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## Political Systems and Health Inequity: Connecting Apartheid Policies to the HIV/AIDS Epidemic in South Africa

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### Abstract

South Africa's transition to a post-apartheid government marked a new era of liberation and equality for black South Africans. However, the notions of white supremacy and racial segregation, ideologies of apartheid government, continue to hinder the South African government's attempts to restructure its healthcare system. In addition, new economic drives toward privatization act as a new barrier to the achieving of equality in the South African healthcare system. The persistent inequality in the delivery of health care within South Africa is illustrated in the nation's distribution of HIV/AIDS; black South Africans bear the highest burden of disease. This paper argues that the current inability of the South African government to adequately address the HIV/AIDS epidemic is symptomatic of still-existing apartheid ideologies in the healthcare system, faulty public-private relationships, and structural gaps between health policy making and implementation.

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Approximately 5.7 million people in South Africa are currently living with HIV, and of these people, 3.2 million are women and 280,000 are children under age 14. 17.8% of South African adults aged 15 to 49 are living with HIV, and there are almost 2 million South African children under age 17 who have been orphaned due to HIV/AIDS (UNAIDS, 2011). By overlapping historical analysis of apartheid health policies with current neoliberal discourse, we can witness patterns emerging between HIV/AIDS treatment and incidence disparities and South Africa's political and economic policies.

Starting in 1948, black South Africans became the target of exclusionary and exploitive laws that separated South Africans on the basis of race. The government forced black

South Africans to live in designated areas that were separate from areas inhabited by white South Africans. These areas, known as Bantustans, comprised of merely 13% of South Africa in size but were home to over 80% of the population (Price, 1986). In each Bantustan, a large number of which were situated in rural South Africa, health care was primarily provided by non-profit missionary hospitals and overseen by local elites. By giving control of the healthcare system to individual Bantustans, the national government of South Africa essentially removed its responsibility to monitor and account for the quality of health services in those areas. Due to little government regulation and oversight of privatized health care during apartheid, health services in Bantustans frequently ignored quality-of-care guidelines and became

places of abuse and maltreatment (Kon & Lackman, 2008).

In many cases, black South Africans who resided in urban areas were largely employed as caregivers, cooks and laborers, and other jobs that put them in contact with the white South African population. Basic health services were provided by the South African government to urban blacks to prevent them from spreading disease to the white South African population that inhabited urban areas (Price 1986). Because very few white South Africans resided in Bantustans, there was little interest amongst South African health policymakers to ensure that basic health care would be provided in rural hospitals. The odds of continuous contact between black populations of Bantustans and white South African populations were low.

Almost two decades after the end of apartheid, vast disparities exist in South African HIV/AIDS prevalence and health care. For example, HIV prevalence in the more urbanized Western Cape province is at 15.1%, in comparison to KwaZulu-Natal, which has an HIV prevalence of 39.1% (UNAIDS, 2011). In addition, infant mortality was 20% among blacks but only 2.7% among whites; life expectancy was 55 years for blacks and 70 years for whites. There was one physician for every 330 whites but only one for every 91,000 blacks (Kon & Lackman, 2008). In addition to diffusing its responsibility to provide national health services, the apartheid-era government limited the budgets for rural health systems. In 1978, for example, merely 0.23% of the South African GNP was allocated to health systems in Bantustans whereas 2.3% was given to urban health centers (Price, 1986).

Even while Bantustan health care was already subject to limited funding and inferior services, the organization and execution of health care within rural areas furthered ethnic divisions. Delivery was organized through ethnically segregated health services that simultaneously reinforced apartheid ideologies of racial division. Hospitals in Bantustans were “staffed by people from the ethnic group of the relevant authority and who were supposed to treat only patients of the same ethnic group” (Price, 1986). As a result, workers and patients were forced to think not only in terms of black and white but also in terms of their sub-ethnic identity, in a setting of communities subdivided based on kinship lineages and marriage. This, in turn, contributed to ethnic consciousness centered on the belief that people needed to be separated into ethnically homogenous nation-states in order to minimize conflict. Such relationships illustrate the broader connection between politics, socialization, and health outcomes. Moreover, even after the end of apartheid, the goals of securing white supremacy and promoting racial segregation set by the apartheid government continued to inhibit South Africa’s potential to implement effective health policies that aimed to reduce social disparities in terms of access, quality of service, and treatment.

Driven by the growing needs of the South African urban middle class during the 1980’s, the emergence of the private healthcare system has made it increasingly difficult for black South Africans to access high quality public health care and treatment (Hunter, 2010). Despite the fact that only 15% of the South African population has access to the private healthcare sector, patients received subsidies and tax benefits for contributing to the private health sector (Kon & Lackman, 2008). The majority of private health facilities are located

in urban areas, not accessible to the black population of the Bantustans. The high costs of private healthcare made it especially unaffordable for indigenous, black South Africans (Kon & Lackman, 2008). Moreover, the influx of funding into the private sector has drawn medical professionals out of public facilities due to the attractiveness of sounder infrastructures and higher profit margins in the private healthcare sector. By the early 1980’s, 40% of South African healthcare professionals worked in the private sector, but, by the 1990s, that percentage had climbed to 66% (Kon & Lackman, 2008).

Overcoming the unequal distribution of human resources between the public and the private healthcare system is a major existing problem in South Africa. Health care professionals in rural clinics tend to have more poorly developed skills and less management experience, and the entire South African public health system is plagued by understaffing and overcrowding of patients (Coovadia et al., 2009). Compounded by the presence of hundreds of community health workers sponsored by non-governmental organizations, there is little standardization in terms of the training, oversight, and supervision of South African healthcare workers, which, in turn, has compromised the delivery of key programs in child health, maternal health, tuberculosis, and HIV/AIDS (Coovadia et al., 2009). In 1990, when privatization of healthcare was still in its elementary stages, the HIV/AIDS prevalence was 0.7% in South Africa; however, by 1994, the HIV/AIDS prevalence was 8%.

When the post-apartheid government came into power, it promised to alleviate the division between the public and private sectors through the unification of Bantustan health systems under the jurisdiction of provincial and national healthcare systems. As a result, the rural health sector was consolidated from 400 independently-run local systems into nine provincial healthcare systems (Kon & Lackman, 2008). Although responsibility for implementing public programs remained at the provincial level, the national government sought to ensure that the collection and distribution of revenue was equitable, and it set new standards for service provision (Schneider & Stein, 2001). In collaboration with the National AIDS Committee of South Africa, the new government also introduced a National AIDS Plan that would place the prevention and treatment of HIV/AIDS at the forefront of the nation’s health policy.

Under the leadership of the post-apartheid government, the National AIDS Plan initiated a cooperative effort to alleviate the burden of HIV/AIDS on the South African population through the promotion of primary health care, preventative interventions, and educational initiatives regarding condoms, safe sex and treatment options—all of which focused heavily on government action via the local level (Wouters, Rensburg, & Meulemans, 2010). While the push to offer such programs to South Africans at the local level was a progressive idea that recognized local diversity and attempted to strengthen the Bantustan health system, the National AIDS Plan grossly overlooked the inability of existing functional organizations and infrastructures to comply with the new standards. South African healthcare became increasingly fragmented and decentralized by this particular policy. At the time, local leaders were ill-equipped to manage the organizing, problem solving, and coordinating needs of the National AIDS Plan (Schneider & Stein, 2001). Consequently, the National

AIDS Plan was unable to counter the transmission of HIV/AIDS or provide necessary treatment to HIV-positive patients.

The failure of the post-apartheid government to address HIV/AIDS highlights the importance of making policies compatible with feasible implementation strategies. The National AIDS Plan was a strategy that was hampered by political instability, concurrent societal reconstruction, and a weak pre-existing healthcare infrastructure. A likely result of the demands made by the black South African population for treatment, government funding for the treatment of HIV/AIDS rose from 6.6% in 2001 to 59.3% in 2004 (Wouters et al., 2010).

Since the seeming failure of the second government's attempt to mount a national strategy against HIV/AIDS and decrease HIV/AIDS mortality and prevalence, the international community has vehemently criticized the inability of the South African government to adequately address the needs of civil society, to involve its citizens in the process of healthcare policy making, and to address the lack of overall governmental accountability in the provision and division of healthcare funds. As a result, the latest National Strategic Plan on AIDS 2007-2011 has incorporated national, non-governmental, and civil bodies, and it has been hailed as "South Africa's most dynamic and comprehensive document yet on AIDS issues" (Wouters et al., 2010). The National Strategic Plan prioritized prevention of HIV (mother to child and among youth), HIV treatment, and HIV research, monitoring and surveillance, with an emphasis on increasing access to HIV/AIDS treatment (Wouters et al., 2010).

However, while the National Strategic Plan 2007-2011 has addressed numerous pressing issues from previous policy failures, it nonetheless fell short of its goals. The main objective of the 2007-2011 Plan was to extend treatment to the majority of people with HIV/AIDS; however, because of poor budgeting and limited human resources, the potential success of this plan was unmet, leading instead to a decrease in treatment options for people with HIV/AIDS. Additionally, the private sector continues to harbor the majority of healthcare professionals even though the public sector supports 82% of South Africans (Wouters et al., 2010). Despite the population's dependence on the public healthcare system, only one out of every three South African doctors works in the public sector, which has become heavily supported by professional nurses. Yet, at the same time, the ratio of nurses to patients within the South African healthcare system as a whole has declined from 251 to 110 per 100,000 South Africans between 1994 and 2007 (Wouters et al., 2010). Although the National Strategic Plan 2007-2011 was formulated using a multi-sector, interdisciplinary approach and with consideration of the failures of past plans, its ideals and aims failed to be in sync with its actual capacity for implementation.

As South Africa nears the end of its latest National Strategic Plan, it is moving closer to developing manageable and feasible ways to address HIV/AIDS. Review and evaluation of the success of the current plan will undoubtedly point to financial budgeting and equal distribution of human resources as key areas for improvement. It is important to be mindful that the elimination of social services that help black South Africans obtain jobs and education and the increasing privatization of the South African healthcare system would further push poor black South African communities into situations of inequity, analogous to those seen during apartheid.

The South African government inherited a political system characterized by unequal distribution of wealth and resources in addition to the challenge of rising HIV/AIDS prevalence in its black population. Whereas the private sector was largely supported by the international community and continues to provide high quality care, it is also extremely limited in scope. Despite increased pressure from international communities to reduce public healthcare expenditure in favor of privatization, the government should be more conscious of the needs of the black South African population when making healthcare policies. Similar to the HIV and AIDS and STI National Strategic Plan 2007-2011, long term solutions that address funding and the redistribution of human resources will give South Africa the potential to overcome the legacy of apartheid and effectively reduce the impact of HIV/AIDS on the South African population.

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