South Africa: a 21st century apartheid in health and health care?

Gavin H Mooney and Diane E McIntyre

ABSTRACT

- The current crisis in health and health care in South Africa results from a combination of factors: the legacy of apartheid; issues of poverty, income inequality and AIDS; and the more recent influence of neoliberal economic policies and globalisation.
- The legacy of apartheid has meant that both health and health care are skewed along racial lines, and 60% of health care expenditure goes largely to the 14% of the population who have private health insurance. A more equitable distribution of health care resources will result from the promised National Health Insurance, the details of which are still being debated.
- The AIDS epidemic in South Africa was exacerbated by the government not introducing antiretroviral treatment (ART) until the early 2000s. In 2005, it was estimated that more than 5.5 million South Africans were infected with HIV. Now all those with a CD4 count below 200 are eligible for ART.
- A better health service will not be enough to improve the health of South Africans. A whole-of-government approach is needed to address the persistent problems of poverty and inequality.

MJA 2008; 189: 637–640

Grave concerns about the health of the people of South Africa are compounded by the inadequate state of the South African health care system. The main factors affecting health in South Africa are the legacy of apartheid and the pressing current issues of poverty, income inequality and AIDS. These same factors affect health care — dealing with AIDS has severely diminished the funding and resources available for other diseases; income inequality is reflected in the split between private and public care; and poverty means that many South Africans have limited access to health care of any kind, and for those able to access services the quality is low. Health care problems are exacerbated by the fact that funding for health, while overall at a reasonable level for a country with a gross domestic product per head of A$634, is skewed in favour of the private sector which mostly caters for the rich. Thus, inequalities in income are reflected in inequalities in health care and in turn in inequalities in health.

Background to the current health crisis

The democratic African National Congress (ANC) government was elected in 1994, after a half century of the nationalist government's racist policies under apartheid (the Afrikaans word for "separateness"), which included political, legal, social and economic discrimination against black people. This legacy of discrimination, one of the key social determinants of health, had a major impact on the health of black South Africans.

From 1994 to 1996, the broad policy agenda of the ANC government headed by Nelson Mandela was the Reconstruction and Development Programme (RDP). Efforts were made to improve health and health care and especially to tackle some of the problems arising from other social determinants of health — poverty, inequality, inadequate housing and poor education. For example, a clinic building program greatly increased the number of primary health care facilities in previously underserved areas.

In 1996, the RDP was replaced by a neoliberal macroeconomic policy — GEAR (Growth, Employment and Redistribution) — favoured by the International Monetary Fund (IMF) and the World Bank. Neoliberalism has been defined by Harvey as

> a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade ... State interventions in markets ... must be kept to a bare minimum.[1]

Persistence of poverty and inequality

Under the influence of neoliberalism, levels of poverty and inequality remain high. A 2004 report from the Human Sciences Research Council states that

> the proportion of people living in poverty in South Africa has not changed significantly between 1996 and 2001 ... [but] those households living in poverty have sunk deeper into poverty and the gap between rich and poor has widened.[2]

According to Statistics South Africa, in 2001 "the 10% of the population in the lowest income decile shared R1.1 billion, whereas the 10% of the population in the highest income decile shared R381 billion".[3] The Gini coefficient, the most commonly used indicator of inequality (the closer to 1, the greater the inequality) is 0.73 for South Africa, which makes it one of the most unequal societies in the world. Average real incomes actually fell from 1995 to 2000.[3]

In his history of inequality in South Africa, Terreblanche writes of his concerns about the problems it is creating.

> The coexistence of a new political system (controlled by an African elite) and the old economic system (still controlled by a neoliberal white elite) constitutes a dual system of democratic capitalism which is morally unjust, dysfunctional, and also unsustainable. We are forced to ask: for how long can white wealth and elitism remain entrenched; for how long can the black elite continue to indulge in black elitism; and how far can the black bourgeoisie and the black lumpenproletariat [the lowest members of society or the underclass] extend before the system cracks?[4]

A similar concern is expressed by Gumede in his account of the rise of Mbeki and the "soul of the ANC".[5]

> So far, the economic cost of South Africa's transition [from the apartheid years] has fallen disproportionately on those it was supposed to benefit most — the millions of black poor ... Unless the economy delivers to the country's poor, South Africa's democratic miracle could unravel.[5]

The 10 leading causes of premature mortality in South Africa in 2000[11]

Cause of death	Years of life lost (%)
HIV/AIDS	39.0%
Homicide/violence	6.8%
Tuberculosis	4.7%
Diarrhoeal diseases	4.2%
Road traffic accidents	3.9%
Lower respiratory infections	3.7%
Stroke	2.8%
Ischaemic heart disease	2.5%
Low birthweight	1.7%
Protein-energy malnutrition	1.5%

Implications of neoliberalism and globalisation

Fourteen years on from the democratic elections, nearly 60% of health care expenditure in South Africa remains private, largely for the 14% of the population who have private health insurance. The reason appears to be that, in essence, the democratically elected South African Government is caught in the web of neoliberal international politics and regulations supported by the IMF and the World Bank. The government has justifiable concerns that if it moves too fast to introduce reforms, in this case health care reforms, this will have financial repercussions for its relations with the IMF and the World Bank.

Neoliberalism creates problems not only for the health of South Africans but also for the health of the peoples of many other low- and middle-income countries. The selfish individualism that neoliberalism engenders — described as "the malaise of modernity" by the Canadian philosopher Charles Taylor[6] — increases inequality within countries, and spills over into global power relations between rich and poor countries.

Accompanying neoliberal globalisation has been a freeing up of trade, with a resultant movement of the workforce, especially doctors and nurses, from developing to developed countries. Mackintosh writes,

> Migration from Africa to high-income countries ... worsens an already intolerable gulf. Its distributive effects may be measured by the perverse subsidy generated ... Migrant African health care professionals were trained in sub-Saharan Africa at public and private expense; the benefits of that training are then experienced in the UK [and other rich countries such as Australia] and lost to those dependent on African health services.[7]

Poor countries are subsidising industrialised countries by about US$500 million a year through the migration of health care workers. In South Africa, the outflow of doctors between 1989 and 1997 represents a loss of training investments of US$5 billion.[8] More specifically, it has been estimated that in Australia in 2000 there were nearly 1000 South African doctors and over 1100 South African nurses.[9] These numbers will have almost certainly increased since then.

Further evidence of the disregard that most rich nations have for the plight of developing nations is their failure to meet the United Nations target of 0.7% of gross national product (GNP) for aid to the developing world. Australia plans to spend only 0.32% of its GNP on foreign aid in 2008–09.[10]

South Africa's major health problems

South Africa suffers from a triple burden of ill health — infectious diseases, non-communicable diseases, and injury and violence (Box). Despite the denialism among some political leaders, HIV/AIDS is the main cause of premature death, accounting for 39% of years of life lost. Other infectious diseases and diseases of poverty, such as tuberculosis, diarrhoea and malnutrition, also impose a major burden.

In 2005, it was estimated that more than 5.5 million South Africans were infected with HIV. Nearly 19% of adults between 15 and 49 years are infected, with prevalence rates of up to 40% among women aged 25–29 years.[12] An associated burden of illness is that of tuberculosis, with the emergence of extremely drug-resistant tuberculosis (XDR-TB) exacerbating this burden. The magnitude of the problem of AIDS and TB was made all the worse by the refusal of the South African Government to introduce antiretroviral treatment (ART) until the early 2000s.

Currently, all those with a CD4 count below 200 are eligible for ART.[12] Although it will take some time to achieve universal cover, South Africa now has more people taking ART than any other country. The financial cost of addressing this epidemic is potentially enormous — if the government health budget continues at its current level, 47% of it would be required to provide first- and second-line ART for all eligible South Africans by 2014.[13] The cost in terms of human life of not addressing the epidemic is even greater.

Proposed health system changes

Given the massive health challenges facing South Africa, and the limited capacity of the health system to meet these challenges, what are the options for change? Mandatory health insurance has been discussed since the late 1980s, but has never been implemented. This is set to change, with the ANC Policy Conference in December 2007 making a very explicit policy commitment to the "implementation of the National Health Insurance System by further strengthening the public health care system and ensuring adequate provision of funding".[14] The precise nature of the proposed National Health Insurance is still the subject of discussion.

For over two decades, annual increases in voluntary private health insurance contributions (medical scheme contributions)

have far outstripped inflation rates. Public sector expenditure on health has barely kept pace with inflation or population growth. As a result, the ratio of private spending per medical scheme member to public spending per person dependent on the public sector has increased from 3.6 in 1996 to 5.8 in 2006.[15] A mandatory health insurance system would seek to redress these imbalances.

How is it envisaged that this could occur? Proposals in the past have focused on introducing what would in effect be a social health insurance; that is, one that only covered health care for those who contributed. The intention was to regulate medical schemes to move them away from risk-rated contributions, and to introduce both a prescribed minimum-benefit package and a risk-equalisation fund between individual schemes. This would introduce risk cross-subsidies (between healthy and ill South Africans), and ultimately move towards income cross-subsidies through further regulation. These regulations might also serve to put an end to the cost spiral in medical schemes, thereby making scheme membership more affordable for a greater proportion of the population.

There are two ways in which this might reduce public–private mix differentials. First, new entrants to medical-scheme insurance cover would, at the time of entry, be using public hospital services. These scheme members would continue to use public hospital services, as use of private hospital services at the existing public–private hospital cost differential would prove unaffordable. However, the medical schemes would be able to cover the full cost of public hospital services, thereby generating revenue. Second, fewer people would be dependent on public funding.

The major drawback of this option is that it could entrench a two-tier system. Although, over time, it is possible that mandatory insurance cover would be extended and differentials between the public and private sectors would diminish, experience in Latin American countries has demonstrated that opposition from powerful stakeholders makes it difficult to move from social health insurance to a universal health care system. Indeed, the major rationale for considering this option was the existence of medical schemes (and private health care providers) as a powerful force in the South African health system. The appropriateness of this reform path was seen as being embedded within South Africa's historical context.

The decision at the ANC conference has created the space for a somewhat different vision of change in the South African health system — one that focuses from the outset on achieving universal coverage by promoting income and risk cross-subsidies in the *overall health system*. The broad vision is to focus energies primarily on rebuilding the public health sector to the point where it once again becomes the provider of choice for the vast majority of South Africans. This would be achieved by reversing the effects of the GEAR policy, and gradually, but substantially, increasing tax funding for health services, as well as introducing a compulsory National Health Insurance contribution for all formal sector employees (those in paid employment). These funds would be pooled to promote access to publicly funded health services that benefit all the population. In this way, all South Africans would be entitled to the benefits of the National Health Insurance, as general tax revenue funding would effectively cover the contributions of those outside of the formal employment sector.

The introduction of an explicit National Health Insurance payroll contribution would have two effects. First, it would create a sense of entitlement to publicly funded health services. Second, it would compel medical-scheme members to seriously consider whether continued medical-scheme membership is worth the additional cost.

The value of this approach is that it would lead to an integrated funding and service provision system, with considerable income and risk cross-subsidies, and this would occur within the shortest possible time. Although the richest individuals may still choose to contribute to medical schemes in addition to their National Health Insurance payments, a visible two-tier system would be diminished, rather than reinforced and entrenched as in the social health insurance option. In addition, by holding the "strings" of the largest health care "purse" (rather than attempting to achieve this only through regulatory means), National Health Insurance is likely to be a much more powerful mechanism for controlling the fees charged by private providers. The extent to which the services of private providers are purchased by the National Health Insurance will depend on the level of public sector service capacity in particular geographical locations, as well as the extent to which private providers are willing to accept the payment rates offered by it.

The need for a whole-of-government approach

At last, welcome progress is being made to address the HIV/AIDS epidemic in South Africa. In addition, National Health Insurance will be introduced, although its final form is still being debated. This will undoubtedly result in a much needed, more equitable distribution of health care resources. Poverty and inequality, however, continue unabated. Public policy under whatever new government is elected next year must address these issues with a whole-of-government approach, if the improvements in population health promised at the end of the apartheid era are to be realised.

Competing interests

None identified.

Author details

Gavin H Mooney, MA, Professor of Health Economics, and Director of the Social and Public Health Economics Research Group (SPHERE)[1]
Diane E McIntyre, BCom, MA, PhD, Professor of Health Economics, Health Economics Unit[2]
1 Curtin University, Perth, WA.
2 University of Cape Town, Cape Town, South Africa.
Correspondence: g.mooney@westnet.com.au

References

1 Harvey D. A brief history of neoliberalism. Oxford: Oxford University Press, 2005: 2.
2 Schwabe C. Fact sheet: poverty in South Africa. Pretoria: GIS Centre, Human Sciences Research Council, 2004. http://www.sarpn.org.za/documents/d0000990/ (accessed Sep 2008).
3 Statistics South Africa. Income and expenditure of households 2005/2006: analysis of results. Report No. 01-00-01. Pretoria: Statistics South Africa, 2008. http://www.sarpn.org.za/documents/d0003023/Income_expenditure_StatsSA_2005-06.pdf (accessed Sep 2008).
4 Terreblanche S. A history of inequality in South Africa 1652-2002. Pietermaritzburg: University of KwaZulu-Natal Press, 2002: 138.
5 Gumede WM. Thabo Mbeki and the battle for the soul of the ANC. Cape Town: Zebra Press, 2007.
6 Taylor C. The malaise of modernity. Toronto: Anansi, 1991.
7 Mackintosh M. International migration and extreme health inequality: robust arguments and institutions for international redistribution in health care. In: McIntyre D, Mooney G, editors. The economics of health equity. Cambridge: Cambridge University Press, 2007: 159.
8 Padarath A, Chamberlain C, McCoy D, et al. Health personnel in Southern Africa: confronting maldistribution and brain drain. Regional Network for Equity in Health in Southern Africa (EQUINET), Health Systems Trust (South Africa), and MEDACT (UK). Equinet Discussion Paper No. 4. http://www.hst.org.za/uploads/files/hrh_review.pdf (accessed Nov 2008).
9 Clemens M, Pettersson G. New data on African health professionals abroad. Working Paper 95. Centre for Global Development, 2006. http://www.cgdev.org/content/publications/detail/9267 (accessed Sep 2008).
10 Australian Government AusAID. About Australia's aid program. http://www.ausaid.gov.au/makediff/default.cfm (accessed Oct 2008).
11 Bradshaw D, Nannan N, Laubscher R, et al. South African National Burden of Disease Study 2000. Estimates of provincial mortality: Summary report, Mar 2006. Cape Town: Medical Research Council of South Aftrica. http://www.mrc.ac.za/bod/estimates.htm (accessed Nov 2008).
12 South African National AIDS Council. HIV and AIDS and STI National Strategic Plan 2007-2011. Pretoria: SANAC, 2007. http://www.info.gov.za/otherdocs/2007/aidsplan2007/ (accessed Nov 2008).
13 Cleary SM, McIntyre D, Boulle AM. Assessing efficiency and costs of scaling up HIV treatment. *AIDS* 2008; 22 Suppl 1: S35-S42.
14 African National Congress. ANC 52nd National Conference; 2007 Dec 16-20; Polokwane, South Africa. http://www.anc.org.za/ancdocs/history/conf/conference52/ (accessed Nov 2008).
15 McIntyre D, Thiede M, Nkosi M, et al. A critical analysis of the current South African health system. SHIELD Work Package 1 Report. Health Economics Unit, University of Cape Town; Centre for Health Policy, University of the Witwatersrand (Johannesburg), 2007. http://web.uct.ac.za/depts/heu/publications/SHIELD_WP1_only_report_SA_final.pdf (accessed Nov 2008).

(Received 29 Sep 2008, accepted 9 Oct 2008) ❑