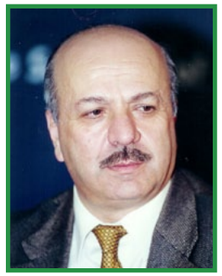
Health Care in a Democratic South Africa



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"The greatest single challenge facing our globalized world is to combat and eradicate its disparities"
(Nelson Mandela)

Introduction

President Nelson Mandela's democratic election in 1994 marked the end of political apartheid in South Africa. Under apartheid, South Africans were classified into four different races: white (9%), black (80%), colored (9%) and Indian/Asian (2%). By 2014, the population is estimated around 54 million with life expectancy at birth for 2014 estimated 59.1 years for males and 63.1 years for females. The estimated overall HIV prevalence rate is about 10.2% of the total South African population. For adults aged 19-49 years, 16.8% of the population is HIV positive.

In preparation for democracy, the ruling party (African National Congress) had developed a National Health Plan for South Africa. The goal was the creation of a unitary, comprehensive, equitable and integrated national health system. The challenge facing South Africans was to design a comprehensive program to redress social and economic injustices, eradicate poverty, reduce waste, increase efficiency and to promote greater control by communities and individuals over all aspects of their lives. In the health sector this involved the complete transformation of the national health care delivery system and all relevant institutions (including the professional councils, research and health professional training institutions). All legislation, organizations and institutions related to health were reviewed with a view to attaining the following:

- ensuring that the emphasis was on health and not only on medical care.
- redressing the harmful effects of apartheid health care services.
- encouraging and developing comprehensive health care practices that were in line with international norms, ethics and standards.
- emphasizing that all health workers had an equally important role to play in the health system, and ensuring that team work was a central component of the health system.
- recognizing that the most important component of the health system was the community, and ensuring that mechanisms were created for effective community participation, involvement and control.
- introducing management practices that were aimed at efficient and compassionate health care delivery.
- ensuring respect for human rights, and accountability to the users of health facilities and the public at large.
- reducing the burden and risk of disease affecting the health of all South Africans.

While significant achievements have been made since 1994, the reality of a dualism in health care delivery has persisted with a significant private-for-profit sector alongside the public health sector. A basic rights / essentials needs approach within the public health system has ensured access to health care for all South Africans, especially the poor, but at the same time has not brought about equity. Unless tackled with similar energy and commitment that galvanized the anti-Apartheid forces, HIV/AIDS, interpersonal violence and a shortage of human resources may be tipping points in preventing the delivery of quality health care while at the same time crowding out other health priorities.

What were the initial hopes?

The initial hopes can be characterized by one statement – "a better life for all". The Mandela government announced far reaching interventions in the first 100 days of government in 1994. For the health sector, they included eradication of racially based services, free health care for pregnant women and children (later extended to people with disabilities), nutrition support in primary schools and a massive clinic building program to improve access to health services.

Were these hopes fulfilled?

By far and large, yes! Access to health care (within available resources) became an entrenched right in the Constitution of South Africa. Section 27(1) states that 'everyone has the right to have access to – (A) health care services including reproductive health care…; (3) no one may be refused emergency medical treatment'. Section 28 (1) – 'Every child has the right to … basic health care services'.

The use of primary health care services has increased steadily with 67 million visits in 1998, 85 million in 2002 and 98 million in 20043. The number of annual visits per person to a health facility in South Africa improved from1.8 per person in 1998 to 2.1 in 2004. Health status indicators showed some improvement – however, disaggregation by race may reveal a different picture.

Indicator	1998	2004
Infant Mortality	45.4/1000	43/1000
Under 5 Mortality	59.4/1000	58/1000
Maternal Mortality	150/100000	83/100000
Expanded Program on Immunisation (EPI)	63%	82%
Births attended	84%	92%
Condom use at last sex (15-59 years)	22%	29%

Table 1: Selected Health Indicators (1998, 2004)

Background

Pre 1994, South Africa had a highly fragmented and bureaucratic health care system. Administration of health care was fragmented, with 14 separate departments to look after the health of the different racial groups, the four homelands, and six "self-governing" territories. At an organizational level, there were multiple ministries and departments based on race (the Tricameral System) and ethnicity (the homeland governments).

Vertical fragmentation was through service differentiation (preventive and curative services) amongst the federal government, the provinces and local authorities. Public health services for whites were better than those for blacks and those in the rural areas were significantly worse off in terms of access to services compared to their urban counterparts. Expenditure on tertiary health services was prioritized above Primary Health Care services. Further inequities were entrenched through the development of a private for profit sector that was unregulated but well supported and organized through private financing (health insurance funds or 'medical aids'), private hospitals,

pharmacies and health practitioners. The irony was that government employees themselves contributed to these health funds and accessed their care from private health facilities.

The artificial paradox of the best of First World medicine and the worst of Third World medicine within a few miles of each other resulted in extreme inequity in the health profile of the country. This inequity was evident in the indicators of health. Infant mortality, maternal mortality, life expectancy at birth, and the incidence of infectious diseases like tuberculosis and measles were all higher among black people. For example, in 1985, the infant mortality for white infants was 13.1/1000 but 70/1000 for black infants. The health status of the population reflected the social and economic divisions of an Apartheid society. Poor access to clean water, sanitation, housing and food contributed to the poor health status of black South Africans. An additional burden of illness was trauma (as a result of state sponsored violence). This had both physical and mental health manifestations and affected both the oppressed and the oppressor.

Post 1994, South Africa was one of the few countries in the world were wholesale transformation of the health system began with a clear political commitment to ensuring equity in resource allocation, restructuring the health system according to the 'district health system' (DHS)9 and delivering health care according to the principles of the primary health care (PHC) approach.

South Africa and the International Health Economy

In 2000, the world GDP was USD 31 trillion and global health spending was USD 2.6 trillion (8%). Health spending in developing countries was USD 280 billion with 0.4 % being spent in Sub-Saharan Africa. In 2005, global pharmaceutical spending was USD 602 billion10 with Africa accounting for a paltry 1.4% of pharmaceutical sales. South Africa is classified as a middle income country with a GDP per capita of USD 3000 and a population of 47.3 million. Approximately USD 16.7 billion is spent on health care which amounts to 8.7% of GDP11. The private sector share is 5.2% and public sector is 3.5%. Its GDP per capita spend on health is USD 300. It has been described as a 'small rich country surrounded by a large poor country'. South Africa has a tax funded public health system covering 85% of the population and a well-entrenched private health system covering the rest. The bulk of private funding comes from medical aid contributions (66%) and out-of-pocket payments (23%). Donor aid plays a minor role in health care.

The public health system is led by the National Department of Health (federal) which is responsible for overall health policy and co-ordination. Implementation and delivery of health services is through the 9 provinces (states) and 284 municipalities (local government authorities). The provinces provide mainly (curative) hospital services with local / municipal government providing primary health care and non-personal (environmental) health services. The Department of Health derives its mandates from the Constitution of South Africa as well as the National Health Act (No 61 of 2003). The Ministry of Defense provides services to the armed forces and Ministry of Correctional Services to prisoners.

The public health budget accounts for between 10 and 11% of the overall budget of government. Since fiscal decentralization (to the provinces) there is great variation between provinces on the actual budget allocations for health. There continues to be significant inter-provincial inequities12 even though the variation in per capita spending between provinces has reduced from 3 to 2 fold. Within each province there is also large intra-provincial inequity, with the rural areas continuing to bear the brunt of poverty and inadequate resource allocation. In the Eastern Cape, for example, some districts are 166% above the equity target whilst others are below by 77%.

Over the last 13 years, a national health system has evolved with 5 year planning frameworks since 1994 reflecting major transformation agendas. The period 1994 to 1999 focused largely on increasing access to health care especially for those who did not have access in rural and other under-served areas of the country. It also concentrated on structural reorganization of the health system especially as it related to the government funded public health system. The next five years (1999 to 2004) concentrated on quality issues in health care while also beginning an interventionist role in private health care through legislative reform. The period 2004 to 2009 consolidates the health system while making substantive inputs to resolving the human resource issues. Capacity building programs for managers were instituted and development of new cadres of health workers are being introduced. The majority of health professionals other than nurses work in the private sector while the 'brain drain' to other countries has deepened the crisis in the delivery of services. To this end, South Africa raised its voice in various international forums such as the WHO and the Commonwealth and has implemented the Commonwealth Code of Practice for the International Recruitment of Health Workers.

The impact of the HIV/AIDS pandemic alongside trauma and interpersonal violence has created additional stress on the health system and on its human and physical resources. Vacancy rates range from 13 to 40% across provinces with an average of 31% for South Africa.

The public health system can be proud of the structural transformation it has effected. Hundreds of new health facilities have been built or rehabilitated, and health care has been made free at the point of delivery for pregnant women, young children, persons with disabilities and all who use the public primary health care system. New posts have been created at the primary level of care, albeit with the inability to fill the posts owing to shortages of personnel. Access to essential health care has been greatly improved. Care in the public sector is delivered through 400 hospitals and 4100 clinics and health centers and the public health sector employs 240 000 persons with 137000 being health professionals.

Health Status

As with many other countries in demographic transition, South Africa faces the quadruple burden of disease. The health status of the population does not reflect the gains of an improved health system. South Africa is ranked low in health system performance compared to other middle income countries and even some lower income countries. The past South African Demographic and Health Survey (SADHS - 2003) found that South Africans are not very healthy, even though we are classified as a middle income country.

The Infant Mortality Rate is 45/1000 and life expectancy is now 50 years for males and 53 years for females. The IMR is projected to increase further as a result of the HIV/AIDS epidemic. Close to 60 children per 1000 die before their fifth birthday. Many mothers die delivering babies - estimated to be 83 per 100000 women.

- **Threats to Health**
  - Natural disasters
  - Interpersonal violence
- **Residual of Infectious Diseases**
  - Cholera, Tuberculosis
- **Emerging Epidemics**
  - HIV/AIDS
  - Drug resistance (TB, Malaria, etc.)
  - New Infections (avian 'flu)
- **Epidemiological Transition**
  - Chronic Diseases and Injuries
  - Occupational & Environmental ill-health
  - Mental health
  - Obesity & Tobacco related

Table 2: Quadruple Burden of Disease

A related problem with the HIV epidemic, but equally important is Tuberculosis (TB).

The TB rate is increasing. In addition, it is estimated that 50% of HIV infected persons will contract TB thus increasing the rate despite the successes achieved via the DOTS15 strategy. The Medical Research Council estimates that the current TB epidemic will increase four fold over the next 10 years due to the effect of HIV/AIDS. Drug resistant TB has now reared its head and has spread to all parts of the country and reflects a failure in TB control alongside the maturing AIDS pandemic.

The disease profile depicted does not reflect a healthy nation or a middle income country that spends 8.7% of GDP on health services.

Achievements

The following summary reflects the key achievements in the health sector since 1994:

- Outlining of the government's health policies through the tabling of the White Paper on the Transformation of the Health System.
- Consolidation of fourteen fragmented health administrations inherited from the apartheid system into a streamlined national (federal), provincial departments and local government health hierarchy.
- Expansion of the primary care infra-structure:

– Since 1994 more than 700 new clinics and 18 new hospitals have been built or had major upgrading (495 of which were completely newly built);
– 2298 existing clinics have received new equipment and were upgraded;
– 124 new visiting points were built; and
– 125 new mobile clinics purchased.

- Health care, free at the point of delivery, for pregnant and lactating women, children under the age of six years and all who use the public primary health care system was introduced.
- The provision of primary school nutrition services through which about 5 million children have benefited and many employment opportunities have been created in communities.
- Major progress was achieved with the implementation of the district health system through the demarcation of health districts and the setting up of the regional and district offices.
- Launching of the National Drug Policy and the development of essential drug lists and standard treatment guidelines for primary health care and hospital levels.
- The introduction of community service and a two year internship for newly graduating South African doctors.
- An impressive record in transforming health legislation. Acts have been passed to:
  – Consolidate the health system under the National Health Act
  – Rationalize the Health Professions Councils and make them more representative of the South African population;
  – Create the Traditional Healers Council;
  – Make drugs more available and affordable in the country;
  – More effectively regulate the private health care industry;
  – Enable safe and legal termination of pregnancies in public and private facilities;
  –Warn the public of the dangers of smoking; and
  – Limit smoking in public places and ban the advertising of tobacco products.

What are the hopes for the next ten years?

A tipping point has been reached – overworked health providers in the public health system and a maturing AIDS epidemic alongside trauma and injury may threaten the sustainability of the system. Health systems are the most complex to manage given the multiplicity of inputs (human resources, technology, drugs and infrastructure) on the supply side and uncertainty on the demand side.

The needs of an aging population alongside the issues of crime and HIV/AIDS needs to be factored into general health care planning. Factors outside the health sector that have an effect on health include poverty eradication and job creation. The policy papers are well developed – the critical need is implementation of policy against a backdrop of a major skills shortage in all aspects of South African society. The health system needs medium term planning as specialist practitioners take a minimum of 12 to 15 years to achieve competency and thereafter continuing professional development to keep them abreast of new knowledge and interventions. Notwithstanding their commitments to appropriate recruitment practice, the developed countries' demand for skilled human resources for their health and social care systems will continue. The developed countries have an aging population, an aging health workforce and poor perception of health and social services as a career. Health care unlike any other system needs human capital.

Challenges

Many challenges remain.

- Economic stability and peace are vital to sustainable health systems. The wider investments in housing and a clean environment, access to water, jobs and food security are important co-factors in creating a healthy nation.
- Planning and management skills are still weak at all levels, but especially in hospitals.
- Management systems need to be upgraded; essential management information is lacking at all levels of the health system
- Ensuring cooperation between the public and private sectors including expanding public private partnerships (PPPs) and Public Private Interactions (PPIs), implementing the Health Charter (access to health services, equity in health services, quality of health services and increasing the stake of Black empowerment players in private health care) and deepening dialogue.
- Decreasing the incidence of HIV/AIDS, STIs and TB. Substantive government and donor resources have been made available. The challenges are in implementation and strengthening service delivery especially with human capacity development. A comprehensive plan to manage HIV/AIDS has been introduced and covers prevention, treatment, care and support activities. This is a cross cutting program and involves community and faith based organizations, other government departments, the private, NGO and donor community.
- Improvement of women's health and reduction of maternal mortality. Maternal mortality ratio remains high at 83/100 000. The major causes of maternal deaths currently are hypertension, HIV/AIDS related conditions, hemorrhage and cardiac disease.
- An integrated approach to reduce the morbidity and mortality associated with chronic disease is essential in order to improve health and social wellbeing of individuals and communities. Dealing with diseases of lifestyle is critical especially given the pace of the epidemiological transition in the country. Mental health issues (especially with the high trauma and violence rates) are subsumed under the overall burden of infectious disease and will need special interventions both within the health system and across other sectors.
- Equity in health care provision remains an issue. The critical area of concern is equity between the public and private sectors while inter and intra provincial inequity has to be managed through structural reforms with budgets and other resources as well as substantial social re-tooling (migrant labor, job creation and spatial development inputs).
- Human resource development. While some progress has been made with respect to the planning, training and deployment of human resources much work remains to be done to produce, recruit and retain health workers especially in the rural and underserved areas.
- Of special note are the development of health programs for vulnerable groups such as refugees and displacees. Given the overall developmental needs of the country, these vulnerable groups may be neglected and may not be able to access services.

Conclusion

The South African health system has come a long way since 1994. Its building blocks are in place to provide a comprehensive health system that is underpinned by quality, a skilled workforce and appropriate infrastructure. There is an impressive constitutional, legal and policy framework that guarantees the right to access health care to all persons in South Africa. Some difficulties lie in its implementation. The HIV/AIDS epidemic and violence has crowded out many of the health gains made since the advent of democracy.

The need to strengthen cooperative governance across the national, provincial and local government spheres as well as between the private and public sectors is recognized and will assist the agenda for further reform and transformation.

Acknowledgements

1. Annual reports of the Department of Health. (2003, 2004, 2005)
2. South African Health Review. Health Systems Trust. (2003, 2004, 2005, 2006)
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4. International Health Summit. (2002; 2004)