Rural Health Advocacy Project

Rural Proofing_ Lessons Learned

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South Africa : Country Context

- Constitutional democracy
- Chapter 2 lays out the bill of rights which includes the right to access health care services
- South African Health Act provides the legislative framework for the regulation and health care services in South Africa (Public and Private)
- Responsibility for Health is shared between National and the 9 Provincial Authorities with the latter responsible for delivery of publicly funded health care services
- Health care delivery is coordinated via a district health system which includes a network of 3500 primary health care clinics and district hospitals .
- These are augmented by a network of specialist hospitals , regional and provincial hospitals
- System very hospicentric with 61 percent of provincial health budgets spent on hospitals
- South Africa also has a large private health care sector that primarily serve the 16% of the population

Poverty and Inequality

- Despite its upper middle-income status South Africa is relatively poor country
- Amongst highest GINI coefficients in the world
- Bulk of the wealth and income concentrated in the 5 urban metro's
- Structural unemployment is key feature of SA labour market with up 60% unemployment amongst black youth and up to 90% of rural youth
- 38 % of the country's population lives in rural areas
- But not rural not the same with underdevelopment particularly severe in former homelands or Bantustans
- South Africa long been in a socio-economic crisis amplified by the persistent COVID pandemic

RHAP approach to Rural Proofing

- Introduced a rural proofing guidelines to inform better planning in 2015
- The guide using the WHO health systems components to assess the extent to which health policy responds to the rural implementation context
- The guide was used to rural proof the NHI health reform proposals and guided our submissions
- We have also trained district management teams in selected rural districts
- Attempts to have the guide institutionalized while generally accepted by stakeholders have been limited

Adapting our approach

- Health care services for the 85% of the population is funded from National Revenue
- Extended periods of low economic growth , increased debt obligations have resulted in health care expenditure not keeping pace with population growth and health need
- Planning is well developed but implementation and monitoring is weak
- The NHI district-based approach offered an opportunity to show rural need greater
- We adopted 3 (health management information systems, human resources for health , health financing) +2 (values and leadership) framework

Notable Successes

- Successfully advocated for the inclusion of sparsity indicators in the resource allocation decisions in provincial and district funding formula
- Successfully advocated for the inclusion of indicators to address the maldistribution of human resources for health
- Inclusions of rural proofing approaches in key policies such as the ward-based outreach teams
- RHAP has great networks with influence in both inside government and civil society
- RHAP is working on building a business case for a rural contracting unit for primary care as part of NHI reforms

Thank you

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