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QUALITY OF LIFE IV:
HEALTH

DECEMBER 2018

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QUALITY OF LIFE IV:
HEALTH

PHOTOGRAPH BY **RAWPIXEL**

PREFACE

The Quality of Life (QoL) survey, run every two years, has become GCRO's flagship project. The QoL survey is designed to provide a regular understanding of the quality of life, socio-economic circumstances, satisfaction with service delivery, psycho-social attitudes, value-base and other characteristics of residents in Gauteng. It serves as a tracking and diagnostic tool, affording a rich information resource for policy makers, business, civil society and the public wanting to see where progress is being made, and where concerns remain.

QoL is a household-based survey with randomly selected adults (18+ years old) as respondents. The GCRO has conducted four QoL surveys and there has been growth in the number of respondents included in each successive sample:

- QoL I (2009) with 5 836 respondents in Gauteng and a total of 6 636 across the wider Gauteng City-Region
- QoL II (2011) with 16 729 respondents
- QoL III (2013/14) with 27 490 respondents
- QoL IV (2015/16) with 30 002 respondents.

The QoL sample is designed to be representative of the Gauteng population and each municipality within the province. Census 2011 was used as a benchmark for the sample frame, and the final dataset was weighted back to these figures. This large sample enables GCRO to analyse, map and model the data through a range of innovative methods with a high degree of confidence and precision.

The QoL sample is also designed to include respondents from every ward in Gauteng. The QoL IV (2015/16) survey drew a minimum of 30 respondents per ward in non-metro wards, and 60 in metro wards, with increased numbers reflecting higher population density. The survey therefore provides critical, local-level data for analysis and assessment to guide targeted government interventions.

This *QoL IV Data Brief* is one of a series that takes a deeper look into the QoL IV (2015/16) dataset, and explores patterns, trends and dynamics in a range of focus areas such as social cohesion, crime, health, quality of life, poverty and inequality, economy, and governance.

Additional information on the Quality of Life survey can be found on the GCRO website: **www.gcro.ac.za**

*Due to rounding of individual values, figure labels in graphs may not add up to 100%.

PHOTOGRAPH BY **CHRISTINA CULWICK**

1

HEADLINE FINDINGS

- Overall, the data reveals a strong relationship between health and wellness, and income. As affluence increased, respondents were more likely to have medical aid, use private healthcare, report high satisfaction with the healthcare facilities they usually use, and report better personal health.
- Of respondents who reported using healthcare, just over 65% usually used public healthcare facilities, while 24% usually used private healthcare facilities (Table 2). These figures have remained relatively constant across all four QoL surveys.
- The sector of healthcare used varied greatly by population group and income category (Figure 2). Of respondents who reported using healthcare, 77% of African respondents usually used public healthcare facilities, compared to only 17% of white respondents. Of those using any healthcare, 89% of respondents with monthly household incomes of less than R1 600 usually used public healthcare, compared to 12% of respondents with monthly household incomes of more than R38 400.
- While the extent of reliance on public healthcare varied geographically across the province, there were no wards where all respondents reported using only private healthcare services (Figure 3).
- While some respondents avoided public healthcare facilities due to concerns about the quality of care received (Figure 4), there were also respondents who sought out public healthcare facilities specifically for good quality of care (Figure 9).
- Access to medical aid was highly differentiated by level of education, household income and population group (Figure 11), and followed a similar trend to the sector of healthcare usually used.
- Where a household member failed to obtain the healthcare they required, 40% of respondents indicated that it was due to financial constraints and 26% indicated that it was due to inadequate facilities or staff at healthcare facilities. (Figure 16).
- 66% of respondents who usually used public healthcare facilities were satisfied with the services provided by these facilities, compared to 93% of respondents who usually used private healthcare facilities (Figure 17).

"As affluence increased, respondents were more likely to have medical aid, use private healthcare, report high satisfaction with the healthcare facilities they usually use, and report better personal health."

- 35% of respondents described their health during the four weeks preceding the interview as excellent. A further 57% described their health as good, 7% as poor, and 1% as very poor. These results varied significantly by age and income group (Figure 20).
- Hypertension, influenza or pneumonia, and diabetes were the three health problems most often reported by respondents (Figure 22).
- Most respondents reported positive subjective well-being, with mean scores of 7.82 out of 10 for 'life is worthwhile' and 7.69 out of 10 for 'happiness'. By contrast, the mean scores for 'worry' and 'depression' were 3.22 and 2.09 respectively.

PHOTOGRAPH BY **LES ANDERSON**

2 INTRODUCTION

Provision of healthcare plays a significant role in the functioning of the Gauteng City-Region and the well-being of its residents. This is especially true for healthcare provided by the public sector. The public health sector is of great significance in terms of its overall budget, as a key locus of day-to-day interactions between residents and government, and in the meeting of essential needs of households and communities across the region.

According to the Gauteng Provincial Government budget for 2018/19, the public health sector currently has the largest share of budgeted expenditure at R45.4 billion, 37% of the provincial total (Gauteng Provincial Government 2018). Local government in Gauteng also devotes many hundreds of millions of Rand to primary healthcare services annually, with the metropolitan municipalities in particular running local clinics.

The 2015/16 District Health Barometer (Massyn et al 2016) reports a total of 472 public healthcare facilities, ranging from clinics through to tertiary hospitals, spread over five heath districts in Gauteng (Table 1). These health districts correspond with the metropolitan and district municipalities in Gauteng: the City of Johannesburg, the City of Tshwane, the City of Ekurhuleni, the Sedibeng District and the West Rand District. The location and type of the public healthcare facilities are mapped in Figure 1, with the exception of a handful of facilities for which location information was not available.

TABLE 1: Healthcare facilities per level and health district in Gauteng

Data source: Massyn et al 2016

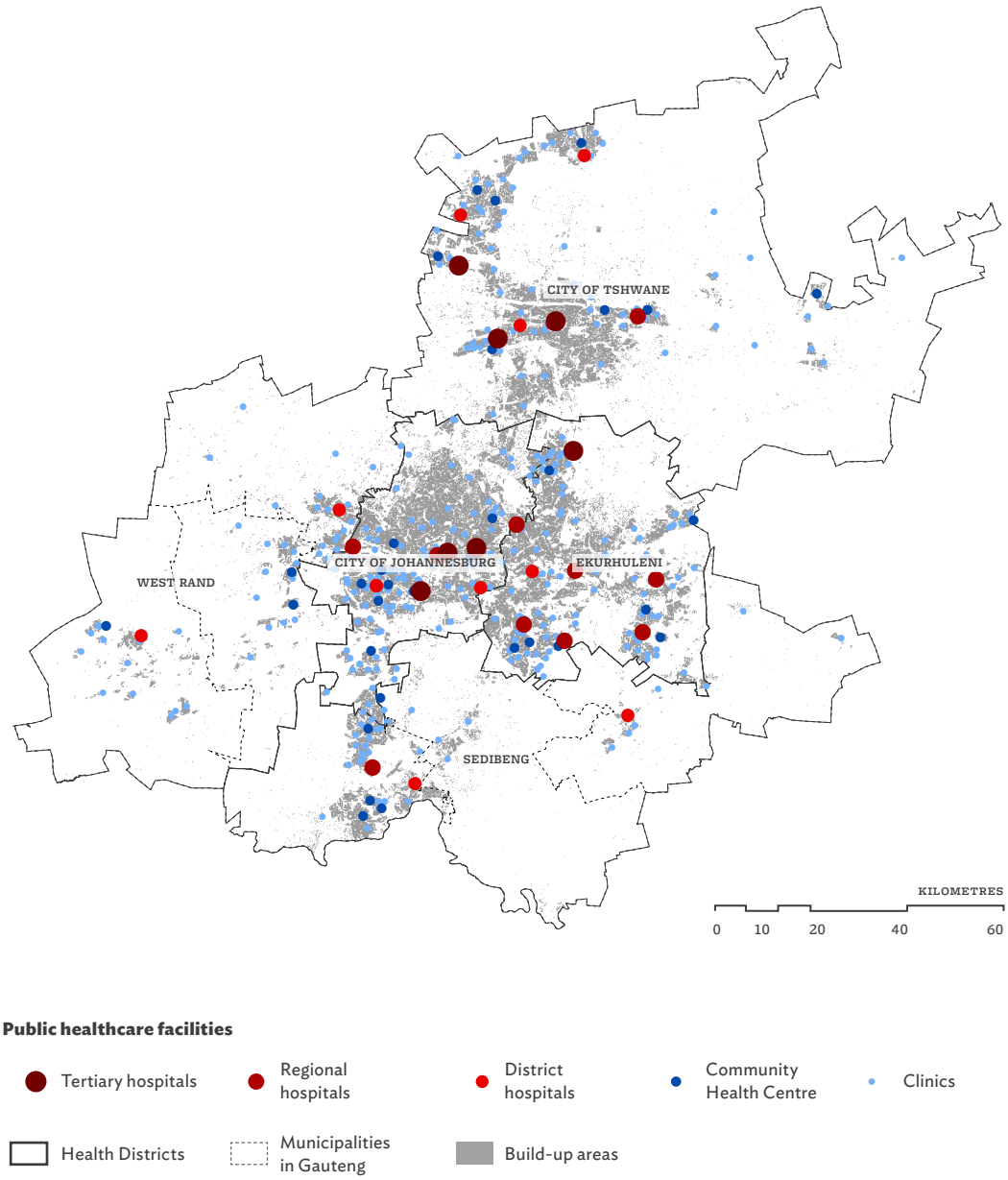
	Clinic	Community Health Centre	District hospital	Regional hospital	Tertiary hospital	Other hospital	Total
City of Johannesburg	111	10	3	2	3	21	150
City of Tshwane	68	8	4	1	3	27	111
City of Ekurhuleni	84	7	1	4	1	13	110
Sedibeng	31	4	2	1	0	5	43
West Rand	43	3	2	1	0	9	58
Total	337	32	12	9	7	75	472

During the 2016/2017 reporting cycle, the Gauteng Department of Health estimated that just over 22 million patients visited healthcare facilities in Gauteng. Access to healthcare was further improved through the services provided by Ward Based Outreach Teams, including community health workers who visit patients in their homes, and school health based services (Gauteng Department of Health 2017). In 2016 the estimated medical aid coverage within the five districts varied between 21% and 31%, with a provincial average of 26%, emphasising the reliance on the public healthcare sector (Massyn et al 2018).

Supported by additional funding from the Gauteng Department of Health, the GCRO was able to include an expanded bank of questions related to personal health and healthcare in the Quality of Life IV (2015/16) survey. Health related questions were designed and workshopped with a group of academics, researchers and practitioners. They covered a range of issues, from respondents' experiences with healthcare services to their self-reported health status and needs. This Data Brief provides an overview of the data collected.

FIGURE 1: Distribution of different types of public healthcare facilities in Gauteng

Data source: ESA, 2016; Gauteng Department of Health, 2017



PHOTOGRAPH BY **CLIVE HASSALL**

3

USE OF PUBLIC SECTOR HEALTHCARE

3.1 Proportion of QoL respondents making use of public healthcare facilities

Asked where they usually go for healthcare services, 7% of respondents in the QoL IV (2015/16) survey reported that they did not usually need healthcare. This was slightly higher than in previous surveys, and we believe this shift is due to data collection challenges rather than real population-level change (Table 2). Consequently, subsequent analysis is limited to those respondents who indicated use of healthcare services. Of these, 65% of respondents in the QoL IV (2015/16) survey indicated that they usually make use of public healthcare facilities while 24% indicated that they usually use private healthcare facilities. The proportion of respondents needing healthcare who use public facilities has remained consistent since QoL I. However, there has been a small decrease in the proportion usually using private healthcare facilities and a corresponding increase in the proportion who make use of both public and private healthcare facilities. For the first time the QoL IV survey gave respondents an option to say whether they usually made use of a spiritual healer, and a small proportion, 0.7%, said they did so.

TABLE 2: Healthcare sector usually used by respondents

Data source: GCRO QoL I, II, III and IV

	QoL I	QoL II	QoL III	QoL IV
Not applicable, don't usually need healthcare	3%	2%	4%	7%
Of those who needed healthcare				
Public healthcare facilities	65%	65%	65%	65%
Private healthcare facilities	25%	29%	29%	24%
Use public and private facilities	10%	5%	6%	10%
Traditional healer	0.3%	0.7%	0.5%	1.0%
Spiritual healer	Not asked	Not asked	Not asked	0.7%

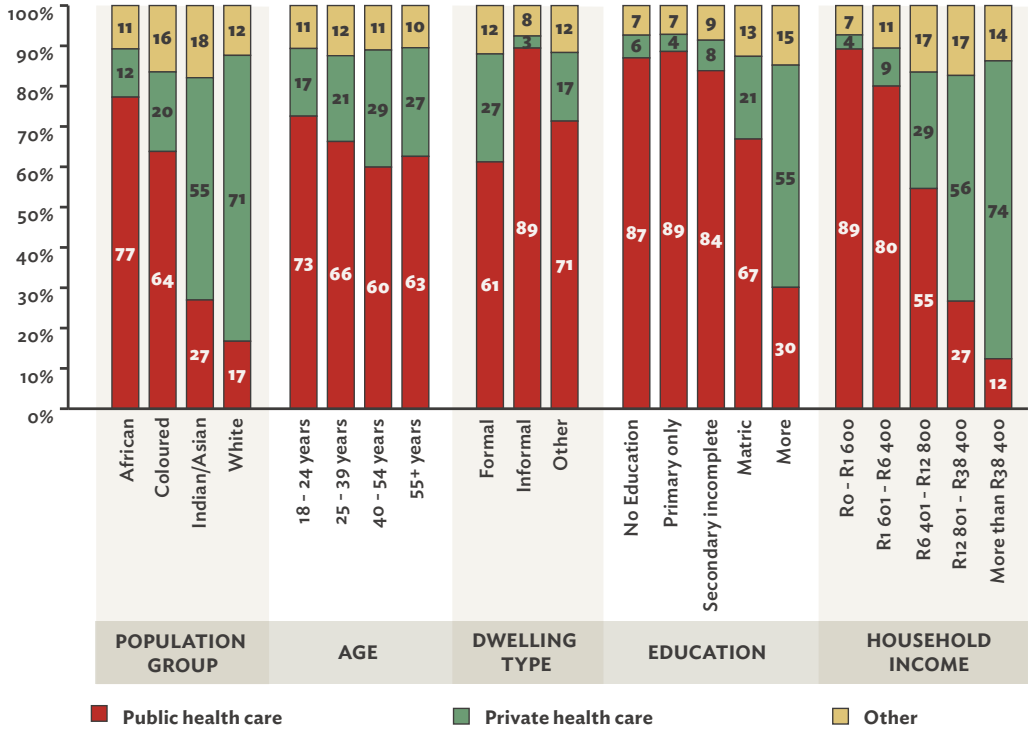
3.2 Variation in use of public and private healthcare facilities

QoL IV (2015/16) results showed substantial variation in the use of public or private healthcare by population group, age group, dwelling type, level of education and income group (Figure 2)[1]. Of respondents who used healthcare services, 77% of African and 64% of coloured respondents reported using only public healthcare facilities, while 71% of white and 55% of Indian/Asian respondents reported using only private healthcare facilities. Variation by age was not as substantial as by population group, but respondents aged 18-24 were most likely to use public healthcare facilities, while those aged 40-54 were most likely to use private healthcare. Given the costs of private healthcare, and the strong relationship between education, income and type of dwelling, it is unsurprising that individuals with only primary school education, from households with a monthly income of R1 600 or less[2], or living in an informal dwelling were most likely to utilise public healthcare facilities. By contrast, respondents with a post-matric qualification, from households with a monthly income above R38 400, or living in formal housing, were more reliant on private healthcare. There was very little variation by gender in terms of the sector of healthcare facilities used. 24% of both males and females needing health services used private healthcare facilities, while 64% and 66% respectively used public healthcare facilities.

1. In Figure 2 'other' refers mainly to those who use both public and private healthcare facilities and a very small proportion of respondents who use traditional and spiritual healers.
2. Our analysis of income trends is restricted to those respondents who disclosed their income (64% of the total sample).

FIGURE 2: Healthcare sector use by population group, age, dwelling type, education and household income

Data source: GCRO QoL IV, 2015/16



3.3 Geographic variation in use of public healthcare facilities

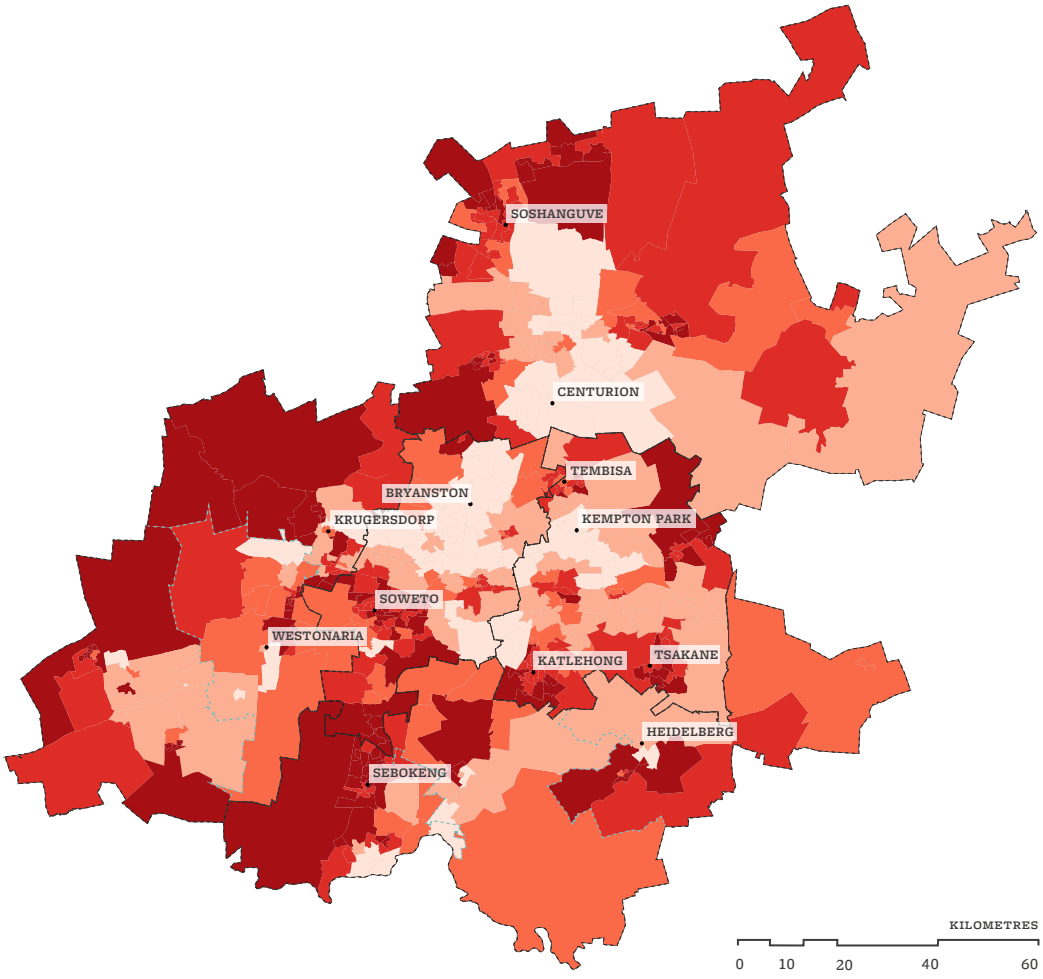
While 65% of respondents who needed health services relied entirely on public healthcare (Table 2 above), this varied from 5% to 100% across wards. That all wards had at least some respondents depending on public healthcare highlights the significance of public healthcare. By contrast, 29 wards had no respondents who relied on private healthcare facilities. The reliance on private healthcare per ward ranged from 0% to 89%.

When mapped geographically (Figure 3), clear spatial patterns in the use of public healthcare were evident, echoing the socio-economic structure of the province. These patterns are strongly related to historical patterns of segregation and socio-economic inequality. The distribution of wards with the highest reliance on public healthcare follows the distribution of wards with higher proportions of respondents who are African or coloured, those with low racial diversity (Hamann & Ballard 2017) and those with lower household incomes (Wray et al 2014). Wards where the highest proportion of respondents usually used public healthcare were in townships (for example, Soshanguve, Tembisa, Soweto, Katlehong), or on the periphery of the province. By contrast, wards where the lowest proportion of respondents usually used public healthcare facilities were in the more affluent suburbs of Johannesburg (around Bryanston), Tshwane (around Centurion) and Ekurhuleni (around Kempton Park).

Figure 3: The use of public healthcare facilities per ward

GCRO

Data source: GCRO QoL IV, 2015/16



Use of public healthcare facilities
(percentage per ward who usually used only public facilities, excluding those who don't usually need healthcare)

4.8 - 32.4 | 32.5 – 53.7 | 53.8 - 72.1 | 72.2 - 85.5 | 85.6 - 100.0

Health Districts | Municipalities in Gauteng

3.4 Reasons for not using public healthcare facilities

Individuals who reported using healthcare, but did not usually use public healthcare (24% of all respondents), were asked why they did not use public healthcare services. The main reasons provided (Figure 4) were poor quality care (38%), access to medical aid (31%), or queues being too long (11%). Reasons for not using public healthcare varied slightly by population group, age group and income group (Figure 5). White and Indian/Asian respondents, those aged 40 and older, and those with monthly household incomes of more than R12 801 were particularly likely to say that they did not use public healthcare due to concerns about quality of care, or because they had access to medical aid. Respondents from households with a monthly income of less than R1 600 were most likely to indicate that they did not use public healthcare due to inadequate or inappropriate services, accessibility constraints, and the attitude or skill of staff. This group was also the only one for whom these issues outweighed concern about long queues as the main reason for not using public healthcare.

Figure 4: Reasons respondents do not use public healthcare facilities

Data source: GCRO QoL IV, 2015/16

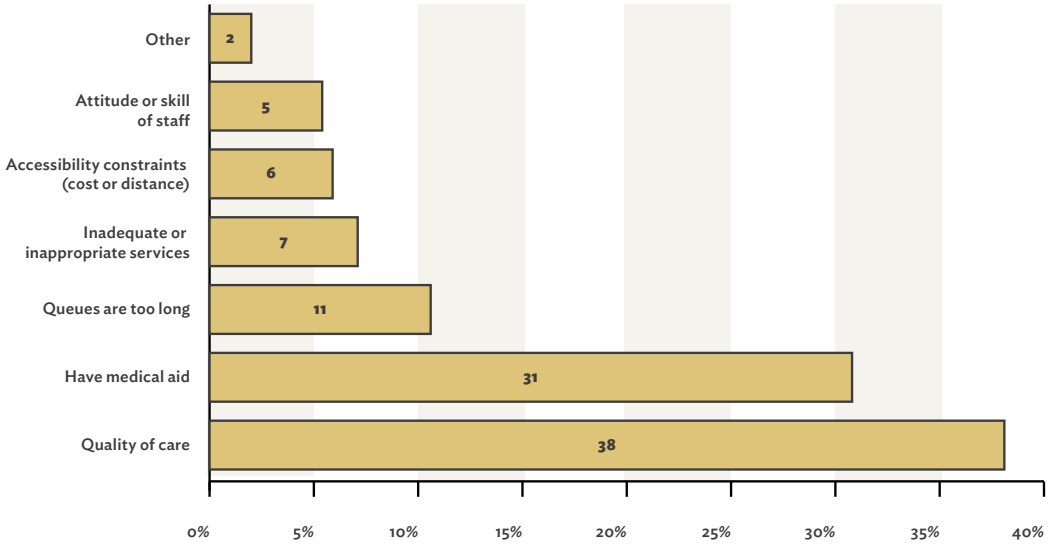
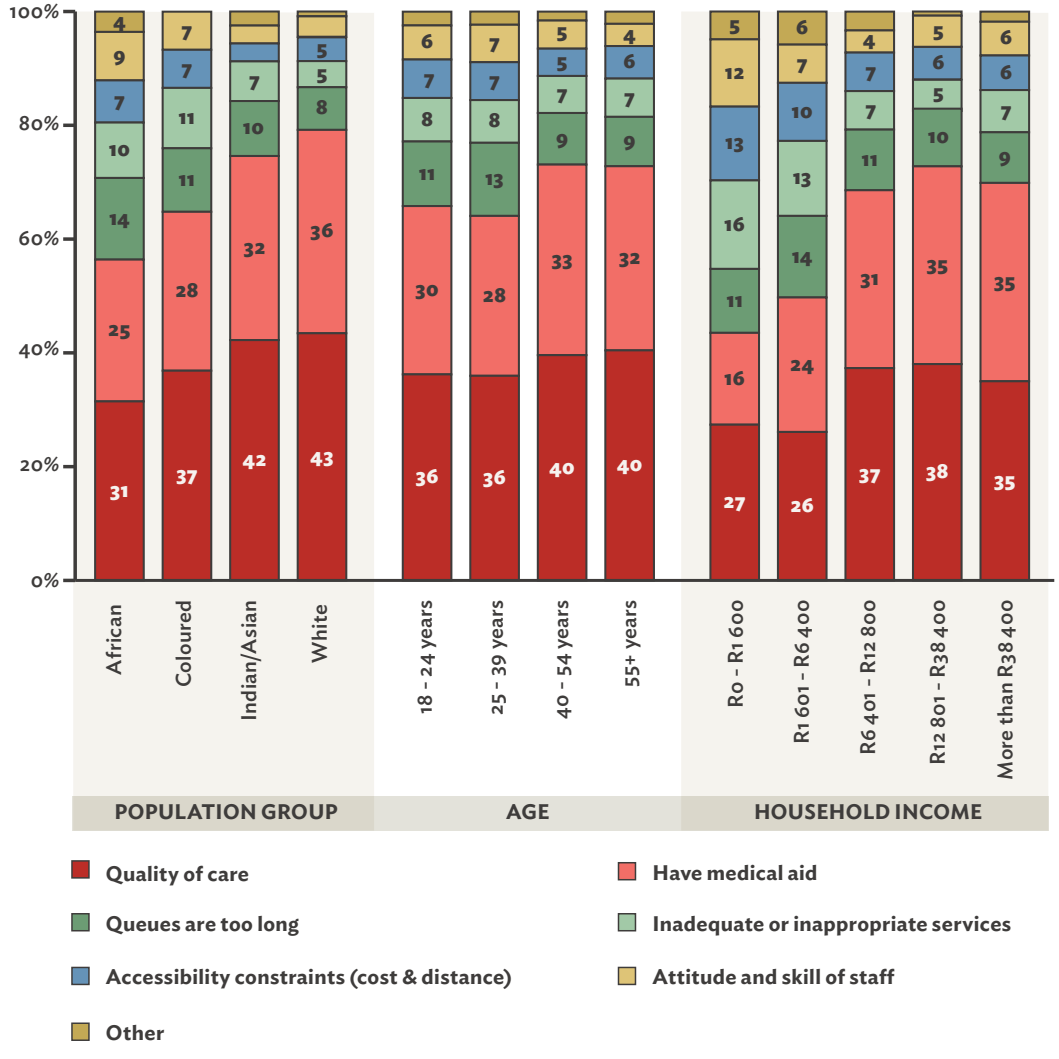


FIGURE 5: Reasons respondents do not use public healthcare facilities, by population, age and income group

Data source: GCRO QoL IV, 2015/16



3.5 The use of clinics as an entry point when accessing the public healthcare system

In line with South Africa's focus on providing high quality decentralised primary healthcare, patients in the public sector are generally encouraged to use clinics as their entry point for healthcare, for referral up the system when necessary. Of the respondents who usually used either public healthcare facilities only, or a combination of public and private facilities, 12% did not start at a clinic the last time that they visited a public healthcare facility.

Respondents who did not use a clinic as their entry point varied somewhat by population group, income group and type of medical aid (Figure 6). Larger proportions of white respondents, those from more affluent households, and those with medical aid (especially in the form of a hospital plan) started their interaction with the public health system somewhere other than a clinic.

There is also clear geographic variability in the distribution, at the ward level (Figure 7), of the proportion of respondents who used a clinic as their entry point to the public health system. In wards around Soshanguve and Katlehong, for example, low proportions of respondents indicated that they did not start at a clinic the last time they visited a public healthcare facility. This might suggest either that clinics in these areas are a suitable and easily accessible first point of interaction, or a lack of alternative options for access.

Wards where more than 29% of respondents did not start at a clinic have an interesting distribution. A number of these wards are relatively affluent, which is in line with the results presented in Figure 6 (above). Respondents in wealthier wards, such as those in the northern suburbs of Johannesburg, showed a higher propensity to say they did not start at a clinic the last time they used public healthcare services. This may reflect referral from private sector GPs, or a greater willingness to travel further to access care at a hospital. In some less affluent wards where high proportions of respondents did not start at clinics, such as those in Atteridgeville, Tembisa, Heidelberg and Carletonville, there are public hospitals nearby which could explain why respondents did not go to a clinic first. However, other less affluent wards, without a hospital nearby, cannot be explained in the same way.

"Respondents in wealthier wards, such as those in the northern suburbs of Johannesburg, showed a higher propensity to say they did not start at a clinic the last time they used public healthcare services."

FIGURE 6: Starting point when accessing public healthcare by population group, household income and type of medical aid

Data source: GCRO QoL IV, 2015/16

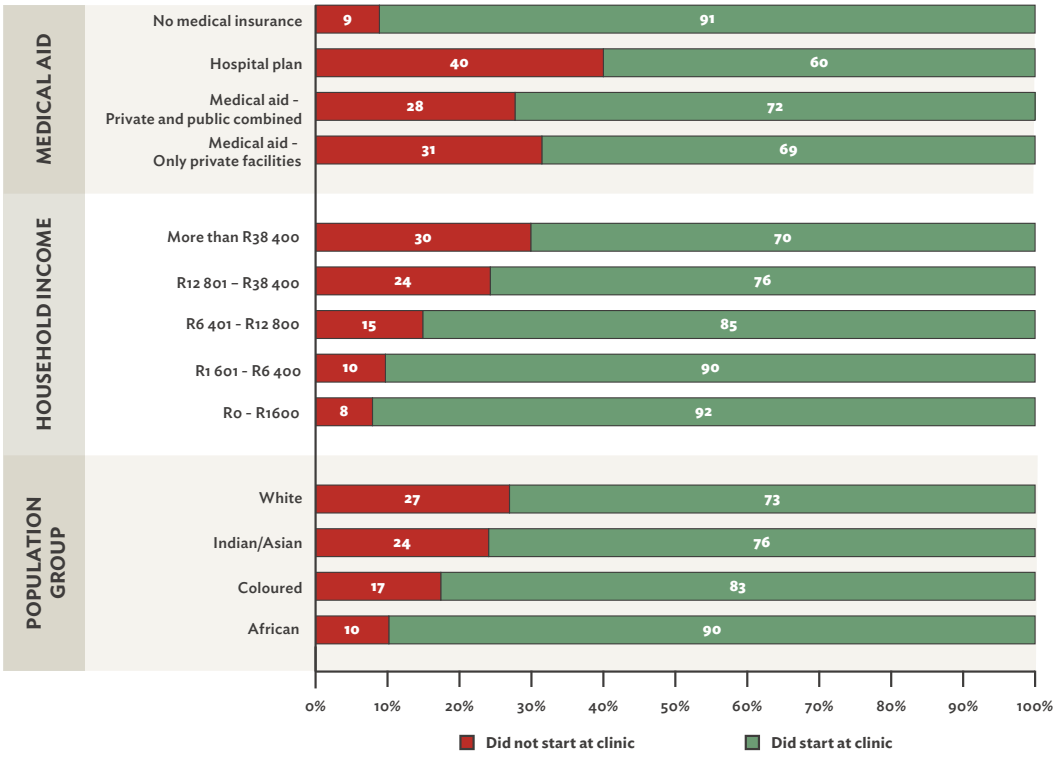
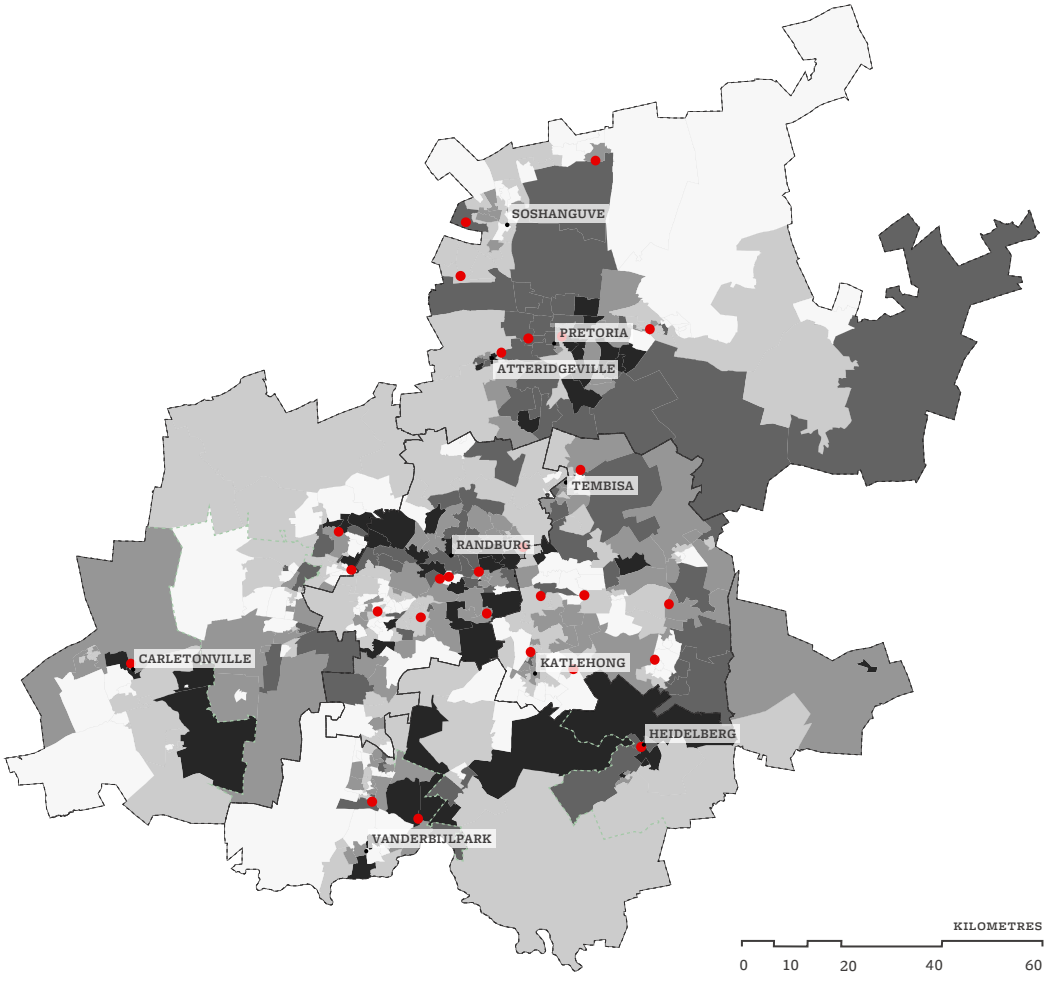


FIGURE 7: Respondents who did not start at a clinic the last time they used a public healthcare facility

Data source: GCRO QoL IV, 2015/16

GCRO



Did you start at a clinic the last time you visited a public healthcare facility?
(percentage per ward who said no)

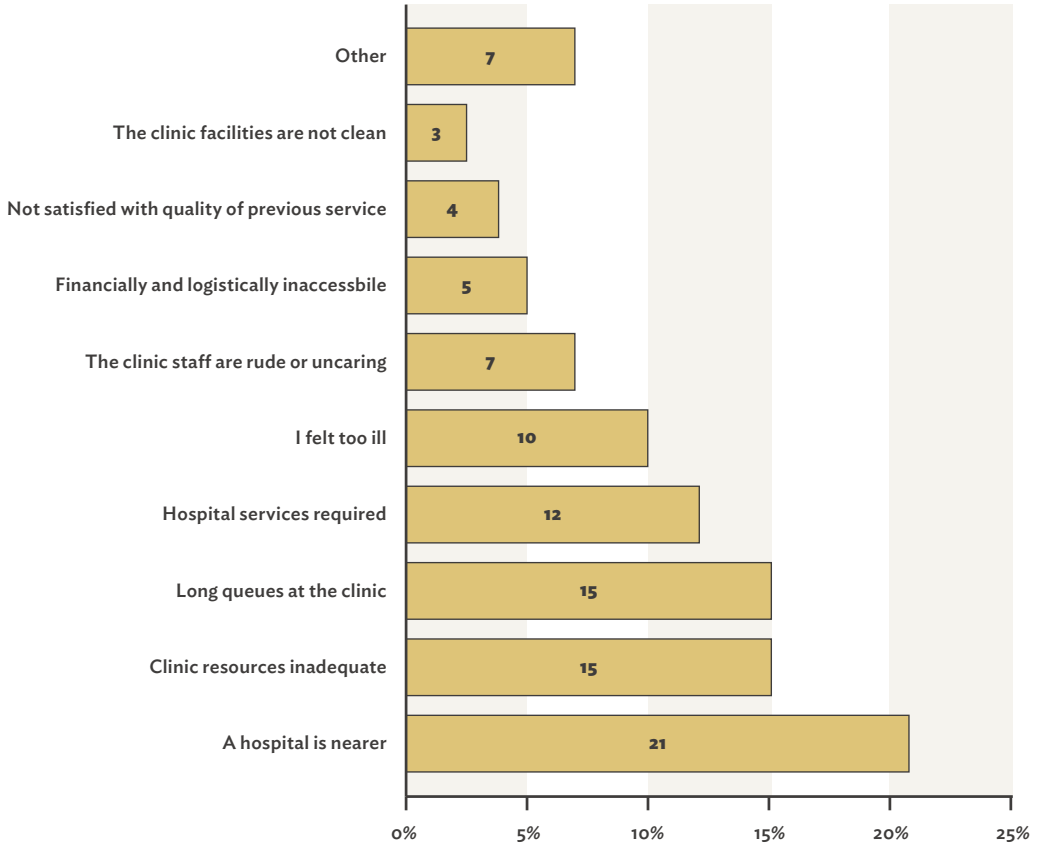
0.0 - 5.0 | 5.1 – 11.4 | 11.5 - 18.8 | 18.9 - 28.8 | 28.9 - 62.5

Health Districts | Municipalities in Gauteng | Public Hospitals

Respondents were asked to provide reasons for their decision to go directly to a hospital when accessing public healthcare (Figure 8). The most frequent were that a hospital was nearer (21%), that there were no doctors or drugs at the clinic (15%) and that there were long queues at the clinic (15%). That many respondents went to a public hospital because it was the closest corresponds with the spatial distribution of these responses in areas such as Atteridgeville, Tembisa, Heidelberg and Carletonville, as seen in Figure 7.

FIGURE 8: Reasons why a respondent did not start at a clinic the previous time they used public healthcare facilities

Data source: GCRO QoL IV, 2015/16



3.6 Use of public healthcare facilities by those with access to medical aid

According to QoL IV (2015/16), 27% of respondents had some form of medical aid. Some 19% had medical aid that covered access to all private facilities; 5% had a medical aid covering only primary health care, without hospital cover; and 3% had a hospital plan [see Section 4.1 for further detail].

Of those who had medical aid 28% nevertheless still made use of public healthcare facilities. And of those, 47% made use of a public clinic and 68% made use of a public hospital (some of these respondents used both types of public facilities).

As illustrated in Figure 9, the main reasons for using public healthcare services while covered by medical aid were the quality of the treatment, the cost of private healthcare, and having run out of medical aid benefits. Main reasons varied for respondents who used a public hospital, a public clinic or both types of facilities. The quality of treatment clearly attracted those respondents who had medical aid to public hospitals, while the cost of private treatment and the limitations of medical benefits attracted respondents who had medical aid to public clinics.

These figures highlight the role of the public sector in providing healthcare even for those with medical aid. The cost of private healthcare and the limits of medical aid cover are key, but particularly notable here is the extent to which individuals with medical aid perceived the public health sector to be providing high quality care, particularly at the hospital level. While some respondents reported avoiding public healthcare due to concerns about poor quality care, others sought out public healthcare specifically for its quality.

FIGURE 9: Reasons why respondents with medical aid used public healthcare facilities, differentiating between those using a public hospital and a public clinic

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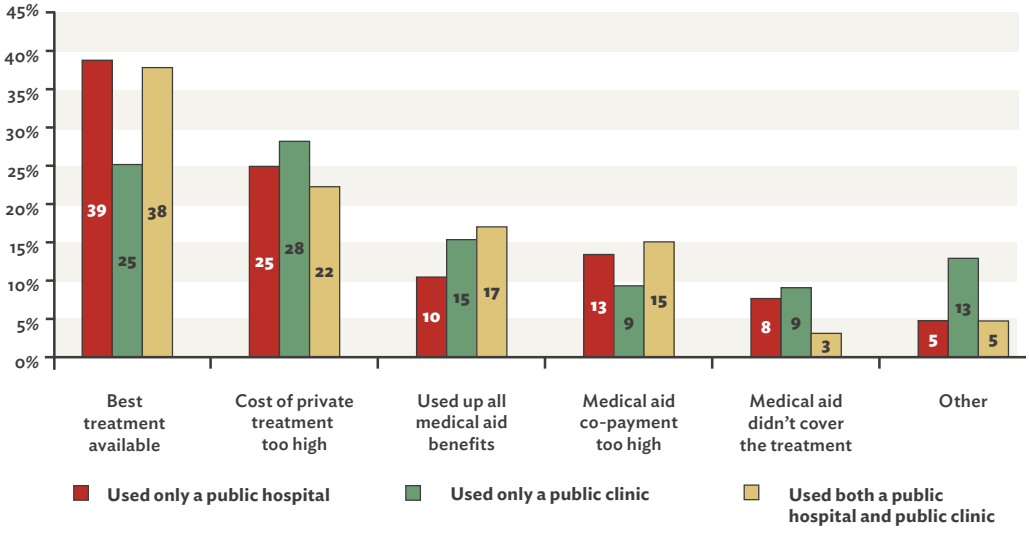
Data source: GCRO QoL IV, 2015/16



PHOTOGRAPH BY **RAW PIXEL**

4

ACCESS TO MEDICAL AID, AND FUNDING FOR HEALTH EMERGENCIES

4.1 Levels of medical aid coverage

The 2016/17 District Health Barometer estimates that about 16% of the South African population is covered by medical aid (Massyn et al 2018). In Gauteng, with a predominantly urban and more affluent population, the estimated coverage is somewhat higher, at 28% in 2015 and 26% in 2016. Coverage ranged from 21% in Sedibeng to a high of 30% in Johannesburg (Massyn et al 2018). QoL IV (2015/16) results concurred with these estimates, finding that about 27% of residents had some form of medical aid, while 70% of respondents indicated that they did not have any medical aid (Figure 10)[3]. With the exception of Midvaal (69%), the non-metro municipalities had the highest proportions of respondents without medical aid. Tshwane had the lowest proportion of respondents without medical aid (65%).

At the ward level, the proportion of respondents without medical aid varied substantially, ranging from 9% to 100% (Figure 12). Wards where more than 87% of respondents did not have medical aid were in townships such as Tembisa, Soweto and Sebokeng or on the periphery of the province. Unsurprisingly, given that these wards are relatively poorer, they also had larger proportions of respondents who usually used public healthcare facilities. Figure 12 illustrates this set of relationships in areas such as Tembisa, Soweto and Sebokeng, where relatively high proportions of respondents per ward did not have medical aid (dark grey shading), and very high proportions of respondents made use of public healthcare facilities (green dots). By contrast, where lower proportions of respondents per ward did not have access to medical aid, very low proportions of respondents usually used public healthcare facilities (red dots), as seen for example around Bryanston and Kempton Park.

3. Some 3% of respondents did not know whether they were covered by medical aid or not.

FIGURE 10: The proportion of respondents per municipality who do not have any medical aid

Data source: GCRO QoL IV, 2015/16

GCRO

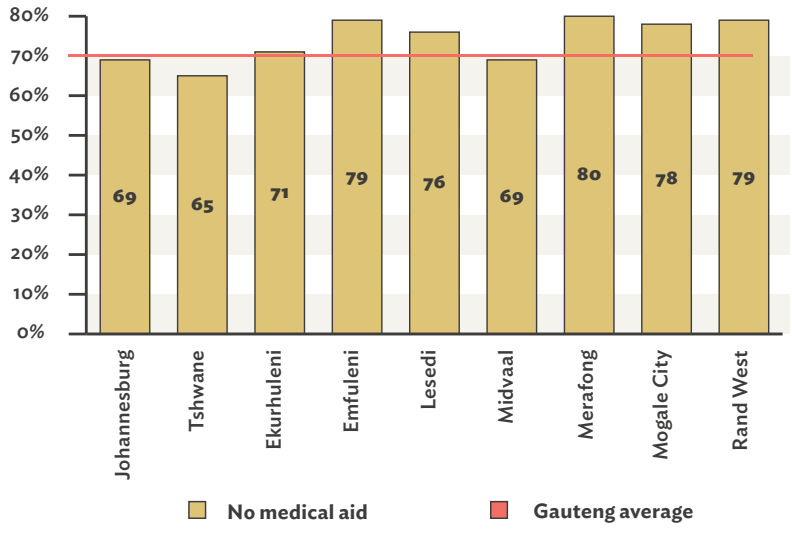


FIGURE 11: Access to medical aid by education, income, population and age groups

Data source: GCRO QoL IV, 2015/16

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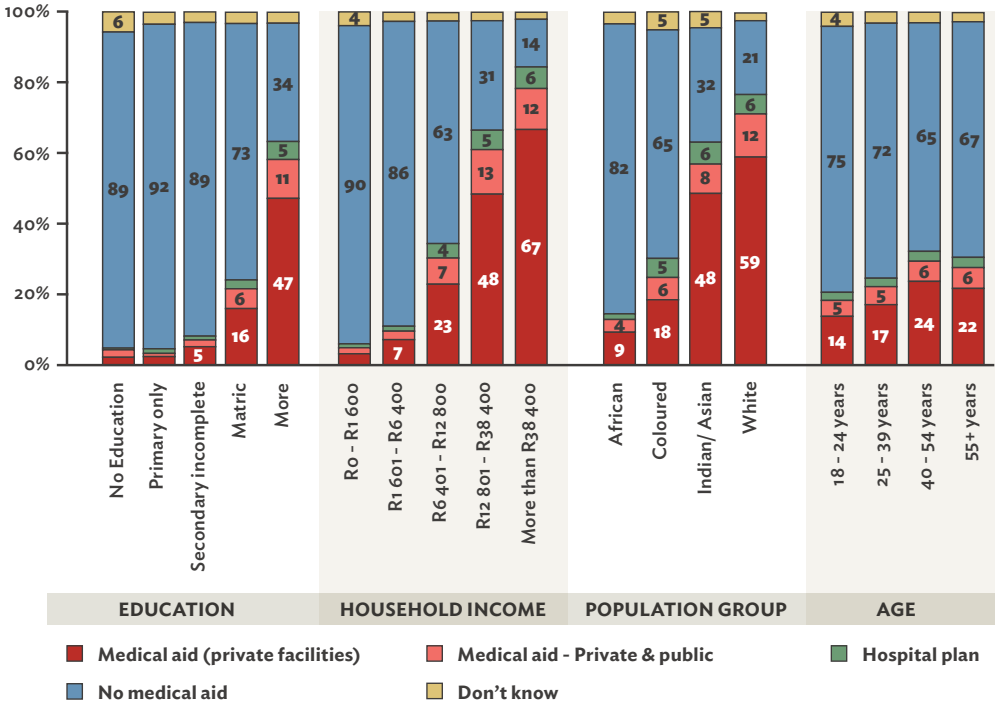


FIGURE 12: The proportion of respondents per ward in Gauteng who did not have medical aid overlaid with the use of public healthcare facilities per ward

Data source: GCRO QoL IV, 2015/16

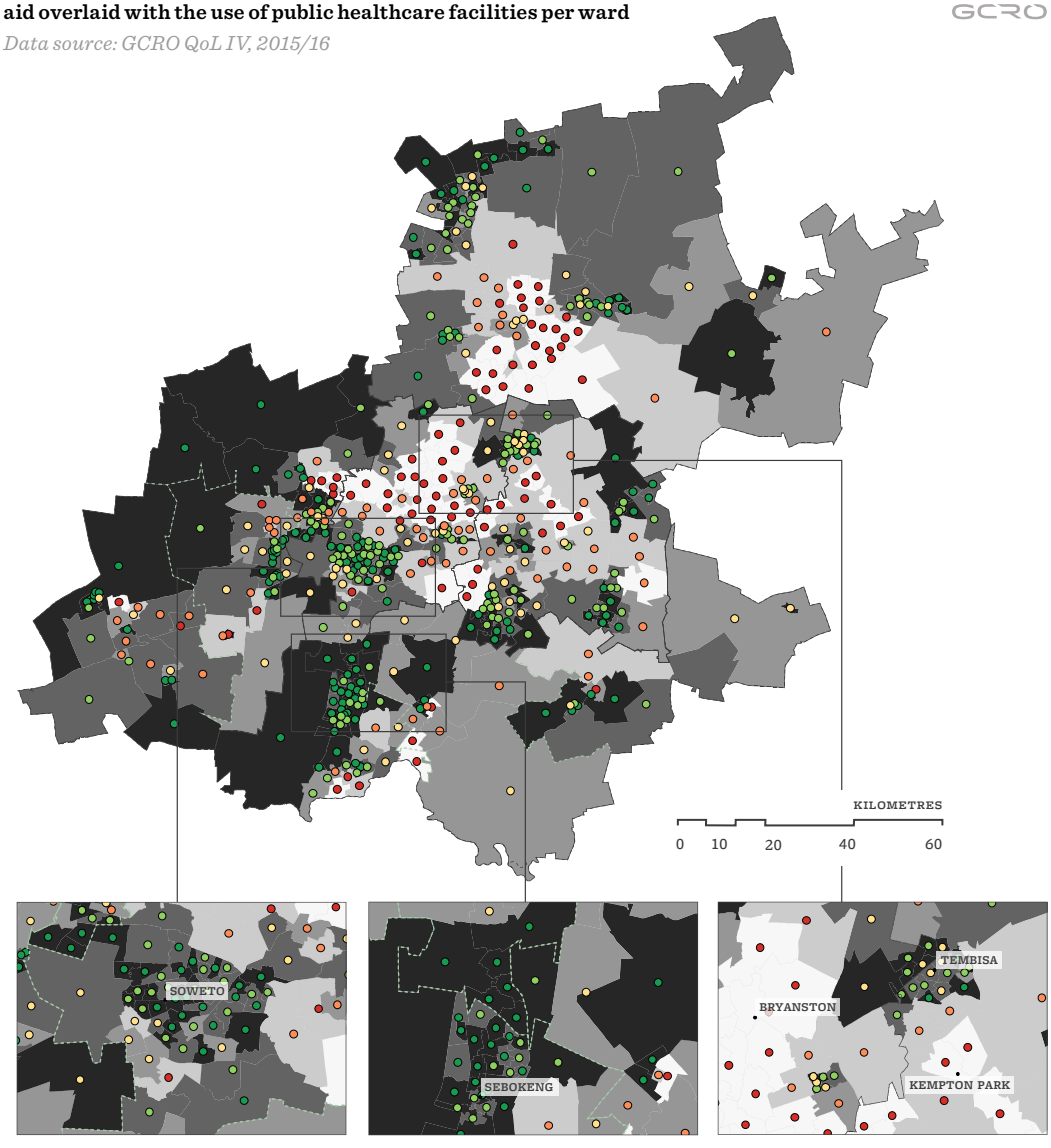


Figure 11 shows access to medical aid by various demographic variables. Respondents with only a primary school education, respondents living in households with monthly income below R1 600, African respondents, 18-24 year old respondents, and respondents born in another country were the least likely to have medical aid. Respondents with a post-matric education, respondents living in households with a monthly income over R38 400, white respondents, 40-54 year old respondents, and those born in Gauteng were the most likely to have medical aid to cover treatment in private healthcare facilities. Again, this reflects closely the spatial distributions illustrated in Figure 12.

The relationship between education levels and medical aid coverage is striking, with a particularly significant jump in coverage (from 16% to 47%) once an individual has a post matric qualification. This highlights the importance of a post matric qualification as a stepping-stone for social mobility. Similarly, the proportion of respondents with medical aid also increases significantly as income increases – not surprising given the cost of medical aid (Fonn, 2018). The distribution of access to medical aid by population group shows the lingering effects of racial inequality in Gauteng.

4.2 Ability to borrow money when faced with a health emergency

Financial support can be critical in the case of a health emergency. Respondents were asked how much money they would be able to borrow from someone if they did face a health emergency. Overall, 46% indicated that they would not have been able to borrow any money in a health emergency, and a further 29% indicated that they would only be able to borrow R500 or less (Table 3). The data suggests that cultural factors influence whether respondents could borrow money from someone, while socio-economic circumstances define how much money they could borrow. Some 54% of white respondents said that they would not be able to borrow money and 17% were unsure. By contrast, 45% of African respondents indicated that they would not be able to borrow money, and 11% were unsure. However, 16% of white respondents said they could borrow R1000 or more, compared to only 4% of African respondents. Despite being less well off financially, 54% of respondents without any medical aid reported that they would be able to borrow money in case of a medical emergency, compared to only 44% of those with medical aid. This did not vary much between population groups.

TABLE 3: The amount of money that respondents would have been able to borrow in case of a health emergency, by population group

GCRO

Data source: GCRO QoL IV, 2015/16

	None	R500 or less	R501 - R1000	R1000 or more	Don't know
African	45%	34%	6%	4%	11%
Coloured	39%	25%	12%	9%	16%
Indian/ Asian	44%	9%	11%	15%	20%
White	54%	6%	6%	16%	17%
Overall	46%	29%	6%	7%	12%

PHOTOGRAPH BY **RAW PIXEL**

5

ACCESS TO HEALTHCARE

5.1 Access to healthcare through home visits by healthcare workers

In recent years, as part of primary healthcare re-engineering, Ward Based Outreach Teams have been tasked with visiting residents in their homes to provide healthcare information and services. About 11% of QoL IV respondents were visited at their homes by a healthcare worker during the year preceding the interview[4]. Of those, 76% reported a monthly income of R12 800 or less. This suggests that outreach efforts are effectively being directed towards less affluent areas and individuals. That said, the extent of coverage of poorer areas varies. As shown in Figure 14, Ekurhuleni was the municipality with the highest proportion of respondents visited at home in the year preceding the interview (16%) while Lesedi had the lowest proportion of household visits (4%). The high rate of household visits in Ekurhuleni is partly explained by a cluster of ten wards covering the Tsakane township, where an average of 39% of respondents reported home visits by a healthcare worker in the year preceding the interview (Figure 13). Numerous wards in the West Rand (around Westonaria and Krugersdorp) and Sedibeng (around Heidelberg) did not contain any respondents who were visited by a healthcare worker. While the QoL data is able to provide information on coverage, it is not able to speak to frequency of visits, or quality of care provided.

4. A small proportion of these visits were probably provided by non-profit or private services, but our data is not able to differentiate this.

FIGURE 13: Respondents per ward who indicated that they were visited by a healthcare worker at their home in the year preceding the interview, per ward

Data source: GCRO QoL IV, 2015/16

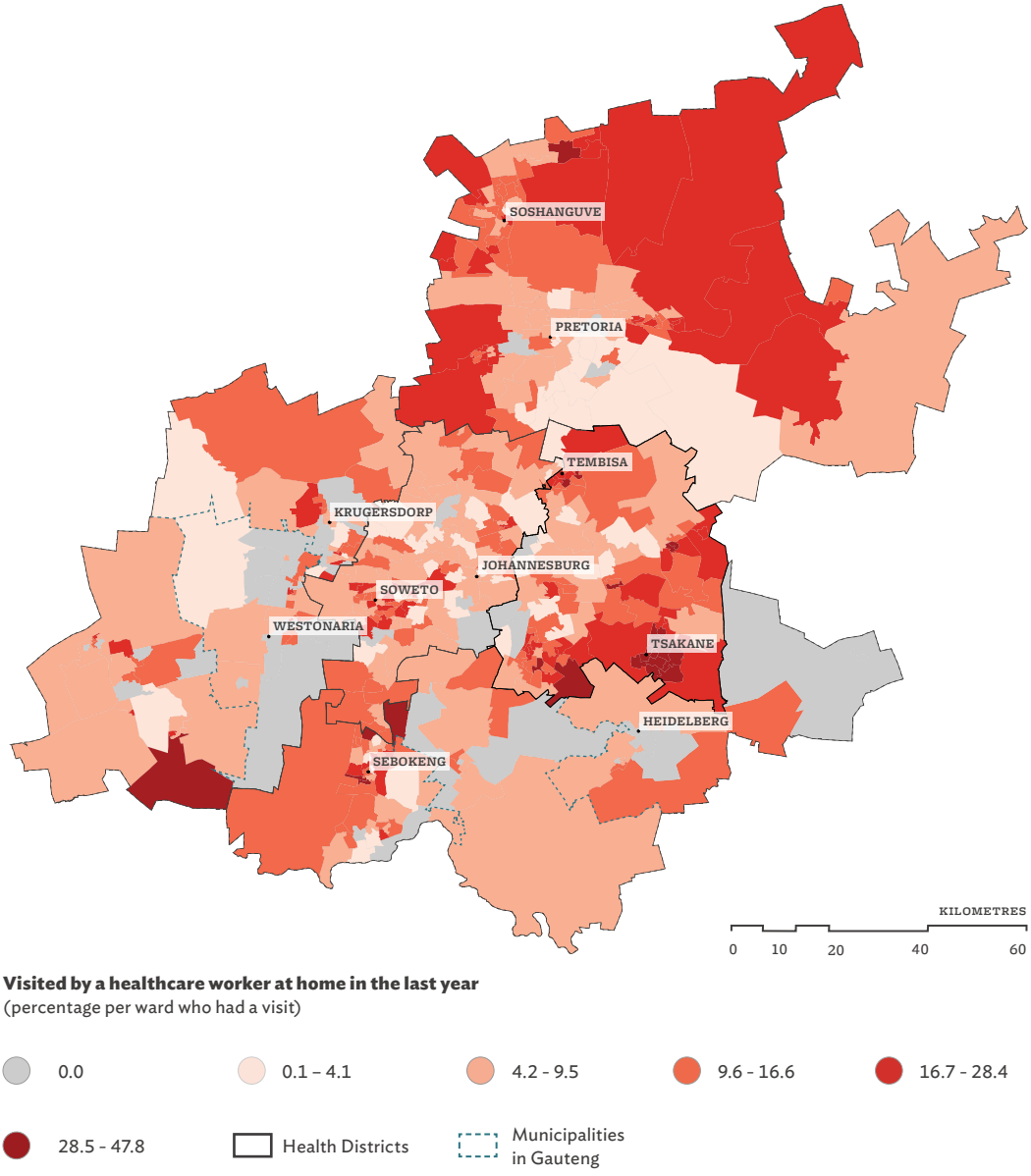
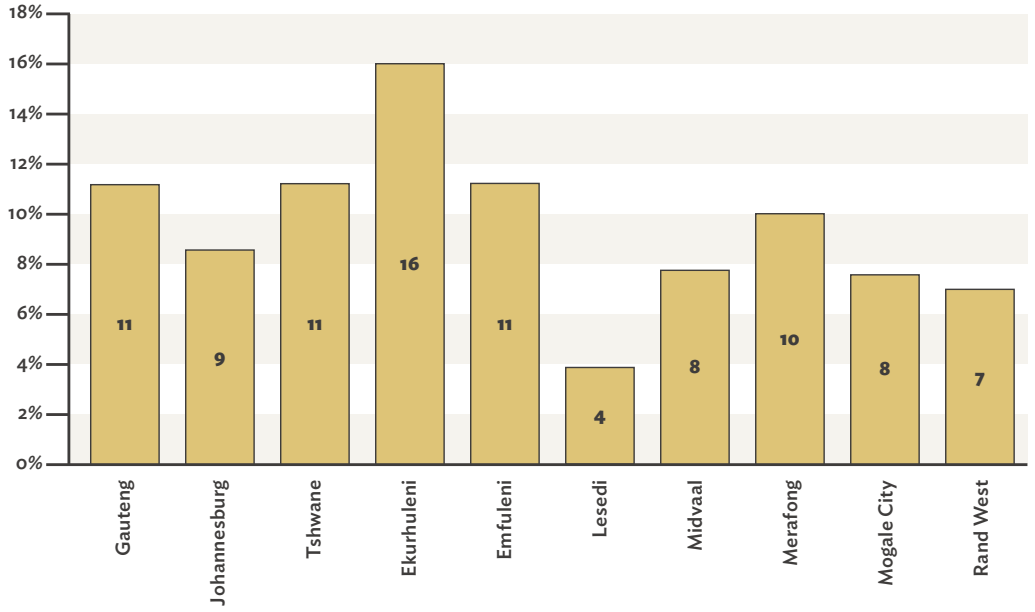


FIGURE 14: Proportion of respondents per municipality who were visited at their homes by a healthcare worker in the year preceding the interview

Data source: GCRO QoL IV, 2015/16



5.2 Reasons for failing to look for healthcare when needed

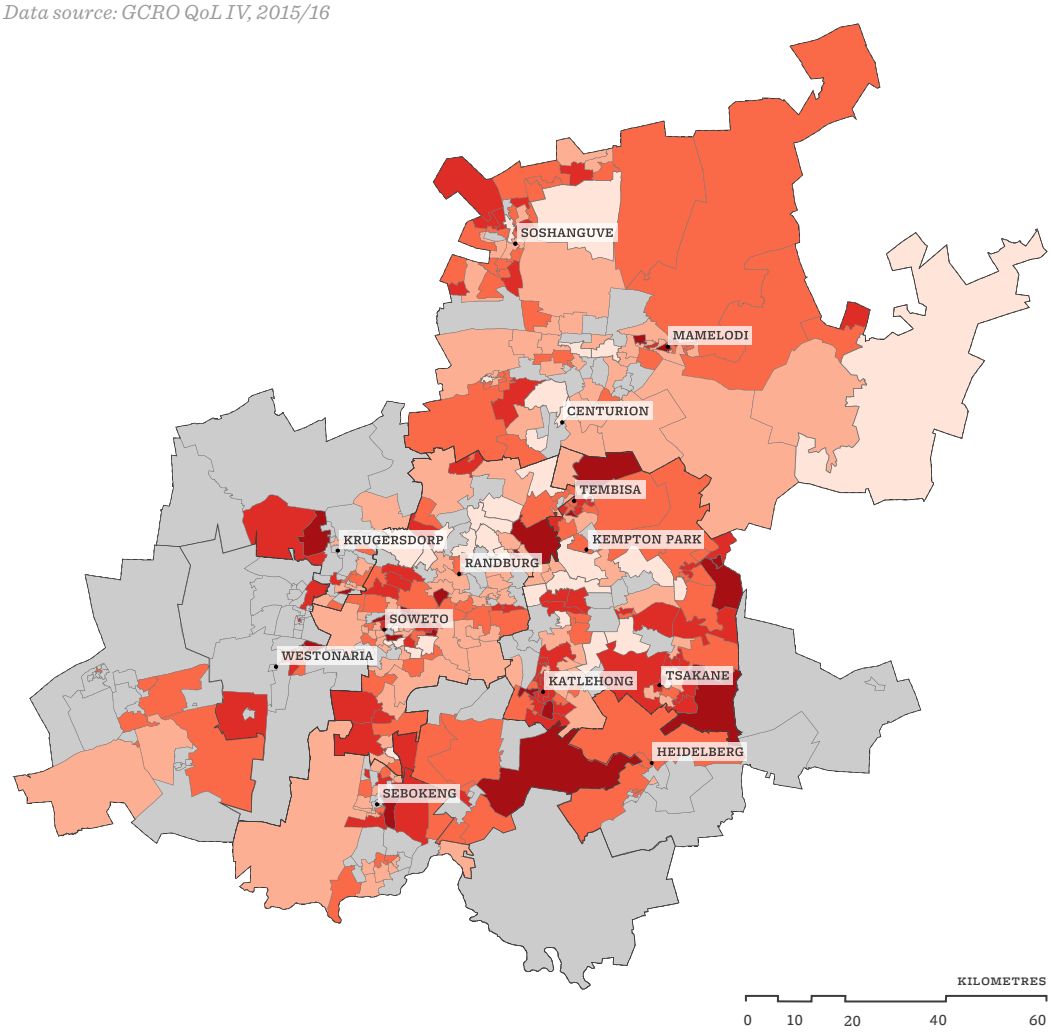
QoL IV respondents were asked whether, in the 12 months before the QoL interview, any member of their household had failed to look for healthcare when they needed it. 5% of all respondents indicated that a household member had failed to look for healthcare when they needed it. Respondents from poorer households were more likely than wealthier respondents to report a household member failing to look for healthcare. Indicatively, 6% of African respondents reported that a household member had failed to look for healthcare when needed compared to just 1% of white respondents. 6% of those from households with monthly incomes of R6 400 or less reported that a household member failed to look for healthcare, compared to just 2% from households with monthly incomes of R38 401 or more.

Figure 15 illustrates the ward-level variability in responses. While average levels were quite low, there are clusters of wards in which over 12% of respondents indicated that someone in their household had failed to look for healthcare when they needed it. These include areas around Mamelodi, Tembisa, Tsakane and Sebokeng, which are all township or informal settlement areas. In most wards in the West Rand health district as well as various wards in affluent parts of Johannesburg (around Randburg), Tshwane (around Centurion) and Ekurhuleni (around Kempton Park), no respondents reported failures to seek healthcare.

FIGURE 15: A household member failed to look for healthcare when needed, per ward

GCRO

Data source: GCRO QoL IV, 2015/16



A household member failed to look for healthcare when needed
(percentage per ward who said yes)

0.0 | 0.1 – 1.7 | 1.8 - 4.6 | 4.7 - 7.8 | 7.9 - 12.5

12.6 - 27.6 | Health Districts | Municipalities in Gauteng

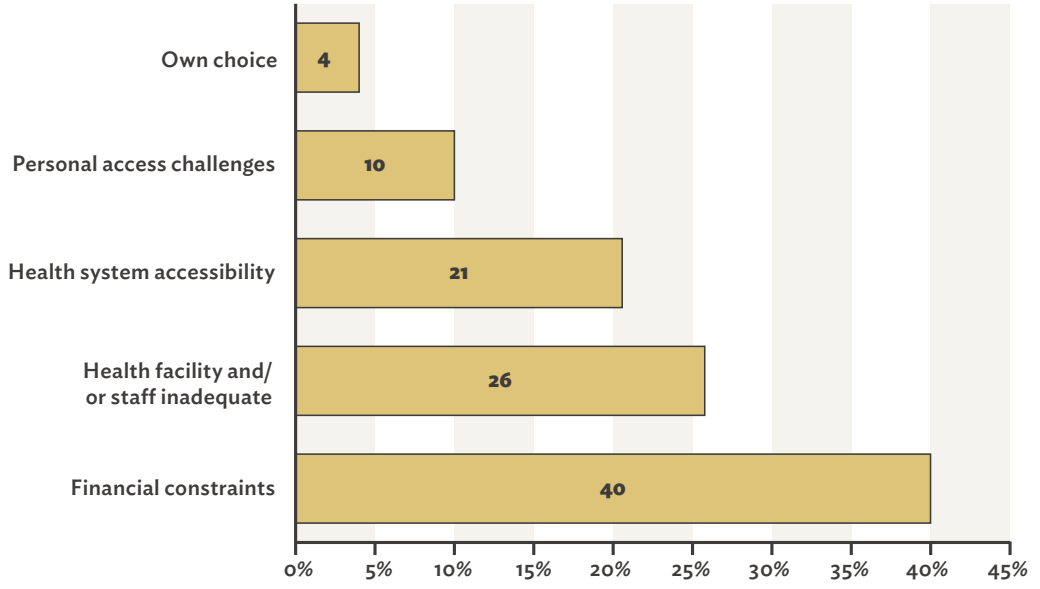
5.3 Reasons healthcare was not obtained

Where a respondent indicated that a household member had failed to look for healthcare, they were then asked why that individual did not obtain healthcare. Figure 16 shows the main reasons provided. Due to the large number of available response options, we aggregated responses into the following categories: 'Financial constraints' (No money, Not enough money for transport); 'Health facility and/or staff inadequate' (No drugs available at health facility, Drugs ineffective, Health workers attitudes are not good, Not enough privacy, Too little time with healthcare worker, or Healthcare facility could not do anything for patient); 'Health system accessibility' (Medical facility is too far, No ID document, Queue too long, Wait too long, or Patient turned away from health facility); 'Personal access challenges' (No time to seek medical care, Nobody could accompany the patient, Nobody to look after the children, or Too sick to travel to healthcare provider); and 'Own choice' (Illness not serious enough, or Thought they would get better by themselves).

40% of respondents indicated that the failure to obtain healthcare was due to financial constraints. A further 26% indicated that this was due to inadequacies of the health facility or staff. Inaccessibility of the health system (21%) was also a challenge.

FIGURE 16: The main reasons household members did not get the healthcare they needed

Data source: GCRO QoL IV, 2015/16



PHOTOGRAPH BY **RAW PIXEL**

6

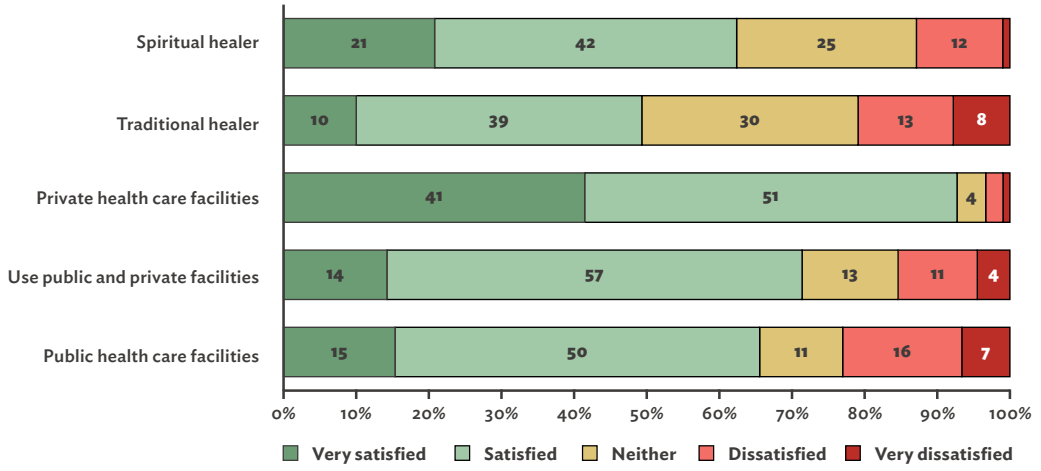
SATISFACTION WITH HEALTHCARE SERVICES

6.1 Satisfaction with healthcare facilities usually used

All respondents were asked to rate their satisfaction with the healthcare facilities that they usually used. Given the generally higher quality of private care, and the costs associated with its use, it is unsurprising that those using only private healthcare reported the highest levels of satisfaction (93%) (Figure 17). Individuals who used spiritual or traditional healers reported the lowest levels of satisfaction, and also the highest levels of feeling neither satisfied nor dissatisfied. Satisfaction with public healthcare (66%) was much lower than satisfaction with private healthcare. Conversely, 23% of respondents usually using public healthcare reported dissatisfaction, compared to only 3% of respondents usually using private services. This suggests substantial room for improvement in public healthcare facilities in Gauteng. This level of satisfaction is also much lower than the average level of satisfaction with public healthcare facilities (81%) reported across South Africa in the 2015 General Household Survey (Statistics South Africa, 2016).

FIGURE 17: Satisfaction with the healthcare facilities usually used

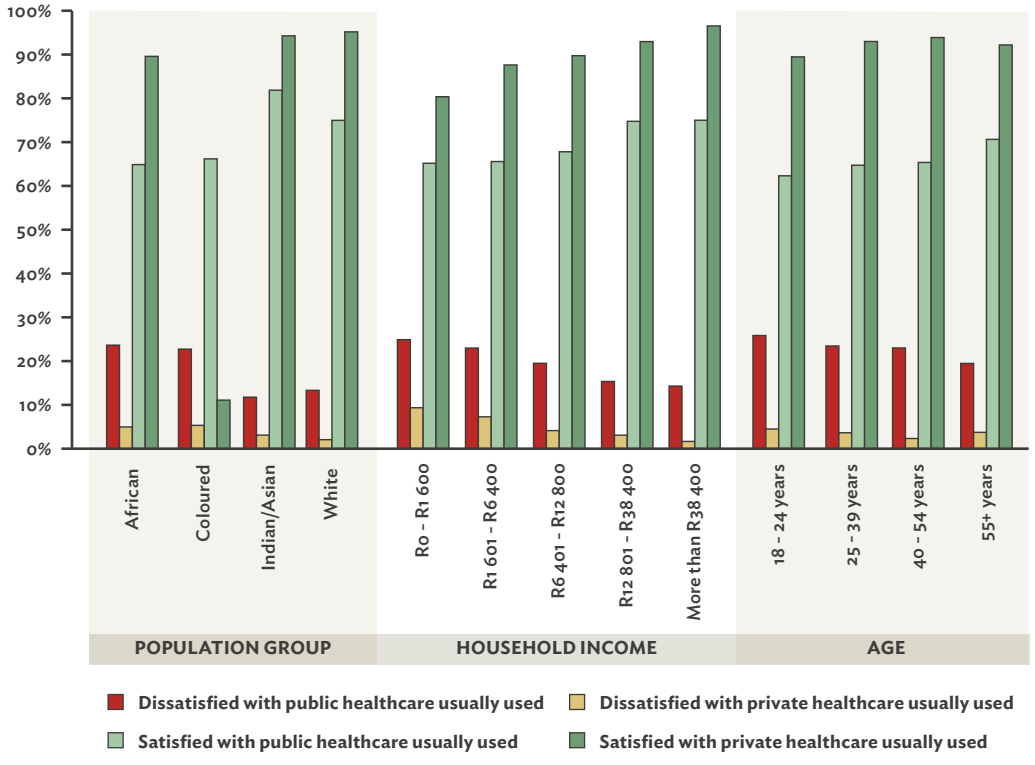
Data source: GCRO QoL IV, 2015/16



Although levels of satisfaction with healthcare services varied with a number of demographic variables (Figure 18), all groups reported greater satisfaction with private healthcare than with public healthcare. Similarly, dissatisfaction with public healthcare was higher than dissatisfaction with private healthcare across all groups. African and coloured respondents were most likely to express dissatisfaction with both public and private healthcare facilities, while Indian/Asian and white respondents were most likely to be satisfied with both public and private healthcare facilities. Similarly, individuals living in households with lower income levels were more likely to express dissatisfaction with public and private healthcare facilities, while those in more affluent households were less likely to do so. It is likely that these racial and socio-economic trends relate to the persistence of variation in the quality of healthcare services based on apartheid-era geography and segregation, and potentially also to inequitable treatment of different groups within facilities. Satisfaction did not vary by gender, as males and females were equally satisfied with both public healthcare (66%) and private healthcare (93%). There is a slight, but clear, trend of increased satisfaction with public healthcare services as age increases. Possible interpretations may include that public healthcare facilities struggle specifically to meet the needs of youth and working age individuals, or that there are generational shifts in terms of expectations of service provision.

FIGURE 18: Satisfaction with healthcare facilities usually used, by population, household income and age groups

Data source: GCRO QoL IV, 2015/16



Focussing explicitly on levels of dissatisfaction with public healthcare services, Figure 19 clearly illustrates lower dissatisfaction in urban centres (around Centurion, Bryanston, Kempton Park and Carletonville), and higher dissatisfaction in townships, informal settlements, and outlying areas (such as Soshanguve, Tembisa and Katlehong). There is very little variation in the level of dissatisfaction between different health districts as a whole. However, within health districts there appears to be substantial variation at the ward level – suggesting that much of the variation may be due to differences at the level of individual facilities. In Ekurhuleni, for example, while the majority of wards had less than 17% of respondents dissatisfied with public healthcare facilities, there were clear clusters of dissatisfaction around Tembisa, Kempton Park and Katlehong.

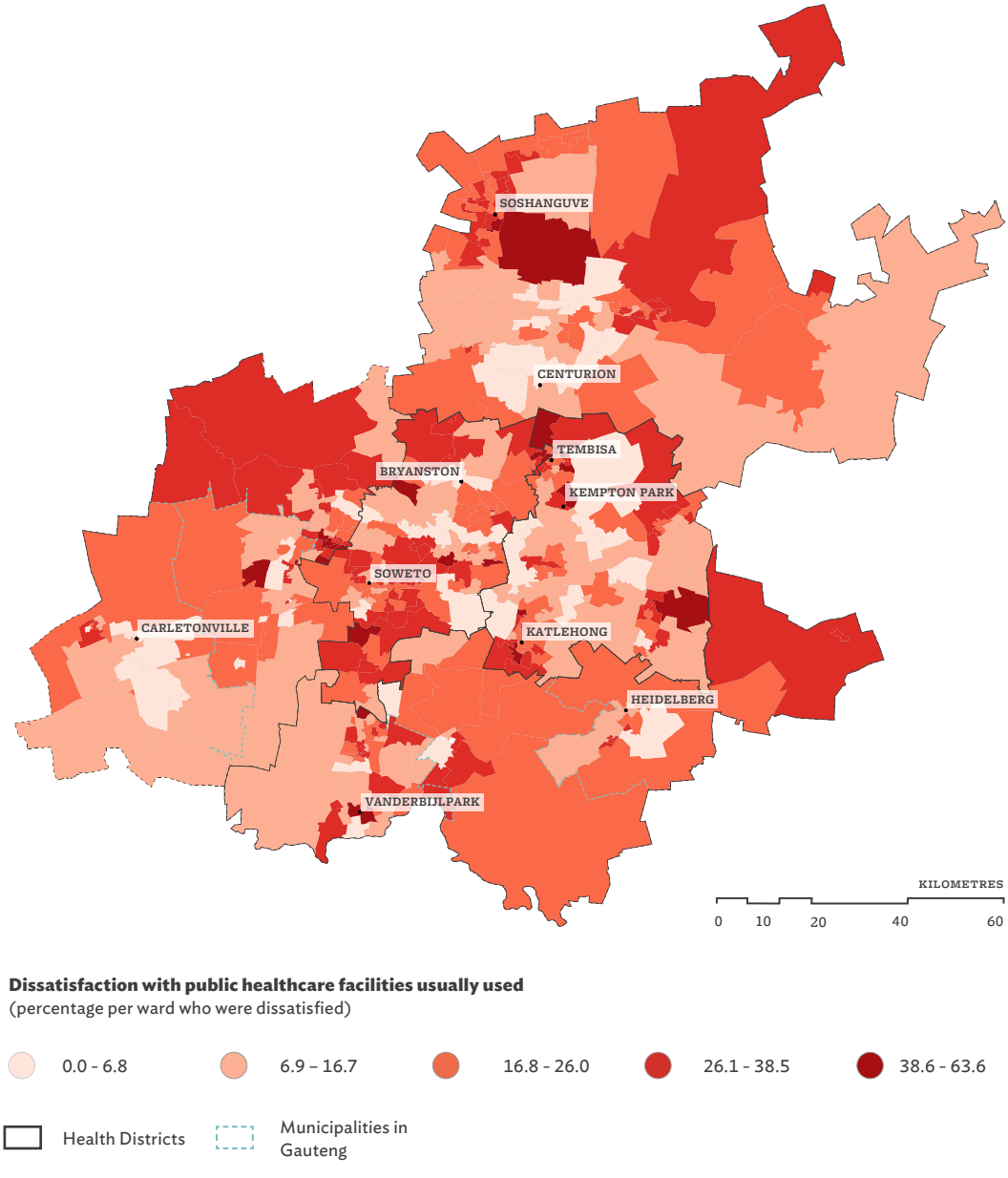
6.2 Assessment of recent interactions with the Department of Health

Of QoL IV (2015/16) respondents who had interacted with a government department in the three months before the QoL interview, 71% had interacted with a clinic, hospital, or other public healthcare facility. Of these respondents, 62% indicated that they were assisted in a reasonable amount of time, 76% indicated that they were treated with respect and dignity and 82% indicated that their needs were met at that time.

These results indicate that while respondents generally felt that they were appropriately treated by healthcare facilities, there was frustration with long waiting times.

FIGURE 19: Dissatisfaction with public healthcare facilities usually used

Data source: GCRO QoL IV, 2015/16



PHOTOGRAPH BY **NATE GRENO**

7

HEALTH AND WELL-BEING

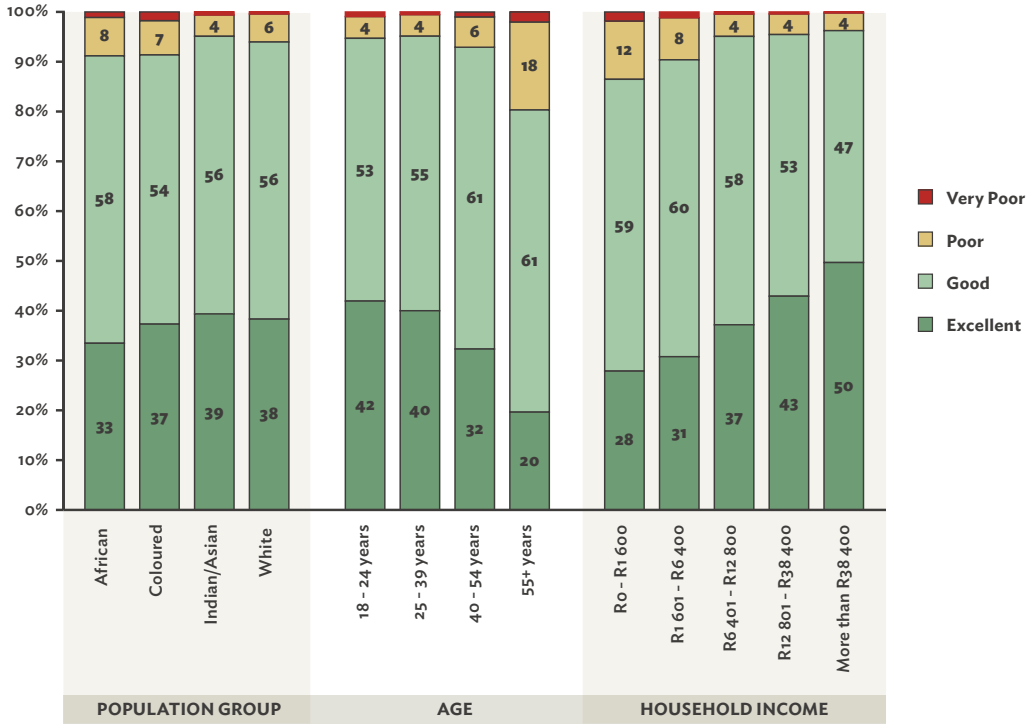
7.1 General health status

When asked to describe their health status during the four weeks before the interview, 35% of respondents described it as excellent, 57% as good, 7% as poor, and 1% as very poor. While self-reported health status did not vary much between population or gender groups, it did vary significantly by income and age (Figure 20). As might be anticipated, the proportion of individuals reporting excellent health in the past four weeks decreased with age, from 42% of respondents in the youngest category, to 20% of those aged 55 years or older. There is a clear trend towards poor or very poor health with increasing age, and a corresponding decrease in the percentage rating their health status as 'excellent' in the age categories 40 and up.

Figure 20 also shows a clear relationship between self-reported health status and household income levels, with those living in the poorest households most likely to report poor health status, and substantially less likely to report being in excellent health. As affluence rises, there were small decreases in proportions reporting poor or very poor health status, as well as a shift from good to excellent health status. The increase in the proportion of respondents reporting excellent health with rising household income was particularly striking (rising from 28% of the lowest income group to 50% of the highest income group).

FIGURE 20: Health status by population, age and household income groups

Data source: GCRO QoL IV, 2015/16



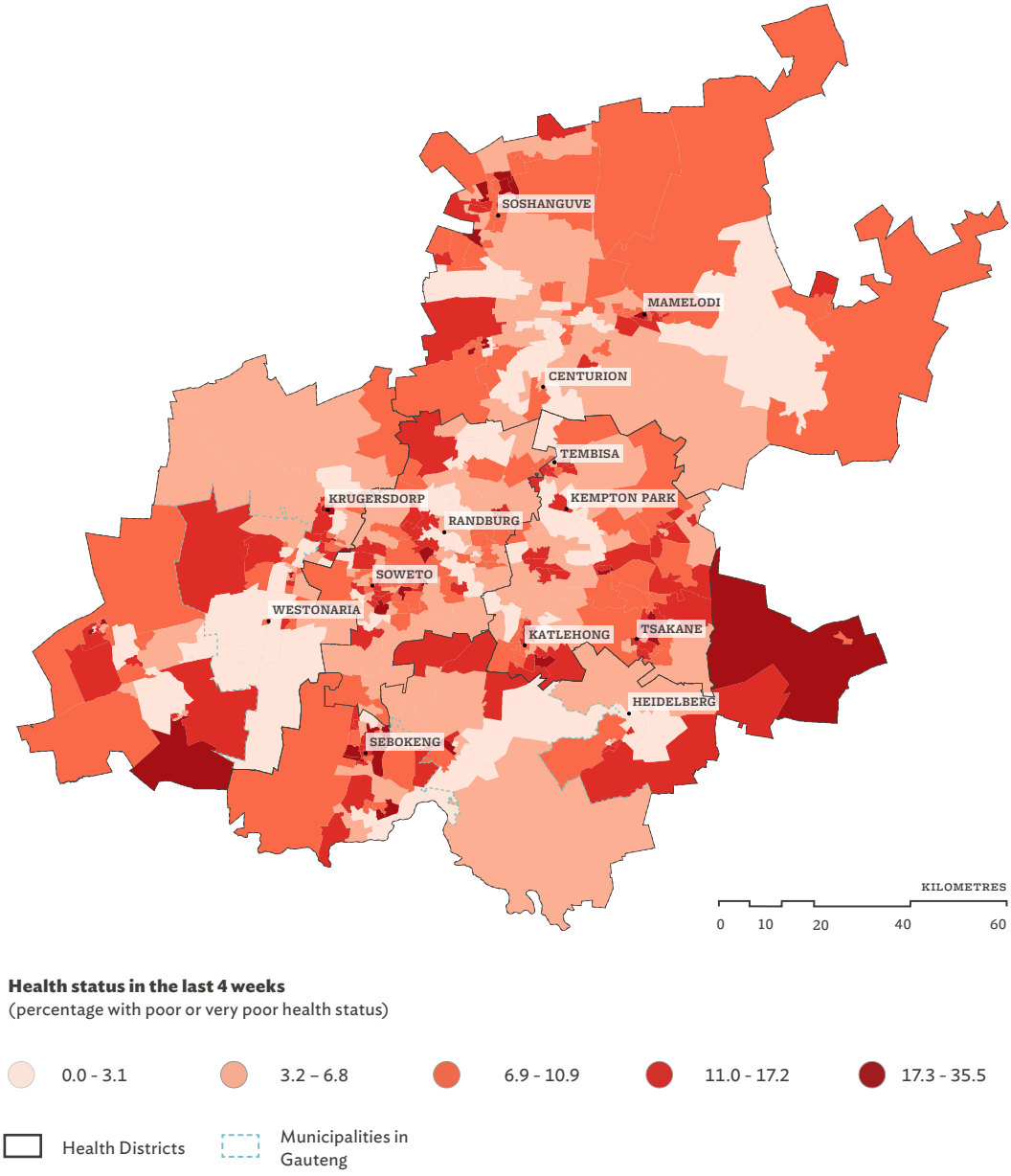
Health status also varied across wards (Figure 21). Wards where less than 3% of respondents reported poor or very poor health status in the four weeks preceding the interview were clustered in central Johannesburg (around Randburg), Tshwane (around Centurion) and Ekurhuleni (around Kempton Park), as well as Westonaria and Heidelberg. Wards where larger proportions of respondents reported poor or very poor health were on the periphery of the province and around some townships, like Soshanguve, Mamelodi, Tsakane and Sebokeng.

Respondents were asked about the frequency with which they exercised, and whether they had a disability. Some 24% of respondents indicated that they exercised every day, compared to 26% of respondents who never exercised. In general, the QoL IV data suggests a positive relationship between exercise and respondents' general health status. Indicatively, of those who said they exercised every day, 46% said that their health status in the four weeks prior to the interview had been excellent. By contrast, of those who never exercised only 31% said their health status in the previous month had been excellent.

When asked about disability, 6% of QoL IV respondents reported some form of disability. Of those reporting a disability, 42% reported a sight disability, 25% a physical disability, 16% a hearing disability, and 4% multiple disabilities.

FIGURE 21: Poor or very poor health status of respondents in Gauteng

Data source: GCRO QoL IV, 2015/16



7.2 Interference of health status with activities

Respondents were asked how often their health status had a negative influence on their daily work, and on their social activities (Table 4). While the large majority of respondents (50% or more) indicated that their health never interfered with their daily work or social activities, 29% of respondents reported that their health always or sometimes interfered with their daily work, and 27% of respondents reported interference with their social activities.

TABLE 4: The influence of health status on daily work and social activities

Data source: GCRO QoL IV, 2015/16

	Always	Some of the time	Hardly ever	Never
Health status prevents me from doing daily work	6%	23%	21%	50%
Health status prevents me from taking part in social activities	5%	22%	22%	52%

7.3 Self-reported distribution of health conditions across Gauteng

Respondents in the QoL IV (2015/16) survey were asked if they, or any other member of their household, had experienced any of a range of health conditions in the year preceding the interview. Self-reported health data is always limited, in that responses are not shaped only by disease levels, but also by household access to medical services, the respondent's knowledge of health conditions present in the household, and their comfort levels in disclosing this information. As we do not know the number of people in each household affected by the various conditions, we are also not able to estimate prevalence of conditions. Nonetheless, this data does provide some guidance around the distribution of various conditions across the province. As illustrated in Figure 22, hypertension, influenza or pneumonia, and diabetes were the most widely reported, followed by asthma, HIV/AIDS, and heart disease or stroke.

Geographically there were clear patterns in the extent to which households reported health conditions (Figure 23). In particular, a lower proportion of respondents in the metropolitan municipalities (Johannesburg, Tshwane and Ekurhuleni) reported experiencing hypertension, and to a lesser degree influenza/pneumonia or diabetes. Hypertension, for example, was reported almost twice as frequently in Sedibeng and West Rand than in the metropolitan municipalities. Similarly, influenza/pneumonia was reported almost two and a half times more frequently in the West Rand health district than in the metropolitan municipalities, such as Tshwane. Asthma, HIV/AIDS and to some extent diabetes showed much less variation across health districts in Gauteng.

FIGURE 22: Most frequently reported health problems in Gauteng

Data source: GCRO QoL IV, 2015/16

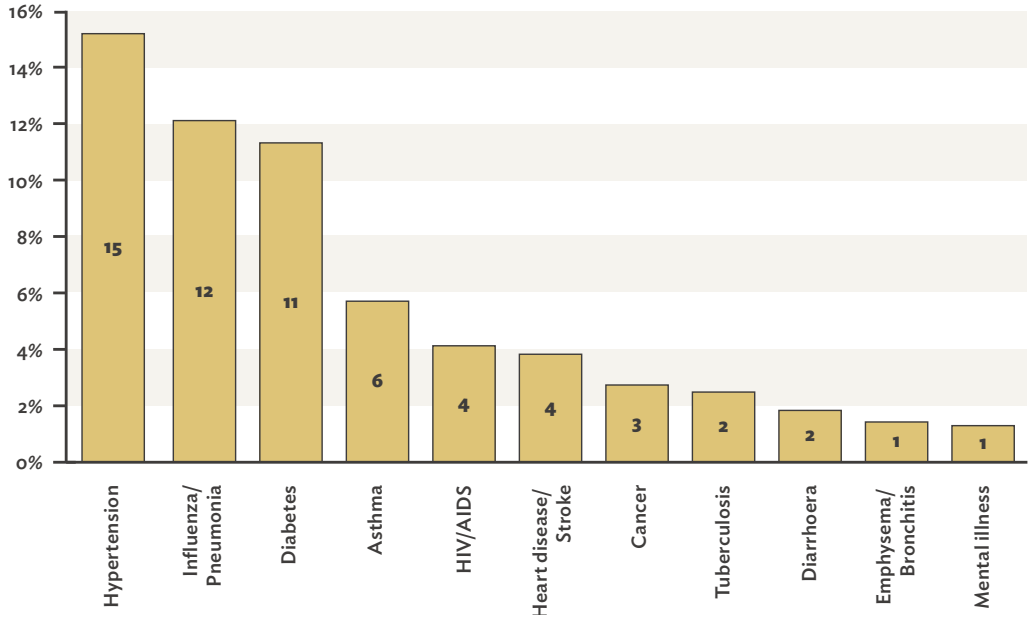
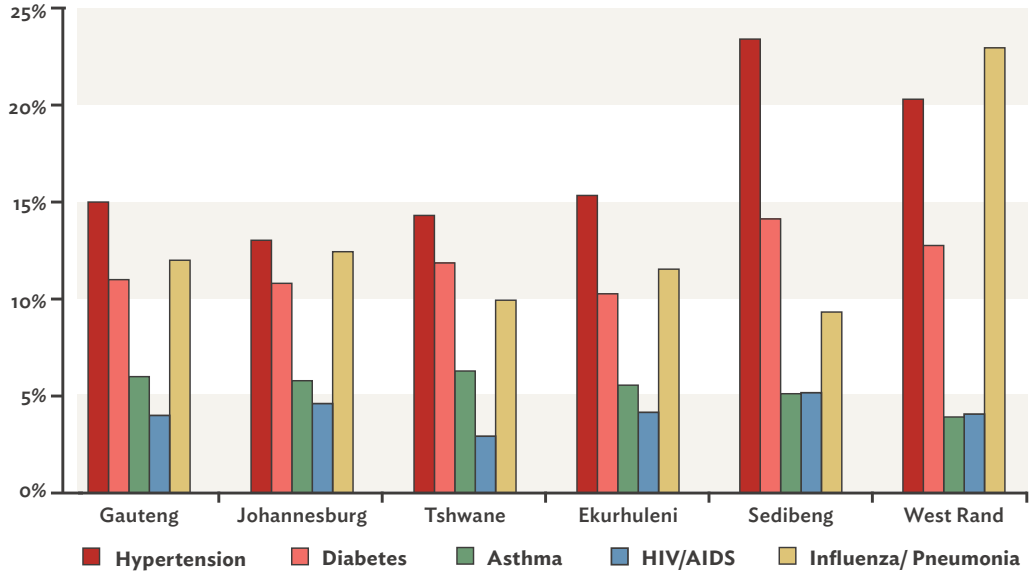


FIGURE 23: Five most frequently reported health problems in Gauteng, per health district

Data source: GCRO QoL IV, 2015/16



7.4 Subjective well-being

The QoL IV (2015/16) survey allows us to describe the subjective well-being of respondents using four questions from the Organisation for Economic Co-operation and Development (OECD) guidelines for measuring subjective well-being (OECD, 2013). Respondents were asked to rate their life as a whole, and indicate the extent to which they experienced feelings of happiness, worry and depression on the day before the interview (respondents were asked to score their feelings out of 10, with 0 indicating no such feelings and 10 indicating such feelings all the time). Responses are summarised in Table 5. When asked to what extent they felt that the things they did in their life were worthwhile, respondents gave a mean score of 7.82 out of 10. 62% of respondents gave a rating of 8 or higher. Similarly, the mean score for how happy respondents felt yesterday was 7.69, again with 62% of respondents scoring this at 8 or higher. These scores affirm that most respondents were in a positive state of subjective well-being.

When asked how worried they felt yesterday, respondents gave a mean score of 3.22, with 48% scoring this at 2 or lower. Similarly, the mean score for how depressed the respondent felt was 2.09, with 68% of respondents scoring this 2 or lower. These figures affirm a generally positive state of well-being, while suggesting that worry is more widely experienced than depression.

As outlined in the OECD guidelines on measuring subjective well-being, the question about happiness can be used to gauge 'positive affect', while the questions on worry and depression can be aggregated to gauge 'negative affect' (OECD, 2013). 24% of respondents scored a zero for negative affect, while only 1% scored a 10. 29% of respondents scored a 10 for positive affect, with 1% scoring zero.

TABLE 5: Descriptive statistics for subjective well-being

GCRO

Data source: GCRO QoL IV, 2015/16

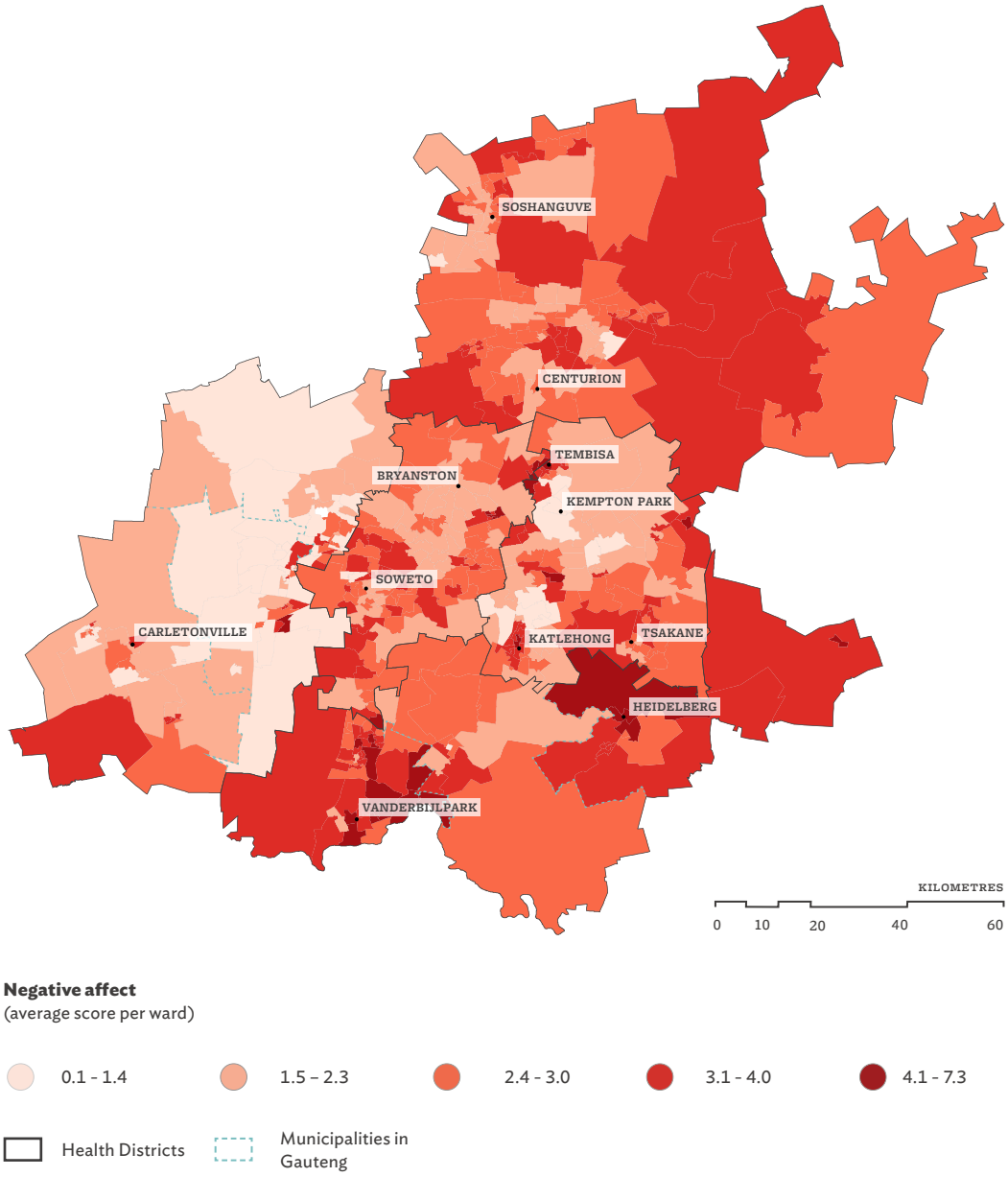
	Mean	Standard deviation
To what extent do you feel the things you do in your life are worthwhile?	7.82	2.02
Positive affect		
How happy did you feel yesterday?	7.69	2.28
Negative affect	2.65	2.58
How worried did you feel yesterday?	3.22	2.90
How depressed did you feel yesterday?	2.09	2.78

The average negative affect score per ward in Gauteng is mapped in Figure 24. Wards where the average negative affect score was higher than 4.1 were clustered around Tembisa, Heidelberg and Vanderbijlpark. Interestingly, central parts of Ekurhuleni (around Kempton Park) and many wards in the West Rand had the lowest average negative affect scores (less than 1.4). Although township areas tended to have higher average negative affect scores, some fairly wealthy areas (around Centurion) also showed relatively high average negative affect scores. Thus, on this measure, affluence seemed to have a slightly less significant effect on positive results than it had on positive results with regard to many other health measures.

FIGURE 24: Average negative affect score per ward in Gauteng

GCRO

Data source: GCRO QoL IV, 2015/16



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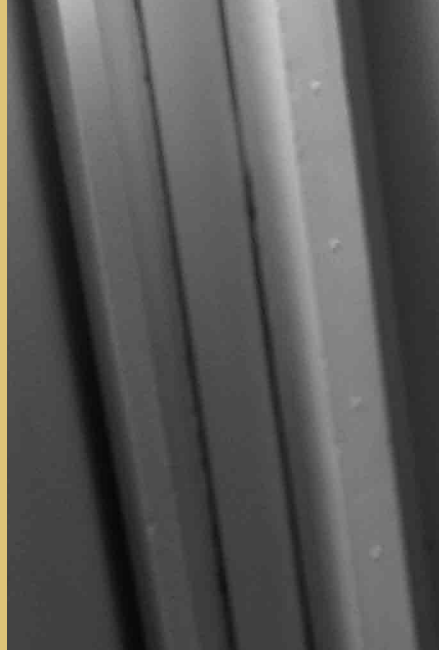

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