HEALTH CARE INEQUITY IN SOUTH AFRICA AND THE PUBLIC/PRIVATE MIX

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ABSTRACT

This working paper presents information and analyses of health care inequity in South Africa, with specific reference to what health economists term the public-private mix in health care. The paper identifies the apartheid legacy of disadvantage in terms of health status and inequitable access to health care, and outlines health policy initiatives since 1994.It draws together household survey data and other evidence to highlight three aspects of the South African health system since that date:

1. increased use of the private sector (all forms of provider) across population groups;
2. stagnation of government funding for publicly-provided health care, which has implications for quality of care and household utilisation preferences;
3. cost escalation in, growth of, and attraction of health personnel to, the private sector, and the implications this has for the sustainability of the overall health system, given household utilisation preferences.

This working paper largely draws upon existing sources and material, but also includes a new analysis of health care utilisation data. The paper provides background material for further assessment of the potential for public-private interactions to support greater cross-subsidy between population groups.

1. THE CONTEXT OF HEALTH AND HEALTH CARE IN SOUTH AFRICA

1.1 The apartheid legacy of disadvantage

A range of household surveys provide data on the extent and nature of socio-economic dis-advantage in South Africa. These include the 1992/93 Project for Statistics on Living Standards and Development (LSDS), the annual October Household Surveys (OHS) conducted by Statistics South Africa, a 1994/5 survey of health inequalities (Hirschowitz and Orkin 1995) the South African Participatory Poverty Assessment (SA-PPA 1997), and the 1996 population census. Analysis of these surveys (see, for example, Reconstruction and Development Programme 1995; May *et al.* 1995; May 1998) suggests that the most crucial indicators of dis-advantage include: race (African and to a lesser extent coloured[1]); housing; access to energy sources; water and sanitation; educational status; employment status; food access and nutritional status; geographic location (especially rural residence); fragmentation of the family, especially labour migrancy; gender (especially single mothers and female heads of households) and age (young children and the elderly who have no wider family support).

As the human development disparities of South Africa are largely attributable to the racially discriminatory economic and social policies of apartheid (Gilson and McIntyre 2002) they can clearly be regarded as unacceptable inequalities. As noted in the 1998 Poverty and Inequality report, "many of the distortions and dynamics introduced by apartheid continue to reproduce poverty and perpetuate inequality. The correct identification of these and the introduction of remedial policies have been identified as *priorities by both government and civil society*" (May 1998: 2 - authors' emphasis). If government resources are to be allocated in line with these priorities, groups who fare the worst in these human development indicators should be awarded priority in the allocation of these resources.

The disparities in socio-economic status have also contributed to inequalities in health status in South Africa. Gilson and McIntyre (2002) found that there are significant differences in the incidence of ill-health between different race groups and geographic areas as well as between groups of different socio-economic status. Using 1992/93 data, the infant mortality rate (IMR) of the African population was found to be nearly six times greater than that of the white population. In addition, the IMR varied by a factor of nearly 5 between provinces and by nearly 3 between the highest and lowest household income quintiles. The authors also found that income is a mediating factor in the relationship between race and health status. For the African and coloured populations, there is a clear trend of declining IMR with rising income.

1.2 The health system legacy of apartheid

Health policy in the apartheid era, like all government action, served the dominant objective of maintaining economic and political power for the white population group. It was shaped to maintain a difference in the quality of life enjoyed by different population groups and so promote political support for the National Party (Price 1986). As a result, the health system inherited by the new government in 1994 can be characterised as:

- centralised and undemocratic (Health Systems Trust 1996);

[1] The use of the terms 'African', 'white', 'coloured' and 'Indian' reflects a statutory stratification of the South African population in terms of the former Population Registration Act. The use of these terms does not imply the legitimacy of this racist terminology.

- highly fragmented in structure: health service delivery was divided between a range of health authorities (e.g. national, provincial, former 'homeland'[2], and local government structures), and curative and preventive primary care services were provided in separate facilities and administered by different health authorities (de Beer 1988; van Rensburg *et al.* 1992);
- inefficiently and inequitably biased towards curative and higher level services (only 11 percent of total public sector health care expenditure was devoted to non-hospital primary care services: McIntyre *et al.* 1995);
- inequitably biased towards historically 'white' areas as certain geographic areas (namely rural areas, particularly former 'homeland' areas, 'township' areas, and informal settlements) were systematically underfunded as a result of apartheid policies;
- inequitably biased towards the wealthy minority who use the private sector, estimated to be around 23 percent of the population (Valentine and McIntyre 1994), and who, for example, had access to the nearly 61 percent of total health care expenditure attributable to this sector in 1992/93 (McIntyre *et al.* 1995)[3].

As a result South Africa has a relatively well developed health sector with health care expenditure accounting for approximately 8.5% of Gross Domestic Product in 1992/93 (McIntyre *et al.* 1995). However, it has poor health status indicators compared to other middle-income countries, many of which devote considerably fewer resources to health care. Table 1 indicates that while South Africa has better health status indicators than some of its neighbours, its health status is worse than Botswana and Zimbabwe. The differences in health status between South Africa and Zimbabwe are particularly striking, given that Zimbabwe has a GNP per capita which is four times lower than that in South Africa. At the same time, although the level of economic development in South Africa is comparable to some Latin American countries, its health status indicators, and its Human Development Index (HDI), are considerably worse than those middle-income countries considered in Table 1.

These apparent anomalies are largely attributable to the mal-distribution of health care resources between the public and private sectors, on a geographic basis and between levels of care.

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[2] In terms of the 1913 'Natives Land Act', Africans were confined to living in ten 'homelands', which were highly fragmented geographic areas scattered throughout South Africa, and established along 'tribal' lines. These 'homelands' comprised less than 14 percent of the total surface area of South Africa. These 'homelands' have recently been reincorporated within the nine newly formed provinces.

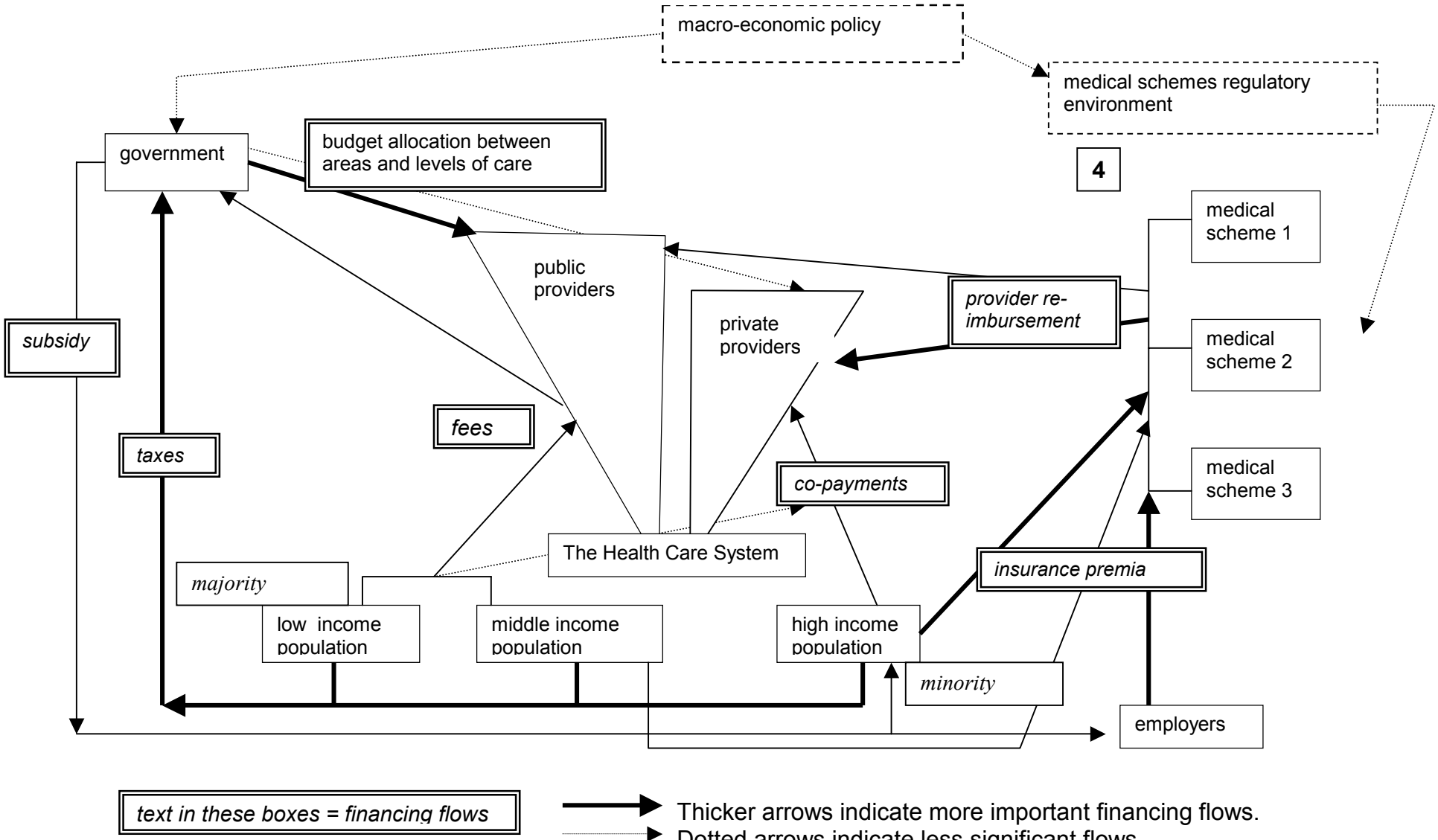
[3] In addition, the majority of the most highly trained health personnel work in the private sector: 62 percent of general doctors, 66 percent of specialists, 93 percent of dentists, 89 percent of pharmacists, and 60 percent of supplementary health professionals (Rispel and Behr 1992).

Table 1: International comparison of health status and other indicators (1990/1991) (From: McIntyre and Gilson 2002)

Country	GNP per capita (US$)	Human Development Index (HDI) (1993)	Infant mortality rate (IMR) per 1,000 live births	Life expectancy at birth (Years)	Incidence of tuberculosis (per 100,000 population)	% of children (12-23 months) with wasting	% of children (24-59 months) with stunting
South Africa	**2,560**	**0.649**	**54**	**62**	**250**	**10**	**53**
Southern African countries							
Mozambique	80	0.261	149	43	189	--	--
Zambia	360	0.411	106	47	345	10	59
Zimbabwe	650	0.534	48	62	207	2	31
Botswana	2,530	0.741	36	68	--	6	37
Selected middle-income countries							
Malaysia	2,520	0.826	15	71	67	6	32
Venezuela	2,730	0.859	34	72	44	4	7
Argentina	2,790	0.885	25	72	50	--	--
Uruguay	2,840	0.883	21	74	15	--	16
Brazil	2,940	0.796	58	66	56	6	29
Mexico	3,030	0.845	36	70	110	6	22

Sources: World Bank (1993): Tables 1, 28, A.3, A.6 and A.7; World Bank (1994): Tables A-1 and A-8; UNDP (1996): Table 1

Figure 1: Financing flows within the South African health care system as at 1994



1.3 Public/private interactions within the health system

Figure 1 outlines the financing flows to different population groups within the country, and indicates the segmentation of the health sector inherited from the apartheid era. Private providers and private insurers play important roles within the sector, but still predominantly serve the white, higher income groups, leaving the public sector to serve the lower income, largely African population. A limited section of the population pay out-of-pocket for private sector services, but this tends to be restricted largely to primary care services (e.g. general practitioners and over-the-counter medicines). However, prior to the 1998 Medical Schemes Amendment Act there was a clear distinction between 'medical aid schemes' and 'commercial health insurance'. The majority of those using private sector services are covered by health insurance in the form of 'medical schemes', most of which are mutual societies governed by the Medical Schemes Act of 1969 (Soderlund *et al.* 1998). These are for the most part employer-based with joint contributions by employers and employees, and provide comprehensive cover primarily in the private sector for employees and their dependants. Providers are reimbursed primarily on a fee-for-service basis. Employers receive a full tax subsidy for their contribution. By law most medical schemes are non-profit organisations each governed by a board representing its members. All schemes employ professional administrators to handle reimbursement and premium collection. Although some administrators are employed in-house, most are administered by for-profit companies that are contracted to provide the service. Medical schemes, through risk pooling, should enjoy a strong element of cross-subsidy from the healthy to the unhealthy and the high income to middle-income groups (van den Heever 1997). Over the 1990s there was also a growing commercial health insurance sector, providing both comprehensive cover and/or hospital coverage. A fundamental difference between medical schemes and commercial health insurance is that health insurance was based on risk-rating leading to cream-skimming and exclusion of the elderly and unhealthy. The Medical Schemes Amendment Act of 1998 has, subsequently, attempted to draw both forms of insurance under the same regulatory framework (see section 2.2).

Table 2 spells out further some of the main elements of the public-private mix in health care, as inherited from the apartheid era. The table uses the standard analytical framework applied in health economics' discussions of the nature and form of the 'public private mix' within any health system. It emphasises that by 1994 the public sector had already established a range of interactions with the private sector. Indeed, in 1995 the value of government contracts with private organisations for the provision of hospital level clinical and non-clinical care was estimated to be 9.4% of the total public hospital budget (Monitor Company *et al.* 1996). South Africa also has