Why equity in health and in access to health care are elusive: Insights from Canada and South Africa

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Why equity in health and in access to health care are elusive: Insights from Canada and South Africa

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ABSTRACT

Health and access to health care vary strikingly across the globe, and debates about this have been pervasive and controversial. Some comparative data in Canada and South Africa illustrate the complexity of achieving greater equity anywhere, even in a wealthy country like Canada. Potential bi-directional lessons relevant both to local and global public health are identified. Both countries should consider the implications of lost opportunity costs associated with lack of explicit resource allocation policies. While National Health Insurance is attractive politically, Canada’s example cannot be fully emulated in South Africa. Short- and medium-term attempts to improve equity in middle-income countries should focus on equitable access to insurance to cover primary health care and on making more use of nurse practitioners and community health workers. In the longer-term, attention is needed to the economic and political power structures that influence health and health care and that ignore the social and societal determinants of sustainable good health locally and globally. This long-term vision of health is needed globally to achieve improvements in individual and population health in a century characterised by limits to economic growth, widening disparities, continuing conflict and migration on a large scale and multiple adverse impacts of climate change.

Introduction

The state of human health varies strikingly across the globe with gaps remaining so wide that long-term human security is threatened on many fronts in an increasingly unstable world (Benatar, 1998, 2001, 2015a; Garrett, 1994). Debates about improving equity in access to health care, narrowing gaps in health locally and globally and regarding global health governance in an era of emerging new infectious diseases, with potentially disastrous consequences, have been long-standing, pervasive and controversial (Gill & Benatar, 2016; WHO, 2008). Equitable access to health care services is widely, and with some justification, seen as a high priority for reducing inequitable health status within countries. Universal access to health care (UHC), long advocated by WHO, is again being described within the Sustainable Development Goals (SDGs) as a major global political goal and ethical endeavour (World Bank, 2003; Reis, 2016). It is being strongly promoted as a panacea for health inequities, and is manifesting in different jurisdictions as voluntary insurance schemes, autonomous programmes for the poor only, and parallel private insurance or co-payments for services beyond a basic package (Cotlear, Nagpal, Smith, Tandon, & Cortez, 2015), and has been ratified...
as one of his priorities by the new Director-General of the World Health Organization (WHO). Some success in reaching this goal has been gratifying (for example in making treatment widely available for HIV and AIDS in South Africa and elsewhere), but much less impressive than what could have been achieved, given available resources, medical advances and our knowledge of the implications of changing patterns of disease in ageing populations in the context of local/global/planetary health challenges.

Here we contrast and compare some illustrative data about health disparities, health funding and access to health care in two very different countries, Canada with 2016 per capita GDP of $42,156 and South Africa with per capita GDP of $5273 (World Bank SA Data Portal, 2015) to illustrate the complexity of achieving greater equity even in wealthy countries and to reveal potential bi-directional lessons of relevance to local and global public health about health care funding approaches and other potential means of reducing health inequities in the future. The rationale for the choice of these two countries is based on the facts that (i) they both have heterogeneous populations spread across large land masses and face complex challenges, including meeting their respective aspirations to improve equity in health and health care, although from very different social contexts and economic status, (ii) both have marginalised populations linked to their colonial history and patterns of socio-economic development, (iii) all the authors have interests in health care equity and in the contrasts within and between these two countries and (iv) Canada has contributed indirectly to health inequity in South Africa through recruitment of physicians and nurses.

**Health**

Good health is in the first instance, and most importantly, dependent on the social, economic and political environments that support populations effectively, so that individuals are able to flourish from conception, through adulthood and into old age (Marmot, Bloomer, & Goldblatt, 2013). In jurisdictions where, in addition to favourable social/environmental conditions for good health, there is access to effective health care ‘from womb to tomb’, spectacular advances in modern medicine have added considerably to longevity and healthy lives. Access to health care services, like access to educational services, should ideally be thought of as an essential social function to be available to all people as citizens of equal moral worth.

Although often ignored, it is notable that the social conditions conducive to good health and access to effective health care modalities are available only to a small minority of the world’s population (about 20–30%) (Benatar, 1998, 2015b; Kochhar, 2015), while an increasing number of people are being displaced into a precarious state of life (Standing, 2014). Even in affluent countries, such as Canada, poverty and other social conditions marginalise many citizens (both within dense urban areas and in remote locations), and especially First Nations’ People, from advantages available to others. While rapidly advancing and expensive modern, technologically based and commercialised medical care, together with public health interventions have dramatically improved health and health care for some, they have simultaneously contributed to widening local and global disparities in access to these benefits and to health and longevity (Birn, 2011).

The scale of disparities across the world is succinctly portrayed by six statistics: (i) maternal mortality in 2015 ranged from 7 per 100,000 pregnancies in Canada, to 134 in South Africa, 789 in Southern Sudan and 1360 in Sierra Leone (range 999–1980) (WHO, 2015a), (ii) the death rate under 5 years ranges from 5 per 1000 live births in Canada to 137 per 1000 live births in Somalia (World Bank, 2012) where the average fertility rate is 6.6 children per woman and 1 out of every 12 women dies due to pregnancy related causes (Child and Maternal Health UNICEF 2012; World Bank, 2012), (iii) life expectancy at birth spans the wide range of 49 years to over 80 years (World Bank, 2012), (iv) per capita income in 2016 ranged from $302 in Malawi to $78,000 in Switzerland and $102,000 in Luxembourg (World Bank, 2015), (v) annual per capita health care expenditure in 2014 extended from a low of less than $50 in many poor countries to over $9000 in the U.S.A. (WHO, 2015a), (vi) the number of physicians per 100,000 people ranges from 2 in Malawi to 351
in the U.S.A., 328 in Sweden and 591 in Cuba (Physicians per 100,000 People, by Country, 2017). Within most countries, these patterns of difference also persist with dramatic (although typically smaller) differences in life expectancy and other key metrics of health between the highest and lowest socio-economic groups and across population groups.

Many health disparities are preventable and therefore inequitable, but not inevitable as illustrated with the success of the Brazilian Bolsa Familia in reducing disparities (Tepperman, 2016). The WHO commission on the social determinants of health (SDOH) highlighted multiple examples of evidence for successful improvements in the health of populations based on employment conditions among a range of other themes (WHO, 2008). We note here that equity is not the same as equality. Equity is an ethical concept, grounded in principles of distributive justice and human rights. Health inequities are differences that are unnecessary, avoidable, unfair and socially unjust and that systematically put the already socially disadvantaged at a further disadvantage with respect to health (Whitehead, 1992).

**Health care systems/services**

Health care systems around the world are diverse mixtures of the public- and privately funded services with widely differing cost implications for patients and payers and variable impacts on access to care and on health outcomes. Health care reform over many decades has been shaped by a dialectic between the ideals of the welfare state based on solidarity within civil societies that respect a broad range of human rights, and an increasingly dominant neoliberal market civilisation attuned to freedom of choice and dominance of civil and political rights.

It should be acknowledged that health care services everywhere are **distorted** (with the structure of health systems not closely geared to the burden of disease), **dysfunctional** (because of the intrusiveness of commercial and bureaucratic considerations) and **unsustainable** (because of fragmentation, lack of co-ordination of care and failure to set priorities explicitly in the face of demands for health care which exceed the ability to supply such care) (Campbell, Morris, & Marsh, 2017; Rosenthal, 2017). Distortions are aggravated by funding mechanisms that fail to focus on the value of care (creating and sustaining health and satisfaction with health status, at the lowest possible cost), the ways that social factors interfere with access to care (even when free at the point of consumption) and that re-enforce barriers between health and social services. Finally, accountability structures that do not promote transparency regarding expenditure and outcomes miss the opportunity to begin correcting these distortions, dysfunctions and sustainability challenges. Both the Canadian and South African health systems – to the extent that they can be described as systems – are burdened by these problems.

Currently evolving global economic challenges have fostered realisation that even in wealthy countries endless economic growth and ongoing escalation of expenditure on health care cannot continue unchecked (Benatar, Gill, & Bakker, 2009, 2011; Brill, 2013). In addition, health service policies and priorities tend to be determined more by specific ideological, scientific or medical interests such as the driving forces of ambitious individual physicians intent on developing specific services, and such commercial stimuli as the pharmaceutical industry and partnerships with technology companies in developing new medical prostheses and diagnostic instruments. These personal, financial and commercial forces have in the past been more influential than deliberate attempts to achieve an economically optimal mix of services that could maximise outcomes of biomedical health care.

Attempts to control and standardise health care services and ensure accountability have spawned a complex bureaucracy that, while advantageous in some ways, also poses significant impediments (Naylor et al., 2015). These challenges are faced by all nations attempting to reform their health services and by international organisations seeking to improve global health. The U.K. has set an admirable example in establishing a National Institute for Health and Care Excellence (NICE, 2017) in an attempt to overcome differential availability of treatments dependent on the National Health Service Health Authority area in which the patient happens to live. It has become well known internationally as an exemplary model for
the development of clinical guidelines, based on the explicit determination of cost–benefit analyses (NICE, 2017).

**Some comparative health-relevant data**

The extent of the many differences in life and health within and between South Africa (Kon & Lackan, 2008) and Canada (Cameron, del Pilar Carmargo Plazas, Santos Salas, Bourque Bearskin, & Hungler, 2014) is succinctly illustrated in the shape of the respective population pyramids (Figure 1) (CIA World Factbook, 2014, 2016) and in Table 1. South Africa has a higher ratio of young to old than Canada, where middle-aged and older people are preponderant with many implications for health care today and into the future. The distribution of diseases contributing to the overall burden of diseases is also very different (Table 1, Figure 2(a,b)) (WHO, 2016a). For example consider the incidence of tuberculosis (TB) and prevalence of HIV infection, the number of people per million who have access to renal dialysis and transplantation and the differences between such access in the public and private sectors in South Africa (Moosa, Maree, Chirehwa, & Benatar, 2016).

The spectra of diseases, with greater prominence of infectious diseases in South Africa, reflects the delayed and as yet incomplete epidemiologic transition resulting from failure to achieve more balanced access to the SDOH during the racially divisive colonial and apartheid periods, the difficulty of dealing with TB over many decades, and the devastation associated with the HIV and AIDS epidemic, inclusive of the recrudescence of TB and the emergence of drug-resistant strains (Benatar, 2004).

We have previously described the South African government’s arrogant denial of the link between HIV infection and AIDS in the face of overwhelming scientific evidence provided by the global scientific community, and its failure to promote an early prevention campaign. Its initial focus on ineffective treatments contributed to the sustained and pervasive denial of the existence of the HIV pandemic as well as the perpetuation of the stigma associated with HIV and AIDS. It has also been noted that although the president, minister of health and others in the government long publicly denied the link between HIV and AIDS and failed to provide high-profile leadership on this issue, the Ministry of Health had quietly formulated a comprehensive national strategic plan for HIV and AIDS that included such vital components as education, programmes for the modification of sexual behaviour, and treatment of opportunistic infections. The many obstacles that frustrated the introduction and maintenance of comprehensive and effective programmes for preventing the transmission of HIV and for treating infected patients with antiretroviral drugs were eventually overcome and the local production of generic drugs and further substantial reductions in prices became possible (Benatar, 2004; Kevany, Benatar, & Fleischer, 2013).

Thus after many years of government denial and minimal funding for HIV and AIDS, local and international pressures resulted in the introduction of an ambitious national programme to provide antiretroviral therapy (ART) to all patients with HIV infection in South Africa. Treatment of an ever-expanding number of patients resulted in HIV and AIDS expenditure increasing at an average annual rate of 48.2% between 1999 and 2005 – consistently higher than in other areas of national health expenditure, and continued at an annual rate of approximately 25%, with dedicated HIV funding estimated at $400 million (in U.S. dollars) per annum, of which about 40% comes from international donors. More than 2 million of 6 million HIV-positive South Africans receive ART. Life expectancy for them has returned close to that of demographically matched patients who are not HIV positive (Mayosi & Benatar, 2014). The large number of untreated HIV positive persons accounts for increasing numbers of disability adjusted life years (Figure 2(a)).

The 2003, 2007 and 2011 national plans for HIV, with funding increasingly skewed toward HIV treatment for many more patients, had implications for a deteriorating national public health system committed to equitably serving all South Africans (Fleischer, Kevaney, & Benatar, 2005; Kevany et al., 2013). For those concerned about spending a large proportion of the health budget on patients
with HIV and AIDS it is noteworthy this expenditure adds many decades of extra life for each patient treated as compared with expenditure on often futile aggressive treatments in the last years of life.

As also previously described South Africa also has one of the worst TB epidemics in the world. In 2007, South Africa, with 0.7% of the world’s population, had 17% of the global burden of HIV infection, with its TB epidemic compounded by rising drug resistance and HIV co-infection (Abdool Karim, Churchyard, Abdool Karim, & Lawn, 2009). Driven by the spread of HIV infection, the

**Figure 1.** Population pyramids South Africa 2016 and Canada 2014 (CIA World Factbook).
incidence of TB increased from 300 per 100,000 people in the early 1990s to more than 600 per 100,000 in the early 2000s, and to more than 950 per 100,000 in 2012. Despite notable progress in improving treatment outcomes for new smear-positive TB cases, the TB burden remains enormous. Multidrug-resistant (MDR) TB accounts for 1.8% of all new cases of TB (and 6.7% of retreatment cases). A study involving patients with extensively drug-resistant (XDR) TB in rural South Africa made international headlines, and South Africa reported the most XDR TB cases in the world. Annual notifications increased from 298 in 2005 to 1545 in 2012. Approximately 10% of MDR TB cases reported in South Africa are XDR TB cases (Mayosi & Benatar, 2014). TB remains the leading underlying natural cause of death in 2015 with 460,236 deaths from TB that year (accounting for 7.2% of deaths, with diabetes mellitus in 2nd place (5.4% of deaths) (allAfrica, 2014).

## Canadian health care – strengths and weaknesses

One of Canada’s major strengths is that it has what many consider to be a desirable universal health coverage system founded on admirable principles, including most notably public administration, that for annual expenditure of 10.9% of GDP on health – about $219 billion in 2015 ($6105 per capita) delivers better overall population health than the U.S.A. (Guyatt et al., 2007) where per capita expenditure on health care is over $8000 (almost 20% of GDP) (Kaiser Family Foundation, 2007). In 2012 among countries with comparable accounting systems, Canada was in the top quartile of 30 Organisation for Economic Co-operation and Development (OECD) countries with per capita health expenditure at U.S.$4602, below that of the U.S.A. (U.S.$8745) and comparable with figures for Denmark (U.S.$4698) and Luxembourg (U.S.$4578) (National Health Expenditure Canada, 2014).

**Insured health care services** in the context of the Canada Health Act, means hospital services, physician services and some surgical–dental services provided to insured persons. A Canadian

### Table 1. South Africa – Canada comparisons.

<table>
<thead>
<tr>
<th></th>
<th>South Africa</th>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>55 million</td>
<td>35 million</td>
</tr>
<tr>
<td>% urbanised</td>
<td>66%</td>
<td>80%</td>
</tr>
<tr>
<td>PC GDP 2016</td>
<td>$5273</td>
<td>$42,156</td>
</tr>
<tr>
<td>PC GDP % world average</td>
<td>64%</td>
<td>465%</td>
</tr>
<tr>
<td>PC expenditure on health</td>
<td>$589</td>
<td>$6105 (2015)</td>
</tr>
<tr>
<td>% GDP on health (2006–10)</td>
<td>8.9%</td>
<td>10.9%</td>
</tr>
<tr>
<td>% spent in public sector</td>
<td>50% (84% of population)</td>
<td>71%</td>
</tr>
<tr>
<td>% spent in private sector</td>
<td>50% (16% of population)</td>
<td>29%</td>
</tr>
<tr>
<td>Life expect at birth</td>
<td>56 years</td>
<td>81 years</td>
</tr>
<tr>
<td>Maternal mortality</td>
<td>145</td>
<td>7</td>
</tr>
<tr>
<td>Infant mortality/1000 live births</td>
<td>34</td>
<td>4</td>
</tr>
<tr>
<td>Under 5 mortality</td>
<td>41</td>
<td>5</td>
</tr>
<tr>
<td>Medical schools</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Graduates per year</td>
<td>1200</td>
<td>3000</td>
</tr>
<tr>
<td>Doctors/1000 people</td>
<td>7.6</td>
<td>20.7</td>
</tr>
<tr>
<td>Nurse/midwife/1000 people</td>
<td>4.9</td>
<td>9.3</td>
</tr>
<tr>
<td>Gini coefficient</td>
<td>0.64</td>
<td>0.34</td>
</tr>
<tr>
<td>Burden of disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB incidence/100,000/year</td>
<td>900</td>
<td>12</td>
</tr>
<tr>
<td>HIV prevalence (15–49 years)</td>
<td>19.1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Number HIV positive</td>
<td>6 million</td>
<td>100,000</td>
</tr>
<tr>
<td>RRT persons per million</td>
<td>73 (public)</td>
<td>620 (private)</td>
</tr>
<tr>
<td>R&amp;D expenditure % GDP</td>
<td>0.82%</td>
<td>1.62%</td>
</tr>
<tr>
<td>% Population &gt;65 years</td>
<td>4%</td>
<td>20%</td>
</tr>
<tr>
<td>% Expenditure on military</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Country debt as % GDP</td>
<td>32%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Note: RRT = renal replacement therapy (renal dialysis and transplantation); NCDs = non-communicable diseases; R&D = research and development.
The constitutional objective is to ‘provide reasonably comparable levels of public services at reasonably comparable levels of taxation’ (section 36 (1)). The net effect of this federal equalisation cash transfer policy is that Canadians enjoy a strong safety net for services from hospitals and physicians despite the difference in geography and provincial fiscal capacity. Of public expenditure on health care, 29.5% is paid to hospitals, 15.7% to purchase of medications and 15.5% is paid to physicians.

Another strength is the range of national (pan-Canadian) and provincial institutions that have been built to support health service delivery, research and evaluation. Provinces remain the key constitutional authority for health services. The Government of Canada plays important complementary roles in funding provincial health services through federal transfers as well as direct federal support for public health and a range of special populations including aboriginal persons, the military, and inmates of federal prisons. The main federal health transfer to the provinces comes with a condition that any supplementary user charges that provinces allow for publicly insured health services will result in dollar for dollar reductions from provincial coffers. In addition, the federal government may levy additional fines as further disincentives. In addition to transfers, the federal government supports several pan-Canadian agencies who assist the improvement of health services with national health data, information technology and technology assessment among others (Government of Canada, 2017b).

Among the weaknesses of the Canadian health care system is that Canada ranked 11th out of 12 when compared with other countries with similar per capita expenditure on health care, even on questions of fairness (equity) (Commonwealth Fund, 2014). Canada has challenges to achieve timely

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**Figure 2.** (a) Changing burdens of disease in South Africa 1990–2015 (WHO Global Burden of Disease) and (b) changing burdens of disease in Canada 1990–2015 (WHO Global Burden of Disease).
access for primary care, specialty care and some elective procedures. Rural areas are most adversely affected, with indigenous people throughout Canada being especially vulnerable. Access issues have also been key considerations in the Chouilli constitutional decision (Flood & Sullivan, 2005), on private payment if wait times are excessive, in the ongoing case of Brian Day regarding the right to private surgical billing in British Columbia (Merti, 2016).

Another weakness is that Canadian provinces have a range of limitations on public coverage for pharmaceuticals, dental care and home and community care. These latter areas are particularly challenging given dramatic growth in the ageing population in the country. Reasons for this are apparent from the evolution of Canadian Medicare, its key actors and geographic variations (Naylor, 1986; Naylor, Girard, Mintz, Fraser Jenkins, & Power, 2015). Inequities in access relate inter alia to the fact that up to 30% of health care expenditure in Canada is not covered by national insurance. This expenditure is mainly on drugs, rehabilitation and a small range of private services which is borne out of pocket (14%) with the heaviest burden falling on those without supplementary insurance typically obtained through employment benefits (Canadian Institute of Health Information, 2015). Concern about expenditure on health care exceeding economic growth rates has focused on many attempts to reduce the costs of health care (Choosing Wisely Canada, 2017; Romanow Report, 2002), rather than on explicit priority setting and allocation of resources that could provide better health outcomes than can be achieved under conditions of implicit and occult resource allocation.
It would seem that the evolution of access to health care in Canada has largely stalled (Marchildon, 2013). In the last decade, attention has been focused on access to primary care and acute care, diagnostic imaging, and surgery. With increased funding, there has been some improvement in long waiting times for elective procedures but minimal progress in access to primary health care (PHC) (Health Council of Canada, 2014). Care of the frail elderly or of patients suffering from multiple chronic diseases is less well managed. Despite regional restructuring within provinces and some consolidation of primary care groups, there is stagnation of reforms related to reimbursement schemes for providers, activity-based payment for hospitals and major health system performance improvements. Recent attention has focused on increasing public access to home care and to pharmacare, which have less well-specified and less complete levels of public coverage compared to physician and hospital services.

The 2015 Naylor report on health care innovation calls for the creation of a federal Healthcare Innovation Agency of Canada with a budget of at least $1-billion annually (Naylor et al., 2015). This would require a new philosophy that involves Ottawa having ‘… a different model for federal engagement in health care – one that depends on an ethos of partnership, and on a shared commitment to scale existing innovations and make fundamental changes in incentives, culture, accountabilities, and information systems’. Weighing all these inputs, and consistent with its mandate, five broad areas were identified where federal action was important to promote innovation and enhance both the quality and sustainability of Canadian health care services and policy across the jurisdiction: (i) patient engagement and empowerment, (ii) health systems integration with workforce modernisation, (iii) technological transformation via digital health and precision medicine, (iv) better value from procurement, reimbursement and regulation and (v) use of industry as an economic driver and innovation catalyst.

Thus, the Canadian system maintains a system of universal access but is facing significant issues around sustainability, to which there are few clear answers while issues of equity and more broadly of access to some types of care (e.g. drugs) persist.

South African health care – strengths and weaknesses

The major weakness of health care in South Africa is its provision within an increasingly disparate two-tiered system (Table 1) with overall health expenditure in the country of R311 billion ($31 billion) (8.6% GDP) during the 2013/2014 financial year. The evolution and structure of inequitable health care services have long been topics of critical debate within the context of the recent history (40 years of apartheid followed by a peaceful transition 23 years ago) (Benatar, 1986, 1997a; Van Rensburg, 2012), its geographic location (in an increasingly impoverished subcontinent, long ravaged by infectious diseases, exploitation, natural and human disasters) (Schwab, 2001) and within a broader global context shaped by global economic policies, that profoundly influence health adversely (Benatar et al., 2009; Deloitte, 2015; Gill & Bakker, 2011; Mayosi & Benatar, 2014; Rowden, 2009; Terreblanche, 2002).

Despite all the legislative, social and economic achievements in the first decade of the new South Africa, some of which have been previously described (Benatar, 1991, 2004; Habib, 2013; Mayosi et al., 2009), increasing corruption within government and widespread mismanagement of public enterprises, has aggravated the economic and health divide and many South Africans remain desperately deprived. While the two-tiered health care system has long been seen by some as a major weakness, it is unlikely that it will be displaced. The challenge is to capitalise on its strengths and weaknesses, and the establishment of National Health Insurance (NHI) is one method in which much hope has been pinned to achieve this (vide infra).

Public sector

Health care in the publicly funded system is provided by 35% of the country’s doctors for 84% of the population through national and provincial departments of health and through medical services in
the army and prisons (Lings, 2014). Public expenditure also covers health educational facilities (Table 2) (Massyn et al., 2016). Provincial departments of health spent R153.8 billion ($15.38 billion) in 2015/2016 (4.1% of GDP and 15.1% of total government expenditure). District health services (DHS) (Table 2) was the largest budget programme, making up 45.4% of total expenditure. This has increased gradually from 43.3% in 2012/2013, largely due to rapidly increasing HIV budgets, which form part of DHS (Table 3). In addition to the spending by provincial departments of health, local governments also use their own revenue to fund health services, including those rendered by clinics owned and operated by municipalities. Own revenue spent by local government on DHS was R3.7 billion ($0.37 billion) in 2015/2016, a real increase from R2.9 billion ($0.29 billion) in 2012/2013.

The public sector is clearly under-resourced for the demands made on it. Hospitals consume 57% of total health expenditure (this includes the salaries of all the health professionals in the public sector), while PHC services account for 17% of total expenditure. The remaining 26% is spent on other aspects of public health services with an overall annual per capita expenditure of about R3225 ($322) per person. This is an overestimate of expenditure on health care itself, given that some of the costs of medical education are built into this expenditure.

Governance (i.e. legislation, regulation and much of the policy and financing decision-making) of health in the public sector is centralised in the National Ministry of Health. Budgets and local control are devolved to nine Provincial Ministries of Health that operate publicly funded institutions. Some private money is generated for the public system through income-related charges for services but this amounts to less than <10% of public hospital financing.

One of the strengths of South Africa’s public-funded health system has been an innovative expansion of ambulatory primary care for the vulnerable. Researchers at the University of Cape Town’s Knowledge Translation Unit (KTU) have spent 14 years developing a series of innovative packages to improve PHC through the use of a Practical Approach to Care Kit (PACK) comprising policy-based/evidence-informed guidelines, onsite, team and case-based training. A combination of algorithmic guidelines based on symptoms, educational outreach training, non-physician prescribing and a cascade system of scaling up the use of nurse practitioners and community health workers (Fairall et al., 2015) has been a more achievable and effective goal than training more physicians to meet health care needs.

Randomised trials have shown the effectiveness of the packages, and methods are now being developed to respond cost-effectively and sustainably to global demand for implementing PACK. Modest but consistent, reproducible improvements have been achieved across a range

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<td>R million</td>
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<td>Administration</td>
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<tr>
<td>DHS</td>
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<td>Emergency medical services</td>
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<tr>
<td>Provincial hospital services</td>
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<tr>
<td>Central hospital services</td>
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<tr>
<td>Health sciences and training</td>
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<td>Health care support services</td>
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<tr>
<td>Health facilities management</td>
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<td>Total</td>
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Source: National Treasury.
of outcomes, including the care of patients with communicable and non-communicable diseases (Fairall et al., 2005). This is important, as strengthening one part of the health system is often accompanied by weakening another part. Improvements extend beyond the quality of care indicators to patient health outcomes (unusual in trials of health systems) and included shifts in health care utilisation (reductions in length/duration of hospital admissions). This effective and empowering low-intensity delivery of educational outreach is highly acceptable and popular among nurses and trainers. Ongoing amplification of such care has a future in South Africa and the hope is that integrated and innovative services could be achieved for low-income South Africans.

**Private sector**

The private health care system in South Africa has evolved into an expensive substitute for the public system for the small proportion of the population it serves (16%), that is now inclusive of all ethnic groups, who can afford health insurance coverage. Much of this is provided through enrolment in corporate health insurance plans, although it should be noted that the range of insurance that can be purchased is very wide – from only in-hospital cover in a limited selection of hospitals, to much wider cover, all dependent on what individuals with differing incomes can afford. The private sector was a much smaller component of health services in the 1960s and 1970s when all sophisticated medical care was provided for all who needed this, in teaching hospitals that were a major component of the state-funded public system. Erosion of the latter was accompanied by the growth of the private sector (Benatar, 1986, 2001). Within this moderately well-resourced fee-for-service private sector, patients have a considerable choice over their physicians who provide generally high-quality treatment. Expenditure in 2013/2014 amounted to R156 billion ($15.6 billion) of which 81% came from private, prepaid medical schemes and medical insurance and about 14% from out-of-pocket payments. Annual per capita health expenditure is R17,730 ($1773) with hospitals accounting for about 35.3% of expenditure, medications for 15.8% and payments to physicians for 28.5%.

Private health sector governance is fragmented across a wide range of health providers. The Council for Medical Schemes (CMS) provides an overall framework of control, with some limitations imposed on its functions by the government. The values of the CMS are claimed to stem from those underpinning the Constitution of South Africa, and from the specific vision and mission of the CMS that subscribes to a rights-based framework – where everyone is equal before the law, the right of access to health care must be protected and enhanced, and access simplified in a transparent manner

<table>
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<tr>
<th>Table 3. DHS sub-programme objectives (Massyn et al., 2016).</th>
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<tr>
<td><strong>District management</strong>: Planning and administration of services; managing personnel and financial administration; co-ordination and management of the day hospital organisation and community health services rendered by local authorities and non-governmental organisations within the metro; determining work methods and procedures; and exercising district control.</td>
</tr>
<tr>
<td><strong>Community health clinics</strong>: Rendering a nurse-driven PHC service at clinic level, including visiting points, mobile clinics and local authority clinics.</td>
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<tr>
<td><strong>Community health centres</strong>: Rendering a primary health service with full-time medical officers in respect of mother and child health, health promotion, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, mental health, etc.</td>
</tr>
<tr>
<td><strong>Community-based services</strong>: Rendering a community-based health service at non-health facilities in respect of home-based care, abuse victim care, mental health and chronic care, school health, etc.</td>
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<tr>
<td><strong>Other community services</strong>: Rendering environmental and part-time district surgeon services, etc.</td>
</tr>
<tr>
<td><strong>HIV and AIDS</strong>: Rendering a PHC service in respect of HIV and AIDS campaigns and special projects.</td>
</tr>
<tr>
<td><strong>Nutrition</strong>: Rendering a nutrition service aimed at specific target groups and combining direct and indirect nutrition interventions to address malnutrition.</td>
</tr>
<tr>
<td><strong>Coroner services</strong>: Rendering forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.</td>
</tr>
<tr>
<td><strong>District hospitals</strong>: Rendering of a hospital service at the district level.</td>
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Source: National Treasury.
All the insurance companies are obliged to take on patients with common chronic medical conditions and to include cover for their medications. The CMS aims to regulate the medical schemes industry in a fair and transparent manner and advises the National Minister of Health on appropriate regulatory and policy interventions that will help achieve national health policy objectives.

**Development of NHI**

The many historical milestones in the quest for UHC are recorded in the recent White Paper on NHI (2015). The central aim of the Department of Health’s Draft Charter of the Public and Private Health Sectors was to address the legacy of apartheid regarding access to health care for all South Africans (Reynolds, London, & Sanders, 2005). There has been an ongoing emphasis on equitable access to health within a PHC oriented system, with simultaneous support for private medical care for those who are able to afford more sophisticated health care. Support includes approval of the provision of social services by private organisations and some tax relief for private expenditure on health care, which saves the nation from having to provide health care for its privileged classes.

The admirable principles underlying the quest for NHI in South Africa include, the (progressively achievable) right to universal access to a comprehensive set of health services with a continuum of care from community outreach, health promotion and prevention to other levels of care. Payment from a single payer and a single fund is intended to provide financial risk protection against financial hardship without deterrence from accessing and utilising needed health services. NHI is also viewed as a means to enhancing social solidarity, through health care as an affordable public good provided within efficient, effective, appropriate and innovative service delivery models tailored to local needs and delivered at appropriate levels of care.

The aspiration is to create a unified health system by improving equity in financing, reducing fragmentation in funding pools, and by making health care delivery more affordable and accessible for the population – in particular at the PHC level – and to eliminate out-of-pocket payments (White paper on NHI, 2015). Movement towards NHI is a priority political goal for the African National Congress Government, and its implementation is planned to take place in 3 phases over a 14-year period, with re-engineering of PHC through 4 streams to improve timely access, and to promote health and prevent disease: a municipal ward-based PHC outreach team, an integrated school health programme, a district clinical specialist team and contracting of non-specialist health professionals. Major hurdles include geographic disparities and long-standing tensions between publicly and privately provided health care that sustain inequity in access to and provision of health care. Initiatives to improve management and governance of health facilities at the PHC and hospital levels are planned through strengthening their physical structures, administrative functions, financial management and accountability.

Antagonism to the private sector has recently been softened, with the Department of Health reconsidering its approach on the role of the private sector in implementing NHI, thus opening the way for the industry to play a greater role (Kahn, 2017). It should be noted that this represents acknowledgement that within health reform debates shaped by a dialectic between the opposing ideas of health care services as a social good governed by a concept of social-efficiency and the market efficiency ideas of neoliberal capitalism, the power of the latter, as promoted by the World Development Report (World Bank, 1993, 2003), helped transform the operation of the state sector into a participant in the capitalist market place.

NHI funding is planned through personal taxation and mandatory employer contributions. Cost estimates from the White Paper on NHI indicate that the roll-out of NHI will require about R10.4 billion ($1.04 billion) every year (total of R145 billion ($14.5 billion) in real terms over the next 14 years), over and above current expenditure on public health care (‘Health financing and National Health Insurance in South Africa’, 2012; KPMG, 2017). These additional resources would increase annual expenditure in the public sector from R149 billion ($14.9 billion) to R159 billion ($15.9 billion).
billion) (about 7%), a significant boost, in particular as those who contributed these additional amounts would probably continue using their private health insurance, thus enabling enhanced care for the poor in the public sector. However, the gap between private and public sector services would only be marginally narrowed (Benatar, 2013). Much more money will be required to significantly narrow the overall gap, and increased taxation of the small proportion of the population paying personal income tax, is the only possibility of achieving this, unless savings can be achieved from other public expenditure, for example, military activities (Visser, 2016). Twenty per cent of the population accrue 83% of the total annual income and the country has a small tax base. Of 51 million South Africans, 13.7 million are registered as tax payers, 3.3 million pay income tax, 8.1% of all taxpayers earn R500,000 ($50,000) or more and they pay the majority of national personal income tax (Gon, 2013; Rolling Alpha, 2017).

In 2014 the government began selecting pilot sites and conducting various projects in selected districts, with significant national and provincial support, as precursors for the roll-out of NHI. Such plans, like so much else in South Africa (as in many lower and middle income countries (LMICs)), are not matched by the ability to put them into effective practice (Kahn, 2016). Given the distribution of forces conducive to improved health and access to health care, and taking into account the failure of wealthy countries like Canada to achieve greater equity, it is arguably naively optimistic to highlight NHI in South Africa as the major route to reducing health inequities (Mayosi & Benatar, 2014).

Estimates of the extent of human resource requirements for staffing PHC in South Africa using an adapted, WHO work load tool, have identified some important resource challenges (Daviaud & Chopra, 2008) with eight thematic priorities defined (South African Government, 2011; Street, 2016). These priorities are all admirable goals, but the means of implementing them have not been clearly defined and the skills required remain to be developed. Doubts about the workability of the NHI have generated an alternative ‘Our Health Plan’ (James, 2016a). Scholarly work on health policy analysis in LMICs (Gilson & Raphaely, 2008) provides insights into the importance of carefully considering the kaleidoscope of social, economic and cultural contexts that characterise a country like South Africa (Gilson & McIntyre, 2008). These considerations are complicated by the potential role of traditional health practitioners (THPs) (Answers Africa, n.d.), and the many complexities associated with regulating 200,000 THPs. Incompetence at many levels within the government and in health services also needs attention and rectification (Odhiambo, 2010). Thus, while South Africa pursues universal access it faces even more significant challenges around sustainability that span the legitimacy of the system(s) and its capacity to modernise and make good on the promise of universal access.

**Health professional requirements and their mobility in both countries**

There are also major challenges in terms of health professional requirements. For example, there is a deficit of 80,000 professional nurses in South Africa (James, 2016b). Recruitment of health professionals into wealthy countries from poorer countries, with little consideration for health and other costs to citizens of those countries, is one of the many adverse manifestations of globalisation. Of the estimated 60 million health care workers in the world, a third are in the Americas, while only about 3% are in Africa which bears 25% of the global burden of disease and is hardest hit by the adverse effects of globalisation and medical migration (Benatar, 2007, 2015b). In the early 2000s, international medical graduates accounted for between 23% and 28% of physicians in the U.S.A., the U.K., Canada and Australia (the major recipient countries in the world) (Mullan, 2005). Low-income countries supply 40–75% of these international graduates (Whelan, Arklies, Dewdney, & Zwi, 2004). In Canada’s rural Saskatchewan more than 50% of doctors are immigrants and about 20% of doctors working there obtained their first degree in South Africa. In 2002, 7% of Canada’s nurses were foreign graduates – 27% of these coming from the Philippines (and almost 25% from the U.K.) (Labonté, Packer, & Klassen, 2006).
Retention of health professionals is a problem for South Africa and Canada. Recognition of the high-quality training of health professionals in South Africa has resulted in active recruitment of local graduates into wealthier countries. In Canada, there is little option but to keep professional incomes close to American neighbours if only to prevent the outmigration of health professionals to the U.S.A. because of better pay. This has occurred periodically in the last few years for nurses and doctors largely over issues regarding full-time employment (McGillis Hall et al., 2009), but current social changes in the U.S.A. may change this.

Solutions to migration have been sought at many levels ranging from ethical arguments, appeals to individuals to be loyal to practising in their home countries and to Governments to improve health governance and conditions of service to enable retention of skills in the country at least for some minimum time after qualification (Brock & Blake, 2015) and, not uncontroversially, allowing some limited private practice to full-time public physicians. Some have suggested trying to prevent wealthy nations from actively recruiting or at least to pay developing countries for the costs of educating the professionals they recruit (Benatar, 2007).

Bi-directional lessons

There are four main bi-directional and global public health lessons to be learned from this brief overview of health care services in two very different countries. The first is that greater equity in health care and in health outcomes could be achieved through explicit priority setting and resource allocation decision-making. The second is that although an efficient, well-funded, single-payer public service system may be the ideal, it is unlikely in either country that a private sector is entirely avoidable. Third, narrowing inequity in health care and in health cannot be achieved through biomedical means alone, without attention to the SDOH. Finally, within the context of many global and planetary threats new approaches will be needed to develop sustainable improvements in health.

Priority setting/resource allocation

It is notable that despite almost 10 times the per capita GDP and per capita expenditure on health care in Canada than in South Africa, glaring disparities in health persist in Canada. The lesson here is that it is not just more money that is needed but also a reconsideration of how that money should be spent within health care. The challenge is to do better with less and hence the need for explicit resource allocation policies. Much scholarly work on, and clinical application of, well-developed resource allocation policies has shown the value of such an approach (Benatar & Ashcroft, 2017; Ham & Coulter, 2001). As admirable as the Canadian health care system may be, its governance and architecture are becoming outdated, notwithstanding radically egalitarian provisions for physician/hospital services and some progress at levelling out the disparity in access to those services. However, given that the focus on the notion of reasonable compensation to physicians has resulted in a fairly stilted set of predictable negotiations with the main professional bargaining bodies for physicians, there is a less than desirable level of focus on value, quality and performance in such agreements (Lewis & Sullivan, 2013).

In both South Africa and Canada, the allocation of resources and priority setting are highly linked to physician preferences and commercial forces as mentioned earlier. Over the past two decades, there has been significant work and some notable successes in the use of health technology assessment and, more specifically, cost-effectiveness analysis in Canada to inform coverage decisions for expensive drugs and to set priorities including an ongoing regulatory reform of pharmaceutical products at entry (Government of Canada 2017a; Levin et al., 2011; Young, Chatwood, & Marchildon, 2016).

However, there is a need to go beyond such technical measure and an ethical basis, inclusive of concern for the principle of justice in health care must underpin much-needed priority setting.
processes to achieve improved population health outcomes. Given the lack of consensus on substantive definitions of justice for setting priorities in health care, successful application of transparent and accountable priority setting (procedurally fair) processes to some high-cost clinical problems and the triage of access to expensive facilities such as renal dialysis and transplantation in South Africa (Moosa et al., 2016), and to some health services in Canada (Gibson, Martin, & Singer, 2004, 2005) could be more widely applied to resource allocation decisions for increasingly large segments of the health care system. To do so it will be necessary to have comprehensive knowledge of the distribution of health care costs across the health care system (hospitals and the cost of different services within these, and in community services), to identify high-cost areas and re-evaluate these. Hospitals operate within global budgets and detailed information is lacking about the distribution of expenditure across disciplines and of the quality of care provided or the results achieved.

The need to explicitly and rationally set defensible limits on very expensive and minimally beneficial practices, must also be acknowledged, even though this may mean withholding or withdrawing treatment from some who could benefit only marginally. This does not imply that patients should be abandoned, but rather that supportive palliative care, delivered with compassion and maximum respect for individual comfort should be encouraged where this is most appropriate (Gawande, 2010).

The recent controversy over continuing treatment under conditions of futility exemplifies the need for explicit priority setting when public resources, contributed to by all, are being spent (CBC News, 2013; Klitzman, 2017). There are vast lost opportunity costs associated with desperate attempts to keep people alive for a few more months in ICU’s, when hope for longer life is minimal. The Charlie Gard case and the Rasouli case, are good examples (CBC News, 2013; Klitzman, 2017). It is also important to acknowledge that the lives of some (for example infants and dying elderly adults with prognoses limited to survival in non-sentient states) seem to be valued more than the lives of others (for example patients with HIV and AIDS who can lead active and productive lives for many additional years on antiretrovirals).

It has been cogently argued that an interpretation of the right to health that ignores resource limitations can only be sustained at the expense of universality if only a small proportion of the population is granted the unlimited right to any benefits at any given time. The minority of individuals who are granted this unlimited right via the judiciary are therefore privileged over the rest of the population. In essence, the challenges are to find a balance between the rationality of private self-interest and the rationality of public health interest.

One of the lessons that South Africa may take from Canada is the need to engage constantly with the public in ways that reflect changing social mores in the setting and maintenance of standards for coverage. In both Canada and South Africa, such considerations do not imply a need to relinquish the quest for progress or excellent medical attention throughout the life cycle. Indeed, high-cost medicine in itself should not be a deterrent to the provision of sophisticated health care. Judicious use of expensive and effective medical and surgical treatments provides great benefits for many, including saving the lives of some very young as well as elderly people, and should be strongly supported. A second lesson may be the importance of capacity development – where Canada has invested heavily – which can help integrate the use of transparent and rational priority setting processes into management activities.

**A mix of public and private health care and funding**

The role of private medicine needs to be reconsidered. Both in Canada and in South Africa this sector should neither be ignored, nor over or under played. The pragmatic short-term aim should be to capitalise on the strengths of both the private and the public sectors and to reduce their weaknesses by constructively altering the balance between them.
Two-tier payment systems can provide a safety net but they cannot adequately control costs in the private payer system. Goals regarding total expenditure on health and on public expenditure on health, need to be clearly specified. In pursuing such goals, it should be appreciated that wherever the private system goes, the public pressures will also tend to increase – a reality for both countries in this comparison. Canada may well be compromised now because the social consensus is obsessed with avoiding private insurance for publicly insured services. But it should also be noted that many health professional services within the universally accessible care system, covered by national health insurance are paid for on a fee-for-service basis (Naylor, 1986). With no alternative, some in the medical profession may seek to re-shape the ethos of organised medicine with consequent adverse effects on health care reform. The intensity of the antagonism between supporters of private and public funding of health care in the Tommy Douglas era is illustrative (Lam, 2011).

Two-tier systems also cannot fully protect against the brain drain between countries although higher overall compensation does seem to have some stability impact when looking at the differences between retaining physicians in South Africa and Canada (Brock & Blake, 2015). In South Africa, the rights of full-time public service physicians to limited private practice, and preservation of a private sector for the practice of tertiary medicine, play a significant role in overcoming the cutbacks in tertiary medicine at the teaching hospitals that can drive ambitious physicians out of the country (Benatar, 1997a, 2004). Moreover, the lesson to both countries is that two-tier systems are neither necessary nor sufficient to prevent brain drain. Overall compensation and work life as well as the relative attractiveness of other markets can have as much or greater impact.

Rather than attempting only to extend the private insurance model, focusing on equal access to physician and hospital services, it may be preferable to limit universal coverage to some services, covering as much as possible for those who need financial assistance, and to allow some element of two-tier service (as in Germany) based on ability and willingness to pay. This would need to be done in an innovative, comprehensive and integrated way, rather than having some services more equal than others within a distorted, dysfunctional and unsustainable system.

Excessive focus on private medicine can create problems where investments that could provide the biggest return in health status are unaffordable in the context of often inappropriate demand for and use of high-cost technology. With the phased introduction of NHI in South Africa it will be essential to enhance the ability to efficiently and effectively utilise additional taxation for NHI to improve access to health care in the public sector, within which improved integrated and cooperative services could be coupled to community participation, and targeted specifically at those areas characterised by the widest disparities. It will also be necessary to develop partnerships with the private sector, despite potential disadvantages (Flood & Archibald, 2001). Success would be dependent on acknowledging the importance of achieving positive outcomes with advantage favouring the public sector and the common good, in recognition of the long-term advantages of this balance. It is essential not to believe that any single health care umbrella can overcome disparities in health that arise more from lack of access to the SDOH than from inadequate access to care.

It is considered likely that with restructuring how health care is delivered, greater use of community-based multi-disciplinary teams, explicit priority setting and improved public education, it should be possible to provide most reasonable health care expectations more equitably within current budgets (at least in Canada). There are sufficient policy tools (focused on maternal and child health, small enterprise development, public health interventions and primary care), but little by way of a well-developed strategic bundle of interventions to simultaneously maximise more equitable population health.

**Social determinants of health (SDOH)**

The third lesson is that health disparities in Canada, as in South Africa, are significantly related to socio-economic status, ethnicity, gender, age and geography (Denburg & Daneman, 2010; Young et al., 2016). Yet in both countries, the focus is on improving health through biomedicine, with
neglect of the SDOH. An assessment of relative contributions to health in Canada is revealing – 50% is accounted for by social and economic determinants, 25% by health care, 15% by biology and genetics and 10% by the built and natural environment (The Standing Senate Committee on Social Affairs, Science & Technology, 2009). Attributable proportions in South Africa would likely show a much larger percentage pertaining to social and economic determinants. The recent UNICEF Report placing the health of Canadian children 26th among 35 of the world’s richest countries (UNICEF, 2016) has provoked questions about Canadian values and social policies (Denburg, 2016), and a call for a new Canadian vision for child health (Picard, 2016).

The plight of the First Nations people that has given rise to the Truth and Reconciliation Commission in Canada is a welcome acknowledgment of the social impact of colonialism and racialisation on aboriginal health. However, beyond some notable exceptions, there remains little attention to equity, outside of the promise that medically necessary care is free at the point of consumption. Similarly, causes of disparities in health and wealth in South Africa go beyond economic differences and include ethnic, gender and age discriminatory forces that reflect ongoing long-term effects of apartheid as well as globally pervasive divisions along all these lines (Alexander, 1996; Van Rensburg & Benatar, 1993).

Both countries also face the prospect of an increasing number of immigrants from war-torn, poor or economically unstable countries. From 2011 to 2015 the number of people displaced globally increased from 42.5 million to 65.3 million. It has been estimated that the overall foreign population in South Africa ranges from 1.6 to 2 million, or 3–4% of the total population, with between 1 and 1.5 million legal and illegal Zimbabwean immigrants (Campbell, 2013). Canada admitted over 4 million (mainly legal) immigrants from 2000 to 2016 (Statista, 2017). Providing health care for immigrants, especially those who are illegal, is a major challenge, and one which will only increase with time if conditions of life remain grossly inadequate for so many in their own countries. Funding of health care for migrants has very different implications for South Africa and Canada that cannot be pursued here.

Yet these SDOH are largely ignored and access to biomedical care through NHI is seen rather naively by some as the single most important thrust towards reducing inequities in health. This is more politically convenient than focusing on improving the efficiency and effectiveness of existing health care services in the public sector and addressing the social and societal determinants of health (Birn, 2011). A price is now being paid (Johnson, 2017) for ignoring insights from 20 years ago regarding the requirements to narrow disparities in South Africa and to promote social justice and better living conditions as a means of avoiding the anger and civil unrest that would only be displaced into the future if progress was limited to the transfer of political power (Benatar, 1990, 1997b, 1997c; Lalonde, 1981).

For South Africa, we should agree that NHI is a necessary contributor to reducing inequities in health in South Africa, but that it is also a form of social compromise, incomplete egalitarianism (even more incomplete than in Canada) and a useful political approach to promoting a measure of social harmony, but that only in part addresses the problem of inequity. The main challenges regarding health equity in South Africa will clearly not be met simply by introducing some form of universal health insurance coverage, as this cannot alone significantly narrow the enormous health and health service gradient effects of widely disparate material living conditions.

Canada, that was an early beacon of light in supporting attention to the SDOH with the Lalonde report of 1981 (Evans, Barer, & Marmor, 1994) and fairly advanced analysis of factors driving the health of populations, (Young et al., 2016) also needs to reexamine its health service system with a view to both rebuilding and focusing on setting priorities for health expenditure generally as well as specifically on marginalised populations. For example, per capita expenditure on health in the North West Territories is double the average for all Canadians with a much poorer outcome (Young et al., 2016). How such priorities could be set remains controversial, but Canada has pioneered transparent and accountable processes. More attention should also be directed at the SDOH.
Global interdependence

The final long-term problem facing both countries is that the state of local and global population health is only one of many signs of an unstable world in a state of entropy (Benatar, 2015a; McMichael, 2014) in what is now called the Anthropocene era. The idea of global health now goes beyond anthropocentric conceptions of health to include the notion of healthy people on a healthy planet on which the health of all life is interdependent. The health and lives of billions of people are being, and will continue to be affected by environmental degradation and climate change – through direct long-term effects on water security, food chain integrity, population migration and displacement, redistribution and recrudescence of vector-borne diseases, increasing anti-microbial resistance and significant short-term health impacts from catastrophic extreme climatic events (Hotez & Murray, 2017). There are also significant environmental health concerns globally that are not directly associated with climate change. These include the cruelty of ‘farming’ of animals in mass production facilities and the impact of this on food safety, anti-biotic resistance, the contamination of food and water supplies with cumulative amounts of toxic industrial agents and climate change (Benatar, 2011; Friel, Butler, & McMichael, 2011).

It is increasingly understood that ‘progress’ along a linear trajectory extending twentieth-century advances and ongoing economic growth is unlikely under conditions of limited renewable natural resources and other constraints on continued economic growth, wasteful consumption patterns, environmental degradation, extinction of species and the effects of climate change on disease vectors and patterns of morbidity and mortality in all countries consequent on these processes. The current global political economy deliberately imposes structural forces that widen rather than narrow local and global disparities at enormous opportunity costs, and prevents meaningful reform beyond the existing paradigm (Benatar 2015b). This may not be widely appreciated by those who enjoy the best that the modern world has to offer, and who have become complacent about their entitlements. Excess mortality from climate change will predictably be much greater in the global south than in the global north, as exemplified by the conservative estimate of 50,000 additional deaths attributable to climate change in the year 2000 in the world’s poorer and vulnerable populations. These lessons are relevant for all countries including the wealthy (Friel et al., 2011).

The fact that disparities in wealth and health and the challenges to narrow these in South Africa, exemplify the situation in low- and middle-income countries where the majority of the world’s people live, adds to the relevance of the issues raised here to public health issues globally. Wealthy countries like Canada also need a wake-up call as they cannot ignore such issues because of linked risks and interdependencies in a globalised world where the emergence and spread of new infectious diseases and many adverse socio-economic and political trends pose major potential threats to global public health (Boushey, Delong, & Steinbaum, 2017). It is notable that there has been a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the U.S.A. between 1999 and 2013, and that this reversal of decades of progress in mortality, unique to the U.S.A., has been attributed in part to adverse social and economic trends. Had mortality rates in this group continued to decline at the same rate between 1979 and 1998, 500,000 deaths would have been avoided in the period 1999–2013. This is similar to the number of lives lost in the U.S. AIDS epidemic through mid-2015 (Case & Deaton, 2015).

Conclusions

We contend that both South Africa and Canada (and indeed many other countries) should be able to learn from the considerations we have raised here, despite one (Canada) that is much better resourced offering incomplete universal coverage, and one (South Africa) that is still building universal coverage. Both countries have widely dispersed populations and struggle to maintain their desired economic growth, both achieve less equity in health and health care than they are capable of doing, and both could achieve more through commitments to explicit resource allocation and
priority setting to reduce waste and unnecessary procedures resulting in the over-payment in some sectors at the risk of others. A lesson from Canada is that a presumed equitable NHI can have a distorted emphasis on physician and hospital payments at the cost of uneven home/community care and pharmaceutical coverage. While it is clear that material and demographic challenges are huge in many rural and remote parts, there may be solutions at hand in both countries to extend national coverage through increased taxation and spread of delivery system and technology innovations which seek to foster human resource solutions, like the nurse practitioner and community clinics in South Africa (Gumede, 2017). For both countries, the expansion of equity and full coverage of health services remain matters begging for better health policy and stronger local implementation of policy and service execution tied to local solutions.

We have outlined elsewhere how health care reform debates over the past 40 years have been shaped by a dialectic between the opposing ideas of: (a) health care services as a social good governed by a concept of social-efficiency; and (b) the notion of a ‘market civilization’ governed by neoliberal political and pro-market forces (Benatar, Sanders, & Gill, in press). Sadly, as is becoming increasingly apparent, the latter route dominates as an unsustainable global model of ‘development’ focused on the flawed economic theory being widely pursued to the detriment of the poorest in our societies and globally (Stiglitz, 2002).

The challenges for South Africa are more daunting in the context of recent upheavals (Latest Africa News, 2017; Powell, 2017). The work noted above on the epidemiological context and transitions is key to focusing on what needs to be introduced and where: Canada needs better home and community services for an ageing population and South Africa needs a stronger material base for the poorest populations, supported by a broader blanket of primary care and continued work on infectious disease reductions alongside the expansion of health care coverage.

Canadians, like so many other privileged people globally, have extraordinarily high expectations for health care. The intractable problem of excessively long waiting periods for available effective treatment of remediable conditions while expenditure seems almost unrestricted for some ineffective, even futile, treatments is in part due to: (i) unrealistic expectations of entitlements, (ii) an uncritical, distorted understanding of what medicine can offer, (iii) expenditure of a large portion of the health budget on attempts to extend biological life when cognitive life has ended, or if there is little, if any, possibility of this being achieved at the beginning of life, (iv) psychological reassurance that ‘all will be done’ in desperate situations and (v) the ‘hope for miracles’.

Even in the wealthiest societies, resources for health care are not limitless (Reuben, 2010). Providing expensive care with minimal benefits to some either diminishes equitable access to effective treatments for others or increases the costs of health care. The result is that most health care ‘systems’ are not designed to deliver what most thoughtful citizens, cognisant of resource limitations, would likely choose to ensure the best quality of life and care for themselves over their life spans. Such opportunity costs need to be examined and addressed. Throughout the world, including Canada, health status is worst among those who are most deprived and whose living conditions are less than adequate (WHO, 2008, 2014, 2015a, 2015b, 2016a, 2016b; Cameron et al., 2014).

Against this background and in the face of a still evolving global economic crisis with limited prospects for endless economic growth, an important question for Canadians is not whether more money is needed to improve their health but rather whether available money could be spent more wisely to provide optimal, balanced, easily accessible and effective care services throughout life (Deber, 2009), and whether political logics would permit such a deliberate redistribution. In the absence of specific health goals at either the provincial or federal levels, priorities in Canadian health care are currently set implicitly and covertly and Canadians do not have the opportunity to choose what the shape and spectrum of their health services should be. Yet research in Canada and elsewhere shows that in democratic societies, explicit, accountable, publicly transparent and negotiable priority setting is possible (Ham & Coulter, 2001).

Although equity is important everywhere, potential responses to the challenges of achieving greater equity in access to sustainable, high-quality health care vary greatly from country to country.
In Canada, where considerable resources are spent on health care, the potential lies predominantly in facilitating choices by Canadians for innovative, integrated and coordinated hospital and home services desired across their life span, within the limits of what they are willing to pay for these through taxation and supplementary insurance or out of pocket payments. In South Africa, the persistence of widespread absolute and relative poverty perpetuates a large deficit in access to the SDOH that are the major causes of health inequities. Here the quest for narrowing very wide inequities across social, economic, ethnic and geographic groups is more complex, given the vast differences in available resources, much wider disparities in wealth, the country’s long history of lack of commitment to treating all its citizens as equals, and very marked differences between the publicly funded health care facilities using moneys accrued through Beveridge style tax financing, and privately provided health care services using payroll or entirely private models of funding.

Perhaps a new understanding is needed of what could be considered to be reasonable and sustainable health care entitlements for all (Benatar, 2009; Bensimon & Benatar, 2006). From the South African perspective, the current economic wealth of Canadians should enable both better health outcomes and reduced inequity. From the Canadian perspective, South Africans have much to learn about egalitarian health care. Based on all the many considerations outlined above and limitations on endless economic growth, achieving equity in health or even in access to health care will remain elusive, and the challenge should include efforts to do better with less. Both societies may have to accept that perfect equity is not achievable and that the goal of equitable use of resources, minimal wastage and optimal individual and community health benefits to develop sustainability remains a long-term social project that should be faced with humility, courage, wisdom and solidarity in the knowledge that the forces influencing health and health care will change significantly over the coming decades.

Notes

1. Richard Horton, Editor of the Lancet has criticized the SDGs as being ‘fairy tales, dressed in bureaucratese of intergovernmental narcissism, adorned with the robes of multilateral paralysis. The goal “attain healthy lives for all at all ages” is a mixture of business-as-usual (the MDGs rebooted), non-communicable diseases and universal health coverage … and a strange assortment of promises …’ (The Lancet, 2014, Vol. 383, Issue 2074).

2. The exchange rate of the SAR and for the Canadian and U.S. dollars has fluctuated considerably over several years. For the purposes of this article, an exchange rate of SAR 10 = CDN $1 is used. It should be noted that this simple conversion does not reflect purchasing power values.

3. The number of people with access to medical aid (insurance) increased from about 7 million in 1993 to about 8 million in 2008 while the number of those without such access increased from about 31 million in 1993 to just over 40 million in 2008.

4. Leadership, governance and accountability; health workforce information and health workforce planning; re-engineering of the workforce to meet service needs; scaling up and revitalising education, training and research, creating the infrastructure for workforce and service development – academic health complexes and nursing colleges; strengthening and professionalising the management of HR and prioritise health workforce needs; ensuring professional quality care through oversight, regulation and continuing professional development; and improving access to health professionals and health care in rural and remote areas.

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References


