

# A National Health Plan for South Africa

30 May 1994

## FOREWORD

The South African government, through its apartheid policies, developed a health care system which was sustained through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care.

The net result has been a system which is highly fragmented, biased towards curative care and the private sector, inefficient and inequitable. Team work has not been emphasised, and the doctor has played a dominant role within the hierarchy. There has been little or no emphasis on health and its achievement and maintenance, but there has been great emphasis on medical care.

The challenge facing South Africans is to design a comprehensive programme to redress social and economic injustices, to eradicate poverty, reduce waste, increase efficiency and to promote greater control by communities and individuals over all aspects of their lives. In the health sector this will involve the complete transformation of the national health care delivery system and all relevant institutions. All legislation, organisations and institutions related to health have to be reviewed with a view to attaining the following:

ensuring that the emphasis is on health and not only on medical care.

redressing the harmful effects of apartheid health care services.

encouraging and developing comprehensive health care practises that are in line with international norms, ethics and standards.

emphasising that all health workers have an equally important role to play in the health system, and ensuring that team work is a central component of the health system.

recognising that the most important component of the health system is the community, and ensuring that mechanisms are created for effective community participation, involvement and control.

introducing management practises that are aimed at efficient and compassionate health care delivery.

ensuring respect for human rights, and accountability to the users of health facilities and the public at large.

reducing the burden and risk of disease affecting the health of all South Africans.

Recognising this need for total transformation of the health sector in South Africa, the African National Congress (ANC) initiated a process of developing an overall National Health Plan based on the Primary Health Care Approach. The first draft of this plan was prepared by a team consisting of members of the ANC Health Department and consultants appointed by the World Health Organization and UNICEF. It was based on documents prepared by the ANC Health Policy Commissions and others in the democratic movement, including a broad process of consultations and amendments.

The second draft was prepared by a similar team, following a national workshop called specifically to discuss and modify the first draft. The second draft was released for public debate and discussions in January 1994. Organisations, institutions and individuals were invited to present written submissions, and the response was enthusiastic and encouraging. The draft was amended accordingly, and the responses received served to strengthen the document considerably.

This document focuses on the health system, but it links with the Reconstruction and Development Programme which involves all other sectors. Health will therefore be viewed from a development perspective, as an integral part of the socio-economic development plan of South Africa.

No planning document can ever be called final: planning for any sector is a dynamic process that must be constantly evaluated and re-evaluated. It is essential that this process is ongoing,

to ensure that the vision for health is attained. This process will ensure the development of more detailed programmes in every sphere of health, and we will continue to adopt as inclusive an approach as possible.

Johannesburg, April 1994

## EXECUTIVE SUMMARY

The health of all South Africans will be secured mainly through the achievements of equitable social and economic development. The legacy of apartheid policies in South Africa has created large disparities between racial groups in terms of socio-economic status, occupation, education, housing and health. These policies have created a fragmented health system, which has resulted in inequitable access to health care. The inequities in health are reflected in the health status of the most vulnerable groups.

Every person has the right to achieve optimal health, and the ANC is committed to the promotion of health, using the Primary Health Care Approach as the underlying philosophy for restructuring the health system. Primary Health Care (PHC) will form an integral part, both of the country's health system, and of the overall social and economic development of the community. Central to the PHC approach is full community participation in the planning, provision, control and monitoring of services. Democratically elected representatives will play a major role in the structure of the health services.

Health problems have many and complex causes whose solution demands an intersectoral approach. Other sectors such as those providing clean water, sanitation, housing, etc. have a greater impact on health, than health services alone. The health sector has an important advocacy role to play and therefore mechanisms will be developed to ensure that intersectoral activity takes place.

The health sector and health services must increase awareness that a healthy population is necessary for social and economic development. International population trends recognise that development strategies which improve the quality of life of the population, contribute to the decline in fertility. Contraception is a necessary, but not sufficient factor in promoting fertility

decline. Population programmes must maximise the capacity for individuals to fully develop their potential for social stability and economic growth. The major aims will be improvements in women's legal, educational and employment status.

The state is responsible for creating the framework within which health is promoted and health care is delivered. It is also a major provider of services. A single comprehensive, equitable and integrated National Health System (NHS) will be created and legislated for. A single governmental structure will coordinate all aspects of both public and private health care delivery and all existing departments will be integrated. The provision of health care will be coordinated among local, district, provincial and national authorities. Authority over, responsibility for, and control over funds will be decentralised to the lowest level possible that is compatible with rational planning, administration, and the maintenance of good quality care. Rural health services will be made accessible with particular attention given to improving transport.

Within the health system, the health services provide the principal and most direct support to the communities. The foundation of the National Health System will be Community Health Centres (CHCs) providing comprehensive services including promotive, preventive, rehabilitative and curative care. Casualty and maternity services will be available as 24-hour services. Community health services will be part of a coordinated District Health System, which will be responsible for the management of all community health services in that district.

Each of the nine provinces will have a Provincial Health Authority responsible for coordinating the health system at this level. At the central level, the National Health Authority (NHA) will be responsible for policy formulation and strategic planning, as well as coordination of the planning and the functioning of the overall health system in the country. It will allocate the national health budget, and will develop guidelines, norms and standards to apply throughout the health system, to translate policy into relevant integrated programmes in health development.

Resources will be rationally and effectively used, and priority will be given to the most vulnerable groups, and to the eradication, prevention and control of major diseases.

Mechanisms that will integrate traditional and other complementary health practitioners will be investigated.

The right of all patients to be treated with respect and dignity will be upheld.

To this end, a Charter of Patients Rights will be introduced.

The emphasis on management support will focus on issues of coordination and integration, rational financial management, human resource management, and a comprehensive health information system. Efforts will be aimed at reforming organisational structures, strengthening support systems, improving skills of staff, and developing learning materials and guidelines.

The basis of funding will continue to be from general tax revenue. It is strongly recommended that health services receive a higher proportion of this revenue, which should be increased to at least 4% of GDP (at least 13% of government expenditure). Additional revenue can be derived immediately by increasing the excise on tobacco, which will have an added benefit of reducing consumption. Increased duties on alcohol may also be used to increase revenue, if further studies warrant this.

Free health care will be provided in the public sector for children under six, pregnant and nursing mothers, the elderly, the disabled and certain categories of the chronically ill. Preventive and promotive activities, school health services, antenatal and delivery services, contraceptive services, nutrition support, curative care for public health problems and community based care will also be provided free of charge in the public sector.

User fees for insured patients using public hospitals will be increased to ensure full cost recovery. Facilities will be allowed to retain a proportion of the revenue generated to improve the quality of service delivered.

Priority will be given to primary care facilities and personnel in rural and impoverished urban areas. The reallocation of resources will be coordinated by the NHA. Provinces which are underfunded relative to their needs, will be subsidised.

The state will play a more active role in encouraging efficiency and high quality care in both the public and private sectors. Mechanisms such as licensing and compulsory public service for graduates will be investigated. Capitation, rather than fee-for-service as a method of remuneration will be encouraged.

A Commission of Inquiry to look at the current crisis in the medical aid sector, and to consider alternatives such as a National Health Insurance, will be appointed.

Financial systems and techniques will be developed to ensure efficiency and effectiveness. Strategies that will be used include an effective resource allocation mechanism; the inclusion of financial plans in all plans and programmes; weighting of certain programmes; and performance budgeting systems.

The challenges of the transformation of the health system will require substantial training and reorientation of existing personnel, redistribution of present and future personnel and development of new categories of health personnel. To achieve this the human resources management and planning systems will be improved, the training programmes and selection procedures will be reviewed, and training programmes to re-orient existing personnel will be developed.

To facilitate redistribution of personnel, and effective human resource development, incentives and rewards for working in underserved areas will be offered; communities will be consulted on selection and recruitment; and effective labour relations will be promoted. In order to ensure the appropriate placement and utilisation of health personnel, epidemiological needs assessments will be carried out, and rotation through underserved areas and primary and secondary level facilities will be emphasised.

Health personnel education will be multi-disciplinary, gender sensitive, problem oriented and community-based in character. A number of fast-track training programmes will be introduced for categories of urgently needed personnel.

A Commission of Inquiry will be established to make recommendations on standard conditions of service and employment for all health workers in the public sector.

A comprehensive health information system that is relevant to local, provincial, and national levels will be established. The system will include indicators to monitor apartheid generated disparities in access to health care and health status, as well as a selected list of the indicators developed by the WHO Regional office for Africa.

Priority programmes have been developed, to provide targets for implementing changes to the current health system. All targets should be seen as goals for progressive improvements and depend on the differential needs at provincial and local levels. The principal priorities are maternal and child health, nutrition, the control of communicable diseases, and violence. Special attention will be given to vulnerable groups and this will include the development of programmes for women's health, occupational health, rural areas, mental health, chronic illness, rehabilitation, and the elderly. In addition, the health priorities will also include health promotion, drugs policy, emergency care, substance abuse, environmental health and oral health. A special emphasis in all health programmes and activities at all levels in the system will be given to health promotion.

Through these priorities and the Plan presented here, the ANC demonstrates its political will and commitment to effect change. Ultimately the most effective way to ensure change and transformation of the health system will be the passing of appropriate legislation to give effect to this political will and commitment.

#### ABBREVIATIONS

AIDS Acquired Immune Deficiency Syndrome

ANC African National Congress

CHC Community Health Centre

CHW Community Health Worker

DBSA Development Bank of Southern Africa

DHA District Health Authority

GDP Gross Domestic Product

GNP Gross National Product

HIV Human Immunodeficiency Virus

HRD Human Resource Development

IMR Infant Mortality Rate

MCH Maternal and Child Health

MLL Minimum Living Level

NGO Non-Government Organisation

NHA National Health Authority

NHI National Health Insurance

NHS National Health System

PHC Primary Health Care

PHA Provincial Health Authority

STD Sexually Transmitted Disease

TB Tuberculosis

UNICEF United Nations Children s Fund

WHO World Health Organization

1. A VISION FOR HEALTH IN SOUTH AFRICA

GUIDING PRINCIPLES

## HEALTH VISION

Equity Right to health PHC Approach National Health System Coordination and decentralisation  
Priorities Promotion of health Respect for all Health information system

## THE PRIMARY HEALTH CARE APPROACH

Political will Accountability and community participation Social and economic justice Changing  
the medical culture The best possible care

## INTERSECTORAL COLLABORATION

Other sectors affect health Health influences other sectors President and cabinet Other  
departments Health, the environment and development

## POPULATION POLICY AND HEALTH

### LINKAGES WITH SOCIAL WELFARE

### THE SOUTHERN AFRICA REGION

## 2. ANALYSIS OF EXISTING SITUATION

### DEMOGRAPHIC PROFILE

### SOCIO-ECONOMIC PROFILE

### HEALTH STATUS

### HEALTH RESOURCES

Fragmentation Hospital Beds Human Resources Financial Resources

### 3. HEALTH POLICIES

ACCIDENT, EMERGENCY AND RESCUE SERVICES APPROPRIATE HEALTH TECHNOLOGY CARE OF THE ELDERLY CONTROL OF COMMUNICABLE DISEASES DISASTER PREPAREDNESS AND HUMANITARIAN ACTION DRUGS POLICY ENVIRONMENTAL HEALTH HEALTH PROMOTION HIV/AIDS and STDs LABORATORY SERVICES MATERNAL AND CHILD HEALTH (MCH) MENTAL HEALTH NON-COMMUNICABLE DISEASES NUTRITION OCCUPATIONAL HEALTH ORAL HEALTH PALLIATIVE CARE REHABILITATION RESEARCH RURAL HEALTH TRADITIONAL PRACTITIONERS VIOLENCE WOMEN'S HEALTH

### 4. THE NATIONAL HEALTH SYSTEM (NHS)

#### COMMUNITY LEVEL

Intersectoral Community Development Committee Community Health Committee Community Health Centres Clinics and Health Posts

#### DISTRICT LEVEL

Intersectoral District Development Committee District Health Authority (DHA) Management Committee District Health Advisory Body Functions of the District Health Authority Health Care Support Services Administration and Finance Planning and Human Resources

#### PROVINCIAL LEVEL

Intersectoral Provincial Development Committee Provincial Health Authority (PHA)  
Management Committee Specialist Hospitals Provincial Health Advisory Body Functions of the  
Provincial Health Authority Health Care Support Services Administration and Finance Planning  
and Human Resources

#### NATIONAL LEVEL

Intersectoral National Development Committee National Health Authority National Health  
Advisory Body Functions of the National Health Authority Health Care Support Services  
Administration and Finance Planning and Human Resources

#### THE ROLE OF THE PRIVATE SECTOR AND INDEPENDENT PRACTITIONERS

The Independent Practitioner Cost Containment Private facilities and institutions Traditional  
and complementary healers

#### STATUTORY BODIES

#### THE ROLE OF NGOs INVOLVED IN HEALTH

#### THE ROLE OF INTERNATIONAL ORGANISATIONS

#### 5. MANAGEMENT SUPPORT SYSTEM

#### MANAGEMENT SUPPORT

## HEALTH CARE FINANCING

### Sources of finance

The allocation of resources for public sector health care

A National Health Insurance

Protecting the public sector

## FINANCIAL MANAGEMENT

## HUMAN RESOURCE DEVELOPMENT

Human resource development Staffing the Public Health Sector

## HEALTH INFORMATION SYSTEM

## 6. HEALTH PRIORITIES

### HEALTH POLICY PRIORITIES

### PRINCIPAL HEALTH PRIORITIES

Maternal and Child Health Nutrition Control of communicable diseases Violence Special programmes for vulnerable groups

### OTHER HEALTH PRIORITIES

## HEALTH SYSTEM PRIORITIES

FINANCING THE NHS HEALTH FACILITIES HUMAN RESOURCES MANAGING THE NHS  
EDUCATIONAL AND RESEARCH INSTITUTIONS

## LEGISLATION FOR THE NHS

## ACKNOWLEDGEMENTS

### 1. A VISION FOR HEALTH IN SOUTH AFRICA: GUIDING PRINCIPLES

#### HEALTH VISION

#### EQUITY

The health of all South Africans will be secured and improved mainly through the achievement of equitable social and economic development such as the level of employment, the standards of education, and the provision of housing, clean water, sanitation and electricity. In addition, reductions in the levels of violence and malnutrition, and promotion of healthy lifestyles should be addressed, as well as the provision of accessible health care services.

#### RIGHT TO HEALTH

Every person has the right to achieve optimal health, and it is the responsibility of the state to provide the conditions to achieve this. Health and health care, like other social services, and particularly where they serve women and children, must not be allowed to suffer as a result of foreign debt or structural adjustment programmes.

## PHC APPROACH

The ANC is committed to the promotion of health through prevention and education. The Primary Health Care Approach is the underlying philosophy for the restructuring of the health system. It embodies the concept of community development, and is based on full community participation in the planning, provision, control and monitoring of services. It aims to reduce inequalities in access to health services, especially in the rural areas and deprived communities.

## NATIONAL HEALTH SYSTEM

A single comprehensive, equitable and integrated National Health System (NHS) must be created. There will be a single governmental structure dealing with health, based on national guidelines, priorities and standards. It will coordinate all aspects of both public and private health care delivery, and will be accountable to the people of South Africa through democratic structures.

All existing public sector departments of health including local authority, homeland, military and prison services, will be integrated into the NHS. All racial, ethnic, tribal and gender discrimination will be eradicated. Both public and private providers have major contributions to make and will operate within a common framework that will encourage efficiency and high quality care.

## COORDINATION AND DECENTRALISATION

The provision of health care will be coordinated among local, district, provincial and national authorities. These will, as far as possible coincide with provincial and local government boundaries. Authority over, responsibility for, and control over funds will be decentralised to the lowest level possible that is compatible with rational planning and the maintenance of good quality care. Clinics, health centres and independent practitioners will be the main points of

first contact with the health system. Rural health services will be made accessible with particular attention given to improving transport.

## PRIORITIES

Health services will be planned and regulated to ensure that resources are rationally and effectively used, to make basic health care available to all South Africans, giving priority to the most vulnerable groups. Maternal and child care, the protection of the environment, services in the rural areas, women's health and the care of the disabled will be prioritised. Appropriate services to adolescents and to young adults will also be provided. In addition there will be a focus on the prevention and control of major risk factors and diseases, especially AIDS, tuberculosis, measles, gastro-intestinal disease, trauma, heart disease and common cancers.

## PROMOTION OF HEALTH

Attention will also be given to health education on sexuality, child spacing, oral health, substance abuse, environmental and occupational health.

Health workers at all levels will promote general health and encourage healthy lifestyles. The government will also seek to establish appropriate mechanisms that will lead to the integration of traditional and other complementary healers into the NHS.

## RESPECT FOR ALL

Within the health system health workers must respect the right of all people to be treated with dignity and respect. A Charter of Patients Rights will be introduced. Furthermore, individuals, interest groups and communities have the right to participate in the process of formulating and implementing health policy.

## HEALTH INFORMATION SYSTEM

Appropriate and reliable data will be systematically collected and analysed, as part of a comprehensive health information system essential for NHS planning and management purposes. It will also allow for promotion of relevant research to address the most important health problems of the community. The public and private sectors will be required to collect and submit relevant data in order to facilitate planning at local, provincial and national levels. The health information system of the NHS will thus gather universal, opportune, reliable, simple and action oriented types of data to inform the entire system and increase its effectiveness.

## THE PRIMARY HEALTH CARE APPROACH

The new Government must follow the Primary Health Care (PHC) approach to the delivery of health services. Within the PHC approach, PHC itself is central and was defined in the Declaration of Alma Ata as: "Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination". PHC will form an integral part of the country's National Health System, of which it will be the central focus, while the PHC approach will guide the overall social and economic development of the community.

## POLITICAL WILL

The PHC approach requires political will on the part of the government, and commitment from communities, health and allied workers, health policy makers, health service managers and the broad range of health-related sectors (education, sanitation, water supply, electrification, finance, agriculture, small business development etc.). The government will formulate national policies, strategies and plans of action to launch and sustain PHC as part of the comprehensive National Health System and in coordination with other sectors.

## ACCOUNTABILITY AND COMMUNITY PARTICIPATION

An important principle in the primary health care approach is accountability to community structures at local, district, provincial and national levels. Democratically elected representatives will be involved in the appointment of staff and the control of budgets. This is seen as an important mechanism for increasing local control and responsibility over health matters. However, control over the executive functions in the health care system is not the same as community participation. Effective community participation as envisaged in the PHC approach means that democratically elected community structures, integrated with representatives of the different sectors and stake-holders involved in health and community development, have the power to decide on health issues. Community participation is an essential element that the NHS must develop at a local level in order to be fully effective, and is not an entity that can be prescribed and legislated into being.

## SOCIAL AND ECONOMIC JUSTICE

The introduction of PHC requires a thorough understanding of its various aspects. Indeed, there are philosophical, sociological, economic, political, technical and strategic considerations which cover a wide range of issues, all of vital importance for the operations of the NHS to become effective. The fundamental principle is that of social and economic justice. This understanding is essential for health providers and for the population at large, and also for other sectors in government, NGOs, trade unions and community organisations.

## CHANGING THE MEDICAL CULTURE

PHC is not just a cheaper, simpler approach to the delivery of health care, nor is it simply basic health interventions. It is a concept which is changing the medical culture. Previously this was centred around health professionals, where the community - the "patients" - were the passive recipients of health services and the doctors and health professionals alone were the dispensers of health. The change will inevitably bring about some radical transformations, not only of the health services and of the training and research institutions, but also of the attitudes

of both health providers and those demanding health care services. These transformations will pose a tremendous challenge to the NHS, to the government and to society as a whole.

#### THE BEST POSSIBLE CARE

In essence, PHC offers the only viable alternative for sustainable and equitable health development. The key to health for all South Africans is a national development strategy that incorporates PHC. With its concern for equity in health care, using available appropriate resources, PHC is the best possible form of health care for everyone, rich and poor alike, in any society.

#### INTERSECTORAL COLLABORATION

Health problems have many and complex causes whose solution demands an intersectoral approach. The health sector has an important advocacy role in ensuring that policies, programmes and plans in other sectors take account of health. Promoting health requires far more than improving medical services. This is particularly obvious in South Africa, where decades of apartheid have led to grossly inferior education, employment opportunities, housing, income, and environmental conditions. All of these play a significant part in undermining the health status of the majority of the population.

Although it is important to improve access to health services, it should also be recognised that this will have a limited impact on reducing the gross discrepancies in health status which exist. An intersectoral approach is necessary if the extensive role of other interventions in health promotion is to be recognised and promoted. In the past little recognition has been given to the detrimental effects of a variety of social and economic activities on health.

#### OTHER SECTORS AFFECT HEALTH

Agricultural policy will influence food availability and price, nutrition, and tobacco smoking. Development activities such as the building of dams, deforestation and the construction of

roads may have adverse health consequences. Economic activity aimed at encouraging investment may fail to ensure that safety at work is adequately protected or that child-care facilities are provided to allow women to have equal access to employment. Policies on migrant labour may have an adverse impact on sexually transmitted diseases and HIV/AIDS unless recognition is given to promoting sexual health. Similarly, education policy heavily influences health. Female education is of crucial importance and health related topics can often be used in the teaching of many subjects. Alcohol policy has an impact on the incidence of trauma, and on mental health, especially in relation to violence within communities and families. Building and town planning regulations, and the degree to which they are enforced, profoundly affect the degree to which people with disabilities are able to function normally in society.

## HEALTH INFLUENCES OTHER SECTORS

Health also influences other sectors. Good health is required if the skills creativity and productive abilities of our people are to be maximised. A healthy and secure community is much more likely to be able to play a positive role in development. A population which is poorly nourished, unwell, in pain, requiring treatment, or psychologically stressed is unlikely to be able to make a positive contribution to the wellbeing of the community at large. The health sector, and health services, must increase awareness that a healthy population is necessary for meeting basic needs as well as for appropriate development on a large scale.

Over the past decades, in many other countries, policies promoting primary health care, safer communities, healthy cities, and 'health for all' have embraced an intersectoral approach. South Africa has relatively little experience of working within such a framework, due to the historical division between government and the people. Developing appropriate methods of cooperation will require a process of establishing trust and working together with representative structures at all levels.

Different methods will need to be employed at different levels of government to ensure intersectoral collaboration, accountability and participation.

## PRESIDENT AND CABINET

The President and the Cabinet must take the major responsibility for ensuring that the different sectors work together to achieve the goals of the Reconstruction and Development Programme, including the promotion of health. The Secretary for Health must ensure that mechanisms for improving communication, integration and collaboration between different health sector activities are promoted and evaluated. She or he must also ensure that other departments understand and take into account the likely positive and negative consequences for health of actions or policies in their own sectors.

## OTHER DEPARTMENTS

The Education authorities in particular must ensure that there is a rapid increase in literacy and must implement specific programmes in schools on sexuality, on healthy nutrition, on diseases of lifestyle and on general health promotion. Those responsible for drafting legislation must take responsibility for ensuring that intersectoral consultation has taken place before any legislation is presented to parliament. The economic departments must take responsibility for the evaluation of health impacts, including environmental impacts, of trade, industry and other economic policies. The police and prison authorities must recognise their potentials for promoting health as well as the negative impacts of their work on health.

Training of health workers must give recognition to the role of other sectors in the promotion of health. Training of development workers and development study programmes should emphasise the potential positive and negative effects of development on health, and of health on development.

Such an approach can be used to ensure proper housing, water and sanitation facilities, to maintain a clean environment, to encourage the development of community facilities such as creches, pre-schools, youth centres and recreation centres, facilities for senior citizens, and to help control criminal activity. All this will lead to very much better mental, physical and social health for the whole population and will facilitate a shift in emphasis from disease and illness to health.

## HEALTH, THE ENVIRONMENT AND DEVELOPMENT

Special attention will be given by the government to the interaction between health, the environment and overall development, in line with the recommendations of the Earth Summit (Rio, 1992), and more specifically with Agenda 21. The goal of environmental strategies for health, as set out in Principle 1 of the Rio Declaration on Environment and Development, is the recognition that human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature.

Attaining this goal of healthy people in a healthy environment requires far more than the application of medical technology or even the total efforts of the health sector working alone. The government will integrate efforts by all sectors, organisations and individuals to make socioeconomic development sustainable and humane, ensuring a sound environmental basis for health. Within such cooperative efforts, health workers have leadership, advisory, and support functions to perform. These functions will be adequately addressed within the NHS to allow for the effective promotion of this multi-disciplinary concept.

## POPULATION POLICY AND HEALTH

The South African population is growing rapidly in spite of the decline in urban fertility rates in recent years. The annual growth rate is 2.5% (1990) with the African population showing the highest growth rate. This must be seen in the context of gross maldistribution and underutilisation of the country's resources.

International population trends recognise that development strategies which improve the quality of life of the population contribute significantly to the decline in fertility. The development of population programmes to maximise the capacity for individuals to fully develop their potential for social stability and economic growth is required. Improvement in women's legal, educational and employment status will help to reduce the rates of infant mortality, maternal mortality and morbidity, and teenage pregnancy.

Contraception is a necessary but not sufficient factor in promoting fertility decline. Moreover, contraception should not be provided independently of broader reproductive health care

within a comprehensive primary health care system. The population policy should promote reproductive freedom of choice and women's right to control their bodies. It should also recognise the human rights of individuals and couples freely and responsibly to decide the number and spacing of their children, and to have the information, education and means to do so.

The increasing numbers of the South African population, the shifting geographical distribution and the patterns of internal and international migration, all call for clear economic and social policies to help achieve a balanced development process which will redress some of the inequalities caused by apartheid.

#### LINKAGES WITH SOCIAL WELFARE

Social welfare, of all the sectors related to health, forms the closest links. Health is defined as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity". Social welfare therefore has a major role to play in improving health status.

An important area of activity for social welfare is the organisation and administration of a social security net. There are also a number of areas of overlap between social welfare and health, such as violence, alcoholism care of the elderly, and services for people with disabilities. Historically, however, health and social welfare departments have tended to work independently. Urgent attention needs to be given to the development of mechanisms to ensure that there are active linkages between health and welfare. One alternative is to combine health and welfare as one department. The danger of this approach is that welfare could be subsumed or dominated by the medical aspects of health. Another alternative is to have separate departments but to have active cooperation between health and welfare especially in areas of common programmes. These and other alternatives need to be discussed with relevant social welfare organisations and departments.

#### THE SOUTHERN AFRICA REGION

As has been pointed out in the Reconstruction and Development Programme published by the ANC, sustainable reconstruction and development in South Africa requires sustainable reconstruction and development in Southern Africa as a whole. Otherwise, the region will face

continued high unemployment and underemployment, leading to labour migration and brain drain to the more industrialised areas. The democratic government must negotiate with neighbouring countries to forge an equitable and mutually beneficial programme of increasing cooperation, coordination and integration appropriate to the conditions of the region. In the health sector, South Africa has a great deal to learn from other countries in the region, particularly about the implementation of primary health care policies and programmes. South Africa can also contribute significantly to health and health care in the region. Sound economic and development policies, technical cooperation and support, and greater access to high technology training facilities and to tertiary care in South Africa, can all benefit the whole region.

## 2. ANALYSIS OF EXISTING SITUATION

The legacy of apartheid policies in South Africa has created large disparities between racial groups in terms of socio-economic status, occupation, education, housing and health. These policies have created a fragmented health system, which has resulted in inequitable access to health care. The inequities in health are reflected in the health status of the most vulnerable groups.

Good quality data on population needs, on local communities, and particular sub-groups are essential for rational planning and evaluation of services. Unfortunately, available data are often inadequate, unreliable, or incomplete. The data used here are taken from the best available, and a very wide variety, of sources.

The South African government has created in its legislation artificial classifications of people into African, Coloured, Indian, and White. It is necessary to use this classification as it highlights the disparities in health status and conditions, as data have been collected according to this, and not according to social class as is customary in other countries. Use of this terminology does not imply its acceptance or legitimacy. In order to separate out the disparities between Whites and the other groups, the term "Black" is used to mean African, Coloured, and Indian groups combined.

## DEMOGRAPHIC PROFILE

South Africa's population for 1991 was 37.7 million but is projected to be 47 million by the year 2000. The growth rate of the African population is 2.7% per annum, compared with 0.7% in the White population. The annual average population growth rate for 1980-1991 was 2.5 percent and is projected to be 2.2 percent for 1991-2000.

Africans comprise 75% of the total population, Whites 13%, Coloureds 9%, and Indians 3%. The White population group is 90% urbanised, compared to only 50% among Africans, although there is rapid urbanisation in the latter group.

In 1991, 36% of the population were children between the ages of 0 and 14 years, while approximately 46% of the population were under the age of 19 years. It is estimated that children under the age of 4 years form 13% of the total population. The proportion of females in the South African population is 52.7%, with a higher proportion in the rural areas.

Historic population growth rates and 1988 projections in percent per annum

Year	African	Coloured	Indian	White	Total
1980	2.98	2.06	2.00	1.41	2.54
1985	3.00	1.94	1.89	1.41	2.66
1990*	2.96	1.87	1.72	0.58-0.76	2.50
1995*	2.88	1.68	1.48	0.58-0.76	2.44
2000*	2.79	1.41	1.28	0.58-0.76	2.36
2005*	2.70	1.16	0.97	0.58-0.76	2.28

\* Population projections

## Percentage distribution of population in 1990

	Urban	Rural	Total
African	49.5	50.5	100
Coloured	83.8	16.2	100
Indian	95.7	4.3	100
White	92.4	7.6	100
RSA	59.0	41.0	100

## SOCIO-ECONOMIC PROFILE

The average annual growth rate of the GDP in the period 1970-1980 was 3%, compared with a declining figure of 1.3% for 1980-1991. The average annual rate of inflation was 13.0 and 14.4 percent in these periods respectively.

Africans comprise 95% of the 18 million people in South Africa currently existing below the accepted "minimum living level" (MLL) of R 750 per month per household, with 60% of this group living in total poverty. Although the African population is in the majority, it is estimated that they receive only 27% of the total income. It is estimated that between 8 and 9 million of this population group are destitute, relying on social grants and support schemes. Approximately 64% of the economically active population are Blacks, but they occupy only 15% of the professional, semiprofessional, technical, managerial and executive positions. Black people perform largely unskilled work, and unemployment rates are high. Illiteracy is a major problem and it is estimated that three million adults in South Africa are functionally illiterate.

## Percentage population below minimum living level in 1989

Urban Rural

## Total

African	31.9	68.3	52.7	
Coloured		23.2	45.0	28.1
Indian	8.3	45.0	10.7	
White	1.5	2.0	1.6	
RSA excl TBVC	21.1	63.3	40.1	
TBVC homelands				65.1
Overall			44.8	

The urban housing backlog in 1990 was conservatively estimated at 1,3 million units. If hostels and rural areas are included, the backlog rises to approximately 3 million units, of which approximately 90% are needed by African households. It was estimated that up to 7 million people lived in informal settlements in the urban areas in 1991. Gross overcrowding and unacceptable sanitary conditions are prevalent amongst the majority of Blacks in the urban and peri-urban areas.

The Development Bank of South Africa (DBSA) estimates that of the 22 million urban population, 62% have waterborne sewage systems, 33% have minimal sewage facilities and 5% have bucket systems, ventilated improved latrines (VIP) or aquatrines. However, local surveys suggest that in many communities, particularly in informal settlements, large numbers of people have no access at all to sanitation facilities. Of the 16 million rural population, rough estimates indicate that 53% have a safe and accessible water supply and 14% have access to adequate sanitation defined as either a VIP or a flush latrine. Sixty five percent of the South African population has no electricity.

## Percentage Africans supplied with electricity by area

Metro formal

Urban 36

Metro informal 20

Rural 11

## HEALTH STATUS

Infectious and parasitic diseases cause 14% of deaths amongst Black people, but only 2% of deaths among Whites. Cardiovascular diseases, on the other hand cause 12% of deaths among Blacks (4 million), but 40% of deaths among Whites (2 million). Mortality and morbidity are strongly related to poor environmental and socio-economic circumstances as well as to lifestyle. Chronic disease is emerging as an increasing problem in all population groups.

There is no compulsory registration of births and deaths for Africans and the data on Infant Mortality Rates (IMR) are variable and unreliable. In 1991 the infant mortality rate was 54 per 1,000 live births. For Black children the IMR was between 94 and 124. The major causes of death are infectious diseases, especially intestinal infection, and respiratory diseases. These figures have been computed from registered deaths, but the estimated deaths are higher, especially in the rural areas.

The maternal mortality rate in 1989 was 8 per 100,000 for Whites and more than 58 per 100,000 for Africans. In 1991 life expectancy was 63 years. The life expectancy at birth for Whites is 9 years more than that for Blacks, as an increase in life expectancy is influenced by a decrease in IMR.

### Infant Mortality Rate in rural areas of the homelands of South Africa

Period	Area	IMR/1,000
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1973-80	Transkei	130.0
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1982	Gelukspan, Bophuthatswana	38.5
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1973-82	Naphuno, Lebowa	51.0
1982-83	Donald Fraser, Venda	36.0
1981-86	Hewu, Ciskei	41.0
1976-88	Elim, Gazankulu	88.0

Maternal mortality rate per 100,000 in South Africa in 1989

Africans	58
Coloureds	22
Indians	8
Whites	5

In 1989, 2.3 million people were considered to be in need of nutritional assistance. Of these, 92% were children below the age of twelve years, and 8% were pregnant and lactating women.

Tuberculosis is by far the most frequently occurring notifiable disease. The annual case load increased by 4% between 1987 and 1988. In 1988 the prevalence rate was 489 per 100,000 population, with the Western Cape having the highest rates in the country. The incidence in 1990 was 229 per 100,000.

Tuberculosis case load in 1988, in thousands of cases

Africans	66
Coloureds	30
Indians	1
Whites	1

In 1989, the measles notification rate per 100,000 population was 43.1 for Africans and 3.8 for Whites. Vaccination coverage varies between the different population groups and geographical areas.

Violence has become one of the most important causes of morbidity, disability and mortality. The non-natural causes of fatalities in South Africa are three times higher than the WHO estimate for the world. It is estimated that violence caused more than 2,000 deaths per month in 1993, and caused many other people to become disabled. Less than 15% of these deaths were politically related. Mortality, morbidity and disability from motor vehicle accidents is also increasing, much of it related to alcohol abuse, with many victims being pedestrians.

Studies estimate that 5 million people in South Africa suffer from mental illness and 150,000 attempt suicide each year.

HIV/AIDS is emerging as a major public health problem, with over 2,000 reported cases at the end of 1993, and 500,000 people infected with HIV. Forecasts to the year 2000 predict that there will be between 4 and 7 million HIV-positive cases, with about 60% of total deaths due to AIDS, if HIV prevention and control measures remain unaddressed. Similarly, credible predictions indicate that by the year 2005, between 18% and 24% of the adult population will be infected with HIV, that the cumulative death toll will be 2.3 million, and that there will be about 1.5 million AIDS orphans.

## HEALTH RESOURCES

## FRAGMENTATION

The public sector health-care system in South Africa is highly fragmented. At the central level there were nominally four departments of health, one for each racial group. In 1993, with rationalisation, these departments were combined into one. In addition, each of the ten homelands has its own department of health. At present there are eleven departments of health.

The provincial administrations of the four provinces are the second tier of government, responsible for hospital services, ambulances and outpatient services. There are almost 800 local authorities which form the third tier of the health-care system. They are responsible largely for environmental services, public health and promotive and preventive health care services.

There is also a strong but fragmented private sector which includes health professionals in private practice, private hospitals, pharmaceutical manufacturers and distributors, medical aid schemes, and others.

## HOSPITAL BEDS

In 1988 there were 693 hospitals in South Africa, and 158,567 hospital beds (public and private), of which 28% were in the private sector. About a quarter of private sector beds are in "fee-for-service" hospitals. There has been a rapid growth in fee-for-service hospitals in recent years, with a 61% increase in the number of these beds between 1983 and 1990. Ninety-four percent of fee-for-service hospital beds are in the urban areas.

The 1988 data showed that there were, overall, 4.4 beds per 1,000 population in South Africa. However, homelands have only 2.7 beds per 1,000 population, and the non-metropolitan areas have 4.0 beds per 1,000 population, compared with 7.1 per 1,000 in the metropolitan areas. There are 1.9 tertiary beds per 1,000 population, compared with 1.5 general acute beds per 1,000 population. There is, therefore, a relative undersupply of acute general beds.

Hospital bed occupancy rates average 75%, but public hospitals in homelands and black urban hospitals often show occupancy rates above 100%.

There are similar disparities in the distribution of laboratory services and pharmacies.

There are 2,218 health care clinics in the public sector in South Africa, and an average of 16,190 people per clinic. If the recommended WHO ratio of 10,000 people per clinic is used as a guideline, the shortfall in the number of clinics needed in 1988 was 1,373. Using population figures to the year 2000, the shortfall to that year will be 2,541.

## HUMAN RESOURCES

In 1990 there were 22,260 medical doctors registered in South Africa out of whom 6,087 had a registered medical speciality. The ratio of doctors to population in the metropolitan areas is approximately 1:700, compared to 1:1,900 in non-metropolitan areas. In the homelands it is estimated that there are between 10,000 to 30,000 people per doctor. In 1980, 48% of doctors worked in the private sector. By 1989, this proportion had increased to 58%. Seventy-seven per-cent of doctors reside in metropolitan areas and female doctors comprise about one third of total doctors; however there are few African female doctors.

In 1988 there were 3,581 dentists registered, with over 93% working in the private sector; there were 1,130 clinical psychologists with 92% in the private sector; and 8,311 pharmacists with the majority in the private sector.

Out of 109,236 qualified nursing professionals in 1990, 48% were African, 35% White, 2% Asian and 15% Coloured. In 1990, about 21% of these nurses were employed in private hospitals, compared with 17% in 1987.

It has been estimated that there are approximately 350,000 traditional healers in South Africa. mainly in the rural areas.

These figures reflect a number of prominent problems in human resources development that need to be addressed, some of which are:

the over-concentration of health personnel in urban areas, in sophisticated curative settings and in the private sector.

the under-provision in rural and peri-urban areas, in informal settlements, and in clinics, health centres and community and secondary hospitals.

the emigration of highly trained personnel.

insufficient personnel with the necessary training or skills to manage change in accordance with the PHC approach.

insufficient or inappropriately trained staff in fields such as environmental health, health education and promotion, advocacy and management.

## FINANCIAL RESOURCES

The health care services at present are geared to the needs of a minority of the population. Health care in South Africa is sharply divided between the private sector, for those who can afford to pay and/or who belong to medical aid schemes, and the public sector for the indigent.

Approximately R21.6 billion is currently spent on health services in South Africa (between 6 - 6.5% of GNP). Within the public sector, there is a maldistribution of financial resources, with provinces having higher per capita expenditure than the homelands, and higher expenditure for tertiary care than primary care. Financial resources are evenly divided between the public and private sectors, with 50% of the total overall health care expenditure attributable to the 20% of the population who are members of a medical scheme. This excludes private expenditures on traditional healers, and out-of-pocket payments.

As at the 1990/91 financial year, the State Government allocated 11.7% of the budget to health care which was not a significant change from the 11.2% allocated in 1985. Public sector health expenditure has been declining in real per capita terms over the past few years. For example, estimated real per capita expenditure by the provincial administrations had decreased to R182 in 1992/93 from a peak of R276 in 1988/89. The provincial administrations, which are largely responsible for hospital-based care, account for more than two-thirds of total public sector health expenditure. Of this, 43% is directed to academic hospitals; approximately 30% of total public sector expenditure is devoted to these hospitals. In contrast, the local authorities, which

are largely responsible for promotive and preventive services, account for approximately 4% of total public sector health expenditure.

Within the ten homelands, where 44% of the total South African population lives, only 19% of the National Health Budget was allocated in 1990/91. In 1993 the ANC initiated, in conjunction with the World Bank, a Health Expenditure Review, because of the poor quality or complete lack of data on health expenditure in South Africa, especially in the homelands and in the private sector. The work of this group will be completed during 1994.

### 3. HEALTH POLICIES

This chapter details the main principles of the ANC policies for a variety of areas, and the mechanisms through which it is felt those policies may best be implemented. Each area is the subject of separate, more extensive documentation, which gives greater operational details. The areas are listed below in alphabetical order. Priorities for implementation of these various policies appear in Chapter 6. Whereas the policies are listed here in the manner given, this is not to be construed that they are viewed as vertical programmes: rather, programmes will be developed such that they are implemented at all levels in an integrated manner as part of the comprehensive services rendered by the total health team.

It should also be emphasised that promotion and protection of health constitutes a major component of each and every health activity, as envisaged in this plan, which is committed to healthy living and healthy life style rather than curative care as the main thrust. To redress the imbalance of the inherited health status from the apartheid period, curative, palliative and rehabilitative measures will be supported by promotion and prevention measures in the health services.

#### ACCIDENT, EMERGENCY AND RESCUE SERVICES

Many accidents and emergency situations can be prevented, and a major element of health policy will be the promotion of accident prevention. This will include interaction with almost every other sector and with the broad public to build a society in which accidents are less frequent and less serious. This section of the National Health Plan deals with services that will be available throughout the country at all times. Planning and preparedness to render

humanitarian assistance in disaster situations is a separate subject and is dealt with later in this chapter.

Accident, emergency and rescue services are very visible and their existence creates a sense of security. Conversely the lack of access to such services in most communities in South Africa causes many people great anxiety and leads to deaths and disabilities that are preventable. Such services can and must be provided in South Africa within a primary health care budget.

The principal tenets of the policy on emergency services include the following:

#### TENETS

All communities must have access to emergency services.

All victims of accidents or emergencies must be treated as medically indicated, including transport to a higher level of facility if necessary, whether or not they are able to pay for the services at the time.

#### MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Each District Health Authority must ensure that all communities within its district have access to such services.

In many rural areas access to emergency services will involve a member of staff, trained in basic emergency care, sleeping at or near the clinic at night and available to provide emergency care and to summon emergency transport as necessary.

Staff at clinics and health centres must develop increased skills in emergency care and must have appropriate equipment and telephones or other reliable forms of communicating with Crisis Control Centres and colleagues in local hospitals.

Appropriate training and equipment will also be important in increasing the number of patients who can be treated locally, in increasing the confidence of the community and in reducing the numbers, costs and risks of referrals. Greater use will also be made of the services of members of voluntary organisations.

Crisis Control Centres must be set up to receive telephone calls, to evaluate the seriousness of the emergency and to despatch a response vehicle as appropriate. Several districts, or a whole province, may share a single Crisis Control Centre.

Depending on the district, the nature of the emergency and the availability of vehicles, the response vehicle may be a motorcycle, a car, a taxi, an ambulance or a helicopter. Ideally, every response vehicle should be equipped with a two-way radio or a cellular telephone for further communication but this may not, at first, be feasible. Where air transport is needed and is cost effective, it will be dispatched by the control centre under previously made arrangements either with the S A Airforce or with commercial interests.

Staff in the response vehicles may be full time or volunteer health workers but they must all have skills in basic (or advanced) emergency care. Ambulance colleges will continue to play a major role in training people in these skills.

Clear protocols must be developed, whether at district, provincial or national level, to guide all staff dealing with emergencies on appropriate referral. Those charged with drawing up and evaluating these protocols will include both medical consultants and those who staff response vehicles.

#### APPROPRIATE HEALTH TECHNOLOGY

An important factor for the success of Primary Health Care is the appropriate use of health technology, by which is meant the association of methods, techniques and equipment which, together with the people using them, can contribute significantly to solving health problems. This includes the use and adaptation of highly sophisticated technology.

However, it is necessary to be aware that there is often pressure from the affluent elite to acquire expensive diagnostic and/or therapeutic technology whilst ignoring the role that a destructive lifestyle may have played in creating the need for that technology.

#### TENETS

The principal tenets of the policy on appropriate health technology include the following:

Technology should be not only scientifically sound but also acceptable to those who apply it and to those for whom it is used. Accordingly, it must be easily understood and applied by community health workers and even by individuals in the communities.

Identification and development of appropriate technology has to be considered in close relationship with strategies for PHC. Efforts will be made to promote locally manufactured equipment, particularly with the use of local materials.

Control of allocations of specialised equipment at all levels will be compatible with decentralised decision-making processes, and based on needs, availability of local expertise, effectiveness, affordability, quality and assurance of adequate maintenance of the equipment.

Equipment purchased, particularly expensive technology, should benefit the entire population and not be used only for a small minority.

#### MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Establishment of a National Commission of Health Technology. It will include representatives of stakeholders from all levels of the NHS, to maintain an appropriate and rational policy and to administer a system of quality control and regulation of importation of expensive technologies. This could include drawing up a national essential technology list.

Training schemes appropriate for the various health cadres will be formulated, in collaboration with clinical and laboratory services, to secure adequate use and maintenance of equipment at all levels of the NHS.

Linkages with academic and research institutions will be established to coordinate the development of new technology and technological procedures, particularly their cost-effectiveness and social implications.

Specialised equipment and technologies are viewed as national resources whether in the public or private sector and mechanisms for their equitable and effective use will be established.

## CARE OF THE ELDERLY

The elderly, like other vulnerable groups, have been neglected by an uncaring apartheid society. Elderly Africans, particularly those living in rural areas, have suffered even more than the rest of the elderly. Furthermore, as South Africa undergoes the demographic transition experienced by most developing countries, the numbers of elderly people are likely to increase significantly. The NHS will have to provide quality health care to many more elderly people.

## TENETS

The principal tenets of the policy on elderly people include the following:

Elderly people have the same right to optimal health as any other group in society.

The NHS has the responsibility to provide the conditions to enable the elderly to maintain or achieve good health.

Elderly patients must be treated at all times respect and dignity.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

All CHCs will be required to develop or expand their services to make reasonable provision for the needs of the elderly. Particular attention will be given to the development of outreach and home care services.

Educational programmes will be developed to give present and future health workers a better understanding of the needs of the elderly and of their potential for health.

Other education programmes will be developed for the elderly and for those about to retire, to encourage healthy lifestyles, to promote safety (especially at home), and to assist them to contain the costs of these programmes.

## CONTROL OF COMMUNICABLE DISEASES

Communicable diseases, both among adult and childhood populations, are one of the main causes of morbidity and mortality in South Africa. Tuberculosis alone is the most frequently occurring notifiable disease and a complex public health problem which continues to deteriorate. Measles and gastrointestinal diseases among children still carry high prevalence and case fatality rates. Hepatitis B, acute respiratory infections, STDs and malaria are also cause for great concern because of their high prevalence.

## TENETS

The principal tenets of the policy on communicable diseases include the following:

Promotion of a multisectoral approach to ensure that the determinants of communicable diseases - lack of the provision of clean water and sanitation, adequate housing, food security, among others - are dealt with in a comprehensive manner.

Social and educational upliftment of underserved sectors of the population through improvement of their basic living conditions.

Integration of individuals and families into community-based prevention and control activities.

Fostering continued epidemiological analysis of reliable, opportune and comprehensive data for planning and management of various control programmes.

Setting up of adequate mechanisms for prompt and effective epidemic control at all levels of the NHS.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Regulations will be established and enforced to secure inputs from various sectors responsible for health determinants: water, sanitation, food availability, housing, transport, communications, education, among others.

Immunisation programmes will be strengthened to improve their coverage, to control spread of the various diseases and to reduce epidemic outbreaks, including immunisation against Hepatitis B.

Reinforcement of vector control activities through adequate multisectoral approaches.

Strategies to control tuberculosis through methods such as improved diagnosis, treatment management, compliance, and effective follow-up.

Community education campaigns will be reinforced through community health centres, on a continual basis (e.g. measles, tuberculosis) and on a seasonal basis (e.g. malaria, diarrhoeal diseases), as appropriate.

Special attention will be given to cost-effective treatment and control methods of some infectious diseases (diarrhoea, acute respiratory infections), with a strong involvement of families/communities.

Increased provision of comprehensive services for high-risk and vulnerable groups through the primary health care network.

Coordination of public sector activities with NGOs, the private sector and interested parties at national, provincial and district levels.

Strengthening of Epidemiological Units at provincial and national levels, through the production and deployment of qualified health personnel, and the appropriate allocation of necessary resources to ensure both continued epidemiological work and surveillance.

Promotion of research studies on clinical (diagnostic/treatment), and epidemiological aspects of communicable diseases to facilitate their management and control.

Coordination with social welfare to secure appropriate arrangements in cases of diseases subject to compensation (eg. tuberculosis among miners).

International and regional technical cooperation in public health measures to prevent the spread of disease.

Increased attention to food hygiene and safety.

**DISASTER PREPAREDNESS AND HUMANITARIAN ACTION**

Different types of emergency situations occur when various kinds of disaster strike. Such disasters include drought, floods, earthquakes, cyclones, socio-political conflicts, epidemics, industrial accidents, etc., which comprise a combination of human and natural causes.

Every disaster has its own special features. Some can be foreseen hours and even days beforehand, but most occur without warning. Whatever the type of disaster, for some hours the communities and local health personnel have only themselves to rely on before outside assistance arrives.

## TENETS

The principal tenets of the policy on disaster preparedness and humanitarian action include the following:

Ensuring community disaster preparedness at local level to prevent and mitigate the consequences of disasters.

Training of community members and health personnel in rescue work and emergency care during disasters.

Mobilisation of local, national and international resources to support and accelerate rehabilitation of disaster victims.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Establishment at various levels, of multidisciplinary and intersectoral disaster management committees responsible for coordination during disasters.

Establishment of an information system for emergencies, including early warning systems and the production of profiles containing risk identification.

Preparation of relief operations at community level, including an inventory of resources, depending on the type of disaster.

Development of written plans at national and provincial levels, coordinated by the Ministry of Health, for the rapid mobilisation of both state and NGO resources (including military resources) to provide coordinated assistance in any disaster situation.

## DRUGS POLICY

A written drug policy entrenched in legislation to ensure its regulation is urgently required. It is necessary to ensure that all people in the country are rationally treated with the necessary drugs and vaccines, to enable their protection and cure from common diseases. The National Drug Policy (NDP) will incorporate strategies for the effective application of drugs within the framework of the NHS. The promotive, preventive and rehabilitative aspects of health care will receive proper emphasis and will not be made subservient to the curative aspect, with its reliance on the use of drugs. A broad approach to cost containment will be taken to ensure overall cost-effectiveness.

## TENETS

The principal tenets of the drug policy include the following:

A registration process to ensure the safety, high quality and efficacy of drugs. At registration, the cost-effectiveness of the drug will influence its initial price. Complete registration will depend on agreement being reached on this initial price.

Encouraging the prescribing of medicines by generic name in both the public and private sectors.

Encouraging the extension of the present system of generic substitution of branded products to the private sector, unless specified otherwise on the prescription.

An Essential Drug List in the public sector.

Increased use of therapeutic protocols.

The procurement of drugs by the government at the best possible prices for the country's public sector.

Adequate and timely distribution of drugs.

The rational use of drugs.

Promotion of the local drug industry.

Capacity building to promote, enforce and monitor all aspects of the National Drug Policy including drug information services and other educational aspects.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Only drugs (including those currently registered) shown by analysis to be safe and of acceptable quality and efficacy will be marketed. Prices of new and old drugs will be set and will be subject to review after discussions between the government, the registering body, the pharmaceutical industry and other industries. Cost-effectiveness motivations will be required when new drugs are submitted for first registration. Good clinical practice and laboratory practice for clinical trials will be developed and monitored.

The setting of maximum prices will be investigated.

A special committee will investigate the safety and potential benefit of traditional drugs.

A system of procurement will be sought to ensure that the best possible prices are attained in the public sector. Non-discriminatory pricing mechanisms will be implemented for all purchasers in the private sector.

Parallel importation by the government will be an option to be used only if necessary to drive down prices of locally based suppliers.

A broad coordinated approach to cost-containment will be adopted.

All distributors, private and public, and including parastatal or semi-independent organisations such as the blood and blood product suppliers, will be drawn into the distribution of drugs nationally.

Actions will be taken to ensure that the income and reimbursements of health workers will not in any way depend on the type and quantity of medication prescribed.

A strong local pharmaceutical and chemical industry will be encouraged, and comprehensive research will be conducted to assess this industry's long term value to the country and the Southern Africa region.

All health professionals and health workers will be suitably educated and trained to enable them to promote the appropriate and rational use of drugs.

## ENVIRONMENTAL HEALTH

Environmental Health services will identify all potential threats to human health in the environment in order to define effective control mechanisms.

## TENETS

The principal tenets of the policy on environmental health include the following:

Equitable access to resources and the satisfaction of people's basic needs are fundamental to the concept of sustainable development.

Environmental health interventions will involve education, promotion, advisory functions, inspection and monitoring, and the setting of standards.

A multidisciplinary approach will be promoted to secure collaboration between sectors within the government.

A review and consolidation of the different areas of legislation that impact on environmental health will be conducted, to produce a legal framework to support environmental health interventions.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

A National Advisory Committee on Environmental Health will be convened, with representation from various state departments (Environmental Affairs, Water Affairs, Mineral and Energy Affairs, Agriculture, etc), plus local authorities, organised business and labour, universities, research organisations and NGOs.

Health impact assessments, using an integrated health and environmental approach will be compulsory for all major development projects.

Adequate numbers of qualified specialist personnel will be produced for the national, provincial and district levels, particularly for environmental epidemiology, surveillance, toxicology and specialised areas of laboratory work.

A review of existing cadres, most notably environmental health officers and assistants, will be performed to redefine roles and training needs, in order to ensure their proper integration into future responsibilities of the NHS in environmental health.

Services such as public utilities (water, sanitation, roads, food-handling premises, recreational facilities) will be the responsibility of local authorities with whom the NHS will interact for technical advice, surveillance, inspection and enforcement purposes.

## HEALTH PROMOTION

Promoting good health and preventing disease is central to the success of Primary Health Care. However, health promotion is not well understood in South Africa and many people equate health promotion with health education.

Health promotion combines diverse approaches such as legislation, fiscal measures such as taxation, controls on advertising, community action and development, intersectoral programmes, environmental monitoring and education.

## TENETS

The principal tenets of the policy on health promotion include the following:

Health promotion is central to the success of primary health care.

Within primary health care the role of health promotion should encompass responsibility for community participation, community development, intersectoral development, education, mass media campaigns and disease prevention and health promotion in specific areas such as women's health, HIV/AIDS, adolescent health etc.

Health promotion requires the skills of a multi-disciplinary team of workers from many different sectors e.g. teachers, drama specialists, workers, community organisers, advertisers, health workers etc.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Health promotion programmes will be set up with primary responsibility for national level mass media campaigns including impact assessment, the design of training materials for use nationally, the development and implementation of national policy, and coordination and networking between regions.

Provincial health promotion units will develop research (impact assessment, educational priorities and educational messages), policy guidelines for districts, and intersectoral programmes at a provincial level. They will also have extensive responsibility for meeting training needs at regional and district levels e.g. HIV/AIDS education, sexuality education.

District health promotion campaigns in collaboration with other sectors and with community participation will be the focus for health promotion activity through a district level unit.

The primary tasks of community workers will be to act as local health promoters working from community health centres.

A priority activity will be the implementation of a comprehensive school health programme involving curriculum development and district level initiatives through an intersectoral initiative between the health and education sectors.

HIV/AIDS and STDs

In view of the devastating implications of the HIV/AIDS epidemic for South Africa, it is mandatory to define prevention and control interventions plus comprehensive care for those already infected, within the context of the Bill of Rights.

## TENETS

The principal tenets of the policy on HIV/AIDS include the following:

HIV/AIDS must not be addressed as a single issue or by a vertical programme. A multisectoral approach is a pre-requisite for the containment of the spread of the infection. HIV/AIDS must therefore be taken into account in all policy areas.

HIV/AIDS policy must engender, enable and support a community-based response. Consultation with communities is a vital first step in this process.

Non-discrimination of HIV infected people must be promoted. Laws and regulations discriminating explicitly or implicitly will be reviewed and repealed.

The compassionate care of HIV infected people must be guaranteed. Acceptance that it is a chronic illness requiring on-going care to maintain the quality of life of those infected is essential.

The social upliftment of all disadvantaged communities will provide a framework in which health promotive and educational activities will be more effective in the prevention and control of the infection.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Endorsement of the AIDS Charter containing the rights and responsibilities of people with HIV/AIDS.

STD and HIV counselling and support services will be established in all community health centres. These services will provide for continuity of care so that as the disease progresses and more support is needed, this can be provided for in an integrated manner.

To prevent the spread of the infection, early detection and treatment of all STDs is of prime importance. Women attending family planning, antenatal and curative clinics should be screened and treated for silent STD infections.

A range of social/welfare services is required. These will include counselling and social work services, child care and family support. Women infected with HIV who become pregnant will be offered easy access to abortion should they choose it.

Recording of the number of all HIV cases by district must be established. All testing must be carried out only by prior consent and with pre- and post-counselling being available. HIV/AIDS will not be notifiable.

Prevention and education should be part of an overall strategy to prevent the transmission of HIV through public awareness campaigns, community-based prevention initiatives and improved infection control procedures. The development of comprehensive education programmes for school children, adolescents and teachers is fundamental for the success of the programme. All STD and HIV/AIDS education must actively promote a culture of women as equal partners in sexual relations.

There should be no restriction on the sale or distribution of high quality condoms, and all duties imposed on them should be removed.

The most effective framework for the development of education and preventive programmes is a mix between government and voluntary bodies developed and encouraged through the NACOSA structures, backed up by funding to voluntary bodies and increased direct spending by government.

Persons with HIV/AIDS are entitled to the rights which are accorded to all citizens in the new Constitution. In this respect, a review of the current situation will be undertaken immediately by asking infected people and those at high risk of becoming infected, whether they feel themselves discriminated against. This information will be used to shape future policies.

Issues of discrimination in prisons, in health care services and at work need to be tackled immediately by means of a review of current practises, and the development of agreements at workplaces between employers, workers and unions concerning HIV infection.

#### LABORATORY SERVICES

South African Health Laboratory services are plagued by gross fragmentation and duplication with serious disparities in laboratory service provision, especially along racial and geographic lines. There is a need, therefore, for restructuring and/or reorienting all existing laboratory services, including private and forensic ones, and the establishment of a National Health Laboratory Service.

## TENETS

The principal tenets of the policy on laboratory services include the following:

Integration of laboratory services into the PHC system.

Provision of relevant services by laboratory personnel appropriate to South African's needs.

Appropriate training of technologists equipped to work in district laboratories .

Restructuring of the laboratory training institutions based on the primary health care approach.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

A census of existing laboratory facilities and personnel in both public and private sectors. Such information will be linked to the training centres where technologists, technicians and specialists are trained.

Accelerated recruitment from disadvantaged and rural communities for prospective laboratory workers.

Establishment and provision of laboratory facilities and services in rural and underserved areas.

Effective public/private collaboration of health laboratory services, and rationalisation of highly specialised services, all of which are considered national resources.

Accreditation of health laboratories and health laboratory personnel with the appropriate statutory body.

Establishment of a system of laboratory audit for public and private laboratories with the right to limit the registration of sub-standard facilities in both sectors.

Development of mechanisms for quality assurance and control at all levels of laboratory services, according to guidelines for Good Laboratory Practise.

#### MATERNAL AND CHILD HEALTH (MCH)

An investment in the health of children is an investment in the future of the nation. The strength of a health system is reflected in the health status of children. As young children are especially vulnerable and dependent on their mothers, they need special protection and support at all times, especially in times of conflicts, natural disasters and economic hardship. MCH policy will be located within a general development policy providing access to an adequate standard of living. The emphasis will be on health promotion and disease prevention, which will have a far greater impact on child survival than just treatment of disease. It is vital that any programme that is developed in MCH is not vertical, and adopts an integrated, comprehensive approach.

The high maternal mortality rates are of great concern, especially amongst the disadvantaged. A key focus of the MCH policy is improving the health status of women and ensuring that mechanisms are created so that no mother dies because of lack of access to health services.

#### TENETS

The principal tenets of the policy on MCH include the following:

##### Reduction in maternal mortality

Mothers and children should be treated with dignity and respect; sensitivity to their cultural and social context will be promoted.

Promotion of intersectoral collaboration in all areas of development, in particular education, welfare, nutrition and law, with health services playing a coordinating role in relevant areas.

Strengthening health promotion activities including health education programmes.

Promoting universal literacy among women.

Facilitation of the health services activities of local, provincial and national levels, the private sector and NGOs, for the benefit of MCH.

Promotion and encouragement of essential maternal and child health research by organisations and institutions.

Promotion of family planning.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Advocate and ensure the rights of children as articulated in the UN Convention on the Rights of the Child, and work towards the promotion and development of a Charter for the rights of women.

Advocate for an environment that is free of violence.

Enact measures to improve the social, political, legal and economic powers of women.

The role and responsibility of men in supporting maternal and child health care must be emphasised.

The provision of services for mothers and children by NGOs, the private sector and the public sector to be coordinated by the District Health Authorities.

General family planning and educational services will be readily available.

Promotion of the survival, protection and development of children and their mothers through a system of appropriate health care delivery, health personnel education, training and support, research, and a range of related programmes.

Rapidly improving immunisation coverage through the Expanded Programme on Immunisation (EPI), using methods that will ensure its sustainability.

Strengthening health education programmes in the management of diarrhoeal diseases.

Promotion of breast feeding through health education programmes, and the development of supportive environments for working mothers to allow continuation of breast feeding, and enforcement of the code of ethics on breast milk substitutes.

Availability of all primary health care services at the same venue which are affordable, and accessible to all mothers and their children.

Free health care services will be available in the public sector to all children under the age of 6 years.

Early identification of high risk pregnancies, improved antenatal care and provision of emergency obstetric services to reduce maternal mortality.

Free antenatal, delivery and postnatal care and support for women, in the public sector.

Development of a network of comprehensive support and information services to improve the mental and physical health of mothers-to-be and families.

Promotive and preventive programmes directed at children of school age and adolescents regarding high-risk behaviour and sexuality, with promotion of effective life skills, including safer sexual practises. \* Appropriate training, support and services to families and children with special needs. The needs of chronically ill children, adolescents and teenage mothers will be addressed.

Programmes for the prevention of child abuse and neglect will be instituted. Provincial multi-disciplinary child abuse management teams will be established to provide training and counselling services.

Educational programmes that promote health within schools will be encouraged and supported.

## MENTAL HEALTH

The aim of the mental health policy will be to ensure the psychological wellbeing of all South Africans and to enhance their ability to conduct themselves effectively in social, interpersonal and work relationships. As psychological well-being is determined by social and material conditions as well as by physical, spiritual and emotional health, the policy will aim to eliminate fragmentation of services and ensure comprehensive and integrated mental health care.

## TENETS

The principal tenets of the policy on mental health include the following:

Promoting the development of an adequate, flexible range of mental health services at a community level wherever possible.

Ensuring a multisectoral and integrated approach to mental health service.

Promoting the empowerment of people and communities, thus enhancing psychological well-being.

Emphasis on the promotion of healthy life styles and the prevention of mental disorder where possible with priority given to high risk groups.

Fostering respect for the rights of people with mental illness and mental handicaps.

Promoting awareness of mental health and mental illness issues.

Promoting mental health in children with priority given to addressing the needs of vulnerable children.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Improved integration of mental health care, including mental disorders, especially at primary level into the sectors where direct mental health care is necessary, namely, the health care system, the welfare system, educational system, correctional services, defence force and the workplace.

Development of intersectoral structures at community, district, provincial and national levels to ensure coordination of mental health care provision between different departments and levels of mental health care services.

Improving the provision of community care, including for the homeless mentally ill, hospital/institutional care, rehabilitation services and education of mentally handicapped,

mentally disabled and mentally ill people. Support services for care-givers and families of these groups will also be developed.

Supporting the development of non-governmental community-based mental health care services and fostering cooperation between the various mental health service providers.

Fostering liaison and cooperation with traditional healers.

Ensuring that mental health care personnel more adequately reflect the language and cultural diversity of South African society.

Supporting and developing programmes aimed at preventing violence and injury.

Supporting and developing services for all those affected by violence and civil conflict.

Developing prevention and promotion programmes to counter alcohol, drug, and substance abuse.

Supporting and contributing to programmes aimed at promoting youth development and effective parenting.

Supporting and extending services aimed at preventing STDs and HIV infection, and at counselling people with AIDS.

Improving and supporting services concerned with the survivors of rape, child abuse and family violence.

Improving institutional care for the acutely psychiatrically disturbed.

Ensuring the participation of consumers of mental health care services in decision making and policy forums at all levels.

## NON-COMMUNICABLE DISEASES

An increasingly large number of South Africans suffer and die from noncommunicable diseases (NCDs), and this has an important negative effect on the South African economy. These include diseases related to personal behaviours - such as alcohol abuse, smoking and unhealthy eating habits as well as those associated with contamination of the environment and food chain by chemical and radioactive substances. Both unhealthy personal behaviours and environmental pollution are ultimately rooted in the way the economy and society are organised, and it will require fundamental structural changes for a reduction in their prevalence to be achieved.

The problem with many of these diseases is the long period between exposure to risk and onset of disease so that controlling the epidemic demands a multifaceted approach. This will involve the promotion of healthy lifestyles, community action for the implementation of healthy public policies, legislation, measures to reduce the consumption and abuse of tobacco and alcohol, environmental protection and improved recreational facilities.

## TENETS

The principal tenets of the policy on non-communicable diseases include the following:

Programmes to promote healthy lifestyles

Development of promotive educational strategies targeting school going youth, young adults and pregnant women, and at the workplace.

## MECHANISMS

These policy principles will be translated into action through the following

Increased prices and other measures including public health legislation to discourage destructive lifestyles.

Programmes for the cost-effective management of chronic diseases.

Programmes to improve the ability of all health workers to detect risk factors, chronic diseases and cancer.

Resources to ensure sentinel surveillance of certain non-communicable diseases, and other epidemiological studies.

## NUTRITION

Good nutrition is basic to development and is of fundamental importance to improve health status, especially that of vulnerable groups. It is the PHC component which is most inter-related with other sectors, and where health has a vital advocacy role to play. In addition, integrated PHC services in South Africa will include a nutrition component to identify and address nutrition-related disorders.

## TENETS

The principal tenets of the policy on nutrition include the following:

A firm political, financial and social commitment to nutritional well-being will ensure that South Africans, and especially children, do not die from hunger, and that people's lives and futures are not damaged by the effects of too little food or food that is not healthy.

Nutrition interventions will promote and support the dignity and self respect of recipients and will acknowledge people's own practises, knowledge and creativity as important forces for change.

Optimal nutrition programmes will be developed for all South Africans, especially for the vulnerable groups - children under six years, pregnant and lactating women, the chronically ill, the elderly and the destitute through community-centred intersectoral mechanisms.

Nutrition programmes will deliberately integrate rehabilitative, curative, preventive and promotive interventions to reinforce good nutrition practice and address nutrition related disorders and their immediate, underlying and basic causes.

Ensuring that households have access to sufficient food at all times will be a central focus of intersectoral action in agriculture, commerce and other sectors, including food pricing policies.

The dramatic increase in the prevalence of degenerative diseases associated with nutrition (diet) and unhealthy life styles will be specifically addressed to prevent the premature death and disability of economically active men and women.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Promotion of sound health and nutrition practises will be developed within community-focused interventions.

Intersectoral action at all levels to improve households' access to sufficient food.

The most vulnerable individuals and groups will be identified and assessed by comprehensive PHC services.

Regular monitoring will be used as a tool for the promotion of the growth of young children.

Appropriate treatment and rehabilitation for those individuals already affected.

Breast feeding will be promoted and protected and measures will be adopted to enable women to breast feed their children.

The vulnerable, especially young children, will be protected by measures to ensure the adequate care and social support they need.

Current information and skills will be provided to families and to health workers so that they can promote adequate nutrition.

The prevalence, impact and causes of micronutrient disorders will be assessed and control programmes developed to address them.

Appropriate information for surveillance, monitoring and evaluation will be collected and fed back to ensure rational planning and effective decision-making.

## OCCUPATIONAL HEALTH

Workers' health protection and promotion will be integrated into the national strategies for health development. Accordingly, occupational health programmes and services will emphasise a comprehensive, multidisciplinary and participatory approach, stressing both prevention and rehabilitation, and identifying high-risk and underserved occupational groups.

## TENETS

The principal tenets of the policy on workers' health include the following:

Employers must provide occupational health services and training of workers appropriate to the health risks in their workplace.

Occupational health services must be comprehensive and include preventive, promotive, curative and rehabilitative care, with emphasis on work-related health problems. Workplace based services will primarily deal with work related health problems.

Occupational health is a multidisciplinary undertaking that has clinical (medical and nursing), engineering, industrial hygiene, inspectoral, educational, legal and welfare components. The effectiveness of any programme or service depends on all these components being present.

Particular attention will be paid to reproductive health and safety, and to ensure the health and safety of pregnant women.

The state, and representatives of workers and employers will participate in policy making, standard setting and research in occupational health. At the workplace level, equal participation of employers and workers will be ensured in the occupational health service.

Responsibility for occupational health will be shared between the departments of health and human resources, with the inspectorate remaining in the department of human resources so as to avoid duplication and fragmentation of services.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Occupational health units will be established as part of provincial health services to coordinate and monitor occupational health services. These units will be responsible for training, information, surveillance, assessment of compensation for occupational disease and injury, advice on workers rights to compensation, research, and specialised medical services.

A high priority will be given at national level to participation in existing tripartite councils that have been established in terms of the Occupational Health and Safety Act and the Compensation of Occupational Injuries and Diseases Act. At the workplace level, Health and Safety Committees will be developed and strengthened.

The implementation of the two new Acts concerned with occupational health will be closely monitored with a view to ensuring their success and revision, where necessary. Special attention will be given to extending the coverage to include domestic workers and to rationalising the laws regarding occupational health for mineworkers.

Attention will be given to the dissemination of information/education about workplace health hazards and possible remedies.

Occupational health will be introduced into the curricula of all health workers; training of personnel with skills appropriate to occupational health must be accelerated.

The NHA will play an active role in setting appropriate standards related to occupational exposure.

Research must initially emphasise the identification of particularly hazardous substances and work processes, as well as groups at high risk of acquiring occupational diseases.

The feasibility of a "work environment fund" to generate finance for research into priority areas of health and safety and the development of preventive strategies, will be investigated.

#### ORAL HEALTH

There is a need to develop new models of oral health care appropriate to South African conditions, by giving priority to comprehensive preventive, promotive and curative primary health care. Profound changes are needed not only in the type and manner of providing oral health care, but also in the way oral health workers are trained, employed, supervised and supported.

#### TENETS

The principal tenets of the policy on oral health include the following tenets:

Priority will be given to reducing community exposure to oral disease risk factors by the introduction of a fluoride policy which enables the effective delivery of fluoride to the whole community; a food policy which promotes the reduction of sugar consumption in those groups where it is excessively high; and promotion of oral health education.

The scope of oral health services available to all and free at the point of service will be defined, recognising the cost limitations of more expensive restorative options for treatment.

In order to bring about a more equitable distribution of resources, administrative and managerial systems will be introduced to ensure greater public accountability of all services. Regulation of the practise of dentistry in South Africa will be reviewed.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Clearly stated health and disease reduction goals will be defined, together with goals for health education and promotion and for the training of personnel.

Selected screening programmes will be carried out to determine and monitor the oral health treatment needs of all South Africans. The data will inform the planning of education programmes and personnel distribution.

A programme will be investigated to ensure that the drinking water of all South Africans contains optimal amounts of fluoride. Where needed, appropriate and proven means will be instituted to fluoridate the mouth.

Financing of oral health services will be made possible through a more equitable distribution of existing resources from the public and private sectors.

Appropriate drugs, materials and equipment will be carefully chosen for each level of the oral health services.

Training institutions will be encouraged to transform their existing curricula to produce the types of oral health workers required to implement the national oral health policy. The possibility of closing or relocating existing institutions will be investigated.

## PALLIATIVE CARE

Relief of chronic pain and care of people with terminal illness are important components of health care that have been seriously neglected in South Africa. Although some cancers are curable, most are not, and 80% of people with advanced cancer suffer from pain, with or

without other major symptoms. Cancers are becoming more common and are now the fourth commonest cause of death. AIDS is another incurable disease which is increasing significantly. If South Africa is to become a more caring society, people with these diseases must receive high quality care, including active and effective management of pain and other symptoms.

## TENETS

The principle tenet of the policy on palliative care is:

To ensure that people with terminal or incurable illnesses receive affordable and effective care including relief from pain and other symptoms.

## MECHANISMS

This tenet will be translated into action through the following:

Encouraging and assisting families and communities to care for people in their own homes.

Encouraging and supporting religious groups and NGOs such as the hospice movement working in the field of palliative care.

Building multidisciplinary teams, including medical specialists, to train and support health workers at primary, secondary and tertiary levels in the techniques of pain and symptom relief.

## REHABILITATION

Rehabilitation is a component of health care that has a special implication for people with disabilities. Rehabilitation services will aim to improve the quality of life of all people, according to international standards, to allow for their total integration into society in a dignified and productive manner, as near as possible to their communities. In addition, special attention will be given to addressing the health needs of people with disabilities under all other health policy areas.

## TENETS

The principal tenets of the policy on rehabilitation include the following:

Comprehensive restructuring of rehabilitation services at all levels but geared primarily towards a community-based system, with active participation of communities, people with disabilities, and all those who require rehabilitation support and their families.

The rights of people with disabilities will be protected.

Intersectoral work will be promoted to ensure effective rehabilitation services within educational, welfare and labour sectors.

Sufficient numbers of properly trained rehabilitation professionals and technicians will be produced to adequately take care of various areas, including physiotherapists, occupational therapists and speech, sight, and hearing therapists.

Rehabilitation services will promote the development of self-help initiatives by assisting people with disabilities to gain the necessary skills and attitudes to sustain such initiatives.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

The Disability Rights Charter of South Africa will be actively promoted and implemented.

Community-based rehabilitation programmes and training of mid-level workers to serve as support for the programmes.

Improving community-based services and facilities by ensuring that each community health centre takes responsibility for coordinating the services catering for the needs of people with disabilities in its area.

Development of structures to ensure coordination of direct and indirect rehabilitation service provision between different departments and levels of service.

Provincial rehabilitation centres will be established for people requiring intensive or long-term specialist rehabilitation. Subsidised transport will be integral to this system to ensure accessibility of the centres.

Appropriate training of rehabilitation personnel including therapists, mid and primary level workers, with appropriate career structures for the latter. Re-orientation of already trained personnel to a primary health care and community-based rehabilitation approach.

Mechanisms will be created to ensure the appropriate placement of rehabilitation professionals and assistants at all levels of service.

Improving the provision of equipment for people with disabilities.

## RESEARCH

It is important to uphold the principles of promoting research that aims at improving the health of people in South Africa and ensuring that resources available for the health sector achieve maximum results. Therefore it is important that a balance is reached between applied, basic and clinical research. The policy is to initiate and sustain effective consultations amongst various health care providers and the public at large to overcome the isolation and fragmentation of research efforts, and to establish and strengthen close links between research, policy and action.

The principal tenets of the policy on research include the following:

## TENETS

The research process and the appropriate application of research can enhance human potential and improve the quality of life for all South Africans.

Advances in research and the application of science and technology must be grounded in sound policies aimed at improving the health of the people and ensuring effective resource utilisation, whilst allowing for creativity and cooperation.

Mechanisms

These policy principles will be translated into action through the following mechanisms:

Health and health-related research activities and institutions must be reviewed in consultation with relevant organisations and in the context of overall national objectives and priorities for research. Appropriate democratic structures will be established to formulate research policy. These structures will need to represent government, the public and the research community.

A sound research policy is based on the recognition that technology and technological knowledge are inputs into national economic development. This requires the development and maintenance of a healthy indigenous and appropriate technological knowledge and skills base, that can specialise in areas such as new materials, medical technologies and biotechnology.

Special attention will be drawn to health systems research to facilitate the development of the primary health care approach, particularly in connection with performance of provincial, district and community structures involved in the delivery of health services. This work should be characterised by a focus on priority health problems; be of a participatory nature; action-oriented; multidisciplinary; and have a cost-effectiveness orientation. Health systems research and the application of appropriate local technology to primary health care will play a major role in the equitable provision of health care and in infrastructure development in both urban and rural areas.

A strong system will be developed for peer and public review of research ethics, such that accepted international guidelines will be applied.

## RURAL HEALTH

All the principles of the primary health care approach become most evident in the need to provide adequate and equitable services in the rural areas. Provision of health care, appropriate health facilities, and human and financial resources are of prime importance, especially as many of the rural areas have been so neglected, and this imbalance should be redressed.

Tenets

The principle tenets of the policy for the rural areas include the following:

The Ministry of Health should play an advocacy role in ensuring that adequate attention is given to the provision of water, sanitation, roads, communication systems, stock health, housing, schools, and shops, as well as health facilities. In addition it should play an advocacy role in activities such as job creation, income generation, land redistribution, education and community development.

Administrative staff should be appropriately trained in management skills and able to work in partnership with the communities.

There should be a redistribution of human resources to rural areas, and all categories of health personnel should have experience of working in rural settings.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Health personnel will be encouraged to work in rural areas by improved conditions of service and other incentives such as travel allowances, children education allowances, training opportunities, promotional credits, etc.

Improved technical support and facilities and opportunities for continuing education, including attendance by personnel from tertiary institutions at rural centres.

Health educational institutions must provide rotation of their students and staff through rural facilities for all categories of health workers, to improve interdisciplinary learning activities at rural community-based primary care facilities. Examining bodies and registering councils must be involved in decisions concerning certification of rural experience for under- and post-graduates.

Provision of health facilities will be based on the specific needs and conditions applicable to each rural community.

Effective referral systems will be established which will take into account the need for reliable and available transport, effective communications systems, and availability of facilities at the referral hospital.

Appropriate technology must be used and applied, and knowledge shared between all areas and provinces.

## TRADITIONAL PRACTITIONERS

Traditional healing will become an integral and recognised part of health care in South Africa. Consumers will be allowed to choose whom to consult for their health care, and legislation will be changed to facilitate controlled use of traditional practitioners.

## TENETS

The principal tenets of the policy on traditional practitioners include the following:

People have the right of access to traditional practitioners as part of their cultural heritage and belief system.

There are numerous advantages in cooperation and liaison between allopathic and traditional health practitioners and interaction will thus be fostered.

Traditional practitioners often have greater accessibility and acceptability than the modern health sector and this will be used to promote good health for all.

Traditional practitioners will be controlled by a recognised and accepted body so that harmful practises can be eliminated and the profession promoted.

Mutual education between the two health systems will take place so that all practitioners can be enriched in their health practises.

## MECHANISMS

Registration and development of traditional health care practices will coincide with expansion of allopathic medicine rather than replace it in any geographical area.

These policy principles will be translated into action through the following mechanisms:

Negotiations will be entered into with traditional practitioners so that a policy acceptable to all health practitioners can be reached.

Legislation to change the position and status of traditional practitioners will be enacted.

Interaction between providers of allopathic and traditional medicine will be actively encouraged, especially at local levels.

Training programmes to promote good health care will be initiated.

A regulatory body for traditional medicine will be established.

## VIOLENCE

Many factors, but most noticeably the inequities generated by apartheid are the root of the extremely violent society that South Africa has become recently. Promoting peace and security for all people is not only a pre-requisite for health development but for the overall process of reconstruction and socio-economic development. The strong support from the broad mass of the people for the National Peace Initiative must be expanded so as to draw in all South African society to combat all forms of violence including domestic violence, child abuse, rape and robbery. Political violence, contrary to common belief, contributes less than 15% to the more than 2000 violent deaths that occur every month.

## TENETS

The principal tenets of the health policy on violence include the following:

Promotion of a society as free of violence as possible.

Adequate health care support for the victims of violence, including psycho-social rehabilitation and legal and welfare components.

## MECHANISMS

These policy principles will be translated into action through the following:

Introduction of legislation to restrict the ownership and use of guns, and promotion of the concept of a gun-free civilian society.

Establishment or support of crisis centres and shelters to care for the victims of violence in a multidisciplinary and humanitarian manner.

Reorientation of the training of health workers at all levels so as to ensure adequate care of victims of violence. This will involve introducing emergency preparedness and response programmes, counselling services and management of the results of violence.

Promotion of democratic and other non-violent dispute resolution mechanisms.

Carrying out multidisciplinary studies to properly and promptly identify causes, precipitating factors, and direct and indirect victims of violence in any of its forms.

## WOMEN'S HEALTH

Women's health shall be understood within a socio-economic context and not within the narrow context of women's reproductive health. Priority will be given to the improvement of women's social and economic status. In addition to legislation which guarantees equality, the development of national infrastructure, specifically on water and fuel, will be made an immediate priority. The aim will be to empower women through improved knowledge about their bodies and their health. Another aim is to reduce the number of abortions, and the physical and psychological morbidity, and mortality associated with "back-street" abortions.

## TENETS

The principal tenets of the policy on women's health include the following:

There will be an emphasis on health promotion in order to enable women to make informed decisions about their health and the health of their families. This will include promoting health advocacy.

Recognition of the right to control the reproductive functions of one's body.

Setting priorities for the improvement of women's economic and social status.

Recognition of women's rights; encouraging women's participation in decision making in health; and freedom from gender oppression.

Every woman must have the right to choose whether or not to have an early termination of pregnancy according to her own individual beliefs. Equally, health workers have the right to refuse participation in termination of pregnancy, according to their beliefs.

Recognition of women's right to live without fear from violence of any kind, and of the need to create a society where violence is socially unacceptable, especially against women.

## MECHANISMS

These policy principles will be translated into action through the following mechanisms:

Development of comprehensive women's health care services, including contraceptive services, which will be geared towards the needs of all women throughout their lifespan.

Giving priority to cost effective screening programmes for diseases which affect women (e.g. carcinoma of the cervix).

Development of regulations to ensure the safe and appropriate termination of pregnancy.

Training and re-orientation of health workers and public officials to correct any negative attitudes to women.

Creation of an integrated approach to women's reproductive health care including a package of promotion, prevention, cure and rehabilitation.

Provision of legal protection for women victims of violence and provision of support and counselling services for victims of violence.

If a woman chooses early termination of pregnancy, pre- and post-counselling services will be available.

Enact a law protecting women against rape.

Provide access to child care, including at workplaces.

Provision of maternity benefits with job security and, where necessary, paternity benefits.

Institute affirmative action programmes for women in health training institutions.

#### 4. THE NATIONAL HEALTH SYSTEM (NHS)

The state has two separate functions with regard to health. The first is to create, monitor and amend the framework (the National Health System) within which health is promoted and health care is delivered. The second function is to be a major provider of services.

The framework is essential for planning, for protecting the public as consumers of health care from exploitation and abuse, and for mediating between conflicting interests. It will be created through legislation and regulation and will be influenced through many other mechanisms, including fiscal and financial policies. The framework includes the powers, functions, rules and regulations of all the various health authorities and of statutory bodies such as the Medicines Control Council and the Councils that register health professionals.

The government's function as a health care provider is to ensure that everyone has access to good quality health care. At present public and private providers are often seen as being in opposition to each other, but if the framework is well constructed then the two sets of providers will complement each other.

The aim of reorganising health services in South Africa is to improve health and health services for all. This will be done by adopting the PHC approach and bringing the services into line with international thinking and practises. Crucial to this will be the strengthening of community services and the development of District Health Systems.

The primary health care approach is centred on the individual, the family and the community. The support they receive for treating and preventing disease, and for protecting, maintaining and improving their health is integrated across health and health related sectors. These include housing, water, sanitation, agriculture, education, social welfare, environment, trade and commerce etc. Within the health system, the health services provide the principal and most direct support to the community.

One of the aims of this Plan is to decentralise management of the delivery of services to provinces, districts and institutions in order to increase efficiency, local innovation, empowerment and accountability. However, in order for decentralisation to be effective, there is an absolute need for central coordination within an integrated, unique and comprehensive NHS. Health services in South Africa have been so fragmented and inequitably distributed that it is essential to unify them into a single system. Decentralisation without coordination and planning could result in a more fragmented, inequitable system.

In this Plan, recognition is given to the central role that the National Health Authority has to play in coordination, evaluation and planning, allocation of budgets, and health personnel issues including conditions of service and employment for health workers. It is envisaged that as the system develops, as management skills increase, as a culture of coordinated action emerges and as there is greater equity of access to health care, greater decentralisation will be both possible and desirable.

The integration of the Defence Force health services (South African Medical Services) with the rest of the public health services will require further discussion. However, as much integration as possible will be encouraged, particularly with regard to supplies and distribution, the adoption of national norms and standards, and the use of military facilities for the communities where they are situated.

Organograms reflecting the structure and function of the health services at all levels usually give disproportionate emphasis to support services in relation to the functions and responsibilities of health care. For this reason health care - promotion, prevention, curative care and rehabilitation - should be viewed as the central task of the health services in support of the health needs of the communities. Health care, as a function at all levels of the health care system receives support from a variety of services (see Fig 15).

An underlying principle is the promotion of the concept of a continuum of health care. There needs to be a change in the culture of health care provision if this is to become meaningful. People who are referred from one part of the health system to another, or from one person to another, must feel that their referral is logical and that they are still within one coordinated system. The structure has been designed to promote teamwork and "Health Care" will include

both primary and hospital care to ensure the continuum of health care from the primary to the tertiary levels.

Until such time as Act 200 of 1993 is implemented, the existing provincial administrations, self-governing states and former TBVC countries will pool their financial and other resources for health care. Joint administrations can be established to ensure the smooth running of the health services during the transitional period. This provides the first steps in the rational reconstitution of health services in the country.

## COMMUNITY LEVEL

The term "community" is used here to represent those people living in the geographical area served by a Community Health Centre. It is not a level of governance but is the most important level for the delivery of comprehensive primary health care.

## INTERSECTORAL COMMUNITY DEVELOPMENT COMMITTEE

All communities will be encouraged to form intersectoral Community Development Committees, whose members will be elected from the community. This committee will have advocacy and advisory roles, to help coordinate all aspects of development, and ensure that resources are used to the best advantage of all in the community. It will be particularly important in rural and other disadvantaged communities.

## COMMUNITY HEALTH COMMITTEE

The function of the Community Health Committee will be to liaise with those employed to run their health facility, to examine the budget and to help determine local policies. They will identify and prioritise community health needs and will present these to the District Health Authority (see later). The committee will comprise voluntary elected community

representatives (who will be in the majority), representatives from the health services in the area, NGOs working in the community, local health practitioners, and others.

## COMMUNITY HEALTH CENTRES

The foundation of the NHS will be Community Health Centres (CHCs) which provide comprehensive services including promotive, preventive, curative and rehabilitative care. Each CHC will be responsible for health in its catchment area and, depending on needs and resources, will also run, as an integral part of its activities, fixed satellite clinics. Staff will also be sent to visit health posts in the area. As a guideline, a CHC will serve, on average, a population of about 50,000 but this may vary widely depending on population density, transport, access and other services in the district. There will be at least one CHC in each health district. In many areas, one of the existing clinics will be upgraded to the level of a CHC. Determination of numbers and siting of CHCs and clinics will be based on a population needs approach.

CHCs are community resources, and ideally should be situated within or close to community development and recreation centres. Parts of existing facilities can be used, for example, for educational support services and other community activities.

The CHC team will include a full range of health workers in order to deliver a comprehensive service. An important part of its activities will be promotive and preventive services. Ambulatory care, with some beds for overnight care, will also be provided. Casualty and maternity services will be available 24 hours a day. Other services will include mother and child care, immunisation, family planning, STD counselling and treatment. treatment for minor trauma and locally prevalent diseases, oral health care, the follow-up treatment and rehabilitation of people with chronic disorders or disabilities, counselling and mental health services, and primary welfare care. The CHC will have an appropriate stock of essential drugs including vaccines, and support services such as radiology and laboratory services for diagnostic and investigative procedures. Independent health practitioners will have ready access to the CHC for follow-through of their patients, and will also be encouraged to undertake sessions at the CHC.

Nutrition rehabilitation and support programmes will also be integrated into the structure and function of CHCs and health teams, as will environmental health services in the district. Depending on local need, outreach education and health promotion and prevention programmes will be run in schools and work-places.

## CLINICS AND HEALTH POSTS

Clinics will offer a comprehensive range of preventive, promotive, curative and rehabilitation services but at a less specialised level than CHCs. Clinics will normally only be open on weekdays but this can be negotiated with the local communities. Where transport and communication are difficult, particularly in rural areas, arrangements will be made for a member of staff to sleep at the clinic and to be available to give first aid and to summon help in an emergency. All clinics must have water, electricity and communication systems.

Health Posts are places that are not used as full time health facilities but are visited regularly by teams of health workers from the nearby clinic or CHC. They are very important for bringing services closer to the people who need them most.

People with disabilities have particular difficulty in gaining access to health services and special consideration will be given to bringing services closer to them.

## \* DISTRICT LEVEL

The development of health districts will be crucial to the transformation of the health system and the decentralised management of the new NHS. Provinces will be subdivided into districts mainly on the basis of functional and geographic coherence. The district boundaries will, as far as possible, be coterminous with those of the administrative and political boundaries in order to facilitate effective, integrated and comprehensive service delivery. Population size will be one of the criteria for subdivision. The population of most districts could vary from 50,000 to 750,000 people given the varying densities in urban and rural areas.

The District Health Authorities (DHAs) will be accountable to the elected political authorities. In the case of districts which coincide with the boundaries of a single Local Authority (LA), the DHA will be an integral part of the LA. Where a district includes more than one LA, the DHA will include representatives from each of the LAs in proportion to their population.

All community level health services in the public sector will fall under the DHAs from which they will receive essential material and logistic support. Community level services in the private sector will also be accountable to, and coordinated by, the DHA.

#### INTERSECTORAL DISTRICT DEVELOPMENT COMMITTEE

Intersectoral coordination will be ensured through the establishment of an Intersectoral Development Committee on which the DHA will be represented. This committee will ensure that health concerns are addressed by sectors such as Education, Engineering, Water Affairs, Agriculture and any other sectors involved in development activities that affect health.

#### DISTRICT HEALTH AUTHORITY (DHA)

The DHA will comprise representatives from the Local Authorities, the Community Health Committees (who could include service providers from clinics, CHCs or community hospitals), the Director of District Health Services, and the Heads of the District Health Units.

The main functions of the DHA and its staff will be to promote primary health care and to plan, coordinate, support, supervise and evaluate services, based on national and provincial norms, policies and guidelines. The DHA will receive a budget for primary care and will allocate this to different community level services. It will also receive and control the budgets for, and run, community hospitals in the district.

Community hospitals (also known as District or non-specialist hospitals) will be an important component of district health care. At these hospitals general practitioner services, including basic anaesthesia and surgery, will be provided. Specialist services may be provided under exceptional circumstances. Community hospitals will work very closely with CHCs and will provide in-patient care close to where people live. They will be staffed by a team of full-time workers and will be visited regularly by specialists from the provincial (specialist) hospital with which they are linked.

The DHA will also be responsible for ensuring that there are efficient referral systems within the district and between the district and provincial and national facilities such as hospitals and training institutions.

#### MANAGEMENT COMMITTEE

This committee will be responsible for the day-to-day management of the district health services, will be led by the Director of District Health Services, and will comprise the Director and the Heads of the District Health Units.

#### DISTRICT HEALTH ADVISORY BODY

To ensure community participation and involvement, the DHA will be advised by the District Health Advisory Body, made up of representatives of Community Health Committees, community-based organisations, trade unions, professional bodies and other health worker organisations.

#### FUNCTIONS OF THE DISTRICT HEALTH AUTHORITY

The DHA will ensure that all health services in the district are rendered within the norms, policies and guidelines agreed to at provincial and national levels, in order to promote equity.

## HEALTH CARE

Promotion of PHC and the monitoring, evaluation and planning of services.

Management and coordination of health promotion activities and of all the different elements of comprehensive health care that are provided by primary care workers. These elements include:

- mental health

environmental health

mother and child health

nutritional services

school health

oral health

control of communicable diseases

control of non-communicable diseases

care of the elderly

occupational health

care for common diseases and injuries

rehabilitation

Provision of clinical services in community hospitals, clinics, community health centres and through outreach services.

Provision of accident, emergency and response services.

Control of the acquisition, storage, handling and disposal of all hazardous substances in the district.

## SUPPORT SERVICES

Procurement, storage, distribution and stock control of pharmaceuticals and medical and laboratory supplies and equipment.

Provision of support services such as dispensaries, laboratories, radiological services in the appropriate public facilities.

#### ADMINISTRATION AND FINANCE

Management and control of the district health budget.

Procurement of additional local funds for projects.

Provision of transport and possibly ambulance services.

#### PLANNING AND HUMAN RESOURCES

Personnel management of public sector employees.

Coordination of all health workers, including NGOs and private providers, in the local area.

In-service training of health workers.

Collection, collation and analysis of all relevant health data and forwarding of appropriate data to the provincial authority.

Planning the provision of health services as part of the development of the district as agreed at the Intersectoral District Development Committee.

#### PROVINCIAL LEVEL

The current provincial health administrations, self-governing territories, former TBVC states and the regional offices of the Department of National Health and Population Development (DNHPD) will be incorporated into the new provincial authorities. Within the single National Health System each province will support, monitor and evaluate district level services and will provide certain provincial level services.

#### INTERSECTORAL PROVINCIAL DEVELOPMENT COMMITTEE

This body will be similar in concept and function to the District and Community Development Committees and will comprise those members of the Development Committee provincial legislature (Members of the Executive Committee - MECs) responsible for all sectors impacting on health. Its task will be to identify development needs in the province and to mobilise and allocate resources to the best advantage of the people of that province, particularly the poorest.

#### PROVINCIAL HEALTH AUTHORITY (PHA)

The PHA will be responsible for the health of all the people of that province and its main task will be to support and supervise the DHAs. Vital components of this support will be specialist hospitals and services, the organisation of training and the coordination, evaluation and planning of primary care services.

Specialists working at provincial institutions will visit district health facilities regularly to provide support and specialist teaching, to learn from the people at district and community level, and to facilitate efficient referral between primary, secondary and tertiary care facilities.

The PHA will be accountable to the elected provincial government and will be chaired by the MEC for Health. Members will include the Provincial Director for Health Services, Heads of the Provincial Health Departments, and representatives from the DHAs. It will, within national guidelines, control the budget allocated for provincial health services. It will also coordinate and monitor the budgets allocated to the DHAs.

#### MANAGEMENT COMMITTEE

This is responsible for the day-to-day management of the provincial health services, and is led by the Provincial Director of Health Services, and comprises the Director and the Heads of the Provincial Departments.

## SPECIALIST HOSPITALS

All specialist hospitals will be coordinated by the PHA. Day to day management of these institutions will be delegated to the staff appointed to run them so that they will have a high degree of decentralised administration but they will remain part of the public sector. Planning, budgeting and general policies will be initiated within institutions and then discussed and coordinated by the PHA.

Whereas these hospitals should not provide care that could be provided at a lower level, they should, like clinics and other components of the health services, be accessible and affordable to all who need their level of care. They form an integral part both of the country's health care system, and of the overall social and economic development of the community.

Apart from their role in providing individual patient care, specialist hospitals can support primary care workers through efficient referral and consultation systems. They can also support and conduct relevant research and they have a role to play in both basic and continuing education and training of all types of health workers.

Academic hospitals as currently defined must form an integral part of the referral networks of the province and the country. To ensure the rational and optimal utilisation of these national resources, certain services will only be provided at designated facilities. These hospitals will therefore be coordinated by, and be accountable to, the National Health Authority.

## PROVINCIAL HEALTH ADVISORY BODY

The Provincial Health Authority will receive input from a Provincial Health Advisory Body, similar in concept and composition to that at district level, and will include representatives of stake-holders in the private health sector and of civil society.

## FUNCTIONS OF THE PROVINCIAL HEALTH AUTHORITY

The PHA will promote community participation and involvement through liaison with community organisations, trade unions, NGOs involved in health, private providers and their organisations, and other stake-holders in the province with a view to rendering a high quality service in terms of the needs of the province. It will also ensure that multisectoral collaboration takes place for the proper development of health programmes and healthy lifestyles

### HEALTH CARE

Monitor, evaluate and plan all health services in the province, based on Health Care national norms, policies and guidelines, including the development of provincial policies and planning guidelines.

Support and coordinate the work of the DHAs in the province.

Provide district level services where the DHA is unable to do so.

Approve, within national guidelines, standards and norms, the building and expansion of public and private hospitals and clinics.

Ensure the provision of hospital care, including specialist hospitals and specialised rehabilitation support centres.

Plan and control the functioning of the referral system.

Ensure the maintenance of a safe environment throughout the province.

Provide certain specialised environmental and auxiliary health services, including forensic services.

Provide supportive emergency services.

### SUPPORT SERVICES

Procurement, storage, distribution and stock control of pharmaceuticals and medical and laboratory supplies and equipment.

Provision of backup services for laboratories and medical equipment, including quality control.

Provision of auxiliary services and coordination of the collection and supply of blood and blood products.

#### ADMINISTRATION AND FINANCE

Coordination of the budgets of the DHAs in the province.

Allocation of budgets to, and financial control over, designated provincial health services.

Management and monitoring of the health finances of the province and reporting thereon as prescribed by the NHA and by other monitoring authorities.

Procurement of additional funds for provincial projects.

Provision of infrastructure and services to underpin primary, secondary and tertiary care facilities in the province.

Preparation of health legislation for tabling in the provincial legislature, and commenting on proposed legislation in other sectors that may affect health.

Provision of the means of communication with health facilities, and health authorities within the province.

#### PLANNING AND HUMAN RESOURCES

In-service and qualifying training of, and supervision over, relevant health personnel.

Provision of technical and logistic support to provincial and district services.

Collection, collation and analysis of all relevant health data for the purpose of provincial planning, and the submission of appropriate data to the NHA.

Coordination of NGOs, private hospitals and other providers with provincial services and facilities.

Planning the provision of health services in accordance with provincial development plans as determined by the Intersectoral Provincial Development Committee.

Coordination of all health and health-related research in the province.

## NATIONAL LEVEL

The single, comprehensive, equitable and integrated National Health System will be planned and coordinated at the central government level.

## INTERSECTORAL NATIONAL DEVELOPMENT COMMITTEE

As with the other levels of the system, all sectors affecting health should be represented on this committee, which will therefore comprise the relevant government Ministers. It will be responsible for intersectoral liaison with other ministries.

## NATIONAL HEALTH AUTHORITY

This will be chaired by the Minister of Health, and will include the Secretary for Health, Heads of the National Divisions, and representatives from the PHAs, and DHAs. The National Health Authority will have overall responsibility for the development and provision of all health care in South Africa. It will be responsible for policy formulation and strategic planning, as well as coordination of planning and the functioning of the overall health system in the country. It will also develop guidelines, norms and standards to apply throughout the health system, and to translate policy into relevant integrated programmes in health development. The central level will elaborate policy statements and health legislation, and will coordinate international and donor support.

The NHA will allocate and distribute the health budget, and coordinate both public and private health care. Funding will be allocated in a manner which encourages local approaches and responsibility for health service delivery.

## NATIONAL HEALTH ADVISORY BODY

This advises the NHA, and has representation from the statutory bodies, the national associations of health professionals, NGOs involved in health, trade unions and national community structures.

## FUNCTIONS OF THE NATIONAL HEALTH AUTHORITY

The NHA will promote community involvement through liaison with the structures of civil society, including trade unions, NGOs involved in health, private providers and their organisations, and other stake-holders, with a view to rendering high quality health services in terms of the people's needs and to eliminating disparities between the regions. Responsibility for the development of the multisectoral collaboration necessary for the implementation of health programmes and healthy lifestyles, as well as for the coordination of training systems for health personnel, rests with the NHA.

## HEALTH CARE

Formulation of national policy, including macro economic analyses in Health Care respect of inter- and intra-sectoral activities.

Determination of national priorities, plans and strategies and ensuring their implementation.

Determination of national norms, guidelines and standards of care.

Overall coordination of both public and private health care.

Coordination of organisations providing national services.

International liaison and coordination of international and donor support, including policies and guidelines for that support.

Planning, coordinating, supporting, supervising and evaluating all services in the provinces and districts, including establishing national norms, policies and guidelines for the building or expansion of public and private hospitals and clinics.

Promotion of health, and support for health education.

Support for the preventive interventions and programmes of provinces and districts.

Planning and controlling the national referral system.

Coordination of emergency services and disaster relief in collaboration with the PHAs, DHAs and other parties as necessary.

#### SUPPORT SERVICES

Procurement, storage and distribution of pharmaceuticals and of medical and laboratory supplies and equipment.

Providing backup services for highly specialised equipment.

Quality control of laboratory services and equipment.

Administering certain national programmes, such as vaccine production, virological services and medicine control.

#### ADMINISTRATION AND FINANCE

Establishing norms, standards and guidelines for all health resources (funds, human resources, facilities and equipment).

Negotiating with the Department of Finance for funds to provide the necessary health services and for training.

Development of financial allocation mechanisms, and monitoring and evaluation of the effectiveness and cost-efficiency of the health system.

Provision of the infrastructure and services needed to underpin the health facilities of the nation.

Preparing and tabling health and health related legislation for the National Assembly.

#### PLANNING AND HUMAN RESOURCES

National human resources planning and development.

Planning and coordination of national health and health-related research and research institutions.

Coordination of academic health institutions.

Establish and coordinate a national health information system.

Provision of special technical advice and expertise to the provinces and districts.

#### THE ROLE OF THE PRIVATE SECTOR AND INDEPENDENT PRACTITIONERS

The private health sector is a large industry, comprising a number of different institutions, organisations and personnel. These include inter alia the pharmaceutical industry, medical technology industry, private hospitals and facilities, medical aids, and a range of private practitioners including traditional and complementary health healers. The high cost spiral within the health care industry necessitates a restructuring and a change in the ethos of the private sector, in consultation with all relevant role players.

The current structure of the private sector has created incentives which detract from the ultimate objective of health for all, and instead has created incentives which allow financial interests to take precedence over the patients' interests. It is a system which has been abused by some, and this detracts from the constructive role that the private sector has been playing.

Under the new and dynamic National Health System restructuring of the private sector can enhance its important role in improving the health of the nation. Active cooperation between the private and public sectors will promote a positive climate in which the two sectors can work together, with the common goal of achieving health for all.

#### THE INDEPENDENT PRACTITIONER

The private practitioner is an important, and often underestimated resource at the primary level of care. It is hoped that the majority of private practitioners of all categories will work increasingly in the public sector, deriving their income from health authorities, but maintaining their independence. This group of practitioners will be referred to as "independent practitioners"

Independent practitioners will be encouraged to form multi-disciplinary group practices which will be recognised as an important contribution to comprehensive health care at the primary level. Independent practitioners play an important role in improving access to the health system, especially in areas where services are difficult to provide. Equity in the distribution of independent practitioners will be encouraged through incentives to work in underserved areas. Licensing for practices will be instituted to act as an attraction for underserved areas, and disincentive for overserved areas. Private practitioners will also be encouraged to work in public clinics, health centres and hospitals on a regular rotational basis. They will have ready access to the CHCs for the follow-through of their patients. Incentives will also be used to encourage health promotional and preventive activities.

## COST CONTAINMENT

The rational and appropriate use of resources is essential. The private sector can play an effective role in helping to identify and implement alternative, more cost-effective therapies. This can be done through the development of therapeutic guidelines, clinical audit, peer and utilisation reviews. All health workers in both public and private sectors will be encouraged to follow agreed NHS protocol for the care of common conditions, including appropriate referral of patients.

The cost spiral within the private sector can be largely attributed to expenditure on drugs and private hospitals. A system of nondiscriminatory pricing of drugs, and generic substitution will be effective in helping to contain costs on drug expenditure. In addition, systems of repayment such as capitation fees or other systems of remuneration will be investigated to replace, where possible, fee-for-service payments in order to reduce the incentive to over-serve patients. In the same spirit, action will be taken to ensure that the income of health workers who prescribe medication does not in any way depend on what or how much medication they prescribe.

## PRIVATE FACILITIES AND INSTITUTIONS

The state will no longer subsidise the private sector. A better regulatory framework will be applied to the licensing of private sector facilities. Other systems of remuneration will be

investigated to replace fee-for-service payments in private health facilities to reduce the incentive to over-service.

Conflicts of interest that promote over- or under-servicing whereby the patient's interest is subordinated to the financial interest of the health worker or institution, will be discouraged. In particular health practitioners will not be permitted to hold shares in private clinics and hospitals.

#### TRADITIONAL AND COMPLIMENTARY HEALERS

Traditional healers play an important role in the health care of a large proportion of population, and the need for a coordinating body will be investigated. The role of complementary health practitioners needs to be recognised, and mechanisms to integrate them into the NHS require investigation.

#### STATUTORY BODIES

All statutory bodies relevant to health will be reviewed with a perspective directed towards rationalisation. Coordination between the statutory bodies is required to ensure that they interpret and implement national health policies.

The objectives of those Statutory Bodies that govern the registration of health personnel shall be to:

uphold the rights of patients and safeguard their interests.

promote health standards and training standards.

authorise the education, training, registration and practise of all health professionals.

regularly review the curricula of health personnel education programmes to be in line with national guidelines.

#### THE ROLE OF NGOs INVOLVED IN HEALTH

NGOs have historically provided local health services under a variety of conditions in South Africa. In most cases NGO services have filled a void created by neglect of health care needs for underserved populations. In many instances NGOs have paved the way for development of sustainable health care services at the community level. In other instances NGOs have the capacity to create innovative services which do not fit into conventional health service provision.

The Government will create, within the national policy, a framework that takes into account specific objectives of NGOs, rationalisation of services, supervision of standards of care and promotion of efficiency and outcome measures. The payment for the provision of specific services will depend on the submission of budgets and performance appraisal. Their services need to be integrated into, and coordinated with the rest of the health services in order to avoid fragmentation, and where they meet the needs of communities they must be encouraged and supported.

#### THE ROLE OF INTERNATIONAL ORGANISATIONS

The government has the responsibility to define areas for which external support is needed. However, it is not only financial resources that international agencies can bring to South Africa's health care reconstruction efforts. International agencies can provide technical assistance and appropriate technology for each level of the country's public and private health sector. A further contribution, is the sharing of knowledge and experience about successful PHC in other countries.

It is imperative that the government swiftly organises a special body to coordinate the significant foreign assistance that will be offered to South Africa as it prepares to reconstruct its health system.

## 5. MANAGEMENT SUPPORT SYSTEM

### MANAGEMENT SUPPORT

The primary concern of management development in the post-apartheid era is to establish, strengthen and sustain the health infrastructure and management systems which will help to:

Support the equitable distribution of resources available for health care;

Facilitate managerial and financial integration of health strategies;

Promote the scrutiny of all development initiatives for their impact on, and relationship to, health status;

Strengthen or establish sustainable institutions, for dialogue and negotiation between all role players.

The future health managers at all levels will deal with issues of planning, coordination and integration, financial management, and human resource management.

### HEALTH CARE FINANCING

Free health care will be provided in the public sector for children under six, pregnant and nursing mothers, the elderly, the disabled, and certain categories of the chronically ill. Preventive and promotive activities, school health services, antenatal and delivery services, contraceptive services, nutrition support, and curative care for public health problems will also be free, in the public sector.

Because of the burden associated with paying for health services at the time of illness, in the long term we are committed to the provision of free health care at the point of service for all citizens of South Africa.

Individuals covered by some form of health insurance will not be eligible to receive free health care. User fees for insured patients using public sector facilities will be increased to ensure full cost recovery. For certain categories of treatment offered only at public hospitals, the fees charged will be negotiated with the insurers.

In addition, user fees may be charged to discourage inappropriate use of the health services. For example, in order to promote better use of the referral system, patients (both insured and uninsured) may be charged higher fees at secondary and tertiary hospitals if they have not been referred from primary care services. Fees for patients following the referral pathway will take into consideration those fees already paid at the lower level.

Facilities will be allowed to retain a proportion of the revenue generated from user fees to be used for improving the quality of health service provision. Mechanisms will be implemented to ensure that uninsured patients are not refused access because of undue emphasis on paying patients. The remainder of the fee revenue will be submitted to the Ministry of Health (and not the Treasury) for redistribution to promote equity in health service provision.

## SOURCES OF FINANCE

The basis of funding the public health sector will continue to be general tax revenue. Despite the competing claims for limited government resources, particularly for provision of other social services such as education, housing and welfare, it is strongly recommended that health services should receive a higher proportion of general tax revenue. In the past few years, government expenditure on health has fluctuated between 2.8 and 3.4% of GDP (11-12% of total government spending) with a recent trend to decreasing the latter proportion. It is proposed that public spending on health should increase to 4% of GDP (at least 13% of government expenditure). This will provide much needed additional resources for the development of health service infrastructure, and ongoing provision (with an emphasis on the primary care level), in areas that are currently underserved (especially rural and peri-urban areas).

Additional budget allocations to the health sector need not place an additional burden on the state coffers. Additional state revenue can be derived immediately from an increase in the excise on tobacco, which will have an added benefit of reducing consumption. Increased duties on alcohol may also provide revenue, but further studies are required to assess this more fully, especially the health impact of this measure.

## THE ALLOCATION OF RESOURCES FOR PUBLIC SECTOR HEALTH CARE

Public expenditure on primary care facilities and personnel in rural and impoverished urban areas will be prioritised. Deficient primary care currently compels people to use hospitals for basic care, and deficient secondary hospitals results in the unnecessary use of tertiary hospitals. There will therefore need to be an injection of additional resources to develop primary level infrastructure and services, as well as secondary level hospitals which are vital to the PHC system.

In the short-term, there is limited scope for the redistribution of financial resources between levels of care. A framework will be established for the redistribution of resources on a relative basis by ensuring the highest growth in real expenditure for those services which have been underfunded.

To ensure that such an approach maintains the existing infrastructure, it must be accompanied by the active pursuit of improved efficiency. This includes the strengthening of referral mechanisms, improving health facility management and operational efficiency, and possibly closing or rationalising those facilities which are under-utilised or where there is service duplication.

The current geographical inequities in health care resources must immediately be assessed in terms of the new provincial boundaries, and systematically redressed. This process must be planned so as to ensure that the existing health service infrastructure is not adversely affected. The National Health Authority will coordinate the reallocation of resources, taking into account revenue generation potential for health service provision within each province. The National Health Authority will use the resources at its disposal to subsidise those provinces which are

under-funded relative to their needs. The indicators of such needs will include provincial population size, disease patterns, age and gender composition of the population, etc.

The National Health Authority will determine the global health budget for each province (adjusting for revenue generating potential from within provinces). The NHA will also define health sector priorities and provide technical planning guidelines to the Provincial and District Health Authorities. The District Health Authority should be responsible for the actual operational planning (determining financial allocations to individual services and facilities), within the parameters of national priorities and guidelines. The Provincial Health Authorities should be largely responsible for reconciling the district operational plans with available resources, and for planning those services not falling under specific District Health Authorities (e.g. tertiary hospitals).

#### A NATIONAL HEALTH INSURANCE

It is recommended that a Commission of Inquiry be appointed by the Government of National Unity as a matter of urgency, to examine the current crisis in the medical aid sector and to consider alternatives such as a compulsory National Health Insurance (NHI) system. The commission will consult all interested parties, including employer, labour, professional, medical aid, and health insurance organisations. The Commission will investigate the appropriateness and economic feasibility of a National Health Insurance system within the South African context and undertake detailed planning for implementation of an NHI if there is sufficient consensus on this option.

A number of alternative structures for such an NHI should be considered by the commission, namely a single state or para-statal NHI, a single privately administered NHI, or an NHI with the current medical aids acting as the financial intermediaries with pooling of contribution revenue for risk adjustment.

The commission will be asked to investigate the feasibility of an NHI based on the following principles:

The current medical schemes could form the basis of the NHI, provided they met with specified statutory conditions governing the NHI system.

Membership would be compulsory for all formal sector employees and their dependants.

Schemes which form part of the NHI should be prohibited from excluding any member (e.g. on the basis of high risk).

The basic package of care to be covered by the NHI should be statutorily defined.

Contributions to cover the basic package would be income related, probably determined centrally, and should be jointly paid by employers and employees.

This contribution revenue (covering the basic package) should be pooled in a central equalisation fund, out of which every scheme would be paid in terms of its overall risk profile i.e. a risk adjusted capitation fee.

Existing health insurance companies and medical schemes would be free to offer "top-up" cover for services not covered in the NHI essential package.

The long term goal would be for all citizens, including the unemployed, to be covered under the NHI system.

## PROTECTING THE PUBLIC SECTOR

Mechanisms must be developed to ensure that the private sector does not undermine the public sector services. Two concerns are the loss of highly trained personnel to the private sector after substantial public investment in their training, and the loss of tax revenue in the form of concessions for contributions to medical aids. The former issue could be addressed through a period of compulsory public service for professional graduates. A policy to counter the loss of tax revenue is complex and the tax concession needs to be reviewed. This should be done by the proposed Commission of Inquiry, working in conjunction with the Department of Finance. While it is likely that some tax concession should remain, it could be adjusted, restructured, and used to promote equitable, comprehensive care.

## FINANCIAL MANAGEMENT

The administration and management of financial resources for health will reflect the thrust of health policies, that is, the recognition of individuals, families, communities and the health system as partners in the provision, financing and management of health care services.

Health financing mechanisms and sources noted above defined the macroeconomic context. A complementary microeconomic analysis, including cost-effective and cost-benefit analyses, will ensure the optimal allocation of funds and, eventually, the attainment of expected outputs.

Within this context, programme budgeting will be effectively promoted to ensure that national, provincial and district allocations not only comply with established planning figures but also allow for adequate monitoring and evaluation of health programmes and interventions at all levels of the health system.

Multisectoral coordination will ensure the provision of the infrastructure required for the efficient functioning of the health delivery system, particularly at provincial and district levels.

The basic financial management functions of the health system will be put in place to control costs of health care interventions, to ensure regular supply and distribution of goods and services, and to guarantee the collection and utilisation of relevant information for decision-making on health care financing. More specifically, the following strategic options will be implemented.

Sources of finance will be clearly identified as part of a rational macroeconomic analysis.

Finance allocation will be made to all levels of the health system in accordance with national health priorities and guidelines, and budget mechanisms for planning, monitoring and evaluation purposes.

Performance budgeting mechanisms will be designed to allow the combination of epidemiological, use and expenditure data in an integrated financial management information system, to improve target setting and regular performance review.

Cost savings strategies will be devised, based on thorough studies of expenditure patterns.

Profiles of the flow of funds will be established to allow better coordination of diverse financial inputs and to increase donors' confidence in resource utilisation.

## HUMAN RESOURCE DEVELOPMENT

Although South Africa has large numbers of highly skilled health workers, much of their training has been inappropriate and they are poorly distributed in relation to health and health care needs. The transformation of the health system to one based on the PHC approach will require reorientation of existing personnel, fuller use of their present skills, and in-service training and acquisition of new skills to enable them to play a more effective role in promoting, maintaining and restoring health. There will also need to be changes in basic training, and the development of new categories of health personnel.

The primary concern of this policy is to support the aims of the National Health System. The policy is designed to respond to the needs of underserved communities and to strengthen primary health care. It considers health personnel to be agents for transforming health and its socio-political environment and it sees health personnel education as a shared responsibility of community, service, and training institutions. It needs to be multidisciplinary, gender-sensitive and community-based in character. Career path flexibility, review, and the redress of historical maldistribution are other prominent features.

A number of actions are required, which will include the following:

Improvement in the planning systems for the evaluation of health personnel and their distribution.

Reviews of the numbers and categories of health personnel required.

The establishment of data bases on the existing numbers and distribution of health personnel by qualification, function, location and a variety of demographic variables.

Reviews of the appropriateness of existing education and training programmes for the health system.

The development and establishment of new programmes and curricula for health personnel education.

The development of more appropriate methods of student selection.

The establishment of special programmes for fast-track training.

Reviews of existing regulations and legislation to give effect to the changes required in health personnel education.

## HUMAN RESOURCE DEVELOPMENT

The government will continue to subsidise the training of health workers at tertiary education institutions. Personnel education will be the shared responsibility of community, service and training institutions and will be coordinated nationally. The standards of total health care will be raised through a comprehensive system of continuing education, including reviews of the skills and competencies of health personnel.

A broad range of people need to be involved in the selection of students for health education institutions including community members, students and health workers from different service levels. All health education institutions must ensure that the composition of their student bodies reflect society in terms of gender, race and geographic distribution. This will require the application of affirmative action principles in the short to medium term in order to redress present imbalances. Effective integrated academic development programmes will be established to strengthen the capacity of all students entering health institutions.

All health education programmes will be facilitated by the introduction of stepwise certification of all categories of health personnel to match their competence to deliver specific levels of care. Training curricula should enable maximum flexibility for movement across and within different parts of the health system. Each occupational category will have clearly laid out career paths for advancement or transition to management, educational or research roles.

Fast-track training programmes will be introduced to train personnel in priority areas including management, environmental health and diagnosis and clinical care at the primary level.

Community Health Workers may also be trained in areas where there is local community and health service support for them.

Tertiary hospitals have very important and specific roles to play in specialist education, in clinical research and in supporting primary and secondary care services, but most training of health personnel will be at the district and community levels.

Rotation through primary and secondary level facilities in under-served areas will be part of postgraduate as well as part of pre-registration training.

#### STAFFING THE PUBLIC HEALTH SECTOR

Guidelines will be developed for the size and composition of the teams needed at different levels but the emphasis will be on the quality of services rather than on rigid staffing norms. Where necessary the numbers and categories of staff working at primary and secondary care levels will be increased. Proper recognition will be given to the major role of nurses in the health system.

The redistribution of health personnel to under-served areas will be addressed by the provision of selected incentives for personnel such as career opportunities, financial, fringe and study benefits, infrastructural support and amenities. Compulsory service in underserved areas will also be introduced for all qualifying health personnel.

In order to deal with the problems created by the present fragmentation and inconsistencies in salary levels between different health authorities, it is recommended that conditions of service for all health workers in the public sector, including salary scales, be negotiated nationally. A Commission of Inquiry into the conditions of service and employment of all health workers in the public sector will be established as a matter of urgency. It should consult widely with all interested parties including all the public sector unions and employers, and must make recommendations within six months.

Community Health Workers can play a unique role in promoting health and in expanding and improving health services provided they have effective support structures and referral systems and they receive ongoing training. They can also be catalysts for community development, mobilising people around health issues. Local programmes will be encouraged provided they are integrated into the local health services, but no national programme will be launched at this stage.

Effective labour relations will be promoted through accepted recognition and negotiation agreements with health worker organisations. Better conditions of service and clear grievance procedures will help to avoid strikes or other industrial action which could compromise patient care.

#### HEALTH INFORMATION SYSTEM

A comprehensive health information system that begins at the local level and feeds into provincial and national levels is essential. It will consist of the collection, organisation, reporting, storage and use of data for planning and managing promotional activities and health care services. International standards or definitions will be used wherever practicable to ensure that the country can be integrated into, and benefit from, international data reporting systems. The system will be sufficiently flexible to incorporate data arising from research programmes. It must also be able to incorporate data gathered from other sectors.

The information gathered will fall into four broad categories:

Health status information including births and deaths, morbidity and mortality profiles, injuries and disabilities, violence etc.

Health related information including access to clean water, sanitation, unemployment, school attendance etc.

Health service information including facilities, finances, personnel, support services etc.

Management information including health workers in training, staff requirements, cost-effectiveness of services etc.

The Health Information System will cover both public and private health care sectors. Information requirements must be established at each level of the health services related to their needs and according to national guidelines.

Specific indicators will be included to monitor the apartheid-generated disparities in health status and access to health care, and in order to do this data will be disaggregated by gender, and in the short term, by "race" as previously defined by the apartheid state.

Information collected by the system will be used for strategic planning, for policy formulation, for monitoring health care delivery, for evaluating specific health care programmes, and for assessing and reviewing progress on district, provincial and national plans. Where necessary, the confidentiality of information collected will be assured, and at all times the accuracy of the data collected will be monitored.

Ongoing development of the Health Information System, and national analyses and comparisons, will be one of the responsibilities of the National Health Authority. Health objectives, health indicators, data collection forms, existing information systems and information technology will all be reviewed, adapted or developed. Those of the 27 health indicators developed by the WHO Regional Office for Africa that are relevant to South Africa will be included. Training in the collection of health information data will be included in the curricula of all health workers.

Legislation will be amended or developed to facilitate the introduction of the national health information system and the enforcement of its ethical aspects. A national health information bulletin will be published to document changes in health and health care, to help provide feedback to those who collect data and to encourage rational decision making.

## 6. HEALTH PRIORITIES

As has been indicated, the lack of comprehensive or even comparable data, and the generally poor quality of the data that are available, makes rational planning difficult. Priorities and targets have been set within these limitations and will be adjusted as better data become available.

The percentages given are national averages which may mask very marked differences between different provinces, districts or communities. Each district and province must therefore aim to achieve a significant improvement in each of the target areas every year.

The order of priorities may vary from one part of the country to another. Priorities identified in a number of areas such as the provision of clean water, sanitation, housing, employment, education, electricity and telephones have not been included here. They often have an even greater impact on health than the health services alone. However, as they are elaborated in the Reconstruction and Development Programme, there are not repeated here.

The speed with which specific goals can be met and targets achieved often depends on the financial implications, and the time taken to adjust budgets and/or to enact new legislation. Both the financial and legal processes may, therefore, affect the order and speed with which the priorities are implemented.

All planning, including priority setting, must be an interactive and dynamic process. Targets will therefore be reviewed regularly both in the light of new information as it becomes available and in the light of comments, criticisms and new ideas.

The health policy priorities included in this chapter are the following:

## HEALTH POLICY PRIORITIES

### Principal Health Priorities

Maternal and Child Health Nutrition Control of Communicable Diseases Violence Special Programmes for Vulnerable Groups

Other Health Priorities

Health Promotion Drug Policy Emergency Care Substance Abuse Oral Health Environmental Health

HEALTH SYSTEM PRIORITIES

Financing Facilities Human Resources Management Educational and Research Institutions

LEGISLATION FOR THE NATIONAL HEALTH SYSTEM

HEALTH POLICY PRIORITIES

PRINCIPAL HEALTH PRIORITIES

MATERNAL AND CHILD HEALTH

Priorities

- Targets/timing

Provide free health care to children under 6 years of age

- Recommendation by Minister of Health by June 1994

- Legislation enacted by 1995

- 80% of children under 2 years have weight recorded regularly

- Progressive reduction in proportion of children with low weight for age

Improve antenatal care, delivery, and postnatal care, which will be free of charge in the public sector

- 50% deliveries supervised and carried out under hygienic conditions by end 1995

- 80% coverage by end 1999

- Over 60% of pregnant women attending clinics at least once by end 1995

- Free services by end 1997

Expand immunisation coverage using measles as a vehicle for expanding the cold chain and services

- Measles coverage to 80% by end 1995

- Measles coverage to 90% by end 1997

- Road to health cards held by 80% children by end 1995

Eradicate polio and neonatal tetanus

- Eradication of polio and neonatal tetanus by end 1999

Improved programmes on breast feeding

- At least 70% of target population breast feeding at 6 months by end 1995

Enforcement of code of ethics regarding breast milk substitutes

- Increased awareness in all sections of population

UN Charter on Children's Rights

- Ratify within 6 months of Parliament sitting
- Legislation reviewed and adjustments enacted by end 1996

## NUTRITION

Priorities

- Targets/timing

Decrease levels of malnutrition and malnutrition-related diseases

Conduct surveys to assess nutritional status

- Extension of the list of basic foodstuffs exempt from VAT

- Consider and implement price controls and subsidies on basic foodstuffs
- Provide nutrition supplementation to people receiving grants, to vulnerable groups, and to those in relief areas
- Reduce prevalence of severe malnutrition by 40% by end 1997
- Increase pensions to those for whom this is their sole source of income

## CONTROL OF COMMUNICABLE DISEASES

### Priorities

- Targets/timing

### Control the spread of Tuberculosis

- Establish strategies to improve diagnosis, treatment management, compliance and effective follow up

### Development of a programme to reduce the incidence of Hepatitis B and its spread in the communities

- Start an immunisation campaign by end 1995 to prevent the spread of Hepatitis B

### Reduce incidence of moderate and severe dehydration in children under five years of age

- Determine current incidence

- Reduce current incidence

Reduce mortality from acute respiratory infections

- Improved management of acute respiratory infections

Development of an education programme for school children, adolescents and teachers, around health promotion, including sexuality and safer sexual practises.

Controlling the HIV epidemic

Improvement of STD services

- All schools to be running comprehensive education programmes on a regular basis by January 1996

- Develop and implement an effective HIV/AIDS strategy by end 1995

- Develop of STD/HIV counselling and support services at all CHCs by end 1999

- Report the number of cases of HIV-AIDS

VIOLENCE

Priorities

- Targets/timing

Services for people affected by violence and apartheid

- Develop and coordinate mental health services

Protection of women and children against all forms of violence

- Legislation for the protection of women and children by the end of 1995
- Counselling services accessible at CHCs, including referral path to other levels, by end 1995

#### SPECIAL PROGRAMMES FOR VULNERABLE GROUPS

Priorities

- Targets/timing

Women's health

- Improve universal access to reproductive health services

Occupational Health

- Development of occupational health services
- Monitoring and enforcement of existing legislation on occupational health and safety

Rural health

- Improve health services in rural areas
- Provide outreach services to all communities

- Improve health of livestock and adequate standards for food handlers

#### Mental Health

- Improve the quality of mental health care through community-based care and also improve institutional care

#### Chronic illness

- Improve the detection and control of risk factors and of chronic illness at the primary level, including appropriate referrals, by end 1995

#### Rehabilitation

- Improve community-based rehabilitation services coordinated by the CHCs

#### The Elderly

- Improve in community-based services and institutional care for the elderly

#### OTHER HEALTH PRIORITIES

##### Priorities

- Targets/timing

##### Health promotion

- Ensure the establishment of health promotional activities within programmes at all levels of the system by end 1995

## Drugs

- Establishment of an essential drug list by end 1994
- Provision of essential drugs in 80% of CHC facilities by end 1995
- Extension of generic substitution from the public sector to the private sector by end 1996

## Emergency care

- Training of appropriate personnel at CHC in first aid by end of 1994
- All health districts to have identified at least one 24-hour facility to provide emergency care by end 1995, including appropriate communications and response services

## Substance abuse

- Educational programmes in schools, media and health facilities established by 1994/95
- Supporting and developing prevention programmes for drug and alcohol abuse
- Apply strict regulations on the advertising of tobacco and alcohol by end 1995
- Increase excise duties on tobacco by end 1994
- Review the effect of increasing prices of alcohol in reducing consumption

- Extend regulations creating smoke-free zones to include public places, working environments, and government buildings

#### Oral Health

- Introduction of measures to fluoridate the mouth, including fluoridation of existing and future developments of water supplies, and provision of fluoride supplementation, by end 1995

- Education programmes to improve diagnosis of early oral lesions for all health workers by end 1999

#### Environmental health

- Endorse and Implement the Rio Declaration on Environment and Development by July 1994

- Carry out health impact studies on the effects of major economic developments

- Monitor respiratory diseases related to air pollution

#### HEALTH SYSTEM PRIORITIES

#### FINANCING THE NHS

#### Priorities

- Targets/timing

Investigate mechanisms for the reallocation of resources towards primary health care, and to areas of greatest need for health services

- Development of national formulae for the allocation of the health budget between and within provinces by end 1995

- District and provincial funds to be allocated to address inequalities by April 1996

Establish a national commission to investigate the crisis in the medical aid sector, and advise on the most appropriate system for financing the health sector

- Establish commission by June 1994, and to report within six months

Free access to specified priority services and for specific vulnerable groups

- No user fees charged for these services and target groups in the public sector by end 1994

Review options for the removal of VAT on medical services

- Recommendations made by end 1994

## HEALTH FACILITIES

Priorities

- Targets/timing

Provide equitable access to health care services

- At least 75% of the population lives within reach of a primary care service by end 1995, especially in the rural areas

Identify areas where primary care facilities (clinics and CHCs) have to be built, according to need and national standards and norms

- Number of services needed identified by end 1994

- National standards and norms defined

Construction of PHC facilities

- Facilities built to redress backlog taking into account future needs by 1999.

Improve and strengthen existing health facilities in keeping with national standards and norms

- Ensure existing facilities are capable of delivering quality health care

Creation of an appropriate health care delivery system

- Initiate discussions on rationalisation of tertiary care institutions

Review the regulatory framework for the licensing of all facilities

- Appropriate regulations by end 1995

HUMAN RESOURCES

Priorities

- Targets/timing

Planning for human resource development

- Elaboration of a long term programme for personnel to cover the needs of the NHS by end 1995

Provision of core teams to every CHC and other primary care facilities

- Training of appropriate primary care providers

- Provide at least one diagnostician, and environmental health personnel to every CHC

- Define and implement incentives to reallocate personnel to the underserved areas

Provide intensive training, retraining and reorientation of health workers to the PHC Approach

- 25% of district health personnel trained by end 1995, and 50% by end 1997

Define new cadres of personnel for all areas of the health sector

- Analysis of competency and skill levels for new cadres by end 1995

Establish mechanisms to integrate traditional and other complementary practitioners into the NHS

- Implement integration by end 1999

## MANAGING THE NHS

Priorities

- Targets/timing

Establish standard conditions of service and employment for health workers in the public sector

- Appoint a Commission of Inquiry by end June 1994, and to report within 6 months

Decentralisation of decision making powers

- Establish the structure and line management functions of the NHS for decentralised decision making to the lowest effective level by end 1994

Establish the National Health Information System which includes both public and private sectors

- Definition of essential information required at each level, including an epidemiological surveillance system by end 1994

- Training of personnel at all levels and facilities by end 1995

- Commencement of collection of information at all levels by end 1995

- Utilisation of existing data to define and monitor health priorities by end 1994

## EDUCATIONAL AND RESEARCH INSTITUTIONS

Priorities

- Targets/timing

Transformation of educational and research institutions

- Reorientation of educational institutions in terms of community-based orientation and accessibility

- Review the need for new educational and research institutions according to the needs of the country by end 1996

- Promote and implement affirmative action

Promotion of essential national health research and development of health research priorities

- Review all existing health research, and resources for health research by end 1994

- Evaluate and coordinate health related research

- Establish health research priorities by end 1995

## LEGISLATION FOR THE NHS

### Priorities

- Targets/timing

Draw up legislation to implement the National Health System

- Definition of the powers and functions of the National, Provincial, and District Health Authorities by end May 1994

- Review the Health Act, Health Policy Act, and legislation relevant to health personnel with the aim to make the necessary changes to respond to the National Health Plan by end June 1994

- Enact new legislation by end August 1994

Review of all other legislation relevant to health in order to make the necessary changes in accordance with the National Health Plan

- Legislation for priority areas

- Prioritise the legislation to be reviewed in the short to medium term by July 1994

- Other legislation during the period of the Government of National Unity

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Family Practitioners Association

Health Systems Trust

Industrial Health Research Group

Medical Association of South Africa

Medical Research Council

National Association of Private Hospitals

National Institute for Virology

National Progressive Primary Health Care Network

Peninsula Specialist Group

Pharmaceutical Manufacturers Association

Representative Association of Medical Schemes

Rural Disability Action Group

Social Aspects of Alcohol Committee of the Liquor Industry

Society of Dispensing Family Practitioners

Society of Medical Laboratory Technologists of South Africa

South African Academy of Family Practice, Western Cape

South African Chamber of Business

South African Druggists

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South African Homeopathic Association

South African Medical and Dental Practitioners

South African National Tuberculosis Association

South African Nursing Association

South African Society of Physiotherapy

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Western Cape Regional Services Council