South Africa is an upper-middle-income country, with some of the world’s widest socioeconomic inequalities. These contribute to poor health outcomes and inequality in access to health care. Poor health in turn aggravates socioeconomic inequalities. Despite spending a relatively large proportion of its GDP on health, the country’s health indicators remain poorer than those of other upper-middle-countries with similar or lower levels of expenditure. This is partly due to inequities in health spending, 51% of which provides services to only 16% of the population. Although skilled personnel attend 96.7% of births and 75.5% of pregnant women receive four or more antenatal visits, maternal mortality remains high at 138 per 100,000 live births. The under-5 mortality rate is 40.3 per 1,000 live births. See Table 1 for key demographic and health indicators.

South African law guarantees access to SRHR services. Death from unsafe abortion has declined by more than 90% since the Choice on Termination of Pregnancy Act was passed in 1996. However, the country’s maternal mortality rate remains unacceptably high, and many women face obstacles when seeking a safe legal abortion. South Africa still has high rates of HIV and unintended pregnancy. Young women face particular challenges: one in three women aged 15-24 experiences an unintended pregnancy before the age of 20, and among females aged 15-24 HIV incidence is more than four times higher than among males in the same group. Gender-based violence and femicide are among the highest in the world.

Since democracy in 1994, the government has tried to redress inequities in access to health care through policies such as the National Department of Health Strategic Plan 2010/11–2012/13 and the National Development Plan. The National Health Insurance (NHI) white paper aims to provide a package of primary health care services to vulnerable populations by 2021 and to the whole population by 2025.

Prioritizing the benefits package: Many benefits packages are available in South Africa, primarily through private health insurers who purchase services from private providers in addition to services available in the public sector. The Medical Schemes Act (No 131 of 198) lists services that all private health insurance schemes must cover. These Prescribed Minimum Benefits are made up of 270 “diagnosis-treatment pairs” together with 27 conditions stipulated in the Chronic Disease List. Different medical schemes and their administrators have each developed a range of benefit options that cover these Prescribed Minimum Benefits plus additional benefits in different forms, based on ability to pay. By

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2 WHO Global Health Observatory, most recent year available.
3 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates’ websites.
design, these benefits are hospital-centric in nature. In contrast, the services available in the public sector are not governed by any benefits package or list of services, so different interventions may be provided at different facilities, according to the resources available in each location.

Work is currently underway to prepare for NHI by creating a single national benefits package, beginning with primary health care and expanding incrementally to cover all levels of care. At this early stage of NHI transition, the focus is less on prioritization and more on ensuring consistency in definition and thus in quality of services: specifying services to be delivered at each level of the health sector, and costing them in order to inform the development of reimbursement rates, which are particularly relevant to the planned contracting of private sector providers. South Africa’s approach to prioritization is to focus on delivering services first at primary health-care level, ensuring that the private sector will also deliver these services at the

Table 1. South Africa: key demographic and health indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2016)</td>
<td>56,015,000</td>
</tr>
<tr>
<td>GNI per capita (PPP international US$, 2013)</td>
<td>12,240</td>
</tr>
<tr>
<td>Life expectancy at birth M/F (years, 2016)</td>
<td>60/67</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP (2014)</td>
<td>8</td>
</tr>
<tr>
<td>Out-of-pocket expenditure as % of current health expenditure</td>
<td>8</td>
</tr>
<tr>
<td>Voluntary health insurance as % of current health expenditure</td>
<td>36</td>
</tr>
<tr>
<td>Nurses &amp; midwives/10,000 pop. (2017)</td>
<td>35.171</td>
</tr>
<tr>
<td>Physicians/10,000 pop. (2017)</td>
<td>9.101</td>
</tr>
<tr>
<td>Percentage of births attended by skilled health personnel (2011-2016)</td>
<td>96.7</td>
</tr>
<tr>
<td>Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2016)</td>
<td>77.9</td>
</tr>
<tr>
<td>Abortion at the woman’s request (Y/N)</td>
<td>Y</td>
</tr>
</tbody>
</table>

1 WHO Global Health Observatory https://www.who.int/gho/en/
2 Global Health Expenditure Database http://apps.who.int/nha/database/
appropriate level of the health system. For example, if a service can be delivered at a clinic but is currently only offered at hospital level by a medical scheme, it should in future also be offered at clinic level, so as to increase access and control associated costs.

Within primary health care, no prioritization process is currently being conducted, although the government plans eventually to prioritize services based on cost effectiveness. The national benefits package is based on the national Standard Treatment Guidelines for primary health care. These guidelines were updated in 2017 and 2018 from a clinical perspective; they may require further revision as they vary in specificity and will need to be sufficiently precise for the private sector to align their coded diagnoses, (i.e. detailed enough to map to specific International Classification of Diseases and procedure codes). The package incorporates an Essential Medicines List and national Clinical Practice Guidelines. Many of the interventions recommended by the Guttmacher-Lancet Commission on SRHR are included (see Table 2). Efforts are also being made to align and rationalize existing guidelines and to identify gaps to be addressed. An online platform (South Africa Health Benefits) has been developed to consolidate all this information in one place, and is currently in beta testing.

Participation: The introduction of NHI is being led by the Office of the President in collaboration with the National Department of Health. The process of developing the health benefits package is therefore government-led and supported by regulatory agencies, including the regulatory body for private medical schemes (the Council for Medical Schemes) and the Office for Health Standards Compliance. It is also supported by individual private sector partners, including key schemes and administrators. It is further informed by the Competition Commission Health Market Report (2019) which recommends “the introduction of a single comprehensive, standardized base benefit option”. In the process of developing South Africa Health Benefits, exploratory analysis has compared the national Clinical Practice Guidelines with the Standard Treatment Guidelines. This includes the Guidelines for Maternal Care in South Africa (2015), the Guidelines for Neonatal Care (2011) and several other instruments. Seventy-six conditions relating to SRHR are captured at primary healthcare level in South Africa Health Benefits, and only minor political challenges have been raised to the inclusion of even the most controversial elements of SRHR. Comprehensive primary health care is widely
regarded as a right, and prioritizing some services for inclusion in a package implicitly excludes others; therefore, prioritization has been seen as politically unpalatable. However, the focus on primary health care is itself a form of prioritization; the current process of defining what is meant by primary health care in South Africa is increasing public awareness of and commitment to a defined and transparent process of priority setting.

**Challenges**: The NHI and Medical Schemes Amendment bills, when enacted, will govern the implementation of a benefits package. The NHI bill was approved by Parliament in August 2019. The NHI fund has yet to be established, but funding continues for the health system strengthening initiatives that are essential to the rollout of NHI. The election in May 2019 led to the appointment of a new Minister for Health who has affirmed support for NHI. Private sector medical service providers, a powerful lobby, are concerned that their role in the proposed structure has not been clearly defined. Other actors, such as trade unions, are concerned that the fund will not achieve the equity aims set out in the white paper. The white paper focused on addressing inequality by delivering services to poor and vulnerable populations. However, implementation will be administered by provinces, which have considerable autonomy, so the realization of that policy presents a major challenge and will depend on further legislative changes (as outlined in the NHI bill).

**Successes**: The South Africa Health Benefits database, which sets out the services and inputs covered by the Standard Treatment Guidelines, is now online as an interactive platform. The adoption of a primary health care package has helped to ensure the inclusion of many SRHR interventions, although those delivered at secondary or tertiary level are omitted, as are those delivered outside the health sector. In general, technical and managerial capacity is strong in the private sector but more limited in the public sector at national level. Data of varying quality are available at facility, provincial and national levels and will be used to inform decision-making for the package. The government plans to conduct service availability assessments to identify services not currently available but which should be delivered when the South Africa Health Benefits are fully implemented.
Reforms, revisions and plans for the future: In preparation for NHI, a number of processes have been initiated. An “ideal clinics” initiative has been put in place to measure input and service availability against a target envelope of operational capacity, infrastructure, human resources, medicine stocks and other supplies. Conditional grants were released, prioritizing school health, maternal health, mental health, cataract surgeries and oncology; however, these have since been allocated to other programmes/areas. The National Treasury is designing a capitation system for provider payment, intended to reduce both administration costs and overprovision of services compared with a fee-for-service model. A coalition of universities and academic partners is building capacity to provide expertise in setting up processes to design and prioritize services institutionally. The NHI white paper states that interventions will be added, based on criteria including cost-effectiveness and equity, and the related bill has been approved by Parliament. The National Tertiary Services Grant, which allocates funds between 28 tertiary-level hospitals across all provinces, is being reviewed to make the allocation formula and process more strategic and more reflective of health and population data. SRHR actors could exert influence here by mobilizing and/or generating evidence on resource gaps for SRHR service availability, to inform the allocation of funds from this grant, and from the NHI Fund once it is established.
Table 12: Overview of interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from South Africa’s health benefits package

<table>
<thead>
<tr>
<th>Interventions recommended by Guttmacher-Lancet Commission</th>
<th>South Africa Health Benefits and Standard Treatment Guidelines - interventions included/omitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive sexuality education¹</td>
<td>• Not included</td>
</tr>
</tbody>
</table>
| Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods | • Emergency contraception  
• Family planning – IUCD  
• Family planning – medroxyprogesterone injection (Depo Provera)  
• Family planning – norethisterone enanthate injection (Nur-Isterate)  
• Family planning – oral pill  
• Family planning – subdermal implant |
| Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care | • Eight antenatal care visits  
• Antenatal care: anaemia in pregnancy  
• Antenatal care: care of the HIV-infected pregnant woman  
• Antenatal care: hypertensive disorders of pregnancy – eclampsia  
• Antenatal care: hypertensive disorders of pregnancy – hypertension, chronic/ mild-moderate and severe  
• Antenatal care: hypertensive disorders of pregnancy – pre-eclampsia  
• Antenatal care: syphilis in pregnancy  
• Bleeding in pregnancy: antepartum haemorrhage  
• Abnormalities in the first, second, third and fourth stages  
• Bleeding in pregnancy: management of incomplete miscarriage in the first trimester at primary health care level  
• Bleeding in pregnancy: miscarriage  
• Breech presentation and transverse lie during pregnancy  
• Urinary tract infection in pregnancy, cystitis  
• Vaginal bleeding: abnormal vaginal bleeding during fertile years  
• Vaginal discharge/ lower abdominal pain in women  
• Genital ulcer syndrome in pregnancy  
• Postpartum haemorrhage  
• Premature rupture of membranes at term  
• Preterm labour  
• Preterm prelabour rupture of membrane  
• Puerperal sepsis  
• Ulcers, vaginal  
• Care of the neonate: neonatal resuscitation  
• Care of the neonate: routine care of the neonate  
• Care of the neonate: sick neonate and neonatal emergencies  
• Neonatal apnoea  
• Neonatal convulsions  
• Neonatal jaundice  
• Congenital pneumonia  
• Cracked nipples during breastfeeding  
• Dysmenorrhoea  
• Ectopic pregnancy  
• Hormone therapy  
• Intrapartum care (normal delivery)  
• Intrauterine death, stillborn babies and neonatal deaths  
• Intrauterine growth restrictions  
• Management of deep vein thrombosis in pregnancy  
• Mastitis |
| Safe abortion services and treatment of complications of unsafe abortion | • Bleeding in pregnancy: management of incomplete miscarriage in the first trimester (includes termination of pregnancy at <9 weeks, 9-12 weeks, 12+ weeks) |
| Prevention and treatment of HIV and other sexually transmitted infections | • Antiretroviral therapy, first and second line, adults and children  
• Post-exposure prophylaxis  
• Male circumcision  
• Pre-exposure prophylaxis (from Standard Treatment Guidelines)  
• Balanitis/balanoposthitis  
• Bubo  
• Genital molluscum contagiosum  
• Genital ulcer syndrome  
• Genital warts, condylomata acuminata  
• Male urethritis syndrome  
• Pubic lice  
• Scrotal swelling  
• Syphilis serology and treatment  
• Vaginal discharge syndrome  
• Vaginal discharge/lower abdominal pain |
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<tbody>
<tr>
<td>Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence</td>
<td>• Rape and sexual violation</td>
</tr>
<tr>
<td>Prevention, detection, and management of reproductive cancers, including cervical cancer and breast cancer</td>
<td>• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies [2]</td>
</tr>
<tr>
<td>Counselling on fertility and infertility</td>
<td>• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies [3]</td>
</tr>
<tr>
<td>Counselling and information on sexual health</td>
<td>• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies [4]</td>
</tr>
</tbody>
</table>

1 Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.


