

Health Care in a Democratic South Africa

“The greatest single challenge facing our globalised world is to combat and eradicate its disparities” (Nelson Mandela)¹

Introduction

In preparation for democracy, the ruling party (African National Congress) had developed a National Health Plan for South Africa². The goal was the creation of a unitary, comprehensive, equitable and integrated national health system. The challenge facing South Africans was to design a comprehensive programme to redress social and economic injustices, eradicate poverty, reduce waste, increase efficiency and to promote greater control by communities and individuals over all aspects of their lives. In the health sector this involved the complete transformation of the national health care delivery system and all relevant institutions (including the professional councils, research and health professional training institutions). All legislation, organisations and institutions related to health were reviewed with a view to attaining the following:

- ∞ ensuring that the emphasis was on health and not only on medical care.
- ∞ redressing the harmful effects of apartheid health care services.
- ∞ encouraging and developing comprehensive health care practices that were in line with international norms, ethics and standards.
- ∞ emphasising that all health workers had an equally important role to play in the health system, and ensuring that team work was a central component of the health system.
- ∞ recognising that the most important component of the health system was the community, and ensuring that mechanisms were created for effective community participation, involvement and control.

¹ Address by President Nelson Mandela on Receiving an Honorary Doctorate from Harvard University, Boston, 18 September 1998.

² A National Health Plan for South Africa. ANC. 1994.

- ∞ introducing management practices that were aimed at efficient and compassionate health care delivery.
- ∞ ensuring respect for human rights, and accountability to the users of health facilities and the public at large.
- ∞ reducing the burden and risk of disease affecting the health of all South Africans.

While significant achievements have been made since 1994, the reality of a dualism in health care delivery has persisted with a significant private-for-profit sector alongside the public health sector. A basic rights / essentials needs approach within the public health system has ensured access to health care for all South Africans, especially the poor, but at the same time has not brought about equity. Unless tackled with similar energy and commitment that galvanised the anti Apartheid forces, HIV/AIDS, interpersonal violence and a shortage of human resources may be tipping points in preventing the delivery of quality health care while at the same time crowding out other health priorities.

What were the initial hopes?

The initial hopes can be characterised by one statement – “a better life for all”. There were high expectations by the majority population especially for greater access and care within the social services sector. The Mandela government announced far reaching interventions in the first 100 days of government in 1994. For the health sector, they included eradication of racially based services, free health care for pregnant women and children (later extended to people with disabilities), nutrition support in primary schools and a massive clinic building program to improve access to health services.

Were these hopes fulfilled?

By far and large, yes! Access to health care (within available resources) became an entrenched right in the Constitution of South Africa. Section 27(1) states that ‘everyone has the right to have access to – (A) health care services including reproductive health care...; (3) no one may be refused emergency medical treatment’. Section 28 (1) – ‘Every child has the right to ... basic health care services’.

The use of primary health care services has increased steadily with 67 million visits in 1998, 85 million in 2002 and 98 million in 2004³. The number of annual visits per person to a health facility in South Africa improved from 1.8 per person in 1998 to 2.1 in 2004. Health status indicators showed some improvement – however, disaggregation by race may reveal a different picture.

Table 1: Selected Health Indicators (1998, 2004)

Indicator	1998	2004
Infant Mortality	45.4/1000	43/1000
Under 5 Mortality	59.4/1000	58/1000
Maternal Mortality	150/100000	83/100000
Expanded Program on Immunisation (EPI)	63%	82%
Births attended	84%	92%
Condom use at last sex (15-59 years)	22%	29%

The Batho Pele (People First) program across the public sector and the Patient’s Rights Charter across the health sector showed government’s commitment to humane service delivery and the creation of accountability of civil servants to local communities and consumers of government services. On the other hand, health sector activism has been lacking except in the HIV/AIDS arena where the Treatment Action Campaign has been extremely successful in influencing the political discourse and the policy process. In the days of Apartheid, when gross human rights were trampled and discriminatory health services prevailed, there were substantial health activist groupings with organisations such as the National Medical and Dental Association (NAMDA) and the Health Worker’s Organisation providing a voice alongside civil society and union based organisations. Under democracy, the roles have shifted and health is seen as part of the social services cluster in a ‘developmental state’. A developmental state needs a bureaucracy that can deliver. Such a bureaucracy must therefore have the necessary authority, structure and

³ <http://www.doh.gov.za/docs/reports/annual/2005-06/overview2.pdf>

expertise to function effectively⁴. Custodianship is in the hands of political office bearers and officials. Some participation by civil society does take place in the transformed professional regulatory councils and at advisory boards for health institutions. Many of these advisory boards and clinic committees, however, are not effective as they enjoy no real powers. A formal complaints system is in place in all provinces and periodic patient satisfaction surveys are undertaken. Some provinces have formal accreditation systems that assist with benchmarking and quality improvement. The private sector has very little community participation. The only role that consumers play in the private sector is through representation on the governing boards of medical aids (health plans).

Health is not high on the agenda of individuals and communities when their daily struggle is for food and jobs. On the other hand, the fact that one can access health care in the public sector during times of need and it is free in most cases is viewed positively. The public health system does deliver services albeit with some inefficiencies, inadequate quality of care in some facilities and poor infrastructure in some places. For those that have the ability to pay, the South African private health system is viewed amongst the top four in the world.

Background

Pre 1994, South Africa had a highly fragmented and bureaucratic health care system. Administration of health care was fragmented, with 14 separate departments to look after the health of the different racial groups, the four homelands, and six "self governing" territories. At an organisational level, there were multiple ministries and departments based on race (the Tricameral System) and ethnicity (the homeland governments). Vertical fragmentation was through service differentiation (preventive and curative services) amongst the federal government, the provinces and local authorities. Public health services for whites were better than those for blacks and those in the rural areas were significantly worse off in terms of access to services compared to their urban counterparts. Expenditure on tertiary health services was prioritised above Primary Health Care services. Further inequities were entrenched through the development of a

⁴ South African Health Review. Health Systems Trust. Pg 4.

private for profit sector that was unregulated but well supported and organised through private financing (health insurance funds or ‘medical aids’), private hospitals, pharmacies and health practitioners. The irony was that government employees themselves contributed to these health funds and accessed their care from private health facilities.

The artificial paradox of the best of First World medicine and the worst of Third World medicine within a few miles of each other resulted in extreme inequity in the health profile of the country. This inequity was evident in the indicators of health. Infant mortality, maternal mortality, life expectancy at birth, and the incidence of infectious diseases like tuberculosis and measles were all higher among black people. For example, in 1985, the infant mortality for white infants was 13.1/1000 but 70/1000 for black infants⁵. The health status of the population reflected the social and economic divisions of an Apartheid society. Poor access to clean water, sanitation, housing and food contributed to the poor health status of black South Africans. An additional burden of illness was trauma (as a result of state sponsored violence). This had both physical and mental health manifestations and affected both the oppressed and the oppressor.

The statistics do not reflect the harsh reality at the human and individual level. The ‘pencil’ test^{6,7, 8} to determine access to care in emergency rooms in white hospitals and size of lips in babies were some of the (un)scientific tests used by health professionals during that era.

Health professional training was also conducted on racial grounds with one medical school for the majority black population up to 1977 and five for whites. A further two medical schools for blacks were commissioned in the late 70s and 80s. Apart from nursing and medicine, there was very little health professional training opportunities in

⁵ Rajendra Kale. South Africa's Health: Impressions of health in the new South Africa: a period of convalescence. *BMJ* 1995;310:1119-1122 (29 April).

⁶ A test using a pencil through the hair – if the hair curled around the pencil, then the patient was not admitted to the white hospital.

⁷ <http://www.art.co.za/johanthom/pencil.htm>

⁸ http://www.rebirth.co.za/apartheid_and_immorality2.htm

the other health disciplines (pharmacy, physiotherapy and dentistry etc) for blacks. This is reflected in the current demographic profile of health professionals where whites still outnumber blacks in all disciplines other than nursing.

Post 1994, South Africa was one of the few countries in the world where wholesale transformation of the health system began with a clear political commitment to ensuring equity in resource allocation, restructuring the health system according to the 'district health system' (DHS)⁹ and delivering health care according to the principles of the primary health care (PHC) approach.

South Africa and the International Health Economy

In 2000, the world GDP was USD 31 trillion and global health spending was USD 2.6 trillion (8%). Health spending in developing countries was USD 280 billion with 0.4 % being spent in Sub-Saharan Africa. In 2005, global pharmaceutical spending was USD 602 billion¹⁰ with Africa accounting for a paltry 1.4% of pharmaceutical sales.

South Africa is classified as a middle income country with a GDP per capita of USD 3000 and a population of 47.3 million. Approximately USD 16.7 billion is spent on health care which amounts to 8.7% of GDP¹¹. The private sector share is 5.2% and public sector is 3.5%. Its GDP per capita spend on health is USD 300. It has been described as a 'small rich country surrounded by a large poor country'. South Africa has a tax funded public health system covering 85% of the population and a well entrenched private health system covering the rest. The bulk of private funding comes from medical aid contributions (66%) and out-of-pocket payments (23%). Donor aid plays a minor role in health care. The public health system is led by the National Department of Health (federal) which is responsible for overall health policy and co-ordination. Implementation and delivery of health services is through the 9 provinces (states) and 284 municipalities (local government authorities). The provinces provide mainly (curative) hospital services

⁹ The District Health System is the lowest management unit that organises health care delivery through clinics, health centres and district hospitals in a geographically defined area. It also covers environmental health.

¹⁰ New products and markets fuel growth in 2005.

http://www.imshealth.com:80/web/content/0,3148,64576068_63872702_70260998_77974518,00.html

¹¹ <http://www.doh.gov.za/docs/reports/2005/inequity.pdf>.

with local / municipal government providing primary health care and non-personal (environmental) health services. The Department of Health derives its mandates from the Constitution of South Africa as well as the National Health Act (No 61 of 2003). The Ministry of Defence provides services to the armed forces and Ministry of Correctional Services to prisoners.

The public health budget accounts for between 10 and 11% of the overall budget of government. Since fiscal decentralisation (to the provinces) there is great variation between provinces on the actual budget allocations for health. There continues to be significant inter-provincial inequities¹² even though the variation in per capita spending between provinces has reduced from 3 to 2 fold. Within each province there is also large intra-provincial inequity, with the rural areas continuing to bear the brunt of poverty and inadequate resource allocation. In the Eastern Cape, for example, some districts are 166% above the equity target whilst others are below by 77%.

Over the last 13 years, a national health system has evolved with 5 year planning frameworks since 1994 reflecting major transformation agendas. The period 1994 to 1999 focused largely on increasing access to health care especially for those who did not have access in rural and other under-served areas of the country. It also concentrated on structural reorganisation of the health system especially as it related to the government funded public health system. The next five years (1999 to 2004) concentrated on quality issues in health care while also beginning an interventionist role in private health care through legislative reform. The period 2004 to 2009 consolidates the health system while making substantive inputs to resolving the human resource issues. Capacity building programmes for managers were instituted and development of new cadres of health workers are being introduced. The majority of health professionals other than nurses work in the private sector while the 'brain drain' to other countries has deepened the crisis in the delivery of services. To this end, South Africa raised its voice in various international forums such as the WHO and the Commonwealth and has implemented the

¹² <http://www.doh.gov.za/docs/reports/2005/inequity.pdf>

Commonwealth Code of Practice for the International Recruitment of Health Workers¹³. The impact of the HIV/AIDS pandemic alongside trauma and interpersonal violence has created additional stress on the health system and on its human and physical resources. Vacancy rates range from 13 to 40% across provinces with an average of 31% for South Africa¹⁴.

At a macro level, interventions in housing, sanitation, water supply and food security have played a major role in improving the health status of all South Africans. The HIV/AIDS epidemic alongside trauma and violence has wiped out some of the gains of the earlier 'peace' dividend. Some progress has been made in achieving the Millennium Development Goals notwithstanding a GINI coefficient of 0.59 and a Human Development Index of 0.653 (rank 121 out of 177 countries).

The public health system can be proud of the structural transformation it has effected. Hundreds of new health facilities have been built or rehabilitated, and health care has been made free at the point of delivery for pregnant women, young children, persons with disabilities and all who use the public primary health care system. New posts have been created at the primary level of care, albeit with the inability to fill the posts owing to shortages of personnel. Access to essential health care has been greatly improved. Care in the public sector is delivered through 400 hospitals and 4100 clinics and health centres and the public health sector employs 240 000 persons with 137000 being health professionals.

Health Status

As with many other countries in demographic transition, South Africa faces the quadruple burden of disease. The health status of the population does not reflect the gains of an improved health system. South Africa is ranked low in health system performance

¹³ General statement by the Minister of Health of South Africa, Dr M.E. Tshabalala-Msimang, during the Fifty-Eighth World Health Assembly held in Geneva. 16 - 25 May 2005.

¹⁴ Percentage of health professional posts vacant. South African Health Review. HST; 2005. p5.

compared to other middle income countries and even some lower income countries. The past South African Demographic and Health Survey (SADHS - 2003) found that South Africans are not very healthy, even though we are classified as a middle income country. The Infant Mortality Rate is 45/1000 and life expectancy is now 50 years for males and 53 years for females. The IMR is projected to increase further as a result of the HIV/AIDS epidemic. Close to 60 children per 1000 die before their fifth birthday. Many mothers die delivering babies - estimated to be 83 per 100000 women.

Table 2: Quadruple Burden of Disease

<ul style="list-style-type: none"> ■ Threats to Health <ul style="list-style-type: none"> ■ Natural disasters ■ Interpersonal violence ■ Residual of Infectious Diseases <ul style="list-style-type: none"> ■ Cholera, Tuberculosis ■ Emerging Epidemics <ul style="list-style-type: none"> ■ HIV/AIDS ■ Drug resistance (TB, Malaria, etc.) ■ New Infections (avian 'flu) ■ Epidemiological Transition <ul style="list-style-type: none"> ■ Chronic Diseases and Injuries ■ Occupational & Environmental ill-health ■ Mental health ■ Obesity & Tobacco related
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A related problem with the HIV epidemic, but equally important is Tuberculosis (TB). The TB rate is increasing. In addition, it is estimated that 50% of HIV infected persons will contract TB thus increasing the rate despite the successes achieved via the DOTS¹⁵ strategy. The Medical Research Council estimates that the current TB epidemic will increase four fold over the next 10 years due to the effect of HIV/AIDS. XDR TB¹⁶ has

¹⁵ Direct Observed Treatment Strategy

¹⁶ Extremely Drug Resistant

now reared its head and has spread to all parts of the country and reflects a failure in TB control alongside the maturing AIDS pandemic.

With respect to chronic diseases, the SADHS¹⁷ found that 8% of adults had asthma, 12% had hypertension, and rates of overweight persons (29% men and 55% women) and obesity (9% men and 29% women) were high.

Violence against women is a growing problem (maybe a result of increased reporting). The SADHS found that 13 % of women were beaten by their partner - most common amongst less educated, non-urban African women. However other studies show higher figures. In addition, 4% of women reported being raped (again, other studies suggesting significantly higher prevalence).

The disease profile depicted does not reflect a healthy nation or a middle income country that spends 8.7% of GDP on health services.

HIV/AIDS

No description of the health system in South Africa is complete without some inputs on HIV/AIDS. HIV/AIDS represents one of the major challenges facing South Africa today alongside crime, interpersonal violence and accidents (transport and workplace related). Of the 39.5m people worldwide living with HIV in 2006, 63% were in sub-Saharan Africa. About 5.54m are estimated to be living with HIV in South Africa with 18.8% of the adult population (15 – 49) infected.

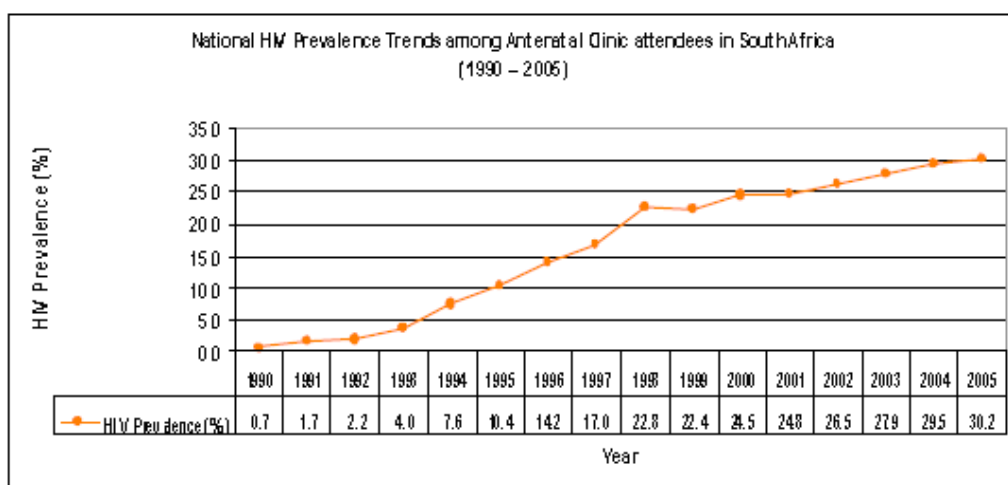
There are geographic variations with the province of KwaZulu-Natal the worst affected. People living in rural and urban informal settlements appear to be most at risk unlike other parts of Africa where the rural populations were relatively isolated from the epidemic.

¹⁷ South African Demographic and Health Survey.

Table 3: People living with HIV/AIDS (top 10 countries)¹⁸

Rank	Country	Number of persons
1	India	5,700,000
2	South Africa	5,500,000
3	Nigeria	2,900,000
4	Mozambique	1,800,000
5	Zimbabwe	1,700,000
6	Tanzania (United Rep. of)	1,400,000
7	Kenya	1,300,000
8	United States of America	1,200,000
9	Zambia	1,100,000
10	Congo (Dem. Republic of)	1,000,000

Figure 1: National HIV prevalence trends among antenatal clinic attendees in South Africa: 1990 –2005



Source: Department of Health, 2006

Women are disproportionately affected and comprise 55% of the total. Women in the age group 25 – 29 are worst affected with prevalence rates up to 40%. HIV prevalence amongst younger women (less than 20 years) appears to be stabilising with prevalence rates around 16%.

¹⁸ People living with HIV/AIDS (adults and children). Global Data, 2006; Country Data, 2005. <http://www.globalhealthfacts.org/topic.jsp?i=1>

The South African epidemic is characterised as a generalised one with the ability to propagate on its own if unchecked. Fortunately, reason has prevailed and South Africa has just announced its national HIV/ AIDS multi-sectoral strategy for the period 2007 – 2011. The targets are ambitious and will see a million people on treatment by 2011. There have been many missed opportunities in the HIV/AIDS response in South Africa and to a large extent was due to the lack of political leadership and high-level commitment. Hope for a renewed commitment has been buoyed by the country's ambitious plan to spend as much as USD 1.9 billion¹⁹ on halving the rate of new HIV infections in the country by 2011 and providing treatment, care and support to at least 80% of people living with HIV/Aids and their families.²⁰

The 10 priorities²¹ are:

- Establishing a national treatment literacy program;
- Initiating an "extensive" HIV testing campaign involving "prominent national and community figures";
- Increasing behavior-change interventions to ensure that more than 70% of the country's population is reached by such interventions;
- Targeting the "spike" in HIV cases among women ages 18 to 21;
- Targeting schools that report five or more pregnancies annually;
- Renewing national efforts to keep young people enrolled in school;
- Reinforcing the beneficial effects of businesses in the fight against HIV;
- Establishing a national "positive prevention" initiative to ensure that HIV-positive people are aware of treatment, prevention and care options;
- Focusing on "key biomedical interventions that can make a big impact"; and
- Setting "clear benchmarks of progress" during the plan's first 100 days.

¹⁹ South Africa: Activists welcome ambitious new AIDS plan.

<http://www.plusnews.org/Report.aspx?ReportId=70725>

²⁰ South Africa's Aids action plan. http://www.southafrica.info/ess_info/sa_glance/health/aidsplan.htm

²¹ http://www.kaisernetwork.org/Daily_reports/rep_index.cfm?DR_ID=43728

The plan brings together a substantial and meaningful partnership between government and civil society. The implementation of the plan has many challenges including supply chain problems and a lack of human and technical resources.

Funding of HIV/AIDS interventions has been increasing over the years, both in the public sector and in donor assistance. Donor funding for HIV/AIDS in South Africa is channeled through bilateral aid to government departments and direct funding to NGOs from international aid agencies. However, funding to NGOs is particularly difficult to track because there is no centralised reporting mechanism in place for all international aid to the NGO sector. There are substantial funds within the government's budget for the HIV/AIDS response and amounts to USD 400m in this financial year. Supplementing this are donor funds. The Organisation for Economic Cooperation and Development conducted a detailed analysis of HIV and AIDS foreign aid commitments to developing countries for 2000 to 2002. The analysis indicated that South Africa was amongst the top five countries that received the largest shares in total HIV and AIDS commitments. Of the total HIV and AIDS commitments, Zimbabwe, Kenya, Nigeria and South Africa received 18%, 11%, 13%, and 8% respectively. According to the OECD 2000 – 2002 report, the 8% for HIV and AIDS to South Africa formed 99% of health-related donor aid in the country.²²

²² Nhlanhla Ndlovu. An exploratory analysis of HIV and AIDS donor funding in South Africa. IDASA. Budget Brief No. 155.

Achievements

The following summary reflects the key achievements in the health sector since 1994²³:

- ∞ Outlining of the government's health policies through the tabling of the White Paper on the Transformation of the Health System.
- ∞ Consolidation of fourteen fragmented health administrations inherited from the apartheid system into a streamlined national (federal), provincial departments and local government health hierarchy.
- ∞ Expansion of the primary care infra-structure:
 - Since 1994 more than 700 new clinics and 18 new hospitals have been built or had major upgrading (495 of which were completely newly built);
 - 2298 existing clinics have received new equipment and were upgraded;
 - 124 new visiting points were built; and
 - 125 new mobile clinics purchased.
- ∞ Health care, free at the point of delivery, for pregnant and lactating women, children under the age of six years and all who use the public primary health care system was introduced.
- ∞ The provision of primary school nutrition services through which about 5 million children have benefited and many employment opportunities have been created in communities.
- ∞ Major progress was achieved with the implementation of the district health system through the demarcation of health districts and the setting up of the regional and district offices.
- ∞ Launching of the National Drug Policy and the development of essential drug lists and standard treatment guidelines for primary health care and hospital levels.
- ∞ The introduction of community service and a two year internship for newly graduating South African doctors.
- ∞ An impressive record in transforming health legislation. Acts have been passed to:
 - Consolidate the health system under the National Health Act

²³ South African Health Review 2005. Health Systems Trust

- Rationalise the Health Professions Councils and make them more representative of the South African population;
- Create the Traditional Healers Council;
- Make drugs more available and affordable in the country;
- More effectively regulate the private health care industry;
- Enable safe and legal termination of pregnancies in public and private facilities;
- Warn the public of the dangers of smoking; and
- Limit smoking in public places and ban the advertising of tobacco products.

Some interventions that have been made include:

Improving Quality of Care

One of the key challenges was to improve the quality of care provided in the public health sector. There were substantive increases in Primary Health Care spending with concomitant infrastructural development in hospitals (a backlog of \$2 billion capital investments was identified in 1996) and consolidation of the laboratory, forensic and other support services. The role of health service users in ensuring that their needs are met and that the quality of care provided is of acceptable standard is critical to the development of a service that provides high quality care. Health care providers also have an important role to play in this regard.

Modernisation of tertiary health services

The creation of an extensive primary, secondary and tertiary health system with appropriate referral pathways required an enhancement of the National Planning Framework for the provision of hospital services throughout the country. This included guidelines for the number of beds at different levels that were required and affordable. It also dealt with the planning and funding options available for the provision of tertiary and highly specialised services for which patients often needed to be referred from one province to another.

Contestation of the public and private sectors

There is gross inequitable distribution of human and financial resources between the private and public health sectors, and in the public sector between the predominantly rural poor provinces and urbanised provinces. The private sector, accessible to less than 20% of the population, consumes more than 60% of the healthcare budget and employs more than 70% of the healthcare specialists.

The public sector has faced the challenges of transformation and re-organisation, budget reform, enhancing quality of care and human resource management. The private sector on the other hand has faced cost escalations with stagnant coverage of the medical aid population. Government reforms have brought about the creation of the Government Employee Medical Scheme (GEMS) with a view to unifying all civil servants into one fund. A further reform is the introduction of a Low Income Medical scheme (LIMS) to cover low wage earners and extend private health insurance cover beyond the 7 million South Africans. Drug prices are being regulated and the introduction of prescribed minimum benefits for chronic diseases under medical aid schemes brought some relief to consumers. Further reforms are allowing for preferred provider networks to be negotiated by medical aid schemes. The Competition Commission has also intervened in the private health industry where consolidation and vertical integration may become a problem. Three hospital groups dominate the private health sector and two are listed on the Johannesburg Stock Exchange. They control approximately 80% of the private beds in the country.

A 'certificate of need' was introduced to ensure that public and private health care facilities met minimum geographic and facility type norms and prevented the construction of new facilities in over-subscribed areas. The purpose of the certificate of need and licensing system is to prevent over-expansion in the supply of health services in areas of relative oversupply and to encourage the development of services in under-served areas.

Contribution to Global Health

Governance and international engagement

Key policy interventions by the South African government included the:

- ∞ WTO / TRIPS and drug policy (this led to substantive decreases in drug prices and improved access to drugs for poor countries)
- ∞ Tobacco control framework (through the WHO)
- ∞ The Truth and Reconciliation commission (healing through dialogue in post-conflict situations)

South Africa has broadened its international engagement considerably within the United Nations (UNICEF, WHO, UNEP etc), European Union, African Union, Southern African Development Community and through bi-national commissions or bi-lateral agreements. Many of these include health related activities and allow South Africans to participate in opportunities to strengthen international health development strategies and share technical assistance with respect to health sector reform.

An Africa wide engagement through NEPAD has been put in place. Explicit health commitments²⁴ include:

- ∞ Reduction of infant and child mortality rates by two thirds by 2015
- ∞ Reduction of maternal mortality ratios by three quarters
- ∞ Provision of access to reproductive health services
- ∞ Revitalisation and expansion of programmes to decrease incidence of communicable diseases including HIV, TB and malaria in collaboration with development partners
- ∞ Encouragement of cooperation between medical practitioners and traditional healers
- ∞ Mobilisation of resources for infrastructure and management capacity
- ∞ Reduction of the burden of disease on the poor

²⁴ Ronald Labonte et al. Fatal Indifference - The G8, Africa and Global Health. IDRC, 2004.

Health related commitments under NEPAD included poverty reduction activities, improved food production and nutrition support and providing a healthy environment. Through its involvement with the Global Fund for AIDS, TB and Malaria as well as the Global Vaccine initiative, the Department of Health has made substantial resource investments in international health.

Human Capital

The health sector was one of the first to acknowledge the racial disparities amongst health professionals. To this end, guidelines for equity targets have been set for all health professional training institutions in the country. This has created tensions with many potential applicants for training and few places (within the 'quota' system).

A further issue facing South Africa and other developing countries is the brain drain and loss of health professionals to the developed countries. South Africa has raised its concerns in various international fora such as the WHO and in bi-laterals with developed countries. Various push and pull factors have been analysed and strategies are in place within the Human Resource Plan²⁵ to address these. They include improving the health facilities and conditions of service, increasing the production of numbers of health professionals and developing new cadres of health workers. HIV/AIDS has also taken its toll on health workers – through increasing patient load as well as infections amongst the health workers. The occupational health of health personnel is of increasing concern given the biological hazards that confront them on a daily basis in inpatient and outpatient settings. Tuberculosis in the health workforce is rising.

South Africa is assisting with the education and training of medical doctors and other health professionals for the SADC region. Through its distance learning activities, the University of South Africa is supporting an extensive Public Health programme within South Africa and across Africa.

²⁵ http://www.doh.gov.za/docs/discuss/2006/hrh_plan/exec_summary.pdf

Private Health Sector

The private health sector is well entrenched in South Africa and has begun substantial international acquisitions. The medical aid (health plans) industry has extensive investments and activities in the region and abroad. The major hospital groups have acquired hospital groups in the United Kingdom and Middle East. The pharmaceutical industry is integrated with Global pharma and has joint ventures with Cuban, Indian and Brazilian companies. At the service level, cross border referrals and medical tourism is a growing business area. Emergency medical service provision within Africa is increasing both as support to South African capital as it moves into other African countries and in the provision of occupational health and safety services especially in the mining industry. The Development Bank funds many health investment projects in the region. Increased corporatisation has raised the profile of the private health sector and it is seen as a major investment opportunity for realising profits by investment analysts.

Medical Research

South African researchers have enjoyed international recognition and were integrated into global and regional research networks even under apartheid. Contributions include the heart transplant program and the CT scanner as well as innovative public health delivery systems (the Pholela experiment with integrated social development and community health²⁶). There are strong legal, ethical and governance frameworks in place and considerable financial and human investments from the international donor community. The Medical Research Council, the Human Sciences Research Council, the Council for Scientific and Industrial Research as well as the medical and other health professional training schools are world renowned and have substantial exchange of scientists and knowledge with their international counterparts.

²⁶ <http://www.kznhealth.gov.za/pholela/history.htm>

What are the hopes for the next ten years?

A tipping point has been reached – overworked health providers in the public health system and a maturing AIDS epidemic alongside trauma and injury may threaten the sustainability of the system. Health systems are the most complex to manage given the multiplicity of inputs (human resources, technology, drugs and infrastructure) on the supply side and uncertainty on the demand side. The needs of an aging population alongside the issues of crime and HIV/AIDS needs to be factored into general health care planning. Factors outside the health sector that have an effect on health include poverty eradication and job creation. The policy papers are well developed – the critical need is implementation of policy against a backdrop of a major skills shortage in all aspects of South African society. The health system needs medium term planning as specialist practitioners take a minimum of 12 to 15 years to achieve competency and thereafter continuing professional development to keep them abreast of new knowledge and interventions. Notwithstanding their commitments to appropriate recruitment practice, the developed countries’ demand for skilled human resources for their health and social care systems will continue. The developed countries have an aging population, an aging health workforce and poor perception of health and social services as a career. Health care unlike any other system needs human capital – even to feed a recuperating patient!

Challenges

Many challenges remain.

- ∞ Economic stability and peace are vital to sustainable health systems. The wider investments in housing and a clean environment, access to water, jobs and food security are important co-factors in creating a healthy nation.
- ∞ Planning and management skills are still weak at all levels, but especially in hospitals.
- ∞ Management systems need to be upgraded; essential management information is lacking at all levels of the health system

- ∞ Ensuring cooperation between the public and private sectors including expanding public private partnerships (PPPs) and Public Private Interactions (PPIs), implementing the Health Charter (access to health services, equity in health services, quality of health services and increasing the stake of Black empowerment players in private health care) and deepening dialogue.
- ∞ Decreasing the incidence of HIV/AIDS, STIs²⁷ and TB. Substantive government and donor resources have been made available. The challenges are in implementation and strengthening service delivery especially with human capacity development. A comprehensive plan to manage HIV/AIDS has been introduced and covers prevention, treatment, care and support activities. This is a cross cutting programme and involves community and faith based organisations, other government departments, the private, NGO and donor community.
- ∞ Improvement of women's health and reduction of maternal mortality. Maternal mortality ratio remains high at 83/100 000. The major causes of maternal deaths currently are hypertension, HIV/AIDS related conditions, haemorrhage and cardiac disease.
- ∞ An integrated approach to reduce the morbidity and mortality associated with chronic disease is essential in order to improve health and social wellbeing of individuals and communities. Dealing with diseases of lifestyle is critical especially given the pace of the epidemiological transition in the country. Mental health issues (especially with the high trauma and violence rates) are subsumed under the overall burden of infectious disease and will need special interventions both within the health system and across other sectors.
- ∞ Equity in health care provision remains an issue. The critical area of concern is equity between the public and private sectors while inter and intra provincial inequity has to be managed through structural reforms with budgets and other resources as well as substantial social re-tooling (migrant labour, job creation and spatial development inputs).
- ∞ Human resource development. While some progress has been made with respect to the planning, training and deployment of human resources much work remains

²⁷ Sexually Transmitted Infections.

to be done to produce, recruit and retain health workers especially in the rural and underserved areas.

- ∞ Of special note are the development of health programmes for vulnerable groups such as refugees and displaced. Given the overall developmental needs of the country, these vulnerable groups may be neglected and may not be able to access services.

Conclusion

The South African health system has come a long way since 1994. Its building blocks are in place to provide a comprehensive health system that is underpinned by quality, a skilled workforce and appropriate infrastructure. There is an impressive constitutional, legal and policy framework that guarantees the right to access health care to all persons in South Africa. Some difficulties lie in its implementation. The HIV/AIDS epidemic and violence has crowded out many of the health gains made since the advent of democracy. The need to strengthen cooperative governance across the national, provincial and local government spheres as well as between the private and public sectors is recognised and will assist the agenda for further reform and transformation.

Acknowledgements

1. Annual reports of the Department of Health. (2003, 2004, 2005)
2. South African Health Review. Health Systems Trust. (2003, 2004, 2005, 2006)
3. National Treasury budget review report. (2004)
4. International Health Summit. (2002; 2004)