The challenges of health disparities in South Africa

The proposal for national health insurance (NHI) is part of a welcome resurgence in public discourse about poverty, health and access to health services in South Africa. Despite certain areas of progress in the country since 1994, disparities in wealth and health are among the widest in the world. In 2008, for example, 54% of South Africans had an income below $3/day. The top 10% of South Africans account for 58% of annual national personal income, while the balance of 70% received a mere 16.9%.[1] The Gini co-efficient, a measure of income inequality, increased from 0.6 in 1995 to 0.679 in 2009.[2]

In 2005, infant mortality rates ranged from 18/1 000 live births among white people to 74/1 000 among black people, which was much the same as rates in the early 1990s. The figures differed across geographical regions, e.g. 27/1 000 in the Western Cape and 70/1 000 in the Eastern Cape.[3] Overall maternal mortality increased from 150/100 000 pregnancies in 1998 to 650/100 000 in 2007.[4] South Africa comprises almost 17% of the world's population living with HIV/AIDS. The country has the largest antiretroviral treatment programme in the world, yet only 40% of eligible adults are receiving treatment. The prevalence of HIV infection among those older than 19 years ranges from 16.1% in the Western Cape to 38.7% in KwaZulu-Natal.[5] These disparities and burdens of disease are the tip of an iceberg of dysfunction and malaise within our healthcare system and nation, and are not conducive to sustainable development or maintaining a stable democracy.

Universal access to basic health care is a highly desirable goal which must be striven for. However, before placing too much confidence in the notion that expanding access to bio-medical healthcare through NHI is **the** solution to narrowing the health gap, the broader social context for achieving greater equity in health outcomes must be considered.

The history of health in rapidly industrialising countries is illuminating. Firstly, with better nutrition and living conditions, health and longevity increased significantly long before modern medical treatment became available. In the UK, for example, the annual mortality rate from tuberculosis in the early 1940s, before anti-tuberculosis medications were discovered, fell from 500/100 000 people in the early 1700s to 50/100 000.[6]

The social circumstances influencing health begin with the physical, mental and nutritional states of women during pregnancy and childbirth and continue throughout life.[7,8] Care of infants, education and nurturing of children, opportunities for further study during adolescence, and access to rewarding work are all enhanced by maternal literacy, as demonstrated in some poor countries with high levels of female literacy.[9] Access to adequate nutrition, clean water, sanitation, housing and basic healthcare is essential. Personal living habits provide individuals with the ability to predispose to, or be protected against, poor health.

Between 1945 and 1970, further health improvements flowed from the reconstruction of a global economy that had been severely compromised by the Great Depression and two world wars. Middle-class growth was promoted by a spirit of solidarity forged by access to jobs, universal availability of education, healthcare and the provision of other social services funded by progressive taxation within well-regulated economies.[9,10] Against this background, modern medical advances could be effectively applied to improve health and expedite the eradication of many epidemic infectious diseases, as exemplified by further reductions in the annual death rate from tuberculosis to about 2/100 000 in the UK, and an increase in life expectancy to about 75 years.

In South Africa, apartheid policies focused economic and health advances to white people in the first 80 years of the 20th century. It is not surprising that multidrug-resistant tuberculosis and HIV became additional markers of the longstanding poor health of the black majority, despite the availability of modern drug treatments. The annual mortality rate from tuberculosis in South Africa in 2009 was similar to that in the UK in 1945.[11]

With the introduction of financial deregulation, privatisation and liberalisation of global trade in the late 1970s, the general trend in global health followed two diverging paths. One pursued boosted economic growth and the application of medical advances for the benefit of the top 20% of the global population (about 1 billion people), living predominantly in wealthy countries. The other was characterised by impediments to economic growth for a poor majority, deterioration in their living conditions and curtailment of public health services.[11,12] In South Africa, apartheid sustained and amplified the effects of both of these pathways.[13] Since 1994, praiseworthy changes have been made in healthcare legislation and practice, and in the living conditions of many.[14] However, continuation of free-market policies, inadequate economic growth, rapid urbanisation, migration, corruption, and poor management of public services by the new government have caused disparities to widen. Most South Africans remain severely impoverished[1,13] despite social grants, with inferior access to healthcare (excepting HIV/AIDS care).[15]

Globally, privileged people have understandably become less aware of the social determinants of health, and their focus has shifted to an expensive bio-medical technological approach to health. Healthcare, especially in the USA, has increasingly become a marketable commodity within a so-called free-market system, where everything is calculated, planned and delivered within an economic and regimented managerial mindset. Endless expectations and increased orientation towards patients as clients have changed the concept of healthcare from a caring, social function, provided through universal access as a social duty to all citizens of equal moral worth, to a profit-driven commercial enterprise run by a medical care industry in the private sector,[16] and a poorly managed, cost-containment exercise in an overwhelmed public sector.[2,4] In both these contexts, healthcare professionalism tends to be eroded.

South Africa is fortunate to have the capacity to train skilled, well motivated, caring practitioners who provide highly valued, individual care with the highest professional standards in many private and public healthcare facilities. To sustain and augment this capacity requires both support for excellence in the education and training of health professionals and enhancing access to such care, which the NHI hopes to achieve.

However, with annual per capita healthcare expenditure as disparate as $150 (R1 200) in the public sector serving 84% of the population, and $1 500 (R12 000) in the private sector for 16% of the population,[17] achieving equity for individuals at levels close to those current in the private sector would require more human and material resources than is possible. Moreover, with the ongoing shift in provision of healthcare away from a socially valued service to a marketable commodity, unaccountable increases in the costs of healthcare have led to escalation of medical insurance premiums and progressive curtailment of benefits even for those currently insured.[16,18]

It is against this background that attention must be re-directed to the vitally important social factors that influence health for most South Africans, because improvements in overall population health have been compromised by colonialism, apartheid, growing economic disparities, incompetence, corruption, and failure or delay in widely applying the benefits of many medical advances.

Modern medicine has developed antiretroviral drugs. Activism and donations from abroad have enabled their provision to save many lives, but bio-medicine is unlikely to be the ultimate solution to pandemics of HIV and tuberculosis that are so deeply rooted in the social conditions shaping health.[7,8,20] Adverse social forces also contribute to an increasing prevalence of non-communicable lifestyle diseases such as obesity and diabetes. Lack of systematic information on the impact of local cultural values and traditional healers on health add further complexities.

Working towards and reaching the admirable NHI goals of more equitable access to high-quality health services through increased social solidarity within healthcare funding and services will be extraordinarily challenging and will probably take many decades. Firstly, run-down and dysfunctional public health care infrastructures must be resuscitated and extended. Secondly, the efficiency and effectiveness of management practices must be significantly enhanced. Thirdly, despite additional resources via NHI, priorities will have to be set in an accountable and transparent manner to ensure that resources are used more effectively and efficiently than at present in the public and private healthcare sectors. Fourthly, tens of thousands of additional skilled and motivated healthcare workers must be trained and retained.

The wide gap between planning and making functional new schools for training health professionals cannot easily be bridged. A priority must be to strengthen existing facilities and to strive for high-quality teaching, conditions of service and an ethos of care in clinical services that would encourage dedication by healthcare professionals to excellence, rather than merely to having job security and a salary.

While much must be done to improve healthcare in the public and the private sectors, it is also imperative to understand that the health of individuals and populations is a complex social construct; it is not easily amenable to improved outcomes simply by spending more money on technologically based medical care.[7,8]

The challenge is to narrow disparities and to generate opportunities for many more people to survive childhood, reach full human potential and lead healthy, productive lives. Achieving these ambitious goals requires actively striving for the social infrastructure for a healthy population, and for innovative ideas and actions in a balanced healthcare system. The still-evolving global economic crisis, resulting from unbridled consumption prompted by dogged pursuit of flawed economic theory with accompanying widespread fraud and corruption, poses threats to health from widening disparities, climate change and environmental degradation.[20] These are stark reminders of the need for new values beyond those perpetuated by prevailing market rhetoric and current ideology.[21-23]

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