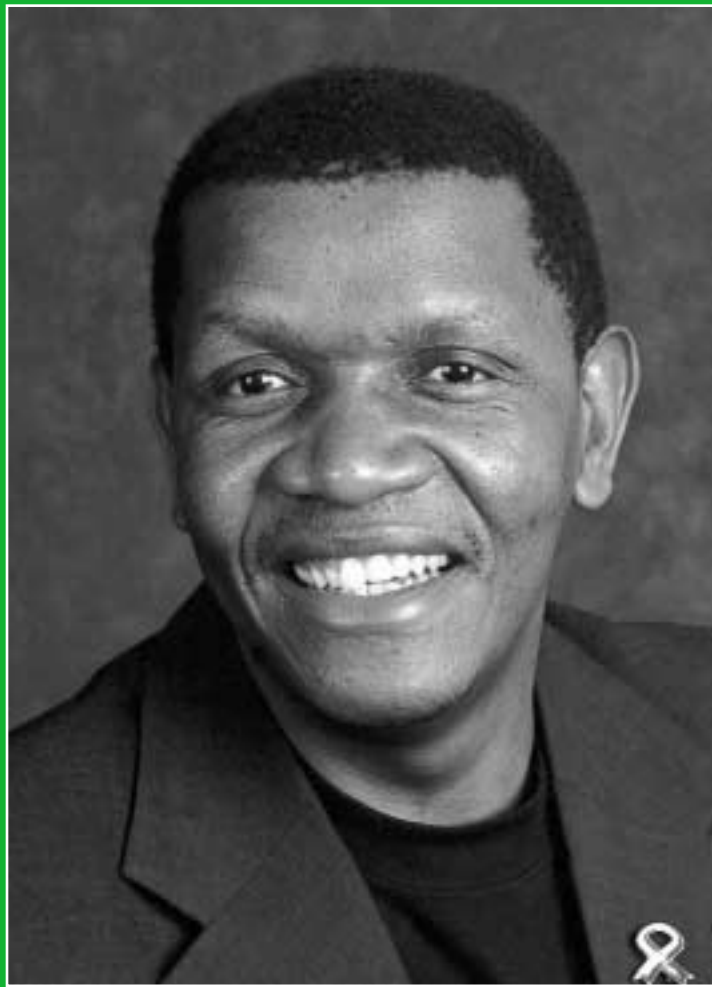


# SECTION 1



# Director-General's Review

The Department of Health, like all government departments, is directed by a five-year strategic plan for the period 1999 - 2004. This plan ensures that there is a common direction to an unusually complex and varied set of activities ranging from the procurement of pharmaceutical supplies, to the design of tobacco control measures and the funding of new hospital complexes.

The strategic plan does not, however, insulate the Department from outside developments. There is a dynamic interplay between unfolding events in society and the Health Department's role as the architect of health policy, legislation and national service norms. In 2000/1 our perspectives were challenged in particular by the growing public debate on programmes of prevention and treatment for HIV/AIDS and the re-emergence of cholera on a massive scale.

These developments, in different ways, underscored the powerful link between poverty and poor health and highlighted particular features of our strategic plan, namely:

- Our unfinished business in relation to equity in health care provision, a condition that underpins reasonable access for all to health services.
- The significance of inter-sectoral collaboration in preventing disease and promoting health.

The lobby for public sector provision of anti-retroviral drugs for HIV/AIDS caused us to reflect seriously on our priorities in the HIV/AIDS programme. In a curious way, it had the effect of highlighting contending priorities and unmet needs, especially the need for stronger poverty relief programmes and better health infrastructure — particularly in rural areas — to cope with the treatment demands of the epidemic.

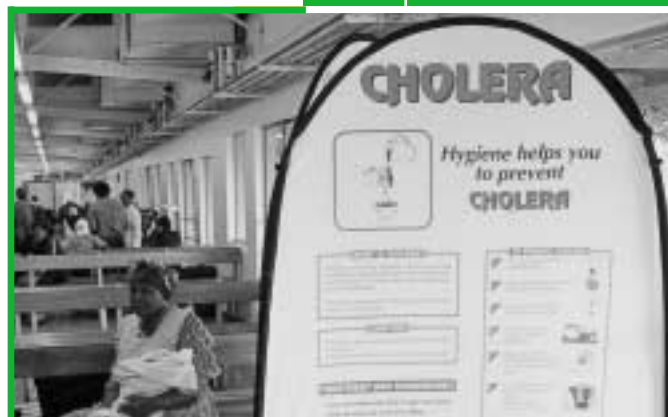
The cholera outbreak, too, was a sharp lesson on the link between poverty, under-development and disease. Once cholera established itself in an area, the absence of sanitation and clean water made its rapid spread almost inevitable. It was obvious that real answers lay in development.

At the same time, the cholera outbreak highlighted the mitigating effect of good health services as effective treatment kept mortality levels extraordinarily low. Many of those who succumbed to cholera were dead on arrival at a health facility, illustrating how critical good access to care can be.

These developments in 2000/1 did not change our basic strategic direction, but they did alter perceptions on the context of health care and cast certain elements of our strategy in bold print. In particular, they strengthened the Department's commitment to the Integrated Sustainable Rural Development Strategy and the Urban Renewal Programme that aim to concentrate resources to effectively combat poverty and underdevelopment.

Performance against a range of strategic objectives is described at some length in Section 2 of this report. This introductory summary takes an overview of progress in terms of the Department's broad mission and reflects on the state of the Department itself.

It is important to remember that there is a division of labour in relation to health care. The delivery of services is the responsibility of the provincial health departments and local government. The national Department, in the main, plays a facilitating and support role through the development of policies and legislation, the design of national programmes of intervention and the setting of national norms.





## Director-General's Review

### Measuring up to our mission

The Department's mission statement for the period 1999 -2004 indicates that we will:

- Consolidate and build on achievements relating to access to care and the reduction of service inequities.
- Improve the quality of care at health facilities by forming partnerships with stakeholders.
- Give special attention to improving preventive and promotive health programmes.
- Achieve greater efficiency in the health care delivery system as a whole.

### Equity and access to care

In the period immediately following the 1994 election, decisive steps were taken to eradicate gross inequities in service provision and ensure greater access to health care for the poorest people in our country. These measures included the building of some 500 new clinics, abolishing user fees for clinic services and promoting comprehensive primary care at clinic level.

The second generation of interventions to address service equity and improve access to care is without question more challenging.

Firstly, financial constraints have been tighter in recent years and this has created a difficult context for redistribution of resources. Since 1997/8, there has been a decline in real per capita spending on health. Along with this, the gaps between provinces in terms of per capita health spending have grown wider once more, after a period in the mid-90s when expenditure tended modestly toward equity.

Secondly, tackling the less obvious service inequities and barriers to health care demands a more refined understanding of the situation and purpose-built tools to effect the required changes.

### Clinics and community health centres

The national Department has a limited ability to determine the flow of resources to primary care services, through the direction of international donor funding and the placement of interns, foreign doctors and community service professionals. Mostly it plays an indirect enabling role through the development of norms and standards. During 2000/1 the Health Systems Trust completed a baseline survey on the resources available and the services offered at our clinics and community health centres. This survey provides comparative information across provinces and illuminates progress or a lack of progress over a period of three years. The report paints a mixed picture (Page 40), reflecting progress in relation to certain services and a deterioration in others.

Additional research suggests that there are persistent gaps in service standards within provinces — between urban and rural areas and between areas previously restricted to white residents and those previously designated for black residents.

In 2000/1 the Department finalised a tool to assist in building equity right from clinic level: the Standard Package of Primary Health Care Services. This comprises a full set of norms for running clinics and health centres. It not only itemises the range of services and specifies — through protocols — how they should be delivered, but also sets out norms for staffing, equipment and pharmaceutical supplies.



The clinic and health centre Service Package was developed in partnership with provincial health providers and a serious effort has been made to take account of resource constraints. The next step in the process will be to conduct an extensive audit of clinic and health centre services in every municipality to establish the gap between current provision and the norm represented by the Service Package. In terms of our strategic framework, we have committed ourselves to closing the gap by 2004.

### Public hospital services

Through conditional grants, the Department makes a substantial contribution to the costs of running central hospitals and other specialised services and to the construction and physical rehabilitation of all categories of hospitals. In total, conditional grants exceed R6-billion and represent about 21% of total public sector health spending. About half this amount is channelled to central hospitals.

Conditional grants are a potential vehicle for promoting equity and improved access to care. Although central hospitals render certain specialised services on a national basis, there is substantial room to increase equity in the funding of tertiary care.

The basis of allocating conditional grants for tertiary care will be fundamentally revised before the end of 2001. During the year under review, research to inform this new policy was undertaken and fine-tuned under the direction of the Provincial Health Restructuring Committee, comprising the heads of national and provincial health departments. The new system of conditional grants for tertiary care will be phased in gradually as from 2002/3.

As in the case of primary care services, the setting of national service norms and standards is a key mechanism for improving equity in hospital service provision. In 2000/1 the Department made substantial progress towards the development of an Integrated Planning Framework. The Framework will include norms for the number of hospital beds, for staffing levels, for hospital occupancy rates and for average length of stay.

The norms are not ideal standards. They represent levels of efficiency that could realistically sustain our services, given available finance and the expected demand for hospital care. As such, they take account of the impact of HIV/AIDS and associated diseases, especially tuberculosis.

We have also begun work on a package of services to be provided in district hospitals.

### Allocation of Conditional Grants

