

REFORMING THE HEALTH SECTOR IN SOUTH AFRICA – POST 1994

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Abstract

This article reviews the efforts of the South African government in recognising development challenges of the post-apartheid era and assesses the approaches employed to bring about economic growth and to address inherited inequalities.

Keywords: Reform, Democracy, Governance, Inequality

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1 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 precepts 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.

2 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.

According to Chikulo (2003) 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.

2.1 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).

2.2 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).

2.3 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. It 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).

3 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 it 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).

3.1 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).

3.2 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. Wade, 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.

According to Mhone and Edigheji (2003: 125) 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 lead 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.

According to the De Beer and Broomberg (1990: 119) 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.

4 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.

According to the twenty year review of South Africa 1994-2014 (2014: 20) 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 & 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).

4.1 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).

According to Ngwenya (2006: 81) 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 health care 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 health care 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 ANCs

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.

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