SPEECH TO THE THIRD SOUTHERN AFRICAN CONFERENCE ON EQUITY IN HEALTH, HELD IN DURBAN: DELIVERED BY PROVINCIAL MINISTER FOR HEALTH KWAZULU-NATAL: Dr Z.L.MKHIZE: 8 JUNE 2004

I wish to thank the organizers for inviting me to share ideas on with you in this very important conference. The theme 'Reclaiming The State, Advancing People's Health, Challenging Injustice' is indeed a challenging theme, which forces us to focus on the human rights as basis good health.

In or experience, violation of human rights generally results in a poor state of health of communities affected by such abuse. Similarly, in South Africa, many health professionals became fighters for human rights simply because they realized the ineffectiveness of improving the health status of people whose human rights were not respected. This is so because government is about power and power is about allocation of resources. For the majority of South Africans, the only hope they had of improving their health status was through the attainment of democracy, the installation of a government that is accountable to the electorate and restoration of justice in the country.

By definition, 'equity' refers to equitable distribution of resources; while 'equitable' refers to anything that is just and fair.

This is a concept that challenges the authorities to continuously review their approach to resource allocation, since the issue of equity arises not in a vacuum but in the context of a history of inequality, past or current disadvantages and injustices that need to be addressed. In our case apartheid had classified communities on racial basis and the allocation of resources followed a racial pattern. The apartheid government at national level distributed more resources to provinces that had more white people irrespective of the size of the Black population. They also considered the relative support of the ruling party as a basis for resource allocation, resulting in KwaZulu-Natal being referred to as a Cinderella province.

The democratic government realized the extent of backlogs and the extent of past inequality in government funding, when it devised a complex formula that factored in many aspects of our reality.
In the case of the National Government the formula takes into account not only the backlogs, levels of poverty but also the economic productive capacity of each province. This helps to balance the needs of each province with the incentive to continue to contribute to the generation of wealth for the country. We must realize that to allocate equal resources would under the circumstances result in the perpetuation of inequality. This is one time equal amounts in monetary terms is not the same as equity.

The balance between funding national departments that shared functions with the provinces, such as Department of Health, generated an interesting debate to determine the baseline allocation. It was through the participation of provinces

and the national government together that resulted in a decision to spend 2% of the Health budget at national level while the rest is divided into the different provinces. The definition of roles became important, where the national level is responsible for setting norms and standards. Implementation occurs at provincial levels. The challenge of ensuring equity in one country between national and provincial and local level has to be determined by a legislative framework that ensures that communities do not get disadvantaged by the force of personal influence of and persuasion by dominant political leaders, since their change with each term of office may result in unpredictable termination of programmes.
In this country, an independent Fiscal and Financial Commission allocates the proportionate shares of financial resources to different spheres, thus ensuring equity, stability and predictability, especially the introduction of medium term expenditure framework.

The variation of resource allocation between national, provincial and local government are a result of tensions and interactions of the different spheres of government, and thus are a reflection of consensus rather than absolute demands by one sphere of government on another. Similarly the allocations between different departments are a result of a process of prioritization by the elected policy makers.

Typically health is a product of many social and economic factors that require intervention of many other departments besides the department of health.
The total expenditure on health by a country is generally expected by WHO standards to be around 8.2% of GDP inclusive of both public and private sectors thus equity does refer to the relative contributions of both sectors to the total health expenditure. A different system of regulation takes care of this aspect. There is currently legislation that deals with factors influencing the cost of private health care, which focus on the various players in the private sector.

Whilst the requirements of previously disadvantaged rural versus the more industrialized advantaged provinces have been taken into account, even ten years has been inadequate to reverse the glaring inequities of the past. The Per Capita spending on non-insured population in 1999/2000, was R660.00 for KZN versus R1203.00 and R1043.00 for Gauteng and Western Cape respectively. Today the disparity persists, with KwaZulu-Natal spending R1006, while for Gauteng and Western Cape it is R1668.00 and R1042.00 respectively. Partly, this had to do with a need to balance and manage the challenge of maintaining a steady process of downscaling of over-funded but unsustainable operations, while reassuring high expectations of our population as under-resourced institutions needed to develop their capacity to manage such increases and start to deliver as expected. However we believe from our province a more efficient method is required to end this disparity, considering that it is the province worst affected by HIV/AIDS, where cholera and malaria was the worst. There is an on-going debate expressing contesting points of view depending on the province affected.

National government has taken a deliberate decision to increase expenditure on the social sector. As a guide all provinces are expected to ensure that the total

expenditure on health, welfare and education constitutes about 85% of the total provincial expenditure. This, together with government investment in the provision of basic services, such as water, sanitation, electricity, roads etc has a major contribution in the improvement of the health status of our population. There is a statutory provision for welfare grants to be paid to the disabled, and children without financial support below the age of eleven years, as well as the females aged 60 years and male aged 65 years. However of late in the process of satisfying the need for social security for the elderly, disabled and the destitute, A new budgetary trend has emerged resulting in a disproportionate increment in the social welfare grants resulting in the unfortunate reduction in the health budget. Another factor, which has to be kept in mind is the dynamics between political parties within a province, which has an influence on the ultimate shaping of the departmental budgets, as provincial legislatures have authority to finalise and pass the budgets utilized by their provinces.

Special care had to be taken to balance between the curative care centers which by nature tend to be more influential, and the primary health care which tended to be neglected.

In this province alternative cost-effective methods have been promoted to bring health services to the rural areas. A large number of primary health care clinics were constructed giving access to millions of our people who had no access to services. This raised the total number of people attending clinics from 1.6 million in 1996/7 to about 16 million per annum by 2002. For this to happen a process of gradual increase in the funding of primary health care whilst a steady re-adjustment was implemented in the curative care centers. Because some of the tertiary and central health services are a national competence, there is protection of funding to these facilities in the form of conditional grants. Sometimes this raises a debate in terms of which is the priority policy between the two, yet there is a need to regulate services at that level to ensure that they are available not only to the province in which such facilities are located.

Health managers are often faced with difficult choices to make in determining whether the expensive therapy for a few needs to be procured as opposed to cost-effective interventions for a large number of people. Such decisions have been tested in the Constitutional Court, as communities challenge the prioritization of services in a resource constrained setting. Recently, in a hospital not far from the venue of this conference, a patient who was refused renal dialysis on the basis of the clinical criteria, took government to court, to demand that he soul be dialysed. The court ruled in favour of government on the basis that the elected policy makers have a responsibility to prioritise the allocation of available resources.

As it often happens the cost of treating an individual in the regional and tertiary centers is much higher than in district hospitals and clinics Together with the development of clinics a strong referral system has been put into place to ensure that people receive appropriate level of care. Together with the above other strategies have been implemented such as the reduction of hospital admissions for example tuberculosis wherein DOTS supporters have proven to be more cost-

effective in the light of overcrowding of wards as a result of HIV/AIDS and Tuberculosis.

It is possible that within a province equity may not be achieved between different districts unless special attention is placed on the human resource issues. Rural districts (and provinces) are less attractive to professional staff. These rural areas turned to have a lower doctor to patient and nurse to patient ratios. Therefore there is a need to adopt a strategy that will ensure that health services reach the poor in rural areas and informal settlements. Therefore there is a need to deploy other cadres of health workers such as community health workers, auxiliary and enrolled nurses in higher numbers. This has been effective in this province.

Another factor in ensuring equity is a strategy to devolve decision making to the lowest possible level, and ensure that health plans are intergrated to the local development plans. Often devolution becomes unsuccessful exercise if it is not accompanied by devolution of resources so that decisions are taken and implemented as close as possible to where people experience problems. Another strategy to achieve equity under the circumstances is community empowerment and mobilization. The goodwill amongst community formations such as traditional healers non-governmental organisation and faith based organisations needs to be tapped. These stakeholders if recruited, as partners assist greatly in the provision of services and leading to the improvement of health status of the community. Traditional birth attendants have assisted in the reduction of infant mortality rates even in situations where midwives were scarce.

We should remember that for the community to participate effectively they have to be well informed so that they can engage in advocacy, challenging health workers if necessary. There have been situations where human rights have not been properly addressed, violations of the Batho Pele spirit of caring and compassion, where it had become necessary that communities assert their human rights. Part of addressing the issues of equity is community education for them to access their available services despite any other constraints that might stand on their way. Example is the problem of social taboos, traditional and religious considerations that have limited the availability of the choice of termination of pregnancy, a service that while available is restricted in different institutions. It is also important that adequate investment is made to adequately develop the skills of health workers as this affects their ultimate delivery of services. An interesting example of lay counsellors who during the introduction of PMTCT emphasized on formula feeding as opposed to exclusive breast-feeding resulted in a skewed choice by mothers, sometimes not in keeping with the circumstances in which they lived.

The issue of equity has to always be considered by policy makers in the provision of health services amongst the poor communities with high unemployment, low levels of education particularly in targeting the vulnerable groups such as women, children the elderly. Similarly the large burden of preventable diseases such as cholera, tuberculosis, malaria etc exists in areas where there are socio economic backlogs.

It is therefore important that in order to address equity in resource allocation, whilst absolute financial figures are significant, focusing on basic health indicators and determining the strategy to improve them is the best guide. This would make our focus to shift towards achieving an improvement in infant, child and maternal mortality rates, and therefore the totality of strategies including financial allocations is the object of our efforts.

May I take this opportunity to welcome you all to the shores of South Africa and thank the sponsors of this conference and the participants for visiting this province of KwaZulu-Natal. This is the land of Shaka. Welcome to the Kingdom of Zulu! We boast here of a temperate clime the whole year round, enabling bathers to swim tin the beaches at any time of winter or summer. Today is of course an exception, since I decided to bring along the cooler weather from the midlands for a change, and it won't last! I hope there will be time for you explore out city and sample the beauty of our mosaic blend of rich traditions. We boast of the five B's, namely:

Beaches,
the berg,
the bush,
the battlefields and
the beautiful people of KwaZulu-Natal with a cosmopolitan diversity of cultures serving you with a generous smile on their faces.

To those of you who come from the African continent and other parts of the world, but particularly those who are citizens of the SADC countries, we owe a great measure of gratitude. For South Africa to celebrate ten years of democracy, and the fact that we can today talk of a free country and a democratic government, is to no small measure the culmination of your efforts. Your countries were so determined to us free as they declared that there can be no freedom in Africa until the rest of the continent is free. South Africa is now a haven of peace and justice. It is haven of peace loving people of the world, because of your contribution. Welcome. South Africa is your Home.

I trust that you will enjoy the rest of your stay in our province. I wish you fruitful deliberations.

Thank you.

ENDS.