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HIV/AIDS and the Health Care Crisis in South Africa

A Study of Health Care Service Providers of HIV/AIDS in Rural
Areas of the Eastern Cape Province

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Abstract

South Africa is the worst impacted country in the world in terms of HIV and AIDS; it is facing an HIV prevalence rate of a good 20 percent and AIDS is today the leading cause of death in the country. As the epidemic is roaming the country, South Africa is facing labour shortages, increased poverty and less children attending school. This in turn impacts on the economic growth and development of the country, causing severe future consequences for its people. South Africa is thus in utmost need of free and effective health care services – services that requires to be provided efficiently and equally. The problem is that the health care sector is a sector with notorious market failures that prevents just this; the public health sector has serious efficiency problems caused by amongst all corruption and maladministration, and likewise, the private health sector fails in providing equal access to health care services for all because it is guided by profit. Moreover, the health sector is itself experiencing severe problems caused by the epidemic; the already overburdened and understaffed sector does not have the capacity to manage the higher patient load of infected people and hospitals and clinics lack resources to provide medical care. In the light of these problems, an alternative service provider of HIV/AIDS related health care is becoming one of South Africa's most important ones in terms of alleviating the rural poor of their health care concerns; home-based care organisations. With the post-apartheid government reluctant to start an anti-retroviral drug roll-out in the public sector and the private sector being of no help to the poor, home-based care might be the better solution to the people of South Africa.

Keywords: South Africa, Health Care Provision, HIV/AIDS, Home-based care

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ARV	Anti-retroviral drugs
CBC	Community-based care
HBC	Home-based care
HIV	Human Immunodeficiency Virus
GEAR	Growth, Employment and Distribution strategy
NGO	Non-governmental organisation
PSAM	Public Service Accountability Monitor
WHO	World Health Organisation
UN	United Nations

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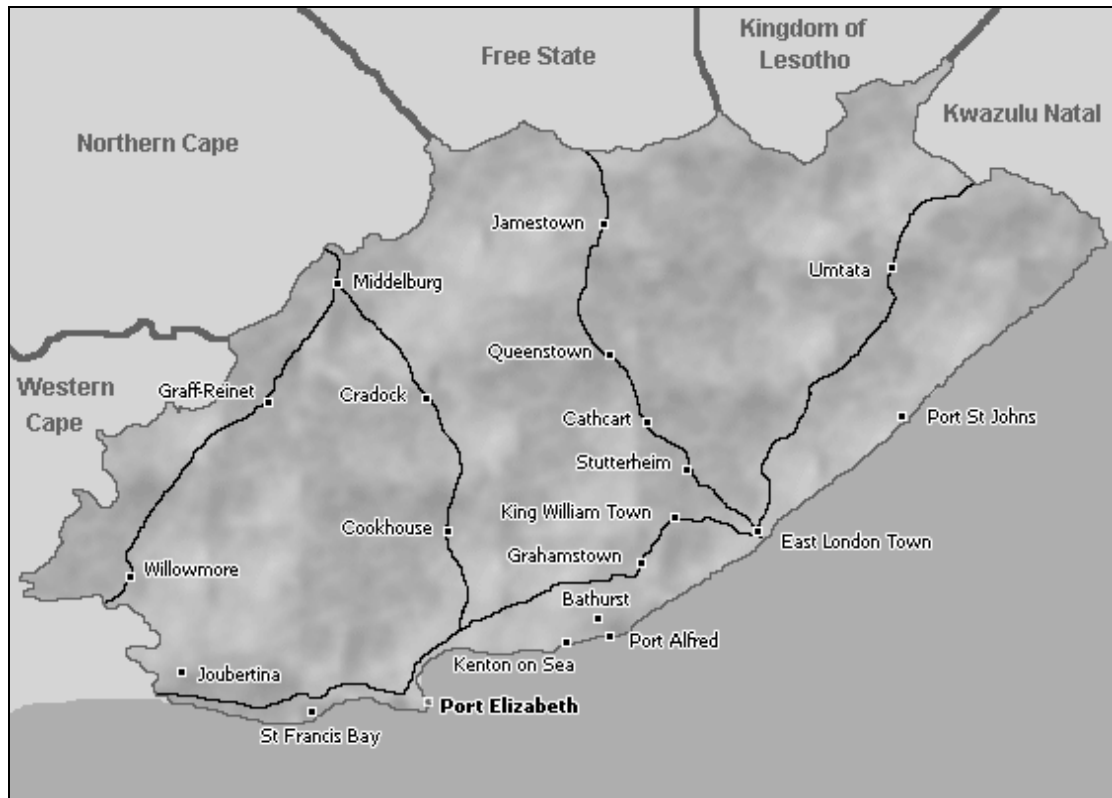
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Map of South Africa



Map of Eastern Cape



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I Introduction

1.1 Background

When the new democratic government, the ANC led by President Nelson Mandela, took office in South Africa in 1994, they legally ended decades of racism and discrimination justified under the apartheid system, launched in 1948 by the National Party. The apartheid system had categorised the peoples of South Africa into three groups; whites, Africans and people of mixed descent with the purpose of then segregating the whites from the others. The goal of the National Party had been to ensure the supply of cheap black labour to white controlled mines, farms and factories. The apartheid system prohibited the blacks and coloureds from marrying outside their race, from obtaining a decent education, from certain jobs and from accessing quality health care services. In 1978, there were 19 million black people in South Africa but only 4.5 million whites. However, the whites owned over 80 percent of the land, had an infant mortality rate of 2.7 percent, held 75 percent of the National Income and had a doctor/population ratio of 1/400. The blacks, on the other hand, owned less than 8 percent of the land, had an infant mortality rate of 40 percent in the rural areas, held less than 20 percent of the National Income and had a doctor/population ratio of 1/44 000.

For the duration of the apartheid, the black population had to rely on mission hospitals for the provision of health care services, hospitals that were most often understaffed, poorly equipped and without medical doctors. With no interest to remedy these problems, the National Party simply removed the blacks from the urban areas to the Bantu Homelands, where the health of these people were no longer of any concern to them. This was warranted under a detailed policy framework known as the “grand apartheid” which restricted the right of permanent residence in urban townships and controlled the migration of the blacks, made possible through strongly enforced labour regulations which gave the government the right to divert black labour to where they saw fit. In 1960 the Bantu Homelands had a population of 4.7 million; in 1980 this number had increased to 11.3 million. This constituted an increase of 239 percent and a high success rate of the “grand apartheid”, which had almost depopulated the urban townships from the black population.

When the HIV epidemic started to seriously spread during the early 1980's in Africa, the apartheid laws greatly impeded the process of prevention, treatment and information early on among the black and coloured population in South Africa. Today, South Africa is the worst affected country in the world with an HIV prevalence rate of a good 20 percent and with AIDS being by far the leading cause of death. Furthermore, the health care system in South Africa is still in no shape to handle this epidemic, which have and will continue to have devastating effects on the country's human, social and economic life. Reports from different parts of the country reveal that hospitals are under-staffed and over-burdened, they lack financial and human resources to treat patients, both with regards to medical drugs and medical equipment, and they lack bedding, soap, ambulances, and are unable to pay their employees. In addition, these reports reveal that maladministration and corruption are severe and is greatly impeding health care service delivery. However, despite being aware of the potential impact of HIV/AIDS in the health care needs of its population, South Africa's post-apartheid government has been extremely slow and reluctant to initiate policy measures to respond to this threat. When it came to office in 1994, only 7.4 percent of women attending antenatal clinics were infected with HIV. By 1999, this number had risen to 22.4 percent.

To remedy the severe HIV/AIDS problem in South Africa, the country needs to provide free and effective health care, it needs to make sure that the health care services are accessible equally since it is predominantly the rural poor population (the Africans) who are infected and it needs to efficiently use its limited resources for the best possible outcome in health care service delivery. If the current situation is not overcome within the next couple of years, the future picture of South Africa is one with augmented poverty, discrimination and illness.

1.2 Objective of Study

The objective of this thesis is to study provision of HIV/AIDS related health care services in rural areas in South Africa with regards to their effectiveness in the delivery of these services. This entails looking at how health care providers allocate and spend their limited resources, i.e. efficiency, if they offer equal access for all to their health care services, and how the providers meet the needs of the HIV/AIDS infected population. The study will focus on:

- The private and public health system in South Africa, expressively problems of financing, efficient use of resources and equality of access. However, more attention is

directed at the public health system as it is the provider of health care services for the rural poor.

- The current state of the HIV/AIDS epidemic and how it is affecting different sectors in the country, both at present and in the future, and how it is inflicting on the supply of health care services in the country.
- And, in the light of the above mentioned problems, what alternatives there are in the country in terms of service providers of HIV/AIDS related health care services in rural areas. Is there a better solution to the present system?

To fully understand the health care situation in South Africa, it is necessary to understand the multifaceted relationship between the health care sector, the HIV/AIDS epidemic and its impact on the country. It is thus also my goal to endow readers of this thesis with this awareness.

1.3 Outline Of Thesis

Section II presents the methods employed for collecting and analysing the information presented in the thesis, and the limitations to the study are spelt out. Section III gives an overview of the conceptual framework when analysing service delivery, and distinctively the equity and efficiency problems that occur between private and public service delivery. Section IV presents the current status of the health and health care in South Africa. Both the private and the public health systems are introduced, although more focus are lent to the public system's financial and provisional health care problems. Section V provides information on the HIV/AIDS epidemic in South Africa and how it is affecting different sectors in the country, expressly the health sector, with vast concerns for the future of the country. Section VI presents an alternative to traditional health care, home-based care, and how it can provide health services where the public sector fails. Section VII contains specific information about health care service providers in the Eastern Cape Province and section VIII concludes the results of the study and presents some recommendations.

II Research Methods

2.1 Collection of Qualitative Information

The study was conducted in the Eastern Cape Province in South Africa, during a period of five weeks in June and July 2004. Respondents at all levels of health care provision were interviewed with the focus on HIV/AIDS related health care in rural areas of the province, the problems with South Africa's public health care system in relation to the epidemic, and the state and future of the HIV-infection in the country. Respondents included home-based care workers outside Mt Frere, a health care administrator at Glen Gray hospital in Queenstown, two non-governmental home-based care organisations in Mt Frere and Umtata, a government performance monitoring researcher in Grahamstown, and the programme officer of the Swedish Africa Groups in East London.

In addition to the respondents I was also able to participate at the People's First Health Summit held in East London in July, where health care workers, health care administrators, government officials, HIV-infected patients and NGOs spent three days discussing and analysing the problems of South Africa's health sector. Participants were estimated to exceed one thousand people.

2.2 Collection of Quantitative Information

Quantitative materials have been collected to bring light upon the issues of health, health care and HIV in South Africa, particularly in the Eastern Cape Province, and HIV/AIDS related health care provided in rural areas in the province. This includes reports received through different organisations' home pages, and through health care organisations and NGOs in the Eastern Cape, as well as articles in local journals. Also of much importance was a recently launched extensive report by PSAM called "The Crisis of Public Health Care in the Eastern Cape".

2.2 Limitations

The principal limitation in collecting the qualitative information was the complete lack of district or provincial government participation. Both the Buffalo municipality as well as the Eastern Cape provincial government was contacted with no result, and thus I lack any first hand information or discussion from this perspective. Time and budget constraints also imposed limitations. Because this was a self-financed research the financial means lasted shorter than other field studies of the same calibre, and since my focus has been on health care in rural areas the travelling has been both time and money consuming. A final concern regards the time limit of the stay. As more information about what organisations to contact surfaced as time went by, the date for my departure also closed in. This meant that I had to leave without being able to interview key organisations or individuals in the field of HIV/AIDS, such as the Treatment Action Campaign in East London, which most likely had much more recent data and information on the epidemic. Because of the government's denial of the HIV/AIDS epidemic, South Africa lacks good quality aggregated data at country, provincial and district level so figures used in this study originate from 2001/2002. In addition, it should be kept in mind that the Eastern Cape Province is not representative of South Africa as a whole, and there are vast differences of health care provision within the province itself.

III Conceptual Framework

3.1 Health Care Provision

Within the field of economics, one of the most stable doctrines holds that private production and distribution of goods and services will result in an efficient allocation of resources.¹ The private sector in this scenario relies on a market condition known as perfect competition in which all firms are price takers, i.e. one firm cannot significantly affect the market price for its output, firms are free to exit and enter the market and transactions costs are low.² Thus if market forces are given the dominion of running the market decisions in a society it will inevitably lead to a Pareto efficient outcome – an outcome where the distribution of welfare cannot make one individual better off without making someone else worse off.³ This outcome is considered economically efficient and satisfying for all parts. However, there are more to markets than goods and services. Without clear definitions of property rights or enforcements of contracts the market will fail in its efficiency – and this provides the rationale for government activity.⁴

Throughout history the provision of health care has swung back and forth between the private sector and the public sector. However, due to poor coordination and complementation between the two sectors the health care system has often been dysfunctional, and with the many market failures of equity and efficiency, governments around the world has taken on the central role of health policy from the 20th century. This has entailed both the financing and the delivering of a wide range of care services. Efficiency problems exist in the health care sector because of information asymmetries, public goods characterisation, externalities, monopolistic market power, absence of functioning markets in some areas and high transaction costs. Likewise, equity problems arise because individuals often disregard to take sufficient protection measures against risk of illness because of the problem of free riding, and

¹ Stiglitz 2000:55

² Perloff 2001:224

³ Stiglitz 2000:59

⁴ *ibid.* 2000:77

inadequacies in the private health insurance market caused by moral hazard and adverse selection further impede adequate protection of individuals.⁵

3.2 Market Failures in the Health Care Sector

For an efficient and equitable provision of health care services there are certain circumstances and conditions that are required to be met. There are however some basic conditions under which markets will fail, and these are;

- Imperfect competition
- Public goods
- Externalities
- Imperfect information⁶

3.2.1 Imperfect Competition

For perfect competition to prevail in a market there must be a sufficiently large number of firms so that they actually follow the criterion of being a price taker. However, health care markets deviate from perfect competition in several ways. Licensure laws and health planning controls on prices and facility constructions barricade entry into the health market. Health care services are neither uniform in quality nor in character, and there is often some degree of monopoly power due the lack of enough firms to prevent monopolistic behaviour. Moreover, the same failures that apply generally to markets apply also here (presented further down): information problems are severe, externalities exist and there is an extensive degree of uncertainty.⁷

3.2.2 Public Goods

Goods and services are most commonly characterised based on their degree of rivalry and excludability which in turn decides their condition as either a public or a private good.⁸ However, because health care services show signs of both conditions they are difficult to

⁵ Preker & Harding 2000:2

⁶ Stiglitz 2000:88

⁷ Folland et al 2001:426

⁸ Shotter 2002:670

clearly characterise. Many services are easily marketable because they can only be consumed by one patient at a time (rivalry) and non-paying patients can easily be excluded from consuming the service, e.g. plastic surgery. On the other hand, some health services are nonexclusive and non-rivalry in consumption. An example of the former is an immunisation programme. Once the programme has been implemented in the community no one can be excluded from the benefits of a contagious free environment, regardless of paying for it or not.⁹ A non-rival good is a good for which additional units can be consumed at zero marginal cost.¹⁰ Health education is an example of such a characterisation; one person's use of this knowledge does not limit other people's availability of this pool of information because the cost of spreading education is zero. The problem of public goods follows from the fact that if people cannot be excluded from consumption they have no incentive to pay for the good and can thus free ride on the people that do pay, and without any prospects of receiving revenue for a good or service private firms have no incentive to provide it and the market fails.¹¹

3.2.3 Externalities

Externalities arise when the action of someone, a firm or an individual, affects someone else, with the result of inefficient resource allocations.¹² A negative externality is the case of an individual or firm imposing a cost on another individual or firm without compensating them for this, e.g. pollution created by a factory on a community.¹³ This occurs because they do not internalize the cost they impose on others.¹⁴ Conversely, a positive externality is an action that creates a benefit for someone else but where the originator loses out on any form of reward for this benefit.¹⁵ The example of the immunisation programme can be used also here; one person's health benefits more people than the individual itself because everyone in the proximity of a healthier individual has one less person from whom to contract a disease, thus benefiting from an action without having to pay for it. Positive externalities are common in the health care sector. When consumers can take advantage of services with a marginal cost

⁹ *ibid.* 2001:670

¹⁰ *ibid.* 2001:670

¹¹ Perloff 2001:630

¹² Stiglitz 2000:215

¹³ *ibid.* 2000:88

¹⁴ Perloff 2001:610

¹⁵ Stiglitz 2000:88

above zero without having to pay for them, firms lose out on profits and consequently the private sector will undersupply the market.¹⁶

3.3.4 Imperfect Information

Another aspect of the health care market is imperfect information. Patients are, compared to the provider, poorly informed about his or her condition, the treatment available, expected outcomes and prices charged by other providers. High transaction costs prevent patients from shopping around for health care and the highly tailored treatment makes reputation an unreliable source of information. How do you know that your problem is similar enough to someone else's who received successful treatment? As patients lack sufficient information about the services available in the market the providers has to act as their agents. This agency relationship is formed because the patient delegates the decision-making authority to the physician. The patient relies on the agent for advice and expects the agent to focus on his or her preferences. However, in most cases the agent will also be the provider of the recommended services. Conflicts of interest arise because the agent wants to maximize his own benefit at the expense of the patient, and this can be done by either over supplying the services or by supplying under quality care. Because patients cannot monitor the quality of care they receive the agent has an incentive to provide less quality than what the patient is paying for to maximize profits. Also, the agent can exaggerate the patient's health status to induce him to buy excess health care. Even without these information problems it is not certain that people would buy an optimal amount of health care from a welfare perspective. Thus, if left entirely to market mechanisms sufficient health care services might not be supplied.¹⁷

The information problem also creates difficulties in the health insurance market. Two concepts are particularly devious; moral hazard and adverse selection. The former deals with the problem of individuals who change their behaviour after they have purchased insurance because the cost of health care no longer falls entirely upon them. The latter – adverse selection – indicates that individuals who know they are at risk of becoming ill have strong incentives to hide their medical condition in order pay as low premiums as possible. This prevents insurance agencies from receiving premiums that correlate to the client's risk of

¹⁶ *ibid.* 2000:216

becoming ill, which in turn prevents their ability to cover expenses incurred by other members. Here as well may free riding occur if healthy individuals underinsure themselves on purpose, hoping for subsidized care when they fall ill. When the insurance market has difficulties in identifying good policy holders from bad ones they might protect themselves by charging a uniform rate that reflects the average cost of insuring any individual in the population. It can also result in risk selection and cream skinning – only enrolling healthy low-cost clients. As a consequence, insurance ends up being too costly for the poor and the system only provide health care to the healthy and wealthy.¹⁸

3.3 Public Provision of Health Services

Because of the problems just mentioned; equity and efficiency, public good characteristics, externalities and imperfect information most countries in the world have chosen to partly or completely adopt the financial and provider responsibility of health care services.¹⁹ There can certainly be good reasons for this in the case of public goods where the government can limit the free riding by publicly provide health care and financing it through taxes or subsidy care when there exist beneficial externalities in a society.²⁰ However, in their efforts to improve efficiency and equity the governments often fail with service delivery because of too few resources and little capability, such as failing to develop effective policies, working with available private sector providers, ensuring that adequate financing arrangements are available for the entire population, and securing access to public goods with large externalities.²¹ Also, because governments are concerned with more issues than just health service delivery, failures of efficiency and resource allocation occur here as well. The most common problems are public accountability, information asymmetry and monopoly power.²²

In the private market the intersection between the supply and demand curves determines the market equilibrium of goods and services.²³ These curves will shift depending on cost of production, consumer preference and price changes – revealing necessary information to the private market in order for efficient resource allocation and to avoid any deterioration in

¹⁷ Folland et al 2001:195-200

¹⁸ Preker & Harding 2000:19

¹⁹ Dencker 2003:14

²⁰ Stiglitz 2000:131, Folland et al 2001:428

²¹ Preker & Harding 2000:3

²² *ibid.* 2000:4

welfare.²⁴ However, the government does not have these market tools so instead they seek information about individuals' preferences through elected representatives, ballot voting or majority voting. Problems arise because these systems are all inferior to letting market forces reveal consumer choice; elected representatives who vote for public budgets may have a very different idea of how to use the public's money than the public itself, ballots usually bundles issues together instead of reflecting only one specific subject and majority voting completely ignores the will of the minorities.²⁵ Being targeted of various special-interest groups who lobby for their preferences and not the preferences of the people can also cloud the work of the government. When the government uses these instruments in order to translate individual's preferences for public policy they will have an imperfect aggregated idea of how to use the resources allocated between different subgroups of the population, made available by the redistribution of income. Thus government action will not be in accord with the will of the people it represents – and this is the problem of public accountability.²⁶

Information asymmetry occurs also in the public sector. Three relationships are particularly noteworthy; between patient and physician, between patient and administrator or between physician and administrator. The difficulties that arise are similar to those in the private sector and they lead to unnecessary agency (the supply side) costs in terms of structuring, monitoring and contracting among agents and principals with conflicting interest. Also here might patients conceal symptoms or conditions to health care administrators to avoid being left out of a medical scheme or not having to pay higher premiums. The care giving physician can also come head to head with the health administrator who is more concerned with cost consciousness and resource allocation than patient welfare. Furthermore, time consuming bureaucratic red tape caused by high transaction costs create severe inefficiencies, and so too does the deliberate information problems created by publicly accountable electives that leave room for corruption, abuse and fraud.²⁷

A last reflection of the inefficiency failures within the public sector involves abuses of public monopoly power. These monopolies exhibit the same negative consequences as occur in the private market; higher prices, lower amounts offered for sale and a deadweight loss because

²³ Stiglitz 2000:157

²⁴ *ibid.* 2000:157

²⁵ *ibid.* 2000:157, Preker & Harding 2000:4

²⁶ Preker & Harding 2000:4

²⁷ Preker & Harding 2000:5

supply does not meet demand as monopolies equalize marginal revenue with marginal cost.²⁸ When the public sector enjoys monopoly power the people who work for it are given wide scope for abusing this power by the extraction of rents, internal distribution of slack employees and lowering of quality.²⁹ These rents might take the form of bribes to physicians to be able to circumvent the hospital procedures, making things even worse for poor patients who do not have these financial resources. Perker and Harding mentions a study on corruption where such abuses in publicly run health services ranked number one in terms of the burden placed on households.³⁰ As monopolies aim for profit maximization they do so at the cost of patient welfare pushing people toward the private sector where treatment is not only expensive depleting the small funds of the poor, but also lacks equality.

3.4 Summary of the Section

To sum up the findings so far it has been stated that as the consumption side of health care is characterised by high positive externalities and public good characteristics the private market is not inclined to provide these services sufficiently. It will also fail to adequately provide protection for the people in the greatest need of it, i.e. the people in greatest risk of becoming ill. Agency relationship results in conflicts of interests at the expense of the welfare of the patient, and the lack of information greatly impedes the patient's monitoring ability, leaving patients blindfolded in the hands of profit and benefit maximizing agents, resulting in a situation where the private health market exists for the already healthy and wealthy individuals. Although the government successfully can remedy many of these difficulties by publicly providing health care, the instruments for investigating the amount demanded create problems of inefficiencies and resource allocation. However, by redistributing resources the government can combat the problem of equity by providing free health care and make sure that everyone is covered under some medical scheme, and by its selective and protective behaviour the private health sector can spend its resources wisely.

Looking at HIV and AIDS in terms of service provision, several problems arise related to the previous discussion. HIV/AIDS related health care has great potential for positive externalities in that individuals treated not only recuperates, but also eliminates the risk of

²⁸ Perloff 2001:344,357

²⁹ Preker & Harding 2000:5

³⁰ *ibid.* 2000:6

spreading the disease to others as well as being able to pass on the knowledge about HIV and AIDS received during their treatment – at no costs for society. Moreover, because of a severe stigmatisation surrounding the disease many South Africans hide their health status in fear of losing jobs or friends, and many do not even want to get tested in fear of the result – rather living in uncertainty. This behaviour creates information asymmetries in societies as people hide their true health status, impeding the true level of HIV/AIDS prevention needed. Hence, as a service, HIV/AIDS related health care provision is characterised by the many market inefficiency problems that speak in favour of a public commitment. However, in financially challenged countries there is more to the issue than the choice between efficient and equal provision of health care because poverty – both individual and national – give rise to problems concerning the national ability to serve its people as well as the people’s ability to consume the services. The HIV/AIDS epidemic is not raging among white, middle-class families in South Africa but among the poor in the townships, the cities and the countryside. However, the state of public sector is beyond dismal and so freely provided health care is of no help when hospitals lack resources to treat patients or prescribe medicines, nor is more efficient private services when the people most in need will not receive coverage or be able to pay for the help they require. The next section will in more detail present the health sector in South Africa.

IV The Health Sector in South Africa

4.1 The State of the Health Care System

After the end of apartheid in 1994, the health and health services in South Africa were in a depressing state. The apartheid system with its promotion of inequalities and racism had left the health sector particularly damaged. Next to an expensive, well run and modern public health system for the white South Africans, operated a nearly non-existent health service for the rest of the population.³¹ The emphasis of the health system was on tertiary and specialised care at the expense of primary health and preventative medicine, i.e. health care existed for the already healthy and wealthy white at the expense of the sick and poor black.³² The apartheid system had pushed the black population out of the cities and towards the rural regions, leaving the country with urban/rural inequalities, inter-regional differences – such as 63 percent of all public sector doctors in 1994/1995 were located in only Gauteng and Western Cape – and a homeland system with poorly run health facilities.³³ However, the inequalities did not rest solely between different regions but also within the health sector itself, where the quality of care differed greatly between the public and the private sector. The private health system, paid for by well off employers and individuals, employed in 1994/1995 nearly 60 percent of the country's medical doctors while only serving 20 percent of the population.³⁴

Despite some positive transformations in the post-1994 South Africa, e.g. a good 700 new public clinics have been built for the improvement of the delivery of health care services in poor and rural communities, immunisations has increased to almost 67 percent in the country and black women today have access to safe in-house abortion, modern methods of family planning and medical assistance at delivery, the results have been less than satisfying.³⁵ The South African health system is over-worked and understaffed, and hospitals are dirty, lacking bedding, meals and medicines for its patients. The health and disease statistics verifies this dismal picture (see table 1).

³¹ Cairncross 2004

³² *ibid.* 2004

³³ Heywood 2004:21

³⁴ *ibid.* 2004:21

Table 1: South African Health Indicators 2002

Indicator	Value	Uncertainty Interval
<u>Life expectancy at birth (years)</u>		
Total population	50.7	
Males	48.8	45.5 - 52.0
Females	52.6	50.0 - 55.0
<u>Child mortality (probability of dying under age 5 years) (per 1000)</u>		
Males	86	61 - 108
Females	81	55 - 105
<u>Adult mortality (probability of dying between 15 and 59) (per 1000)</u>		
Males	598	404 - 818
Females	482	321 - 653
<u>Healthy life expectancy at birth (years)</u>		
Total population	44.3	
Males	43.3	39.8 - 46.8
Females	45.3	39.8 - 50.8
<u>Healthy life expectancy at age 60 (years)</u>		
Males at age 60	10.6	10.0 - 12.0
Females at age 60	12.1	11.5 - 13.1
<u>Expectation of lost healthy years at birth due to poor health (years)</u>		
Males	5.5	
Females	7.3	
<u>Percentage of total life expectancy lost due to poor health (%)</u>		
Males	11.3	
Females	13.8	

Source: World Health Organisation

4.2 The Private Health System

The threats to the well being of South Africa's population continue to this day. The private and the public health system, rather than complementing each other in the fight for good and quality health, compete over the scarce resources inhabited by the country.³⁶ Today the private sector control approximately 59 percent of the health market, leaving a total of 41 percent to the public sector, while at the same time the number of people covered by private medicine is decreasing and is by far a minority of the population.³⁷ This decrease is reflected in an increased unaffordability of medical scheme membership as costs spiral in the private

³⁵ Cairncross 2004³⁶ Heywood 2004:25

sector, also preventing on-site health services for employees.³⁸ The increasing unemployment throughout the country – today estimated at about 30 percent – is also affecting private health coverage as former employees lose out on medical benefits as they lose their jobs.³⁹ The situation on the health market thus indicates that 59 percent of the health funds cover a meagre 16 percent of the population while the remaining 41 percent that go into the public health care cover the remaining 84 percent.⁴⁰

Despite the fact that the private health sector has more financial means – receiving funding through health insurance and medical schemes, more resources and better working conditions than the public health sector, it is suffering from grave inefficiencies. The main driving force behind the escalating costs in the medical schemes sector is private hospitals, which is spending more funds on beneficiaries per year.⁴¹ Moreover, a doubling of private hospital beds between 1989 and 1998, and an increasing per annum expenditure on medicines, increases costs even further. Total administrative costs of medical schemes also increased substantially during the late 1990's, with an annual growth rate of 26 percent, mostly caused by escalating costs in managed care activities. Inefficiencies in the private health sector in South Africa also arise due to over utilisation of services promoted by fee-for-services and third-party payer arrangement.⁴²

4.3 The Public Health System

In 1997, the former Minister of Health tabled the White Paper on the Transformation of the Health System in South Africa in Parliament. The White Paper established a plan for the restructuring of the health system, reforming it so as to be able to ensure accessible and equitable health care for all. One of the key objectives of this reformation was to unify the country's fragmented health services into a comprehensive and integrated National Health System. However, not until the National Health Bill became law in 2003 did the provinces finally have the integrated legislative framework needed for the reformation of South Africa's health system. The lack of an actual national framework up until that point had prevented the

³⁷ Cairncross 2004

³⁸ Doherty 2002:22

³⁹ Steinberg 2000:22,310

⁴⁰ Cairncross 2004

⁴¹ Doherty 2002:31

⁴² *ibid.* 2002:32

provinces from using the White Paper as anything but a guide, resulting in disjointed processes of change amongst the provinces with results differing widely between them. In 2003 the National Health Bill also provided a framework for the provision of free public health services.⁴³

South Africa's Public health provision is divided between the National Department of Health, the provincial departments of health and the district health systems. The National department of Health implements policies and decisions made by the government on health matters, such as developing norms and standards and identifying national objectives. The provincial departments of health then have the responsibility of providing this health care within their province. This comprises the accountability of planning public and private health facilities, quality control, district support and encouragement of community participation in all aspects of health care. Furthermore, the district health systems are the operational system for the delivery of primary health care packages and services in the 285 municipalities that South Africa is made up of. It consists of schools, workplaces, homes, health facilities and communities, all of which have a contribution to make towards the delivery of health services.⁴⁴

The objectives of the district health system are to:

- Overcome the fragmentation of the past, to bring all health services together under one umbrella.
- Promote equity in accessing quality services, to ensure that all have access to the quality health care services that they need, regardless of whether one lives in rural or urban areas.
- Develop and support community participation, to ensure more effective coordination of health services with all relevant stakeholders at this level taking part in this process.⁴⁵

In terms of the National Health Bill, it is the responsibility of the province and not local government to provide primary health care. However, it allows for "service level agreements"

⁴³ Heywood 2004:27

⁴⁴ Heywood 2004:27-28

⁴⁵ Heywood 2004:28

between provinces and municipalities, so that primary health care or other health services already effectively provided by the municipality can continue.⁴⁶

4.3.1 Government Policy and Attitudes

On paper, the objectives of the South African public health care system promises a unified, organised, efficient and equal provision of health services. In reality, however, the actions of the people in charge correspond very inadequately to these promises made. In 2003 President Thabo Mbeki declared his scepticism about HIV actually causing AIDS, which helped deter an already reluctant South African government in supporting anti-retroviral treatment (ARV), greatly impeding any action in response to the epidemic. Also the promising commitment to ARVs by the Cabinet in April 2002 failed. However, the government's problem in reacting to the HIV/AIDS problems lies more within their attitudes than their capacity; in the 2003 Budget the Minister of Health declared an over R3 billion allocation for HIV/AIDS, enough to begin providing ARV in the public sector. But not long after that the minister stated that prescribing ARVs was similar to "Wester voodoo" and demonstrated the same sceptical attitude as akin to the President's. The minister even proclaimed knowing the cure for AIDS on national television, stating that a glass of water with some lemon would increase the vitamin levels in the body and thereby dissuade the disease. The government's behaviour in opposing treatment and the lack of response to the discrimination and stigma associated with the disease are perceived by many in civil society and the medical professions as altogether inadequate and violation of the constitutional rights.⁴⁷

The response by the government to the HIV/AIDS epidemic have been characterised by pitiable conditions, limited inter-sectoral collaboration and inconsistent commitments from the actors. The explanation to these problems is public policy issues, such as service delivery, budgeting, financing, and provincial administration management responses. An example is the National Integration Plan which is the umbrella plan guiding the strategy for a national government response to HIV/AIDS. However, according to the Constitution the plan relies upon the provincial tier of government for implementation and provincial capacity is extremely uneven with many provinces experiencing severe under-spending. Another example is The National AIDS Unit within the Department of Health, launched in 2000,

⁴⁶ Heywood 2004:28

which steers the HIV/AIDS strategic plan for South Africa 2000-2005 and with the purpose of increasing efficiency and effectiveness. The plan has five priority areas: (1) prevention, (2) treatment, care and support, (3) human rights and legal issues, (4) research, surveillance, monitoring and evaluation, and (5) information, education and social mobilisation. Criticism against this plan includes a lack of a guaranteed or dedicated AIDS budget to support training and serious omissions concerning guidelines on treatment. However, by January 2000 the Partnership Against AIDS was formalised within the South African National AIDS Council, under leadership of Deputy Prime Minister, Jacob Zuma, with the aim of bringing together other government departments besides health, in concert with other key sectors of society in order for a broad multi-sectoral fight against the disease.⁴⁸

4.4 Financing

Despite the many public policy problems of delivering efficient and effective health care and the societal outcry for a better governmental response to the HIV/AIDS epidemic, the South African government is unable to provide better services because the per capita health expenditure keeps decreasing.⁴⁹ Although South Africa devoted R70.2 billion to health care in 1998/1999, which represented 8.8 percent of the GDP – a fairly high number in comparison to other countries of similar economic size – the health care remains in a poor state.⁵⁰ Health finances in South Africa comes from four main sources; government, households, employers and donors. The central government is the largest source of health care finance. Through taxes, licenses and other sources of income it allocated in 1998/1999 94 percent to the health care budget.⁵¹ However, over the period 1990-2000 the government contribution dropped by 4.8 percent.⁵² The rationale behind this declining total health pool was said to be the global economic recession, a lack of prioritising towards health care by the government and above all the macroeconomic policy called the Growth, Employment and Redistribution strategy (GEAR).⁵³ According to the GEAR, South Africa's taxation must not increase out of proportion to economic growth, which then decreases the total money available to the government. The GEAR also entails that growth in social expenditure must be lower than

⁴⁷ Jones 2003

⁴⁸ *ibid.* 2003

⁴⁹ Cairncross 2004

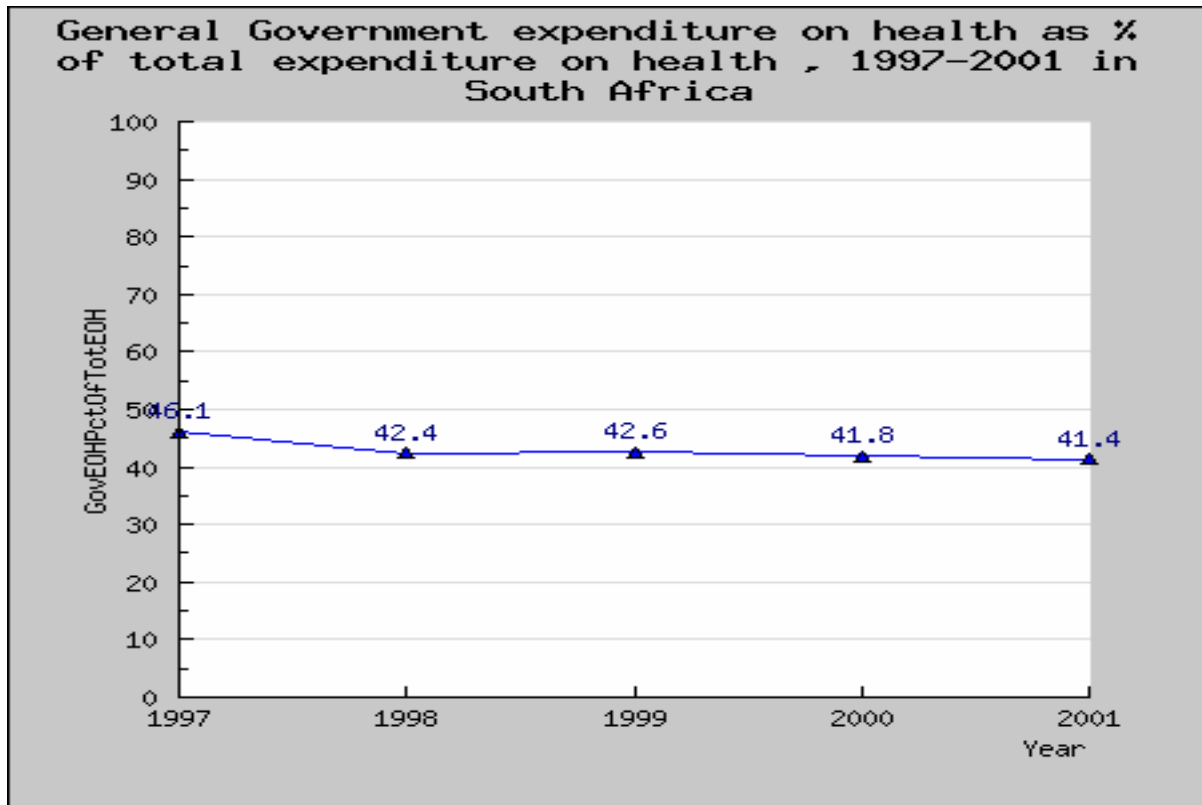
⁵⁰ Doherty 2002:14

⁵¹ *ibid.* 2002:15,16

⁵² Cairncross 2004

overall economic growth, meaning that as the overall government budget increase, spending on social services will grow at a lower rate. For health, the GEAR has involved a per year growth of only 0.8 percent, i.e. and annual decrease in per capital spending as the population increases.⁵⁴ In other words – less money to spend on health for each person even though the total in rand may be increasing.

Figure 1: General Government Expenditure on Health 1997-2001



Source: World Health Organisation

The second largest source of finances for health care is the households. Households either pay contributions to medical schemes or other forms of private health insurance or out-of-pocket expenditure for health.⁵⁵ However, as government contributions are decreasing so is household health expenditure increasing. Over the same period that government contribution declined by 4.8 percent, the household contribution increased by 4.5 percent.⁵⁶ This increased burden was mainly a result of increased out-of-pocket expenditure and this is an unsatisfying form of financing because it is the least equitable of all, achieving little cross-substitution

⁵³ Doherty 2002:16

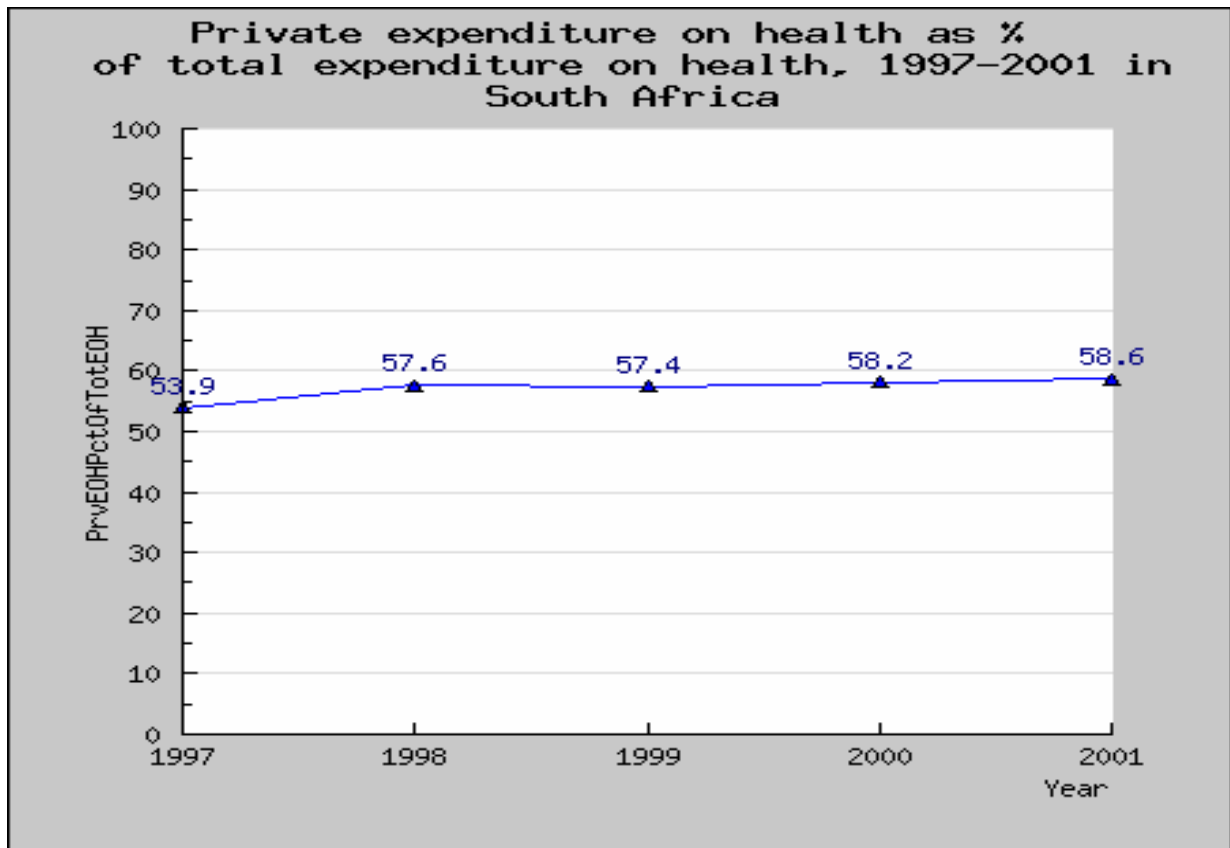
⁵⁴ *ibid.* 2002:17

⁵⁵ *ibid.* 2002:17

⁵⁶ Cairncross 2004

between the healthy and well-off and the ill and poor.⁵⁷ It may also indicate that people use private facilities when public services are inaccessible.⁵⁸ Furthermore, also employers and donors experienced an increase in health care expenditure during the previously mentioned period.⁵⁹

Figure 2: Private Expenditure on Health 1997-2001



Source: World Health Organisation

4.5 Present Concerns in the Public Health Sector

South Africa's public health sector is facing enormous difficulties on every level of care provision. The span of problems is causing enormous problems for the future of not only the health sector itself but for South Africa's population. These are:

- Inefficiencies
- Resources

⁵⁷ Doherty 2002:17

⁵⁸ Cairncross 2004

⁵⁹ Doherty 2002:18

- Staff shortages
- Management
- Working hours
- Training
- Urban/rural divide
- Impact of HIV/AIDS

Inefficiencies occur in the public health sector and come in the form of too much expenditure being absorbed by personnel instead of on patients and equipment, the use of higher skilled and more expensive staff for tasks that should be done by cheaper and less skilled nurses and health care workers, unnecessary costs for administration and the lack of appropriate capital investment for the maintenance, upgrading and repairing of health facilities – some of which are in such a poor condition that they cannot fulfil their duties.⁶⁰

There is a general lack of resources in the public health sector caused by inappropriate allocation of funding to provinces, mismanagement of existing funds and the overburdened public health sector – a result from the private health sector “dumping” patients onto the public one. However, within this general lack of resources there are areas where these concerns result in more noticeable problems, such as low salaries – especially for nurses, lack of medicines, medicine equipment and medicine supplies. These problems then affect the health care workers ability to provide quality health care, especially as they are unable to bridge the gap between the health care that is needed and the limited health care provided.⁶¹

Due to the lack of resources, manifested in many different guises, the health care workers are leaving the public health sector. They leave for jobs in the private sector or abroad, but some of them are even leaving without an alternative employment – choosing unemployment rather than continuing as a public health care worker. The reason for the emigration is the inability of the health care workers to provide proper care when hospitals and clinics are without even the most basic necessities. Health care workers also experience physical and emotional stress that is caused by huge workloads, which also contribute to the inability to care for their patients. There is also a low moral amongst the workers caused by the lack of reward and appreciation from patients, hospital management and seniors, a lack of a discernable career-

⁶⁰ Doherty 2002:33

⁶¹ ALP 2004:68

path for medical professionals and a lack of a comfortable working environment for the health care workers. All these issues result in the public health sector being severely under-staffed, and this problem feeds itself – as more health care workers are leaving the more serious the problems becomes, pushing more and more nurses, doctors and other health care workers from the public facilities.⁶²

Management, including departmental heads, hospital superintendents and senior staff, is often ineffectual and autocratic. Recurring problems are human resource mismanagement and cutting cost by cutting the quality of care. Within the former category are issues such as the management not taking the staff's concerns seriously, doctors and nurses not being managed as a team, the management failing to support the staff or encouraging improved performance, a lack of managerial skills and too much red-tape. The latter category entails hospital superintendents being more concerned about keeping budget than meeting health care needs and nurses being forced to provide care they have not been trained for. Also, exceptionally long working hours are a considerable cause for stress, fatigue and lack of job satisfaction. Long hours have negative implications for the quality of care that is provided to patients, and it may result in chronic sleep deprivation, depression and other psychological problems.⁶³

The stance of denial of HIV by the government has meant that there has been a lack of training of health care workers for HIV/AIDS treatment, despite the fact that hospitals and clinics have been swamped with patients presenting HIV-related illnesses. This has resulted in a shortage of health care workers trained to provide ARV treatment. The public sector also suffers from a lack of training capacity; there are very few trained staff, limited financial resources available for training and a lack of proper training facilities. In order for nurses to attend training workshops they need someone to cover their shift and there is no training in personnel relations, ethics and human rights.⁶⁴

Most, if not all, of the above mentioned issues are felt more acutely in rural areas. The lack of human, financial and infrastructural resources is especially severe in these remote places. Health care workers in rural areas live in very poor conditions and the feeling of isolation both socially and academically make rural areas unattractive workplaces. Nurses are afraid for

⁶² *ibid.* 2004:69

⁶³ *ibid.* 2004:71

⁶⁴ *ibid.* 2004:71

their safety when going home after being paid and the lack of proper training feeds an unreasonable fear of being infected with HIV. Unions are also very weak in rural areas. Moreover, most of the provincial health budget is absorbed by hospitals – leaving nothing to the clinics that provide the care in these rural areas. There are also difficulties in transporting patients from clinics to health centres due to poor infrastructure, there is a lack of health facilities and the mismanagement is severe.⁶⁵

The HIV epidemic has resulted in the public sector being severely overburdened. The lack of ARV treatment in the public sector results in the health care workers either feeling overwhelmed or apathetic regarding the appropriate care to be given to patients. The political unwillingness to address HIV/AIDS as a health crisis means that the epidemic has been allowed to flourish and has now reached a stage where the only solution to the problem is the ARV treatment plan. The next section will deal with the impacts of HIV, both in overall society and the public health sector.⁶⁶

⁶⁵ *ibid.*2004:72

⁶⁶ *ibid.* 2004:73

V The HIV/AIDS Epidemic in South Africa

5.1 The impact of HIV/AIDS on Society

In terms of the HIV/AIDS epidemic, Sub-Saharan Africa is the worst affected region in the world, with South Africa being one of the worst affected countries.⁶⁷ The most recent data at hand is from 2001 and estimates that approximately 5.3 million people are living with HIV in the country – a number that most likely has increased substantially since then – and approximately 900 000 are living with an AIDS defining illness, such as TB, pneumonia and diarrhoea⁶⁸, leaving South Africa with an adult HIV prevalence rate of a good 20 percent.⁶⁹ AIDS, which caused 360 000 deaths in 2001, is today by far the leading cause of deaths in the region, accounting for up to 25 percent of all total deaths – a number that will increase progressively over the next 5 – 15 years if there is no intervention.⁷⁰ However, the extent of the epidemic is only now beginning to be evident in many African countries, as the numbers of people infected and dying are increasing. In the absence of sufficient financing, prevention and care efforts the AIDS toll on the continent is expected to continue rising before peaking around the end of the decade, causing a devastating demographical impact (see box 1).⁷¹ This means that the worst of the epidemic's impact on society will be felt in the course of the next ten years and beyond. Its social and economic consequences are already being felt widely not only in health but in education, industry, agriculture, transport, human resources and the economy in general.⁷²

⁶⁷ Grimwood et al 2000:288

⁶⁸ UNAIDS/WHO 2002:2, Cairncross 2004

⁶⁹ Elsey & Kutengule 2003:10

⁷⁰ Cairncross 2004

⁷¹ Jones 2003:5

Box 1: Demographic impacts of HIV/AIDS in South Africa

- Number infected will rise from 5.3 million currently to peak between 7-8 million in 2009/10.
- Prevalence rate is over the critical threshold of 20%, And over 40% in many ante-natal clinics.
- A total of between 5-6 million will probably have died of HIV/AIDS by 2010.
- Child mortality will increase by approximately 50% in the next ten years.
- Adult mortality (measured by the probability of a 15 year old dying before they reach 60 years) is expected to increase by around 150% by 2010, from 30% to 80%.
- Life expectancy will decrease from over 60 years in the mid 1990's to slightly above 40 years by 2010.
- Number of deaths from AIDS is shortly expected to exceed the number of deaths by all other causes, peaking in about 2010 with 800 000 deaths per year.
- Number of maternal AIDS orphans is expected to rise from some currently 300 000 to around 3 million by 2011.
- The total number of children comprised by having lost one or both parents is likely to reach its highest level in 2015, of 5.7million.
- By 2015, AIDS orphans will constitute between 9%and 12% of South Africa's total population.
- As adult mortality increases, the number of child-headed households will rise, currently estimated at around 3%.
- By 2011, 56% of the population will live in households where at least one person in HIV-positive or has died of AIDS.

Source: Jones 2003

5.1.1 Microeconomic Impact

HIV/AIDS is most prevalent among the most productive and fertile in South Africa's population, with a good 20 percent of all 15-49 year olds in South Africa infected.⁷³ The HIV/AIDS epidemic is affecting every aspect of economic, social and human life in South Africa. It is reducing life expectancy – with estimates of reaching 36.5⁷⁴ years in 2010 – erasing decades of progress in extending and improving life.⁷⁵ So far, life expectancy has dropped from 63 in 1990 to 52 in 2002.⁷⁶ HIV/AIDS is also affecting women's chances of bearing children, let alone giving birth to healthy children, leading to a decline in population growth. South African women, on average, bear the lowest number of children of any country

⁷² AVERT.org

⁷³ Kenyon et al 2001:162

⁷⁴ The difficulty in measuring and estimating the HIV/AIDS impact entail sometimes very different figures, such as in life expectancy by 2010 which is ranging from about 40 years according to Jones 2003 and 36 according to avert.org. I include both to indicate just this problem of collecting and conducting data.

⁷⁵ Kenyon et al 2001:162

⁷⁶ Bradshaw et al 2000:91, Cairncross 2004

in sub-Saharan Africa, with an average of 2.9 child births.⁷⁷ Furthermore, the epidemic is affecting child mortality which, without prevention of mother to child transmission of HIV, will double in the next ten years from 60 per 1000 live births in 1998 to 120 in 2008.⁷⁸ The reduction in life expectancy in concert with the decline in population growth is leaving South Africa economically challenged to the extent that it is threatening the future of the country.

The most severe impacts of HIV/AIDS occurs at household level, where HIV/AIDS results in household income depletion as family members become too ill to work and thus are unable to provide for their family. The time and financial burden of caring for the ill results in the poor reallocating their time away from food production which in turn results in a reduction of basic necessities. Also, because HIV/AIDS usually strikes more than one family member it increases the numbers of orphans and their chance of a future above poverty levels. Today it is estimated that there are 620 000 orphans in South Africa, and by 2010 that number will have risen to 1 950 000.⁷⁹ With less financial means in the household and the loss of manpower, the children are taken out of school to care for family members or to earn an income, and with the inability to afford school fees and other expenses this means that fewer children are attending school. However, the impact on the education sector is also burdened by teacher absenteeism as they themselves become infected with HIV or take time off to care for sick relatives. With children losing out on education – and this is especially severe in rural areas where schools are dependent upon only one or two teachers – together with the loss of teachers which is estimated to reach a shortage of 70 000 by 2010, the future for South Africa's education sector is demoralizing. This, in turn, has a negative affect on the country's public budgets for health and education (see box 2).⁸⁰

HIV/AIDS also acts as a significant brake on economic growth and development in South Africa.⁸¹ As the HIV/AIDS epidemic primarily affects the working age adults, it far outweighs any other threat to the health and well being of South Africa's employees as well as setting back economic activity and development.⁸² AIDS deaths will soon exceed all other causes of death put together amongst employees in South African workforces and over the next ten years, the numbers of employees lost to AIDS is expected to be the equivalent of 40-

⁷⁷ *ibid.* 2000:91

⁷⁸ *ibid.* 2000:103

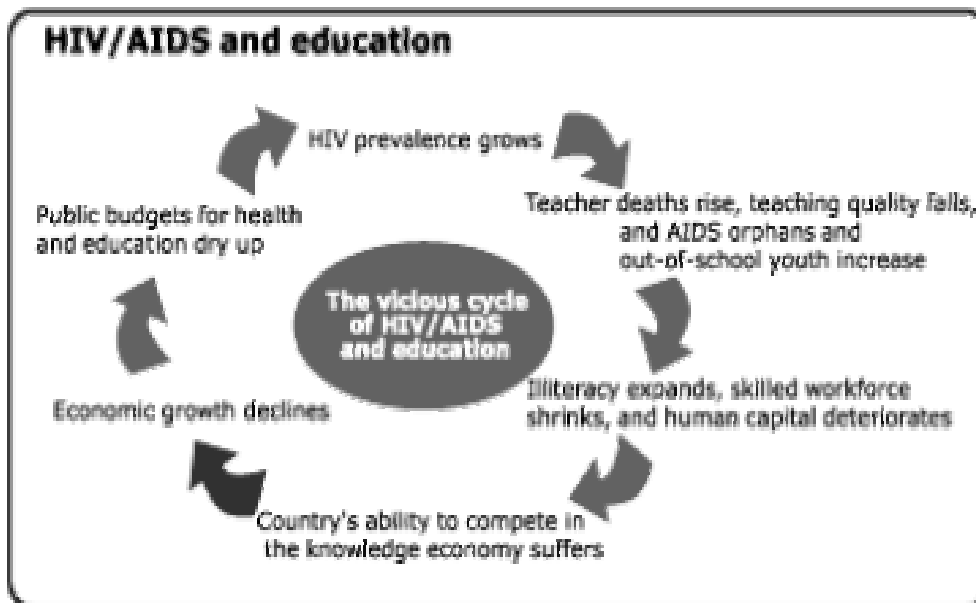
⁷⁹ Steinberg et al 2000:309

⁸⁰ AVERT.org

⁸¹ AVERT.org

50 percent of the current workforce in many South African firms.⁸³ This will result in enormous labour shortages in every economic sector. At the level of individual business, HIV/AIDS among managers, employees and their families will impose significant indirect and direct costs. Direct costs to companies come in the form of costs of health care and other employee benefits, and indirect costs – estimated to be more significant – include absenteeism due to illness, loss of skills, training and recruitment costs, and reduced work performance and lower productivity.⁸⁴ Today South Africa has an unemployment rate of about 30 percent, with large provincial differences ranging from about 19 percent in Western Cape to 41 percent in Eastern Cape. By 2010 it is estimated that 15 percent of the country's skilled workers will have contracted HIV.⁸⁵ However, the vulnerability of business to HIV/AIDS impact will vary, depending on factors such as capital and labour intensity, and production process. Moreover, the epidemic will also impact on the growth of many markets for goods and services, as it pushes more and more people towards poverty and thus the buying power in the country is reduced.

Box 2: The vicious circle of HIV/AIDS and education



Source: Millennium Development Goals

⁸² Steinberg et al 2000:310

⁸³ *ibid.* 2000:310

⁸⁴ *ibid.* 2000:311

⁸⁵ *ibid.* 2000:311

5.1.2 Macroeconomic Impact

Although the impact of HIV/AIDS on economic growth is anticipated to be relatively small compared to other shocks like war, natural disasters and global economic events it nonetheless has the potential to reduce growth through reducing international competitiveness by reducing human capital and increasing production costs, and reducing investment and driving up the costs of capital by decreasing public sector, corporate and personal savings caused by HIV/AIDS related expenses. This affects the government allocation of resources, away from necessary infrastructure and education and towards expenditures of HIV/AIDS needs. Furthermore, HIV/AIDS is also likely to increase socio-economic disparities and aggravate poverty and discrimination.⁸⁶

5.2 HIV/AIDS and the Health Sector

The impact on the health sector is difficult to measure as long as the government denies the problems associated with the HIV/AIDS epidemic. However, what is known is that the number of admissions to all hospitals has been increasing drastically; stretching between 20 – 40 percent depending on where in the country you look⁸⁷, and the HIV toll among South Africa's health workers are estimated at 16 percent.⁸⁸ Also known is that the HIV/AIDS epidemic is putting additional pressure upon an already burdened and ill-equipped sector, impairing the overall quality of health care services provided by hospitals, thus reducing the chances of patient recovery.⁸⁹ As the private sector is only in charge of providing 34 percent of the country's HIV/AIDS related health care, while at the same time facing fewer patients who can afford private services (as mentioned in 4.2), it is the public sector who alone is facing the epidemic, serving a good 80 percent of the population with the remaining provision of HIV/AIDS related health care.⁹⁰ But as patients are denied clear treatment protocols, effective use of ARVs and access to appropriate health facilities, more and more health workers are becoming demoralised and despondent about the care they can provide.⁹¹

⁸⁶ Steinberg et al 2000:312

⁸⁷ Cairncross 2004

⁸⁸ Dr Shisana 2004

⁸⁹ AVERT.org

⁹⁰ Dr Shisana 2004

⁹¹ Cairncross 2004

The HIV/AIDS epidemic has had – and continues to have – a very negative impact on the public health sector. The increased burden on medical wards and staff due to the opportunistic diseases causes long working hours, high patient load and above all stress (discussed in section IV). Together with the lack of access to precautionary measures when working with infected patients, health workers are driven towards the private sector or even to other countries.⁹² The problem of brain drain not only leaves the country short of educated and trained health personnel but the resources spent on them is entirely wasted as the country does not reap the benefits of these physicians and nurses.⁹³ Those who do stay are very unevenly distributed within the country to where they are needed the most (see table 2 and 3) – a problem inherited from the apartheid system. The provinces of Mpumalanga and North West, both predominantly black provinces, have very high HIV prevalence rates while at the same time having the lowest health worker-to-patient ratios.⁹⁴ Gauteng and Western Cape, on the other hand, are provinces with large white populations and are allocated among the highest health resources per 100 000 population in the country. The high HIV prevalence rate in Gauteng is almost exclusively found within the poor black community.⁹⁵ The lower count of HIV prevalence between years in some provinces is most likely due to the data sample collected than a reduction in HIV infected. However, an overall trend is the difference between urban and rural areas in the distribution of health care workers and health facilities, with the rural areas suffering not only from lack of access but also from the lack of the same quality and effectiveness promoted in the cities.⁹⁶

The severe inefficiencies and the rigorous HIV/AIDS impacts experienced by the public health sector is preventing and impairing the health care service provision needed by the equally impacted population by the epidemic, with devastating future consequences for the whole of South Africa. There is thus an urgent and great need of an alternative health service provider, one that will not impair the equity stance of delivery, and one that can more efficiently use its resources for effective health care provision. One of the current hoped-for institutions is home-based care, presented in the next section.

⁹² *ibid.* 2004

⁹³ AVERT.org

⁹⁴ AVERT.org, Hansson 2004)

⁹⁵ AVERT.org, Hansson 2004).

⁹⁶ Kakaza & Zide 2004

Table 2: Estimated HIV (%) prevalence among antenatal clinic attendees 2000-2002

Province	2000	2001	2002
Eastern Cape	20.2	21.7	23.6
Free State	27.9	30.1	28.8
Gauteng	29.4	29.8	31.6
KZN	36.2	33.5	36.5
Limpopo	13.2	14.5	15.6
Mpumalanga	29.7	29.2	28.6
Northern Cape	11.2	15.9	15.1
North West	22.9	25.2	26.2
Western cape	8.7	8.6	12.4
National	24.5	24.8	26.5

Source: AVERT.org

Table 3: Distribution of selected health personnel per 100 000 population 2000-2002

	Professional nurses		Nursing assistants		Medical practitioners		Medical specialists	
	2000	2002	2000	2002	2000	2002	2000	2002
Province	per 100 000		per 100 000		per 100 000		per 100 000	
Eastern Cape	106.1	74.9	72.3	59.9	12.3	11.3	2.6	2.3
Free State	128.9	124.1	94.4	93.5	24.3	23.4	10.9	9.2
Gauteng	172.5	136.3	108.2	92.7	36.6	29.1	32.4	25.0
KZN	119.8	109.0	71.8	72.2	24.0	22.4	7.4	6.3
Limpopo	104.6	110.5	57.6	53.6	12.5	9.1	1.0	0.7
Mpumalanga	90.5	89.6	59.6	53.3	16.4	16.6	1.2	0.7
Northern Cape	122.3	107.1	82.2	77.2	28.9	24.2	2.0	2.2
North West	94.3	94.1	79.1	77.4	11.9	11.8	1.5	1.5
Western Cape	139.9	130.0	131.2	134.9	39.7	33.1	42.7	39.3
Average	120.3	106.8	81.3	75.9	21.9	19.3	11.2	9.8

Source: South African Health Review 2001:321

VI Community- and Home-Based Care

6.1 Definition

Community-based care (CBC) has been around for more than 20 years, ever since the World Health Organisation's declaration of Alma Ata in 1978 that established the Primary Health Care paradigm.⁹⁷ Community-based care is usually based outside formal health facilities, but work together with government sectors in partnerships with e.g. the Department of Health or the Department of Social Welfare.⁹⁸ It comprises care during every portion along the continuum of illness, and specifically in relation to HIV/AIDS, from time of infection to after-death counsel to family and friends left behind.⁹⁹ Home-based care is a part of community-based care but with the focus primarily on physical/medical and palliative care of the patient in its home, with the support of family and immediate community – giving it a strong relationship with the formal health sector.¹⁰⁰ It relies, as all other forms of community-based care, on the training of health auxiliaries who then work in the community in which they live, usually without any professional education.¹⁰¹

6.1.1. The Importance of CBC in South Africa

Due to the great successes and achievements in health during the past decades made possible by community-based health workers, few communities in South Africa are today without any form of community-based care, as in many areas this form of health provision is crucial. Health workers around the country have reduced child morbidity and mortality through promoting nutrition, breast feeding, growth monitoring and immunisation. They have also involved themselves with disabled children and on inter-sectoral social issues, such as poverty, water and sanitation, food security, literacy education and care dependency grants. The health workers have furthermore been immensely important in terms of helping adults with diseases such as TB, cholera, diabetes and cancers. Had it not been for the HIV/AIDS

⁹⁷ Friedman 2002:162

⁹⁸ Fox et al 2002:6

⁹⁹ *ibid.* 2002:6

¹⁰⁰ *ibid.* 2002:6

¹⁰¹ Friedman 2002:162

epidemic, community-based health workers would today probably have played the most critical role in reducing child mortality, controlling fertility, and improving life expectancy in South Africa.¹⁰²

Community-based health workers are highly valued because they:

- are outstanding health promoters, with important roles in prevention and treatment.
- enhance community participation.
- provide the District Health System with a communicational tie to the communities, providing them with information on community needs.
- help people with social problems to access health care services.
- bring all participants of health care services together under one umbrella.¹⁰³

However, despite its positive success rate, many challenges hinder the community-based programmes to be as effective as they could be. These include:

- The fragmented roles of many different kinds of community-based health workers; instead of joining forces and working together, many community-based health workers compete in their provision of health services, resulting in service duplication. Their specialisation also makes them unfit to deal with any issue outside their range of expertise and knowledge.
- The large variation in incentives for payments for similar kind of work; although many health workers work as volunteers they do receive some salary for their work. This amount can differ widely between regions.
- The excessive amounts of days per week that unpaid or partially paid health workers are expected to work.
- The difference in amount and quality of training between regions due to lack of cooperative work.
- The inconsistent support and supervision given to different groups of health workers.
- Transportation constraints, both infrastructural and financial, prevent travelling to patients.
- Weak programme monitoring and evaluation.

¹⁰² Friedman 2002:164

¹⁰³ *ibid.* 2002:165

- Inadequate linkage with the district health system and their lack of involvement in the community work.
- Poor integration between different community-based professionals, NGOs, CBO's, FBO's, and local and provincial government in different sectors.¹⁰⁴

6.2 Home-based Care

Home-based care is considered as an alternative to traditional health care in hospitals and clinics, and focuses on palliative care within the home, most often in rural areas where access and transportation to public health care facilities are limited.¹⁰⁵ As more and more people are becoming infected their time of hospitalisation is also increasing, depleting the resources in the health care system. Today HIV patients far outnumber patients with any other illness¹⁰⁶, and in overcrowded, under-resourced and under-staffed health facilities these patients, with little ability to care for themselves, are putting enormous pressure on both hospital and health worker capacity. Discharging HIV/AIDS patients into home-based care programmes therefore shortens their hospital stay, making more beds available for other patients and reduces the cost.¹⁰⁷ Also, because of the search for high patient turnover by hospital policy combined with the hospital nurses lack of sufficient knowledge about palliative care, releasing patients into the care of proficient home-based care organisations can allow hospital staff to enhance the moral and strength in the midst of the epidemic.¹⁰⁸ However, other reasons exist for turning to home-based care, especially in rural areas, where home care sometimes is the only solution due to, as previously mentioned, lack of public health facilities and means of transportation, but also poor infrastructure and an overall poverty and demoralisation of the infected that prevents them from seeking institutionalised care.¹⁰⁹

¹⁰⁴ *ibid.* 2002:167

¹⁰⁵ Sinqa 2004

¹⁰⁶ Fox et al 2002:4

¹⁰⁷ *ibid.* 2002:4

¹⁰⁸ *ibid.* 2002:4

¹⁰⁹ Sinqa 2004

6.2.1 Models of Home-based Care

Home care is defined “as the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person’s maximum level of comfort, function and health including care towards a dignified death”. Home care services can be classified into six categories; preventative, promotive, therapeutic, rehabilitative, long-term maintenance and palliative care. Community-based and home-based care can deal with a number of the public sector health care problems, including;

1. shortage of hospital beds;
2. shortage of hospital staff;
3. lack of resources for treatment and drugs;
4. hospital overcrowding;
5. high cost of institutionalised care.¹¹⁰

Five models of care have been suggested by the Department of Health;

1. Community-driven model → this model is based on integrated service provision through locally-driven initiatives. A Community Developer coordinates with partner organisations and train volunteer caregivers, who then directly deal with patients and their families.
2. Formal government sector model → this model is led by government departments which then work in collaboration with various sectoral partners. The care is coordinated at the district level by a team of doctors, nurses and social workers within the hospital structure. A patient is treated at a hospital and home visits are conducted by professional nurses and community health workers. Clinics are available for follow-ups and referrals.
3. Integrated home/community-based care centre model → this model is structured around a care centre located within the community, e.g. a church or a school. The centre is volunteer-run but professional health workers can be sent by the Department of Health. The centre offers a wide variety of services, including home visits, follow-ups, referrals and day care.
4. NGO home/community-based care model → this model is similar to the previous one with the exception that it is initiated and coordinated by an NGO. Funds are received

¹¹⁰ Fox et al 2002:6

by various public departments, social welfare organisations, donor organisations and other NGOs and CBO's. Both professional as well as volunteers work in the home care team.

5. Integrated community and home-based care (ICHC) model → this model is similar to the NGO care model with the difference that it is supported by a hospice and run by an already established and self-supporting NGO.¹¹¹

The exact objective of each model differs according to whether it is run by the public sector or by an NGO, but generally the overall aim in the community is to create a strong relationship, both between the caregivers and the patients, but also between the community and the health sector.¹¹² Other themes on the agenda include being able to provide quality care in the home and to provide a continuum of this care – from infection till death, and to educate and inform the community about preventative measures such as hygiene, nutrition and proper food preparations.¹¹³ The success and sustainability of these models depend upon, amongst other things, the availability of resources, the level community participation and the level of ongoing commitment and organisational capacity of the coordinating body.¹¹⁴

6.2.2 Benefits of Home-based Care

There are many benefits of providing home-based care for patients. First, because of the close personal relationship, the caregiver can make sure that the patient take its medication and can follow-up on changes in the patient's health, treating symptoms before they turn into something serious or refer them to clinics. This has improved the health of the patients, who not only receive medical aid and treatment but also someone who listens and who gives moral and spiritual support. Second, home-based care can help people who, for various reasons, fail to seek health care or are not recognised by the formal health system because as the caregivers themselves live in the community they serve, they can identify these people and thus prevent the negative outcomes of information asymmetries. Third, gains from positive externalities arise by amplifying the visibility of people infected with HIV through home visits, where the care givers also educate family and community members about the transmission of HIV, encouraging discussion and understanding. Home-based care can further help communities

¹¹¹ Fox et al 2002:7-10

¹¹² *ibid.* 2002:7

¹¹³ Sinqa 2004

combat the stigma and fear surrounding the disease by providing them with someone to turn to for questions and information, thereby encouraging the normalisation of the virus.¹¹⁵

6.2.3 Limitations of Home-based Care

Although caregivers normally live in the community in which they work and therefore should be able to walk to visit their patients, the increase of HIV-infected people have increased the geographical area the caregivers have to cover, impacting on their time with each patient as more and more of the day is spent travelling.¹¹⁶ This means long waiting periods until the caregiver's next visit, in which time the patient's condition can seriously deteriorate. Even with means of transportation the lack of proper infrastructure, especially in wet conditions when the mud roads turn to mud rivers, imply that very remote areas continue to be without health care.¹¹⁷ Also, as many of the caregivers are paid a very small salary or work as volunteers, and as the increasing number of infected continue to increase, the NGOs running many of the home-based care organisations face many of the similar problems as the public health care sector are, such as lack of resources and over-worked and sometimes demoralised caregivers.¹¹⁸

¹¹⁴ Fox et al 2002:7

¹¹⁵ Fox et al 2002:21-22, Sinqa 2004

¹¹⁶ Somhlaba 2004

¹¹⁷ Fox et al 2002:23

¹¹⁸ Kakaza & Zide 2004

VII Service Providers of HIV/AIDS Related Health Care in the Eastern Cape Province

7.1 The Eastern Cape Department of Health

During the last decade, the Eastern Cape provincial government earned itself a reputation of persistent service delivery failure and weak management of public resources. Corruption and maladministration was high and adequate monitoring capacities was lacking. In 1999 the Public Service Accountability Monitor (PSAM) established an independent research project at Rhodes University in Grahamstown with the objectives of monitoring the performance of the provincial government, monitoring the behaviour of government departments in search of corruption and malpractice, and empowering the civil society. By using South Africa's new democratic Constitution, the PSAM forced the government to handover documents and information that previously had never been obtained, often through court proceedings.

7.1.1 Public Health Care – an Overview of the Inadequacies

The failures of the Eastern Cape provincial government to comply with good government behaviour is caused mainly by failures to sufficiently plan, spend and account for received budget allocations, and corruption. In terms of spending, the provincial government has during the financial years of 2000 and 2003 routinely acquired significant over- and under-spending. Throughout this period the Eastern Cape Department of Health failed to spend an amount of R309 million of its R12.4 billion budget allocation, and R283.3 million of its R1.458 billion infrastructure budget between 1999 and 2004. This spending pattern is caused by the department's failure to undertake strategic planning and to use appropriate budget programming. It was found that between 1999 and 2004, none of the department's annual strategic plans for this period contained accurate or time-bound capital expenditure or maintenance plans. The strategic plans also fell short of containing accurate information on the Eastern Cape public health service delivery environment or the demand for these services that needed to be met by the department. Alongside the spending and planning problems there is the failure of the government to properly account for spent budget allocations. Between

1999 and 2003 the department failed to account for 81.9 percent, or R20.6 billion, of its R25.2 billion budget allocation. Any records of the financial transactions did simply not exist. Furthermore, the National Department of Health could not account for the use of R7.1 billion of its R7.6 billion budget transferred to provinces for purposes of provincial hospital rehabilitation. Furthermore, both financial misconduct and misconduct of other forms are a continuing trait of the department. Several cases of unauthorised, irregular or wasteful expenditure have been identified between the years 2000 and 2003, and so have cases where government officials have failed to meet set-out responsibilities or to comply with the Constitution's Ethics Act.¹¹⁹

Additionally, scarce resources, poor infrastructure and inadequate transportation in many rural areas prevents delivering of medical drugs and equipment to the clinics, especially in rainy conditions, and hospitals in general lack enough space to do their work properly, preventing sufficient service delivery. The lack of staff, medicines, blankets and access to water means that the hospital services are not up to standard, preventing them from efficiently and effectively using their capacity. This capacity problem has led the government to outsource many of its services to private companies. But the inability of the government to monitor these services have led even these privately performed services to be inadequate, e.g. ambulatory services have not improved as expected after being outsourced.¹²⁰

7.1.2 The HIV/AIDS Treatment Crisis

By the end of 1999 the Eastern Cape Department of Health officially acknowledged that the province had one of the highest growth rates in the world of HIV, and that over 450 000 people in the province had been infected. When the National Department of Health finally responded to the epidemic by the development of the 2000-2005 Strategic Plan (mentioned in 4.3.1), some success was established in the province with regards to condom use and training of secondary school teachers on HIV/AIDS awareness. However, the resolved reluctance of South Africa's national government towards the use of ARVs within the public health sector to treat people living with HIV, has resulted in the deaths of 15000 children and at least 3150 adults in Eastern Cape. This is estimated from the fact that it is recognised that some 33 percent of HIV-positive mothers transmit the virus to their children, which in a year would

¹¹⁹ PSAM Press conference 2004, Allan et al 2004

amount to a total of 10 500 HIV-positive children, given the infection rate in the Eastern Cape. Conservative estimates suggest that nevirapine, an ARV drug, has a 50 percent success rate when used with breast milk substitute, and a 30 percent success rate when used alone. This means that had a general roll-out of the drug for Prevention of Mother-To-Child Transmission (PMTCT) purposes begun in 1998 instead of mid-2003, it would have saved the lives of over 15000 people in the Eastern Cape Province.¹²¹

7.1.2.1 Budgeting and Spending on HIV/AIDS Programmes

Between the financial years of 2000/2001 and 2003/2004 the Eastern Cape Department of Health was issued a total budget allocation of R238.2 million for HIV/AIDS purposes. However, they only produced business plans for the utilisation of R145 million, or about 60 percent of this amount, thus failing to effectively plan for 40 percent of its HIV/AIDS budget. In terms of conditional grant allocation and provincial government allocation, it failed to produce business plans for 23 respectively 48 percent of those amounts. Moreover, in the absence of accurate and up-to-date reports on the levels of spending of existing budget allocation, it is extremely difficult for programme managers to identify their future budget needs.¹²²

Table 4: Eastern Cape HIV/AIDS Budget vs. Expenditure 2000-2004

	2000/2001		2001/2002		2002/2003		2003/2004	
	Cond. grant	Prov. grant	Cond. grant	Prov. grant	Cond. grant	Prov. grant	Cond. grant	Prov. grant
Budget allocation	R2.2m	R33m	R8.28m	R33m	R33.63m	R57.2m	R38.9m	R32.013m
Amount spent	Unknown	Nil	R2.899m	Unknown	R24.76m	Unknown	R38.7m	In process
% spent	Unknown	0%	35%	Unknown	73%	Unknown	99.4%	In process

Source: Allan et al 2004:124

¹²⁰ Somhlaba 2004

¹²¹ Allan et al 2004:117

¹²² Allan et al 2004:123

Table 5: Utilisation of Eastern Cape HIV/AIDS Budget

	Total Conditional Grant 2000-2004		Total Provincial Allocation 2000-2003	
	Amount	%	Amount	%
Budget allocation	R83m	100	R123.2m	100
Spent	R66.37m	79	unknown	unknown
Unknown	R2.213m	2.6	R90.2m	73.2
Unspent	R14.48m	17.4	R33m	26.7

Source: Allan et al 2004:125

The Eastern Cape Department of Health’s HIV/AIDS business plans reveals a litany of examples of spurious and ad-hoc budgeting. For instance, the conditional grant business plan for 2001/2002 contains a budget item of R1 million for the purchase of home-based care kits, yet the plan provides no indication of the number of kits to be purchased, their exact contents, their unit cost nor intended location. Moreover, the failure to undertake reconciliation between its budget objectives and its previous expenditure between the 2000 and 2004 period has resulted in the duplication of spending on the same activities from one financial year to the next.¹²³

It is recognised that the President’s personal view on the epidemiology and transmission of HIV, alongside the National Government’s reluctance towards rolling out anti-retroviral drugs, have fostered a weak state of financial management and weak political leadership in the Eastern Cape, resulting in lethargy among those officials responsible for the implementation of the province’s HIV/AIDS programmes. It is thus evident that without help the public health sector will fail severely in their task of health care service provision, making the future problems in South Africa with regards to the HIV/AIDS epidemic a most likely outcome.

¹²³ *ibid.*2004:125

7.2 Home-based Care in Eastern Cape

This section presents two home-based care programmes; one run by the local government in the Chris Hani District Municipality and the other by an NGO in the O.R. Tambo District Municipality.

7.2.1 Home-based Care Provided by the Eastern Cape Provincial Department of Health

The Eastern Cape provincial Department of Health has assigned the provision of home-based care within the Chris Hani District Municipality between six sub-districts: Lukhanji, Engcobo, Intsika Yetho, Sakhisizwe, Emalahleni, and Inxuba Yethemba. Each of these districts are severely affected by HIV and AIDS and in great need of training and empowering care givers with nursing skills and knowledge. Thus the objectives of these home-based care organisations are:

- To empower caregivers with knowledge and skills to function as the extended hand of nurses.
- To train caregivers to integrate with other government sectors so as to be able to refer clients and their patients to relevant sector.
- To pay special attention to children in distress as well as the youth who have lost their parents.

In the provincial budget of 2004, each sub-district was awarded R145 600 for the training of home-based care workers on the policy guidelines and management of opportunistic infections (R30 000), the procurement of Home Care kits (R40 000), and the training of five home care givers in each facility (R75 000)

7.2.1.1. The District of Emalahleni

Glen Grey hospital in Lady Frere, outside Queenstown, has the assignment of providing home-based care to the Emalahleni municipality. It has seventeen rural clinics attached to the hospital and a good one hundred health care workers. For the hospital itself the most noticeable problems are long waiting periods for the patients, overcrowding of patients and

the facility being under-staffed. Also, because the hospital is currently being renovated and expanded, the present condition of the facility is very poor, inflicting on the treatment of the patients. In terms of the home-based care work, the promised home-based care kits from the provincial government – containing just painkillers and gloves – has been left out since the provincial government needed to save money and decentralised the task to the sub-districts. Moreover, the awarded lump-sum to the hospital from the provincial government for their home-based care work has not nearly been enough, and the huge span of the district together with the lack of proper infrastructure creates a large workload for the caregivers.

The hospital has focused its attention on the provision of HIV/AIDS related health care on Prevention of Mother-To-Child Transmission of HIV (PMTCT). The programme follows a five-step plan:

1. Gives pre-test counselling to mother and admit her to an antenatal clinic.
2. Gives PMTCT counselling and provide nevirapine to the mother if infected. It also gives instructions of how to take the drug appropriately.
3. At delivery, the programme ensures that the mother has taken nevirapine and it gives the baby the drug within 72 hours of birth.
4. The baby then receives follow-up on site, a test for HIV, and is provided with trimoxazole from 6 weeks onwards.
5. Monthly data is then collected using infant summary and the PMTCT programme, as well as from clinics.

During 2003, a good 20 home-based caregivers were trained in Lady Frere Town for 20 days and another training session took place at Dodrecht for Dodrecht and Indwe home-based caregivers. During the year a World Aids week was organised and held by the Department of Health, the Department of Education, and Sports & Culture at Indwe, Dodrecht and Lady Frere. From the 1st to the 5th of December the home-based caregivers were active in those activities and the Department of Health gave information about HIV/AIDS and organised a candlelight memorial on those days. There was also a Provincial World Aids day and candlelight memorial, which was staged by the Department of Education at Ndonga on the 28th of November. On the 11th of November the home- and community-based caregiver director was invited by Rural Support Services (an NGO) to empower caregivers as well as the community members at Mtikakra Hall about opportunistic diseases caused by HIV.

During 2003 it was found that the biggest strength in the home-based care programme was the enthusiasm of the caregivers towards training. However, the absence of home-based care kits has hindered the progress and the lack of trainers in some areas has delayed training.

7.2.2 Home-based Care Provided by an NGO

7.2.2.1 Public Health Care in O.R. Tambo District Municipality

In January 2004 the new and modern hospital in Umtata was officially open for business, the Nelson Mandela Academic Hospital, looking quite expensive. The old Umtata General Hospital was incorporated within the new one, providing health care services as one body in the community. However, the new hospital is already infested with the same problems as the old one; it is overcrowded and under-staffed. The queues to see a doctor is too long, and once patients acquire a prescription, there is an even longer wait for the drugs to be dispatched by the hospital – usually a day. The lack of beds which forces patients to sleep on the floors and the lack of sufficient means of transportation to get there makes the people of the community reluctant to use the hospital and its health services. The hospital's attempt at dealing with the staffed shortages by brining back retired nurses has not relieved the situation sufficiently.

There also exist four clinics in the community, all run by the municipality; Northcrest, Stanford Terrace, Zimbare and Ngangelized. These are more accessible to the people because they are placed within the community and they are also equipped to handle a vast amount of medical conditions. The problem is that despite all of them having professional nurses on their staff only two of them also employs doctors (Stanford Terrace and Ngangelized), making people disinclined to use the clinics as they believe that they will receive better services at the hospital, which is not the case. The poor state of the hospitals and their services, as well as the shortage of doctors at the clinics, results in a reluctance of the people to use these available service providers. This in turn makes the people in the community feel that they have nowhere to turn for quality health care services.

7.2.2.2 Temba Community Development Services

Temba Community Development Services is a non-governmental organisation based in King Sabata Dalindyebo Local Municipality, in O.R.Tambo District Municipality of the Eastern Cape Province. They were founded in 1999 with programmes mainly focused on poverty alleviation, but changed the following year to combat the increasing problems of the HIV/AIDS epidemic in the community, more specifically the two towns Umtata and Mqanduli, and the villages around the Misty Mountains. Temba is a member of a few large organisations working with HIV/AIDS, such as Partnership in HIV/AIDS Support Organisations (PHASO), Action Group for Children in Distress (CINDI), and Eastern Cape NGO Coalition and Regional Progressive Primary Health Care Network (RPPHCN). They are also one of the endorsing organisations for Treatment Act Campaign (TAC) and are also involved in working relationships with organisations like PPASA, NAPWA, Hospice, Hope Worldwide, UNITRA, and the following government departments; Health, Social Development, Education and Local Government.

Temba runs a home shelter with a capacity of 20 patients at a time, with 10 volunteers attending to the needs of the in-house patients, and another 10 volunteers working in the villages as home-based caregivers, usually in the village in which they themselves live.

The objectives of Temba are:

- To provide outreach programmes, by conducting capacity building & training workshops with emphasis on HIV/AIDS; counselling, treatment, nutrition, home-based care and TB within the context of community development.
- To provide a home-based care centre / drop-in centre for the chronic, terminal, rejected and neglected, which will also support the discharge of patients from hospitals with chronic and terminal conditions.
- To conduct home visits, offering counselling services, medication, care, support and provision of food parcels to destitute families, as a temporary relief.
- To assist employers / corporate sector to have HIV/AIDS Policy and Programme in place, and train managers and supervisors as counsellors, so as to encourage workers to come forward and get help.

- To provide and facilitate community support groups, for both infected and affected, with voluntary counselling and testing facilities, and train them on income generating activities as poverty exacerbates the effect of HIV/AIDS.
- To identify and assist in placing orphans with foster families and arrange grants with the Department of Welfare and Action Group for Children in Distress (CINDI).

Programmes and Activities

To meet their objectives Temba has set up five programmes with specific activities within each to form the work which they intend to do. The first programme consists of *capacity building and training*. Through workshops emphasising on HIV/AIDS, counselling, nutrition, home-based care and TB within the context of the community, Temba wishes to train and educate the people in order for a behavioural change with regards to the epidemic (activity 1). They also meet with different parts of the community, e.g. hospitals, teachers, youths, churches, clinic nurses, the corporate sector and rural communities to enforce awareness about how the epidemic affects them differently (activity 2).

The second programme consists of *care and support services*. To meet the problems of overburdened hospitals and the lack of aftercare of patients with chronic or terminal conditions, Temba conducts home visits to help and train the families at home to care for the sick. They can also admit people to their home shelter which eases the burden on family members for a while (activity 1). The home visits are conducted through referrals from communities, clinics, hospitals, churches and private doctors and the families are provided with medication, support and home-based care training so that they themselves can care for family members or relatives (activity 2).

The third programme consists of *community support groups, counselling services and psychosocial support*. Temba trains and facilitates the formation of support groups within the community with the task of continuing the counselling, care and support even when the NGO is not there. This activity is meant to promote community support networks (activity 1). Through the delivery of food parcels and medication, Temba provides some relief in the midst of the ongoing poverty that prevent many of the people in the community to eat sufficiently and nutritiously. Temba also encourages and help establishes food gardens and to apply for government grants (activity 2). Temba is also training counsellors to be equipped to provide

psychosocial support and counsel to the infected and affected people. This activity is designed to reduce the level of stigma and discrimination caused by HIV/AIDS.

The fourth programme consists of *mitigating and coping at family and community level*. By recruiting and training more volunteers to perform fieldwork, Temba means to identify needy families, especially children who have no one to take care of them. Families are encouraged to identify foster parents while they still can to ensure a future for the children they are leaving behind. This enables children to access government grants (activity 1). Temba also trains parents and young adults on parenthood to provide poor parental guidance that leaves children neglected or victims of abuse, situations which encourages children to leave home at an early age (activity 2).

The final programme consists of *managing HIV/AIDS in the workplace*. Temba assists the corporate sector, as well as its employees, to put their HIV/AIDS policies and programmes in place, and also train them to be able to manage and support people with disabilities in the workplace.

Challenges

Temba is meeting the same challenges as other home-based care organisations described in section 6.2.3. The 10 volunteer caregivers who work in the villages conducting home visits are facing an increasing number of patients, larger geographical areas to cover and thus a decrease in time available for each home visit. As the caregivers have to travel longer distances to meet with their patients (Temba covers a radius of about 20 kilometres around the community), and with no other means of transportation than by foot, the time spent with each patient is lessening. The increase in patient load also entails a longer time span between visits, in which time the patient's condition can severely deteriorate.

With regards to the financial situation, running a home-based care service is expensive, despite volunteers running the organisation. Normal expenditure for the shelter on food is on average R3000 per month and on rent R2500 per month. Electricity, water, equipment and drugs are other necessities. The Department of Health provides Temba with between R70 000 – 100 000 at the end of each financial year to sustain them for about three to four months, but not more. Because of government regulation requiring two audited annual financial reports

before allowing organisations to apply for funding, this year is the first year Temba is able to do just that. In 2003, Temba received about R250 000 in donations from e.g. the Africa Groups of Sweden, but they would need an amount double that size to be able to provide good quality home-based care. To be able to buy a 4x4 vehicle would also ease the workload for some of the caregivers.

Finally, the last of Temba's big challenges has to do with the local government's poor performance. The municipality's Department of Health is supposed to provide Temba with home-based care kits, merely consisting of (as mentioned above) gloves and painkillers. But these are provided irregularly, and without gloves the home-based care workers are prevented from being able to take precautionary measures when working with infected patients. Through Temba the local government provides the poorest parts of the community with food parcels – this was last done in the summer of 2003 – but being only a short-term arrangement for three months the effort was not enough. The government intended the people to start food gardens and to embark upon other means of self-reliance. The result, however, was that people became unwilling to take such measures since they expected the government to come to their aid if they needed it.

Achievements

In 2003 the home shelter admitted a total of 490 chronic patients, and 70 percent of these survived and were able to lead normal lives after being discharged. Temba was also able, with the aid of TAC, to provide their patients with a drug called Biozale brought in from Malaysia since it is not available in the country. This drug is used to treat opportunistic diseases, such as TB, pneumonia and diarrhoea, and have great positive effects on the patients.

Temba has also managed to train approximately 2000 community members, people who has continued to make a difference in their own communities and workplaces. They assisted in the policy and programme development and implementation of Amatola Water Board and Meeg bank, including training their personnel. Furthermore, Temba assisted Pick 'n Pay, Shoprite Checkers (both supermarkets) and Transnet to launch their HIV programmes.

7.3 Concluding Remarks

This section has presented the most frequently occurred public health sector problems in the Eastern Cape Province, i.e. the failures of the provincial government to act according to set norms and standards within the field of public policy in South Africa. Not surprisingly are the issues experienced by Eastern Cape similar to the ones on national level, and even acts as pure extensions of the national government's lack of morals. This section has furthermore presented two home-based care organisations in different parts of the province; a formal government sector model and an NGO home/community-based care model. The difference in activities and programmes between Temba and Glen Grey hospital, with the former delivering a wider and fuller range of home-based care services, has to do with the size and use of allocated resources. Because Temba receives funding from both the government and donors – although not in sufficient amounts – whereas Glen Grey only receives funding from the provincial government, the span of service delivery will differ between the two. Also, because resources allocated to Temba can exclusively be used in their home-based care programme, they can focus their work entirely on providing home-based care services, whereas Glen Grey hospital has to allocate resources between many different sections in the hospital and can thus not provide the same scope of care. A more extensive discussion of the public and private health sectors, as well as home-based care, follows in the next section.

VIII Conclusion

8.1 The State of the Health Sector

8.1.1 The Health Sector Problems

The private health sector in South Africa is controlling a majority of the health care market. However, the increasing unemployment in the country is limiting the affordability of private health insurance, restricting the ability to consume HIV/AIDS related private health care as a majority of the infected people live in rural areas where both job prospects are scarce and poverty persistent. On the supply side, the problems of positive externalities and the inability to receive payment for many of these services results in an under-supply of health care services by the private sector. Being guided mainly by profit incentives, the private market has no interest in serving a market where the consumers are unable or unwilling to pay for the use of the provided services. Even though, theoretically, private provision of a good or service is a more efficient option than public provision, the private health sector in South Africa is experiencing just these problems. However, despite being or not being the more efficient solution to health care provision, if the private health sector will not provide free and equal health care, then it is not an alternative for the infected people of South Africa.

The public health sector can remedy many of the problems experienced by the private health sector by providing free health care funded through taxes and by redistributing income within the country. However, although surpassing the problem of equal access to health care the public health sector is hampered with inefficiencies that leave room for abuse by the people in charge. Corruption and maladministration is particularly severe in South Africa, resulting in failures to account for allocated budget resources and failures to accurately use these resources, with disappointing consequences for the general public who has to put their trust in these public officials. The inefficiencies in South Africa's public health sector are further fuelled by the government's lack of response and action to the HIV/AIDS epidemic, where the reluctance to initiate a roll-out of anti-retroviral drugs has had devastating effects and resulted in lives being wasted.

Having to cope solely with the HIV/AIDS epidemic in the country, the public health sector is burdened heavily by high patient loads, inflicting on the already scarce sector resources. Hospitals and clinics around the country are already experiencing staff shortages, ineffectual managements, limited financial resources to provide medical care, long working hours and an ignorant government in terms of grasping the severity of the epidemic. By augmenting these problems, the HIV/AIDS epidemic is further putting pressure upon the public health sector, resulting in even more dismal prospects for future health care provision. As hospitals and clinics are facing a higher patient load without the additional resources to manage the situation, caregivers have to work under enormous stress. More patients mean longer working hours, and as the HIV/AIDS patients are flooding the medical facilities around the country – blocking out other patients with their long hospital stays – hospitals and clinics are experiencing even more severe staff shortages. This is the result of nurses having to leave to care for sick relatives or because they themselves have become infected, or simply because they can no longer cope with the situation of not being able to provide the needed care without any resources and simply leave for work in the private sector or abroad. The situations feed on each other, creating an evil circle of high patient load, a demoralising work atmosphere and labour shortages. With the negligence and ignorance presented by the government, their lack of monitoring ability on established plans and policy frameworks, and the President's disbelief in the relationship between HIV and AIDS, the future situation in the public health sector of South Africa does not appear to be in a better condition than the present one. And without the will or capacity to change the present state of the public health sector, the future of South Africa and its people is one of amplified poverty and segregation, of stagnated economic growth and development, and of a health care sector unable to care for its population on even the most primary level of health care.

8.1.2 Problems of Rural Health Care Provision

As previously stated, the majority of the HIV/AIDS infected people are black, poor and live in the rural areas of South Africa. Apart from limiting their partaking in private health insurance this also creates problems when trying to access public health care facilities. This has to do with the fact that hospitals most often are situated in urban areas, or when outside, in locations too far from a majority of the villages it is serving. In rural areas, clinics therefore usually take over the function of hospitals, but even they are too few to avoid long travelling hours to see a

nurse or a medical doctor, especially without any means of transportation. Often these clinics only employ nurses, making people reluctant to use these facilities in fear that the services that will be provided will not be as good as if medical doctors were performing them, which is not the general case. However, the largest problem in the provision of rural health care is the lack of infrastructure that prevents easy access to health care facilities, whether it is hospitals or clinics. The roads in the countryside consist of nothing but mud and are anything but smooth, and in rainy conditions it is impossible for transportation vehicles loaded with supplies to reach the rural clinics, or for ambulances to reach patients. Furthermore, the deplorable conditions in the countryside in terms of access to clean water, isolation from the towns and from other colleagues, and the lack of transportation makes nurses and medical doctors reluctant to work there – depopulating these areas of vital health care skills.

8.1.3 Home-Based Care

Home-based care can rectify some of the problems experienced in the public health sector since it provides care in the community in which the infected live. Because the caregivers most often live in the communities in which they work, they are able to form a more personal relationship with the patients than nurses and medical doctors. This benefits the patient's health as the caregiver can on a more personal level follow-up on symptoms and treatment, but also provide moral and spiritual support by praying or singing together. This is especially important in the countryside where faith in God is sometimes the only aid left to provide the infected with and can offer enormous comfort. The home-based care givers also work closely with the District Health System, providing them with a link of communication on community needs. This facilitates the rural clinics to know what the medical demand is in the community in terms of care and drugs, paving the way for a more effective outcome of health care services as they can be "tailored" to the needs of the community. Moreover, by activating and educating the whole community the home-based care givers can enhance the understanding of HIV/AIDS and contest the stigma and discrimination surrounding the infected. Having the support of family- and community members is many times equally important to patients as medical or spiritual support.

There are thus many benefits of home-based care. However, the detriments are of equal magnitude. Home-based care programmes within the public sector are just as exposed to

corruption and maladministration as other parts of the sector and in constant need for more allocated resources. Likewise are non-governmentally run home-based care programmes under-funded and resource lacking. However, the effectiveness of these programmes is not only mired by limited financial means but also of a lack of standardised policies and norms for the country as a whole. A difference in expected roles, working hours, training, payments, and integration between different NGOs or with the District Health System creates a fragmented outcome. Moreover, there appears to be the opinion among public health care officials that NGO run home-based care programmes should be incorporated within the public health sector, to then be “forced” to follow standards set up the government, whereas NGOs feel that a co-operation on equal terms would result in the best outcome for the poor. This lack of communication and common ground between the two has resulted in a rivalry over provincial government resources for home-based care programmes and a duplication of providing these services.

Many of the same difficulties experienced by the public health sector are also felt within home-based care programmes. The poor infrastructure prevent easy or even possible access to many of the villages in the community, resulting in areas being either without health care or only receiving visits very seldom. The higher patient load caused by the HIV/AIDS epidemic is resulting in greater geographical areas to cover for one caregiver and thus longer working hours as the transportation time increases. This affects the health of the patients as they receive fewer and shorter visits, but also creates a demoralised and stress related work atmosphere for the caregivers. Moreover, despite having an incredible drive and passion toward the work they perform, many caregivers work as volunteers – although sometimes receiving a small endowment – and without sufficient resources, appreciation and support it is hard to imagine that they will have the strength to continue in the same manner.

8.2 Recommendations

There is no straightforward or swift solution for the problems experienced in the health care sector in South Africa. The Public Service Accountability Monitor spent over five years collecting information on the health care crisis in the Eastern Cape, using every available channel for obtaining documents that had never been published before in order to both inform the general public, but more importantly to provide much needed recommendations to the

government. However, since the report came out in July 2004, it is too soon to see if there will be any effect of it yet.

In my search for the better choice between public health care and home-based care, all answers came back that the one could not do without the other. Hence it becomes apparent that the only solution for the best and most effective outcome of HIV/AIDS related health care for the poor is a partnership between the public health care sector and home-based care organisations in providing these services – on equal terms. This is of great importance because of the many flaws and failures in the public health care system of South Africa created by corruption and maladministration that would most likely infect NGO run home-based care programmes if they were to be incorporated within the public health care sector instead of being equal partners. A partnership could evaporate the fight over government resources for home-based care programmes and the duplication of the same services in the same area. It could also entail a system of information exchange and support, especially in relation to staff shortages, patient capacity and medical resources, between NGOs and the District Health System (since they are the providers of public health care in the provinces, see section 4.3) which could bring about a more effective outcome in terms of meeting the health care needs of the people in the rural areas. And in terms of future scenarios in South Africa in relation to HIV/AIDS, this is exactly what the health care sector should strive towards.

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