THE RIGHT OF ACCESS TO HEALTH CARE SERVICES AND THE QUALITY OF CARE AFFORDED TO RURAL COMMUNITIES IN SOUTH AFRICA WITHIN THE CONFINES OF THE STATE'S RESOURCES.

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THIS DISSERTATION IS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE MASTERS IN PUBLIC HEALTH LAW IN THE SCHOOL OF LAW, FACULTY OF LAW, ECONOMICS AND MANAGEMENT AT THE UNIVERSITY OF DURBAN-WESTVILLE.

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DECLARATION

The Registrar (Academic)
UNIVERSITY OF DURBAN WESTVILLE

Dear Sir

I Nondumiso Beatrice Khumalo

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Hereby declare that the mini dissertation entitled:
" The right of access to health care services and the quality of care afforded to rural communities in South Africa within the confines of the state's resources"
is a result of my own investigation and research and that it has not been submitted in part or in full for any other degree or to any other University.

.....NBKhumalo..... .....19/03/02.....

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INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

In contrasting the right of access to health care as envisaged in the White Paper for the Transformation of the Health System in South Africa[1] with that of the White Paper on Transforming Public Service Delivery: *Batho Pele* (People First),[2] one notes that the criteria for reprioritization developed by the Department of Health is that services must be accessible to the majority of the population with focus on the most vulnerable groups, especially women and children, the rural, peri urban and urban poor.

Activities should have maximum impact on the health status of the entire population (with the emphasis on women and children) based on cost effective interventions targeting those areas with the highest infant and maternal mortality. Services should be comprehensive and be provided in an integrated manner. The probability of success, acceptability and participation by communities should be taken into account.[3]

About 75% of the South African population consists of people from a disadvantaged background. Three quarters of rural South Africans live below the poverty line compared to a third of their urban counterparts with the average income of rural adults being R137 per month against R363 in urban areas per month. About 56% of the rural population live 5 km away from a health facility as compared to the 13% of their urban counterparts.[4]

Infant Mortality Rate (IMR) of rural South Africa is 1.6 times higher than that of urban South Africans. Rural children are 77% more likely to have malnutrition, underweight and be stunned for age. Countries which spend less on health care than South Africa have better health status for their citizens.[5]

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[1] White Paper for the Transformation of the Health System in South Africa (1997) at 47
[2] White Paper on Transforming Public Service Delivery : *Batho Pele* - People First (1997) at 3
[3] *Ibid.*
[4] A Boulle , *Rural Health Care and Rural Poverty - Inextricably linked* (1997) at 2
[5] *Ibid.*

When looking at rural health care one realises that poor health conditions are more prevalent in rural areas and there is a high level of infectious diseases (for example malaria, HIV /AIDS, TB etc). Rural practitioners (both doctors and nurses) are dealing with a full spectrum of health problems everyday, with limited resources at their disposal compared to their counterparts in urban and metropolitan areas.

The limited number of qualified medical practitioners in rural areas also affects service delivery in these places. There are few rural hospitals that enjoy the luxury of anything approaching a maximum health team including doctors, nurses, therapists, dentists, laboratory technicians, and radiographers. A shortage of professional nurses results in staff nurses working under stressful circumstance such as the running of theatres and outpatient departments for which they are not trained.

1.2 BACKGROUND OF *BATHO PELE* (PEOPLE FIRST) PROGRAM

The introduction of the new South African constitution in 1996 came along with transformation in different government departments in relation to the delivery of public resources.[6] This transformation was geared towards a better life for all especially the historically disadvantaged sectors of the society. The introduction of the transformation in public service delivery: *Batho Pele* (People First) program was a strategy to ensure that health service delivery was equitable and efficient throughout South Africa (SA). According to the *Batho Pele* program, access to decent public service was no longer seen as a privilege to be enjoyed by few, but as a rightful expectation of all citizens especially those who were previously disadvantaged.[7]

The adoption of the White Paper on the Transformation of the Public Service Delivery came up with a new policy framework defining the role of the public service with an emphasis on a public service, which is:

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[6] National Conference on Public Service Delivery (1997) at www.gov.za
[7] *Ibid.*

- more responsible and relevant to the needs of the citizens ,
- more efficient and effective in the usage of public resources,
- more representative of the diversity and the needs of all especially the most disadvantaged sectors of the society .

One of the prime aims of *Batho Pele* is to provide a framework for making decisions about delivering public services to many South Africans who were and still are denied access to them, within the parameters of the government's Growth, Employment and Redistribution Macro Economic Strategy (GEAR). *Batho Pele* also aims to rectify the inequalities of the distribution in existing services. All national and provincial departments are required to specify and set targets for progressively increasing access to their services for those who have not previously received them. In setting these targets, institutions that promote the interests of previously disadvantaged groups, such as the Gender Commission, and groups representing the disabled should be consulted.[8]

The purpose of *Batho Pele* is to provide a policy framework and a practical implementation strategy for the transformation of public service delivery. The White Paper on *Batho Pele* is primarily about how public services are provided, and specifically about improving the efficiency and effectiveness of the way in which services are delivered. It is not about what services are to be provided, their volume level and quality, which is a matter for Ministers, members of the executive Councils (MEC'S), other executing authorities and the duly appointed heads of government institutions.

One significant factor affecting access to health is geography. Many people who live in remote areas have to travel long distances to avail themselves of public services. National and provincial departments must develop strategies to eliminate the disadvantage of distance when drawing up their service delivery programmes so that resources are drawn closer to those in greatest need. Lack of infrastructure is another significant factor, which exacerbates the difficulty of communication and transportation to remote areas. Service delivery programmes should therefore specifically address the disadvantages that relate to

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[8] *Supra* (note 2) at 4

access to health services. According to the White Paper on Transforming Public Service Delivery the following are the *Batho Pele* principles:

(a) Consultation: citizens should be consulted about the level, and quality of the public services they receive and wherever possible, should be given a choice about the services that are offered.

(b) Service standards: citizens should be told what level and quality of public services they receive so that they are aware of what to expect.

(c) Access: all citizens should have access to the services to which they are entitled.

(d) Courtesy: citizens should be treated with courtesy and consideration.

(e) Openness and transparency: citizens should be told how national and provincial departments are run, how much they cost, and who is in charge.

(f) Redress: if the promised standard of services is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response.

(g) Information: citizens should be given full, accurate information about the public services that they are entitled to receive.

(h) Value for money: public service should be provided economically and efficiently in order to give citizens the best possible value for money.

In focusing on accelerating quality health service delivery, the Department of Health's Strategic Framework[9] has the following ten-point plan:

- Decreasing morbidity and mortality rates through strategic interventions;
- Improving quality of care;
- Speeding up delivery of an essential package of services through the district health system;
- Revitalization of hospital services;
- Improving resource mobilisation and the management of resources without neglecting the attainment of equity in resource allocation;
- Improving human resource development and management;

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[9] Health Sector Strategic Framework 2000-2004 : *Accelerating Quality Health Service Delivery*, www.hst.org.za

- Reorganization of certain support services;
- Legislative reform;
- Improving communication and consultation within the health system and the communities served ; and
- Strengthening co-operation with partners internationally.

Within the context of accelerating quality health service delivery in the period 2000-2004, the mission of the Department of Health is to consolidate and build on the achievements of the past five years in improving access to health care for all and reducing inequality. The department also aims to focus on working in partnership with other stakeholders to improve the quality of care to all levels of the health system, especially preventive and promotive health and to improve the overall efficiency of the health care delivery system.[10]

1.3 THE RIGHT TO HEALTH CARE IN SOUTH AFRICA

The right of access to health care is set out in section 27 of the constitution of the Republic of South Africa.[11] This section provides as follows:

27 (1) Every one has a right to have access to –

(a) Health care services, including reproductive health care;

(b) Sufficient food and water; and

(c) Social security, including, if they are unable to support themselves and their dependants the right to social assistance.

However in the case of *Soobramoney v Minister of Health Kwazulu Natal*,[12] the Constitutional Court said the following in respect of access to health care, within the South African context and lack of resources:

> "...the great disparities in wealth, poverty and the consequences of apartheid have far-reaching implications for public health and access to health care. Access to specific health treatment also had to be within the context of the health needs of others".[13]

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[10] *Ibid.*
[11] Act 108 of 1996
[12] 1998 1 SA 430 (D)

In the *Soobramoney case,* the appellant a 41 year old diabetic suffering from ischaemic heart disease, cerebrovascular disease and irreversible chronic renal failure could not receive regular renal dialysis to prolong his life. He did not receive this type of treatment because he did not meet the guidelines set out in the hospital for dialysis treatment. These guidelines were set out in the hospital because of the high demand of dialysis treatment and the shortage of dialysis machines. His right to access to health care services was therefore violated.

It was argued that adopting a holistic approach to the larger needs of society meant that one could not at times focus on the specific needs of particular individuals in society. It was also noted that the rights created in the Bill of Rights are not absolute and without limitation. Combrink J expressed the view that rights are limited by section 36 (1), by the rights of others and also where others enjoy the same right and are competing for recognition of such right.[14]

Sachs J noted that the absence of principled criteria for regulating access to public medical resources is open to more challenges than the existence and application of such criteria. Any patient having no prospect of recovering like Soobramoney requesting the form of treatment that he did (dialysis) is precluded from treatment. The preclusion is based on guidelines that are there to ensure that more patients benefited from the treatment. If every person was admitted for treatment this could cause a serious problem for the government and for the people who meet the criteria.[15]

It is worth noting that in refusing Soobramoney treatment the Constitutional Court took into consideration the situation of other people who required the same treatment and adhered to the specified guidelines. Noting the Constitutional right of access to health, Madala J posed a question whether everyone in the context of scarce resources could realize the right to health. For Chakalson P the lack of resources was the context (a) for the ambit within which section 27 had to be interpreted and (b) wherein access to health

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[13] *Ibid.*
[14] *Ibid* at 435
[15] S Nadasen , *Public Health Law in South Africa : An Introduction* (2000) at 81

services had to be situated against the needs of others of access to housing, food, water, employment opportunities and social security. When Soobramoney based his claims on section 11 (right to life), Chaskalson P argued that this would substantially increase the difficulty of the state to provide health care to everyone within its available resources.[16]

In the case of *Azanian Peoples Organization (AZAPO) v President of the Republic of South-Africa*[17] the following was said in respect to resources:

> "...the resources of the state have to be deployed imaginatively, wisely, efficiently and equitably to facilitate the reconstruction process in a manner which best brings relief and hope to the widest sections of the community, developing for the benefit of the entire nation the latent human potential and resources of every person who has directly or indirectly been burden with the heritage of the shame and the pain of our racist past".[18]

It was also pointed out in the *AZAPO* case that, difficult choices had to be made by the negotiators for a new dispensation in South Africa. Hard choices had to be made as far as limited resources were concerned between giving preference to delictual claims of persons who had suffered from acts of murder, torture or assault perpetrated by servants of the state with the need for resources in the crucial areas of education, housing and primary health care.[19]

In the cases of *Soobramoney v Minister of Health Kwa-Zulu Natal*[20] and *B v Minister of Correctional Services*[21] it was clear that the right to health (section 27) as envisaged in the constitution is not as easily accessible to everyone as the constitution states that it is. Section 27 is open to different interpretations. Access to health care services largely depends on the resources available and the guidelines that are followed to determine who gets what form of treatment based on limited resources that the government has.

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[16] *Supra* (note 12) at 171
[17] 1996 8 BCLR 1015 (CC)
[18] 1038F-G.
[19] *Supra* (note 12) at 435
[20] *Supra* (note12) at 438
[21] 1997 6 BCLR 789 (C)

The White Paper on Transforming Public Service Delivery[22] stipulates that relevant to access to health care services and the quality of health care is the duty of national and provincial departments to identify, ***inter alia*** , the following:

- A mission statement for service delivery , together with service guarantees;
- The services to be provided ,to which groups and at which services charges;
- In line with the Reconstruction and Development Program (RDP) priorities, the principle of affordability and the principle of redirecting resources to areas and groups previously under-resources;
- Service standards , defined outputs and targets and performance indicators , benchmarked against comparable international standards;
- Monitoring and evaluation mechanisms and structures , designs to measure progress and introduce corrective action , where appropriate;
- Plans for staffing, human resource development and organisational capacity building tailored to service delivery needs;
- The redirection of human and other resources from administrative tasks to service provision, particularly for disadvantaged groups and areas;
- Financial plans that link budgets directly to service needs and personnel plans;
- Potential partnerships with the private sector , non-governmental organisation (NGO'S) and community based organisations (CBO'S) which will provide more effective forms of service delivery ; and
- The development, particularly through training, of a culture of customer care and of approaches to service delivery that are sensitive to issues of race, gender and disability.

1.4 RURAL HEALTH AND SERVICE DELIVERY

As far as rural areas are concerned the White paper on Transforming Public Service Delivery: *Batho Pele* (People First) mentions that improving the delivery of public services means redressing the imbalances of the past while maintaining continuity of service to all levels of society. It also involves meeting the needs of the 40% of South

[22] *Supra* (note 2) at 4

Africans who are living below the poverty line and those, such as the disabled, and black women living in rural areas who have previously been disadvantaged in terms of service delivery. Improving service delivery calls for a shift away from inward-looking, bureaucratic systems, processes and attitudes. It also means a complete change in the way that services are delivered.[23] The objectives of service delivery therefore include welfare, equity and efficiency. If rural people requiring access to health services and quality health care also have to be treated as customers, that would improve service delivery because it embraces certain principles which are fundamental to public service delivery as the government officials will be providing services for commercial gain.

Implementation of *Batho Pele* will require a complete transformation of communication with the public. Information must be provided in a variety of media and languages to meet the different customers. This is essential to ensure the inclusion of those who are or have previously been disadvantaged by physical disability, language, race, gender, geographical distance, or in any other way. [24]

1.5 RESEARCH METHOD

In investigating the right of access to health care services and the quality of care that is afforded to rural communities in South Africa within the confines of the state's resources, the type of research method that is used is the quantitative research method.[25] The quantitative research method often makes it easier to aggregate and summarize data. Quantification often makes observations more explicit, it opens up possibilities of statistical analysis ranging from simple averages to complex formulae and mathematical models. [26]

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[23] *Supra* (note 2) at 5
[24] *Supra* (note 2) at 4
[25] C Bless & C Hignson-Smith , *Social Research Methods* (1995) at 41
[26] *Ibid.*

1.6 AIM AND OBJECTVIVES OF THE STUDY

This study explores the community understanding of health care delivery and public service delivery (especially *Batho Pele* program) in rural areas. The aim is to gain insight into what the community and health personnel feel is appropriate health service delivery within the confines of the state budget and in relation to *Batho Pele* principles.

The objectives of the study are to:

- Assess the effectiveness of the government strategies in health care delivery in rural areas.
- Assess factors that contribute to the lack of accessibility of health care services in rural areas.
- Investigate obstacles that affect health care delivery in rural areas.
- Investigate the knowledge and understanding of the new public service delivery program by health workers and community people.

1.7 CONCLUSION

It is clear in this chapter that the White Paper on Public Service Delivery aims to redress past inequalities in access to health care services. One of the principles in *Batho Pele* is that all citizens should have equal access to services and this principle is consistent with section 27 of the South African Constitution. In order to redress past imbalances in delivery of public services in rural areas *Batho Pele* aims to meet the needs of the 40% of South Africans living below poverty line. For this aim to be realised resource allocation needs to be equitable. The following part of this study will explore important contributing factors towards realisation of the right of access to health care services (for example budget allocation and equitable distribution of financial resources and public expenditure). The section will further explore equitable distribution of health care services between the rural, peri-rural and urban areas.

2. CHAPTER TWO

ALLOCATION AND USE OF PUBLIC EXPENDITURE FOR URBAN AND RURAL HEALTH CARE

2.1 FINANCIAL RESOURCES AND PROVISION OF HEALTH CARE

South Africa has a population of over 40 million, 73 % of whom are women and children. Although classified as a middle-income country and spending 8,5% of the Gross Domestic Product (GDP) on health care,[27] South Africa exhibits major disparities and inequalities. This is the result of former apartheid policies, which ensured racial, gender and provincial disparities. The majority of the population of South Africa has inadequate access to basic services including health, clean water and basic sanitation.

1994 Statistics suggest that between 35% and 55% of the population live in poverty.[28] In considering the level of poverty and lack of access to basic human needs like health care this chapter looks at the allocation and use of public expenditure for urban and rural health care. Availability, distribution and allocation of financial resources within the health sector form an assessment background to and provide the framework for the analysis and reconstruction of the various components and facets of health care provision in South Africa.[29] Not only do financial resources determine the boundaries to the extent, degree of sophistication, quantity and quality of health care supply, but there are also vital considerations in policy decisions, preferences and priorities regarding health care.[30]

In South Africa like elsewhere in the world health authorities attempt to achieve a balance and comprehensive approach in the aim to render an optimal service to the entire population in accordance with availability of resources. The availability of resources

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[27] Statistics South Africa www.statssa.co.za
[28] *Ibid.*
[29] A C J Van Rensburg , A Fourie , E Pretorius *Health Care in South Africa : Structure and Dynamics* (1994) at 5
[30] *Ibid.*

ultimately determines priorities in the provision of care as well as the scope, standard and availability of such care.[31] The financing of health care does indeed address important principles and values in the provision of such health care.

Important considerations such as cost-effectiveness (for example allocation and expenditure of available resources to the optimal advantages of maximum number of people), the internal effectiveness of supply system (such as the extent to which available resources are used to optimize the internal functioning of the system in order to advance goal attainment) as well as justice in the provision of health care (that is appropriateness, availability, affordability and acceptability of health care) ultimately depend on priorities contained in macro-decision making regarding the financing of health care.[32]

Financing and expenditure on health care in South Africa are consequently reconstructed at a general national level, and thereafter on the basis of more specific budgeting and expenditure figures in order to point out and illustrate the interaction of the availability and allocation of financial resources on one hand and the nature, extent and quality of services rendered on the other.

The total amount spent annually on health care in a country by all institutions, in all types of health care provision and on all care-related services, facilities and products is generally regarded as a rough indication of the standard and quality of health care in that country. It is also used in international comparisons.

2.2 ALLOCATION AND PUBLIC EXPENDITURE BEFORE 1994

Every health care system has a financial economic component. This component incorporates the ways in which financial and economic matters (ever present in health care) are organized and regulated. This component actually includes the entire spectrum of methods and mechanisms by which the payment or remuneration of service providers

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[31] *Ibid.*
[32] *Ibid.*

by the consumer, the remuneration of care providers or personnel, the recovery of costs by the clientele and service providers as well as the financing of services and the ownership or shareholding of facilities take place.[33]

Health care financing also involves a component of policy/control and administration (the political administrative component). It is generally concerned with the ordering and organization of the health care system. This component therefore involves general policy guidelines and specific regulative measures and administrative procedures by which personnel and clientele are controlled, activities are managed and services regulated.

The determinants of national health care systems can be counted to include the prevailing economic climate, the economic systems of the country and specific economic factors. In the classification of national health care systems the main types of health care systems which are the public assistance, national health services and national health insurance are linked directly to the three basic economic systems, that is, pre-capitalism, capitalism and socialism.[34] More specifically, a country's particular modes of economic control and the distribution of resources and wealth, directly affect the institution and traditions within the health care system.

A country's economic ability, economic prosperity, levels of economic development, industrialization, economic growth and dependence on international economic aid as well as national and international economic tendencies and crises have a profound effect on its national health care system. Economic determinants noticeably affect all dimensions of the health care system. It *inter alia* determines what proportion of the Gross National Product (GNP) is spent on health care and to what degree the country concerned is dependent on other countries for: (a) medicaments (b) equipment and scientific knowledge.[35]

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[33] *Supra* (note 27) at 8
[34] *Ibid.*
[35] *Ibid.*

Economic factors also determine:

(a) how extensive the investment in scientific research will be in the field of health care;

(b) the country's ability to generate and provide resources and facilities for health care; and

(c) the manner in which such resources, facilities and personnel will be deployed, distributed, financed and remunerated.

South Africa spent about R30.15 billion on health services between 1992-93. This amount is equivalent to 8.5 percent of GDP.[36] Health expenditure per person was R740. Because of this it is clear that South Africa spends a high percentage of its GDP on health services by international standards but a substantial proportion of this spending is on private health care for a minority of the population and on expensive government referral hospitals.[37]

In South Africa, before the introduction of the 1996 constitution, funds were made available from the central state budget for the provision of health care and they were administered on three levels of government. The National Department of State Expenditure (DSE) played a key role. The DSE negotiated a budget with various agencies like the Function Committee (which existed for a specific sector such as health and education, where a number of departments at national, provincial and 'homeland' level had a service delivery role) and the individual departments (if their functions largely related to the national level).

Within the health sector, the Health Functioning Committee was the body responsible for drafting the health budget submission to the DSE. The Health Functioning Committee was chaired by the Department of Health and Population Development and included representatives of the 4 Provincial and 6 'Self-governing' territory, health departments as well as a representative of DSE, department of finance (DoF) and the Central Economic Advisory Services (CEAS).[38]

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[36] *Supra* (note 26).

[37] D McIntyre ,G Bloom , J Brijlal, *Health Expenditure and Finance in South Africa* (1995) xiii

[38] *Supra* (note 27) at 215

The central coordinator of health care in the public sectors, the Department of National Health and Population Development annually submitted a budget to the Cabinet for consideration. Funds eventually apportioned to this department were mainly for administrative and executive purposes by this department itself as well as own affairs departments of health and welfare, the regional service councils, local authorities and the health departments of the 'self-governing' and independent states.[39] The Health Function Committee (HFC) used a historical budgeting process to determine allocation to national, provincial and 'self-governing ' territory.

With regard to public health expenditure, provincial administrators absorbed nearly 60% of the total budget for public health care. That would leave only approximately 40% allocation via the Department of National Population Development to all other public bodies responsible for providing health care, including the 'self -governing' and independent states. Besides provincial administrations the bulk of public funds for health care was allocated to the Department of National Health and Population Development (this was for executive responsibilities regarding the provision of health care) and to the homelands. Each of these institutions received almost 14% of the total budget for public health care and the Department of National Health and Population Development (DNHPD) administered approximately one third of the funds.[40]

Local authorities (who were mainly responsible for providing primary and preventive health care) were apportioned only 4,3% of the total budget for public health care. The Department of National and Population Development channeled only about 10% of the available funds to local authorities .The total health budget for 1991 / 92 increased by 8,9 over 1990/ 91. The overall government budget increased by approximently 14% for the same period and inflation was approximately 14-15% .The public health budget was neither keeping pace with general government expenditure nor with inflation.

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[39] *Supra* (note 27) at 207
[40] *Supra* (note 27) at 213

In terms of the National Health Plan (1986) local authorities were responsible for the community health and primary health care in particular. Local authorities were subsidised between 33% and 100% from the budget of the Department of National Health and Population Development for the provision of specifically defined Primary Health Care services. The remaining part was financed from funds generated locally mainly by means of fees, fines and tax levies.[41]

Local authorities were also responsible for several other services which had a direct bearing on the health status of the population in their areas, but which were for subsidization purposes not regarded as health services. These included garbage removal, sanitary services, sewerage and the inspection of foodstuffs and meat. The largest part of local authorities health expenditure was absorbed by the preventative, promotive and rehabilitative services rendered. Bulk of subsidies coming to local authorities from state budget was specifically for preventative services.[42] Expenditure on curative health care represented only about 13% of the total health expenditure by local authorities.

Local health care financing inevitably strained the standard of local health services merely because the level of subsidization was inadequate in relation to the scope of services rendered (for example smaller local authorities were unable to provide certain services due to the lack of funds). Fragmentation of public health services increased cost because of the duplication of services that existed. It also made it difficult to develop strong preventative programms, to establish an effective referral system and, to apply the primary health care approach.[43]

Figure one below will illustrate how the budget was allocated between different spheres of government between 1987 to 1988.

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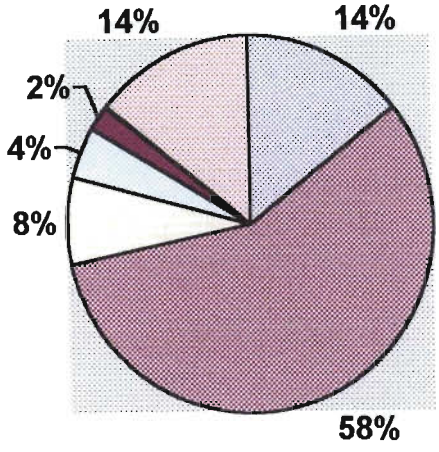
[41] *Ibid.*
[42] *Supra* (note 34) 214
[43] *Supra* (note 34) at 55

Figure 1. Allocation of financial resources in the public health sector in South Africa, 1987/88



- Department of National health and Population Development (R749 million)
- Own Affairs Administrations - (R 188 million)
- Local authorities - (R225 million)
- Other state departments - (R399 million)
- Provincial administrations - (R3 029 million)
- 'Self-governing' and independent states - (R762 million)

Source: *Department of National Health and Population Development 1991*

2.3 BUDGET ALLOCATION AND EXPENDITURE AFTER 1994

After the 1994 elections a needs based formula was used to determine budget allocations between provincial health departments. This formula consisted of the provincial population size, which was weighted. Budget allocation changed after introduction of the new constitution (1996). The constitution ensured equal distribution of resources amongst

people in South Africa. According to the South African constitution distribution of resources should be effective, efficient, equitable and equal.

After the introduction of the new constitution the budget was allocated firstly through a broad allocation procedure by the central government. Allocation of funds could be both vertical and horizontal. The first stage of allocations is when some money is reserved or set aside from the total revenue. This form of allocation is called the "top slice".[44] This allocation is for repayment of the national department, as well as an emergency reserve for meeting specific policy priorities and comprises of 23% of the total allocation by the government. It is not available for sharing between the different levels of government.

The next stage is the decision of allocation of funds for national, provincial and local government. These are broad allocations which are made through a process called vertical division. The Department of Finance (DoF) has indicated that each year it will try to keep the proportions allocated to national, provincial and the local levels relatively constant. From the allocation at national, provincial and local levels the last decision that is then taken on the allocation of funds is how much each individual province must get.

The lump sum allocated for all the provinces has to be divided into 9 parts (that is according to 9 provinces). This process is called the horizontal division, the DoF formula decides on the horizontal formula while attempting to move towards equity. It starts off by using old expenditure patterns on social services as based on equity. The department of finance rewards provinces that are able to bring in a high proportion of revenue through their economic activities. This provision also applies to the highly impoverished provinces (for example Eastern Cape).[45] How they are expected to do that is an open question. The new constitution made fundamental changes to the way the horizontal division is made. Previously, the central government decided on amounts for all different provincial departments, now each province receives a lump sum called a global

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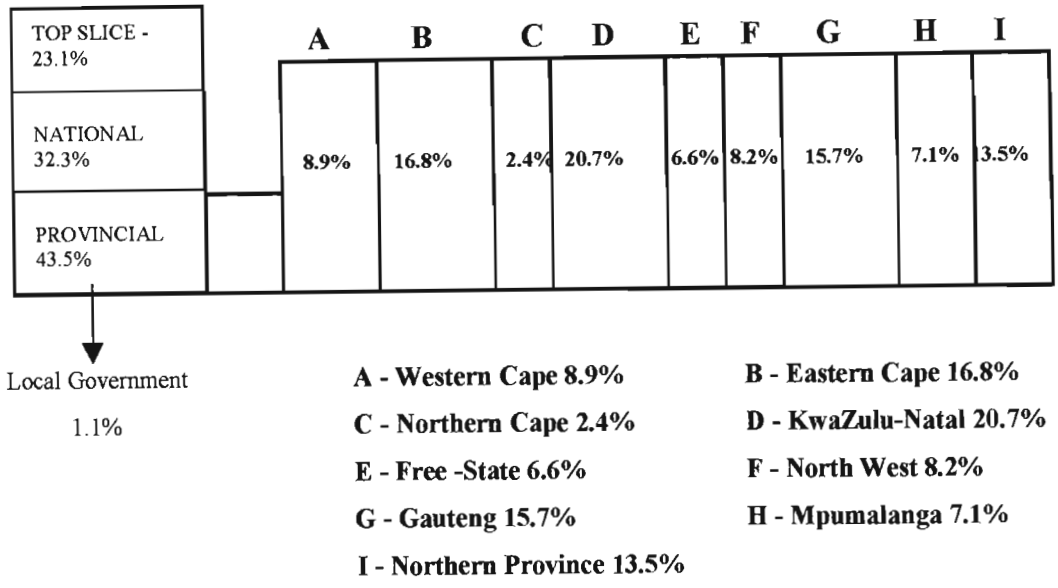
[44] D McIntyre , J Nicolson *The Budget Process : A Guide for South African Legislation* (1999) at 15
[45] *Ibid.*

allocation.[46] Unlike before the 1996 constitution there has been a move to a more decentralized system.

Figure 2. Percentage of provincial allocation



Source: *The Budget Process: A Guide for South African Legislation.*

Each province receives an allocation that is largely based on its needs. This is an attempt to try and correct past inequities. Over the past few years a number of formulae have been recommended for deciding how to allocate budget. At present the department of finance uses a formula that takes the following into account:

(a) Education - the overall size of the school-age population and the number of learners in public and ordinary schools,

(b) Health - the size of the population that does not have private health insurance, with a small allowance for those with private who may use some public sector services,

(c) Social welfare - the estimated number of people entitled to security grants ,this is targeted at the elderly , the disabled and children ,

(d) Basic component - each province 's share of the total population of the country

[46] *Ibid.*

(e) Economic activity - this is the amount of money paid in wages and salaries in each province, and

(f) The backlogs - this is where it tries to compensate for backlogs in health and education infrastructure in the province, with extra weight given to provinces with a large rural population.

Decisions on how to allocate the vertical and horizontal divisions of the budget are critically important to the issue of equity. These decisions affect the realization of equity. The Northern Province is one of the most disadvantaged provinces. It is estimated that 77% of its population are poor, 37% of residents over the age of 20 years have no schooling and unemployment levels are at 46% of all adults.[47] Only 18% of households in this province have access to water compared to 45% of households nationally.[48] Only 13% of households have access to a flush or chemical toilet, compared with 51% nationally.[49]

The Northern Province has therefore severe backlogs in basic needs. Thus, 13% of the part of the budget that has been set aside for provinces is allocated to the Northern Province even though this province only accounts for 12.1% of the total population.[50] Some people believe that provinces like Northern Province and Eastern Cape should be given a bigger share of budget than what is allocated to them and that the present moves towards equity are not fast enough. Northern Cape covers the largest territory and Guateng the smallest with their respective populations varying from less than a million in Northern Cape to over 8 million in Kwa-Zulu Natal.

The provinces differ considerably in their level of development: Gauteng and Western Cape account for half of South Africa's Gross Domestic Product in spite of containing only a quarter of its population. These differences are reflected in the average personal

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[47] *Supra* (note 39) at 9
[48] *Ibid.*
[49] *Ibid.*
[50] *Supra* (note 39) at 19

income per capita, which ranges from 4,992 rands in Guateng to 725 rands in other provinces. [51]

2.4 STAGES OF BUDGET PROCESS

According to McIntyre and Nicholson[52] the budget process in South Africa goes through the following stages before it is completed: -

- *Step one* - Setting policies, estimating revenue and setting an upper limit on spending. In this step the cabinet sets broad policy priorities. Detailed budgets are then evaluated against these policies .The DoF estimates how much the economy will grow as well as how much revenue can be expected through the collection of taxes for the next three years. The DoF then uses Growth, Employment and Redistribution Macro Economic Strategy deficit reduction targets to work out how much overspending will be allowed and then sets the upper spending limit for the total government budget for the next three years. Finally the DoF presents this to the cabinet.

- *Step two:-* The departments estimate their expenditure and submit draft expenditure applications. The national and provincial departments go through strategic planning sessions to identify their department goals and prepare an initial three-year budget estimate. They need to try to keep in line with the three year allocations determination in the previous Medium - Term Expenditure Framework (MTEF) cycle. Although government makes the important budget decisions the actual drawing up of the budgets is done almost entirely by civil servants in these directorates.

  It is s the civil servants in these directorates or sub - departments that draft the initial budget estimates. They are meant to consult with other civil servants in the health department to find out what their budgetary needs are (i.e. they would talk

[51] *Supra* (note 27) at 212
[52] *Supra* (note 39) at 20

to the person responsible for hospitals, for district level services, for infectious diseases and so on) before preparing a budget for the health department.

- *Step three:-* There are guideline estimations that are determined for vertical and horizontal allocations. The Budget Council meets to work out how to divide the revenue into three lump sums for national, provincial and local governments. Once the Budget Council has done this vertical division it then works out the provincial allocations amongst the nine provinces.

- *Step four:* -This is a stage where there is a combination of all the departmental estimates into one sum, matching it with the Budget Councils allocation. Civil servants at the Department of State Expenditure combine the separate departmental estimates into one national-level estimate. Civil servants at the nine provincial treasuries combine all their separate departmental estimates into one provincial estimate. Provincial treasuries have a further challenge, they have to ensure that at least 85% of their total provincial budget is allocated to social services.

- *Step five*: -the national MTEF Committee makes a decision on what budget allocation to recommend for each national department as part of the national budget. This recommendation goes to the Cabinet. The Provincial Executive Councils meet to consider their draft consolidated provincial MTEF. Sectoral teams for education, health, welfare, justice and defence also look at the estimates. Proposals for conditional grants to each province are also developed.

These conditional grants are the following: the Primary School Nutrition Programmes, research and training of health professionals, hospital construction or rehabilitation, a central hospital grant and a grant to help with the redistribution of health care services.

Step six:- This is a stage where a draft of the overall MTEF is finalised and a Medium Term Budget Policy Statement is published. Once the Cabinet, the Provincial Executive Councils and the Sectoral MTEF Teams have reviewed all the national and provincial MTEFs , a draft overall MTEF is compiled and submitted to the Budget Council and the Cabinet. This document shows how the budget matches the broad policy framework set out at the beginning of the cycle. This document also suggests allocations for the three year period and also analyses the implications of these allocations and suggests alternative expenditure options.

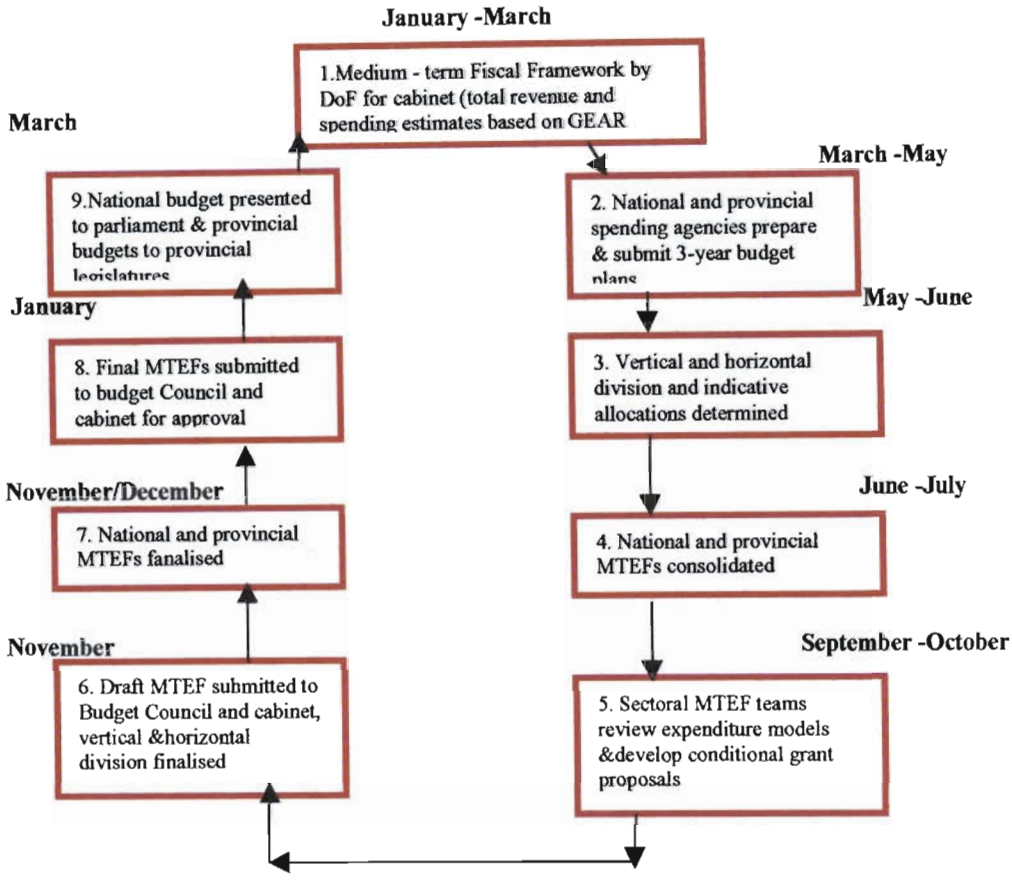
Step seven: - The final METF is submitted to the Budget Council and Cabinet for approval. Detailed national and provincial expenditure estimates for the year immediately ahead are finalised and documentation is prepared.

Step eight:- The national budget is presented to the National Assembly . The Division of Revenue Bill accompanies it. This outlines how the vertical and horizontal divisions were worked out. The provincial government budget is presented to the provincial legislature.

Step nine:- Portfolio committees and provincial standing committees hold hearings and report to the legislators. The budget of each department has to be voted on. At present no amendments to the overall budget are allowed. Shifts in the department allocation of money from one department to another (for example from the Department of Health to the Department Education) are not allowed.

Figure 3 below shows how the budget allocation steps follow each other. It is important to note that parliament does not for example suggest the reduction of the health budget and give more money to education. However parliament can make changes to the way the money has been allocated within a department (for example if the parliamentarians feel that not enough money has been allocated to HIV/AIDS programs and too much money has been allocated to subsides for medical research).

Figure 3: Budget cycle after introduction of the new constitution and MTEF.



Source: (President Review Commission (1998) Footnote equity report)

According to the White Paper for Transformation of the Health System in South Africa,[53] the revised procedure for budgeting aims to:

(a) Create awareness of the activities for which a health department is responsible ,

(b) Align health departments activities with the goals of the government and to establish new activities where current activities do not address all such goals,

(c) Re-examine the rationale for and extent of the need for an activity,

(d) Determine the cost of each activity from zero,

(e) Prioritise all the activities of the department of health on the basis of cross-cutting criteria which have been established by the department of health, and

[53] *Supra* (note 1) at 46

ch will enhance the ability of the government to evaluate

(f) Create a database quest in a rational manner, provide the information required for spending and improve strategic financial management in the health sector.

policy White Paper for Transformation of the Health System in South Africa[54]

r that budget controls will promote the following:

of expenditure towards Primary Health Care (PHC),

ommissioning of buildings and equipment for the delivery of PHC services,

Management of patients at the appropriate level of care,

- Improved efficiency with regard to the use of resources,
- Improved decision support systems for health care managers at all levels,
- Reduced wastage and loss of drugs,
- Eliminating duplication of facilities and services,
- Limited inappropriate level care in academic hospitals,
- Reduced number of tertiary care beds,
- Better use of underutilized hospitals, and
- Greater cost recovery at higher levels facilities.

2.5 KEY POLICIES INFLUENCING FINANCING AND EXPENDITURE WITHIN THE PUBLIC HEALTH SECTOR

In South Africa since the 1994 elections various government policies have been developed which have an impact on financing and expenditure challenges faced by the health sector. These policies have been identified by Van Rensburg *et al*[55] as:

(a) The White Paper for Transformation of the Health System in South Africa which states that its goals are to unify the fragmented health system, to reduce disparities and inequalities in the health service delivery and increase access to improved and integrated services based on Primary Health Care principles.

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[54] *Supra* (note 1) at 47
[55] *Supra* (note 27) at 204

(b) The Growth, Employment and Redistribution Macro Economic Strategy (GEAR) which is the government's macro-economic policy. The component which has been the most vigorously implemented to date is the fiscal policy which aims to :

- Cut budget deficit (i.e. to reduce the amount by which government expenditure exceeds revenue)
- To avoid permanent increase in the overall tax burden
- Reduce consumption expenditure by government relative to Gross Domestic Product (GDP). Although these fiscal goals have been part of government policy for some time, the importance of GEAR is that it sets explicit and stringent targets for reducing the budget deficit.

(c) Policies relating to the distribution of revenue between spheres of government and between provinces. The Financial and Fiscal Commission (FFC) in this regard has made the main proposal. The Commission suggests a largely 'population-based ' formula for determining the equitable allocation of resources between individual provinces. The Department of Finance (1997) put forward a different (also 'population -based') formula which was accepted by the Budget Council as the basis for determining the 1998/1999 budgets.

(d) The Medium-Term Expenditure Framework (MTEF) introduced a three-year rolling budget for all national and provincial departments. The MTEF is intended to encourage departments to evaluate their objectives within realistic budget projections and to enable government to make strategic policy choices between expenditure priorities.

All these policies mentioned above have some impact on equity in health care financing and expenditure. The macro-economic environment would appear to be hostile to the achievement of equity in the health sector. Between 1995 and 1996 there was healthy growth in the GDP, the economy slowed significantly in 1998 to 1999 with the contraction in GDP per capita.[56] It has always been argued that GEAR imposes additional

[56] South African Health Review (2000) 2

constraints on the resources flowing to the health sector. Recent studies claim that GEAR targets for the budget deficit and tax to GDP ratio place limits on the expansion of public expenditure.[57]

Table 1: Illustration of macro-economic indicators, 1995-2000

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
GPD (R million)	548.1	614.9	680.2%	737.8	793.2	862.6
Real GDP Growth	3.1%	4.2%	2.5%	0.5%	0.9%	3.5%
Real GDP Growth per capita	0.9%	2.0%	0.3%	-1.7%	-1.3%	1.3%
Inflation :Headline	8.7%	7.4%	8.6%	6.9%	5.5%	5.2%
Current Account balance (% of GDP)	1.5%	1.3%	1.5%	1.6%	-0.5%	-1.3%

Notes:

- Figures for 1999 and 2000 are projections
- Real GDP Growth -this refers to the change from year to year in real GDP where the GDP figures have been deflected to remove any notional increase caused by rising prices.
- Headline inflation - this is a year to year growth rate of the Consumer Price Index
- Current Account Balance - this is the balance of physical goods and services trade with other countries.

Source: Department of Finance and Statistics South Africa

McIntyre *et al* have argued that central bargaining of civil service salaries also affects the proportion of health sector expenditure, placing limits on the potential of the redistribution. This also reinforces the importance of redistributing human resources in the pursuit of equity. Since one of GEAR's objectives is to reduce budget deficit, this affects the budget. Through GEAR the government has set deficit reduction targets and to meet them, overall government spending has to be reduced for example the government spent about R3, 720 on each person in 1995/96 fiscal year but it plans to spend only R3, 720 per person in the year 2000/01.[58]

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[57] *Ibid.*
[58] *Supra* (note27) at 215

GEAR is just one strategy for economic growth and it is argued that the deficit reduction should not be given such a high priority in a country which has so much poverty to overcome.[59] Economic growth alone cannot solve the problems that face South Africa. Internationally, it has been shown that unless growth policies are accompanied by strong redistribution policies the rich will get richer and the poor will get poorer.

2.6 SOURCES OF FINANCE FOR PUBLIC HEALTH CARE

There are three major sources of finance for public health care, namely: (1) funding from general tax revenue, (2) local rates, utility sales and taxes and (3) the user fee. Until recently, capital expenditure was fully funded by the government, now donor agencies have become willing to fund government services.[60]

General tax revenue centrally collects finance of about 94% of public health recurrent expenditure. Before 1994 taxes collected in former provinces were placed in the State Revenue Account and taxes collected in the former homelands were placed in homeland revenue accounts. The former homelands received substantial budgetary transfers from the State Revenue Account. All taxes are now credited to a consolidated National Revenue Account.

The National Department of Health is responsible for the use of central government health funds. The Function Committee for Health (whose members include representatives from the National and Provincial Health Departments, the Central Economic Advisory Service (CEAS), the Department of Finance and the Department of State Expenditure), advises it on resource allocation.Until recently budget allocations were based largely on the previous year's budget. The Department of Health plans to rapidly reduce historically determined regional inequalities in funding.

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[59] *Supra* (note 27) at 216
[60] *Supra* (note 27) at 32

For this reason the White Paper for the Transformation of the Health System in South Africa has a principle that states that health care financing and resource allocation policies should promote equity of access to health services between urban and rural areas, rich and poor people and between the public and private sectors.[61] In recent years non-governmental organizations such as the Independent Development Trust have become involved in the development of health infrastructure. Local rates utility rates and taxes are a relatively small amount of health funding (1.5%). This amount is derived from local rates and taxes. This is a source of funds between a third and a half of the recurrent health care expenditure by local authorities according to different sources.

Local authorities in large metropolitan areas fund a higher proportion of expenditure from their own sources when compared with those in small towns or rural areas. The provincial department of health funds the balance of expenditure by local authorities in the form of subsidies. The future role of this source of finance depends a great deal on the final distribution of tax authority between government levels under the new constitution.[62]

User charge fee generates 4.5% of the income. The health departments of the former provincial administrations introduced a uniform fee structure several years ago, but the ex-homelands still have their own fee policies. The level of fees in the uniform fee structure depends on the sophistication of the health facility and on the declared income of the patient. Certain patients and services are totally exempted from fees. There are several reasons why so little revenue is generated from user fees. Fee levels are low, except for private patients. Until recently private patients were not allowed to use public hospitals unless they did not have easy access to a private facility.

All fee revenue is effectively returned to the Provincial Revenue Account, since each department's health budget is reduced by the amount of fees it collects.[63] The result of a study done by Deloitte and Tuoche in 1994 on the expenditure of donor agencies on

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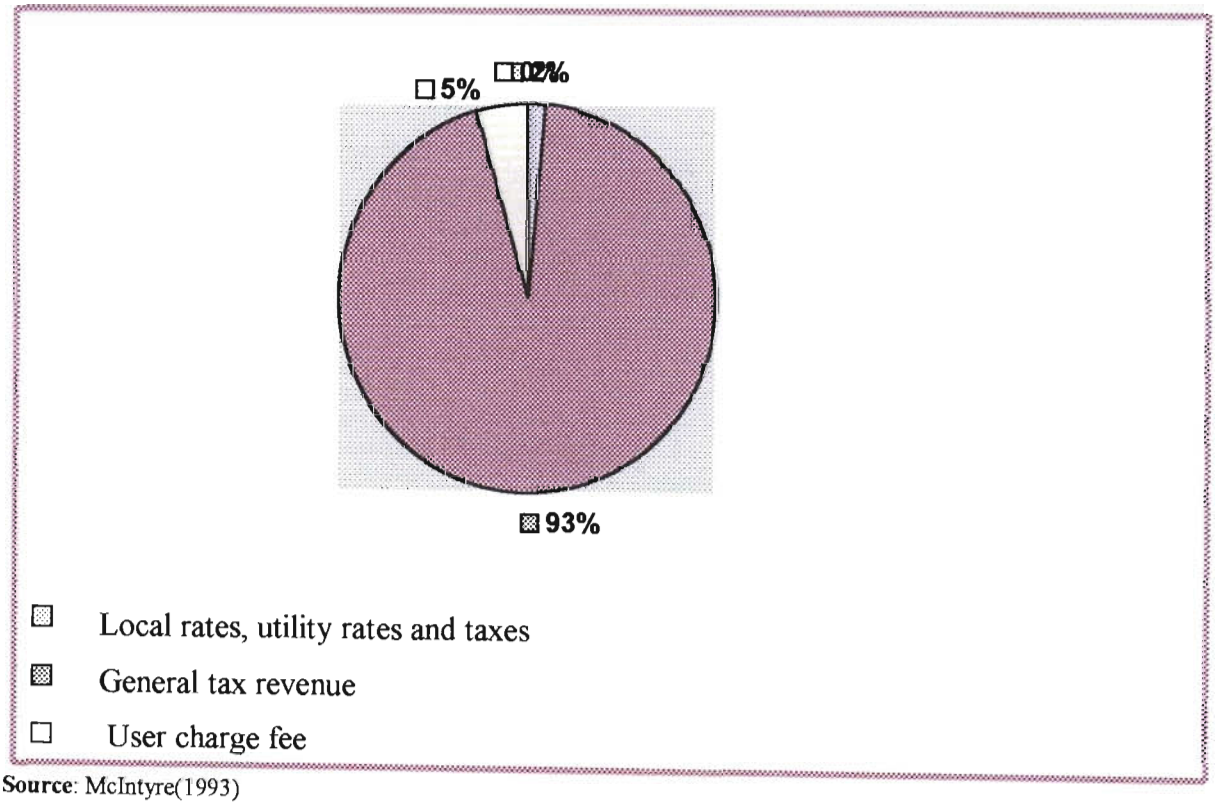
[61] *Supra* (note 1) at 42
[62] *Supra* (note 27)at 33
[63] *Ibid.*

health care, showed that donors spent about 145 million rands on health sector projects.[64] Nearly 20% of donor funding was used in South African institutions, less than 2% was used by national embassies and over 78% by international organizations. The largest single contributors were the W.K. Kellogg Foundation and United Nations Development Programme (UNDP). Donor support is increasing rapidly.[65] The new donor projects primarily support infrastructure development and the strengthening of basic health services through training and technical assistance but they also support specific programmes such as HIV/AIDS.

Figure 4 : Different sources of finance
for public health services (1992/93)



Source: McIntyre(1993)

[64] The research done by Deloitte and Tuoch in 1994 is not 100% conclusive because there were many data deficiencies, partially due to low response rate.
[65] *Supra* (note 27) at 34

2.7 DIFFERENCES BETWEEN PUBLIC AND PRIVATE SECTOR SPENDING IN RELATION TO ACCESS TO HEALTH CARE

Once the Department of Health has been allocated its budget a substantial part of that money goes towards spending in private health care for the minority of the population and it also goes towards expensive governmental referral hospitals.[66] In the private sector the ratio between the volume of expenditure on one hand and the size of the consumer population on the other implies, a favorable basis for care provision than in the public sector where the consumer population is exceedingly large in relation to the volume of expenditure.

The private sector is continually able to offer a higher standard of services to the clientele of a manageable size. This is not the case with the public sector, which tries its best to uphold the current standard of services with limited financial resources at its disposal against a background of the growing need for services and an unmanageable number of clientele. These foster discrepancies between the standard and the quality of health care provided by the public sector. The private sector provides a curative oriented type of healthcare. People will "buy " health care only when they need it. The public sector is not only supposed to provide curative health care but also to provide preventative and primary health care for the majority of the population. The available resources in this sector must thus be distributed amongst a wider variety of services for a far greater consumer population.[67]

If South Africa was to pay for health care for all citizens with the extravagance that the private sector lavishes on its customers, the country would have to spend about 13% of the Gross National Product on health care which is unattainable and probably, an undesirable goal. At present the private sector is responsible for about 45% of the total health expenditure in South Africa. The public sector provides care to 80% of the population while the remaining population of about 20% is catered for by the private

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[66] *Supra* (note 27 at 32
[67] *Supra* (note 27) at 217

sector. The funding or the budget that is allocated to the public sector has to care for health goals such as programmes on maternal, women reproduction and health, child and adolescent health, care of older people and mental health, nutrition, oral health, environmental health, occupational health, emergency health services, human resource development, substance abuse, sexually transmitted diseases and HIV/AIDS, technology and drug policies, health information systems and health research. Some of the money has to go towards tertiary and highly specialized public health services.[68]

Provinces without such services will have to refer patients to provinces that provide them. The 'client ' province will pay the 'provider' province for these services, but the level of the fees in the next several years will take into account the fact that equity in provincial government funding will not yet have been achieved.[69] This means that those provinces, which do not have highly specialized treatment services, will refer their patients to the provinces which do have those services but they will be expected to pay for them.

Academic health service complexes incur extra cost as a result of their academic functions (the cost of teaching and research as such are met by the Universities). The additional service cost associated with teaching and research have been termed the 'National Increment for Teaching Education and Research (NITER). There is the NITER grant that is allocated to the provinces which have academic health services, this grant is a lump sum estimate which is based on historical expenditure. A more rational and equitable funding mechanism will be introduced in the form of a standard allocation for each enrolled medical student.

The apartheid era left a legacy of inequality in South Africa, both in relation to income distribution and in access to social services.[70] The challenges that face equity in public health sector financing and expenditure are:

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[68] *Supra* (note 1) 501
[69] *Supra* (note 1) 44
[70] D McIntyre ,L Baba & B Makan *Equity in Public Sector Financing and Expenditure in South Africa* (2000) at 41

I. Improving the geographic distribution of public sector health care resources between and within provinces;

II. Increasing primary care utilisation levels, particularly for currently disadvantaged groups including redistributing resources between levels of care to improve resources of primary care services, while still maintaining adequate referral services and reducing barriers to primary care services;

III. Seeking alternative sources of finance for public health services to reduce the reliance on general tax revenue.

Geographic distribution of public sector health care resources has been the major focus in the government goal of trying to address health sector inequalities in South Africa. Access to health services is not the only determinant of health status. It has been shown that excess suffering and premature death rates could be reduced at a relatively low cost through primary care interventions such as increased coverage by preventative programs and improved access to basic medical care.[71]

2.8 EQUITY AND DISTRIBUTION OF HEALTH CARE SERVICES

Equity is about trying to make sure everyone in the country gets a fair share of its resources. It means that those who have the least should be given more than average, and those who have the most should be given less than average.[72]This is a way of redistributing the wealth of the country. Equity is not the same thing as equality.[73] Equality is when everyone already has the same share of resources, or when everyone is given an equal share irrespective of their needs.

The budget plays a very important role in achieving equity. Government, through the budget, should make sure that the poor receive more than the average, and the rich receive less than the average. However in most government departments a large amount of expenditure goes on staffing. In the Department of Health, as has been mentioned

[71] World Bank Report on Equity and Health Care 1993/94 at 25
[72] *Supra* (note 27) at 220
[73] *Supra* (note 39) at 8

above,[74] 70% of expenditure goes on staffing. One challenge in achieving equity is to shift staff so that there is a more equitable spread across the country. With regard to health personnel there are some worrying factors in terms of equity. The number of professionals being produced and their demographic characteristics give rise to concern. The distribution of professionals within the urban, metropolitan centers is different from distribution of health professionals in rural areas. In Guateng there are less than 200 people to every pharmacist whilst in Northern Province there are more than 16000 people to every pharmacist.[75]

In 1997 less than 2000 nurses and slightly less than 1000 doctors graduated. The primary health care approach suggests that South Africa has a much greater need for nurses than for doctors. An important basis for improving equity in public health financing is an expanding health sector budget accompanied by the regular and predictable sources of funding. This allows authorities to anticipate additional funds and plan for their redistribution to under-funded activities or geographic areas.[76]

It has been noted that pursuing equity in a framework of fiscal federalism is difficult. One of the key challenges facing the public health sector is addressing the historical disparities in resource allocation between geographic areas.[77] Essentially, provinces with the greatest burden of ill health had the least access to health services. In 1995/96 and 1996/1997 progress was made in the redistribution of resources amongst the provinces, with most provinces coming closer to the national average per capita level. Since global provincial budgeting has been fully implemented the pace of redistribution slowed somehow in some provinces.[78]In provinces like Gauteng the trend towards inter-provincial equity in health budgets has been reversed. Based on MTEF projections the Gauteng health province received a substantial budgetary increase from 1997/98 despite it being the most over-resourced province (in terms of financial health resources). This suggests that the provincial determination of health budgets since 1997 /1998 may have

[74] Supra (note 39) 9
[75] *Supra* (note 27) at 22
[76] *Supra* (note 27) at 40
[77] *Supra* (note 27) at 17

impacted on the inter-provincial health equity initiatives.[79] It has been suggested that the lack of progress towards improving equity is the bargaining power of different provincial health sectors. Some commentators feel that health is losing out to other sectors in provincial budget negotiations. The share on provincial resources devoted to health appeared to have increased slightly between 1996/97 and 1998/99 in all provinces except Mpumalanga and Northern Province.[80]

Nevertheless, the share of total funding received by the health sector varies from province to province, probably as a result of existing health infrastructure and service activity. If incremental budgeting continues, historical inequities will be perpetuated. The provincial department of health (exclusive of tertiary care) absorbs approximately one fifth of Gauteng's provincial expenditure.[81] This is a far higher proportion than in under-resourced provinces such as Mpumalanga and Northern Province.

Table 2: Provincial Department of Health spending (less tertiary hospitals) as a percentage of estimated total provincial spending 1996/99 (1999/00)

	1996/97	**1997/98**	**1998/99**
Eastern Cape	16	17	18
Free State	17	18	18
Gauteng	19	20	20
KwaZulu -Natal	22	24	22
Mpumalanga	12	14	12
Northern Cape	14	15	13
Northern Province	16	16	16
Northern West	17	20	23
Western Cape	15	15	17
Average	16	18	18

Source: *Intergovernmental Fiscal Review 1999*

[78] *Supra* (note 27) at 18
[79] *Supra* (note 27) at 17
[80] *Supra* (note 27) at 7
[81] *Supra* (note 27) at 9

Notes: *This does not include Provincial Department of Works expenditure therefore capital expenditure may be reflected for some provinces eg . Northern Province but not for others.*

Recent research has highlighted that disparities in the distribution of public health sector resources within provinces are even greater than the disparities between provinces.[82] This is particularly the case in provinces that include former 'homeland' areas. To a large extent, these inter-district disparities reflect the differential resourcing of facilities located in urban and rural areas.The research by Brijlal *et al* evaluated the distribution of district health service resources between districts within three provinces namely Eastern Cape, NorthWest and Mpumalanga.[83]

In this study, efforts were made to include expenditure (or budgets) for district hospitals, non-hospital primary care services (both provincial-provided services and provincial subsidies to local government health services) as well as level 1 care within regional hospitals. Most provinces are coming closer to their 'equity target' budget allocations. While there has been progress, inequities in the distribution of the total provincial budgets have been somewhat less progressive in addressing inter-provincial inequities in health budgets.

The allocation of health care resources between geographic areas (such as district) within provinces is of concern to national and provincial health departments. The White Paper for Transformation of the Health System in South Africa priorities an increase of allocation of the resources to the primary health care services.

A redistribution of resources in favor of district health services is also one of the major objectives of the health sector MTEF.[84] Provinces are making some progress in this

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[82] J Brijlal , B Gilson , B Makan & McIntyre D *District Financing in Support of Equity : Tender Contract to Provide Technical Assistance to Provinces with Obtaining Equity in District Financing* (2000) at 31
[83] *Supra* (note 27) at 11
[84] *Supra* (note 27) at 16

regard with an increasing proportion of provincial health budgets being allocated to district health services in most cases. This relative redistribution has been insufficient to translate into real per capita district health services. The extent to which the fiscal policy incorporated in GEAR is impacting on the health sector must be monitored. As the government has committed itself to using social service spending as the main instrument of redistribution, the extent to which the health and other social sectors are protected from significant budget cuts should be assessed routinely.[85]

[85] *Supra* (note 27) at 15

3. CHAPTER 3

CASE STUDY OF KWADEDANGENDLALE AND MARIANHILL RURAL COMMUNITIES

3.1 INTRODUCTION

In KwaZulu-Natal there are 39 rural hospitals. This research focuses only on one rural Hospital and one rural clinic, namely the Valley Trust Clinic in the rural community of Kwadedangendlale and St. Mary's Marian Hill Hospital. The specific issues that are researched in this study relate to access to health care, state expenditure and *Batho Pele* principles. The participants of this study were both the health personnel (nurses and doctors) and the community people.

3.2 BACKGROUND OF HEALTH CARE DELIVERY IN KWADEDANGENDLALE AND MARIANHILL RURAL COMMUNITIES

3.2.1 Kwadedangendlale rural community

Kwadedangendlale is a rural community that is approximately 30 kilometers from Pinetown. This rural community is made up of many small rural communities (Nyuswa, Ngcolosi, Embo, Molweni and Qadi). Health delivery in this community has been sponsored by an NGO called the Valley Trust. This NGO was established in 1953 and it has been existing for 48 years. Valley Trust has developed an international reputation for the quality of health care delivery in most disadvantaged communities in South Africa and Kwadedangandlale is one of those communities.[86] This organisation has developed a socio-medical project for the promotion of health. It takes a holistic view of health promotion and implementation in partnership with structures within the local community and has a range of projects designed to improve rural people's quality of life.

[86] The Valleytrust www.thevalleytrust .org.za

3.2.2 Marian Hill rural community

St. Mary's Hospital is a district hospital that is approximately 10 kilometers away from the city (Pinetown). This hospital is outside Westmead. It provides health care services to rural communities like Ntshogweni, Dabeka, Ntshelimnyama, Mpula and Clemount). These rural areas are characterised by high levels of poverty and ill health. This hospital provides health care services to the population of about 750 000 rural and peri -rural people. For rural people to access health care services, a payment of about R50.00 is required as consultation fee and R60.00 for admission in the hospital. This community experiences different health problems and this is due to limited health resources that are available and easily accessible to them.

There are several diseases that are predominant in this rural community especially TB and the HIV/AIDS epidemic. Health facilities are not easily accessible to the majority of the population. Lack of transportation is one of the obstacles in accessing health care facilities. St. Mary's Hospital in Marianhill is the only hospital that provides health care services to this community. There are few community clinics that provide health care services to this rural community.

3.3 DATA COLLECTION

Questionnaires, telephonic interviews and face to face interviews are the methods of data collection that were used. Interview surveys involved direct personal contacts with the participants who were asked to answer questions contained in a questionnaire.[87] This method was used to test the respondent's knowledge and attitudes towards the type of health care afforded by the department of health in relation to the *Batho Pele* principles in rural areas. The questions were open-ended. They were personally administered to the respondents by the researcher. Two sets of questionnaires were administered: one set was directed towards the users of health services and the other towards the health personnel delivering health services to the rural communities.

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[87] C Bless & C Higson-Smith *Social Research Methods* (1995) at 99

A Sample is defined as a subset of the whole population, which is actually investigated by the researcher and has generalized characteristics of the population.[88] The sample size for the study comprised of 20 respondents of between 15-50 years from each rural area. The total number of respondents was 40 and these respondents were drawn from the two rural areas (for example Kwadedangendlale and Marianhill rural communities). Stratified random sampling was used and the population or the sample size for this research was divided into three different groups.

There was a group drawn from the educated community, the other group was drawn from uneducated and poor community and lastly the health personnel who provide health care services. Since the methods of data collection that were used in this study were questionnaires, telephonic interviews and face to face interviews, the analyses of this data was an evaluation of all the responses. In analysing data obtained from this study, percentages, graphs, tables and figures were used to show the responses.

3.4 LIMITATIONS

The limitations anticipated were the following:

- Not all of the questionnaires were going to be returned.
- Respondents might not have been honest when answering some of the questions, they may have provided answers that they thought the researcher was looking for rather than what they saw happening.
- Illiteracy can be a problem especially because some of the respondents for this study were people from rural communities where there is a high number of illiterate people. In order to avoid that situation there was a set of questioners that was written in Zulu so that it would be easier for those people who do not understand English to respond to the questionnaires.

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[88] *Ibid.* at 88

The methodology, aim and objectives of the study have already been discussed in chapter one. The findings of the study are now presented and analysed here below and the questionnaires are attached in appendix 1.

3.5 PRESENTATION AND ANALYSIS OF FINDINGS

The majority of the respondents were between 15-50 years old and the number of the people interviewed was 40, which comprised of 20 respondents from each rural area including 20 respondents from health care workers giving a total of 40 participants. The number of people who responded was 38 meaning that not all of the participants in the research returned their questionnaires. The response rate was therefore 95%.

Table 3: Illustration of the number of participants by gender

	Number	**Percentage**
Females	**26**	**65%**
Males	**12**	**30%**
Total	**38**	**95%**

Table 4: Illustration of the number of participants by sector

	Number	**Percentage**
Health workers	**18**	**45%**
Rural people	**20**	**50%**
Total	**38**	**95%**

About 45% respondents conceived appropriate health care to include comprehensive primary health care services, preventative measures, curative and rehabilitative health care services, accessibility of health care services to the majority of the population, availability of health care medical equipment, basic health care needs and family

planning. 50% of rural community members conceived appropriate health care services to include any form of health care service that is available whether of a lower quality or of a high quality standard. This is because to them any form of health care service available is better than no service at all.

For most respondents (83%), rural hospitals do not have enough resources to cater for community needs. There is a lack of essential drugs, shortage of health care trained staffs, poor construction of roads and poor telecommunication facilities. Only 13% respondents stated that the basics health care services are available in the rural community hospitals. These respondents are mainly the health care workers. About 86% of the participants in this research cited the following reasons, as contributing to the lack of accessibility to health facilities in rural areas: poor reconstruction of roads, lack of transportation, shortage of medical drugs, poverty, unfair distribution of health resources, shortage of hospitals and clinics in rural areas and shortage of health care workers.

Only 6% of the respondents stated that health care services are easily accessible to the majority of the communities. This is because there are community clinics and community health workers that are available to provide health care services for those community members that are far from the hospitals. Only 25% of the respondents stated that the DoH is effective in its health delivery initiatives.70% of the respondents stated that the department is taking too long to uplift the standards of health care in rural areas.

When asked about the involvement of the community in policy decision making processes especially those which affect the rural communities, 66% responded that they are not involved in any policy decision making process and in any health care programs. These people are not told what to do and when to participate in policy-making processes. Only 28% of the respondents stated that the community is involved in policy decision making and in health care matters. Through community leaders (Inkosi), the community is notified about health interventions that are carried out by health care personnel.About 50% of the respondents from rural areas stated that they did not know anything about *Batho Pele*, and 45% of the respondents who were mainly health care personnel knew

what *Batho Pele* is. When asked about the treatment they get when presenting themselves for treatment, 50 % of rural people answered that the courtesy principle and several other *Batho Pele* principles have never been practically applied to them.

This is because of the bad treatment that they get whenever they are in the clinics or hospitals. 45% of health care personnel stated that because of the workload and limited number of staff members it is difficult to practically implement *Batho Pele* principles. The reasons cited by health care personnel as contributing to the failure of *Batho Pele* are lack of supervision for nurses and all those who are involved in health care delivery, shortage of health care staff, heavy worked, and lack of incentives.

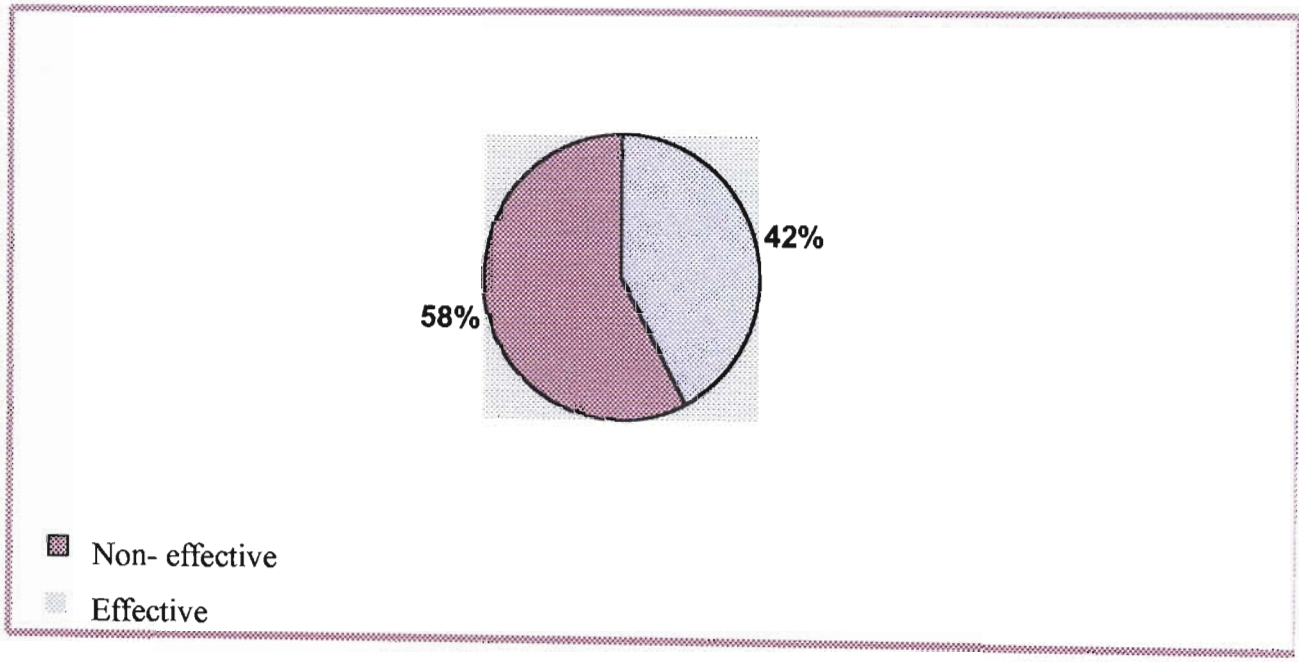
All the health care personnel stated that the hospital does have health care programs that are geared towards *Batho Pele*. According to 40% of the respondents, the White Paper for Transformation of the Health System in South Africa is not effective in its mission to readdress health delivery and to focus on the previously disadvantaged communities. This is because there is a shortage of clinics as well as health care staff and essential drugs in rural areas. 55% of the respondents stated that the DoH's mission is effective to some point. This is because there are programs that have been introduced by the DoH that are geared towards health delivery in rural areas (for example compulsory community service for medical students and the recruitment of medical practitioners from countries like Cuba to work in South African rural areas).

According to 55% of the respondents these initiatives show that with time the rural areas will have high quality health care standards. According to 50 % of the respondents the DoH's Five Year Plan which involves decreasing morbidity and mortality rates through strategic interventions, improving quality of care, speeding up delivery of an essential package of services through the district health system, revitalization of hospitals services, improving human resources development and management, reorganization of certain support services and legislative reform is not effective. Only 45% of the respondents stated that the DoH is effective and the reason cited by these respondents is that the

present health care status in South Africa is far better than the health care status that South Africa experienced during apartheid era.

In advising the DoH, the participants of this study suggested that the DoH should involve rural people in issues that affect their health. The community should be consulted and resources should be shifted to those areas, which were previously disadvantaged. Availability of drugs and health care personnel in the clinics and hospitals is important for effective and efficient health care delivery in rural areas. Health care providers argued that health care standards in South Africa are far from the standards recommended by the World Health Organization.

Figure 5: Percentage of the participants regarding the effectiveness of the White Paper for Transformation of the Health System in South Africa in redressing service delivery to the previously disadvantaged communities.



According to the above illustration only 42% of the participants stated that the Department of Health is not effective in its health care delivery strategies while 58% of the respondents argued that it is effective.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

Batho Pele was launched in KwaZulu Natal on the 31 of August 1999 by the DoH and it has almost 2 years of existence. This means that the Department of Health was committing itself in ensuring that every member of its staff was aware of the concept of *Batho Pele*. Series of workshops followed after the launch of this public services delivery strategy. These workshops were structured towards selling this strategy to the health care workers. The mistake that was made by the Department of Health was to assume that this public service delivery strategy would be effective in health care delivery if applied alone. It is clear that *Batho Pele* cannot be delivered overnight as this strategy involves a lot of change in many systems and attitudes. Until the rural people practically see health care delivery in their areas they can not claim that the democratic government is effective in re-addressing previous socio-economic imbalances.

In order for *Batho Pele* principles to be effective several issues need to be addressed namely the shortage of health personnel and resources. Even though *Batho Pele* does not require financial investment, resources have to be available in the clinics and hospitals. These resources involve availability of medicine, technology, medical equipment and essential drugs. When hospitals do not have enough resources and if health care workers are short-staffed it becomes hard for the health workers to apply *Batho Pele* principles like courtesy, right to information, openness and transparency, redress and equal access to health care resources.

Community involvement in policy processes is important. South Africa is a democratic country, it is important to embrace participatory democracy, which entails transparency, community participation and accountability if any policy or program is to be accepted by the community. Even though it is said that when *Batho Pele* was launched in Kwa-Zulu Natal the community was involved, this study shows that rural people are not aware of *Batho Pele*. This is an indication that the government is not doing what it needs to do to

effectively involve community members in issues that affect them. If the community was aware of programs like this they would know what to expect from the health care establishment because when the perceptions of the community are negative the most common compliant is that health services are poor and that there is a poor interpersonal relationship between provider and patient. It is therefore important to involve the community in any health care program and policy.

Community participation can be effective if rural people are informed about how and when they must participate. Ongoing programs of information sharing about health and development issues are essential for rural development and participation. Particular attention should be paid to informing people through their community and traditional leaders in rural areas about the proposed health care policies and programs.

Strategies like Health Workers For Change (HWFC) need to be strengthened and if applied alone these strategies will not be effective. The HWFC consists of a series of workshops that are facilitated for the health care workers aimed at "problem posing", presenting back to health workers their own conditions and asking them to reflect on them. In each workshop adult learning methods are used. Health care workers share experience with one another and also learn from each other. HWFC workshops lead to discussions about provider/patient relations. The objectives of WHFC are to create a positive attitude among staff and reinforce their commitment to work despite the day to day frustrations that they encounter.

Health care resources can be effectively delivered in rural areas if initiatives like *Batho Pele* program, department of health's mission statement, District Health System and Department of Health's Five-Year Plan and several other programs and strategies are linked together and are practically implemented. For example the principles of *Batho Pele* are closely related to the principles of the District Health System (i.e. community participation and community consultation). In order to avoid unnecessary duplication of health care delivery strategies, which would be costly for the government, emphasis should be placed on practical implementation of the already existing programs.

It is important to acknowledge several pieces of legislation that the government has passed that have a substantial impact on health care delivery. The Pharmacy Amendment Act [89] is important for rural health care delivery. This Act has important provisions, which contribute towards making health services accessible to the majority of the population especially the rural areas. For example section 22 (1) that deals with opening up of pharmacy ownership to non-phamarcists is an important measure to ensure adequate distribution of pharmacies in rural areas and other areas.

The Medicines and Related Substance Control Amendment Act of [90] which was passed with the view to introduce measures to bring down the cost of medicines, thereby making health care more accessible and affordable, is another piece of legislation that the government is using to make health services accessible. Besides all these pieces of legislation mentioned above there is a need for a new National Health Act. The absence of the Health Act contributes negatively to health care delivery. The 1977 Health Act [91], which is still in effect, provides an inappropriate legislative framework to guide the substantial transformation of health system, which is currently in progress.

The absence of a new National Health Act leads to the regulation of health issues by other legislation. Since there is a change in the government's health delivery strategy, laws like the Local Government: Demarcation Act [92] and Local Government: Municipal Structures Act [93] regulate specific health issues because of the absence of a national health Act.

The Local Government: Demarcation Act makes provision for a Demarcation Board, which is responsible for determining municipal boundaries for the whole of South Africa. This is in preparation for the implementation of the District Health System, which is another strategy for health care delivery that will make health services affordable and

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[89] 88 of 1997
[90] 90 of 1997
[91] 63 of 1977
[92] 27 of 1998

accessible to the majority of the population. The Local Government: Municipal Structures Act provides for the establishment of various categories and types of municipalities as well as their functions and powers.

This is because the White Paper on Transformation of Health System in South Africa does not assist in clarifying important issues that relate to the transformation of the health system in South Africa. This white paper has shortcomings and this is because it is a policy that is not enforceable legally. Compulsory community service for medical students is one of the programs that benefit the rural areas positively. Several other programs like this should be initiated (for example compulsory community services for final year dental, pharmacist, nurses, social workers, occupational therapists and psychologists).

A World Declaration on rural health needs to be considered with practical strategies on effective delivery of health care resources in rural areas. The Durban Declaration, which resulted after the second world rural health congress in 1997, came up with the following demands: the governments must provide adequate infrastructure for rural practice, they must improve the status of the rural health care workers and change the curricula at medical and nursing schools in order to provide training appropriate to the rural context.

The recommendations contained in this Declaration were that:

- there is a need to redress the inequities that prevail in rural areas around the world,
- to make health care provision in these areas suit community needs,
- to put heath care in the context with housing , sanitation and clean water ,
- to afford the rural health worker the same status as the urban health worker,
- to provide training that will suit the needs of health care workers as well as rural people, and
- to make rural health care community-oriented and driven.

For all these recommendations to be effectively implemented different departments (for example Department of Education, Department of Environment and Tourism,

[93] 117 of 1998

Department of Housing) should coordinate with one another in ensuring efficient service delivery. The DoH should use all its available resources to realise the recommendations that were made in the Durban Declaration so that people in the rural areas can be able to exercise their right to health as envisaged in the constitution. This entails that the national government, provincial government and local government should assist one another in health care delivery. Intergovernmental cooperation is therefore very important.

Health care delivery in rural areas needs to be monitored by the DoH. For example in the United States there are policy measures that have been developed to ensure that rural health is monitored. This is to ensure that the standard of care provided for rural people is of a good quality. Establishment of programs like Medicare Choice Program and the Medicare Rural Hospital Flexibility Program go a long way in ensuring that health care in rural areas is efficient. These programs are geared towards community participation. Even though South Africa is a developing country it does have health care delivery programs. The problem is that there is no effective monitoring of the implementation of these programs. This results in a series of health care delivery strategies that are not implemented or are not practically implementable.

Under the constitution the right to health care is outlined as a right that every South African should realize. There are several initiatives that the government has introduced that are geared towards the realisation of this right. Having different health care policies is not enough. There is a need for practical implementation of these policies. The government equity strategies need to be speeded up in order for the rural communities and other under served communities to realize their right to health and to have equal access to health care services.

About 70% of the DoH budget goes towards staffing. An initiative of equitable distribution of health care workers is important. The distribution of health professionals within urban, metropolitan centers is different from the distribution of health professionals in rural areas. This problem poses major difficulties in the delivery of health care in rural areas.

Resources should be redistributed in favor of district health services with a special emphasis on rural health. It is important to acknowledge that the White Paper for the Transformation of the Health System in South Africa and the White Paper on Transforming Public Service delivery - *Batho Pele* 'People First' have made an important shift in health delivery and in re-addressing past inequalities. The criteria for reprioritization developed by the Department of Health, which is about making health services accessible to the majority of the population with a specific focus on vulnerable groups, women and children, rural, peri-urban and urban poor, are important shifts that contribute towards addressing past inequalities.

The public service is a principal vehicle through which the promise of health care services to the majority of the population can be realised. This is not forgetting that for Public Service strategy of *Batho Pele* to be effective resources have to be available.

APPENDIX 1

QUESTIONIARE

RESEARCH TOPIC

The right of access to health care services and the quality of care that is afforded to rural communities in South Africa within the confines of the state's resources

1. Gender: Female ☐ Male ☐
2. Home language : English ☐
   Zulu ☐
   Other _____
3. Occupation

_____

_____

_____

4. What is your understanding of appropriate health service delivery?

_____

_____

_____

5. Does your hospital have enough resources to cater for community needs?

_____

_____

_____

6. Are the health services easily accessible to the majority of the population?

_____

_____

_____

7. What are the reasons that contribute to lack of accessibility to health resources?

8. Do you think the Department of Health in Kwa-Zulu Natal is effective its health delivery initiatives?

10. What are the rural people health needs?

11. Is the community involved in any policy decision making process about health care delivery?

12. What do you understand about *Batho pele* 'people first' program and its principles?

13. When submitting your self for treatment does the health personnel apply the courtesy principle?

14. Does *Batho Pele* strategy help in effective delivery of health services?

15 If the answer mentioned above is no, what do you think are the *Batho Pele's* shortcomings?

15. Does the hospital have any programmes that are geared towards *Batho pele* ?

16. Is *Batho Pele* effective in bringing the services closer to the community especially the disadvantaged communities?

17. In the White Paper for Transformation of Health System in SA, the Department of Health promises to readdress health delivery and to focus on the previously disadvantaged communities. Is it effective on this mission?

18. The theme of the Department of Health's Five Year Plan, is to improving quality of care which involves ensuring that facilities, drugs, equipment, health personnel are available, how effective is this?

19. If you were to advise the Department Health in their health delivery strategies what would you want them to do?

21. How do you feel about the difference in health service delivery between rural hospitals and urban hospitals?

22. General comments about health service delivery in South Africa

LIST OF ACRONYMS

AZAPO	**Azanian Peoples Organisation**
AIDS	**Acquired Immune Deficiency Syndrome**
CEAS	**Central Economic Advisory Service**
CBO'S	**Community Based Organisations**
DoH	**Department of Health**
DoF	**Department of Finance**
DSE	**Department of State Expenditure**
DNHPD	**Department of National Health and Population Development**
FFC	**Financial and Fiscal Commission**
GDP	**Gross Domestic Product**
GNP	**Gross National Product**
GEAR	**Growth Employment and Redistribution Macro Economic Strategy**
HIV	**Human Immunodeficiency Virus**
HWFC	**Health Workers For Change**
HFC	**Health Function Committee**
IMR	**Infant Mortality Rate**
MTEF	**Medium-Term Expenditure Framework**
NITER	**National Increment for Teaching Education and Research**
NGO'S	**Non-governmental Organisations**
PHC	**Primary Health Care**
SA	**South Africa**
UNDP	**United Nations Development Program**

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