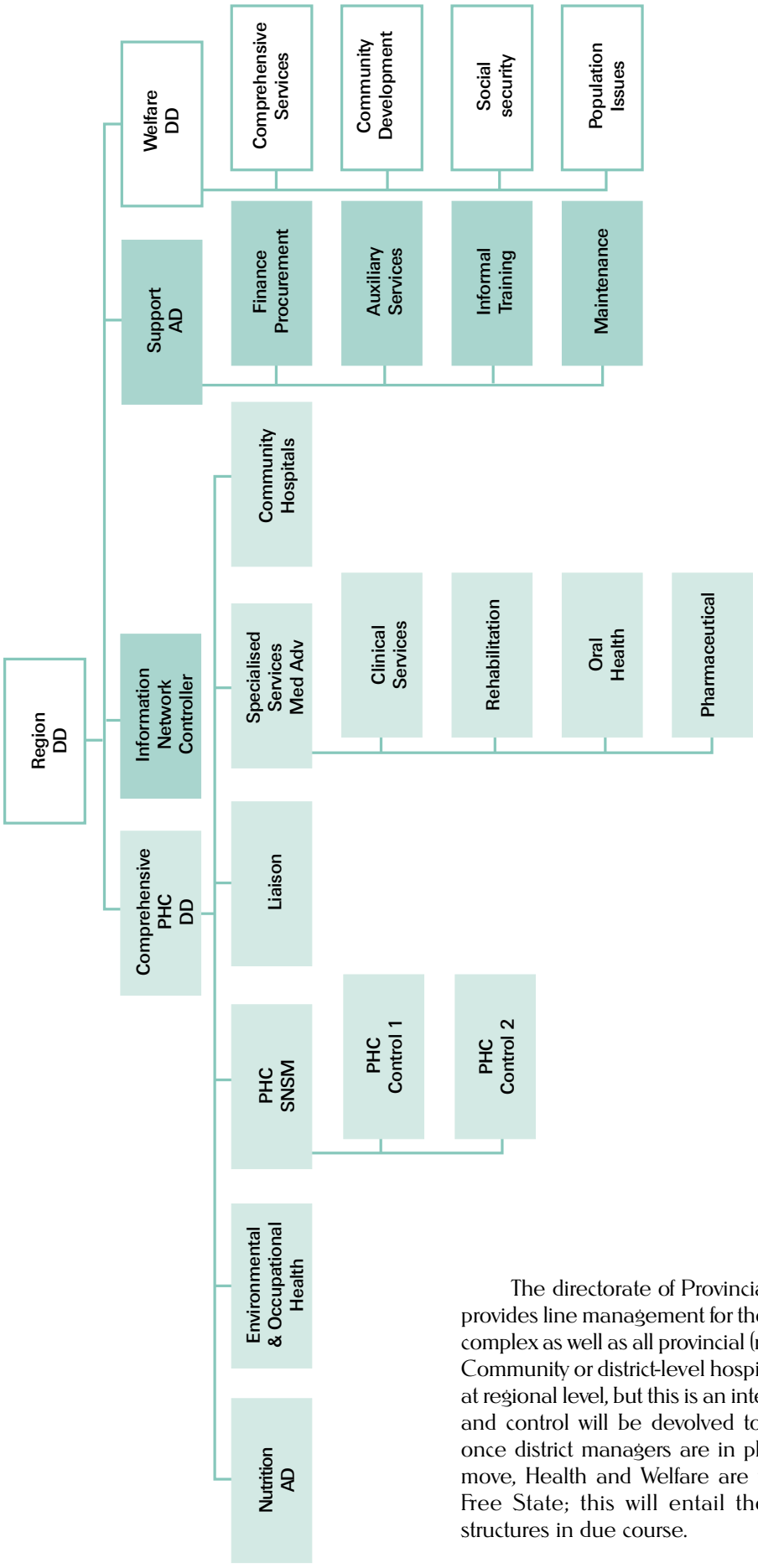


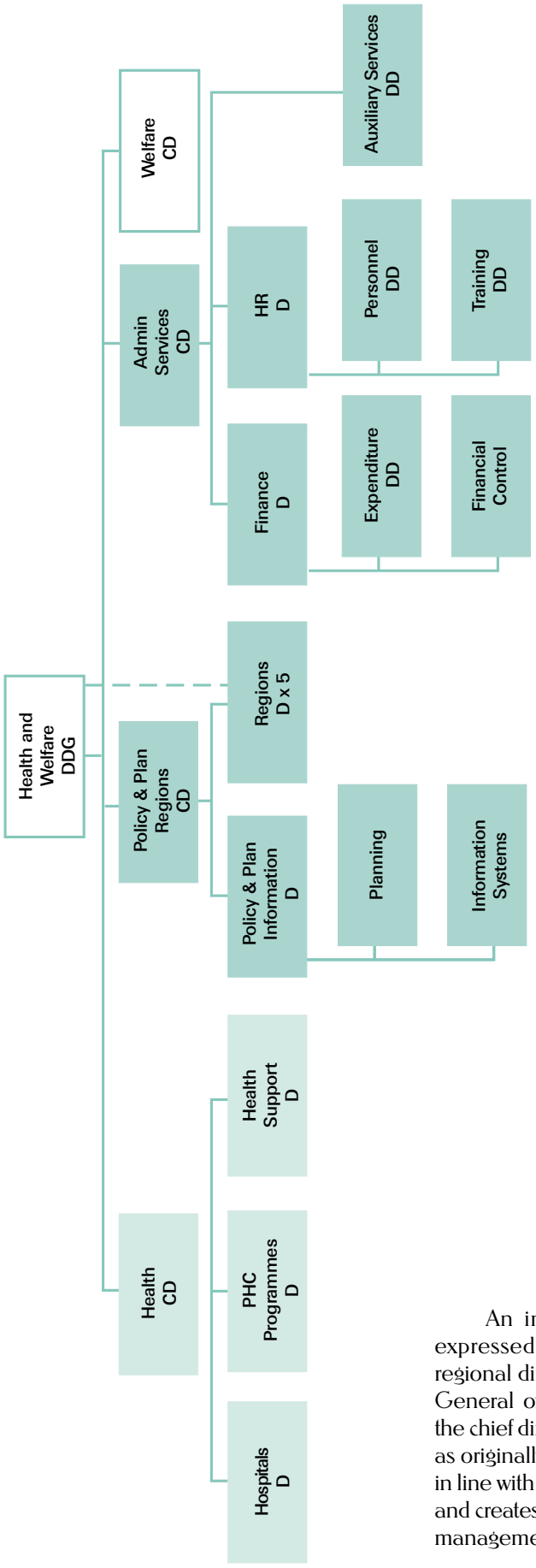
FIGURE 4.11 REGIONAL ORGANOGRAM FOR THE FREE STATE



The directorate of Provincial Health Services provides line management for the academic health complex as well as all provincial (regional) hospitals. Community or district-level hospitals are controlled at regional level, but this is an interim arrangement, and control will be devolved to the district level once district managers are in place. In a surprise move, Health and Welfare are to be split in the Free State; this will entail the design of new structures in due course.

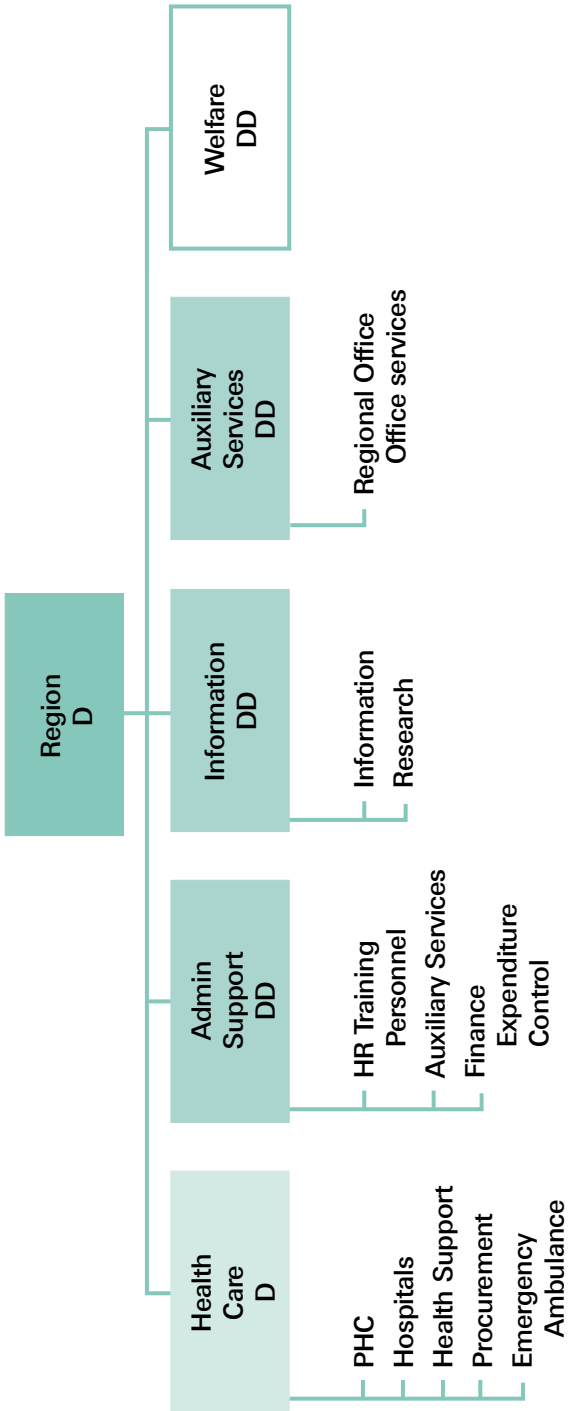
Eastern Cape

FIGURE 4.12 PROVINCIAL ORGANOGRAM FOR THE EASTERN CAPE



An important modification in Figure 4.12 is expressed by the dotted line connecting the five regional directorates directly with the Deputy Director-General of Health and Welfare, rather than through the chief directorate of Policy and Planning and Regions as originally drawn. This brings the Eastern Cape more in line with the generic organogram previously outlined and creates a clear division between line and functional management structures.

FIGURE 4.13 REGIONAL ORGANOGRAM FOR THE EASTERN CAPE



Western Cape

FIGURE 4.14 PROVINCIAL ORGANOGRAM FOR THE WESTERN CAPE

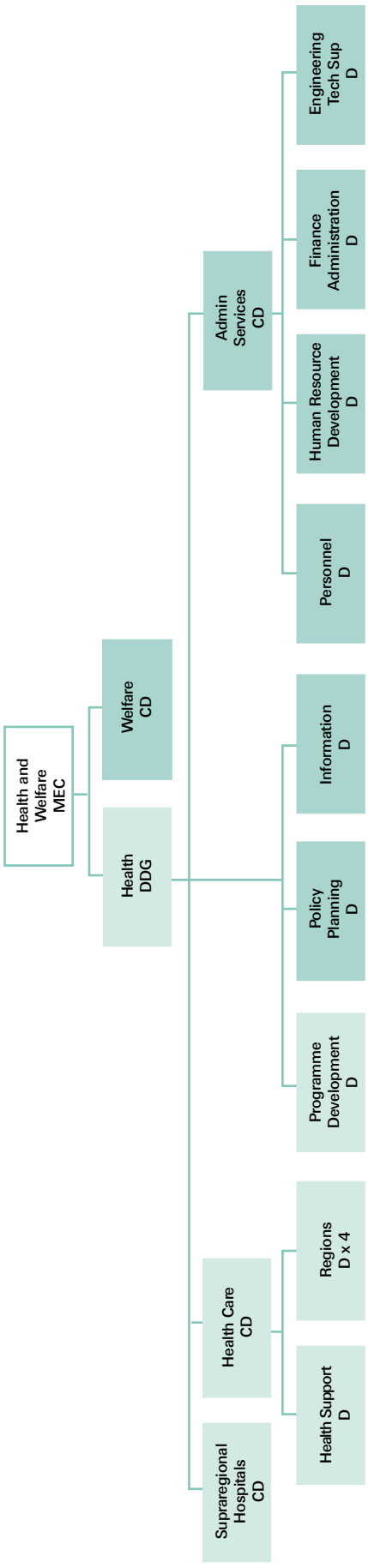
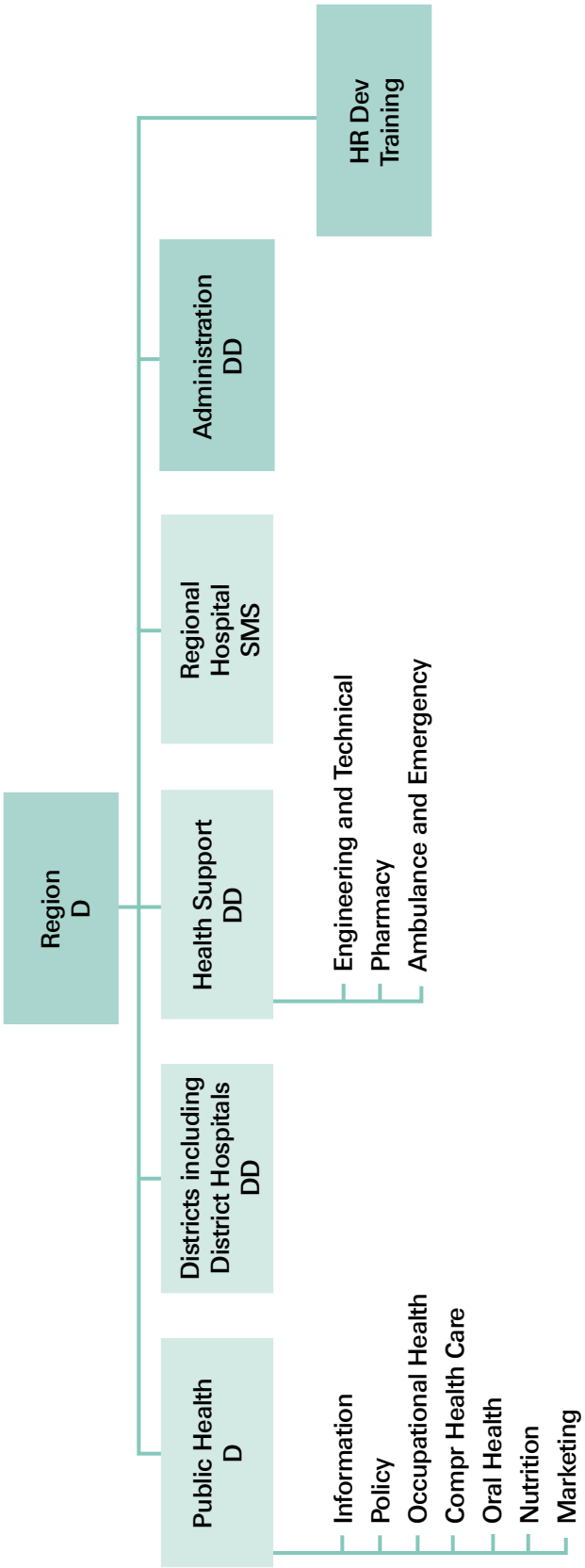


FIGURE 4.15 REGIONAL ORGANOGRAM FOR THE WESTERN CAPE



Hospital management in the Western Cape is based on the ideal model of district health, where district authorities manage their own hospitals, regions manage theirs, while supra-regional hospitals are managed by their own chief directorate.

Northern Cape

FIGURE 4.16 PROVINCIAL ORGANOGRAM FOR THE NORTHERN CAPE

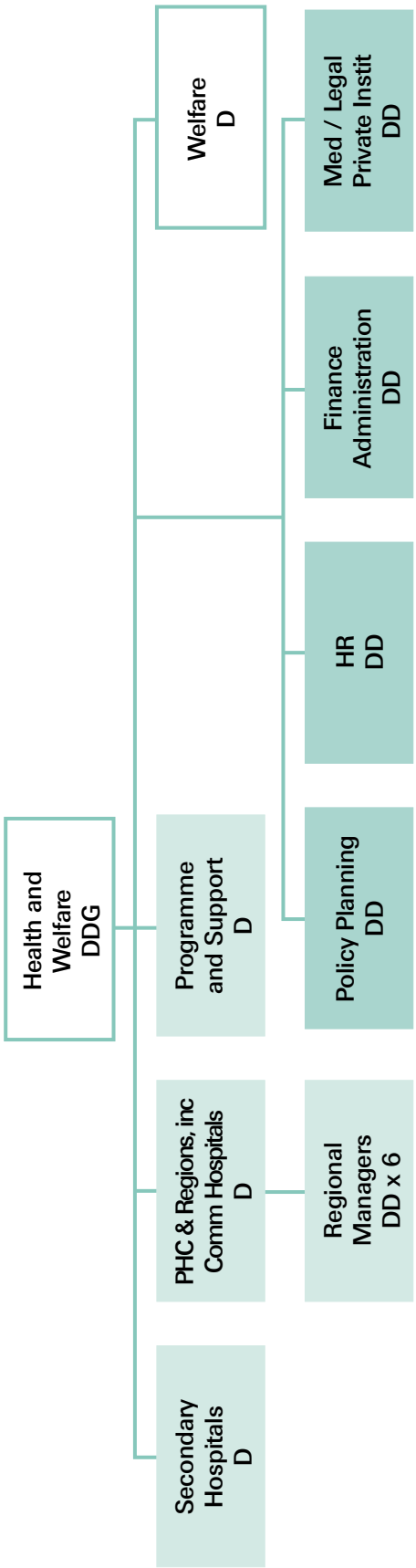
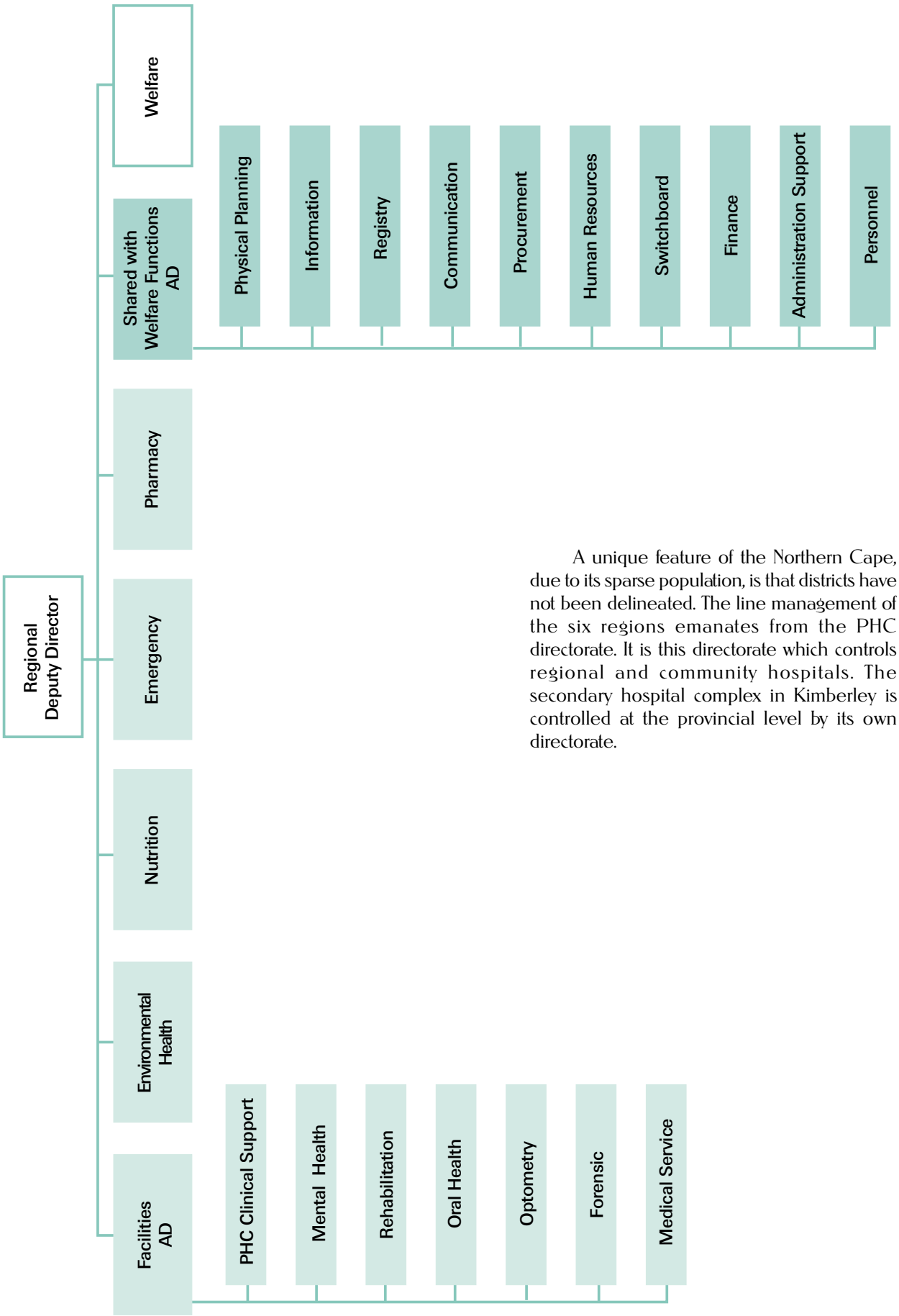


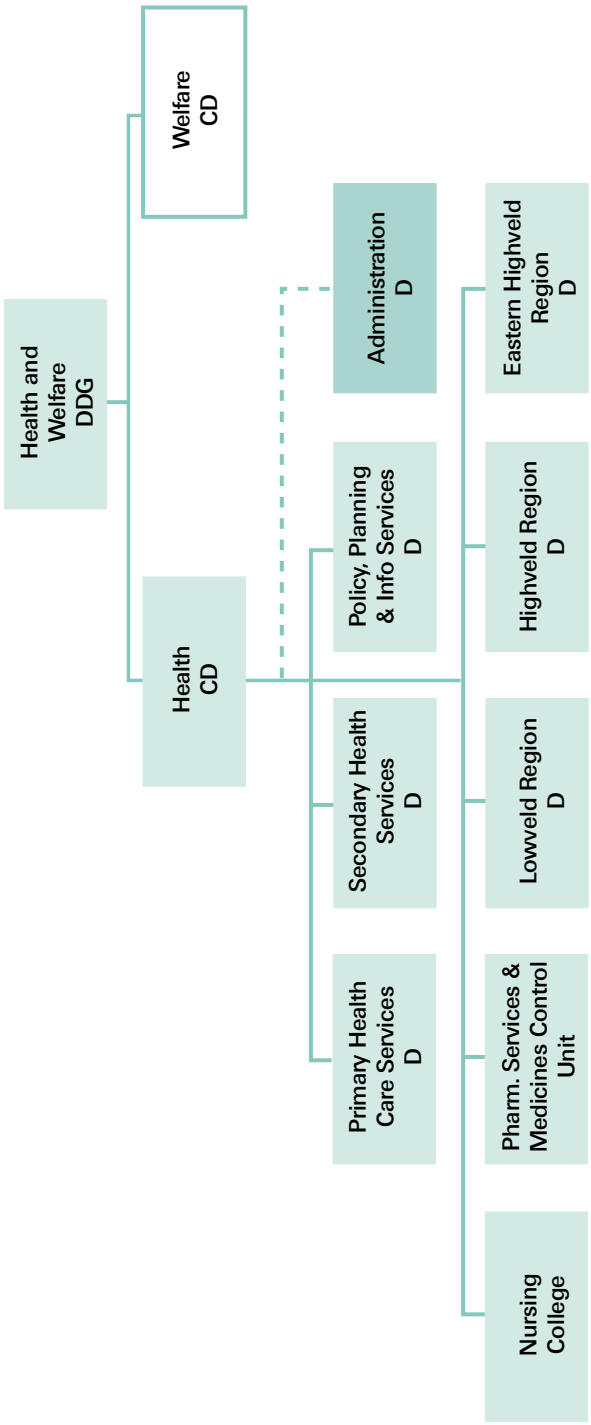
FIGURE 4.17 REGIONAL ORGANOGRAM FOR THE NORTHERN CAPE



A unique feature of the Northern Cape, due to its sparse population, is that districts have not been delineated. The line management of the six regions emanates from the PHC directorate. It is this directorate which controls regional and community hospitals. The secondary hospital complex in Kimberley is controlled at the provincial level by its own directorate.

Mpumalanga

FIGURE 4.18 PROVINCIAL ORGANOGRAM FOR MPUMALANGA



SOME RECURRING THEMES

An inescapable impression to be gained from comparing the organograms first submitted by the various provinces and those published here (which represents a time lapse of less than three months) is the wide-ranging changes to which most of the provincial structures are still subject. Hardly an organogram has remained the same; and we can be equally certain that more changes are still to come. The restructuring process is still in a state of considerable flux, and it will be some time before managerial patterns settle.

In spite of this ongoing process of trial and error, however, certain broad trends or themes have emerged which are worthy of comment.

To begin with, a clear distinction is not always drawn between "line" and "functional" management. Line management "delivers" a service directly; functional management "supports" such delivery. But listen to some of the verbs used (on just one organogram) to describe the purpose of the various directorates and sub-directorates in a new health management structure: the directorate or sub-directorate "plans, renders, promotes, monitors, co-ordinates, conducts, facilitates, maintains, provides, ensures, handles, establishes", and many more. Which of these verbs refer to line management and which to functional management? The picture is far from clear. Confusion between these two managerial purposes can of course create serious problems for the smooth delivery of health care at a variety of levels, and anecdotal evidence of this occurring in several provinces has already emerged.

As a general rule, however, it appears that most provinces have arranged for functional management at provincial and sometimes regional levels, while line management of actual services has moved through the directorates controlling the regions and thence to the districts.

When considering the new structures in relation to their avowed aim, that of facilitating the delivery of PHC via the district model, clear distinctions between the two main management functions (line or functional) become crucial. The district health system is supposed to see the control of all health workers and health facilities within the district, up to and including hospitals at the first referral level, and the appropriate laboratory, other diagnostic, and logistic support services being held by a management team at the district level. This is not happening evenly across all the provinces.

Take hospitals as an example of this. Clearly, provincial and tertiary hospitals must be (and are) line managed at the provincial level. But what happens to the community (or first referral) hospitals? In an ideal "district" situation, these should be controlled at the district level. But only in North West Province, Western Cape and Eastern Cape is this currently the case. It is interesting to see what arrangements have been made in other provinces. In the sparsely populated Northern Cape, regions form the lowest subdivision, and community hospitals are in consequence line managed from the regions. The Northern Province, although fully delimited into 30 health and welfare districts, follows the same arrangement. Regional control of community hospitals also pertains in Free State, but only until district managers are fully in place.

Gauteng, with its highly developed hospital infrastructure, provides a fascinating glimpse of the gradualist approach. Hospital areas (distinct from the general health regions) have been set up across the province, but the intention is to merge these with the regions in time. The hospital area authorities currently control all hospitals in the province, although the intention is to devolve control of community hospitals to the districts when (and if) the districts are ready to assume this responsibility.

The same unevenness of approach can be seen when we turn our attention from the hospitals to such specialist services as radiography, pharmacies, laboratories, ambulances and so on. Some provinces have gone for immediate decentralisation; others have seen benefits such as economies of scale in retaining control at the provincial level; still others have opted for a gradual transition from central to district control.

It could be argued that to retain too much control at the provincial level may well dilute the impact of community participation and bottom-up planning which is supposed to characterise a district health approach. In some quarters, on the other hand, there is clearly a reluctance to relinquish control of expensive infrastructure too early. Time will tell which route is the more successful.

Provinces have also come up with different solutions with regard to the line management of regional and district services. Seven of the nine provinces appear to have routed this line management from the top civil service post in health and welfare through at least one intermediate level before it reaches the regional directorates. The intermediary is usually the chief directorate in charge of health.

In the Northern Province, on the other hand, regional directors report directly to the deputy director-general and superintendent-general respectively.

The Eastern Cape is a good example of a shift in thinking from the former system to the latter. The five regional directors currently report to the chief directorate responsible for policy and planning and the regions. But presently under discussion is a change (marked on the organogram) which would allow these regional managers a direct reporting line to the deputy director-general of health and welfare.

Two points can usefully be made about these differing approaches. First, in the large provinces (where no sharing of regional and district structures is likely to take place between health and welfare) it makes sense to route line management through an intermediate health-dedicated level. In the smaller provinces (where sharing will clearly take place) this approach might be harder to justify. Second, the routing of regional and district line management through intermediate provincial levels whose major concerns are with functional support could increase the danger of confusing the delivery process with that of its support.

Those provinces which have opted for direct line management from the top, on the other hand, may find difficulty in effectively plugging functional support (which could appear to be by-passed) into a delivery service which is line managed via another, more direct route.

A final observation: in the provinces with the largest populations there is complete separation between the policy and planning and administrative services for health and those for welfare. As provinces decrease in size, some planning functions remain dedicated to health, while the administration services are usually shared. In the smaller provinces, the planning and administrative services are common to both health and welfare. These differing responses are a logical outcome as provinces have confronted their own demographic realities while searching for a balance between efficient services and the most cost-effective deployment of their civil service.

THE NEW FACE OF HEALTH ADMINISTRATION

A breakdown of appointees to posts of director and above indicates that the majority of these senior positions are held by people from the previous civil service, or civil services in those provinces which include the old homelands. Indeed, across the eight provinces to have responded to the relevant questions, only 24 out of 103 incumbents so far appointed are new to the civil service. All the rest are old hands, but not necessarily in old jobs. For example, of the 16 Northern Province appointees from the old civil services, two were appointed one level below their old rank, five at the same rank, and nine at one level higher than their old rank.

The provincial figures showing how many of the total number of appointees are new to the civil service are as follows:

Northern Province:	3 out of 19 are new.
Mpumalanga:	1 out of 7 is new.
North West:	5 out of 14 are new.
Gauteng:	4 out of 15 are new.
Free State:	1 out of 12 are new.
KwaZulu-Natal:	No information given.
Eastern Cape:	3 out of 17 are new.
Western Cape:	6 out of 15 are new.
Northern Cape:	1 out of 4 is new.

With less that 25% of new blood represented among senior people so far appointed to the provincial departments, the temptation might be to conclude that the new face of health administration is not looking markedly different from the old. However, the figures do not give a complete picture as many of the appointees from the old civil service have been drawn from non-managerial positions.

MANAGEMENT TRAINING

Responses to the original questionnaire reveal a definite awareness of the need for the training of new health service managers. Indeed, all provinces have expressed this need, albeit to varying degrees. Although some training initiatives are used by more than one province, the general impression is that each province is very much pursuing its own agenda.

What follows is a list of some of the health management and related courses, plus relevant details, mentioned as being used by the various provincial health authorities in the training of their health managers:

Health Management Training Courses

1. **name:** **Diploma in Health Services Management.**
   run by: Community Health Department, University of the Witwatersrand.
   funded by: Fees.
   aimed at: A post-graduate course for middle managers (not restricted to medical doctors).
   content: General principles include planning, organisational behaviour, basic economics, and how to run and record meetings. The personnel management segment includes skills development, preparation of job descriptions, disciplinary procedures, improving staff performance, health personnel planning and communication. Financial management deals with basic financial principles as applied to public and private health service settings. The health information component includes data management, use of computers, and the use and abuse of information and mechanisms for data storage and retrieval.
   duration: Four weeks a year for two years.

2. **name:** **Short course in Health Economics.**
   run by: Health Economics Unit, University of Cape Town (run under the auspices of the Committee for Public Health Education (COPHE).
   funded by: Fees.
   aimed at: Mid-level managers within the public health sector and non-governmental organisations.
   content: Basic economics, alternative methods of health-services financing, health sector budgeting and the allocation of resources, and economic analysis to evaluate the inputs, processes and outcomes of health care provision.
   duration: Three weeks.

3. **name:** **Summer School Public Health Programme.**
   run by: University of the Western Cape.
   funded by: Fees.
   aimed at: Middle and senior level managers and decision makers.
   content: Courses include, community water supply and sanitation, communicable diseases, essential drugs programme, health promotion, community-based nutrition programmes, oral health, district health management and planning, mental health with PHC, PHC and restructuring the health service, school health promotion, health economics and financing, rural and farm health, training of PHC facilitators, Project Planning and Monitoring Methods (ZOPP) for districts, maternal and child health, participatory media and PHC, tobacco control.
   duration: One, two and three week courses.

4. **name:** **Oliver Tambo Fellowship in Public Health Management.**
   run by: Community Health Department, University of Cape Town
   funded by: Henry J. Kaiser Family Foundation.
   aimed at: Chief directors, directors, senior health managers.
   content: Health policy and health systems change, planning for equity; managing service delivery and improving effectiveness and efficiency; the manager and the new health system.
   duration: One year course work including 4 one week blocks, and six months to complete a project/report.

5. **name:** **Primary Health Care Service Management Course.**
   run by: Wits Graduate School of Public and Development Management.
   funded by: Self-sustaining.
   aimed at: Individuals and institutions who are striving to promote health and development at the strategic interface between the health service and communities.
   content: Health service management; introduction to management; human resource management; the management of other resources, and applied projects.
   duration: Five 30-hour compulsory modules over a period of five months, preceded by a one week orientation programme.

All the above courses are being used by one or more of the provinces. It is worth mentioning, however, that the Oliver Tambo initiative is probably the most widely used managerial training programme. All provinces have managers on the course, with the exception of the Northern Province.

Other courses mentioned by the various provinces include those funded by the Overseas Development Administration (ODA) and the European Union. ODA funding amounts to R3-million over two years for the Northern Cape, Northern Province, and the national Health Department for managerial training for all provinces. The ODA training initiatives use UK Open University materials adapted for South Africa.

Also of importance in the overall training effort are in-house training programmes. The Free State health department is developing such courses in conjunction with the Centre for Health Systems Research and Development at the University of the Free State. The Gauteng health department has been able to hook into the training capacity of the provincial administration as a whole, and senior managers, as well as their middle and junior counterparts are undergoing general management and industrial relations courses. Mpumalanga, on the other hand, has become involved in a German exchange programme for managers.

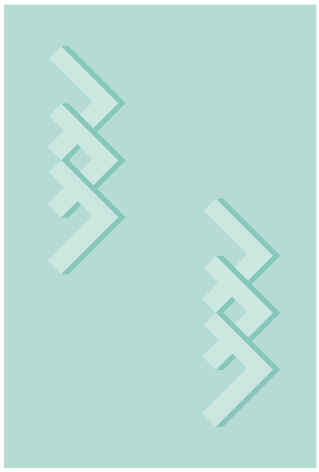
It is worth noting that although there appears at first sight to be a bewildering array of health management training courses, the trend is very definitely towards integration of what might have begun as unrelated efforts. In particular it is worth mentioning the degree of co-operation between universities and the development of the Transvaal School of Public Health which will launch its first masters degree in Public Health in 1997. This school has emerged as an umbrella body embracing most of the tertiary teaching institutions involved in health management training in the old Transvaal province. The effect has been the development of deliberately integrated courses leading to a common set of qualifications. To a lesser extent, there is co-operation in the Western Cape among tertiary teaching institutions which work together under the auspices of the Committee for Public Health Education.

From the point of view of the development of relevant managerial training for health managers, this trend towards trainer and course integration must be regarded as a positive initiative. Not only is individual manager mobility (from one province or training institution to another) enhanced, but the chances of implementing cost-effective training and workable quality-control mechanisms across the entire country become more possible.

CONCLUSION

The task of transforming South Africa's health care services is an enormous one. At first glance, the breaking down of this task into nine provincial segments has served to create an uneven approach and widely differing results. On closer examination, however, the organisational and managerial structures now emerging appear to follow distinct trends, showing more sensitivity to local conditions, including the internal demands of top-heavy bureaucracies, than they do to any text-book definitions of PHC delivered via the district model. Will this generally pragmatic approach dilute the ultimate impact of the transformation?

It's probably too early to tell. Most provincial systems are still in a state of considerable flux. The fluidity of many of the provincial organograms, even during the past few months, is testimony to that. In spite of a lingering sense that most provincial health departments are still struggling through a difficult and complex transition, there can be little doubt about the energy and the seriousness of the struggle.



PRIVATE SECTOR

Over the past decade, expenditure in the private sector, particularly medical schemes, has increased more rapidly than the rate of inflation. Medical scheme contributions were equivalent to 7.1% of average salaries in 1982, but amounted to 15.2 percent of average salaries by 1992.[1] During the time that there was this increase of more than a 100% in the contributions, the number of people covered by medical schemes increased by only 20%.[2] Private health care expenditure grew from 6.3% to 17.4% of per capita gross domestic product during the ten years to 1992.[3]

Several factors have driven these cost increases, including:

- the fee-for-service reimbursement of providers
- some doctors having a stake in the financial performance of hospitals
- many health service providers (including hospitals and medical practitioners) benefitting financially from selling medicines[2]
- an increase in the average age of people belonging to medical schemes
- a deteriorating exchange rate with imports of medical technology costing more.

Changes to the Medical Schemes Act (particularly the 1989 amendments), have created a situation in which the cross-subsidisation of higher risk persons is undermined by the introduction of experience and risk rating approaches by health care funders. This means that funders try and enrol low risk people who have previously not claimed extensively on their medical aids and discourage those people who are more likely to claim; in short health care funders would like to insure the young and healthy and not insure the elderly and sick.

These two issues of increasing costs in the private sector and the policies of funders trying to insure "low risk" individuals are likely to increase demand for publicly funded health care services. This is not helping public sector policy makers who are trying to use limited resources in a way which serves all South Africans in an equitable manner.

With a political need to expand health services to under served communities, there is thus pressure on the government to introduce health care reforms in the private sector which help to release public funds for reconstruction and development initiatives and improve primary level services.

THE NATIONAL DEBATE

A Committee of Inquiry into a National Health Insurance System was established early in 1995 to consider and develop the ideas presented by the Health Finance Committee of 1994.[4] The Department of Finance was represented on the Committee of Inquiry. This Committee of Inquiry released its report in June 1995.[5] It made a number of recommendations but many of these have not yet been translated into policy.

There were a number of basic principles on which the Report of the Committee of Inquiry is based.

These principles include:

- that all South African permanent residents should have equal access to the public funded primary health care system
- that citizens should retain the right to use private health care providers and to insure themselves for doing so
- that it was not appropriate to remove primary health care from private delivery systems
- that primary care could not be developed separately from other levels of the health care system and was dependent on the appropriate referral mechanisms to secondary and tertiary care.

These key principles were adopted by the Department of Health in January 1996.[1]

As part of the phasing in of the above principles, the Department of Health has decided to make primary health care free only to uninsured patients.

Author : Reg Magennis

It is clear from the above principles that scarce resources have placed severe limitations on the timing, nature and extent of government health care reform initiatives. The government has been forced to strictly prioritise reform initiatives and recognise the role of the private sector for as long as free government social services do not meet with standards deemed to be acceptable to economically independent persons.

PROPOSED REGULATION OF THE MEDICAL INSURANCE INDUSTRY

The Department of Health's reform proposals are based on the Committee of Inquiry's recommendations and aim to expand publicly funded primary care, particularly to the under served. As part of this overall strategy, it is proposed that private sector activities will be regulated in a manner which:

- ✧ minimises the unfunded use of public health facilities by employed persons
- ✧ maximises the use of privately funded health care so as to reduce dependency on the publicly funded system

In order to help finance primary care the Department of Health has recommended

- ✧ The introduction of mandatory health insurance coverage for a defined hospital benefit package. All employed individuals and their families will be required to obtain coverage for at least the costs of using the public hospital system. This proposal is currently being reviewed by the Department of Health, with a view towards finding the optimum approach to implement mandatory coverage of core services.

There are also proposals which are designed to make sure that the medical schemes cover the sick and old as well as the young and healthy.[1]

A number of proposals have been put forward to contain costs in the private sector. To contain private health care costs involving hospitals in the private sector the provincial authorities should be responsible for authorising the construction of new private hospitals and regulating supply of expensive technology in both the public and private sectors.

To contain costs in the pharmacy related areas it has been proposed that:

- ✧ Pharmacies may be owned by any legal persona, but control over all issues related to dispensing must be the responsibility of a registered pharmacist (who may be employed or contracted by the pharmacy owners). The idea behind this is that it would allow managed care structures and group practices to emerge which would bring down costs.
- ✧ The dispensing of medicines by medical practitioners should be strictly controlled, with permission to dispense granted only to medical practitioners who practice in areas in which pharmacies are not easily accessible. Draft regulations to this effect have already been published (See Chapter 8 for details).
- ✧ Remuneration of pharmacists and dispensing doctors should be based on a professional fee and costs, and should not be related to the cost of the items dispensed. This should apply to prescription and to over-the-counter medicines.

In order to regulate the number of health workers in the private sector and the maldistribution between the urban and rural areas it has been proposed that:

- ✧ A policy requiring new medical graduates to spend a defined period working in the public sector prior to being allowed to enter private practice should be investigated and negotiated. This will be implemented through introduction of a two year period of limited registration after the completion of internship.
- ✧ To ensure adequate geographical distribution, it is proposed that licensing procedures should be introduced to control access to private practice in over served areas, and to encourage practice in under served areas.

To rationalise medicine pricing and usage in the private sector a number of reforms have been proposed by the national Department of Health in their Drug Policy Document:

- Manufacturers may not discriminate between purchasers when setting prices. The same terms shall be available to all purchasers for given volumes and terms of payment. At present dispensing doctors are able to command preferential prices. Manufacturer prices shall be transparent to all buyers.
- The wholesale and retail percentage mark-up system will be replaced with a pricing system based on a professional fee.
- Price increases will be regulated. In this regard the government is investigating a reference pricing system.
- If essential drugs are not available to the private sector at prices that are considered reasonable, the government shall make these medicines available at State tender price plus transaction costs.
- Prescriptions in the private sector shall be written using the approved international non-proprietary name. Until this aim is achieved, generic substitution will be allowed. It will be incumbent on the pharmacist, prior to dispensing a prescription, to inform the patient of the benefits of generic substitution. A regularly updated list of products that cannot be substituted, will be prepared and disseminated by the government.
- Promotion in the form of financial or material benefits shall not be offered to or sought by health care practitioners to influence them in the prescribing of drugs.[6]

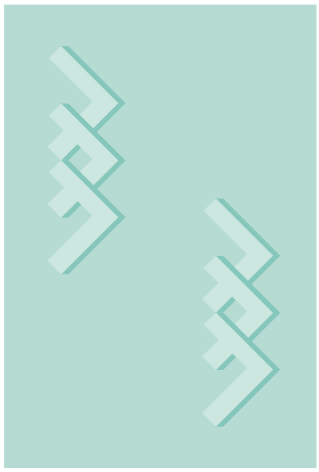
SYNOPSIS OF KEY TRENDS

Notwithstanding that there are a number of proposed policies coming from the Department of Health, the private health care sector is evolving. A number of new products and schemes have been launched or are soon to be launched.

The life insurance industry is expanding its range of employment linked products by integrating into the health industry. Already certain life insurers have launched what they call "new generation" medical schemes. These schemes attempt to apply age related group ratings which are coupled to patient oriented financial disincentives. Certain of these life insurers have made considerable investments into the importation of managed care technology and skills from the United States of America, and will be launching new integrated managed care options during the latter part of 1996.

Managed care initiatives can involve substantial investment with limited short term returns. It is therefore likely that schemes will continue to follow the experience rating approach, until government reform proposals are actually implemented to eliminate this option.

The private health care sector is likely to be driven by the distribution of individual incomes rather than by national policy aimed at promoting equity and primary health care. Currently in South Africa 5% of the population pay 70% of the personal tax and it appears difficult to achieve radical shifts in private health funding to lower income groups in the formal employment sector in the short term.[7] Greater access to private health care for the majority of the population is more likely to be achieved through the growth in so called "Black Business" and aggressive staffing policies adopted in the government sector. These shifts are likely to be at least partially at the expense of existing employed populations, and are not likely to result in significant financial growth in the private health sector as a whole.



5 HEALTH FACILITIES

INTRODUCTION

In some ways, the planning of health facilities may appear to be simple and therefore an easy aspect of health service provision. The building of a new clinic or hospital always generates excitement and, when the facility is finished, it represents concrete proof that things have improved for the community it serves and the health professionals that will work in it.

However, new buildings can quickly fall into disrepair. Alternatively, it may soon become apparent that a new facility is badly located and designed. Sometimes new facilities cannot be opened because there is no money to employ staff or purchase the supplies necessary to provide a service.

This chapter highlights the need for the careful planning of future facilities to avoid the inequitable, inappropriate and wasteful habits of capital planning in the past. It also gives an indication of the progress made in the improvements of health facilities over the past year. Because this is the first time the topic of health facilities is being presented, an overview of a strategy for the planning of facilities is given.

DEFINITIONS

In a discussion of this sort it is useful to have a common understanding of the meaning of terms used to describe different sorts of facilities. Recently some definitions have been proposed which differentiate between *facility types* and the *level of care* delivered within these facilities.

THE CURRENT STOCK OF FACILITIES

The maldistribution of beds and clinics

In 1993 there was a total of 4.0 public and private hospital beds per 1 000 population.[1] This figure is comparable to the level of resources in countries with a similar per capita income.[2] However, the distribution of beds varied greatly between provinces, ranging from 2.1 beds per 1 000 population in Mpumalanga to 6.0 per 1 000 in Gauteng.[1]

In 1994/95 in the public sector, there were 2.0 acute beds per 1 000 population, ranging from 1.5 beds per 1 000 in Mpumalanga to 3.0 per 1 000 in the Northern Cape.[3] If the population who belongs to medical aid schemes is excluded from the population denominator used in calculating these ratios, the national average is 2.5 acute beds per 1 000. While this level is slightly below target levels for a middle-income country, it is probably not necessary to expand this number of beds in the short term. More important a problem is the uneven geographic spread of hospital beds. Most beds are concentrated in in the urban areas and especially the metropolitan urban areas. This distribution results in unequal and inadequate access to hospital care especially for rural poor Africans.

In 1994/95 there were 0.8 clinics per 10 000 population. It is difficult to judge the adequacy of this coverage by comparing it to the standard of the World Health Organisation of 1 clinic per 10 000 people in rural areas.[4] Many urban clinics in South Africa serve very large populations living close to the facility. For example, in Soweto in 1993 an average of 150 000 people lived within a distance of 1.5 kilometre of a health centre.[5]

Authors : Jane Doherty, Rodion Kraus and Kobus Herbst

Hospital Categories and Level of Care Definitions

Primary health care (PHC) includes non-personal as well as personal promotive, preventive, curative and rehabilitative ambulatory care which is available through an outpatients' department in a hospital, a fixed or mobile clinic, or a general practitioners (GP's) office. A **primary health care facility** sometimes has limited radiographic and laboratory support as well as a few overnight beds, but tends not to have a theatre or fully developed wards.

Acute hospital care is provided in three categories of institutions:

> ***Level 1*** patients require treatment which may be adequately and appropriately provided at a **district hospital** (the first level of referral) by a generalist with access to basic diagnostic and therapeutic facilities. For example, basic X-rays would be administered by a radiographer and a basic range of laboratory tests would be performed by a technician, but there would not be an intensive care unit. Theatre facilities would be available but not a specialist anaesthetist. Occasionally such hospitals would have access to specialists in internal medicine, obstetrics-gynaecology, paediatrics, surgery and radiology.
>
> ***Level II*** patients require the use of equipment and facilities found at a **regional or secondary hospital** (which represents the second level of referral) and the expertise and care associated with any of the following specialists: physicians, general surgeons, orthopaedic surgeons, anaesthetist, paediatricians, obstetrician-gynaecologists, psychiatrists, general radiologists and general pathologists. The hospital would be equipped with an intensive care unit. Level I patients can also be treated at a secondary hospital.
>
> Patients require the expertise and care associated with the sub-specialities and less common specialities (such as cardiology, endocrinology, oncology, organ transplantation, plastic and trauma surgery, neonatology, sophisticated paediatrics and specialised imaging), or require access to scarce, expensive and specialised therapeutic and diagnostic equipment found only at a **central or tertiary hospital** (the third level referral). Patients with uncommon ambulatory conditions who attend the hospital for highly specialised outpatient services are also classified as receiving care at this level. Level I and Level II patients can also be treated at a tertiary hospital.
>
> A tertiary hospital may also serve ***Level IV*** patients. These patients require care by sub-specialists that is currently very costly or requires significant expertise. This type of care is not routinely available in the sub-speciality, is very new and is usually found in only one or two hospitals in the country.

A ***chronic hospital*** is a hospital which provides long-term care for patients, usually after discharge from acute care hospitals. Psychiatric hospital and tuberculosis hospitals are chronic hospitals. Psychiatric hospitals and tuberculosis beds may also occur in acute hospitals.

Academic care is care that is associated with a Medical Faculty. Academic care may be delivered from a hospital with beds at any level or care, or it may be delivered from primary care facilities in an ambulatory setting.

Source: Doherty 1994
Hospital Strategy Project 1995a
Hospital Strategy Project 1996

However, it is clear that access to PHC services in many areas is far from ideal, with services often being provided centrally through hospital outpatients departments rather than at the periphery. Also, it is estimated that only 39 percent of South African clinics provide comprehensive care.[3] Estimates of the number of new clinics required to meet the shortfall in PHC provision range from between 600 and 1 000.[6]

The physical condition of facilities

Much of the existing stock of facilities (especially hospitals) is in a dilapidated state with crumbling electrical, water and steam systems. This is partly due to the fact that facilities have not been upgraded or replaced as they reach the end of their natural lifespan, and partly because maintenance has been minimal, resulting in accelerated decay. Consequently many facilities are nearing the end of their useful lifespan.

The basic infrastructure of primary level facilities is inadequate. A national survey in late 1995 showed that in the Northern Province, of the 302 clinics, more than 20% had no electricity supply or telephone and 30% did not have an adequate water supply. The situation was similar in the North West, Eastern Cape and KwaZulu-Natal provinces.[3]

TABLE 5. 1. PERCENTAGE OF CLINICS AND HEALTH CENTRES WITHOUT BASIC AMENITIES

	Northern Province	KwaZulu Natal	North West	Eastern Cape	Free State	Northern Cape
Total Number (Clinics, clinic satellites and health centres)	333	407	300	645	281	134
% no adequate water supply	30	20	30	46	7	7
% no telephone	23	15	43	38	10	13
% no grid electricity	23	11	42	52	9	12

Source: Health Systems Trust and Department of Health. ReHMIS analysis, 1996

The inefficiency of facilities

Many facilities are inappropriately designed, leading to overcrowding, lack of privacy and expensive modes of service delivery. Some hospital wards contain many more beds than originally planned e.g. Northern Province wards have 25% more beds now than originally planned.[7]

By way of a contrast, many hospitals are functioning at occupancy rates far below the ideal eg. the 1992/93 ReHMIS Survey found that 39 acute care hospitals had occupancy rates less than 40 percent.[6] This situation often exists in hospitals which were located in formerly white areas while another hospital, designed for blacks, was located in a nearby township.

Another aspect of inefficiency is the over-concentration of resources in central hospitals, especially the urban tertiary hospitals, to the detriment of the development of district hospitals located at the periphery. It is the latter category of hospital which should meet the bulk of the need for hospital care.

The challenge from the private sector

The building of hospitals by the private sector and the minimum standards for the design of facilities are governed through a licensing process and regulations. For the past year, a moratorium has been placed on the building of private hospitals but pressure is mounting to allow some projects to proceed. But there are loop-holes in the regulations which have allowed certain sorts of private facilities, which in reality are small hospitals, to develop.

These facilities are not subject to quality control by government inspectors. This development is of concern both to the government and to the regulated component of the private sector. While the increased provision of private hospitals in under-served areas could improve access to care for some public patients, in many situations it could threaten the viability of nearby public facilities. Thus, alongside the careful examination of the licensing and regulatory process for private facilities, the government also needs to consider other ways of harnessing the potential of the private sector, for example, through allowing private practitioners to access under-utilised beds in public hospitals.

CURRENT INITIATIVES TO ADDRESS FACILITY DEVELOPMENT

The upgrading of clinics and the construction of new ones has been the focus of several programmes in recent years. Both the Independent Development Trust and the Central Economic Advisory Services were involved in clinic building programmes in the early 1990s. Clinic development has become one of the presidential lead projects of the Reconstruction and Development Programme (RDP) of the new government. "Between May 1994 and August 1966 a total of 60 new clinics have been built and 47 existing clinics have been upgraded. A projected total of 301 new clinics will have been built and 100 upgraded by the end of 1997".[7] As at April 1996, a total of R190 million had been allocated to clinic development.[8,9]

Until recently, little attention was paid to the development of hospital facilities, the exception being the intense debate in the early 1990s regarding the future of certain of the academic complexes.[10]

In the last year, however, it has been accepted that the development of well-functioning district health systems cannot take place without resolving the crisis in hospitals. This has led to the commissioning by the national Department of Health of the Council for Scientific and Industrial Research (CSIR) to perform a national audit of health facilities. It is estimated that 27% of the total capital stock will need to be replaced or upgraded over the next ten years. As yet the exact cost of improving facilities across the country has not been properly determined, but all indications are that it will cost in the order of several billion rand.

Outside government, the Centre for Health Policy, CSIR and the Hospital Strategy Project have been working on developing guidelines for PHC and hospital facilities.

CONSTRAINTS POSED BY THE LEGACY OF APARTHEID

The distribution, physical state and functional design of facilities in South Africa reflect the racial planning of the past. These characteristics also reflect the unsystematic and unco-ordinated planning typical of fragmented services which are not guided by a strategic plan. It is difficult to rectify this situation in the short term as it is expensive and time-consuming to replace existing facilities with more appropriate ones.

Thus in one sense South Africa is locked into the pattern of service delivery of the past. The challenge is to use existing facilities creatively and to grasp the opportunity presented by the poor state of some of the existing physical stock to build new and appropriate facilities elsewhere.[10]

CRITICAL POLICY ISSUES

In the past the location and design of facilities had more to do with political decision than health service delivery needs. For example, several of the more recently constructed public hospitals are unnecessarily large and expensive and fail to meet the essential health care needs of the population they serve. There is growing appreciation of the fact that future facility development should occur within the framework set by reform priorities for the health care system. There are a number of policy issues which need to be resolved before a large programme of facility development is embarked upon. These issues include:

- the appropriate model for the delivery of services and at what level of facility particular patients will be treated
- how and where academic training will take place in the future i.e. decisions about whether academic activities will be concentrated in one academic hospital or dispersed throughout the system will have an impact on the size, complexity and cost of facilities
- what are the alternatives to hospital-based care (eg. ambulatory care or hospice care); this has an impact on the number, location and sorts of facilities that are built
- the expansion of the private hospital industry.

A stepwise approach for planning the development of facilities within a policy framework is presented below:

A strategy for planning the development of facilities

Once the policy framework within which facility development must occur has been clarified, strategies for the upgrading, building and even closure of facilities need to be formulated. These strategies should be comprehensive in that they take account of all developments in the health care sector and respond to district, regional, provincial and national priorities. It is the absence of such strategies which leads to piecemeal facility development and the squandering of resources. The essential steps in developing a comprehensive strategy are summarised below.[11,12]

Step 1: Assessment of existing health facilities

A methodical analysis of the existing stock of facilities is a crucial first step in the development of a strategic plan. The national audit of clinics and hospitals which has recently been completed grades buildings and other infrastructure (such as water, steam and electrical systems) in terms of their physical state and functional suitability.[7]

Step 2: Development of facility guidelines

In the interests of equity, nationally accepted guidelines should be used to decide when it is justifiable to provide a community with a new or upgraded facility and to prioritise new projects. These guidelines should be affordable within a national context. The present PHC facility guidelines developed before the current restructuring are very limited in their content and application.

Guidelines for hospitals were applied rigorously but led to inappropriately expensive hospitals. These norms had been conceptualised as maximum limits for the purpose of guiding contractors but in practice became the minimum standards according to which all new hospitals were designed.[13,14] This highlights the need to apply guidelines within a consistent and comprehensive framework.

Rispel *et al* have recently published guidelines for locating PHC facilities (Table 5.4).[15] These guidelines were developed through an extensive process of research and consultation.

TABLE 5.2 INDICATORS OF ADEQUACY OF PROVISION OF HEALTH FACILITIES (PUBLIC SECTOR)

	Eastern Cape	Free State	Gauteng	KwaZulu Natal	Mpuma-langa	Northern Cape	Northern Province	North West	Western Cape
Acute beds per 1 000	2.8	2.4	-	2.9	-	2.7	2.4	1.6	-
Chronic beds per 1 000	0.7	0.4	-	0.7	-	0.7	0.8	0.7	-
Population per PHC exam. unit	6 027	4 528	-	3 950	-	3 410	11 349	6 630	-
Population per clinic	10 464	10 787	-	22 050	-	5 540	15 822	11 641	-

Source: ReHMIS analysis. Health Systems Trust and Dept of Health. 1996

TABLE 5.3 INDICATORS OF UTILISATION OF HEALTH FACILITIES (PUBLIC SECTOR)

	Eastern Cape	Free State	Gauteng	KwaZulu Natal	Mpuma-langa	Northern Cape	Northern Province	North West	Western Cape
Bed occupancy (%)	64	41	-	79	-	66	52	58	-
Ave. length of stay	7.0	7.0	-	9.0	-	5.9	5.3	7.8	-
Bed turnover rate	34	38	-	32	-	46	24	27	-
Visits per PHC exam unit per day	31	39	-	48	-	19	66	41	-

Source: ReHMIS analysis. Health Systems Trust and Dept of Health. 1996

TABLE 5.4 FACILITY GUIDELINES FOR DIFFERENT GEOGRAPHICAL AREAS

Type of PHC	Type of area facility	Population per km²	Catchment population	Maximum catchment radius
Mobile clinic	Dense metropolitan	› 10 000	5 000 per visiting point	0.33 km for each visiting point
	Large urban	1 000-2 000	3 000-6 000 per visiting point	1km for each visiting point
	Smaller urban	200-400	600-5 000 per visiting point	1-2km for each visiting point
	Deep rural or semi-desert	5-40	250-2 000 per visiting point	4km at each visiting point
Medium-sized clinic or health centre	Dense metropolitan	› 10 000	80 000	1.4km
	Large urban	1 000-2 000	50 000	2.8-4km
	Smaller urban	200-400	10 000-20 000	4km
	Deep rural or semi-desert	5-40	-	-
Major 24 hour health centre	Dense metropolitan	› 10 000	80 000 for general care 180 000 for specialised and 24 hour services	1.4km 2km
	Large urban	1 000-2 000	50 000 for general care 180 000 for specialised and 24 hour services	2.8-4km 5.4-7.6km
	Smaller urban	200-400	100 000-180 000	9.9-15.9km
	Deep rural or semi-desert	5-40	-	-

Source: Rispel *et al.* Confronting Need and Affordability: Guidelines for PHC Services in South Africa. 1996

Preliminary guidelines for hospitals have also been proposed by the Hospital Strategy Project.[12, 15, 16] These guidelines focus on bed to population ratios of 2, 1, 0.3 and 0.4 beds per 1 000 for district, regional, tertiary and chronic hospitals respectively as well as the organisational layout of district hospitals. Detailed design guidelines for PHC and hospital facilities have been published by the CSIR.[17, 18, 19, 20, 21]

Step 3: Needs assessment

An assessment of need is performed by comparing the existing stock with what is desired based on facility guidelines and a number of other factors. These factors include the existence of *geographical barriers* (such as hills, rivers and railway lines) which make it difficult to access otherwise nearby facilities, the availability of important *infrastructure* (such as transport routes, water and sewerage systems, and an electricity supply) and, very importantly, the *general policy context* of health services development which was referred to earlier.

Because of the long lifespan of buildings (20 to 50 years), and because even the planning and construction of a large hospital could take as long as 5 years, facilities must be planned on the basis of future as well as current requirements. Important issues to take into account are the *changing size of a catchment population* over time and *potential changes in the utilisation of health services* (especially due to the HIV/AIDS epidemic).

Step 4: Development of a prioritised master plan

Given that health facilities, especially hospitals, are expensive and take a long time to build, a comprehensive plan for capital development includes the prioritisation of facilities according to explicit and rational criteria. A capital development master plan should indicate which facilities are going to be closed, down-graded, upgraded or simply maintained. It will also indicate which new facilities will be built and at which location. This information will be expressed within the relevant time frame for implementing the plan.

A research project in Soweto developed criteria and ratings for prioritising the upgrading of existing clinics.[10] Criteria used for the prioritisation of medium and large health centres were:

- ✧ physical condition of existing facility
- ✧ functional suitability
- ✧ additional functional units required
- ✧ presence of geographic barriers
- ✧ presence of high-density residential areas (eg. informal settlements, hostels) or areas considered to be very poor
- ✧ priority accorded to clinic by the health authorities (eg. their assessment of the need for repairs)
- ✧ whether money has already been set aside for development of the clinic

A method for prioritising the upgrading of hospitals has also been proposed.[11] This method includes the evaluation of facilities against *technical* as well as *policy* criteria. Technical criteria include an assessment of whether buildings, mechanical and electrical equipment, and biomedical equipment require emergency, critical, urgent or essential attention. Policy criteria include an assessment of whether facilities are of high, moderate or low strategic importance in terms of ensuring equity of access, affordability and the achievement of health care goals. Weighted scores for these criteria are combined to rank facilities in the order of their importance. The Project also developed a modification of the above method that can be used for prioritising the upgrading of health centres and clinics.

Whilst the projects mentioned in the previous paragraphs provide some guidance on how to prioritise facilities for development, it is important that widely accepted criteria be developed within provinces, especially for the prioritisation of new facilities.

Step 5: Identification of recurrent cost implications of capital development plans

Budgeting for capital expenditure often occurs in isolation from budgeting for the costs of personnel and other resources to operate the facility. In the past this has led to facilities being built and then being left idle. It is that essential that the services to be delivered by new facilities be planned in conjunction with the facilities themselves. A facility should not be constructed if there is no foreseeable mechanism for funding the services it is meant to provide.

Step 6: Financing the capital development plan

At present the capital expenditure components of provincial health budgets are really recurrent budgets intended for maintenance purposes. Budgets for the building of new facilities have usually been held by the Departments of Public Works. It is unlikely that these budgets will be able to fund the extensive rehabilitation of facilities which is required in South Africa. Possible new sources of funds are the RDP and donor funding.

Step 7: Co-ordination of facility planning with other departments and contractors

It is important to emphasise here that the Departments of Health and Public Works should operate as an efficient team, understanding one another's constraints and objectives. Likewise, the relationship between these departments and the contractors responsible for the construction of the new facility should be a close one. This will avoid unnecessary delays in construction as well as the development of facilities which are not responsive to the needs of health care workers.

Step 8: Development of a strategic plan for maintenance

Maintenance has habitually been neglected in facilities across the country. This has led to the unnecessarily rapid decay of buildings and infrastructure, often beyond the point of salvage. Thus, it is as important to develop a maintenance plan as it is to develop a building plan. A maintenance plan should provide for the monitoring of existing capital stock, its timely repair and its eventual replacement, if necessary. It should also alert planners to changing priorities.

CONCLUSION

This chapter has emphasised how past mistakes in facility planning have wasted resources and constrained present opportunities for health systems reform. It is essential that future facility development should proceed with caution and care, conserving resources and supporting new directions in health care wherever possible. A comprehensive and co-ordinated building and maintenance plan is required for the whole country. This plan should evolve continuously as the health care needs of the population change over time and as old facilities come to the end of their useful lifespan.

6 FINANCING AND EXPENDITURE

INTRODUCTION

The recent experience of many developing countries has been that the process of integrating the PHC (primary health care) approach into health systems is most complex when confronted with financial constraints. Given these complexities, there is a need for health sector planning and implementation cycles to be constantly monitored and modified in order to achieve broad health policy goals.

The national Department of Health's first five year planning and implementation cycle was initiated in the 1994/95 financial year. It is thus opportune to assess progress in relation to the Department of Health's broad goals over the first two years of this cycle. In particular, it is important to evaluate whether current financing and expenditure measures are being directed towards achieving these long term goals.

This analysis briefly reviews the key policy challenges identified in the "Financing and Expenditure" chapter of the South African Health Review 1995.[1] It also highlights the recommendations of the "Health Expenditure and Finance in South Africa" publication, and the "Committee of Inquiry into a National Health Insurance System".[2, 3] Within this context, the 1995/96 and 1996/97 health budgets are examined, the progress in implementing key health policies is assessed and various challenges for the public health sector are identified.

SETTING THE SCENE

Revisiting the financing and expenditure problems

In 1992/93 an estimated R30 billion, equivalent to 8.5% of Gross Domestic Product (GDP), was spent on health care in South Africa. The major sources of finances were medical schemes (40%), general tax and local government revenue (38%), and out-of-pocket payments (14%). Total health care expenditure comprised of spending on private health services (58.2%), public health services (38.6%), public and donor funded capital projects (1.3%) and research and training (1.8%).[1, 2]

Despite the relatively high level of health care expenditure by a developing country, South Africa has high levels of preventable morbidity and mortality. The health sector policies and expenditure patterns of the previous government have contributed to this apparent anomaly. In particular, the current Department of Health inherited a health system which is characterised by a maldistribution of resources between the public and private sectors, levels of care, geographic regions, and socio-economic groups. The extent of these resource disparities can be summarised as follows.[1, 2]

- **Public and Private Sector Mix :**

  Only 21% of South Africans have some degree of access to private sector health care on a regular basis, with only 17% of the entire population having medical scheme cover. The private sector in South Africa has been in a financially more advantageous position relative to the public sector, especially in terms of its main source of funds (medical schemes) and its allocation of expenditure. As a result, a higher proportion of the national human resource base, with the exception of nurses, is located in the private sector (57% of doctors, 87% of dentists and 94% of pharmacists work in the private sector).

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- **Geographic Distribution of Resources :**

  A number of studies have illustrated the effect of apartheid policies, whereby health services in the former "homelands" were systematically underfunded relative to the former provinces. As a result, there are significant disparities in the allocation of public sector health care resources between and within the new provinces. In addition, there is a concentration of private sector resources (such as private hospital beds and practitioners) and medical scheme members in the large metropolitan and urban areas.

- **Distribution of Public Sector Resources between Levels of Care :**

  There is a relative concentration of resources within the hospital sector. The Health Expenditure Review showed that in 1992/93, 76% of public sector expenditure was allocated to acute hospitals. Academic and other tertiary hospitals alone accounted for 44% of total public sector expenditure.

  In contrast, only 11% was spent on non-hospital primary care services in 1992/93. This includes expenditure on clinics, community health centres, environmental health services, school health services, community nursing and district surgeon services.

On the basis of these expenditure patterns and resource allocation issues, McIntyre outlined the major challenges facing the South African health sector.[1] These are summarised below according to the private and public sectors.

- **Private Health Sector :**
  - There is a need to improve the routine estimates of private sector expenditure, to adequately assess changes in the private health sector.
  - There is an urgent need to control the current cost spiral. This requires pro-active interventions by medical schemes, with the active involvement of other stakeholders such as employer and employee groups. In addition, government regulation of the private sector should be revised.
  - Mechanisms for making resources currently located in the private sector accessible to a broader section of the population should be explored.
- **Public Health Sector :**
  - Given the reliance on general tax revenue within the public sector, which constrains the ability to restructure health services and to move towards universal access, there is a need to investigate alternative sources of finance for health services. In particular, the potential role of user fees at public sector hospitals and the proposed Social Health Insurance should be further explored.
  - In redressing the maldistribution of health care resources between and within provinces, a carefully designed funding formula is required. Such a formula should take into account geographic differences in population size, demographic composition, health status, population density, cross-boundary flows to utilise academic and other tertiary hospital services, migration patterns between provinces (particularly in relation to urbanisation trends), and access to and utilisation of private sector health services.
  - The maldistribution of resources between levels of care should be addressed. Improving the provision of primary care services for the poor was seen as a particular priority.

It is evident from the above discussion, that unless fundamental change in resource allocation and distribution is achieved within the annual budgets, the Department of Health's long term goals will be compromised. The health budget is a reflection of the level of commitment of the Department of Health to implement key health sector policies; while there may be a verbal commitment to various policies, these policy goals will not be achieved unless there is a shift in resources to support their implementation.

Based on the above overview of the challenges facing the health sector in South Africa, the budgets in the early years of the current five year cycle should particularly reflect a redistribution of resources between geographic areas and levels of care. In addition, there should be some indication of efforts to consider alternative health service funding sources, and to introduce regulatory mechanisms to support cost-containment efforts in the private sector. One caveat is necessary before presenting

an analysis of recent developments; it is essential to recognise that the extent of the resource maldistribution that the current Department of Health inherited will constrain its ability to achieve rapid, visible changes in resource distribution.

Committee of Inquiry into a National Health Insurance System

The brief of the Committee of Inquiry into a National Health Insurance System for South Africa was to design a system that would ensure universal and non-discriminatory access to quality primary health care for all South Africans.[3] The major recommendations of this Committee were summarised in the 1995 South African Health Review.[4] These include measures to promote improved access to the PHC system, the development of a district-based health care system, a review of public sector human resources (especially those working at the PHC level), the training and redeployment of existing personnel, improving the conditions of service for public sector health personnel, the introduction of accreditation for private providers, the implementation of an essential drugs list and ensuring the availability of medicines at all public sector primary care facilities.

In terms of the funding requirements for the PHC system, the committee estimated the costs of the proposed PHC system over a five year period, beginning in April 1996. The estimated expenditure on PHC services in 1992/93 was R1.85 billion, which is equivalent to R2.2 billion in 1995/96 prices. It was estimated that this expenditure could be increased to approximately R3.97 billion (in 1995/96 prices) if there was a redistribution within the health budget in favour of primary care services. This was based on the preliminary 1995/96 budget for PHC services. To implement the full proposals of the Committee of Inquiry, an additional R1.96 billion would be required for PHC services in the 1997/98 financial year. By the year 2000/01, the PHC budget would require an additional R4.89 billion (in 1995/96 prices). It was anticipated that a small proportion of these additional PHC budgetary requirements could be met by redistributing government resources from the national defence budget to the health sector, and by improving efficiency within the health sector.

The Committee also estimated that R350 million would be required in the 1996/97 financial year for certain "fast-track" elements of their plan (such as the building of clinics and training of PHC nurses). It was anticipated that some of these resource requirements could be met by local and international donor funding, with the remainder being met out of current budgets.

The potential sources of finance for the additional PHC budgetary requirements, as identified by the Committee, were as follows:

- an increased allocation to health from general tax revenues
- dedicated funding to the public health sector from excise duties and/or value added tax
- dedicated tax funding derived from reductions in tax expenditure through modification of the tax treatment of contributions to medical schemes
- dedicated payroll taxes
- imposition of a user charge on voluntary private health insurance contributions.

The next section will assess whether the above recommendations have been taken into account in the most recent annual health budgets. In particular, it will be evaluated whether the PHC budget has yet reached the R4 billion mark, and whether adequate provision has been made for funding the abovementioned "fast-track" elements of the Committee's proposals.

DIAGNOSING THE 1995/6 AND 1996/7 HEALTH BUDGETS

Overview of the 1995/6 and 1996/7 health budgets

The 1996/97 health budget of R17.2 billion is 9.9% of total estimated government expenditure. When compared to the 1995/96 budget of R15.4 billion, this represents a nominal increase of 11.7%. However, after accounting for inflation, it translates into a minimal real increase of 2.6%. In relation to other social services, the health sector is said to have received a "survival budget".

According to the revised estimates of expenditure in 1995/96, the health allocation as a proportion of the government's total budget has stabilised at approximately 10%, maintaining previous levels and matching the inflation rate. Prior to 1994/95 there was a progressive decline in the health budget as a percentage of the total budget from 11% in 1991/92 to 10.2% in 1994/95. Table 6.1. provides an overview of the health budget allocations for the 1995/96 and 1996/97 financial years.

TABLE 6.1. 1995/96 AND 1996/97 HEALTH BUDGETS AND PROVINCIAL ALLOCATIONS :

Provinces	1995/96 (thousand Rands)	% of Total	1995/96 Per Capita Public Sector Health Care Budget (Rands)	1996/97 (thousand Rands)	% of Total	1996/97 Per Capita Public Sector Health Care Budget (Rands)
Eastern Cape	1 974 219	12.79	301	2 502 666	14.55	366
Northern Cape	262 306	1.70	366	289 176	1.68	376
Western Cape	1 893 317	12.26	513	2 120 160	12.33	576
Kwazulu-Natal	2 907 793	18.84	334	3 130 742	18.20	356
Free State	1 060 189	6.87	383	1 230 879	7.16	432
Mpumalanga	604 707	3.92	203	783 590	4.56	268
Northern Province	1 444 376	9.36	271	1 594 712	9.27	300
North West	917 737	5.94	271	1 109 637	6.45	307
Gauteng	3 241 925	21.00	458	3 726 193	21.66	537
Sub-total	**14 306 569**	**92.67**		**16 487 755**	**95.86**	
National	1 131 103	7.33		711 699	4.14	
Total	**15 437 672**	**100.00**	**347**	**17 199 454**	**100.00**	**421**

Source: South Africa (1995). Department of Finance and Makan *et al*, 1996

Note : Some sources have used preliminary budget estimates which may account for slight differences in provincial allocations.

In addition to the above health budget, a budgetary allocation for health personnel salary increases was included on the "improvement of conditions of service" vote. For the 1996/97 period, this translated into an additional R1.3 billion for the adjustment of salaries of health sector personnel. This budgetary measure signifies the substantial commitment to implementing health sector human resource development policy recommendations.

Matching the 1995/96 and 1996/97 budgets to policy recommendations

The Role of the National Department of Health

Table 6.1 indicates that there has been a substantial decrease in the budgetary allocation to the national Department of Health. Their budget has declined from R1.13 billion in 1995/96 to R712 million in 1996/97. This shift reflects the implementation of the policy to decentralise responsibilities for health service provision to the provinces. However, it should be noted that much of this budget reduction relates to the devolution of provincial level services that were incorporated into the national budget when the previously segregated "own affairs" departments were disbanded. It is thus difficult to determine the extent to which there has been a real reduction in the size of the national Department of Health, in line with its more limited responsibilities in a decentralised health system.

Approximately R241 million of the R712 million is to be transferred to the provinces for "policy and planning", with specific reference to optimising the utilisation of health care resources. This amount has been allocated as a capital transfer for the upgrading of supra-regional and national functions. The national Department of Health determines the allocation of these funds to provinces ". . . on the basis of differential need".[5] It should be noted that no indication was given of how this differential need will be determined.

Provincial Resource Allocation Adjustments

As indicated previously, one of the major challenges facing the health sector is that of redressing the historical maldistribution of resources on a geographic basis. Internationally, it has been recognised that geographic resource reallocation should occur gradually. The ability of provinces, which have previously been relatively underfunded, to absorb significant budget increases is limited. Conversely, well-resourced provinces require adequate time to adjust to budgetary cuts to minimise the potentially adverse effects on existing health services. On this basis, the more gradual resource re-allocation process adopted by the Department of Health in the 1996/97 budget is to be welcomed (see Table 6.1).

After the substantial, and unsustainable, budget cuts experienced by the relatively "over-resourced" provinces of Gauteng and the Western Cape between 1994/95 and 1995/96, the allocation to these provinces remained fairly constant between 1995/96 and 1996/97. Gauteng accounted for 21% of the total public sector health budget in 1995/96 and 21.66% in 1996/97, while the Western Cape accounted for 12.26% and 12.33% in the respective years. Table 6.1 indicates that Mpumalanga, which has the lowest per capita expenditure, received the largest budgetary increase of nearly 30%. The province receiving the second highest budget increase (26.8%) was the Eastern Cape.

Despite this reallocation process being a gradual one, it is important to recognise that gains are being made. In 1995/96, the per capita health budget in the Western Cape was 153% greater than that in Mpumalanga. By 1996/97, the gap between the per capita budget in the most well-resourced and least well-resourced provinces (Western Cape and Mpumalanga respectively) had declined to 115%. It is therefore evident that the overall inter-provincial budgetary trend between 1995/96 and 1996/97 is positive; redistribution is occurring and at a pace which is more appropriate in terms of provinces' ability to absorb budgetary changes.

It is however important to note that these observations are based on budgeted figures. Certain provinces (such as the Western Cape and Gauteng) have experienced substantial budget cuts for much of the 1990s and have incurred massive over-expenditure on their health budgets. Within this context, any real budget reduction places a significant burden on their activities.

It should also be recognised that the above data only refer to changes between the 1995/96 and 1996/97 financial years. As was indicated in the 1995 South African Health Review, it is intended that provincial differences in the per capita budget (weighted by a particular formula) should be completely eradicated during the current five year cycle. The magnitude and pace of the geographic resource redistribution planned for this five year period, is regarded by many as being unrealistic. It has also been argued that the formula that is used is inadequate for the following reasons:

- The baseline population data are not regarded as accurate.
- The impact of migration patterns, particularly urbanisation trends, and differential birth and death rates on the longer term inter-provincial population distribution are ignored.
- Differences in population density between provinces, which will affect the relative cost of service provision, are not adequately or systematically accounted for.
- Inter-provincial differences in health status (reflected in morbidity and mortality) patterns are not taken into account.
- The allocation procedure for funding academic hospitals significantly disadvantages provinces which have large academic complexes.
- Cross-boundary flows to utilise health services, particularly at the tertiary and quaternary levels, are inadequately accounted for.
- Inter-provincial differences in access to and utilisation of private sector health services are not taken into account.

The current mechanism for allocating health budgets, where the Function Committee (with representatives from national and provincial Departments of Health) determines each province's

health budget, will be changed in line with the new constitution. Each province will be allocated a global budget from which they will determine the health budget for their province.

The Financial and Fiscal Commission (FFC) has proposed a formula for determining these global provincial budgets. There would be a basic grant to establish and maintain institutions within the province to fulfil their constitutional obligations. This would be based on the provincial population size and would be weighted by 25% of the rural population (as a proxy of the relative wealth of the province). Then, a "national standards" grant would also be awarded to provide services which are regarded as a national priority. In the health sector this comprises the cost of achieving an average of 3.5 visits to a primary care facility per person, per annum (or 0.5 visits per annum for members of medical schemes). There will also be conditional "spillover grants", specifically for provinces which have academic hospitals.[6]

At a recent meeting of the Budget Council, the FFC's inter-provincial budget allocation formula was only partially accepted. The global allocations to the provinces were accepted but not the components of the formula.[7] It is thus unclear at this stage on what basis the process of achieving greater inter-provincial equity in health care financing will be carried forward.

Intra-provincial Resource Allocation

The Health Expenditure Review also highlighted substantial disparities in the allocation of health care resources within provinces (i.e. between magisterial districts).[2] The mechanism for determining budget allocations from the provincial level to newly established regions and health districts requires urgent attention. A national "Task Group on District Financing for Intra-provincial Equity" has been established to consider these issues. It has representatives from the national and provincial health departments, as well as relevant research organisations.

Strengthening Primary Level Health Care Services

In reviewing the 1995/96 budget, the National Portfolio Committee on Health noted that 28% (R4.4 billion) had been dedicated to academic hospitals as compared to 15% (R2.4 billion) allocated to PHC personal services and 3.7% allocated to non-personal PHC services.[8] However, it was noted that if the estimated budget for "Level 1" outpatient services provided at hospitals were included, the total budget for primary care services would be approximately 31.3% of the total health budget. It is unclear from this document how the budgets for "Level 1" outpatient services were extracted from total hospital budgets. The Committee noted that although the total budget for primary care services could be as high as one-third of the health budget, ". . . primary care services are inappropriately located for the population they are intended to serve.".[8] Thus, the relative distribution of expenditure between hospitals and community health centres/clinics should be addressed, as should the intra-provincial resource allocation.

Table 6.2 provides a detailed breakdown of the 1995/96 health budget according to the major categories of health services.

TABLE 6.2 ALLOCATION OF 1995/96 HEALTH BUDGET ACCORDING TO SERVICE CATEGORY (THOUSAND RANDS)

Service category	Current	Capital	Total	% of Total
Nurse training	165 047	5 412	170 459	1.06
Academic hospitals	4 240 098	197 85	4 437 883	27.52
Regional hospitals	1 856 481	113 532	1 970 013	12.22
Community hospitals	3 403 445	194 637	3 598 082	22.32
PHC (Personal)	2 261 503	167 056	2 428 559	15.06
PHC (Non-personal)	586 847	12 897	599 744	3.72
Psychiatric hospitals	575 184	23 233	598 417	3.71
TB hospitals	403 318	14 378	417 696	2.59
Emergency services	422 149	53 540	475 689	2.95
Administration	1 221 795	205 527	1 427 322	8.85
TOTAL [1]	**15 135 867**	**987 997**	**16 123 864**	**100.00**

Source: National Assembly Portfolio Committee on Health. Report on the 1996/97 Health Budget Vote. Cape Town, 1996.

1 Note that the totals differ slightly from those presented in Table 6.1. due to the inclusion of RDP allocations in Table 6.2. and other small adjustments. These totals also differ from those in the Portfolio Committee's report, due to errors identified in the source document's calculation of totals.

Unfortunately, the same information could not be obtained for the 1996/97 budget. This is largely due to changes in the presentation of budgets between the 1995/96 and 1996/97 financial years, which makes it difficult to determine the distribution between the above categories. Table 6.3 presents an overview of the Western Cape province's health budgets for the past two financial years, to illustrate this difficulty. Although the allocation to primary care services appears to have more than doubled between the two years, most of this apparent increase relates to combining the budgets for "community health services" with the budget for community hospitals to form a budget line for district health services. The extent to which there has been a significant real increase in the overall budget for primary care services between 1995/96 and 1996/97 is thus impossible to determine, due to changes in budget structures.

TABLE 6.3 PROVINCIAL ADMINISTRATION WESTERN CAPE : 1995/96 AND 1996/97 HEALTH BUDGETS (THOUSAND RANDS)

Programme Classification :	1995/96	1996/97
Health Administration	65 497	57 098
Community Health Services	330 745	
District Health Services		684 025
Hospital Services	1 825 063	
Provincial Hospital Services		604 173
Academic Health Sciences		901 165
Health Sciences		49 831
Auxiliary and associated services	123 911	
Health Care and Support Services		67 830
Total	**2 345 216**	**2 364 122**

Source: Provincial Adminstration, Western Cape 1995 and 1996.

Note : The above provincial allocation to the Western Cape differs to that presented in Table 6.1, due to the inclusion of additional budgetary allocations from the RDP fund, transfers from the national Department of Health etc.

The continued redistribution of health care resources between levels of care will be enhanced by the Medium-Term Expenditure Framework, which has been recently developed by the national Department of Health. This framework recommends an annual real budgetary increase for PHC services of 9%, and annual real increases of 1.3%, 2.1% and 3% for academic, provincial and district hospitals respectively. Thus, in terms of this framework hospital budgets will not be cut in real terms. Instead, there will be a relative redistribution between levels of care by setting differential rates of real increase in favour of PHC services.

It is useful to evaluate the recent budgets for primary care services relative to the Committee of Inquiry's recommendations. As indicated previously, the Committee estimated that the budget for PHC personal, PHC non-personal services and community hospital outpatient services should be approximately R4 billion by 1995/96. The extent to which a relative shift in PHC expenditure has been achieved should be evaluated once audited 1995/96 expenditure statements are available for all provinces.

The Committee recognised the constraints on further redistribution between levels of care. International experience has demonstrated that increased utilisation of PHC services tends to result in increased referrals to higher levels of care. It is therefore essential that the existing hospital infrastructure should not be jeopardised in the process of strengthening PHC services. It was for this reason that the Committee recommended that an additional R1.96 billion be made available for PHC services in 1997/98, from sources outside of the present health budget.

All of the potential alternative funding sources suggested by the Committee require the approval and intervention of the Department of Finance. It is thus extremely concerning that there has been no publicly stated commitment by the Department of Finance to pursue any of these options. In the absence of such a commitment, it is extremely unlikely that the Committee's proposals for strengthening PHC services will be implemented.

RDP Allocations to Health

In addition to the health budget for 1996/97, the Reconstruction and Development Programme contributed a further R1.76 billion to the health sector, representing 21% of the total estimated RDP budget. This allocation includes provision for free health services (R680 million), primary school nutrition schemes (R500 million), the clinic building programme (R65 million), HIV/AIDS projects (R65 million), and for the restructuring of tertiary hospitals to shift resources towards primary care (R450 million).

The RDP allocation of R65 million for the clinic building programme does not compare favourably with the recommendations of the National Committee of Inquiry. The committee proposed that a sum of R327 million be set aside for the building of new clinics in 1996/97. The decreased allocation to clinic building appears to be linked to the inability of the relevant health departments to absorb the 1995/96 clinic building allocation.

MONITORING PROGRESS ON OTHER ISSUES

Alternative sources of finance for health services

As indicated previously, both last year's South African Health Review and the Committee of Inquiry report recommended urgent consideration of alternative sources of health care finance.[1,3] Such funding is particularly required to contribute to strengthening PHC services and to achieve universal access to basic health services. In addition, it has been indicated that there has to date been no explicit support by the Department of Finance for any of the potential sources of additional finance suggested by the Committee of Inquiry.

The only measure which the health sector has adopted is the recent increase in the level of user fees at public sector hospitals in the Western Cape. The intention is not only to increase revenue generation through user fees, but also to discourage patients from bypassing the correct referral route. For this reason, fees at academic hospitals are higher than those at regional hospitals, which are in turn higher than those at district hospitals. The Western Cape Department of Health decided to adopt this strategy for deterring service use at the inappropriate level of care, as opposed to implementing a bypass fee. The national Department of Health has recommended that a R50 fee be imposed on all patients who bypassed lower levels of care.

It should however be noted that these fees will not necessarily result in additional finances being generated for the health sector. At present, all fees have to be submitted to the provincial treasury and provincial health departments have to motivate to receive additional budgetary allocations from fee revenue. Retention of at least a proportion of fee revenue at the facility collecting such revenue will provide a significant incentive to improve fee collection. There is thus an urgent need for more pressure to be exerted on the Department of Finance to allow user fee revenue retention within the health departments.

A recent research project estimated the revenue generating potential of user fees at public sector hospitals, if fee revenue were retained within the health sector.[7] The report indicated that the majority of fee revenue is currently generated from medical scheme members, and recommended that insured patients should be the primary target for revenue generation purposes. However, given that relatively few South Africans are currently members of medical schemes, the research found that it is unlikely that significant additional resources will be generated through user fees at the existing levels of health insurance coverage.

Public sector hospitals would have to actively compete with the rapidly growing private hospitals for the limited number of medical aid scheme patients, and would have to offer amenity services (eg. smaller private wards for patients with improved "hotel" services such as televisions, bedside telephones, improved catering, etc.). It is extremely likely that this option will be considered politically unacceptable. This implies that the prospects for significantly increasing user fee revenue generation from the currently insured population must be regarded as negligible.

This research project also found that if a Social Health Insurance (SHI), covering all formal sector employees and their dependants for at least the costs of public sector hospital care (as proposed by the Committee of Inquiry), is implemented, an additional (i.e. in addition to current user fee revenue) R3.9 billion can realistically be generated through user fees.[3] This represents an increase of 527% on actual user fee revenue collected in 1992/93, and is equivalent to 46% of expenditure on public sector acute hospitals or 36% of total public sector recurrent health care expenditure. This is nearly

double the additional financing requirements for achieving universal access to primary care services (see section above on the Committee of Inquiry report). It is important to note that the costs of service provision will not increase, as public sector hospitals will not have to compete for new patients. Instead, formal sector employees and their dependants who currently use public sector hospitals will continue to do so, but will be able to pay more than they currently do for these services.[9]

In order to generate this level of revenue, SHI contributions would have to *average* approximately R36 per person per month, which is similar to the contribution level recommended by the recent Committee of Inquiry .[3] As SHI contributions would be income related, low income earners would pay considerably less than the above-mentioned amount. Thus, contributions are likely to be affordable for formal sector employees, particularly if employers cover part of the SHI contribution.

This research thus shows that significant additional revenue can be generated at public sector hospitals through charging insured patients higher user fees.[9] However, this is only feasible if the extent of health insurance coverage in South Africa is increased. Thus, the implementation of the recent Committee of Inquiry's recommendation for a SHI, to cover at least the costs of public sector hospital care for all formal sector employees and their dependants, should be regarded as a prerequisite for substantially increasing revenue generation at public sector hospitals in South Africa.

Given the commitment not to increase taxes, and given the competing claims for limited tax resources from other social sectors, there is little likelihood that the health sector will receive a significant budgetary increase. The option of introducing a Social Health Insurance, combined with increased user fees for insured patients at public sector hospitals, is likely to be one of the most realistic and sustainable mechanisms for financing universally accessible primary care services in South Africa, and as such, deserves more serious attention from policy-makers.

Private sector regulation and public/private sector co-operation

Total expenditure on health care is projected to increase to just over 9.2% of GDP by the year 2000/01.[10] The majority of this increase would be attributable to the continued cost spiral in the private health sector. One of the major contributory factors to this cost spiral is the prevailing fee-for-service reimbursement mechanism by third-party payers, which encourages "supplier-induced demand" and excessive utilisation by patients.[2]

As highlighted in last year's South African Health Review, there is an urgent need for proactive efforts by all relevant role players to contain these cost increases.[1] This would include government regulation of private sector activities. There appears not to have been any serious consideration of the recommendations of the Melamet Commission, which reported in April 1994.[11] The Committee of Inquiry into a National Health Insurance System made extensive recommendations on possible private sector regulatory mechanisms. There has been a similar lack of progress in consulting stakeholders about these proposals and initiating their implementation.

There is also a need to make resources currently located in the private sector accessible to a broader section of the population. One mechanism for achieving this is to encourage private practitioners to participate in the provision publicly-funded primary care services.

RECENT PROGRESS AND REMAINING CHALLENGES

In considering the current five year financial cycle, several interventions were expected of the 1995/96 and 1996/97 budgets.[11] These budgets were assessed in terms of the extent to which they addressed the following issues:

- the strengthening of primary level health care services as a priority
- the redistribution of resources between levels of care i.e. from the hospital sector to the primary health care sector
- the decentralisation of functions and resources
- the redistribution of resources on a geographic basis (both inter- and intra-provincial).

In addition, certain other health care financing and expenditure issues were considered, namely:

- alternative financing mechanisms
- private sector regulation.

The above discussion indicates that some progress has been made in the following areas:

- **Strengthening of, and improving access to, primary level services:** There appears to have been some progress in redistributing resources to support primary care services. The budget allocation for non-hospital primary care services was 19% in 1995/96, as compared with the 11% of total public sector health care expenditure being devoted to these services in 1992/93. A Medium-Term Expenditure Framework has been adopted to guide the relative redistribution of resources towards primary care services over the remainder of the current five year cycle. In addition, the introduction of free primary care services for all South Africans will improve access to such services.
- **Inter-provincial resource distribution:** Although the redistribution of resources between provinces appeared to slow down somewhat in the 1996/97 budget, this is regarded as a positive development. There has been progress towards greater inter-provincial equity, and a gradual redistribution process is regarded by many as being more feasible, given the limited capacity of provinces to adjust to budget changes. The substantial decrease in the Department of Health budget suggests that there has been some decentralisation of functions and resources.

Areas which are still unresolved and require urgent attention are the following:

- **Effects of the "free care" policy extension:** As utilisation will have increased as a result of this policy, there is a need to clarify what additional resources (for improved staffing and increased drug expenditure) will be made available to meet the increased demand.
- **Redistribution between levels of care:** There is a need to achieve greater consistency in the budget structure, and budgetary definitions of levels of care, within provincial health departments. This will ensure that progress towards level of care resource redistribution can be clearly identified.
- **Recurrent expenditure implications of the clinic building programme:** The source of additional funding to meet the recurrent expenditure requirements of newly constructed clinics must be explicitly stated.
- **Alternative financing sources to strengthen primary care services:** A clear statement of intent should be sought from the Department of Finance in relation to the funding sources proposed by the Committee of Inquiry into a National Health Insurance System. In addition, immediate steps should be taken to consult with key role players, and to develop detailed implementation plans in relation to the Committee of Inquiry's recommendation that a Social Health Insurance be introduced.

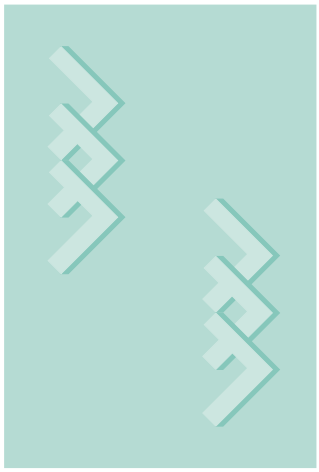
  As has been indicated above, the Social Health Insurance combined with increased user fees at public sector hospitals for insured patients, is likely to be the most feasible and sustainable mechanism for funding the development of primary care services. It is thus also necessary that a commitment to allow fee revenue retention in the health sector should be sought from the Department of Finance.

- **Geographic redistribution of resources:** Given the move to allocating global provincial budgets, mechanisms for ensuring that the process of achieving greater inter-provincial equity in health budgets continues, should be explored. The health sector should be more proactive in these debates which should be widened to include all stakeholders, including academics who have carried out research on the topic.[12]
- **Intra-provincial resource distribution:** With the implementation of the district health system, it is essential that mechanisms for achieving greater equity in the intra-provincial resource distribution be investigated. This should include consideration of the funding responsibilities and capabilities of provincial and local authorities for district health services. The tax bases and revenue generating potential of different local authorities will be particularly important in this regard.
- **Private sector regulation:** With the exception of the Department of Health's drug policy, little progress has been make in regulating the private sector to promote cost-containment efforts. This should also be regarded as urgent.
- **Public/private sector co-operation:** Urgent research is required into options for establishing referral contracts with private providers and for accrediting private group practices. It is essential that the provincial departments of health have sufficient capacity to develop contracts, and to monitor the quality of contracted health services before more extensive contracting with private sector providers is undertaken.

CONCLUSION

As noted by the National Assembly Portfolio Committee on Health, in its first ever analysis of the South African health budget, *"... the health system is constantly fluctuating and evolving with the development of new methods for financing, and for rendering, managing and monitoring health service delivery".*[8] It is within this context that it is important to routinely monitor changes in the health budget.

The budget is a barometer of the extent of government's commitment to implementing health policies. As such, the budget is the key indicator of progress towards realising the Department of Health's main policy objective of achieving universal access to comprehensive and integrated primary care services.



HUMAN RESOURCES 7

INTRODUCTION

A glance at the 1995 Review

In 1995, the main challenges facing policy makers with regard to the development of human resources were to:

- address the maldistribution of health personnel
- use available human resources optimally
- improve the motivation and morale of health workers and thereby increase efficiency and effectiveness
- promote compassionate health care
- transform the composition of the personnel complement to correct class, race and gender imbalances
- develop support mechanisms necessary for the development of human resources for health.[1]

These still constitute the major areas around which health policy and guidelines for the development of human resources for health are being developed.

Sources of information

In order to assess progress with regard to the above, reliable information is required. However, information sources are still patchy and unreliable. Data is presented in this chapter with due recognition of possible inaccuracy, but with the view that it is of good enough quality to profile human resources for health in South Africa.

Information used in this chapter came from both public and private sector information sources. Public sector data was based largely on the Regional Health Management Information System (ReHMIS), a database originally designed by the Medical University of Southern Africa. ReHMIS consists of data collected at facility level, and aggregated at higher levels of management. Databases maintained by statutory councils (e.g. Interim Nursing Council), although useful, consist mainly of information provided by personnel when they register or renew registration with the councils. Other sources of information are academic institutions, particularly within research departments and centres.

A lot of information is collected by the corporate sector, particularly the pharmaceutical industry. Unfortunately, most of this information is not freely available for reasons of secrecy, among others. Information about private sector health personnel has been provided by the Representative Association of Medical Schemes.

Focus of the chapter

This chapter will only focus on those aspects of human resource development where information was available; specifically, issues related to:

- development of national and provincial policies on human resources
- creation of management structures to implement, monitor and evaluate projects and programmes

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- planning to meet existing and future human resource needs
- production of human resources i.e. education and training
- improving the quality of care
- labour relations

In addressing each of the above, policy positions by relevant authorities will be presented, followed by an assessment of actual progress.

DEVELOPMENT OF NATIONAL AND PROVINCIAL POLICIES

Policy directions

The national Department of Health is responsible for developing policy relating to the development of human resources for health. Specifically, the Directorate: Human Resources within the Chief Directorate of Resource Planning plays a central role in spearheading this process. Broad policy guidelines on human resources have been developed and are contained in a report released by the Department of Health.[2] The Department recognises the important role that non-governmental organisations (NGOs) and other organs of civil society need to play in establishing a consensus viewpoint on "national priorities and programmes", and has established a number of advisory and consultative structures to assist with policy formulation (see below). The national Department is responsible for overall policy formulation and co-ordination, and for establishing norms and standards. Provincial departments of health on the other hand, "promote and monitor the health of the people in the province, develop and support a caring and effective provincial health system...".[2] In this way, provinces are expected to support, monitor and evaluate the development of human resources.

Progress to date

The Department of Health has recommended the establishment of three structures to assist with the development and co-ordination of human resource activities and the training of health personnel. These are the Consultative Forum, the Co-ordinating Education Committee, and the Health Management Training Committee. The Consultative Forum comprises representatives of the "health profession at all levels of health care and the non-governmental sector". Its stated purpose is to provide a forum to "share information, discuss matters of mutual concern, such as personnel and education needs, resource distribution and referral systems; and [to] ensure that policy-makers are aware of the needs of and challenges facing health professionals".[2]

According to the report, the composition of the Co-ordinating Education Committee should include representatives from technikons, universities, nursing colleges, the ministries of Health and Education, health service providers, health sciences students, NGOs and the public. The Health Management Training Committee will also comprise similar representation but its focus will be on management training.

The Consultative Forum has been meeting every third month since July 1995.[3] The Co-ordinating Education Committee and the Health Management Training Committee have not been established as yet. As a result, the Forum either by default or intention, serves the purpose of discussing training and education issues in addition to its original intention as a platform for sharing information.

The Consultative Forum, which has drawn interest from a wide spectrum of stakeholders has still not managed to bring into its fold, its stated important partner in training and education of personnel, namely the Department of Education. Technikons and colleges are also not adequately represented on the Forum (see Table 7.1). Because of its large membership, it is sometimes not possible to discuss issues exhaustively. Also, the lack of consistency of representation affects continuity. The content of their deliberations is described in the relevant sections below.

TABLE 7.1 REPRESENTATION IN THE CONSULTATIVE FORUM

Date of meeting	Health Dept*	Technikons & colleges	Universities bodies	Councils	Professional	NGOs	Other	Total
July 1995	23 (15)	3	4	6	3	4	3	46
Sept 1995	25 (12)	1	4	4	3	8	4	49
Nov 1995	24 (13)	1	3	3	16	2	7	56
Jan 1996	28 (20)	0	3	6	33	6	7	83
March 1996	21 (11)	2	16	3	15	4	7	68

(* Brackets indicate provincial representation)

Source : Minutes of the Consultative Forum meetings, July 1995 to March 1996

CREATION OF MANAGEMENT STRUCTURES

Policy directions

In line with district systems development and decentralisation of management authority, district managers will be appointed in all provinces (with the exception of the Northern Cape, where vast geographical areas and low population densities render conventional district structures less appropriate). It is intended that district managers will eventually be responsible for personnel within their districts. The appointment of regional managers is regarded as a transitional step by some provinces, although it is unlikely that they will be disbanded once established.

In almost all provinces, support for human resource development within the province and liaison with the national Chief Directorate: Resource Planning will be a dedicated staff function.

Progress to date

Appointments of senior management within the Chief Directorate of Resource Planning has been completed. All provinces, with the exception of KwaZulu-Natal, have designated Human Resource divisions at Chief Director, Director or Deputy Director level. All of these positions have been filled (see Table 7.2).

TABLE 7.2 LOCATION OF HUMAN RESOURCES FUNCTIONS IN THE DEPARTMENT OF HEALTH

Management level	Province	Region
Chief Director	Gauteng, Northern Province	None
Director	Free State, Eastern Cape, Western Cape, North West, Mpumalanga	None
Deputy Director	Northern Cape	Northern Province

Source : Department of Health, 1996

To date, only Mpumalanga has completed the appointment of district managers. In three of the other provinces (Eastern Cape, Northern Province and North West), some or most appointments have been made. No appointments have been made in the Free State, Gauteng, KwaZulu-Natal or the Western Cape. As mentioned above, the North Cape will decentralise to regional level only.

DISTRIBUTION OF PERSONNEL IN THE PUBLIC HEALTH SECTOR

Policy directions

Emphasis is being placed on the optimal utilisation of existing health personnel (including those acquired from outside South Africa) and distributing personnel equitably throughout the country.

As advised by the World Health Organisation , the Department of Health will conduct an audit of health personnel and training institutions in the country.[4] Information from this audit will be used to support planning and other human resource development activities.

The "individual health worker" is now seen in a new light, that is, as an integral part of the health care team. These teams will be established throughout the various levels of the health system. Traditional and other non-formal health workers will be brought in as partners in health care delivery, without incorporating them formally into the public health sector. Health legislation which currently limits the extent to which certain health personnel categories may be utilised, e.g. optometrists, psychologists and nurses will be reviewed and amended.[2]

In line with other national goals, the composition of health personnel, particularly at management level will be transformed to sufficiently reflect the demographic realities of South Africa.

Progress to date

Numbers of personnel

There are currently about 200 000 nurses and 26 425 doctors in South Africa.[5] Table 7.3. shows that the ReHMIS database contains information on a total of 134 663 health personnel working in the public sector.

The province with the highest and lowest number of health personnel is KwaZulu-Natal (31 812) and the Northern Cape (2 281) respectively. Most health personnel are based in hospitals (83%) - an indication of how unevenly South African health personnel are distributed. Although Community Health Workers (CHWs) are currently not recognised as formal public sector employees, there are still about 1 500 CHWs who continue to be employed by the State. Debate still surrounds CHW training and deployment. The National Assembly Portfolio Committee on Health recommends a speedy resolution to the debate and suggest that the national and provincial departments should finalise the matter urgently.

A report based on an assessment of community-based health programmes recommends that a task group be established to review existing community-based health programmes and investigate how those that are playing an important role can be supported. The extent of the Department of Health's involvement in supporting such programmes should be determined in the review.[6]

TABLE 7.3 DISTRIBUTION OF ALL HEALTH PERSONNEL IN THE PUBLIC HEALTH SECTOR 1994/5 (EQUIVALENT WORK UNITS)

Categories of Personnel	Western Cape	Northern Cape	Free State	Eastern Cape	KwaZulu Natal	Mpuma-langa	Northern Province	Gauteng	North West	South Africa
CHWs	56	1	113	276	717	11.00	130	65	43	1 412
Nurses	10 040	1 793	6 700	17 001	24 500	4 012	11 459	20 038	7 793	103 336
Dieticians	51	6	7	2	2	11	18	87	17	201
Therapists	246	2	51	43	165	17	59	212	52	847
EHOs	253	61	66	1 893	323	29	162	220	82	3 089
Pharmacists	179	27	49	85	208	45	55	246	59	953
Dentists	67	3	18	27	44	18	18	183	40	418
GPs	1 255	112	300	649	1 219	199	274	3 006	357	7 371
Specialists	600	10	202	120	673	17	39	984	42	2 687
Other	2 196	266	1 240	903	3 961	438	1 262	2910	1 173	14 349
All personnel	**14 943**	**2 281**	**8 745**	**21 002**	**31 812**	**4 796**	**13 476**	**27 950**	**9 658**	**134 663**

Source : Regional Health Information Management Systems (ReHMIS) 1994/5

Information for private sector personnel was only available for nurses, pharmacists, dentists, general practitioners and specialists. Nurses constitute the biggest category of health personnel in the public (103 336) and private (16 586) sectors. According to available information, there are 10 067 and 7 371 general practitioners in the private and public health sectors respectively. These are followed by pharmacists (15 794) and dentists (3 748). There are 6 342 specialists, the majority of whom (3 657) are in the private sector (see Tables 7.4 and 7.5).

TABLE 7.4 DISTRIBUTION OF MAJOR CATEGORIES OF HEALTH PERSONNEL IN THE PUBLIC AND PRIVATE HEALTH SECTORS

Categories of Personnel	Western Cape	Northern Cape	Free State	Eastern Cape	KwaZulu Natal	Mpuma-langa	Northern Province	Gauteng	North West	South Africa
Nurses (All)	**13 287**	**1 966**	**7 589**	**18 284**	**27 348**	**4 459**	**11 722**	**26 749**	**8 995**	**119 922**
Public	10 040	1 793	6 700	17 001	24 500	4 012	11 459	20 038	7 793	103 336
Private	3 247	173	889	1 283	2 848	447	174	6 711	814	16 586
Pharmacists (All)	**2 806**	**203**	**1 005**	**1 193**	**2 141**	**641**	**381**	**6 718**	**706**	**15 794**
Public	179	27	47	85	208	45	55	246	59	953
Private	2 627	176	958	1 107	1 933	595	326	6 472	647	14 841
Dentists (All)	**867**	**62**	**148**	**201**	**407**	**132**	**80**	**1 748**	**104**	**3 748**
Public	67	3	18	27	44	18	18	183	40	418
Private	800	58	130	174	363	114	62	1 565	64	3 330
GPs (All)	**2 852**	**296**	**983**	**1 541**	**3 581**	**634**	**484**	**6 449**	**644**	**17 438**
Public	1 255	112	300	649	1 219	199	274	3 006	357	7 371
Private	1 597	184	683	892	2 362	435	210	3 443	261	10 067
Specialists (All)	**1 412**	**49**	**363**	**354**	**1 237**	**89**	**85**	**2 627**	**128**	**6 342**
Public	600	10	202	120	673	17	39	984	42	2 685
Private	812	39	161	234	564	72	46	1 643	86	3 657

Source : Regional Health Information Management Systems (ReHMIS) 1994/5
Representative Association of Medical Schemes (RAMS) 1996

Table 7.5 thus illustrates the following:

- 86% of nurses work in the public sector
- The majority (57%) of general practitioners work in private practice
- The same applies to specialists, where 58% work in the private sector
- 13% of dentists work in the public sector
- Only 6% of pharmacists work in the public sector.

Adequacy of provision

It has often been said that the number of doctors and nurses in South Africa compares favourably with other middle-income countries. This conclusion is mainly based on the human resources / population ratio which indicates that, for every 10 000 people there are:

- 29.1 nurses
- 3.8 pharmacists
- 0.9 dentists
- 4.2 doctors
- 1.5 specialists.

These figures compare well with international averages quoted by the Hospital Strategy Project and recommendations of a study by the Centre for Health Policy in 1987. The Hospital Strategy Project quotes a recommended international average of 4.9 and 22.7 doctors and nurses per 10 000 respectively. The Centre for Health Policy recommended ratios of 1.6 and 10 doctors and nurses per 10 000 population respectively.[7]

However, the Hospital Strategy Project points out that these kinds of averages can hide inadequacies. The national average of 4.2 doctors per 10 000 "masks the considerable differences between provinces".[8] As Table 7.5 indicates, the ratio is much lower in provinces such as the Northern Province, the North West, Mpumalanga and the Eastern Cape than in other provinces. The ratio may also fail to show inequities within provinces, and the absolute shortage of health personnel in some areas. In some of the provinces where the ratio is higher and appears adequate at first glance, the majority of health personnel are based in urban areas. Viewed on their own, rural areas show an inadequate supply of health personnel.

The health worker/population ratio also obscures the fact that nearly three-fifths (57%) of doctors work in the private sector. When only doctors in the public sector are taken into account, the ratio decreases to 1.8 doctors per 10 000 people. In the North West for example, there are 60 unfilled medical officer posts and a shortage of 120 doctors.[9] The steady emigration of health personnel from South Africa has compounded the problem of inequitable distribution.

Another concern is that the majority of public health personnel work in hospitals, particularly in secondary and tertiary hospitals. This fact is not consistent with a commitment to primary health care. There are thus several important dimensions to the maldistribution of health personnel:

- First, the majority of doctors, dentists, pharmacists and supplementary health professionals work in the private sector - catering for the needs of a minority of South Africans
- Second, health personnel are concentrated in predominantly urban provinces, and in urban areas within provinces
- Third, relatively few public health personnel work in primary level facilities - although many are inappropriately involved in primary care within secondary and tertiary level hospitals.

TABLE 7.5 DISTRIBUTION OF SELECTED HEALTH PERSONNEL PER 10 000 POPULATION IN THE PUBLIC AND PRIVATE HEALTH SECTORS

Categories of Personnel	Western Cape	Northern Cape	Free State	Eastern Cape	KwaZulu Natal	Mpuma-langa	Northern Province	Gauteng	North West	South Africa
Nurses (All)	**35.7**	**26.5**	**27.3**	**28.2**	**31.4**	**14.8**	**21.7**	**37.9**	**26.8**	**29.1**
Public	26.9	21.2	24.1	26.2	28.1	13.3	21.2	28.4	23.3	25.1
Private	8.7	2.3	3.2	1.9	3.2	1.5	0.3	9.5	2.4	4.2
Pharmacists (All)	**7.5**	**2.7**	**3.6**	**1.8**	**2.5**	**2.1**	**0.7**	**9.5**	**2.1**	**3.8**
Public	0.5	0.4	0.2	0.1	0.2	0.2	0.1	0.4	0.2	0.2
Private	7.1	2.3	3.4	1.7	2.2	1.9	0.6	9.2	1.9	3.4
Dentists (All)	**2.3**	**0.8**	**0.5**	**0.3**	**0.6**	**0.4**	**0.2**	**2.5**	**0.3**	**0.9**
Public	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.1	0.1
Private	2.2	0.8	0.5	0.3	0.4	0.4	0.1	2.2	0.2	0.8
GPs (All)	**7.7**	**3.9**	**3.5**	**2.4**	**4.4**	**2.1**	**0.9**	**9.1**	**1.9**	**4.2**
Public	3.4	1.5	1.1	1.0	1.4	0.7	0.5	4.3	1.1	1.8
Private	4.3	2.5	2.5	1.4	2.7	1.5	0.4	4.9	0.8	2.4
Specialists (All)	**3.8**	**0.7**	**1.3**	**0.6**	**1.4**	**0.3**	**0.2**	**3.7**	**0.4**	**1.5**
Public	1.6	0.1	0.7	0.2	0.8	0.1	0.1	1.4	0.1	0.7
Private	2.2	0.5	0.6	0.4	0.7	0.2	0.1	2.3	0.3	0.9

Source: Regional Health Information Management System (ReHMIS 1994/5)
Representative Association of Medical Schemes (RAMS) 1996

Strategies for redistribution

Redistributing health personnel will not be simple, because a number of factors including geography, service needs and the level of care need to be taken into consideration. The Needs Norms Research Project of the Centre for Health Policy has developed various models of combinations of personnel for various service and geographical situations.[10] In each case, teams of personnel are constituted differently to meet the conditions in the health district or facility (see Table 7.6). These models go a long way towards suggesting how health personnel should be redistributed within health districts.

In addition, the introduction of free health services at primary health care level in 1994 flooded clinics and outpatient departments with children and antenatal care visits. This increase in the number of people to be taken care of was not matched by an increase in the health personnel to deal with the increased workload.[11]

Two research projects currently underway are expected to shed more light to the different kinds and compositions of teams for health personnel. The studies are being carried out by the Department

of Community Health at Wits University and the Public Health Programme in collaboration with the Education Policy Unit in the Western Cape. The studies will among other things determine the "range, type, quantity, and process of health personnel education and training courses and programmes" in tertiary institutions and determine the categories and numbers of health personnel required for health care teams at district, regional and national levels.[12,13]

TABLE 7.6 MODELS OF DISTRIBUTING HEALTH PERSONNEL FOR DIFFERENT TYPES OF FACILITIES IN DIFFERENT GEOGRAPHICAL AREAS

Area	Facility	Personnel requirements per 10 000 population	
Dense rural areas with population densities of 200 people/km^2	24 hour facility (major health centre	Professional nurse : PHC Nurse : Enrolled nurse : Psychiatric nurse : Comm. rehab. facilit : Medical doctor :	19.92 3.00 19.30 0.04 1.52 1.92
	Medium sized clinic or health centre	Professional nurse : PHC Nurse : Enrolled nurse : Psychiatric nurse : Comm. rehab. facilit : Medical doctor :	6.99 6.00 6.37 0.04 0.04 1.52
	Mobile clinic	Professional nurse : Enrolled nurse:	0.23-0.88 0.14-0.56
Dense metropolitan areas with population densities greater than 10 000/km^2	24 hour facility (major health centre)	Professional nurse : PHC Nurse : Enrolled nurse : Psychiatric nurse : Comm. rehab. facilit : Medical doctor :	39.66 22.90 34.48 0.23 4.1 12.85
	Medium sized clinic or health centre	Professional nurse : PHC Nurse : Enrolled nurse : Psychiatric nurse : Comm. rehab. facilit : Medical doctor :	24.49 22.90 24.65 0.23 4.1 12.85
	Mobile clinic	Professional nurse : Enrolled nurse :	0.88 0.56

Source : Rispel L, Price M., Cabral J., Centre for Health Policy, University of the Witwatersrand 1996

Increasing the number of students trained in institutions is another way of addressing existing inadequacies. However, this may not be applicable for all health personnel. For example, the emphasis on Primary Health Care (PHC) may demand that more PHC nurses and nurse clinicians be trained rather than more medical doctors.

Another option mooted by the Department is the introduction of compulsory public service by doctors for two years. This, the Department argues, is in view of the investment made by the State in training medical doctors. It is hoped that implementation of this policy will increase medical personnel in rural areas. Reaction to these proposals have been mixed. A survey conducted by the Department of Community Health, University of Natal, found that the majority of private practitioners (80%), academic consultants (62%), registrars (53%) and first year medical students (52%) were supportive of a once-off compulsory service in rural areas post-internship. Senior health service managers (74%) felt that such a compulsory service should only be made a requirement for those wishing to specialise. Only fifth year students in the sample were opposed to any form of compulsory service.[14] Those opposed to the option warn that the policy will exacerbate the problem of emigration from South Africa by medical doctors. They emphasise the preference of incentives to attract health personnel to areas where their services are most required. Although there is no final consensus on what the incentives should be, it appears there is a preference for non-financial incentives. Such incentives could be in the form of improved working conditions, continuing education and improving their physical, communication and personal conditions, including the provision of housing.[15] The Department has substantially increased salaries of nurses (7.5% to 42%) and medical doctors (28% to 122%).[16] It still has to be seen whether these adjustments will stem the tide of health personnel leaving the public sector and South Africa.

In July 1996, the South African Interim Medical and Dental Council announced the introduction of a compulsory two-year vocational training programme for all medical graduates post-internship.

Ostensibly, the motivation was that new graduates are ill-equipped for general practice, and require further training. Groups such as the Junior Doctors' Association of South Africa argue that the policy is an admission of an inappropriate undergraduate medical curriculum which should first be revised, and a way of implementing compulsory public service without the risk of legal recrimination. Whatever the merits or truth of the case, its implementation constitutes a great challenge to both academics and the Department of Health. Placing new doctors in remote and rural areas without adequate back-up and systems of support and training may exacerbate discontent and this may be counter-productive in the long-run; locating new graduates in settings in which there is existing supervision, expertise and training may aggravate the urban/rural divide. Vocational training programmes such as that offered by McCords Hospital in Durban demonstrate how doctors working in rural areas can be supported by a systematic training programme.

Other measures taken by the Department of Health include the recruitment of foreign health personnel through bilateral agreements. In the North West, 80% of the doctors are foreign.[9] To date, 206 Cuban doctors have been recruited. In addition, the Department of Health is recruiting doctors from the United Kingdom, Germany and some African countries. In the case of African countries, bilateral agreements will attempt to ensure that health personnel are not permanently lost to their countries of origin.

Concern has been expressed by some South African medical doctors about the recruitment of foreign doctors. They argue that, at best, foreign doctors constitute a short-term solution, detract from the need to find more permanent answers and improve conditions for South African doctors, and exacerbate the poor communication between doctors and patients. However, the National Assembly Portfolio Committee on Health reports that some provinces have reported positively about doctors recruited from outside South Africa. Nevertheless, the Committee stresses the need to find long-term solutions.[9]

PRODUCTION OF HUMAN RESOURCES

Educating and training of new personnel

Policy directions

The Department of Health argues that through education and training, competent health personnel which meets the health needs of South African communities will be developed. To this end, a national framework for the training and development of health personnel is proposed by the Department. As indicated earlier on, it is planned to establish a Co-ordinating Committee of stakeholders.

There are two main priority areas for training and development, namely, PHC and health management. It is envisaged that, through PHC training, health personnel will be re-directed and re-oriented to the new vision of the Department - and thereby strengthen the drive toward needs-based health care. These important areas of training are expected to be nurtured by a proposed School of Public Health as envisaged by the Department of Health.[2]

Health management in South Africa has been "administered in a closely and centrally regulated way" which promoted a rigid hierarchical organisational and occupational structure.[17] This structure needs to be fundamentally changed. The process of restructuring training institutions is likely to be substantively affected by the recommendations by the Department of Education's National Commission on Higher Education which was established to develop a framework for restructuring tertiary education in South Africa. The Commission established a Health Sciences Working and Reference Group which looked specifically at "what the organisational and financial model regarding the training of people in the health sciences (medical, paramedical and veterinary) should be; and what the responsibilities of the education sector on the one hand, and the health sector on the other should be".[18]

The Working Group's report recommends the establishment of a "Health Personnel Education Council" whose composition will include representatives from both the Departments of Education and Health. This Council should co-ordinate policies, organisation and funding of health personnel education and training".[18]

Progress to date

This discussion will focus on the training and education of nurses and doctors because of the lack of information with regard to other types of health personnel.

Developing new human resources for health

The Department of Health's report on "Restructuring the national health system for universal PHC" suggests that a total of an additional 7 187 professional nurses and 10 766 PHC nurses are required in 1996/7 (the term "PHC nurse" applies to a nurse with comprehensive primary health care training, including the management of common medical conditions). The report estimates that 14 479 and 1 000 of these categories of nurses respectively will be supplied through existing means, leaving an oversupply of 7 292 professional nurses and a shortage of 9 766 PHC nurses.[19] However, Table 7.5. presents a slightly different picture, especially in relation to professional nurses. The only province that seems to be below the recommended international average of 22.7 nurses per 10 000 is Mpumalanga which requires about 2 367 nurses to be able to reach the required average. Further training and recruitment should be directed at addressing the shortfall in that province. There is a definite need to train more nurses in primary health care. However, this category of nurses should logically be expanded primarily through advanced training of existing nurses.

TABLE 7.7 FORMAL TRAINING AND EDUCATION INSTITUTIONS FOR NURSES AND DOCTORS IN SOUTH AFRICA

Province	Nursing colleges	Students who completed -1995	Medical schools students -1994	Final year
Western Cape	4	293	2	340
Northern Cape	1	13	-	-
Free State	3	242	1	88
Eastern Cape	4	100	1	18
KwaZulu-Natal	3	403	1	94
Mpumalanga	1	18	-	-
Northern Province	3	67	-	-
Gauteng	12	813	3	483
North West	4	69	-	-
Total	**35**	**1 206**	**8**	**1 023**

Source: Khosa M, Review of Academic Health Complexes, 1994
Interim South African Nursing Council, 1996

At the moment, formal training for new health personnel occurs in 21 universities (of which 8 have medical faculties and 13 have nursing departments), 14 technikons, 35 nursing colleges (with over 80 nursing schools affiliated to them). There are also 3 training and development programmes considered by some as the embryos of Schools of Public Health, namely, the Public Health Programme (Western Cape), Transvaal School of Public Health (Gauteng) and the Natal Institute for Community Health Education.

An assessment of the physical location of institutions shows that the institutions are not equitably distributed. Only one nursing college (currently with 273 students) is based in the province of Mpumalanga. The 8 medical schools are in the Western Cape, Free State, Eastern Cape, KwaZulu-Natal and Gauteng. The over concentration of medical schools in the Western Cape and Gauteng is a matter under intense discussion. There have been proposals that the medical schools be restructured (with possible amalgamation/closure of some) in order to do away with the over concentration. As far as nursing schools are concerned, the Department of Health in the Northern Province and the Western Cape have already identified the rationalisation of nursing colleges as a priority and decisions in this regard are expected soon.[3] It appears that the need for rationalisation is even greater in Gauteng than the other provinces.

In terms of access to the institutions, South African tertiary institutions enrol students on a national basis. A central database for applications to medical schools has recently been introduced. However, students coming from provinces where there are no academic and training institutions have to make an added effort to access education and training opportunities.

✧ Training nurses

A major recommendation by the Health Sciences Working Group that fundamentally affects nurses training is that "the education and training of nurses [be] rationalised and relocated in the education sector, with nurse training preferably occurring through schools or departments of nursing linked to universities ...".[18] The Department of Health is still to respond formally to the report, but it appears that the Chief Directorates: Academic Health Services and Resource Planning hold divergent views on the location of nurse training.

As stated earlier, the only province that seems to require more nurses is Mpumalanga, where 2 376 nurses are needed to meet the suggested norm international norm of 227 nurses per 10 000 population. This may be prove difficult for the province noting that only 18 student nurses graduated from its nursing college in 1995. As far as the other provinces are concerned, focus should be on sustaining the existing number of nurses, while at the same time improving skills of those already in service.

The emphasis on PHC heralds a new challenge. Rationalising nursing colleges should be accompanied by changing curricula in these institutions. Mpumalanga has already embarked on a process of developing PHC nurse training in the college. Particular attention is also being paid to training in TB management and AIDS counselling.[3] The Department of Health has also embarked on a number of initiatives to train PHC nurses. Some of the criticism that has been levelled at these initiatives is that the training is not locally based and tends to focus more on curative aspects of health than the preventative, promotional and educational.

NGOs are also making a number of initiatives to equip nurses with relevant skills. The Health Systems Development Unit in Mpumalanga has developed an 18 month "integrated PHC/community-based training programme" for nurses. The programme has been developed jointly with the health services authorities and is based in Tintswalo Hospital.[21]

There are a number of initiatives to equip health professionals with new skills. Courses for nurses are organised by the provincial departments and a number of training NGOs and institutions - in some instances, in collaboration with the health service authorities.

✧ Training doctors

All other things being equal, South Africa will have to produce 15 times more graduates than the 1 023 produced by its 8 medical schools in 1994 - if it wants to meet the internationally recommended average of 4.9 doctors per 10 000 population in the public sector.[20] It is not only the inadequacy of available resources which makes it difficult to attain such a goal, but the fact that most South African doctors prefer the private sector or emigrate. Existing medical schools are unlikely to expand their current intake of medical students. In fact, possible closure of one or more medical schools due to rationalisation is possible. Inevitably, the emphasis must fall on consideration of new selection criteria, curricular reform, and on equipping new graduates with appropriate skills for general practice in South Africa.

✧ Health management development

Addressing weaknesses in management capacity has been identified as one of the "most neglected areas" by the Department of Health.[2, 22] Among a number of challenges contained in a report compiled by a British consultant who was asked to "assist the Department of Health officials to develop a comprehensive management development strategy..." is the need to develop capacity to "manage change" in the health sector. This is vital especially in the context of attempts to reform the South African health system into "modern, high quality and equitably distributed health services".[17]

The Department of Health has identified training as the main strategy to be used to develop management capacity. This will be done in the context of the decentralisation of authority to what is considered as the most strategic level of the health system for intervention, the district health level.[2, 22] Among areas of management that the training should focus on are effective and efficient management of both financial and human resources, ability to use information for planning and decision making, monitoring and evaluation.

On a national level, it is intended to establish a "Health Management Training Committee" representing a wide spectrum of stakeholders, from both the government and non-government sectors to co-ordinate activities related to management capacity training.[2] This committee will work together with the Consultative Forum already discussed in previous sections.

Although management training strategies are still being developed by the Department of Health, some aspects are already being implemented. As reported earlier on, the Consultative Forum has been established and meets regularly. The Health Management Training Committee has not been established as yet. A number of initiatives are emerging with regard to management training.

Through the Consultative Forum, over 13 presentations on running and planned courses and training programmes have been made. These include an ophthalmological course in Bristol University, the PHC course offered by Goldfields, a Glaxo-Wellcome asthma management course, PHC Trainer's course by BASICS/ United States Agency for International Development, and the Oliver Tambo Fellowship in Public Health Management.

Provincially, a number of initiatives have also been embarked upon. The Department of Health in the Northern Province has developed a joint training programme with the University of the North to address the problem of computer illiteracy in the province. The Gauteng Department utilises the PHC and management programmes offered by the Public Management Programme at the Wits University. In particular, attention has been paid to courses in labour relations because of the labour unrest that engulfed that province in 1995. The Western Cape Public Health Programme has been commissioned by the Department of Health to provide management training for District Health Managers. A District Team Problem Solving Programme, initiated by the Health Systems Trust, is currently underway in KwaZulu-Natal and the North West Province, facilitated by the Centre for Health and Social Studies based at the University of Natal. A partnership has been established between the University of the Free State and the Department Health in the Free State to train health and welfare managers.[3] These partnerships between provincial departments and academic and training institutions are likely to be an effective strategy for meeting the immediate management training needs of health services.

A number of obstacles remain, though. District management training is a new concept in South African health services, and the training requirements of district managers are still being defined. The fact that not all district managers have been appointed in some provinces - and none in others - is impeding training within districts. This applies particularly to problem-based training programmes, which seek to implement actual change through training. It is estimated that eventually, 385 district managers will be required.[19]

Another problem is that some of the training initiatives are not based where the trainees are. This is contrary to the Department's preference for training that should occur "within the trainees' work environment", to ensure direct and immediate application. It is also possible that the people who are currently being sent to courses and training programmes may eventually not become members of the district management teams.

Co-ordination between provinces and the national office needs to go beyond meeting at the Consultative Forum. For example, most of the provinces have identified their management training needs. However, these needs seldom inform the decisions regarding training courses and programmes endorsed for managers by the Forum. There is a problem of co-ordination of initiatives. A number of these training initiatives address the same issues - often directed at the same people. As a result, confusion sometimes arises. More efforts could also be made to integrate some of the initiatives, particularly in instances where the initiatives involve organisations and consultants from outside South Africa. Encouraging non-South African training consultants to work with local trainers will help develop local capacity.

TRANSFORMING THE FACE OF THE HEALTH SERVICE

Policy directions

The South African government adopted as one of its major goals, the transformation of the public sector so as to correct historical gender, class and racial imbalances. Motivated by the desire to attain this goal, the Department of Health decided to embark on a deliberate process of bringing into the public health sector, sectors of the South African population previously excluded, particularly at management levels.

Progress to date

Although the number of new people who have joined the Department of Health since 1994 is relatively small, there are significant changes in terms of the composition of people at management level. According to the Department of Health, prior to 1994, whites accounted for 90.2% of management staff, while 87.8% of all managers were male. Since then, more blacks and women have been brought into management positions in the national Department of Health (see Table 7.8).[5]

Nine of the twelve people in top management within the Department of Health (Chief Directors and above) are black.

TABLE 7.8 RACE AND GENDER COMPOSITION OF MANAGEMENT WITHIN THE NATIONAL DEPARTMENT OF HEALTH IN 1995

Race	Male	Female	Total	%
White	16	2	18	48
Coloured	1	2	3	8
Indian	3	1	4	11
African	5	7	12	32
Total	**25 (68%)**	**12 (32%)**	**37**	**100**

Source: Department of Health Annual Report, 1995.

The situation may differ slightly in the provinces, but the trend is similar. Only four of the nine provincial heads of health departments are white, representing a dramatic change from the past.

The transformation of the composition of the health personnel brings along with it the tension of attracting people who understand the new vision of the Department and those from previous administrations who may have valuable experience.

IMPROVING THE QUALITY OF CARE

Policy directions

The Department of Health intends enabling its workforce to provide a caring and compassionate service. On the one hand, patient's and health personnel's rights will be guaranteed through charters developed jointly with all stakeholders, and on the other, "an active campaign will be launched to engender a "culture of caring throughout the health services".[2] Some of the activities that are regarded as essential are greater opportunities for training and continuing education, rewards and incentives to reinforce appropriate behaviour by health workers and improved working conditions. Health personnel will be encouraged to work in teams when rendering services to communities and patients. Training is also encouraged to occur within teams.

Progress to date

The problem of staff shortages and inadequate supervision and support to health workers is more pronounced in some provinces than in others. In some areas, it is not unusual for health workers to see sixty to ninety patients per day.[3]

The improvements in salaries and the introduction of various incentives as a means of encouraging health personnel to provide a caring service have been discussed in previous sections. There are also a number of initiatives by provincial departments and NGOs.

The Health Systems Trust has recently combined forces with the Department of Health to initiate a new programme in support of health personnel working at the sub-district level. Among other factors, the initiative specifies a number of human resource-related issues that affect health personnel including morale, attitudes, skills and heavy workload due to staff shortages. These are manifest in indifference to the problems of health service users, shoddy care, and more spectacularly, occasional strikes and work stoppages related to salaries and working conditions. Inappropriate staff attitudes range from aggression to condescension or indifference. Apart from staff morale, effective and efficient

service provision depends on sound administrative, clinical and community outreach management skills.[23] This Initiative for Sub-District Support intends to develop support strategies which will impact favourably on factors affecting quality of care.

There is also significant new activity in PHC training for people already in the services. Much of this occurs within the embryonic "Schools of Public Health". For example, over 800 health workers from all provinces participate in short courses held under the auspices of COPHE (Committee on Public Health Education) in the Western Cape. The courses cover a wide range of subjects, most programme related, such as nutrition, maternal and child health, management of tuberculosis and sexually transmitted diseases. Other courses focus on systems development, such as essential drugs programme implementation. The Transvaal School of Public Health has recently also begun to hold short courses.

LABOUR RELATIONS

Policy directions

Public sector personnel are regulated by the 1994 Public Service Labour Relations Act. This Act created central and provincial bargaining chambers of the Public Servants' Bargaining Council, through which labour matters affecting health personnel are discussed and decided upon, All public servant employee organisations, except those for teachers and police, are represented in the Chambers, as are the employers. The Public Service Labour Relations Act will be replaced by the new Labour Relations Act of 1995 in the near future.

Progress to date

1995 was characterised by a series of strikes, particularly by nurses which led to disruptions of services in many health facilities. The situation was particularly critical in the Eastern Cape and Gauteng. The national Department of Health believes that the underlying grievances of health personnel were thoroughly investigated and addressed, "thus the strikes were terminated in a reasonable period"[5]. These include the significant adjustments to health personnel salaries.

It became evident to health service managers that there was limited capacity to deal with labour relations within the department. The Gauteng and Western Cape Departments of Health have responded by sending some of its personnel for training in labour relations.

Organisations representing health workers have expressed dissatisfaction at being represented together with most other public servants in the Chambers, and prefer a separate bargaining mechanism for themselves. Nurses are particularly concerned by the fact that their direct representation on the Council is only through 2 representatives, one each from the South African Nursing Association and the Ciskeian Nursing Association.[24]

CONCLUSION

It is still difficult to get adequate information in South Africa. The culture of free dissemination of information for the public good has yet to take root. Where information is available, it is wracked by problems of inconsistency and unreliability. Reviews of this nature may be compromised by the problem of inadequate information. However, ReHMIS has gone a long way in creating a national database for health service information. The database needs to be validated and updated to improve the quality of its data.

The priority areas for policy development for human resources for health have not changed from those identified in 1995. These are currently being refined by the various policy-making organs of the Department, although at a slightly slower pace. Current policy positions are mostly contained in draft documents. There has been little movement in addressing some of the main policy issues facing the Department of Health, most notably, the issue of redistributing health personnel.

The transformation of the personnel structure to reflect more the face of South Africa has been quite successful. Capacity development is visible within management. However, this is still mainly at higher levels of the system. More attention is required to ensure adequate management development at the lower end of the health system, particularly the district and local levels of health care.

Training and skills development among health personnel has been identified as the main strategy to address some of the major problems facing human resources for health. The Department of Education should be a major partner in this regard. It is important that mechanisms are identified to define how the Department of Education will be engaged and how it will be brought into the centre of joint co-ordination of training and education activities.

Developing human resources for health remains the make-or-break of health care reform in South Africa. In a nutshell, real progress will be reported when all the dimensions of maldistribution begin to change, and when health service users begin to experience a caring, compassionate and quality health service.

8 DRUG POLICY AND PHARMACEUTICALS

INTRODUCTION

A rational drug policy was considered one of the key issues of the national Department of Health and the Minister appointed a drug policy committee in the second half of 1994 to determine the issues that needed to be addressed and ways in which to address them.[1, 2] The most important **public sector** steps taken regarding drug policy in 1995 were:

- the consolidation of previous efforts to produce a National Drug Policy (NDP)
- the appointment of a representative, national committee to consider Standard Treatment Guidelines (STGs)
- creation of an Essential Drug List (EDL) for primary care.[1, 2]

There have been a number of developments in the **private sector** over the past year that are important to the overall pharmaceutical policy:

- mergers of companies in the pharmaceutical manufacturing industry
- vertical integration, by which pharmaceutical manufacturing companies determine and control not only what drugs are produced, but also how and by whom they are prescribed
- the purchase of the country's largest "clearing house" for prescription payment by a pharmaceutical conglomerate.[3, 4] This purchase included what was regarded as South Africa's major independent drug information centre. Critics argue that industry can now determine what information prescribers, pharmacists and other private sector health care providers, as well as patients, are given about their medication, although the new shareholders have apparently guaranteed the independence of information dissemination.

THE PHARMACEUTICALS MARKET

During 1995 the prescription pharmaceuticals market can be estimated to have been worth approximately R4.7 billion. Of this amount around R3.1 billion was prescribed and dispensed to medical (insurance) scheme beneficiaries.[5, 6] Some of the balance would have been paid for directly by private sector patients. The remainder of the balance (± R1.6 billion) was purchased by the public sector, but did not necessarily reach its intended users, due to poor control systems and mechanisms.[7]

The proprietary, or over-the-counter market was estimated to be R1.7 billion, making a total pharmaceuticals market of R6.4 billion.[8] This figure provides an average **per capita** annual expenditure on medicines, in all sectors except traditional remedies, of R160 (± US $35). To place this figure in context, the World Bank quote an average drug expenditure of US $2.1 in ten African countries in the mid-1980s.[9]

POLICY ISSUE

The National Drug Policy (NDP)

The launch of the NDP by the Minister for Health in February 1996 is a very important step indeed to rationalise and improve the use of drugs in South Africa, as well as to ensure that they are accessible to all.

Authors : Rob Summers and Fatima Suleman

This NDP arose out of recommendations of the Drug Policy Committee which were discussed with all stakeholders.[10] The main goal of the NDP is to provide a framework to develop fully the potential that drugs have to improve health status, within the available resources, in South Africa.

Background information

Over the years a number of studies and estimates have indicated that South Africa's pharmaceutical sector is characterised by:

- indiscriminate and irrational drug use
- polypharmacy
- high drug prices
- poor financial and physical controls in the public sector
- a high level of illegal drug trading (because of huge price differentials, drugs are an attractive target for theft from the public sector for re-sale in the private sector)[7, 12, 13]

The NDP seeks to address these and other important medicinal drug-related issues.

Main components and policy aims

Some of the important points and aims of the NDP are highlighted.

Legislation and regulation

The aim of ensuring that drugs used in South Africa are safe and effective and meet approved standards will be achieved through strengthening the Medicines Control Council (MCC), rationalising drug registration, controlling the registration of practitioners and the licensing of premises, enhancing the inspectorate and laboratory functions, and promoting other quality assurance measures.

In particular, special attention will be given to the needs of health providers in primary health care environments. This step may include rescheduling of certain drugs to improve patient access to appropriate treatment. It is also envisaged that medical practitioners and nurses will not be permitted to dispense drugs, except where separate pharmaceutical services are not available. In such cases, dispensing licences will have to be obtained, subject to geographical limits, accompanied by proven competency to dispense. Non-pharmacist ownership of community pharmacies will be considered, although it will still be expected that the pharmacy is under the full-time management and supervision of a registered pharmacist.

At the time of writing, regulations have been passed regarding the licencing requirements of dispensing doctors. This issue is being hotly contested by these medical practitioners.

Drug pricing

The aim of providing safe and effective drugs at the lowest possible cost will be achieved by monitoring and negotiating drug prices, by rationalising the drug pricing system in the public and private sectors, and by promoting the use of generic drugs. Special attention will be given to the work of a drug pricing committee with clearly defined functions to monitor and regulate drug prices.

The need for transparency in the pricing of drugs in the private sector in particular, is of vital importance, to ensure that there is control over escalating drug prices. With this objective in mind, it is probable that a system of professional fees will replace the current percentage mark-up system.[1, 2, 14] International drug prices will be monitored, to ensure that local pricing is competitive and cost-effective.

It is further envisaged that all drugs at the primary care level will be supplied free of charge. At the secondary and tertiary levels, a fixed affordable co-payment for drugs supplied by the State will be levied. The use of generic drugs, to be promoted through generic prescribing and dispensing in both private and public sectors, is regarded as a major tool in reducing drug costs and expenditure.

Drug selection

The Essential Drugs concept, which is based on internationally accepted criteria of needs, proven scientific data, safety and risk/benefit ratios, and single component products, will be used to promote the rational choice of drugs. Currently over 9 000 drug products are registered with the MCC, with

approximately 2 600 being available through the public sector procurement system. In addition, institutions can "buy out" items direct from manufacturers and other suppliers. In essence, the number of drugs available far exceeds the number required to satisfy the country's actual needs. In many therapeutic categories there are over 20 similar drugs. It is clear that they cannot all be the best compound for a particular condition, although industry advertising is aimed at suggesting that this is the case, despite often only minor differences between products.

Procurement and distribution

There have been poor, and sometimes non-existent, controls over drug procurement, distribution and use in the public sector.[7] This statement does not mean to say that the majority of health care providers who handle drugs are not competent and dedicated. What it does say is that they have not been provided with the appropriate systems and methods, to enable them to monitor and control their drug supply and stocks.

The systems were so poor in the past that losses and thefts could not be identified, controlled and stopped. As a result two provincial governments, Northern Province and Eastern Cape, have contracted out drug procurement and distribution to a private organisation. Theoretically, contracting out has a number of advantages, especially when there is a lack of management and planning expertise.[15] These advantages include:

- the private organisation taking responsibility for all insurance of stock until delivery at the hospital (overcoming the risk inherent in the self insurance policy of government)
- the private organisation will be responsible for ensuring continuity of services and will not be affected by public sector labour disputes
- the private organisation will be responsible for the distribution system, decreasing the costs of public sector transport which is a major cost component in the distribution cycle.

During 1995 the National Co-ordinating Committee for the Provision of Medical Supplies (COMED) established a steering committee, which was given the task of formulating proposals for the re-structuring of COMED and the way in which it carried out its work.[16] Although recommendations on this restructuring have been available since September 1995, they had not been implemented at the time of writing.

Local manufacture of drugs on the national EDL will be encouraged and supported, provided that prices are right, e.g. by a maximum 15% price preference over international prices.[1]

Rational use of drugs

Studies of drug use in South Africa have shown that the following practices apply:

- Inadequate or incomplete patient evaluation and diagnosis
- Polypharmacy
- High antibiotic use
- High injection use
- Lack of monitoring of treatment outcomes.[15, 17, 18]

These problems will only be overcome through a concerted effort to train all health personnel in appropriate methods for rational drug use, or what is known in Australia as the quality use of medicines.[19] The general public, as patients and as consumers, must also be encouraged to develop a more critical attitude to drug advertising and commercial information.

Other measures to be promoted include:

- provision of practical and scientifically validated information on the correct handling and use of drugs through the support and establishment of independent Drug Information Centres
- providing the public with access to objective and practical information on drugs and their proper use, written in lay language, and including appropriate self-diagnosis and treatment
- encouraging research on social and cultural factors which influence medicine usage
- the establishment and strengthening of Pharmacy and Therapeutics Committees in all hospitals

- ✧ enhancing the role for pharmacists, particularly in quality assurance and in the safe and effective administration of drugs
- ✧ the expansion and standardisation of the training of pharmacy support staff, to include the management of drug supply and dispensing in primary care clinics
- ✧ strict controls over the advertising and promotion of drugs by manufacturers and others.[20]

Human resources development (HRD)

The National Drug Policy highlights the requirements for institutional and in-service training and lists priority training needs for various categories of staff involved with pharmaceuticals. In addition to training, incentives will have to be introduced to encourage pharmacists and other professionals to move to under-serviced areas.[21] The number of pharmacists registered in the country increased by only 33 to 9 963 during 1995.[22] This was an **0.3%** increase! It has been shown previously that South Africa needs an increase of at least 374 pharmacists per year until 2010 to maintain current population : pharmacist ratios, let alone the increased demand of implementing an effective NDP.[23]

Implementation plan for the National Drug Policy

The flagship for the implementations of the National Drug Policy is the South African Drugs Action Programme, launched in September 1996. SADAP's four year plan aims to improve the drug supply system in the public sector and better regulate the private pharmaceutical sector. This comprehensive programme will seek to address inefficiencies related to pricing, procurement, storage, distribution and use of drugs. The sequence of changes will be governed, to an extent, by the need for accompanying legislative or regulatory reform.[24]

Phase one will comprise aspects for which no regulatory or legislative changes are necessary, such as the essential drugs list for primary care.

Phase two will include issues which require amendment to the regulations in terms of current legislation and for which parliamentary approval is not required.

Phase three will consist of aspects where major changes to current legislation are needed, eg. to the Pharmacy Act and the Medicines and Related Substances Control Act.

At the time of writing Phase one and two were well under way and draft regulations regarding Act 101 of 1965 (Medicines and Related Substances Control Act), including the tightening of controls over dispensing practitioners, were put out.[25] These controls have been hotly contested in the media by the representatives of dispensing doctors.

It is understood that writing of a new Pharmacy Act is far advanced and that it will come forward for legislation in 1997.

Standard Treatment Guidelines and Essential Drugs List for Primary Care

The Standard Treatment Guidelines (STGs) and Essential Drugs List Publication was released at the end of March 1996.[11] This publication forms a major component of the NDP. Through the STGs, the principles and objectives of rational prescribing and effective treatment for approximately 100 common conditions will be widely disseminated.

The primary care EDL, which is part of the same publication, will be used as a foundation for

- ✧ the basic health care package at primary care level
- ✧ procurement and use of drugs in the public sector
- ✧ standard treatment guidelines and training in rational prescribing
- ✧ drug information to health care providers, including a national formulary
- ✧ support to the national pharmaceutical industry
- ✧ drug donations.[1]

The use of the EDL and STGs at all public sector facilities will be mandatory. Its application by private providers contracted to provide health care services on behalf of the Department of Health will be one of the conditions of accreditation of such providers.

The National EDL Committee used the following working principles

- ✧ **conditions** included are those which comprise the majority of contacts at the primary level
- ✧ **treatment** for the conditions will be managed at the primary level
- ✧ **treatment** will follow recommended STGs and will be based on drugs in the EDL
- ✧ **drug scheduling** will facilitate practice and will enable health workers at primary level access to recommended drugs.[11]

Through the application of these principles, approximately 160 drugs were selected for inclusion on the list. Some opposition to the list was expressed, even before its publication, predominantly by organisations with vested interests in the *status quo*.[26] There has also been some criticism of the EDL by public sector users who feel that the composition of the EDL committee was dominated by pharmacists and excluded primary care providers. However the introduction of the EDL should be seen as a major step forward towards equity and the improvement of the quality of primary level health care.[11, 27, 28]

THE PRIVATE SECTOR

Medical insurance and cost-containment measures

The medical insurance industry is the main funder of prescription medicines in the private sector. Since 1991, this category has comprised approximately 30% of medical scheme expenditure (See Table 8.1). From 1988 - 1993, medicines expenditure followed a rising trend (26.1% in 1988 to 32.9% in 1993). The proportion dropped slightly in 1994 (to 30.5% of approximately R14 billion). Of the 1994 expenditure on medicines of around R4.2 billion, 61% was paid to pharmacies, 27% to doctors and 11% to hospitals.[5, 6]

TABLE 8.1. PERCENTAGE BREAKDOWN OF EXPENDITURE BY PRIVATE MEDICAL INSURANCE SCHEMES (1988 - 1994)

	1988	1989	1990	1991	1992	1993	1994
GPs	16.1	16.3	14.6	14.0	11.5	10.5	10.4
Specialists	18.0	17.6	16.4	17.0	17.8	18.0	18.5
Dentists	11.3	10.8	10.1	10.0	9.7	9.0	8.4
Provincial hospital	5.8	5.3	5.2	5.0	4.3	3.7	2.9
Private hospital	15.8	16.3	18.5	17.3	17.5	18.7	22.1
Hospitals (Total)	21.6	21.6	23.7	22.4	21.9	22.4	25.0
Medicines	26.1	26.5	27.4	29.0	31.8	32.9	30.5
Ex gratia	0.4	0.3	0.3	0.3	0.3	0.3	0.3
Other	6.5	6.9	7.6	6.9	7.0	6.8	7.0

*S*ource: Magennis R and Coetzee W. Survey of the South African Medical Scheme Industry 1995

The proportion of the private sector drug expenditure in provincial hospital has declined. Part of the reason for this decline is the lack of a proper and efficient billing systems for public sector hospitals to claim reimbursements from the medical schemes, but mostly it is due to a decline in the numbers of private patients using these facilities.

Private hospital expenditure has increased from 15.8% of the total in 1988 to 22.1% in 1994, a 39.9% rise. These changes and others are reflected in Table 8.2, particularly for medicine costs which rose by 45% per member in 1992.

TABLE 8.2. MEDICAL SCHEMES: PERCENTAGE GROWTH IN ANNUAL MEDICAL COSTS (PER MEMBER)

	1990	1992	1993	1994
General Practitioners	24	8	5	11
Specialists	37	35	16	18
Dentists	28	28	6	5
Provincial hospitals	24	14	2	10
Private hospitals	22	33	23	32
Medicine	37	45	19	6
Other	19	33	12	9
Total	29	31	15	11

Source: Magennis R and Coetzee W. Survey of the South African Medical Scheme Industry 1995

This rising trend led to the medical schemes instituting a number of cost-containment measures, which are listed in Table 8.3. This table shows all cost-containment measures instituted, not just those for medicines, but 7 of the 10 most common measures are concerned directly with medicines.

TABLE 8.3. ACTIONS TAKEN BY MEDICAL SCHEMES TO MANAGE HEALTH CARE COSTS IN 1994

Action taken	%
Agreement and liaison with service providers / suppliers	32
Drug utilisation reviews	25
Chronic medication management	21
Fixed hospital / day clinic fees	18
Maximum Medical Aid Pricing (medicines)	14
Pharmacy advised therapy	13
Limits on medical scheme benefits	10
Member education / communication	9
Co-payments and medicine levies introduced or increased	8
Case management / clinic audit / managed access	6
Benefits expressed as a % of claims	5
Pre-authorisation (dental and other)	5
Mail medicine - courier services	2
No / low claim bonuses	2
Savings plans	1
Preventative medicine programme	1
Diagnostic and procedure code pilot study	1

Source: Magennis R and Coetzee W. Survey of the South African Medical Scheme Industry 1995

The extent to which cost-containment measures affected the amounts paid against claims is shown in Table 8.4. Another effect of these measures was to maintain the number of community pharmacies in the country at ± 2 900 in early 1995.[29] There were however approximately 8 300 dispensing doctors who may also have played an important role.[30] During 1995, the number of pharmacies who closed exceeded those who opened and by the end of the year there were 69 fewer pharmacies than at the beginning.[31]

TABLE 8.4. COMPARISON BETWEEN AMOUNTS CLAIMED FROM MEDICAL SCHEMES AND ACTUAL BENEFITS PAID

	% of claim value paid
General Practitioners	85
Specialists	88
Dentists	84
Hospitals	96
Provincial Hospitals	92
Medicines	77
Other	74

Source: Magennis R and Coetzee W. Survey of the South African Scheme Industry 1995

The Government appears to regard the high private sector expenditure on medicines in a very serious light and has already taken steps to take the profit motive out of the dispensing of medicines, for private sector dispensing doctors and community pharmacies.[32]

VERTICAL INTEGRATION IN THE PHARMACEUTICALS MARKET

Vertical integration was mentioned as an important trend in the introduction to this chapter. It is not unique to South Africa. It has occurred in sufficient instances in other countries for the main characteristics to be well-known.[33] We trace the path of a medicine from invention to manufacturer to patient, including payment, to discern the details.

The prescription, supply, payment and use steps are now elements of pharmaceutical benefit management, an element of managed care. The differences between this approach and that illustrated by Figure 8.1 have been highlighted recently[33] (see Figure 8.2). The convergence between the activities of funders (ie. medical insurance schemes) and pharmaceutical manufacturers is shown in Figure 8.3. The rationale behind the purchases by pharmaceutical manufacturers of medical scheme management companies can now be seen clearly. So too can the potential influence of pharmaceutical manufacturers on prescribing practices through managed reimbursement for medicines, eg. when Glaxo-Wellcome and Eli Lilly purchased Medikredit in May, 1995, it was reported that "Medikredit has access to a lot of health plans, and has the capacity to influence doctors to prescribe certain drugs".[3] Whether this influence will improve health care outcomes for patients remains to be seen. It is a fact of life that the pharmaceutical manufacturing industry has been the most profitable sector of the manufacturing industry. Will this situation continue, but in this instance at the cost of appropriate health care?

Internationally, the ongoing takeovers and amalgamations among the world's top pharmaceutical producing companies have occurred in an effort to ensure ongoing original research. The procurement of any new drugs which result in South Africa will depend on the price that may be obtained for them here.

Local pharmaceutical companies continue to upgrade their facilities as they explore export opportunities. Seeking acceptance for inclusion on the essential drugs list will be driven by the prospect of volume increases and economies of scale.

FIGURE 8.1 TRACKING A MEDICINE FROM INVENTION TO USE

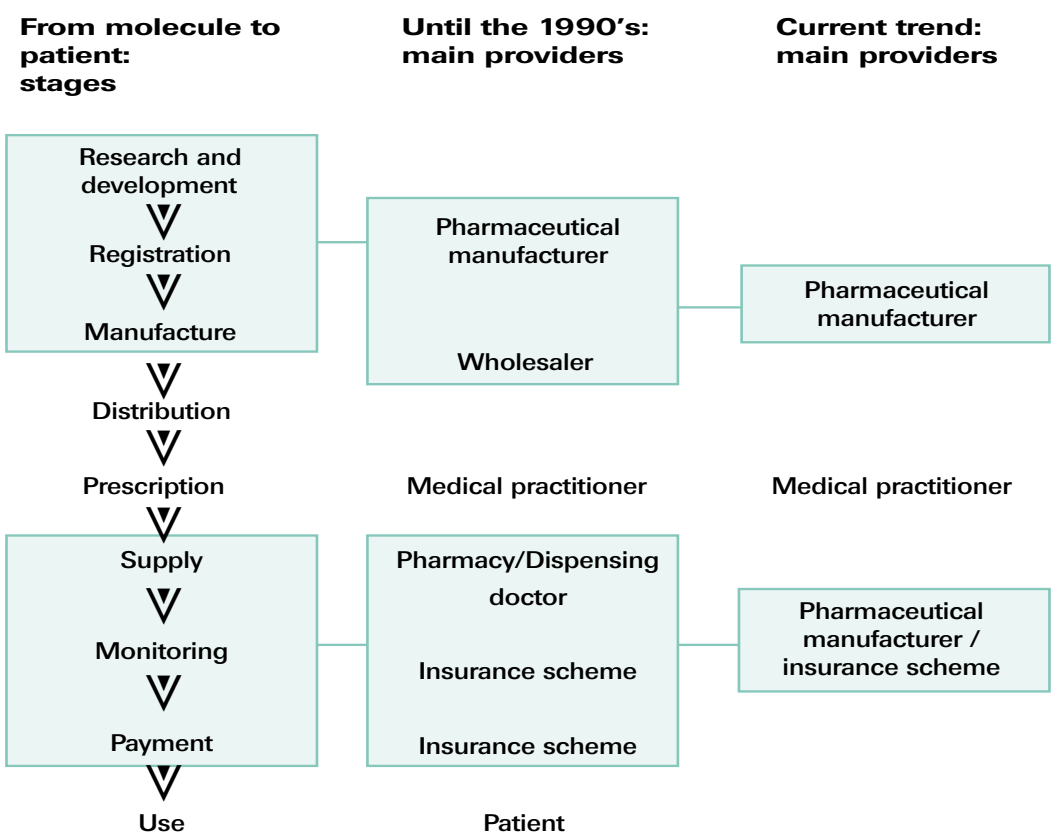
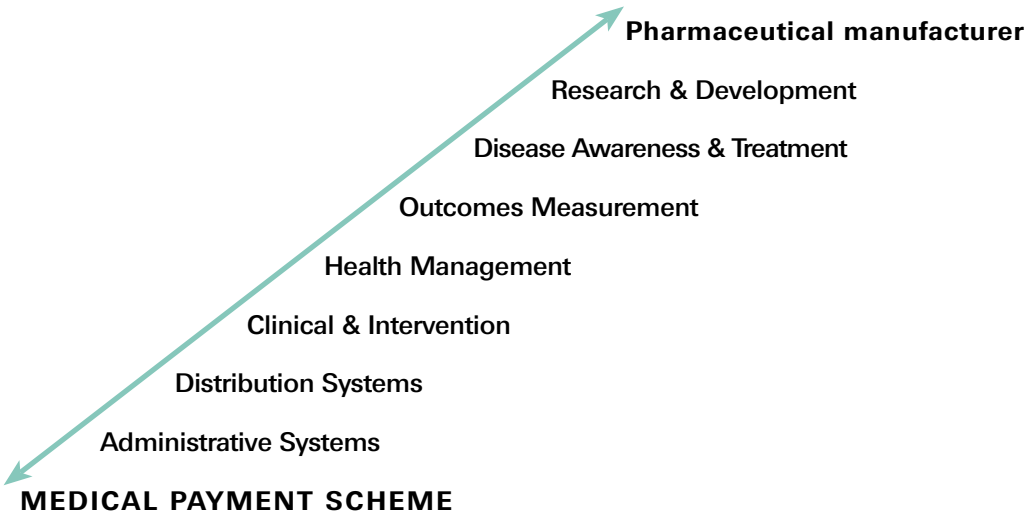


FIGURE 8.2 PHARMACEUTICAL BENEFIT MANAGEMENT AS AN ELEMENT OF MANAGED CARE

Traditional Pharmacy Management		Pharmaceutical Benefit Management
Distribution Management	⩥	Care Management
Drug Utilisation Review	⩥	Clinical Decision Support
Transaction Intervention	⩥	Targeted Intervention
Event Measurement	⩥	Health Outcomes Measurement
Drug Orientation	⩥	Disease and Patient Orientation

Source: Pharmaciae, November 1995

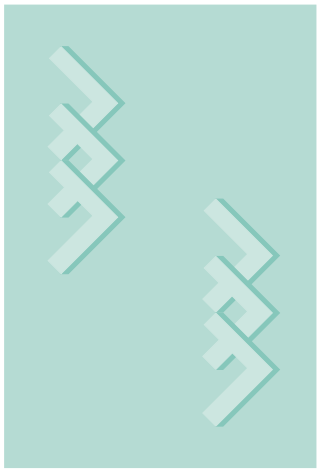
FIGURE 8.3 CONVERGENCE OF PHARMACEUTICAL MANUCFATURER AND HEALTH CARE MANAGEMENT



Source: Modified from Pharmaciae, November 1995

CONCLUSION

It is clear then, from the material presented in this chapter, that during 1995 and the early part of 1996, South Africa put in place many of the elements required for an efficient and cost-effective pharmaceutical sector. Whether these elements, and other measures still in the planning stage, are allowed to bring their objectives to fruition is another matter. The degree of opposition by vested interests to the implementation of such progressive policies cannot be overestimated. World-wide experience suggests that all role-players and stake-holders must be committed to the principles of equity and accessibility to health care by all people in a country. This commitment must go beyond lip service to include active participation in the process of initiation, review and improvement.



9 INFORMATICS SUPPORT

THE IMPORTANCE OF INFORMATION

Information is vital at all levels of health service provision. Sandiford *et al* accurately sum up the importance of information in health as follows: "Despite the difficulties of unrealistic expectations, information can lead to improvements in health by influencing decisions which affect the funding, efficiency, effectiveness and equity of a health system".[1] The Department of Health fully appreciates this. In fact the most important initiative in Health Informatics during the year 1995/1996 was taken by the Department of Health with their plan for a National Health Information System for South Africa (NHIS/SA).

THE EXISTING SYSTEM

The national Department of Health has, however, inherited a very fragmented paper-based information system. Further, the provincial information systems, where they exist were and in fact still are, equally fragmented and designed to provide information to centrally managed provincial health service units and hospitals. The information collected therefore had and still has very little meaning to those responsible for data collection, since managerial control and responsibility has not yet been passed over to the clinics and hospitals. The Department of Health does have a growing need to collect the information needed to derive indicators of equity, service usage, health status, for resource allocation and other health management functions. The assumption is, that if information is available then management will improve, and health service provision will be more equitable. One of the first problems would be to allocate resources on a scientific basis. This is easier said than done. Green and Barker drew attention to the fact that some 'rational decision making models' whether based on Epidemiology, Economics or Social Epidemiology may obscure built-in value judgements, and may just create a feeling of security based on the belief that allocations have been 'scientifically' made.[2] Considerable experience is needed with these 'model building tools'.

The main focus during the year has been on Information Technology rather than Information. NHIS/SA's main emphasis has been on component systems, probably to the detriment of fully analysing the potential flow of information within the restructured Health System. In particular, the information needs at, and between, institutions, districts, regions, provinces and the national Department as well as with the private sector still needs to be defined. The cost of collecting and encoding all this information on a routine basis needs to be assessed and compared with the possible use of periodic sample surveys at least for an interim period.

PROGRESS TOWARDS A NATIONAL INFORMATION SYSTEM

During the year under review, the NHIS/SA Committee established by the Minister was restructured to become a sub-committee of the provincial Health Restructuring Committee.[3] Many of the technical committees initially established were disbanded, as provincial representatives became more involved in the process. Salah Mandil, the principal consultant for the Department of Health, spelt out the policy and strategy for NHIS/SA as follows:

- ✧ It is to be based entirely on the health policy and strategies adopted by the Reconstruction and Development Programme
- ✧ It is to be primarily developed by and based on consensus between the provincial and national institutions, who would be the primary users of the resulting system

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- NHIS/SA would be viewed and developed as one parent system with a number of component systems, governed by nationally accepted standards on the methodology, technology and procedures used for the NHIS/SA development and operation
- Data would have to be collected at the point of generation to enable service assessment as well as self assessment (i.e. data must first and foremost be required by the echelon collecting it; where feasible, the basic analysis of the data would be carried out at the point of collection). Collection, aggregation and analysis should follow the organisational structure of the Health Services, that is national data would comprise the sum of the provinces, provincial data of the sum of its regions, regional data the sum of its districts
- Whilst the resources for the NHIS/SA initial development would be sought and obtained from various sources, the resources for the ongoing operation and further development of the various components of the NHIS/SA would have to come from a re-orientation of resources of the respective health authorities at the provincial and national levels.[4]

The plan of the NHIS/SA committee was to work hand in hand with the provinces. It was required to formulate issues, propose solutions which the provincial representatives would in turn take back to their provincial line structures and provincial workshops. Following this, the outcome of their provincial discussions would be transferred back to the NHIS/SA committee for re-discussion until consensus would be reached.[5]

In the NHIS/SA Progress Report of June 1995, the provinces were given a key role to play in the implementation of NHIS/SA.[6] In terms of this they would have the responsibility to:

- enable the districts to perform their roles efficiently and effectively
- set standards in accordance with nationally agreed standards
- develop planning and policy at provincial level
- co-ordinate and monitor the development of information systems in the districts and province
- budget for NHIS/SA in the province
- facilitate the development of aggregated data in NHIS/SA
- support the provincial hospitals to run their systems effectively
- maintain a provincial NHIS/SA.

This interaction between the Ministry of Health and the provincial Departments of Health referred to above often did not function as planned. The main reasons for this were that during the meetings of the NHIS/SA committee, line structures in the provinces were not in place or were still in the process of restructuring. The Western Cape, for example, only appointed its Health Information Manager in February 1996 and in some provinces, Health Information Managers had very little prior informatics experience. The result was that the NHIS/SA committee found itself far ahead of the provinces which tended to exacerbate the top-down nature of the interaction process. This tendency needs to be rectified, since user-participation and involvement has long been considered a critical factor in system development. A recent case in point was the Coventry Mental Unit, which had to abandon a R160 million information system because the proposed patient administration module was said not to satisfy user need.[7] It is thus necessary for NHIS/SA to appreciate that the problem with Health Information Systems implementation is often not technical, but rather sociological and behavioural.

The Department of Health has planned a rapid implementation approach: the complete installation of four modules (patient registration, minimum data set or master patient record, an appointment scheduling module and a patient billing module) in 369 general hospitals, 54 specialist hospitals, 3 143 primary health centres and a number of support centres in a period of twenty-four months. Simultaneously a national patient data base is to be created and linked to all hospitals and primary health care centres. These modules would support initial components of the National Health Care Management Information System that will ultimately be developed.[8] Uganda, in contrast plans to implement their National Information system in one district first to be followed by a step-wise national implementation strategy.[9] Some systems analysts would consider smaller phased implementation as a safer option. For example, Hugh Lang, the Information Manager for the South Kent Hospital's Trust opted to spend a fair amount of time in prior business process analysis.

The appropriateness of a hospital information system at the clinic level also needs careful consideration since NHIS/SA intends to implement the same information system at both clinic and

hospital levels. Molefane, Parshotam and Smith have studied information systems in tertiary care hospitals as well as information needs for primary care, and concluded that a down-scaled hospital information system will not serve the needs of a community health centre providing primary care.[10] The method they used included qualitative and limited interviews. A more systematic, dynamic modelling exercise is urgently needed.

The tender for the core modules of the single National Health Information system was issued in November 1995. While the Department of Health was endeavouring to expedite the process as rapidly as possible it ran into difficulties with the Tender Board. By September 1996, it was not clear whether a single national tender would be proceeded with, or whether provinces would be asked to tender as individual entities. Both options have pros and cons. A single tender for South Africa would have the advantages of economies of scale both in development and in human resource needs. The sheer magnitude would give the issue considerable leverage in obtaining a system which would precisely meet the specifications of the invitation to bid. On the other hand, a uniform system could be difficult or expensive to adapt in those provinces which already have some form of information system in place. Alternatively, multiple provincial systems, even though following some basic common design, would allow for a diversity of approach which would enable the more successful features of each system to be universally adopted, although the human resources requirements in this approach would be greater. In such a situation, compatibility and smooth interchange of data would need to be ensured. It has now been decided to opt for separate provincial tenders, as opposed to a single national tender.

It must be stressed that even after the four core modules are completed, considerable development will still be needed to obtain a fully functioning Health Information System.

Education and training in Health Informatics

Informatics skills are in short supply. A survey ranking 48 countries with similar levels of development in terms of Information Technology skills placed South Africa forty-third on the list. The NHIS/SA Committee itself declared that there are no professional human resources for informatics at the district/local level, and only between 10 and 40% of what is required at provincial level.[11] Further, the mere availability of information is not sufficient. Understanding and interpretation is crucial. Like literacy, numeracy (developing quantitative skills and culture) must also be acquired.

Education and training will thus be a key issue. The British National Health Service (NHS) is taking this need for training in informatics very seriously and South Africa with its extreme educational backlog should take training even more seriously. The British NHS now has a large training division which has embarked on an "Enabling People Strategy". If health management at all levels is to become 'action-led' rather than 'data-led', then education is indeed a priority. At the upper levels, only the University of Cape Town offers a degree in Medical Informatics. The University of Stellenbosch is now including Health Informatics in its public administration course and the Schools of Public Health established in the Cape and Gauteng have included Health Informatics courses in their health management programmes. Technikons have not as yet initiated courses in Health Informatics. Last year, a start was made by the South African Medical Informatics Group (now the South African Health Informatics Association) with their workshop on curriculum development for Health Informatics for health care workers. The report was published by the Health Systems Trust.[12] The workshop had input from a wide spectrum of health care and health managers. Four target groups for Health Informatics training have been identified by this workshop. These are the operational staff (clinical and administrative staff); management; health informatics staff; and the community. Training for specific systems such as NHIS/SA need also be considered. No further strategy has as yet been devised.

In the Western Cape, a district was asked to develop and run a District Health Management Information System training course and R208 000 from European Union and Norwegian Government funds were set aside for this. The objective is to develop capacity in district, metro and rural Health Information Systems.

With training will come the need for proper recruitment and retention of Health Informatics personnel. Health Informatics managers are still appointed with no or very little knowledge of Health Informatics. Informatics staff thus often find

" That the Captain they trusted so well
Had only one notion for crossing the ocean,
And that was to tingle his bell.
He was thoughtful and grave - but the orders he gave
Were enough to bewilder a crew."[13]

Recognition and career paths for Health Informatics personnel also need to be established. A strong Health Informatics Association is still not in existence in South Africa. The South African Medical Informatics Group (SAMIG) is only now in the process of re-engineering itself. It is hoped that with its evolution into the South African Health Informatics Association (SAHIA) this gap will gradually be filled. A formal relaunch took place at Helina96.

At provincial levels, Health Information Managers are appointed into different ranks. In the Western Cape the Health Information Manager holds the rank of director, whereas in the Free State he holds the rank of deputy director.

Cost considerations

The cost of any new Information System has not been clearly spelt out to the provinces as yet. It seems that the provinces will be expected to fund a large proportion of the cost, especially the hardware. However, provinces with severe budget cuts would rather divert their funds to establish and extend badly needed services at local or district levels while trying desperately to de-escalate its tertiary care centres where they exist. Personnel cost also seems not to have been entered into the cost equation for any National Health Information System. Cognisance must be taken of the fact that personnel costs takes up about 70% of the budget, and training costs an additional amount.

Health informatics standards

The development of uniform standards both within NHIS/SA and the whole health care system is crucial. NHIS/SA has established a standing sub-committee on standards covering the whole range of data and technical standards.

A decision has been taken to adopt the International Classification of Diseases 10th Revision (ICD-10) as the uniform coding system for morbidity and mortality. The Department is considering the use of the Current Procedural Terminology for procedural coding, and the International Classification for Primary Care for reasons for encounter. The acceptance of these standards also has the support of the private sector. It has further been decided to utilise the people's identity numbers as the identifier to be used by NHIS/SA, with an additional field for encryption where necessary. Interchange of data between the private and public sector will become more important, particularly with respect to the proposed national health insurance where agreed standards will be vital. In view of this, the Private Sector Electronic Data Interchange Steering Committee has been restructured as the Private Sector Health Informatics Standards Committee.

Surveys

NHIS/SA is also undertaking sample surveys to provide quality data. A demographic and health survey is planned for 1997 while a disease surveillance module is being developed. The Demographic and Health Survey will be an expanded version of that previously carried out in Africa with more emphasis on health related information than on fertility and demographics.

ReHMIS

ReHMIS, the survey of resources in the public sector was repeated in all the provinces during July to October 1995. Currently, a series of provincial reports on the implications for planning health care is in varying stages of publication. To date, reports have been published jointly

by the Health Systems Trust and the Department of Health for KwaZulu-Natal, Northern Province, North West, Free State and Eastern Cape. These will be followed by a national report. These publications have demonstrated the information which is available, and presented it in an attractive way useful for planning and feedback to those who collected the data.

Objectives and goals

The Department of Health has been developing a series of National Health objectives and indicators. A draft of this document was circulated for public comment.[14]

HEALTH INFORMATICS ACTIVITY OUTSIDE OF NHIS/SA

Helina96 and the Africa Region of IMIA

The Second Africa Regional Health Informatics Conference of IMIA (International Medical Informatics Association) was held in Midrand during April 1996, preceded by a very well attended Autumn School. Helina96 was sponsored by the Department of Health, the South African Medical Research Council, WHO, SAHIA, and IMIA. The Autumn School was organised by the South African Health Informatics Association.

During the Conference delegates from the various African countries present were invited to attend a meeting chaired by Prof Otto Rienhoff, the IMIA president to discuss the formation of the Africa Region of IMIA. SAHIA will help with the establishment of National Health Informatics Associations in African countries who require assistance.

Free State PHC/INFO project

This is a co-operative effort between the Department of Health and Welfare of the Free State, the Centre for Health Systems Research and the Health Systems Trust. The objective is to contribute to the development a comprehensive primary health care information system in the province, focusing particularly on the use of information.

The Health Worker Information Needs Conference

A conference was organised by the Health Systems Trust to discuss the information needs of the health worker. Nkosi (1995) summarised this needs as follows: "An important element making up the sense of isolation is that of being cut off from new developments in the field of Health, of feeling left behind, of being sidelined from the flow of information. Information might be readily available but the Health Worker nevertheless needs training in how to access that information."[15]

This conference has given rise to a number of initiatives aimed at meeting the information needs of health workers, including support for the Free State Medical School Library to package and make information available to health workers; access to the Medicines Information Centre via electronic communication for HealthLink users; and monthly dissemination of written publications such as *HST Update, MCH News* and *Networker* to every public hospital and clinic in the country.

HealthLink

HealthLink is an initiative spearheaded by the Health Systems Trust to promote the use of electronic communication and information exchange as a tool for health service management and support for isolated health workers.

There are over five hundred users of this store-and-forward e-mail system, primarily in the Free State, Northern Province, Eastern Cape and KwaZulu-Natal. Efforts are now being concentrated in developing its potential for applications such as distance learning, problem-solving and access to libraries, as well as promoting the use of computers amongst health workers.

CONCLUSION

The road ahead for Informatics in Health is not going to be an easy one, but the potential benefits are such that a considerable investment of resources is well justified. For a national health information system to serve its purpose effectively, strategies need to address not only technical and cost considerations, but education and training needs. At the end of the day, the infrastructure and networks are simply the pipelines through which information can be channelled, interpreted and used for action.

HEALTH RESEARCH 10

SUMMARY

- Health research in South Africa lacks a coordinated approach. The Essential National Health Research (ENHR) initiative offers a framework which could address this.
- Health research agendas have emphasised clinical and laboratory research over public health research. While all types of research can have a part to play in overall health development, there is a need to reassess priorities.
- There are significant deficiencies in information relating to the financing and expenditure on health research. In addition there is a lack of information and co-ordination relating to current research activities which are underway or planned by various researchers.
- Research skills development and capacity building is essential in order to utilise important potential research groups, particularly within the historically black universities and technikons.

SETTING HEALTH RESEARCH PRIORITIES

Health research encompasses a wide range of disciplines and methodologies. These include epidemiology, social and behavioural research, clinical and biomedical research, health systems research and policy analysis. Each have a role to play in the overall goal of improving health, yet finding the balance between them is difficult and influenced by many issues.[1, 3] Many have argued that South Africa's research agenda has in the last few decades, been biased towards laboratory based research at the expense of public health research.

The question is, how should we set priorities for health research? The Essential National Health Research is a process which may assist us (see case study on ENHR). The implementation of an ENHR framework has been under discussion in South Africa since 1991, and was endorsed prior to April 1994 by both the Medical Research Council (MRC) and an alliance of progressive non-governmental health organisations. In December of 1994, the new Department of Health took the initiative by organising a national meeting of stakeholders in research to plan the implementation of ENHR. In March 1995, the Minister of Health appointed a national technical committee to further develop recommendations for the implementation of ENHR. This was presented to the Minister in November 1995.[3]

The committee recommended that the Chief Directorate for Information, Epidemiology and Research should promote and facilitate the setting up of the ENHR process and mechanism. It also recommended the formation of a national task force for a period of two years to facilitate the development of the ENHR mechanism, along with the Chief Director and the nine provincial departments. The committee's main arguments for the need for an ENHR strategy were that:

- It is a research management strategy that maximises health research investment
- It is a research strategy that will address the burden of disease and the quality of health in the country
- It will promote health and development on the basis of equity and social justice
- It will address the current imbalances in the distribution of health resources

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While many developing countries use their ENHR to lobby for external funding, the focus of the South African ENHR is to redirect existing internal resources. It is argued that the implementation of an ENHR strategy is essential if we are to ensure that the health of all South Africans is improved, and that inequities between rich and poor, black and white, and rural and urban are redressed.

Various options were discussed for priority setting, with the recommendation that it be a continuous process requiring innovative methods, guided by the analysis of burden of disease. The process should be a goal-oriented priority setting exercise that draws upon relevant role players at various levels of involvement in health research. It is important that there be a dynamic interaction between the various levels e.g. regional, national, provincial and district, so that the priorities reflect the needs of the community. It is essential that priority setting not be divorced from the process of resource reallocation. Funding should follow priority setting, and evaluation will be needed to ensure that the process itself has the desired output.

In order for an ENHR to be effective, a framework needs to be developed and specific roles assigned to organisations best equipped to fulfil mandates at various levels. The committee recommended a Health Research Council be established with equal representation from the health services, researchers and the community. This council would set priorities in accordance with health research needs and ensure that these are funded, monitored and evaluated. The council would be responsible to the Minster of Health; however it was felt strongly that the mechanism should not be situated within the Department of Health, and that any organisation or agency involved in allocation of funds through this process should not undertake intramural research. This recommendation has been supplanted by the White Paper developed by the Department of Arts, Culture, Science and Technology. This White Paper proposes the establishment of a unified National Research Council, and places emphasis on the research, rather than funding agency functions of existing statutory councils.

Essential National Health Research

Resources for health research are limited, and it is therefore important that a strategy be established by which these are directed in an efficient and fair manner, and in a way which enhances the impact of these resources and maximises health investment. ENHR is a process which has been promoted internationally for developing such a strategy for organising and managing health research. ENHR does not dictate a particular type of research or methodology, but is an integrated approach which assists in ensuring that research is directed at priority problems and addresses the burden of diseases of the country.

The ENHR process is committed to linking research, policy and implementation. It does this through an integrated approach which links research and implementation and fosters partnerships among researchers, health services and the community.

The ENHR strategy has two approaches. The first is an ENHR country agenda which is directly relevant to that country, and therefore addresses the health needs which are specific to that country. This research may be undertaken by many different institutions, but unlike much current research, it is part of an integrated and systematic strategy. In other words, it ensures that the important questions are researched in a co-ordinated manner, and thus sees that research is not neglected nor unnecessarily duplicated. The second addresses research which has a longer term vision and is globally relevant. In the past there has been a considerable amount of duplication between (and within) countries, yet the research outcomes are relevant to many countries, such as vaccine development and recombinant DNA technology. This is clearly a waste of resources, which through international co-operation and communication, can be prevented. Each country needs to determine its own balance between the two approaches, determined by its needs and available resources.

The development of an ENHR mechanism will require accurate and reliable information on what research is currently underway, by whom and its funding sources. At present this information is not collected in any co-ordinated way, and therefore it is impossible to determine an accurate overall picture of health research in South Africa. This must be an urgent task for the Chief Directorate of Research. This Directorate will be convening the first annual ENHR Congress in November 1996, at which an *ad hoc* national ENHR Committee will be established.

Discussions regarding the ENHR continue. It will require wide consultation and involvement of the major stakeholders. It must be recognised that health research in South Africa in recent decades has not focused on the priority problems of South Africa, and the ENHR will require considerable political will and commitment to sustain it in the face of vested interests and the powerful role players involved in health research in South Africa. We believe this is an important mechanism requiring support by all those who are committed to deliberately developing strategies which redress current imbalances.

CURRENT RESEARCHERS

The universities are by far the largest sector undertaking health research, with smaller amounts being undertaken by the MRC and other statutory councils; health services, particularly in the larger teaching hospitals; technikons; non-governmental organisations and the private sector.

Despite inadequate information on the research being undertaken by these various groups, it is indisputable that the historically black universities are doing considerably less research than the other universities. Table 10.1. shows that the allocation of research funding towards the historically black universities has begun; nonetheless, it is not clear how much of the money is used within the universities for research, or absorbed into the general university funds.[4]

TABLE 10.1 STATE SUBSIDY FROM THE DEPARTMENT OF EDUCATION, ALLOCATED FOR ALL RESEARCH AT SOUTH AFRICAN UNIVERSITIES IN 1991/92 AND 1995/96

University	1991	1995	% Change
Cape Town	64 682 000	39 064 360	-40
Durban-Westville	11 791 000	15 656 482	33
Fort Hare	*	9 469 983	
Medunsa	9 693 000	11 898 035	23
Natal	57 895 000	36 456 559	-37
North	3 359 000	18 002 132	436
North West	*	13 106 084	
Orange Free State	46 354 000	22 794 003	-51
Port Elizabeth	11 833 000	9 920 702	-16
Potchefstroom	20 215 000	16 550 427	-18
Pretoria	76 598 000	54 192 430	-29
RAU	42 295 000	20 569 774	-51
Rhodes	14 667 000	9 909 823	-32
Stellenbosch	52 175 000	33 662 419	-35
Transkei	*	14 593 375	
Unisa	34 135 000	42 686 202	25
Venda	*	6 389 616	
Vista	8 361 000	16 591 943	98
Western Cape	9 779 000	17 007 143	74
Witwatersrand	77 023 000	46 943 527	-39
Zululand	3 920 000	7 864 390	101
TOTAL	**544 775 000**	**463 329 409**	**-15**

Source: Minnaar PC. Report to the Medical Research Council 1995
* Former Homeland's allocation was from the Department of Foreign Affairs and not the Department of Education

It is very clear that resources are being shifted towards the disadvantaged institutions, not only from government, but also other national and international funders. This change needs to be carefully managed, and these institutions need to develop a clear vision of their future, and strategy of how their priorities will be addressed. In many cases this does not appear to be happening, and development appears to be happening in a haphazard and unco-ordinated way. Without an explicit strategy, which is clearly communicated, there are likely to be problems of duplication on some issues, while other issues are neglected. There is also the danger that funders will be able to swing agendas towards their priorities, and not those of the University.

Shifting resources is a very positive step towards encouraging research, and will enable these institutions to address a number of key problems. For example, enhancing libraries and gaining access to the Internet will make it possible for them to keep in touch with international debates and literature. Extra financing will also enable the procurement of research equipment, computers, vehicles for doing field work, and develop basic services (such as telephones which currently either insufficient to cope with the demand, or are not fully functional).

However, there remain other problems which are preventing extensive research agendas. Many historically black universities lack experienced research staff, as the past has not offered the opportunity for research. One major reason is that these institutions' original mission was to teach and not undertake research. There are therefore very few *full time* research positions, leaving only the most enthusiastic to undertake research, often on top of full teaching loads. This is made worse by increasing class sizes. Thus many senior staff, while expected to teach research, do not have much, if any research experience. In addition, a research culture has not been encouraged, for example promotion has not being linked to research and publications unlike other universities.

Nonetheless, there have been some who have undertaken research. However the lack of a research culture has not encouraged many to remain at these universities. Many have therefore left to work in other universities of research establishments. In addition others have left to work in government or the private sector. The lack of experienced staff is compounded by the inability of the historically black universities to attract a sufficient number of new academic staff, often because of poor working conditions and also the remote location of some historically black universities. There is therefore a need to develop practical research skills, including proposal development, research design and project management, computer literacy and report writing skills. This can be assisted by research skills development within the universities and also developing linkages between institutions. Shifting research to the historically black universities will require concerted and deliberate effort, and realistically may take many years to fully redress.

Capacity building and development

The **Department of Health** is responsible for developing and co-ordinating a national capacity building strategy, which seeks to strengthen all disciplines – as well as individuals, organisations and communities involved in research.

In 1994, the **Medical Research Council** established a Research Capacity Development Group in response to the growing need to address deficiencies in research capacity, due to historic imbalances during the apartheid era in South Africa.[5] Historically black universities, technikons and nursing training colleges will be targeted for support in research infrastructure development, promoting faculty professional development in research, enhancing student research skills and strengthening research curriculum development and training within the institutions.

The MRC has a policy for ensuring 20% of all requests for proposals, bursaries and fellowships is allocated to people from disadvantaged communities. The MRC has also been involved in faculty development courses at historically black universities, and assisted in building partnerships between historically black and historically white educational institutions, and Schools of Public Health for research collaboration and skills transfer.

The MRC is also to establish an MRC research unit at MEDUNSA, one of South Africa's historically black universities. The unit is to focus on diarrhoeal diseases.

The **Health Systems Trust** (HST) has also had a pro-active policy aimed at encouraging and supporting research skills development amongst disadvantaged groups, including the historically black universities and technikons. Proposal development workshops have been run by the HST throughout many of the historically black institutions and many individuals supported in their proposal development and research. New researchers from disadvantaged groups have also been funded by the HST to serve internships with established researchers. Linkages have been developed and supported between more and less experienced research groups. All proposals supported by the HST are expected to include skills / capacity development components.

The Health Systems Trust has also launched a national proposal development competition for nurses and environmental health officers to encourage health research amongst two groups, which in the past, have been largely excluded from research activity.

ISSUES ADDRESSED BY HEALTH RESEARCH IN SOUTH AFRICA

Many reasons have been put forward for the health research agendas in South Africa, including the apartheid policies of the 1950s which drove many of the community-oriented public health scientists out the of country, and left laboratory-based scientists to dominate. This may be one of the reasons, but there have been other contributing factors. These include the striving of many South African scientists to be at the cutting edge of profitable, international, 'first world' research, thus ignoring the unprofitable 'third world' research on their door steps. Other influences have been the agendas of funding agencies and, in particular, the pharmaceutical industry, who have found South Africa to be an important site for international drug research and development. Whatever the reason, it is clear that there is a tremendous amount of neglected health research in South Africa.

Nonetheless, we do not have an accurate or reliable source of information on current health research. Some directories do exist, however they often focus on specific aspects of research, and even these are criticised for their omissions. Another way to determine current health research is through a review of the South African literature. A review of published literature in the 1995 South African Health Review showed clinical and basic research dominating the published research field, with public health research only contributing about 10% to the literature. This shows a dominance of research more appropriate to a first world country.

How can we assist the process of turning research into policy?

Many have argued that research findings, even from impeccably designed scientific studies, are ignored by policy makers and hence do not result in changes in service delivery or health outcome. There are many reasons why this may happen. One is that the research problem identified by the researcher is not the same as that of the policy maker. Another reason is that there is often disagreement amongst scientists, and this 'scientific uncertainty' leads to policy makers ignoring all related research until there are answers! A further problem is that research runs over time, and decisions are necessary before the research results are released. Finally, research is often presented in an abstract and inaccessible format, suitable for the academic community, but not the policy makers.

To influence policy, the following points should be taken into consideration.

- **Involve policy makers and service providers in the identification of research questions and in the research process. This way the research is relevant and the research results are more likely to be implementable.**
- **Aggregate various research results, making clear on which issues there is consensus, and on which still remains uncertainty. A good example is the production of policy briefs which summarise major research, providing clear direction on issues where there is consensus. The Department of Health has commissioned such publication, categorising research results by disease category. In similar vein, the Health Systems Trust is preparing a synopsis of results and recommendations of research which it has funded.**
- **Research should be timely, and therefore should usually have relatively short study designs. Communicating results and findings at intermediate stages during the research process also helps, as it provides at least some advice to policy makers and keeps them interested in the research!**
- **'Translate' and communicate the research results to the relevant policy makers and service providers. Many policy makers will not read academic journals nor long technical reports, therefore reports need to be reduced and translated into a format they will read!**

However, reviewing published literature excludes much health research. For example, it excludes much of the research commissioned by the pharmaceutical industry, and also research literature which is not published in peer-reviewed journals. Many would argue that if it is not published, it is not good research. This is reflected by 'research outputs' being included in the research funding formula of universities. However, this approach reflects a narrow understanding of the purpose of research. For example, the quality of health systems research should be judged largely by its ability to influence policy, and not by the number of publications from the research. We conclude that reviewing published literature is not an accurate method of capturing all health research, yet is probably the best existing method given the absence of other ways to determining health research in South Africa.

It therefore appears clear that there is a need for a central database (or a series of linked databases) of health research, including research in progress as well as completed research. Ideally this should be accessible to all health researchers through the Internet. The Department of Health is presently negotiating the establishment of a central database on health research with many of the Science Councils and other research agencies. This database should be available in 1997.

FINANCING AND EXPENDITURE OF HEALTH RESEARCH

The ENHR initiative has highlighted the need for accurate data on the sources of funding for health research. Such data are important for several reasons: (1) priority-setting processes need to involve funders if they are to be successful; and (2) certain funding sources may adversely influence the medium and long term direction and impact of research. To date, there is no accurate data set of such information. One reason is the difficulty of collecting such data with any accuracy. This is reflected by discrepancies between data from various sources. It is also not possible to disaggregating health research from total funding by some sources; in other cases, such as the pharmaceutical industry, there is hesitance to disclose such information.

As part of the Health Expenditure Review in 1994, a review was done on research expenditure, and this was presented in the South African Health Review of 1995.[6] It is likely that this review is an underestimate of total funding as it appears the diversity of funding sources is much wider previously estimated.[7] In addition, it appears that previous estimates have significantly underestimated the funding of health research from the private sector, and in particular the pharmaceutical industry. Estimates have put funding from this source to be greater than all other sources put together.

Health research is funded by a diverse range of sources, both public and private.

- Public funds are mainly channelled through three central departments, namely, Health; Education; and Arts, Culture, Science and Technology. Some of this is channelled through statutory councils such as the MRC and Human Sciences Research Council (HSRC), but the majority flows directly to the universities and technikons through the Department of Education.
- Both local non-governmental organisations (e.g. cancer associations, Arthritis association) and international non-governmental organisations (e.g. Oxfam) also fund some health research.
- The private sector is also a significant funder of health research through private foundations and corporate investment. Multilateral and local pharmaceutical companies spend a considerable amount on drug research and development in South Africa.
- International donors, for example the European Union, Norwegian Government and the Overseas Development Administration, also commit funding for health research.

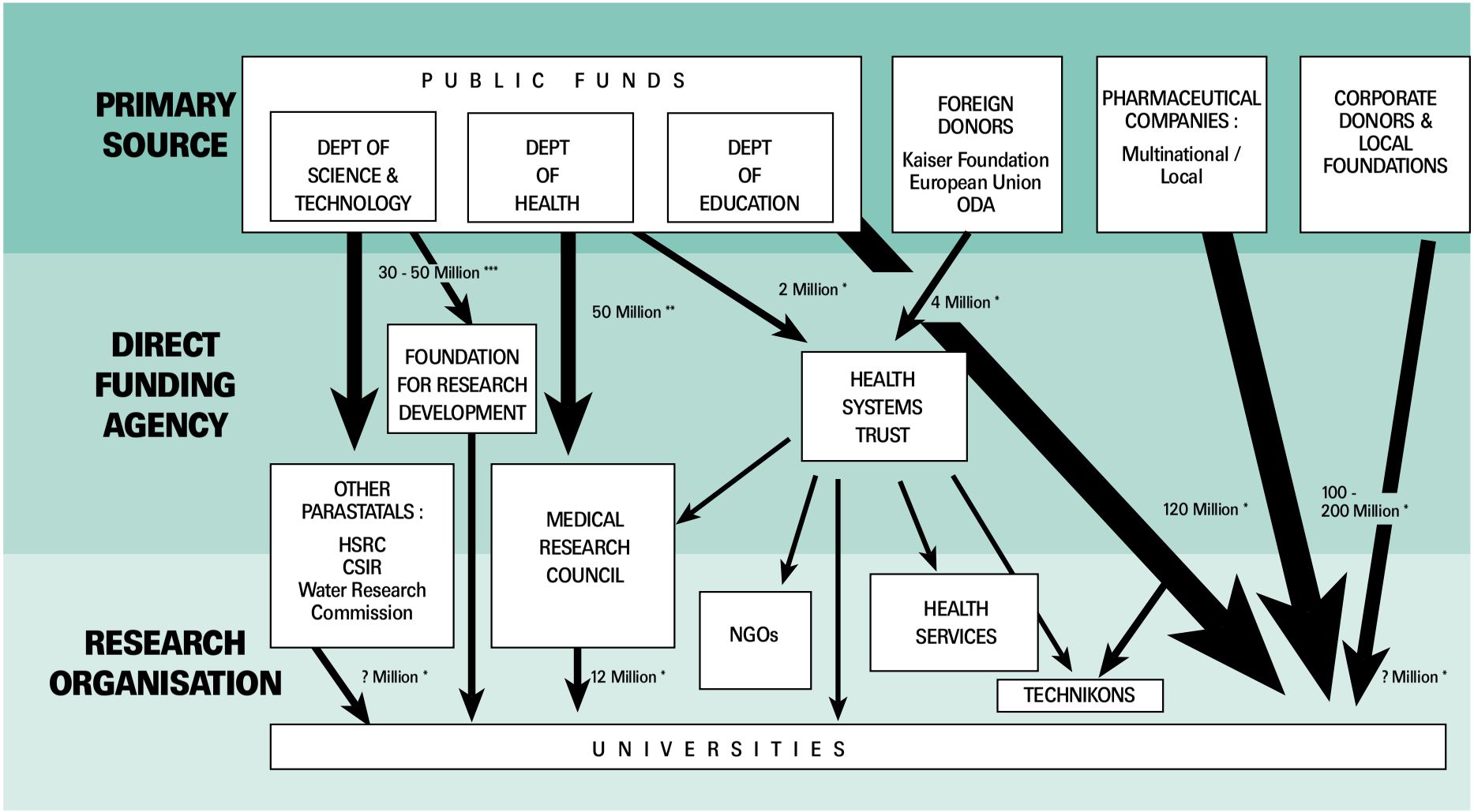
An attempt was made for this review to update data on health research and expenditure. This process highlighted the problems in collecting such data. Of note was the difficulty of collecting data from all sources, and disagregating health research from other research. This emphasises the need for commitment and action from all the various stakeholders if this initiative is to be successful. This information is essential as part of developing South Africa's Essential National Health Research framework.

PROGRESS TO DATE

Science and Technology White Paper

During 1996 a White Paper on Science and Technology has been prepared and circulated for comment.[8] The paper has implications throughout many sectors, including that of health research. It argues that South Africa has an ailing national system of innovation which is fragmented and is neither co-ordinated within itself nor with national goals. Investment in research and development is decreasing relative to RDP, at a time when South Africa most needs to become internationally competitive.

FUNDING FLOWS FOR HEALTH RESEARCH IN SOUTH AFRICA 1996



KEY : * Approximate allocations for health research ** Funding for Medical Research Council *** Estimated expenditure on health related research eg. safe water / sanitation

FIGURE 10.1 FUNDING FLOWS FOR HEALTH RESEARCH IN SOUTH AFRICA

This paper attempts to bring together a co-ordinated strategy for science and technology and proposes policies:

- to create clear channels for capacity building, human resource development and inequity redress
- to create channels to promote innovative solutions to some major problems of the country relating to Science and Technology.
- to establish mechanisms to reallocate government spending according to new priorities, particularly the problems of the disadvantages
- to set in motion processes that will challenge government research institutions to derive more support for competitive sources of funding
- to introduce a longer-term perspective in thinking, planning and budgeting which will be facilitated by the introduction of the Medium-Term Expenditure Framework
- to introduce institutional changes and new management approaches.

Changes within the MRC

During the last year, the MRC has been undergoing a process of restructuring its research and funding activities. The goal of the reorganisation is to make the best possible use of public resources, which Parliament gives to the MRC to fulfil its statutory duty of conducting and supporting research which can contribute to improving the health of the nation. The MRC's research programme has been divided into seventeen research Thrusts, which are being grouped into content and bridging Thrusts. It is proposed that, in the future, all the MRCs research funding for work within the scope of a Thrust will be channelled through the Thrust mechanism i.e. funding for in-house research, MRC units and research conducted at universities and institutions outside the MRC. This is a significant change and will provide new opportunities for focusing a broad range of skills on priority questions for the country and ensuring that research results in improved health outcomes. Concern has however been expressed that managerial and administrative costs associated with so many thrusts will limit the funding available for research. The restructuring exercise has involved inputs from key stakeholders from the academic sector, state departments, other Science Councils and the private sector. The final plans are being debated and will take into consideration the recommendations from the White Paper on the future of Science and Technology in South Africa.

It is not yet clear whether the Medical Research Council will accept the recommendation of the Ministerial ENHR Committee that it should serve increasingly as a research systems support and funding agency, and reduce the amount of research which is done by in-house researchers. At the time of publication, it appeared that the MRC intended to position itself primarily as a "do-er" of research, relinquishing much of its funding agency function to the National Research Council proposed by the Department of Arts, Culture, Science and Technology.

The Health Systems Trust

The Health Systems Trust has a very explicit agenda with regard to research, namely to fund and support health systems research which will help clarify health policy options and lead to improvements in health care delivery.

The Health Systems Trust is established as a leading non-government agency for health reform in South Africa. It is recognised within public sector services, research and academic institutions and non-government organisations as:

- the primary funder of policy-relevant health systems research
- the leading non-government clearing-house for information related to health and health care in South Africa
- a major resource for capacity-building in health management, research and planning
- a leader in the development of computer networks as an instrument for health service management and health worker support
- a catalyst for policy development through a variety of strategic initiatives.

Critical success factors

Several factors have been critical to the development and success of HST, namely:

- the funding partnership between the national Department of Health and foundations such as the Henry J. Kaiser Foundation. This partnership ensures an active interest in the activities of HST by the Department of Health, and has served to lever additional funding from a number of other agencies (Commission of the European Union, Rockefeller Foundation, Independent Development Trust, Overseas Development Administration, and United States Agency for International Development).
- the development of the Project for Health Information Dissemination (PHID), which has ensured high visibility by regular, attractive documentation of work supported by the Health Systems Trust. This Project was initiated together with the Henry J. Kaiser Family Foundation. The evolution of HealthLink - an electronic communications system - has provided a means of linking these information sources to rural and otherwise isolated health workers in the public and non-government sectors.
- funding for capacity-building, which has enriched HST's research programme and enabled support for health services to move beyond planning toward support for implementation
- the flexibility offered by a non-government organisation, permitting greater responsiveness.
- innovative research systems support. The Health Systems Trust has sought to assist researchers in: proposal development; through project support and implementation; through support for skills development, and in dissemination and application of results and recommendations. Strategies such as the part-time employment of the health journalist on a major daily newspaper have proved highly successful.

Future direction

The Board of the Health Systems Trust is committed to maintaining and developing the role of HST as an independent non-government organisation supporting health systems reform in South Africa for the following reasons:

- It is clear that South Africa is still in a phase of transition, and support for planning and policy development needs to translate into support for implementation if that transition is to be complete.
- There is a need for continuing independent review and assessment of health policy developments.
- Many non-government organisations have failed to survived the transition. HST has demonstrated that non-government organisations (NGOs) can continue to play a critical and constructive role. Together with other NGOs within the health sector, HST has a particular responsibility to strengthen smaller and more localised NGOs to ensure effective community participation in health care.
- HST recognises that individual and institutional capacity building is a medium- to long-term strategy, and the seeds which have been sown within health services, historically black institutions and non-government organisations need to be nurtured.

Over the next five years, the efforts of the Health Systems Trust, will be directed at consolidating and developing its key programmes. This entails continuing support for national and provincial policy development, and concentrating support for local or service delivery level within a selected number of sites throughout South Africa (through the Initiative for Sub-District Support).

CONCLUSION

Gaining an accurate understanding of health research in South Africa is significantly hampered by the lack of reliable information. This includes information on:

- ***Funding sources*** of health research. Of particular note is the contribution of the pharmaceutical industry.
- ***Expenditure*** on health research.
- ***Research issues*** which are being addressed.
- ***The researchers*** who are undertaking research.

Essential National Health Research is probably one of the most important initiatives which will shape the future of health research in South Africa. Important in that it sets out a systematic strategy for research. However this process depends on accurate and reliable information on all the above issues. At present, there is considerable wariness of ENHR by many academics who fear that its implementation will diminish their available resources, and stifle their research options. Considerable wisdom and sensitivity is required that strategies around ENHR do in fact bolster health research which addresses the country's health problems, while sustaining and strengthening the research capacity and considerable expertise which has already been developed.

QUALITY IN HEALTH CARE 11

INTRODUCTION

South Africa is undergoing extensive health care reform. This reform is motivated by the drive towards democratisation at all levels, including that of health service provision. Quality of care is increasingly seen as an important consideration when decisions have to be made of the best way to use limited health resources.[1]

The health sector is now faced with the challenge of finding ways to improve quality of care, and monitor such changes. This chapter will review some of the theoretical aspects of quality of care and its measurement, and provide a few examples of initiatives to measure the quality of health care in South Africa.

QUALITY IN HEALTH CARE

Quality in health care can be defined as the success of the health services in meeting the health related needs of the population in a manner that is consistent with local goals, national goals and resource constraints. Put this way, quality is all important. Understanding the quality of health care thus requires examination of the whole health system. This includes the inputs into the system (for example the physical infrastructure, the people and their training, the equipment and drugs etc.), the processes (i.e. the way the inputs are applied, for example the treatment and care of patients) and the outcome (for example, the change in health status, or the prevention of ill-health).

THE RELATIONSHIP BETWEEN THE QUALITY OF CARE AND RESOURCE REQUIREMENTS

Over the years there has been a change in the way that many health service providers perceive the relationship between the provision of quality of care and resource requirements.[2] Clinicians once believed (and possibly some still do) that 'bigger was better'. In other words, it was felt that if there were more staff, equipment, health facilities etc. then the quality of care would automatically improve. More recently the field of quality management science has given a new perspective to the relationship between quality of care and resource requirements. This perspective considers the efficiency with which existing resources are used, and looks at ways to increase quality while at the same time pruning waste.

Another emerging perspective which has come to light recently in South Africa, regarding the relationship between resources and quality, is the issue of consumerism. This perspective suggests that quality can be improved through market mechanisms that allow purchasers of health care to choose between health care providers on the basis of quality. Market mechanisms assume that if the quality is poor or the service too expensive, then the service will not be bought, and therefore the provider (eg. hospital, clinic) will go out of business. The assumption is that if health care is exposed to these type of market pressures, then the providers of care will have incentives to provide the best quality care they can, and also to provide it at a competitive price. However there is considerable international debate as to whether market type approaches work in the health sector. Many people believe that there are insufficient numbers of providers for there to be any competition, and therefore people are stuck with a provider regardless of the quality or price. In addition, many purchasers of care are unable to judge if they are buying good quality care. Added to this there are poor information systems for purchasers to choose or monitor the providers. There are many other arguments for and

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against market based approaches, and it is the challenge of researchers to test these various perspectives.

QUALITY ASSURANCE

This is a formal process whereby the various elements of quality are judged against predefined standards. This may be done by the professional group responsible for the care or within a multidisciplinary team.[3]

The relationship between quality assurance and research needs clarification.[4] Reasons for the activity, the extent to which the health care providers contribute additional time and effort to accomplish the activity, and the audience for the information gained can all be said to differ. Quality assurance is usually funded by internal sources for an internal audience to provide information helpful to improving services. On the other hand, the nature of research may be that the intended audience is broader. The aim of research may be broader, to generate new knowledge whose generalisability can be assessed by whether it is replicable in other settings.

However, quality assurance offers a great deal to developing countries, because a focus on standard setting, monitoring and systematic analysis and implementation of changes, can help to solve local problems, improve performance, improve outcome, and serve as a model for adaptation or replication in other settings.[5,6]

Elements of quality

Accessibility	Geographical, financial, social, and physical access to health care services.
Effectiveness	The efficacy of a process or intervention.
Comprehensiveness	The ability of the service to meet the wide ranging needs of individuals and communities.
Appropriateness	The level and range of care, given the needs of the patient and the community, and the resources available.
Acceptability	Assesses the match between patient and community expectations and the care provided.
Coverage	Measures the proportion of the target population that were successfully in contact with the health services.
Adherence	Assesses factors in both the clinical and patient's community that determine how well treatment regimens were followed.
Continuity	Assesses the potential for continued interaction between the health service and patients or communities, such as through defaulter tracing programmes, outreach and a coherent record keeping system.
Respect	Measures the quality of the social interaction between health workers and patients.
Efficiency	Assesses the relationship between inputs and outputs.
Equity	Assesses whether all these elements of quality have been equally available to all people.

UTILISATION RESEARCH AND UTILISATION MANAGEMENT

Utilisation research and utilisation management are vital tools with which to pursue and achieve quality objectives.[4] Utilisation research emphasises volumes of services, appropriateness, effectiveness and efficiency. Utilisation research is a precondition for effective utilisation management. Utilisation management (eg. accreditation programmes) is a formal series of processes designed to optimise the use of scarce resources and to achieve the goals of the service, programme, institution or system. One of the main principles of utilisation research is that evidence is preferable to anecdote and opinion. Logicians and judges have little conceptual trouble with this premise, but anecdote and opinion remain valued currency in health care.

ACCREDITATION IN HEALTH CARE

Accreditation is a quality assurance method and can be effective for achieving improved quality.[7] For example, hospital accreditation judges a hospital against an accepted level of performance, and is therefore able to determine the quality of various aspects of the service. In this process, the facility is informed of weakness in its operations, and help and advice can be given on how to correct the detected problems. Once successful in achieving accreditation, the hospital achieves public acknowledgement that it has complied with accepted standards.

The criteria for measuring the success of an evaluation system generally include:

- ✧ acceptance and adoption of the programme
- ✧ level of compliance with the standards
- ✧ alteration in practice
- ✧ improvement in performance.[8]

Contrary to industrial models, the correlation between what is done and the subsequent outcome is difficult to assess in health care.[9] Measuring medical practice interventions in terms of outcomes is a very complex problem and, as yet, there are no sure generalised methods available. A number of studies have attempted to show the benefit of accreditation in terms of improved medical outcomes of care. The American Joint Commission on the Accreditation of Healthcare Facilities has spent in the order of $70 million attempting to measure medical outcomes but with little success. This remains a challenge to researchers.

Although it is difficult to assess the benefit of accreditation in terms of health outcome, studies have shown other benefits to have arisen from such initiatives:

- ✧ communication between departments and levels of the organisation
- ✧ medical record quality
- ✧ medical staff structures set up to examine the quality of patient care provided
- ✧ staff focus on providing quality patient care
- ✧ staff development and education.[10]

MEASURING QUALITY OF HEALTH CARE IN SOUTH AFRICA

In October 1995, the Council for Health Service Accreditation of Southern Africa (COHSASA) was registered as a non-profit incorporated association. COHSASA represents a national collaborative effort between the state, private industry, consumers and health care professionals with the following aims:

- ✧ to develop a national standard of service and quality for South African health care institutions, including hospitals and primary health care services
- ✧ to assess accurately the existing situation in participating facilities and to identify and rectify deficiencies
- ✧ to introduce policies which enable staff to achieve their full potential through quality improvement and participative management
- ✧ to provide for the optimal use of resources.

COHSASA, in collaboration with professional health care associations and groups, has developed standards for 40 different hospital service elements, including clinical services such as medicine, surgery and nursing, and general support services such as domestic, maintenance and catering. The standards defined for each service element include management and staffing requirements, staff development and education programmes, policies and procedures to guide operational practice, facilities and equipment, patient interactions and internal audit programmes that are required to be in place for each of these services. The system is flexible in that standards and criteria that are not applicable to a particular facility can be excluded from the analytical system. This makes it possible for the system to accommodate facilities that carry out highly technical procedures, as well as facilities that provide services that require little technology.

The standards are implemented in participating facilities through a participative management approach based on continuous quality improvement techniques during a 9 to 18 month preparatory phase. The programme is supported by a comprehensive computerised information system that scores

compliance both qualitatively and quantitatively. Independent surveyors and technical advisors evaluate the facility at the end of the preparatory phase and accreditation is granted once an organisation has the necessary systems in place to substantially comply with the standards. Close collaboration with participating professional groups will allow research to be carried out on common problems affecting health care facilities and to suggest possible solutions.

THE SEARCH FOR HOSPITAL PERFORMANCE INDICATORS

The aim of measuring performance, and the reasons why certain levels are achieved are important, particularly given the demands for accountability to the public, purchasers of care and policy makers. However, it must be remembered that although performance statistics may show whether a process can be improved, they do not generally show how. For example, clinical indicators are influenced by a wide range of factors, and it is difficult to determine the precise cause in each individual case.[11]

The Maryland Hospital Association Quality Indicator Project stresses that indicators are measures of aggregate hospital performance and do not measure quality *per se*. It is in the analysis of indicator rates over time that the level of quality is determined by the participants themselves. With regard to the measurement of quality by indicators the following principles apply:

- Indicators of performance do not measure quality; people do.
- Indicators of performance may be measuring the quality of data and not the quality of care.
- Demonstrated usefulness is the best test of validity.

The questions for researchers interested in developing performance indicators therefore are:

- How useful are institution specific indicator rates?
- Could these rates readily translate into trends and profiles that would help identify differences in performance between hospitals?

The Hospital Strategy Project was established in October 1995 to provide guidance and technical assistance to the national and provincial Departments of Health on the transformation of hospital service and management. One component of this project is currently developing a set of hospital performance indicators. It is possible that this initiative may spur researchers to seek answers to many of these questions.

QUALITY OF CARE IN PRIMARY HEALTH CARE SETTINGS

During 1996, the Centre for Health Policy at the University of the Witwatersrand published a report setting out suggested standards for the delivery of primary health care. This is the culmination of a project which assessed the cost and quality of primary care in various settings. This report is likely to be an important baseline for a model for quality assessment at the primary care level in South Africa.

MEDICAL COMPETENCE

The Medical Association of South Africa (M.A.S.A.) views diplomas available to general medical practitioners as playing an important role in encouraging improved competence in particular fields. The best known are probably the Diploma in Anaesthetics, the Diploma in Obstetrics and the Diploma in Paediatrics. A much longer structured course leads to the Diploma in General Practice and there is a recently introduced 2 year course in Internal Medicine.

To attain these diplomas, a practitioner needs to work in an accredited department and is assessed in both a written and oral examination. Dedication and perseverance needed to acquire such a diploma are themselves important qualities, and it is hoped that these practitioners will be retained in the public sector for as long as possible. To this end, M.A.S.A. is involved in negotiations with the Department of Health for an adjustment to the salary grading of successful doctors.

In a wider area, relating more to the specialist fields, M.A.S.A. is involved with all the faculties of the College of Medicine, University departments and specialist and special interest groups within

M.A.S.A. There is a need to define in which areas practitioners are indeed competent, as attaining a specialist degree no longer implies competence in all the facets of that particular discipline. It seems that for certain fields of practice and for certain procedures, additional training and qualification would be required. This may be obtained by examination or by credentials awarded by the head of an approved department, confirming that the candidate has complied with requirements and has adequate expertise in a particular field. The ultimate aim is that hospital privileges would only be granted to practitioners in those areas where they have acceptable competence.

CONTINUING MEDICAL EDUCATION

This is widely propagated but inadequately utilised or even ignored by some practitioners. M.A.S.A. is negotiating with the groups outlined in the previous section, to seek consensus suggesting that compliance be made compulsory. In order to implement this successfully, it will be necessary to introduce a term limitation for degrees, registration, certification, credentials and hospital privileges. Special arrangements would need to be considered for rural practitioners who would have greater difficulty in complying with all the requirements of continuing medical education.

We believe that improved competence and rational continued medical education will lead to an improvement in the quality of health care. This should be shown by an outcomes review programme, however this can only be done once the programmes are in place, and the difficulties of judging activities by outcome in the health sector have been discussed above.

MANAGED HEALTH CARE

Managed care is most common in the United States of America. However in recent years, there has been increased interest in incorporating its principles into the health systems of many developed and developing countries, including South Africa.[13]

Managed care is a system of health care delivery that influences the cost of services, the utilisation of services and measures performance.[13] It integrates the delivery system by establishing relationships between health care providers and purchasers (eg. the patient). By merging provider and patients interests, it promotes incentives to provide cost-effective care of high quality.[13]

Managed care uses capitation or fixed fee systems to pay providers instead of traditional fee-for-service systems. Fee-for-service systems of payment operate by payment for each service that is provided to the patient. The disadvantage of this system is that health care providers face an incentive to over-treat the patient, just to get the extra payment. In a capitation system, the provider is paid a set amount of money for each patient, and is obliged to give what ever treatment is necessary without receiving extra fees for each service. The advantage of this method is that there is no incentive to over-treat but unfortunately this may be replaced with the incentive to undertreat or provide poor quality care. Managed care is emerging in the South African private health care sector and is likely to play an important role in the future. Furthermore, these systems could form the vital interface between the private and the public health sectors in the medium to longer term.[14]

The impact on quality

In any system where patient and provider choices are restricted, or where capitation and fixed fee payment systems apply, there must be a constant monitoring to ensure that the care received by the patient is of high quality. The National Committee for Quality Assurance , an accrediting body for managed care plans in the United States of America, led the effort to create the Health Plan Employer Data and Information Set which is a standardised report card. The major areas of performance measured include quality, access, utilisation and costs.[15]

Traditional managed care systems concentrated on measuring quality care using the structural, process and outcomes approach.[13] Structural requirements include minimum accepted standards and are often defined in regulations. Measuring conformity to standard processes of care is normally conducted using case audits and peer review. While outcome studies are difficult to perform, there is growing evidence that poor outcomes have their roots in inappropriate or poorly implemented processes.[16]

Clinical Practice Guidelines

Clinical practice guidelines are concise decision aids for clinicians faced with various circumstances. Their effect, if properly implemented, is to narrow the range of practice to a series of options for which there is an evidence-based rationale and a sensible decision algorithm. There are now apparently about five thousand clinical practice guidelines in existence, doubtless varying in quality, format and impact. Despite their prominence and growth, clinical practice guidelines are so far largely unevaluated. Unfortunately they are at the moment an example of another technology that has diffused widely before its value has been properly determined.

In an attempt to improve clinical outcomes, managed care plans turn to clinical guidelines to decrease variations in practice patterns.[17] Guidelines are intended as an aid to the practice of medicine - they are no substitute for an experienced doctor's clinical judgement. In order to ensure acceptability and successful implementation, the medical profession should be involved in the guideline development process. In 1993 the Medical Association of South Africa embarked on a clinical guideline project. Already the second edition of the directory of national clinical guidelines has been published. This comprises 250 clinical guidelines.

It is important that guidelines should continuously be reviewed based on research and clinical data which is standardised for diagnosis and procedures. In South Africa, the International Classification for Diseases - tenth version (ICD 10) and the International Classification for Primary Care (ICPC) have been chosen as the preferred diagnostic coding systems in both the private and the public health sectors. Current Procedural Terminology (CPT) is the preferred procedure coding system.

Evidence shows that the patient-doctor relationship is the primary determinant of patient satisfaction.[18] Specific determinants include length of the patient-doctor relationship, the amount of time a doctor spends with a patient, the efficiency and courtesy of office staff and the length of time to get an appointment.[18] Managed care plans use the information gleaned from patient satisfaction surveys for continuous quality improvement and bench marking purposes. The popularity of these patient satisfaction surveys is providing the momentum for the trend towards standardisation.[19]

SOUTH AFRICAN SOCIETY FOR QUALITY IN HEALTH CARE

The South African Society for Quality in Health Care is a multi-professional national society which has been formed to promote a health care quality focus and culture in South Africa. The South African Society for Quality in Health Care was established on 6 May 1995 after the adoption of its constitution and election of the Executive Committee members.

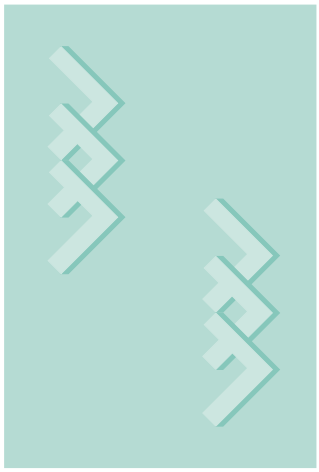
The goals of the South African Society for Quality in Health Care are to :

- represent South African quality in health care interests nationally and internationally
- identify and create networks to assist health care quality processes
- promote the exchange of information on quality activities
- identify, develop and utilise resources for quality activities
- investigate the need for and design of an appropriate infrastructure
- promote the development of appropriate quality in health care policies
- stimulate the advancement of quality in health care in Southern Africa by means of various strategies.

THE FUTURE OF QUALITY OF CARE

This chapter has shown that the concept of quality assurance in South Africa's health care delivery system is still relatively new, but one which is gaining momentum. Appropriate methods for the evaluation of different quality assurance approaches must also be developed. In line with the present emphasis on development of a district level delivery system, particular attention should be given to the availability of information on quality at the district level. Quality assurance should not be a vertical programme. It will only be effective if it is a value upheld by all staff, a widely supported goal and a regular part of daily activities.

Quality is a social and political, as well as a technical concept. The quality of the whole is not the sum of the quality of the parts. While there is no formula for dividing health resources or designing health systems, one thing is certain: the fragmented pursuit of quality from narrow perspectives does not serve a population-based, goal-orientated health system.



12 PUBLIC PARTICIPATION

INTRODUCTION

During the apartheid era, progressive non-government organisations played a vital role in communication with marginalised and disenfranchised communities. In many instances, these organisations were the only support available to many disadvantaged communities. Health organisations have often been pivotal in articulating people's needs - and health, in particular has served as a rallying point for political mobilisation. In recent years, despite strong leadership and close links with those that they represent, some of these organisations have been sidelined by the political changes within South Africa. In many cases, alternative systems to ensure sustained public participation are not in place. The ensuing lack of public participation is a risk to the stability of civil society and democracy in South Africa.

The idea of public participation in politics is as old as the idea of democracy itself. It is linked to what can be termed the "democratic imperative"; defined as the principle that those who will be substantially affected by social, political and economic decisions, should be involved in the making of those decisions. The growth of bureaucracies, centralised political and economic power, and the size and complexity of modern society, mean that traditional guarantees and assurances of democracy need to be strengthened and extended. The complexity and scale of government often makes the implementation of public participation difficult because of the need for rapid and clear-cut decisions. However, it is at these times of decision making that public participation is most needed, as the impact of those decisions lies with the public, and not the decision makers themselves.

PUBLIC PARTICIPATION IN SOUTH AFRICA

Impact of poverty

Poverty affects people's ability to participate.

Apartheid created a legacy of massive social neglect for the majority in South Africa. It now has among the highest income inequality rates (Gini-coefficient of 0.61) in the world, approaching that of the worst, Brazil (0.63). Barriers to participation for the majority of South Africans have been highlighted in the recent Reconstruction and Development Programme publication: Key Indicators of Poverty in South Africa, October 1995. The extent of absolute poverty, based on minimum required levels of food consumption for survival, is about 40% in South Africa. Most of these people (75%) live in rural areas, compared with 53% of the population overall living in rural areas. Thus rural areas have much higher poverty rates than urban or metropolitan areas (see Chapter 2). Compounding this is the fact that rural areas have the lowest levels of services, including channels of communication and access to decision-makers. For example, the KwaZulu-Natal Department of Transport estimates a backlog of more than 17 000 km of community access roads in rural areas needed to link populations to the provincial and national road network. In addition to the constraints of poverty, limited services and channels of communication, patriarchal customs prevalent within rural communities often further limit the ability of women to participate.

Essentially, public participation in South Africa involves issues of how to redistribute power and influence. Discussions around the new South African constitution elicited over 2 million submissions. This is tremendous participation by ordinary people in the process of policy making and implementation. However this debate inevitably excluded the more than 36% of the South Africa population who are illiterate. Policies must address such difficulties, which may prevent the very people who are supposed to gain from increased participation from being able to take part.

Authors : Peter Derman and Vijay Makanjee

Access to information and decision makers

Increasingly, information is recognised as power, and so denying access to information becomes a way of enforcing control. It is well recognised that bureaucracies are not always effective communicators with marginalised communities. They may be inclined to adopt a top-down approach and dictate policy, rather than listen to opinions which may challenge their systems.

Within the context of South Africa's peaceful transfer to democracy, many aspects of the established bureaucracy may be slow to change. To some extent, the institutional framework which traditionally supported inequality and structured privilege is still in place. Old bureaucracies may be reluctant to implement new policies. The private sector is also slow to change - indicated by the fact that major government contracts, awarded by tender are still usually awarded to the major corporate groups, or to these in partnership with newly created black firms. The process of tendering, the inviting of comments and the ability to produce slick "RDP-speak" documents, by their very nature, exclude the involvement of the vast majority of South African citizens. Within the health sector, these participation problems can be best reflected by example.

Within KwaZulu-Natal, the Lower Tugela district health initiative is driven by the recognition that communities are not in isolation and that health planning needs to take place at district level. For the past two years many meetings, workshops and strategy sessions have taken place. In response, the government sector appears unable to provide basic information such as what was spent on health sector activities in the district during the past 3-5 years. Further, since district health planning involves a change in health planning frameworks, the process of change entails entering the bureaucratic minefield of departmental line functions, policy procedures and reluctance by civil servants to take decisions which may prove risky. Certainly, new information is being generated in the name of transparency and open government procedures. But it remains to be seen how accessible this is to the majority.

STRATEGIES FOR PUBLIC PARTICIPATION IN HEALTH

Government initiatives

This section comments on initiatives to promote public participation in health by national, provincial and local government.

National

The National Parliamentary Portfolio Committee on Health was thrust into the limelight by the Sarafina 2 debacle, which simultaneously exposed a number of unresolved issues regarding the respective roles of the legislative and executive arms of government, and their relationship to each other. In the eyes of the media and a number of observers, the Health Committee had proved to be one of the most organised and effective of all Parliamentary Committees, under the leadership of Dr Manto Tshabalala. Exercising its role as a public watchdog, the Committee called the Minister of Health to account for expenditure related to the AIDS-awareness play, Sarafina 2.

Subsequently, media reports suggest that the Committee was effectively muzzled by the President, Nelson Mandela, himself, and African National Congress parliamentarians were instructed to fall in behind the Minister. Certainly, the Parliamentary Committee hearing and assembly debate highlighted the sharp division between highly critical opposition parties and the majority party, which expressed solidarity with the Minister of Health. Political commentators were quick to point out that this intervention undermined the role of parliament as guardian of public interests. Sarafina 2 rapidly became a standard reference in debates about government transparency and accountability.[1-5] The handling of Sarafina 2 was a severe setback to both the national Department of Health and the Portfolio Committee. However, by mid-1996, it was clear that the Portfolio Committee had extricated itself enough to adopt a more pro-active stance, and once again to begin to address substantive issues of health reform.[6]

Another perturbing development has been the cloak of secrecy cast over the drafting of the new Health Act. By September 1996, the seventh draft had been completed, but had yet to be circulated outside of the national and provincial departments and the Portfolio Committee of Health. However, it is understood that the new Act will make provision for a National Health Consultative Forum, which will serve as an advisory body to the national Department of Health. This body will be representative of both statutory and non-statutory organisations involved in health. While the establishment of such

a Forum is to be welcomed, careful consideration will need to be given to its effective functioning. Without real teeth, the Forum is likely to follow the ignominious path of its predecessors: the all-inclusive National Health Council established as a result of the Gluckman Commission of 1946 proved too large and unwieldy to work; and the Health Matters Advisory Committee (later the Health Matters Committee) appointed in terms of the Health Act of 1977 served little real purpose.[7,8]

Two other mechanisms proposed for public participation in the draft Health Act are district health councils, and the creation of governance structures for health establishments. The thinking behind these proposals emerges from work done by the inter-provincial District Health Systems Committee and the Hospital Strategy Project.

The report of the national District Committee outlined functions for community health committees, district hospital boards and the district health council.[9] Little clarity is provided on the specific functions of community health committees, other than they may have both advisory and decision-making roles. The functions of district hospital boards are more explicit, namely to: advocate on behalf of the committee and participate in hospital management; raise additional funds for the hospital; and ensure co-ordination between the hospital and other facilities in the area. The powers and responsibilities of District Health Councils will vary depending on the district governance option chosen by provinces (see Chapter 17):

- **Local authority option**

  Where districts form part of the local authority, a sub-committee for health is proposed for each district controlled by the local authority. In addition, the report recommends that a more broadly representative advisory body be established to assist the local authority health sub-committee in each district.

- **Provincial option**

  In provinces where the provincial health department is responsible for all district health services, the District Health Council will support the district health manager with respect to a range of functions, such as motivating budgetary requirements and allocating revenue generated within the district (assuming revenue retention is permitted).

- **Statutory District Health Authority**

  In provinces which opt for an independent district authority, fully devolved powers will be vested in the District Health Council.

The Hospital Strategy Project has prepared a position paper on the decentralisation of hospital management for the Department of Health.[10] Recommendations relating to hospital governance and accountability include:

- the establishment of a Board of Directors representative and accountable to community and the Provincial Health Authority for every hospital. Board functions in Level 1 hospitals will be performed by the District Health Authority
- accountability of the Board to higher authorities to meet provincial output targets and standards of health care and service delivery, as well as proper use of funds
- full authority for the Hospital Board to set hospital policy, within the parameters of overarching health policies.

Two other national government initiatives will in time influence public participation within the health sector. The Deputy President's office has established a task team to investigate the relationship between the government and civil society in South Africa. This team should have reported back by the time of publication of this Review. Another team, also appointed by Mbeki has recommended the dissolution of the rather cumbersome South African Communication Services. Comtask proposes its replacement by a more streamlined professional body to disseminate information about government activities.[11]

Provincial

Three provinces have taken the lead in promoting public participation in health, namely the North West, Free State and Mpumalanga.

The North West Province has drafted a Bill related to the governance of health, developmental social welfare and hospitals.[12] The Provincial Portfolio Committee on Health is presently consulting with all stakeholders.

The Bill makes provision for:

- Community Health and Developmental Social Welfare Forums
- District Health and Developmental Social Welfare Committees
- Hospital Boards

The role of the Community Forums is two-fold: First, they are intended to nominate people to Hospital Boards and District Health Committees. And second, when directed by the Member of the Executive Council for Health, they are expected to investigate and consider health and welfare matters and make recommendations. These recommendations are in no way binding on the Member of the Executive Council (MEC).

District committees will advise the district health and welfare managers on matters such as: the district management; budgeting and expenditure; procurement and distribution of pharmaceuticals; appointment and evaluation of staff; and purchasing of services from private and non-government providers. Their role is strictly advisory.

Hospital boards will advise hospital management on policies and strategies, equipment purchases and staffing. They will also report back to the Member of the Executive Council concerning, among others, capital expenditure, the economy and efficiency of hospital services, and user satisfaction with hospital services.

Similarly, the Free State has also drafted a Bill related to the establishment of hospital governing bodies.[13] The provincial Bill sets out the selection, membership, functions and authority of these governing bodies, which are responsible for overseeing the procurement of equipment, approval of capital expenditure, and ensuring the efficient allocation and productive use of resources. It is now under discussion within the provincial portfolio committee on health.

Although not yet legislated for, Mpumalanga has outlined structures for community participation within districts and their respective functions, in an innovative manual for district managers.[14]

These structures are:

- district health authorities
- clinic committees
- community health committees

This guide demonstrates a clear commitment to public participation through the integration of these structures into district management.

Local

In Mpumalanga, significant progress has been made in establishing community health committees.[15] In the North West, certain districts have taken the lead in creating functional community and clinic committees.[16] In the Free State, the Primary Health Care Information (PHC/INFO) Project has developed models of community involvement in primary health care in Mangaung and Sasolburg.[17, 18] But in general, creating effective relationships with community members and structures has often ended up at the bottom of the list of activities for newly appointed and hard-pressed health managers.

Non-government initiatives

During the years of apartheid, public participation and development dialogue were principally conducted through international support to a vibrant and vocal non-governmental organisational sector. This sector in turn supported community based organisations. Many of these organisations built strong networks that supported family survival through a broad based, multi-sectoral approach which attempted to address all aspects of poverty. Non-government organisations in South Africa have a wealth of experience which should be exploited during the current phase of transition. Their holistic approach recognises that many of the causes of ill health fall outside of the health sector. For example overcrowding, poor sanitation, lack of water, poor transport and telecommunications all impact on an individual's health status. In contrast, government is often constrained in its delivery system and often cannot easily adopt a very community-based approach. The size and delivery scope of some community based organisations is not adequately recognised in South Africa.

The Ithusheng Community Association (ICA) in the Northern Province is an example of an organisation where community members actively participate in the design, implementation and cost

estimates of programmes. It is a grassroots organisation that has the legitimacy to lead a process to encourage and foster public participation in health policy formulation and implementation. It has played this role for the past 17 years despite little external support or funding. Their important role is well illustrated by their current successful public information and education campaign on AIDS. The ICA has consistently provided training in primary health care for community members to become Village Health Workers (VHW), and for traditional healers. There is a long established system of referrals between VHW and traditional healers and *vice versa*. The ICA uses the important role that traditional healers play within communities and has in fact increased their participation levels within the health service sector. They have trained more than 200 traditional healers who are now organised in a traditional healers' association. A central tenet for the ICA is that the marriage between traditional healers and the more modern healers is a beneficial one for both sides, with the community members emerging as clear winners. At a recent AIDS awareness day, the ICA attracted some 3 000 community people.

Similarly the Hlatlolanang Health and Nutrition Education Programme, in the Northern Province, which grew out of the Ithusheng experience, was established to build community capacity to monitor and control health and other development intervention processes. Its success is indicated by the fact that the programme now works within 36 villages in the Sekhekuneland sub-region, with requests to work in more villages being received. Despite this, Hlatlolanang's application to undertake the government funded schools nutrition programme in the sub region was ignored.

The above examples are by no means isolated case studies. There are many well developed networks that have provided vital grass-roots support to communities. This is readily evident through an assessment of burial societies, *stokvels*, farmers' associations and other community programmes which all require considerable centralised organisational supports. These organisations have both strong leadership and close links with those that they support. They are recognised by the poor as often being their only link to much needed support.

The demands on such organisations to provide services, information and training have increased dramatically over the past 2 years. It had been anticipated that their post-apartheid performance would be much higher than community support levels achieved prior to the 1994 elections. Despite this, there is little acknowledgement from government - regional or national - that such organisations are best placed to ensure the long term stability of the democratic process. Historically, community based organisations were often inadequately public about their activities within development and political circles to contribute to policy making. While these organisations contributed significantly to securing civil society in South Africa and towards cutting the costs of governance they have not always been in the forefront of policy development. It is an irony that the non-government sector that took on the responsibility of providing survival strategies for resource poor communities by initiating dialogue on progressive alternatives, is itself now threatened. Many such organisations recognise that this threat is due to lack of access to information and funding and they have begun to develop innovative co-operative programmes to overcome this.

Examples of initiatives to redress access to information and funding difficulties are the Healthlink programme of the Health Systems Trust - which connects health facilities by a simple form of e-mail (see Chapter 9); and an internship and information training programme which aims to build capacity in community organisations to use information well and to evaluate their activities. The latter is based on the premise that effective community participation will only occur when community members and organisations are strengthened with the same vigor and intent as training and support programmes for health personnel.

The National Progressive Primary Health Care Network (NPPHCN) has been instrumental in helping people understand and respond to policy developments. During August and September 1995, NPPHCN conducted a series of provincial consultative workshops to inform people of the findings of the Committee of Inquiry into a National Health Insurance System, and to co-ordinate a response to government.[19] NPPHCN has also spearheaded a Patient's Rights Campaign, aimed at making people aware of their rights as a health service user. The response has been illuminating: over 47 000 calls were received to a hotline number over a six month period. This illustrates the tremendous need for channels of communication and feedback for health service users.

The objectives of such non-government initiatives are to engage government - not to replace it. Important experiences of the non-governmental organisational sector should be used to inform government policy and delivery systems. This is particularly true in South Africa's case, where an emergent democracy has inherited few institutions which are specifically targeted to support resource poor communities or are capable of mass delivery.[20]

FACTORS CRITICAL TO EFFECTIVE PARTICIPATION

Information

Apartheid encouraged a combative relationship between the government and non-government sectors. Organisations which have traditionally operated outside of the realm of government institutions are now faced with the challenge of understanding them in order to be able to begin to participate and influence government activity. The more professional the institutional body, the more difficult they may be to penetrate. Some may have vested interests in securing a continuation of past delivery systems. Information is vital to show communities how to bridge the gap between their experience and their ability to influence or become decision-makers.

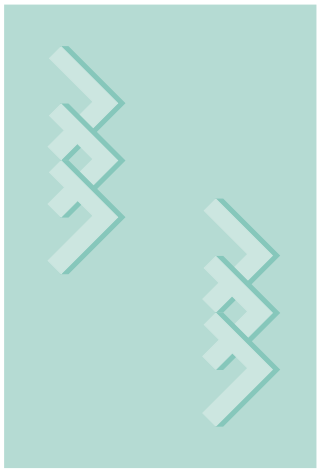
Funding

Funding issues for non-government organisations has been complicated by donor attentions shifting away from social concerns towards larger issues of economic growth and trade. In addition, the Reconstruction and Development Programme concentrates overwhelmingly on the delivery of 'hard' products such as water, housing and sanitation. However, it is also vital to fund information services, processes and products to encourage public participation and allow fundamental needs to be expressed.

Organisations that support and strengthen the cause of the poor need support themselves. It is thus essential to address the financial and personnel crisis that many community-based organisations face before their expertise is lost. Most are credible, efficient and have a 'presence on the ground': they are a resource waiting to be tapped.

PART III

Priorities of the Ministry of Health



13 NUTRITION

INTRODUCTION

Nutrition has become a "hot" issue in South Africa over the past few years. Adequate food was a rallying cry for the African National Congress during the 1994 elections, and has featured prominently in leading government strategies since then. Because it touches on so many other disciplines and so many stakeholders are involved, more developments have taken place in this field over the last year than probably in any other health discipline.

This chapter reviews progress regarding the proposed Integrated Nutrition Strategy of the Department of Health in terms of its three major components: community-based nutrition programmes; health facility-based nutrition programmes; and nutrition promotion, communication and advocacy.[1] In addition this chapter also focus on important developments in research over the past year, particularly those which have implications for future intervention programmes.

THE INTEGRATED NUTRITION PROGRAMME

On the 15 August 1995, the first director was appointed to the newly created Directorate of Nutrition within the Department of Health. Ms Nobayeni Dladla, masters graduate in health sociology, was assigned the mammoth task of implementing the recommendations of the Nutrition Committee appointed by the Minister of Health in 1994, which have been accepted in principle.[1]

During the latter part of 1995 continuous discussions and workshops were held within provinces to inform all stakeholders of the objectives and conceptual framework proposed by the Directorate of Nutrition. By the end of 1995, five of the provinces had developed an operational plan, with the remaining provinces in the planning phases. The long-term objective was to establish an intersectoral action team in every province. These teams were to comprise members from the Departments of Health, Education, Agriculture, and the Reconstruction and Development Programme (RDP). A key focus area identified by the planning teams in 1995 was the need for capacity building and training with regard to the planning and implementation of community-based nutrition programmes.

During September 1995 the director held workshops with national and provincial (nutrition) staff to:

- build consensus regarding the objectives of the Nutrition Committee[1]
- devise ways of operationalising these objectives in terms of community-based and health facility-based programmes
- attain consensus regarding the conceptual framework provided by the United Nations Children's Fund (UNICEF), which was adopted as the broad framework within which nutrition programmes would be planned (Figure 13.1).[2]

Community-based Nutrition Programme

The major thrust of the community-based programme is multi-sectoral Government support of communities in solving their own nutritional problems. The aim is to develop projects that will strengthen household food security, the care of women and children and the health services, while promoting a healthy environment. It is intended that the community-based nutrition programme should combine the relevant projects of the Primary School Nutrition Programme (PSNP) and the National Nutrition and Social Development Programme (NNSDP) within the context of the RDP.[3]

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Impact objectives to be reached by the year 2000

- **Reduction of the prevalence of underweight for age** (more than two standard deviations below the mean weight for age of NCHS reference standard) to less than 10 per cent among children under three and under six years of age (estimated present prevalence approximately 15 per cent).
- **Reduction of the prevalence of stunting** (more than two standard deviations under mean height for age of NCHS reference standard) by one third among children less than six years of age (estimated present prevalence approximately 30 per cent).
- **Reduction of severe malnutrition** (more than three standard deviation below the mean weight for age of the NCHS reference standard) by one half among children under three and under six years of age (estimated present prevalence approximately 2-3 per cent)
- **Reduction of prevalence of low birth weight neonates** by one third (estimated present prevalence approximately 15 per cent).
- **Reduction of iron deficiency in pregnant women** by one third and in infants and young children under 36 months by one half (estimated present prevalence in pregnant women 50 per cent; estimated prevalence in infants and young children 25 per cent).
- **Elimination of iodine deficiency disorders** and the universal iodation of salt for human consumption within three years (iodation of salt presently estimated at 30 per cent).
- **Reduce sub-clinical vitamin A deficiency** by 50 per cent in children under six years of age (estimated present prevalence 20-50 per cent).
- **Mortality from diseases of lifestyle** not to rise above the current 28.5 per cent of all adult mortality.

Source: Department of Health. An integrated nutrition strategy for South Africa: Report of the Nutrition Committee to the Minister of Health. Pretoria 1994

Primary School Nutrition Programme

The aims of the PSNP are to:

- contribute to the improvement of education quality by enhancing primary school pupils' active learning capacity, school attendance and punctuality
- contribute to general health development by alleviating short-term hunger
- educate pupils on nutrition and also improve their nutritional status through micronutrient supplementation and parasite eradication where indicated
- to develop the nutrition component of the general curriculum[4]

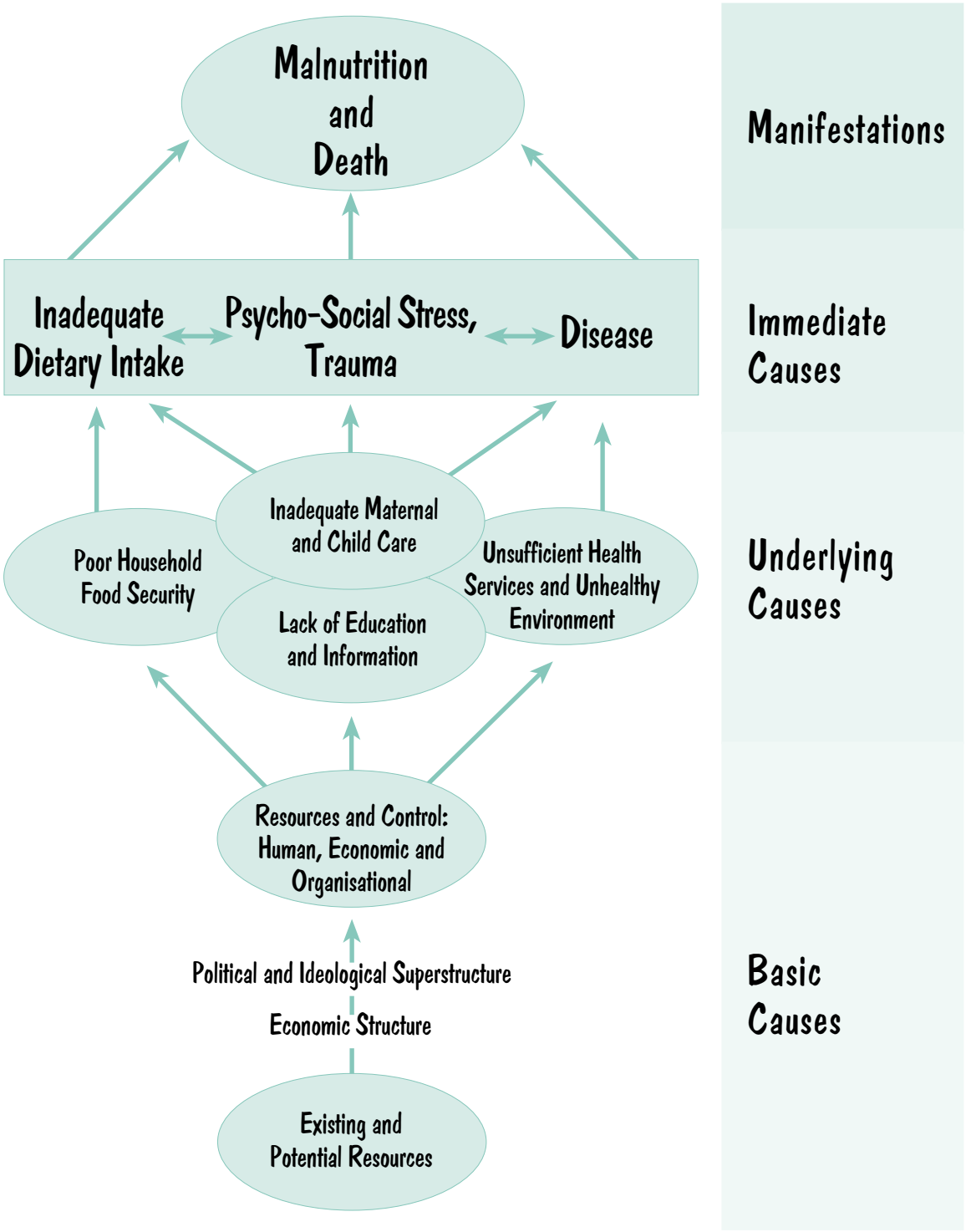
The scope of the programme is: "the provision of an early snack, meeting 30% of the energy requirement to 3.8 million children (50% of primary school children), in areas targeted on the basis of the poverty criteria". [4]

To assist the provinces / local authorities with the implementation and operation of the PSNP a National Policy Framework and Operational Guidelines document was developed.[5] This document provides guidelines regarding the vision, principles and aims of the programme. It also provides information regarding targeting, budgetary implications, intervention components and organisational arrangements. Strong emphasis is laid on the following principles:

- community participation and empowerment
- holistic approach
- multi-sectoral and interdisciplinary intervention
- sustainability.

To ensure that the PSNP meets its objectives a monitoring, evaluation and research strategy was developed by the Department of Health.[6] This provides a frame of reference and broad action plan for monitoring and evaluation of the programme at local, provincial and national level, on a continuous basis. The implementation of this plan has been patchy, and no integrated system of management and monitoring is in place.

FIGURE 13.1 CONCEPTUAL FRAMEWORK FOR THE ANALYSIS OF THE SITUATION OF WOMEN AND CHILDERN IN SOUTH AFRICA



Source: UNICEF. 1990

During 1995, 15 894 schools participated in the programme serving 5 508 866 children (Table 13.1).[7] The number of project committees involved increased to 8 791, and 10 463 employment opportunities were reported. Actual expenditure was reported as R198 779 938; approximately 39.76% of the available funds.[7] The Eastern Cape served the largest number of children, followed by KwaZulu-Natal and the Northern Province (Table 13.1).

TABLE 13.1 THE NUMBER OF PRIMARY SCHOOL PUPILS AND SCHOOLS (PSNP) TARGETED AND REACHED IN EACH PROVINCE FOR JANUARY 1996.

Province	Number of Children targeted	Number of Children reached	% Coverage	Number of schools targeted	Number of schools reached	% Coverage of targeted
Western Cape	348 473	334 453	96.0%	1 006	925	91.9%
Northern Cape	50 000	42 302	84.6%	124	94	75.8%
Eastern Cape	1 700 000	1 700 000	100%	5 500	5 500	100%
Free State	536 857	428 299	79.8%	3 046	1 310	43.0%
Kwazulu-Natal	1 970 500	1 518 114	77.0%	4 114	3 287	79.9%
Mpumalanga	530 074	267 956	50.6%	1 240	599	48.3%
Northern Province	1 200 000	844 867	70.4%	2 640	2 022	76.5%
Gauteng	300 266	141 875	47.2%	363	363	100%
North West	241 000	241 000	100%	2 077	1 794	86.4%
TOTAL	**6 877 175**	**5 508 866**	**80.1%**	**20 110**	**15 894**	**79.0%**

Source: Department of Health. Primary School Nutrition Programme (PSNP). Progress Report on the PSNP. 31 January 1996.

However, these statistics mask a number of significant problems. Inadequate systems of management and control brought the Programme to a virtual halt in the Eastern Cape and KwaZulu-Natal and curtailed activities in Mpumalanga during 1996. Many of the project committees experienced considerable difficulty with administration and financial management, and many of the "employment opportunities" generated very little actual income for local participants.

During May 1995, the National Progressive Primary Health Care Network (NPPHCN) was requested by the RDP within the office of the State President to undertake a rapid appraisal of the PSNP in conjunction with the Departments of Health and Education.[8] The purpose of the rapid appraisal was to:

- assess the perceptions of children, parents, teachers, project committees, communities, and programme staff to the PSNP
- assess its impact on learning capacity, hunger, nutritional status, nutritional knowledge, general health of the children and the development of communities
- identify problems with the programme and suggest ways of improving the efficiency and effectiveness of the programme.[8]

A sample of 36 schools were randomly selected using a stratified sample which included metro, urban, peri-urban and rural schools in the Western and Eastern Cape. Table 13.2 provides a summary of the main findings related to the objectives of the RDP.[8]

TABLE 13.2 SUMMARY ASSESSMENT OF THE EXTENT TO WHICH THE PSNP IS MEETING ITS SPECIFIC OBJECTIVES

SPECIFIC OBJECTIVE	WESTERN CAPE	EASTERN CAPE
Alleviate temporary hunger among pupils	Majority of the children appear satisfied that the programme is making a difference	Children are generally satisfied where they are consistently getting fed. Some peripheral areas did not receive food for extended periods
Improve nutritional status of primary school pupils with micronutrient deficiencies	Appears to be reaching most needy children with about 20% of requirements (RDA) for energy and about 50% for protein. The impact on micronutrients is not clear	Is inconsistently reaching many needy children with what appears to be somewhat less than 20% of energy and 50% protein micronutrients is not clear
Ensure that pupils severely infected by parasites benefit optimally by integrating a parasite eradication programme	Not yet systematically introduced	Not yet systematically introduced
Improve nutrition knowledge, perceptions and attitudes amongst primary school children by including nutrition education in all projects	Nutrition education undertaken in a sporadic and inconsistent manner, dependent on teacher knowledge and awareness. Little awareness of the importance of energy-dense foods	Nutrition education undertaken in a sporadic and inconsistent manner, dependent on teacher knowledge and awareness. Little awareness of importance of energy dense foods
Develop a nutrition education component as part of the general educational curriculum	Specific business plan makes specific recommendations for the liaison between the Education Department and School Health Services to ensure co-ordination. Specific suggestions are made regarding the introduction of an innovative child to child programme	No formal plans evident regarding the integration of nutrition education into the curriculum
Link projects in the programme to other development initiatives	Although involving a minority of schools, several experimental development programmes including community kitchens and various environmental health projects are documented. Strong participation from NGOs with experience in school feeding. Specific recommendations in business plan to strengthen this aspect of the programme	No linkages noted. Virtual absence of non-governmental organisations(NGOs) and community-based organisations (CBO) participation except from SANCO and certain groups whose main interest appeared financial. No clear strategy to address this aspect of the programme
Link PSNP to RDP	Tentative plans, but still vague	Linkages tenuous

Source: National Progressive Primary Health Care Network (NPPHCN). Rapid appraisal of the primary school nutritional programme. Braamfontein, 1995

It appears that in the two provinces studied the overall objective of the PSNP to alleviate hunger has been met. Another survey conducted in the Northern Province, Gauteng, North West and KwaZulu-Natal reported similar findings.[9] However those specific objectives related to nutrition education, parasite eradication, micronutrient supplementation and improved linkages were not sufficiently addressed. The positive impact on nutritional status is also debatable, as this was evaluated in terms of the amount of food the children received and not in terms of improved weight and/or physical parameters of children receiving food. Improved school attendance and punctuality were also evaluated very subjectively in terms of teachers impressions.

Some of the negative perceptions of parents, teachers, and communities toward the PSNP include the following:

- ✧ Children receive only a small proportion of their daily energy and nutritional needs.
- ✧ Preschool children do not benefit.
- ✧ Teachers, parents and communities appear to have little knowledge about the operation and objectives of the programme.
- ✧ Teachers are the main participants in the programme instead of project committees.
- ✧ There is an overall lack of community participation.
- ✧ Planning, management and control is mainly centralised.
- ✧ Corruption frequently occurs.
- ✧ Few developmental linkages have been formed.[8]

During 1995, numerous newspapers published very negative findings relating to the PSNP. These ranged from reports on mismanagement to corruption, some of them severely criticising government. As the PSNP can be viewed as one of the RDP showcases, these reports were given high priority by the Department of Health.

Many of the problems reported can be attributed to the fact that the PSNP was established with insufficient consideration to the staffing needs of such a programme. The staff complement was insufficient, and consisted largely of seconded or contracted employees. The uncertainties related to this have had a negative impact on continuity, staff commitment and morale. The Department itself states: "Due to lack of sufficient human resources in the programme it was only possible to conduct limited training, monitoring and control. This has resulted in cases of misappropriation of funds and corruption."[7]

However since 1 November 1995, 534 posts have been allocated to the Nutrition Programme nationally. The Office of the Reconstruction and Development Programme is in the process of appointing PSNP management support teams to each province and the national office, with a focus on improving operational and financial control systems. Reports from the Eastern Cape, where a management support team has already been established, suggest that this strategy has been very successful. Enhanced capacity building for project committees was meant to occur during 1996, but this did not really materialise.

Another important step taken by the Ministry of Health was to request the Health Systems Trust to assist them in designing a framework for evaluating the PSNP. The rationale for this step being that about 7% of the total public health budget is spent on direct nutritional interventions, without there being clarity as to whether this expenditure is being used efficiently and appropriately. In addition, there is also the recognition that nutrition is high on the national political agenda, but in order to remain so, the success of these high-profile interventions needs to be demonstrated.

The intended evaluation has three explicit aims: "First, to help improve the efficiency and effectiveness of the school feeding programme *per se* as a matter of urgency. Second, to enhance the effectiveness of the PSNP as an instrument of development through community involvement, income generation, job creation and other 'add-value' activities related to the school feeding programme. Third, to examine the nutritional basis for the PSNP and other nutritional interventions, and to use the information about South Africa's nutrition to help shape future strategies."[10] The latter objective is a particularly important one since interventions are frequently launched (eg. iodisation of salt) without sound baseline data. The process of shaping an evaluation framework has resulted in a document with a short-, medium- and longer term research agenda.[10] The research programme is currently underway, spearheaded by the Health Systems Trust.

National Nutrition and Social Development Programme (NNSDP)

As recommended by the Nutrition Committee, the NNSDP will gradually be phased out to be replaced by projects with a strong community-based focus.[1] The latter will become part of the Integrated Nutrition Programme for South Africa. The Department of Health has realised the importance of linking all nutrition-supportive projects (health, water, agriculture or RDP generated), to prevent duplication and share existing resources.[11] At present however, the NNSDP still supports a substantial number of programmes and projects, particularly in KwaZulu-Natal, Eastern Cape and Gauteng (Table 13.3).[12] The NNSDP (with funds) was transferred to the provinces on 1 November 1995. These funds are intended as "seed funds" to help communities improve their food security by developing self-sustaining and local infrastructure. It is intended that communities that participate in the INP should be the most needy based on poverty and anthropometric data and/or situational analyses. Application for community-based programmes will be required to go through local community-based committees that assess the needs, design a suitable project(s) and apply for funding from the district Department of Health.[3]

TABLE 13.3 PROGRAMMES, PROJECTS AND NUMBER OF PERSONS REACHED BY THE NNSDP FOR JANUARY 1996

Province	Number of programmes	Number of projects	Persons reached	Official population	% of population
Western Cape	351	1 098	285 763	3 633 077	7.87%
Northern Cape	271	280	68 352	737 306	9.27%
Free State	218	218	45 605	2 726 840	1.67%
Eastern Cape	533	3 158	306 069	6 436 790	4.75%
KwaZulu-Natal	2 023	3 430	404 527	8 505 338	4.76%
Mpumalanga	518	889	181 139	2 921 559	6.20%
Northern Province	1 252	1 217	364 471	5 201 630	7.01%
Gauteng	576	2 418	847, 44	6 869 103	12.34%
North West	400	02	76 276	3 252 991	2.34%
Total	**6 142**	**12 810**	**2 580 146**	**40 284 634**	**6.40%**

Source: Department of Health. National Nutrition and Social Development Programme (NNSDP). Monitoring report for 31 January 1996.

In theory, this sounds ideal but one cannot help wondering how this will work in practice. Will district health offices have the human resources and capacity to initiate, assess, and assist local community committees? And will local committees have the capacity to initiate and drive projects, particularly in view of the problems experienced with community participation in the PSNP? The Department of Agriculture does not appear to be visible during this process and it is not clear what their role is in addressing issues of household food security.

Health Facility-based Nutrition Programme

A health facility-based nutrition programme is intended to be an integral part of the primary health care package, to address the major problems of under-nutrition and micronutrient deficiencies and prevent the chronic diseases of lifestyle.[3]

Essential elements of the programme are described as the following:

- growth monitoring and promotion
- nutrition education for caregivers and pregnant and lactating women
- provision of food supplementation to malnourished children and pregnant women, addressing micronutrient deficiencies by means of micronutrient supplementation and fortification of staple foods
- ensuring appropriate nutrition management for diseases of infection.

The existing protein-energy malnutrition (PEM) scheme is being incorporated into this strategy.

During the past year, two of these aspects have been specifically singled out by the Ministry of Health. The Directorate Nutrition is currently compiling a draft document for the transformation of the PEM scheme. It is proposed that the PEM scheme be incorporated into the Integrated Nutrition Programme, as part of growth monitoring and promotion programmes. The transformed programme should be closely linked to pre- and post-natal care, growth monitoring of preschool children immunisation, nutrition education, parasite control, rehydration therapy and possible food supplementation, after careful evaluation of the underlying causes of malnutrition.[13]

The second aspect deals with micronutrient deficiencies. Those objectives related to iron and vitamin A deficiency are currently being addressed by the Directorate of Nutrition who are engaged in drawing up a draft document relating to micronutrient malnutrition control. This document will take into account the results of the preschool study carried out by the South African Vitamin A Consultative Group (SAVACG).[14]

A specific criticism against the health facility-based programme is that it does not describe any essential element of dealing with the chronic diseases of lifestyle. The following additions are recommended:

- ✧ nutrition education aimed at the prevention of chronic diseases of lifestyle
- ✧ provision of disease-specific nutritional support and counselling eg. for obesity, diabetes mellitus and hypertension.

One area in which there appears to have been little progress relates to parasite control. The corresponding chapter in the 1995 Health Review argued that routine deworming for children living in endemic area is a cost-effective intervention. In fact, a health facility and school-based nation-wide programme for nematode control in preschool and primary school children is likely to cost much less than 10% of the annual budget of the Primary School Nutrition Programme.

Clearly, there are a number of preconditions to the implementation of such a programme, including community education and determination of areas of endemicity of nematode infestation and bilharzia. But in view of the high levels of infestation recorded in areas like KwaZulu-Natal and anaemia documented by the SAVACG study, and international evidence of the nutritional and economic benefit of mass deworming programmes, its introduction should be given urgent attention.

Nutrition Promotion - Communication, Advocacy and Legislation

Priority areas of programme communication are breast feeding; sound infant-feeding practices; and causes of childhood undernutrition.[3] Once again, causes of overnutrition and chronic diseases of lifestyle have been neglected. Legislative priorities are: to protect breast feeding; mandatory fortification of appropriate foods; and ensuring food safety and quality.[3] Advocacy for breast feeding and legislation of salt iodisation have both occurred in the past year.

Fortification

Three micronutrients are receiving priority worldwide, namely vitamin A, iron and iodine. Collectively, deficiencies of these micronutrients contribute to significant morbidity, mortality, growth retardation and diminished cognitive development and work capacity in adults and children.[1] One of the impact objectives to be reached by the year 2000, according to the Nutrition Committee, is the elimination of iodine deficiency disorders and the national iodation of salt for human consumption. One question which has however never been adequately addressed is the extent of iodine deficiency in South Africa. Is iodine deficiency really a problem in South Africa?

In 1995 it became compulsory for salt for human consumption in South Africa to be iodated.[15] According to this Government Gazette :"(1) No person shall sell food grade salt or other salt intended for use in or on foodstuffs unless iodine has been added thereto" and "(2) Iodated salt means food grade salt or other salt intended for use in or on foodstuffs to which between 40 and 60 ppm (mg/kg) iodine in the form of potassium iodate has been added."

In August 1996, the Department of Health, supported by the Health Systems Trust and the International Micronutrient Initiative, held a conference to develop a plan for the fortification of staple carriers with key micronutrients. A Task Group has been created to spearhead the implementation of a national fortification programme.

Advocacy for Breast Feeding

A draft document has been drawn up by the Directorate of Nutrition on guidelines for breast feeding and a "Baby-Friendly Hospital Initiative" (BFHI). The long-term goal of the BFHI is to contribute to the achievement of the global breast feeding goal as stated in the Innocenti Declaration, adopted by the World Summit for Children and the Nutrition Committee : "All women should be able to practise exclusive breast feeding and all infants should be fed exclusively on breast milk from birth to 4 to 6 months of age, and thereafter, children should continue to be breast fed, while receiving appropriate and adequate complementary foods, up to two years of age and beyond."[1, 16]

The major objectives of the BFHI are to:

- ✧ implement the Ten Steps to Successful Breast Feeding
- ✧ establish lactation resource and training centres
- ✧ enact necessary laws and regulations to bring about the long-term goal.

The Tens Steps to Successful Breast feeding in Health Facilities

1. **Have a written breast feeding policy that is routinely communicated to all health-care staff.**
2. **Train all health-care staff in skills necessary to implement this policy.**
3. **Inform all pregnant women about the benefits and management of breast feeding.**
4. **Help mothers initiate breast feeding within half an hour of birth.**
5. **Show mothers how to breast feed, and how to maintain lactation even if they should be separated from their infants.**
6. **Give newborn infants no milk feeds or water other than breast milk, unless indicated for a medical reason.**
7. **Allow mothers and infants to remain together 24 hours a day from birth.**
8. **Encourage natural breast feeding frequently and on demand.**
9. **Do not give, or encourage, the use of artificial teats or dummies to breast fed infants. Do not encourage the use of the nipple shields either.**
10. **Promote the establishment of breast feeding support groups and refer mothers to these on discharge from the hospital or clinic.**

Source: Department of Health, Directorate: Nutrition. Breast-feeding and baby friendly hospital initiative (BFHI) in South Africa. Policy guidelines for implementors of breast-feeding and BFHI in South Africa. Pretoria 1995

Specific objectives of the BFHI and breast feeding promotion strategy in South Africa are to:

- eliminate the distribution of breast milk substitutes in all health facilities
- transform hospitals and make them breast feeding friendly
- improve the knowledge of health workers regarding breast feeding and infant feeding
- empower communities with knowledge regarding breast feeding and child feeding
- review legislation regarding the code of marketing of breast milk substitutes
- create supportive work places for women to enable them to breast feed successfully
- stimulate communities to initiate child feeding strategies.[15]

NUTRITION SURVEILLANCE

The Nutrition Surveillance Consultancy, under leadership of Prof Rob Fincham, were requested by the Directorate of Nutrition, and funded by UNICEF, to develop a national nutrition surveillance strategy.[17] The reason for this being that, to date, there has been no integrated national nutrition surveillance strategy for South Africa. Although a great deal of data is collected at health facilities, this process has been unco-ordinated and fragmented and data has not been available at the national level to enhance decision making and policy formation.

During 1995, three workshops were held with nutrition representatives from the provinces and national office as well as other stakeholders, including representation from the Directorate: Health Systems Research. Two workshops focused on operational issues related to nutrition surveillance and a third workshop dealt with the issue of indicators. During the first workshop, an inventory of current nutrition surveillance initiatives was drawn up to obtain information on what is already happening in each province in South Africa. One of the main problems identified was the lack of feedback from data collected at clinics. Statistics are collected and sent to the provincial office, but no feedback is received from the latter.

During the first workshop it was decided to concentrate on children under five years of age. The following indicators have been proposed:

- weight-for-age as an indicator of past and present nutrition status
- weight-for-age at 6 month intervals
- height-for-age as an indicator of the overall nutrition and health status of the child, and an overall indicator of social and economic development
- birth weight as a measure of the nutritional status of the child at birth and as a predictor of the child's likelihood to grow and develop exclusive breast feeding
- haemoglobin in pregnant women and infants as indicators of anaemia.[17]

It was also emphasised that once a national nutrition surveillance system is in place, other indicators reflecting household food security should be included. The working group also stress the importance of community-based nutrition surveillance which is currently being piloted in five areas of KwaZulu-Natal. The emphasis on this type of surveillance is for members of each community (health workers and mothers) to collect information which will be useful to community members in making decisions which affect them.[17] While the benefits to local communities of better information are generally accepted, it is not yet clear that community-based surveillance systems can be implemented throughout the country, nor that this constitutes a priority. In addition, the link between community-based surveillance systems and the National Health Information System remain obscure. Future research into nutrition surveillance indicators should consider those factors which contribute to household food security and ways in which these factors can be identified.

NUTRIENT INTAKES OF SOUTH AFRICANS

There has never been a national dietary survey in South Africa. However in 1995 a meta-analysis of South African dietary surveys was undertaken by the South African National Nutrition Survey Study (SANNSS) Group.[18] They published nutrient intake results obtained with the 24-hour recall method from more than 6 000 subjects aged 2 - 70 years, and of 2 060 children aged 0 - 2 years, published since 1979. Some of the main findings were:

- The lowest energy intakes were found in rural African children aged 2 - 6 and 6 - 11 years
- The highest energy intakes (compared with requirements) were noted in rural African women (Table 13.4)
- Total protein intakes appeared adequate in all groups studied
- Vitamin A intakes were low in African children and in African and Indian men
- There were indications that iron, zinc and copper intakes were inadequate in many groups
- African, Coloured and Indian women generally had low calcium intakes
- Many African and Indian groups had low intakes of vitamin C, thiamine, riboflavin and niacin
- Rural African women had low folate intakes
- All population groups had low vitamin B6 intakes
- Only Africans had fat intakes, which complied with guidelines aimed at prevention of degenerative diseases ie. ‹ 30% total energy. White, Indian and coloured groups consumed 34 - 39% of total energy as fat.[19]

TABLE 13.4 MEAN ENERGY INTAKE IN KILOJOULES (KJ) OF SOUTH AFRICAN CHILDREN, BOYS, GIRLS, MEN AND WOMEN

Age group and gender	White	Urban African	Coloured	Indian	Rural African	RDA[1]
children, 0-1.9[2]	4 607	3 241	5 893	3 625		2717-5434
children, 2-5.9	5 368	5 145	6 330		4 541	5460-7560
children, 6-10.9	7 823	6 067	8 743		6 546	8400-10500
boys, 11-15.9	10 012	7 345	7 899	8 572	7 130	12 600
girls, 11-15.9	8 306	7 223	7 612	8 762	7 014	9 240
men, 16-24.9	12 655	8 500	10 600	9 692		12 180
women, 16-24.9	7 572	6 400	9 400	8 047		9240
men, 25-64.9	10 633	8 500	9 129	8 170		12 180
women, 25-64.9	6 431	6 400	6 398	5 623	10 148	9 240

[1] Recommended dietary allowance to the USA Food and Nutrition Board, 1989
[2] No 24 hour recall data available, food frequency questionnaire/diet history was used

Source: Vorster HH, Jerling JC, Oosthuizen W, Becker P, Wolmarans P. Nutrient intakes of South Africans: An analysis of the literature. Roche: Isando. 1995

Fibre intakes were low in all groups except for rural African women in KwaZulu-Natal. The meta-analysis indicated a paucity of dietary data available on vulnerable groups such as pregnant and lactating women, children, and the aged. Future research should focus on these groups.

NUTRITIONAL STATUS OF SOUTH AFRICANS

Pre-school Study

The SAVACG was formed in 1993 with the aim of assessing the anthropometric, vitamin A and iron status of South African preschool children, in order to develop preventive and intervention programmes.[14] The study was later extended to include the assessment of immunisation coverage, prevalence of visible goitre and prevalence of breast feeding. The survey was sponsored by the Department of Health with support from UNICEF and took place between July and October 1994.

A national probability sample of children aged 6 - 71 months was drawn with disproportionate stratification by province. A total of 18 219 households (19 003 families) were included in the study. A total of 4 788 blood samples were drawn for determination of serum vitamin A, serum ferritin and a full blood count. Findings on nutritional status follow (Table 13.5)[14]

TABLE 13.5 SUMMARY OF NUTRITIONAL INDICATORS FOR CHILDREN AGED 6-71 MONTHS. (SAVACG STUDY 1994)

	Northern Cape	Western Cape	Eastern Cape	KwaZulu Natal	Mpum-alanga	Northern Province	Gauteng	North West	Free State	South Africa	Rural	Urban
Weight for age % less -2SD	15.6	7.0	11.4	4.2	7.3	12.6	5.6	13.2	13.6	9.3	10.7	6.9
Height for age % less than - 2SD	22.8	11.6	28.8	15.6	20.4	34.2	11.5	24.7	28.7	22.9	27.0	16.1
Weight for height % less than -2SD	2.5	1.3	3.2	0.7	1.7	3.8	1.2	4.5	4.5	2.6	2.8	2.1
Vitamin A-% less than 20 ug/dl	18.5	21.0	31.1	38.0	33.0	43.5	23.5	32.0	26.8	33.3	37.9	25.1
Haemoglobin concentration -% less than 11 g/dl	21.5	28.6	20.6	10.4	27.7	34.2	16.3	24.5	17.1	21.4	21.1	20.7
Ferritin concentration - % less than 12ug/l	10.9	16.4	5.0	13.4	11.5	11.0	9.2	8.1	6.8	9.8	8.3	12.1
Ferritin and Haemogloblin -% Hb ‹ 11 and ferritin ‹ 12	6.5	8.2	2.4	3.5	7.0	9.1	3.8	5.0	3.9	5.0	4.6	5.4

Source: The South African Vitamin A Consultative Group. Children aged 6 to 71 months in South Africa. 1995.

Vitamin A Status

One in three children (33.3%) had a marginal vitamin A status (serum vitamin A ‹ 20 Fg/dl). A national prevalence of 33.3% indicates that the country has a serious public health problem of vitamin A deficiency. The most disadvantaged children were those in the rural areas with poorly educated mothers.[14]

Iron Status

One in five children (21.4%) was found to be anaemic (Hb ‹ 11g/dl), one in fifteen (6.8%) moderately anaemic and one in five hundred (0.2%) severely anaemic (Hb ‹ 7g/dl). Anaemia and poor iron status were more prevalent in urban areas, and children in the 6 - 23 month age group were the most severely affected. Children with marginal vitamin A status were at a significantly higher risk of also being anaemic and of having iron deficiency anaemia. Those with vitamin A deficiency (serum vitamin A ‹ 10 Fg/dl) had an even higher risk of being anaemic. Three out of 20 children appeared to have an underlying infection or inflammation, or (alternatively) may have had an underlying vitamin B12 or folate deficiency.[14]

Anthropometric Status

Nearly one in four children (22.9%) was stunted (height ‹ -2SDs of NCHS median), and one in ten (9.3%) was underweight (weight ‹ -2SDs NCHS median). Only 2.6% were wasted (weight-for-height ‹ -2SDs NCHS median). In practical terms, this means that about 660 000 preschool children are identifiably malnourished and 1 520 000 are stunted because of chronic malnutrition. Stunting is a major nutritional problem in South Africa, particularly in children living in rural areas in traditional or informal housing, and whose mothers have little formal education.[14] The largest numbers of malnourished children were found in the Eastern Cape, Northern Province and KwaZulu-Natal.

Iodine Status

Visible goitre was noted in one percent of children nationally. The rate varied from 0.2% in Gauteng to 4% in the Northern Cape. No difference was noted when comparing rural with urban areas or age strata. However these findings need to be interpreted with caution, according to the authors, since the assessment of visible goitre, on its own, is subjective and may underestimate the prevalence of iodine deficiency disorders.[14]

Prevalence of Breast feeding

Nearly 90% of children three years of age had been breast fed for a varying duration. More rural children (91%) were breast fed compared with urban children (83%) and generally rural children were also breast fed for longer periods (Table 13.6). Over the last few years there has been a tendency to breast feed for less than three months, particularly in urban areas by mothers who are well educated.[14]

TABLE 13.6 PERCENTAGE OF CHILDREN AGED 36 TO 47 MONTHS WHO WERE NEVER BREASTFED OR WHO WERE BREASTFED FOR VARIOUS DURATIONS

	Northern Cape	Western Cape	Eastern Cape	KwaZulu Natal	Mpum-alanga	Northern Province	Gauteng	North West	Free State	South Africa	Rural	Urban
Number of children	181	162	310	252	247	294	153	309	272	2180	1250	930
Percentage who were:												
Never breastfed	20.3	24.0	12.9	13.9	13.4	3.4	10.3	12.9	12.0	11.9	9.2	16.8
Breastfed for unknown duration	1.7	5.0	1.9	3.2	1.2	1.7	1.3	0.7	2.1	2.1	2.0	2.3
Breastfed for less than 1 month	0.6	0.6	0.3	1.2	0.4	0.0	0.6	0.0	0.4	0.5	0.5	0.5
Breastfed for 1-2 months	3.9	6.2	3.6	3.6	3.2	2.0	9.2	3.3	4.4	4.0	2.8	6.1
Breastfed for 3-5 months	9.5	13.5	10.6	6.8	5.2	1.4	9.9	6.5	5.3	7.1	4.8	11.1
Breastfed for 6-11 months	6.6	9.3	7.8	7.5	9.3	4.1	6.5	7.2	6.2	7.0	7.2	6.6
Breastfed for 12-23 months	21.1	14.2	33.5	32.1	29.3	43.2	36.0	32.6	23.1	32.7	36.1	26.9
Breastfed for 24-35 months	26.3	13.0	24.2	29.3	35.2	37.8	22.3	29.8	35.7	29.1	32.5	22.9
Breastfed for at least 36 months	10.0	14.2	5.2	2.4	2.8	6.4	3.9	7.0	10.8	5.6	4.9	6.8
Percentage breastfed for less than 3 months out of those who were breastfed at all	5.6	8.9	4.5	5.5	4.2	2.1	10.9	3.7	5.5	5.1	3.6	7.9
95% confidence interval	1.6:9.6	2.7:15.2	2.3:6.6	2.5:8.5	0.9:7.5	0.0:4.4	4.4:17.4	1.3:6.2	2.0:9.0	3.9:6.3	2.4:4.8	5.3:10.5

Source: The South African Vitamin A Consultative Group (SAVACG). Children aged 6-71 months in South Africa, 1994:

Main Recommendations

- The study recommends that a national high dose vitamin A capsule distribution programme be instituted, for a period of three years for all children 6 - 71 months of age.
- Vitamin A capsules should be administered every six months through primary health care clinics and the dose recorded on the Road to Health card. High dose vitamin A supplements should also be administered to all children who present with malnutrition, measles or diarrhoea. Lactating mothers should receive a single high dose vitamin A post-partum over a period of three years.[14]
- An iron sulphate syrup supplement distribution programme should be instituted for all children aged 6 - 23 months. A screening system using haemoglobin concentration, should be introduced, with iron supplements as required for children at risk and all children aged 24 - 71 months.[14]
- All children with anthropometric parameters below two standard deviations below the reference median should be targeted. Preschool children, particularly below two years of age, should be considered a prime target group for nutritional intervention and the mother for nutrition education. Supplementary foods provided to malnourished children should concentrate on energy as well as dietary quality and micronutrient composition.[14]
- Exclusive breast feeding for four months should be promoted and implemented wherever possible. Factors detrimental to breast feeding should be identified and a "warm chain" established which should include the alleviation of everyday constraints facing lactating mothers at home and in the work place.[14]

The recommendations of the SAVACG study related to micronutrient supplementation, though necessary, should be recognised as a fairly costly short-term intervention. In the longer term, fortification of basic foodstuffs is likely to be a more sustainable and cost-effective option.

Overweight, Obesity And Chronic Diseases of Lifestyle

According to the World Health Organisation, the process of urbanisation in Africa can be exemplified by what has happened in Tanzania and Zimbabwe over the last 20 years.[20] Economic development over the last two decades has resulted in greater purchasing power and has brought about dietary behavioural changes in all sectors of the population.

The rural population have generally maintained their traditional diet. However, total food intake, especially of fat, has increased. Due to increased industrialisation, the population migration from rural to urban areas has created urban slums where residents face serious nutritional inadequacies. One example is the increase in obesity among non-working women in this group due at least in part to physical inactivity.[20] The urban elite have also drastically changed their food habits and now consume high-fat, high-salt, and processed sugar-based items. Ready-to-eat food items, fast foods and increased soft drinks and alcohol consumption have changed the traditional dietary pattern. Because no nutritional programmes are in operation in these areas, stroke, diabetes and coronary heart disease are increasing. Thus the dual problems of over-nutrition and under-nutrition have emerged in the same context.[20]

To date, the primary focus of the Directorate of Nutrition of the Department of Health has been on under-nutrition. Most of the impact objectives of the Nutrition Committee[1] are related to issues of under-nutrition. Over-nutrition and associated diseases of lifestyle have not yet been addressed, even though recent dietary studies have indicated that the prevalence of obesity is increasing in urban Africans and is very common in Indians, whites and coloured women.[21] Closely associated with this are hypertension, coronary heart disease, dental caries, diabetes and certain cancers related to changes in diet and other environmental factors.[21]

A study of rural adults in Venda indicated that women had an average body mass index (BMI) of 25.4 (Table 13.7).[22] It was lower in men (22.5) but 15% were found to be hypertensive. A recent study of African women in the Northern Province found that between 30 and 32% of women were overweight and between 12 and 28% were obese (BMI $\geq$ 30). It was also noted that 42% of the caretakers of underweight children ($<$ -2SDs w eight-for-age) were overweight.[23] In other words, under-nutrition and over-nutrition were found in the same households.

TABLE 13.7 BODY MASS INDEX, BLOOD PRESSURE AND CHOLESTEROL VALUES OF DIFFERENT ETHNIC GROUPS IN SOUTH AFRICA.

Parameters	Rural Africans[1]		Urban Africans[2]		Rural Whites[3]		Urban Coloureds[4]		Urban Indians[5]	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Body mass index (weight/height^2)	22.5	22.5	26.0	31.8	27.1	27.3	24.4	30.2	34.0	31.0
Blood Pressure (mmHg)	125.8	110.0	130.0	122.0	144.5	149.3	135.5	141.4	136.8	136.4
Systolic	74.7	66.8	84.0	80.0	90.6	91.3	91.2	92.6	86.8	81.8
Diastolic										
Total serum cholesterol (mmol/l)	4.7	4.4	4.3	4.0	6.37	6.89	6.09	6.30	6.28	5.86
HDL Cholesterol (mmol/l)	1.7	1.7	1.4	1.4	1.15	1.44	1.42	1.52	1.26	1.22

Source: 1. Vorster *et al.* 1994
2. Steyn *et al.* 1991
3. Rossouw *et al.* 1990
4. Seedat *et al.* 1992

Urban African women have been found to have a very high mean BMI of 31.8 (Table 13.7). Hypertension was found in 27% men and 25% of the women.[24] Urban coloureds and rural whites have the highest mean systolic and diastolic values (Table 13.7).[24, 25] Indians have the highest mean BMI values of all groups.[26] Total serum cholesterol is high in urban coloureds, whites and Indians. High density lipoprotein cholesterol values were lowest in rural white men.[26]

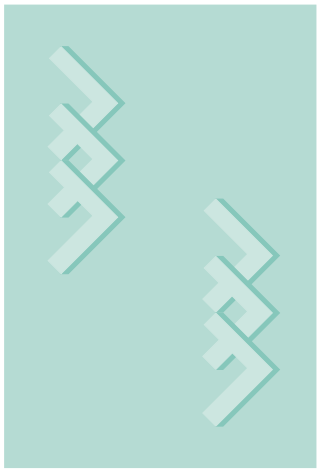
According to the WHO: "Some of the countries in the African region have now developed their own food and nutrition policies. Most of these aim to eradicate malnutrition, but it is important to maintain awareness of the emergence of over-nutrition and its resultant effect on chronic diseases. This awareness should not be limited to the urban elite, but should encompass the emerging affluent commercial / business sector in rural areas and small towns".[20]

SUMMARY OF RECOMMENDATIONS

In summary, this review has highlighted the following:

- The need for capacity building and training regarding the planning and implementation of community-based nutrition programmes
- Research to focus on planning and evaluation of nutrition education programmes for schoolchildren
- Research to focus on evaluating the benefits of the PSNP
- The need for improved community participation and increasing linkages of those schools participating in the PSNP
- Research to focus on the nutrient intakes of vulnerable groups such as pregnant and lactating women, and the aged
- Research to focus on factors affecting household food security
- Policy should be formulated regarding over-nutrition and chronic diseases of lifestyle
- Greater clarity regarding the role to be played by the Department of Agriculture in community-based programmes.

The final word goes to the Minister of Health, Dr Nkosasana Zuma. In an interview with *HST Update* in April 1996, she established a clear yardstick for measuring the success of health systems reform: "We have credited ourselves with beginning to change the concept of health services. It is longer a market commodity, but something that the government has to take full responsibility for. But if after five years, there is still widespread kwashiorkor and marasmus, I don't think we can really say we have transformed health".[27]



14 "FREE HEALTH CARE" POLICIES

BACKGROUND

In South Africa, barriers to health care have resulted in a level of health service utilisation that is sub-optimal. These barriers vary from a basic lack of health facilities, the perception of poor quality of care, and the inability to afford health insurance or user fees for health care.[1] In one survey, 20% of the respondents said that they had failed to receive medical treatment because they could not afford to pay for it.[2]

On May 24 1994, the State President declared in his State of the Nation speech that all health care for children under the age of 6 years, and pregnant women would be free. It was believed that this would improve access to health care for women and children by removing the barrier of health service fees.[3]

This policy was also in line with the recognition that priority should be focused on women and children. The World Health Organisation gives the following reasons for this :

- children represent the future of the community and nation
- women and children form the majority of the population
- mothers and children are particularly vulnerable to disease
- most conditions that cause morbidity and mortality in children and pregnancy are preventable
- women and children represent the least powerful members of society.[4]

CONTEXTUALISING FREE HEALTH CARE

When discussing the issue of free health care, it should be noted that there is no form of health care provision that is really "free". All health services have to be financed in some way whether through taxation, donor funding, fees or health insurance. The policy of providing free health care for children and pregnant women therefore only means that a decision was taken to remove the previous system of "user fees".[5] However, the public is still effectively paying for health care indirectly through taxation.

User fees are implemented for two reasons: firstly, as a means of generating revenue and secondly as a way of influencing the pattern of health service utilisation. However, experience in developing countries has highlighted a number of difficulties associated with both these objectives. User fees also have the potentially harmful effect of reinforcing patterns of inequity.

Empirical evidence from Africa suggests that fees do not generally generate more than 5% of total operating costs.[6, 7] These figures are of gross revenue, and do not include the cost of administering a fee system which would cause the net yield to be lower, and in some cases even negative.

For South Africa, in 1992/93, user charges generated the equivalent of 4.5% of total recurrent health expenditure.[8] Of the user fees that are collected, the bulk appears to come from secondary and higher level hospitals. In the former Cape Provincial Authority, less than 1% of total health service fee revenue was attributable to the clinics and day hospitals in 1992/3.[9]

At the individual facility level however, the proportion of fee revenue to recurrent expenditure can be as much as 56%.[5] Results from a national survey also indicate that the bulk of public hospital fee revenue comes from private patients and medical scheme members.[10]

Authors : David McCoy and Solani Khosa

As far as utilisation of health services is concerned, most studies have shown that an increase in the price of health care leads to falls in the demand for health care.[11, 12, 13] In Swaziland, fee increases caused a 17% decrease in average attendances at health facilities.[14] Of particular concern was the fact that visits designed to protect against childhood diseases showed larger declines in attendance. There is now general agreement that user fees reduce health demand and health service utilisation.

Work from several countries has shown that the effect of fees is greatest on lower income groups and on children.[15, 16, 17] A study from Bangladesh concluded that ". . . fees may impede access of the most needy to medical care and thereby may have a negative impact on the health of individuals.[18] The fact that the poor have greater "health needs" and greater "capacities to benefit" means that user fees can be considered to be un-economic, as health is an asset which the poor use to sustain their livelihoods, employment and income.[19]

Furthermore, unhindered access to health care for the vulnerable sections of society can have benefits to the population as a whole. The fact that user fees may encourage patients to delay seeking health care for tuberculosis could lead to permanent lung damage, or to the disease being spread to other people.[20, 21]

Government Gazette Notice 657 (1994): Rendering of Free Services

1. As from 1 June 1994, free health services must be provided to:

(a) pregnant women for the period commencing from the time the pregnancy is diagnosed to 42 days after the pregnancy has terminated, or if a complication has developed as a result of the pregnancy, until the patient has been cured or the conditions as a result of the complication has stabilised;

(b) children under the age of 6 years;

non-citizens of South Africa who are in the groups mentioned in par (a) and (b), and who incidentally develop a health problem whilst in South Africa.

2. Free health services rendered to persons in paragraph 1 will only be provided-

(a) at State health care facilities, including hospitals, community health centres, clinics, mobile clinics, satellite clinics;

(b) at State-aided hospitals of which more than half their expenditure is subsidised by the State;
and

(c) by district surgeons.

3. Free health services included the rendering of all available health services to the persons mentioned in paragraph 1, including the rendering of free health services to pregnant women for conditions that are not related to the pregnancy.

4. The following persons are excluded from the free health services:

(a) Persons and their dependants who are members of a medical scheme.

(b) Non-citizens of South Africa who visit South Africa specifically for the purpose of obtaining health care.

However, in certain situations where the quality and funding of health care is so bad, user fees can be used to raise revenue for improving the standard of care such that they can be used to improve the quality of care and make health care more accessible.[22] However, there have been no large-scale and consistent experiences of fees being used to improve the quality and accessibility of services.

Although in theory it should be possible to have a user fee system that exempts the poor and disadvantaged, this does not generally happen in practice.[23] This is mainly due to a lack of administrative capacity which is aggravated in high volume facilities where there may be even less time, space and privacy to identify those people who are exempt from fees. Other problems include a reluctance amongst staff to grant exemptions, and a reluctance amongst patients to request exemptions despite being eligible.[24]

A survey of patients at Niger's central government hospital actually found the average income of patients who had to pay to be less than that of all patients as a whole![25] There is therefore no evidence from developing countries of measures that consistently and cost-effectively identify the poor so that they can be granted exemption from fee payment.

Finally, there is no evidence that user fees act as a disincentive to patients seeking health care for "frivolous" reasons, or that differential fees based on the level of facility can be used to limit the use of expensive higher level facilities for health services that are available at a lower level.[26] In Swaziland when user fees were increased, the greatest drop in attendance was for sexually transmitted diseases, immunisation and preventive health services, which highlights the concern that the use of fees to reduce "frivolous" use could be harmful.[27]

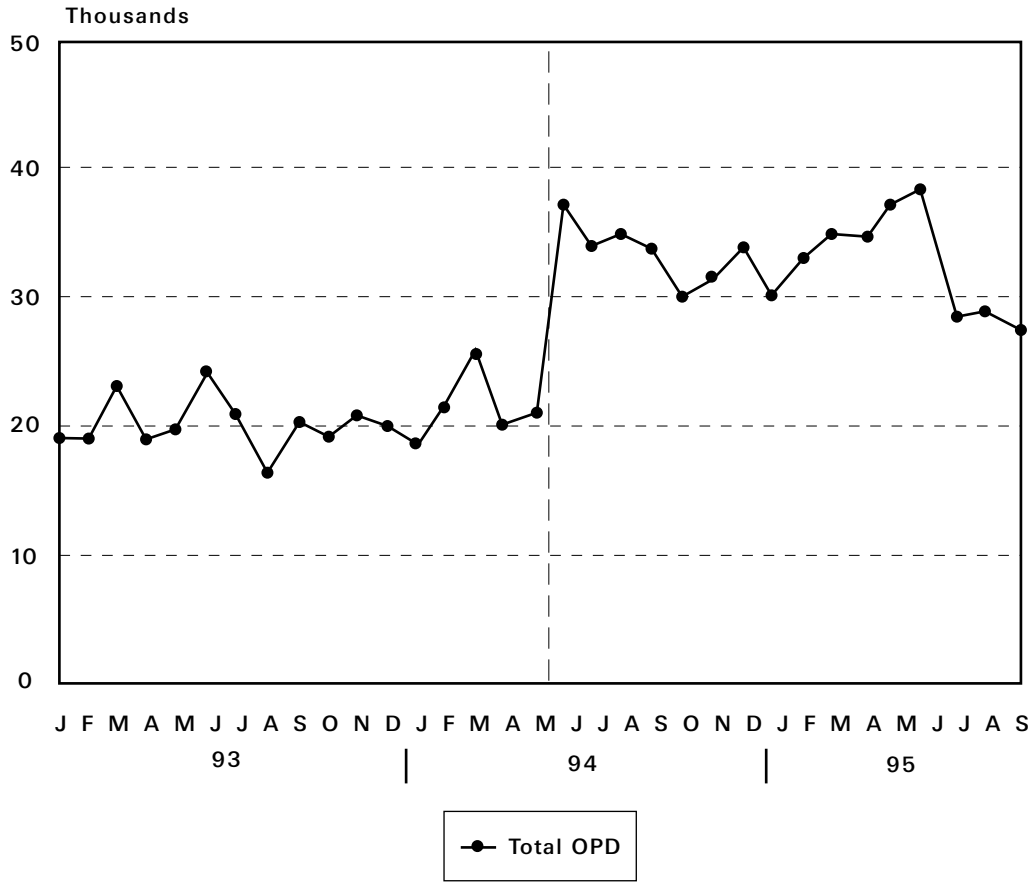
FREE HEALTH CARE FOR PREGNANT WOMEN AND CHILDREN UNDER SIX YEARS - ITS IMPACT

In 1995, a team of research organisations were commissioned by the Health Systems Trust to conduct an evaluation of the Free Health Care (FHC) policy.[28] Although the evaluation was conducted retrospectively and within the constraints of a poor and limited health information system, the report made a number of findings.[29]

Utilisation of public sector health services

Overall, the policy resulted in a rise in the attendance of patients at public sector health facilities, and confirms the findings from other countries that user fees are a barrier to accessing health care (see Figure 14.1). Of great significance were findings that there had been an improvement in the utilisation of antenatal and maternal health services following the policy (see Figure 14.2). The increased number of women booking for antenatal care, and the consequent reduction in the proportion and numbers of unbooked deliveries are trends likely to be associated with improved health outcome (see Figure 14.3).

FIGURE 14.1 PAEDIATRIC OPD ATTENDANCE AT SOWETO CLINICS, GAUTENG

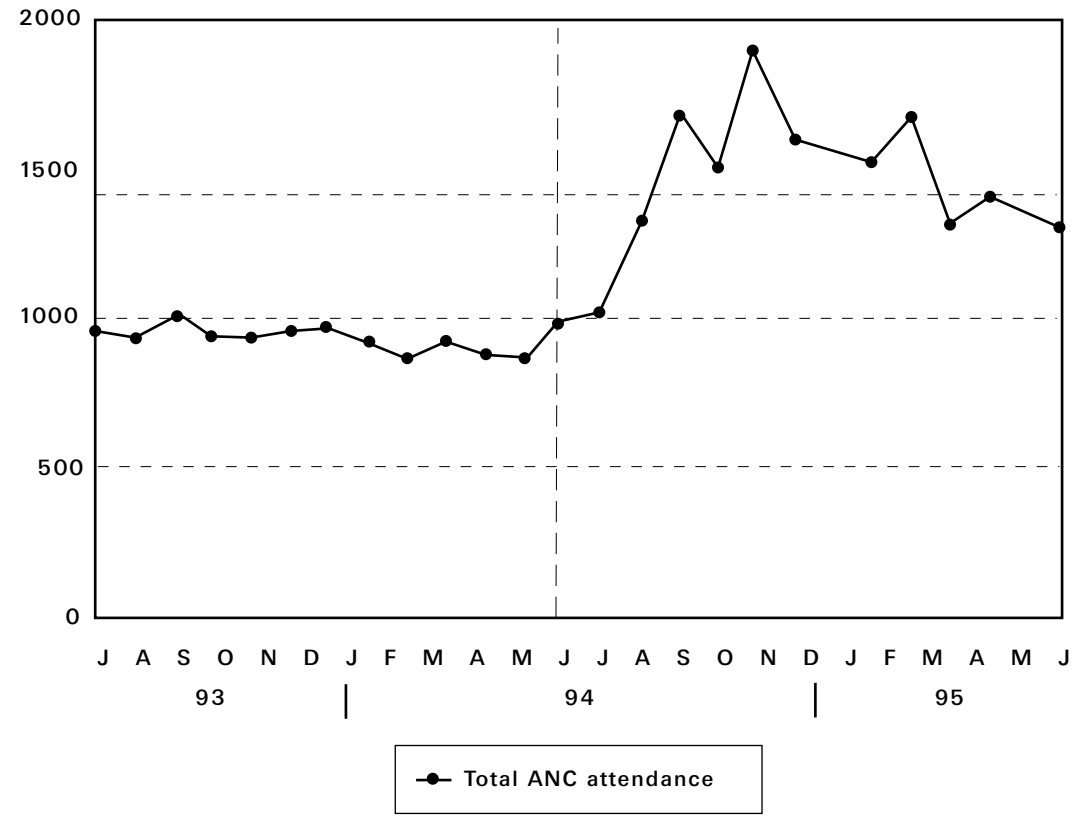


Source: Health Systems Trust. Free Health Care for Pregnant Women and Children under Six in South Africa.1996

FIGURE 14.2 FIRST ANTENATAL CLINIC (BOOKING) VISITS AT KWADABEKA AND PINETOWN MUNICIPAL CLINICS

Source: Health Systems Trust. Free Health Care for Pregnant Women and Children under Six in South Africa. 1996

FIGURE 14.3 ANTENATAL CLINIC ATTENDANCES- GOLDFIELDS REGIONAL HOSPITAL, WELKOM



Source: Health Systems Trust. Free Health Care for Pregnant Women and Children under Six in South Africa.1996

In other instances, it is not possible to say if the increased utilisation of health services necessarily meant an improvement in health outcome or health status, or whether the beneficiaries of the policy include those members of the population who most require health care. However, studies from other countries indicate that it is reasonable to assume that the policy has contributed towards meeting South Africa's policy objective of promoting greater equity within the health sector, and of promoting the principle of preventive health care.

Surprisingly, the study did not show any differences between rural and urban facilities, although it is known from the literature that people living in rural areas have poorer access to health care due to lack of transport and living long distances away from health facilities. Demand for health care is also influenced by other factors, and in some places utilisation patterns were influenced by local political violence, the national elections, and hospital strikes.

On the negative side, there was some evidence that the policy may have encouraged patients with minor ailments to bypass primary level services and to use tertiary level care "inappropriately". However, a comparison of the effect of the policy on a number of tertiary hospitals indicated that where there was a good network of primary level clinics, the inundation of patients with "inappropriate" conditions was less. The use of nurse practitioners to screen all patients and manage those with minor ailments in hospital outpatients' departments was also another demonstrable way to protect secondary and tertiary level medical services from unrestricted patient access.

Health workers and patients both explained that a lot of "inappropriate" use was because of the poor actual and perceived quality of primary level services. Therefore, from the patient's perspective, by-passing primary level services may in fact represent a rational and understandable decision.

The findings from this study also disputed any claims that the FHC policy would encourage women to become pregnant. Family Planning clinic attendances actually increased, and there was no evidence of any rise in the overall number of deliveries.

Financial cost of Free Health Care

The biggest item of recurrent public health expenditure, staffing costs, was not altered by the policy. This was not because extra staff were not needed, but because the health services were unable to hire staff or to pay over-time for a variety of reasons. However, the cost of staffing primary level clinics so that they could cope with the increased utilisation of health services should not be attributed to the FHC policy as these clinics should be adequately staffed regardless of whether health care is free or not.

Although the evaluation did not correlate utilisation figures with drug expenditure, on the basis of analysing drug expenditure alone, any increase attributable to the FHC policy was estimated to be less than 1% of the total public sector health budget. However, the practice of historical budgeting (where the annual budget is simply based on the amount spent in the previous year) may have caused an under-estimation of the true cost of the policy on drug expenditure.

Before the free care policy was introduced, fee revenue had been calculated to amount to less than 5% of the public health budget. Following the FHC policy, revenue from user fees was estimated to have dropped by about 30%. In other words there was a decrease of about 1.5% of the total public sector health budget. The bulk of this lost revenue occurred at the large referral hospitals. However, it is not possible to quantify how much of this drop in fee revenue was directly attributable to the FHC policy.

The figures mentioned above are based on data from the 1992/3 Health Financing and Expenditure Review, and should be seen to reflect the impact of the policy on fee revenue at a macro level. For individual hospitals, the reduction in fee revenue as a result of the policy may have caused more substantial reductions in total income.

Perceptions of health care users

For the users of health services, the FHC policy was acknowledged to have important benefits. Appreciation for the policy was especially strong amongst those living in rural and informal settlement areas. On the negative side, the policy was associated with problems like irregular supplies of medicines, increased waiting times, and rude and impatient staff attitudes.

The study also highlighted the fact that there are still many barriers to health care. High on the

list are problems related to the availability and physical accessibility of health facilities. In many rural parts of South Africa, the travel costs of getting to a health service will be far more than the costs of user fees. For such groups of the population, access and availability of services remain major problems that need to be addressed.

In the focus group discussions, patients emphasised their concern about the lack of transport and access to health services during emergencies, or for when women go into labour. This was a concern for both rural and peri-urban people, and suggests the need to provide more 24-hour health services, better transport services, and better telecommunication services.

Perceptions of health workers

The views of health workers were generally more negative than positive. However, most of the criticism was related to general problems of the health service and not specifically to the FHC policy. These include a lack of morale, dissatisfaction with working conditions and low pay. Other criticisms were related to the poor support that clinic nurses and primary level facilities receive in terms of training, staffing, and clinical support. They also felt strongly that there should have been more consultation before the implementation of the FHC policy, and that FHC would encourage women to become pregnant.

On the other hand, nearly three-quarters of the public sector health workers in the survey believed that FHC was successful in preventing serious illness or death among pregnant women and children under six. About half of them also felt that the policy had benefitted poor and malnourished children.

Private sector and part-time district surgeons

According to a limited survey, district surgeons experienced large increases in the attendance of children under six and pregnant women, which was generally greater than the increase experienced by the public sector. Many claimed that their services had been overwhelmed, and that patients who had previously attended privately, were now attending as public patients for free, thereby affecting the income of these part-time district surgeons.

Criticisms by district surgeons about the FHC policy included the view that it takes away the responsibility of parents to provide for their children, that patients are now presenting with trivial complaints, that it would contribute to population growth, and that it was not financially sustainable.

In a survey of private general practitioners (GPs), only 25% of respondents had a positive view towards the FHC policy compared to 39% who were against it. The most common complaint was that it leads to the misuse of health services. Respondents were also concerned that the policy encourages pregnancies and that South Africa can not afford the FHC policy.

More than two out of five (42%) of the GPs said that utilisation of their services had decreased as a result of FHC, and some complained of a consequent loss of revenue. GPs serving predominantly black, cash-paying patients were most affected by the reduction in clients.

According to a very limited number of informants, medical schemes did not respond specifically to the implementation of the FHC policy by reducing the benefits package to pregnant women and children, or by increasing their contribution rates for medical cover. Neither was there any indication that children under the age of six had been removed from scheme membership.

There was some indication that medical scheme members were switching away from public hospitals to private hospitals for in-patient care. According to the informants, the number of medical scheme members admitted to private hospitals increased from 1994 to 1995, while the number of members using public hospitals decreased.

EXTENDING FREE PRIMARY CARE TO ALL

In April 1996, the country was greeted with the sudden announcement that free health care was to be extended to all groups of patients at the primary level of care. The announcement was made during the parliamentary budget speech, and took most people by surprise. It was also a little surprising that the decision had been made prior to the findings of the evaluation of the initial FHC policy being made. Although this policy had not yet been gazetted, provinces were expected to implement the

extension of free care from 1 April 1996. Some provinces appeared more willing and able to do this than others. At the point of writing there has been a lack of clarity about the precise nature of this new policy. Efforts to obtain documentation and details from the Department of Health have been unsuccessful.

Apparently, the policy will provide free health care to all patients at the clinic level. This will not include patients seeking outpatient care at hospitals unless they had been referred from a lower level of care. Patients with medical aid or health insurance would also be excluded. At least one province also announced that patients above a certain income category would also be excluded from the benefit of free health care, and that there would be at least a R50 "by-pass fee" for those who by-pass PHC facilities and present at public hospitals for outpatient services.

It is not entirely clear what the status of GP referrals would be regarding the by-pass fee, and what would happen to patients who live close to a hospital but far away from a clinic (as would be the case in many rural areas). If these problems are not carefully thought out, the policy could have the paradoxical effect of actually reducing accessibility for some patients.

The effect of this policy on district surgeons was also unclear, although it also appears that they would be expected to provide free health care. This may have significant consequences on their income, and may cause them to implement strict embargoes on the number of public patients they will see per week. It is possible that another consequence of general free care would be that the prioritisation of women and children could be lost at some health facilities.

DISCUSSION

Given the findings of the above-mentioned evaluation, the initial Free Health Care policy should be supported. Extending free health care to all patient groups at the primary level could also be supported as the fee revenue from primary level services is minimal, and because the human and other resources used to administer a fee system in primary level facilities could be used more productively.

However, given some of the other findings of the evaluation, the capacity of primary level services to cope with further increases in utilisation must now be established as a matter of urgency. It is clear that in order to get a more appropriately used and efficient tiered health service to work, there is a need for patients to know that they can receive good all-round quality health care provided by nurse practitioners at clinics. By extending the provision of free health care, it could be argued that the national Department of Health is sending a message to provincial health departments to hasten the development and improvement of primary level services.

Another argument in favour of the extension of free health care at the primary level is that it may help to draw patients away from hospital services so that they will use primary level care more readily. However, the policy of imposing by-pass fees in hospitals to "compel" patients to use primary level services first may in the short term actually reduce access and reinforce inequity.

Mechanisms to encourage the appropriate use of health services by compulsion should only be justified if both the health services and the public are satisfied that there is a decent standard of health care operating at all levels of the service. In our opinion, the introduction of by-pass fees should only be considered when patients and primary level workers are satisfied with the standard and quality of primary level care, and should be a local decision and plan made jointly by both the health services and the community. This should be combined with providing information and education to the community to promote more appropriate use of health services, and to build public confidence in the capabilities of nurses.

In rural areas in particular, it would be wrong to send patients away, or to impose a "by-pass" fee if they live closer to a hospital than to a clinic. Furthermore it would be virtually impossible to be able to effectively and efficiently identify those patients who deserve exemption from a "by-pass" fee because of where they reside.

In order to improve the quality of health care, a number of steps need to be taken. Health providers must be happy and satisfied with their working conditions, which includes providing them (especially clinic nurses) with greater support in terms of accommodation, supervision, training and teaching, and remuneration.

Many of these considerations indicate how important it is for policy to be carefully planned and thought out. The way in which both the free health care policies were announced and implemented

seems to indicate a lack of detailed planning, and inadequate consultation with and warning to those who have to implement the policy.

As well as this, all policies of this nature should include a built-in mechanism for the evaluation of the policy. It is always unsatisfactory to evaluate policies retrospectively, and there is evidence that policies and programmes with in-built monitoring and evaluation components are more likely to succeed than those without.

Finally, as far as hospital in-patient services are concerned, any future policy must carefully assess the balance between cost recovery with access and equity. In terms of health, it is extremely important that patients who need in-patient care are not deterred by any mechanism or policy that is designed to recover costs.

HIV and AIDS

15

INTRODUCTION

The past year has not been a particularly good one for combatting the HIV epidemic in South Africa. The prevalence of HIV continues to rise at an alarming rate in the country (Table 15.1), with the Health Department estimating that there were 1.8 million South Africans infected with HIV at the beginning of the year. Evidence shows that we are deep in the epidemic with worse still to come.

The Department of Health has made intervention against AIDS one of its top priorities. However, although the HIV/AIDS and sexually transmitted diseases (STD) Control Programme of the Department of Health has expanded its staff, some have argued that it has taken time to get off the ground and find its direction. In addition, although the budget doubled, the amount of money allocated to the programme is woefully inadequate when compared to the projected need.

Non-governmental organisations (NGOs) also have an important role in combatting the epidemic. However the capacity for many of them to respond has been hampered by reduced funding as money is diverted away from them and directed towards the new government.

The response to the epidemic has been further hampered by the Sarafina 2 debacle which damaged government credibility, demoralised many people working in the field, and soured relations with donors. The far-reaching implications of this controversy are dealt with in more detail in Chapters 12 and 18.

This 1996 review of the HIV/AIDS epidemic will argue that there are two key issues that need to be addressed:

- The issue has to be addressed beyond its biomedical features (and solutions). Social factors that drive behaviour must equally be recognised and addressed.
- The issue of those already HIV infected South Africans who will become ill requires more attention, both from the health and the national development points of view.

WHY IS THE HIV/AIDS EPIDEMIC DIFFERENT FROM OTHER EPIDEMICS?

The HIV/AIDS epidemic differs from most other epidemics and diseases, and consequently, requires a different and much broader response - one which goes beyond the health sector. The factors that make it unique are:

(a) It is a new epidemic. AIDS was first recognised as a specific condition only in 1981 and it was not until 1984 that the cause, and a test to detect it, was identified.

(b) It has a long incubation period. Persons who are infected by the virus may have many years of productive normal life, although they can infect others during this period. The latent period varies between individuals, from about five to fifteen years, with the shorter period being found in the developing world where many people are less healthy, have less access to health care and are under nourished. It is known that good health and nutrition and early treatment of opportunistic infections will extend the period of healthy and productive life. Infected children will, for the most part, die before their fifth birthdays.

(c) There is no effective cure. At the end of the incubation period, a person will experience periods of sickness increasing in severity, duration and frequency, until he/she dies.

Authors : Alan Whiteside and Tony Barnett

(d) The disease is found mainly in two specific age groups, children under five and adults aged between 15-40 years. Teenage girls are one of the most affected groups. In the developing world, slightly more females than males are infected. As the epidemic affects adults when they should be in their most economically productive years, there are profound consequences on the workplace and the economy. This is in terms of lost income, decreased productivity, and increased consumption of health care.

(e) The scale of the epidemic is different from most other diseases. Recent data has indicated that in some urban settings of South Africa, up to 30 per cent of ante-natal clinic attendees are infected. This means that between 20-25 per cent of sexually active adults may be infected in these areas. The epidemic in South Africa has yet to reach its peak.

(f) HIV is mainly sexually transmitted, which means it is passed on through a fundamental human activity, but one which is not comfortably discussed openly.

(g) There are links between HIV and other diseases, most notably tuberculosis, which have further implications for public health.

(h) In general, the epidemic is still spreading in the developing world and this includes South Africa. HIV affects all racial groups, and although the prevalence is highest in African communities, there is clear evidence that the epidemic is spreading rapidly throughout the whole population of South Africa.[1]

The epidemic clearly must be treated differently from other diseases because of the effect it will have on social, economic and developmental goals. As well as trying to slow and halt the spread of HIV, we must deal with its consequences.

TABLE 15.1 NATIONAL HIV SURVEY IN SOUTH AFRICA: ESTIMATED PREVALENCE OF WOMEN ATTENDING ANTENATAL CLINICS: SUMMARY OF RESULTS OF 1990-1995

	Prevalence rate %					
By Region	**1995**	**1994**	**1993**	**1992**	**1991**	**1990**
Cape			1.33	0.66	0.37	0.16
KwaZulu-Natal			9.62	4.77	2.87	1.61
Free State (including Qwa Qwa)			4.13	2.87	1.49	0.58
Transvaal			4.01	2.56	-	-
Gazankulu			2.61	1.58	-	-
KaNgwane			3.62	3.28	1.71	-
KwaNdebele			1.22	1.10	0.70	-
Lebowa			0.85	1.10	0.55	-
Tvl. including Gazankulu			3.09	2.16	1.11	0.53
Ciskei			2.48	1.20	0.94	-
Transkei			1.54	0.83	0.49	-
Venda			1.45	0.64	0.45	-
RSA (excluding TBVC)			4.69	2.69	1.49	0.76
SA (excluding Bophutswana)			4.25	2.42	1.35	-
By Province	**1995**	**1994**				
Western Cape	1.66	1.16				
Eastern Cape	6.	4.52				
Northern Cape	5.24	1.81				
Free State	11.03	9.19				
KwaZulu-Natal	18.23	14.35				
Mpumalanga	16.18	12.16				
Northern Province	4.89	3.04				
Gauteng	12.03	6.44				
North West	8.3	6.71				
SOUTH AFRICA	**10.44**	**7.57**				

Source: DNHPD Epidemiological Comments Vol. 21 (11). 1994
Directorate: HIV/AIDS/STDS. Dept of Health. 1995

FACTORS DRIVING THE EPIDEMIC

Factors which determine the risk of infection and behaviour that puts people at risk need to be clarified. This is set out diagrammatically in Figure 15.1 which shows a complex relationship between many factors.[2] Transmission of HIV and sexual behaviour itself is determined by a wide range of social, cultural and economic factors in a society. Interventions at all these levels are required, but have yet to be put in place.

FIGURE 15.1 DETERMINANTS OF THE RISK OF HIV INFECTION

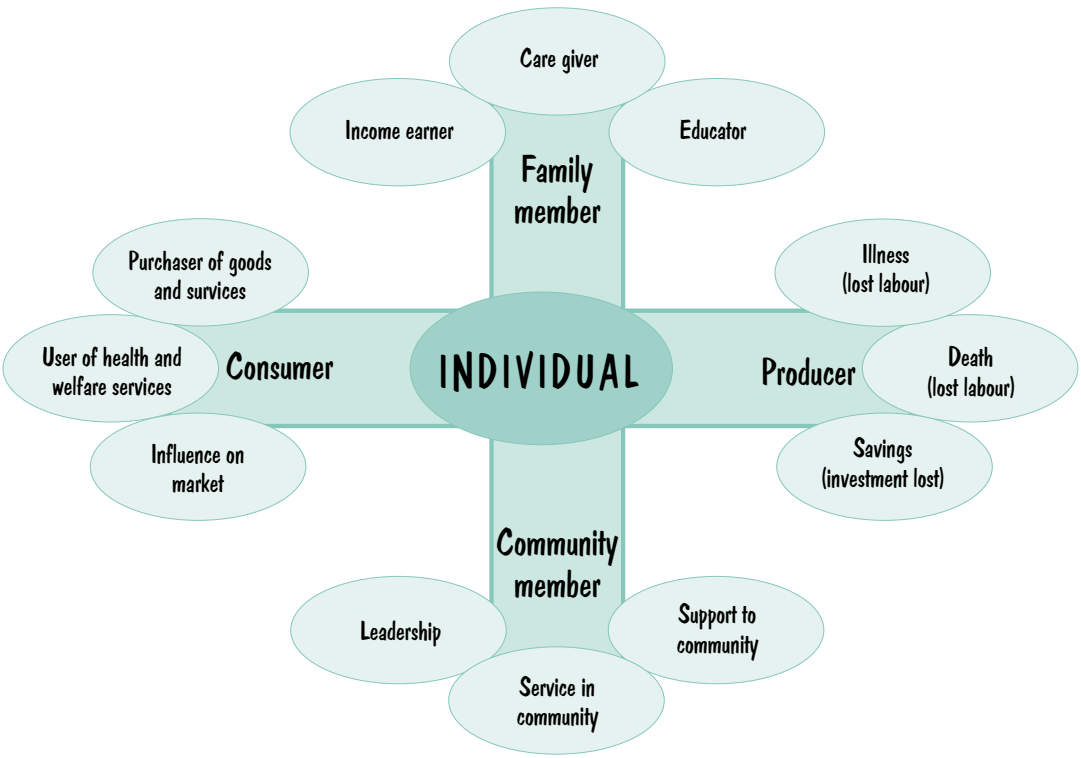
Macro environment	Socio-economic environment	Sexual exposure to HIV	HIV Transmission
National wealth (GDP) Income distribution Social determinants Cultural determinants	Migration Status of women Rate of urbanisation Access to health Levels of violence Education	Pattern of sexual mixing extent of concurrent partners Rate of partner change Condom use Virus subtype Disease stage	Sexual practices Circumcision Other STIs

Source: Developed from Anne Buve, Michel Carel, Richard Hyes and Noah Jamie Robinson, Variations in HIV prevalence between urban areas in sub-Saharan Africa: do we understand them? AIDS 1995,9 (suppl. A): S103-S109

THE IMPACT OF HIV/AIDS

The HIV/AIDS epidemic has a number of important effects that occur at various levels in the society and economy. HIV infects individuals who then fall sick and die. Thus the first and worst effect of the disease is felt by the person who falls ill, and his or her family. Indirect effects then spread like a ripple through the household, community, and the country as a whole. This interaction is illustrated in Figure 15.2. It should be remembered that while an individual may not be a producer, he/ she will always be a **consumer** and have other roles in society.

FIGURE 15.2 THE INDIVIDUAL AS AN ECONOMIC AND SOCIAL ACTOR



The HIV/AIDS epidemic will have three broad effects that must be considered**: demographic, economic, and developmental**.

Demographic Consequences

HIV/AIDS will affect the population in a number of ways. There will be increased mortality (more people will die) and many of these people may be in their reproductive years, which could reduce fertility rates. However the epidemic is unlikely to stop population growth, nor will it cause populations to fall, thus any idea that AIDS is the solution to the population problem is unfounded. What it will do, in some regions, is slow the rate of population growth and alter the structure of the population. Also of great importance will be the number of children orphaned as they will have special needs, especially as the numbers grow and the extended family is no longer able to cope.[3]

Economic Implications

At the household level the effect of HIV infection is obvious; there will be an increase in some kinds of expenditure, as the person requires medical care and so on, and if the infected person is an adult then production and income will be reduced.

It is expected that the epidemic may also affect national economies through the illness and death of producers and the diversion of resources from saving (and, eventually, investment) to care. Estimates have been made that by the year 2005 up to three quarters of the projected health budget could be consumed dealing with the consequences of the epidemic.[4] Quite clearly this means that the health sector needs to plan for the future. One important aspect will be the development of primary health care. The best care for people with AIDS is symptomatic management of their disease which can be best done at the primary health care level. If the primary care system is not in place, then the AIDS patients will clog up the hospital system by filling the beds. This is already being seen in KwaZulu-Natal, highlighting the urgent need to develop the primary health care system.[5]

Attempts to model the economic impact for specific countries show that HIV will probably reduce the rate of economic growth; up to 25% over a period of 20 years.[6] However, in order to make this prediction, two sets of projections have to be combined - first, of the epidemic, and the second, of economic trends: both are difficult to model and combining them compounds the uncertainty. This means that the implications of the macroeconomic impact are far from clear and not really useable - other than to invest in prevention activities and plan for the impact of the epidemic.

An additional problem is that HIV/AIDS is only one of a number of pressing problems faced by policy makers in developing countries. In South Africa, the need to develop the economy and provide houses, education, health and employment have all been seen as more important than the HIV/AIDS epidemic. The possible exception to this has been in KwaZulu-Natal where a provincial leadership forum was established. This brought together the most senior business people, politicians, religious, community and other leaders to discuss issues of pressing importance for the province. The first meeting focused on the HIV/AIDS epidemic and arising from this has been an initiative to try to deal with the issue at this level. Even though the province has the worst epidemic in the country, the leadership has faced problems by firstly prioritising the issue; secondly knowing where their comparative advantage lies; and thirdly motivating their staff to take action.[7]

Development Consequences

If it is accepted that development is about more than economic growth and increases in GDP per capita, and includes things such as longevity, standard of living, infant, child and maternal mortality and distribution of income then it is here that the impact of the epidemic will be felt first and worst.

Particularly vulnerable are the indicators of life expectancy; infant mortality rates; child mortality rates and the crude death rate. Way and Staneki (1994) predict infant mortality rates nearly doubling in Zambia and Zimbabwe and increasing by 50 per cent in Kenya and Uganda.[8] Child mortality rates will increase even more, as many infected infants will survive beyond their first birthday. They further predict that life expectancy will fall by between 9 and 25 years in the worst affected countries by the year 2010.

The effect of AIDS will be to reverse hard won development gains and make people and nations worse off. It is possible that these effects may last for decades. The people who fall ill and die

are the parents and leaders in society, which means a generation of children may grow up without the care and role models they would normally have.[9]

Again it is apparent that there has not really been a consideration of these issues in South Africa. There is a drive to produce policy papers that will lead to action. These are not considering the effect of HIV/AIDS on the demand for services; the ability to supply them; or the ways in which the demand may change. For example, provision of affordable housing is a national priority and a White Paper has been produced. The paper does not consider the effect that AIDS will have on the population (will there be fewer people wanting houses?); the supply (if banks and financial institutions are to provide at least part of the funding, AIDS may affect the availability of these funds); and the ability to pay (it has been shown that there is actually very little disposable income in the poorest households) and the effect of AIDS in this (for example; care, funeral expenses and so on), may mean people are unable to afford the most basic housing, as envisaged in the report.

RESPONSE TO THE EPIDEMIC

The possible responses to the epidemic are well documented. Risk of sexual transmission can be reduced by use of condoms, and/or cutting down on numbers of partners, and treating sexually transmitted diseases . Recent research from Tanzania has shown that a 42% reduction in HIV infection rate can be achieved through effectively treating STDs. Blood and blood products can be made safer through screening of both the donors and their blood. Drug users can be encouraged to sterilise or exchange needles. Work on developing means of reducing mother to child infection is also underway.

It is relatively easy to implement these 'technical' responses, but changing behaviour to ensure people use condoms; reduce the numbers of partners; and have their STDs treated has proven to be more difficult. Indeed, although we know what we have to do to respond to the epidemic, we have generally not succeeded in dramatically altering its course. This points to the key issue identified above: we need to go beyond the biomedical determinants and responses to the epidemic; try to understand what makes people behave in the way they do; and see what can be done to alter this.

RESPONSE IN SOUTH AFRICA

Governmental response

The Department of Health has made interventions against AIDS one of its top priorities. However the establishment of staff structures, and the appointments of key people within the programme has been hampered by the slow processes of bureaucracy. In addition, while there are AIDS Training and Information Centres (Atics) across the country, it is argued that the governmental response needs more than these structures alone, to implement strong programmes at the provincial level.

Nonetheless, despite these initial problems, there have been successes. 97 million condoms were distributed in 1995, and there is a coherent 5 pronged medium term strategy. These five strategies are:

1 **Life skills and responsible sex programmes** are run at schools and youth centres, in conjunction with NGOs.

2 **Mass communication strategies** such as the Faces of AIDS project, which uses people with HIV and celebrities such as Jonny Clegg to give messages, aim to raise awareness and reduce the stigma attached to AIDS.

Vivid murals in seven cities illustrating the issue of AIDS, and the project to train taxi drivers to give AIDS information and provide free condoms has already taken off. At taxi ranks the longest queues were usually for "AIDS taxies", which also had audio taped music interspersed with AIDS related messages. There are now 200 "AIDS taxis" roving around Gauteng, KwaZulu-Natal and the Western Cape, and another 50 in each province.

3 **Increased access to barrier methods**. Condom distribution is underway and the introduction of the female condom has begun. Primary health care and family planning staff have already been trained in its use.

4 **Stepping up STD management**. At present STDs are often inappropriately managed with the wrong drugs being used. The department is spearheading the introduction of a syndromic approach to STD management which doesn't rely on sophisticated laboratory technology. Clinics are training their staff in more up to date clinical management and are attempting to change their attitudes.

5 Providing norms, standards and guidelines for the **care of AIDS patients** from hospital to home, will facilitate the introduction of alternative models of care.

Non-Governmental response

The governmental interventions will only be successful if every component of civil society, including churches, schools, clubs and communities play their part in assisting the formal health sector. Many NGOs and CBOs (Community Based Organisations) have developed important strategies and interventions, however others have suffered from decreased funding and been unable to respond as they would have liked. The National AIDS Coordinating Committee of South Africa - NACOSA, continues to be an important group bringing together all the key role-players. Their strategy includes a set of principles and approaches regarding education and prevention, counselling, care, welfare, research, human rights and law reform. NACOSA now has structures in all the nine provinces and plays an essential role in networking, lobbying and monitoring.

The National Progressive Primary Health Care Network's (NPPHCN) National AIDS Programme was launched in 1991 to develop community based AIDS intervention programmes but was formally closed in 1995 due to funding problems. During 1996 NPPHCN have launched an initiative to encourage better communication between youth and their parents on issues of sexuality. Approximately 100 workshops have been held so far.

The Planned Parenthood Association has a number of examples of successful projects around the country, demonstrating their commitment to the fight against AIDS. An example is a successful youth centre in Johannesburg's Carlton Centre, which promotes the prevention of STDs through the use of condoms and provides education and counselling. It also diagnoses and treats STDs and distributes condoms and other contraceptives. This is all done in an atmosphere where the young people are treated with respect, and staff are sensitive to their needs. Other projects include life skills and sex education courses for teachers in the surrounding schools to equip them with skills to deal with questions on sexuality in their respective schools. As separate but related initiatives, the Planned Parenthood Association is also strongly active in developing successful models for social marketing and community based distribution of condoms.

The Society for Family Health has also launched a social marketing project for condoms. In partnership with the American based Population Services International, this initiative to increase knowledge and use of condoms is based on two principal strategies: broad-based and diverse distribution through traditional and non-traditional outlets, and a mass media motivation campaign to create and sustain demand for condoms among sexually-active South Africans. Social Marketing projects have been expanded from the original pilot in KwaZulu-Natal to the Greater Johannesburg area, the Western Area mining communities and the Free State gold fields. During 1995 the Society for Family Health distributed nearly two million LOVERS PLUS condoms. Goals for 1996 include a full-scale national project launch with Overseas Development Administration funds, a national advertising campaign and the launch of the female condom.

In addition, many South African NGOs, some in co-operation with international partners, are running programmes throughout the country to support home based care interventions, and address the needs of the growing numbers of children orphaned by AIDS. These are just a few examples of many projects which are underway. One important message is that these groups all have a role to play in combatting AIDS, however these initiatives will be most successful if they are done in a coordinated way, working with each other to learn lessons from their experience. Communication with government structures is also important, to ensure a coordinated approach, and prevent the fragmentation of services we saw in the past.

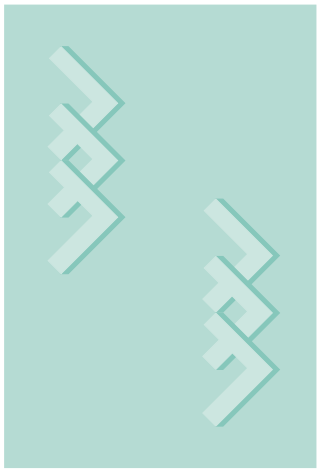
CONCLUSION

What are the implications of this? Perhaps the most important one is that this epidemic does not 'belong' to the medical establishment and they do not have all the answers to it. The epidemic requires a multi-sectoral and imaginative response. We need to look at what it is in society that makes people behave in certain ways that puts them at risk and we need to identify particularly susceptible groups. Once this has been done interventions can be targeted, and some of these may seem at first glance to have little to do with HIV. For example educating and providing condoms to long distance truck drivers is an accepted intervention, but it might also make sense to provide secure rest areas on national highways with televisions and food and speed up the passage of trucks across borders - both would reduce the chance of people putting themselves at risk.

The second area of concern is the impact of the existing epidemic. South Africans have not yet exercised their minds in looking at what is going to happen as the AIDS (as opposed to the HIV) epidemic gains momentum. We will see a change in the demographic structure of the population, and increase in demand for social, health and welfare services, and the loss of scarce skilled and professional manpower. The impact of the epidemic needs to be planned for. It is not a "wild card" anymore. At the very least, population projections should include the effect of HIV; it should be given consideration in government policies and the White Papers of all ministries; and the private sector needs to be involved, both in its own right, and as a contributor to national policy.

There are some glimmers of hope. The latest HIV data are not good, but as the Department points out " 10.44% of the women attending antenatal clinic of the public health services nationally were infected with HIV by the end of 1995. This compares favourably with the 11 - 12% expected in 1995 if HIV infection had increased at the same rate as the results of the five previous surveys showed".[1]

The challenge is to ensure that South Africa takes the epidemic seriously now. The fact that AIDS is not yet visible means that we can ignore it, but we will do so at our peril. The need for prevention and planning for impact are more urgent than ever, and this must be made a comprehensive and inclusive process.



MATERNAL, CHILD AND WOMAN'S HEALTH

16

RECAPPING ISSUES IN THE 1995 REVIEW

Policy

The corresponding chapter in the South African Health Review 1995 was written at a critical time of transition for national health policy.[1] The government had recently signed the Convention of the Rights of the Child and soon thereafter committed itself to its implementation by the announcement of free care for mothers and children under the age of 6 years and the creation of a primary school nutrition programme.

A special ministerial commission on Maternal, Child and Women's Health (MCWH) had recommended that MCWH be accorded national programme status and had provided a framework for the restructuring of MCWH services and programmes within a three-tiered National Health System based on primary health care (PHC). National and provincial directorates were mooted to support MCWH health service delivery within districts.

Information

The Review 1995 noted that existing national data on the status of mothers, women and children was incomplete, unreliable and out of date. There was a need for recent and accurate indicators of health status and coverage with MCWH services.

Mothers and Women

Their concerns about the quality of the data notwithstanding, the authors concluded that maternal mortality rates were unacceptably high, showed great disparity between different racial groups and, though overall much better than the rest of sub-Saharan Africa, could well be worse than available figures indicated. Causes of maternal morbidity and mortality were antepartum and intrapartum bleeding, infections, ruptured uterus, abortions and pregnancy-induced hypertension. Iron deficiency was a common and significant problem in pregnancy.

Priority health problems for women included the growing spectre of HIV/AIDS, sexually transmitted diseases, given added significance by their role in HIV/AIDS transmission, and carcinoma of the cervix. Other pressing issues were the need for more effective fertility education and the problem of violence against women.

Children and Adolescents

Available infant mortality rates (IMR) in African children varied from 30-73 per 1 000 live births and were up to 7 times higher than in children from other population groups. Significantly, perinatal deaths constituted a relatively high proportion (33%) of these deaths. The main causes of these deaths were, understandably, the same as those responsible for maternal deaths. This pointed to antenatal care, safe delivery and postnatal care, elements of the Safe Motherhood Initiative, as key programme priorities.

Malnutrition and infection, especially diarrhoeal disease and acute respiratory infections , together or separately, were the most important causes of mortality and morbidity in infants and young children. The main health problems in adolescents arose from risk-taking behaviour often with psycho-social origins. As in women, HIV/AIDS was a rapidly increasing threat to the health of children of all ages.

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Implementation

Implementation of an appropriate response was linked to the development of district health systems and to the integration of MCWH services and programmes into the overall PHC strategy in the district. A list of clear targets and objectives for MCWH services and programmes was provided for planners and managers. Collaboration with other sectors and involvement of communities in this task were considered critical to achieving these MCWH objectives.

PROGRESS AND UPDATES

Policy

The MCWH committee report was adopted by the Department of Health and integrated into an overarching policy document for a national health system, in which it continues to have a prominent place as a central national programme.[2] The principles, targets and objectives, and the proposed health service framework for this programme have not changed significantly, though a little more substance and detail have been provided (Figure 16.1). The government's Plan of Action on women's health, arising from the 1995 Beijing conference, has provided more clarity and given greater prominence to policy issues in relation to women's health.[3]

A significant addition to the national MCWH programme has been the inclusion of services and programmes to prevent and manage genetic disorders.

Women and Mothers

There have been significant developments in the relatively neglected area of women's health policy since the last report.

Convention for the Elimination of Discrimination Against Women

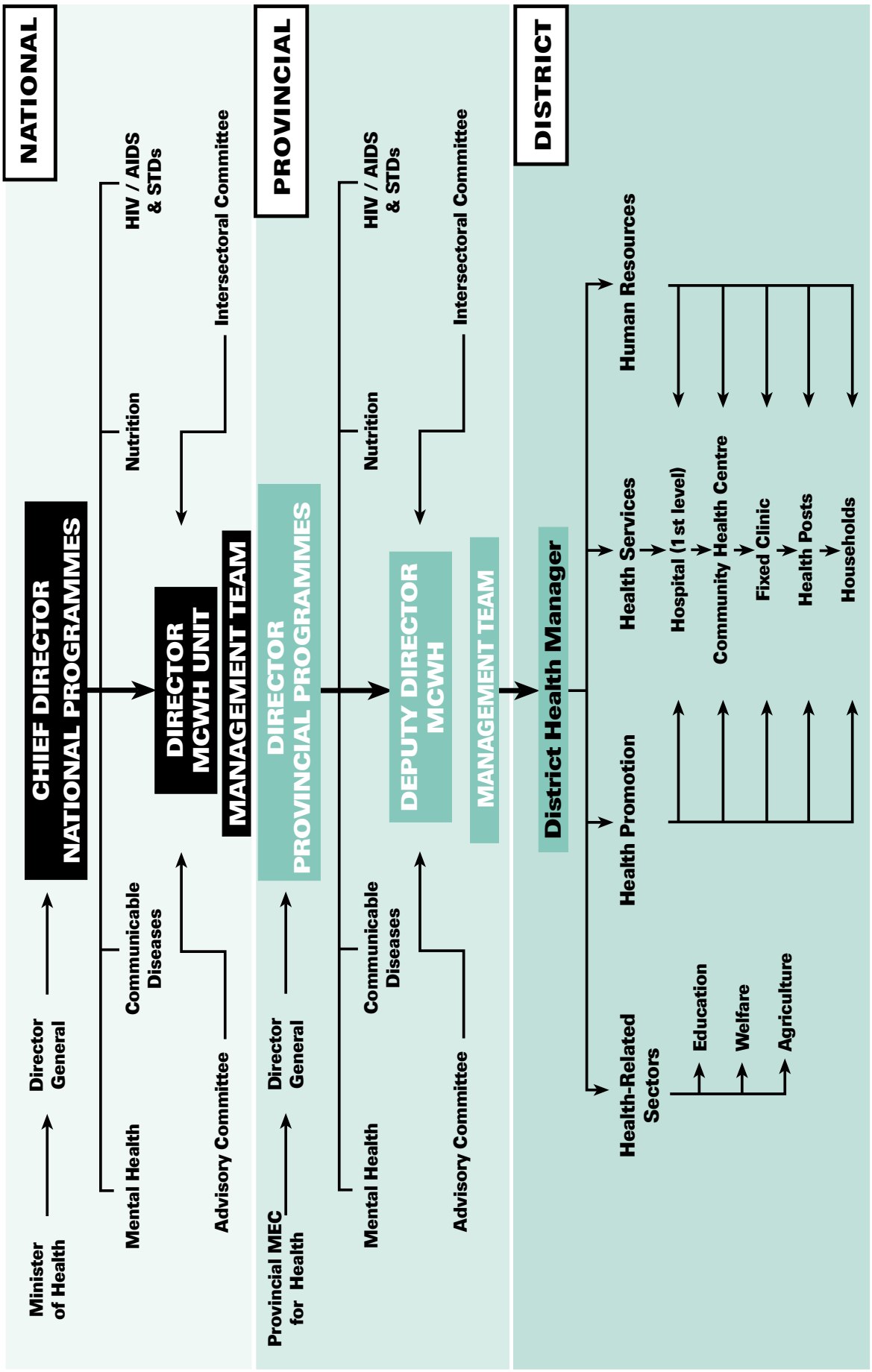
The Convention for the Elimination of Discrimination Against Women has been signed by the South African Government and it will be required to report on its progress in implementing the convention in January 1997.

National Conference on Women's Health Policy

In December 1994 the first national conference on women's health policy was held in Johannesburg. This conference involved women from diverse walks of life, in line with the principle of involving women in policy formulation.[3] Information from this conference was used in the build-up process to the Beijing United Nations Conference on Women and Development by non-governmental organisations and also informed governmental strategies. Policy proposals were developed in thirteen areas of women's health, viz:

- women, development and the environment
- mental health
- violence against women
- ageing
- lesbian health issues
- occupational health
- women's health in nursing curricula
- women's health in medical school curricula
- abortion
- cancers
- sexually transmitted diseases, AIDS and infertility
- contraception
- maternal and neonatal care.[4]

FIGURE 16.1 PROPOSED HEALTH SERVICE FRAMEWORK FOR THE MCWH PROGRAMME.



Source: Liberally adapted from the Maternal,Child and Women's Health Policy Document, February 1995

Women's Empowerment Policy

The Women's Empowerment Policy, that is currently being finalised by government, drew extensively from the 1994 women's health conference. Commitments to the Women's Empowerment Policy have been obtained from different line ministries and plans are well underway in 1996 to merge these commitments with the Plan of Action for South Africa emerging from the Beijing Conference. Acceptance of the Women's Empowerment Policy will require a broader approach to women's health policy than is contained in the existing MCWH policy. It will be necessary to give greater emphasis to women's empowerment as a health policy issue, to adopt an intersectoral approach to the promotion of women's health and to address neglected issues in women's health like violence against women, abortion and mental health.

Policy Relating to Abortion

There have also been important developments in policy relating to abortion. The *ad hoc* Select Committee on Abortion and Sterilisation, constituted in November 1994, has recommended that the current Act be repealed and that the new Act contain the following provisions:

- ✧ that abortion should be available at the woman's request up to 14 weeks of gestational age and, under certain broadly specified conditions, between 14 and 24 weeks gestation
- ✧ that current cumbersome, time consuming and discriminatory procedures should be simplified
- ✧ that counselling should be available to all women requesting an abortion
- ✧ that the consent of the woman's partner or husband should not be mandatory
- ✧ that, in the case of minors, the woman should be advised, but not compelled, to consult parents, responsible family members or friends and that counselling should be mandatory
- ✧ that any doctor or health worker who has conscientious objections to taking part in the abortion procedure should be free to excuse himself or herself but be required to refer the woman.

The Abortion Bill which contains the recommendations of this committee is soon to be debated in Parliament. The Department of Health supports the woman's right to optimal sexual and reproductive health and has committed itself to providing appropriate services if the Bill is passed.

Violence Against Women

In a recent study conducted by the Human Rights Watch on violence against women in South Africa certain recommendations have been made to the South Africa government.[5] These include:

- ✧ the provision by government of effective and accessible health services that are specifically responsible for the examination and treatment of rape survivors and that are responsive to the needs of these women
- ✧ the setting of minimum standards for care provided by district medical officers that goes beyond the collection of medical evidence and includes medical treatment, emotional support and referral to the nearest counselling service
- ✧ the establishment of Rape Reporting Centres throughout the country and, particularly, in townships. Such facilities must be staffed by trained police and medical personnel to allow victims to report rape or battery, and, at the same time, to have access to examination and appropriate treatment and counselling
- ✧ the protection of the rights of rape victims to abortion without discrimination.

This report confirms the observation made in the 1995 review that information on violence against women is patchy and of poor quality. It also points out that the prevalence of violence against women in South Africa is amongst the highest in the world.

Information

National Health Information System

Within the proposed National Health Information System (NHIS/SA), a number of finite indicators have been developed to monitor trends in the health status of mothers, women and children and to evaluate the impact of MCWH services and programmes (Table 16.1).[2]

TABLE 16.1 NATIONAL INDICATORS FOR THE MONITORING OF THE HEALTH STATUS OF MOTHERS WOMEN AND CHILDREN IN SOUTH AFRICA

	GOALS	OBJECTIVES	INDICATORS
(a)	To reduce maternal, mortality and morbibity	Reduce the maternal mortality rate by 50%.	Maternal Mortality Rate.
		Ensure that 75% of all maternity facilities are "mother and baby-friendly".	Proportion of all hospitals and maternity facilities which are "baby-friendly", according to the global Baby-Friendly Hospital Initiative.
		Increase the proportion of deliveries in institutions with trained birth attendants to 90%.	Proportion of deliveries in institutions attended by trained personnel.
		Increase the proportion of pregnant women who are immunised against tetanus to 80%.	Proportion of pregnant women immunised against tetanus.
		Increase the proportion of pregnant women who receive antenatal care to 90%.	Proportion of pregnant women who receive antenatal care within the first, second and third trimester of pregnancy.
		Increase clinic attendance for contraceptive and family planning services.	Clinical attendance for contraceptive and family planning services.
(b)	To reduce infant and child mortality and morbidity	Reduce the infant and under 5 child mortality rate by 30%, and reduce disparities in mortality between population groups.	Cause-specific neonatal, post-neonatal, infant and ‹5 mortality rate.
		Reduce the prevalence of low birth weight to 10% of all live births. (Baseline: estimated current prevalence is approximately 15%)	Proportion of infants with birth weight ‹2 500 gms
		Increase immunisation coverage among children of one year of age against diphtheria, pertussis, tetanus, measles, poliomyelitis, hepatitis and tuberculosis to at least 80% in all districts, and to 90% nationally.	Proportion of children immunised against diphtheria, pertussis, tetanus, polio, hepatitis, tuberculosis and measles before their first birthday.
		Eradicate poliomyelitis by 1998.	Annual number of reported cases of acute flaccid paralysis.
		Reduce neonatal tetanus	Incidence of neonatal tetanus

Source: Department of Health, Towards a National Health System in Year 2000 Health goals, objectives and indicators for South Africa, 1995

Mothers and Women

Maternal Mortality Rate

There is no reliable figure for the maternal mortality rate (MMR), its variation between different population groups and the trends over time.[6] Estimates that have been produced from different sources are widely discrepant and each have their own methodological flaws (Table 16.2). Problems associated with the provision of accurate national MMR's are cited as: paucity of data on the proportion of home deliveries in South Africa; the exclusion from health service data of deaths from the private sector and home deliveries; under-reporting and misclassification in national vital registration and surveillance systems.

TABLE 16.2 ESTIMATES OF MATERNAL MORTALITY IN SOUTH AFRICA

DATA SOURCE	YEAR	MATERNAL MORTALITY RATE (per 100 000 live births)				
		White	Asian	Coloured	Black	Total
Hospital-based (Edendale - PMB)	1973				454	
Hospital-based (267 hospitals in SA)	1980-82					84
Hospitals and MOU's (Cape Peninsula)	1981-83			38	52	
Hospital-based (Pelonomi - Bloem)	1983				287	
Population-based survey (KwaZulu/Natal)	1983				550	
Hospital-based (King Edward - Durban)	1984				170	
Vital Statistics (Whole of SA)	1989	8	5	22	32	
Vital Statistics (Whole of SA)	1990	3	15	30	23	
Indirect Demographic Technique (SA)	1991					258

Source: Crichton DA, Parkes JR.The principles of prevention of avoidable maternal death. S Afr Med J 1973;47:2005-2010.
Boes EGM. Maternal mortality in Southern Africa 1980-1982. S Afr Med J;71:158-161.
Van Coeverden de Groot HA. Maternal mortality in Cape Town 1978-1983. S Afr Med J 1986;69:797-802.
Cooreman BF, Cronje HS, Grobler CJF. Maternal deaths at Pelonomi hospital, Bloemfontein,1980-1995. S Afr Med J 1983;76:24-26.
Larsen JV, Msane CL, Monkhe MC.The fate of women who deliver at home in rural KwaZulu. S Afr Med J 1983;63:543-545.
Melrose SB. Maternal deaths at King Edward VIII hospital, Durban. S Afr Med J 1984;65:161-165.
Department of National Health and Population Development. Maternal mortality rate for 1989. Health Trends in South Africa 1991;7-11.
Department of National Health and Population Development. Maternal mortality rate for 1990. Health Trends in South Africa 1992;18-19.
Fawcus S *et al* . Measuring maternal mortality in South Africa (editorial). S Afr Med J;1986:403-406.

In the light of these problems it has been recommended that maternal mortality surveillance be incorporated into the NHIS/SA; that consideration be given to compulsory notification of maternal deaths; that vital registration be improved to provide data on maternal mortality; that population surveys be undertaken at regular intervals to estimate home-based mortality in areas where home deliveries are frequent; and that the system of confidential enquiries into maternal deaths be strengthened.[6]

National Health Systems Study

A recent national health systems study commissioned by the Department of Health generated substantial information on the quality of family planning, antenatal and postnatal services and elicited women's views on these services.[7] This report stressed the need to include additional services that specifically meet women's needs and suggested specific services that should be considered.

According to a recent hospital based study on incomplete abortion an estimated 425 women die each year from unsafe abortions while an estimated 12 847 women have unsafe abortions each year.[8] In this study the cost of treating incomplete abortion in hospital was estimated and the relationship between cost and severity examined (Table 16.3). The total costs of treating incomplete abortion cases in one year was estimated at R18 695 948.[9]

TABLE 16.3 ESTIMATED COST OF THE TREATMENT OF ABORTIONS BY SEVERITY AND LEVEL OF CARE.

SEVERITY CATEGORY	LEVEL OF CARE	
	District hospital	Tertiary hospital
Low	R212	R422
Middle	R441	R576
High	R834	R1 487

Source: Presentation to the parliamentary select committee on abortion on behalf of the Medical Research Council's Incomplete Abortion Research Group. Centre for Epidemiological Research in South Africa. Medical Research Council. 1995

These data suggest that abortions are responsible for a substantial number of preventable deaths in women. As these figures are hospital-based, they may underestimate the true prevalence of abortion-related deaths. Community-based data are needed to properly assess the size of this problem. An abortion policy that makes safe services accessible to more women is expected to reduce the cost of treating incomplete abortions.

Reported Rape

During 1994, 32 107 cases of rape were reported to the police.[5] This was a 16% increase from the previous year, translating to a yearly rate of 148.5 rape cases per 100 000 population. The need for an inter-departmental approach starting at national level is recommended as an effective way of beginning to address this problem.[5]

Women's Health Book

The first comprehensive book from South Africa on women's health has just been published.[10] It gives information that will contribute to the future development of woman-centred health systems research and policy.

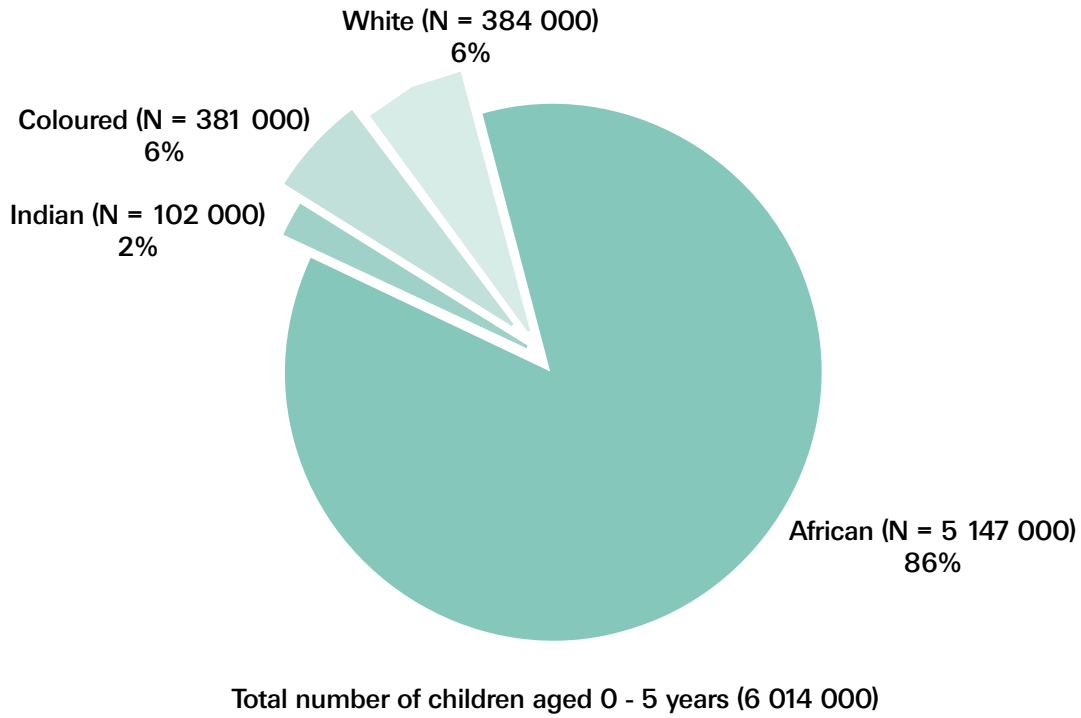
Health Systems Trust - Reproductive Health Research Fund

It is also anticipated that the recent establishment of the Reproductive Health Research Fund by the Health Systems Trust will enable a wide range of research activities to occur in this previously neglected area of work.

Children (0-5 years of age)

The 1991 census, supplemented by estimates of populations from the former "homelands", indicates that there are approximately 6 million children between 0-5 years, representing 16% of the total South African population.[11] A breakdown of children in this age group by race is presented in Figure 16.2.

FIGURE 16.2 PROPORTION OF CHILDREN AGED 5 YEARS OR YOUNGER BY RACE



Source: National Household Survey of Health Inequalities in South Africa. Prepared by the Community Agency for Social Enquiry (CASE) for the Kaiser Foundation,1995.

Infant Mortality Rates

Estimates of South African infant mortality rates over the past 5 years show large variations between 11 and 81 per thousand live births (Table 16.4). There is a need for reliable IMR's disaggregated, at least, by province but ideally by smaller geographical units. There is also a need for recent estimates of perinatal, neonatal and under-five mortality within the same categories.

TABLE 16.4 ESTIMATES OF THE SOUTH AFRICAN INFANT MORTALITY RATE

YEAR	IMR per 1 000 live births
1990	40.2
1991	46.0
1992	71.0
1993	11.0
1994	81.0

Source: Development Bank of South Africa 1990
Department of Welfare 1991
United Nations Children's Fund 1992
October Household Survey 1993
South African Labour and Development Research Unit 1994

Household Survey of Health Inequalities in South Africa

A recent household survey of health inequalities in South Africa still shows enormous disparities between different racial groups and has major implications for policy and planning in child health.[11] 70% of African children live in rural areas (58% in former homelands and 12% on white-owned farms) in contrast to children in other race groups who live predominantly in urban areas. A large proportion of African children live in provinces in which the former homelands were located, namely 24% in KwaZulu-Natal, 21% in the Eastern Cape and 19% in the Northern Province, compared with 9% in Gauteng, 2% in the Western Cape and 1% in the Northern Cape. Some of the disparities in household conditions between children from different racial groups are summarised in Table 16.5.

TABLE 16.5 DISPARITIES IN HOUSEHOLD CONDITIONS BETWEEN CHILDREN FROM DIFFERENT RACE GROUPS

	% of Race Group Affected			
Household Condition	White	Coloured	Indian	African
Formal Brick House	±100%	±100%	±100%	58%
Overcrowding	1%	57%	17%	66%
Below Minimum Living Level	3%	31%	14%	76%
No Electricity	-	-	-	70%
Water fetched from River, Stream or Borehole	-	-	-	32%
No Toilet	-	-	-	22%

Source: National Household Survey of Health Inequalities in South Africa. Prepared by the Community Agency for Social Enquiry (CASE) for the Kaiser Foundation, 1995.

In the same national survey five out of six children (84%) were found to have been breast fed at some time. There was a higher prevalence and duration of breast feeding in African children, in children from rural provinces and from poorer socio-economic circumstances and in those children whose mothers had lower levels of education.

National Survey of Children aged 6-71 months

A 1994 national survey of children aged 6-71 months has provided useful up-to-date information on the vaccination coverage, anthropometric status and the vitamin A and iron status of preschool children.[12]

One in three (33%) of children were found to have a marginal vitamin A status (‹20 micrograms per decalitre) indicating that vitamin A deficiency is a serious public health problem in this country. In reviewing iron status, one in five children was found to be anaemic, one in ten was iron depleted, one

in twenty severely iron depleted and one in twenty also had iron deficiency anaemia. Children under the age of 2 years and living in urban areas were more commonly iron depleted.

Vaccination Coverage

The most optimistic estimate of vaccination coverage in South Africa, based on both documented and recalled doses, shows high coverage - 95.2% for BCG gradually decreasing to 85.5% for measles (Table 16.6). This estimate obscures regional differences but even provinces with large former homelands, such as Eastern Cape and KwaZulu-Natal have relatively high coverage. 74.4% of children were fully vaccinated with BCG, measles and 3 doses each of DTP and OPV and 63.3% had received these antigens in the first year of life as prescribed. Children in rural areas had significantly lower vaccination coverage than those in urban areas.

TABLE 16.6 IMMUNISATION COVERAGE OF CHILDREN 12-23 MONTHS OF AGE BY PROVINCE.

		BCG	DTP 1	DTP 2	DTP 3	OPV 1	OPV 2	OPV 3	Measles	All
Northern Cape	Documented	83.5	82.3	80.6	77.2	78.2	76.6	74.2	76.6	69.6
	Document & Recall	98.2	94.8	91.6	87.0	92.5	90.3	86.8	88.6	80.6
Western Cape	Documented	83.4	84.5	82.8	76.2	79.8	77.4	71.5	83.9	69.7
	Document & Recall	98.2	97.0	94.7	85.7	92.3	90.5	81.0	95.2	80.4
Eastern Cape	Documented	78.9	75.9	71.7	64.2	72.1	66.8	59.2	64.5	50.5
	Document & Recall	92.1	84.9	79.6	70.2	81.1	74.7	65.6	71.6	58.0
KwaZulu-Natal	Documented	69.6	71.1	66.9	56.7	70.4	66.9	56.3	68.8	53.9
	Document & Recall	94.2	91.4	86.4	73.1	91.1	86.4	72.7	86.0	70.7
Mpumalanga	Documented	77.8	78.2	75.4	73.0	76.6	73.4	71.0	69.5	64.3
	Document & Recall	93.8	90.6	87.8	84.2	89.0	85.8	81.8	78.6	73.8
Northern Province	Documented	83.0	86.2	85.8	81.2	85.1	84.1	79.1	83.0	73.1
	Document & Recall	96.1	95.4	94.7	89.7	93.6	92.6	87.2	91.5	84.4
Gauteng	Documented	80.5	82.5	80.9	76.1	81.5	80.9	75.6	77.2	71.4
	Document & Recall	98.4	97.3	95.7	88.8	95.7	95.2	87.7	89.3	85.1
North West	Documented	85.2	86.5	84.0	80.3	84.8	82.6	78.9	81.5	74.9
	Document & Recall	96.6	93.1	90.7	86.4	91.4	89.4	85.0	87.7	82.0
Free State	Documented	77.6	79.6	76.5	70.2	76.5	74.6	68.8	72.9	62.8
	Document & Recall	96.2	91.9	86.9	80.6	87.7	85.0	78.8	82.9	72.7
South Africa	Documented	78.4	79.3	76.5	70.1	77.3	74.6	68.1	73.8	63.0
	Document & Recall	95.2	92.0	88.6	80.6	89.9	86.7	78.5	84.5	74.4

Source: Department of Health. Children aged 6 to 71 months in South Africa, 1994: their anthropometric, vitamin A, iron and immunisation coverage status. Epidemiological Comments 1995;22(9):185-214.

Nutritional Status

Anthropometric assessment identified one in four children as stunted and one in ten as underweight for age. This confirms that chronic undernutrition is still the dominant nutritional problem in preschool children. The policy implications of this finding will be discussed later.

Congenital Anomalies

Incidence data on congenital anomalies in rural black South African neonates (± 15 per 1 000 live births) suggests that genetic services should be given a higher priority than has previously been the case.[13] Neural tube defects (3.6 per 1 000) and Down's Syndrome (2.1 per 1 000), both potentially preventable through prenatal screening, represent a significant proportion of these anomalies. Folate supplementation offers a simple strategy for the primary prevention of neural tube defects.[14]

Children in Distress

Against a backdrop of a rapidly evolving HIV/AIDS epidemic, a 1995 report from KwaZulu-Natal focuses on the impact of social disruption and the epidemic itself on the care of children in difficult circumstances.[15] A representative survey in urban, peri-urban and rural communities around Pietermaritzburg reveals that 19% of children do not live with their mothers. 48% of these children

have been displaced, usually because of the mother's entry into a new relationship, 32% have been orphaned and 11% have been abandoned. 90% of these children are accommodated within their family network and 78% of households within these communities show a willingness to care for similar children in distress. Given the widespread social disruption in communities, national data are required on the prevalence of children in difficult circumstances and community responses to children in need of care.

Children (6-15 years of age)

Community Agency for Social Enquiry (CASE)

In the CASE survey only 3% of children in this age range were perceived by their caregivers to have any health problems.[11] No specific morbidity data was collected. The authors suggested that, having survived infancy and early childhood, poverty has a less noticeable effect on the health status of children of school-going age.

Anthropometric Survey of School Entrants

In a national anthropometric survey of school entrants in 1994, 2.6% of children were underweight for height or 'wasted', 9.0% were underweight for age and 13.2% were underheight for age or 'stunted'.[9] This mirrors the pattern in younger children. This study identified regions and districts in which there were higher prevalences of wasting, stunting or underweight, and which should be preferentially targeted for the implementation of integrated nutrition programmes.

There is clearly a need for more comprehensive morbidity and mortality data in children of school-going age.

IMPLEMENTATION

National MCWH Directorate

The national MCWH directorate, based within the chief directorate of national programmes, has been established and staff appointed. Directorates or subdirectorates for MCWH have also been established in the majority of the 9 provinces. Assessments of provincial MCWH priorities and resources have been completed and presented to the national directorate. The great disparity between provinces in the health status of their mothers, women and children and in the available material and human resources to address these problems is clearly evident.

The implementation of policy arising from the MCHW document has, generally, been slower than anticipated. Two main reasons have been cited for this, namely the delay in setting up the relevant structures and lack of human resources.[17] In addition appointments in the provinces have often been held up by their slow passage through the Public Services Commission.

The key to the implementation of the national MCWH goals and objectives is the development of districts. Progress in this regard is described further in Chapter 17.

Mothers and Women

National Cervical Screening Programme

A start has been made with the setting up of a national cervical screening programme. This will require a number of essential steps including education programmes for both service users and service providers, upgrading of pap smear-taking skills, logistical planning and programme monitoring. The Free State and KwaZulu-Natal provinces have been given the task by national government to implement a province-wide screening programme. Pilot projects are also being encouraged by government in other circumscribed areas of the country.[17]

Women's Health Card

The women's sub-directorate of the MCWH directorate has supported a national initiative to develop a women's health card. This card, based on the concept of the Road to Health card for under-fives, will provide a patient-held continuous health record for women. This card is in final draft form and will be introduced in the very near future.

Distance Education Initiatives

Distance education initiatives such as the Decentralised Education Programme in Advanced Midwifery and Neonatal Nursing and the Perinatal Education Programme, are being implemented in a number of the provinces. The AIDS Directorate is engaged in training trainers in the use of the female condom. Protocols for post abortion care are being developed.

An Integrated Approach to Developing Women-centred Services

Departments of Health in the Northern, North West and Northern Cape provinces are currently engaged in a programme, with technical input from the Women's Health Project, which aims to enhance the quality and comprehensive nature of existing services through the following strategies:

- **A situation analysis of the capacity of the existing services to provide comprehensive services**
- **Workshops with service providers to explore client provider relationships from a health worker perspective, using the manual "Health workers for change".[18]**
- **Increasing consumer awareness and demand for services in the communities**
- **Evaluation of the existing basic and in-service education for nurses**
- **Gender and health workshops for service providers and senior management;**

This integrated approach will also address overall management issues including district health systems and specific aspects such as the provision of integrated STD, family planning, maternal health, cervical screening, abortion and prevention and management of violence against women. The next phase of this project in 1997 will develop and implement strategies to extend and improve services on the basis of issues identified in the initial study.

Children and Adolescents

National Programme

Specific national programmes, such as the Expanded Programme on Immunisation, nutrition programmes (facility-based, school-based and community-based) and programmes for the control of diarrhoeal diseases and acute respiratory infections have been initiated and will have impact on the MCWH goals and objectives. Some of these programmes are driven by parallel directorates, such as nutrition and communicable diseases. There are already indications that these complementary programmes, directed at similar target groups, may not be sufficiently aware of each others activities.

Sub-national polio campaigns were conducted between June and August 1995 in all provinces besides the Western Cape and reached almost 90% of targeted children.[19] A measles and polio vaccination campaign was repeated in August and September 1996. At least part of the rationale for these campaigns was the fact that South Africa is approaching polio-free status - the last proven case was notified in 1991. There is a real prospect for the elimination of both polio and neonatal tetanus in South Africa and national strategies to achieve this goal must be implemented at all levels of the health system.

Presidential Lead Programmes

The two presidential lead programmes, viz. the primary school nutrition programme and implementation of free health care, are discussed in Chapters 13 and 14 but merit some mention in a review of maternal, child and women's health. The free care policy has resulted in increased attendance at public health facilities by both pregnant women and children under the age of six years.[20] It is too early to say whether this has had a beneficial impact on the health status of this target group but conventional wisdom would predict such a benefit. An unintended consequence of this policy has been the inappropriate over-utilisation of second and third level facilities in areas where first level PHC facilities are inadequate.

The Primary School Nutrition programme has temporarily alleviated hunger in large numbers of pupils from needy areas all over South Africa. However numerous weaknesses have emerged which urgently need to be addressed.[21]

National Programme of Action

The National Programme of Action for children is being strongly promoted by the Department of Health with the backing of UNICEF, and is largely being driven through the MCWH directorates at national and provincial level. The National Programme of Action is a broad-based consortium of governmental departments, non-governmental organisations and community-based organisations from different sectors, such as health, education and welfare. It monitors the implementation of the Convention of the Rights of the Child and lobbies at all levels to ensure that the survival, development and protection of children remains on national agendas.

FUTURE POLICIES AND STRATEGIES

Policy

A national programme concerned with the health of women mothers and children gains its prominence from three important facts - that it targets a large proportion (73%) of the total population, that groups within it are particularly vulnerable to ill-health, and that insults to their health often have long-standing consequences both for the individuals concerned and for the rest of the population. Since it is concerned with a population group rather than with a particular health issue, it straddles the policies of other programme directorates that target mothers, women and children. This applies particularly to the national nutrition programme, largely dedicated to the same target group, and to an important but lesser extent, to the HIV/AIDS and communicable diseases programmes. This overlap of targets and objectives has implications for the way these different programmes are conceptualised and organised, especially at a provincial and district level.

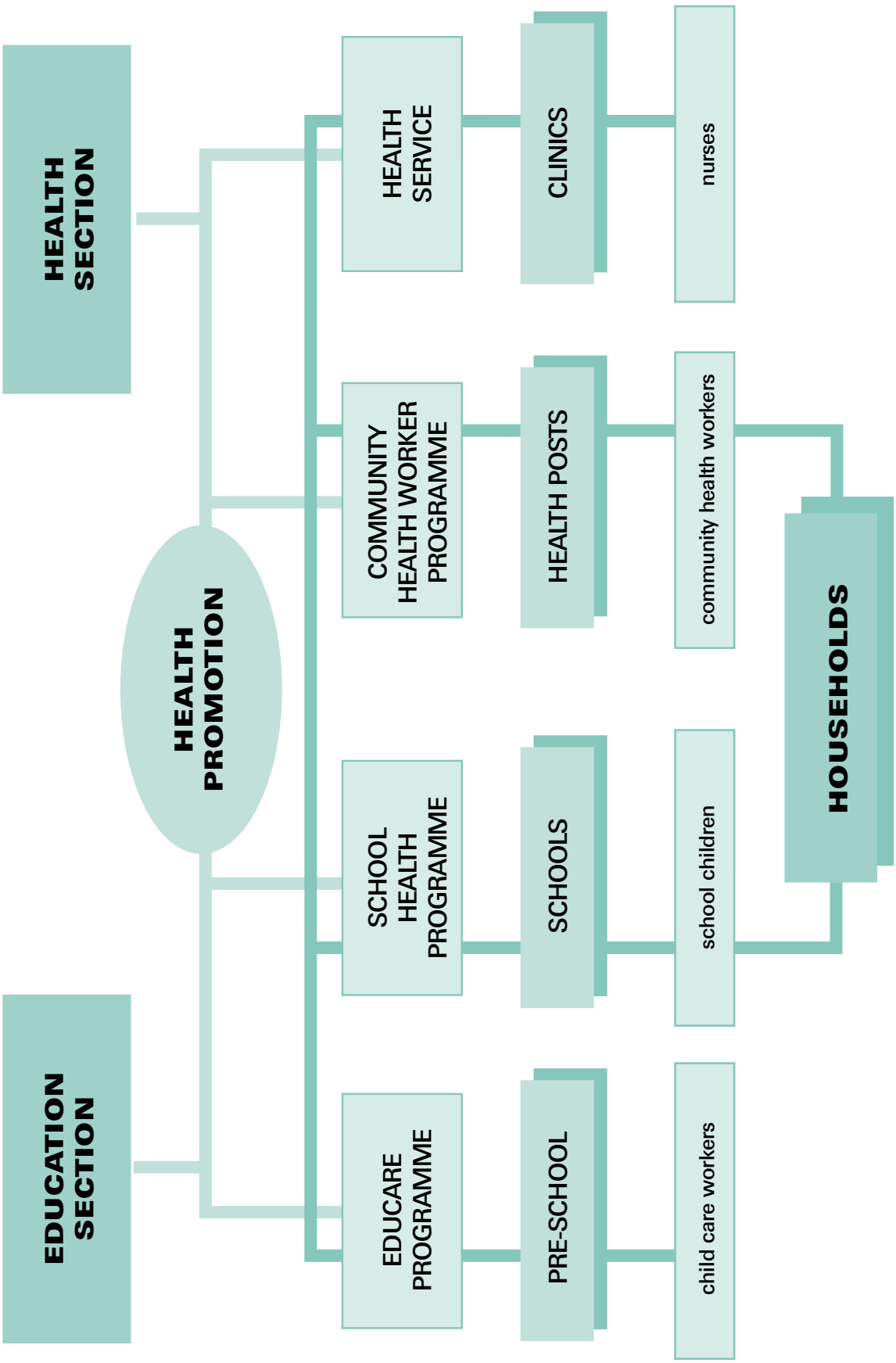
The implementation of comprehensive and integrated MCWH services and programmes requires a health system framework at a district level that co-ordinates the different programmes within the health sector and also promotes collaboration between health and health-related sectors, such as education, welfare and agriculture. Models and frameworks of this kind are badly needed. There is a particular need, for reasons already mentioned, to co-ordinate nutrition and Expanded Programme on Immunisation activities with those emanating from the MCWH programme. There is a real danger that national programmes with strongly driven central agendas and often with dedicated resources may swamp attempts at setting up integrated programmes within the district.

The Child Health Project in the Valley of a Thousand Hills

There are four potential channels or sites through which children can be regularly accessed for health interventions in most districts, viz. health professionals at clinics, community health workers at homes, teachers and nurses at schools and child care workers at creches. These personnel and facilities are present in most health districts in KwaZulu-Natal, though they may vary considerably in their capacity, degree of development and ability to reach large numbers of children for health promotion.

These observations and principles have informed the development of a *site-based model* which links health and education sector activities in the KwaDedangendlale district, which and integrates child health services with child health promotion activities provided at schools, creches and homes. In the operational area of the Valley Trust the health post (sub-centre) is an additional fixed facility one step down from the fixed clinic that is used as a base for community health workers and as a visiting point for mobile clinics. This model has been used as a framework to co-ordinate and integrate existing child health activities around the sites where they occur and as a point of purchase for future activities or programmes that target the under-fives. By providing a relational framework for all child health activities within the district, this model makes it possible to incorporate national directives for disease-specific programmes so that they supplement rather than interfere with existing child health strategies.

FIGURE 16.3 CHILD HEALTH PROMOTION AT THE DISTRICT LEVEL - A SITE-BASED MODEL



Source: Solarsh G, Brookes H, Radebe G, Ngubo T. Child Health Project, Valley Trust

Mothers and Women

There is inadequate development of policies relating to women's health in the existing MCWH document, which views women as child bearers and as people at risk for sexually transmitted diseases. While these are valid and important issues, it is necessary to acknowledge that women have a lower social status than men and that this has negative consequences for womens's health.[22] A lead in this direction has been provided in the "Plan of Action for South Africa", arising from the 1995 Beijing conference on women, but these ideas will need to be incorporated into national health policies and programmes.

Following the provision of clear legal guidelines on abortions in South Africa, which now seems imminent, there will be an urgent need to formulate a clear policy on safe abortion and this will need to be integrated into programme development at district level.

Children and adolescents

The overall health status of rural under-fives continues to be worse than that of their peers in urban areas. Priority should therefore be given to the plight of rural children and to provinces and districts where the majority of these children reside.

The task of identifying and accessing preschool children in greatest need, especially in rural areas, has proven to be very difficult and has bedevilled attempts to implement national programmes such as the National Nutrition and Social Development Programme. Child health services at fixed and mobile clinics have functioned largely as immunisation clinics and have therefore not provided access to most preschool children for preventive and promotive care beyond 6 to 12 months of age.[23] The most vaunted strategy for reaching these children beyond the period of regular clinic attendance has been through community-based health promotion programmes organised around community health workers (CHW). Doubts about the efficacy of CHW programmes has resulted in luke-warm support for them from the Department of Health (see Chapter 7). There remains a strong lobby for these programmes amongst many who believe that their failure to demonstrate measurable benefits lies with poor supervision and organisation rather than with intrinsic limitations of the programmes themselves. It now seems likely that further training of CHW's will be suspended and that existing CHW programmes will be maintained at the discretion of district health managers within the priorities and constraints of district health system budgets.

This policy decision places greater pressure on facility-based child health services to achieve the objectives and targets of the MCWH programme using different strategies. Since most of the important child health problems and interventions have their onset and greatest impact during the first 1-2 years of life, it is suggested that child health services should aim to achieve attendance rates above 85% for all children under 2 years of age - monthly in the first year of life and two monthly in the second year of life. Thereafter only those children with identified problems should require on-going surveillance. Unless the attendance of young children at these facilities both increases and extends over a longer period of time, facility-based child health programmes will have limited additional impact.

Expansion of the creche and preschool sector will provide institutional access to children between 3-5 years of life for health promotion activities. At present relatively small numbers of children attend these facilities in most areas, facilities are often very rudimentary and undeveloped and child health workers are not equipped to make meaningful health interventions. Attempts must be made to provide greater linkage between the child health services and health promotion activities taking place in these educare centres and the formal educational sector.

The care and nurturing of children, traditionally the role of parents within supportive family structures, is surfacing as a health issue that is worthy of a separate and specific focus in the promotion of child health in South Africa. The UNICEF conceptual framework for nutritional interventions has for some time identified inadequate maternal and child care as an important underlying cause of childhood malnutrition and has allocated this issue a central and pivotal place within its framework for nutritional interventions.[24] This focus has been incorporated into the strategy of the National Nutrition Programme in South Africa.

The rising HIV/AIDS epidemic is poised to add considerably to the large number of South African children already in need of care as a result of social breakdown and the high level of violence in some communities. This will rapidly overwhelm the capacity of families and communities to care for these children and requires a governmental strategy to deal with this crisis that includes alternative models of care. It also emphasises the importance of greater communication and joint planning between the Departments of Health and Welfare.

Information

There is a critical need for up-to-date and reliable maternal, infant and child mortality rates, morbidity profiles and indicators of MCWH service coverage. These data should ideally be available by province and, wherever possible, by region and district. 'Action-led' information systems of this kind will enable administrative units responsible for service delivery and programme implementation to set targets, evaluate their own progress and plan rationally for the future.

It is hoped that the Demographic and Health Survey planned for 1997 will generate useful and much needed information on women's health status in South Africa (see Chapter 1). The main purpose of this survey is to provide a reliable baseline of important health and health-related indicators, many of which are only available from household surveys, and to fill some of the data gaps referred to repeatedly in the *South African Health Review 1995*.

Implementation

Mothers and Women

The promotion of the health of women need to be given a higher priority within the comprehensive primary health care strategy. Clinic-based programmes are needed to promote women's health and, specifically, to prevent violence against women and to support women with special needs. Current training of health workers does not equip them to deal effectively with victims and survivors of violence.[25]

Immediate implementation priorities in relation to maternal and women's health are the reorientation of services, service provider attitudes and training, the improvement of the quality of care in maternal and family planning services and the introduction of a cervical screening programme. An attempt should be made to target those changes that do not require major financial inputs.

Pilot projects should be set up at a district level to:

- address violence against women
- improve collaboration between health services and communities
- test the acceptability and effectiveness of barrier methods
- deliver emergency contraception
- reduce deaths from unsafe abortions.

Children and adolescents

Vaccination coverage for South Africa as a whole has been shown to be higher than expected from routine reporting and substantially higher than averages for the World Health Organisation African region. A surveillance system for vaccine-preventable diseases should be used for rapid reporting, identification of outbreaks and targeted immunisation campaigns. Concerted efforts need to be made in rural districts to further boost coverage.

Routine administration of high dose vitamin A capsules twice a year during the first 3 years of life must be introduced as soon as possible. This should be instituted through the CHW programme, where operative, or at mobile and fixed PHC clinics, though achieving coverage at clinics beyond 12 months may pose some difficulties. High dose vitamin A must also be administered to all children who present with measles, malnutrition or diarrhoea. All doses administered should be recorded on the Road to Health Card. Lactating mothers must also be given high dose vitamin A within the first month postpartum. The fortification of foods is likely to be a more sustainable strategy in the longer term. Iron supplementation during infancy from 3 months of age in full term infants and from 6 weeks of age in preterm infants may be a feasible strategy and may provide additional incentive for monthly clinic attendance and for continuation beyond completion of the primary course of vaccination at 9 months. Food fortification with iron also needs to be investigated. Folate fortification of foods consumed frequently by young women is needed to boost folate stores in women prior to conception and thereby to decrease the incidence of neural tube defects.

Individual growth monitoring at all visits during the first 2 years of life will form part of routine facility-based and community-based approaches to nutrition promotion. Early detection of growth faltering followed by appropriate intervention will probably be more effective in dealing with wasting than with stunting which is the main problem in South Africa. Attempts to intervene in the genesis of stunting will require strategies that are broad-based, commence early in pregnancy and involve multi-sectoral inputs.

Although more accurate and reliable IMR estimates are needed for South African children, a review of the data suggests that the national IMR is probably somewhere between 40-50 per thousand live births - a relatively modest figure by African standards. We can expect a further drop in the IMR within the next few years as PHC services are established and greater access is provided to communities which make the greatest contribution to those rates. Since perinatal deaths have been shown to be responsible for up to half of infant mortality in many developing countries and are known to make a substantial contribution (± 33%) in South Africa, improved antenatal care, safe deliveries and better postnatal care should be immediate priorities in any national MCWH programme.[26]

Diarrhoeal disease, acute respiratory infections, communicable diseases and acute malnutrition will continue to be major problems in some parts of the country. However we already have a relatively high immunisation coverage and a low prevalence of wasting in many areas. As we continue to implement child survival strategies against a backdrop of falling IMR's, we need to be aware that more qualitative child health issues are likely to be increasing priorities in the very near future. These include the management and care of children with chronic illnesses, mental and physical handicap and morbidities with psycho-social origins. Our policies and plans will need to give increasing emphasis to these changing realities.

CONCLUSION AND RECOMMENDATIONS

- Health system frameworks are required that allow the implementation of comprehensive MCWH services and programmes at a district level and that, at the same time, enable the effective integration of national initiatives, such as the Expanded Programme on Immunisation.
- There is a critical need for up-to-date and reliable maternal, perinatal, infant and child mortality rates, morbidity profiles and indicators of MCWH service coverage.
- Policies and programmes concerned with the health of women need to be given a higher priority within the comprehensive primary health care strategy.
- There will be an urgent need to formulate a clear policy on safe abortion and this will need to be integrated into programme development at district level.
- Since perinatal deaths are known to make a substantial contribution in South Africa: improved antenatal care, safe deliveries and better postnatal care should be immediate priorities in any national MCWH programme.
- Priority should be given to programmes that focus on the health of rural children and to provinces and districts where the majority of these children reside.
- There is a need to develop operational systems that enable children under the age of five years to be targeted more effectively for health interventions.
- In order to improve the impact of clinic-based child health of the under-fives, regular attendance of young children at these facilities needs to both increase and to extend over a long period of time (up to the age of 2 years).
- Routine administration of high dose vitamin A capsules twice a year during the first 3 years of life must be introduced as soon as possible.
- Iron supplementation during infancy from 3 months of age in full term infants from 6 weeks of age in preterm infants should be introduced.
- Early detection of growth faltering followed by appropriate intervention will probably deal more effectively with wasting rather than stunting. Attempts to address problems of stunting will require a more broad based strategy.
- The care and nurturing of children, traditionally the role of parents within supportive family structures, is surfacing as a health issue that is worthy of a separate and specific focus in the promotion of child health in South Africa. The breakdown of traditional family structures and the increasing numbers of orphans and abandoned children requires a governmental strategy that includes alternative models of care.
- In the face of falling infant mortality rates, more qualitative child health issues are likely to be increasing priorities in the very near future. These include the management and care of children with chronic illnesses, mental and physical handicaps and morbidities with psycho-social origins.

17 DISTRICT SYSTEMS DEVELOPMENT

INTRODUCTION

The political transformation in our society which resulted from the April 1994 election ushered in new policy changes in all government sectors. Although most of the work on policy changes predated elections, the new democratic order gave new impetus to these processes. One area where tremendous strides have been made in policy changes in the post-April 1994 era has been health.

The key area in our health sector transformation has been the District Health System (DHS) model, a vehicle for the provision of the comprehensive primary health care (PHC). Although DHS is a new concept in South Africa, it has been overwhelmingly accepted and supported by the different role players.

This chapter attempts to review the policy changes in respect of the DHS. This critique will be presented in three parts; namely, the national policy formulation, implementation of districts and improved health care.

NATIONAL POLICY FORMULATION

Process Issues

Over the past eighteen months there has been extensive debates over the restructuring of the health services especially at the level of the district. This started with the formation in August 1994 of the national District Health Systems Committee, initially chaired by Dr T Wilson and now by Mr V R Mabope.[1] Similar committees but on a lower scale were formed at provincial level.

This process has been largely driven by the above committee except for two or three national consultative conferences where other role-players had a chance to influence the process. At the National Workshop held in Durban in December 1994, the following long term goal was unanimously agreed upon:

> **"To have a unitary national health service based on a district health system that allows access to everyone to improve their health. The country should be divided into geographically coherent functional health districts. There will be a single health service and health management team for each health district. The health system in each health district will be accountable to elected local government. A single local government body will be the employer of the health team. The health team will be responsible for providing comprehensive health services throughout the district up to and including community hospital level."[2]**

At the same workshop the Minister of Health indicated her flexibility and acceptance of any workable solution to the implementation of the DHS.

Almost all the role-players have accepted the definitions and the broad principles as enunciated.[1,3] Extensive debate exchanges centered around the issue of the transitional mechanisms and strategies from the present to the above shared goal. Three options were proposed and provinces had to make a decision as to the viable option in respective areas.[1] The uneven development of the health services both at inter- and intraprovincial levels compounded this.

The DHS policy changes have been driven by the national Health Department with full representation from all the provinces. Some provinces allowed other role-players to be part of this

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process at provincial level. The national committee, however, was conspicuous in its lack of representation from the local government and other stakeholders.[1]

While it is inconceivable that this wider representation would have improved the technical inputs, their presence and perspective would, it may be argued, have enhanced the process. It is most probable that the adversarial relationship between the local government officials and their counterparts in some provinces would have been avoided.

Decentralisation is a very sensitive political issue, and the early stages, therefore, require a great deal of consultation between all the authorities concerned in order to clarify the new roles and allay unfounded fears. The following quotation captures this argument:

> **"The "top-down" implementation by a strong central government of a new policy for decentralisation, without due regard for a process of consultation and adaptation, is very likely to fail. The policy may well be adopted but there is likely to be a wide gap between the intentions and the reality. Decentralisation implies greater responsibility and authority for local governments, organisations and communities, but it will only be accepted and made to work through a process of consultation that allows genuine "top-down" and "bottom-up" interaction. And that, it may be argued, is what decentralisation is all about."[4]**

This lack of extensive consultation has not only impeded the debate on governance issues (and choice on the different options), it has alienated some union groupings. The suspicion and mistrust (as shown by the union threats in the media) have failed the debate on equalisation of salaries and conditions of service for health workers in different government levels.

While it is conceded that consultations of community groups by the national DHS committee would be an enormous and daunting task, lack of attempts in this direction may later be viewed by the affected communities as paternalistic. In Papua New Guinea the danger of the provincial elite becoming over-powerful has also been recognised.[4] The point therefore is that while consultation does not come without cost, the principle of consultation should be maintained and will most likely outweigh those potential problems.

It should be noted that the process in the different provinces has not been uniform. Some provinces have shown openness and transparency and these are commended. The National Health Department as the driving force behind the national District Health Systems Committee has the responsibility to ensure wider consultation at all levels.

Issues On Content

Governance issues

There has been broad convergence of ideas on DHS governance issues. The difference of opinion revolves around which level of government authority should be responsible for the implementation of the DHS policy changes.

It may be argued that the decision should, technically speaking, be based on the balance of the need to decentralise (as supported by the long term goal) and the capacity at peripheral level to implement that. Without taking anything from the overall political or constitutional responsibility of the provinces, the position of most local governments is to consider capacity as the deciding factor. It is unfortunate and regrettable that some officials have turned this into a political decision.

There is lack of informative investigations on the capacity (or lack thereof) of local government to run the DHS. That would inform the committee and the provinces of which option to opt for. The choice of options should also not be on the basis of all-or-none. There should not be any major problem in having a combination of options even within one province.

Resource allocation and control

The issues of revenue generation and budgetary controls are the most sensitive. The most taxing question concerns how much power and responsibility should be devolved to lower levels of government (in both the deconcentration and decentralisation forms).[4]

Normally, funds would flow from the national to the lower tiers of government (because that reflects revenue generating capacity), and the proposal that some monies should be returned to provinces is legally and administratively questionable. Innovative mechanisms of resource allocation from the centre to achieve equity objectives without taking away from the base are both feasible and desirable.

Although much more financial independence for the lower tiers may be argued for, accountability is required and necessary. The question therefore would be whether funding should be based on output or outcome indicators. While the former reflects performance levels, the latter would satisfy the broad objectives of the province. Where managerial capacity at the local level is in place resource allocation based on outcome indicators may be preferable.

Salaries and conditions of service of the public health personnel

The human resource issue comes second in terms of sensitivity. One of the arguments put forward for the "provincialisation" of the local government health services has been the disparity of salaries and conditions of service between local government and provincial staff. The issue of parity of salaries and conditions of service is very complex. The committee decided to refer this issue to the working group that was established between the Ministry of Health, and the Ministry of Provincial Affairs and Constitutional Development.

This issue has to be understood within the context of the principle of a single employer of health workers within a DHS. The transfer of staff from one authority to another is unavoidable, and the technical question might be which of the two options is less costly. The issue of transfer of staff should not necessarily delay the implementation of the DHS. This could be negotiated and implemented on a phased basis.

The new salary agreement will definitely change the content of this debate. The new salary scales for the public sector employees (which will be phased in July 1996 and April 1997) will ensure greater parity with the larger local authority. It is however likely that these salary scales will exceed those of staff at small local authorities. Should salary parity be confined to the health sector, what are the implication of this on other sectors ?

The legal, constitutional and political complexities associated with our DHS policy changes in South Africa call for extensive consultation with the affected parties.

Community participation.

Community participation is a very complex and difficult concept to implement. While there is uniformity on the need and the desirability of this, the difficulty has always been how best to implement this.

The national committee has suggested Community Health Committees which will be formed from either a Community Development Forum or Community Health Forum.[1] The document also suggests that the District Health Council with representations from the Community Health Committees will be the governance structure in the district. District Hospital Boards with representation from the lower structures will govern district hospitals. The membership to these structures and their functions will be statutorily determined by the provincial legislation.

While some of these ideas indicate the commitment of the authorities on the issue of community participation and should be commended, the successful implementation will depend on their acceptance by the community (need for consultation), costs of setting up and maintaining these structures and other implementation practicalities.

It is therefore suggested that further and on-going consultation with communities be put in place and enabling legislation (rather than specific) be used for the establishment of these structures. This will accommodate different community dynamics in the development of the DHS. The development of these organisational structures should be phased in at the pace determined by the communities rather than that prescribed by the authorities.

IMPLEMENTATION OF THE DISTRICT HEALTH SYSTEM

The implementation of the District Health System has been slow. The unique nature of the different provinces in terms of their uneven development and the historical problems inherited from the past has caused some delays. In some cases there has been some difference of opinions between the provinces and the local governments.

In most of the provinces plans have been designed, provinces have been delineated into regions and health districts, and regional directors have been appointed to take the process forward. Progress on the approval by the Public Service of the regional organograms and the district manager posts has been reported from some provinces.[5]

In Gauteng province, the only province so far which has openly supported the local government option, regional directors are in place and the Interim District Management Teams are being developed.[6]

While there is a sense of urgency on the part of the provincial authorities, the issues are complex and not easy to resolve. Some of the problems cited by the provinces are the discrepancies in salaries and conditions of service between the different authorities.

The Department of Health in KwaZulu-Natal has selected eight participating districts to pilot the District Team Problem Solving technique. This technique was originally designed and field tested by the World Health Organisation and has been found to be an effective way of improving the delivery and management of PHC services in some countries.[7]

An example of the district health team in Kilmum (see the box) shows how different role-players in the district are brought together to first jointly analyse the problem and later attempt to solve it.[7]

On a biting cold morning, Alfina Mbanjwa has walked for four hours with a baby on her back with three other young children following behind. They have crossed three rivers with no bridges and walked over the craggy, mountainous terrain of Kilman to get to the mobile clinic to be immunised. This Wednesday, her trip was worthwhile - the mobile clinic has arrived. She has made the past two trips to no avail as rain had left the roads too muddy for the mobiles to get through. The two mobiles visit "Zuma's shop" and Mashayilanga, respectively, once a week, but the roads end just beyond these two points. Most of the district of Kilmun, which lies in the foothills of the Drakensberg near the Underberg, is accessible only by horse or by foot. Those who are too sick and weak to walk are carried to the clinic on a sledge. Abigail Ntleko, a sister at the Underberg health centre who organises the mobile clinic, says that the District Team Problem Solving programme has been set up to make inroads into the Kilmun district. Kilmun was targeted as it had the worst problems, the greatest poverty and the highest infant mortality and malnutrition rates.

In March the local induna convened a large gathering where the community discussed pressing health problems in the area. The information that out of the gathering was analysed by an elected health team at a workshop and diarrhoea emerged as the problem. The community elected two of its members and a traditional healer to serve on the health team. Other members of the team were Abigail, nurse Antonia Masiko and Dr Alistair Bull.

Antonia said all members of the team have differing impressions of which of the multitude of problems in the area was the most pressing. The initial workshop was invaluable in identifying the central problem and focusing the efforts of the team. The Kilmun health team embarked on a survey to determine the pattern of diarrhoea in the district. Team members chose a sample and walked from door to door, of scattered homesteads, findings out how many children have died to diarrhoea, how survivors were treated and what caused the illness.

The health team has identified unpurified water, harmful medicine, bottle feeding and malnutrition as the contributing factors to be tackled within a year. The next step is to design a plan of action to reduce the incidence of diarrhoeal disease. Bhekani Mthembu, one of the community members elected on to the team, believes his understanding of the problem in the area is important in finding solutions. One of his tasks is to demonstrate to people ways of purifying water. However, he finds many only take in the information when a nurse is present. Rather than being disheartened, he believes this illustrates the importance of having the health services and the community work together as a team. Using the information and the presentation skills he learnt from the programme, he also teaches the community about malnutrition.

Alaistair Bull, a medical officer at the nearby St. Apollinaris Hospital in Centocow, is also a member of the team. He believes the project can give a vision of hope to the community. "It is a vision that comes from within the community, it is something they can do themselves", he says. The programme, he says, is about learning skills and knowing how to take the process forward and to motivate the community into accessing resources. "We go out and see depressing poverty-related illnesses and end up bringing half of them back. It makes us think about what we are achieving at the hospital." Because the problems rises out of poverty, underdevelopment and low health awareness, they can only be alleviated through community effort. Typical Western-style health care, based on a system of mobile clinics, will not be able to deliver effective care, he says. "Most of the area is inaccessible to clinics and another way has to be found. We need people trained in health care who live and work in the area." The programme hopes to take the focus beyond the hospital and to understand the circumstances people are living in so they can be treated more holistically. The programme is still in its early phases, but the team hopes to widen its scope by training other members of the community.

FIGURE17.1 PROGRESS ON THE IMPLEMENTATION OF A DISTRICT HEALTH SYSTEM

Source: HST Update, Issue No.17. 1996

While it is still early to assess the success (or lack of it) of this pilot project, it is important to mention certain factors which have an impact on this. The issue of resource allocation and the intersectoral collaboration are very critical for the success of these endeavors. Most of the problems isolated by these teams will need resources and if these are not forthcoming the teams will be demoralised and demotivated. Andrew Green says that a distinction ought to be made between strategic or allocative (resources) planning and operational planning (or activity), and emphasis on the latter should not made at the expense of the former.[8]

Quotations from the assessment of problems from the Paulpietersburg and Escourt districts respectively highlight the plight of these teams :

"Although the district health team in Paulpietersburg has come a long way, they have now reached the most difficult phase of the process - implementing the solution of their health problem. They will no doubt encounter major difficulties, both in obtaining resources and overcoming bureaucracies."; and

"Although every attempt has been made to make the district concept real in the pilot eight districts, there remains little clarity on boundaries, composition of district health authorities and management structures. This programme has operated on a "best-guess" approach, which has demonstrated that the transformation of health care need not necessarily be neutralised by unresolved political issues and policies. But at the same time, this lack of certainty has constrained developments. Most participants hold full-time positions and responsibilities elsewhere. At one level, the creation of these district teams remains artificial unless they are officially recognised and integrated into a single, concerted health strategy for that area."[7]

One area where debate is lacking is the discussion on the strategic shift of resources from the expensive curative and hospital services towards the PHC services. While Malcolm Segall concedes that it is difficult to substantially shift resources and maintains that redistribution of resources "can be achieved more practically over time by the judicious allocation of new resources", it is important that discussion on strategies to achieve this is commenced.[9]

IMPROVED HEALTH CARE

This is the optimal goal of the district health system development; attainment of the improved health care for our communities. Initiatives have been commenced by the Health System Trust with provincial Departments for a sustained multi-site support for the practical implementation of health sector development at local level.[6] It is envisaged that donor funding will be part of this process. These initiatives are still at consultation and preparatory phase and it would be difficult to make sound comments on these. It is however important to note that successful development of the DHS will depend on the successful and acceptable macro policies as much as micro initiatives.

CONCLUSION

An outline of the current status of the DHS development and critical comments on the process and the content of some of the policy changes were made.

The national committee has done a tremendous work in the development of these policy changes. This paper, however, tries to show that the issues are complex, there are many role players, and extensive consultations with these stakeholders is advisable.

It has been shown that the most sensitive and difficult areas in the decentralisation debate are the finances, community participation and human resources. These problems are not insurmountable and if the process of decentralisation is managed properly, South Africa will achieve good results. The paper also argues that diversified implementation of DHS by the provinces within broad policy guidelines should be allowed.

18 LEGISLATIVE REFORM

Although the Department of Health has drafted and circulated multiple policy documents during its first two years, little new national health legislation has been passed. Thus, legislation has played a very minor role in the transformation of the health system. As a result, major health policies are not backed by the force of law, leaving them vulnerable to legal challenges and severely limiting the authority of the Department to implement them.

Drafting and passing legislation is a difficult but essential task in the transformation of South African health care system. While laws, lawyers, and politicians are often viewed with disdain and mistrust by the South African public, laws must be at the heart of any efforts to affect long-term policy changes. Laws are the publicly agreed-upon rules that govern conduct within society. From a policymaker's perspective, laws provide the authority necessary to ensure swift and efficient implementation of policy proposals. Individuals who do not comply with laws are subject to the penalties prescribed. Because laws hold force in society, they remain in effect long after the policymakers have departed, creating permanence for the proposed reforms. In the absence of laws, policymakers must rely on their own moral authority to implement and enforce their ideas. Internal policy documents do not become legislation unless enacted by Parliament; therefore, internal policies are of no effect and no public interest at this stage.

THE NEW CONSTITUTION

During the past two years the Constitutional Assembly, composed of all members of the National Assembly and the Senate, with the notable exception of the Inkatha Freedom Party , who refused to participate in the process, worked to draft a New Constitution for South Africa. By most accounts, the constitutional drafting process was both participatory and inclusive, as evidenced by the more than two million public submissions received. The New Constitution is the "supreme law of the Republic" and as such it will have profound implications for health and development in South Africa. All legislation and policies must fall within the same spirit as the Constitution.

Bill of Rights

Chapter two of the New Constitution contains the Bill of Rights, the most fundamental rights of citizens by which all levels of government (and other individuals in some cases) are bound. The "Bill of Rights is the cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity; equality and freedom. The state must respect, protect, promote, and fulfil the rights in the Bill of Rights."[1]

Rights pertaining to health and development contained in the Interim Constitution have been expanded significantly in the final Constitution. The limited right to an environment that is not harmful to a person's health or well-being has been retained.[2] In addition, the state is required to take reasonable legislative and other measures to protect the environment for present and future generations.[3]

This change in conceptualisation from a negative right to a positive right should significantly expand its scope. Rather than the burden of proof resting solely with an individual to prove that the environment is detrimental to her / his health, the state must show that it is taking "reasonable legislative and other measures" to protect the environment.

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Beyond broadening the scope of environmental rights, specific health care rights also have been included. "Every person has the right to have access to:

(a) health care services, including reproductive health care
(b) sufficient food and clean water
(c) a social security system including, if they are unable to support themselves and their dependants, appropriate social assistance."[4]

Further, "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."[5] Again, this places the burden on the government to take measures to provide health care services, food, water, and social security to all South Africans. Finally, no one may be refused emergency medical treatment.[6]

Beyond health rights, a whole series of related rights should provide an enabling framework for improving the health of the population. The comprehensive rights of children, including the rights to basic nutrition, shelter, basic health care services, and social services, remain unchanged from the Interim to the Final Constitution.[7] Rights to adequate housing, basic education, including adult basic education, the right to life, the right to have their human dignity respected and protected, and access to any information held by the state should also promote conditions in South Africa that are conducive to development.[8, 9, 10, 11, 12]

In order to fully understand the scope of these new rights, certain important terms and phrases will need further clarification from the courts. "Anyone . . . has the right to approach a competent court alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief."[13] Civil society must approach the Constitutional Court to challenge the government concerning the precise definitions of "reasonable legislative and other measures," "progressive realisation" and "within its available resources" and the application of many of these rights as legal challenges arise.

Competency for Health Issues

In the New Constitution, health services have been listed as a concurrent functional area where legislation can be passed at both the National and Provincial levels. Additionally, national government and the provinces can delegate authority for concurrent issues like health care services to local authorities by means of national and provincial laws.

The Constitution calls for co-operation between the different levels of government. For example, National Parliament, comprised of the National Assembly and the National Council of Provinces, can pass national health legislative frameworks and acts that affect the entire Republic. Each province will pass provincial legislation to implement and regulate the delivery of health services. In the case of conflict between national and provincial laws, national legislation has precedence if certain conditions are met. National laws would prevail if:

- National uniformity is in the best interest of the country to establish norms and standards, frameworks and national priorities
- The issue cannot be "regulated effectively" by provinces individually
- It is necessary to preserve national security, economic unity, and protection of the common market, and promotion of equal access to government services
- It prevents unreasonable actions by a province, which would prejudice another province or impede implementation of national economic policy.[14]

An Act of Parliament must provide for appropriate mechanisms and procedures to settle intergovernmental disputes should they arise.[15] If these procedures are exhausted, the courts can then be asked to resolve these disputes. The Democratic Party has raised questions whether this reformulation of power sharing actually reduces the power of the provinces *vis-a-vis* the national government, violating one of the thirty-four constitutional principles agreed to at Kempton Park. Technical issues like this were considered by the Constitutional Court during July 1996.

NATIONAL HEALTH LEGISLATION

While the New Constitution pressurises the government to begin to improve the health care and social services provided to all South Africans, the Department of Health has passed no national health legislation to give legal substance to these promises for people on the ground. The Department of Health has drafted numerous policy documents and begun implementation on a series of health issues, but none of the proposals has the force of law. These documents serve as guides for public servants within the Ministry of Health for implementation of reforms, but they do not hold force for people outside the Ministry.

This lack of enabling legislation is troubling for many reasons. Because health services are listed as a concurrent responsibility of national and provincial governments, provinces are reluctant to introduce their legislative frameworks in the absence of a national framework. If a province develops its own enabling legislation before national legislation has been passed, there is a real possibility that provincial laws could later be overruled, causing administrative and political chaos. In the absence of legislation, the transformation framework has not been tested against the principles of the Constitution. Finally, without new enabling legislation, the Department could potentially find itself without legal support for its plans. They would have little scope to deal with persons who did not want to implement or comply with their proposed reforms. If challenged in the courts, the Department may find it difficult to defend their actions without legislation.

According to senior Department of Health officials, national health enabling legislation is currently being drafted and reviewed by national and provincial officials. The final bill is expected to be comprehensive, covering most aspects of the Department's work including district health development, national health system restructuring, transformation of hospital services and management, medicines and essential drug programmes, health information systems, and the Department's regulatory functions. According to the current time table, the final bill will be sent to the State Law Advisors by October 1996, with tabling in Parliament scheduled during the first session of 1997.

Until new enabling legislation is passed, however, South Africa remains subject to the Health Act of 1977 and a myriad of other conflicting health legislation from the apartheid era. If the drafting of new enabling legislation continues at its current pace, serious thought should be given to cleaning up conflicting laws in the interim.

If the policy development process is any indicator, it is unlikely that the health act will present an integrated framework for the new health system. Since the African National Congress's health plan was published in 1994, no unified vision for the transformation of the health system has been presented by the Department. The Department has not published a "white paper" on transformation, instead choosing to publish a series of separate policy recommendations. The role of national government is to co-ordinate activities happening at the provincial level and to create an enabling environment.

Instead of developing a broad, enabling framework, the Department of Health has chosen to take the lead on:

- ✧ developing a national health information system
- ✧ creating an essential drug programme
- ✧ establishing a district health system
- ✧ restructuring primary level care financing and delivery
- ✧ reforming hospital level services.

Although each of these projects is reforming a piece of the health system, the lack of an integrated development strategy reinforced by legislation could undermine these efforts in the long-term. People on the ground are already expressing confusion about the relationship between all of the different policy initiatives and the various acronyms associated with each.

Rather than using legislation to support implementation, the Department is trying to implement its plans based on its moral authority and public pressure. In late March, the Department released an official policy document entitled, Restructuring the National Health System for Universal Access to Primary Health Care, which contained a proposal to eliminate user fees for all primary level care services for all South Africans by 1 July 1996.[16] Although this policy change was not formally announced in the *Government Gazette* before 1 July and there is no legislation enforcing it, in practice, primary care user fees at clinics have been eliminated for all people to meet the public's expectations. Thus far, this approach has been successful because no one has challenged the Department's authority to carry out popular reforms. It is not clear that this strategy will work for more complex and controversial issues.

LEGISLATION ON SPECIFIC ISSUES

An *Ad Hoc* Select Committee on Abortion and Sterilisation was convened in August 1994 to review the Abortion and Sterilisation Act of 1975, to receive public comments on these issues, and to make recommendations on the way forward. The Committee, chaired by Dr S A Nkomo, received 452 written submissions and heard oral testimony from more than 100 persons between 9 May and 8 June 1995. On 29 June 1995, the Committee submitted its final report including specific recommendations to Parliament. The Committee recommended that the current Abortion and Sterilisation Act be repealed. In addition, it stated that abortion and sterilisation were different issues which should be dealt with separately.

The *Ad Hoc* Committee's report recommended that a new Termination of Pregnancy Act should provide for abortion at the request of the woman up to 14 weeks gestational age, and under certain broadly specified conditions between 14 and 24 weeks. Current requirements to consult with two doctors should be dropped and a wider range of health professionals should be trained and authorised to perform abortions to expand access. Voluntary counselling should be available to all women. Partner or parental consent should not be required. Anonymous statistics on abortion should be kept centrally. Finally, health workers with conscientious/religious objections should not be forced to perform abortions, but they must refer women to other health workers who would.[17]

The Termination of Pregnancy Bill was approved by Cabinet on 3 July 1996, and tabled in Parliament in September 1996.

Because of the considerable media attention that this issue received during 1995 and people's lack of understanding of the legislative process, many South African women believe that a new abortion law was passed last year. Consequently, women have begun queuing at hospitals like Groote Schuur in Cape Town requesting abortions. Because of budget constraints, however, Groote Schuur Hospital has set a maximum limit of 16 procedures per week, turning other women away. This brief account shows that delaying the introduction of legislation is not merely an academic concern. It can have real and sometimes tragic implications for South African women and men.

As reported in the South African Health Review 1995, National Parliament passed only four health-related acts during 1995. All four acts dealt with the creation of interim health professional councils responsible for registering, evaluating, and disciplining health professionals. These interim structures were created for two years and given the responsibility to draft legislation to "permanently" restructure themselves.

The South African Interim Nursing Council has drafted legislation to permanently reconstitute itself. This bill has been published in the *Government Gazette* and is awaiting introduction into Parliament. In response to the proposed bill, the National Education and Health Workers Union has staged a series of marches throughout the country to demand a single health professional council, funded by the Department of Health.

The South African Interim Medical and Dental Council is currently drafting a bill to finalise its composition, roles, functions, and authority. In early 1996, the interim structure called for public submissions on these issues. No consensus has been reach on several critical issues. Thus, it is unlikely that legislation will be introduced in Parliament during the second half of 1996.

During the first six months of 1996, the Department also has drafted numerous regulations to clarify and amend technical aspects of existing legislation. The majority of these regulations refer to the professional bodies and the registration and dispensing of medicines.

In the Department's official policy document about restructuring the health system, wide ranging reforms were proposed for the private health insurance and medical aid scheme markets. These reforms still need to be discussed by National Economic Development and Labour Advisory Council and the Katz Commission before any legislation is drafted. It is not clear when this private sector regulatory framework will be finalised and legislation drafted for consideration by Parliament.

PROVINCIAL HEALTH LEGISLATION

In the two years since the first democratic elections, no health-related bills have been passed at the provincial level. Without clarity from the national level, provinces have been reluctant to amend and rewrite provincial health legislation. Thus, the health services of each of the nine provinces continue to be governed by the previous laws of the four pre-1994 provinces, the former independent states, and self-governing territories that existed within provincial boundaries.[18] In some provinces many conflicting statutes exist, making the situation unworkable in the long-term. Even where there are no conflicts, provinces, like the national government, are operating under apartheid era health laws. With national enabling legislation due in 1997 at the earliest, it could be December 1997 or early 1998 before provincial health legislation is passed to harmonise previous health laws. It could take even longer to draft and enact new provincial legislation that fleshes out the national framework.

The South African Health Review 1995 reported that KwaZulu-Natal had made significant progress in drafting a new Provincial Health Act. This process moved forward during the past year. To expedite the legislative process and to reduce potential conflict with the Department of Health, the provincial department has divided health policy issues into two categories: matters that should be regulated by the province and matters that should be competencies of the Department of Health. New health legislation on non-controversial issues has been prepared for introduction into the provincial legislature during 1996. Senior provincial officials have expressed a commitment to enact enabling legislation on provincial health matters with or without clear direction from the national level.

The Free State provincial health department has drafted a bill to restructure hospital level services in the province. This bill is pending introduction into the provincial legislature. The bill attempts to rationalise hospital services, management, and staff in the province. It sets out policies governing admission and discharge of patients and the establishment of Hospital Boards. Finally, it establishes the province's authority to oversee private hospitals.[19] This draft bill draws many of its recommendations from the findings of the national Hospital Strategy Project that is advising the Department of Health on the transformation of hospital services and management.

The North West Province has drafted a bill which would establish community governance structures for the health and welfare system at the district level. The draft bill gives the Members of the Executive Council wide ranging powers to establish community health committees, district health committees and hospital boards. The bill specifies the composition, selection, powers, and functions, authority, and payment of these governance structures. It will be introduced for consideration in the provincial legislature during late 1996.

OTHER LEGISLATIVE DEVELOPMENTS AFFECTING HEALTH

The Sarafina 2 Controversy

Unfortunately, the biggest political story of 1996 involving the Department of Health did not relate to its transformation policies or legislative initiatives. The most publicised and criticised project of the year began in August 1995 when the Department of Health awarded a R 14.27 million contract to internationally acclaimed playwright Mbongeni Ngema to produce a sequel to the musical, Sarafina, about AIDS that would reach young people.

In late January 1996, many questions were raised about the Sarafina 2 project in the print media. At that time, journalists questioned the amount of money spent on a single play, the selection and tendering process which awarded the contract to Ngema, and the source of funding for the play. Further concerns were raised by AIDS activists about the lack of consultation around this initiative and the inappropriateness of the play's content and message to change youths' sexual behaviours.

The National Assembly Health Portfolio Committee invited Minister Zuma and senior health officials to a public meeting to discuss the play and related issues which had been raised. It was reported in the media that President Mandela intervened to cancel the Portfolio Committee hearing.[20] This claim was subsequently denied by the President's office. If true, this allegation raises serious concerns about the separation of powers between the executive and legislative branches of government. It also calls into question the ability of Parliament to independently carry out its duties to oversee government ministries as assigned by the Constitution.

Further, the reluctance of some members of the Health Portfolio Committee and Parliament to ask difficult questions of the Ministry of Health during its investigations raises serious questions about

the role of Parliament in ensuring transparency and accountability within government. According to the Standing Rules of the National Assembly, "a portfolio committee shall monitor, investigate, enquire into and make recommendations relating to any aspect of the legislative programme, budget, rationalisation, restructuring, functioning, organisation, structure, policy formulation or any other matter it may consider relevant, of the government department falling within the category of affairs assigned to the committee."[21] Among other duties, parliamentary portfolio committees are thus expected to serve as watchdogs over government departments to ensure that public funds are being spent appropriately and to ensure the accountability of the public administration to the people.

Because of the public controversy and the many unanswered questions about the play, the Office of the Public Protector decided to investigated the project at the request of Mr Mike Ellis, Member of Parliament for the Democratic Party. The Office of the Public Protector is mandated by the Constitution "to investigate any conduct in state affairs, or the public administration in any sphere of government, that is alleged or suspected to be improper or to result in any impropriety or prejudice."[22] The Public Protector's report found that awarding of the contract to Committed Artists was not in accordance with State or European Union tendering procedures making it an unauthorised expenditure[23] In addition, questions raised in the report about the poor drafting of the contract with Committed Artist because of the inexperience of the Department's legal advisors have serious implications for future health legislation.[24] As recommended by the Public Protector and others, upgrading of the Department's legal unit should be done with immediate effect.

The Sarafina 2 storm has left much political and economic damage in its wake. The credibility of Minister Zuma and senior Department officials has been severely damaged. The Public Protector's report notes that Minister Zuma and Dr Olive Shisana, Director General, misled Parliament and the media. The allegations and counter-allegations about the source of funding for the play between the European Union and the Department could jeopardise future international funding for the Department. The policy work of the Department was put on hold as this controversy unfolded. Drafts of a new Health Act and a new Abortion Bill were further delayed because of this crisis.

Parliament's inability to demand greater accountability on behalf of the public could adversely impact future international donor funding for the Department of Health, the Reconstruction and Development Programme (RDP), and the entire Government of National Unity. Perhaps the most distressing aspect of the entire débâcle was that the views of most South Africans were largely ignored because they do not have access to their democratically elected officials. If people on the ground had the advocacy skills needed to apply pressure to their elected officials and their civil servants, these officials may have made greater efforts to be more transparent and accountable.

Closing of the Reconstruction and Development Programme Office

Another political development with long lasting implications for health and development in South Africa was the announcement on 28 March 1996 by President Mandela of the closure of the RDP office as a result of a cabinet reshuffling. The RDP office was established as an intersectoral link to help solve the complex development problems facing the country. During its tenure, the RDP office expressed difficulties engaging line departments in intersectoral processes. Prospects for intersectoral collaboration look even more bleak without it.

The RDP was formulated as the cornerstone for development in South Africa. The RDP office also served as a contact point between government and civil society. Without the RDP office, it unclear what will happen to all the RDP structures established at local level to co-ordinate negotiations between civil society and government. Its sudden closure and the reassignment of responsibilities to line ministries without consultation threatens future partnerships between government and civil society which ultimately threatens development.

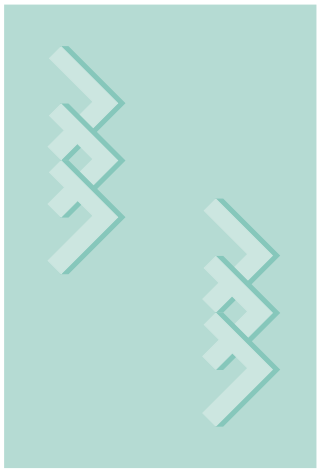
IMPLICATIONS

Unfortunately, this year's review of health legislation is not very encouraging. The only major positive legislative change occurred outside the Department of Health. The New Constitution includes the dramatic expansion of health and development rights that will impose obligations on the government to deliver quality health care services, food, and social security to all South Africans. This document will be provide much needed to leverage to advocates and community members to demand delivery from government.

There will be no national health act, however, in 1996. Without legislation, it is not clear on what authority the Department of Health will implement its policies. Thus far, no one has challenged the legal basis of their policies. The Public Protector questioned the capacity of the Department's Legal Unit and recommended its restructuring. Clearly, this is a matter of urgency. Without legislation, it is clear that the Department of Health will quickly fade from one of the "lead departments" to a developmental straggler.

The Sarafina 2 controversy raised serious doubts about the accountability of the Department of Health and Parliament. The media, non-government organisations and even a Supreme Court judge persistently questioned the degree of transparency exhibited by the Department of Health during the investigations, and subsequent agreement with an anonymous donor. Finally, the closure of the RDP office militates against joint planning and integrated development.

Practical health reform is clearly underway. But this reform needs to be supported by a systematic and comprehensive legislative programme if it is to be sustained and effective.



AN AGENDA FOR POLICY-DIRECTED RESEARCH

RATIONALE

A new health systems research agenda for South Africa should mirror the country's shift from policy formulation to the mechanics of implementation. In practice, this means support for research which is **linked to, and sustained through, the process of implementation**. Sites for research need to become more localised within districts, so that the impact of change can be more readily gauged.

Clearly, there is a need to continue to support policy development at national and provincial levels as well, as there are a number of significant policy decisions still to be made. Both emphases, of broad policy development and the nitty gritty of practical implementation, need to be nurtured side by side if health systems reform is to continue to be supported by relevant research.

FRAMEWORK

Underpinning this reform in South Africa are the principles of equity, efficiency, effectiveness, and accessibility of services. These principles should serve as the basis for a national health systems research agenda. Within this framework, some of the major areas of work are described below.

Equity

Resource allocation

Procedures for **allocating funds** from both national and provincial levels, and within districts, require further review and modification. At national level, the allocation formula for academic hospitals and supra-regional services is still being refined. Allocations to districts and sub-districts have yet to be developed. The specific research requirements should be formulated in conjunction with the Financial and Fiscal Commission.

Norms and standards for health care

Norms and standards related to the provision of resources for primary health care require further development. The Centre for Health Policy has done much of the groundwork, but the implementation of a minimum package of primary health care services in districts throughout the country requires further definition, implementation, costing and impact assessment.

Efficiency

Hospital efficiency

This work should aim to optimise hospital resources, and liberate resources for primary health care and extension of services to underserved areas. Much of the preliminary work has been done by the Hospital Strategy Project, but considerable work remains to be done to effect improvements in hospitals of all levels.

Key areas include:

- the implementation and evaluation of standard management procedures
- performance indicators linked to expenditure and outcome
- evaluation of rationalisation of services, diagnostic procedures etc.
- development of ambulatory services and evaluation of impact

Primary care facilities

Key areas include the development and evaluation of simple systems for:

- record keeping
- stock management and control
- patient screening and flow
- dispensing
- collecting, analysing, interpreting and presenting information

Primary health care services

Operational research can help to define standards of service provision with respect to each priority health problem. More efficient management can be brought about by the implementation and evaluation of simple, cost-effective strategies of prevention, promotion, treatment and rehabilitation.

Operational research for PHC

Health care element	Research area
Prevention	Development of clear protocols for preventive management of conditions Evaluation of impact of the above on patient management
Promotion	Formulation of simple, effective messages Simple, efficient methods of health promotion
Treatment	Sustained systems of clinical management support (including in-service training and means of rapid and less urgent referral or consultation)
Rehabilitation	Implementation and evaluation of recovery paths, referral systems and community-based support

Some of the priority areas include the management of: maternal and child health; sexually transmitted diseases/AIDS; other reproductive health services; priority communicable diseases (TB, infantile diarrhoeal disease, acute respiratory infection, and other immunisable illnesses); nutrition; mental health; and disability.

Pharmaceutical procurement, storage, distribution

It is estimated that losses of pharmaceuticals through theft amount to about R500 million per year, approximately 3% of the annual public health budget. Poor stock control and inventory keeping results in wastage, and/or use of expired medications. Theft often results in shortages of medication, and consequent inappropriate or inadequate dispensing. Efficient systems for procurement, storage and distribution are priorities within health care facilities, sub-districts, districts and provinces.

Information systems

As the National Health Information System evolves, initiatives which help define methods of collecting, analysing and presenting data require support. In addition, the implementation of new systems which form the backbone of National Health Information System of South Africa will require evaluation and review.

Particular effort needs to be made to design systems which link data analysis with plans of action. Two particularly pressing areas are the development of **district-based** information systems, and revision of the information collected by **environmental health officers**.

Financial systems

The design and implementation of simple cost-centres and accounting procedures related to performance within health facilities and districts is the first step toward greater efficiency in service provision.

Efficiency of non-government organisations

Non-government organisations need support in the development and testing of simple systems for: financial control; assessment and planning; monitoring; documentation; and evaluation. This will strengthen partnerships in service provision within districts.

Effectiveness

Human resources

Priority areas for research include:

- Appropriate composition of the frontline health team, and optimal use of various categories of personnel
- Functions of environmental health officers
- Optimal collaboration between non-government health providers and public sector
- Development of support systems for personnel, such as:
  - effective systems of communication
  - routine and easy access to information
  - effective programmes and processes for skills upgrading and continuing education

Community participation

Effective community participation will only be achieved if genuine mechanisms for participation are in place, and if community and non-government representatives are enabled to participate. Some of the key mechanisms which need to be demonstrated relate to district governance, district and sub-district management, and systems for collaboration between community-based organisations and public sector service providers. Equally important are the development of mechanisms which gauge community perceptions of health care provision, and establish simple, effective systems for day-to-day communication among all involved in service provision and management.

Training needs for community and non-government participants in health care governance, management and delivery should be assessed, addressed and re-evaluated.

Intersectoral collaboration

Some of the critical areas include: mechanisms for joint planning and management within districts; mechanisms for joint community-based programmes around problems in common; and the design of common communication and shared information systems

Effectiveness of Service delivery

Changes in health care should be measured in terms of their effect on:

- **Behaviour:** improved compliance and diminished risk-taking behaviour by clients
- **Severity and nature of illness presenting to health services**
- **Health service coverage public health outcomes**

Accessibility of services

Accessibility refers to: physical access; removal of language and cultural barriers; and alleviation of financial constraints and organisational arrangements which impede access. At national and provincial level, the introduction of a system of revenue collection which permits accessibility to necessary services requires design and evaluation. Locally, barriers to access need to be assessed and overcome.

AGENTS OF ACTION - NOT AGENTS OF PLANNING

Health systems researchers in South Africa have a choice. Either, they can see themselves as agents of planning. In other words, helping to clarify policy options and design systems of implementation. Or, they can see themselves as agents of action, in which case their task is not complete until the changes introduced are assessed in terms of their impact on health service delivery and even health outcome. Such researchers can help drive health systems reform from policy formulation and administrative restructuring to tangible change in health service delivery and the quality of people's lives.

At the end of the day, and in typically South African parlance, the question will be asked: "What difference did it all make to the people on the ground?" As agents of action, researchers can help define that difference in terms which will permit assessment of real change.

REFERENCES

Chapter 1

1 Chimere-Dan O. Demographic Patterns. In *The South African Review 1995.* Durban, Health Systems Trust and the Henry J. Kaiser Family Foundation, 1995

2 Department of Health. South African demographic and health survey: draft document for discussion. Coordinated by the SAMRC. 1996

3 Personal communication with Dr. D. Bradshaw, MRC. March 1996.

4 Personal communication with Dr. R. Hirshovitz, CSS. March 1996.

5 Ministry for Welfare and Population Development. A green paper for public discussion: population policy for South Africa? Pretoria, April 1995.

6 Van Zuydam J. Demographic transition versus democratic transformation - a critical overview of the population policy green paper, Second Annual Congress of the South African Sociological Association. July 1995.

7 African National Congress.A national health plan for South Africa. Johannesburg, 1994.

Chapter 2

1 United Nations. Copenhagen Declaration and Programme of Action. United Nations Press, 1995.

2 United Nations. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. 1994.

3 Department of Health. The white paper on the Reconstruction and Development Programme. Pretoria, 1994.

4 Hirschowitz R, Orkin M. *A national household survey of health inequalities in South Africa.* CASE/Henry J. Kaiser Family Foundation, California, 1995.

5 October Household Survey. Central Statistical Service, 1995.

6 Republic of South Africa. Key indicators of Poverty in South Africa. Reconstruction and Development Programme, 1995.

7 Hirschowitz R, Orkin M. *A national household survey of health inequalities in South Africa.* CASE/ Henry J. Kaiser Family Foundation, California, 1995.

8 United Nations Development Programme. Human Development Report, 86, 1996.

9 Department of Finance. Budget Review. 13 March 1996.

10 Department of Finance. Growth, employment and redistribution: a macro-economic strategy. 1996.

11 Meintjies C J, Rousseau BJ, Viljoen DJ. Statistical macro-economic review. Development Bank of South Africa, 1996.

12 President Mandela as quoted in United Nations Development Programme. Human Development Report, p.87, 1996.

13 *Government gazette* no. 5649, notice no: R373

14 Department of Welfare and Population Development. The white paper on social welfare. 1995

15 Department of Welfare and Population Development. Report of the Lund Committee on Child and Family Support. September 1996.

16 Republic of South Africa. Water supply and sanitary policy. November 1994.

17 Palmer Development Group. Review of Rural Sanitation in South Africa. Report to Mvula Trust and the Water Research Commission. (WRC no. KV 71/ 95), April 1995.

Chapter 3

1 Yach D, Buthelezi G. Health Status. In *The South African Health Review 1995.* Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban 1995.

2 1994 October Household Survey. Central Statistical Services, Pretoria, 1995.

3 Hirschowitz R, Orkin M. *A National Household Survey of Health Inequalities in South Africa.* CASE/Henry J. Kaiser Family Foundation, USA, 1995.

4 Bradshaw D, Dorrington RE, Sitas F. Trends in adult mortality in South Africa 1920- 1985. Paper presented at the 5th African Regional Meeting of the IEA. 1994.

5 Frenk J, Bobadilla JL, Sepulveda J, Cervantes LM. Health transition in middle-income countries: new challenges for health care. *Health Policy and Planning* 1989;4(1):29-39.

6 Bradshaw D, Laubscher R, Schneider M. Estimated cause of death profiles for the nine new provinces based on the 1990 data. Technical report. Centre for Epidemiological Research in Southern Africa. 1995.

7 Department of National Health and Population Development. Health Trends in South Africa 1991, p7-11.

8 Fourie J, Steyn K (eds).Chronic Diseases of Lifestyle in South Africa: review of research and identification of essential health priorities. MRC Technical Report 1995.

9 Department of Health. *Epidemiological Comments*. vol 22 (10) 1995.

10 Glattaar E, Barends LJA. The Community and TB Control: A success story. *CHASA Journal of Comprehensive Health*, vol 6 no 4, 1995.

11 Cape Times. 25 March 1996.

12 Schoub BD, Martin DJ. Lessons from the 1992 measles epidemic in South Africa. *S Afr Med J* 1993; 83: 82-83.

13 Yach D, Martin G (eds). Building a healthy nation through research. Review of Medical Research Council's Essential Health Research Group. Proceedings of Seminar / Review. Cape Town, 21-23 June 1993.

14 The Mercury. 31 July 1996.

15 The Daily News. 21 February 1996.

16 Fawcus S, Moodley J, Bradshaw D, Theron GB, Abdool Karim SS. Measuring maternal mortality in South Africa. *S Afr Med J* 1996 ;86(4):403-406.

17 Department of Health. Towards a National Health System. Pretoria, 1995.

18 Yach D. Focus on Health in a changing South Africa in 1995. Medical and Health Annual, *Encyclopaedia Britannica*. Chicago, 1994.

19 The South African Vitamin A Consultative Group (SAVACG). Children aged 6 to 71 months in South Africa, 1994: their anthropometric, vitamin A, iron and immunisation coverage status. Isando, SAVACG, 1995.

20 Department of Health. Media release: Sixth international HIV survey of pregnant women attending antenatal clinics. Pretoria, 1996.

21 Coetzee N, Mofokeng M, Bachmann M, Cooper D. The Site B Community Health Centre in Khayelitsha: An unrecognized resource in sexually transmitted disease care and control. University of Cape Town, 1994.

22 Levitt NS, Mollentze WF. Diabetes Mellitus and impaired glucose tolerance: A review of South African studies. In Fourie J, Steyn K (eds). Chronic Diseases of Lifestyle in South Africa: Review of research and identification of essential health research priorities. MRC Technical Report 1995.

23 Seftel HC, Raal FJ, Joffe BI. Dyslipidaemia in South Africa. In Fourie J, Steyn K (eds). Chronic Diseases of Lifestyle in South Africa: Review of research and identification of essential health research priorities. MRC Technical Report 1995.

24 Sitas F, Norman RP. Lifestyle-induced cancers. In Fourie J, Steyn K (eds). Chronic Diseases of Lifestyle in South Africa: Review of research and identification of essential health research priorities. MRC Technical Report 1995.

25 Department of Health. *Epidemiological Comments*. Vol 22 (3) 1995.

26 Ensink K, Robertson B, Parry C. Prevalence of psychiatric disorder amongst Xhosa speaking children and adolescents in Khayelitsha, an informal settlement area. *Urbanisation and Health* Newsletter, 1995;27:39-44

27 Health Systems Trust. *HST Update* no 10 September 1995.

28 Lerer L, Matzsopolis R, Bradshaw D. Violence and Injury Mortality in Metropolitan Cape Town. MRC Report 1995.

29 Van der Spuy JW. The economic impact of trauma . *SA Bone and Joint Surgery* 1996;VI(2):5-11

30 Meumann C, Peden MM, van der Spuy, Gouws E and Naidoo S. Who dies of trauma in Durban? An epidemiological profile. Presentation to the Trauma Society of South Africa Congress 1996.

31 Muckart JJ, Meumann C, Botha JBC. The changing pattern of torso trauma in KwaZulu-Natal: a clinical and pathological review. *S Afr Med J* 1995;85(11):1172-1174.

32 Oral Health Committee. Summary Report to the Minister of Health Dr N C Zuma. 1995.

33 Hille JJ, Shear M, Sitas F. Age Standardised Incidence Rates of Oral Cancer in South Africa, 1988-1991. Presentation to IAOP. 1996. Toronto.

Chapter 4

1 Department of Health. Restructuring the national health system for universal primary health care. January 1996.

2 Report of the Registrar of Medical Schemes. Pretoria, 31 December 1993.

3 Department of Community Health. Paying for private care: a report on the findings of the Melamet Commission. University of the Witwatersrand, November 1994.

4 Report of the Health Finance Committee to the Minister of Health. November 1994.

5 Department of Health. Report of the committee of inquiry into a national health insurance system. Pretoria, June 1995.

6 Department of Health. National drug policy for South Africa. January 1996

7 Department of Finance. Budget Review. 22 June 1994.

Chapter 5

1 Chetty KS. An integrated analysis of health facilities in the nine provinces of South Africa. *S Afr Med J* 1995;85(4):245-250.

2 Barnum H, Kutzin J. *Public hospitals in developing countries; resource use, cost, financing.* Baltimore, John Hopkins University Press (for the World Bank), 1993.

3 Department of Health. Regional health management information system survey.1994/5.

4 World Health Organisation. *Development of indicators for monitoring progress towards Health for all by the year 2000.* Geneva, World Health Organisation, 1981.

5 Diehard J, Rispel L. What facility norms should be used in an urban setting? : the experience of Soweto. *MRC Urban Newsletter* (in press), 1995.

6 McIntyre D, Bloom G, Doherty J, Brijlal P. *Health Expenditure and Finance in South Africa.* Durban, Health Systems Trust and World Bank, 1995.

7 Personal communication with Jones M. 1996.

8 Department of Health. RDP clinic upgrading and building programme report. Monthly Report no. 7, 1996.

9 Department of Health. Regional health management information system survey. 1994/5.

10 Abbott G, Broomberg J, Diehard J, Jones M. Report of the independent evaluators on the redevelopment of the Pretoria academic hospital. Centre for Scientific and Industrial Research, 1994.

11 Centre for Health Policy, Chris Steel Architects, Rosmarin and Associates. Planning for health facility at the primary level: the case of Greater Soweto. Johannesburg, Centre for Health Policy, 1994.

12 Hospital Strategy Project. Developing a capital investment and maintenance plan for hospitals: strategy and issues. Johannesburg, Hospital Strategy Project, 1995b.

13 Abbott G, Cowan D. Norms system and application - an alternative approach. Paper presented at the bi-annual conference of the South African Federation of Hospital Engineering. Durban, CSIR, 1989.

14 Abbott G. The development of appropriate standards for health facilities in South Africa- expectations vs. affordability. Paper presented at the 13th Congress of the International Hospital Federation. Cape Town, CSIR, 1994.

15 Rispel L, Price M, Cabral J, Lazarus R, Marawa N, Schneider M, Xaba M, Fonn S. *Confronting need and affordability: guidelines for PHC services in South Africa.* Centre for Health Policy, Johannesburg, 1996.

16 Hospital Strategy Project. Defining hospitals by level of care: towards a consensus position. Johannesburg, Hospital Strategy Project, 1995a.

17 Hospital Strategy Project. Priorities for restructuring referred hospitals in support of hospital reform. Johannesburg, Hospital Strategy Project, 1996.

18 Abbott G. Primary health care: planning manual. Pretoria, CSIR, 1992.

19 Cowan D. Operating department planning and design guide. Pretoria, CSIR, 1991.

20 Boltman B. Hospital ward design guide. Pretoria, CSIR, 1992.

21 Cowan D, Smith I, Fourie C. Sterilisation and disinfection unit planning, design and management guide. Pretoria, CSIR, 1992.

22 Division of Building Technology of the CSIR, The Fabric Care Research Association (UK). Laundry and linen service planning, design and operation. Pretoria, CSIR, 1995.

Chapter 6

1 McIntyre D. Financing and Expenditure. In *The South African Health Review 1995.* Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban, 1995.

2 McIntyre D, Bloom G, Doherty J, Brijlal P. *Health Expenditure and Finance in South Africa.* Durban, Health Systems Trust and the World Bank, 1995.

3 Department of Health. Restructuring the national health system for universal primary health care : report of the committee of inquiry into a national health insurance system. Pretoria, 1995.

4 Tollman S, Rispel L. Organisation, Planning and management. In *The South African Health Review 1995.* Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban, 1995.

5 Personal communication with Department of Health. 1996.

6 Financial and Fiscal Commission. The Financial and Fiscal Commission's recommendations for the allocation of financial resources to the National and Provincial Governments for the 1997/8 Financial Year. Halfway House, 1996.

7 Personal communication with Clive Pintusewitz. 1996.

8 National Assembly Portfolio Committee on Health. Report on the 1996/7 Health Budget Vote. Cape Town, 1996.

9 McIntyre D, Khosa S. User fees for public sector health services: international experience and options for South Africa. Health Economics Unit working paper no.23. Cape Town, 1996.

10 Van den Heveer AM. Unpublished report on the Health Budget, submitted to the Finance Standing Committee. 1996.

11 Makan B, Valentine N, Kirigia J. Wisdom in gradual reorientation. *IDASA Budget Watch* 1996;2(2):4.

12 Doherty J, van den Heever A. Issues in resource allocation: an inter-provincial formula in support of equity. Johannesburg, Centre for Health Policy, 1996.

Chapter 7

1 Pick W. Human resources development. In *The South African Health Review 1995.* Durban, Health Systems Trust and the Henry J. Kaiser Family Foundation, 1995.

2 Department of Health. Towards a national health system - Draft Report Department of Health, Pretoria, 1995.

3 Minutes of the meetings of the Consultative Forum from July 1995 to March 1996.

4 World Health Organisation. Expert Committee Technical Report, Series 717, 1985.

5 Department of Health. Annual Report. 1995.

6 Lomax K, Mametja LD (ed). Assessing the feasibility of greater state support to community-based health programmes. Health Systems Trust, Durban, 1995.

7 Buch E, De Beer C. Minimum standards for personnel services in Mhala. Centre for Health Policy, Johannesburg, 1987.

8 Hospital Strategy Project. Use of indicators of hospital service provision, utilisation and efficiency, Johannesburg, 1995.

9 The National Assembly Portfolio Committee on Health. Report on the 1996/97 health budget.1996.

10 Rispel L, Price M, Cabral J. *Confronting need and affordability: guidelines for primary health care services in South Africa.* Centre for Health Policy, Johannesburg, 1996.

11 McCoy D. Free health care for pregnant women and children under six in South Africa : an impact assessment. Health Systems Trust, Durban. 1996.

12 Pick W. Planning the compositions of health care teams. Proposal submitted to the Health Systems Trust, 1995.

13 Public Health Programme and Education Policy Unit. The education and training of health personnel for the National Health System - Research proposal. University of the Western Cape, November 1995.

14 Sanker U, Jinabhai CC, Munro GD. Identifying human resource needs and priorities for urban and rural KwaZulu. Department of Community Health, University of Natal, 1995.

15 Deloitte and Touche. Human resource policy for health. Report prepared for the Medical Association of South Africa (MASA), 1994.

16 Personnel Administration Standards as amended, 1996.

17 Mapplebeck T. Towards a management development strategy for the health services of the new South Africa. 1995.

18 National Commission on Higher Education - Health Sciences Working and Reference Group. A future organisational and financial model for the health sciences- Final Draft. 1996.

19 Department of Health. Restructuring the National Health System for Universal Primary Health Care, Report of the Committee of Inquiry into a National Health Insurance System. 1995.

20 Khosa M. Academic health centres in South Africa : Staff and student composition and regional co-ordination, a report submitted to the Health Systems Trust. 1994.

21 Health Systems Development Unit, University of Witwatersrand. Support for the health management training programme - Grantee report to the Health Systems Trust. March 1996.

22 Health Policy Co-ordinating Unit and the Department of Health. A policy for the development of a district health system for South Africa. 1995.

23 Health Systems Trust. Initiative for Sub-district Support (ISDS) proposal. 1996.

24 Personal communication with the representatives of nurses on the Central Council for Public Servants.

Chapter 8

1 Department of Health. National Drug Policy for South Africa. Pretoria, 1996.

2 The Sowetan. Why South Africa needs a national drug policy. 22 February 1996.

3 Business Report. Global drug giants buy leading SA benefits scheme. 16 May 1995.

4 South Africa - Medikredit Partnership. *Pharm. J* 1995;225:371.

5 Magennis R, Coetzee W. Survey of the South African Medical Scheme Industry. Johannesburg, Representative Association of Medical Schemes, 1995.

6 Report of the Registrar of Medical Schemes for 1994. Pretoria, Council for Medical Schemes, 1996.

7 Pharasi OMB. A study of the effect of centralized procurement on cost-containment and affordability of appropriate medicines in South Africa. Centre for Health Policy, Johannesburg. 1995.

8 SA Pharmaceutical Market. Johannesburg, Proprietary Association of South Africa, 1996.

9 World Bank. Better health in Africa. Washington, 1994.

10 Department of Health. Drug Policy Committee. Pretoria, 1994.

11 Department of Health. Standard Treatment Guidelines and Essential Drugs List, Essential Drugs Programme (Primary Health Care) South Africa. Pretoria, 1996.

12 Du Toit JJ. Report to the University of Cape Town Summer School on the costs of medicines, for Midland Medical Scheme. 1990.

13 Pharasi OMB. South Africa's pharmaceutical services in a primary health care perspective. Centre for Health Policy, Johannesburg. 1992.

14 Professional fee to replace profit on medicines. *Pharmaciae*, April 1, 1995 - 31 July, 1995. Pretoria, Interim Pharmacy Council of South Africa.

15 Evaluation of pharmaceutical services in the Northern Transvaal Province. Pretoria, School of Pharmacy/Medicos Pharmacy Project, MEDUNSA and Centre for Health Policy, University of the Witwatersrand, 1994.

16 Department of Health. Restructuring of the Co-ordinating Committee for the Provision of Medical Supplies (COMED). Pretoria, 1995.

17 Sundararaj K. Drug use in public health services in the Umzimkulu district. MSc(Med) dissertation, MEDUNSA. Pretoria, 1996.

18 Moola F. Antipsychotic drug use in black patients in a peri-urban KwaZulu-Natal hospital. MSc(Med) dissertation, MEDUNSA. Pretoria, 1996.

19 Department of Human Services and Health. Quality Use of Medicines. Canberra, Australia, Pharmaceutical Benefits Branch, 1996.

20 Wilkes M, Doblin BH, Shapiro MF. Pharmaceutical advertisements in leading medical journals: experts' assessments. *Ann Int Med* 1992;116:912-919.

21 Our most significant contribution: human resource policy for health. *S Afr Med J* 1995; 84:11.

22 *Pharmaciae* November 1, 1995 - March 31, 1996. Pretoria, Interim Pharmacy Council of South Africa. 28.

23 Summers RS, van den Berg A, Summers B. Does South Africa have enough pharmacists? Part I: Entrants, the gender effect and projections. *S Afr Pharm J* 1994; 61:49-50, 52, 54.

24 Putter S. A national drug policy for South Africa. *Pharmaciae* November 1, 1995 - March 31, 1996. Pretoria, Interim Pharmacy Council of South Africa. 7-9.

25 *Government Gazette* no.17137, 12 July 1996.

26 Pretoria News. Drug industry alarmed by proposed health reforms. 9 January 1996.

27 Kanji N *et al. Drugs Policy in Developing Countries*. Zed Books, 1992. 1-20.

28 Daily News. A bitter pill to swallow. 30 August 1995.

29 *Pharmaciae* November 1, 1995 - March 31, 1996. Pretoria, Interim Pharmacy Council of South Africa.

30 Report of the Council. Pretoria, Interim Medical and Dental Council of South Africa, 1996.

31 Pharmacies opened/closed in RSA, January - May 1995. *Pharmaciae* November 1, 1995 - March 31, 1996. Pretoria, Interim Pharmacy Council of South Africa.

32 Business Day. Medicine prices to be slashed after government's prohibition on mark-ups. 1 April 1996.

33 Gattinella W. Vertical integration by the pharmaceutical industry in managed care. *Int Pharm J* 10(1):13.

Chapter 9

1 Sandiford P, Annett H, Cilbulkis R. What can information systems do for primary health care? An international perspective. *Soc Sci Med* 1992;34 (10):1077-1087.

2 Green A, Barker C. Priority setting and economic appraisal: whose priorities - the community or the economist? *Soc Sci Med* 1988;26(9):919-929.

3 Bradshaw D, Mbobo L. Informatics support. In *The South African Health Review 1995*. Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban. 1995.

4 Mandil SH. The National Health System of South Africa (NHISS/SA): from conception to the start of implementation. 1995.

5 Shisana O. Address to the National Conference on the Development of a NHIS/SA. 1995

6 NHIS/SA Committee. National Health Information System of South Africa: Progress Report. 1995.

7 Wilcox D. NHS still cheers on HISS projects. *Computing*, 1 September 1994.

8 Department of Health. Invitation to bid for a National Health Care Management Information System: component of the National Health Information System of South Africa (NHIS/SA). 1995.

9 Lutalo T. Establishing a health information system in Uganda: the past, the present and the future. A paper presented at Helina96. Midrand, 1996.

10 Molefane. Honours thesis, Department of Informatics. University of Cape Town, 1995.

11 REF Progress Report. June 1995.

12 Health Systems Trust. The SAMIG workshop to develop a basic curriculum for health informatics. Cape Town, 1995.

13 Lewis Carrol. "The Hunting of the Snark"

14 Department of Health. Year 2000 Health goals, objectives and indicators for South Africa. 1996.

15 Nkosi F. Information backup to a rural nurse: an interview with Florence Nkosi. Policy in Progress, Information needs of rural health workers. *HST Update* no.12. 1995.

Chapter 10

1 Mbewu AD. South African medical research - ugly stepsister or fairy godmother? *S Afr Med J* 1996;86;5.

2 Van Rensburg HCJ. Can we support high-tech research in South Africa. *S Afr Med J* 1996;86;5.

3 Household KC. Essential National Health Research, Report of the National Technical Committee as appointed by the Minister of Health Dr NC Zuma. November 1995.

4 Minnaar PC. Report to the Medical Research Council on the extent of state subsidisation of research at South African Universities. 1995.

5 Medical Research Council. Annual Report 1994/5 Health Impact Report. 1995.

6 Blecher M, McIntyre D. Research Expenditure in South Africa 1991/1992, National Health Expenditure Review, Technical Paper no 6. 1994.

7 Pflugler B, Yach D. Financial support for South African Medical Journal research. *S Afr Med J* 1994;85; 11.

8 The White Paper on Science and Technology. Preparing for the 21st Century. 1996.

Chapter 11

1 Department of Health. Restructuring the National Health Systems for Universal Primary Health Care. Guidelines on the Structure and Functions of the District HealthAuthority, Appendix 2. January 1996.

2 Palmer H. Editorial, Quality of Care and Health Care Resources. *International Journal for Quality in Health Care* 1995,7(2):79.

3 ACHS Accreditation Guide Standards for Australian Health Care Facilities. The Australian Council on Health Care Standards. 11th Edition, 12a.

4 Lewis S. Quality, content and distributive justice: the role of utilization research and management. *International Journal for Quality in Health Care* 1995,7(4):325-331.

5 Brown LD. Lessons learned in institutionalisation of quality assurance programs: an International perspective. *International Journal for Quality in Health Care* 1995,7(4): 419.

6 Rafeh N, El-Tobgi D. Clinical practice and the use of laboratory tests at the May 15 hospital in Egypt. *International Journal for Quality in Health Care* 1995, 7(1): 29.

7 Becker GC. A model hospital standards and accreditation system for Pakistan. *World Hospitals* 1996,31(1):24.

8 Hayes J, Shaw CD. Implementing accreditation systems (23 May 1994, Trenso, Italy). *International Journal for Quality in Health Care* 1995,7(2):165 - 171.

9 Kazandjian VA, Wood P, Lawthers J. Balancing science and practice in indicator development: the Maryland Hospital Association Quality Indicator (QI) Project. *International Journal for Quality in Health Care* 1995,7(1):39 - 46.

10 Pickering E. Evaluating the Benefits and Limitations of an Accreditation System. *World Hospitals* 1996, 31(1):31 - 35.

11 Fahey PP, Gibbard RW. Monitoring postoperative pulmonary embolisms in Australia - I: variation between hospitals. *International Journal for Quality in Health Care* 1995, 7(4):373-380.

12 Rispel L, Price M, Cabral J. *Confronting need and affordability: guidelines for primary health care services in South Africa*. Johannesburg, Centre for Health Policy, 1996.

13 Kongstevdt P. *Managed health care handbook*, 2nd Edition. Aspen Publishers, 1993.

14 Veliotes GP, *et al. An introduction to managed health care in South Africa*. MASA publications, 1993.

15 Gulino KM. Measuring up to HEDIS. *HMO Magazine*, volume 36, no.1, January / February 1995.

16 Packer-Tursman J. Outcomes research in HMOs - studies in quality. *HMO Magazine*, volume 35, no.5, September / October 1994.

17 Zablocki E. Practice guidelines - from theory to best practice. *HMO Magazine,* volume 35, no.5, September / October 1994.

18 Ribner SA. How patients judge physicians. *HMO Magazine*, volume 36, no.1, January / February 1995.

19 O'Connor K. Measuring satisfaction. *Health Plan*, volume 37, no.2, March / April 1996.

Chapter 12

1 Sunday Times. 15 September 1996.

2 The Mercury. 27 February 1996.

3 Daily News. 29 February 1996.

4 Sowetan. 6 June 1996.

5 Institute for a Democratic Alternative for South Africa. Parliamentary Whip, 25 March 1996.

6 Institute for a Democratic Alternative for South Africa. Parliamentary Whip, 21 June 1996. p7.

7 Union of South Africa. National Health Service Act no. 51 of 1946.

8 Republic of South Africa. Health Act no.63 of 1977.

9 Owen CP. A policy for the development of a district health system for South Africa. Department of Health and Health Policy Co-ordinating Unit, December 1995.

10 Hospital Strategy Project. Position paper on the decentralisation of hospital management. Prepared by the Hospital Strategy Project for the Department of Health, December 1995.

11 Mail and Guardian. 13-19 September 1996. p8.

12 North West Province. Health, Developmental Social Welfare and Hospital Governance Institutions Draft Bill, August 1996.

13 Free State Provincial Hospital Bill, 1996.

14 Mpumalanga Department of Health. Primary health care in Mpumalanga: guide to district based action. Health Systems Trust, October 1996.

15 Health Systems Trust. District Barometer. *HST Update* issue no.17, July 1996.

16 Department of Health North West Province. Primary health care delivery through the district vehicle, a report of a workshop held at the Agricor Centre, Mmabatho, 24 July 1996 .

17 PHC/INFO Project. A community perspective of involvement in primary health care: case studies from Mangaung and the Sasolburg sub-region. Centre for Health Systems Research and Development, University of the Orange Free State, February 1996.

18 Heunis JC, van Rensburg HCJ. Community involvement in primary health care: guidelines for facilitation and evaluation. PHC/INFO Project Task Group on Community Involvement, 1995

19 National Progressive Primary Health Care Network. Provincial public education workshops: committee of inquiry into national health insurance report. August - September 1995

20 Health Systems Trust. NGO's: Non-entities or crucial partners in health? *HST Update* no.18, September 1996.

Chapter 13

1 Department of Health. An integrated nutrition strategy for South Africa. Report of the Nutrition Committee to the Minister of Health. Pretoria, 1994.

2 United Nations Children's Fund. Conceptual framework for improved nutrition of children and women in developing countries. UNICEF, 1990.

3 Department of Health. Towards a National Health System - Draft Document. Pretoria, November 1995.

4 Government of National Unity. RDP White Paper Discussion Document. September 1994.

5 Department of Health. Primary School Nutrition Programme (PSNP), National Framework and Operational Guidelines. Pretoria, 1995.

6 Department of Health. Primary School Nutrition Programme (PSNP). Monitoring, Evaluation and Research Strategy. Pretoria, 1995.

7 Department of Health. Primary School Nutrition Programme (PSNP), Progress Report on the PSNP 31 January 1996. Pretoria, 1996.

8 National Progressive Primary Health Care Network (NPPHCN). Rapid Appraisal of the Primary School Nutrition Programme. Braamfontein, NPPHCN, 1995.

9 Steyn NP, Hanekom SM, Nesamvuni AE, Oosthuizen W, Laubscher I. An analysis of perceptions of schoolchildren regarding the PSNP in four provinces of South Africa. Unpublished report, 1995.

10 Health Systems Trust. *Designing an Evaluation of the Primary School Nutrition Programme*. Durban, Health Systems Trust, 29 February 1995.

11 Personal communication with Dladla N. Director of Nutrition, Department of Health. 1996.

12 Department of Health. National Nutrition and Social Development Programme (NNSDP), Monitoring Report for 31 January 1996. Pretoria, 1996.

13 Personal communication with De Hoop M. Directorate of Nutrition, Department of Health. 1996.

14 The South African Vitamin A Consultative Group (SAVACG). Children aged 6 to 71 months in South Africa, 1994: Their anthropometric, vitamin A, iron and immunisation coverage status. Isando, SAVACG, 1995.

15 *Government Gazette*, no. R.996. Regulations relating to salt. 7 July 1995.

16 Department of Health, Directorate of Nutrition. Breast-feeding and baby-friendly hospital initiative (BFHI) in South Africa. Policy guidelines for implementors of breast feeding and BFHI in South Africa. Pretoria, 1995.

17 Fincham R, Gibson C, Ross F, Zondi M. Development of a nutrition surveillance strategy and a plan of action for implementation in 1996. Pretoria, 1995.

18 Voster HH, Jerling JC, Oosthuizen W, Becker P, Wolmarans P. Nutrient intakes of South Africans: An analysis of the literature. Isando, Roche, 1995.

19 American Heart Association, Nutrition Committee. Dietary guidelines for healthy American adults: a statement for physicians and health professionals. Circulation 1988; 77:721A-724A.

20 World Health Organization. Diet, Nutrition, and The Prevention of Chronic Disease. Geneva, World Health Organisation, 1990.

21 Walker ARP. The nutrition challenges in the new South Africa. *Nutr Res Rev* 1996 (in press).

22 Vorster HH, Venter CS, Menssink E, van Staden DA, Labadarios D, Strydom AJC, Silvis N, Gericke GJ, Walker ARP. Adequate nutritional status despite restricted dietary variety in adult rural Venda. *S Afr J Clin Nutr* 1994; 7(2):3-16.

23 Steyn NP, Nel JH, Dhansay MA, Tichelaar HY, Kriek JA, Prinsloo JF, Benadj AJS. Differences in nutritional status between caretakers of underweight and normal weight Pedi preschool children. *S Afr J Food Sci Nutr* 1995; 7:53-59.

24 Steyn K, Jooste PL, Bourne L, Fourie J, Badenhorst CJ, Bourne DE, Langenhoven ML, Lombard CJ, Truter H, Katzenellenbogen J, Marais M, Oelofse A. Risk factors for coronary heart disease in the black population of the Cape Peninsula: The BRISK study. *S Afr Med J* 1991;79:480-485.

25 Rossouw JE, Thompson ML, Jooste PL, Swanepoel ASP. Choice of coronary heart disease risk factor variables in a cross-sectional study of white South Africans. *S Afr Med J* 1990;78:570-577.

26 Seedat YK, Mayet FGH, Latiff GH, Joubert G. Risk factors and coronary heart disease in Durban blacks - the missing links. *S Afr Med J* 1992;82:251-256.

27 Interview with the Minister of Health, Dr NC Zuma. In *HST Update* issue no.15, Health Systems Trust, 1996.

Chapter 14

1 Mahomed H, Valentine N, Khosa S, McIntyre D. The utilisation of health services in a sample of Cape Peninsula suburbs, unpublished report. Health Economics Unit, University of Cape Town, 1995.

2 Hirschowitz R, Orkin M. *A national household survey of health inequalities in South Africa.* CASE/Henry J. Kaiser Foundation, California, 1995.

3 Khosa S, Thomas E. " Free health care" policies. In *The South African Health Review 1995.* Health Systems Trust and Henry Kaiser J. Kaiser Family Foundation, Durban, 1995.

4 World Health Organisation. Global strategy for health for all by the year 2 000. Geneva, 1981.

5 *The South African Health Review 1995.* Health Systems Trust / Henry J. Kaiser Family Foundation, Durban, 1995.

6 Creese AL. *User-charges for health care: a review of recent experience.* World Health Organisation, 1990.

7 McIntyre D, Bloom G, Doherty J, Brijlal P. *Health expenditure and finance in South Africa.* Health Systems Trust and World Bank, 1995.

8 McIntyre D. User fees for public sector health services in South Africa: revenue generating potential and equity implications, working paper no.6. Health Economics Unit, University of Cape Town, 1994.

9 Shaw RP, Griffin CC. *Financing health care in sub-Saharan Africa through user fees and insurance.* Washington DC, World Bank, 1995.

10 Gertler P, van der Gaag. *The willingness to pay for medical care.* Baltimore, John Hopkins University Press, 1990.

11 Waddington C, Enyimayew K. A price to pay: the impact of user charges in Ashanti-Akim district, Ghana. *International Journal of Health Planning and Management* 1989,4:17-47.

12 Yoder R. Are people willing and able to pay for health services? *Social Science and Medicine* 1989,29:35-42.

13 Gertler P, Locay L, Sanderson W. Are user fees regressive? The welfare implications of health care financing proposals in Peru. *Journal of Econometrics* 1987,36:67-88.

14 Ching P. User fees, demand for children's health care and access across income groups: the Philippine case. *Social Science and Medicine* 1995, 41(1):37-46.

15 Sauerborn R, Nougarta A, Latimer E. The elasticity of demand for health care in Burkina Faso: differences across age and income groups. *Health Policy and Planning* 1994,9(2):185-192.

16 Stanton B, Clemens J. User fees for health care in developing countries: a case study of Bangladesh. *Social Science and Medicine* 1989, 29:1199-1205.

17 Berman P, Ormond BA, Gani A. Treatment use and expenditure on curative care in Indonesia. *Health Policy and Planning* 1987,2(4):289-300.

18 Huber JH. Ensuring access to health care with the introduction of user fees: a Kenyan example. *Social Science and Medicine* 1993, 36(4):485-494.

19 Litvak J, Bodart C. User fees plus quality equals improved access to care: results of a field experiment in Cameroon. *Social Science and Medicine* 1993, 37(3):369-383.

20 Russell S, Gilson L. User fees at government health services: is equity being considered? Public Health

and Policy publication no.15, London School of Hygiene and Tropical Medicine, London, 1995.

21 Weaver M, Kadi H, Zeynabou M. Patient surveys at Niamey National Hospital: results and implications for reform of hospital fees. USAID project 683-0254, Washington DC, 1990.

22 Gilson L, Mills A. Health sector reforms in sub-Saharan Africa: lessons of the last 10 years. Health Policy Unit, London School of Hygiene and Tropical Medicine, 1995.

23 Research team of the: National Progressive Primary Health Care Network, Centre for Health Systems Research (University of the Orange Free State), Centre for Health and Social Studies (University of Natal), Health Economics Unit (University of Cape Town), and Child Health Unit (University of Cape Town).

24 McCoy D. *Free Health Care for pregnant women and children under six in South Africa: an impact assessment.* Health Systems Trust, Durban, 1996.

Chapter 15

1 Department of Health. Summary of the results of the sixth national HIV survey of women attending antenatal clinics of the public health services in South Africa, October/ November 1995. April 1996.

2 Buve A, Carel M, Hayes R, Robinson NJ. Variations in HIV prevalence between urban areas in sub-Saharan Africa: do we understand them? AIDS 1995, 9(suppl.A):S103-S109.

3 Barnett T, Blaikie P. *AIDS in Africa: its present and future impact.* London, Belhaven Press, 1992.

4 Cohen D. *The economic impact of the HIV epidemic.* New York, UNDP, 1992.

5 Whiteside A, Wilkins N, Mason B, Wood G. The impact of HIV/AIDS on planning issues in KwaZulu-Natal. Town and Regional Planning Supplementary Report vol.42, Town and Regional Planning Commission. Pietermaritzburg, 1995.

6 Cuddington JT. Modelling the macro-economic effects of AIDS, with an application to Tanzania. *World Bank Economic Review* 1992, 7(2).

7 Cross S, Whiteside A (eds). *Facing up to AIDS - the socio-economic impact in Southern Africa.* Chatham, St. Martin's Press, 1993.

8 Way PO, Staneki KA. *The impact of HIV/AIDS on world population.* US Bureau of Census, US Government Printing Office, Washington DC, 1994.

9 Over M. *The macro-economic impact of AIDS in sub-Saharan* Africa. Africa Technical Department, Population, Health and Nutrition Division, Technical working paper. Washington DC, World Bank, 1992.

Chapter 16

1 Coovadia HM, Buthelezi G. Maternal Child and Women's Health. In *The South African Health Review 1995.* Health Systems Trust and Henry J. Kaiser Family Foundation, Durban. 1995.

2 Department of Health. Towards a National Health System. April 1996.

3 Klugman B, Stevens M, Arends K. Developing women's health policy in South Africa from the grassroots. *Reproductive Health Matters* no.6, November 1995.

4 Budlender D. Health in our hands: Proceedings and policies of the 1994 Women's Health Conference, Women's Health Project, Centre for Health Policy.

5 Violence against women in South Africa: The state response to domestic violence and rape. Human Rights Watch (Africa). Human Rights Watch Women's Rights Project, November 1995.

6 Fawcus S, Moodley J, Bradshaw D, Theron GB, Abdool Karim SS. Measuring maternal mortality in South Africa (editorial). *S Afr Med J* 1996,86:403-406.

7 Rispel L, Price M, Cabral J, Beattie A, Fonn S, Lazarus R, Marawa N, Schneider M, Xaba M. *Confronting need and affordability: guidelines for primary health care in South Africa.* Centre for Health Policy, 1996.

8 Presentation to the parliamentary select committee on abortion on behalf of the Medical Research Council's Incomplete Abortion Research Group. Centre for Epidemiological Research in South Africa. Medical Research Council, 1995.

9 Crichton DA, Parkes JR. The principles of prevention of avoidable maternal death. *S Afr Med J* 1973,47: 2005-2010.

10 Goosen M, Klugman B (eds). *The South African Women's Book. Women's Health Project.* Oxford University Press, Southern Africa, 1996.

11 Hirschowitz R, Orkin M. *A National Household Survey of Health Inequalities in South Africa.* CASE/Henry J. Kaiser Family Foundation, California, 1995.

12 Department of Health. Children aged 6 to 71 months in South Africa, 1994: their anthropometric, vitamin A, iron and immunisation coverage status. *Epidemiological Comments* 1995,22(9): 185-214.

13 Venter PA, Christianson AL, Hutamo CM, Makhura MP, Gericke GS. Congenital anomalies in rural black South African neonates- a silent epidemic? *S Afr Med J* 1995, 85:15-20.

14 Czeizel AE, Dudas I. Prevention of the first occurrence of neural tube defects by periconceptual vitamin supplementation. *N Eng J Med* 1992,327: 1832-1835.

15 Personal communication with McKerrow NH, Verbreek AE. Models of care for children in distress. Pietermaritzburg, 1995.

16 Department of Health. Report of the National Anthropometric Survey on School entrants, February - April 1994. *Epidemiological Comments* 1995,22(4):69-75.

17 Personal communication with Dr E Mahlanga, Chief Director, MCWH directorate, Department of Health. Pretoria, May 1996.

18 Fonn S, Xaba M. Health worker's for change: a manual to improve quality of care. The Women's Health Project and UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, 1995.

19 Department of Health. Summary of the sub-national polio campaigns held in South Africa, June/July/ August 1995. *Epidemiological Comments* 1995,22(10):220-224.

20 McCoy D. *Free health care for pregnant women and children under six in South Africa - an impact assessment.* Health Systems Trust, Durban, 1996.

21 National Progressive Primary Health Care Network. Rapid Appraisal of the Primary School Nutrition Programme. 1995.

22 Doyal L. *What makes women sick? Gender and the political economy of health.* Macmillan Press, 1995

23 Solarsh GC, Sanders DM, Gibson CA, Gouws E. Community-based survey versus sentinel site sampling in determining the nutritional status of rural children - Implications for nutritional surveillance and the development of nutritional programmes. *S Afr Med J* 1994,84:747-752.

24 United Nations Children's Fund. Strategy for improved nutrition of women and children in developing countries. UNICEF policy review, 1990-1991.

25 Motsei M. Detection of woman battering in health care settings: the case of the Alexandra Health Centre, Women's Health Project, Centre for Health Policy, 1993.

26 Turmen T. Is child survival enough? (editorial) *J Trop Ped* 1995, 41:321-324.

27 Fonn S and Xaba M. Health Workers for Change: A manual to improve quality of care. The Women's Health Project, Johannesburg, South Africa and UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. June 1995.

Chapter 17

1 Owen CP. A policy for the development of a district health system for South Africa. Johannesburg, Health Policy Coordinating Unit. 1995.

2 Proceedings of the workshop on district health systems (unpublished). Durban, 1994.

3 Health Systems Trust. *The South African Health Review, 1995.* Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban. 1995.

4 Mills A *et al* (eds). *Health system decentralisation: concepts, issues and country experience*, Part 1,2 &3. Geneva, World Health Organisation, 1990.

5 Health Systems Trust. *HST Update* no.10. September 1995.

6 Health Systems Trust. Improving quality of care: the nuts and bolts of health reform. May 1996.

7 Health Systems Trust. Making district health care a reality in KwaZulu-Natal. October 1995.

8 Green A. *An introduction to health planning in developing countries.* Oxford, Oxford University Press, 1992.

9 Segall M. Planning and politics of resource allocation for primary health care: promotion of meaningful national policy. *Social Science and Medicine* 1993,17(24):1947-60.

Chapter 18

1 Constitution of the Republic of South Africa. Section 7(1,2). 1996.

2 Constitution of the Republic of South Africa. Section 24(a). 1996.

3 Constitution of the Republic of South Africa. Section 24(b). 1996.

4 Constitution of the Republic of South Africa. Section 27(1). 1996.

5 Constitution of the Republic of South Africa. Section 27(2). 1996.

6 Constitution of the Republic of South Africa. Section 27(3). 1996.

7 Constitution of the Republic of South Africa. Section 28(1). 1996.

8 Constitution of the Republic of South Africa. Section 26. 1996.

9 Constitution of the Republic of South Africa. Section 29. 1996.

10 Constitution of the Republic of South Africa. Section 11. 1996.

11 Constitution of the Republic of South Africa. Section 10. 1996.

12 Constitution of the Republic of South Africa. Section 32. 1996.

13 Constitution of the Republic of South Africa. Section 38. 1996.

14 Constitution of the Republic of South Africa. Section 147(a,b,c). 1996.

15 Constitution of the Republic of South Africa. Section 41. 1996.

16 Department of Health. Restructuring the national health system for universal access to primary health care, Official policy document. Pretoria, January 1996.

17 Report of the *ad hoc* select committee on abortion and sterilisation. Cape Town, 29 June 1995.

18 Harrison S. Legislative reform. In *The South African Health Review 1995*. Health Systems Trust and the Henry J. Kaiser Family Foundation, Durban. 1995.

19 Province of the Free State. Draft Free State Hospital Bill. April 1996.

20 Strachan K. Business Day. 27 February 1996.

21 National Assembly. Standing rules for the National Assembly, and for joint business and proceedings of the National Assembly and the Senate. Cape Town, February 1995.

22 Constitution of the Republic of South Africa. Section 182(1). 1996.

23 Office of the Public Protector. Report no.1(special report). Investigation of the play Sarafina 2. June 1996.

GLOSSARY

Acute beds:
Includes bassinets, obstetric beds, paediatric beds, intensive care beds, and other acute beds.

Adolescent mortality rate:
The number of deaths between the ages of 14-24 years per thousand population in this age category

Adult mortality rate:
The number of deaths between the ages of 15-64 per thousand of the total population in this age category

Bed occupancy rate:
A measure of the proportion of beds that are occupied over a period of time (one year in this instance)

Bed turnover rate:
An indication of the average number of patients that will occupy a single bed during one year; calculated by dividing the number of admissions by the number of beds.

Child (under 5) mortality rate:
The number of children who die before reaching the age of 5 years, per thousand live births in a given year.

Contraceptive prevalence:
The percentage of sexually active men or women who use contraceptive methods

Crude birth rate:
The number of live births occurring per thousand population in a year .

Crude death rate:
The number of deaths occurring per thousand population in a year.

Age dependency ratio:
Percentage of people aged between 0-14 years and 65 and over per percentage of people between the ages of 15-64.

DMFT:
Decayed, missing or filled teeth; used as an indicator to quantify the oral health status within a community.

Disability adjusted life years:
The present value of the future years of disability-free life that are lost as the result of the premature deaths or cases of disability occurring in a particular year. It is a unit used to measure both the global burden of disease and the effectiveness of health interventions, as indicated by reductions in the disease burden

Economically active population:
Comprises all workers and unemployed persons

Grid electricity:
An existing connection to the main line electricity supply.

Infant mortality rate (IMR):
The number of live born children who die under one year per 1000 live births

Life expectancy at birth:
The number of years a newborn baby would live if patterns of mortality prevailing at the time of its birth were to stay the same throughout its life

Literacy rate:
The percentage of persons 13 years and older with at least standard 5 qualification

Low birth weight babies:
Children born weighing less than 2 500 grams

Maternal mortality rate:
A number of female deaths that occur as a result of complications of pregnancy and childbirth per 100 000 live births

Neonatal mortality rate:
The number of deaths before one month of age per 1 000 live births in a given year.

Notification rates:
Number of disease cases notified to the Department of Health per 100 000 population

Perinatal mortality rate:
The number of stillbirths and early neonatal deaths per thousand live and stillbirths in a given year.

Population groups:
In this review, the following terms have been used to define different population groups: Africans, Coloured, Indian and White. The term "black" is used to encompass African, Coloured and Indian groups. (Classification by race has been used to quantify and qualify inequities, and has implications for the targeting of interventions)

Potential years of lives lost (PYLL):
The sum of the years lost to premature death (less than 65 years of age) per thousand population

Secondary hospital:
Hospitals offering care to patients on a continous (full-time) basis by in at least three of the following specialities:

Obstetrics and gynaecology

Paediatrics

Internal medicine

Surgery

Stunting:
Height for age less than 2 standard deviations from the median of a reference population.

Teenage birth rate:
The percentage of all live births during a specific year, to women younger than 20 years of age, irrespective of marital status.

Tertiary Hospitals:
Hospitals offering specialised care to patients on a continous (full-time) basis by any of the following specialities:

Cardiology

Cardiothoracic / thoracic surgery

Dermatology

Neurology

Neurosurgery

Nuclear medicine

Opthalmology

Total fertility rate:
The average number of children that would be born live to a woman during her child-bearing years (15-49 years), assuming that prevailing rates remain unchanged.

Underweight:
Weight for age less than 2 standard deviations from the median of a reference population.

Unemployment:
Persons who are 15 years or older who are not in paid or self employment; are available for either paid or self employment; have taken specific steps to find employment and have the desire to work.

Wasting:
Weight for height less than 2 standard deviations from the median of a reference population.

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
BFNI	Baby-friendly hospital initiative
BMI	Body Mass Index
CASE	Community Agency for Social Enquiry
CBO	Community Based Organisation
CHW	Community Health Worker
COHSASA	Council for Health Service Accreditation of Southern Africa
COMED	Coordinating Committee for the Provision of Medical Supplies
COPHE	Committee for Public Health Education
COSATU	Congress of South African Trade Unions
CPT	Current Procedural Terminology
CSIR	Council for Scientific and Industrial Research
CSS	Central Statistical Services
DHS	Demographic Health Survey
DHS	District Health Systems
EAP	Economically Active Population
EDI	Electronic Data Interchange
EDL	Essential Drugs List
ENHR	Essential National Health Research
EU	European Union
FFC	Financial and Fiscal Commission
FHC	Free Health Care
GDP	Gross Domestic Product
GEARS	Growth, Employment and Redistribution Strategy
HDLC	High Density Lipoprotein Cholesterol
HIV	Human Immunodeficiency Virus
HRD	Human Resource Development
HSRC	Human Sciences Research Council
HST	Health Systems Trust
ICA	Ithusheng Community Association
ICD 10	International Classification for Diseases - 10th Version
ICPC	International Classification for Primary Care
ICPD	International Conference on Population and Development
ILO	International Labour Organisation
IMC	Interministerial committee
IMIA	International Medical Informatics Association
IMR	Infant Mortality Rate
JUDASA	Junior Doctors Association of South Africa
MASA	Medical Association of South Africa
MCC	Medicines Control Council
MCWH	Maternal, child and women's health
MEC	Members of the Executive Council
MEDUNSA	Medical University of Southern Africa
MIFF	Municipal infrastructure investment framework
MMR	Maternal Mortality Rate
MRC	Medical Research Council
NACOSA	National AIDS Coordinating Committee of South Africa
NDP	National Drug Policy
NGO	Non-Governmental Organisation
NHIS/SA	National Health Information System of South Africa
NHS	National Health Service
NNSDP	National Nutrition and Social Development Programme
NPPHCN	National Progressive Primary Health Care Network
ODA	Overseas Development Administration
PEM	Protein - energy malnutrition
PHC	Primary Health Care
PHID	Project for Health Information Dissemination
PSC	Public Service Commission
PSNP	Primary School Nutrition Programme
RDP	Reconstruction and Development Programme
ReHMIS	Regional Health Information Management System
SAHIA	South African Health Informatics Association
SALDRU	South African Labour and Development Research Unit
SAMIG	South African Medical Informatics Group
SANNSS	South African National Nutrition Survey Study
SAVACG	South African Vitamin A Consultative Group
SHI	Social Health Insurance
STD	Sexually transmitted diseases
STG	Standard treatment guidelines
TB	Tuberculosis
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
VHW	Village Health Worker
WHO	World Health Organisation
ZOPP	Project Planning and Monitoring Methods

HEALTH AND RELATED INDICATORS

We have tried to demonstrate changes to indicators by showing increases or decreases as ⇑ or ⇓ respectively. However, the limitations of the quality of data remain and the use of varying sources may also influence the significance, or otherwise of changes. It is nevertheless important to begin to show trends which can be confirmed or refuted over time.

Disaggregation by province

DEMOGRAPHY

	Eastern Cape	Mpumalanga	Gauteng	KwaZulu-Natal	Northern Cape	Northern Province	North West	Free State	Western Cape	South Africa Total/Average
% Pop per province 1994[1]	16.1	7.2	17.0	21.2	1.9	12.4	8.3	6.9	9.0	100
1995[2]	15.7 ⇓	7.3 ⇑	17.1 ⇑	21.1 ⇓	1.8 ⇓	13.1 ⇑	8.2 ⇓	6.7 ⇓	9.0 ⇔	100
Annual pop. growth rate (1985-1993)[3]	2.6	3.0	1.3	2.8	0.8	4.0	3.1	1.5	1.7	2.4
Crude birth rate 1994 (based on hospital deliveries)[4]	17.3	-	-	21.6	-	-	15.8	-	-	-
Crude death rate[5]	5.7	3.2	6.1	3.5	8.5	2.6	5.7	5.8	6.8	4.9
Total fertility rate 1991[3]	4.6	4.3	3.0	4.3	2.9	5.8	4.5	3.7	2.7	3.3
Teenage birth rates 1991[3]	13.1	13.5	12.9	15.3	12.8	16.4	12.6	14.9	11.8	14.6
Average household size (1990)[1]	5.2	4.6	3.5	5.7	4.3	5.2	3.8	3.9	3.9	4.5
1994[6]	4.9 ⇓	4.8 ⇑	3.9 ⇑	5.0 ⇓	4.1 ⇓	4.7 ⇓	4.5 ⇑	4.0 ⇑	3.9 ⇔	4.5 ⇔

Sources: 1 Chimere-Dan in Demographic patterns in South Africa, South African Health Review 1995.

2 Central Statistical Services. RSA Statistics in brief 1995. Pretoria, 1996.

3 Development Bank of South Africa. South Africa's nine provinces: A human development profile. Halfway House, 1994.

4 Health (and Welfare) in Eastern Cape. Implications for Planning, 1996. Health Systems Trust, Durban, 1996
KwaZulu Natal: Implications for Planning, 1996. Health Systems Trust, Durban, 1996
North West: Implications for Planning, 1996. Health Systems Trust, Durban, 1996.

5 Bradshaw *et al* Estimated cause of death profiles for the nine new provinces based on 1990 data. Medical Research Council. 1995.

6 Central Statistical Services. October Household Survey 1994. Pretoria, 1995.

SOCIO-ECONOMIC INDICATORS

	Eastern Cape	Mpumalanga	Gauteng	KwaZulu-Natal	Northern Cape	Northern Province	North West	Free State	Western Cape	South Africa Total/Average
Area as a % of total area of SA[1]	13.9	6.7	1.5	7.5	29.7	9.8	9.7	10.6	10.6	100
Pop. density (persons per km²)										
1994[2]	38.0	37.3	365.2	92.3	2.0	42.2	28.0	21.1	28.1	33.0
1995[3]	38.2 ⇑	38.4 ⇑	374.7 ⇑	94.5 ⇑	2.0 ⇔	43.8 ⇑	28.8 ⇑	21.5 ⇑	28.8 ⇑	33.8 ⇑
Functional urbanisation - 1993 (%)[3]	55.4	43.2	99.6	77.9	78.2	12.1	43.9	73.7	95.1	65.5
% Urban (1994)[4]	35.0	31.6	96.0	38.0	73.1	8.0	30.0	54.0	86.4	48.8
% Rural (1994)[4]	65.0	68.4	4.0	62.0	26.9	92.0	70.0	46.0	13.6	51.2
Literacy rate										
1991[1]	59.0	54.6	69.0	58.7	67.6	52.7	55.8	60.0	71.9	61.4
1995[5]	59.0 ⇔	55.0 ⇑	69.0 ⇔	59.0 ⇑	68.0 ⇑	53.0 ⇑	62.0 ⇑	59.0 ⇓	72.0 ⇑	-
% non-school attendance 1991[1]	9.4	8.5	8.7	11.3	7.3	8.6	13.7	9.7	6.4	9.6
Unemployment rate										
1991[1]	23.6	16.3	16.6	25.2	16.7	24.8	22.3	15.3	13.3	19.4
1994[6]	45.3 ⇑	36.4 ⇑	28.7 ⇑	32.2 ⇑	32.5 ⇑	47.0 ⇑	36.6 ⇑	24.4 ⇑	17.3 ⇑	32.6 ⇑
Dependency ratio (1994)[1]	3.7	2.1	0.9	2.3	1.6	4.8	1.6	1.4	1.2	1.9
Per capita income (Rands) 1994[1]	1 358	2 164	4 992	1 910	2 865	725	1789	2 419	4 188	2 566
% house-holds with tap water in dwelling (1994)[6]										
White	97.5	96.6	98.6	99.1	98.9	91.4	99.7	97.4	99.4	98.4
Coloureds	-	-	93.7	-	29.2	-	-	-	85.5	76.0
Indians	-	-	99.5	-	-	-	-	-	-	97.7
Africans	16.3	20.1	57.2	25.9	20.2	12.9	21.1	19.1	39.5	27.4
% households using electricity as main energy source (1994)[6]										
Whites	95.8	99.1	98.4	99.4	81.9	97.9	99.7	99.8	99.4	98.2
Coloureds	53.7	-	93.5	-	37.1	-	-	-	83.9	75.7
Indians	-	-	99.8	-	-	-	-	-	-	98.5
Africans	12.0	20.0	64.6	31.7	29.9	14.0	25.1	31.7	46.5	30.5
% without sanitation facilities (1994)[6]										
Whites	0.1	-	-	0.0	-	-	0.0	0.0	-	0.0
Coloureds	5.8	-	0.1	-	-	-	-	-	-	2.4
Indians	-	-	-	-	-	-	-	-	-	0.1
Coloureds	28.8	16.8	2.6	8.9	-	-	13.0	12.7	-	12.6

Sources: 1 Development Bank of South Africa. South Africa's nine provinces: A human development profile. Halfway House 1994.

2 Chimere-Dan in Demographic patterns in South Africa. South African Health Review 1995.

3 Central Statistics Services. RSA Statistics in brief. 1995. Pretoria, 1996.

4 Health (and Welfare) in the: North West: Implications for Planning. Health Systems Trust, Durban, 1996.
KwaZulu Natal: Implications for Planning. Health Systems Trust, Durban, 1996.
Northern Province: Implications for Planning. Health Systems Trust, Durban, 1996.
Free State: Implications for Planning. Health Systems Trust, Durban, 1996.
Eastern Cape: Implications for Planning. Health Systems Trust, Durban, 1996.
Northern Cape: Implications for Planning. Health Systems Trust, Durban, 1996.

5 Portfolio of South Africa, 1995. Gauteng, 1995.

6 CSS October Household Survey 1994. (Provincial Reports). Pretoria, 1995.

MORTALITY	Eastern Cape	Mpumalanga	Gauteng	KwaZulu-Natal	Northern Cape	Northern Province	North West	Free State	Western Cape	South Africa Total/Average
Infant mortality rate 1990[1]	44.7	45.1	32.3	44.9	42.9	52.9	40.1	45.8	24.4	40.2
Neonatal deaths per 1 000 public hospital deliveries (1995)[2]	15.0	-	-	7.0	9.8	14.7	9.8	12.2	-	-
Perinatal mortality rate	–	–	–	–	–	–	–	–	–	–
Child mortality rate 1990[3]	19.4	14.8	13.1	14.3	19.6	8.3	24.7	23.3	12.3	-
Adolescent mortality rate	-	-	-	-	-	-	-	-	-	-
Adult mortality rate	-	-	-	-	-	-	-	-	-	-
Maternal mortality rate[4]										32
1994[2]	63	–	–	44	–	52.8	70	61	-	-
Still born per 1000 deliveries[2]	22	–	–	19	–	17.3	26.5	21.3	–	–
Potential years of life lost 1990[5]	1 039 876	191 076	778 771	638 198	139 750	231 919	635 889	383 383	385 045	-
Trauma related deaths, excluding MVA (%) 1990[6]	-	-	1.2	-	1.8	-	1.1	-	1.6	-
% Transport related deaths 1990[6]	-	2.7	7.7	13.8	3.0	3.4	4.2	2.9	1.6	-
Life expectancy at birth M / F (1990)[1]	61 / 68	63 / 69	63 / 69	62 / 69	60 / 65	62 / 68	64 / 70	61 / 66	63/ 68	62 / 68
Deaths due to respiratory causes in children ‹ 5 yrs	-	-	-	-	-	-	-	-	-	-
MORBIDITY										
Communicable Diseases										
Incidence of TB 1993[7]	280.6	84.2	191.9	115.3	417.2	53.2	83.0	472.0	702.6	224.9
Incidence measles 1992[8]	51.7	93.4	69	44.5	115.5	47.8	27.8	105.5	40.2	57.2
Incidence malaria 1993[9]	0.1	131.0	9.0	45.1	2.9	42.7	4.4	0.5	0.5	27.5
Incidence typhoid 1993	3.0	7.7	2.4	5.2	0.3	11.4	0.2	0.9	0.6	-
1994[10]	1.3 ⇓	9.6 ⇑	1.5 ⇓	1.4 ⇓	0.0 ⇓	3.7 ⇓	0.3 ⇑	0.5 ⇓	0.6 ⇔	2.0
Incidence hepatitis	-	-	-	-	-	-	-	-	-	-
Incidence meningiococcal infection1992[11]	0.9	0.8	0.5	0.4	2.2	0.6	0.3	0.6	8.5	1.3
Incidence congenital syphilis 1992[11]	4.8	0.4	1.9	0.4	2.4	0.9	0.2	0.2	7.0	2.0
HIV (antenatal) (%) 1994[12]	4.5	12.2	6.4	14.4	1.8	3.0	6.7	9.2	1.2	7.6
(%) 1995[13]	6.0 ⇑	16.2 ⇑	12.0 ⇑	18.2 ⇑	5.2 ⇑	4.9 ⇑	8.3 ⇑	11.0 ⇑	1.7 ⇑	10.4 ⇑
Non-communicable diseases										
Trauma attendances at health care facilities	-	-	-	-	-	-	-	-	-	-
Prevalence of dental caries amongst 6 yr olds and 12 yr olds	-	-	-	-	-	-	-	-	-	-
Cervical cancer	-	-	-	-	-	-	-	-	-	-

DISABILITY	Eastern Cape	Mpumalanga	Gauteng	KwaZulu-Natal	Northern Cape	Northern Province	North West	Free State	Western Cape	South Africa Total/Average
Prevalence of blindness %	-	-	-	-	-	-	-	-	-	-
Physical disability %	-	-	-	-	-	-	-	-	-	-
RISK TAKING BEHAVIOUR										
Smoking										
% adults who smoke (1995)[14]	29	23	37	33	55	14	46	40	48	34
% men	48	42	52	56	72	35	62	56	51	52
% women	12	6	20	8	33	4	31	23	45	17
NUTRITIONAL STATUS										
% Wasting										
Primary school children in sub-standards 1&2 1994[4]	2.5	1.8	2.1	1.9	5.4	3.1	4.4	1.8	2.8	2.6
Children 6-71 months[15]	3.2	1.7	1.2	0.7	2.5	3.8	4.5	4.5	1.3	2.6
% Stunting										
Primary school children in sub-standards 1&2 1994[4]	16.8	11.4	7.1	11.8	19.2	13.4	14.1	11.2	13.8	13.2
Children 6 - 71 mnths[15]	28.8	20.4	11.5	15.6	22.8	34.2	24.7	28.7	11.6	22.9
% Under-weight										
Primary school children in sub-standards 1&2 1994[4]	9.2	6.2	4.6	5.6	20.9	10.4	12.0	8.0	12.0	9.0
Children 6-71 months[15]	11.4	7.3	5.6	4.2	15.6	12.6	13.2	13.6	7.0	9.3
% Low birth weight babies[2]	4.3	-	-	-	-	-	-	-	-	-
Obesity	-	-	-	-	-	-	-	-	-	-
Incidence of marasmus	-	-	-	-	-	-	-	-	-	-
Incidence of kwashiokor	-	-	-	-	-	-	-	-	-	-

Sources: 1 Chimere-Dan in Demographic patterns in South Africa, in South African Health Review 1995.

2 Health (Care)(and Welfare) in Eastern Cape, Northern Cape, Northern Province, North West and Free State: Implications for Planning, 1996. Health Systems Trust, Durban, 1996.

3 Bradshaw D *et.al* unpublished report. Medical Research Council, 1990.

4 Department of Health. Epidemiological Comments; Vol 22 (4). Pretoria, 1995.

5 Bradshaw D *et.al* Estimated causes of death Profiles for the nine new provinces based on 1990 data. MRC, 1995.

6 Fourie J, and Steyn K,. Chronic Diseases of Lifestyle in South Africa. Medical Research Council, 1995.

7 Department of Health. Epidemiological Comments; Vol 22 (1). Pretoria, 1995.

8 Department of Health. Epidemiological Comments; Vol 21 (5). Pretoria, 1994.

9 Department of Health. Epidemiological Comments; Vol 21 (6). Pretoria, 1994.

10 Department of Health. Epidemiological Comments; Vol 22 (2). Pretoria, 1995.

11 Development Bank of Southern Africa, 1994.

12 Department of Health. Epidemiological Comments; Vol 22 (5). Pretoria, 1995.

13 Department of Health. Annual Report, 1995. Pretoria, 1996.

14 MRC / HSRC Survey, 1995.

15 The South African Vitamin A Consultative Group. 1995.

HEALTH SERVICES PROVISION (PUBLIC SECTOR)

EXPENDITURE	Eastern Cape	Mpumalanga	Gauteng	KwaZulu-Natal	Northern Cape	Northern Province	North West	Free State	Western Cape	South Africa Total/Average
Per capita public health expenditure (rands) 1992 / 93[1]	227.0	136.6	381.7	236.9	221.2	164.1	178.9	266.5	491.1	262.6
1995 / 6[2]	301	203	458	334	366	271	271	383	513	347
1996 / 7[3]	366	268	537	356	376	300	307	432	576	421
HUMAN RESOURCES										
Doctors per 100 000 pop 1994[4]*	9.6	12.6	43.9	18.0	14.2+	6.6	1.01	11.0	34.7	-
Nurses per 100 000 pop 1994[4]**	130.7	-	-	151.0	116.0	107.9	100.0	70.5	-	-
Dentists per 100 000 pop 1994[4] ***	0.7	1.4	2.7	1.7	0.3	0.5	1.2	0.9	1.9	
Pharmacists per 100 000 pop 1994[4]	1.4	2.1	3.6	2.6	1.5	1.1	1.7	1.6	4.9	-
FACILITIES										
Hospital beds per 1 000 pop 1992/93[5]	3.5	2.1	6.0	3.8	4.0	2.5	3.3	4.1	5.4	4.0
Distribution of hospital beds by type of hospital										
Academic hospitals (%)	6.8	-	57.6	8.2	-	-	-	31.0	37.5	18.5
Tertiary hospitals (%)	22.0	5.5	9.2	30.7	-	29.2	19.4	9.6	14.5	19.7
Secondary hospitals (%)	12.6	38.4	19.8	20.9	44.4	5.2	17.9	17.5	18.1	18.4
First level hospitals (%)	58.6	56.1	13.4	40.2	55.6	65.6	62.7	41.9	29.9	43.4
Acute beds per 1 000 pop 1994[4]	2.2	-	-	1.6	2.7	2.4	1.6	2.3	-	-
Chronic beds per 1 000 pop 1994[4]	1.0	-	-	0.2	0.7	0.8	0.7	0.5	-	-
Bed occupancy rate (%) 1994[4]	64.0	-	-	79.0	66.6	52.0	58.0	41.0	-	-
Average length of stay (days) 1994[4]	7.0	-	-	9.0	5.9	5.3	7.8	7.0	-	-
Bed turnover rate 1994[4]	34.0	-	-	32.0	44.5	24.4	27.2	-	-	-
No. of hospital deaths per 1 000 admissions 1994[4]	25.0	-	-	36.0	33.8	32.4	19.0	19.0	-	-
No. of hospital beds per professional nurse 1994[4]	2.8	-	-	3.1	3.7	3.2	3.3	2.7	-	-
No of hospital beds per doctor 1994[4]	-	-	-	-	25.2	44.1	25.7	-	-	-
No of admissions per professional nurse 1994[4]	44	-	-	-	-	-	150	-	-	-
% of clinics and health centres with basic amenities 1994[2]										
Adequate water supply	54	-	-	80	93	70	70	93	-	-
Grid electricity	48	-	-	89	88	77	58	91	-	-
Waterborne sewerage	45	-	-	59	43	51	42	73	-	-
Telephone	62	-	-	85	87	77	57	90	-	-
Obstetric and child care										
Caesarian section (as a % of total deliveries in health facilities)[2]	10	-	0.9	10.1	8.7	8.7	8.2	-	-	-
% of clinics with comprehensive MCH services[2]	41.4	-	-	12.8	79.2	70.0	57.0	41.0	-	-
Ratio of antenatal visits to deliveries[2]	-	-	-	6.4	3.4	4.5	5.5	3.9	-	-
IMMUNISATION (% UP TO DATE)										
% of PHC facilities with refrigerators[2]	83.4	-	-	80.6	72.3	79.0	42.0	61.0	-	-
Documented	50.5	64.3	71.4	53.9	69.6	73.1	74.9	62.8	69.7	63.0
Documented and recall	58.0	73.8	85.1	70.7	80.6	84.4	82.0	72.7	80.4	74.4

Sources: 1 ReHMIS Survey in Health Expenditure Review. Durban, 1995.

2 Dept of Finance, South Africa. 1995

3 Makan B et al. IDASA Budget Watch 1996;2(2):4

4 Health (Care) (and Welfare) in : Eastern Cape; KwaZulu-Natal; Northern Cape; Northern Province; North West and Free State: Implications for Planning, 1996. Health Systems Trust, Durban, 1996.

5 Chetty in Health Expenditure Review,Health Systems Trust and World Bank, Durban, 1995.

6 Department of Health. Epidemiological Comments 1995;22(9):185-214

Notes: * General Practitioners and interns

** Professional Nurses in public sector

*** Dentists and Dental specialists (public sector)

+ General Practitioners only

Disaggregation by race

DEMOGRAPHY

	Whites	Coloured	Indian	African	South Africa Average / Total
% Population per province 1994[1]	12.8	8.5	2.6	76.1	100
1995[2]	12.7 ⇓	8.5 ⇔	2.5 ⇓	76.3 ⇑	100
Average annual rate of growth (%) 1994[1]	0.7	1.5	1.5	2.5	2.1
1995[2]	0.7 ⇔	1.4 ⇓	1.4 ⇓	2.4 ⇓	2.1 ⇔
Crude birth rate 1994[1]	13.7	21.7	18.1	25.3	23.4
Crude death rate 1994[1]	6.7	7.2	7.3	10.2	9.4
Total fertility rate 1990[1]	1.8	2.7	2.3	3.7	3.3
1994[3]	1.6 ⇓	2.3 ⇓	2.2 ⇓	3.7 - 4.3 ⇔	2.9 ⇓
Contraceptive prev.rate 1990[1]	75.1	69.5	70.1	50.7	-
1994[1]	80.0 ⇑	74.0 ⇑	77.0 ⇑	66.0 ⇑	-
% Teenage pregnancy 1990[1]	6.3	14.8	6.1	10.7	-
1993[1]	-	8.5 ⇓	-	15.2 ⇑	-
Average household size 1990[1]	3.0	4.7	4.4	4.8	4.5
1994[4]	2.7 ⇓	5.3 ⇑	4.5 ⇑	5.3 ⇑	4.5 ⇔

Sources 1 Chimere-Dan. Demographic Patterns in South Africa in South African Health Review, 1995. Durban, 1995.
2 Central Statistics Services. RSA Statistics in brief. Pretoria, 1995.
3 Central Statistics Services. 1994 October Household Survey. Pretoria, 1995.
4 CASE. A National Household Survey of Health Inequalities in South Africa. 1995.

SOCIO-ECONOMIC

	Whites	Coloured	Indian	African	South Africa Average / Total
% Urbanised 1993[1]	91.1	83.2	96.2	35.8	48.3
% Literate 1993[2]	99	66	84	54	-
Unemployment rate 1994[3]	6.4	23.3	17.1	41.1	33 (40)[4]
Age dependency ratio[5]	49	57.1	48.7	61.6	-
Personal income per capita (R)	-	-	-	-	-
% of Pop with electricity 1994[3]	98.2	75.7	98.5	30.5	36.6

Sources: 1 Yach D, and Harrison D in Public Health in North-South Perspective 1994.
2 Development Bank of Southern Africa in Race Relations Survey, 1993/94. SAIRR, Johannesburg, 1994.
3 CSS October Household Survey 1994. Pretoria, 1995.
4 Lund F and Patel Z. in South African Health Review. 1995.
5 Key Indicators of Poverty in South Africa. Reconstruction and Development Programme. 1995.
6 Medical Research Council. Electrification and Health. A South African perspective. Unpublished. 1994.

	Whites	Coloured	Indian	African	South Africa Average / Total
MORTALITY					
Infant mortality rate 1990[1]	7.4	28.6	15.9	48.3	40.2
1994[2]	7.3 ⇓	36.3 ⇑	9.9 ⇓	54.3 ⇑	48.9 ⇑
Neonatal	-	-	-	-	-
Perinatal mortality rate	-	-	-	-	-
Under 5 mortality rate	-	-	-	-	-
% of deaths ‹ 5 years (1990)[3]	12	19	13	20	-
Adolescent mortality rate	-	-	-	-	-
Adult mortality rate	-	-	-	-	-
Maternal mortality rate 1990[4]	3	30	15	23	32
1992[2]	8	22	5	58	-
Potential years of life lost	-	-	-	-	-
Trauma related deaths:					
Motor vehicle accidents	-	-	-	-	-
Other	-	-	-	-	-
Life expectancy at birth 1990[1]					
Males	69	59	64	60	62
Females	76	65	70	67	68
% deaths due to respiratory causes:					
children ‹ 5 years per 100 000 (1990)[3]	7.0	15.7	7.4	12.0	-
MORBIDITY					
Communicable Diseases					
Incidence TB per 100 000 1993[5]	18.8	712.5	50.8	206.6	224.9
Incidence measles/ 100 000	-	-	-	-	-
Incidence malaria per 100 000 1993[6]	15.3	0.3	0.9	32.8	27.5
Ave annual Incidence of typhoid per 100 000 pop 1985-1994[7]	0.6	0.7	2.1	10.1	7.8
Incidence hepatitis/ 100 000	-	-	-	-	-
Incidence meningococcus	-	-	-	-	-
Incidence congenital syphilis	-	-	-	-	-
% HIV +ve (antenatal) 1994[8]	0.4	1.3	7.0	7.3	7.6
Deaths due to respiratory causes in the under 5 per 100 000	-	-	-	-	-
Non communicable diseases					
Trauma attendances at public facilities	-	-	-	-	-
Private facilities	-	-	-	-	-
Prevalence of dental caries:					
% amongst 6 yr olds (1989)[9]	59.5	79.2	76.3	65.3	66.3
DMFT scores for 12yr olds 1989[10]	1.8	2.1	1.3	1.7	-
Incidence of cervical cancer	-	-	-	-	-

	Whites	Coloured	Indian	African	South Africa Average / Total
DISABILITY					
Prevalence of blindness (%)	-	-	-	-	-
Physical disability (%)	-	-	-	-	-
RISK TAKING BEHAVIOUR:					
% of adults who smoke (1995)[11]	35	59	36	31	34
% of men who smoke[12]	40	63	48	46	47
% of women who smoke[12]	34	49	8	6	13
NUTRITIONAL STATUS OF CHILDREN					
Wasting (%)					
Children ‹ 6 years	-	-	-	-	-
Children in substandards 1 & 2 (1994)[13]	0.9	4.1	5.2	2.4	2.6
Under-weight (%)					
Children ‹ 6years	-	-	-	-	-
Children in substandards 1&2 (1994)[13]	1.1	16.9	6.2	8.7	9.0
Stunting (%)					
Children ‹ 6 years (1994)[14]	4.9	19.1	6.1	28.3	-
Children in substandards 1&2 (1994)[13]	1.8	18.2	4.1	14.6	13.2
Low birth weight babies born (%)	-	-	-	-	-
% Prevalence of Obesity (BMI › 30) adults aged 15-64 (1994)[15]					
Male	14.7	6.1	3.2	7.9	-
Female	18.0	25.9	21.6	34.4	-
Incidence of marasmus	-	-	-	-	-
Incidence of kwashiokor	-	-	-	-	-

Sources: 1 Chimere-Dan in Demographic patterns in South Africa. South African Health Review 1995.

2 Department of Health. Annual Report 1995. Pretoria, 1996.

3 Department of Health. Health Trends in South Africa, 1993. Pretoria, 1994.

4 Department of Health. Health Trends in South Africa, 1992. Pretoria, 1993.

5 Department of Health. Epidemiological Comments; Vol 22 (1). Pretoria, 1995.

6 Department of Health. Epidemiological Comments; Vol 21 (6). Pretoria, 1994.

7 Department of Health. Epidemiological Comments; Vol 22 (2). Pretoria, 1995.

8 Department of Health. Epidemiological Comments; Vol 22 (5). Pretoria, 1995.

9 National Survey Data, 1988 / 89 in Health Status Chapter. South African Health Review 1995. Durban, 1995.

10 Department of Health in Health Status Chapter, South African Health Review 1995. Durban, 1995.

11 Medical Research Council and Human Sciences Research Council Survey. 1995.

12 Community Agency for Social Enquiry. A National Household Survey Health Inequalities in South Africa. 1995.

13 Department of Health. Epidemiological Comments; Vol 22 (4). Pretoria, 1995.

14 SALDRU/ World Bank Report 1993-1994. South Africa Rich and Poor: Baseline household statistics.

15 Walker ARP in Fourie J and Steyn K. (Eds) Chronic Diseases of Lifestyle in South Africa. MRC, 1995.

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