- All provincial departments of health agreed to the standard of services to be provided at all government clinics, health centres and district hospitals.
- Hundreds of clinic committees were established to give communities a voice in the running of facilities.

Recent advances

The scrapping of patient fees and the increase in clinics has undoubtedly born fruit.

Use of primary health care services has increased steadily. In 1998 there were 67 million visits to these services countrywide. By 2002 this figure had risen to 85 million and in 2004 it exceeded 98 million.

The average number of annual visits was 1.8 per person in 1998 and increased to 2.1 by 2004. For children under five years – a critical stage of development – visits are more frequent, averaging 4.5 a year in 2004.

Provinces have made a concerted effort to ensure that health districts function as strongly managed, coordinated units. In most provinces, all health districts have district managers in place.

Presently not all health districts are able to provide the full range of services stipulated in national standards: Two out of three districts meet the requirement. Those that do not offer the full package of services nevertheless provide a significant range of services.

Looking ahead

Better planning and allocation of sufficient financial and human resources are key to improving primary health care services.

As a basis for this, the strengths and weaknesses of every health district will be mapped out on a clinic by clinic basis to establish the gap between what clinics should offer and what they do offer their communities.

The participation of communities in

health programmes and services is a basic value of primary health care. In many areas this is achieved through the development of clinic committees. The National Health Act of 2003 gave a boost to community participation by formally recognising clinic committees and district health councils and requiring provinces to pass additional laws to govern the functioning of these structures.

Centres for specialised care

Regional and provincial hospitals

Specialised care for more complicated health conditions is provided by regional hospitals and central hospitals.

Every province has several regional hospitals to which district facilities can refer patients. Regional facilities have specialist doctors and are better equipped than district hospitals to deal with more serious health problems.

There are only 10 central hospitals in the country and they are concentrated in four provinces: Free State, Gauteng, KwaZulu-Natal and Western Cape. All are major training centres for health sciences faculties and they attract many highly qualified health professionals. Central hospitals are national services and patients who need the highest levels of care are referred across provincial boundaries from all corners of the country to these hospitals.

In the first decade

- Hospitals were reorganised according to the kind of services they could provide instead of on racial lines.
- Funding for hospitals was spread more evenly between the urban centres and outlying towns.
- Major building projects were carried out in 249 hospitals in all provinces and 18 new hospitals were built, including three major teaching hospitals.
- A long-term plan to renew and re-equip the country's public hospital network, the Hospital Revitalisation Plan, was launched.
- Better management structures and financial systems were introduced for hospitals.

Recent progress

The Hospital Revitalisation Programme is building up steam. A total of 42 hospitals have been revamped or newly built since it began in 2003, and a further 21 are under construction or being planned in 2006/7.

The new hospitals are not just attractive, modern buildings. They are better planned for the needs of communities. For example, several hospitals built under the revitalisation programme are intended to improve access to health services:

- Moses Kotane Hospital in North West is situated to cater for the burgeoning population around Sun City.
- In Soweto three new hospitals, spread across the area, will allow Chris Hani Baragwanath Hospital to downscale to a more manageable size.
- In the Northern Cape and KwaZulu-Natal the project has focused on providing new psychiatric hospitals.

The Revitalisation Programme also provides up to date equipment, strengthens hospital management and creates systems to improve quality of care.

Across the 400-plus public hospitals there has been a successful drive to appoint chief executive officers with overall responsibility for managing the facility.

Accountability to communities has grown stronger, as the practice of appointing hospital boards has spread across all provinces. The picture is not perfect as there as still hospitals without boards in some provinces, but the goal of 100% of hospitals with hospital boards is within sight with provinces committed to reaching this target in 2006. The contribution of hospital boards is formally recognised in the National Health Act.

Three out of the four provinces with central hospitals have reported a drop in death rates among patients undergoing surgery and one province – Western Cape – has achieved the national target of 3%. Since these hospitals deal with severe injuries and the most complex surgery, low mortality rates are a sign of excellent treatment.

Looking ahead

The future of the Revitalisation Programme is assured, provided that provinces produce good quality business cases and the programme attracts generous allocations from Treasury. Four projects are expected to be completed in 2006/7: George Hospital (Western Cape), Mary Theresa Hospital (Eastern Cape), and Jane Furse and Lebowakgomo Hospitals (Limpopo).

Statistics on use of hospital beds suggests that we have too many beds scattered across many small hospitals. Revitalisation funds could in future be used to combine some small hospitals into larger hospitals that are better equipped and offer better access to specialised staff.

Decision-making powers of hospital chief executives will be increased to eliminate bureaucratic delays that interfere with service delivery, and to promote local decision-making and accountability.

Urgent action will be taken in terms of the National Human Resource Plan (See page X) to address the skills and staff shortages that undermine quality of hospital care.

Lifeline when crisis strikes

Emergency medical services

The public often measures the effectiveness of the health service by how well it responds in emergencies, when life is truly in the balance. The provincial ambulance services and emergency sections of hospitals are responsible for this aspect of care.

Provinces experience different challenges in terms of providing ambulance services. For some it is vast distances and poor roads; for others, a huge burden of trauma due to interpersonal violence and road traffic accidents. A lack of dedicated transport for non-emergency patients in many areas means that ambulances are often diverted for this purpose.

In the first decade

All provinces invested considerable sums in renewing and expanding their ambulance fleets. Despite this, many provinces still experienced weaknesses in ambulance services and fell short of targeted response times to varying degrees.

Recent developments
All provinces are continuing to increase the number of ambulances in operation. However, a lack of adequately trained emergency medical personnel continues to limit the services even in urban centres.

Looking ahead
Over the next three years, all provinces will implement plans to strengthen ambulance services. These include:
Increasing the number of emergency personnel by boosting training, especially in relation to intermediate and advanced life support.
Improving communities' awareness of toll free numbers for emergency use.
Strengthening the management of emergency call centres.

New approaches will be explored to provide care for residents of remote areas, for example the use of air ambulances for long-distance transfers of patients between hospitals or flying doctor services.

The heart of health care
The nation's health workers

Any health system is only as good as the people who provide the services. In South Africa, 65% of public sector health spending goes to paying the people who provide care and manage health services. Where there are major gaps in staffing and when health workers are lacking in skill, the quality of service suffers.

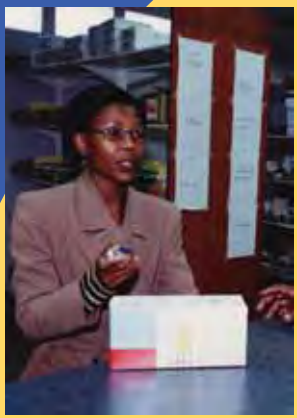
South Africa has a tradition of sound training of health professionals and this was a genuine asset as we set about reorganising our health system to provide access to health care for everyone.

In the first decade
Important changes in relation to training of health professionals included:

- Measures to encourage our medical schools and other training

institutions to admit greater numbers of students from historically disadvantaged communities

- Streamlining the network of nursing colleges to create larger colleges and to eliminate the duplication arising from racial segregation under apartheid.
- Introducing a system of continuous professional development, which links registration of health professionals to ongoing study.
- Encouraging health science faculties to adjust curricula to supply health personnel that are committed to building a strong primary health care foundation.
- Fast-tracking production of primary health care professionals, including the training of primary health care nurses domestically and increasing the number of doctors through a country-to-country agreement with Cuba.



Policies to increase the number of health professionals in government hospitals and clinics, especially in rural areas, included:

- Employing doctors from countries with surplus doctors through contracts with their governments.
- Introducing a year of community service immediately after graduation for most health professions. In 10 years, 11 000 young professionals enhanced health service delivery, mainly in rural areas, through community service.
- Paying special allowances to doctors, nurses and other health professionals working in rural areas or possessing scarce skills.
- Training and employment of mid-level workers such as pharmacy assistants.

Recent developments

There are still considerable shortages of professional staff in public clinics and hospitals in all provinces. The

seriousness of the situation varies and generally rural areas are most severely affected. This is an international phenomenon which afflicts developing countries in particular and is made worse by the brain drain of health professionals from developing to developed countries.

To address this situation, a National Plan for Human Resources for Health was developed in consultation with important stakeholders during 2005. It was formally launched on World Health Day, 7 April 2006, a day dedicated to health workers across the globe by the World Health Organisation.

In contrast to the late 1990s, when tight health department budgets often limited the filling of posts, in recent years it is the shortage of professionals that poses the problem. Many fully funded posts in the public health sector remain vacant in spite of efforts to fill them.

This is largely due to the international "brain drain" of health professionals and the exodus from the public sector to the private sector. Higher pay, better working conditions, and a desire for international experience , are some of the factors that health professionals give for leaving our public health sector.

The shortage is also due to under-production of health professionals in some categories. For example, the combined output of all nursing colleges between 1998 and 2003 averaged 424 graduates a year.

The Plan is serious about correcting this situation and states that production of sufficient numbers of health professionals, improved remuneration and better working conditions are the keys to solving the longstanding human resource shortages.

It argues that South Africa has to train enough health workers to supply domestic needs despite the impact of migration. At the same time, the public health sector has to "improve the work-life experience" of its skilled personnel to prevent them from leaving for greener pastures.

Looking ahead
The systematic implementation of

the National Plan for Human Resources for Health is the key to medium- and long-term improvements in professional staffing of the health system.

Ahead of this, some immediate steps have been taken: Some nursing colleges that were closed in the 1990s will be reopened, as President Thabo Mbeki announced in his 2006 State of the Nation address. The intake of student nurses increased in most provinces in 2006.

Salaries of health professionals are under review, with the target of producing a new, improved salary structure around the middle of 2006.

A system to employ private doctors on a part-time basis in government hospitals and clinics is being developed.

Good experience, good results

Quality of care initiatives

Quality in the health services depends heavily on appropriate staffing, equipment and physical facilities. But it does not end there. It also depends on whether there is a culture of caring and an emphasis on excellence in hospitals and clinics. These are cultivated in clinics and hospitals by developing systems and routines that express commitment to quality. In addition, there is a need for community involvement in the provision of health care services.

In the first decade

Important milestones in the first 10 years included:

- Introduction of the Batho Pele Programme across the public service.
- Development and promotion of the national Patient's Rights Charter.
- Institution of annual service excellence awards for health at provincial and national levels.
- Development of a range of treatment guidelines and protocols for various health problems.
- Training of personnel to implement health care guidelines.
- Inclusion of a section on the rights and responsibilities of patients and health workers in the National Health Act.

Recent progress

All provinces have developed quality assurance programmes.. They have

appointed personnel in these quality assurance units and are implementing their programmes which combine elements to improve standards of health care and to address overall service quality.

Quality assurance programmes in all provinces include:

Clinical audits and monitoring of mortality and morbidity
These activities, which aim to establish whether personnel are complying with clinical guidelines, are beginning to occur in public hospitals. They provide health teams with important information that enables them to address weaknesses in the provision of medical care.

Complaints systems
The National Health Act requires every province to have a formal complaints system covering all levels of care. Provinces report that increasing numbers of patients have the confidence to make formal complaints. The existence of telephone hotlines has also made the process easier. Provinces monitor the pattern of complaints and performance in responding to complaints.

Patient satisfaction surveys
These are conducted from time to time among people using clinics and hospitals to check how they experience different aspects of service, from waiting times, to cleanliness of facilities, the treatment received and the manner in which health workers deal with patients.

Accreditation systems
All provinces use accreditation systems to review and strengthen the quality of care, especially in hospitals. A number of public hospitals in various provinces have already been accredited using a set of standards that are also used in the private health sector. One province has developed its own standards and established an independent panel of experts to conduct reviews.

In spite of these unfolding quality assurance programmes, the standard of care in state facilities remains uneven. Within the same province it is possible to find health facilities with very good standards and some offering unsatisfactory care.

Looking ahead
The Department of Health recognises that relieving existing shortages of skilled health professionals will make a significant

contribution to quality of care. In addition, improving the level of skills of existing health workers and managers, strengthening infrastructure – as the Hospital Revitalisation Programme is doing — and ensuring the availability of necessary equipment will all assist in improving quality of care.

Health and development

By reducing the burden of disease and by saving lives, the health sector makes a significant contribution to the development of any nation. People who are healthy are more likely to learn, to work, to care for their families and to contribute to their communities – in other words, to drive the social and economic development of their villages, towns and countries.

Heads of State recognised this vital link between health and development when they adopted the Millennium Development Goals, a plan to create a more equal and humane world for the 21st century.

This plan sets particular targets in relation to protecting the health of children and women, and reducing some of the world's most disabling diseases. South Africa's President has signed the Millennium Declaration which means that we have a commitment to do everything possible to meet the stated targets.

Protecting the future

Child health programmes

Health-wise, the first five years of life are crucial. Not only is there an increased risk of death in these years, but illnesses contracted at this stage may adversely affected individuals for the rest of their lives.

If we are able to carry out a small number of health programmes effectively we can make a huge difference to the health of our children – particularly in these critical pre-school years.

These programmes involve immunisation against childhood diseases,

few sub-districts registered much lower immunisation rates.

The Integrated Nutrition Programme has been expanded to all 53 health districts and now includes benefits for the youth.

School health services were extremely unequal under apartheid and it took time to develop a national programme that would benefit all learners equally. The programme was adopted in 2004 and is being phased in. It has two aspects:

- The assessment of learners to identify malnutrition and hearing, sight and other impairments.
- Health education and promotion.

Assessment of learners and referral for treatment are now happening in one out of three health districts in most provinces. In KwaZulu-Natal, for example, health workers are not only conducting assessments but also introducing health education in schools.

The Integrated Management of Childhood Illnesses is a strategy that trains health workers to check the child's overall health condition every time the child presents with a specific health problem. It encourages prevention and early diagnosis. It also encourages parents to become involved in their children's health care. By March 2005, 60% of health workers dealing with children had been trained in this strategy.

Improved malaria and TB control, better responses to outbreaks such as cholera and expansion of services to prevent HIV and manage AIDS also impact on the health status of our children. (See pages X and X)

Looking ahead

A number of clinics still do not have health workers with the necessary training to implement the Integrated Management of Childhood Illnesses strategy. Therefore training remains a priority in the short-term.

Sub-districts with low immunisation rates will be targeted for special attention in order to prevent future outbreaks of measles — and possibly other diseases.

The Department of Health will continue to support inter-sectoral initiatives to upgrade water and sanitation provision.

Saving mothers
Maternal health

Safety during pregnancy and childbirth is a factor that separates industrialised countries from the developing world, where women commonly pay a heavy price for conceiving and bearing children.

In the first decade
In order to save mothers from serious illness and death, the Department of Health:

- Introduced a nationwide reporting system for all deaths occurring during pregnancy, childbirth and the six weeks following birth.
- Put in place a system to assess the trends revealed by the reporting system and to address deficiencies in care.
- Passed legislation facilitating access to safe termination of pregnancy during the first 20 weeks of pregnancy.

Recent developments
The systematic reporting of maternal deaths has resulted in four national reports analysing the causes of these deaths. It is clear that the greatest number are caused by pre-existing health conditions – and that the remainder, many of which are preventable, are due both to shortcomings in the health service and factors beyond the health facility, such as lack of transport and telephones, especially in rural areas.

Looking ahead
The reports on maternal deaths chart the way to achieving safer motherhood. Measures to reduce maternal deaths include:

- Having suitably trained health professionals at all maternity units.
- Ensuring maternity units all have the necessary supplies and equipment and that equipment is in working order.
- Detecting complicated pregnancies earlier and referring these mothers to the appropriate facility.
- Ensuring transport is available to "at risk" mothers to reach the facilities they need as quickly as possible.