Special Article

Reconstructing and developing the health system — the first 1 000 days

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This paper attempts to document the successes and failures of the Department of Health during the first 1 000 days of the Government of National Unity. The achievements of the Department are reflected against the backdrop of the legacies inherited by the current Ministry and Department.

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Milestones are important for reflection. The Department of Health, established by the Government of National Unity, was 1 000 days old in the last week of January 1997, and we reflect on our achievements and shortcomings in an effort to provide the public with a balance sheet against which our work can be critically evaluated.

Legacies of the past and need for new policies

The achievements of this department must be viewed against the backdrop of its predecessors and the legacy they left, so that there is a legitimate point of reference. In the light thereof, the achievements of this department can be clearly seen and appreciated.

The department inherited a highly fragmented and bureaucratic system, which provided health services in a discriminatory manner. Services for whites were better than those for blacks; people in the rural areas were significantly worse off in terms of access to services than their urban counterparts. Expenditure on tertiary services was given priority over that on primary health care services.

While many of the ills of the health system were known and some ideas for intervention existed, one of the first actions of Minister Zuma was to appoint ministerial committees on a wide range of issues, from maternal and child health to health-financing mechanisms. These committees consulted widely when developing their reports, which were used to draft a set of policies for the Department of Health. These proposed policies were again released for public comment in the form of the document entitled 'Towards a National Health System'. This revised document was recently published as the department's White Paper on the transformation of the health sector.

The White Paper clearly lays out the vision of the department and the Ministry of Health on a wide range of subjects. These range from the mission and goals of the department to the role of non-governmental organisations and year 2000 health goals, objectives and indicators. The White Paper details what needs to be done to correct the ills of the health system and explains how the department intends to go about the process of reconstruction.

Achievements of the Department

The Department has begun the process of implementing its mission statement as documented in the White Paper: 'To provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary health care approach.' Considerable progress in the attainment of this mission can be reported.

Rationalising 14 departments of health

The 14 health departments that existed in January 1994 have been rationalised into a national Department and 9 provincial departments of health. This task involved integration and rationalisation of functions and resources — a major task, given the size of the resource base. The budget of the Department of Health was about R14 billion and the total staff complement more than 230 000.

In line with the new Constitution, provincial departments of health have significant powers in respect of the rendering of services while the national Department retains national policy-making and the development of norms and standards as its major functions.

Equity and access to primary health care

The Minister of Health has committed the Department to the achievement of equity in the allocation of health resources with a focus on public health care resources in the first instance. The attainment of equity, while not an event but a process, started with the creation of mechanisms to ensure that all provinces are equitably funded. This has resulted in increased funding for the Northern Province, North-West, Eastern Cape and KwaZulu-Natal, which were grossly underfunded under the previous dispensation.

In addition, the Department's commitment to the primary health care approach, which is supported by the World Health Organisation and the World Bank, has resulted in a shift of resources from tertiary to primary health care. This shift is in line with South Africa's disease profile which means that we are beginning to put our money where it is most needed. This shift is projected to result in the health system's being able to finance more primary health care visits by the year 2005 (from an average of 1.8 visits per person in 1992/3 to 3.5 visits by the year 2005). The

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projection is that primary health care expenditure will increase from R4.8 billion in 1995/6 to R7.2 billion in 2000/01 — an average annual increase of 8.3%.

To improve accessibility to primary health care, free health care for children and pregnant women was introduced in June 1994. This was extended to all South African citizens in 1996, thus effectively removing cost of primary health care services as a barrier to access. The importance of this issue is illustrated by the fact that access to health care has been codified as a right in the Constitution. It may be argued that the Department of Health has therefore been in the forefront of implementing the Constitution — indeed, this right was provided for even before the Constitution was adopted by Parliament! Independent evaluation of the project suggested that it has achieved its aims: most clinics report increased attendance; attendance at antenatal and family planning clinics has improved; and nearly three-quarters of health workers surveyed believed that the policy was successful in preventing serious illness or death among pregnant women and children.

This does not mean that there were no attendant problems. We believe that there is sufficient evidence to suggest that this policy has begun to address a critical need in our country. The solution to the overcrowding that this policy has caused in some of our health facilities is not to reverse the policy and thereby reduce access. Instead we need to speed up the process of establishing a good primary health care infrastructure and appropriate referral pathways. This approach is consistent with our central objective, viz. the provision of affordable and good quality health care to all the people of this country.

A major clinic building programme was initiated to ensure adequate access to primary health care services. Between April 1994 and September 1997, 393 new clinics were built nationally and an additional 152 clinics extended. This suggests that an average of 9.6 clinics per month were built during this period. This compares with the building of 17 new clinics (or 1.4 per month) by the previous government in 1993, of which 13 were prefabricated. The staffing requirements of these additional facilities have also been considered and approximately 4 750 new primary health care posts have been created in the first 1 000 days.

Decentralisation of services

Part of the Department's strategy to render care more efficiently is to decentralise services and their management to the lowest possible level. This is also in line with the policies of the Government of National Unity. The Department inherited a highly centralised and bureaucratic administrative machinery, and the challenge was to transform the system into one which is decentralised, with management authority and responsibility being delegated. The implementation of this decision has resulted in the creation of a significantly smaller national Department. In January 1994 there were 7 086 posts in the national Department compared with 1 694 in January 1997 — a decrease of 76%.

In addition to the devolution of responsibilities to the provinces the Department has also decided to implement the district health system as the vehicle for the delivery of primary health care services. This system is designed to bring decision-making closer to the community so that community participation can be maximised. We have made significant strides in this respect with the demarcation of districts in all provinces except KwaZulu-Natal completed. We now have 155 health districts nationally. North-West, Eastern Cape and Northern Province have already appointed district managers. The speed with which the Department has facilitated the creation of this system illustrates its commitment to the decentralisation process.

Drug policy

The Department's mission is not only to improve access but to improve the quality and affordability of services as well. These issues underlie the national drug policy and essential drug list (primary health care) of the Department. The drug policy is aimed not only at controlling costs but also at improving distribution and management of drug supplies and ensuring rational drug use by both health providers and patients. To this end 44 000 copies of the essential drug list have been distributed nationally and seven provincial depots are now fully computerised.

Nutrition

The importance of proper and adequate nutrition for primary school children was identified by government as one of the major programmes of the presidential lead projects. By the end of October 1996 this programme was providing meals to 5.6 million children at 15 800 primary schools nationally. Reports indicate that this programme has had a significant impact on its target population. It has improved school attendance, decreased school drop-outs, improved concentration levels in the classroom and improved the general health of children. Besides the Primary School Nutrition Programme the Department also launched an Integrated Nutrition Programme in 1996 in an effort to establish a more co-ordinated and sustainable nutrition programme. This programme emphasises the importance of community participation and community-based initiatives that focus on intersectoral action.

Right to reproductive health care

The Constitution makes provision for the right to access to reproductive health care. The Department has responded to this provision by: (*i*) expanding reproductive health services, including family planning counselling and free access to contraceptive measures; (*ii*) the development of a life-skills programme for inclusion in school curricula; and (*iii*) the drafting of legislation on the termination of pregnancy, which was passed by Parliament.

The importance of the passage of the Choice on Termination of Pregnancy Act cannot be overstated. The Department is committed to ensuring that women have access to safe reproductive health services. This Act will play a major role in limiting deaths and illness that result from unsafe methods of termination of pregnancy. So-called 'back-street abortions' also contributed to increased health care costs, given the numerous patients with incomplete terminations who presented for treatment at hospitals.

Currently 300 public health and 50 private health institutions are able to terminate pregnancies safely. Since the implementation of the policy in February 1997, over 4 000 women have had access to the service.

Hospital services

The Department has not neglected the provision of hospital services, despite its prioritisation of primary health care. There is a recognition of the importance of services delivered at hospital level to ensure that there is reliable and effective back-up to the primary health care system. This Department commissioned the first-ever audit of all hospitals in the country. We found that the previous government had neglected the hospitals of the country. The audit revealed that one-third of all hospitals in South Africa will need to be replaced. It is estimated that it will cost approximately R8 billion over the next 8 - 10 years to rehabilitate our hospitals. The Department and the government are committed to exploring ways to secure the funds necessary to remedy this backlog so that the provision of hospital care in South Africa can complete with the best in the world but within the resource constraints that the country faces.

HIV/AIDS

Despite a significant increase in expenditure on HIV/AIDS we appear not to be winning the battle against this pandemic. The budget for HIV/AIDS and sexually transmitted diseases increased from R70 million in 1995/6 to R80 million in 1996/7, compared with R21 million in the 1993/4 financial year. Of the total budget for 1996/7, 25% was allocated to non-governmental organisations to extend the work of the Department. The increase in the prevalence rate suggests that we need to develop more innovative methods to fight this disease. The use of all types of media should be explored as part of the campaign against the HIV virus. One such attempt was the play 'Sarafina 2'. The Department accepts that in the implementation of this project several procedures were not followed and, in response to the Public Protector's recommendations, has taken various steps to ensure that proper controls are now in place.

Prevention of illness and diseases

From April 1995 the hepatitis B vaccine became part of the routine immunisation schedule for children for the first time in South Africa. This means that all children will be protected against hepatitis B through their receiving three doses of the vaccine as part of their routine immunisation. This is an important preventive strategy as hepatitis infection is a major cause of adult liver cancer, a fatal disease.

We also aim to make South Africa polio-free by 1998. In June 1995 a national polio campaign was undertaken in South Africa. Almost 90% of all children were reached in the first round of immunisation and approximately 80% were reached in the second round. More than 7 million doses of the polio vaccine were administered to children under 5 years of age during 1995.

In August 1996 nationwide measles and polio mass immunisation campaigns were undertaken. In addition, surveillance for acute flaccid paralysis was initiated. It is estimated that approximately 8.1 million children were immunised during these campaigns and thus protected from the debilitating effects of polio and measles.

In May 1995 the Minister of Health announced regulations about mandatory health warnings which were to appear on cigarette packages and advertisements as well as regulations prohibiting smoking in certain indoor public places. These measures were aimed particularly at reducing smoking rates among young adults and teenagers. These strategies already appear to be making an impact. Studies conducted by the Medical Research Council and the Human Sciences Research Council show that the prevalence rate of smoking dropped by 2% in 1996, compared with 1995 levels. This means that half a million fewer South Africans smoked in 1996.

Importation of doctors

The Department has been criticised for 'importing' Cuban doctors. The issue was not so much that foreign doctors were being imported, but that they were Cuban. The implication was that because they were Cuban they were poorly trained and that the South African health care system would not benefit from the experiences of Cuba. It is important that this issue be appropriately contextualised. There were 680 funded, but vacant, medical officer posts in the public service which South African doctors were reluctant to fill, despite vigorous attempts at recruitment. While many non-South African doctors were already in the country, especially in the former homelands and rural areas, they were largely from other developing countries, and many were from other African countries. This obviously constituted a significant brain drain from these countries. A decision was therefore taken not to support this brain drain from countries which were worse off than South Africa. Instead it was decided to find countries with surplus doctors and for government-to-government agreements to be reached. The Interim Medical and Dental Council, the statutory council which regulates the medical profession in South Africa, sent a delegation of highly qualified South African registered medical practitioners and specialists to Germany and Cuba to select adequately qualified doctors.

By the end of 1996, we had been able to recruit 302 Cuban and 17 German doctors. These doctors have been deployed in all nine provinces. This programme meets a vital need for doctors, especially in rural and under-served areas of the country, and reports from the provinces indicate that despite a few isolated problems this project is a major success. Communities that never had the benefit of being served by doctors in the past are the major beneficiaries of this programme. While the Department regrets any loss of life in any of its health facilities as a result of poor clinical judgement or unforeseen circumstances, the death of patients treated by Cuban doctors must be judged in the same way as those treated by health professionals trained anywhere else in the world. The Department's position is therefore that the Interim Medical and Dental Council is the most appropriate body to intervene should instances of poor professional conduct be found in either the public or private health care sector, regardless of the country of origin of the doctor.

The Department is highly appreciative of the effort and dedication of our foreign medical colleagues. Their assistance has helped to increase access to appropriate health care for many who previously did not have access to the skills and expertise of doctors. Their efforts therefore contribute to the national project of building a better life for all in a non-racial and non-sexist democracy.

Lessons from our experiences

Clearly the Department has been on a steep learning curve in its desire to fulfil its mission and it has made mistakes. Equally clearly, significant strides have also been made in increasing access to health care. The commitment of the Department to its mission cannot be questioned. A young Department can but learn from its mistakes, and this Department is as committed to this as it is to its mission. The Department looks forward, with optimism, to the challenges of the next 1 000 days and is committed to do whatever it can to improve the health status of all South Africans.

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