There has been much debate and controversy in respect of healthcare transformation in South Africa. On the other hand media reports indicate a collapse of the South African healthcare system. Public hospitals are under siege, in terms of public opinion from all sectors of society. It is under resourced, poorly run, there are shortages of basic medicines, medical equipment is in short supply or poorly managed, there is an acute and chronic shortage of medical personal, and administrative staff, are not academically equipped to shoulder the burden of modern healthcare. The costs of private healthcare has escalated and is escalating with the passage of time and as each year passes and, more importantly, is now becoming prohibitive and beyond the reach of ordinary citizens. All of this assumes great significance, in essentially a Third World economy. The proposed National Health Insurance Scheme (NHI) is now in pilot form and has contributed and generated much controversy, in spite of its merits and necessity, in respect of overdue implementation, in order to redress the imbalances of healthcare from our historical and sad past. Amongst a host of other issues that plague and confront the healthcare system of the Republic of South Africa, post 1994, it is necessary to ask the question – Is it not better and more plausible for the South African healthcare sector to consider equity rather than modernization, in order to provide sound basic health services to the sun total of the South African population, by consolidating the Primary Health Care Model (PHC) and, thereby, maintaining costs to acceptable levels, in terms of equity and delivery?

There is no doubt that there has been extra – ordinary output in respect of healthcare over the last decade, not only in South Africa, but in many other countries, both so – called ‘First World’ and ‘Third World countries.’ It is therefore incumbent upon the system and government to take a broad, analytic, often normatively and comparatively evaluative view of the entire healthcare system or of its major components. Such an investigation, evaluation and analysis will most certainly have the considerable advantage of a long overdue, overall view of the system. However, it could suffer from an inability to look closely and critically at specific application in a particular area, which might be a serious flaw in discussing a system that serves nearly 60 million people and others from
surrounding Southern African countries, living under a diverse variety of ecologic, economic, social, and cultural circumstances.

South African health literature are microscopic observations and analyses of the operations of specific aspects of the healthcare system in specific areas, are difficult to comprehend, given the task of transforming a system from apartheid healthcare, but this should not be an excuse by the authorities, after nearly twenty years of freedom and democracy, post 1994. It has to be acknowledged by critics that enormous difficulties of access, language, and culture must be overcome in South Africa, to obtain data for purposes of cogency of analysis and for purposes of clarity. It appears that these manifest realities are not understood and appreciated by the Eurocentric population that has historically lived under privileged circumstances. This has increasingly become the order of the day, also among the rising Black middle classes. This is no defence in respect of the government and the South African healthcare system, post 1994. There remain, nonetheless, a series of problems with ‘microscopic’ studies, because in a country like South Africa in which services are characterized by a large degree of decentralization through the nine provinces and due to local autonomy, care has to be taken, not to generalize from observations severely limited in space and time to the current status of the entire system. Compounding the problem in South Africa’s healthcare system is the all embracing reality and fact, given the shortage of medical doctors and medical specialists, in which foreign medical experts are likely to work, or allowed to enter private practice, which remains largely uncontrolled and unregulated and further exacerbated, by the fact that the Department of Home Affairs, doles out permanent residence status and citizenship without stringent controls. Most of these medical professionals are almost always urban – based, and are usually among the most technologically – advanced (many less so), though far less so than comparable institutions and settings in a developed country.

The literature abounds with the contributions in relationship to equity of access by patients to tertiary care, whether in developing of developed countries. In order to understand and critically examine the access question, any study or investigation, would have to study appropriately – selected sample populations from a variety of geographic, socio – economic, and cultural circumstances to determine if patients with equivalent needs in South Africa, have been offered medical care without differential financial, travel, institutional, or other barriers. Equity does not demand that the patient or family accept the care offered. An example, of refusing equity could be justified on religious grounds. In South Africa, with its enormous cultural differences between urban and rural areas, and from region to region, such distinctions are particularly important.

If, for example, any investigation or study is not community – based, but based on a particular tertiary care unit, a number of other methodological issues will arise, for example, are patients from a distant area referred to the unit in fewer numbers or at a more advanced state of the illness than are patients from closer areas because there are adequate secondary care institutions much closer to them? If so, transfer to the tertiary care facility in smaller numbers or at a later stage in the illness may represent better, rather than poorer, access to healthcare. This is not to suggest that the technological level
of medical care in South Africa’s rural areas is adequate by the standards of industrialized countries. It is basically to suggest that a sample of patients in a tertiary care unit is a methodologically – dangerous starting point for a study on equity of access to appropriate healthcare.

This methodological problem can be overcome some what, under special limited conditions, by studying all the institutions in a broad catchment area that offer a particular service, so as to account for all patients in the area receiving the service. This issue is controversial but technological advances in many parts of the world show that, it may increase rather than decrease the inequities between poor and rich and between racial minorities and Blacks in particular, compared to Whites, in South Africa. The question therefore, arises: Can research and development on such technology at public expense, and its performance in institutions publicly subsidized be justified in a society that allocates the technology inequitably? The fundamental priority for resource allocation by the South African National Department of Health in respect of all preventive and therapeutic services and professional education must be through the primary and preventive health services of the state, provided that these services are professionally administered with effectiveness and the requisite efficiency. The goals for the South African healthcare system and the government must be to increase life expectancy, given the gross national product per capita and the amount allocated to healthcare in monetary terms. The preventive services that will make this possible is the provision of safe water supplies, and even more important, efforts to ensure adequate food, housing, clothing and basic literacy for all of South Africa’s people by remaining highly ranked national priorities. Nevertheless that must remain a bulwark of rural primary healthcare and their technical quality is clearly improving in South Africa. The balance between prevention and treatment between city and countryside must be assured by government, also between professionalized, centralized, specialized services and decentralized primary healthcare services provided by locally trained personal. In South Africa the hopes for continued progress and increasing equity are still high, but dangers to continuation of unprecedented progress that South Africa has made are clearly present.

There has also to be a balance in terms of avoidance of unnecessary hospitalization, avoidance of use of expensive medication, laboratory and surgical procedures, without documented benefit, and greater transfer of technologic resources to rural institutions. The question is simple, whether South Africa’s leaders can move in this direction in respect to healthcare and maintain their commitment to prevention, at a time when South Africa is looking for various models, and therefore seem to view rapid ‘modernization, as the central solutions to South Africa’s healthcare challenges and problems, is a critical question, important not only to the people of South Africa, but to people in many parts of the developing world, and particularly to the people of Southern Africa. It is hoped that the South African Health Ministry, health professionals and the South African government, will take cognizance of the issues raised and discussed in this commentary.
REFERENCES AND ACKNOWLEDGMENTS

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