Building South Africa’s Public Health System: Is the Health System Providing Value for Money and is it Putting Patients at the Centre?

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Abstract

The paper attempts to focus on the title of the paper. In so doing, it attempts an expose on building South Africa’s Public Health System, given the disarray that the health system finds itself in, post democracy 1994. The issue permeates as to whether the health system is providing value for money and more importantly whether the system is putting patients at the centre. It posits that in order to achieve a world class public healthcare system, infrastructure is of utmost importance and requires the necessary investment. It therefore argues that necessity is the mother of invention. The paper also attempts very briefly to indicate why policy is failing South African communities. It argues that the community health worker system is in a state of chaos, leaving vulnerable communities at risk and that all of these issues have to be urgently addressed by both the government and the private health sector, in terms of building South Africa’s health sector, after 21 years of democracy. Other issues as concerns health care management will be enunciated were applicable.

Keywords: health system, public, private, value, money, infrastructure, patients. democracy

INTRODUCTION

Every society has a range of more or less desirable jobs and inputs to build the health care management system of a country. Economists argue from the model of a competitive market, and maintain that those that are exposed to the greatest risks will be compensated by higher than average earnings and will be in a position to contribute more productively to the development of society. This has not generally been the case” (Edward Weber Ed. 2008: 161). It must be recalled that the second arena where considerations of economics intersect with health care and public health management goals involves the costs that the state is able and willing to inflict upon its population and employers to undertake expenditures that will reduce the risks of disease and death. However, in the face of chronic shortages of jobs and work opportunities in South Africa, exacerbated by very “high unemployment, which stands at between 38 and 42 percent of the youth and adult population” (Statistics South Africa, 2015), the imposition of standards requiring sudden and large investments in health protection can prove dysfunctional and costly to the economy. Karodia and Soni (2013) point out that “the issue of weighing the economic costs to the government itself, which might follow radical interventions, can be devastating to the economy, and that the large constraint possibly stems from their unwillingness to risk the discontent of a large part of the population, who enjoy one of the few indulgences that their controlled society permits.”
Jooste (2009: 7) describes several factors influencing today’s health care organizations. According to Jooste (2009), the macro – environmental and intermediate factors are as follows:

- “The tremendous pressure to achieve greater productivity and efficiency through better expenditure control, maintaining universal accessibility, affordability and equitable distribution of health care resources.
- The changing demographic patterns with people living longer and healthier lives in some countries, and the increasing population and varying life expectancies of people has fuelled this challenge.
- People are becoming more knowledgeable about health matters, and patients’ rights also influences the demand placed on the health system.
- Financing the health system is becoming more difficult in South Africa, and this places a huge burden on the resources available and the mobility of the labour force. The length of stay in health institutions, levels of disease (acute), and chronic lead to far more work and greater responsibilities for health care professionals and other health workers.
- Health care statutory bodies serve as watchdogs to ensure the delivery of health care by strictly abiding to ethical codes of conduct. The ethical and moral dilemmas that health care professionals and other health workers are faced with daily, places additional strain on the system.
- The White Paper on Transformation of Health Care in South Africa (1997) focuses on the decentralization of responsibility, accountability, power and authority to the lower levels of health care delivery. It also informs community involvement, decrease in bureaucratic practices and effective use of resources.”

Doubts over South Africa’s Costly Primary Health Care

It is obvious to understand that if the primary health care strategy introduced by South Africa’s democratic government post 1994 fails, it will have devastating consequences upon the public health care system of the country. After nearly twenty years of democracy, post 1994 and the comprehensive introduction of primary health care as a policy imperative by the national government, in order to allow access to the public health care system and to redress the imbalances created by apartheid legacy, the primary health care system was incorporated into the district health care programmes across South African provinces. “Serious doubts have been expressed in December 2008 (Regent MBA Module, 2013: 72) about the very costly Primary Health Programme (PHC) and with very little effect upon the health of its recipients.” This will most certainly have very serious health implications and ramifications for South Africa and its health care system, but moreover, upon the poor as recipients of PHC. The South African Health Review (Chapter 1 on Financing) for PHC published by the non – profit Health Systems Trust (2008) and also reported in the Business Day (2008:1, December, 24) reports that “government spending on primary health care has risen almost eight times faster than the increase in patient visits to clinics over the past three years, raising the question as to whether South Africa is getting value for money.” Karodia, Makumbe, and Linganiso (2014: 23 – 24) state that “Public sector spending on PHC has grown 8.6 percent per year in South Africa (in real terms)n over the past three years from R8.89 billion in 2004 – 2005 to R13. 8 billion in 2007 – 2008 and is increasing drastically with each passing year. Yet according to the PHC report, the number of patient visits to PHC facilities rose only 1.3 percent a year, from 103 million to 104 million.”

More information is required to determine thoroughly whether South Africa is receiving – better quality of care for the increased expenditure. Many of South Africa’s health indicators, according to Ganesh, Panday and Karodia (2014: 16), such as maternal mortality and tuberculosis care rates, compared unfavourably to peer countries, for example South Africa is only one of twelve countries in the world where child mortality is getting worse, due largely to the lack of effective HIV / AIDS prevention programmes.” Early in 2014, a report published by Lancet Journal (2014) “showed South Africa was almost certainly going to fail to meet the United Nations Millennium Development Goals of reducing child and maternal deaths by two – thirds and three quarters respectively between 1990 and 2015, as child mortality rates had increased from 60 to 69 deaths per 1000 live births between 1990 and 2006, while maternal death rates had remained unchanged.”

The Regent MBA module (2013: 73 – 74) points out that “Just over a fifth of the South African government’s health spending (excluding HIV / AIDS) is earmarked for PHC and is set to rise from R15 billion in the current fiscal year (22 percent of the total R87.7 billion set aside for public health) to R19.2 billion in 2010 – 2011 (22 percent of the total public health budget of R97.3 billion). “The funding allocation signals the government’s commitment to the principles of PHC. This commitment however, does not have the corresponding commitment from the 9 provinces, district health care services, hospitals and professionals because of corruption, inefficiency, a lack of productivity, and the total collapse of monitoring, evaluation and a lack of accountability. The question arises is this funding enough. This is exacerbated by the reality that more than half of all district health authorities are unfunded. This is a very serious problem, in respect to the promotion of PHC as a driving force of the healthcare system of South Africa” Karodia and Soni, 2014: 76 – 85).
The above expose clearly indicates that in spite of certain gains within the public health care system of South Africa, a purposeful analysis shows that the South African public health sector is in disarray and after two decades of democracy not much has been achieved, in terms of redressing the legacy of apartheid healthcare. It is therefore necessary that the government of South Africa involves itself as a state within the healthcare system and not leave it to the health bureaucracy alone to accomplish health for all. In this regard, the states involvement should straddle some of the following issues according to Karodia and Soni (2014: 76 – 85).

- “The state political system must provide a framework for people’s participation in policy formulation and implementation.
- The state must dictate economic policy.
- Social welfare policies, such as those involving health and education, are often heavily dependent on state resources and to this end government must prioritize its funding initiatives.
- Government must regulate tariffs at both the private and public health systems for allowing access to all citizens to obtain equitable health services.
- The Government of South Africa must be involved in promoting preventive health care for all and provide rehabilitative services.
- Regulating the health services must be a priority through statutory health bodies with oversight from the government.
- Major decisions involving health care are multi – sectoral and require government oversight, such as the introduction of a new health care programme to manage tuberculosis and other diseases. It must involve private and public healthcare providers, pharmaceutical companies. Non – governmental organizations and so on.
- Government must be very seriously involved in health worker training and so on.

As was explained by Boysens (2009: 8), the transformation of the South African health care system has been an ongoing process. The goals of health care reform since 1994 have been to:

- "Unify the fragmented health services into a comprehensive and integrated National Health System (NHS);
- Reduce the disparities and inequities in service delivery and health outcomes;
- Extend access to an improved health service."

The South African public health care system is in shambles and is on the verge of collapse, so are many other sectors of public administration. This is due to the ineptitude of the South African government and the inefficiency of the bureaucracy. In this regard the South African Broadcasting Corporation on the 5 of June on its prime time news reported that the World Economic Forum held in Cape Town from the 3 to the 5 of June, 2015 stated that “South Africa is in dire straits and is not faring well in terms of health care and education. If something drastic is not done to overcome this burden, South Africa will soon be on the precipice of disaster.” On the other hand the South African news channel ANN7 reported on the 8 June, 2015 that “South Africa is in the midst of a medical crisis, in terms of the excessive shortage of drugs at hospitals and clinics throughout the country and, is now reliant on drugs from overseas destinations. That the situation is so dire that the health care system is on the verge of collapse with patients being very seriously compromised. The irony of the situation is that the government is in denial. This was confirmed by Dr. Johan Kruger of the Pharmaceutical Society of South Africa and further confirmed by Mr. Vusi Khumalo, spokesperson of the KwaZulu Natal province's health department.” The newspapers in South Africa and, critics according to Karodia (2015: 5) and overseas media “have painted a very poor picture of the country, in that the country could be economically downgraded in the months that lie ahead and was lucky not to be downgraded by the rating agency Fitch to junk status, in June of 2015. It now stands at BBB status and things are looking bleak. The country is embroiled in the FIFA football scandal with grave consequences, the labour unions are in dispute and in a tangent with government, corruption is endemic and rampant, the National Prosecuting Authority is in disarray, the Nkandla scandal in which the President is involved has tarnished the reputation of the country, the rand has collapsed and is trading at R12 58 to the United States dollar, load shedding and the electricity shortage is damaging the economy, there is a water crisis looming, public service salaries are beyond control with the salaries costing the government an extra R61 billion, bringing the wage bill to just under half of the budget of South Africa, standing at more than 40 percent, education and health is failing the citizens, inflation is rising, fuel prices are rocketing and food prices are now beyond control, poverty is increasing, inequality is widening and unemployment stands at between 24 and 36 percent, university students are on the rampage because government has failed to pay the fees of thousands of students, strikes and civil unrest is on the rise. In reality, every sector is in disarray and the country is reeling almost to a point of no return.” “The Deputy President of South Africa categorically emphasized on national television that one needs to be deaf and blind, if one cannot see the upward development
trajectory that South Africa is in” (ENCA Television News, 2015). This statement is false and the Deputy President is playing to the gallery and misleading the citizens because, there is no upward trajectory of development currently in South Africa. There is only a downside to the economy and the people are getting poorer whilst the rich and politicians amass large amounts of money to the detriment of the poor and to development.

It is against this background that the title of the paper will be discussed and nuanced. However, it is evident that poverty is related to level of intelligence, psychosocial adjustment and achievement. This can be detected in infancy, in that psychological and educational deficits in children can be detected. Thus poor health according to Karodia and Soni (2014: 76 – 85) “becomes a mechanism for perpetuating the cycle of poverty. It is obvious that the health care system and health care managers, health professionals, the government and its health bureaucracy, must take cognizance of these factors, when operating within the system and design programmes to deal with issues of this nature.” An effective strategy must involve public education and changes in social policy and its implementation.

**Building South Africa’s Health Care System**

Mcebisi Jonas (2014: 1 – 4) states that “The financial year 2013 – 2014 saw the construction or major refurbishment of eight new hospitals with 2600 beds across South Africa. Twenty six new and revitalized hospitals and new ones were completed in the last decade.” The hospital build programme comprises strategic integrated project (SIP). These new and planned hospital projects have provided input to a revamp of the health care system of South Africa. It is aimed at the optimization, acquisition and management of the floundering and almost many collapsed public healthcare infrastructure across the country. This is being rolled out across the 9 provinces in order to streamline construction management within the sector. “The idea is to improve quality, consistency and efficiency infrastructure delivery. This in turn will support quality health care service provision” according to Mcebisi Jonas (2014: 1). The complexity of the SIP programme reflects the diversity of health needs in South Africa and in many rural areas clinics will be built for the first time. It will shorten the route that patients will have to travel to access health care. If this is achieved Jonas (2014: 4) indicates that “people will access health professionals that were not previously available in the rural areas and the critical incentive of housing will be provided as an incentive to attract qualified personnel in rural areas. The clinics and hospitals will be equipped with modern facilities and in some cases the state of the art equipment.” The idea is simple. Improve the lives of communities. The SIP programme will also contribute to the economic development and job creation initiatives of the government. The public health sector in itself is a major source of employment and in 2013 according to Jonas “it employed over 300 000 people and is particularly important for women’s employment and in South Africa it accounts for 6 percent of women’s employment in the formal sector and employs almost 10 percent of women who earn more than R10 000 a month.”

New hospitals and clinics in the rural areas of the country form the much needed developmental nodes and stimulate public transport hubs, with taxi ranks, street and food markets stimulating the local entrepreneurial spirit that is sorely lacking in the rural areas. These hospitals and clinics will bring with it improvements in roads, water access and electricity for disadvantaged and previously marginalized rural communities. However, the financing of public hospitals and clinics is a challenge and much is dependent on good expertise, commitment and accountability. Local communities are poor and therefore a clear oversight has to be given by the government in terms of monitoring and evaluation of these projects to avoid shoddy work and possible corruption which has become endemic in South Africa post 1994. In addition careful budgeting and well – packaged financing provided by government are crucial to avoid disruptions to the construction process. Jonas (2014: 4) points out that “the next phase of SIP will involve six large new teaching and tertiary hospitals; revamping the facilities at 122 nursing colleges; and building 240 more clinics and primary health care facilities in the next five years.”

This is obviously a challenging agenda for the national and provincial governments and their health departments and the public works department – and for design and construction companies around the country. It will, require careful budgeting and planning and close collaboration between the private and public sectors. The SIP programme can contribute to South Africa’s overall development effort to secure a developmental state provided all role – players are committed to the success of the programme. It is a move in the right direction. Time will only tell.

**Citizens Deserve the Best**

In a growing economy such as South Africa’s, the provision of world class public health care infrastructure is of utmost importance. De Buys Scott and Andre Bernot (2014: 1) state that the “average hospital stays are prolonged mainly due to the lack of theatre capacity and therefore because of the current health care system and infrastructure are unable to address the primary health problems and thus this leads into more serious and secondary health care problems with
major cost and other serious implications.” Since the inception of South African democracy in 1994, the state has failed to secure and provide the much talked about National Health Insurance Scheme (NHI) and above all has dismally failed to provide universal access to health care for all South African citizens. Both these issues seem to straddle more talk than action and the democratic government in two decades of freedom has failed its citizens, particularly the poor and historically marginalized. The idea to a better health care system which will be accessible to citizens, the government has to increase Gross Domestic Product growth (GDP), but its economic performance has been poor and growth levels are depressed. There is no doubt that there is insufficient building and hospital infrastructure through to social justice in spite of government’s efforts via its revitalization of public health facilities. The idea through these initiatives must be geared towards the reduction of hospital stays, improve access to medicine and shorten waiting time in queues for patients in both the rural and urban areas. As things stand after two decades of democracy and the legacy of apartheid, this seems a utopian ideal. The lot of the poor has not improved and there is increased frustration by the poor exemplified by increased social unrest, strikes and an increasing loss in confidence in the government.

By the same token De Buys Scott and Bernot (2014: 1) state that “health care man – power is currently insufficient throughout South Africa and, cannot keep pace with growing health care demand.” The new flagship SIP envisaged hospital programme in five selected provinces via memorandum of understanding with the Development Bank of Southern Africa (DBSA) and the national treasury to promote cooperation in the health public – private partnership programme. This is being done with legislative mandates, but has proved challenging because of required redesign of these projects. The delays experience in the process according to De Buys Scott and Bernot (2014: 1) “have had a negative effect on the private sector’s perception of the government’s commitment to see these projects to completion, creating a potential gap in the finance and expertise required for the programme to succeed.” Another problem that is being experience in auctioning infrastructure build is the reality that it has been a most difficult task of getting the various stakeholders to work together because there are too many stakeholders and too many government departments involved. This is the reality of South Africa, less action but too much unnecessary bureaucratic red tape and no one in government has the ability to deal with this quagmire.

The Aim of the Study

The principle aim of the study is to attempt to address the title of the paper with a view of attempting to address some salient issues that confront the South African Health System as a whole.

The Objectives of the Study

- To delineate through discussion some of the important issues that confronts the South African Health System after 21 years of democracy.
- To identify some key health issues that requires urgent attention in order to build South Africa’s health system.
- To determine whether the health system is providing value for money in terms of the services it provides and as to whether the patient is being put at the centre of health services delivery.
- To briefly underscore why policy is failing communities and as to why the health worker system leaves vulnerable communities at risk.

METHODOLOGY

The paper is a discussion paper and therefore, does not follow the classical research methodology or methodologies. It unpacks health issues using articles that appeared in the South African popular press and relies upon texts and periodicals were applicable. The authors also use and rely upon their experiences and therefore, use critical analysis to articulate their narrative. The paper therefore, is not an attempt to impinge upon both the public and private health sectors of South Africa. It is hoped that this paper will in some ways open up debate and discussion on important and, salient issues that confront the health sector of South Africa post democracy in 1994.

LITERATURE REVIEW

The literature review in this paper limits itself to some pertinent issues that affect the narrative and discussion. This is undertaken from the perspective of looking at the political economy of health care, the structure of the South African
health sector, post 1994. This will allow the reader to situate the South African health sector within a broader understanding of this important sector and, what might be required to address certain salient issues as outlined within the title of the paper. Other important issues will be touched upon within the confines of this literature review. According to Karodia (2013: 1) “Politics is the art of the possible and economics is focused on the effective utilization of scarce resources. Advances in health care management will therefore depend on the prior allocation of scarce economic resources, primarily through actions in the political arena. But there is nothing easy about eliciting a favourable response through the political process to attract the required economic resources even in the face of the probability of significant health gains being achieved. It is thus obvious that ensconced autocracy, will enter upon new policies or programmes that are a direct challenge to the status quo without strong reasons. Even if the benefits appear substantial, the leadership might still hesitate to start innovations on the ground that the existing political equilibrium should not be jeopardized.”

“Given the new democracy in South Africa, post 1994 and the entrenched corruption that permeates the body politic of South Africa (Karodia and Soni, 2014: 78) the time has come for the South African government to invest heavily in both healthcare and education, if it wants to survive as a government.” However, there is a second ground for caution because most innovations require investments that can be made only to the extent that government is able to extract from the tax – paying public some part of their income or capital. But all peoples, those who live close to the level of subsistence as well as those who are citizens of an affluent nation, are resistant to transferring their money to the state. In this regard the Regent Health Care Management Module states that “Even when one third or one half of the gross national product (GNP) flows through the government sector, as is the case in most developed nations, the public authorities are not free to spend what they might like on health.” This is the reality in both developed and developing nations and South Africa is no exception, in this regard. Demand on health expenditures must compete with other priority areas such as defense, education, social security and housing. Ferlie, Lynn and Polllitt (2005: 432 – 433) point out that “there is yet another reason why innovations in health programming are seriously constrained. The knowledge base is never as broad or as deep as one would wish. Not enough is known about the direct, much less the indirect, consequences of various types of societal interventions.” This is precisely what confronts the South African democratic government given the negative history of apartheid, as it grapples to consolidate democracy, given the demands of the people who were historically marginalized and live on the edge of poverty, inequality and the tide of unemployment. The quest of creating a developmental state in South Africa is therefore, a distant mirage and dream.

According to Carr (2010), healthcare facilities encompass a wide range of types, from small and relatively simple medical clinics to large, complex, and costly, teaching and research hospitals. South Africa has inherited a large number of small clinics and there is an absence of these clinics in the predominantly rural areas and patients have to travel long distances to such clinics. The urban sector has also inherited a number of state of the art hospital clinics. These are becoming run down in the recent past and given the large urban migration to the cities, they cannot cater for the large number of users and patients. Boysens (2009: 2) states that “the systems approach is an important tool in both the planning and control functions of management. A system can be open or closed and is described as a set of goals and elements in interaction to achieve a specific goal. The system must therefore, follow in its feedback loop – inputs, the process and the outputs.” This is largely absent in South Africa’s health care system, particularly in the public health sector as opposed to the private health sector, which is very sophisticated and most expensive. The South African Health system is part of a complex environment, which consists of past apartheid history, which destroyed the health sector of the majority Black population, overtly political under democracy, cultural in nature, unsound economic allocations, serious social , legal and technological factors that hampers progress in respect of health reform and transformation in democratic South Africa. All of this affects the health industry of South Africa, including especially the public health sector, as a whole.

Typically, a health system includes all activities whose primary purpose is to promote, restore or maintain health. The goal of a health system is to improve the health of the population and raise the level of health through (UCT, 2005).

These are as follows:

- Improving access to healthcare;
- Community involvement and participation;
- Innovation; and creating sustainability in the healthcare system.”

In this regard the UCT document (2005) indicates that the functions of a health care system are:

- “Financing of healthcare within specific budgets;
- Provision of various services within the health care context;
- Resource generation;
- Stewardship by setting rules and standards, establishing equity for all participants in the system; and
- Strategizing the direction for the system.”
It is therefore obvious that a health system of a country within the ambit of the public health system must respond to the people’s expectations and should provide financial protection against the cost of ill health. In this regard Karodia and Soni (2013) state that “South Africa post democracy in 1994 has failed the population in respect of transformation and equity because it has failed to provide the best average level of health possible and has maintained since apartheid the status quo and has failed dismally in respect to the reduction of health inequalities.” In this regard some of the challenges within the South African public health care system that confronts government after two decades of democracy are:

- “Attracting more resources while improving their efficient and equitable allocation, and delivery of quality healthcare;
- Integral data collected regularly and well managed for monitoring and evaluation;
- Harnessing other sectors (private, voluntary and so on) for better levels of healthcare; and
- Becoming more flexible and innovative to address the changing needs of the South African population.” (UCT, 2005).

Health Care in South Africa

“The Republic of South Africa is a non-racial democracy and obtained freedom from apartheid, in April of 1994. In this sense, it is a relatively young and emerging nation, grappling to come to terms with its past oppression by the White minority government and, by implication, it is confronted with mammoth inherited problems, in all spheres of development, including healthcare. It is a country of 1.2 square kilometers and with a population of plus/minus 50 million and a number of illegal immigrants from all parts of the world. This adds tremendous pressure upon the public healthcare system. The country is becoming increasingly urbanized. Since 1994, the public health care system serves all citizens, and immigrants irrespective of race, class or colour. This right is enshrined in the Constitution of the Republic and protected by the Bill of Rights.

The private health care sector serves the needs of about 20 percent of the population, especially the affluent, the emerging middle class and, a large number of public servants who have access by virtue of being subsidized by the government. The private sector offers excellent services and can be compared with any first world country. The private sector health services is very expensive and beyond the reach of the ordinary citizen. The public health sector varies drastically according to an urban and generally peripheral or rural setting, in terms of quality of health care offered to the general population. The quality varies from good to very mediocre. Most public health services are poor and mediocre. Generally, government hospitals cannot meet the precepts of quality, due to scarce budgets, overcrowding, chronic staff shortages, corruption, and inefficiency, coupled with a lack of motivation and lessened productivity with no accountability” (Karodia et al, 2013; Regent Manual, 2013; UCT, 2005).

The Regent Health Care MBA Management Module (2013: 96 – 98) points out with regards health systems and the problems in terms of the South African public health sector that the following factors exacerbate and compromise the system. (These are listed hereunder, but not discussed).

- Misallocation of funds and resources;
- Inequity;
- Inefficiency;
- Exploding costs;
- World Health Spending;
- Low income countries
- A host of other variables.

It is against the above brief literature review that the discussion in this paper will be undertaken to encapsulate the issues raised in the title of the paper and the abstract of the discussion.

Target Population

There is no target population that was assembled and delineated for this review article. The target population is therefore, by implication the many readers that will view the article once published. It is hoped that the paper will
appeal to a wide audience that is interested in the health sector of South Africa.

Limitations of the Research

Papers of this nature that use critical analysis and other review articles, in the formulation of such narratives, with the absence of classical empirical research, courts criticism from various quarters. However, the authors are mindful of such criticism and place on record that such criticism will be accepted as par for the course, but in no way will such criticism alter the thrust of the outcomes of the paper and what it attempts to portray in respect of the South African Health Sector. In this sense the methodology and approach is open to criticism and as such is the main limitation of the paper.

Ethical Considerations

There are no classical ethical considerations that the authors had to keep in mind. This view permeates from the standpoint that it is a review article that confines itself to certain criticisms of the South African health system, which is pertinent to the narrative as a whole. However, it also details some positives and articles of this nature are necessary, in order to contribute to an analysis of both the positive and negative aspects of a growing health sector post 1994. There were thus no classical ethical considerations that need to be explained in the formulation of such an article.

Putting Patients at the Centre of South Africa’s Health Care System

Governments and private healthcare systems including the public health care system, the world over are fighting an increasingly intense and complex battle to maintain the fragile balance between quality, access and the cost of health care. Nozuko Basson states that “Discovery Health Chief Executive Dr Jonathan Bloomberg, a private medical aid scheme in South Africa has a strategy that the private health care provider’s, is to dramatically improve the quality of health care offerings as well as to reduce health care costs by achieving rewarding value on patient needs.” Lomax, Naranjee and Karodia, however point out (2014:43 – 71) that “the cost of private health care in South Africa is increasing with each year and is becoming too expensive for the rich also and that many middle class citizens have no option to opt out of private medical aid schemes. This is exacerbated by the fact that government leaves market forces to dictate and those medical aids schemes are a cartel were one sees specialists being allowed to charge 500 percent higher than the specified tariffs set by the Medical Council of South Africa.” Medical aid schemes are now generally beyond the capabilities of the middle class population, let alone the poor and, the situation will not get better. It is therefore imperative that universal health coverage and the implementation of the NHI out of necessity be implemented as soon as possible. The reality is that the current way of providing private health care is not sustainable and therefore, a new approach is needed. Achieving this new paradigm will require major changes to the way health care professionals, hospitals, funders and patients operate and interact with each other including decisive intervention by government to keep the escalating costs of private health care at bay. The private and public health systems of South Africa have to be value driven. On the other hand the public health care system must be one that affords quality at a minimum price and must compete with the private health care system.

What does this mean asks Nozuko Basson? (2014: 3) “For achieving value and affordability in the health care system of South Africa. Health care costs are driven by a combination of supply – side and demand – side factors, he argues and further states that “Supply – side factors refer to issues such as the numbers of health care professionals, hospitals, and other service providers and how these are organized and paid for; new medicines and technologies are also key supply – side factors, for they often provide huge improvements in survival rates and quality of life but come on to the market at dramatically higher prices than the older technologies they are replacing.” On the demand side, South Africa faces severe demographic challenges, including an ageing insured population, and a rapidly increasing chronic disease burden, driven by increases in diseases of lifestyle and cancer across all population groupings. This leads to significant increases in the volume of health care services consumed each year, compounding the impact of the tariff increases, Nozuko Basson adds. The only way to ensure that health care remains affordable while accommodating new technologies is to enhance productivity in both the private and public health sectors, through the more efficient use of scarce skills of general Practitioners (GP’s), specialists, and other health care professionals. This requires more collaboration between the private and public health sectors of the country, more team work. Multidisciplinary medical teams encourage more collaboration and an integrated approach to the care of patients. Inflation has to be managed by government effectively through price and contract negotiation. Costs must be reduced and private health care must afford competitive premiums.
Figure 1. Health expenditure per capita, PPP (constant 2005 international $)

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Expenditure per Capita, PPP (constant 2005 international $)</th>
</tr>
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<tbody>
<tr>
<td>Russian Federation</td>
<td>1,473.6328</td>
</tr>
<tr>
<td>Brazil</td>
<td>1,108.6497</td>
</tr>
<tr>
<td>South Africa</td>
<td>982.2888</td>
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<tr>
<td>China</td>
<td>479.9673</td>
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<tr>
<td>India</td>
<td>156.8455</td>
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Note: South Africa's number in Figure 1 includes both public and private sector expenditure on health care. When these numbers are broken down and presented as a percentage of Gross Domestic Product (GDP), the result is reflected in Figure 2.

Is South Africa’s Health Care Providing Value for Money?

According to van der Avoort and Anuschka Coovadia (2014: 2) “Customer is king but this is not so unfortunately in South African healthcare in both the private and public healthcare system of South Africa, because the patient cannot determine what quality they are buying before undergoing treatment. The largest part of the population relies on the public sector health care system, which suffers from a high burden of disease and a shortage of resources, both financial and human. Thus we find that the customer is not king.” Avoort and Coovadia (2014) further point out that “South Africa’s health care system is characterized by a sharp contrast between the mechanics behind the public provider and payer system and the private provider and payer system.” However, the two are not mutually exclusive, since the sectors share their workforce and the patients they look after. Also the amount of money that is spent in public sector health care more or less equals the amount of money spent in the private health sector. “The big differentiator is the denominator in the equation as the private sector caters for 8.6 million South Africans (17 percent of the population) while the public sector caters for the balance of the population” (83 percent according to Avoort and Coovadia, 2014: 2). Coupled with an HIV and AIDS pandemic, this places a severe burden on the South African public health care system. Spending on healthcare differs significantly when looking at health care expenditure per capita as seen in Figure 1 below. (However, it is worth looking at what the Brics countries achieve in terms of money spent versus outcomes achieved, on the basis that South Africa is part of the Brics alliance (Brazil, Russia, India, China, and South Africa).

This shows that public health care expenditure as a percentage of GDP for those countries based on communist / socialist principles exceeds the private health care expenditure as a percentage of GDP. When looking at out of pocket expenditure as a percentage of private health care expenditure, the number for South Africa is low compared to other Brics countries. “This means that most private health care is covered and funded through insurance mechanisms in South Africa and that most of the private health care in the other countries is largely fully paid for by patients themselves, according to Avoort and Coovadia (2014: 2). The question therefore arises in respect to the value for money. Literature indicates as confirmed by Avoort and Coovadia (2014) that “In other Brics countries life expectancy is highest in China and Brazil at 75 and 74 years. The lowest life expectancy is that of South Africa at 56 years. India’s life
expectancy is 66 years and Russia’s is 70 years. On the other hand when one looks at mortality rates for infants and children under 5, mortality rate, India’s figures are the highest. The Russian Federation has the lowest mortality rates while South Africa’s numbers are close to those of India with 44.6 under – 5 deaths per 1000 live births.”

Although these brief health indicators are well documented and known in the international health care industry, it alludes to the fact and clearly shows that pouring in more and large sums of money into a health system, does not necessarily lead to better health outcomes. In this regard, a classical example is the United States of America, which has the highest spend on health care as a percentage of GDP and, one does not require Solomon’s wisdom to determine this obvious reality, but lags behind its Northern European and Asian counterparts when it comes to life expectancy. A further question arises in respect to South Africa, where does it leave the country and its people, given the data furnished in this discussion? The issue is even more complex and complicated given the government’s inability to action and implement the National Development Plan (NDP), and moreover the government’s inability for many years, in fact more than two decades to address the inequalities that permeate all facets of South African life and its inability to implement the National Health Insurance Scheme (NHI). The reality at the present time within the health sector and system in South Africa is that, its citizens are not getting value for money. In other words there has to be a realization by the South African government that after two decades of democracy, a health care system needs to protect every patient. The government has to check private health care initiatives that is market driven through the scourge of capitalism and overt profit making. It has to secure universal health coverage and implement the National Health Insurance Scheme (NHI), in order to secure the development of the country and, serve the much required health needs of the population and erase apartheid health legacy. The issue is simple and the question must be answered by bureaucrats and the government, don we in South Africa want to be more like our Brics colleagues, with strong social and universal health care systems, or do we want to be more like the United States with a system that leaves more space for private initiatives. We are essentially a “Third World” country in drastic need for the development of a health sector that will equitably serve the sum total of the South African population and the system must guarantee quality, and free access to all.

Health Workers Fail Communities in South Africa

The community health worker system is in a state of chaos, leaving vulnerable communities at risk, according to Mia Malan (2014: 34). She further adds that the salaries paid to community health workers is paltry and pathetic, ranging
from R1000 to R1500. In some provinces they are paid by Non – Government Organizations (NGO’s) and there is no guarantee that they will receive this money, because the stipends are dependent on government. It is so easy to lose your job because the system is inconsistent. Some provinces follow different systems and there is no uniformity of work for the community health worker.” In South Africa, there is a serious lack of doctors and nurses and therefore, community health workers are often used to address the crippling high worker shortage through “task shifting” – transferring some of the easier but time – consuming tasks of professional health workers. These workers live in the communities they derive from. They undertake home visits and track people’s health. The system is in shambles and cannot compare with the system in Brazil and other countries according to Mia Malan (2014). Helen Schneider (In Mia Malan, 2009) states that “the average domestic worker earns more than community health workers. In other countries the system is far more structured and formal. There is no accountability and the system is rarely linked to formal health facilities. They are not properly trained in many disciplines and tend to concentrate on single health issues.” Mia Malan (2014: 35) states that “In Brazil, Ethiopia and Pakistan, community health workers are trained comprehensively and can deal with more or less all conditions. In Brazil and Ethiopia they have been absorbed into the public health system and the government pays them directly. The system has failed the poor and the health worker.” It appears that the government of South Africa is not serious, and it does not have a plan to alleviate the problems of the poor in rural areas. It does not fit into a comprehensive health strategy linked to the proposed NHI. In reality South Africa’s public health sector is in shambles and does not serve the needs of the majority of the population.

Necessity is the Mother of Innovation

Africa has 25 percent of the world’s disease burden and only 3 percent of its health care workforce. Therefore, the priority in Africa and South Africa should be affordable health care. It is thus obvious that necessity is the mother of innovation. South Africa is attempting to provide affordable health care through the proposed National Health Insurance (NHI) plan, which seems to introduce universal health coverage, comprehensive cover of nearly all medical conditions with zero medical co – payments and allow patients to use their provider of choice to treat their condition. Many in South Africa including Malao and Martin (2014: 3) believe that “the proposed 14 year time – line for the implementation of the NHI is optimistic and that it is unlikely that the NHI will be rolled out in the next 15 to 25 years. They add that South Africa does not have the funding for NHI and there is the absence of human resources, which includes doctors and nurses. There has to be a mindset change within government, and the industry, in order to engineer pervasive adaptations to the NHI plan and thus policy changes would be required to implement the NHI.”

A purposeful reading of the implementation plan indicates that targeting a zero co – payment scheme is clearly unrealistic. In other words a co – payment system will be more viable. This will not be expensive and could be applicable to treatments over and above those constituting basic health care. The use of the co – payment system would control the cost of health care and counter any unnecessary use of medical facilities. Malao and Martin (2014: 3) point out that “The NHI is expected to result in an exponential increase in demand for health care services. For the scheme to work effectively and to ensure its sustainability, this increase will need to be curbed”. Thus the implementation of effective clinics is essential, in order to draw demand away from hospitals, because currently clinics and hospitals work in isolation. Collaboration is therefore required in order to allocate patients to these facilities, depending on patient needs. The South African health care industry, both private and public health care must adapt if affordable health care is to be achieved. This must include a review of hospital and exorbitant doctor’s fees and prohibitive specialist charges as set down by the Medical Council and Medical Association of South Africa. Current hospital and doctor’s fees are too expensive and it is therefore essential that remuneration policies should target cheaper and more effective ways to pay hospital staff.

Fees are currently levied based on time as the main cost driver. A doctor’s appointment fee which is a pre - determined fee is paid in full, irrespective of time taken by the doctor. Fees must not be determined on consulting time and thus ignores the outcome of the treatment. In other words a developing country like South Africa needs to absorb the modalities of innovation, embrace it in full and the aim should be one to look at implementing new, sustainable, flexible community solutions to combat increasing demand and costs rather than attempting to replicate Western health care models that could lead to long term distress and destroy the health care sector before it is transformed. At the other level of the continuum, flexible financing techniques such as leasing and buy – back schemes need to be used. The idea is costs must be reduced drastically.

The Importance and Necessity of Change Management

Given the fact that South Africa is a young and emerging democracy, change management must assume great significance in respect of consolidating and harnessing complex management issues, in an ever changing and complex
work, social, economic and political environment in South Africa. Karodia (2013: 355 in the Regent MBA Module Notes) states that "To this end the process of change must be managed to the advantage of organizations and institutions as a whole, in an attempt to bring about greater efficiency, faster and sustained economic growth and for purposes of improving and promoting the general welfare." It must therefore, be noted that that the environmental variable in which the healthcare organization operates undergoes change which influences the sustainability of the organization. The management is expected to act proactively by anticipating the changes and also adding to these changes. These changes may be developmental, or transitional or transformational. It must be further noted according to Karodia (2013: 356) that the “contexts are relevant to change management in the health care organization: global; national; provincial and local; type of ownership; and characteristics of the organization.” Change management, it is obvious from this discussion, is necessary to align the healthcare organization to changes internal and to external forces, in order to make possible improvements in quality and to ensure sustainability in the long term, and in this regard the (Regent MBA Module, 2013: 356) points out that the main role players are “the top technical team that ensures product improvement through innovation; team members who through individual abilities contribute to product improvement and development; competent managers who organize resources for effective and efficient pursuit of predetermined goals related to change management; effective leaders who stimulate higher performance; and the executive who secures a balanced external and internal alignment gradually.” It is therefore, important for the health system and the role – players within it to examine regularly the requirements of change management, the actual process, models of change and selected dimensions of organizational change. It can be confidently asserted from this expose and the narrative that, the concepts of change management are sorely lacking in the South African public health care sector.

Findings and Recommendations

The explicit findings and recommendations are dispersed throughout the narrative and discussion. There are therefore, no finite findings and recommendations that are made within the ambit of the discussion undertaken within the paper. It is hoped that the narrative would have unpacked important and salient issues that affect the health sector of South Africa and, those involved with the transformation agenda of the health sector in South Africa, would take cognizance of the findings and recommendations made throughout the discussion in the paper.

CONCLUSION

The transition to majority rule required South Africa’s health care system to address two major transformations. One was to transform a system organized by race into a system in which race based health care was no longer a consequential criterion and the promotion of equitable and truly accessible health care service to the entire population of a historically marginalized people because of the legacy of apartheid. The other was to transform a system designed to educate and care for an elite into a system that could provide quality health care to all South Africans, irrespective of race, class, colour, and economic standing. The two transformations according to Joel Samoff (2008: XIV, In Weber Ed.) are intertwined. Both remain incomplete. Both are at risk.” Quality and equity are not alternatives. Each requires the other. Transformation requires that each energize the other. As matters stand today, after two decades of freedom, the public health sector of South Africa is in shambles and disarray and, there is no doubt that the democratic government has failed the country and its predominantly Black and poor citizenry. There has to be a new narrative concerning the health sector of South Africa, and there has to be drastic change within the health sector, in order to serve the people of the country and grow the economy, to deal with increasing poverty, rampant inequality and devastating unemployment.

References

Republic of South Africa.