RESEP
Research on Socio-Economic Policy

Access to healthcare in South Africa:

Comparing supply- and demand-focused approaches

UNIVERSITY *of the* WESTERN CAPE

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PPHF, Lentegeur Hospital – 1 April 2016

Outline

- ❑ Orientation and motivation
- ❑ Data and method
- ❑ Results and discussion

Orientation

- Post-1994: Health reforms high on government's development agenda

- Status quo:
  - Fragmented and polarised health system in RSA
  - Increasing quadruple burden of disease
  - Sub-optimal access to social co-determinants of health

- Poor health outcomes relative to health inputs
  - Critical health indicators worse than comparable MICs (even LICs)

Motivation

- Dept. of Health's primary goal: universal access
  - proposed vehicle = NHI

- Emphasis on achieving equity ito:
  - *availability* of healthcare (supply-side issues)
  - *affordability* of healthcare (financing and payment mechanisms)

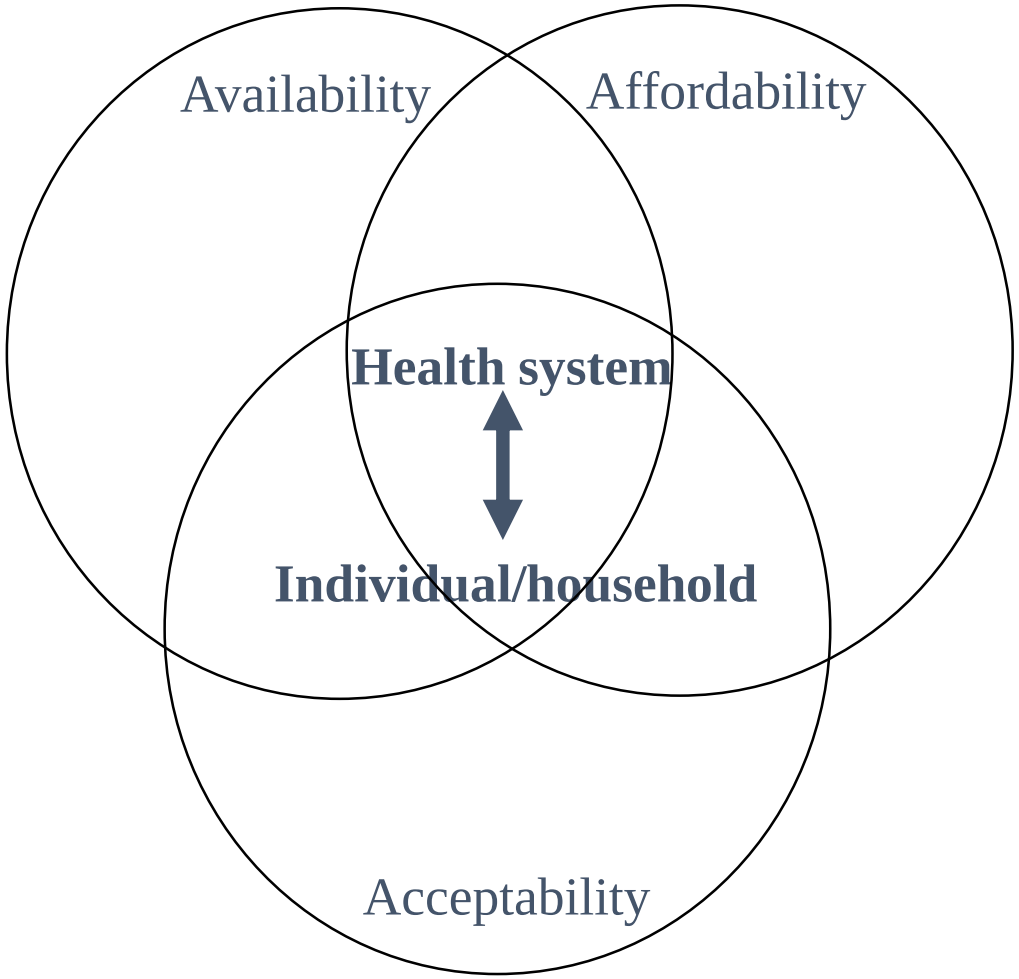
- Equity ito *acceptability* (demand-side) overshadowed
  - *under-researched* and *ominously absent* from health policies

Question

How equitable is access to healthcare in post-apartheid South Africa?

- empirical investigation of healthcare equity across 3 dimensions of access
- ***availability, affordability, acceptability***
- 2009/2010

Access framework: Thiede et al. (2007)



Adapted from Pechansky & Thomas (1981)

Data

- ❑ Annual General Household Survey (GHS) Data, 2009-2010
- ❑ Nationally representative
- ❑ +- 100 000 individuals per GHS (ensures statistical power)

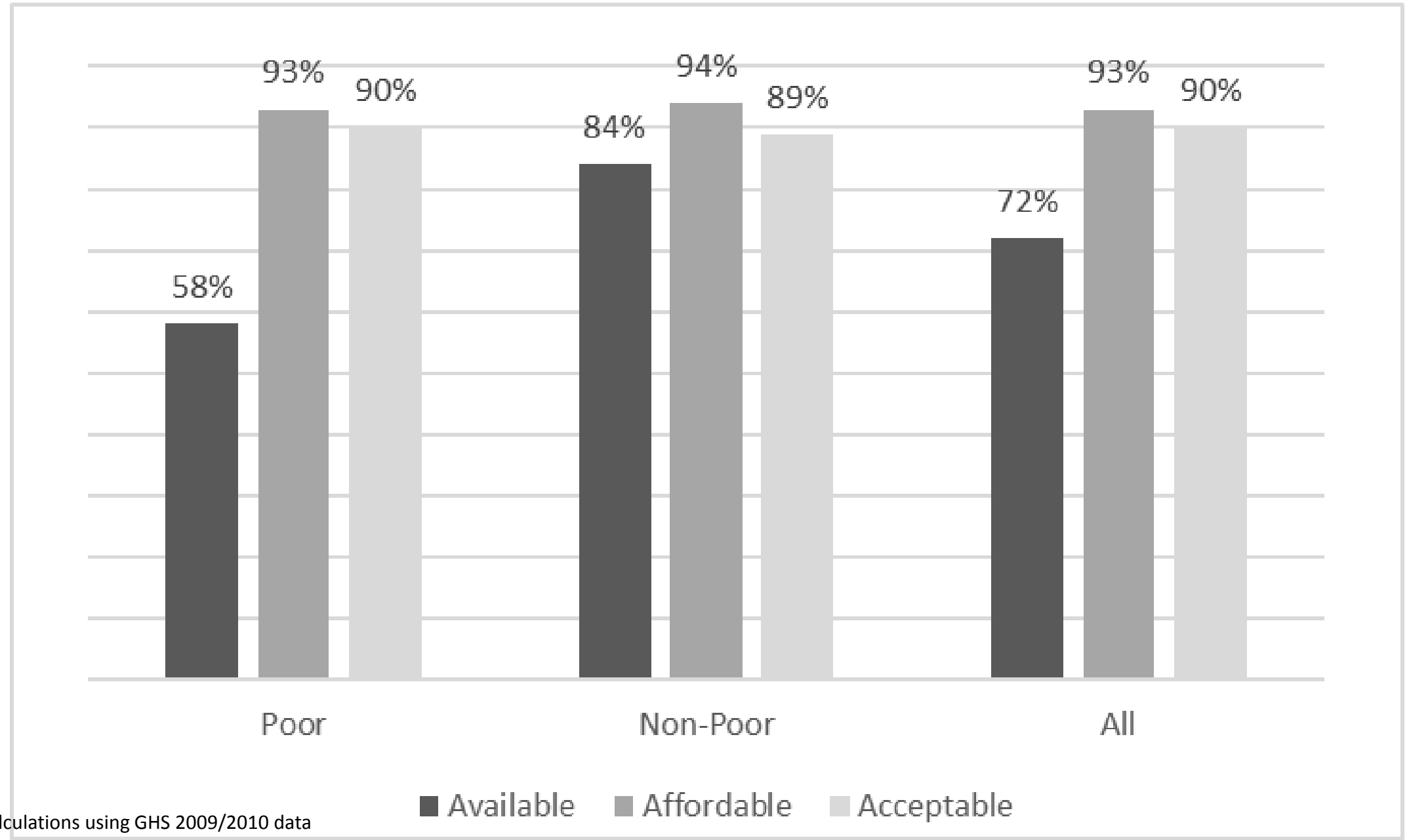
Method

- ❑ Descriptive statistics: Univariate and bivariate analysis
- ❑ Multivariate analysis: qualitative response regression model
  - Linear Probability Modelling (LPM) and Probit Modelling

Outcome variables

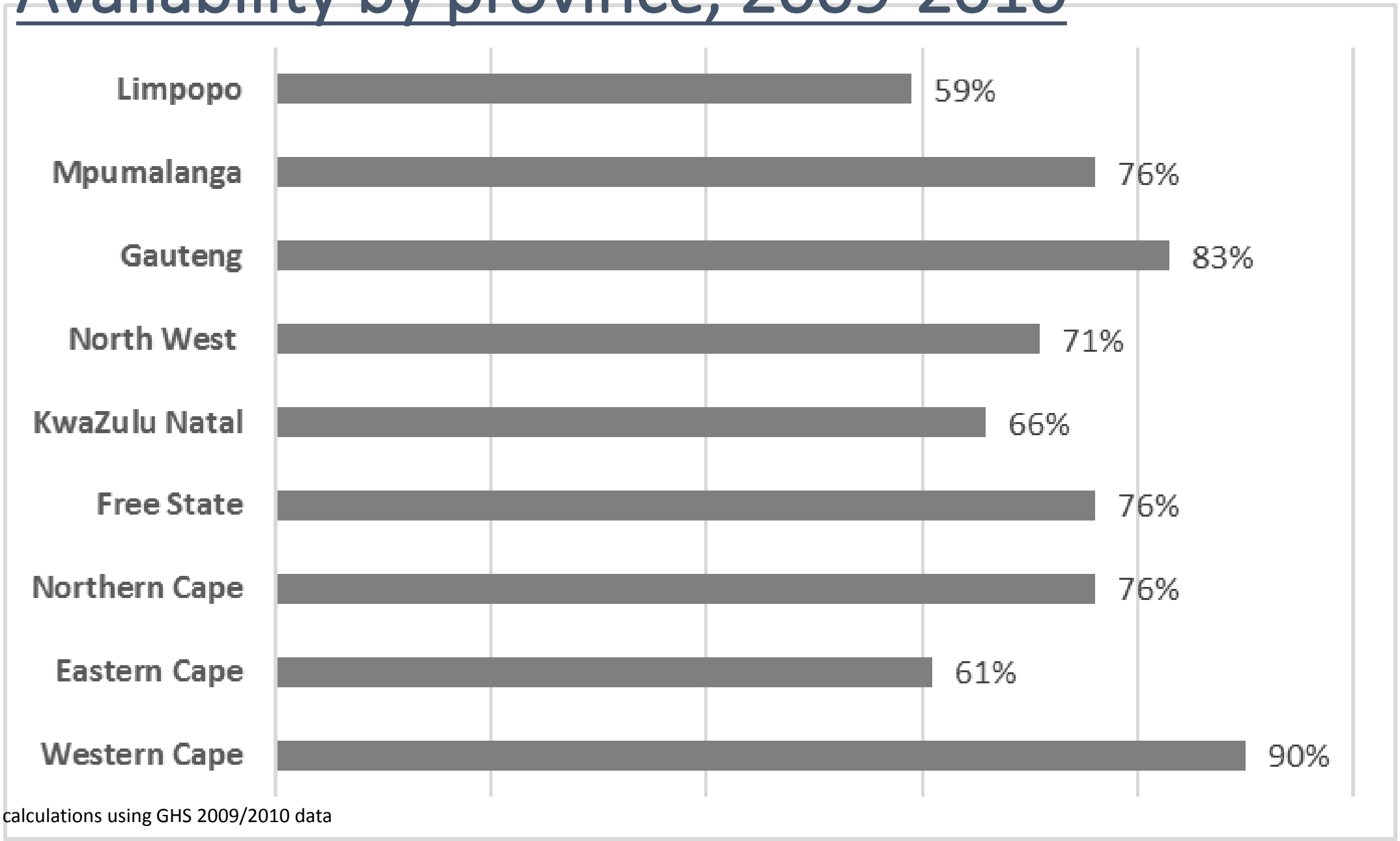
- ***Available***:
  - Travel time < 30 min to facility
- ***Affordable***:
  - Restricted by unavoidable out-of-pocket payments for health visits
- ***Acceptable***:
  - Share of community bypassing nearest facility
  - Reasons for bypassing: *not clean / inconvenient / drugs needed not available / rude staff / incorrect diagnosis / not satisfied*
  - >75% did **not** bypass closest facility = acceptable

Share (%) of access for poor and non-poor (1)



Source: Own calculations using GHS 2009/2010 data

Availability by province, 2009-2010



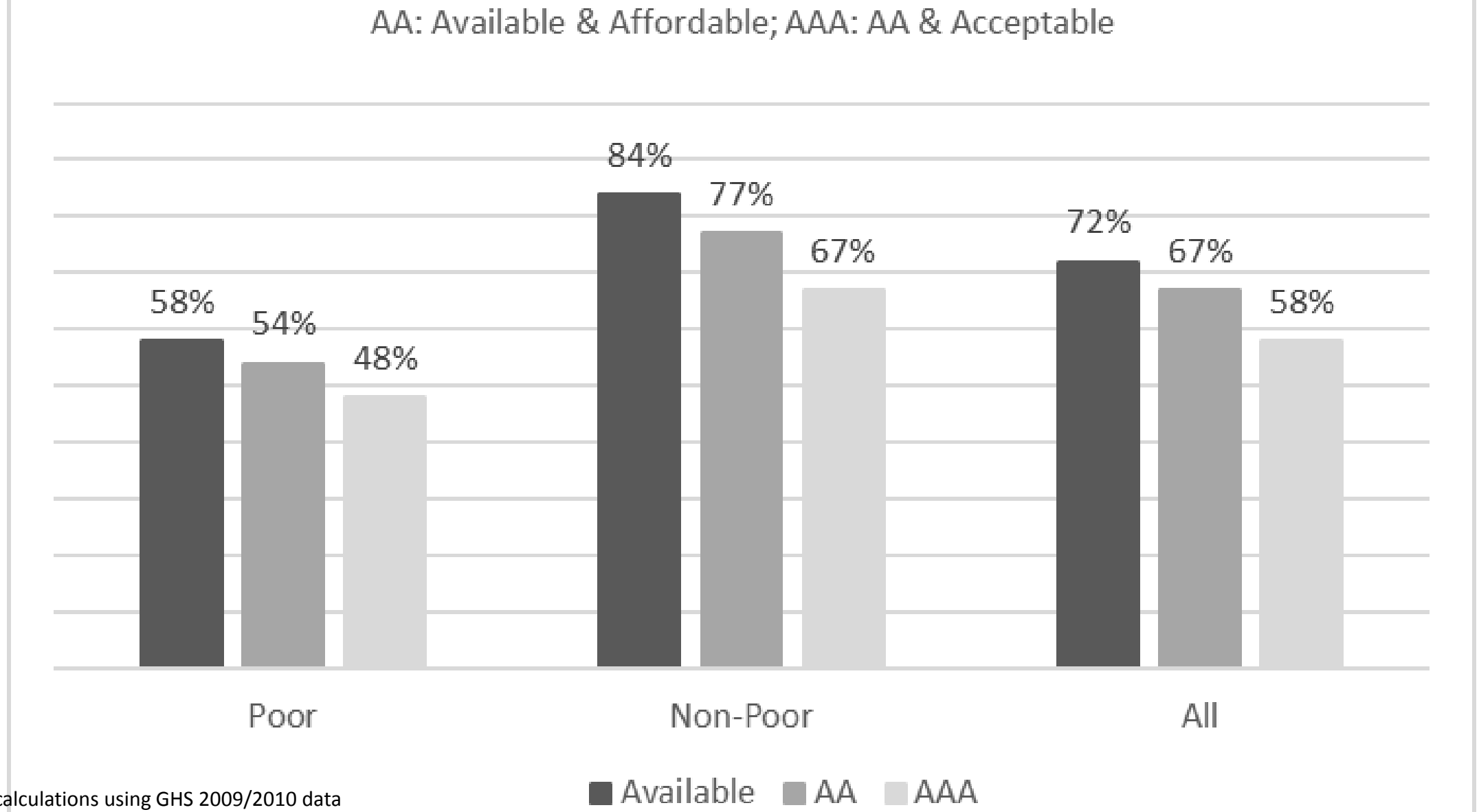
Source: Own calculations using GHS 2009/2010 data

Health visit satisfaction versus complaints, 2009-2010

	Very satisfied	Somewhat satisfied	Indifferent
Long waiting times	20%	65%	78%
Rude staff	2%	18%	38%
Drugs not available	6%	29%	47%

Source: Own calculations using GHS 2009/2010 data

Share (%) of access for poor and non-poor (2)



Source: Own calculations using GHS 2009/2010 data

Results: who is last in the queue? (correlates)

- Most vulnerable subgroups
  - ***Availability*: poor, less educated, unemployed and <u>especially</u> rural inhabitants**
  - ***Affordability:*** no evidence of higher burden for the poor (in fact, pro-poor correlation)
  - ***Acceptability:*** no association with SES (minimal variation across SES spectrum)

Results: how large are the gaps? (levels)

- ***Availability*: 28% of individuals – 42% poor and 16% non-poor – face constraints**
- ***Affordability:*** 7% of individuals reported unavoidable out-of-pocket expenditure to access health services
- ***Acceptability:*** high - 90% - but **caveat**!!!
  - More research needed in this area: mystery client approach, vignettes

Take home message

- Multi-dimensional access → prerequisite for universal coverage
  - Important to look beyond surface when investigating disparities in access to healthcare
  - Failure to understand (and address) demand-side → undermine health policies aimed at increasing access

- Innovative solutions are required to address this situation
  - NHI: conditional grant to contracting out GPs…poor uptake thus far
  - Use of incentives (e.g. nudges) to influence health-seeking behaviour

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Thank you

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