

TWENTY YEAR REVIEW

SOUTH AFRICA

1994 - 2014



BACKGROUND PAPER: HEALTH



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The background papers are written by officials in the Presidency and other government departments using inputs from literature reviews, commissioned research, government reviews, reports and roundtable discussions with a range of stakeholders. The views reflected in the background papers do not represent those of the Presidency, but rather reflect authors' views on sector developments.

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Policy Summary

This is a headline view of selected key policies impacting on health since 1994

1996: Free health care for children under 6 years of age and pregnant women and free primary health care for all, which improved access to primary services for all South Africans.

1996: The Choice in Termination of Pregnancy Act legalised abortion, leading to a decline of over 90% in abortion-related mortality.

1997: The White Paper for the Transformation of the Health System in South Africa set the framework for the Health Act of 2004; many of the principles of the White Paper were later legislated in the National Health Act, 61 of 2003.

1999: The Tobacco Products Control Amendment Act, 12 of 1999 prohibited smoking in public places, restricted tobacco product promotion, and enhanced taxation; contributed to substantial reduction in smoking.

2000: The Mental Healthcare Act legislates against discrimination against mental health-care users.

2003: Comprehensive HIV and AIDS Care, Management and Treatment Plan (CCMT) Operational Plan facilitated the provision of antiretroviral treatment (ART)

2004: The National Health Act, 61 of 2003 legislates for a unified national health system incorporating public and private sectors and the provision of equitable health care services throughout South Africa.

2007: The HIV & AIDS and STI Strategic Plan For South Africa 2007-2011; a broad framework for a comprehensive approach to dealing with HIV including prevention, treatment and care as well as human rights issues.

2010: The Primary Health Care Re-engineering strategy aims at strengthening preventive and promotive health care and improving the quality of care through taking care closer to the people and strengthening the district health system.

2011: The Green Paper for the establishment of National Health Insurance, ensuring universal coverage for a specified basket of services available free at the point of service delivery.

2011: Human Resources for Health Strategic Framework for South Africa.

Executive Summary

This 20-year review of the health sector (1994-2014) lends insight into the progress made by the democratic government of South Africa towards ensuring access to health care for its all citizens. The review also provides a reflection on the key challenges and persistent constraints that continue to afflict the South African health sector.

The health system inherited by the democratic government in 1994

In 1994, the new government inherited a fragmented, inequitable, predominantly curative and racially segregated health system, characterised by racial and geographical inequalities. The country had a total of 14 health departments, including those of the homeland administrations. Public health scholars in South Africa described the health system legacy of apartheid as: centralised and undemocratic; highly fragmented in structure; inefficiently and inequitably biased towards curative and higher level services; and inequitably biased towards historically white areas. The burden of disease in South Africa mirrored the structural racial and socio-economic inequalities, with the African and Coloured population carrying the heaviest burden. Key health indicators including life expectancy; the maternal mortality rate; infant mortality rate; incidence of Tuberculosis (TB); and measles cases, were the worst amongst the African and Coloured population, while the white population manifested the best health status indicators.

Transformation of the South African health system

The National Health Plan for South Africa, produced by the African National Congress (ANC) in 1994, envisaged an integrated, equitable and comprehensive health system, based on the Primary Health Care (PHC) approach. The Constitution of the Republic of South Africa buttressed the right of access to health care. In 1997, the White Paper for the Transformation of the Health System, produced by the National Department of Health, codified into government policy the vision for a transformed health system. The National Health Act (No 61 of 2003) provided the legal framework for the policies outlined in the preceding documents. The health system priorities of the democratic government were embodied in three sets of documents known as the Health Sector Strategic Framework 1999-2004; Strategic Priorities for the National Health System 2004-2009; and the 10 Point Plan for 2009-2014.

Achievements

Achievements of the country during the first 10-15 years of democracy, which are encompassed in previous reviews included: (i) the development of the policy and legislative framework for the creation of a single integrated health system in the country, (ii) improved access to health care services for all South Africans, through a massive expansion of health infrastructure; (ii) the construction or refurbishment of 18 new hospitals across South Africa through the Hospital Revitalisation

Programme; (iii) the policy of free health care for pregnant women and children under-6, which resulted in enhanced access to primary care services for all South Africans; (iv) improved immunisation coverage for children under the age of one; (v) significant decreases in severe malnutrition amongst South African children, through massive provision of Vitamin A supplementation; (v) approval and implementation of the Comprehensive Plan for HIV and AIDS Care, Treatment and Management in 2003. Various pieces of legislation were also passed to protect Public Health, such as the Tobacco Control Products Control Amendment Act, 12 of 1999.

During the fourth term of democracy, government accelerated the implementation of key health programmes such as the provision of ART; strengthening of the Prevention-of-Mother-to Child-Transmission (PMTCT) of HIV programme; introduction of the HIV Counselling and Testing programme, and the use of social mobilisation and new technology in combating Tuberculosis. Major achievements attained during the fourth term of democracy, building on the foundation laid during the first 15 years of democracy, which are borne out by empirical evidence are as follows:

- (a) An increase in overall life expectancy from 56,5 years in 2009 to 60.0 years in 2011. This has resulted from efforts to reverse the frontiers of HIV and AIDS, both in terms of the massive provision of antiretroviral therapy (ART) to eligible people living with HIV, as well as the reduction of new HIV infections and mortality from AIDS.
- (b) A significant improvement in child health and a major reduction infant mortality rates (IMR) and under-5 mortality rate (U5MR). The under-5 mortality rate (U5MR) from 56 deaths per 1,000 live births in 2009, to 44 deaths per 1,000 live births in 2012; and a decrease in the Infant Mortality Rate (IMR) from 40 deaths per 1,000 live births in 2009, to 29 deaths per 1,000 live births in 2012. This was due to the successful implementation of the PMTCT programme, introduction of the two new child vaccines, and measures to address social determinants of health, including housing, clean water and proper sanitation. The mother-to-child transmission (MTCT) of HIV decreased from 8,5% in 2008, to 3,5% in 2010 and to 2,5% in 2011; and
- (c) A decrease in total number of people dying from AIDS from 300,000 in 2010 to 270,000 in 2011.
- (d) 50% decrease in the number of people acquiring HIV infection, from 700,000 in the 90s to 350,000 in 2011.
- (e) Third, major milestones have been attained towards combating Tuberculosis (TB). TB cure rates have improved while TB defaulter rates have decreased. Most importantly, all these achievements can be traced back to major strategic interventions made by government.

Empirical evidence unequivocally attests to these improvements. Most importantly, all these achievements can be traced back to major strategic interventions made by

government at all levels. The 20-year reviews produced by Provincial Administrations in South Africa in July 2013 corroborate these achievements.

Challenges

Notwithstanding the major successes achieved during the twenty-years of democracy, the health sector continues to be besieged with major challenges. These include the following:

- (a) Poor quality of care, illustrated by persistent complaints and evidence from patients, civil society and the media about services provided at health facilities.
- (b) Persistent health inequities
- (c) Spiralling costs of care in the private health sector
- (d) Limited progress with the implementation of the District Health System
- (e) Operational management weaknesses
- (f) Declining levels of community participation
- (g) High Maternal Mortality Ratio
- (h) Rising burden of Non-Communicable Diseases
- (i) Violence and injuries
- (j) Unaddressed social determinants of health
- (k) Instability of the Health Leadership

These challenges have several root causes. First, South Africa has a dual and fragmented health system, which has given rise to major health inequalities. The private sector serves only 17,9% of the population (9,285 million people), and the public sector serves 82,2% (51,943 million people). The private sector has the majority of medical specialists; medical doctors; pharmacists and dentists, but remains accessible to only a segment of the population that can afford medical aid. Second, although health care delivery is a concurrent function between the national and provincial spheres of government, while local government is responsible for municipal health services, co-ordination of policy implementation between the three spheres has not been optimal. The inability of the health sector to implement a well-functioning District Health System (DHS) as a vehicle for the delivery of Primary Health Care (PHC) is a case in point. Whereas the country has been demarcated into 52 health districts, and district managers appointed, there has been limited delegation of powers by provinces to district and facility health management.. Fourth, community participation in health issues has also diminished over the years. Fifth, Gross financial mismanagement also exists, and has, for instance, led to the Department of Health in Limpopo Province being placed under national administration, and several senior government officials being subjected to disciplinary processes for financial misconduct. Efforts to combat such unethical behaviour in the public health sector must be escalated.

In most parts of the country the health sector has weak operational management capacity at subnational levels. This is evidenced by poor financial management

reflected in the reports of the Auditor-General of South Africa; inefficient patient information systems; inefficient drug supply and management systems, which impact on patient care and patient waiting times. Management capacity has also been compromised by inappropriate appointments made over the years in critical positions, including those of Chief Executive Officers of Hospitals. Furthermore, although health outcomes in South Africa have improved enormously, particularly during the fourth term of democracy, they are not yet commensurate with the country's expenditure on health, which amounts to 8,5% of the Gross Domestic Product (GDP). These outcomes also do not yet compare favourably with those of other middle income countries, including the BRICS countries. The country's progress towards the health related MDGs is regarded as significant, but insufficient.

Summary and recommendations

The National Development Plan (NDP) 2030 NDP 2030 envisions a health system that works for everyone and produces positive health outcomes, and is accessible to all. South Africa remains one of the most unequal societies. The development of NHI is an important reform of the health sector, aimed at addressing the persistent inequities between the public and private sectors, and ensuring an equitable distribution of resources, an improved access to quality health care for all South Africans. However, this requires commitment and support from the whole of society, particularly when the financing mechanisms are finalised. The NDP 2030 also underscores the importance of meaningful public-private partnerships in the health sector, including civil society organisations, particularly for NHI. A well-functioning DHS delivering quality PHC services in a fundamental pillar for the successful implementation of NHI. Provincial Departments of Health should ensure that District Managers with full authority and accountability for service delivery in their districts, as well as fully fledged District Management Teams, are appointed in all districts. Following an external assessment of the qualifications, competence and skills of hospital managers and district managers, the health sector commenced with a remedial process of ensuring that public sector facilities are managed by officials with the requisite skills and competencies. This process has to be fast-tracked, to overcome the current challenges of weak operational management.

The culture of community participation in securing and promoting their health, which was at its peak during the first decade of democracy, should be revived. Provincial Administrations need to ensure stability in the leadership and governance of the health sector. Stability in the provincial executive (MEC and HOD) is a necessary condition for a well-functioning provincial health department. It is critical that the health sector demonstrates zero tolerance towards financial misconduct and other forms of corruption, where these are detected, at all levels of the health system. Given the uneven performance across districts on key health indicators, greater effort is required to support districts with insufficient capacity to enhance their performance outputs.

Review

1. Introduction and background

This chapter reviews the progress made by the democratic government of South Africa towards ensuring access to quality health care for its all citizens, over the 20 years of democracy.

The frame of analysis adopted in this review is the World Health Organisation's (WHO) health systems framework. WHO (2007) defines six essential building blocks for a health system namely: (a) service delivery; (b) health workforce; (c) information; (d) medical products, vaccines and technologies; (e) financing and (f) leadership/governance. Effective implementation of the six building blocks should lead to increased access and population coverage with essential interventions; as well as improved quality and safety of services. This should in turn lead to the attainment of the desired outcomes namely: improved health (level and equity); health system responsiveness; social and financial risk protection; and improved efficiency.

2. The journey since 1994

2.1 Historical endowment in 1994

In 1994, the new government inherited a fragmented, inequitable, predominantly curative, and racially segregated health system, consisting of 14 health departments, which generated poor health outcomes for the majority of the population. Wadee, Gilson et al. (2003) systematically reviewed the literature describing the health system legacy of apartheid as follows: (a) centralised and undemocratic (Health Systems Trust 1996); (b) highly fragmented in structure, as curative and preventive primary care services were provided in separate facilities and administered by different health authorities (de Beer 1988; van Rensburg et al. 1992); (c) inefficiently and inequitably biased towards curative and higher level services; and (d) inequitably biased towards historically white areas as rural areas.

2.2 Health Status and Outcomes

The burden of disease mirrored the structural racial and socio-economic inequalities, with the African and Coloured population carrying the heaviest burden. Life expectancy amongst white South Africans was 69 years for males and 76 years for females. By contrast, life expectancy amongst Africans was 60 years for males and 67 years for females. Amongst Indians, life expectancy was 64 years for males and 70 years for females. Life expectancy for the Coloured population was slightly lower than that of blacks, at 59 years for males and 65 females. In 1995, the Infant Mortality Rate amongst Africans (48,3 per 1,000 live births) was six times higher than that of Whites (7,4 per 1,000 live births). Amongst the Coloured population, IMR was 28,6 per 1,000 live births, while it was 15,9 per 1,000 live births amongst Indians.

2.3 Impact of HIV and AIDS

The rise in the HIV epidemic was the single most important challenge that confronted the health sector in the past two decades. HIV played a significant role in preventing optimal improvements in maternal and child health, particularly in the first 15 years of democracy. It is estimated that over 6,4million adults are currently infected with HIV. Patterns of mortality worsened in South Africa between 1990 and 2005 in all age groups largely because of HIV and AIDS (Mayosi et al, 2012).

Ntuli (2000) observed that: “During the 1980’s many South Africans spent the greater part of their weekends at funerals [as a result of political violence]. As we move into the first decade of the 21st Century this pattern is re-emerging, although for entirely different reasons. Every South African is becoming increasingly intimate with the effects of the HIV/AIDS epidemic, and, as with most preventable diseases, it is the most vulnerable and poorest communities whose lives are most adversely affected.” Collinge (2005) noted that a large and increasing number of people had become terminally ill with AIDS and the death rate soared between 1997 and 2001. AIDS and its consequences became an undeniable reality. Many people were learning not only through campaigns but through direct experience. As reflected later in this Chapter, this situation has since improved immensely. The number of AIDS-related deaths in the country has decreased significantly.

Table 1: Selected Socio-economic and Health indicators in South Africa pre-1994 and at the dawn of democracy¹

Population Group	Life Expectancy at birth (1990)	Maternal Mortality Rate per 100,000 (1990)	Infant Mortality Rate per 1,000 live births (1990)	Incidence of Tuberculosis (TB) in 1993	TB Notification Rates per 100,000 (1995)	Measles Notification Rate per 100,000 (1995)
African	Males: 60 Females: 67	23	48,3	206,6	159	12,4
Coloured	Males: 59 Females: 65	30	28,6	712,5	612	16,9
Indians	Males: 64 Females: 70	15	15,9	50,8	64	4,5
White	Males: 69 Females: 76	3	7,4	18,8	14	4,8

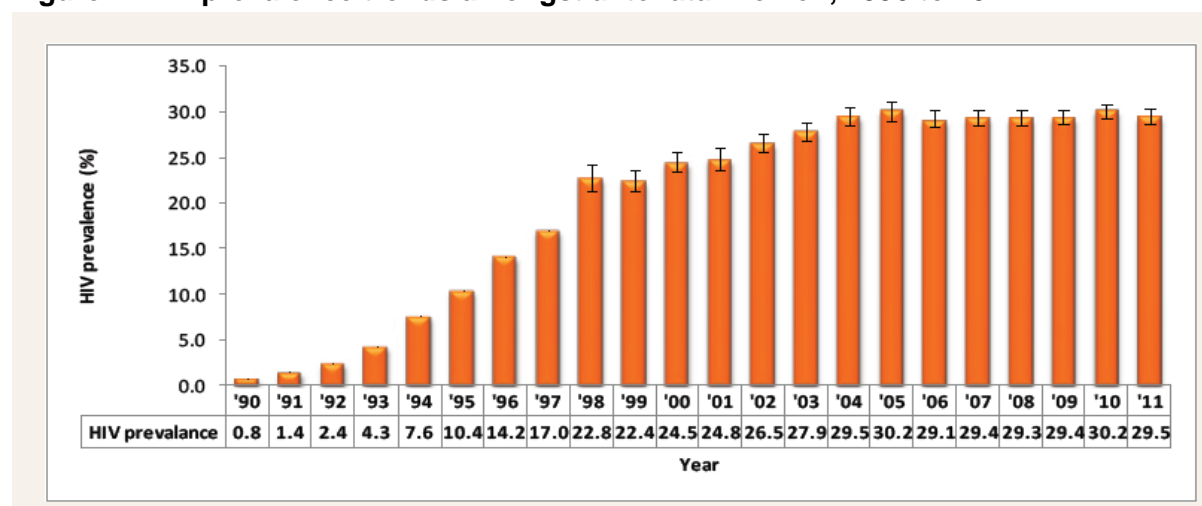
Source: Adapted from the South African Health Review, 1996

The 2009 Lancet series on South Africa (Coovadia 2009, Chopra 2009a, Abdool Karim 2009, Mayosi 2009, Seedat 2009, Chopra 2009b) noted that fifteen years after democracy, South Africa faced four colliding epidemics namely: HIV and tuberculosis; a high burden of chronic disease and mental illness; deaths related to

¹ Data extracted from South African Health Review 1996, published by the Health System Trust

injury and violence; and persistently high maternal, neonatal, infant and child mortality. The burden of disease per capita was the highest of any middle-income country in the world with the brunt being carried by the poorest families. Of these four, HIV was of greatest importance and magnitude. In 1990, less than one in a hundred (1%) pregnant women was infected and this rose to around thirty in a hundred pregnant women (30%) by 2004 when this rate stabilised. This rise is clearly shown in Figure 1 below.

Figure 1: HIV prevalence trends amongst antenatal women, 1990 to 2011.



Source: Department of Health, National Antenatal Sentinel HIV & Syphilis Prevalence Survey, 2011.

The HIV and tuberculosis epidemics have had a major impact on health status. From 1994 to about 2005, there was an increase in mortality. Key maternal and child health indicators worsened, including those linked to the health-related Millennium Development Goals. Government's 15-year review noted that while infant and child mortality rates were fairly stable, the absence of a decline comparable in scale to most countries was largely associated with mother-to-child transmission of HIV.

2.4 Human Resources

Over the past 20 years, South Africa has faced key challenges with respect to human resources for health. These included a shortage of personnel in rural and underserved areas; and the lack of an appropriate skills mix in the clinical environment (Barron, 2013). The distribution of human resources for health between the public and private health sectors was inequitable (Gray and Day, 2012). The migration of health workers was also a key constraint. In 2000, 21% of medical practitioners born in South Africa were living in another country, but 834 medical practitioners born in one of the developed countries were living in South Africa. Similarly, 5% of South African-born nurses were resident in one of the 8 "receiving" countries, but 261 born elsewhere were living in South Africa (Clemens and Pettersson, cited in Day and Gray, 2012).

2.5 Information Systems

In 1994, health information systems (HIS) in South Africa were fragmented and emphasized curative care. Much data was collected but these were largely neither processed nor used at the appropriate level. Information systems were generally uncoordinated and underdeveloped and there was gap in population-based surveillance. Also, information was often not utilised in the management of the services. Financial information was not linked to the health information system. There were many stand-alone systems with no integration across health authorities (Barron, 2013). There was a complete split between private and public sector information with little consolidation of the two (Bradshaw 1995).

2.6 Towards equitable health financing in the Public Sector

The pre-1994 health system was characterised by huge inequities in resource allocation across the country. As McIntyre (2012) states, at the time of the first democratic elections in 1994, substantial disparities existed in public spending on health care across the nine provinces and among the districts within these provinces. In the early 1990s, the best-resourced province had health care spending levels per person 4.5 times greater than the least well-resourced province. With respect to districts, in 2001/02, the ratio between the best and worst funded district was 9.3 (Massyn, et al, 2013).

2.7 Health Service Delivery

In 1994/95 the provision of primary care facilities to communities was inadequate. There were only 0.8 clinics per 10 000 population (Doherty et al, 1996). WHO's recommended norm was 1 clinic per 10 000 people in rural areas. There were many small, dilapidated and collapsing hospitals located in close proximity to each other, while other geographic areas lacked health facilities (Doherty et al.1996). In 1996, a Hospital Strategy Project was established, which produced a new vision for South Africa's public hospital system and an integrated strategy. In 2003/04, a Hospital Revitalisation Programme was designed to ensure integrated delivery of health facilities, incorporating physical infrastructure, health technology, and human resources. A total of 18 hospitals have since been newly built or refurbished since the Hospital Revitalisation Project commenced in 2003/04, across the 9 Provinces. A formal evaluation of the impact of hospital revitalisation on these aspects of quality of care is essential. The initial challenges of slow progress with the delivery of health infrastructure and low expenditure on the grants has consistently improved. Expenditure on the Hospital Revitalization Grant and the Health Infrastructure Grant reached actual expenditure levels of 81% and 94% respectively in 2012/13 (National DoH, 2013).

3. Dynamics of the transformation of the health system

The National Health Plan for South Africa, produced by the African National Congress (ANC) in 1994 outlined a vision for an integrated, equitable and

comprehensive health system, based on the primary health care (PHC) approach. The Constitution of the Republic of South Africa (No 108 of 1996) also buttressed the right of access to health care. Section 27(2) enjoins the government to ensure a progressive realization of the right of the people of South Africa to basic health services, including reproductive health. In 1997, the *White Paper for the Transformation of the Health System*, produced by the National Department of Health, codified into government policy the vision for a transformed health care system in South Africa. The National Health Act (No 61 of 2003) provided the legal framework for the implementation of policies outlined in the preceding documents. The key health systems priorities embodied in the ANC Health Plan, the White Paper and the National Health Act of 2003 were translated into specific priorities of government, and embodied in three sets of published documents known as the Health Sector Strategic Framework 1999-2004; Strategic Priorities for the National Health System 2004-2009; and the 10 Point Plan for 2009-2014.

In 2000, South Africa was one of the signatories to the United Nation's Millennium Declaration, which includes three health related goals with specific targets (WHO, 2010). These are: *reduce child mortality* by two thirds (MDG 4); *improve maternal health*, which carries a target of reducing maternal deaths by three quarters and achieving universal access to reproductive health (MDG 5), and *Combat HIV and AIDS, malaria and other diseases*, which requires nations of the world to halt and reverse the spread of HIV/AIDS and achieve universal access to treatment for HIV/AIDS by 2015, and halt and reverse the incidence of malaria and other major diseases (MDG 6) (WHO, 2010). South Africa's MDG baselines were derived from the 1998 South Africa Demographic and Health Survey, which found the key health outcome indicators to be: (a) An infant mortality rate (IMR) of 45 per 1000; (b) An Under-5 mortality (U5MR) rate of 59 per 1000 and a Maternal Mortality Ratio (MMR) of 150 per 100 000. The implications of the baselines and the MDG targets were that IMR had to decrease to 15 per 1000 or less (two thirds reduction); under-5 mortality to be reduced to 20 per 1000 (two thirds reduction) and MMR had to decline to 38 per 100 000 by 2015.

4. Summary of the Situation now

4.1 Health Status and Outcomes

Empirical evidence reflects unequivocally that the health status of South Africans has improved significantly. As South Africa completes the second decade of democracy, life expectancy has increased by 3,5 years, for both males and females. There has been a decline in fertility as well as crude birth and death rates over this period. The antiretroviral treatment (ART) programme and the prevention of mother to child transmission (PMTCT) programmes have had the most profound impact on the health outcomes of South Africans (Mayosi et al, 2012; Barron, 2013). Table 2 below clearly tells a story of general improvement of health in South Africa.

Table 2: Assumptions about fertility and mortality levels, 2002–2013

Source: Adapted from StatsSA 2013a

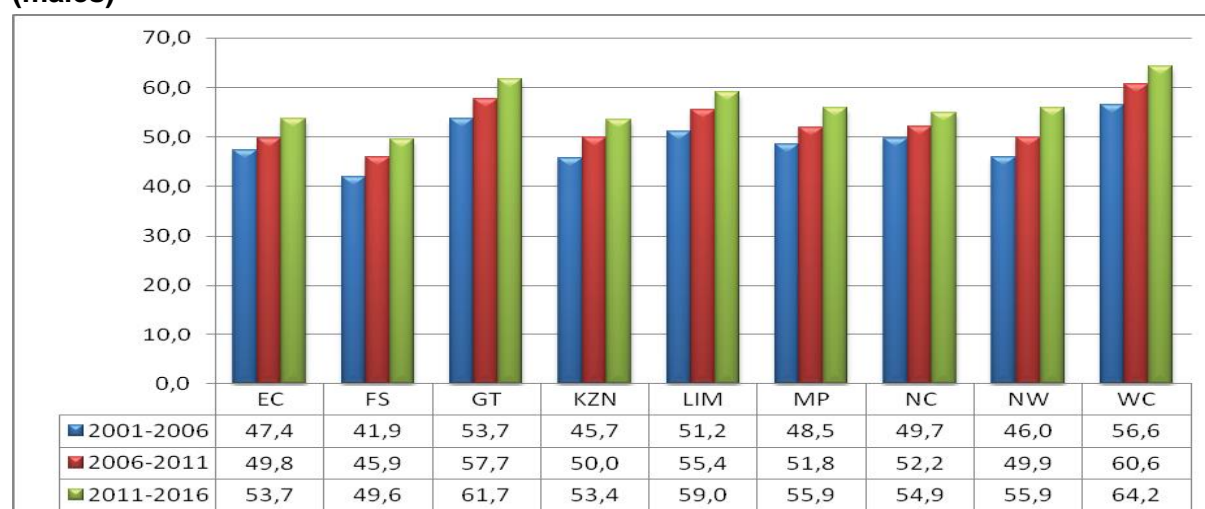
Table 3 also highlights the recent improvements in health status. It is based on the data from the Rapid Mortality Surveillance system of the Medical Research Council in 2012. It reflects that there was a 25% decrease in child and infant mortality rates between 2009 and 2011.

Table 3: Key Mortality Indicators, rapid mortality surveillance 2009-2011

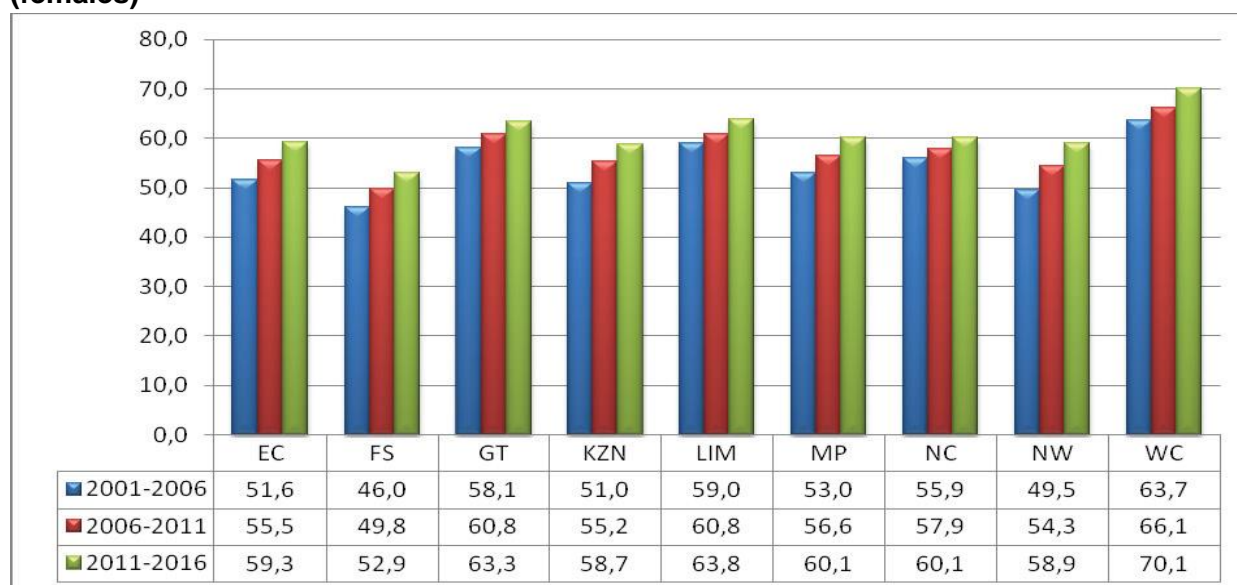
Indicator						2009	2010	2011	
Life Expectancy at birth, total						56.5	58.1	60.0	
Life Expectancy at birth, male						54.0	55.5	57.2	
Life Expectancy at birth, female						59.0	60.8	62.8	
Under- 5 mortality rate per 1000 live births						56	53	42	
Year	Crude birth rate	Total fertility rate	Life expectancy at birth			Infant mortality rate	Under- 5 mortality rate	Crude death rate	Rate of natural increase %
			Male	Female	Total				
2002	24,5	2,71	50.0	55.2	52.7	63.5	92.9	13.9	1.06
2003	24,2	2.68	49.5	54.4	52.1	62.6	91.9	14.6	0.96
2004	23.6	2.61	49.3	53.9	51.7	60.1	89.3	15.0	0.86
2005	23.1	2.56	49.4	53.6	51.6	58.0	85.4	15.2	0.79
2006	22.8	2.53	50.2	54.6	52.5	55.6	80.9	14.6	0.82
2007	22.6	2.53	51.7	56.1	54.0	53.6	76.7	13.5	0,91
2008	22.5	2.52	53.3	57.6	55.5	50.8	72.3	12.6	0.99
2009	22.3	2.51	54.6	58.8	56,8	49.1 ¹	68.5 ²	11.8	1.05
2010	22.2	2.50	55.5	59.5	57.6	47.1	65.2	11.5	1.07
2011	21.6	2.44	56.1	60.0	58.1	45.1 ³	62.1 ⁴	11.3	1.03
2012	21.0	2.39	56.8	60.5	58.7	43.5	59.5	11.0	1.00
2013	20.5	2.34	57.7	61.4	59.6	41.7	56.5	10.6	0.99
Infant mortality rate per 1000 live births						40	37	30	
Neonatal mortality rate (<28 days) per 1000 live births						14	13	14	

Source: Adapted from Bradshaw, Dorrington and Laubscher 2012

Figure 2: Provincial Life expectancy at birth, 2001–2006, 2006–2011 and 2011–2016 (males)



Source: Statistics South Africa, Mid-year population estimates 2013, P0302

Figure 3: Provincial Life expectancy at birth, 2001–2006, 2006–2011 and 2011–2016 (females)

Source: Statistics South Africa, Mid-year population estimates 2013, P0302

5. What can we celebrate? What are the achievements?

5.1. An effective HIV and AIDS response

The significant gains in the health status of South Africans have resulted from the country's efforts to reverse the frontiers of HIV and AIDS, both in terms of the massive provision of antiretroviral therapy (ART) to eligible people living with HIV, as well as the reduction of new HIV infections and mortality from AIDS. Johnson (2012) reviewed the coverage of the ART programme against the targets set in the National Strategic Plan for HIV&AIDS for 2007-2011, and concluded that the programme had grown exponentially from 47,500 patients receiving ART in the public sector in 2004 to 1.79 million patients on ART in 2011. This figure subsequently grew to over 2,4 million by the end of June 2013.

Table 4: Numbers of patients receiving ART in South Africa 2004-2011

Currently on ART	2004	2005	2006	2007	2008	2009	2010	2011
Total	47 500	110 900	235 000	382 000	588 000	912 000	1 287 000	1 793 000
Men	17 700	37 500	75 000	120 000	183 000	283 000	396 000	551 000
Women	25 600	63 600	138 000	228 000	354 000	553 000	777 000	1 090 000
Children (<15)	4 200	9 800	22 000	35 000	51 000	76 000	113 000	152 000
By provider								
Public sector	9 600	60 600	163 000	290 000	470 000	748 000	1 073 000	1 525 000
Private sector	34 100	43 800	57 000	68 000	86 000	117 000	154 000	190 000
NGOs	3 900	6 400	15 000	24 000	32 000	47 000	60 000	78 000

Source: Johnson, LF (2012): *Access to Antiretroviral Treatment in South Africa, 2004–2011*, *Southern African Journal of HIV Medicine*

South Africa has significantly improved child health and reduced its infant mortality rates (IMR) and under-5 mortality rate (U5MR). Both infant and child mortality have decreased by 25%, between 2009-2011. Many more infants are able to reach their first as well as their fifth birthdays. In 2005, South Africa was one of only four countries globally with an under-five mortality rate higher than the 1990 baseline for the Millennium Development Goals (MDG). Latest empirical evidence illustrates that the country has achieved one of the fastest rates of child mortality reduction in the world. South Africa achieved an average annual rate of decline of child mortality of 10,3% between 2006 and 2011. This was the fourth fastest rate of decline globally, with Rwanda being the only country in the region to achieve faster progress (Kerber et al, 2013). Adults are also living for longer. The increasing trend of the so-called “*AIDS orphans*” has been halted. Parents are living longer and taking care of their children. These are the demographic dividends of the massive Antiretroviral Treatment (ART) programme implemented by the democratic government.

South Africa’s bold leadership in turning the tide against the HIV&AIDS epidemic, as well as the results achieved and the empirical evidence, are also acknowledged by UNAIDS in its February 2013 publication. The great strides observed by UNAIDS include the following:

- a) A decrease in total number of people dying from AIDS from 300,000 in 2010 to 270,000 in 2011;
- b) A 50% decline in the number of aged 0-4 years who acquired HIV between 2006-2011;
- c) A 50% decrease in the number of people acquiring HIV infection, from 700,000 in the 90s to 350,000 in 2011; and
- d) A 25% decrease in the annual number of infants and children younger than 5 years dying in the past two years.

The Prevention of Mother-to-Child Transmission of HIV programme has been pivotal in decreasing the numbers of children infected with HIV and by so doing has impacted positively on infant and child mortality rates, as well as improving the health of pregnant women (Mayosi et al, 2013; Barron, 2013). For two decades, HIV/AIDS and its concomitant conditions such as TB had placed a heavy yoke on the South African health system. With the country having begun to turn the tide against the challenges, the health system should be better able to sustain the gains made and to respond to other emerging challenges such as Non-Communicable Diseases.

Case Study: Prevention of Mother to Child Transmission (PMTCT) of HIV

The Medical Research Council (MRC) has conducted systematic studies of mother and baby pairs to periodically monitor the effectiveness of the PMTCT Programme in reducing perinatal transmission of HIV from mothers to infants, measured at 4-8 weeks after infant birth. In 2008, the MRC found the mother to child transmission rate to be on average 8,5%, nationally. As reflected in Table 4 below, in 2010, the MRC PMTCT study found that 31,4% of babies were exposed to HIV, but the mother to child transmission rate had decreased substantially to 3,5%. In a follow up study in 2011, 32,2% of babies were found to have been exposed to HIV, and the transmission rate had decreased further, to 2,67%. The MRC study concluded that since 2010, there was an additional 23% (95% CI 22-28%) reduction in mother-to-child transmission following implementation of Option A PMTCT regimens (MTCT 3.5% in 2010 versus 2.7% in 2011). This achievement implies that a total of 107 000 babies (95% CI 105 000-110 000) were saved from the HI virus, assuming that the perinatal MTCT without SA National PMTCT programme was 30%. In 2011, an additional 3 100 babies were saved from infection compared with 2010 results. The 3.5% (2.9-4.1%) perinatal MTCT in 2010 and 2.7% (95% CI 2.1-3.2) in 2011 suggested that South Africa is potentially on track to reach the 2015 target of <2% perinatal HIV transmission by 2015.

Over 100,000 South African babies will reach their first and fifth birthdays, and live beyond. They will receive care and support from parents whose lives have been saved through the massive roll-out of the ART programme.

Table 5: Perinatal Infant HIV-Exposure and MTCT: Weighted results by Province % (95% CI)

Province	2010		2011	
	Infant HIV-Exposed	MTCT % (95%CI)	Infant HIV-Exposed	MTCT % (95%CI)
Eastern Cape	30.0 (26.3-33.7)	4.7 (2.4-7.0)*	32.0 (29.6-35.5)	3.82 (2.1-5.54)
Free State	31.1 (28.9-33.3)	5.9 (3.8-8.0)	30.9 (28.6-33.3)	3.80 (2.29-5.3)
Gauteng	30.2 (27.7-32.8)	2.5 (1.5-3.6)	33.1 (29.8-36.4)	2.13 (0.91-3.36)
KwaZulu Natal	43.9 (39.7-48.0)	2.9 (1.7-4.0)	44.4 (39.8-48.9)	2.10 (0.94-3.26)
Limpopo	22.6 (20.4-24.8)	3.6 (1.4-5.8)	23.0 (19.9-26.2)	3.06 (1.21-4.91)
Mpumalanga	36.2 (33.6-38.9)	5.7 (4.1-7.3)	35.6 (33.3-37.8)	3.32 (2.17-4.48)
Northern Cape	15.6 (13.0-18.3)	1.4 (0.1-3.4)*	15.1 (12.7-17.5)	6.06 (2.48-9.63)*
Northwest	30.9 (28.6-33.1)	4.4 (2.9-5.9)	30.8 (28.5-33.1)	2.57 (1.13-4.00)
Western Cape	20.8 (16.8-24.9)	3.9 (1.9-5.8)	17.8 (14.8-20.8)	1.98 (0.65-3.31)
National	31.4% (30.1-32.6%)	3.5 (2.9-4.1)	32.2% (30.7-33.6%)	2.67 (2.13-3.21)

*Note unstable estimates due to smaller sample size realisation precision is low.

Coupled with the acceleration of interventions to combat HIV and AIDS in 2009, the Ministry of Health implemented new strategies to curb the scourge of Tuberculosis (TB). Major milestones have been attained. TB cure rates have improved while TB defaulter rates have decreased. Most importantly, these achievements can be traced back to major interventions made by government. Empirical evidence unequivocally attests to these improvements. Most importantly, all these achievements can be traced back to major strategic interventions made by government at all levels. The 20-year reviews produced by Provincial Administrations in South Africa in 2013 corroborate these achievements. TB treatment outcomes have also improved. The TB cure rate has increased from 57.7% in 2006 (National DoH, 2007) to 73,8% in 2011 (National DoH, 2013). The target set by the WHO is 85%.

The proportion of people who default on their TB treatment decreased from 9% in 2006 to 6.1% in 2011. The numbers of patients notified with TB decreased from a high of 405,699 notifications in 2009 to 346,895 in 2012.

Notwithstanding these significant achievements, South Africa cannot afford to be complacent. Efforts to ensure reduction of new HIV infections, HIV related deaths and stigma should be reinforced into the future, in keeping with the goals set in the HIV/AIDS and TB Strategic Plans of the country.

5.2 Improved Access to Primary Care Services

Access to primary care services for all South Africans, measured in terms of visits per annum, increased from 67,021,961 million in 1998 to 128,984,040 by the end of March 2013 (National DoH, Annual Reports 2008/09 & 2010/11). As reflected in the 15-year review of government performance, the policy of free health care for pregnant women and children under-6, which was adopted in 1994, and the policy of free PHC for all, removed the financial barriers to health care. Geographic access was significantly expanded as a result of the massive expansion of health infrastructure.

The country has achieved improved health outcomes with respect to conditions sensitive to primary care. Severe malnutrition amongst South African children has decreased from 88,971 in 2001 to 23,521 in 2011 (DHIS, National DoH). The South African National Health and Nutrition Examination (SANHANES-1) survey, conducted by the Human Sciences Research Council in 2012, found that Vitamin A deficiency amongst children under-five years of age decreased from 63,6% in 2005 to 43,6% in 2012. SANHANES-1 also reflected that anaemia and iron deficiency anaemia in children under-5 decreased by 63% and 83,2% respectively, compared to the findings of the National Food Comparison Survey of 2005. There were no cases of severe anaemia. The survey also identified a significant decrease in wasting and underweight in children under-5.

SANHANES-1 attributes these significant achievements to the beneficial impact of the food fortification intervention programme introduced by government in 2003. In October 2003, the regulations for the mandatory fortification of all maize meal and white and brown bread flour, with six vitamins and two minerals, (i.e. vitamin A, thiamin, riboflavin, niacin, pyridoxine, folic acid, iron and zinc), developed by the National Department of Health, came into effect. The fortification programme was implemented in response to the findings of the 1999 National Food Consumption Survey which showed that “one out of two children aged one to nine years did not meet half their daily requirement for several nutrients” (National DoH, 2007).

Areas of concern identified in SANHANES-1 included the major problem of overweight and obesity (combined) amongst preschool-aged children and the slight increase in stunting amongst children under the age of five.

Primary care facilities in the public health sector remain the first choice service provider for the majority of South Africans. In the General Household Surveys (GHS) conducted by Statistics SA (StatsSA) between 2004-2012, the proportion of the households who reported using public sector clinics increased consistently from 44,5% in 2004 to 59,6% in 2012, with a slight decline in 2011. Collectively, 69,6% of households reported in 2012 that they would first consult public sector clinics and hospitals in case of illness or injury. The utilisation of other types of health facilities, except General Practitioners (private doctors) and pharmacies reflects a net decline between 2004 and 2012. This is depicted in Table 5 below.

Table 6: Type of healthcare facility normally consulted by the household when someone falls ill

Period	Public Sector Clinic	Public Sector hospital	Other public sector facilities	Private Sector Hospital	Private Sector Clinic	Private doctor	Trad. Healer	Pharmacy	Other
	%	%	%	%	%	%	%	%	%
2004	44,5	24,6	0,2	5,2	3,6	20,6	0,2	0,4	0,7
2005	47,1	22,2	0,2	4,6	2,7	22,0	0,6	0,5	0,3
2006	52,1	18,7	0,6	4,5	2,3	20,9	0,4	0,4	0,1
2007	48,0	22,0	0,3	5,7	2,1	20,9	0,3	0,3	0,3
2008	52,1	20,5	0,5	6,0	2,8	17,3	0,3	0,5	0,0
2009	58,9	10,5	0,4	2,3	1,4	25,4	0,2	0,4	0,6
2010	60,2	9,5	0,3	2,4	1,8	24,9	0,2	0,4	0,5
2011	60,8	9,4	0,3	2,0	1,8	24,7	0,1	0,5	0,5
2012	59,6	10,0	0,3	2,7	2,4	23,9	0,2	0,5	0,4

Source: Adapted from Stats SA, General Household Survey, 2012

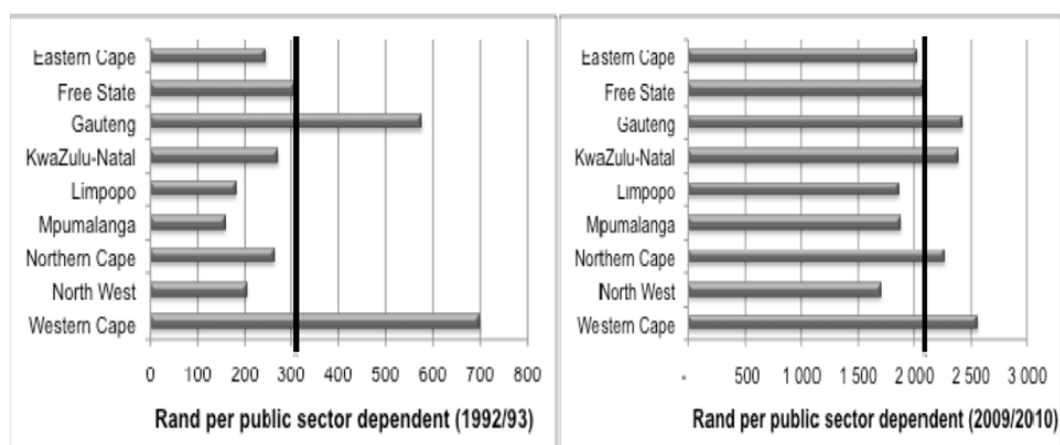
The implementation of the PHC approach has also faced its own challenges, which include: high rates of medical migration and severe health worker shortages; deep-seated imbalance of resources and inequities in the distribution of personnel; a complex and evolving burden of disease; a curative-oriented health service; and deficiencies in managerial capacity and health system leadership (Kautzky and Tollman, 2008). In 2010, the health sector adopted a new re-engineered ward-based PHC model for South Africa, which consists of three streams namely:

establishment of Municipal Ward-based PHC Outreach Teams; establishment of District Specialist Clinical Specialist Teams (DCST); and implementation of Integrated School-based Health Services. Empirical evidence from countries such as Brazil where the Family Health Programme has been implemented successfully reflects improved health outcomes (Perez et al, 2006; La Forgia, 2008).

5.3 Progress towards Equitable Financing

Post 1994, the health sector introduced a needs-based resource allocation formula to determine the health budgets for individual provinces (McIntyre, 2012). The aim was to reach equitable target budget allocations within five years. During the 20 years under review, there was notable improvement in the resource distribution among provinces and districts. This is reflected in Figure 2 below. There have also been significant improvements in most provinces with respect to intra-provincial inequity in district resource allocations improvement. By 2007/08, the ratio between the best and worst funded district had been reduced from 9 to 3.3. However, in some provinces there are persistent inter-district inequities, notably in the Eastern Cape where paradoxically the rural district of Alfred Nzo spent less than 40% on primary health care per person than did the urban districts of Buffalo City and Nelson Mandela Metropolitan Municipality (Massyn et al, 2013). The public health sector has also given greater priority to spending at the district level and primary health care and the increases in this area is growing at a faster rate (around 8% per year in real terms) than the rest of the public health sector. Despite these increased resources, the need for health care outstrips the supply of resources available and a need exists to be a clear prioritisation of what resources will be spent on.

Figure 4: Changes in Public Health Spending in Provinces



Source: McIntyre, D (2012): *Equinet Discussion Paper 91*

5.4 Human Resources

Several key policies were developed by the democratic government to address the country's Human Resources for Health challenges. These included the Rural and Scarce Skills Allowances; mandatory community service for medical doctors, which

was later extended to almost all categories of health care providers, as well as Occupation Specific Dispensation (OSD), aimed at improving the remuneration of health professionals, starting with nurses and later expanded to include medical doctors, pharmacists and emergency medical services. Implementation of OSD encountered key challenges including incorrect data on the number of eligible health care professionals, and incorrect interpretation and implementation of the policy. Through country-to-country agreements, additional health care providers were also recruited, including Cuban, Tunisian and Iranian medical doctors, who were placed in the predominantly rural provinces. Between 1997-2011, a total of 1,200 medical students graduated from Cuban Medical Training programme, and returned to South Africa.

Notwithstanding these successes, the overall supply of human resources in the public sector remains insufficient. In the year 2012, the Health Professions Council of South Africa had 38 444 medical practitioners (including specialists) registered. However, of this figure, only 12 508 (32,5%) were working in the public sector. During the same period, the Pharmacy Council had 13,003 pharmacists registered, of whom only 3,902 (30%) were in the public sector. Of the 124,045 professional nurses registered with the South African Nursing Council (SANC), only 58,890 (47,5%) were practicing in the public sector (Gray and Day 2012). In October 2011, the health sector produced a Human Resources Strategy for Health, which was for the first time linked to the output of health workforce at university level to ensure that universities are responding to the burden of disease facing the country.

5.5 Developments in information systems

Demographic and vital statistics arising from births and deaths data have improved remarkably, due to the work of Stats-SA, the Medical Research Council of South Africa and the Department of Home Affairs, as has the macro-economic data related to finances from the Treasury (Barron, 2013). A system of routine PHC information in the form of the DHIS has been institutionalised. Many population and annual surveys, such as the national annual antenatal HIV sero-prevalence survey, now take place regularly. The quality and quantity of data that is being collected and the information derived from these data have improved immeasurably. However, the demographic and household survey (DHS), which is essential to getting key population based indicators on maternal and child health, was last carried out in 2003. Also, the analysis, interpretation and use of this information by managers at all levels of the system require further improvement. Electronic information systems are in their infancy in the health sector in South Africa. Much more needs to be done in terms of infrastructure, software and capacity development to use technology to greater effect.

5.6 Medical products, vaccines and technologies

Major accomplishments have also been noted in the pharmaceutical and medicines supply landscape. The National Drug Policy of South Africa was produced in 1996,

with the aim of providing equal access to medicines for all South Africans. Key achievements of the sector since the adoption of the National Drug Policy of South Africa include the implementation of the national Essential Medicines Lists and supporting structures in the form of provincial and facility-based Pharmacy and Therapeutics Committees. This introduced levels of rigour in assessment of medicine selection (Pharasi and Mioti, 2012). Secondly, the relocation of the medicines tender processes from the National Treasury to the National DoH resulted in significant savings in several tenders and reducing the cost of medicines, as well as improving access and availability (Pharasi and Mioti, 2012). Other positive developments include the establishment of the National Essential Medicines List Committee and Pharmaceutical and Therapeutic Committees (PTC) to oversee medicines selection and rational use. In 2009, two new vaccines were added which are effective against rotavirus that causes diarrhoea and pneumococcus that causes pneumonia, two of the biggest killers of children. Within three years of the introduction of these vaccines, coverage rates of over ninety percent were achieved (Barron, 2013). As a result, forty percent fewer South African children are being hospitalised for pneumonia and severe diarrhoeal disease than in 2009 and the under-five mortality has been reduced by 10% (Green, 2013).

There have also been key limitations. Measures implemented in the medicines supply chain have had a limited impact on medicines availability at PHC level (Pharasi and Mioti, 2012). Many facilities still lack access to appropriately trained and registered human resources and inadequate managerial systems for pharmaceuticals. Resultant stock-outs are frequent throughout the primary level system. The Medicines and Related Substances Act (Act 101 of 1965) has been amended twice, and is in the process of a fundamental change. Implementation of the 1997 amendments was delayed by court action, and only started in 2003. The medicine pricing interventions have delivered some relief, but the dispensing fees prescribed in terms of the Act remain contested. The Amendment Act will replace the Medicines Control Council with a new South African Health Products Regulatory Authority.

6. Reflection on the achievements, how they came about and how they are seen by citizens

6.1. Stewardship, leadership and governance

During the first 15 years of democracy, there was a widespread perception that stewardship, leadership and good management were lacking at all levels of the health system, and that this was the major obstacle to improving the health system in South Africa. In the 2007 State of the Nation Report (Schneider 2007) captured the essence of this perceived lack of leadership as follows:

“From within the health sector a rather blunt approach to the management of actors and complex interests has been a key problem. It is most obvious in the inability to

unite governmental and non-governmental players in the national response to HIV/AIDS, but is also evident in difficulties of cooperative governance between spheres of government, in creating strategic alliances to achieve significant financing and pharmaceutical reforms and in achieving buy-in of front-line providers to the process of change...”

Perceptions about the lack of stewardship in the health sector were significantly altered during the second decade of democracy. The new Minister of Health, Dr. Aaron Motsoaledi, identified HIV/AIDS as a common factor fuelling the huge burden of disease in South Africa and accelerated interventions to reverse the frontiers of HIV/AIDS, in partnership with civil society, community leaders and key stakeholders in academic and research institutions that were previously alienated from the health sector. On World AIDS Day on 01 December 2009, the President of South Africa, Mr. J. Zuma announced the following ground-breaking policies with respect to combating HIV and AIDS: (a) massive campaign would be implemented to mobilise all South Africans to get tested for HIV. This referred to the HIV Counselling and Testing Campaign (HCT); (b) treatment would be provided for all children living with HIV younger than one year of age; (c) treatment would be provided for everyone with living with HIV and TB with a CD4 count of less than 350 per m2. (d) treatment would be provided for all pregnant women living with HIV with a CD4 count of less than 350 per m2; (e) treatment for all other pregnant women living with AIDS will start at 14 weeks and (f) Counselling, testing and treatment services would be expanded to all health facilities. The national HCT campaign was subsequently was launched by President Zuma in Gauteng Province, in April 2010. The campaign reached over 20,2 million South Africans during the period April 2010 to June 2012. A total of 8,9million people accepted testing during 2012/13. Close to 30 million people accepted testing since the onset of this unique campaign.

The expansion of access to ART for people living with HIV resulted from several strategies successfully implemented by the Ministry of Health. The included negotiations with pharmaceutical companies for a substantial decrease in the prices of antiretroviral medicines, which resulted in a saving of 53% (R4.4billion). This enabled the health sector to treat more patients with the same resource envelope (National DoH, Annual Report, 2010/11).

6.2. Governance and management of the health sector

With respect to improving governance and management of the health sector, the Ministry of Health has also attempted to increase accountability within the public sector by reviewing the competencies of district managers and chief executive officers of hospitals. Andrews and Pillay (2005) identified the following as critical to the implementation: (a) Leadership, and in particular, political leaders as well as managers in the health system, must clearly articulate and communicate a vision and a mission that will resonate with front line health workers; (b) a programme of action that is developed with, and that captures the imagination of, those charged

with its implementation. This would require greater empowerment of leaders at the local level to drive the change agenda; (c) a critical mass of skilled and motivated health managers and health workers at all levels of the health system; and (d) Mechanisms and structures to facilitate community participation, especially of poor and marginalised groups and strengthened accountability.

6.3. Role of civil society in securing and promoting health

From the pre-democracy era, civil society formations have played a key role in the delivery of health care services in South Africa, particularly in the provision of primary care services to deprived communities. As Kautzky and Tollman (2008) state, a range of organisations and individuals were organised in the 1980s to develop and promote a national PHC strategy for South Africa. The National Progressive Primary Health Care Network (NPPHCN) was established, with a broad membership of activists and health professionals, and provided a platform whereby policies of the undemocratic government could be effectively challenged and a future national health system could be debated. The NPPHCN remained active post-1994. As Friedman (1996) states, between 1995-1997, the NPPHCN launched a campaign to raise awareness amongst communities that “Health Rights are Human Rights”. The campaign culminated in the development of a Patients’ Charter for South Africa, which was launched by government in 1999.

Post-1994, civil society organisations contributed immensely to the discourse on HIV&AIDS. In the first decade of democracy, this often included litigation against the state, when it was believed that the state was not honouring its Constitutional obligations (Pillay et al, 2002). Mbali (2005) argues that: “as a result of the TAC’s campaign, in September 2003 the South African Cabinet instructed the health ministry to develop a comprehensive HIV treatment and prevention plan. The government has now begun to roll-out HIV treatment at public health care facilities across South Africa. TAC is now in many ways seen by many commentators as a successful example of civil society pushing for government policy to reflect socio-economic rights in the post-apartheid era”. Under the stewardship of South African National AIDS Council (SANAC), the rancour between government and civil society has been replaced with rapport and collaboration. SANAC was restructured in 2007, and the new formation consisted of 19 sectors, of which 17 were civil society formations. The other two sectors are government and the business sector. The role of NGOs and CBOs in enhancing the country’s efforts to combat HIV and AIDS and Tuberculosis programmes is also well documented (eg. Wilkinson et al, 1996; Kironde and Neil, 2004). For the future, a need exists for a state-civil society model to be delivered for delivering services to communities. Such a model should facilitate greater transparency and, accountability by NGOs; ensure adequate funding for NGO services, and enable the development of seamless information systems between NGOs and government.

7. Why are we achieving in some areas and not others – what are enabling and disabling factors

The main enabling factors for the key successes achieved over the 20 years of democracy are a combination of effective stewardship, improved resource allocation, improved access to services and health interventions and improved partnerships with civil society. However, notwithstanding the major successes achieved during the twenty-years of democracy, the health sector continues to be besieged with major challenges, inclusive of the following:

- a) Poor quality of care, illustrated by persistent complaints and evidence from patients, civil society and the media about services provided at health facilities.
- b) Persistent health inequities
- c) Spiralling costs of care in the private health sector
- d) Limited progress with the implementation of the District Health System
- e) Operational management weaknesses
- f) Declining levels of community participation
- g) High Maternal Mortality Ratio
- h) Rising burden of Non-Communicable Diseases
- i) Violence and injuries
- j) Unaddressed social determinants of health
- k) Instability of the Health Leadership

7.1 Quality of Care

In the 2012 General Household Survey (GHS) conducted by Stats SA, only 79,2% of users of public health care facilities reported being satisfied with the services provided, compared to 97,1% of users who were satisfied with private facilities. Only 57,3% of individuals that used public health-care facilities were very satisfied, compared to 92,2% who were very satisfied with private facilities. This is most likely attributable in part to the fact that the private health sector, which serves only 17% of the population, has the majority of medical specialists; medical doctors; pharmacists and dentists, which are produced at state-subsidized academic institutions, and remains inaccessible to the majority of the population. However, it is also in part to weaknesses with the quality of service provided in public health facilities.

Concern about quality of care in the public sector has also been raised by different scholars, as well as by government itself. Harrison (2009) noted: “There are still significant inefficiencies in the health system stemming from poor quality of care. These weaknesses are endemic, and require a multi-faced approach including facility-based accreditation and monitoring, and programme based monitoring and quality improvement”. Marshall (2012) observed that: “Unfortunately, although what we call “patient satisfaction” or “patient experience” is so fundamental, it does not seem to be regarded as a priority in the public healthcare system, rather as

something between a threat and a nuisance, or at the most as a “nice to have but rather idealistic” addition. This is an area where the private sector has a clear lead – why else would patients choose to pay for their services. Add to this the many complaints about “rude, uncaring staff” to the point where the essential trust and confidence in the public health services is being eroded”.

A nursing summit convened by the health sector in 2010, attended by about 1800 participants, including representatives of trade unions in the health sector, emphasised that the nursing profession used to be known and respected as a noble profession and a calling (National DoH, 2011c). The summit conceded that in recent times this has changed and the profession has been characterised by an uncaring attitude and at times outright rudeness. Participants at the summit agreed that the nobility and respect for the profession has to be brought back (National DoH, 2011c).

In 2011/12, the health sector produced the National Core Standards for Health Establishments in South Africa. From three domains of these standards, a set of six critical areas were identified for fast-tracking namely: (a) Values and attitudes of staff; (b) Cleanliness; (c) Waiting times; (d) Patient safety and security; (e) Infection prevention and control and (f) availability of basic medicines and supplies. Based on these standards, the health sector commissioned an independent baseline audit of services delivered in all 3,880 public sector facilities in 2011/12. The audit revealed that enormous work is still required to improve quality of care. Empirical evidence also reflects that users of private health care facilities report significantly higher levels of satisfaction with the services provided compared to users of public health services. The majority of public sector facilities were found to be non-compliant with the vital measures of the core standards. In 2012/13, the Office for Health Standards Compliance assessed over 272 health facilities for compliance with the 6 priorities of the core standards. The results of these assessments illustrate the extent of the remaining challenge to transform the quality of service in the public health sector. Most of the health facilities assessed attained low scores against the standards for availability of medicines and supplies; cleanliness; patient safety; infection prevention and control; staff attitudes and waiting times.

The goal of improving quality of care services is reflected in all strategic priority documents of the health sector. Institutionalisation of the National Core Standards is imperative, to improve improvements in patient experiences of health care delivery in the public sector. Improvement in the quality of care provided in the health sector is one of the critical factors for the success of NHI. In July 2013, the President of South Africa assented to the National Health Amendment Act, which provides for the establishment of an independent Office of Standards Compliance. This Act provides an important legal framework for the institutionalisation of quality in the public sector.

7.2. Persistent health inequities

South Africa remains one of the most unequal societies in the world, with a gini coefficient of 0,65. These inequities mirror themselves in access to good quality health care, as well as in the health status of different income groups in the country. Although health outcomes in South Africa have improved enormously, particularly during the fourth term of democracy, they are not yet commensurate with the country's expenditure on health, which amounts to 8,6% of the Gross Domestic Product (GDP). Furthermore, these outcomes do not yet compare favourably with those of other middle income countries, including the BRICS countries. South Africa has a dual and fragmented health system, which has given rise to major health inequalities. The private health sector has the majority of medical specialists; medical doctors; pharmacists and dentists in the country, which are produced at state-subsidized academic institutions, but remains accessible to only a segment of the population that can afford medical aid. (National DoH, 2011a). To compound this problem, there have also been widespread reports of how medical practitioners and specialists steal time from the public sector to work in the private sector or in their own private practices, by abusing a policy known as remunerative work outside the public sector (Bateman, 2012).

In the *Budget Review 2013*, National Treasury observed that: "Primary health care is available free of charge and hospital services are provided at relatively low cost according to income level, with exemptions provided for children under six, pregnant women and social grant beneficiaries. It was further noted that: "private health services mainly operate on a fee-for-service basis and are largely out of reach of households not insured through medical schemes, which cover about 16 per cent of the population. Private health services are generally better resourced than public facilities, and so the quality of available health care is strongly correlated with income level. There are also considerable regional disparities in the quality of public health facilities. The introduction of NHI [National Health Insurance] will seek to address these inequalities, making quality health care accessible to all" (National Treasury, Budget Review 2013)

The health sector has made strides with the preparatory work on the piloting of NHI, which include the production of a *Green Paper on NHI* in August 2011, designation of 10 NHI pilot districts, and the onset of quality improvement and health systems strengthening interventions in the pilot districts. National Treasury is working with the Department of Health to examine the required funding arrangements for NHI (National Treasury, 2013). Implementation of NHI will be phased in over a 14-year period (National DoH, 2011a). It is anticipated that National Treasury will publish a discussion paper inviting public comment on various options in 2013, which will also examine arrangements for risk and revenue pooling, mechanisms for the purchasing of health services – including the size and cost of the proposed health benefits package – and the mix of public and private provision of health care (National Treasury, 2013).

A key limitation is that there has been inadequate cooperation between the public and the private sectors, despite a possible wide scope for collaboration. The National Health Act, No. 61 of 2003 enjoins government to promote a spirit of co-operation and shared responsibility among public and private health professionals and providers, within the context of national, provincial and district plans. Historically, this has not happened systematically. There has been poor articulation of the private and public sectors in South Africa, and limited efforts to leverage on the strengths of each, in all probability due to mutual mistrust. The foregoing analysis has shown that the private sector commands the majority of health care providers in the country; has patients that report higher levels of satisfaction with services provides, and has strong operational management capacity than the public sector. However, health care remains elusive to the majority of South Africans, due to its exorbitant prices. It loses out on the economies of scale that would accrue from its collaboration with the public sector. Efforts are underway in the public sector to formally contract General Practitioners to provide clinical support to primary care facilities, as part of the revitalisation of PHC, which is also an important building block for NHI.

7.3. Spiralling costs of care in the private health sector

South Africa country has a highly developed private sector with around 14% of the population belonging to medical schemes (Barron 2013). From 1994 to 2002, there was an increase in private sector spending with a disproportionate amount of the total health resources, around 50%, being spent in the private sector. This resulted in an extremely inequitable distribution of health resources between people getting care in the private sector and those people getting the bulk of their care in the public sector. This inequity has been improving over the past few years (2008/09-2013/14) and the private-public differential reveals a narrowing trend.

In 2011/12, South Africa spent about R258.4 billion (8.6 per cent of GDP) on health services, which was split almost equally between public and private expenditure (National Treasury, Budget Review 2012). Total public sector expenditure on health amounted to R122,4 billion. Total private sector expenditure on health amounted to R120,8 billion. While the gap in actual expenditure between the public and private sectors has narrowed, reaching levels of almost 50-50%, it remains a concern that this occurs against the backdrop of the private sector still serving only 16-17% of the total population of South Africa.

Table 7: Health expenditure in public and private sectors, 2008/09-2013/14

Rmillion	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	Annual realchange 2008/09 – 2013/14
Public Sector							
Department of Health	1 436	1 645	1 736	1 784	1 864	1 961	0.9%
Provincial	75 12	88 593	98066	110 01	119 00	126	5.3%

Departments of health	0			4	3	831	
Defence	2 177	2 483	2 770	2 961	3 201	3 377	3.6%
Correctional services	2 82	300	318	339	356	374	0.4%
Local government (own revenue)	1 793	1 829	1 865	1 977	2 096	2 221	-1.0%
Workmens' Compensation	1 415	1 529	1 651	1 718	1 804	1 894	0.5%
Road Accident Fund	797	740	860	980	1 029	1 080	0.8%
Education	2 134	2 350	2 503	2 653	2 812	2 981	1.4%
Total public sector health	85 15 4	99 469	1 09 769	122 42 6	132 16 5	140 7 19	4.9%
Private sector							
Medical schemes	74 08 9	84 863	90 973	98 069	105 71 8	113 9 64	3.4%
Out-of-pocket	15 42 9	16 200	17 172	18 202	19 294	20 45 2	0.3%
Medical insurance	2 452	2 660	2 870	3 094	3 336	3 596	2.4%
Employer private	1 172	1 271	1 372	1 479	1 594	1 718	2.4%
Total private sector health	93 14 2	104 99 4	112 38 7	120 84 4	129 94 2	139 7 30	2.9%
Donors or NGOs	5 212	6 319	5 787	5 308	5 574	5 853	-2.9%
Total	183 5 08	210 78 2	227 94 3	248 57 8	267 68 1	286 3 02	3.7%
Total as % of GDP	8.0%	8.6%	8.3%	8.3%	8.1%	7.9%	
Public as % of GDP	3.7%	4.1%	4.0%	4.1%	4.0%	3.9%	
Public as % of total government expenditure non-interest)	13.0 %	13.0%	13.6%	13.7%	13.6%	13.4 %	
Private financing as % of total	50.8 %	49.8%	49.3%	48.6%	48.5%	48.8 %	

Source: National Treasury (2012), National Budget Review 2012

The proportion of total government spending (i.e. public sector spending on health) has improved to 13,4% and was fairly constant over the period 2008 -2014. This reflects major progress towards the call of the African Union for countries to spend 15% of their total budgets on health. The reduction of the costs of health care in the private sector is one of the two main priorities of the National Health Insurance policy, the second being improvement of quality of care in the public sector.

7.4 Limited progress with the implementation of the District Health System

The White Paper of 1997 committed the democratic South Africa to the development of the District Health System, as a vehicle for the delivery of PHC. The White Paper envisaged a single National Health System, based on a District Health System (DHS) that facilitates health promotion, provides universal access to essential health care and allows for the rational planning and appropriate use of resources, including the optimal utilisation of the private health sector resources.

Three governance options were proposed in The White Paper namely: (a) The provincial option, i.e. the province is responsible for all district health services through the district health manager. (This option can be exercised where there is insufficient independent capacity and infrastructure at the local level; (b) The statutory district health authority option, i.e. the province, through legislation, creates a district health authority for each health district. (This option can be exercised in instances where no single local authority has the capacity to render comprehensive services) and (c) The local government option, i.e. a local authority is responsible for all district health services. (This option can be exercised if a local authority, whose boundaries are the same as that of a health district has the capacity to render comprehensive services.)”

Co-ordination of policy implementation between the three spheres of government has not been optimal. A review of progress towards the DHS in South Africa reveals a mixed bag of major achievements and key impediments. The achievements are captured succinctly in a treatise by Barron (2013) as follows: (a) The demarcation of South Africa into 52 districts, with every part of the country falling into one of these geographical areas; (b) Appointment of district management teams by the Districts, which include a district manager, at director level or above, leading that team; (c) Development of District Health Plans to the National DoH by 46 districts, excluding those in the Western Cape Province; and (d) Review of the competencies of managers of districts and CEOs at district hospitals, and based on these reviews, development of skills and training programmes to ensure that these managers have the right competencies.

However, the inability of the health sector to implement a well-functioning DHS has been a major impediment to the delivery of Primary Health Care. There has been limited delegation of powers by provinces to district and facility health management. Other challenges articulated in the National Development Plan 2030 include weak management, accountability and support. A need exists to strengthen the implementation of the DHS. It is imperative that every manager needs is given the authority to make decisions regarding the resources that they manage; to take responsibility for the resources that they manage and to achieve the expected performance; and to be held accountable to another manager, who gives the appropriate level of support.

7.5. Operational management weaknesses

In most parts of the country the health sector has weak operational management capacity at subnational levels. This is evidenced by poor financial management reflected in the reports of the Auditor-General of South Africa (AGSA); inefficient patient information systems; inefficient drug supply and management systems, which impact on patient care and patient waiting times. For the financial year 2012/13, only 3/10 health departments namely, the National DoH; North West and Western Cape, obtained an unqualified audit opinion from the AGSA. Management capacity has

also been compromised by inappropriate appointments made over the years in critical positions, including those of Chief Executive Officers of Hospitals. This is being reversed. A new policy prescribing the minimum requirements for appointment of CEO posts has been developed (National DoH, 2012d). A total of 104 new CEOs have been appointed (National DoH, 2013).

Gross financial mismanagement and corruption also exist, and has, for instance, led to the Department of Health in Limpopo Province being placed under national administration in 2012, and several senior government officials being subjected to disciplinary processes for financial misconduct. In the Eastern Cape DoH, between 2009-2012, the Department reversed approximately 1,000 irregular promotions, amounting to R80 million per annum, a saving of some R400 million over five years. A total of 1,284 departmental staff were sacked for offences ranging from corruption to non-performance and incapacity. Millions of rands were saved through discovery and stoppage of duplicate and/or corrupt payments; pervasive tendency of top officials using multiple service provider companies run by relatives or friends; and misuse of the ambulance service for flying private patients, at a cost to taxpayers of R25 million (Watermeyer, 2013). It was also discovered that the whole supplier database was corrupt, with more than 3,000 people registered more than once. A single investigation uncovered duplicate payments to single companies, amounting to a total of R34,109,375.56. An internal investigation also found that 10,221 employees of the department's 47,000 workforce were illegally receiving government grants. Ghost payments were also discovered. Investigation showed that nearly R700,000 in payments were made without naming a specific beneficiary (Kardas-Nelson, 2012).

7.6. Declining levels of Community Participation

The PHC approach requires strong community participation in securing and promoting health. Chapter 5 of the National Health Act (NHA) of 2004 empowers the Provincial Health MECs to establish health districts and sub-districts, for the delivery of PHC services. The Act further empowers the Provincial MECs to create governance structures such as Clinic Committees and Hospital Boards. However, implementation of this provision of the legislation has progressed much slower than anticipated over the two decades of democracy, and generated poor results.

However, by the end of 2007/08, only 30% of PHC facilities in the country had a minimum of one documented PHC facility committee meeting every second month (National DoH, 2008). A study conducted in 2008 by an independent NGO, the Health Systems Trust, concluded that on average, only 57% of facilities surveyed reported having clinic committees. By the end of 2010/11, PHC facility committees had been established in 43/52 districts and District Health Councils in 32/52 districts. The decreased public participation in the running of the health system has contributed to diminished accountability in the public sector. Enhancing community participation in health requires focused attention in the future.

7.7. High Maternal Mortality Ratio

South Africa's maternal mortality ratio (MMR) remains high, with population-based MMR of 269 per 100,000 and an institutional MMR of 146,7 per 100,000. This is largely attributable to HIV and AIDS. The country's efforts to reduce maternal deaths date back to 1997, when the then Minister of Health established the National Committee of Confidential Enquiry into Maternal Deaths (NCCEMD), which was the first on the African continent. The NCCEMD has since released five triennial reports. In 2010, the World Health Organisation estimated South Africa's MMR to be 300 per 100,000 live births. A positive development is South Africa's MMR, both population-based and institutional, reflect a downward trend. Annual data from the NCCEMD reflect that institutional MMR has decreased from 188,9 per 100,000 live births in 2009 to 146,7 per 100,000 live births in 2012. South Africa's 2013 Millennium Development Goals (MDG) country report reflects MMR as 269 per 100,000.

The health sector has implemented various initiatives to address causes of maternal mortality, including the Campaign for the Accelerated Reduction of Maternal Morbidity in Africa (CARMMA), which was developed by the African Union in 2009. The Free State reduced its maternal mortality by 48% between 2011 and 2012, through the implementation of key interventions, which included provision of dedicated obstetric ambulances in all its 30 hospitals to facilitate swift transfer of pregnant women experiencing complications; training and continuous supervision of health care providers, and effective monitoring and use of information for clinical decision making. The Free State case study provides reason for optimism and model to be replicated in other provinces struggling to reduce MMR. More should be done to the health sector and other departments to mobilise communities around the issue of women presenting late for antenatal care, to improve maternal health outcomes. More remains to be done to reduce MMR. Progress made towards the health related MDGs is significant but insufficient.

7.8. Rising burden of Non-Communicable Diseases

The prevalence of non-communicable diseases (NCD), such as cardiovascular diseases, diabetes, chronic respiratory conditions, cancer, kidney disease and muscular-skeletal conditions, has increased globally, and in South Africa. Common risk factors for NCDs, which are also emphasized in health sector's National Strategic Plan for NCDs 2013-2017, include the following: tobacco use; physical inactivity; unhealthy diets, and harmful use of alcohol. SANHANES-1 reflects that government's tobacco control policy has succeeded in reducing adult smoking by half, from 32% in 1993 to 16,4% in 2012s. However, 29% of adults revealed exposure to 'environmental tobacco smoke' i.e. non-smokers who inhaled other people's cigarette smoke. However, SANHANES also revealed high prevalence of pre-hypertension as well as hypertension amongst survey participants. The levels of physical activity or aerobic fitness amongst the population aged 18-40 years were

found to be low, with 45,2% of females and 27,9% of males found to be unfit. Combating NCDs requires behaviour change and lifestyle change, which are extremely difficult to implement. The national Strategic Plan for NCDs 2013-2017 produced by the health sector reflects 10 goals and associated targets that must be achieved by 2020. Full participation of all government departments is required to meet the set targets.

7.9. Violence and injuries

Violence and injuries constitute the fourth component of the quadruple burden of disease that South Africa faces. The country has an injury death rate of 158 per 100 000, which is twice the global average of 86,9 per 100 000 population and higher than the African average of 139,5 per 100 000 (National DoH and Health Policy Initiative, 2012). Key drivers of the injury death rates are intentional injuries due to interpersonal violence (46% of all injury deaths) and road traffic injuries (26%), followed by suicide (9%), fires (7%), drowning (2%), falls (2%) and poisoning (1%) [National DoH and Health Policy Initiative, 2012]. The burden of disease from violence and injuries places a huge strain on the health system. It also stretches state resources in other sectors, such as the South African Police, the Criminal Justice System and the Welfare Sector. Looking ahead, a need exists to implement a comprehensive and intersectoral response to combat violence and injury, and significantly reduce the country's injury death rate.

7.10. Unaddressed social determinants of health

Social determinants of health are defined as the economic and social conditions that influence the health of people and communities, and include employment, education, housing, water and sanitation, and the environment. South Africa's 2010 MDG Country Report to the United Nations indicated that the country made progress towards the goal of eradicating extreme poverty. This is evidenced by the decline in the proportion of population living below the poverty line and the increase in access to free basic services by indigents, including housing, water and electricity. Also, the net enrolment for female; the functional literacy rate of 15 to 24 year olds and the completion rate of primary education by 18 year olds have significantly improved. An evaluation study into the Child Support Grant (CSG) commissioned by the Department for Social Development, SASSA and UNICEF in 2012 concluded that the CSG promotes early childhood development, reduces stunting, improves school retention and better school outcomes, increases access to health care, lowers the risk of child labour (especially for girls), and lowers risky adolescent behaviour for the most vulnerable children. This is reason for optimism. However, there are also persistent reports of poor health care especially in rural areas and schools in low socio-economic communities. Much needs to be done to address the social determinants of health.

7.11. Instability of the Health Leadership

Another key challenge has been the instability of the leadership of the provincial health departments, the Member of the Executive Council (MEC), and the Head of Department, (HOD) as well as the relationship between the MEC and the HOD. A number of provinces have made multiple changes to their health MEC within relatively short periods of time. Each such change impacted on the post of the HOD, with consequent change in this position.

8. What do we need to think about and do differently?

The National Development Plan (NDP) 2030 adopted by Cabinet in 2012, aptly captures the acute challenges confronting the health sector; the progress made in the two decades of democracy, as well as the key milestones to be achieved over the next 15 years leading to 2030. The NDP 2030 envisions a health system that works for everyone and produces positive health outcomes, and is accessible to all. By 2030, South Africa should have:

- (a) Raised the life expectancy of South Africans to at least 70 years;
- (b) Produced a generation of under-20s that is largely free of HIV;
- (c) Reduced the burden of disease;
- (d) Achieved an infant mortality rate of less than 20 deaths per thousand live births, including an under-5 mortality rate of less than 30 per thousand;
- (e) Achieved a significant shift in equity, efficiency and quality of health service provision;
- (f) Achieved universal coverage;
- (g) Significantly reduced the social determinants of disease and adverse ecological factors.

To achieve this vision, the NDP 2030 asserts that the country should address the social determinants that affect health and diseases; strengthen the health system; improve health information systems; prevent and reduce the disease burden and promote health; improve financing for universal healthcare coverage; improve human resources in the health sector; improve quality by using evidence and develop meaningful public-private partnerships.

9. How do government and other sectors of society work together more effectively to address this?

A community mobilisation strategy, akin to the highly successful HIV Counselling and Testing (HCT) Campaign of the health sector, should be implemented to raise consciousness awareness about key health challenges, for instance, the late presentation by pregnant women to health facilities for antenatal care. According to the African Union (2013): “communities should help to define and prioritise relevant reproductive, maternal and neonatal health problems, understand the short-and-long

term consequences of women and children's health, feel ownership of interventions and outcomes, and participate in planning, implementing, monitoring and feedback. Not only should African governments make a commitment to engage communities, communities likewise must have mechanisms by which to engage the state". Mechanisms and structures must also be put in place to facilitate community participation.

10. Summary and recommendations

- The commendable gains made in reversing the frontiers of HIV and AIDS and Tuberculosis, as well as decreasing infant and child mortality, must be sustained into the future. South Africa cannot afford to be complacent. For instance, although a 50% decrease was achieved in the number of people acquiring HIV infection, from 700,000 in the 90s to 350,000 in 2011, this figure remains quite high and requires of government and its partners to enhance efforts at HIV prevention.
- The progress made towards the health related MDGs is significant but insufficient (Mayosi et. al, 2012).
- Social determinants of health require focused attention. Beyond the bilateral agreements and joint programmes between the health sector and individual government departments, the health sector should enhance its capability to coordinate and enlist the participation of government departments responsible for line functions that constitute the social determinants of health in both the Implementation Forum and the Technical Implementation Forum for Outcome 2. A "*Health in All Policies*" approach should be adopted.
- The implementation of NHI is an important reform of the health sector, aimed at addressing the persistent inequities between the public and private sectors, which requires commitment and support from the whole of society, particularly when the financing mechanisms are finalised.
- Government and civil society organisations should work together to develop a state-civil society model for delivering services to communities, which facilitates greater transparency, accountability and funding for NGO services.
- Provincial Administrations need to ensure stability in the leadership and governance of the health sector. Stability in the provincial executive (MEC and HOD) is a necessary condition for a well-functioning provincial health department.
- Given that only 3/10 health departments obtained an unqualified audit opinion from the Auditor-General of South Africa for 2012/13, financial management capacity and internal control systems must be enhanced in the health sector.
- Provincial health departments should explore mechanisms to improve supportive supervision, particularly of staff working at lower levels of the service and in rural areas, to improve quality of health services.
- An urgent need exists to strengthen the implementation of the District Health System in South Africa. District Managers with full authority and accountability for

service delivery in their districts, as well as fully fledged District Management Teams, should be appointed in all districts.

- Given the uneven performance across districts on key health indicators, greater effort is required to support districts with insufficient capacity to enhance their performance outputs.
- Communities should be mobilised to participate in securing and promoting their health, as it was the case in the first decade of democracy.

11. Conclusion

Twenty years into democracy, empirical evidence converges around the fact that the health of South Africans has improved. The South African health system has made great strides towards reversing the legacy of the apartheid health system and the impact of HIV and AIDS and Tuberculosis. The legislation, policies and programmes implemented in the first three terms of the democratic government provided an important foundation for the achievements that became visible and celebrated in the fourth term of democracy. Between 2009-2011 a new sense of urgency was infused in efforts to reverse the scourge of the HIV and AIDS pandemic and the concomitant Tuberculosis, and in efforts to improve maternal and child health outcomes. Looking ahead, the South African health system has been placed on a very good trajectory for the future.

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