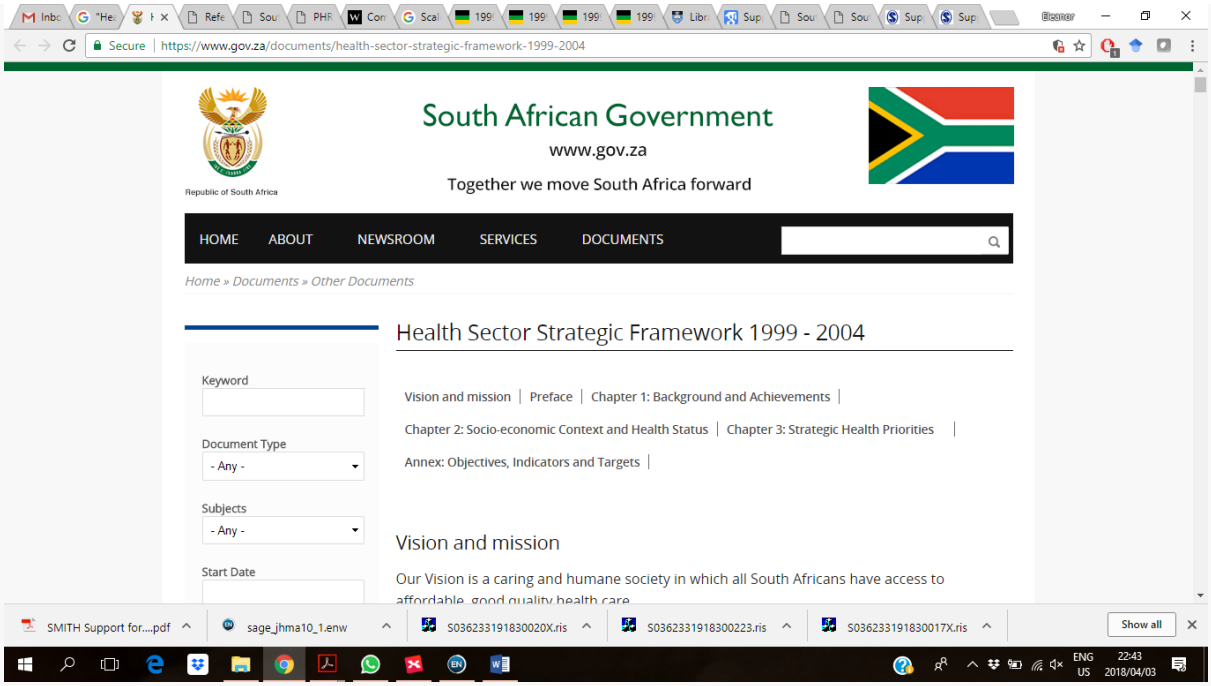

Health Sector Strategic Framework 1999 - 2004

Vision and mission

Our Vision is a caring and humane society in which all South Africans have access to affordable, good quality health care.

Our Mission is to consolidate and build on the achievements of the past five years in improving access to health care for all and reducing inequity, and to focus on working in partnership with other stakeholders to improve the quality of care of all levels of the

health system, especially preventive and promotive health, and to improve the overall efficiency of the health care delivery system.

Preface

This document sets out the strategic thrust of the health sector for the period 2000-2004. It will form the basis of more detailed and province-specific plans - which will be operationalised through annual business or operational plans.

This strategic framework builds on our understanding of our current strengths and weaknesses and relates these to our vision of the future. The document has to be read in conjunction with others, particularly:

- The Reconstruction and Development Programme (RDP) - 1995;
- The ANC's National Health Plan, 1995;
- The White Paper on the Transformation of the Health System - April 1997;
- Review of Public Health Service Delivery - June 1999; and
- Demographic and Health Survey - June 1999.

We also drew from the lessons of many other discussions, conferences, reports and publications of the past 5 years.

The key message that constitutes the essence of what we have to do in the coming years is the need to:

- consolidate achievements in improving access to care and advancing equity;
- deal decisively with the HIV/AIDS epidemic and its ramifications which threatens to undo our developmental gains;
- stabilise the hospital sector, including the need to promote greater efficiency and consider additional sources of funding for this sector; and
- adopt a multidimensional approach to ensure steady improvement in quality of care.

The overarching strategies that are critical for our success include:

- the need to strengthen partnerships with communities, key stakeholders, the private sector, NGOs and CBOs and;
- to build an accountable public health sector geared towards improving the standard of health care delivery to ensure a healthier nation, rallying under the banner of Batho Pele.

This document represents the shared views of my colleagues the MECs for Health from all the nine provinces. I thank them sincerely for their co-operation. We believe that the implementation of this programme will add further impetus to our project of a 'better life for all". It will also lay a solid foundation for our country as we enter the African

Century. I hope that this will provide a rallying point for all of us particularly the health workers as we tackle the challenge of transforming our country.

Dr M.E Tshabalala Msimang
Minister of Health

CHAPTER 1: BACKGROUND AND ACHIEVEMENTS

By solid co-operation between national and provincial health departments, supported by others inside and outside government, a national health system has been created.

1.1 BACKGROUND

Prior to 1994 the South African health system was built on apartheid ideology and characterised by racial and geographic disparities, fragmentation and duplication and hospi-centricism with lip service paid to the primary health care approach. There were 14 Departments of Health each having their own objectives. Access to health care for rural communities and those classified as 'black' was difficult. Besides the lack of facilities, the financial burden of finding and financing transport to health facilities and payment for health services acted as barriers to access to care. Many rural hospitals had very limited access to medical doctors and medicines were not always available at public health facilities and expensive.

Over the past few years, our country has been through an exciting process of transformation. During this time we have benefited from the lessons of others and believe that we have also contributed to humanity's common foundation of wisdom.

We have firmly placed before our country a perspective of health that recognises good health as both a prerequisite for social and economic development as well as an outcome of that process. Health must be considered as an investment rather than simply as expenditure. It is also a perspective that sees good health as a product of many determinants - many of which lie outside the formal health sector. For our country to succeed and our citizens to be healthy - government and all associated institutions cannot and should not function in isolation. Our inability to form strong partnerships has been one of our key weaknesses as a government over the past 5 years, a weakness that must be urgently corrected.

It is common knowledge that lack of water and sanitation is a common cause of cholera, diarrhoeal and other illnesses that afflict so many in our country and that there is a relationship between various communicable diseases, including TB, and conditions of squalor. Yet we often have not structured our institutions and service delivery systems in ways that can easily respond to these realities. The adoption by this government of the Primary Health Care Approach forces us to challenge this model. We share the vision captured in the President's "State of the Nation" address - a vision of integrated planning and delivery. This is the only way to optimise use of resources and derive the full utility of our investments.

In spite of these shortcomings, we believe we have made significant gains in the past five years. By solid co-operation between national and provincial health departments,

supported by others inside and outside government, a national health system has been created. The policy of Primary Health Care was clearly enunciated and now commands national support. The public health system has been transformed from a fragmented, racially divided, hospital-centred service favouring the urban population into an integrated, comprehensive national service driven by the need to redress historical inequities and to give priority to the provision of essential health care to disadvantaged people, especially those residing in the rural areas.

The public health system can be proud of the structural transformation it has effected. Practical progress has also been made in filling in the details of this transformation. Hundreds of new clinics have been built or rehabilitated, and health care has been made free at the point of delivery for pregnant women, young children and all who use the public primary health care system. New posts have been created at the public primary level of care. The access of poor people to essential health care has thereby been greatly improved. The policy of the delivery of primary health care through the district health system has been clearly formulated and implementation has commenced.

Inevitably, a multitude of challenges remain: planning and management skills are still weak at all levels, but especially in hospitals; management systems need to be upgraded; essential management information is lacking at all levels of the health system; more primary health care nurses need to be trained; the quality of care that is provided in public health facilities must be improved; many clinics are short of equipment; drug procurement, distribution and management must be improved; and the consolidation of the district health system is bedevilled by the continuing territorial divide between provincial and local governments.

We need to focus more attention on the building of a culture of quality and efficiency throughout the health care system. We need to explore possible areas of co-operation between the private and public sectors. Despite these challenges we are certain that we are well on the road to building a health service that all South Africans can be proud of.

1.2 ACHIEVEMENTS

The following summary reflects the key achievements since 1994:

- Outlining of the government's health policies through the tabling of the White Paper on the Transformation of the Health System in April 1997.
- The elimination of discriminatory structures and practices in the public health system.
- Consolidation of fourteen fragmented health administrations inherited from the apartheid system into a national and nine provincial health departments.
- Transformation of the public health system from a fragmented, racially divided hospital-centred service to an integrated, comprehensive national service that

emphasises the health needs of disadvantaged people especially those living in rural areas.

- Expansion of the primary care infra-structure:
- Since 1994 more than 700 new clinics have been built or had major upgrading (495 of which were completely newly built);
- 2298 existing clinics have received new equipment and were upgraded;
- 124 new visiting points were built; and
- 125 new mobile clinics purchased.
- Health care, free at the point of delivery, for pregnant and lactating women, children under the age of six years and all who use the public primary health care system was introduced.
- Introduction of the Integrated Management of Childhood Illnesses (IMCI), with training of health workers.
- The provision of primary school nutrition services through which about 5 million children have benefited and many employment opportunities have been created in communities.
- Major progress achieved with the implementation of the district health system through the demarcation of interim health districts and the setting up of the regional and district offices.
- Launching of the National Drug Policy in 1996 and the development of essential drug lists and standard treatment guidelines for primary health care and hospital levels (paediatric and adult levels of care) and some improvement in the availability of essential drugs in public facilities.
- Realignment of tenders in line with the essential drug lists.
- Introduced the World Health Organisation recommended Direct Observed Treatment Short-course (DOTS) strategy to combat TB in 1996.
- Employment of 402 Cuban and 44 other foreign doctors to strengthen hospital based care for rural communities and to provide proper support to our primary health system.
- n The introduction of community service for newly graduating South African doctors.
- n An impressive record in transforming health legislation. Acts have been passed to:
- Rationalise Health Professions Councils and make them more representative of the South African population;
- Make drugs more available and affordable in the country;

- Promote the use of generic products;
- More effectively regulate the medical schemes industry;
- Enable safe and legal termination of pregnancies in public and private facilities;
- Warn the public of the dangers of smoking; and
- Limit smoking in public places and ban the advertising of tobacco products.
- Commencement of a system of inquiries into maternal deaths to ensure the prevention of unnecessary deaths.
- Implementation of the Choice on Termination of Pregnancy Act, 1996, with the training of midwives in termination of pregnancy, and in post-abortion counselling.
- Training of advanced midwives and facilitators for most provinces.
- Prioritisation of the health of children has ensured that South Africa is firmly on the road to polio free certification and the achievement of a significant decline in measles due to mass immunisation campaigns.
- Introduction of Hepatitis B vaccine in April 1995 and HiB vaccine in July 1999.
- Advanced preparations for the establishment of a Telemedicine network including 28 pilot sites in the public health system by July 1999 to enhance access to expertise and resources in rural areas.
- Carried out the first ever hospital audit in South Africa in 1996, which resulted in the introduction of the hospital rehabilitation programme.
- Carried out a cost centre study as the first step in the implementation of a system of decentralized management to promote greater efficiency in our hospitals.
- Launch of "Partnerships Against AIDS" by Deputy President Mbeki in October 1998 to intensify efforts aimed at arresting the epidemic and the development of the Government AIDS Action Plan under the auspices of the Inter Ministerial Committee on HIV/AIDS.
- Conducted the first ever "Demographic and Health Survey" in South Africa that provides a reliable baseline for monitoring health status change.

CHAPTER 2: SOCIO-ECONOMIC CONTEXT AND HEALTH STATUS

The disease profile depicted below does not reflect a healthy nation nor a middle income country, nor a country that spends 8,5% of GDP on health services. South Africans will continue to depend on the public health system, and the high levels of unemployment and poverty suggest that this majority will not be able to make any

significant contribution towards the cost of their health care. All arms of government need to work in unison to reverse these trends.

2.1 SOCIO-ECONOMIC CONTEXT

South Africa is classified as a middle income country by the World Bank. This, classification, however, tends to mask the reality of two worlds in one - one rich and predominantly white and, the other, poor and predominantly black. There are high levels of unemployment (37.8% according to STATSA) and high levels of poverty (70,9% in rural areas, 28,5% in urban areas, 49,9% overall according to the Poverty and Inequality Report, 1998). The majority of the poor live in rural areas. Economic growth has not matched the level of population growth, let alone the levels needed to address the enormous backlogs, which are a legacy of our past. Furthermore, government has adopted a tight macroeconomic policy framework (GEAR) which emphasises, inter alia, deficit reduction and a progressive reduction in the tax burden. This scenario impacts significantly on the health sector and our planning has to be rooted in this reality.

It is clear that the majority of South Africans will continue to depend on the public health system for the foreseeable future. Also, the high levels of unemployment and poverty suggest that this majority will not be able to make any significant contribution towards the cost of their health care. To this burden on the public health sector the growing burden of the HIV/AIDS epidemic must be added.

The fiscus currently provides between 40 and 45% of health care expenditure - yet the public health sector provides services to about 80% of the population. Clearly any sustainable strategy for effective health care delivery must include mechanisms for tapping into the large pool of private resources in ways that also benefits those currently dependent on the public health system.

The public health budget accounts for between 10 and 11% of the overall budget of government. This reflects an upward trend since 1995/96. Since fiscal decentralisation there is however great variation between provinces on the actual budget allocations for health. There continues to be significant inter-provincial inequities even though the variation in per capita spending between provinces has reduced from 3 to 2 fold. However there are indications that this movement towards inter-provincial equity in health spending has slowed down and may even have reversed (Review of the Public Health Service 1999).

Within each province there is also large intra-provincial inequity, with the rural areas continuing to bear the brunt of poverty and inadequate resource allocation. In the Eastern Cape, for example, some districts are 166% above the equity target whilst others are below by 77%.

Our vision of a caring and humane society and the constitutional assertion of our equality and humanity obliges us to make decisive interventions to reverse these trends. All arms of government need to work in unison on this. It is particularly in this context that the Presidential call for an integrated rural development strategy strikes a

responsive chord amongst us. The health sector commits to being an active partner in this initiative.

2.2 HEALTH STATUS

The recently conducted South African Demographic and Health Survey (SADHS) found that South Africans are not very healthy, even though we are classified as an upper middle income country and despite the fact that we spend a considerable amount of our GDP - more than many other countries - about 8.5%, on health services.

About 45 babies of every 1000 born live die in infancy. This figure is projected to increase to 60/1000 by 2004 as a result of the HIV/AIDS epidemic. Close to 60 (59) children per 1000 die before their fifth birthday. Many mothers die delivering babies - estimated to be 150 per 100000 women. It is projected that our current life expectancy of 60 years will reduce to 40 years by 2008 as a consequence of the impact of AIDS. All this means that we have to turn back the spread and impact of HIV/AIDS if we are to maintain our current mortality rates.

The impact of the HIV epidemic is growing and we do not seem to be able to halt its growth. Data from the annual national antenatal clinic surveys has shown an increase of 33,8% in the prevalence of HIV infection between 1997 and 1998. More disturbing is the high rate of increase in teenager's aged 15 to 19 years (65.4%). These findings highlight the need for carefully targeted health promotion strategies to this age group. The SADHS showed that whilst over 95% of teenage respondents had some knowledge of HIV/AIDS, this information was not always adequate because over 50% of these respondents did not know that persons who looked healthy or fat could be HIV positive. Instead they were of the opinion that only thin and unhealthy looking persons could be HIV positive.

Besides decreasing the prevalence of sexually transmitted diseases one of the more important strategies to reduce HIV infection is the use of condoms. A high percentage of sexually active women know that condoms can protect one against AIDS (87%). However according to the SADHS only 22% of sexually active women reported ever 'using' a condom and only 8% reported having used one during their last sexual encounter.

The impact of AIDS is significant currently but estimated to grow significantly. The number of HIV infections by year is projected to grow from 3,75 million in 1999 to 5,5 million in 2004. The number of people dying from AIDS is projected to grow from 175 000 in 1999 to 400 000 in 2004. The number of AIDS orphans is projected to grow from 250 000 in 1999 to 750 000 in 2004. With respect to hospital beds, it is estimated that this will grow in Gauteng alone, from 2000 to 8000 beds.

A related, but equally important, problem is TB. The TB rate appears to be increasing. In addition, it is estimated that 50% of HIV cases will contract TB thus increasing the rate despite the successes we may achieve via the DOTS strategy. The Medical Research Council estimates that the current TB epidemic will increase four fold over the next 10 years due to the effect of HIV/AIDS.

One of the most cost effective health interventions is immunisation. Yet the EPI routine coverage in the country is low and more importantly has not improved significantly in the last five years. It currently stands at 63% (with the urban areas being a bit better than the rural areas at 67% compared to 60%).

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

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

Clearly, the disease profile depicted above does not reflect a healthy nation nor a middle income country, nor a country that spends 8,5% of GDP on health services. It should be noted that the figures quoted in this section do not reflect on the large intra and inter-provincial differences that must be taken into consideration in planning interventions.

There is therefore an urgent need to prioritise interventions, to act collaboratively with social partners both within and outside of government and to increase the effectiveness and efficiency of the health care system.

CHAPTER 3: STRATEGIC HEALTH PRIORITIES

Despite the significant achievements of the past five years much work remains to be done.

While the first five years focused largely on increasing access to health care especially for those who did not have access in rural and other under-served areas of the country, the next five years will focus on accelerating quality health service delivery.

3.1 A TEN POINT PLAN TO STRENGTHEN IMPLEMENTATION OF EFFICIENT, EFFECTIVE AND HIGH QUALITY HEALTH SERVICES

A ten-point plan to strengthen the implementation of efficient, effective and high quality of services throughout the health system is proposed.

The components of the strategy include the following:

- Reorganisation of certain support services;
- Legislative reform;
- Improving quality of care;
- Revitalisation of hospital services;

- Speeding up delivery of an essential package of services through the district health system;
- Decreasing morbidity and mortality rates through strategic interventions;
- Improving resource mobilisation and the management of resources without neglecting the attainment of equity in resource allocation;
- Improving human resource development and management;
- Improving communication and consultation within the health system and between the health system and the communities we serve; and
- Strengthening co-operation with our partners internationally.

Details of each of these strategies are provided below.

3.2 REORGANISATION OF SUPPORT SERVICES

3.2.1 Health information system

The need for an effective and efficient health information system is vital for planning and managing health service delivery. Whilst some progress has been made in the last five years, progress must be accelerated during the next five years.

It is imperative that health districts, municipalities, provinces, the private sector and the national department work together to build such an information system. In addition, various other government department systems, like those of Home Affairs, Public Services and Administration and State Expenditure, impact on the health system and we must ensure that these systems are integrated with that of the health system.

The key objectives in strengthening the health information system include:

1. Completion of the existing 28 telemedicine sites and the creation of a further 73 sites, including consolidation of the Telemedicine network (which includes the medical schools);
2. Expansion of the NHC/MIS to all clinics and hospitals and the adoption of a common fee schedule of hospitals;
3. Adoption of a common procedural code and a common data dictionary in the public and private health sectors;
4. Strengthening of the vital registration system of births and deaths and the implementation of page two of the birth registration form;
5. Expansion of the district-based health information system; and
6. Migration of COMED systems to improve the pharmacy management information system.

3.2.2 Transformation of laboratory services

The provision of laboratory services is fragmented between the SAIMR and provincial laboratories, and this has led to duplication of services and inequalities in the provision of these services. The challenge is how efficiency can be improved within existing

resources. A National Health Laboratory Service is proposed, to integrate the specialised laboratories and provincial services in a parastatal set up through an Act of Parliament.

The absence of a co-ordinated food laboratory service means that we do not have a national food safety database to inform the various aspects of food control. The challenge is to develop an integrated food safety and control system backed by appropriate legislation, co-ordination mechanisms, and adequate surveillance systems. This task requires a partnership particularly between the departments of Health and Agriculture.

3.2.3 Transfer of mortuaries services to Department of Health

Medico-legal services are currently under the control of the South African Police Service. In view of the policy that the police services should not be in charge of both criminal evidence and of the deceased, it is important that responsibility for mortuaries be transferred to the provincial departments of health.

Key objectives for the next five years include:

1. Finalisation of the proposal to transfer mortuaries currently under the control of the South African Police Services to the provincial departments of health;
2. Securing Cabinet approval for such a transfer and for the funding of these services through the provincial departments of health; and
3. Implementation of the proposal to ensure that these services are effectively and efficiently rendered.

3.2.4 Transformation of the blood transfusion services

There are currently seven blood transfusion services in the country. This level of fragmentation conflicts with the recommendations of the World Health Organisation and other international agencies that propose that a single organisation should render these services. The key objective is to transform the current fragmented blood transfusion services into a single national blood transfusion service.

3.2.5 Reorganisation of the Office of the Registrar for Medical Schemes

The office of the Registrar of Medical Schemes will be reorganised into a unit that will be able to provide more effective oversight over the medical scheme industry in line with the provisions of the recently promulgated Medical Schemes Amendment Act, 1998. This office will be autonomous and located outside the public service but will remain accountable to the Minister of Health.

3.3 LEGISLATIVE REFORM

While the number of new pieces of legislation passed in the first five years is impressive, the legislative reform programme will continue during the next five years. Among the major pieces of legislation that will be introduced during this period are: the National Health Bill (to replace the current National Health Act); the Mental Health Care Bill (to replace the Mental Health Act); and revisions to the South African Medicines and

Medical Devices Regulatory Authority Act. At the same time we shall accelerate the completion of subordinate legislation (regulations) to comprehensively give effect to the intentions of our primary legislation passed over the first five years.

In addition to the above, provinces will pass provincial health bills during this period.

3.4 IMPROVING QUALITY OF CARE

One of the key challenges during the next five years is to improve the quality of care provided in the public health sector. The role of health service users in ensuring that their needs are met and that the quality of care provided is of acceptable standard is critical to the development of a service that provides high quality care. Health care providers also have an important role to play in this regard.

The challenge of improving the quality of care rendered in the public health sector also includes ensuring the availability of affordable, good quality drugs and the training of health providers in the rational use of drugs. The use of the Essential Drugs Lists and the training of health providers in procurement and rational prescription must be strengthened.

The key objectives to improve quality of care include:

1. Strengthening the Batho Pele programme that has already been implemented;
2. The development and operationalisation of a National Policy on Quality;
3. The launch of a Patients Charter that spells out the rights and obligations of patients;
4. The establishment of complaints mechanisms in all health facilities;
5. The development and implementation of clinical management guidelines;
6. The introduction of peer review and clinical audits at all health facilities;
7. The establishment of boards and committees in all health facilities through which communities and users can change the way in which health services are provided in the public sector;
8. The development of mechanisms to regularly ascertain the views and expectations of users of health services;
9. Introduction of programmes to enhance users' awareness of their rights and obligations; and
10. The training of health personnel in strategies to improve the quality of care rendered.

3.5 REVITALISATION OF PUBLIC HOSPITALS

3.5.1 National Planning Framework

There is an urgent need to continuously further develop and improve the National Planning Framework for the provision of hospital services throughout the country. This includes guidelines for the number of beds at different levels that are required and affordable. It also deals with the planning options available for the provision of tertiary and highly specialised services for which patients often need to be referred from one province to another.

It is crucial to ensure that the planning framework for hospitals is considered within the overall context of health services required at all levels, including primary health care. Such plans should be developed for all health services, including those provided by the private sector.

The framework should be fully developed by March 2000 and implemented over the following four years. The key objectives of the national planning framework are to:

1. Ensure equity of access to appropriate hospital services for all South Africans;
2. Ensure that hospital care is provided in the level of facility most appropriate to the level of care needed;
3. Promote clear and efficient referral systems both within and between provinces;
4. Ensure that hospital services are planned rationally and delivered in line with modern, efficient, cost-effective and caring practices;
5. Ensure that all hospital services are affordable and sustainable;
6. Ensure that planning choices are made as explicit as possible; and
7. Ensure appropriate long term planning and funding for the highly specialised services that the country can afford.

3.5.2 Rehabilitation of hospital stock

In 1996 we carried out a facilities audit - the first ever in South Africa (434 hospitals and 108 community health centres were involved). This revealed that a third of our facilities, by value, need complete replacement. We further estimated that to rehabilitate these hospitals we need around R12 billion (including equipment) over the next 8 years. Cabinet gave in principle support for a major revamp of the hospital infrastructure. We hope also to use the opportunity presented by this rehabilitation programme to reverse the decades long impact of apartheid planning by reshaping our hospital portfolio. We shall build up new facilities whilst we close or downscale others. Currently each province is working on a comprehensive strategic plan for hospital development. The intention is to build appropriate facilities closer to where people live and facilities that are easily accessible to the disabled. These strategic plans should be finalised by March 2000.

During the 1998/99 financial year R100 million was allocated for this programme nationally. This year, 1999/2000 - R200 million has been allocated to this programme. Over the next 2 years of the MTEF cycle, R400 million & R500 million respectively have been allocated. The amounts budgeted for the 5-year period will not be sufficient to rehabilitate all needy hospitals. Efforts to find additional sources of funding are in progress as are planning processes to determine the actual need for some of these hospitals.

A key challenge is to align this rehabilitation programme with the National Planning Framework for the hospital sector. Particularly the need overall to increase the number of district (community) hospital beds whilst significantly reducing the numbers of tertiary beds and the need to build up provincial tertiary capacity through the use of the redistributive grant.

3.5.3 Decentralising hospital management for improved efficiency and quality of care

Numerous investigations of our hospital sector reveal significant levels of inefficiencies. A fundamental contributor to this is the archaic management structures, systems and culture. This often causes management paralysis. A compounding, related, element is the pervasive lack of appropriate management competencies and capacity among our management teams. We need to accelerate the implementation of our decision to decentralise management authority, which should be completed during this 5-year term.

In the context of hospital decentralisation, the following strategies will be implemented:

1. Equipping managers with the requisite competencies necessary for this major reform. In some instances this will mean new managers being brought into the public sector, especially in light of our decision to move to general management.
2. Professional managers will be employed and given authority to manage, and sufficient administrative support capacity will be provided to ensure that the most cost-effective management system is introduced and conditions created for clinicians to do their work efficiently and effectively.
3. Creating the right combination of incentives to drive the entire system towards greater efficiency. Performance agreements, performance-linked bonuses and retention of portions of revenue generated to improve service delivery are among the instruments to be used.
4. The new uniform patient fee billing system should be introduced by April 2000.
5. Effective Hospital Management Boards will be set up through legislation to ensure that they have the necessary authority over specified strategic development issues in the hospital.

The rationale for these reforms is that they will bring about increased efficiencies in the hospital sub-sector by overhauling the archaic management systems in place and replacing them with a system that promotes innovation and accountability to clients and funders.

3.6 PRIMARY HEALTH CARE AND THE DISTRICT HEALTH SYSTEM

3.6.1 Comprehensive Primary Health Care Package

The health sector has over the last five years up-graded clinics and built new ones. Furthermore, there has been a steady shift in resources to primary care facilities. With existing plans for new clinics, the country will have close to 3,000 public sector clinics and this will provide a clinic for every 13,000 population. The challenge is to fully staff and equip these facilities so that they can provide a comprehensive health service and lead to more cost-effective service delivery.

A key element of our reform initiative is the entrenchment of primary health care. Much has been done to improve the availability of physical infrastructure, to trained

personnel in both clinical and management skills, to provide essential pharmaceutical supplies and equipment. This work needs to continue.

A critical challenge now is the definition and provision of a comprehensive package of services. This package should be capable of tackling the leading causes of mortality and morbidity in the country using the most cost-effective strategies. Such a package would also constitute the foundation of a well structured referral system whilst also ensuring equity by relating concrete services to a level of care - be it in an urban, peri-urban or rural setting.

The platform for the delivery of this package are the clinics and the community health centres (and district hospitals where access to clinics and CHCs is limited). This package must be universally accessible and be guaranteed for every citizen of our country. In addition, in implementing the package the importance of health promotion and the prevention of diseases and illness must be emphasised.

A proposed package is currently being piloted in all the 9 provinces. It is envisaged that a revised package will be implemented incrementally beginning in April 2000. This process should lead to the full provision and availability of this package in all primary health care facilities by 2004.

Our recent review and analysis of expenditure patterns over the past 3 years particularly - shows the negative impact of fiscal constraints on the further development of PHC services. The resource requirements of hospitals, especially the tertiary institutions, under these conditions tend to undermine the policy intention to shift resources to primary health care. It is important that we resist this danger. An explicit and properly costed primary health care package and a deliberate policy decision to provide it can act as a strong counter force that could ensure optimal use of resources.

Given high levels of unemployment and poverty this package must be provided free at the point of delivery throughout the public primary health care system. A mechanism should also be negotiated with the Department of Finance to ensure the protection of the budget of this package, for example through ring fencing within the provincial budgets.

The necessary support services should also be in place at all times to raise the confidence of the users of our services on the ability of our primary health care facilities to provide good quality care. This is important to achieve since it is more cost effective to provide this package at the lowest levels of the referral system. The users must also be confident that systems are in place for speedy referrals where necessary. In particular:

1. We must work in partnership with other sectors to ensure that at the end of this period (i.e. 2004) all existing and new clinics and community health centres have electricity, telecommunication services, water and sanitation and are easily accessible by road.
2. An essential equipment package, including refrigerators and diagnostic kits should be defined and be available in all these facilities.

3. The drugs on the essential drug list (EDL) for the primary level of care must be available at all times in all facilities.
4. Appropriately trained personnel such as primary health care nurses (PHCNs) must be available in all facilities. All primary care facilities must have consistent and visible backup by doctors.
5. All primary health care facilities must run community outreach programmes aimed at galvanising the energies of communities so that they actively participate in health programmes, in particular the preventive and promotive aspects of the health service.
6. Tele-education and telemedicine should be used, where appropriate to support the primary care system.
7. Each facility must have a visibly displayed statement of agreement between the providers and users on what to expect from each other. Well functioning community committees should be established for all facilities to ensure that the users' voices are heard and acted on by the management.

3.6.2 The District Health System: towards efficient delivery of high quality care

The District Health System provides the health sector with a management framework that can deliver health care in a cost-effective and integrated manner. While much progress in DHS development can be anticipated once current local government restructuring is complete, our challenge in the health sector is to consolidate gains in health care provision and to participate in the establishment of the district health system governed by local government where they have the capacity to render services.

In addition to the issue of local government restructuring, two further issues need resolution. One is the difference in conditions of employment and salaries between those employed by municipalities (and the differences between municipalities of different sizes) and those employed by provincial Departments of Health. The second is the role and functions of health regions. With respect to the first issue, differing salaries and conditions of employment it is important that mechanisms, possibly through the appropriate bargaining chambers, be found to resolve this issue. In terms of the role of health regions, it is important that these facilitate rather than retard the development of health districts. We also need to accept that the roles of regions will differ depending on the capacity and maturity of service districts related to them. As the districts mature, the regions, where they are retained, should function more as administrative extensions of provinces with their role being co-ordination of regional services and the provision of technical support to the districts.

A critical element that impacts on the provision of integrated services at the primary level relates to the interaction between the provincial and local spheres of government. This interaction is further complicated by the different capacities within the different municipalities.

The vehicle for the delivery of the PHC package is the district health system. The re-demarcation of municipalities is likely to result in a better fit between health districts and municipalities and many may therefore be suitable and able to render the comprehensive PHC package. In health districts in which municipalities, either individually or collectively, can render the comprehensive package of PHC services, this should be explored and facilitated by provinces. The delegation of these services to a

district health authority (which may either be a municipal council or group of councils or a provincially established authority) should be regulated by service agreements.

The task of providing integrated and co-ordinated care will be facilitated by the implementation of the essential package through the district health system. National and provincial departments of health need to find ways of supporting service delivery at local level in ways that strengthens integration.

Both the provincial and local spheres should explore the roles that the private sector, NGO's and CBO's can play in extending capacity to deliver these services.

There is broad consensus that poor service quality is of major concern, as evidenced by the findings of the recently conducted review of the public health sector. Therefore, the improvement and assurance of the quality of care in all public health facilities and programmes (both technical quality and responsiveness of service to users' felt needs) will be the main thrust of the public health system during this period.

Since the introduction of free primary care services, clinics are seeing more patients, while there are many instances where the movement of patients away from hospital outpatient departments to clinics has not been accompanied by a transfer of staff. Combined with the incomplete integration of curative and preventive health services in clinics, this increase in patient loads in clinics has led to some compromise in the quality of care at that level.

Improving quality is the single biggest challenge facing the public health sector, and a start has been made by the provision of more doctors for communities that have traditionally had to do without their services. While a start has also been made to train PHCNs in improved clinical practice, much remains to be done - with fewer resources.

Modern technology has made it possible to disseminate knowledge quite cheaply. Telemedicine application is a viable strategy for both distance education as well as ensuring utilisation of expertise largely concentrated in urban areas to the benefit of rural and under-served communities. The initial steps being taken to establish this programme need to be consolidated and accelerated.

3.7 STRATEGIC INTERVENTIONS TO DECREASE MORBIDITY AND MORTALITY

Note: Whilst we focus here on key interventions we will continue to provide all other health services as indicated in the essential PHC package. These services will focus on all levels of care, viz., prevention, promotion, curative and rehabilitative and will be provided in partnership with relevant stakeholders, especially communities, community-based organisations and non-governmental organisations.

3.7.1 Promote integration of government interventions

Although fiscal decentralisation to provinces is supported, there is need to ensure that there is a systematic approach to the adoption of public health interventions to produce

a coherent national health service in the whole country. It will be important to ensure that investments in one province are mirrored in neighbouring provinces in response to the spread of infections and health problems across borders.

There is a tendency by government departments to operate in 'silos' when tackling development problems, and health in particular needs to eliminate these silos because they often lead to duplication and fragmentation of services. In the health sector, some of the ever-present problems needing inter-sectoral action are malnutrition, injuries related to all forms of violence, diarrhoea, HIV/AIDS, Sexually Transmitted Diseases, and TB.

The promotion of integration action among government departments is especially important given the emphasis on prevention and promotion of wellness. While the Department of Health is committed to strengthening its commitment to prevention and promotion of health, this cannot be effectively done without the commitment and participation of many other stakeholders, both in and outside of government. Every effort will be made to enhance co-operation with all stakeholders to increase our focus on wellness.

Models for the integration of services at district level coupled with coherent programme-based support from national and provincial levels must be developed and introduced as a matter of urgency. The national Department of Health must provide the leadership to ensure that such models are developed and implemented.

3.7.2 Child, Youth and Adolescent Health

It is generally accepted that immunising children is one of the most cost-effective health interventions. This is particularly true in our country where preventable communicable diseases contribute significantly to childhood mortality and morbidity.

It is unacceptable that in South Africa, a middle-income country only 63% of children are fully immunised at 1 year. There have been problems of stock-outs for vaccines, delays in paying suppliers, and resistance to integrate services at the level where immunisation should be provided, viz., clinics and community health centres. There has been a lack of adequate supervision as shown in provincial reviews of the Expanded Programme on Immunisation (EPI). These shortcomings need to be addressed as a matter of urgency.

The key challenges for the EPI programme should be to:

1. Achieve Polio eradication by 2000.
2. Eliminate indigenous measles in South Africa by 2002.
3. Achieve 90% full immunisation among 1 year olds by December 2003 with every province achieving at least 80% coverage.
4. Establish routine school vaccination programmes to deliver booster doses of hepatitis B, measles tetanus and Diphtheria vaccine.

In order to achieve these targets there are 3 fundamental areas of support that must be ensured:

1. Political commitment and support to ensure that high immunisation coverage and follow-up campaigns as needed, remain a high priority in each province;
2. Assurance of vaccine quality, supply and availability, including an effective and efficient cold chain; and
3. Regular and accurate monitoring of the programme and risk surveillance through coverage surveys, routine reporting and sero-surveillance.

South Africa has an infant mortality rate (IMR) of 45 and an under-5 mortality rate of 59 per 1000 live births. Furthermore, the level of teenage pregnancy is high (16,4%), there is a growing burden of AIDS, a growing number of AIDS orphans and high levels of sexual abuse and of violence against children.

The World Summit for Children urged all governments to prepare national programmes of action guided by the principle "First call for children". The summit led to the United Nations Convention on the Rights of the Child. South Africa is a signatory to the Convention and is therefore bound by its articles.

The former President of South Africa, Mr Nelson Mandela stated that "we have the resources, if we use them wisely, to change the situation (of children)" when he launched the National Programme of Action - Children in South Africa (NPA). We need to make a concerted effort to invest in the future of our nation.

The key objectives of our programme should be to:

1. Reduce IMR and U5 mortality;
2. Implement the NPA in all 9 provinces;
3. Full implementation of the IMCI in all provinces;
4. Finalise and implement the clinical guidelines for youth and adolescent health;
5. Reduce teenage pregnancy;
6. Reduce mortality and substance abuse including smoking among adolescents; and
7. Reduce prevalence of wasting (from 2,6% to 1,0%) and stunting (from 23% to 15%) among children as well as underweight-for-age amongst children less than six years of age from 9% to 5%.

3.7.3 Decreasing the incidence of HIV/AIDS, STDs and TB

The rising HIV/AIDS epidemic with a number of AIDS-related conditions makes this issue the top priority for the health sector in partnership with all agencies concerned with human development. It is because of the multi-sectoral nature of HIV/AIDS that an Inter-Ministerial Committee (IMC), chaired by the Presidency has been established, to develop strategies to deal with the epidemic. A wide range of activities are now being implemented by the various sectors (health, education, welfare, justice, security, NGOs, private, and others) to address HIV/AIDS and related issues. The challenge is to build upon existing partnerships so that sufficient behavioural changes can be brought about. This should result in a levelling off in the rate of HIV/AIDS cases and in a decline in the incidence of the disease.

It is also important that we to develop joint approaches to HIV/AIDS and share lessons with other countries in Africa, through the OAU, SADC and the WHO/AFRO. Collaboration with other African countries may take the form of participation in vaccine development, bulk purchasing of drugs, sharing IEC material, etc.

In July 1999, two major initiatives were undertaken:

1. To secure stakeholder endorsement of a common programme; and
2. To launch a youth specific initiative - the South African National Youth AIDS Initiative.

The key objectives of our HIV/AIDS Campaign should be to:

1. Strengthen current efforts to prevent the spread of the virus through for example, social mobilization and increasing public awareness, especially targeting the youth;
2. Curtail any further rise in the epidemic and commence a downward trend;
3. Actively participate in the international effort to develop appropriate vaccines;
4. Provide affordable packages of care and support for those infected or affected;
5. Ensure that effective care and support is available for AIDS orphans; and
6. Declare HIV/AIDS a national emergency if not a global emergency.

Implementation of the following strategies should assist us to achieve the objectives set out above:

- Establishment of a National AIDS Council comprising government and civil society representatives to co-ordinate HIV/AIDS activities and the establishment of similar co-ordinating mechanisms at provincial and local government levels;
- Social mobilisation of communities following the lessons learned from such countries as Uganda, including the use of the ABC model (A-abstinence; B-be faithful to your partner or single partner; C-use condoms);
- Strengthening of condom distribution and use especially among those at risk;
- Reducing the incidence and improving treatment of STDs using the syndromic management approach;
- Search for affordable and practical strategies to reduce mother-to-child transmission;
- Creating partnerships with Civil Military Alliances in all provinces;
- Ensuring the 80% of workplaces have workplace programmes;
- Strengthen the Interdepartmental Committee on HIV/AIDS to ensure that all government departments have medium and long-term plans to mitigate the impact of the epidemic amongst their employees and sectors within their ambit of influence;
- Increase the use of community and home based care, and strengthen the support and referral mechanisms for patients and their care-givers; and
- Expanding the Life Skills Programme to both primary and secondary schools.

Given the link between HIV/AIDS and STDs an important objective is to improve the quality of STD management in the public and private sectors. This can be achieved through the following:

1. Establish Provincial STD Management Task Teams that ensure adequate training of health workers on the Syndromic Management of STDs, and also ensure adequate supply of the essential drugs in appropriate health facilities;

2. Ensure that private practitioners adopt the Syndromic Management of STDs by using continuing professional development (CPD) to update them; and
3. Encourage the inclusion of the Syndromic Management of STDs in the curricula of all health professionals.

TB incidence in South Africa makes the disease an epidemic according to WHO definitions (defined as any country with more than 200 cases per 100 000 population - South Africa has an incidence of 311). The HIV/AIDS epidemic expands the TB problem and complicates TB control. We have adopted the Direct Observed Treatment Short - course (DOTS) strategy advocated by the WHO and have initiated new approaches to TB/HIV intervention in four pilot sites in the country.

The country's budget for tackling TB suggests that we should bring down the incidence quite rapidly but we do not appear to be doing so. The challenge, therefore is to identify and tackle reasons for this gap between resources dedicated to TB control and our achievements. The TB programme must work more closely with the development of health districts so that efforts that strengthen district development have an impact on TB control and vice versa.

The key objectives of our TB programme should be to:

1. Achieve cure rates of at least 85% in new smear positive cases;
2. Implement and evaluate a comprehensive prevention, care and support package for HIV/AIDS/STD/TB;
3. Reduce overall mortality due to TB; and
4. Reduce MDR TB to be < 1% of all new cases.

3.7.4 Malaria control

In 1998, 26 440 cases and 198 deaths were reported. Malaria illness and death statistics are on the increase and remain a cause for great concern. Active detection and correct treatment of cases is critical. In addition, co-ordination with neighbouring states to strengthen implementation of malaria control is necessary.

The key objectives our Malaria Control Programme should be to:

1. Improve disease management;
2. Implement appropriate and effective vector control measures; and
3. Improve co-operation with neighbouring states.

3.7.5 Improve women's health and reduce maternal mortality

In the first 100 days of the first democratic government - free health services for pregnant mothers and children less than 6 years old was introduced in all public health facilities. This ensured that ability to pay no longer became a barrier to access particularly in poorer communities. This has resulted in increased attendance for health care by these groups. According to the South African Demographic and Health Survey 94% of pregnant women now attend antenatal care and 80% of pregnant women have supervised delivery. This is a significant increase from previous studies.

However, quite disturbing is that the maternal mortality ratio remains high at 150/100 000. The level of maternal mortality varies considerably internationally. Worldwide there are 480 maternal deaths for every 100, 000 births. However, the Population Council (1997) estimates ratios in developed countries to be between 7 and 22. Maternal deaths account for 5.5% of the total number of deaths in women of childbearing age, but this proportion increases substantially in 15-19 and 20-24 year olds with 8.2% and 10.5% respectively.

Quite clearly major interventions are needed to reduce these high levels of deaths due to childbirth, particularly the provision of basic obstetric care at and after delivery.

Among strategies already introduced to deal with this problem has been the notification of maternal death which commenced in December 1997. This instrument, once fully used, would enable us to investigate every maternal death and take steps to deal with preventable causes. The major causes of maternal deaths currently are hypertension, HIV/AIDS related conditions, haemorrhage, septic abortions and cardiac disease.

Another key intervention has been the empowerment of women to take informed decisions about how to plan pregnancy and how to intervene in the case of unwanted pregnancies, through the enactment of the Choice on Termination of Pregnancy Act, 1996.

We need to build on this foundation and continue our efforts to improve women's health. The key objectives of our programme should be to:

1. Reduce maternal mortality;
2. Reduce maternal mortality due to unsafe abortions;
3. Strengthen and expand national programmes for cervical and breast cancer awareness and screening; and
4. Reduce the incidence of violence and rape against women.

3.7.6 Mental Health and Substance Abuse

Mental health and the prevention of substance abuse have been areas of relative neglect, which need to be urgently addressed. The vision is to improve the mental wellbeing of all South Africans through appropriate mental health interventions and the prevention of substance abuse within the primary health care approach. In order to achieve this the following key objectives have been identified:

1. A new Mental Health Care Act should be passed by December 2000;
2. Mental health services should be integrated into primary heath care;
3. Strategies to reduce the level of substance abuse must be introduced, with a special emphasis on prevention;
4. Violence prevention at primary, secondary and tertiary levels with special focus on women and children must be introduced;
5. Guidelines for the treatment of rape victims must be implemented in all districts;
6. Chronic mental illnesses/disorders should be treated through community based psycho-social rehabilitation services wherever possible; and
7. Strategies to reduce the rate of suicides, especially amongst the youth must be implemented.

3.7.7 Chronic Diseases

According to the SADHS the prevalence of hypertension is at 9% for men and 13% for women with overweight at 29% for men and women. High blood pressure is considered both as a disease and as one of the major risk factors for heart disease, stroke and kidney disease. Many predisposing causes of chronic disease are associated with lifestyle and can be modified through targeted health promotion programmes. An integrated approach to reduce the morbidity and mortality associated with chronic disease is essential in order to improve health and social wellbeing of individuals and communities. Dealing with diseases of lifestyle is critical especially given the pace of the epidemiological transition in our country.

The key objectives of our Chronic Disease Management strategy should be to:

1. Implement national guidelines on the control of hypertension, diabetes; and obesity;
2. Control asthma in children and adults;
3. Strengthen and expand the National Cancer Control Programme;
4. Increase the cataract surgery rate; and
5. Ensure access to assistive devices.

3.7.8 Promote poverty alleviation and food security strategies

Although South Africa is a middle-income country, the existence of wide income disparities has left a large number of South Africans living below subsistence levels. The result is rather high levels of poor nutrition for a country that is classified as 'Nationally Food Secure'. Household food insecurity is to be found in poor households, where at least 9,3% of children under the age of five are underweight, and wasting affects 2,6% of children less than six years of age.

Due to prolonged periods of inadequate food intake, the country has a high stunting rate of 22,9% amongst children less than six years of age, and it is here that inter-sectoral poverty-alleviation strategies will have a major impact in the long term. In addition, the country has a low rate of breast-fed children which denies such children the protective effect of exclusive breast-milk.

The feeding of five million primary school children and the implementation of community nutrition projects over the last five years needs new tools to allow the transition from food and input hand-outs to projects that are sustainable at the community level.

The key objectives of our Integrated Nutrition Programme should be to:

1. Intensify efforts to implement the INP;
2. Promote community-based Growth Monitoring;
3. Strengthen nutrition interventions at both health facility and community levels to rehabilitate malnourished children;
4. Work with other sectors to tackle the root causes of poor nutrition and poverty; and
5. Promote food fortification.

In addition to food security the importance of food safety is vital to the health of all South Africans, especially that of malnourished children. Therefore the delivery of an effective and integrated food safety service needs to be ensured to limit the detrimental effects of food borne diseases.

3.7.9 Tackle violence against women and children

This is an important priority health program that requires multi-sectoral interventions, quickly followed by changes in the inherited culture of violence in society. While recognising the role of inter-sectoral actions to deal with the consequences of violence, the challenge is to find lasting solutions. Working with traditional and religious leaders to promote changes in cultural practices across all cultural and religious groups could provide one such solution but there will be need for others.

The key objectives to reduce the levels of violence towards women and children will include:

1. Raising awareness of the basic human rights of all, especially that of women and children through mass mobilisation strategies, the development and dissemination of IEC materials and hosting of work shops with men who are typically the perpetrators of violence against women and children;
2. The training of health personnel to enable them to provide the necessary support to victims of violence, including early diagnosis, counselling and the collection of forensic evidence; and
3. Developing protocols for the management of violence and abuse by December 2000.

3.7.10 Emergency medical services

The levels of violence in the country are high. This results in large numbers of cases of trauma needing emergency care. In addition, many patients requiring emergency care, like maternity, often do not present because of inadequate emergency medical services.

In order to improve access to these services the approach needs to be multi-faceted and involve such areas as hiring and training of personnel, provision of appropriate equipment, and purchasing of vehicles.

Parallel to this is the need to develop in-hospital emergency medical services, in particular, the categorisation and establishment of regulations for emergency centres, and the implementation of an emergency physician speciality.

Key objectives for the prevention and treatment of trauma and the provision of emergency medical care include:

1. The improvement in emergency medical services, facilities, equipment and vehicles;
2. Improvements in the training of EMS personnel throughout the country; and
3. Improvement of in-hospital emergency medical services.

3.8 RESOURCE MOBILISATION, ALLOCATION AND MANAGEMENT

3.8.1 Strengthening planning and budgeting and monitoring of inter and intra-provincial equity

Effective resource mobilisation and allocation can only be accomplished if the systems, processes and procedures for planning and budgeting are strengthened. The Medium Term Expenditure Framework (MTEF) is currently the primary medium term budgeting instrument used by government which should be used to strengthen both planning and budgeting exercises at all levels of the public health system. These exercises must be complemented by the setting of priorities in line with the strategic framework presented in this document.

We also need to better understand revenue and expenditure flows within the health sector. The introduction of a system of National Health Accounts will assist in this regard.

The legacy of the past has resulted in intra and inter-provincial inequities in resource distribution. Large differences in both inputs, like per capita expenditure and outputs, such as health status cannot be ignored and must be addressed. While the use of national and provincial norms and standards will assist in addressing these inequities all spheres of government and their partners are challenged to work together to address these inequities. The targeting of resources to areas that lag behind provincial and national averages in terms of health status should be considered as one intervention strategy.

3.8.2 Certificate of Need and Licensing

New legislation is planned for the licensing of public and private health establishments to control the supply, distribution and quality of health services. This will include a Certificate of need process, through which the Department of Health will access proposals for major new health establishments, services and equipment on the basis of the need for such services. Such factors as demography, epidemiology and the availability of existing public and private services.

The purpose of the certificate of need and licensing system will be to prevent over-expansion in the supply of health services in areas of relative oversupply and to encourage the development of services in under-served areas. This is turn will have a beneficial effect on the availability and overall cost of health care.

3.8.3 Secure PHC funding and implement effective referral systems

Given the Department's emphasis on primary health care and the decision to implement an essential PHC package of services nationally, every attempt must be made to secure adequate funding for this package. Funding for adequately trained and sufficient health and support personnel, drugs, infrastructure, maintenance and equipment must be secured through provincial legislatures and municipal councils. National norms and standards will be the basis for determining funding levels in the first instance and national legislation will only be considered should the need for such legislation present itself to ensure the funding of the essential package which is accessible to all South

Africans. This also implies the need to correct historic imbalances in resource allocation both between and within provinces.

Allocation of funds to the primary health care system must be accompanied by a reassessment of hospitals budgets. Improvements in the efficiency of the hospital sector should be used to release funds for use at primary care level.

A strict referral system will be introduced so that all patients can enter the health system through the clinic and CHC wherever possible. Bypass fees will be introduced and enforced where PHC facilities exist. Where appropriate, gateway clinics should be established on hospital grounds to cater for populations living around the hospital.

The key objectives to be reached include:

1. The finalisation of the essential package including the development of norms and standards and the costing thereof by November 1999;
2. The phased implementation of the essential package beginning April 2000 with full implementation by 2003/2004; and
3. Implementation of effective referral systems, including by-pass fees by March 2001.

3.8.4 Medical Schemes and Social Health Insurance

The Medical Schemes Amendment Act provides an opportunity to curb the rate of medical inflation and the influence of other cost drivers in the private health sector that is fuelled by the fee-for-service reimbursement system. Over the next few years we need to study the impact of this piece of legislation and make the necessary adjustments where necessary. At the same time, work must proceed on proposed Social Health Insurance (SHI) system in the context of an integrated social security system.

A creative approach to the Medical Schemes Amendment Act and the SHI could assist in opening possibilities for tackling the unsustainable total dependence on general taxation particularly for the hospital sector.

3.8.5 Revenue generation and retention

The strategy to revitalise public hospitals is partly dependent on our ability to increase revenue generation by these facilities. However, incentives such as revenue retention are required to encourage greater revenue generation. Various pilots are being used to explore this issue and widespread implementation will follow once sufficient lessons are learned.

Two other strategies are being implemented to support an increase in revenue generation. These are the Uniform Patient Fee Schedule, which will harmonise fees throughout the country, and the implementation of billing systems that will increase the efficiency of fee collection. In addition, the Medical Aid Scheme Amendment Act is likely to generate additional demand for private services in public hospitals that will result in greater revenue generation.

3.8.6 Public-Private Partnerships

There is need to develop partnerships with the private sector that will optimise the use of all available health care resources and will improve equity of access for all citizens. Partnerships can be important ways of reducing or controlling cost, improving quality, and/or generating revenue for the public sector. Such partnerships may involve sharing under-utilised public or private resources, or gaining access to private sector finance and expertise.

At the same time, the public health sector must guarantee the provision of quality health care to all citizens, and will, therefore, remain the main provider of core clinical services. Furthermore, the acid test for partnerships will be the extent to which they enable the government to deliver quality care on a sustainable and cost-effective basis, particularly to the majority of South Africans who are dependent on the public health system.

Partnerships will be developed within the context of a national health system, based on comprehensive long-range national, provincial and district health service plans. Such plans will form a basis for the rationalisation of services and will help to identify the need for partnerships.

For government to benefit maximally from these partnerships it is vital that systems and skills be developed in the following areas: contract negotiation, contract drafting and monitoring and evaluation of contracts.

Key initiatives which will be pursued in the coming years include:

1. Expanding the outsourcing of non-clinical services where appropriate, based on the principles contained in the White Paper on the Transformation of the Health System;
2. Improving the management of current contracts with the private sector for chronic psychiatric and TB services, and with state-aided hospitals;
3. Entering into lease agreements with suppliers for certain types of hospital equipment;
4. Exploring, with the Department of Finance, the role of Private Finance Initiatives (PFIs), particularly in helping with the rehabilitation process and where appropriate the further expansion of our physical infrastructure. Pilot projects, for example, with Chris Hani Baragwanath Hospital, will be boldly pursued.
5. Sharing under-utilised public hospital space and equipment with the private sector, on condition that differences in services are restricted to "hotel" services and that those services will be available to non-paying patients should the need arise (for example for increased numbers of HIV/AIDS patients).

3.8.7 Conditional Grants

The current conditional grant system for the hospital system, especially the conditional grant for Central Hospitals, has limitations. It is both not appropriately directed (given to institutions rather than to services) as well as not costed satisfactorily. We need to improve on this. The ongoing work in this regard, scheduled for completion in March 2000 needs to be accelerated. Only when this is done shall we be better able to bring more coherence between the grant system and the underpinning policy intentions including equity in resource allocation between provinces.

3.8.8 Donor Funds

Since the election of the first democratic government in 1994, an increasing number of governments, United Nations agencies and philanthropic organisations have provided and/or offered financial assistance to the Department of Health. The national Department of Health co-ordinates donor activity within the sector by identifying, evaluating and accessing international resources that can support the programmes and priorities of the Department as a whole.

Donor co-ordination with provinces has been strengthened by the formation of an Interprovincial Coordinating Steering Committee that will be responsible for the establishment of the necessary systems for the effective management of donor-funded projects. In addition, a donor policy, which includes the priorities spelled out in this document, will be developed by December 1999.

3.8.9 Health technology

One of the major cost drivers in the health sector is the cost of expensive health technology. It is critically important that we introduce a more rational system of purchasing, deploying and utilisation of health technology. Such a system must apply to both the public and private health sectors. Strategies for the optimal, and appropriate use of health technologies must be introduced. This could, for example, include the sharing of expensive health technology resources between the public and private sectors.

The key objectives to be achieved are:

1. Proper integration of health technology into the overall strategic objectives of the Department of Health to ensure equity in the distribution of and access to these resources;
2. Reduction of the high health technology costs that result from unsystematic and unplanned acquisition and inappropriate use of these technologies;
3. The implementation of a health technology management system that ensures the safety and efficacy of all health technology used in the country; and
4. Introduction of health technology packages starting with the primary level of care.

3.8.10 Financial management: systems and skills

The need to improve financial management systems and skills in the public health sector is urgent especially given the decision to decentralise authority and responsibility to the lowest possible level.

Whilst many managers have been trained in components of financial management there is a need for more systematic identification of who should be trained and what the content of the training should be. Equally important is the identification of the type of systems necessary for effective financial management. It is conceded that as such systems are transverse systems, any changes to the financial management systems would have to be agreed by all role players, especially the Department of State

Expenditure. Whilst new systems are being put in place more effective use of existing systems should be considered a priority.

3.9 HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

3.9.1 Human resource development

While some progress has been made with respect to the planning, training and deployment of human resources much work remains to be done. It is vital that a human resource plan for the health sector be developed as a matter of urgency. It is important that such a plan includes plans for entry level providers of each occupational class, postgraduate and plans for continuing professional education.

Key activities that must be completed to contribute to the plan include:

- A determination of the human resource needs of the country for each level of care;
- A determination of the skill mix needed at each level of care that the country can afford;
- An audit of the current human resources in both the public and private health sectors for each occupational class to determine areas of over- and underproduction and the distribution of health providers (urban-rural and public-private);
- The development of human resource norms and standards;
- An audit of all training institutions, which includes the numbers of health providers being trained and their curricula;
- The impact of the HIV/AIDS epidemic on potential entrants to training institutions and health providers already in practice; and
- The determination of the gap between current levels of human resources, current training programmes and the need.

The prioritisation of primary health care and the introduction of community and home-based care implies that the training of primary health care nurses and community health workers must be fast tracked. The human resource plan must take these needs into account.

In order to aid the development of the human resource plan a task team on specialist training should be established to deal with a number of key concerns in this area. The task team should present a report to the national Department of Health by December 1999. Particular attention must be given to:

1. Admission and support for those previously disadvantaged, especially Africans;
2. More rational focus on numbers and areas of specialisation;
3. Accreditation of training facilities to advance decentralised training; and
4. Review of criteria for accreditation of training institutions.

The human resource plan should be used to determine how our training institutions, in particular the medical schools need to be transformed. Training institutions must be challenged to meet the needs of the health sector in terms of who is trained (skills mix required and the need for affirmative action to correct the imbalances of the past) and the content of the training (training should include primary health care and management skills, for example).

The introduction of community service for newly qualified medical doctors should be followed by the introduction of a similar programme for dentists and pharmacists during the next 5 years. Consideration must also be given to the introduction of community service for other health professionals as well. Such expansion will be dictated by both need and affordability.

Mechanisms must be found to ensure that once trained health providers can be directed to areas of need. The Certificate of Need process described earlier should be used to match the need for services with the deployment of health human resources.

Skill levels within and between provinces vary greatly. As skills are developed the deployment of personnel to areas of greatest need must be considered. This 'internal consultancy' system will result in the sharing of scarce resources within the public health system and may ensure the retention of staff if accompanied by appropriate incentives. Indeed, such a system may itself contain many intrinsic non-financial incentives.

3.9.2 Human resource management

The most important input into the health system is the health provider. This implies that we must strengthen our skills and systems in human resource management to gain optimal efficiency. It is also important that health providers render health care of high quality.

In order for managers to have the tools to manage personnel and improve productivity there is a need to streamline disciplinary procedures, improve supportive supervision, implement a strict referral system for the efficient use of available resources, and introduce professional management practices. The required change in work practices will not be possible without the support and co-operation of labour organisations.

An important human resource management tool is a functional human resource information system. Such a system should enable management to have on line information on all personnel from the time of their recruitment to the point at which they leave the Department. Besides being useful for increasing the efficiency of human resource use such information is also useful for strategic planning purposes.

One of the more demanding challenges is the retention of staff in the public service given the attractive salary packages and conditions of employment offered by the private sector. The financial resources allocated to the health sector are predominantly spent on human resources i.e. up to 65% of provincial budgets. This implies that very

little room for additional financial incentives is possible without negatively impacting on our ability to afford other inputs.

We therefore need to explore the use of non-financial incentives to attract and retain scarce health professional categories e.g. advanced midwives, pharmacists, rehabilitation personnel and medical specialists. This is particularly urgent in rural and other under-served areas. We need to move boldly to develop proposals and secure agreements with labour organisations under the auspices of the Health and Welfare Service Bargaining Chamber and other state institutions on these non-monetary incentives.

The key objectives of a new human resource management strategy should include policies and implementation strategies for the following:

1. Organisational structures with clear roles and responsibilities at national, provincial and district levels;
2. Management culture and systems;
3. Recruitment and retention of personnel;
4. Supervision and leadership;
5. Training and retraining;
6. Appraisal, remuneration and advancement; and
7. Labour relations.

3.10 COMMUNICATION AND EMPOWERMENT OF HEALTH SERVICE USERS

3.10.1 Communication within the National Health System

Efforts must be made to improve the communication at and between all levels of the National Health System. These efforts must be led by visible political leadership at national, provincial and local government level.

Health personnel must be involved in decision-making as appropriate and all health personnel must be informed timeously of decisions taken. In addition, appropriate strategies must be established to keep lines of communication open to enable management to obtain feedback from health personnel. Examples of these strategies include: electronic communication (intra-net, e-mail, electronic discussion groups), newsletters and staff meetings.

Special attention must be given to communication with and support of local government and to the health regions and districts that have been established.

3.10.2 Communication between the Department of Health and stakeholders

The Department of Health, both nationally and provincially requires input from and support of a host of stakeholders. In order to maximise the involvement of relevant stakeholders effective strategies for communication must be established, and where they already exist, strengthened. Strategies to improve communication could include regular national and province-wide meetings, the participation of stakeholders in

committees and task teams, inviting stakeholder comment on draft policy documents, and involving communities in decisions about service provision at facility, district and provincial levels. The use of electronic communication tools to inform stakeholders, like the Internet and non-electronic forms of communication like newsletters should also be used to strengthen communication.

3.11 INTERNATIONAL CO-OPERATION

President Mbeki has emphasised the need for us to contribute to an African Renaissance. Whilst there are many opportunities to do this, our involvement in the OAU represents a unique opportunity for us to contribute to the strengthening of health systems and decreasing the burden of disease on the continent.

Our current Chairpersonship of the Non-Aligned Movement further presents both challenges and opportunities and will enable us to participate in opportunities to strengthen international health development strategies. In particular efforts must be made to share technical assistance with respect to health sector reform.

South Africa is now a member of the Southern African Development Community (SADC). The country has been given the responsibility to co-ordinate the SADC Health Sector, which was established in 1997. This is an important challenge that will allow South Africa to learn from the experiences of others and to contribute to regional health sector development.

In terms of our SADC obligations, five priority areas have been identified and included in a Protocol that was signed by all Heads of State. This Protocol now needs to go through the final stage of ratification, which is by the Parliaments of each Member State by June 2000. The five priority areas in the Protocol and the 1999-2000 biennium programme of action are: HIV/AIDS and STDs; reproductive health; standardisation of health information and surveillance systems; communicable disease control and prevention; and resource mobilisation, especially finances and human resources to implement the Protocol.

It is also vital that commitments made by the government with respect to international treaties and agreements must be fulfilled. This would include decisions taken by the World Health Organisation and UNICEF, for example, to which the Department is a party.

The wide range of bilateral and multi-lateral health agreements entered into over the last five years will be consolidated, but also revisited in line with the changing needs of the South African heath service. Our challenge is to further expand agreements with Africa and the Middle East, the Americas, Asia and the South Seas, all the UN Agencies and other multilateral agencies.

3.12 ASSUMPTIONS

The ability of the Department of Health to deliver on the various priorities set out above will depend in part on the actions of others. A series of assumptions were made in developing this Strategic Framework.

They include:

1. The availability of sufficient financial resources, the assurance of financial stability during and between financial years and the absence of unfunded mandates;
2. The ability to train, retrain, retain, and deploy health personnel as needed;
3. Solid co-operation from all partners notably, other national government departments, provincial and local spheres of government, the private sector, NGOs and CBOs and communities;
4. Our ability to reverse the HIV/AIDS epidemic (mortality and morbidity rates particularly among women and children will be greatly undermined by the AIDS epidemic); and
5. Removal of legislative and other obstacles so as to implement more responsive management systems, in particular tools to design and implement an appropriate workforce configuration.

Annex

DRAFT OBJECTIVES, INDICATORS AND TARGETS FOR THE HEALTH SECTOR STRATEGIC FRAMEWORK, 1999-2004

	OBJECTIVE	INDICATOR	TARGET
1.	Reorganise laboratory servicesS	New legislation passed and parastatal created	Legislation passed by February 2000 and new entity created by April 2000
2.	Agreement on National Planning Framework as the basis for the pospital rehabilitation programme	National Planning Framework further developed and used to determine hospital rehabilitation programme	National Planning Framework finalised by March 2000 and provincial strategic plans to underpin hospital rehabilitation to be completed by June 2000
3.	Management of all hospital decentralised	Number of hospital with authority for key functions devolved	Management decentralised to all central, regional, district and specialised hospitals. PMAs signed with all hospitals by April 2003.

4.	Hospital Billing System implemented	Number of hospitals with billing systems in place	Billing system introduced in selected hospitals by April 2000 and full implementations in all hospitals by April 2001
5.	Equity in access to PHC	Number of primary care facilities that render the full package of essential services number of new telemedicine sites	Essential package introduced in selected facilities in April 2000 with full implementation by 2003/4 73 new sites functional by 2004
	OBJECTIVE	**INDICATOR**	**TARGET**
6.	Fully functional clinics and CHCs	Number of existing and new facilities which have water, sanitation, electricity and roads.	All facilities to have services by 2003/2004 financial year.
7.	Health delivery by LG to be regulated by service agreements	Number of municipalities rendering comprehensive health services and have service agreements with provinces.	Service agreements to be signed by September 2001.
8.	Improve immunisation coverage	At least 150 cases of AFP found & investigated Number of cases of measles Immunisation coverage of one year olds	Polio eradication certified by 2000 Indigenous Measles eliminated by 2002 Achieve 90% coverage of one year olds by December 2003 (at least 80% in each province) 90% coverage by 2004
9.	Improve child health	Number of provinces who have implemented NPA Prevalence of wasting and stunting among children	All 9 provinces implemented NPA Reduce prevalence of wasting from 2,6% to 1%

		and underweight for age among children under 6 IMCI implemented	stunting from 23% to 15% and underweight children from 9% to 5% by 2004
	OBJECTIVE	**INDICATOR**	**TARGET**
10.	Improve youth and adolescent health	Guidelines for youth and adolescent health published and distributed Teenage pregnancy rate Substance abuse rates amongst adolescents	Guidelines implemented in all provinces Teenage pregnancy reduced by 20% Substance abuse reduced by 10%
11.	Introduce strategies to deal with the HIV/AIDS epidemic	Incidence of HIV/Number of cases of STD effectively treated in public and private sectors Packages of affordable care and support for infected and affected developed Number of projects supporting AIDS orphans Strategy for active participation in vaccine development in place.	50% of cases treated effectively by 2001 Packages available nationally Projects in each province
12.	Strengthen the TB programme	Smear conversion rate DOTS programme expanded Percentage decline in MDR-TB	Achieve smear conversion rate of at least 85% in new cases by December 2003 DOTS in all districts by December 2001 Reduce MDR TB to less than 1% of all new cases.
	OBJECTIVE	**INDICATOR**	**TARGET**
13.	Improve malaria control	Annual review of past malaria season using a standard format	Meeting held in June each year to review reports and plans

		Annual plans for each province Plans co-ordinated with neighbouring countries including SDI projects	Present plans for inter-country review at annual meeting Implementation and evaluation of Lobombo SDI
14.	Improve women's health and reduce maternal mortality	Number of districts that have implemented the national programme for cervical and breast cancer awareness and screening. Number of facilities that have implemented ANC protocols Incidence of violence against women and rape.	Programme implemented in all districts by 2004 Protocols on ANC implemented by all facilities by 2002-05-31 Develop protocols for management of violence and abuse by December 2000
15	Improve management of chronic diseases	Number of provinces implementing the national guidelines on control of hypertension, diabetes, obesity, and asthma % improvement in reduction in cataract surgery backlog Increase access to those with disabilities to: Health facilities Assistive devices Employment	Guidelines implemented in all districts by December 2002 Increase cataract surgery rate to 2000/million population per year by 2004 60% health facilities accessible by 2003 Proposals implemented by 2001 2% of workforce of Department of Health being disabled persons
	OBJECTIVE	**INDICATOR**	**TARGET**
16	Strengthen poverty alleviation and food security programmes	Number of districts implementing INP Number of districts that has strategies that promote community-based growth monitoring Number of facilities and community based projects that provide	INP implemented in all districts by 2004 All districts promoting growth monitoring All districts were appropriate All districts to implemented intersectoral action to

		nutrition interventions for malnourished children Number of districts with intersectoral plans to tackle the causes of poverty and poor nutrition Legislation to ensure food fortification promulgated	reduce levels of poor nutrition and poverty Legislation in place by 2002
17	Improved resource mobilisation, allocation and management	Essential PHC package costed to determine affordability Number of provinces with effective referral systems SHI implemented Number of hospitals generating increased revenue Donor policy in place	Package costed by February 2000 All provinces with effective referral systems by March 2001 SHI implemented by 2002 All hospitals to generate more than 1998/9 levels by 2001/2002 Donor policy implemented by December 1999
18	Strengthen HRD & HRM	National HR Plan Plan for post-graduate training in place	HR Plan completed by June 2000Task team to report to DG by December 1999 All PHC facilities to be supported by doctors by 2004
	OBJECTIVE	**INDICATOR**	**TARGET**
		Number of PHC facilities that are supported by a medical doctor Incentive plan for scarce personnel Implementation of community service for dentists Implementation of	Incentive plan negotiated in Bargaining Chamber by 2001 Community service commences July 2000 Community service commences January 2001

		community service for pharmacists	
19.	Improve communication	Existence of effective communication policy and strategy in national and provincial departments	The national and all provincial departments have and implement communication strategies by April 2000