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The political pathology of health care policy in South Africa

Summary

South Africa is currently dealing with the transformation of health care into an equitable, national health care system driven by a primary health care approach. This requires a complicated set of administrative and, in particular political changes. The problem is exacerbated by the fact that several of the visible changes in health care hastily implemented to make good on election promises did not result from policies based on genuine community needs. This article argues that the main reason for the presence of this health care pathology is that the government has tried to effect transformation by means of hastily constructed visible changes, despite the absence of the structures needed to drive and support these changes. It also attempts to explain why a sizeable sector of the population is unable to experience the transformation of health care as an improvement.

Die politieke patologie van gesondheidsorg in Suid-Afrika

Suid-Afrika worstel op die oomblik met die transformasie van 'n sosiaal-ongelyke gesondheidsorgsisteem na 'n nasionale gesondheidsisteem met as oorhoofse doelwit: primêre gesondheidsorg. Sodanige transformasie stel hoë eise aan beleidmakers, administrateurs en gesondheidsorgpersoneel. Hierdie pogings word voorts ook vertroebel deurdat sommige van die sigbare veranderinge in die gesondheidsarena oorhaastig as gevolg van verkiesingsbeloftes aangebring is. Die resultaat is strukture en funksies wat nie weldeurdagte beleid gebaseer op werklike behoeftes van gemeenskappe reflekteer nie. Die artikel probeer aantoon dat die belangrikste rede vir die patologie in die gesondheidsisteem daarin gesoek moet word dat die regering in gebreke gebly het om eers die strukture wat hierdie veranderings moet ondersteun en laat funksioneer, te voorsien. Die artikel probeer redes verskaf waarom 'n aansienlike gedeelte van die bevolking die transformasie in gesondheidsorg nie noodwendig as 'n verbetering ervaar nie.

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When Aaron Wildavsky (1977: 105-23) tried to explain why people do not necessarily feel better when health care improves, he was actually referring to the political pathology of health policy: the more government spends on medicine, the less credit it gets. The reason for this is that more money can only buy more care, not more health; most people, however, fail to understand this correlation. When governments spend money on health care for political rather than health reasons, they should expect to be criticised rather than praised. The South African health care arena provides several examples of money being spent on health care measures which are not necessarily the result of policies based on the real health needs of the communities they are suppose to serve.

Before the new political dispensation, *i e* before 1994, the battle lines in the health sector were clearly drawn. On the one hand, the government and most of the private health care establishment were promoting the privatisation of health care. On the other hand 'progressive' voices, including anti-apartheid organisations and academics, vigorously opposed privatisation and called for the creation of an equitable and affordable National Health Care System — an aim which the new government energetically pursues. According to Crisp (1997: 46) the main vehicle for this new initiative would be a primary health care system, seen by government as the starting point for addressing the social evils created by the apartheid system. It should at the same time reduce the discrepancies between the highly developed, technologically advanced sector of society and the severely disadvantaged, underdeveloped and culturally traditional world. A health care system able to produce quality care on an equitable basis for two such diverse populations — one characterised by chronic diseases and the other by infectious diseases — requires careful planning, relevant policies and effective management.

This paper[1] focuses on some of the aspects that impede the implementation of an effective health care delivery system. It argues

1 Expanded version of a paper presented at the conference on Health and Health Care in Transition in Portugal, August 1998.

that, while there are compelling reasons for improving and extending primary health care services in South Africa, many such initiatives fails because in its political haste to change and improve functions, the government fails to establish the structures needed to drive and support these functions.

1. Problems precluding effective Primary Health Care

1.1 Budget problems

Despite appearances, post-apartheid South Africa is in serious debt, and health is but one of the sectors in which the government struggles to come to terms with the realities of its painful past. Much of the government's Reconstruction and Development Plan (RDP) for health services focuses on restructuring the inherited health system to make it more equitable, accessible and efficient. In respect of the primary health care aspect alone, the budgetary demands are massive. It requires, on the one hand, a shift in the allocation of resources in order to achieve universal access to basic services. On the other hand, it must also develop institutions which emphasise community involvement, the relationship between health and other sectors, and appropriate health management information systems — to name only a few priorities (Price & Van den Heever 1994: 34). To achieve some of these goals the government during 1994 embarked upon the creation of a variety of priority programmes, which are considered to be essential to a primary health care approach. Table 1 provides an estimate of the cost of implementing certain such programmes.

Table 1: Total cost of nine priority health programmes (in 1994 prices)

Programme	R (million)
Child health	225
Maternity care	138
Nutritional supplementation	2013
Clinic expansion	90
Emergency services	227
Hepatitis B immunisation	25
AIDS/STD prevention	55
Mental health	10
Rural salary allowance	256
Total	3039

(Source: Price & Van Heerden 1994)

The increases required to implement the RDP health plan amount to something in the region of 10 to 20% of current government spending on health. It is highly unlikely that such increases will be available, taking into consideration that South Africa already spends R23 billion, or 8% of its GDP, on health. Tuft (1997: 30) calculates it at 8.5% or R30 billion of South Africa's gross national product (GNP)! This is much higher than the WHO estimation of 6 to 6.5% of GDP. Coupled with this problem is the fact that most of this money is at present spent on private health care, which means that increases will have to be coupled with redistribution — from private to public services — an aspect too problematic to deal with in this paper. The National Portfolio Committee on Health recommended an additional R1 billion for primary health care services in 1997/98 from sources outside the present health budget (Harrison 1997). Even if such amounts are obtainable, primary health care delivery needs much more efficient organisational and management systems at the site of delivery and the district level than it has at present. The Health Ministry, however, has at the moment no coherent and systematic mechanism in place to assess whether national policy formulation and high profile strategies, such as the above, indeed lead to improvement in service delivery (Health Systems Trust 1999: 1).

1.2 The prioritisation of programmes

Budgetary problems aside, it is also doubtful whether the government's strategy of prioritising certain programmes while neglecting others (for example a population programme which would seem equally urgent) can possibly be correct. In this regard Van Rensburg (1996: 397) and Smith *et al* (1997: 90) say that the explosive population growth of South Africa tends to systematically devour any capacity for economic growth, human upliftment or socio-economic development, thus neutralising most of the gains made in health and social security. The fundamental critique of this type of prioritisation of health programmes, however, is that it defies practical implementation and, to a great extent, makes a mockery of attempts to cost it. In fact, no service can be introduced or expanded without taking into account what other supportive programmes are going to cost. Such programmes include not only related health care services but the whole spectrum of inter-related environmental elements needed to maintain a healthy population.

The prioritisation of programmes can also be criticised on economic grounds. If only certain programmes are funded, vertical bureaucracies are often formed, with their own budgets, line accountability, targets and indicators of success and with little incentive for an integrated, holistic health care approach. Vertical and selective programme interventions are, by definition, hostile to a comprehensive health care approach. Past experience of vertical programming (family planning, HIV/AIDS, TB etc) has taught the expensive lesson that the duplication and fragmentation resulting from such programmes simply cannot produce an integrated, comprehensive health care system. The attempt to solve the HIV/AIDS problem without simultaneously addressing the social problems of rape and child protection, as well as that of sex workers with their drug-related behaviour, is a case in point (Leggett 1999: 86).

Prioritising programmes can also result from mistaken paradigms. The implication is that what the government is doing must be considered to be in order, the only further requirement being that it needs to do more of the same. While it is true that more service provision increases access, it is unfortunately not the case that

access to care automatically equals better health. The best estimates are that the medical system affects about 10% of the usual indices for measuring health — the remaining 90% being determined by factors over which medical professionals have little or no control (Wildavsky 1977: 105). At the moment, however, it seems as if the governments' main goal is to spend more money on programmes which can demonstrate that changes do occur and to convince people that quantity of care equals quality of care. Not only does such an approach fail to critique the effectiveness and efficiency of health care services; it clearly presumes that more money can be made available to provide more such services. This is clearly not so (Price & Van den Heever 1994: 34). In his study on district expenditure and resource allocation, McCoy (1998) found that the problems experienced by the newly introduced District Health System result mainly from the absence of a standardised system for health expenditure and resource allocation. This failing creates considerable confusion about how much money is available for any specific type of service.

1.3 Equity versus quality

Nobody will deny that the government's emphasis on primary health care makes sense in the humanitarian, health, health service and economic contexts. However, the factors crucial to the successful extension of primary health care delivery involve far more than simply ensuring that there are enough clinics, enough nurses and enough drugs (which at the moment are severely underprovided). Primary health care can only make a difference to the health status of a community if it is implemented within a national social policy framework which includes strategies for equity, social justice, development and economic advancement. If there is too narrow a focus on growth (*i e*, merely more of this and that) as an objective, there is a danger which the complex inter-relationships which create the conditions needed for a healthy nation at all levels may be rendered subordinate (Portfolio Committee on Health 1997).

The political pathology emerges when the process of health care investment becomes more important than the purpose. At the moment the major emphasis is on projects whose benefits can be measured in the short term, such as the establishment of clinics and

of certain programmes such as feeding schemes, mother and child care, and so on (Smith & Niedermeier 1997: 88). Despite the fact that some of these 'concrete' interventions have a political agenda, most of them are indeed necessary. The problem is that many of them are not well-designed products of a comprehensive health plan. They are rather intermediate interventions whose main function is to provide more 'medicine' or more food for more people, whether this improves health or not. Health has been equated with equal access to medicine. But as Wildavsky (1988: 106) says, medicine is not synonymous with health. Access does equal quantity but not necessarily quality of care. Access can be measured; quality not so easily. Clinics, doctor-patient ratios, feeding schemes and free medical care can be quantified, look impressive on paper and, above all, imply change. But what about quality? The recently established free medical care programme creates the same problems in South Africa as elsewhere in the world. While it guarantees equal care for the poor and the aged it does nothing to ameliorate the situation of the 'near poor' who do not have medical insurance and must therefore pay for medical care in an even more 'unequal' situation. The same applies to everybody else: one must pay twice, first in taxes to support care for others and again in increased costs for themselves. Moreover, free medical care brings with it increased utilisation of medicine, thus crowding the system; medical care is not only more costly but harder to obtain. One merely has to visit hospitals and clinics to substantiate this fact. Many of the clinics which are supposed to serve as gatekeepers for hospitals do not have the structural support to do so, which means that hospitals have to cope with larger numbers on a restricted budget. Thus, as the situation improves in quantitative terms, it in fact deteriorates.

1.4 Private versus public: the case of medical doctors

The public/private divide remains thé largest source of inequality in health care, with the private sector absorbing up to 94% of health professionals in certain categories, while serving only 25% of the population (*The Star* 1997). Only the issues of the availability and distribution of doctors will be dealt with here. In order to lessen the rural/urban disparity in the provision of doctors, the government has

introduced a two-year period of compulsory community service for junior doctors. The arguments in favour of this action are simple. There is a shortage of doctors exactly where there is a desperate need of them — in rural and peri-urban areas. The country does produce sufficient doctors, but many prefer the comparatively lucrative world of private practice or greener pastures abroad. These 'selfish' doctors should thus be forced to fulfil their responsibilities in the needy areas (Begg 1997: 65). Compulsory community service, however, is not a solution in the sense of stemming the tide of emigration or private practice because it does not address the reasons for doctors' reluctance to work in rural areas or public institutions. Instead of threatening doctors, rural posts should be made attractive and viable, with an acceptable standard of living — at the moment they are not. Apart from an additional R19 000-00 annual allowance allocated to hospital doctors in the most remote and inhospitable areas, very little is being done to attract doctors. If the government fails to provide an inclusive package of attractive incentives, it is doubtful whether it will lure young doctors to rural areas since, as Wildavsky (1977: 110) says: "people who are forced to live in places they don't like make endless efforts to escape". The present importation of foreign doctors is in some cases also driven more by the ideal of access than by concern for the quality of care. Many of these doctors are not trained to serve in general practices, do not even understand English and have to serve mainly the indigenous population, which they understand even less well. Furthermore, as the turnover of foreign doctors is high, treatment modalities and equipment are frequently changed. This means that a considerable amount of expired medicine and expensive, disused equipment is consigned to storerooms all over the country — a situation which the country can ill afford (Crisp 1997: 47).

The Ministry of Health needs to regain and retain the loyalty of emigrated and alienated doctors. Inefficiency and delays in implementing revised salary scales, confusion in respect of the remuneration of private doctors rendering services to public patients, and the conflicting restrictions imposed on dispensing doctors, coupled with compulsory community service, do little to attract doctors to the public sector. At the same time private doctors are

urged to provide more patients with better care and then criticised for making more money. Patients are urged to make use of preventive medicine, only to discover that they are then targeted by resrrictions. If private hospitals keep wages down, this is viewed as exploitation of workers; raising wages is regarded as an attempt to lure workers away from public institutions. The Portfolio Committee on Health (1997) stated that South Africa is at present, in effect, paying for the training of doctors for the healthiest countries in the world. So the government pays twice — once to train doctors and again to replace them with foreign doctors. Does anybody win? If money is a barrier to equality in medicine, the system is discriminatory; if money is no barrier, the system becomes overcrowded. The inability to break out of this paradoxical situation has made the politics of health care transformation pathological.

1.5 District development

The development of South Africa's district health system forms an essential part of the RDP. This involves the development of a level of health delivery focused on primary health care services, including district and community hospitals. Central to this policy is the development of decentralised and financially accountable structures located close to the communities they serve. Nobody can argue with the validity of such a 'bottom-up' approach to health care delivery. However, in practice this development provides several examples of functions which have been changed or replaced without ensuring that the necessary supporting structures are in place. The meeting of local needs encompasses a wider range of services and therefore the cost per patient rises considerably. In general, the problem is one of allocation of funding at central, provincial and district levels. Basing the formula on numbers puts remote areas at a disadvantage; basing it on areas would disadvantage populous places. How should provincial authorities decide how much money should be spent on the various services? At the moment there are few objecrive criteria. Who should make such decisions? If teams of medical specialists are involved, professional divisions will create problems. If administrators must decide, their lack of medical expertise may do so too. In the context of affirmative action appointments, the

administration of scarce resources is really infected with the political pathology of health care. Sensitivity to local needs and district control often implies control by local laymen rather than more impartial professionals. Lesetedi (1995: 7) comments in this regard:

> One big lesson we have learnt from our type of decentralisation is that when you decentralise services, you must be willing to decentralise authority or power and this may entail relinquishing some of the powers that you very much cherish.

Without adequate legislation and a clear definition of roles, conflict and confusion are to be expected as a result of the decentralisation of services. Several of these problems are discussed below.

1.5.1 Organisational

The Health Systems Trust (1997) mentions the following problems in respect of district development:

- The provincial government structure, with nine departments of health enjoying equal status, is a recipe for the misapplication of resources, duplication and in-fighting. Unequal development within provinces or even among districts pits one locality against another.
- There is a lack of effective authorities able to accept accountability for a budget financing all primary health care services.
- No financial system exists for the allocation of budgets on a geographical basis.
- Health authorities have no information system about the subsidies, budgets and actual expenditures of local governments; nor are there any standards for dealing with these matters on an equitable basis.
- No minimum norms and standards for primary health care are linked to available budgets.
- There is no uniform policy on conditions of service.
- Without the right people in the right places, no policies, plans or objectives will be achieved.
- No system exists which would facilitate integration and co-operation among the Departments of Health, Public Works and Public Administration.

- The national systems are designed to function at a national level rather than on a provincial basis, aiming at primary health care within a decentralised district system of delivery.

All of the above results from the fact that, despite the rhetoric, support for capacity building remains limited to training and the provision of visible and quantifiable services at the expense of the development of viable management structures and systems. Hsiao (1999: 1), noting the tendency of leaders to focus on financing strategies, stresses that human resource development, management capacity and information systems are equally important factors in the attainment of equity.

If the changes in health care policy are to provide services which are acceptable and appreciated by the community and simultaneously raise the morale of health care providers, a common vision must be developed and communicated to both providers and users. In this context, Chabikuli (1999: 5) in an analysis of health care and welfare services, emphasises rhe considerable management problems which hamper efficient service delivery, singling out problems of communication, the management of drugs and supplies, information and transport. In a study on communication systems in health districts, Ramduny (1998) notes that, apart from the infrastructural deficiencies that bedevil existing health care communication systems, the process itself leads to confusion and frustration among health workers.

1.5.2 Demarcation of districts

The confusion about the exact geographical location of district boundaries has a serious impact on health services. Hospitals and clinics often do not know under which provincial jurisdiction they work or which patients they are supposed to serve. In the Northern Province, for example, there are hospitals and clinics without basic facilities such as ambulance services because nobody knows who is to serve whom (personal observation). Lines of communication and authority are far from clear, with the result that health workers at the point of delivery are sometimes faced with a situation in which multiple programme demands compete for limited resources and personnel. The immunisation programme, for example, is very

vulnerable as a result of the confusion surrounding district demarcation. The lack of reliable data on the immunisation programme can be attributed primarily to a lack of information from the provincial and district levels. There is an urgent need for a comprehensive, integrated information system which will provide managers and staff at every level with the information they need (Verburg 1999).

1.5.3 Cross-boundary flows

The district system also suffers from another severe problem — budget administrators do not take into consideration, or cannot prevent people from making use of the bigger and better hospital facilities in the urban areas. Budgets are allocated according to local population figures without taking into account the fact that academic hospitals, in particular, serve people from all across the country. This has created serious financial problems for these hospitals and has a detrimental effect on both service provision and staff morale.

1.6 Facilities

Only two types of facilities and the problems they experience will be dealt with here: hospitals and clinics.

1.6.1 Hospitals

It is perfectly true that the development of primary health care services is crucial to the efficient running of higher-level services. It is, however, equally true that primary health care can prevent some diseases but will also identify others requiring treatment at primary, secondary or tertiary level, resulting in additional expenditure. There should consequently be no reduction in funding or staffing of hospital-based medicine until and unless the system of primary health care has reduced the number of people requiring these services. Tertiary hospital services should not be restricted until secondary hospitals are functioning efficiently (McCusker 1997: 27).

At the moment, hospital budgets have been cut by 9%. Although it makes monetary sense in terms of the greater emphasis on primary health care, the decrease in supply of hospital services did not take

place at the same time or the same rate as a decrease in demand for these services. The restrictions were enforced on hospitals simultaneously with the introduction of free health care for a large section of the population and the legalisation of abortions, which increased the demand for hospital services dramatically. The introduction of better primary health care in a country where it has been neglected for decades has meant that many previously neglected cases are now being detected and need hospital care. Hospital services cannot be deflected to the community if clinics and health centres are not in place or do not function properly. Scaling down hospital services in urbanised areas overlooks the fact that the South African population is becoming increasingly urbanised and that a considerable percentage of this population suffers from chronic diseases, many of which require hospital care. In spite of all this, it was recently decided, for example, to de-institutionalise patients with mental illnesses. Daertnell *et al* (1999: 2) warn that, given the current lack of community services, very few patients can or should be discharged without the special provision of appropriate community resources prior to the scaling down or closure of hospital-based care in South Africa.

A further reason why hospitals (and this is also true of clinics) cannot cope with the workload is, on the one hand, the shortage of staff and, on the other hand, the lack of properly trained staff. Usually staff projections are based on 'ideal' standards — so-called staff-population ratios and norms. Many of these are borrowed from industrialised countries with very little adaptation to the economic realities and organisational structures of low-income, developing countries. Gray & Strasser (1999: 5) discuss one such problem, namely the fact that the prescription of medicine by primary level nurses is, at the moment, the norm rather than the exception. Yet the present model for training nurses to prescribe seems, according to the authors, overly idealistic as it involves the removal of large numbers of nurses from the workplace for lengthy periods in order for them to receive training at educational or health care institutions. Alternative models, applicable to local conditions, should therefore be adopted.

Staff projections are also job-specific without regard for staff integration or staffmix. Co-ordination between education and

training institutions and policies of recruitment is often poor, resulting in heavy over- or under-production of certain staff categories. Job descriptions are scarce and those that do exist are vague and do not lend themselves to performance appraisal (Brookman-Amissah 1997: 93). Such a situation is not conducive to high levels of productivity.

Certain aggravating aspects in terms of the overcrowding of hospitals have a political basis. With the opening-up of the South African borders, particularly to sub-Saharan Africa, the country has had to deal with an onslaught of both legal and illegal immigrants. Not only do they place additional strain on the capacity of hospitals; they have also contributed to the increase of tropical and sexually transmitted diseases, in particular. Also, as a society in transition, South Africa is at the moment experiencing very high levels of crime and violence, which has created an urgent need for emergency and trauma services. The lack of funding to replace expensive equipment or to train staff in a professional way, particularly in the surgical arena, also creates serious problems for efficient service delivery. It is consequently not uncommon to hear surgeons complain that they have to operate without the help of the necessary anaesthetists or theatre nurses (Brookman-Amissah 1997: 93).

Another political legacy responsible for overcrowded facilities is the question of hospital preference. Because the greater section of the population was, in the past, denied the services of the so-called 'white' hospitals, most of them now demand to be admitted to these and not to the larger, formerly 'black' hospitals. In rural areas these formerly 'privileged' hospitals are usually small, with limited facilities and staff. With the reduction in hospital budgets, these hospitals now have to render services to at least twice the number of patients with the same facilities and staff. There are instances where hospitals have run out of food, as well as very basic medical supplies. One of the consequences of hospital preference is a very high rate of referral to urban and academic hospitals which do not themselves have the resources (whether physical or managerial) to cope with this influx.

With the change in the political system, many health care managers and administrators were appointed with the aim of

reflecting this political transformation. They are well aware of the need to restructure the health care arena but quite a number are inexperienced and have little detailed knowledge of the systems they are supposed to manage and transform. This causes frequent breakdowns in the provision of services, a situation which is, in addition, exacerbated by the administrative confusion concerning the responsibilities of the Department of Health and other supporting departments (Health Systems Trust 1997: 47). The major problem confronting hospitals is probably not the cut in budgets but the lack of managerial skills and of measures to ensure that the money available is well spent.

1.6.2 Clinics

Despite the government's commitment to primary health care for all, the disparity between service provision in rural and urban areas persists, with rural people and the poorer provinces still running a poor second in terms of health care provision. Although some R710 million has already been spent on the building of 461 new clinics in rural areas, many of these clinics lack the infrastructure to function properly. The Health Systems Trust (1997) found in its latest health survey that 20% of rural clinics did not measure up to the basic indicators of service provision. Only 41% of rural clinics had ambulances available within an hour of the relevant emergency while only 60% provided family planning services on a daily basis. Twenty per cent did not even have functioning taps and more than 10% had no functioning refrigerator or stove. Less than 50% had a reliable telephone service. With an unreliable electricity supply, radio communication was also ineffective. Twenty-two per cent of rural clinics were entirely without taps and had a very unreliable water supply while a large percentage were without proper sanitary facilities or waste removal systems. Only 42% of rural clinics received monthly visits by a doctor. Often, blood or sputum smears could not be collected as there was no refrigeration and the dispensary service responsible for collecting and bringing supplies was unreliable. Many of the clinics did not have enough or properly trained staff and did not deliver a 24-hour service.

One of the most serious problems in terms of clinic services is the fact that nurses and community workers are expected to work together, yet are hardly ever trained together or to work in teams, which is considered the backbone of primary health care. They are also trained predominantly in large hospitals where the emphasis falls on the medical, rather than the social model of health. This latter model is essential if prevention, rather than cure, is to be the objective of clinics. In many facilities preventive and curative services are still rendered separately with the result that the already scarce resources and skills of health workers are inappropriately used. Administrative procedures are cumbersome, and the volume of paperwork completed by health workers, though large, is generally meaningless.

The problem experienced with the emphasis on primary and preventive health care is that it is not always equated with good care or with the degree of care they require. The population at large does not understand that every move to improve one aspect of health care necessarily impacts negatively on another. Many are dissatisfied with clinic services, while at the same time finding themselves refused access to hospitals. But as Mechanic (1976) says:

> No system of care in the world is willing to provide as much care as people will use and all such systems develop mechanisms that ration services. Just as there is no free lunch there are no free services.

South Africa is at the moment trying to ration tertiary care in order to supplement primary care, but by rationing hospital services before there is a proper clinical structure in place serves only to exacerbate the problem, not to solve it. If it were true that providing ample opportunity for patients to consult health officials outside the hospital system would reduce their need for hospitals, then the provision of outpatient services would reduce costs. However, the little evidence that has become available since the new health policies came into being, suggests otherwise.

1.7 Women and children's programmes

The new health plan explicitly gives priority to the needs of women and children, particularly in the form of free health care and the primary school nutrition programme. While such an emphasis is

clearly needed, it provides a further example of a situation in which programmes were introduced without the supportive structures being in place. For example, the well-being of women and children is the responsibility not only of the Department of Health, but also of Education, Social Welfare, Housing, Labour, Justice, and so on, together with non-government organisations. Ensink *et al* (1997: 1200) refer in this regard to the lack of intervention strategies or community services able to promote mental health in general and reduce the anti-social behaviour of children in particular. Preventing mental illness ultimately results in considerable savings in public expenditure on othet departments such as education and the criminal justice system. Intervention strategies which effectively reduce antisocial behaviour are of particular relevance here, given the threat to public health posed by the present levels of violence and social instability in South African society (Gilchrist & Knapp 1994: 11)

The rapidly introduced national programme for nutrition has been marred by incidents of gross mal-administration, corruption and theft. The half a billion rand per year allocated to the Primary School Nutritional Programme (PSNP) is hard to justify, since it is a vertical programme without proper pre-school nutrition programmes or services. In addition, there is evidence that deworming, education about nutrition and micronutrient supplementation are more cost-effective components of a school nutrition programme than feeding. Most of the potential benefits of feeding programmes are simply not gained, due to inappropriate, inconsistent or badly timed feeding of poor or even unhealthy foods. The fraud and corruption involved in feeding schemes have been so rife that the government has already had to spend R2,5 million on investigations — money which could have been saved if proper structures had been in place to plan, implement and evaluate the nutritional programmes. Another negative effect of feeding programmes is that, since children are fed at school, impovetished parents are given the impression that they do not have to feed them at home. The result is that children suffer even more, particularly when the food provided at school is of low nutritional value.

Programmes such as the above do of course fit in with the objective of comprehensive health services but the introduction and

funding of poorly structured vertical programmes is unlikely to achieve this goal. If the development of people is the main objective of government, people's needs should be provided for on an equal basis. If medicine is a right, so are education, housing, employment, and so on. Without them, health is in any case not attainable. The major advantage of a comprehensive approach to health care is that it is supposed to keep expenditure in line with other objectives. Prioritising and funding certain programmes to the detriment of others will not achieve this objective. In this regard Coughlan (1995: 11) notes that building clinics and desegregating hospitals were both steps in the right direction but will have only minimal impact unless issues of income, access to resources and other legacies of apartheid are completely dismantled. The problem, however, is that it is left to the Department of Health to co-ordinate all these into a comprehensive, holistic approach. To judge by the fragmentation, duplication and lack of proper management that characterise these programmes, the department finds this very difficult indeed (Health Systems Trust 1997: 140).

2. Disease profile

Considering the present disease profile of South Africa, one would hardly credit that the present government is spending billions more on health care for the poor than was previously the case. Only two diseases, namely HIV/AIDS and tuberculosis will be discussed in this study.

2.1 HIV/AIDS

At the World Summit on Aids in Geneva in 1998 it was estimated that 80% of the approximately 30 million infected people are Africans — the bulk of them living in sub-Saharan Africa. Recent trends in South Africa suggest an explosive epidemic of HIV-infection — some of the highest figures in the world (*Eastern Province Herald* 1998). A study commissioned by Population Action International (PAI) concluded that the sub-Saharan region's prospects for economic development depend largely on the success or failure of governments in accelerating efforts to expand family

planning services, and to combat infant mortality and AIDS (*The Citizen* 1998).

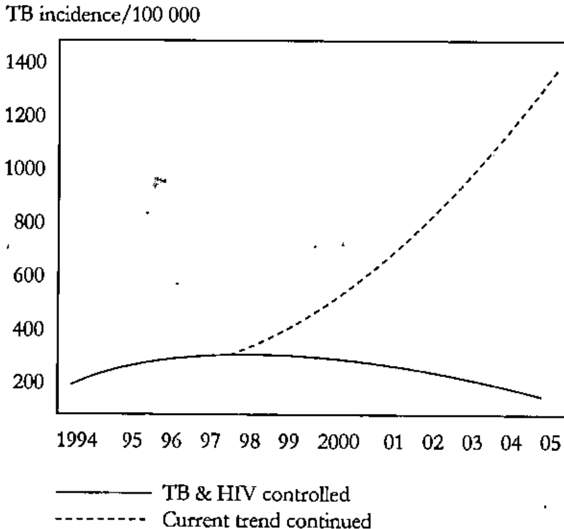
After the introduction of the National Aids Plan in 1994 one would have expected a decrease in the rate of infection (as in Uganda and Thailand), however small, to be apparent by 1999, yet the increase is still exponential. The original programme was highly centralised and vertical and its policies and planning were largely ineffective.

Recently the Aids plan was amended to include a less technical and more community-driven approach. Nevertheless, despite all the emphasis on education in the new Aids plan, a recent study among primary school children found that only 40% of the 24% who are sexually active protect themselves from HIV (Visser & Moleko 1999: 74). These issues need to be addressed in order to prevent high-risk behaviour. The translation of the Aids policy into an approach truly based on community-wide participation is still to be realised. Collaboration between government, non-governmental organisations and the private sector is essential in order to improve public awareness and to enhance the capacity to deal with the problem. Despite much talk and many good intentions, the Clinic Survey of 1997 indicated thar the epidemic has increased tenfold over the last five years (National Portfolio Committee on Health 1997).

2.2 Tuberculosis (TB)

South Africa is facing one of the worst TB epidemics in the world, with disease rates more than double those observed in other developing countries. Given that more than R500 million is spent annually on TB in South Africa, the financial implications of a continuation of current trends is staggering. On the other hand, progressively successful HIV/AIDS control together with effective TB control would mean a turnabout of the epidemic by the year 2003, as indicated in Fig 1.

Figure 1: Future trends in TB in South Africa (1995-2005)
(Source: Health Systems Trust 1997: 202)



Although the National TB Plan is a well-designed policy statement, the structures to set the plan in motion have been slow to emerge. Provincial and district TB co-ordinators, for example, has been appointed in only four of the nine provinces. The absence of district management structures, in particular, is one of the major causes of the low rate of success in TB control. Another reason for the failure in TB control must be sought at clinic level. According to the clinic survey conducted by the Health Systems Trust (1997), only 16% of clinics offering TB treatment are able to receive sputum results within 48 hours, the recommended guideline set by the TB Control Programme. Despite considerable funding for microscopy services, state bureaucracy cannot succeed in establishing enough centres for this. In spite of the fact that an up-to-date TB register is the key management instrument for control, the quality of TB clinic records throughout the country is very poor. The Directly Observed Treatment procedure would also be much more effective if clinics

made use of community health workers to monitor patients. In the Northern Province there is little evidence of this. Clinic nurses readily admit that their TB programme is frustrated because they do not have the time to visit patients regularly (personal observation).

3. Conclusion

Despite the much-needed transformation taking place in the health care arena, there is at the moment a widespread public perception that access to health services and quality of care in many instances, are no better than they were. One of the reasons seems to be that the transformation of delivery is not based on a sustainable management system. Health service systems are complex, and therefore need a national system based on the planned, rational and equitable distribution of resources. At the moment the health system is threatened and its services undermined by structural problems occurring at national, provincial and district levels. Good health care policies are thwarted when a government tries to translate them into election promises. Opponents to the transformation process also exploit the situation, criticising it and trying to frustrate any move to change the *status quo*. No wonder that the transformation process is at the moment characterised by a government which insists that it is doing better while a large percentage of the population complains that it is feeling worse.

If nothing else is certain, one thing is: if the South African health care system is to serve the population in a truly equitable and quality-driven manner, a fundamental re-examination of structures, administration and finances is essential. While nobody would argue with the need for incisive institutional reform, this will not guarantee an improvement in the degree of health unless it is founded on viable management structures and systems capable of supporting the new functions in a sustainable way.

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