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MONITORING THE RIGHT OF ACCESS TO HEALTH CARE IN SOUTH AFRICA

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An analysis of health budgets and indicators

Monitoring the Progressive Realisation
of Socio-Economic Rights Project

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Stephanie Brockerhoff 'A Review of the Development of Social Security Policy in South Africa' (2013) Studies in Poverty and Inequality Institute, *Working Paper 6*.

PREFACE

The Studies in Poverty and Inequality Institute (SPII) is an independent research think tank that focuses on generating new knowledge, information and analysis in the field of poverty and inequality studies.

The working paper has been undertaken as part of the 'Monitoring the progressive realisation of socio-economic rights' project conducted by SPII with the support of Foundation for Human Rights and the endorsement from the South African Human Rights Commission (SAHRC). The objective of this project through the combination of policy and budget analysis and statistical indicators is to provide a comprehensive framework and set of tools to monitor the progressive realisation of socio-economic rights. It is hoped that this project will be a useful tool for policy makers, for those that exercise oversight over the executive, including Parliament and Chapter Nine institutions (notably the SAHRC), and civil society.

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Contents

KEY FINDINGS

ABBREVIATIONS

ART	Anti-retroviral treatment
ASSA	Actuarial Society of South Africa
CPI	Consumer price index
DHB	District Health Barometer
DoH	Department of Health
DPME	Department for Performance, Monitoring and Evaluation
HAART	Highly Active Anti-Retroviral Therapy
ICESCR	International Covenant on Economic, Social and Cultural Rights (ICESCR)
MTSF	Medium Term Strategic Plan
NHI	National Health Insurance
NIDS	National Income Dynamics Survey
NSDA	Negotiated Service Delivery Agreement
PCR	Polymerase chain reaction
RHAP	Rural Health Advocacy Project
RuReSa	Rural Rehab South Africa
Stats SA	Statistics South Africa
TAC	Treatment Action Campaign
TB	Tuberculosis

LIST OF FIGURES:

LIST OF INDICATORS:

LIST OF INDICATORS:

CHAPTER ONE:
BUDGETING FOR HEALTH CARE IN SOUTH AFRICA

> 'The long-term challenges in South Africa are to narrow disparities in wealth, health, and education and to generate opportunities for many more people to survive childhood, reach their full human potential, and lead healthy, productive lives… short-term measures should include strengthening public health care services, improving resource-allocation policies, and training an appropriate balance of health care professionals.[1]
>
> *New England Journal of Medicine*

1.1 INTRODUCTION

The right to access to health care is one of several fundamentally transformative socio-economic rights provided for in the South African Constitution. Section 27 (1)(a) of the Bill of Rights in the Constitution states that, 'Everyone has the right to have access to health care services, including reproductive health care.'[2] This constitutional right is bolstered by the International Covenant on Economic, Social and Cultural Rights (ICESCR), which South Africa ratified in 2016. In Article 12 of the ICESCR it is echoed that everyone has the right, '…to the enjoyment of the highest attainable standard of physical and mental health.'[3]

Quality health care is imperative for any country's development as it has significant implications for the improvement of people's living standard. South Africa's public health care system has been plagued by challenges since the dawn of democracy in 1994, not least in the early 2000s, when South Africa became the epicentre of a global HIV and AIDS pandemic, which was by then the leading cause of death in sub-Saharan Africa. Government's response to the crisis at the time was riddled in controversy. Characterised by what have become the well documented denialism and refusal by government to roll out the provision of anti-retroviral treatment, especially to reduce the mother-to-child transmission of HIV. It has been argued that the government was recklessly and directly responsible for untold loss of life during the decade which followed.

More recently, the public health system has struggled with medicinal stock-outs in provinces such as the Free State, medical specialist shortages, as recently witnessed in Kwa-Zulu Natal, collapsing infrastructure and ever tightening budgets in an environment of low economic growth. In what has been described as "the greatest cause of human rights violation since the dawn of our democracy,"[4] more than 118 psychiatric patients recently lost their lives when the Gauteng Department of Health ended its contract with the private service provider which had been providing care for the patients in a cost-cutting attempt. The patients were transferred to various NGOs not qualified or resourced to provide the requisite care, resulting in extreme neglect, insufficient and rotten food, exposure to cold, lack of medication, overcrowding, abuse, and death. South Africa's health care service clearly still faces very real challenges.

FOOTNOTES:

1. Mayosi, B.M and Benatar, S.R. The New England Journal of Medicine (2014), Health and Healthcare in South Africa- 20 Years after Mandela. Available at: http://www.nejm.org/doi/full/10.1056/NEJMsr1405012
2. The Constitution of the Republic of South Africa, Act 108 of 1996.
3. World Health Organisation (Health and Human Rights). International Covenant on Economic, Social and Cultural Rights. Available at: http://www.who.int/hhr/Economic_social_cultural.pdf
4. Bornman, J. (2017). 'Life Esidimeni: The greatest cause of human right violations since democracy' in Mail & Guardian.

The right of access to health care is enshrined in the Constitution. In other words, the state is obliged to progressively realise the universal right of access to all in South Africa. Admittedly, the post-apartheid government inherited a fragmented two-tiered system that bred- and continues to breed- inequality between different race and class groupings in the country. The public health care system carries the burden of providing services to almost 84% (overwhelmingly poor and black) of South Africa's population, while a smaller proportion of the population (overwhelmingly well-off and white) benefit from immediate access to health care professionals and relevant technological resources through the private health care sector.[5] It is for this reason that, unless otherwise stated, the findings in this report refer to South Africa's public health care services.

In 2007, the South African Human Rights Commission conducted public hearings on the right to health care after receiving numerous complaints with regard to poor health care service delivery throughout all provinces in South Africa.[6] The Commission found poverty to be 'the main over-all inhibitor to accessing health care services.'[7] It was found that inequalities between private and public health care expenditure, staff shortages and stressful conditions, lack of resources and discriminatory attitudes towards vulnerable groups were the main limitations to the full realisation of the right to basic health care.[8]

As articulated in the statistical indicators in Chapter 3 of this paper, despite poor services, vulnerable groups such as those in rural areas will express satisfaction with state services. Results from subjective satisfaction ratings on the quality of public health services overestimate client satisfaction particularly among the visitors of public clinics in rural areas.[9] Often these clients are accustomed to lower service standards and therefore have lower levels of expectations of quality standards compared to more affluent clients in urban areas. This shows South Africa's failure in addressing its apartheid history which continues to impact vast disparities in quality of and access to services in poor rural areas compared to urban parts of the country.

Despite persistent challenges, government has made great strides in increasing access to health care, and continues to increase funding (although in recent years to a less degree) for public health care expenditure (see Chapter 2 of this paper). From 2009, the state strengthened its efforts towards addressing the HIV and AIDS pandemic in the country, by allocating more resources in the form of the Comprehensive HIV/AIDS conditional grant. The spending of this grant has also shown positive trends, which has resulted in real changes on the ground. New HIV infections, HIV incidence and deaths due to AIDS have all fallen dramatically since the early 2000s.

In the Chapters that follow, we further unpack the progressive realisation of access to health care services, and shed light on the gains and losses made by the South African state in this regard. Through a human rights analysis of the state's policy and budgetary efforts with regard to health care, and a statistical exploration of the enjoyment of health care services in people's lives, we profile South Africa's shifting epidemiological mortality profile, the implications for government with regard to non-communicable diseases and HIV, TB and other communicable diseases. We also provide a detailed account of, amongst others, mother and children's access to and experience of health care services.

It should be noted at the outset that one important dimension to the health care system which we have been unable to address in this paper, and which should remain central to our continued monitoring of the right to health care services in the future, concerns disability. We were unable to source publically and freely available data concerning the access of people living with disabilities to health care services, as well as the adequacy of those services and their effect on people's quality of life. One crucial advocacy agenda, as a result, concerns more readily accessible data regarding the health care services available to people living with disabilities in South Africa.

FOOTNOTES:

5. Marius Pieterse (2014) The impact of human rights litigation on South Africa's health system, 120.
6. South African Human Rights Commission, National Human Rights Institution Report (2011). Initiatives that exemplify good or effective practices in adopting a human rights based approach to eliminating preventable maternal mortality and morbidity. Available at: http://www2.ohchr.org/english/issues/women/docs/responses/South_African_Human_Rights_Commission.pdf
7. ibid
8. ibid
9. Ronelle Burger R., Ranchod S., Rossouw L., Smith A. 2016. 'Strengthening the measurement of quality of care.' in: Padarath A, King J, Mackie E, Casciola J (eds) South African Health Review 2016. Durban: Health Systems Trust: 191.

Nevertheless, the 2016 Community Survey updates data on the **number of people with disabilities** from the 2011 census. The data showed that about 7.7% of the population above 5 years is living with one or several disablities. This is a slight increase compard to 7.5% in 2011. Free State (11%) had the highest disability prevalence while the Western Cape had the lowest rate (6.3%).

Comparing disability prevalence with the total number of **recipients of a disability or a child dependency grant** shows great differences among provinces. While disability prevalence is about 11% both in Free State and the Northern Cape, the number of people who receive disability related social grants per 1 000 population is much lower in the Free State (28) compared to the Northern Cape (47). Western Cape has the lowest disability prevalence in the country but has a relatively high number of recipients of disability related grants (26 per 1 000 population) compared to other provinces. More research is required to better understand whether differences among provinces are related to barriers to claim disability related grants or whether they are due to the different types and degrees of disabilities.

We hope that this report will be used extensively by policy makers, oversight actors, Chapter Nine institutions and ordinary women and men who wish to learn more about their rights and the health of our nation.

The rest of this chapter explores SPII's unique three step methodology to monitoring the progressive realisation of rights, as well as providing an overview of the South African government's policy efforts with regard to health care services. Chapter 2 examines health care allocations and expenditure from a human rights perspective. Chapter 3 sets out the statistical indicators that we have developed and populated indicating enjoyment of the right.

The final chapter contains our key findings, recommendations and conclusions.

1.2 THE SOCIO-ECONOMIC RIGHTS MONITORING TOOL

SPII has developed a three step methodology to offer clarity on the progressive realisation of socio-economic rights and bolster advocacy efforts in this regard. These steps include an analysis of the policy effort (Step 1) and the allocation and expenditure of resources for specific rights (Step 2). These two steps assist in monitoring and evaluating the attainment of rights (Step 3) on the ground through specific outcome indicators.

A summary of the three steps is provided below.

STEP 1: ANALYSE THE POLICY EFFORT

The first step of the analysis takes a closer look at the underlying policies and legislation guiding the realisation of socio-economic rights (SERs). This step firstly assesses whether the actual content of social and economic policies adequately reflects the **Constitution and international treaty obligations** and international standards that the State has ratified.

Secondly, this step evaluates both the **content and implementation** of existing legislation, policy frameworks and government programmes to assess what gaps (in principle and in practice) exist. This assessment is based upon a fundamental human rights framework that includes non-discrimination, gender sensitivity, dignity, participation, transparency and progressive realisation.

An important component of evaluating the policy effort is an assessment of the **policy making process** in terms of transparency and public participation in decision-making by the relevant civil society organisations and communities specifically affected by the policy under review. Another important dimension is to analyse the departmental responsibilities and institutional arrangements to assess the **capacity challenges and accountability mechanisms** currently in place.

STEP 2: ASSESS RESOURCE ALLOCATION & EXPENDITURE

The second step assesses the reasonableness of the budgetary priorities in light of the obligations on the State and human right principles and standards. This requires an analysis of firstly, the **generation of government revenue.**

Secondly, an analysis of the allocation and expenditure of such resources to reduce disparities, prioritise the most vulnerable and disadvantaged groups, and progressively realise SERs, must take place. This step uses various budget analysis techniques to monitor planned (i.e. budget allocations) and actual resource expenditures at both national and provincial levels and therefore assesses the delivery and implementation of government policy and programmes as they relate to the realisation of rights.

Thirdly, an analysis of the **budget cycle process** from the perspective of human rights principles of participation, non-discrimination, transparency and accountability. An assessment of resource availability cannot be separated from an analysis of institutional arrangements, human resources and local capacity which are necessary for the efficient and effective spending of budgets.

STEP 3: EVALUATE & MONITOR ATTAINMENT OF SERs

The third step measures the enjoyment of rights by rights holders and therefore monitors and evaluates the State's obligation to fulfil the realisation of SERs. This step evaluates the State's performance via the development of statistical indicators which provide a clearer and more specific illustration of SERs enjoyment on the ground over time. The outcome indicators make reference to the three dimensions of access (physical and economic), quality and adequacy over time. This requires that quantifiable and replicable indicators (proxies for the different dimensions of SERs) be developed along with agreed benchmarks and targets.

The indicators need to be aligned to data that is freely and easily available in annual surveys and data sets, and must be capable of being decomposed (disaggregated) by region, race, gender and age – wherever possible and useful. This allows disparities between e.g. different population groups or geographical region to be identified, and an assessment of the extent to which progress has been made over time.

The 3-step methodology provides a comprehensive framework from which to monitor and assess progress made to date.

The purpose of the tool, however, goes beyond constitutional compliance and aims to achieve specific objectives:

- Clarify and unpack the **content of the SERs** and the **obligations on the State** to ensure access to and enjoyment of SERs is continuously broadened.

- Determine the extent to which organs of the State have respected, protected, promoted and fulfilled their obligations. This involves identifying achievements, deprivations, disparities, and regression to illuminate both **causation and accountability** in terms of policies, resources spent, implementation and institutional capacity.

- Provide **evidence** for **advocacy initiatives** and **legal interventions**, and make **recommendations** that will ensure the protection, development and universal enjoyment of SERs.

In this report, the progressive realisation of the right to access to health care will be assessed.

1.3 OVERVIEW OF THE SOUTH AFRICAN GOVERNMENT'S POLICY EFFORTS

One of the most significant strides made by the newly elected ANC government in 1994 to turnaround the status quo was the introduction of the **Reconstruction and Development Programme (RDP)**.[10] This was the ANC's first policy document after the demise of apartheid. The RDP articulated a developmental and redistributive vision for the new democratic dispensation. This policy also crafted plans for programmes that would provide access to basic needs, such as water, education, electricity, telecommunications, transport, housing and health care.[11] In particular, the RDP policy called for a complete transformation of the health system. This meant past discriminatory legislation would have to be reviewed and abolished; institutions and organisations formed during apartheid would have to be reorganised, and most importantly, the government needed to develop and adopt practices that would be seen to be in line with the agreed international norms and standards.

The RDP made provision for programmes and initiatives that promoted equality through the redistribution of resources in an effort to redress the injustices of the past. The RDP envisioned a health system which provided: free health care at public clinics and health centres for children under the age of six; quality antenatal, delivery and postnatal services for free in government hospitals and clinics in the third year after the introduction of the RDP, in order to improve maternal and child health outcomes. Early treatment of Sexually Transmitted Diseases (STDs) and HIV related illnesses at all health facilities was encouraged and promoted alongside improved access to 24-hour emergency health care services for communities, including access to ambulance services, especially in rural areas.[12] However, soon after some of these programmes were introduced, the RDP ran into serious trouble. Implementation became a challenge due to capacity constraints in government, hostile bureaucrats and unreliable private sector partners.[13]These challenges have persisted 20-years into democracy. To continue with the ideals of the RDP and provide universal access to health care, the notion of National Health Insurance was introduced in 2011.

The government released a policy paper that put forth recommendations for a comprehensive National Health Insurance (NHI) that would be rolled out over a period of fourteen years, beginning with a five year pilot in ten selected districts in 2012.

FOOTNOTES:

10. ANC, 1994. The Reconstruction and Development Programme: A policy framework. Umanyano Publications, Johannesburg.
11. Ibid, p.6
12. Ibid.
13. Wessel, V. Shifting RDP into GEAR: The ANC government's dilemma in providing an equitable system of social security for the 'new' South Africa. Paper presented at the 40th ITH Linzer Konferenz, 17 September 2004.

The overarching objective of the NHI is to bring about reform in the present health care system which remains fragmented, both within the public health sector and between the public and private sector, and is skewed to benefit only a privileged minority. By making quality health care affordable and accessible to all, the NHI aims to challenge the status quo in the present health system by providing non-discriminatory public health care to all South Africans regardless of their socio-economic status. In theory this has the makings of a progressive pro-poor policy and if implemented effectively would improve the livelihoods of many destitute South Africans who are currently not able to afford quality private health care.[14]

Budget developments on the NHI direct conditional grant to provinces, provided in Chapter 2 of this paper, show erratic allocation and expenditure trends. Very little is allocated to provinces towards the objectives of the NHI and provinces are not able to fully utilise these funds. What is positive, according to the New England Journal of Medicine is that, health economists have suggested that it would be feasible to raise the additional required funding to roll-out the NHI comprehensively.[15]

FOOTNOTES:

14. For more extensive policy review on the right to health care, see:
15. Mayosi, B.M and Benatar, S.R. The New England Journal of Medicine (2014), Health and Healthcare in South Africa- 20 Years after Mandela. Available at: http://www.nejm.org/doi/full/10.1056/NEJMsr1405012

2.1 INTRODUCTION

The best laws and policies on health care are meaningless if they are not backed by sufficient resource allocations in respective government budgets. The passage of laws and adoption of policies should, in terms of basic principles of good governance, be accompanied with costing analyses that help to predict implementation costs and inform budgeting processes.

Budget documents reveal how government intends to raise funds and how to spend them. Budgets also show how much was spent on what in previous years. It is possible to see whether government institutions stuck to spending plans, how they re-allocated funds, and whether they under or overspent. The analysis of budget and expenditure trends is critical to hold governments accountable to whether public resources are allocated and spent in line with policy priorities such as those set out in the National Development Plan 2030 [16], and the parliamentary adoption of annual budgets as voted in terms of the Division of Revenue Acts (DoRA).

Section 27(2) of the Constitution obliges the state to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation" of everyone's right to have access to health care services.[17] The International Covenant on Economic, Social and Cultural Rights (ICESCR), to which standards South Africa legally bound itself in 2015, even sets a stricter benchmark and requires the use of "maximum available resources".[18]

This section of the paper will provide an analysis of both national and provincial budget allocation and expenditure trends and how these contribute to the progressive realisation of access to health care in South Africa.

Budgetary trends and inflation

To assess whether the progressive realisation of the right to health care is reflected in budgetary decisions it is important to assess whether allocations to the health sector and its programmes grew in real terms, meaning above the inflation rate. If budgets increase below the inflation rate they are in fact shrinking, which is a prima facie indication of regress, and merits overview in terms of the state's obligations of progressive realisation. Government documents often only refer to nominal amounts without taking inflation into account. Whenever relevant, budget and expenditure amounts from previous budget cycles will therefore be adjusted to 2016 price levels in this paper. In South Africa, the most widely used measurement of general inflation is the Consumer Price Index (CPI), which is updated and published regularly by Statistics South Africa (StatsSA).[19]

Data sources

To be replicable and easy to update the analysis of budgets and expenditure data is kept as simple as possible, yet sufficiently detailed to allow for an assessment from a human rights perspective. All data used in this budget analysis is publicly available and can be accessed on the website of the National Treasury.[20]

FOOTNOTES:

16. National Planning Commission (2011) National Development Plan Vision for 2030. Pretoria: National Planning Commission. Available at: http://www.npconline.co.za/medialib/downloads/home/NPC%20National%20Development%20Plan%20Vision%202030%20lores.pdf.
17. Constitution of the Republic of South Africa, 1996. See: www.thepresidency.gov.za/docs/reports/annual/2008/preamble.pdf.
18. International Covenant on Economic, Social and Cultural Rights (ICESCR) ILM 360 (1967); 993 UNTS 3 adopted on 16 December 1966, ratified by the South African Government on 12 January 2015 and entered into force on 12 April 2015.
19. Statistics South Africa (2017) CPI headline index numbers. Available at: http://www.statssa.gov.za/publications/P0141/CPIHistory.pdf
20. See: www.treasury.gov.za

To assess whether the government has used its available resources effectively and reasonably towards the progressive realisation of the right to health care in South Africa this chapter will address following questions:

Did the government raise sufficient resources? What resources are available to the government? Did the government raise sufficient resources through taxes and revenue collection? Did the government manage to generate sufficient resources through progressive fiscal and tax policies?

Did the government allocate adequate resources to the health sector? Did the national and provincial governments allocate sufficient resources to the various health programmes, hospital, clinics etc. so that they can fulfil their respective roles and responsibilities? Are budget and expenditure trends growing faster than the inflation rate over time? Are spending cuts reasonable and justifiable (and have they formally been justified?) from a human rights-perspective?

Did the government allocate resources to different programmes and areas in an equitable manner? Are resources being utilised to prioritise the needs of the most vulnerable and disadvantaged? Is the spread of resources across departments, spheres of government and geographic localities fair and justified?

Did the government spend resources in the health sector in an efficient way? Are institutions capable to spend the funds allocated to them in a cost-effective manner? Are funds being accounted for and spent on their intended purposes? Are there any under or over-expenditure patterns? Can their cause and impact be identified? Are steps taken to rectify such patterns?

Before looking at these questions more closely it is important to first understand the legal and policy framework which guides the allocation of funds to the health sector.

2.2 HOW HEALTH CARE FINANCING WORKS IN SA

The Constitution lists health as one of the functional areas of concurrent national and provincial legislative competence. In practice, this means that national government is largely responsible for **setting policy** standards and adopting national laws while provinces are largely responsible for **implementing** these policies. The national sphere of government further has the responsibility to **monitor** provincial implementation. It is however not clear what the possible consequences for non-compliance by provinces are. Since provinces have full authority over setting their respective budgets and can decide how much is spent on their health sector, national government has only very limited influence on health spending at provincial level.

Provincial allocations to the health sector (excluding conditional grants) account for approximately 75% of overall public health resources in South Africa. It is therefore important to understand how resources are raised and divided among the different spheres of government and among provinces.

This process can be broadly summarised in five steps:

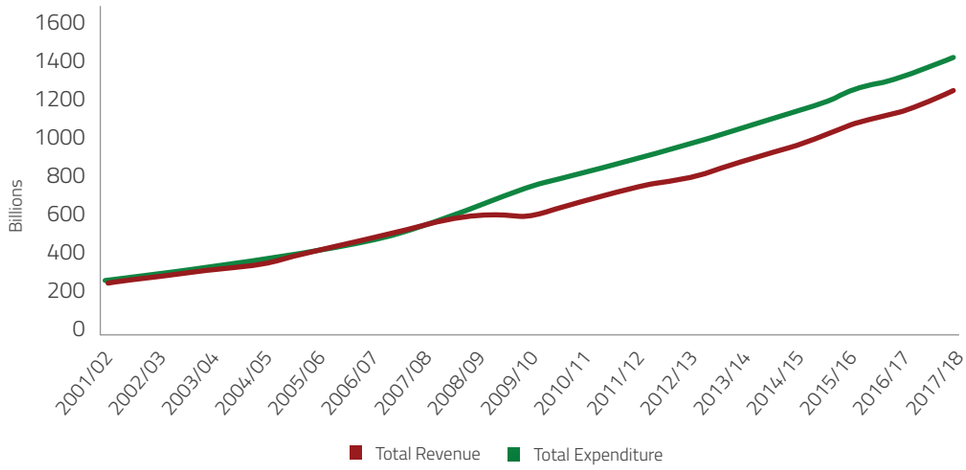
Revenue Collection	Most revenue is raised by the national government. Provinces only raise about 3% of their budget through revenue collection. Provinces are therefore largely dependent on national transfers to provide health care services to the population in their respective areas.
Costs for Debt	Before national revenue is divided between the three spheres of government a so-called 'top slice' is deducted to cater for national debt servicing costs and to set aside a contingency reserve for disaster response or changes in economic circumstances.
Division of Revenue	Nationally raised revenue gets first divided among the national, provincial and local government also known as the vertical division of revenue. The national share gets allocated to the different national departments and institutions including the National Department of Health. The provincial share gets divided among the 9 provinces based on the equitable share formula.
National Transfers to Provinces	Provinces receive about 80% of their budgets through an unconditional grant (equitable share). Provinces decide how they distribute this grant among their provincial sectors and departments such as education, health, social services etc. In addition, provinces receive approximately 20% of their budget through conditional grants. These grants are financed through national funds and can only be spent on a particular purpose.
Provincial Health Budgets	Provinces allocate on average 32% of their provincial budgets to their health sector. They can set their own priorities but have to consider national strategic plans and policies in their budgetary decisions. The national Department of Health has oversight over the implementation of conditional grants in the health sector.

2.2.1 Revenue Collection

In 2016/17 the government experienced a R30.4 billion shortfall in revenue collection. This is the largest gap between estimated and actual revenue collection since 2009/10. Low economic growth has led to decreased imports and slower wage growth which in turn have contributed to lower revenues. Figure 1 shows that since the global financial crisis in 2008 the total government expenditure was higher than collected revenue, while preceding years show revenue and expenditure being in line, with a surpluses between 2003 and 2005. To cover this deficit government had to borrow money to meet the shortfall. This has led to raising costs for paying back debt- with the result of the impact as set out below.

Figure 1: Total national revenue compared to total government expenditure 2001/02 to 2017/18

Data Source: National Treasury, 2017 Budget Review

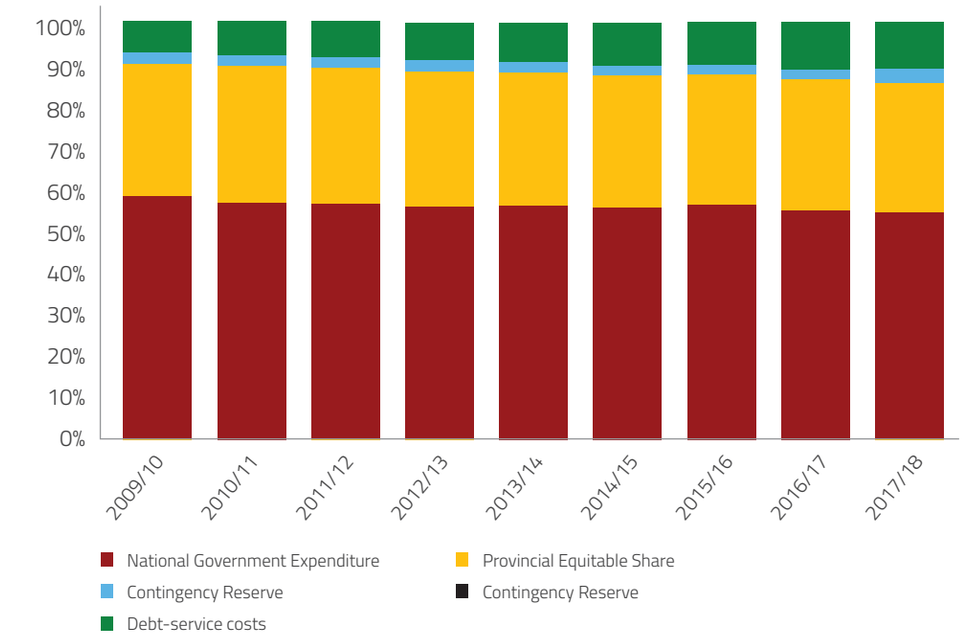


2.2.2 Government deficit and debt

Before national revenue gets distributed between national, provincial and local government, costs for paying back debts are deducted. These costs have a direct impact on the left over resources available for financing health care. For the 2017/18 budget, debt service costs amount to R162.4 billion which is 10.4% of total government expenditure and 3.4% of GDP. In comparison expenditure by the national Department of Health together with the provincial health departments make up 12% of total government expenditure and 4% of GDP. Figure 2 shows that debt servicing costs as a share of total government expenditure have increased from 7.6% in 2009/10 to 11.5% in 2017/18 as government has had to borrow more due to reduced tax recovery. This situation has been further exacerbated by

Figure 2: Percentage of government expenditure and allocations 2009/10 to 2017/18

Data Source: National Treasury, 2017 Budget Review



South Africa's recent credit down-grading by the international credit ratings agencies, which has resulted in all new foreign borrowing being more expensive to repay.

The 2017/18 Budget Review aims to strike a balance between maintaining spending commitments on the social sector including health, growing the economy and containing the growth of public debt. To decrease the spending deficit, in this Budget Review, the state expressed its commitment to raise tax rates of primarily higher-income earners and introduce further spending cuts. It is important to monitor that tax rises are in fact progressive and do not put an additional burden on low-income segments of the population, as the flat rate VAT tax does (as everyone pays the same rate, regardless of your income). In addition, service delivery indicators (quality, access, efficiency) in health and other sectors will need to be analysed to ensure that balancing the deficit will not reduce the quality and reach of public services, particularly those targeted at children, the elderly, people with disabilities and people living in poverty.

The financial position of state-owned companies has deteriorated over the last few years. There is a risk that debt and related borrowing costs are likely to increase due to demands for additional capital injections for state-owned companies. The National Treasury, which has an oversight role over the financial status of state-owned companies, has listed operational inefficiencies, poor procurement practices, weak corporate governance and failures to abide by fiduciary obligations as key factors which have led some state-owned companies to run into serious financial difficulty.

Some of South Africa's state-owned companies are not financially sustainable. Since June 2017, South African Airways has been bailed out of debt by National Treasury on two occasions, to the tune of R3.9 billion.[21] While state-owned companies only made 0.8% profits, government's average cost of borrowing is 8%. The difference between government's borrowing costs, to provide capital to state-owned companies, and the profit of these companies puts a financial burden on the public resources and indirectly reduces funds available for health, education, social development and other important sectors.[22]

2.2.3 Division of revenue among the national, provincial and local government

After costs for debts and a contingency reserve are taken off, the total amount of nationally raised revenue gets divided among the national, provincial and local spheres of government. This process, which is detailed in Annexure W1 of the National Budget Review is often referred to as the **vertical division of resources**.[23] The 2017/18 budget allocates 65% of national revenue to national government, 31% to provincial and 4% to local government. The decision how much is allocated to each sphere is an executive decision made by Cabinet and National Treasury.

The national Department of Health is financed through the national share of the allocation while the provinces finance their respective health departments and health facilities through allocations from the provincial equitable share and through conditional grants.

The division of resources among provinces is often referred to as the **horizontal division of revenues**. It is based on the provincial equitable share formula which allocates an unconditional grant as a lump sum to each province based on objective criteria. Provinces then decide how much of this share gets allocated to their respective health sector and how much goes to other functions. Local governments, including municipalities and metros, receive their share of national revenue based on the local government equitable share formula.

FOOTNOTES:

21. Paton, C. Business Day (2016). New, R5bn Debt Crisis Looms for South African Airways. Available at: https://www.businesslive.co.za/bd/companies/transport-and-tourism/2017-10-13-new-r5bn-debt-crisis-looms-for-saa/
22. National Treasury (2017) 2017 Budget Review, p. 99.
23. National Treasury (2017) W1 Explanatory memorandum to the division of revenue, 2017 Budget Review.

2.3 Overall budget and expenditure trends in South Africa's health sector

In the 2017/18 budget, government allocated a total of R187.5 billion to the health sector which amounts to 13.4% of the overall government budget (**excluding** debt service costs and contingency reserve) and makes up about 4% of the GDP forecast for 2017 (R4 657.5 billion).[24] Even though South Africa allocates a higher share of its budget to health than most other countries of a similar level of economic development, it falls short in reaching the target of allocating at least 15% of the annual budget to the health sector as agreed by members of the African Union in the 2001 Abuja Declaration.[25]

The latest comparable data on health financing shows that South Africa spent a higher proportion of its GDP on health (8.8%) compared to most other upper middle-income countries (6.2%) in 2014.[26] When only public health expenditure is taken into account, the difference becomes less significant. South Africa's public health expenditure accounted for 4.2% of GDP compared to 3.5% in other middle-income countries in 2014. This is because the public share of overall health spending in South Africa is considerably lower (48%) compared to other middle-income countries (55%).This means that private contributions to the health sector including out of pocket payments and contributions to private medical insurance are higher in South Africa compared to most other middle-income countries.

Public health budgets will continue to be under pressure because of increased personnel costs, higher expenditure on the antiretroviral programme and currency depreciation. Government estimates to save R1.6 billion per year through the centralised procurement of medicine, will be largely offset by the weaker rand, which otherwise drives up the cost of imported medicines.

Government responses to the tight budget outlook include:

- limiting staff numbers
- improving efficiencies in medicine procurement and distribution
- delaying large infrastructure projects and reprioritising budgets.

To compensate provincial health departments and protect them from future currency depreciation, it is planned that R1 billion will be added to the provincial equitable share in 2019/20.

2.4 Public versus private health expenditure

South Africa's health sector can be described as a two-tiered health system which is divided along socio-economic lines. Only about 17.4% of the population are members of medical aid schemes which gives them access to private health care.[27] The rest of the population is dependent on public health services or has to pay out-of-pocket to access private health care services.

Almost half of South Africa's overall expenditure on health (i.e. including both public and private health expenditure) stems from payments to medical schemes, out-of-pocket health payments, medical insurance and employer contributions. Yet, only about a 17 % of the population has access to private health facilities through medical aid coverage.[28] No accurate data exists on the percentage of people who access private health facilities by paying directly to the provider. Data from the 2016 General Household Survey showed that overall, 27% of households (insured and uninsured) said that they would first consult a private doctor or health facility when household members fall ill or have accidents.[29] This means that overall, only about a quarter of the population benefit from private health services.

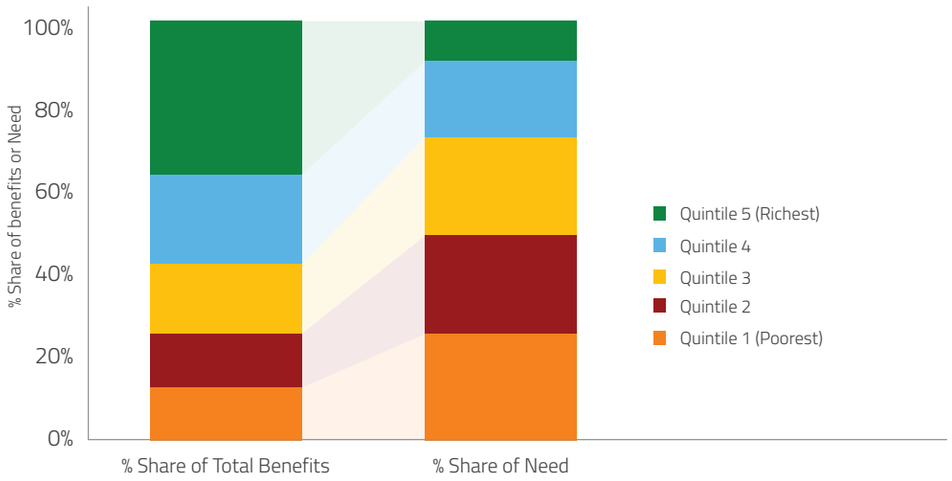
FOOTNOTES:

24. National Treasury (2017) Budget review 2017. p.7.
25. Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases. OAU/SPS/ABUJA/3. Adopted on 27 April 2001.
26. WHO Global health expenditure database. Available at: http://apps.who.int/nha/database
27. Statistics South Africa (2017) General Household Survey 2016, p.24.
28. Statistics South Africa (2017) General Household Survey 2016, p.24.
29. Statistics South Africa (2017) General Household Survey 2016, p 22.

Aruga and McIntyre (2013) have illustrated that health care benefits in South Africa are not distributed in line with the need for healthcare services. Figure 3 shows that the three poorest wealth quintiles (quintiles 1 to 3) have the highest needs but benefit disproportionally less from overall health benefits. On the other hand, the wealthiest quintile on the top has the lowest needs for health services yet has the biggest access to benefits.

Figure 3: Comparison of health benefits and need across socio-economic quintiles.

Data Source: Ataguba & McIntyre (2013): Health Economics, Policy and Law



Inequalities between the private and public health sector are further aggravated by the fact that the private-health sector employs the majority of health care professionals, and contains a disproportionate share of relevant technological resources.[30]

The cost of health care in the private sector grew significantly over the last few years (8.7% between 2010/11 and 2014/15). Increasingly fewer patients can afford either medical insurance or out of pocket payments which means that even more patients will rely on the public-health sector, causing increased strain on provincial health budgets.

In their roles as employers, both government and state-owned enterprises contribute to inequalities in health financing as they pay significant amounts of public funds to medical schemes for their employees. Estimates indicate that government paid more than R20 billion annually to the private health sector to subsidise state employees to meet the rising costs of health care in the private sector.[31]

The state's commitment to the introduction of the National Health Insurance (NHI) is supposed to address the inequity in the distribution of health benefits through a single, publicly owned and administered NHI Fund that purchases health services on behalf of the entire population from suitably accredited providers. It is however unclear how this model will be financed. Given the slow economic growth, which has a negative impact on revenue collection, it is unlikely that the health budget will increase sufficiently in the next few years to fund the proposed financing model. Contributors to medical schemes on the other hand will be unwilling to pay more for less service. The most pertinent questions with regard to the funding of the NHI are how generated funds will be pooled and how quality services will be purchased, and when will it be implemented?

FOOTNOTES:

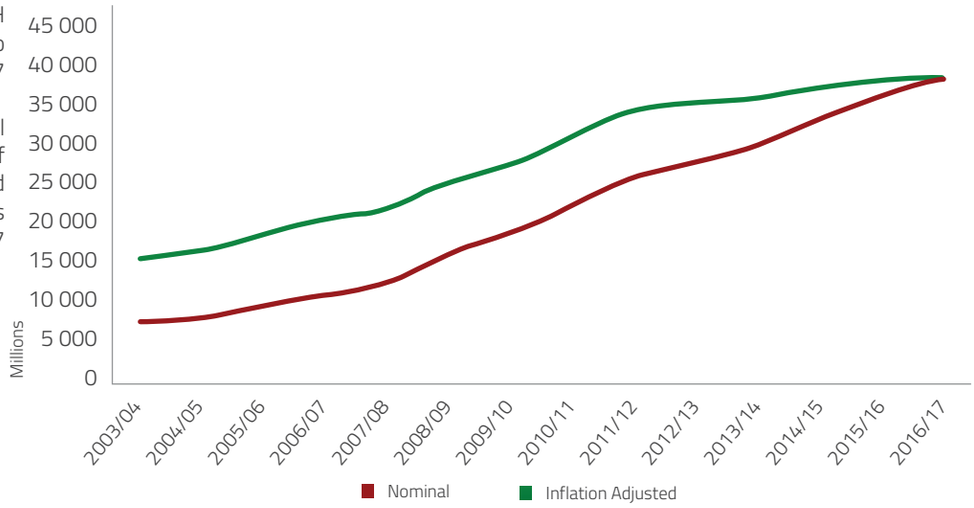
30. Marius Pieterse (2014) The impact of human rights litigation on South Africa's health system, 120.
31. Department of Health (2015) National Health Insurance for South Africa. Towards universal health coverage. Version 40, 18.

2.5 Budget and Expenditure trends of the National Department of Health

Over the last ten years, budget allocations to the National Department of Health (DoH) grew in nominal terms from R12.7 billion in 2007/08 to R42.6 billion in 2017/18. When adjusted for inflation the budget almost doubled over this period. Figure 4 shows the growth rate of nominal values versus the growth rate when adjusted by inflation. Inflation adjusted values show a steep growth rate up to 2011/12 which then flattens over the following five years. Between 2012 and 2016 the DoH budget only grew by 2.2% annually, in real terms.

Figure 4: National DoH expenditure trends 2003/4 to 2016/17

Data Source: National Treasury, Estimates of national expenditure and national expenditure trends 2003/04 – 2016/17



In the 2017/18 budget, the national government allocated 3% of its resources to the Department of Health. In 2006/07, it had only allocated 2.4% to the national health department. This shows that despite a slowdown in growth rate of the DoH budget, national government has increased the overall share of resources it devotes to the DoH. However this has not fully translated into access to quality services on the ground.

The DoH budget and expenditure is structured in six programmes:

1. Administration
2. National Health Insurance, Health Planning and Systems Enablement
3. HIV and AIDS, Tuberculosis, and Maternal and Child Health
4. Primary Health Care Services
5. Hospitals, Tertiary Health Services and Human Resource Development
6. Health Regulation and Compliance Management

During the next three years, the department will transfer 88.3%, or R123.4 billion, of its budget to provincial departments of health through **conditional grants** which will focus on three key issues:[32]

- expanding treatment and prevention programmes for HIV and AIDS and tuberculosis (TB)
- revitalising public health care facilities and;
- ensuring that specialised tertiary hospital services are provided

These priorities are reflected in the key estimated expenditure trends for the next three years. The biggest increases in expenditure are projected for HIV and AIDS, Tuberculosis, and Maternal and Child Health (Programme 3) and Hospitals, Tertiary Health Services and Human Resource Development (Programme 5). These two programmes take up more than 90% of the 2017/18 DoH budget. While allocations to Programme 3 are expected to grow from 39% to 44% compared to the previous MTEF

FOOTNOTES:

32. 2017 National Budget. Estimates of National Expenditure, Vote 16, p.292.

period from (2013/14 – 2016/17) allocations to Programme 5 are decreasing from 54% to 48%. This means that provinces which provide tertiary health services (i.e. Western Cape, Gauteng, KwaZulu-Natal, Eastern Cape and Free State) will receive less national funding to finance highly specified and costly tertiary-health care.

Expanding HIV and AIDS, and TB treatment and prevention

Spending in the HIV and AIDS, Tuberculosis, and Maternal and Child Health programme will increase at an average annual rate of 12.8 per cent over the next three years from R16 billion in 2016/17 to R22.9 billion in 2019/20.

These additional allocations are supposed to fund the implementation of the **universal test-and-treat policy**, which will offer treatment to everyone diagnosed with HIV, regardless of their CD4 count. Additional funds will be used to support provinces to **intensify screening campaigns** to ensure early detection and treatment of TB and increase the success rate of TB treatment from 84 percent in 2016/17 to 90 percent in 2019/20. These funds are channelled to provincial health departments through the comprehensive HIV, AIDS and TB grant.

Revitalising public health care facilities

Over the next three years, the department will invest R20.8 billion in healthcare infrastructure, prioritising areas with the greatest need for investment.

These funds will be distributed through two conditional grants:

The direct health facility revitalisation grant with R17.8 billion will be transferred to provincial departments of health over the next three years to fund the building of new facilities and the upgrading, refurbishing and maintenance of existing health facilities.

The national health insurance indirect grant has a health facility revitalisation component to which R3 billion will be allocated over the next three years. This grant is exclusively for infrastructure improvements in the 11 national health insurance pilot districts.

Ensuring accessible specialised tertiary health services

Allocations in this programme are supposed to compensate provinces which offer highly specialised, hospital-based health care (tertiary health services). These tertiary health services are not distributed equally across South Africa which means that many patients have to seek specialised care in neighbouring provinces because the required service is not available in their home province. Funds will be dispersed through the direct national tertiary services grant which makes up over a quarter of DoH expenditure over the next three years.

Primary health care services

Since the DoH's role is limited to policy making, coordination and monitoring expenditure on primary health care services only makes up 0.6 % of overall DoH expenditure estimates for the three-year budget period from 2017/18 to 2019/20. The objectives of this programme include:

Improve district governance and strengthen the management and leadership of the district health system;

Improve access to community-based primary health care services;

Improve the quality of care by ensuring that all fixed primary health care facilities qualify as ideal clinics by 2019/20;

Improve the quality of services at district hospitals through the ideal district hospital programme;

Reduce risk factors and improve the management of non-communicable diseases.

DoH expenditure in this programme (programme 4) is supposed to grow by 7.1% over the next three years which is just above the projected inflation rate of 6%. Considering that non-communicable diseases have surpassed communicable diseases as the main causes of death and disease in recent years, it is important to highlight that the budget of the national DoH has not adapted to this shift in burden of disease.[33]

FOOTNOTES:

33. Statistics South Africa (2017) 'Mortality and causes of death in South Africa, 2015: Findings from death notification'.

2.6 NATIONAL TRANSFERS TO PROVINCES

Provincial health budgets are funded almost entirely through national transfers, which can be categorised in two groups:

Unconditional Grant/ Equitable Share	Conditional Grants
Fund on average 80% of provincial health budgets,	Fund on average 20% of provincial health budgets,
Provinces decide how to allocate these resources,	Provinces can only spend these resources for certain programmes/ activities,
Provinces receive them based on the equitable share formula,	Provinces have to apply for grants or get them allocated through the national DoH,
DoH monitors whether national priorities are taken into account in the provincial allocation processes.	National DoH has an active monitoring role.

Unconditional grants based on the equitable share formula

Every year, the National Treasury determines the share each province receives to fulfil their constitutional functions such as providing health care and basic education. The distribution of this share among the 9 provinces is guided by the so called equitable share formula. More than 80% of transfers to provinces are allocated through this formula which consists of six components that are supposed to capture the relative demand for services amongst provinces:

How does the Equitable share get distributed among provinces?

Suppose that the total amount of the equitable share is R100.

The total health component would be R28 which then gets distributed among the 9 provinces based on criteria reflecting the demand and need for health services.

Education component	48% of the total share are distributed based on number of school-age children (grade R to grade 12) and the number of learners enrolled in public ordinary schools in each province.
Health component	27% of the total share are distributed based on provinces' risk profiles and utilization rates of health systems.
Basic component	16% of the total share are distributed based on each province's percentage of the national population.
Institutional component	5% of the total share is divided equally between the provinces to recognise costs associated with running a provincial government.
Poverty component	3% of the total share is distributed based on the number of people living in the lowest 40% of household incomes.
Economic output component	1% of the total share based on regional GDP as a proxy for provincial tax capacity and expenditure assignments.

Provinces are, however, not bound to spend allocations based on the health component on their respective health sector. Since it is an unconditional grant, provinces can decide how much gets allocated to their provincial departments. They are nevertheless supposed to consider national priorities in their budgetary decisions.

The way that each province's health component is calculated is rather complex and is based on factors such as population figures, risk profile and the caseloads in public health clinics and hospitals. The risk profile only considers uninsured people and takes into account each person's likely need of health services. Children below the age of 1 year, for example, are attributed with a high risk since their need for health care services is higher compared to older children. Women in child bearing years also have a higher need for health care compared to men in the same age group.

Figure 5: Per capita allocations to provinces, 2017/18

Data Source: National Treasury, Budget Review 2017

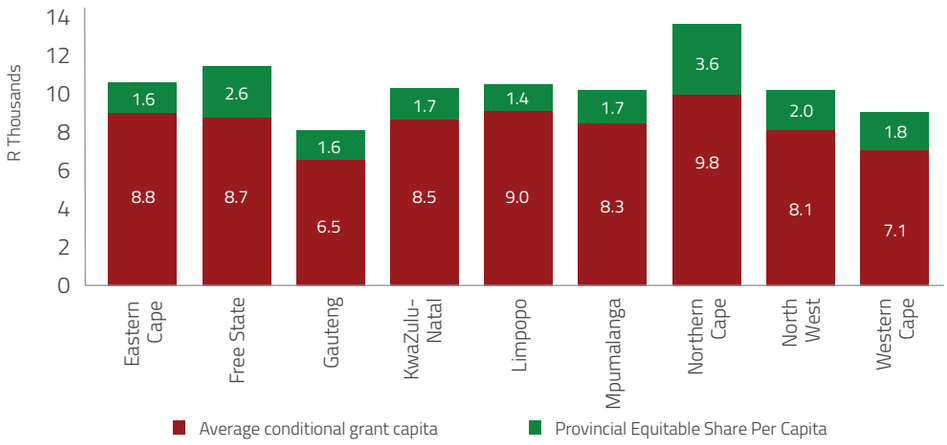


Figure 5 shows that per person allocations in predominantly rural provinces are slightly higher compared to the rest of the country. This is supposed to compensate for higher demand for public health care and schooling in these areas. The formula however has been criticised for not sufficiently considering higher costs for delivering health services in rural areas. The Rural Health and Advocacy Project (RHAP) has highlighted that approximately 40% of the South African population lives in rural areas where they are exposed to higher levels of deprivation which translates into higher needs for public services.[34] Factors such as low population density, higher costs for transport including emergency services and lack of economy of scale make the delivery of health care services more expensive. RHAP therefore argues that the formula of the health component needs to be adjusted to better compensate rural provinces for higher costs in delivering public health care.[35] The National Treasury, in consultation with provincial treasuries, national departments, the Financial and Fiscal Commission and Stats SA, is currently reviewing the formula to better reflect differences in the cost of service provision. [36]

FOOTNOTES:

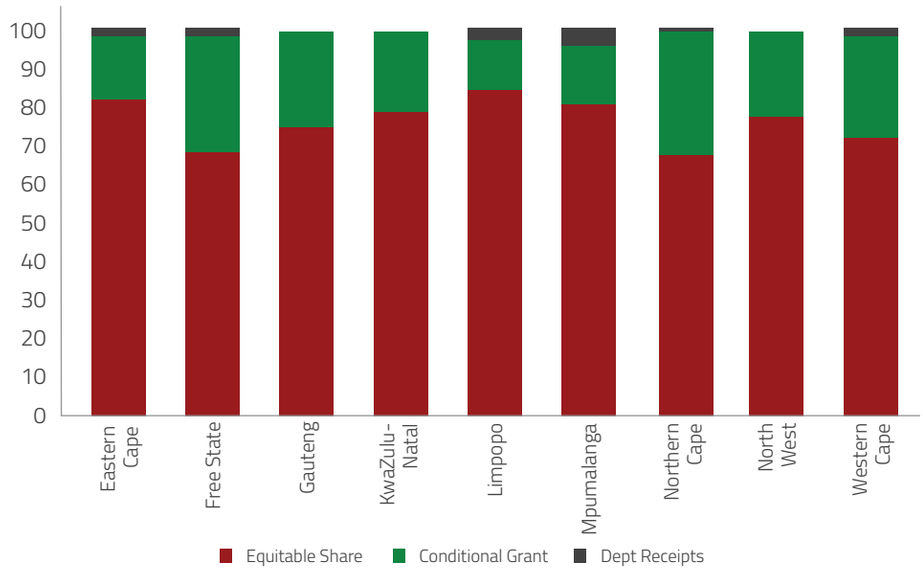
34. Rural Health Advocacy Project (2015) Rural-Proofing for Health: Guidelines. Available at: http://www.rhap.org.za/wp-content/uploads/2015/02/2015-01-13-RHAP-Rural-Proofing-Guideline-A4-Email-1.pdf.
35. Rural Health Advocacy Project (2016) MTBPS 2016: The Rural Health Advocacy Project warns against further health service cuts to those most in need following continued fiscal consolidation. Press statement 27 October. Available at: http://policy3817.rssing.com/browser.php?indx=55764565&last=1&item=7.
36. National Treasury (2017) Budget Review 2017, p. 71.

Conditional Grants

Conditional grants are transferred by the responsible national department to the corresponding department at provincial level to fund specific objectives or programmes. In the 2017/18 budget, provinces are supposed to receive between 13% to 31% of their health budgets through conditional grants. Figure 6 shows that the Northern Cape and the Free State fund almost a third of their health budgets through conditional grants while in Limpopo conditional grants make up only 13% of the health budget

Figure 6: Percentage of funding sources of health budgets by province 2017/18

Data Source: 2017 Estimates of Provincial Revenue and Expenditure



Since provincial governments can decide how much they allocate from their equitable share to their health budgets, conditional grants offer the Department of Health a mechanism to make sure that provinces spend funds on key national priorities. They also serve as a funding modality to compensate provinces for health expenditure that benefit more than one province such as big infrastructure programmes or specialised tertiary health care services which are only available in some provinces.

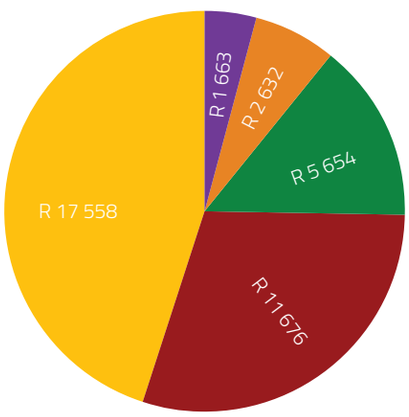
The 2017/18 budget includes 5 conditional grants:

- Comprehensive HIV, Aids and TB grant;
- Health facility revitalisation grant;
- Health professions training and development grant;
- National tertiary services grant;
- National health insurance grant (indirect grant managed by national DoH).

The Comprehensive HIV, AIDS and TB grant is by far the best funded grant followed by the grant for national tertiary services (see Figure 7). Together they make up three quarters of the total of R39 billion which get transferred to provinces through health grants.

Figure 7: Health conditional grants 2017/18 (millions)

Data Source: National Treasury, 2017 Budget Review



Between 2012/13 and 2016/17 transfers through conditional grants in the health sector increased in real terms only by 1.5% per year on average. Between 2016/17 and 2017/18, however, transfers grew by 10% due to increases in the Comprehensive HIV, AIDS and TB grant and the grant for national tertiary services. Below we provide an analysis of the 5 conditional grants over a 5 year period. Allocation and expenditure figures are provided in real terms. The budget data has been sourced from national and provincial estimates of national expenditure. Expenditure figures for the 2016/17 financial year have not been provided as this data could not be sourced.

2.7 CONDITIONAL GRANTS- ALLOCATION AND EXPENDITURE ACROSS 9 PROVINCES

Comprehensive HIV/AIDS grant

This grant enables the healthcare sector to develop an effective response to HIV and AIDS, including universal access to HIV counselling and testing. It also partly subsidises the antiretroviral treatment programme. The grant seeks to increase the number of new patients on ART, HIV testing and medical male circumcision, amongst other outputs.

AIDS-related deaths have almost halved due to government's efforts in the roll-out of the anti-retroviral programme (see indicator 24). The South African Medical Research Council states, however, that additional efforts are needed to treat more people infected with HIV, improve prevention efforts and integrate TB care in HIV treatment.[37]

As indicated in Figure 8 below, there have been real term increases in budget allocations between 2012/13 and 2016/17 to provinces. However growth in allocations has slowed down over this period, from a 12.4% increase in 2012/13 to 4.8% in 2016/17. As illustrated in Figure 9, provinces generally spent this grant well, with the exception of 2012/13 and 2013/14, where the Eastern Cape had real term over-expenditure. Due to housing the greatest proportion of the population, Kwa-Zulu Natal and Gauteng provinces receive the lion's share of the grant, with real term 2015/16 allocations of R4 billion and R3,1 billion, respectively. Increased allocations towards combatting HIV and AIDS have borne fruit, with the number of deaths having decreased over the years and rate on infection on the decline.

Figure 8: Comprehensive HIV/AIDS grant- real allocations, expenditure and annual % change 2012/13 to 2016/17[38]

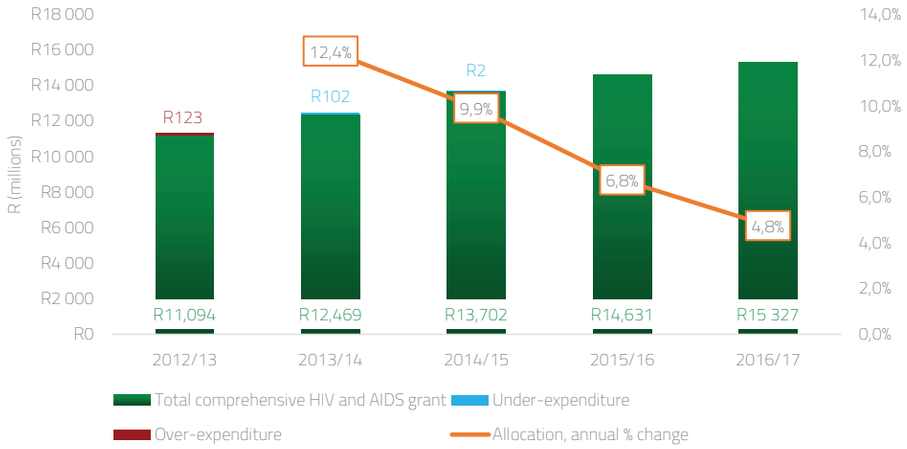
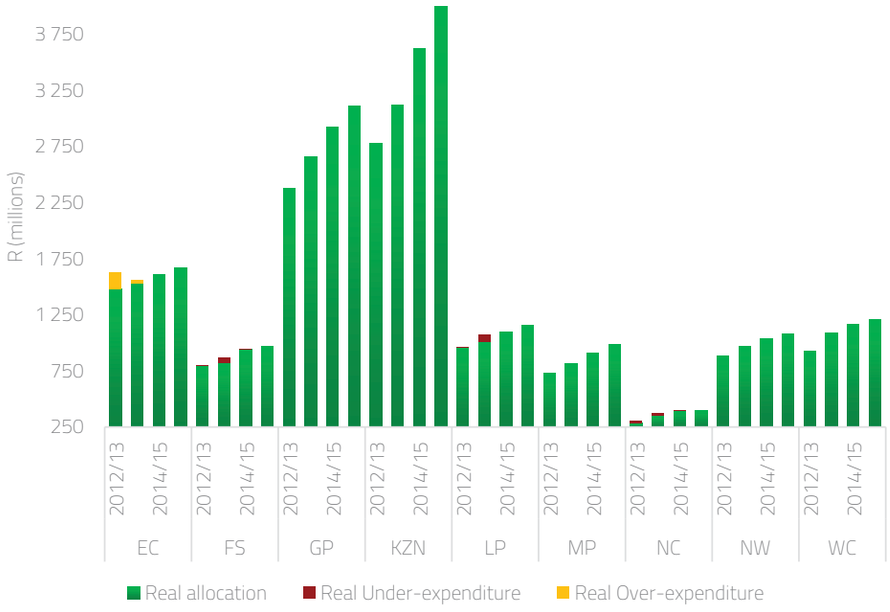


Figure 9: Comprehensive HIV/AIDS grant: real allocations and expenditure by province, 2012/13 to 2015/16[39]



FOOTNOTES:

37. Health24 (2016) Death Rate Halved but HIV Remains SA's Biggest Killer. Available at: http://www.health24.com/Medical/HIV-AIDS/The-South-African-culture/death-rate-halved-but-hiv-remains-sas-biggest-killer-20161130
38. Estimates of Provincial Revenue and Expenditure (2013-2017)
39. ibid

Hospital Facility Revitalisation grant

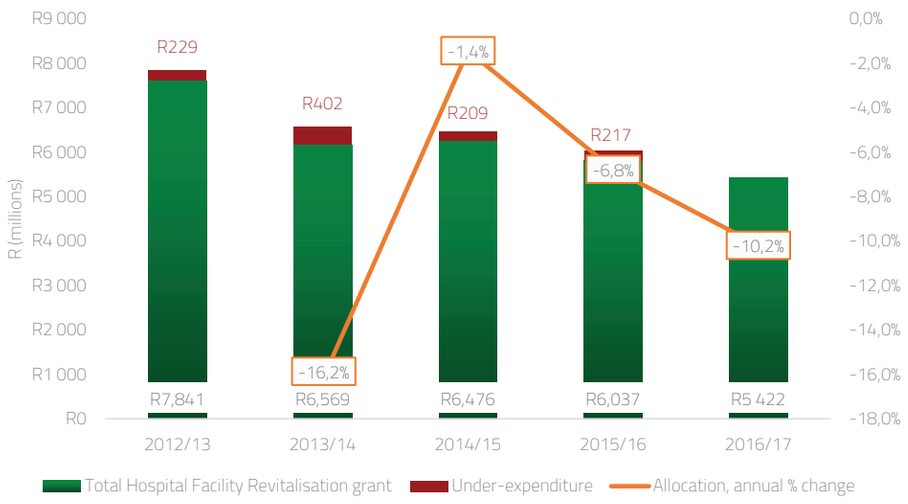
In 2013/14 three health-infrastructure related conditional grants, namely the hospital revitalisation, health infrastructure and nursing colleges and schools grants, were combined to form the Health Facility Revitalisation grant.[40] For the purposes of this paper we have combined the allocation and expenditure figures for these three grants in 2012/13.

The grant contributes towards the rehabilitation of health facilities to enhance patient experiences of healthcare delivery, and improve healthcare worker morale by providing a conducive work environment.[41] Under the grant, hospital, community health centre and clinic infrastructure is improved.

As highlighted in Figure 10, between 2012/13 and 2013/14 there was a dramatic 16% real allocation decrease of the revitalisation grant. The latter years are followed by steady decreases in funding. This may be due to the fact that the conditional grant has been riddled by low spending across most provinces. According to the Financial and Fiscal Commission's 2012/13 submission to Parliament[42], the revitalisation grant continued to face high levels of delay in the completion of projects and in certain cases infrastructure was not correctly identified. Regretfully this manifests in dire public facility infrastructure, which impacts on people's right to healthcare.

In an inspection report of over 600 public facilities, published earlier this year by the Office of the Health Standards Compliance, it was found that the crippling effect of budget constraints had led to inadequate infrastructure and maintenance budgets, shortage of medical equipment and medical supplies.[43] These challenges are echoed in a press release by the Inkhatha Freedom Party (IFP) on the Kwa-Zulu Natal provincial budget vote, which stated that, 'government hospitals and clinics [were] generally in a run-down state and short of equipment and medicines.' [44]

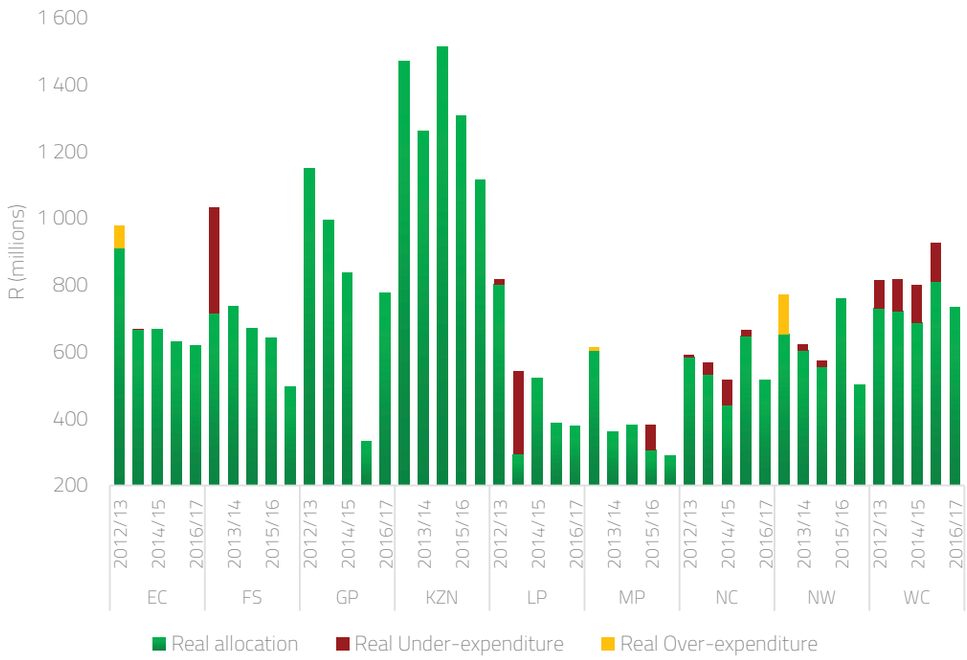
Figure 10: Hospital Facility Revitalisation grant- real allocations, expenditure and annual % change 2012/13 to 2016/17[45]



FOOTNOTES:

40. Department of Health, 2013/14 Annual Report, p. 54
41. Department of Health, 2012/13 Annual Report, p.128
42. Parliamentary Monitoring Group (2013), Department of Health: Financial and Fiscal Commission and Auditor-General's briefing; Medical Research Council 2012/13 Annual Report. Available at: https://pmg.org.za/committee-meeting/16494/
43. Kerry Cullinan, Health-E News (2017). Grim Findings after Health Facilities Inspection. Available at: https://www.health-e.org.za/2017/04/18/grim-findings-health-facilities-inspections/
44. Press Release on Health Budget Vote, Inkatha Freedom Party (2016). Available at: http://allafrica.com/stories/201604141218.html
45. Estimates of provincial revenue and expenditure (2013-2017)

Figure 11: Hospital Facility Revitalisation grant- real allocations, expenditure and annual % change 2012/13 to 2016/17[45]



Health professions training and development grant

Figure 12 shows that there have been real term allocation cuts within this conditional grant- the most significant taking place between 2014/15 and 2015/16. Nominal allocations of the grant show increases over the period of review, however, when adjusted for inflation it becomes evident that allocations decreased in real terms. As stated earlier in this paper, nominal increases that fall below the inflation rate, actually mean budgets are shrinking. What is encouraging is that there is minimal under-expenditure, as highlighted in Figure 12 and Figure 13.

The real term decreases in the health profession and training development grant are extremely worrying. This grant is intended to assist in funding costs for the training and recruitment of health professionals.[47] **According to a paper published by the New England Journal of Medicine in 2014, the South African public health sector, which is staffed by about 30% of doctors in the country, remains the sole provider of healthcare for about 84% of the country's population.** [48] The paper also states that South Africa needs at least 3 times the current workforce to provide adequate care for patients with HIV. [49]

Earlier this year, it was revealed that, 'cancer treatment in Kwa-Zulu Natal's health department [had] all but ground to a halt as a result of severe shortage of staff, numerous resignations and equipment that is no longer functioning.'[50] In a 2016 news article, The Citizen, highlighted that two of the five oncologists in the Durban area had resigned at the end of the year.[51]

The Cancer Association of South Africa stated that the challenges facing the delivery of cancer care in public hospitals were not limited to the Kwa-Zulu Natal province.[52] Indicator 13.6 in chapter 3 of this paper illustrates the severity of specialist shortages in South Africa's public health care system, particularly in the rural areas of the country.

FOOTNOTES:

46. Estimates of provincial revenue and expenditure (2013-2017)
47. Section27, Health Budgeting and HIV: A Budget and Expenditure Monitoring Forum Factsheet. Available at: http://section27.org.za/wp-content/uploads/2010/05/BudgetingActivistPamphlet.pdf
48. Howard, J. CNN (2017), South Africa's Cancer Doctor Shortage: 'There is a Real Crisis.' Available at: http://edition.cnn.com/2017/06/13/health/cancer-doctor-shortage-south-africa-bn/index.html
49. Mayosi, B.M and Benatar, S.R. The New England Journal of Medicine (2014), Health and Healthcare in South Africa- 20 Years after Mandela. Available at: http://www.nejm.org/doi/full/10.1056/NEJMsr1405012#t=article
50. The Citizen (2016), Meltdown for Cancer Treatment at KZN Health Department. Available at: https://citizen.co.za/news/south-africa/1371813/meltdown-cancer-treatment-kzn-health-department/
51. ibid
52. Howard, J. CNN (2017), South Africa's Cancer Doctor Shortage: 'There is a Real Crisis.' Available at: http://edition.cnn.com/2017/06/13/health/cancer-doctor-shortage-south-africa-bn/index.html

Figure 12: Health Professional Training and Development- total real allocations, expenditure and annual % change 2012/13 to 2016/17[53]

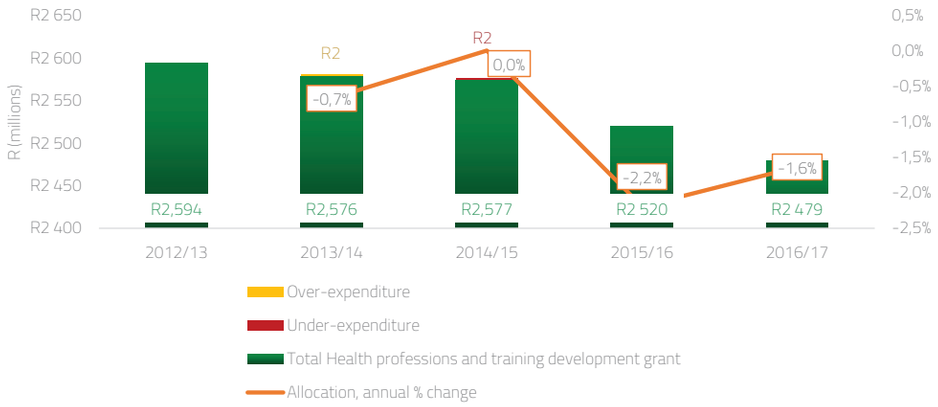
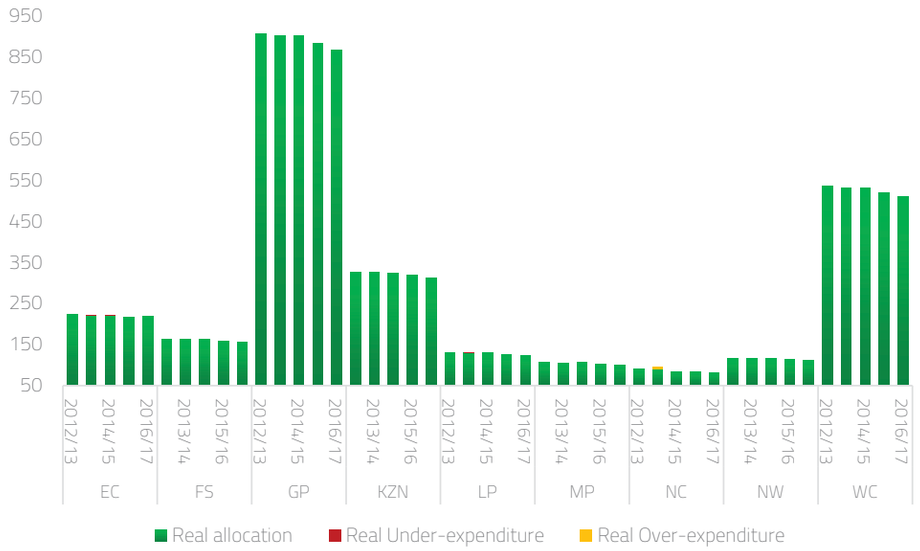


Figure 13: Health Professional Training and Development- real allocations and expenditure by province, 2012/13 to 2016/17[54]



National Tertiary Services grant

This grant aids in paying the costs of running tertiary hospitals. These hospitals, '…provide high level health services that are expensive and they often provide services to people from other provinces.'[55] Tertiary hospitals also provide training services for healthcare providers. This conditional grant, and the Comprehensive HIV and AIDS grant, are well-funded.

Figure 14 below shows however, that there have been real term allocation decreases over the period of review, with the exception of a 2.6% real allocation increase between 2012/13 and 2013/14. Government has sought to encourage the use of primary health care facilities as the first port of call for patients, which may be the reason for allocation decreases (see indicator 2). However, these decreases will have an impact on the quality of services provided in major hospitals in provinces such as Gauteng, Western Cape, Kwa-Zulu Natal and Eastern Cape. There is a pattern of funds not being spent in full, but under-expenditure as a percent of the total budget falls below 2%. This is considered acceptable by normal accounting standards.[56]

FOOTNOTES:

53.
54. Estimates of provincial revenue and expenditure (2013-2017)
55. ibid
56. Section27, Health Budgeting and HIV: A Budget and Expenditure Monitoring Forum Factsheet. Available at: http://section27.org.za/wp-content/uploads/2010/05/BudgetingActivistPamphlet.pdf

Figure 14: National Tertiary Services grant- total real allocations, expenditure and annual % change 2012/13 to 2016/17[57]

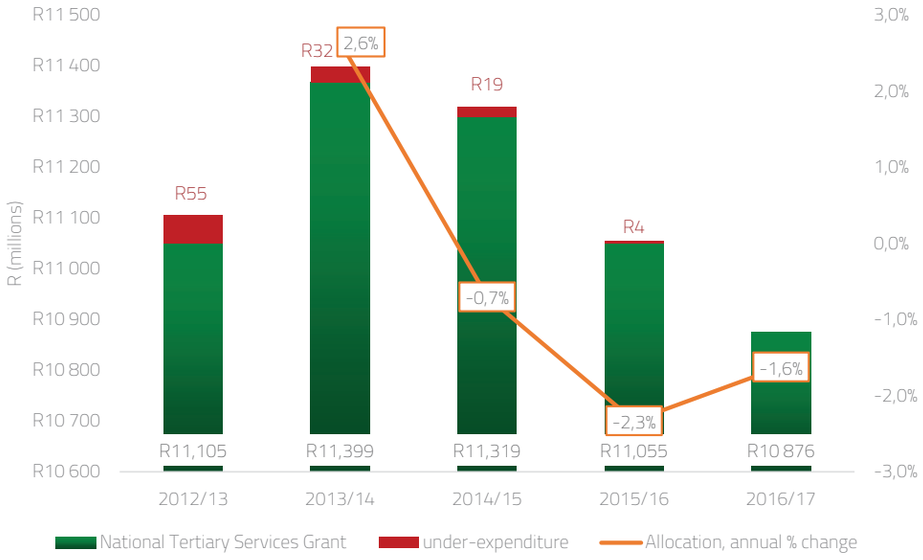
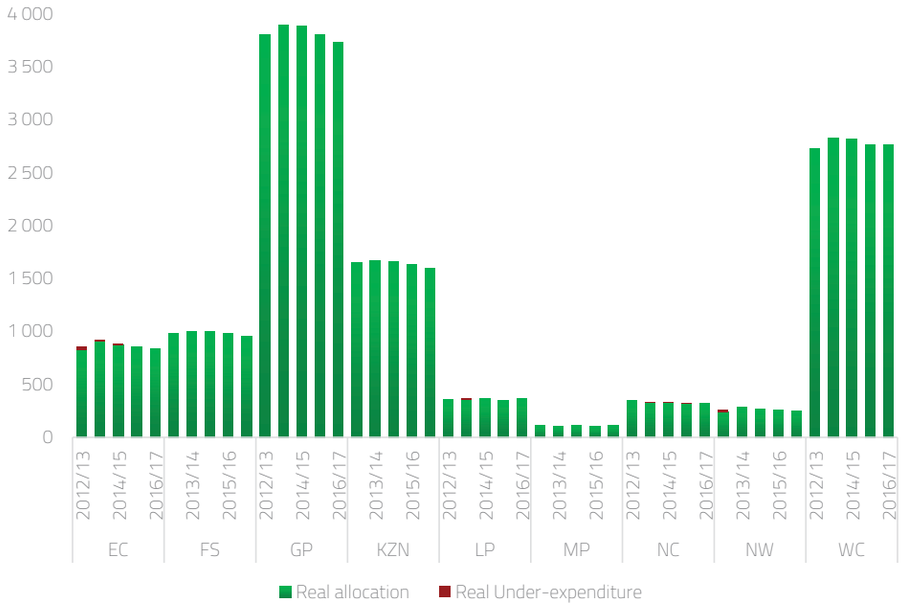


Figure 15: National Tertiary Services grant- real allocations and expenditure by province, 2012/13 to 2016/17[58]



National Health Insurance grant (Direct)

This grant is to, amongst others, support selected pilot districts in implementing identified service delivery interventions and to provide a model for revenue collection and a management model for identified central hospitals.

As is evident in Figures 16 and 17, the grant has been riddled with low spending and allocation cuts during the period of revenue. Reasons for under-expenditure have been cited as including, '…lack of capacity, supply chain hurdles, lack of support and inability to spend on infrastructure.'[59]

FOOTNOTES:

57. Dawson, H. & McLaren, D. 2014. Monitoring the right of access to adequate housing in South Africa: An analysis of the policy effort, resource allocation and expenditure and enjoyment of the right to housing. SPII Working Paper 8
58. Estimates of provincial revenue and expenditure (2013-2017)
59. https://pmg.org.za/committee-meeting/15944/

Figure 16: National Health Insurance- total real allocations, expenditure and annual % change 2012/13 to 2016/17[60]

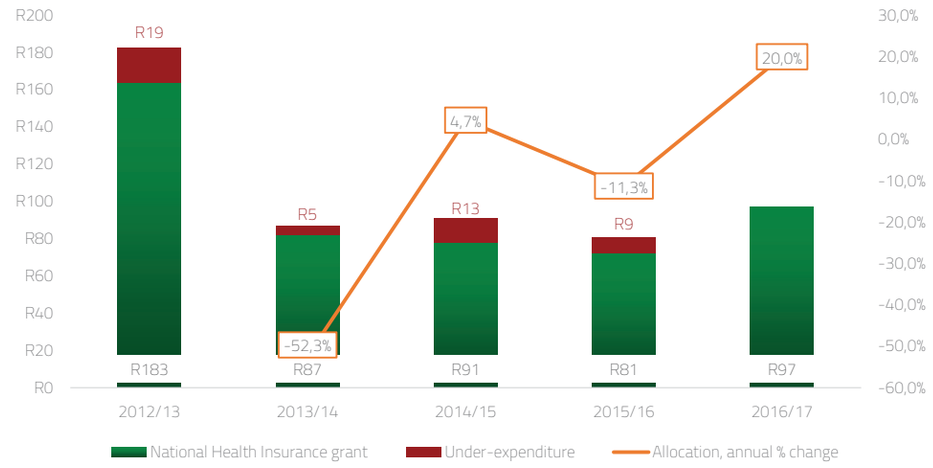
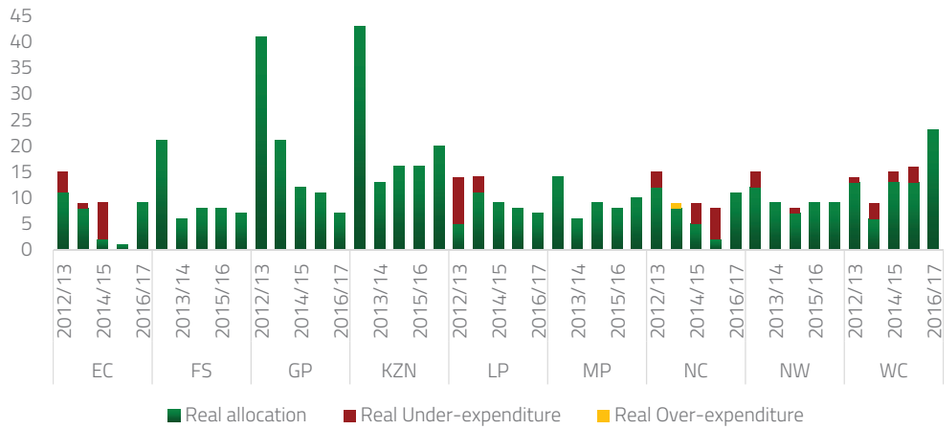


Figure 17: National Health Insurance grant- real allocations and expenditure by province, 2012/13 to 2016/17[61]



2.8 BUDGET AND EXPENDITURE TRENDS OF THE 9 PROVINCIAL HEALTH SECTORS

How do provinces fund their health sectors?

Provinces account for approximately 94% of the total public health expenditure in South Africa when expenditure on conditional grants is included.[62] It is therefore extremely important to analyse how provinces allocate resources to their respective health sectors and how they spend them.

As described in section 4.6, provinces finance in average 80% of their health budgets through allocations from the provincial equitable share. Since provinces have only very limited authority to raise revenue, the health component of the equitable share formula is supposed to compensate provinces for delivering health services in their areas. The constitution empowers provinces to develop their provincial budgets and to allocate their equitable share to their various provincial sectors including health. They are therefore not bound to allocate the health component of the equitable share to their health sector.

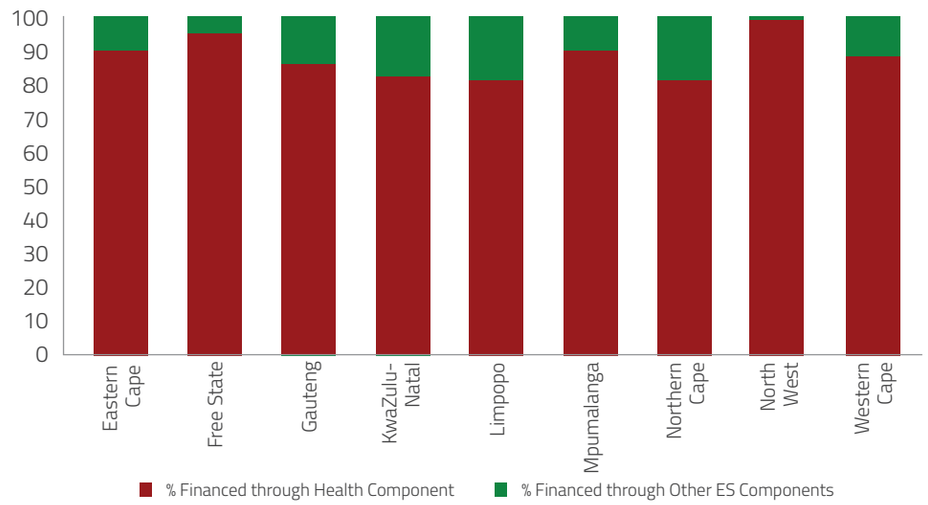
In fact, provinces allocate on average 15% more funds (from their overall equitable share) to their health sector compared to the resources they receive through the health component of the equitable share formula. In other words, provinces take resources from other components of the equitable share formula to fund their respective health sectors. This can have a potential knock on effect to fund other public services such as education or the provision of social grants. For example, in 2017/18 Limpopo allocated 15.2 billion from its equitable share to the health sector. Limpopo's health component however was only 12.3 billion which means that 2.9 billion (or 19% of the 15.2 billion) were added from other components of the equitable share to the health sector. North West Province on the other hand only added about 2% to its health component from other equitable share components. Figure 18 shows that all provinces added resources from their equitable share allocation on top of their health component to fund their public health sectors. This indicates that the health component does not fully compensate provinces for their costs of delivering health services.

FOOTNOTES:

60. ibid
61. Estimates of provincial revenue and expenditure
62. Fiscal and Financial Commission (2017). Briefing to the Portfolio Committee on Health. Available at: file:///C:/Users/Birgit/Downloads/FFC_Briefing_to_The_Portfolio_Committee_on_Health_2_May_2017.pdf.

Figure 18: Percentage of Health Component of Equitable Share allocation to health sector by province, 2017/18

Data Source: Own calculations based on 2017/18 Estimates of Provincial Revenue and Expenditure and 2017 Budget Review



How much do provinces allocate to their health sectors?

In 2016/17, provinces allocated in average 32% of their overall resources (including conditional grants) to their health sector. In comparison, in 2008/09 provinces spent on average only 29% of their overall budgets on health.[63] Figure 19 shows the percentage provinces allocate to their respective health sector from their overall budget. Western Cape and Gauteng allocated the biggest share of their provincial budgets (36%) to the public health sector even though they have the lowest proportion of uninsured population in their province (Figure 20). Mpumalanga and North West province have more than 10 percent higher shares of uninsured people living within their boundaries yet they only allocated 26% to their provincial budgets to health.[64]

Figure 19: Percentage allocation to health sector by province, 2016/17

Data Source: 2016/17 Estimates of Provincial Revenue and Expenditure

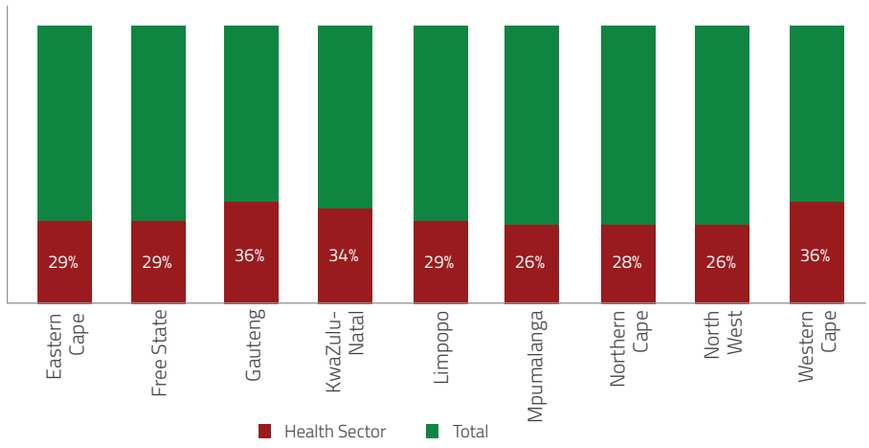
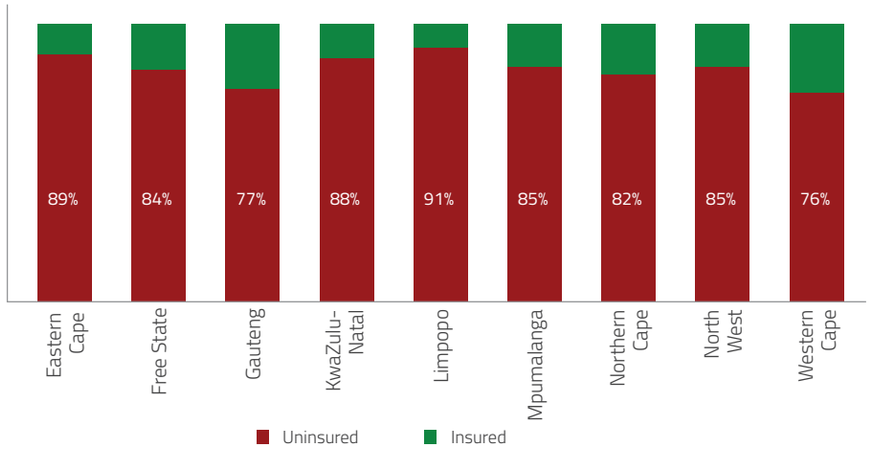


Figure 20: Percentage of uninsured population per province, 2015

Data Source: General Household Survey 2015



FOOTNOTES:

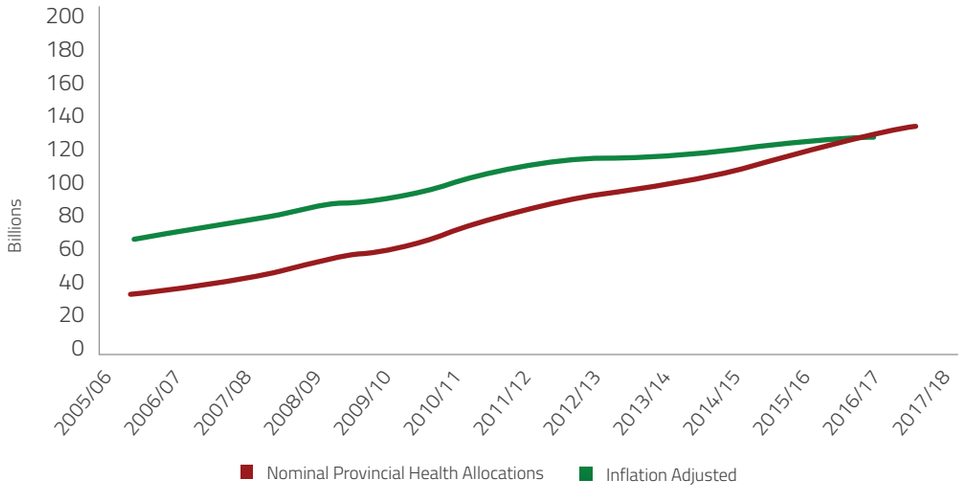
63. National Treasury (2009) Provincial Budgets and Expenditure review: 2005/06 – 2011/12. Available at: http://www.treasury.gov.za/publications/igfr/2009/prov/default.aspx.
64. National Treasury (2016) Estimates of Provincial Revenue and Expenditure.

What are the trends in provincial health care spending?

Between 2006/07 to 2016/17 provincial allocations to their respective health sectors tripled from R54 billion to R170 billion in nominal terms. When prices are adjusted to inflation the expenditure curve starts flattening after 2011/12. The same trend can be observed with regard to expenditure trends of the national Department of Health (see Figure 4). Between 2012/13 and 2016/17 provincial expenditure on the health sector grew in average by 2.7%, in real terms.

Figure 21: Provincial expenditure on health sector in nominal and real terms 2005/06-2017/18

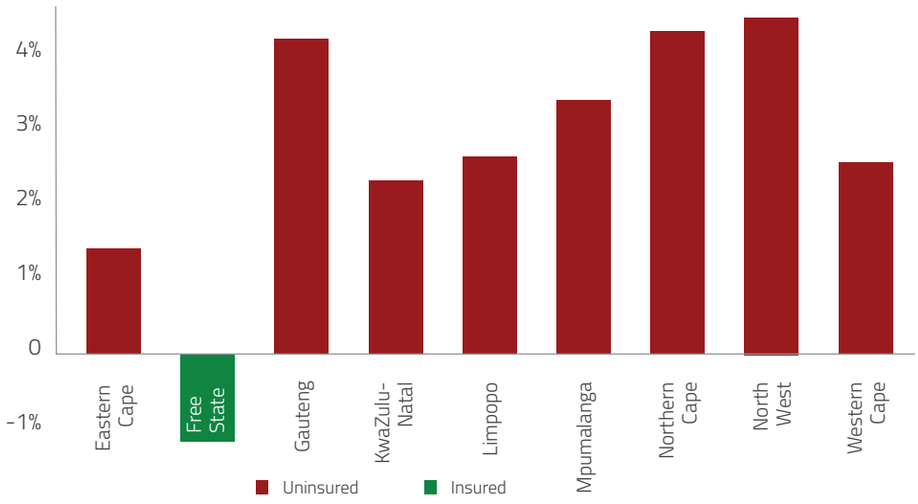
Data Source: Estimates of Provincial Revenue and Expenditure



While allocations to the health sector grew in average above 4% annually in North West Province, Northern Cape and Western Cape, they decreased in real terms in the Free State. This means allocations to the health sector in the Free State grew slower than the inflation rate which led to an actual decline when inflation is taken into account.

Figure 22: Annual average growth rate of allocations to the health sector by province 2012/13 to 2016/17

Data Source: Estimates of Provincial Revenue and Expenditure



How much do provinces spend per uninsured person?

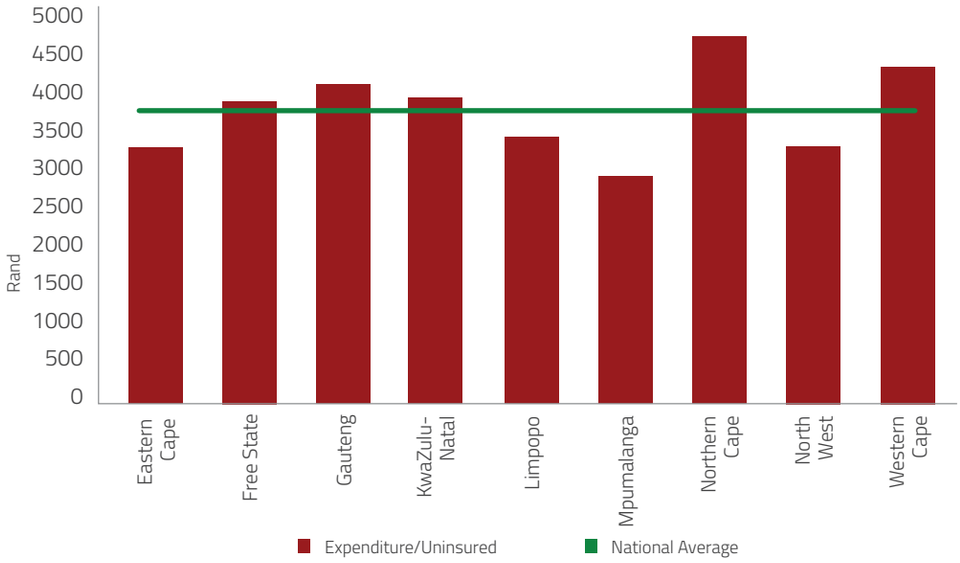
Differences in allocations to the provincial health sectors as well as in the proportion of uninsured people result in different per capita expenditure rates. Mpumalanga and North West Province allocate the lowest percentage of their public resources to the health sector and have the lowest allocations per uninsured person with approximately R2 900 and R3 240 respectively.[65] Limpopo and the Eastern Cape, the two poorest provinces with the highest percentage share of uninsured population have similarly low expenditure rates per capita (uninsured) with approximately R3 300.

FOOTNOTES:

65. Own calculations based on 2016 Community Survey population figures and Estimates of Provincial Revenue and Expenditure 2017/18.

Figure 23: Public health expenditure per capita (uninsured) by province, 2016/17

Data Source: Own calculations based on StatsSA mid-year population estimates 2016, General Household Survey 2016 and estimates of Provincial Revenue and Expenditure 2017/18



How much do provinces allocate to the different programmes of their health sector?

All provincial budgets are structured in eight programmes which each have sub-programmes.

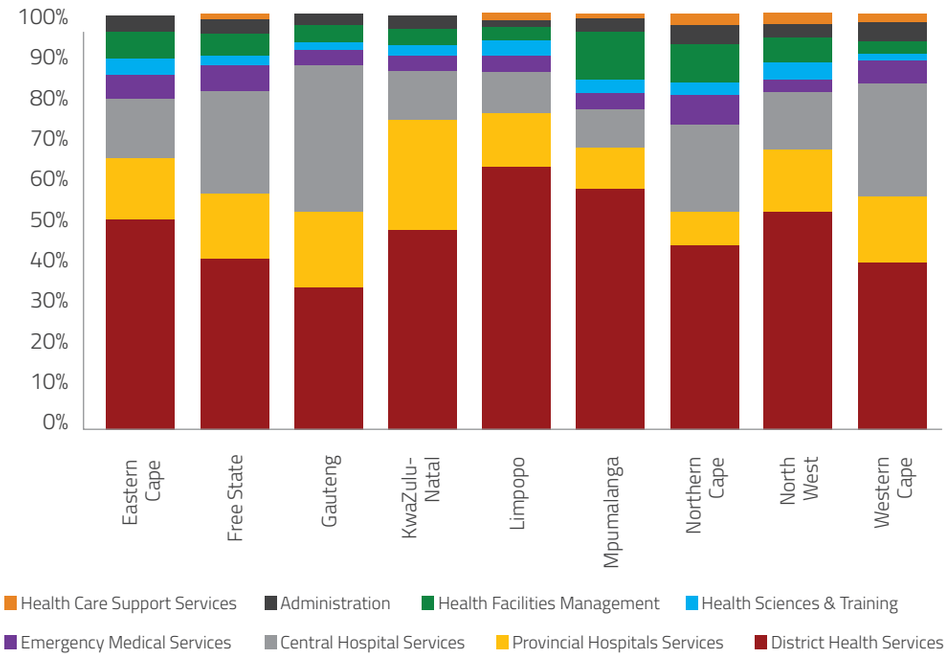
Programmes	Sub-programmes	Description
Administration	Office of the MEC	Strategic management and overall administration of provincial Departments of Health
	Management	
District health services	District Management	Provide comprehensive primary health care services, deliver district hospital services, comprehensive HIV and AIDS care and nutrition. Delivery of priority health programmes.
	Community Health Clinics	
	Community Health Centres	
	Community Based Services	
	HIV and Aids	
	Nutrition	
	Coroner Services	
	District Hospitals	
Emergency medical services	Emergency Transport	Pre- hospital emergency services incl. inter-hospital transfers, and planned patient
	Planned Patient Transport	
Provincial hospital services	General (Regional) Hospitals	Provide general and specialised hospital services through regional hospitals and specialised hospitals on TB, Psychiatric/Mental and Dental Training.
	TB Hospitals	
	Psychiatric Mental Hospitals	
Central hospital services	Central hospital services	Highly specialized health care services; training of health workers; research; specialist referral centres for regional hospitals and neighbouring provinces.
Health sciences and training	Nursing Training Colleges	Plan, produce and manage the education, training and development needs of DoH staff and health professionals.
	EMS Training College	
	Bursaries	
	Other Training	
Health care support services	Orthotic & Prosthetic Services	Non-clinical services, including uninterrupted and reliable supply of medicines and consumables.
	Medicine Trading Account	
Health facilities management	Community Health Facilities	Plan, provide and equip new facilities/assets, and to upgrade, rehabilitate and maintain hospitals and clinics.
	Emergency Medical Rescue Services	
	District Hospital Services	
	Provincial Hospital Services	
	Other Facilities	

In the 2017/18 budget, almost half of provincial health resources were allocated to District Health Services which include primary health care. In relative terms, allocations to this programme grew from 42% in 2010/11 to 46% in 2017/18. This growth is largely related to growing HIV budgets which are a sub-programme of District Health Services. In the same period, the percentage share of allocations to tertiary health care increased from 18% to 20% while allocations to Provincial Hospital Services and Health Facilities Management have slightly decreased.

Figure 24 shows great differences in how provinces allocated their public health resources among the different programmes in 2017/18. Whereas Limpopo allocated 63% of its health budget to District Health Services, Gauteng only allocated 34%. Gauteng, Western Cape and Free State had the lowest allocations to District Health Services but allocated the highest proportions of their health budgets to central hospitals (35%, 28% and 25% respectively). The Northern Cape and the Free State, the two provinces with the lowest population density, had relatively higher allocations to emergency services (including transport) compared to other provinces. The share of provincial budgets allocated to administration (programme 1) ranged from 2% in Gauteng and Limpopo to 4% in the Western Cape and the Northern Cape.

Figure 24: Provincial health allocations by programme (percentage) 2017/18

Data Source: Estimates of Provincial Revenue and Expenditure 2017/18



How much do provinces allocate to primary health care?

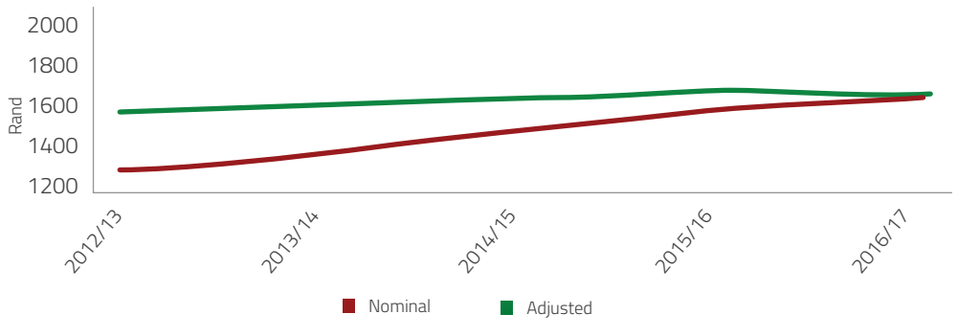
In all 9 provinces, District Health Services is the biggest programme accounting for almost half (46%) of the 2017/18 provincial budgets. This programme is particularly important for monitoring the health expenditure since its biggest component is primary health care. Except for the Northern Cape, all provinces allocated a higher percentage of their health budget to District Health Services in 2017/18 compared to 2010/11.

In 2016/17 provincial departments of health budgeted a total of R75 billion for District Health Services. When divided by the number of uninsured people, approximately R1 622 should have been spent per person not covered by a medical scheme. A large proportion of expenditure on District Health Services goes to district hospitals. Since district hospitals are not evenly spread across provinces and districts it is not useful to compare expenditure across provinces and districts.

Comparing provincial expenditure trends on District Health Services per uninsured person between 2012/13 and 2015/16 shows that there has been a real growth between 2012/13 and 2015/16. However, expenditure per uninsured population was only R1 622 in 2016/17. This is a 2% drop compared to the previous budget period when nominal values are adjusted for inflation (see Figure 25).

Figure 25: Consolidated district health service expenditure per uninsured person (2012/13 to 2016/17)

Data Source: Estimates of Provincial Revenue and Expenditure 2012/13 to 2016/17, 2016 General Household Survey, StatsSA 2016 mid-year population estimates.



Provincial expenditure on primary health care can be calculated by only including following sub-programmes which all fall under district health services:

- Community health clinics,
- Community health centres
- Community-based services,
- Other community services,
- HIV and AIDS and
- Nutrition.

Figure 26 shows the differences in primary health care expenditure per uninsured person by province for 2016/17. Eastern Cape, Mpumalanga and Limpopo have the lowest expenditure rates, ranging from R820 to R870 per person without medical aid. On the other side of the spectrum are the Northern Cape and KwaZulu-Natal and the North West Province which spent more than R1 000 per uninsured person in 2016/17.

Figure 26: Primary health care expenditure per capita (uninsured) by province, 2016/17

Data Source: Own calculations based on Stats SA Mid-year population estimates 2016, General Household survey 2016 and Estimates of Provincial Revenue and Expenditure 2017/18

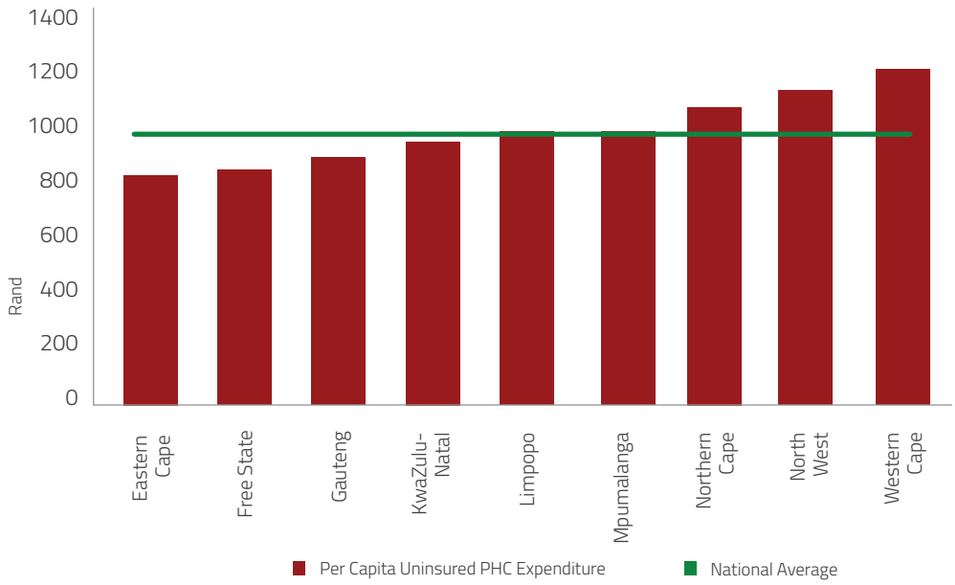


Figure 27 shows that the three provinces with the lowest PHC expenditure rates per uninsured person also have the lowest percentage allocations to their primary health care sector. Whereas expenditure on primary health care programmes in Gauteng, North West Province and the Northern Cape take up more than 65% of the overall budget on District Health Services they are below 50% in Limpopo and Mpumalanga and just slightly above 50% in the Eastern Cape.

FOOTNOTES:

66. Massyn N, Peer N, English R, Padarath A, Barron P, Day C, editors (2016) District Health Barometer 2015/16. Durban: Health Systems Trust, p.8.

Figure 27: Percentage allocation to PHC compared to other sub-programmes of District Health Services

Data Source: Estimates of Estimates of Provincial Revenue and Expenditure 2016/17

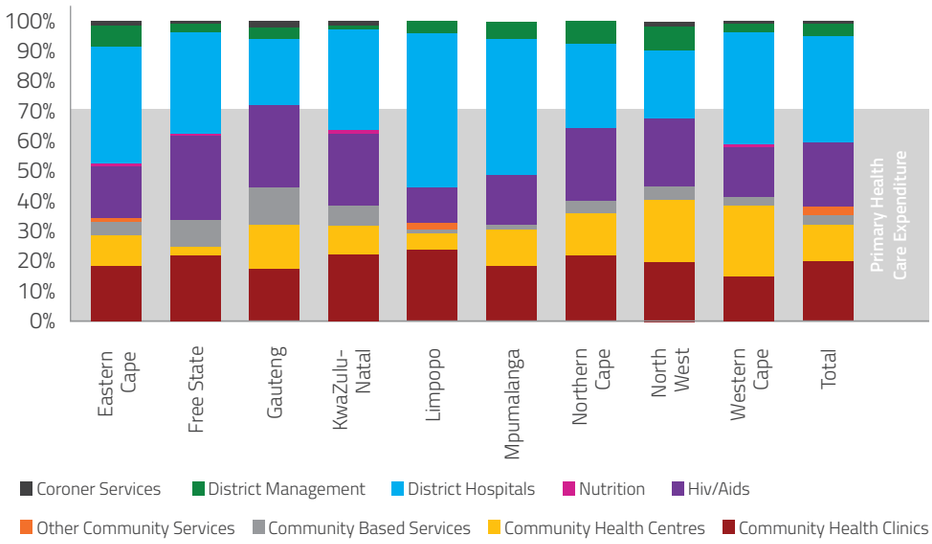
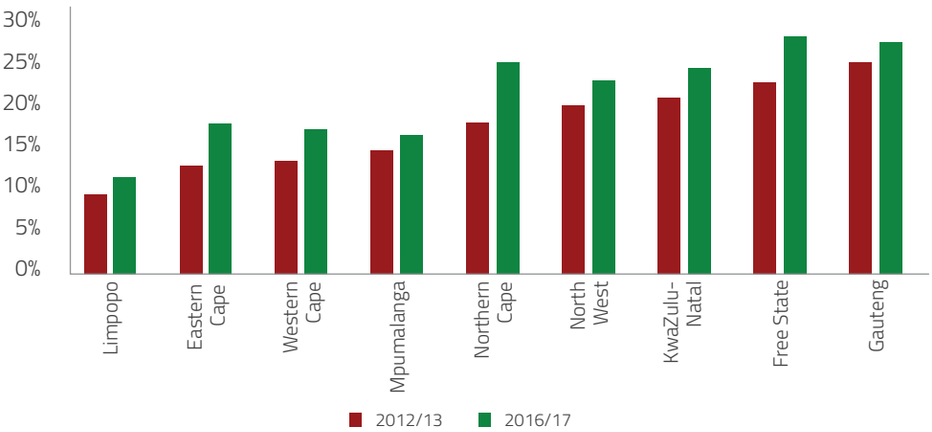


Figure 28 shows that Limpopo and the Eastern Cape allocated the smallest amount of their budget on District Health Services to HIV and AIDS in 2012/13 (10% and 13% respectively). While Limpopo is still at the bottom of the list in 2016/17, allocations in EC have increased up to 18%. On average, provinces allocated 21% of their district health budgets to HIV and AIDS interventions in 2016/17. The biggest percentage increases in allocations to the HIV and AIDS between 2012/13 and 2016/17 happened in the Free State and the Northern Cape.

Figure 28: Percentage OF allocation to HIV AND AIDS sub-programme from budget on District Health Services

Data Source: Estimates of Provincial Revenue and Expenditure 2012/13 to 2017/17



How much are provinces spending on personnel costs compared to other categories?

During the last five years personnel costs and costs for medicines and supplies increased above inflation. This trend is reflected in provincial budget allocations. Provincial expenditure estimates for 2016/17 show that provinces spent a bigger share of their health budgets on salary costs and goods and services (e.g. medicines and equipment) compared to 2010/11. Increased spending on salaries and commodities consequently led to decreasing expenditure on capital costs including infrastructure (see Figure 29).

Figure 29: Budget payments on health services by province 2016/17

Data Source: NT, Provincial budgets and expenditure review: 2010/11 - 2016/17

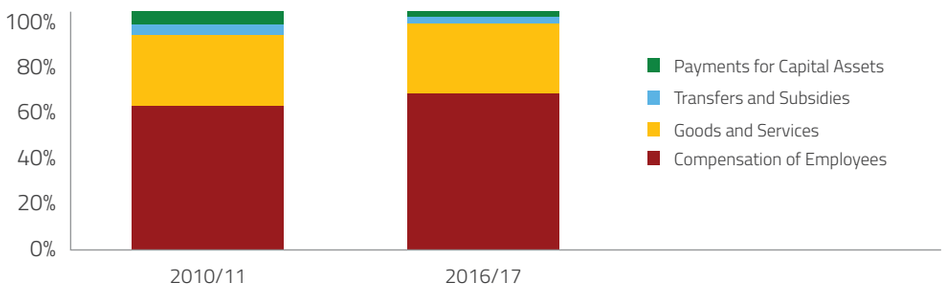
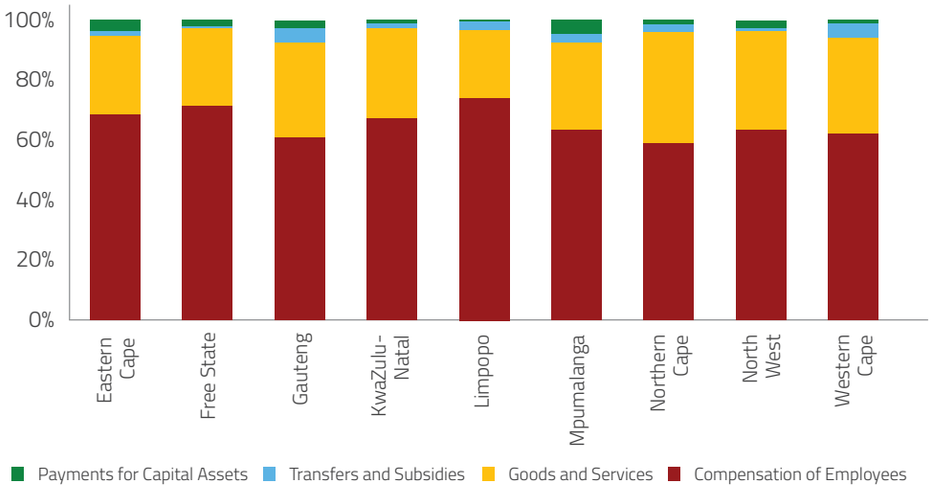


Figure 30 shows the differences in how provinces allocated their health resources to different spending categories. Limpopo and Free State allocate more than 70% of their health budgets to personnel costs while Gauteng and Northern Cape only allocate around 60% for compensation of employees. The trend is reversed with regard to costs for goods and services such as medication and health equipment. Limpopo and Free State allocated only 22 and 26% respectively of their budget to goods and services while Northern Cape and Gauteng allocated 37% and 32%.

Figure 30: Provincial allocations to health budget by economic classification 2016/17

Data Source: NT, Provincial budgets and expenditure review: 2010/11 - 2016/17



2.9 SUMMARY OF FINDINGS

Slow economic growth, a depreciating rand and increasing debt servicing costs are continuing to put pressure on public expenditure in South Africa. The government, so far, has managed to protect health expenditure from major budget cuts. Between 2016/17 and 2019/20, expenditure by the national and provincial health departments is expected to grow on average by 8.3% per year from R170.9 billion to R217.1 billion. Consolidated health spending is the third fastest growing budget item after debt service costs and higher education. Growth in health expenditure is mainly driven by the expansion of the universal HIV test-and-treat policy and the establishment of a national health insurance fund.

Almost half of South Africa's overall expenditure on health stems from private expenditure on health including payments to medical schemes, out-of-pocket health payments, medical insurance and employer contributions.[67] However, only about a fifth of the population are members of medical aid schemes who benefit from private health services.[68] The rest of the population is dependent on public health services or has to pay out-of-pocket to access private health care services. In most other upper-middle income countries the pubic share of health spending is higher than in South Africa.

The proposed introduction of the National Health Insurance (NHI) is supposed to address the inequity in the distribution of health benefits through a single, publicly owned and administered NHI Fund that purchases health services on behalf of the entire population from suitably accredited providers. It is however unclear how this model will be financed. The most pertinent questions with regard to the funding of the NHI are how generated funds will be pooled and how quality services will be purchased.

Budget allocations to the National Department of Health (DoH) grew steeply between 2007/08 and 2011/12 after which they increased slightly above the inflation rate. In 2017/18, the overall budget of the department amounts to R42.6 billion. 92% of this budget will get transferred to provinces through conditional grants.

FOOTNOTES:

67. National Treasury (2015) Provincial Budgets and Expenditure Review: 2010/11 - 2016/17, 53.
68. Statistics South Africa (2017) General Household Survey 2016, p.24.

Approximately 94% of the total public health expenditure in South Africa is spent by or channelled through provincial health departments. It is therefore crucial to analyse how provinces allocate resources to their respective health sectors and how they spend it. In 2016/17, provinces allocated in average 32% of their overall resources (including conditional grants) to their health sector. Allocations to the health sectors ranged from 36% in Western Cape and Gauteng to 26% in Mpumalanga and North West province. The latter two provinces also had the lowest allocations per uninsured person (R2 900 and R3 240 respectively) followed by Limpopo and the Eastern Cape (both approximately R3 300) in 2016/17.

Great differences among provinces also exist with regard to expenditure on primary health care. In 2016/17, Limpopo, Mpumalanga and Eastern Cape had the lowest percentage allocations to their primary health care sector and the lowest expenditure rates per capita, ranging from R820 to R870 per person without medical aid.

During the last five years personnel costs and costs for medicines and supplies increased above inflation which put additional strain on provincial health budgets. Increased spending on salaries and commodities consequently led to decreasing expenditure on capital costs including infrastructure.

The 2017/18 budget reflects spending cuts of personnel costs amounting to R97 million or 11.3% compared to the previous year. These reductions were introduced to comply with spending ceilings set by the National Treasury. In 2017/18, personnel costs account for 62% of the total health budget. It will be crucial to monitor that provinces do not freeze critical health professional posts in underserved and rural areas. Further clarification is needed to help provinces determine which posts are critical and in which settings.

CHAPTER THREE:
THE STATUS OF THE RIGHT TO HEALTH CARE:
what indicators tell us

SPII's monitoring of socio-economic rights combines analysis of the content and implementation of government policies and budgets with an assessment of their outcomes on the ground. This requires the development of performance and impact indicators relevant to the right to health care that can be tracked and monitored over time, using public and easily accessible data.

Three statistical dimensions of the progressive realisation of socio economic rights:

Access indicators assess both physical and economic access to rights. Assessing physical access includes availability – i.e. are there sufficient facilities, goods and services, and programmes available for accessing the relevant right. Access indicators also measure economic access or affordability which includes the upfront and on-going costs incurred in accessing rights for right-holders.

Adequacy indicators measure the quality and acceptability of the facilities, goods and services, and programmes. These indicators also evaluate if basic norms and standards (as a minimum) have been met, and acceptability standards - if facilities, goods and services are ethically sensitive, culturally appropriate and gender sensitive.

Quality indicators although similar to adequacy, focus on outcome or impact. Indicators measure wellbeing and how much the quality of life of an individual or household has changed by gaining access (or not) to the right.

The indicators are designed to measure the enjoyment of the right of access to health care in South Africa, and to evaluate the state's performance in providing accessible and adequate health services which lead to improved health outcomes. To identify disparities among different population groups and assess progress over time it is important that the data can be disaggregated by province and ideally, income, race, gender and age – wherever possible and useful. An on-going challenge with the development of indicators is the balance between a set of indicators which capture the complexity of rights which are at the same time focused, accessible and easy to understand for non-experts.

To ensure broad ownership of the monitoring framework of the right to health care in South Africa, SPII has consulted experts and key stakeholder in the health sector in the selection process of indicators.

In total 11 interviews were conducted with representatives of following institutions and organisations:

Health Systems Trust	Wits University
National Treasury	Treatment Action Campaign (TAC)
UNICEF South Africa	Section 27
Rural Health Advocacy Project (RHAP)	Rural Rehab South Africa
	Centre for Economic and Social Rights

The selection of indicators is based on a broad literature review to unpack the right to health and to align selected indicators to already existing reporting formats such as the Sustainable Development Goals or the indicators monitored by the Department for Performance, Monitoring and Evaluation (DPME) in the Presidency, including the Constitution and the National Development Plan.

The criteria used to select the final set of indicators include:

- data is publicly available from a reliable source
- data is updated annually
- data can be disaggregated by geographic area, income group, race or gender
- the indicator is easy to understand by the general public
- the indicator is SMART – Specific, Measurable, Attainable, Relevant and Time-bound

In line with SDG 3 "Ensure healthy lives and promote well-being for all at all ages" and Outcome 2 of the Negotiated Service Delivery Agreement (NSDA) "A Long and Healthy Life for All South Africans" the initial list of indicators was structured in five focus areas:

- Child and Maternal Health
- TB and HIV
- Non-communicable diseases
- Family Planning
- Health system and infrastructure

Unless otherwise stated, the indicators in this section reflect the public health care sector.

Figure 31: Indicators for the right of access to health care services

ACCESS INDICATORS

HEALTH CARE BURDEN ON THE STATE

1. Percentage of people covered by medical aid schemes

HEALTH CARE SYSTEM AND INFRASTRUCTURE

2. Percentage use of different health care facilities
3. Percentage of households using nearest health care facility of its kind
4. Time taken to nearest health care facility

CHILD AND MATERNAL HEALTH CARE AND FAMILY PLANNING

5. Percentage of pregnant women visiting health care facility within first 20 weeks of pregnancy
6. Immunisation coverage rate
7. Couple year protection rate

HIV, AIDS AND TUBERCULOSIS

8. Percentage of population who tested for HIV
9. Percentage of eligible HIV positive women initiated on ART during pregnancy
10. Percentage of HIV-exposed neonates who received HIV PCR test within 6 days of life

ADEQUACY INDICATORS

ADEQUACY OF HEALTH CARE SYSTEM AND INFRASTRUCTURE

11. Satisfaction rate with public health care facilities.
12. Bed utilisation rate
13. Number of health workers per 100 000 population

ADEQUACY OF CHILD AND MATERNAL HEALTH CARE

14. Maternal mortality rate in facilities
15. Inpatient early neonatal mortality rate
16. Inpatient under 5 years mortality rate

ADEQUACY OF HIV, AIDS AND TUBERCULOSIS HEALTH CARE

17. TB cure rate

QUALITY INDICATORS

QUALITY OF LIFE

18. Life expectancy
19. Teenage pregnancy
20. Infant mortality rates

HEALTH OUTCOMES DUE TO DISEASE

21. Burden of disease
22. HIV prevalence
23. HIV and AIDS indicators
24. Percentage of deaths due to AIDS

DISEASE INCIDENCE AND PREVALENCE

25. Tuberculosis incidence rate
26. Hypertension prevalence
27. Diabetes incidence

The remainder of this chapter presents our 32 indicators developed to monitor the progressive realisation of the right of access to health care services in South Africa. They have been populated with data from 2002 – 2016 wherever possible, though some indicators have smaller date ranges, due to availability of consistent (comparable) data The indicators present trends, both historically, and presently emerging, which can help us identify successes, failures, and causes for concern in the process of increasing access to health care services. This evidence of present and past levels of respect, protection, promotion and fulfilment[69] of the right to healthcare services will be useful to government officials who want to accelerate the pace of change in the country, as well as those outside government involved in advocacy initiatives, community interventions and legal assistance that seek to promote the advancement of this right. Combined with the findings of the budget analysis in subsequent chapters, this evidence feeds into recommendations at the end of the paper which aim to ensure the rectification of gaps and retrogression as well as enhanced protection and accelerated progressive realisation and fulfilment of the right of access to health care services.

Absolute change vs relative change

The majority of the trends tracked in the indicators that follow are presented in terms of relative change (see below), which is then converted into a percentage.

$$\textbf{Absolute Change} = \text{Latest Value} - \text{Initial Value}$$

$$\textbf{Relative Change} = \frac{\text{Latest Value} - \text{Initial Value}}{\text{Initial Value}}$$

This is done for two reasons. The first is that measuring the change in indicators in relative terms allows us better insight into the trends that develop over time in the measurement of indicators because our measure of change is relative to where the measurements for the indicator began, i.e. the measure of change is anchored to the indicator's initial performance.

The second reason is that converting relative change to a percentage allows us to establish a conformity for tracking change across indicators, even if those indicators are measuring very different quantities. Some indicators will generally present low quantities, and others will generally present high quantities. The inpatient mortality rate for children younger than 5 years (Indicator X), for instance, will always present low percentages. The immunisation coverage rate for children younger than 1 year, on the other hand, will always present high percentages. This has implications for measuring the levels of change in a given indicator.

As an example, an indicator which changes from 1% to 2% over the data period (this indicator clearly presents low quantities) would have an absolute change of 1%. An indicator which change from 50% to 100% over the same period (this indicator clearly presents higher quantities) would have an absolute change of 50%. On a measurement of absolute change, the second indicator in this example would have a far higher rate of change. This is misleading, however, as using a measurement of relative change shows that both indicators changed by 100%.

The conformity allowed for by relative change also allows us to compare indicators which are measuring very different things. The change in the number of medical professionals per 100 000 population (Indicator 13), for instance, is a measurement of a quantity ratio. This is incomparable with a measurement of percentage, such as the percentage of people living in South Africa who are covered by a medical aid scheme (Indicator 1), unless we use relative change to track the performance in these indicators.

FOOTNOTES:

69. As per the state's mandate in terms of Section 7(2) of the Constitution of South Africa.

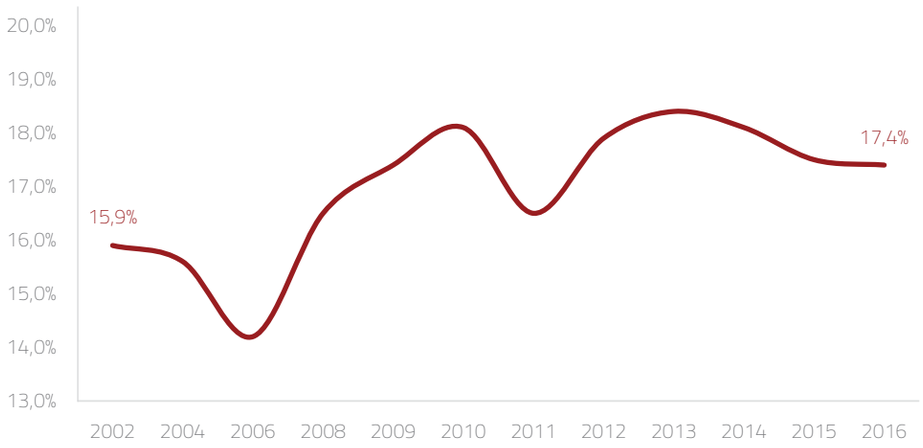
3.1 ACCESS INDICATORS:

ACCESS – STATE HEALTH CARE BURDEN

DESCRIPTION: This indicator tracks the extent of medical aid coverage in South Africa. This gives us an indication of the percentage of the population dependant on the state's provision of health care due to not being covered by the private sector, which allows us to gauge the extent of the state's health care burden.

INDICATOR 1: Percentage of people covered by a medical aid scheme, 2002 – 2016.

DATA SOURCE: General Household Survey (StatsSA), 2002 – 2016.



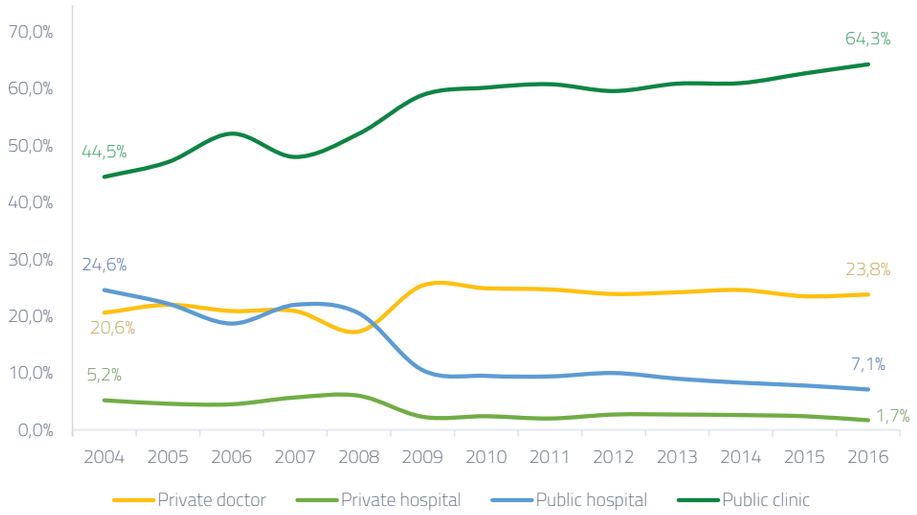
The percentage of people covered by a medical aid scheme since 2002 has fluctuated, but overall has increased by 9.4% from 15.9% to 17.4%. With more than 4 in every 5 people in South Africa falling outside the protection of the private health care sector, the state must shoulder a considerable majority of the health care needs of people living in South Africa. This only emphasises the urgency with which National Health Insurance (NHI) must be implemented.

In the next indicator, we explore the distribution of this burden across different health care facilities.

INDICATOR 2: Percentage of use of different health care facilities, 2002 – 2016.

DATA SOURCE: General Household Survey (StatsSA), 2002 – 2016.

DESCRIPTION: This indictor tracks the use of different kinds of health care facilities in South Africa, which allows us to gauge the distribution of the burden of health care services across facilities.



The use of health facilities represents a dramatic increase of the use of primary health care facilities in both the private and public sector. A 71% drop in the use of public hospitals since 2004 is mirrored by a 67% drop in the use of private hospitals. Conversely, there has been a 44.5% increase in the use of public clinics and a 15.5% increase in the use of private doctors. Less than half (44.5%) of people in South Africa made use of public clinics in 2004, while almost two-thirds (64.3%) were using public clinics in 2016. More people (24.6%) used public hospitals in 2004 than private doctors (20.6%), while in 2016, more than twice as many people (23.8%) used private doctors than public hospitals (7.1%).

The increasing use of primary health care facilities is a positive trend. It suggests that secondary health care facilities, like district hospitals, will be less burdened by cases which can be managed at the primary level and more able, as a result, to deal with more complex cases. Increased use of primary facilities also means that these facilities are succeeding in fulfilling the intention of being more accessible. Because there are more of them, they are more often than not closer to people's homes than the nearest secondary facility.

In the following indicator, we further explore the geographical accessibility of health care facilities.

ACCESS – HEALTH CARE SYSTEM AND INFRASTRUCTURE

INDICATOR 3: Percentage use of nearest health care facility of its kind, 2002 – 2016.

DATA SOURCE: General Household Survey (StatsSA), 2002 – 2016.

DESCRIPTION: This indictor tracks how regularly people are using the health care facilities of its kind, which allows us to gauge people's confidence and satisfaction with the health care facilities near to where they live.

This indicator reflects how regularly people use the nearest health facility of its kind, that is, if people use the clinic, that is closest to them, and if people use a hospital, whether they go to the hospital that is nearest to them. This reflects people's confidence in the health care facilities to which they have the easiest access.

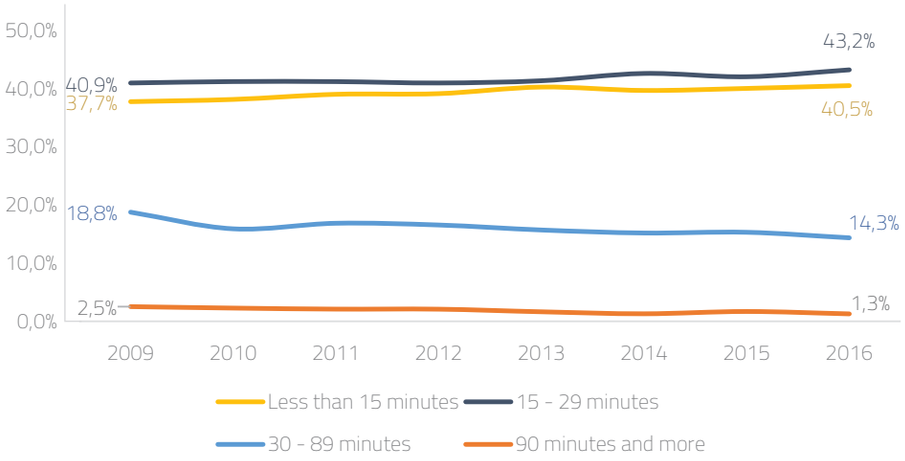
While a high percentage of people in South Africa use the nearest health care facility of its kind (92.6%), only slightly more people were using the nearest health facility in 2016 when compared with 2009. Nevertheless, this indicator shows that more than 9 in every 10 people in South Africa have some confidence in the health care facilities nearest to where they live.

ACCESS – HEALTH CARE SYSTEM AND INFRASTRUCTURE

INDICATOR 4: Time taken to nearest health care facility, 2009 – 2016.

DATA SOURCE: General Household Survey (StatsSA), 2002 – 2016.

DESCRIPTION: This indictor tracks the time people take to reach their nearest health care facility in South Africa, which allows us to gauge the geographical accessibility of health care services.



Between 2009 and 2016 there were moderately positive trends in the time it takes for people to get to their nearest health care facility. The percentage of people spending less than 30 minutes to get to the nearest health care facility increased by 6.5% over the period, while the percentage of people spending more than 30 minutes to get to their nearest health care facility decreased by 27% over the period, which is a positive indicator of improved access.

Overall, more than 8 in every 10 people living in South Africa live within 30 minutes of their nearest health facility. This too is a positive indicator, and suggests that health care facilities are generally geographically accessible.

Care must be taken in the interpretation of this indicator, however. People living in more densely populated and better resourced urban areas in South Africa are naturally located nearer to health care facilities. Higher population density also allows for single facilities to serve a greater number of people. Geographic access to health care facilities in far-flung rural areas, however, remains uneven. Dispersed rural populations mean that people are regularly required to travel long distances, in areas where transport infrastructure is often poor, to reach a health facility.

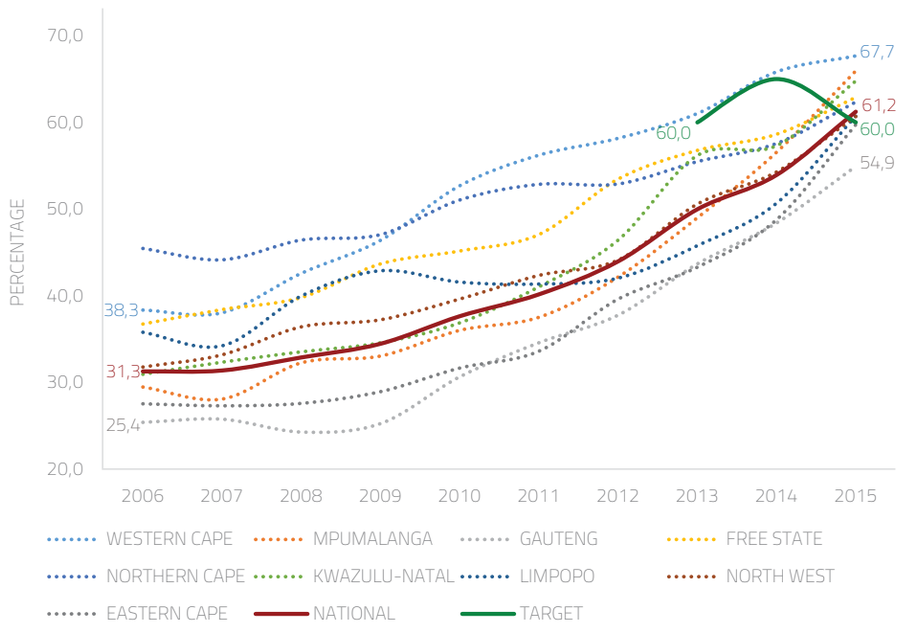
Despite a generally strong performance in this indicator, the above concern cannot be overlooked. Building, maintaining and staffing enough health care facilities in these parts of the country is financially unfeasible, especially in light of the current financial constraints faced by the Department of Health. Increased government support of community health care workers does, however, have the potential to offset the inequalities in geographical access to health care facilities by taking health services directly to communities and homes. Well supported community health care work has been shown to improve health outcomes in poor communities globally, and especially with regard to reducing maternal and infant mortality rates. Government must do more to formalise this service, however, and employ more community health care workers as a direct component of South Africa's primary health care system.

ACCESS – CHILD AND MATERNAL HEALTH CARE AND FAMILY PLANNING

INDICATOR 5: Percentage of pregnant women who visit a health care facility within the first 20 weeks of their pregnancy, 2006 – 2015, per Province.

DATA SOURCE: District Health Barometer, 2006 – 2015.

DESCRIPTION: This indictor tracks the percentage of pregnant women in South Africa per province who visit health care facilities within the first 20 weeks of their pregnancy, which allows us to gauge women's access to services which are critical to the reduction of maternal and child mortality.



The revised target of the Medium Term Strategic Plan (MTSF)[70] for 2019 is that 70% of pregnant women attend antenatal care at a primary health care facility before their 20th week of pregnancy. Quality health care services for pregnant women and girls are crucial to reduce maternal and child mortality. Antenatal care services offer an important opportunity for linking pregnant women with the formal health system and for increasing the chance of a skilled attendant at birth. During these visits, pregnant women are screened for complications that may develop during pregnancy and are tested for HIV. If tested positive, they are supposed to receive ART treatment to prevent transmission of HIV from mother to infant.

While it must be kept in mind that this indicator does not cover women who choose to see private gynaecologists, antenatal visits before 20 weeks have seen positive trends nationally and in every province. While less than one in three pregnant women visited a health care facility within the first 20 weeks of their pregnancy in 2006, almost two in every three visited a health care facility within the first 20 weeks of their pregnancy in 2015, which was also the first year in which antenatal visits exceeded the departmental target of 60%. This number is still low considering that antenatal care is free in South Africa.

FOOTNOTES:

70. The MTSF is government's strategic plan for an electoral term. The current administration's final MTSF year is 2019.

A 2014 study by Amnesty International on access to antenatal care in South Africa identified that access to these essential services was curtailed by three main barriers:

- Violations of the right to privacy and confidentiality about HIV status of pregnant women;
- Need for more health information about contraception, HIV prevention and the importance of antenatal care,
- Transport and cost barriers due to lack of available, reliable and affordable transport to health care facilities particularly in rural areas.[71]

However provincial performances in this indicator are generally strong. Antenatal visits before 20 weeks increased by 123.4% in Mpumalanga between 2006 and 2015. Western Cape, the province with the highest percentage of antenatal visits before 20 weeks in 2015 (67.7%), saw a 77% rise in antenatal visits over the period. Gauteng, the province with the lowest percentage of antenatal visits before 20 weeks in 2015 (54.9%), and the only province below the national target, saw a 116% rise in antenatal visits over the period.

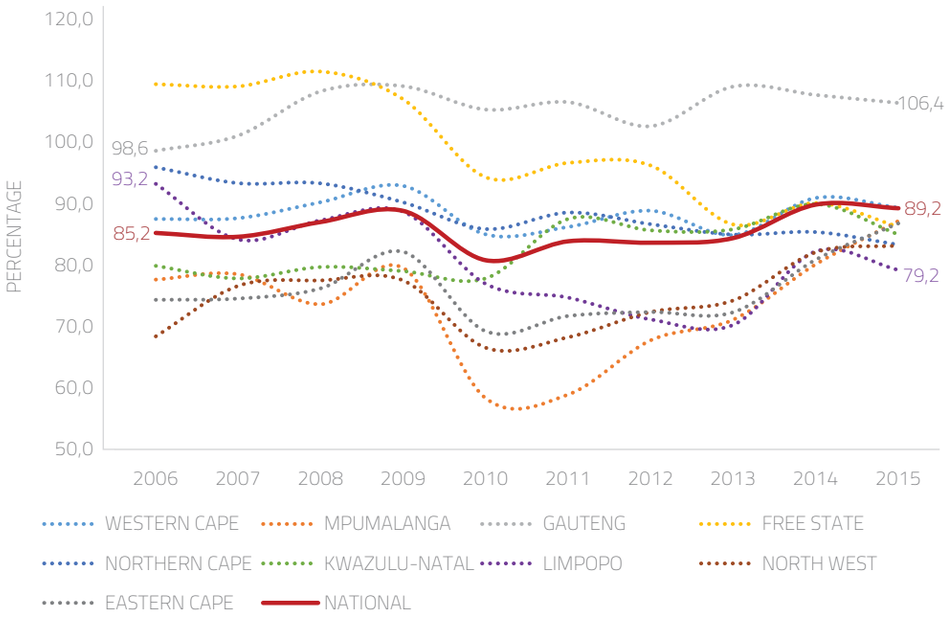
At district level, the rate of antenatal visits before 20 weeks ranged widely from 43% in A Nzo (Eastern Cape) to 79% in Overberg (Western Cape) in 2015. More than 75% of districts managed to achieve the 2015 target of at least 60% ANC attendance rate before the 20th week of pregnancy. At provincial level, only Gauteng missed this target. Data on this indicator is also encouraging since it shows that the gap in antenatal attendance rates between poorer and better off districts has closed, indicating that socio-economically disadvantaged women are not disproportionally excluded from this health service.[73]

ACCESS – CHILD AND MATERNAL HEALTH CARE AND FAMILY PLANNING

INDICATOR 6: Immunisation coverage rate under 1 year old, 2006 – 2015.

DATA SOURCE: District Health Barometer, 2006 – 2015.

DESCRIPTION: This indictor tracks the percentage of children younger than 1 years old who have been vaccinated against the main vaccine-preventable diseases, a key intervention in reducing mortality and protecting children from illness and disability.



The six main vaccine-preventable diseases are:

Pertussis | Childhood Tuberculosis | Tetanus | Polio | Measles and Diphtheria

Children are considered to have recevied all basic vaccinations when they have recevied vaccinations against:

Tuberculosis | Diphtheria, Tetanus, Pertussis (3 doses of combined vaccine)

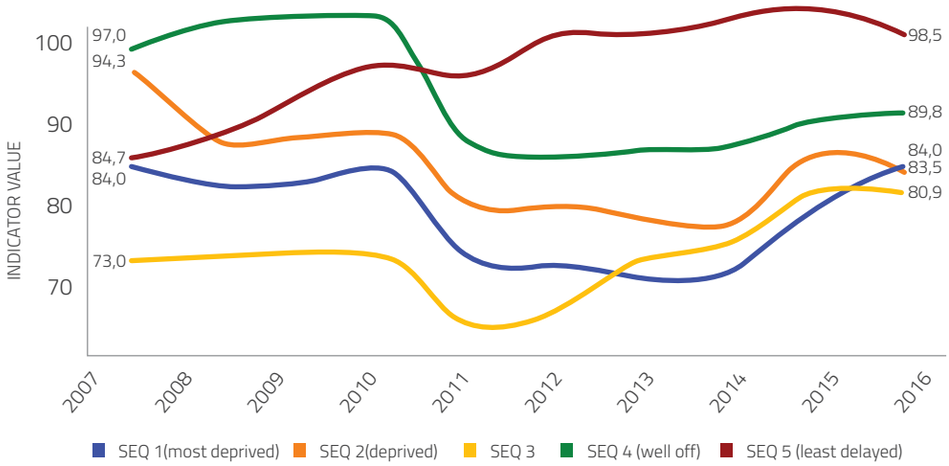
Polio (3 doses) | Measles (1 dose)

FOOTNOTES:

71. Amnesty International (2014) Struggle for maternal health. Barriers to antenatal care in South Africa. London, p. 61.
72. National Department of Health. Annual Performance Plan 2012/13–2014/15. Pretoria: National Department of Health; 2012.
73. District Health Barometer 2015/16, p.96.

Figure 32: Trends in average district values for immunisation coverage under 1 year by socio-economic quintile

DATA SOURCE: District Health Barometer 2015/16: 160.



The quality of the administrative data on immunisation coverage used to populate this indicator has been brought into question, however. The fact that Gauteng regularly had immunisation rates in excess of 100% between 2006 and 2015 illustrates these data weaknesses, which are likely due to inaccuracies in population estimates and the number of vaccinations received.[74] Considering an alternative data source for comparative purposes is thus prudent.

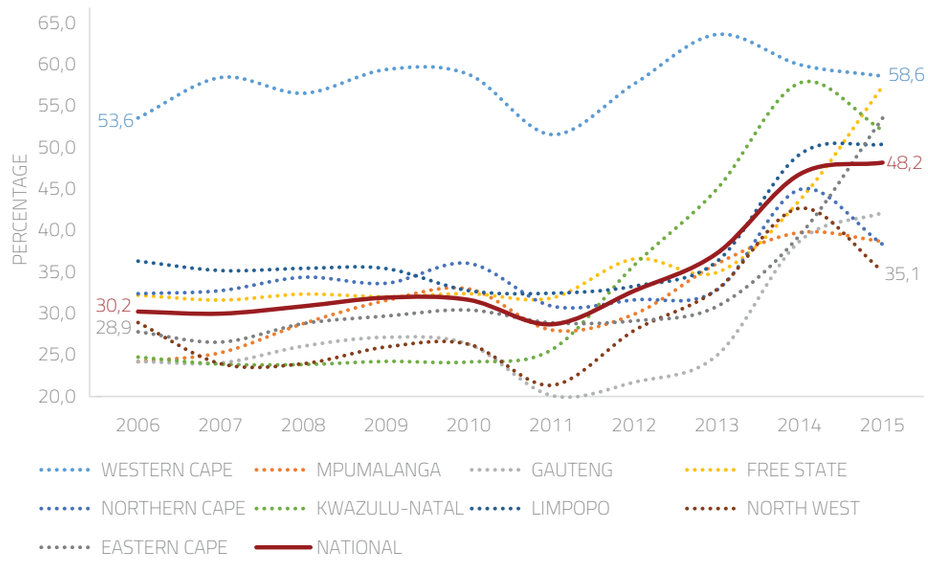
The 2016 Demographic Health Survey, based on replies from interviewed mothers and their children's vaccination records, found that only 61% of children aged between one and two years received all basic vaccinations. North West, Gauteng and Mpumalanga provinces had coverage rates below the national average (in contrast to figures gleaned from administrative data, where Gauteng was the best performing province). Girls were less likely to be vaccinated compared to boys. Among boys, 64% received all basic vaccinations while among girls only 59% were fully vaccinated. Interestingly, the proportion of children who received all basic vaccinations was lower in urban areas (59%) compared to non-urban areas (64%).[75]

ACCESS – CHILD AND MATERNAL HEALTH CARE AND FAMILY PLANNING

INDICATOR 7: Couple year protection rate, 2006 – 2015.

DATA SOURCE: District Health Barometer, 2006 – 2015.

DESCRIPTION: This indicator measures the proportion of women, aged from 15 to 49 years, who are protected against unplanned pregnancies for a year using modern contraceptive methods.



Access to contraception is a key component of women having greater control over their reproductive health. Access to family planning is also one of the most cost-effective interventions to reduce maternal mortality. South Africa has increased its couple year protection rate by 60% since 2005. This has been driven by increases across all provinces. Despite these increases, however, there remain worrying disparities between provinces. In 2015, North West's couple year protection rate was 23.5% less than the Western Cape's.

FOOTNOTES:

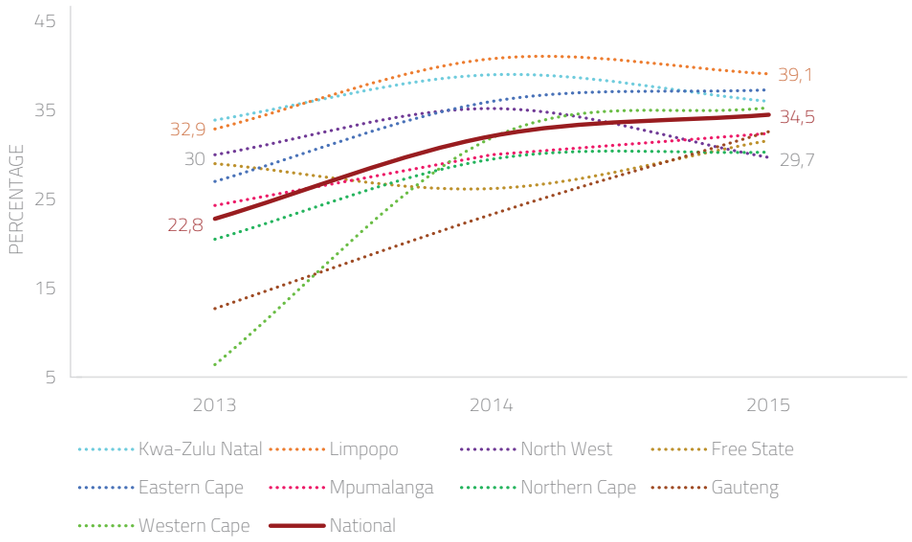
74. The District Health Information Software calculates vaccination coverage by dividing the total number of children under 1 year of age who have received all basic vaccines and by the estimated total population of children under 1 year.
75. StatsSA (2017) South Africa Demographic and Health Survey 2016: Key Indicator Report, p.23.

ACCESS – HIV, AIDS AND TUBERCULOSIS

INDICATOR 8: Percentage of population who tested for HIV, 2013 – 2015.

DATA SOURCE: District Health Barometer, 2013 – 2015.

DESCRIPTION: This indicator measures the percentage of the population, aged from 15 to 49 years, who tested for HIV per year.



More people were tested for HIV in 2015 than 2013 in every province in South Arica, except North West where there was a 1% decrease in HIV testing over the period. Nationally, there was an increase of 51.3% in HIV testing over the period. Limpopo has the highest testing coverage with 39%, followed by the Eastern Cape with 37% and KZN with 36%. In contrast, North West and Northern Cape (both 30%) have the lowest rates in HIV testing followed by Free State (32%). Gauteng managed to increase coverage by more than 10 % within one year and reached a testing coverage of 33% in 2015.

The 2016 Demographic Health Survey showed that 93% of respondents between the age of 15 and 49 knew of a place where they could get an HIV test.[76] Among younger respondents between 15 and 19 years only 86% knew where to get tested. The survey further found that knowledge of a place to get an HIV test increased with wealth. There was no urban – rural divide both with regard to knowledge where to get tested and actual testing.[77]

At a district level Johannesburg (23%), despite some improvement, had the lowest HIV testing coverage in 2015. Mgcawu in the Northern Cape and Sarah Baartman and Nelson Mandela Bay, both in the Eastern Cape, had similarly low coverage rates of under 25%. From an equity perspective, it is important to note that districts with more deprived populations (38%) have higher testing coverage rates than better-off districts (33%) which shows that this service is not affected by poverty related access barriers.

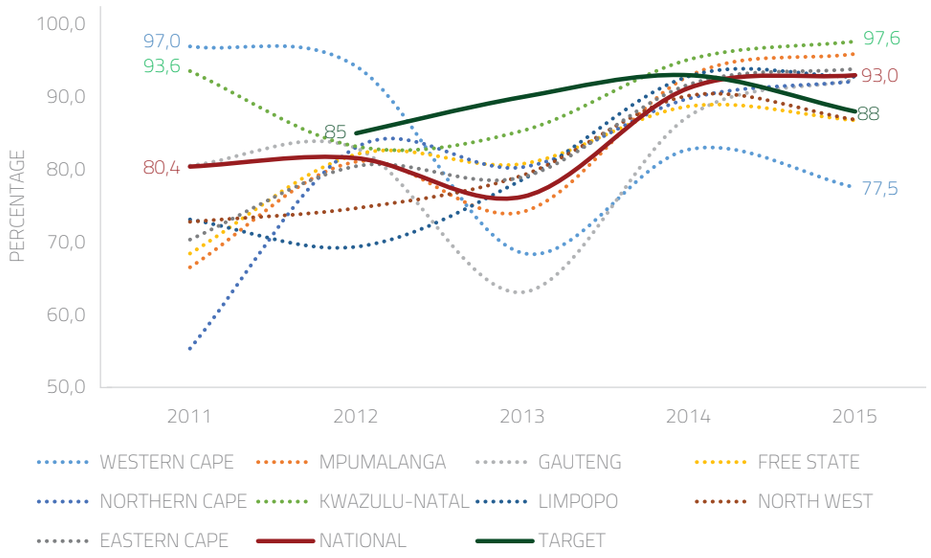
FOOTNOTES:

76. StatsSA (2017) South Africa Demographic and Health Survey 2016: Key Indicator Report, p.34.
77. DHS 2016, p. 34.

INDICATOR 9: Percentage of eligible HIV positive women initiated on ART during current pregnancy, 2011 – 2015.

DATA SOURCE: District Health Barometer, 2011 – 2015.

DESCRIPTION: This indicator measures the percentage of HIV positive women who began anti-retroviral treatment during their pregnancy, a crucial health care intervention to reduce mother-to-child HIV transmission.



The revised MTSF target for 2019 is a rate of 98% of HIV positive pregnant women initiated on ART. In 2015, South Africa adopted the WHO guidelines which recommend the initiation of ART for all HIV-infected pregnant and lactating women regardless of their CD4 cell count. This policy (Option B+) reduces the chance of mother-to-child transmission of HIV during pregnancy as well during and after the delivery and while breastfeeding.[78] South Africa has made unprecedented progress towards reducing mother to child transmission of HIV compared to other countries and has managed to reduce the risk of infant HIV infection from 8% in 2008 to an estimated 1.4% in 2015.[79]

This is partly due to South Africa's rate of antenatal clients initiated on ART increasing by 15.7% between 2011 and 2015,[80] when 93% of pregnant women who tested positive and were eligible for treatment were initiated on ART, 5% above the departmental target. However, provincial performance has largely been erratic in the measurement of this indicator. This is best exemplified by the Western Cape. The best performing province in 2011 and worst performing province in 2015, the rate of antenatal clients initiated on ART regressed by 20% over the period. North West also regressed in this indicator for the same period. KwaZulu-Natal (98%), Mpumalanga (96%) and Eastern Cape (94%) had the highest pregnancy related ART initiation rates in 2015.

At district level ART initiation rates ranged from 103.9% in West Rand (Gauteng) to 46.3% in the Central Karoo (Western Cape) in 2015. The rates above 100% are most likely the result of underestimation of the denominator, or due to client migration between sub-districts, districts and provinces. 39 out of 52 districts had rates above 90% in 2015. The 2015/16 District Health Barometer did not find differences in uptake of ART by socio-economic quintile, suggesting that access barriers with regard to benefitting from this important health service are not poverty related.

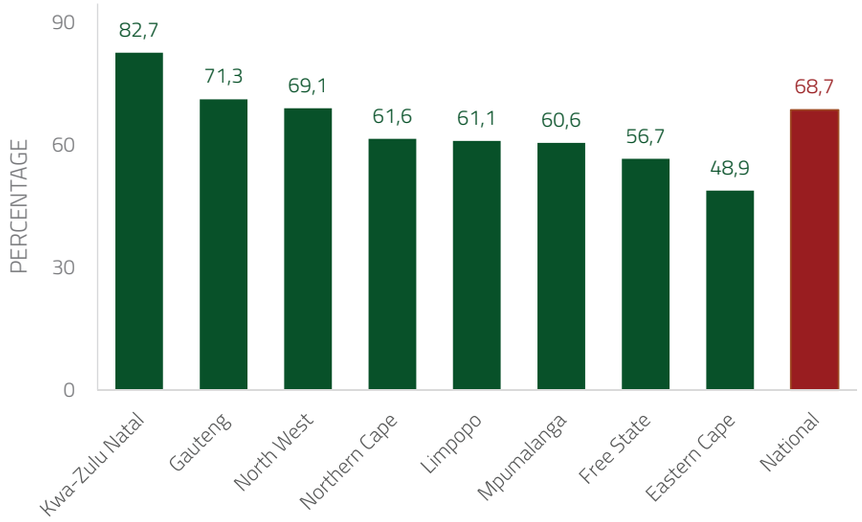
FOOTNOTES:

78. South African National Department of Health. National Consolidated Guidelines for the Prevention of Mother-to-child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults. Pretoria: NDoH; April 2015.
79. Medical Research Council of South Africa. 2016. 'Early mother-to-child transmission of HIV stats plunge' Press Release dated 19 July 2016.
80. The 'Antenatal client initiated on ART rate' indicator is calculated by dividing the numerator, which is the number of ANC clients initiated on ART by the denominator, which is the total number of ANC clients eligible for ART. See DHB 2015/16, p. 97.

INDICATOR 10: Percentage of HIV-exposed new-borns who received an HIV polymerase chain reaction (PCR) test within the first 6 days of life 2015.

DATA SOURCE: District Health Barometer, 2015.

DESCRIPTION: This indicator measures the proportion of HIV-exposed neonates who received an HIV PCR test within the first six days of life, a crucial health care intervention to encourage early ART initiation.



*No data available for Western Cape.

In 2015, South Africa introduced new guidelines to test all HIV-exposed new-borns for HIV polymerase chain reaction (PCR). 68.7% of HIV exposed neonates in South Africa received an HIV PCR test within the first 6 days of life.[81] HIV PCR birth testing coverage was highest in KwaZulu-Natal (82.7%) and lowest in the Eastern Cape (48.9%).

Some alarming coverage rates can be observed at the district level for this indicator - Lejweleputswa in the Free State, for instance, had a coverage rate of only 32.2%, and A Nzo and OR Tambo in the Eastern Cape had coverage rates of 33.8% and 24.5% respectively. One cannot help wonder what the accountability is for health care providers is who fail to meet their targets in this function, given the dramatic consequences of failure to test and treat neonates in this time period.

Coverage rates also ranged widely within provinces. For example, OR Tambo district in the Eastern Cape had a testing coverage of 25% while it was 81% in Sarah Baartman district. Four out of eight districts had birth testing coverage rates below 60% in the Eastern Cape. This indicates that the implementation of routine testing of HIV-exposed neonates in that province is lagging well behind the rest of the country.

Due to the introduction of routine HIV PCR testing at birth, a number of HIV positive neonates are being detected soon after delivery which provides the opportunity for early initiation of ART. At national level approximately, 1.1% of new-borns tested positive within the first 6 days after birth in 2015. KwaZulu-Natal (0.7%) had the lowest rate of positive tests among new-borns while Limpopo had the highest (1.7%).

FOOTNOTES:

81. The indicator on HIV PCR birth testing coverage is calculated by dividing the number of PCR tests performed on neonates within the first six days of life (numerator) by the number of HIV-exposed neonates (denominator). The denominator, HIV-exposed neonates who require a PCR test, was obtained from the DHIS indicator 'Live births to HIV-positive women'. See: DHB 2015/16, p. 104.

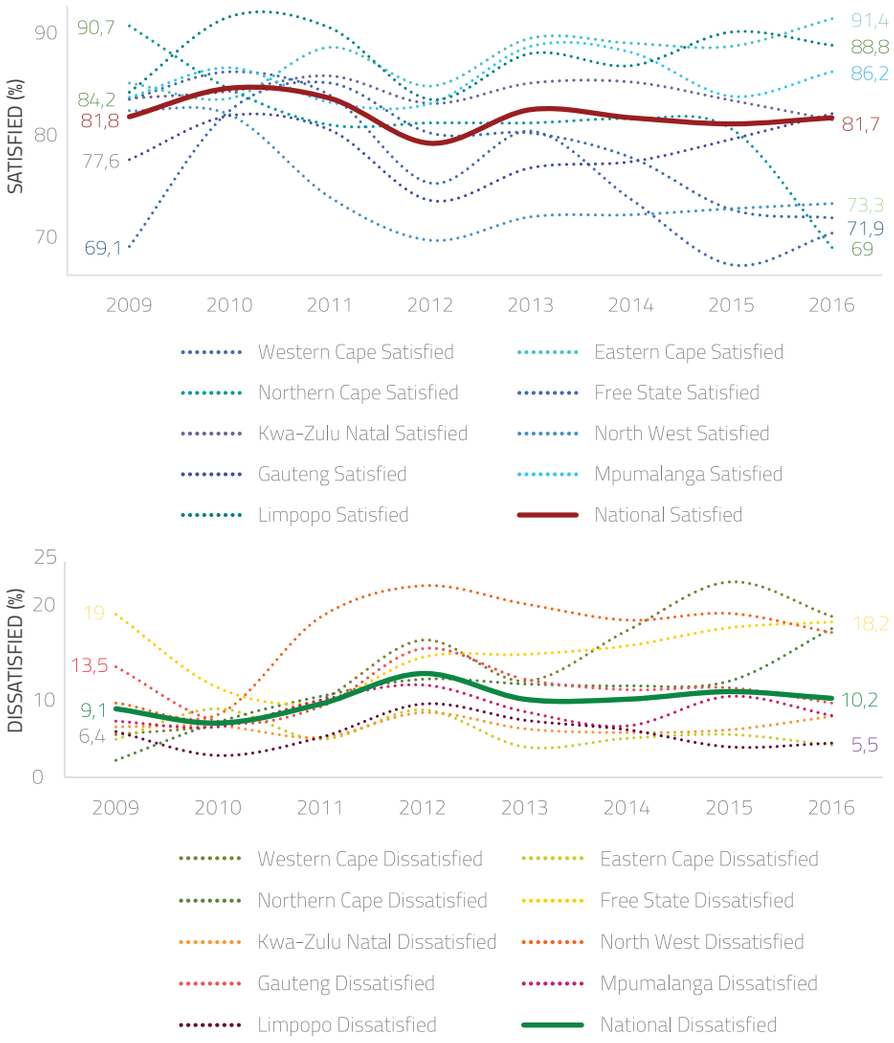
3.2 ADEQUACY INDICATORS:

INDICATOR 11: Satisfaction with public health care facilities, 2009-2016.

DATA SOURCE: General Household Survey (Stats SA), 2009-2016.

DESCRIPTION: This indicator measures people's satisfaction with public health care facilities in South Africa, and allows us to gauge the subjective experience of public health care in the country.

ADEQUACY – HEALTH CARE SYSTEM AND INFRASTRUCTURE



In the graphic above, national and provincial levels of satisfaction are tracked in shades of blue against the left-hand axis, while national and provincial levels of dissatisfaction are tracked in shades of orange against the right-hand axis.

This indicator must be interpreted with a high degree of caution. South Africa's failure to adequately overcome its apartheid heritage means that desperate poverty persists in South Africa's rural areas when compared to the urban parts of the country.[82] Often, this results in people living in rural South Africa being satisfied with far poorer health care services than their urban counterparts. Furthermore, rural residents are generally more dependent on the state for the provision of services and social security in the form of social grants. They are likely less comfortable in expressing criticism of the state's services (such as health care) as a result. When interpreting this indicator, then, the reader should keep in mind that drastic inequalities between urban and rural South Africa likely mean that levels of satisfaction are likely to be overestimated particularly amongst the poor.[83]

Overall, the change in the national levels of satisfaction with public health care facilities may at first seem minor – satisfaction levels fell by 0.1% between 2009 and 2016 - while dissatisfaction levels grew by 12.1%.

FOOTNOTES:

82. Stats SA's latest analysis of poverty trends shows that more than 8 in every 10 people living in rural South Africa are living in poverty. This can be compared to 4 out 10 people living in poverty in urban South Africa.
83. Ronelle Burger R., Ranchod S., Rossouw L., Smith A. 2016. 'Strengthening the measurement of quality of care' in Padarath A, King J, Mackie E, Casciola J, (eds) South African Health Review 2016. Durban: Health Systems Trust: 193.

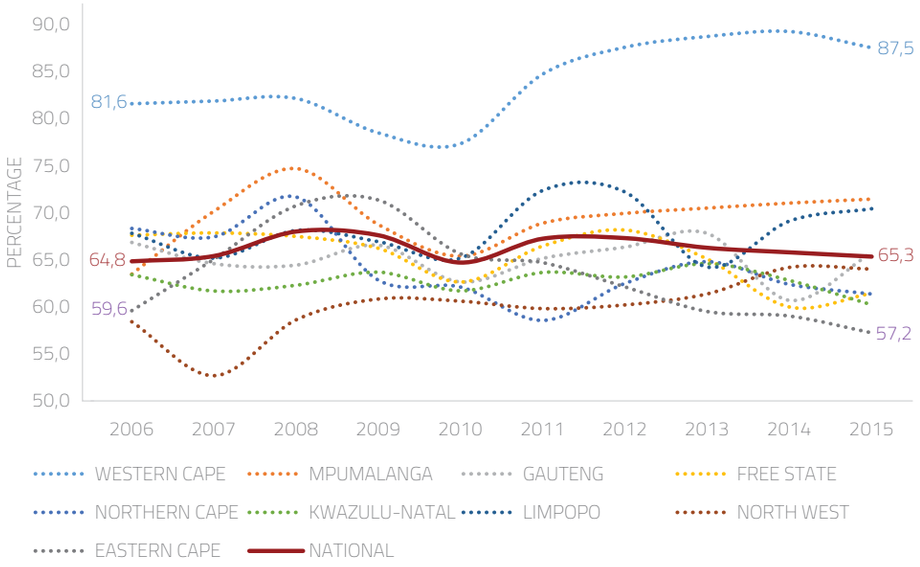
Disaggregating these trends to the provincial level is more telling, however. While only one province had satisfaction levels below 75% in 2009 (Free State), four of the nine provinces had fallen below that level by 2016 (Western Cape, Northern Cape, Free State and North West). This trend of retrogressive enjoyment is mirrored in levels of dissatisfaction with public health care facilities. While only one province had levels of dissatisfaction above 15% in 2009, four provinces had higher than 15% dissatisfaction in 2016 (again, Western Cape, Northern Cape, Free State and North West).

ADEQUACY – HEALTH CARE SYSTEM AND INFRASTRUCTURE

INDICATOR 12: Bed utilisation rate in district hospitals, 2009 – 2015.

DATA SOURCE: District Health Barometer, 2009 – 2015.

DESCRIPTION: This indictor tracks the occupancy of available beds in district hospitals in South Africa, which allows us to gauge how efficiently hospitals are using their available capacity.



District hospitals perform crucial functions in South Africa's public health care system, supporting primary health care and serving as the entry point to more specialised care. Awareness of the efficiency with which these facilities are managed is thus crucial. This indicator should be interpreted with some caution, however. A low bed utilisation rate is not always a direct reflection of poor facility management or inefficient use of resources. This is especially true, for instance, in rural parts of the country, where populations are more thinly dispersed and health care facilities are less accessible geographically.

The utilisation of available beds in district hospitals has barely increased (by 0.8%) between 2006 and 2015. This is underwritten by a severe and entrenched inequality in provincial utilisation rates. The Western Cape's utilisation rate was 30.3% higher than the Eastern Cape's was in 2015 (the former was 22.2% above the national average while the latter was 8.1% below it). The gap between the same two provinces was 22% in 2011. This means the difference between the provinces grew over the period, which is a worrying trend and suggests that consolidation between provinces in the performance of this indicator remains far-off.

ADEQUACY – HEALTH CARE SYSTEM AND INFRASTRUCTURE

INDICATOR 13: Number of health workers per 100 000 population.

Well trained, adequately paid and motivated health workers are the bedrock of any functioning health system. The 2016 South African Health Review, however, highlighted drastic shortages of human resources for health, as well as the persistent maldistribution of such resources as the two main challenges with regard to health staffing. Austerity measures have resulted in staffing moratoria in the public health sector which put service delivery at risk, as can be clearly seen below.[84] While salary increases of publicly employed health workers prevented migration of staff to the private health sector or abroad they put a huge burden on the health budget. Figure 33 shows that this austerity is particularly observable since the 20012/13 financial year, when the annual change in both filled posts in the health sector and the expenditure on compensating those posts dropped dramatically. Indeed, the sector is still reeling from the negative growth in filled posts in 2013. While filled posts in provincial Departments of Health increased by 80 679 between 2006 and 2012, they fell by 5 473 between 2012 and 2016.[85]

The Rural Health Advocacy Project has highlighted that staffing moratoria which are implemented without protecting critical posts threaten the right of access to health care.[86] Rural Rehab South Africa, an organization for occupational therapists, physiotherapist, speech- language therapists and audiologists working in rural areas, emphasize that publicly funded posts of therapists who cater for the needs of people with disabilities are often the first ones to be cut in the face of budgetary constraints.[87] Both organisations argue that health services in rural areas are particularly vulnerable during austerity and should be protected from staffing moratoria. The obligation on the state of progressive realisation of the socio-economic rights in the constitution demands that any repressive steps need to be rationally and reasonably justified. This is a requirement that oversight bodies should monitor far more proactively.

More publicly available data on health staffing is required to assess disparities in access to doctors and medical specialists between the public and private sector as well as between Provinces and districts. In particular, there is no data available on the number of pediatricians or psychiatrists working in the public sector. Rural Rehab South Africa (RuReSa) highlighted the fact that official numbers on health workers in the public sector are not always accurate and do not reflect at what level (primary, secondary and tertiary health care) and in which health district they are working.[88]

Figure 33: Trends in filled posts, real personnel expenditure and real unit costs of personnel in the health sector, South Africa, 2005/06– 2015/16 (2015/16 prices)

Data Source: South African Health Review 2017: 29.

YEAR	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Filled posts (n)	228 789	237 887	255 091	265 856	271 971	284 191	308 813	314 636	303 631	306 784	309 367
Real average unit cost (Rand per filled post)	201 285	208 011	218 615	234 080	250 837	271 638	272 601	277 161	299 501	304 359	312 598
Real expenditure on compensation (Rand million)	46 052	49 483	55 767	62 232	68 220	77 197	84 183	87 205	90 938	93 373	96 707
ANNUAL CHANGE											
Filled posts (%)	2.7	4.0	7.2	4.2	2.3	4.5	8.7	1.9	-3.5	1.0	0.8
Real average unit cost (Rand per filled post)(%)	2.2	3.3	5.1	7.1	7.2	8.3	0.4	1.7	8.1	1.6	2.7
Real expenditure on compensation (Rand million)(%)	5.0	7.5	12.7	11.6	9.6	13.2	9.0	3.6	4.3	2.7	3.6

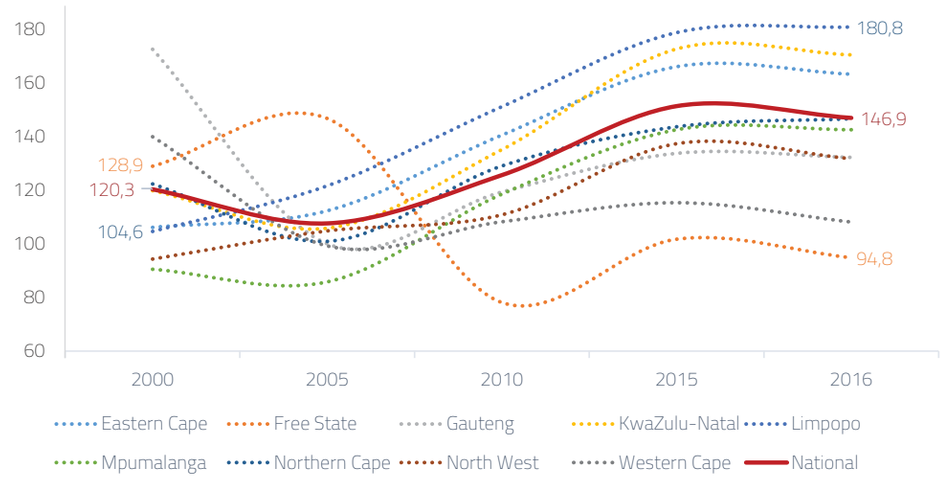
FOOTNOTES:

84. Day, C., Gray A, Vawda Y. Health and Related Indicators. In: Padarath A, Barron P, editors. South African Health Review 2017. Durban: Health Systems Trust; 2017. Available at: http://www.hst.org.za/publications/south-african-health-review-2017.
85. South African Health Review 2017: 30.
86. Rural Health Advocacy Project (2016) Causes, implications and possible responses to the implementation of staffing moratoria in the public health system in South Africa during times of budget austerity. Johannesburg: RHAP. Available at: http://www.rhap.org.za/wp-content/uploads/2016/02/RHAP_Working_Paper_V2_Frozen_posts_February_2016.pdf.
87. Bezuidenhout M., (chair of RuReSA), personal communication, June 23, 2017.
88. Bezuidenhout M., (chair of RuReSA), personal communication, June 23, 2017.

INDICATOR 13.1: Number of professional nurses per 100 000 population, 2000-2016.

DATA SOURCE: South African Health Review, 2017.

DESCRIPTION: This indicator measures how many nurses are working in the public health sector per 100 000 people.

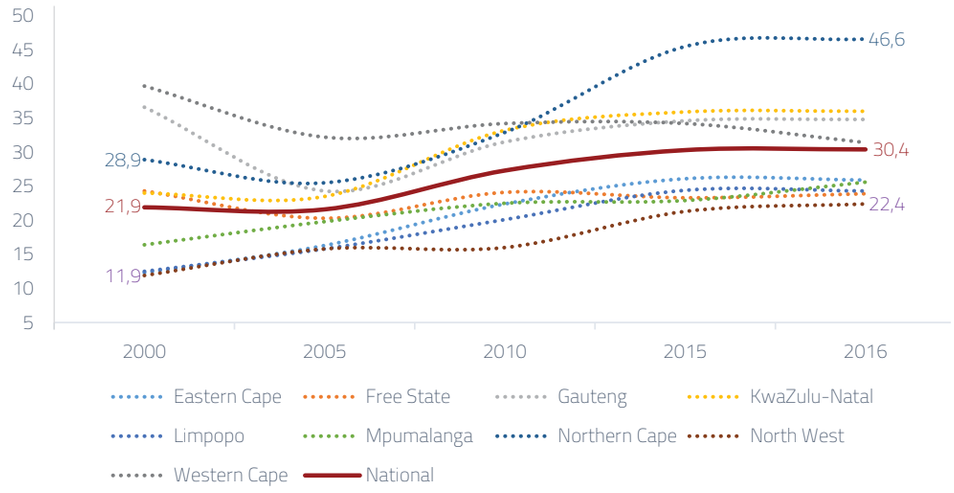


Nurses make up the largest single group of health-practitioners. They are considered the backbone of a health system since they are primary providers of healthcare to communities. The number of professional nurses in the public health sector in South Africa increased by 22.1% between 2000 and 2016 to 146.9 per 100 000 population. Increases are similarly observable in 6 of the country's 9 provinces, however the number of nurse in Free State, Gauteng and Western Cape fell by 26.5%, 23.4% and 22.7% respectively. Severe inequality exists between the provinces with regard to professional nurses: in 2016, almost twice as many nurses per 100 000 population were working in Limpopo as in the Free State.

INDICATOR 13.2: Number of medical practitioners per 100 000 population, 2000-2016.

DATA SOURCE: South African Health Review, 2017

DESCRIPTION: This indicator measures how many medical practitioners are working in the public health sector per 100 000 people.

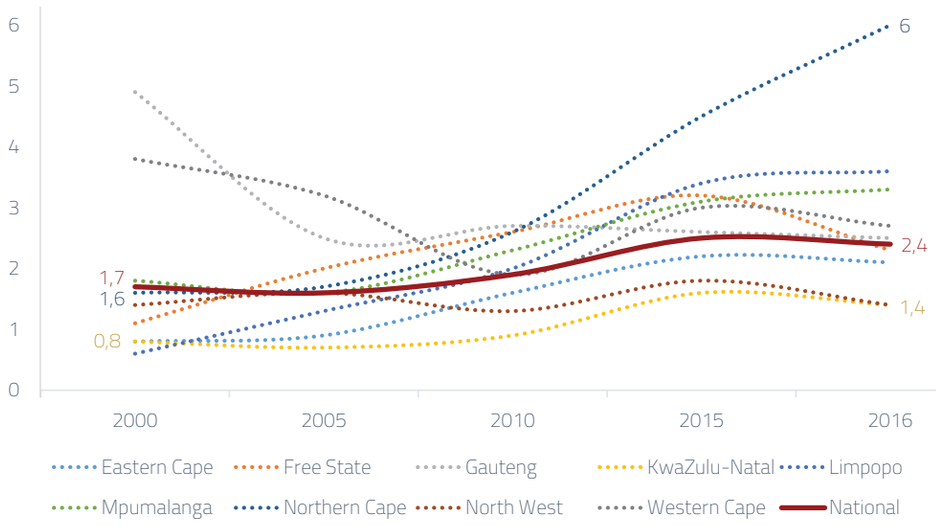


The number of medical practitioners per 100 000 population has increased steadily in the public sector from 21.9 per 100 000 population in 2000 to 30.4 in 2016, a 38.8% increase. Again, severe inequalities exist between the provinces with regard to medical practitioners: in 2016, there were more than twice as many per 100 000 population in the Northern Cape than in the North West. It is also clear that provinces which bear the brunt of internal migration (usually driven by perceived economic opportunities in urban centres) perform poorly in the measurement of this indicator during the period. The number of medical practitioners fell by 21% in the Western Cape between 2000 and 2016, for instance, and by 5% in Gauteng, while it rose by 110.5%, 94.4% and 61.2% in the Eastern Cape, Limpopo and Northern Cape respectively. In 2016, the provinces with the lowest ratios were North West (22.4), Free State (23.9) and Limpopo (24.3).

INDICATOR 13.3: Number of dental practitioners per 100 000 population, 2000-2016.

DATA SOURCE: South African Health Review, 2017.

DESCRIPTION: This indicator measures how many dental practitioners are working in the public health sector per 100 000 people.

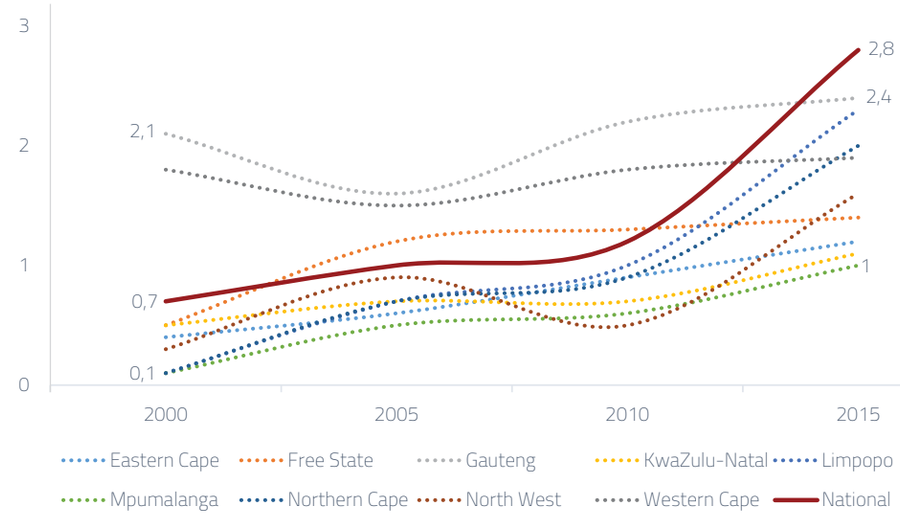


The number of dental practitioners per 100 000 population in South Africa increased by 41.2% between 2000 and 2016. The only provinces which saw overall decreases in the number of dental practitioners were Gauteng and the Western Cape, the two provinces which traditionally experience the highest levels of in-migration in South Africa. Here the number of dental practitioners decreased by 49% and 29% respectively.

INDICATOR 13.4: Number of psychologists per 100 000 population, 2000-2015.

DATA SOURCE: South African Health Review, 2017.

DESCRIPTION: This indicator measures how many psychologists are working in the public health sector per 100 000 people.

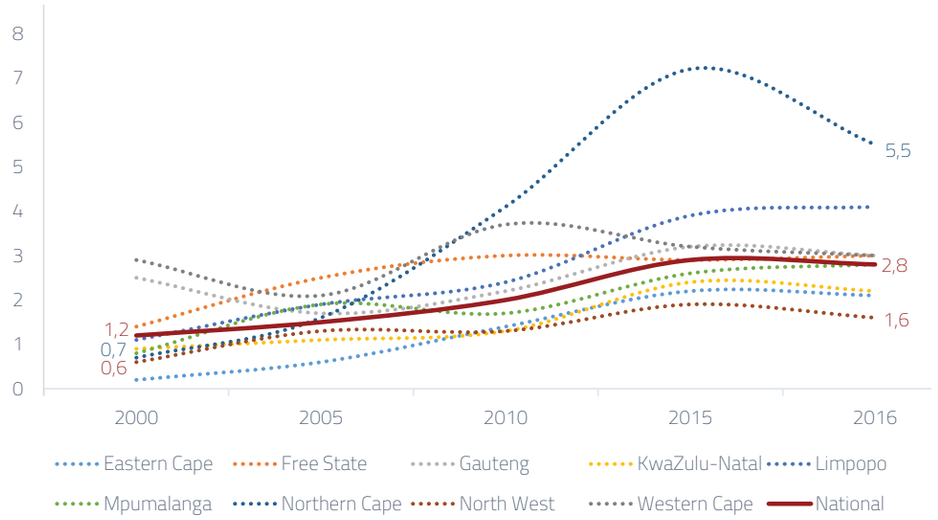


The average number of psychologist in the public sector per 100 000 population tripled between 2000 and 2016 from 0.7 to 2.8 in South Africa. As the national average was higher than all provinces in 2015, however, there is clearly a problem with the data quality. Nevertheless, leaving aside clear problems with the national level data, increases in the number of psychologists are observable in each of the 9 provinces. Great disparities can again be observed among provinces. In 2016, Mpumalanga, KwaZulu-Natal and Eastern Cape had the lowest ratios of 1, 1.1 and 1.2 psychologists per 100 000 population while Gauteng had the highest with 2.4.

INDICATOR 13.5: Number of occupational therapists per 100 000 population, 2000-2016.

DATA SOURCE: South African Health Review, 2017.

DESCRIPTION: This indicator measures how many occupational therapists are working in the public health sector per 100 000 people.



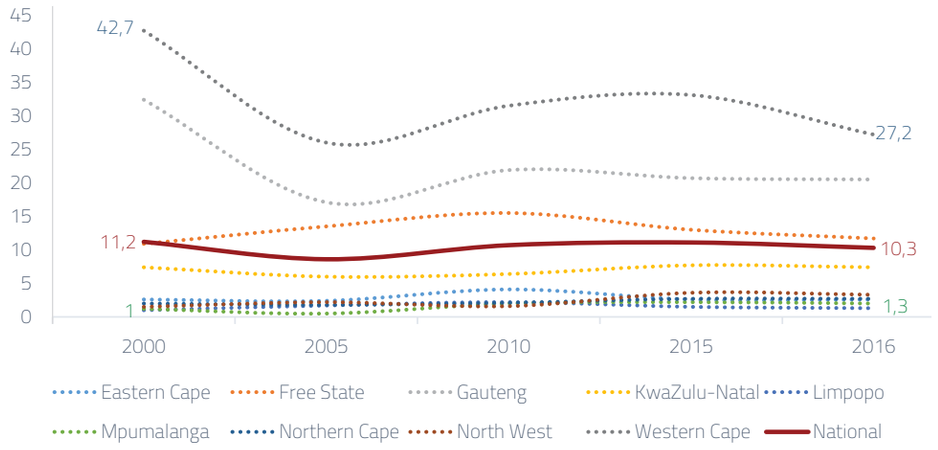
The number of occupational therapists per 100 000 population increased in all nine provinces between 2000 and 2016, leading to an overall national increase of 133.3% during that period, from 1.2 to 2.8 occupational therapists per 100 000 population.

However, worrying disparities are again observable between provinces in the measurement of this indicator. In 2016, there were 3.9 more occupational therapists per 100 000 people in the Northern Cape than North West.

INDICATOR 13.6: Number of medical specialists per 100 000 population, 2000-2016.

DATA SOURCE: South African Health Review, 2017.

DESCRIPTION: This indicator measures how many medical specialists are working in the public health sector per 100 000 people. It should be noted that the indicator does not disaggregate for different kinds of medical specialists.



An alarming national decrease of 8% in the number of medical specialists is observable between 2000 and 2016. This decrease cannot be attributed to internal migration – it simply means that the number of specialists in the country has not kept pace with population growth. The decrease was driven by stagnation in the Eastern Cape and KwaZulu-Natal, and regressions in Gauteng (where the number of medical specialists fell by 36.7%) and the Western Cape (where the number of medical specialists fell by 36.3%).

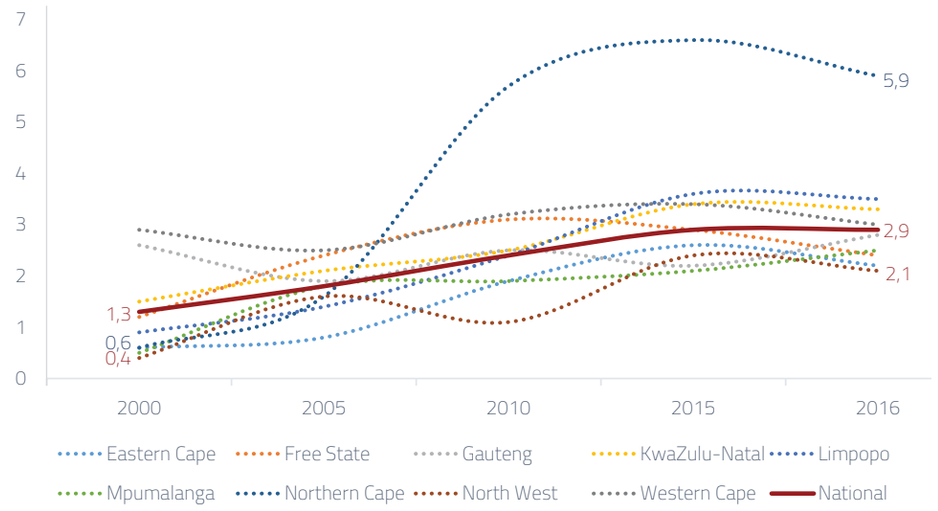
As worrying as the regression in the measurement of this indicator is the drastic inequality between provinces throughout the period between 2006 and 2016 with regard to the number of medical specialists. In 2015, there were 25.2% more specialists per 100 000 population in the Western Cape than in Mpumalanga (an astronomical 1260% difference). Equally alarming figures were observable in 2015 in Eastern Cape, Limpopo, Northern Cape and North West, where there were only 2.6, 1.3, 2.7 and 3.3 medical specialists per 100 000 population respectively.

Further data is required which disaggregates this indicators to shed light on which kinds of medical specialists are working in respective provinces. It is crucial that people have access to particular kinds of medical specialists, and are not forced to travel long distances in order to access specialised medical attention of whatever kind. Government's efforts in this regard should be informed by how many gynaecologists, paediatricians, oncologists, and so forth, there are in each province per 100 000 population.

INDICATOR 13.7: Number of physiotherapists per 100 000 population, 2000-2016.

DATA SOURCE: South African Health Review, 2017.

DESCRIPTION: This indicator measures how many physiotherapists are working in the public health sector per 100 000 people.

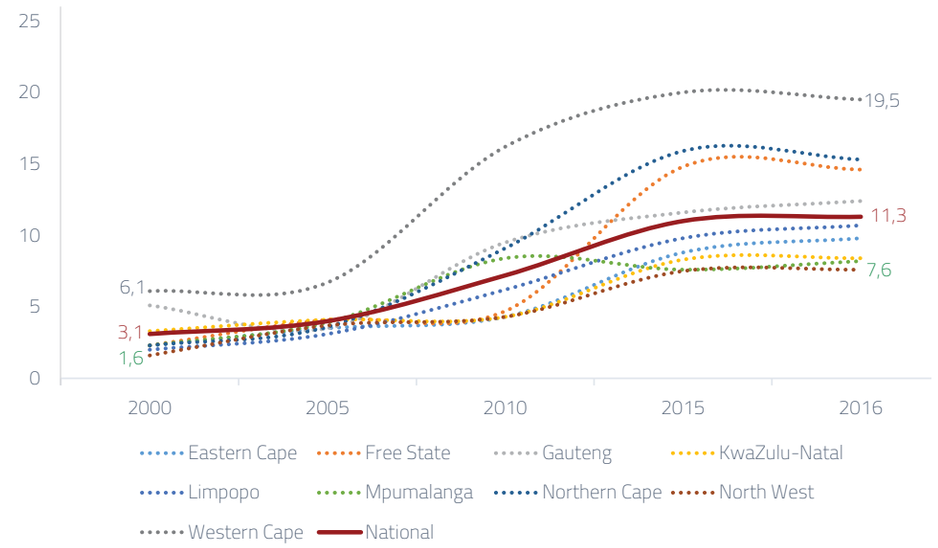


An increase in the amount of physiotherapists per 100 000 population in all nine provinces between 2000 and 2016 contributed to a national increase in the number of physiotherapists of 123%. Again, provincial discrepancies in the measurement of this indicator are a worrying trend. In 2016, there were 3.8 more physiotherapists per 100 000 people living in the Northern Cape than in North West.

INDICATOR 13.8: Number of pharmacists per 100 000 population, 2000-2016.

DATA SOURCE: South African Health Review, 2017.

DESCRIPTION: This indicator measures how many pharmacists are working in the public health sector per 100 000 people.

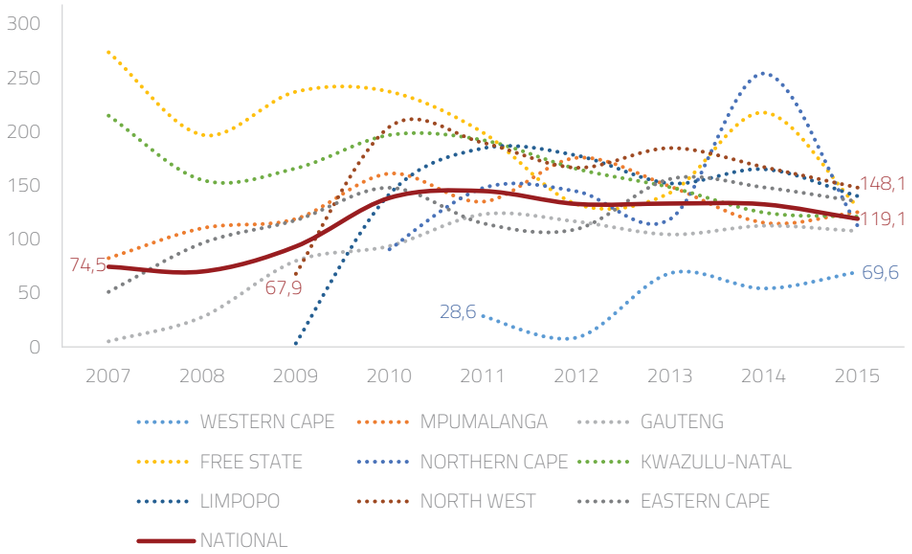


An increase in the amount of pharmacists per 100 000 population in all nine provinces between 2000 and 2016 contributed to a national increase in the number of pharmacists of 264.5%. Despite this marked increase – a positive achievement in the measurement of this indicator – inequalities persist, and are in fact deepening, in the provincial distribution of pharmacists. In 2016, there were 11.9 more pharmacists per 100 000 people living in the Western Cape than in North West.

INDICATOR 14: Maternal mortality rate in facilities, 2007-2015.

DATA SOURCE: District Health Barometer, 2007-2015.

DESCRIPTION: This indicator measures the number of women who die in health care facilities during pregnancy as a result of childbearing or within 42 days of delivery or termination of pregnancy in one year, per 100 000 live births during that year.



The revised target of the MTSF for 2019 is less than 100 maternal deaths per 100 000 live births.[89] The 2030 target of the Sustainable Development Goals for maternal mortality is 70 deaths for every 100 000 live births.

South Africa's maternal mortality ratio increased between 2007 and 2015 by 44.6, from 74.5 to 119.1 – a 60% increase. There has however been a reduction in maternal mortality between 2011 and 2015 from 145 to 119 maternal deaths per 100 000 live births. It is important to remember that this is a regression. Regressions in the measurement of this indicator are also observable in all of the country's provinces with the exceptions of Free State (maternal mortality fell by 52.4% there) and KwaZulu-Natal (maternal mortality fell by 43.6% there). North West had the highest in- facility maternal mortality rate in 2015 with 148 deaths per 100 000 live births. Limpopo and Eastern Cape had similarly high maternal mortality ratios with 140 and 135 deaths respectively. It is particularly worrisome that North West and Eastern Cape are also the two provinces with the lowest proportions of women delivering in a health facility[90]. This indicates that the actual maternal mortality rate might be even higher in these provinces. It is worth noting that both provinces also have some of the lowest rates of women attending antenatal care services within the first 20 weeks of their pregnancy. In addition, the Eastern Cape also has one of the lowest rate of women who make use of postnatal care visits within 6 days of delivery.

At district level, Capricorn in Limpopo (317 deaths), Xhariep in Free State (270 deaths) and OR Tambo in the Eastern Cape (245 deaths) had by far the highest number of maternal deaths per 100 000 live births in health facilities. The rates in these districts were more than double the national average of 119 deaths. While it is encouraging that 80% of districts managed to reach maternal mortality rates below 120 deaths it also highlights the great disparities among districts which ranges from 0 to 317 maternal deaths per 100 000 live births.

There is a limitation inherent in this data as it does not capture the number of women who die outside of health facilities. It is the only available data source which allows for monitoring disparities among provinces and districts, however.[91]

Due to issues around the quality and representativity of the data, the usefulness of maternal mortality must be interrogated.[92] Other available estimates on maternal mortality in South Africa indicate that maternal deaths per 100 000 live births have decreased from 154 in 2010 to 138 in 2015.

FOOTNOTES:

89. Revised Health Chapter of the Medium Term Strategic Framework 2014-2019, 15 July 2016. Available at: http://www.poa.gov.za/MTSF%20Documents/Outcome%202%20refined%20Health%20MTSF%20Chapter.pdf.
90. Day C., Gray A. 2016. 'Health and Related Indicators.' In: In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Durban: Health Systems Trust; 2016, p. 176.
91. DHB 2015/16, p. 68.
92. Day C., Gray A. 2016. 'Health and Related Indicators.' In: In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Durban: Health Systems Trust; 2016, p. 175.

These estimates show that 32% of maternal deaths are estimated to be AIDS-related.[93] While the Rapid Mortality Surveillance report estimated that the maternal mortality ratio was at 153 deaths per 100 000 pregnant women in 2014, estimates based on the Global Burden of Disease Study 2013 indicated a maternal mortality ratio of 174 for 2014.[94]

The 6th report of the National Committee on the Confidential Enquiries into Maternal Deaths found that complications linked to HIV infection (35%) were the main cause of maternal death in South Africa between 2011 and 2013, followed by bleeding linked to childbirth (16%), and complications related to high blood pressure (15%). The report reported a decrease in maternal deaths between 2011 and 2014, which it attributed to the decrease in HIV related deaths.[95]

The report highlights two important factors which led to fewer HIV related maternal deaths:

- More women agreed to be tested for HIV and
- An increase of CD4 threshold for initiating Highly Active Anti-Retroviral Therapy (HAART) in pregnant women from 200 to 350 cells/µml in 2010.[96]

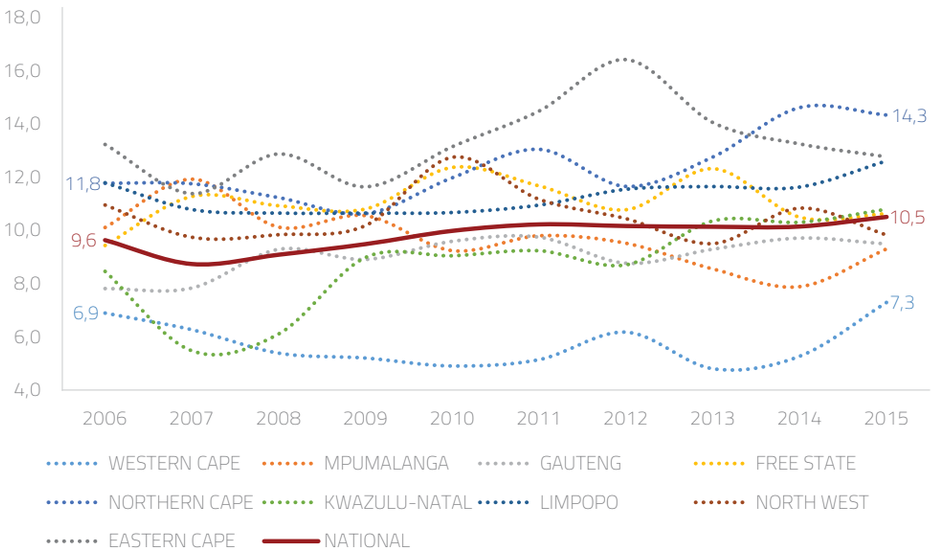
Several studies point to the fact that the most significant gains in reducing maternal deaths could be made by focusing on contraceptive coverage (see Indicator 9 in this report).[97]

ADEQUACY – CHILD AND MATERNAL HEALTH CARE

INDICATOR 15: Inpatient early neonatal mortality rate, 2006-2015.

DATA SOURCE: District Health Barometer, 2006-2015.

DESCRIPTION: This indicator measures the number of live born babies who died within the first 7 days after birth in a public health facility per 1 000 live births.



South Africa's rate of early neonatal deaths increased by 9.4% between 2006 and 2015, a notable regression in the measurement of this indicator. Mpumalanga, North West and Eastern Cape were the only provinces in which regressions are not observable over the period (these provinces decreased their early neonatal death rates by 7.9%, 10.9% and 3% respectively). Northern Cape, Eastern Cape and Limpopo are the provinces with the highest rates of early neonatal deaths in health facilities. The remaining provinces had rates close to or below the national average in 2015.

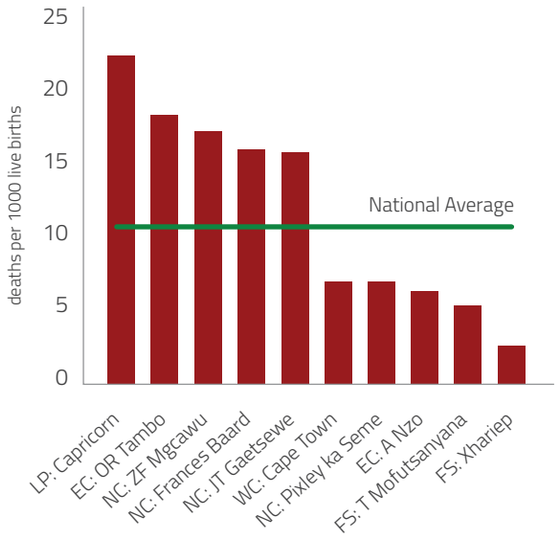
Figure 34 highlights that great disparities in early neonatal mortality rates exist among districts within provinces. The district with the highest early neonatal mortality rate in 2015 was Capricorn in Limpopo with 22 deaths per 1 000 live births. This is almost three times higher than the 2019 target of 8 neonatal deaths per 1 000 live births.

FOOTNOTES:

93. Trends in maternal mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2015) Geneva: World Health Organization, p 75.
94. SAHR, p. 275.Kassebaum NJ, Bertozzi-Villa A, Coggeshall MS, Shackelford KA, Steiner C, Heuton KR, et al. Global, regional, and national levels and causes of maternal mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet. 2014;384(9947):980–1004.
95. National Committee on the Confidential Enquiries into Maternal Deaths, National Department of Health (2015) Saving Mothers 2011–2013: Sixth report on confidential enquiries into maternal deaths in South Africa.
96. Ibidem.
97. McGee SA, Chola L, Tugendhaft A, Mubaiwa V, Moran N, McKerrow N, et al. Strategic planning for saving the lives of mothers, newborns and children and preventing stillbirths in KwaZulu-Natal province South Africa: modelling using the Lives Saved Tool (LiST). BMC Public Health. 2016;16(1):49.

The data used to populate this indicator does not capture early neonatal deaths which happened outside of a health facility. As a result, it is prudent to explore a second data source. The 2015 Rapid Mortality Surveillance Report, which does not include provincial and district level data, shows that at national level the number of new-borns who died within the first 28 days after birth increased from 11 to 12 deaths per 1 000 live births between 2012 and 2015. This indicator falls far below the revised national target of the Medium Term Strategic Framework (MTSF) of 8 deaths per 1 000 live births.[98] The SDG target for neonatal mortality is a rate of less than 12 per 1 000 live births.

Figure 34: Inpatient early neonatal death rate in 5 best and 5 worst performing districts, 2015/16



Almost half (47.1%) of neonatal deaths resulted from respiratory, cardiovascular and other disorders specific to the perinatal period which begins at 22 weeks of pregnancy and ends within the first seven days of life.[99] This highlights the importance of quality antenatal care, safe delivery and post-natal care.

FOOTNOTES:

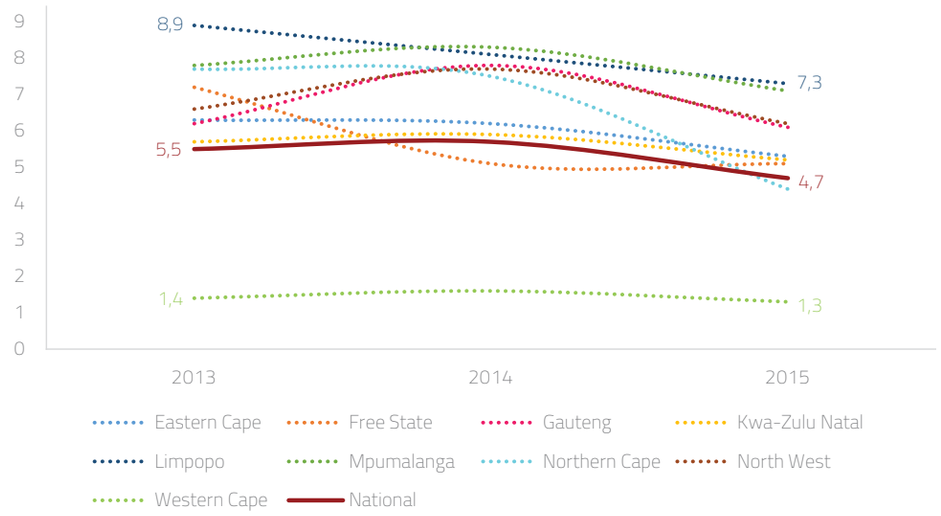
98. Revised Health Chapter of the Medium Term Strategic Framework 2014-2019, 15 July 2016. Available at: http://www.poa.gov.za/MTSF%20Documents/Outcome%202%20refined%20Health%20MTSF%20Chapter.pdf.
99. Statistics South Africa (2017) 'Mortality and causes of death in South Africa, 2015: Findings from death notification', p. 36.

ADEQUACY – CHILD AND MATERNAL HEALTH CARE

INDICATOR 16: Inpatient mortality rate under 5 years, 2013-2015.

DATA SOURCE: District Health Barometer, 2013-2015.

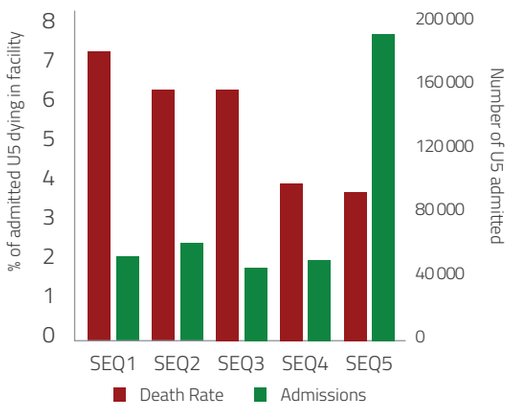
DESCRIPTION: This indicator measures the percentage of children under 5 who die in a health facility after they were admitted.



South Africa's rate of inpatient deaths under 5 years decreased by 14.5% between 2013 and 2015, which is a relatively laudable achievement. Decreases were also observable in all 9 provinces, the most significant of which was in the Northern Cape where a decrease of 42.9% in inpatient deaths under 5 years over the period is observable.

The data also shows that inpatient deaths rates in children under 5 years were higher in poorer districts as well as in rural districts.[100] This can either point to the fact that children are admitted too late and cannot be saved because of the advanced stage of disease or because the quality of health service is low. In Figure 35, the grey bar shows that the percentage of inpatient deaths in children under 5 is almost double as high in the poorest (7%) districts compared to the richest (3.6%).[101] In contrast, the grey bar shows that the total number of admissions in the richest quintile is almost 4 times higher. This shows that children in poorer districts are far less likely to be admitted compared to their peers who live in the 20% of the best-off districts.

Figure 35: Number of admissions and impatient death rates in children U5 by socio-economic quintile, 2015



HIGH MORTALITY RATES OF CHILDREN WHO ARE ADMITTED TO HEALTH FACILITIES IN OR TAMBO DISTRICT

With 16.8% OR Tambo district in the Eastern Cape has by far the highest percentage of children below 5 years who die in a health facility after being admitted. The national average among districts in inpatient death rates of children under 5 is 4.7%.

OR Tambo also has the second highest inpatient death rates in new-borns within their first 7 days of life (18.1%) as well as of children under 5 who were admitted due to diarrhoea (5.8%) and pneumonia (5.3%).

FOOTNOTES:

100. The District Health Barometer uses the South African Index of Multiple Deprivation (SAIMD) to categorize districts into socio-economic quintiles according to their level of deprivation. See: District Health Barometer 2015/16, p.v. Noble M, Zembe W, Wright G, Avenell D. (2011) 'Multiple Deprivation and Income Poverty at Small Area Level in South Africa in 2011', Southern African Social Policy Research Institute and Southern African Social Policy Research Insights (SASPRI).

101. District Health Barometer 2015/16, p.144.

When data is disaggregated between metropolitan and non-metropolitan municipalities, as the only available proxy for urban and rural districts, it shows that children under 5 who are admitted to facilities in non-metropolitan municipalities are more likely to die after having been admitted compared to those admitted in metropolitan municipalities (3.7% versus 5.6% in 2015/16).[102] The gap between metro and non-metro municipalities with regard to death rates of children under 5 in facilities had, however, narrowed between 2012 and 2016.

This data used to populate this indicator also has some inherent limitations. The quality and representativeness of the data is limited by lack of consistent and standardised reporting of admission as well as by the large number of children who die outside health facilities.[103] Since a high proportion of child deaths in South Africa are preventable the indicator nevertheless provides some information on the quality of service that children under 5 receive at health facilities,[104] as well as provides information on disparities among provinces and districts.

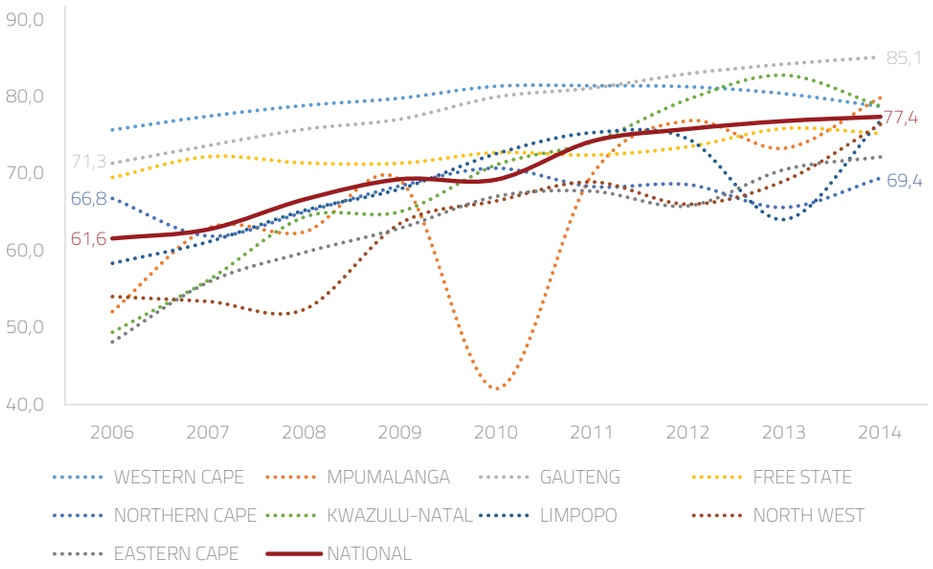
It is prudent, as a result, to investigate other data sources, some of which have the national mortality rate of children under 5 years decreasing from 41 in 2012 to 37 in 2015.[105] The MTSF target for 2019 is 33 deaths per 1 000 live births. The SDG target for 2030 is 25. Data on mortality rates of children under 5 years at provincial level published in the 2008 Actuarial Society of South Africa HIV/AIDS Model showed that the Eastern Cape, KwaZulu-Natal and Free State had the highest mortality rates of children under 5 years (59.6, 57.8 and 53.5 respectively) while Western Cape and Northern Cape had the lowest rates (23.1 and 32.2).

ADEQUACY – HIV, AIDS AND TUBERCULOSIS HEALTH CARE

INDICATOR 17: Tuberculosis cure rate, 2006-2014.

DATA SOURCE: District Health Barometer, 2006-2014.

DESCRIPTION: This indicator measures the proportion of all new TB patients who have bacteriological proof of cure and who test negative in the last month of treatment and on at least one other occasion. As TB remains South Africa's number one cause of death, this is a critical indicator to monitor.



TB remains the number one cause of death in South Africa. Globally, South Africa has the second highest TB incidence rate. South Africa also has one of the highest rates of multidrug-resistant tuberculosis MDR-TB. The national TB cure rate increased by 25.6% between 2006 and 2014. This was underwritten by increases in all provincial cure rates, most notably in KwaZulu-Natal (where the TB cure rate increased by 59.3%), Mpumalanga (where the TB cure rate increased by 52.6%) and the Eastern Cape (where the TB cure rate increased by 50.1%). In 2014, in Gauteng (85.1%) had the highest TB cure rate in the country followed by Mpumalanga (79.8%) and KwaZulu-Natal (78.7%). In turn, Northern Cape, Eastern Cape and Free State had the lowest cure rates (69.4%, 72.2% and 75.2% respectively).

FOOTNOTES:

102. District Health Barometer 2015/16, p.144.
103. The Committee on the Morbidity and Mortality in Children under 5 years found that in 2011 45.5% of children under 5 died outside a health facility. See 2nd Triennial Report of the Committee on the morbidity and mortality in children under 5: 2014. Available at: http://www.kznhealth.gov.za/mcwh/2nd-CoMMiC-Triennial-Report-Abridged.pdf.
104. Committee on Morbidity and Mortality in Children. 2014. 2nd Triennial Report of the Committee on Morbidity and Mortality in Children under 5 Years (CoMMiC). Pretoria: National Department of Health.
105. Dorrington RE, Bradshaw D, Laubscher R, Nannan N (2016) 'Rapid mortality surveillance report 2015', p. i.

South Africa has adopted the 90:90:90 strategy for TB:

Screening 90% of people in risk populations

90% of people diagnosed with TB **start treatment**;

ensuring that 90% of those started **treatment complete** it successfully.

Key populations vulnerable to TB:

People living with HIV

People with diabetes

Household contacts of people with TB

Pregnant women

Children under the age of five years

Miners, former miners and people working and living near mines

Healthcare workers

Prison inmates and Prison employees

During this period, national TB incidence reduced from 762 cases to 593 cases per 100 000 population, and the death rate decreased from 9% to 7%. However, the proportion of TB patients who interrupted treatment has remained at around 6%, and the proportion of cases not evaluated has increased significantly over the last two years from 4% to above 7% in 2014.

At district level, TB cure rates ranged from 96.1% in uThungulu in KwaZulu-Natal to 58.4% in JT Gaetswe in Northern Cape. Capricorn (Limpopo), ZF Mgcawu (Northern Cape), Dr K Kaunda, RS Mompati (both North West) and eThekwini (KwaZulu-Natal) had successful treatment rates below 70%. Three of these districts (Capricorn, ZF Mgcawu and Dr K Kaunda) did not show improved TB programme performance between 2014 and 2015.

MDR-TB is associated with high mortality in settings with HIV co-infection. Treatment requires the use of drugs, which are less potent and more toxic than typical TB medications and lasts up to two years. Treatment puts a high financial burden both on the family of the patient as well as on the public health system. While the Eastern Cape had the highest proportion of co-infected patients on ART (96%), the Western Cape had the lowest proportion (76%). MDR-TB treatment success rate was reported for the first time in the 2015/16 District Health Barometer. Despite improvements, quality and completeness of MDR-TB data remains a concern. Improving the validity of the MDR-TB data is crucial to improve treatment success rates.

In order to reach SDG 3, which includes ending the TB epidemic by 2030, it will be crucial to further invest in local data systems, which would allow for targeted interventions to address 'hot spots' of transmission.[106] eThekwini district, for instance, had the highest number of TB cases in South Africa in 2014 yet it also had one of the lowest TB cure rates. Compared to other districts, eThekwini had the highest proportion of TB patients which were not evaluated (18.5%). It was also among the five districts with the lowest proportion of HIV-positive TB patients on ART (70%).

FOOTNOTES:

106. SAHR 2016, p.

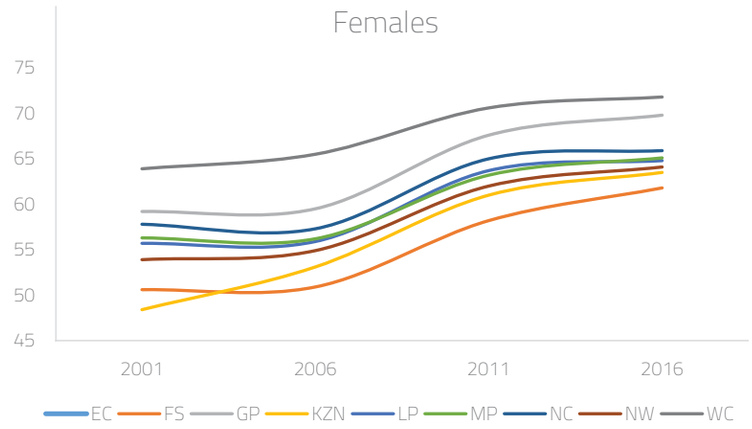
3.3 QUALITY INDICATORS:

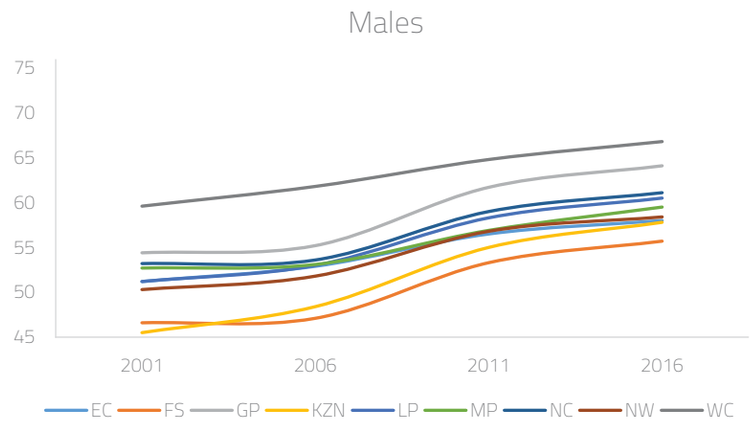
QUALITY – QUALITY OF LIFE

INDICATOR 18: Life expectancy by sex per province, 2001 – 2016.

DATA SOURCE: Mid-year population estimates (Stats SA), 2017.

DESCRIPTION: This indicator tracks South Africans' life expectancy.





Life expectancy, which remains higher for females than for males across South Africa's nine provinces, has risen steadily since 2001. This is particularly true in Kwa-Zulu Natal, where life expectancy for males increased by 12.3 years between 2001 and 2016, and life expectancy for females increased by 15.1 years over the period. This can largely be attributed to government's success in addressing the effects of the HIV/AIDS pandemic in the second half of the 2000s.

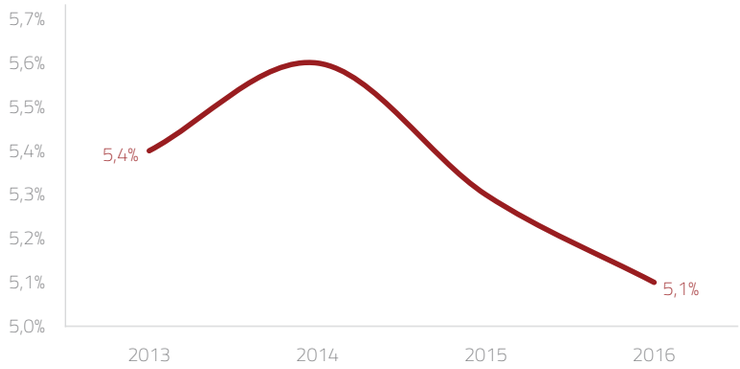
There are, however, fairly persistent inequalities in the life expectancies of people living in different provinces in South Africa. Free State had the lowest life expectancy for both sexes in 2016 (55.7 years for males and 61.8 years for females). This can be compared to the life expectancy of males and females in the Western Cape in 2016 (the province with the highest life expectancy for both sexes) – 66.8 years 71.8 years respectively. This means that males in the Western Cape live for 11 years longer than their Free State counterparts, and females in the Western Cape live for 10 years longer than their Free State counterparts.

QUALITY – QUALITY OF LIFE

INDICATOR 19: Teenage pregnancy rate, 2013 – 2016.

DATA SOURCE: General Household Survey (Stats SA).

DESCRIPTION: This indicator measures the percentage of women in South Africa between the ages of 14 and 19 years who were pregnant during the year prior to the survey.



Teenage pregnancy and motherhood have health as well as social implications. Teenage mothers have higher risks of experiencing complications during pregnancy and delivery and their children are at increased risk of sickness and death. Pregnancy and motherhood also have a negative impact on educational opportunities of young women and are one of the reasons for school-drop out. Teenage pregnancy in South Africa fell by 5.6% between 2013 and 2016.

The data used to populate this indicator considers women between the ages of 14 and 19 who reported being pregnant during the year prior to being surveyed. The teenage pregnancy rate rises with age, however, and is higher when a broader age definition is considered. Data from the Demographic Health Survey 2016, for instance, suggests that 16% of women between the age of **15 and 19** in South Africa have either given birth or were pregnant at the time of the interview.[107] On this measurement, the national rate of teenage pregnancy and motherhood have not changed compared to 1998 when it was also at 16%. More young women fell pregnant or already had a child in non-urban areas compared to urban areas (19% versus 14%, respectively). At provincial level, Northern Cape and North West had the highest rates of teenage pregnancy and motherhood with 20% each, closely followed by KwaZulu-Natal (19%), the most populous province in the country.

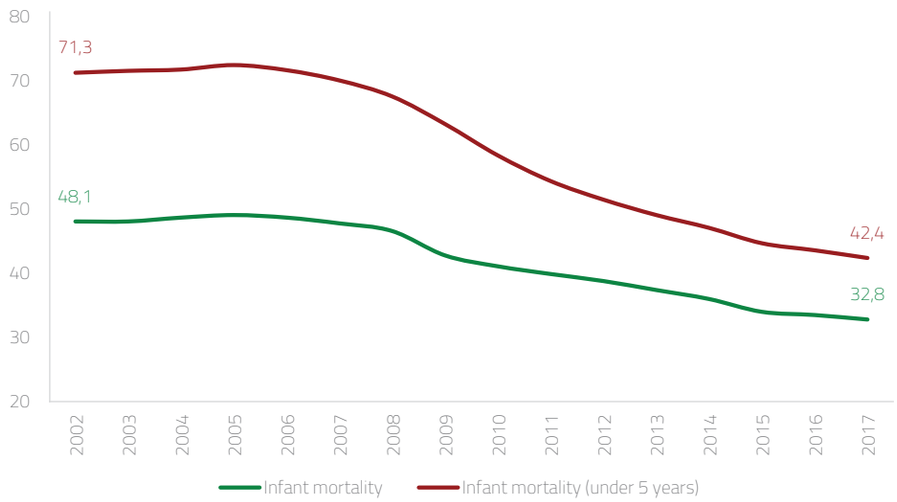
The rate of teenagers who have begun childbearing was significantly higher in the three poorer wealth quintiles (20% quintile 1, 22% quintile 2, 18% quintile3) compared to the two wealthiest quintiles (9% quintile 4, 7% quintile 5).

QUALITY – QUALITY OF LIFE

INDICATOR 20: Infant mortality rates, 2002 – 2015.

DATA SOURCE: Mid-year population estimates (Stats SA), 2017.

DESCRIPTION: This indictor tracks infants' probability of dying. It measures the number of deaths per 1000 live births of children younger than 1 year old and 5 years old.



There were measurable decreases in both infant mortality (a relative decrease of 32%) and infant mortality of children under 5 years old (by 41%) between 2002 and 2017.

FOOTNOTES:

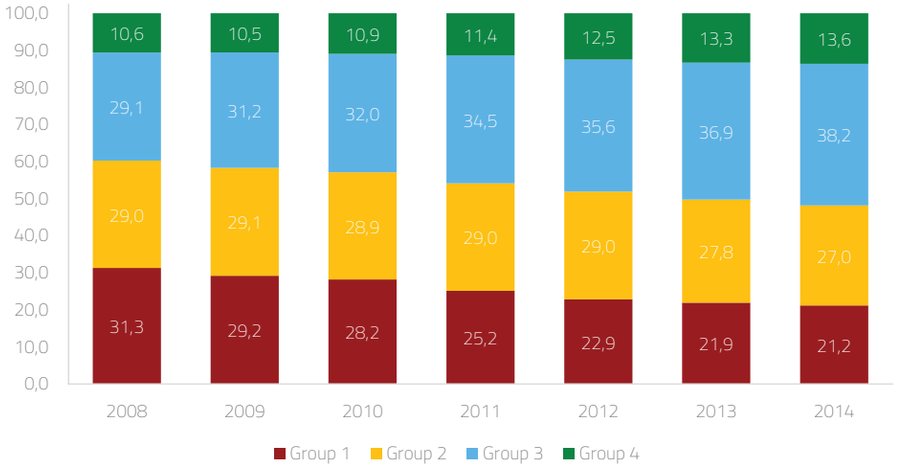
107. StatsSA (2017) South Africa Demographic and Health Survey 2016: Key Indicator Report, p.12.

QUALITY – QUALITY OF LIFE

DESCRIPTION: This indictor tracks the proportion of years of life lost due to the four main causes of death in South Africa, categorised into four groups. Group 1 represents communicable diseases, but excludes HIV and TB. Group 2 represents HIV and TB. Group 3 represents non-communicable diseases. Group 4 represents injuries. Years of life lost is a measure of premature mortality based on ages of death measured against the highest observed national life expectancy. It highlights causes of death that should be targeted for prevention.

INDICATOR 21: Burden of disease, 2008 – 2014.

DATA SOURCE: District Health Barometer 2015/16.



Burden of disease is an important measure for informed policymaking. It enables understanding of the changing health challenges which people face, and provides a tool to quantify and compare the effects of different diseases in South Africa. The epidemiological mortality profiles provided by the burden of disease measurement should be used as part of a measure of need for equitable resource allocation and priority setting.

The high number of HIV and AIDS-related deaths in South Africa (see Indicator 24) demand a unique burden of disease profile which separates HIV out from other communicable diseases in order to lay bare the particular burden resulting from HIV. Since many HIV deaths are misclassified as tuberculosis (TB), TB deaths are reported together with HIV deaths. This is in contrast to most international measurements of burden of disease (including the measurement used by Stats SA[108]), which utilise a three part profile of burden of disease comprised of communicable diseases, non-communicable diseases and injury.

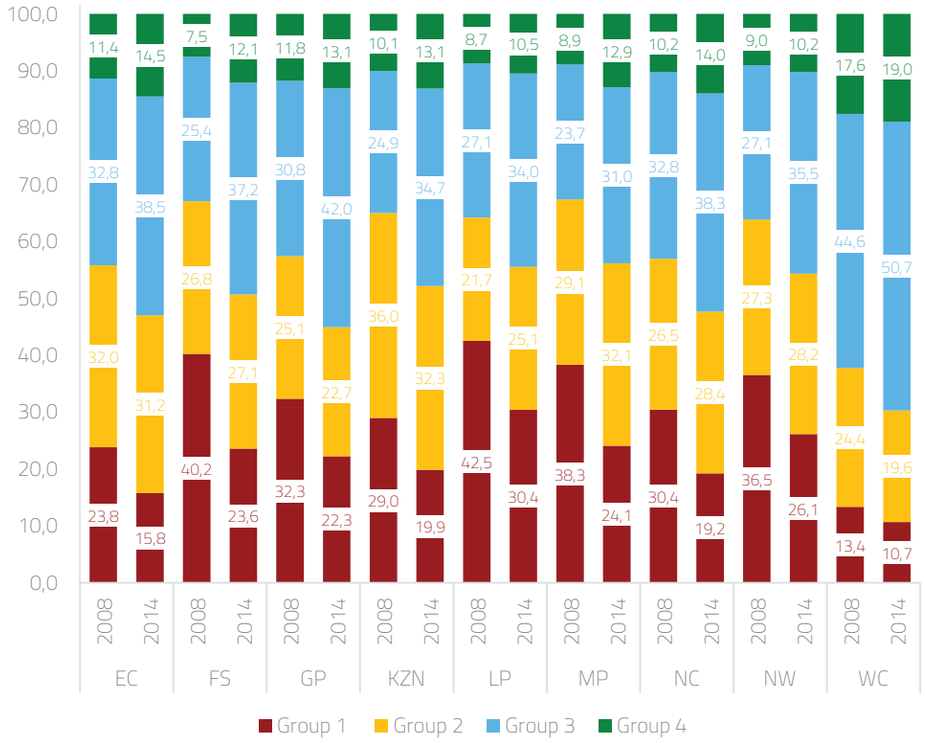
As a result, South Africa faces a quadruple burden of disease. These are:

- Communicable diseases with maternal, perinatal and nutritional conditions (Group 1 in this indicator).
- HIV and TB (Group 2)
- Non-communicable diseases (Group 3)
- Injuries, including homicides and suicides (Group 4).

The percentage of the burden due to HIV and TB and Group 1 communicable diseases declined nationally between 2008 and 2014 from 60% to 48%, with a corresponding increase in the burden due to non-communicable diseases (from 29% to 38%), and a slight increase in the burden due to injuries (from 11% 13.6%).

FOOTNOTES:

108. See Stats SA's Mortality and causes of death in South Africa, 2015: Findings from death notification (2015).



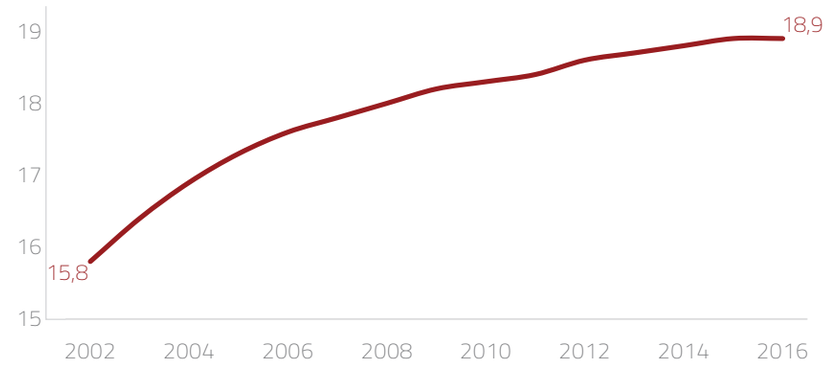
South Africa's quadruple burden of disease varies across provinces. The Western Cape had a higher proportion of years of life lost due to injury (19.0%) and non-communicable diseases (50.7%) than any other province. KwaZulu-Natal, Mpumalanga, Limpopo and North West had the highest proportions due to HIV and TB and communicable diseases (in the region of 55%). Some severe inequalities are observable at the district level. uMkanyakude (KZN) had the highest burden due to HIV and TB (40.2%), while Overberg (WC) had the lowest (14.3%). Districts in the two highest socio-economic quintiles had higher proportions of years of life lost due to injuries and non-communicable diseases, while districts in the three lowest socio-economic quintiles had higher proportions of years of life lost due to HIV and TB and other communicable diseases.[109]

QUALITY – HEALTH OUTCOMES DUE TO DISEASE

INDICATOR 22: HIV prevalence, 2002 – 2016.

DATA SOURCE: UNAIDS.

DESCRIPTION: This indicator tracks the percentage of people tested each year who were HIV-positive.



South Africa's HIV prevalence increased by 19.6% between 2002 and 2016, from 15.8% to 18.9%. This suggests that almost 1 in every 5 South Africans is HIV-positive. An increase in this indicator does not necessarily mean an increase in HIV prevalence, however. It may also reflect 1) increased HIV testing coverage (see Indicator 8) and 2) increased life expectancy for people living with HIV or AIDS.

FOOTNOTES:

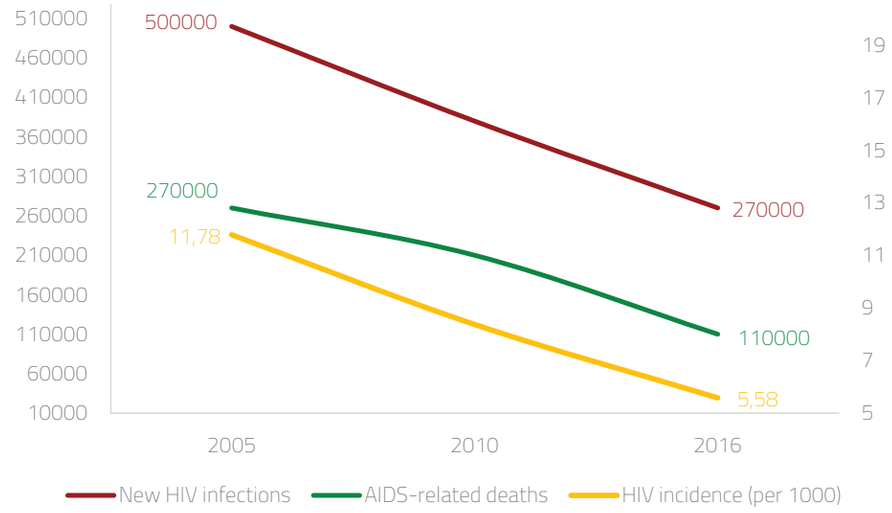
109. District Health Barometer 2015/16: 264.

QUALITY – HEALTH OUTCOMES DUE TO DISEASE

INDICATOR 23: HIV and AIDS indicators, 2002 – 2015.

DATA SOURCE: UNAIDS.

DESCRIPTION: This indicator tracks new HIV infections, AIDS-related deaths and HIV incidence, which is the number of new HIV infections per 1000 population.



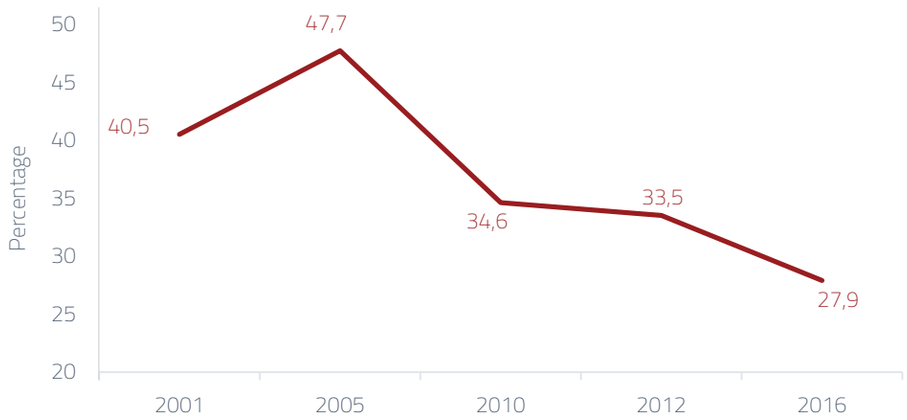
Dramatic reductions in new HIV infections (by 46%), HIV incidence (by 52.6%) and AIDS-related deaths (by 59.2%) in South Africa are observable between 2005 and 2016. This suggests that the increased HIV prevalence observable in Indicator 25 does not reflect a growing number or rate of HIV infections, but rather an increase in testing coverage and awareness of the extent of HIV in South Africa. This is borne out in Indicator 10 earlier in this report, which showed commendable increases in the number of people who had been tested for HIV.

QUALITY – HEALTH OUTCOMES DUE TO DISEASE

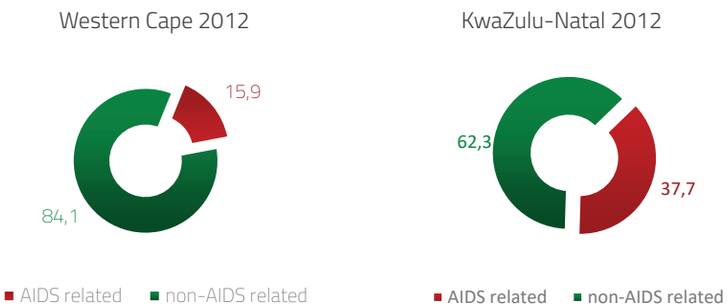
INDICATOR 24: Percentage of deaths due to AIDS, 2001 – 2016.

DATA SOURCE: South African Health Review 2017.

DESCRIPTION: This indicator tracks the percentage of deaths in South Africa caused by AIDS.



The percentage of deaths in South Africa due to AIDS fell by 31.1% between 2001 and 2016, but still made up more than a quarter of the country's deaths. These deaths remain unequally distributed amongst the provinces. An Actuarial Society of South Africa (ASSA), which includes provincial level data up to 2012,[110] suggests that AIDS related deaths made up less than a 6th of deaths in the Western Cape (see below), while they made up more than a third of total deaths in KwaZulu-Natal.



FOOTNOTES:

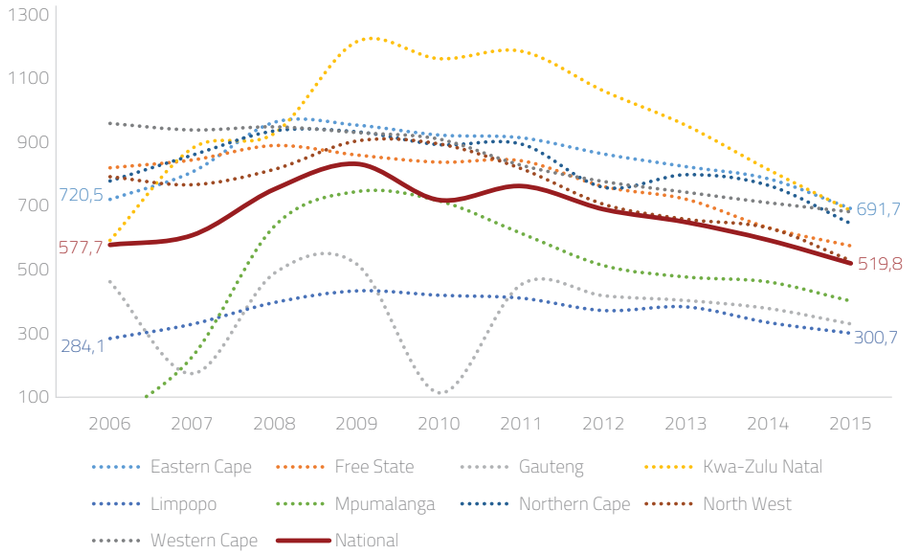
110. See South African Health Review 2017: 255.

QUALITY – DISEASE INCIDENCE AND PREVALENCE

INDICATOR 25: Tuberculosis incidence rate, 2006 – 2015.

DATA SOURCE: District Health Barometer, 2006 – 2015.

DESCRIPTION: This indicator tracks the proportion of diagnosed TB cases reported in the electronic TB register in one year per 100 000 population. TB is the number one cause of death in South Africa, making this a crucial indicator to monitor.



South Africa's TB incidence rate fell by 10% between 2006 and 2015. After peaking in 2009 at 832 cases per 100 000, it declined to 520 diagnosed TB cases per 100 000 population in 2015. However the TB incidence rate of the following provinces[111] increased over this period: KwaZulu-Natal (by 15.8%) and Limpopo (by 5.8%). Some of this may be explained by weaknesses in the data, however, as incidence rates declined in all provinces between 2009 and 2015. Converse to its overall trend, KwaZulu-Natal halved the number of diagnosed TB cases from 1185 to 685 cases per 100 000 population after 2009. Of concern is the inequality in provincial TB incidence rates. In 2015, there were 391 more cases of TB per 100 000 population in the Eastern Cape than in Limpopo, a 130% difference. The Eastern Cape (692 cases/ 100 000), KwaZulu-Natal (685 cases/ 100 000) and Western Cape (681/ 100 000) had the highest incidence rates in the country in 2015.

At district level, S Baartman in the Eastern Cape was the district with the highest incidence rate of 1 022 new cases per 100 000 followed by Pixley ka Seme (Northern Cape) with 943 cases and N Mandela Bay (EC) with 938 new cases. Between 2011 and 2015 the incidence rate in these districts has not changed significantly.

The 8 metros in South Africa account for about 40% of TB infections. The three metros of eThekwini, Cape Town and Johannesburg have the highest number of cases per district (24 588 cases, 23 815 cases and 15 912 cases respectively).

FOOTNOTES:

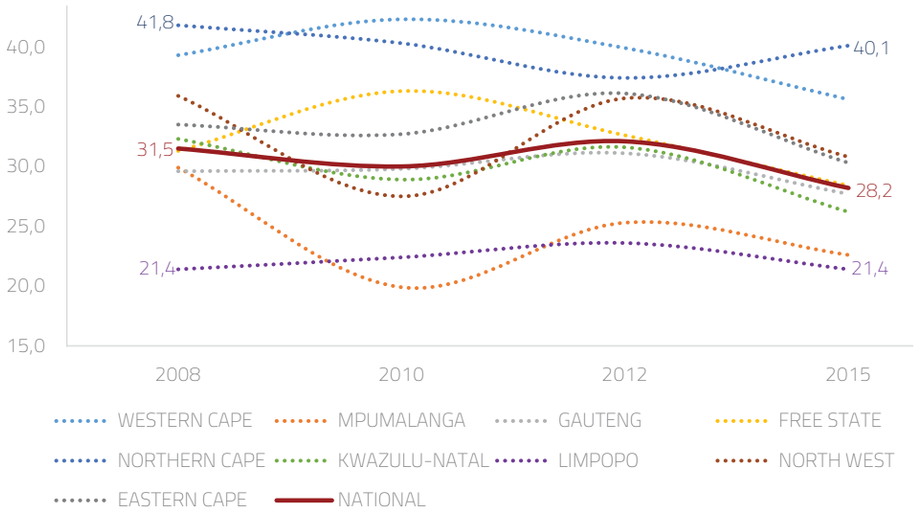
111. Mpumalanga's TB incidence rate also increased dramatically over the period (by 1670%), but it is difficult to tell how much of this increase can be explained by obvious problems in the data.

QUALITY – DISEASE INCIDENCE AND PREVALENCE

DESCRIPTION: This indicator tracks the percentage of adult South Africans (15 years and older) who suffer from hypertension, the second most commonly reported cause of death in South Africa. The measured prevalence of hypertension is defined as those with blood pressure equal or above 140/90 mmHg and/or taking anti-hypertensive medication.[112]

INDICATOR 26: Hypertension prevalence, 2008 – 2014.

DATA SOURCE: National Income Dynamics Survey (NIDS), Waves 1-4.



2015 data on mortality and causes of death in South Africa show that hypertensive diseases were the second most commonly reported cause of death (11%).[113] It is important to bear in mind some crucial data weaknesses regarding the measurement of the prevalence of hypertension in South Africa. The administrative data on which this indicator relies is affected by reporting incongruences and by imprecision in the estimates of population totals. These incongruences may lead to significant and improbable year-to-year variations in some measurements of hypertension prevalence.[114]

Hypertension prevalence in South Africa fell by 10.5% between 2008 and 2015. Similar decreases are observable in all provinces over the period with the exception of the Northern Cape, which had the same prevalence in 2015 as it did in 2008. The data shows that hypertension prevalence rates vary widely among provinces. While Northern Cape has the highest hypertension prevalence rates with 40%, Limpopo has the lowest with 21%.[115] Between 2008 and 2015, treatment coverage also increased nationally from 36% to 48%. The lowest treatment coverage rates were observed in Limpopo (38%) followed by Mpumalanga (40%) and Northern Cape (46%).

FOOTNOTES:

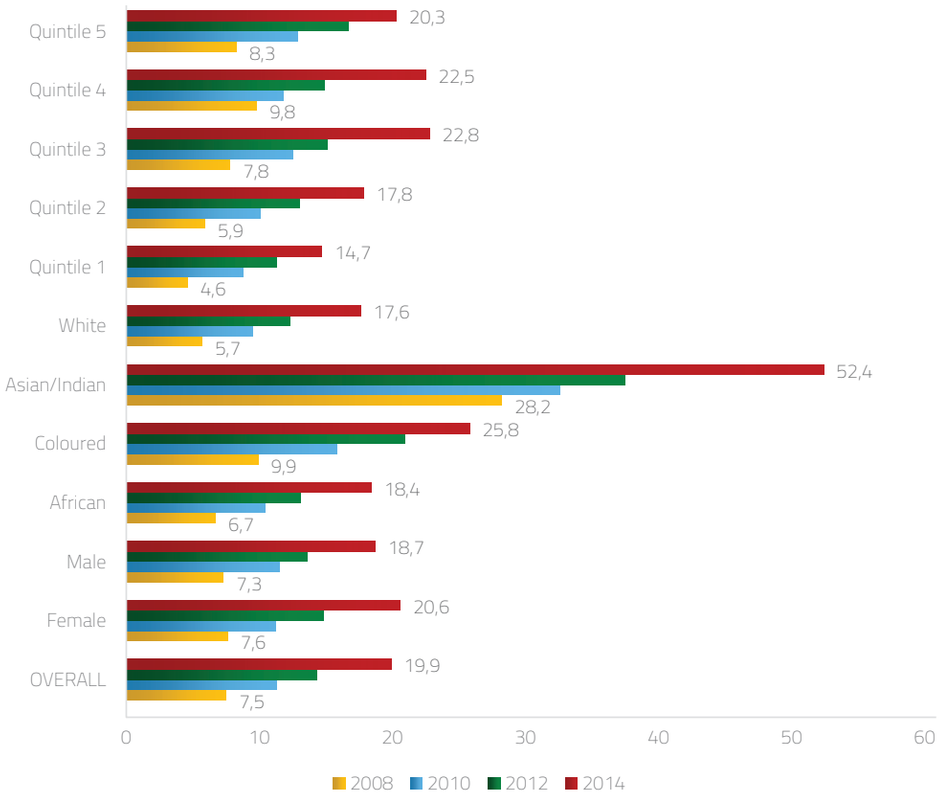
112. District Health Barometer 2015/16: 232.
113. StatsSA (2017) 'Mortality and causes of death in South Africa, 2015', p. 4, 49.
114. See District Health Barometer 2015/16: 247
115. Ibid: 232.

QUALITY – DISEASE INCIDENCE AND PREVALENCE

INDICATOR 27: Diabetes incidence, 2008 – 2014.

DATA SOURCE: National Income Dynamics Survey (NIDS), Waves 1-4.

DESCRIPTION: This indicator tracks the percentage of South Africans who suffer from diabetes.



The 2015 Diabetes Atlas, which was published by the International Diabetes Federation, estimates that between 7.2% and 11.4% of the global population is living with diabetes. The report also highlights that the highest number of undiagnosed patients with diabetes was expected to be in Africa.[116]

2015 data from the civil registration system suggested that diabetes mellitus was the second leading underlying cause of death in South Africa, accounting for 5.4% of the deaths registered in 2015. In 2013 diabetes was the fifth leading underlying cause of death and accounted for 4.9% of deaths.[117] The experience of developed countries suggests that diabetes is a growing health threat. As South Africa moves towards becoming a middle-income country, the prevalence rate of diabetes is likely to increase due to its relationship with diet and lifestyle.

This is reflected in the data, which shows that the incidence of diabetes has increased across all sectors of the South African population, and most notably amongst the Asian/Indian and Coloured race groups.[118] While less than 1 in every 10 of South Africans suffered from diabetes in 2008, almost 1 in every 5 South Africans suffered from the disease in 2014.

The data shows that being overweight or obese significantly increases the risk of diabetes (see Figure 36). In 2008, 6% of overweight respondents reported that they had diabetes. In 2014/15 diabetes was much more widespread among overweight respondents, amounting to 18%. A similar increase was observed in the group of obese and morbidly obese respondents.

FOOTNOTES:

116. Cavan D, da Rocha Fernandes J, Makaroff L, Ogurtsova K, Webber S, editors. IDF Diabetes Atlas. Seventh edition, 2015. Brussels, Belgium: International Diabetes Federation; 2015.
117. The underlying cause of death is defined as the disease or injury which initiated the train of events leading directly to death, or the circumstance of the accident or violence which produced the fatal injury. See: StatsSA (2017) 'Mortality and causes of death in South Africa, 2015', p. 4, 30.
118. The trend amongst the Asian/Indian race group should be interpreted with caution, however, as this group was underrepresented in the NIDS survey sample. See Matsebula, Ranchhod (2016) for a discussion.

Education levels also played a role in the prevalence of diabetes among those interviewed. The most highly educated group had the lowest prevalence rates while respondents with intermediate levels of education had the highest prevalence rates (24%). Respondents who never completed secondary school, had prevalence rates between the two more educated groups.

The findings show that maintaining a healthy weight matters most in reducing the risk of getting diabetes. Targeted education and awareness raising campaigns about the importance of maintaining a healthy weight may help reduce the increasing levels of diabetes within the adult population.

The latest reliable data on diabetes prevalence at provincial level comes from the 2012 South African National Health and Nutrition Examination Survey (see Figure 36).[119] Northern Cape had the highest prevalence with 22% followed by North West (13%) and Western Cape (11%). The lowest rates were found in Limpopo with 5% and Mpumalanga with 6% respectively.

The 2015 Stock Outs National Survey shows that Free State had the highest percentage of facilities reporting stock outs on Metformin in 2014 and 2015, the most common first-line medication used in diabetes mellitus (2014: 7%, 2015: 6%). The national average for both years was 3% stock out rates.[120] In 2015, 6% of health facilities in North West, the province with the second highest prevalence rate in the country, reported a stock-out of medication used for diabetes (see Figure 37).[121]

Figure 36: Percentage of respondents who reported diabetes.

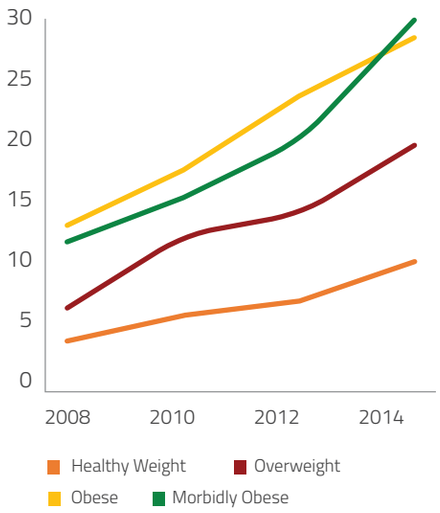
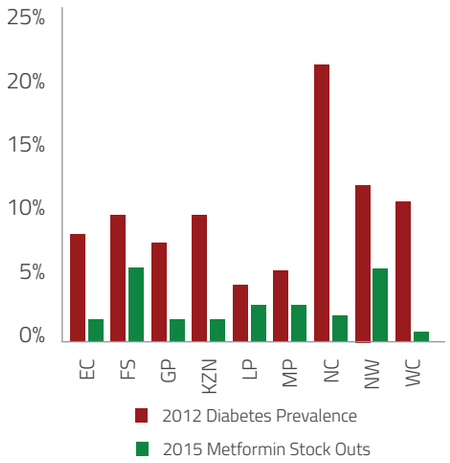


Figure 37: 2012 Diabetes prevalence (2012) and stock-outs of diabetes medication (2015) by province



Data Source: SANHANES-1 2012, 2015 Stock Outs National Survey

FOOTNOTES:

119. Shisana O, Labadarios D, Rehle T, Simbayi L, Zuma K, Dhansay A, et al. South African National Health and Nutrition Examination Survey (SANHANES-1). Cape Town: HSRC Press; 2013.
120. 2015 Stock Outs National Survey. Third Annual Report – South Africa (2015), Stop Stockouts, p. 44.
121. Ibid.

CHAPTER FOUR:
KEY FINDINGS:

South Africa's health profile

1. South Africans now live around 9 years longer when compared to 2005 (see Indicator 18 in this paper). This overall improvement in health status is largely related to expanded access to antiretroviral treatment. Government has progressively allocated more resources towards addressing the HIV and AIDS pandemic in the country in the form of the Comprehensive HIV/AIDS conditional grant (see Figure 8 in this paper). The spending of this grant has also shown positive trends, which has resulted in real changes on the ground. New HIV infections, HIV incidence and deaths due to AIDS have all fallen dramatically since the early 2000s. In 2001, over 40% of deaths in South Africa were as a result of AIDS. In 2016, this figure had fallen to 27.9%.

2. In 2015, 35% of 15 to 49 year olds tested for HIV (see Indicator 8 in this paper), which is a significant increase compared to 26% testing coverage in the previous year. Testing is an important suggestion of levels of awareness and a necessary precursor to treatment. 93% of the population between 15 and 49 years knew where to get tested for HIV. Among the younger population between 15 and 19 years, however, only 86% knew where to get tested. Since girls in this age group are particularly at risk of infection, therefore targeted services need to improve their knowledge about risks, prevention and counselling and testing services. It is worrying that Johannesburg, the most populous metro in South Africa, had the lowest HIV testing coverage – 23% in 2015. Given the higher levels of education in Gauteng province, where Johannesburg is located, this deserves further examination.

3. Trends related to the prevention of HIV transmission from mother to child are very positive, and show that the risk of infant HIV infection decreased from 8% in 2008 to an estimated 1.4% in 2015. In 2015, 93% of HIV positive pregnant women were initiated on ART according to administrative health data. It is encouraging that no significant differences in uptake of ART by socio-economic quintile were observed, which suggests that there are no poverty related access barriers with regard to benefitting from this important health service.

4. Due to the introduction of routine HIV PCR testing at birth, a much greater number of HIV positive newborns are being detected soon after delivery which provides the opportunity for early treatment. Early measurements in the performance of this indicator suggest some worrying trends, however (see Indicator 10 in this paper). Less than 1 in every 2 HIV-exposed new-born born in the Eastern Cape received an HIV PCR test within the first 6 days of life. At the district level, Lejweleputswa in the Free State had a coverage rate of only 32.2%, and A Nzo and OR Tambo in the Eastern Cape had coverage rates of 33.8% and 24.5% respectively.

5. South Africa's epidemiological mortality profile has also changed over the last decade, due in part to the country's aggregate economic growth. Non-communicable diseases have surpassed communicable diseases as the main cause of years of life lost in South Africa (see Indicator 21 in this paper). In 2014, non-communicable diseases (excluding HIV and TB) contributed to 38% of years of life lost in South Africa, more than any of the other three main causes of death in the country. Other figures attributed 56% of deaths in 2015 to non-communicable diseases, compared to 33% as a result of communicable diseases and 11% as a result of injuries.[122] Non-communicable diseases are often chronic in nature and impose a significant financial and operational burden on an already overstretched public health care system. It is important that health budgeting and planning reacts to this shift in disease burden and that national and provincial policies on non-communicable diseases are accompanied with costed budgets and a monitoring framework that tracks implementation.

FOOTNOTES:

122. Stock Outs National Survey. 2015. Third Annual Report – South Africa. Stop Stockouts: 52.

6. The deadly duo of Tuberculosis and HIV was responsible for 27% of years of life lost in 2014. Government interventions to tackle TB-HIV co-infections have been successful in identifying TB patients who are HIV positive. In 2015, 95% of TB patients knew their HIV status compared to only 43% in 2006. Also, the percentage of TB-HIV co-infected patients who started on ART increased from 28% in 2011 to 85% in 2015. The Western Cape had the lowest proportion of co-infected patients on ART (76%) in 2015.

7. While Tuberculosis continues to be the number one single cause of death among South Africans, data on new infection rates show that the TB incidence rate has declined since 2009 from 832 cases per 100 000 population to 520 cases in 2015. The Eastern Cape (692 cases/ 100 000), KwaZulu-Natal (685 cases/ 100 000) and Western Cape (681/ 100 000) had the highest incidence rates in the country. It is important to highlight that the 8 metros in South Africa account for about 40% of TB infections. eThekwini had the highest number of TB cases in South Africa in 2014 yet it also had one of the lowest treatment success rates. It also had the highest proportion of TB patients who were not evaluated (18.5%) and was also among the five districts with the lowest proportion of HIV-positive TB patients on ART (70%).

Non-communicable diseases

8. Lack of reliable survey data makes it hard to make accurate estimates about how many people are suffering from non-communicable diseases. Evidence indicates, however, that the number of people living with non-communicable chronic conditions has increased over the last several years which puts a growing pressure on health-care services.

9. In 2015, approximately 28% of South Africans adults (15 years or older) suffered from hypertension (see Indicator 28 in this paper). In the same year, hypertensive diseases were the second most commonly reported cause of death (11%). Hypertension prevalence rates varied widely among provinces, with the highest rates of 40% in Northern Cape and the lowest rates in Limpopo with 21%. In general, prevalence of hypertension has decreased across all provinces while treatment coverage has increased. The Northern Cape stands out as the province with by far the highest hypertension prevalence rates and relatively low treatment coverage rates.

10. 10. Diabetes accounted for 5, 4% of deaths in 2015. In 2014, almost 1 in every 5 South Africans suffered from Diabetes (see Indicator 27). Compared to 2008, significant increases of diabetes prevalence were especially observed among the group of overweight and obese respondents. The findings show that maintaining a healthy weight matters most in reducing the risk of getting diabetes. Targeted education and awareness raising campaigns about the importance of maintaining a healthy weight may be a very effective and relatively cost-effective way to help reduce the increasing levels of diabetes within the adult population.

Health care services for mothers and children

11. Another aspect of the health care system which is crucial to monitor concerns the services required by mothers and children. Quality antenatal care services, for instance, are an important factor for reducing the mortality of pregnant women, new mothers and their new-borns. They offer an important entry point for linking pregnant women with the formal health system and for increasing the chance of using a skilled attendant at birth. Although antenatal care is free in South Africa, only about 60% of pregnant women and girls attended such services before the 20th week of their pregnancy in 2015. It is however encouraging that the gap in antenatal care attendance rates between poorer and better off districts has closed in recent years. This shows that pregnant women who are socio-economically disadvantaged are not disproportionally excluded from this health service.

12. Issues around the quality and representativeness of data make it difficult to estimate maternal mortality rates. Various data sources indicate a decrease in maternal deaths between 2010 and 2015, which was linked to the successful roll out of HIV testing among pregnant women

and the initiation of Highly Active Anti-Retroviral Therapy (HAART) of HIV-infected pregnant women. With latest estimates of about 138 maternal deaths per 100 000 live births, however, South Africa continues to lag far behind the 2019 national target of less than 100 maternal deaths and the 2030 SDG target of less than 70 deaths. It is important to focus interventions in areas with particularly high maternal mortality rates such as Capricorn district in Limpopo, Xhariep district in Free State and OR Tambo district in the Eastern Cape, which had the highest number of maternal deaths per 100 000 live births in health facilities.

13. Access to family planning is one of the most cost-effective interventions to reduce maternal mortality. While teenage pregnancy declined slightly during the period under review, only about 48% of women between 15 and 49 years were protected against unplanned pregnancies in 2015 by using modern contraceptive methods. North West had the lowest rates of women using contraceptives and it also had the highest maternal mortality ratio in health facilities. Alarmingly, it is also the province with the lowest proportion of women delivering in a health facility which might mask an even higher maternal mortality ratio.

14. The majority of deaths among children below the age of 5 in South Africa are preventable. Early childhood mortality rates are therefore important indicators to assess the accessibility and quality of health services catering to the needs of children. Reliable annual estimates on neonatal and under 5 mortality rates are only available at national level. Infant mortality rates of children younger than 1 year old and 5 years old have both steadily decreased. Inpatient death rates in children under 5 years were higher in poorer districts as well as in rural districts. Children living in poorer districts are far less likely to be admitted to a health facility, and more likely to die there once they are admitted. This can either point to the fact that children are admitted too late and cannot be saved because of the advanced stage of disease or because the quality of health service is low.

15. It is worrying, however, that the data indicates that the number of new-borns who die within their first 28 days after birth has slightly increased from 11 to 12 deaths per 1 000 live births in 2015. The national target for 2019 is 8 neonatal deaths per 1 000 live births while the SDG target is less than 12 deaths. Administrative data, which only included new-borns who died in a health facility within the first 7 days after birth, showed that the highest number of deaths were recorded in Northern Cape, Eastern Cape and Limpopo. Capricorn district in Limpopo and OR Tambo district in Eastern Cape were the districts with the highest in facility early neonatal mortality rates of above 18 deaths per 1 000 live births.

16. Vaccinating children against the main vaccine-preventable diseases is a key intervention to reduce mortality and protect children from illness and disability. The national immunisation coverage rate of children under 1 year has increased from 81% in 2010 to 89% in 2015. The revised MTEF target for immunisation coverage of children under 1 year is 95% by 2019. It will be important to further focus interventions in the poorer of districts where immunisation coverage rates have increased significantly but continue to lag behind the national average. The 2016 Demographic Health Survey found, in contrast, that only 61% of children aged between one and two years received all basic vaccinations. The survey also made the particularly worrying finding that girls were less likely to be vaccinated compared to boys (59% versus 64%).

CONCLUSION:

1. Finally, some notable trends regarding the number of health workers working in the public sector demand discussion and attention (see Indicator 13 in this paper). Despite a national increase in the number of nurses in South Africa, the number of these most crucial health care workers have decreased in Free State, Gauteng and Western Cape. An alarming national decrease of 8% in the number of medical specialists is observable between 2000 and 2016, driven by stagnation in the Eastern Cape and KwaZulu-Natal, and regressions in Gauteng (where the number of medical specialists fell by 36.7%) and the Western Cape (where the number of medical specialists fell by 36.3%).

2. Crucially, dramatic provincial inequalities are observable in the measurement of the distribution of almost every type of health care worker. It deserves mention that North West is regularly the worst performing province in the measurement of these indicators. In 2015, there were 25.2 more medical specialists per 100 000 population in the Western Cape than in Mpumalanga. The number of physiotherapists and occupational therapists working in the public sector also varies greatly among provinces. It is worrying that North West has the lowest number of therapists per 100 000 uninsured population while it also has the highest disability prevalence in the country.

3. Worryingly, real allocation trends in budgets for the training and development of health professionals (see Figure 12 in this paper), have seen dramatic cuts. North West consistently the worst performing province with regard to the distribution of health workers of different kinds (Indicator 13 in this paper). Alarming cuts have also been made to the budgets for tertiary health care services (see Figure 14 in this paper), placing undue strain on hospitals in the delivery of health care. While this may be partly driven by government's important attempts to encourage the use of primary health care, one need not suffer to achieve the other. Indeed the principle of the progressive realisation of the right to health care services demands that it does not.

4. Current budgeting for the implementation of National Health Insurance (NHI) remains scant. While there have been notable successes in the government's efforts at ensuring everyone in South Africa enjoys the right to health care services, especially with regard to addressing the HIV/AIDS pandemic, there remain very real challenges in the health care system. Indeed, as discussed throughout Chapter 3 of this paper, there are numerous instances in which aspects of people's right to health care services have regressed, and in some cases quite dramatically. When one considers that more than 4 in every 5 people in South Africa fall beyond the purview of the private health care system (see Indicator 1 in this paper), it becomes clear that the burden of addressing these shortcomings will fall squarely on the shoulders of the state. An important and urgent step in meeting that demand will be the successful roll out of NHI, which if taken seriously will require not only greater allocation of funds, but robust capacity building in order to support the programme.

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NOTES

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