

The Mellon Mays Undergraduate Fellowship Journal 2015

A collection of scholarly research by fellows of the Mellon Mays Undergraduate Fellowship Program

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South African Healthcare: Utopian Dream or Failed Reality?

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In 2011, South Africa released their proposal for National Health Insurance, “premised on the ideology that all South Africans are entitled to access quality health-care services.” The National Health Insurance scheme has not yet been implemented, but follows up on the constitutional promise to provide free basic healthcare for all South African citizens after years of unequal treatment of Black South Africans, Indians, and Coloured people. In this paper I argue, based on the Peoples’ Health Charter, that the National Health Insurance alone is not enough to fix health disparities in the country if the commodification of healthcare and the alienation of rural and unpaid healthcare workers is not first addressed.

Introduction

The 1978 Alma-Ata Declaration, developed and endorsed by multiple countries, proclaimed access to quality healthcare an inalienable right. This belief, however, has not stopped the commodification and privatization of healthcare. The Alma-Ata Declaration, established during the International Conference on Primary Health Care, sought to fight against widening the health disparity between the rich and the poor by declaring that primary healthcare was in crisis. Modeled on the Alma-Ata Declaration, the 2000 South African People’s Health Charter serves as the backbone of South Africa’s new National Health Insurance (NHI). Proposed in 2011, yet still not implemented, NHI plans to cover all South African citizens and long-term residents with free healthcare for basic services. The NHI model invests heavily in the public sector, but what will happen when privatization is solidified in ink? This paper builds upon Greenberg’s (2006) notion that “privatization of health care leads to the consolidation of inequality” (p. 91). In a country with a history of a private sector that serves the ‘haves,’ and an under-resourced public sector that serves the ‘have-nots,’ will the implementation of such a

program truly benefit the underserved? This paper argues that while NHI may alleviate health inequalities in South Africa today, NHI cannot successfully deliver equitable healthcare services without simultaneously addressing the commodification of healthcare and the alienation of the healthcare workers.

The People’s Health Charter

The Peoples’ Health Charter further develops the concept of holistic health developed in the Alma-Ata Declaration, declaring health a right. In this view, “health” is more than just “the absence of disease or infirmity” (Declaration of Alma-Ata, 1978, p. 1). Health is not just about disease, but also about the economic and social determinants of health that play a crucial role in overall wellbeing (People’s Health Assembly, 2000, p. 3). These determinants of health encompass not only the minimal resources required to meet daily needs such as housing and sustenance, but also the ability to access basic resources. One cannot live a healthy life without access to basic services such as adequate sanitation, electricity, or civil societal functions like proper education and community hubs. These services and societal functions exemplify the interlocking nature of health, society, and the economy, highlighting that health is a fundamental human right that is not currently treated as such.

The major problem South Africa faces in achieving this vision of universal healthcare, according to the Peoples’ Health Charter, is ridding itself of the unfortunate consequences of globalization. Globalization refers to the interconnected nature of the globe today, seen through the movement of capital between countries and the rise of multinational and transnational corporations as the result of innovative technologies like airplanes and the internet. The Charter details the devastating effects of such globalization on health and healthcare, and condemns the uneven distribution of globalization’s negative effects on postcolonial nations like South Africa. Francis B. Nyamnjoh (2006) describes globalization as “a process marked by accelerated flows and, paradoxically, accelerated closures” (p. 1). Nyamnjoh’s globalization manifests in accelerated capital that funds national healthcare coverage for more citizens while simultaneously closing rural health clinics. Globalization’s endless pursuit for profits is met by outsourcing cheap labor to private corporations. Stephen Greenberg (2006) defines privatization as “the outright sale of state assets to private interests” (p. 3). In other words, a private owner or corporation takes over a formerly public entity and prioritizes profit. For example, under the NHI, a private corporation can take over a facility and ignore rural patients that the previous iteration of the hospital was previously helping. The process of privatization places the focus on generating income and

cutting costs in all fields—including the costs of care—even if this focus actually reduces care.

The Charter identifies the commodification of care and the privatization of healthcare as major threats to a holistic understanding of quality healthcare. Commodification refers to the process whereby services like healthcare become commodities, products, to be bought and sold. However, the right to basic healthcare should not be repackaged in quick fixes, but instead delivered in a holistic manner considerate of various social determinants of health like home environment (Lake & Reynolds, 2010). The Charter seeks to eliminate privatization and commodification, which are arguably toxic byproducts of globalization. Scholars like Nyamnjoh (2006) often discuss how joining the global economy—where private forces take over public entities—threatens the average worker or migrant. Unfortunately, this focus on reduced employee wages ignores those citizens most affected by the high cost of recently privatized healthcare, the poor and working-class people of color. The NHI proposes broader coverage and new jobs, but does not address healthcare workers who do not fit into the private industry of selling care as a commodity. The aim of the People's Health Charter is to champion the unpaid healthcare workers and patients who do not fit neatly into public or private healthcare schemes.

Private vs. Public Healthcare

As far as the South African healthcare system is concerned, the disparity in both funding and quality between private and public systems and institutions is rooted in privatization. The unequal distinction between public and private healthcare stems from South Africa's racially destructive apartheid legacy. Greenberg (2006) writes, "under apartheid, healthcare services were fragmented, inefficient, and ineffective, and resources were mismanaged and poorly distributed" (p. 87). This trend of fragmented healthcare services continued over time along racial lines and economic class lines, where the poorest populations access low-quality public institutions and the middle-class and rich populations access high-quality private institutions (Greenberg, 2006, p. 91). According to Classen (2011), the "payment on motivation" system—where doctors' salaries directly correlate to the economic class standing of their patients—has contributed to the commodification of care in South Africa. Classen (2011, p. 54) argues that "markets are compatible with caring," yet the vast majority of doctors are working within the private sector and leaving the severely under-resourced public sector, both rural and urban (Child, 2011).

The lack of formal hospitals and clinics within rural areas stems from a lack of profit motive: the patients in rural

areas cannot afford private medical schemes, or insurance plans and are, therefore, patients "unworthy" of the doctors' time. The NHI's number one enemy is, in fact, the "unequal distribution of health professionals between the private and public sector, and between urban and rural areas," (Republic of South Africa, 2014, p. 14). The NHI plans to increase medical school graduates—encouraging professionals to return to their home country of South Africa from abroad—and recruit from other countries. However, given that this is a pilot program limited to select areas, this particular solution will not solve the current doctor shortage anytime soon. The NHI hopes to boost the public-sector doctors who would attend rural populations, yet even with these proposed measures, the more attractive route for students and doctors is the private sector. The higher wages in the private sector reflect the higher cost of healthcare that establishes the private-sector medical practice as more lucrative. This theme is made clear by the Treatment Action Campaign (2011), which reports that public-sector and private-sector spending are equal—R57 billion—yet the private sector covers only 15% of the population (p. 8–9).

Although the Charter—on which the NHI is based—recognizes that the privatization of healthcare increases health inequalities for poor and rural areas, the NHI has still turned to a public-private partnership (PPP) to deliver comprehensive primary care for all regardless of their ability to pay. At first, the PPP approach appears consistent with the Charter's outline in that all citizens are covered, thereby actually reducing health inequalities by increasing access to preventative services and treatment. However, the Charter merely serves as a guide, not as fully developed policy recommendations, so it is questionable to what extent NHI can deliver the Charter's stated goals of healthcare for all. Additionally, both the Alma-Ata Declaration and the subsequent People's Health Charter call for cooperation among South Africa's various sectors, among all countries, and generally "peaceful aims" to achieve a comprehensive national health system (Declaration of Alma-Ata, 1978, p. 1). While the PPP premises itself on uniting public interest with private assets, the question is always "at what cost and on whom does that cost fall?" There is not a reliable standard in South Africa for evaluating how these private assets will be used in the public interest of healthcare services. There is also cause for concern regarding the current and historical national environment on human rights abuses, including healthcare. For example, South Africa has signed the International Covenant on Economic, Social and Cultural Rights, but it remains one of the few countries yet to ratify this major treaty addressing human rights issues (Pillay, 2014).

Convincing the Public

A general lack of confidence in the NHI's PPP approach comes not only from the structural level, as former United Nation High Commissioner for Human Rights Navi Pillay points out, but also the individual level. The Charter calls for community participation at all levels, but social movements and legislation can only go so far in turning individuals from spectators into participants in a vastly unequal country (Declaration of Alma-Ata, 1978, p. 1). Needless to say, South Africa has a sordid legacy of apartheid. In that vein, recovery programs designed to close racial gaps such as the Black Economic Empowerment programs have not been favorably received (Greenberg, 2006). Likewise, the dominant public narrative pushes back against NHI, classifying it as an additional program whereby poor people are further relying on the state (Page, 2005). Such claims ignore systems of structural oppression that, for example, block access to higher education and the safer, higher-paying jobs that often accompany such upward mobility. Instead, poor, Black working-class women have to ask themselves, "Which is more important: me, or [cleaning] the [asthma-inducing] carpet?," balancing their respiratory health with the need to earn an income from available domestic work (Grossman, 2007).

Two of the largest public concerns have been around the notion of subsidizing the poor and the current state of the public healthcare system. And in spite of assertions that both private and public healthcare financial backing will come from the same fund with the same quality of care, the general public is skeptical (Republic of South Africa, 2014, p. 9). The NHI will run on the NHI fund, which will be subsidized through general governmental taxes as well as additional contributions by employed workers who meet a to-be-determined income threshold (Republic of South Africa, 2014, p. 8). Basic healthcare will be free, but many middle class citizens oppose the very notion itself, particularly in a country with an almost 25% unemployment rate (AfricaCheck.org). Such high national unemployment rates create an environment where survival takes precedence over a policy that can be reduced to "paying it forward." These middle- and upper-class citizens often feel that they because they earn money, that allows them the choice to spend it as they please, rather than how the government mandates. In truth, they can still choose to keep their medical aid—the South African equivalent to medical insurance—but they *will* have to pay for it in addition to the mandatory contribution to the NHI Fund. In paying their dues, they are taking the necessary step toward allowing those who are not fortunate enough to be employed the access to the healthcare they so desperately need. Returning to the argument of this paper, it is clear that private healthcare has hitherto encouraged individualism. This individualistic ethos where

citizens look out for themselves and not their neighbor leads to alienation from each other as well as the alienation from the people providing care for the children in the home and care for individuals in healthcare facilities.

Alienation of Healthcare Providers

The NHI has the potential to eliminate the two-tiered system (public-private system) (Nair, 2009) by closing the gap in service, but it is not clear if the government is ready to take this next step. The African National Congress—the majority-Black governmental party in power—has the political authority to implement the NHI, but the NHI will not be successful unless the commodification of care and the alienation of the healthcare workers and patients are also tackled. Borrowing from Chris Yuill (2005), alienation can be described as the "lived experiences of [workers under] capitalism" (p. 126). Yuill argues that capitalism—and, in this case, globalization—creates a sense of human detachment where health and care are deprioritized (Yuill, 2005, p. 141). Not only are unpaid care workers separated because they are relegated to a form of underclass, but the commodification of care creates a hierarchy where paid workers only see patients who can *afford* care. Care is a commodity to be bought and sold by those with the privilege of medical aid in the unbalanced South African market. It can further be argued that the privatization of healthcare exacerbates the alienation of healthcare workers who happen to be primarily non-white. When those with the socioeconomic privilege and educational capital are those who land well-paying jobs or access high-quality healthcare, where does that leave historically disenfranchised populations? Globalization does not just breed commodification or alienation, but also xenophobia and classism, both intraracially and interracially (Nyamnjoh, 2006). Black South Africans are just one group othered based on "the hierarchies of humanity informed by race, nationality, culture, class and gender" (Nyamnjoh, 2006, p. 38). Globalization creates the circumstances where those with intergenerational wealth continue to encounter opportunities while those without capital fall further behind in the wake of privatization.

In actuality, this has been exemplified at all levels of healthcare practice. Physicians sometimes bear the brunt of the work both in the field and long after they have gone home. For example, in 2009, Dr. Wasserman and his colleagues—public-sector doctors in the township of Gugulethu—went on strike for better wages and to bring attention to "inadequate delivery of this most basic service," calling their daily work "soul destroying" (Wasserman, 2009).

Medical specialists and specialty practices are completely unable to meet the demand for their services. For example, the Gugulethu Clinic is the sole dental clinic in

charge of serving multiple poor Black communities with only one state dentist. Thus there is one dental specialist for a population of 98,000 (according to the 2011 Census). Gugulethu serves as a case study; however, their dilemma is not unique. The Department of Health (2014) reports that only 1 in 10 dentists in 2008 worked in South Africa's public hospitals or clinics (p. 16). And while there is a Black middle-class in South Africa, the majority of the poor people are of color, as opposed to white. This disparity in care is not just along class lines, but also along racial lines. The need is so great that for U.S.\$2–\$3 one can buy a spot in the line, because the queues for the dentist begin as early as 2am, and people have to walk to reach their places of work (Mzantsi, 2014).

Finally, home-based healthcare workers in the public sector are aware that no matter how great the needs, the reality rarely matches the necessity. Underpaid and overworked, these workers are considered lucky to have work in the face of so many people who provide care for free. There is often little to no clean water or soap to perform the most basic functions, even though these neglected caregivers are on the front lines of public health (Industrial Health Resource Group, 2012, p. 4). These workers all experience a sense of alienation, or disconnection, in one form or another. The lowest-paid ranks, such as community health workers, are ignored and taken advantage of, furthering their distance from the patients they serve and the doctors they support. They fill in the “skills gap” when and where the lack of nurses and doctors are unavailable, but they have few chances for career progression or even a living wage (Sander & Lloyd, 2009). The highest-paid ranks often work within the private sector, further defining themselves as different from the rural village or the very poor and very Black townships. Individual townships are teeming with the Black, Colored, and Indian mothers, grandmothers, sisters, aunts, neighbors, and community service workers who are most likely to give unpaid care in South Africa. While these populations will have access to NHI services, they still bear the responsibility of providing non-basic services for their loved ones. It is important to consider who provides care to those performing daily care work.

Broader Implications for the Commodification of Care

Care requires more value within post-colonial nations like South Africa where apartheid was the literal manifestation of alienation and state-sanctioned violence; not just the care that occurs within hospitals or clinics, but also the care provided within homes by poorly paid domestic workers and unpaid caregivers. Care, as defined by Classen (2011), “refer[s] to a restricted set of activities: caring activities on a structural basis for people who are in a position

of dependency or vulnerability . . . both a kind of action (“caring for”) and a motive (“caring about”)” (p. 44). This theory of care—further explored in Paula England's (2005) “Emerging Theories of Care Work”—shows an opening on how market care, or care to be bought and sold as a commodity, could be a “welcome form of care” in that it would meet the gap in care provided within the home (p. 60). Yet, when care is classified as a “thing” to be bought and sold, the result is a care deficit (Block, 2003). The country of South Africa is in a care deficit that NHI proposes to fix, but NHI provides only basic health services, which maintain advanced care as a luxury. If water, a public good, can be commodified and privatized in South and Southern Africa, care will definitely not be the one exception to the capitalist rule (Bond, 2003). When the exclusivity of healthcare and the efficiency of care take priority over genuine care itself, it is evident that access to free healthcare is an inalienable right that the South African government is failing to deliver.

The 2014 wave of Ebola is a critical global example of how *genuine* care should never become a commodity. The effects of Ebola in West Africa were devastating due to both a lack of resources and the nature of the virus itself. The Ebola virus viciously attacks anyone who has contact with the slightest bit of infected bodily fluid, often from a loved one for whom one is providing care (CDC, 2016; Hale, 2014). In many African countries, formal care workers are not the first respondents, unpaid caregivers are. While Western Africa and Southern Africa are very different, it is worth noting that neither region compensates or officially recognizes the unpaid caregivers providing daily preventative care. Even with an expanded network, genuine care must never become a commodity because of the informal nature of care explored by Classen (2011). This sort of care is motivated by personal connection, and ultimately love, love that a private-public partnership or a large salary cannot provide. Due to the level of care required, the lack of professionals, and the lack of respect, these *pro bono* caregivers are currently isolated and will continue to be, even with the introduction of NHI. Until unpaid healthcare workers are valued as much as private-sector salaried healthcare workers, thereby reducing worker alienation, the NHI will only add a patch to a broken system.

Conclusion

The final challenge for NHI's transformation of primary care is placing trust in any government with the responsibility of one's life and health, let alone the African National Congress (ANC) government. It is not a secret that South Africa's leadership has often been publicly and vehemently criticized for “corruption” (Motsoeneng & Toyana, 2015). Combine this with a PPP, which traditionally focuses

on “value for money and affordability,” rather than compassionate care, and the problems are apparent (Khanyile, 2009). Although the author believes that truly compassionate, genuine care can never be commodified, the NHI is a step in the right direction. South Africa has discussed the possibility of universal healthcare for seventy years, and, if implemented, the NHI would provide support to millions who need it. Additionally, the Department of Health and the ANC government will reduce the unbalanced market power of the private sector if they implement the NHI. Nevertheless, this paper asserts that healthcare, much like access to clean running water, needs to be thought of outside of the context of the economy and inside the context of a given right for every single human being, regardless of age, gender identity, class, race, nationality, sexual orientation, religion, political affiliation, or ability.

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