Rural Health
Advocacy Project

The Rural Health Advocacy Project's Oral Submission to the Competition Commission inquiry into the private health sector

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Who we are

The Rural Health Advocacy Project was established in 2009 as a partnership initiative between the Rural Doctors Association of Southern Africa (RuDASA), the Wits Centre for Rural Health (WCRH) and SECTION27. Our work revolves around the constitutional right of rural and remote communities to have equitable access to comprehensive, quality health care. Informed by the voices of rural health care workers and communities on the ground, the RHAP aims to facilitate self-advocacy, generate debate, monitor implementation of health policies in rural areas, support pro-equity government interventions, and influence decision-making that is in tune with local rural realities.

Why Rural Health

Rural communities have been estimated to make up approximately 38% of South Africa's population (World Bank, 2012). As with all people who live in South Africa these communities have a right to the progressive realisation of full access to quality, comprehensive health care under Section 27 of the South African Constitution (1996).

Yet in reality, the public health care system in rural areas is often under-resourced and access to quality healthcare is severely limited for many living in these often marginalised communities.

The relationship between poverty, poor health and healthcare outcomes has been well established; not only do poor people experience higher burdens of disease because of various social determinants, they also have less access to care (Peters *et al*, 2008). Research continues to show that this is particularly acute for rural populations, which tend to carry a disproportionate burden of both communicable and non-communicable diseases and across almost all indicators experience worse health outcomes.

While access to health care is not the only determinant of health it certainly plays a significant one. There are a number characteristics common to most rural health contexts that play a role in limiting access to health care services (Peters *et al,* 2008 and Kenny *et al.*, 2013). These include:

- Geographic accessibility: lack of transport to and from facilities
- Availability of healthcare: inequitable distribution of healthcare workers between rural and urban areas
- Acceptability: services are often not of an acceptable quality or acceptable based on social and cultural norms of the people accessing them
- Financial accessibility: Socioeconomic disadvantage of rural populations, additional and higher costs in seeking care, and lower levers of health insurance, which often means that rural people often cant afford to access care at all

Geographic access to health care—both the availability of and distance to—is amongst the most significant barriers to care rural communities face (Smith, 2001). In both developing and developed nations health care infrastructure, including both facilities and equipment, tend to be concentrated in urban centres.

Our starting point is that the impact of rurality on access to care is particularly pronounced in South Africa. This is largely because of persistent structural inequities caused by colonisation and apartheid when it comes to infrastructure, health care workers, and the means to improving social determinants of health.

What we do

We work from the premise that if access to care is to be promoted in rural settings then rural friendly policies must be adopted; there must be equitable and adequate financing for rural health; there must be sufficient, caring health workers; and implemetation of policy and the delivery of services must be effective and efficient.

In advocating for the fulfilment of the right to health in rural settings the RHAP uses evidence based research that focuses on four main areas:

- Rural Health Policy: do policies adequately meet the needs of rural populations?
- Rural Health Care Financing: are budgets allocated in a way that (i) address historical inequities in health infrastructure and personnel between urban and rural areas as well as between the public and privare sectors; (ii) adequately account for the health care needs of rural populations?
- Human Resources for Rural Health (HR4RH): (i)is there an adequate number and mix of health care workers woring in rural areas; (ii) is there an equitable distribution of healthcare workers between urban and rural areas; and (iii) are there sufficient mechanisims in policy and practice to attract and retain healthcare workers in rural areas?
- Rural policy implementation: are healtcare policies developed in such a way as to account for the unique needs of service provision in rural areas?

Our interest in the market inquiry

Generally the RHAP does not allocate a great deal of its time on researching the private sector. This is mainly because services in rural settings are largely accessed in public sector facilities. There is little private health sector presence in rural areas beyond a proportionally small number of General Practitioners (GPs) offering services in rural communities and the presence of some private pharmacies in small towns.

High levels of poverty and low levels of medical scheme membership in rural areas mean that there is little incentive for for-profit private sector providers to 'set-up-shop' in rural areas.

We are, however, acutely aware of the fact that the proceedings of the inquiry and its findings could have significant implications for the transformation of the health system under the National Health Insurance Process. In this regard, the Commissions findings could have implications for how private providers are integrated into the NHI and on what basis they will provide services to public sector patients.

It is with this longer-term reform process in mind that we make this oral submission. Our submission will focus primarily on how the absence of clear regulation and controls on the distribution and rationing of health care services in private sector sustains and could potentially exacerbate inequity in access to health care.

We start by highlighting the virtual absence of private sector provision, particularly hospital and specialised care, in rural settings. We will then highlight how the high concentration of private hospitals in urban settings could be said to amount to over servicing of private patients (an issue that seems to be increasing). We also highlight how access to specialised care for public patients, particularly in rural areas, is actually declining.

We end our submission by presenting a scenario where if private sector service provision is not meaningfully regulated, particularly in private hospitals and by specialists, opening this care to public sector patients under the NHI could actually deepen geographical inequities in access to services. So while urban residents will have greater access to care and private sector hospital groups will have a larger client base to draw from, access in rural settings where no private infrastructure exists will continue to decline.

Our general point is that health care cannot be treated as a commodity like any other and evidence from virtually every developed and middle-income country shows that increasing regulation and intervention in the 'market' is necessary. This is especially true where the progressive realisation of the right to have access to health care is enshrined in the constitution and that overcoming

historical inequities in access to care is a constitutional imperative. An imperative that may place limitations on Constitutional clauses relating to the freedom of association and right to property—although this assertion needs to be tested.

[ENDS]