CHAPTER FIVE

HEALTH CARE AND

HEALTH CARE SERVICES FOR CHILDREN

PART A: OVERVIEW

1 INTRODUCTION

The post-apartheid South African government inherited a health system with huge inequalities in access to services. Some of the key features of this system included:

- discriminatory laws that resulted in inequitable access to health care services
- a highly curative health care services that did not sufficiently focus on prevention
- fragmented service delivery in racialised health departments
- limited access to health care services by women, children and farm workers
- lack of health infrastructure in rural areas
- limited information on health issues

The results of these factors were: high infant mortality rates especially amongst Africans, high maternal mortality rates, high rates of communicable diseases such as measles, and inequitable access to medical insurance. Due to the fact that relevant health statistics were not collected, appropriate interventions could not be made. The then government also introduced a number of regulations that had the effect of discriminating against people with HIV/AIDS.

In the last two reports to the South African Human Rights Commission, national and provincial health departments reported that they had introduced legislative and other measures to reorient health care services towards primary health care; taken steps to address inequitable access to health services; reorganised the delivery system; and reprioritised the health budget.

This chapter reviews measures instituted during 1999/2000 in the realisation of the right to health care in accordance with the provisions

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2 These regulations were: Admissions of Persons to the Republic Act of 1972 which allowed immigration officials to detain or deport people who were HIV-positive; and regulations relating to Communicable Diseases and the Notification of Notifiable Medical Conditions of 1987 promulgated under the Health Act of 1977.
Health rights are contained in three sections of the Constitution. These are ss 27(1) and 27(3) dealing with the right of access to health care (including reproductive health); and emergency medical treatment respectively; s 28 dealing with children’s access right to basic health care services and s 35 dealing with the health rights of arrested, detained and accused persons.

2.1 Health care including reproductive health and emergency medical treatment

The first of the three sections mentioned above is s 27, which provides for the right of access to health care for everyone. Section 27(1)(a) specifically states that ‘everyone has a right of access to health care including reproductive health’.

Also singled out in s 27 is emergency medical treatment. Section 27(3), states that everyone is entitled to emergency medical treatment. The concept of health care as used in the Constitution, although not yet interpreted by South African courts at the time of writing this report, is understood at the international level to include medical care; preventive health care; primary health care; child health care; family planning; pre- and post-natal health services; and mental health care services.

The right to health is a part of, and need not be confused with the broader concept of the right to health as contained in the Constitution of the World Health Organisation (WHO) and interpreted by the Committee on Economic, Social and Cultural Rights. The WHO Constitution defines health as a ‘state of complete physical, mental and social well being and not just the absence of disease or infirmity.’

Certain interpretations of health rights would refer to the right to health and not the narrower concept of the right to health care. Where an interpretation of health rights goes beyond health care, reference is also made to what are often referred to as underlying preconditions (determinants) for health, which together with health care, constitute the right to health. The all-encompassing term for these preconditions/determinants is environmental hygiene. It is mentioned in articles (12)(2)(b) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and articles 24(2)(c) and (e) of the Convention on the Rights of the Child (CRC). Environmental hygiene includes access to

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3 Section 27(1)(a) of the Constitution of the Republic of South Africa Act 108 of 1996
5 The Committee on Economic, Social and Cultural Rights is a United Nations body responsible for the implementation of the International Covenant on Economic, Social and Cultural Rights.
6 Preamble to the Constitution of the World Health Organisation.
clean drinking water; adequate sanitation; adequate nutrition and food; environmental health; occupational health; and abolishment of harmful traditional practices. The Committee on Economic, Social and Cultural Rights has specifically stated that it interprets the right to health beyond timely and appropriate health care but to also include, underlying determinants/preconditions for health, and access to health-related education and information, especially sexual and reproductive health.\(^7\)

Section 27(3) provides that no one may be refused emergency medical treatment. This is understood to require that bureaucratic obstacles not prevent the provision of emergency medical treatment. This right, like all the rights in the Bill of Rights, applies not just vertically but also horizontally, meaning that private health care providers also have obligations. However, emergency medical treatment does not necessarily require that the service be provided free, but that its provision should not be prevented by lack of funds, and that payment arrangements may be made later.\(^8\) The Soobramoney case has interpreted s 27(3) of the Constitution, which deals with emergency medical treatment. According to the court’s interpretation, s 27(3) on the right of non-refusal of emergency medical treatment, referred to a person suffering from a sudden catastrophe calling for immediate medical attention. The person should not be denied ambulance or other available medical emergency services and admission to hospital and should be provided with treatment. Terminal conditions such as chronic renal failure were thus not considered as emergencies calling for immediate remedial treatment.

### Basic health care services for children

The second provision of the Constitution addressing health rights relates to children, and is contained in s 28. Section 28(1)(c) states that every child has a right to basic health care. What should constitute basic health care for children is to be found in several international and regional instruments. Basic health care services for children are an area that has received considerable attention from WHO. The rights of children to basic health care also receive special mention in the ICESCR, CRC and the African Charter on the Rights and Welfare of the Child.

In article 12 of the ICESCR, and in the context of the nature of state obligations in the realisation of health rights for children, it is stated that one of the things State Parties have to do is to reduce infant mortality and stillbirths.\(^9\) Further guidance on what would constitute basic health care services for children is to be found in articles 23, 24 and 28 of the CRC. Article 23 of the CRC refers to children in general and requires states to:

- diminish infant and child mortality

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\(^7\) General Comment 14 of the Committee on Economic, Social and Cultural Rights (2000) para 11.


• provide assistance to all children with an emphasis on Primary Health Care
• combat diseases and malnutrition, while providing clean drinking water and paying attention to the risks of environmental pollution
• provide appropriate pre-natal and post-natal health care for mothers
• provide information and access to education about health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and prevention of accidents
• abolish traditional practices prejudicial to the health of children

Article 24 of the CRC pays attention to children with disabilities, and requires that assistance be provided to these children free of charge if possible, taking into account the financial resources of parents. The rights of children of migrant workers receive mention in article 28 of the CRC, which requires that migrant workers and members of their families receive medical care to preserve life and prevent irreparable harm to their health on the basis of equality of treatment.

The African Charter on the Rights and Welfare of the Child is also relevant in the discussion of basic health care services for children. Article 14 of the Charter provides that every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health. Article 14(2)(b) mandates State Parties to take measures, inter alia, to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.

In the light of the above, it can be said that basic health care services for children are those services that are aimed, amongst other things, at reducing infant mortality, childhood illnesses, malnutrition amongst children and providing care to mothers during and after pregnancy and clean drinking water. Emphasis in the provision of basic health care services for children has to be placed on primary health care. Although the right to basic health care services for children applies to all children, particular attention has to be paid to the needs of children with disabilities, and children in emergency situations.

2.3 The rights of arrested, detained and accused persons

The rights of arrested, detained and accused persons to health care are contained in s 35 of the Constitution. Section 35(2)(e) states that 'everyone who is detained, including every sentenced prisoner, has a right to conditions that are consistent with human dignity, including at state expense, medical treatment'. Section 35(f)(iv) specifically deals with the rights of prisoners to communicate with a medical practitioner of their choice.

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11 Article 24 Ibid.
2.4 Differences between ss 27(1), 27(3), 28(1)(c) and 35(2)(e)

There are differences between ss 27(1), 27(3), 28(1)(c) and 35(2)(e), especially as regards the role of the state in the realisation of health rights. The right to health care contained in s 27 is qualified by s 27(2), which requires the state to take reasonable legislative and other measures, within its available resources to progressively realise, the right to health care contained in s 27(1). This means that the realisation of health rights is primarily, reliant on resource availability, and may therefore not be realised immediately, but progressively in the medium to long-term. However, the state must take reasonable measures that demonstrate the effective use of available resources in its effort to realise the right to health care.

The issues that have to be dealt with are what the meanings of ‘reasonable’, available resources and ‘progressive realisation’.

In Government of the Republic of South Africa v Grootboom and Others and in defining reasonableness, the Constitutional Court held that for measures to be considered reasonable, they needed to be reasonable in both conception and implementation.\(^{13}\) The conceptual soundness of a measure is not sufficient to meet the reasonableness test. If measures were to be reasonable in conception but not reasonable in implementation, they would not be considered to be in compliance with s 27(1). Measures had to make appropriate provisions for crises in the short-, medium and long-term. Moreover, a programme that excluded a significant segment of society would not pass the reasonableness test. It was also held that a statistical advance might also not pass the reasonableness test if it fails to meet the needs of a significant segment of society. As regards progressive realisation, the Court held that the state should progressively facilitate accessibility.

The unavailability of resources is a justifiable ground for failure to take legislative and other measures towards the realisation of the right. Moreover, resource availability would also determine the pace at which the right to health care can be realised. The issue of resource availability however, has to be treated cautiously. The Limburg Principles states that irrespective of the level of economic development every state is obliged to ensure respect for minimum subsistence of the rights.\(^{14}\) The minimum subsistence in the area of health rights is to be found in General Comment Number 14 of the Committee on Economic, Social and Cultural Rights, in what the Committee refers to as core obligations. These include:

- ensuring that the right of access to health care facilities, goods and services are enjoyed on a non-discriminatory basis especially by vulnerable groups

\(^{13}\) Government of the Republic of South Africa v Grootboom and Others 2000 (11) BCLR 1169 (CC) para 39.

• ensuring access to minimum essential food which is sufficient, nutritionally adequate and safe, to ensure freedom from hunger for everyone
• ensuring access to basic shelter, housing and sanitation and an adequate supply of safe and potable water
• providing essential drugs defined from time to time by WHO's Essential Drugs List
• ensuring the equitable distribution of health care
• developing a national strategy and plan of action towards the provision of health care

2.5 Equality and the issue of vulnerable groups

Section 27(1) of the Constitution specifically states that 'everyone' has the right to health care. One of the immediate implications of this is that access to health care has to be premised on the equality clause in s 9 of the Constitution, particularly on the prohibited grounds for discrimination listed in s 9(3). This is consistent with the Convention on the Elimination of All Forms of Racial Discrimination that requires states to prohibit and eliminate discrimination and guarantee everyone without distinction to race, colour, national or ethnic origin, the enjoyment of economic and social rights, including health rights.

At the international level, the issue of discrimination in the context of health rights has received considerable attention. This has been the case especially in the contexts of mental health and the control of the spread of communicable diseases, which have in certain instances been used to discriminate against migrants and in more recent times persons infected with HIV/AIDS. The overall aim of the international organisations, including WHO, has been to discourage states from introducing excessive measures in attempts to control the spread of communicable diseases for fear that such measures could result in unfair discrimination.

Such discrimination as may be deemed appropriate, should be fair and directed at addressing the special needs of those groups that for economic and social reasons, may not be able to provide for themselves. The state is therefore required not only to introduce negative measures to remove discrimination, but to also introduce positive measures to correct existing discrimination, especially as regards the provision of health care.

2.6 State obligations regarding health rights

Obligations of the state regarding health rights have to be understood against s 7(2) of the Constitution, which requires the state to respect, 17

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15 General Comment 14 (note 7 above) para 43.
17 Section 7(2) of the Constitution.
18 The obligation to respect means that the state must not engage in activities that undermine people's own efforts to realise rights contained in the Bill of Right.
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protect,\textsuperscript{19} promote\textsuperscript{20} and fulfil\textsuperscript{21} rights contained in the Bill of Rights. The Committee on Economic, Social and Cultural Rights has devoted considerable attention in explaining in particular, the obligations to respect, protect and fulfil in the context of health rights.\textsuperscript{22}

The obligation to \textit{respect} requires states to refrain from:

- denying or limiting equal access to health
- imposing discriminatory practices relating to women’s health
- prohibiting or impeding traditional preventive healing
- marketing unsafe drugs and applying coercive measures except in the case of mental health where conditions for the application of coercive measures need to be clearly spelt out
- limiting contraception
- censoring, withholding or misrepresenting health information
- preventing participation
- unlawful pollution
- nuclear testing where that will jeopardise people’s health

The obligation to \textit{protect} requires states to:

- ensure that privatisation does not constitute a threat to the availability,\textsuperscript{23} accessibility,\textsuperscript{24} acceptability\textsuperscript{25} and quality of health facilities, goods and services\textsuperscript{26}
- control the marketing of health equipment and medicines by third parties

\textsuperscript{19} The obligation to protect means that the state must protect third parties from violating rights contained in the Bill of Rights.
\textsuperscript{20} The obligation to promote means that the state must raise awareness about the rights contained in the Bill of Rights.
\textsuperscript{21} The obligation to fulfil means that where people are not on their own, able to realise the rights contained in the Bill of Rights, the state must take legislative and other measures to assist.
\textsuperscript{22} General Comment 14 (note 7 above).
\textsuperscript{23} Functioning public health care facilities, goods, services and programmes in sufficient quantities. General Comment Number 14.
\textsuperscript{24} Accessibility has four overlapping dimensions, namely non-discrimination, physical accessibility, economic accessibility and information accessibility. The principle of non-discrimination however, recognises that certain vulnerable groups may require special measures for the enjoyment of the right to health. Physical accessibility means that health care facilities be physically accessible to all, especially vulnerable groups. Economic accessibility (affordability) relates to the payment for services, which has to be based on the principle of equity, ensuring that both publicly and privately provided services are affordable to all, including poorer households. Information accessibility means the right to seek, receive and impart information and ideas concerning health issues. However, this should not impair the right to have personal information and data treated with confidentiality.
\textsuperscript{25} Acceptability relates to the need for the respect for medical ethics and cultural appropriateness
\textsuperscript{26} Scientifically and medically appropriate. Ibid.
• ensure that medical practitioners and related professionals meet the appropriate standards of education, skill and ethical codes of conduct
• ensure that harmful traditional practices such as the mutilation of female genitals are prohibited
• prevent third parties from coercing women into harmful traditional practices
• protect vulnerable groups from gender-based violence
• prevent third parties from withholding the dissemination of health information

The obligation to *fulfil* requires states to:

• give legal recognition to the right to health
• ensure access to the underlying preconditions (determinants) of health mentioned above
• ensure that public health infrastructure provide for sexual and reproductive health including safe motherhood especially in rural areas
• provide appropriate training of health personnel, sufficient number of clinics and related facilities
• provide health insurance
• undertake medical research and health education

The Committee has also spelt out special considerations that need to be given to women, children and adolescents, persons with disabilities, older persons and indigenous groups.

3 KEY DEVELOPMENTS FOR THE YEAR UNDER REVIEW

The developments that took place during the reporting period have to be contextualised within the constitutional provisions mentioned above, the White Paper on the Transformation of the Health System in South Africa, and measures instituted before the reporting period, reported to the Commission in the 1st and 2nd Economic and Social Rights Reports.

The White Paper on the Transformation of the Health System in South Africa proposed prioritisation in the provision of health care, of previously disadvantaged racial, gender, geographical and other groups. The White Paper proposes a unitary health system where all could enjoy equitable and affordable access to basic health care services.27 The policies laid out in the paper include:

• a focus on primary health care services;
• ensuring the availability of safe, good quality essential drugs;

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- financial resources rationalisation through budget reprioritisation;
- development of a National Health Information System; and
- establishment of the Integrated Nutrition Programme for sustainable food security.28

Flowing from the White Paper, the national and provincial departments reported in the first two reports to the Commission that they have taken measures towards the realisation of health rights. These included the development of a Comprehensive Primary Health Care Package; the development of health infrastructure mainly through the Clinic Building and Upgrading Programme; the development of a Patient’s Rights Charter in order to instil a human rights culture in the rendering of health care services; the development of policies in the area of HIV/AIDS; and development of programmes to address childhood illnesses.

During the reporting period of 1999/2000, a number of key developments took place with regard to the realisation of the right to health. Although most of the developments were the introduction of legislative measures, there will also be outlined, policies, programmes and services; and budgetary measures.

3.1 Policies, programmes and other interventions

Several policy and related developments took place during the reporting period. While many of these developments were positive in that they contributed to the progressive realisation of the right to health care. There were also negative developments that did not augur well for the realisation of the right.

3.1.1 Positive developments

On the positive side, the following developments occurred: the re-demarcation of health districts in line with the District Health Model; the launch of the Patient’s Rights Charter which was developed before the reporting period; the development of guidelines for health professionals on the protection of older persons against abuse; and further developments in the fight against HIV/AIDS.

With the local government elections scheduled for late 2000, reform of the health care sector was directed at the District Health System. The District Health System is central to the government’s Primary Health Care that, as mentioned above, is one of the areas considered appropriate as an element of health care. This involved the demarcation of health district boundaries alongside municipal boundaries.29

28 See the Chapter Four on Food rights.
Another important policy development for the reporting period was the launch of The National Patients’ Rights Charter on 2 November 1999. The Charter had been developed before the reporting period and the details of its rationale and contents were included in the 2nd Economic and Social Rights Report. The aim of the Charter was to improve the quality of health care by defining twelve core health rights of users of health care facilities. The Charter is consistent with the obligation to promote the right to health, described above, in which the state is obliged to provide information and education on health.

As part of the International Year of Older Persons in 1999, the Department of Health developed guidelines for health professionals on how to prevent and address physical and sexual abuse of older persons. It is important to note that older persons are a vulnerable group in the provision of the right to health, and in the specific context of state obligations.

The scourge of the HIV/AIDS epidemic and the public debate on the relationship between poverty and HIV/AIDS focused attention on the Department of Health’s Programme to address the epidemic. New developments in the government’s strategy to deal with HIV/AIDS were in three main areas:

- Drug Intervention to prevent Mother to Child Transmission (MTCT)
- Development of an AIDS Vaccine
- Establishment of an AIDS Council to advise government on the approach to HIV/AIDS

There was also released during the reporting period, a report titled Review of Public Health Service, a study commissioned by the Department of Health and undertaken by the Institute of Development Studies at Sussex University. The study focused on trends in public health expenditure, issues of quality in the delivery of health care, experiences with the introduction of the Primary Health Care Model, and a review of health infrastructure, particularly clinics and hospitals.

Policy developments for child health care included a new Road to Health Card for monitoring, which was developed and implemented nationally during 1999. The new card focuses on the use of growth surveillance statistics to promote and monitor child growth. Policy guidelines for the management and prevention of genetic disorders, birth defects and disabilities were also developed during 1999. Breast-feeding guidelines for health workers were finalised during December 1999 and included guidelines on the feeding of infants of HIV-positive mothers.

As part of the Expanded Programme on Immunisation (EPI), the Department successfully introduced a new vaccine, Haemophilus influenzae type B (HIB) in July 1999 at a budgeted cost of R58 million. Infection with HIB can result

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30 Ibid.
31 Ibid 18.
in pneumonia, meningitis, septic arthritis, osteomyelitis, cellulitis, pericarditis, epiglottitis and septicaemia. The mortality rate due to infection with HIB can be as high as 30 percent in developing countries.

During the reporting period, the Department of Health with assistance from WHO, reviewed the implementation of the Integrated Management of Childhood Illnesses (IMCI) in KwaZulu-Natal, Mpumalanga, Northern Cape and Northern Province. The IMCI is a strategy to promote child health and improve child survival as part of the National Plan of Action for Children. The core intervention is integrated case management of the five most important causes of childhood deaths (acute respiratory infections, diarrhoea, measles, malaria and malnutrition). The strategy was first launched in 1998 in the provinces mentioned above. Implementation of IMCI began in the remaining provinces during the reporting period, with a commitment by the Minister and MECs of Health to implement IMCI in every district throughout the country by the end of 2003.  

3.1.2 Negative developments

While the abovementioned developments were positive, there were also other developments during the reporting period that did not positively contribute to the progressive realisation of the right to health care. These include human resources problems; reports of maladministration and corruption; and drug shortages and theft.

There were reports of serious personnel problems in the country. Senior health personnel at four major Gauteng hospitals reported via the media that the hospitals were on the brink of collapse, caused by a complete moratorium on the filling of posts for many months due to budget constraints. The affected hospitals were Chris Hani Baragwanath, Johannesburg, Coronation and Helen Joseph, together serving an estimated 10 million people. South Africa’s largest hospital, Chris Hani Baragwanath, had a shortage of about 2,282 staff members, including more than 100 doctors. As a result of this shortage, the hospital administration decided to close the neonatal intensive care unit, stop admissions to paediatric wards at night and suspend the provision of emergency services after 22h00. The hospital was also forced to curtail the provision of termination of pregnancy (TOP) services. The superintendent-general of Gauteng hospitals estimated that the province required about R300 million more than the allocated budget to sustain these services.

Reports of maladministration and corruption also surfaced during the reporting period. During May 2000, an investigation conducted by the Star newspaper revealed that doctors were getting kickbacks from some pathology laboratories in return for ordering tests. The investigation showed that two of South Africa’s pathology groups, Ampath and Lancet

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32 Ibid.
were paying millions of rands to certain doctors in kickbacks each year. Commissions paid to 84 doctors by Lancet averaged R247 000 a month in 1999; Ampath paid a total of R3, 9 million to 103 doctors for the year. It is argued that the financial incentives were given to maintain or increase the number of referrals and that laboratories sometimes carry out more tests than requested or is medically necessary. The practice of kickbacks is considered to be unethical and in contravention of the ethical rules of the Health Professionals Council of South Africa. Whilst the Forum of Statutory Health Councils decided to address the issue by establishing guidelines forbidding doctors from accepting payment in return for referring pathology tests, it is doubtful whether the envisaged guidelines shall prove to be a deterrent. In 1998, of the 155 cases of doctors, psychiatrists and dentists heard by the Council’s disciplinary committee on charges of negligence and improper or disgraceful conduct, none was removed from the medical register.³⁴ The 80 professionals found guilty were given suspended sentences or fines, and allowed to return to work immediately.

Other negative developments were reports of drug shortages and theft of medicines. In April 2000, it was reported that poor administration had resulted in a shortage of BCG percutaneous vaccine (the tuberculosis [TB] vaccine given to babies) since March 2000.³⁵ The shortage occurred at a time when TB rates had doubled in most provinces over the past five years up to the 1999/2000 financial year, and were expected to increase five-fold by 2005 if current trends were to continue. A switchover from local production of the vaccine to importation was blamed for the shortage. Bureaucratic bungling had resulted in local production being stopped whilst supply from importation was only expected in September 2000.

Amidst the shortage of tuberculosis and other essential drugs, the review period was also marred by theft of medicine by public sector health care professionals and organised crime.³⁶ In KwaZulu-Natal, a state pharmacist who reported a number of suspected thefts from the state hospital in which he worked was poisoned. In a separate incident, state medicines estimated to be worth thousands of rands were found in the possession of a local nurse who worked at KwaMaphumulo Hospital.³⁷ The theft of drugs is also believed to be the work of crime syndicates that costs the pharmaceutical industry close to R2 billion per year.³⁸ Alarmingly, it is estimated that half of all state medicines are stolen. In an effort to address overwhelming theft from hospitals and clinics, medicines destined for state hospitals were to be packaged differently to distinguish them from drugs intended for the private sector.

### 3.2 Legislative developments

³⁴ *The Saturday Star* 28 April 1999.
³⁵ *The Star* 25 April 2000.
³⁸ *The Cape Argus* 3 September 1999.
Several key legislative developments, all of them causing intense lobbying, debate and review, took place during the reporting period. These included the Tobacco Products Control Act 12 of 1999, the promulgation in 1999 of the Medical Schemes Act 131 of 1998, the implementation of the Pharmacy Amendment Act 88 of 1997 and the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (PEPUDA).

The Tobacco Products Control Amendment Act 12 of 1999 places certain restrictions on the marketing, sale and consumption of cigarettes. The main aim of the Act is to make it more difficult for people to smoke with an emphasis on making smoking less attractive to people who have never smoked. In terms of the Medical Schemes Act 131 of 1998, and aims to ensure that participants enjoy fair and adequate cover, and are not discriminated against on their age or health status. The most important section of the Pharmacy Amendment Act 88 of 1997, implemented during the reporting period concerns the introduction of community service for newly qualified pharmacists. The Act provides for 12-months of community service starting from January 2001. All graduates who register as pharmacists will have to work in the public health care sector for one year before being able to practice privately. Community service is expected to make additional 500 pharmacists a year available to public health institutions.

Another important piece of legislation that was developed during the reporting period was the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. Although the Act is not specifically directed towards addressing health issues, the new legislation is aimed at prohibiting unfair discrimination towards people with disabilities, people who are HIV positive and pregnant women.

While the abovementioned developments were certainly positive in that they were in line with the obligations of the state mentioned above, there were also reports of implementation problems of some of the legislation introduced earlier. A major negative development was growing reports of under utilisation of Termination of Pregnancy Services. According to the South African Health Review of 1999, of the 246 public health facilities responsible for offering abortions to South African women, only 73 were rendering those services. Of these, approximately half (49 percent) of all terminations were carried out in Gauteng while only 1 percent were carried out in the North West.

3.3 The Budget

The health budget for the financial year 1999/2000 was increased by R157 million, bringing the total to R24 billion. Additional funds went to vaccine production, expansion of the Influenza Immunisation Programme and the government’s HIV/AIDS Action Plan. Provinces received R8.8 billion to

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fund hospital services; and upgrade and rehabilitate dilapidated institutions.

Between 1997/1998 and 1999/2000, capital expenditure including spending on new clinics declined by almost 12 percent in real terms. A declining portion of provincial health budgets was allocated to the construction and maintenance of provincial health buildings since 1997/1998, and the national conditional grant for Hospital Rehabilitation and Reconstruction, has not been large enough to compensate for the inadequate provincial expenditure. Also, provinces had not spent what they budgeted for on the maintenance and construction of health facilities. Provinces spent only 57 percent of budgeted expenditure between 1997/1998 and 1998/99. This means that provinces were even less able to keep their facilities from deteriorating than their budgets suggest.

Another problem was under-spending on the AIDS budget. The budget for the AIDS programmes was about R109 million in 1999/2000 and R182 million for the following year. The department’s Government AIDS Action Programme (GAAP) spent only 25 percent of its budget of R40, 4 million, with R30, 3m unspent even though R29, 9 m of these unspent funds were 'committed' to GAAP projects.

4 The measures instituted by the state before and during the reporting period were positive and contributed to the progressive realisation of the right to health care. In particular, these are measures such as the institutional restructuring of the district health model, human resources development, maternal health, and infrastructure development. The actual results of these measures however, are mixed. There is clearly evidence that there is increasing use of the public health care sector. This attests to increasing accessibility of the sector. Moreover, the state has been relatively successful in addressing childhood illnesses such as measles, although there is still a lot that has to be done in this area. In terms of legislation, there is need for attention to be paid to medical insurance in order to continue to increase the affordability of health care. One issue that is becoming clear is that health care is being implemented in a situation of declining budgetary resources and where there is also difficulty in the efficient application of budgetary resources.

40 Idasa BIS. ‘Capital expenditure in provincial Health budgets’” (1999) at http://www.idasa.org.za/bis/briefs/brief42.htm,
PART B: ANALYSIS OF RESPONSES BY ORGANS OF STATE

This section focuses on the assessment of information provided by the national and provincial departments of health on policy, legislative and budgetary measures instituted during the 1999/2000 financial year, to realise health rights. In each of these sections, departments were asked to report on the way any instituted measures met constitutional obligations in s 7(2) of the Constitution stated in the overview section; special considerations given to vulnerable groups; and implementation difficulties experienced. In the case of budgetary measures, departments were asked to account for any variances in the budgets, whether budgeted amounts were adequate, impacts of any inadequacies, and measures instituted to cope with budget inadequacies and special considerations given to vulnerable groups. The Commission also required departments to provide information on the state of the indicators that are relevant to the determination of progress with the realisation of health rights, as well as information on mechanisms that departments have put in place to monitor the realisation of health rights.

RIGHT OF ACCESS TO HEALTH CARE SERVICES

1 POLICY MEASURES

1.1 National Sphere

Policy measures, programmes and services of the national Department of Health, including the measures instituted during the reporting period, are derived from the White Paper for the Transformation of the Health System in South Africa. The White Paper purports to transform the health system towards Primary Health Care, address racial, geographical, gender and other disparities in access to health care, introduce a human rights culture in the provision of health care, oral health and develop Information Technology for monitoring patient and other data systems.

The measures that the department reported on for the 1999/2000 reporting period were the Clinic Building and Upgrading Programme; Confidential Enquiry into Maternal Health; Training of Staff; Community Service for Health Professionals; and a policy on Drugs and Pharmaceutical Supplies. It is important to note that these were not new measures instituted during the reporting period, but were measures instituted before the reporting period.

Clinic Building and Upgrading Programme

The programme attempted to address infrastructure backlogs and disparities, with emphasis on rural areas. It entails the construction of new clinics and rehabilitation of existing ones. According to the department, over 400 clinics had either been constructed or rehabilitated under the
programme. This resulted in higher utilisation rates, as communities travel shorter distances to health care facilities.

**Confidential Enquiry into Maternal Health**

In 1998, the department commissioned an enquiry into South Africa’s alarming maternal mortality rate. The report found that the maternal death rates in South Africa were 22 times higher than in developed countries, but nearly four times lower than in countries such as Kenya, Zimbabwe and Zambia. The major causes of maternal deaths in South Africa were found to be hypertension (23.2 percent); HIV/AIDS (14.5 percent); bleeding before, during and after delivery (13.3 percent); pregnancy-related sepsis (11.9 percent); and pre-existing medical conditions, mostly heart disease (10.4 percent).

In response to the findings of the report, the department began implementing strategies to address some of these problems. The strategy entailed the institution of in-depth monitoring of maternal deaths, mandating notification of all maternal deaths and investigating causes of notified deaths. As part of this monitoring, a card for women’s reproductive health to improve continued care and promote healthy lifestyles for men and women was developed. Other interventions include the training of health workers, strengthening of staff support, provision of more clinics and the improvement of the quality of care.

**Staff development programme**

This entailed training and community service, and was directed at addressing reproductive health issues with a specific focus on rural areas that have the highest shortage of human resources. The training component of the measure took the form of a Staff-Training Programme that mainly concentrated on enhancing the skills of midwives, by providing advanced midwifery and neonatal nursing science courses. The Policy on Community Service was introduced as a means of improving the level of service provided to communities, especially in rural areas. The department stated that the Community Service for Dentists in particular, had assisted in improving the level of oral health care services provided to rural communities.

**Policy on drugs and pharmaceutical supplies**

The policy was meant to address the provision of essential drugs, including prescribing guidelines for the management and distribution of drugs and pharmaceutical supplies.

Although the department stated in its response to the protocol that the abovementioned measures affect the obligations to respect, protect,
promote and fulfil the right to health, were reasonable and effective, they did not clearly explain this in a way that would lend itself to analysis.

The department did not specifically address the issue of special considerations given to vulnerable groups identified in the protocol, except to mention that all the measures instituted benefited previously disadvantaged groups.

1.2 Provincial Sphere

Most provinces provided information on their different policies, programmes and services. The Gauteng, KwaZulu-Natal, Northern Cape and Western Cape Departments of Health provided the same answers as in the 2nd Economic and Social Rights Report with slight variations and additions.

A number of areas identified in the White Paper for the Transformation of the Health System in South Africa received attention in the provinces. The Table below identifies areas that received attention in the provinces, and the actual provinces that instituted measures in the identified areas.

<table>
<thead>
<tr>
<th>Policies, programmes and services</th>
<th>Provincial departments that instituted the measures</th>
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<tr>
<td>Batho Pele Principles on Service Delivery</td>
<td>Northern Province</td>
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<tr>
<td>Patients' Rights Charter</td>
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<td>HIV/AIDS</td>
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<td>Maternal health</td>
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<td>Mental health and substance abuse</td>
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<tr>
<td>Rehabilitation</td>
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<tr>
<td>Chronic care</td>
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<tr>
<td>Communicable diseases</td>
<td>Eastern Cape; Free State; Mpumalanga</td>
</tr>
<tr>
<td>Oral health</td>
<td>Free State</td>
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</table>

**Batho Pele Principles on Service Delivery**

The Northern Province Department of Health instituted the monitoring of service standards as part of implementing the Batho Pele 'White Paper on Transforming Public Service Delivery'.

**Patients Charter**

In line with the national department, Gauteng, Northern Province and Western Cape Departments of Health launched the Patients' Rights Charter during 1999.

The Gauteng Department of Health further conducted workshops on the Charter to all health care institutions.
The Northern Province Department of Health set up a Toll Free line for lodging complaints. Health summits were also held in all the regions to conscientise health workers about patients' rights.

The Western Cape Department of Health developed a Patient's Complaint Procedure. The mechanism for implementing the Charter was set up in many health care facilities in the province.

**HIV/AIDS**

As shown in Table 1, the Eastern Cape and the Free State reported on measures in the area of HIV/AIDS.

The Eastern Cape Department of Health increased the number of sites for voluntary testing and counselling, and the training of health care workers. The department also extended the service on rapid testing for the virus to other clinics and a community based HIV/AIDS project was established. The Faces of AIDS Project was implemented to raise awareness on AIDS.

The Free State Department of Health (FSDH) finalised the development of the policy on Post Exposure Prophylaxis to HIV/AIDS for employees. This measure outlines how patients should be dealt with, and the prevention of HIV/AIDS. The FSDH also developed strategic plans to address key performance areas such as:

- HIV/AIDS Workplace Policy
- Effective Management of Sexually Transmitted Diseases (STD) and condom distribution
- Voluntary Testing and Counselling
- Home-Based Care

The FSDH reported that the policy on HIV/AIDS mentioned above respected, protected, promoted and fulfilled the right of access to health care. The policy ensured that personnel were informed about the treatment of and work with HIV-positive persons. The FSDH also stated that patients were treated fairly and not discriminated against as prescribed by the Patient's Rights Charter and the HIV/AIDS Rights Charter.

**Maternal Health Programmes**

The FSDH and North West's Departments of Health (NWDH) developed policy guidelines for:

- the provision of Termination of Pregnancy (TOP) services;
- contraception; and

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42 The Patients' Rights Charters’ main objective is the fulfillment of the rights of all patients as equal claimants to human dignity.

43 The HIV/AIDS Charter lays down those basic rights that should be enjoyed by all citizens, that should not be denied to persons affected by HIV/AIDS.
• cervical cancer screening.

The NWDH further developed guidelines for breast examination and family planning, and launched the maternal deaths notification programme. The department also offered in-service education to health personnel in order to improve the quality of services provided to clients. The courses included the Perinatal Problem Identification Programme (PPIP), Perinatal Education Programme (PEP) and the Decentralised Education Programme in Advanced Midwifery (DEPAM).

The FSDH on the other hand, was still reviewing the DEPAM Curriculum which was to be used for training health care workers in the province. Other measures reported by the FSDH included the expansion of existing Primary Health Care (PHC) services to include antenatal and postnatal services and the development of tools for monitoring Maternity Services in order to regulate and improve the standard of care.

Mental Health and Substance Abuse

Policies on mental health and substance abuse were introduced in the Free State, Gauteng and Mpumalanga. The FSDH instituted the Mental Health Draft policy guidelines.

The GDH instituted the Interdepartmental Programme on substance abuse. The Mpumalanga Department of Health (MDH) was drafting policy guidelines at the close of the reporting period. However, there were treatment guidelines and protocols in place. The department also introduced the Community-Based Mental Health programmes.

In terms of special considerations given to vulnerable groups, the Mpumalanga Department stated that outreach programmes conducted by psychiatrists were offered to peripheral hospitals. The needs of homeless persons were met through community-based mental health services offered by day care centres. The assistance provided took the form of meals and psychological rehabilitation.

Rehabilitation

The Eastern Cape, Free State and Gauteng instituted measures in the area of rehabilitation. The Eastern Cape Department of Health provided assistive devices such as wheel chairs and hearing aids to persons with disabilities. According to the department, this helped to address existing backlogs in hearing aids and wheel chairs.

The FSDH produced a document that informed health care professionals on the new approach to rehabilitation services. Health care facilities had been made more accessible to persons with disabilities. The Gauteng Department of Health (GDH) provided counselling services to victims of violence and introduced a pilot project aimed at improving the detection of cases of domestic violence.
Care of the Elderly

The Eastern Cape, Free State and Gauteng provinces paid attention to the elderly during the reporting period.

The Eastern Cape Department of Health (ECDH) indicated that for the elderly, the availability of the treatment protocol ensured the provision of services such as the diagnosis and treatment of diabetes mellitus, arthritis and hypertension.

The FSDH utilised the existing National Prevention of Blindness Programme, and training on eye care. Other measures included the International Year of Older Person's Programme. Some clinics had projects such as gardening and handwork targeted at the elderly. The FSDH stated that the projects were effective because they imparted skills, which would help the elderly to support themselves.

The GDH offered training to health workers on the care of the elderly.

Communicable Disease Programme

The Eastern Cape and the Free State instituted measures towards addressing the spread of communicable diseases.

The ECDH introduced the Directly Observed Treatment Short Course (DOTS) programme targeted at low-income groups, which assisted in the treatment and prevention of the spread of TB. The DOTS programme had been expanded to over eighty Demonstration and Training Districts. The department further stated that under this programme a high success rate was achieved with smear conversion rates when the programme was first implemented during 1996. The department also reported that implementation of the programme was in line with the protocols endorsed by WHO.

The following programmes were instituted by the FSDH during the year under review:

- TB Control Programme and the Management of Rabies and Leprosy Control Programme
- a Programme on reporting adverse events following immunisation, elimination of measles and the eradication of polio through investigation of all Acute Flaccid Paralysis

Oral Health

The FSDH instituted the Oral Health Services Guidelines for the province, and was planning to implement the Community Service for Dentists

44 No explanation provided on what this means.
Programme from 1 July 2000, as a means of increasing accessibility to oral services especially in rural areas.

1.3 Critique

The national Department of Health's report continues to lack useful information that could be used for the assessment of policy measures, related programmes and services. In terms of the question on policy measures, the response of the department is lacking in two respects. The first is lack of information on measures instituted during the reporting period. Although the protocol clearly states that it is the measures instituted during the reporting period that are the object of inquiry, the department continued to report on measures that were instituted before the reporting period.

The second shortcoming of the report is that there were measures instituted during the 1999/2000 reporting period that the department failed to mention. Independent research showed that the following measures were instituted during the reporting period:

- the demarcation of the health districts based on the Primary Health Model to coincide with local government boundaries: this involved the demarcation of health district boundaries alongside municipal boundaries in view of the local government elections scheduled for late 2000. In keeping with this policy, all primary level services including 24-hour emergency services and level 1 hospitals would fall under local government. Consequently, a significant amount of provincial health services and personnel were to be transferred to the newly formed local authorities. It was intended that over 50 000-health workers would be transferred from the provincial public service to local authorities staff, and that local authority health budgets would increase more than five times.
- the launch of the National Patients Charter: The Charter was developed before the reporting period and was reported in the 2nd Economic and Social Rights Report
- development of guidelines for health professionals on how to prevent and address physical and sexual abuse of older persons

The national department did not explain the rationale for the measures, the contents of each measure and its intended outcomes. Questions on instituted measures and constitutional obligations in s 7(2) of the Constitution were answered at such a level of generality that there was no clear demonstration that the department understands these obligations. The same is the case with the question on vulnerable groups.

In view of the above, it is fair to infer that reporting by the national department is less than satisfactory. By and large, measures instituted by the national department, including those introduced before the reporting period, are relevant to the realisation of the right to health care. Moreover,

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45 Department of Health (note 29 above) 7.
they help meet the obligations of the state in s 7(2) of the Constitution as elaborated by the Committee on Economic, Social and Cultural Rights. The difficulty is more pronounced at the implementation level.

The national Department of Health has taken great strides before and during the reporting period, towards the realisation of health rights contained in the Constitution. Whereas the situation before 1994 was dominated by the private sector, which was largely inaccessible to the majority of poor people, there is growing evidence of the use of the public health sector. The October Household Survey published in 2001, which covered the period up to 1999, has demonstrated an increase in the use of the public health sector.46

The monitoring of maternal deaths was progressively realising the right to have access to health care services, especially reproductive health.47 Notification of maternal deaths would compel medical health practitioners to take note and record causes of death. Maternal mortality notification was meant to ensure that the high incidence of pregnancy related deaths is reduced.

Although the Clinic Building and Upgrading Programme was also a positive measure given the centrality of the measure to the Primary Health Care approach of government, questions can be raised about the sustainability of the Programme. It took four years to upgrade 2 547 clinics, build 495 new ones and provide 215 mobile clinics for the entire country.48 The national department’s Annual Report indicates that during 1998, only 68 new clinics were built and 14 upgraded using Reconstruction and Development (RDP) funds.49 This was quite critical in the context of free Primary Health Care (PHC) services to children under the ages of six, including pregnant and lactating women for the entire country. The programme was also developed to support access to Primary Health Care services to those whose nearest clinic was more than 5 km away.50 Moreover, in the Annual Report of the Department of Health, it was stated that funding from the RDP Fund and Independent Development Trust (IDT) for the Clinic Building and Upgrading Programme would end during the 1998/1999 financial year. No report was provided on the budgetary allocation for this programme for the year under review.

While the department was taking active measures to address human resources development, some more urgent problems were beginning to surface. For instance, the department stated that the introduction of Community Service for Doctors and Dentists has assisted in improving the level of care provided to rural communities. However, some hospitals and

46 P Lehohla South Africa in Transition: Selected Findings from the October household survey of 1999 and changes that have occurred between 1995 and 1999 (2001) 86.
48 Department of Health (note 29 above) 7.
49 Ibid.
clinics experienced staff shortages. Budget cuts were the major causes of these problems. For instance, following budget cuts for personnel, some Johannesburg hospitals were compelled to close their neo-natal intensive care units and suspend emergency services for children between 10 p.m. and 8 a.m.\footnote{Staff cuts may close baby wards, June 23, 1999 at \url{http://www.iol.co.za}.}

Despite the institution of measures on drug policy, patients were still forced to wait in long queues for hours, sometimes the whole day for their medication.\footnote{Patients forced to wait up to hours', \textit{The Star}, July 06, 1999.} In the Western Cape, medication for patients at state hospitals across the Peninsula was often in short supply due to the late delivery by manufacturers.\footnote{Patients wait in vain for medicine', \textit{The Cape Argus}, November 29, 1999.} In provinces such as KwaZulu-Natal, there were also problems of corruption and mismanagement in some hospitals and clinics, with doctors and nurses involved in the theft and illegal sale of medicines.\footnote{Nurses and doctors caught selling medicine', \textit{Daily News} September 06, 1999.} AIDS patients suffered more because drugs were often not available at some clinics.\footnote{The Mail & Guardian Aids policy is a disaster at \url{http://www.mg/co/za/mg/news/99jul2/19jul-aids.html}. Site visited on the 16/03/2001.}

It is worth noting that the department was silent on the manner in which instituted measures had been implemented, and the difficulties faced therein. While conceding that the role of the national department is largely that of policymaking, monitoring and evaluation, as implementation occurs mainly in the provinces, it is necessary that the national department is aware of the manner in which these policies were being implemented. This is particularly critical, as it has emerged that while most of the policies developed by the department have generally been reasonable in conception, it is at the point of service delivery where increasing attention needs to be directed.\footnote{Department of Health (note 29 above) 25.} Some of the evidence for this claim is that there continues to be under-utilisation of new facilities such as the Termination of Pregnancy services.

Most provincial departments have reported adequately on policies, programmes and services instituted during the reporting period. However, and with the exception of the Free State, most provinces still fail to demonstrate the way the measures undertaken address constitutional obligations and give special considerations to vulnerable groups.

Reports from the provinces highlight diverse measures introduced by various provincial health departments in an effort to realise the right of access to health care services. It is however important to highlight that some provinces were not instituting measures to address priority problem areas. A number of examples attest to this:

- The Eastern Cape instituted the DOTS programme as it is one of the provinces with high incidence of TB. Other provinces that also have a
high incidence of TB were the Western Cape and KwaZulu-Natal, although these provinces do not seem to be taking measures to address this issue

- The 2\textsuperscript{nd} Economic and Social Rights Report noted that KwaZulu-Natal, facing one of the highest rates of HIV/AIDS, did not present information on how it dealt with HIV/AIDS. During this reporting period, it was only the Eastern Cape and the Free State that reported on measures in the area of HIV/AIDS. A similar report from KwaZulu-Natal was still unavailable
- Only the Free State Department of Health reported on oral health care services suggesting that other provinces were not taking measures to address this issue
- It is worth noting that most provinces were silent on the implementation of the Patient's Rights Charter, despite the centrality of the Charter in entrenching a human rights culture in the provision of health care services

All the measures instituted in the provinces were relevant and contributed to the realisation of the right to health care. It is thus inconceivable that some provinces were not taking steps to institute these policy measures.

Measures such as the National Prevention of Blindness and the International Year of Older Person's Programme were given attention by all other provinces.

It is worth commending Mpumalanga for successfully implementing the DOTS programme. It was the first province to have a successful treatment rate of 80 percent, and the national department stated that lessons learnt could be used in the improvement of the approach that could be taken by other provinces.\textsuperscript{58} The Patients' Rights Charter can be regarded as progressively realising the right of access to health care services. Its principles are aligned to the Batho Pele paradigm, which emphasises access to information, accountability and transparency.\textsuperscript{59} The implementation of the Charter however, remains even more critical.

\textbf{1.4 Recommendations}

National and provincial departments should provide information on the progress or lack thereof in the implementation of policy measures, instituted before the reporting period. In reporting on each measure, departments should state the rationale for each measure and the actual content of the measure. The report also needs to highlight how the measure addresses obligations in s 7(2) of the Constitution, whose context in the right to health is contained in General Comment No. 14 of the Committee on Economic, Social and Cultural Rights. It is also necessary

\textsuperscript{57} Department of Health \textit{TB in South Africa: The People's Plague} (1997) 8.
\textsuperscript{58} Ibid 20.
\textsuperscript{59} Ibid.
that more specific information be provided on special considerations given to vulnerable groups.

There is a need by national government to develop comprehensive mechanisms to support policy implementation by provincial departments. This is particularly so in the light of research findings that clearly indicate that while policy interventions have redirected health care services towards addressing historical imbalances, attention is needed in service delivery. The particular issues that require scrutiny are the sustainability of capital facilities such as clinics, wherein issues of operation and maintenance need to feature prominently.

Another area of service delivery that requires attention is staff. As stated earlier, the moratorium on staff shortages was reportedly having a crippling effect on staffing in major hospitals.

The national department needs to ensure that the Drugs and Pharmaceutical Supplies Policy is properly implemented and monitored for better service provision. Problems of corruption and mismanagement create a barrier to adequate service provision.

Provinces such as the Western Cape and KwaZulu-Natal, and others that have a higher prevalence of TB need to adopt and implement the DOTS programme as a matter of urgency.

All provinces need to implement the Patient’s Rights Charter. It was unsatisfactory that only few provinces have started to develop strategies to implement the Charter, given its pivotal role in entrenching a human rights culture in the provision of health care services. The Charter is also in line with the obligation to promote the right in that it is aimed at informing members of the public about their health rights.

Government needs to take measures to address the shortages of medicines. As outlined in the overview section, one of the contributing factors to these shortages is theft of medicines.

There is still a tendency of government not to identify vulnerable groups and explicitly state how the measures instituted give special considerations to these groups. Government needs to be more explicit about special consideration given to refugees and asylum seekers.

2 LEGISLATIVE MEASURES

2.1 National Sphere

In its report, the department did not provide information on new legislative measures instituted during the reporting period to realise the right to health care. Instead, it mentioned two Acts that were instituted before the reporting period. These were the Medical Schemes Act 131 of 1998 that
was promulgated in February 1999, and the Choice of Termination of Pregnancy Act 92 of 1996.

**The promulgation of the Medical Aid Schemes Act 131 of 1998**

The Act is directed at protecting the right of access to health care by ensuring broad access to medical insurance. It removes discriminatory practice in the private sector. In terms of the Act, medical aid schemes had until December 1999 to redesign their products, benefits and rules to conform to regulations and have them approved by the Registrar for Medical Schemes. The main aims of the Act are to ensure that participants enjoy fair and adequate cover, and are not discriminated against on the basis of their age or health risk status. In so doing, the Act prevents schemes from barring the sick and the elderly through prohibitively expensive membership. The regulations provide for the guaranteed acceptance into a medical scheme and a minimum benefits package. Contributions to a medical scheme were to be standardised.

According to the Department of Health, the Act takes precedence in cases where there is conflict with any legislation other than the Constitution. Important provisions of this law that deal with contributions and benefit structures are contained in the regulations published in October 1999 and brought into effect in January 2000, with the exception of other limited regulations that came into effect in November 1999. The regulations state a list of prescribed minimum benefit conditions, in respect of which medical schemes are required to reimburse in full without co-payment or the use of deductibles, the diagnostic, treatment and care costs in at least one provider or provider network, which must include the public hospital system. While medical aid schemes may still employ techniques such as pre-authorisation, they are not entitled to refuse authorisation in a public hospital of standard treatment for any prescribed minimum benefit.

The objectives behind the prescribed minimum benefits are to avoid instances where individuals lose their medical scheme cover in the event of serious illness, and the consequent risk of unfunded utilisation of public hospitals; and to improve efficiency in the allocation of private and public health care resources. The regulations further provide that due to changes in medical practice and technology, the national Department of Health will review the prescribed minimum benefits every two years. This is to be done in consultation with other role players in the health sector, namely the Council for Medical Schemes, provincial Health departments and consumer representatives.

**Choice of Termination of Pregnancy Act 92 of 1996**

This Act meets constitutional obligations stated in s 7(2) of the Constitution. On the one hand it gives legislative recognition to the right to reproductive health contained in s 27(1) of the Constitution. It also has the benefit of providing termination of pregnancy (TOP) services, thereby protecting women against potential exposure to hazardous 'backstreet
abortions'. The department has reported that over a five-year period (the actual years were not given), South African health facilities were admitting hundreds of women with incomplete abortions, of whom 450 died annually. Most of these women were from poorer backgrounds and could thus not afford abortion services in the private sector. The measure is thus also a positive measure in that it makes available public facilities available towards the termination of pregnancy. As a result of the Act, about 270 health facilities have been designated for TOP services.

According to the department, the major difficulty with the implementation of TOP was conscientious objections.

2.2 Provincial Sphere

Departments of the Eastern Cape and Mpumalanga did not submit responses on the right to health care. The Northern Cape Department submitted a replica of the report submitted in the previous reporting period. The remaining six provincial departments instituted their own health legislation.

The Free State province passed, \textit{inter alia}, the Free State Provincial Health Act 8 of 1999. No information on the content of the measure was provided.

As a follow-up to the White Paper on District Health Services, the Gauteng province developed the District Health Services Bill, which was due to be tabled in June 2000. The purpose of the Bill is to effect the devolution of District Health Services to local government. The Emergency Services Bill was also developed during the reporting period. The Nursing Education and Training Bill was reportedly due for distribution and consultation during the reporting period. No further information was made available.

In KwaZulu-Natal, the provincial department drafted the Provincial Health Bill. The department also reported that two hospitals have been established in line with the TOP services. Furthermore, the department implemented the Sterilisation Act to make sterilisation more accessible to the disabled.

There was no new legislation passed in the North West province. However, the department has indicated that there has been a continued implementation of the Choice of Termination of Pregnancy Act of 1996 and the Domestic Violence Act 116 of 1998. These laws were reported to have been helpful in the protection of women from discrimination.

The Western Cape Department continued to implement national legislation such as the Choice of Termination of Pregnancy Act, and was also using the Draft National Health Bill to guide the delivery of health care services.

2.3 Critique
The report from the national department failed to mention key legislative measures instituted during the reporting period. These include the Medicines and Related Substances Control Amendment Act 90 of 1999; and the Pharmacy Amendment Bill of 1999. A brief description of each of the Acts instituted but not reported on by the department is hereby given.

**Medicines and Related Substances Control Amendment Act 90 of 1999**

This legislation was passed to bring down the cost of medicines and to make health care more accessible and affordable. One of the main objectives of the Act was to provide for the supply of affordable medicines in certain circumstances. The major amendment to Act 101 of 1965 was the insertion of section 15(c), which empowers the Minister of Health to take measures to ensure the supply of more affordable medicines by prescribing conditions so as to protect the health of the public.

**The Pharmacy Amendment Bill of 1999**

This Bill introduced the system of community service for pharmacists, similar to the one introduced for medical practitioners through the Medical, Dental and Supplementary Health Service Professions Amendment Act 89 of 1997. According to the Bill, a first time registering pharmacist is subject to the completion of one year of remunerated pharmaceutical community service. The Bill was intended to come into effect on the same day that section 13 of the Pharmacy Amendment Act 88 of 1997 came into force. It was expected that additional 500 pharmacists a year would be made available to public health institutions. The Act was an attempt to address shortages of pharmacists and to address the inter-provincial disparities in pharmacists in the public health sector. For example, whilst Gauteng has one pharmacist for every 1,738 people, the Northern Province has one pharmacist for every 16,446 people.

Also worth mentioning is the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000. Although the Act is not specifically directed at the health sector, it prohibits discrimination on a number of grounds. After the Act was passed in 2000, further research was conducted to investigate additional grounds for unfair discrimination. HIV status is one of the grounds under investigation.

While the above-mentioned measures are certainly positive in that they move towards meeting constitutional obligations, there are several areas requiring attention. There are policies of government whose implementation is hindered by lack of a legislative framework such as the demarcation of health districts, gaps in some legislative measures for instance the Medical Aid Schemes Act, and difficulties experienced in implementing legislation such as the Termination of Pregnancy Act.

One of the factors that stood in the way of the re-demarcation of District Health boundaries mentioned in the section on policy measures was lack of a legislative framework to guide the process. There were no definitive
guidelines on the scope and depth of primary level services to be rendered by the district health services. Without national legislation, each province would have had to introduce legislation resulting in significant variability between provinces.

The Medical Aid Schemes Act is a particularly useful measure to protect the violation of the right to health care by third parties. However, it is important to note that the state itself has not made a statement on the feasibility of a state-funded or subsidised form of health insurance, as is provided in some countries. It is a fact that the Act as it is would benefit people who are either already members of medical aid schemes, or those who are simply being prevented from doing so by unfair discrimination. Nevertheless, many South Africans are simply not able to afford health care, hence the continued prevalence of diseases in the country. One of the findings of the October Household Survey mentioned earlier was that medical insurance provided in the private sector, continues to be inaccessible to the majority of people in the country. The Survey showed that only 10 percent of Africans had medical cover, compared to 20 percent for Coloureds, and 25 percent for Indians, while seven out of every 10 Whites had such cover.\textsuperscript{60} The state is thus required to comment on the feasibility of a publicly funded or subsidised form of health insurance.

While the Termination of Pregnancy Act 92 of 1996 is positive for the reasons mentioned above, the implementation of the measure tells a slightly different story. Although the overall national figure of 70 000 abortions conducted since the passing of the Act before the 1999/2000 reporting period seems encouraging, these national figures hide the way in which certain groups of women have poorer access to abortion services than others. According to the South African Health Review of 1999,\textsuperscript{61} a total of 246 public health facilities were responsible for offering abortions to South African women, but only 73 were delivering the service. Of the 73, almost half (49 percent) of all terminations of pregnancy were carried out in Gauteng while only one percent were carried out in the North West. When comparing the female population per province with the number of reported TOPs, KwaZulu-Natal with the highest female population in the country (21 percent) registered only 10 percent of the total TOPs.

The Review also showed that young women were still unaware of their right to request a safe and legal abortion without their parents or partner’s consent. Moreover, health care workers still have negative attitudes towards abortion with most nurses being unaware that by law, young women (including minors) have the right to an abortion on request. Budgetary constraints have also resulted in the training of very few personnel to conduct terminations of pregnancy. There were only 31 qualified, practising midwives who could legally perform an abortion. Although the Act was promulgated in February 1997, the curriculum for the training of midwives was only finalised in October 1998.

\textsuperscript{60} Lehohla (note 46 above) 86.
\textsuperscript{61} Varkey (note 39 above).
Generally, provincial departments did not provide the Commission with adequate information as required by the protocol. Information dealing with the constitutional obligations and the impact of instituted measures on the progressive realisation of the right was not provided. Neither was the information on the reasonableness and effectiveness of the measures provided.

There were significant legislative developments in some of the provinces that did not respond at all, namely the Eastern Cape, Mpumalanga and Northern Province. For example, the Eastern Cape Provincial Health Bill was to be tabled in the provincial legislature in November 1999. In Mpumalanga, there were two pieces of legislation that were being developed, namely the Mpumalanga Health Bill and the Health Facilities Bill. The latter was to be submitted to Cabinet for consideration in early 2000. The Northern Province Legislature passed the Northern Province Health Bill during the reporting period.

2.4 Recommendations

The national department should develop legislation to guide the transformation of the District Health System that is at the heart of the Primary Health Care Model. Such legislation should clearly spell out definitive guidelines on the scope and depth of primary level services to be rendered by the district health services.

There is a need for government to make a definite statement regarding the feasibility of a publicly funded or subsidised form of medical insurance. Such a form of insurance could be targeted at poorer households that are not able to afford medical insurance due to either low income or unemployment. The development of such a system should be accompanied by continued monitoring of the private provision of medical insurance.

There is also a need for government to continuously monitor the implementation of key legislation such as the Termination of Pregnancy Act. Such monitoring should pay specific attention to the level of utilisation of services, against trends in the rate of 'backstreet abortions'.

3 BUDGETARY MEASURES

3.1 National Sphere

Most of the information requested from the national Department of Health on budgetary allocations towards specific health care programmes for the reporting period was not provided. Information was only provided for the total allocation for the department and for the prevention and treatment of HIV/AIDS.
The department reported that it does not disaggregate the total allocation according to the format of the protocol, wherein budget information was required according to the following programmes: health care services, including reproductive health care; primary health care; and health care facilities. The respective provincial departments were the ones who would have this information as they implement national policies. The national department is involved only in the administrative oversight of these services. However, the department stated that review of the public health system showed that more resources were being committed to the District Health System.

3.2 Provincial Sphere

The Mpumalanga Health Department provided information from its various districts and the information could thus not be used, as it was not collated into a comprehensive provincial report. Gauteng and the Northern Cape Health Departments did not provide information on their respective total provincial health budgets. The Table below shows the overall budgetary allocations to health for the provinces.

Table 2 Provincial health budgets

<table>
<thead>
<tr>
<th>PROVINCE</th>
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<th>TOTAL ALLOCATION IN RAND(S)</th>
<th>ACTUAL EXPENDITURE IN RAND(S)</th>
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<td>3 027 061 000</td>
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<tr>
<td></td>
<td>1999/2000</td>
<td>3 434 091 000</td>
<td>3 496 262 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>3 318 018 000</td>
<td>3 650 636 000</td>
</tr>
<tr>
<td>Free State</td>
<td>1998/1999</td>
<td>1 589 708 130</td>
<td>1 688 028 273</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>1 724 403 018</td>
<td>1 588 986 823</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>1 780 454 000</td>
<td>-</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>1998/1999</td>
<td>4 804 355 000</td>
<td>4 867 437 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>5 115 056 000</td>
<td>5 109 604 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>5 109 604 000</td>
<td>-</td>
</tr>
<tr>
<td>Northern Province</td>
<td>1998/1999</td>
<td>1 906 185 000</td>
<td>2 056 005 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>2 282 601 000</td>
<td>2 220 525 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>2 395 065 000</td>
<td>1 156 805 000</td>
</tr>
<tr>
<td>North West</td>
<td>1998/1999</td>
<td>1 361 710 000</td>
<td>1 341 992 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>1 431 592 000</td>
<td>1 383 842 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>1 565 328 000</td>
<td>-</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1998/1999</td>
<td>3 024 055 000</td>
<td>3 023 826 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>3 072 888 000</td>
<td>3 106 704 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>3 322 532 000</td>
<td>-</td>
</tr>
</tbody>
</table>

All the provinces that provided information on budgetary allocations had nominal increases in their budgets. The Free State, KwaZulu-Natal, Northern Province and the North West under-spent on their budgets. The departments that over-spent were the Western Cape, the Eastern Cape and Northern Cape.

Health care services
Some provincial departments did provide information of that portion of the health budget that went into health care services including reproductive health. Figures are shown in the Table below.

Table 3  
Budgetary allocations towards health care services including reproductive health

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>YEAR</th>
<th>TOTAL ALLOCATION IN RAND(S)</th>
<th>ACTUAL EXPENDITURE IN RAND(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>1998/1999</td>
<td>114 607 000</td>
<td>90 989 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>88 658 000</td>
<td>84 000 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>30 496 000</td>
<td></td>
</tr>
<tr>
<td>Free State</td>
<td>1998/1999</td>
<td>1 484 334 130</td>
<td>1 584 121 581</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>1 501 724 891</td>
<td>1 391 996 631</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>1 544 430 000</td>
<td>-</td>
</tr>
<tr>
<td>Gauteng</td>
<td>1998/1999</td>
<td>672 170 000</td>
<td>587 452 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>941 874 000</td>
<td>648 645 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>1 123 675 000</td>
<td>-</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>1998/1999</td>
<td>4 803 355 000</td>
<td>4 867 437 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>5 115 056 000</td>
<td>5 109 604 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>5 574 263 000</td>
<td>-</td>
</tr>
<tr>
<td>North West</td>
<td>1998/1999</td>
<td>1 361 710 000</td>
<td>1 341 992 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>-</td>
<td>1 383 842 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1998/1999</td>
<td>2 717 725</td>
<td>2 754 941 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>2 868 209</td>
<td>2 919 619 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>3 303 142</td>
<td>-</td>
</tr>
</tbody>
</table>

All provincial departments with the exception of the Eastern Cape had nominal budget increases from the 1998/1999 to the 1999/2000 financial years. The Eastern Cape experienced a substantial reduction in the allocation towards the health care services budget. What is also worth noting is that during the reporting period, with the exception of the Western Cape that over-spent on its budget, all provincial departments variably under-spent on their health services budget.

Some provinces provided information on variances, budget adequacy and special considerations given to vulnerable groups.

*Explanations of variances*: Northern Province, Gauteng, the Northern Cape and Mpumalanga did not provide any information on variances.

In the Western Cape, the R41 million variance was attributed to the fact that there was only a 1,5 percent increase in the budget, which was far below the inflation rate.

The Free State Department of Health indicated there was an 8,2 percent increase from the 1998/1999 to the 1999/2000 financial year. The department attributes the variance to Growth Employment and Redistribution (GEAR), the Medium Term Expenditure Framework (MTEF) and the Transformation of the Financial Management System.
In KwaZulu-Natal, the department stated that during the reporting period, there was under-spending of funds earmarked for special projects. As a result, an application was made for rollover funds, approval of which would result in over-spending of R 72 million. The department had expected that during the 2000/2001 financial year, there would be over-spending.

In the Eastern Cape, adjustments were made towards the end of the financial year, which resulted in under-spending. During the 2000/2001 financial year, projections were that there would be over-spending and the matter was receiving attention.

**Budget adequacy:** Gauteng, Northern Cape, Northern Province and Mpumalanga Health departments did not provide information on budget adequacy.

The FSDH indicated that the allocated budget was not adequate. An attempt was made to address this problem through reprioritisation and budget realignment, management of cost drivers, and the improvement of financial management skills and methods.\(^{62}\) As a result, there were severe staff shortages although no actual figures of the extent of the shortages were provided. Medicines were under-budgeted for. The department ended up cutting down on staff through Voluntary Severance Packages and on costs such as consumables at academic hospitals.

In KwaZulu-Natal, there was insufficient funding to fill vacancies, maintain stocks of medicines, provision purchase, replace essential equipment and maintain buildings. Measures taken to deal with the problems included freezing of posts resulting in unacceptable pressure on key personnel and reduction of stock levels.

The ECDH reported that budgetary allocations were adequate for personnel but not for non-personnel costs, clinical purposes, medicines, hospital support services, maintenance of machinery, generators, coal, etc. Consequently, the department introduced cost containment measures, including curtailment of expenditure, budget envelopes per section and containment committees to closely monitor expenditure.

**Special considerations given to vulnerable groups:** In the Western Cape, the health department reported that it increased allocations towards rural areas and that its PHC and HIV/AIDS Programmes took into consideration some of the vulnerable groups identified in the protocol.

\(^{62}\) The Department provided a detailed list of measures that it has implemented to address budget inadequacies. These include the development of a three-year strategic Service Plan linked to a costed Business Plan; capacity building of management at all levels in terms of performance, budgeting and financial management; appointment of a finance management officer; financial management strategies to ensure effectiveness and efficiency; centralisation of monitoring and approval of expenditure; revision of staff establishments; implementation of essential list drugs and the implementation of cost centres.
The KwaZulu-Natal Department of Health gave a more extensive account of the way special considerations were given to the groups identified in the protocol.

- People with HIV/AIDS benefited from the HIV/AIDS Programme
- New clinics and free rural clinics benefit people in rural areas
- Although no special considerations were given to older persons, all facilities were made available to the elderly. The same was the case for the homeless
- For people with disabilities, specific funding was being provided for prosthetic aids. Moreover, construction of buildings takes into account the needs of the disabled. There were also specific programmes such as physiotherapy, occupational therapy and rehabilitation
- Low-income groups benefit from free PHC services and funding specifically made available for nutritional support. No special provisions were made to refugees and asylum seekers

The Free State, Northern Province and the Eastern Cape Departments of Health did not respond to the question.

**Primary health care**

The Northern Province, Northern Cape and Mpumalanga Departments of Health did not provide the required information on budgetary allocations towards Primary Health Care. Figures received are provided in the Table below.

**Table 4  Budgetary allocations towards Primary Health Care**

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>YEAR</th>
<th>TOTAL ALLOCATION IN RAND(S)</th>
<th>ACTUAL EXPENDITURE IN RAND(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>1998/1999</td>
<td>418 826 000</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>305 675 000</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Free State</td>
<td>1998/1999</td>
<td>593 000 000</td>
<td>609 113 493</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>606 573 000</td>
<td>577 203 501</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>657 030 000</td>
<td>183 753 490</td>
</tr>
<tr>
<td>Gauteng</td>
<td>1998/1999</td>
<td>35 078 000</td>
<td>18 882 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>75 069 000</td>
<td>56 503 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>75 069 000</td>
<td>-</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>1998/1999</td>
<td>1 973 763 000</td>
<td>1 961 903 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>2 085 607 000</td>
<td>2 141 290 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>2 618 764 000</td>
<td>-</td>
</tr>
<tr>
<td>North Cape</td>
<td>1998/1999</td>
<td>-</td>
<td>234 540 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>27 836 000</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Northern Province</td>
<td>1998/1999</td>
<td>1 906 185 000</td>
<td>2 056 005 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>2 282 601 000</td>
<td>2 220 525 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>2 395 065 000</td>
<td>955 413 365</td>
</tr>
<tr>
<td>North West</td>
<td>1998/1999</td>
<td>786 732 000</td>
<td>854 747 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>865 707 000</td>
<td>943 848 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>920 571 000</td>
<td>-</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1998/1999</td>
<td>507 384 000</td>
<td>492 474 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>554 790 000</td>
<td>569 768 000</td>
</tr>
</tbody>
</table>
What was also worth noting under the Primary Health Care budget was that four of the seven provincial departments that provided the Commission with the required information namely, the Northern Cape, the North West, the Western Cape and the Northern Province had under-spent on their budgets.

**Variance**: the Western Cape Department of Health reported that there was about R15 million over-spending with a 9.3 percent increase from the 1998/1999 to the 1999/2000 financial years. No reasons were given for this over-spending.

In KwaZulu-Natal, there had been inadequate funding in respect of rank promotion, and important medicines, mainly at the district hospital level. During the 2000/2001 financial year, there was anticipated, a shortfall in respect of the cost of medicines, equipment and escalating inflation.

The Department of Health and Social Services in the North West reported that the variance between the years was only an adjustment for inflation and not growth or expansion of services. Some personnel costs for provincial hospitals (secondary level services) were paid from the District Health Service allocation, hence the difference between the budget and actual expenditure.

The FSDH reported that the budget allocation had increased annually from 1998 to 2000. The main difference, the report said, was between 1999/2000 and 2000/2001 financial years. Two reasons were given for variances. The first was the transfer of Ambulance Services from Local Government services to the province and the second was the fact that the TB budget from SANTA and private hospitals was transferred to Primary Health Care from the Hospital Services Budget.

The ECDH did not provide information on variances but indicated that the same reasons given for variances in the health care service budget discussed above, were the same as the ones for primary health care.

**Budget adequacy**: There were no responses from the Gauteng, the Northern Cape and Northern Province’s Departments of Health.

The North West Department of Health and Social Services indicated that the budget was not adequate, as it was based on available funds not needs. As a result, services have had to be scaled down to fit into available resources.

In the Western Cape, the amount allocated was dependent on the total health allocation represented above. Amidst ongoing efforts to expand
Primary Health Care, population growth and the escalation of health care, costs were the main factors increasing pressures on the budget.

The KwaZulu-Natal Department of Health also said the budgetary allocation towards health care was inadequate.

In the case of the ECDH, it was reported that the budget was inadequate to provide effective Primary Health Care. There were significant cuts in expenditure on stores and livestock, and professional and special budget allocation. This, the report said, affected the ability of clinics and district hospitals to purchase drugs, conduct laboratory tests and supplies.

The department was thus unable to extend services including staffing of clinics, as had been envisaged. The FSDH indicated that after reprioritisation, the budget was adequate.

Measures embarked upon to address the inadequacy of budgetary allocation towards Primary Health Care: In the Free State, areas of under-spending were identified and funds moved. The Eastern Cape Department of Health applied for a lifeline allocation. In the Western Cape, the Health and Social Services Department earmarked further funding for the commissioning of health facilities. KwaZulu-Natal reported the same measures as were reported for health care services. The North West Department of Health and Social Services resorted to reprioritisation in an attempt to cope with the inadequacy of the budget.

HIV/AIDS

The Commission required information on budgetary allocations for both the prevention and treatment of HIV/AIDS.

Prevention

Limited information was provided on the prevention of HIV/AIDS, as the Table below illustrates.

Table 5  Budgetary allocations towards Prevention of HIV/AIDS

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>YEAR</th>
<th>TOTAL ALLOCATION IN RANDS</th>
<th>ACTUAL EXPENDITURE IN RANDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>1998/1999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>9 000 000</td>
<td>-</td>
</tr>
<tr>
<td>Free State</td>
<td>1998/1999</td>
<td>3 000 000</td>
<td>5 000 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>3 000 000</td>
<td>10 000 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>3 000 000</td>
<td>20 000 000</td>
</tr>
<tr>
<td>Gauteng</td>
<td>1998/1999</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KwaZulu Natal</td>
<td>1998/1999</td>
<td>6 998 000</td>
<td>7 193 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>15 800 000</td>
<td>12 298 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>35 800 000</td>
<td></td>
</tr>
</tbody>
</table>
The North West Department of Health explicitly stated that the department did not have a specific allocation for the prevention of HIV/AIDS. However, it estimated that about R 113,000,000 was spent on HIV/AIDS prevention during 1999/2000. About R 1,200,000 was spent on information, education and communication activities. Items such as condoms, which were provided by the national Department of Health, were not part of the provincial budget.

The Northern Cape reported that the figures for HIV/AIDS prevention only reflected conditional grants for the phases High Transmission Project and Lay Counsellor Programmes and not the amount spent by the department in the provincial office and in the districts. The Financial Management System did not distinguish between expenditure on different health programmes.

**Variance**: Only the Free State and Western Cape Departments of Health provided information on variances and the reasons thereof.

The Free State Health Department reported that while it acknowledges that HIV/AIDS was a high priority, it had to be balanced against other priorities, although support and prioritisation of HIV/AIDS led to more funds being allocated.

The Western Cape Health and Social Services Department attributed variances to inadequate funding during the 1998/1999 financial year, the late implementation of a Special AIDS Unit and the difficulty in finalising contracts with NGOs for workers in the field for the 1999/2000 financial year.

**Budget adequacy**: Limited information was provided on budget adequacy, the impact of inadequacies, and measures put in place to address inadequacies.

The Western Cape Department of Health reported that the budget was not adequate for the prevention of HIV/AIDS, and that it was becoming difficult.
to manage the HIV/AIDS pandemic. A motivation was made for an increased budget.

The Free State Health Department reported that the budgeted amount was not adequate as the province had the second highest incidence of HIV infection in the country, although this claim was not corroborated by the figures provided by the same department in the outcomes section. What was needed, the report stated, were massive allocations of resources such as staff, time, community work, funds, and targeted sustainable projects and programmes on a large scale. Regarding problems encountered as a result of budget inadequacy, the department stated that it was difficult to report, as HIV/AIDS was not a notifiable disease. Measures taken by the department to cope with budget inadequacy include amongst others:

- lobbying for more funds
- creation of partnerships with other organisations to deal with HIV/AIDS
- allocation of funds towards CBOs/NGOs to supplement public funds
- public awareness campaigns and additional staffing

There was also limited information on special considerations given to vulnerable groups. The KwaZulu-Natal and the Western Cape Departments of Health reported that health resources towards HIV/AIDS do accommodate all the people in the province. The remaining departments did not respond to the question.

Treatment

The Eastern Cape and the Free State Departments of Health were the only ones that responded to questions on budgetary allocations for the treatment of HIV/AIDS. For both the 1998/1999 and 1999/2000 financial years, the Eastern Cape Department of Health did not make a separate allocation for the treatment of HIV/AIDS, as the focus was on treating opportunistic infections. The Free State Department reported that there was no data on HIV/AIDS treatment.

Health care facilities

Budgetary allocations towards health care facilities are provided in the Table below.

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>YEAR</th>
<th>TOTAL ALLOCATION IN RANDS</th>
<th>ACTUAL EXPENDITURE IN RANDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>1998/1999</td>
<td>114 607 000</td>
<td>90 989 000</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>88 658 000</td>
<td>84 000 000</td>
</tr>
<tr>
<td></td>
<td>2000/2001</td>
<td>30 496 000</td>
<td>-</td>
</tr>
<tr>
<td>Free State</td>
<td>1998/1999</td>
<td>4 053 861</td>
<td>3 772 861</td>
</tr>
<tr>
<td></td>
<td>1999/2000</td>
<td>63 309 604</td>
<td>46 238 366</td>
</tr>
</tbody>
</table>

221
Budgetary allocations towards health care facilities went up from the 1998/1999 to the 1999/2000 financial year in the Free State, Gauteng, KwaZulu-Natal the North West and the Western Cape. They were reduced in the Eastern Cape. What was particularly noticeable about the health care facilities budget was the high level of under-spending. All the provincial departments that had provided information under-spent on their health budgets, with KwaZulu-Natal spending the least (70 percent) of the allocated amount.

Variance: The Eastern Cape reasoned that articulation of over- and under-spending as regards capital works programmes was not always possible as programmes spread over three years and were dependent on contract slippage. Savings and excesses can thus only be reflected on completion of the project(s). A similar response came from the Free State Health Department.

The KwaZulu-Natal, Western Cape and North West Departments of Health attributed variances to delays in tendering procedures. Gauteng, Northern Province and the Northern Cape did not respond to the question.

Budget adequacy: The Eastern Cape Health Department reported that the budget was not adequate and as a result, maintenance of facilities was not properly undertaken.

The Free State Health Department stated that except for Minor Works, the budget was adequate as the department also received, through the national Health department, financial assistance towards infrastructure development from the Embassy of Ireland. The issue of maintenance raised above was also stated as a problem for the department. Where funds were inadequate, projects could not be implemented in time. Measures taken to cope with inadequacy included reprioritisation, shifting
of deadlines and the urgent upgrading of district hospitals where the need was greatest.

The KwaZulu-Natal Health Department said the budget was adequate. In the case of the North West Department of Health, the budget was also found not to be adequate, and several capital works projects determined on the basis of need could not be built and no measures could be taken in this regard. The Western Cape Health Department also mentioned that the budget was inadequate especially for maintenance, and that as a result significant effort was increasingly going towards allocating funds towards maintenance. The Gauteng, Northern Cape and Northern Province Departments of Health did not provide information.

**Special considerations given to vulnerable groups:** No specific information was given on special consideration given to vulnerable groups.

The Western Cape and KwaZulu-Natal Health Departments stated that facilities were being made available to all the people in the province, with the former specifically stating that newly constructed facilities made provisions for people with disabilities.

The North West and Eastern Cape Health Departments indicated that new facilities were being constructed in under-served areas such as rural areas.

The Free State Health Department stated that there was an involved, participatory process for identifying needs, which served as the basis for prioritisation, aimed at determining needs, rationalising previously segregated facilities and ensuring that every town had at least one clinic, including mobile clinics.

The Northern Province, Gauteng and the Northern Cape Departments of Health did not respond to the question.

### 3.3 **Critique**

Reporting by organs of state at both the national and provincial levels continues to be unsatisfactory. What hinders better analysis of especially provincial comparisons was the non-provision of information on per capita allocations, meaning that it was not possible to see how provincial inequities were being addressed through budgetary measures.

However, compared to other sections of the protocol, the budget section is relatively satisfactory. What is completely unacceptable is for the Mpumalanga Department of Health not to provide provincially aggregated information. It is their duty to collate district information into a provincial report that can be submitted to the Commission.

The health budget has become a focus of considerable attention in the last few years, mainly due to numerous projections that have been made.
regarding needs in the future. A number of issues have featured prominently in these analyses. These issues included:

- the tendency of the budget to take a downward trend in real terms towards the end of the 20th century after having registered positive gains during the mid 90s,
- substantial reductions in the capital budget,
- rising inequalities,
- over-spending and under spending,
- personnel crises that have emerged as a result of budget cuts in some parts of the country.

An analysis of the health budget for the period before the 1999/2000 financial year has identified several trends that, while likely to continue during and after the reporting period, pose serious challenges to the realisation of policy goals contained in the White Paper on the Transformation of the Health System in South Africa. These include downward movements in real term budget allocations, after what had before appeared to be upward movements. The Health budget rose from R22, 6 billion during the 1995/1996 financial year, to R24, 9 billion (10 percent increase) in the 1996 financial year. However, it fell down in real terms to R23, 5 billion during the 1997/1998 financial year. It was expected that the budget would be declining in real terms in subsequent years. The figure has looked even more serious when calculations are done on a per capita basis. When population growth figures were taken into account, average per capita growth moved from R572 to R614 from 1995 to 1997, fell to R601 during 1998, and was budgeted to fall again to R557 during 1999. Budget cuts have had serious implications on the provision of health care. Two areas, namely the capital and personnel budget, have suffered as a result of this scenario. One of the immediate upshots of declining budgetary allocations towards health is declining capital spending. Although the focus of the National Health Plan has been to move away from tertiary health facilities to primary level care, between 1997/1998 and 1999/2000 capital expenditure including spending on new clinics has declined by almost 12 percent in real terms. A declining portion of the provincial health budgets has been allocated to the construction and maintenance of provincial health buildings since the 1997/1998 financial year. The national conditional grant for Hospital Rehabilitation and Reconstruction has not been large enough to compensate for the inadequate provincial expenditure. Also and as vividly noted in the presentation of provincial budgets, provinces had not spent what they budgeted for on the maintenance and construction of health facilities.

Personnel problems have also arisen from decreasing budgets. Community service doctors threatened to work to rule because of late

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payment of their salaries, overtime and rural allowances. Interns from Frere Hospital in the Eastern Cape said their salaries were more than two weeks late whilst community service doctors in the Free State, Gauteng, Mpumalanga, Northern Province, and North West complained of not being paid overtime and rural allowances.

An issue that has featured prominently in the analysis of health budgets is the degree to which budgetary allocations are addressing historical inequities. As stated in the introduction, the South African health system has inherited a legacy characterised by huge geographical, racial and gender disparities. One of the goals of the government is to address, mainly through resource prioritisation, inequities. Table 7 below shows wide variations in the health budgets between provinces. The projected health budgets until 2003 suggest that the health budgets for the provinces of the Eastern Cape, Northern Cape and Western Cape were set to decrease in real terms in the next few years. The total provincial health expenditure is expected to remain stagnant until 2003. The 2000 Intergovernmental Fiscal Review also suggests that inequalities between provinces (as measured by per capita health expenditure trends) were increasing. For example, in 1998/1999 the difference between Gauteng and Northern Province was R330 whilst the budgeted difference for 1999/2000 was R350.

Table 7 Provincial health budgets for 1999/2000

<table>
<thead>
<tr>
<th>Province</th>
<th>Total provincial health budget in Rand(s) million</th>
<th>Per capita expenditure in Rand(s)</th>
<th>Capital expenditure as proportion of total health budget (%)</th>
<th>Expenditure on clinic upgrading &amp; building programme in Rand(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>3 566</td>
<td>574</td>
<td>3.9</td>
<td>16 305 000</td>
</tr>
<tr>
<td>Free State</td>
<td>1 604</td>
<td>577</td>
<td>2.3</td>
<td>37 164 000</td>
</tr>
<tr>
<td>Gauteng</td>
<td>5 610</td>
<td>819</td>
<td>6.7</td>
<td>13 847 000</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>5 110</td>
<td>573</td>
<td>9.7</td>
<td>134 691 000</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1 147</td>
<td>451</td>
<td>3.8</td>
<td>5 018 000</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>429</td>
<td>597</td>
<td>1.7</td>
<td>2 499 000</td>
</tr>
<tr>
<td>Northern Province</td>
<td>2 260</td>
<td>469</td>
<td>9.2</td>
<td>27 205 000</td>
</tr>
<tr>
<td>North West</td>
<td>1 388</td>
<td>458</td>
<td>5.6</td>
<td>28 344 000</td>
</tr>
<tr>
<td>Western Cape</td>
<td>3 125</td>
<td>658</td>
<td>1.2</td>
<td>6 378 000</td>
</tr>
<tr>
<td>Total/Average</td>
<td>24 239</td>
<td>-</td>
<td>5.9</td>
<td>271 452 000</td>
</tr>
</tbody>
</table>

Notes: 1 Adapted from Tables 5 and 8 in Idasa BIS. The 2000 Intergovernmental Fiscal Review: A Response. (2000) at http://www.idasa.org.za/bis/briefs/brief49.htm and Tables 5 and 7 in Idasa BIS.
Excludes health conditional grants and people with access to medical aid.

A number of reasons have been advanced to explain this declining and inequitable resource allocation. These range from macro-economic policies that do not favour increased allocation towards equitable allocations for health, and decentralisation that has relocated decision

66 Department of Finance. 2000 Intergovernmental Fiscal Review.
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making on the budget, to provincial authorities, sometimes at the expense of centrally determined equity goals.\(^67\)

While the above factors relate more to issues of allocations, some of the problems that have arisen are more suggestive of inefficiency in the application of allocated resources. Under spending is one such a problem. For instance, funding for the Department of Health’s AIDS programmes was about R109 million in 1999/2000 and R182 million for the following financial year. The department’s Government AIDS Action Programme (GAAP) spent only 25 percent of its budget of R40, 4 million, with R30, 3 million not spent.

Under spending is not only experienced at the national sphere but also in the provinces. As was shown above, several provinces have under-spent in at least one of their programmes. For instance, of the R 63 309 609 allocated towards health care services for the Free State Department during the reporting period, only R 46 236 366 was actually spent. What was particularly noticeable as an instance of under-spending in the Free State Province Health Department was in the HIV/AIDS Programme in that of the R 10 000 000 made available, only R 3 000 000 was actually spent. In the case of the Gauteng Health Department, of the R 75 069 000 allocated for primary health care, only R 56 503 000 was spent.

3.4 Recommendations

The declining capital spending requires immediate attention, as it is central to the success of the Clinic Building and Upgrading Programme and other capital programmes of organs of state involved in the delivery of health care services, given the need to provide basic services to unserviced areas.

There is a need to address the issue of under-spending, which is noticeable in assessing provincial budgets, even at the superficial level.

Another issue requiring attention is measures to address maintenance of health care facilities arising from budget cuts and lack of institutional capacity to utilise existing funds. Health officials faced with declining resources resort to the neglect of maintenance as a way of keeping essential services. As a result, the long-term sustainability of health services faces severe threats.

Human resources development remains a challenge. While the department is developing a human resources strategy for the medium to the long-term, it is important that short-term measures be put in place to address some of the crises such as payment of salaries and shortage of staff.

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4 OUTCOMES

National and provincial Departments of Health were required to provide information on health care personnel, hospitals and clinics, availability of Termination of Pregnancy services, disease indicators, primary health care indicators and general indicators.

4.1 National sphere

4.1.1 Health care personnel

The Table below indicates that, more nurses were employed in the public sector (102 900) than in the private sector (71 447). However, the figure was different for doctors, dentists, pharmacists and other allied medical personnel, who were mostly concentrated in the private sector. Such a situation is largely responsible for the continued lack of access to health care, especially amongst the rural poor, mainly due to lack of such personnel in the rural areas.

Table 8 Type of Health Professionals in South Africa

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>102 900</td>
<td>71 447</td>
</tr>
<tr>
<td>Doctors</td>
<td>9 569</td>
<td>19 935</td>
</tr>
<tr>
<td>Paediatrics (included in specialists)</td>
<td>1 938</td>
<td>5 888</td>
</tr>
<tr>
<td>Dentists</td>
<td>327</td>
<td>3 868</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>1 206</td>
<td>8 581</td>
</tr>
<tr>
<td>Other Allied Medical Personnel</td>
<td>2 868</td>
<td>9 581</td>
</tr>
<tr>
<td>Ambulance drivers</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

4.1.2 Notifiable medical conditions

The department provided information on a number of medical conditions, showing changes between 1998 and 1999. The figures for 1999 were however, incomplete and it would therefore not be particularly useful to provide these figures. However, projected figures from the 1999 HIV ante-natal survey indicate that there were 2.2 million women between the ages of 15 and 49 as compared to 1.9 million men and between 94 608 and 102 000 babies who were infected. The prevalence of HIV infection in antenatal clinic attendees rose from 1 percent in 1990 to 23 percent in 1998. South Africa’s HIV/AIDS epidemic was one of the fastest growing in the world with an estimated 3.6 million people already infected with HIV.\(^{68}\)

4.2 Provinces

Tables 9 and 10 below give an indication of health care personnel in the public sector. KwaZulu-Natal had the highest number of nurses employed in the public sector (130 474), followed by the Eastern Cape (14 111) and the Northern Province (10 841). The picture was different for doctors,

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where the Western Cape had the highest number (1,377),\(^{69}\) followed by KwaZulu-Natal (1,338) and Gauteng (1,211). The lowest number of doctors was in the Northern Cape.

Gauteng had the highest number of specialists (2,167), the difficulty of comparison being that the Western Cape did not differentiate between general practitioners and specialists. The North West had the lowest number of specialists (21), followed by the Northern Province and Northern Cape.

Table 9  
Public health personnel for Eastern Cape, Free State, Gauteng and KwaZulu Natal

<table>
<thead>
<tr>
<th></th>
<th>Eastern Cape</th>
<th>Free State</th>
<th>Gauteng</th>
<th>KwaZulu Natal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>14 111</td>
<td>*</td>
<td>14 400</td>
<td>130 474</td>
</tr>
<tr>
<td>Matrons</td>
<td>91</td>
<td>*</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td>668</td>
<td>399</td>
<td>1 211</td>
<td>1 338</td>
</tr>
<tr>
<td>Specialists</td>
<td>119</td>
<td>93</td>
<td>2 167</td>
<td>220</td>
</tr>
<tr>
<td>Dentists</td>
<td>35</td>
<td>0</td>
<td>254</td>
<td>33</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>195</td>
<td>42</td>
<td>210</td>
<td>218</td>
</tr>
<tr>
<td>Other</td>
<td>1,355</td>
<td>705</td>
<td>1,146</td>
<td>753</td>
</tr>
<tr>
<td>Ambulance</td>
<td>851</td>
<td>-</td>
<td>246</td>
<td></td>
</tr>
</tbody>
</table>

Nurses

<table>
<thead>
<tr>
<th></th>
<th>Eastern Cape</th>
<th>Free State</th>
<th>Gauteng</th>
<th>KwaZulu Natal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>14 111</td>
<td>*</td>
<td>14 400</td>
<td>130 474</td>
</tr>
<tr>
<td>Matrons</td>
<td>91</td>
<td>*</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td>668</td>
<td>399</td>
<td>1 211</td>
<td>1 338</td>
</tr>
<tr>
<td>Specialists</td>
<td>119</td>
<td>93</td>
<td>2 167</td>
<td>220</td>
</tr>
<tr>
<td>Dentists</td>
<td>35</td>
<td>0</td>
<td>254</td>
<td>33</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>195</td>
<td>42</td>
<td>210</td>
<td>218</td>
</tr>
<tr>
<td>Other</td>
<td>1,355</td>
<td>705</td>
<td>1,146</td>
<td>753</td>
</tr>
<tr>
<td>Ambulance</td>
<td>851</td>
<td>-</td>
<td>246</td>
<td></td>
</tr>
</tbody>
</table>

Nurses

Table 10  
Public health personnel for Northern Cape, Northern Province, North West, Western Cape

<table>
<thead>
<tr>
<th></th>
<th>Northern Cape</th>
<th>Northern Province</th>
<th>North West</th>
<th>Western Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>260</td>
<td>10 841</td>
<td>#</td>
<td>8 499</td>
</tr>
<tr>
<td>Matrons</td>
<td>932</td>
<td>-</td>
<td>-</td>
<td>80</td>
</tr>
<tr>
<td>Doctors</td>
<td>195</td>
<td>519</td>
<td>289</td>
<td>1 374</td>
</tr>
<tr>
<td>Specialists</td>
<td>59</td>
<td>36</td>
<td>45</td>
<td>50</td>
</tr>
<tr>
<td>Dentists</td>
<td>1</td>
<td>29</td>
<td>39</td>
<td>50</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>20</td>
<td>101</td>
<td>46</td>
<td>112</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>357</td>
<td>199</td>
<td>1 051</td>
</tr>
<tr>
<td>Ambulance</td>
<td>129</td>
<td>253</td>
<td>0</td>
<td>1 090</td>
</tr>
</tbody>
</table>

Nurses

<table>
<thead>
<tr>
<th></th>
<th>Northern Cape</th>
<th>Northern Province</th>
<th>North West</th>
<th>Western Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>260</td>
<td>10 841</td>
<td>#</td>
<td>8 499</td>
</tr>
<tr>
<td>Matrons</td>
<td>932</td>
<td>-</td>
<td>-</td>
<td>80</td>
</tr>
</tbody>
</table>

\(^{69}\) Although the response indicated that the figure given includes both general practitioners and specialists.
3rd Economic and Social Rights Report

<table>
<thead>
<tr>
<th></th>
<th>Northern Cape</th>
<th>Northern Province</th>
<th>North West</th>
<th>Western Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>195</td>
<td>519</td>
<td>289</td>
<td>1 374 $</td>
</tr>
<tr>
<td>Specialists</td>
<td>59</td>
<td>36</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>1</td>
<td>29</td>
<td>39</td>
<td>50</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>20</td>
<td>101</td>
<td>46</td>
<td>112</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>357</td>
<td>199</td>
<td>1 051</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>129</td>
<td>253</td>
<td>0</td>
<td>1 090</td>
</tr>
</tbody>
</table>

Notes: *
# - includes matrons and midwives
@ - the figure given covers both doctors and specialists
$ - the figure given covers both doctors and specialists

Only the Free State and to some degree the Eastern Cape provided information on private health care personnel.

4.2.1 Public clinics

KwaZulu-Natal and the North West Province did not provide information on public clinics. Mpumalanga and Gauteng provinces did not provide information that the Commission could use. It was therefore only the Free State, Eastern Cape, the Northern Cape, the Western Cape and the Northern Province that presented usable information.

The information presented by the six provinces was depicted in the Table below.

Table 11  Availability and utilisation of health facilities

<table>
<thead>
<tr>
<th></th>
<th>Northern Province</th>
<th>North West</th>
<th>N. Cape</th>
<th>E. Cape</th>
<th>F. State</th>
<th>Western Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/doctor ratio</td>
<td>1.5/10 000</td>
<td>88 139:1</td>
<td>-</td>
<td>No permanent allocation to clinics</td>
<td>59 852:1</td>
<td>-</td>
</tr>
<tr>
<td>No of clinics</td>
<td>476</td>
<td>328</td>
<td>206</td>
<td>716</td>
<td>348</td>
<td>251</td>
</tr>
<tr>
<td>Number of patients for the year</td>
<td>8 836 487</td>
<td>7 227 402</td>
<td>-</td>
<td>4 662 129</td>
<td>1 908 288</td>
<td>10 112 188</td>
</tr>
<tr>
<td>No. of beds</td>
<td>(200 EU + 220)</td>
<td>-</td>
<td>1 894</td>
<td>None</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Average number of visits to clinics</td>
<td>1 300 per clinic per month</td>
<td>2.2</td>
<td>6 511</td>
<td>159 024</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

Note: * the values in the table are recorded as per responses

Of the six provinces that responded, the Eastern Cape had the highest number of clinics (716), followed by Northern Province (476), Free State (348), North West (328), Western Cape (251) and Northern Cape (206). However, the Western Cape had the highest number of patients for the year (10 112 188), followed by the Northern Province (8 836 487), the Eastern Cape (4 662 129) and the Free State (1 908 288). The Western Cape went further to provide the rural/urban distribution of clinics and patients for the year. Of the
251 clinics, 146 were in rural areas and 105 in urban areas. Of the 10 112 188 patients’ visits for the year, 6 335 999 were in urban areas, while 3 776 189 were in rural areas.

4.2.2 Hospitals

The Mpumalanga, Gauteng, KwaZulu-Natal and the North West provincial Departments of Health did not answer the question on the number of hospitals in their provinces. The remaining five provinces reported on the number of public and in some instances private hospitals. The Eastern Cape reported the highest number of public hospitals (98), followed by the Northern Province (46 despite the fact that five were non-functioning), the Western Cape (32) and the Free State (31). The Eastern Cape had the highest number of patients per year (2 901 109) in hospitals when both inpatients and outpatients are combined, followed by the Northern Province (2 808 016), the Western Cape (6 315) and the Free State (185 150). However, the picture looked different when the number of daily visits is the focus of attention. The highest number of day visits was registered in the Western Cape (6 412), followed by the Eastern Cape (2 289) and the Free State (1076.67). The lowest number of day visits was in the Northern Province (183).

Information on access to health care facilities was not presented in ways that could be of specific use for the purposes of the SAHRC’s monitoring process.

4.2.3 Termination of pregnancy

The Gauteng, Mpumalanga, KwaZulu-Natal, Northern Cape and Western Cape Health Departments did not submit the requested information on the termination of pregnancy. Information came from the remaining four provinces. The most terminations of pregnancies occurred in the Free State (3 566), followed by the Northern Province, the Eastern Cape and the North West.

Table 12 Provincial termination of pregnancy

<table>
<thead>
<tr>
<th>Province</th>
<th>Public Clinic/ Hospital</th>
<th>Number of Terminations of Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>14</td>
<td>2 504</td>
</tr>
<tr>
<td>Free State</td>
<td>4</td>
<td>3 566</td>
</tr>
<tr>
<td>Northern Province</td>
<td>20</td>
<td>3 085</td>
</tr>
<tr>
<td>North West</td>
<td>4</td>
<td>196</td>
</tr>
</tbody>
</table>

4.2.4 Disease indicators

The Eastern Cape, Northern Cape, Western Cape, Free State and Northern Province Departments of Health provided information on rates of HIV infection. The North West reported the highest incidence (21.3 percent), followed by the Eastern Cape (18 percent), the Northern Province (11.4 percent), the Free State (8.9 percent) and the Western Cape (7.2 percent). However, these figures need to be treated with absolute caution due to provinces such as KwaZulu-Natal not having responded to the question, but also due to the fact raised in the Free State’s report, namely
that there were many people who were HIV-positive, but who have not been tested.

4.2.5 Primary Health Indicators

As was stated in the overview section, the state’s policy was to shift towards primary health care. The Gauteng, Mpumalanga, KwaZulu-Natal and Northern Cape Departments did not provide useful information on primary health care indicators. It was only the remaining five provinces that provided such information, and the results are presented in Table 13 below. With regard to the percentage of clinics with TB services everyday, the Northern Province and North West Department reported the highest figure (100 percent), followed by the Free State (94 percent). The Western Cape reported the lowest figure (84 percent).

The Northern Province and the North West also reported the highest figure for the provision of Sexually Transmitted Disease (STD) services (100 percent), followed by the Eastern Cape. The Western Cape again reflected the lowest figure (78 percent) for the provision of STDs services. The Western Cape however, reported the highest figure for the percentage of clinics with cervical cancer services (97 percent), followed closely by the Free State (94 percent). The Northern Province had the lowest percentage of clinics with cervical cancer facilities (5.9 percent), with the Eastern Cape also having a lower percentage (30 percent).

The Northern Province and the North West however, reported the highest percentage of clinics with family planning services, followed by both the Free State and the Eastern Cape (99 percent), with the Western Cape having only 72 percent. Antenatal services were available in all the clinics of the Northern Province and the North West. In the Eastern Cape, 95 percent of the clinics had such facilities, the figure being 91 percent in the Free State. The Western Cape had the lowest percentage of 22 percent of clinics providing antenatal services. The Northern Province and the North West reported that all the clinics in the province have available, free condoms. The figure was also high in the Eastern Cape (85 percent), but lowest in the Western Cape (72 percent).

Table 13 Primary Health Indicators

<table>
<thead>
<tr>
<th></th>
<th>Free State</th>
<th>North West</th>
<th>Western Cape</th>
<th>Northern Province</th>
<th>Eastern Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of clinics with TB</td>
<td>94%</td>
<td>100%</td>
<td>84%</td>
<td>100%</td>
<td>89%</td>
</tr>
<tr>
<td>services everyday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clinics with STD</td>
<td>90%</td>
<td>100%</td>
<td>78%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>services everyday</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of clinics with cervical cancer Screening Services</td>
<td>94%</td>
<td>97%</td>
<td>5.9%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>
4.2.6 General indicators

Gauteng, Mpumalanga, the Northern Cape and KwaZulu-Natal did not submit useful information on general disease indicators. Information from the remaining provinces is presented in the Table below. Of the five provinces that presented information, the Eastern Cape had the highest infant mortality rate of 62 per 1000 births, followed by the Northern Province at 47.3. The lowest infant mortality rate of 26 was reported by the Western Cape, followed by the North West at 36. The North West however, had the highest maternal mortality rate of 154, followed by the Eastern Cape at 135. The lowest maternal mortality rate of 24.4 was recorded in the Free State, followed by the Western Cape at 49.8.

<table>
<thead>
<tr>
<th>Province</th>
<th>Infant Mortality</th>
<th>Maternal Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>62</td>
<td>135</td>
</tr>
<tr>
<td>Free State</td>
<td>36.8</td>
<td>24.4</td>
</tr>
<tr>
<td>Northern Province</td>
<td>47.3</td>
<td>66.7</td>
</tr>
<tr>
<td>North West</td>
<td>37</td>
<td>154</td>
</tr>
<tr>
<td>Western Cape</td>
<td>26.9</td>
<td>49.8</td>
</tr>
</tbody>
</table>

4.2.7 Life expectancy - provinces

The KwaZulu-Natal and Mpumalanga Departments of Health did not submit requested information regarding the life expectancy. The information for the remaining six provinces is shown in Table 15 below. The highest life expectancy (64.9 years) was reported in the Western Cape, followed by the Northern Province. The lowest was in the North West.

<table>
<thead>
<tr>
<th>Province</th>
<th>Life expectancy (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>60.70</td>
</tr>
<tr>
<td>Free State</td>
<td>61.55</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>60.00</td>
</tr>
<tr>
<td>Northern Province</td>
<td>63.50</td>
</tr>
<tr>
<td>North West</td>
<td>59.70</td>
</tr>
<tr>
<td>Western Cape</td>
<td>64.90</td>
</tr>
</tbody>
</table>
4.3 Critique

One of the obligations of the State, a subject often referred to in the presentation of state reports to the Committee on Economic, Social and Cultural Rights is information availability. The question is often raised indirectly, when states are required to identify groups that do not have access to rights identified in the Covenant on Economic, Social and Cultural Rights, the level of need for the services, and the degree to which state measures have gone in reducing the number of these people. It is clear from the information presented by national and provincial health departments, that such information is not being comprehensively collected, making the assessment of the effectiveness of the measures on the basis of information from organs of state, difficult. This also suggests gaps from within organs of state themselves, to track the effectiveness of their own measures. Organs of state argue that they either do not keep information, or that available information is not kept in the format required by the protocol.

Especially at the provincial sphere of government, the implausibility of the argument that the required information is not available is made all the more obvious when the different responses of the different provincial departments are taken into consideration. It is clear from the varying quantity and quality of responses from provinces that it takes a certain level of commitment and will on the part of government departments to make the required information available to the Commission. In particular, the Free State Department of Health has gone to great lengths in providing the Commission with the required information.

Mpumalanga in particular provided a highly unsatisfactory report on district information, without collating it into a provincial report. The Department of Health in the province should be reminded that it is the department’s and not the Commission’s responsibility to collate the information from its health districts. To some degree, the Gauteng Department of Health is also not collating some of the useful information that could be immediately analysed by the Commission. The KwaZulu-Natal Department of Health should provide information on public clinics. The Eastern Cape, Western Cape, Northern Province, Mpumalanga and the North West should provide information on private clinics. In a sector with such a high dominance of the private sector, such information is particularly useful in analysing the realisation of the right. The Mpumalanga, Gauteng and KwaZulu-Natal departments should report on the number of hospitals in the provinces.

It is clear from the assessment of these indicators even at a superficial level that despite efforts being made by the State to progressively realise a larger proportion of the right to health care, a lot still needs to be done. A particularly serious issue for the government is the high rate of HIV/AIDS infections in the country and the continuing need to address this phenomenon.
There are several observations that could be made in the different provinces in which the government’s health policy is being implemented. The first relates to the availability of doctors. As shown in the preceding sections, the Northern Province had the lowest number of doctors, and thus requires attention. Also particularly alarming is the fact that the North West had the lowest number of specialists, which requires some attention. Also important to note is the high level of day patients in the Western Cape, especially when compared to poorer provinces such as the Northern Province.

It is highly disturbing to note that in both the Eastern Cape and the Free State, very few patients are utilising public health facilities when compared with the Western Cape. There is a need for this phenomenon to be properly investigated to ascertain the reasons for the whether the low levels of utilisation of these facilities.

It is particularly disappointing to see that the coverage for Termination of Pregnancy services is limited, with utilisation being concentrated mainly in the Gauteng province. The Termination of Pregnancy programme requires close scrutiny.

The figure for HIV/AIDS infection of 8.9 percent provided by the Free State is not corroborated by statistics from independent research. The UNAIDS Report released in 1998, estimated the infection rate in the Free State to be 19.6 percent in 1997. Notwithstanding the department’s own concession that the information provided is an underestimation of the actual rate of infection in the province, the figure provided is highly questionable against the abovementioned figures.

The Northern Province and the North West should be particularly commended for the considerable attention they were paying to Primary Health Care, in line with government’s shift towards Primary Health Care. However, the availability of services for cervical cancer in the Northern Province is particularly concerning. The Western Cape Province in particular, should pay attention to providing more TB services. The Eastern Cape should pay attention to the high infant mortality rate. The North West Province had the highest maternal mortality rate, which is a source for concern.

4.4 Recommendations

For the national government, there is a pressing need to continue to address infant mortality rate, especially in the rural areas where the phenomenon continues to be marked. As argued in the overview section, addressing infant mortality rate goes beyond activities of the health sector and is also reliant on addressing underlying preconditions for the enjoyment of the right to health care.

Both national and provincial government should pay attention to the substantially low figures of doctors in the Northern Province and specialists in the North West. This raises serious concerns.

An issue that also remains unclear is why there were so many day patients in the Western Cape, but so few in the poorer provinces of the Northern Province. In the next reporting period, national and provincial departments should shed some light on the causes of this phenomenon.

There is need for the close monitoring of the implementation of the Termination of Pregnancy Act of 1996. While it is clear that the utilisation of available facilities varies across provinces, there is a need for insight into the correlation between rates of 'backstreet abortions' and the level of the utilisation of TOP services. This will establish whether the availability of TOP services has any impact on the rate of unsafe abortions.

Another issue that requires immediate attention is whether the slow pace of the Western Cape, in making available PHC facilities, has any impact on the progressive realisation of the right to health care, especially among the poorer sections of the population in the Western Cape. This might require some active measures on the part of the State.

5 MONITORING SYSTEMS

Only the Eastern Cape and the Free State Departments of Health commented on systems for monitoring the progressive realisation of the right of access to health care.

The Eastern Cape Department collects data through supervisors’ monthly tools (these were not explained), quarterly meetings, monthly-analysed statistics, reports (no indication of what types of reports) and physical visits to facilities. The department did not provide useful information on the type of statistical information collected.

The Free State simply said that most of the information is posted on the Intranet. The information collected is categorised into:

- Primary Health Care
- Hospital statistics
- TOP statistics
- Notifiable medical conditions
- Mortality statistics

5.1 Critique

It is clear that there is limited information being collected to track the realisation of the right to health.
BASIC HEALTH CARE FOR CHILDREN

1 POLICY MEASURES

The National Programme of Action (NPA) guides policy measures of government in the area of basic health care services for children. The NPA is based on the Convention on the Rights of the Child. Significant policies that were developed before the reporting period and reported to the Commission include the Integrated Management of Childhood Illnesses (IMCI) which focuses on key causes of death during the child’s first 5 years and the Expanded Programme on Immunisation (EPI).

1.1 National sphere

The department did not necessarily report on new policy measures instituted but commented on progress with the implementation of EPI, IMCI, policy on free health care and the Primary Health Care in general.

1.1.1 EPI

As part of the Expanded Programme on Immunisation (EPI), the department successfully introduced a new vaccine, *Haemophilus influenzae* type B (HIB) in July 1999 at a budgeted cost of R58 million. Infection with HIB can result in pneumonia, meningitis, septic arthritis, osteomyelitis, cellulitis, pericarditis, epiglottitis and septicaemia. The mortality rate due to infection with HIB can be as high as 30 percent in developing countries. This measure needs to be seen within the overall context of the EPI, which is to combat communicable childhood diseases by providing children with immunisation against various diseases such as measles, tetanus, whooping cough, hepatitis B, polio and tuberculosis.

1.1.2 IMCI

A review of the IMCI implementation took place in November 1999 with the assistance of WHO. Implementation of IMCI began in the remaining provinces during the reporting period with a commitment by the Minister and MECs of Health to implement IMCI in every district throughout the country by the end of 2003.

With regard to free health care and PHC in general, the department simply reported that this has specifically benefited children up to the age of six.

1.1.3 The reasonableness and effectiveness of the measures

The department considered its programmes as reasonable and effective due to increased attendance of children and women at public health care

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72 Ibid 17.
facilities. In terms of reasonableness, the department reported that the UNICEF and WHO review of IMCI showed that there was a better integrated management of children as patients in the provinces where the programme had already been implemented before 1999. According to the department, the EPI has also been effective for the following reasons:

- there were no reported cases of polio in 2000, South Africa was about to be declared polio-free
- the measles campaign had reached 90 percent of children by 1999
- no district in the country had reported a more than 1 case per 10 000 of neonatal tetanus between 1998 and 2000

The department further stated that no claims can be made about the impact of policies on the Infant Mortality Rate, as it would ordinarily take about 5-8 years for that to be determined.

1.1.4 Instituted measures and vulnerable groups

Except for children with HIV/AIDS, the department did not necessarily report on any special considerations given to the groups identified in the protocol, except to mention that the general direction of government policies is towards addressing the needs of the groups identified. With regard to children with HIV/AIDS, paediatric guidelines for the treatment of HIV/AIDS and those for obstetrics management of mothers with HIV/AIDS were developed; a policy for breastfeeding in the context of HIV/AIDS was developed and IMCI guidelines were reviewed to include the HIV/AIDS module.

1.2 Provincial Sphere

The Gauteng and Northern Cape Departments of Health submitted the same report on basic health care services for children as the one submitted for the 1998/1999 financial year. The measures that received attention in the provinces are shown in the Table below.

Table 1 Measures instituted by the various provinces

<table>
<thead>
<tr>
<th>MEASURES</th>
<th>RELEVANT PROVINCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Plan of Action for Children</td>
<td>North West, Western Cape</td>
</tr>
<tr>
<td>Batho Pele</td>
<td>North West</td>
</tr>
<tr>
<td>IMCI</td>
<td>Eastern Cape; North West; Western Cape</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Free State</td>
</tr>
<tr>
<td>Maternal Child and Women’s Health</td>
<td>Northern Cape</td>
</tr>
<tr>
<td>EPI</td>
<td>Eastern Cape</td>
</tr>
<tr>
<td>Children with Disabilities</td>
<td>Western Cape</td>
</tr>
</tbody>
</table>

Most of the provinces did not provide any information on the specific manner in which they adapted what were essentially, national policies to provincial situations. The exceptions were the Free State, Northern Cape and the Western Cape that specifically described the nature of interventions made in the area of HIV/AIDS.

The Free State concentrated on guidelines on breastfeeding and HIV/AIDS; mother-to-child transmission and treatment of children with HIV/AIDS. It was
not clear from the report whether this simply meant the implementation of guidelines developed nationally or the development of provincially-developed guidelines.

The Northern Cape described the Maternal Child and Women’s Health (MCWH) services. These services were re-organised at provincial, regional and community levels to facilitate planning, implementation, supervision, monitoring and evaluation, and to ensure effective coverage of the majority of children and women. This also entailed the training of health workers as part of orientation towards primary health care concepts and principles.

In the Western Cape, the department specifically focused on interventions to combat the spread of diarrhoea, which was reportedly the number one childhood killer in the Western Cape, and impacts significantly on children from disadvantaged background. The measure entailed treatment and prevention. The department attempted to treat the problem through developing standardised guidelines for management at the primary and secondary levels and a training manual for new trainers to be trained. Prevention was undertaken through education awareness raising programmes.

1.2.1 The measures and constitutional obligations

The Western Cape Department of Health reported that measures implemented were reasonable and effective to a certain extent, despite changes in the information systems used. For instance, children were routinely monitored for growth developmental disabilities. Training of health care workers was being conducted to improve the management of health problems, which has resulted in increased immunisation coverage of infectious diseases including measles and hepatitis B.

The Free State, KwaZulu-Natal, Mpumalanga, and North West Departments of Health did not respond to questions on reasonableness and effectiveness of the measures implemented to realise the right to basic health care services for children. Furthermore, the departments did not provide reasons for their failure to respond to this question.

The Eastern Cape, Mpumalanga, North West and Western Cape Departments of Health stated that difficulties experienced in implementing the instituted programmes included insufficient budget committed to child health. With the exception of the Western Cape, other provincial departments of Health stated that lack of health care personnel and resources were some of the problems experienced.

1.3 Critique

National and provincial Departments of Health did not provide information required in the protocol. The responses failed to provide the rationale for and objectives of the measures.
Departments of Health did not provide sufficient information on how vulnerable groups were given special considerations in the instituted measures. For instance, the Free State, KwaZulu Natal, Mpumalanga and North West Departments of Health reported that all the measures were meant for vulnerable children. A detailed account on how the measures impacted on the various categories of vulnerable children did not emerge from the submissions made by the provincial departments of Health.

In the past few years, significant progress has been made by the government in improving the health status of children in South Africa. The IMCI and the EPI, and the signing of the Convention on the Right of the Child are perhaps the most visible examples of this commitment. However, the experience of the new government was best encapsulated in the comment made by the Committee on the Convention on the Right of the Child. The Committee noted in its assessment of the submission of a report submitted by the South African government, the country’s efforts in introducing policies addressing children’s rights; there is a need for more efforts to go into implementing many of these policy and legislative measures.\(^{73}\)

Immunisation coverage needs to continue and be extended. The EPI had envisaged that by 2003, immunisation coverage would be about 90 percent nationally, with 80 percent minima in the provinces. The latest figures suggest that this figure is still far from being met. Nationally, the rate of immunisation is sitting at 63 percent; 60 percent in non-urban areas, and 67 percent in urban areas.\(^{74}\)

Another point of criticism that has been directed at government is the little attention that the Patient’s Rights Charter gives to children’s health care rights. The Charter does not make specific mention of children, despite the fact that children have been singled out as specific vulnerable groups in the Constitution, deserving of special measures in the realisation of the right to basic health care services. Moreover, those provisions of the Constitution addressing children’s rights to basic health care services in s 28 of the Constitution are not subjected to the internal limitation like the right to health care in s 27(2).\(^{75}\)

There have however, been areas that have shown remarkable progress. There has been high a reduction in measles cases, poliomyelitis and tetanus. Moreover, it is generally accepted that children have benefited from free health care and the shift of resources from academic to primary health services. Service utilisation has also increased substantially, but the main shortcoming of this policy is that it is limited to children up to six years, and this deprives other vulnerable children of the right of access to health care services for children between seven and 18. According to s 28(3) of the Constitution, a child is a person under the age of 18 years.\(^{76}\)


\(^{74}\) Ibid 370.

\(^{75}\) Ibid.

\(^{76}\) Section 28(3) of the Constitution.
further states that every child has the right to basic health care services,\textsuperscript{77} and this policy has not catered for the needs of the vulnerable children that suggests that it has not been reasonably implemented.

An issue that continues to demonstrate that provinces need to specifically increase efforts to address the health care rights of children is infant mortality. The latest figures suggest that infant mortality remains high in the Eastern Cape, Free State and KwaZulu-Natal. As expected, infant mortality rates were higher in rural areas, babies from mothers with no formal education and in cases of shorter birth intervals.

The programmes implemented during the year under review showed the departments’ commitment to fulfilling the right to basic health care services for children.

Whilst one acknowledges the achievements made by the different departments of Health, there remains a challenge in terms of building on these achievements, and to contribute to the building of a better life for children.

1.4 Recommendations

The national Department of Health should provide clear objectives of policy measures implemented during the reporting period and report on how vulnerable children, especially children with disabilities, benefited from such policies.

The provincial departments of Health should provide information on measures instituted during the period under review with clear objectives and the intended plans to implement those policies. The Commission needs to see how the needs of the vulnerable children were addressed by the policy measures or programmes instituted. The departments of Health in the Eastern Cape, Free State, KwaZulu Natal, Mpumalanga, North West and Western Cape provinces should provide a detailed account of how the measures impacted on vulnerable children.

Whilst financial and human resources play a crucial role in service delivery, proper planning is imperative to ensure the realisation of the right. The national Department of Health needs to channel its budgetary allocation towards programmes that would ensure the realisation of the right.

Government should investigate the constitutionality of not providing free health care services to children between six and 18, given the definition of the child in the Constitution.

2 LEGISLATIVE MEASURES

\textsuperscript{77} Ibid s 28(1)(c).
2.1 Measures instituted at the National level

The national Department of Health did not report on new measures instituted.

2.2 Provincial Sphere

All provincial department mentioned national legislation they were implementing and did not report on their own provincial legislative measures.

The Free State department of Health only mentioned the Child Care Act 74 of 1983. Similarly, the Gauteng Department reported that it relies on the Child Care Act for guidance on the treatment of children with HIV/AIDS.

2.3 Critique

The response from the national department of Health did not provide adequate information on measures instituted for the protection of the right of children to basic health care services. Other sources have revealed that there was a legislative measure instituted during the reporting period. This was the Tobacco Control Act 12 of 1999.

The Tobacco Control Act 12 of 1999 protects the right of the children to a smoke-free environment. The banning of tobacco products also helps in protecting children from smoking. This Act came into force in 1999. Among other things, the Act prohibits the advertising and promotion of tobacco products. There were also regulations that provide for the prohibition of public smoking in offices, bars, restaurants and other public places unless there is a designated smoking area separated by a solid partition. The Act places certain restrictions on the marketing, sale and consumption of cigarettes. The regulations further state that signs indicating the sale of tobacco would have to be written only in black on white and 'shall not be more than a metre away from the point of sale'. Tar and nicotine yields per cigarette would also be reduced. The then existing tobacco sponsorships were allowed to continue until 31 December 2000.

The response also failed to provide information on how the constitutional obligations in s 7(2) of the Constitution were affected by the instituted measures. The response did not adequately address the protocol, especially regarding vulnerable groups of children. There was no indication of how the measures were instituted.

It would have been ideal if the national department had provided information on the implementation of the Child Care Act and its subsequent amendments.

South Africa has ratified the Convention on the Rights of the Child. Article 24 of the Convention provides for the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment
Health rights

of illness and rehabilitation of health. In implementing this right, State Parties shall take appropriate measures, *inter alia*, to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care. The Constitution has enshrined children’s rights pertaining to health as basic rights that require minimum health care services for children. The Constitution makes it a duty of the state to take legislative and other measures for the realisation of these rights.

The Constitution provides for children’s rights that are basic in nature. This means that the rights are not subject to progressive realisation. By their very nature, the rights of children to basic health care services require significant positive action on the part of the state to effect the realisation of these rights. This is imperative because children are more vulnerable to social problems that affect their standard of living, especially their health. From the national Department of Health responses, there has not been much done to respect, protect, promote and fulfil the right to basic health care services. It is therefore safe to conclude that the few measures instituted by the national Department of Health are not sufficient to warrant a realisation of the right.

There was no single provincial government that introduced a new law during the period under review.

The mention of the Child Care Act in the responses from the Free State and Gauteng provinces is not enough. The responses were supposed to have reflected more on how the Act was being implemented for the realisation of the right to basic services for children.

2.4 Recommendations

Legislation should be formulated in such a way that it would give effect to the constitutional obligations to respect, protect, promote and fulfil the right. The main objective of passing legislation should be to increase access to health care services and the provision of minimum basic health care for children.

In the formulation of legislation, regard should be had to the needs of vulnerable and disadvantaged children,78 that includes the poor, rural people, children, the aged and refugees. Legislative protection for these groups of people should be clear from the measures that are instituted.

There is a need to increase the utilisation of the TOP services. In particular, government should continue to raise awareness amongst the public and health workers about these services

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78 This finding was also made by the Constitutional Court in the *Grootboom Judgement.*
3 BUDGETARY MEASURES

The national department did not provide information on budgetary measures towards basic health care services for children.

All provincial departments except the Free State and Eastern Cape failed to provide information on budgetary allocation for children. What is particularly unsatisfactory in the case of Mpumalanga in particular, was that the department simply sent to the Commission responses from the individual districts and did not collate the information. The remaining provinces explicitly stated that the organisation of the budget does not make specific provision for children but that the budgets are organised in an integrated manner. To some degree, the Free State Department of Health, has been an exception in this regard. Although the department did indicate that it was not possible to provide budgetary information due to existing formats of the budget, it estimated that budgetary allocations towards children are as follows:

- total budgetary allocation - R 1,724,403,000
- per capita allocation - R 653
- total allocation per children below 18: The figures do not reflect actual expenditure towards children. They were derived from the Free State population figure of 2,715,000, of which 1,054,000 (32.7 percent) was below 18 years. It was therefore represented as 32 percent of the health budget

The Eastern Cape Department of Health provided information on expenditures for basic health care services for children. During the 1999/2000 financial year; the total allocation that went to children under the age of 15 was R 1,404,236, with a per capita allocation in rands of R 616 per child. The amount allocated for children in this category made up 40 percent of the department’s total health budget. The department projected and spent R 1,398,504. For children under 5, an amount of R 351,059 was made available, with the same per capita allocation as the one for children under the age of 15. However, this amount was only 10 percent of the province’s health budget. For Primary Health Care in particular, the total allocation for children under the age of 15 was R 122,270, with a per capita average R 48 per child.

The Western Cape Health Department also stipulated how special considerations are given to vulnerable groups when deciding on budgetary allocations.

Table 2  Special considerations to vulnerable groups by the Western Cape Department of Health in allocating the budget

<table>
<thead>
<tr>
<th>Category of Children</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in rural areas</td>
<td>An equity study was conducted and equity was specifically being pursued in order to address rural/urban disparities</td>
</tr>
</tbody>
</table>

79 The reason the Eastern Cape department of Health is able to provide this information is that the department has a programme called the Child Health Programme.
<table>
<thead>
<tr>
<th>Category of Children</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children living in informal settlements</td>
<td>55 new clinics in mostly informal settlements are being financed by the department</td>
</tr>
<tr>
<td>Homeless children</td>
<td>Programmes in this area are developed by the department of Social Services</td>
</tr>
<tr>
<td>Children with disabilities</td>
<td>Increased funding was allocated to the Prosthetic and Orthotic Centre for the provision of assistive devices for disabled children</td>
</tr>
<tr>
<td>Children from low-income groups</td>
<td>The increase in the primary health care budget from 13% to 19% attests to increasing attention towards children from low income groups, as do free PHC and the establishment of Regional Hospitals in the four regions</td>
</tr>
<tr>
<td>Children with HIV/AIDS</td>
<td>Continuing increase of the HIV/AIDS budget</td>
</tr>
<tr>
<td>Abused children</td>
<td>Several hospitals have established specialised focus for rape victims and abused children</td>
</tr>
<tr>
<td>Previously disadvantaged racial groups</td>
<td>Basic health care implicitly benefits these groups</td>
</tr>
<tr>
<td>Child refugees and asylum seekers</td>
<td>no special arrangements</td>
</tr>
</tbody>
</table>

### 3.1 Critique

Provinces argue that they were not able to provide information in the format in which they were being required to in the protocol. There are some problems with this way of responding. First, provinces still have a duty to show that budgetary allocations do indeed take into account the needs of children. Moreover, the example of the Eastern Cape Department of Health, which has specifically developed a programme on basic health care for children should further show that it is feasible to allocate the budget with a specific view towards children.

Given the lack of information on budgetary allocations towards children by most health departments, it is not possible to tell whether special considerations are being given to the needs of children in the allocation of public budgets. Provinces may not necessarily be in a position to provide information required in the protocol, but they still need to demonstrate how their budgetary allocations consider access to basic health care services for children.

### 4 OUTCOMES

National and provincial departments of health were required to provide information on a number of indicators that are considered to be necessary in determining the realisation of basic health care for children. The specific indicators on which information was require were: health care personnel, public and private clinics, ratios of personnel to hospitals and clinics, general disease indicators, health status of children and notifiable medical conditions of children.
4.1 National Department of Health

The department stated that as far as public clinics were concerned, it was not in a position to provide information on:

- child/doctor ratios
- child/nurse ratios
- doctor/nurse ratios;
- number of child patients
- the average distance of primary health clinics
- the number of people residing within radius identified on the protocol.

The same applies to private clinics. Information on personnel was not collected and stored in terms of the urban/rural divide, but a process started in 1999 to collect appropriate data on the issues raised.

Vast disparities continue to be reflected in the distribution of hospitals although the department did not specify the urban/rural distribution of hospitals. The number of public hospitals was 509 of which 25 were mental hospitals. Of the 25 mental hospitals, 18 were located in urban areas whilst seven were in rural areas. The total number of private hospitals was 162 (142 in urban area and 20 in the rural area).

4.1.1 General Indicators

Of the information requested on general indicators, the Department of Health has not been able to provide information on congenital malformation, incidence of drug abuse, and prevalence of mental health problems amongst children.

Information was provided on infant mortality rates, which continued to show sharp inequalities of a racial and geographical nature. The infant mortality rate was 45, 33 per 1 000 live births in urban areas and 53 in rural areas showing that more children die in the rural areas than in the urban areas. The figure for African children was 47 per 1 000 live births, 19 for Coloureds and only 12 for White children.\(^80\) With regard to the under-5 mortality rate, the average rate was 59 per 1 000 for the entire country. Again it was in the rural areas where the majority of children died before reaching the age of five. It was reported that 43 of under-5 children die in urban areas as opposed to 71 in rural areas. African children bear the brunt of these deaths. The figure for African children was 64, 28 for Coloureds and 15 for White children.

Teenage pregnancy stood at a national average of 16 per 1000. A higher prevalence was shown in the rural areas with 21 as compared to 13 in the urban areas. Moreover, teenage pregnancy was highest in the Coloured (19.3 percent) and the African communities (18 percent), as compared to negligible levels for Indians (4.3 percent) and Whites (2.2 percent).

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\(^{80}\) No figures were given for Indian children.
4.1.2 Health status

The department also provided information on health status, based on the South African Demographic and Health Survey of 1998. Most of these indicators have not been broken down into urban and rural dimensions. The figures show that 3.7 percent of the children between 6 and 71 months in South Africa suffer from wasting; the figure being 2.6 percent for children in Grade 1 and 2. Figures for stunting were as follows:

- 13.3 percent for children in grades 1 and 2; and
- 22 percent for children between 6 and 71 months.

Throughout the country the percentage of children not immunised against measles was 2.15 percent. There was a marked reduction in the number of notified measles cases in South Africa, from 22 798 in 1992 to 1070 in 1998. This followed the measles catch-up campaigns in 1996 and 1997, wherein all children under the age of 15 received an additional dose of the measles vaccine, regardless of their vaccination status. Coverage for measles was improved from 76 percent in 1994 to 82 percent in 1998.\(^1\)

4.2 Provincial sphere

None of the provinces provided information on indicators on basic health care for children.

4.3 Critique

It is clear from the responses obtained from government departments that there is critical information relating to basic health care services for children that is not at the disposal of organs of state. In particular, information on facilities available to children, ranging from health personnel to infrastructure is not available. This is particularly so at the provincial level.

However, progress with the reduction of some childhood illnesses such as measles and tetanus remains positive and commendable.

What remains an issue of concern is the continuing high rate of infant mortality, especially in the poorer provinces such as the Eastern Cape. Some of these figures were above the World Health Organisation's recommended 50 per 1000.

Another issue of concern is the high rate of teenage pregnancy, especially amongst the Coloured and African groups. This raises the critical issue of reproductive health for adolescents. Teenage pregnancy remains a big challenge for not only the Department of Health but the Departments of Education and Social Development as well. It is also symptomatic of the bigger issue: the high risk of infectious sexual diseases including HIV/AIDS that teenagers are exposed to.

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\(^1\) Department of Health (note 71 above).
4.4 Recommendations

In the reporting cycle, and in instances where government departments are not able to provide information on indicators, they must demonstrate to the Commission on how, without these indicators, they are able to meet the constitutional obligations on the right to basic health care services for children.

Infant mortality rates and teenage pregnancy are issues that continue to require attention.

5 MONITORING

5.1 National Sphere

The national Department of Health reported that it uses the National Health Information System of South Africa (NHISA), which was formally established to co-ordinate, manage and standardise data collection in the country. Also in use were the EPI, AFP and statistics collected around childhood conditions. Data is collected through an Immunisation Calendar. Notification and surveillance of EPI diseases information was obtained through surveillance and was used to measure the success of immunisation efforts, identify, investigate and control. Acute Flaccid Paralysis surveillance entailed full investigation and supplemental investigation of children in the affected district or province. Neonatal Tetanus was data captured in GW 20/8 FORM.

5.2 Provincial Sphere

Health departments in the Eastern Cape Northern Province, Northern Cape and KwaZulu-Natal did not provide information on this section. Gauteng and Mpumalanga did not provide useful information on monitoring systems.

In the North West, the department had an Information and Epidemiology Unit responsible for information management. Each of the 18 district offices has an information officer, responsible for data collection. In 1999, the department introduced the Information System Program, which includes a new system for collecting and analysing data from all health facilities. Data was submitted every month to the district information officer who then transmitted it to the provincial office. The following types of information were collected:

- children under 5 seen in clinics
- number of births
- number of prenatal deaths
- birth deliveries by children under 18 years
- child immunisation by type of vaccine
- malnourished children
Health rights

- diarrhoeal diseases in children
- acute respiratory tract infections in children
- number of children under 12 years screened in schools
- number of schools visited by a school health personnel

The Western Cape Health Department reported that it collected information through regular meetings between all institutional heads and data were collected and captured by staff on a daily basis throughout the province. The data were then compiled as monthly or annual Statistical Reports by different sections of the department. The following statistics were collected:
  - immunisation
  - infant mortality rate
  - low birth-weight babies
  - diarrhoeal diseases and acute respiratory infections
  - children with developmental delays

In the Free State, the department reported that it collected information through growth monitoring cards for children, which were kept in clinics. There was being developed, a Primary Health Care Information System. Statistics that were to be collected include:
  - register of PEM patients recorded at clinics
  - number of school children

5.3 Critique

It is disappointing that so few provincial departments were able to provide information on monitoring systems available. It was clear from this lack of information that there was not available, mechanism for the determination of the realisation of the right to basic health care for children.
PART C: CONCLUSION

Conceptually, most of the measures instituted by the relevant organs of state, including those reported in this monitoring cycle, were reasonable in terms of the obligations of the state contained in s 7(2) of the Constitution, and ss 27 and, 28 and 35 that deal with health rights.\textsuperscript{82} It is at the implementation of the measures that the picture is mixed. On the one hand there are positive reports such as the one on improved utilisation of the public health sector. Considerable progress has also been made in the reduction of some communicable diseases, especially those in the area of basic health care services for children. In particular, measures such as the institutional restructuring of the district health model, human resources development, maternal health and the management of childhood illnesses were positive measures. Although there is evidence that there is an increase in the use of the public health care sector, tertiary care facilities in the private sector remains unaffordable to the majority of South Africans. This suggests a need to reform medical insurance coverage so as to increase the affordability of health care.

There were also other factors that detracted from the realisation of health rights. These included shortages of health care personnel due to a moratorium on filling vacant posts, maladministration, corruption, shortages of drugs and theft of hospital equipment and medicines which compounded existing problems in service delivery.

\textsuperscript{82} Sections 27, 28 and 35 of the Constitution of the Republic of South Africa, Act 108 of 1996.
ABBREVIATIONS

DEPAM - Decentralised Education Programme in Advanced Midwifery
ECDH - Eastern Cape Department of Health
EPI - Expanded Programme on Immunisation
FSDH - Free State Department of Health
GDH - Gauteng Department of Health
GEAR - Growth, Employment and Redistribution
IMCI - Integrated Management of Childhood Illnesses
KZDH - KwaZulu-Natal Department of Health
MCWH - Maternal Child and Women’s Health
MDH - Mpumalanga Department of Health
MTCT - Mother-to-Child-Transmission
MTEF - Medium Term Expenditure Framework
NCDH - Northern Cape Department of Health
NHISA - National Health Information system of South Africa
NPDH - Northern Province Department of Health
NWDH - North West Department of Health
PEP - Perinatal Education Programme
PEPU - Promotion of Equality and Prevention of Unfair Discrimination
Act of 2000
PHC - Primary Health Care
PPIP - Perinatal Problem Identification Programme
STD - Sexually Transmitted Disease
TOP - Termination of Pregnancy
WCDH - Western Cape Department of Health
WHO - World Health Organisation

BIBLIOGRAPHY


