

Inequalities in South African health care

Part II. Setting the record straight

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Abstract While Part I of this article analysed the problem of structural inequalities in South African health care, this follow-up explores feasible and socially accountable principles as well as a policy strategy to equalise existing discrepancies and disparities. In addition, the prospects of equalising the disparities and discrepancies are weighed against prevailing realities. The conclusion: for the foreseeable future the chances for equality in South African health care appear to be rather slim; a myriad interest groups with vested interests in the status quo are at play, opposing any fundamental reform to ensure greater equality. However, what is more important than the acceptance of this fate is our sincere endeavours to minimise these inequalities.

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Equalising the inequalities in health care

Judging from the complex origins and diversified nature of inequalities in South African health care — as described in Part I of this article — a simple and straightforward approach to equalisation would not be applicable and feasible. Instead a broad and multi-faceted approach seems necessary. Above all, it appears obvious that reform strategies that aim fundamentally to address inequalities in health care should commence at the root causes and their complex interconnectedness, thus stretching far into the broader, problematic societal order.¹⁻³ Furthermore, structural inequalities represent but one dimension of the structural problems haunting South African health care. An isolated concentration on equalisation without addressing the total nexus of problems would therefore be futile. For too long the country's health care problems were dealt with by 'reformist

reforms', i.e. minor material improvements while leaving intact current political and economic structures and rejecting objectives and demands which are incompatible with the preservation of the system.^{4,5} Entirely new ways of thinking and progressive measures appear to be imperative. The following are paramount:

1. **A re-evaluation of prevailing principles and value-orientations in South African health care** is necessary. In particular a retreat from dominant values sustaining the pluralistic health care system, which serve as an unlimited source of inequality, should be made. The values of racial superiority, market-justice and individualism must be played down in the health sector. At the same time values conducive of equality must be cultivated, especially those of co-operation, common good, altruism and equity.

2. **A refocusing of prevailing policies with a concomitant reorganisation of existing structures of health care** also appear necessary, so as to render services and facilities more available, affordable, accessible and acceptable for the entire clientele, but also rendering them less fragmented, more co-ordinated and more effective in their functioning. This clearly means curtailing the roles played in the health care system by apartheid, the private sector, the provincial bureaucracies and the medical profession in particular.

3. **A redistribution of funds, personnel and other resources in the health sector** to accomplish more equal provision and more equitable allocation also seems inevitable. This implies a scaling down of the major role of purchasing power, geographical area and race in the present distribution, provision and accessibility of health care.

4. In accordance with the abovementioned measures, it would subsequently be a prerequisite **to explore new value-orientations, new policy frameworks and measures, alternative models of care and other categories of health care providers**, which will be able to incorporate easier access, greater relevance and more acceptance into South African health care.

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* 'Reformist reforms' is distinguished from 'nonreformist reforms', i.e. true and lasting changes in the present system's structures of power and finance.^{4,5}

To embody these prerequisites in definite reform strategies, and thus equalise South African health care, it seems necessary that particular principles should be accepted as guidelines for providing and organising health care. In addition, and flowing from these principles, the phasing in of specific policy measures of a practical nature and particular structures/models of health care delivery seem conditional for progressive equalisation.

Juxtaposed to the aforementioned diversity of inequalities, equality in South African health care can only be realised if those universally accepted principles for equitable, just and socially accountable health care are more deliberately honoured, cultivated and implemented in the provision, distribution and rendering of health care. These principles include particularly that health care should become more available, accessible, affordable, appropriate and relevant, acceptable, adaptable and flexible so as to render it more equal and equitable.⁶⁻¹³ Thus, the demand is first and foremost for the creation of a health care system that is more sensitively attuned to the demands, needs and capabilities of its heterogeneous clientele, likewise finding its legitimacy in the approval and acceptance of that clientele.¹⁶

There is abundant proof that the pluralistic health care system currently in force in South Africa falls far short, in almost every respect, in realising the above. The dominant emphasis on liberalism^{6,14,17,18} and the concomitant value-orientations of entrepreneurialism and individualism, as well as the perception that health care is a privilege and an exchangeable commodity, render the prevailing dispensation in many respects unequal, also exceptionally inequitable and unjust, and thus greatly indifferent to human suffering. A first step in equalisation must, therefore, occur at the very basic level of value-orientations, implying specifically the sensitisation of government, the professions and the clientele at large toward those fundamental values conducive to equality. In the health sphere this particularly boils down to the recognition and institution of health care as a *basic human right* and *public concern*,³ and along with this the acceptance of egalitarianism^{6,14,17,18} — rather than liberalism as hitherto — as the prime philosophical framework encompassing altruism, equality, justice and equity as cherished value-orientations.

It is, however, equally important that the acceptance of the principles/values of egalitarianism and the recognition of health care as a basic human right be supported by concordant applicable and innovative strategies/measures on the policy and structural level. To bridge this gap, several interrelated policy decisions have to be implemented to equalise the present inequalities optimally.† First of all there must be what Navarro²⁰ referred to as a *universalisation of health care benefits*. This implies the equalisation of opportunities in the consumption of offered services and facilities. Phrased differently, this would mean that all improper conditions hindering access and consumption — e.g. income, race, class, geographical location — be removed and that no person's claim to the health resources of his/her country may be dominated or cancelled by those of another on any grounds whatsoever; the highest priority must be a com-

mitment to provide a universal standard of health care to all who require such care, regardless of their ability to pay, race or geographical location.^{21,22} Equality in health care, according to the universalisation of health care benefits, thus comprises that (i) *access* to health resources should be *non-competitive* and (ii) *consumption* should *not be mutually exclusive*.

Furthermore, in order to equalise health care there has to be a *social contextualisation of health care provision* — a recognition that health and disease have social origins, and that the health care supply should therefore be sensitively synchronised with the unique socio-economic, socio-cultural, geographical and political needs, preferences and backlogs of the vastly different communities in South African society. This prerequisite applies in order to equalise the appropriateness, relevance and acceptability of health care for different communities. Where the social conditions of people and their resultant needs and preferences differ as widely as in South Africa the realisation of equality requires all the more that the planning process be diversely focused on communities with different conditions and needs. Tannen²³ referred to this requirement as *population-based planning* — in contrast to the *resource-based* approach in health care planning; a process which determines health needs and establishes resource requirements based upon an assessment of risk levels and health status of a given population. The determination of need is derived solely from attributes of the population, initially ignoring all existing resources. Thus, besides the fact that this broadened planning process is particularly capable of accommodating the unique social, economic and environmental conditions of smaller communities in synchronising supply and need/demand, the health-orientated nature and social view of health of this strategy also provides an appropriate basis for the effective provision of comprehensive health care in accordance with the real needs and risks of these smaller communities. Logically this in itself is conducive to equalisation in health care.

A population- or community-based approach necessarily implies the *regionalisation of health care*. As a method of deploying, distributing and organising health care, regionalisation implies/involves that a number of regions, determined by administrative efficiency as well as by appropriate administrative and care delivery structures, will have to be created to implement an equal and equitable resource allocation strategy sensitive to and in accordance with the needs and preferences of smaller communities. Essentially this means that the equalisation of health care can be greatly advanced if planning is devoluted to community level, and policy-making is democratised so as to attune and adapt health care more specifically to the unique health needs and preferences of smaller communities.^{25,26}

In extension of these, the closer alignment of health care to the specific needs of particular communities implies a profound reorientation in the rationale and nature of health care. The essential message — stemming originally from the Alma Ata Conference — is that health care must be provided at the site closest to where people live and work, and at a point where they are able to exert maximum control over their lives.²⁷ With the real needs of all communities as the main criterion in provision and allocation, a shift in emphasis towards pri-

† It must be conceded, however, that the right to health care is only a right to an adequate floor or decent minimum. It is not a 'limitless right'; in particular the right of the state to ration health care for the common good is not really a matter of dispute.^{8,19}

‡ Apart from deliberate policy measures to equalise health care provision and distribution, bear in mind that there are also those mechanisms and processes which unwittingly contribute towards equalisation in the field of health care. Among these, active and conscious democratic struggles, civil rights movements, the demands of labour unions, mass culture, the mass media, mass education, social mobility, etc. are enduring equalising factors in South African health care.

§ Tannen²³ distinguished *population-based planning* from *resource-based planning*, the latter referring to planning in accordance with objectively determined indicators of health status such as mortality, morbidity and life expectancy. Apart from being a retrogressive planning process which on the one hand rests on the availability of resources and on the other works with incomplete and sometimes inclusive returns of negative indicators of the population's health status, it also reflects a very negative disease-orientatedness towards planning which stands prominently as a limiting factor in effective, appropriate health care provision.^{11,24}

mary, preventive and community-based health care — thus a shift in emphasis from disease and the ill person towards health and the healthy person — should prove particularly appropriate and promote equality in the South African situation. As need becomes the principal criterion for supply and distribution, the present high profile of curative and institutional care, as well as the accompanying expensive, experimental, superspecialised and high-tech care, will automatically be scaled down. In effect this will curtail one of the most powerful generators of inequalities and disparities in the affordability, availability and accessibility of health care. Such a shift in emphasis towards primary, preventive and community-based health care naturally brings the need for different categories of health workers and adjusted orientations in the training of such workers to the fore.²⁸⁻³¹

The above prerequisites for equalising South African health care already foreshadow some of the structural adjustments needed to steer South African health care toward greater equality⁴. Here the most important requirement is for the health care system to become organisationally unified or structurally integrated. This means that the present and past proliferation of fragmentation, division and pluralisation of control and financing — according to race, function, socio-economic status and geographical area, highly conducive of numerous inequalities along these lines — in the health sector should be stopped. Restructuring should rather be directed towards a unitary or unified system, striving for greater integration of all dimensions of health care delivery. Such structural integration appears to us a precondition for the elimination or at least mitigation of many blatant inequalities ensuing from the myriad divisions in present South African health care.

First of all this structural integration presupposes a different system of control. In stark contrast to the current fragmented, overlapping and confusing lines of authority and responsibility, stands the need for a *central controlling body* which could be invested with the mandate to formulate, execute and control a binding health policy at the national level and in accordance with universally accepted principles of justice. This centralisation of control/authority is necessary to render and deploy health care more in co-ordination with need and according to a national plan and priorities. Such a central health authority needs effectively to counteract the power and influence of many existing interest groups which at present are so strikingly responsible for disparities, maldistributions and inequalities in South African health care.

In tandem with the centralisation of control/authority, greater equality also demands the *centralisation of the financing process* in health care.¹¹ Such a collectivisation of financial resources seems indispensable should any meaningful redistribution of health care facilities and personnel be effectuated and should equalisation of access, affordability, availability and attainability be achieved. Bluntly speaking, this means that free-market forces, vulgar commercial interests and the pluralism of financing institutions will be replaced with a single, collective financing mechanism. Thus, in the words of Mechanic,³⁵ a global budgeting approach with implicit rationing measures also seems necessary for the more equal and affordable financing of health care in South Africa.

⁴ For more elaborated expositions of the proposed structural or organisational reforms necessary to render the South African health care dispensation more equal and equitable, see Centre for Health Policy;²⁸ De Beer;³² De Beer and Broomborg;³³ Fourie;¹⁶ Klopper *et al.*;²⁹ MRC;³⁰ Van Rensburg *et al.*;³ Zwarenstein and Barron.³⁴

¹¹ The financing process as such differs significantly among centrally financed systems, ranging from *national health insurance systems, national health service systems* and *socialised/socialist systems*. See Buchanan;¹⁸ Van Rensburg *et al.*⁹

A further step in promoting equality in South African health care may be considered. It comprises the *consolidation of both authority and financing of health care* in a single, impartial locus from which the rationing and the regulation of the basic right to health care are managed.¹¹ Such a central controlling and financing body should have neither self-centred financial motives nor sectoral political interests. Nevertheless, consolidation of authority and finance in the same structure is more than any other measure capable of advancing equality, and thus equity and justice in health care. A single controlling-financing agent can accumulate the resources for health care within the limits of affordability and equity from society; it can also allocate such resources to the maximal benefit and in accordance with the real health needs of the total clientele. Acceptance of such structural consolidation naturally implies an admission that prevailing pluralist measures in the financing and payment undermine the principles of equality, especially in so far as financial ability determines the right of access and consumption of health care. As a result of the drastically unequal distribution of wealth in South Africa — and more specifically the unequal channelling of health insurance — certain sectors and categories of consumers cannot utilise the available services and facilities according to their needs. The correction of such dividing and discriminatory measures demands in the very first place recognition of health care as a public rather than a private matter, or alternatively recognition of health care as a collective right rather than an individual privilege, and the subsequent inevitable consolidation of health care authority and financing within a single, socially accountable, public controlling body.

To recapitulate our strategy for the equalisation of South African health care the following measures and steps seem desirable and necessary: a recognition of health care as a basic human right and a public concern, and the ensuing universalisation of health care benefits to every citizen; a social contextualisation of health care provision accompanied by community-based, democratised planning and regionalisation of health care; and the integration of authority into a central controlling body, the simultaneous centralisation of the financial process, and finally even the consolidation of both authority and financing of health care in the same single locus.

This rather idealistic exposition of health reform indicates neither unawareness of nor indifference towards the obstacles in the way of its implementation. We are acutely aware that the acceptance of these proposed principles, policy measures and health care structures stands in direct opposition to and in fact would mean the outright rejection of the official approach prevailing in the present health care system. Most of these strategies are, however, already informally yet strongly crystallised and legitimised in the expectations of many a South African, as well as in the visions of many a contending party and movement shaping the future South Africa.

The prospects of equalising the inequalities

Within the prevailing framework of dominant values, policies and structures the prospects of equalising South African health care are rather slim. Even with change pending in a rapidly democratising South African

^{**} The *consolidation of both authority and financing of health care in a single body* is evident in both *national health service systems* and *socialised health care systems*, although the manner and extent of this centralisation differ significantly between these two national types. See Buchanan;¹⁸ De Beer;¹⁹ Van Rensburg *et al.*⁹

society, we are far from greater equalisation. Many contending interest groups, with a wide array of ideological, political, economic and professional interests at stake, will continue to battle fiercely over either the maintenance or the change of the status quo in order to bridge the numerous dilemmas, and make the necessary choices for an equitable health care dispensation in South Africa.^{6,15,16,27,28,34,36,37}

On the one front, there are the many interest groups with a manifold of vested interests impregnating the present dispensation. To be mentioned particularly in this regard are: (i) the many capital and business interests in the private health sector (including the pharmaceutical and private hospital industries, the health insurance companies, and the many private practitioners and entrepreneurs in the medical and related fields) for whom investment, profit-taking and maintenance of existing income levels are of prime consideration; (ii) professional interest groups, especially those of the medical profession, for whom the protection of professional autonomy, entrepreneurialism and particular health institutions and bureaucracies are still top priorities; (iii) the present government and state bureaucracy have pronounced political interests at stake in maintaining the status quo: on the one hand, by promoting the free-market health care system, the State exempts itself from considerable financial and moral responsibilities and blame regarding the provision of health care; and on the other, it simultaneously protects its own political power base, which is deeply rooted in capitalism and its associated institutional and social relations. Prospects of an enforceable, national health policy, the abolition of fee-for-service remuneration, centralised control and collective financing, constitute real threats to these interest groups and evoke fierce reaction/resistance from them. In the present circumstances there is a striking lack of economic, professional and political will or desire among these establishment powers to change the health care system fundamentally along lines that will promote equality.

On the other front, there is a formidable array of oppositional political, civil, professional and worker interest groups and movements — mostly deprived in some sense — favouring and furthering ideologically and in practice the profound and rapid equalisation of South African health care. For them hope has at long last appeared on the health care horizon. Understandably the temptation of radical, even undeliberated, equalisation of persistent inequalities is strong in these reform-minded oppositional groups.

It is hoped that a *right to health care* will in South Africa — as was the case in many developed countries in the past — be wrung from this confrontation in the health care arena. However, to optimise the dividends of the inevitable reform and eventually to reconstruct the health care system along more equal and equitable lines, many dilemmas are still to be settled and numerous choices have to be made. Recently, two prominent protagonists of health care reform in South Africa synoptically portrayed the crucial facets of these dilemmas and choices in the reform of South African health care by using the same proverbial comparison, although each with quite a different content and message. Coovadia²⁷ stated: 'Majority decisions must prevail. In South Africa's case we are prisoners of our history with regard to the treatment of minority groups. On the one hand is the naked manoeuvre to use minority rights to entrench white privilege and on the other is the unambiguous lesson of modern history that minority issues are intractable and cannot be easily resolved. We are condemned to navigate very carefully between the Scylla of entrenching apartheid's legacy of white privilege and ethnic chauvinism, and the Charybdis of repressing indi-

vidual rights and liberties in the name of non-racialism.' In turn, Benatar,³⁶ with reference to the debate on the applicability of either socialism or capitalism, highlighted the following facades of our dilemmatic choices: 'Although polar value systems are almost irreconcilable, it is important to concede that not all of each ideology's concepts are monolithic or mutually exclusive and that there is considerable common ground for negotiated solutions. The challenge is to steer between the Scylla of socialism and the Charybdis of capitalism and to couple political aspirations to economic activities that will provide the resources to sustain growth and equity.'

In our endeavour to equalise South African health care, these hints could well serve as practicable moderations amid enduring extremities. As to the prospects of equality in health care in a future South Africa, or rather the persistence of inequalities: it is a harsh realisation that even though the advent of democratic government may facilitate a redistribution of health resources and changes in health policy, the basic health pattern is not likely to change soon. In addition, unifying the system will not immediately terminate the unequal allocation of health resources.²⁸ Furthermore, it is a sad and demoralising sociological truism that, despite all our ardent efforts to effectuate equality, inequalities will never be eradicated.³⁸ Whatever reform or equalising strategies are contemplated, inequalities will always be present or reappear in new guises. However, more important, and also a more elevated challenge than the dismal acceptance of this fate, is our painstaking endeavour to minimise these inequalities and especially to soften the human suffering caused by enduring and new inequalities, thus rendering them more bearable, though always deeming them deplorable.

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