



Access to health care in South Africa — the influence of race and class

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Objectives. The first democratic government elected in South Africa in 1994 inherited huge inequities in health status and health provision across all sections of the population. This study set out to assess the impact of the new government's commitment to address these inequities and implement policies to improve population health in general and address inequalities in health care in particular.

Design. A 1998 household survey assessed many aspects of health delivery, including their own perceived and actual access to health care among different segments of South African society.

Results. Race was the main predictor of perceived changes in access to health care, with black, coloured and Indian respondents significantly more likely to feel that access had

improved since 1994, compared with white respondents. Socio-economic status (SES) was the main predictor of actual access to health care, with low and middle SES classes significantly less likely to access care when ill.

Conclusions. One-third of respondents perceived health care access to have improved between 1994 and 1998, and this response was partially determined along racial lines. About one-quarter reported an inability to access health care when they required it, and this response was partially determined along socio-economic lines. This set of contrasting responses suggests that at a political level perceptions are largely influenced by race, but at the operational level actual access is influenced by SES.

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Through a differential allocation of health care resources, the apartheid government in South Africa systematically denied access to health care to segments of the population.¹ Consequently, race and socio-economic status (SES) were important determinants of access to and utilisation of health care services during the apartheid era.¹⁻⁵

In an attempt to reduce poverty and inequities that characterised South African society, the new democratically elected government in 1994 committed itself to the Reconstruction and Development Programme (RDP) which aimed to meet the basic needs of all South Africans and provide the assurance that each citizen would have a decent standard of living and economic security.⁶ A number of policies were implemented within the RDP framework to improve health and access to health care and to address the inequities that had been inherited in these areas. The policies implemented ranged from free health care for children and

pregnant mothers, to clinic-building programmes and community service for medical and dental graduates.¹ Little is known about whether these policies have resulted in improved access, utilisation or perceptions thereof, particularly among groups previously denied health care services.

For this study, data from the second Kaizer Household Survey of 1998⁷ were analysed to assess the impact of the policies implemented within the RDP framework by the newly elected government in 1994. More specifically, the data were analysed to: (i) assess whether the South African public perceived any improvement in access to health care to have taken place and how this perception was influenced by racial and socio-economic differences,* and (ii) determine the health care utilisation patterns of the South African public and to map any inequities that may have been present across racial and/or socio-economic classes 4 years after the election of the new government.

Methods

The aim of the 1998 Kaizer National Household Survey on Health Care in South Africa⁷ was to document the South

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*Before 1994 all people in South Africa were classified black, Indian, coloured or white according to the Population Registration Act of 1950. Use of these terms does not imply the legitimacy of this racist terminology, but is necessary for highlighting the impact of former apartheid policies on people in this country.



African public's awareness, perceptions and attitudes towards health policy, health status, quality of and satisfaction with health care, health care utilisation, and access and barriers to health care.

Data for the 1998 survey were collected through a national survey of almost 4 000 households, with 4 households selected in 1 000 selected enumerator areas (EAs). The selected EAs were stratified by province, race and urban or rural area type. (The household survey adopted the urban/rural definitions used in the 2001 national census. Cities, towns, townships, suburbs, etc. were classified as urban settlements. EAs comprising informal settlements, hostels, institutions, industrial and recreational areas, and smallholdings within or adjacent to any formal urban settlement were also classified as urban. Any area that was not classified urban was considered to be rural.) In each EA, the stands to be visited were identified by the fieldworker supervisor after the selection of a random starting point.

This study analysed data relating to perceived and actual access to health care services. In the survey respondents were asked their opinion on whether access to health care had 'improved', 'stayed the same' or 'got worse' since 1994. They were then asked if they were able to access health care services when last ill (actual access). The perceived and actual access were compared by race and SES. A socio-economic indicator was created based on: (i) the basic services that the household accessed; (ii) the difficulty a household experienced in paying for a range of basic goods and services; (iii) an estimate of the number of consumer durables in the household; (iv) the highest educational level in the household; (v) the reported monthly income of the household; and (vi) the number of people per room in the household.⁷

Initially cross-tabulations comparing perceived access and actual access by race and SES were assessed. Responses to perceived access (improved versus same or worse) and actual access (yes versus no or cannot remember) were dichotomised so that binary logistical regression analyses could be carried out on their responses, against two explanatory variables (race and SES), adjusting for three control variables (gender, age and area type). An odds ratio (OR) where the 95% confidence interval excluded 1 was considered statistically significant.

Results

In the sample of 3 819 households, 73% of respondents interviewed were women (Table I). (Missing data were generally less than 1% for the variables analysed, except for actual access to health care, where 3.8% of the data were missing.) More than 70% of respondents were less than 55 years of age. Two-thirds of the sample was black and almost one-fifth white. Coloureds and Indians made up 12% and 4% of the sample respectively. There was an equal distribution

Table I. Sample distribution of controlling, explanatory and outcome variables (N = 3 819)

	Sample (N)	Percentage
Control variables		
Gender		
Male	1 039	27.3
Female	2 773	72.7
Age groups		
< 36 years	1 173	30.8
36 - 55 years	1 636	43.0
> 55 years	1 000	26.2
Area type		
Metropolitan	1 603	42.3
Small urban	1 081	28.5
Rural	1 109	29.2
Explanatory variables		
Race		
Black	2 537	66.6
Coloured	440	11.5
Indian	138	3.6
White	697	18.3
Socio-economic status (SES)		
High	1 277	33.4
Middle	1 287	33.7
Low	1 255	32.9
Outcome variables		
Perceived access to care		
Improved	1 210	31.9
Stayed the same	1 825	48.1
Got worse	763	20.1
Actual access to care		
Yes	2 706	73.7
No	967	26.3

across the three SES categories. Almost 60% of the sample was resident in small urban or rural settings.

Overall, 32% of the respondents felt that access to health care had improved in the 4 years since the first democratic elections in 1994. Race was the main predictor of changes in perceived access to care. While both race and SES were significantly related to perceived access in the unadjusted analysis, only race was significantly related to perceived access in the adjusted (for SES, gender, age and area type) analysis. After adjustment, black respondents (OR 5.03) and to a lesser extent coloured (OR 3.06) and Indian (OR 2.44) respondents were significantly more likely to feel that access had improved since 1994, when compared with white respondents (Table II).

About three-quarters of respondents had accessed a health care service when last ill. Socio-economic status was the main predictor of actual access to care in both the unadjusted and adjusted analyses. After adjusting for other factors, low SES (OR 0.71) and middle SES (OR 0.64) respondents were significantly less likely than high SES respondents to have accessed care when last ill (Table III).


Table II. Cross-tabulation and binary logistical regression analysis of determinants of perceived access to health services

Perceived improvement in access	Improved (N (%))	Same/worse (N (%))	Unadjusted OR (95% CI)	Adjusted OR* (95% CI)
Socio-economic status				
Hight†	297 (23)	973 (77)	1	1
Middle	451 (35)	831 (65)	1.78 (1.50 - 2.11)	0.85 (0.69 - 1.05)
Low	462 (37)	784 (63)	1.93 (1.62 - 2.30)	0.82 (0.65 - 1.04)
Race				
White†	84 (12)	612 (88)	1	1
Black	968 (38)	1 553 (62)	4.53 (3.56 - 5.77)	5.03 (3.76 - 6.74)
Coloured	123 (28)	314 (72)	2.85 (2.09 - 3.88)	3.06 (2.20 - 4.26)
Indian	33 (24)	104 (76)	2.31 (1.47 - 3.63)	2.44 (1.54 - 3.86)

*Adjusted for the remaining variables among SES, race, gender, age and area type.
†Reference category.

Table III. Cross-tabulation and binary logistical regression analysis of determinants of actual access to health services when last ill

Actual access when last ill	Yes (N (%))	No (N (%))	Unadjusted OR (95% CI)	Adjusted OR* (95% CI)
Socio-economic status				
Hight†	966 (78)	272 (22)	1	1
Middle	892 (73)	337 (27)	0.75 (0.62 - 0.90)	0.71 (0.56 - 0.91)
Low	848 (70)	358 (30)	0.67 (0.56 - 0.80)	0.64 (0.49 - 0.83)
Race				
White†	531 (78)	151 (22)	1	1
Black	1 777 (73)	666 (27)	0.76 (0.62 - 0.93)	1.05 (0.80 - 1.39)
Coloured	308 (73)	112 (27)	0.78 (0.59 - 1.04)	0.95 (0.69 - 1.31)
Indian	86 (71)	35(29)	0.70 (0.45 - 1.08)	0.75 (0.48 - 1.17)

*Adjusted for the remaining variables among SES, race, gender, age and area type.
†Reference category.

Discussion

The policies implemented within the RDP framework⁶ by the newly elected government in South Africa were geared towards improving the health status and health care access of South Africans and to reducing any inequities present in these areas.

The findings of this study indicate that about one-third of South Africans perceived some improvement in access to health care services after 4 years of the newly elected government. A review of the literature did not bring to light any established objective or benchmark against which this perception can be evaluated, but it could be argued that the fact that almost one-third of South Africans perceived an improvement in access to health services is a significant achievement.

Perceived improvements in access to health care services, however, have to be seen in the broader sociopolitical context. Race was a significant determinant of perceived improvements

in access to health care services, with black respondents most likely to report a perceived improvement in access, followed by coloured and Indian respondents, with white respondents least likely to have perceived an improvement. Two explanations can be offered. The findings could be a reflection of reality whereby access to health care has actually improved along racial lines. Alternatively, the findings could be a reflection of the inherent bias of the respondents, with their broader level of support for the government being mirrored in the extent to which they perceive health care services to have improved.

Despite the perceived improvement in access to health care services, actual access to health care services (as reflected by respondents having utilised health care when they were last ill or felt that they needed treatment) remained poor, with just over one-quarter of South Africans unable to access health care when required. A comparison of the 1994 and 1998 household survey findings showed an overall decrease in the percentage of respondents accessing health care services when needed.⁷ For example, 81% of black respondents sought care when last



ill in 1994 compared with 73% in the 1998 survey.

Despite the implementation of policies specifically designed to remove the inequities in health and health care access, 4 years into the new era significant inequities in health care access persisted. After adjusting, it was interesting to note that SES and not race was the most significant determinant of actual access. Access for the low and middle SES classes was significantly lower than that of high SES class (OR 0.64 and OR 0.71). Disparities in access to health care by race and SES are not unique to South Africa. Studies from most parts of world highlight these disparities.⁸⁻¹²

Given its unique history and the strong correlation between race and SES in South Africa,¹³ the findings with regard to perceived and actual access are worth noting. While race (independent of SES) was the primary determinant of perceived improvements in access, SES/class (independent of race) was the primary determinant of actual access. This contrast suggests that for access to health care to be made more equitable, allocation of resources on the basis of SES rather than race may have a greater capacity to reduce inequities in access to health care.

In summary, the findings of this study indicate that one-third of respondents perceived access to have improved between 1994 and 1998, and this perception was determined partially along racial lines. About one-quarter did not access health care when they required it, and this perception was determined partially along socio-economic lines. This suggests that at a political level perceptions are largely influenced by race, but at the operational level actual access is influenced by SES.

To understand public perception and health care experiences

better in future, firstly more clearly defined benchmarks need to be established so that the impact of policies and programmes can be evaluated. Secondly, it may be better to address inequities in access to health care by the deliberate allocation of resources to low SES class. Thirdly, although the use of race or racial categories in health research has been contested^{14,15} we recommend that the effects of both race and SES still need to be assessed as their role as proxy indicators of health status and health care experience remains significant.

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