THE SECOND KAISER FAMILY FOUNDATION SURVEY *of*

HEALTH CARE IN SOUTH AFRICA

PREPARED BY
THE COMMUNITY AGENCY FOR SOCIAL ENQUIRY (CASE)

FOR
THE HENRY J. KAISER FAMILY FOUNDATION

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The Second Kaiser Family Foundation Survey of Health Care in South Africa

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SUMMARY OF RESULTS

The following summarizes the findings from the *Second Kaiser Family Foundation National Household Survey on Health Care*. Overall, the survey documents real initial progress in improving health care for historically underserved populations in South Africa. For example, approximately one-third of Africans report that public health services are better than they were four years ago. Solid majorities of South Africans also expressed strong support for the government's major health policies. On the other hand, many South Africans have not seen positive changes in health care, and virtually everyone regards the HIV epidemic in South Africa as a very serious national challenge. Perhaps surprisingly, South Africans perceive the health of children and adults to be somewhat poorer than five years ago. Whether this reflects a true decline in health status or growing expectations about health and quality of life is difficult to determine.

HEALTH STATUS

PHYSICAL HEALTH

- Overall, 30% of South Africans rated their health as fair or poor, up from 19% in 1994. This decline in self-reported health status was most notable among Africans and Indians. Poor people and women were also more likely to rate their health as fair or poor.

- Elderly South Africans were more likely than their younger counterparts to report being in poor health. More than one half (55%) of all South Africans ages 65 and older rated their own health as fair or poor.

- The health status of nearly one in five South African children (19%) was assessed as being fair or poor. There were significant differences by race, area type and socio-economic status. For example, 5% of white children were assessed as being in fair or poor health compared to 20% of African, 17% of Indian and 14% of coloured children.

- Overall, about a quarter of South Africans reported that their ability to carry out day to day functions is affected by their health.

PERSONAL SAFETY

- Overall, about one in three (34%) of South Africans said they feel unsafe in the area where they live, and 16% said they, personally, or others in their household had been victims of some type of crime in the preceding year. While there were no significant differences by race in the proportions of respondents feeling unsafe, whites and Indians were more likely to report being victims of crime.

UTILISATION AND ACCESS TO HEALTH CARE

HEALTH CARE UTILISATION IN PAST YEAR

- Overall, one half (51%) of South Africans reported having visited a primary care facility (a doctor or clinic) within the 12 months preceding the survey. One in five (21%) South Africans visited a hospital in the same time period.

PUBLIC VERSUS PRIVATE SECTOR

- Overall, South Africans who visited a primary care facility in the past year were equally likely to report having visited a *public* facility (49%) as a *private* one (51%). Those who visited a hospital in the past year disproportionately visited a public facility.
    - Utilization of the two sectors varied significantly by race and differed somewhat by urban or rural area. For example, while a majority (59%) of Africans who visited primary care facilities in the past year made use of *public* facilities, majorities of all other races reported using *private* services when seeking primary health care.

TYPE OF PRACTITIONER

- On the whole, South Africans visiting a primary care facility were more likely to be treated by a doctor (59%) than a nurse (35%). However, the survey suggests that type of practitioner varies according to whether the patient visits a public versus a private facility.
    - At the primary care level, nearly two thirds (64%) of those treated at a *public* institution were treated by a nurse (27% by a doctor). Fewer than one in ten (8%) who visited a *private* site were treated by a nurse (88% by a doctor).
- For hospital care, the variation in practitioner type was not as pronounced. About a quarter (27%) of those who visited a *public* hospital were treated by a nurse (72% by a doctor) compared to one in ten (10%) individuals seeking care at a *private* hospital (86% were treated by a doctor).

MEDICAL AID COVERAGE

- As in 1994, this survey documents low overall rates of medical aid coverage as well as significant disparities along racial and socio-economic lines. Fewer than one in five (19%) South Africans have access to medical aid coverage with rates of complete coverage ranging from about one in ten (11%) Africans to more than three-fourths of whites (77%).
- The survey revealed a decline in rates of medical aid coverage since the 1994 survey. Twenty-six percent of South Africans reported having full medical aid coverage in 1994, compared to 19% in the current study. Losses of coverage among Indians and coloureds appear to account for the overall decline.

FACTORS INFLUENCING ACCESS TO CARE

Travel Costs

- Overall, 51% of South Africans who visited primary care facilities in the past year incurred no costs in travelling to their site of care; 45% paid R1 to R19, while 4% paid R20 or more.
- Travelling costs to reach hospitals were generally higher than the travelling costs to primary care facilities: 32% incurred no costs in travelling to a hospital, 57% paid R1 to R19 and 12% paid R20 or more.

Consultation Costs

- Overall, 43% of South Africans who visited primary care facilities in the past year received their care for free, but this varies by sector of care -- 86% who sought care in the *public* sector and 6% who received primary care services in the *private* sector received free care.

- One third of hospital visitors received services at no cost (38% of those using public hospitals and 6% of those using private hospitals). Only 5% of patients visiting *public* hospitals paid more than R100 for their care compared to 89% of those visiting *private* hospitals.

Method of Payment

- South Africans who visited private sector facilities--especially private hospitals--were far more likely to pay through medical aid than were those using public sector facilities.
  - For primary care, patients using *public* facilities were most likely to receive care for free (84%) or to pay out of pocket (15%), while those using *private* primary care facilities were equally likely to pay for those services out of pocket (49%) as with medical aid coverage (48%).
  - For hospital care, 85% of patients visiting *private* institutions paid for their care via medical aid, while 13% paid out-of-pocket for their care. Only 4% of those visiting *public* hospitals paid for services through medical aid; most (96%) paid for their care out of pocket (63%) or received care at no cost (33%).

- Reflecting the disparate rates of medical aid coverage among race groups, whites were far more likely to pay for health care services through medical aid.

Travel Time

- Overall, about one in six respondents who sought care traveled an hour or more to receive primary (17%) or hospital (15%) care. Not surprisingly, those in rural areas were the most likely to travel more than an hour when seeking care.

- When shorter travel is examined, traveling times of respondents in the 1998 survey appear to have decreased over those reported in 1994: 61% of respondents in 1998 were within 15 minutes travelling time of their health care facility (primary and secondary combined) compared to only 47% in 1994. However, there was no change in the proportions of South Africans who traveled an hour or more to reach care.

Waiting Time

- Overall, 35% of respondents waited more than an hour to be seen by a practitioner at a primary care site and 53% waited more than hour to be seen at a hospital. Compared to other races, whites were less likely to wait an hour or more at either site.

Availability of Health Care Services

- Over a quarter (27%) of South Africans indicated that “a new clinic” had been built in [their] area within the two preceding years. Africans (28%) were the most likely and Indians (16%) the least likely to report a new clinic.

- One quarter of Africans (27% of urban, 21% of rural) and 37% of coloureds (38% of urban, 29% of rural) reported that primary care facilities were open seven days a week, compared to 49% of Indians and 43% of whites. Access to hospitals that are open seven days per week appears about equal across groups, due in large part to most hospitals being open every day.

- With respect to hours of operation, four in ten (44%) South Africans who attended *public* primary care facilities in the past year and 51% who visited *private* primary care facilities said that these facilities are open only during working hours.

HEALTH CARE ACCESS WHEN ILL

- About three-fourths of South Africans (73%) indicated that they had sought help when last ill. One in six (17%) had not sought needed care. Rates of seeking care when ill did not differ by race.

- South Africans overall, and within all race groups, were less likely to have sought needed medical care in the past year compared to respondents in the 1994 survey. The drop was most significant among Indians (from 86% to 72%), rural coloureds (66% to 56%) and Africans (81% to 72%).

- Cost was the major reason given for not seeking care when needed (66%), followed by the unavailability or inaccessibility of services (23%) and time involved in going for treatment (21%).

QUALITY OF CARE

QUALITY OF FACILITY

- South Africans visiting a *private* facility were more likely than those attending a *public* facility to give that facility a rating of excellent.
  - For primary care, 45% who visited a *private* facility gave it a rating of excellent (1% rated it poor), as opposed to 19% who visited a *public* facility (6% rated it poor).
  - For hospital care, 59% visiting a *private* hospital gave a rating of excellent (2% rated it poor), as opposed to 14% who attended a *public* hospital (11% rated it poor).
- Among all who attended *private* sector facilities in the past year, whites were somewhat more likely to rate the facility they visited as excellent. There were no real differences in the ratings of South Africans who had used a *public* facility in the past year.

TIME WITH PROVIDER

- Overall, South Africans who sought primary health care in the past year report significantly shorter visits with practitioners at *public* facilities compared to those at *private* facilities.
  - At *public* sites, two in five respondents spent 5 minutes or less, another two out of five spent about 15 minutes and just one in five had a visit of 30 minutes or more.
  - At *private* facilities, about one in five (18%) spent five or less minutes with a practitioner, about half (47%) spent 15 minutes and 35% spent 30 minutes or longer.

ASSESSMENTS OF TREATMENT BY PRACTITIONER

- Whether they saw a doctor or a nurse, a majority of South Africans who visited primary care facilities gave positive assessments to the care that they received. Eighty-six percent said their treatment was excellent or good, 91% said their practitioner listened carefully, and 79% were made to understand the diagnosis they were given.

- Patients seeing nurses were less positive in their assessments than those who saw doctors.

OUTLOOK ON THE HEALTH SYSTEM AND HEALTH POLICY

CHANGES IN HEALTH CARE OVER THE PAST 4 YEARS

- A plurality (47%) of South Africans reported the perception that their *access to the health system* has gone unchanged over the past four years. About a third of South Africans said their access to health care has improved (34%).

- Respondents were asked to comment on whether they had noticed any improvements over the past four years in terms of *waiting times*, *availability of medicines* or *the quality of the doctors and nurses who treated them*. One in five to three in ten South Africans say that things have gotten better in these areas.

AWARENESS OF KEY HEALTH POLICIES

- There was a high level of awareness (86%) of the *policy of free health care for children under 6* among South Africans overall. Awareness of this policy was higher among Africans (91%) and coloureds (83%) than among whites (58%) and Indians (61%).

- There were far lower levels of awareness of the of *referral policy for entry into public hospitals*, with just over half (57%) of South Africans aware of this policy. Again, Africans (48%) and coloureds (59%) were more likely to be aware of the policy than whites (27%) and Indians (31%).

SUPPORT FOR KEY POLICIES

- There was strong support among South Africans for three of the government's major health policies. Sixty-seven percent voiced support for the increased tax on tobacco, 71% for the higher tax on alcohol and 74% for compulsory community service for medical students. However, there were differences in the degree of support among racial groups. For example, only 42% of white respondents supported community service for medical students, compared to more than 70% of other races.

VIEWS ON ABORTION POLICY

- The survey found opposition to the notion that abortion is a woman's right (only 10% agree) with most South Africans either holding the view that abortion is morally wrong (48%) or justifiable only in the narrow case of rape (41%).

GOVERNMENT'S BEST AND WORST POLICIES

- A majority (58%) of South Africans named free primary health care (PHC) as the government's best health policy. Africans (63%) and coloureds (53%), who also report greater use of public services, voiced the highest support for this policy.

- School feeding (22%), the clinic building program (15%), the HIV/AIDS program (15%) and child immunisation (9%) were other government programs that were viewed positively by respondents.

MOST IMPORTANT HEALTH CONCERNS

- More than seven in ten South Africans (71%) ranked HIV/AIDS as their most important health concern, followed by cancer (11%). Levels of concern varied significantly among race groups, with the plurality of Africans (79%), Indians (57%) and coloureds (53%) naming HIV/AIDS their main concern and the plurality of whites naming cancer (39%).

PRIORITIES FOR THE HEALTH SERVICE

- Asked, "What, if anything, would you like to see change in the Government Health Service?" most South Africans named changes related to improving the quality of care. More than a third (37%) mentioned better services, 26% mentioned better treatment from staff, 24% mentioned increased availability of drugs and medicines and 13% called for improved staff skills.

INTRODUCTION

In 1994, the Henry J. Kaiser Family Foundation commissioned the first *National Household Survey of Health Inequalities in South Africa*[1]. Since the time of that survey, the health and health care environment in South Africa has entered a period of profound change. The new government's commitment to addressing disparities in health among races has resulted in a dramatic shift in resources from secondary and tertiary level care towards primary health care and from the private to the public health sector. The private sector, faced with rapidly escalating costs and a turbulent regulatory environment, has seen significant incorporation of managed care principles pioneered in the United States, along with the development of "new generation" schemes[2].

In the second half of 1998, the fieldwork was conducted for the *Second Kaiser Family Foundation National Household Survey on Health Care* by the Community Agency for Social Enquiry (CASE). The aim of the study was to document public perceptions regarding health policy, health status, health care utilisation, access and barriers to access and the quality of health care in South Africa. Where possible, comparisons were made among the views of different segments in South African society and results were examined in light of 1994 survey findings to assess changes over the past four years.

The specific objectives of the 1998 study were:

- To measure and develop better indicators of the population's:
  - self-reported health status;
  - utilization of health care services by level (primary, secondary, tertiary) and sector (public, private);
  - access to health care and major barriers to accessing care;
  - assessments of the quality of health care and satisfaction with care provided by different practitioners and in the different sectors (public, private);
- To identify the health or health care issues that are of the greatest concern to individuals, especially in the poorer segments of the population.
- To measure South Africans' awareness and attitudes towards key health policies introduced over the past four years.
- To identify root causes of the poor relationship between public sector health care providers and the communities they serve.
- And, where possible, to assess changes in key demographics, the public health environment, and health-status indicators since the first survey in 1994, with specific attention to the impact of new government policies.

[1] The "1994 Survey" referred to throughout this report refers to this survey which was titled "A National Household Survey of Health Inequalities in South Africa".
[2] The new generation schemes feature individual savings accounts out of which members meet the cost of day-to-day benefits, while other benefits like major medical expenses are still provided on a pooled basis.

Quantitative and qualitative methods were employed to meet these objectives. In the first part of the study, 4000 households were visited and up to two individuals in each household were interviewed. Respondents were chosen from all provinces and all race groups so as to be representative of the South African population as a whole. To the extent that the final sample deviated from the profile of the South African population, individual data have been weighted to reflect the race, gender and provincial population distribution based on the 1996 census.

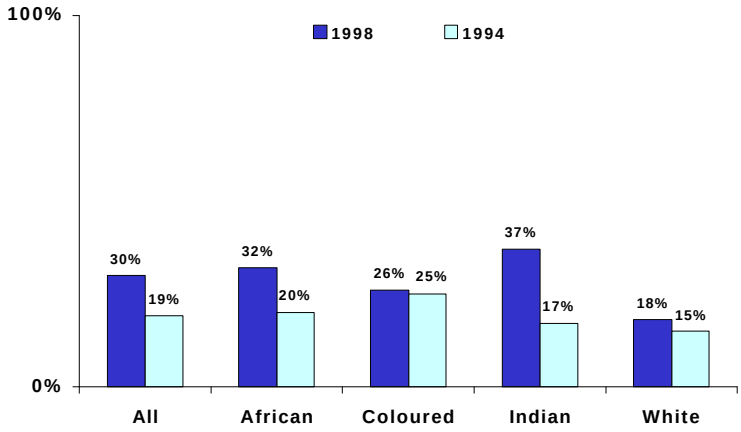
In addition to the household survey, 28 focus groups were conducted amongst rural South Africans in order to provide more detailed information on the nature of health inequalities in South Africa. Personal in-depth interviews were also conducted with health care providers at the focus group sites in order to gain insight into provider perspectives and concerns.

HEALTH STATUS

PHYSICAL HEALTH STATUS

FIGURE 1

Proportion Rating Own Health Status as Fair or Poor 1994 and 1998, by Race



Source: Second Kaiser Family Foundation National Household Survey of Health Care

As the main indicator of health status, respondents were asked to rate their physical health in relation to people of their own age using a four-point scale: excellent, good, fair, or poor.[3]

	Good/Excellent	Fair/Poor	N[4]
African	**68%**	**32%**	**1677**
Coloured	**74%**	**26%**	**219**
Indian	**63%**	**37%**	**62**
White	**82%**	**18%**	**272**
African urban	**69%**	**31%**	**1068**
African rural	**67%**	**33%**	**597**
Coloured urban	**71%**	**29%**	**158**
Coloured rural	**81%**	**19%**	**59**
All	**70%**	**30%**	**2230**

Table 1. Self-reported health status: adults age 17-64 years, by race.

Overall, 30% of South Africans rated their health as fair or poor. While there was little difference between urban and rural respondents, there were significant racial differences in self-assessed health status. Africans (32%) and coloureds (26%) were more likely to rate their health as fair or poor than whites (18%). There was also a positive correlation between socio-economic status and health status. Four-tenths (40%) of South Africans from low socio-economic households reported fair or poor health compared to 24% of South Africans from high socio-economic households.

[3] These types of perceptions are subjective and may be influenced by a number of variables, including the people with whom the respondents compare themselves, their expectations in relation to their life-style and their definitions of health. However, research conducted to test the validity of these indicators, has proved them to be fairly accurate measures of health status.
[4] The symbol, N, is used throughout to represent "Sample Size," referring to the number of individuals or cases.

	Fair or Poor Health			
	Male	**N**	**Female**	**N**
African	**26%**	**688**	**36%**	**982**
Coloured	**21%**	**91**	**30%**	**124**
Indian	**37%**	**30**	**40%**	**30**
White	**18%**	**113**	**17%**	**159**
African urban	**25%**	**449**	**36%**	**615**
African rural	**30%**	**235**	**36%**	**360**
Coloured urban	**24%**	**68**	**33%**	**88**
Coloured rural	**7%**	**23**	**24%**	**36**
All	**25%**	**922**	**33%**	**1295**

Table 2. Proportion of adults with fair or poor self-reported health status, by race, area type and gender.

As shown in table 2 above, there were also differences in health status by gender. Women (33%) were more likely than men (25%) to rate health as fair or poor. This pattern was consistent across groups except among whites, where men and women rated their health status similarly.

	Fair or Poor Health	
	1994	**1998**
African	**20%**	**32%**
Coloured	**25%**	**26%**
Indian	**17%**	**37%**
White	**15%**	**18%**
All	**19%**	**30%**

Table 3. Proportion of adults (17 to 64) with fair or poor self-reported health status 1994 & 1998, by race.

South Africans rated their health more poorly on the survey in 1998 than in 1994. In 1998, three out of ten (30%) South Africans rated their health as being fair or poor compared to 19% in 1994. This decline in self-reported health status was most notable among Africans and Indians. Whether this reflects a true decline in health status associated with worsening conditions or health, or reflects growing expectations about quality of care is difficult to assess without routine health statistics that could confirm or dispute these self-perceptions.

	Good/Excellent	**Fair/Poor**	**N**
All	**45%**	**55%**	**267**

Table 4. Self-reported health status (elderly 65+ years).

Elderly South Africans were more likely than their younger counterparts to report being in poor health. More than one half (55%) of all South Africans ages 65 and older rated their own health as fair or poor compared to 30% of those ages 17 to 64. There self-assessed health status of the elderly appears unchanged from 1994, when 52% of elderly South Africans reported fair or poor health.

To assess the health status of children aged 16 and younger, caregivers of children selected for the survey were asked to rate the children's health status in comparison to other children of the same age.

	Good/Excellent	Poor/Fair	N
African	80%	20%	1005
Coloured	86%	14%	91
Indian	83%	17%	22
White	95%	5%	67
African urban	78%	22%	541
African rural	83%	17%	456
Coloured urban	84%	16%	72
Coloured rural	96%	4%	18
All	81%	19%	1186

Table 5. Reported health status of children under 16, by race and area type.

The health status of nearly one in five South African children (19%) was assessed as being fair or poor. There were significant differences by race, area type and socio-economic status. For example, while only 5% of white children were assessed as being in fair or poor health, 20% of African, 14% of coloured and 17% of Indian children were thus assessed.

As with adults, there is a reported decline in the health status of children in 1998 compared to 1994. Among children 0-6 years 19% were assessed by a caregiver as being in fair or poor health in 1998, compared to 13% in 1994, and among those 6-16 years 19% were assessed by a caregiver as being in fair or poor health in 1998, compared to 12% in 1994.

As a further indicator of children's health status, caregivers were asked:

1. If they had ever been told by a doctor or a nurse that the child weighs too little and,
2. If they had ever received extra milk or food from a clinic for the child.

	Told child weighs too little	Given extra food or milk for child
African	10%	4%
Coloured	3%	1%
White	5%	2%
African urban	11%	3%
African rural	9%	5%
All	8%	4%

Table 6. Weight and supplemental food status of children, by race and area type.

Few children (8%) had been designated by a doctor or nurse as weighing too little. However, such a designation was twice as common for African children (10%) as for white children (5%). Four percent of caregivers had received extra food or milk for a child from a health clinic.

FUNCTIONAL HEALTH STATUS

As indicators of functional health status, respondents were asked how often their health:

1. Prevents them from working/studying,
2. Limits the type of work/study they do and
3. Limits what they can do at home.

Responses were recorded on a four-point scale: often, sometimes, seldom or never. The proportions saying "often" or "sometimes" are presented below.

	Health prevents work/study	Health affects work/study	Health limits home activity
	"Often" or "Sometimes"		
African	28%	26%	26%
Coloured	23%	22%	22%
Indian	25%	25%	25%
White	10%	9%	9%
African urban	27%	25%	25%
African rural	27%	28%	28%
Coloured urban	22%	21%	21%
Coloured rural	33%	30%	30%
All	24%	23%	25%

Table 7. Functional health status (adults 17 to 64), by race and area type.

Overall, about a quarter of South Africans reported that their ability to carry out day to day functions is affected by their health. Whites were substantially less affected than other groups, with about one in ten reporting each of the three limitations. Rural-dwelling coloureds were more likely than their urban counterparts to report that health problems interfere with activities of daily life.

CHRONIC ILLNESS

As an indicator of the prevalence of chronic health conditions among elderly South Africans, respondents aged 65 and older were asked if they had ever been told by a doctor or a nurse that they had an on-going or chronic problem, "such diabetes, high blood pressure, a heart condition, epilepsy, arthritis etc."

	1998
African	17%
Coloured	19%
Indian	24%
White	26%
African urban	20%
African rural	13%
Coloured urban	22%
Coloured rural	8%
All	18%

Table 8. Proportions reporting chronic conditions, by race and area type

Overall, about one in five elderly South Africans (18%) said they a chronic health condition. Indians (24%) and whites (26%) were more likely to report a chronic condition compared to coloureds (19%) and Africans (17%). Urban Africans and urban coloureds were also more likely to report a chronic condition compared to their rural counterparts.

Those who reported having a chronic condition were asked to name the condition and the four most common chronic conditions reported in the 1994 and 1998 studies were compared to see what, if any, changes had occurred over the past four years.

1994 Study	1998 Study
1. Hypertension	1. Hypertension
2. Arthritis	2. Asthma
3. Asthma	3. Heart Problem
4. Heart Problem	4. Diabetes

Table 9. Four most common chronic conditions: 1994 & 1998.

As in 1994, hypertension, asthma and heart problems remain among the most common chronic conditions reported. Arthritis, named by many in 1994, was replaced by diabetes as one of the most common complaints in 1998.

SMOKING

	Male	N	Female	N	Total
African	41%	688	10%	982	21%
Coloured	59%	91	39%	124	45%
Indian	40%	30	11%	30	25%
White	33%	113	24%	159	24%
African urban	41%	449	9%	615	21%
African rural	43%	235	10%	360	22%
Coloured urban	59%	68	38%	88	44%
Coloured rural	57%	23	43%	36	48%
All	42%	922	14%	1295	25%

Table 10. Proportion of respondents who smoke, by race, area type and gender.

Overall, a quarter of South Africans (25%) indicated that they smoked. Coloureds were almost twice as likely to be smokers compared to other race groups. Males (42%) were three times more likely than females (14%) to be smokers.

CRIME AND SAFETY

Crime and safety has become a major issue for all South Africans. Respondents were asked how safe they felt living in the their neighbourhood. Responses were recorded on a four-point scale: very safe, safe, unsafe and very unsafe. In a related question, respondents were asked if they or anyone in their household had been a victim of crime in the preceding 12 months.

	Feels rather unsafe/very unsafe where they live	Has been a victim of a crime in the past 12 months?
African	35%	15%
Coloured	29%	14%
Indian	38%	25%
White	30%	29%
African urban	40%	18%
African rural	27%	10%
Coloured urban	31%	15%
Coloured rural	15%	6%
All	34%	16%

Table 11. Sense of safety and incidence of crime, by race and area type.

Overall, one in three (34%) of South Africans said they feel rather or very unsafe in the area where they live, and 16% said they, personally, or others in their household had been victims of some type of crime in the preceding year. While there were no significant differences by race in the proportions of respondents feeling unsafe, Africans and coloureds in rural areas were less likely than those in urban areas to report feeling unsafe where they live. These rural-dwellers were also less likely to report being victims of crimes than those living in towns and cities. On the whole, whites and Indians were more likely to report being victims of crime then either Africans or coloureds. There were no significant differences by gender in perceptions of safety or experiences of crime.

UTILISATION AND ACCESS TO HEALTH CARE

Since 1994, government policies have placed considerable emphasis on improving access to health care (especially primary health care) and reducing racial disparities in access to health care. This section reports on South Africans' experiences using the health care system and factors that influence in health care access, including availability of services, cost of care, time costs, and transportation. To assess whether and how the situation has changed since 1994, comparisons are made where possible between 1994 and 1998 survey findings.

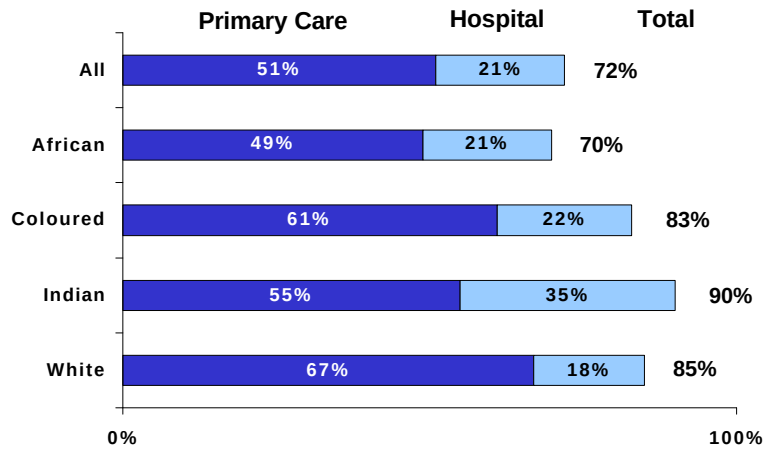
UTILISATION OF HEALTH CARE SERVICES

Utilization of health care services in the past year was examined on an absolute scale (utilized services in past year or not) and in specific terms: what type of facility did respondents visit (primary care clinic or a hospital) and in which sector (private versus public/government facilities).

Primary and Secondary (Hospital) Care

FIGURE 2

Proportions Seeking Health Care in Past Year, by Race



Source: Second Kaiser Family Foundation National Household Survey of Health Care

Overall, one half (51%) of South Africans reported having visited a primary care facility (a doctor or clinic) within the 12 months preceding the survey. One in five (21%) South Africans visited a hospital in the same time period.

	Primary Care	Hospital
African	49%	21%
Coloured	61%	22%
Indian	55%	35%
White	67%	18%
African urban	52%	23%
African rural	44%	18%
Coloured urban	64%	23%
Coloured rural	41%	14%
All	51%	21%

Table 12. Proportions visiting primary care facility and/or hospital in the last year, by race and area type.

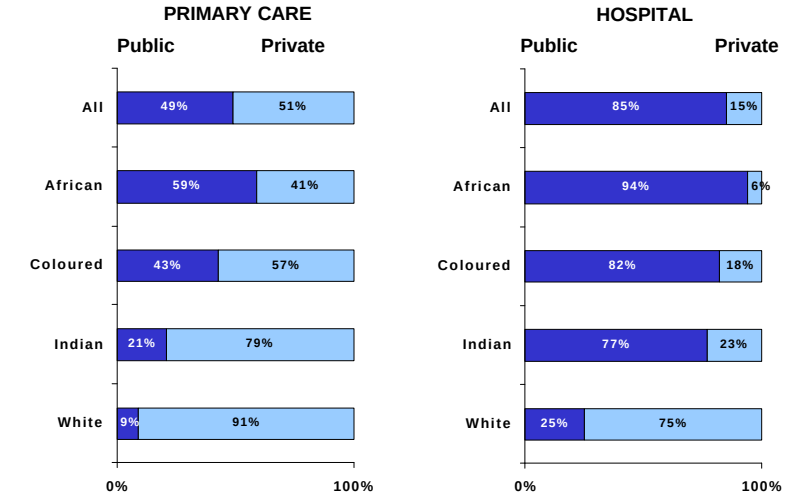
Whites (67%) and coloureds (61%) were slightly more likely to have visited a primary care facility than Indians (55%) and Africans (49%). Indians (35%) were more likely than other race groups to have visited a hospital in the past year. Urban Africans and urban coloureds were more likely than their rural counterparts to have sought both levels of care.

Public Versus Private Sector for Health Care

When seeking health care, South Africans may have a choice between public/government facilities and private sector services. Overall, South Africans who visited a primary care facility in the past year were equally likely to report having visited a public facility (49%) as a private one (51%). South Africans who visited a hospital in the past year disproportionately visited a public facility. Comparative utilization of the two sectors varied significantly by race and differed somewhat by area type (Figure 3 and table 13).

FIGURE 3

Proportions Seeking Health Care in Public Versus Private Sector in the Past Year, by Race



Source: Second Kaiser Family Foundation National Household Survey of Health Care

	Primary		Hospital	
	Public	**Private**	**Public**	**Private**
African urban	54%	46%	93%	7%
African rural	68%	32%	96%	4%
Coloured urban	41%	59%	79%	21%
Coloured rural	56%	44%	100%	0%
All	49%	51%	85%	15%

Table 13. Comparative Use of Public versus Private Facility when Seeking Health Care in the Past Year, by Area Type.

While a majority (59%) of Africans who visited primary care facilities in the past year made use of *public* facilities, majorities of all other races reported using *private* services when seeking primary care, including eight out of ten (79%) Indians, nine out of ten (91%) whites and more than half (57%) of all coloureds. Among Africans and coloureds, rural dwellers reported somewhat heavier reliance on public services compared to their urban counterparts.

Across all race groups, utilization of public facilities when seeking hospital care was significantly more common than when seeking primary care. Again, utilization varied significantly by race. Africans (94%), coloureds (82%) and Indians (77%) relied almost exclusively on public hospitals

when visiting hospitals in the past year, while three-fourths (75%) of their white counterparts went to private hospitals.

FROM THE FOCUS GROUPS…

On public sector facilities, affordability and access:

- *"Every one has easy access to the clinic because it is situated nearer our homes, secondly it is free of charge. When you are sick it is better to go to the clinic and be examined rather than waiting to accumulate money to go and see a private doctor or a traditional healer, while undiagnosed." (Male, aged 18-30, from rural Eastern Cape).*

On private sector facilities, quality of care and speed of service:

- *"They [private doctors] are fast and they are efficient. They do not cheat because the community controls them. With hospitals it is very difficult. The government pays the staff. Whether you are cured or not cured they do not care because they receive their salaries from the government." (Male Farm worker. 40+ in the Western Cape)You are not satisfied with the treatment you get at the hospital and feel that it is better to borrow money and go to a place where they will tell me what I'm suffering from. And also with a private doctor you get proper treatment." (Female, 40 +, rural Eastern Cape)*

Health Practitioner Type

Respondents who visited a primary care facility in the past year were asked to identify whether a nurse or a doctor had treated them at that visit. Results are presented for all primary care visits as well as by sector in which the primary care visit took place.

	Who treated you?			N
	Nurse	Doctor	Other	
Public	64%	27%	9%	488
Private	8%	88%	3%	524
All	35%	59%	6%	1012

Table 14. Type of health practitioner at primary health care facility last visited, by sector

On the whole, South Africans visiting a primary care facility were more likely to be treated by a doctor (59%) than a nurse (35%) or "other" practitioner (6%). However, the survey suggests that type of practitioner (doctor versus nurse) varies according to whether the patient visits a public versus a private facility. At the primary level, nearly two thirds (64%) of those treated at a public institution were cared for by a nurse (27% by a doctor). In contrast, fewer than one in ten (8%) South Africans who visited a private site were treated by a nurse (88% by a doctor).

Sector	Who treated you?			N
	Nurse	Doctor	Other	
Public	27%	72%	1%	378
Private	10%	86%	4%	41
All	25%	74%	1%	419

Table 15. Type of health practitioner at hospital last visited (outpatients only), by sector

At the secondary level, the variation in practitioner type was not as pronounced. About a quarter (27%) of those who visited a public hospital were treated by a nurse (72% by a doctor) compared to one in ten (10%) individuals seeking care at a private hospital (86% were treated by a doctor). When public and private hospital visits are combined, 74% of patients saw a doctor and 25% were treated by a nurse.

	Who treated you?			N
	Nurse	Doctor	Other	
Public	49%	50%	1%	254
Private	2%	96%	2%	185
All	30%	69%	1%	439

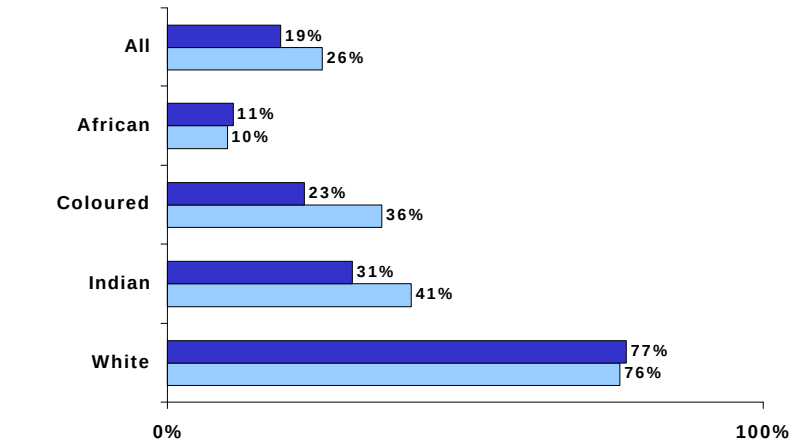
Table 16. Type of health practitioner at Rehab/Chronic facility last visited, by sector

Almost half the respondents (49%) who visited a public rehab/chronic facility were treated by a nurse (50% by a doctor), whereas almost all the respondents (96%) who visited a private facility were treated by a doctor (2% by a nurse).

Access to Medical Aid Coverage

Another important variable influencing access to health care, as well as choice of sector, facility and services, is medical aid coverage. As in 1994, this survey documents low overall rates of medical aid coverage as well as significant disparities among race and socio-economic groups.

FIGURE 4



Source: Second Kaiser Family Foundation National Household Survey of Health Care

Figure 4 shows that fewer than one in five (19%) South Africans have access to medical aid coverage with rates of complete coverage ranging from about one in ten (11%) Africans to more than three-fourths of whites (77%).

	Medical Aid?		
	Yes	No	N
Low	2%	98%	1260
Medium	11%	89%	1298
High	53%	47%	1260
All	19%	81%	3818

Table 17. Medical aid by socio-economic status.

In addition to differences by race, there was a very strong correlation between socio-economic status and medical aid coverage. Only 2% of the 'low' and 11% of the 'medium' socio-economic groups had medical aid coverage, compared to half (53%) of the 'high' socio-economic group.

After stratification by socio-economic status there were still significant racial differences in medical aid coverage as shown in table 18 below.

	Low	Medium	High	All
African	**2%**	**11%**	**11%**	**11%**
Coloured	**3%**	**28%**	**28%**	**23%**
White	**-**	**41%**	**79%**	**77%**
All	**2%**	**13%**	**24%**	**19%**

Table 18. Proportion of respondents with medical aid coverage, by race and socio-economic status category.

In the 'medium' socio-economic status category, whites were almost four times more likely than Africans to have medical aid coverage. Coloureds in this category were more than twice as likely as Africans to have coverage. Whites in the 'high' socio-economic group were over 7 times more likely have medical aid coverage compared to Africans in the same category.

Medical aid coverage also varied significantly with area type. Urban South Africans (25%) were a little more likely to have coverage than South Africans overall (19%) and much more likely to have coverage than South Africans from rural areas (6%) (table 19).

	Urban	Rural	All
Complete	**25%**	**6%**	**19%**
Partial	**1%**	**1%**	**1%**
None	**73%**	**93%**	**77%**
N	**878**	**1374**	**3818**

Table 19. Medical aid coverage by area type

The survey revealed a slight decline in rates of medical aid coverage since the 1994 survey. Twenty-six percent of South Africans reported having full medical aid coverage in 1994, compared to 19% in the current study. Losses of coverage among Indians and coloureds appear to account for the overall decline. Coverage rates among Africans and whites remained unchanged between 1994 and 1998.

	1994	1998
African	**10%**	**11%**
Coloured	**36%**	**23%**
Indian	**41%**	**31%**
White	**76%**	**77%**
All	**26%**	**19%**

Table 20. Medical aid coverage 1994 and 1998, by race

FACTORS INFLUENCING ACCESS TO CARE

To further explore utilisation patterns and the barriers to care, respondents were asked detailed questions about costs, travel effort, and time involved in seeking care as well as the availability of health care services when needed.

Cost of Care

First, respondents who sought health care in the past year were asked to quantify the costs involved.

Travel costs

	Primary			Hospital			N
	No Cost	R1 to R19	R20 or more	No Cost	R1 to R19	R20 or more	
African	57%	39%	4%	30%	59%	11%	1321
Coloured	63%	33%	4%	49%	22%	19%	193
Indian	62%	30%	8%	34%	59%	7%	49
White	12%	81%	7%	19%	58%	23%	277
African urban	58%	39%	3%	31%	58%	12%	824
African rural	55%	39%	5%	28%	63%	9%	484
Coloured urban	60%	38%	2%	47%	36%	17%	166
Coloured rural	-	-	-	-	-	-	26
All	51%	45%	4%	32%	57%	12%	1840

Table 21. Reported cost of travel to site of primary care by sector, by race and area type. Based on respondents who sought some form of health care in the past year.

Overall, 51% of South Africans who visited primary care facilities in the past year incurred no costs in travelling to their site of care; 45% paid R1 to R19, while 4% paid R20 or more.

Travelling costs to reach hospitals, as would be expected, were generally higher than the travelling costs to primary care facilities. Overall, while 32% incurred no costs in travelling to a hospital, 57% paid R1 to R19 and 12% paid R20 or more.

Consultation costs:primary care

	Free	< R50	R51-R100	> R100	N
Public	86%	11%	2%	1%	842
Private	6%	17%	64%	14%	761
All	43%	14%	35%	8%	1603

Table 22. Reported cost of primary care consultation by sector. Based on respondents who sought primary health care in the past year.

Overall, 43% of South Africans who visited primary care facilities in the past year received their care for free. As would be expected, there were substantial differences in cost of care between the public and private sectors. Nearly nine out of ten care-seekers (86%) did not pay for their health consultation in the public sector compared to one in fifteen (6%) seeking care in the private sector. Three percent of patients paid more than R50 for their primary care visit in the public sector compared to 78% paying such an amount in the private sector.

FROM THE FOCUS GROUPS…

On the costs of health care:

"I went to this other doctor and he told me that the doctor comes back on Monday. I didn't have money for transport, so I didn't go." (Female, 40 +, rural Mpumalanga).

- *"I think Kalafong [a public hospital] practices Apartheid. They only help you when you have money. If you don't have money they don't help you...Yes, he is telling the truth. The way they do it is that when you are injured or ill and you go there in the morning, they will first attend to those who have money."*

Consultation costs: hospital care

	Free	< R100	>R100	N
Public	38%	57%	5%	441
Private	6%	5%	89%	65
All	33%	48%	19%	506

Table 23. Cost of hospital consultation by sector. Based on respondents who sought hospital care in the past year.

Overall, a third of hospital visitors received services at no cost (38% of those using public hospitals and 6% of those using private hospitals). Again, there were substantial differences in the costs of public versus private hospital care with only 5% of those visiting public hospitals paying more than R100 for their care compared to 89% of those visiting private hospitals.

Method of payment

To understand payment dynamics, respondents who visited a primary care facility or a hospital in the past year were asked to describe their method of payment.

	Primary Care		Hospital	
	Public	Private	Public	Private
Out of pocket	15%	49%	63%	13%
Medical Aid	1%	48%	4%	85%
Free	84%	2%	33%	2%

Table 24. Method of payment for health care services by type of care received. Based on respondents who sought care in the past year.

Generally, South Africans who visited private sector facilities--especially private hospitals--were far more likely to pay through medical aid than were those using public sector facilities. For primary care, patients using public facilities were most likely to receive care for free (84%) or to pay out of pocket (15%), while those using private primary care facilities were equally likely to pay for those services out of pocket (49%) as with medical aid coverage (48%).

For hospital care, 85% of patients visiting private institutions paid for their care via medical aid, while 13% paid out-of-pocket for their care. Only 4% of those visiting public hospitals paid for services through medical aid; most (96%) paid for their care out of pocket (63%) or received care at no cost (33%). The results confirm that the high cost of care at private hospitals makes them readily accessible mainly to those who have medical aid or resources to pay for services out-of-pocket.

When analysed by race, whites were generally more likely to pay for their care through medical aid than other respondents. For instance, 70% of whites paid for private primary care through medical aid compared to 40% of Indians, 43% of coloureds and 29% of Africans. These differences reflect clearly the disparate rates of medical aid coverage among race groups.

Time Costs

To better understand the time involved in seeking health care in South Africa today, travel and waiting times were explored in-depth among respondents who had sought care in the past year.

Travelling time

Respondents who visited a primay care facility or a hospital in the past year were asked to recall how long it took to travel to the site of care (Table 25).

	Travel 1 or more hours to facility	
	Primary	Hospital
African	18%	22%
Coloured	9%	10%
Indian	13%	18%
White	3%	15%
African urban	11%	16%
African rural	31%	31%
Coloured urban	6%	10%
Coloured rural	25%	16%
All	17%	15%

Table 25. Proportion traveling 1 hour or more to each type of facility, by race and area type. Based on respondents who sought primary or hospital care in the past year.

Overall, about one in six respondents who sought care traveled an hour or more to receive primary (17%) or hospital (15%) care. Rural Africans were the worst off in terms of travel time: 31% of those who sought care traveled an hour or more to reach the health care facility. Rural coloureds who sought primary care also reported long traveling times: 25% traveled an hour or more to reach the facility.

	15 minutes or less		1 hour or more	
	1994	1998	1994	1998
African	36%	54%	24%	18%
Coloured	61%	70%	12%	9%
Indian	81%	69%	3%	13%
White	85%	85%	4%	3%
All	47%	61%	20%	15%

Table 26. Traveling times to health care facility (primary and secondary combined) 1994 and 1998.

When shorter travel is examined, traveling times of respondents in the 1998 survey appear to have decreased over those reported in 1994: 61% of respondents were within 15 minutes travelling time of their health care facility (primary and secondary combined) in 1998 compared to only 47% in 1994. The improvements appear to be particularly marked for Africans and coloureds who sought health care. However, there appears to be little change over the past four years in the proportions of South Africans who traveled an hour or more to reach care.

Waiting times

South Africans who sought health care were asked how long they waited before receiving medical attention as a measure of average waiting times, and to assess whether waiting represents a barrier to care.

	Primary care	N	Hospital	N
African	40%	771	56%	528
Coloured	37%	82	47%	109
Indian	27%	10	63%	37
White	12%	24	31%	247
African urban	42%	438	58%	369
African rural	37%	325	53%	155
Coloured urban	37%	67	47%	97
Coloured rural	43%	15	37%	11
All	35%	887	53%	921

Table 27. Proportion of respondents reporting waits of an hour or more at last visit by type of care, by race and area type. Based on respondents who had a primary care or hospital visit in past year.

Overall, 35% of respondents waited more than an hour to be seen by a practitioner at a primary care site and 53% waited more than hour to be seen at a hospital. Compared to other races, whites were less likely to wait an hour or more for treatment at their primary care or hospital visits.

FROM THE FOCUS GROUPS…

On new clinics: clinic:

- *"It has become more easy to get medical treatment because the government built us a new clinic that is nearer our homes, to enable us to go to the clinic without using transport. Nowadays, even if you don't have money you can walk to the clinic…It is easier to get medical treatment because we receive free medical care…" (Female, 18-30, rural Eastern Cape)*

On waiting to be treated at a clinic:

- *"The problem is that the clinic only attends to patients in the morning. After 13h00, they don't treat you especially if you are not a school child. They want to rest. If you were to become sick now and go to the clinic, they would ask you why you didn't come in the morning. Sometimes you can only go in the afternoon because in the morning you are preparing your children for school." (Female, 40+, rural Eastern Cape).*

On waiting for emergency care:

- *"Sometimes it happens that a person becomes injured during the night and when you rush him to the hospital you are told that the doctors are not available or that they are sleeping. Then we will have to wait for medical attention till the following day; meanwhile the patient is becoming critical." (Male, aged 18-30, from rural Eastern Cape).*

Transport Used When Seeking Health Care

To further explore access to health care facilities, respondents who sought primary or hospital care in the past year were asked to list the mode(s) of transport they used to reach their site of care.

	Public transport		Private transport		Walked	
	1994	1998	1994	1998	1994	1998
African	51%	40%	7%	10%	37%	48%
Coloured	20%	18%	30%	33%	43%	45%
Indian	11%	12%	64%	62%	25%	23%
White	5%	4%	81%	90%	12%	4%
All	41%	31%	13%	26%	43%	41%

Table 28. Mode of transport to health facility[1] 1994 and 1998, by race. Based on respondents who sought primary or hospital care in the past year.

South Africans who sought health care in the past year were about as likely to walk (41%) as they were to take public (31%) or private (26%) transport. However, mode of transport differed by race. The majority (88%) of Africans either walked (48%) or used public transport (40%) to get to their site of primary care. The majority of Indians (62%) and whites (90%) used private transport to get to their site of primary care.

When compared to modes of transport used by respondents in the 1994 survey, the respondents in the 1998 survey were less likely to use public transport and more likely to use private transport to reach a health care facility. The number who walked to their site of care did not change between 1994 and 1998.

AVAILABILITY OF HEALTH CARE SERVICES

Access to health care depends in large part on the number of clinics near where people live, as well as the days and hours those clinics are open. To assess health care availability, all respondents were asked whether a clinic had recently been built in the area where they live. In addition, respondents who had visited a primary care facility or hospital in the past year were asked what days and hours that facility was typically open.

New Clinics in Area

	New clinic built in past 2 years?
African	**28%**
Coloured	**21%**
Indian	**16%**
White	**24%**
African urban	**28%**
African rural	**28%**
Coloured urban	**21%**
Coloured rural	**22%**
All	**27%**

Table 29. Proportion reporting construction of new clinic, by race and area type

Just over a quarter of South Africans indicated that “a new clinic had been built in [their] area within the two preceding years.” Africans were most likely and Indians least likely to report new clinic construction.

Days of Clinic Operation

	Primary Care		Hospital	
	Public	**Private**	**Public**	**Private**
Every day	**30%**	**33%**	**97%**	**92%**
Working days + Saturdays	**16%**	**51%**	**1%**	**3%**
Working days	**49%**	**15%**	**2%**	**5%**
Intermittent	**5%**	**2%**	**0%**	**0%**

Table 30. Number of days health facility is open per week, by type and sector of facility

Only 30% of South Africans who visited a public primary care facility and 33% of those who visited a private primary care facility said these facilities were open every day. And while half (51%) who visited *private* primary care clinics said they were open on working days plus Saturdays, an equal proportion (49%) of those who visited *public* primary care facilities said were open on working days only. Nearly all South Africans who visited hospitals (97% who visited public and 92% who visited private) said the hospitals were open every day.

	Primary care	Secondary care
African	**25%**	**96%**
Coloured	**37%**	**95%**
Indian	**49%**	**92%**
White	**43%**	**92%**
African Urban	**27%**	**96%**
African Rural	**21%**	**97%**
Coloured Urban	**38%**	**94%**
Coloured Rural	**29%**	**100%**
All	**29%**	**96%**

Table 31. Proportions reporting that facility in their area is open seven days a week, by race and area type.

Table 31 summarises the proportions of South Africans by race that said the health care facility they visited was open every day. The data suggest the presence of racial disparities in access to primary care facilities that are open seven days per week. Only 27% of urban Africans, 21% of rural Africans and 29% of rural coloureds who visited a primary care facility in the past year reported that the facility was open every day, compared to 49% of Indians and 43% of whites who sought care. Access to hospitals that are open seven days per week appears about equal across groups, due in large part to most hospitals being open every day.

Hours of Clinic Operations

Not only do the days that a facility is open affect health care access but so do the facilities' hours of operation. Therefore, the survey asked respondents to give the opening hours of the facilities they visited in the past year.

	Primary Care		Hospital	
	Public	**Private**	**Public**	**Private**
24 Hours	**27%**	**15%**	**97%**	**90%**
Working hours +	**10%**	**33%**	**0%**	**4%**
Working hours	**56%**	**48%**	**3%**	**6%**
Few hours a day	**7%**	**3%**	**0%**	**0%**

Table 32. Hours of operation for health care facilities visited, by type and sector of facility

Four in ten (44%) South Africans who visited public primary care facilities in the past year and 51% who visited private primary care facilities said the sites they went to are not open outside of working hours. A quarter (27%) who went to public primary care sites and 15% who went to private said these facilities are open 24 hours per day. Ninety-seven percent who visited public hospitals and 90% who went to private hospitals reported that the hospitals are open 24 hours per day.

HEALTH CARE ACCESS WHEN ILL

As a final measure of health care access, respondents were asked whether they sought medical care the last time they were ill and felt that they needed treatment. And, if they did not, what factors stood in the way of getting care.

	Yes	No	Don't know/ Can't recall
African	72%	17%	11%
Coloured	73%	16%	11%
Indian	72%	17%	11%
White	76%	17%	7%
African urban	73%	16%	11%
African rural	72%	18%	10%
Coloured urban	78%	16%	6%
Coloured rural	56%	18%	26%
All	73%	17%	11%

Table 33. Proportion who sought health care the last time they were ill, by race and area type

About three-fourths of South Africans (73%) indicated that they had sought help when last ill; 17% had not. While rates of seeking care did not differ by race, coloureds living in rural areas reported seeking needed care in much lower numbers compared to other groups. (56% got care, 18% did not, 26% said they did not know or did not recall).

	Sought care when ill	
	1994	1998
African	81%	72%
Coloured	72%	73%
Indian	86%	72%
White	84%	76%
African urban	80%	73%
African rural	81%	72%
Coloured urban	73%	78%
Coloured rural	66%	56%
All	80%	73%

Table 34. Proportion who sought health care when last ill, 1994 and 1998, by race and area type.

South Africans overall, and within all race groups, were less likely to have sought needed medical care in the past year compared to respondents in the 1994 survey. The drop was most significant among Indians (from 86% to 72%), rural coloureds (66% to 56%) and Africans (81% to 72%).

Reasons for Not Seeking Care When Ill

Cost was the major reason given for not seeking care when needed. Two thirds (66%) of South Africans who did not seek care explained that they could not afford to. The unavailability or inaccessibility of services (23%) and time involved in going for treatment (21%) were other significant reasons named.

Reason for not seeking care	1998
Could not afford	66%
Service unavailable or inaccessible	23%
No time to get treatment	21%
Concerns regarding treatment	9%
No transport	6%

Table 35. Reasons for not seeking health care when last ill, for those who did not seek care

QUALITY OF CARE

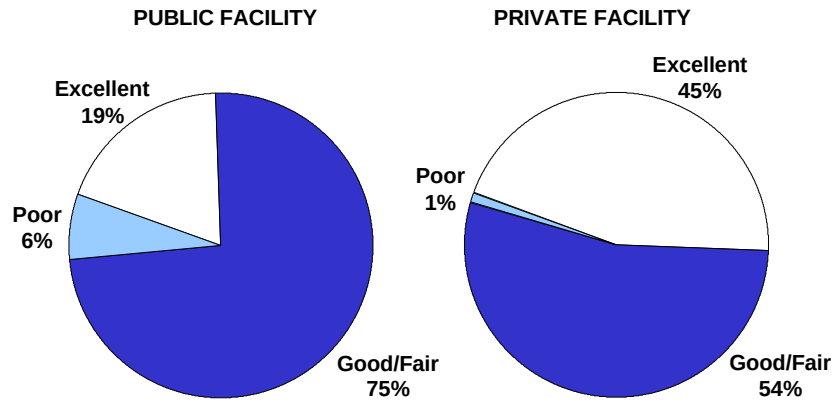
This section presents South Africans' ratings of the quality of the health care facilities and health practitioners they visited in the past year. In particular, the section points to significant differences between the experiences of respondents using public facilities and those using private facilities when seeking health care.

QUALITY OF FACILITY

Respondents visiting health facilities were asked to rate the quality of those facilities on a three-point scale: excellent, fair or poor. Results are shown in figure 5 and table 36 below.

FIGURE 5

Ratings of Quality of Primary Care Facility, by Sector



Source: Second Kaiser Family Foundation National Household Survey of Health Care

	Last visit to primary		Last visit to hospital		Last rehab/chronic visit		All
Sector	Public	Private	Public	Private	Public	Private	
N	896	935	528	97	256	185	
Excellent	19%	45%	14%	59%	18%	52%	35%
Good/Fair	75%	54%	75%	40%	75%	48%	62%
Poor	6%	1%	11%	2%	7%	0%	3%
Total	100%	100%	100%	100%	100%	100%	100%

Table 36. Reported quality of facility last visited by sector

South Africans visiting a private facility were more likely than those attending a public facility to give that facility a rating of excellent. At the primary level, 45% who visited a private facility gave it a rating of excellent, as opposed to 19% who visited a public facility. At the secondary level, 59% visiting a private hospital gave a rating of excellent, as opposed to 14% who attended a public hospital. Fifty-two percent of those who visited a private rehab/chronic facility gave the facility a rating of excellent, compared to 18% of those who visited a public facility.

The data was analysed to explore whether ratings of facilities differed across race groups. Because there were clear race differences in patterns of utilisation of public versus private facilities, quality ratings were examined within subsets of those using public and private sector *primary care* facilities. Sample sizes limit this comparison to Africans, coloureds and whites for private sector facilities and Africans and coloureds for public sector facilities.

	Quality of facility				Quality of facility			
	Public				Private			
	Excellent	Good/Fair	Poor	N	Excellent	Good/Fair	Poor	N
African	20%	74%	6%	779	42%	56%	2%	538
Coloured	15%	82%	3%	82	39%	61%	0%	109
Indian	-	-	-	10	52%	44%	5%	38
White	6%	83%	11%	24	53%	47%	0%	248
African urban	20%	73%	7%	445	40%	57%	2%	377
African rural	20%	75%	5%	326	46%	54%	0%	156
Coloured urban	16%	80%	4%	67	41%	59%	0%	96
Coloured rural	-	-	-	15	-	-		11
All	19%	74%	7%	896	45%	54%	1%	932

Table 37. Reported quality of primary care facility last visited by sector, by race and area type

Among all private sector visitors, whites were somewhat more likely to the facility they visited as excellent. Fifty-three percent of whites compared to 42% of Africans and 39% of coloureds using a private facility gave a rating of excellent. There were no significant differences in the ratings of African and coloureds who had used a public primary care facility in the past year.

FROM THE FOCUS GROUPS…

On dissatisfaction with public health facilities:

- *"You won't like the smell. … The children's feces. … When you walk through the door you can smell the odour…[When Matthews Phosa visited] they cleaned the whole day. They cleaned as if Jesus was coming. They went up and down cleaning...It means they are aware of their wrong doings. Even in the wards they changed the sheets to clean ones. When we had to sleep you would see stains on the linen. Hoooo wee." (Female, 40+, from rural Mpumalanga)*

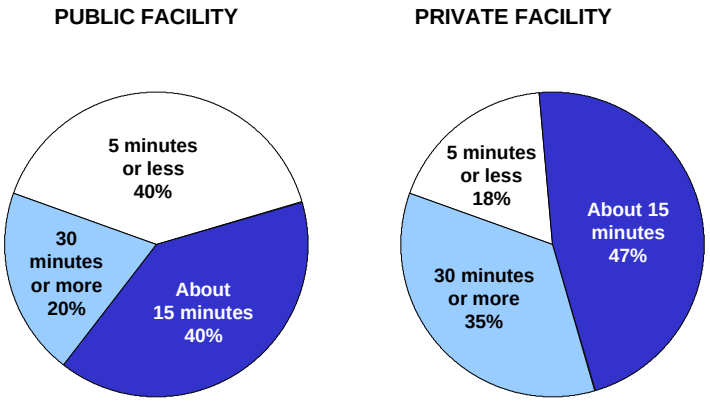
- *"A sick person must stay in clean surroundings, they must stop cooking as if they are doing it for mad people. There are cockroaches and they don't clean the toilets, they say patient must clean toilets….If they admit your baby, you, the mother will sleep outside on a cement floor." (Young mother, 18-30, from an informal settlement in KwaZulu Natal).*

TIME SPENT WITH PRACTITIONER

Another common measure of quality of care is the amount of time a practitioner spends with a patient during a visit. The survey asked respondents who consulted a health care practitioner in the pat year to approximate the amount of time the practitioner spent with them. Results are depicted in figure 6 and table 38 below.

FIGURE 6

Reported Time with Practitioner at Primary Care Facility, by Sector



Source: Second Kaiser Family Foundation National Household Survey of Health Care

Overall, South Africans who sought health care in the past year report significantly shorter visits with practitioners at public primary care facilities compared to those at private facilities. At public sites, two in five respondents spent 5 minutes or less, another two out of five spent about 15 minutes and just one in five had a visit of 30 minutes or more. By comparison, at private facilities, the time trend was reversed. About one in five (18%) spent five or less minutes with a practitioner, about half (47%) spent 15 minutes and 35% spent 30 minutes or longer. Given clear racial differences in the patterns of utilisation of public versus private sector facilities, time with practitioner was analysed for primary care visits within each sector to explore whether differences by race or area type were evident. Again, small samples limited analysis to Africans and coloureds visiting primary care facilities in the public sector and Africans, coloureds and whites visiting primary care practitioners in the private sector.

	Time with Practitioner				Time with Practitioner			
	Public				Private			
	5 minutes or less	about 15 minutes	30 minutes or more	N	5 minutes or less	about 15 minutes	30 minutes or more	N
African	42%	39%	20%	775	26%	43%	31%	533
Coloured	30%	51%	19%	82	10%	55%	35%	107
Indian	-	-	-	10	19%	28%	53%	38
White	-	-	-	24	5%	57%	38%	246
African urban	44%	36%	20%	441	25%	41%	34%	373
African rural	38%	42%	19%	325	27%	46%	27%	156
Coloured urban	30%	50%	19%	67	11%	54%	35%	94
Coloured rural	-	-	-	15	-	-	-	11
All	40%	40%	20%	891	18%	47%	35%	924

Table 38. Reported time spent with practitioner at a primary care facility by sector, by race and area type

Within the public sector, 42% of Africans who visited a primary care site reported that they spent five minutes or less with a practitioner compared to 30% of coloreds who sought primary care. Urban and rural Africans within each sector reported similar amounts of time spent with providers. In the private sector, 26% of Africans who sought primary care, as opposed to only 5% of whites, reported spending 5 minutes or less with a health provider.

ASSESSMENTS OF TREATMENT BY PRACTITIONER

Respondents were asked to assess the care provided by a health practitioner across several aspects of their last visit.

	Rating	Practitioner type			All
		Nurse	Doctor	Other	
How well were you treated?	Excellent/Good	76%	92%	82%	86%
	Fair/Badly	24%	8%	18%	14%
Did the person treating you listen carefully?	Yes	85%	97%	76%	91%
	No/Don't know	15%	3%	24%	9%
Did you understand the diagnosis?	Yes	64%	88%	70%	79%
	No/Don't know	36%	12%	30%	21%

Table 39. Assessments of treatment at primary health care facility, by type of practitioner seen.

Whether they saw a doctor or a nurse, a majority of South Africans who visited primary care facilities gave positive assessments to the care that they received. Eighty-six percent said their treatment was excellent or good, 91% said their practitioner listened carefully, and 79% were made to understand the diagnosis they were given. However, patients seeing nurses were less positive than those who saw doctors, an important finding in light of the fact that some respondents (Africans and coloureds) report much higher reliance on public facilities where patients are disproportionately cared for by nurses.

FROM THE FOCUS GROUPS…

On preference for being seen by a doctor:

- *"Usually doctors do not let patients wait for hours. They begin treating patients as soon as they arrive. Unlike the nurses who spend more than half an hour chatting among themselves before attending to patients. Usually after the doctor's treatment, the doctor gives you another date to come and see him, to monitor your health and to determine if the medication is working for you or not. [The nurses] just gives you tablets." (Female, 18-30, rural Eastern Cape).*

On dissatisfaction with doctors:

- *"Doctors were arguing in front of me. One said this and the others said that. They ended up leaving me and discharging me." (Female, 40 +, rural Mpumalanga).*

On dissatisfaction with nurses:

- *"I have a child who had a broken limb, and he went and slept at Makiwana. If he urinated on himself, the nurses would beat him up until my other children phoned me and told me that they found him crying because the nurses had beaten him up". (Female, 40 +, rural Eastern Cape).*

- *"Sometimes a patient may be suffering from an embarrassing sickness such as STDs, so the nurses have the tendency of coming to the patient and asking him about his illness. Then five nurses will come to find out what are you suffering from, laugh about it in the presence of other patients and you end up being embarrassed because this is confidential". (Female aged 18-30, from rural Eastern Cape).*

OUTLOOK ON THE HEALTH SYSTEM

PERCEIVED CHANGES IN HEALTH CARE OVER THE PAST 4 YEARS

To capture South Africans' broad outlook on changes in the health system, respondents were asked to indicate whether they felt that access to the health system in general had improved, remained the same or worsened over the past four years.

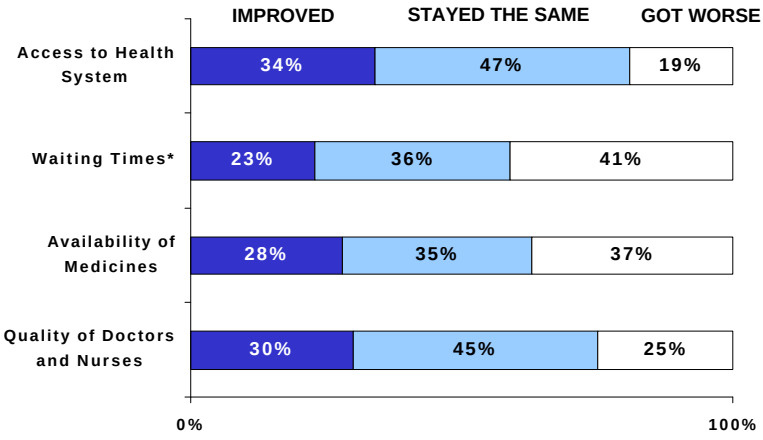
	Access has improved	Access has stayed the same	Access has got worse	N
African	38%	44%	18%	2929
Coloured	28%	49%	23%	346
Indian	24%	51%	25%	100
White	12%	61%	27%	416
African urban	38%	42%	20%	1759
African rural	39%	46%	14%	1148
Coloured urban	28%	48%	24%	267
Coloured rural	28%	53%	19%	77
All	34%	47%	19%	3792

Table 40. Perceived changes in health system access over the past four years, by race and area type.

A plurality (47%) of South Africans reported the perception that their access to the health system has gone unchanged over the past four years. About a third of South Africans said their access to health care has improved (34%). Among all race groups, the most commonly reported view was that access has stayed the same over the four-year duration (61% of whites, 51% of Indians, 49% of coloureds and 44% of Africans). Compared to other groups, more whites (27%) said their access has gotten worse while more Africans (38%) said their access has improved. Urban Africans were more likely to feel that their access had worsened compared to their rural counterparts (20% versus 14%).

FIGURE 7

Perceived Changes in Health System Over the Past Four Years



* Refers to waiting times at primary care facilities.

Source: Second Kaiser Family Foundation National Household Survey of Health Care

Respondents were further asked to comment on whether they had noticed any improvements over the past four years in terms of waiting times, availability of medicines or the quality of the doctors and nurses who treated them. On the whole, South Africans reported few

improvements, with just one in five to three in ten saying that things have gotten better across the three aspects. Africans, particularly rural Africans, were most likely to say there have been improvements.

	Waiting Times…		
	Improved	Stayed the same	Got Worse
African	26%	32%	42%
Coloured	13%	40%	47%
Indian	7%	37%	56%
White	8%	56%	36%
African urban	22%	33%	45%
African rural	32%	31%	37%
Coloured urban	12%	36%	52%
Coloured rural	17%	54%	30%
All	23%	36%	42%

Table 41. Perceptions of waiting times at primary health care facilities over the past four years, by race and area type.

Just under a quarter of South Africans (23%) reported that waiting times had improved, 42% said waiting times had gotten worse and 36% said waiting times have stayed the same over the past year. African rural respondents (32%) were most likely to have noticed an improvement, and white (8%) and Indian (7%) respondents were the least likely to have noticed an improvement. Pluralities of all groups except whites said waiting times have gotten worse. Most whites (56%) said that waiting times have stayed the same. Again, variations in assessments may reflect utilization of different primary health care facilities.

	Availability of medicines…		
	Improved	Stayed the same	Got Worse
African	31%	29%	40%
Coloured	22%	44%	34%
Indian	19%	50%	32%
White	11%	72%	17%
African urban	31%	29%	41%
African rural	32%	28%	39%
Coloured urban	21%	43%	36%
Coloured rural	26%	47%	27%
All	28%	35%	37%

Table 42. Perceptions of availability of medicines over the past four years, by race and area type.

More than a quarter (28%) of South Africans noted an improvement in the availability of medicines in the past four years, 37% reported that medicines are not as available as they were four years ago, 35 percent said there has been no change. Substantial proportions of coloureds (44%), Indians (50%) and whites (72%) said access to medicines remains the same today, while the plurality of Africans (40%) said access to medicines has gotten worse.

	Quality of doctors and nurses…		
	Improved	Stayed the same	Got Worse
African	35%	43%	23%
Coloured	21%	51%	28%
Indian	16%	45%	39%
White	11%	58%	32%
African urban	34%	40%	26%
African rural	36%	45%	19%
Coloured urban	23%	49%	29%
Coloured rural	17%	60%	23%
All	30%	45%	25%

Table 43. Perceptions of quality of doctors and nurses at a primary health care facilities over the past four years, by race and area type

Many South Africans (45%) noted that the quality of doctors and nurses at primary care facilities has not changed over the last four years. Three out of ten noted improvements, one in four said quality has gotten worse. Africans (35%) were more likely than coloureds (21%), Indians (16%) or whites (11%) to report improvement in the quality of primary care practitioners.

FROM THE FOCUS GROUPS…

A change in health care not asked about on the survey, but described in the focus groups, is the decline in discrimination in health care:

- *"One significant change is that we are now being treated with whites. There is no longer discrimination". (Female, 40 +,from an informal settlement in Gauteng).*
- *"There are changes, for example, previously whites only hospitals are now open to all races. And some of these hospitals are very fast when attending to patients". (Male Farm worker, 40+, in the Western Cape).*

HEALTH POLICY

Since the country's first democratic elections in 1994, a number of policies have been implemented aimed at improving the health of the population in general and addressing inequalities in health care in particular. This section reports on the awareness and attitudes of South Africans towards key policies introduced over the past four years.

AWARENESS OF KEY HEALTH POLICIES

Much of the focus of government policies over the past four years has been on improving access to primary health care. To assess public awareness of these government policies, respondents were asked whether the following statements were true or false:

1. Children under the age of 6 do not have to pay for health care at a government facility. (True)
2. If you use a government hospital you need to be referred by a doctor or clinic. (True)

	Free medical treatment for children.	Referral necessary for govt. hospital	N
African	91%	48%	2935
Coloured	83%	59%	346
Indian	61%	31%	100
White	58%	27%	418
African urban	91%	46%	1762
African rural	92%	52%	1150
Coloured urban	83%	60%	266
Coloured rural	82%	57%	78
All	86%	57%	3773

Table 44. Awareness of health policies, by race and area type

Public awareness of the policies varied, by policy and by race. There was a high level of awareness (86%) of the free health care policy among South Africans overall. Awareness of this policy was higher among Africans (91%) and coloureds (83%) than among whites (58%) and Indians (61%).

There were far lower levels of awareness of the of referral policy for entry into public hospitals, with just over half (57%) of South Africans being informed of this policy. Again, Africans (48%) and coloureds (59%) were more likely to be aware of the policy than whites (27%) and Indians (31%).

Different utilisation patterns may explain much of the variation in awareness of these policies. Africans and coloureds, who generally make greater use of public services, had substantially higher awareness of the two public health policies. Whites and Indians, by contrast, rely much more on private health care facilities and, as such, are far less aware of policies affecting access to public/government services.

FROM THE FOCUS GROUPS…

On the free clinic policy:

Many focus group participants reported the view that the free clinic policy is the only significant change in health care since 1994. One participant's response illustrates this point:

Q. " What changes have you seen since the new government was elected in 1994?"

R. "None except free admission in the clinics." (Male, 18-30, informal settlement, Gauteng)

On the referral policy:

- *"If a patient arrives at the hospital without being transferred from the clinic, the charge is R50 which must be paid in cash." (Female, 18-30, rural Eastern Cape)*

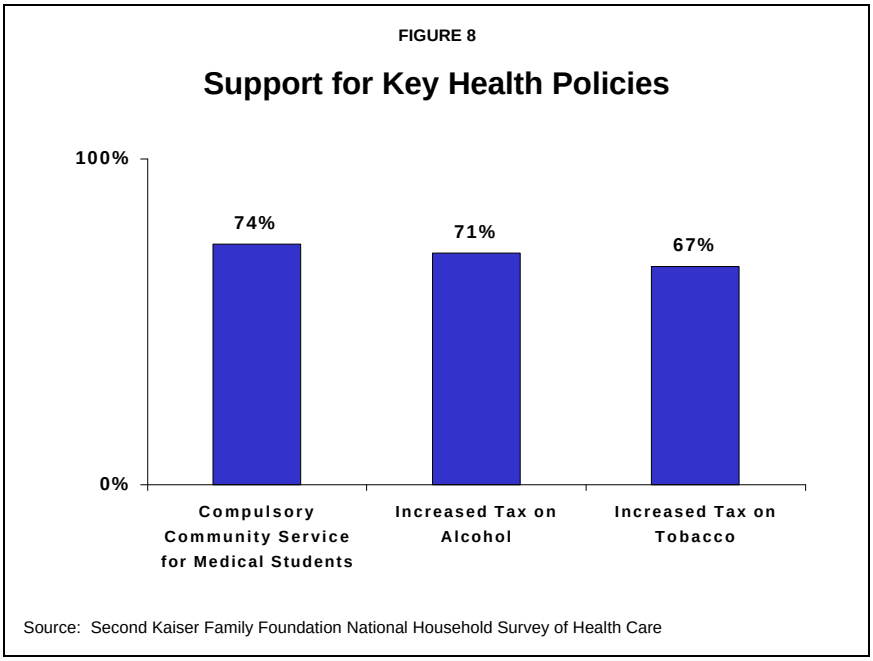
PUBLIC ATTITUDES TOWARDS HEALTH POLICIES

To assess attitudes towards key health policies, respondents were asked whether they supported three specific policies implemented over the past four years: the increased tax on tobacco, the increased tax on alcohol, and the policy of compulsory community service for medical students.

Support for Key Policies

There was strong support for all three policies as shown in figure 8 and table 45 below. Sixty-seven percent of South Africans support the increased tax on tobacco, 71% favors the higher tax on alcohol and 74% favors compulsory community service for medical students. However, there were differences in the degree of support among races and area types. For instance, only 42% of white respondents supported community service for medical students, compared to more than 70% of other races. Rural coloureds were least likely of all groups to support increased taxation on tobacco (48%) and alcohol (57%).

FIGURE 8



Source: Second Kaiser Family Foundation National Household Survey of Health Care

	Tax on Tobacco	Tax on Alcohol	Community Service for Medical Students	N
African	68%	70%	79%	2920
Coloured	59%	74%	73%	346
Indian	58%	75%	86%	100
White	70%	78%	42%	417
African urban	71%	73%	80%	1757
African rural	64%	65%	77%	1140
Coloured urban	62%	79%	76%	266
Coloured rural	48%	57%	64%	77
All	67%	71%	74%	3782

Table 45. Proportion favoring each health policy, by race and area type.

FROM THE FOCUS GROUPS…

On community service in rural areas.

- *"We support it because it will enable the new doctor to work with others doctors at the hospital and become acquainted in working with the community at large and familiarise himself with those working conditions before he can open his own surgery",(Male, aged 18-30, from rural Eastern Cape).*
- *"I also support it because there is shortage of doctors in Government clinics and hospitals. So this will be able to bridge that gap" (Male, aged 18-30, from rural Eastern Cape).*

On increased taxes on tobacco and alcohol.

Favor:

- *"These people who are smoking usually end up in the hospital because of smoking. The tax, which is collected from them, helps them when they are at hospital that's how I see it. I see the policy being fair in this sense." (Female, aged 18-30, from informal settlement in Gauteng).*

Oppose:

- *"I don't think it's fair. I drink and smoke. If they continue increasing the price of alcohol and tobacco some people will stop buying and the companies will close down. I also had a business of selling alcohol. I was making good money. Since the prices have gone up I cannot afford to buy and sell at a reasonable price. So I am out of business. Although the motive might be a good one, it is also unfair on the other side. Many people will be out of work." (Female, 40 +,from an informal settlement in Gauteng).*

Views on Abortion Policy

The implementation of the Choice of Termination Act which gives women the right to choose whether or not to terminate a pregnancy is one of the most contentious government policies of the past four years. The survey found strong opposition to the notion that abortion is a woman's right (only 10% agree) with most South Africans holding the view that abortion is morally wrong (48%) or justifiable only in the narrow case of rape (41%) (table 46).

	Abortion is morally wrong	Abortion is justified only in the case of rape	Abortion is a Woman's right	N
African	54%	38%	8%	2928
Coloured	37%	52%	11%	346
Indian	39%	41%	20%	99
White	19%	57%	24%	416
African urban	53%	39%	9%	1755
African rural	57%	37%	6%	1149
Coloured urban	38%	51%	11%	267
Coloured rural	35%	51%	14%	77
All	48%	41%	10%	3789

Table 46. Views on abortion, by race and area type.

Women and men were in agreement on abortion but views differed somewhat by race. The position that abortion is a women's right was held most widely among white respondents (24%) with only 8% of African respondents sharing this view. Most Africans (54%) held the view that abortion is morally wrong.

Government's Best and Worst Policies

As further assessment of public opinion on government policies, respondents were asked what they considered to be the government's best and worst policies on health.

	Free PHC	Clinic building	School feeding	HIV-AIDS	Child immunisation
African	63%	17%	27%	15%	9%
Coloured	53%	8%	11%	14%	7%
Indian	31%	8%	3%	15%	5%
White	36%	8%	6%	20%	13%
African urban	65%	14%	18%	15%	7%
African rural	62%	21%	40%	14%	12%
Coloured urban	57%	8%	10%	13%	7%
Coloured rural	42%	5%	15%	17%	5%
All	58%	15%	22%	15%	9%

Table 47. Proportions saying each is the government's best health policy, by race and area type

A majority (58%) of South Africans named free primary health care (PHC) as the government's best health policy. Africans (63%) and coloureds (53%), who also report greater use of public services, voiced the highest support for this policy. Despite government's emphasis on improving health access in the rural areas, rural coloureds were less likely than their urban counterparts to name free primary health care as the government's best policy (42% versus 57%).

School feeding (22%), the clinic building program (15%), the HIV/AIDS program (15%) and child immunisation (9%) were other government programs that were viewed positively by respondents.

When asked, "What is the Government's worst policy" a substantial proportion of the respondents (48%) mentioned "abortion" and the policy of bringing Cuban doctors to serve in rural areas (13%).

FROM THE FOCUS GROUPS…

On the policy of primary care:

Favor

- *"We don't know about the quality of the services, what we know is that it [free primary health care] is helping black people because they are the ones who have suffered the most….This policy is helping the needy. We support this policy.…People might not be getting the best services but they are getting adequate services to survive. This move by the government helps those who don't have money. Even those who do have money have been helped because they can now save their money." (Male aged 40+ from rural Northern Province).*

Oppose:

- *"There is a big difference. When we were paying treatment was very good. Now everything has changed. They even add little water in the medicines…It was better when we were paying, you wouldn't go home without help, but now we do (they all agree). Even when they give it to you it will be Disprin, when you ask for more they will tell you to go to the chemist. I think we must pay….Everybody must pay to get proper service." (Male, aged 18-30, from informal settlement in KZN)*

On the "antipathy" of health workers under the policy of free primary health care:

- *"The main reason for nurses' bad attitude is because we are not paying…. Yes, they even say it that since medical treatment is free of charge, we come to the clinic even if there is nothing wrong with us." (Female, aged 18-30, from rural Eastern Cape).*

On the school feeding program:

- *"Personally I am very please with this feeding scheme because during our childhood we would spend the whole day at school without eating anything so I would like to personally thank the Government for this contribution as a half a loaf is better than nothing .I would like to advise the Government to continue with this feeding scheme but to change the diet." (Male, aged 18-30, from rural Eastern Cape)*

On the HIV program, the controversial "Virodene" saga had not escaped the attention of participants:

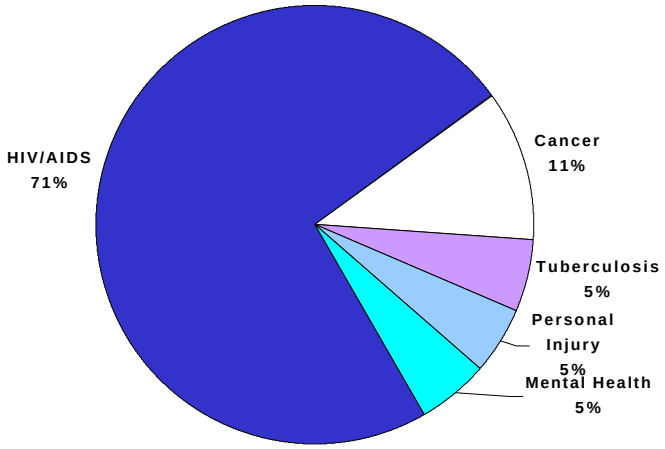
- *"If I can have AIDS I will go to Nkosazana Zuma to tell her to give me this Virodene, and tell her I don't care if I die. This government has its own scandals--they give money to those who have it." (Female, aged 18-30, from informal settlement in KZN)*

Most Important Health Concerns

As another measure of respondents' personal health status and outlook on health, respondents were asked to indicate which of HIV/AIDS, tuberculosis (TB), personal injury, mental health and cancer ranks as their most important health concern. Results are shown in figure 9 and table 59 below.

FIGURE 9

Proportions Rating Each as their Most Important Health Concern



Source: Second Kaiser Family Foundation National Household Survey of Health Care

	HIV/AIDS	TB	Personal Injury	Mental Health	Cancer	N
African	79%	5%	3%	5%	5%	2933
Coloured	53%	12%	6%	6%	20%	340
Indian	57%	1%	9%	4%	27%	99
White	29%	4%	15%	8%	39%	416
African urban	82%	4%	2%	4%	5%	1764
African rural	75%	5%	4%	6%	6%	1146
Coloured urban	54%	10%	5%	7%	22%	262
Coloured rural	53%	18%	11%	2%	11%	75
All	71%	5%	5%	5%	11%	3788

Table 48. Most important health concern, by race and area

Just under three-fourths of South Africans (71%) ranked HIV/AIDS their most important health concern. Among Africans, urgency centered on HIV/AIDS with nearly eight out of ten (79%) naming this their most important health concern. No more than one in 20 Africans named any of the other health problems as most important. By comparison, just over half of coloureds (53%) and Indians (57%) ranked HIV/AIDS their top concern, with one-fifth to one quarter naming cancer (20% and 27%, respectively). About one in ten (12%) Indians named tuberculosis (TB) their most important concern. Whites, in contrast, ranked cancer first (39%), followed by HIV/AIDS (29%) and personal injury (15%).

	HIV/AIDS	TB	Personal Injury	Mental Health	Cancer	Other	N
Western Cape	49%	11%	5%	7%	23%	5%	359
Eastern Cape	68%	6%	3%	6%	16%	1%	588
Northern Cape	33%	9%	34%	5%	16%	3%	75
Free State	74%	7%	3%	5%	10%	2%	244
KwaZulu/Natal	83%	3%	3%	1%	8%	3%	798
North West	83%	4%		3%	5%	5%	314
Gauteng	68%	4%	7%	5%	12%	4%	700
Mpumalanga	75%	5%	4%	6%	7%	4%	258
Northern Province	68%	5%	6%	11%	5%	5%	460
All	71%	5%	5%	5%	11%	3%	3795

Table 49. Most important health concern by province

There was also a close relationship between the level of concern over a particular condition voiced by a particular province and the prevalence of that condition within the province. For example, respondents from Western and Northern Cape were far less concerned with HIV/AIDS but more concerned about TB.

Health Information: The Example of HIV/AIDS Education

Fitting with the high concern over health issues reported here, especially with regards to HIV/AIDS, the government has spent substantial resources in recent years on health education programs and, in particular, on public education around HIV/AIDS. To asses the extent to which these messages are reaching the public, and which information sources figure most prominently for South Africans, respondents were asked if and where they received information about HIV/AIDS in the past year.

	Received HIV information	N
African	80%	2907
Coloured	63%	329
Indian	73%	98
White	55%	402
African urban	82%	1752
African rural	78%	1132
Coloured urban	65%	251
Coloured rural	59%	76
All	76%	3735

Table 50. Proportions receiving any HIV information in the past year, by race and area type.

Overall, a large proportion (76%) of South Africans received at least some information on HIV/AIDS in the past year. However, there were substantial differences among races. While 80% of Africans had received HIV information, only 55% of whites had. In general, urban Africans and urban coloureds were more likely than their rural counterparts to have received HIV information.

	Health Department	NGO/Church/ Community organisation	Workplace education	Private Doctor	Media
African	53%	14%	3%	3%	27%
Coloured	42%	19%	5%	11%	23%
Indian	44%	22%	6%	8%	20%
White	16%	13%	11%	21%	38%
African urban	51%	16%	4%	3%	26%
African rural	55%	11%	1%	4%	29%
Coloured urban	41%	19%	5%	10%	25%
Coloured rural	44%	18%	8%	14%	16%
All	49%	15%	4%	5%	28%

Table 51. Proportions receiving any HIV/AIDS information from each source, by race and area type.

South Africans were most likely to receive HIV information from the Department of Health (49%), followed by the media (28%) and NGO/Church/Community organisations (15%). Whites were more likely to name private doctors (21%) and workplace education programs (11%) as sources, compared to other groups.

PRIORITIES FOR THE HEALTH SERVICE

In addition to capturing the public's views on current and past health policies, and health issues of greatest concern, the survey aimed to collect the public's priorities for future government health initiatives. Respondents were asked, "What, if anything, would you like to see change in the Government Health Service?" Multiple responses were accepted.

Suggestion	%
Better service	37%
Get the staff to treat us better	26%
Increased availability of drugs/medicines	24%
Improve staff skills	13%
Nothing	11%
Make it affordable	10%
More convenient hours of opening	9%
Don't know	9%
Wider range of services	8%
Make it easy to get to	6%
Other	13%

Table 52. Suggestions for changes in the Government Health Service.

Changes related to improving the quality of care in the Government Health Service emerged as the clear priority. More than a third of South Africans (37%) mentioned better services, 26% mentioned better treatment from staff, 24% mentioned increased availability of drugs and medicines and 13% called for improved staff skills. Despite free primary health care, greater affordability of public services remained a priority for 10% of South Africans.

FROM THE FOCUS GROUPS…

Focus groups revealed that access to health care is not the only issue of public concern with respect to health.

On the environment:

- *"Our main concern is this dirty water which is making a good home for the mosquitoes and flies…There is a difference between the environment here and that of the townships. … The air at our squatter camps is polluted because so many people use coal for fire. Obviously because we are living in an unhealthy area, we can't be healthy." (Female, 40+ from an informal settlement in Gauteng).*

- *"We would like to have a good sewerage system….Dirty water is just flowing in the streets." (Male, 18-30, from informal settlement in Gauteng).*

SPECIAL FOCUS

REASONS FOR THE POOR RELATIONSHIP BETWEEN PROVIDERS AND THE COMMUNITY

One of the objectives of the study was to gain insights through focus groups into the root causes of the poor relationships between the public sector providers and the communities they serve. In order to gain these insights in-depth-interviews were conducted with nurses working at the sites at which the focus groups were held. As with the focus groups these interviews are by no means representative of the views of the nursing population in South Africa. Nevertheless, the interviews help the reader understand the conditions under which nurses work in the rural areas. Issues raised by the nurses included:

INADEQUATE OR INAPPROPRIATE TRAINING:

- *"We received good basic training and in-service training, but this does not always help us run a clinic".*

NOT LIVING IN THE COMMUNITIES:

- *"Daily travelling is a hassle. I stay in Bisho and spend about R19-00 a day. I cannot stay nearer because my husband also works far and my kids are still too young to be left on their own. I have to hike to work".*

NUMBER OF PATIENTS:

- *"I see over 150 patients a day".*
- *"Nurses work under a lot of strain. There is shortage of nurses and they are over-worked".*

PERCEPTION THAT PATIENTS COME TO THE CLINIC TOO OFTEN:

- *"I get worried when patients visit the hospital a lot. For instance some patients come to the hospital twice or thrice in two weeks. Others default on treatment. Perhaps some come because they are used to a certain nurse or doctor and they only want to be examined by the nurse or doctor".*

FINANCIAL CONCERNS:

- *"The salary that we get is not enough for the work that we are doing".*
- *"I think these days they join nursing for the sake of money. In olden days nurses did not worry about money".*

POOR EQUIPMENT AND POOR BUILDINGS:

- *We've got small clinics, which need upgrading. We have lots of clinics, which need renovation. We have areas that have no clinics. We have transport problems; we are unable to reach out to the communities.*
- *Others are too old. The buildings are in a terrible mess, they have cracks. For instance, our clinic has cracks along the wall. There is need of a new structure.*

POOR COMMUNICATION EQUIPMENT:

- *"There are clinics, which have no telephones, no radios".*

POOR RELATIONSHIP WITH DISTRICT MANAGEMENT:

- *"What discourages me is that we always write reports but our problems are not solved. We recommend at the end but our problems are not sorted. Those recommendations are not attended to. Ever since I started working as a supervisor, I have been sending my reports down that we need such and such manual, capital works for such and such a clinic but it has not been done".*

SECURITY:

- *"In some clinics that have security guards those guards are unarmed. If criminals come to the clinic, they start with the watchman then go to the nurses. For instance, in one of the clinics it happened, that they tied the security guard and went to the nurses and asked for the vehicle key and took it. That is why it was decided that it must be closed after hours".*

- *"We have closed down the 24-hour services in our clinics because of some of the problems. Problems like accommodation for nurses, security and telecommunications. At the moment we are doing an 8-hour service to all our clinics".*

APPENDIX A

SURVEY METHODOLOGY

This section describes the techniques used to collect the data presented in this study and the methods used to analyse the data.

A nationwide probability sample of 4000 households was selected. One thousand enumerator areas (EA's) were chosen with a probability proportional to their size. Fieldworkers from the Community Agency for Social Enquiry (CASE) then visited 4 households in each selected EA. The selected EA's were stratified by province, race and urban or non-urban area type. The smaller provinces were over-sampled (in particular the Northern Cape) and the white, coloured and Indian populations in certain provinces in order to have sufficiently large sample sizes to make comparisons between and within categories. The data was weighted by race, area and province to reflect the composition of the population as given in the 1996 Census.

The fieldwork was carried out in October, November and December of 1998 by the CASE fieldwork staff or their appointed representatives. In each EA, the stands to be visited were identified by the fieldwork supervisor after the selection of a random starting point. Where there were two or more households on a stand the household to be interviewed was selected using a random number grid. Two call-backs were made to a selected household before it was substituted with an adjacent household.

CASE fieldworkers performed quality control check-backs on approximately 15% of the total sample. In each case it was verified that the correct household had been visited and that a selected range of factual questions had been correctly answered.

In each household visited, fieldworkers asked to speak to the person mainly responsible for the health of the household. This person then answered questions about the health status of the household, its access to basic services and a range of policy and information questions about political issues and health provision in particular. All the members of the household[5] were then listed and a random number grid was used to select a second respondent, possibly but not necessarily different to our first respondent. The second respondent was asked about his/her use of various components of the health service (primary care, hospital care or rehabilitation or chronic care) in the past year. If this respondent was 16 years old or younger the questions were answered on his/her behalf by his/her main care-giver. If the chosen respondent had used a component of the health care service in the past year he/she was asked a range of questions about the cost, quality and accessibility of the particular service. If the chosen respondent had not used a component of the health care service in the past year at all or who had made use of the health service more than a year before the interview took place, he/she was not asked any subsequent questions.

[5] We defined a household as a group of people who generally live, eat and sleep together for at least four days a week.

DATA ANALYSIS

The data was coded, manually punched and prepared for analysis using the SPSS format.

Throughout, the report has been restricted to commenting only on the information contained in the data set as revealed by simple two- or three-way cross-tabulations. It was felt that it would be inappropriate for a report of this nature, intended mainly for use as a general reference accessible to the general public, to perform complex statistical analyses. Multivariate analysis techniques were therefore not used. The reader is cautioned against the uncritical use of the information presented in this report. Where statistically significant differences have been identified tests to determine difference at the 95% confidence level have been performed.

There was a close correlation between the socio-economic indicator and the race-area interaction. Despite this high correlation race and area were used as explanatory variables for this report. This was necessary in order to allow comparisons with the 1994 study. While the intention was to report on race, area and socio-economic status, the already significant size of this report mitigated against the inclusion of both. In addition, race and area were considered to be relevant in the South African context, to the measure of access and inequality in the health sector.

In order to present the data in the simplest and most meaningful way, categories within a particular variable were collapsed where necessary. Where this was done clear indication is given in the table. In particular, when dealing with scale variables (e.g. a rating of the quality of care received from a practitioner or a rating of the quality of the facility) extreme categories (subject of course to the counts within the categories) were maintained whilst collapsing the interior categories. In other cases categories were collapsed in order to construct indicator variables, e.g. length of waiting times or costs of transport to a facility. In such cases the choice of categories to collapse was based on the applicability of the categories, the number of responses within each category and the possibility of comparisons with the 1994 survey.

In all tables the proportion of responses within a particular category are presented, e.g. the proportion of urban Africans respondents who waited for less than an hour for treatment at a primary care facility. The (weighted) cell counts upon which the percentages are based are also presented, unless these counts can be deduced from other tables within the section. Where cell counts are less than 20, percentages are not reported, since such percentages are not meaningful. In many cases this means that the Indian and coloured rural groups are excluded from the table.

A copy of the complete data set in ASCII format is available on request.

COMPARISONS WITH THE 1994 SURVEY

The 1994 and 1998 samples were constructed on a similar basis and the resultant data was weighted to reflect the 1991 and 1996 population census respectively. It is thus possible to make valid comparisons between the two surveys without the risk of large sampling bias. As far as possible questions were repeated from the first survey. However, given the change in focus of the 1998 survey, far more detailed information was collected on the different levels of care (primary, secondary and rehabilitation). In instances where it was not possible to make direct comparisons (because of the more detailed information in the 1998 survey) the primary care figures for the 1998 survey were compared to the total figures for the 1994 survey. Such comparisons are not ideal and generalisations of the figures presented must be undertaken with extreme caution.

It should be recognised that many of the questions in the survey measure perceptions. Such perceptions are subjective and may be influenced by a number of variables, including the people with whom the respondents compare themselves, their expectations in relation to their life-style. It is therefore possible that changes that have been measured since 1994 are due to changes in perceptions rather than changes in real circumstances.

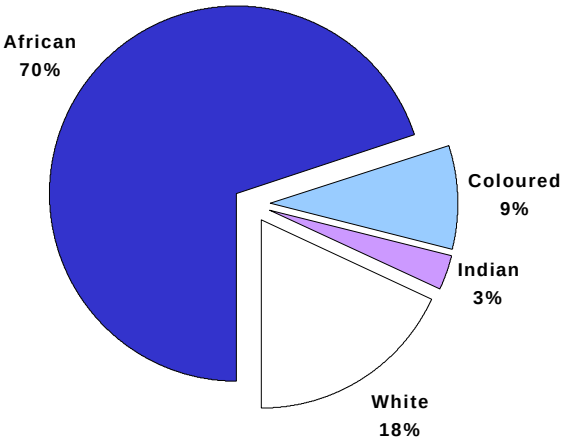
APPENDIX B

SAMPLE CHARACTERISTICS

This appendix reports on the basic characteristics of the sample respondents.

FIGURE B1

South African Households by Race



Source: Second Kaiser Family Foundation National Household Survey of Health Care

The distribution of the sample (weighted) by province and by race is presented in Table B1.

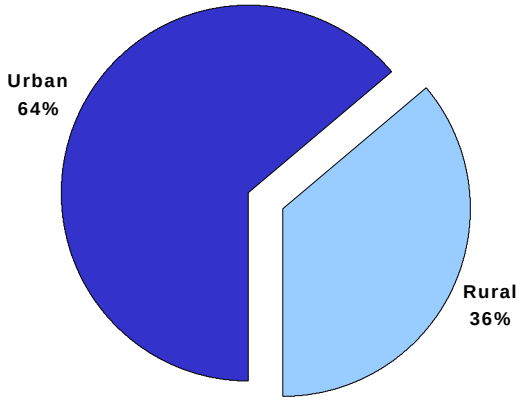
	African	Coloured	Indian	White	Total
Western Cape	3%	5%	0%	3%	11%
Eastern Cape	13%	1%	--	1%	15%
Northern Cape	0%	2%	0%	1%	3%
Free State	5%	0%	0%	1%	6%
KwaZulu/Natal	15%	0%	2%	2%	20%
North West	6%	0%	--	1%	7%
Gauteng	15%	1%	0%	7%	23%
Mpumalanga	5%	0%	--	1%	6%
Northern Province	9%	--	0%	1%	9%
All	70%	9%	3%	18%	100%

Table B1. Sample by province and race (N=4000)

African respondents made up seventy percent of the sample, white respondents 18%, coloured respondents 9%, and Indian respondents 3%. Twenty three percent of the sample was from Gauteng, 20% from KwaZulu/Natal, 15% from the Eastern Cape and 11% from the Western Cape.

FIGURE B2

South African Households by Area Type



Source: Second Kaiser Family Foundation National Household Survey of Health Care

The distribution of the sample (weighted) by province and area is presented in Table B2.

	Urban	Rural	Total
Western Cape	86%	14%	100%
Eastern Cape	52%	48%	100%
Northern Cape	86%	14%	100%
Free State	72%	28%	100%
KwaZulu/Natal	66%	34%	100%
North West	44%	56%	100%
Gauteng	100%	0%	100%
Mpumalanga	54%	46%	100%
Northern Province	27%	73%	100%
All	64%	36%	100%

Table B2. Sample by province and type of area[6].

Sixty four percent of the sample was drawn from urban areas and 36% from rural areas. The distribution of the sample by age and gender is presented in Table B3.

Age (in years)	Male	Female	All
0-2	4%	5%	5%
3-10	14%	15%	15%
11-20	16%	21%	20%
21-30	22%	18%	19%
31-45	21%	19%	20%
46-60	14%	12%	13%
61+	9%	10%	10%
Total	100%	100%	100%

Table B3. Sample by age and gender (N = 4000)

Approximately one-fifth of the sample falls into each of the categories 0-10, 11-20, 21-30, 31-45 and 46+. The only significant gender differences occur in the category 11-20 year old category, which has proportionally more females, and the 21-30 year old category, which has proportionally more males.

[6] Urban areas include towns, cities, and metropolitan areas. Rural (or non-urban) areas include commercial farms, small settlements, rural villages, and other areas which are further away from towns and cities.

The age and population distribution of the sample is presented in Table B4.

Age	African	Coloured	Indian	White	All
0-2	5%	3%	1%	3%	5%
3-10	16%	12%	7%	7%	15%
11-20	21%	18%	19%	6%	20%
21-30	19%	17%	29%	18%	19%
31-45	20%	24%	19%	13%	20%
46-60	10%	16%	22%	31%	13%
61+	9%	11%	3%	23%	10%
Total	100%	100%	100%	100%	100%

Table B4. Sample by age and race.

African respondents in the sample were significantly younger than the total sample. In particular 42% of African respondents were younger than 21 years old while only 33% of the coloured, 27% of the Indian and 16% of the white respondents fall into this category.

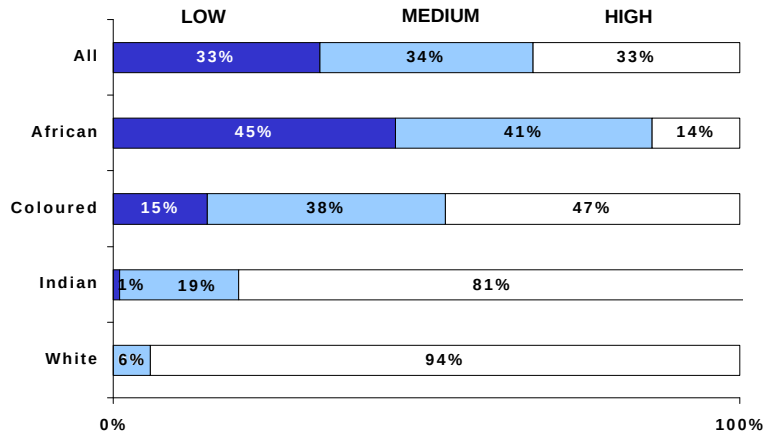
SOCIO-ECONOMIC STATUS

A socio-economic indicator was created based on:
the basic services that the household accesses;
the difficulty a household experiences in paying for a range of basic goods and services;
an estimate of the number of consumer durables in the household;
the highest educational level in the household;
the reported monthly income of the household and
the number of people per room in the household.

The measure of socio-economic status was divided into 3 (equal) categories, which were designated low, medium and high socio-economic status.

FIGURE B3

Socio-economic Status of South African Households by Race



Source: Second Kaiser Family Foundation National Household Survey of Health Care

There was a highly significant correlation between the measure of socio-economic status and race. African respondents were significantly more likely to fall into the low and medium categories (45% and 41% of the total African population respectively) and white and Indian respondents significantly more likely to fall into the high socio-economic category (94% and 81% of their total populations respectively).

		low	Medium	High	Total
African	Urban	30%	50%	20%	100%
	Rural	71%	26%	3%	100%
	All	45%	41%	14%	100%
Coloured	Urban	8%	42%	50%	100%
	Rural	50%	43%	7%	100%
	All	15%	38%	47%	100%

Table B5. Socio-economic status by race and area.

Within both the African and coloured populations there were significant differences in socio-economic status between the metropolitan, urban and rural areas. Amongst Africans respondents, those living in metropolitan areas were significantly more likely to fall into the medium (55%) or high (24%) categories, whilst rural Africans respondents were more likely to fall into the 'low' category (71%). A similar pattern was evident amongst coloured respondents: Metropolitan residents (68%) were likely to be in the 'high' category, urban respondents (52%) were more likely to fall into the medium category and rural coloured respondents (50%) more likely to be in the 'low' category.

White respondents did not display any significant deviations across the different area types while the small counts in the Indian sample precluded any area-based analysis.

HOUSEHOLD SIZE

	Average household size
African	5.0
Coloured	4.5
Indian	4.5
White	2.8

Table B6. Average household size by race.

There were significant differences in average household size by race. African households, with an average size of 5 people per household, were significantly larger than coloured (4.5 people per household) or Indian (4.5) households. White households (2.8) were, in turn, significantly smaller than those of other races.

It is perhaps more revealing to consider the average household size in relation to the space available to the household. The survey asked about the number of rooms available to the household, excluding the bathroom. This figure was used to calculate the number of people per room, which was used as a measure of overcrowding or density.

	Density
African	1.5
Coloured	1.2
Indian	.9
White	.5

Table B7. Density by race.

There were significant differences in household density by race, as indicated in the table above. In particular, African households tend to be 3 times more densely populated than white households.

Race	Area	Density	N
African	Urban	1.4	1769
	Rural	1.7	1150
	All	1.5	2920
Coloured	Urban	1.2	267
	Rural	1.2	78
	All	1.2	345
Indian	Urban	1.0	98
	Total	1.0	99
White	Urban	0.5	378
	Rural	0.5	38
	All	0.5	416
All	Urban	1.2	2513
	Rural	1.6	1268
	All	1.36	3781

Table B8. Density by race and area.

Amongst African respondents, household density varied significantly by the type of area. White and coloured households did not display any significant variation in density across urban or rural areas. Rural African households were the most densely populated (an average of 1.7 people per room) and were significantly more densely populated than African households in urban (1.4) areas.

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