Inequalities in South African health care

Part I. The problem — manifestations and origins

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Abstract **This exposition analyses and contextualises the complex problem of structural inequality in South African health care. Socio-economic conditions, racial divisions and geographical location are isolated as the main determinants of inequality in the provision, allocation and distribution of health care; the prevailing inequalities are attributed to a wide range of underlying causes, including the absence of a central, binding health policy, the prominent role of apartheid and white domination, the free market and the medical profession, as well as the unique sociocultural set-up of the country. The urgent need for deliberate strategies to equalise the prevailing disparities and discrepancies is posed.**

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At present, as has been the case for decades now, health care in South Africa is plagued by a multitude of problems, constraints and deficiencies. Their nature relates on the one hand to the *health care system* as a provider or distributor of health care and on the other to the population as *clientele* of that system. Recently the crux of these problems and their complex interrelatedness was aptly depicted as 'a bureaucratic entanglement of racially and ethnically fragmented services; wasteful, inefficient and neglectful of the health of more than two-thirds of the population'.[1] The diversified manifestations of these problems and deficiencies have recently been documented extensively.[1-17] In essence, their origin is the many grave disparities in accessibility, attainability and affordability of care; this stems from severe primary shortages and backlogs in the availability of personnel, finance and other resources, and still more from the maldistribution, malmanagement, misallocation and misapplication of available resources. Highly inappropriate emphases and orientations in health care, driven by professional, political and financial interests, have given rise to indiscriminate, unjustified and wasteful decisions regarding the provision of care. The result is an alarming lack of synchronisation and co-ordination in South African health care — both among the various composing parts of a structurally fragmented health care system, and between the supply of and the demand/need for services. From this problematic set-up, the question of inequality and inequity in health care emerges most prominently.

Also, and particularly owing to the protracted history of these inequalities and inequities, South African health care is at present at a crossroads. As is the case in society at large, reform in health care is pending and inevitable.[1,2,4,14,15,18-20] Amid an ever-increasing demand for democratisation in the wider, highly undemocratic societal dispensation, inequalities in health care have logically become prime targets of the reform process. Amid the broader democratisation process and the concomitant universalisation of human rights in South Africa and elsewhere, it is only apt to put the problem of persistent inequalities and the ensuing demands for equalisation — as it has sedimented in the health care field in particular — under renewed scrutiny. We are convinced that a more equal and equitable dispensation is indeed possible in South African health care, provided that a more decisive and directive political will to embark on fundamental reform emerges from the present paralysing impasse. The purpose of our exposition is analytically and systematically to explore the possibilities and prospects of greater equality in South African health care.

The nature and types of inequality in health care

Inequalities in South African health care arise along various dividing lines according to which the distribution and provision of resources are regulated, and they find expression in various degrees of accessibility, attainability, utilisation and quality of services and facilities in the health sector. As a result marked inequalities in supply and consumption spill over into significant inequalities in the health status and in differential health risks and survival chances for certain population groups and people. Inequality in health care in South Africa is therefore no singular and simple problem. As elsewhere, its origins and guises are numerous.[1,2,6] The main divides from which inequalities in this sector emanate are those of socio-economic status, wealth or purchasing power (rich/poor; insured/non-insured), race or colour group (white/non-white), and geographical area and conditions (urban/peri-urban/rural)*. Despite their mutual interplay in actual health care, they are nevertheless distinguished here for purposes of analysis.

Apart from these broader divides, inequality in South African health care also encompasses a myriad related dimensions: (*i*) it manifests itself in disproportionate distribution and thence also overconcentration and underconcentration of personnel, services and facilities; (*ii*) it refers to unequal provision and availability of services and facilities, and to the accompanying over- and underprovision, over- and underservicing, and problematic phenomena such as over-/underhospitalising, over-/underdoctoring and over-/undermedication; (*iii*) it is expressed in differential or unequal accessibility of services and facilities together with the phenomena of in-/exclusion from services and amenities, as well as obstructive and discriminatory measures which limit or bar admission or access to sectors of the health care system; (*iv*) it assumes the guise of differential attainability and even unattainability of services and facilities, especially in relation to the location of facilities and the

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* In this exposition the focus is on structural inequalities in health care, as distinguished from individual inequalities in health; thus on inequalities emanating from and pertaining to social, political, economic and cultural contexts or sources. Put differently, the inequalities analysed here pertain to the conditions and opportunities regarding the provision and distribution of health care as opposed to health outcomes for people.

deployment of personnel; (*v*) it refers to consumption or utilisation inasmuch as the clientele do not to an equal extent make use of available services and facilities, resulting in either excessive, unnecessary and unjustified consumption or underutilisation of services and facilities; and (*vi*) it also surfaces in the differential quality of services and facilities in the sense that some receive more and better services and facilities while others receive less and poorer. As a matter of fact, these inequalities are closely related to, and are indeed a mere reflection of, the socio-economic, racial and political disparities in the broader societal context, where access to wealth and political power so far has been regulated by a white political élite. On the one hand this served to strengthen the privileged socio-economic and political position of the whites, while on the other it perpetuated a vicious circle of repression, poverty and deprivation of non-whites.

More about these most marked inequalities in South African health care and their multiple manifestations is to follow.

Socio-economic conditions

Variables associated with *socio-economic conditions*, such as *material wealth*, *employment status* and *purchasing power*, represent the first important dimension of unequal distribution and provision and of differential accessibility, attainability, utilisation and quality of health care. The most important cause of these inequalities is financial ability, which determines whether people can afford health care, how much and what quality they can afford, and whether they must simply forgo health care.

In South Africa, the wealthy, permanently employed and health-insured undoubtedly have the better health care, being in a position to avail themselves of high-standard private health services. In contrast, the poor, unemployed and non-insured find themselves in a relatively deprived position; for them health care is largely unaffordable and financially inaccessible, rendering them dependent on the State and/or on charity, or simply forcing them to forgo health care. Many factors nowadays aggravate this situation. On the one hand there is the desperate and ever-worsening socio-economic position of an exceptionally large proportion of the population, among whom poverty, unemployment and irregular employment are prevalent. On the other hand the prevailing free-market dispensation in health care, together with intensified measures to effectuate privatisation, contribute to a situation where financial ability and purchasing power play an increasingly important role in the provision and distribution of health services and facilities, also giving rise to stronger manifestations of inclusion and exclusion, overprovision, deprivation and excessive and underutilisation of health care.[2,9,11,12,21,22] Inequalities pertaining to socio-economic differentials are listed in Fig. 1.

Race and colour divisions

Socio-economic inequalities are further complicated in that they largely coincide with existing race and colour divisions in the population. Whites find themselves, generally speaking, in a more favourable socio-economic position than their non-white compatriots. Whites are most often to be found in permanent employment and also have the larger share of health insurance by far — thereby ensuring their preferential claim on the health care resources of the country. Blacks, on the other hand, are generally in a relatively unfavourable to desperate socio-economic position, proportionally few have the privilege of permanent employment and purchasing power for private health care, and fewer still are insured against disease and indisposition. This implies that *membership of a specific race or colour group* constitutes the second significant differential connected with inequality in health care. This cannot, however, be ascribed to coincidence or mere fate. Many an inequality of this sort has systematically been created and maintained in South Africa's protracted apartheid history. Apartheid's oppressive and discriminatory measures secured whites their privileged position in South African society — the health sector is no exception. In general, the majority of South Africans (non-whites) were excluded from any participation in health decision-making by the failure to grant them political rights. There is a long tradition of concentrating the health care supply (in terms of both quantity and quality) in favour of the white population. There is also an equally long history of exclusion of non-whites from facilities which were reserved exclusively for whites or kept separate, but strikingly unequal, for the different colour groups. At present the white population is better served and provided for in almost every area of health care, while the other population groups are in markedly deprived positions, the rural and peri-urban blacks being in the most desperate situation. For Benatar[23] the elimination of apartheid is indeed the first and most important step towards reducing these disparities. Inequalities emanating from the race/colour divide in South African health care are listed in Figs. 1 and 2.

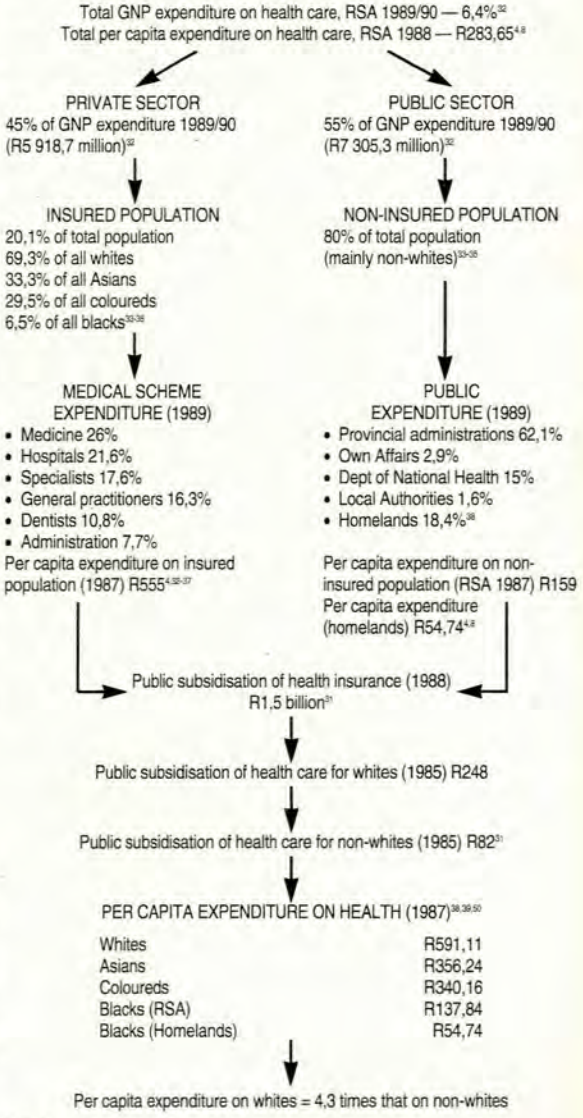

FIG. 1.
Inequalities in health expenditure in South Africa.

Geographical factors

Geographical area and *geographical conditions* constitute the third important divide from which gross inequalities in South African health care emanate.[1,2,24,25] Health personnel and facilities concentrate in the urban and metropolitan areas, leaving rural areas, and the rural homelands in particular, in a relatively underprovided and underserviced position. This has yet another, deeper dimension: white business and residential areas in urban areas have a disproportionately high allotment of health personnel and amenities serving mainly the white clientele, resulting in distortions such as overprovision, overservicing and overuse. Yet, in the corresponding non-white peri-urban and squatter areas of those same cities, such services and facilities are meagrely provided or even entirely absent. These geographically related inequalities are further aggravated by geographical conditions and impediments. Much of South Africa consists of inhospitable, impassable and vast areas in which rendering of and access to health care is very difficult. Where these areas — especially the homelands — are also characterised by widespread poverty and backwardness, and a poorly developed infrastructure, the effects of geographical inaccessibility become far worse. Inequalities relating to geographical area in South African health care are listed in Fig. 2.

The essence of inequalities in South African health care can be summarised as follows: on the one hand, the well-developed private health care sector provides a 'first-class' service to the wealthy, insured, mainly white urban clientele; on the other hand, this privileged situation stands diametrically opposed to and obviously aggravates the overloaded 'second-class' public sector services which have to cater for the poor, non-insured, mainly non-white rural clientele. From this deep division in South African health care many a qualitative and quantitative inequality emerges.

The origins/causes of structural inequalities in health care

In order to contemplate any significant solution to the multidimensional problem of inequality in South African health care, it firstly seems necessary to grasp its origins, that variety of forces which introduces, facilitates and reinforces the emergence and sedimentation of these inequalities. Apart from being the source of much concern and discontent in South African health care, these causative forces also indicate departing points from and guidelines along which reform and thus the equalisation of health care provision and distribution can be launched.

In reviewing the historical development of South African health care, a myriad events and determinants which to a greater or lesser degree instigate and strengthen these inequalities in health care, or particular dimensions thereof, can be identified.[2,26-30] Furthermore, in reducing these formative factors to the most common denominators, it seems reasonable to abstract a few

FACILITIES AND PROVIDERS	SECTORAL MIX		GEOGRAPHICAL DISTRIBUTION		RACIAL DISTRIBUTION				
	Public	Private	Metropolitan	Non-metropolitan	Whites	Indians	Coloureds	Blacks (RSA)	Homelands
Hospital beds[32,37,39-42,47]	74% of all beds	26% of all beds	50% of all beds	50% of all beds	1:61	1:505	1:346	1:337	1:417
	ACUTE CARE BEDS/1 000 DEPENDENT POPULATION		PUBLIC SECTOR						
			45%	55%					
			PRIVATE SECTOR						
	4,5:1 000	4:1 000	94%	6%	8,2:1 000		4,2:1 000		2,4:1 000
Doctors[26,32,39,43,44,52]	41% of all practising doctors	59% of all practising doctors	PUBLIC SECTOR		PRACTISING DOCTOR/POPULATION RATIOS				
			80% of all GPs	20% of all GPs	1:282	1:661	1:10 264	1:53 543	1:8 333
	TOTAL DOCTOR/POPULATION RATIO		PRIVATE SECTOR						
	1:2 175	1:487	62% of all GPs	38% of all GPs					
	GP/POPULATION RATIO		TOTAL DOCTOR/POPULATION RATIO						
	1:3 007	1:685	1:875	1:12 700			1:3 030		
Nurses[37,42,44-47,50]	79% of all nurses	21% of all nurses			REGISTERED NURSE/POPULATION RATIO				
					1:155 (64,5:10 000)	1:592 (17:10 000)	1:505 (20:10 000)	1:698 (14:10 000)	
	TOTAL NURSE/POPULATION RATIO				ENROLLED NURSE/POPULATION RATIO				
	1:368	1:265	Not a meaningful distinction. Nurses are mainly employed in public sector hospitals and are consequently distributed accordingly.		1:943 (10,6:10 000)	1:731 (5,8:10 000)	1:670 (15:10 000)	1:330 (7,5:10 000)	
					HIGHEST AND LOWEST FOR HOMELANDS:				44,6:10 000 (1:224) Ciskei; 7,6:10 000 (1:1314) KwaNdebele
Dentists[32,43,44,47-50]	20% of all dentists	80% of all dentists	57% of all 'general dentists' and 70% of all tooth and mouth specialists in 4 largest metropolitan areas	43% of all 'general dentists' and 30% of all tooth and mouth specialists in non-metropolitan areas	TOTAL DENTIST/POPULATION RATIO				
					5:10 000	1,3:10 000	0,25:10 000	0,005:10 000	
	TOTAL DENTIST/POPULATION RATIO								
	1:137 970 (Ratio in public sector = 62 times that in private sector)	1:2 213			(1:2 000) (±90% of all dentists are white)	(1:7 692)	(1:40 000)	(1:2 million)	
Pharmacists[32,44]	16% of all registered and 10% of all practising	84% of all registered and 90% of all practising	10% of all practising pharmacists in South Africa manage 80% of all pharmaceutical stock.						

FIG. 2.
Inequalities in the provision of health care in South Africa.

overarching clusters of causes which appear to have made a particular contribution. These can be summarised under five headings.

Firstly, and from the start, South African health care was strikingly characterised by *absence of a central, binding health policy*. Rather, loose and incoherent legislation has in the course of decades been enacted in this field. As a result various *problematic authority structures* and *policy measures*, and eventually also a typically pluralistic health care system, were established. These, in turn, gave shape to a highly divided health care structure, fragmented along lines of race, control, function and geographical area, all conducive of different forms of inequality.

Secondly, and flowing from the first cause, the *sedimentation of the apartheid system* and *white dominance* stand prominent in the creation of structural inequalities in South African health care. From these originated numerous undemocratic, discriminating measures and concomitant structures and practices of inequality based on race and colour. Consequently, the health interests of the population at large were served unilaterally and the health needs of various population groups were met unequally.

Thirdly, the *prominent role of the free market and the reification of the principles of market-justice, entrepreneurialism and profit-taking* in South African health care gave rise to specific mechanisms and channels of provision, financing and spending, to *laissez-faire* deployment patterns of health personnel and facilities, and to a minimum of planning and a concomitant lack of co-ordination in health care. Obviously these resulted in many instances of unequal allotment and grave forms of deprivation.

Fourthly, the *dominance of the medical profession* in South African health care established specific priorities and emphases and modelled care delivery structures to suit its own vocational and professional interests, often neglecting and even ousting — officially or non-officially — those kinds of care which the country and its people needed more and which would in any case have been more appropriate. From these emanated the heavy emphasis on curative and institutional care, themselves strikingly conducive to disparities.

Fifthly, South Africa's *unique sociocultural set-up*, with its diversity of ethnic groupings with many parallel and contrasting cultural systems of knowledge, beliefs and symbols, strikingly impinge on the health, illness and consumption behaviour of its people. These determine what people conceive as health and illness, what they deem as appropriate health care, and whom they prefer as healer and consult during episodes of illness. Naturally, these factors produce another dimension of inequalities in health care, albeit in the acceptance or rejection of provided health care.

These, then, are the structural inequalities characterising South African health care and the diverse determinants which generate these deeply entrenched inequalities and also firmly keep them in place. By and large, it is evident that the health care system, and in particular the myriad of structural inequalities in this system, in no way stand isolated from the deeper niches of inequality in South African society at large; indeed they reflect these and are even predetermined by them, be they political, economic or ideological in nature.

But what are the prospects of and appropriate strategies for equalising or levelling these discrepancies and disparities? In a follow-up article, guidelines, a strategy and the possibilities for equalising health care in South Africa are explored more extensively.

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