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Health and health care in South Africa in transition: a macro perspective

Summary

The South African health care system, along with society in general, is undergoing profound transformation. After almost five years, questions may well be posed about the nature of this transition, the benefits of the reform for health care, and the effects of the transformation on the health and well-being of the population. The argument is that reform of a fundamental nature has indeed taken place in numerous dimensions of the health sphere. However, crucial aspects of the health system remain unchanged. Regarding the effects of the transition on the health and well-being of the population, one may certainly assume that significant gains have been achieved as a result of the reform measures, although practice thus far also adduces some evidence to the contrary.

Gesondheid en gesondheidsorg in Suid-Afrika in oorgang: 'n makro perspektief

Die Suid-Afrikaanse samelewing, en so ook sy gesondheidsorgsisteem, ondergaan tans ingrypende transformasie. Na byna vyf jaar kan vrae met reg gevra word oor die aard van die transisie, die voordele van die hervorming vir gesondheidsorg, en die uitwerking van die transformasie op die gesondheid en welsyn van die bevolking. Die argument is dat fundamentele hervorming inderdaad in talle dimensies van die gesondheidsfeer plaasgevind het. Nogtans bly sekere kernaspekte in die samestelling van die gesondheidsisteem onveranderd. Ten opsigte van die uitwerking van die hervorming op die gesondheid en welsyn van die bevolking, sou mens kon aanvaar dat winste sekerlik as gevolg van die hervormingsmaatreëls gerealiseer het, hoewel die praktyk tot dusver ook op die teendeel dui.

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South Africa is undergoing a profound transformation which in many respects resembles a full-scale social revolution.¹ The thrust, direction and significant markers of this reform (as intended for the health sector) were spelled out in broad terms in the Reconstruction and Development Programme (ANC 1994a), which subsequently became the government's framework for reform the essence of which has later been formally captured in the Constitution (RSA 1996). Today, after almost five years of rule by a democratically elected government, questions may well be posed about the progress of this transformation in the health sphere. In an attempt to give an account of the reform process, its direction, depth and pace, as well as its effects on health and health care, the following questions are relevant: What is the essence and direction of the transition, and how fundamental has it been? What are the main achievements and gains of the health care reforms which have been implemented; what could realistically be expected within the relatively short timespan, and how is the pace of reform affecting its outcomes? What has been the effect of reform on the health and well-being of the population?²

Reform of a fundamental nature has indeed taken place, generally in the direction intended by the new government and at a remarkable pace. This applies particularly to health policy, but also to the structure and content of the health care system. However, certain crucial aspects of the health system remain unchanged, have been only superficially altered, or are even drifting in the same problematic direction which so strikingly characterised the previous dispensation. In respect of the effect of the reform measures on the health and well-being of the population, it is perhaps too early to infer real gains, although, theoretically at least, positive outcomes for health and well-being seem logical. There are, however, also signs testifying to the contrary.

1 This is an adapted version of a paper presented at the Conference of the International Geographical Union (Commission on Health, Environment and Development), Coimbra, Portugal, 24-28 August 1998.

2 The financial support of the CSD and the UOFS for this research is gratefully acknowledge.

1. Rationale and aims of health reform in South Africa

Current health sector reform is driven by the desire to rectify the many structural distortions and inequities which characterise the health sphere.³ These can be summarised as follows:

First, manifold fragmentation of the health care system along structural, functional, racial, geographical and socio-economic lines, resulting in a dire lack of synchronisation and the total absence of a unitary system. Secondly, major inequities and disparities in the provision of health care, which is apportioned and accessible along racial, geographical and socio-economic lines, favouring a white, urban, wealthy and medically-insured clientele. Thirdly, severe shortages of resources, some indeed real, but others due to maldistribution, mismanagement and wastage, with overprovision in the private sector and in metropolitan areas, leaving those dependent on the public sector, particularly in rural or peri-urban areas and in the erstwhile homelands, notoriously underprovided and underserved. Fourthly, highly inappropriate emphases and orientations in health care, with a persisting emphasis on high-tech curative, hospital-based and doctor-oriented services, strongly provider-orientated and driven by the interest of professionals and the market, obviously at the cost of the neglect of preventative, primary and community health services. Fifthly, striking discrepancies and inequalities in the health and the health status of the population, partly as a result of the aforementioned structural deficiencies, with which the health system has to cope.

An awareness of these problematic features has galvanised the system into action, with an urge to effect fundamental reform of health care in its totality, and in particular greater efficiency and equity. The current health reforms are targeted precisely at eliminating the deficiencies (Department of Health 1996a; 1996b).

3 Cf ANC 1994b; MRC 1991; Savage & Benatar 1990; Van Rensburg & Benatar 1993; Van Rensburg *et al* 1992.

They aim

- to unify the fragmented health services into a comprehensive and integrated national health system;
- to reduce disparities and inequities in service delivery and health outcomes, and
- to extend access to an improved health service.

2. Fundamental reforms in the South African health sector

It should be recognised that current health reforms are not entirely the initiative of the new government. Several reform measures had already been introduced by the previous government, although most of these were largely nullified by the constricting influence of the unchanging socio-political order, which had little room for fundamental reform of the health system (Van Rensburg *et al* 1992). The new political order changed this. The ANC-led government embarked on fundamental reform, with the Reconstruction and Development Programme (ANC 1994a) and the National Health Plan (ANC 1994b) serving as frameworks for conceptualising and directing the reform process, both at the broader societal level and in the health sector. During the past years these frameworks have been detailed and are still being detailed and mandated by a series of official policy papers and legislation at national and provincial levels (Department of Health 1997a & 1997c).

Two main policy strategies steer the reforms: first, a pronounced shift towards primary health care (PHC) and, secondly, the introduction of a district health system (DHS). These two strategies set out definite plans for the redress of structural deficiencies and distortions created by previous dispensations. From these policy reforms, numerous changes in the structure and contents of the health system and in health care have resulted. Among these, the following may be seen as the most important.

2.1 Primary health care: shifting the emphasis and echeloning care

Universal access to comprehensive PHC constitutes the crux of the government's health plan and enjoys the highest priority in current health policy. The aim is to change the focus of health care from health professionals at secondary and tertiary levels to the community, patients and primary care. Much has already been achieved in this respect, *inter alia* as part of the Clinic Building and Upgrading Programme — between 450 and 500 new clinics have been built, significantly reducing the estimated backlog of some 1000 clinics (Abbott 1997). The 1994/95 budget allocated R3,5 billion to PHC, which was 25% of the national budget, as against 20% in the year before (SAIRR 1994/95).

Along with the shift to PHC, there is an inevitable change in the relative importance of the levels of care. In the public sector, increasing emphasis is being placed on first-line care and facilities, accompanied by a more pronounced positioning of community or district and regional hospitals to support the PHC referral network. To curb the once strong emphasis on hospital, curative and specialised care as well as to allow for the development of PHC, the health budget is being systematically diverted away from tertiary academic and specialised hospitals while significantly increased funding is being allocated to PHC (Department of Health 1996b; Ruff 1997). From 1996/97 to 1997/98, reprioritisation has meant a shift of 8% away from hospital services and 10,7% towards district health services (Van den Heever & Brijlal 1997).

2.2 District health system: decentralising and regionalising health care

The inauguration of the DHS as the organisational basis for the South African health system represents another fundamental reform. In broad terms it implies the regionalisation of services, i.e. dividing the country and, in turn, the nine provinces into smaller administrative and service units — 50 health regions and about 170 health districts (Owen 1995; Sharp *et al* 1998). Simultaneously, authority and decision-making are increasingly devolving on regional and

emerging district offices, while management autonomy at the level of the health facility is being maximised. District health authorities are to have greater responsibility for both the determination of priorities and the allocation of funds in their areas of jurisdiction.

The emerging DHS is already firmly established in the state machinery. At national level a chief directorate for health district development was inaugurated during the massive restructuring of 1994/95. Likewise, all nine provincial health departments now include rather large directorates for district health services, within which most of the provincial health staff are located, and through which most of the provincial health budget flows. An advanced degree of decentralisation has already been achieved in health regions in the provinces, with ongoing devolution to the emerging health districts. Moreover, current DHS development intends to consolidate previously fragmented authority and service structures (i.e., provincial and municipal structures). In more recent times there has also been a significant reprioritisation in favour of district health services, which is already reflected in provincial budgets (Van den Heever & Brijlal 1997: 86).

Though health district development is currently the slogan, the greater part of the concept is still to be transposed into practice, which leaves the aim of the foremost current reform far from accomplished. Universal obstacles hindering the development of the DHS have only recently begun to surface, *viz* the preparedness of the centre to devolve authority and the ability of the periphery to assume responsibility effectively.

2.3 Dismantling fragmentation: unifying segregated and divided structures

In the previous dispensation, as has been indicated, health care was highly fragmented: geographically, structurally, racially, and in terms of authority with 14 health authority structures — one national, ten 'homeland' and three 'own affairs' ministries. This formerly fragmented health structure is now consolidated under a single national ministry of health, which is responsible for overseeing, supporting and co-ordinating the entire health system of the country.

The health authorities of the nine provincial governments (PHAs) embody a decentralised, 'federal' style system, with more power entrusted to the provinces than before. In turn, these PHAs are now developing, co-ordinating and supporting the emerging district health authorities (DHAs) which in coming years are to assume ever greater responsibility for the health of local communities. This process is far from complete. In fact, the recent publication of the White Paper on Local Government (Ministry of Provincial Affairs and Constitutional Development 1998) has introduced an entirely new phase in the restructuring of health, shifting the responsibility for PHC increasingly to local authorities and communities. In turn, this implies that the currently still fragmented provincial and municipal authorities and service structures are to be integrated into consolidated district structures supported by co-operative government structures.

2.4 Dismantling apartheid: Africanising and feminising the system

It stands to the credit of the new government that it has, in a relatively short time, decisively succeeded in dismantling apartheid structures, laws and measures relating to the public health sector, including those which had resulted from the homelands, separate amenities, group areas and tri-cameral policies. As part of this de-racialisation of the public sector, the reform process thus far has introduced forceful affirmative action, designed to Africanise the public health system, with due sensitivity to gender.

Prior to 1994, whites accounted for 90,2% of management staff, while 87,8% of all managers were male. These once almost 'all-white' and 'all-male' top management structures have been systematically revised, starting with the top echelons of political and management bodies at the national and provincial levels, moving steadily downwards in the personnel structure, and producing a thoroughly reconstituted staff corps more accurately reflecting the demographics of the country (Mametja & Reid 1996). Hence blacks (Africans, Indians and coloureds) and women figure prominently and overwhelmingly in the national Portfolio Committee for Health and in the provincial standing committees on health; most of the

executive committees for health in the provinces are headed by Africans and women, while Africans and women also feature strongly as provincial heads of health, as chief directors and directors in the various directorates of health at both national and provincial levels. Similarly, significant race- and gender-sensitive transformation may be seen as the health reform process moves towards the regions and districts. These personnel reforms have involved a concerted effort in terms of human resource development, although they drew criticism from certain quarters for being implemented in an unco-ordinated way (Van Niekerk & Sanders 1997).

2.5 Rectifying discrepancies and distortions:

· redistributing personnel and redirecting patients

The rectification of prevailing discrepancies and inequalities in health care is a two-pronged process. First, it implies equalisation in terms of the geographical, racial and socio-economic distribution of personnel and facilities — thus, large-scale reallocation of resources. Secondly, it involves the more even and appropriate referral and flow of patients to the various providers and facilities. With reference to the elimination of discrepancies in the distribution of health facilities and providers, as well as in the quality and accessibility of care, explicit provincial reallocation of resources commenced in 1995/96. It aimed to accomplish greater interprovincial equity, i.e., *per capita* equity in provincial health allocations by the national government (making allowance for provinces with academic health facilities) within five years (Department of Health 1996b).

Various measures and mechanisms intended to achieve such equity are contemplated, and the combination of the PHC approach and the DHS, once fully functional, could eventually pay significant dividends in this regard. The array of options under consideration includes redistributing personnel to underresourced areas by means of retraining; providing incentives to encourage medical workers to work in rural areas; limiting opportunities for private practice in overserved areas; introducing contractual obligations for those receiving subsidised training; requiring newly qualified medical and other health professionals to spend a certain period working in the public sector prior to entering private practice; introducing compul-

sory community service (or further in-service training) for doctors on completion of training (Department of Health 1996b); importing Cuban doctors to serve communities in underserved areas, and strengthening the public sector in order to attract staff from the private sector.

With regard to the flow of patients to providers and facilities, various guidelines and measures are being devised to effect a more appropriate and cost-effective referral flow. Both the PHC and the DHS approaches dictate that patients utilising the public sector should enter the health care system at the lowest level of care (PHC clinics) and, if required, systematically move upwards into the higher echelons of care. To restrict the bypassing of PHC facilities, and thus the unjustified use of public hospital facilities, financial barriers in the form of penalty charges are being built into the system. Furthermore, the whole intention of the DHS is to regionalise health care, which implies that facilities and health workers be deployed in such a manner and in such numbers as to ensure that patients are able to receive the appropriate health services in their own regions and districts, with the sole exception of services of a tertiary nature.

2.6 Free health care: rendering services more accessible and affordable

Historically, the ANC has always been an ardent agitator against private-for-profit health care in South Africa, envisaging the eventual phasing-out of private care. Originally stated in the Freedom Charter (1955) of yesteryear, this commitment has been more recently reiterated in both the Reconstruction and Development Programme (ANC 1994a) and the National Health Plan (ANC 1994b). In line with this approach, and with the principles of equity and accessibility, and particularly in order to remove financial barriers for vulnerable groups, the new government has thus far systematically phased in and expanded free health services. Such socialisation of health care stands in sharp contrast to policy under the previous government where the deliberate strengthening and expansion of the private sector in health care was one of the mainstays of health policy, *inter alia* to alleviate the burden on the state by curbing state expenditure and scaling down the public sector. This resulted in a

strong, competitive and lucrative free market in the health sector, encouraging high-tech medicine and pharmaceutical development, but eventually also inflating costs.

Since mid-1994, formidable strides have been made towards free services, first introduced at all state health care facilities for children under the age of six years and for pregnant women. Subsequently free PHC services were expanded to include all public health centres and clinics; still later, free services were introduced for children up to twelve years of age at all public clinics. In tandem with these measures, and in particular to limit the expansion of the private health sector, a number of regulatory measures have been proposed which are aimed at reforming the private health sector. These apply to private providers, private hospitals and the health insurance industry. Among others, proposed measures include the requirement that the construction of new private hospitals be authorised by the minister; the cutting of state subsidies to private hospitals in order to discourage their growth; the barring of doctors from holding shares or having other financial interests in private hospitals; regulation of the importation of expensive technology in both the public and the private sector; control over the dispensing of medicines by medical practitioners; the introduction of mandatory health insurance coverage for a defined hospital benefit package; ensuring cross-subsidisation and risk-pooling in health insurance, and enhancing efficiency and cost-containment in the health insurance market (Department of Health 1996b).

2.7 Participatory health care: involving communities in public health structures

True to the aim of the RDP to create a people-driven culture, the decision-making process in public health is also undergoing significant reform. The new government's policy focuses strongly on empowering communities to participate actively in planning, prioritising and monitoring PHC services in their specific areas and to take greater responsibility for their own health.⁴

4 Department of Health 1996b; Department of Health 1997a & 1997c; Ministry of Provincial Affairs and Constitutional Development 1998.

In practice, community involvement and participation do not remain empty slogans. These concepts are pertinently introduced into the new, emerging governance structures of health care. Such involvement and participation has been instituted *inter alia* by the creation of formal and informal health forums and intersectoral forums, boards, councils and committees of all sorts and at all levels (from the national, provincial and regional levels down to the district, local and facility levels, eventually), pertinently representing and involving civil society, local communities and non-governmental organisations in governance (Levendal *et al* 1997). Decision-making is becoming a participatory affair and being devolved to the lowest levels of the district and community. This is a fundamental change from the past when a top-down, authoritarian approach was characteristic of the functioning of the public sector, excluding in particular the non-white population from policy and decision-making processes.

3. Outcomes of the transition for health care

The aforementioned reforms have transformed the South African health care system in many fundamental ways, and with effects both beneficial and detrimental to health care.

3.1 Positive outcomes for health care

The previous section has already highlighted the many positive outcomes of the transformation in the health sector. Among these are the following:

- Consistent progress in eliminating discrimination and domination from the public health sector, affecting both personnel and client populations, by means of deliberate affirmative action and equalising measures.
- Greater accessibility of health care to disadvantaged groups, created by the PHC policy which is systematically channelling financial and human resources towards care at the first level, and by the policy of free health care which has removed a major barrier to access.
- Significant strides towards interprovincial equity by means of purposeful budgetary mechanisms at central government level

which have moved funds for health to underresourced provinces in order to attain equity in *per capita* expenditure.

Table 1: Increasing provincial equity in *per capita* expenditure on health, 1994/95 and 1997/98

Province	<i>per capita</i> 1994/5	<i>per capita</i> 1997/98	% change	% under/over average
Western Cape	749	707	-5,6	50,9
Eastern Cape	466	444	-4,8	-5,2
Northern Cape	544	543	-0,2	16,0
Free State	536	510	-4,7	9,0
KwaZulu-Natal	442	418	-5,3	-10,7
Mpumalanga	281	263	-6,4	-43,7
Gauteng	830	773	-6,8	65,2
North West	446	417	-6,4	-10,8
Northern Province	331	309	-6,8	-34,0
South Africa	496	468	-5,7	0,0

Source: Van den Heever & Brijlal 1997: 84.

- Increasing intraprovincial equity in the provision of services, brought about by deliberate reprioritisation and redistribution of resources in favour of PHC, as well as by the decentralisation and devolution of decision-making to lower levels.
- Increasing involvement and participation of communities in health matters at local, district, provincial and national levels, ensuring greater accountability and democracy in health matters.
- The unification of a previously fragmented health system by means of the integration of facilities and services which were segregated along racial and political (homeland) lines.
- The initiation of a series of health programmes particularly targeting the most acute health problems, including HIV/AIDS, tuberculosis (TB), maternal, child and women's health (MCWH), and nutrition and protecting the most vulnerable groups in society.
- A new mode in the training of health personnel which is less focused on hospitals and high-tech solutions and more practice-oriented, thus producing staff who are more efficient and effective in delivering care in PHC settings, as well as in remote rural areas.

In all these respects, and more, one may generally conclude that the transformation of the health sector has indeed made a significant difference particularly in terms of the equity, accessibility and efficiency of health care.

3.2 Constraining factors and negative outcomes for health care

The reforms have also had some negative effects on health care, as well as achieving little or no progress due to particular constraining factors. These will now be analysed.

Despite major changes in the health system and extensive legislation on many aspects thereof, with the tenth draft of the Health Bill still in circulation, the absence of a national legislative framework is a major concern. Aspects of health services are in a vacuum, unarticulated and uncertain, resulting in a disjointed restructuring process, lacking in uniformity among the provinces (Stuurman-Moleleki *et al* 1997).

Despite the dismantling of apartheid, race and gender distortions in health care are bound to persist for decades to come, partly due to the backlog created by the previous system, and partly as a result of the continuation of a type of health provision in a system segregated by race and class, with the more wealthy catered for by the private sector, while the less wealthy must rely on a less effective public health sector.

Despite major gains in respects of equity, fairness and representativeness, affirmative action, as implemented in the public health sector since 1994, is beset by problems. It has involved the rapid and large-scale introduction of less experienced (or completely inexperienced) personnel and managers into key positions in state bureaucracies; it has triggered voluntary severance packages, resignations, retrenchments and dismissals of senior and experienced staff in significant numbers; it also demoralises and demotivates existing staff by limiting opportunities for promotion and so on. The net effect has been that these developments have inevitably led to concern (and, indeed, to sure signs) that standards are dropping (Ruff 1997; SAIRR 1997) and, more generally, that public health services are collapsing.

Budgetary mechanisms implemented by the central government at the beginning of the 1997/98 fiscal year have been suspended in favour of, and aimed at eliminating *inter*provincial inequities, *en bloc* grants for all functions of each province, thus jeopardising the attempts of central government to move funds for health to previously underfunded provinces. Such moves, as well as rectifying glaring provincial inequalities in the availability, access and quality of services, are now dependent on intraprovincial budget allocations and on the discretion of the various provinces. Thus health is now in competition with the other provincial departments for a share of the available funding. The achievement of interprovincial equity in health has thus been compromised and lost its priority status — all the more so in the light of the increasingly stringent budgets confronting the provinces.⁵

The current government has not succeeded in creating unity among the many roleplayers and stakeholders in the health sector. This failure has led to divisiveness, rivalry and the undermining of otherwise sound government initiatives. The health scene displays and is negatively affected by contradictions and open conflicts of interest and endeavour between the public and private sectors; by contradiction, confusion and conflict among national, provincial and local levels of government; by conflictual relationships between local government structures and civil organisations; by unfulfilled expectations on the part of traditional healers; by the frustrated interests of private health providers, medical professionals and pharmaceutical companies. There is growing estrangement among several stakeholders in the health sector, as is demonstrated by continual clashes between government, the health professions, and the private sector on matters such as compulsory community service (extended vocational training), parallel importation of medicines, recruitment of Cuban doctors to serve in the public sector, attitudes to free health care and generic medicines, and many other issues.

The introduction of free health care was not adequately planned or budgeted for, thus the increased attendance at and utilisation of

5 Cf Barron *et al* 1997; Buthelezi *et al* 1997; Robb *et al* 1997; Ruff 1997; Van den Heever & Brijlal 1997.

most public health facilities and services led in many cases to severe overcrowding, shortages of supplies and equipment, poor working conditions at clinics, low staff morale, excessive use, deterioration in the quality of care, and even abuse of scarce resources (McCoy & Barron 1996; McCoy & Khosa 1996; SAIRR 1997). The “overloaded, cash-strapped health system” is simply not able to keep up with the demand. It is not clear whether the policy has resulted in real benefits in terms of health outcomes; neither is it clear whether the beneficiaries are indeed those who most require health care (McCoy & Barron 1996).

The health system still retains its notorious two-class character — a weak public sector providing ‘second-class’ services for the majority of the population (who are dependent upon the state) and a strong private health sector providing for the minority: ‘first-class’ services for the wealthy and insured. Current developments point to the expansion and strengthening of the private sector and, along with this, to the perpetuation of structural distortions, disparities and inequalities as well as market- and provider-driven initiatives leading to excessive health spending and cost escalation. On the one hand, new deals are lavishly accommodating the private sector and firmly securing its future and prosperity; on the other hand, it is left to explore and establish its own niche in the health market. There are ample indications that the private sector is gaining ground as private facilities, private financing and the health market are growing, while part of the public sector is increasingly infiltrated by and surrendered to the private sector and private enterprise. The private sector thus remains healthy: in the eight years prior to 1997 (1988-1996) there was a growth of 113% in the number of private for-profit hospital beds in South Africa. Everything thus points to development in the same direction as in the past — the increasing privatisation of South African health care and the ongoing expansion of the market. This surely marks one of the areas least affected (or left intact) by the reform process.

Table 2: Health personnel practising in the private sector

Category	Total South Africa	N private sector	% private sector
General practitioners	17 438	10 067	57,7
Specialists	6 342	3 657	57,7
Dentists	3 748	3 330	88,8
Pharmacists	15 794	14 841	94,0
Nurses	119 922	16 586	13,8

Source: Wolvardt & Palmer 1997: 39.

In contrast with the private sector, there are rumours (and some clear indications) that public health services are collapsing. The trend is towards a weaker public sector, further weakened by government's fundamental concessions to the private sector, which represent a deviation from its original anti-private stance. Deep inroads are being made into the public sector as the movement of profits, staff and patients to the flourishing private sector gains momentum and valuable resources are lost as a result of the increasing emigration of health professionals. Furthermore, amid new challenges facing the private sector (e.g. the pressure of rising costs and the changing make-up of the insured population), broadening access to the resources of the public sector appears unlikely; instead, private sector patients, are likely to be moved (with concomitant cost-shifting) to the already overstretched public sector (Van den Heever & Brijlal 1997; Wolvardt & Palmer 1997).

The pending devolution of control over health care to district health authorities (DHAs) certainly raises questions as to whether current local governments are capable of assuming responsibility for the entire spectrum of comprehensive primary health services. These questions become more daunting when the present state of local government is taken into consideration. Many local governments are weak in management capacity, poor in infrastructure, and in a state of actual or imminent bankruptcy, further exacerbated by shrinking intergovernmental grants and the persisting culture of non-payment for services. Under such circumstances, the wholesale transfer of current provincial responsibilities to local governments would in

most cases be risky in the extreme (Naidoo 1997: 57). There is also much confusion regarding the principle of co-operative government according to which provincial and local governments are jointly responsible for primary health services, as well as in relation to the definition of municipal health services to be rendered by local government.

Despite the extraordinary transformation that has taken place, there is a general feeling of low morale and lack of motivation among staff within the public health sector. There is also a widespread public perception that access to health services and quality of care is no better than it was before. A number of structural problems within the public health sector threaten to undermine the consensus and the enormous gains that have been achieved (Robb *et al* 1997). Large-scale involvement of staff in the reform process, in addition to their daily duties, has resulted in frequent absences from service facilities and in extra work for the remaining staff, thus inevitably leading to failure to render proper services and quality of care (Gaigher 1998; Naidoo 1997).

In spite of good intentions and every effort to realise the set ideals over the past few years, the general performance record of civil society in terms of large-scale community participation and involvement in matters pertaining to health care is not always encouraging, and, at times, even disappointing (Levendal *et al* 1997). Also, such involvement and consultation often comes at a price in terms of protracted delays caused by lengthy consultation in legislative and decision-making processes (Stuurman-Moleleki 1997). This is not to be ascribed simply to reluctance and apathy, but is also due to a lack of leadership, support, capacity and material resources.

Several health and health-related programmes devised to deal with the most acute problems and to look after the needs of the most vulnerable groups have been introduced (especially for HIV/AIDS, TB, immunisation, nutrition, and MCWH). One may say that many policies with clear objectives and targets have been drawn up. However, the extent of health problems still to be addressed suggests that general implementation is far from adequate and that performance leaves much to be desired. The intent has been stated; what is needed

is the transformation of good intentions into practices which can make an impact (Floyd 1997; Jacobs *et al* 1997; SAIRR 1997).

Health reform has also brought major reforms and restructuring to health training and medical education. Medical training and specialised medicine have come under particularly severe pressure as medical schools, which offer the best prospect of retaining the best of modern medicine within the public sector, have been 'dismantled' due to the impetus of the PHC initiative. Inadequate understanding of the long-term implications, as well as the narrow perspectives of political decision-making cannot be escaped (Benatar 1997).

In concluding this section, one may say that health reform in South Africa has vast potential and opened numerous new avenues for better, easily accessible and more equitable health care. However, despite these positive outcomes, the reforms have not been altogether fundamental, effective and beneficial; the overhasty pace and the political thrust of the transition has in many respects also introduced unintended negative results detrimental to the effectiveness and efficiency of the system, as well as to the quality and user-friendliness of the health service.

4. Outcomes of the transition for health

Apart from the outcomes of these reforms for health care, it is also important to reflect on their effect on the health of the population. Theoretically, the commendable gains of recent years, especially in terms of the accessibility, affordability and attainability of public health care, should have meant concomitant benefits in terms of the health and well-being of the people. Whether this has indeed been the case remains difficult to determine, for several reasons.

First, it is difficult, even impossible, to monitor the outcome of health care reform over the short timespan of four years, in terms of improved health status and quality of life, fulfilment of health needs, decreases in mortality and morbidity rates, higher life expectancy, and so on. Secondly, the supposed decline in health status indicators since 1994 is part of a longer-term trend which has been noticeable for the past decade or three. For example, between 1960 and 1994 the infant mortality rate (IMR) almost halved, from 80 per 1 000 in

1960 to 43,1 per 1 000 in 1994. Despite this general decrease, there remains enormous differentials in IMR for the various population groups — for Africans 54 per 1 000; for coloureds 36; for Asians 9,9; and for whites 7,3 per 1 000. Furthermore, trends in IMRs are inextricably linked to trends in socio-economic improvement.

Table 3: Projected trends in infant mortality rate by race, 1990-2020

Year	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015	2015-2020
African (A)	53,4	39,0	26,7	20,6	16,9	15,1
African (B)	53,4	49,5	46,7	43,9	41,7	40,8
Coloured	42,4	36,5	30,7	24,8	18,9	15,5
Indian	13,4	11,1	9,7	9,7	9,7	9,7
White	10,2	9,7	9,7	9,7	9,7	9,7

Source: Calitz 1996.

A = with an improvement in quality of life because of better housing, electricity, clean water and a drop in the unemployment rate, IMR for Africans will drop to 15 per 1 000, i e, by 72% in the 30-year period.

B = without any marked improvement in general living conditions, IMR of Africans will not drop below 40 per 1 000, i e, by only 24% in the 30-year period.

Thirdly, the lack of information, and more specifically the inconsistency and unreliability of current health status indicators (in particular for the African population), rules out any reliable deductions on short-term trends in health status at this stage (Bradshaw 1997). Fourthly, there is ample evidence that several important indices of mortality and morbidity have recently tended to increase rather than decline — tuberculosis and HIV/AIDS are examples. Fifthly, recent gains regarding mortality, morbidity and life expectancy could in coming years be dramatically eroded by the AIDS pandemic (SAIRR 1997). Sixthly, health and disease are not simply matters of health care; they are equally, or even predominantly, the result of prevailing socio-economic conditions and life-style, and thus do not necessarily respond to bio-medical or health care interventions. The prevailing socio-economic situation does not indicate encouraging prospect for the health and well-being of the majority of the population.

Table 4 Inequality in South Africa: select social indicators

Indicator	Black	Coloured	Indian	White	South Africa
Infant mortality rate	54.3	36.3	9.9	7.3	48.9
Female life expectancy at birth	67	65	70	76	68
Human Development Index	0.500	0.663	0.836	0.901	0.677
Gini coefficient	0.53	0.44	0.47	0.45	0.58
Mean annual household income — urban	17 900	22 600	40 900	59 800	
Poverty rate	60.7	38.2	5.4	1.0	
Unemployment rate	41	23	17	6	33
Access to services: piped water in dwelling	33	72	97	97	51
Electricity for lighting from public supply	51	84	99	99	65
Telephone in dwelling	14	38	74	85	32

Source: Müller 1998: 15.

One should realise that health reforms, and health care generally, can play only a small part in the improvement of health. More important for health are the life-style and general living and working conditions of a specific population. With reference to South Africa, there is not enough evidence to conclude convincingly that the general living and working conditions of the majority of the South African population have improved over the past four to five years to an extent which would reflect positively in health indicators. Poverty and unemployment rates are high; large proportions of the population remain undernourished and illiterate; the disruption of family life is escalating; levels of crime, violence and trauma are rising; backlogs in the provision of housing, pure drinking water and sanitation remain; mass labour migration and illegal migration persist, while South Africans are also smoking more (Bradshaw 1996; SAIRR 1997). Amid these broader trends, improvements in health care would have minor effects, if any, on the health of South Africans. In addition, current health reforms cannot react swiftly enough to

compensate for or reverse historical neglect and the backlog in health and health care in the short term.

On the positive side, focusing on the effects of improved health care and free health services on the health of the people, one certainly could justifiably infer that more accessible and affordable services automatically would have an ameliorating effect on the health of the population, especially those sectors previously seriously disadvantaged and deprived. The presidentially led programmes of nutrition, free health services, mother and child health, clinic building and upgrading have certainly also had immediate effects, for example on the alleviation of hunger and undernutrition, the accessibility of mother and child care and so on. However, looking at the outcomes of the health reforms on health, matters do not appear all that positive. A few examples will suffice to illustrate this gloomier side.

South Africa is generally agreed to be the country where the rate of HIV/AIDS contagion is showing the fastest increase (Williams 1998). The proportion of the sexually active population who tested HIV+ has increased drastically: in 1994 it was near to 5%, or half a million people, with a doubling of numbers every 13 months; in 1996 between 12% and 16% of the sexually active population were infected, up to two million South Africans could be HIV+, and the doubling time was 5-12 months. South Africa may expect to accumulate between 5 and 7 million HIV-infections and about 1,5 million cases of AIDS by 2005. Unless the epidemic is turned around, expenditure on HIV/AIDS could hypothetically take up at least a third and possibly as much as 75% of the health budget within the next decade (Floyd 1997; SAIRR 1997). There is in any case little doubt that the escalation of HIV/AIDS in South Africa will inevitably have a major distorting effect on the general provision of and access to health services.

Table 5: HIV-infection rates in women attending antenatal clinics

Year	1993	1994	1995	1996	1997
% infected	3%	7,57%	10,44%	14,17%	17%

Source: Bradshaw 1997:10; Department of Health 1998; Epidemiological Comments Dec 1996/Jan 1997:7; Floyd 1997: 187; SAIRR 1997: 460.

South Africa is also facing one of the worst tuberculosis epidemics in the world, with disease rates more than double those observed in other developing countries (Weyer 1997). In 1994 the incidence of TB in South Africa stood at 300 per 100 000 of the population, with 2 000 reported deaths for that year. More recent figures show that the incidence rate increased by 6% between 1995 and 1996 — from 340 to 362 per 100 000 of the population. In 1995, an estimated 23% of all TB cases were HIV+. This figure had increased to 27% by 1996. An investigation of 150 countries by the World Health Organisation showed that South Africa had the worst TB epidemic. If this trend continues, some 3,5 million people will have become infected with TB by 2006. Multi-drug-resistant TB is also on the increase (SAIRR 1997; Weyer 1997).

Table 6: TB cases (incidence rates and % HIV+) in South Africa, 1995, 1996

Cases		Incidence rate		% cases HIV +	
1995	1996	1995	1996	1995	1996
141 255	158 589	340/100 000	362/100 000	23,4%	27,0%

Source: SAIRR 1997: 466.

Furthermore, the notification of measles reveals an increasing rather than a decreasing trend: 3390 in 1994, 6891 in 1995 and 8723 in 1996.⁶ Trauma, road accidents and violence show no sign of abating. With the strong emphasis on PHC and the concomitant de-emphasising of sophisticated hospital and specialised care, it is to be expected that certain disease conditions and patient categories will receive less attention from the point of view of treatment — expensive treatment procedures and free options have certainly diminished.

Regarding the influence of health reform on the health and well-being of the people, one may conclude that, over the past four to five years, these reforms have in all probability contributed constructively to improving the health of the population and alleviating the heavy burden of disease and ill-health on the deprived and vulnerable. However, there are still areas in which the new policies and structures of health care do not yet make any significant practical

6 Department of Health 1997b; Epidemiological Comments Dec 1996/Jan 1997; SAIRR 1997.

difference. Only an improved standard of living and changed lifestyle can ensure such a difference.

5. Conclusion

In the short period since 1994, the transformation of the South African health system has been remarkable. Health policy, health structures and the content of health care have changed fundamentally. Nonetheless, neither the intended reform and restructuring nor the implementation of the new policies is yet complete; it is a slow and tardy process hampered by many difficulties and even deliberately opposed by forces with different convictions, aims and interests. Generally, however, the transformation is on track, in numerous respects firmly on track and irreversibly so.

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