EQUITY PROMOTING HEALTH CARE POLICIES IN SOUTH AFRICA

A literature review commissioned by the Health Systems Knowledge Network

K.S. Chetty

March 2007
Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.
Acknowledgments

This paper was reviewed by at least one reviewer from within the Health Systems Knowledge Network and one external reviewer. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

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INTRODUCTION

South Africa is one of the youngest democracies in the world, with twelve years of a democratically elected government. Prior to the democratic elections, it was a country marked by oppression and extreme inequality. The democratic government has introduced a range of pro poor and pro equity policies. This paper reviews the system that was inherited by the democratic government, the equity promoting policies of the new government and the strategies adopted to implement these policies. It further analyses if the policy objectives have been met and the challenges that need to be addressed to reach these objectives.

METHODOLOGY

This paper has been drafted by reviewing the literature on equity issues in South Africa. It draws substantially on the work done by Professor Dianne McItyre from the Health Economics Unit, University of Cape Town and Professor Lucy Gilson, centre for Health Policy, University of Witwatersrand. The statistics have been drawn from the the Intergovernmental Fiscal Review, the District Health information System and statistics from the Department of Health. Information has been provided by Mr Siyabonga Jikwana, Director, Health Economics in the National Department of Health, Dr Yogan Pillay, Chief Director Strategic Planning in the National Department of Health and Dr Anban Pillay, Director of Pharmaceutical Planning and Evaluation in the National Department of Health.

Most of the analysis is from the authors personal experience in dealing with the policy issues. The author has been personally involved in the drafting of the ANC Health Plan, the health sections of the Reconstruction and Development Programme, the National Health Act, and the Health Charter. She is also responsible for policy issues on health financing.

BACKGROUND

The Apartheid Era
Prior to 1994 South Africa was a country marked by extreme inequalities, with the health policies being instrumental in maintaining economic and political power for the white population group. The differences in the health status and allocation of health resources reflected the extreme inequalities between the black and white population groups, urban and rural communities, the rich and the poor. The essential features of the apartheid era health system were (Chetty K.S (1992)):

**Fragmentation:** The health system was fragmented between fourteen different Departments of Health, with ten ‘homelands’ departments, three ‘own affairs’ departments, and one ‘general’ affairs department. This resulted in a system which was not cost effective, lacked coordination, decreased access and provided differential quality of care for the different population groups.

**Racial Segregation:** The most obvious feature of the apartheid era health system was the racial segregation of the health facilities. Reports of overcrowded, understaffed black hospitals, with underused, overstaffed white hospitals had been confirmed by the then Minister of Health in her 1990 budget speech (Venter E.H. (1990). The former ‘homeland’, ‘township’ and informal settlements were systematically underfunded as a result of apartheid policy.

**Primary Health Care:** The apartheid era government lacked a coherent primary health care strategy. The health system was biased towards curative services with only 11% of total public sector health care expenditure devoted to non-hospital primary care services (McIntyre *et al* 1995).

**Private health Care:** A key feature was a strong emphasis on the privatization of health which promoted an increase in the inequalities in health. The private sector was mainly accessible to the white population group and a minority of black people who could afford it. In 1987 South Africa spent 5.8% of its Gross National product on health care. Of this 44 percent was spent in the private sector which cared for 20 percent of the population. The remaining 56 percent was spent on care of 80% of the population dependent on the public
sector. In 1992/93 expenditure in the private sector was estimated to be 61% of total health expenditure which cared for approximately 23% of the population (McIntyre et al 1995).

POST 1994 POLICIES

The African National Congress (ANC) won an overwhelming victory in the first democratic elections in 1994. In preparing to govern the ANC prepared, through a widely consultative process, the ANC National Health Plan. The ANC National Health Plan was one of the first comprehensive sectoral plans for post apartheid South Africa which firmly entrenched the principles of social justice and equity. The vision clearly outlines that ‘The health of all South Africans will be secured and improved mainly through the achievement of equitable social and economic development such as the level of employment, the standards of education, and the provision of housing, clean water, sanitation and electricity (African National Congress (1994a). The ANC Health Plan outlined in the foreword that ‘The challenge facing South Africans is to design a comprehensive programme to redress social and economic injustices, to eradicate poverty, reduce waste, increase efficiency and to promote greater participation by communities and individuals over all aspects of their lives” (African National Congress (1994b). The Plan further states that “This document focuses on the health system, but it links with the Reconstruction and Development Programme which involves all other sectors. Health will therefore be viewed from a development perspective, as an integral part of the socio-economic development plan of South Africa” African National Congress (1994c). Arising from the Plan the key health sector goals were integrated into the Reconstruction and Development Programme (RDP), which was adopted by the newly elected government as its guiding policy document. The RDP described a package of social and economic policies that were aimed at redressing the massive inequities within all spheres of South African life. Many of the broader social sector policies (e.g. improved access to water and sanitation) were specifically motivated in terms of their likely positive impact on health status. In addition, the health sector was given a relatively high priority in the overall RDP, as it was argued that there could be more rapid ‘delivery’ in meeting RDP targets through health service improvements relative to other sectors African National Congress (1994d). Thus, health equity goals were seen as an integral part of the overall political commitment to tackling poverty and redressing inequity by the first democratic government.
Subsequently the new government, using the ANC Health Plan and the RDP, drafted the White Paper for the Transformation of the National Health System for South Africa (Department of Health (1997a)), which mapped out the proposed direction and programme of action for the transformation of the health sector in South Africa. Equity and social justice is therefore a central theme of the White Paper.

The White Paper was used as a basis for the drafting of the National Health Act No 61 of 2003 (Department of Health (1997a). The preamble of the National Health Act states right at the outset that ‘ the socio-economic injustices, imbalances and inequities of health services of the past; the need to heal divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights. The Act further states that “in order to establish a health system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognized standards of research, and a spirit of enquiry and advocacy which encourages participation” the National Health Act is enacted.

The objects of the Act are “to regulate national health and to provide uniformity in respect of health services across the nation by-

(a) establishing a national health system which-

   (i) encompasses public and private providers of health services; and
   (ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford

   • The National Health Act which is recognised as one of the most progressive health legislation globally, entrenches values of equity and social justice, and lays the basis for the legal environment to promote equity.

This background has provided a brief overview of the extremely inequitable health system before the first democratic elections in 1994, and has reviewed policy intentions of the new democratic government in pursuing equity in health. Whilst the policy proposals for the transformation of the health sector is comprehensive, this paper will review implementation,
progress and challenges of key policy issues to promote equity. These have been identified by McIntyre et al (McIntyre D, Gilson L, Wadee H, Thiede M, Okorafor O (2006). as:

1. Equity in health service delivery and financing
   - Redistributing public sector health care resources between and within provinces
   - Increasing primary care utilization levels for currently disadvantaged groups
   - Addressing the public/private mix – facilitate making resources currently located in the private sector accessible to a broader section of the population, and/or redistributing resources from the private to the public sector

2. Improving access to primary care services
3. Policies and programmes targeting vulnerable groups and diseases of poverty

EQUITY IN HEALTH SERVICE DELIVERY

Addressing inequities in allocation of public sector funding

One of the greatest challenges facing the democratic government in 1994 was addressing the inequities in public sector financing. In 1994/1995, the Dept of Health introduced a resource allocation formula, aimed specifically at addressing the massive inequities that existed between provinces in terms of public health care spending. The formula was introduced through the ‘Functions Committee’ process of determining provincial allocations. In this approach each function, e.g. Health was given a National budget, and the Function Committee was then responsible for determining the split between provinces and the National allocation based on a population based formula (McIntyre and Gilson 2002).
A five-year plan was put forward to address inequity, with a top-heavy phasing strategy, i.e. the major shifts were to occur in the early years of phasing. This formula was implemented in 1995/1996. However, the substantial reductions in certain provinces and massive increases in other provinces raised concerns around financial instability and capacity of provinces to cope. For these reasons the phasing in was slowed down in the 1996/1997 period. With the adoption of the new constitution for South Africa in late 1996, significant autonomy was afforded to provinces in many respects, including the responsibility of Provincial Legislatures to determine functional/sectoral budgets for their respective provinces. This quasi-federal process was called fiscal federalism in South Africa. The implication of the introduction of this process was that the function committees were abolished. A new budgeting system was introduced, whereby National Treasury determined the divisions of revenue between different spheres of Government. The formula worked (and continues to work) as follows:

• The Vertical Split – the division between national functions and provincial functions and more recently also local government functions. The vertical split includes conditional grants for certain programmes, which flow from National departments to provinces. It is the responsibility of the respective national department to determine the division of conditional grant revenue between provinces.

• The horizontal split – division of revenue for provincial functions between provinces and recently also division of revenue for local government functions between local governments. This is also commonly referred to as the equitable share, and is an unconditional allocation of revenue to each province to cover all provincial functions. It is then the responsibility of each Provincial Legislature (through the Provincial treasury) to determine the division of revenue between functions, e.g. Health education, social development.

Depending on provincial priorities and pressures, the provincial legislature determines how much goes to each function. The allocation is also dependant on the capacity of each provincial department to motivate for funding. Hence, there is no ability for a national department to directly influence a provincial function allocation, except for conditional grants. Fiscal Federalism was introduced with the budget of 1997/1998, and has been
functioning ever since. The most important implication and unintended consequence of fiscal federalism was the fact that it actually resulted in the expansion of inequities for some provinces.

**Trends in Inequities in Public Health Spending**

Overall, over the past twelve years, in nominal terms health care spending has improved significantly. However, taking into account the effects of general inflation and population growth, the trends indicate that health care spending has fluctuated since 1995/96, with slight real decreases between financial years in the earlier years, and improvement in the later years.

Table 1 shows the trends in consolidated public health expenditure. In current prices spending increased from R17.4 billion in 1995/96 to R34.0 billion in 2002/03 and is projected to increase to R47.8 billion in 2005/06.
## Table 1 Consolidated public health expenditure (R million)

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<td>Nominal</td>
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<td>21,296</td>
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<td>23,528</td>
<td>25,472</td>
<td>28,061</td>
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<td>34,392</td>
<td>38,673</td>
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<td>Real</td>
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<td>19,829</td>
<td>19,726</td>
<td>18,598</td>
<td>18,557</td>
<td>18,841</td>
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<td>19,616</td>
<td>20,330</td>
<td>20,504</td>
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<td>Gross Domestic</td>
<td>80,371</td>
<td>838,326</td>
<td>860,515</td>
<td>864,968</td>
<td>885,365</td>
<td>922,148</td>
<td>947,373</td>
<td>982,327</td>
<td>1,015,556</td>
<td>1,056,771</td>
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<td>Total govt</td>
<td>154,525,000</td>
<td>175,331,000</td>
<td>189,947,000</td>
<td>204,293,000</td>
<td>231,780,000</td>
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<td>331,685,000</td>
<td>368,904,000</td>
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<td>Health care</td>
<td>126,058,000</td>
<td>146,519,000</td>
<td>163,490,000</td>
<td>184,005,000</td>
<td>198,162,000</td>
<td>215,592,000</td>
<td>248,262,000</td>
<td>278,508,000</td>
<td>299,431,000</td>
<td>347,854,000</td>
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<td>Health care% of</td>
<td>11.71</td>
<td>11.25</td>
<td>11.57</td>
<td>11.48</td>
<td>11.93</td>
<td>12.26</td>
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<td>11.84</td>
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<td>Total GDP</td>
<td>11.0%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>1.1%</td>
<td>1.1%</td>
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<td>1.1%</td>
<td>1.1%</td>
<td>1.2%</td>
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<tr>
<td>Health care budget</td>
<td>14.04%</td>
<td>-0.52%</td>
<td>-5.72%</td>
<td>-0.22%</td>
<td>1.53%</td>
<td>3.72%</td>
<td>0.37%</td>
<td>3.64%</td>
<td>0.86%</td>
<td>4.00%</td>
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<td>Medical Inflation</td>
<td>9.3%</td>
<td>7.8%</td>
<td>18.8%</td>
<td>12.3%</td>
<td>10.7%</td>
<td>8.9%</td>
<td>12.0%</td>
<td>12.4%</td>
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Source: IGFR, National Treasury
Comparison between percentage increase in govt revenue, nominal increase in health care budget and real growth of health care budget.
In summary, whilst public health spending had not kept pace with growth in the population nor with growth in the economy in the earlier years, over the latter few years there has been improvement in the health budget, with the funding of the public health sector recovering significantly since the late 1990’s. Health expenditure has grown in real terms overall from 2002/03. However this will need to be improved to increase the per capita expenditure of the health sector.

Trends in provincial public health expenditure

In 1995/96 provinces showed great inequalities in levels of public health expenditure. These varied from lows of R223, R316 and R321 per uninsured person in Mpumalanga, North West and Limpopo respectively to highs of R812 and R766 per uninsured person in Western Cape and Gauteng. Tables 2 and 3 show public health expenditure, and public health expenditure per uninsured person, by province.
### Table 2 Provincial public health expenditure (R million)

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<td>Eastern Cape</td>
<td>2,206</td>
<td>3,066</td>
<td>3,031</td>
<td>3,048</td>
<td>3,496</td>
<td>3,790</td>
<td>3,992</td>
<td>4,493</td>
<td>5,242</td>
<td>5,173</td>
<td>6,122</td>
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<td>Free State</td>
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<td>1,659</td>
<td>1,692</td>
<td>1,777</td>
<td>1,953</td>
<td>2,194</td>
<td>2,563</td>
<td>2,797</td>
<td>3,099</td>
<td>3,250</td>
<td>3,470</td>
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<tr>
<td>Gauteng</td>
<td>3,902</td>
<td>4,643</td>
<td>5,299</td>
<td>5,478</td>
<td>5,942</td>
<td>6,838</td>
<td>7,685</td>
<td>6,190</td>
<td>8,597</td>
<td>9,973</td>
<td>10,404</td>
<td>11,011</td>
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<tr>
<td>KwaZulu Natal</td>
<td>3,285</td>
<td>4,234</td>
<td>4,806</td>
<td>4,900</td>
<td>5,772</td>
<td>7,033</td>
<td>7,535</td>
<td>8,343</td>
<td>8,950</td>
<td>10,517</td>
<td>11,737</td>
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<td>Limpopo</td>
<td>1,424</td>
<td>1,999</td>
<td>1,954</td>
<td>2,081</td>
<td>2,524</td>
<td>2,664</td>
<td>3,166</td>
<td>3,724</td>
<td>4,196</td>
<td>4,790</td>
<td>5,448</td>
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<td>Mpumalanga</td>
<td>541</td>
<td>817</td>
<td>1,047</td>
<td>1,058</td>
<td>1,117</td>
<td>1,457</td>
<td>1,689</td>
<td>2,007</td>
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<td>2,654</td>
<td>2,912</td>
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<td>Northern Cape</td>
<td>277</td>
<td>330</td>
<td>376</td>
<td>392</td>
<td>433</td>
<td>466</td>
<td>517</td>
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<td>North West</td>
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<td>Western Cape</td>
<td>2,346</td>
<td>2,780</td>
<td>2,937</td>
<td>3,032</td>
<td>3,468</td>
<td>3,731</td>
<td>3,984</td>
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<td><strong>Total</strong></td>
<td>16,094</td>
<td>20,617</td>
<td>22,484</td>
<td>23,024</td>
<td>24,376</td>
<td>25,900</td>
<td>26,617</td>
<td>29,884</td>
<td>33,367</td>
<td>35,762</td>
<td>40,575</td>
<td>46,917</td>
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Source: IGFR, National Treasury

### Table 3 Provincial public health expenditure per uninsured person (R)

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<td>706</td>
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<td>802</td>
<td>849</td>
<td>855</td>
<td>880</td>
<td>923</td>
<td>998</td>
<td>1,083</td>
<td>1,118</td>
<td>1,203</td>
<td>1,352</td>
<td></td>
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</tr>
</tbody>
</table>

*Source: IGFR, National Treasury*
The average provincial health expenditure per uninsured person in 1995 was R685 (table 3). Most provinces beginning the series with below average *per capita* health expenditures experienced positive overall rates of *per capita* growth, while those starting the series with above average expenditures all exhibited contraction in *per capita* spending.

In Figure 2, it is clear that the pattern, with respect to inequities in per capita public health care expenditure still exists. By 2005/06, five of the nine provinces are above the national average. Whilst the four formerly disadvantaged provinces are still well below the national average.
Figure 3, below, quantifies the distance from the national average, or equity. That is, the extent to which certain provinces are above or below the national average.

Gauteng and Western Cape remain by far the highest above the national average per capita expenditure on public health care. At the same time, Eastern Cape, Mpumalanga, Limpopo, and the North West are significantly lower than the national average.

By 2005/2006, the Free State, KwaZulu-Natal and Northern Cape have moved above the national average.
Figure 3: Real per capita trends - Distance from national average
In the earlier years the North West and the Limpopo Province had moved significantly further away from the national average, whilst in the latter three there have been improvements in moving towards the national average. The Limpopo province in particular is showing a steady move towards the national average. The Mpumulanga Province showed a dramatic improvement towards the national average, but in 2005 this was reversed. The Free State province and Kwazulu Natal have moved above the national average in the latter years. The Northern Cape has been showing steady improvement over the last three years.

Whilst there are promising signs from Gauteng and Western Cape of moving downwards towards the national average, the annual rate of change is quite mixed. Until 2000/01, Gauteng was rapidly moving further away from the national average, since then this has steadied with a slow downward movement. The Western Cape on the other hand is showing trends of moving away from the national average for the latter years.

In summary, whilst funding for the public health sector is showing improvement, vast disparities still exist between provinces.

THE PUBLIC PRIVATE MIX

Given that health care expenditure in South Africa was approximately R107 billion in 2003/4 equivalent to 8.7% of GDP in that year, and that this compares favourably with many other countries in terms of percentage of GDP, there is a strong basis for arguing that the key challenge facing the national health system is not necessarily one of inadequate resources but inequitable and inefficient application of resources. Inequitable application of resources results in inadequate access for many. In 2003/4 medical schemes spent approximately R8 800 per beneficiary while in the public sector the figure was approximately R1050 for persons who were not members of medical schemes.
There is a small minority of South Africans, (between 15 and 20 percent of the population) who have a high degree of access to health services and a large majority (between 80 and 85 percent of the population) who have limited access to health services. According to the latest figures, the state spends some R33.2 billion on health care for 38 million people while the private sector spends some R43 billion servicing 7 million people.

The most significant challenge facing the South African health system is to provide an equitable distribution of resources between the public and private health care sectors, urban and rural areas, and across and within provinces relative to the population served by each.

The financing of health care in South Africa currently contributes to the inequity between the public and private health sectors. Slightly more than 38% of total health care funds in South Africa flow via public sector financing intermediaries (primarily the national, provincial and local departments of health) while 62% flows via private intermediaries. Medical schemes are the single largest financing intermediary accounting for nearly 47% of all healthcare expenditure followed by the provincial health departments at 33% and households (in terms of out-of-pocket payments directly to health care providers) at 14% of all health care expenditure. The national and local government health departments and direct expenditure by firms account for less than 6%. In relation to the original sources of finance, the vast majority of funds flowing through public sector financing intermediaries are funded through nationally collected general tax and other revenues. From the provider perspective, about 39% of all health care expenditure occurs on public sector providers and 61% on private sector providers. This is inequitable when one considers the number of persons treated by private sector providers as opposed to public sector providers.

There has been extensive transformation of the medical scheme legislation over the past few years. The Medical Schemes Act promulgated in had sought to:
• Promote non-discriminatory access to private health funding.
• Put medical schemes on a more sound financial footing
• Improve scheme governance in interests of members
• Improve consumer protection through enhanced regulatory oversight.

Previously exclusion and risk rating practices resulted in age and risk rated financing and significant declines in coverage of vulnerable groups. Access to coverage by vulnerable groups was also being negatively affected by erosion of benefits. This was compounded by the practice of ‘dumping’ patients who had run out of benefits in private hospitals into the public sector. At the same time, deregulation and inadequate regulatory capacity had allowed other problems to emerge, including poor solvency levels, and inadequate accountability and member participation in scheme governance. Rapid cost escalation had resulted in stagnation in medical scheme membership.

There has been significant progress since the Act has been passed. Not all schemes have reached the prescribed solvency level of 25%, but there has been a drastic improvement since the Act was passed. However, continued escalation of both health and non-health care costs remains a challenge as this will weaken these gains.

From 2000 to 2003, total non-health care costs increased by approximately 67%. The major part of the expenditure was due to administration (70% of non-health expenditure). But whilst non-health care costs are of concern, expenditure on private hospitals have been rapidly increasing and account for about one third of expenditure. This has a result of increasing contribution levels which affects affordability, and decreases the amount to fund other benefits. Hospital influenced benefits grew from 20% to 60% between 1990 and 2003, whereas the benefits for general practitioners, dentists and primary care decreased from 25% to 14%. This has an impact as it decreases access to primary care and members tend to rely on out of pocket payments, which is a regressive form of payment.
Social Health Insurance was identified both within the 1994 ANC Health Plan and the 1997 White Paper for the Transformation of the Health System in South Africa, as an important policy issue to address the health financing issues in South Africa. The development of the SHI policy framework appropriate for South Africa evolved out of a number of policy processes and committees of Inquiry, which included the National Health Insurance Committee of 1995; and the Taylor Committee of Inquiry. Out of these processes and interventions the Department of Health has finalised the model of SHI required as part of the broader vision of health systems reform (Department of Health (1997b). The policy framework comprised three broad components: a mechanism for achieving risk related cross subsidies through a risk equalization fund; a mechanism for achieving income cross subsidies; and ultimately mandatory membership of medical schemes.

The first component of risk equalization has been broadly accepted by most stakeholders, including the Department of Finance. The Medical Schemes Amendment Bill® has been published for public comment, which includes the introduction of the risk equalisation fund. The process has therefore started for this first component of SHI. However there has been no agreement with Treasury on the other two components of income cross subsidies and mandatory cover. Discussions are ongoing to reach consensus on the framework for SHI. Full implementation of this important policy issue to address equity has therefore been slow.

A further strategy to address the costs within the private sector was the introduction of the National Reference Price List (NHRPL), which provides a reference price for both consumers and providers. The NHRPL began after a ruling in 2003 by the Competition Commission effectively ending the system of bargaining between schemes and groups of providers. The NHRPL is currently going through a transition phase, as it has been emphasized that it is not a recommended tariff and that benefit levels need to be determined individually by medical schemes. Currently a system is being put in place to determine the true costs of services and review the overall affordability of private health services.
Recognising the inequities between the public and private sectors, the government initiated a process to develop a Health Sector Charter. This Charter is an agreement between the public, private and NGO sector to transform the health sector in South Africa. The charter has four pillars which are:

- Access to health services
- Equity in health care
- Quality of Health Services
- Broad based black economic empowerment.

In the opening preamble it is stated that “The Parties acknowledge that it is essential to ensure the sustainability and efficiency of the health sector in order to achieve the transformation goals for each of the four key areas of access to health services, equity in health services, quality of health services and Broad Based Black Economic Empowerment.”

The Charter further acknowledges “the urgent need to effect transformation of the national health system in a co-operative, constructive and mutually beneficial relationship in such a manner as to reflect the diversity and meet the various health care needs of the total population of South Africa and recognise the important role of all stakeholders in achieving the objectives of access, equity, quality and Broad Based Black Economic Empowerment”

The Charter is structured such that it outlines principles that all stakeholders commit themselves to, reviews the challenges in the health sector, and finally proposes. A range of solutions and recommendations to address the four pillars that have been outlined.

The Charter is in its final stages of completion, and has drawn all stakeholders together to address these issues. The negotiating team comprises representatives from the private health industry and private sector organisations, government, the non-
governmental organization sector and organized labour. At this stage in the negotiations it will be premature to discuss the content of the charter as the final document has not been finally agreed to. It can be mentioned that an innovative strategy in the Charter is the implementation of the Public Health Enhancement Fund, which sees the private sector contributing a percentage of their funds to strengthen public health. The charter also recommends an intensive monitoring system to evaluate how effective the charter is. All parties are committed to ensuring that the charter is effective and will be an innovative strategy that could be utilized in other countries.

**IMPROVING ACCESS TO PRIMARY CARE**

*Health-promoting and equity-oriented policies*

After 12 years South Africa has a national health system that decentralises the management and provision of health care services to provincial, district and sub-district levels with the national level playing a policy and stewardship function. An emphasis on equity, effectiveness, efficiency, quality care and improved health led to the provision of free health care at the point of delivery for vulnerable sectors of the population, the building and upgrading of health facilities especially in rural and other under-served areas of the country, an integrated nutrition programme, expanded programme of immunisation, improved access to health care including reproductive health care, partly decentralised health management systems, a developing culture of planning and priority setting, and increasing use of and appreciation for health information for management and planning.

The public health delivery system is based on a district health system as the vehicle for the delivery of the primary health care. Clinic committees and hospital boards are in place to facilitate community participation and empowerment. Various initiatives are in progress to ensure that services are integrated. In order to pursue the government's objective of equity and equality of outcomes in human capital a range of health
Programmes have been designed and implemented by the Department of Health (DoH) since 1994:

- Free health care for children under six and for pregnant and lactating women at public clinics and health centres;
- Provision of essential drugs in all PHC facilities based on the Essential Drug List;
- Maternal and child health services through access to quality antenatal, delivery and postnatal services for all women is offered free at the point of delivery;
- Integrated Management for Childhood Illnesses is implemented in all provinces;
- An Expanded Programme of Immunisation to reduce vaccine preventable diseases;
- Integrated Nutrition Programme including the Primary School Nutrition Programme;
- Various measures to reduce substance abuse and improve the accessibility to mental health support and counselling services, particularly for survivors of rape and child abuse and those affected by domestic violence and other forms of violence;
- A comprehensive National HIV/AIDS/STI Programme which includes mass education, the ABC campaign, condom distribution, Voluntary Counselling and Testing, Home based care, nutritional education and support, treatment of opportunistic infections, Prevention of Mother to Child Transmission, vaccine development initiative, and anti-retroviral treatment;
- The National TB Control Programme which introduced Directly Observed TB Treatment Short Course (DOTS) in 1996 to prevent, treat and control tuberculosis;
- Treatment of cancer of the cervix, hypertension and diabetes;
- The promotion of healthy lifestyles;
- A national human resource strategy; and
- Patient Rights' Charter premised on constitutional imperatives to promote, protect and monitor the proper implementation of the right of access to health care services.
The first four years of the new government saw a sustained process of budget reprioritisation in favour of primary care. The percentage of the public sector health budget allocated to ‘basic health services’ doubled between 1992/93 and 1997/98, from 11 to 21 percent (de Bruyn et al. 1998). In contrast, from 1997/98 onwards, is characterised by falling per capita public health sector funding, a reversal of redistribution across provinces and limited growth in PHC expenditure.

Table 4: Primary care visits and unit costs, 2000/01 – 2005/06

<table>
<thead>
<tr>
<th>Primary care visits</th>
<th>2000/01</th>
<th>2001/02</th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
<th>2005/06</th>
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<td>Eastern Cape</td>
<td>14 339 786</td>
<td>14 383 889</td>
<td>13 746 488</td>
<td>14 503 175</td>
<td>15 312 880</td>
<td>14 618 214</td>
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<td>5 069 882</td>
<td>5 446 065</td>
<td>5 725 472</td>
<td>5 972 199</td>
<td>6 031 495</td>
<td>5 912 089</td>
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<td>12 396 325</td>
<td>13 059 604</td>
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<td>18 000 507</td>
<td>19 428 937</td>
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</tr>
<tr>
<td>Limpopo</td>
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<td>15 253 259</td>
<td>14 862 213</td>
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<td>6 063 243</td>
<td>6 193 706</td>
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<tr>
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<td>2 010 410</td>
<td>2 124 661</td>
<td>2 420 212</td>
<td>2 332 201</td>
<td>2 175 354</td>
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<td>8 892 998</td>
<td>9 668 768</td>
<td>9 822 014</td>
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</tr>
<tr>
<td>Western Cape</td>
<td>14 618 214</td>
<td>14 862 213</td>
<td>15 253 259</td>
<td>14 862 213</td>
<td>13 623 772</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>81 907 039</strong></td>
<td><strong>87 571 063</strong></td>
<td><strong>92 438 180</strong></td>
<td><strong>96 330 998</strong></td>
<td><strong>100 874 486</strong></td>
<td><strong>101 758 377</strong></td>
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<td>Visits per capita</td>
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<tr>
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<tr>
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<td>3.8</td>
<td>3.8</td>
<td>4.0</td>
<td>3.9</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>2.3</strong></td>
<td><strong>2.4</strong></td>
<td><strong>2.5</strong></td>
<td><strong>2.5</strong></td>
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<td>Cost per visit (nominal prices local government)</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>63.8</strong></td>
<td><strong>73.0</strong></td>
<td><strong>79.6</strong></td>
<td><strong>84.1</strong></td>
<td><strong>95.3</strong></td>
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Source: IGFR, National Treasury
Output data provided by provinces suggest that increased PHC funding led to improved access to health services. Visits to primary health care facilities have increased from 81.9 million in 2000/01 to 101.8 million in 2005/06. This brought utilisation rates up to 2.5 visits per capita by each uninsured person (the range starts at 2.1 for Gauteng up to 3.9 for Western Cape), thus bringing the rate closer to the long-term national target of 3.5. Unit costs (all five subprogrammes and local government own funding included) have increased from an average of R64 per visit in 2000/01 to an average of R95 per visit in 2005/06.
Research conducted by the Health Economics Unit of the University of Cape Town and the Centre for Health Policy at the University of Witwatersrand®, shows the levels of expenditure by health district (coterminous with A and C municipalities) on primary health care in clinics and health centers financed from all sources in 2001/02 and relates the level of spending to the district deprivation index score (DIS). Expenditure varied enormously across districts, ranging from some R300 per person per year at the top end to less than R50 per person per year at the bottom.
The introduction of free care for pregnant women and children under the age of six years was announced by the first democratically elected President in his inaugural address on 1 June 1994. Free primary care services for all South Africans was introduced on 1 April 1996, together with a by-pass fee for those who chose to access hospital care without first using a primary care facility. This was followed by free health services for disabled people in 2003. The National Health Act also has a section that will allow for free health services to be extended to other categories of persons, especially taking into account vulnerable groups.

The first phase of the Clinic Upgrading and Building Programme (CUBP) commenced in the 1994/95 financial year, followed by phase two in 1995/96, and phase three 1996/97. From the start of the programme up until the end of 1999 a total of 506 new clinics were built using RDP, IDT and provincial funding. Also, a further 252 existing clinics had major upgrading such as the building of new maternity units, and 2298 clinics received new equipment and/or had minor upgrading done to the value of R10,000 per clinic. A total of 113 “visiting points” have also been built. Most of these consist of at least one consulting room and a hall and are used as a clinic on one day a week. Provinces using various funding sources after the CUBP came to an end in 2000 built about 230 more clinics. Over a ten-year period, more than 1300 clinics and health centers were built or upgraded, which vastly improved access to primary care services.

ACCESS TO AFFORDABLE MEDICINES

Access to affordable medicines and drugs was one of the key priorities of the new government. A National Drug Policy (NDP) was developed to take forward this objective. However, implementation of this policy has led to many court challenges, including the constitutional court. This has led to many landmark decisions in the fight for access to affordable medicines. The key components of the NDP were generic substitution, a transparent pricing system and licensing for dispensing.
Whilst there was initial resistance to generic substitution, this aspect was eventually accepted by stakeholders. However there was a massive resistance to the introduction of the pricing regulations.

The pricing regulations introduced a system of transparent pricing where the price from manufacturer through to patient is available to the public. The regulations also introduced the concept of a single exit price (SEP) – manufacturers must sell at one price to all purchasers (irrespective of volume purchased). Some of the multinational pharmaceutical companies took the Department to court in the late 1990s, but withdrew just before the hearings.

In addition to the single exit price, the dispensing fee had been fixed. Retail pharmacists challenged this fee, which led to a protracted legal battle, during which time professionals were charging different fees. The court ruled that whilst there is no problem with the regulations, the Department should review the amount of the fee. Currently, the pricing committee is reviewing the fee in light of this judgment. Despite these court challenges, the policy of access to affordable medicines is being realised.

Another aspect of the NDP was the introduction of lay ownership of retail pharmacists to promote the development of rural pharmacies. The introduction of this legislation has not achieved the policy objective – chain stores have used the legislation to introduce more pharmacies in already over-serviced urban areas. There has been little pharmacies established in rural areas.
CHALLENGES AND LESSONS LEARNT

While the Department of Health, South Africa has put in place structures and policies for improving the health of the people and addressing inequities, a number of challenges in service delivery remain. It is not within the scope of this paper to discuss all the challenges, but a few key challenges are discussed. These have been grouped together under funding and provision of health services.

Funding Issues – Public Sector Funding

With the introduction of the quasi-federal process to determine sectoral budgets, inequities between provinces have increased, as allocations to health are dependent on provincial priorities and pressures. The health sector in the provinces have to compete with other social demands such as education, housing and social development. The national departments have limited ability to influence the provincial health allocations.

One of the strategies used by the national departments was to utilize the allocation of conditional grants to influence the funding patterns. It is not within the scope of this paper to review the pros and cons of conditional grants, suffice to say that conditional grants are national allocations made for specific programmes with strict conditions on what and how it can be used. With certain of the conditional grants which were intended to fund existing services, such as tertiary services, the National Department of Health had protracted discussions with the National Treasury and provincial departments of health to introduce a development component to allow those provinces that did not have the services to develop them through the use of the conditional grant. Through this strategy the National Department was able to help reduce some of the inequities between provinces.
Funding Issues – Public private Mix

Tackling the inequities between the public and private sectors has proved to be very challenging. Because of the vested interests within the private sector, any attempt at transformation has resulted in resistance. There is often conflicting positions within the private sector as there is differing positions between the providers, funders and industry groups. Whilst most stakeholders will maintain that they support the principles of affordability and sustainability of the health system, each stakeholder will still want to ensure their hegemony within the sector. The Health Charter process has been successful to the extent that it has brought all stakeholders to the same table to discuss and debate the differing viewpoints. The charter has committed stakeholders to a common vision and set of principles, and solutions that will address the challenges. The success of the health charter process cannot be evaluated at this early stage and needs to be carefully monitored. However, most stakeholders have confirmed that the process itself has been helpful, as it has brought the various stakeholders together and established a forum where issues can be debated. This has resulted in greater confidence amongst stakeholders that there concerns will be taken seriously, and has resulted in a greater sense of trust and respect between stakeholders.

It is of interest to note however, that the process of engagement only assists to a certain extent in issues of costs and reimbursements of services. The National Reference Price List and the Pricing Regulations have shown that regardless of processes followed, stakeholders will continuously utilize legal and other channels to challenge any perceived cost containment measures.

Provision of services

A major challenge that has been faced by the democratic government is that progressive policies have been ineffectively implemented because of capacity and human resource issues. These include:
• poor management of health service facilities including hospitals;
• shortage of certain categories of health workers, e.g., primary health care nurses, doctors and pharmacists;
• shortage of skilled health professionals in rural areas;
• migration of health professionals to the private sector and overseas;
• lack of essential equipment and poor management, procurement and distribution of drugs;
• rapidly escalating HIV rates since 1990’s, an escalating TB epidemic and the emergence of Multi-drug resistant Tuberculosis; and
• deficiencies in infrastructure and management capacity in underprivileged areas;
• difficulties of recruiting and retaining health personnel in deprived areas;
• users not satisfied with quality of health services;

To address these problems, government initiated a number of strategies. These included a hospital revitalisation programme, the introduction of allowances for health professionals to recruit and retain health professionals and the drafting of a human resources plan. The hospital revitalisation programme has seen and aims to see the revitalisation of hospitals, which includes the infrastructure, the management and technology of hospitals. This programme has been very successful, but is dependent on the funds received from Treasury.

The human resource issues is much more complex. The introduction of a scarce skills and rural allowance has resulted in better recruitment and retention of health professionals. However, it has also resulted in a number of labour conflicts from those professionals who do not receive these allowances.

In the SAZA study, Gilson et al (2003) have identified a number of issues impeding policy implementation. They conclude that ‘Health care financing reform has, in particular, often be seen as the preserve of health economists, yet it has frequently floundered because too little attention has been paid to the contextual, political,
personality and strategic factors that always shape policy change’. The conclusions drawn from this study focused on the need to develop both technical capacity and strategies that support policy change. They recommend it is important to increase the number of analysts working within government, provide in-service training to develop technical skills, strengthen the links between government and non-government analysts. For policy developments such strategies might include identifying and working with key individuals who can support proposals at the highest political level, countering, for example, possible opposition from the national economic ministries as well as identifying and working with social actors, such as trade unions.

CONCLUSION

Whilst South Africa faces major challenges in addressing inequities, equity is high on the health and social policy agenda and a range of specific policies and programmes have been developed to effect the equity goal.

Fiscal constraints will slow the progress towards this goal. Although the public health sector has received greater budgetary protection than other sectors and does have additional financing options open to it, it faces large and growing demands.

There are a number of lessons that can be learnt from the South African experience. There are a number of factors which have enabled health equity to receive a relatively high policy priority in South Africa. Firstly, the constitutional entitlement to health services is important in establishing a clear goal for policy action. This constitutional right has been entrenched in the National Health Act. Secondly, political advocacy for the importance of health equity gains has been critical. One of the key reasons that health strategies have received support from a wide range of politicians is that the health sector was seen by the new government as an area where rapid equity gains could be achieved. However, improvements in geographic access and the quality of health services have proved difficult to achieve rapidly, despite the policy imperatives.
Reasons for this have been highlighted under challenges. A key obstacle is the issue of human resources. Thus whilst investment in infrastructure is of paramount importance, the capacity to spend and to maintain quality services depends on the quantity and quality of human resources.

Another issue that needs to be addressed is the need to inequities in health care financing within and between the public and private sectors. Currently there are strategies that are been developed to deal with these issues. In particular, the finalization of the Health Sector Charter, will address many of these issues.

Finally, the South African experience indicates that good intentions on the part of government and even some good government policies are simply not enough to promote equity. The promotion of equity requires buy-in from a number of stakeholders, to prevent obstacles and challenges arising. In addition, effective policy action also requires the strengthening of health systems, as good policies cannot be implemented without the appropriate vehicle.
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