

**PUBLIC HEALTHCARE IN A POST-APARTHEID SOUTH
AFRICA: A CRITICAL ANALYSIS IN GOVERNANCE
PRACTICES**

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202523731

**THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS
FOR THE DEGREE OF DOCTOR OF PHILOSOPHY (POLICY AND
DEVELOPMENT STUDIES) IN THE COLLEGE OF HUMANITIES AT
THE UNIVERSITY OF KWAZULU-NATAL, SOUTH AFRICA**

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JULY 2016

As the candidate's supervisor, I hereby approve this thesis for examination

Supervisor: Dr Anne Stanton

DECLARATION 1: PLAGIARISM

I, Melody Brauns declare that:

- (i) The research reported in this thesis, except where otherwise indicated, is my original work.
- (ii) This thesis has not been submitted for any degree or examination at any other university.
- (iii) This thesis does not contain other person's data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
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ABSTRACT

The South African public healthcare system has undergone fundamental changes since 1994. There is a solid constitutional and legislative policy framework in place that guarantees the right to access to healthcare. However, difficulties remain in its implementation. The HIV/AIDS epidemic has negated many of the health gains made since 1994. Numerous studies have concluded that South Africa lacks the necessary skilled workforce and infrastructure. Nevertheless, while this is not disputed, this study argues that the implementation of public health policies in South Africa needs a governance approach that will strengthen cooperative governance across national, provincial and local spheres of government; as well as strengthen relationships between the private and public healthcare providers if the government is to meet its legislative obligations.

This study determines why, after almost 20 years of democracy; substantial transformation in the healthcare sector; significant increase in national revenue allocation; and numerous healthcare policy interventions; the South Africa government continues to struggle to provide public healthcare services. This study identifies the various public healthcare sector reforms that have been undertaken and the respective governance approaches that have been adopted. The study concludes that the lack of resources (human, financial and technical) are not the only or primary stumbling block to providing universal public healthcare. There is a serious disparity between theory and practice: On the one hand, there is a comprehensive legislative health policy framework in place, on the other hand, there is a vacuum on how this is meant to be implemented. The institutional arrangements within the public health sector; the intergovernmental relations between the different spheres of government; as well as the lack of mechanisms, processes and institutions which govern the relationships between the private and public sector remains vague. As long as this remains, policy implementation in the public healthcare sector will remain flawed and limited.

DEDICATION

I dedicate this thesis to the memory of my father, Henry King (1939-2015) who knew that I had the commitment, drive and perseverance to accomplish what I set out to do but could not witness my success because he was defeated by death. A man of integrity who taught me that the journey of knowledge is of no value unless you put it into practice. He showed me that confidence comes from careful preparation and a belief in one's abilities to a point where fear deserts you and boldness takes over. His words of wisdom and encouragement still linger on.

ACKNOWLEDGEMENTS

I am greatly indebted to the many people who assisted me in carrying out and completing this study. I am delighted to submit this thesis which has been prepared by intensive research. First and foremost, I must thank the Almighty God who has granted me countless blessing, knowledge, and opportunity to work towards accomplishing my goal.

I wish to express my sincere gratitude and appreciation to my supervisor, Doctor Anne Stanton, for her continuous support, expert guidance, patience and encouragement throughout the various stages of the study.

I would like to thank my mother, Mary King for her inspiration and unwavering support during this study. You have listened and laughed with me, praising my wise actions and criticising my foolish ones.

This journey would not have been possible without my phenomenal husband Leon, my soul mate and my rock for his priceless support, patience and encouragement during this educational journey.

Mercedes and Brittany my two cherished and exceptionally brilliant daughters for inspiring me in ways that you may never understand. You believed in me before I believed in myself. The unexpected courtesy, consideration and thoughtful deeds are appreciated. May I prove worthy to be called MUM.

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LIST OF ABBREVIATIONS

ADB	African Development Bank
ANC	African National Congress
BTECH	Bachelor of Technology
CAP	Constitutional Assembly Project
COSATU	Congress of South African Trade Unions
GDP	Gross Domestic Product
DHS	District Health System
DoH	Department of Health
DUT	Durban University of Technology
GEAR	Growth, Employment and Redistribution Programme
HST	Health Systems Trust
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
IMF	International Monetary Fund
MDG	Millennium Development Goals
NDoH	National Department of Health
NDP	National Development Plan
NEDLAC	National Economic Development and Labour Council
NGOs	Non-Governmental Organisations
NHA	National Health Act

NHI	National Health Insurance
NHIS	National Health Insurance Scheme
MINMEC	Minister and Members of the Executive Council
NP	National Party
NPM	New Public Management
OECD	Organisation for Economic Cooperation and Development
PEPFAR	Presidents Emergency Plan for AIDS Relief
PHC	Primary Health Care
PSC	Public Sector Comparator
RDP	Reconstruction and Development Programme
SACP	South African Communist Party
SHI	Social Health Insurance
TB	Tuberculosis
TNC	Trans National Corporation
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organisation
WTO	World Trade Organisation

CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE RESEARCH TOPIC

INTRODUCTION

This chapter introduces and provides a background to the dissertation. The rationale for the study is explained, and the research objectives and research questions are identified. This chapter also presents the conceptual theoretical framework upon which the study is grounded. It must be explained upfront that this dissertation is a portfolio of articles published in SAPSE accredited, peer reviewed journals as opposed to a standard doctoral thesis. This chapter provides a brief summary of the different articles and how these are integrated into one thesis.

BACKGROUND TO THE STUDY

This study is, in many ways, motivated by the fieldwork which I undertook as part of my Masters degree which I completed in 2012. My Masters thesis, entitled Healthcare Reform and Service Delivery: A Case Study of Montebello Hospital, was a qualitative, empirical study of service delivery in the public health sector. This study adopted an in-depth mixed-method approach of public healthcare service delivery at the Montebello Hospital in KwaZulu-Natal, South Africa. One of the objectives was to assess the quality of public healthcare services provided by public healthcare workers at the Montebello Hospital as perceived by the healthcare workers and patients. My study evaluated this hospital's approach and policies for improving healthcare delivery, and analysed its health outcomes through evidence-based research.

The perceptions of patients, nurses and doctors at the Montebello Hospital were gathered for the purposes of the study. The sampling technique was convenience sampling. It included staff and patients at the Montebello Hospital: 100 male patients and 100 female patients from the Montebello Hospital's approximately 3,700 monthly out-patients were interviewed. At the time of conducting the questionnaire, the Montebello Hospital had 205 nurses in its employ, 50 randomly selected nurses took part in the questionnaire. The Montebello Hospital employs eight doctors on a full-time basis and eight doctors on a part-time basis. The questionnaire was

administered to 13 doctors (each of the full-time doctors and five of the part-time doctors). Data collection methods for this study consisted of a combination of both semi-structured questionnaires and interviews. Two key documents, namely The Waiting Time Survey (2009) and the Patient Satisfaction Report (compiled and published by the Montebello Hospital) were analysed and provided the conceptual framework for the study. The main findings of my Masters study revealed the following:

The healthcare practitioners believe that they are under-resourced in terms of equipment, staff and funding. They believe that political leaders have not ensured the sound management of finances and human resources. Many felt that it is important to monitor performance on a regular basis (Brauns 2012: 136).

Patients were of the opinion that staff are reliable and respond promptly when needed. They indicated that the physical appearance of the hospital, that is the premises, restrooms, equipment, wards and beds are clean and well maintained. Only a small portion (13%) indicated that doctors and nurses are not skilled and knowledgeable. Some (5.5% patients) maintained that medication was not readily available (Brauns 2012: 100).

The public healthcare practitioners agreed that their performance should be monitored on a regular basis to promote accountability and transparency. They support continuous training programmes and are of the opinion that the Batho Pele Principles are indeed practised at the Montebello Hospital (Brauns 2012: 111 and 114).

Most of the patients were happy with the service delivery process. They indicated that the queues tend to be short and they do not have to wait too long time before being seen to. Only a total of 28% of the respondents revealed that there are lengthy queues and turnaround times were too slow. Patients were in agreement that healthcare practitioners at the Montebello Hospital provide personal care. Doctors exhibited a general feeling of empathy, mental support and understanding of their problems. In addition, there was consensus among patients that doctors and nurses communicate clearly and in a friendly manner regarding test results, diagnoses, prescriptions, health regimes etc. (Brauns 2012: 100).

My Masters research revealed that patients, nurses and doctors were all positive about the nature of care provided at the Montebello Hospital. Everyone attested to the approachability of doctors and nurses, as well as the fact that their positive behaviour and attitude are of major benefit to the institution. Particularly reassuring is the abundance of empathy of the healthcare practitioners, their sympathetic demeanour, their elevated levels of competence and their awareness for the suffering that patients endure. The skill and knowledge of the doctors and nurses provide a sense of assurance that they have the patients best interest in mind and that services at the hospital are delivered with integrity. In other words, despite the challenges facing the health practitioners at the Montebello Hospital, the feeling was that they were providing the best healthcare services that they could (Brauns 2012: 137 and 138).

The findings of my Masters study led me to question why then are the health outcomes not better given that South Africa has high expenditure and poor outcomes? The mortality rate for example remains high. According to the World Bank (2015) estimates, South Africa's under-5 mortality had declined between 2013 and 2015 from 43 to 41 per 1000 live births. The decline was attributed to better services being delivered to communities. However, the number of child deaths in South Africa is unacceptable. No child should die from treatable diseases such as a low birth weight, diarrhoeal diseases, malnutrition and tuberculosis. These deaths are preventable through the delivery of the primary healthcare approach.

The World Bank (2015) shows a decline in the maternal mortality ratio between 2013 and 2015 from 145 to 138 per 100,000 live births. However, the Millennium Development Goals (MDGs) specify that South Africa should attain a level of maternal mortality ratio of 38 per 100,000 live births by 2015.

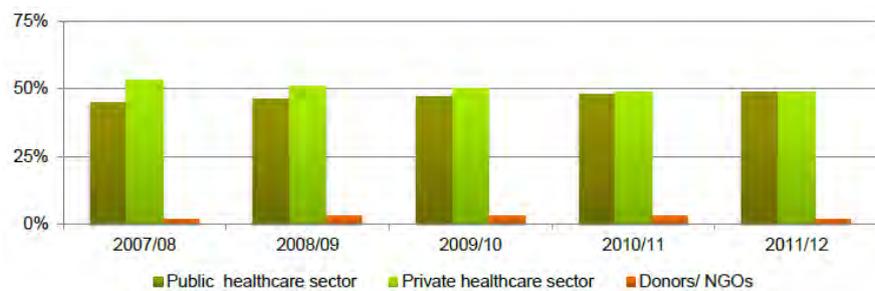
South Africa is one of the countries with the highest burden of Tuberculosis (TB). The World Health Organisation (WHO) statistics gives an estimated incidence of 450,000 cases of active TB in 2013 whilst the figure for active TB in South Africa in 2011 was 390,000.

South Africa has the biggest and most high profile HIV epidemic in the world, with an estimated 6.3 million people living with HIV/AIDS in 2013 (UNAIDS 2014). South Africa has the largest antiretroviral treatment programme globally and these efforts have been largely

financed from its own domestic resources. Maurice (2014) points out that the country now invests more than \$1 billion annually to run its HIV/AIDS programmes.

A cursory analysis of secondary sources revealed that services in many public healthcare facilities have deteriorated over the past few years, largely due to the growing HIV/AIDS epidemic and staff shortages. As a result, even the well performing hospitals are struggling to deal with the influx of patients. There is mounting concern over the growing perception that public healthcare services are inferior to private healthcare. Many South Africans would prefer to make use of private healthcare services however private healthcare is too expensive. The table below indicates that private medical scheme members account for 17% of the population, whilst 83% of the population is supported by the public health sector.

Figure 1: Public/private healthcare expenditure mix in South Africa, 2007/08 – 2011/12



Source: National Treasury, Budget review 2012

The perceived state of South African healthcare, illustrated in figure 1, is indicative of a largely unequal distribution of resources. The government has voiced concern in this regard, with public statements contained in the National Health Insurance White Paper (2015) stating: “the amount spent in the private health sector relative to the total number of people covered is not justifiable and defeats the principles of social justice and equity”.

Many countries in the developing world experience a shortage of healthcare workers but this does not mean that their health outcomes are poor. However, issues of hospital administration, financial mismanagement, corruption, unethical practices, lack of qualified healthcare workers and infrastructure challenges exacerbate problems within the public health sector in South Africa.

I therefore undertook to examine public healthcare in South Africa from a broader perspective.

OUTLINE OF THE RESEARCH TOPIC AND KEY QUESTIONS TO BE ANSWERED

Based on the ongoing challenges facing the public healthcare sector - inequitable healthcare financing, the high cost of private healthcare, the mal-distribution of health professionals between the public and private health sectors, the unequal doctor-patient ratio, weak or poor management and the burden of disease - one of the key research objectives of this study is to (i) explore and (ii) critically analyse the manner in which South Africa's public healthcare system is governed.

South Africa has undergone major governance reforms since 1994. This study aims to investigate the nature of these governance reforms with specific reference to the public healthcare system. This study aims to explore the public healthcare reform process, its outcomes, and the implications thereof on the provision of public healthcare. In order to do this, the study provides a conceptual framework based on the literature on governance. It also considers the literature on public management and its various approaches.

The key questions guiding this study are:

- i. How is the public healthcare sector governed in South Africa?
- ii. How was the public health sector governed during apartheid in South Africa?
- iii. What are the governance objectives of public healthcare?
- iv. What was the rationale for reforming the public health sector in South Africa?
- v. What public management approaches have been adopted in the public healthcare sector in South Africa, and how have these been implemented?
- vi. What are the major public sector reform outcomes in South Africa's public healthcare sector?
- vii. How can governance alleviate the challenges facing the public healthcare sector in South Africa?

THE CONCEPTUAL FRAMEWORK OF THE STUDY

This is a study in governance. The thesis establishes a conceptual framework based on an examination of Weber's theory on bureaucracy and the New Public Management (NPM)

paradigm. Weber's theory on bureaucracy regards government as having the rational-legal authority, making it forceful and effective and the fundamental basis for effective organisation. From this, he developed his concept of the ideal bureaucratic organisation (Naidu 1996: 81-82). Weber's work (although dating back to the early 1900s) has been credited for initiating studies on bureaucracy. His theory posits that if bureaucracy is organised in a rational and efficient manner, and if it is specifically designed for carrying out a specific task and given the necessary means – then specified outcomes will be achieved. His theory emphasized the importance of the specialisation of tasks and deployment of expertise in the public sector – all within a strict hierarchy of authority. Hogwood and Gunn (1984), cited in Hill and Hupe, 2002: 50) support his theory for a strong rational bureaucracy and argue for “a single implementing agency that need not depend upon other agencies for success, or, if other agencies must be involved, that the dependency relationships are minimal in number and importance”.

However, Weber's theory of a rational bureaucracy has been criticized for being misleading, because it offers ‘neither a desirable state nor an empirical reality’ (Stillman, 2010). It is suggested that Weber over-emphasises the formal elements of bureaucracy i.e. rules, division of labour, hierarchy of authority etc. whilst ignoring the informal dimensions of communication, leadership and human relations. Still, other scholars portray Weber's concept as being both time-bound and culture-bound, idealising the German bureaucratic state that dominated that era (Stillman, 2010). Despite the criticism of Weber's rational bureaucratic model, it continues to serve as an analytical tool for describing the structural characteristics of public institutions in the literature on governance and public administration.

Towards the end of the 1970s a paradigm shift emerged. According to Sharma (2007: 4) the emergence of NPM is associated with the changed role of the state and the growing demands for good governance practices worldwide. Robbins and Lapsky (2005: 111) identify several dimensions to NPM which include: 1) the reorganising and restructuring of public services; 2) the arrival of a new management focus to displace old-style administration; 3) a more explicit role for management in a top down, hierarchical functional concept; 4) the stress on quantification as a means of demonstrating efficiency gains and 5) holding persons with responsibility accountable. Moreover Zhange (2007: 557-558) mentions that NPM ideas include the retrenchment of public employees; reducing the scale of public expenditure; decentralisation; privatisation; contracting out; shifting out government services to the outside;

importing private sector instruments to the public sector; deregulation; fostering a culture based on performance utilising quality as measuring instruments; emphasising results and outcomes instead of processes as well as emphasising the priority of customers.

Phillip and Daganda (2013: 9) assert that the NPM advocates a basic change in the role of state in the society and economy. They assert that NPM aims at 3Es: i) economy - the eradication of waste; ii) efficiency - the streamlining of services and iii) effectiveness - the specification of objectives to ensure that resources are targeted on problems. Laxmikanth (2006) suggests that NPM is a series of shifts of emphasis in the way in which the public sector should be organized and managed to meet the new challenges of liberalisation, globalisation and privatisation.

The emphasis of new public management according to Phillip and Daganda (2013:9) is on performance appraisal, managerial autonomy, cost-cutting, financial incentives, output targets, innovation, responsiveness, competence, accountability, market orientation, quality improvement, contracting out, flexibility, competition, choice, information technology, de-bureaucratisation, decentralisation, down-sizing and entrepreneurialism.

The traditional bureaucracy (as espoused by Weber), founded on the principles of bureaucratic hierarchy, planning, self-sufficiency and independence (from the private sector) and direct control - are, according to the theory on NPM, now replaced by efficiency, individualism and a market-based public service culture. The philosophy of NPM, according to Fatemi and Behmanesh (2012:42) rationalises government, decentralises management authority, and is motivated by efficiency and effectiveness.

The introduction of NPM has sparked a debate over the virtues of public versus private provision of public goods and services. Stein (2001: 36) mentions that proponents of private service providers maintain that the private sector can offer better services in a more effective manner at a lesser cost for the public sector. The private sector, it is argued, offers greater flexibility, involves less red tape and accommodates innovation which is lacking in the public sector. In addition, the public sector lacks skilled and experienced personnel to provide quality services. As a result, public service provision will be more efficient under private sector control.

However, the NPM approach to governance has been criticized in its own right. For example, i) it has been accused of compromising quality in favour of service roll-out; ii) savings haven't always been forthcoming; iii) accountability has been questionable; iv) job losses have resulted and v) opportunities for corruption have been created (Stein 2001: 36).

The two approaches to governance – Weber's insistence on a traditional bureaucratic model, and the NPM approach each have their strengths and weaknesses. This study examines these different types of governance approaches and considers their feasibility and relevance to the provision of healthcare services in the South African context.

PROBLEM STATEMENT

Public healthcare in South Africa remains an area in need of development. The practice of providing healthcare in a racially discriminatory manner during Apartheid has resulted in a society where the standard of healthcare and healthcare facilities remains lacking. The newly democratically elected government of 1994 inherited a highly fragmented and bureaucratic system that provided healthcare services in an inequitable manner.

Apart from the challenges of the high burden of infant and maternal mortality, elevated levels of TB and HIV/AIDS and incompetent management, the country is experiencing a shortage of qualified doctors and nurses. According to the Econex 2015 report, South Africa had 60 doctors per 100,000 citizens in 2013, the world average was 152 doctors per 100,000 citizens in the same year. The Econex 2015 report also points out that in South Africa, there are 500 nurses per 100 000 people. The WHO recommends that there should be 200 nurses for every 100 000 people in a country. When this figure is broken down by removing enrolled nurses and nursing assistants, the figure drops to 246 professional nurses per 100 000 people. However, at least half of the country's nurses work in the private sector, which services only 17% of the population that can afford private healthcare. The public healthcare sector provides treatment and care to 83% of the population, with the same number of nurses.

The 2012 National Health Facilities Baseline Audit reported on a survey of 3,356 clinics and community health centres that found that most clinics had facility managers, but nearly half of the clinics had no visiting doctors; 84% had no assistance from a pharmacist or pharmacy

assistant; 11% had no lay counsellors; 57% had no administration support and 79% have no information management staff. The chronic shortage of healthcare workers inherited from apartheid had become an acute and catastrophic shortage.

According to Jobson (2015:6) the impact of the HIV/AIDS pandemic alongside trauma and interpersonal violence has created additional stress on the public health system and on its human and physical resources. Vacancy rates range from 13 to 40% across provinces with an average of 31% in South Africa.

More than 80% of South Africa's population depend on public healthcare. Yet, patients struggle to access care particularly in the rural areas. Although South Africa has developed a robust system of social security which includes disability, care dependency and old-age grants, substantial barriers remain in receiving care even in the context of free PHC in the public health sector. For instance greater access barriers are experienced by rural communities compared to urban communities including distance, time and cost of accessing health services including emergency transport (Gaede and Versteeg 2011).

Weaknesses in training, support, supervision and of appropriate leadership to manage underperformance in the public health sector are additional issues of concern. Another major challenge for the public health service according to the ANC's National Health Plan for South Africa (1994) is the human resource crisis, especially at community and primary healthcare levels in the public health sector, with a lack of health personnel in rural areas. According to Schaay, Sanders and Kruger (2011: 6) weaknesses in training, support, supervision and of appropriate leadership to manage underperformance in the public health sector are additional issues of concern. Moreover, deficiencies in stewardship, leadership, quality of care, inefficient management, and an absence of managerial oversight and accountability further thwart any real progress. Other challenges include a health sector that is under-resourced, failure amongst political leaders to sustain the system, issues of remuneration, ageing infrastructure and the HIV/AIDS epidemic create immense demand on South Africa's public healthcare system.

The Department of Health has developed a number of policy documents and programmes that govern the provision of healthcare, (such as the Patients' Rights Charter, The Health Sector Strategic Framework 2014-2019, The National Health Act (61 of 2003); the White Paper for

the Transformation of the Health Sector in South Africa (released in April 1997), and most recently the White Paper for National Health Insurance released in December 2015. The underlying premise of this study is that the manner in which such public policies and programmes are implemented and managed, is a matter of governance.

From an international perspective an NHI scheme has been modelled in various countries, and both successes and failures have been reported. Universal access to a quality healthcare programme is a basic human right; hence the worldwide attempts to provide sustainable healthcare to the public. Governments such as those of the United States of America (USA) and the United Kingdom (UK) have drafted and implemented sustainable healthcare systems. The US Government passed the Patient Protection and Affordable Care Act (PPACA) in 2010. The British National Health System (NHS), which is publicly funded, was launched in 1948. South Africa also made history in 2015 by launching the White Paper on the NHI, which is intended to offer quality service to citizens. Although the South African context certainly entails many challenges, several countries facing similar issues have implemented a national healthcare system such as Uganda, Ghana and Nigeria.

Reforming healthcare in South Africa does not mean that the country should copy any country's institutions precisely. South Africa cannot adopt another country's structure but they can adapt those approaches to the country's inherited conditions. Therefore adaptation is clearly the key, for it is not possible to import one nation's healthcare system into another. Socio-economic conditions amongst others differ from country to country. South Africa can learn from other countries because, ideas and practices flow across borders. Hence, the quest for solutions has become global in scope, as South Africa looks beyond its borders to examine how other nations provide and finance healthcare.

RESEARCH DESIGN AND METHODOLOGY

This study undertakes a broad analytical view of the provision of public healthcare services in South Africa. The objective is not to collect more qualitative or quantitative data than already exists in the public realm. Nor to review such data in depth since many studies have already done so. This study aims to identify and understand the underlying causes for the ongoing challenges experienced in the public healthcare sector in South Africa. It posits that South

Africa's particular socio-economic, political and historical contexts are defining factors in the provision of public healthcare. More importantly, this study posits that public healthcare outcomes are largely a result of how the sector is governed. In order to improve access to public healthcare services, the governance of the public healthcare sector in South Africa needs to be understood and analysed.

This study adopts a desktop research approach. Desktop research refers to seeking facts, general information on a topic, historical background and study results that have been published or exist in public documents. According to Shajahan (2014) desktop research, also called secondary data, refers to information that has been collected by someone other than the researcher for purposes other than those involved in the research project at hand. Books, journals, manuscripts, diaries, letters, newspapers and government publications are all secondary sources of data as they are written or compiled for different purposes. Depending on the necessity and relevance, a researcher may use the data, findings or results incorporated in these documents. Van Thiel (2014: 106-107) points out that desktop research is suitable for research of a historic nature or when exploring the background or content of a certain research problem. The main requirement for desktop research is that there must be substantial objective unbiased data available from wide-ranging sources. The advantage of using existing data is that this research strategy is relatively efficient and cost-effective. Moreover the researcher can act independently, without the help of others, although assistance may be needed to gain access to documents and archives. Existing information can be both qualitative and quantitative.

There are three common methods for analysing existing data: content analysis, secondary analysis and meta-analysis. Content analysis requires the researcher to study the content of the existing data, which will usually consist of written material or documents. The main interest lies in the message that the author of the text tries to convey to the audience. The researcher then selects material that is relevant to the subject of study (Van Thiel 2014:108-113).

Secondary analysis involves the use of existing data, collected for the purposes of a prior study, in order to pursue a research interest which is distinct from that of the original work; this may be a new research question or an alternative perspective on the original question (Van Thiel 2014:108-113).

The meta-analysis approach transcends the level of just one piece of research, and makes use of several previously conducted studies. In a meta-analytical study, the results of all kinds of existing research – inductive or deductive, different strategies and methods, collecting qualitative or quantitative data – are brought together, with the aim of arriving at a new conclusion (Van Thiel 2014:108-113).

Desktop research can be applied for different purposes: description, explanation, testing, or diagnosis. Likewise the three data analysis methods distinguished above can be used for various types of research, although they differ in their emphasis. For example, content analysis is best used in exploratory research. Secondary analysis requires an existent body of (often statistical) data, which means that it is suitable for testing, but less so for exploration (Van Thiel 2014: 115).

The data analysis method for this PhD study is meta-analysis. Various documents were examined. For example, academic literature, legislation, policies, managerial procedures, protocols, statistical reports, and so forth, in order to elicit meaning, gain understanding and develop empirical knowledge. The procedure entailed finding, selecting, appraising and synthesising data contained in these different types of documents. This study undertook an in-depth analysis of legislation and policies pertaining to public sector reform with particular reference to the healthcare sector. Datasets and publications from independent research outfits and non-governmental organisations (NGOs) focusing on public healthcare, such as the Centre for Health Policy, the Health Systems Trust (HST), and others, were analysed. The Health Systems Trust, for example, publishes annual District Health Barometers. These barometers detail comprehensive quantitative data on healthcare services across South Africa.

LIMITATIONS TO THE STUDY

This study has a number of inherent limitations. Some are deliberate, others are unfortunate. This study does not delve much into the privatisation of public healthcare services even though it is a key governance approach. The reason for not addressing this topic is because the ANC-led government has been very vocal in its rejection of privatisation of the public healthcare sector and will not likely consider this approach. In addition, the role of the private sector was only scantily considered because at the time of writing this thesis, the Competitive Commission

had not concluded its findings of the private healthcare sector in South Africa. One of the initial objectives of the study was to examine South Africa's National Health Insurance (NHI) policy. However, the White Paper on the NHI was only released on the 19th December 2015. There is no substantial data available on the programme or on the pilot studies that have been underway since. This means that it is clearly too early to provide an analysis of the NHI, or to comment on its progress in any meaningful manner. Nevertheless, this study analysed the NHI policy itself and considered the potential implications of the governance of the NHI.

Each article is an independent publication. As a result, there is some unavoidable repetition across the articles, but the repetition is limited to background information in order to contextualize the argument of each individual article. Presenting the context was regarded as important since the articles were published in international journals, hence some duplication was inevitable.

STRUCTURE OF THE THESIS

This is a PhD through publication. The articles were written over a period of time. Each article explores and analyses different aspects of governance in the public healthcare sector in South Africa.

This thesis is comprised of the following chapters:

Chapter 1: Introduction

This chapter presents the research topic, the problem statement, and the research objectives. The principle theories that inform the conceptual framework guiding the study are presented. The chapter also provides a background to the study and contextualises the articles.

The thesis then presents the different articles in respective chapters. The articles are presented in 6 separate chapters:

Chapter 2: Article 1

Brauns, M. 2015. The public health care sector and governance in South Africa. *Journal of Governance and Regulation*. Vol. 4 (2), pp. 105-112.

This article establishes the significance of governance for the public healthcare sector in South Africa. The article establishes the public healthcare mandate of the democratic government. The article presents a conceptual summary of the literature on the different theoretical approaches to governance. The article distinguishes between two key approaches namely the traditional bureaucratic model and New Public Management (NPM).

Chapter 3: Article 2

Brauns, M. and Stanton, A. 2015. Governance of the public health sector during apartheid: The case of South Africa. *Journal of Governance and Regulation*. Vol. 5 (1), pp. 23-30.

This article provides a historical review of the governance of the public health sector during the apartheid era. The objective of the article is to contextualise the current public healthcare challenges facing the democratically elected government by tracing the origins of the current health challenges facing the Department of Health.

Chapter 4: Article 3

Brauns, M. and Stanton, A. 2015. Good governance and the implementation of NHI in the public health sector: A case of South Africa. *Journal of Governance and Regulation*. Vol. 4 (4), pp. 17-25.

The third article focuses on good governance and the proposed implementation of the NHI in the public health sector and explores the governance objective of public healthcare. The article considers the relationship between the proposed NHI and good governance practices.

Chapter 5: Article 4

Brauns, M. and Stanton, A. 2015. Reforming the health sector in South Africa. *Risk governance and control: Financial markets and institutions*. Vol. 5 (3), pp.167-179.

The article examines the nature and extent of reforms that have taken place in the health sector since 1994. The article describes the public healthcare legacy inherited by the democratically elected government. It emphasises the extent of the public healthcare challenges facing the ANC-led government.

Chapter 6: Article 5

Brauns, M. 2013. Aligning strategic human resource management to human resources, performance and reward. *International Business and Economics Research Journal*. Vol.12 (11), pp. 1405-1410.

The article is a conceptual exploration of the concept of performance management as a public management strategy approach and examines in what way it can improve public service delivery. The article considers whether the implementation of public healthcare policies in South Africa, such as the NHI, will benefit from having a system of performance management that fosters good governance.

Chapter 7: Article 6

The District Health System and National Health Insurance in South Africa.
(Submitted to the South African Medical Journal for publication).

This article examines the decentralisation of public healthcare services in South Africa with particular reference to the establishment of the district health system (DHS). It looks at the rationale for decentralising public healthcare and considers current governance issues. The article also examines the NHI to the extent that the implementation thereof is meant to be at the district health level.

Chapter 8: Conclusion

This chapter contains a summary of the key arguments of the respective articles and presents recommendations based on the findings of this study.

CHAPTER TWO

THE PUBLIC HEALTH SECTOR AND GOVERNANCE IN SOUTH AFRICA

INTRODUCTION

Public healthcare in South Africa remains an area in need of development. The practice of providing healthcare in a racially discriminatory manner during Apartheid has resulted in a society where the standard of healthcare and healthcare facilities remains lacking. According to Pillay, McCoy and Asia (2001) the newly democratically elected government of 1994 inherited a highly fragmented and bureaucratic system that provided healthcare services in an inequitable manner. Healthcare services for Whites were better than those for Blacks and those in the rural areas were significantly worse off in terms of access to healthcare services compared to their urban counterparts. Whites, Blacks and Coloured's were racial terms used to label the different categories of race groups.

However, since 1994, the South African government has put in place a legislative framework to guide the realisation of equal access to quality healthcare. For example, the Constitution (Act 108 of 1996), in particular its Bill of Rights, acknowledges the injustices of the past, and binds the state to work towards the progressive realisation of basic human rights, including the right to health (Section 27):

- 1) Everyone has the right to have access to:
 - (a) Healthcare services, including reproductive healthcare;
 - (b) Sufficient food and water; and
 - (c) Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- 2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
- 3) No one may be refused emergency medical treatment.

Besides establishing a comprehensive legislative framework, Harrison (2009: 2) explains that the public health sector underwent substantial reorganisation post-1994 which involved the

rationalisation and amalgamation of previously separate health administrations located in the various Bantustans of South Africa.

Harrison (2009) indicates that despite progress made in establishing a legislative framework protecting people's rights to equal access to healthcare, many programmes that have been implemented have been thwarted by the severity of health issues facing the population of South Africa. HIV/AIDS for example, has reduced life expectancy by almost 20 years. The country is plagued by four other health problems described in the Lancet report (2009) as the quadruple burden of disease; TB (directly related to HIV/AIDS), maternal, infant and child mortality, injury and violence and non-communicable diseases. These diseases place an additional responsibility on an already burdened and underdeveloped public healthcare delivery system, struggling to overcome poor administrative management, low morale and lack of funding (Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, Jewkes, Karim, Flisher, Mayosi, Tollman, Churchyard, Coovadia, 2009: 1023).

The Department of Health has developed policies that focus on specific healthcare functions, norms and standards. There are a number of policy documents and programmes that pertain to the provision of healthcare, (such as the Patients' Rights Charter, The Health Sector Strategic Framework 1999-2004, even the White Paper for the Transformation of the Health Sector in South Africa released in April 1997), and most recently the National Health Insurance policy. How these are implemented are issues of governance.

The introduction of new legislation regarding transformation and service delivery brought about a change in which the South African public service functioned. The publication of the White Paper on the Transformation of the Public Service (Notice 1227 of 1995) serves as a point of departure for the transformation of the South African public service. One of the important political changes post-1994 was the translation of the 1993 Interim Constitution into a final constitution that guarantees amongst others access to health services for all citizens. The National Health Act (NHA) (Act 61 of 2003) can be regarded as a fundamental policy determining the legislative framework for healthcare delivery in South Africa, replacing all previous health policy. The White Paper on the Transformation of the Health System in South Africa (1997), established a detailed framework for healthcare delivery, and identified the manner in which Government intends to transform South Africa's healthcare system. It remains

one of the most important policy documents and is a benchmark that guides health sector transformation today.

GOVERNANCE

According to Abdellatif (2003: 5), the concept of governance “encompasses the functioning and capability of the public sector, as well as the rules and institutions that create the framework for the conduct of both public and private business, including accountability for economic and financial performance, and regulatory frameworks relating to companies, corporations, and partnerships”. The United Nations Development Program (UNDP) defines governance as “the exercise of economic, political and administrative authority to manage a country’s affairs at all levels. It comprises mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences” (Abdellatif, 2003: 4).

Loffler (2009: 216) states that governance is not a new term. The significance awarded to governance depends on the particular historical period, or the approach of the state and people of that period towards the exercise of control over their freedom and what they expected of their government. Sivaraman (2013: 109) argues that because complexities in the world have increased with global, political, economic and social integration, the concept of governance has become indefinable but intuitively understandable with respect to government, companies and institutions. Pierre and Peters (2000:1) suggest that the term governance was first used in France in the fourteenth century where it meant ‘seat in government’.

The World Bank popularised the term governance (1989: 60) which signalled a new approach to development that was based on the belief that economic prosperity is not possible without a minimum level of rule-of-law and democracy. Today, governance is used in a variety of fields mainly due to changing social theories or as Chhotray and Stoker (2009: 2) point out that the world has changed and governance seeks to understand the implications of these changes, and how they might best be managed.

The United Nations Development Programme (UNDP) provides a very broad definition, merely stating that governance’s primary interest lies in how effectively the state serves the

needs of its people (1997: 2-3). By the same token the United States Agency for International Development (USAID) maintains that governance is the ability to develop an efficient and accountable public management process that is open to public participation aimed at strengthening rather than weakening the democratic system of governance (2005:1). Other scholars such as Hyden, Court and Mease (2004: 16) define governance as “the formation and stewardship of the formal and informal rules that regulate the public sphere, the area in which the state as well as economic and societal actors interact to make decisions”. The above definitions indicate that governance is associated with relational connotations in which the focus is on how government organises itself and its relationship with civil society.

Grindle (2007: 553) suggests that governance is significant for development and capacity to address difficult issues of poverty reduction which has become the buzz word for development professionals. Grindle mentions that while many are pleased to see development debates move beyond an earlier approach that promised development when poor countries ‘get the policies right’, the adoption of the governance paradigm implies a very wide range of institutional preconditions for economic and political development and for poverty to be significantly reduced. According to Chibba (2009: 79) the word governance does not carry a universally accepted definition, but views governance as encompassing two key overlapping dimensions. The first refers to all aspects of the way a nation is governed, including its institutions, policies, laws, regulations, processes and oversight mechanisms. The second dimension is its cultural and ideological setting, for governance is perceived and shaped by values, culture, traditions and ideology.

According to Chhotray and Stoker (2009: 16) the theory of governance is about the practice of collective decision making based on the expansion of networks and the altering of public-private borders that emerged in the late 1990s and is probably one of the core developments in public administration. Public administration networks according to Wachhaus (2008: 152) “are structures or relationships that exhibit complexity because not only do they span organisational and institutional boundaries it also involves many actors simultaneously pursuing multiple agendas and designed to account for a lack of information or resources. These networks are different from hierarchies in that they facilitate interaction among participants for the exchange of information and resources so that collectively a common goal may be pursued”. Sørensen (2006: 99) states that traditionally, politicians have been seen as democratically authorized

sovereign rulers who govern society through their legitimate monopolised right to pass laws and regulations, while public administrators have been perceived as neutral and loyal servants who loyally implement laws and regulations. Seen from this role perspective Agger et al (2008: 23) suggest that “citizens and stakeholders are not supposed to play an active part in the governing process, and if they do, this is regarded as democratically illegitimate and problematic. Allowing them to take direct part in processes of public governance through various forms of network participation would undermine the parliamentary chain of governance which ensures an equal distribution of political influence the citizens as well as politicians”. As such efforts to enhance civic engagement through governance networks that involve both public and private sectors do not bode well with the traditional image of what it means to be a politician and a public administrator. In other words, the surge of network governance calls for the development of new roles for politicians and administrators that allow for close interaction between public authorities as well as private actors in civil society.

DIFFERENT APPROACHES TO GOVERNANCE

TRADITIONAL BUREAUCRATIC MODEL OF PUBLIC ADMINISTRATION

Weber (1922) reasoned that bureaucracy establishes the most efficient and rational way for government to organise human activity and is essential to the modern world. According to Weber (1947), the ideal type bureaucracy is the most efficient type of organisation for policy implementation as well as the most effective instrument of administration and political control. Weber studied bureaucracy from the point of view of authority which characterises every organisation. He distinguished between power and authority and regarded power as the exercise of coercion, and authority as the right to give orders and the expectation that it will be followed by those instructed. Weber examined different types of authority present in organisations and classified them as: (1) traditional authority – (because of people’s beliefs in the age-old customs and traditions; (2) charismatic authority – (because of the extraordinary personal qualities of the person in authority; and (3) rational-legal authority (granted through laws, statutes and regulations). Weber regarded rational-legal authority as more forceful and effective and it became the fundamental basis for effective organisation. From this, he developed his concept of the ideal bureaucratic organisation (Naidu 1996: 81-82).

Pollitt and Bouckaert (2004) point out that the literature on Weberian administration reveals some specific characteristics: (1) the reaffirmation of the state as main facilitator of solutions; (2) the reaffirmation of the role of representative democracy and the legitimating elements within the state apparatus; (3) the reaffirmation of the role of administrative law; and; (4) the preservation of the idea of public service.

Social concepts refer to a very broad range of ideas that relate to society as a whole such as the structure of society or social interactions. To this effect, Weber believed that the bureaucratisation of economic, political and social life was imminent, inevitable and had the most profound significance for civilisation. Weber argued that the modern state could not sustain itself without bureaucratic organisation. His model of bureaucracy described that social, economic and political control could be firmly established only by routine and authoritative administration of public policy. At the core of Weber's argument was an assumption that certain requisites of control had to be established in order for the modern state to exist. One of these requisites was economic infrastructure creation and its public administration and the other was absolute pacification through the establishment of bureaucratic systems of justice. Weber maintained that the state was a unique entity which exercised legitimate control over force and coercion through law. It did so, he believed, through the creation of bureaucratic organisations (Lewis, 1988: 46).

However, by World War II, criticism of Weber's ideas of rational bureaucracy began to surface. Farazmand (2002: 25) argued that Weber's bureaucratic organisation, while it may produce efficiency, has a tendency to dehumanise organisations, promote red tape, delay decision making and as well as being inflexible and rigid in rule application. Barnard(1938) argued that administrative efficiency could be increased through informal relations rather than through Weber's structural approach while March and Simon (1958) have emphasised that Weber has neglected human behaviour, they argue that by concentrating merely on structure and technicalities, administrative efficiency cannot be increased.

Not only is Weber's concept of bureaucracy criticised, according to Self (2010: 99) it has now outlived its usefulness in two important aspects. Firstly, the bureaucratic exercise of discretionary powers has grown allowing bureaucracy to become increasingly involved with discretionary forms of intervention, arbitration and financial support often carried out in

conjunction with interested parties. Secondly, the political environment of modern bureaucracy has been transformed by the weakened capacity of political leadership to direct or control bureaucracy from the top down and by the complex political pressures which surround the work of bureaucratic agencies.

According to Naidu (1996: 85) Weber was the first to explore the positive and negative consequences of bureaucratic administration and his bureaucracy was the most advanced form of organisation at that time. Weber wrote “bureaucracy is superior to any other form in precision, in stability, in the stringency of discipline and in its reliability” Weber was not however blind to the negative consequences of bureaucracy. In fact, he recognised the potential to do serious harm to valued social and political institutions. Naidu (1996) maintains that he was pessimistic about the ability of democratic institutions to maintain control over bureaucratic apparatus of the state mainly because of bureaucrats’ technical expertise and control over the instruments of government. Weber nevertheless saw no viable alternative to bureaucracy in managing large-scale organisations with efficiency.

Parsons (1998: 91) shows that Weber’s bureaucratic model was about uniformity and predictability. He states that this model provided public administration with a way of thinking about responsibility which was viewed as the notion of administration of the state organised in a hierarchical way. In Weber’s bureaucratic model there was a place for everything and everything had its place. Civil servants knew their position and parliaments knew where things were and who was responsible for them. However, matters became more complex as these hierarchical forms of organisation began to give way to new patterns of inter-organisational relationships. Whereas in the past it was easy to identify who did what, when and how it becomes far more problematic when shifted away from the Weber’ bureaucratic model.

In a more coherent argument on Weber’s bureaucratic model, Suleiman (2005: 29) describes Weber’s model as top-down democracies that are simply too slow, too unresponsive and too incapable of change or innovation. The work of Osborne and Gaebler (1992) stated that the Weberian top-down administration was an outdated form of organisation associated with the factory system of the nineteenth century which was inflexible, slow and incapable of meeting the demands of modern citizens. Osborne and Gaebler (1992: 17) observe that Weber’s bureaucratic model was relevant in its day as long as the tasks were simple, straightforward and

the environment stable. But for the last 20 years cracks were beginning to appear in a world of rapid change, technological advancement and global economic competition.

This form of rigid, hierarchical specialised structure was shrouded in major contradictions. Naidu (1996: 86) points out that Weber pays no attention to the pattern of interaction of bureaucracy with the political, social, and cultural environment and ignores the social psychological influences on the behaviour of people in organisations. According to Berberoglu (2007: 16) Weber argued that the bureaucratic form of social organisation lends itself to control and domination of society and the individuals within it and generates as a by-product a social alienation that puts managers and workers, bureaucrats and citizens, in opposite camps, thus leading to conflict between those who control and govern and those who are controlled and governed at all levels of society.

NEW PUBLIC MANAGEMENT (NPM)

The 1980s and 1990s saw the emergence of a new managerial approach in public administration in response to the inadequacies of the traditional model of administration. According to Zhang (2007: 557) the concept of NPM movement originated from New Zealand, Australia and the United Kingdom and later disseminated to the United States and other countries. The essence of NPM is borrowing and applying the concepts and techniques of private sector management into public sector management thus reducing the functions of the public sector through contracting out and privatising. The rigid, hierarchal, bureaucratic form of public administration which had dominated for most of the twentieth century began to be replaced with more flexible, market-based form of public management. Traditional public administration was discredited theoretically and practically, and the adoption of NPM introduced the emergence of a new paradigm in the public sector (Hughes 1998: 1).

According to Sharma (2007: 4) the emergence of NPM is associated with the changed role of the state and the growing demand for good governance practices worldwide. Hood (1991: 5) describes the emergence of NPM as a marriage of opposites. One partner was the new institutional economics which was built on the familiar story of the post-World War II development of public choice, transactions cost theory and principle agent theory. The new institutional economics movement helped to generate a set of administrative reform doctrines

built on ideas of contestability, user choice, transparency and close concentration of incentive structures. The other partner in the marriage was the latest of a set of successive waves of business-type managerialism in the public sector. This movement helped to generate a set of administrative reform doctrines based on the ideas of professional management expertise over technical expertise, requiring high discretionary power to achieve results (free to manage), better performance and the active measurement of organisational outputs.

Hood (1991: 503) states that while there is no single accepted explanation of why NPM came about when it did, NPMs rise seems to be linked with four other administrative megatrends namely 1) attempts to slow down or reverse government growth in terms of overt public spending and staffing, 2) the shift towards privatisation and quasi-privatisation and away from core government institutions with renewed emphasis on subsidiarity in service provision, 3) the development of automation, particularly in information technology in the production and distribution of public services and 4) the development of a more international agenda, increasingly focused on general issues of public management, policy design, decision styles and intergovernmental cooperation on top of the older tradition of individual country specialisms in public administration. Hood (1989: 350) suggests that these trends are not jointly exhaustive of developments in this field – they overlap and are casually related. NPM therefore is often interpreted as a consequence of a shift to smaller government and as a form of intellectual privatisation of the study of public administration.

The traditional model of bureaucratic organisations and delivery of public services, such as the Weberian model of bureaucracy came under scrutiny. Hierarchy, centralisation, direct control and heavy emphasis on rules and procedures were replaced by the NPM framework which proposed to make public sector administration more efficient, effective and responsive Hood (1995). Garson and Overman (1983: 275) define NPM as an “interdisciplinary study of the generic aspects of administration . . . a blend of the planning, organising, and controlling functions of management with the management of human, financial, physical, information and political resources.”

NPM, according to Vigoda (2003: 1) represents a “method in public administration that combines knowledge and experiences obtained in business management and other disciplines to enhance effectiveness, efficiency, and general performance of public services in modern

bureaucracies”. Dent and Barry (2004: 7) suggest that “the attraction of NPM lies in the claim that it delivers improved public services and that it symbolises an empowerment of those it employs and those it seeks to serve”. The term NPM according to Falconer (nd) “signifies a series of themes intended to reform the procedures and organisation of the bureaucracy/public sector to make it more competitive and efficient in the manner that resources are efficiently used and services timeously delivered”. NPM is concerned with the state’s role in delivering services to its citizens, and of the state’s relationship with its citizens.

Robbins and Lapsky (2005: 111) identify several dimensions to NPM which include: 1) reorganising and restructuring of public services, 2) the arrival of a new management focus to displace old-style public administration, 3) a more explicit role for management in a top down, hierarchical functional concept, 4) the stress on quantification as a means of demonstrating efficiency gains and 5) of holding persons with responsibility accountable. Moreover Zhange (2007: 557-558) mentions that NPM ideas cover the retrenchment of public employees, reduces the scale of public expenditure, privatising, contracting out, shifting out government services to the outside, importing private sector instruments to the public sector, decentralisation, deregulation and re-regulation, fostering a culture based on performance utilizing quality as measuring instruments, emphasizing results and outcomes, instead of processes, as well as emphasizing the priority of customers.

Dunn and Miller (2007) state that when NPM was introduced it was seen as a direct assault on the Weberian model of administration arguing that it was too rigid and inflexible to meet increased demands for economic efficiency and adaption of new demands from society. Furthermore, economic problems meant governments reassessed their bureaucracies and demanded change. Caiden (1991: 74) states that bureaucracy received the brunt of criticism, relating to the poor performance of public bureaucracies, the daily annoyances of restrictions, red-tape, unpleasant officials, poor service and corrupt officials.

One of the key characteristics of NPM according to Van de Walle and Hammerschmid (2011: 192) was to do away with hierarchist public sector monoliths, which were, in many cases inefficient. Hood (1991: 3) elaborating on the seven doctrines of NPM suggest that the core principle of NPM is that systems of public administration can be strengthened through the adoption of micro-management practices associated with the private sector. The new public

management agenda places emphasis on professional management, performance management, greater output controls, decentralisation of units, greater competition, private sector management styles and efficiency and effectiveness.

Stein (2001: 36) argues that supporters of private provision maintain that the private sector can offer better services in a more efficient manner at less cost than the public sector. The private sector, it is argued, offers greater flexibility, involves less red tape and proposes innovative approaches which is lacking in public sector. In addition, the public sector lacks experienced personnel to provide quality services, and programme implementation will be more efficient under private sector control. However, arguments against private sector provision claim that savings are not always realised, service quality is compromised in favour of profits, privatisation diminishes the accountability of government officials, that it threatens the jobs of public service employees, and there is no guarantee that the competition necessary to yield cost savings exists.

CONCLUSION

This paper posits that public policy implementation is an outcome of governance and that governance can be implemented in a number of ways which may be affected by socio-economic conditions and various actors including the type of relationships that exist between the actors. It is argued that governance, is about developing the necessary institutions and processes necessary for policymaking and policy implementation.

REFERENCES

1. Abdellatif, A.M. 2003. *Good governance and its relationship to democracy and economic development. Global forum III on fighting corruption and safeguarding integrity*, Seoul 20-31 May 2003 [Online]. Available at: <http://www.pogar.org/publications/governance/aa/goodgov.pdf> Accessed 30 March 2015.
2. Agger, A., Sørensen, E. and Torfing, J. 2008. It takes two to tango: When public and private actors interact. In Yang, K and Bergrud, E (Eds.). *Civic Engagement in a*

Network Society. North Carolina, Information Age Publishing Inc. [Online]. Available at:

<http://books.google.co.za/books?id=K2ZMbTgfJgcC&pg=PA23&dq=how+do+networks+in+governance+affect+public+administration&hl=en&sa=X&ei=qN5uVOX8Fsr4igKa24HgCQ&ved=0CD0Q6AEwBTgK#v=onepage&q=how%20do%20networks%20in%20governance%20affect%20public%20administration&f=false> Accessed 29 March 2015.

3. Barnard, C.I. 1938. *The functions of the executive*. Massachusetts: Harvard University Press.
4. Berberoglu, B. 2007. *The state and revolution in the twentieth century: Major social transformations of our time*. Maryland, Rowman and Littlefield Publishers [Online]. Available at:
<http://books.google.co.za/books?id=2d0UDTYyByQC&pg=PA17&dq=description+of+the+socio+economic+state+of+the+weberian+bureaucracy&hl=en&sa=X&ei=ENS6U8TGBsa7O8ragLgJ&ved=0CCgQ6AEwAzgK#v=onepage&q=description%20of%20the%20socio%20economic%20state%20of%20the%20weberian%20bureaucracy&f=false> Accessed 30 March 2015.
5. Caiden, G.E. 1991. *Administrative reform comes of age*. New York, Walter de Gruyter.
6. Chhotray, V., Stoker, G., 2009. *Governance theory and practice*. Hampshire, Macmillan.
7. Chibba, M. 2009. Governance and development: The current role of theory, policy and practice. *World Economics*, Vol. 10(2), pp. 79 -108.
8. Chopra, M., Lawn, J.E., Sanders, D., Barron, P., Karim, S.S., Bradshaw, D., Jewkes, R., Karim, Q., Flisher, A. J., Mayosi, B.M., Tollman, S.M., Churchyard, G.J. and Coovadia, H. 2009. Achieving the health millennium development goals for South Africa: challenges and priorities. *The Lancet*, Vol. 374(9694), pp. 1023-31.

9. Dahl, R.A. 1971. *Polyarchy: Participation and opposition*. London, Yale University Press.
10. Dent, M. and Barry, J. 2004. *Questioning the New Public Management*. In Dent, M., Chandler, J. and Barry, J (Eds.). Burlington, Ashgate Publishing Limited [Online]. Available at:
http://books.google.co.za/books?id=3mziNCdh__AC&printsec=frontcover&dq=questioning+the+new+public+management&hl=en&sa=X&ei=De8uUoyiJ43o7AbF7YHABg&ved=0CCwQ6AEwAA#v=onepage&q=questioning%20the%20new%20public%20management&f=false Accessed 02 April 2015.
11. Dunn, W.N. and Miller, D.Y. 2007. A critique of New Public Management and the Neo-Weberian State: Advancing a critical theory of administrative reform. *Public organisation review*, Vol. 7(4), pp. 345-358.
12. Farazmand, A. 2002. *Organisation theory: From pre-classical to contemporary and critical theories – an overview and appraisal*. Connecticut, Praeger/Greewood Publishing [Online]. Available at:
http://books.google.co.za/books?id=5hhOtD_xR8cC&pg=PA25&lpg=PA25&dq=has+a+tendency+to+promote+red+tape+and+delayed+decision+making+and+as+well+as+being+inflexible+and+rigid+in+rule+application&source=bl&ots=_R7EO7zaPm&sig=VGDOGUXSzqH7GedTtDhA-XZF_Nw&hl=en&sa=X&ei=g14IVK-mA4iHOLmAgagC&ved=0CBwQ6AEwAA#v=onepage&q=has%20a%20tendency%20to%20promote%20red%20tape%20and%20delayed%20decision%20making%20and%20as%20well%20as%20being%20inflexible%20and%20rigid%20in%20rule%20application&f=false Accessed 30 March 2015.
13. Garson, G.D. and Overman, E.S. 1983. Public management research in the United States. New York, Prager. In Ehsan, M. and Naz, F. (Eds.). Origin, ideas and practice of new public management: Lessons for developing countries. *Asian Affairs*, Vol. 25(3), pp.30-48 [Online]. Available at: <http://www.cdrb.org/journal/2003/3/2.pdf> Accessed 03 April 2015.

14. Grindle, M.S. 2007. Good enough governance revised. *Development policy review*, Vol. 25(5), pp. 553-574.

15. Harrison, D. 2009. An Overview of Health and Healthcare in South Africa 1994 – 2010: Priorities, progress and prospects for new gains: A discussion document commissioned by the Henry J. Kaiser family foundation to help inform the national health leaders' retreat Muldersdrift, January 24-26 2010 [Online]. Available at: <http://www.doh.gov.za/docs/reports/2010/overview1994-2010.pdf> Accessed 28 March 2015.

16. Hood, C. 1989. Public Administration and Public Policy: Intellectual challenges for the 1990s. *Australian Journal of Public Administration*, Vol.48, pp.346–58.

17. Hood, C., 1991. A public management for all seasons. *Public Administration*, Vol. 69(1), pp. 3-19 and 4-5.

18. Hood, C. 1995, The 'New Public Management' in the 1980's: Variations on a theme. *Accounting, Organizations and Society*, Vol. 20(2/3), pp. 93-109.

19. Hughes, O.E. 1998. *Public management and administration*. New York, Palgrave Publishers.

20. Hyden, G., Court, J. and Mease, K., 2004. *Making sense of governance: Empirical Evidence from Sixteen Developing Countries*. London, Lynne Rienner Publishers [Online]. Available at: <http://books.google.co.za/books?id=vZ3h2gOBIfQC&printsec=frontcover&dq=making+sense+of+governance&hl=en&sa=X&ei=QHNU7GQKcTZPKrFgeAP&ved=0CB oQ6AEwAA#v=onepage&q=making%20sense%20of%20governance&f=false> Accessed 04 April 2015.

21. Lancet Report. 2009. The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, Vol. 374(9692), pp. 817-834.

22. Lewis, E. 1988. *American politics in a bureaucratic age: Citizens, constituents, clients and victim*. London, Winthrop Publishers [Online]. Available at: <http://books.google.co.za/books?id=DaBRwoLU720C&pg=PA46&dq=description+of+the+socio+economic+state+of+the+weberian+bureaucracy&hl=en&sa=X&ei=3KW6U-vuPOSe7AamtoH4CQ&ved=0CCoQ6AEwAw#v=onepage&q=description%20of%20the%20socio%20economic%20state%20of%20the%20weberian%20bureaucracy&f=false> Accessed 29 March 2015.
23. Loffler, E. 2009. Public governance in a network society. In Bovaird, T. and Loffler, E. (Eds.). *Public management and governance*. New York, Routledge [Online]. Available at: <http://books.google.co.za/books?id=wjuz75AiVWQC&pg=PA216&dq=the+term+governance+was+first+used+i+France+in+the+fourteenth+century&hl=en&sa=X&ei=ZiKoU4DgPMOV7AbPiIDQBg&ved=0CBwQ6AEwAA#v=onepage&q=the%20term%20governance%20was%20first%20used%20i%20France%20in%20the%20fourteenth%20century&f=false> Accessed 15 April 2015.
24. March, J.G. and Simon, H. 1958. *Organisations*. New York: John Wiley.
25. Naidu, S. P. 1996. *Public administration: Concepts and theories*. New Delhi, New age international publishers [Online]. Available at: <http://books.google.co.za/books?id=GWrZhzhPfoC&pg=PA82&dq=max+webers+rational+legal+bureaucracy&hl=en&sa=X&ei=gA6wU6X-HIjY7Ab-mIDgBQ&ved=0CCEQ6AEwAQ#v=onepage&q=max%20webers%20rational%20legal%20bureaucracy&f=false> Accessed 15 March 2015.
26. Osborne, D. and Gaebler, T. 1992. *Reinventing government: How the entrepreneurial spirit is transforming the public sector*. California, Adison Wesely.
27. Parsons, W. 1998. *Fuzzy in theory and getting fuzzier in practice: post-modern reflections on responsibility in public administration and management*. Berlin, IOS Press [Online]. Available at: <http://books.google.co.za/books?id=21T7XnOp->

[fwC&pg=PA91&dq=the+weberian+way+of+governance&hl=en&sa=X&ei=q1KxU3YMO-h7Aa13YCwCA&ved=0CBoQ6AEwAA#v=onepage&q=the%20weberian%20way%20of%20governance&f=false](http://www.google.co.za/search?q=the+weberian+way+of+governance&hl=en&sa=X&ei=q1KxU3YMO-h7Aa13YCwCA&ved=0CBoQ6AEwAA#v=onepage&q=the%20weberian%20way%20of%20governance&f=false) Accessed 10 March 2015.

28. Pierre, J. and Peters, G. 2000. *Governance, politics and the State*. Illinois, Macmillan.
29. Pillay, Y., McCoy, D. and Asia, B. 2001. *The district health system in South Africa: Progress made and next steps*. US Agency for International Development (USAID)/South Africa [Online]. Available at: <http://www.doh.gov.za/docs/policy/dhsystem.html#conctact> Accessed 11 March 2015.
30. Pollitt, C. and Bouckaert, G. 2004. *Public management reform: A comparative analysis*. Oxford, Oxford University Press.
31. Republic of South Africa. 1996. *The Constitution of the Republic of South Africa (Act No. 108 of 1996)*. Pretoria: Government Printers.
32. Republic of South Africa. 1997. Department of Health. *White Paper for the Transformation of the Health System in South Africa*. Government Gazette, Vol. 382, No: 17910 16 April 1997. Pretoria: Government Printers.
33. Republic of South Africa. 2003. *National Health Act* [Online]. Available at: <http://www.google.co.za/url?sa=t&rct=j&q=the%20national%20health%20act&source=web&cd=1&ved=0CGUQFjAA&url=http%3A%2F%2Fwww.info.gov.za%2Fview%2FDownloadFileAction%3Fid%3D68039&ei=hwmxT7WiPIT64QS2lbHPCQ&usq=AFQjCNEHWPMMEB5AeY2NEoFoi5BajAv0GA> Accessed 21 March 2015.
34. Robbins, G and Lapsky, I. 2005. New Public Management and the Irish public sector: From reluctant reformer to statutory codification. In Guthrie, J., Humphrey, C., Jones, L.T and Olson, O. (Eds.). *International Public Financial Management Reform: Progress, Contradictions and Challenges*. United States of America, Information Age Publishing Inc. [Online]. Available at: <http://books.google.co.za/books?id=->

[gowgK38fWQC&pg=PA111&dq=new+public+management+came+about+as+a+result+of&hl=en&sa=X&ei=Nht0VJL0C4LXyQOPooHwDg&ved=0CCoQ6wEwAQ#v=onepage&q=new%20public%20management%20came%20about%20as%20a%20result%20of&f=false](http://books.google.co.za/books?id=gowgK38fWQC&pg=PA111&dq=new+public+management+came+about+as+a+result+of&hl=en&sa=X&ei=Nht0VJL0C4LXyQOPooHwDg&ved=0CCoQ6wEwAQ#v=onepage&q=new%20public%20management%20came%20about%20as%20a%20result%20of&f=false) Accessed 04 April 2015.

35. Self, P. 2010. *Political theories of modern government: It's role and reform*. New York, Routledge [Online]. Available at:
<http://books.google.co.za/books?id=kKOLAgAAQBAJ&pg=PA99&dq=why+did+weberian+become+outdated&hl=en&sa=X&ei=wwGwU9WGHcyv7AbiroDoDQ&ved=0CBoQ6AEwAA#v=onepage&q=why%20did%20weberian%20become%20outdated&f=false> Accessed 20 March 2015.
36. Sharma K. C. 2007. Global trends in new public management: Challenges and constraints confronted by developing countries. *Administrative Change*, Vol. 34(2), pp. 20 – 40.
37. Sivaraman, M.R. 2013. Governance and development. In Chathapuram, S.R. and Dutta, S., (Eds.). *Governance, Development and social work*. India, Routledge [Online]. Available at:
<http://books.google.co.za/books?id=AUdtAAAQBAJ&pg=PA106&dq=authors+that+have+criticised+the+concept+of+good+governance&hl=en&sa=X&ei=7wqsU4ufO6fX7Aag8YDQBg&ved=0CEEQ6AEwBQ#v=onepage&q=authors%20that%20have%20criticised%20the%20concept%20of%20good%20governance&f=false> Accessed 15 March 2015.
38. Sørensen, E. 2006. Meta governance: The changing role of politicians in processes of democratic governance. *American review of public administration*, Vol. 36(1), pp. 98-114.
39. Stein, T.J. 2001. *Social policy and policymaking: By the branches of government and by the public at large*. New York: Columbia University Press [Online]. Available at
<http://books.google.co.za/books?id=qz5jCFoQJpwC&pg=PA36&dq=who+would+more+efficiently+provide+health+services+->

[+the+public+of+private+sector&hl=en&sa=X&ei=y3g5Ut-9GILj4QTt34CoDw&ved=0CDMQ6AEwAQ#v=onepage&q=who%20would%20more%20efficiently%20provide%20health%20services%20-%20the%20public%20of%20private%20sector&f=false](#) Accessed 02 April 2015.

40. Suleiman, E.N. 2005. *Dismantling democratic states*. New Jersey, Princeton University Press [Online]. Available at:
<http://books.google.co.za/books?id=J8a7AgAAQBAJ&pg=PA29&dq=the+problems+associated+with+the+weberian+top-down+bureaucracy&hl=en&sa=X&ei=mQa0U9OYEcX07AaihIGwBQ&ved=0CCoQ6AEwAw#v=onepage&q=the%20problems%20associated%20with%20the%20weberian%20top-down%20bureaucracy&f=false> Accessed 19 March 2015.
41. UNDP 1997. Governance for sustainable human development. UNDP policy paper.pp. 2-3
42. Van de Walle, S. and Hammerschmid, G. 2011. The Impact of the new public management: Challenges for coordination and cohesion in European public sectors. *Halduskultuur – Administrative Culture* 12(2), pp.190-209 [Online]. Available at:
<http://www.halduskultuur.eu/journal/index.php/HKAC/article/viewFile/43/55> Accessed 23 March 2015.
43. Vigoda, E. 2003. New Public Management. In Rabin, J, (Ed). *Encyclopaedia of Public Administration and Public Policy*, Vol. 2. New York, Marcel Dekker [Online]. Available at:
http://books.google.co.za/books?id=55ghk_xYpToC&pg=PA813&dq=In+conclusion+Hoods+seven+principles+of+NPM&hl=en&sa=X&ei=3GYSVL-bJe7X7Aa5goCAAg&ved=0CBsQ6AEwAA#v=onepage&q=In%20conclusion%20Hoods%20seven%20principles%20of%20NPM&f=false Accessed 27 March 2015.
44. World Bank. 1989. *From Crisis to Sustainable Development: Africa's Long-Term Perspective*. Washington D.C, World Bank.

45. Zhang, M. 2007. Administrative reforms in China: Globalisation or localization? In Farazmand, A. and Pinkowski, J., (Eds.). *Handbook of Globalization, Governance, and Public Administration*. New York, Marcell Dekker [Online]. Available at: <http://books.google.co.za/books?id=4g91oclalP4C&pg=PA572&dq=Zhang+the+concept+of+NPM&hl=en&sa=X&ei=Gkl0VLSVJcfTaM2HgfgK&ved=0CDYQ6AEwBQ#v=onepage&q=Zhang%20the%20concept%20of%20NPM&f=false> Accessed 15 March 2015.

CHAPTER THREE

GOVERNANCE OF THE PUBLIC HEALTH SECTOR DURING APARTHEID: THE CASE OF SOUTH AFRICA

INTRODUCTION

The passage from apartheid to democracy has been tainted by unjust laws and a wide range of human rights violations. It is not possible to appreciate the history of apartheid and to understand what South Africa went through and is still going through without some reference of how White minority rule influenced present political structures and economic patterns. Any assessment of South Africa's predicament, and any effort to recover from its past, must acknowledge the weight of history. Here we follow Coovadia, Jewkes, Barron, Sanders, and McIntyre (2009: 817) who point out that South Africa's history has had a marked impression on the health of its people, health policies and services of the present day. These limitations can be attributed to a diverse combination of factors such as: the elevated level of medical migration, critical health worker shortages, imbalance of resources, inequities in the recruitment of staff, an evolving burden of disease and inadequacies in managerial capacity.

The American Association for the Advancement of Science and the Physicians for Human Rights Organisation (1998) state that the apartheid healthcare system restricted access to healthcare for Blacks and often ignored quality-of-care standards. It established an environment in which abuses such as the denial of emergency care treatment, falsification of medical records and limitation of Blacks' access to continuous medical care were prevalent.

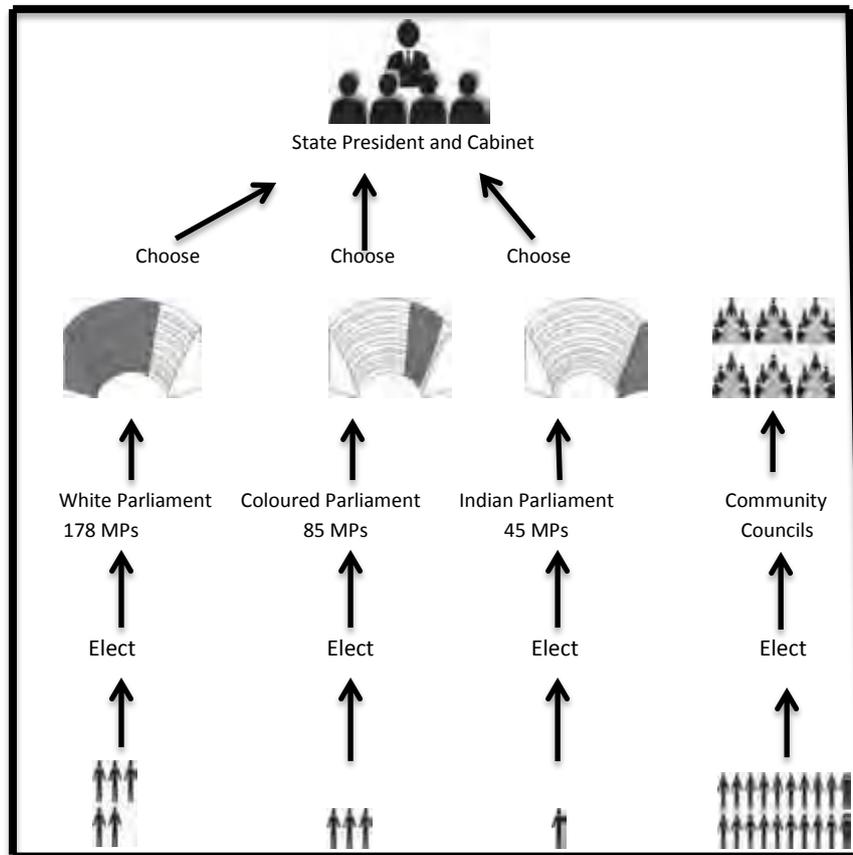
THE HISTORY OF APARTHEID IN SOUTH AFRICA

South Africa's history is engulfed in discrimination, segregation and unjust laws. This racism was demonstrated in every aspect of health such as: 1) rigid segregation of health facilities; 2) disproportionate spending on the health of Whites as compared to Blacks - resulting in world-class medical care for Whites while Blacks were usually referred to congested and dirty facilities; 3) public health policies that disregarded diseases primarily affecting Black people; and 4) the denial of basic sanitation, supply of clean water and other components of public

health to rural areas and townships. Moreover, people with mental illness and retardation were locked away in institutions, deprived of human rights and access to community-based programmes that would enable them to recover (The American Association for the Advancement of Science and the Physicians for Human Rights Organization, 1998).

Apartheid, a system which endured from the late 1940s to the early 1990s, was a system of institutionalised racial segregation created by the government of South Africa, which gave preference to a very small minority of White South Africans. It also created class divisions, forcing people to migrate to “homelands” which were divided along ethnic grounds. Prinsloo, Jansen and Vanneste (1999) note that in terms of the institutionalised state structures on the national level, the 1983 Constitution provided for legislative authority lodged with Parliament. Separate, racially segregated houses were created: the House of Assembly (178 white representatives), the House of Representatives (85 Coloured representatives) and the House of Delegates (45 Indian representatives). Not only was the tricameral parliament racially segregated, but it excluded Africans altogether. In addition, the new proposals were not commonly accepted by either Coloureds or Indians, many of whom rejected the subordinate status afforded to them in the new system. The executive authority was vested with the State President, the Cabinet and three Ministers' Councils (one for each of the Houses Parliament). The judiciary was executed by a connection of courts, including the Supreme Court as well as lower courts. The diagram below indicates how Botha’s new tricameral parliament was supposed work.

Diagram 1: How Botha's new tricameral parliament was supposed to work



Source: Culpin (2000: 114)

The provincial level of government, consisted of four provinces (Natal, Cape, Transvaal and Orange Free State) was made up of a Provincial Council, an Administrator and an Executive Committee (all white). Second tier government was not limited to the four provinces, given the existence of four independent (black) homelands (Transkei, Bophuthatswana, Venda, Ciskei) and six self-governing territories (Lebowa, Qwaqwa, Gazankulu, KaNgwane, KwaNdebele and KwaZulu). However, like the four provinces, these homelands and self-governing territories remained accountable to central government. Separate racially based establishments were created for Blacks, Whites, Indians and Coloureds on the local level of governance. Residents of the non-white areas generally dismissed these autonomously elected local bodies. Added to this separation was the significant advantage that white local authorities had in terms of resources, facilities and services (Prinsloo, Jansen and Vanneste 1999).

Political processes and organisations that shaped the political arena during the apartheid era were of both a conventional and an unconventional nature. According to Janda, Berry and

Goldman (2009: 193) conventional participation can be defined as a relatively uncommon behaviour that uses institutional channels especially campaigning for candidates and voting in elections. Conversely, unconventional participation is regarded as a relatively uncommon behaviour that challenges or even defies established institutions and dominant norms. Because most conventional channels of political participation were limited to Blacks, their resistance to White domination took on the form mainly of unconventional political participation. The ANC is probably the best known organisation associated with resistance to apartheid. Many examples of defiance and unrest mark the apartheid years. Yet, it was possibly the Soweto uprising of 1976 that can be regarded as a turning point. What began as a student protest to compulsory education in the Afrikaans language, soon extended to the rest of South Africa (Prinsloo, Jansen and Vanneste 1999).

It was not only the general population that endured racial discrimination. Few Blacks were permitted into the medical field. Those who were accepted were subjected to schools with limited resources and, when admitted to White institutions, were demeaned by practices like prohibitions on Black medical students wearing white coats and stethoscopes in White hospitals. In addition, Black nurses were denied adequate training resources and the opportunity to use their skills in an appropriate manner (The American Association for the Advancement of Science and the Physicians for Human Rights Organization, 1998).

According to Van Rensburg (1991) in Ngwena and Cook (2005: 128) at the height of apartheid, Whites disproportionately enjoyed the bulk of public expenditure on healthcare and received four times more per capita than their African counterparts, while Coloureds and Indians received a somewhat intermediate share. According to Van Rensburg, Fourie and Pretorius (1992) there was also racial fragmentation of services which was taken to absurd heights by the creation of separate departments of health for each of the ten 'Bantustans' serving the African population under the homelands policy of the Bantu Authorities Act, (Act No. 68 of 1951) subsequently renamed the Black Authorities Act, 1951. Frankental and Sichone (2005: 146) describe the Bantustans as being dependent on the South African state for their administrative, economic and security operations and were excluded from all international political, cultural and economic life. The main function of the Bantustans according to Frankental and Sichone (2005: 147) was to provide cheap labour to South African mining, manufacturing and agricultural industries. Williams (2010: 61) notes that under this legislation the government

established a hierarchy of authorities consisting of tribal authorities, regional authorities and territorial authorities. However, at the top of this hierarchy were the White officials from the Department of Bantu affairs who supervised their activities. The lack of financial resources within the Bantustans was crippling. According to De Beer (1984: 57) no system of healthcare could cope with the epidemic of ill health in the Bantustans. There was a constant shortage of doctors and healthcare resources had serious consequences for the people living in the Bantustans. Van Rensburg and Benatar (1993) maintain that it was not until 1990 that social amenities such as healthcare were desegregated. But by then the dye of pervading and lasting socially engineered inequality in healthcare had been firmly cast.

Following the creation of the Bantustans, Lengfeld and Pienaar (2006: 52) state that the government began to force Black people who lived in so-called White areas to move into the homelands. Their land was taken away from them and sold to White farmers at very low prices. Subsequently, between 1960 and 1983 over three and a half million people were deliberately uprooted from their livelihoods, and plunged into poverty and hopelessness in the barren Bantustans. De Beer (1984: 49) states that the relocation of 'surplus people' into independent and self-governing Bantustans meant that the worst political problems associated with unemployment, housing shortages and squatter camps were experienced in the homelands. De Beer (1984: 51) substantiates this view by maintaining that the reserves were unable to provide an adequate subsistence for the population. As the population increased, forced settlement and overuse of natural resources continued to deteriorate.

De Beer (1984: 60) recounts three instances where the attitudes of health officials show how the poison of ethnic thinking has seeped into health services:

- It was reported in November 1982 that two student nurses at Sebokeng Hospital in Vereeniging were told to leave the hospital when it was discovered that they had Bophuthatswana and Transkei travel documents. A spokesperson for the hospital said that it was common knowledge that student nurses from 'foreign countries' could not be accepted without prior consent from their government;
- Dr G de Klerk, head of the Medical Association of South Africa is on record as blaming the spread of epidemics in South Africa on the breakdown of health services in the 'Black states'. South African health services, according to Dr de Klerk, compared with

the best in the world. However, the health services of the neighbouring states and of the homelands were either in a state of collapse or totally inadequate; and

- In the White areas of Natal, an estimated 60 percent of African patients come from the homelands. This influx was at its greatest at the Taylor Bequest Hospital in Matatiele, where 98 percent of patients came from the Transkei. This led Dr Clark, in charge of hospital services in Natal to complain: “Natal’s biggest health problem is that every one of our hospitals is burgeoning with foreign Blacks”.

De Beer (1984: 62) states that health services in the apartheid era were not an attempt to meet the needs of the people; rather their operations reflected the needs and policies of the apartheid state.

Table 1 reflects the differences between White and African populations in Johannesburg in 1968.

Table 1: Rates per 1 000 of population

	White	African
Birth	21,63	46,46
Infant mortality	19,41	101,11
Maternal mortality	0,22	2,66
Tuberculosis incidence	0,28	4,56
Tuberculosis deaths	0,03	0,36
Death	8,12	11,95

Source: Report by the medical officer of health (1968). In Wells, L.G (1974:1)

Wells (1974: 2) draws a distinction between the common causes of death amongst Whites and Africans in Johannesburg where the most common causes of death among Whites were:

- Heart disease;
- Neoplasm’s (e.g. cancer);
- Diseases of the nervous system;

- Diseases of the respiratory system; and
- Accidents, poisonings and violence.

Amongst Africans the most common causes of death was:

- Accidents, poisoning and violence;
- Diseases of the respiratory system;
- Heart disease;
- Diseases of early infancy; and
- Diseases of the digestive system.

Seedat (1984: 23) mentions that the economic, social and political status of Africans under apartheid ensured that the vast majority lived in conditions of great poverty and deprivation. The effect that these conditions had on their health and well-being is evident in the severe morbidity and death of the African population. Seedat (1984: 31) takes up the argument by stating that Tuberculosis (TB) was rife in the Bantustans. The medical journal, the *Lancet* reported in 1970 that TB was present in 20 percent of babies under six months and that the majority of adults in the Transkei showed evidence of TB. Over 27 percent of notified cases of TB in 1981 were in the Bantustans. The South African institute of race relations (1982: 526) in Seedat (1984: 31) suggests that while the incidence of TB was halved amongst Whites since the beginning of the late 1970s it had increased by more than 40 percent amongst Blacks. In 1980 a total of 2 050 deaths were officially attributed to TB. De Beer (1984: 11) makes it clear that in the rural areas TB was flourishing and even possibly spreading. With sparse health services those with TB could possibly affect others or a person remained infected for life if malnourished or strained through over-work or some other illness.

Amongst the Black population, particularly the Coloured and African groups Seedat (1984: 11) maintains that unnatural deaths through homicide and violence took a major toll on adult lives. Disease of the respiratory system notably pneumonia, enteritis, diarrhea and heart diseases were an important cause of death. Hypertension was the second most common cause of heart failure amongst African adults, particularly found among the urban population. This form of hypertension was extremely rare in rural Africans – suggesting that stress in the urban areas under apartheid conditions, might have been a factor.

The country's health system remains unequal and ineffective – a lasting legacy of the apartheid system that still has an effect on its people and services of the present day. The notion of White supremacy and racial segregation were central pillars of the apartheid ideology that continue to hinder the government's attempts to restructure its healthcare system. This persistent inequality in the delivery of healthcare is illustrated in the nation's distribution of HIV/AIDS where Black South Africans bear the highest burden of disease.

The next section analyses how the health sector was governed, highlighting apartheid ideologies and how this has impacted the way in which health services are delivered today.

HOW THE HEALTH SECTOR WAS GOVERNED DURING APARTHEID

Although apartheid ended over 20 years ago, the country is still grappling with massive health inequalities. The HIV/AIDS pandemic for example emerged into prominence during the period when South Africa was striving to build a new dispensation based on non-racialism. It is argued that HIV/AIDS is a disease of poverty since various colonial and apartheid-era policies left the majority of the Black population impoverished. The problem with this argument according to Kenyon and Zondo (2011: 52) is that there is little available evidence in refuting the relationship between high levels of poverty and HIV/AIDS in South Africa. According to Coovadia et al (2009:8) there are marked differences in the rate of disease and mortality between the different races in South Africa. In their study on national HIV/AIDS prevalence among the different race groups, Shisana and Simbayi (2002: 46) conclude that the observed national prevalence among Africans is significantly higher as compared to other race groups. Some features of the apartheid healthcare system were:

- The health needs of the majority of South Africans were ignored;
- Most resources benefited Whites in Whites-only facilities;
- Some health services were developed in the 10 'homelands' but they were inadequate;
- Services for the Black population were extremely under-funded, and health workers battled to deal with the overwhelming need for healthcare. Patients, including young children and the elderly, commonly queued for hours to receive care;
- Hospitals serving the Black population were notoriously overcrowded with patients often sleeping on mattresses on the floor;

- By the 1980s, there were 14 health departments, each serving a specific area or racial group;
- Altruism on the part of private individuals and missionary societies went some way towards improving the plight of the Black population;
- Urban services were far better funded than underdeveloped rural services (Horwitz 2009: 1).

According to Coovadia et al (2009: 826) the backbone of the health system in the Bantustans were non-profit, missionary-run hospitals. Similarly Wells (1974: 20) suggests that a large part of the health services of rural South Africa was founded by missions. Wells (1980) builds on his previous statement by maintaining that mission doctors first started arriving in South Africa in the early nineteenth century. O'Reagan (1970) proposes that originally, health services were established to provide for the needs of the missionaries and their families, who were subjected to new tropical illnesses and required hospital services for this purpose. Subsequently, mission health services were set up to provide medical care for the African population, and also to play a part in the educational and religious uplift of the Bantu.

Roux, (1974) writing about mission hospitals in South Africa states that after the Second World War there was an expansion of mission stations in South Africa. By 1962, as many as 77,2% of the total of 14 976 hospital beds in homeland areas were administered by over 100 mission hospitals, while 10,7% were controlled by the Department of Health. Doyal (1979) noted that in many rural areas the mission hospitals provided the only healthcare services in the vicinity. Initially the state supported the activities of the mission hospitals as they clearly provided a valuable service at little direct cost to the state.

But by the late 1960s Van Rensburg and Mans (1982) wrote that a combination of factors led to the introduction of a policy by the South African state to take over rural mission hospital services. The state began this process of take-over by providing subsidies to these hospitals, initially on a 50-50 basis. This involved a certain degree of control being handed to the state by allowing the hospitals to be inspected by the provincial administrations. Wells (1980) was of the opinion that most of the missions certainly needed the financial assistance although many saw it as a first step towards complete government control.

SEGREGATION OF HEALTH SERVICES

According to Dookie and Singh (2012: 1) the historical inequalities of healthcare delivery in South Africa have placed a huge strain on an already over-burdened public health sector. South Africa has a legacy that is deeply entrenched in racial discrimination; in fact this subject has received widespread attention where researchers have long described the various ways in which the deeply entrenched differential allocation of privileges based on race have had adverse consequences on the health of Black individuals. Extensive research suggests that there is constant interest in the degree to which perceptions of discrimination are stressful life experiences that can adversely affect health. Gilson and McIntyre (2002) maintained that the disparities of South Africa are largely attributable to the racially discriminatory economic and social policies of apartheid - regarded as unacceptable inequalities.

Williams, Gonzalez, Williams, Mohammed, Moomal and Stein (2008: 4) suggest that there is limited population-based studies in South Africa that have assessed the levels of perceived discrimination and its potential health consequences, and there is reason to believe that assessing perceived racial discrimination will be challenging. Hunt (2006: 204) observes that discrimination and stigma amount to a failure to respect human dignity and equality by devaluing those affected, often adding to the inequalities already experienced by vulnerable and marginalised groups.

Table 2: Medical staff in selected Bantustans, 1981

Bantustan	Medical and dental staff	Nursing staff	Paramedical staff	Pharmacists	Other
Lebowa	95	1	13	12	5
Gazankulu	40	6	6	5	7
Venda	17	15	5	3	4
Ciskei	81	12	17	6	12
KwaZulu	265	23	28	21	184
QwaQwa	3	2	1	1	5
Bophuthatswana	90	46	8	7	20
Transkei	124	18	4	2	6

Source: Survey of race relations in South Africa, (1982: 541)

PRIVATE PRACTISE

De Beer (1984: 19-20) explains that services provided by private doctors were totally inadequate – not according to need but according to means. In other words, the best medical care was available to those who could afford it. One of the consequences of private medical care was that doctors congregated where affluent people lived. During this time there was one doctor for every 308 White person in Cape Town as compared to one doctor for every 22 000 people in Zululand and one doctor for every 30 000 people in the Northern Transvaal.

Thus the provision of private care accelerated inter-racial health inequalities. According to Muiu (2008: 163) as a result of unequal access to health services, Whites lived longer than Africans, a pattern that has continued in the new South Africa. As a result of apartheid Whites only hospitals were empty while hospitals that catered for Africans were poorly staffed, poorly equipped and over-crowded. Apartheid health services ensured full provision for the minority and prejudicial services for the majority. These services did not emphasis preventative medicine, such as immunisation, nutrition and sanitation. Instead they focused on curative medicine. Most people who could not afford to pay for health services were forced to depend on over-the-counter medicine, which, in most cases, worsened their situation. Privatisation of

health services served as an economic need for the wealthy because it reinforces interest groups that influence government medical policy.

HOSPITAL APARTHEID

Seedat (1984: 64) states that being a patient of the public health sector in the apartheid era meant spending an entire day including the evening waiting for treatment at some busy major hospital. Although some clinics were set up in townships to provide a quicker service, these were badly staffed, often only with nurses, and possibly a doctor coming in for a few hours per day. Worst off were the inhabitants of rural areas where the population was served only by mission hospitals to which many patients had to travel long distances. In contrast White patients had better access to better facilities. This included less crowded hospitals, speedier referral and better equipped surgeries. All facilities were segregated, those for Whites being amongst the best in the world and those for Blacks being greatly inferior.

According to Seedat (1984: 64-66) an investigation by journalists who visited Baragwanath Hospital in 1983 revealed that in one ward 40 beds were occupied by 89 women. Stickers marked 'urgent' were stuck on the foreheads of critically ill patients because it was the only way that doctors could identify urgent cases. At night more than half of the patients slept on the floor. Similar conditions existed in other hospitals. Coronation Hospital which only had 505 beds was supposed to serve the entire Coloured and Indian population of Johannesburg, which included outlying areas such as Lenasia. In Natal, King Edward Hospital was supposed to serve the entire Black population of the province with 2 000 beds. Statistics revealed that the hospital dealt with 600 000 out-patients per year. In 1977, the Livingstone Hospital in Port Elizabeth demonstrated appalling conditions where women in labour were subject to laying two to a bed, on mattresses on the floor and on trolleys in the corridors. Meanwhile there were empty beds in the White section of the hospital. In 1976 Black patients at the Groote Schuur Hospital in Cape Town slept on trolleys – sometimes for weeks. During this time bed occupancy in the Black section was 110 percent and in the White section 75 percent.

Discriminatory attitudes according to Seedat (1984: 12) were evident in family planning services, which were largely concerned with controlling the size of the Black population. Whites feared being swamped by a numerically larger Black population, evident in Whites

increasing the size of their families. The state spending on family planning in 1976 was increased to R5.3 million. In 1971, the Director-General of the Department of Health, Welfare and Pensions, DR Johann De Beer, warned that sterilisation and abortion might have to be made compulsory unless certain ethnic groups accepted family planning measures. During this time White and Indian birth rates both stood at 16 percent per 1 000, the Coloured birth rate was 26 percent per 1 000, and the Africans 35 percent per 1 000.

HEALTH WORKERS

Seedat (1984: 84) explains that by the end of 1981, a total of 3 920 medical specialists and 16 787 general medical practitioners were registered with the South African Medical and Dental Council. The doctor patient ratio was 1: 330 for White people, 1: 730 for Indian, 1: 12 000 for Coloured and 1: 91 000 for African. Medical practitioners were unequally distributed. While approximately 60 percent of the population lived in rural areas, only 5 percent of doctors practised there. The distribution of doctors by universities also illustrates the bias of skills and expertise towards the urban areas. For example, 30 percent of all doctors operating in rural areas came from non-South African universities. Immigration also led to the shortage of medical practitioners. Between 1970 and 1975 it is estimated that 14 percent of all medical graduates left the country permanently. Since then, emigration by doctors from South Africa for financial and political reasons has continued. A total of 123 doctors have left South Africa permanently in 1979, 59 doctors in 1980 and 55 doctors in 1981.

One factor which affects the distribution of doctors according to Wells (1974: 32-33) is that they are unreasonably disqualified from entering the profession. Educational opportunities for Africans, from primary schools upwards, were controlled by Whites through the restraint of finances for education. There was only one medical school in the country which would admit African medical students, and in 1972 only 15 Africans qualified as doctors against 440 Whites. Yet, even if all medical schools were open to Black students; the numbers would be restricted based on the limited education available to Africans.

Table 3: The South African school applications received and accepted by race 1986

University	White	Asian	Coloured	Black
Cape Town	260/116	43/20	81/7	53/37
MEDUNSA	-	-	-	1495/180
Natal	0	25/2	334/39	153/37
Orange Free State	447/123	0	0	0
Pretoria	838/224	0	0	0
Stellenbosch	693/169	124/18	0	0
Witwatersrand	792/142	53/13	371/33	332/2

Source: Survey of race relations in South Africa (1987/88)

According to O'Reagain (1970: 89) there were also marked differences in the salary scale of Whites and non-Whites. A White medical officer, for example, received a salary by the end of his/her fourth year equal to that of a Coloured or Indian senior specialist. In 1966, salaries paid to White doctors were increased by about 20 percent while those paid to non-Whites remained the same. According to Baldwin-Ragaven, De Gruchy and London (1999: 40) African doctors were paid even less than their Indian and Coloured counterparts and African females less than African males. In addition Black doctors did not receive annual bonuses - only Indian and Coloured doctors received bonuses. It was only when Indian and Coloured doctors threatened to return bonuses that the authorities agreed to grant bonuses to all doctors.

O'Reagain (1970: 89) goes on to argue that Black doctors were granted less leave than White doctors. Black junior doctors were given one-and-a-half days leave per month worked compared to two days for their White colleagues. Postgraduate training, particularly in the subspecialties, was limited for Black doctors. In order to become a cardiologist for example, Black doctors had to leave the province, or even the country, to receive training. Other difficulties experienced by Black doctors included obtaining housing subsidies, qualifying for pension schemes, withdrawal of special travel/inconvenience allowance and difficulty in successfully pursuing an academic career.

The humiliation of medical personnel on the grounds of skin colour was also experienced by nurses. According to Baldwin-Ragaven et al (1999: 167-68) the Nursing Amendment Act which was passed in 1957 stipulated that all members of the South African Nursing Association

(SANA) had to be White and could only be elected by White nurses. Different registers were maintained for different race groups, and the SANA Board was to be elected and controlled by Whites only. The act also stipulated that Black nurses could not give orders to White nurses; Black doctors could however give orders to White nurses. However, this practise was not well accepted by many White nurses and, up until 1979, there were reports of White nurses refusing to work under non-White doctors. In the 1970s Black nurses were prohibited by law for attending to White patients. Marks (1994: 190) states that private hospitals faced losing their registration if they allowed Black nurses to attend to White patients.

Wells (1974: 40) states that Black nurses received less pay than White nurses, they were often blocked from promotion and had very little contact with nurses visiting from overseas. In addition they worked in overcrowded understaffed wards, with sicker patients than their White counterparts dealt with. Remarks about Coloured nurses were expressed openly in their hearing – seen as Coloured first and nurses second.

CONCLUSION

Change especially in the health sector has been profound and yet it seems as though nothing has changed. Agreed – apartheid no longer exists, society has been desegregated and inequality has been deracialised. However old patterns of segregation and inequality persist where old hierarchies reach into the present.

Twenty years into democracy, many features of apartheid still plague the health system. Whilst the fourteen health departments of the apartheid era were problematic, the sharing and co-ordination of responsibilities between the present national, provincial and local levels of government remains a complex process. Although the new health system is based on the concepts of primary healthcare, the health status of much of the Black population remains poor, reflecting the level of poverty and other factors, both social and educational, which impact negatively on the health of communities. Judged on these criteria apartheid was a failure.

Despite these obstacles, progress has been made. Apartheid healthcare systems have been eradicated. All South Africans have constitutional protection of the right to healthcare and there is a commitment among the medical fraternity to provide high-quality health services for all.

The professional bodies: the Health Professions Council of South Africa and the Medical Association of South Africa have been transformed. There is improved access to healthcare and greater attention to healthcare priorities including the present AIDS epidemic.

REFERENCES

1. American Association for the advancement of science and the physicians for human rights organisation. 1998. Washington DC.
2. Baldwin-Ragaven, L., de Gruchy, J. and London, L. 1999. *An ambulance of the wrong colour: Health professional, human rights and ethics in South Africa*. Cape Town, Cape Town University Press.
3. Coovadia, H., Jewkes, R., Barron, P., Sanders, D. and McIntyre, D. 2009. The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*, Vol. 374(9692), pp. 817-834.
4. Culpin, C. 2000. *South Africa since 1948*. London, Hodder Murray Publishers.
5. De Beer, C. 1984. *The South African disease: Apartheid health and health services*. Johannesburg, South African research service.
6. Dookie, S. and Singh, S. 2012. Primary health service at district level in South Africa: A critique of the primary healthcare approach. *BMC Family Practice*, Vol. 13 (67), pp. 1-4 [Online]. Available at: <http://www.biomedcentral.com/content/pdf/1471-2296-13-67.pdf> Accessed 19 September 2014.
7. Doyal, L. 1979. *Political economy of health*. London, Pluto Press.
8. Frankental, S. and Sichone, O.B. 2005. *South Africa's diverse peoples*. California, ABC-CLIO, Inc.
9. Gilson, L. and McIntyre, D. 2002. Experiences from South Africa: dealing with a poor health legacy of apartheid. In: Whitehead M, Evans T, Diderichsen F and Bhuiya A

(Eds.). *Challenging inequities in health: From ethics to action*. New York, Oxford University Press.

10. Horwitz, S. 2009. *Health and healthcare under apartheid*. Johannesburg, University of the Witwatersrand [Online]. Available at:
<http://www.wits.ac.za/files/res253e5b1de6c5471dafa4a0eba59b78ae.pdf> Accessed 30 September 2014.
11. Hunt, P. 2006. The right to health: Key objectives, themes and interventions. In Claude, R.P. and Weston, B.H. *Human rights in the world community: Issues and action*. Pennsylvania, University of Pennsylvania Press [Online]. Available at:
<http://books.google.co.za/books?id=enyHJgQvF0AC&pg=PA204&dq=racial+stigma+and+discrimination&hl=en&sa=X&ei=ro0VU6eXHKOs7Qbe24CYCg&ved=0CDgQ6AEwA#v=onepage&q=racial%20stigma%20and%20discrimination&f=false> Accessed 05 October 2014.
12. Janda, K., Berry, J.M. and Goldman, J. 2009. *The challenge of democracy*. Boston, Wadsworth Publishing [Online]. Available at:
<http://books.google.co.za/books?id=7DDBtUz6TugC&pg=PA193&dq=conventional+political+participation+definition&hl=en&sa=X&ei=jd-CU6DuLYuO7QbnpYDICw&ved=0CCwQ6AEwAA#v=onepage&q=conventional%20political%20participation%20definition&f=false> Accessed 11 October 2014.
13. Kenyon, C. and Zondo, S. 2011. Why do some South African ethnic groups have high HIV rates and others not? *African Journal of AIDS Research*, Vol.10 (1), pp. 51-62.
14. Lengfeld, C. and Pienaar, S. 2006. *Understanding apartheid: A learner's book*. Cape Town, Oxford University Press Southern Africa (Pty) Ltd.
15. Marks, S. 1994. *Divided sisterhood: Race, class and gender in the South African nursing profession*. Johannesburg, Witwatersrand University Press.

16. Muiu, M. 2008. *The pitfalls of liberal democracy and late nationalism in South Africa*. New York, Palgrave Macmillan [Online]. Available at:
https://books.google.co.za/books?id=ZV7JAAAAQBAJ&pg=PA163&lpg=PA163&dq=as+a+result+of+unequal+access+to+health+services,+Whites+lived+longer+than+Africans,+a+pattern+that+has+continued+in+the+new+South+Africa&source=bl&ots=PUiTvhmBef&sig=YonV_S1oBrdltOwBcUEImXb-Zro&hl=en&sa=X&ei=h_IVPG3FKPn7ga4voBY&ved=0CBwQ6AEwAA#v=onepage&q=as%20a%20result%20of%20unequal%20access%20to%20health%20services%20C%20Whites%20lived%20longer%20than%20Africans%20C%20a%20pattern%20that%20has%20continued%20in%20the%20new%20South%20Africa&f=false
 Accessed 19 September 2014.

17. Ngwenya, C. and Cook, R. 2005. Rights concerning health. In Brand, D. and Heyns, C. *Socio Economic rights in South Africa*. Cape Town, Pretoria University Law Press.

18. O'Reagain, M. 1970. The hospital service of Natal. *Natal Regional Survey*. Vol.8, University of Natal, Durban.

19. Prinsloo, R., Jansen, M. and Vanneste, D. 1999. *South Africa. Spatial transformation in the post-apartheid era*. Manual with the website course. Belgium, Acco Leuven.

20. Roux, J P. 1974. Die ontwikkeling van Bantoe-gesondheidsdienste in die Republiek van Suid Afrika met spesiale bekleding van die ontwikkeling van gesondheidsdienste in die tuislande. Unpublished M.D. Thesis, University of Pretoria.

21. Seedat, A. 1984. *Crippling a nation: Health in apartheid South Africa*. London, IDAF

22. Shisana, O. and Simbayi, L.S. 2002. *South African national HIV prevalence, behavioural risk and mass media: Household survey 2002*. Cape Town, Human Sciences Research Council.

23. The South African institute of race relations. 1982. *Survey of race relations in South Africa*. Johannesburg.

24. The South African institute of race relations.1987. *Survey of race relations in South Africa*. Johannesburg.
25. The South African institute of race relations. 1985. *Survey of race relations in South Africa*. Johannesburg.
26. Thompson, L. 2001. *A history of South Africa*. London, Yale University Press.
27. Van Rensburg, H.C.J. 1991. South African healthcare in change. *South African Journal of Sociology*, Vol. 22 (1), pp. 1-10.
28. Van Rensburg, H.C.J., Fourie, A. and Pretorius, E. 1992. *Healthcare in South Africa: Structure and dynamics*. Pretoria, Academica.
29. Van Rensburg, H.C.J. and Benatar, S.R. 1993. The legacy of apartheid in health and healthcare. *South African Journal of Sociology*. Vol. 24, pp. 99-111.
30. Van Rensburg, H.C.J and Mans, A 1982. *Profile of disease and healthcare in South Africa*. Johannesburg, Academica.
31. Wells, L.G. 1974. *Health, healing and society*. Johannesburg, Raven Press.
32. Wells, L.G. 1980. *The contribution of mission hospitals to medical care in South Africa. Critical Health No.1*.Johannesburg, National Union of South African Students (NUSAS).
33. Williams, J.M. 2010. *Chieftaincy, the state and democracy: Political legitimacy in post-apartheid South Africa*. Indiana. Indiana University Press [Online]. Available at: [http://books.google.co.za/books?id=84cNYzYBNFsC&pg=PA61&dq=the+Bantu+authorities+Act+and+the+relations+between+national+government+,+the+state+and+the+bantustans&hl=en&sa=X&ei=kfiCU8D9LeTE7Abit4GQBw&ved=0CDYQ6AEwAg#v=onepage&q=the%20Bantu%20authorities%20Act%20and%20the%20relations%](http://books.google.co.za/books?id=84cNYzYBNFsC&pg=PA61&dq=the+Bantu+authorities+Act+and+the+relations+between+national+government+,+the+state+and+the+bantustans&hl=en&sa=X&ei=kfiCU8D9LeTE7Abit4GQBw&ved=0CDYQ6AEwAg#v=onepage&q=the%20Bantu%20authorities%20Act%20and%20the%20relations%20)

[20between%20national%20government%20%2C%20the%20state%20and%20the%20bantustans&f=false](#) Accessed 05 September 2014.

34. Williams, D.R., González, H.M., Williams, S., Mohammed, S.A., Moomal, H. and Stein, D. J. 2008. Perceived discrimination, race and health in South Africa: Findings from the South Africa stress and health study. *Social Science and Medicine*. Vol. 67, pp. 441-452.

CHAPTER FOUR

GOOD GOVERNANCE AND THE IMPLEMENTATION OF NATIONAL HEALTH INSURANCE IN THE PUBLIC HEALTH SECTOR: A CASE OF SOUTH AFRICA

INTRODUCTION

The issue of poor service delivery and ineffective policy implementation regarding healthcare has received considerable critical attention of late. Dr Manto-Tshabalala-Msimang (Department of Health 2000) claimed that since 1994, the post-apartheid government and the Department of Health have developed and implemented a number of policies and pieces of legislation that impact directly and indirectly on the delivery of health services. South Africa has some of the world's best policies, yet sometimes struggle with their implementation.

Pre 1994, public health services were fragmented to perpetuate discrimination. The system was founded on an apartheid ideology that was characterised by racial and geographical differences. The people, who needed health services the most, were denied such services. The dawn of democracy promised freedom and expectation of a better life for all as espoused in the 1994 Election Manifesto of the African National Congress. After 18 years, South Africa is still grappling with the remnants of apartheid and the challenges of transforming institutions and promoting equity in the health sector.

For many years it has been argued that implementation failure is one of the main reasons why policies do not yield the results expected. In South Africa, a version of this argument, which often features, is that good policies are drawn up but then not implemented. Meyer and Cloete argue that 'bad implementation' has been a major obstacle to progress in developing countries' (Meyer and Cloete 2006: 301). The government insists that the policy framework is transparent and well-defined and that what is needed is effective implementation. Regrettably, the transition of policy into practice is more complex than the perceived judgement of government. Critical concerns regarding issues about how policy can be effectively implemented and who should be responsible for implementing policy is one of major concern.

Ham and Hawkins (2003: 86) claim that the implementation of policies as a means of improving services in the health sector will vary depending on the degree of consistency between the values embedded in these policies and those held by actors in the system. Decisions on service delivery, policies and the implementation thereof, should be guided by constitutional requirements which aim to:

- Take steps to progressively realise the rights of everyone to have access to healthcare services;
- Promote and protect the right of children to basic healthcare services;
- Ensure that no-one is refused emergency medical treatment (sections 27(1) (a), (2) and (3) and section 28(1) (c) of the Constitution of the Republic of South Africa – 1996).

According to Cloete (1998: 159), policy making is a prerequisite in the provision of goods or services. Officials within the public health sector concerned with the formulation and the implementation of policy must always be aware of techniques that may be used to improve the performance of the actions involved. Policy making involves identifying needs, preparing legislation, and analysing existing policies whilst policy implementation involves setting missions/objectives/goals, planning, programming, marketing of policy missions/objectives/goal and identifying and reporting shortcomings.

GOOD GOVERNANCE AS A NORMATIVE CONCEPT OF GOVERNANCE

Chhotray and Stoker (2009) contend that the growing interest in governance is precisely because established institutional forms of governance appear under challenge and new forms appear to be emerging. Newman (2001: 11-12) in Fenger and Bekkers (2007: 16) writes that the general argument in governance literature is that a wide variety of developments have undermined the capacity of governments to control events within the nation state. As a consequence the state can no longer assume a monopoly of expertise or of the resources to govern, but must rely on a plurality of interdependent institutions and actors drawn from within and beyond government.

Hyden, Court, and Mease (2004) identify six fundamental principles that are widely accepted by researchers and governance stakeholders in developing and transitional societies around the

world, 1) participation - the degree of involvement by affected stakeholders, 2) fairness - the degree to which rules apply equally to everyone in society, 3) decency - the degree to which the formation and stewardship of the rules is undertaken without humiliating or harming people, 4) accountability - the extent to which political actors are responsible to society for what they say and do, 5) transparency - the degree of clarity and openness with which decisions are made, and 7) efficiency - the extent to which limited human and financial resources are applied without unnecessary waste, delay or corruption.

A number of multilateral organisations including the International Monetary Fund (IMF), the World Bank and the United Nations Development Programme (UNDP) have deliberated on the elements of good governance. As the experiences of these organisations vary, so too, do their perceptions of what constitutes good governance. The IMF (2005: 1) suggests that good governance ensures the rule of law, improves the efficiency and accountability of the public sector, and tackles corruption. The UNDP (2005: 12) characterises good governance as participatory, transparent, accountable, effective and equitable. It promotes the rule of law and ensures political, social and economic priorities are based on consensus in society and that the voices of the poorest and most vulnerable are heard in decision-making.

Kofi Annan (1998: A21) recognised good governance as ensuring respect for human rights and the rule of law, strengthening democratization and promoting transparency and capability in public administration. In 1992 the World Bank argued that good governance was an essential complement to sound economic policies and although not easy to offer a simple definition of good governance it is possible to argue that corruption among government officials would destroy the fundamental basis of good governance. On the other hand poor governance is characterised by corruption and mismanagement which drain a countries resources and present a significant barrier to development and a lack of information exchange with citizens which prohibits public participation. (Alsayed, 2008: 78). According to the World Bank, some of the symptoms of poor governance include, 1) failure to make a clear separation between what is public and what is private, thus a tendency to divert public resources for private gain, 2) failure to establish a predictable framework of law and government behaviour conducive to development, 3) excessive rules and regulations which impede the functioning of markets and encourage rent-seeking, 4) priorities inconsistent with development, resulting in misallocation of resources, and 5) excessively narrow based or non-existent decision-making.

Government failure is a reality. Pound (1995: 81) points out that just as corporations survive according to whether they make good decisions, so to governments fall or are re-elected on whether they make good decisions. Pound argues that governance failure does not stem solely from bad managers, but emanate also from culture, behaviour, personalities, politics and motivation within the organisation. This statement is supported by Lumumba (2011: 41) who states that bad governance are decision making processes that are devoid of proper thinking processes and governance supported by weak institutions.

Dahl's (1971) definition of democracy is based on two essential elements namely political participation and public contestation. The former refers to the chance of all citizens to have a meaningful impact on the selection of both personnel and policies. The latter by contrast, concerns the supply of politics. There has to be meaningful competition of candidates for public office and policy solutions. These two elements define the essence of modern democracy. When it comes to inclusiveness a participative democracy aims at including the maximum number of citizens in public decision-making processes. Yet, only small minorities of people are actually interested in getting involved in democratic institutions (Talpin, 2011: 100 - 102). According to Doorenspleet (2002: 56) political regime is considered as democratic when it fulfils the requirements of inclusiveness.

GOOD GOVERNANCE AND ACCOUNTABILITY

The concept of accountability and good governance cannot be overemphasised where accountability is considered the cornerstone of democracy. Druke (2007: 61) suggests that accountability is not restricted to public governance - it is the basic principle of regulation and expectation in all social relations arguing that accountability is essential for the legitimacy of governance. In keeping with the argument of inclusiveness Druke states that citizens have the right to good governance based on the premise that the public administration must deliver high quality social services and allow participation in political processes. Saarenpää (2002: 10) points out that this is an old term given that the prevailing mentality was that citizens were subjects of government and the process of guiding governments towards serving the citizenry was overlooked. Druke (2007: 62) makes it clear that accountability is an important feature of good governance, not only in the sense of effective bureaucracy but also in the sense of democratic governance. He mentions that accountability facilitates good governance insofar as

active involvement of citizens in transparent decision-making shapes good governance. This statement brings one to the understanding that citizens have a right to take an active part in governance and to have public services of good quality.

The African Development Bank (ADB) has identified five elements of good governance, 1) accountability is defined as the imperative to hold public officials, individuals and organisations charged with a public mandate, accountable to the public for actions and decisions from which they derive their authority. It also means establishing criteria to measure the performance of public officials, as well as oversight mechanisms to ensure that standards are met, 2) transparency is defined as public access to knowledge of the policies and strategies of government. It requires that public accounts are verifiable, that provision is made for public participation in government policy-making and implementation, and that contestation over decisions impacting on the lives of citizens are allowed for, 3) fighting corruption is seen by the ADB as a key indicator to commitment to good governance, a critical area for managing scarce resources, 4) participation is a process whereby citizens exercise influence over public decisions. It should focus on the creation of an enabling regulatory framework and economic environment in which citizens and private institutions can participate in their own governance, generate legitimate demands and monitor government policies and actions, and 5) legal and judicial framework in which laws, regulations and policies that regulate society are clear, fair and consistently applied through and objective and independent judiciary. An effective legal framework promotes the rule of law, respects human rights and protects private capital flows (ADB, 1999: 2-3).

GOVERNANCE AND ITS ACTORS

Crucial to governance concepts is the increasingly important role of non-state actors, among them multinational corporations, NGOs and social movements. A narrow definition of non-state actors formulated by Judge (1995) claims that NGOs mediate between the state and its citizens taking over essential functions pertinent to sustain democratic culture. These non-state actors can be categorised into firms and industrial groups on the one hand and NGOs and civil society on the other hand. Both these categories appear on the world stage and appear to take over governance (Abbott and Snidal, 2009: 506). Whereas traditional governance comprises mandatory laws and regulations, centralised authority and bureaucratic expertise, governance

encompasses soft law, state orchestration and broad participation characterised by decentralised authority and dispersed expertise (Abbott and Snidal, 2009: 520). The emerging collaboration of diverse actors enable pursuing common goals while combining complimentary competencies along with sharing expertise, capacities, resources and commitment (Abbott and Snidal, 2009: 526).

Given the growing involvement of non-state actors in governance helps to lower the pressure on the state, it has also been linked to a number of governance failures (Taulbee, 2000). According to Howe (1998) decreased transparency and accountability are among the most frequently noted problems with the growing role of non-state actors in governance. According to Kennett (2008: 210) one way in which the emergence of governance is challenging established norms and decision-making arrangements is with the dissolution of state sovereignty and clear lines of responsibility. While under governmental arrangements political responsibility rests with the legislative and executive, in governance it is distributed among a multiplicity of public and private actors. Since these actors cooperate in the making and implementation of policies, no single actor can be held responsible for the outcomes of this process.

CHALLENGES OF HEALTH DISPARITIES

The public service as a whole in South Africa prior to 1994 was characterised by poor quality of services, ineffectiveness and lack of commitment. The system was founded on an apartheid ideology that was characterised by racial and geographical differences. For those living in poor rural communities, access to healthcare was difficult. The first democratic election in April 1994 was an important landmark in the history of South Africa. Effectively, an end to white minority political rule was initiated and replaced by the adoption of a progressive constitution. In particular, section 27 (1) of the Constitution of the Republic of South Africa (Act 108 of 1996) states that: everyone has the right to access healthcare services.

Sarkin (1999) points out that South Africa's human rights record is appalling, largely due to apartheid which affected almost every sphere of South African life, including access to healthcare. In the past, where healthcare was available it was delivered in a discriminatory manner. During the first five years of democratic governance much progress has been made to

combat the legacy of apartheid and deliver equitable health to all South Africans. The first democratic parliament passed a number of new, often controversial pieces of legislation supported by regulations aimed at ensuring a more accessible and cost-effective healthcare system. However, in many cases, legislation was driven without adequate consultation and negotiations, which led to resentment on the part of the affected parties. Unfortunately, the increase in health legislation has been hampered by a shortage of skilled personnel in health law which in turn has inhibited the evolution of a coherent health law structure at both national and provincial levels. The health sector is still a long way from providing the population with proper health services. According to Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) the country is plagued by four major health problems namely; 1) HIV/AIDS and TB, 2) maternal, infant and child mortality, 3) non-communicable diseases and 4) injury and violence.

A chronic misalignment of resources between the public and private sectors is perhaps the most common criticism of the healthcare system in South Africa. The need to address the inefficient and inequitable distribution of resources between these two sectors relative to the population served by each is a significant challenge. There is more than twice as many hospital beds per beneficiary of private hospital services as there are for those dependant on the public sector. The disparities are even greater in relation to health professionals where pharmacists in the public sector serve between 12-30 times and each generalist doctor in the public sector serves 7-17 times more people than those in the private sector. There is a six fold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor working in the public sector in South Africa.

Reform in the public health sector was necessary to redress the past imbalances that existed (ANC General Council on NHI 2010: 13).Lack of funding in the health sector is compounded by severe human resource shortages. According to the ANC (2010: 10) there is a serious misdistribution of health workers in the country, with 60% serving 85% of the population using the public health sector. Most of the health workers work in urban areas while there is a serious shortage in the rural areas. Nurses form the backbone of the healthcare system and yet they are in short supply. This is largely due to a number of factors including cuts in provincial budgets and the closure of nursing colleges which has resulted in fewer nurses being trained. But, even those who were trained do not all go to practice in this country. Some leave the country to seek greener pastures in countries such as Saudi Arabia, Canada, Australia and the United Kingdom.

Linked to the issue of nurses is the shortage of medical practitioners and all other allied professionals. Access to quality healthcare for the majority of South Africans using the public health sector is negatively affected by inadequate supply of medical practitioners and allied professionals. Many migrate to developed countries citing reasons such as crime, deteriorating conditions in the public sector, better pay abroad and active foreign recruitment. These are challenges that the state must address if South Africa is to retain the doctors that it trains at R780 000 per doctor (Breier and Wildschut, 2006).

The shortage of key health professionals is being experienced at a time when the size of the population dependent on public health services has been increasing, and the burden of ill-health among the population primarily due to the HIV/AIDS epidemic is increasing. This has placed incredible strain on public sector health services, and on the staff who work in public sector facilities (ANC General Council on NHI, 2010: 11).

Another challenge facing the public health sector is the shortage of drugs at public health facilities especially AIDS drugs and the ability to access medicines at lower prices. The private sector on the other hand has an over-supply of pharmacies resulting in pharmacies being located in close proximity to one another in urban areas. The rural population on the other hand has little or no access to pharmacies. This misdistribution is the result of the disproportionate healthcare financing system. Despite government efforts to reduce the prices of medicines in the private sector, they remain unaffordable to the majority of South Africans (ANC General Council on NHI 2010: 11).

An added challenge is translating health policies into practice. Meyer and Cloete (2006: 301) argue that bad implementation has been a major obstacle to progress in developing countries – a comment which this chapter argues is applicable to South Africa. While the government insists that the policy framework is transparent and well defined, regrettably the translation of policy into practice is more complex than the statements of the government. There remain critical issues about how policy can be effectively implemented and who should be responsible for implementation.

In the NHI Policy Proposal - Republic of South Africa (2009), it is stated that the rationale for introducing NHI is to remove the current tiered system where those with the greatest need have

the least access and have poor health outcomes. The Taylor Committee Report of 2002 provides a vision for the transformation of healthcare reform. The Taylor Report (2002: 101) recommends that South Africa shift towards a NHI system based on multiple funds and a public sector-related environment. This is an essential document on healthcare reform and the recommendations are still being applied.

PAST ATTEMPTS AT NHI

The Green Paper on NHI - Republic of South Africa (2011) states that the history of healthcare reform actually dates back more than 80 years. NHI was recommended in 1935 for whites. However, the proposal was never taken forward. The World Health Organisation (WHO) (2000:13) reveals the attempted introduction of a National Health Service in South Africa in the 1940s, stating that a scheme for a national health service similar to the British model was recommended in South Africa in 1944. Such a scheme was to consist of free healthcare and a network of community centres and general practitioners as part of a referral system, but it was not implemented. The Green Paper mentions that, during the period 1942-1944, a commission led by Dr Henry Gluckman, called the National Health Service Commission, was set up. It proposed the implementation of a National Health Tax to ensure that free health services be provided to all South Africans. The Gluckman Commission proposals were accepted by the government led by General Jan Smuts; however, it was decided to implement them as a series of measures rather than in a single phase. Advances from the Gluckman Commission process were reversed after the National Party (NP) government led by General DF Malan was elected in 1948 (Phillips, 1993: 1037- 1039).

The Green Paper confirms that by the early 1990's interest had again turned to the prospect of introducing some form of mandatory health insurance. After the 1994 elections, there were numerous policy initiatives that considered either social insurance or NHI. According to the Healthcare Finance Committee of 1994, it was recommended that all formally employed individuals and their immediate dependents should form the core membership of Social Health Insurance (SHI). This would eventually be expanded to cover other groups over time. It was proposed that a comprehensive set of services be covered under such a system and that both public and private providers be involved (Doherty, McIntyre and Gilson, 2003: 47 - 58). The 1994 Finance Committee was followed by the 1995 Commission of Enquiry on NHI which

fully endorsed the recommendations of the Health Finance Committee. In 1997, the SHI Working Group developed the regulatory framework that resulted in the enactment of the Medical Schemes Act in 1998. This Act was meant to regulate private health insurance. However, the level of coverage for the national population has remained below 16 percent and is only affordable to the relatively well-off (Gilson, Doherty, McIntyre, Thomas, Brijlal, Bowa and Mbatsha, 1999: 4).

The White Paper states that Professor Vivienne Taylor was appointed in 2002 by the Department of Social Development to chair the Committee of Enquiry into a Comprehensive Social Security for South Africa following principles outlined in the White Paper. The Commission proposed that there should be mandatory cover for all those in the formal sector earning above a given tax threshold and that contributions should be income related and collected as a dedicated tax for health. The Committee further recommended that the state should establish a national health fund through which resources would be routed to public facilities through the government budget process.

The Department of Health established the Ministerial Task Team on SHI in 2002 to implement the recommendations of the Taylor Committee. The task was to draft an implementation plan with proposals on how to advance towards SHI. In addition, the team had to create supporting legislative and institutional mechanisms to influence the long-term result in the enactment of legislation of NHI in South Africa. However, the path to achieving universal coverage was not widely supported resulting in the supporting proposals being stalled. The Ministerial Advisory Committee on NHI was established in August 2009. The committee was tasked with providing the Minister of Health and the Department of Health with recommendations regarding the relevant health system reforms relating to the design and roll-out of NHI. This was to carry forward the resolution passed at the ruling party's (ANC) conference in December 2007 in Polokwane.

PROPOSAL FOR NHI

Given the specific burden of disease that plagues South Africa it is necessary for the formulation of a National Health Insurance (NHI) system. The proposed NHI according to McIntyre (2011) is about attaining a universal health system which means that everyone enjoys

financial protection from high healthcare costs; and everyone is able to access good health services. The reality however for millions of South African citizens is that they do not receive appropriate healthcare from the public health sector. NHI is intended to address this reality.

A Green Paper outlining the government's broad policy proposals for NHI was released in August 2011. The significant inequity in healthcare delivery to the South African population makes it essential that government arrives at a solution that is equitable and sustainable. Therefore, the green paper was seen by many as a welcome document. It forms part of a multi-faceted approach which includes infrastructure and improving human resources. The proposals have been reviewed and supported by the National Planning Commission (Sunday Times 2012: 12).

There is little doubt that the NHI will require funding 'over and above current budget allocations to public health', funding options are identified as payroll tax, surcharges on taxable income and increased Value Added Tax (Republic of South Africa 2012a: 25). The longer term depends on further uncertainties, related to 'institutional reforms and health service delivery capacity', a statement implying better performance if not referring to it directly. There are also risks because of the amount of money entailed. Public health services now stand at about 4% of Gross Domestic Product and could reach 6% by 2025 (Republic of South Africa 2012b: 81). Performance management will have to be effective to ensure that value for money is attained. An Office of Standards Compliance has been established in the Department of Health to 'improve monitoring and raise standards across all health facilities'; it will eventually become an independent public body (Republic of South Africa 2012b: 84).

Led by Dr Aaron Motsoaledi, the Minister of Health since 2009, the NHI proposal is a plan to redirect the public health system. According to the Minister for the NHI to succeed there are two critical things that the country must do:

"Improvement of quality of service in public hospitals must be non-negotiable and pricing of healthcare in the private sector must be tackled equally seriously" (Department of Health media statement by the minister of health on NHI, 2011).

Pointing out that only 16% of the population have private cover (medical aid), Dr Motsoaledi argues that a system is needed to provide better healthcare for all citizens (Department of Health 2012: 14). These sentiments were echoed in the recently released National Development Plan which points to a ‘crumbling health system and a rising disease burden’ requiring major reform, including better management at institutional level (Republic of South Africa, 2012c: 51).

The proposals entail a system of contributions for universal care to be paid in advance of an illness. The broad plan is for these contributions to be made by individuals (presumably families), employers and the state. There is no doubt that this effort represents a significant attempt to redistribute both the payment for, and the availability of, healthcare: ‘An important consideration is that the revenue base should be as broad as possible in order to achieve the lowest contribution rates and still generate sufficient funds to supplement the general tax allocation to the NHI (Republic of South Africa 2011: 35). A similar reform is currently being introduced in Kenya so that low income and unemployed Kenyans may have better access to healthcare (Adera 2012: 10).

The green paper makes it clear that NHI is a long-term project that will be rolled out over 14 years. The first five years will focus on building the health sector and preparing for NHI. The paper states that the primary phases of NHI will focus on improving the services of the public healthcare system. The green paper introduces the start of a complete transformation of the country's health system which would begin in a pilot phase in 11 districts. In an interesting article titled “health within a comprehensive system of social security: is national health insurance an appropriate response”? A keynote address by the previous minister of health, Dr Tshabalala-Msimang (2008: 7-8) revealed that it took Germany close to 100 years to achieve an inclusive social health system. On the other hand, it took South Korea only 12 years to cover the whole population, including the poor and the unemployed. Dr Tshabalala-Msimang mentioned that solidarity is a crucial foundation for healthcare financing (general tax and compulsory health insurance) where some countries such as the United Kingdom (UK) and Sweden chose the tax route while others such as France and Germany have chosen the insurance route.

On the 22nd March 2012, Dr Motsoaledi announced the 11 districts where the NHI pilot programme will be rolled out. The 11 districts represent a district in each of the nine provinces,

with three sites identified in KwaZulu-Natal. Motsoaledi mentioned that two districts were identified in KwaZulu-Natal because it has the second largest population in the country and it has the highest burden of disease. According to Motsoaledi, the programme was to begin on the 1st April 2012 because it coincides with the beginning of the financial year (Department of Health Government Information, 2012).

This marks the start of the three phases of the NHI, which will be implemented over 14 years where the first phase will focus on the strengthening of primary healthcare and service delivery. The districts were selected according to their demographic composition, their socio-economic situation and burden of disease. The selected NHI pilot districts per province are:

- 1) Eastern Cape – OR Tambo;
- 2) Mpumalanga – Gert Sibande;
- 3) Limpopo – Vhembe;
- 4) Northern Cape – Pixley ka Seme;
- 5) KwaZulu-Natal – uMzinyathi, uMgungundlovu and Amajuba;
- 6) Western Cape – Eden;
- 7) North West – Dr K Kaunda;
- 8) Free State – Thabo Mofutsanyane; and
- 9) Gauteng – Tshwane.

The pilot tests are the building blocks for the successful implementation of NHI. The programme will focus on the most susceptible sectors of the country and aims to strengthen the operation of the public health system. The National Development Plan takes the view that, for the pilot phase to work well, the following are needed: more personnel, new forms of managerial authority and stronger statutory structures for community representation (Republic of South Africa 2012c: 52).

It is intended that doctors in private practice will be instrumental in strengthening the success of the government's proposed NHI. According to the Minister of Health, the Department of Health (DOH) will guarantee the payment of private general practitioners, who work in public clinics in the NHI pilot districts. However, the NHI has not been universally welcomed by those who benefit from the status quo. This is one of the reasons why the debate has become quite heated, as noted by a distinguished Australian health economist who observed much of the anger and resistance coming from the private medical schemes and healthcare providers (Mooney 2011: 3).

Encouraging foreign doctors to work in rural areas could reduce staff shortages. However, the Health Professions Council of South Africa tends to be slow to register these doctors. Staff appointments take up to 5 months to be approved. The government has the prime responsibility of ensuring access to healthcare for all, especially for the most vulnerable groups. It is important for government to ensure that services are brought closer to the people and the communities be made aware of services being rendered pertaining to how, when and where. The government must ensure that hospitals and clinics have fully equipped offices with staff who display the necessary knowledge and skills.

CONCLUSION

From the beginning of the 21st century good governance principles have been practiced all over the world, based on the concept of reinventing government, implementing policy changes and instilling good practices. As a policy approach good governance is aimed at increasing the public sectors efficiency and citizen satisfaction from having a responsible and committed government. From a global perspective good governance is aimed at learning and sharing knowledge among scientists, practitioners and policymakers.

South Africa is building a better understanding of what NHI is and why it must be implemented. There will probably remain many who question the policy for good and bad reasons, so continued consultation and dialogue by all players in society will be essential. The National Department of Health (NDoH) has agreed on a timetable for implementing the NHI, which is ambitious by international standards, but definitely possible. This review has shown that there has been good progress in many areas but in others there is still considerable work to be done.

It will take time for these major changes in the financing and delivery of services to impact on people's lives. Universal coverage is no longer a dream for the country and if all players work together it will become an increasing certainty. NHI is only a funding mechanism and not a general panacea for South African healthcare – delivery is essential and will need careful examination in the existing South African context of poor public health systems. Therefore, the many failings in our health system are based on design faults that continue to entrench inequities, disparities in health outcomes and unfairness in access to quality healthcare. With such a big policy change we are likely to encounter implementation challenges.

REFERENCES

1. Abbott, K.W. and Snidal, D. 2009. Strengthening international regulation through transnational new governance: Overcoming the orchestration deficit. *Vanderbilt Journal of Transnational Law*, Vol. 42(2), pp. 501–578.
2. Adera, A.A. 2012. An evaluation of the various forms of financing the proposed national social health insurance fund in Kenya. Durban, Regent Business School (Masters in Business Administration dissertation).
3. African Development Bank. 1999. *Bank group policy on good governance* [Online]. Available at: http://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/21-EN-Bank_Group_Policy_on_Good_Governance.pdf Accessed 15 March 2015.
4. African National Congress (ANC) General Council on NHI. 2010. *Towards 100 years of self-less struggle*. Pretoria, Government Printers.
5. Alsayed, A.M. 2008. Discourse versus practice in civic education for development: the case of USAID assistance to Palestine. In Stevick, E.D. and Levinson, B.A.U. (Eds.). *Advancing democracy through education*. North Carolina, New Age Publishers [Online]. Available at: http://books.google.co.za/books?id=rpqb0oqtEhcC&pg=PA78&dq=the+relationship+between+good+governance+and+democracy&hl=en&sa=X&ei=SvO8U_HLJLGp7A

bKxYHICQ&ved=0CE0Q6AEwBg#v=onepage&q=the%20relationship%20between%20good%20governance%20and%20democracy&f=false Accessed 01 April 2015.

6. Annan, K. 1998. An Africa responsible for itself. *The Washington Post*, p. A21, April 29.
7. Breier, M. and Wildschut, A. 2006. *Doctors in a divided society: The profession and education of medical practitioners in South Africa*. Cape Town, Human Sciences Research Council Press.
8. Chhotray, V. and Stoker, G. 2009. *Governance, theory and practice*. Hampshire, Macmillan.
9. Cloete, J.J.N. 1998. *South African public administration and management*. Pretoria, Van Schaik Publishers.
10. Coovadia, H., Jewkes, R., Barron, P. Sanders, D., McIntyre, D. 2009. The Health and Health system of South Africa: Historical roots of current public health challenges. *The Lancet*. Vol. 374 (9692),pp. 817-34.
11. Dahl, R.A. 1971. *Polyarchy: Participation and opposition*. London, Yale University Press.
12. Department of Health. 2011. *Media statement by Minister of Health: Release of Green Paper on National Health Insurance*. National Department of Health. Pretoria, Government Printers.
13. Department of Health. 2012. *A clean bill of health. New Agenda. First quarter, 2012*. Pretoria, Government Printers.
14. Department of Health. 2012. *e-Health strategy South Africa*. Pretoria, Government Printers.

15. Department of Health. 2012. *South African government information*. Pretoria, Government Printers.

16. Doherty, J., McIntyre, D. and Gilson, L. 2003. A tale of two visions: The changing fortunes of social health insurance in South Africa. *Health policy plan*. Vol. 18 (1),pp. 47-58 [Online]. Available at: <http://heapol.oxfordjournals.org/cgi/reprint/18/1/47> Accessed 26 March 2015.

17. Doorenspleet, R. 2002. Development, class and democracy: Is there a relationship? In Elgstrom, O. and Hyden, G. (Eds.). *Development and democracy: What have we learned and how?* New York, Routledge [Online]. Available at: <http://books.google.co.za/books?id=G4OBAgAAQBAJ&pg=PA56&dq=inclusiveness+and+democracy&hl=en&sa=X&ei=1gO9U4vxOrLA7AaK4oDgCQ&ved=0CEUQ6AEwCA#v=onepage&q=inclusiveness%20and%20democracy&f=false> Accessed 28 March 2015.

18. Druke, H. 2007. Can e-government make public governance more accountable? In Shah, A. (Ed). *Performance, accountability and combating corruption*. Washington, World Bank [Online]. Available at: http://books.google.co.za/books?id=Ho6v_b_7CAC&printsec=frontcover&dq=performance+accountability+and+combating+corruption&hl=en&sa=X&ei=Dim9U5_GO_NSP7Aa4qIDwCQ&ved=0CCgQ6AEwAA#v=onepage&q=performance%20accountability%20and%20combating%20corruption&f=false Accessed 28 March 2015.

19. Fenger, M. and Bekkers, V. 2007. *The governance concept in public administration*. Burlington, Ashgate Publishing [Online]. Available at: <http://books.google.co.za/books?id=EuChAgAAQBAJ&pg=PA16&dq=from+government+to+governance&hl=en&sa=X&ei=QHioU8bCGqn17Aa0pYGABg&ved=0CDMQ6AEwBQ#v=onepage&q=from%20government%20to%20governance&f=false> Accessed 02 April 2015.

20. Gilson, L, Doherty, J., McIntyre, D., Thomas, S., Brijlal, V., Bowa, C. and Mbatsha, S. 1999. *The dynamics of policy change: Healthcare financing in South Africa, 1994-*

1999. Monograph No. 66, Johannesburg: Centre for health policy, University of Witwatersrand/Cape Town: Health Economics Unit, University of Cape Town [Online]. Available at: <http://uct-heu.s3.amazonaws.com/24Polan2 Exercise.pdf> Accessed 05 April 2015.

21. Ham, C. and Hawkins, L. 2003. *Innovations in health service delivery. The corporatisation of public hospitals*. Washington, the World Bank [Online]. Available at: <http://books.google.co.za/books?id=iFIVuwFa7GEC&pg=PA86&dq=the+relationship+between+policy+implementation+and+service+delivery&hl=en&sa=X&ei=lmOTUa=0JsOStAbvmIHgDg&ved=0CEoQ6AEwBA#v=onepage&q=the%20relationship%20between%20policy%20implementation%20and%20service%20delivery&f=false> Accessed 27 March 2015.
22. Howe, H. 1998. Private security forces and African stability: The case of executive outcomes. *Journal of Modern African Studies*, Vol. 36(2), pp. 307-331.
23. Hyden, G., Court, J. and Mease, K. 2004. *Making sense of governance: Empirical evidence from sixteen developing countries*. London, Lynne Rienner Publishers [Online]. Available at: <http://books.google.co.za/books?id=vZ3h2gOBIfQC&printsec=frontcover&dq=makin+g+sense+of+governance&hl=en&sa=X&ei=QHNU7GQKcTZPKrFgeAP&ved=0CB0Q6AEwAA#v=onepage&q=making%20sense%20of%20governance&f=false> Accessed 27 March 2015].
24. Kennett, P. 2008. *Governance the state and public policy in a global age*. Massachusetts, Edward Elgar Publishers [Online]. Available at: <http://books.google.co.za/books?id=SLRFLlIrqLsC&pg=PA210&lpg=PA210&dq=Ulbee,+2000+non+state+actors+in+governance&source=bl&ots=h-Vj5F3TAN&sig=C6Bj7mCUuTHmsNrXiINdI2FA4s4&hl=en&sa=X&ei=VXnOU4S>

[8Dsil0QXn1YHgCw&ved=0CBsQ6AEwAA#v=onepage&q=Taulbee%2C%202000%20non%20state%20actors%20in%20governance&f=false](http://books.google.co.za/books?id=IyirPSzbrEYC&printsec=frontcover&dq=bad+governance&hl=en&sa=X&ei=ajjpU_CcAbKO7Qa87IAQ&ved=0CEUQ6AEwCA#v=onepage&q=bad%20governance&f=false) Accessed 02 April 2015.

25. Lumumba, P.L.O. 2011. *The leadership Kenyans deserve*. Nairobi, East African Educational Publishers [Online]. Available at: http://books.google.co.za/books?id=IyirPSzbrEYC&printsec=frontcover&dq=bad+governance&hl=en&sa=X&ei=ajjpU_CcAbKO7Qa87IAQ&ved=0CEUQ6AEwCA#v=onepage&q=bad%20governance&f=false Accessed 29 March 2015.
26. McIntyre, D. 2011. *Can South Africa afford not to have NHI?* Health-e-News service [Online]. Available at: <http://www.health-e.org.za/2011/08/22/can-south-africa-afford-not-to-have-a-nhi/> Accessed 10 April 2015.
27. Meyer, I.H. and Cloete, F. 2006. Policy dynamics: Change, failure and success. In Cloete, F. Wissink, H. and De Coning, C. (Eds.). *Improving Public Policy: from theory to practise*. Pretoria: Van Schaik Publishers.
28. Mooney, G. 2011. NHI: History repeats itself. *Mail and Guardian Health*. August 26-September 3, 2011.
29. Newman, J. 2001. *Modernising governance: New Labour, policy and society*. London, SAGE Publications.
30. Phillips, H.T. 1993. The 1945 Gluckman report and the establishment of South Africa's health centres. *American Journal of Public Health*. Vol. 83 (7), pp. 1037-1039.
31. Pound, J. 1995. The promise of governed corporation. *Harvard Business Review*. Vol. 73(4), pp. 81-82.
32. Republic of South Africa. 1996. *The Constitution of the Republic of South Africa (Act No. 108 of 1996)*. Pretoria: Government Printers.

33. Republic of South Africa. 2000. Department of Health. *A synopsis of health policies and legislation: 1994-2000*. Pretoria: Government Printers.
34. Republic of South Africa. 2009. *National Health Insurance policy proposal*. Pretoria, Government Printers [Online]. Available at: <http://www.health-.org.za/documents/5b5e24462cdf6e214072c2e3f92ab1b9.pdf> Accessed 25 April 2015.
35. Republic of South Africa. 2012a. *Budget 2012. Budget speech*. Pretoria, National Treasury.
36. Republic of South Africa. 2012b. *Budget 2012. Budget review*. Pretoria, National Treasury.
37. Republic of South Africa. 2012c. *National Development Plan, 2030. Our future: Make it work*. Pretoria, the Presidency (National Planning Commission).
38. Saarenpää, A. 2002. *E-Government: Good Governance? An impossible equation? Paper presented at the public policy forum-Integrating government with new technology: How is technology changing the public sector?* Commonwealth center for electronic governance. Ottawa, February 25.
39. Sarkin, J. 1999. Health and Human Rights in post-apartheid South Africa. *South African Medical Journal*. Vol. 89 (12), pp. 1259-1263.
40. Talpin, J. 2011. *Schools of democracy. How ordinary citizens (sometimes) become competent in participatory Colchester, European consortium for political research (ECPR)* [Online]. Available at: <http://books.google.co.za/books?id=5cNMAQAAQBAJ&pg=PA100&dq=inclusiveness+and+democracy&hl=en&sa=X&ei=1gO9U4vxOrLA7AaK4oDgCQ&ved=0CEoQ6AEwCQ#v=onepage&q=inclusiveness%20and%20democracy&f=false> Accessed 01 April 2015.

41. Taulbee, J. L 2000. Mercenaries, private armies and security companies in contemporary policy. *International Politics*, Vol. 37(4), pp. 433-456.
42. Taylor Committee of inquiry into a comprehensive system of social security in South Africa. 2002. *Transforming the present-protecting the future Africa; Report of the committee of inquiry into a comprehensive system of social security in South Africa* [Online]. Available at:
http://www.sarpn.org/CountryPovertyPapers/SouthAfrica/march2002/report/Transforming_the_Present.pdf Accessed 15 March 2015.
43. Republic of South Africa. *The Green Paper on NHI in South Africa. 2011*. Pretoria, Government Printers.
44. Tshabalala-Msimang, M. 2008. Health within a comprehensive system of social security: Is national health insurance an appropriate response? In Botha, C. and Hendricks, M. *Financing South Africa's national health system through national health insurance*. Cape Town: Health Sciences Research Council Press.
45. World Health Organisation. 2000. *The world health Report, 2000: Health systems: Improving performance*. Geneva [Online]. Available at:
<http://www.who.int/whr/2000/en/inde> Accessed 25 March 2015.

CHAPTER FIVE

REFORMING THE HEALTH SECTOR IN SOUTH AFRICA – POST 1994

INTRODUCTION

The legacy of South Africa's socio-economic inequalities has encountered major challenges of attempting to advocate good governance, democratisation, and sustainable human development against a backdrop of gross domestic socio-economic disparities and a history of past conflict. According to Mhone and Edigheji (2003: 5) South Africa is a country that has emerged from one of the most oppressive and exploitative regimes in modern history in which racial, class and gender oppression were consciously intertwined to underpin a system of domination that kept the majority of the African population in relative poverty and destitution, while it empowered the White minority economically, socially and politically. Thus, the previous system was undemocratic, reflecting what is commonly termed bad governance. This system was challenged resulting in its collapse and the emergence of a new dispensation based on democratic and development precepts.

Mhone and Edigheji (2003: 5-6) state that the new South Africa has one of the most progressive constitutions. It is a country that has committed itself to good governance through various initiatives that encompass the establishment of consultative and participatory bodies such as the National Economic Development and Labour Council (NEDLAC) and the Gender and Youth Commissions. It has advanced to support independent structures to monitor relations between the state and the polity through bodies such as the Human Rights Commission and the Public Protector. Hence, the apparatus of the state has been transformed to ensure that it has the capability and potential to live up to good governance as indicated for instance, in the Batho Pele which is an initiative aimed at enhancing the quality and accessibility of government services by improving efficiency and accountability to the recipients of public goods and services. Thus, South Africa is committed not only to formal democracy, but also to good governance in both its narrow and broad dimensions.

Aspirations of democratic South Africa and expectations of domestic constituencies together with various external parties require the development of effective governance mechanisms to

make its economy globally competitive while simultaneously improving the standard of living of all South Africans, particularly the previous disadvantaged communities. The activities of Trans-National Corporations (TNCs) and multilateral organisations such as the World Bank, the International Monetary Fund (IMF) and the World Trade Organisation (WTO) are shaping governance in South Africa whereby these actors apply pressure on the state to liberalise and deregulate the economy as well as to privatise public enterprise. However, the ability of the South African government to meet its democratic commitments to the people – by for instance, expanding job and income generating opportunities, providing improved services, expanding its global competitive economy, depends on the governance capacity within and between the state and society (Mhone and Edigheji 2003).

Mhone and Edigheji (2003: 3) mention that the concept of governance is understood to refer to the manner in which the apparatus of the state is organised, how it executes its mandate and its relationship to society. Good governance may be understood to have at least three aspects: 1) the need for a rule-based, open, transparent, efficient and accountable government; 2) the need for the government to undertake its task in a manner that is participatory and consultative and that generally lives up to the democratic prescripts of formal democracy and 3) the need for the government or the state to ensure that substantive aspects of democracy are achieved. Thus, good governance refers both to the overall environment that is deemed conducive to all three outcomes, and to which each of the outcomes is formalised and made routine in the everyday affairs of the government and state.

WHAT DEMOCRATIC SOUTH AFRICA INHERITED IN 1994?

According to Mogale (2003: 216) the existing post-apartheid democratically elected government in South Africa inherited a perplex melange of administrative, economic, financial and political structures derived from the legacy of decades of apartheid reign. For example, the legal and administrative structures inherited were not intended to serve the broad population of the country, but rather small divided ethnic or racial categories. Neither was the apartheid system known for upholding participatory norms of decision-making and, as a result, different sets of local government administrative structures for different racial groupings were imposed to operationalise discriminatory policies, rather than to deliver basic services to all.

Chikulo (2003) reaffirms that with the advent of the new democratic political dispensation, the new South African government faced the problem of how to correct the inherited socio-economic imbalances. In an effort to reduce not only socio-economic imbalances but also meet the high expectations among the majority of the black population, the government pledged itself to rapid socio-economic development by placing alleviation of poverty and inequality at the centre of its development agenda.

The twenty year review of South Africa 1994-2014, (2014: 20) states that South Africa's first democratic government inherited a fragmented, unaccountable and racially divided governance system consisting of homeland administrations also referred to as "Bantustans" or "self-governing territories", national and provincial administrations, as well as separate administrations for certain racial groups. The homeland administrations were poorly organised and resourced, largely without local government, and the services they provided were determined by the apartheid state. Those municipalities that were well capacitated were mostly in the urban areas and served the needs of the White minority. These separate apartheid-era institutions had to be amalgamated into a single democratic, non-racial system.

Prior to 1994, the frameworks governing the public service were highly centralised and regulated, resulting in a bureaucratic, unresponsive and risk-averse public service. In addition, the public service lacked transparency and accountability, providing space for abuse of power and corruption. Post-apartheid South Africa needed a reformed governance system that would allow all South Africans to claim political and social ownership of the country. This meant changing the systems of governance to be geared towards transformation by addressing the legacy of apartheid. There was a need to modernise the public service, to make it more efficient, effective, accountable and people-centred, so that it would be able to fulfil its transformative role (the twenty year review of South Africa 1994-2014, (2014: 20) .

Mhone (2003:46) maintains that democratic South Africa inherited an economy that was governed by an enclave formal sector, based on protectionist and discriminatory policies, and which while utilising part of the majority population as its labour force also excluded and marginalised it through apartheid. The overall problem confronting the economy and on the basis of which the development problem rests, relates to the fact that a significant proportion

of the labour force is marginalised and under-utilised, because of the historical reasons of discrimination and the very manner in which settler-capitalism developed.

Unlike the apartheid governance system that catered for the interests of the White minority, the governance system in the new dispensation would have to cater for the needs of all South Africans (Edigheji 2003: 70). In its electoral manifesto, the ANC set the scene for future policy. It pledged to promote representative and participatory democracy. This entailed the restructuring of state institutions to make them efficient, effective, responsive, transparent and accountable (ANC 1994: 120). According to Hassen (2003: 123) the new government inherited a public service based on apartheid racial structures, coupled with a rule-based and hierarchical work organisation. The central characteristics of this system included: 1) fragmentation - the public service consisted of a plethora of institutions, provincial administrations, administrations in the self-governing territories and racially based administrative structures; 2) pay determination - salaries were set by a commission, without formal negotiations. Staff associations, especially the Public Service Association (PSA), which predominantly represented White workers in the public service, were consulted. Unions organising African workers were excluded; 3) discrimination - salaries and benefits differed according to race and gender and 4) career progression - incentives and benefits were aimed at ensuring long tenure. Systems for career development were not established. Instead, public service workers received a mixture of benefits, merit awards and training that were not linked to increased responsibility or an improvement in their competencies.

Hassim, Heywood and Berger (2007: 16-17) state that in 1994, South Africa's first democratic government inherited great inequalities in health. These included inequalities in: 1) the impact of disease across races; 2) access to health services between urban and rural areas, and between South Africa's nine new provinces and 3) the quality of health services in the public health system compared to the private health system. These 3 aspects are described in more detail below.

RACIAL INEQUALITIES

Owing to apartheid, the different races in South Africa experienced different diseases and different outcomes in the management of those diseases. While White people generally

experienced low levels of infant and child mortality (due to access to clean water and antenatal services), they had higher levels of “life-style diseases”, including cardiovascular disease. By contrast, African people experienced high rates of infectious or transmissible diseases such as TB, as well as diseases of poverty such as cholera and kwashiorkor. The table below shows comparative mortality rates – however, it hides the full extent of discrimination because it does not reveal the different ages at which African and White people died, or the differences between the races on key indicators such as infant mortality and maternal mortality (Hassim, Heywood and Berger 2007: 16-17).

GEOGRAPHIC INEQUALITIES

Great inequalities also existed in access to health services between urban and rural areas, and between South Africa’s nine new provinces, several of which incorporated former “homelands” such as Venda and KwaNdebele that had become the most poverty-stricken parts of South Africa. Thus, a detailed report on the distribution of health workers in South Africa in 1994/1995 found that: 1) 63% of public sector doctors, 70% of dentists and 61% of pharmacists were located in 2 provinces – Gauteng and the Western Cape and 2) in one Bantustan, Lebowa (now a part of Limpopo), the ratio of doctors to the population was 1: 33 000 people (Hassim, Heywood and Berger (2007: 16-17).

PUBLIC AND PRIVATE INEQUALITIES

There was also serious inequality between health services in the public health system, paid for with tax revenue, and the private health system, paid for mainly by employers and individuals who could afford it. For example, in 1994/1995, although the private sector served only 20% of the population, it had 58% of medical doctors, 89% of dentists and 94% of pharmacists. Unfortunately, this division remains much the same today (Hassim, Heywood and Berger (2007: 16-17).

Wooldridge and Cranko (1995: 332) state that the new political party inherited organisational structures from the previous era that were based on regulatory frameworks and scientific management practices that assumed there is a rational response to each organisational issue. The result was an over-reliance on rigid regulatory frameworks which centralised power in the

hands of senior management. The tendency towards centralised hierarchies and top-down planning resulted in layers of middle managers who lacked the discretionary power to manage in the operational sense, and rather administer rules. Jobs lower down the hierarchy were deskilled, resulting in the disempowerment of the front-line worker and the subsequent failure of the organisation to respond to user need. The traditional local government administration is a typical example of a rational administration. Benington (1993) states that this environment comprised of separate departments and committees, co-ordinated by a Chief Executive Officer and/or a policy committee which inclined to disperse power away from the centre of the administration into the hands of department heads. This resulted in strong departmentalism with little interdepartmental coordination.

According to Wooldridge and Cranko (1995: 333) the rational administrative model assumes stability and continuity in society. Its practices and working style is based on long-term rigid plans which are scientifically determined and once on track are almost impossible to reorient. The rational model may be appropriate for an organisation that mass-produces standard products. The state, however, is an increasingly differentiated organisation, providing a wide range of services to an increasingly diverse population with diverse needs. The state as a public organisation allocates resources across society through its daily activities. State institutions do not operate in a resolved or perfect world, but rather in an unresolved and conflicted environment, characterised by material scarcity, political divergence and a lack of consensus over the rules of the game. Shifting policy priorities and the ongoing realignment of interest groups cannot be managed in a rigid and inflexible working environment. The rational model effectively closes off the space for negotiation and dialogue, and in particular the ability to take account of such interactive processes in policy and strategy formulation and implementation.

Rational administration emerged when Max Weber made a crucial intervention in shaping the nation state. In response to the corruption, nepotism, unequal access and lack of accountability that had characterised emerging states. Weber developed a conception of the rational bureaucracy. Today, the word bureaucracy evokes images of endless queues, triplicate forms, archives, state records and musty books of regulation. At the time of its conception the rational bureaucracy was hailed as the solution to the problems of the state. The rational bureaucracy was to overcome abuse of power, ensure accountability for state expenditure, treat all citizens in an equal way and organise the administration mass produce services. However, noble

attempts have been made to move beyond the rational administration. Internationally the failure of the rational model has been recognised and increasingly, governments representing diverse ideologies are beginning to translate their political agendas into institutional strategies and to develop a state apparatus modelled along political lines (Wooldridge and Cranko 1995: 334).

REFORM IN SOUTH AFRICA

According to Vil-Nkomo (1999: 86) when governments seek transformation, it is often an indication of the need to meet new priorities, policies and strategies. In this process a country may emerge with its own innovative and unique ways of approaching its challenges. Often, however, it engages in a logic of discovery based on learning from what other countries have been or practising. Thus, existing ways of doing things are adapted to suit the particular country's needs. The outcome of the transformation process is therefore not always what was initially advocated or in line with the rhetoric which preceded it. Furthermore, in this process the distinction between the areas of reform and transformation within the system of governance become blurred.

The three most important documents framing post-apartheid, socio-economic policy, as well as governance for a new democratic South Africa, are the Reconstruction and Development Programme (RDP) (ANC 1994), the Growth, Employment and Redistribution policy (GEAR) (ANC 1996), and the Constitution of the Republic of South Africa (ANC 1996).

THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)

According to Schmitz and Kabemba (2001) the first policy model setting out the government's thinking on reform in social development was the RDP. The ANC used this radical programme of reconstruction and development as a blueprint for social and political transformation in South Africa and later proclaimed this programme as an instrument of fundamental change in the new South Africa.

When the ANC came to power in 1994, it promised to implement the principles of the Freedom Charter, and set these out in more detail in a policy document known as the RDP. The RDP recognised that: "The mental and physical health of South Africans has been severely damaged

by apartheid policies and their consequences. The healthcare and social services that have been developed are grossly inefficient and inadequate and there are by international standards, probably enough nurses, doctors and hospital beds. South Africa spends R550 per capita per annum on healthcare. This is nearly ten times what the World Bank estimates it should cost to provide basic public healthcare services and essential clinical care for all, yet millions of our people are without such services or care. Health services are fragmented, inefficient and ineffective, and resources are grossly mismanaged and poorly distributed. The situation in rural areas is particularly bad”(RDP 1994).

Heywood (2004: 21) states that long before 1994, the African National Congress (ANC) and other progressive organisations developed an alternative framework for the provision of healthcare that was based on racial equality and human rights. This started with the Freedom Charter, which was drawn up by the people in Kliptown in 1955. In respect of health, the Freedom Charter, proclaimed as follows: 1) a preventive health scheme shall be run by the state; 2) free medical care and hospitalisation shall be provided for all, with special care for mothers and young children; 3) slums shall be demolished, and new suburbs built where all have transport, roads, lighting, playing fields, crèches and social centres and 4) the aged, the orphans, the disabled and the sick shall be cared for by the state (The Freedom Charter 1955).

Under Healthcare, the RDP promised that “the government will develop a national health system offering affordable healthcare. The focus will be on primary healthcare to prevent disease and promote health, as well as to cure illness. The national health system promised to: 1) give free medical care to children under 6 years and to homeless children; 2) improve maternity care for women; 3) provide free services to disabled people, aged people and unemployed people within five years; 4) organise programmes to prevent and treat major diseases like TB and AIDS; 5) expand counselling services (for victims of rape, child abuse, and other kinds of violence); 6) give women the right to choose whether to have an early termination of pregnancy; 7) improve and expand mental healthcare; 8) run special education programmes on health, aimed particularly at young people; 9) improve occupational health in the workplace and 10) involve the fullest participation of communities”(RDP, 1994).

According to Landsberg (2004: 203-204) the overarching goals of the RDP included sustainable growth, viable employment creation and a movement to full employment, reduction

in income disparities, and an equitable system of rights. The RDP set some key targets: 1) creating 2, 5 million jobs in 10 years; 2) building one million low-cost houses by 2000; 3) providing electricity to 2, 5 million homes by 2000; 4) redistributing 30% of arable agricultural land to African farmers within five years; 5) providing 10 years of compulsory, free education and instituting adult basic education and training programmes and 6) democratising and restructuring state institutions to reflect the racial, class and gender composition of society.

The RDP was institutionalised in the form of the RDP Ministry and the RDP Fund, both of which became highly centralised in their decision-making. The RDP office formed a focal point of donor support from 1994 to early 1996. It sought to facilitate cross-cutting policy approaches and encourage new approaches to public sector management and budgeting in order to meet the government's overall reconstruction objectives. Criticism of the institutional arrangements and operational mechanisms established under the RDP broadly centred on the fact that it was highly centralised in its operations. Critics suggested that there was a real centralisation of planning associated with the programme. However, there was also an increasing understanding within the state that the RDP was not a full strategy for governance and development and it was open to wide interpretation (.Landsberg 2004: 204).

According to Chikulo (2003) the RDP was viewed as the cornerstone of government development policy – a yardstick against which the success of the government development policy could be assessed. However, as a development policy document, the RDP had a number of shortcomings. First, it looked more like a 'wish list' than a strategy document focusing on opportunities and constraints. Second, it made no attempt to set priorities; or to assign responsibility for the implementation of each programme component. Third, it lacked mechanisms for inter-departmental coordination. Finally, local government, which has been assigned constitutional responsibility for promoting socio-economic development, did not have adequate planning and implementation capacity.

Even though the government appeared to have been content with the RDP's broadly humanitarian thrusts, problems began to surface from 1995. The economy, in particular, was not growing at the envisaged rates. The sluggish performance of the economy in turn impacted negatively on the RDP, with achievements falling behind expectations. The welfare orientations of the programme also came under critical scrutiny as investors and international

financial institutions began demanding greater clarity on national economic policy. Given the major implementation problems caused by this, it was decided to shelve the RDP (Chikulo (2003)).

GROWTH, EMPLOYMENT AND REDISTRIBUTION POLICY (GEAR)

According to Landsberg and Mackay (2006: 8) a prime characteristic of post-1994 economic policies was the desire to create a favourable environment for market-led economic growth. To this end, in 1996, the government launched its macro-economic strategy — Growth, Employment and Redistribution (GEAR). Through GEAR, government committed itself to: 1) creating productive employment opportunities for all citizens with a living wage; 2) alleviating poverty, low wages and extreme inequalities in wages and wealth; 3) meeting basic needs; 4) democratising the economy and empowering the historically oppressed; 5) removing racial and gender discrimination and 6) providing a balanced and prosperous regional economy in southern Africa. The core elements of GEAR were: 1) a renewed focus on budget reform; 2) a faster fiscal deficit reduction programme; 3) a monetary policy to keep inflation low and stable; 4) liberalised financial controls; 5) a strong privatisation programme; 6) tax incentives to stimulate new investment in competitive and labour absorbing projects; 7) an expansionary infrastructure programme to address service deficiencies and backlogs; and 8) wage restraint by organised workers and the introduction of regulated flexibility in the labour market. The government in turn has been hard pressed to highlight some of GEAR's successes. Its Ten Year Review addresses these successes by pointing out that: 1) the budget deficit has come down from 9, 5% of GDP in 1993 to a fraction over 1% in 2002/03; 2) investment as a percentage of GDP has averaged around 16% to 17% and 3) since 1999, the government's investment expenditure has grown from 5, 3% to 9, 3%. While per capita growth was negative in the decade prior to 1994, the economy has since 1994 grown at a rate of 2, 8% per annum; but this is way under par if South Africa is to address the problems of poverty and underdevelopment.

According to Landsberg and Mackay (2006: 8) the new state placed an emphasis on financial management, and government passed the Public Finance Management Act of 1999. This led to improved budgeting and planning at national and provincial levels. The National Planning Framework was also introduced to improve policy planning. Outside government and the private sector, GEAR has been consistently criticised by, among others, the labour movement

and the South African Communist Party (SACP). Among the criticisms advanced is that GEAR failed to facilitate growth and bring about serious redistribution of income and, as a result, South Africa witnessed a widening gap between the rich and poor.

According to the OECD/ADB (2002: 207) one of the major objectives of GEAR was to enhance the credibility of the South African government by signalling to the international investor community South Africa's commitment to a stable macro policy. Moreover, the fiscal policy was designed to solve the employment crisis through significant growth increases. One of GEAR's biggest problems is that growth has remained low while unemployment has increased massively. Landsberg and Mackay (2006: 8) suggest that the rapid depreciation of the South African currency during 2001 and 2002 put further pressure on the economy. It was only towards the last quarter of 2003 that the currency appreciated again. Privatisation of state assets remained government policy despite criticism from its social partners, especially the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP). The main objections from these critics centred on the potentially negative impact on employment and consumer prices of privatised services.

Mhone and Edigheji (2003: 123-124) maintain that it is within this context that South Africa during the period 1994 and 1999 was characterised by the development of a coalition for change. The expectations of unions, utilising the wider political alliance to forge a progressive agenda for public service transformation, were heightened with the release of the RDP. The RDP argued for people-centred development, participatory democracy and an accountable development state. However there were ambiguities in the RDP document in relation to the public service. In particular, the clauses on privatisation were left open. The RDP argued that the democratic government would have to assess whether to increase or decrease the size of the public service. During this period the government and unions attempted to forge a common agenda that would take on board the needs of all parties.

The first democratic government of the country, elected in 1994, explicitly committed itself to redress inequality in South Africa. For example, the RDP stated that attacking poverty and deprivation must be the first priority of a democratic government (ANC 1994: 4). This commitment was supported by the 1996 Constitution and associated Bill of Rights. Although equity has remained a key policy goal across sectors since 1994, the approach to its

achievement has been heavily shaped by the 1996 GEAR. GEAR overtook the RDP as the governments' pre-eminent policy framework and places greater emphasis on economic growth as a strategy for redistribution than the RDP.

McIntyre and Gilson (2002: 1652) state that while the RDP set the broad parameters for the government's economic policy, it was the development of the GEAR policy in 1996 which has had the most dramatic impact on social sector policies. Much subsequent policy development in the social sectors, including health, has been strongly shaped by GEAR (Gilson and McIntyre 2002). Gilson, Doherty, McIntyre, Thomas, Brijlal, Bowa and Mbatsha (1999) suggest that GEAR is comprised of three main objectives: 1) promoting private (especially foreign) investment; 2) encouraging export-led growth 3) and improving productivity. These objectives are to be achieved by: 1) reducing the deficit to improve business confidence and private investment; 2) increasing government spending at a rate slower than overall economic growth and 3) tight monetary controls and the removal of import tariffs and exchange controls to encourage private (notably foreign) investment. The emphasis on private investment and export promotion has constrained job creation and raising income levels for the poor. Wadee, Gilson, Thiede, Okorafor and McIntyre (2003: 11) maintain that the macro-economic environment is one that encourages private investment creating the space for greater private sector engagement in the health system.

Mhone and Edigheji (2003: 125) state that the government started experiencing pressure to transforming the public service. For instance, the White Paper on Transforming Public Service Delivery under the rubric of Batho Pele, fundamentally redefined citizenship, whereby citizens were equated with customers. To treat citizens as customers according to the Batho Pele White Paper entailed: 1) listening to the views and taking account of them; 2) treating them with consideration and respect; 3) making sure that the promised level and quality of service is always of the highest standard and 4) responding swiftly and sympathetically when standards of service was not met.

According to Muthien, Khosa and Magubane (2000: 5-6) given the legacy of repression and discrimination, systematic destruction of the African family life and social capital, and the distorted nature of service delivery and social structures under apartheid, the democratic state faced a formidable challenge to not only establish new democratic forms of governance, but

fundamentally transform society. According to Khosa (2000) a key feature of this transformative agenda is the delivery of substantive political and economic democracy. This agenda according to Muthien et al (2000: 6) was captured in the RDP, aimed at not only transforming the state and society, but also on substantially improving the material well-being of the majority of the population. According to Bond and Khosa (1999) the programme led to public debt escalation amidst a drive to reduce the size of the civil service. In addition, the RDP Office, created a 'super ministry' in the President's Office, did not realise the aim of policy implementation. Hence the RDP Office was abolished and a new policy framework premised on neo-liberal economic assumptions was operationalised. This new macro-economic policy framework – the Growth, Employment, and Redistribution (GEAR) policy emphasises the redistributive thrust of the reprioritisation of government expenditure and the role of social and sectoral policies in meeting basic needs, improving services available to the poor and building social infrastructure. It stresses that growth needs to be translated into redistribution of incomes and opportunities through appropriate social development policies and programmes and deliberate promotion of employment creation. GEAR envisages increased state expenditure on infrastructure as an enhancer of growth.

De Beer and Broomberg (1990: 119) mention that change began to occur from about 1990 where individuals and health organisations campaigned for a better, healthier future for all citizens, and debated the ways in which more inclusive healthcare for instance could be brought about through radical change. Planning an equitable system that would end the vested interests of apartheid was perceived to be part of a broader democratic process involving a wide process of consultation. According to Benatar (1990) there was recognition that South Africa was one of the most unequal societies in the world, and hence an acceptance that it was imperative to have universal access to healthcare, as a right rather than a privilege.

DEVELOPMENTS SINCE 1994

According to Savage (1979) in Digby (2006: 424) practical attempts after 1994 to improve health by redressing the racially-based injustices of the past needed to reach beyond a restructuring of hospitals and clinics to a broader environmentally-based government strategy to improve the basic infrastructure in which millions lived. Arguably, it was not medical care

but inadequate socio-economic structures and environment that most affected the health of the African population.

The twenty year review of South Africa 1994-2014 (2014: 20) states that the country's governance landscape has been significantly transformed since 1994. The Constitution of the Republic of South Africa (1996) provided the foundations for building a democratic and inclusive state and is hailed as one of the most progressive in the world. Apartheid laws were repealed and a Bill of Rights enshrined in the Constitution, guaranteeing all citizens' socioeconomic and human rights. Independent institutions were established under Chapter 9 of the Constitution to strengthen accountability, safeguard democracy and build a responsive state. An independent judiciary and the constitutional freedom of speech and assembly were legally established. This has enabled citizens to pursue their political views and ideals freely and to trust the decisions of the judicial system.

Post 1994 the structures of the state were reorganised by the Constitution. The previous so-called independent Bantu homelands were re-incorporated into South Africa, and the self-governing Bantu homelands were dissolved. In their place nine provinces with their own legislatures and executives were established. These nine provinces each have a legislature with significant, delegated powers yet integrating the former administrations and Bantustans into a unified public service, operating in the national and provincial spheres, proved to be a daunting task (The twenty year review of South Africa 1994-2014 2014: 20).

The twenty year review of South Africa 1994-2014 (2014: 20) admits that despite this dramatic expansion, access to quality services remains uneven. These disparities result from apartheid spatial and governance systems, compounded by institutional weakness in some provinces and municipalities. In short, the state's capacity is weakest where socio-economic pressures are the greatest. The National Development Plan (NDP) mentions that there is unevenness in capacity that leads to uneven performance in the public service. This is caused by a range of factors, including tensions in the political administrative interface, instability of administrative leadership, skills deficits, insufficient attention to the role of the state in reproducing the skills it needs, weaknesses in organisational design and low staff morale. Other causal factors include the lack of a culture of continuous improvement, insufficient attention to operational management and a lack of management accountability. The last part of this article identifies

the steps that are being taken to overcome these challenges and build a capable and developmental state that can drive the country's development and transformation.

According to Muthien, Khosa and Magubane (2000: 8) an important feature of transformation during the first term of office of the democratic state was the decentralisation of public policy making. The new political environment introduced a variety of new processes and practices that differed radically from those that marked policy making during the apartheid era. In particular, the previously semi-secretive, technocratic, authoritarian mode of policy making was replaced by a more public and accountable policy making. Perhaps the most significant example of this new political culture was the Constitutional Assembly Project (CAP), which aimed to draw civil society in constitution writing. The objective was to empower institutions and community organisations outside of the state to participate in decision making. The creation of the new democratic state, which was more inclusive and more responsive to the needs of the previously excluded majority, required a fundamental overhaul of all policy and implementation frameworks for service delivery. The ANC took office armed with new policy initiatives, contained in the RDP, which in itself was developed through constituency inputs and consultation. Hence, policy making in the new government became open to mass public input, thus introducing participatory democracy, accountability and transparency.

The opening sentence of the State and Social Transformation of the ANC (1996) reads: "The struggle for the social and economic transformation of the South African society is essentially the task of replacing the apartheid state with a democratic one". The ANC's Draft Strategy and Tactics (1997) under the heading 'Programme of National Democratic Transformation in the Current Phase', points out four main transformative tasks for the democratic state: 1) democratisation and governance – the central aim is to a democratic state underpinned by the principles of good governance; 2) transformation of state machinery – the aim is to change the doctrines, composition and the management style of civil service; 3) Economic transformation – the central aim is to promote growth and development and 4) meeting social needs – the central aim of transformation is to improve the living conditions of the people, especially the poor. According to Muthien, Khosa and Magubane (2000: 42) the transformative role of the state is explicitly recognised in most policy documents of the new democratic state. These policy documents include the term 'transformation' in their titles. These include the White

Paper of the Department of Health, Transformation of the health system, the White Paper of Transformation of the Public sector and the White Paper on Transforming Service Delivery.

When the democratic government came into power, it promised to alleviate the division between the public and private sectors through the unification of Bantustan health systems under the jurisdiction of provincial and national healthcare systems. As a result, the rural health sector was consolidated from 400 independently-run local systems into nine provincial healthcare systems (Kon and Lackman, 2008). Although responsibility for implementing public programs remained at the provincial level, the national government sought to ensure that the collection and distribution of revenue was equitable, and it set new standards for service provision (Schneider and Stein 2001).

According to Landsberg and Mackay (2006: 6), since 1994 government has had to systematically and deliberately unscramble apartheid institutions and replace them with new democratic and legitimate institutions. It was determined to replace the apartheid-order and polity with a rule based democratic society based on the principles of equity, non-racialism and non-sexism. The state has been gradually democratised and universal franchise has been extended to all citizens. However, the government's highly ambitious transformation programme placed enormous strain on an inexperienced state. The transformation of the state involved overhauling the state machinery, fundamentally changing the entire policy tapestry, and introducing a new legislative framework. To this end, some 90 pieces of legislation were passed per annum for instance the Bantustans were reincorporated and their public services were melded with those in South Africa to create a single public service.

According to Landsberg and Mackay (2006: 6), the restructuring of the public service also involved reskilling and retraining. It addressed representivity to the extent that some 72% of all public servants are now Africans. The affirmative action and equity drive has ensured that the civil service reflects the demographics of society. The size of the public service was reduced from 1, 2 million in 1994 to just over a million in 2001. But the public service faced many capacity constraints making it heavily reliant on consultants, with 25% to 30% of state tenders going to consultants. Governance and administration objectives were also focused around delivery, and the government introduced the idea of integrated governance between different departments at the national level, strengthening the centre, and the co-ordination between the

national, provincial and local government spheres. By 2002, a new focus had emerged and the government and governance stressed support for the New Partnership for African Development (NEPAD) activities. Thus, South Africa's continental objectives began to be reflected in its internal policies.

According to Venter and Landsberg (2011: 9) the reign of the ANC since 1994 faced formidable challenges of governance. Four White provincial governments and nine former Bantu homeland governments had to be incorporated into nine provincial governments and one national government. Moreover, the whole state administration had to be restructured into a non-racial system, and African people who had historically been excluded from high-level civil service positions had to be recruited, appointed and trained. The new government had to follow a balancing act in maintaining system stability - mainly White staff expertise and new Black empowerment in the civil service. Moreover, the economy had to be revitalised from an apartheid economy to one that had to face the international economy in which highly developed industrial economies had to be engaged.

Twenty years later, the evidence of the ANC as government in restructuring the South African body politic is varied. The formal institutional structures of the nine provinces and 280 local governments have been achieved. The civil service has been restructured to demographically reflect the face of South African society. The economy has adapted to the new international political economy. South Africa has been accepted in the international community of states as a valuable member of the group of developing nations. The ANC has to get credit for managing such a fundamental reorientation of the South African political landscape (Venter and Landsberg (2011: 9).

POLICY-MAKING AND IMPLEMENTATION

According to Landsberg and Mackay (2006:9) when South Africa's new inclusive democracy was initiated in 1994, the government sought to adopt policies and practices designed to serve the interests of all, regardless of race or gender, rather than separate development. The new government was open to innovative approaches to policy. However, policy and policy challenges took place against the backdrop of a tough developing country setting. Resources and skills were limited, and the capacity to implement the new policies was in short supply.

The Nelson Mandela government placed an emphasis on policy-making and overhauling the old policy landscape. The government felt pressed to make new and progressive policies which enjoyed legitimacy. The Mbeki government in turn felt the need to shift away from policy-making to a greater emphasis on consolidation and the implementation of policy. The emphasis was on policy formulation, with an increased focus on improving the effectiveness of implementation systems and enhancing the provision and delivery of basic services. The government articulated a programme of action aimed at 'speedier transformation towards delivery, and an improved quality of life for all South Africans, especially the poor'. Both the Mandela and Mbeki governments adopted policies and policy implementation strategies that had to respond to the massive and daunting apartheid legacy by focusing on alleviating poverty, creating African middle class or 'patriotic bourgeoisie', free market policies in search of foreign direct investment and job creation, and putting in place a responsive civil service.

However, ten years into South Africa's democracy, there was clearly a gap between policy and implementation. Policy-makers and bureaucrats charged with implementation have often been unaware of the many unintended consequences of policies and the fact that policies were often highly ambitious. Policies often came up against tough practicalities in the field for instance the implementation of policies was often more costly than initially anticipated at the policy-making phase. Furthermore, the government was under constant pressure to revamp the skills of those people intended to implement them. This often brought about uncertainty in the ranks of implementers about their competencies and skills (Landsberg and Mackay 2006: 9).

According to Landsberg and Mackay (2006:9) suggest that while the intentions behind many of the policies were always good and noble, often unexpected consequences resulted. For example, the government had a clear goal of empowering local communities, but policy sometimes achieved the opposite. Where policy-makers failed adequately to consult the intended beneficiaries, such policies had unintended consequences. Foisting policies that worked in developed countries into a developing country may have negative consequences. The quest for 'world class policies' denotes such a practice. South Africa developed a penchant for trying to learn from and emulate the developed countries. Sometimes, such 'world class' policies were not always readily implementable, as the necessary conditions for their successful implementation did not exist on the ground. Thus the policies are set up for failure, or they benefit only those sectors of the population that are able to access them.

Yet, policies do not have to be world class to be successful; what is needed are good policies for the particular circumstances that they seek to address. Policies based on one important consideration may have consequences for other areas. Many policy areas also required co-ordination with other sectors in order to ensure the delivery of the intended end-product to the beneficiaries. In the health sector, for instance, the policy decision to provide primary healthcare in rural areas through the provision of clinics was an important one, as the intention was to bring accessible healthcare closer to rural populations. However, several of these clinics have been built and are standing empty. This is because there are no roads leading to them, or there is no energy to power basic equipment, or there is no sufficient and professionally competent staff. So the Department of Public Works for instance should also have been consulted when making of this policy (Landsberg and Mackay (2006: 9).

Ngwenya (2006: 81) states that as part of the transformation from apartheid, South Africa has followed international human rights jurisprudence in recognising rights concerning health as fundamental rights. While the South African Constitution has a number of provisions dealing with rights concerning health, the most significant is Section 27, which provides that:

- (1) Everyone has the right to have access to:
 - (a) Healthcare services, including reproductive healthcare;
 - (b) Sufficient food and water; and
 - (c) Social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
- (2) The state must take reasonable and other measures, within its available resources, to achieve a progressive realisation of each of these rights.
- (3) No one may be refused emergency medical treatment (Constitution of the Republic of South Africa Act 108 of 1996).

Since 1994, numerous major reforms have taken place. Health policy, health legislation, and the structure and content of the healthcare system have fundamentally changed (Van Rensburg 1999). The reforms are essentially aimed at rectifying the gross disparities in access to healthcare that characterised the pre-democratic era. The RDP of the ANC and the ANC's National Health Plan were initially instrumental in delineating the direction of reform. Subsequently, however, the 1997 White Paper on the transformation of the health system in

South Africa (1997) has articulated comprehensively the direction, strategies and pace of reform whilst the Constitution has served as a firm basis for legitimising ongoing reforms.

The edifice of policies, laws and structures that ensured differential and unequal access to healthcare services, as part of shoring up separate amenities, homelands and tri-cameral policies, have been dismantled. The erstwhile 14 departments of health have been dismantled in favour of a unified, but decentralised, system with one national department and nine provincial departments. The current National Health Act puts the new structure on a statutory footing (Ngwenya 2006: 81).

According to Ngwenya (2006: 81) Primary HealthCare (PHC) is now the concept around which healthcare is organised, born out of the World Health Organisation's (WHO) Alma Ata Declaration. A central tenet of PHC is universal access to a package of essential health services. The government has developed a framework for implementing PHC which according to Van Rensburg (1999) is organised around a decentralised system — the District Health System (DHS). The DHS is an instrument for decentralising, regionalising and democratising healthcare so as to bring it as close as possible to the people. The DHS entails dividing the nine provinces into smaller administrative and service units — 50 health regions and 170 districts. Communities become part of the planning and organisation of healthcare services. Both the PHC and the DHS call for a fundamental shift in allocation of healthcare resources. They entail not only dismantling the racial bias of the past, but also, equally significant, dismantling the curative and urban biases of the past. According to Van den Heever and Brijlal (1997) the health budget has been diverted from academic and tertiary hospitals to fund PHC and DHS. From 1996/97 to 1997/98, there was a shift of 8% from hospital services and 10, 7% towards district health services. Abbot (1997) states that as part of rectifying the dearth of services in rural areas, a massive Clinic Building and Upgrading Programme has been underway to reduce an unmet need of 1 000 clinics. From 1994 to 1999, between 450 and 500 clinics were built.

Since 1994, significant progress has been made towards removing income as an impediment to access healthcare services. Notice 657 of 1994, 1 July 1994, states that the state will provide free health services for pregnant women and children under the age of 6 years. Van Rensburg (1999) maintains that access to free healthcare has also been broadened to PHC services. This is in line with the egalitarian values that underlie the concept of PHC. Free services have also

been introduced for children up to 12 years at public clinics. Several pieces of legislation that impact on free healthcare policies have been passed. For instance, the Choice on Termination of Pregnancy (Act 92 of 1996) has radically transformed access to abortion services. In the first 12 weeks of pregnancy, abortion is obtainable on request. Abortion services are free at the point of access. Parliament introduced new laws to regulate healthcare to meet the needs of people. The Medical Schemes Act (131 of 1998) makes it illegal for a medical scheme to refuse membership to a person on the grounds of disability and state of health. The Act requires medical schemes to offer a prescribed minimum of benefits to all members.

The Pharmacy Amendment Act (88 of 1997) for example extends ownership to non-pharmacists providing that prescribed medicines are dispensed under the supervision of a pharmacist. It is envisaged that this measure will encourage the setting up of pharmacies in underserved areas, such as rural areas. The Medicines and Related Substances Control Act (90 of 1997) was passed with a view to making medicines cheaper through a variety of ways, including parallel importation; institution of price controls; promotion of generic substitution; and prohibition of bonusing and rebates, which drug companies use to offer discounts to dispensers of medicines. Another important new policy was the 1996 National Drug Policy that set out to ensure the universal availability of high-quality, low-cost drugs. This policy aimed to: 1) rationalise the use of medicines by creating an Essential Drug List (EDL) of medicines that should be available at all health facilities and 2) encourage the use of affordable generic medicines, rather than expensive patented medicines.

Subsequently there has also been significant restructuring within the health sector. The ANC's national health plan for South Africa (1994) defines this restructuring. The national Department of Health is now largely responsible for policy making and co-ordination functions, while the provincial health departments are responsible for the vast majority of health service provision. In addition, local governments have a constitutional responsibility for the provision of municipal health services (a contested term, variously defined as including environmental health services only, or also primary care facilities or also the district hospital). There is a commitment to establishing a district health system that will integrate the primary care services currently provided by provincial administrations and local governments. However, the major obstacle to establishing health districts has been lack of clarity about their governance structure specifically, whether the district health system will be rooted in deconcentration of authority to

provincial health departments or devolution to local governments. Recent legislation suggests that local governments will become the dominant structure at health district level in the future, but in the interim provincial health departments are likely to continue to play the dominant role in primary care provision in most provinces.

According to Hassim, Heywood and Berger (2007: 19-20) the government faces great challenges in fulfilling its duty to ensure that all people are able to access healthcare services. These involve improving the social conditions that influence health and restructuring the management of the health sector by: 1) integrating racially divided health services – 14 separate health departments had to be integrated into a national health department and nine provincial health departments; 2) establishing a district-based health system - this was seen as critical to implementing the PHC approach.

An additional obstacle was the difference on conditions of service between staff in different authorities, e.g. provincial health departments paying their staff differently to local authority staff; 3) creating equity in access to health services – equity was needed between races, classes and people in different parts of the country. This may require government to increase spending on historically disadvantaged parts of the country and decrease spending in other areas and 4) transforming the human resources profile of the health system – apartheid skewed the distribution of health workers, depriving African people of access to healthcare and African healthcare workers from access to skills, training and experience. The new government has plans to:

- Improve racial and gender diversity among health workers;
- Redistribute health workers to rural and poor urban areas; and
- Provide new skills to health workers in order to manage and provide an effective primary healthcare system (Hassim, Heywood and Berger 2007: 19-20).

The new vision of health was to be achieved through a re-organisation of the structure and management of the health system, and through reforms in policy legislation and financing.

In April 1997, the government published the White Paper for the transformation of the health system in South Africa to improve health through achieving a new mission, goals and objectives

for the health sector. It stated that in future the national health system would aim to provide caring and effective services through primary healthcare approached, based on the district health system. The White Paper maintained that the challenge was to establish an integrated health system and an effective referral system between the different levels of care. The objective was to ensure that most people enter the health system at the primary care level, where they receive basic care and health education, and that more complicated healthcare services are dealt with by district and specialist hospitals.

Under apartheid, health funding was predominantly directed at White people in urban areas who used hospitals for healthcare. The new challenge was: 1) fund health for all people in both urban and rural areas and 2) correct the balance between funds available for the private sector and the public sector, by spending more on the public sector as the sector servicing the majority of South Africans.

According to Benatar (1990: 441) the current healthcare system can be accurately described as mal-distributed, poorly funded and coordinated, fragmented and duplicated, discriminatory on a racial basis, hospital-based and supported by very poorly developed ancillary services. According to Digby (2006: 434) practical changes in healthcare have been slow to emerge after the democratic transition. The ANC's RDP of 1994 included requirements for basic health needs in its proposals and in the following year workshops were held in the provinces to develop health goals, objectives and indicators. In 1995 a policy document on a district health system was issued by the department of health, and in April 1997a White Paper on health system transformation was endorsed by Parliament. Its objectives included unifying the fragmented health services into a comprehensive and integrated system that would promote equity, accessibility and community participation.

CONCLUSION

This article has noted that pre-1994 South Africa created political, socio-economic and human rights crises that will likely haunt South Africa for decades. Pre-1994 South Africa was one of the worst violators of human rights and thus came to be dubbed by the UN and many states as committing a 'crime against humanity'. South Africa is a democracy with deep-seated poverty and inequality. This is a challenge that South Africa must confront.

Although there have been many important reforms in healthcare for example, there are many challenges that remain. It can also be argued that whilst discrimination on the grounds of race is no longer allowed, there is still great discrimination on the grounds of class – and that the people who benefited under apartheid continue to have access to a better quality of care in the new South Africa.

REFERENCES

1. Abbot, G. 1997. Upgrading health facilities. Health Systems Trust, *South African Health Review* pp. 119–127.
2. African National Congress (ANC) 1994. *The reconstruction and development programme*. Johannesburg, Umanyano Publications.
3. African National Congress. 1996. *The state and social transformation*. Johannesburg, Government Printers.
4. Benatar, S.R. 1990. A unitary health service for South Africa. *South African Medical Journal*. Vol. 77, pp. 441.
5. Benatar S.R. 1990. Universal access to healthcare: gathering momentum. *South African Medical Journal*. Vol. 78, pp. 55-56.
6. Bond, P. and Khoza, M. 1999. *An RDP policy audit*. Pretoria, Human Sciences Research Council Publishers.
7. Republic of South Africa. *Choice on the termination of pregnancy. Act 92 of 1996*. [Online]. Available at: http://www.capetown.gov.za/en/CityHealth/Documentation/Documents/Act_Choice_on_Termination_of_Pregnancy_Act_92_of_1996.pdf Accessed 03 March 2015.
8. Chikulo, B. C. 2003. Development Policy in South Africa: A Review. *Development policy management network bulletin*. Vol. X (2) [Online]. Available at:

- <http://www.dpmf.org/images/south-africa-devt-policy-chikulo.html> Accessed 07 February 2015.
9. Congress of the People. 1955. *The Freedom Charter adopted at the Congress of the People*, Kilptown, South Africa, on 26 June 1955. [Online]. Available at: <http://www.anc.org.za/ancdocs/history/charter.html> Accessed 03 March 2015.
 10. Republic of South Africa. Department of Finance. 1996. *Growth, employment and redistribution: A macro-economic strategy*. Pretoria, South Africa.
 11. Republic of South Africa. Department of Health. *White Paper for the transformation of the health system in South Africa*. Government Gazette Vol. 382, Number 17910. Notice 667 of 1997. Pretoria, Government Gazette.
 12. Republic of South Africa. Department of Public Service and administration. 1999. *Annual report*. Pretoria, Government Gazette.
 13. De Beer, C. and Broomberg, J. 1999. Achieving healthcare for all. *South African Medical Journal*. Vol. 78, pp. 119 [Online]. Available at: <http://archive.samj.org.za/1990%20VOL%20LXXVIII%20Jul-Dec/Articles/02%20August/1.1%20EDITORIAL.ACHIEVINGHEALTH%20CARE%20FOR%20ALL,%20A%20TIME%20TO%20CHOOSE.pdf> Accessed 03 March 2015.
 14. Digby, A. 2006. *Diversity and division in medicine: Healthcare in South Africa from the 1800s*. Oxford, Peter Lang International Academic Publishers.
 15. Edigheji, O. 2003. State-society relations in post-apartheid South Africa: The challenge of globalisation on co-operative governance. In Mhone, G. and Edigheji, O. (Eds.). *Governance in the new South Africa: the challenges of globalisation*. Cape Town, University of Cape Town Press.

16. FitzGerald, P., McLennan, A. and Munslow, B. 1995. *Managing sustainable development in South Africa*. Cape Town, Oxford University Press.
17. Gilson, L., Doherty, J., McIntyre, D., Thomas, S., Brijlal, V., Bowa, C and Mbatha, S. 1999. *The dynamics of policy change: Healthcare financing in South Africa, 1994-99*. Monograph No. 66, Johannesburg, Centre for Health Policy, University of Witwatersrand/ Cape Town, Health Economics Unit, University of Cape Town.
18. Republic of South Africa. *Free Health Care Services*. Government Gazette. Notice 657 of 1994, 1 July 1994 [Online]. Available at:
http://www.fshealth.gov.za/portal/pls/portal/PORTAL.wwsbr_imt_services.GenericView?p_docname=3139200.PDF&p_type=DOC&p_viewservice=VAH&p_searchstring
Accessed 03 March 2015.
19. Hassen, E.K. 2003. The power behind the desk: Democracy, collective bargaining and the public service in South Africa. In Mhone, G. and Edigheji, O. (Eds.). *Governance in the new South Africa: the challenges of globalisation*. Cape Town, University of Cape Town Press.
20. Hassim, A., Heywood, M. and Berger, J. 2007. A background to health, law and human rights in South Africa. In Hassim, A., Heywood, M. and Berger, J. (Eds.). *Health and democracy*. Cape Town, Creda Communications.
21. Heywood, M.J. 2004. *Introduction to health and the South African health system*. East London, South African Health Rights, Law and Policy Manual.
22. Kon, Z. and Lackan N. (2008) Ethnic disparities in access to care in post-apartheid South Africa. *American Journal of Public Health*. Vol. 98(12), pp. 2272-2277.
23. Landsberg, C. 2004. The quiet diplomacy of bridge building. In Landsberg, C. (Ed.). *The quiet diplomacy of liberation: the international politics of South Africa's transition*. Johannesburg, Jacana Media.

24. Landsberg, C. and Mackay, S. 2006. South Africa 1994-2004. In Rembe, N. (Ed.), *Reflections on democracy and human rights: A decade of the South African Constitution*. Johannesburg, Human Sciences Research Council.
25. McIntyre, D. and Gilson, L. 2002. Putting equity in health back onto the social policy agenda: Experience from South Africa. *Journal of Social Science and Medicine*. Vol. 54, pp. 1637–1656.
26. McLenan, A. 1995. Into the future: restructuring the public service. In FitzGerald, P., McLenan, A. and Munslow, B. (Eds.). *Managing sustainable Development in South Africa*. Cape Town, Oxford University Press.
27. Republic of South Africa. *Medical Schemes Act 131 of 1998* [online]. Available at: <https://www.bhfglobal.com/files/bhf/files/MSREGS19July2004.pdf> Accessed 03 March 2015.
28. Republic of South Africa. *Medicines and Related Substances Control Act (90 of 1997)* [Online]. Available at http://www.saflii.org/za/legis/num_act/marscaa1997450.pdf Accessed 03 March 2015.
29. Mhone, G. 2003. Democratisation, economic liberalisation and the quest for sustainable development in South Africa. In Mhone, G. and Edigheji, O. (Eds.). *Governance in the new south Africa: the challenges of globalisation*. Cape Town, University of Cape Town Press.
30. Mhone, G, and Edigheji, O. 2003. *Governance in the new South Africa: The challenges of globalisation*. Cape Town, Cape Town University Press.
31. Mogale, T.M. 2003. Developmental local government and decentralised service delivery in the democratic South Africa. In In Mhone, G. and Edigheji, O. (Eds.). *Governance in the new south Africa: the challenges of globalisation*. Cape Town, University of Cape Town Press.

32. Muthien, Y.G., Khosa, M.M and Magubane, B.M. 2000. *Democracy and governance review: Mandela's legacy 1994-1999*. Pretoria, Human Sciences Research Council.
33. Republic of South Africa. *National Drug Policy. 1996*. [Online]. Available at: <http://apps.who.int/medicinedocs/documents/s17744en/s17744en.pdf> Accessed 03 March 2015.
34. Ngwenya, C. 2006. Health. In Rembe, N. (Ed.). *Reflections on democracy and human rights: A decade of the South African Constitution*. Johannesburg, Human Sciences Research Council.
35. Organisation for Economic Co-operation and Development (OECD) and African Development Bank (ADB). 2002. *African economic outlook* [Online]. Available At: <http://www.oecd.org/australia/1826412.pdf> Accessed 02 March 2015.
36. Patel, I. 2000. Growing pains: collective bargaining in the public service. In Adler, G. (Ed). *Public service labour relations in a democratic South Africa*. Johannesburg, University of Witwatersrand Press.
37. Republic of South Africa. *Pharmacy Amendment Act (88 of 1997)* [Online]. Available at: http://www.saflii.org/za/legis/num_act/paa1997178.pdf Accessed 03 March 2015.
38. *Reconstruction and Development Programme (RDP) 1994. A policy framework*. Johannesburg, Umanyano Publications [Online]. Available at: <https://www.nelsonmandela.org/omalley/index.php/site/q/03lv02039/04lv02103/05lv02120/06lv02126.htm> Accessed 2nd March 2015.
39. Republic of South Africa. 1996. *The Constitution of the Republic of South Africa (Act No. 108 of 1996)*. Pretoria: Government Printers.
40. Savage, M. 1979. The political economy of health in South Africa. In Digby, A. (Ed), *Diversity and division in medicine: healthcare in South Africa from the 1800s*. United Kingdom, Peter Lang International academic Publishers.

41. Schmitz, T. and Kabemba, C. 2001. *Enhancing policy implementation: lessons from the Reconstruction and Development Programme*. Johannesburg, Centre for Policy Studies.
42. South African Presidency. 2014. *Twenty year review of South Africa*. Pretoria, Government Printers.
43. Schneider, H. and Stein, J. (2001) Implementing AIDS policy post-apartheid South Africa. *Journal of Social Science and Medicine*. Vol. 52, pp. 723-731.
44. Van den Heever, A.M. and Brijlal, V. 1997. Healthcare financing. Health Systems Trust, *South African Health Review*. Vol. 8, pp. 81-89.
45. Van Rensburg, H.C.J. 1999. Health and healthcare in South Africa in transition: A macro perspective. *Acta Academica*, Vol. 31, pp. 1-26.
46. Venter, A. and Landsberg, C. 2011. *Government and politics in South Africa*. Johannesburg, Van Schaik Publishers.
47. Vil-Nkomo, S. 1999. Transformation and change: issues for consideration by governments and their societies. In Wessels, J.S. and Pauw, J.C. (Eds.). *Reflective public administration: Views from the South*. Cape Town, Oxford University Press.
48. Wadee, H., Gilson, L., Thiede, M., Okorafor, O. and McIntyre, D. 2003. Healthcare inequity in South Africa and the public/private mix. Draft paper prepared for the RUIG/UNRISD project on Globalization, Inequality and Health, a collaborative international project forming part of the RUIG research programme on The Social Challenge of Development. United Nations Research Institute for Social Development (UNRISD).
49. Wooldridge, D. and Cranko, P. 1995. Transforming public sector institutions. In Fitzgerald, P., McLennan, A. and Munslow, B. (Eds.). *Managing sustainable development in South Africa*. New York, Oxford University Press.

CHAPTER SIX

ALIGNING STRATEGIC HUMAN RESOURCE MANAGEMENT TO HUMAN RESOURCES, PERFORMANCE AND REWARD

INTRODUCTION

Without a strategic plan, management and the organisation, as a whole, would not be in a position to achieve its goals and objectives as outlined in the organisation's strategic plan. Challenges surrounding Strategic Human Resources are the responsibility of every manager within the department and not as in the past where human capital issues were the sole responsibility of the personnel department.

The way in which people are managed within organisations needs to be aligned with the strategy of the business. The management of Human Resources can no longer be viewed as an activity relegated to Human Resource staff. It is a fundamental activity in the mainstream of formulating and implementing business strategy. This paper, therefore, aims at aligning Strategic Human Resource Management with Human Resources, Performance, and Reward.

DEFINING STRATEGIC HUMAN RESOURCE MANAGEMENT AND STRATEGIC MANAGEMENT

The definition of Strategic Human Resource Management, according to Johnson and Scholes (2002: 10), can be defined as *“the direction and scope of an organisation over the longer term, which ideally matches its resources to its changing environment, and, in particular, to its markets, customers and clients to meet stakeholders' expectations”*.

Another widely used definition of Strategic Human Resource Management has been provided by Ellers and Lazenby (2007: 1) who assert that it is *“the process whereby all the organisational functions and resources are integrated and coordinated to implement formulated strategies in order to achieve the long-term objectives of the organisation and therefore gain a competitive advantage through adding value for the stakeholder”*. Competitive advantage, in this context,

refers to the edge that an organisation has over another, particularly what makes one firm better than the other or why some companies out-perform their competitors.

Boxall and Purcell (2003: 44) define Strategic Management as a process of strategy making, of forming and reforming its strategy over a period of time. This is amplified by David (2003: 5) who refers to Strategic Management as “*the art and science of formulating, implementing and evaluating cross-functional decisions that enable an organisation to achieve its objectives*”. To a large extent, this definition implies that Strategic Management focuses on integrating core functions to achieve organisational success. Strategic Management, as a process, consists of the following three stages:

- Strategy formulation;
- Strategy implementation; and
- Strategy evaluation (David, 2003: 5).

Strategy formulation includes developing a vision and mission, identifying an organisation’s external opportunities and threats, determining internal strengths and weaknesses, establishing long-term objectives, generating alternative strategies, and choosing particular strategies to pursue. Strategy formulation issues include deciding what new business to enter, what business to abandon, how to allocate resources, whether to expand operations or diversify, whether to enter international markets, whether to merge or form a joint venture, and how to avoid a hostile takeover (David, 2003: 5).

Strategy Implementation requires a firm to establish annual objectives, devise policies, motivate employees, and allocate resources so that formulated strategies can be executed. Strategy implantation includes developing a strategy supportive culture, creating an efficient organisational structure, reducing marketing efforts, preparing budgets, developing and utilising information systems, and linking employee compensation to organisational performance. He continues that strategy implementation is often called the action stage of Strategic Management (David, 2003: 5).

Strategy Evaluation is the final stage in Strategic Management. Managers need to know when particular strategies are not working well; strategy evaluation is the primary means of obtaining

this information. All strategies are subject to future modification because external and internal factors are constantly changing” (David, 2003: 6).

ALIGNING STRATEGIC HUMAN RESOURCE MANAGEMENT AND HUMAN RESOURCE MANAGEMENT

There is a growing realisation among organisations to align its Human Resource practices with corporate strategies to meet the needs of its business in order to gain strategic advantage from its Human Resources. Human Resource Management is significantly aligned to Strategic Human Resource Management and is one of the fundamental policy objectives to ensure that Human Resource policies and practices are applied by managers as part of their everyday work. Ellers and Lazenby (2007: 256) maintain that successful strategy implementation can be achieved if resources are allocated in a manner that supports the organisations long- and short-term goals, chosen strategy, and structure.

More importantly, Ehlers and Lazenby (2007: 257) argue that the knowledge era is important for strategy implementation in that employees are allocated the most important task in implementing the strategy. Organisations can no longer generate profits without the ideas, skills, and talent of knowledgeable workers. Technologies, factories, natural resources, and capital are no longer difficult to obtain and are increasingly less important in developing and sustaining a competitive advantage for the organisation. While capital is becoming less scarce, the opposite may be said of talent and skills, especially in developed countries. This issue may be one of the reasons for the rise in Chief Executive Officers (CEO’s) and executives’ compensation in the last decade. Demand for talented and highly skilled knowledgeable workers is stripping supply.

This approach, emphasising Human Resources, echoes Nel, Werner, Haasbroek, Poisant, Sono and Schultz’s (2008: 553) comment on Human Resources practices, which emphasises that Human Resources practices may be successful if they are aligned with the strategic objective of the business, make business sense, and are focused on business operations. Nel et al. (2008) concludes that the strategic partner role focuses on aligning Human Resource strategies (including policies and procedures) with the business strategies and the execution thereof. Armstrong (2006: 124) is of the opinion that the distinction between Strategic Human Resource

Management and Human Resource Management is underpinned by a philosophy that supports the Strategic Management of Human Resources in accordance with the plans of the organisation concerning the future direction it wants to take. As a result of this process, a stream of decisions over time emerges to form the pattern adopted by the organisation for managing its Human Resources to identify areas in which specific Human Resource strategies need to be developed.

Because the world has become a global marketplace, the focus nowadays lies on Human Resource Management and the successful integration of strategies within an organisation. The emphasis is on managing people within the employer-employee relationship, maintaining that staff is the major reason for the success of an organisation. The Human Resources of an organisation represent one of its largest investments, illustrating that employees should be supported in reaching their full potential and thus enjoy sound quality of life and job satisfaction (Nel et al., 2008: 6).

DEFINING PERFORMANCE MANAGEMENT

The Oxford Dictionary defines performance as carrying out, accomplishing, or fulfilling an action, task or function, whilst Armstrong (2006: 497-499) defines performance as the achievement of quantified objectives which is not only a matter of what people achieve but how they achieve them. More importantly, performance must examine how results are achieved because this provides the required information to consider what needs to be done to develop those results. Armstrong argues that one of the fundamental purposes of performance management is to align individual and organisational objectives. Alignment can be accomplished by a flowing process so that objectives can cascade from the top, thereby allowing team or individual objectives to be defined in light of these higher level goals.

Carrell and Elbert (2000: 224) suggest that Performance Management is a box of 'tools'. This opinion is developed by pointing out that management uses a variety of 'tools' to guide, control and improve the performance of employees. Tools, such as reward systems, leadership, job design, training efforts, and performance appraisals, can be regarded as part of an effective human performance management system and a significant part of most managers' jobs.

CHARACTERISTICS AND PURPOSE OF PERFORMANCE MANAGEMENT

Price (2007: 452) observes that the Performance Management system is owned and implemented by line managers, which is amplified by the role of Human Resource specialists to aid and advise line managers on the development of the Performance Management systems. Performance Management is characterised by the following:

- A clear statement of what is to be achieved by the organisation
- Individual and group responsibilities support the organisations goals
- All performance is measured and assessed in terms of those responsibilities and goals
- All rewards are based on employee performance
- Organisational structured, processes, resources, and authority systems are designed to optimize the performance of all employees
- There is an on-going effort to create and guide appropriate organisation goals and to seek newer, more appropriate goals (Price, 2007: 452)

The purpose of Performance Management is a means of achieving improved results from the organisation, groups, teams, and individuals by understanding and managing performance within an agreed framework. It is a process of establishing and understanding what is to be achieved, as well as an approach to managing and developing people in a way which increases the achievement of short- and long-term objectives. DeCenzo (2005: 246) echoes Armstrong's purpose of Performance Management by asserting that without proper two-way feedback about an employee's effort and its effect on performance, there is a risk of decreasing the employee's motivation.

PERFORMANCE MANAGEMENT SYSTEMS

The strategic aspects of performance assessment; namely, the three C's - consistency, coordination, and control - are represented in the integration of appraisals and performance-related pay procedures within performance management systems (Price, 2007: 450). The following are regarded as the functions of a performance management system:

- Reinforcement of the organisations values and norms;

- Integration of individual objectives with those of the organisation;
- Allowing individuals to express their views on the job; and
- Providing the means for managers and staff to share their expectations of performance (Armstrong, 1991: 162).

Performance Management Systems comprise of various activities, suggesting that it entails more than simply reviewing what an employee has done. DeCenzo (2005: 246) develops this point by recommending that the Performance Management System must fulfil several purposes, taking into consideration it is often hindered by difficulties in how they operate. Performance Management system should include the following actions:

- Develop clear job descriptions;
- Select appropriate people with an appropriate selection process;
- Negotiate requirements and accomplishment-based performance standards, outcomes and measures;
- Provide effective orientation, education, and training;
- Provide on-going coaching and feedback;
- Conduct quarterly performance development discussions;
- Design effective compensation and recognition systems that reward people for their contributions;
- Provide promotional/career development opportunities for staff; and
- Assist with exit interviews to understand why valued employees leave the organisation (Heathfield).

REWARD

Why is reward so important? This is a simple question that perhaps has complex answers. Could it be that people only work for reward? Is this the reason why we wake up in the morning? For some, reward may be in the form of financial gain and, for others, it may be a question of a good company to work for, status, and even mental stimulation. The question of whether money can motivate people to work has been a contentious issue for both employer and employee alike. Here we follow Maslow (1954) who pointed out the hierarchy of needs as a motivational theory, laying emphasis on the fact that higher-order needs gradually become more important

when lower-order needs have been satisfied. Herzberg (1966) observed that remuneration is a significant source of satisfaction when it is seen as a form of reward or recognition. Vroom's (1964) expectancy theory emphasizes the need for organisations to relate reward directly to performance and to ensure that the reward provided is desired and deserved by the recipients. Bratton and Gold (2007: 358) point out that reward pertains to *“all of the monetary, non-monetary, and psychological payments that an organization provides for its employees in exchange for the work they perform”*. Swanepoel, Erasmus, and Schenk (2008: 476) distinguish between intrinsic and extrinsic rewards. Intrinsic rewards are self-administered and are associated with the job itself, such as the opportunity to perform meaningful work, experience variety and receive feedback on the work results. In other words, it is the satisfaction that a person derives from doing the job. Extrinsic rewards include those that an employee gets from sources other than the job itself. This involves benefits obtained as a result of doing the job, such as promotion or remuneration.

Performance and reward are closely aligned due to the fact that work can be more rewarding if it gives you what you want. As a result, an employee is likely to perform at a high level if the work is rewarding; hence, reward is an important component of Human Resource Management. According to Price (2007: 467), the term reward management encompasses both the strategy and the practice of remuneration systems. There are two basic types of remuneration schemes, although many organisations have systems that comprise of both elements:

- Fixed level of pay – wages or salaries that do not vary from one period to the next except by defined pay increases, generally on an annual basis. There may be scales of payments determined by age, responsibility or seniority. Most ‘white collar’ jobs were paid in this way until recently; and
- Reward linked to performance – the link may be daily, weekly, monthly, or annually. Payment for any one period varies from that for any other period, depending on quantity or quality of work (Price, 2007: 467).

Armstrong (2002: 10) suggests that an employee reward system is made up of an organisation's integrated policies, processes, and practices aimed at rewarding its employees in terms of skill, competence, and their market worth. An employee reward system is established within the

framework of the organisation's reward philosophy and policies which take into account the appropriate types and levels of pay, benefits, and other forms of reward.

AIMS OF EMPLOYEE REWARD – FROM AN ORGANISATIONS POINT OF VIEW AND FROM AN EMPLOYEE POINT OF VIEW

Armstrong (2002: 13) claims that *“a reward system expresses what the organisation values and is prepared to pay for”*. It is regulated by the need to reward good performance and to get the right message across about what is important from the organisation's perspective. The specific aims of employee reward are to:

- Help to attract, retain, and motivate high quality people;
- Play a significant part in the communication of the organisations values, performance, standards, and expectations;
- Encourage behaviour that will contribute to the achievement of the organisations objectives and reflect the ‘balanced score card’ of key performance drivers;
- Underpin organisational change programmes concerned with culture, process, and structure;
- Support the realisation of the key values of the organisation in such areas as quality, customer care, teamwork, innovation, flexibility, and speed of response; and
- Provide value for money – no reward initiative should be undertaken unless it has been established that it will add value, and no reward practice should be retained if it does not result in added value (Armstrong 2002: 14).

Armstrong (2002: 14) states that from an employee's point of view, the reward system should:

- Treat them as stakeholders who have the right to be involved in the development of the reward policies that affect them;
- Meet their expectations that they will be treated equitably, fairly, and consistently in relation to the work they do and their contribution; and
- Be transparent – they should know what the reward policies of the organisation are and how they are affected by them (Armstrong, 2002: 14).

CONCLUSION

The above discussion indicates that Strategic Human Resource management is indeed closely aligned with Human Resource management, Performance, and Reward. Strategic Human Resource management is the core component of which Human Resource management, Performance, and Reward are secondary. Without Strategic Human Resource management, the Human Resource function cannot perform at its optimum.

REFERENCES

1. Armstrong, M. 1991. *A handbook of personnel management practice*. London: Kogan Page.
2. Armstrong, M. 2002. *Employee reward*. 3rd edition. London: Cromwell Press.
3. Armstrong, M. 2006. *Armstrong's handbook on human resource management practice*. 11th edition. London: Kogan Page.
4. Boxall, P.F. and Purcell, J. 2003. *Strategy and human resource management*. New York: Palgrave Macmillan.
5. Bratton, J., and Gold, J. 2007. *Human resource management: Theory and Practice*. 4th edition. Houndmills: Macmillan.
6. Carrell, M.R and Elbert, N.F. 2000. *Human resource management*. 8th edition. Orlando: Dryden Press.
7. David, F.R. 2003. *Strategic management: Concepts and cases*. New Jersey: Prentice Hall.
8. DeCenzo, D.A. 2005. *Fundamentals of human resource management*. 8th edition. New York: John Wiley and Sons.

9. Ehlers, M.B. and Lazenby, J.A.A. 2007. *Strategic management: South African Concepts and Cases*. Pretoria, Van Schaik.
10. Heathfield, S.M. (n.d) *Performance management* [Online]. Available at: <http://humanresources.about.com/od/glossary/g/perform-mgmt.htm> Accessed 18 April 2013.
11. Johnson, G. and Scholes, K. 2002. *Exploring corporate strategy*.6th edition. London: Prentice Hall.
12. Nel, P.S., Werner, A., Haasbroek, G.G., Poisat, P., Sono, T. and Schultz, H.B. 2008. *Human resources management*.7th edition. Cape Town: Oxford University Press.
13. Price, A. 2007. *Human resource management in a business context*.3rd edition. London: Thompson Learning.
14. Swanepoel, B.J., Erasmus, B.J. and Schenk, H.W. 2008. *South African human resource management: Theory and practice*.4th edition. Cape Town: Juta & Co Ltd.
15. Walker, J.W. 1992. *Human resource strategy*. New York: McGraw-Hill.

CHAPTER SEVEN

HEALTH SECTOR REFORMS IN SOUTH AFRICA: THE ESTABLISHMENT OF A DISTRICT HEALTH SYSTEM AND NATIONAL HEALTH INSURANCE

INTRODUCTION

Since 1994, extensive and widespread reforms have been made to the legislative and institutional framework for public healthcare in South Africa. This article shows that the outcomes of these reforms are mixed. In fact, there continue to be many problematic and unresolved public healthcare concerns. Twenty years into democracy, the government continues to face serious challenges in implementing some of its public healthcare reforms. Challenges facing the South African healthcare sector seem to be as a result of a fragmented health system inherited from the apartheid era government. This article shows that in some instances, the governance challenges facing the provision of public healthcare have increased.

This article contends that governance affects how policies are implemented. It posits that despite South Africa's comprehensive reform to the legislative and institutional framework for public healthcare since the end of apartheid, the shortcomings of governance are causing it to fail to fulfil its newly established policy mandates.

This article provides an analysis of South Africa's public healthcare system and reveals that the District Health System (DHS) is a key outcome of healthcare reforms in South Africa. The DHS is responsible for the provision of primary healthcare (PHC) services. It is also where the future implementation of the recently adopted National Health Insurance (NHI) policy will be located. The concern raised in this article is that the NHI is a cumbersome policy and depends on a public healthcare system that is capable of providing universal healthcare across South Africa. Whether the DHS is capable give effect to policies such as the NHI is of concern. The implications thereof for governance is considered.

BACKGROUND

Given the inequitable and racial discriminatory features of the apartheid healthcare system, the need for fundamental changes to the entire healthcare system was unquestionable. The apartheid government, through its discriminatory policies, developed an inequitable public healthcare system. This was supported through the years by the promulgation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the healthcare professions and facilities. The outcome was a public healthcare system which was fragmented; biased towards curative care and the private sector; inefficient and inequitable. The task at hand for South Africa's first democratically elected government in 1994 was to initiate a complete transformation of the national healthcare delivery system.

In its National Health Plan for South Africa, the first democratic government adopted the principles of PHC which are: community participation; social and economic development; equity; health promotion; interventions focused on the determinants of poor health; prevention; rehabilitation; an integrated referral system; teams of health professionals with specific and sophisticated biomedical and social skills; a client-centred approach to healthcare; and adequate resources. These principles were now regarded as the central tenet of future health practice and the benchmark against which all health policy and planning should be measured (ANC, 1994).

In its National Health Plan for South Africa, the ANC announced that “the aim of reorganising health services in South Africa was to improve health and health services for all. This was to be done by adopting the PHC approach and bringing the services in line with international thinking and practices. Crucial to this was the strengthening of community services and the development of the District Health System” (ANC 1994). The district level was identified as the level of government where health policies and health sector reforms were to be implemented.

Primary healthcare according to Thurston (2014: 136) is typically the first point of contact with the healthcare system for people. In 1978, the World Health Organisation (WHO) adopted the PHC approach as the basis for effective delivery of health services as outlined in the Declaration of Alma-Ata (WHO 1978). The Alma-Ata Declaration defined PHC as:

“Essential healthcare based on practical scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation; and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO 1978: 15).

The South African government has recognised the key role individuals, families, households and communities play in reaching health related goals. For instance, the White Paper for the Transformation of the Health System in South Africa (1997) provides a number of methods for the active participation in the planning and provision of services, such as including women, children, vulnerable groups, the underserved and the development of community-based information systems that would identify local needs and monitor service delivery. One of the main sub-principles of community involvement is that PHC cannot be handled from ‘high up’ (WHO/UNICEF 1978). This means that providers of health services should be made accountable to the community they serve rather than to a distant ministry of health. According to Macdonald (2013: 78) the PHC approach originated from the perceived inadequacies of conventional centralised healthcare to meet the needs of people in developing countries. It was an attempt to chart the way towards a more decentralised, people-centred public healthcare system.

REFORMS IN SOUTH AFRICA

Reforms in South Africa resulted in the decentralisation of public healthcare structures and services. National public health sector reforms in South Africa entailed a sustained process of fundamental change in national policy and institutional arrangements, led by government and were designed to improve the functioning and performance of the health sector with the aim of improving access to, and the health status of the population. Health sector reforms in South Africa was a deliberate and planned undertaking intended to bring about lasting changes. It was never an *ad hoc* or emergency action. Nor was it a once-off project. In fact, it is an ongoing process that brings about structural changes to existing organisational, management and financing systems.

In theory, health sector reform should lead to changes in health policy, health systems and health services. These changes, in turn, should lead to health system development and strengthening, which are prerequisites for improving the performance of health systems and services, which in turn necessitate other health sector reform. Improvement in the performance of health systems and services leads to greater access and better utilisation of quality health services which are produced and provided in a more efficient, equitable and sustainable way. Ultimately, improvements in the performance of health systems and services should lead to improved health status which is measured by such impact indicators as infant and child mortality, maternal mortality and life expectancy at birth (Chatora and Tumusiime 2004: 16).

The main expected goal of health sector reform is health improvement. To achieve the main outcome, health sector reform is concerned with achieving: i) improved equity in health and healthcare services, ii) increased and better management of health resources. iii) improved performance of health systems and quality of care and iv) greater satisfaction of consumers and providers of healthcare (Chatora and Tumusiime 2004: 14).

In practice, the National Health Act (Act 61 of 2003) became South Africa's overarching legislative framework that provides for the establishment of the national health system, as well as the DHS. It establishes the governance structures required for the provision of healthcare. The highest policymaking body is the National Health Council, which is comprised of: a) the Minister, or his or her nominee, who acts as chairperson, b) the Deputy Minister of Health, c) the relevant members of the Executive Council, d) one municipal councillor, representing organised local government and appointed by the national organisation contemplated in section 163 (a) of the Constitution, e) the Director-General and the Deputy Directors-General of the national department, f) the head of each provincial department, g) one person employed and appointed by the national organisation contemplated in section 163(a) of the Constitution and h) the Head of the South African Military Health Service.

The functions of the National Department of Health (NDoH) are to ensure the implementation of national health policy insofar as it relates to the national department and issue guidelines for the implementation of national health policy. The National Consultative Health Forum (NCHF) is made up of stakeholders in the health sector. The Minister of Health consults and shares information on national health matters with this forum.

The NHA establishes similar structures at provincial level. The functions of the provincial health departments are to ensure the implementation of national health policy, and the national norms and standards in the province. In other words, to facilitate the sharing of information on provincial, district and municipal health issues. At provincial level, the NHA provides for the establishment of a Provincial Health Council (PHC) which is comprised of: a) the relevant member of the Executive Council, or his or her nominee who acts as chairperson, b) one Councillor from each of the metropolitan municipalities in the province if there are such municipalities in the province in question, c) one Councillor from each of the district municipalities in the province, d) the head of the provincial department, e) not more than three representatives involved in the management of local government and f) such number of other persons as the relevant member of the Executive Council may consider appropriate.

Chapter five of the NHA deals with the establishment of the DHS which consists of health districts that coincide with the municipal boundaries and the creation of District Health Councils. The District Health Council which is comprised of the following: i) a member of the metropolitan or district municipal council situated in the health district in question, nominated by the relevant council, ii) a person appointed by the relevant member of the Executive Council to represent him or her, iii) a member of the council of each municipality within the health district nominated by the members of the relevant council and iv) not more than five other persons appointed by the relevant member of the Executive Council. The role of these councils is to: a) promote cooperative governance, b) ensure coordination of planning, budgeting, provisioning and monitoring of all health services that affect residents of the health district for which the council was established and c) advise the relevant members of the Executive Council, through the Provincial Health Councils, and the municipal council of the relevant metropolitan or district municipality, on any matter regarding health or health services in the health district for which the council was established.

The Constitution (Section 156(1)) states that local government is responsible for the delivery of Municipal Health Services (MHS) and should be defined to include the following:

- Environmental health services;
- Provision of clean water and sanitation;
- Prevention of infectious and communicable diseases;

- Health promotion and education;
- Provision of community rehabilitation services;
- Treatment of minor injuries and diseases; and
- Provision of essential medicines for primary care.

What is clear from the above legislative provisions is that each respective policy document makes provision for local government representation. The establishment of national, provincial and district health councils are the most influential health policymaking bodies in South Africa. The responsibilities of these councils are spelt out in the NHA, and reiterate that health is no longer purely a national or provincial government function, but has (in theory) been decentralised to local districts.

The proposal that primary healthcare should be provided at local government level through a district health system was not a novel idea. In fact, it was first mooted in 1994 in the ANC's National Health Plan for South Africa (1994) which proposed the establishment of the DHS. It was translated into public policy in 1995, and initial attempts were made to put into place a district health system. This was no easy feat. The first step was the creation of local health districts. This comprised, first and foremost, defining geographical territories clearly delineated administrative boundaries. Prior to 1994, local governments were not responsible for the provision of healthcare. In fact, prior to 2000, there were no clearly delineated local municipal boundaries. This made the establishment of local health districts difficult (de Bakker 1989: 59)

The term 'district health system' as defined in 1986 by the World Health Organisation (WHO) Global Programme Committee states that "a district health system based on PHC is a more or less self-contained segment of the national health system. It comprises first and foremost of a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing healthcare in the district, whether governmental, social security non-governmental, private or traditional... It also includes self-care and all healthcare workers and facilities, up to and including the hospital at the first referral level. (WHO 1986: 6).

Health districts in South Africa had to be large enough to justify the costs involved pertaining to their establishment as well as the management of health services, particularly where hospitals

are concerned. Yet, health districts had to be small enough to take account and understand the demographic and socio-economic conditions. In theory, the top-down and bottom-up planning approaches can easily be coordinated between districts and other levels of government because of direct contact at all levels. Communication with the target population and its participation in planning and organisation should, theoretically, be fairly easy to handle. Management is more transparent and reliable (Chatora and Tumusiime 2004: 3).

It was the NHA that officially put in place conditions for a functioning DHS. The decentralisation of the health system must be legalised and implemented by means of regulations and legislation. In theory, the necessary financial and human resources must be mobilised. Health service institutions and providers must have the autonomy in the use of physical and human resources, and income generated by health services must remain at their disposal. Sufficient personnel, qualified in planning and management activities, must be available. It is important to understand the distinction between district health systems and national health systems functions in order to avoid redundancy and overlap. (Table 1).

Table 4: Functions of health systems

HEALTH SYSTEM FUNCTION	NATIONAL SYSTEM	DISTRICT SYSTEM
Stewardship	<ul style="list-style-type: none"> • Regulatory functions 	<ul style="list-style-type: none"> • Implement and enforce regulations
	<ul style="list-style-type: none"> • Policy formulation 	<ul style="list-style-type: none"> • Interpret and implement policies e.g. essential health packages
	<ul style="list-style-type: none"> • Setting standards 	<ul style="list-style-type: none"> • Interpret and enforce standards
	<ul style="list-style-type: none"> • Liaison with bilateral and multilateral agencies 	<ul style="list-style-type: none"> • Partnership establishment and sustenance through private/public mix, community involvement and multisectoral approach (planning, monitoring and evaluation)
	<ul style="list-style-type: none"> • Formulation of strategic research priorities and plans 	<ul style="list-style-type: none"> • Conduct health system research • Take part in national surveys • Take part in piloting interventions of national priority • Involve NGOs in health systems research • Conduct cost-effective public health intervention
<ul style="list-style-type: none"> • Establish HMIS 	<ul style="list-style-type: none"> • Put HMIS into operation by collecting, processing and analysing data • Use information for evidence-based comprehensive health planning • Link HMIS data for research 	
Resource generation	<ul style="list-style-type: none"> • Development of a national human resource development strategy plan • Training of high and middle level health workers • Development of national health infrastructure development and maintenance plan • Development of a national equipment policy • Policy development on procurement and rational use of essential supplies, including drugs 	<ul style="list-style-type: none"> • Assessment of local human resource needs • Rational deployment and utilisation of HRH • Continuing education for health workers • Training and orientation of CORPs for health (TBAs, VHWs, traditional practitioners, CBDs) • Identifying physical infrastructure and equipment needs • Routine maintenance of physical infrastructure and equipment • Identifying drug and other essential supply requirements and placing orders • Proper storage, distribution and use of essential supplies
Service delivery	<ul style="list-style-type: none"> • Tertiary healthcare services • Technical back-up and support supervision • Setting standards • Quality assurance • Monitoring and evaluation • Provision of incentives for service organisations and providers 	<ul style="list-style-type: none"> • Identification of healthcare needs and prioritisation of health services • Provision of identified and prioritised healthcare packages in an integrated continuous and comprehensive manner • Encourage community-based care • Identification and involvement of all stakeholders • Development and implementation of action plans • Ensuring customer/client satisfaction

Financing	<ul style="list-style-type: none"> • Budgeting • Financing strategies • Donor coordination • Development of pooling mechanisms (e.g. insurance and prepayment schemes) • Development and use of purchasing mechanisms (e.g. contracting) • Maintenance of national health accounts 	<ul style="list-style-type: none"> • Budgeting • Allocation of funds to activities • Implementation of insurance and prepayment schemes • Implementation of exemptions • Provision of proper accountabilities • Implementation of co-funding schemes
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Source: Chatora and Tumuaiime, 2004: 31

The White Paper for the transformation of the health system in South Africa lists the principles that inform South Africa's DHS:

- (i) Overcome fragmentation;
- (ii) Promote equity;
- (iii) Provide comprehensive services;
- (iv) Be demonstrably efficient;
- (v) Be economically efficient;
- (vi) Provide services of the highest quality;
- (vii) Allow access to all;
- (viii) Be accountable to the local communities served;
- (ix) Allow for full community participation;
- (x) Decentralise appropriate powers and functions;
- (xi) Be based on a developmental and intersectoral philosophy; and
- (xii) Be sustainable (Department of Health, 1997).

The configuration of the DHS was only finalised in 2003 with the enactment of the National Health Act, which formalised a decentralised system of public healthcare for South Africa.

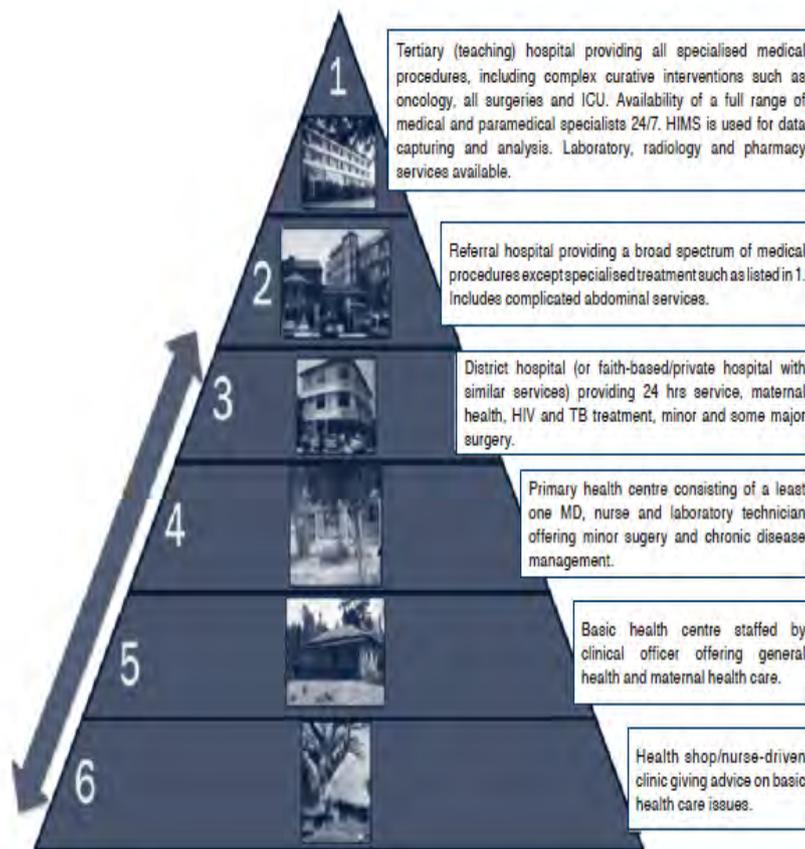
The South African public health sector follows a hierarchical referral system that comprises a network of health facilities made up of the following:

○ **Clinic**

A facility at and from which a range of primary health care services is provided and that is normally open eight or more hours a day based on the need of the community to be served.

- **Community Health Centre**
A facility that normally provides primary health care services, 24 hour maternity, accident and emergency services and beds where health care users can be observed for a maximum of 48 hours and which normally has a procedure room but not an operating theatre.
- **District Hospital**
A hospital which receives referrals from and provides generalist support to clinics and community health centres with health treatment administered by general health care practitioners or primary health care nurses.
- **Primary Health Care Services**
Accessible first level health services included as part of the package of basic essential health services.
- **Provincial Tertiary Hospital**
A hospital which receives health care users from and provides sub-specialist support to a regional hospital and requires the expertise of clinicians working as sub-specialists.
- **Regional Hospital**
A hospital which receives referrals from and provides specialist support to a district hospital and where health care users require the expertise of teams led by resident specialists.
- **Specialised hospital**
A hospital which provides care for specified groups of health care users
- **Tertiary Institution**
Any institution providing health education at a tertiary level within the Province.

Figure 2: Types and description of healthcare facilities



Source: SafeCare Initiative, 2011

Category 3-6 facilities typically represent the main healthcare delivery channels for low income citizens. Category 2 facilities represent referral hospitals and can be defined as any process in which healthcare providers at lower levels of the health system, who lack the skills, the facilities, or both to manage a given clinical condition, seek the assistance of providers who are better equipped or specially trained to guide them in managing or to take over responsibility for a particular episode of a clinical condition in a patient. Category 1 facilities represent highly specialised staff and technical equipment such as, cardiology, intensive care units, specialised imaging units and clinical services highly differentiated by function. Tertiary hospitals could have teaching activities and ranges in size from 300 to 1,500 beds. When required, a lower level facility should refer a patient to the next level for a service that cannot be provided at the lower level.

Generally, a hospital should not compete with primary care facilities or get too involved with solving community health problems. Instead, it should concentrate on providing the level of

technological medical care that lower levels cannot provide. The district hospital serves three critical roles in a well-functioning district health system, namely to:

- Provide support to health workers in clinics and community services, both in terms of clinical care and public health expertise;
- Provide the first level hospital care for the district; and
- Be the place of referral from clinics and/or community health centres, and be responsible for referring patients to higher levels of care, when necessary.

The DHS is the platform designed by the national government for the provision of primary healthcare services. The DHS outlined the governance framework for the transformation of the health system in South Africa, describing functions of the national department, the provinces and the districts/municipalities.

DECENTRALISATION

The effectiveness of the DHS depends on a decentralised system of governance whereby powers and functions from national and provincial government are transferred to local government (in this case districts). Centralisation, in theory, refers to the reservation of authority at a central point within an organisation. In a centralised system of government, control and decision-making reside at the top levels of management. Decentralisation on the other hand, grants authority to managers of sub-units within an organisation. This definition is useful because amongst other reasons, it identifies the importance of the transfer of powers, functions and resources from one level of government to another.

The World Bank (2001) defines decentralisation as the transfer of authority and responsibility for public functions from the central government to intermediate and local governments or quasi-independent government organizations and/or the private sector. This definition presents a broad concept of decentralisation, including four different processes: 1) deconcentration – dispersing some tasks to territorial branches of central government, 2) delegation – transferring some responsibility to local or regional government units that enjoy some scope of autonomy, yet are ultimately accountable to the central government, 3) devolution – based on transferring responsibilities and authority from the central level to an autonomous unity and 4) privatisation

– engaging private entities in public service delivery, mainly on a contractual basis (Utomo 2009: 2).

Decentralisation is considered by the United Nations Development Programme (UNDP) as part of the overall governance system of any society. It is the process by which authority, responsibility, power, resources and accountability are transferred from the central levels of government to sub-national levels. Conceptually, decentralisation relates to the role of, and the relationship between, central and sub-national institutions, whether they are public, private or civic. Improved governance will require not only strengthened central and local governments but also the involvement of other actors from civil society organisations and the private sector in partnerships with government at all levels (UNDP 1997: 4). This means that decentralisation in a democratic state system, such as South Africa with its three spheres of government (national, provincial and local) can transfer power from either the national or provincial sphere to the local sphere. The National Health Act (61 of 2003), for example, points out that local government has the power, authority and responsibility to make by-laws, policies and decisions on municipal health services as long as these do not contravene any of the tenets of the Constitution.

The Constitution provides for the decentralisation of health services to local government. In terms of Section 156(4) of the Constitution, national and provincial governments may assign to a municipality, by agreement and subject to any conditions, the administration of a matter listed in Part A of Schedule 4 or Part A of Schedule 5 related to local government if:

- (a) The matter relates to local government
- (b) The matter would most effectively be administered locally
- (c) The municipality has the capacity to administer it.

In 2001 the Minister and Members of the Executive Council (MINMEC) decided that the district and metropolitan municipalities would be the level at which the DHS would be developed. This meant that the decentralisation of PHC services to local government had become national policy. The Health MINMEC took the following decisions regarding the implementation of the DHS and the role of local government in public health service delivery:

- District and metropolitan council areas were to be the focal point for health service coordination and delivery;
- Provincial departments of health were to coordinate the planning and delivery of PHC within the districts in collaboration with local government;
- A Provincial Health Authority (PHA), comprising the MEC for Health and councillors responsible for health from each district and metropolitan councils in the province, would be set up in each province. The role of the PHA was to be advisory to the MEC for Health;
- The MEC would facilitate the establishment of District Health Authorities (DHA);
and
- The long term goal would remain to capacitate municipalities for deliver the full range of district health services, although initially district hospitals would be excluded.

Constitutionally, health is a concurrent function of both national and provincial spheres of government with national government largely responsible for setting policies, and provinces largely responsible for monitoring the implementation of these policies. The country is divided into 53 health districts as part of the governments drive to decentralise health services.

The Constitution refers to the three spheres of government as “distinctive, interdependent and interrelated”. No sphere can succeed on its own. The Constitution emphasises the role of national and provincial government in supporting local government, and stresses that this role goes beyond simply producing legislation and regulations. South Africa operates on a system of decentralising responsibility for implementation while maintaining national oversight and using centralised funding mechanisms to achieve redistribution. However, the challenge is to ensure that these structures deliver services as enshrined in the Constitution which establishes the distribution of powers and functions between national, provincial and local government, and provides a set of principles for how the system should operate.

Significant reference to the issue of decentralisation is made by the ANCs (1994) National Health Plan for South Africa which asserts that “the provision of public healthcare will be coordinated among local, district, provincial and national authorities. Authority over, responsibility for, and control over funds will be decentralised to the lowest level possible that is compatible with rational planning and the maintenance of good quality care. Clinics, health

centres and independent practitioners will be the main points of first contact with the health system". The Department of Health (1995) published the DHS policy framework in support of the ANC's (1994) National Health Plan for South Africa, stating that, with regard to the governance of health services, the final home for the delivery and provision of PHC services would be "the level closest to people and communities", and local government has been understood and readily accepted as such.

The underlying essence of South Africa's DHS is the organisation of district public healthcare facilities according to geographic sub-divisions of the country, which are managed through a decentralised management structure (McCoy and Engelbrecht 1999: 1). These geographical sub-divisions are in line with the political boundaries as determined by the National Demarcation Board.

The DHS is an instrument for decentralising and regionalising healthcare in South Africa. The transformation of the public health sector was characterised by the development and establishment of the DHS across the nine provinces (DoH 1995). In a decentralised system of public healthcare, the organisation and management of the entire public health system is district-based, meaning that even policy areas such as health sector financing, utilisation of regional and tertiary hospitals, the relationship with the private sector and its own governance is located at the district level.

The development of the DHS was an important part of decentralising public healthcare. The objective was to transfer power, authority and functions from the national sphere to the local sphere. However, the abdication of power, authority and responsibility does not mean that the central government relinquishes constitutional or legal accountability. In fact, this means that the central government grants decentralised entities room to make decisions within the context of local conditions. The main purpose of the DHS in South Africa according to Tshotsho (2003: 382) was to decentralise the responsibility for public healthcare delivery and place it at the local level. This level of the public healthcare system is responsible for the overall management and control of its own budget and the provision and purchase of comprehensive PHC services within its area of jurisdiction.

The district management structure is supposed to be the point and level at which different health service activities are integrated into a comprehensive and holistic approach to healthcare. It is clear from the analysis above that the DHS, in theory, represents a profound break from the apartheid healthcare system built on a centralised health system, characterised by fragmentation, inefficiency, centralised authoritarianism and the separation of curative services from preventive care (McCoy and Engelbrecht 1999: 1).

Proponents of decentralisation suggest that decentralisation in theory, improves administrative efficiency, transparency, finance management, quality and accessibility of services. Decentralisation creates space for learning, innovation, community participation and the adaptation of public services to local circumstances.

There are arguments that decentralisation holds disadvantages or has its limitations. It is not necessarily a panacea for all government and developmental problems and there are several issues which constrain the impact of decentralisation. For instance, weak administrative or technical capacity at local levels may result in services being delivered less efficiently and effectively in some areas of the country. Decentralization can sometimes make coordination of national policies more complex and may allow functions to be captured by local elites (Technical Cooperation Department of the United Nations n.d).

The concept of decentralisation is essentially about transferring different powers and functions to lower levels of state administration and relies on a bottom-up philosophy. It is aimed at spreading decision-making and responsibilities to ensure efficient public service provision. Some studies have shown that the DHS is decentralised in principle, but its real powers remain limited. As such, the DHS is not achieving the anticipated benefits of a decentralised public health system. In other words, there is no evidence of technical efficiency; allocative efficiency or quality of service improvement because accountability of its officials remains to reside with the central DOH as opposed to the local health council. In 2013 Wolvaardt reviewed and produced a report titled: How to fix the DHS. Data was collected using structured questionnaires compiled by 233 operational and district managers. It included interviews with representatives of the Presidents Emergency Plan for AIDS Relief (PEPFAR) and District Management Teams (DMTs) and incorporated an analysis of baseline assessments done by some PEPFAR partners. The study provided a snapshot of 25 districts, both urban and rural

and covered all provinces in South Africa. His study concluded that the institutional design problems identified in the DBSA 2008 Report still exist and issues around delegation of authority and management autonomy are yet to be resolved. In addition the districts should be granted the authority to implement District Hospital Plans (DHPs), as only under such a scenario will it be possible to hold DMTs accountable for service delivery.

However, one must bear in mind that centralisation and decentralisation are not ‘either-or’ conditions. The South African situation dictates that striking the right balance between centralisation and decentralisation is essential for the effective and efficient functioning of government. There is a need for a combination of a centralised/decentralised mix because not all functions can and should be decentralised. For example, from a centralised perspective national governments often retain or hold on to important policy and supervisory roles whereas from a decentralised perspective they must create an enabling environment that allows sub-units to take on more responsibilities.

Probably one of the most challenging policy tasks facing the DHS will be the introduction of NHI. In December 2015 South Africa’s NDoH launched the White Paper (more than 4 years after the release of the Green Paper) on the NHI scheme as part of developing the healthcare system. It is a plan for significant reforms to the public and private health sectors and aims to make affordable healthcare available to all South Africans. The rationale for the provision of NHI stems from the apartheid legacy of unequal access to quality healthcare that undermines the rights of some citizens, especially those in the low-income class or the unemployed. Therefore, the implementation of a system such as the NHI is anticipated to bring about a radical transformation that will influence administration, financing, service delivery, orientation of health facilities’ infrastructure and affordability. The scope of the NHI is governed and guided by Section 27 of the Bill of Rights, thus it observes the following principles: i) the right to access healthcare, ii) social solidarity, iii) equity, iv) healthcare as a public good, v) affordability, vi) efficiency, vii) effectiveness and viii) appropriateness. The introduction of the NHI presents an opportunity for South African policymakers to improve upon mistakes of the past and fulfil their commitment to redressing the inequities of the past.

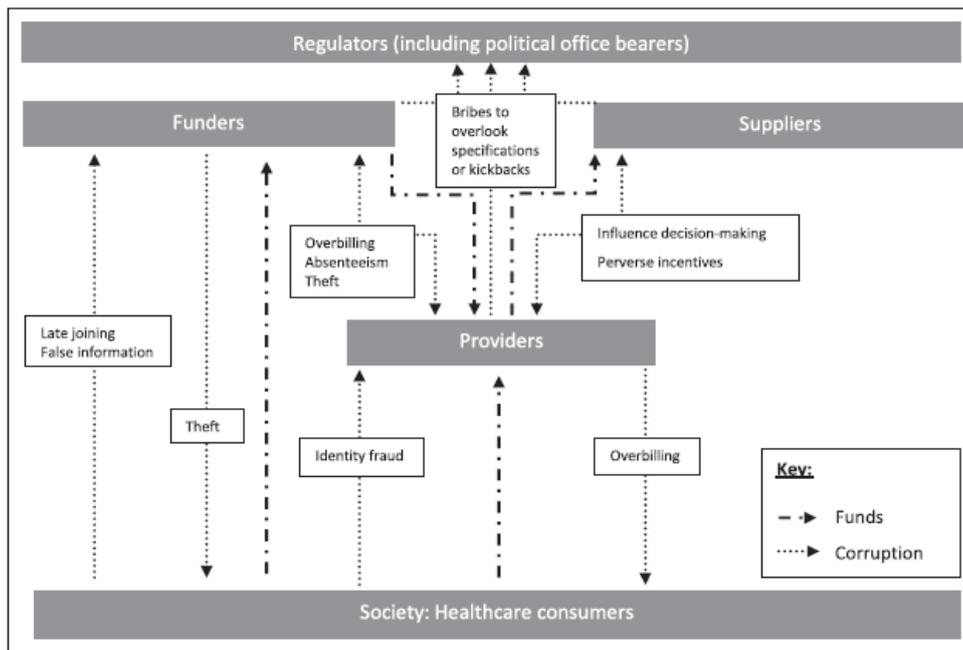
One of the challenges in establishing an NHI system is to ensure that every South African, irrespective of socio-economic class, has an equal opportunity to access quality healthcare

services. Other challenges include the types of PHC services that will be provided under the NHI has not yet been determined. The role the private sector can and will play has not been determined. Attracting and retaining doctors/staff to district health facilities is currently a problem. As pointed out earlier the burden of disease puts the provision of healthcare services under pressure. This relates to: HIV/AIDS and TB; maternal, child and infant mortality; non-communicable diseases like high blood pressure, diabetes, chronic heart disease, chronic lung disease, cancer and mental illness (Botha and Hendricks 2008: 5-6).

The objective is to have fully implemented the NHI scheme by 2025. A central fund will be established to contain the mandatory contributions of all South Africans, either by increasing taxes on individuals or increasing value added tax (VAT), or a combination of these. Services will be paid for from this pool (National Health Insurance for South Africa 2015: 48). But the introduction of such a scheme, even if introduced in a phased way, will not work if aspects of collapse in the public health system, which are often fuelled by corruption, are not addressed and halted. Recent scholarly attention has focused on weak governance and the negative effects of corruption on the provision of health services. Not only does corruption have negative consequences for economic growth and development but also adversely affects health service delivery, accessibility, affordability, efficiency and as well as health policy and spending priorities.

Figure 2 provides an illustration of the study “exploring corruption in the South African health sector” by Rispel, de Jager and Fonn (2015: 3). In their study, an organizational view was taken where the health sector was simplified into four main actors: 1) regulators, 2) funders, 3) suppliers and 4) providers. From this, they hypothesize how various stakeholders and the nature of their relationships may create opportunities for corruption.

Figure 3: Opportunities for corruption



Source: Savedoff and Hussmann (2006: 7)

Figure 2 illustrates the flow of funds as well as a priori principal agent relationships that could result in corrupt practices. Information asymmetries characteristic of the health sector, create opportunities for corruption. Healthcare providers may bill consumers for services not rendered. Suppliers of medical equipment, technology or pharmaceuticals may influence provider behaviour by creating perverse incentives such as gifts or financial kickbacks. Funders, suppliers and providers may offer bribes to regulators to overlook failures in meeting statutory or contractual obligations or quality standards and specifications. Consumers could collude with providers to misuse private insurance funds.

Another challenge is the issue of capacity. Facilities are already burdened, with NHI in place, it may increase the burden. Some argue that with the current prices of private sector healthcare, more people will rely on public healthcare. Outdated and insufficient facilities and poor quality of care. Public sector facilities are also ill equipped to deal with many health problems and to support the successful implementation of these policies.

A shortage of sufficiently trained healthcare personnel in the public sector is another major hindrance to the implementation of NHI. PHC facilities in particular will need an influx of trained doctors and nurses to support the PHC focus of the NHI. While data shows growth in

the number of professional registrations across most health professions and increases in public sector appointments, South Africa remains severely undersupplied with key health professionals and faces huge challenges in this area. As the most highly trained health workers, doctors with sufficient capabilities are crucial to the success of any health system. Doctor shortages have produced a health system heavily reliant on nurses. Yet a scarcity of nurses also plagues the healthcare system. In addition to healthcare workers with high levels of formal training, the South African system also lacks people with sufficient management skills to effectively implement policies.

Problems with policy implementation and monitoring have been attributed to a lack of planning and rushed implementation. The rushed implementation of these policies also prevented the extensive consultation with stakeholders needed to produce policies that would best suit the needs of South Africans. In some areas, policies simply have not been implemented. Significant numbers of patients still pay user fees for primary care services, which undermines FHC's equity objectives and reveals the discretionary power of the providers and bureaucrats who ultimately determine the realization of policies. Problems with the implementation of past policies hindered their effectiveness and similar issues may very well plague this policy.

On the 22nd March 2012, the Minister of Health, Doctor Aaron Motsoaledi, announced the 11 districts that will launch the onset of the National Health Insurance system, (as illustrated in appendix 1). The pilot studies have brought the following issues to the fore. Firstly, there is a shortage of doctors and specialists. The NHI pilot has tried to encourage private doctors to work in public clinics and hospitals. However, the public health sector infrastructure is criticized as being derelict, outdated equipment, lack of safety in rural areas, no defined salary and irregular working hours mainly due to staff shortages. Subsequently, critics argue that the pilot projects are not experimental enough. In other words, new models or governance approaches must be considered, for example contracting private general practitioners to work in the public health sector. Consequently, the pilots have not made much progress. Plans to extend the pilot studies from 11 to 20 districts have been considered.

Introducing the NHI was a slow process. The government published a broad outline of its plans in a Green Paper in August 2011. Appendix 1 indicates that as early as 2010 the health department begun the introduction process. But it was only in December 2015 that the White

Paper was finally launched. Past attempts at introducing the NHI has been high on the ANC-led government's political agenda since the party's 2007 elective conference in Polokwane.

The health system in South Africa is undergoing considerable change in the context of the NHI establishment. In most countries decentralisation of health services is central to these changes, and consequently there is a need to prepare and empower those working at the district level for new responsibilities and tasks.

CONCLUSION

There had been considerable achievement with regard to the DHS since the South African government committed itself to the development of the District Health System based on the Primary HealthCare approach. For instance, there has been: i) an abolition of user fees at PHC level; ii) uniform patient fee schedule at hospital level, with the indigent not required to pay; iii) PHC visits have increased from about 68 million in 1997/98 to over 128 989 087 in 2013/14 and iv) the largest Antiretroviral (ART) programme, with 2,5 million people on treatment (Hunter 2015:15).

However, health problems and ill-health continue to exist despite laudable initiatives, for example, inequity in healthcare delivery still exists. Much has to do with poor management, especially in the organisation of district health systems and the difficulties faced in translating PHC principles and health sector reform proposals into practice. These problems can be attributed to lack of appropriate knowledge, skills and capacities among those who are responsible for managing district health systems and programmes. New and heavy responsibilities are placed on the shoulders of the district who are the main implementers of the national health policies and strategies (Chatora and Tumusiime 2004: xi).

Barron (2000: 3 and 4) points out that the process of implementing and integrating the health system at district level has been slow and inconsistent with some areas reflecting well-functioning health units while other areas have fragmented and poorly coordinated PHC delivery systems. According to Kautzky and Tollman (2008: 23 and 24) inequalities in the coverage and quality of health services; inherent inequities in resource allocation; coupled with

the historical burden of disease indicates that provinces and districts are not at the same level of healthcare delivery.

Meanwhile, the argument raised here is that the success depends on the ability of the district health system to implement primary healthcare services. Policies must be clear and precise. In a decentralised system of public healthcare, a good policy provides the framework for action and provides direction without unduly limiting implementers. In other words, decentralisation means empowering districts to pursue the implementation of nationally determined policies in an autonomous manner. The role of the Ministry of Health is to establish a widely accepted health policy which provides the vision for solving health problems and create uniformity in health development.

In closing, whilst there has been substantial progress in health sector reform, there still exists structural and capacity problems in the DHS. This article has also highlighted the potential burden of the implementation of the NHI. The argument made is that the DHS needs empowering and capacity development in order for it to be able to provide PHC. In addition, it is posited here that the roll-out of the NHI at the district level will furthermore increase the pressure on the DHS.

REFERENCES

1. African National Congress. 1994. *A national health plan for South Africa*. Johannesburg: African National Congress.
2. Barron, P. 2000. The district health system. Progress to date. *Health Systems Trust*. Issue 51, pp. 3–4.
3. Botha, C. and Hendricks, M. 2008. *Financing South Africa's National Health System through National Health Insurance Possibilities and Challenges (Colloquium Proceedings)*. Pretoria: Human Science Research Council Press.
4. Chatora, R. and Tumuaiime, P. 2004. *Health sector reform and district health systems*. Brazzaville: World Health Organisation [Online]. Available at:

<http://www.who.int/management/HealthSectorReformDHS.pdf> Accessed 20 November 2015.

5. Department of Health. 1995. *A policy for the development of a District Health System for South Africa: Executive summary*. South Africa: Government Gazette.
6. Department of Health. 1997. *White paper for the transformation of the health system in South Africa*. South Africa: Government Gazette.
7. Department of health. 2015. *National health insurance for South Africa. Towards universal coverage*. South Africa: Government Gazette.
8. Hunter. J. 2015. *Primary healthcare services within South Africa's district health system*. South Africa: Department of Health.
9. Kautzky, K. and Tollman, S. 2008. A perspective on primary healthcare in South Africa. In: Barron P, (Ed.). *South African Health Review*. Durban: Health Systems Trust [Online]. Available at: <http://www.hst.org.za/uploads/files/sahr2008.pdf> Accessed 05 December 2015.
10. Macdonald, J.J. 2013. *Primary healthcare: Medicine in its place*. London: Routledge Taylor and Francis group.
11. McCoy, D. and Engelbrecht, B. 1999. *South African health review, Briefing summary. Establishing the district health system*. Durban: Health Systems Trust [Online]. Available at: <ftp://gega.org.za/pubs/sahr/1999/summary/bsdhs.pdf> Accessed 11 December 2015.
12. Republic of South Africa. 1996. *The Constitution of the Republic of South Africa (Act No. 108 of 1996)*. Pretoria: Government Gazette.
13. Rispel, L.C., de Jager, P. and Fonn, S. 2015. Exploring corruption in the South African health sector. *Health policy and planning*. Vol. 27(5), pp.1-11.

14. SafeCare Initiative. 2011. *Certificates of improvement: Five steps on the path to accreditation* [Online]. Available at: <http://www.safe-care.org/index.php?page=certificates-of-qualificationn> Accessed 08 December 2015.
15. Savedoff, W.D. and Hussmann, K. 2006. Why are health systems prone to corruption? In Kotalik, J., Rodriguez, D. (Eds.). *Global corruption report of 2006*. London: Pluto Press.
16. The World Bank. 2001. What, Why, and Where? Decentralisation and subnational regional economics. The World Bank Group [Online]. Available at: <http://www1.worldbank.org/publicsector/decentralization/what.htm> Accessed 20 November 2016.
17. Utomo, W. 2009. *Balancing decentralisation and deconcentration: Emerging need for asymmetric decentralisation in the unitary states*. Discussion paper no: 174. Nagoya: Nagoya University Press.
18. UNDP. 1997. *The global research framework of the decentralised governance programme*. New York: United Nations Development Programme.
19. Wolvaardt, G. 2013. *How to fix the district healthcare system: What district managers told us in 2013 about the obstacles and challenges they face?* Annual report 2014/2015, foundation for professional development [Online]. Available at: http://www.foundation.co.za/FPD/about-fpd/PDFs/annual%20reports%20pdfs/AR%202014_2015.pdf Accessed 17 November 2015.
20. World Health Organisation. 1978. *International conference on primary healthcare*. Declaration of Alma Ata: USSR
21. World Health Organisation. 1986. *The challenge of implementation: District health systems for primary healthcare*. Geneva [Online]. Available at: <http://www.ais.up.ac.za/med/pcm870/challenge.PDF> Accessed 17 November 2015.

CHAPTER EIGHT

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This chapter presents the key findings of this study and makes some recommendations on what should be considered when considering how to govern the implementation of national healthcare policies such as the recently approved National Health Insurance policy. The chapter commences by providing a synopsis of the respective research articles that comprise this thesis on the governance of the public healthcare sector in a post-apartheid South Africa.

MAIN FINDINGS OF THE STUDY

The key research objective of this study was to (i) explore and (ii) critically analyse the manner in which the South African public healthcare system is governed. In order to address the main objectives above, the key questions that guided this study were:

- i. How is the public healthcare sector governed in South Africa?
- ii. How was the public health sector governed during apartheid in South Africa?
- iii. What are the governance objectives of public healthcare?
- iv. What was the rationale for reforming the public health sector in South Africa?
- v. What governance approaches have been adopted in the public healthcare sector in South Africa, and how have these been implemented?
- vi. What are the major governance reform outcomes in the public healthcare sector in South Africa?
- vii. How can governance alleviate the challenges facing the public healthcare sector in South Africa?

The first research article, *The Public Healthcare Sector and Governance in South Africa* established the significance of governance for the public healthcare sector in South Africa. The article discussed, in a descriptive manner, the public healthcare mandate of the democratic government. The article established a conceptual summary of the literature on the different

theoretical approaches to governance. The article distinguished between two key approaches namely the traditional bureaucratic model of governance and New Public Management (NPM). The article argued that the strengths of the traditional model of bureaucracy (also referred to as the Weberian Model) were accountability, control and efficiency. Criticism of the traditional model of bureaucracy was that as a form of governance it is top-down, hierarchical, too slow, rigid and unresponsive to change or innovation in the policy domain.

In response to the traditional bureaucratic model, the NPM paradigm emerged. This paradigm called for proposed reforms to the traditional bureaucratic governance approach. NPM favours loosening the structures and systems of the traditional model to allow for more creativity and flexibility in governing in order to achieve more efficient service delivery and better customer service. The article identified strategies of NPM as government becoming customer service-orientated. NPM also calls for professionalism in the public service, increasing the managerial skills of staff and the role of leaders in creating and maintaining high performing public organisations. Decentralised forms of governance is identified as a core component of NPM. However, the article did highlight that in situations where there was a lack of local capacity, decentralisation, in fact, may lead to more centralised decision-making by public managers in public organisations. A second concern highlighted was that the application of private sector management techniques was not always suitable for the public sector. As a result, NPM strategies were open to abuse and corruption.

The key argument made in the article was that while the NPM approach has inherent shortcomings when applied in public sector management, some elements of NPM may be beneficial to selected sectors. The article points to the ongoing relevance of NPM as a governance strategy. It concludes that the manner in which the public healthcare sector in South Africa is governed (whether in a traditional bureaucratic or according to the principles associated with NPM) will have implications for how policy is implemented.

The second research question on the provision of public health services during apartheid was addressed in significant detail in the second article. The article, *The Governance of the Public Health Sector during Apartheid: The case of South Africa* (presented in Chapter Three) provided a historical review of the governance of the public healthcare sector during the apartheid era. The objective of the article was to contextualise the current public healthcare

challenges facing the democratically elected government. In answering the research question, the article demonstrated the vastness of racial discrimination in the provision of public healthcare during apartheid and showed that the apartheid regime set up different governance structures of healthcare in a racially discriminatory manner across South Africa, including the former homelands or Bantustans. One of the apartheid policies forced Black South Africans to live in areas known as Bantustans. These areas were underdeveloped, overcrowded and had no source of revenue. Black leadership was expected to organise their own system of healthcare separate from the apartheid government.

The article identified resultant healthcare disparities between Whites and Blacks. For example, hospitals and clinics for Blacks were often located far from where they resided. Facilities were severely overcrowded and under-resourced. The healthcare system under apartheid not only limited access to healthcare but also created an environment in which abuses such as the refusal of emergency care treatment, denial or limitation of Blacks accessing medical care and treatment occurred frequently. Stark shortages of skilled doctors and nurses became the norm as few Black doctors were permitted into the medical field of study, and Black nurses were denied adequate training opportunities.

The article unveiled how the policies of the apartheid government adopted a highly centralised traditional bureaucratic governance approach. The article also illustrated the apartheid regime's highly centralised governance approach in policy decision-making and implementation which left no room for public participation. As a result, it did not accommodate the needs of the majority of the population, resulting in discriminatory governance practices. This meant that access to quality healthcare services became the domain for the selected few. The article concludes that many features of such disparate institutionalised sites of apartheid service delivery still plague the healthcare system. It argues that the underdevelopment in Bantustan, the quadruple burden of disease (the HIV/AIDS epidemic, TB, high maternal and child mortality rates) as well as high levels of violence and injuries; and a growing burden of non-communicable diseases, constitutes the current government's legacy of apartheid public healthcare.

The third research question asked what the governance objectives are of public healthcare in a post-apartheid South Africa. The third article, Good Governance and the Implementation of

NHI in the Public Health Sector: A case of South Africa (presented in Chapter Four) found that good governance is a recurring theme. The provision of universal access to healthcare within the framework of good governance has been identified by South Africa's democratic government as being its current key healthcare objective. The third article emphasised the widespread reference to good governance in government legislation pertaining to public healthcare and the proposed implementation of the NHI in the public health sector and explored the governance objective of public healthcare. The article considered the relationship between the proposed NHI and the principles of good governance. The article concurred with the literature on good governance insofar as good governance should be aimed at improving public sector service delivery. It argued that, if implemented according to its theoretical premises, good governance, in theory, would result in better public service delivery. Citizen's satisfaction with public healthcare services can be a reality if governance is exercised in a responsible and committed manner.

The article explicated the South African governments' proposed NHI policy and its intent on providing country-wide universal primary healthcare. The article showed that one of the main objectives of the NHI is to eradicate the legacies of the apartheid regime's racially discriminatory public health practices. The article also noted that the proposed NHI subscribes to the principles of good governance. However, how government aims to do so was at the time of writing not yet evident.

The fourth article, Reforming the Health Sector in South Africa (presented in Chapter Five) examined the nature and extent of public sector reforms that have taken place in the health sector since 1994. The article argues that the ANC's macro-economic policy shift from the RDP to GEAR in effect was a transition in governance thinking too. The policy shift signified a transition from a purely state-centred governance approach to a governance approach that includes considering the adoption of market mechanisms in the supply of public services. This resonates with the theoretical premises of the NPM paradigm analysed in the first article (presented in Chapter Two) of this study.

The article reiterated the significance of the public healthcare legacy inherited by the democratically elected government. It emphasised the extent of the public healthcare challenges facing the ANC-led government. For example, it showed how the government inherited a

fragmented, unaccountable and racially divided governance system consisting of different homeland administrations, each with their separate systems of public administration. Moreover, the article brought to the fore the causes of inequalities in health. It also explains the stark racial disparities on: diseases across races, access to health services, (the urban-rural divide), and the divergence in quality of health services in the public health system compared to the private health system. The article analyses, in detail, the broad and extensive government reforms that have been implemented in the public healthcare sector across South Africa in order to address apartheid healthcare legacies. The article has shown that South Africa has made progress in terms of: eradicating apartheid's separate health systems; implementing a national legislative framework that now guarantees all South African citizens' equal rights to healthcare; dismantling racial discriminatory public healthcare facilities; repealing apartheid laws and enshrining a Bill of Rights in the constitution; dissolving the self-governing homelands and re-incorporating the Bantustans into South Africa.

However, the article concludes that despite extensive reforms of the public healthcare sector, policy implementation challenges remain. One of the key challenges is that while race is no longer a determinant of who receives healthcare or not, there is still discrimination on the grounds of class, and that those who benefited under apartheid (Whites) continue to have access to a better quality healthcare under the current government. This has been identified as one of the main governance problems.

The fifth article, *Aligning Strategic Human Resource Management to Human Resources, Performance and Reward* (presented in Chapter Six) discusses the different public management approaches that have been adopted in the public health sector in South Africa, and how these have been implemented. The article is a theoretical exploration of the concept of performance management as a public management strategy approach and examines in what way it can improve public service delivery. Performance management is currently a popular public management strategy in assessing the performance of public sector workers in South Africa. It is a key public management strategy of the NPM approach to governance.

The theoretical arguments considered in the article is whether the implementation of public healthcare policies in South Africa, such as the NHI, can benefit from having a system of performance management. One conclusion is that performance management can foster good

governance. For example, through performance management public servants can be made more accountable for their actions and for the use of public resources. Performance management can be used to promote excellence in governance and promote the delivery of quality services. Performance management strategies can, in principle, bring to the fore poor performing employees, and managers can assist to encourage good or even average workers to perform better, thereby enhancing organisational efficiency and effectiveness.

The last research question of this study aimed to establish the outcomes to date of the reforms in the public healthcare sector. The last article, *The District Health System and National Health Insurance in South Africa* traced the origins of the DHS and concludes that the creation of a DHS is by far the most complex system of public sector healthcare reform set up to date. The article brought to the fore that the public healthcare sector in South Africa has undergone some formidable reforms since 1994. This study found that the establishment of a country-wide district health system (DHS) was one of the most fundamental outcomes of South Africa's public healthcare reform process.

The article highlighted both achievements and challenges. For example, the article demonstrated that South Africa has successfully established a policy framework for the provision of public healthcare. Some of the key policy documents are the National Health Act (No.61 of 2003), which provides a framework for a single health system for South Africa and obliges each sphere of government to provide for basic healthcare rights. In the process, apartheid institutions and discriminatory measures have largely been dismantled and replaced by a decentralised system of public healthcare in an attempt to make access to public healthcare equitable and affordable to all.

However, the article showed that the district health management system is plagued by low staff morale; a lack of leadership; indecision; capacity deficiencies of many local governments and power struggles among interest groups. Such challenges are brought to the fore as data on the status of health show that the burden of disease and failures in effective planning for meeting health needs in the country remains a challenge. The article argued that these conditions limit the functioning of the DHS. The article considered some of these concerns with particular reference to the NHI since the DHS is recognised as the fundamental building block of South Africa's unified health system. The article noted that the NHI is still in its infancy stage, and

that one cannot predict its outcome. However, it is posited here that the NHI cannot succeed unless the issues facing the DHS are resolved.

CONCLUSION AND RECOMMENDATIONS

This study concludes that the public healthcare system in South Africa has undergone fundamental and comprehensive changes since 1994. There is now a solid constitutional and legislative policy framework in place aimed at improving quality, equitable access, efficiency and effectiveness in the health system. This framework upholds the principles of good governance namely: i) right to access healthcare, ii) social solidarity, iii) equity, iv) healthcare as a public good, v) affordability and vi) efficiency. It demands that public services are provided to citizens in an equitable and efficient manner.

My study identifies a number of key issues facing the South African public health sector and makes a number of recommendations.

- The literature identifies the concept of equity as being a fundamental principle of primary healthcare. Equity here means that health should be for all people and not just for the few that can afford it. This study found that health inequities still exist in South Africa. Health inequities exist when there are inequalities in health status, risk factors of health service utilisation between individuals or groups that are unnecessary, avoidable and unfair. Inequity in health is also evident in South Africa's ongoing two-tiered healthcare system where a mal-distribution of key health professionals between the public and private health sectors exist. The scarce health professionals naturally migrate towards the private healthcare system which is better resourced financially. Despite attempts to achieve equity (for example, since 1996 more than 44,000 health professionals have been deployed for community service especially in rural and underserved areas. In addition, a large number of doctors were recruited from Cuba to further expand coverage to these underserved areas. In subsequent years more doctors were also recruited from countries such as Iran and Tunisia. Nursing remains the backbone of the South African health system. A PHC category for nursing was introduced to support the PHC system. From 2009 to 2013, the number of nurses trained

on Nurse Initiated Management of Anti-Retroviral Therapy (NIMART) increased from 250 to 23, 000 (NHI White Paper 2015: 5-6). Nevertheless, this remains inadequate.

The shortage of key health professionals remains in part because South Africa continues to experience growth in the size of the population that is dependent on public health services; increased patient visits in the public sector; the increasing burden of ill-health among the population primarily due to the HIV/AIDS and TB epidemic and non-communicable diseases. This will continue to place a strain on public sector health services and on staff who work in public health facilities (NHI White Paper 2015: 15).

This study acknowledges that increasing human resources for health is a key component to promoting health equity. As such, it is recommended that private health practitioners render their services (be it on a contractual basis) aimed at improving health equity and reducing the burden of disease. The provision of healthcare needs to become a more collaborative governance endeavour which includes the private sector, non-profit organisations and individuals to provide for certain specialist healthcare services. It is also recommended that more incentives for attracting private health professionals to work in rural and hard-to-reach areas are necessary as part of broadening access to quality services in these areas. This will require a multi-sectoral approach to providing basic social infrastructure and amenities. Apart from this, the public health sector must consider expanding the platforms for international collaboration such as with the Mandela-Castro Collaboration Programme in Cuba. Healthcare professionals working in the private sector must also be engaged through contractual arrangements to contribute to addressing the human resources gap. In addition, medical schools can be supported to increase their intake of students as part of broader human resources for health production strategy. Moreover, the process of strengthening nursing colleges as the primary training platform is essential. This is necessary to reverse the trend that started in 1987 which has undermined nursing colleges through a policy which favoured universities as primary training platforms, resulting in disinvestment in nursing colleges. In collaboration with the Department of Higher Education and Training, provision of scholarships for health science students must be increased and post-graduate training and specialisation must be supported. This study found general government mistrust of the private sector in South Africa. The success of the country's

NHI for example, will ultimately depend on all the stakeholders involved. The NHI cannot be achieved and delivered by government alone, but requires a joint, collaborative approach by public, private and non-governmental sectors together with citizen participation and involvement.

- A major characteristic of the South African health system is its dual configuration. One is a public healthcare system, serving the poor; the other a private healthcare system, serving the rich. This fragmentation results in two distinct pools of funding. The effect of fragmentation is that a majority of South Africans, particularly the unemployed and the poor, are not provided with adequate financial risk protection from catastrophic health expenditure and their health needs are not adequately met. Fragmentation is also a key driver of inequality and contributes to inequality in the distribution of health benefits (NHI White Paper 2015: 15). The implementation of NHI will result in growth in public health financing. The impact of tax allocations on individuals and families will vary, however, a key question concerning how the government will meet health expenditure as the phased implementation of NHI progresses is of concern.

One of the recommendations which is not necessarily new but still needs to be reiterated is that the tax system must impose obligations on all residents or qualifying taxpayers in proportion to their ability to contribute to the fund. The high levels of income inequalities in South Africa require that a progressive tax system be maintained. In addition, economic growth is needed to ensure an expansion of the tax base, and if tax revenue is re-channelled into the economy in the form of productive public expenditure, it will support and stimulate growth. An efficient and cost-effective health sector will lead to improved health outcomes that will improve productivity and enhance economic growth. In order for taxes to play a role in promoting economic growth, revenues need to be collected, allocated and spent in an efficient manner. NHI requires the establishment of strong governance mechanisms and as such it is recommended that improved accountability for the use of allocated funds be employed. Given the high unemployment rate in South Africa, the NHI budget should be tightly controlled, because there is a possibility that it may collapse due to lack of finances, as affordability of this insurance has been a major challenge in the past.

- One of the most prominent factors identified in this study that contributes to the poor delivery of public healthcare in South Africa is inappropriate, weak or poor management. The management of public healthcare facilities, such as hospitals, has been characterised by over-centralisation, with hospital managers having almost no authority to manage their own institutions. Instead hospitals are simply administered by provincial health department head offices, rather than being actively managed at facility level. This has led to the consistent under-development of management systems and capacity at hospital level and the demoralisation of hospital managers. This is further exacerbated by poor remuneration, limited training and support and inadequate career paths for managers. Over-centralisation has also undermined the legitimacy and functioning of Hospital Boards, diminishing public accountability and trust in the hospital system.

This study recommends that in order to strengthen management capacity through improving managers' skills and upgrading information systems, managers must be empowered to delegate greater management responsibilities to the district level so that the necessary decisions related to service delivery can be made and managers held accountable for their performance. In order to improve accountability, quality of health services, performance and effectiveness, managers must be provided with more decision-making space in management domains. This must include delegations on the management of human resources; finance and supply chain/procurement; areas of facility management; cost centre management and maintenance of essential equipment and infrastructure. It is also recommended that health managers have a health management qualification for continuous professional development. Therefore, monitoring and evaluating the performance of managers must be a priority in guiding the transformation of the public health sector into an effective organisation that delivers on the objectives of government. In an effort to ensure sound governance, monitoring and evaluation must ensure that democratic ideals are practiced and provide credible and useful information to decision makers and stakeholders on policy, programmes and projects. In other words, decentralisation must be accompanied with capacity, accountability and adequate autonomy.

- Another problem that remains is the burden of disease. South Africa is faced with a quadruple burden of disease such as HIV and AIDS and TB; maternal and child mortality; non-communicable diseases such as hypertension and cardiovascular diseases, diabetes, cancer, mental illness, chronic lung diseases such as asthma; as well as injury and trauma. HIV/AIDS and TB have significantly contributed the most to the quadruple burden of disease. The WHO Global TB Report of 2012, estimates that South Africa has the third highest TB incidence rate and the second highest Multiple-Drug Resistant (MDR) TB incidence globally.

Maternal and child mortality still contributes significantly to overall mortality even though the specific contributions to overall mortality have decreased over time. According to Dorrington, Bradshaw, Laubscher and Nannan (2015) the Maternal Mortality Ratio (MMR) rose from 281 per 100 000 live births in 2008 to peak at 302 per 100 000 live births in 2009 before dropping significantly to 155 per 100 000 live births in 2013. The under-5 Mortality (U5MR) rate has reduced from 56 deaths per 1 000 live births in 2009 to 41 deaths per 1 000 live births in 2013. Violence and injury also contribute significantly to the burden of disease. South Africa has an injury rate of 158 per 100 000. The most recent South African Burden of Disease data indicates that road traffic accidents and interpersonal violence are the leading causes of Years of Life Lost (YLL).

It is recommended that multi-sectoral collaboration and cooperative governance between stakeholders from government and non-government sectors address the risk factors that contribute to the HIV/AIDS epidemic, maternal and child mortality as well as violence and injury. The move towards National Health Insurance must therefore be informed by a deliberate effort to eliminate this fragmentation from the health system. A well implemented NHI could contribute significantly to improved life expectancy. Economic impact assessments indicate that the NHI can have positive impacts in the long-run in improving the health indicators of the country, including significant improvement in life expectancy and child mortality. It is recommended that public health be placed on the socio-economic development agenda as this ensures that the public health perspective is recognised as being key to poverty reduction. Poverty leads to ill-health, and ill-health spreads poverty. Good health is crucial to protect the family

for instance from poverty, so health is central to poverty reduction. It is important to view this bidirectional relationship between ill-health and poverty as equally important in breaking the vicious cycle of ill-health and poverty.

It is paradoxical that the recent increase in life expectancy and reduction in mortality rates cannot be sustained under the present healthcare system that is mainly curative, fragmented and unaffordable. The high burden of disease, mal-distribution and inadequate human resources as well as the poorly financed health system has contributed to the inability of the health system to maintain the above gains on a sustained basis.

Governance of the public health sector in South Africa has shown to be complex. In large part because of the apartheid healthcare legacy it inherited. In addition, South Africa's healthcare system has been totally restructured. It is now comprised of different governance structures at different levels of government. Healthcare is provided at national, provincial, and local levels of government – each providing different levels of care, and each tasked with different administrative functions. For example, the National Department of Health is responsible for developing national health policy, norms and standards, and overseeing implementation. Three tiers of hospitals exist (namely tertiary, regional and district); a primary healthcare system (at local government level through primary healthcare facilities responsible for preventative and curative services); and a private health system (consisting of general practitioners and private hospitals, with care in the private hospitals mostly funded through medical schemes). These different permutations emphasise the need for establishing meaningful governance systems and structures that can assist with the implementation of health policies. This study argues that government cannot and should not do this on its own. This study has shown that South Africa has a solid legislative public healthcare framework and that adequate structures for public healthcare are in place (although there is room for these to be better equipped, funded and staffed). This study concludes that the provision of equitable public healthcare in South Africa is affected by governance. Governance in South Africa is currently too state-centred, and policies such as the NHI will require government to adopt a wider definition of governance.

CONCLUDING STATEMENT

The current limitations facing the government of South Africa in the provisions of public healthcare services can be alleviated if the government adopts a concerted approach to governance. According to Sharma (2007) the term governance covers all those aspects of the way a country is governed. Governance is a multidimensional concept which consists of political, economic and socio-cultural elements. Governance as such, is understood as encompassing “the implementation of economic, political and administrative authority to direct the affairs of a country at all levels. It encompasses the mechanisms, procedures and establishments through which citizens and groups express their interests’, exercise their legal rights, meet their obligations and mediate their differences”. (UNDP, 2002: 66).

This may, as Fukuyama (2013: 49) stresses, include “procedural measures, such as Weberian criteria of the bureaucratic modernity; capacity measures, which includes both resources and degree of professionalisation; output measures and measures for bureaucratic autonomy”.

However, as Stockemer (2014: 179-180) argues, governance is also the process through which political authority is exercised and political decisions are made and implemented. The important point to note is that the concept, governance, includes many facets that combine the public with the private sector, from public institutions, which set the legal framework of all actions, to public servants, who determine the allocation of resources, to bureaucracies that ensure the provision of public goods and services.

In a liberal democracy, it is important that a culture of good governance is imposed and inculcated. (Diamond, 1999). The study supports Turner’s (2011) argument that governance is a primary element for prosperous development, in any country, in particular good governance for attaining better economic growth and human development. Kaufmann, Kraay, and Mastruzzi (2010: 2) describe the term governance as “the traditions and institutions by which authority in a country is exercised. Governance includes a) the process by which governments are selected, monitored and replaced; b) the capacity of the government to effectively formulate and implement sound policies and c) the respect of citizens and the state for the institutions that govern economic and social interactions among them”. In its legislative framework South

Africa makes provisions for good governance. However, there remains a large vacuum in most of South Africa's traditions and institutions of good governance.

It is the ultimate argument of this study that, given South Africa's political and socio-economic history, as well as ongoing limited resources - governance is fundamental to the provision of public healthcare in South Africa.

REFERENCES

Primary reference

1. Brauns, M. 2012. *Healthcare reform and service delivery in the public health sector: A case study of Montebello Hospital*. Durban University of Technology (Masters in Public Management).

Secondary references

1. African National Congress. 1994. *A national health plan for South Africa*. Johannesburg: African National Congress.
2. Department of health. 2015. *National health insurance for South Africa. Towards universal coverage*. South Africa: Government Gazette.
3. Diamond, L. 1999. Diamond, Larry. 1999. *Developing Democracy: Toward Consolidation*. Baltimore: The Johns Hopkins University Press.
4. Econex. 2015. *Identifying the determinants of and solutions to the shortage of doctors in South Africa: Is there a role for the private sector in medical education?* [Online]. Available at: http://www.econex.co.za/wp-content/uploads/2015/08/ECONEX_Doctor-shortages-and-training_FINAL.pdf
Accessed 27 January 2016.

5. Fatemi, M. and Behmanesh, R. 2012. New public management approach and accountability. *International journal of management, Economics and social science*. Vol. 1(2), pp. 42-49 [Online]. Available at: <http://www.ijmess.com/volumes/volume-I-2012/issue-II-12-2012/full-3.pdf> Accessed 17 November 2015.
6. Fukuyama, F. 2013. *What is governance? A working paper 314, January 2013*. Washington: Center for global development [Online]. Available at: http://www.cgdev.org/files/1426906_file_Fukuyama_What_Is_Governance.pdf Accessed 21 June 2015.
7. Gaede, B. and Versteeg, M. 2011. *The state of the right to health in South Africa*. Durban: Health systems trust [Online]. Available at: <http://www.hst.org.za/sites/default/files/Chap%209%20State%20of%20right%20Rural%20Health%20pgs%2099-106.pdf> Accessed 27 August 2015.
8. Hill, M. and Hupe, P. 2002. *Implementing public policy: Governance in theory and in practice*. London: Sage Publications.
9. Hogwood, B.W. and Gunn, L.A. 1984. *Policy analysis for the real world*. London: Oxford University Press.
10. Jobson, M 2015. *Structure of the health system in South Africa*. Johannesburg: Khulumani support group.
11. Kaufmann, D., Kray, A. and Mastruzzi, M. 2009. *Governance Matters VIII: Governance indicators for 1996-2008*, World Bank Policy Research Working Paper No. 4978 [Online]. Available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1682130 Accessed 02 September 2014.
12. Laxmikanth, M. 2006. *Public administration, for the UPSC civil services preliminary examination*. New Delhi: Tata McGraw Hill Publishing Company Limited

13. Maurice. J. 2014. South Africa's battle against HIV/AIDS gains momentum. *The Lancet*. Vol 393(9928), pp. 1535-1536.
14. Naidu. 1996. Naidu, S.P. 1996. *Public administration: Concepts and theories*. New Delhi, New Age International Publishers [Online]. Available at: <https://books.google.co.za/books?id=GWrZhzdhPfoC&pg=PR3&dq=Naisu,+s.p.+1996.+publicadministrartion&hl=en&sa=X&ved=0ahUKEwi-1bKMherKAhVEfxoKHcSDBokQ6AEIGjAA#v=onepage&q=Naisu%2C%20s.p.%201996.%20publicadministrartion&f=false> Accessed 19 December 2015.
15. National Health Facilities Baseline Audit. 2012.
16. National Treasury Budget Review. 2012. *Local government budgets and expenditure review, 2006/07–2012/13*:Pretoria: National treasury.
17. Phillip, D.D. and Daganda. A.T. 2013. New public management and public sector administration in Nigeria. *International affairs and global strategy*. Vol. 14, pp. 9-16
18. Dorrington, R., Bradshaw, D., Laubscher, R. and Nannan, N. 2015. *Rapid Mortality Surveillance Report 2014*. Burden of disease research unit, medical research council. Cape Town: University of Cape Town Press [Online]. Available at: <http://www.mrc.ac.za/bod/RapidMortalitySurveillanceReport2014.pdf> Accessed 27 December 2015.
19. Republic of South Africa. 1996. *The Constitution of the Republic of South Africa (Act No. 108 of 1996)*. Pretoria: Government Gazette.
20. Robbins, G and Lapsky, I. 2005. NPM and the Irish public sector: From reluctant reformer to statutory codification. In Guthrie, J., Humphrey, C., Jones, L.T and Olson, O. (Eds.). *Debating public sector financial management reforms: An international study*. New York: Information Age Publishing Inc. [Online]. Available at: <http://books.google.co.za/books?id=-qowgK38fWQC&pg=PA111&dq=new+public+management+came+about+as+a+resu+lt+of&hl=en&sa=X&ei=Nht0VJL0C4LXyQOPooHwDg&ved=0CCoQ6wEwAQ#v=>

[onepage&q=new%20public%20management%20came%20about%20as%20a%20result%20of&f=false](#) Accessed 25 November 2014.

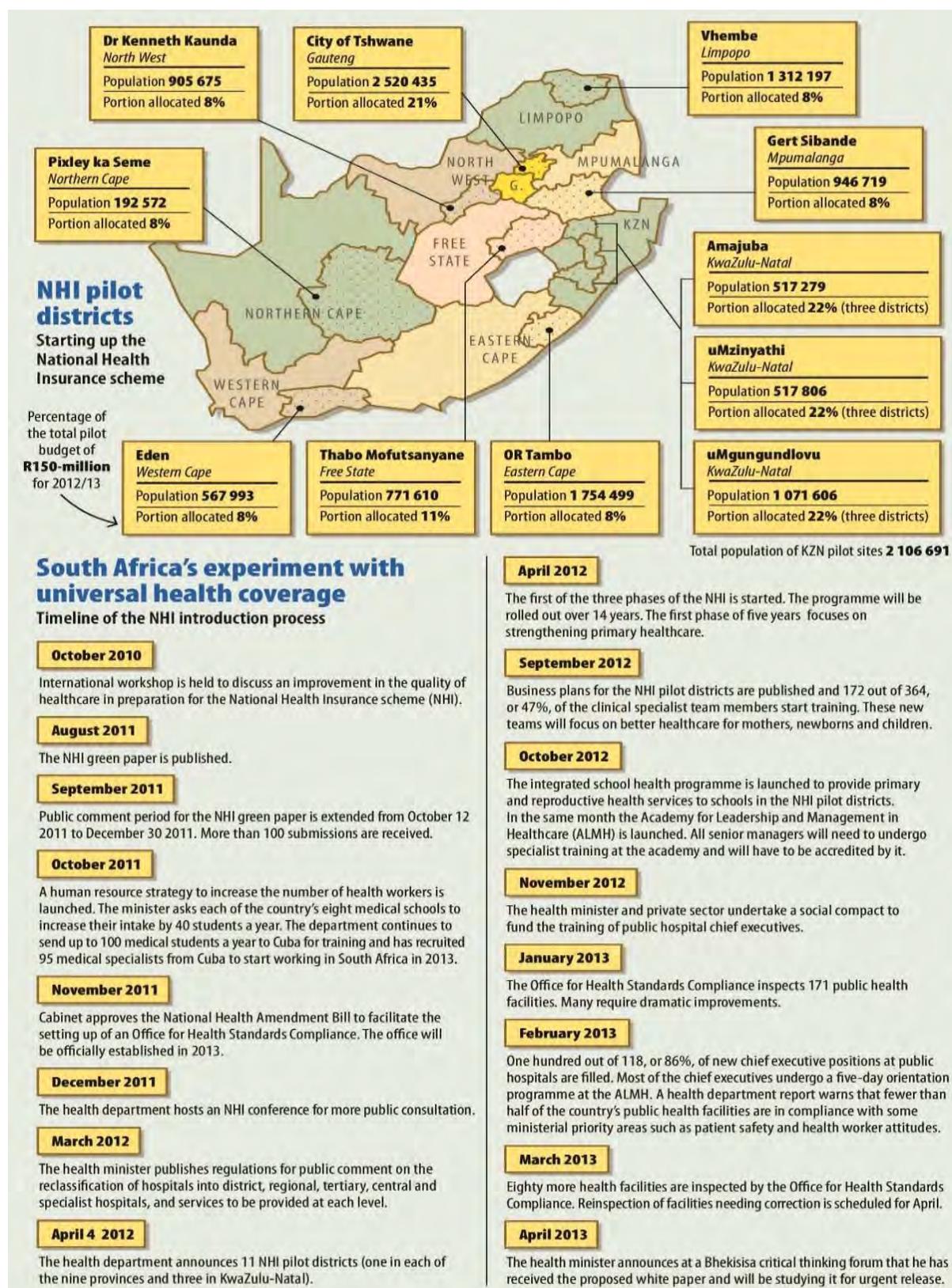
21. Schaay, N., Sanders, D. and Kruger, V. 2011. *Overview of health sector reforms in South Africa*. London: Human development resource centre, department for international development [Online]. Available at: http://www.heart-resources.org/wp-content/uploads/2014/06/OVERVIEW_OF_HEALTH_SECTOR_REFORMS_IN_SOUTH_AFRICA.pdf Accessed 19 December 2015.
22. Shajahan, S. 2014. *Business research methods*. Mumbai, Jaico Publishing [Online]. Available at: <https://books.google.co.za/books?id=UIJ7AgAAQBAJ&pg=PT247&dq=desktop+research+as+research+methodology&hl=en&sa=X&ved=0ahUKEwj4mL6XlcLJAhUBtBoKHcNYDrE4FBD0AQhRMAg#v=onepage&q=desktop%20research%20as%20research%20methodology&f=false> Accessed 03 December 2015.
23. Sharma K. C. (2007) *Global trends in new public management: Challenges and constraints confronted by developing countries in administrative change*. Vol. XXXIV No.2 & Vol. XXXV No.1, January- December, 2007, pg.20 – 40.
24. Stein, T.J. 2001. *Social Policy and Policymaking: By the branches of government and by the public at large*. New York: Columbia University Press [online]. Available at <http://books.google.co.za/books?id=qz5jCFoQJpwC&pg=PA36&dq=who+would+more+efficiently+provide+health+services+-+the+public+of+private+sector&hl=en&sa=X&ei=y3g5Ut-9GILj4QTt34CoDw&ved=0CDMQ6AEwAQ#v=onepage&q=who%20would%20more%20efficiently%20provide%20health%20services%20-%20the%20public%20of%20private%20sector&f=false> Accessed 18 September 2013.
25. Stillman, R.J. 2010. *Public Administration: Concepts and Cases*. Boston: Wadsworth Cengage Learning [online]. Available at:

<http://books.google.co.za/books?id=Q97BVAOxFvMC&pg=PA53&dq=criticism+of+weber's+bureaucratic+model&hl=en&sa=X&ei=Iyo4Uq2pEMem4AT28oDgBw&ved=0CD0Q6AEwAw#v=onepage&q=criticism%20of%20weber's%20bureaucratic%20model&f=false> Accessed 17 September 2013.

26. Stockemer, D. 2014. Regime type and good governance in low and high income states: What is the empirical link? *Democratisation*. Vol. 21, pp. 179-193.
27. Turner, K. 2011. The importance of good governance in achieving economic growth for developing nations: An analysis of Sub-Saharan Africa. *Bryant Economic Research Paper*. Vol. 4(4).
28. UNAIDS. 2014. *Report on the global AIDS pandemic*. Geneva: United Nations joint programme on HIV/AIDS (UNAIDS).
29. UNDP. 2002. *Human development report 2002: Deepening democracy in a fragmented world*. New York: Oxford University Press [Online]. Available at: http://hdr.undp.org/sites/default/files/reports/263/hdr_2002_en_complete.pdf Accessed 02 July 2015.
30. Van Thiel, S. 2014. *Research methods in public administration and public management: An introduction*. London, Routledge Taylor and Francis group [Online]. Available at: <https://books.google.co.za/books?id=RLwTAwAAQBAJ&pg=PA106&dq=the+reasons+for+using+desktop+research+as+research+methodology+were...&hl=en&sa=X&ved=0ahUKEwjZmM3KqcLJAhWGPhQKHWypDHgQ6AEINDAC#v=onepage&q=the%20reasons%20for%20using%20desktop%20research%20as%20research%20methodology%20were...&f=false> Accessed 03 December 2015.
31. World Bank. 2015. *Mortality rate indicators*. United Nations interagency group [Online]. Available at: <http://data.worldbank.org/indicator/SH.DYN.MORT> Accessed 19 February 2016.

32. World Health Organisation. 2012. *Global TB Report*. Geneva: World Health Organisation Press [Online]. Available at: http://apps.who.int/iris/bitstream/10665/75938/1/9789241564502_eng.pdf Accessed 12 December 2015.
33. Zhang, M. 2007. Administrative reforms in China: Globalisation or localisation? In Farazmand, A. and Pinkowski, J. (Eds.). *Handbook of globalisation, governance and public administration* [Online]. Available at: <https://books.google.co.za/books?id=4GzLBQAAQBAJ&printsec=frontcover&dq=Zhang+Administrative+reforms+in+China+Farazmand+and+Pinkowski&hl=en&sa=X&ved=0ahUKEwjTotyigurKAhVFOxoKHbSWAWwQ6AEIHjAB#v=onepage&q=Zhang%20Administrative%20reforms%20in%20China%20Farazmand%20and%20Pinkowski&f=false> Accessed 11 November 2015.

ANNEXURE 1: Pilot Districts and the Timeline of the NHI introduction process



Source: NHI spending report, ministerial speech, 2012