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policy brief

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Health inequalities and the poor: Disadvantaged in every way

Summary

Inequality (including inequalities in health and healthcare) is pervasive and on the increase in South African society. This policy brief provides an overview of the extent of socioeconomic inequalities in access to healthcare. Evidence suggests that the healthcare system is characterised by deep socioeconomic inequalities across the different dimensions of access to healthcare. A well-coordinated intersectoral policy response to address the social determinants of health and the effective implementation of an efficient national health insurance (NHI) programme would go some way in addressing these inequalities.

Background

Inequality is pervasive and on the increase in South African society, including inequalities in health and healthcare. (1–5) Promoting health equity is essential to achieving the third Sustainable Development Goal (SDG) of good health and well-being for all. Particularly important is SDG 3.8: Achieve universal health coverage (UHC), which means that all people and communities should receive quality health services and be protected from health threats without suffering financial hardship. (6) In addition, the National Development Plan is aimed at reducing these inequalities. (7)

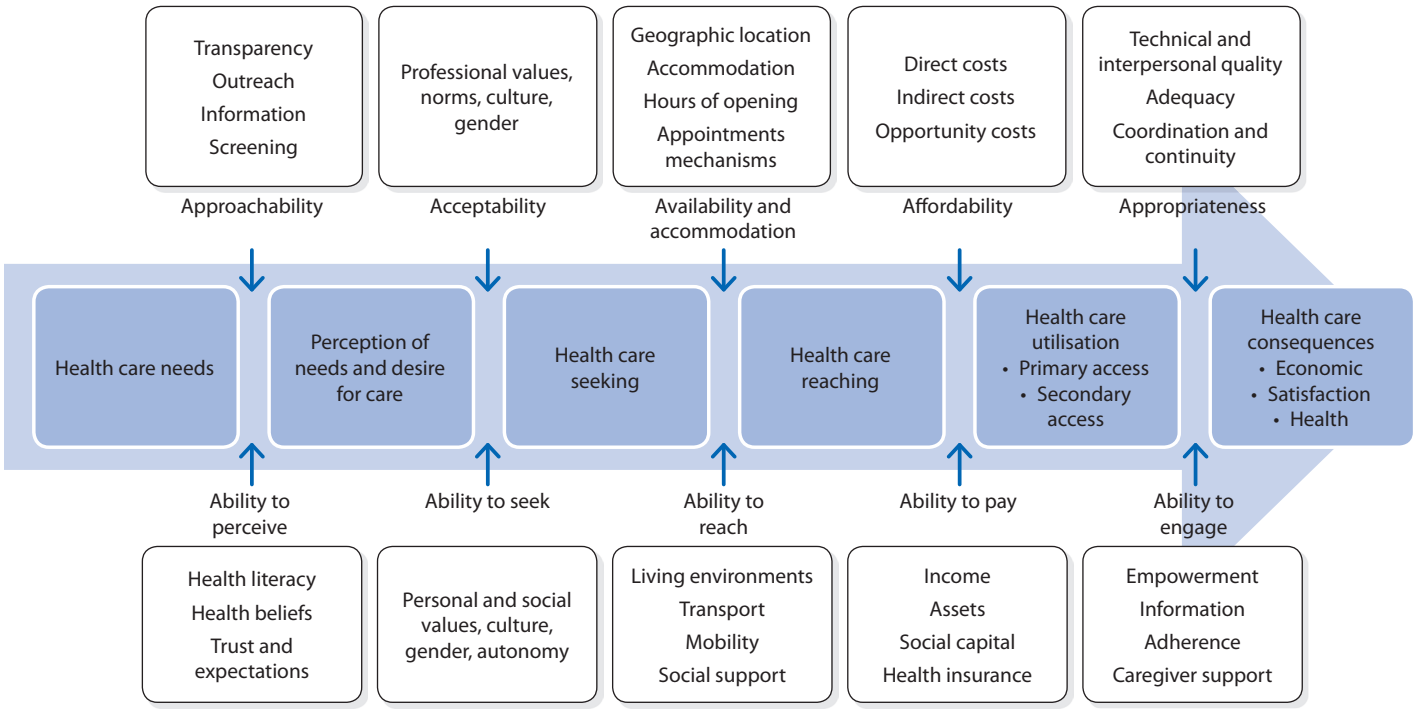
Aim

As South Africa embarks on the implementation of NHI to achieve UHC, monitoring inequalities in the health system is of paramount importance. This policy brief provides an outline of the extent of socioeconomic inequality in various dimensions of access to healthcare, using the 2012 South African National Health and Nutrition Examination Survey.

Framework

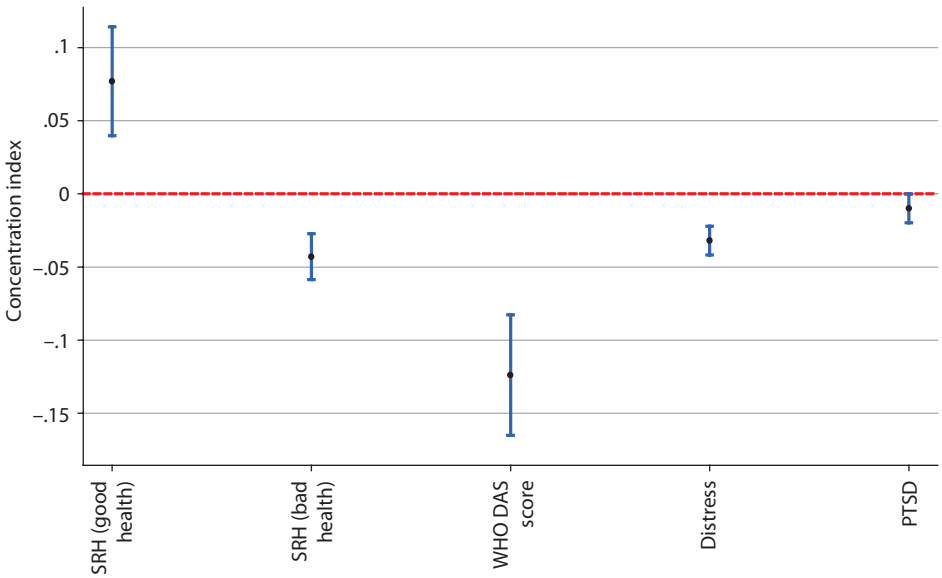
Health equity here is defined as 'the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically'. (8) As outlined in Figure 1, the study takes a broad view of inequality in access to healthcare, extending beyond use only and incorporating a study of inequalities in the whole health and healthcare seeking experience (including disparities in both demand-side and supply-side factors). (9) Equally important is clients' experiences of the health services encounter, including the quality of healthcare services. (10–12) In essence, the perceived need and desire for care culminate in healthcare seeking. Those seeking care may not be able to reach a facility in order to use health services that have important consequences for users.

Figure 1: The multiple dimensions of access to healthcare



Source: (p. 5) (9)

Figure 2: Socioeconomic inequality in health status



Note: SRH – self-reported health; WHO DAS – WHO Disability Assessment Schedule; Distress – Kessler Psychological Distress Scale (K10); PTSD – post-traumatic stress disorder

Methods

Two measures of inequality are used in this analysis, namely the concentration curve and the concentration index (CI). The concentration curve plots cumulative health outcomes against cumulative socioeconomic status, using a wealth index. If the curve falls on the diagonal, there is perfect equality. A curve above the diagonal denotes the concentration of the health outcome among the poor, while a curve below the diagonal indicates that the health outcome is concentrated among the rich. The CI takes on a value of zero for perfect equality. Negative values represent pro-poor distributions of health outcomes, while positive values denote pro-rich distributions of health outcomes. (13)

Findings

Greater healthcare needs

Generally, the poor are in worse health compared to the non-poor. Figure 2, which illustrates this point, shows that good health is concentrated among the rich (CI +0.076) and ill health among the poor (CI –0.043). The graph also illustrates that the poor have significantly greater health needs across a variety of measures of poor health status, including disability (CI –0.123), mental health (CI –0.031) and stress (CI –0.010). Consequently, the question is whether poor individuals who are ill

Figure 3: Socioeconomic inequality in healthcare seeking

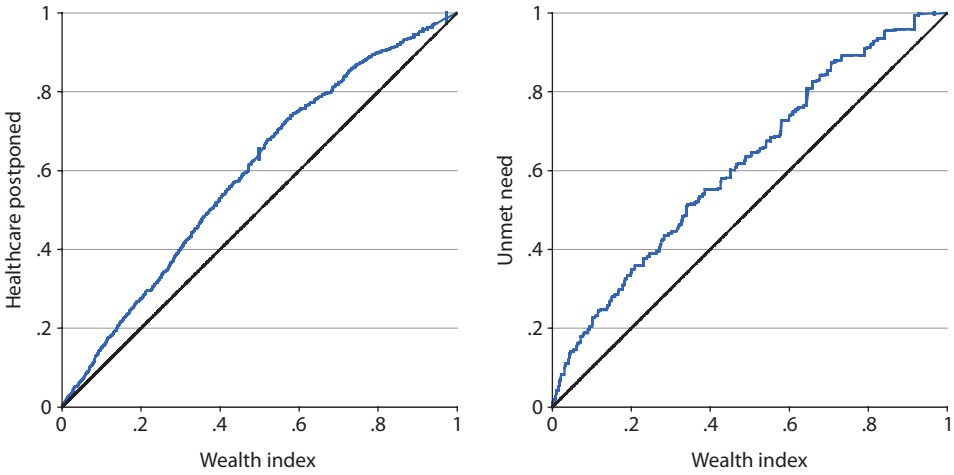
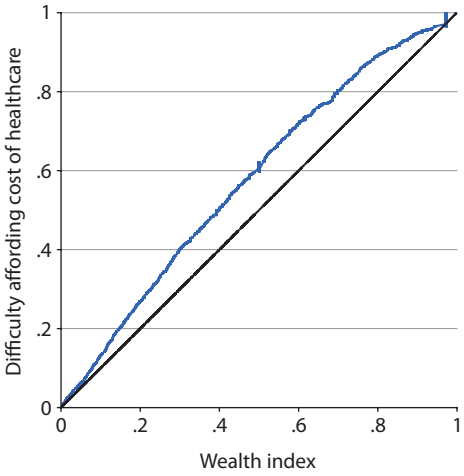


Figure 4: Socioeconomic inequality in affordability of healthcare

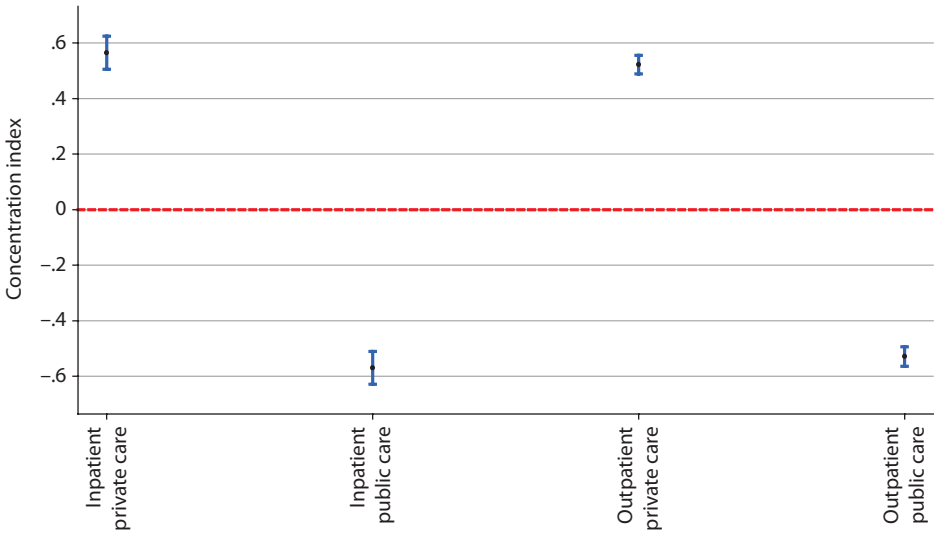


and who perceive a need and desire for care are in a position to access appropriate healthcare.

Postponement of care and greater unmet need

According to Figure 3, the stark reality is that the poor are at a considerable disadvantage when seeking healthcare. The presence of the postponement of healthcare (CI –0.152) and of unmet healthcare needs (CI –0.031) is more prevalent among the poor compared to the non-poor (that is, the concentration curve is above the diagonal). Not only are the poor more ill, but they are also more likely to not receive healthcare.

Figure 5: Socioeconomic inequality in healthcare usage



Lesser ability to pay

Affordability is an important barrier to seeking, reaching and using healthcare. As shown in Figure 4, the poor are significantly more likely to experience difficulty in affording the cost of healthcare (CI –0.164) – thus facing greater constraints in terms of financial protection against catastrophic and impoverishing healthcare expenditure.

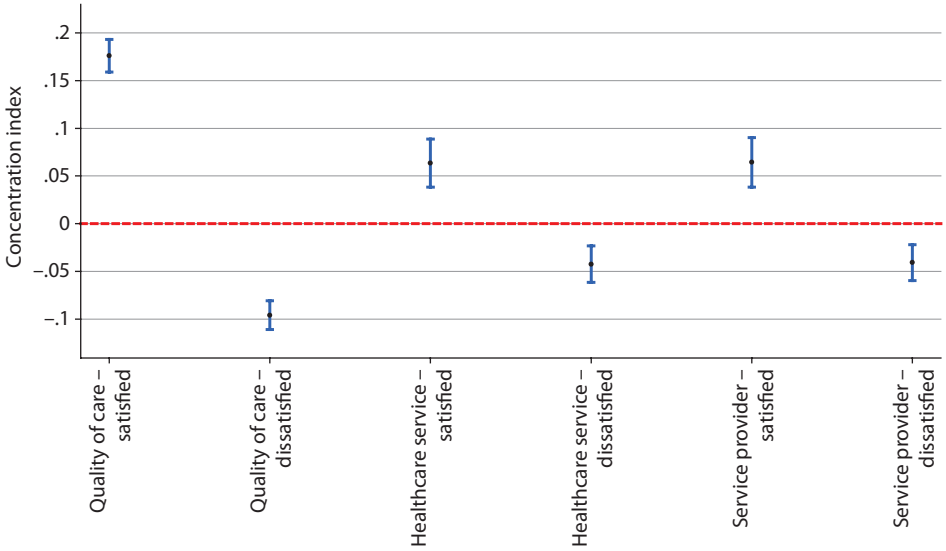
The public–private healthcare divide

Usage patterns are largely driven by ability to pay. Poor users access free and less costly public healthcare services, while non-poor users access more expensive private healthcare services financed mainly through medical insurance. Figure 5 illustrates that the poor who manage to reach a healthcare facility rely on the overburdened public healthcare sector, whereas the more affluent have the luxury of receiving care in the well-resourced private healthcare sector. These inequalities are considerable in size and are present in the case of both inpatient healthcare services (public CI –0.569 versus private CI +0.565) and outpatient healthcare services (public CI –0.528 versus private CI +0.522). Being confined to using public healthcare begs the question of whether the care received by the poor is also of a poorer quality compared to the care provided in the private healthcare sector.

Lower satisfaction

Considering subjective self-reported satisfaction as an appropriate – though flawed – measure of quality of care, the non-poor are significantly more satisfied with the healthcare services they receive (Figure 6). This applies to the general quality of care (CI +0.176) as well as healthcare services (CI +0.063) and healthcare providers (CI +0.064). In contrast, dissatisfaction is more pronounced among the poor: CI –0.093 (quality of care); CI –0.042

Figure 6: Socioeconomic inequality in satisfaction with healthcare



(healthcare services); and CI –0.040 (healthcare providers).

Ultimately, the inequalities in health and healthcare faced by the poor are compounded as one moves across the various dimensions of access to healthcare. Basically, the poor have greater health needs, but poor access to poorer quality services.

Policy response

Health inequalities in South Africa remain stark and extensive. The wider social determinants of health are key in shaping the large disparities in access to healthcare discriminating against the poor. (14) This dilemma warrants serious attention through a more concerted push towards the implementation of a Health in All Policies (HiAP) approach at the local municipal level. (15) This approach should be implemented with the aid of win-win strategies that enhances the acceptability and feasibility of such intersectoral collaboration, going beyond strategies of raising awareness and directives (see Box 1). (16) Inequalities in access to healthcare and to quality healthcare also call for efforts to ensure UHC. In the case of South Africa, the specific policy response in this domain is the implementation of NHI.

Conclusion

The poor are at a disadvantage across the continuum of access to healthcare, from healthcare needs and healthcare seeking and usage to affordability and satisfaction – thus compounding and ensconcing or hiding the degree of inequality.

Recommendations

When implemented effectively, NHI promises to play an important role in bringing quality healthcare services to the economically disadvantaged in order to address socioeconomic inequalities in healthcare and achieve UHC. The first-line response, however, should be a concerted effort to address the various social determinants of health through a well-coordinated multisectoral and intersectoral policy response.

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Box 1: Win-win mechanisms to facilitate the implementation of HiAP

- Specific capacity-building exercises;
- Financial incentives;
- Community engagement;
- Adequate time;
- Dedicated teams;
- Leadership engagement;
- Developing a shared language;
- Using dual outcomes;
- Integrating health into intersectoral agendas;
- Evidence of effectiveness;
- Health impact assessment to support decision making; and
- Policy coordination for health outcomes.

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