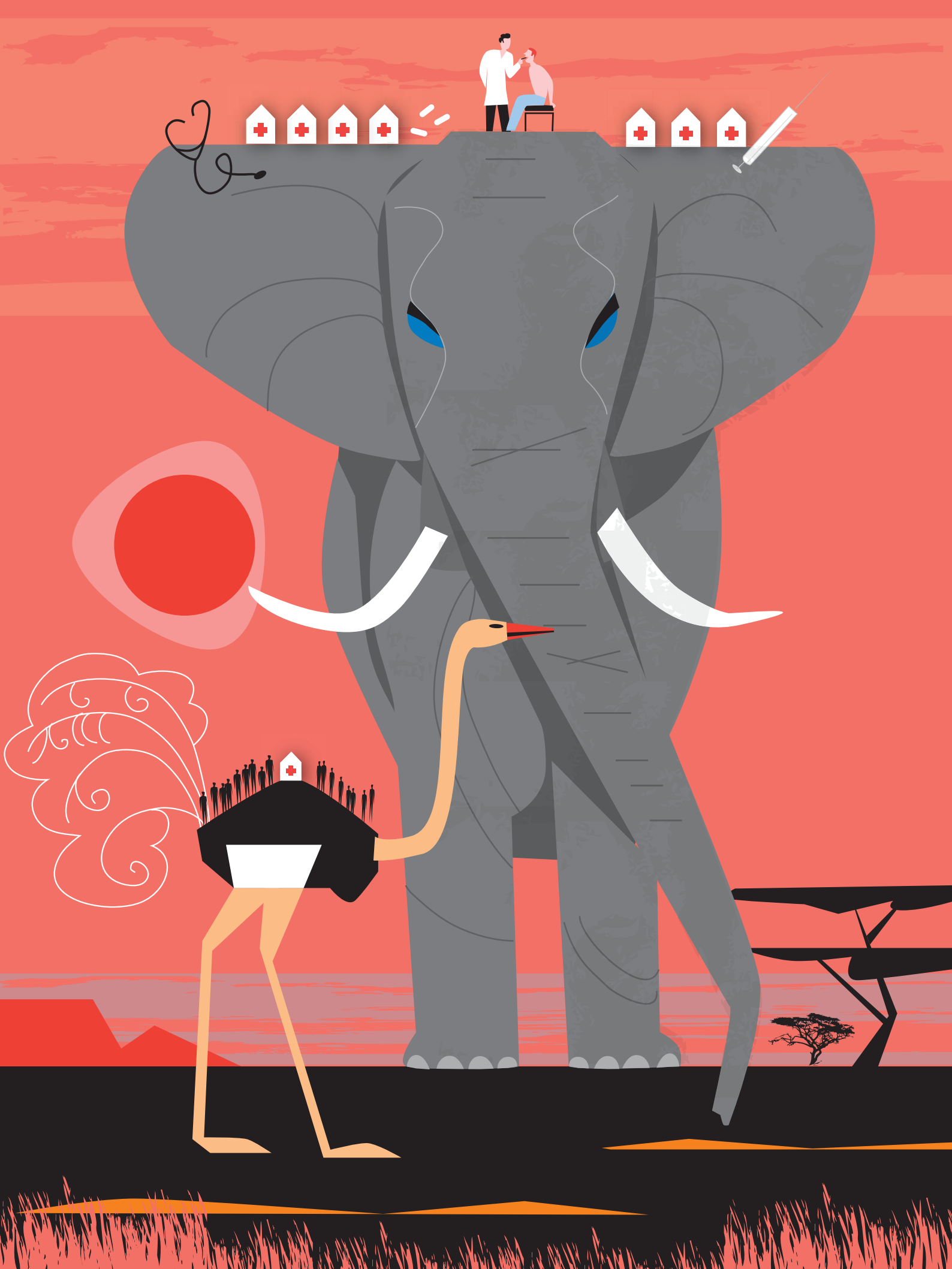

The South African Healthcare System: A Goal of Quality Healthcare for All

By Olive Shisana, ScD, Chief Executive Officer, Human Sciences Research Council, Cape Town, South Africa

The South African healthcare system has been evolving over the last four centuries[1]. Prior to the arrival of Dutch colonialists en route to India via the Cape, the local population, i.e., the Khoisan and Africans, relied on indigenous healthcare. Even today, many continue to use this system. Jan van Riebeeck arrived in the Cape in 1652, carrying in his three ships sick, hungry, and poor Dutch sailors. The Dutch East India Company, an organization he served as an administrator, required him to establish a food station and medical care for the crew as well as other settlers. Van Riebeeck, a medical doctor turned merchant who brought white settlers to South Africa, converted his house into a hospital to care for the sick, using Dutch medically trained surgeon-merchants. This hospital was later used not only by settlers, but also by local people. This was the beginning of western medicine in South Africa, which also made great efforts to subordinate indigenous medicine.

With trade between the East and Europe via the Cape growing, diseases came. One that played a pivotal role in formalizing medical care in South Africa was the smallpox epidemic of 1713, which brought by sailors who arrived from India with infected clothes to be washed by local people, the Khoisan. The disease spread and killed one-fourth of the European settlers and decimated the Khoisan workers. With increased demand for healthcare due to smallpox, health services were restricted to whites. Another smallpox outbreak that occurred in 1751 further decimated the local and the European population. The 1755 smallpox epidemic brought by a ship from Ceylon (now Sri Lanka) was responsible for racial segregation in healthcare, only providing care according to one's skin color.

Influences on Health Policy

There were many events that contributed to the development of public health in all four provinces of South Africa – Cape, Orange Free State, Transvaal, and Natal. These included the outbreak of diseases such as leprosy, bubonic plague, tuberculosis, and venereal diseases. But the biggest event that influenced the establishment of public health in South Africa was the Spanish influenza of 1911–1918, which led to the passage of the National Public Health Act in 1919. Coming after the establishment of the Union of South Africa in 1910, the Act established the Department of Health in South Africa and allocated functions for health at national, provincial, and local government levels, leaving the latter to provide personal care services paid by individuals, instead of state resources. Various committees advocating for state responsibility for healthcare were established between 1920 and 1935, arguing that the National Public Health Act did not extend to the provision of healthcare for all. In 1941, there was an effort to establish a national health insurance (NHI) plan for South Africa, led by J. Collie, who chaired the Committee of Enquiry into the National Health Insurance, which aimed to cover all people of all races, except those in rural areas. There was resistance from various quarters, including the medical fraternity. Eventually, the Department of Health's Henry Cluver, inspired by the community-based care approaches of Sydney and Emily Kark, decided to establish a community-based care system that treated patients holistically, including a good understanding of their culture, provision of health promotion services, and curative services. As a result of the pressure, the state appointed the Gluckman Com-

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mission to investigate the establishment of a new public health system. Its chairman, Henry Gluckman, was probably also influenced by the British reformists, who had major challenges regarding their own health system. The recommendation of his commission, which would have seen a much more state-centralized healthcare system with integration of curative and preventive services, was excluded from the revised 1946 National Health Act.

The apartheid government, which came into office in 1948, simply entrenched the racial segregation that had started in the 18th century and began segmenting the population by ethnic group and rural/urban divide, allocating resources according to different racial groups, a move that was to contribute to disparities in health outcomes by race. Africans, largely based in rural areas in what was later called Bantustans, suffered from diseases of poverty, such as diarrhea, tuberculosis, and respiratory disorders, while the whites suffered from diseases of affluence, common in industrialized countries.

With the release of Nelson Mandela and other political prisoners and the unbanning of exiles, the new democratic state was formed, culminating in the historic 1994 elections that brought the African National Congress in power. The post-apartheid government started introducing major changes in the healthcare system in 1994, amalgamating the 14 health departments created by apartheid – ten for blacks who lived in Bantustans and four for population groups comprised of Whites, Coloreds, Indians, and Africans who lived in urban areas. The balkanization of South Africa into these racial and ethnic groups had enabled the apartheid government to establish a state-determined policy of allocation of resources (including health resources) to ensure that inequality was maintained. It is against this background that we discuss the current challenges faced by South Africa's health system.

Healthcare Financing

The reform of South Africa's healthcare system is challenged by the historically state-generated inequalities, inadequate financing of the public healthcare system, the existence of a two-tiered healthcare system, human resource gaps, poor quality of healthcare, and a high burden of diseases. First, let us look at healthcare financing.

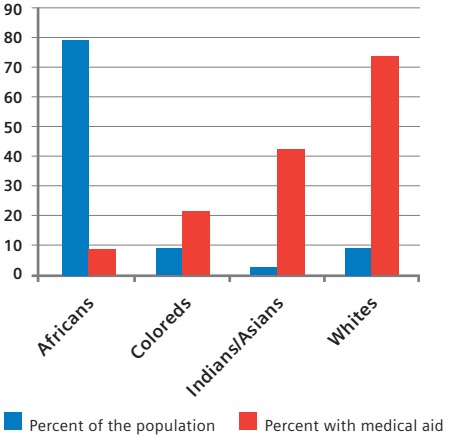
Although South Africa is located in Africa, its health spending differs from its neighboring countries. It allocates more to health than other African countries. Much of South Africa's health spending is generated domestically, while in other parts of the African continent, donor aid plays a critical role in financing healthcare.

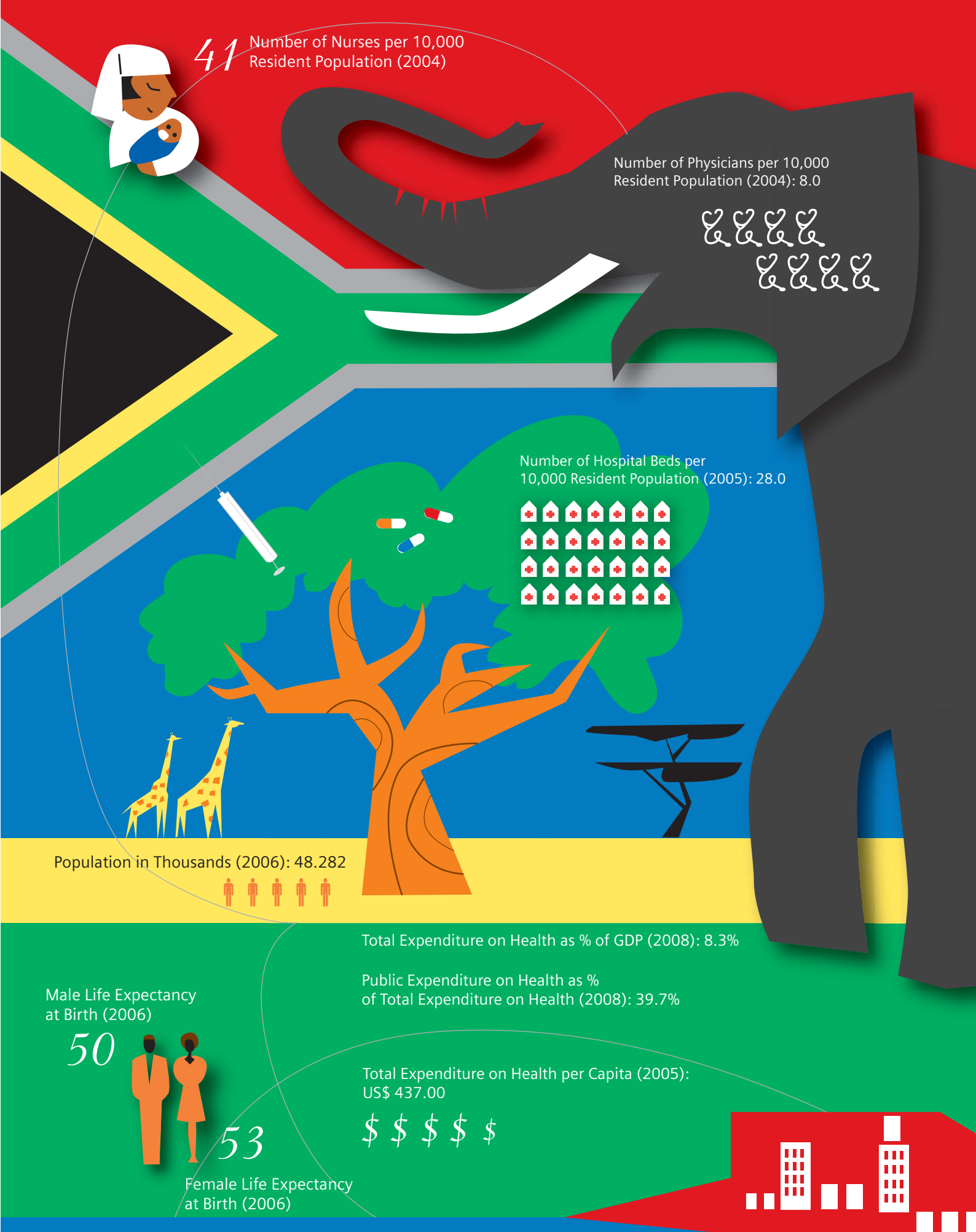
South Africa's spending on health is fairly comparable to industrialized countries, but it has some outcomes that are worse than those of the Organization for Economic and Cooperative Development (OECD) countries and more comparable to other African countries. This is partially due to the above mentioned inequities in resource allocation and poor living conditions inherited from the past, but it is also due largely to a heavy burden of HIV/AIDS, which is reversing the quality of life of the population.

On the face of it, the country has enough resources – R102 billion in 2010 – to spend on healthcare to serve the entire population of nearly 50 million people. In 2008, the country spent 8.3 percent of its gross domestic product (GDP) on health, of which 3.6 percent was public sector funding. The 8.3 percent spending is comparable to that spent by other OECD[2] countries such as Ireland, the United Kingdom, Australia, Norway, and Finland; it is slightly higher than the expenditure in Japan and significantly higher than the expenditure in Chile and Mexico.

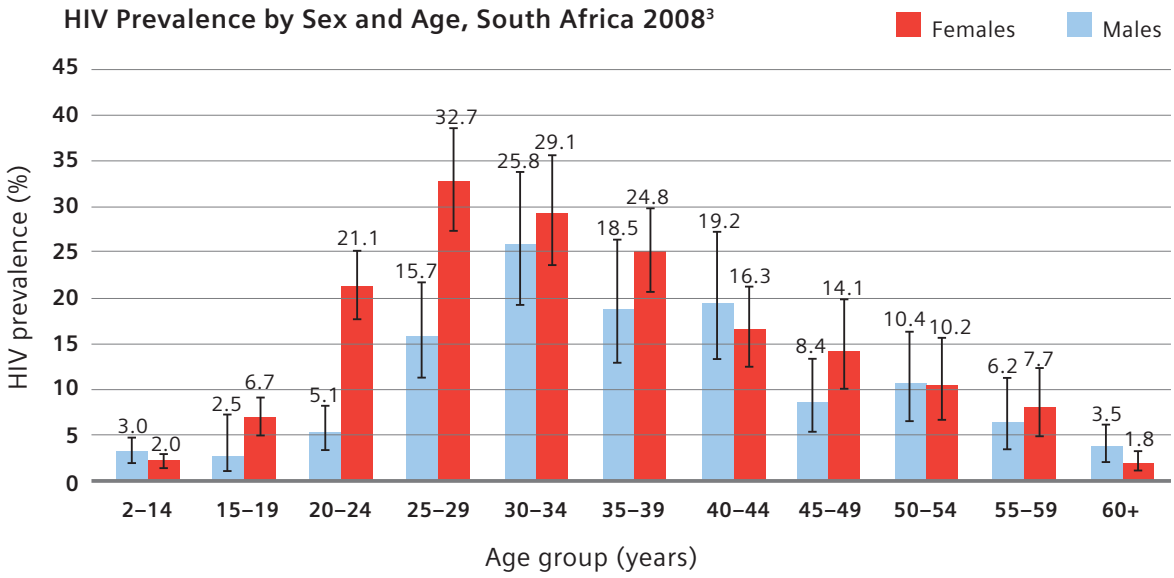
The public sector spending on healthcare as a percentage of all healthcare expenditures in South Africa was 39.7 percent in 2008, not a significant increase from 38.5 percent in 2005. However, this is significantly lower than government spending in other OECD countries, which averaged nearly 73 percent. What is not apparent from these figures is that the 59.7 percent public spending is inadequate to provide care to the majority (68 percent) of the population who use the public health sector and do not have medical aid coverage. The balance of 40 percent comes from private sources, including medical aid and out-of-pocket expenses, and it provides services for the remaining individuals with medical aid and those who pay out of their own pockets. The distribution of medical aid coverage differs very much by race. The post-apartheid government is under pressure to allocate more resources for public healthcare and to protect the public from financial risks related to healthcare. Currently, the minority white population is the major beneficiary of access

Distribution by Race and Percent with Medical Aid Coverage by Race, South Africa 2010





Source: WHO Global Health Observatory Website. http://www.who.int/gho/en/. Last accessed July 22, 2011.



to private medical care, as shown on the graph on page XX.

Such inequity is at the center of debate in South Africa, causing many to demand a change in the way healthcare is financed. Many are calling for the introduction of national health insurance, which has been under discussion since 1941. At the core of the debate is the existence of a two-tiered healthcare system with a strong private sector that serves a minority of the population who use private hospital services. The private health sector provides care that is found in highly industrialized countries – not only for local South Africans, but also for patients coming from all over the world who seek modern state-of-art medicine. Funding in the public health sector, on the other hand, remains inadequate to address the generally poor health status of the black population in South Africa and the populations of its neighboring countries who seek healthcare in this country, which is better than what is available in their own. This inequity in access to financial resources and poor social living conditions contribute to poor health outcomes.

High Premature Mortality Rates

High infant mortality contributes to reduction in life expectancy at birth. Unlike other OECD countries, as well as middle-income countries such as Brazil and Mexico, South Africa's life expectancy is decreasing, largely due to HIV/AIDS affecting the young population (see graph above) and high rates of tuberculosis (TB). The country is home to the largest number of people living with HIV/AIDS at 5.6 million – 10.9 percent of the population – and it is also one of the 20 highest TB-burdened countries in the world. Maternal mortality is rising largely due to HIV/AIDS. Unlike the Mbeki administration, which denied AIDS was a problem, the current Zuma administration is providing antiretroviral therapy for pregnant women at higher CD4 cell counts and has a large antiretroviral treatment program to reduce premature mortality. The high non-communicable disease burden, which fell off the radar screen for some time while the focus was on HIV/AIDS, is also contributing to high death rates. Ischemic heart disease, stroke, hypertensive heart disease, and diabetes impose a huge burden on the population. Premature mortality due to these diseases contributes to a decrease in life expectancy. The recent government's focus on non-communicable diseases is welcome.

But for the country to provide good quality healthcare coupled with good health outcomes requires an adequate supply of well-qualified people in the workforce, starting with good managers who can attend to better organization and planning of health service provisions, ending stock-outs of medicines, deploying staff in adequate numbers, and fostering a positive attitude among health workers towards patients. The country produces well-trained medical doctors and nurses who are often recruited and hired by OECD countries such as Canada, the United Kingdom, Australia, and also Arab States such as Saudi Arabia and the United Arab Emirates. Doctors are often recruited to work in urban areas, away from where the majority of the needy population lives. The distribution of doctors is also skewed towards high-income provinces like Gauteng and the Western Cape, where the doctor-to-population ratios approach those in industrialized countries. Training of doctors and nurses has recently begun to decline in South Africa at the time when the burden of diseases is increasing. When doctors migrate to industrialized countries, they leave a gap that is filled by foreign doctors, mostly from African countries, and philanthropic doctors from industrialized countries willing to provide healthcare in rural and underserved areas. This migration, coupled with those doctors preferring to work in the private sector and those concentrated in high-income areas, contributes to the poor quality of healthcare. When doctors are overloaded

and overworked, the patients suffer; they wait in long queues. Reduction of the shortage of healthcare providers will require not only an increase in enrollment at medical schools and the opening of more nurse training colleges, but also the introduction of task shifting, where community health workers are trained to provide primary healthcare at home and in communities – a move that the government is enthusiastically embracing.

Seeking Solutions for the Future

Given South Africa's health systems' challenges, it is essential to improve its organization and financing, which is fundamental to solving the ills it confronts. The direction taken by the African National Congress at its National General Council meeting, held in September 2010 in Durban to adopt a new national health insurance plan, is a correct path to take. The policy is envisaged to be based on the principles of the right to healthcare, social solidarity, and universal coverage. A national health insurance fund that is state funded, publicly administered, and a single payer for health services provided by both the public and private sectors will go a long way to make healthcare accessible by redistributing health workers to serve people of all races living in urban or rural areas, young or old, male or female. Such a system will use scientific evidence to select prevention, diagnostic, treatment, and care interventions to be implemented, rely on national staffing norms ratios to reduce overcrowding and work overload, and require accreditation of facilities to ensure the availability of quality healthcare. The state has taken a first step with the fiscal year 2011 budget to allocate funding for the implementation of national health insurance. The country is anxiously awaiting the release of the policy document that outlines the nature of the state proposal on national health insurance.There will be many detractors opposed to the implementation of the national health insurance system, behavior that is not unique to South Africa. One can only look at a recent example in the United States, where President Obama continues to be challenged by vested interest groups and political opponents. In South Africa, despite the fact that the majority of South Africans and the majority of private medical schemes holders want national health insurance to be implemented, there are a few who vehemently oppose it, just like the detractors who blocked adoption of policy on NHI in 1941 or implementation of the Gluckman Commission report. This time, the major difference is that the ANC has a policy adopted by its members, and it holds the majority, evidenced by the latest landslide victory in the local government elections. The policy has the support of its allies, the strong Congress of South Africa Trade Union, and the South African Communist Party. Implementation of this policy will not be easy, but will require political determination such as that seen when Thailand introduced NHI. South Africa is ready. The time is now.

WHO Health Indicators

Infant mortality rate (per 1,000 live births) both sexes	56.0 (2006)
Neonatal mortality rate (per 1,000 live births)	17 (2004)
Under-5 mortality rate (probability of dying by age five per 1,000 live births) both sexes	69 (2006)
Maternal mortality ratio (per 100,000 live births)	400 (2005)
Deaths due to HIV/AIDS (per 100,000 population per year)	675 (2005)
Deaths due to tuberculosis among HIV-negative people (per 100,000 population)	84.0 (2006)

Source: WHO Core Health Indicators Website: http://apps.who.int/whosis/database/core/core_select_process.cfm. Last accessed July 4, 2011.

The opinions reflected in this article are those of the author and do not necessarily reflect those of Siemens Healthcare.

[1] The history of public health in South Africa is based on an unpublished paper prepared earlier by O. Shisana, S. Zondi, A. Hadland, S. Mfecane, MA and T: South African Public Health System and Communicable Diseases, 2003.
[2] OECD Health Data 2010. How Does South Africa Compare with OECD Countries: http://www.oecd.org/dataoecd/20/40/45703998.pdf. Last accessed July 22, 2011.
[3] Shisana O, Rehle T, Simbayi LC, et al. South African National HIV Prevalence, HIV Incidence, Behavioural and Communications Survey, 2008. Cape Town: Human Sciences Research Council Publishers, 2009.

Olive Shisana obtained a Doctor of Science degree from Johns Hopkins School of Hygiene and Public Health (now Bloomberg School of Public Health), served as a group manager at the South African Medical Research Council, and later became the first post-apartheid Director General of Health in the Mandela Administration. She also worked for the World Health Organization as Executive Director for Family and Community Health. She previously served as Professor of Health Systems at the Medical University of Southern Africa, and Executive Director for Social Aspects of HIV/AIDS and Health at the Human Sciences Research Council. Currently, she is Chief Executive Officer of the Human Sciences Research Council, President of the International Social Sciences Council based in Paris, Chair of the Ministerial Advisory Committee on National Health Insurance, and member of the Economic Advisory Panel in South Africa.