Critical Health Perspectives

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The District Health Barometer 2005/6

What does it say about promises and practice of PHC?

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South Africa's post-election health policy rhetoric was littered with statements about Primary Health Care, Equity, Health Promotion and the importance of a District Health System for health care delivery. But the extent to which this ideology of optimism has translated into measurable or experienced outcomes, remained until now, an open question.

The Health Systems Trust recently published the second South African District Health Barometer (DHB II)[1]. The report compares the performance on key health indicators for all 53 South African health districts. While the study suffers some limitations of data quality, it nevertheless provides a useful snapshot of health care across the country.

The paper begins with a brief overview of selected socio-economic, input, process and outcome indicators reported in the survey and asks whether health sector performance in 2006 represents success or failure to address post-liberation promises.

Socio Economic Indicators

These findings were all linked to Millennium Development Goal[2] No.1 to eradicate extreme hunger and poverty. It was found that rural districts are much more deprived (deprivation index) than metro districts. In 2001 85% of households in South Africa had access to piped water Water access varied across the districts, with metro districts generally faring better than rural districts. In 5 out of 13 rural districts, less than half the households had access to piped water.

Some Input Indicators

These were included to reflect Government commitment to Equity in health resource allocation and to health spending on Primary Health Care and District Health Services.

There has been considerable progress to a more equitable distribution of resources across districts, but there remains a significant variation in per capita health expenditure. Resources are not necessarily directed to districts with the greatest need and expenditure on rural nodes is generally lower than for metro nodes.

Non-hospital PHC expenditure per capita increased by 8% per annum from 2001 to 2005. This outstrips inflation and the overall growth rate of the health budget, reflecting a real prioritisation of Primary Health Care.

On average 5% of total district health expenditure is spent on district management activities, 45% on district hospitals, and the remaining 50% on PHC services. These proportions vary widely across the districts. These averages hide large differences between districts and represent district-level shifts in policy and programmatic priorities. It could also reflect their capacity to deliver basic PHC or DHS services.

Process Indicators

The clinical workload of nurses, measured as the average daily number of patients attended in PHC facilities, was used as measure of efficiency. Low values indicate sub-optimal utilization of resources. High values either mean poor data quality or that nurses are over-worked, raising concerns about quality of care and potential burn-out, or both. Nurses averaged 31.6 patients per day in 2006, unchanged from 2005, again with wide variation across districts. Nurses in metro

[1] http://www.hst.org.za/publications/701

[2] http://www.doh.gov.za/docs/mdgd-f.html

districts generally had a higher workload than nurses in the rural districts.

The average length of stay (ALOS) in district hospitals is a proxy measure for the quality of care received as well as hospital efficiency. The ALOS national average was 4.3 days with metro districts generally lower than rural districts. This is a decrease of 0.3 days from 2003 to 2005.

The bed utilization rate (BUR) is a measure of efficiency that shows how well a hospital is using its available capacity. The National DOH has set a normative value of 72%. The average BUR for South Africa in 2005 was 63.9% an increase of 3% from 2003. Metro districts had higher BURs than Rural districts.

Output/Service Delivery Indicators

The annual male condom distribution rate by DOH at public health facilities has steadily increased from 5.9 per man (15 years and older) in 2003 to 8.8 in 2005. The City of Cape Town health district performance on this indicator was far better than any other health district.

The capacity of immunisation to reduce childhood mortality and morbidity is fundamentally determined by the achievement of high immunisation coverage and low drop out rates. The national goal to get 90% of children under one year to complete their primary course of immunization was achieved and is one of the success stories of PHC in South Africa. Linked to this was the great news of South Africa declared polio-free in 2006. Only 10 districts had immunization coverage less than 80%. The national target to keep immunisation drop-out rates (% children dropping out between first and third dose of DPT-Hib vaccine) below 10% was achieved. The 2005 rate of 4.7% compares with the best in the world.

The Caesarean section rate measures the proportion of deliveries (at a facility) in which a Caesarean section was performed. In 2005, the national average for all South African hospitals was 18.4%, a 2.2% increase from 16.2% in 2003. The wide variation across districts and provinces, suggests differences in the protocols being followed. It is unclear what the national target of 11% actually represents.

Promises and Delivery

It has to be said that the initial debates around PHC and DHS policy occurred before the new democratic constitution was negotiated in the run up to the 1994 elections. Many activists were still thinking (or dreaming) of a unitary, single national health system for South Africa. Instead, nine very unequally resourced Provinces emerged. The constitutional responsibility to deliver health care was decentralized to provinces and it is tempting to trace the wide variation in district health indicators reported here, back to those legislative choices.

There were some significant positive aspects reflecting improvements in community well-being such as improvement in immunization coverage. However other important indicators of improving health status leave much to be desired. These include indicators reflecting outcome and impact of TB programme (e.g.TB cure rate) and HIV programme (Prevention of mother to child transmission).

Although there has been a very significant move to decreasing inequities based on resource inputs there are still large differences between the best and worst funded districts. However, perhaps the biggest issue revealed by this report is the serious inability to achieve real equity in health outputs and outcomes and health care experience for post-apartheid South African communities. Time and again the results of this survey refer to the "wide variation across the districts". It is clear that the historically advantaged provinces remain way ahead in the health indicator stakes while those riddled with former homeland dynasties bring up the rear.

Another recurring theme is the difference in rural and urban experience. South Africa's rural communities remain at a great disadvantage with respect to health and health care. And this is in addition to the very real socioeconomic disadvantages of poverty and limited development opportunities.

Sadly, inequity remains as prominent a feature of community health and wellbeing now, as it was in the pre-democracy era.