PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

Case study from South Africa
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South Africa was selected as one of five countries (with Bangladesh, Nigeria, Pakistan and the United Republic of Tanzania) for a first round of PRIMASYS case studies. The study was conducted as a rapid assessment over a three-month period (mid-December 2015 to mid-March 2016) by a team from the School of Public Health, University of the Western Cape, in partnership with Andrew McKenzie of Health Partners International, who with Helen Schneider played the main anchoring role for the project. Guided by a template for the case study provided by the Alliance for Health Policy and Systems Research, we sourced and reviewed a wide range of available documentation and consulted with 29 key players in the field who provided further insights and information. They included national government policy-makers (spanning health, treasury and the presidency), provincial, district and programme managers, statutory bodies (research councils, National Institute for Communicable Diseases), nongovernmental organizations and technical agencies providing support to government and higher educational institutions.

We are deeply indebted to all those who agreed to meet us at short notice and who offered inputs and commented on the draft. Thanks in particular go to Peter Barron who read and commented on drafts of the briefing document. Responsibility for the contents, however, remains with the authors.
Abbreviations

ARV  antiretroviral
GDP  gross domestic product
NGO  nongovernmental organization
NIMART  nurse-initiated management of antiretroviral therapy
OECD  Organisation for Economic Co-operation and Development
PHC  primary health care
PMTCT  prevention of mother-to-child transmission of HIV
TB  tuberculosis
UNICEF  United Nations Children’s Fund
WHO  World Health Organization
WISN  Workload Indicators of Staffing Need
Background to PRIMASYS case studies

Health systems around the globe still fall short of providing accessible, good-quality, comprehensive and integrated care. As the global health community is setting ambitious goals of universal health coverage and health equity in line with the 2030 Agenda for Sustainable Development, there is increasing interest in access to and utilization of primary health care in low- and middle-income countries. A wide array of stakeholders, including development agencies, global health funders, policy planners and health system decision-makers, require a better understanding of primary health care systems in order to plan and support complex health system interventions. There is thus a need to fill the knowledge gaps concerning strategic information on front-line primary health care systems at national and subnational levels in low- and middle-income settings.

The Alliance for Health Policy and Systems Research, in collaboration with the Bill & Melinda Gates Foundation, is developing a set of 20 case studies of primary health care systems in selected low- and middle-income countries as part of an initiative entitled Primary Care Systems Profiles and Performance (PRIMASYS). PRIMASYS aims to advance the science of primary health care in low- and middle-income countries in order to support efforts to strengthen primary health care systems and improve the implementation, effectiveness and efficiency of primary health care interventions worldwide. The PRIMASYS case studies cover key aspects of primary health care systems, including policy development and implementation, financing, integration of primary health care into comprehensive health systems, scope, quality and coverage of care, governance and organization, and monitoring and evaluation of system performance.

The Alliance has developed full and abridged versions of the 20 PRIMASYS case studies. The abridged version provides an overview of the primary health care system, tailored to a primary audience of policy-makers and global health stakeholders interested in understanding the key entry points to strengthen primary health care systems. The comprehensive case study provides an in-depth assessment of the system for an audience of researchers and stakeholders who wish to gain deeper insight into the determinants and performance of primary health care systems in selected low- and middle-income countries. Furthermore, the case studies will serve as the basis for a multicountry analysis of primary health care systems, focusing on the implementation of policies and programmes, and the barriers to and facilitators of primary health care system reform. Evidence from the case studies and the multi-country analysis will in turn provide strategic evidence to enhance the performance and responsiveness of primary health care systems in low- and middle-income countries.
1. Background to South Africa case study

The primary health care (PHC) approach as envisioned by the 1978 Alma Ata Declaration on Primary Health Care is enshrined in key health policy statements and legislation in South Africa. PHC is provided in the main through a nurse-based, public PHC infrastructure of around 3500 clinics and health centres, available within 5 kilometres to more than 90% of the population, and free at the point of use. These facilities provide a comprehensive package of basic services including maternal, child and reproductive health, HIV and tuberculosis (TB) testing and treatment, screening and care for noncommunicable diseases and treatment of common ailments. Facilities relate to a large and diverse nongovernmental organization (NGO)-based community care sector that emerged in response to the HIV and TB epidemics and is being reorganized into a system of ward-based outreach teams as part of PHC. Per capita funding of PHC has doubled over the last 10 years, largely due to a rapid expansion of access to ARV treatment for HIV, now provided to more than 3 million people, as well as other entitlements (such as pneumococcal and rotavirus vaccines).

Despite increasing resources and growing utilization, quality of PHC is a major problem, with drug stock-outs common and poor interpersonal quality a frequent complaint. Access to mental health, rehabilitation, and oral and eye health care is low. Management capacity at the front line is weak, and the development of the District Health System as the key support to PHC is still highly uneven across the country. Training of health professionals in higher education institutions is still hospice-centric and curative. In the face of a very high burden of preventable morbidity and mortality, intersectoral action on the social determinants of health remains underdeveloped. While structures for citizen participation in PHC through clinic committees are mandated in the National Health Act, these are often not functional. A quasi-federal system of governance has led to unequal implementation across nine provinces, and a perceived policy implementation gap.

A Primary Health Care (PHC) Re-engineering Strategy is prioritized in South Africa’s proposals for NHI. The national Ideal Clinic initiative is taking steps to revitalize PHC by standardizing the inputs and processes (infrastructure, staffing, records, treatment protocols, governance) of PHC and establishing monitoring and quality improvement mechanisms.

A private ambulatory general medical practitioner sector exists in parallel to the public sector, providing regular care to the 16% of the population with private health insurance and to the uninsured who can afford out-of-pocket cash payments. A traditional healer sector is also widely consulted but exists separately and is uncoordinated with the public health system.

This report provides an overview of key developments in and features of PHC in South Africa, situated in the socioeconomic and health system context of the country. It examines the key inputs, outputs and outcomes of this system, summarizes its strengths and weaknesses and proposes priorities for further strengthening of PHC. The latter include a major focus on the human resource base of PHC, policy and strategies to address the social determinants of health, developing the District Health System as the key support to PHC, and transferring the lessons learned from and investments in HIV/AIDS into other areas of the PHC system.
2. Overview of developments since 1994

South Africa is a middle-income country of 55 million people, two thirds of whom are urban dwellers. Since the advent of democracy in 1994, key policy statements, such as the White paper for the transformation of the health system in South Africa (1997) \(^1\) and the National Health Act (2003) \(^2\), have placed PHC and the District Health System at the heart of the transformation of South Africa’s National Health System (Figure 1).

South Africa is a signatory to the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, commemorating the 30th anniversary of the Alma Ata Declaration on Primary Health Care \(^3\). In 2010, the Department of Health adopted the national PHC Re-engineering Strategy \(^4\), which, among other objectives, seeks to strengthen community-based and preventive strategies. A commitment to PHC is further entrenched in the recently released White paper on National Health Insurance (NHI), where PHC is described as the “heartbeat” of NHI \(^5\). The PHC Re-engineering Strategy and the NHI white paper stress the importance of the PHC approach within the framework of the District Health System. The PHC Re-engineering Strategy has four priority streams: (a) ward-based PHC outreach teams consisting of community health workers and a professional nurse as team leader; (b) maternal, child, neonatal and women’s health district clinical specialist teams; (c) an integrated school health programme; and (d) contracting of private general practitioners to work in public facilities.

**Figure 1. Developments in PHC since 1994**

- **1994**
  - End of apartheid – a racially fragmented health system is united into one national and nine provincial health departments

- **1996**
  - Free PHC policy – Implemented first for women and children, then for all users

- **1997**
  - White paper: transformation of the health system – emphasis shifts from curative hospital care to PHC

- **1997**
  - White paper: transformation of the health system – emphasis shifts from curative hospital care to PHC

- **1997**
  - White paper: transformation of the health system – emphasis shifts from curative hospital care to PHC

- **2001**
  - PHC package – set norms for the provision of comprehensive PHC (updated in 2010 and currently being revised)

- **2003**
  - National Health Act (No. 61 of 2003) – formalisation of the legal status of the District Health System

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- **2003**
  - National Health Act (No. 61 of 2003) – formalisation of the legal status of the District Health System

- **2010**
  - PHC re-engineering discussion document – reasserting the centrality of PHC and the District Health System

- **2010**
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- **2010**
  - PHC re-engineering discussion document – reasserting the centrality of PHC and the District Health System

- **2013**
  - Ideal Clinic initiative – defining the functions of the PHC clinic

- **2013**
  - Ideal Clinic initiative – defining the functions of the PHC clinic

- **2013**
  - Ideal Clinic initiative – defining the functions of the PHC clinic

- **2013**
  - Ideal Clinic initiative – defining the functions of the PHC clinic

- **2013**
  - Ideal Clinic initiative – defining the functions of the PHC clinic

- **2013**
  - Ideal Clinic initiative – defining the functions of the PHC clinic

- **2015**
  - National Health Insurance white paper – PHC described as the “heartbeat of the NHI”
Public PHC is provided through a nurse-based, doctor-supported infrastructure of over 3500 clinics and community health centres, available within 5 kilometres to more than 90% of the population, and free at the point of use (5). Since 1994, there has been a clinic building and upgrading programme involving 1500 facilities and a considerable expansion of resources and entitlements through, and increased utilization of, the PHC system (5). In 1998, there were 68 million visits (1.6 visits per capita) to PHC facilities; by 2015 this had risen to 120 million visits (2.2 visits per capita) (key informant interview). It has enabled access to ARV therapy to more than 3 million people, and reduced mother-to-child transmission of HIV to 1.5% (6). This PHC system is supported by an emerging system of community-based outreach teams consisting of community health workers. In parallel, primary care is also provided by fee-for-service private general practitioners as well as traditional healers. Reforms to PHC have been implemented with other measures by the State to address absolute poverty, including a large programme of social grants (reaching 16 million people), and expanded access to water, sanitation, electricity and housing.

However, South Africa faces a formidable burden of disease, disproportionately impacting the poor. It has serious generalized HIV and TB epidemics, a rapidly growing burden of noncommunicable disease, high rates of injury and violence and still unacceptably high levels of maternal and child mortality. The HIV epidemic in particular has had devastating effects on the health system and on society at all levels, including a rapid decline in life expectancy, overwhelming health care needs, and social and political crises. A concerted national response over the last decade, including a programme of universal access to ARV therapy, has reversed some of these impacts (e.g. by raising life expectancy) and stimulated broader health system strengthening (e.g. increased staffing of PHC), but only recently has space been opened to focus on other health care needs (e.g. noncommunicable diseases). However, there is consensus that despite a high overall proportion of gross domestic product (GDP) spent on health, health outcomes are poor. The key issues facing the health sector are the redistribution of resources within the sector and improving the functioning of the public health system, whilst also addressing the social determinants of ill health, which have their roots in poverty and inequality.
3. Macroeconomic and health sector context

The achievements of PHC in South Africa occur against a backdrop of significant health system, social and economic challenges. South Africa has one of the highest levels of income inequality in the world, with a Gini coefficient of 0.69 (7). Estimates of poverty in South Africa range from 46% to 65% (7, 8). Poverty is particularly severe among the one third of the population that live in rural areas, where estimates of poverty exceed 70%. Agriculture contributes only 2.4% to GDP (2011 data; down from 2.6% in 2006) (9), though approximately 8.5 million people, or 17% of the population, depend directly on it.

In the health sector, inequalities are present in stark differences between a well resourced, insurance-based private sector serving only 16% of the population, but consuming half the total funds flowing through the health sector in the country, and a tax-funded public health system providing care for the remaining 84% (Table 1) (5).

### Table 1. Health system indicators for South Africa

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Results</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure as % of GDP</td>
<td>8.6%</td>
<td>2015</td>
<td>National Department of Health (5)</td>
</tr>
<tr>
<td>Public expenditure as % of total health expenditure (including donors)</td>
<td>48.5%</td>
<td>2015</td>
<td>National Department of Health (5)</td>
</tr>
<tr>
<td>% of total provincial public sector expenditure on district health services</td>
<td>46%</td>
<td>2015</td>
<td>Padarath, King and English (10)</td>
</tr>
<tr>
<td>% of total provincial public sector expenditure on PHC</td>
<td>26%</td>
<td>2015</td>
<td>Padarath, King and English (10)</td>
</tr>
<tr>
<td>Per capita provincial public sector expenditure on PHC</td>
<td>US$ 60</td>
<td>2015</td>
<td>Padarath, King and English (10)</td>
</tr>
<tr>
<td>Out-of-pocket payments as proportion of total expenditure on health</td>
<td>6.4%</td>
<td>2015</td>
<td>National Department of Health (5)</td>
</tr>
<tr>
<td>Voluntary health insurance as proportion of total expenditure on health</td>
<td>42.8%*</td>
<td>2015</td>
<td>National Department of Health (5)</td>
</tr>
<tr>
<td>Proportion of households experiencing catastrophic health expenditure</td>
<td>0.42%</td>
<td>2005/6</td>
<td>Ataguba, Day and McIntyre (11)</td>
</tr>
<tr>
<td>Physicians registered per 1000 population</td>
<td>0.93</td>
<td>2014</td>
<td>Padarath, King and English (10)</td>
</tr>
<tr>
<td>Nurses registered per 1000 population (all categories)</td>
<td>6.1</td>
<td>2014</td>
<td>Padarath, King and English (10)</td>
</tr>
</tbody>
</table>

a. Note that public expenditure plus out-of-pocket expenditure plus private expenditure = 98.2% with the balance (1.8%) from donors
In South Africa, spending on private health insurance as a proportion of total health expenditure is the highest in the world, and 6 times higher than the average in Organisation for Economic Co-operation and Development (OECD) countries (5). The presence of a high-technology and costly private health system, characterized by an oligopolistic hospital sector and significant inflationary pressures, accounts for the overall very high proportion of GDP (8.6% in 2015) spent on health (5).

As Ataguba and McIntyre (12) have shown, the distribution of health benefits relative to need in South Africa is highly inequitable (Figure 2). A household survey found that while total utilization was similar across socioeconomic groups (2.3–3.7 visits/year), the profile of providers used was different. The poorest (socioeconomic quintile 1) were the most likely to use public PHC facilities (68.8%), while conversely, 60.8% of the richest (socioeconomic quintile 5) made use of private primary care providers (13).

The health system is structured into a National Department of Health, nine provincial health departments and 52 health districts. In South Africa’s quasi-federal political system, the national sphere sets overall policy and frameworks, and provincial and local authorities are responsible for implementation. The provincial sphere has the main responsibility for service delivery, including PHC and the District Health System. Local authorities provide environmental health services and some preventive services. In some metropolitan areas, they also provide clinic-based PHC in parallel to that of the provinces.

Government revenue is collected nationally and redistributed to provinces in the form of block grants (the so-called equitable share), based on a needs-adjusted, population-based formula. This is then allocated to sectors, including health. Certain funds, notably for the HIV/AIDS and TB programme, are ring-fenced nationally and transferred as conditional grants. Over the last five years close to 80% of provincial expenditure has come from the equitable share, with the rest from conditional grants and less than 3% from provincial own revenue (14). Private sector funding flows through a fragmented system of 83 individual medical schemes. The NHI white paper outlines proposals to pool these resources with the tax-funded base into one NHI fund that will ensure more equitable distribution of resources across the country through purchasing services from accredited public and private sector providers.

The overall governing body of the public health sector is the National Health Council, which links the provincial health ministers and members of executive councils with the national minister. The Director-General of the National Department of Health and
the nine provincial heads of department form the Technical Advisory Committee to the National Health Council. Frameworks for financial and performance accountability are provided nationally, and include systems of budgeting, planning and accounting, including reporting on a set of core national indicators. Key regulatory bodies include the Medicines Control Council, which will become the South African Health Products Regulatory Authority (manufacture, registration, distribution and pricing of medicines and medical products), the health professions councils (training and professional registration), the Office of Health Standards Compliance (facility accreditation in private and public sectors), and the Medical Schemes Council (regulating private health insurance). Public accountability is through statutorily mandated councils and consultative forums at various levels, hospital boards and health facility committees. However, in practice these structures are very unevenly constituted. Figure 3 provides a map of the South African health system, outlining its architecture and governance.
4. Demographic and health profile

Based on the 2011 census, the estimated midyear population for 2015 was 55 million with a population growth rate of 1.65% (15). Around 59% of the population are aged below 30 years, with the highest percentage being in the 0–4-year age band (10.8%) followed by 5–9 years (10.1%). There were 26.9 million (48.9%) males counted in the 2011 census, compared to 28.1 million (51.1%) females.

The average life expectancy of 62.5 years has increased by 9 years since a low of 53.5 years in 2005. This reflects a drop in the levels of both child mortality and adult mortality, largely due to the roll-out of ARV treatment and prevention of mother-to-child transmission of HIV (Table 2).

South Africa’s PHC system faces a large burden of ill health in four major categories, giving it a “quadruple burden of disease”: (a) HIV/AIDS and TB; (b) maternal, perinatal, nutritional and communicable diseases other than HIV and TB; (c) noncommunicable diseases; and (d) injury and violence.

4.1 HIV/AIDS and TB

South Africa has more people living with HIV than any other country globally, estimated at 6.2 million in 2015. The national HIV prevalence among the general adult population aged 15–49 years has remained stable at around 17.3% since 2005, with females about 2% higher than males in the same age group. However, these steady states hide the underlying epidemic dynamics of declining incidence (apart from in young women) and increased survival (15).

The World Health Organization (WHO) Global tuberculosis report 2015 (19) reports South Africa as the country having the second highest incidence of TB in the world, at 860 persons per 100 000

### Table 2. Demographic and health indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Results</th>
<th>Year</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>55 million</td>
<td>2015</td>
<td>Statistics South Africa (15)</td>
</tr>
<tr>
<td>Distribution of population</td>
<td>64% urban</td>
<td>2015</td>
<td>World Bank indicators (16)</td>
</tr>
<tr>
<td>Population growth rate</td>
<td>1.65%</td>
<td>2015</td>
<td>Statistics South Africa (15)</td>
</tr>
<tr>
<td>Population density (people/sq km)</td>
<td>45.0</td>
<td>2015</td>
<td>Statistics South Africa (15)</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td></td>
<td></td>
<td>Statistics South Africa (15)</td>
</tr>
<tr>
<td>Infant mortality (per 1000 live births)</td>
<td>34.4</td>
<td>2015</td>
<td>Statistics South Africa (15)</td>
</tr>
<tr>
<td>Under-5 mortality (per 1000 live births)</td>
<td>79.1</td>
<td>2005</td>
<td>Statistics South Africa (15)</td>
</tr>
<tr>
<td>Maternal mortality in facility ratio (per 100 000 live births)</td>
<td>160.0</td>
<td>2010</td>
<td>Massyn et al. (6)</td>
</tr>
<tr>
<td>HIV-infected population (%)</td>
<td>6.2 million (11.2%)</td>
<td>2015</td>
<td>Statistics South Africa (15)</td>
</tr>
<tr>
<td>Number on ARV therapy</td>
<td>3.1 million</td>
<td>2015</td>
<td>National Department of Health (17)</td>
</tr>
<tr>
<td>Mother-to-child transmission of HIV at 6 weeks</td>
<td>1.5%</td>
<td>2015</td>
<td>National Department of Health (17)</td>
</tr>
<tr>
<td>Immunization coverage under 1 year (including pneumococcal &amp; rotavirus)</td>
<td>70%</td>
<td>2015</td>
<td>UNICEF/WHO (18)</td>
</tr>
<tr>
<td>TB cure rates (new smear positive)</td>
<td>80%</td>
<td>2014</td>
<td>Padarath et al. (10)</td>
</tr>
</tbody>
</table>
population, making it one of 22 high-burden countries that account for about 82% of the global burden of TB. However, local data show that the incidence of TB peaked in 2009 at 832 per 100 000 and had decreased to 593 per 100 000 by 2014/2015. The decline in incidence is probably due to an increasing number of HIV-infected patients on ARV therapy. Because of this disparity in estimates, a national survey to determine the true prevalence of TB in South Africa is being planned. Levels of HIV and TB co-infection are very high, with as many as 61% of patients having HIV-associated TB.

4.2 Maternal and child health
The maternal mortality in facility ratio (annualized) declined from 160.0 per 100 000 live births in 2010 to 132.5 per 100 000 live births in 2014/2015 (15). In 2011–2013, the “big five” causes accounting for 86.2% of maternal deaths were non-pregnancy-related infections (34.7%, mainly deaths due to HIV infection complicated by TB), obstetric haemorrhage (15.8%), complications of hypertension in pregnancy (14.8%), medical and surgical disorders (11.4%) and pregnancy-related sepsis (9.5%) (20).

4.3 Noncommunicable diseases
Along with trends globally, South Africa is facing a growing prevalence of noncommunicable diseases, including cardiovascular conditions (mainly hypertension), some cancers, chronic respiratory diseases and type 2 diabetes. The prevalence of hypertension in adults aged over 15 years, based on blood pressure measurements, rose from 2.4% for males and 3.7% for females to 26% in 2012 for both sexes (21). The government’s tobacco control policy has succeeded in reducing a key risk factor, adult smoking, by half over a 20-year period, from 32.0% in 1993 to 16.4% in 2012 (21). On the other hand, low levels of physical activity or aerobic fitness still characterize the population aged 18–40 years, with 45.2% of females and 27.9% of males assessed as unfit in a national survey (21). In 2000, an estimated 7% of all nationally recorded deaths were attributed to excess body weight. Currently, more than 45% of men and women above the age of 35 are either overweight or obese (22). In another national survey – the South African Stress and Health Study – the 12-month prevalence rate of common mental disorders (such as anxiety and depression) among South Africans was estimated at 16.5% and the lifetime prevalence at 30.3% (23).

4.4 Injury and violence
Violence and injuries form one of the four components of the quadruple burden of disease in South Africa. The country has an annual injury death rate of 158 per 100 000 population, which is nearly twice the global average of 86.9 per 100 000 and higher than the African average of 139.5 per 100 000 (24).
5. Governance of PHC: the District Health System

The District Health System is considered the core building block of South Africa's health system in policy and legislation. In practice, however, the capacity of the District Health System as a governance structure remains very unevenly developed across the country, with still insufficient decentralized authority and decision space at this level (25).

The NHI white paper (5) proposes the establishment and strengthening of district health management offices and a reorganization of the PHC system through the contracting of accredited multidisciplinary teams (previously public or private), on a capitation basis, for the provision of “personal” comprehensive PHC services (preventive, promotive, curative and rehabilitative) for geographically defined populations. As outlined in the white paper: “The comprehensive set of personal health services will include a continuum of care from community outreach, PHC level based on the ideal clinic model, health promotion and prevention to other levels of curative, specialized, rehabilitative and palliative care. Health service benefits will be provided and described in terms of the types of services to be provided at each level of care with guidance on referral mechanisms. Services covered under NHI will also include access to pharmacies and Emergency Medical Services.”

In a purchaser–provider split arrangement, both public and private providers will be able to bid to provide services and will be reimbursed on a capitation (for PHC) or prospective/diagnostic-related group (for hospitals) payment system. In the process the intention is that spare capacity in the private sector will be more equitably distributed to the current public sector-dependent population. However, inequity between urban and rural areas may increase, since the private sector is overwhelmingly urban based.

With NHI, intergovernmental relations and funding flows will progressively change as authority is delegated to district health management offices and individual hospitals. Thus there will need to be changes in how districts are organized and governed in the medium to long term. A key issue to resolve will be the respective roles of the National Department of Health, provincial departments of health and district health management offices with respect to control over resource allocation and contracting. These changes will have political and possibly constitutional implications.

The estimate is that full implementation of the financing reforms in NHI will require a 6.7% expansion in health care expenditure above inflation per annum for a decade, and a rise in public expenditure from 4% to 6.2% of GDP (5). Some consider this unlikely, given the limited fiscal space in South Africa at this time.
6. Community participation in PHC

In South Africa, the value of community participation and accountability as one of the central components of a PHC approach is highlighted in legislation, policy documents and strategic plans, such as the *White paper for the transformation of the health system* (1997) and the National Health Act (No. 61 of 2003), and the more recent PHC Re-engineering Strategy (2010) and National Core Standards (2011). As a recent review indicated: “The adoption of the Alma-Ata conception of PHC as the foundation of South Africa’s post-apartheid national health system and the emphasis on the centrality of community participation … reflect the influence of progressive civil society forces mobilized under the banner of the liberation movement” (26).

Clinic or health facility committees and hospital boards have been identified as the principal organizational arrangements through which community participation occurs. Establishing the specific roles and functions of these committees and the accompanying legislation is a task deferred to provincial government. Seven of the nine provinces in South Africa currently have legislation in place that allows for the establishment of health facility committees in those provinces (27).

Despite these intentions, the functioning of health facility committees is not as robust as would be expected given the country’s history. The last national assessment of health facility committees, conducted in 2003 as part of a National Primary Health Care Facilities Survey, found that such committees existed in three out of five facilities in the country, with only 35% of these structures reportedly having met in the recent past (28). More recently, a quarterly national monitoring system has been instituted, assessing whether committees are constituted, meet monthly (with minutes) and have action plans. Of the approximately 3700 clinics and 252 district hospitals across the country, 1300 (about one third) had verified clinic committees and hospital boards in place, suggesting little improvement from the situation in 2003 (key informant interview).

Numerous factors have been identified as impacting negatively on health facility committee functioning. These include a lack of political commitment, cooperation and support from the health services; the limited participation by facility managers and local government councillors in such structures; the negative attitude of health workers towards the committees and their members; lack of resources; the limited capacity and skills of committee members; and lack of clarity about the role and mandate of the committees. A key factor is the insufficient funding of health facility committees, for example to support the travel and participation of committee members (25, 29–31). A regional intervention in the Western Cape training facility managers and health facility committees found that facility managers felt better equipped to assist community members on the committees but were constrained by an unsupportive policy environment, in which participation was not perceived as a priority (32).

In response to the problems identified, the National Department of Health is currently finalizing detailed guidelines and an accompanying training manual focusing mainly on health facility committees, and is intending to launch a national training initiative. In the guidelines that are being developed it is proposed that a stipend be paid to committee members to support their participation and involvement in these structures. The National Department of Health plans to use health facility committees to support the Ideal Clinic initiative (see below) and conversely use the Ideal Clinic programme to institutionalize health facility committees.
7. PHC financing

Over the last 10 years there has been a doubling of expenditure (in real terms) on public sector PHC, from 443 South African rands (US$ 27) per capita per year in 2005/2006 to 897 rands (US$ 56) in 2014/2015 (Figure 4) (10). This is in large measure due to a rapidly expanding programme of access to HIV treatment, integrated into the PHC system through nurse-initiated management of antiretroviral therapy (NIMART), supported by above-inflation increases in the salaries of health care workers related to the occupation-specific dispensations. Since 2009, 24,000 nurses have been trained in NIMART (key informant interview).

Overall, donor funds form a small proportion, less than 2%, of total public health sector expenditure, but have a significant presence in the HIV/AIDS programme, making up one third of spending.

Public PHC services are free at the point of use (a policy implemented first in 1994 for pregnant women and children and then universally in 1996). Out-of-pocket payments are relatively small – less than 7% of total health expenditure, although this does not take into account the costs of utilizing health services (mainly transport), especially for chronic conditions (33).

Figure 4. General government expenditure on PHC services per capita 2005/6–2014/15 (real 2014/15 prices)

Source: Padarath, King and English (10).
8. Human resources for PHC

Nurses are by far the largest category of health workers in South Africa. Of the 173,761 health professionals working in the public health system in 2015, 77% were nurses, 11% were doctors (generalists and specialists), and the remainder were distributed between other cadres – pharmacists, dentists, therapists, psychologists and environmental health practitioners (10) (Figure 5). Nurses form the backbone of PHC in South Africa, and are made up of three cadres – professional nurses (four years of training), enrolled nurses (two years of training), and nursing assistants (one year of training).

The National Health Care Facilities Baseline Audit in 2011/2012, drawing on the National Core Standards from the Office of Standards Compliance within the National Department of Health, assessed 3074 clinics and 282 community health centres or day centres across the country. This assessment included the presence of selected categories of staffing considered crucial to ensure high-quality, efficiently delivered services meeting the expected scope per type of facility. Significant gaps were found in a number of areas: medical doctors and advanced midwives for community health centre services, lay counsellors and administrative support (especially in clinics), and a still limited scope of services rendered (in particular regarding dental, optical, rehabilitation and social work services in community health centres).

Over the last 15 years there has been a rapid growth in lay health worker involvement in the health system, largely to support the HIV/AIDS programme, and deployed through a system of NGO contracting. In 2011 a national audit (34) counted more than 72,000 such workers, fulfilling both community- and facility-based functions. The PHC Re-engineering Strategy seeks to integrate, formalize and strengthen this infrastructure into a system of ward-based outreach teams consisting of community health workers and a nurse team leader closely associated with the local PHC facility. The ward-based outreach teams are intended to proactively engage households and communities and address health needs comprehensively. A nationally accredited curriculum for community health workers has been developed, as well as a monitoring and evaluation system through the District Health Information System. By 2014/2015, nearly 3000 teams had been established out of a total of 4200 electoral wards (68% coverage), although less than half (41%) were reporting data through the District Health Information System (17).

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1 Subsequently becoming the independent Office of Health Standards Compliance in 2013.
Formal national policy on the ward-based outreach teams is yet to be developed and the sector is underresourced, especially with regard to the remuneration of community health workers, who are often expected to work full time.

Although staffing models have been developed in South Africa over the years, there are as yet no agreed national human resource norms for PHC. However, in 2015, as part of the Ideal Clinic initiative (see below), the Department of Health issued a South African adaptation of the WHO Workload Indicators of Staffing Need (WISN), giving ranges of staffing norms for different levels of facilities based on utilization. The most basic facility, a PHC clinic open eight hours a day during weekdays, would be staffed by 14 to 25 people, consisting of nurses (some trained and clinical nurse practitioners), lay counsellors, pharmacy assistants and support staff (35).

Public sector provision of PHC occurs against a backdrop of large inequities in distribution of professionals across public and private sectors. Of the 41 000 doctors registered with the Health Professions Council in 2014, less than half (45%) worked in the public sector (Figure 6) (10).

The introduction of occupation-specific dispensations has improved salaries, thus making it easier to attract professional staff to public service posts. However, one of the consequences has been a massive increase in the wage bill and the danger of long-term unaffordability of health professionals. Mid-level health worker policy, which could compensate for this, is not well developed in South Africa. Initiatives have been piecemeal – notably the development of the pharmacy mid-level worker and clinical associate. The latter was introduced as a mid-level medical cadre, and is being trained at two universities. However, numbers of clinical associates are still small (221 in 2014) (10) and their place in the health system and in health teams is still not finalized, with additional issues around registration and post structure (key informant interview).

Three different bodies regulate the health professions in South Africa – the Nursing Council, the Pharmacy Council and the Health Professions Council (grouping a number of professionals), each established through a statute (Table 3). Practitioners are required to register with these councils on an annual basis. Basic training and continuing professional development are also regulated through these councils. Box 1 illustrates the regulatory processes governing the pharmacy profession in South Africa.

The consensus from key informants is that, despite numerous proposals and task teams, there is still a disconnect between the orientation of professional training mandated through the professional councils, which is heavily curative and hospice-centric, and the needs of PHC in the country as outlined in key policy statements. This problem is especially acute in nursing. A recent review concluded that the South African Nursing Council “as the regulatory body is largely dysfunctional and provides sub-optimal leadership in policy development and implementation” (36). The Nursing Council is seen as too slow, bureaucratic and a stumbling block to change. Curriculum reforms begun in 2003 are yet
**CASE STUDY FROM SOUTH AFRICA**

An impending nursing crisis caused by a combination of attrition and mortality (due mainly to HIV/AIDS), external migration in the early 2000s and underproduction (due mainly to closure of nursing colleges) has resulted in a shortage of (especially younger) nurses.

Steps are also being taken to recognize traditional healers and traditional medicine (37). These include the establishment of a Directorate of Traditional Medicine within the National Department of Health, the enactment of the Traditional Health Practitioners Act (No. 22 of 2007), and the establishment of an interim Traditional Health Practitioners Council. This signals significant intent, although the regulatory process is still unfolding and there is considerable uncertainty as to how the traditional and biomedical sectors will be integrated in the National Health System.

The status and training of community health workers, of increasing important to PHC in South Africa, is as yet unregulated. A nationally accredited curriculum exists through the Quality Council for Trades and Occupations (which regulates trades), and is in the early stages of being implemented across the country.

**Table 3. Bodies regulating health professions in South Africa**

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Statutory body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctors and dentists</td>
<td>Medical and Dental Board of the Health Professions Council</td>
</tr>
<tr>
<td>Nurses: professional nurse (four years training), enrolled nurse (two years training), nursing assistant (one year training)</td>
<td>Nursing Council</td>
</tr>
<tr>
<td>Pharmacists and pharmacy support personnel</td>
<td>Pharmacy Council</td>
</tr>
<tr>
<td>Rehabilitation professionals (occupational therapists, physiotherapists, speech therapists)</td>
<td>Professional Boards of the Health Professions Council</td>
</tr>
<tr>
<td>Environmental health practitioners</td>
<td>Professional Board of the Health Professions Council</td>
</tr>
<tr>
<td>Traditional healers</td>
<td>Interim Traditional Health Practitioners Council</td>
</tr>
<tr>
<td>Community health workers</td>
<td>None</td>
</tr>
</tbody>
</table>

**Box 1. Regulatory process governing the pharmacy profession in South Africa**

The pharmacy profession in South Africa is governed primarily by two acts:
- the Medicines and Related Substances Act, No. 81 of 1965 (controls the different schedules of medicines);
- the Pharmacy Act, No. 53 of 1974 (controls the personnel – education, regulation and training).

There are nine schools of pharmacy, whose courses include a four-year professional qualification, one year of internship and one year of community service. Schools of pharmacy are all accredited with the South Africa Pharmacy Council and governed by the Pharmacy Act, No. 53 of 1974. The council accredits qualified pharmacist (BPharm) and other courses (e.g. pharmacy assistant courses). All personnel defined in the Pharmacy Act must be registered with the Pharmacy Council. All programmes and providers of training of pharmacy-related courses must be accredited by both the Pharmacy Council and the South African Department of Education. The council visits the institutions and accreditation lasts four to five years.
9. Infrastructure, equipment and supplies

The 2011/2012 National Health Care Facilities Baseline Audit, referred to above, also assessed infrastructure, access (through geographical positioning), and availability of essential equipment and medicines (38). It found that almost all PHC facilities in the country were accessible by road (96%), while access via taxi was also high (87%). However, access to facilities by public transport is more limited: 58% of facilities were accessible by bus and 9% by train, adding considerably to the cost of access, especially in rural areas (38). In only 6% of the PHC facilities surveyed with a maternity ward (n = 2161) was all essential equipment available and functional.

The PHC Standard Treatment Guidelines and Essential Medicines List, now in their fifth iteration (39), determine the procurement and prescribing of medicines. Despite these regulatory measures, the National Health Facilities Audit found that only 23% of PHC facilities had all tracer medicines available as stipulated in the national Essential Medicines List. This contrasts with the national stock-out rate (defined as any tracer essential item out of stock) of 24% reported through the official District Health Information System in 2014 (Figure 7).

Similarly, an independent stock-out survey of HIV and TB drugs in 2454 clinics, conducted by civil society, showed that 25% of the facilities had experienced an ARV/TB stock-out in the three months prior to interview in 2014, rising from 2013 in six out of nine provinces, and nationally from 21% in 2013 (40). This is despite the priority given to the HIV/TB programme nationally (Figure 8).

Figure 7. Tracer items stock-out rate (fixed clinics, community health centres, community day centres) by province, 2014/2015

Figure 8. ARV/TB stock-outs in clinics, 2013 and 2014 (n = 2454)

Key: EC = Eastern Cape; FS = Free State; GP = Gauteng; KZN = KwaZulu-Natal; LP = Limpopo; MP = Mpumalanga; NC = North Cape; NW = North West; WC = Western Cape; SA = South Africa.

Source: Padarath, King and English (10).

Source: Treatment Action Campaign et al. (40).
Medicine use outside the public sector is regulated by the Medicines and Related Substances Control Amendment Act (1997), which mandates:

- a transparent pricing system that includes a single exit price for manufacturers, and fees for distributors and dispensers, adjusted annually;
- that drugs can only be sold in licensed retail or hospital-based pharmacy outlets, supervised by a qualified pharmacist.

Although South Africa does not have a formal monitoring system in place for this, the view of interviewees was that informal medicine markets and counterfeits are not a major issue.\(^2\)

The Medicines Control Council currently registers medicines and will be replaced by the South African Health Products Regulatory Authority, which will have responsibility for the monitoring, evaluation, regulation, investigation, inspection, registration and control of medicines, clinical trials and medical devices and related matters in the public interest.

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\(^2\) One interviewee suggested, however, that there was an informal market in the manufacture of dentures, which are not normally supplied in the public sector, and are very expensive in the private sector.
10. Access to essential care

With respect to access to essential care, the National Health Facilities Audit found that a basic package of services was almost universally available. However, availability of dental, therapeutic, dietetic and psychosocial services was still low (Figure 9) (38).

By the end of March 2015, there were more than 3.1 million people remaining on ARV therapy, the largest treatment programme in the world. During the 2014/2015 financial year, more than 9.5 million people aged between 15 and 49 years underwent HIV counselling and testing, the entry point for diagnosis and treatment, up from 6.7 million the year before. The percentage of TB cases with known HIV status more than doubled from 43.6% in 2008 to 92.8% in 2013/2014, and the TB/HIV co-infected clients initiated on ARV therapy improved from 31.2% in 2013/2014 to 73.7% in 2014/2015 (6).

South Africa has invested heavily in making HIV/AIDS and TB prevention, testing and treatment universally accessible, much of it implemented through and therefore indirectly supporting the strengthening of PHC. However, innovations developed for HIV/AIDS and TB, such as adherence clubs and enhanced monitoring systems, have tended to be implemented in a vertical manner, and the lessons learned have not necessarily been generalized to other needs such as noncommunicable diseases.

A number of initiatives, such as the district clinical specialist teams and the implementation of National Guidelines for Basic Antenatal Care (41), have also ensured a special focus on maternal and child health. Over the past three years, attendance for antenatal care before 20 weeks increased by 5% annually, rising to 53.9% in 2014/2015 (6). The official immunization coverage under 1 year (annualized) rate has stabilized around 90% (17), although the United Nations Children’s Fund (UNICEF) has assessed immunization coverage at 70% (18). In 2009, the government added the pneumococcal and rotavirus vaccines to the immunization schedule, resulting in a significant impact on pneumonia and diarrhoea. The National Institute for Communicable Diseases documented a 70% decline in invasive pneumococcal disease in children and a 66% reduction in rotavirus hospitalizations in the first two years after the introduction of the new vaccines. Diarrhoea case fatality in children aged under 5 years was 3.3% for 2014/2015, showing a significant decline from the 8.9% recorded in 2007/2008. Similarly, the pneumonia case in facility fatality rate for children
aged under 5 years declined from 6.6% in 2009/2010 to 2.9% in 2014/2015. Vitamin A coverage in children aged 12 to 59 months increased from 12.8% in 2004/2005 to 52.2% in 2014/2015 (17).

The prevention of mother-to-child transmission of HIV (PMTCT) has also been key to improving maternal and neonatal health. Since January 2015 all pregnant HIV-positive women are offered lifelong ARV therapy regardless of CD4 count (PMTCT option B+). This will be further strengthened since South Africa adopted the “test and treat” (90–90–90 strategy) policy in 2016.

Maternal deaths are routinely evaluated in a confidential enquiry into maternal deaths (20). In 2015, the report concluded that the systems strengthening needed for avoiding maternal deaths (e.g. transport, emergency obstetric care, life-saving skills, blood transfusions), at the interface of PHC and district hospitals, is not as well developed as the systems strengthening involved in HIV/AIDS treatment and care.

District hospitals are key to the functioning of PHC and have a pro-poor utilization pattern, in contrast to regional and central hospitals, which have a pro-rich pattern of utilization (Figure 10) (42). Different models of interaction exist between PHC and district hospitals across provinces. In some provinces they are integrated in a “hub and spoke” arrangement, while in urban areas they tend to exist in parallel. Key informants interviewed were of the view that the district hospital is a weak link in the District Health System, and is not adequately supportive of PHC.

Figure 10. Distribution of use of public sector inpatient health services across socio-economic groups in 2008

<table>
<thead>
<tr>
<th>Socio-Economic Group</th>
<th>Provincial/central hospital</th>
<th>Regional hospital</th>
<th>District hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest 20%</td>
<td>14%</td>
<td>16%</td>
<td>23%</td>
</tr>
<tr>
<td>2nd poorest</td>
<td>25%</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>2nd richest</td>
<td>23%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Richest 20%</td>
<td>42%</td>
<td>17%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: McIntyre and Ataguba (42).
11. Improving the quality of PHC

The Office of Health Standards Compliance, established in 2013, utilized the National Core Standards for Health Establishments in South Africa as a benchmark of quality against which the delivery of health services can be monitored. The National Core Standards are based on internationally recognized standards. The Office of Health Standards Compliance and the National Core Standards are mandated by the National Health Act, and require an annual self-assessment by hospitals using 140 indicators, submitted through the District Health Information System, while PHC facilities now use the Ideal Clinic metrics.

The National Department of Health has prioritized six areas as fundamental to the provision of quality health care in all establishments: (a) positive and caring attitudes; (b) short waiting times; (c) cleanliness; (d) patient safety and security; (e) infection prevention and control; and (f) availability of medicines and supplies. Achieving 100% compliance to vital measures in each of the ministerial priority areas is what distinguishes a high-ranking facility (ideal facility) from a low-ranking facility. Vital measures are those core measures that ensure that the safety of patients and staff is safeguarded so as not to result in unnecessary harm or death. The National Health Facilities Audit of public sector facilities found an average national score of less than 50% compliance on vital measures in two areas: patient safety and security (34%) and positive and caring attitudes (30%). Using a combination of patient interviews, observations and document reviews, the audit also found that only 25% of PHC facilities met the full standards for positive and caring attitudes.

The Ideal Clinic programme is a more recent (2015) comprehensive intervention seeking to specifically address the quality of PHC and is at the core of the PHC system strengthening proposed in the NHI white paper (5). An Ideal Clinic is defined in the white paper as:

“A clinic with good infrastructure (which is defined as: physical condition and spaces, essential equipment and information and communication tools), adequate staff, adequate medicine and supplies, good administrative processes and sufficient bulk supplies that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community. An Ideal Clinic will cooperate with other government departments as well as with the private sector and non-governmental organizations to address the social determinants of health. PHC facilities must be maintained to function optimally and remain in a condition that can be described as the “Ideal Clinic”. Integrated clinical services management (ICSM) is a health system strengthening model that builds on the strengths of the HIV programme to deliver integrated care to patients with chronic and/or acute diseases or who came for preventative services by taking a patient-centric view that encompasses the full value chain of continuum of care and support. ICSM will be a key focus within an Ideal Clinic.

The Ideal Clinic programme is structured into 10 components and initially 220 elements, measured through a web-based dashboard on a biannual basis. It is supported by guidelines such as WISN, referred to earlier, and Primary Care 101, a symptom-based integrated clinical management guideline for the management of common symptoms and chronic conditions in adults (43). The Ideal Clinic programme is in the process of developing an improvement component (through district-level change management teams) linked to the monitoring.

4 There are also “essential” and “developmental” measures. Essential measures are those considered fundamental to the provision of safe, decent quality care and are designed to provide an in-depth view of what is expected within available resources. Developmental measures are those elements of quality of care to which health management should aspire in order to achieve optimal care. Developmental measures were not assessed.
PHC facility supervision is assessed in an indicator of the District Health Information System, which assesses the proportion of fixed PHC facilities, including community health centres and community day centres, visited by a clinical supervisor at least once a month. A dedicated clinic supervisor or local area manager conducts the visit following the clinic supervision manual, which entails use of regular review tools. While there has been an upward trend in the supervision rate across the country, key informants questioned the quality of supervision. The supervisory manual is seen by many (including the key informants) as unwieldy and time consuming, “red flags” are often not addressed, and the process does not leave enough time for facilities to raise their own concerns or engage in problem solving. The National Health Core Standards have been similarly criticized as compliance and assessment oriented, as duplicating each other and as not focusing sufficiently on output and outcome indicators.

A number of other quality initiatives are being experimented with across the country, emerging from programme-strengthening initiatives around maternal and child health and HIV/TB. The “three feet model”, popularized by UNICEF, for example, integrates problem identification, problem solving and monitoring at the point of service delivery.
### 12. Monitoring and evaluating PHC

The PHC system is supported by a well established District Health Information System, which was developed and trialled in a bottom-up fashion from the mid-1990s, and rolled out to the rest of the country from 2002. Since 2004, the data are reported annually in the District Health Barometer (6). A subcommittee of the National Health Council – the National Health Information Systems Committee of South Africa – defines and reviews a National Indicator Data Set for routine reporting by provincial and district authorities. Data sources from the District Health Information System and other sources (surveillance, population surveys, management information) are integrated in a National Health Information Repository and Database, and made available to managers. The District Health Barometer and South African Health Reviews (extensively cited in this report) provide good examples of using the District Health Information System to track delivery indicators and health outcomes. Although there has been significant investment in training at district levels over the last few years, use of data is still variable, and poorly integrated into planning and budgeting processes.

There are institutionalized systems of data quality assessment, triangulating annual reports with District Health System data and facility registers, which now form part of the annual audits of the Auditor-General. Tools have been developed – such as the Rapid Internal Performance Data Audit – to check data quality prior to the audits.

The increase in programmatic and other initiatives (including those reported in the previous section) targeting the PHC system has resulted in a plethora of indicators and reporting systems, experienced as an overload of monitoring and an excessive focus on compliance, to the detriment of service delivery. In some clinics there are up to 62 different registers. A National Department of Health-commissioned initiative is under way to streamline and standardize registers in use in PHC facilities. The aim of the Rationalization of Registers project is to ensure that appropriate data are collected, collated, analysed and used for management decision-making. The multiple paper-based system is being reduced to six PHC registers supported by standardized patient folders and filing systems (key informant interview).

In a newer generation of information systems development linked to NHI, the IT infrastructure of PHC facilities is being developed to enable a shift from paper-based to integrated electronic patient and management information systems. Currently, the shift to “e-tick” registers is being implemented in 700 NHI pilot site facilities. Work is also under way to design a health patient registration system that will link the population to public health facilities (key informant interviews).

South Africa has well established systems and institutions to identify and measure the disease burden. Thirty-three diseases are notifiable and there is a clear notification process. The Medical Research Council, the National Institute for Communicable Diseases, and the National Cancer Registry are all involved in disease and mortality surveillance. The plan is for these functions to be brought together into the National Public Health Institute of South Africa, for which draft legislation has been prepared.
13. Strengths and weaknesses of PHC

PHC in South Africa presents a mixed picture of strengths and weaknesses, as summarized in Table 4. In sum, the public PHC system provides an important safety net and source of health care for South Africa’s citizens. PHC and the District Health System are prioritized in key health policies and have received recent renewed emphasis in the PHC Re-engineering and Ideal Clinic strategies. However, a very large burden of disease and the multiple initiatives responding to this burden place heavy demands on front-line providers and the PHC system. The supports to this system – such as the District Health System, the district hospitals, the training of health workers, intersectoral action on health, and managerial and leadership capacity – are inadequately developed.

A quasi-federal system of governance has led to uneven implementation across the nine provinces, and a perceived policy implementation gap. Despite an ever-increasing number of reporting systems and audit mechanisms, there is also a perception of low accountability, for example in the areas of performance, use of resources, and in particular, community service.

Table 4. Strengths and weaknesses of PHC in South Africa

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHC policy context</strong></td>
<td>Since 1994, significant number of PHC-relevant policy developments and health reforms</td>
<td>Health professional education not oriented to PH</td>
</tr>
<tr>
<td></td>
<td>Adoption of the PHC Re-engineering Strategy in 2010</td>
<td>Weak district hospitals</td>
</tr>
<tr>
<td></td>
<td>NHI white paper prioritizes PHC as the “heartbeat of NHI”</td>
<td>Uneven District Health System</td>
</tr>
<tr>
<td><strong>Establishment of District Health System</strong></td>
<td>Legal status of District Health System formalized in 2003 National Health Act</td>
<td>Differing interpretations and implementation of District Health System across the country</td>
</tr>
<tr>
<td></td>
<td>Role of District Health System prioritized in NHI white paper</td>
<td>District Health System structures very unevenly established across the country</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decision-making still mostly centralized at provincial level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low managerial capacity and accountability at district level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dual authority (province and local government) for PHC and fragmented, inefficient delivery in Metro areas</td>
</tr>
<tr>
<td><strong>Financing of PHC</strong></td>
<td>Doubling of public sector per capita expenditure on PHC from 2005/2006 to 2014/2015, largely due to investments in access to HIV and TB services</td>
<td>Higher-than-inflation increases in human resource remuneration has limited investment in expanding services</td>
</tr>
<tr>
<td></td>
<td>PHC services free at point of use</td>
<td>Ensuring that gains in HIV and TB benefit all services</td>
</tr>
<tr>
<td><strong>Access to health facilities: PHC and district hospitals</strong></td>
<td>Clinic construction and upgrading programme involving more than 1500 facilities</td>
<td>Other access barriers still exist – transport, staff attitudes, waiting times</td>
</tr>
<tr>
<td></td>
<td>Geographical availability of services within 5 kilometres to more than 90% of population</td>
<td>The district hospital has not been seen as fully part of the PHC system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The district hospital has been realigned from PHC to district hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of quality of care at district hospitals, especially emergency obstetric care and anaesthesia</td>
</tr>
<tr>
<td><strong>Equity in access</strong></td>
<td>Division of resources from national to provincial and local government is based on a formula that has, amongst other criteria, a poverty index</td>
<td>Within-district inequities (e.g. between informal settlements and other areas) not generally assessed and if done not usually acted upon</td>
</tr>
<tr>
<td></td>
<td>Deprivation index tracks spending and other health indicators across districts in District Health Information System, showing progressive narrowing of indicators</td>
<td>Key fault line in inequity of access and resources between public and private sectors</td>
</tr>
<tr>
<td>Dimension</td>
<td>Strengths</td>
<td>Weaknesses</td>
</tr>
<tr>
<td>-------------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Human resources for PHC</strong></td>
<td>Well established nurse-based system of public PHC provision</td>
<td>High levels of burnout and demotivation amongst front-line providers</td>
</tr>
<tr>
<td></td>
<td>Growth and diversification of PHC teams to include a number of new cadres such as pharmacy assistants, data capturers, lay counsellors and community health workers</td>
<td>Significant gaps in a number of areas: medical staff and advanced midwives for community health centres and limited numbers of certain cadres (such as rehabilitation workers) No agreed national norms for PHC teams Poor alignment between professional training and needs of PHC Little discussion on mid-level workers and no developed strategy</td>
</tr>
<tr>
<td><strong>Information systems</strong></td>
<td>Development of District Health Information System, based on National Indicator Data Set and part of an integrated Health Management Information System Formation of National Health Information Systems Committee of South Africa Rationalization of Registers project Development of IT infrastructure and plans to shift to electronic systems</td>
<td>Still low levels of use and interpretation of data at point of service delivery and at district level Ongoing problem of data quality Compliance and monitoring overload Excessive numbers of indicators</td>
</tr>
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<td><strong>Comprehensive service delivery</strong></td>
<td>Formulation of an essential PHC package that sets norms for the provision of comprehensive PHC in 2001, updated in 2011 to include new HIV/AIDS services (currently being revised) New programmatic interventions, including expansion of childhood immunization and prevention and treatment of HIV/AIDS and TB Development and implementation of Essential Drugs List and Standard Treatment Guidelines for Primary Health Care Focus on quality through Office of Health Standards Compliance, National Core Standards and Ideal Clinic initiative</td>
<td>New programmatic interventions focused on HIV/AIDS have been critical, but have also diverted attention from other programmes and the underlying systems and “pillars” of PHC, including noncommunicable diseases, maternal, neonatal and child health, nutrition, intersectoral action (including preventive, promotive aspects) and community participation Rehabilitation, oral and eye health and mental health services inadequately developed</td>
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<tr>
<td><strong>Community-based services</strong></td>
<td>Ward-based outreach team strategy seeks to formalize and integrate community-based services developed in the context of HIV and TB</td>
<td>National policy on ward-based outreach teams not finalized Ward-based outreach teams poorly resourced and implemented and everyone “doing their own thing” at provincial level Funding of ward-based outreach teams and especially the remuneration of community health workers remains unresolved</td>
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<tr>
<td><strong>Intersectoral action on social determinants of health</strong></td>
<td>Tobacco control legislation, reduction of salt in processed foods, and taxation of surgery beverages all implemented since 1994 South African National AIDS Council has enabled engagement with NGOs and civil society organizations NHI white paper proposes National Health Commission to look at noncommunicable diseases, injuries/violence and road traffic accidents</td>
<td>Very high levels of preventable morbidity and mortality not systematically addressed Curative-oriented service provision While some health issues such as HIV/AIDS have engendered intersectoral action, others such as violence and injury and mental health have not</td>
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<tr>
<td><strong>Community participation and accountability</strong></td>
<td>Legislation for facilitating community participation through governance structures in the public health sector are laid out by National Health Act Seven of the nine provinces in the country have legislation in place that allows for establishment of facility health committees</td>
<td>Level of functioning of health facility committees is low Little citizen involvement in the planning and evaluation of health service delivery Little emphasis on community participation in NHI</td>
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<tr>
<td><strong>Leadership and management</strong></td>
<td>There is recognition of the problem of leadership and management capacity Many initiatives and courses to strengthen management Establishment of Academy for Leadership and Management in Health Care by National Department of Health</td>
<td>Bottom-up planning at PHC and district levels not well developed Corruption and patronage especially in interference with supply chain and procurement systems Training poorly coordinated and integrated into human resource development systems and insufficiently practical Despite a plethora of mechanisms, accountability for outcomes and to the public is weak, and sanctions limited</td>
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</table>
14. Going forward

From this analysis, the key priorities for PHC in South Africa are as follows:

• addressing the large burden of disease through a much stronger focus on health promotion and wellness, and concerted action on upstream factors through intersectoral action at both national and local levels on the social determinants of health;
• linked to this, developing the capacity of communities to engage meaningfully with the health sector through formal and informal mechanisms of participation and enhanced community-based services;
• strengthening accountability mechanisms such as facility health committees and hospital boards;
• strengthening a still uneven District Health System in South Africa, including defining the roles, functions and capacity required of the District Health Authority that will form the core governance structure for the future NHI;

• strengthening the human resource base of PHC through ensuring that the training curricula of PHC cadres (especially nurses) are reoriented towards PHC, expanding the PHC team to include rehabilitation therapists and other cadres, reviewing and developing policy on mid-level cadres, formalizing the status and conditions of employment of community health workers, and developing the management and leadership capacity of front-line managers;
• translating the innovations from the HIV and TB programmes – including enlarged scope of practice of PHC cadres, adherence support, community-based follow-up, monitoring, quality assurance, and resource mobilization – into other programme areas and the PHC system as a whole.
References

27. Haricharan H. Rapid appraisal of health committee policies in South Africa. Learning Network for Health and Human Rights, School of Public Health and Family Medicine, University of Cape Town; 2015.


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