The Second Equity Gauge

Monitoring Fairness in Access to Basic Services Essential for Health

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MONITORING FAIRNESS IN ACCESS TO BASIC SERVICES ESSENTIAL FOR HEALTH

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INTRODUCTION

Post apartheid South Africa continues to experience the enduring legacy of a society afflicted with inequities. Apartheid policies intentionally nurtured an environment that favoured one section of society to the detriment of others. As a result, South Africa is one of the world's most inequitable countries today; the richest 10% of households accrue over 40% of the country's total income, while the poorest 40% of households, constituting 50% of the population, account for only 11% of total income. Although South Africa is categorised as an upper middle-income country, more than half the population lives in poverty.

The health status of a person is linked not only to access to health care but also to broader infra-structural and socio-economic issues such as education and literacy, transport, the social security system, and access to water, energy and housing. Resources allocated to these sectors are in turn, dependent on the economy and the macro-economic policies of the government.

Both economic and social policies influence the health sector's ability to limit or reverse health inequities within the population. Sustainable health gains therefore, can only be achieved within a broader context of equitable economic and social development. Differences between groups in health outcomes such as infant mortality rates, are not only a result of health system shortcomings but also a reflection of a broader social and economic environment that is inequitable.

This document will show that in South Africa today, 10 years after the official end of apartheid, access to a decent standard of living, to decent housing, sanitation, education, and employment are all strongly associated with race, gender, and the provinces where people live. – All of these factors are well-established basic and powerful determinants of health. This means that South Africans' opportunity to be healthy varies with one's skin colour, gender, and where one is fortunate – or not – enough to reside.

Human rights principles require governments to remove obstacles faced by certain groups who have suffered discrimination and marginalisation that get in the way of disadvantaged groups realising their rights, including their right to health. South Africa's first democratic government introduced a number of highly regarded, and often equity promoting, policies throughout most sectors of society. Significantly, despite global trends increasingly being towards charging for health care, the South African government has protected the concept of health care as a public good, and public sector primary health care and care to pregnant women and children under six is provided free of charge. But the redress of previous disadvantage and the promotion of equity have proven to be more elusive goals than had been anticipated and the gap between policy and implementation has become a serious concern and frustration for policy makers and activists alike. The basic human right of participation in, and enjoyment of, the benefits of progress is not enjoyed uniformly throughout South Africa. Many communities face obstacles of social and economic deprivation, and rights to water, sanitation, shelter and food remain hugely unequal.

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WHAT IS EQUITY?

The country's long history of state-sanctioned inequity has resulted in a particular importance being attached to human rights and the attainment of equity since 1994 and equity considerations underpin much policy development. The goal of equity is explicitly referred to in the strategic plans of the Department of Health and rests as one of the cornerstones of our democracy.

Inequities in health refer to those differences in health that are unfair, unacceptable and avoidable. Equity is not the same as equality. Equality implies providing the same level of services to everyone regardless of the need they have for the service. Equity on the other hand requires that more resources are targeted towards meeting the needs of those who are most disadvantaged and vulnerable. One would expect people living in poverty, with inadequate water, sanitation, housing, food, and/or education, to need more health services because of the health-damaging effects of deprivation. Unfortunately the entrenched backlogs created prior to 1994 are proving hard to redress for a number of reasons, and as a country we have not nearly reached even equality of service provision in key sectors such as education, water, sanitation and health, despite access to socio-economic rights being guaranteed in our Constitution.

In 1999, the Health Systems Trust published the first ***Equity Gauge***, which focused strongly on the relationship between access to and quality of health care systems and health outcomes, and attempted to measure whether health care was being provided in a fair and equitable way. To that end it focused on health status indicators and, to a much more limited degree, socio-economic factors surrounding health care and access to health services.

The second ***Equity Gauge*** seeks to place the goal of equitable health care within a broader framework that links socio-economic disparities with health outcomes.

This publication highlights the fact that people do not get sick at random and that health is intimately tied up with living and working conditions. In focusing on this interdependence of socio-economic determinants with health outcomes, the document also points to the relationship between health status and geographical, racial and gender-related issues.

Further it will show that despite attempts by the government to improve access to essential infrastructure for poor communities, and that despite there having been some improvement in the delivery of primary health care in previously disadvantaged areas, key measures of health, widely thought to be indicative of the general well being of a community, have worsened since 1999.

The *Gauge* is primarily aimed at assisting national and provincial legislators and councillors to understand and monitor health policies and measure their impact on equity, although we hope it will be of use to a wider audience including NGOs and CBOs.

A wide range of sources of information has been used to prepare the indicators included here. They present a broad overview of progress towards equity and highlight particular areas that might benefit from accelerated action or specialised intervention.

This *Gauge* starts by analysing selected economic and social indicators, which set the scene for indicators of health equity. Indicators have been chosen to highlight the policy response to health needs. A number of the indicators specific to the measurement of health status were also included in the first Gauge and wherever possible new information is presented to show the extent to which progress has been made. However, we have also included economic indicators in line with our attempt to highlight the impact of the broader social and economic context on the attainment of health equity.

EQUITY IN THE SOCIO-ECONOMIC DETERMINANTS OF HEALTH

KEY INDICATORS
1. Household access to Basic Amenities
2. Provincial contributions to Gross Domestic Product
3. Annual average economic growth
4. Unemployment

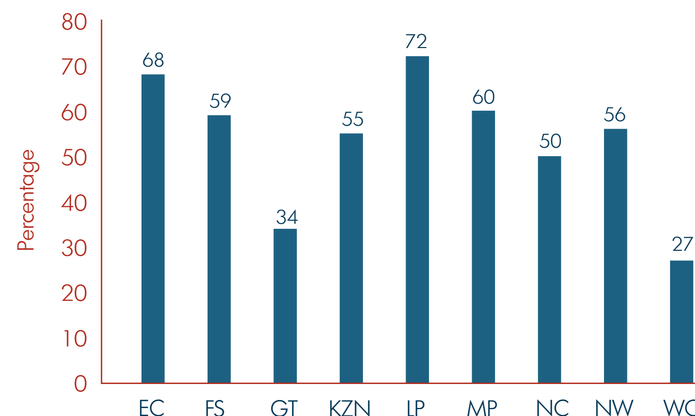
Household monthly incomes

Income plays an important role in determining access to basic services including access to water, electricity, health care, housing and education. The higher the number of poor households, the greater the number of people, who will have difficulty in accessing basic services. It is accepted that there is a link between poverty and ill health, with poor families experiencing much higher levels of ill health than better off families. In turn, ill health also creates poverty as a result of the financial and human stress exerted on families coping with sickness.

The data in figure 1 are consistent with previous data confirming Gauteng and the Western Cape as the economic powerhouses of the country. What is not captured by this data from 1996 is the impact of social grants. Between 1994 and 2003 the number of beneficiaries increased from 2.6 million to 6.8 million. This substantial increase is likely to play a role mitigating some of the negative impacts of poverty.

Figure 1

Households with monthly income below R800 (Census 1996)



Source: Statistics South Africa, 2000

- In 1996,[1] the majority of households in six of the nine provinces were living on less than R800 per month. While it is possible that this figure may have improved since then, given the link between employment and household income, this seems unlikely in view of the fact that unemployment has increased from 34% in 1996 to 41% in 2001.
- The poorest provinces are Limpopo and the Eastern Cape where 72% and 68% of households survive on less than R800 per month respectively.
- The richest provinces are Gauteng, where only 34% of households live on less than R800 per month, and the Western Cape, where this figure stands at only 27%.

1 Most recent data from Census 2001 not available at the time of compilation. 1996 data used for illustrative purposes.

Household access to basic amenities

People do not get sick (or recover) at random, but rather in relation to their living, working and socio-political circumstances. Socio-economic status is a reliable predictor of quality of life, burden of disease, access to basic amenities, education, employment and uptake of basic government services. While certain basic services may exist in theory, in reality access to and uptake of these services is severely constrained for many people due to a number of factors associated with poverty and social exclusion. Inequities can be found in differences in access to the service, in levels and costs of the service and in the waiting periods and level of maintenance of the services.

Between 1996 and 2001 the population increased from 40.4 million to 44.8 million, and the number of households rose by more than 2 million from 9.7 million in 1996 to 11.8 million in 2001. This increase in the numbers of people and in households that require access to services impacts on government's ability to increase the percentage of the population who access services. So even though more households and individuals may be accessing services now, there has been little progress in reducing the gaps between advantaged and disadvantaged South Africans.

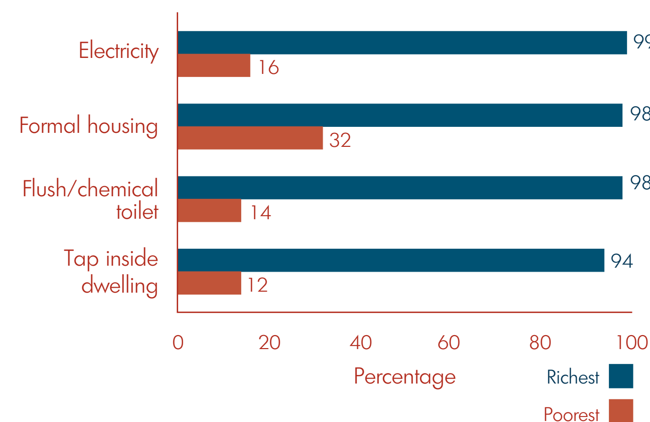
Access to Basic Facilities

The lack of access to and differential provision of basic services has a strong impact on how people live and on the time and energy expended in compensating for and accessing alternative sources. Lack of water and electricity, for example, means people spend substantial amounts of time and physical resources collecting water and firewood. This is physically arduous work which devolves disproportionately onto women (and on rural women and young girls in particular). The health and safety aspects of such work have been well documented with women being vulnerable to sexual attacks, snakebites and other injuries incurred by the heavy labour. Because attaining basic amenities in resource scarce situations becomes a priority of life and death, such activities take precedence leaving little time and opportunity to spend on life enhancing activities (for example adult education and income generating activities) which ultimately impedes the ability to fully develop and harness human capital.

It is commonly accepted that access to basic amenities affects health. For example the most important determinants of infant mortality are access to safe water, sanitation, nutrition and the mother's education.

Figure 2

Access to basic facilities according to income



Source: Statistics South Africa, 2000

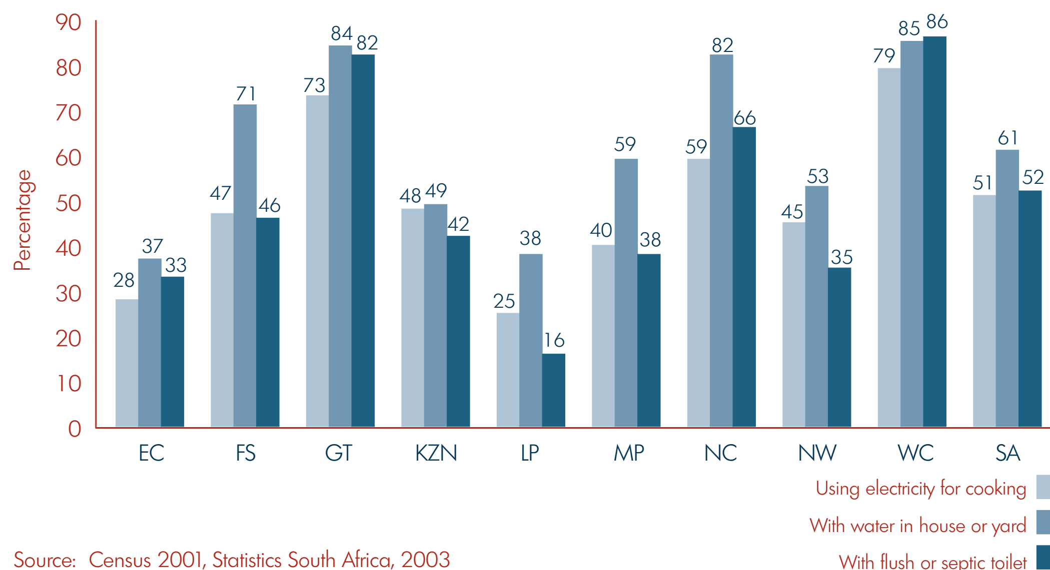
- 88% of the poorest South Africans do not have access to water in their dwellings.
- Access to formal housing is restricted to 32% of the poorest South Africans.

- The most pressing needs for the poorest appear to be access to water in their dwellings, chemical or flush toilets and electricity.

Figure 2 demonstrates the close link between class, access to basic facilities and standard of living. While the state is responsible for providing many of these services, exclusionary rules and practices (based largely on income) of the private sector further compounds inequities. Access to credit to purchase or rent a home for example, is not readily or easily accessible to poorer people, which further affects their eligibility to acquire electricity, running water etc. However, the corollary is not necessarily true and many people who live in formal housing do not have access to water, electricity and adequate sanitation.

Figure 3

Household access to basic facilities by province



Source: Census 2001, Statistics South Africa, 2003

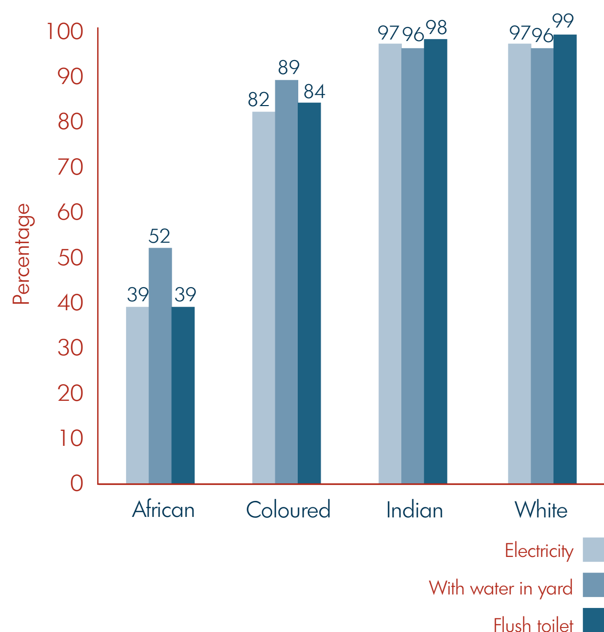
Figure 3 illustrates substantial gaps in access to basic amenities between provinces.

- Households in the Limpopo and Eastern Province have the least access to running water, with only 38% and 37% of households having tap water in the house or the yard. These figures suggest that these areas, which are amongst the poorest, are also the most susceptible to poorer hygiene and water-borne diseases. By contrast, the two largest contributors to the country's GDP – the Western Cape and Gauteng – have the best access to tap water in the house or yard, at 85% and 84% respectively.
- 86% of the households in the Western Cape are equipped with flushing/chemical toilets compared to only 16% in the Limpopo and 33% in the Eastern Cape.
- The Limpopo and Eastern Cape also have the least number of houses electrified with only 25% and 28% of households respectively using electricity for cooking.
- In the Northern Cape, 59% of households use electricity for cooking while 66% of households have flushing/chemical toilets. These figures are well above the national average of 51% and 52% respectively.

While it is clear that substantial inter-provincial inequities exist with regard to provision of basic amenities, an analysis of the figures indicates that some poorer provinces, like the Northern Cape in particular, have made reasonable progress in improving basic infrastructure and services.

Figure 4

Household access to basic facilities by race



Source: Census 2001, Statistics South Africa 2003

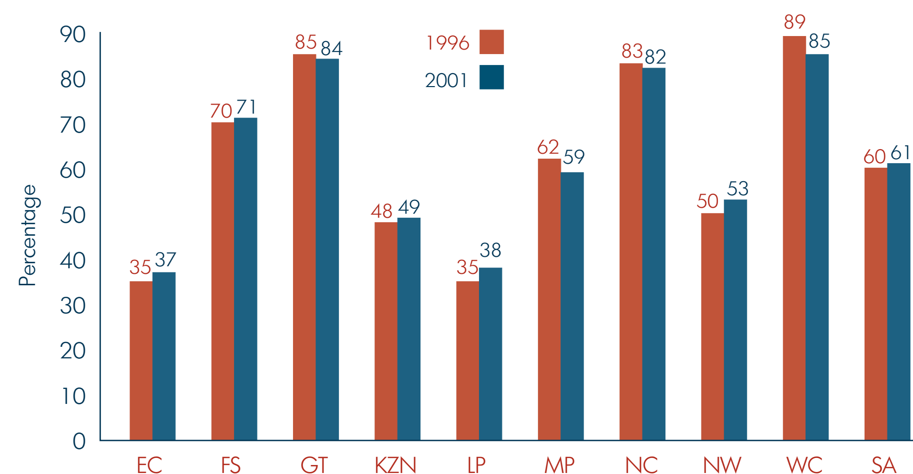
- African communities still experience the least access to basic facilities.
- 39% of African people have access to electricity and flush toilets compared to 97% White and Indian people.
- Access to water is higher among all race groups than access to electricity and flush toilets although significant differences exist among the numbers of people in the different race groups that do have access.

The above figures demonstrate the enduring nature of the apartheid legacy and the significant challenges that lie ahead in redressing these inequities.

Given the dependence of good health on basic facilities, it can be anticipated that African people suffer from higher mortality and morbidity rates than other race groups.

Figure 5

Household access to water in their yard between 1996 & 2001



Source: Census 2001, Statistics South Africa, 2003

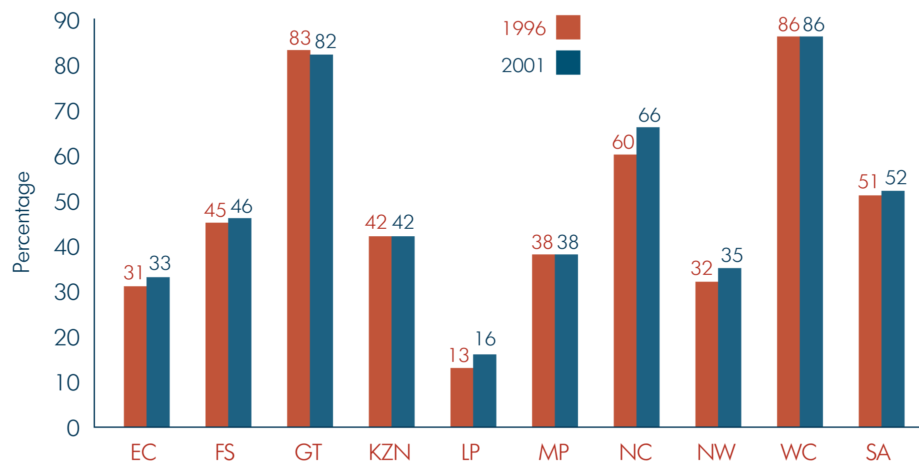
- In a period of five years, household access to water increased at a national average of 1%. However in four provinces household access to water decreased. This is likely to reflect a bourgeoning population and the mushrooming of informal settlement areas.
- Household access to water in the Eastern Cape and Limpopo provinces remains low, at approximately 37% and 38% respectively, while traditionally richer provinces like the Western Cape and Gauteng reflect access levels of approximately 84%.

- The Northern Cape, classified with a 55% poverty rate in 1998, has household access to water at approximately 82% - a figure that is comparable to the wealthier provinces.

These figures confirm that the rural poor still bear the burden of insufficient water supply. This lack of clean water poses significant health and personal safety risks, as evidenced by the outbreak of cholera in KwaZulu-Natal in 2001. Continuing dependence on rivers and streams is clearly neither a desirable nor sustainable source of water.

Figure 6

Household access to flush toilet between 1996 & 2001



Source: Census 2001, Statistics South Africa, 2003

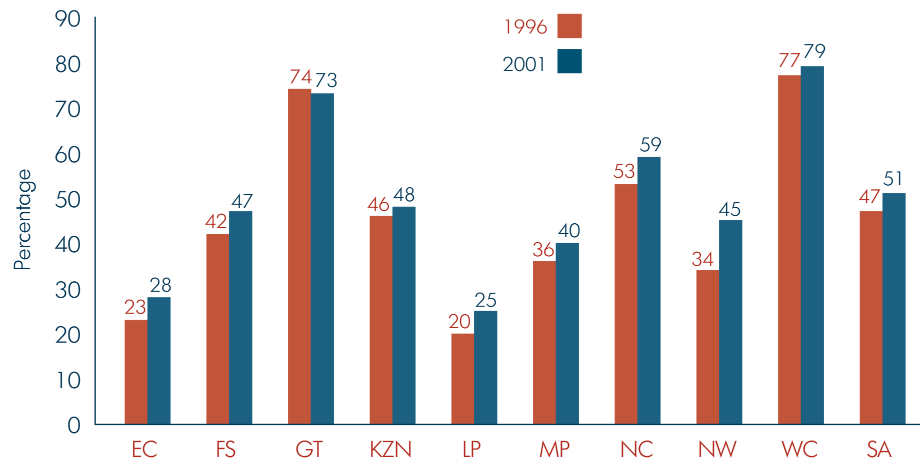
- Household access to flush toilets increased at a national average of only 1% over a five-year period. This figure masks the fact that in Gauteng access to flush toilets actually decreased and in two provinces with little provision, Mpumalanga and KwaZulu-Natal, access remained at the same level. The highest increase in the percentage of households with access to flush toilets was in the Northern Cape.
- While the national average for households with flush toilets is 52%, this figure belies the fact that in some provinces, access is as low as 16%, which reiterates other patterns of intra-provincial inequities.

Adequate sanitation remains a critical area for improved service delivery. Access to adequate sanitation becomes especially important in homes where there are special health needs. For example, in a survey of 771 AIDS affected households, those households hardest hit by HIV/AIDS were usually the most underserved in terms of basic public services like sanitation and piped water. Only 43% of households in the survey had a tap in the dwelling and nearly a quarter of rural households didn't have a toilet at all. Respondents cited chronic diarrhoea as the most difficult condition to deal with.

Electricity

Figure 7

Household access to electricity for cooking between 1996 & 2001



Source: Census 2001, Statistics South Africa, 2003

- National access to electricity for cooking increased by 4% from 1996 to 2001.
- The North West province made significant progress in this regard, showing an 11% increase from 1996 to 2001.
- Six of the country's nine provinces have access to household electricity rates that are below the national average of 51%.

Access to and use of electricity reduces environmental pollution and minimises a variety of related illnesses and hazards e.g. predisposition to respiratory diseases, asthma and burns. However, access to electricity is not always accompanied by ability to pay necessary charges, and brings with it a host of hire purchase/debt traps as low income groups are targeted by dealers to buy expensive electrical appliances at seemingly 'too good to be true' deals and prices, thereby locking people into spiralling debt.

The universal introduction of charges for water and electricity is a regressive measure, that impacts most on poor families despite the provision of 6K*l* of water free of charge every month. Households that were able to use water and electricity free of charge prior to 1994, now have to find the resources to pay their bills or risk services being cut. This has led to increasing tensions in many very poor areas where desperate families steal water from neighbours, and serious accidents arise from households illegally connecting electricity.

In analysing the trend data of delivery of basic services such as water, sanitation and electricity it becomes clear that the steady and progressive equitable realisation of the delivery of these services remains elusive. While there may have been an increase in the *number* of households which are accessing services, the *proportion* of the population has changed little, and there remains a big gap between those provinces that were formerly well resourced and those that were formerly underserved. At a provincial level, inequities based on race and income and former urban and homeland axes (rural areas) appear to be perpetuated. In some provinces, there has been no improvement or a decline in the proportion of the population accessing basic services, while other provinces have made significant inroads into addressing the shortages. These provincial variations tend to distort national average figures, and obscure the fact that service delivery might be taking place in already well-resourced areas.

The danger in assessing delivery of social services in broad national averages is that such figures could obscure more than they reveal. Assessing whether development efforts targeted those most in need for example cannot be ascertained from national figures. A further shortcoming with assessing

delivery in purely quantitative terms is that they do not provide sufficient information about quality, extent and acceptability of services rendered.

Development projects and infrastructural delivery tends to be concentrated in urban areas, probably due to the higher costs associated with such initiatives in rural areas. This urban bias is also reflective of the political sophistication and power that is associated with urban electorates, as compared to rural voters who are perceived to traditionally vote along ethnic and cultural lines. The emaciation of the countryside has resulted in a rapid urbanisation and increasing pressure being put on services and resources in urban areas.

While policies may often appear gender neutral, the lack of infrastructural development and delivery affects men and women in different ways. Most vulnerable, are women and girls in impoverished communities who are responsible for procuring firewood and fetching unpolluted water. Time spent looking for firewood is increased due to deforestation and polluted sources of water lead to them having to walk even farther to access clean water. In their roles of primary caregivers, caring for those with illness and disease arising out of poor living conditions is borne by women and girls in the family – effectively diverting time and energy away from any income generation or schooling activities.

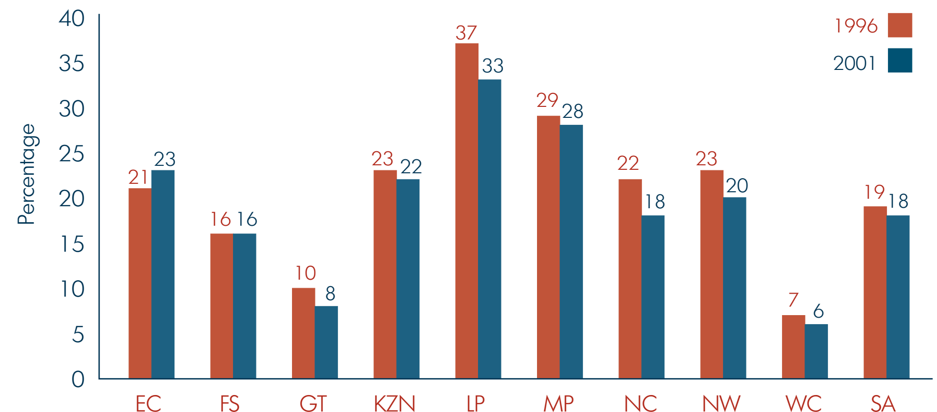
Education

Levels of education are commonly accepted as an indication of a person's life path. The effects of education or lack thereof accrue over a lifetime and influence many other social variables. Besides having a significant impact on whether a person will get a job, education also affects the level and nature of employment. Low levels of education result in people working as manual labourers, which carry significantly greater health hazards than white-collar jobs. At an individual level, improved education represents the possibility of a better income. At a general level, an educated population leads to improved economic growth. Educated people, due to their socio-economic status are also better equipped to deal with the financial and social effects of ill-health and it has been suggested that survival chances are strongly related to the level of education. In addition, education has also been linked to the acceptance of messages encouraging and promoting healthy and hygienic living practices.

- 18% of the adult population in South Africa has had no formal schooling.
- In a period of five years (between 1996 and 2001) the number of people who had no schooling dropped by 1% from 19% to 18%.
- Eastern Cape shows deterioration in the number of people with no schooling, while Limpopo with the highest numbers of people with no schooling has shown a 4% reduction over a period of five years.

Figure 8

Population 20 yrs and above with no schooling

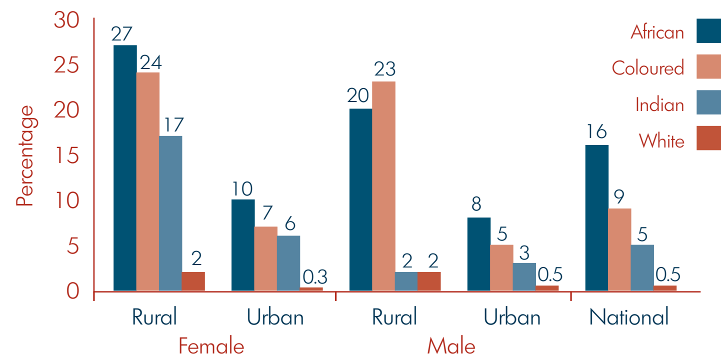


Source: Census 1996 & 2001, Statistics South Africa, 2003

The link between low levels of education and health status has been well documented. High illiteracy rates will impact negatively on any attempts towards achieving equity in health, especially as it is the poorer provinces that have the highest population with no schooling. Although there has been a small drop in the overall proportion of the population with no schooling, reversing this trend is a long-term process, and at the current rate of progress it will take approximately 40 years to realise a drop from 18% to 10%.

Figure 9

Percentage of people 20 yrs and above in rural and urban areas who cannot read, by race



Source: October Household Survey of 1999, Statistics South Africa 2001

- Nationally, 0.5% of the White population cannot read, while 16% of the African population are unable to read.
- 27% of rural African women and 10% of urban African women cannot read. This contrasts with 2% of rural white women and less than 1% of urban white women who cannot read.
- Approximately 24% of the rural Coloured population cannot read. Nationally this figure stands at 9%.

Figure 9 demonstrates that illiteracy and education levels are still disaggregated along racial lines. Africans suffer from the highest illiteracy rates, especially in rural areas followed by the rural Coloured population.

In all instances, rural dwellers had lower educational levels than those living in urban centres, again highlighting the inequities between rural and urban areas. Rural areas, where unemployment is the highest, tend to have a large proportion of adults who are not educated. The low levels of education rates in certain areas suggest the need for an accelerated Adult Basic Education and Training (ABET) programme.

Unemployment

The unemployment rate is the percentage of people who are of working age and wanting to work or seeking employment but are unable to find a job. Unemployment is poorly measured in South Africa and estimates vary greatly depending on the source as well as the broadness of the definition. Figures range from 22.5% for the narrow definition, to 41.0% for the broad definition of unemployment, which includes those who have been out of work for a long time and no longer actively seek work. This document uses the broad definition of unemployment.

Employment rates are a good indicator of a citizenry's ability to generate income and of growth in an economy. However, growth can also be achieved through the intensification of the technology and capital rather than increased utilisation of labour. This has been the case in South Africa over the 1990s when jobs have actually been lost in the economy as a result of industrial restructuring. In the late 1990s and early 2000 there has been an increase in the total number of new jobs, but the increase has not kept pace with the increase in the number of people of economically active age.

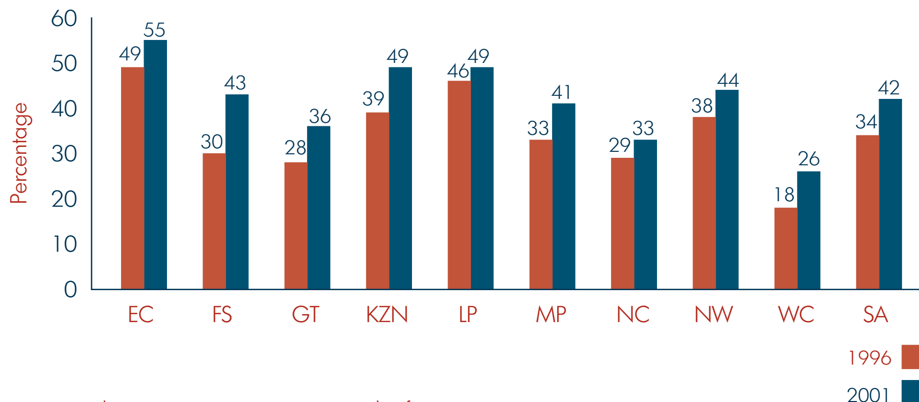
Unemployment rates are an important indicator because the close correlation between poverty and poor health means that high unemployment rates are likely to result in high levels of ill health.

General employment rates, however, mask a variety of equity issues with regard to the nature and type of employment people are involved in and the health and safety risks thereof. People with low levels of education are likely to be employed in arduous and hazardous jobs that can result in increased health problems.

Unemployment by Province

Figure 10

Provincial unemployment rates



Source: Labour Force Survey, Statistics South Africa, 2002

- The national unemployment rate in South Africa is 42% which reflects an increase of 8% within a five-year period.
- The most significant increase in the unemployment rate is in the Free State which rose from 30% to 43%.
- Traditionally wealthier provinces like Gauteng and the Western Cape have also recorded substantial increases in unemployment.

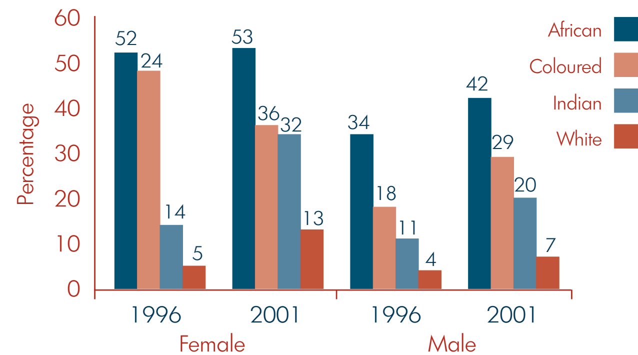
The increase in unemployment rates in Gauteng and Western Cape could in part be attributed to the migration of work seekers from poorer provinces to the economically prosperous provinces. The latest census data (2001) shows that the Western Cape and Gauteng both experienced larger than average growth in their population, and that in some of the larger cities and towns, almost 20% of the population are new migrants.

The push and pull factors in favour of richer provinces, coupled with the decline in traditional formal employment, has the potential to lead to the spiralling of urban poverty and an increase in urban slums which would place a strain on the infrastructure of these areas.

Unemployment by Race and Gender

Figure 11

Racial and gender dimension of unemployment



Source: Census 1996 & Labour Force Survey 2002, Stats SA

- In 1996, 34% of African men were unemployed; by 2001 this figure had increased to 42%.
- Women, in particular African women, represent the largest proportion of the unemployed in South Africa, as 53% of African women are unemployed.

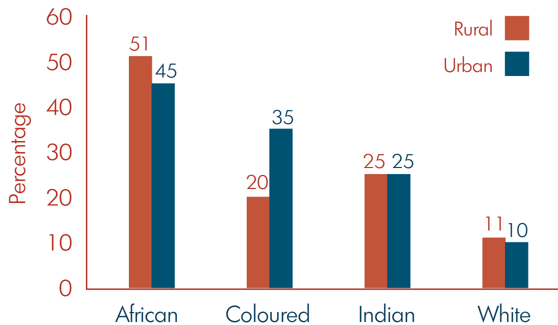
The above figure demonstrates that there has been little progress made in redressing the institutionalised inequities of the apartheid era.

Unemployment rates have increased for all race groups and gender inequities persist at the same levels as before. Concerted affirmative action policies to reverse the inequities in employment trends have had limited impact as white men for example, continue to experience the lowest levels of unemployment. The concentration of poverty among African women is linked to their low education and training levels as well as their tendency to be living in rural, underdeveloped areas.

Unemployment by Rural-Urban Distribution

Figure 12

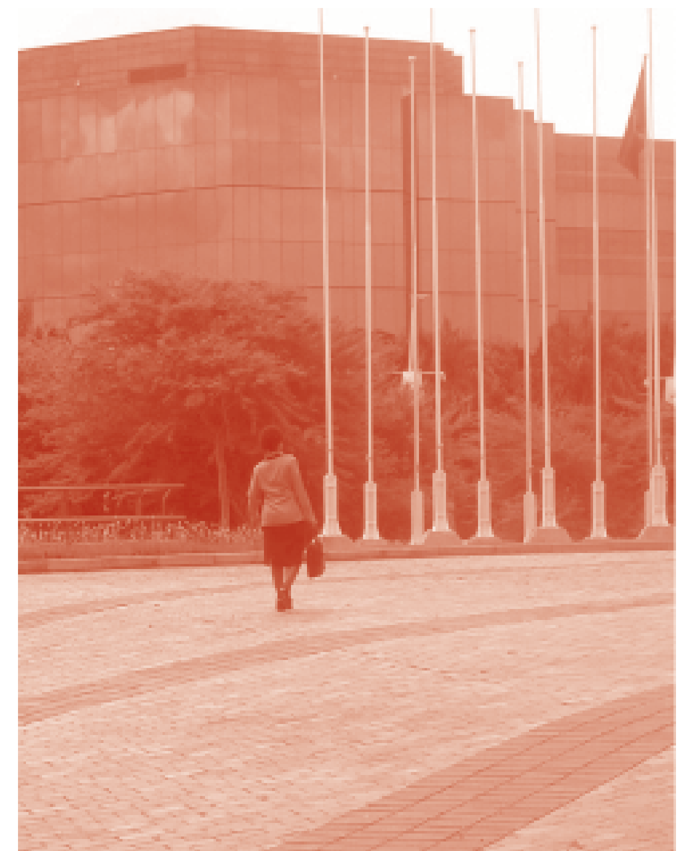
Rural vs urban unemployment by race 2001



Source: Labour Force Survey, Statistics South Africa, 2002

- African women living in rural areas are the most affected by unemployment and poverty. Access to health services that can play a role in prevention and treatment of ill health among unemployed rural people is also likely to be constrained by poor provision of such services and a lack of resources (financial, infrastructural) to travel to such facilities.

Structural and cyclical unemployment results in a surplus labour economy, which is concentrated in the poorer, more rural provinces. Employment opportunities in rural areas are likely to be seasonal and tenuous due to the vagaries of the weather and harvesting cycles. The reserve army of cheap labour that is created coupled with international trends of the casualisation of labour contribute to ongoing low wages as more people compete for scarce jobs. The absence of a comprehensive social security system or coherent job creation programme designed to assist those most in need, results in the poor becoming trapped in cycles of poverty.



Strength and growth of provincial economies

The economy plays a central role in defining the overall social and economic activity in a society. Economic activity reflects what resources are available and how they are used, which in turn determines the formal employment rate as well as revenue collected in the form of taxes. Economic policies not only dictate the path and intensity of a country's economy, they also play a crucial role in the determining the budget that is allocated to social services. In addition economic policies impact on the resources that are available within a country for addressing developmental needs. This section surveys the country's economic performance and highlights the key disparities in the South African economy and how they relate to health inequity.

Provincial contributions to gross domestic product

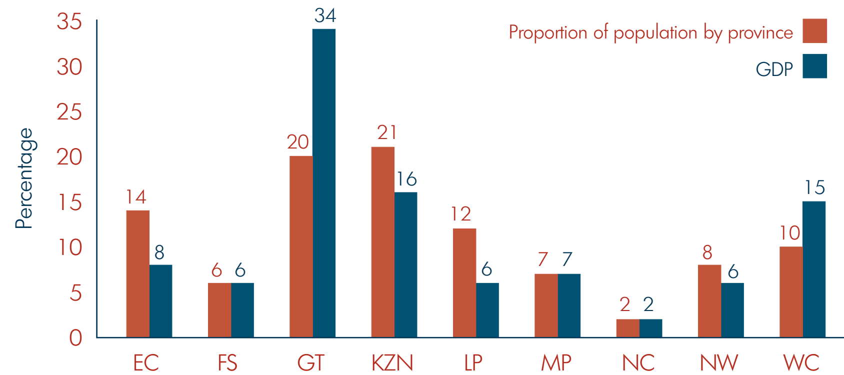
The economy influences health on many different levels from households to the national budget. For example: The budget available for any sector, including health, is dependent on how much revenue government has collected which is linked to the economic strength of the country.

Definition of Gross Domestic Product (GDP) and Gross Geographic Product (GGP): GDP is the value of all goods and services produced by a country within a given time (usually a year). GGP is the value of all goods and services produced within a region or province within a given time. The sum of all GGP in a country equals the GDP.

Figure 13 represents the economic contribution of each province (GGP) to the country's economy (GDP) and reflects the differing economic strengths of each province. The distribution of the population by province is also included to provide a reference point for the economic developmental needs of each province. When the proportion of GDP is smaller than the proportion of the population, the economy of that province is considered to be weak as is the case of Eastern Cape, KwaZulu-Natal, and Limpopo.

Figure 13

Distribution of GDP vs population



Source: Gross Domestic Product, Stats SA, 2001 Census 2001, Stats SA, 2003

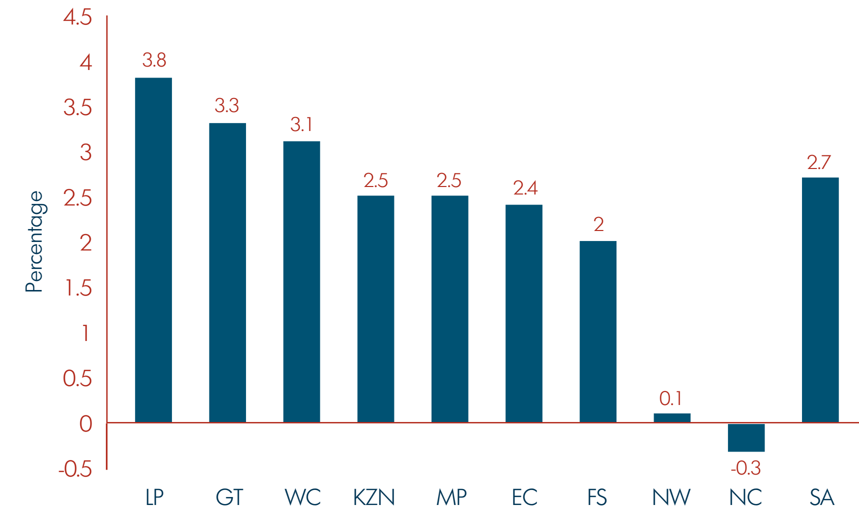
- Economic activity is concentrated in three provinces, Gauteng, the Western Cape and KwaZulu-Natal.
- Economic development is biased towards Gauteng and Western Cape. These are the only provinces where the proportion of the GDP is significantly higher than the proportion of the population.
- The Eastern Cape, KwaZulu-Natal, Limpopo and North West are under performing economically.

This data suggests that economic activity is concentrated in the traditionally wealthy provinces like Gauteng and the Western Cape, thereby exacerbating existing inequities. The concentration of economic activity probably accounts for internal migration patterns and increasing urbanisation in favour of the flourishing economic provinces, further sharpening rural-urban disparities.

Average annual economic growth

Figure 14

Average annual economic growth



Source: Statistics South Africa

- The economy grew on average by only 2.7% per year between 1995 and 2001. Growth in individual provinces varied. The Limpopo province showed the strongest economic growth of 3.8%.
- The Northern Cape was the only province to experience a negative growth rate of 0.3% for the periods 1995 to 2001 and the North West reflected an economic growth of only 0.1%.

All provinces reflect a growth rate that is far below the recommended growth rate of 6% as set out by government's Growth, Employment and Redistribution (GEAR) strategy. While the policies of GEAR have provided a

reasonably stable economic environment it has failed to deliver the much needed growth rates to the economy. From an equity perspective, this has continued to disadvantage less developed provinces. Development is generally much harder to achieve in provinces with relatively small Gross Geographic Product (GGP) as there are fewer resources and economic opportunities. Provinces are allocated revenue in terms of the equitable shares formula.

The equitable share refers to money that is given to provinces to distribute to their various departments. The amount of money that is given to the provinces is determined by a formula that is intended to benefit poorer provinces. The equitable shares formula has seven components: education, health, welfare, basic population, backlog, economic output and institutional. Unfortunately, many of the figures upon which the formula is based have not been updated.

Shortcomings of the Equitable Shares Formula Include

- The backlogs component has the smallest weighting of 3%, which prejudices the provinces with the highest levels of backlogs.
- The economic weighting of 7.1% over-rewards the key economic hub provinces (Gauteng, Western Cape and KwaZulu-Natal at the expense of the poorer provinces).
- The weighting for women, children and elderly in the health component has been removed.
- The health component has remained at 18% while medical inflation has been high.

A further area of contention is government spending on the private sectors' services to its employees. Medical aid subsidies and tax deductions for medical aid members divert resources away from the public sector and are a form of reverse subsidy to the private sector – thereby exacerbating inequity. Spending on "non productive" departments such as defence also constitutes a drain on scarce financial resources that could be used for closing the health inequity gaps.

EQUITY IN ALLOCATING RESOURCES FOR HEALTH

KEY INDICATORS

1. Percentage of budget on social services
2. Per capita health expenditure
3. Per capita expenditure on primary health care
4. Medical and headline Inflation

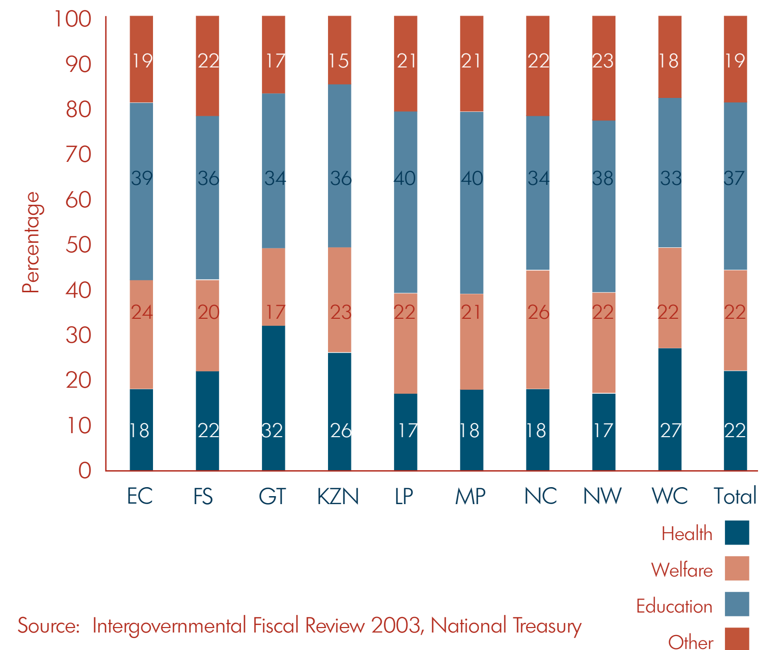
Budget allocations and expenditure are one way of measuring equity. Fiscal federalism gives provinces relative autonomy in the allocation of the funds they receive from the national treasury. There is therefore a trade-off between resources allocated to other sectors and those going into the health sector. This is necessitated by the limited pool of funds available for distribution among all the needs identified by the government.

In an effort to redress the inequities of the apartheid era, provinces are required to allocate at least 85% of their total provincial budget to social services (health, education and welfare). General trends indicate that provinces spend the most money on education, followed by welfare and health interchangeably.

Prescribing an appropriate mix of spending between these sectors is a slippery slope as an increase in one sector invariably means a decrease in another as funds are simply moved around. In the face of competing priorities, this trade off between sectors has negative implications for the promotion of equity, as significant expenditure is required in all three sectors for the advancement of equity. Provinces that have failed to apportion the required 85% to social spending must be called to account for this oversight and the trend towards spending in 'other' sectors must be reversed.

Figure 15

Percentage of total government expenditure on social services 2002/3



Source: Intergovernmental Fiscal Review 2003, National Treasury

- Currently, only KwaZulu-Natal allocated the required 85% of its provincial budget to social services.
- The Limpopo province allocates only 77% of the provincial budget to social services.
- Gauteng and Western Cape have the highest proportion of expenditure spent on health at 32% and 27% respectively, with the lowest being North West and Limpopo at 17% each.

Per capita health expenditure

Per capita health expenditure refers to the amount of money that government allocates for the maintenance and provision of health care and services for every citizen in the country within a specific time frame (usually one financial year). This is a useful indicator because it provides information on how much government is spending on health care for each person in the country. Per capita expenditure is usually adjusted to allow for the effects of inflation if it is used to compare spending patterns over a number of years.

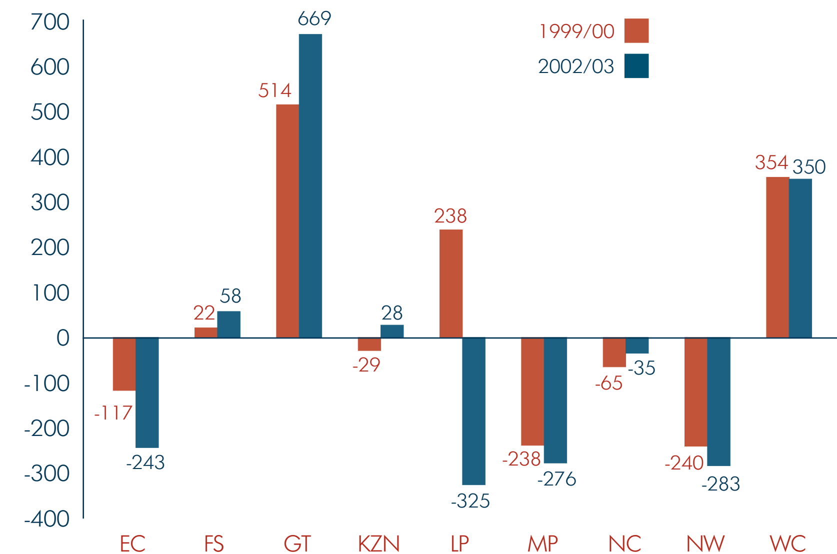
In figure 16, if provinces were all spending the same amount of money per person on health care, then all provinces would fall on the zero line, which is the average expenditure per person in the country. In fact some provinces are spending much more than the average, and some much less.

- Per capita health expenditure across provinces varies substantially.
- During the financial year 1999/2000, almost three times more money was spent on health per person in Gauteng than in Mpumalanga, Limpopo and North West.
- By 2002/2003 inequity had worsened in expenditure as poorer provinces deviated further away from the average expenditure and richer provinces continued to spend way above the mean per capita spending.
- In 2002/3 Gauteng spent R1450 per person – compared to Limpopo, which spent on average R511 per person.

In many instances, per capita spending has decreased in real terms and equity gaps in relation to spending in health have worsened between 2000 and 2003. There are still huge differences between provinces such as Gauteng and Western Cape on the one hand, and Mpumalanga, Eastern Cape and Limpopo on the other.

Figure 16

Public sector per capita health expenditure inequities for 1999/00 and 2002/03



Source: IGFR, National Treasury, 2003

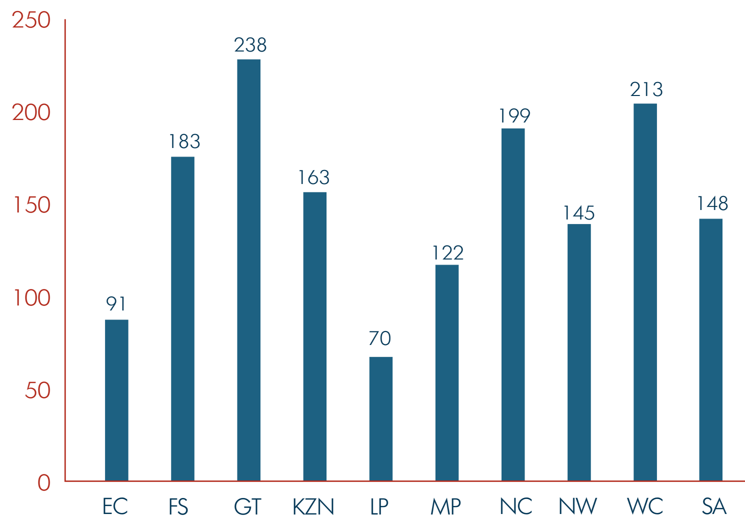
While Gauteng and Western Cape have a greater number of national referral hospitals contributing to the high budgets, when the national referral services are removed from the budget, the overall trend in inequities still holds.

Per capita primary health care expenditure

Primary health care (PHC) is the bedrock of the district health system as it attempts to improve access and quality of care to the most needy. The objective of the PHC approach is to provide a holistic, comprehensive set of services at clinics. The ability of PHC services to meet this challenge will largely be determined by the existence of appropriate levels of funding backed by proper planning and support. A further premise of the PHC approach is that it will target those most in need and compensate for lack of preventative and curative care in many rural areas.

Figure 17

Per capita out-of-hospital primary health care spending



Source: IGFR, National Treasury, 2003

- Huge disparities exist between provinces with respect to funding of PHC services.
- Limpopo spends R70 per capita against R238 for Gauteng.
- After Limpopo, the Eastern Cape spends the least amount on primary health care per capita at R91.

A possible reason for the vast discrepancies in per capita expenditure is the reliance on district hospitals to provide primary health care in the more rural poorer provinces.

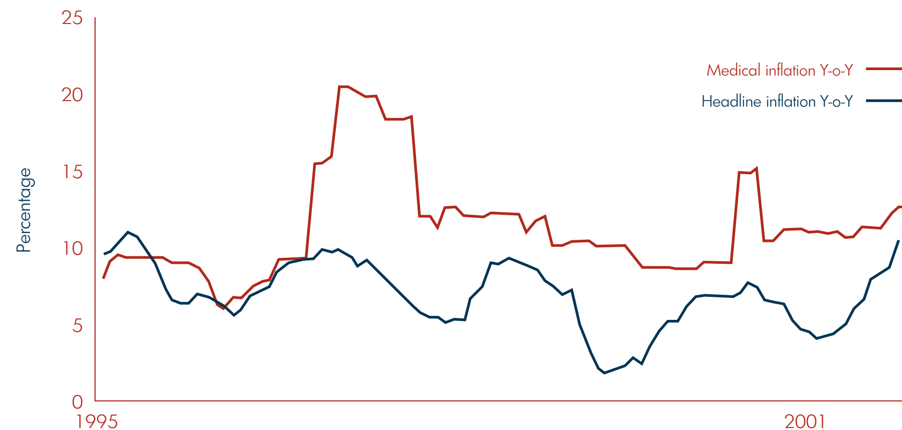
Based on estimates of future funding set out by the Medium Term Expenditure Framework, these inequities will persist for a number of years to come. More effort needs to be made in dealing with these inequities. More equitable means of financing health services, especially PHC services, need to be explored. One option is to look a targeted funding such as conditional grants for PHC services.

Medical versus headline inflation

Definition of Inflation: Inflation is the persistent increase in the general price level. The formal Consumer Price Index measure tries to find out the average annual increase in the cost of the basket of goods and services for the typical consumer in the economy over a period of time. Headline inflation measures the change in prices in the overall consumer basket while medical inflation measures the change in prices of medical goods and services only.

Figure 18

Medical vs headline inflation



Source: Data Stream, Thomsons Financial, 2002

Figure 18 shows that medical inflation has been persistently higher than general inflation over the last few years. Although it is users of private medical services who bear the brunt of the costs arising from medical inflation, all health service users are affected to some extent. Increased health costs impact on low-income families more than wealthy families. The high rate of medical inflation is likely to exacerbate inequity. In addition, spiralling medical inflation leads to unaffordable medical aid premiums which diverts more people away from the private to the public sector, placing a further strain on limited resources.

EQUITY IN HEALTH STATUS

KEY INDICATORS

1. Infant mortality
2. Stunting
3. HIV/AIDS prevalence rates
4. TB cure rates

The dynamic interactions between the various economic and socio-economic variables in the country ultimately culminate into specific health status outcomes. If one of these variables shows a poor result, it will become evident in the health status indicators. This information, therefore, can be used to assess health equity.

Children are the most vulnerable group and have been prioritised by the Department of Health as a target group. The introduction of free access to health services was intended to facilitate greater equity in access to care and improved outcomes in health status.

Infant mortality

> **Definition of Infant Mortality:** The number of children less than one year old who die in a year, per 1000 live births during that year.

The infant mortality rate (IMR) helps to monitor the survival and healthy development of children. A healthy childhood increases the chances of a healthy life as an adult. Factors influencing infant mortality are access to safe water, sanitation, nutrition and the level of the mother's education, quality of maternal care, availability of vaccines which should be given in the first year of life and effective referral systems.

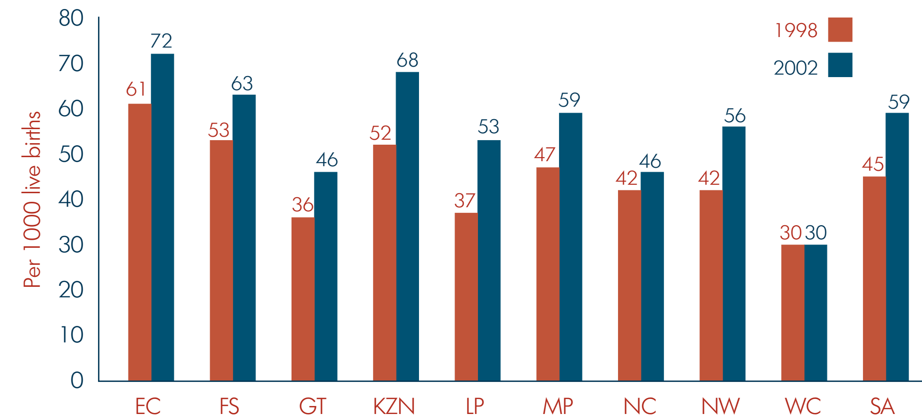
Figure 19 reveals an alarming rise in infant mortality rates. Nationally the number of deaths in one year old infants per 1000 live births rose from 45 to 59 between 1998 and 2002.

- IMR increased in all provinces except Mpumalanga where it remained at same levels of 30 per 1000 live births.
- In 2002, the Eastern Cape had the highest infant mortality rate at 72 per 1000 live births followed closely by KwaZulu-Natal with 68 per 1000 live births.
- Between 1998 and 2002 Limpopo, North West and KwaZulu-Natal experienced the highest proportional increase in IMR.

Possible reasons for the increase in infant mortality include the impact of HIV/AIDS, and the increasing impact of poverty exacerbated by unemployment.

Figure 19

Infant mortality rates by province, 2002



Source: SAHR 2002, Health Systems Trust, 2003

Ultimately however, infant mortality will decline in a society that is stable, has adequate safety nets to catch people in times of lifetimes crises and a well developed community and kinship support system. The concentration of poverty among people who are already vulnerable to the uncertainties of an unstable economy, the absence of any sustainable assistance from the state, coupled with the breakdown of traditional support systems has probably contributed to creating an environment conducive to increased infant mortality rates.

Stunting

Definition of Stunting: Stunting refers to the number of children in the under 5 age group who have a low height for the age when measured or compared to the normal height for the age group.

The measurement of stunting reveals the nutritional status of a population and suggests the existence of malnutrition among children as this often leads to stunting.

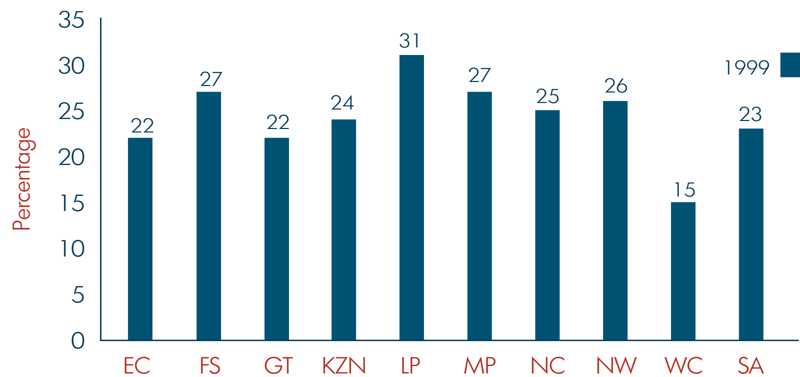
Stunting stems primarily from poor nutrition, poverty, repeated infections, poor feeding practices over sustained periods and low socio-economic status of households. The prevalence of stunting is also related to maternal education, the less education a mother has the more likely are the chances that her child will be stunted.

The level of stunting for children has not improved in the period between 1994 and 1999, having remained at 23% in this period. However, there are wide provincial variations and the Western Cape is the only province that reflects stunting levels below the World Health Organization's global target of 20%.

These levels of stunting are unacceptably high for a country with a GDP per capita of approximately R24 186, and the fact that stunting has remained constant over a period of five years is an indictment of South Africa's attempts to raise the level of living standards of the poor.

Figure 20

Stunting



Source: South African Health Review 2000, Health Systems Trust

HIV/AIDS prevalence rates

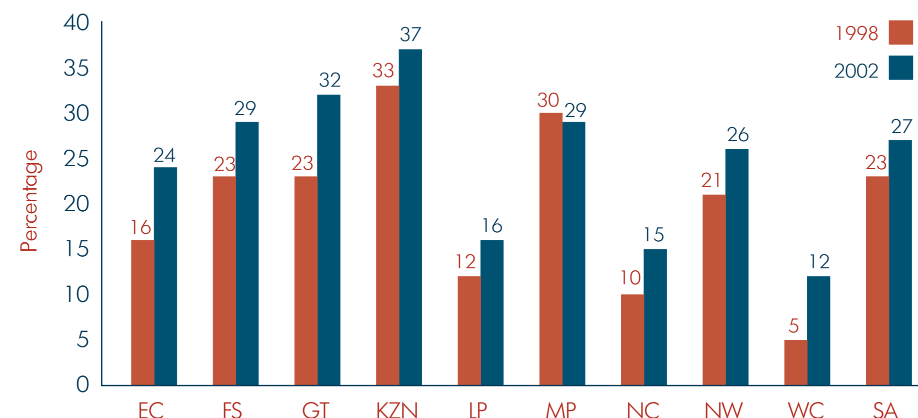
Definition: HIV/AIDS prevalence rates are determined by testing women attending public service antenatal clinics. If two hundred of one thousand women attending antenatal clinics during the course of a year are found to be HIV positive, the HIV/AIDS prevalence rate is 1 in 5 or 20%. Prevalence is different to incidence. Incidence is the rate of occurrence. Prevalence is the percentage of a population affected at a given time.

There is general agreement that social and economic inequalities largely explain the high prevalence rates of HIV/AIDS in South Africa. Entrenched poverty and gender inequity, inequality, an institutionalised system of migrant work, and high levels of road haulage coupled with persistent stigma, have all contributed to the spread of the epidemic.

HIV disproportionately affects disadvantaged communities who may be most vulnerable to HIV infection because they have least access to prevention in the form of education, condoms, and treatment for sexually transmitted infections. They are also the communities with the least access to general treatment and care. The demands of HIV/AIDS and related illnesses are already having a profound effect on an overburdened and under-resourced health care system.

Figure 21

HIV prevalence among antenatal clinic attendees 1998 – 2002



Source: National HIV Survey in South Africa, Department of Health, 2002

Nationally, HIV/AIDS antenatal prevalence rates have increased from 23% to 27% from 1998 to 2002. The estimated prevalence among people with medical aids is thought to be about 5% - suggesting that the burden of care and treatment accrues largely to the state.

HIV/AIDS prevalence rates vary considerably from province to province. KwaZulu-Natal has the highest rate of 37% and Western Cape the lowest at 12% for 2002. There is also variation among provinces in the increase in prevalence.

Provincial rates of increase in HIV/AIDS prevalence rate

Province	Rate of increase between 1998 to 2002
Western Cape	140%
Eastern Cape	50%
Northern Cape	50%
Gauteng	40%
Limpopo	33%
Free State	26%
North West	24%
KwaZulu-Natal	12%
Mpumalanga	-3%
National	17%

- Western Cape, Northern Cape, Eastern Cape, Gauteng and Limpopo show a more marked increase in prevalence rates between 1998 and 2002.
- Mpumalanga is showing signs of stabilizing the infection rates, as it is the only province with a small decrease in the prevalence rates, from 30% to 29%. It is unclear whether this can be attributed to an actual decrease in prevalence rates or to other operational factors.
- Low prevalence rates seen in some provinces do not necessarily reflect success in containing the spread of the virus in these provinces. For example, the Western Cape, with the lowest prevalence rate for both 1998 and 2001, has the highest rate of increase of all provinces. The rate more than doubled from 5% to 12% in four years.

Women comprise the majority of individuals infected with HIV/AIDS. The epidemic is fuelled among women for a number of reasons. Transactional and coerced sex, entrenched patriarchy, financial dependence on men and polygamous relationships all contribute to a climate where women are unable to negotiate safe sex practices with their partners. The effect of the epidemic is also borne disproportionately by women in their roles as caregivers, especially as home-based care is central to the country's strategy for caring for people with AIDS.

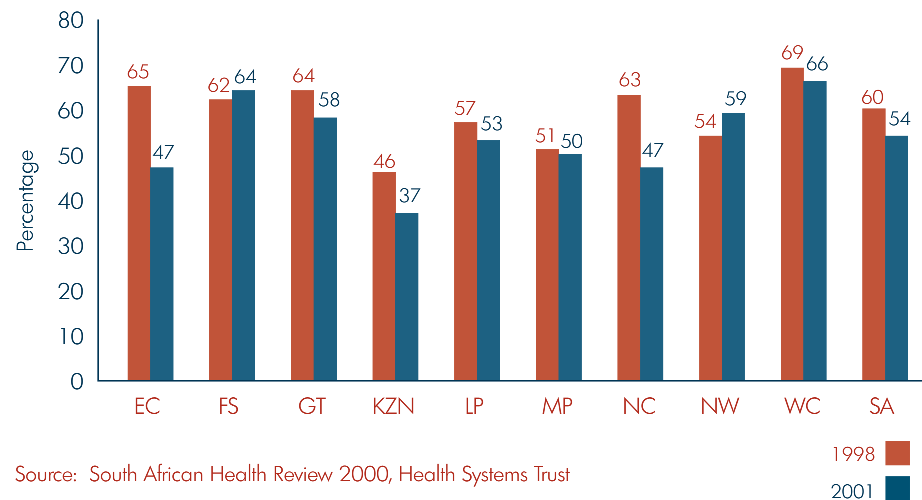
As the epidemic progresses, it will impact negatively on economic growth. Estimates predict that HIV/AIDS will shave-off around 0.5% from GDP per year over the next 15 years resulting in GDP growth being 5.7% lower by 2015 than it would have been without the impact of HIV. This will make it more difficult for the economy to achieve growth rates needed to make a dent in unemployment and reduce poverty.

Tuberculosis (TB) cure rates

South Africa has the 7th highest number of TB cases in the world. In 2001 TB incidence per 100 000 was 423.5. This rose to 493.7 per 100 000 in 2002. The TB epidemic is being fuelled by the HIV epidemic, and it is estimated that 55% of all adult TB cases are HIV positive. The emergence of Multi-Drug Resistance (MDR) TB also presents significant challenges to controlling this disease.

Figure 22

Tuberculosis cure rates



Source: South African Health Review 2000, Health Systems Trust

Note: Between 1998 and 2001 there was a change in which patients are included in the data and this makes the cure rate appear worse.

- Nationally, the TB cure rate of 54% is well below the SA and WHO target of 85%.
- Eastern Cape, KwaZulu-Natal, Mpumalanga and Northern Cape all have cure rates of 50% or below.
- It is difficult to assess progress in cure rates because of the change in how information is collected. However, cure rates in most provinces appear to have declined.

Clear TB policies and guidelines are in place and the DoH has achieved considerable success in developing and implementing a National TB Control Programme (NTCP). Directly Observed Treatment Short course (DOTS) is now being implemented in almost every health district. However lack of capacity and poor management systems are hampering the success of the NTCP. TB thrives in living conditions experienced by poor families and communities and the double burden of HIV and TB is a serious equity challenge.

EQUITY IN ACCESS TO CARE

KEY INDICATORS

1. Percentage of personnel in public and private sector
2. Distribution of public sector personnel
3. Availability of drugs
4. Clinics with toilets for people with disabilities
5. Utilisation of primary health care facilities
6. Community participation

This section looks at systemic indicators and attempts to analyse what they suggest about the current health system. For example, a minimum number of key health personnel and adequate financing are needed to provide effective health care. It is thus logical to assume that areas receiving the least amount of resources are more likely to have difficulty in providing good quality care.

The poorest, whose need is the greatest, rely on care provided by the public sector and clinics are usually the first point of contact for patients in the public health service. The indicators in this section focus on care provided by clinics rather than hospitals.

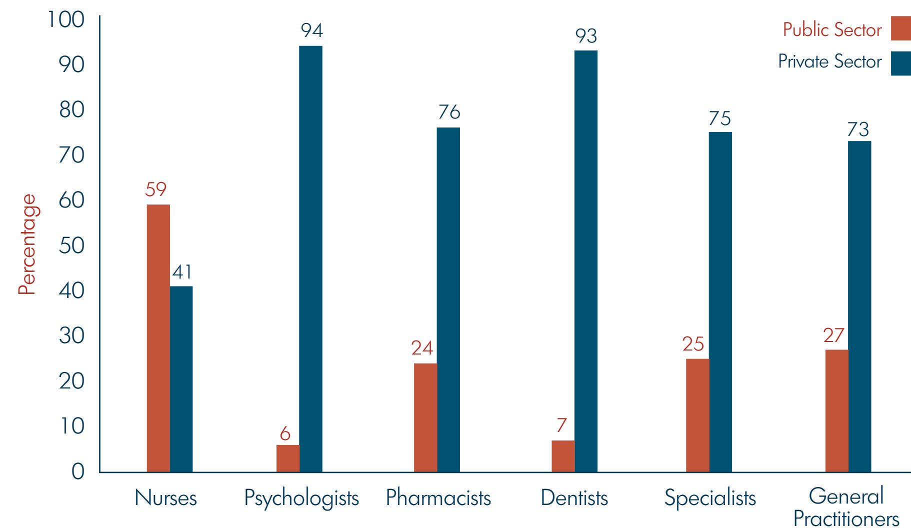
Health care personnel in the private and public sectors

Without a foundation of skilled human resources healthcare systems cannot function adequately or effectively, particularly in the public sector and at the primary level of care. However, health systems in South Africa face a variety of health personnel problems, including overall scarcity and an inequitable distribution of health personnel.

An abiding feature of the South African health system is the prevailing inequities between the public and the private sectors. This is clearly demonstrated in the distribution and availability of health personnel between the two sectors. The private sector employs by far the largest proportion of all categories of health professionals except for nurses, but caters for less than 20% of the population. However only 59% of nurses work in the public sector now compared to more than 80% in 1995, suggesting that nurses are leaving the public sector for the private sector and to work abroad.

Figure 23

Health care personnel in the private and public sectors 1999



Source: The private sector report, National Health Accounts 2002

- 73% of general practitioners work in the private sector, while only 7% of the country's dentist's work in the public sector.
- A startling 94% of psychologists work in the private sector.

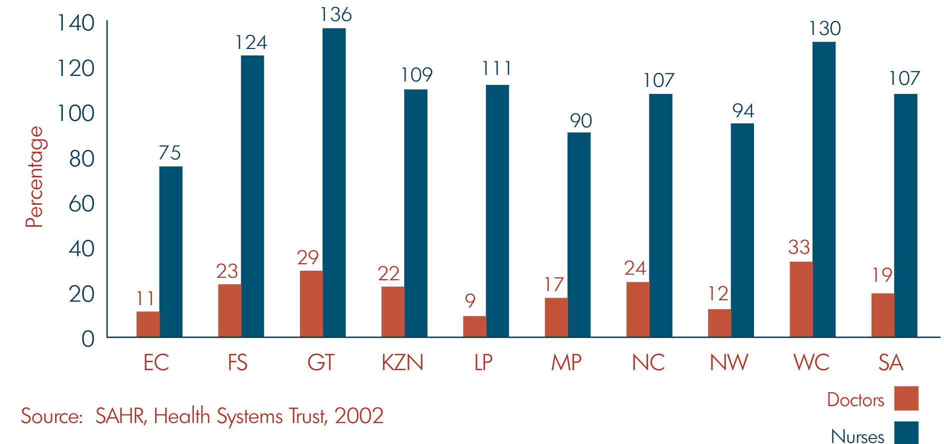
The relative oversupply of health professionals in the private sector seems to be one of the most intractable problems facing the South African health system. An overall shortage of personnel is compounded by the inequitable distribution of health personnel between geographic areas and between levels of care and increasing migration of personnel to developed countries. The introduction of community service for key cadres of health workers is one strategy attempting to ameliorate the shortage of personnel in the public sector, however as yet there has been no systematic review of the impact of the community service initiative on the health care delivery.

Public sector personnel

Within the public sector inter-provincial inequity in the distribution and availability of personnel occurs between rich and poor provinces and within provinces – between urban and rural areas.

Figure 24

Public sector personnel per 100 000 population 2002



Source: SAHR, Health Systems Trust, 2002

- The national average for the doctor population ratio is 19 per 100 000. The 4 provinces with below average ratios are historically disadvantaged, predominantly rural provinces.
- The distribution of doctors is influenced by the presence of national referral hospitals in Gauteng, Western Cape and KwaZulu-Natal. However the inequities are extreme with for example a doctor population ratio in Limpopo of 9 per 100 000 against 33 per 100 000 in the Western Cape.

- The Eastern Cape has 75 nurses per 100 000 population while Gauteng's ratio of nurses to 100 000 population is 136.

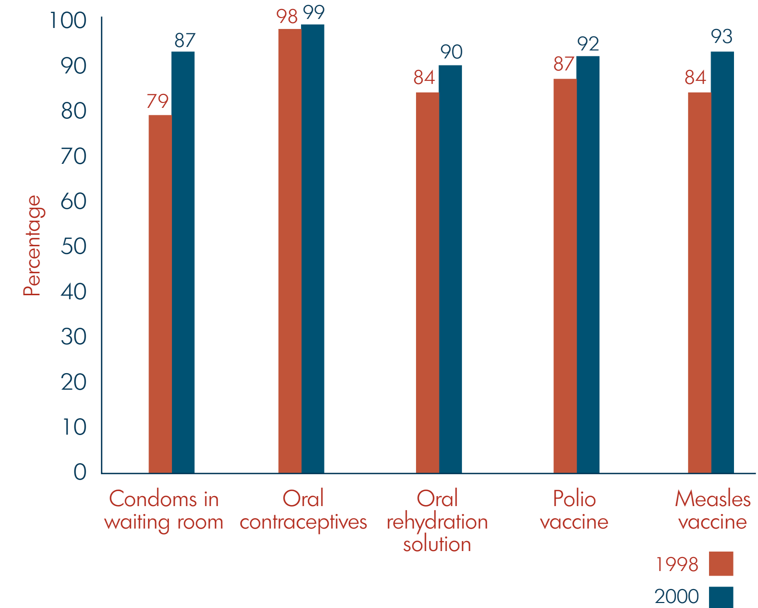
The above figure demonstrates that there is a critical shortage of personnel in the public sector which is probably being exacerbated by general unhappiness with public sector employment conditions and the effect of HIV/AIDS.

Supply of drugs in PHC

If the PHC approach is to succeed, it is crucial the drugs as set out in the Essential Drug List are available at all clinics. Drug availability is fraught with difficulties as there needs to be an effective distribution, storage and administration system to deliver and keep track of the drugs. In addition, there has been anecdotal evidence of informal over-the-counter sale of drugs that should be dispensed free of charge.

Figure 25

Clinics with selected PHC drugs



Source: NPHCF Survey, Health Systems Trust, 2000

- Compared to 1998, there has been an increase in the availability of selected Primary Health Care (PHC) drugs.
- There is a 99% availability rate for oral contraceptives.
- Availability of condoms is of concern given the current HIV epidemic even though it rose from 79% in 1998 to 87% in 2000.
- The increase in availability of Oral Rehydration Solution is encouraging, although the failure to provide such a basic and potentially life saving substance to all clinics in the country is cause for some concern.

Even though there has been an overall increase in the availability of selected drugs of the essential drug list (EDL), the caveat is that this does not mean these were dispensed or properly administered due to shortages of staff.

Primary health care performance

Uptake of PHC services in most provinces is less than the World Health Organization's recommended rate of 3.5 visits per year, with the national average sitting at 2.3 visits per year. Equitable and high quality primary health services are commonly associated with improved health status and the low levels of utilisation are cause for concern.

Province	PHC visits 2001/02 (headcounts per capita)
Eastern Cape	2.3
Free State	2.2
Gauteng	2.3
KwaZulu-Natal	2.0
Limpopo	2.2
Mpumalanga	1.5
Northern Cape	2.8
North West	2.7
Western Cape	3.8
Total	2.3

Source: Intergovernmental Fiscal Review 2003

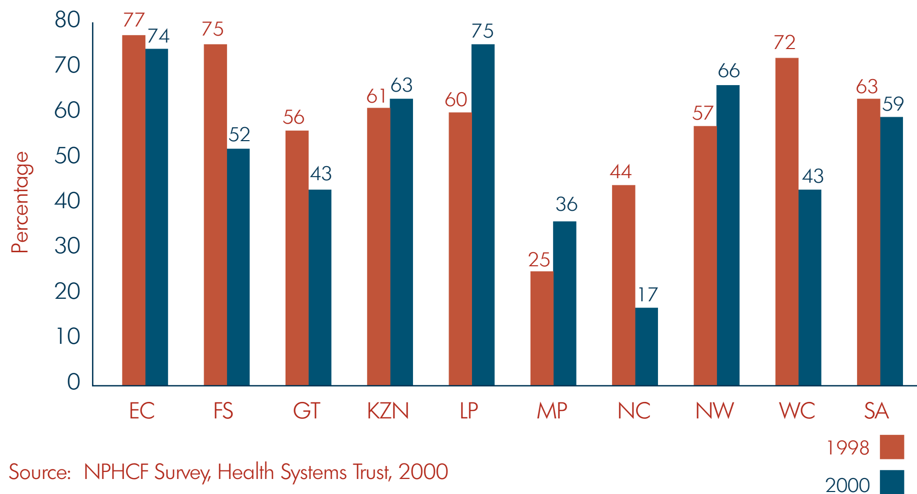
- The Western Cape has the highest number of PHC (3.8) visits for the period 2001/02 followed by the Northern Cape at 2.8 visits per capita.
- Mpumalanga has the lowest number of visits at 1.5 per capita.

Community participation

Community participation rests as a cornerstone of the Primary Health Care approach. Sound community partnerships with health establishments lead to the strategic guidance of clinics and improved quality and quantity of operations However, this has proved difficult to achieve, as there has been little progress made in getting communities to participate in clinic matters.

Figure 27

Clinics with functioning health committees



Source: NPHCF Survey, Health Systems Trust, 2000

- Overall, the percentage of clinics with functioning committees has declined by around 4% between 1998 and 2000.
- The national average of clinics with functioning health committees is currently 59%. 5 provinces do not meet this average.
- The steady progress in Mpumalanga which increased its number of clinic committees from 25% to 36% contrasts with the decline of community involvement nationally.

It is often held that those with the greatest health needs have the least control over health resources and the decline in the number of clinic committees in the public sector suggests that a potentially powerful avenue for decision-making in health care delivery and resource allocation is not being exploited. The National Health Act makes provision for the establishment of clinic committees on a national basis and it is yet unclear what the practical implications of this will be.

CONCLUSION

Poverty and health combine to form a vicious cycle where the existence of one pre-disposes vulnerability to the other. Ill health can easily drag families into poverty, while poverty creates conditions that are conducive to ill health and inhibits people from seeking health care.

The joint World Health Organisation (WHO) and World Bank report, *Dying for Change*, chronicled the views and health needs of poor people in over 60 countries. The report found that poor people most frequently describe ill health in multidimensional terms, which include hunger, pain exhaustion, shame, social exclusion, insecurity, fear, powerlessness and anger. Respondents spoke of the devastating consequences of ill health rather than particular illnesses. People also viewed good health in a holistic manner, citing good health as a balance of physical, psychological and community well-being.

Inequities outside the health system influence health outcomes directly or indirectly as illustrated in this document. This means that any attempt to reduce health inequity has to take into account what is happening in the broader socio-economic environment. This implies that policy makers have to be concerned not only about sector specific reforms and programmes but also with the overall socio-economic environment.

Because the socio-economic challenges inherited in 1994 still persist the country now needs to move beyond a purely economic approach to development. The myriad of global factors that are forever derailing domestic economic policies can no longer be kept at bay by one economic strategy. Tangible health gains will only be reaped in a broader context of general economic and social equity and development. Government policy at all tiers of government needs to be better geared towards the development of comprehensive strategies and solutions, backed with appropriate funding, to tackle health improvements. If this is not done, health equity will remain an elusive target.

The increasingly porous nature of country boundaries means that international factors increasingly impact on efforts to improve equity. Globalisation, wars, and international economic and monetary policies, all present formidable obstacles to reducing and eradicating inequities. The challenges presented by responding to the HIV/AIDS epidemic are drawing energy from debate and discussion about the potential hazards for South Africa implied by the General Agreement on Trade and Services (GATS).

Fortunately, matters of equity and poverty remain on the international social policy agenda and in recent years have gained momentum. The push for achievement of the Millennium Development goals by 2015 is one example. It is particularly important that these triggers of momentum are used as an opportunity to reaffirm government's commitment to addressing health inequity. At the same time, civil society needs to play a more vigilant and watchdog role, monitoring and enforcing the implementation of government's commitments. The Abuja Declaration for example, where governments undertook to commit at least 15% of their national budgets to health has not yet been realised in South Africa.

Improved health outcomes are most likely to be triggered by a comprehensive social security system that could 'catch' people in times of lifetime crises. The introduction of a basic income grant, that would provide a basic amount of money to all citizens, could potentially play a powerful role in alleviating food insecurity and would, in a small way, start to redress the income poverty experienced by so many South Africans. A concomitant job creation and public works programme targeted at those most in need would also enhance efforts to stimulate development and growth in the country. Aligned to this, is the need to create a national health system as recommended by the Taylor Commission and to consolidate efforts designed to contain the excesses of the private health sector.

Equity cannot be achieved without addressing the development and basic amenity needs of the country's poor and rural areas. While the identification of the thirteen rural development nodes together with eight urban renewal sites is a step in the right direction, progress in these areas will remain nebulous unless accompanied by a shift in macro-economic policy. The absence of any meaningful reduction in inequity between historically well resourced urban areas and less well resourced rural areas in the ten years that have elapsed since 1994, raises questions about whether governmental policy is in fact consistent with redistribution.

In South Africa the HIV epidemic has resulted in more and more families descending into poverty due to the burden the disease has placed on them. A recent study found that poor families caring for a family member with HIV/AIDS spent a substantial percentage of the household income caring for that individual. Thus the challenge of HIV/AIDS extends beyond the boundaries of responding to treatment and care needs of those affected, and reaches to the heart of issues of equity. Government's AIDS treatment initiative will provide a much-needed lifeline to millions of people in the country. However, there is a need to ensure that funding attached to this initiative will benefit strengthening the health system as a whole in under-resourced areas; a failure to do so would result in the ARV programme exacerbating rather than ameliorating existing inequities.

Within the health system, the current shortage of health care personnel is probably the most significant factor perpetuating inequity and needs to be urgently addressed. In the long term, determining the appropriate mix of personnel that is required for the country's primary health care orientated health system must also take place. In this regard, the potential of community participation and community health workers to strengthen services available to most needy communities must be factored into the equation.

Addressing inequities in our society ultimately depends on whether there is a political will, backed by the appropriate resources to do so. Addressing inequities also depends on policy makers choosing political and strategic options which do not favour only economic growth in major provinces and cities, but also choosing a concerted pro-rural policy which focuses on improving life and support systems in these areas as a long term strategy.

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