Introduction

A nation now defined by the intersection of the Western and Non-Western worlds, South Africa’s evolving healthcare system provides an invaluable reference for the perils that segregation and class control can create for large groups of a population. Under apartheid, the system propagated such separation in the availability and delivery of medicine to its peoples in a caste-like manner. To be of Western descent in South Africa was a ticket that admitted one to the amenities of Western medicine; those without the whiteness of such validating paper found themselves trapped in substandard care. As apartheid was dissolved with the inauguration of the African National Congress, or ANC, in 1994, a set of goals regarding healthcare reform reflected the burdens created by the inefficient and inconsistent paradigms of segregated care in the decades prior. Still, the inequalities and unpardonable restraints on human rights are not so easily ameliorated with legislature and some of the most critical divisions persisted as a division between the public and private sectors of healthcare. The United States often imagines itself as a model system for other nations to imitate, and we rarely assign equivalent value to the tactics of other nations—especially developing nations. It would be prudent to examine the strengths and pitfalls that other systems have in the development of a more recognizable healthcare plan for our own country and its peoples. It stands to reason that there is much to be gained from studying a country as extreme as South Africa—one that has evolved from developing to developed in a short time span—and one that is plagued by a problem with which America is hesitant to admit itself infected—the constraints of a traditionally hierarchical health care system that consistently favors certain racial and ethnic groups, even if we attempt to claim that the stratification is founded in socioeconomic systems have in the development of a more recognizable healthcare plan for our own country and other nations to imitate, and we rarely assign equivalent value to the tactics of other nations—especially developing nations. It would be prudent to examine the strengths and pitfalls that other systems have in the development of a more recognizable healthcare plan for our own country and its peoples. It stands to reason that there is much to be gained from studying a country as extreme as South Africa—one that has evolved from developing to developed in a short time span—and one that is plagued by a problem with which America is hesitant to admit itself infected—the constraints of a traditionally hierarchical health care system that consistently favors certain racial and ethnic groups, even if we attempt to claim that the stratification is founded in socioeconomic standing alone, thus exempted from the propagation of “separate but equal” undertones in care. “The tragedy is that things are not broken. The tragedy is that things are not mended again.

- Alan Paton

Pre-Apartheid Divisions—Before 1994

• Four separate ethnic or racial groups prevailed: Whites, Asians, Coloreds, and Blacks.
• In the above order, so followed the prestige and importance in a mass triaging of need of good care.
• Same race physicians worked with each population, yet the density of physicians per capita was inversely related to the population of each of these groups. In 1981, there was one physician for every 930 white South Africans, while only one physician for every 9,500 black South Africans.
• Public expenditure on healthcare demonstrated a four-fold amount spent on whites compared to black African groups.
• Such figures exemplify where the emphasis of resources laid within the system; this distribution also insinuates the perception of health and human value at that juncture of time and location.
• Health insurance plans were entirely unavailable to non-white persons until after 1970. Rationing included increased mortality from acute illnesses and a staggering difference in infant mortality rates (2.7% in white populations vs. 20% within black populations).
• Antithesis of the etymology of the word “Health,” from an old Germanic root, “halth,” meaning “whole.” It is not so serendipitous that healthcare is a pelvis extension of the nature of all those grouped together within some political domain.

Goals of the African National Congress

• Eliminate the racial and socioeconomic divisions in healthcare.
• Increase health education in under-represented populations.
• Help equalize the care in rural vs. urban settings (analogous to America’s own healthcare clash in the spirit of Establishment vs. the Hinterlands).
• Immediate Expansion of Programs, prioritizing: Vaccinations, number and staffing of rural care clinics, nutritional and preventative health campaigns, and expanded free access to healthcare for new mothers and children under six years of age.
• These goals are all problematic for the American healthcare system as well, evidencing a common sense identification of issues, but a failure to correctly outline a plan for reasonable actualization.
• Ultimately, a hopeful path to fruition of one, all-encompassing healthcare system as current fragmented care is simultaneously disestablished.

Current Healthcare Challenges:

• South Africa is ranked third in the world for countries with the highest BMIs (United States is first).
• 70% of South African women are overweight, 40% are obese.
• BMI inversely correlates with income.
• Nearly 20% of South Africans are HIV positive.
• Wealthiest 20% has access to 80% of the physicians (those in private sector).

South African Healthcare—Twenty Years Later...

• Economic standing has replaced racial segregation as a driving force of the chaos.
  - Can we really say that America’s system does not fail in a similar way?
  - Furthermore, such a division is still largely determined by racial subjugation.
• While a complete change will undoubtedly take generations, there is still a fundamental problem of adequate governmental funding to hasten a significant impact.
• Problems have been intensified, and confounded, by the increasing prevalence of HIV/AIDS, especially in members of the medical community, as well as multi-drug resistant and extensively drug-resistant tuberculosis.
• Improvements have been made in measures such as infant mortalities, and to a lesser extent, increases in opportunities for education and occupation in healthcare.
• Sadly, these improvements have been matched by worse statistics in other markers of healthcare, such as a decreased life expectancy for the South Africans of both sexes (falling from 63 years in apartheid conditions circa 1990 to 58 years in 2011).

Applications in Solving America’s Healthcare Crisis

• What doesn’t work in any system: Unrealistic and idealistic legislation with little feasibility in appropriation.
• In keeping with this, policy-makers must be vigilant in the active avoidance of development of programs that are inherently doomed due to lack of sustainable government funding.
• Allowing a public and private sector to continue to expand in the difference of care is counter-productive.
  - It is a good thing for more people to receive public healthcare, but the standards of that care should not increase in discrepancy from the “gold standard” of private healthcare quality. Preventative care ought to be ubiquitously accessible.
• We must prioritize both underserved urban and rural healthcare clinics.
• We must prioritize creating opportunities for all races to study careers in healthcare.
• Frequent reevaluation of efficiency and improvisation based on climate of medicine in a broad sense (Ex. what should be changed in response to a mounting problem, such as MDR Tuberculosis, while the problem is still able to slow growth or perhaps even be reversed).
• Reconciliation between the desirable swiftness of improvement and the reality of progress can only be achieved through the aid of idealistic legislation.

The status of healthcare within a population of a certain region reveals the entrenched perceptions of humanity, in terms of innate human value, both at the individual and more aggregate societal levels.

References:


