HUMAN CAPITAL

Research article

HEALTHCARE IN SOUTH AFRICA: WHAT DETERMINES ACCESS TO MEDICAL SERVICES

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Abstract. This study investigates disparities in access to healthcare in South Africa. The first part of the study provides a detailed review of the existing literature, which highlights various demographic and socio-economic factors of access to healthcare. However, previous works on South Africa are based on surveys prior to 2012 and do not account for recent changes, including the shock caused by the COVID-19 pandemic and the worsening energy crisis in South Africa in 2022–2024. This study includes data from General Household Surveys of South Africa from 2002 to 2024. Factors such as gender and race, education level, place of residence (province and city/village), and income level are considered. The study presents the main results for assessing the physical accessibility of healthcare. Overall, there is a positive trend, although the values of 2024 still reflect the shock of the pandemic and the energy crisis, showing worse results than in 2019. The study also presents the assessment for inequality in financial affordability of healthcare. Socio-economic factors (race, education, and income level) have a much greater impact on financial accessibility. Comparison with previous literature shows that in 2024, the healthcare access landscape in South Africa remained largely similar to the situation in 2012: the same population groups remained vulnerable (black Africans, poor people, rural residents, and people with low education level), and the level of inequality in financial access to medicine remained high.

Keywords: South Africa, inequality, healthcare, physical accessibility and financial affordability, income level, education level, racial discrimination

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INTRODUCTION

Modern economic theories increasingly recognize the importance of human capital development, with healthcare systems serving as a crucial mechanism for its formation and sustenance. The Millennium Development Goals, followed by the Sustainable Development Goals, have provided a framework for countries in the 21st century, underscoring, in particular, the necessity of developing this sector[1]. African states also identify their own set of priorities within the framework of “Agenda 2063,” a strategy for the sustainable development of African countries, cooperation among the countries of the continent, and the strengthening of Africa’s position on the global stage[2]. Addressing inequality in healthcare is a priority for many nations, including the Republic of South Africa. For South Africa, characterized by the highest level of inequality globally (with a Gini Index of 63% according to a 2025 survey[3]), the issue of access to various social services, such as education, social support, and, of course, healthcare, is particularly pressing.

An important factor contributing to contemporary inequality is the legacy of the apartheid regime, which existed until 1993 [Maphumulo, Bhengu 2019; Burger, Christian 2020]. After the abolition of apartheid, the state undertook measures that had a dual nature. On the one hand, the policy of preferential hiring of Black and Coloured individuals, initially aimed at overcoming racial inequality, led to a shortage of qualified personnel in hospitals due to the limited number of Black individuals with sufficient education in the country [Filatova 2016]. On the other hand, some progress was made in increasing the accessibility of healthcare for vulnerable social groups: racial segregation was abolished, and a new legislative framework was created—in modern South Africa, the healthcare sector is regulated by the Constitution of the Republic of South Africa (1994)[4] and the National Health Act (2003)[5], which proclaim the right of every citizen to receive medical care. In 1994–1996, free primary healthcare was introduced in state clinics for all citizens in several stages [Leatt, Shung-King, Monson 2006]. During the first quarter of the 21st century, a gradual three-stage preparation for the introduction of a national health insurance system took place, and in 2024, the law establishing it was finally signed[6].

Despite these legislative measures, the level of inequality in access to healthcare in South Africa as of 2024 remains significant for several reasons: a high level of economic inequality, differences in the quality of services between state and private clinics, persistent racial inequality. The main goal of this study is to identify the factors

[1] The Sustainable Development Goals (SDGs) are a global program of the United Nations (UN), adopted at the UN General Assembly in 2015 within the framework of the “2030 Agenda,” declared as creating conditions for the prosperity of humanity and the preservation of the planet for future generations. The SDGs replaced the Millennium Development Goals (MDGs). The 17 Goals. *United Nations: Department of Economic and Social Affairs*. https://sdgs.un.org/goals (accessed: 10.05.2025)

[2] Agenda 2063: The Africa We Want. *African Union*. https://au.int/en/agenda2063/overview (accessed: 03.08.2025)

[3] Gini Coefficient by Country 2025. *World Population Review*. 2025. https://worldpopulationreview.com/country-rankings/gini-coefficient-by-country (accessed: 10.05.2025)

[4] The Constitution of the Republic of South Africa. *Parliament of the Republic of South Africa*. 1996. https://www.parliament.gov.za/storage/app/media/Acts/constitution/SAConstitution.pdf (accessed: 06.05.2025)

[5] The Presidency. № 61 of 2003: National Health Act, 2004. *Government Gazette Republic of South Africa. South African Government*. 23.07.2004. https://www.gov.za/sites/default/files/gcis_document/201409/a61-03.pdf. (accessed: 06.05.2025)

[6] The Presidency. Act № 20 of 2023: National Health Insurance Act, 2023. *Government Gazette Republic of South Africa. South African Government*. 16.05.2024. https://www.gov.za/sites/default/files/gcis_document/202405/50664nathealthinsuranceact202023.pdf (accessed: 06.05.2025)

influencing inequality in healthcare accessibility in South Africa during the first quarter of the 21st century.

Inequality in healthcare in South Africa is primarily examined in the works of South African researchers using data collected before 2012. The scientific novelty of the present study lies in the use of new data from 2024, which contains information on the impact of key events of recent years on inequality in access to healthcare in South Africa.

LITERATURE REVIEW

The problem of inequality in healthcare accessibility among different social groups, identified by demographic, socioeconomic, or geographic characteristics, exists to some extent in all countries worldwide, and South Africa, which is examined in this study, is not an exception. One of the most important factors in healthcare inequality for South Africa is racial disparity (this factor is mentioned in several studies, for example, [Ohonba, Kirsten, Mkhize 2023]). This factor is also significant for healthcare in middle-income countries, such as Brazil [Constante et al. 2021; Bruce et al. 2020] and Mexico [Serván-Mori et al. 2025].

The impact of income inequality on inequality in healthcare affordability is characteristic of many countries: for example, this problem is relevant for Brazil [dos Santos et al. 2019] and Indonesia [Mulyanto et al. 2019]. In South Africa, inequality in the financial affordability of healthcare is also a pressing issue [Ohonba, Kirsten, Mkhize 2023]. One of the possible reasons for this is the absence of a universal public health insurance system in South Africa until 2024 (the law establishing it was signed by the country's president only in 2024[7]). In some countries, the problem of the absence of a unified national health insurance system or insufficient insurance coverage is relevant: for example, the public health insurance system is highly fragmented in India, with separate programs that do not cover the entire population [Dubey et al. 2023].

In many countries, the problem of unequal access to healthcare for urban and rural residents is also relevant: access to healthcare tends to be higher in cities than in rural areas. This situation is characteristic of India [Banerjee 2021], some African countries [Samuel, Zewotir, North 2021], China [Ma et al. 2021], and Indonesia [Sambodo et al. 2021]. In South Africa, this problem also exists: in this country, the problem of a shortage of human resources and equipment in rural areas is more pressing than in urban areas [Mvikweni 2024].

A separate body of research is dedicated to econometric studies based on microdata (household surveys, individual surveys) to identify the links between access to medical services and individual characteristics (such an approach is used, for example, in the article by R. Burger and C. Christian [Burger, Christian 2020] for South Africa and A.D. Azad [Azad et al. 2020] for Malawi). Various statistical tests are also conducted to identify causal relationships; for example, in the article by R. Mutwali and E. Ross [Mutwali, Ross 2019], the chi-square test and Cramer's V test were used to determine the relationship between access to healthcare and its various factors.

If a study is based on individual survey data, variables such as the level of education [Bago d'Uva et al. 2011; Ohonba, Kirsten, Mkhize 2023], income [Larson, Halfon 2009; Ohonba Kirsten, Mkhize 2023], and place of residence (region of the country/urban or

[7] The Presidency. Act № 20 of 2023: National Health Insurance Act, 2023. *Government Gazette Republic of South Africa. South African Government.* 16.05.2024. https://www.gov.za/sites/default/files/gcis_document/202405/50664nathealthinsuranceact202023.pdf (accessed: 06.05.2025).

rural area) [Ohonba, Kirsten, Mkhize 2023] may be included in the models. In the case of using household survey data, various variables that reflect their well-being are of interest. These variables may include income and wealth levels, as well as housing characteristics and the presence or absence of specific assets—the methods for constructing a well-being variable are described in the work of O. O'Donnell [O'Donnell et al. 2008], examples of using this index in studies of inequality in healthcare accessibility in South Africa are found in the articles by F. Booysen and T. Gordon [Booysen, Gordon 2020] and B. Harris [Harris et al. 2011].

Various approaches are also used to determine an indicator of healthcare accessibility. The concept of assessing healthcare accessibility in three dimensions is widespread: physical accessibility, financial affordability and quality of services [Gelders et al. 2006; Wallace, MacEntee 2012; Balharith et al. 2023; Burger, Christian 2020; Harris et al. 2011; Ohonba, Kirsten, Mkhize 2023]. A study may include all three dimensions, or some individual ones. To measure physical accessibility, a numerical or binary variable is used, constructed on the basis of the distance to the nearest medical facility [McLaren et al. 2014] or the travel time to it [Burger, Christian 2020]. Variables of financial accessibility and service quality are often determined based on responses to direct questions included in a questionnaire for individuals or households, for example, questions about the fact and reasons for refusing to see a doctor in case of illness, as in [Ohonba, Kirsten, Mkhize 2023].

FEATURES OF THE SOUTH AFRICAN HEALTHCARE SYSTEM AND MAJOR DEVELOPMENT TRENDS IN THE FIRST QUARTER OF THE 21ST CENTURY

As in most countries worldwide, South Africa has both public and private healthcare systems. The majority of the South African population uses public clinics (80.4%, according to the South African General Household Survey of 2024), but despite this, public hospitals in South Africa are more likely than private ones to suffer from shortcomings such as a rather modest range of services offered, a shortage of personnel, excessive workload, inefficient management, and a lack of equipment and materials [Scheffler et al. 2015].

In addition to scientific medicine, traditional medicine exists in African countries. In many countries of the continent, traditional medical practices are officially permitted, legally regulated, and supported by the state, as traditional healers can successfully treat some diseases [Grishina 2024]. For example, according to proponents of traditional medicine, traditional practices can be effective in treating diseases common in Africa, such as cold, influenza, typhoid fever, malaria, etc. [Adu-Gyamfi et al. 2024]. In 1982, South Africa passed the Health Professions Act, which contained a provision on the legal status of physicians who use traditional practices [Grishina 2024]. In 2007, the Traditional Health Practitioners Act was adopted, which defined the modern institutional structure of traditional medicine in South Africa: the purpose of this law was to create an organization responsible for certifying and training physicians specializing in traditional medicine and for protecting the interests of their patients. Traditional medicine is studied in a number of educational programs at universities in South Africa [McFarlane 2015]; the University of Eswatini has an Institute for Research in Traditional Medicine, Medicinal and Indigenous Food Plants[8].

[8] University of Eswatini / Eswatini Institute for Research in Traditional Medicine, Medicinal and Indigenous Food Plants. *University of Eswatini*. https://www.uneswa.ac.sz/research/eirmip (accessed: 25.07.2025)

Previous studies indicate that traditional and scientific medicine interact in South Africa: traditional healers can provide assistance in cases where surgery is not required for treatment, explain the causes of illnesses to patients, and refer them to doctors in cases where the illness cannot be cured using traditional methods [Gracheva 2019]. Furthermore, the activities of traditional healers are particularly important in cases of physical or financial inaccessibility of scientific medicine. A negative consequence of the prevalence and official recognition of traditional medicine can be the spread of dangerous misconceptions. For example, some well-known traditional healers denied the need for antiretroviral therapy for the treatment of HIV infection [McFarlane 2015].

In the 21st century, the South African government implemented a number of programs aimed at improving access to healthcare. Government measures were quite diverse and included increasing the number of hospitals, supporting low-income population groups, transitioning to a national health insurance system, combating HIV infection and AIDS.

One of the first measures was the introduction of free primary care for all citizens and free inpatient treatment for a number of vulnerable population groups. These measures were implemented in 1996–2003 [Leatt, Shung-King, Monson 2006]. Programs aimed at increasing the availability of quality medical services were also launched: the Hospital Revitalisation Programme (since 2003)[9] and the Primary Healthcare Re-engineering Programme (since 2009) [Naledi, Barron, Schneider 2011]. Prior to the implementation of a national health insurance system in 2024, the government supplemented citizen access to medical services through financial assistance. A notable example of this intervention was the establishment of the Government Employees Medical Scheme (GEMS). This scheme operates on a principle analogous to that of private medical aid schemes in South Africa, whereby member contributions are pooled to finance the provision of medical services. However, contribution rates to the public scheme are set at a lower level compared to those of private schemes[10]. Furthermore, prior to 2024, the government also provided subsidies to citizens for the utilization of private hospital services[11].

One of the most significant recent interventions aimed at enhancing healthcare accessibility and reducing inequities in this sector has been the implementation of a national health insurance system. While the enabling legislation for this system was enacted in 2024, its development was preceded by numerous pilot projects. The implementation of national health insurance in South Africa was undertaken in three distinct phases. The initial phase, spanning 2012–2017, focused on improving primary healthcare systems, encompassing measures such as the establishment of working groups to coordinate healthcare services, the launch of health promotion programs for schoolchildren, the engagement of private practitioners in non-public hospitals to enhance service quality, and the implementation of electronic systems to optimize healthcare processes. The second phase of national health insurance implementation, conducted between 2017 and 2022, entailed the creation of necessary legislative

[9] The Presidency. Twenty-Year Review South Africa: 1994-2014 Background Paper: Health. *Department of Planning, Monitoring and Evaluation Republic of South Africa*. https://www.dpme.gov.za/publications/20%20Years%20Review/20%20Year%20Review%20Documents/20YR%20Health.pdf (accessed: 14.05.2025)

[10] Overview. *GEMS*. https://www.gems.gov.za/en/About-Gems/Overview (accessed: 10.07.2025)

[11] Department: Health Republic of South Africa. National Health Insurance: Healthcare for All South Africans. Understanding National Health Insurance. *Health Systems Trust*. https://www.hst.org.za/publications/NonHST%20Publications/Booklet%20-%20Understanding%20National%20Health%20Insurance.pdf (accessed: 10.07.2025)

frameworks and the provision of medical services to socially vulnerable populations. The third phase of the program involved the formal enactment of the National Health Insurance Act and the commencement of the new system's operations (*Table* 1)[12].

Table 1. **Key Phases of National Health Insurance System Implementation in South Africa**

Stages of the national health insurance system implementation project	Major goals
Phase 1 (2012–2017)	The execution of pilot projects and assessment of their outcomes; enhancement of the primary healthcare system
Phase 2 (2017–2022)	Development of the legislative framework; provision of support to socially vulnerable segments of the population in accessing healthcare services
Phase 3 (2022–2026)	Full implementation of the national health insurance system

Source: Authors' compilation based on data provided by the Government of South Africa. Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa. *The Government of South Africa*. 2019. https://www.health.gov.za/wp-content/uploads/2020/11/nhi-evaluation_evaluation-report.pdf (accessed: 10.07.2025)

The South African government justifies the necessity of establishing a new healthcare system by citing significant imbalances that lead to inequitable access to medical care. According to data from the South African Department of Science, Technology and Innovation, only 16% of South African citizens utilize private healthcare facilities, while these facilities employ two-thirds of all physicians. The national health insurance system in South Africa stipulates that every citizen is entitled to state-funded coverage for specified medical services at public or licensed private hospitals. This does not preclude the option of acquiring private health insurance or membership in a private medical aid scheme. The system is financed through mandatory contributions from all citizens. State-funded insurance covers medical services such as primary healthcare, inpatient treatment, palliative care, rehabilitation, mental health treatment, emergency care, and patient transportation[13].

An important dimension in the development of South Africa's healthcare system has been the fight against HIV infection. The steady increase in the proportion of HIV-positive individuals during the late 20th and early 21st centuries posed a significant challenge to the South African healthcare system. According to World Bank data, the proportion of the population infected with HIV increased from 1.3% to 18.8% between 1990 and 2018; notably, this figure had already reached a substantial level of 13% by the year 2000, ranking South Africa third globally at that time[14]. Inequitable access to medical care exacerbates this problem: when antiretroviral therapy is available only to a limited segment of the population, individuals who do not receive treatment remain potential vectors of HIV transmission and are at elevated risk of developing AIDS.

[12] Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa. *The Government of South Africa*. 2019. https://www.health.gov.za/wp-content/uploads/2020/11/nhi-evaluation_evaluation-report.pdf (accessed: 10.07.2025)

[13] National Health Insurance. Department of Science, Technology and Innovation of the Republic of South Africa. 2023. https://dsti.gov.za/index.php/media-room/latest-news/4099-national-health-insurance (accessed: 10.07.2025)

[14] Prevalence of HIV, total (% of population ages 15–49). *The World Bank*. https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?view=map (accessed: 25.07.2025)

To address the issue of unequal access to HIV therapy, the government has implemented a range of interventions. Since 2004, free HIV treatment has been available in South African public hospitals [Burger et al. 2022], and by March 2005, antiretroviral therapy had become accessible in all provinces of South Africa [Simelela et al. 2015]. Nevertheless, the period from 2000 to 2005 remained catastrophic, with over 330,000 deaths attributed to AIDS during this time, as the government was unable to implement a high-quality antiretroviral therapy program [Delobelle 2013]. In 2010–2011, large-scale campaigns were organized to conduct mass HIV testing and to train healthcare workers in the administration of antiretroviral therapy [Simelela et al. 2015]. Furthermore, the United States extended its President's Emergency Plan for AIDS Relief (PEPFAR) to South Africa[15].

Despite these interventions, progress in reducing the proportion of HIV-infected individuals within the general population has been observed only after 2018 (decreasing from 18.8% in 2018 to 17.8% in 2022). However, as of 2022, South Africa still exhibits the highest prevalence of HIV carriers globally[16]. Nevertheless, the South African government reports certain successes in addressing this challenge: 94% of South African citizens infected with HIV are aware of their status; 77% of individuals aware of their HIV-positive status are receiving antiretroviral therapy; and 92% of patients undergoing therapy have achieved viral suppression[17].

In 2025, South Africa faced a new challenge in its HIV/AIDS response: the United States discontinued funding for the President's Emergency Plan for AIDS Relief (PEPFAR) and the disbursement of research grants from the National Institutes of Health, which resulted in financial constraints for organizations providing HIV/AIDS therapy (e.g., MatCH, Anova) and the layoff of numerous personnel employed in this sector. Consequently, the accessibility of antiretroviral therapy within the country has significantly decreased. According to expert estimates, a lack of decisive action by the South African government in this situation will lead to extremely negative consequences, with the number of HIV-related deaths projected to increase by 56,000–65,000 compared to a scenario in which U.S. funding is maintained[18].

DATA DESCRIPTION AND RESEARCH METHODS

This study utilizes data from the South African annual General Household Survey (GHS) for 2002[19], 2005[20], 2012[21], 2019[22], 2020[23], 2023[24] and 2024[25]. The selection of the

[15] Where We Work – PEPFAR. U.S. Department of State. https://www.state.gov/where-we-work-pepfar (accessed: 25.07.2025)

[16] Prevalence of HIV, total (% of population ages 15-49). *The World Bank*. https://data.worldbank.org/indicator/SH.DYN.AIDS.ZS?view=map (accessed: 25.07.2025)

[17] Mokale S. Fighting HIV and AIDS in South Africa. *South African Government*. 29.02.2024. https://www.gov.za/blog/fighting-hiv-and-aids-south-africa#:~:text=In%20South%20Africa%2C%20we%20have,have%20come%20in%20tackling%20HIV. (accessed: 25.07.2025)

[18] Venter F. South Africa's HIV programme is collapsing. *University of the Witwatersrand*. 08.05.2025. https://www.wits.ac.za/news/latest-news/opinion/2025/2025-05/south-africas-hiv-programme-is-collapsing.html (accessed: 25.07.2025)

[19] Statistics South Africa. General Household Survey 2002. Version 1.3. Pretoria: Statistics South Africa. 2017. Cape Town. *DataFirst*. 2020. https://doi.org/10.25828/d2xh-m039

[20] Statistics South Africa. General Household Survey 2005. Version 1.4. Pretoria. Statistics South Africa. 2017. Cape Town. *DataFirst*. 2020. https://doi.org/10.25828/0agk-ne11

[21] Statistics South Africa. General Household Survey 2012. Version 2.1. Pretoria: Statistics South Africa. 2017. Cape Town. *DataFirst*. 2020. https://doi.org/10.25828/jpfy-2g79

study period is justified by data availability (the University of Cape Town provides survey data for 2002–2024) and by significant healthcare-related events that occurred in South Africa. Specifically, the National Health Act was enacted in 2003; data from 2002 reflect the situation immediately preceding its enactment, while data from 2005 capture its initial potential effects. Data from 2012 capture longer-term effects of the National Health Act, as well as the early results of several government programs (Government's Programme of Action 2009, Hospital Revitalisation Programme, Primary Healthcare Re-engineering). The 2019 and 2020 data reflect the situation before and during the coronavirus pandemic, respectively; and the 2024 data reflect the situation several years after the pandemic and the exacerbation of the energy crisis in 2022–2023.

The South African General Household Surveys present respondents with a range of questions designed to identify factors contributing to inequality, including, for example, demographic characteristics (gender, age, race, presence of chronic illnesses or disabilities, etc.), socioeconomic status (income, employment, ownership of specific assets, housing conditions, health insurance coverage, etc.), life satisfaction (including subjective assessments of health status and happiness) etc. Statistics South Africa compiles the microdata from the survey results, and the University of Cape Town provides access to these data upon request. The General Household Survey data are utilized in several studies concerning healthcare in South Africa, as the survey sample is considered representative of the entire South African population [Burger, Christian 2020; Mutwali, Ross 2019]. Responses from respondents under the age of 18, as well as from citizens who declined to provide information relevant to the research questions, were excluded from the sample. All calculations were performed using the Python programming language and the Jupyter Notebook environment (Anaconda).

In this study, respondents from all considered surveys were divided into groups based on several characteristics: gender, race, province of residence, urban or rural residence, educational attainment. For the surveys conducted in 2012, 2019, 2020 and 2024, population quartiles based on per capita household income were also delineated; the delineation of quartiles was not feasible for 2002 and 2005 due to the absence of household income data in the surveys for those years.

Healthcare accessibility was examined along two dimensions: physical and financial. Physical availability was deemed satisfactory for an individual if he or she spent no more than 14 minutes traveling to a healthcare facility. Private health insurance coverage was used as an indicator of financial affordability. The measurement of the level of and factors contributing to inequality in physical healthcare availability was not conducted on the 2020 survey data, as the survey questionnaire lacked questions regarding travel time to healthcare facilities.

Descriptive statistics (the proportion of the population with satisfactory healthcare accessibility within each group) were used to assess the level of inequality in healthcare accessibility across various dimensions and its primary determinants. For 2012, 2019, 2020, and 2024, the concentration index was also calculated, employing per capita

[22] Statistics South Africa. General Household Survey 2019. Version 1. Pretoria: Statistics SA. 2019. Cape Town: *DataFirst*. 2019. https://doi.org/10.25828/vtvj-pv21

[23] Statistics South Africa. General Household Survey 2020. Version 1. Pretoria: Statistics SA. 2020. Cape Town: *DataFirst*. 2021. https://doi.org/10.25828/pjzq-hn39

[24] Statistics South Africa. General Household Survey 2023 [dataset]. Version 1. Pretoria: Statistics SA [producer], 2023. Cape Town: DataFirst [distributor], 2024. DOI: https://doi.org/10.25828/9khq-h317

[25] Statistics South Africa. General Household Survey 2024. Version 1. Pretoria: Statistics SA. 2025. Cape Town: *DataFirst*. 2025. https://doi.org/10.25828/rx6h-3r34

household income as the welfare variable. The concentration index is a metric commonly applied in research on healthcare inequality. Its calculation methodology is analogous to that of the Gini index: to measure the concentration index, a coordinate system is constructed, with the horizontal axis representing the cumulative proportion of the population sorted by increasing welfare variable, and the vertical axis representing the cumulative proportion of a binary healthcare accessibility variable. The resulting curve is termed the concentration curve [Gordon et al. 2020].

FACTORS OF INEQUALITY IN PHYSICAL AVAILABILITY OF HEALTHCARE

According to World Bank data, South Africa maintains the lowest life expectancy at birth among the BRICS nations, registering at 66.14 years in 2023. This metric experienced a notable contraction during the period of exogenous shock of 2020, receding from over 66 years in 2019 to approximately 62 years in 2021[26]. While South Africa's governmental and overall healthcare expenditure is relatively elevated, exceeding the average for upper-middle-income economies (the category to which South Africa is classified[27]), there is evidence to suggest resource allocation inefficiencies and inequities.

By 2024, improvements had been achieved in the area of physical healthcare availability: while in 2002, 21.2% of the population spent up to 15 minutes traveling to a healthcare facility and 71.8% spent up to 30 minutes, these figures had increased to 36% and 83.8%, respectively, by 2024 (*Table* 2). These observed improvements may plausibly be attributed to governmental policies implemented to mitigate healthcare inequality. Since 1994, South Africa has undertaken the construction of numerous new hospitals, particularly in rural areas [Gaede, Versteeg 2011]. Complementing this expansion, the Hospital Revitalization Program, initiated in 2003–2004, facilitated the comprehensive renovation of 18 medical facilities by 2014[28]: this may have contributed to the increase in physical healthcare availability, as citizens residing near renovated hospitals may have reoriented their healthcare-seeking behavior towards these facilities, even if they had previously preferred to visit more distant hospitals due to their superior equipment and resources.

In 2009, a primary healthcare re-engineering program was initiated, aiming to achieve a more efficient allocation of human resources within this sector: the creation of new qualified teams to deliver primary care, with clearly defined job responsibilities and accountability, as well as systems to support these teams. Each team serves citizens residing within a specific geographic area [Naledi, Barron, Schneider 2011]. Collectively, these measures may have contributed to improvements in physical healthcare availability in South Africa. Unfortunately, due to the absence of relevant data in the 2020 and 2021 surveys, it is not possible to specifically assess the impact of the COVID-19 pandemic; however, it can be posited that, in conjunction with other factors (the exacerbation of the energy crisis), the excessive strain on the healthcare system led to a negative trend.

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[26] Life Expectancy at Birth, Total (Years) - South Africa. *The World Bank.* 2023. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=ZA (accessed: 24.06.2025)

[27] The Global Health Expenditure Database. *World Health Organization.* 2025. https://apps.who.int/nha/database. (accessed: 24.06.2025)

[28] The Presidency. Twenty-Year Review South Africa: 1994-2014 Background Paper: Health. *Department of Planning, Monitoring and Evaluation Republic of South Africa*. https://www.dpme.gov.za/publications/20%20Years%20Review/20%20Year%20Review%20Documents/20YR%20Health.pdf (accessed: 14.05.2025)

Table 2. **Physical Availability of Healthcare in South Africa, %**

Criterion / Year	2002	2005	2012	2019	2023	2024
Proportion of the population living within 0–14 minutes' travel time to a hospital	21.2	20.7	39.0	39.8	35.2	36.0
Proportion of the population living within 0–29 minutes' travel time to a hospital	71.8	66.9	79.8	83.8	82.2	83.8

Source: authors' calculations based on data from South African General Household Surveys for 2002, 2005, 2012, 2019, 2023 and 2024.

Table 3 presents statistics disaggregated by selected social groups. The data reveal that positive trends are evident across all groups, although governmental support measures were primarily targeted at improving accessibility for the most vulnerable populations (i.e., Black Africans and low-income individuals). However, a persistent consequence is the maintenance of inequality between groups; populations that held an advantage in 2002 continue to retain it with a substantial margin.

An examination of the dynamics of inequality in physical availability of healthcare in South Africa reveals the explicit aim of the implemented governmental policies: significant progress has been achieved only in reducing racial inequality. The gap between the most privileged and the most vulnerable groups based on these criteria (White Africans and Black Africans, respectively) has decreased by approximately 1.5 times. Regarding geographic factors of inequality, no significant positive trend is observed; the gap between urban and rural areas widened in 2024 compared to 2002. The disparity between provinces in 2024 was lower than in 2002 but higher than in 2012. The situation concerning inequality between individuals with differing incomes in 2024 is nearly the same as the situation in 2012 (see *Table* 3). The 2024 survey data does not demonstrate significant changes compared to 2023—it is likely that the adoption of the new law has not yet had a significant impact on the system as a whole.

Table 3. **Proportion of the Adult Population of South Africa Living Within 0–14 Minutes of a Hospital, %**

Criterion / Year	2002	2005	2012	2019	2023	2024
Sample size, persons	60,577	63,956	56,437	43,057	44,897	44,703
Urban/Rural						
Rural	13.1	10.1	20.4	20.0	19.0	18.7
Urban	26.9	28.8	50.0	50.9	44.6	45.7
Province						
Eastern Cape	19.2	19.5	29.6	33.6	27.5	27.1
Free State	25.4	25.0	45.6	38.3	37.0	34.9
Gauteng	22.4	21.0	48.3	55.1	48.9	49.1

Criterion / Year	2002	2005	2012	2019	2023	2024
KwaZulu-Natal	11.1	13.3	26.6	29.2	20.0	24.7
Limpopo	18.9	12.9	30.7	22.2	21.6	23.4
Mpumalanga	21.7	15.0	33.9	30.7	32.4	27.0
North West	17.6	22.2	37.0	37.9	31.4	29.7
Northern Cape	23.9	30.3	36.2	32.9	38.6	35.9
Western Cape	38.4	37.2	60.9	62.5	58.6	59.4
Population Group						
Black African	16.2	15.0	33.6	35.6	31.6	31.9
Coloured	34.5	35.8	54.1	56.0	54.1	57.2
Indian/Asian	19.4	38.7	57.6	57.4	41.9	52.8
White	43.0	43.6	62.2	61.9	55.9	57.7
Education						
No education/only primary education	15.4	14.6	27.7	27.6	25.0	24.8
Secondary education is not completed	19.6	19.9	35.4	35.8	30.7	31.6
Secondary education	23.4	23.8	41.1	41.1	36.1	36.5
Tertiary education	34.3	40.2	53.0	52.3	44.3	47.0
Income Quartile						
1	–	–	28.9	38.9	27.6	25.6
2	–	–	31.7	32.3	30.2	31.4
3	–	–	41.6	38.7	37.7	38.6
4	–	–	53.9	49.2	45.3	48.3

Source: authors' calculations based on data from South African General Household Surveys for 2002, 2005, 2012, 2019, 2023 and 2024.

To evaluate income-related inequality in physical healthcare availability, the concentration index was calculated for 2012, 2019, and 2024. The resulting index values were 0.14, 0.06, and 0.14, respectively. These figures suggest that, in 2019, physical healthcare accessibility was redistributed in favor of lower-income individuals; however, by 2024, the disparity between high- and low-income groups had reverted to the level observed in 2012. The relatively low, positive values of the concentration index indicate a limited degree of income-related inequality, while also suggesting that individuals in lower income brackets are, on average, more vulnerable than their higher-income counterparts.

An interesting effect is observed in 2019: the concentration curve in the lower deciles lies above the line of equality. This implies certain advantages for the poorest segments of the population. Undoubtedly, this is related to the second phase of the national healthcare insurance system implementation, which provided services for the most vulnerable populations. The graphs for 2012 and 2024 have a standard form, where the curve lies below the line of absolute equality, meaning that better physical access to healthcare is available to the more affluent population (*Fig.* 1, 2, 3).

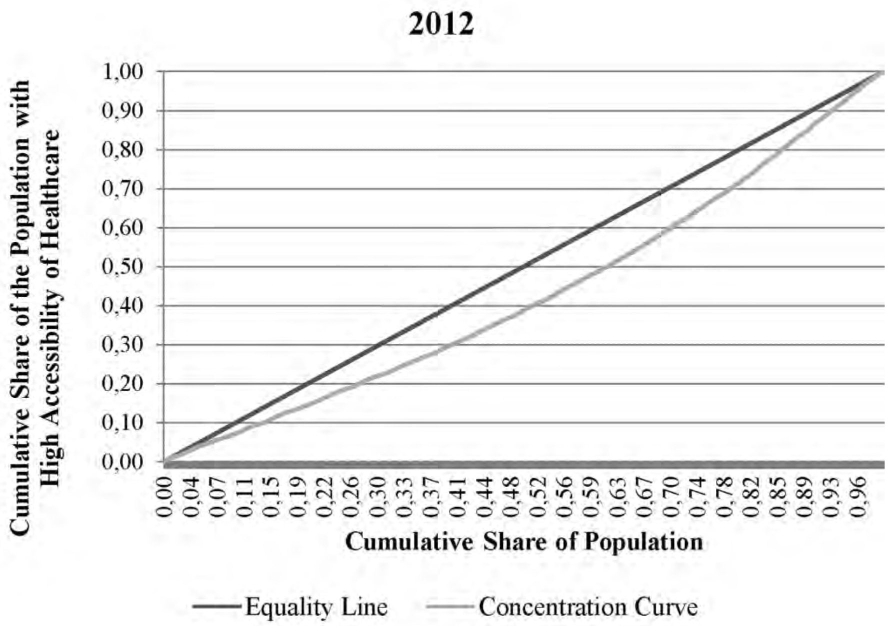

Fig. 1. **Concentration curve for physical availability of healthcare in South Africa in 2012 (accessibility criterion – 0–14 minutes travel time to a hospital).**
Source: Authors' calculations based on data from South African General Household Survey for 2012.

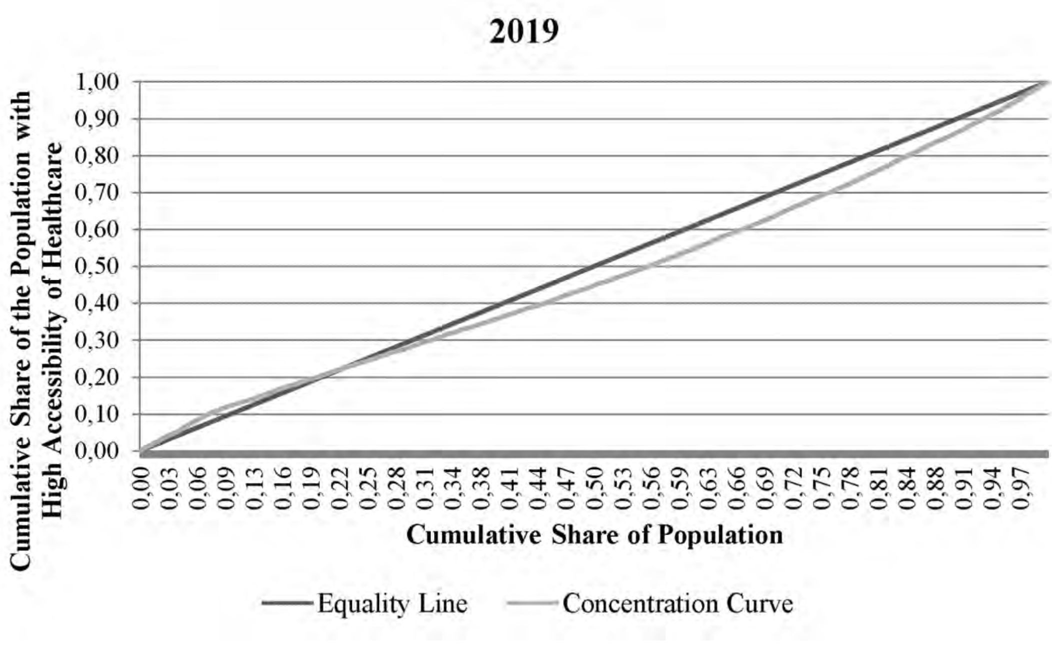

Fig. 2. **Concentration curve for physical availability of healthcare in South Africa in 2019 (accessibility criterion – 0–14 minutes travel time to a hospital).**
Source: authors' calculations based on data from South African General Household Survey for 2019.

Logistic regressions for physical accessibility using survey data from 2012, 2019, and 2024 demonstrate high marginal effects for the variable of urban residence: for an urban resident in 2012, 2019, and 2024, the probability of living within 0–14 minutes of a hospital is higher by 24%, 22%, and 17%, respectively, than for a rural resident (*Table* 4), with a decrease in marginal effects observed over time. Furthermore, significant marginal effects are observed for the urbanized provinces of Western Cape (for all the years) and Gauteng (for 2019 and 2024). Racial variables are also significant in this model: being Asian, White African, or Coloured significantly increases the probability of physical availability of medicine compared to being part of the Black population. The marginal effects of income and education variables are mostly low; the models do not identify a statistically significant difference in physical accessibility to medicine for women and men.

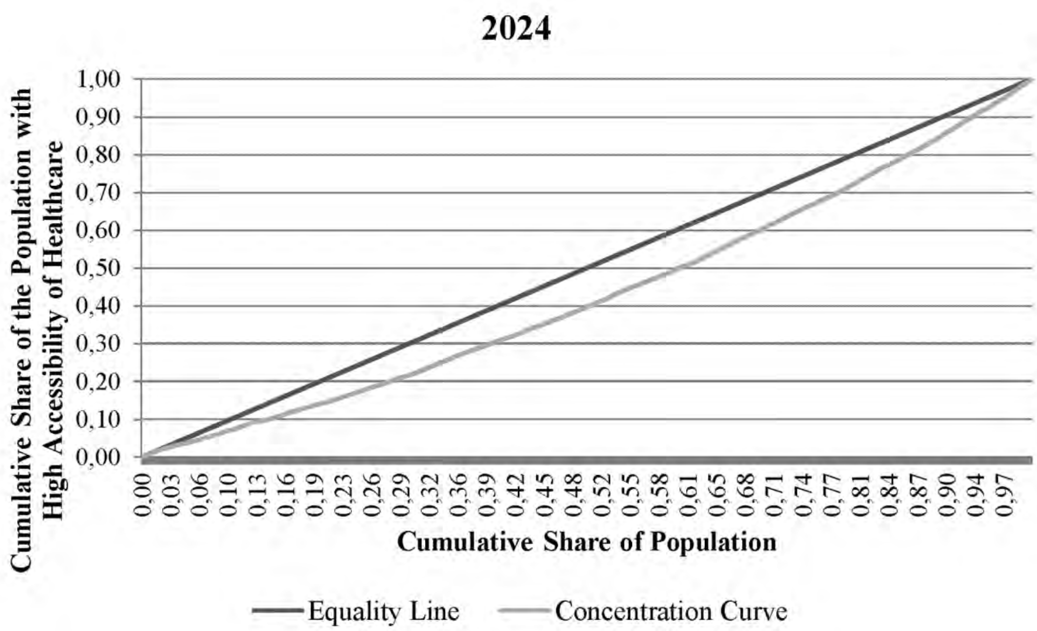

Fig. 3. **Concentration curve for physical availability of healthcare in South Africa in 2024 (accessibility criterion – 0–14 minutes travel time to a hospital).**
Source: authors' calculations based on data from South African General Household Survey for 2024.

Table 4. **Marginal effects of logistic regression for physical availability of healthcare (accessibility criterion – 0–14 minutes travel time to a hospital)**

Variable	2012	2019	2024
Urban	0.2411***	0.2161***	0.1688***
Male	0.0007	0.0025	0.0041
Free State	0.0682***	-0.0348***	0.0176
Gauteng	0.0387***	0.0788***	0.1085***
KwaZulu-Natal	-0.0698***	-0.0514***	-0.0237***
Limpopo	0.1323***	-0.0437***	0.0240**
Mpumalanga	0.0635***	-0.0094	0.0182*
North West	0.0884***	0.0529***	0.0461***
Northern Cape	-0.0269***	-0.0901***	-0.0054
Western Cape	0.1228***	0.1079***	0.1272***
Coloured	0.0516***	0.0654***	0.1129***
Indian/Asian	0.153***	0.1214***	0.1111***

Variable	2012	2019	2024
White	0.0971***	0.1036***	0.0887***
Secondary education is not completed	0.0263***	0.0307***	0.0247**
Secondary education	0.0381***	0.0465***	0.0369***
Tertiary education	0.0563***	0.0915***	0.0678***
2 quartile	0.0123**	-0.0028	0.0404***
3 quartile	0.0512***	0.0106*	0.0595***
4 quartile	0.0855***	0.0197***	0.0854***

Note: *** – marginal effect is significant at the 1% significance level;
** – marginal effect is significant at the 5% significance level;
* – marginal effect is significant at the 10% significance level.

Source: authors' calculations based on data from South African General Household Surveys for 2012, 2019, 2024.

Thus, the main factors of inequality in physical access to medical services are geographical and social factors: White Africans or Asian citizens from urban areas of more developed provinces generally have more convenient access to medical infrastructure. Overall progress is observed, especially in absolute terms; however, the difference between residents of different provinces and residents of urban and rural areas remains high.

Success in reducing racial disparities in the healthcare system is particularly evident. Inequality between the poor and the wealthy was also reduced by 2019, but in 2024, the situation deteriorated again, likely due to the escalation of the energy crisis.

FACTORS OF INEQUALITY IN FINANCIAL AFFORDABILITY OF HEALTHCARE

Analysis of financial healthcare affordability from 2002 to 2024 reveals a lack of clear positive progression; the proportion of the South African population possessing health insurance remained consistently below 20%. Furthermore, the indicator exhibited a decline in 2024 compared to 2002 (Table 5), with positive trends only evident during the 2005–2012 period. Existing literature attributes this to the activities of the Government Employees Medical Scheme (GEMS) [Willie, Maqbool 2023]. Notably, the observed trend indicates further deterioration despite the implementation of relevant measures, with the insured population decreasing from 14% in 2023 to 13.7% in 2024.

Table 5. **Dynamics of financial affordability of healthcare in South Africa, %**

Criterion/Year	2002	2005	2012	2019	2020	2023	2024
Proportion of the population with private health insurance / contributions to a medical scheme	16.0	12.3	17.6	16.0	12.3	14	13.7

Source: authors' calculations based on data from South African General Household Surveys for 2002, 2005, 2012, 2019, 2020, 2023, and 2024.

The structure of financial affordability of healthcare has hardly changed over the years examined (*Table* 6). An exception is the dynamics of healthcare affordability for different social groups, categorized by income level. In 2012, the proportion of people with private health insurance increased as they moved from a less affluent group to a more affluent one; in the wealthiest group, more than half of the respondents had private insurance, while in other quartiles, the proportion of respondents with insurance was small. In 2019, the situation changed quite dramatically for the top and bottom quartiles: the proportion of people with insurance in the poorest group increased significantly, and in the wealthiest group, it decreased substantially. This, as with physical availability to healthcare, is related to measures taken in the second phase of reforms to support the most vulnerable populations (low-income citizens).

In 2020, the COVID-19 pandemic disproportionately impacted the most economically vulnerable segments of the population, a trend reflected in a substantial decline in the proportion of individuals contributing to medical schemes, falling from 15.5% to 2.5% between 2019 and 2020. In contrast, the health insurance status of the wealthiest population remained relatively stable. By 2024, the structure of access to fee-based medical services across various income groups had reverted to a configuration similar to that observed in 2012; however, the overall proportion of individuals possessing private insurance remained lower across all income quartiles. Notably, an analysis of the changes between 2023 and 2024 reveals multidirectional trends, exhibiting a reduction in racial inequality alongside a slight increase in inequality related to income level and type of settlement. Overall, these results suggest that the most recent phase of healthcare reforms has not yet translated into substantial improvements in the population's lived experience.

Across all years examined, and under any population disaggregation criterion employed, the proportion of individuals with health insurance or a medical aid scheme in the most privileged group (urban residents, White Africans, those with higher education or the highest income quartile) was consistently more than double that observed in the most vulnerable group (rural residents, Black Africans, those with elementary education or no formal education, and the lowest income quartile) (see *Table* 6).

Table 6. **Dynamics of financial affordability of healthcare in South Africa by specific population groups, %**

Criterion/Year	2002	2005	2012	2019	2020	2023	2024
Sample size. persons	60577	63956	56437	43057	21422	44897	44703
Urban/Rural							
Rural	6.4	5.0	5.8	6.7	5.4	5.4	5.6
Urban	22.6	17.8	24.5	21.1	17.6	18.9	18.3
Province							
Eastern Cape	12.7	11.4	13.3	11.1	9.7	10.3	10.5
Free State	15.7	12.9	16.9	15.0	12.4	13.3	11.8
Gauteng	24.7	19.7	24.1	19.9	14.7	17.8	16.9
KwaZulu-Natal	12.1	8.1	15.9	13.8	7.5	10.9	9.3
Limpopo	10.2	8.4	7.8	10.2	7.2	9.5	10.1
Mpumalanga	13.0	9.4	14.1	11.4	7.6	9.4	10.0
North West	14.4	11.0	15.1	16.2	18.4	12.2	11.9
Northern Cape	17.7	15.1	19.5	17.5	18.6	15.4	16.6
Western Cape	22.9	18.3	27.3	26.9	29.6	25.4	25.4

Criterion/Year	2002	2005	2012	2019	2020	2023	2024
Population Group							
Black African	8.5	6.6	10.2	9.9	8.1	8.9	9.1
Coloured	16.6	12.7	20.2	21.3	19.5	19.3	19.1
Indian/Asian	27.8	27.4	41.0	46.5	35.4	44.4	39.6
White	66.7	61.4	74.3	71.3	73.9	69.5	68.1
Education							
No education/only primary education	3.0	2.0	3.5	2.2	1.6	1.5	1.4
Secondary education is not completed	7.1	4.9	6.1	5.2	3.0	2.9	2.8
Secondary education	20.2	18.3	16.7	13.5	10.1	10.7	10.4
Tertiary education	61.0	69.8	63.5	57.7	47.6	51.4	49.9
Income Quartile							
1	–	–	2.9	15.5	2.5	1.4	2.0
2	–	–	3.1	3.9	1.9	2.9	2.4
3	–	–	12.2	6.7	5.7	7.5	8.1
4	–	–	52.0	38.0	39.0	43.8	42.2

Source: authors’ calculations based on data from South African General Household Surveys for 2002, 2005, 2012, 2019, 2020, 2023, and 2024.

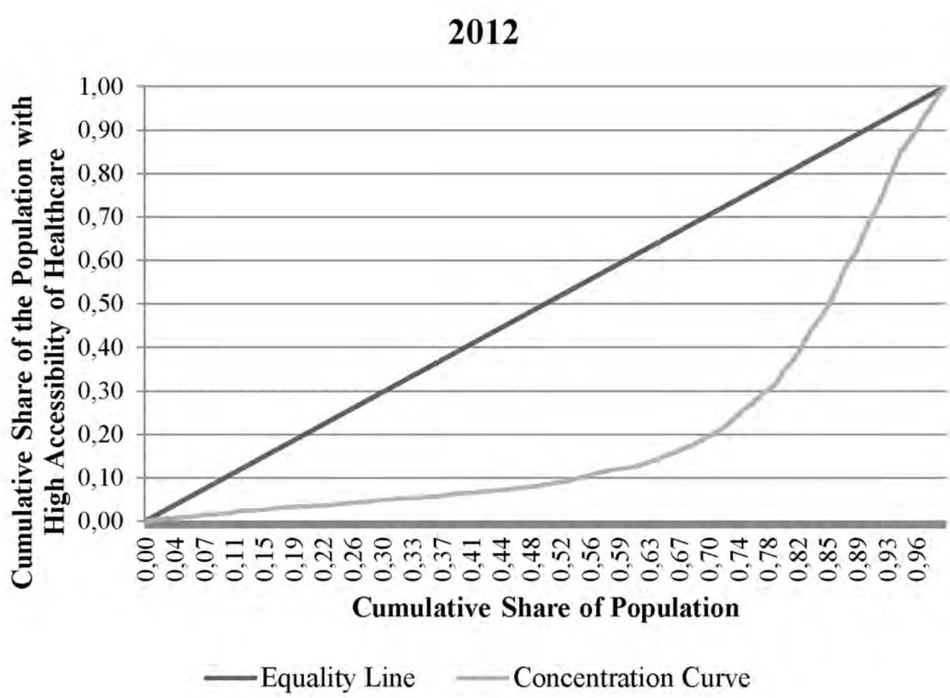

Fig. 4. **Concentration curve for financial affordability of healthcare in South Africa in 2012.**
Source: authors’ calculations based on data from South African General Household Survey for 2012.

The concentration index for the financial affordability of healthcare is 0.59 (2012), 0.29 (2019), 0.63 (2020), and 0.64 (2024), indicating a rise in inequality in financial accessibility to healthcare. Interestingly, the concentration curves for financial affordability of healthcare are much more convex than those for physical availability, signifying greater inequality. As with physical availability, there is a clear effect of government measures—the curve for 2019 and, in addition, the curve for 2020. That means that healthcare services were more accessible to citizens from the poorest segments of the population in these years than to members of the middle class (*Figs*. 4, 5, 6, 7). Indeed, the pilot project of national health insurance implied the payment of medical services for vulnerable groups of the population by the state. In 2024, South Africa returned to the situation that existed in 2012.

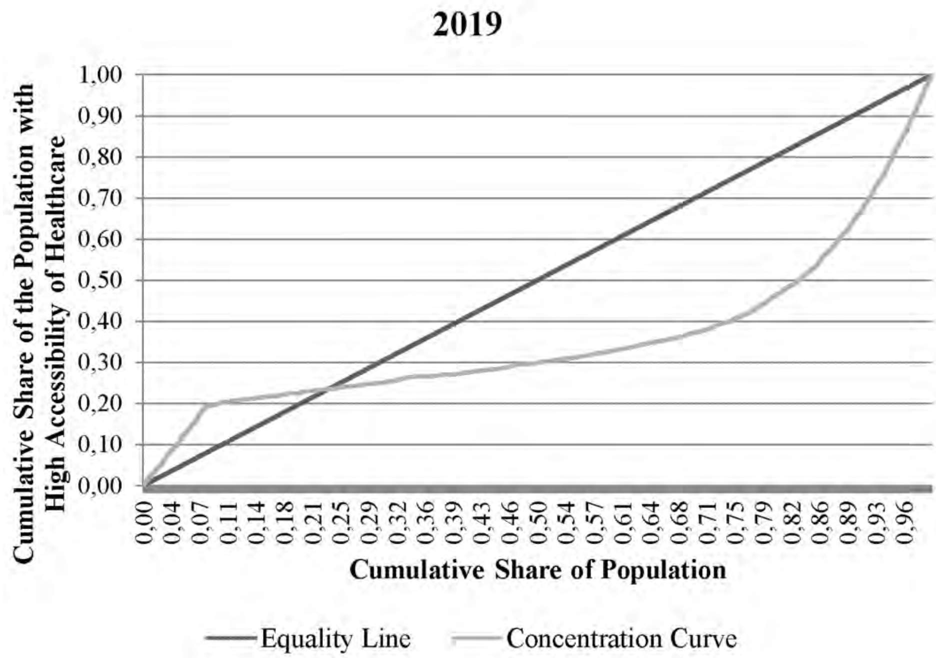

Fig. 5. **Concentration curve for financial affordability of healthcare in South Africa in 2019.**
Source: authors' calculations based on data from South African General Household Survey for 2019.

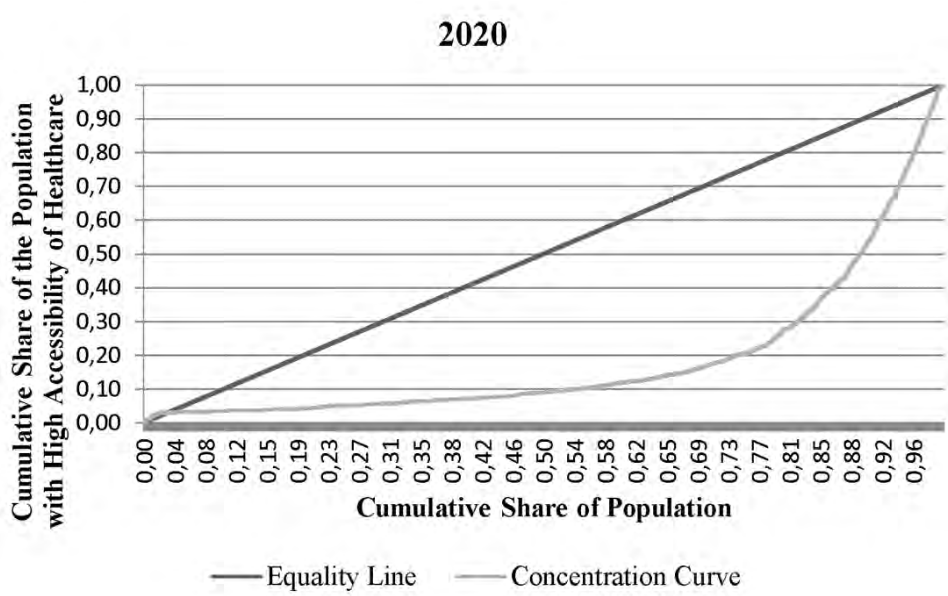

Fig. 6. **Concentration curve for financial affordability of healthcare in South Africa in 2020.**
Source: authors' calculations based on data from South African General Household Survey for 2020.

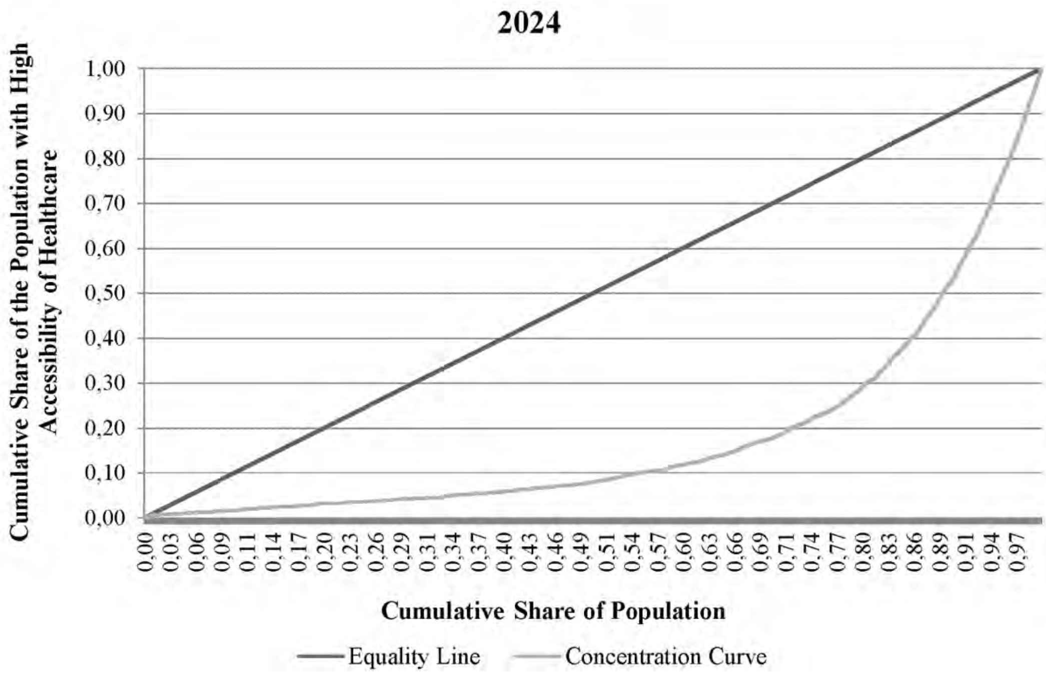

Fig. 7. **Concentration curve for financial affordability of healthcare in South Africa in 2024.**
Source: authors' calculations based on data from South African General Household Survey for 2024.

The logistic regression for financial affordability of medicine, unlike the model for physical availability, shows low or statistically insignificant marginal effects for geographical factors (Table 7). The most significant marginal effects in the models based on 2012, 2019, 2020, and 2024 data are observed for income, education, and race variables. While the situation for racial variables and education level indicators is similar in all the years considered (the most vulnerable groups are Black Africans and people with low levels of education, while Whites and people with higher education are in the most advantageous position), an atypical situation is observed for the income variable in 2019. While in the other years considered, representatives of the first quartile in terms of per capita household income were the most vulnerable group or at least did not have a statistically significant advantage over other quartiles, in 2019, the probability of living near a hospital for representatives of the 2nd and 3rd quartiles is significantly lower than for the poorest population (by 9% and 5%, respectively). This result is consistent with the conclusions that were made based on the concentration index.

Table 7. **Marginal effects of logistic regression for financial affordability of healthcare**

Variable	2012	2019	2020	2024
Urban	0.0518***	0.0468***	0.0262***	0.0286***
Male	-0.0141***	-0.0126***	-0.0114***	-0.0139***
Free State	0.01*	0.0091	0.0189**	0.0224
Gauteng	-0.0176***	0.0013	-0.0095	-0.0128***
KwaZulu-Natal	-0.0031	0.0076	-0.022***	-0.0188***
Limpopo	-0.004	0.0198***	0.0002	0.0109*
Mpumalanga	0.0073	0.0049	-0.0023	-0.0025
North West	0.0235***	0.0574***	0.0658***	0.0265***
Northern Cape	0.0186***	0.0181**	0.0375***	0.0193***

Variable	2012	2019	2020	2024
Western Cape	-0.0204***	-0.0037	0.011	-0.0118**
Coloured	0.0466***	0.0717***	0.0157**	0.0427***
Indian/Asian	0.0652***	0.1183***	0.0761***	0.1006***
White	0.1619***	0.2007***	0.1484***	0.1390***
Secondary education is not completed	0.0241***	0.0513***	0.02	0.0290**
Secondary education	0.0693***	0.1102***	0.0754***	0.0973***
Tertiary education	0.1936***	0.2669***	0.1774***	0.2076***
2 quartile	0.002	-0.0867***	-0.0102	0.0111
3 quartile	0.0999***	-0.0527***	0.0545***	0.0877***
4 quartile	0.2134***	0.0707***	0.1683***	0.1969***

Note: *** – marginal effect is significant at the 1% significance level;
** – marginal effect is significant at the 5% significance level;
* – marginal effect is significant at the 10% significance level.
Source: authors' calculations based on data from South African General Household Surveys for 2012, 2019, 2020, 2024.

Thus, as with physical accessibility, financial accessibility is influenced by various factors, including geographic, demographic, and social, but economic factors stand out particularly strongly. In the wealthiest quartile, more than 40% of the population has private health insurance or contributes to medical aid schemes, while in the other groups, the proportion of people with private insurance does not exceed 10%. However, there is limited evidence of significant advancement in either enhancing overall financial affordability of healthcare or mitigating disparities between various social groups. The influence of geographical factors on inequality remained largely unchanged from 2002 to 2024, and the degree of inequality in access to medical services between individuals with differing levels of education and income has increased.

By 2019, progress had been made in reducing inequality between representatives of different races by providing insurance to the most vulnerable population, but the crisis caused by the COVID-19 pandemic led to the positive results of previous years being effectively nullified, which may be due to the negative impact of government measures (lockdown, restriction of freedom of movement, cancellation of mass events) on economic activity and on the situation of socially vulnerable groups [Abrahams et al. 2022; Staunton et al. 2020]. Furthermore, divergent trends emerged when considering racial inequality versus income inequality: while the disparity between racial groups in financial healthcare access decreased in 2024 compared to 2020, the inequality in healthcare access between individuals with varying income levels experienced a significant increase.

The introduction of a national health insurance system has not improved the situation with inequality in financial accessibility to medicine in South Africa: in 2024, the situation was nearly the same as in 2012. This may be because, at the time of the household surveys, people were not sufficiently aware of the national health insurance program or had not yet terminated contracts with private insurers or funds (if they wished to), as little time had passed since the introduction of the new system. Significant changes will likely be observed in data from later surveys.

Studies on inequality in access to healthcare in South Africa cover its various aspects: inequality in physical availability and financial affordability, differences in the perception of the quality of services provided between different social groups. The results of this study mostly correspond to previous estimates, highlighting racial, economic, and geographic characteristics as influencing access to healthcare. The identified vulnerable population groups also align with economic logic and previous results [Burger, Christian 2020; Ohonba, Kirsten, Mkhize 2023; Harris et al. 2011]. Certain differences include a different assessment of the impact of the rural factor on access to healthcare (in the study [Ohonba, Kirsten, Mkhize 2023], this factor proved insignificant).

Thus, it is premature to say that the situation has significantly changed with the implementation of government policies, and it can also be argued that by 2024, the situation had not returned to normal after the COVID-19 shock.

CONCLUSION

The study of factors influencing inequality in physical and financial accessibility to healthcare in South Africa revealed that the factors for physical and financial inequality are similar—they include geographical, demographic, and social differences. Citizens living in cities and the most urbanized provinces, with high incomes, and people of certain races (most often, White Africans) are in the most advantageous position. It is particularly noteworthy that the level of inequality in financial availability of healthcare, as indicated by the proportion of individuals with health insurance, is significantly greater than the level of inequality in its physical affordability, which is measured by the proportion of individuals residing within a 15-minute commuting distance to a hospital.

Since 2002, the South African government has managed to significantly increase the proportion of the population that does not spend a lot of time traveling to a hospital; in addition, it has managed to reduce the level of inequality in physical accessibility to healthcare between people of different races and citizens with different levels of education. On the one hand, this allows us to conclude that the Constitution of South Africa and the National Health Act of 2003 laid the foundation for improving the situation in the healthcare sector, but given the continuing high level of inequality in both directions, further efforts are required. In the field of physical accessibility to healthcare, the energy crisis of 2022–2023 had an additional negative impact: rolling blackouts led to disruptions in public transport, which is mainly used by low-income citizens. This led to an increase in travel time to hospitals.

Financial accessibility to healthcare does not show positive dynamics, and in 2024, this indicator is lower than in the previous year, 2023, and even than in the base year, 2002. The high level of income inequality still translates into unequal access to healthcare for the population. In 2024, despite the completion of the phased reform of the healthcare system and the signing of the law on the creation of a national health insurance system, the situation has not significantly changed compared to 2023, and in some aspects, there is even a negative trend. However, minor fluctuations may be more related to the specifics of the survey and sample than to a real deterioration of the situation during the year. What is important is that rapid positive changes have not occurred, unlike the measures of the second phase of the reform, when the physical and financial accessibility of medical services for the vulnerable population significantly increased.

Simultaneously with the development of the system after legislative changes, a decrease in inequality in financial accessibility can be expected, as during the pilot project of the second phase of the reform. However, this will depend on the effectiveness of the implementation of legislative initiatives, which will be evident from the results of further household surveys.

Additional materials[29]: Appendix 1. Coefficients of logistic regressions, standard errors and p-values.

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Научная статья

ЗДРАВООХРАНЕНИЕ В ЮАР: ЧТО ВЛИЯЕТ НА ДОСТУП К МЕДИЦИНСКИМ УСЛУГАМ

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Аннотация. Данное исследование посвящено вопросу неравенства в доступности медицинских услуг в Южно-Африканской Республике (ЮАР). В первой части исследования дан подробный обзор существующей литературы, в которой выделяются различные демографические и социально-экономические факторы доступа к услугам здравоохранения. Однако предшествующие работы по Южной Африке основаны на опросах до 2012 г. и не учитывают изменения последних лет, включая пандемию *COVID-19* (краткосрочные эффекты переполненности больниц и экономический эффект снижения доходов), а также обострение энергетического кризиса в ЮАР в 2022–2023 гг. Настоящее исследование включает данные из опросов домохозяйств ЮАР с 2002 по 2024 гг. Рассматриваются такие факторы, как пол и расовая принадлежность респондента, его уровень образования, место жительства (провинция и город/село), уровень дохода.

В исследовании представлены основные результаты для оценки физической доступности здравоохранения. В целом видна положительная динамика, хотя уровень 2024 г. все еще отражает эффект энергетического кризиса, показывая более низкие значения, чем в 2019 г. В исследовании представлены результаты оценки неравенства финансовой доступности здравоохранения. На финансовую доступность в гораздо большей степени оказывают влияние социально-экономические факторы (расовая принадлежность, образование и уровень дохода). Сравнение результатов исследования с выводами из более ранней научной литературы показывает, что в 2024 г. ситуация с доступностью здравоохранения в Южной Африке во многом осталась похожей на ситуацию 2012 г. – те же самые группы населения остались социально незащищенными (черные африканцы, малоимущие слои населения, сельские жители, люди с низким уровнем образования) и уровень неравенства финансовой доступности медицины остался высоким.

Ключевые слова: ЮАР, неравенство, здравоохранение, физическая и финансовая доступность, уровень дохода, уровень образования, расовая дискриминация

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