

Perceived health and other health indicators in South Africa

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Executive summary

The democratic government in the country has paid much attention to improving access to health care for all, and reducing inequity in access to health care. Objective assessment of the health status of individuals would necessitate medical examination. In the absence of this examination, perceived health status provides a good indication of health status.

This report examines how the health status of various sectors of the South African population was perceived in 1999. It includes a special focus on women and children, and on household living conditions in relation to perceived health status. It also focuses on indicators of quality of life, and the use of health services.

It uses data from the October household survey (OHS) of 1999 in which information was gathered on approximately 107 000 people living in 30 000 probability-sampled households. The data was then weighted to reflect estimates of the population size in 1999, based on the population census of October 1996, as adjusted by a post-enumeration survey (PES). Key concepts and definitions used in this summary and elsewhere in the report are provided in the introductory section of the report.

Respondents in the 1999 OHS were asked to describe the health status of household members in terms of five categories: excellent, good, average, poor and very poor. It is important to note that this was one person reporting on what they perceived the health status of all other members of the household to be. The question on perceived health status is an internationally accepted indicator of possible health.

Findings regarding perceived health status and individual life circumstances

This report examines the perceived health status of individuals and links it to individual circumstances such as gender, age, population group, place of residence and employment status. In addition, it looks at the perceived health status of women of childbearing age and children.

Population

- Over half of the population (51,3%) was perceived as being in excellent health and 36,1% in good health, while 12,0% had their health described as average, poor or very poor (grouped as poor for reporting purposes). There were some differences in the perceived health status of women and men, and of individuals according to place of residence, namely, (1) proportionately more men (53,7%) than women (50,1%) were perceived as being in excellent health; and (2) the health status of individuals residing in urban areas was perceived as being better than that of individuals in non-urban areas.
- The health status of individuals aged 15-65 was perceived as worse than that of children aged 0-14 years. However, the health status of this group aged 15-65 was perceived to be far better than that of individuals aged 66 years and above.
- In comparison to other population groups, white people were perceived as having a better health status than the other groups.

- Among people aged 20 years and older, those with matric or more as their highest level of education were reported as having a better health status than those with less education.
- The health status of individuals that were not economically active was perceived as being worse than that of employed or unemployed individuals. However, there was very little difference in the perceived health status of the employed and the unemployed, using either the official or the expanded definition of unemployment.
- Comparatively, a large percentage of professionals (62,5%) and managers (59,7%) were reported to be in excellent health.
- Compared to other industries, a large percentage of employed people in the finance (59,5%) and utility (59,4%) sectors were perceived as having excellent health. On the other hand, people working in agriculture (14,8%) and those in private households (15,7%) had the highest proportion perceived as having a poor health status.

Women of childbearing age

- Of the women aged 14-49 who gave birth in the twelve months prior to the interview, 76,4% did so in hospitals, 13,3% in clinics and 10,3% elsewhere. Proportionately more of the women who gave birth in hospitals were perceived as being in excellent health than of those who gave birth elsewhere.
- A substantial proportion (13,8%) of women aged 14-19 gave birth in the twelve months prior to the interview.

Children

Teenagers (13-17 years) and pre-teenagers (7-12 years) were perceived as having a better health status than younger children (0-6 years).

Findings regarding perceived health status and living conditions

The findings below are based on perceived health status in relation to people's living conditions, such as type of dwelling, overcrowding in households, and households' access to water, sanitation facilities and refuse removal.

Housing

The reported health status of people living in formal dwellings was found to be slightly better than that of people living in traditional dwellings. The health status of people living in informal dwellings was perceived as being worse than that of individuals in both formal and traditional dwellings.

Overcrowding

- Overall, 52,0% of people living in households that were not overcrowded were perceived as having excellent health, while this percentage was slightly lower (47,7%) among those living in overcrowded households.
- A higher proportion of people living in overcrowded households (18,6%) were described as having poor health status than those living in households that were not overcrowded (11,8%).

Water

There was very little difference in the perceived health status of individuals according to type of water source. However, individuals whose households used boreholes or rainwater tanks were perceived as having slightly better health than those in households using taps or other sources of water.

Sanitation

The highest proportion of individuals whose perceived health status was described as poor was among those whose households used bucket latrines (14,5%), followed by those whose households had no latrines or used places such as a river, stream or bush (13,9%).

Refuse removal

Method of refuse removal had very little bearing on perceived health status.

Findings on health care

The report examined individuals' access and use of health care facilities, choice of health workers when ill or injured and access to medical aid or health insurance.

Medical aid and health insurance

Only 18,5% of the population aged 20 and above was reported to have access to medical benefits. Access to medical benefits was more common among white people than among other population groups. Among whites, over two-thirds of the population were reported to have access to medical benefits. The health status of individuals with medical benefits was perceived as better than of those without access to medical aid.

Health care services

- Overall, 62,7% of South African households had a clinic within 2km while 37,3% of the households had a clinic further than 2km from the dwelling in which they lived. Over three-quarters of households in urban areas had a clinic within 2km. For non-urban households, the proportion with a clinic within 2km was considerably lower (42,5%).
- Overall, 11,0% of the total population had consulted a health worker in the month prior to the interview. Disaggregating by age, 26,6% of the population aged 66 years or older, 11,7% of those aged between 15 and 65, and 7,8% of those aged 14 years or younger were reported to have consulted a health worker in the month prior to the interview of 1999. In addition, proportionately more women than men consulted a health worker in the month prior to the survey. People who did not visit a health worker were perceived to be in better health than those who visited a health worker.

Private versus public health care facilities

- One in every five people (20,7%) who visited a health worker in the month before the survey went to a public hospital, while 29,8% visited a public health clinic and 38,5% went to a private doctor, specialist or pharmacist.
- Although the difference in the proportion of men and women who went to private versus public health services was small, there were more significant differences when comparing population groups.

- Proportionately more people who went to a private sector health facility were perceived as having better health status than those who went to a public sector health facility.

Immunisation

Road to Health immunisation or clinic cards are used by the health system to record inoculations and other health details. The overwhelming majority of babies under 24 months in the country were reported to have Road to Health cards. This was the case in both urban and non-urban areas.

Findings on quality of life

Findings on the quality of life are based on whether respondents felt that their life had improved, remained the same or become worse compared to their life twelve months before the survey. Findings are also based on information on psychological, cultural and economic crisis events experienced by households; disability; and nutrition.

Perceived quality of life

- In October 1999, in 32,6% of households, respondents felt that life had got worse in the past year and in 19,4% of households, individuals felt that life had improved in the past year, while in 48,0% of households, respondents felt that life had remained the same. For respondents living in urban households, life had got relatively better than for those living in non-urban households. Compared to households headed by other population groups, proportionately more respondents in households headed by Africans perceived their quality of life to have got worse.
- Individuals living in households in which respondents felt that life remained the same were described as having relatively better health than those in households in which life got worse in the past year and relatively worse health than those living in households in which respondents felt that life had improved in the past year.

Crisis events within the household

With regard to traumatic events that occurred in the household in the year preceding the survey, the most commonly reported crisis was death or illness in the household (8,6%), followed by serious injury (7,8%), loss of a regular job (6,7%), and theft, fire or destruction of household property (5,7%). Individuals in households in which members experienced none of the traumatic events were perceived to be in better health than those in households in which members experienced at least one traumatic event.

Disability

Of the estimated 43,3 million people in South Africa in October 1999, 1,5 million had disabilities. Among those with disabilities, 49,9% were male. Coloured people had proportionately higher levels of reported disabilities (4,5%). The most common form of disability was that of movement (30,4%), followed by eye defects (24,5%) and inability to stand for a long time (22,7%). The least common form of disability was that associated with communicating (13,0%). The survey also found that the perceived health status of people with disabilities tended to be worse than that of people without disabilities.

Nutrition

- In over a quarter (26,5%) of the households with children aged below seven years, it was reported that children under seven years went hungry at some stage in the year before the interview because there was not enough money to buy food.

- The proportion of households in which at least one person of any age went hungry in the year before the interview was the highest among households headed by Africans (29,7%) and lowest among households headed by white people (2,9%).
- People in households in which no one went hungry in the year preceding the survey had better perceived health status than those in households where at least one person went
- Individuals in households which spent the highest amount of money per month on food were reported to have better health status than members in households which spent less.

Summary

The report reveals that there are still disparities between rural and urban areas, men and women, population groups, different age cohorts and those with and without disabilities in terms of perceived health status. In addition, there appears to be a link between perceived health status and subjective assessment of the household's quality of life. The linkages observed do not necessarily establish causation in a particular direction.

Section 1

Introduction

The South African government is committed to a better life for all. As part of its investment in the future of the country, it aims to ensure that all South Africans have access to affordable, good quality health care. It has been working on improving access to health care for all, and reducing inequity in access to health care. This report looks at how the health status of various sectors of the South African population was perceived by fellow household members in 1999 in relation to life circumstances. The following are considered:

- the perceived health status of the South African population, with a special focus on women and children;
- household living conditions as a differential of perceived health status; and
- inhibitors and enablers of health status, for example, indicators of the quality of life, and the use of health services.

The report uses data from the October household survey (OHS) of 1999, which was an annual survey, based on a probability sample of 30 000 households.

Respondents in the 1999 OHS were asked to describe the health status of household members in terms of five categories: excellent, good, average, poor and very poor. It is important to note that this was one person reporting on what they perceived the health status of all other members of the household to be. A question on perceived health status is an internationally accepted indicator of possible health.

1.1 Methodology

Sample design for the 1999 OHS

The database of enumeration areas (EAs), established during the demarcation phase of Census '96 and finalised after the enumeration phase, constituted the sampling frame for OHS 1999. The sampling procedure involved explicit stratification by province and within each province by urban and non-urban area. Independent samples of primary sampling units (PSUs) were drawn for each explicit stratum. A disproportionately large number of PSUs were allocated to the smaller provinces.

Altogether, 3000 EAs were drawn in 1999, by means of probability proportional to size principles in each stratum. The measure of size was the number of households in each EA. Ten households were then drawn systematically in each of these 3 000 EAs.

This means that 3 000 EAs were identified as primary sampling units, and 30 000 households were visited as ultimate sampling units.

Weighting the 1999 OHS

The 1999 OHS was weighted to reflect estimates of the population size in October 1999, based on the population census of October 1996, as adjusted by a post-enumeration survey (PES). The weights made use of post-stratification by province, gender and five-year-interval age groups.

Definition of terms

Perceived health status is based on how respondents described the health status of household members in terms of five categories: excellent, good, average, poor and very poor. Average health status as a category offers little useful information, especially in relation to excellent health status (which could include people with no health problems) and good health status category (which could include people who have some problems). For the purpose of this report, therefore, the average, poor and very poor categories are grouped to form one category called “poor health status”.

Medical benefits include coverage by medical aid, medical schemes or any private health insurance.

Overcrowding is assessed using the number of household members per room. Overcrowded households are those with three or more people per room.

Quality of life in this report refers to human welfare in terms of what it means to have a meaningful or good life. It incorporates psychological, social, cultural and political aspects. The following measures of human well-being are used in the report as indicators of quality of life: perceived quality of life; and crisis events within households, namely the death of a household member; serious illness or injury; loss of a regular job by a household member; theft, fire or destruction of property; failure or bankruptcy of a family business; cut-off or decrease of remittances; cut-off or decrease of a government grant which was not the result of the death of the beneficiary; and abandonment or divorce. Disability, nutrition and household expenditure on food are also considered.

Children refers to individuals below 18 years of age. This is because South Africa's constitution and the United Nations Convention on the Rights of the Child (UN, 1989; RSA, 1996) define a child as someone who is under 18 years of age. In addition, 18 is also the age at which South African citizens become eligible to vote in national, provincial and local government elections.

Disability refers to conditions which limit individuals in their daily activities at home, at work or at school because of a long-term physical or mental condition lasting six months or more. Disability refers to difficulties seeing even with glasses, if worn; hearing even with a hearing aid, if used; communicating, moving, standing, grasping or learning; and difficulties associated with psychological well-being. It is important to note that disabilities were self-reported.

A *household* consists of a single person or a group of people who live together for at least four nights a week, who eat together and who share resources.

Population group describes the racial classification of a particular group of South African citizens. The previous government used legislation to impose this type of classification, to divide the South African population into distinct groupings on which to base apartheid policies. Stats SA continues to use these classifications wherever possible, as they reveal the effects of past discrimination, and permit monitoring of policies to alleviate discrimination. In the past, population group was based on a legal definition. For Stats SA surveys, it is based on self-perception and self-classification.

An *African/black* person is someone who classified him/herself as such. The same applies to a *coloured, Indian/Asian or white* person.

It should be noted that the sample consisted of 83 761 African, 12 205 coloured, 8 275 white and 2 254 Indian people. Because of the small Indian population, analysis related to this population group in this report should be treated with some caution.

The *employed* are those who performed work for pay, profit or family gain in the seven days prior to the household survey interview, or who were absent from work during these seven days, but had some form of paid work to which they would return.

The *unemployed* are those people within the economically active population who (a) did not work during the seven days prior to the interview, (b) wanted to work and were available to start work within a week of the interview, and (c) had taken active steps to look for work or to start some form of self-employment in the four weeks prior to the interview.

The definition of expanded unemployment includes criteria (a) and (b) but excludes criterion (c).

All other respondents within the working age population (15-65 years) are classified as *not economically active*.

An *enumeration area* can be found in either an urban or non-urban *milieu*. The distinction is as follows:

- An *urban* area is one that was previously legally proclaimed by the apartheid government as being urban. This included towns, cities and metropolitan areas.
- All other areas were classified as *non-urban*, including informal settlements adjoining urban areas, commercial farms, small settlements, rural villages and other areas which are further away from towns and cities.

Dealing with unspecified responses

In this report, non-responses are excluded in calculating percentages unless otherwise stated.

1.2 The people of South Africa in October 1999

Table 1.1 indicates the estimated number and percentage of individuals with certain selected background characteristics, which will be used later in the report in relation to perceived health status. The distribution is provided for males, females and the total South African population. The totals sometimes differ, because of non-response in respect of a particular characteristic.

Table 1.1: Distribution of individuals by background characteristics and gender, October 1999

Background characteristics	Male		Female		Total	
	N ('000)	%	N ('000)	%	N ('000)	%
Milieu						
Urban	11 504	54,9	11 835	52,9	23 339	53,9
Non-urban	9 444	45,1	10 520	47,1	19 964	46,1
Total	20 948	100,0	22 355	100,0	43 303	100,0
Province						
Western Cape	2 048	9,8	2 116	9,5	4 163	9,6
Eastern Cape	3 144	15,0	3 625	16,2	6 769	15,6
Northern Cape	439	2,1	450	2,0	889	2,1
Free State	1 394	6,7	1 419	6,3	2 813	6,5
KwaZulu-Natal	4 247	20,3	4 750	21,2	8 997	20,8
North West	1 775	8,5	1 815	8,1	3 590	8,3
Gauteng	3 990	19,0	3 783	16,9	7 774	18,0
Mpumalanga	1 466	7,0	1 532	6,9	2 998	6,9
Limpopo	2 445	11,7	2 864	12,8	5 310	12,3
Total	20 948	100,0	22 355	100,0	43 303	100,0
Population group						
African	16 261	77,7	17 447	78,2	33 708	78,0
Coloured	1 872	9,0	1 988	8,9	3 860	8,9
Indian	547	2,6	566	2,5	1 112	2,6
White	2 235	10,7	2 322	10,4	4 557	10,5
Total	20 915	100,0	22 323	100,0	43 238	100,0
Age						
0-14	7 541	36,1	7 487	33,5	15 028	34,8
15-65	12 607	60,3	13 656	61,2	26 263	60,8
66 and over	757	3,6	1 174	5,3	1 932	4,5
Total	20 906	100,0	22 317	100,0	43 223	100,0
Education (among those aged 15 years or more)						
No formal education	1 177	9,0	1 768	12,1	2 945	10,6
Less than grade 7	2 566	19,6	2 670	18,2	5 236	18,9
Less than matric	5 979	45,6	6 703	45,8	12 682	45,7
Matric and above	3 382	25,8	3 504	23,9	6 885	24,8
Total	13 104	100,0	14 645	100,0	27 749	100,0
Official employment status (among those aged 15-65 years)						
Employed	6 009	47,7	4 353	31,9	10 362	39,5
Unemployed	1 480	11,7	1 677	12,3	3 157	12,0
Not economically active	5 119	40,6	7 626	55,8	12 744	48,5
Total	12 607	100,0	13 656	100,0	26 263	100,0
Expanded employment status (among those aged 15-65 years)						
Employed	6 009	47,7	4 353	31,9	10 362	39,5
Unemployed	2 573	20,4	3 307	24,2	5 880	22,4
Not economically active	4 026	31,9	5 996	43,9	10 022	38,2
Total	12 607	100,0	13 656	100,0	26 263	100,0

Excluding unspecified categories and item non-responses

Table 1.1 indicates the following:

- In October 1999, there were an estimated 43,3 million people, of whom about 20,9 million were male and about 22,4 million were female. In addition, there were slightly more people in urban than rural areas, with 53,9% of the total population found in urban areas. There were proportionately more women (47,1%) than men (45,1%) in

non-urban areas and proportionately more men (54,9%) than women (52,9%) in urban areas.

- Overall, 78,8% of the population was estimated to be African/black, 10,5% white, 8,9% coloured and 2,6% Indian. Among all population groups, as was the case in the population as a whole, women slightly out-numbered men.
- The province with the largest percentage of the country's population was KwaZulu-Natal (20,8%) followed by Gauteng (18,0%) and the Eastern Cape (15,6%). Gauteng was the only province where men outnumbered women.
- In terms of the age composition of the population, there were proportionately more young people (0-14 years; 34,8%) than those in the older age group (66 and above; 4,5%); and 60,8% of the total population was in the middle age group (15-65 years). This indicates a youthful population.
- In terms of educational attainment, only 24,8% of the population aged 15 and above had completed matric or higher levels of education. Proportionately more men than women had completed matric or attained a level of education higher than matric.
- There were about 26,3 million people aged 15-65 years (the working age population). Of these, using the official definition of unemployment, 48,5% were not economically active, while 12,0% were unemployed (and had looked for work in the four weeks prior to the interview), and 39,5% was employed.

1.3 Households of South Africa in October 1999

Table 1.2 provides a distribution of households in urban and non-urban areas by selected household characteristics. These are important, as the living conditions in households can be expected to influence the health status of the individuals occupying them. The total number of households differs for each variable reported, since non-responses are excluded.

Table 1.2: Distribution of households by household characteristics and milieu

Household characteristics	Urban		Non-urban		Total	
	N	%	N	%	N	%
Type of dwelling						
Formal	5 172 217	79,8	2 820 422	66,4	7 992 639	74,5
Informal	1 074 186	16,6	254 855	6,0	1 329 041	12,4
Traditional	62 199	1,0	1 111 262	26,2	1 173 461	10,9
Other/caravan/tent	171 275	2,6	61 579	1,4	232 854	2,2
Main cooking fuel						
Electricity/solar	4 746 664	73,4	930 098	22,3	5 676 761	53,3
Paraffin/gas	1 456 494	22,5	1 086 726	26,0	2 543 221	23,9
Wood/coal	255 806	4,0	2 136 464	51,1	2 392 269	22,5
Other	6 575	0,1	24 376	0,6	30 951	0,3
Total	6 465 540	100,0	4 177 663	100,0	10 643 203	100,0
Water source						
In dwelling, on site or public tap	6 378 916	98,6	2 667 431	71,9	9 046 348	88,9
Borehole/rainwater tank	14 413	0,2	392 220	10,6	406 633	4,0
Other	76 902	1,2	650 018	17,5	726 921	7,1
Total	6 470 231	100,0	3 709 670	100,0	10 179 902	100,0

Household characteristics	Urban		Non -urban		Total	
	N	%	N	%	N	%
Distance to water source (when water source was not in the dwelling or in the yard)						
Less than 200m	581 916	81,9	1 352 775	48,7	1 934 691	55,5
200m or more and less than 1 km	112 545	15,8	1 015 773	36,6	1 128 317	32,4
1 km or more	16 238	2,3	406 556	14,7	422 794	12,1
Total	710 699	100,0	2 775 103	100,0	3 485 802	100,0
Toilet facility						
Flush/chemical	5 331 026	82,3	650 130	15,3	5 981 156	55,7
Pit latrine	681 638	10,5	2 576 778	60,6	3 258 416	30,4
Bucket	318 855	4,9	25 673	0,6	344 528	3,2
Other/none	145 848	2,3	999 326	23,5	1 145 174	10,7
Total	6 477 367	100,0	4 251 906	100,0	10 729 274	100,0
Refuse removal						
Formal (by community or local authority)	5 701 508	88,3	338 289	8,0	6 039 797	56,5
Non-formal (own or communal dump)	546 319	8,5	3 300 940	77,9	3 847 259	36,0
None or other	209 441	3,2	600 851	14,2	810 293	7,6
Total	6 457 268	100,0	4 240 081	100,0	10 697 348	100,0

Excluding unspecified categories and item non-response

Table 1.2 indicates that:

- In October 1999, there were an estimated 10,8 million households, of which 6,5 million were found in urban areas and 4,2 million in non-urban areas.
- In both locations, a large percentage (74,5%) of households lived in formal dwellings. However, proportionately more households in urban (79,8%) than non-urban (66,4%) areas occupied formal dwellings. In non-urban areas, more than a quarter of all households (26,2%) occupied traditional dwellings, whereas this proportion of households was small (1,0%) in urban areas.
- In urban areas, 73,4% of households used electricity or solar energy for cooking, while the proportion of households in non-urban areas using electricity for cooking (22,3%) was relatively small. Instead, most non-urban households (51,1%) used wood for cooking.
- Almost all households in urban areas (98,6%) had access to safe water (that is, piped water inside the dwelling or in the yard, communal taps or public water tankers). The proportion that had access to safe water was relatively high in non-urban areas (71,9%), although lower than that in urban areas (98,6%). Of households where water had to be fetched from a source other than the dwelling or the yard, for the majority of households in urban areas (81,9%) the source was less than 200 metres from the dwelling, whereas in non-urban areas only 48,7% of such households had the source less than 200 metres from dwelling.
- Slightly over half of the households (55,7%) used flush or chemical toilets. However, there was a large difference between urban and non-urban households in that 82,3% of urban households used flush or chemical toilets, compared to the 15,3% in non-urban areas. The most commonly used form of sanitation facility among non-urban households was a pit latrine (60,6%). As many as 23,5% of non-urban households used places other than a flush or chemical toilet, a bucket toilet or a pit latrine.

- Although 56,5% of households had their refuse removed by the community or local authority, 7,6% of households had no systematic form of refuse disposal.

1.4 Outline of the rest of the report

The next section (Section 2) of this report contains an analysis of perceived health status and individual circumstances such as gender, age, population group, place of residence and employment status. The section focuses on the health status of the whole population, women of childbearing age and children. The third section (Section 3) looks at subjective health status in relation to people's living conditions such as type of dwelling, overcrowding in households and households' access to amenities such as water, sanitation facilities and refuse removal. Section 4 focuses on health care. The section looks at, among others, individuals' access to and use of health care facilities, choice of health worker when requiring health care, and access to medical aid or insurance. Section 5 discusses indicators of quality of life and links these to perceived health status. It considers indicators such as perceived quality of life, crisis events experienced by households, disability and nutrition.

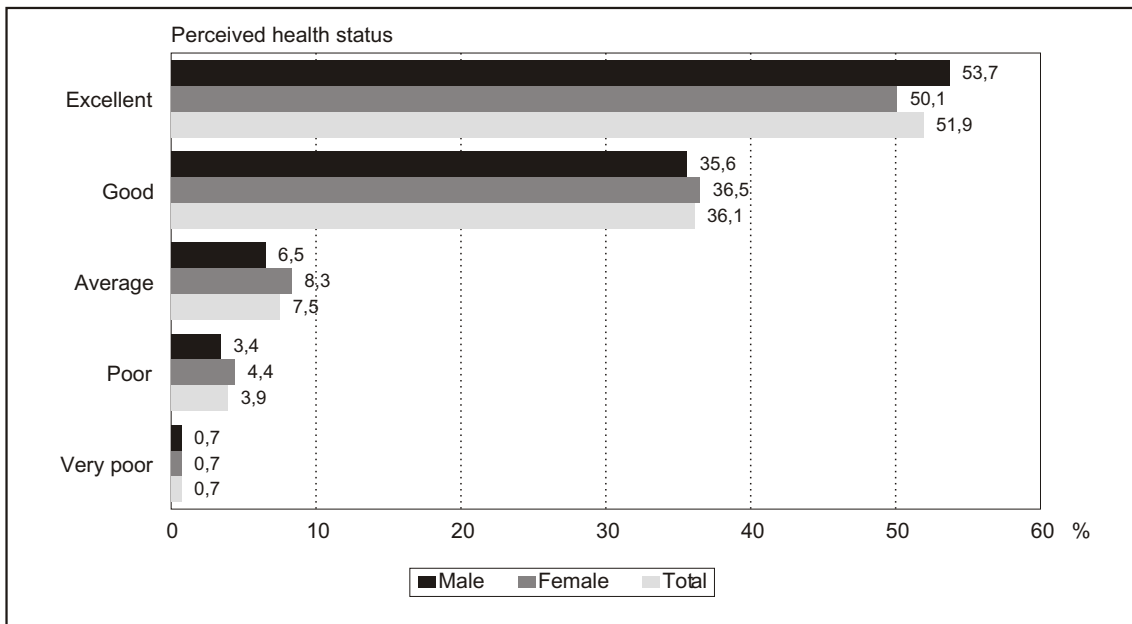
Each section has a summary at the end which highlights the major findings of the preceding analyses.

Perceived health status and individual circumstances

2.1 The whole population

Figure 2.1 below indicates that over half of the population in 1999 was reported as having excellent health and 36,1% as having good health. Hence, 88% of the population in 1999 had their health status described as either excellent or good, and only 12% as average, poor or very poor. There were some differences in the perceived health status of women and men. For example, 53,7% of men were perceived as having excellent health, while for women this percentage was 50,1%.

Figure 2.1: Perceived health status of men and women



The percentage of the total population reported as having average, poor or very poor health status was relatively small (12,0%), and considered individually these categories would yield inaccurate results especially when disaggregated further. This would make it difficult to draw any meaningful conclusions. Therefore, in the analyses that follow, the three categories are combined to form one called 'poor health status'.

Although individuals whose health status was reported as average were probably in better health than those whose health was described as poor or very poor, in relation to the total population, in which 51,9% were described as having excellent health and 36,1% as in good health, they become part of the vulnerable group of people who were not in good health. People whose health was described as average together with individuals whose health was reported as poor and very poor therefore become a developmental policy priority. Grouping average, poor and very poor perceived health status makes even more sense if you consider that the goal should be good health and individuals who are not perceived to be in good health are vulnerable. Average health status as a category offers little useful information, especially if considered alongside the

categories of excellent health status (which could include people with no health problems) and good health status (which could include people who have some health problems).

Differences can be expected between urban and non-urban areas because different living circumstances prevail in these areas, as seen in the previous section. There are also likely to be differences in access to health services between the two types of areas. Nevertheless, in terms of individuals' perceived health status, differences are minimal although in the expected direction. For example, a slightly higher percentage (52,6%) of individuals in urban areas were reported as being in excellent health than those in non-urban areas (50,9%). Similarly, a slightly lower percentage of individuals living in urban areas (11,3%) were reported as having poor health than of those in non-urban areas (13,0%).

Figure 2.2: Perceived health status of individuals in urban and non-urban areas

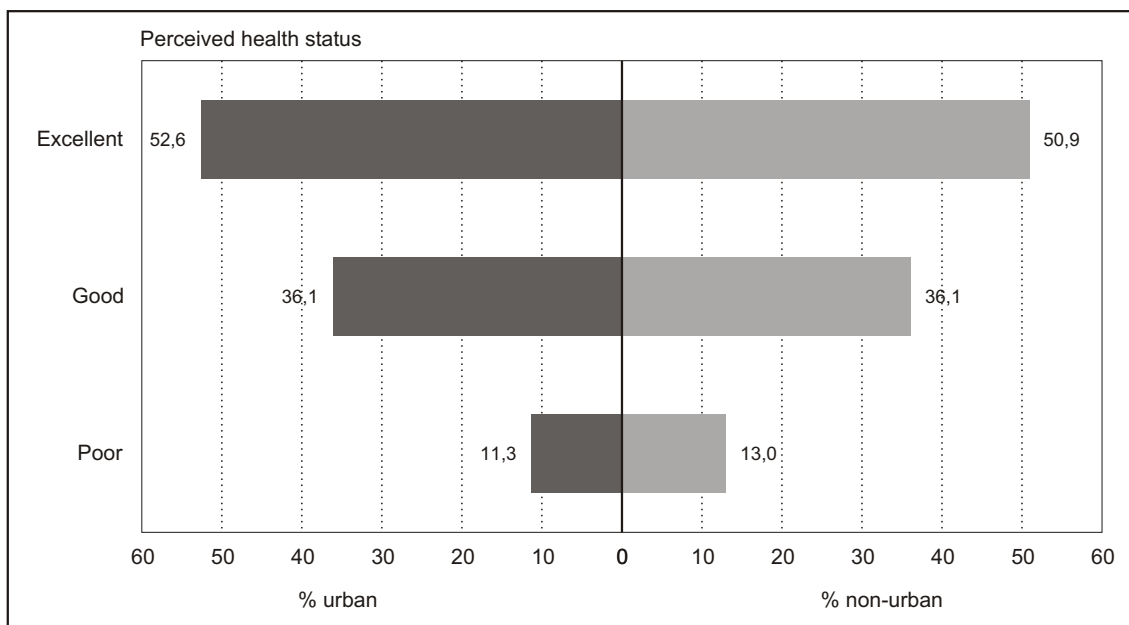
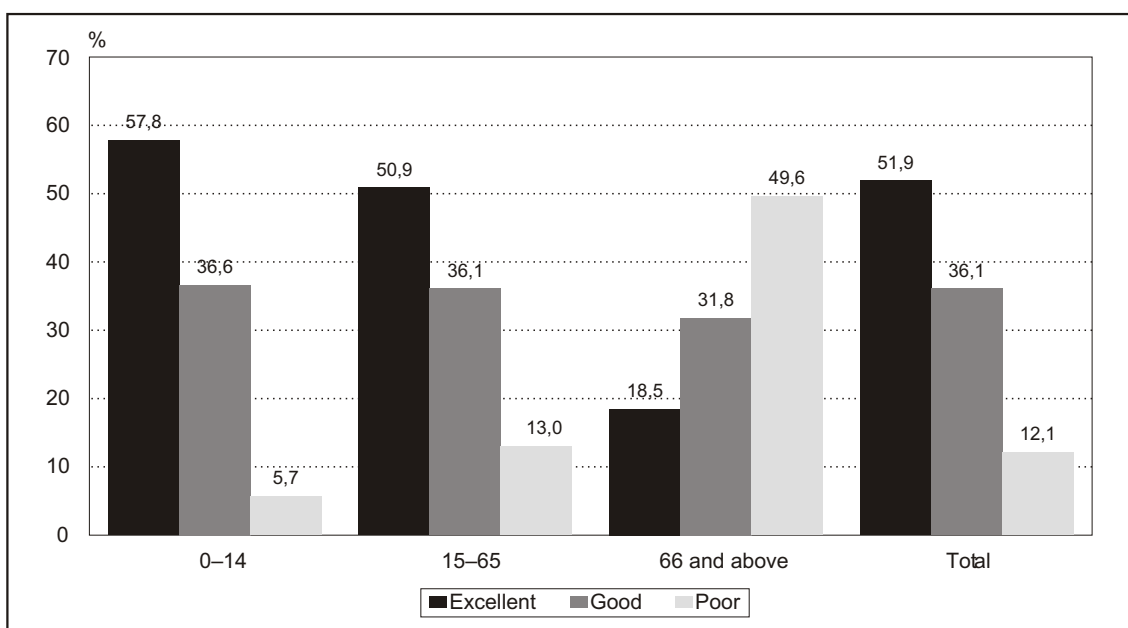


Figure 2.3 indicates that younger people (0-14 years) were perceived as being in better health than individuals aged 15-65 and those aged 66 and above. Well over half (57,8%) of the children aged between 0 and 14 years were described as having excellent health, while a proportionately lower proportion (5,7%) was described as having poor health. The health status of individuals aged 15-65 was perceived as worse than that of children aged 0-14 years; however, the health of individuals in this group (15-65 years) was perceived to be far better than that of individuals aged 66 years and above. Conversely, among those aged 66 years or older, only 18,5% were perceived as having excellent health, while 49,6% were perceived as having poor health.

Figure 2.3: Perceived health status of individuals within broad age groups



While there is no longer any formal discrimination in terms of population group in post-apartheid South Africa, population group is still an important indicator of socio-economic status, and access to services, including health services. Figure 2.4 shows how the health status of individuals from different population groups was perceived at the time of the interview. The figure shows that white people were perceived as being in better health than the other population groups. On the one hand, 58,0% of the white population was considered (by the respondents from their households) to be in excellent health while only 8,7% was reported as having poor health status. Indian people, on the other hand, tended to give lower ratings to their health status and that of other people in their households, since 43,5% was described as having excellent health and 43,4% as having good health, while 13,1% was described as being in poor health.

Considering individuals whose health status was perceived as excellent, Africans were perceived as having a health status second to that of whites and better than that of coloureds. However, when looking at poor health, Africans seemed to be worse off than coloured people, with 12,7% of the African population perceived as having poor health compared to 10,4% of the coloured population.

Figure 2.4: Perceived health status of individuals within population groups

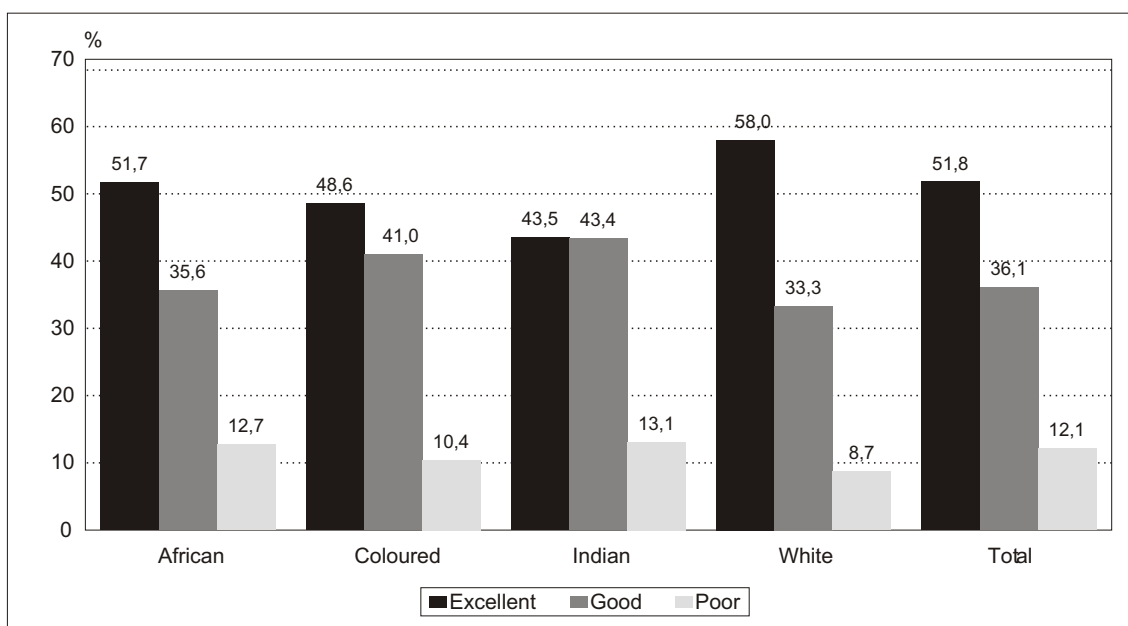
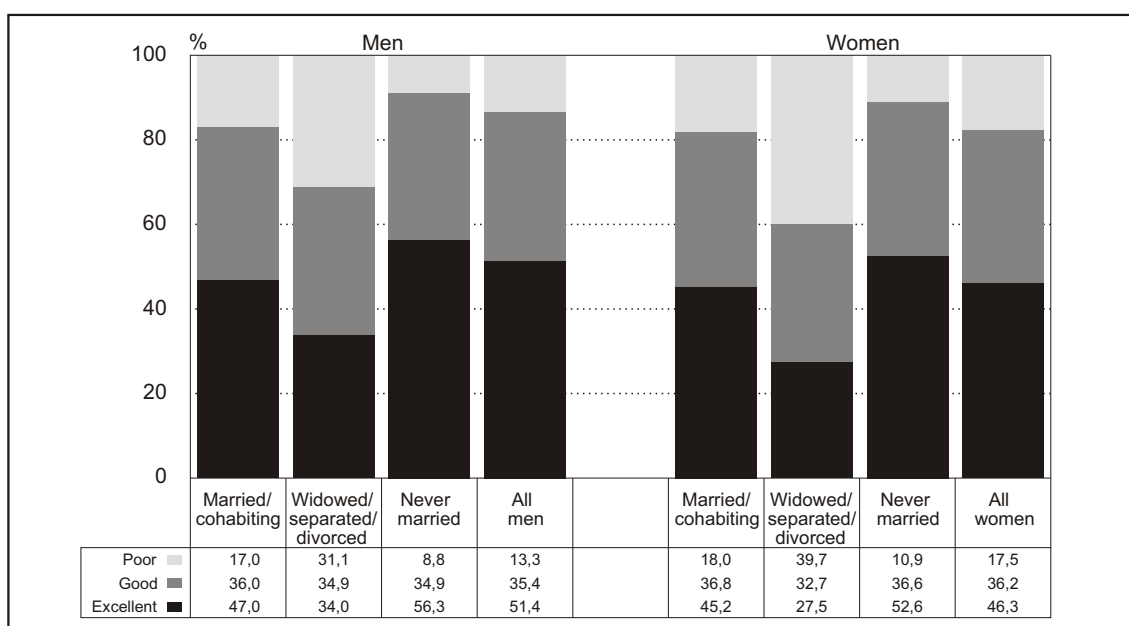


Figure 2.5 looks at the health status of women and men aged 15 years and above by marital status. 'Married' in this case includes people who were reported as married either traditionally or through a civil marriage, and those in cohabiting unions. Across all marital status categories, proportionately more men than women were perceived as being in excellent health, while proportionately more women than men were described as being in poor health. The gender differences are generally small, except among divorced people.

The figure also shows that among both women and men, those who had never married were generally perceived as having better health than those who were married. However, this may be the effect of age on health status perceptions rather than that of marital status. Compared to other individuals, a larger proportion of divorced men and women were perceived to be in poor health.

Figure 2.5: Perceived health status of men and women aged 15 years and above for each marital status



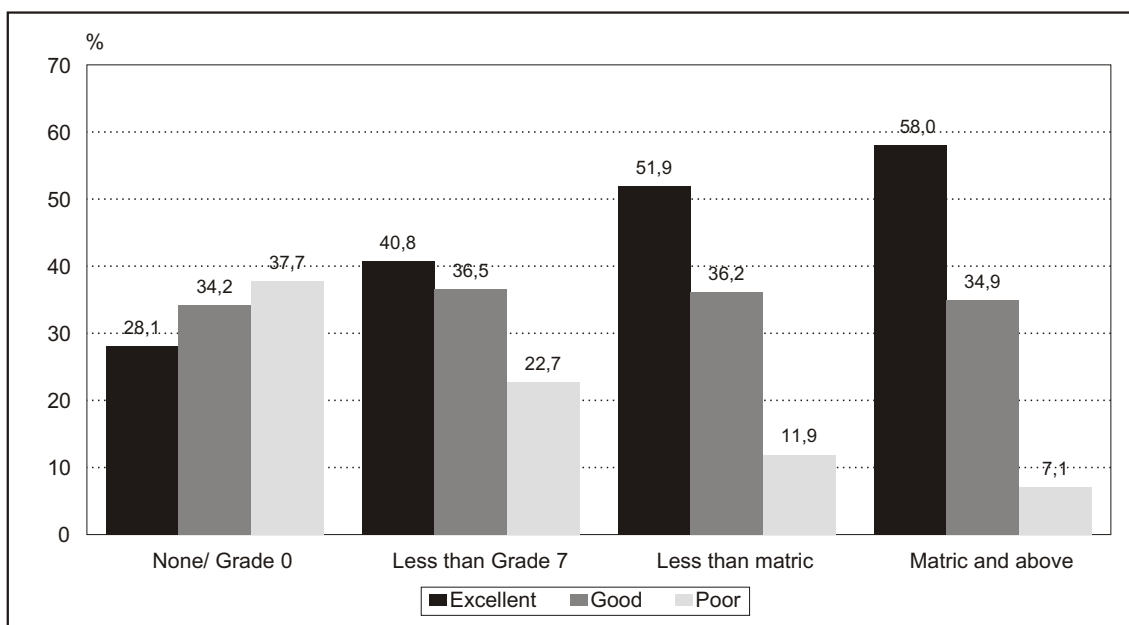
Education

Formal education in South Africa is reaching the vast majority of children between the ages of 7 to 15 years, since more than 94% of children in this age group were attending school in 1999. However, actual educational attainment among school-goers (as well as adults) tended to be rather low. Few people attended tertiary institutions. Furthermore, in October 1999, 16% of South Africans aged 20 years or more said they could not read in at least one language (Stats SA, 2001: 31).

Figure 2.6 indicates that:

- Among individuals aged 15 years or more with no education, more than a third (37,7%) were reported as being in poor health and a smaller percentage (28,1%) as having excellent health. The smallest proportionate percentage (7,1%) of individuals whose health was perceived as poor was observed among individuals with matric and above as their highest educational qualification. This was also the group in which a large percentage (58,0%) was reported as having excellent health.
- Individuals who have no formal education constituted the only group where more people (37,7%) were perceived as having a poor health status than as having a good health status (34,2%), while those whose health status was perceived as excellent constituted the smallest proportion (28,1%).

Figure 2.6: Perceived health status of those aged 15 years and above by the highest level of education completed



Employment

The employment status of an individual may have a bearing on how people perceive their health. Among the employed, the occupation or industry in which the employed person works may influence their health status.

As indicated in Section 1, Stats SA uses two definitions of unemployment, the official (also called the strict) and the expanded definition. Both definitions include people aged between 15 and 65 who are not employed but are available for work. The main distinguishing requirement of the official definition is that an individual must have taken specific steps to seek employment in the four weeks prior to a given point in time. With the expanded definition, the main focus is on availability for work, irrespective of whether or not a person has taken active steps to find work.

Figure 2.7 is based on the official definition of unemployment. It shows that the health status of people who were not economically active was perceived to be worse than those who were either employed or unemployed. Although 48,5% of not economically active people were described as having excellent health, 16,3% were reported as being in poor health. Figure 2.8, based on the expanded definition of unemployment, shows a similar pattern.

In general, there was very little difference in the perceived health status of the employed and the unemployed, using either the official or the expanded definition.

Figure 2.7: Perceived health status of individuals aged 15-65 by employment status, according to the official definition of employment

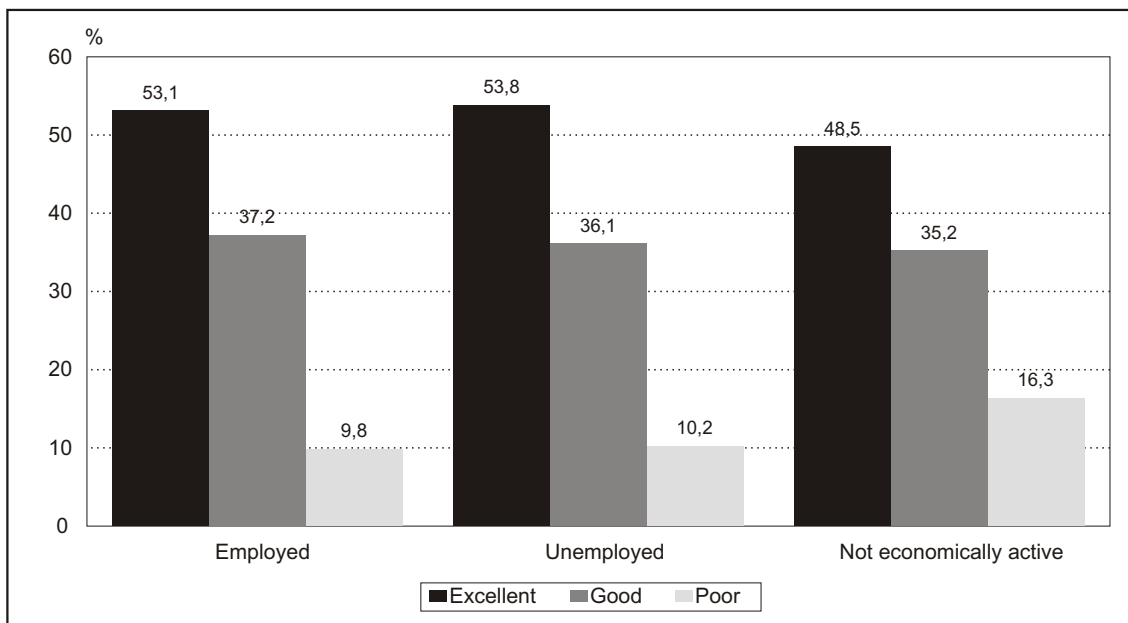


Figure 2.8: Perceived health status of individuals aged 15-65 by employment status, according to the expanded definition of employment

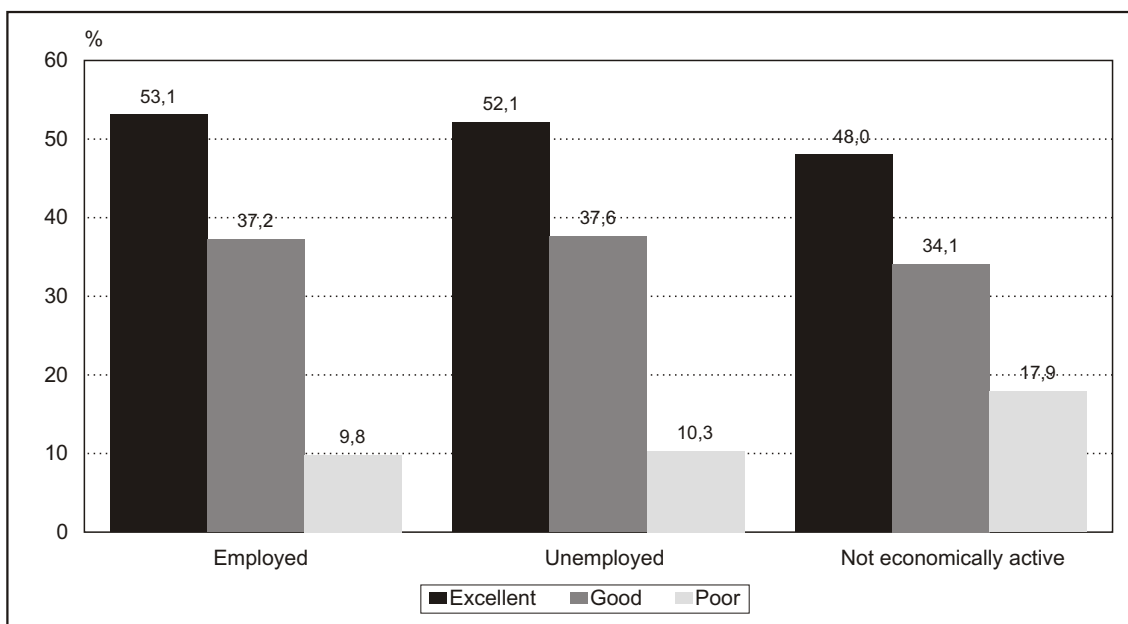
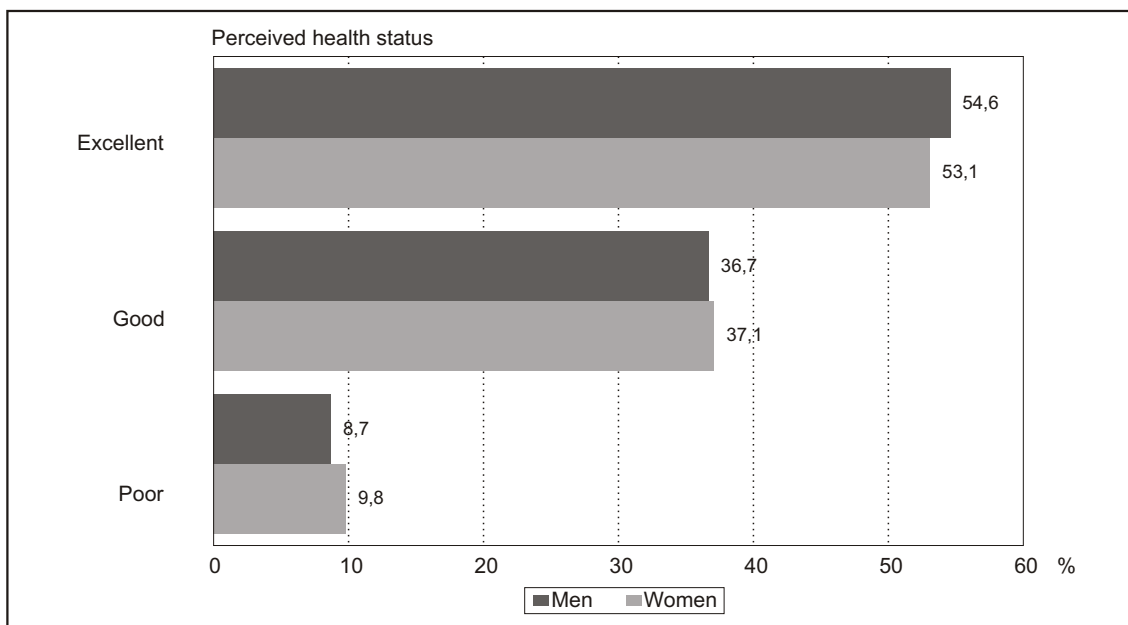


Figure 2.9 compares the perceived health of employed women to that of employed men. Women and men who were perceived as having excellent health accounted for the largest proportion of employed people. However, a slightly larger percentage of employed men (54,6%) were perceived to be in excellent health than employed women (53,1%). Generally the difference between the perceived health of employed men and employed women was very small.

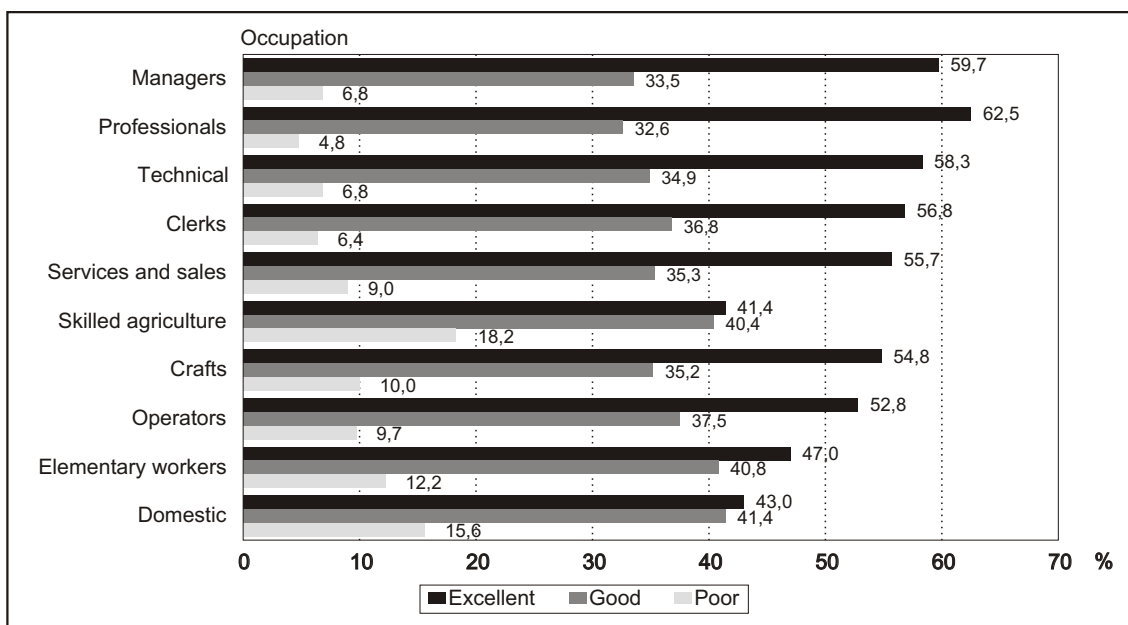
Figure 2.9: Perceived health status of employed men and women



An estimation of the percentage distribution of employed individuals aged 15-65 by occupation and gender indicates that, among employed men, the largest proportion was found in artisan and craft-related occupations (19,6%), followed by those in elementary (18,1%) and operator (15,7%) occupations. Only a small percentage (0,6%) of employed men were found in domestic services. Among employed women, the largest proportion was found in elementary (19,4%), domestic (17,8%) and clerical (16,3%) occupations. Relatively few employed women were found in skilled agricultural (2,8%), operator (3,7%) or managerial (4,0%) occupations. The proportion of employed men found in managerial occupations was twice that of employed women.

Figure 2.10 shows that the largest percentage of both professionals (62,5%) and managers (59,7%) were reported to be in excellent health. The occupations with the largest proportions of individuals with perceived poor health status were skilled agriculture (18,2%) and domestic work (15,6%).

Figure 2.10: Perceived health status of the employed within occupations



An estimation of the percentage distribution of employed men and women in various industries in the economy as a whole indicates that women dominated in only a small number of industries. There were proportionally more women than men only in the trade and services industries and in private households. The largest percentage of employed women was found in services (24,7%) while the largest percentage of employed men worked in trade (18,3%). For both men and women, relatively few people worked in utilities.

Figure 2.11 opposite indicates the perceived health status of employed people according to the industry in which they work. Compared to other industries, a proportionately large percentage of employed people in finance (59,5%) and utility (59,4%) industries were perceived as having excellent health status. On the other hand, private households and agriculture were the industries with the largest proportion of individuals perceived as being in poor health (15,3% and 14,8% respectively). In South Africa, these are the industries which in South Africa tend to be female-dominated.

2.2 Childbearing women

The following section looks at perceived reproductive health status. Reproductive health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. It implies the right of access to appropriate health care services that enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (UN, 1994). The country's constitution provides that everyone has the right to access to health care services, including reproductive health care (RSA, 1996), while primary health care was declared free for pregnant women and children below the age of 6 years from 1 June 1994.

Figure 2.11: Perceived health status of the employed within industries

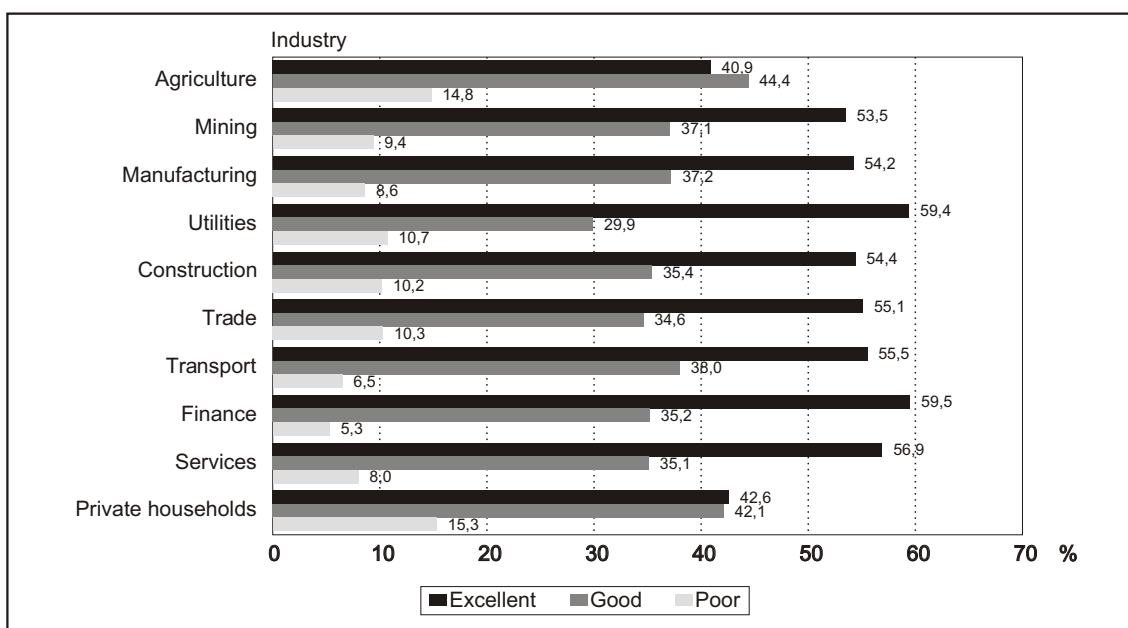


Figure 2.12 gives the distribution of women who had given birth in the twelve months before the interview of October 1999 by five-year age groups. As expected, a large proportion of women aged 14-49 had given birth in the middle of the reproductive period, and the proportion decreases towards the end of reproductive period. A substantial proportion (13,8%) of women aged 14-19 had given birth in the twelve months prior to the interview. This has implications for adolescent reproductive and sexual health care.

Figure 2.12: Distribution of women aged 14-49 who had given birth in the twelve months prior to the survey by age

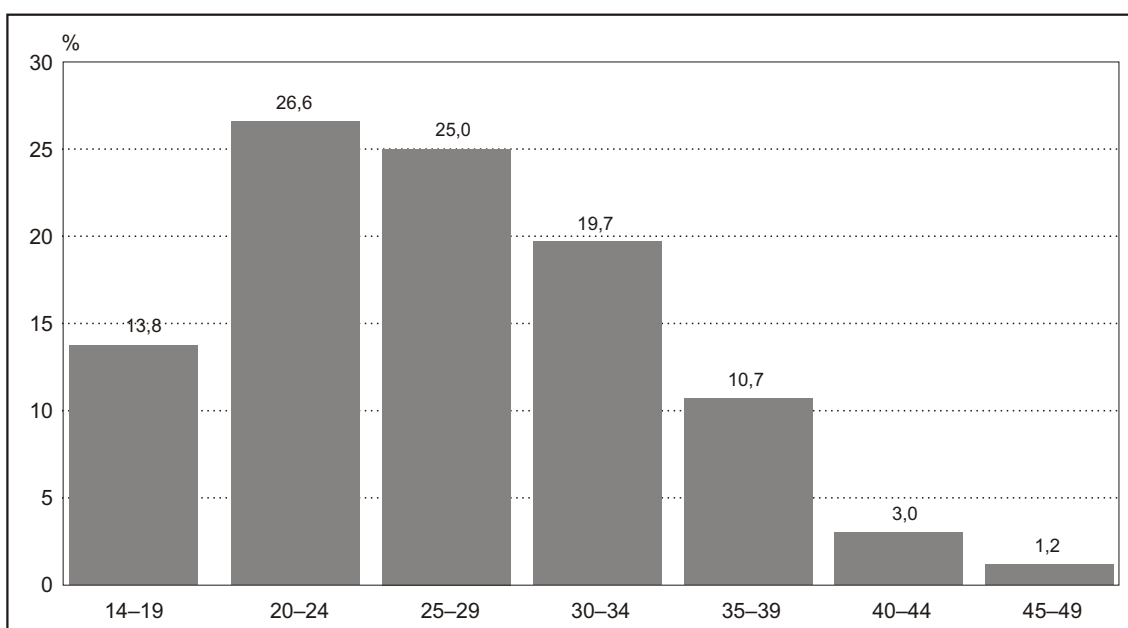
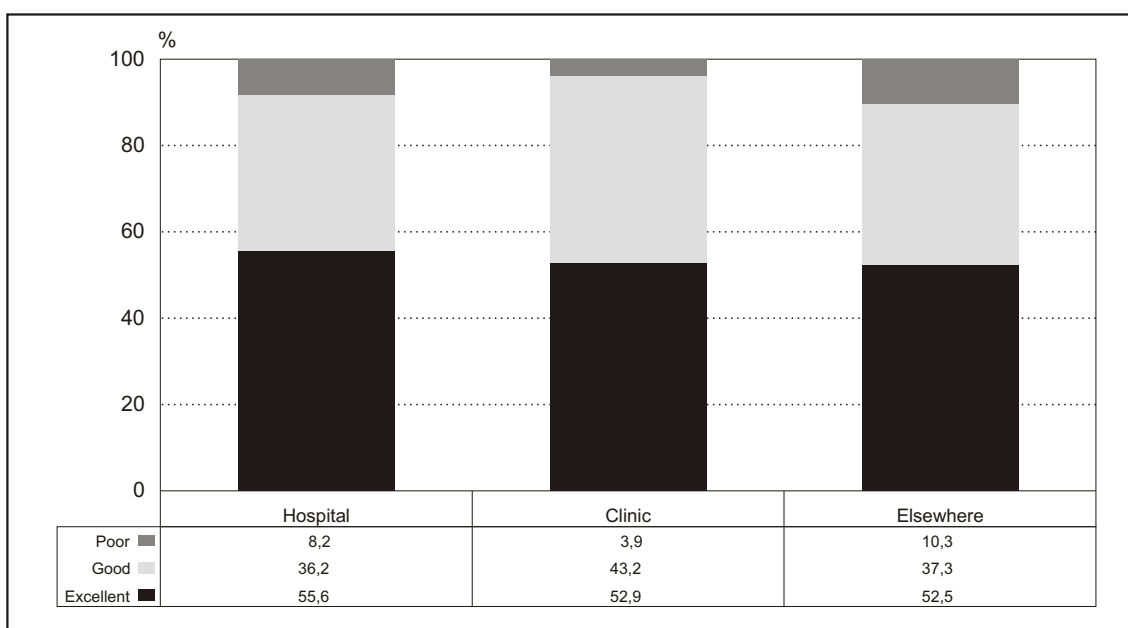


Figure 2.13 looks at the perceived health status of women aged 14-49 who gave birth in the twelve months before the survey, according to where the birth took place. Overall, 76,4% of women gave birth in hospitals, 13,3% in clinics and 10,3% elsewhere.

The figure shows that among women whose children were born in clinics, 52,9% were perceived as having excellent health, 43,2% as having good health and 3,9% as having poor health. Among those whose children were born in hospitals, 55,6% were described as being in excellent health, 36,2% in good health and 8,2% in poor health. For those who gave birth elsewhere, 52,5% were described as being in excellent health, 37,3% in good health and 10,3% in poor health.

Figure 2.13: Perceived health status of women aged 14-49 who had given birth in the twelve months prior to the survey by place of delivery

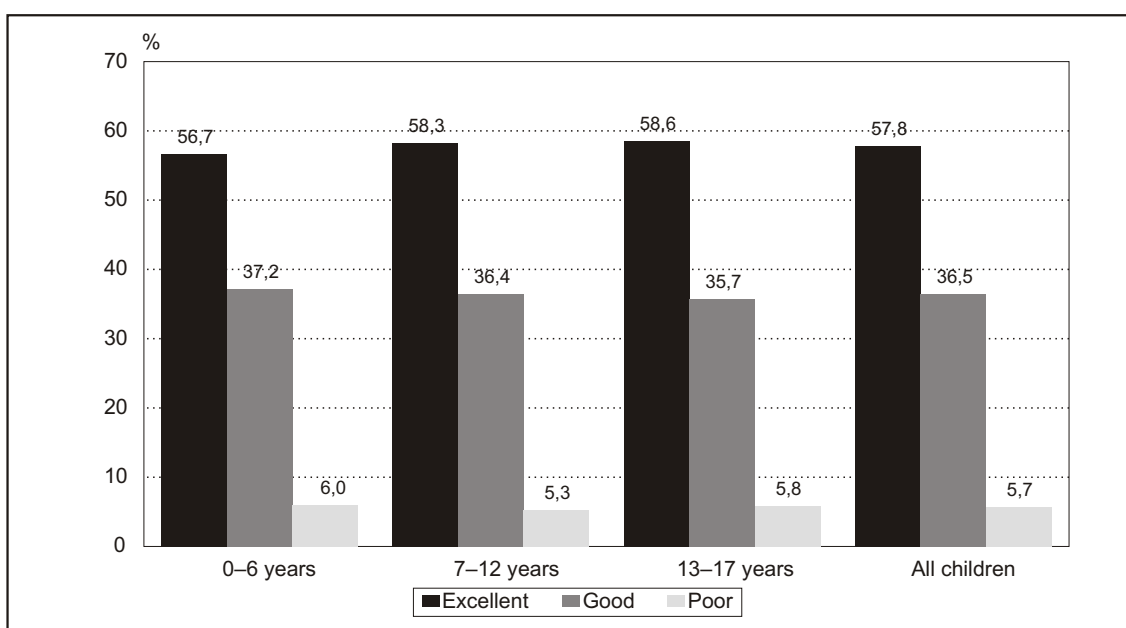


2.3 Children

South Africa's constitution and the United Nations Convention on the Rights of the Child (1989) define a child as someone who is under eighteen years of age. Eighteen is also the age at which South African citizens become eligible to vote in national, provincial and local government elections. Eighteen is therefore used as a cut-off age in this report when defining children. In October 1999, about 36,3% of children were aged between 0 and 6 years, 35,8% between 7 and 12 years, and 27,9% between 13 and 17 years. Of all children, 45,1% were living in urban areas while 54,9% were living in non-urban areas.

Figure 2.14 below indicates the differences in the perceived health status of children. The first five years of life are seen to be critical to future health; however, results indicate that teenagers (13-17 years) and pre-teenagers (7-12 years) were perceived as having a better health status than younger children (0-6 years).

Figure 2.14: Perceived health status of children aged 0-17 years



2.4 Summary

In terms of how the South African population's health is perceived, it was found that:

- There was a difference between how the health status of men and women was perceived, with proportionately more men than women perceived as being in excellent health.
- The health status of individuals residing in urban areas was perceived as being better than that of individuals living in non-urban areas.
- The health status of individuals aged 15-65 years was perceived as worse than that of children aged 0-14 years; however, it was perceived to be far better than that of individuals aged 66 years and above.
- In comparison to other population groups, white people were perceived as having a better health status.
- Of people aged 15 and above, those with matric or more as their highest level of education were reported as having a better health status than those with a lower level of education. In addition, individuals with no formal education were described as being in poorer health than those in other educational level groups.
- The health status of individuals that were not economically active was perceived as worse than that of employed or unemployed individuals.
- Among women who had given birth in the twelve months prior to the interview, proportionately more women who gave birth in hospitals were perceived as being in excellent health than among those who gave birth elsewhere.
- Young children (0-6 years) were perceived as being in worse health than children aged 7-17.

Section 3

Perceived health status among individuals and living conditions in their households

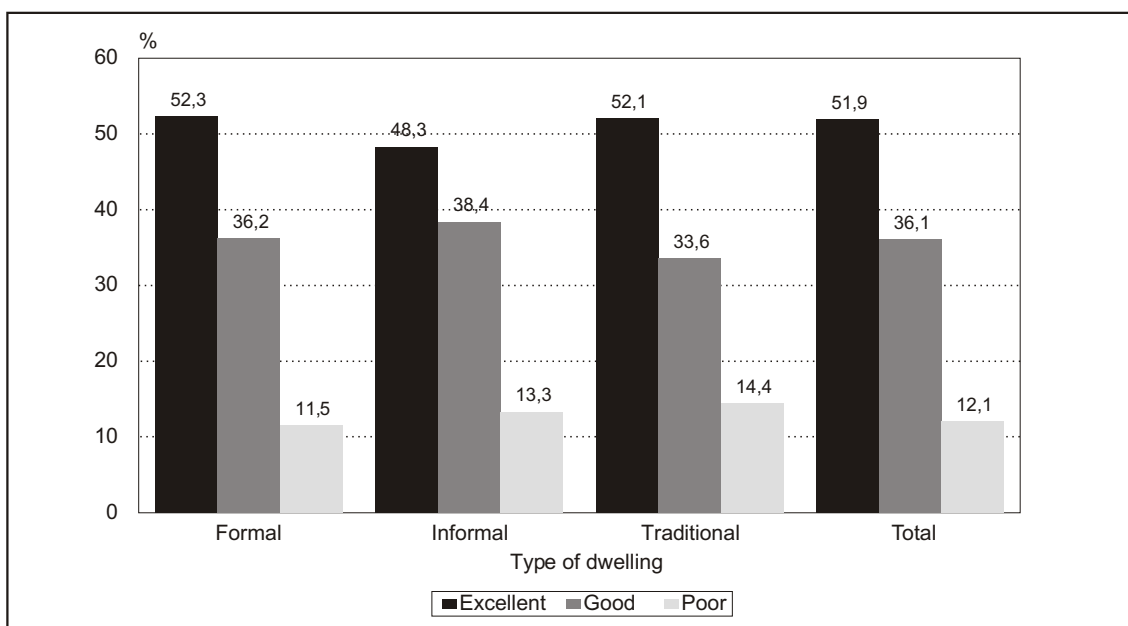
This section focuses on household living conditions and their relation to perceived health status.¹ For example, I consider people living in households with safe water, and then find out how many of these people were perceived as having excellent, good or poor health status.

3.1 Housing

Statistics South Africa (2001:71) has found that between 1995 and 1999, the proportion of households occupying formal dwellings in South Africa showed an overall gradual increase. However, there was also a slight increase in the proportion of households living in informal dwellings, accompanied by a steady decrease in the proportion of households living in traditional dwellings.

In October 1999, out of 43 million people, almost 32 million lived in formal dwellings, over 6 million in traditional dwellings, about 4,5 million in informal dwellings, and 0,4 million in other places including caravans and tents.²

Figure 3.1 Perceived health status of individuals according to type of main dwelling occupied by their households



¹The analysis of individuals' perceived health status by living conditions of the households in which they live focuses on people within households instead of the actual households. It involves putting together people and household records and raising the population to the total South African population. The weighted total number of people (using person weight) adds up to about 43,3 million people.

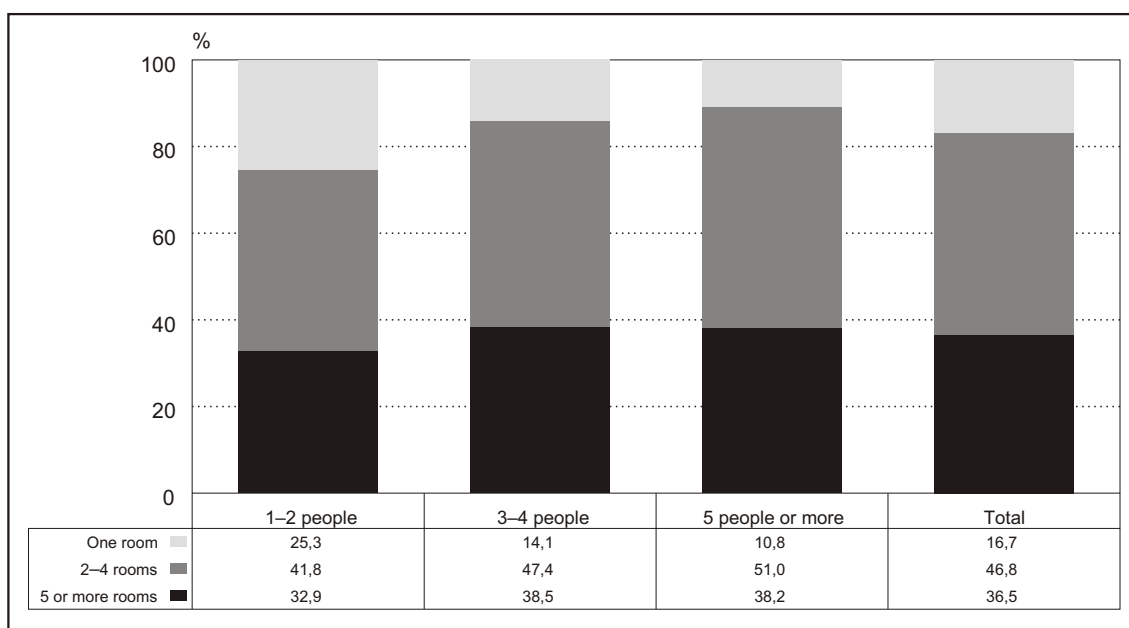
²A *formal dwelling* is a house on a separate stand or yard; a flat or apartment in a block of flats; a townhouse, cluster or semi-detached house; a unit in a retirement village; a house, flat or room in a backyard or on a shared property; or a room or flatlet elsewhere. A *traditional dwelling* is a hut or a dwelling made of traditional materials. An *informal dwelling* is a makeshift structure or shack not erected according to approved architectural plans, either in a backyard or elsewhere such as in an informal settlement.

Figure 3.1 indicates the perceived health status of people in households according to the main type of dwelling. The figure shows that similar proportions of people living in formal and traditional dwellings had their health status reported as excellent. However, there were proportionately more people living in traditional (14,4%) than formal (11,5%) dwellings whose health was perceived as poor. This implies slightly better perceived health status for people occupying formal dwellings than for those occupying traditional dwellings. The figure also indicates that the health status of individuals living in informal dwellings was perceived to be worse than that of individuals in formal and traditional dwellings.

3.2 Overcrowding

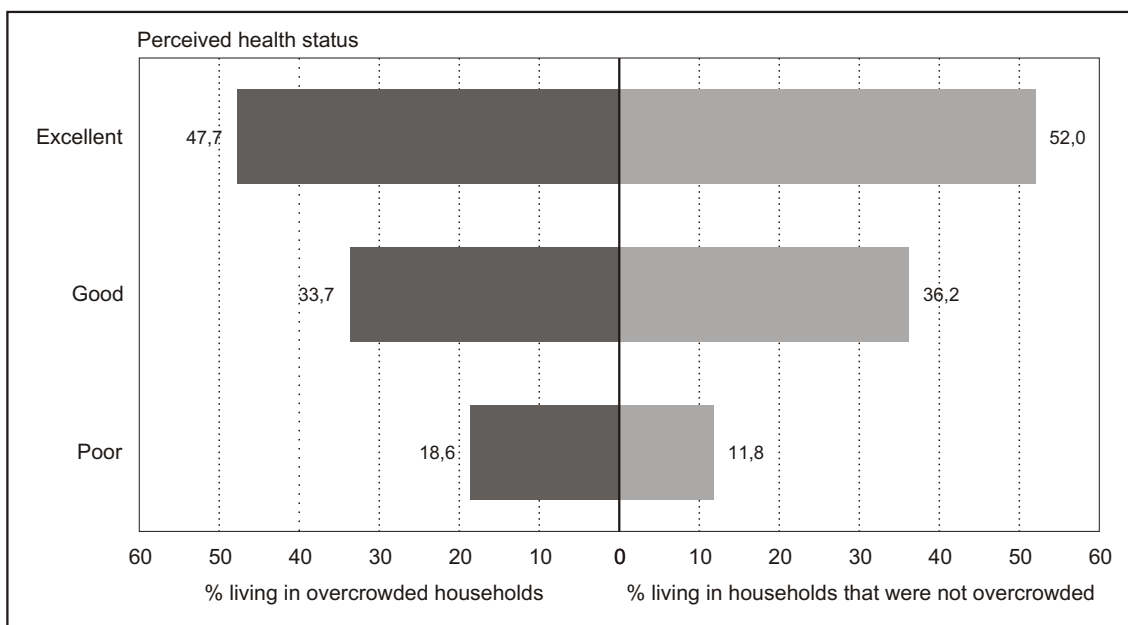
The total number of rooms a household occupies together with the number of household members can be expected to have a bearing on the health of individuals. Figure 3.2 shows the distribution of households, in terms of the number of people living in the household and the total number of rooms the household occupied. As expected, households with three or more people were noticeably less likely than smaller households to live in a one-roomed dwelling. However, the figure shows that 32,9% of households with one or two people occupied more than four rooms, while 10,8% of households with more than five people shared one room. These statistics imply marked inequality in dwelling occupancy.

Figure 3.2: Distribution of households by size of household and number of rooms



Households are divided into those that were overcrowded and those that were not. Overcrowded households are defined as those with three or more people per room. According to Figure 3.3, 52,0% of people living in households that were not overcrowded were perceived as having excellent health, while this percentage was lower (47,7%) among those living in overcrowded households. A similar pattern can be observed when looking at people whose health status was perceived as good. However, a higher percentage of people living in overcrowded households (18,6%) were perceived as having poor health than of those living in households that were not overcrowded (11,8%).

Figure 3.3: Perceived health status of individuals in overcrowded and not overcrowded households



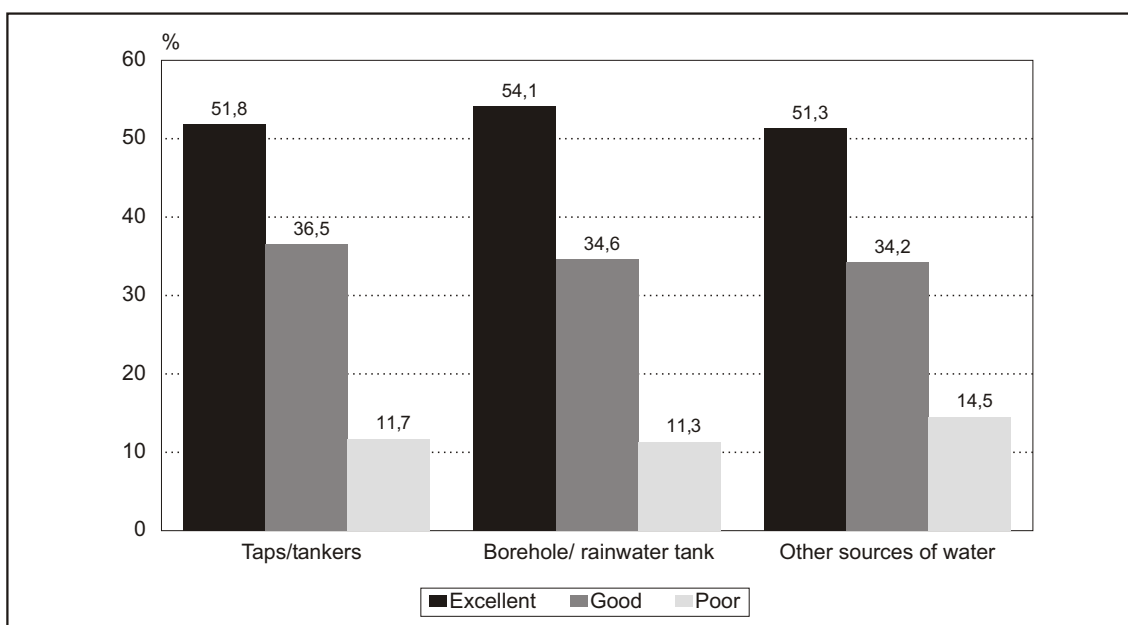
3.3 Water

In the five years from 1995 to 1999, Stats SA (2001:75) found that there was a gradual increase in the proportion of households that had access to clean water (piped water inside the dwelling or on site, communal tap or public tanker). At the same time there was a decrease in the proportion of households using water from boreholes and rainwater tanks. The proportion of households obtaining water from rivers, streams and dams remained more or less constant over time.

Looking at individuals rather than households, in October 1999, 79,6% of people lived in households that used clean water as defined above. When disaggregated into urban and non-urban areas, almost all the people (98,5%) in urban areas had access to clean water whereas this proportion was far lower (65,4%) among people in non-urban areas. In non-urban areas, moreover, a significant proportion of people (32,6%) used water sources such as a river, stream, well, spring or dam.

Figure 3.4 provides the percentage distribution of individuals whose perceived health status was described as excellent, good and poor for a given source of household water. Proportionately more people whose households used water sources such as rivers, dams, springs and wells (14,5%) were reported as having poor health status than those using taps or tankers (11,7%) and boreholes or rainwater tanks (11,3%). However, the proportion of people using these other sources whose health was perceived as excellent was equal to those using taps or tankers and slightly smaller than the proportion of those who used boreholes or rainwater tanks. This is counter-intuitive because availability of clean water is supposed to improve health, yet the health status of those using boreholes or rain water tanks was perceived as better than those using taps or water tankers.

Figure 3.4: Perceived health status of individuals according to household's main water source



3.4 Sanitation

Between 1995 and October 1999, there was a slight decrease in the proportion of households with access to a flush or chemical toilet. At the same time there was a slight increase in the proportion of people who used places such as a river, stream or bush (Stats SA, 2001:90).

In October 1999, out of about 43,2 million people, almost half of them (20,9 million people) lived in households that used flush or chemical toilets, 15,5 million in households using pit latrines, 1,4 million in households using bucket latrines, and 5,0 million in households that used other places. However, Figure 3.5 shows that there are differences between rural and urban areas in terms of access to sanitation facilities. It shows, for example, that most people (81,6%) in urban areas lived in households using flush or chemical latrines, while most people (64,9%) in non-urban areas lived in households that used pit latrines. Moreover, 5,7% of the urban population used bucket latrines while only 0,5% of people in non-urban areas used bucket latrines.

In terms of the health status of people using various types of sanitation facilities, it was found that the highest proportion of individuals whose perceived health status was described as poor was among those who lived in households which used bucket latrines (14,5%), followed by those who had another form of sanitation facility (13,9%) and those whose households used pit latrines (13,0%). The lowest proportion with a poor health status was found among those whose households used chemical or flush toilets (10,8%).

Figure 3.5: Distribution of individuals according to household sanitation facility and milieu

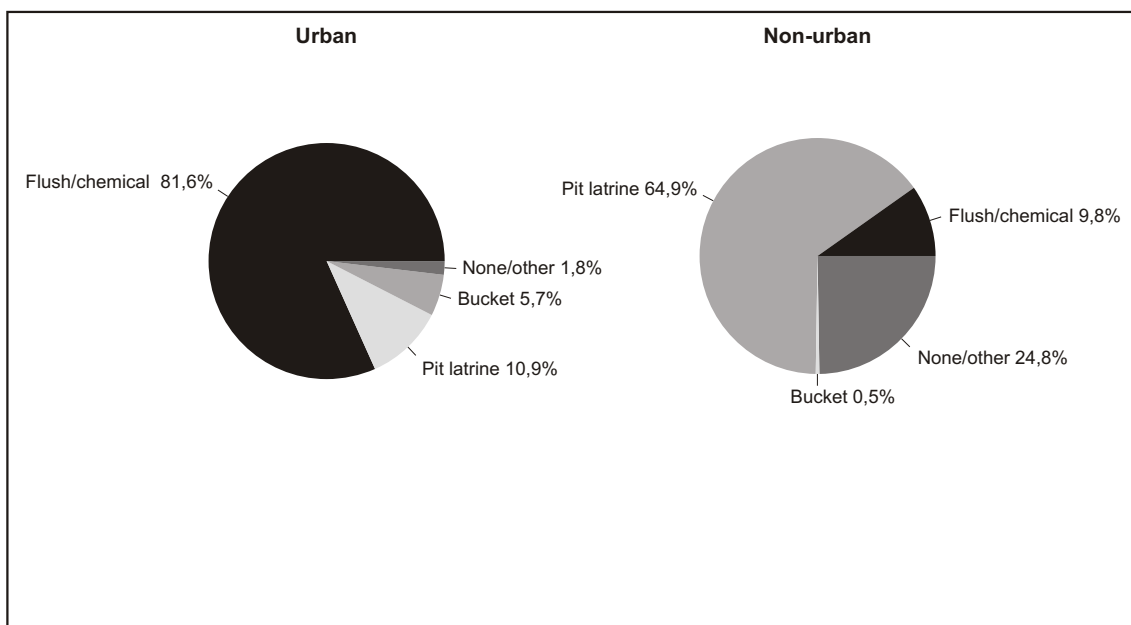
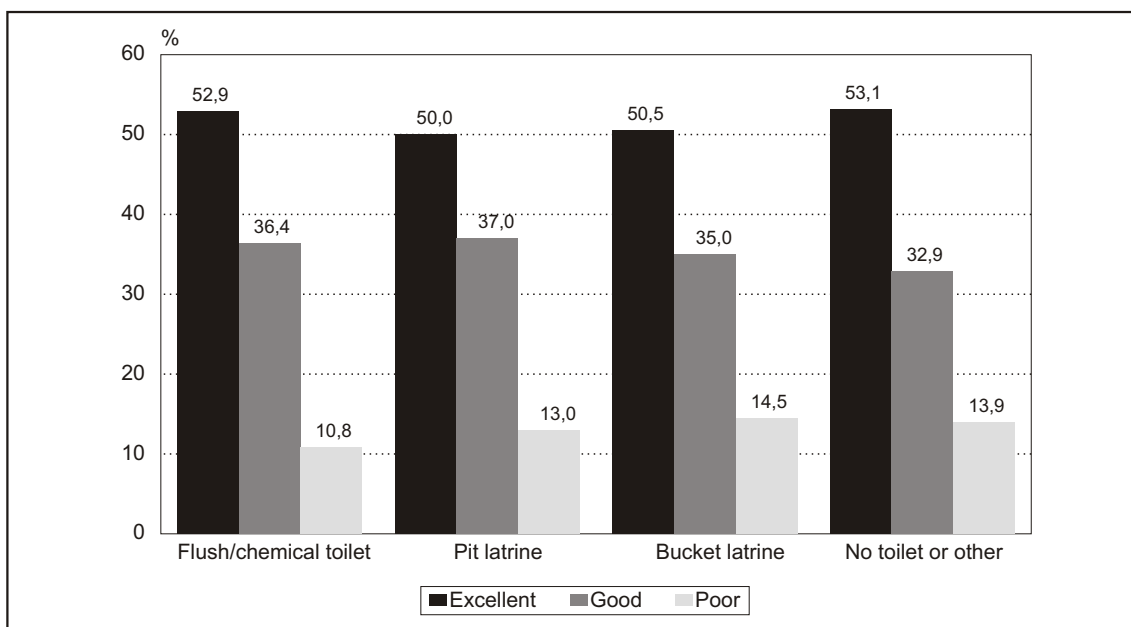


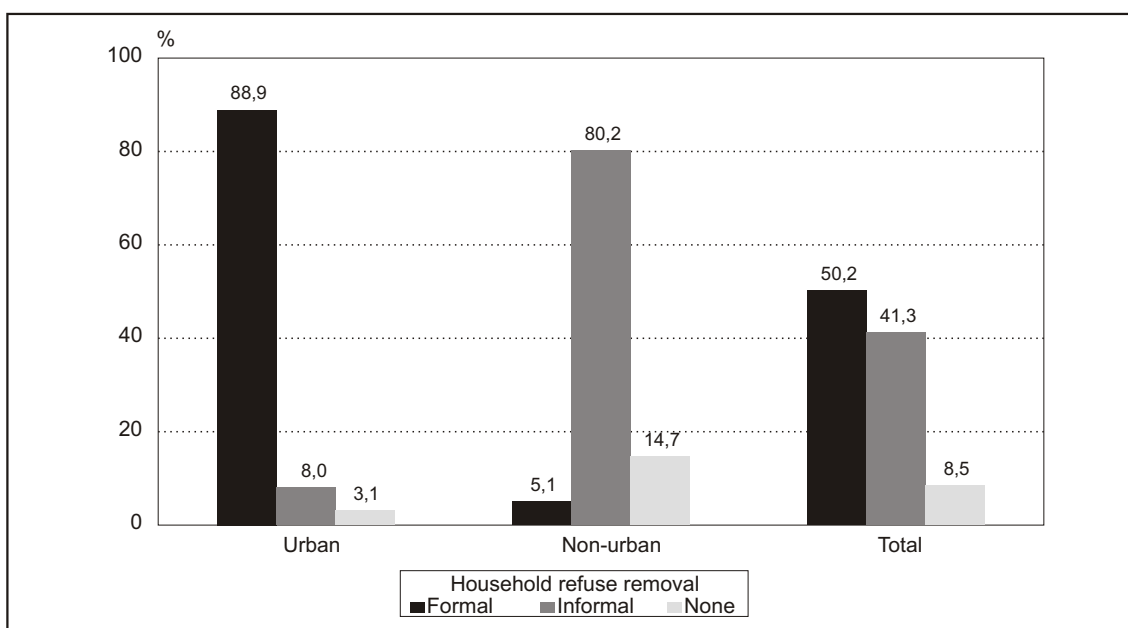
Figure 3.6: Perceived health status of individuals according to household sanitation facility



3.5 Refuse removal

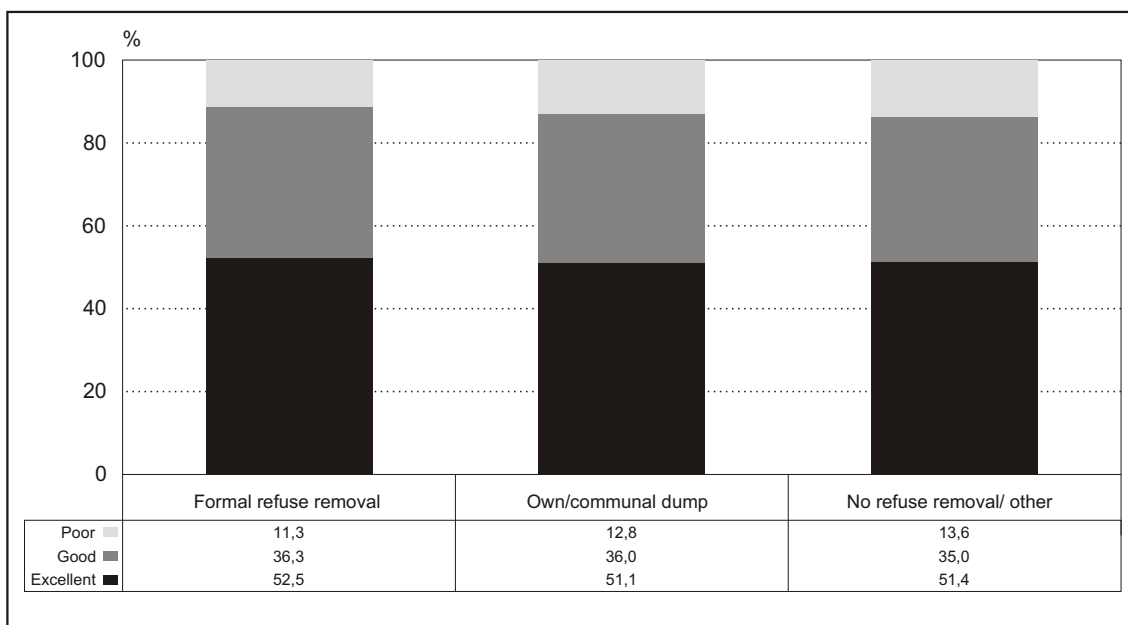
The method and frequency of refuse removal are likely to have a bearing on the health of members of the household. According to Figure 3.7, most people in urban areas (88,4%) lived in households that had their refuse removed by the local authority or community members (formal removal). On the other hand in non-urban areas, most people lived in households that had non-formal methods of removal (80,2%) such as the use of their own or a communal dump. In addition, proportionately more people (14,7%) in non-urban areas than in urban areas had no form of refuse removal.

Figure 3.7: Distribution of individuals in urban and non-urban areas according to method of household refuse removal



In terms of perceived health status, Figure 3.8 shows that the method of refuse removal had very little bearing on perceived health status. The differences in perceived health status according to method of household refuse removal were very small.

Figure 3.8: Perceived health status of individuals according to method of household refuse removal



3.6 Summary

The reported health status of people living in formal dwellings was found to be slightly better than that of people living in traditional dwellings. In addition it was found that:

- A higher proportion of people living in overcrowded households were described as having a poor health status than of those living in households that were not overcrowded.
- Individuals whose households used boreholes or rainwater tanks were perceived as having better health than those living in households using taps or other water sources.
- Among individuals whose health status was perceived as excellent, those who used flush or chemical toilets seemed to be better off than individuals in households using other forms of sanitation facility.

Method of refuse removal had very little bearing on perceived health status.

Section 4

Health care

This section examines patterns of health infrastructure as an enabler or inhibitor of perceived good health. It focuses, among others, on people's access to and use of various health facilities, choice of health workers, and access to medical aid and health insurance; and the links between these indicators and perceived health status.

4.1 Medical aid and health insurance

Medical scheme and health insurance benefits may be available to people either through their work or privately. In many cases, the dependents of the member of the medical association will also have access to benefits through the scheme. Figure 4.1 provides the percentage distribution of the population aged 20 years or more of each population group according to whether or not they have access to medical benefits in the form of a medical aid or benefit scheme or private health insurance.

The figure shows that only 18,5% of the population aged 20 and above had access to medical benefits. Access to medical benefits was more common among white people than among members of other population groups. Among whites, over two-thirds in this age group had access to medical benefits in 1999. Access to medical benefits among Africans was poorest, with only 8,9% having access.

Figure 4.1: Distribution of individuals aged 20 and above by access to medical aid or health insurance benefits and population group

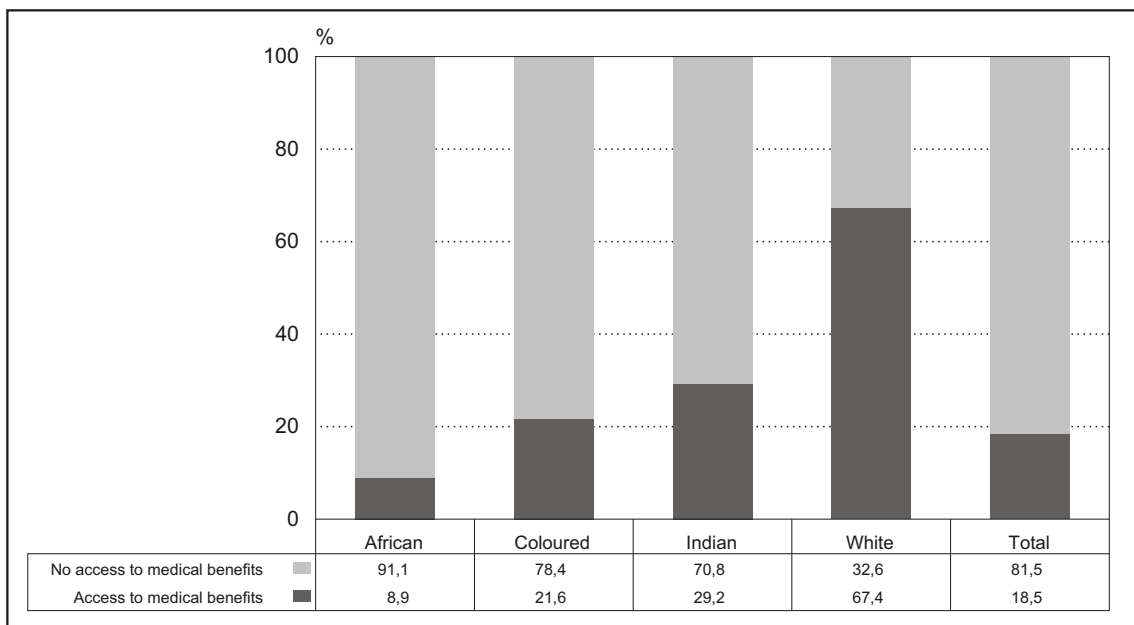
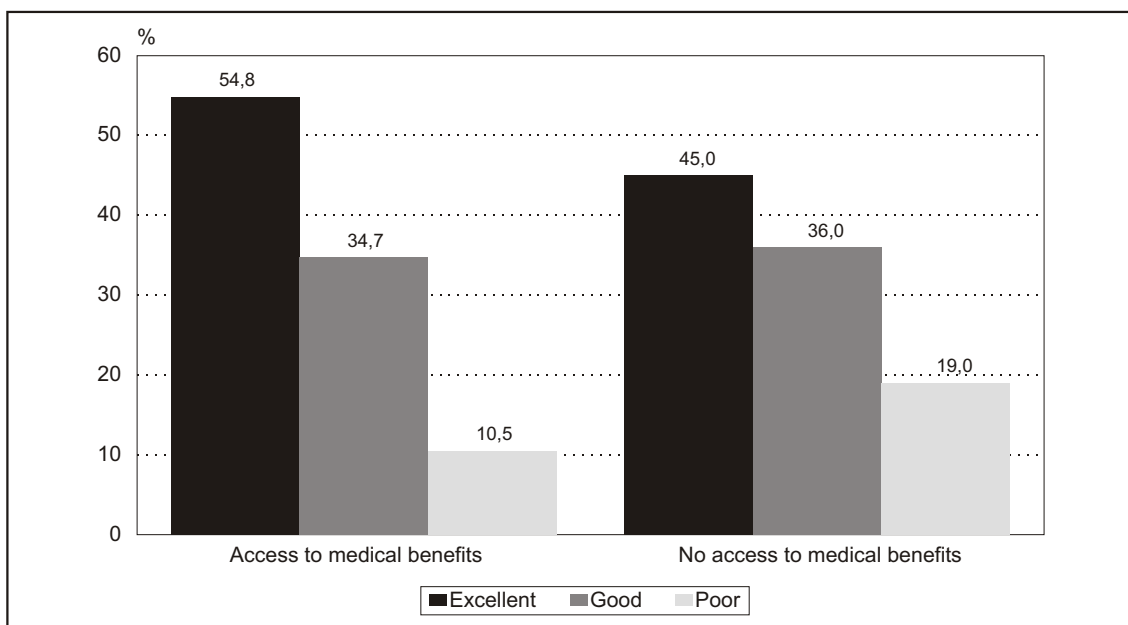


Figure 4.2 indicates that there was a significant difference in the perceived health status of individuals with and without medical benefits. Proportionately more of those with medical benefits (54,8%) than of those without medical benefits (45,0%) were perceived as being in excellent health. Conversely proportionately fewer people with medical benefits were perceived to be in poor health.

Figure 4.2: Perceived health status of individuals aged 20 years and above according to access to medical aid or health insurance benefits



4.2 Health services

Figure 4.3 gives the distribution of urban and non-urban households and their distance from the nearest clinic. The figure shows that 62,7% of South African households had a clinic within 2 km. Three-quarters (76,0%) of households in urban areas had a clinic within 2 km. For non-urban households, the proportion with a clinic within 2 km was considerably lower at 42,5%.

Figure 4.3: Distribution of households in urban and non-urban areas according to distance of clinic from the dwelling

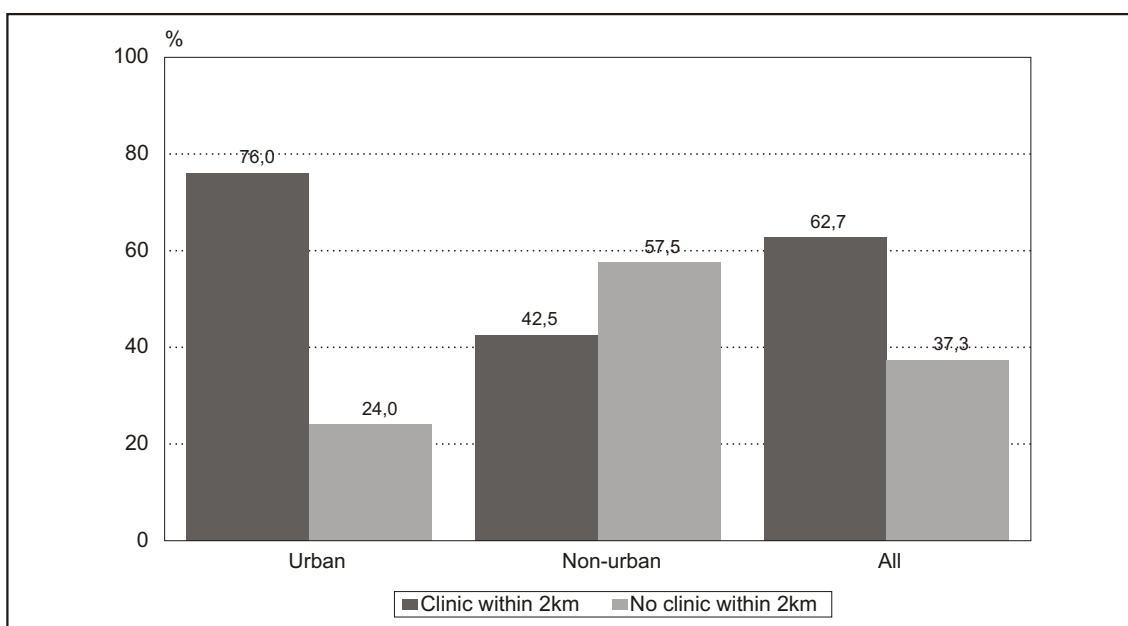


Figure 4.4 below provides information as to whether individuals did or did not consult a health worker, such as a nurse, doctor or traditional healer, as a result of illness or injury in the month before the interview of 1999. The information is broken down by gender and age group. The figure indicates that 11,0% of the total population consulted a health worker. This percentage conceals age differences, in that 26,6% of the population aged 66 years or older, 11,7% of those aged between 15 and 65, and 7,8% of those aged 14 years or younger were reported to have consulted a health worker in the month before the survey. This age pattern is similar for both females and males although the differences between age groups were more marked for females than for males.

Figure 4.4 also suggests that proportionately more females than males consulted a health worker in the month preceding the survey especially within the 15-65 years age group. This would be expected because of childbearing and other reproductive health needs. However, among those aged 0 to 14 years, the percentage of boys (8,0%) and girls (7,6%) that visited a health worker was almost the same. In all instances, fewer people consulted a health worker than did not.

Figure 4.4: Distribution of individuals according to whether they consulted a health worker in the month before the survey, age group and gender

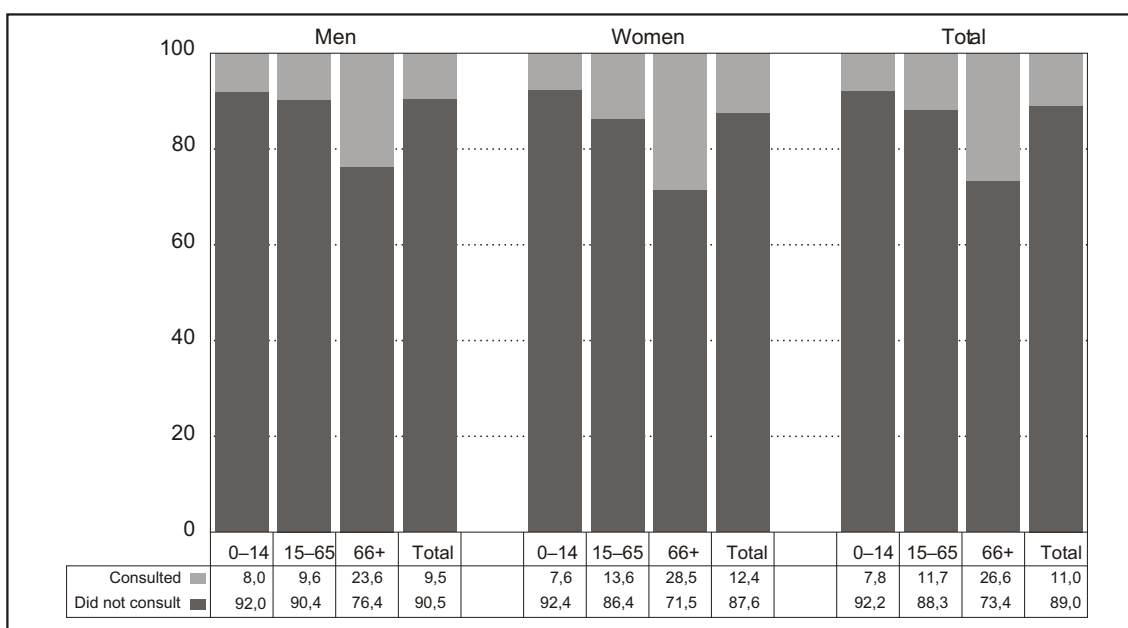


Figure 4.5 shows the perceived health status of all individuals according to whether they consulted a health worker in the month prior to the survey. Presumably, the fact that someone visited a health worker would make the respondent more inclined to say that person had a poor health status. As expected, people who did not visit a health worker were perceived to be in better health than those who visited a health worker. Overall, 35,9% of people who consulted a health worker were perceived to be in poor health, while the percentage was 9,2% among those who did not consult a health worker.

Figure 4.5: Perceived health status of individuals according to whether they consulted a health worker in the month before the survey

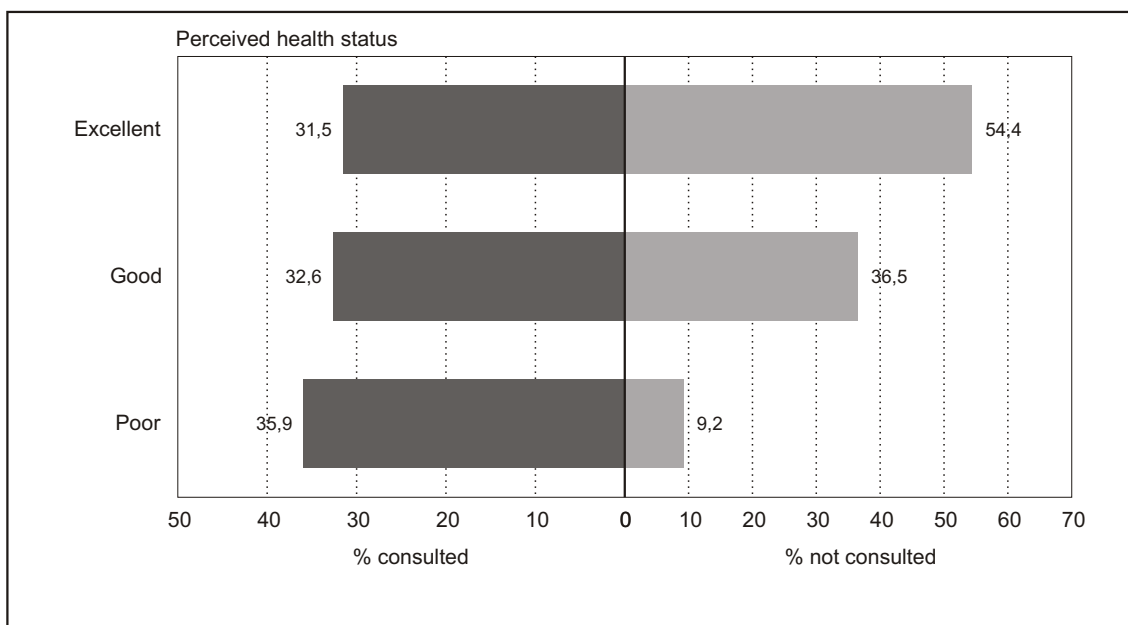
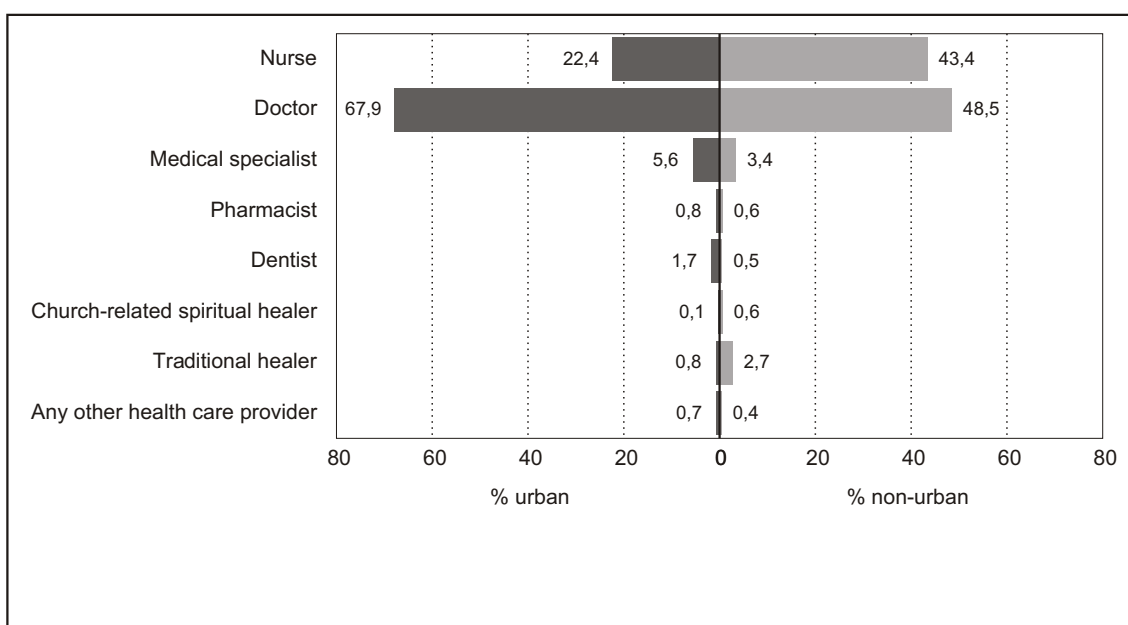


Figure 4.6 focuses on individuals in urban and non-urban areas who consulted a health worker in the month prior to the interview and the type of health worker they visited. Overall, 67,9% of people in urban areas who visited a health worker consulted a doctor, compared to 48,5% among those in non-urban areas. In addition, proportionately more people in non-urban areas (43,4%) than urban areas (22,4%) were reported to have consulted a nurse.

Figure 4.6: Distribution of urban and non-urban residents who visited a health worker in the month before the survey according to type of health service



Use of public or private sector health services

Stats SA (2001:86) found that between 1995 and 1998, public facilities were the most commonly used health care facility in South Africa, and that there was a gradual increase over time in the use of public health care facilities, and a gradual decrease in the use of private facilities.

Table 4.1 reveals that about one in every five people (20,7%) who visited a health worker in the month prior to the interview went to a public hospital, 29,8% visited a public health clinic and 38,5% went to a private doctor, specialist or pharmacist. Where an individual made more than one visit during the reference month, information about the most recent visit was recorded. Overall, about half of the population that visited a health facility in the previous month visited a public sector facility.

Use of different type of health services by males and females in the month prior to the interview in October 1999 was similar. However, female utilisation of public clinics was higher (31,5%) than male utilisation (27,4%).

Table 4.1: Percentage distribution of individuals who visited a health facility during the month before the survey by type of facility and gender

Health facility	Male		Female		Total	
	N ('000)	%	N ('000)	%	N ('000)	%
Public hospital	408	21,8	526	20,0	934	20,7
Public clinic	514	27,4	830	31,5	1 345	29,8
Other public sector facilities	18	1,0	26	1,0	43	1,0
Private hospital/clinic	154	8,2	200	7,6	355	7,9
Private doctor/specialist/ pharmacist	734	39,1	1 001	38,0	1 734	38,5
Traditional healer	35	1,9	38	1,4	74	1,6
Other private sector facilities	10	0,5	9	0,3	18	0,4
Alternative medicine	1	0,1	4	0,1	5	0,1
Total	1 875	100,0	2 633	100,0	4 508	100,0

In Figure 4.7, we group together various private health care facilities. Overall, 49,8% of male visits and 47,5% of female visits were to private health facilities.

The difference between the proportion of males and females who went to private versus public health services is small. But the proportion that visited private versus public facilities varied significantly by population group. White people were most likely to use private services. Overall, 84,7% of white male visits and 81,2% of white female visits were to private facilities. Africans and coloureds were least likely to utilise private services. Among females, only 40,1% of the coloured and 39,7% of the African populations visited private health facilities. Among males, 44,2% of the coloured population and 41,3% of the African population visited private health care facilities.

Estimation shows that over one-third (34,3%) of individuals who visited a public sector health facility in the month prior to the interview of 1999 paid for the consultation.

Proportionately more people who went to a private sector health facility were described as having better health than those who went to a public sector health facility. Figure 4.8

reveals that over a third (36,2%) of people who went to a private sector health facility were described as being in excellent health and 34,9% were described as being in good health. Among those who went to a public sector health facility, just over a quarter (25,7%) were perceived to be in excellent health and 29,9% in good health.

Figure 4.7: Percentage of individuals who visited a private health facility in the month before the survey by population group and gender

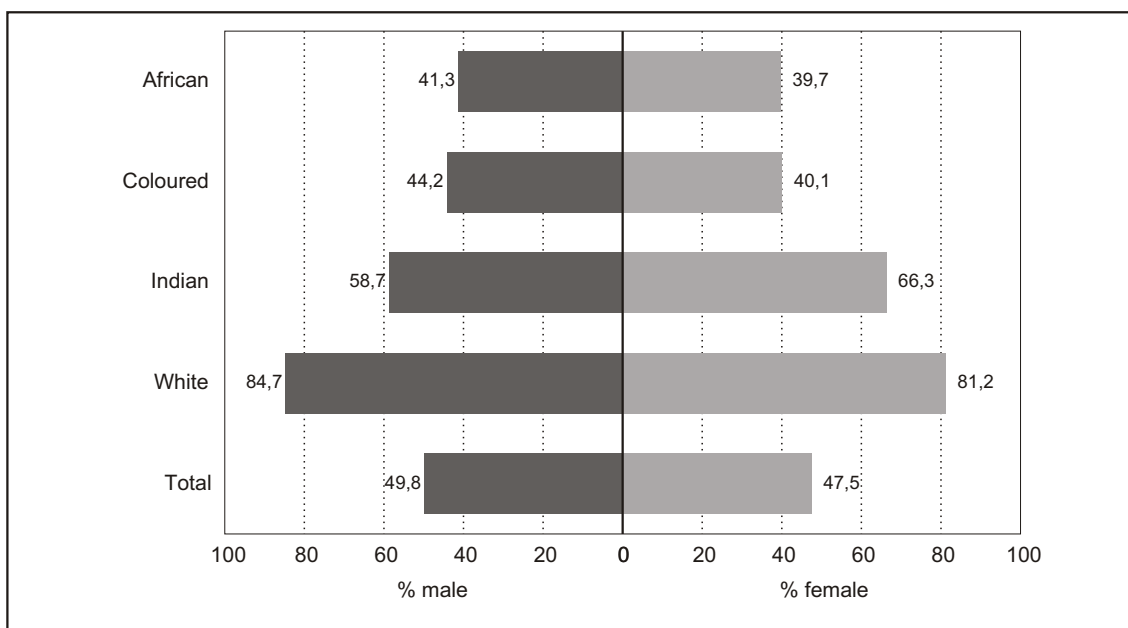
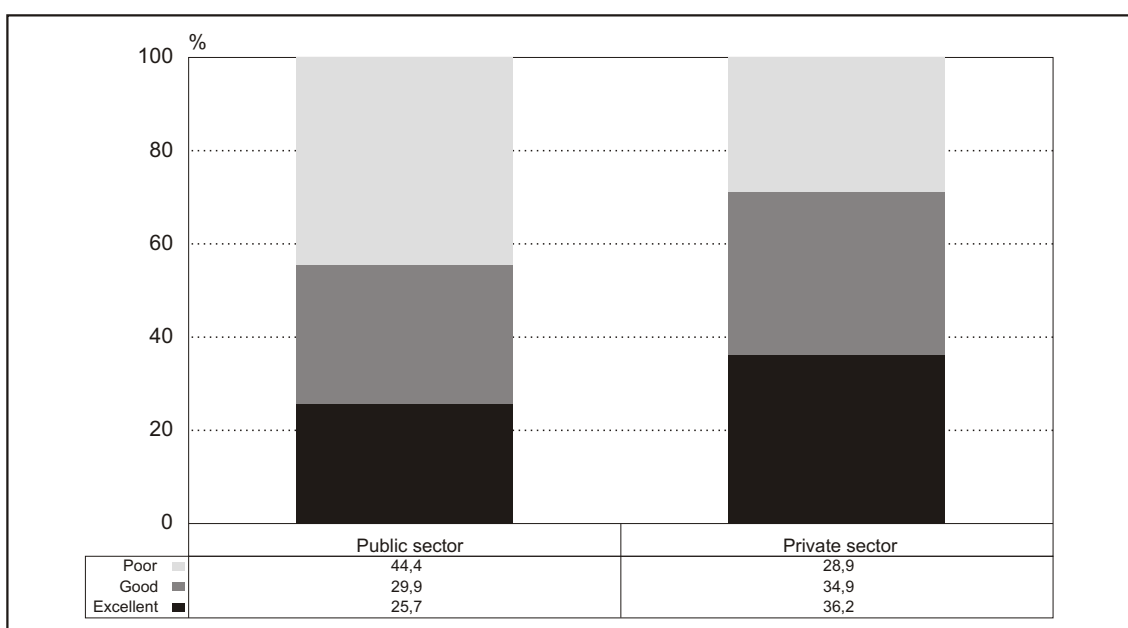


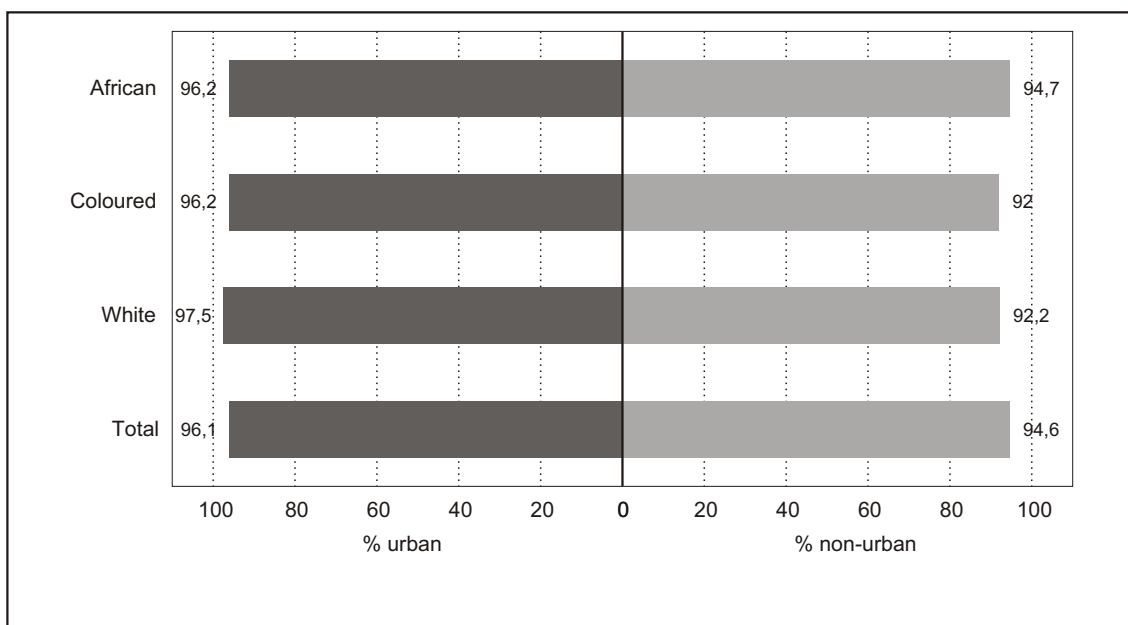
Figure 4.8: Perceived health status of individuals who utilised a health service in the month before the survey by sector of the health service



4.3 Immunisation

Road to Health, immunisation or clinic cards are used by the health system to record inoculations and other health details. The overwhelming majority (95,3%) of babies under 24 months were reported to have one of these cards. This was the case in both urban and non-urban areas. Figure 4.9 indicates only minor differences between the population groups in this respect. However for all population groups, there was a larger difference between urban and non-urban residents. This difference was least among Africans.

Figure 4.9: Distribution of children aged less than 24 months with a Road to Health, immunisation or clinic card by population group and milieu



4.4 Summary

The analysis of use of health care services in the country as at October 1999 indicated that:

- Only 18,5% of the population aged 20 and above had medical aid or health benefits. Access to medical benefits was more common among white people than other population groups; in 1999, over two-thirds of the white population had access to medical benefits. The health status of individuals with medical aid or health benefits was perceived as relatively better than those without access to medical benefits.
- Overall, 62,7% of South African households had a clinic within 2km . Over three-quarters of households in urban areas had a clinic within 2km. For non-urban households, the proportion with a clinic within 2km was lower, at 42,5%.
- Overall, 11,0% of the total population consulted a health worker during the month preceding the interview. Disaggregating by age, 26,6% of the population aged 66 years or older, 11,7% of those aged between 15 and 65 years, and 7,8% of those aged 14 years or younger were reported to have consulted a health worker in the month prior to the interview of 1999. In addition, proportionately more women than

men consulted a health worker in the month prior to the survey. People who did not visit a health worker were perceived to be in better health than those who visited a health worker.

- One in every five people (20,7%) who visited a health worker during the month preceding the interview went to a private hospital, 29,8% visited a public health clinic and 38,5% went to a private doctor, specialist or pharmacist.
- The differences in the proportion of men and women who went to private versus public health services were small, but more significant differences emerged between population groups. Proportionately more people who went to a private sector health facility were perceived as having a better health status than those who went to a public sector health facility.
- There were minor differences between the population groups in the likelihood that a baby would have a Road to Health card. There were, however, noticeable differences in this respect between urban and non-urban populations.

Section 5

Quality of life

This section focuses on indicators of quality of life and links these to how the health status of individuals was perceived.

5.1 Perceived quality of life

This sub-section uses a question on perceived quality of life. The main respondent in each household was asked to think back and compare his or her present life to twelve months before. This was the same respondent who was asked about the health status of each member of the household. The response to this question therefore reflects the main respondent's perception of the general quality of his or her life at the time of the interview in October 1999 compared to twelve months earlier.

Figure 5.1 indicates that in October 1999 respondents in nearly half (48,0%) of South African households felt that their life had remained the same over the past year. In 32,6% of the households, respondents felt that life had become worse and in about 19,4% of the households, respondents felt that life had improved in the past year.

When households are disaggregated according to urban and non-urban milieu, in 21,3% of urban households, respondents felt that their life had improved in the past year, while this was the case for 16,7% of non-urban respondents. Conversely, there were proportionately more non-urban (34,3%) than urban (31,4%) households in which respondents felt that their life had become worse in the past year. This suggests that for people living in urban households life had become relatively better than for those living in non-urban households.

Figure 5.1: Distribution of households in urban and non-urban areas according to respondents' perception of quality of life compared to twelve months before the survey

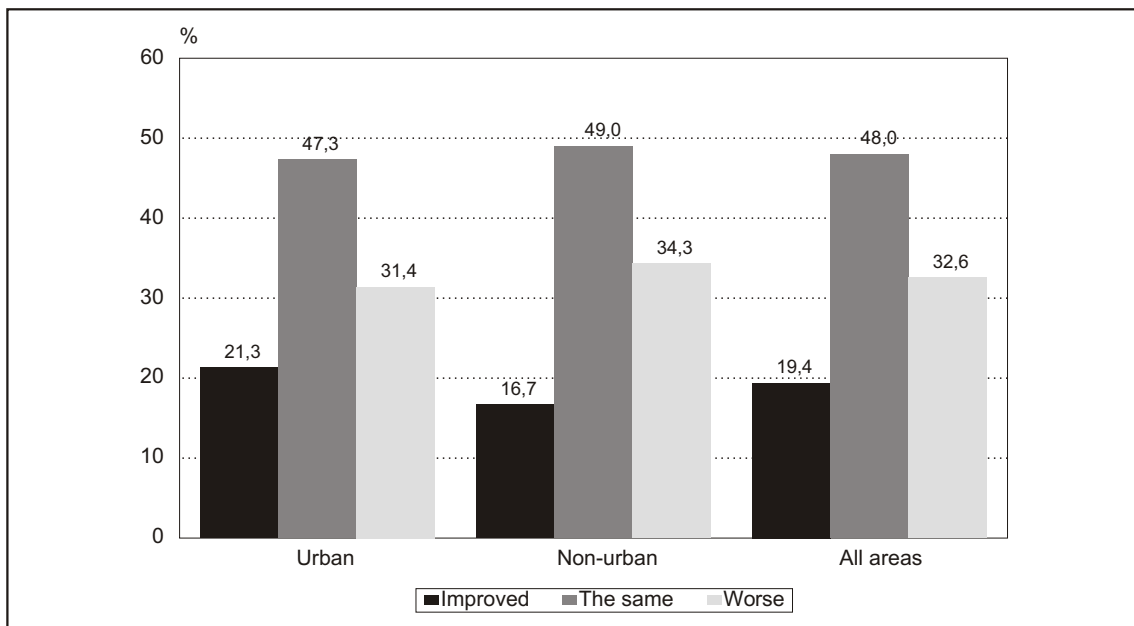


Figure 5.2 looks at the perceived quality of life of households by population group of the head of household. Differences are evident.

- Proportionately more respondents from African-headed households perceived their quality of life to have become worse than a year earlier.
- Households with Indian heads had the highest percentage of respondents who felt that life had improved.

Figure 5.2: Distribution of households according to respondents' perception of quality of life compared to twelve months before the survey and population group of the head of household

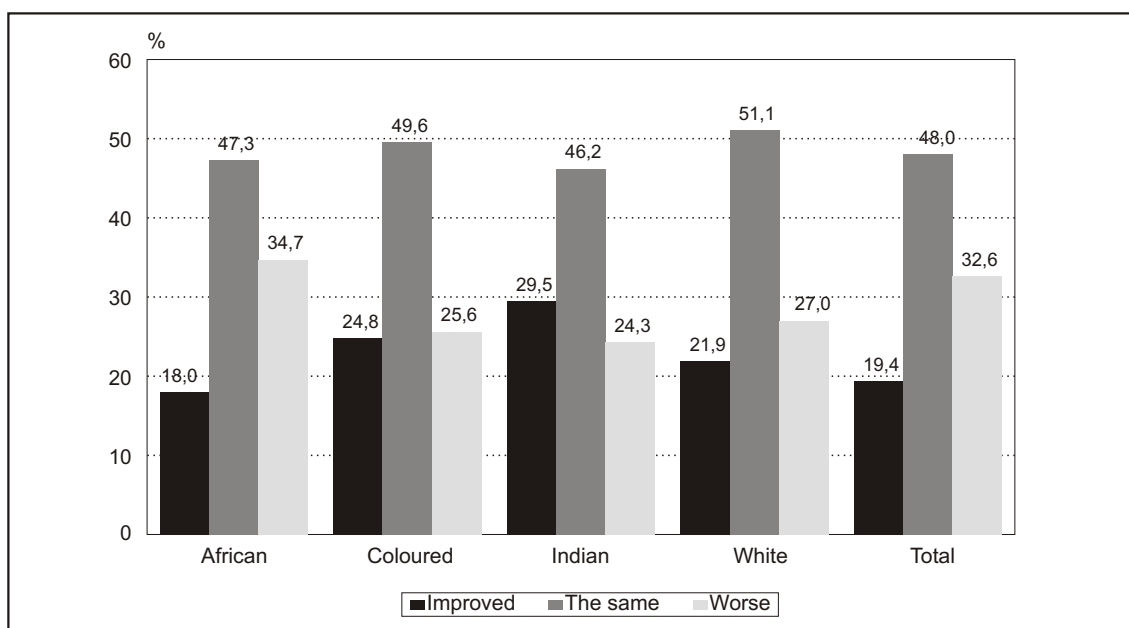
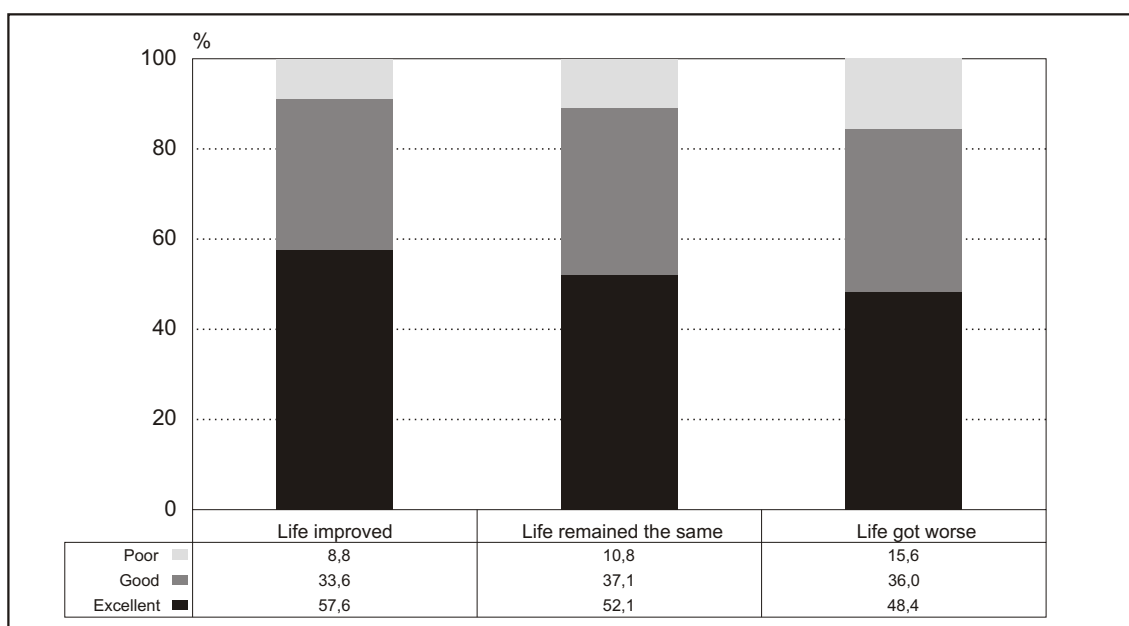


Figure 5.3 indicates that people in households where respondents perceived their household's quality of life to have improved, were generally perceived as having a better health status. For example,

- In households in which respondents felt that their life had improved, 57,6% of the members were described as having excellent health compared to the 48,4% in households in which the respondent felt that their life had become worse.
- In households where respondents felt their life had become worse, proportionately more people's health status was perceived as poor (15,6%) than people in households in which individuals felt that their quality life had improved over the past one year.

Overall, in households in which respondents perceived their life as having remained the same, the percentage of members that were described as having excellent health status (52,1%) was less than that of people in households in which respondents perceived their life as having improved (57,6%) and more than that of people in households in which respondents perceived their life as having become worse (48,4%). Conversely, the percentage of people whose health status was perceived as poor in households in which life was reported to have remained the same (10,8%) was less than in households in which respondents perceived their life as having improved (8,8%) and more than in households where respondents perceived their life as having become worse in the past year (15,6%).

Figure 5.3: Perceived health status of individuals according to respondents' perception of quality of life compared to twelve months before the survey



5.2 Crisis events within the household

In the OHS of 1999, respondents were asked if any of selected crisis or traumatic events or situations had occurred in their households over the twelve months before the survey. The listed events were as follows: death of a household member; serious injury or illness keeping a household member from doing normal activities; loss of a regular job of a household member; cut-off or decrease of remittance to a household member including private maintenance payments; cut-off or decrease of government grant which was not the result of the death of the beneficiary; abandonment or divorce; theft, fire or destruction of household property; and failure or bankruptcy of a family business. Crisis events or situations are likely to have a bearing on the quality of life of the households concerned. For vulnerable households, they may upset a delicate balance. For example, cut-off or decrease in grants or remittances, job losses, bankruptcy and death (especially in the case of a breadwinner) will have a bearing on the economic well-being of the household. Events such as death, abandonment or serious injury of a household member will have a bearing on the emotional well-being of household members, and may also affect economic and other aspects.

Figure 5.4 indicates the percentage of households experiencing the selected traumatic events during the twelve months prior to the interview. For example, the bottom bar of the chart indicates that 0,5% of all households experienced a cut-off or decrease of grants. Any one household can experience more than one of these events. The figure indicates that the most common reported crisis was death, which affected 8,6% of households. This was followed by serious injury or illness keeping a household member from doing normal activities. Theft, fire or destruction of household property were among the most common traumatic events experienced by households during the year preceding the survey.

Figure 5.4: Percentage of households that experienced each of selected crisis events in the twelve months before the survey

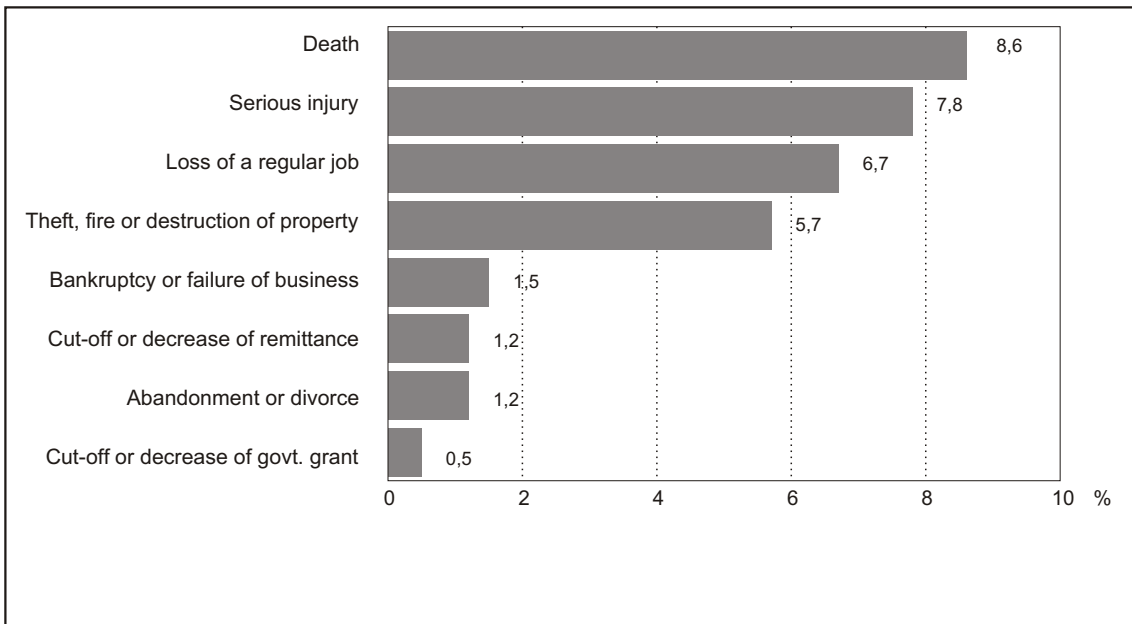
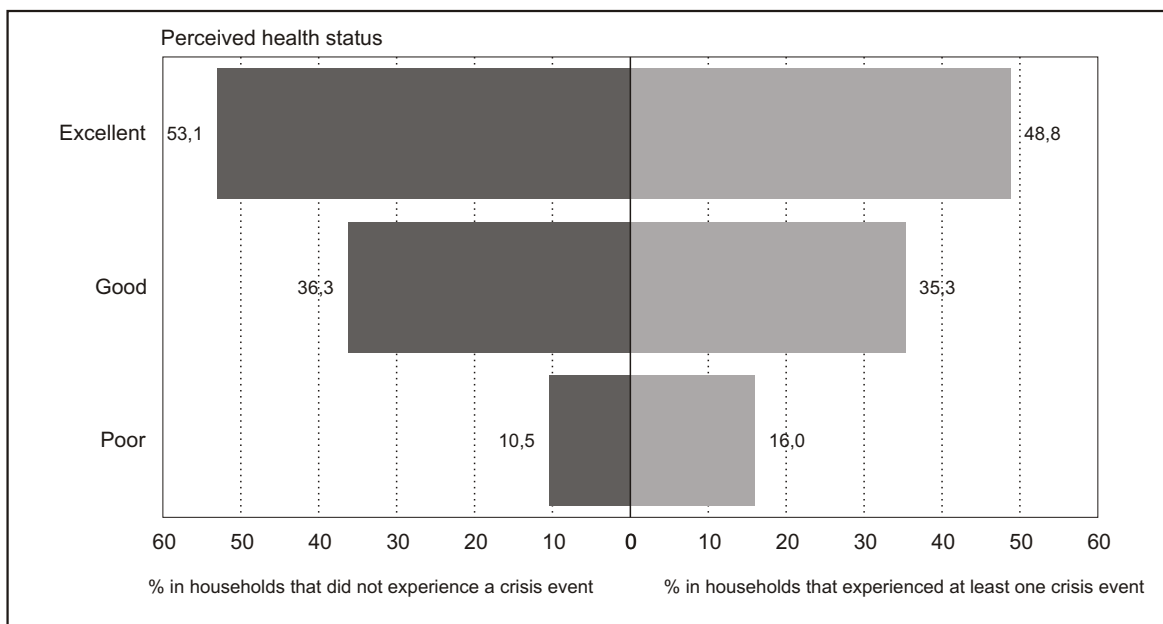


Figure 5.5 shows the perceived health status of individuals according to whether or not a crisis event was experienced in the household in the year preceding the survey. The figure indicates that individuals in households where none of the traumatic events was experienced were perceived to be in better health than those in households where at least one traumatic event was experienced. Overall, 53,1% of individuals in households where no traumatic event was experienced were described as being in excellent health, compared with 48,8% in households where at least one traumatic event was experienced.

Figure 5.5: Perceived health status of individuals according to whether a member of the household experienced a crisis event in the twelve months before the survey



5.3 Disability

Respondents were asked about major disabilities experienced by household members. More specifically, they were asked whether members were limited in their daily activities because of a long-term physical or mental condition. Where members were reported as having a disability, respondents were asked to describe the nature of the difficulty. The level and type of disability reported depend partly on the definition, but they may also depend on perceptions and the extent to which respondents are prepared to report disability. The following analysis should therefore be treated with caution, although it does provide some insights into disability in the country.

Out of 43,3 million South Africans in October 1999, 1,5 million were reported to have disabilities. Of those that had disabilities, 49,9% were male. Figure 5.6 reveals that coloured people had a proportionately higher level of reported disability.

Figure 5.6: Percentage in each population group with a disability

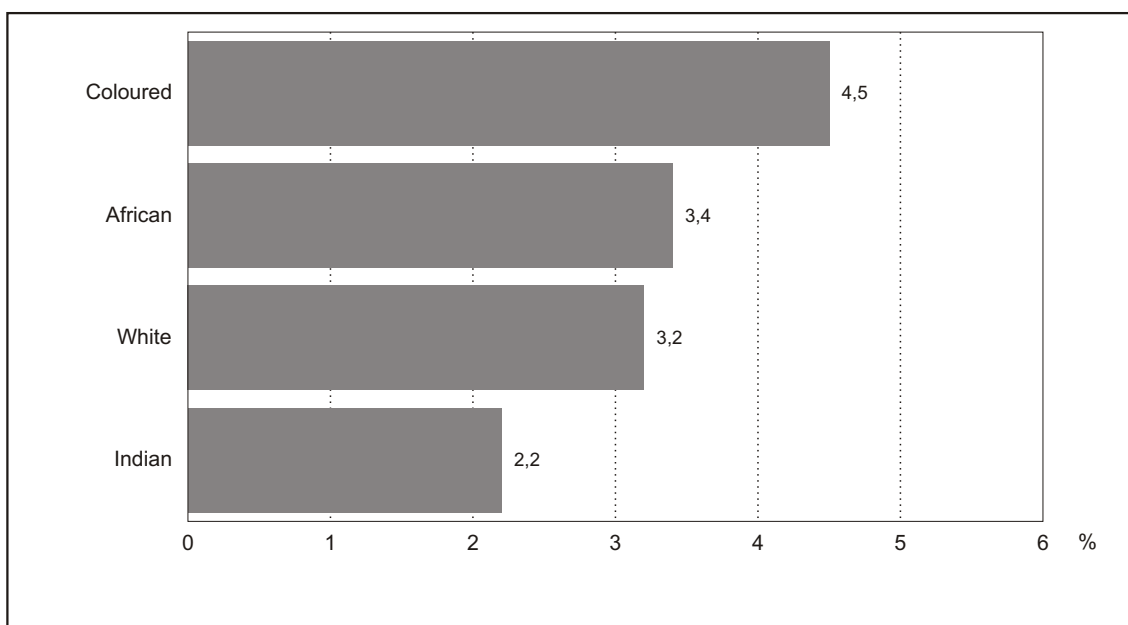


Figure 5.7 indicates the percentage of the disabled population that experienced specific forms of disability. An individual could have more than one type of disability and would therefore be represented more than once. The bars in the graph therefore sum to more than 100%. The first bar shows the most common form of disability. It shows that 30,4% of people with disabilities had movement disabilities, while 69,6% of the disabled population did not have movement disabilities. The second most common form of disability was sight defects (24,5%), followed by the inability to stand for a long time (22,7%). The least common form of disability was that associated with communicating, such as difficulty in talking, conveying information or hearing.

Certain types of disability are age-related. In addition, there could be population group and other differences in the incidence and nature of disability among males and females. Unfortunately, investigation of these is not possible because of the small numbers of people with each disability for each age category.

Figure 5.7: Percentage of people with disabilities who experienced each type of disability

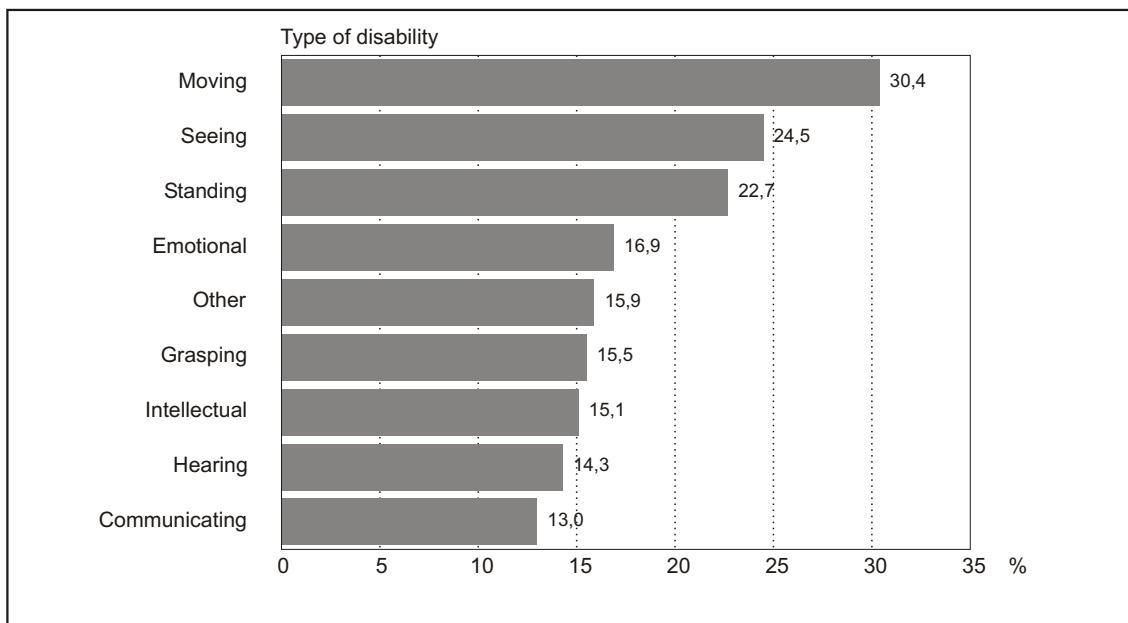
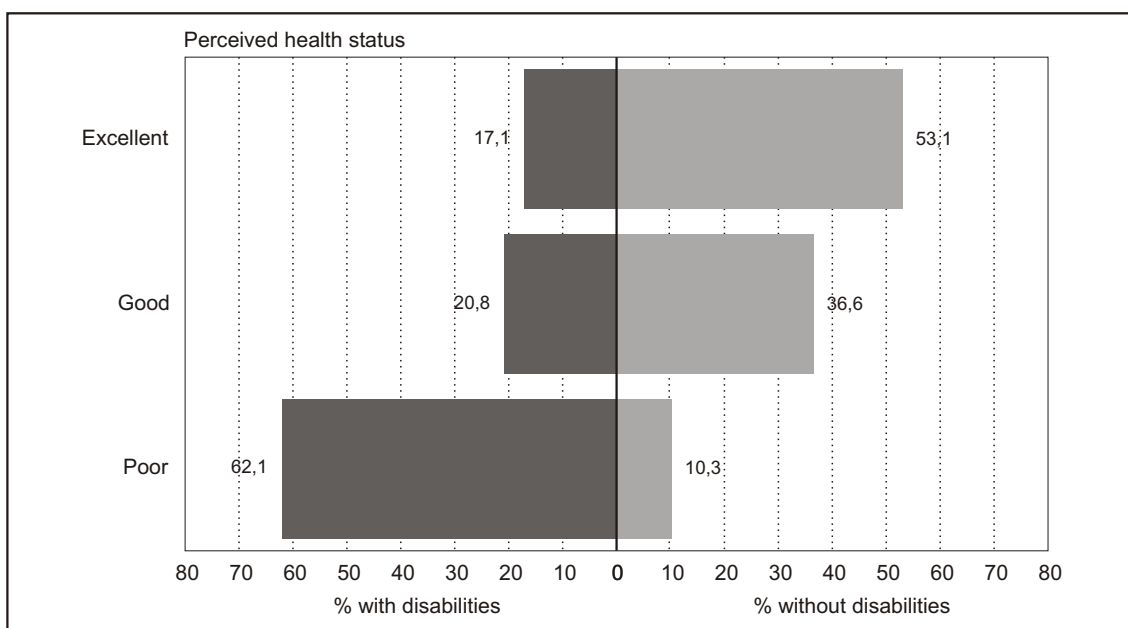


Figure 5.8 shows the reported health status of individuals with and without disabilities. Close on two-thirds of people with disabilities were described as having a poor health status while this percentage was 10,3% among those without disabilities. Conversely, more than half of individuals without disabilities were perceived as having excellent health, while this was true for only 17,1% of those with disabilities.

Figure 5.8: Perceived health status of people with and without disabilities



5.4 Nutrition

This sub-section discusses nutrition as an indicator of quality of life and a determinant of health status.

In October 1999, there were 27 183 households with children under seven years of age. In over a quarter (26,5%) of these households, it was reported that children under seven years went hungry at some stage in the twelve months prior to the interview because there was not enough money to buy food.

Figure 5.9 shows the percentage of all households according to whether any member of the household went hungry due to lack of money for food in the year preceding the interview by population group of the household head. The proportion of households in which at least one person went hungry in the year preceding the interview was highest among households headed by Africans (29,7%), followed by those headed by coloureds (16,5%) and Indians (6,5%), and lowest in households headed by whites (2,9%).

Figure 5.9: Distribution of households according to whether at least one member of the household went hungry in the twelve months before the survey due to lack of money for food, and population group of the household head

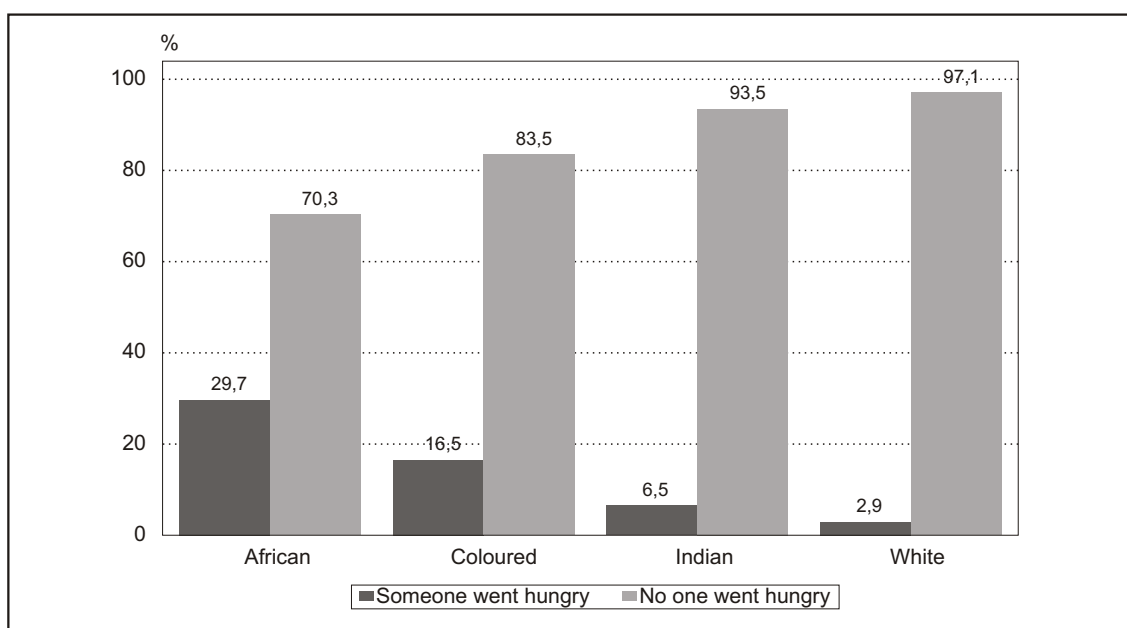
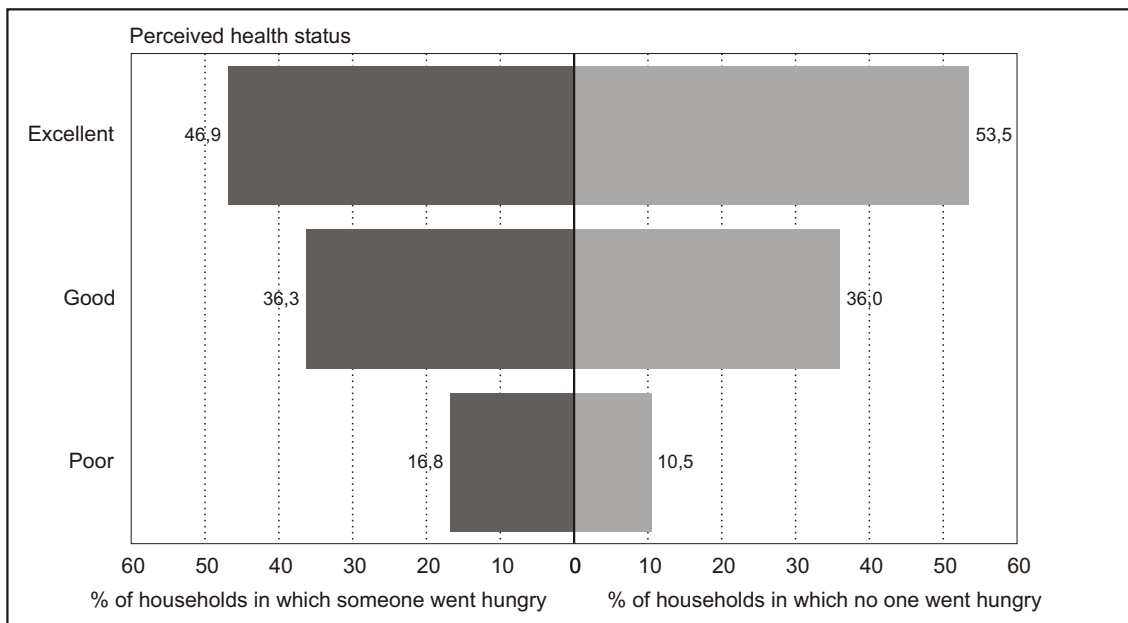


Figure 5.10 shows the health status of individuals according to whether or not they lived in households in which at least one person went hungry at any point in time in the past year because there was not enough money to buy food. Relatively, individuals living in households in which no one went hungry because there was no money for food had a better perceived health status. Of the people in households in which no one went hungry, 53,5% were described as having excellent health, and 10,5% as having poor health, whereas in households in which at least one person went hungry at some stage, 46,9% of people were described as having excellent health, and 16,8% as having poor health.

Figure 5.10: Perceived health status of individuals according to whether at least one member of the household went hungry in the twelve months before the survey due to lack of money for food

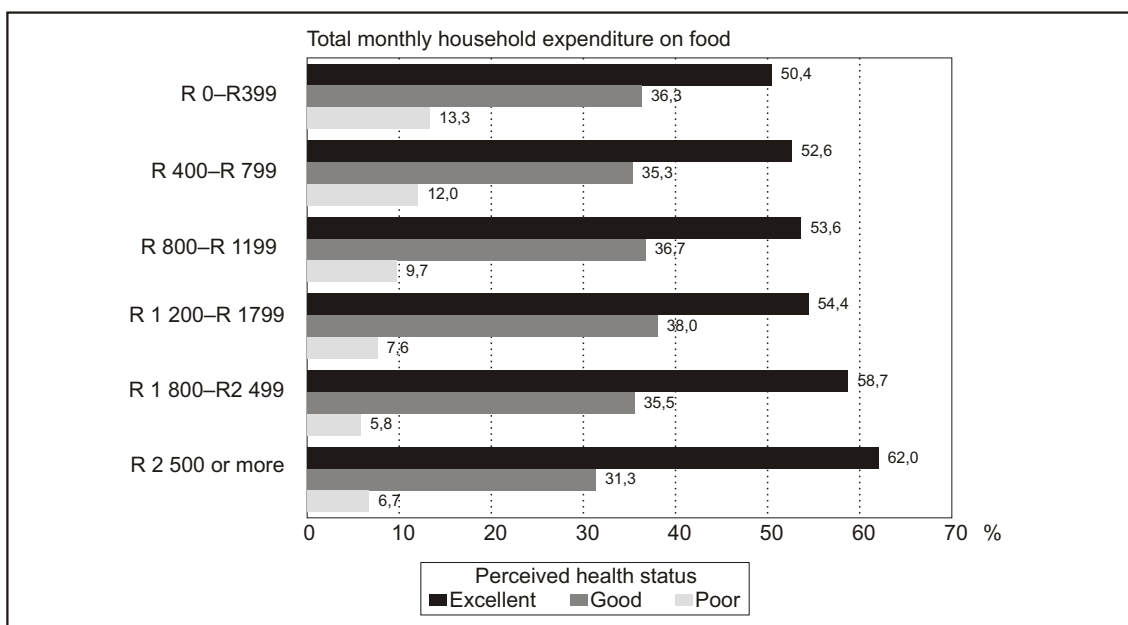


5.5 Household food expenditure

Individuals were asked to indicate the household's expenditure on food for the month preceding the interview. This expenditure on food included expenditure when people ate away from home but excluded non-food groceries. Generally, household surveys that ask simple questions on expenditure and income tend to get severe under-reporting of levels. However, it is assumed that the patterns are more or less correct. Household expenditure on food over the month prior to the interview as an indicator of household consumption and quality of life is considered below.

Figure 5.11 looks at the relationships between the total amount of money households spent on food a month and the perceived health status of members. Individuals in households which spent R2 500 or more a month on food, were reported to have a better health status than members in households which spent less. The proportion of individuals whose health was considered excellent increases with increased household expenditure on food.

Figure 5.11: Perceived health status of individuals according to total monthly household expenditure on food



5.6 Summary

Analysis of the quality of life of households shows that:

- In October 1999, in 32,6% of the households, respondents felt that life had become worse in the past year and in about 19,4% of the households, respondents felt that life had improved. For respondents living in urban households life was perceived to have become relatively better than for those living in non-urban households. Comparing population groups, more respondents in households headed by Africans perceived their quality of life to have become worse. Individuals living in households in which respondents felt that life remained the same were described as having relatively better health than those in households in which life became worse in the past year and relatively worse health than those living in households in which life had improved in the past year.
- Death in the household was the most commonly reported crisis, followed by serious injury, and then loss of a regular job. Individuals in households in which members experienced none of the eight selected traumatic events were perceived to be in better health than those in households in which members experienced at least one traumatic event. Individuals in households in which members experienced none of the crisis events were perceived to be in better health than those in households in which members experienced at least one traumatic event.
- Out of 43,3 million South Africans in October 1999, 1,5 million were reported to have disabilities. The most common form of disability was that of movement, followed by eye defects and the inability to stand for a long time. The least common form of disability was that associated with communicating. The survey also found that the health status of people with disabilities was relatively worse than that of people without disabilities.

- The proportion of households in which at least one person went hungry in the year before the interview was highest among households headed by Africans (29,7%) and lowest among households headed by whites (2,9%). Relatively, people in households in which no one went hungry in the year preceding the survey had a good perceived health status.
- Individuals in households which spent the highest amount of money per month on food were reported to have a better health status than members of households which spent less.

Section 6

Conclusion

In order to improve access to health care for all South Africans and reduce inequity, government is committed to, among others, improvements in the quality of care; revitalisation of public hospitals; further implementation of the district health system and primary care; and a decrease in the incidence of HIV/AIDS, sexually transmitted diseases and tuberculosis.

Objective assessment of the health status of individuals would necessitate a medical examination. In the absence of this examination, perceived health status provides a good indication of health status. This report describes the perceived health status of the South African population including childbearing women, children, and people with disabilities; differences in the perceived health status of individuals according to their living conditions; and indicators of quality of life and the use of health services as a health inhibitor or enabler. The linkages observed do not necessarily establish causality in a particular direction or significant association. However they are probably indicative of the objective health status of the population as well as of access to and use of health services.

The conclusions and implications discussed below are based on the synthesis of the findings from the earlier sections.

6.1 Perceived health status of the South African population including women, children and people with disabilities

Over half of the population was reported as having excellent health, 36,1% as having good health and only 12,0% as having average, poor or very poor health (combined in this report as poor). These levels, although positive, conceal variations between groups of people in how their health status was perceived; for example, there were differences in the perceived health status of women and men. In addition individuals residing in urban areas, younger people, white people and those who had achieved matric or a higher level of education were described as having a better health status than others. It is only among people with no formal education that the percentage whose health was described as poor was higher than the percentage described as having excellent health.

In terms of reproductive health the report focuses on indicators related to childbearing. A substantial proportion (13,8%) of women aged 12-19 gave birth in the twelve months prior to the interview. Generally, women who gave birth in clinics and hospitals were perceived as enjoying better health than those who gave birth elsewhere.

Findings about the perceived health status of children indicate that even among children there were differences, such as those between older and younger children. Most probably there were differences, among children of different population groups, although this is not analysed here. Analyses indicate that teenagers (13-17 years) and pre-teenagers (7-12 years) were perceived as having a better health status than younger children (0-6 years).

Out of 43,3 million South Africans in October 1999, 1,5 million had disabilities. The survey found that the health status of people with disabilities, even though perceived in this case, was reported to be relatively worse than that of people without disabilities.

6.2 Household living conditions as a perceived health status differential

The health status of people living in formal dwellings was perceived as being better than that of people living in traditional dwellings. Moreover, a higher proportion of people living in overcrowded households were described as having poor health than of those living in households that were not overcrowded. Relatively, individuals who used flush or chemical toilets seemed to be perceived as having a better health status than others.

Small differences were found in the perceived health status of individuals in households using various sources of water, whilst method of refuse removal seemed to have very little bearing on people's perceived health status.

6.3 Indicators of the quality of life and health care usage as inhibitors or enablers of health status

Overall, 62,7% of South African households had a clinic within 2km while 37,3% of the households had a clinic further than 2km from the dwelling. Over three-quarters of households in urban areas had a clinic within 2km. For non-urban households, the proportion with a clinic within 2km was found to be proportionately lower than that of urban households.

More than one in every ten (11,0%) of the total population consulted a health worker at some point during the month before the survey. In addition, 26,2% of the population aged 65 or older, 11,6% of those aged between 15 and 64 years, and 7,8% of those aged 14 years or younger were reported to have consulted a health worker in the month before the survey. This pattern persists for women and men. Consultations were evenly split between public and private health facilities.

Proportionately more people who went to a private sector health facility were described as having better health than those who went to a public sector health facility.

Only 16,3% of the population aged 20 and above had access to medical benefits. Access to medical benefits was more common among white people than other population groups. The survey indicated that the health status of individuals with medical aid was perceived as relatively better than that of those without access to medical aid.

In October 1999, in 48,3% of households respondents felt that life had remained the same over the past year, followed by households in which members felt that life had become worse (32,6%) and finally households in which individuals felt that life had improved in the past year (19,4%). For people living in urban households, life seemed to have improved more than for those living in non-urban households. The quality of life was perceived to have got worse in more households headed by Africans than in households headed by members of the other population groups. Death in the household was the most common traumatic event, followed by serious injury, and then loss of a regular job. Individuals in households where none of the selected traumatic events was experienced were perceived to be in better health than those in households where at least one such event was experienced.

There appears to be a link between perceived health status and subjective assessment of the quality of life. Individuals living in households in which life remained the same were described as having relatively better health than those in households in which life had got worse, and relatively worse health than those living in households in which life had improved.

Results further indicate that individuals in households which spent the highest amount of money per month on food, were reported to have a better health status than members in households which spent less.

6.4 Implications

The report provides a baseline picture of perceived health status and utilisation of health care services. It also provides information on levels and prevalence of other health indicators such as nutrition, subjective quality of life, household expenditure on food, level of disability, access to medical aid, overcrowding and living conditions, and the relation of these indicators to the perceived health status of individuals. In conjunction with other sources of information, this analysis can assist in tracking progress in accessibility and choice of health services and variations among different sections of the population. The paper reveals that there are still disparities between rural and urban areas, men and women, population groups, different age cohorts and those with and without disabilities. This implies a need to pay particular attention to the scope and nature of any interventions.

At a broader level, the report provides some idea of vulnerable groups with regard to access to and use of health care facilities, hence groups that may be targeted by policy. It also provides indicators of socio-economic and human development issues that can be targeted by integrated policy, which will ultimately impact on the health status of the population.

At a methodological level, the paper indicates the need for information on the actual types of illness and injuries people experience in order to understand patterns of morbidity and emerging forms of diseases, and on some psychosocial factors which might have a bearing on the health status of individuals. In addition, household surveys could also include some objective health measures, although this would need considerable resources.

One limitation of the question on perceived health status as asked in the October household survey is the fact that the respondent reports on the health status of other household members, instead of each person self-rating their own health. Assessment will therefore depend greatly on the respondent. For instance, optimistic respondents might tend to overrate the health status of other members of the household. Moreover, the question does not differentiate between psychological and physiological health. However, the report has been able to ascertain the prevalence of health-related indicators. In most instances the reported links and trends between health status and other variables are as expected. This offers support for the usefulness of subjective health assessment in the absence of objective measures.



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