South Africa's health system
What are the gaps?

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Features of SA health system

- "Quadruple" burden of disease (Mayosi et al, 2009)
  - communicable diseases
    - e.g. tuberculosis and HIV/AIDS
  - growing burden of non-communicable diseases
    - e.g. diabetes and cardiovascular disease
  - injuries of which many are due to interpersonal violence
  - underdevelopment and associated maternal and child health problems

Features of SA health system

- Total health expenditure was 8.7% of GDP in 2011
- Total government expenditure on health 12.7% of total government expenditure
- Large gap in expenditure between the public and private health sectors in South Africa
- Government expenditure is 47.7%
- Private health expenditure is 52.3%
  - private health insurance accounting for 81.1% of private health expenditure

Features of SA health system

- 16 /17% of South Africas covered by health insurance
- Uninsured mainly utilise public healthcare services
- But even amongst the poorest quintile of households about 20% access private healthcare services (Burger, Bredenkamp, Grobler & Van der Berg, 2012).

Tracking progress

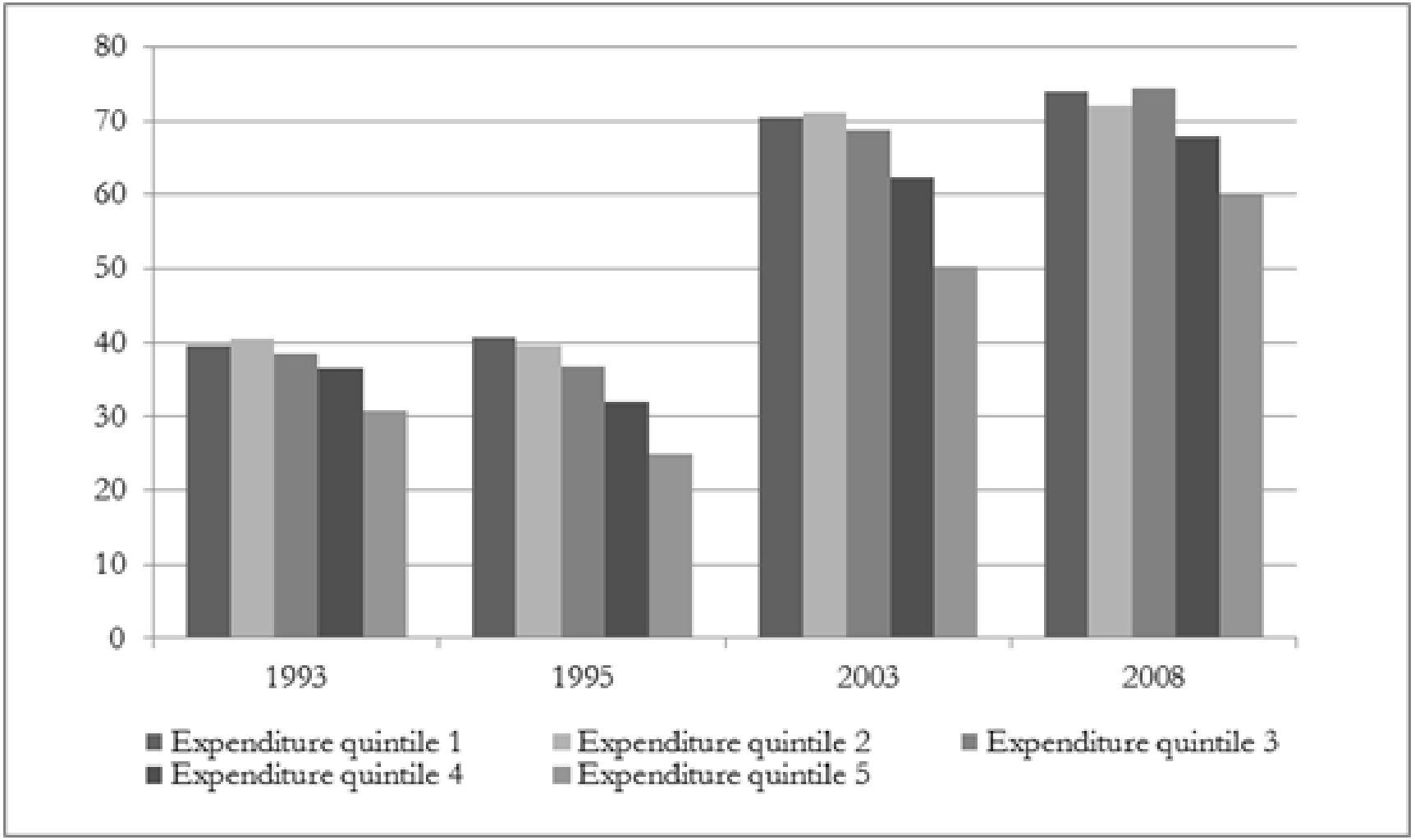
- Medical Schemes Act of 1998
  - risk-rating to community rating (only allowed to differentiate price based on income, number of lives covered and the type of dependent)
  - “prescribed minimum benefits”, requiring medical schemes to cover a list of chronic and accidental conditions and their treatments at full cost
  - accreditation of brokers and the regulation of their commissions

Tracking progress

- Since the political transition in 1994, much effort has been invested in improving health outcomes by making public health care more accessible to the poor
  - **Affordability:** free care for pregnant mothers and young children in 1994 and free primary health care for all in 1996
  - **Travel distance:** Since 1994 the primary health care facility network has been expanded, with more than 1300 clinics built or upgraded

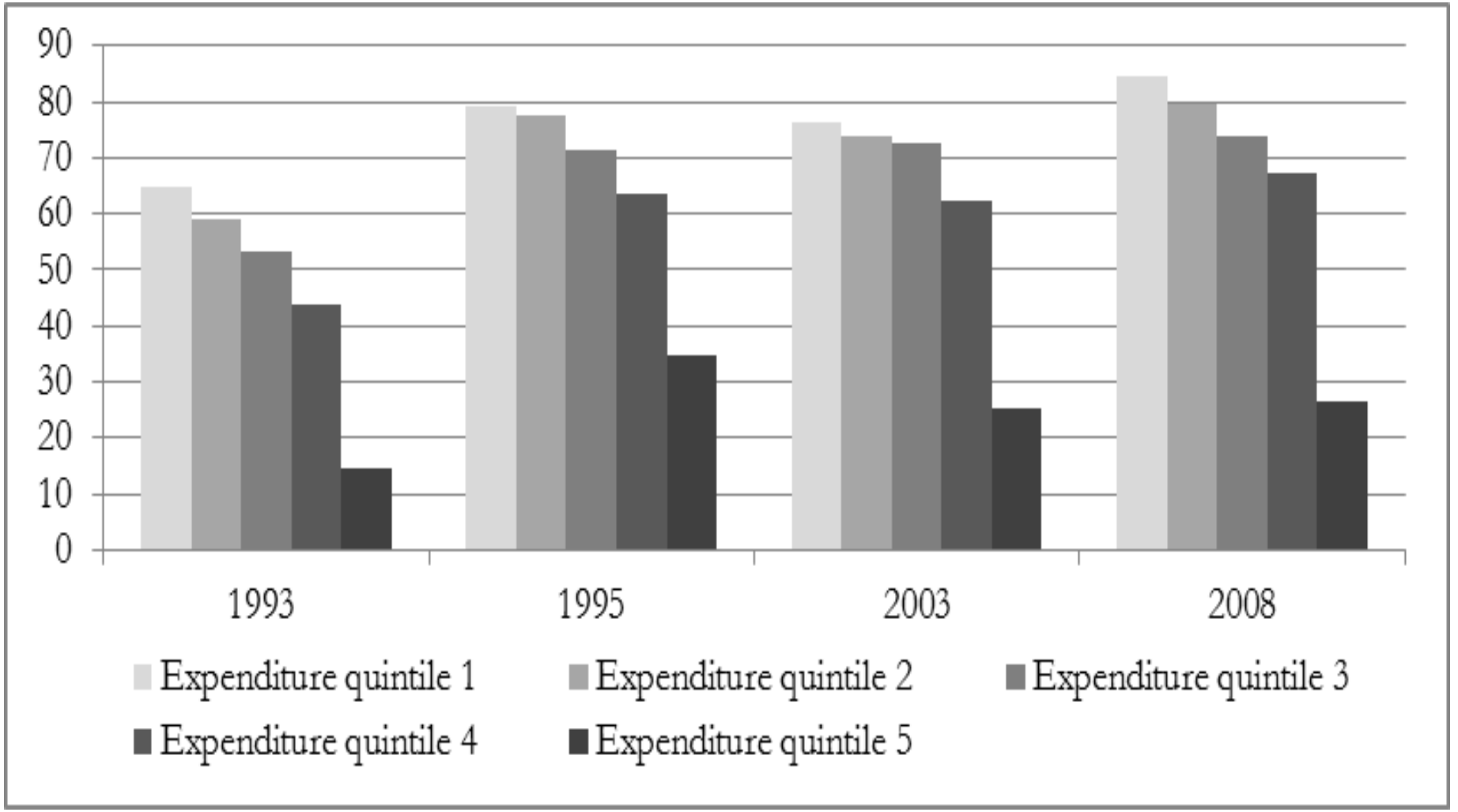
Tracking progress

Share of clinics in total utilisation of public health facilities, by per capita household expenditure quintile, 1993–2008



Tracking progress

Share of public health care facilities in total health care utilisation, by per capita household expenditure quintile, 1995–2008



Tracking progress

- Real per capita public expenditure on health has increased over this period
- To improve equity, budget allocations have been shifted towards historically poorly endowed provinces and, within provinces, particularly to primary health care
- In 2000 the government was spending just over R2 on primary care for every R10 it spent on hospitals but by 2007 the rate was R3 for every R10
- This shift was achieved by both increasing the share of the health budget allocated to primary care and reducing the share allocated to hospitals.

Affordability

- Much progress has been made on affordability
- Decline in affordability ratios between 1993 and 2003
- Relatively low prevalence of catastrophic expenditure
- Some may be “falling through the cracks” e.g. those who need to pay for public hospital visits, but are too poor to afford insurance
- But on the whole this does not appear to be an important constraint at current levels
- According to latest GHS only 4% of users decide to not consult a health worker when they were ill because of affordability concerns

Affordability

Average affordability ratios for the uninsured by per capita household expenditure quintile, 1993 – 2008 (%)

Per capita household expenditure quintiles	1993	1995	2000	2005	2008
Poorest 20%	1.5	1.0	1.1	2.8	4.0
Quintile 2	0.8	0.9	1.3	2.4	2.9
Quintile 3	0.7	0.8	1.3	2.2	2.1
Quintile 4	1.0	0.8	1.2	1.7	2.0
Most affluent 20%	2.4	1.3	1.2	1.5	1.7
Total	1.3	0.9	1.2	2.3	2.7

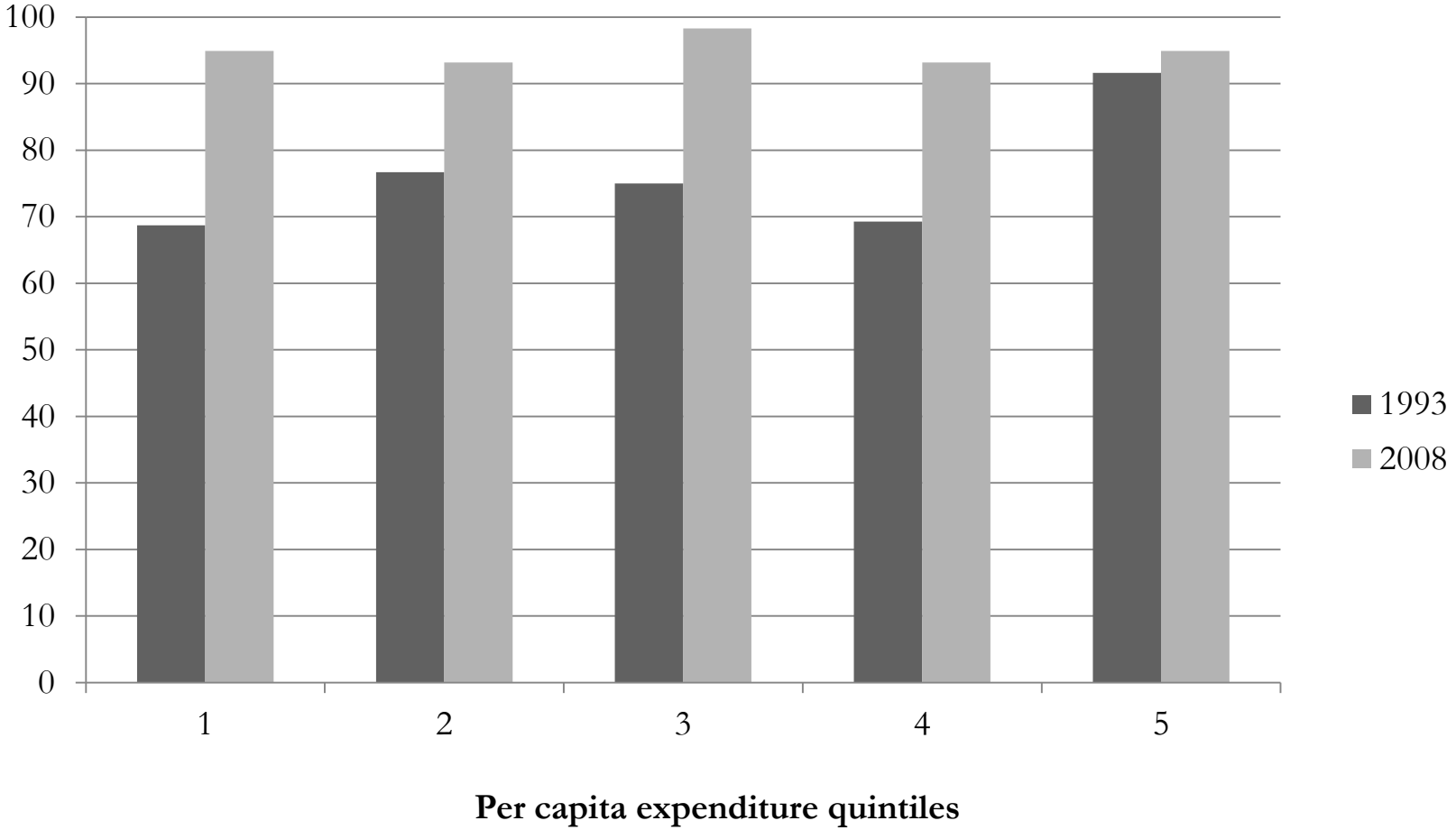
Note: This analysis uses the PSLSD 1993, the 1995, 2000 and 2005 IES surveys and the 2008 NIDS. Estimates do not include health insurance and thus only reflect direct out-of-pocket payments for health services, medicine and medical supplies. Affordability ratios express health expenditure for households as a share of their non-food expenditure

Affordability

Prevalence of catastrophic expenditure for the uninsured by per capita expenditure quintiles, 1993 - 2008 (%)					
Per capita household expenditure quintiles	1993	1995	2000	2005	2008
Poorest 20%	2.8	1.2	1.6	4.0	8.3
Quintile 2	2.7	1.2	2.2	2.1	6.6
Quintile 3	2.9	0.7	1.8	2.2	8.0
Quintile 4	4.3	0.7	1.5	1.7	5.7
Most affluent 20%	7.6	2.0	2.1	0.8	4.7
Total	4.1	1.1	1.8	2.3	7.1

Note: This analysis uses the PSLSD 1993, the 1995, 2000 and 2005 IES surveys and the 2008 NIDS. “Catastrophic expenditure” is here defined as health expenditure per annum exceeding 10% of non-food expenditure. O’Donnell et al. (2008) recommend a threshold of 10%, when defined relative to total household expenditure, and 40% when defined relative to expenditure minus nondiscretionary expenses (which is usually taken to mean non-food expenditure). By these measures, the incidence of catastrophic expenditure is virtually zero. These estimates are only slightly below the ratios reported by McIntyre and Ataguba (2009). They are also in line with the findings of Xu et al. (2003).

Private provider share of out-of-pocket expenditure by per capita household expenditure quintile, 1993 and 2008

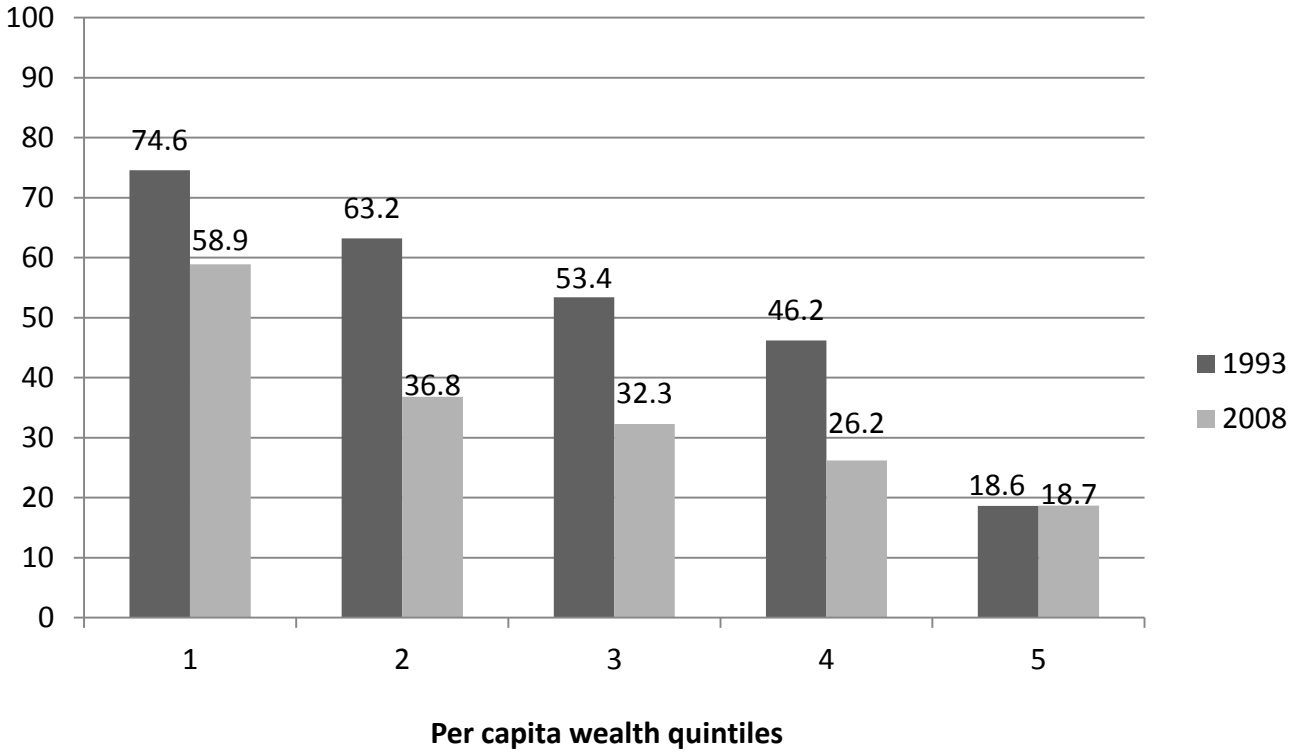


Travel time and costs

- Considerable improvement in travel time to clinics
- Also see that travel to clinics no longer a major constraint in terms of acute care
- According to Smith et al. (1999) the proportion of black respondents who travelled less than 15 minutes to their closest public health facility rose from 36% to 54% between 1995 and 1998.
- According to latest GHS only 1% of users reported that they did not consult a health worker when they were ill due to the distance of travel to the closest facility
- May be impediment to preventative and chronic care

Travel time

More than 30 minutes travel time to the closest public health facility by per capita wealth quintile, 1993 & 2008

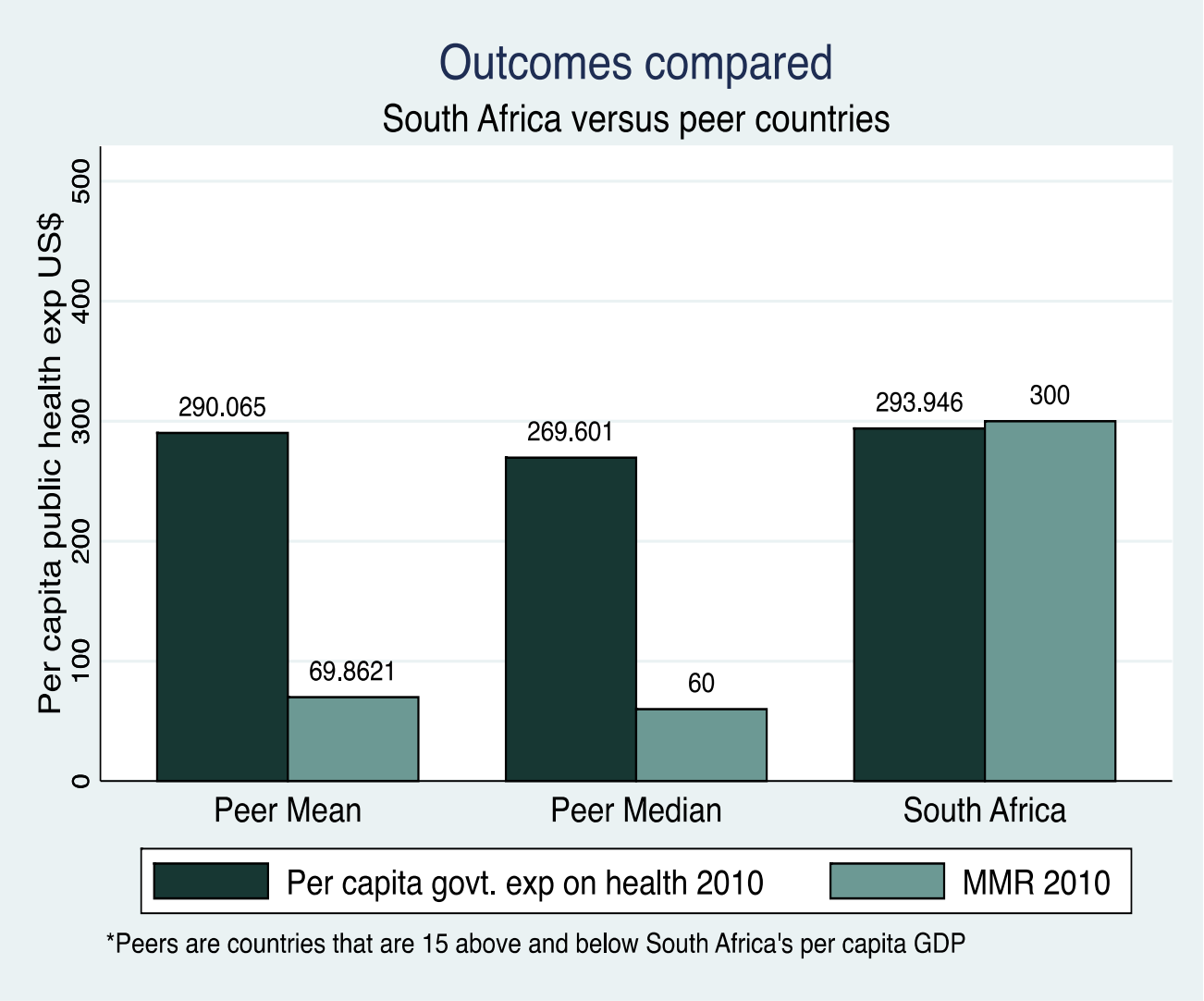


Source: 1993 PLSD and 2008 GHS.

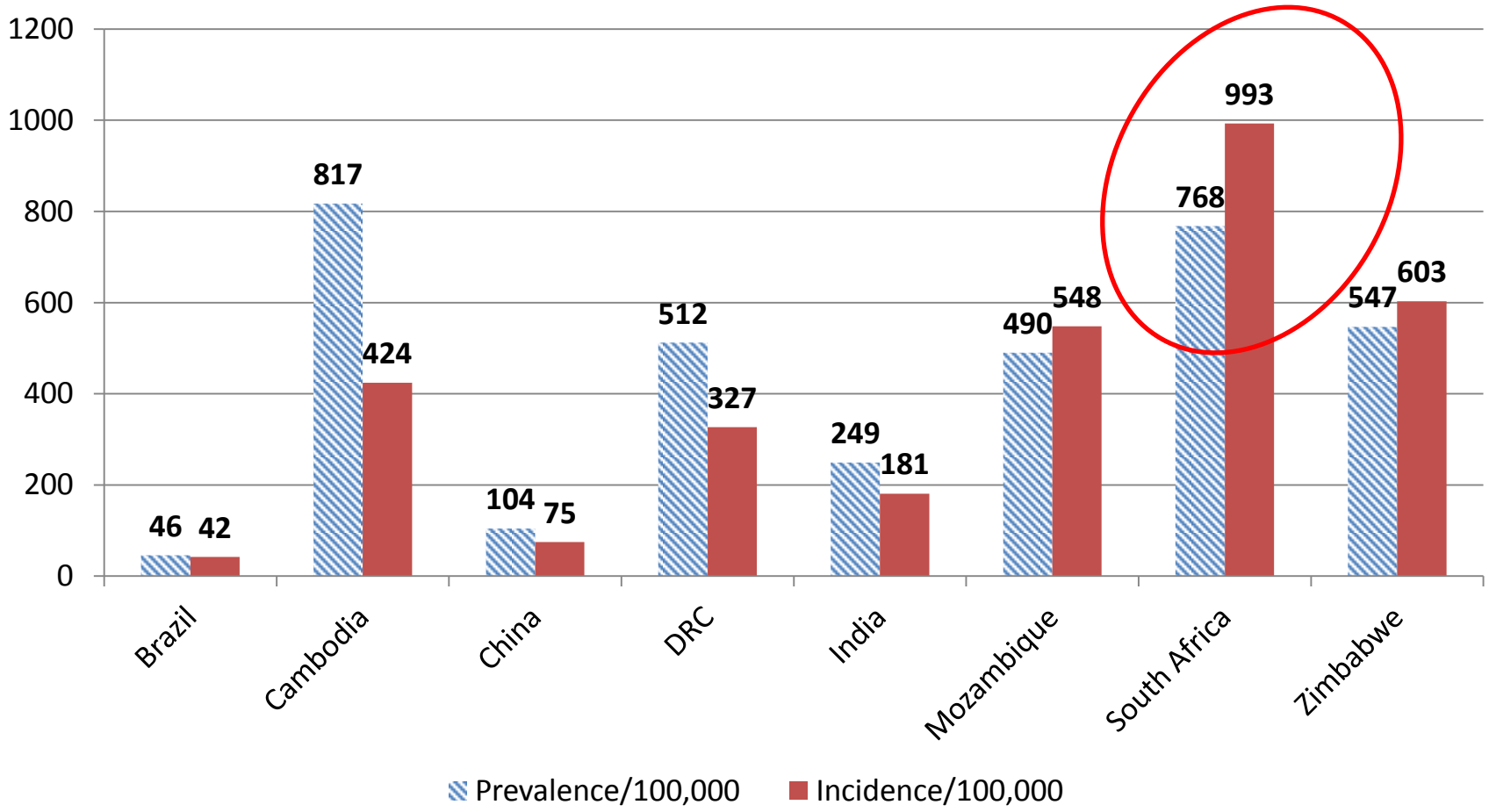
Quality of care: user acceptability

- High utilisation of private providers amongst individuals in poorest quintile of households
- Work on GEMS as natural experiment also clearly shows strong move away from clinics and towards private GPs when low income households receive insurance
- GHSes show high proportion of users complain about
    - long waiting times
    - availability of prescribed drugs
    - staff attitudes
- Same complaints surface in focus groups, exit interviews (Schneider and Palmer, 2002; Palmer, 1997), but also few others
    - perceptions of inferior service
    - a lack of power due to absence of the payment mechanism

Effectiveness/quality: maternal mortality rates



Effectiveness/quality: TB treatment performance



Source: WHO Global Tuberculosis report 2012

Planned reforms under NHI

- The majority of health expenditure in South Africa to occur through a single payer NHI system
  - pooling funds from general taxes and mandatory NHI contributions
  - contracting with both public and private providers for the delivery of healthcare services
- Re-engineering of the existing primary healthcare system to deliver services through
  - district- based clinical support specialist teams
  - school-based primary healthcare services and
  - “municipal ward-based primary healthcare agents” (i.e. community healthcare workers)

Planned reforms under NHI

- All public health facilities will be accredited to enable contracting with the NHI
- Introduction of a coding system to allow for better cost management and contracting
- Reimbursement to primary (including private) providers to occur on a capitation basis
- Hospitals to receive global budgets
- No co-payments for services rendered within the defined minimum benefit package to South Africans

Affordability

Prohibitive cost cited as reason for not consulting a health worker, 1993 – 2009 (%)				
Wealth quintiles	1993	2002	2005	2008
Poorest 20%	8.9	8.7	5.1	3.7
Quintile 2	8.7	6.5	4.0	2.5
Quintile 3	7.5	5.7	3.8	2.6
Quintile 4	5.2	5.3	3.7	3.4
Wealthiest 20%	2.7	3.3	1.4	1.2
Total	6.2	5.9	3.6	2.7

Notes: Due to the lack of expenditure data in the GHS surveys, an asset index was estimated in the PSLSD and the GHSs using a set of 10 overlapping household assets and characteristic to create asset quintiles. The 2002, 2005 and 2008 estimates are from the GHS and from identical questions, but the 1993 estimates are from the PSLSD where the question was different and other responses categories were provided.