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The Politics of Poor Health in South Africa

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Authors' contributions

This work was carried out in collaboration between all authors. Author AMK designed the study, wrote the protocol and supervised the work. Author AMK managed the analyses of the study. Authors AMK and DS wrote the first draft of the manuscript and managed the literature searches and edited the manuscript. All authors read and approved the final manuscript.

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ABSTRACT

The paper attempts to unpack certain salient and important issues as concerns health in South Africa and Africa as a whole. It does not pretend to capture all the issues that permeate healthcare on the continent. It outlines the vision to transform South Africa's health system into a social institution. It further argues that the South African states proposed certificate of need will not address inequities in rural healthcare. The paper posits that South Africa can learn from Brazil's healthcare model because the favelas (slums) are served by teams of community workers, who are the doctors' eyes and ears. The paper further looks at the possibilities of improving the lives of millions and posits that the Global South must derive pro – poor policies on the world stage. Finally the paper concludes by positing arguments in term of how Africa can settle its health bill and argues briefly that social factors affect health inequity.

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1. INTRODUCTION

Politics is the art of the possible and economics is focused on the effective utilization of scarce resources. It is therefore important to concentrate upon the political economy of healthcare management in relationship to public health issues. "Advances in preventive medicine or public health 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" [1]. On the other hand it must be appreciated 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. 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. "Even when one third or one half of the gross national product 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" [2].

It therefore, has to be clearly understood that demand for health expenditures must compete with other priority areas such as defense, education, social security and housing. 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. In this regard the softness of the knowledge base affects the selection of means even in the face of prior arrangement as to goals. Consideration of the above discussion must be understood by the state, the population, health organizations, in terms of the title of the paper. This leads us to the factors influencing today's healthcare organizations. These are discussed or rather summarized hereunder:

2. FACTORS INFLUENCING TODAY'S HEALTHCARE ORGANIZATIONS

Jooste describes several factors influencing today's organizations [3]. The macro – environmental and intermediate factors are:

- "The tremendous pressure to achieve greater productivity and efficiency through better expenditure control, maintaining universal accessibility, affordability and equitable distribution of healthcare resources.
- The World Health Organization (WHO) has for example recently declared tuberculosis a global emergency and with the HIV/AIDS pandemic, the role played by healthcare professionals and managers has become ever more difficult in contrast, and 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, 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 healthcare professionals and managers.
- Healthcare statutory bodies must serve enhance patients' rights and serve as watchdogs to ensure the delivery of healthcare strictly abiding by ethical codes of conduct. The ethical and moral dilemmas that healthcare professionals and managers are faced with daily, places additional strain on the system.
- There has to be decentralization of responsibility, accountability, power and authority to the lower levels of healthcare delivery. It also informs community involvement, decrease in bureaucratic practices and effective use of resources

(These issues in South Africa has been captured in the White Paper on transformation of healthcare" [4]. All of these factors therefore assume importance and significance in the context of the analysis of the politics of poor health in South Africa. The relevance of these factors must therefore be taken into consideration for a purposeful interpretation of the politics of poor health in South Africa and indeed the so called "Thirld World."

Given the rapid growth of population Karodia states that the "shortfall in food supply, or an outbreak of another catastrophic disease (Like Ebola in 2014 has devastated West Africa and is a threat to the entire world) can roll back much or all of the progress earlier achieved [5,6,7]." The import of this formulation in respect of the healthcare management system and the provision of healthcare and the advancement of public health are to establish "close links that exist between advances in public health and family planning, education, economic productivity. And the strengthening of communal and governmental infrastructures" [5,6,7].

A country whose people live at or close to the margin of subsistence will find it exceedingly difficult, like in South Africa and many other African countries, to break the constraints that retard progress on the healthcare front. But even poor countries usually have a few centres where economic development is occurring, illiterate farm families do learn about contraceptive devices; and governments, often with foreign assistance are able to mount some modest health improvement. Because of the power and influence of the elite, usually represented by those who fill the principal governmental positions in urban centres, the modest investments made on the health front are often concentrated on funneling new resources into therapeutic medicine, improving the local hospital, and starting a medical school and so on. The classic example or illustration of such action has been shown by Karodia [5,7] "Such actions were seen in the former homelands of South Africa and at times in democratic South Africa and throughout the African continent. For example, the late Emperor Haille Selassie of Ethiopia built a 400 bed hospital in Addis Ababa, which preempted almost all the available doctors in the country" [8]. The leadership in African countries must be concerned with improving access to healthcare, a goal that it can define, pursue and often achieve. It often fails to do so, owing to corruption, and poor accountability. The massive unemployment, increasing levels of poverty and the deepening processes of rampant inequality in South Africa and many African countries is therefore, a major concern and hampers the equitable delivery of healthcare in these countries.

On the other hand, the leadership does not possess enough leverage to elicit the cooperation of the mass of the population to undertake smaller and larger projects that might significantly improve their health status. Karodia points out that the "People's Republic of China and India are in major ways the exception: leadership has been able to define major health goals, such as the eradication of a host of diseases, which command the support, enthusiasm and above all else the labour of the masses [5,7]. Weak and dictatorial governments as seen in democratic South Africa and a host of other African governments, tend to be both the cause and the consequence of underdevelopment which are impediments not only to economic progress but also to progress on the health front. In the continent of Africa, Tunisia has made tremendous progress on the health front, in respect to healthcare management and overall public health. In many ways it is a model to emulate by African countries, South Africa included." What then is the involvement of the state in the healthcare system? This can be summarized as follows: [9,5,6,7]

- The state political system provides a framework for people's participation in policy formulation and implementation.
- The state dictates economic policy.
- Social welfare policies, such as those involving health and education, are often heavily dependent on state resources.
- Governments are centrally involved in health regulation and provision from public health measures, for example, control of epidemics, to specific private sector regulations.
- In most countries, governments are involved in the promotive, preventive, causative and rehabilitative services.
- There are regulatory state bodies of health professionals and regulating the services is a function of these statutory bodies, with oversight from the state.
- Major decisions involving healthcare are multi – sectoral and require government

oversight, such as the introduction of a new healthcare programme to manage tuberculosis in the country (involves private and public healthcare providers, pharmaceutical companies, non – governmental organizations and so on.

- Governments may often be signatories to international conventions that impact upon the health of the people, such as the Framework Convention on Tobacco Control of 2003.
- Most governments are involved in health worker training.

3. HEALTHCARE IN SOUTH AFRICA

Karodia [5,6] states that "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 former white minority apartheid government and by implication, it is confronted with mammoth inherited problems and challenges, in all spheres of development, including healthcare. It is a country of 1.2 million square kilometers and with a population of plus/minus 50 million. After 1994, a number of expatriates and illegal immigrants from African countries and an array of other countries have entered the country. This adds tremendous pressure upon an already compromised and overburdened healthcare system. The country is becoming increasingly urbanized over the last two decades. Urbanization has intensified post 1994 and this rapid urbanization has been due to several factors. Since 1994 the healthcare system of South Africa, services the entire population. The legacy of apartheid exemplifies the great disparity between the provision of healthcare services between the public and private healthcare systems and sectors. "

Karodia further adds that "the private 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 government for purposes of using the private healthcare services [10,6]. The private healthcare sector offers excellent facilities and modern care that compares with the best in the world, whilst the public sector healthcare system, varies drastically according to an urban and generally peripheral or rural setting. In terms of the quality of healthcare offered to the general population. The quality varies from good to mediocre and very poor, but generally cannot meet the demands of quality, due to scarce budgets, overcrowding, chronic staff shortages, at all levels of service provisioning and, a host of other debilitating factors. Naturally, due to the mammoth inequalities that were inherited in respect of private versus public provisioning of health, the government had to intervene decisively and this prompted necessary regulatory frameworks, in an attempt to rectify imbalances with the primary aim to better distribute resources and provide accessible primary healthcare to the majority poor population that straddles the length and breadth of South Africa. Grave doubts have been registered about South Africa's Primary Health Care System including policy approaches, nepotism and corruption which dampens the emergence of the public healthcare sector to provide equitable healthcare to the majority of the population."

4. INTERACTIONS BETWEEN HEALTH AND DEVELOPMENT

Improvement of health has important interactions with total socioeconomic development. In economic terms health has been thought of as a consumer good but not a production good. "Health has received a small share of public expenditure ranging from 2 to 6 percent of Gross Domestic Product (GDP). Discrepancy most dramatically is shown when the total expenditures on health of all developing and developed countries in the world are compared with other kinds of expenditures and with population" [11]. Developing countries according to Buchan and Dovlo, show that "developing countries have only about 7 percent of the total expenditure on health, but they have 72 percent of the world population [12]. As economic planning led to more systematic allocation of resources under the limited funding constraints of poor countries, it became necessary to justify public investment in health activities in comparison with sectors such as agriculture and education. According to the trickle – down theory of economic development raising Gross National Product (GNP) was the primary objective because, it was assumed that people would take care of their own social needs if they had more money. It became increasingly evident that per capita income growth was being neutralized by rapid population growth that occurred when death rates began to fall but birth rates stayed high." The somewhat erratic relationship between per capita GNP and indices of fertility and

mortality in developing countries became a serious issue in respect of socioeconomic development.

Karodia points out that "as it became apparent that simplistic notions about trickle – down development were not working, experience in various countries has demonstrated the impact of alternative approaches. Experience has shown that lack of equity in access to services may lead to general deterioration in the quality of life even when national economic indices are rising. Under such conditions, no decline in birth rates has occurred and population growth in the developing world has been dramatic" [5]. This is the reality of so – called "Third World population dynamics and in many countries and there is incremental change taking place in terms of population growth. There have been few countries in the so – called "Third World" with little or no economic growth in which all available resources have been directed toward improving living conditions. Development is thus an inseparable complex of economic and social forces. A combination of personal health, maternal and child health (MCH), Primary Health Care (PHC), family planning and nutrition coupled with preventive medicine can provide an entering wedge in the overall development process.

Having delineated some important issues as concerns South Africa and the healthcare challenges of the developing world with particular reference to Africa, the paper now turns to some issues, in order to give impetus to the title of the paper. In this regard the following issues will be explored:

- The politics of poor health in terms of the Global South which must drive pro – poor policies on the world stage.
- The South African state's proposed certificate of need will not address inequities in rural healthcare.
- South Africa can learn from Brazil's health model.
- How can Africa settle its health bill?

5. THE POLITICS OF POOR HEALTH

Indicators of health are a mirror of what goes on in societies, how the world works and who benefits most. The world over, poor people are sicker and die earlier than those who are affluent and better off. The World Health Organization (WHO) Global Health Report sends out a strong message [13]: "People will continue to die of infectious and non - communicable diseases if governments continue to neglect the need for universal access to healthcare." Health and disease are profoundly political issues driven by inequality and other social factors. South Africa will do well to partner with friends in the Global South to make this issue a key feature to its foreign engagement. Penford states that "Given the link between poverty and disease, pro – poor policies should become of greater global concern, to ensure equitable distribution of healthcare and medicine to impoverished populations. Pro – poor policies directly target poor people and are aimed at reducing poverty" [14].

The 67th session of the World Health Assembly (the body that governs the WHO) was held in Geneva earlier this year. The assembly is specifically interested in the social determinants of health. These are the conditions into which individuals are born, in which they grow, live, work and age, including the national health system. These determinants are influenced by money, power and resources, which are influenced by policy choices. Social health determinants are largely responsible for health inequity and the large divide between health statuses within and between countries. Key questions that need to be asked at the multilateral level of global health governance are whether international, regional and national organizations have a committed pro – poor focus in their healthy policies, particularly regarding access to healthcare and medicine. The benefits of focusing efforts on pro – poor agendas are that all members of society will benefit [15]. There is no implicit 'pro – rich' agenda but in poorer countries, where the wealthy can afford private healthcare, the lack of specific healthcare availabilities for the poor is starkly evident.

Penford points out that "South Africa is a good example of a developing country that has made some progressive inroads into pro – poor policy. South Africa's system of social grants is one of the primary initiatives in mitigating poverty. It must be remembered that the policy of social grants was an inherited policy from the Apartheid government. The democratic government has increased the types of grants made available and has brought about parity in the monetary allocation of grants on an equal basis. This was not the case under apartheid. The grant model to social security lends itself to abuse by recipients but increases the safety network. However, given the high unemployment and increasing poverty in South Africa, eventually the grant system will not prove a panacea to development [14]. "The

challenges it faces as an upper middle – income country with social indicators comparable to the poorest countries in the world include high rates of poverty and poor health services" [14]. The proposed National Health Insurance Scheme (NHI) is an additional government effort towards establishing a pro – poor health policy. It is a system of funding that will create a single pool for health. This will require an increased national health budget. The fund will be supplemented by mandatory contributions made according to individual income that is, those that earn more pay more and vice versa. User fees and co payments are to be abolished for healthcare. As matters stand Karodia states that although the NHI is pro – poor, it appears to be a utopian ideal given its exorbitant costs to implement, the failing public health sector, shortage of professional staff, criticisms from various quarters and the disarray and chaos currently being experienced at public hospitals throughout the nine provincial departments of health in South Africa [1]. The quality of health services in public healthcare clinics and hospitals is often questionable. Those who can afford medical cover benefit from excellent private healthcare [16]. Those who cannot must use public health institutions, subject to delays, poor conditions, absence of equipment and shortages of staff and medicines and the lack and delay in resources. It is a move in the right direction and only time will tell, if it will be successfully implemented."

There is no doubt that health services in South Africa have slowly become more accessible and affordable for the poor. This however, has not guaranteed the required quality. Yet, despite this situation, the government is far from achieving universal access to healthcare and equity for the poor. These concerns are reflected in South Africa's attempts to reach its millennium development goals by 2015. South Africa has lagged behind in poverty and hunger reduction and in reducing child mortality, possibly attributable to a lack of pro – poor policy for healthcare. "International and regional organizations provide a way of impelling international and national actors to engage with pro – poor policy issues. This is becoming increasingly prevalent for North – South and South – South development agendas and generates more development initiatives and research. But there is still limited knowledge about pro – poor initiatives in impoverished regions and how regional commitments on poverty are being implemented" [14].

The Southern African Development Community health protocol is the guiding regional health policy in the region, but does not contain pro – poor clauses or strategies. There needs to be increased focus at the assembly level to address these limitations. It has to ensure adequate attention to pro – poor health policies, particularly in the form of social protection. Fewer people will die or live miserable lives if the issue is taken up at the WHO assembly's decision making forum. South Africa in partnership with other Global South partners such as Brazil and India should make this issue a key feature of an emerging health diplomacy role, regionally, internationally and multilaterally. The diagram below (Fig. 1) reflects that the Millennium Goals on health targets may not be met in time.

What then are the social factors that affect health inequity? The World Health Organization, the South African Institute of Race Relations and the Health Systems Trust states "that health is affected by conditions often beyond the control of individuals. Factors such as education, income and the physical environment have an effect on health outcomes. South Africa scores very low on all the issues raised above and this is a matter of serious concern. This divide in health status is evident between countries of varying economic status. For example, a women in Sweden has a one in 17400 risk of dying during pregnancy, child birth or shortly thereafter, whereas the risk for a woman in Afghanistan is one in eight. The divide is also present within countries. In Bolivia, for example, babies born to women with no education have a one – in – ten chance of dying before their first birthday, but the risk for babies born to women with at least a secondary education drops to about one in twenty five" [17,13]. In South Africa, the "three poorest district municipalities, all in the Eastern Cape province have worse health outcomes than the three richest districts which are in the Western Cape province. The poverty rate measures the proportion of households with a collective income of below R2300 a month (plus / minus $ 200 dollars)" (Penfold, (2014: 35). In the Eastern Cape Province and within the Alfred Nzo district, "has the highest poverty rate (79 percent) in the country. Here, 8.6 percent of children under five die of diarrhea while in hospital. The two wealthiest districts, West Coast and Cape Winelands, with poverty rates of 47 percent and 48 percent respectively, have an under – five diarrhea fatality rate of only 0.1 percent. HIV prevalence at antenatal clinics in the Alfred Nzo

is 28.4 percent. The West Coast has the second lowest in the country at 9.9 percent" [18].

6. SOUTH AFRICA CAN LEARN FROM BRAZIL'S HEALTH MODEL

The favelas of Brazil are the equivalent of South Africa's townships. In these favelas accommodation, government subsidized townhouses and flats, self – built houses that are stacked on top of one another in a way that would leave even Londoners cringing with discomfort, and the shack like homes that millions of South African would know well. Paid government officials "who know all and even their businesses, the officials are required to visit each family in the favelas at least once a month [19]. These visits present an opportunity for dwellers to ask the government official visiting questions. Each official wears a light blue waist coat with SUS printed on it, meaning Unified Health System, Brazil's public healthcare system, which was created in 1988. The government official works for a nearby state clinic and is part of a multidisciplinary team comprising a doctor, a professional nurse, two nursing assistants and six community health workers like herself. There are six such teams at the clinic; each serves 3 500 people (about 20 000 people). Community health workers are recruited from the communities. This is because they understand their people the best." Such a situation does not occur in South Africa. This is exacerbated by poor facilities, the shortages of health personnel, very poor administrative services, a lack of finance and resources but above all a lack of political will on the part of the government.

In South Africa the Mail and Guardian just last week reported that "several patients in the Free State Province had defaulted on their tuberculosis treatment because community health workers were no longer available, after 2200 of them were dismissed in April, 2014 [20]. The South African Minister of Health "wants to replicate the Brazilian community health worker model, and started with this when he announced the creation of specialized ward – based primary healthcare teams in 2011 as part of his plans for South Africa's proposed National Health Insurance Scheme (NHI)" [21]. According to Mark Heywood [19] of the social justice group Section 27, the training of community health workers, however, lags far behind schedule and so does the policy making process; no policy has yet been finalized." "In Brazil the chief community officer in the favelas is responsible for 150 families. The names of the families are personally known by the community worker, how old they are, their medical histories, their clinic visits, whether they are receiving welfare grants, whether they smoke or drink alcohol as well as their favourite brand of sin. They work out of a former rubbish dump. None of the people using the former rubbish dump have formal jobs and they are waiting for government housing so they have put up their own structures within the former rubbish dump. They are now 34 such people living in the dump, which is clean, has toilets and running water. They are all single mothers. The antenatal visits are almost every two weeks and are told that a scan will be done and also determine the sex of the baby. The favelas are divided into colour coded areas and the same team works with them throughout" [19]. These are examples of health care intervention strategies that can assist the South African provincial health departments to emulate and allocate the necessary resources in order to reconstruct the South African health system which is in dire straights since the advent of democracy in 1994.

The community workers undergo about a week's training before starting their jobs and earn about 1000 Brazilian real (about R5000) a month and, like the doctors and nurses, is paid by the government. They are regular meetings to update the entire team. Doctors say that the community workers are indispensible because they cannot relate to patients in the same way that community health workers do. The health workers bring the 'reality' to doctors and nurses because patients have a social, and not just a medical link with them. They relate to them on the same level" [19]. In spite of higher salaries paid to South African health workers in these categories, the productivity levels are low, there is a lack of commitment and very poor oversight and supervision by administrators within the healthcare system and massive interference by labour unions. When the family health strategy component of Brazil's public healthcare system was implemented in 1994, it leaned heavily on community health workers, because Brazil like South Africa had a serious shortage of doctors and nurses. According to a study in the Journal of Globalization and Health, "Brazil's 257 265 community health workers now cover just over half of the country's population. They make sure that pregnant women get the care they need, help young mothers with breast feeding problems, check whether children receive their vaccinations and ensure that people take their

chronic medication correctly. Community health workers also book home visit appointments." "They have been responsible for a drop of two – thirds in mortality rates of children under five, from 58 per 1000 live births in 1990 to 15. 6 in 2011 [17].

The uptake of vaccines and a host of other necessary and required health variables have improved considerably. They are responsible in curbing disease spread. The vaccination cards issued assisted illiterate mothers to read. Mia Malan [19] reports that "in contrast to South Africa's under five mortality rates are more than triple that of Brazil. In fact all parameters of the health system have improved tremendously because of dedicated community workers and their health teams. In other words in Brazil, the bridge between patients and doctors is in the form of community health workers. In South Africa the bridge has yet to be constructed." South Africa can learn from the Brazilian health model and it might be a worthy strategy to emulate from one of its BRICS partners (Brazil, Russia, India, China and South Africa). Fig. 2 hereunder indicates that Brazil did not only get better at savings children's lives, whilst South Africa got worse at saving mothers' lives.

7. THE SOUTH AFRICAN GOVERNMENTS VISION TO "TRANSFORM SOUTH AFRICA'S HEALTH SYSTEM INTO A SOCIAL SYSTEM: MYTH, REALITY OR FICTION

The South African health system has undergone a number of transitions in the past two decades, post freedom in 1994. The government has often indicated that within the area of health financing, government has at various times intervened in the determination mechanisms in which health services should be financed. Under the leadership of former and late President Mandela government declared primary healthcare services free of charge, initially for children, people with disability and pregnant women, and later on for the entire population. This is more rhetoric on the part of the South African government because implementation has been hampered by a lack of resources, a lack of adequate personnel, poor infrastructure coupled with poor skills, a lack of work ethic and so on. In this regard Karodia states that "research on the primary healthcare system shows that visits have declined and the cost of the prograame is too expensive and is not achieving the desired results" [1] "The introduction of the uniform patient fee schedule for public hospital services was intended to ensure that the population access health services in a rational manner but at the same time that mechanisms are in place to ensure that those who are not able to afford the stipulated fees are not denied access to health services they require," according to Deputy Minister of Health Gwen Ramokgopa [22]. This is a utopian ideal, given that some 25 percent to 45 percent of the population is unemployed, utopian in the sense that the distances in the rural areas are great and people cannot reach the hospitals regularly and often times have to walk for hours to these facilities. In this sense universal healthcare coverage is being denied to the most vulnerable. This is also exacerbated by a lack of medical equipment and medicines in many clinics and hospitals. The situation is dire and government fails to acknowledge these poor healthcare conditions in South Africa particularly for poor and vulnerable people.

South Africa, according to Karodia [1] although has streamlined the private healthcare interventions to strengthen overall private health insurance regulation in the form of the Medical Schemes Act in 1998, for purposes of prescribed minimum benefits, community rating and open enrolment, it does not address access to medical schemes for the poor, but in reality has impacted on the performance and growth of the medical schemes industry. As long as access is not granted to the poor through the proposed implementation of the National Health Insurance Scheme, not much will change in the healthcare system inherited from apartheid and, therefore. Government has to wake up from its deep slumber after 20 years of democracy." Government parades its achievements with regards cutting edge ICT medical technology and fraud detection and prevention. Karodia again points out that government intervention in South Africa is playing to the gallery and shows that there is an implosion of corruption throughout all health departments in the nine provinces of the country, where poor services, fraud, nepotism, poor budgetary controls, the absence and shortages of the most basic medicines is the order of the day" [1,23].

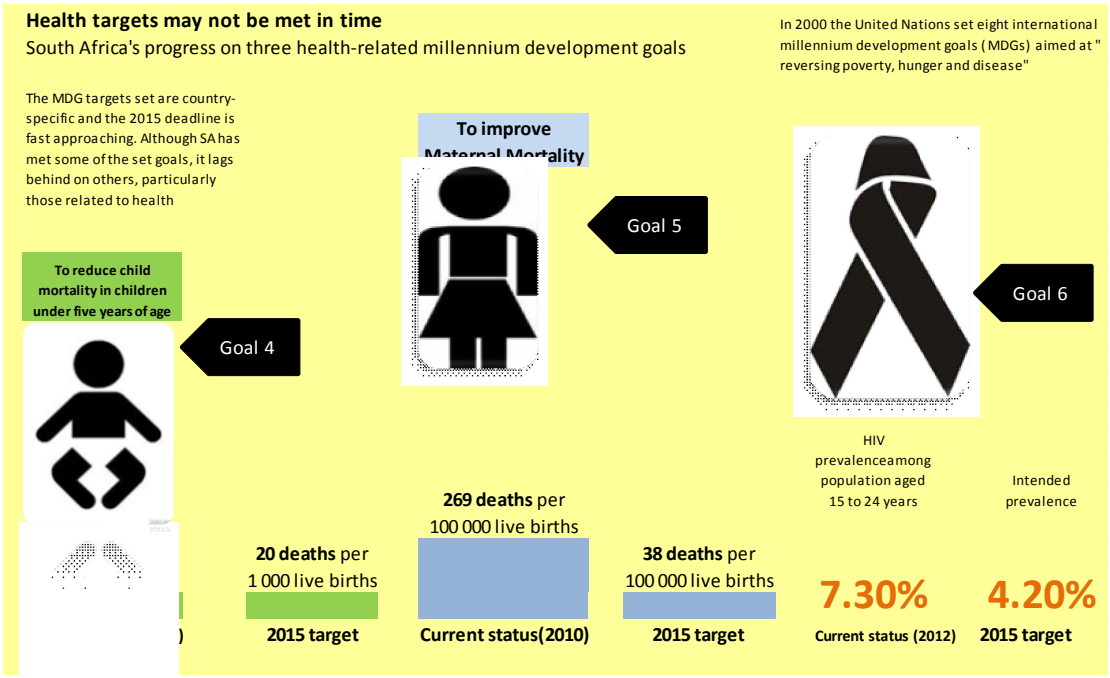

Fig. 1. Health targets may not be met on time
Source: South Africa MDG Report 2013

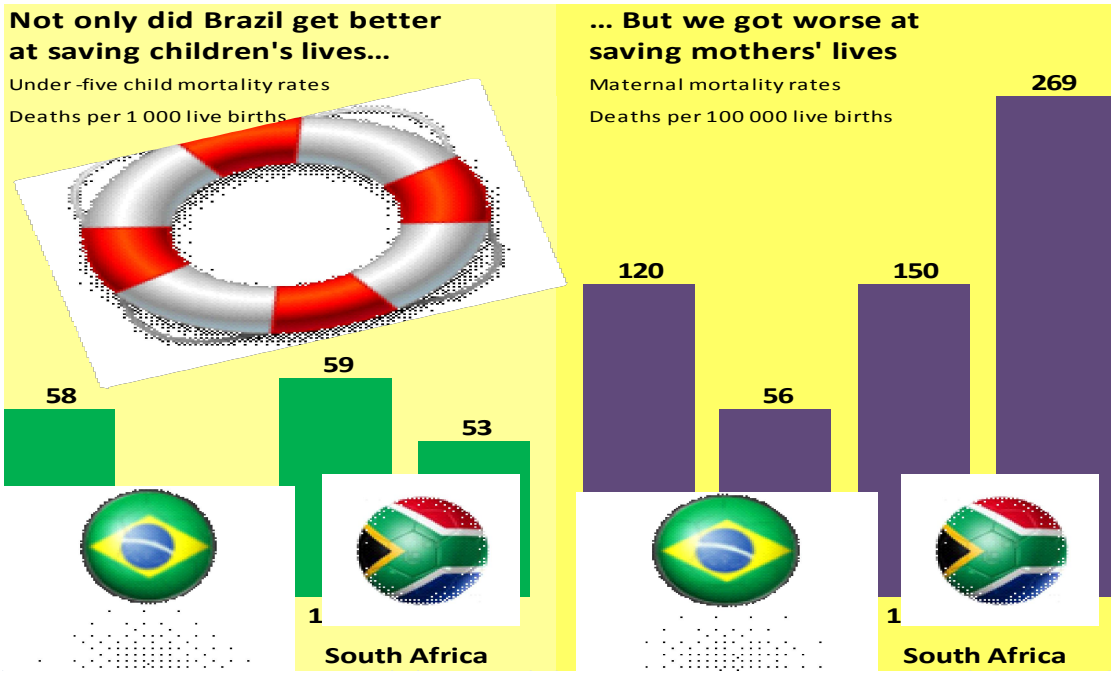

Fig. 2. Mortality rates for Brazil and South Africa

What government does not address adequately in terms of its desire to achieve universal access to healthcare is the all embracing reality that it must be aimed at the sustainable development agenda by finding an appropriate balance between healthcare financing and access to healthcare, as a basic human right. This is not being achieved or rather progress is too slow. It

is an established fact that the majority of the population relies on public sector health facilities; the sector is challenged by a shortage of key human resources and waiting times as well as poor management without the necessary controls has allowed the public health system to be in a state of collapse for several years. On the other hand costs for private healthcare is escalating given the inflation and economic recession in South Africa with rising interest rates and food costs and therefore more people are leaving the Medical Aid Schemes and entering the public healthcare services. Another problem confronting the hospital services in South Africa is the emphasis on hospital – based care with little emphasis upon health promotion and prevention of diseases. The reality is that the public health system is underfunded and the private health sector is shaped on the basis of profit focus and a hospital – centric approach and the government is unable to intervene decisively because it does not have a decisive intervention strategy in order to allow universal access, and moreover, its proposed NHI it appears is a pipe dream and mirage of a distant future.

It must be appreciated that because of the elasticity of demand and the public good characteristics of health, that the 8 percent of GDP in healthcare has not and dies not go into healthcare but to huge profit margins, especially in the private health sector. The government cries foul but fails to regulate the private health sector and has played directly into the hands of the capitalists, who continue to consolidate the neoliberal agenda of the state and at the expense of the poor. This status quo must end and be broken once and for all and the government must take steps to redress the fragmentation of the South African health system depicted in a two – tier system. It therefore has to be a government imperative to protect the rights of the population to health promotion and healthcare services regardless of which sector the population uses (private or public).

Given the arguments in this paper, the government's vision as it stands after twenty years of democracy in terms of transforming South Africa's health system into a social institution is a pipe dream and a vision that is more rhetoric than a cogent and implementable strategy. There needs to be a common vision pointing to social solidarity, risk pooling, efficiency, effectiveness and affordability. It must also be realized by government and its policy makers that the proposed NHI is not a panacea for all of the inadequacies that characterize the South African health system. It can only act as a catalyst to achieving much needed milestones.

8. CONCLUSION

The paper underscores the reality of the deteriorating healthcare system in South Africa. It showed that much still needs to be done and showed that there is an absence of a government willingness to transform the health sector of South Africa. This is because there is some growth without development. The marginals (those living on the edges of prosperity amidst a sea of poverty) are in majority in every African society. There is no sign of the trickle – down effects manifesting itself in South Africa and this is characterized by growth without development. There is no construction of socioeconomic structures in South Africa at present that can address the health problems and challenges of the country. The health sector exhibits growth in the private sector in terms of conventional economic indicators but is stagnant coupled with growing misery for the majority of the population. In former apartheid and colonial South Africa what had occurred, was and is the reality - where the blood of the people has flowed and where the length of the period of armed warfare has favoured the backward surge of intellectuals, it is the national bourgeoisie in South Africa and many African countries that, has taken over from the imperialist powers. These classes of people run their countries very much in the same way that their previous masters had run these countries. "Then there are those men and women who fight in certain measure for the mass participation of the people in the ordering of public affairs" [24]. These are the honest intellectuals who have been shut off in South Africa and excluded from the body politic of South Africa. Their timidity and indecisiveness are partly due to the apparent strength of the bourgeoisie. Therefore, the road to the national bourgeoisie must be closed in order to obtain true and sustained development.

It has to recognized in political discourse with special reference to the political economy of healthcare that that the contribution of the elites and the rising middle classes prevent the attainment of genuine national liberation. As perceived by the national bourgeoisie, its mission in South Africa and other African countries, does not include the transformation of the nation, which puts on a mask of neocolonialism. In order to be able to fulfill its role Offiong quoting Fanon

states "powerless economically, unable to bring about the existence of coherent social relations, and standing on the principle of its domination as a class, the bourgeoise chooses the solution that seems to be the easiest. It does not have conscience and the calm of economic power and the control of the state machine alone can give" [25]. This is the reality in South Africa; the revolution has been subverted by the revolutionary classes that are today's bourgeoisie. This is a great indictment to African and South African leaders as healthcare issues are placed in the background of lip service and the populations of many African countries die because of hunger and starvation, under their watch, whilst they amass large fortunes at the expense of the poor. In reality they perpetuate the master – servant relationship. The South African health sector is in tatters, it is in complete disarray. This is an indictment to the South African liberation struggle, to the current government and to human rights. Something has to be down urgently and this must be done swiftly in order to serve the masses, who have suffered for far too long. The healthcare system requires an urgent overhaul for the benefit of the poor and vulnerable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Karodia AM. The Inextricable Relationship between the Apartheid State and Public Sector Chaos in South Africa. International Journal of Development Research and Quantitative Techniques. 2014;3(2).
2. Bloom BR. Health Research and Developing Nations. Hastings. United States of America; 1976.
3. Jooste K. (editors). Leadership in Health Services Management. 2nd Edition. Cape Town. Juta and Company. South Africa; 2009.
4. South African Health White Paper. Government Printer. Pretoria. South Africa; 1997.
5. Karodia AM. The Impact of Political Legitimacy on the Management of Veterinary Services in the Former State of Bophuthatswana. PhD Thesis. North West University. North West Province. South Africa; 2008.
6. Karodia AM. Health Care Management. A Module for MBA Students. Regent Business School. Durban. Republic of South Africa. Copyright; 2013.
7. Regent Business School. Healthcare Module for MBA Students. January. Durban, South Africa; 2014.
8. Last JM. Public Health and Preventive Medicine. Prentice Hall. London; 1980.
9. Business Day. Insights: Vision to transform South Africa's health system into a social institution. Johannesburg. South Africa. 2014;15.
10. Eagar D. Too much stick, not enough carrot. Health. Mail and Guardian. Johannesburg. South Africa. 2014;34.
11. Booysens SW. (editors). Introduction to Health Services Management. 3rd Edition, Cape Town. South Africa; 2009.
12. Buchan J, Dovlo D. International Recruitment of Health Workers to the UK; 2004. Available:http://www.healthsystemsrc.org/publications/reports/int-rec-main.pdf
13. World Assembly of the World Health Organization. 67th Session of the World Assembly Resolutions. Geneva, Switzerland; 2013.
14. Penford GA. Income and poverty levels: South Africa versus world figures. Mail and Guardian. Johannesburg, South Africa. 2014;14
15. Heywood M. SA can learn from Brazil's health model. In Malan, Mail and Guardian. Johannesburg. South Africa. 2014;16.
16. Karodia AM. The Erosion of Constitutional Democracy, the Rule of Law. Public Accountability and Governance in South Africa. International Journal of Human Development and Sustainability. 2009;6(2):Autumn.
17. United Nations. Statistics on Health. New York and Geneva. Geneva. Switzerland and United Nations, New York. United States of America; 2012.
18. Green. Healthcare in South Africa: Urgent Intervention Required. Mail and Guardian. Johannesburg. South Africa. 2014;11.
19. Malan M. SA can learn from Brazil's health model. Health. Mail and Guardian. Johannesburg. South Africa. 2014;16.
20. Mail and Guardian. South Africa can learn from Brazil's health model. Johannesburg. South Africa. 2014;16.
21. Malan R. How can South Africa settle its health bill? Interview with Bill Gates. Health. Mail and Guardian. 2014;17.

22. Ramokgopa G. Vision to transform SA's health system into a social institution. (In Business Day) June 19. Johannesburg. South Africa. 2014;15.
23. Karodia AM. The Scope of Health Planning on Irrigated Agriculture with Reference to Primary Healthcare, Education and Water Resources. (Referenced for critical analysis only). Unpublished Manuscript. Development Southern Africa. Sandton. South Africa; 1992.
24. Fanon F. The Wretched of the Earth. Translated by Constance Farrington. Grove Press Inc. New York; 1966.
25. Offiong DA. Imperialism and Dependency: Obstacles to African Development. Howard University Press. Washington, D.C. United States of America; 1982.

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