



**South Africa’s**

Develpoment

GROUP MEMBERS- AYUSH GARG - 20102026 ARINDAM NEGI - 20102022 SHOOLIN TYAGI - 20104052 SHIVAM NEGI - 20104036 KARAN SINGH - 20104033

**DEMOGRAPHC PROFILE**

South Africa’s youthful population is gradually aging, as the country’s total fertility rate (TFR) has declined dramatically from about 6 children per woman in the 1960s to roughly 2.2 in 2014. This pattern is similar to fertility trends in South Asia, the Middle East, and North Africa, and sets South Africa apart from the rest of Sub-Saharan Africa, where the average TFR remains higher than other regions of the world. Today, South Africa’s decreasing number of reproductive age women is having fewer children, as women increase their educational attainment, workforce participation, and use of family planning methods; delay marriage; and opt for smaller families.

As the proportion of working-age South Africans has grown relative to children and the elderly, South Africa has been unable to achieve a demographic dividend because persistent high unemployment and the prevalence of HIV/AIDs have created a larger-than-normal dependent population. HIV/AIDS was also responsible for South Africa’s average life expectancy plunging to less than 43 years in 2008; it has rebounded to 63 years as of 2017. HIV/AIDS continues to be a serious public health threat, although awareness-raising campaigns and the wider availability of anti-retroviral drugs is stabilizing the number of new cases, enabling infected individuals to live longer, healthier lives, and reducing mother-child transmissions.

Migration to South Africa began in the second half of the 17th century when traders from the Dutch East India Company settled in the Cape and started using slaves from South and southeast Asia (mainly from India but also from present-day Indonesia, Bangladesh, Sri Lanka, and Malaysia) and southeast Africa (Madagascar and Mozambique) as farm laborers and, to a lesser extent, as domestic servants

n the late 19th century and nearly the entire 20th century, South Africa’s then British colonies’ and Dutch states’ enforced selective immigration policies that welcomed "assimilable" white Europeans as permanent residents but excluded or restricted other immigrants. Following the Union of South Africa’s passage of a law in 1913 prohibiting Asian and other non-white immigrants and its elimination of the indenture system in 1917, temporary African contract laborers from neighboring countries became the dominant source of labor in the burgeoning mining industries. Fewer African labor migrants were issued temporary work permits and,

instead, increasingly entered South Africa with visitors’ permits or came illegally, which drove growth in cross-border trade and the informal job market. A new wave of Asian immigrants has

also arrived over the last two decades, many operating small retail businesses, poor services, and a reduced quality of life. The 2002 Immigration Act and later amendments were intended to facilitate the temporary migration of skilled foreign labor to fill labor shortages, but instead the legislation continues to create regulatory obstacles. Although the education system has improved and brain drain has slowed in the wake of the 2008 global financial crisis, South Africa continues to face skills shortages in several key sectors, such as health care and technology.

Some estimated parameters of south Africa’s demographic profile according to the surveys are as follows

Population 56,978,635 (July 2021 est.)

Ethnic groups Black African 80.9%, Colored 8.8%, White 7.8%, Indian/Asian 2.5%

(2018 est.)

Age structure 0-14 years: 27.94% (male 7,894,742/female 7,883,266)

15-24 years: 16.8% (male 4,680,587/female 4,804,337)

25-54 years: 42.37% (male 12,099,441/female 11,825,193)

55-64 years: 6.8% (male 1,782,902/female 2,056,988)

65 years and over: 6.09% (male 1,443,956/female 1,992,205) (2020

est.)

Population growth rate 0.95% (2021 est.)

Infant mortality rate total: 26.82 deaths/1,000 live births

male: 29.9 deaths/1,000 live births

female: 23.68 deaths/1,000 live births (2021 est.) Education expenditure 6.5% of GDP (2019)

.

SOUTH AFRICA’S DEVELOPMENT PLAN

**South Africa Health Policy**

**Overview**

Healthcare in South Africa is administered by the Department of Health. However, South Africa does not have a system of universal healthcare. Instead, it has two parallel systems. A private healthcare system and a public healthcare system operate in tandem with one another.

The majority of the public, up to 80% of the population, relies on the public system for their care. The public system is subsidized by the government. In general, it is underfunded and poorly managed. There are more than 400 public hospitals in South Africa. Large, regional hospitals are managed by provincial health departments. Smaller hospitals and primary care clinics are managed at the municipal level.

On the other side, an estimated 80% of doctors work in the private system, serving just 20% or so of the population, primarily middle class and upper-class families, as well as expats. As such, the public system is constantly short of resources, while the private system is very strong.

**Cost Of Healthcare**

South African public healthcare is funded by the government by taxation, as well as through point-of-care spending from patients.

Public healthcare in South Africa is subsidized by up to 40%. The system uses the Uniform Patient Fee Schedule or UPFS to regulate patient billings and physician payments. Patient charges are based on income and family size and the UPFS uses three categories of patients to determine the cost of different visits and procedures.

Full paying patients are either being treated by a private physician, are externally funded, or are non-citizens. This would apply to expats, who are eligible to use public facilities but must pay the highest billing category.

Partially subsidized patients are eligible to have the cost of their care partially covered on the basis of their income. Finally, fully subsidized patients are those who are referred to a hospital by the Primary Healthcare Services. This mostly applies to people who have a lower income.

Additionally, there are also some occasions in which certain medical services are free. For instance, there are nearly 3,500 clinics that provide free healthcare to pregnant women and children under the age of six.

**Notable Health Policies**

* **The National Health Insurance**

To ameliorate the lack of quality and access to care, the government plans to establish the National Health Insurance in 2026. It intends to ensure access to all citizens and residents of South Africa to quality health services provided by both the public and private sector, regardless of socioeconomic status. It would be a social health insurance in that it enforces contributions from employers and employees to partially fund the system. South Africans would have federal government-sponsored plans to choose from that will pay directly for health services from all providers. The aim of the program is to encourage the wealthiest to pay into the public system and incentivize them to use public health services.

* **National Adolescent and Youth Health Policy**

This Adolescent and Youth Health Policy aims to promote the health and wellbeing of young people, aged 10-24 years. The mission of this policy is to improve the health status of young people through the prevention of illness, the promotion of healthy lifestyles, and the improvement of the health care delivery system by focusing on the accessibility, efficiency, quality, and sustainability of adolescent and youth friendly health services (AYFS).

Ultimate goal is to provide guidance to departments and organisations working with the Department of Health on how to respond to the health needs of young people. This requires an integrated approach that is not just problem-oriented, but with focus on promotion of healthy life-styles, mitigation of risk factors and puts in place ‘safety nets’ for prevention, early detection and intervention.

* **National Health Laboratory Service**

The National Health Laboratory Service was established in terms of the National Health Laboratory Service Act of 2000. The entity operates more than 230 laboratories in nine provinces and is the sole provider of training for pathologists and medical scientists, provides comprehensive and affordable pathology services to more than 80% of the South African population, and plays a significant role in the diagnosis and monitoring of HIV and TB. Over the medium term, the entity will continue to focus on providing laboratory testing services to healthcare providers mainly in the public sector, and expanding its provisions in response to increased demand for its services in priority programmes such as HIV and TB care. The COVID‐19 pandemic has had a negative impact on overall testing in that fewer patients sought care at health facilities during lockdown, resulting in a 12% decrease in tests conducted from 2019/20 to 2020/21. However, as at 20 January 2021, the entity had conducted an estimated 3.3 million COVID‐19 tests.

**Eminent Health Authorities and their functionalities**

* **The Compensation Commissioner for Occupational Diseases in Mines and Works**

It was established in terms of the Occupational Diseases in Mines and Works Act of 1973. The act gives the commissioner the mandate to collect levies from controlled mines and works; compensate workers, former workers and the dependants of deceased workers in controlled mines and works that have developed occupational diseases in their cardiorespiratory organs; and reimburse workers for any loss of earnings while being treated for TB. Over the medium term, the commissioner was expected focus on improving access to services provided to current and former mineworkers, increasing the number for claims paid, and fast‐tracking the claims management process. The payment of claims is funded through levies collected from controlled mines and works on behalf of their employees. These funds are used to compensate current and former mineworkers for diseases for which they are entitled to receive compensation.

* **The Council for Medical Schemes**

It is a regulatory authority designated in terms of the Medical Schemes Act of 1998 to oversee the medical schemes industry. The Act sets out the functions of the council, which include protecting the interests of beneficiaries, controlling and coordinating the functions of medical schemes, collecting and distributing information about private healthcare, and advising the Minister of Health on matters concerning medical schemes. Over the medium term, the council was expected to ensure the efficient and effective regulation of the medical schemes industry, and support the department in its efforts to achieve universal health coverage for all South Africans through national health insurance. The council aimed to achieve this by developing and implementing the guidance framework for low‐cost benefit options, and finalising proposals for the Medical Schemes Amendment Bill and the health market inquiry.