
Monitoring the right to health care in South Africa

An analysis of the policy gaps, resource allocation and
health outcomes

September 2013

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Monitoring the Progressive Realisation of Socio- Economic Rights Project

Project made possible with funding from the



FORDFOUNDATION

Introduction

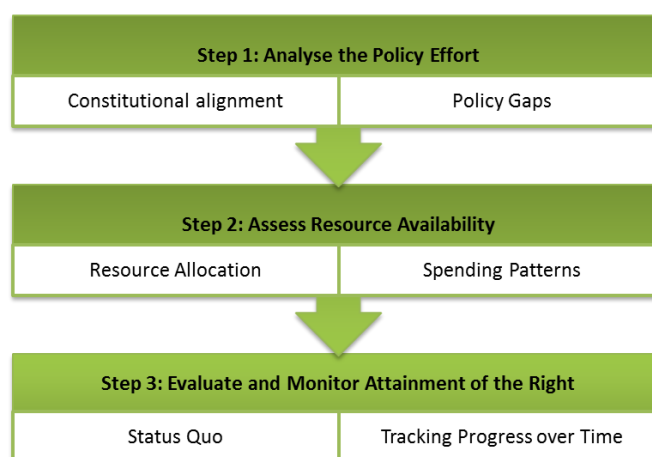
The realisation of socio-economic rights (SERs) is crucial to South Africa overcoming the persistent challenge of poverty and inequality. However, unless the implementation of SERs as promised in the Constitution is monitored and tracked over time, their inclusion on paper might not be felt in reality by millions of poor people.

The implementation of SERs, however, is subject to the internal limitation of “progressive realisation subject to available resources”, contained in the Constitution. Section 27(2) of the Constitution states that “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.”

The limitation clause is silent on timeframes, the percentage or coverage of people over time or even how the state should finance access to SERs. The challenge for policy makers and oversight bodies alike is how best we are able to evaluate government programmes and budget allocations against this binding obligation on the state.

There is increasing interest both internationally and in South Africa in the development of new methodologies and tools for measuring, monitoring and evaluating the progressive realisation of SERs. This work, however, is still in its infancy. The Studies in Poverty & Inequality Institute (SPII) in partnership with the South African Human Rights Commission (SAHRC), which is constitutionally obliged to report annually on the defence and advancement of the rights in the Constitution, has developed a methodology based on international best practice. The methodology combines various approaches to monitoring socio-economic rights including policy and budget analysis and statistical indicators.

The methodology is based on three distinct steps (see figure below).



Step 1: Analysing the policy effort

The first step of the analysis takes a closer look at the underlying policies and legislation guiding the realisation of SERs. This step firstly, assesses whether the actual content of social and economic policies adequately reflect the Constitution and international treaty obligations. Secondly, this step examines what policy gaps exist in the existing legislation (in both principle & practice) in terms of access, adequacy and quality, non-discrimination, progressive realisation and the ‘reasonableness test.’

Step 2: Assess Resource Availability

The second step focuses on analysing budget and expenditure allocations at both national and provincial level to assess the reasonableness of amounts for specific SERs and relevant government departments and population groups. Things that ought to be born in mind are: Is the relevant government line department tasked with the delivery provided with adequate funds? Where does under-spending occur? Are resource allocations increasing or decreasing overtime and why?

Step 3: Evaluate and Monitor Attainment of SERs

The third step focuses on evaluating and monitoring the attainment of SERs with reference to the three dimensions of access (physical and economic), quality and adequacy over time. This provides a clearer and more specific illustration of SERs enjoyment on the ground. This requires quantifiable and replicable indicators (proxies for the different dimensions of SERs) to be developed along with agreed benchmarks and targets. The indicators need to be aligned to data available in annual surveys, and be capable of being decomposed by province and ideally, income decile, race, gender and age – wherever possible and useful. This allows disparities between different population groups to be identified and an assessment of the extent to which progress has been made over time. An on-going challenge with the development of indicators is the balance between a set of indicators which capture the complexity of SERs and are at the same time focused, accessible and easy to populate for non-experts.

The **criteria** for selecting final set of indicators are the following:

- 1) Data available at least annually,
- 2) Data disaggregated at provincial level (at minimum)
- 3) Data is of public interest.

The **purpose** of monitoring goes beyond holding government accountable and aims to achieve specific objectives.

- 1) Aid clarity on the content of SERs to ensure access to ensure access to and enjoyment of SERs is continuously broadened.
- 2) Determine the extent to which organs of the state have fulfilled their obligations. This involves:
 - Identifying achievements
 - Detecting failures, gaps and regression
 - Identifying discriminatory laws, policies, programmes and practices
- 3) Advance evidence-based empirical debate on the implementation of SERs to guide policy and move all actors towards developing roadmaps that will ensure the protection, development and universal enjoyment of SERs.

SPII has to date developed a set of indicators for social security and health which have been populated with data from 2010 and 2011. Over the next two years, indicators will also be developed for housing, education, food, water and sanitation, and the environment.

These policy briefs aim to provide a succinct **summary** of the analysis of 1) the policy effort (step 1), 2) resource allocation and expenditure (step 2) and 3) the **process** undertaken in developing the indicators (step 3) for each of the SERs. The policy brief also includes the list of indicators for the

particular SER under review and a selection of the populated indicators which build up the information at a national level to evaluate and monitor the progressive realisation of SERs.

Defining the content/meaning of the right in its context (step 1)

Access to *quality* health care plays a vital role in any country's development as it has significant implications for policy and overall improvement in living standards. South Africa has a fragmented two-tiered system of health care which it largely inherited from apartheid. On the one hand, there is the private health sector which is exclusive, providing high quality health care at a premium cost financed through medical aid schemes and out-of-pocket payments. This sector serves a select minority, mainly the middle-class and elite. On the other hand, the public health care system is besieged with problems of maladministration, human resource constraints and suffers from shortages in medical equipment, facilities, and adequate medication. This is the sector that is responsible for the health care needs of 80% of the population.

Given that the work on SERs is premised on the **state** obligations that are set out in the Constitution, the focus of this work is on the attainment of the right to health care in **public** health facilities including clinics and hospitals.¹

Legal interpretation

The right to health care is one of several socio-economic rights guaranteed in the South African Constitution of 1996.²

*'Everyone has the right to have access to health care services, including reproductive health care.'*³

*'The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.'*⁴

*'No one may be refused emergency medical treatment.'*⁵

Unlike the right to education and children's rights, the right to health care is subject to an internal limitation - i.e. the availability of state resources over time. This is what is known as progressive realisation (PR). Understanding and interpreting what is meant by the progressive realisation of SERs over time has been the subject of debate in several platforms recently. The contention lies in the ambiguity of the time-frames in which enjoyment of SERs must be realised, but also what is meant by "available resources". The work on SERs that SPII has been involved in for the past two years has been able to prove that resources are being made available to realise the SERs contained in the Constitution, however, the inability of government Departments to spend their budgets efficiently presents somewhat of a stumbling block in addressing some of the daily pertinent social and economic challenges that this young democracy grapples with.

¹ It is envisioned that this work could expand in the future to include the private sector.

² The Constitution of the Republic of South Africa, Act 108 of 1996. From now on referred to as the Constitution.

³ See section 27(1) (c) of the constitution.

⁴ See section 27 (1) (2) of the constitution.

⁵ See section 27 (1) (3) of the constitution.

The imminent issues around the progressive realisation of health care came under rigorous scrutiny in 1997 in the infamous Soobramoney case. In sum, what happened was a certain Mr Soobramoney, who was unemployed and chronically sick approached a state hospital in Durban where he was denied access to the required dialysis treatment. Mr Soobramoney suffered from ischaemic heart disease and cerebro-vascular disease and required emergency treatment. The basis for the refusal was that the hospital had limited resources and that there was a certain criteria used by the hospital to determine patient eligibility for dialysis treatment. The refusal raised two important issues. Firstly, in terms of section 27(3) a state hospital and/or health care facility are obliged to make emergency treatment available to all patients provided the necessary resources are available. Secondly, how is the right to life upheld in the context of receiving emergency medical treatment or put differently, can the right to medical treatment be read together with the right to life? In determining whether the state had taken measures within its available resources, the court focused on the resources of the KwaZulu-Natal (KZN) Department of Health. What ensued was that the Department was already overextended in as far as providing health care services to the public. There were several other impediments raised that pointed to issues of wear and tear of dialysis machines, and also problems of overcrowding in that specific public renal unit of the hospital.

Ultimately the Judge made the point that the wording of the Constitution inherently accepts and reconciles the state to the realisation that the evils sought to be addressed by these rights cannot be addressed in one fell swoop. What should happen is that the state must, on an on-going basis plough efforts into addressing social issues until such time that it can do so to the satisfaction of many if not all.

Analysis of the policy effort

When the ANC government came into power in 1994, it inherited a two-tiered, highly curative based model of health care that was divided along racial lines. The challenge was to reduce the disparities in the health care system and create an inclusive system that would cater for all South Africans, irrespective of race and socio-economic background. This would be carried out through three thematic areas, viz, strengthening the role of Primary Health Care (PHC), human resource development, and efficient financing of public health care. Other legislation was passed post 1994 as a means of strengthening health care provision in the country. Amongst these were the: Medical Aid Schemes Act, Act 131 of 1998, National Health Laboratories Service Act, Act 37 of 2000, Council of Medical Schemes Levy Act, Act 58 of 2000, National Health Act, Act 61 of 2003, Nursing Act, Act 33 of 2005, the 2005 Health Charter, and more recently the National Health Insurance (NHI) policy paper released in 2011.

Perhaps one of the most significant strides made by the newly elected ANC government in 1994 to turnaround the status quo was the introduction of the **Reconstruction and Development Programme (RDP)**.⁶ This was the ANC's first policy document after the demise of apartheid. The RDP articulated the vision of the new democratic dispensation. This policy also crafted plans for programmes that would provide access to basic needs, such as water, education, electricity, telecommunications, transport, and health care.⁷ In particular, the RDP policy called for a complete

⁶ ANC, 1994. *The Reconstruction and Development Programme: A policy framework*. Umanyano Publications, Johannesburg.

⁷ *Ibid*, p.6

transformation of the health system. This meant past discriminatory legislation would have to be reviewed and abolished; institutions and organisations formed during apartheid would have to be reorganised, and most importantly, the government needed to develop and adopt practices that would be seen to be in line with the agreed international norms and standards.

The RDP made provision for programmes and initiatives that promoted equality through the redistribution of resources in an effort to redress the injustices of the past. The RDP envisioned a health system which provided: free health care at public clinics and health centres for children under the age of six; *quality* antenatal, delivery and postnatal services for free in government hospitals and clinics in the third year after the introduction of the RDP, in order to improve maternal and child health outcomes. Early treatment of Sexually Transmitted Diseases (STDs) and HIV related illnesses at all health facilities was encouraged and promoted alongside improved access to 24-hour emergency health care services for communities, including access to ambulance services, especially in rural areas.⁸ However, soon after some of these programmes were introduced, the RDP ran into serious trouble. Implementation became a challenge due to capacity constraints in government, hostile bureaucrats and unreliable private sector partners.⁹

Since 1994, a number of other good policies have been passed, as will be discussed below, but challenges persist including the highly unequal quality of care provided, massive human resource constraints, and huge backlogs in the provision of essential services.

Many of the principles to reform the health system, as envisioned by the RDP, were spelled out in the 1997 **White Paper for the Transformation of the Health System**. This policy centred on the notion of promoting a comprehensive PHC system with the aim of redressing historical inequities and to provide essential health care to disadvantaged people in accordance with the health objectives set out in the RDP. As part of the process of changing the state of health care in the country, the white paper expressed the need for a Social Health Insurance (SHI). Unlike a National Health Insurance (NHI) which is intended to benefit the entire population irrespective of contributions made to the fund, a Social Health Insurance restricts beneficiaries to contributors and their dependents. This form of insurance would require all persons employed in the formal economy to be insured for the medical costs of public health care for themselves and their dependents.¹⁰

The debate on the possibility of implementing a SHI was first discussed in great detail in the mid-1980s. The rationale for its introduction was twofold. Firstly, the government wanted to create more room for the private sector to expand in the economy, and secondly, by shifting the financial burden to private sources of funding, the SHI would be some form of mechanism that the government could use to curb public expenditure on health care which had begun to rise very rapidly.¹¹

⁸ Ibid.

⁹ Wessel, V. Shifting RDP into GEAR: The ANC government's dilemma in providing an equitable system of social security for the 'new' South Africa. *Paper presented at the 40th ITH Linzer Konferenz*, 17 September 2004.

¹⁰ McIntyre, D., and Van den Heever, A. 2007. "Social or National Health Insurance." Accessible on: http://www.hst.org.za/uploads/files/chap5_07.pdf. According to a 2003 report by the WHO, a SHI is usually limited to individuals employed in the formal sector.

¹¹ Ibid

Following the release of this White paper, a SHI was formally adopted by the DoH in 1997.¹² Shortly thereafter, it became obvious that this kind of social insurance posed many challenges and soon became the subject of criticism by key stakeholders and policymakers. Trade unions argued that with the introduction of a SHI, people would now be obliged to pay for the same quality of health care they had previously received at little or no cost.¹³ Such a policy would directly exclude individuals at lower income deciles from accessing *quality* health care as they would not be able to afford to make the compulsory payments required for this insurance. It was these challenges that eventually led to the canning of this system of insurance and opened up a debate that would consider a more inclusive approach to financing health care. The alternative was an NHI scheme.

Over and above the proposal for a SHI, the White paper also called for the management of health services to be decentralised which included giving some power to the district health authorities with the aim of making PHC services more accessible to everyone without cost to users. Furthermore, the DoH committed to making essential drugs available in all health facilities, reprioritising the budget to ensure that resources are spent where they are most needed, and strengthening disease prevention through initiatives that promote health care awareness and promotion in HIV/AIDS, STDs and maternal, child and women's health.

In 2011 the government released a policy paper that put forth recommendations for a comprehensive **National Health Insurance (NHI)** that would be rolled out over a period of fourteen years, beginning with a five year pilot in ten selected districts in 2012. The overarching objective of the NHI is to bring about reform in the present health care system which remains fragmented, both within the public health sector and between the public and private sector, and is skewed to benefit only a privileged minority. By making quality health care affordable and accessible to all, the NHI aims to challenge the status quo in the present health system by providing non-discriminatory public health care to all South Africans regardless of their socio-economic status. In theory this has the makings of a progressive pro-poor policy and if implemented effectively would improve the livelihoods of many destitute South Africans who are not able to afford to pay for *quality* health care. It has been argued, however, that realistically rolling out this type of insurance will not solve the country's critical health challenges. For example, the question of how the existence of a NHI will address the human resource shortages currently experienced in the country has been raised. Other concerns revolve around the cost of implementation, the question of who should bear responsibility to fund such a scheme and lastly, concerns over corruption and misuse of funds. These are some of the questions and concerns that have been raised, the answers to which lie at the heart of the success of this policy.

Key policy gaps and summary

With the development of health legislation and policy over the last two decades, the public health system has been transformed into an integrated, comprehensive national service with one national and nine provincial health departments.¹⁴ This marks a significant achievement given the apartheid

¹² Doherty, J., *et al.*, "Social Health Insurance". Briefing summary based on chapter 7 of the 2000 South African Health Review. Published by the Health Systems Trust.

¹³ Doherty, J., *et al.*, "Social Health Insurance". Briefing summary based on chapter 7 of the 2000 South African Health Review. Published by the Health Systems Trust.

¹⁴ Coovadia, H. *et al*, The health and health system of South Africa: historical roots of current public health challenges, Health in South Africa 1, 2009.

legacy which entrenched the fragmentation of health care and focussed on hospitals over primary health care facilities. As discussed, PHC has been the cornerstone of the approach to delivering health services which are now available to large parts of the population, especially in rural areas. Despite this achievement and the development of good policies, the low health outcomes and massive disease burden, human resource constraints, weak management and inadequate and/or uneven implementation and monitoring of policies, has perpetuated massive health inequities between different provinces in the public health sector and between the public and private sector.¹⁵ It is still to be seen how the NHI will enable all South Africa citizens, as enshrined in the Constitution, to benefit from health service delivery on an equitable and sustainable basis.

Budget analysis (step 2)

National Department of Health Budget

In the past eight years, expenditure on health care has been at an average rate of 8% of the country's Gross Domestic Product (GDP).¹⁶ This, for example is well above the average that SADC member states for example spend on health care expenditure (5.45% of GDP).¹⁷ In spite of all the resources allocated to the Department of Health (DoH), however, socio-economic indicators show that there has only been a minor improvement in the state of health care and health outcomes in the country.

In 2012 SPII conducted an in depth analysis on the budget allocations and spending patterns of three key government departments, namely the Department of Health (on which this report is based), Department of Basic education, and the Department of Social Development (see Social Security policy brief). This analysis was based on data collected between 2007/08-2010/11. The expenditure trends for the NDoH over this period are presented below.

Table 1: DoH Expenditure trends, 2007/08-2010/11

	2007/08	2008/09	2009/10	2010/11
	R'000			
Total expenditure	13 091 136	15 851 169	18 423 459	21 661 512
Percentage in(de)crease	14.29	21.08	16.23	17.58
Under expenditure	328 402	386 699	457 249	742 933
Spending rate (%)	97.50	97.56	97.52	96.57
% under spent	2.50	2.44	2.48	3.43

Source: DoH Annual Report, various years, and own calculations based on same

Table 1 shows that there has been a steady increase in the expenditure patterns of the Health Department between 2007/08 and 2010/11. The percentage of funds under -spent also increased from 2.50% in 2007/098 to 3.43% in 2010/11. This is the equivalent of approximately R328 million and R743 million respectively which was not spent by the Department. Most of this expenditure is mainly the result of poor planning and implementation of agreed targets, delays in payments to suppliers, but also the inability to fill vacant posts. For example, one of the programmes that the

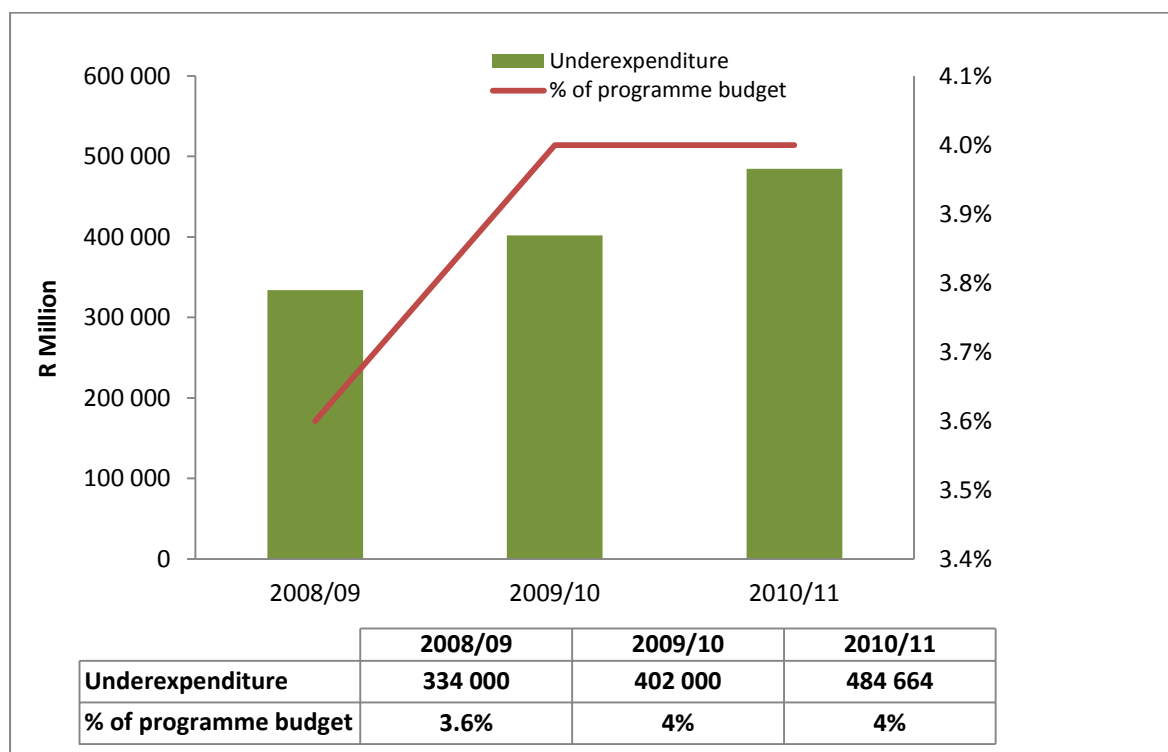
¹⁵ Ibid

¹⁶ World Health Organisation, 2012. *World Health Statistics*. Accessible on <http://www.who.int/en/>.

¹⁷ This is according to 2009 statistics from the World Health Organisation. Country data can be accessed on <http://www.who.int/countries/en/>.

DoH is responsible for is to support the delivery of health services at a Provincial and Local level. Between 2008/09 and 2010/11 under expenditure in this programme was at a consistent level of 4% of total programme budget, a monetary equivalent of around R400 million per annum. This is demonstrated in Figure 1 below.

Figure 1: Under expenditure in Programme 5: Health services - special programmes and health entities management

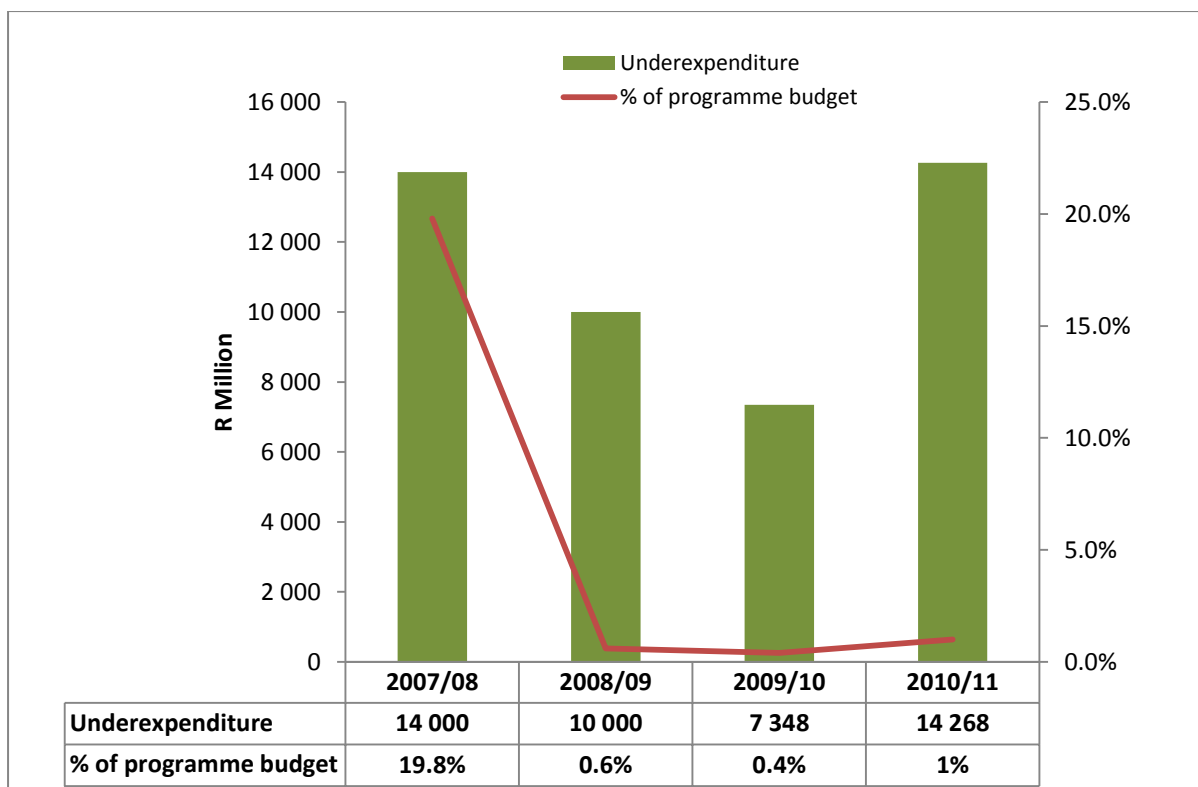


Source: Own *calculations* based on *DoH Annual Report*, various years

The pattern of under expenditure is evident in all the Department’s six programs,¹⁸ with some programs even under spending by up to 8% of the total program budget in 2010/11. There has, however, been some improvement in the rate of under expenditure in certain programs. For example, in the program responsible for development and management of a human resource plan (program 4).

Figure 2: Under expenditure in Program 4: Human resource management and development

¹⁸This analysis was based on the expenditure of the then National Department of Health’s six respective programmes, namely: Administration, Strategic Health Programmes, Health Planning and Monitoring, Human Resource Management and Development, Health Services – Special Programmes and Health Entities Management, International Relations, Health Trade and Health Product Regulation. In 2011/12 these programs were renamed.



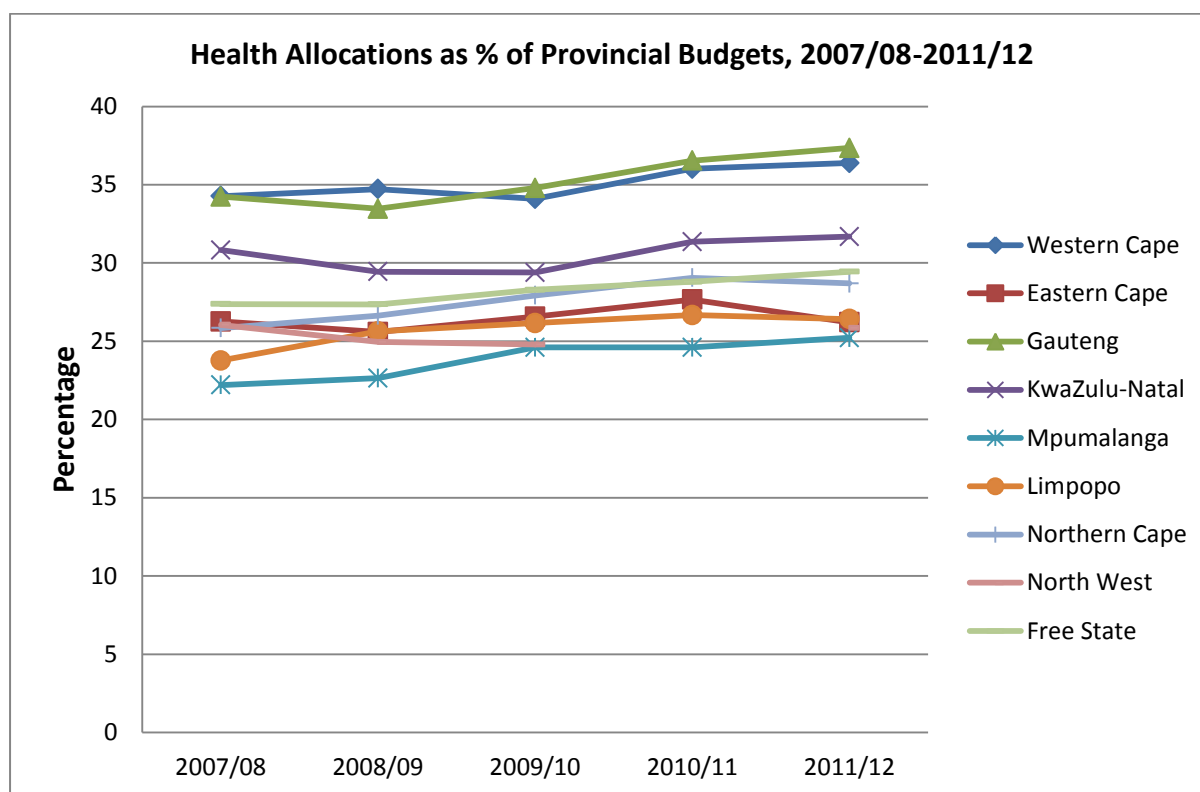
Source: Own calculations based on DoH Annual Report, various years

From this illustration it is evident that over the years the Department of Health (DoH) has managed to adequately keep its expenditure on human resources in check. In 2010/11, under expenditure in this program comprised 1% of total program budget compared to almost 20% in 2007/08. Taking cognizance of this, one should however not overlook the fact that even though the share of total budget has decreased over this period, in monetary terms the amount under spent is still significantly high. These are resources that are appropriated in order to facilitate the delivery of services to the people that need them the most. Failure to spend these resources efficiently delays progress on full enjoyment of SERs.

Provincial Health Budget Outlook

In almost all the nine South African provinces, the Department of Health receives the second largest budget allocation after the Department of Education. The exception was in 2010/11 and 2011/12 where the Western Cape government allocated the largest share of its total provincial budget to the Provincial Department of Health. Moreover, in the years 2007/08 – 2011/12, expenditure on health care in this Province amounted to an average of 35.10% of the total provincial budget. The North West on the other hand allocated the smallest share (20.33%) of its Provincial budget to health care relative to the other provinces in the review period. This along with the health expenditure patterns of other provinces are illustrated in Figure 3.

Figure 3: Percentage share allocated to Provincial Health Departments, 2007/08-2011/12



Source: Own calculations based on Estimates of Provincial Revenue and Expenditure (EPRE), various years

Summary

Despite total health care expenditure at approximately 8% of GDP and provincial budgets for health making up the second largest budget allocation, the low health outcomes paint a different picture. These can be attributed partially to the disparities in the distribution of infrastructure, financial and human resources between different provinces and rural and urban areas. Another glaring factor is the inefficiencies in the distribution of resources between different levels of care, with significantly more money allocated to hospitals over primary health care facilities.¹⁹

Developing indicators (step 3)

The process of developing indicators was largely informed by background research on each of the individual SERs. This was an integral part of the process as it allowed us to identify backlogs, gaps and areas of enquiry that would feed into the conceptualization of the indicators that we would later select. In the research on health care in South Africa for example, factors such as medical personnel shortages in hospitals and clinics, and the quality of health care in the public sector were identified as being deterrents to the attainment of the right to adequate health care. It is for this reason that indicators such as *medical practitioners per 100 000 population* and the *percentage of users of public health services highly satisfied with the service received* were selected. Identifying what indicators would be of public interest was only the first step in this process, but like many other measurement tools, indicators are only as reliable as the data that are available. That is why the availability of data to populate the selected indicators was a crucial step in this work, but also why

¹⁹ Coovadia, H. et al, The health and health system of South Africa: historical roots of current public health challenges, Health in South Africa 1, 2009.

the data scoping exercise was important – to be able to look for reliable national survey and administrative datasets which were available annually and could be disaggregated by province. During this step, there were a few indicators that were developed but did not make it to the final list of indicators presented below because of data availability challenges. Some of these indicators have been mentioned in the footnotes to the indicator table. This so called ‘wish list’ has been set aside for now, but it is hoped that these indicators will be included in future national household surveys – through ongoing stakeholder consultations with our external data partner, StatsSA.

Consultations with the SAHRC and other experts and stakeholders were useful in refining the list of indicators before scoping available data sets. After extensive consultation and knowledge of available data, a final set of indicators for health care were developed and endorsed under three dimensions i.e. Access, Adequacy, and Quality.²⁰ *Access* indicators measure both physical access and economic access or affordability. *Adequacy* measures the provision of service at health facilities themselves and *quality* measures both health outcomes and satisfaction with service offered. The final set of indicators come from a range of national data sets including both national surveys such as the General Household Survey (GHS) which is published annually and administrative data from annual reports of the respective government Departments.

The final list of indicators is provided in Table 2 below.

²⁰ More on the description of these dimensions and the decision to adopt these three baseline categories can be found in the SERs methodology paper on SPII’s website, www.spii.org.za

Table 2: Health Care Indicators

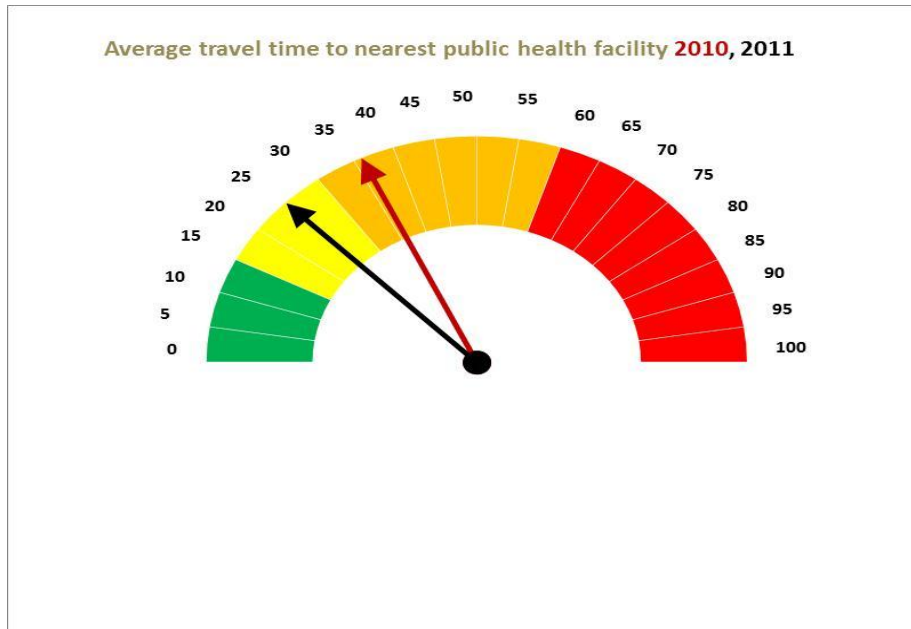
ACCESS ²¹	ADEQUACY ²²	QUALITY
<ul style="list-style-type: none"> • Average time it takes to get to the nearest public health care facility (GHS) • Average number of visits per person per year to primary health care facility (PHC) facility (DHIS) • % of population not on medical aid (GHS) 	<ul style="list-style-type: none"> • Number of public health facilities²³ (DHIS) • Number of useable beds per 1 000 population (DHIS) • % of medical practitioners per 100 000 population (PERSAL) • % of professional nurses per 100 000 population (PERSAL) • % of dental practitioners per 100 000 population (PERSAL) • % of psychologists (as opposed to psychiatrists) per 100 000 population (PERSAL) • % of users that do not use the nearest health facility due to lack of adequate medication (GHS) • % of Professional Nurse posts vacant (PERSAL) • % of Medical Practitioner posts vacant (PERSAL) 	<ul style="list-style-type: none"> • % of stillbirths per 1000 of births (DHIS) • % of neonatal mortality per 1000 births (DHIS) • % of perinatal mortality per 1000 births (DHIS) • % of maternal mortality per 100 000 live births (maternal mortality ratio) (DHIS) • Crude death rate (deaths per 1000 population) (StatsSA) • Infant mortality rate (deaths under 1 year per 1 000 live births) (StatsSA) • % of population (age 15-49) estimated to be HIV positive (StatsSA) • % of total deaths attributed to AIDS related causes (StatsSA, ASSA) • % of users of public health services highly satisfied with the service received (GHS) • Life expectancy (StatsSA) • Under 5 mortality rate (deaths under 5 years per 1000 live birth) (StatsSA)

²¹ The 'wish list' for measuring access includes the following indicators amongst others: average waiting time it takes to see nurse/doctor, likelihood of seeing a GP at a PHC facility and response rate of emergency ambulatory services (average time it takes an ambulance to get to emergency scene). The following three indicators will be included in the StatsSA CPS survey from 2015 which will then be included: cost of medication, km (distance) it takes to get to the nearest health facility, and cost to get to nearest health facility (transport).

²² The project had previously included nurse and doctor clinical work load as indicators for measuring adequacy. The data from the DHIS has not been available since 2009 and hence, the indicators have been removed from the list. Additional indicators which we currently lack reliable data for include amongst others: % of babies between 0-12 years that receive free immunisation and medicines from essential list which are available.

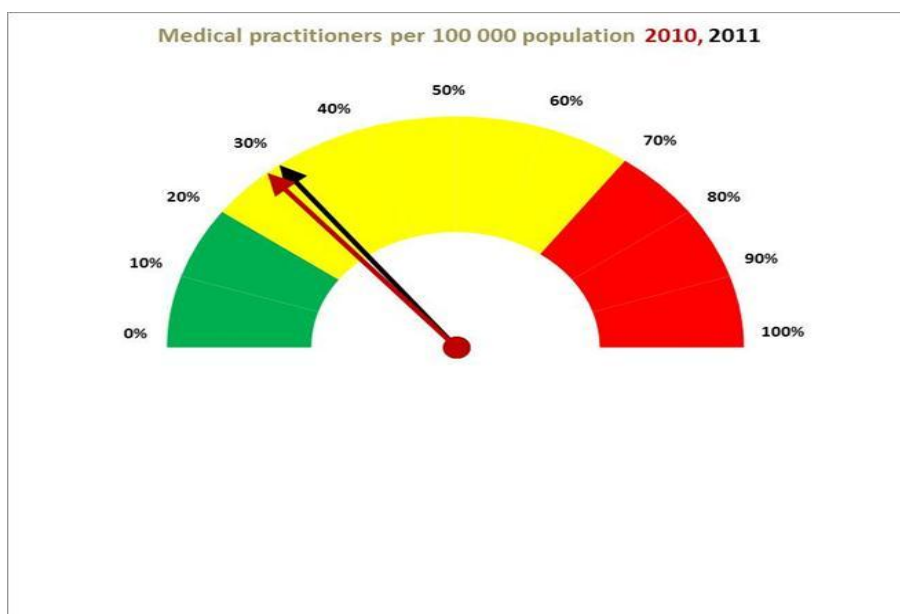
²³ The number of public health facilities is broken down into the following sub-categories: District hospitals, national central hospitals, provincial tertiary hospitals, public clinics, regional hospitals, specialised hospitals and community health centres.

The **time it takes to get to the nearest public health facility** is an important indicator to measure **access** to health care. Public clinics and hospitals should be built in close proximity to communities to allow for quick access to health care, especially in cases that require emergency treatment. According to the GHS data, in 2010 the average time it took for individuals to access the nearest public health facility was 36 minutes. There was a slight improvement in 2011 with the average time taken to get to the nearest public health facility reducing to 25 minutes.



Source: **GHS**

Following on the example of medical practitioners referred to above which measure the **adequacy** of the overall public health care system, the dashboard below shows a visual representation of this populated indicator for years 2010 and 2011. The advantage of presenting the populated indicators in this way is that one is able to see how much change has taken place over time, and whether this 'change' has been progressive, regressive or negligible.



Source: **PERSAL**

From this analysis it is evident that South Africa has an overall shortage of doctors. The data shows that in 2010 there were only 27 300 doctors per 100 000 population (27.3%), and 29 000 per 100 000 population (29%) in 2011, indicating a slight increase.

Socio-economic indicators for South Africa indicate that the mortality rate for infants has been on a downward spiral since 2005. However, the numbers are still very high. **Infant mortality rate (deaths under 1 year per 1 000 live births)** is an important measure of the **quality** of health outcomes over a period of time. In 2010 for example, there were 391 infant deaths per 1000 live births (39.1%). This ratio decreased marginally to 379 deaths per 1000 live births in 2011 (37.9%). This is presented in the diagram below.



Source: **StatsSA**

These indicators begin to build up the information at both a national and provincial level (when decomposed) to evaluate and monitor people's enjoyment of health care services in terms of access, adequacy and quality. It is crucial to acknowledge that no one indicator can tell the full story, hence the importance of evaluating various indicators for each dimension and over time. It is also important to acknowledge the indivisibility of socio-economic right and that an evaluation of people's right to health care, given the social determinants of health, cannot be divorced from the right to food (good nutrition), water and sanitation amongst others.

Indicators say nothing without clear benchmarks against which to evaluate governments' performance and achievements over time. It is therefore essential to have road maps or long term plans for each of the SERs to provide tangible benchmarks to evaluate whether there has been progress, stagnation or regression. For example, the infant mortality data presented in this paper are based on the mid-year statistics published by StatsSA. However, a special advisory committee set up by the Department of Health in 2010 to improve the quality and integrity of data on health outcomes (known as the Health Data Advisory and Coordination Committee) found the baseline infant mortality rate (IMR) to be at 40 per 1 000 live births in 2011/12. The committee then set a target of decreasing the IMR to 36 per 1 000 live births in 2014/15.

Summary

The application of the monitoring tool based on policy and budget analysis and statistical indicators to South Africa's public health care system reveals that despite major transformation in health legislation, policy and the delivery of health service, the health care system remains fragmented with a two-tiered system (public and private) perpetuating inequalities.

The Constitution explicitly states that 'everyone has the right to have access to health care services.' This is not an unqualified right, but one that should be realised over time given the resources available to government. The available data on health care have been able to show that there has been an improvement in the level of access to public health facilities, however factors like for example the shortage of medical personnel in these institutions present a threat to the full realisation of health care in the country. Furthermore, the financial resource allocations to the NDoH and Provincial health Departments have been on the rise. This Department has consistently received the second largest share of the budget (after Education) in the past, and continues to be the case even in the latest budget review. Arguably, this shows government's commitment to the fight against unequal access to health care and improving the country's health outcomes. The challenge is and has been ensuring that these resources translate into better health outcomes. With the use of the monitoring tool, one will be in a position to be able to make informed judgments on the progress achieved in the attainment of this socio-economic right over time.

Conclusion

Advocacy efforts to ensure effective implementation and enforcement of SERs are undermined if there is no methodology to monitor and address critical issues relating to the progressive realisation of these rights. The monitoring tool developed by SPII aims to build up empirical information to allow the SAHRC and civil society to assess progress made to date, as well as provide government with information on the effectiveness of their policy programmes.

This ambitious and important task requires increased input from both government and civil society to ensure broader ownership and coordinated advocacy for comprehensive road maps, spelling out how each right will be realised. This will provide a basis for public debate on the critical choices that policy makers are faced with regarding trade-offs and priorities for SERs implementation.



*Building up knowledge
to break down Poverty*

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