IMPROVING HEALTH SYSTEM EFFICIENCY

SOUTH AFRICA

Implementation of reforms under the National Drug Policy

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1 SETTING THE SCENE: THE APARTHEID PAST

Prior to the democratic transition in 1994, health services in South Africa were provided in a fragmented manner as they were primarily informed, and enforced, by the racially-inspired policy of "separate development" – usually referred to as *apartheid*. In 2009, a paper on the history of the South African health system described the deep roots of the fragmentation as follows: "A notable feature of the history of health services in South Africa has been fragmentation, both within the public health sector and between the public and private sectors. At an early stage, health facilities were racially segregated, and curative and preventive services were separated (by the Public Health Amendment Act of 1897)" *(1).* The structural basis of the fragmentation of health services was thus entrenched in law for almost a century before the transition to democracy in 1994.

In alignment with the racial laws, health services in the public sector durinng the apartheid era were provided separately to different ethnic groups. Separate health facilities were provided for Black Africans, whites, those of mixed race (so-called "coloured") and those descended from South Asian (usually Indian) immigrants. Not only were these facilities separate in physical terms, but they were also funded differentially and managed separately. Reflecting the prevailing orthodoxy, as opposed to any racist theory, health services were also divided between predominately curative services managed and provided by provincial authorities and services designated as preventive and promotive which were managed and provided by the National Department of Health (previously called the National Department of Health and Population Development). The definition of preventive and promotive services was, however, idiosyncratic, as it included psychiatric services as well as the provision of family planning.

Under the application of *grand apartheid*, the South African government created a series of tribal "bantustans" (also referred to as "homelands") for Black African ethnic groups. Some of these attained a degree of independence from South Africa though this was not formally recognized by any other state. The supposedly independent bantustans of Bophuthatswana, Ciskei, Transkei and Venda operated their own departments of health in parallel to South African structures. The remaining bantustans varied in the extent to which provision of health services was separate from or integrated with services offered by the surrounding provinces. Prior to 1994, South Africa was divided into four provinces – the Cape Province, Natal, Orange Free State and Transvaal. Each operated its own provincial department of health, responsible for curative services. In the larger urban centres, city health departments also operated primary health care facilities and provided a range of preventive, promotive and curative services. As Coovadia et al. summarized: "The apartheid system further entrenched fragmentation of health care when the bantustans were created, each with its own health department. The bantustans (and their government departments) acted separately from each other, like quasi-independent powers, with control carefully manipulated by Pretoria. By the end of the apartheid era, there were 14 separate health departments in South Africa, health services were focused on the hospital sector, and primary-level services were underdeveloped" *(1).*

This level of fragmentation had direct and far-reaching implications on the provision of medicines. The selection of medicines in the public sector was decided separately by each of the provincial departments of health for predominately curative services, by the National Department of Health and Population Development for preventive and promotive services, and by each of the bantustans. If each of these separate medicine selection processes had been based on evidence, the impact on efficiency would have been minimized. An evidence-based selection of essential medicines would have resulted in a smaller list, avoiding

unnecessary duplication and in turn enabling more effective procurement, distribution and use of those medicines. The selection processes were, however, weak and reflected the biases of individual prescribers and academics. The procurement lists were increasingly illogical, duplicative and, hence, inefficient.

Each of the four predemocracy provinces operated its own pharmaceutical depot (central store), with the Cape Province maintaining two such facilities. Medicines procured by the provinces were generally delivered to the depots and then distributed to health facilities. For white patients only, ambulatory care medicines prescribed by district surgeons were provided from private-sector pharmacies and paid for by the provincial Department of Health. These services were predominantly accessed by white pensioners who lacked private health insurance. From the end of World War II until 1988, medicines for the National Department of Health and Population Development and the bantustans were procured by the Medical Base Depot operated by the South African Defence Force. The medicines were distributed via a series of subdepots located in major centres to hospitals and other facilities.

The extent to which racial divisions informed health-care funding was also described by Coovadia et al: "Health services in the bantustans were systematically underfunded–by 1986/87, public sector health-care spending per head ranged from R 23 (about $ 11) in Lebowa to R 91 (about US$ 45) in Ciskei (bantustans) and from R 150 (about US$ 75) in Transvaal to around R 200 (about US$ 100) in Natal province and the Cape province" *(1)*.[1] This had a major impact on the degree to which access to medicines could be funded by the different departments of health and the facilities they operated, and thus on the range of medicines available.

The challenges facing the South African health system were summarized in 2009 as follows: "South Africa exemplifies a country that has undergone a protracted and polarised health transition, which is shown by the persistence of infectious diseases, high maternal and child mortality, and the rise of non-communicable diseases. This confluence of several transitions (health, demographic, and epidemiological) needs to be understood in the context of the country's development pathway; South Africa has been substantially shaped by its colonial and apartheid past that divided society by race, class, and sex" *(2)*. The same factors that shaped the health system thus shaped access to medicines. Medicines were financed in ways that reflected racial privilege or discrimination, the were selected by weak and fragmented health authorities, and they were procured, distributed and used in ways that were not designed to maximize efficiency but rather reflected the prejudices and polarized history of the country.

1 In this quotation, R = South African Rand (or ZAR).

2 TACKLING THE HEALTH SECTOR: POST-APARTHEID POLICY

The major post-apartheid health policy reforms addressed key social determinants of health and access to health services. They had relatively little direct impact on access to, and the use of, medicines but illustrate the policy environment in which pharmaceutical policy was being developed.
Table 1 shows the major policy changes in the post-apartheid period.

Table 1. Major post-apartheid health-related policy changes

Year	Nature of policy shift	Implications for access to and use of medicines
1996	Introduction of free care for children younger than 6 years and pregnant women	Removed user fee barriers at the point of care; later extended to free primary health care for all who are not beneficiaries of medical schemes (private health insurance)
1996	Passage of the Choice on Termination of Pregnancy Act, which legalised abortion	No direct impact on medicines issues, but posed a challenge for selection, as misoprostol was not registered for this indication; increased access to abortion, and led to marginal declines in septic abortions and stabilisation in maternal mortality from septic abortions
1999	Tobacco Products Control Amendment Act prohibited smoking in public places, restricted tobacco product promotion, and enhanced taxation	No direct impact on medicines issues; contributed to a substantial reduction in smoking
2000	Firearms Control Act restricted access to firearms	No direct impact on medicines issues; resulted in a reduction in gun-related homicides
2001	Free Basic Water Strategy defined water as a social and developmental good and basic human right	No direct impact on medicines issues, but significant impact on social determinants of health
2002	Mental Health Care Act legislated against	No direct impact on medicines issues