Healing inequalities: The free health care policy

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Children's right to health care is expressed in two sections of the South African Constitution. Section 27 accords "the right to have access to health care services for all South Africans". Section 28 (1) (c), which is that portion of the Bill of Rights dealing specifically with children's rights, states that children have "the right to basic health care services".

This essay discusses the South African government's free health care policy and the extent to which it meets children's right to basic health care services, with a particular focus on the accessibility of services.

The information in this essay comes from *The Means to Live: Targeting poverty alleviation to realise children's rights,* the forthcoming report on a three-year research project of the Child Poverty Programme at the Children's Institute, University of Cape Town. The *Means to Live Project* aims to investigate how government poverty alleviation programmes are targeted and the consequences of the targeting for children and their caregivers[1] – particularly where it results in very poor children being excluded from programmes. This essay is an abridged version of the more comprehensive discussion of the free health care policy in the full *Means to Live* report, to be released in 2007. (See the essay starting on page 31 for more details on this research project.)

This essay focuses on the following questions:

- What is free health care?
- What is basic health care?
- Are children accessing free health care?
- What are the barriers to accessing health care?
- What else impacts on health?
- What are the conclusions?

What is free health care?

In 1994, during his first hundred days in office, former President Nelson Mandela announced the provision of free health care to children under six years and pregnant and lactating women as one of several programmes led by the Presidency. This initiative was coupled with an extensive clinic-building programme to ensure greater physical availability of health care services to people in South Africa, especially for those who live in poverty. Free health care in South Africa currently means that services at public sector clinics and community health centres are free of charge for all people, and public sector hospital services are free for some groups of people. This policy was implemented in different stages since 1994.

Initially, free health care was offered to all children under six and to pregnant and breastfeeding women making use of public sector health facilities including clinics, community health centres and hospitals. The exceptions are those children and women who are covered by medical aid or medical insurance and/or who live in households that earn more than R100,000 per year. Then, in 1996, free health care was extended to all people using primary level public sector health care services. More recently, in 2003, free hospital care was further extended to include children older than six with moderate and severe disabilities.

The only type of public sector facility where some payment must be made is public hospitals. The groups that have to pay for public sector hospital services are adults, children older than six who do not have disabilities and anyone covered by medical aid or medical insurance and/or who live in households that earn more than R100,000 per year.

1 Caregivers are those who undertake the primary responsibility for parenting children from day to day. In most, but not all, cases, this is the child's biological mother. Many children are cared for by grandparents, siblings, other relatives, or non-relatives. In the *Means to Live*, specific criteria were used to define one primary caregiver per child to replicate assessments of eligibility. In reality, however, care arrangements are often shared between parents or other household members.

The amount that must be paid for hospital services is determined according to a sliding scale, based on the annual family income. If a family has no income at all, the service is provided free of charge – but only if the family can prove their "indigent" status.

What is basic health care?

The free health care policy was, and remains, an important step towards realising children's right to basic health care services. Many other child health policies and programmes help to give effect to this right. However, the effectiveness of all these measures in fulfilling children's right to basic health care services can only be assessed against a clear definition of what 'basic' health care services for children include. It is therefore important to note that a clear definition of what constitutes basic health care, as outlined in the Constitution, still has to be developed.

Arriving at a definition of basic health care services for children in South Africa is a process that will require discussion with many role-players in the health and related sectors. It is reasonable to assume though that all services for children currently rendered at primary level health care facilities, including preventative health interventions and curative care for common and uncomplicated childhood conditions, form part of basic health care services.

The extent to which curative care for more complicated health conditions and care for children with chronic (or long-term) health conditions are included in a definition of basic health care services are some of the elements that require clarification. *Project 28* at the Children's Institute is currently conducting research and legal analyses to define the actual meaning of constitutional socio-economic rights provisions for children. This includes the right to "basic health care services".

In addition to supporting the advancement of children's right to basic health care services, the policy gives effect to the three important principles of the Alma Ata declaration of Primary Health Care of 1978 – which South Africa has adopted – namely ensuring that health services are *available, accessible* and *affordable*. One of the potential ways of making health services more affordable and accessible is to remove or reduce health care fees. Free health care has been shown to improve utilisation of health care greatly in other developing countries. The opposite is also true: the re-introduction of fees results in many people not being able to access much needed health care.

Are children accessing free health care?

The *Means to Live* research team set out to discover if free health care was in fact free in its research sites – an urban site in the Western Cape and a rural site in the Eastern Cape.

Primary level services always free

On the whole, the application of free health care worked well as no fees were being charged at the primary level health care facilities in both the rural and urban research sites of the *Means to Live Project*. This is in keeping with reports from a few sites around the country that free health care at the primary level facilities worked well and was applied as envisaged in the policy.

Not all hospital services are free

At the hospital level it was found that the free health care policy is not always being applied consistently and correctly. In the rural site in particular, some children who should not have been charged user fees were charged, although overall it involved a small number of children.

Access not just about fees

While it is clear that the free health care policy has largely delivered on the intention to make basic health services free, fees are not the only barrier to accessing health care. The *Means to Live* also looked at the broader question of whether children who needed health care accessed it successfully.

Just more than a quarter of children in the urban site and about one third of children in the rural site were identified by their caregivers as having needed health care in the three months prior to the study. The study looked at whether these children were able to access health care successfully in line with the policy. A successful health care interaction was defined as children getting to a public sector health care facility and obtaining the necessary medication. More detailed investigation into quality of care did not fall within the scope of the study.

About six out of 10 children who needed health care were found to access a public health care facility successfully. This means however that four out of 10 children who needed health care did not successfully get it. The logistical and other challenges to accessing health care facilities are described in the case study on page 53.

CASE STUDY 3: Access to rural health services

The cluster of three villages that make up the Theko Springs administrative area in the Eastern Cape province includes 776 households across the villages of Nkelenkethe, Theko Springs and Krakrayo. The only health care service available within the area is a mobile clinic, which arrives in the centre of Theko Springs for one day every six weeks – when the roads are accessible.

For the rest of the time, whether it is an emergency, a regular visit to monitor an infant's weight, or for a child who is sick, parents and children need to travel long distances to access health care.

A previous temporary clinic at Theko Springs was closed after the building was deemed unsafe. The building of a new clinic has since been contested, with different local leaders mooting different places for its location, and with the local municipality prioritising a community hall over a clinic.

There are a number of primary health care facilities in adjacent areas. A long walk down the valley from Nkelenkethe, across the Theko River and up the steep slopes of the next hill, is the Gcaleka clinic in Holela. However, the river is impassable during the rainy season, and there is no footbridge.

From all three villages it is possible to walk to the taxi area in Theko Springs and take a ride to the T-junction where the gravel road meets the main road to Butterworth. This of course requires money. From this junction it is possible to walk to Tutura clinic, another 20 minutes at a good pace. Alternatively, one can continue by taxi to Butterworth where there is a Gateway clinic[2] adjacent to Butterworth hospital. The taxi fare to Butterworth is extra, and the round trip costs R18. A little further away, in the other direction, is the Community Health Centre in Centani.

Aside from these primary health care facilities, people in the three villages also use the two closest district hospitals. Butterworth hospital is in the town with the same name, and Tafalofefe district hospital is further north from Theko Springs towards the coast, and can be reached on foot in about two hours or by a taxi from Butterworth. Although there is no official Gateway clinic at Tafalofefe, the hospital also offers primary level care because of the lack of alternative clinics in the area. Physical access to the hospitals facilities cost money, and they are particularly hard to reach after-hours as there are few ambulances operating in the area.

2 Gateway clinics are attached to hospitals offering primary level of care.

Source: Hall K, Leatt A & Rosa S (forthcoming) *The Means to Live: Targeting poverty alleviation to realise children's rights.* Cape Town: Children's Institute, UCT.

What are the barriers to accessing health care?

The *Means to Live* research underlined some of the reasons why children are not able to access health care services.

Distances too far

Distance to the nearest clinic made access to health care difficult for many caregivers and their children, especially in the rural site.

> *I have to get up early, and leave around four [am] because I am going to walk, so that I should get there at half past seven or eight; but when I get there just before eight, then I am early. Then I know that at half past or at nine I will be on my way back.*
> [58-YEAR-OLD MOTHER AND GRANDMOTHER, RURAL SITE]

Mothers reported not being able to carry older or very sick children the many kilometres to the clinic. They also reported having no money for a taxi or to hire a car to get to the hospital in serious cases. Where there is money for a taxi – about R18 each way – they indicated that taxis returning from Butterworth (the nearest town) are sometimes too full to pick up people returning from the rural clinic.

Based on the *General Household Survey 2004,* Table 10 below shows the number and proportion of children across South Africa who are reported to be living 'far' or 'not far' from their nearest clinic. A clinic is regarded as far when more than half an hour of travel is needed to get there. The table shows great provincial variation, with the Western and Eastern Cape provinces representing the best and worst scenarios respectively. In the Western Cape, 92% of children are not far from a clinic, whereas in the Eastern Cape, only 43% of children do not need to travel far to access their nearest primary level facility.

Medicines not available

As shown in Table 11, the *Means to Live* found that, even if children did reach the nearest health care facility, medicines were not always available.

> *Right now there are no pain tablets here in the clinic; they are finished.* [SISTER, RURAL CLINIC]

Medicines were reported as being unavailable by 24% of caregivers who had taken a child to a clinic in the urban site and 17% of caregivers in the rural site. Health workers cited delays between ordering medicine and it arriving, and others referred to the insufficient number of vehicles available to supply the clinics.

TABLE 10: Number and proportion of children living 'far' or 'not far' from nearest clinic in 2004

Province	Number of children living far	Number of children living not far	Total number	% not far	% far
Eastern Cape	1,826,453	1,389,394	3,215,847	43	57
Free State	293,607	770,235	1,063,842	72	28
Gauteng	536,256	2,105,480	2,641,736	80	20
KwaZulu-Natal	1,801,092	1,991,283	3,792,375	53	47
Limpopo	1,296,013	1,319,593	2,615,606	50	50
Mpumalanga	562,792	745,073	1,307,864	57	43
Northern Cape	96,411	240,781	337,192	71	29
North West	614,290	874,355	1,488,645	59	41
Western Cape	129,266	1,429,443	1,558,708	92	8
Total	**7,156,179**	**10,865,636**	**18,021,815**	**60**	**40**

Source: Statistics South Africa (2005) *General Household Survey 2004.* Pretoria, Cape Town: Statistics South Africa. Analysis by Debbie Budlender, Centre for Actuarial Research, UCT.

TABLE 11: User satisfaction or quality of care at public health service points at *Means to Live* sites
(Base: Children who accessed public heath service points)

Problem (prompted)	Urban site		Rural site		Total	
	Number	%	Number	%	Number	%
Long waiting time (over an hour)	63	**46**	61	**43**	124	**44**
Opening times not convenient	34	**25**	29	**21**	63	**23**
Medicines not available	33	**24**	24	**17**	57	**20**
Facilities not clean	26	**19**	9	**6**	35	**12**
Rude staff/turning patients away	17	**13**	16	**11**	33	**12**
Expensive	1	**1**	3	**2**	4	**1**
Incorrect diagnosis	1	**1**	0	**0**	1	**0**

Source: Hall K, Leatt A & Rosa S (forthcoming) *The Means to Live: Targeting poverty alleviation to realise children's rights*. Cape Town: Children's Institute, UCT.

Staff under pressure

Very long waiting times at facilities sometimes resulted in patients being turned away as staff cannot always cope with the large numbers that turn up each day.

> *Gone are the days when you would sit with the client and you would know everything about the client; now we don't have that time and for me it is important and unfortunately I'm retiring quite soon, and I don't feel good; I don't know what I'm doing now. For me it's no longer caring.* [SISTER, RURAL CLINIC]

The health sector workers interviewed in the *Means to Live* study consistently identified staffing as a constraint to providing high quality services. Although this was less of a problem in the urban areas, the negative effects of capacity constraints were found to impact on staff morale in the urban site too.

> *It's a terrible cycle this thing of not enough staff, so low morale, so more people feel too tired and they get burnt out.* [HEAD SISTER AT MATTHEW GONIWE CLINIC, THE BIGGEST IN THE URBAN SITE]

This may explain another difficulty described by caregivers, especially in the urban site: rude or unhelpful treatment from nurses.

> *I took Sibulelo*[3] *to the clinic but I was not treated well. I was scolded because I got there late – they said the time to get to the clinic is eight [am], and I had come after eight. So I sat there and persevered and it was like I would not be attended to but I sat on the chair and I didn't leave until they attended to me.* [MOTHER, URBAN SITE]

Prevention and cure

Some health care workers spoke of a shift from preventive to curative services at the primary level since the introduction of the free health care policy.

> *[Before,] I was able to go and do home visits, which I can't do now. For instance our immunisation coverage has dropped because we are not visiting the crèches where most of the children are, and they are not immunised because the mothers are working and they can't come to the clinic here. So you find … we have shifted from preventive to more curative because you can't leave a sick child and go out there.* [SISTER, URBAN CLINIC]

These challenges were also evident in earlier evaluations of the introduction of free primary health care. Shung-King, McIntyre and Jacobs discussed how the simultaneous introduction of curative roles at clinic level led to the problem of preventative services being crowded out by the drive to deliver curative services. This is of particular concern for children's health, as they need good preventative services.

Use of private health care

The *Means to Live* established that 15% of all children in need of health care in the research sites were taken to private practitioners rather than public health services. The extent of the use of private health services is rather surprising, given the extent of poverty in the two research sites. The decision to spend precious money on private health care was found to be largely the result of dissatisfaction with the public health service.

Although physical access to health services posed a greater barrier in the rural site than the urban site, the quality of service received was less satisfactory to the urban caregivers where, for instance, nearly half of those who attended a public health service experienced long waiting periods before being attended to. Children in the urban site were also slightly more likely to be taken to private practitioners rather than clinics.

Caregivers in both sites reported that they were dealt with more seriously and with more respect by private doctors, and that better treatment was consistently available. When caregivers judged that they or their child was too sick to wait at a clinic, they chose to go to a general practitioner instead.

What else impacts on health?

> *The situation of living here is bad because it's also dirty here in this area. This is where they threw all the rubbish. And the children are not safe because they eat this sand and it's dirty and we also put dirt on it, and then again we dig it up and then the child takes that while playing and eats it … We have no toilets and no water here, the children are getting sick from the area that we live in … And the children have diarrhoea, the children from this area are filling up the Red Cross [Children's Hospital].* [CAREGIVER, URBAN SITE]

3 All names have been changed to protect identities.

Access to basic health care services must be seen as just one of many factors influencing the health and survival of children. Nutritious food, clean water, adequate housing and sanitation, a quality education, safe roads and safe, clean spaces for children to play are also very important to children's health and well-being. Poverty has a negative impact on the range of factors that contribute to child health. The association between poverty, poor health and health care outcomes for children and adults alike is very strong.

In South Africa, where inequality is a feature of society, the differences in health and health care availability between rich and poor are very stark. One clear example of health inequality is the infant mortality rate (IMR) – the death rate of children under one year old. The IMR is an indicator used internationally to reflect access to health care as well as the socio-economic status of communities. According to the *South African Health Review 2000,* the IMR in a wealthy suburb of Cape Town was eight deaths per 1,000 live births. Just 10 kilometers away, on the outskirts of the city in an area where poverty is rife and access to services is more difficult, the IMR was 64 deaths per 1,000 live births – eight times as high.

Differences between regions and between provinces show a similar IMR pattern. According to the South African Medical Research Council's National Burden of Disease Study for 2000, the relatively wealthy Western Cape province had an average infant mortality rate of 32 per 1,000 live births, while its poorer neighbour, the Eastern Cape province, had double that rate: 71 deaths per 1,000 live births.

Given the multi-dimensional nature of health, as well as the impact of poverty on health outcomes, promoting good health and ensuring access to health care for children is not just the business of the Department of Health, but of all government departments. Other government programmes that impact on poverty and a range of other deprivations are discussed in the other essays of this *PART TWO: Children and poverty* section of the *South African Child Gauge 2006.*

What are the conclusions?

The provision of free health care is an appropriate and commendable policy objective, and it is working well as far as correct application of the no-fee policy is concerned. There are, however, some inconsistencies at hospital level where people are sometimes charged user fees when they should not be.

The major barriers to basic health care are not due to fees at health facilities, but are attributed to many other factors such as transport to and from health care facilities and a shortage of nursing staff and medicines.

Overcoming these barriers requires an improved understanding on the part of all duty-bearers as to what exactly children's right to basic health care entails. It also requires a better understanding of what duty-bearers' specific contribution should be, whether in the health sector or the many other sectors and government departments that influence children's health and survival.

Nevertheless, the dedication and commitment of thousands of health workers throughout the health sector must be commended and, with the required budget increases and improvements in implementation, all children in South Africa should be able to successfully access the quality health care that they require and are entitled to.

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