

**PUBLIC HEALTH POLICY IN RESOURCE ALLOCATION: THE ROLE OF UBUNTU ETHICS IN  
REDRESSING RESOURCE DISPARITY  
BETWEEN PUBLIC AND PRIVATE HEALTHCARE IN SOUTH AFRICA**

**by**

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April 2019

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## **DEDICATION**

I dedicate this thesis to my family, CJ and Ogi.

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## **LIST OF ABBREVIATIONS**

AIDS – Acquired Immune Deficiency Syndrome

CDC – Centre for Disease Control

COPC – Community Oriented Primary Care

CCEAM – Commonwealth Council for Educational Administration and Management

CHW – Community Health Workers

DCST – District Clinical Specialist Team

DHA – District Health Authority

DHS – District Health System

FPL – Food Poverty Level

GDP – Gross Domestic Product

GP – General Practitioner

HIV – Human Immunodeficiency Virus

HPCSA – Health Professions Council of South Africa

LBPL – Lower Bound Poverty Line

LCS – Living Conditions Survey

MDG – Millennium Development Goals

NCD – Non-Communicable Diseases

NDP – National Development Plan

NGO – Non-Governmental Organization

NHA – National Health Act

NHI – National Health Insurance

NPC – National Planning Commission

OECD – Organization for Economic Cooperation & Development

PHC – Primary Health Care

SDH – Social Determinants of Health

SHT – School Health Teams

STATS SA – Statistics South Africa

TB - Tuberculosis

TFR – Total Fertility Rate

UBPL – Upper Bound Poverty Line

UCT – University of Cape Town

UHC – Universal Health Coverage

UN – United Nations

U5MR – Under 5 Mortality Rate

WBOT – Ward Based Outreach Teams

WHA – World Health Assembly

WHO – World Health Organization

XDR-TB – Extreme Drug Resistant Tuberculosis

## ABSTRACT

This thesis under the title “Public Health Policy in Resource Allocation: the Role of Ubuntu Ethics in Redressing Resource Disparity between Public and Private Healthcare in South Africa” explores health care disparities pertaining to resource allocation between public and private sector. It is of relevance and importance in South Africa where 54% of the population live on less than US\$3 per day. Although the government has instituted certain changes aimed at transforming the public health care system, the resource allocation gap between the two persists and remains wide. The research gives special attention to the role that Ubuntu ethics can play in redressing the resource allocation disparities between public and private health care sectors in South Africa, pointing out the existing gap in financing, as well as human resource between public and private health care sectors, which leads to poor health outcomes in public sector. Therefore, the problem is the prevalent inequality of resource allocation between private and public health care sectors.

The analysis of policy gaps, as well as evaluating the cause of disparities in the health system is the goal of this research. The study endeavours to redress the disparities within the context of Ubuntu ethical principles and proposes a change in public policy so as to enhance healthcare for the benefit of the people. The study is philosophical and ethical, so the methodology used is discursive in nature, majorly focusing on critically reviewing existing literature, that is, the philosophical resources on Ubuntu ethics and justice theories as well as a range of government resources inclusive of public health policy documents.

Social determinants of health and their impact in a South African context are discussed with the implication that health is not merely freedom from disease and or incapacity, but rather being well mentally, physically and socially. The attainment of a healthy status goes beyond ability to access healthcare services, and incorporates social determinants including but not limited to conditions in which people have been born into, stay, establish career and grow old in. It also includes the arrangements put in place to deal with illness and determine health. Issues of revenue, literacy, communal safety networks, vocation and conditions under-which vocation is undertaken, lack of work and vocation insecurity, early stages of human development, gender, cultural group, dietary insecurity, housing communal exclusion and disability all come into the picture as factors that determine health. But there is also discussion of the socio-economic status as contributors to health inequity wherein alcohol

abuse, sugar intake, and smoking are identified as behavioural factors that complicate public health.

One outstanding feature of this research is that it establishes a link between Ubuntu and public health policy. The researcher establishes that Ubuntu ethics is appropriate for not only discussing public morality, but also for formulating public policy that is morally tenable for South Africa, especially for the public health sector. This thesis calls for an application of Ubuntu in a proper context in order to enhance societal well-being for the benefit of many, if not all. The research proposes the fundamental principle of Ubuntu ethics in which the good of the community is as important as the good of every member of the community. Since Ubuntu ethics does not merely seek to fulfil what benefits the majority, as would be the case in a utilitarian society, the researcher advocates for the building of consensus on the common good, which should be understood to imply not just what is good for everyone in the community, but also what is good for the continued well-being of the community as a single unit. In this regard, the research finds it important that deliberate effort be made to integrate Ubuntu ethics into policies, citing the example of the National Health Insurance (NHI). The good health of all the members of a community is an assurance of the well-being and continuity of the whole national community. The research concludes that public health policy should integrate Ubuntu ethical values such as community, sharing, care, solidarity, identity, harmony, respect, and dignity into policy documents and legislation.



## OPSOMMING

Hierdie proefskrif onder die titel "Openbare Gesondheidsbeleid in die toekenning van hulpbronne: die rol van ubuntu-etiek om die hulpbronverskil tussen openbare en privaat gesondheidsorg in Suid-Afrika reg te stel" ondersoek gesondheidsverskille ten opsigte van hulpbrontoewysing tussen openbare en private sektor is van belang en belangrik in Suid-Afrika waar 54% van die bevolking minder as US \$ 3 per dag leef. Alhoewel die regering sekere veranderinge ingestel het wat daarop gemik was om die openbare gesondheidsorgstelsel te transformeer, bly die hulpbrontoekenningsgaping tussen die twee voort en bly wyd. Die navorsing gee besondere aandag aan die rol wat Ubuntu-etiek kan speel om die hulpbrontoewysingsverskille tussen openbare en private gesondheidsorgsektore in Suid-Afrika te herstel, en wys daarop dat die finansiële gaping tussen openbare en private gesondheidsorgsektore gefinansier word, wat lei tot swak gesondheid uitkomst in die openbare sektor. Daarom is die probleem dat die heersende ongelykheid van hulpbrontoewysing tussen privaat en openbare gesondheidsorgsektore.

Die ontleding van beleidsgapings, sowel as die oorsake van ongelykhede in die gesondheidstelsel, is die doel van hierdie navorsing. Die studie poog om die ongelykhede binne die konteks van Ubuntu etiese beginsels reg te stel en stel 'n verandering in openbare beleid voor, ten einde gesondheidsorg tot voordeel van die mense te verbeter. Die studie is filosofies en eties. Die metodologie wat gebruik word, is diskursief van aard. Hoofsaaklik fokus dit op die kritiese hersiening van bestaande literatuur, dit wil sê die filosofiese bronne van Ubuntu-etiek en geregtigheidsteorieë, asook 'n verskeidenheid staatshulpbronne, insluitende openbare gesondheids beleidsdokumente.

Sosiale determinante van gesondheid en hul impak in 'n Suid-Afrikaanse konteks word bespreek met die implikasie dat gesondheid nie bloot vryheid van siekte of onbevoegdheid is nie, maar eerder geestelik, fisies en sosiaal goed is. Die bereiking van 'n gesonde status gaan verder as die vermoë om toegang tot gesondheidsorgdienste te verkry, en sluit sosiale determinante in, insluitende maar nie beperk nie tot die omstandighede waarin mense groei, leef, werk en ouderdom en die stelsels wat in plek is om siekte te hanteer, gesondheid bepaal. Kwessies van inkomste, onderwys, sosiale veiligheidsnetwerke, indiensneming en werksomstandighede, werkloosheid en werksonsekerheid, vroeë kinderontwikkeling, geslag, ras, voedselonsekerheid, behuising sosiale uitsluiting en gestremdheid kom almal in die prentjie as faktore wat gesondheid bepaal. Maar daar is ook

'n bespreking van die sosio-ekonomiese status as bydraers tot gesondheidsaardigheid waarin alkoholgebruik, suiker inname en rook geïdentifiseer word as gedragsfaktore wat die openbare gesondheid bemoeilik.

Een uitstaande kenmerk van hierdie navorsing is dat dit 'n verband tussen Ubuntu en openbare gesondheidsbeleid vestig. Die navorser stel vas dat Ubuntu-etiek gepas is om nie net openbare moraliteit te bespreek nie, maar ook om openbare beleid te formuleer wat vir Suid-Afrika moreel aanvaarbaar is, veral vir die openbare gesondheidssektor. Die tesis vereis dat ubuntu in gepaste konteks aangewend word om maatskaplike welsyn tot voordeel van almal te verbeter. Dit stel die fundamentele beginsel van Ubuntu-etiek voor, waarin die gemeenskap se belang net so belangrik is as die voordeel van elke lid van die gemeenskap. Aangesien die Ubuntu-etiek nie net probeer om te voldoen aan die voordele van die meerderheid, soos die geval sou wees in 'n utilitariese samelewing, bepleit die navorser vir die opbou van konsensus oor die gemeenskaplike goed, wat verstaan moet word, impliseer nie net wat vir almal goed is nie in die gemeenskap, maar ook wat goed is vir die volgehoue welsyn van die gemeenskap as 'n enkele eenheid. In hierdie verband vind die navorsing dit belangrik dat doelbewuste pogings aangewend word om Ubuntu-etiek in beleid te integreer, met verwysing na die voorbeeld van die Nasionale Gesondheidsversekering (NHI). Die goeie gesondheid van alle lede van 'n gemeenskap is 'n versekering van die welsyn en kontinuïteit van die hele nasionale gemeenskap. Die navorsing het tot die gevolgtrekking gekom dat die volksgezondheidsbeleid Ubuntu se etiese waardes soos gemeenskap, deel, sorg, solidariteit, idenititeit, harmonie, respek en waardigheid in beleidsdokumente en wetgewing moet integreer.

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## CHAPTER 1: STUDY BACKGROUND AND RATIONALE

### 1.1 INTRODUCTION

Exploring health care disparities pertaining to resource allocation between public and private sector is of relevance and importance in South Africa. Despite the changes made by the government to transform the public health care system, the resource allocation gap between the two persists and remains wide. This research focuses on public health policy in resource allocation, giving special attention to the role that Ubuntu ethics can play in redressing the resource allocation disparities between public and private health care sectors in South Africa. The South African health care system “is two-tiered financially, and in terms of organizational structure; and it is highly inequitable both in access and quality” (Surender, 2014). This two-tier health system came into existence during the colonisation era. To the present day, it emulates “a deeply unequal society which is a result of apartheid health system” (+Section27, 2012-13). During colonisation, “policies focused on economic and health advances only beneficial to the white people in the first 80 years of the 20<sup>th</sup> century” (Benatar, 2013). Inequity<sup>1</sup> and inequality in health care not only is the result of apartheid, but it also results from slow transformation processes in socio-economic status amongst the different population groups of South Africa. Prof Solomon Benatar (2013) states that, “despite certain areas of progress in the country since 1994, disparities in wealth and health are among the widest in the world.” These disparities in wealth distribution directly or indirectly determine access to health care facilities. Those who are more financially sound are in a better position to access quality health care, mainly through private health, while it is the opposite for the average South African and those living below poverty line. The study is instigated by the grim facts and reality of inequality in resource allocation between the public and private health care sectors.

### 1.2 RATIONALE FOR THE STUDY

According to WHO (2015 a), “South Africa’s health expenditure levels compare well with those of its upper-middle income peers. In 2013, the total health expenditure constituted 8.9% of Gross Domestic Product [GDP]” per annum. As reiterated by Smith (2016),

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<sup>1</sup>According to Braveman and Gruskin (2003), “inequities are unjust and unnecessary”. Deduced from the definition of equity offered by WHO, inequity can be defined as the presence of “avoidable or remedial differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically”. [www.who.int/healthsystems/topics/equity/en](http://www.who.int/healthsystems/topics/equity/en). Accessed 11 August 2017

the World Bank Development Indicators showed in 2015 that this is “higher than the average share of 6.3% of the total health expenditure percentage of GDP” between the “upper middle-income” nations, just modestly “below Brazil’s 9.7% total health expenditure as share of GDP, and exceeds China’s 5.6%.” In the same thought line, Benatar points out that “Over the past 30 years, expenditure for health care in private sector has grown to consume a much larger proportion of the total national expenditure on health” (2004). He further notes that, “in the 1970’s, 30% of all the health care expenditure were concentrated in the 20% of the population that had private insurance. Today, approximately 9% of the nation’s GDP is spent on health care, with 60% of these funds going to care for the 18% of citizens who have private health insurance” (Benatar, 2004:81-2). Inequality in human resource allocation also exist between private and public health sectors. According to Prof Solomon Benatar (2004: 82), “the percentage of physicians who work in the private sector and care for patients with insurance has grown from 40% in the 1970’s to 66%” over a decade ago. Five years ago, on a study done by Econex, it was revealed that the public sector has “25 doctors per 100 000 people and 92 per 100 000 in private sector, with an average of 60 per 100 000 in South Africa” (<https://m.news24.com>, October 2016). South Africa’s average doctor-patient ratio is below half of the World’s average which is said to be at “152 per 100 000”. From the doctor-patient ratio statistics compiled by Econex and published by News24, the disparity of healthcare professionals between public and private sector is quite obvious. The contributing factors to these gaps could be that, the public sector has poor working conditions and the remuneration rates probably higher in private health care sector.

A financing gap between public and private health care sectors exist, and it could be accountable for poor health outcomes in public sector. According to WHO (2015a), “in 2013, the total government expenditure on health was equivalent to 14% of total government expenditure. Of the total spent on health, 51.5% was private health expenditure and 48.4% was public health expenditure” (Smith, 2016). The inequality of resource allocation that is evidently reflected above is not only confined in wealth and health, but rather spread out through all the aspects of social structure in South Africa. According to Leibbrandt, Woolard, Finn, *et al* (2010), “in 2008, about 54% of South Africans had an income below 3 USD per day.” The “top 10% of the South Africans account for 58% of the annual national personal income, while the balance of 70% of South Africans received a mere 16.9%” (Benatar, 2013). “The Gini co-efficient, a measure of income inequality, increased from 0.6 in 1995 to 0.679 in 2009”

(National Planning Commission [NPC], 2011). More elaborate facts and figures will be explored in Chapter Two of this research.

Prior to democracy, discriminatory practices that benefited the minority group during apartheid pervaded the socio-economic and all other aspects of life. In “the periods from 1950’s to late 1980’s, urban health development was characterised by publicly funded hospital construction accompanied by an expanding private sector, both skewed towards privileged White minority group” (Tollman & Pick, 2002). The remnants of past policy practices are still pervasive today, reflected as disparities of resource allocation between public and private health care sector. This is affirmed by Ataguba *et al* (2012) who state that:

“decades after the end of the apartheid dispensation, deep and deepening disparities, inequalities and inequities still prevail in the distribution of resources, in access to healthcare services, and in quality of care delivered and received by the South African population, and that they are still present between public and private health care sectors.”

According to Prof Benatar and Prof Van Rensburg (1995:19) “...the healthcare system” in South Africa during apartheid has been “mainly influenced by forces reflecting the core of (predominantly Western and increasingly economic) values common to the subculture of medicine” world. In this research, by applying Ubuntu ethics, I hope to incorporate in the recommendations an African value system that will resonate with the South African policy makers. By suggesting an adoption of African Moral Theory or Ubuntu ethics into Public Health Policy, it is not to asset that there is only one African global sight which exists, nor am I claiming that the conceptions put forward by the African moral theory are solely African. Furthermore, it is not to claim that Ubuntu ethics will be the only solution to the disparities, but the ultimate goal is to come up with suggestions that will be all-inclusive, and implementable in a public health policy that can be beneficial to most, if not all persons living in South Africa.

### **1.3 STATEMENT OF THE PROBLEM**

The identified problem under study is inequality of resource allocation between private and public health care sectors.

According to Sweeney & Johnson, (2007), “the healthcare industry is one of the largest industries in the service sector.” For any country or nation, one of the crucial aspects of

service delivery is providing healthcare services to enable the economy to survive. It is essential to provide this crucial service for the economy to survive and this is affirmed by Fitzsimmons, Fitzsimmons & Bordoloi (2014), who state that, “the provision of health care services is a crucial aspect of service delivery for any nation to survive and for the people therein to prosper”. The current public healthcare sector status is that of being under-funded in addition to limited resources and is over-burdened with disease in the light of HIV & AIDS epidemic. As already alluded to, South African healthcare system is a two-tier system divided between private and public sectors. In a paper written by Jobson (2015), it surfaces that the healthcare system division is a consequence that resulted from “the unjust system that has taken place over the past 300 years.” From literature review it surfaces that the healthcare system fragmentation is a legacy of the apartheid regime. The fragmentation of the healthcare system has subsequently led to division in the healthcare services. This division entailed providing services primarily to the minority group. According to Coovadia, Jewkes, Barron, Sanders and McIntyre, (2009), “the fragmentation in the health care services that has been a noticeable feature of the history of healthcare services in SA, is not only between the public and private sectors, but also within the public healthcare sector”. The aforementioned characteristics are traceable abaft “to the days in South African history where healthcare facilities were racially segregated; and both curative and preventative healthcare services were separated by the Public Health Amendment Act of 1897” (Coovadia *et al*, 2009; Arhete & Erasmus, 2016), under the ruling government at the time. The point of focus for medicine and medical technology was on curative measures rather than preventative; and hospital care in urban areas was designed to meet the health needs of the minority population group under the apartheid regime. According to Coovadia *et al*, (2009), “...further fragmentation in the healthcare was entrenched when the Bantustans<sup>2</sup> were formed, each with its own health

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<sup>2</sup>*Encyclopædia Britannica* explains the term Bantustan as follows: “Bantustan, also known as Bantu homeland, South Africa homeland, or black state, any of 10 former territories that were designated by the white-dominated government of South Africa as pseudo-national homelands for the country’s black African (classified by the government as Bantu) population during the mid- to late 20th century. The Bantustans were a major administrative device for the exclusion of blacks from the South African political system under the policy of apartheid, or racial segregation. Bantustans were organized on the basis of ethnic and linguistic groupings defined by white ethnographers; e.g., KwaZulu was the designated homeland of the Zulu people, and Transkei and Ciskei were designated for the Xhosa people. Other arbitrarily defined groups provided with Bantustans were the North Sotho, South Sotho (see Sotho), Venda, Tsonga (or Shangaan), and Swazi. Despite the efforts of the South African government to promote the Bantustans as independent states, no foreign government ever accorded diplomatic recognition to any of the Bantustans.” (Source: Bantustan: Historical Territory, South Africa. <https://www.britannica.com/topic/Bantustan>).



department, during colonisation.” By the time apartheid regime ended, “there were fourteen separate departments that were set in South Africa, one for each racial group [White, Coloured, Indian and Black] and one for each nominally independent apartheid homeland, resulting in fragmentation, duplication and differential funding” (Coovadia *et al*, 2009). With this brief background information, it becomes clear and easy to appreciate that the fragmentation led to disparities not only in resource allocation, but also in access to quality healthcare services, training of healthcare professionals and work conditions. In this context, the goal of this research is to pursue and establish potential equal and equitable solutions in healthcare that will benefit South Africans at large, irrespective of gender, race, or socio-economic background.

#### **1.4 PURPOSE OF THE STUDY**

The research seeks to analyse policy gaps and attempts to establish the cause of resource allocation disparities between these two health systems while in pursuit of finding an implementable solution to redress the disparities. The research will apply distributive justice within the context of Ubuntu ethic principles and suggest a proposal that constitutes viable solutions to the challenge, thereby reducing the current inequity in the South African healthcare system. The research proposes a change in policy so as to enhance healthcare services for the benefit of the people.

#### **1.5.1 ASSUMPTIONS AND RESEARCH QUESTIONS**

##### **1.5.1 Assumptions**

- a) It is assumed that South African people have an unequal and unequitable access to good quality health care.
- b) It is assumed that equal and equitable resource allocation will or can lead to improved access to health care and good health outcomes for many, if not all.

##### **1.5.2 Hypotheses**

- a) It is hypothesised that through integration of Ubuntu ethics in provision, development and implementation of policy frameworks, equal and equitable access to health care by many, if not all in South Africa can be achieved.
- b) It is hypothesised that through incorporation of Ubuntu ethics in public health policy in resource allocation, the Constitutional right to access healthcare can be realised.

### 1.5.3 Research Questions

- a) What are the causes of unequal and inequitable resource allocations between private and public health care sectors?
- b) What are the implications and or the impacts of unequal resource allocation for the general public without means to access private health care?
- c) How can allocation and management of resources be improved in public health?
- d) How can Ubuntu ethics assist policy makers in addressing the challenge of distributive justice in resource allocation in South Africa?

### 1.5.4 Research Design and Methods

Given that the nature of this study is philosophical and ethical, the methodology used is discursive in nature, majorly focusing on critically reviewing existing literature, that is, the philosophical resources on Ubuntu ethics and justice theories as well as a range of government resources inclusive of public health policy documents. Throughout the study I remained in constant engagement and close consultations with my supervisor Dr L. Horn. I have also critically reviewed justice theories and Ubuntu ethics in order to apply the principles in establishing a solution for the problem under research.

On a brief note below, I discuss what I understand about Ubuntu ethics, and define what role it may play integrated together with justice, specifically distributive justice, in resource allocation in general.

Ubuntu is an African moral theory that “addresses our interconnectedness, our common humanity and our responsibility to each other that flows from our connection” (Nussbaum, 2003). By African, it does not necessarily imply exclusivity to Africans alone or the whole of Africa. From the literature it emerges that the origin of the word ‘Ubuntu’ is linked or traced back to the “Bantu/Nguni” speaking people in some or many parts of Sub-Saharan Africa.

To great extent, human beings are closely intertwined and somewhat rely on each other with liability or obligation to secure the well-being of the other. For in the absence of someone else, a person cannot be a complete person in seclusion or isolation. This conception is concisely expressed by Shutte (2001), “our deepest moral obligation is to become more fully human. And this means entering more and more deeply into community with others. So, although the goal is personal fulfilment, selfishness is excluded.” Enshrined in the South

African Constitution is the Bill of Rights amongst which is the right to access to health care for all, in turn promoting and protecting the well-being of people. In taking reasonable measures by government in realising these rights, I think Ubuntu moral theory exhibits value system that embraces the notion of helping those who cannot help themselves. Ubuntu ethics encourages a sense of sharing one's goods for everyone's benefit; and a sense of caring for all persons, "for in your existence I, too, exist." At the core of Ubuntu moral theory is an expression of general truth which states that "a person is a person through other persons" which is a direct translation of "*umuntu ngumuntu ngabantu*" for Nguni speakers (Metz, 2010). Ingrained in this expression of general truth is the conception that a person cannot completely be him/herself in the absence of another person. It then follows that without people belonging to a nation, the government can never be fully functional as a government. There would be no one to elect anyone into any government position and the existence of the government would cease without the people of the nation to serve, and there would be no-one's well-being to maintain and sustain.

## CHAPTER 2: OVERVIEW OF THE PROBLEM

### 2.1 INTRODUCTION

Socio-economic inequalities exist amongst the different population groups in South Africa, a statement of fact readily apparent to anyone living in South Africa. In this country, these inequalities date back to colonial times and are not only confined to healthcare sector, but rather widespread throughout the other sectors. These socio-economic disparities are not unique to South Africa, but affect many other people inhabiting other countries, whether developed and developing. From reviewing existing literature on *Social and Economic Determinants of Health* it comes to the fore that despite “medical and technological advancements” in the healthcare sector, health inequities between population groups in South Africa remain wide and are seemingly increasing (WHO, 2016, [www.afro.who.int](http://www.afro.who.int)). The inequalities that exist within and between countries are a source of challenges globally. At the core of the “principle of the World Health Organization [WHO] is equity in health” (Ibid). In a conference held in 1978 by WHO, in the declaration of Alma-Ata, it was acknowledged that “the existing gross inequalities in the health status of the people between developed and developing countries, as well as within countries is politically, socially, and economically unacceptable” (Alfredsson & Tomasevski, 1998). It was further stated that “governments have a responsibility for the health of their people which can be fulfilled only by provision of adequate health and social measures” (Ibid). The attainment of health, as well as economic and social development, is of relevance and essence to decrease the gaps currently existing in South Africa between different population groups.

As reiterated by Heywood & Hassim (2007) health is defined by WHO (1946) as “a state of complete physical, mental and social well-being.” In 2008, the call for “Health for All” celebrated its 30<sup>th</sup> anniversary and it was reaffirmed that the “health is not merely the absence of disease or infirmity, but rather a fundamental human right, which is part of the Alma Ata declaration” (Bradshaw, 2008: 52). To achieve good health and to enable a state of well-being as defined by WHO, there needs to be a balance between physical, emotional, psychological, social as well as economic factors. Without such a positive and more or less equal balance between all of these factors, inequalities plus inequities in health will continue to persist. According to a report on *Equity, Health Policy and Human Development*, globally, “economic and scientific advances have increased the length of life, as well as the quality of life for many, however, close to 50% of people in African countries are living in poverty”

(WHO, 2016: [www.afro.who.int](http://www.afro.who.int)). Since poverty is closely intertwined with ill-health, therefore, it would mean that a sizable number of people living in South Africa are unable to enjoy a complete state of well-being, with an estimate of “32.3% of the population living below lower-bound poverty line in 2011” (Statistics South Africa, 2014).

## **2.2 RESOURCE ALLOCATION IN HEALTHCARE SECTOR IN SOUTH AFRICA**

South Africa spends billions of funds on its health services, yet its population suffers from a considerable number of preventable diseases and early deaths. With the country having a population of about 56 000 000, “in 2012, a total of 8.8% of the GDP was spent within healthcare including both public and private sectors. This is just slightly less than average of the Organization for Economic Cooperation and Development [OECD] countries, which is at 9.3%. Of the total GDP, only 4.24%, which is about 48% of the total GDP healthcare-spend was spent for healthcare services that were rendered in the public sector serving 80% of the population. In the same year, 4.55% of the GDP, which is about 52% of the total GDP healthcare-spend was spent in the private healthcare sector” (OECD, 2014). Of the total population, less than 20% is catered for by a small well-funded and well-equipped private health care sector. The rest of the people receive healthcare services from an under-resourced and overused public sector whose health expenditure is reflected to be less than that of the private sector. With the public health sector spending at about 48% of the total GDP spend on healthcare, the figures reflected for public-sector health care spend is way below that of the countries falling under OECD, of which the average is at about 72% of the GDP. The “annual per capita healthcare expenditure is about R1 200 in public sector servicing about 84% of the population and R12 000 in private sector for 16% of the population is skewed, unjust and a reflection of the disparities between these two sectors” (Benatar, 2013).

The country’s public health sector spending is not far from the level of the United States of America “(48%), Chile (49%) and Mexico (51%)”, which are the three states or nations with an inferior portion of public health spending. However, “in the United States of America, private health insurance accounts for most of the private spending,” a picture that is completely different for South Africa (OECD, 2014). Only six years ago, that is, “in year 2012, South Africa only had 0.7 physicians per thousand [1000] people, well below the OECD average of 3.2. There were also only 1.1 nurses per thousand [1000] population in South Africa compared with an OECD average of 8.8 nurses per 1000” (OECD, 2014). These figures reflect

and reveal inequality and lack of equity in allocation of resources, that is, financial, human and other forms of resources between the two sectors, that is, public and private. Hence the necessity for this research to explore and establish probable equitable and equal resource allocation solution for use by all South Africans, without reserving the good quality healthcare access for only the elite few.

According to OECD, “health spending tends to appreciate with income, and generally countries with higher GDP per capita also tend to spend more on health. Therefore, it is not surprising that South Africa ranks below the OECD average in terms of health expenditure per capita, with spending of 982 USD in 2012 (calculated based on purchasing power parity), compared with an OECD average of 3484 USD” (OECD, 2014). It then follows that the South African government needs to establish new ways of generating income for the country so as to be able to increase GDP per capita and therefore invest more on public health system. In South Africa,

“...there are about 4200 public health care facilities. More than 1600 primary health care facilities were either built or upgraded since 1994. Each clinic provides for 13,718 people on an average, a figure that exceeds the WHO guidelines of 10,000 per clinic. For a sizable amount of people in the South African population, which is about 2.5 million people, the location of the nearest clinic is more than 5km away from their homes” (Jobson, 2015).

This is again a reflection of over-used and under-resourced public healthcare system with some people still having difficulty accessing healthcare facilities with ease. With this research, I hope to come up with recommendations that will help bridge the gap between public and private healthcare systems.

For both public and private sector, “there are about 165,371 qualified health practitioners registered with the Health Professions Council of South Africa (HPCSA). Of this total number, there is about 38 236 medical doctors and 5 560 dentists. 73% of General Practitioners work in private sector leaving the public sector with 1 doctor per 4 219 people” (Jobson, 2015). In a report on Health Expenditure and Finance in South Africa, it was established that, “approximately, 66% of specialists, 93% of dentists and 89% of pharmacists practice in the private sector” (McIntyre, D. Bloom, G. Doherty, J. Brijlal, P. 1995). Between 2012 and 2013, it was estimated that about

“...1 200 medical practitioners were produced by the eight medical schools around the country. Of the 1 200, 50% leave the country, while 75% of the remainder join private healthcare sector. Only 25% join the public healthcare sector which services more or less 80% of the population, while private healthcare sector caters for only about 16% of the population. In public health care sector, the services are being rendered by about 43 general practitioners and 32 specialists per 100 000 people. Only 4 414 specialist and 12 470 give service to 80% of the population of South Africa between 2012 and 2013. On the other hand, the minority of the population, with private health insurance, is being serviced by 6 171 of specialists and 7 673 of general practitioners” (+Section27, 2014: 36-37).

The figures above referring to both financial and human resource allocations bring to the fore the disparities between the two sectors, and that, according to WHO, the public health care system is under-resourced while it provides healthcare services for 80% of the population. Its counter-part is, on the other hand small, well-equipped and well-funded. Of the private sector spending, “about 81% comes from the prepayment plans, albeit for most of the South African population, private health insurance is unaffordable unless enrolled in a corporate health insurance plan” (Deloitte, 2015). With National Health Insurance (NHI) slowly coming into effect, though still in its early stages, hopefully, the intended objective of access to comprehensive quality healthcare for the less fortunate will be achieved without infringing on the right to choose for those who are willing, able and can afford to pay for private health insurance.

According to 2008/2009 statistics 56.8% of the population is considered to be poor. On a Living Condition Survey [LCS] conducted by Statistics South Africa between 2014 and 2015, it was established that

“Consumption expenditure in health was only 0.9% of the total household expenditure. During the LCS, it was noted that there was a decline of 28.75% in household health expenditure in the periods between 2011 and 2015. This noticeable decrease was in real terms and more baffling was the actual decline of 12.7% in nominal terms. The out of pocket expenditure for healthcare expenses dropped by 35.71%.”

Health expenditure by many households is the second last area of focus in terms of prioritizing household expenses, as noted in the Living Condition Survey; yet deeply embedded in the South African Constitution is “the right to access health care including reproductive health care” for all persons, a provision made for in section 27. The hefty decrease could be attributed to high unemployment rate currently at about 27% coupled with high poverty rate, leaving many unable to pay for access to healthcare from out of pocket. The cost I refer to here for the access to healthcare is not only the practitioner’s fees, but rather inclusive of all costs incurred while one is needing and seeking healthcare services. Another factor could have been due to the introduction of free Primary HealthCare [PHC] for all, where user fees had been removed. However, though the access may have improved to a certain degree, according to Jobson (2015), “the quality of care at primary health care level has dropped.” With the decline of quality of care in primary health care facilities, people are left without much of a choice other than to opt for other means to access health care. For some, if not for many, one of the remaining options is private health care financed from one’s own resources, or out of pocket and for some, traditional healers remain part of the option or solution. Whether the traditional healer aspect forms part of Ubuntu ethics is a topic of its own beyond the scope and aim of this research. The option of private healthcare, including that of traditional healers, financed from one’s own pocket remains unviable for some due to poverty affliction where one has no source of income.

By poor, it means “living on an annual income below poverty datum line, also referred to as minimum living levels” (McIntyre, Bloom, Doherty, Brijlal 1995). “Potgieter estimated the minimum living level in South Africa to be approximately R9 500 per annum, per household in 1993” (Ibid). With these estimated figures on minimum living levels, it becomes clear that many South Africans remain unable to access healthcare services, despite it being everyone’s constitutional right. Since 1994, the South African government has committed itself to different programmes, not only exclusive to health care sector, to try and improve the lives of its population. However, much more still remains to be done to emancipate its citizens from poverty as the 2008/2009 statistics showed that 56.8% of the population remains poor. Through justice (distributive justice) within the context of Ubuntu Ethics, I hope to come up with solutions that could potentially improve the lives and health status of those living below food poverty line as well as below low-bound poverty line.



As stated in the Reconstruction and Development Programme [RDP] (1994), and reiterated in the National Development Plan [NDP] (2011), “no political democracy can survive & flourish if the mass of our people remains in poverty without land, without tangible prospects for a better life ...attacking poverty and deprivation must therefore be the first priority of a democratic government.” Poverty is closely intertwined with ill health. It is therefore, of essence that a whole lot more is done to realise the vision of RDP and NDP to alleviate poverty and some of the diseases closely linked to poverty and poor sanitation, because, a hungry people, as well the sick cannot build any nation. In this research, I hope to be able to come up with recommendations that will drive the nation towards bridging the gap within the healthcare sector, as well as in other relevant sectors, with the application of Ubuntu ethics in distributive justice.

In 2012, a set of three national poverty lines was published after a study conducted by Statistics South Africa. The study was titled, *‘An examination of absolute poverty between 2006 to 2011’*. The following the categories of poverty were identified:

“...a) Food Poverty Line [FPL] where the consumption is below the individual’s ability to purchase sufficient food to provide adequate diet. b) Lower-bound poverty line [LBPL] which includes non-food items, but requires that individuals sacrifice food items in order to obtain these. c) Upper-Bound Poverty Line [UBPL] where individuals falling on this category can purchase both food and non-food items.”

Though it is said that poverty levels have dropped since 2006 from 57.2% to 45.5% with application of UBPL in 2011, a large number of people are still living below bare minimum levels. In 2011, Statistics South Africa estimated that “20.2% [10.2 million people] are living in extreme poverty”, that is, below FPL. “This is higher than the level of the international goal of less than 15% in 2015” (Udjo, Simelane, & Booysen, 2015:8). It was also reported that “32.3% of the population [16.3 million people] were living below LBPL” (Stats SA, 2011). In 2015, Statistics South Africa estimated that “14.1% of the population lived in an informal dwelling, with 14.5% of the population without access to electricity”. In the Universal declaration of Human Rights, article 25 (1), it was declared that “everyone has the right to a standard of living adequate for health and well-being of himself and of his family including [...] housing [...]” (UN, 1948). It is clear that post 1994, the South African government has taken steps and actions towards the realization of this universal right, albeit some more

ground remains uncovered as there is still a large number of South Africans with no access to formal housing. Living in informal housing with poor sanitation means congested living conditions with high risk of ill-health and spread of communicable diseases. This group remains vulnerable to some physical and mental ills, with minimal contribution towards the production, development and improvement of their own at a personal level, of their communities, let alone that of the country. It is therefore imperative that more is done to permanently eradicate poverty in order to, and in turn, improve the lives and health of the people. With improved lives and health, individuals can in turn play a role, no matter how minimal, in contributing towards the economic growth of the country with better future prospects for the nation as a whole.

Access to water has generally improved for South African households. Nonetheless, there is about “4.4% of the households that still has no access to piped water” (Stats SA, 2015). These households still rely on fetching water from the open sources such as the rivers, dams, springs, etc. According to Stats SA, “about 4.7% of the households have no access to sanitation facilities or they have to use bucket toilets in 2015.” It is praiseworthy that there has been some improvement in the socio-economic status of some people in the country, but one need not be complacent until most, if not everyone’s socio-economic status has been ameliorated. At the United Nations Water Conference held in 1977, it was acknowledged and concluded that “all peoples, whatever their stage of development and their social and economic conditions, have the right to have access to drinking water in quantities and of a quality equal to their basic needs.” For any country or nation, it is not expected that the amelioration process will happen overnight with application of only one principle. But, with application of different principles of ethics while drafting and implementing policies, specifically those of Ubuntu in this case, additional to existing ones, maximization of provision of services to the less fortunate will hopefully drastically improve. I certainly hope that in this research, such an amicable policy will come to the fore with application of distributive justice within the context of Ubuntu ethics, which is likely to significantly improve the lives of the majority of South Africans.

### 2.3 SOCIAL DETERMINANTS OF HEALTH AND THEIR IMPACT IN A SOUTH AFRICAN CONTEXT

On its definition of health, WHO acknowledges that, the physical human body is composed of different parts and organs, of which for a complete state of well-being, there must be a balance of other factors outside the physical body. From the definition, it is deducible that health does not imply only being emancipated from disease and or incapacity, but rather being well mentally, physically and socially. As implied by the definition, attainment of a healthy status is not limited to being able to access healthcare services, but rather dependant on multiple factors. These factors are referred to as Social Determinants of Health [SDH]. According to World Health Organization [WHO], in a document titled, *Commission on Social Determinants of Health*, social determinants are defined as “the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness, determine health. In turn, these conditions are determined by political, social and economic forces and policies” (2008). Put slightly differently, it is those “conditions in which people are born, grow, work, live and the wider set of forces and systems” (Ibid). These forces and systems include “income, education, social safety networks, employment and working conditions, unemployment and job insecurity, early childhood development, gender, race, food insecurity, housing social exclusion and disability” (SAHR, 2012/13). According to the *African Regional Health Report* these conditions also include “economic policies and systems, development agendas, social norms, social policies and political systems” (WHO, 2014).

The conditions or circumstances are “shaped by distribution of money and power at a global, national and local levels” (Ibid). The effects of the circumstances or conditions referred to on the definition determine the level of vulnerability to illness and actions that can be put in place to hinder people from falling sick or to treat sickness when it presents itself. Inequities and inequalities in health are preventable between groups of people within nations and between nations, and therefore, measures to reduce the inequalities need to be taken by all stakeholders. If these health “inequities and inequalities are to be reduced, both social determinants of health (SDH) and universal health coverage (UHC) need to be addressed in an integrated and systematic manner” (WHO, 2008). With National Health Insurance (NHI) still in its early stages of implementation, South Africa seems to be on its way towards attaining Universal Health Coverage [UHC]. However, ensuring access to healthcare alone does not guarantee reduction of health inequities and inequalities if people still go back to

the same living and or working conditions that contributed to an illness which prompted a person to seek medical attention. If people still do not have adequate access to appropriate nutritional intake, still remain unemployed and illiterate, health inequalities will likely remain since these factors play a contributory role to the well-being of an individual.

According to Marmot, “...at the root of much of the inequalities in health lies the social determinants” (2005:1099-1104). These “social determinants are relevant to communicable and non-communicable diseases alike. Therefore, health status should be of concern to policy makers at large and not just those involved in health policy” (Marmot, 2005: 1099-1104).

Health inequities are a global concern and challenge. As such, WHO set up a Commission for Social Determinants of Health with intentions of focusing attention to the “social determinants of health which are broadly general socio-economic factors, cultural and environmental factors, living and working conditions, social and community factors, as well as individual lifestyle factors” (Bradshaw, 2008). The purpose of the commission is to “review the evidence, raise societal debates and make policy recommendations with the aim to improve health of the world’s most vulnerable people” (Marmot, 2005). On its report, the Commission on Social Determinants of Health, highlights that, “addressing the social determinants of health [SDH] and their unequal distribution within the populations of the world represents one of the major frontiers for global health” (INTREC, 2012). As much as it is still a major challenge to address social determinants of health, it is however a necessary exercise if nations, including South Africa, are to redress the inequalities and inequities.

According to a report on *Trends in Determinants of Health* between 1996 and 2008, “there is still a degree of uncertainty on the exact levels and rates of disease and mortality” (Bradshaw, 2008: 60). It is therefore, of essence to understand the “SDH and the mechanisms by which determinants of health influence population” (Ataguba *et al*, 2015) in attempting to make just health inequities and improve health outcomes. Further understanding of the impact of SDH, level and rate of disease and mortality amongst the South Africans would aid in directing the government and policy makers to focus and invest on areas that are likely to improve the health status of its population, therefore improving on health equity and equality.

As alluded to above, achieving health equity “is a shared responsibility and requires the engagement of all sectors of government and all segment of society” (WHO, Rio, 2011). It has been acknowledged that action on social determinants of health is key towards

achieving health equity at global and national scales. As such, at the World Conference on *Social Determinants of Health* held in Rio in 2011, it was reaffirmed that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”, an underscoring principle set in the World Health Organisation Constitution, in the Alma-Ata Declaration of 1978 and the Ottawa Charter of 1986. In taking actions on SDH, three recommendations were agreed upon at the sixty-second World Health Assembly [WHA62.14] and reiterated at the Rio Declaration on Social Determinants of Health in October of 2011. The three recommendations made are: “i) to improve daily living conditions; ii) to tackle the equitable distribution of power, money and resources; and iii) to measure and understand the problem as well as assess the impact of action” (WHO, 2011).

South Africa, being a diverse multi-cultural society set against the back-drop of apartheid which favoured political, social and economic well-being of the minority, now with more than twenty years into transformation, still has a considerable ground to cover to achieve health, social and economic equity. A multi- and inter-sectoral approach moving forward, towards equitable health attainment is promising and seems to be the way for the nation.

Bradshaw points out that, South Africa is categorised as a “middle-income country with a well-established economy, and despite having a well-established economy, South Africa is classified as one of the most unequal countries in the world” (Bradshaw, 2008: 53). Discrimination based on gender and race during the apartheid era left a legacy of inequalities socially, economically and in healthcare sector. To date, since post-1994 democratic government, health and socio-economic inequalities remain persistent. On the economic front, South Africa “has one of the highest income inequalities with a Gini coefficient that remained at 0.68, showing a slight overall change since 1994” (Bradshaw, 2008: 53). Health inequities and inequalities remain high in South Africa despite the efforts effected by the government to transform the health systems. Gender, race and geographical location remain the key contributing factors to social and economic inequities, as well as the poor health outcomes.

These inequities are heightened by complimentary challenges posed by a “quadruple burden of disease [Tuberculosis; HIV & AIDS; high levels of maternal and child mortality; violence and injuries; and non-communicable disease] and sub-optimal performance of the

health system” (SAHR 2012/13: 90; Ataguba, *et al*, 2015:2). The “quadruple burden of disease is linked to poverty and deprivation.” (Ataguba, *et al*, 2015: 2). Poor access to sanitation system, access to clean water and to formal housing are some of the contributing factors to the quadruple burden of disease, especially for the communicable diseases. Even though non-communicable disease burden is on the rise, communicable disease burden still remains a source of concern. The Copenhagen Declaration and Programme of Action of the Social Summit convened in 1995 (UN) consequent to the acknowledgement that “communicable diseases constitute a serious health problem in all countries and are a major cause of death globally, in many cases, their incidence is increasing” (Alfredsson & Tomasevski, 1998:28). These diseases are a hindrance to social development and are often the result of poverty and cause of social exclusion. The “prevention, treatment and control of these diseases covering a spectrum from tuberculosis and malaria to the human immunodeficiency virus/acquired immunodeficiency syndrome [HIV/AIDS], must be given the highest priority” (Ibid). In response to the challenges in health, in October of 2010, the South African Minister of Health formulated and signed a Negotiated Service Delivery Agreement [NSDA] for the health sector. “The aim and focus is to increase life expectancy, decreasing maternal and child mortality, combating HIV/AIDS, tuberculosis [TB] and decreasing the burden of disease and strengthening health system effectiveness” (SAHR 2012/13). “Despite uncertainty about the exact levels of mortality, it is clear that the health of the South African population has worsened over the last decade as a consequence of the effects or challenges of the quadruple burden of disease, including diseases and conditions related to poverty and under-development” (Bradshaw, 2008:i). New economic and social policies that were adopted post 1994 have resulted “in economic growth and some improvements in access to basic services such as water, sanitation and electricity” (Bradshaw, 2008: i). Notwithstanding the improvements, high unemployment rate and unequal wealth distribution are likely to play a role in poor health outcomes. And they are likely to be linked to high rate of injuries resulting from violence, which in turn lead to deaths from injuries that are on the rise in South Africa according to Stats SA.

#### **2.4 SOCIO-ECONOMIC STATUS AS CONTRIBUTORS TO HEALTH IINEQUITY**

There are three behavioural factors that continue to complicate the public health system in South Africa namely alcohol abuse, sugar intake, and smoking. Peltzer, Ramlagan,

and Satekge (2012) have done a study on the use of alcohol among South African Youths between the ages of 18 and 24, and associated health risks. The study concludes that “...currently alcohol use was relatively more common among male (40.7%) than female youths (21.3%). Similarly, hazardous or harmful drinking was more prevalent among males (24.3%) than among women (12.9%).” The study further pointed out that alcohol abuse had led to sexual permissiveness, high peer pressure, and spending more nights away in a week. Business Tech South Africa (2016) also carried out a survey where it was established that “South Africa’s alcohol consumption rate has climbed, with the country now ranked as one of the top 20 biggest drinking nations in the world.” Their finding, which was affirmed by WHO, was that in South Africa “...pure alcohol consumption (per litre) is at 11.5 litre per capita per year – up from 11.0 litres in 2014.” As a result of this habit, drunk driving is responsible for 58% of road-accident-caused deaths in South Africa (Ibid). This makes alcohol consumption to one of the matters of deep concern for the South African healthcare sector.

Sugar intake has recently become a national topic as parliament sought to control it through taxation. Health24 (February 2017) refers to a study by the Centre of Excellence in Food Security which revealed that “...most South Africans consume too much in the way of sugar and carbohydrates.” This is causing an increase in diabetic complications, thereby further compounding the issue of desirable health outcomes. In their research on sugar and related health matters in South Africa, Myers, *et al*, (2017:98) have reported that “...excessive sugar consumption is driving epidemics of obesity and related non-communicable diseases (NCDs) around the world. South Africa (SA), a major consumer of sugar, is also the third most obese country in Africa, and 40% of all deaths in the country result from NCDs.” Their research conclusion recommends an application of financial and legal frameworks to deliberately reduce sugar consumption among the people. Sugar, therefore, is another cause for concern in the healthcare sector that needs to be adequately addressed.

A report by Katharine Child (2017) reveals that “smoking rates in South Africa have declined following the years-long ban on cigarette advertising, high taxes on cigarettes and the banning of smoking indoors in public places.” How low, one may ask? Well, the figures have gone down “from 24% of adults who smoked in 2000, to about 17% of all adults in SA currently.” This is not such a big decline, considering that “...the life of a smoker is cut short by 10 years on average, resulting in premature loss of economically active citizens” (Ibid). It is encouraging that the Ministry of Health has consistently implemented smoking-ban



measures that have led to the decline mentioned above. The current Minister of Health is reported to be working on reducing further down the available public smoking space from the current 25% to zero (Essop, 2016). Despite the efforts to date, smoking remains a serious health challenge that should continue to receive priority attention in public health policy.

South Africa is a diverse multicultural society with multitudes of traditions and customs affecting the way we live, hence, it is almost inevitable that there are some health related behaviours that are bound to manifest and fuel certain disease patterns. Health related behaviours contribute to morbidity and mortality rates. Some of the health-related behaviours based on cultural backgrounds are sexual behaviours which have played a role in HIV/AIDS prevalence. Use of violence as a conflict-solving approach is another act linked to some belief systems in some cultures which impacts on health status and outcomes. Recent xenophobic attacks and outbreaks “reveal a disturbing dehumanisation in sectors of society, and highlight the complexities of social relations that play out in the context of frustrations around lack of basic services compounded by high unemployment rates” (Bradshaw, 2008:54). Therefore, it may be of relevance and benefit to take into account the cultural differences by government and policy-makers when addressing social determinants of health, and try to refrain from using the “one glove fits all” approach. According to Policy Co-ordination and Advisory Services, “the macro-social review has highlighted how South Africa’s value system reflect a tension between market-based competitive relations and the desire for more equitable development” (2006).

South Africa has high levels of poverty with approximately “45.5% of the population living in poverty with the application of the Upper-Bound Poverty Line [UBPL], and 20.2% living in extreme poverty” (Stats SA, 2014). Poverty has been a challenge and source for concern globally. It has been well established that poverty and ill-health are closely intertwined. With high levels of poverty, poor access to clean drinking water and poor sanitation result in manifestation of communicable diseases. Without attending to and correcting these determinants, health outcomes are likely to be poor. With acknowledgment of the link between poverty and ill-health, On the Programme of Action of the World Summit (UN, 1995), it was declared that

“We commit ourselves to the goal of eradicating poverty in the world, through decisive national actions and international cooperation, as an ethical, social, political and economic imperative of humankind. Governments, in partnership



with all other development actors, in particular with people living in poverty and their organizations, should cooperate to meet the needs of basic human needs of all, including people living in poverty” (Alfredsson & Tomasevski, 1998:28-9).

By improving the living conditions of the people living in poverty and by using a multi-sectoral approach in policy making can lead to the betterment of the standard of living for the people. Health status as well as health outcomes are also likely to improve.

Although there is a general improvement in access to water and sanitation in South Africa, for communities who are without these services still remain faced with a challenge of being at risk of having illnesses related to poor access to clean drinking piped water. With current water shortages and draught in some parts of the country, outbreaks of diseases related to availability of clean piped water may become a challenge. To curtail disease occurrence and its extent; and to prevent disease spread, it is of relevance and essence for governments to make provision to meet these basic needs for its people. In a report of the Mar del Plata Water Conference, (UN, 1977), it was acknowledged that “all peoples, whatever their stage of development and their social and economic conditions, have the right to have access to drinking water in quantities and of quality equal to their basic needs” (Alfredsson & Tomasevski, 1998:33). Poverty, lack of drinking water, poor sanitation and poor access to adequate housing are not the only contributing factors to health inequalities. Access to good quality education and knowledge also affects health status and health outcomes. Some research founded on decades of experience has buttoned down education as one of the predictors of health outcomes. On a discussion paper by Zimmerman and Woolf (2014, June 5.), it is reported that those with lower levels of education have a “decreased life expectancy” compared with those that have “high school diplomas, especially among women”. Educated individuals are therefore likely to adopt healthier life-styles that contribute to better health outcomes. Knowledge on the other hand is not always equivalent to engaging to less risky behaviours because many educational programmes on diseases such as HIV & AIDS have been conducted and still continuing, but new HIV infections are surfacing daily. On a study conducted in “Korea, Nigeria, Guatamala, Thailand, Vietnam and the Phillipines” to establish a relationship between knowledge and behaviour, it was found that “knowledge about

sexuality” is not a guarantee that one will or does “practice safe sex” (Prog Hum Reprod Res, 1997; (41): 6-7. [www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov))

Without access to education resulting to lack of skills, there comes challenges like unemployment, poor living conditions and poor housing. Unemployment rate is currently at about 27% in South Africa. “Unemployment is particularly high among the young, the unskilled who are African by ethnicity. An economic review of human resources in South Africa describes that there is current skills shortage in the economy” (Bradshaw, 2008:56). Apart from income, “unemployment has health consequences which result from psycho-social factors, and high-risk behaviours related to unemployment such as binge drinking of alcohol and substance abuse” (Ibid.). Alcohol and substance use are coupled with violence, gender-based and child abuse. Violent acts lead to injuries which are at times fatal, adding to South African mortality rate. Fatal injuries related to an underlying alcohol and substance use not only result from violence, but also from road accidents which occur while the driver and/or pedestrian was under the influence of alcohol. In a comparative risk assessment study done by Department of Health in 2002, it was established that “the burden of disease was attributed to 17 risk factors that were considered to be modifiable”. The top three risk factors on the list were “unsafe sex, interpersonal violence and alcohol use. Each of the three factors accounted for a significant burden of disease” (Bradshaw, 2008:60). Compounding the challenge of unemployment is a chance of likelihood to be exposed to poor access to good nutrition. Having poor access to nutrition will inevitably lead to under-nourishment and or malnourishment which, in turn, puts one at risk of being vulnerable to a variety of communicable diseases. Bradshaw (2008:55) defines under-nourishment as “...having an energy consumption that is continuously below a minimum dietary energy requirement for maintaining a healthy life and carrying out light physical activity.” He continues to explain that “...malnutrition still features both direct and indirect causes of mortality” and that in 2000, “it was estimated that being underweight accounted for 12% of childhood deaths. Exclusive breastfeeding has been shown to have an important role in reducing child mortality” (Bradshaw, 2008:56).

With poor living conditions and poor access to appropriate housing, the result is likely to be that of overcrowding which increases the risk of communicable disease and its spreading. There is also likelihood to have an increased risk of exposure to indoor air pollution considering that in some parts of South Africa, there are communities relying of wood fire

and or solids fuels for cooking in enclosed environments. This form of air pollution can be reduced by improved living conditions with access to electricity. “In 2000, an estimated 20% of South African households was exposed to indoor smoke from solid fuels, resulting in a considerable burden of disease. Almost 99% of this burden of disease occurred in the South African population living in rural and peri-urban areas” (Ibid). A variety of diseases emanates from the underlying social indicators of health and lead to decreased life expectancy; high maternal and infant mortality rates; and high adult death rates. Additional to the mentioned causes of death, the scourge of HIV & AIDS related illnesses contributes to high death rates.

## **2.5 DEMOGRAPHY**

According to CIA world fact-book (2017), “South Africa’s youthful population is slowly aging as the country’s total fertility rate [TFR] has drastically declined from about six children per woman in the 1960s to roughly 2.2 in 2014.” It is further stated that,

“The pattern shows similarities to fertility trends in countries such as South Asia, the Middle East, and North Africa. However, South Africa’s fertility decline sets it apart from the rest of the sub-Saharan Africa where the average TFR remains higher than the other regions of the world” (CIA World Fact Book, 2017).

The South Africans young working –age population has increased in relation to “children and elderly, albeit South Africa has been unable to achieve a demographic dividend as a result of persistent high unemployment rate and prevalence of HIV & AIDS” (CIA, 2017). Generally, it is believed that “nations undergoing transition have an opportunity to capitalize on demographic dividend offered by the maturing of formerly young population. However, demographic dividend is not automatic. The right kind of policy environment can help produce a sustained period of economic growth” (Bloom, 2003). With an increased proportion of working-age population coupled with policies that ensure these added or extra workers are productively employed, coupled with the prevalence of HIV/AIDS affecting the young adults in a working age group under control, then this country would be in a position to unleash the economic growth surge. The gains from the economic growth surge would in turn benefit the people when invested into improvement and development of social infrastructure. With improved social infrastructure, some of the social determinants of health would be greatly reduced, therefore leading to a decline in disease burden, and increase in

life expectancy. Demographic dividend is defined as the “...accelerated economic growth that can result from improved reproductive health, a rapid decline in fertility, and the subsequent shift in population age structure” ([www.demographicdividend.org](http://www.demographicdividend.org)). Taking into account the effects of the scourge of the quadruple burden of disease affecting the South African population, a larger than usual adult dependent population compared to the ordinary dependent population constituting mainly of children and elderly in other countries has resulted. Therefore, the window of opportunity for economic growth seems to may have been missed considering that demographic dividend is time limited.

Since 1994, it is said that “the availability of population health statistics has improved considerably. However, there is still a degree of uncertainty on the exact levels and rates of disease and mortality” (Bradshaw, 2008:60). According to report by Stats SA, “South Africa has come a long way since 1994 when a representative vital registration system was non-existent. Improvements of death registrations substantially improved from 1996 to 1997, hence, available data is from 1997” (Stats S.A, 2006). According to the report on *Determinants of Health and their Trends*, “the increase in death rates amongst young adults and children between 1997 and 2005 is relentless during the period. The noted increase amongst the young adults was particularly pronounced in young women with ages ranging from 30-34 years of age group” (Bradshaw, 2008:61). The figure had quadrupled in 2005 compared to 1997. Over the same period, it was noted that “total deaths due to injuries had declined from 17% to 9%” (Ibid). Despite the noted decline, fatalities resulting from injuries have “remained constant from year to year, indicating that the drop-in proportion is related to an increase in the natural causes, rather than an actual drop in injuries” (Ibid). Communicable diseases, specifically tuberculosis [TB], “increased the proportion of deaths due to infectious and parasitic causes from 13.1% to 25.5%. Pneumonia increased the proportion of deaths due to respiratory diseases from 4.8% to 8.7%. Discerning the actual rates of death trends in South Africa from Stats SA alone poses a challenge, taking into account the under-registration and mis-classification of deaths” (Ibid.).

## **2.6 INFANT MORTALITY RATES**

The findings of South Africa Survey undertaken by Institute of Race Relations [IRR] in 2016, established that:

“There has been a marked decrease in child mortality rates. It was established that the under-five mortality rate had declined from 77.2 deaths per 1000 live births deaths in 2002 to 45.1 deaths per 1000 live births deaths in 2015. Deaths of under one year of age declined from 51.2 deaths per 1000 live birth in the same period of 2002 to 34.4 deaths per 1000 live births in 2015. It is suggested that the decline in infant mortality rate may be attributed to the different factors such as: i) increase in immunisation rates from 67% of immunised children under age of one in 2001 to 89.8% in 2014. ii) Decline of severe malnutrition rate among under five from 12.5% per 1000 children in 2001 to 4.5 per 1000 in 2014. iii) The increased percentage of the social grant beneficiaries from 9% of the total national population in 2001 to 30% in 2015.”

The above findings are slightly different from the statistics provided by Stats SA on Millennium Development Goal [MDG] report in 2015. The difference could be due to reference to different periods. On the table below, it is noted that there is no mention of 2001/2. Although South Africa has made some progress on reducing infant and under-five mortality rate, it is not sufficient to achieve the MDG goals of reducing under-five mortality rate. Below is table 1 consisting of MDG goal 4 indicators, current South Africa status and what has been or has not been achieved.

**Table 2.1: Summary of Goal 4 indicators, current status and target achievability Goal 4: Reduce by two-thirds, between 1990 and 2015, the mortality rate of children under five<sup>3</sup>**

Indicators	1994 baseline (or nearest year)	2010 status (or nearest year)	2013 status (or nearest year) 2015	Current status (2014 or nearest year) 2015	2015 target	Target achievability	Indicator type
Under-five mortality rate (per 1 000 live births)	59 (1998)	38.7 (2011)	37.5 (2012)	34.3 (2013)	20	Not Achieved	MDG
Infant mortality rate (per 1 000 live births)	54 (1998)	26.5 (2011)	24.9 (2012)	23.6 (2013)	18	Not Achieved	MDG
Proportion of 1-year-old children immunised	68.5 (2001)	84.8	87.3	91.2	>95%	Not Achieved	MDG

<sup>3</sup> MDG goal 4 report, Statistics South Africa

against measles							
Immunisation coverage under one year of age	66.4 (2001)	79.9	84.1	87.0	100	Not Achieved	Domesticated
Life expectancy at birth	57.6 (2001)	60.4 (2007)	60.2	61.2	70	Not Achieved	Domesticated
Diarrhoea (with dehydration) incidence under 5 years of age (per 1 000 children)	138 (2002)	16.9	12.8	14.1	No target	N/A	Domesticated
Pneumonia incidence under 5 years of age (per 1 000 children)	21 (2003)	79.4	55.1	52.9	No target	N/A	Domesticated
Neonatal mortality rate (per 1 000 live births)		13.0	11.0	11.0	No target	N/A	Domesticated
Prevention of Mother-to-Child Transmission: Infant 1st PCR test positive around 6 weeks rate		9.0	2.1	1.6	No target	N/A	Domesticated

#### UNDER-FIVE MORTALITY RATE

**Table 2: Summary of Goal 4 indicators – Under-five mortality rate**

Indicator	1994 baseline (or nearest year)	2010 status (or nearest year)	2013 status (or nearest year) 2015	Current status (2014 or nearest year) 2015	2015 target	Target achievability	Indicator type
Under-five mortality rate (per 1 000 live births)	59 (1998)	38.7 (2011)	37.5 (2012)	34.3 (2013)	20	Not Achieved	MDG

Source: Adapted from "Stats SA MDG goal 4 report 2015"

The information from Stats SA reveals, "...the under-five mortality rate (U5MR) is expressed as the number of deaths of children under the age of five years per 1 000 live births per year. It is the probability (per 1 000) that a new-born baby will die before reaching age five, subject to age-specific mortality rates. U5MR is a key indicator of population health and development. It generally reflects the socio-economic and environmental conditions in which children live" (Stats SA, 2015). Considering that the "U5MR in 2013 was at 34.3 per 1000" (MDG, 2015), and that the MDG goal of 20 per 1000 was not met, deducing from the U5MR

definition, it is then suggestive that to achieve the goal and more, an improvement of the socio-economic and environmental conditions is required. To achieve the MDG goals and more, the South African government needs to pay more attention on the environmental and socio-economic factors affecting the health outcomes of the under five years of age. Some drastic measures would need to be taken to improve the conditions under which these children live. Current statistics indicate that, among infants below the age of five years, there is a death rate of 34.3 deaths per 1 000 live births, which is beyond the MDG target of 20/1 000 by 2015 (DHS, 1998; Stats SA 2015).

Prior to and in 1994, no data is available for neonatal mortality rate. “In 2010, neonatal mortality rate was 13 per 1000 live births and slightly declined to 11 in 2013 and 2014” (Stats SA, 2015). “The neonatal mortality rate is expressed as the probability of a child dying within 28 days after birth. This is a critical period in which many new-borns die from mostly preventable causes. The major causes of neonatal mortality in South Africa are birth asphyxia, preterm birth and infections. The neonatal mortality rate was not included in the MDG targets, even though deaths of children under the age of one month contribute significantly to infant and child mortality” (Stats SA, 2015).

The decline in infant mortality rate in South Africa is praiseworthy, however, some countries have much lower mortality rates. Data from World Bank shows that “the under-five mortality rate in Germany was 3.9 per 1000 live births” (IRR, 2016). To reach similar levels of the global norms, the South African government and policy makers have some ground to cover. Addressing the underlying social determinants of health is crucial to further decrease the infant mortality rates.

According to CIA fact-book, in 2008, South Africa’s “life expectancy plunged to less than 43 years secondary to the effects of HIV & AIDS and rebound to an approximately 50 years in 2014” (2017). It is stated that “on average, women tend to live longer than men in every country of the world and in every WHO region” (business tech, 2016). According to WHO, globally, an “average life expectancy was 71.4 for women in 2015. Overall female life expectancy is 73.8 years and for males, life expectancy is 69.1 years on the globe. However, some 29 countries have an average life expectancy of 80 years or higher” (business tech, 2016). In South Africa, “between 2002 and 2016, the average life expectancy increased from 55.2 to 62.9” (Statistics South Africa, 2016). South African average life expectancy “ranks number 24 amongst the African countries with highest life expectancy, of which at the top is

Maldives at 78.5 years” (business tech, 2016). In an article published on ‘The Lancet’ about a study done by University of Washington, on average, it was established that “South Africa’s life expectancy dropped between 1990 and 2013. The average life expectancy for men was found to have had decreased from 60.5 years in 1990 to 57.7 years in 2013. For women, the average life expectancy dropped from 68.9 years in 1990 to 63 years in 2013. This decline put South Africa amongst the eleven countries that saw a decline in average life expectancy” (Malan, 2014). However, the country’s average life expectancy is on the rise again as already mentioned for periods between 2002 and 2016, as per Statistics South Africa’s publication. It is not surprising to see a plummet in life expectancy during the specified periods considering that there was an increase in new HIV & AIDS infections being diagnosed and increased death rates from HIV & AIDS compounded by opportunistic infections for those in stage four of the disease. During those periods, antiretroviral drugs were not available until much later on. Without drugs to slow the progress of the disease, many lost their lives, succumbing to opportunistic infections resulting from severe immune-compromise. Another contributing factor would have been high prevalence of tuberculosis [TB] with emergence of Multi-Drug Resistant TB [MDR-TB] as well Extreme Drug Resistant TB [XDR-TB]. On an article published on [www.bhekisisa.org](http://www.bhekisisa.org), according to “University of Washington report, the top causes of death in South Africa were found to be HIV & AIDS, followed by stroke and pneumonia. These last two conditions accounting for 51% of all deaths in South Africa in year 2013” (Malan, 2014).

Statistics South Africa, however, released somewhat different findings in December of 2014, with “TB being the top killer followed by influenza and HIV disease” (Malan, 2014). On the research “violence and injuries were also amongst the leading causes of death in South Africa. Hypertension, together with diabetes mellitus, was found to be amongst some of the leading cause of death in South Africa. Additionally, research showed that diabetes mellitus is a fast-growing epidemic in South Africa” (Ibid). This finding of increasing number of people with diabetes mellitus is probably attributable to the findings of high sugar intake that was found on research about the rate of sugar intake amongst South Africans, a study done by the Centre of Excellence in Food Security, published on Health24.

From the above stated findings, it surfaces that not only communicable diseases are the leading causes of death in South Africa. Some evidence exists which shows that non-communicable diseases are almost equally responsible for morbidity and mortality in South Africa. It is of relevance and significance to therefore adopt a multi- and inter-sectoral



approach to finding solutions that will improve health status and life expectancy in South Africa. Through this multi-disciplinary approach, equity in health will most likely be achieved.

## **2.7 CONCLUSION**

Social determinants of health are multiple and complex. However, understanding these key factors which play a contributory role to the health status of individuals is a vital step towards achieving improved morbidity and mortality, and increasing the life expectancy of the people of South Africa. In addition to understanding the role and mechanisms by which they influence health, commitment to invest in health would not only lead to attainment of health equity; it would also lead to economic growth of the country in the long run. Healthy people lead to economic growth of a nation as they tend to be more productive. It is reasonable to hypothesise that if more money was to be spent on health, the economy would significantly improve and there would be better living conditions and social amenities. It makes much sense to agree that when people are able to live longer, the economy benefits and grows. Therefore, investing in health and social infrastructure would prove beneficial for South African economy long term, even though it would be initially costly. However, the long-term benefits would outweigh the initial cost. It is both relevant and significant to note that any improvement in health services helps alleviate the disease burden and, at the same time, improve human rights concerns and uplift the growth of the economy for the benefit of society.

## CHAPTER 3: THEORETICAL CONCEPTS

### 3.1 INTRODUCTION

In this third chapter I will now reflect on three theoretical concepts that are relevant to this thesis. The three theoretical concepts are Ubuntu ethics, distributive justice, and public health ethics. Ubuntu ethics is relevant because it is a possible moral theory that can be used to redress the disparity of resource allocation, within which the problem of resource distribution in healthcare is being evaluated within the South African context. Distributive justice is relevant in this research because it enables a clear development of understanding of the nature of the problem. Moreover, where there is need for distribution of resources in any State, application of a justice theory is needed for gatekeeping and maintaining of fairness. Resource distribution in healthcare is a distributive justice issue which this study seeks to address as a matter of social justice. Finally, public health ethics are relevant because it enables a contextual appreciation of the public health sector, the challenges the sector faces with regard to resource distribution, and any attempts to solve or resolve such challenges. Public health ethics offer a framework which enables one to go through policy development process in a critically constructive and strategized manner. The Public health ethics' framework demands that the public health practitioner takes into account certain considerations before implementation phase of a policy developed that will not infringe much on the rights of some people upon implementing such a new policy. My intention is to adopt a pluralistic approach and thus not to use Ubuntu moral theory exclusively. Instead, my intention is to examine how relevant theoretical concepts address aspects of the research problem of resource distribution in public health, before suggesting a conceptual framework that will incorporate Ubuntu as the theory for addressing the problem holistically.

### 3.2 UBUNTU ETHICS

#### 3.2.1 Background Information

Many years before Africa was colonized by Europeans, very little, if anything, was known to the global community or written about Ubuntu as an African moral theory. Instead, Ubuntu was experienced by those who lived amongst communities that practiced Ubuntu as a way of life. It was passed through generations by oral transmission and shared communal life. As a consequence, "for hundreds of years a view that ethics originated mainly from western and religious traditions has dominated. In years following post-colonization of Africa,

a view of ethics emerged” (Murove, 2009). The basis of this view of ethics is mainly rooted on the knowledge systems of indigenous traditions and cultures in Africa. Its values are closely intertwined with dignity of each person, seeking to establish and maintain relationships that are mutually beneficial and or enhancing for all concerned in a community or society. Once again, as earlier mentioned in Chapter 1, in referring to Ubuntu as African, does not necessarily imply exclusivity to Africans alone or the whole of Africa. From the literature it emerges that the origin of the word ‘Ubuntu’ is linked or traced back to the “Bantu/Nguni” speaking people in some or many parts of Sub-Saharan Africa. The actual sense of interconnectedness and or being part of the whole of human kind is not necessarily uniquely African, but a trait common to all human beings. This notion emerges in John Donne’s famous poem titled “*No man is an island*” written as far back as year 1624, 394 years ago.

The term ethics is described as “the generic term covering several different ways of examining and understanding the moral life” (Beauchamp & Childress, 2009: 1). As reiterated by Rachels and Rachels (2012:1), moral life or morality is, according to Socrates, “how we ought to live” and or behave. Ubuntu as an ethics theory generally conforms to the definition and answers the question[s].

Definitions of Ubuntu have been suggested by various authors. The late former President Nelson Mandela, describes Ubuntu “as a philosophy constituting a universal truth, a way of life, which underpins an open society” (2006:xxv). Tutu (1999:34-5), Luhabe (2002:103), Nussbaum (2003:21), Mandela (2006:xxv & Khoza, 2006:6) describe Ubuntu “as the capacity in an African culture to express compassion, reciprocity, dignity, humanity and mutuality in the interests of building and maintaining communities with justice and mutual caring.” Put slightly differently, Broodryk (2002:56 & 2006:2) defines Ubuntu as an “ancient worldview based on the primary values of intense humanness, caring, sharing, respect, compassion and associated values, ensuring a happy and qualitative human community life in the spirit of family.” Bhengu (1996: 16) on the other hand describes Ubuntu as “the art of being a human being.” On the definitions offered, Ubuntu ethics encapsulates values and or character traits that are considered good to have and enable a person to practice Ubuntu. These values and or traits are also considered worthy to have for those in position of power or who are leaders.

### 3.2.2 Origins of Ubuntu

Although Ubuntu is said to have its origins associated with African societies with special reference to Southern African societies, it is not easy to conclude that Ubuntu origins are exclusively African. Even though that may be the case, existing literature suggests concordantly Ubuntu philosophy is a way of life closely related to multiple societies in Africa. With regards to the origins of Ubuntu, Khoza (2006) is of the view that the origins of Ubuntu are envisaged in the African understanding of how a human being was created [out of need] from the dawn of life. Although human beings may have different colour and race, however, humanity belongs together by virtue of having a shared or common origin. In his writings about Ubuntu and its origins, Khoza states that:

“Ubuntu has its origins in the African conceptions of being. The conventional conception of the genesis of life is that of *Umvelingqangi* [in isiZulu], or *Uqamatha* [in isiXhosa], or *Nkhumbyani* [in Xitsonga] created humankind from need. Therefore, all of humanity has a common origin and *ipso facto* belongs together. This creates a common bond and destiny for humanity. The individual is absorbed into the collective, yet retains an identity as an empirical being. Hence I am because you are, and you are, because we are. One finds an abundance of common idioms across Africa where *Ubuntu* gains expression, such as *umuntu ngumuntu ngabantu* [a person is a person because of others], has a universal application across Africa... All of these are manifestations of a belief system where the collective supersedes the individual; interdependence is seen as a superior value to independence” (Khoza, 2006: xx-xxi).

From this view point, it becomes clear that, Ubuntu origins are not necessarily exclusively African although prominently experienced and practiced amongst some African societies.

### 3.2.3 General Overview

Generally, Ubuntu concept is described as shared correlative humanness or humaneness conjugated with a strong communal sense, inclusive in its approach not just to persons of a particular community, but also of outsiders or foreigners. The notion or approach of inclusiveness of Ubuntu is somehow correlative to David Crocker’s global ethics’ writings titled “*Insiders and Outsiders in international Development*” where outsiders become insiders by being accepted, allowed to participate in communal activities, and in turn strive to

understand and contribute to the development of the community for the benefit of all. At the same time, insiders can easily become outsiders as they may not conform or agree with the way of life of a particular community even if they may have been were into that same community.

In its inclusivity or inclusiveness, Ubuntu also has a strong link to respect for nature and environment.

According to Murove (2009: 4), “Ubuntu forms a big part of what is called African Ethics.” African Ethics refer to a moral tradition that includes a belief system which is lived or experienced and practised on a day to day basis. The “beliefs are centred and grounded around what is thought to be right or wrong, good and evil and they are deeply incorporated into the many and various cultures of sub-Saharan Africa”. According to Shutte:

“Ubuntu is an ethical vision with fullness of humanity, the moral life seen as a process of personal growth, just as well as the participation in community with others is the essential means to personal growth. So the participation in community with others is the motive and fulfilment of the process. Everything that promotes personal growth and participation in community is good and everything that prevents it is bad” (Shutte 2001:30)

Because Ubuntu is premised on humanness, the Black Consciousness leader, Steve Biko (1970:40) asserted that, “the great powers of the world may have done wonders in giving the world an industrial and military look, but the great still has to come from Africa – giving the world a more human face.” Senghor gave an account of a “much-respected description of African personality, similar to the Ubuntu personality, which has an ability to withstand life in a different manner when compared with the general global personality” (1965). Ubuntu personality is resilient in its nature, hence Broodryk suggests that, this “personality could be of tremendous benefit to human beings in the global world today where violence, human exploitation, extreme stress, material greed and power- lust seem to be the dominating factors influencing the life of leaders and ordinary people.” On the NHI White Paper it was noted that there is a hiatus in clinical governance skills amongst some managers, therefore, incorporation of Ubuntu ethics into public health policy, which exhibits these positive values, would help curb some of the insufficiencies demonstrated by some managers within the health sector. Incorporation of, coupled with instillation of Ubuntu values through education

of managers within the health sector would help bring about some of the changes needed to strengthen clinical governance and therefore health systems.

Nussbaum is of the view that Ubuntu is an African moral theory that pontificates “our interconnectedness” as human beings and recognizes our common humanity. Encapsulated in Ubuntu is our responsibility as human beings towards “each other that flows from our interconnectedness” (2003:21). It is a fact of life that human beings, are all closely intertwined and in need of each other for continuity of life and for completeness of self. Each person has “a responsibility to secure the well-being [physical, mental, spiritual and social] of the other person in a community” since one person cannot evolve into completeness in seclusion (student paper, Stellenbosch University, 2016). This notion is concisely expressed by Shutte (2001:30) who says, “Our deepest moral obligation is to become more fully human. And this means entering more and more deeply into community with others. So, although the goal is personal fulfilment, selfishness is excluded” ([scriptura.journals.ac.za](http://scriptura.journals.ac.za)).

Ubuntu fosters people to participate in developing and maintaining a community while those that are not able to, for various tangible reasons, are encouraged and assisted back into being incorporated with their communities. As reiterated by Nussbaum (2003:21), Mkhize (1998:1) explicates that in “traditional African cultures, *self* is rooted in community” throughout many South African cultures. “The African view of personhood denies that a person can be described solely in terms of the physical and psychological properties. It is with reference to the community that a person is defined.” It is with innuendo to the other person that “I” is explained or identified. At the core of Ubuntu moral theory is an expression of general truth which states that “a person is a person through other persons” which is directly translated from “*umuntu ngumuntu ngabantu*” for Nguni speakers, (Shutte 1993:46; 2001:12; Ramose 2002; & Louw 2010). Ingrained in this expression of general truth is the conception that a person cannot be complete without another person. This adage simply implies that no person can have actual being in isolation, thrive, and be self-sufficient, as in some way, depicted by John Donne’s (1624) poem titled, “*No Man is an island*”. Being reliant on another is a matter that cannot be escaped. As reiterated by Nussbaum (2013a: 2), Bishop Dandala explicates it more crystal and broadly:

“Ubuntu is not a concept easily distilled into methodological procedure and it is rather a bedrock of a specific lifestyle or culture that seeks to honour human relationships as primary in any social, communal or corporate activity. It

essentially states that no one is self-sufficient and that interdependence is the reality for all” (1996).

When an indigenous person of South Africa utters the words, “*umuntu ngumuntu ngabantu*”, for Nguni speakers, and “*motho ke motho ka batho babang*” for Sotho-Tswana speakers, according to Metz, the words are not mere utterances making only an “empirical claim”. The claim rather carries with it a deeper meaning which “captures a normative account of what we ought to most value in life, that is, personhood, selfhood, and humanness” (2011:536-540). The assertion that “a person is a person through another person is a call to develop one’s personhood, a prescription to exhibit humanness” (Ibid).

At its centre, Ubuntu seeks to esteem relationships between human beings. It identifies that humans have an inherent worth and or value that deserves to be recognized and celebrated not only at societal level, but also in the place of work. Ubuntu recognizes and appreciates humans are interconnected and interdependent. Prof Michael Battle of Duke University concurs that “Ubuntu reflects the strong interdependence of human beings.” According to Battle,

“We say, ‘a person is a person through the other persons.’ We don't come fully formed into the world ...We need other human beings in order to be human. We are made for togetherness, we are made for family, for fellowship, for community to exist in a tender network of interdependence” (Battle, 1997).

African cultures are diverse, yet, amongst them exists shared commonalities in the sphere of ideals and customs, beliefs and practices. These ideals and or customs, beliefs and practices are reflective of largely the African global sight whose principle is Ubuntu. African ethics are rooted on or “arise from an understanding of the world as being an interconnected whole wherein what it means to be ethical is inseparable from all spheres of existence” (Murove, 2009:28). Another perspective of African ethics where affiliation or relationality is explicit is in the thought development of a person that is believed to be existing relationally in an abiding state of dependence and interdependence. As reiterated by Murove, Harvey Sindima (1995) is of the view that:

“The African concept of person is grounded in the concept of life, which is the basis for understanding all creation and is central, all-embracing and overarching notion informing a manner of living in the world. The sense of

being connected, bounded in one common life, informs human relationships and defines behavioural patterns” (2009: 29; uir.unisa.ac.za).

Ubuntu is an old system of principles and a certain manner of life, which, for multiple centuries has kept communities going throughout South Africa and in other African countries as well. According to Louw (2016), the word “Ubuntu means ‘humanity’; ‘humanness’ or even ‘humaneness’.” According to Munyaka and Mothlabi (2009) the “word ‘Ubuntu’ is said to be a derivative of the word ‘muntu’ which means a person or a human being.” Ubuntu has the following positive attributes tabled out in table 3, as identified by Broodryk:

**Table 3.1: Positive attributes and meanings of the African Ubuntu philosophy**

Ubuntu attribute	African Ubuntu meaning
U- Universal	Global, intercultural brotherhood
B- Behaviour	Human (humane), caring, sharing, respect, compassion (love, appreciation)
U- United	Solidarity, community, bond, family
N- Negotiation	Consensus, democracy
T- Tolerance	Patience, diplomacy
U- Understanding	Empathy (forgiveness, kindness)

*Source: Adapted from Broodryk (2005:175)*

With these attributes of Ubuntu and their meaning, public health policy based on Ubuntu would assist in bringing people together, fostering care and sharing, identity and solidarity with those who are less fortunate, take away the self-enriching attitude that does not care much about the rest of the people, especially for the leaders.

Ubuntu is considered to be the fulfilment of person’s potential and a modus operandi of becoming a certain kind of a human-being considered to be humane, carrying oneself in a manner that is befitting or desired for a human-being. Because of this expectation to carry oneself in a particular way towards another being, it is very likely for a person to be reckoned inhuman under Ubuntu ethics, even as far as environment is concerned in some instances. In addition to acts and a person’s behaviour, Ubuntu is intertwined with what is best described by Munyaka & Motlhabi (2009:65) as

“...a spiritual foundation, a person’s inner state, an orientation and a temperament intended for good which motivates, challenges and makes one



inwardly take, as well as feel in a humane way towards other persons in harmonious relations within a society.”

Chinkanda (1994) is of the view that “Ubuntu is an internal state of being or the very essence of being human.” According to Saule (1996), the ethic is said to be “instilled into an individual over a period of time through socialisation processes carried out in established traditional institutions.”

According to Louw, “...the ultimate goal of a person in the biological sense should be about becoming a full person, a real self or genuine human being through communal, harmonious or friendly relationships” (2016:1-2). He goes on to say that “one gets to identify with others in a way that renders him or her to think of others and self as ‘we’ or as members of the same group and to cooperate with them in a sense that allows to work towards achieving the same ends while exhibiting compassion towards others in the process.”

Munyaka and Mothlabi (2009) are of the view that Ubuntu adage which states that “a person is a person through others” is one of the “basic and central tenets of the Ethic of Ubuntu.” To further explicate on Ubuntu, they state that, in Ubuntu global sight, a person is the foundation, centre and end of everything with all other things making sense only in relation to a person with no regard to gender, or his/her race” (Munyaka & Mothlabi, 2009: 66). Since Ubuntu means “humanity, humanness or humaneness, it articulates an identification with and compassion [caring, sharing, empathy, respect, warmth and understanding] for others. Ubuntu as an ethic inspires morally and reveals meaning [that is, value, relevance or significance] of life to those who participate in it” (Louw, 2014: 2). Deducing from the aphorism it comes afore that respect for others, personhood, harmonious living, morality and community form the foundation of Ubuntu Ethic. As earlier alluded to, at the core of Ubuntu ethic exists the principle of connectedness of persons with each other, coupled with the principle of caring for the others. And as such “a person is viewed as the cornerstone of a society with a man or woman being taken as valuable in him or herself with all his/her ramifications not just the welfare or material being” (Biko, 1978:46).

It can be deduced that “...the African view of an individual is that a human being cannot exist alone but within a community, that a human being cannot be separated or be complete without others” (Murove, 2009:68). According to John Mbiti’s explication,

“...it is only in terms of other people that the individual becomes conscious of his being, his own duties, privileges and responsibilities towards others and himself. The individual can only say, ‘I am because we are and since we are, therefore I am.’ This is the cardinal point in the understanding of the view of a man” (1969:108-9).

Ubuntu does not fully subscribe to individualism, though it respects particularity. It is about relationality, embracing communality, and is penetrated by a strong sense of caring for others, not simply as a cold hypothetical spiritual way of life. Particularity makes sense insofar “as an individual relates to others in a solid humane way; and humanity is not something that one can develop by him/herself in isolation but can only fulfil or exercise humanity as long as one remains in touch with others” (student paper, Stellenbosch University, 2016), not simply as a sociological conception, but rather as a moral notion. As much as Ubuntu is somewhat opposed to individualism, however, “Ubuntu respects particularity of the other, which links up closely to its respect for individuality” (Louw, 2007).

In my view, Ubuntu seems to promote a concept of treating others not only as means to an end, but rather as ends in themselves since human beings are inherently valuable and based on being mere human, thus they must be treated with respect. Ubuntu also seems to predispose one into “treating the other as one would want to be treated” if in similar circumstances. The concept of Ubuntu seems to be aligned to the “*Universal Golden Rule*”. In a certain way, Ubuntu appears to be encouraging actions which one would agree to be made universal for everyone in an analogous position, not simply out of duty, but more from a sense being [self-realisation process], through another person. From this point of view, it makes Ubuntu ethic somewhat similar to Kant’s categorical imperative, in addition to being aligned with “*Universal Golden Rule*”. Contrary to Kantianism, Ubuntu is antagonistic to anything that is harmful to other human beings. As such, the post-1994 Constitution of South Africa is partly founded on the Ubuntu concept. Ubuntu encourages one to care for the well-being of the other person. This is attested to by the South African Governmental White Paper for Social Welfare which recognizes that:

“The principle of caring for each other’s well-being and a spirit of a mutual support, each individual’s humanity is ideally expressed through his or her relationship with others and theirs in turn through a recognition of the

individual's humanity. Ubuntu means that people are people through other people. It acknowledges both the rights and the responsibilities of every citizen in promoting individual and societal well-being" (SA White Paper, 1997).

As reiterated by Manda D.S. (2009, Africa Files), "Ubuntu is a concept which dictates that a high value be placed on the life of a human being." It is deeply rooted on a premise which states that, in each person resides inherent goodness, for all persons are born with innate capability to care, love, ensure and contribute towards the well-being of the other person, by being actively involved in bringing about the change that improves the physical, mental, social and economic status of the other person. As Nussbaum explains,

"Ubuntu's inclusive approach with its awareness of the need to keep open lines of communication and the processes required to build and maintain communal relationships offers what American business-speak refer to as 'social technologies,' known for their subtle yet profound effects" (2009:239-245).

Nussbaum goes on to say that "Ubuntu has influenced business thinkers to increasingly articulate the need for people to recognise their common humanity". According to Metz, in Ubuntu as a moral theory,

"...actions are wrong not merely in so far as they harm people [utilitarianism] or degrade an individual's autonomy [Kantianism], but rather to the extent that they are unfriendly or, more carefully, fail to respect or the capacity for it. Actions such as deception, coercion and exploitation are anti-communal as they fail to honour communal relationships" (Metz, 2011:540).

Ubuntu moral theory, has something to offer, not only on communal structures, but also in "the global world of business and to some degree, the world of law, religion and politics, in the field of biomedical ethics" (student paper, Stellenbosch University, 2016), as well as in policy making in South Africa. Certainly, in the context of this thesis, Ubuntu comes out strongly as a viable theory through which the disparities in the health care system in South Africa can be addressed.

### **3.3 DISTRIBUTIVE JUSTICE IN THE CONTEXT OF RESOURCE ALLOCATION FOR HEALTH CARE IN SOUTH AFRICA**

#### **3.3.1 Introduction**

With advancements of biomedical technology, it is almost inexorable not to apply rationing in health care. This responsibility carries with it the need for fair and or just distribution of resources available at our disposal as a people of South Africa. In using rationing and applying distributive justice in resource allocation for healthcare in South Africa, due consideration needs to be taken into account as far as addressing some of the underlying causes of the existing inequalities and inequities within the health care sector.

Generally, the concept of distributive justice is not easily applied as there are many views that exist. Distributive justice is a form of social justice which is seen as being a central value or a foundation of public health. Gostin & Powers (2006: 1053) argue that “justice on its own cannot determine the ‘correct’ policy nor can it give answers to all arising questions regarding public health at large.” In actuality, no single principle or moral theory can, hence the proposal of adoption of Ubuntu into public health policy in addition to the existing principles. In dealing with public health, it is unavoidable that questions of justice come to the fore since public health on its own is a matter of social justice. Dan Beauchamp (1976, 105) succinctly puts it that “...the historic dream of public health...is a dream of social justice.”

Jonathan Wolff (1991: 76) states that, “theories of justice address what is commonly known as the problem of distributive justice: how the goods of our society ought to be justly distributed.” Globally, some people are of the view that distributive justice is applied when handling resources or goods that are scarce in the absolute sense. However, Friedrich Breyer (2009: 395), argues that medical resources are not by own nature a scarce resource, but rather, “scarcity is a necessary by-product of collective financing arrangements,” such as the planned NHI in South African context.

Within the context of health care, these goods vary greatly “amongst citizens according to need measured by risk of illness, partly for reasons beyond the control of an individual” (Breyer, 2009: 395), even more so when referring to genetically related disorders or diseases. Because of the varying needs between different people, an unfair distribution of resources may occur especially amongst those who do not have the means to purchase private health insurance for procedures or treatment not covered by a State facility.

### 3.3.2 An Overview of Distributive Justice

Before delving into distributive justice, it is important that an explanation of the term justice be given in order to arrive at a reasonable understanding of the concept of distributive justice in the context of resource allocation for health care in South Africa. From the writings of John Rawls (1971), “justice is fairness or reasonableness in a manner in which people are treated or decisions are taken.” John Rawls’ *justice* theory is based on two principles where ...a person ought to have an equal right to the most basic freedom “compatible with similar” freedom for other persons. The second principle addresses “social and economic inequalities” which should be handled in a manner that will be of “benefit to everyone”, and to have “attached positions and offices open to all...” (Ibid). In common and regular conversations, justice is used interchangeably with fairness, because it is natural of human beings to desire fair treatment in all circumstances in life. Secondly, the interchange between justice and fairness could be stemming from the Latin word “*justitia* which means fairness, equity” (Smith, 2015). As Edmonds (2017:1) points out, “...we shouldn't be judged more harshly because of our skin colour, we shouldn't be paid any less because of our gender, and we shouldn't have to wait longer for a drink because of what we're wearing. We feel we deserve equal and impartial treatment.” Within the context of this research, one should not have to suffer from an illness or disease whose treatment is not available in the public health care sector, but only accessible via private health insurance. In the context of *justice* theories when people are assured of justice, the society is generally perceived to be a good society. In a just system, people feel a sense of being equal, especially in the sharing of resources to which they should have access. This notion of justice is explained in detail by Warren who compares social justice with legal justice and concludes that,

“The basic needs of humanity – shelter, education and healthcare – are sometimes advocated on the basis of a fundamental humane entitlement. If the entitlement is not met then a denial of social justice is asserted. Arguments prevail about the haves and the have-nots. It is said to be ‘unjust’ that some in society are homeless, receive a different standard of education or are unable to access necessary healthcare. In this sense, the concept of justice is merged with factors of equality, opportunity and equity” (Warren, 2014:2).

I am of the view that, it is with this explanation in mind laid out above that distributive justice should be understood. Lamont and Favor (2016, <https://plato.stanford.edu>) explain in the Stanford Encyclopaedia the various dimensions of distributive justice as follows:

“Distributive principles vary in numerous dimensions. They vary in what is considered relevant to distributive justice (income, wealth, opportunities, jobs, welfare, utility, etc.); in the nature of the recipients of the distribution (individual persons, groups of persons, reference classes, etc.); and on what basis the distribution should be made (equality, maximization, according to individual characteristics, according to free transactions, etc).”

Each society or country has its own economic framework which consequently leads to distribution of benefits and burdens amongst the citizens. According to Stanford Encyclopaedia (2013, <https://plato.stanford.edu>), “these economic frameworks result from human political processes and change is constant across and within societies.” From the ancient time of human evolution, it is an established fact that people lived in reasonably inflexible environment of economy whereby “nature or God” was thought to be responsible for the “distribution of economic benefits and burdens” (Ibid). Through times past, it was appreciated that these economic burdens’ and benefits’ distribution could be altered by government. That realization gave birth to the livelihood of distributive justice.

There are different justice theories, such as, Utilitarian, Libertarian, Egalitarian and Communitarian, which are referred to as traditional theories by Beauchamp and Childress, as well as Capabilities theories and Well-Being theories, which they refer to as recent theories. Although there are in total six theories of justice according to Beauchamp and Childress, some tension exists between two theories. Below, I will briefly discuss these two theories of justice, that is, Egalitarian and Libertarian. Additionally, I will also briefly discuss Communitarian theories which closely links up with Ubuntu and are relevant for the purpose of this research. The scope of this research is limited and it is therefore not possible to discuss all theories of justice. For the aim of this research, I have chosen to limit my discussion to these three theories of justice. I have decided to include Libertarian justice theories to try and highlight the incompatibility it brings for a nation that is striving to achieve equality and redress the inequities stemming from a past of “divide and rule”. I have decided to specifically focus on Egalitarian and Communitarian justice theories because their point of focus is on achieving

some form of equality in as far as accessing resources is concerned. Bridging the gap and achieving some form of equality is an area of interest and focus for this research, hence the choice to discuss these two theories. My decision not to discuss the Utilitarian justice theory is because both Communitarian and Egalitarian are focused on utility for the benefit of the public.

### **3.3.2.1 Libertarian Justice Theories**

Ordinarily, theories of justice are in a quest to clarify “what is meant by just distribution of goods among members of society” ([www.iep.utm.edu](http://www.iep.utm.edu)). Libertarians’ comprehension of justice tends to focus more on disencumbered “operations of fair procedures and transactions, rather than on public utility or on acting to meet the health and welfare needs” of community members (Beauchamp & Childress, 2009:255). In libertarian view, distribution of “public health measures and health care is just and justified if individuals in the relevant community freely opt for it” (Ibid), without being coerced by any State authority or official. Under this libertarian view, the State is “not morally obligated to provide health care” (Ibid) to the people as it cannot forcefully collect funds through taxations and the State is in no position to compel physicians to service communities.

From the above, it comes to the fore that, this theory of justice would be difficult to apply in practice as some countries, specifically South Africa, has many people still living below poverty line. If this theory was to be applied on policy of public health in a South African setting, many of the people would be left destitute without means to access health care services.

### **3.3.2.2 Egalitarian Justice Theories**

From the egalitarian perspective, all human beings have an inherent value and therefore deserve to be treated equally as they each possess a moral status by virtue of being human. Though they advocate for equality, the application of equality is only as far as certain respects, because they do not necessarily advocate for “equal sharing of all social benefits to all persons” (Beauchamp & Childress, 2009:256). One of the popular egalitarian theories is put forth by Rawls. In some of his writings and teachings, Rawls states that, “what justifies a conception of justice is not its being true to an order antecedent and given to us, but its congruence with our deeper understanding of ourselves and our aspirations” (Rawls, 1980).

In other words, Rawls theory is not about who first got hold of the goods in question or at hand, his theory is more about comprehending the persons beyond the materials or goods, and about what it is we as human beings want to achieve. These achievements not only apply to individuals, but also to a community or a society. Rawls' theory concept is, in some ways, compatible with Ubuntu ethics which views a person in totality, rather than partiality. Additionally, because Rawls' theory is about just and equal distribution of goods, in this case [though not explicitly stated by Rawls], it extends to equal distribution of health care access, services and resources. Norman Daniels is of the view that, "health care needs are special and that fair opportunity is to any acceptable justice theory" (2007). He goes on to say that, "the central moral importance, for the purpose of justice, of "preventing and treating disease and disability with effective health care services derives from the way in which protecting normal functioning, health care preserves for people the ability to participate in the political, social and economic life of their society" (2001: 3).

Deducing from Daniels' perspective, it is morally required and of significance for distributive justice theory to ensure that a life of a human being is preserved, and kept safe from illness or disability by ensuring just and equal distribution of health care services in public health. In ensuring preservation of human life through prevention and treatment of disease, a healthy status of an individual and of the community is maintained.

### **3.3.2.3 Communitarian Theories of Justice**

Communitarians have minimum room or none at all, to accommodate for individual rights. The theories are based on general welfare of all persons within a nation or country. According to Beauchamp and Childress, "communitarians consider principles of justice as pluralistic, deriving from as many conceptions of good as there are diverse moral communities" (2009:258). Alasdair MacIntyre (1998) is of the view that anything that "is owed to the individuals or groups depends on the community-based standards." This theory underscores the importance of community and common good for all. Beauchamp and Childress state that, its emphasis on common good and on the community appears in policies for the allocation of health. Callahan (1990), a communitarian, is of the view that "we should enact public policy from a shared consensus about the good of the society rather than on the basis of individual rights."



This justice theory's core emphasis is on the common good of the community, something that Ubuntu ethics is concerned with. Nobody can exist alone and "everyone's existence is connected and dependent to other persons, since an individual person can be empowered within a relational context with others" (Have, 2016:114). Just as with Ubuntu, emphasis is put on "commonality and interdependence of the members of the community". Therefore, "individuals have duties and responsibilities towards each other rather than merely rights" (Chuwa, 2014).

From the discussion of justice theories or concepts, it comes to the fore that some theories share commonalities about, and promote collective community goodness rather than focusing on individual rights. Therefore, in public health policy concerning resource allocation, I think that Ubuntu ethics, together with other moral theory concepts and or some theories of justice, has a role to play in bridging the gap that exists in health care sector.

### **3.3.3 Principles of Justice**

Different Principles govern the application of distributive justice. Rawls proposed two principles of justice. The first principle requires that there is an equal claim amongst the concerned persons in the assignment of "basic rights and duties or liberties" (Rawls, 1971: 275), which Immanuel Kant mentions in his writings about social and political philosophy. The second principle requires fairness where "social and economic inequalities are arranged in such a way that they are both reasonably expected to be to everyone's benefit, more so for the least advantaged members of community" and the "inequalities be attached to positions and offices open to all" (Rawls, 1971: 275). Some theorists have argued that the principles of distributive justice should be applied based on: welfare, desert, liberty, difference, feminism as well as, egalitarian-based.

In the context of healthcare issues in South Africa, health services are viewed as a welfare service provided by the state, and related resources are a common national wealth. As a welfare service, healthcare should therefore be accessible not to individuals, but rather to all communities in South Africa in an equitable manner according to their needs. Yet, as Lamont and Favor (2016) state, "...there has never been, and never will be, a purely libertarian society or Rawlsian society, or any society whose distribution conforms to one of the proposed principles, so rather than guiding ideal societies, distributive principles provide moral guidance for the choices that each society faces now and every year." As a result,

differences emerge in perspectives as to how distribution should be done to ensure justice. So, while “advocates of Rawls' Difference Principle are arguing that we should change our institutions to improve the life prospects of the least advantaged in society,” others “are arguing for changes to bring economic benefits and burdens more in accordance with what people deserve” Lamont and Favor (2016). If Lamont and Favor’s view or approach was to be applied in South African context, avoidable and remedial differences existing amongst South Africans would further widen considering some of the root causes of inequality and inequity in South African history.

With regard to resource distribution in healthcare, some may argue that we must establish structures like the NHI so that the least advantaged or the poor can have access to healthcare, while others will likely argue that it may be better to work on improving the economy of South Africa so that citizens get what they deserve rather than what they are simply given. It may be thought by libertarians that “reductions in government intervention in the economy will better respect of liberty and/or self-ownership of its citizens,” yet it has to be balanced with the view that extreme poverty removes all respect and dignity from a human being, especially when it comes to healthcare. Capp, Savage and Clarke, (2001:1) also argue that,

“The allocation of resources to providers and the way in which the resources are then prioritised to specific service areas and patients remain the critical ethical decisions which determine the type of health system a community receives. Health care providers will never be given enough resources to satisfy all the demands placed upon them by a community that is becoming increasingly informed and demanding.”

The challenge that government has to deal with is to bring equity into public health within the limits of the resources available.

In discussing the allocation and rationing of resources in the healthcare system, one cannot avoid touching on gate-keeping as a converse practice in healthcare. Smith presents three different roles that healthcare professionals play with regard to resource distribution:

“(1) the *de facto* role, which recognizes a responsibility to practice medicine which is both beneficial and effective for the patient; (2) negative gate-keeping which operates under a prepayment system and, in turn, requires a physician

to limit, within the rules of the system, the use of health care services; (3) or positive gate-keeping, where the physician encourages patient use of the health care system for either personal or corporate profit” (Smith, 2002:424).

It can be observed that all the three forms of gate-keeping have been practised in South Africa. In some cases, some patients have benefited, while in other cases, many patients have been disadvantaged. This is part of the reason interventions have to be sought in terms of restructuring government policy and legislation through parliament using Ubuntu approach. With that said, with NHI implementation and looking at the details given out concerning how it will work, it seems negative gate-keeping will be inevitable, something that the health care sector cannot completely avoid.

### **3.4 PUBLIC HEALTH ETHICS**

#### **3.4.1 Introduction**

Public Health Ethics<sup>4</sup> is relatively a new field of study which emanated, as a branch, from bioethics when inexorable facts and reality about infectious diseases continued to ravage communities in various countries, both developed and under-developed, and when it was realized that “the health of populations is a function more of good public health measures and socioeconomic conditions than advances in biomedicine” (Callahan & Jennings, 2002:169). Although Public Health Ethics is considered to be a subgroup of bioethics, the field has “two parent disciplines, that is, public health which rests on the logic of scientific discovery and ethics which rest on the logic of right action and good decision making” (Ortmann, Barret, Saenz, Bernheim, Dawson & Reis; 2016:4). The emergence of this field of study began as a result of numerous moral issues in the sphere of public health which “extended beyond the borders of bioethics.” These moral issues necessitated their “own form of ethical analysis” (Callahan & Jennings, 2002:169). As the attention of policymakers shifted “toward outcomes of health, cost-effectiveness and preventive measures [primary,

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<sup>4</sup> According to Centre for Disease Control and Prevention [CDC], Public Health Ethics is defined as a “systematic process to clarify, prioritize, and justify possible courses of public health actions based on ethical principles, values and beliefs of stakeholders, scientific and other information” (2011. <https://www.cdc.gov>, accessed 23/08/2017). Defined slightly differently by Gostin (2003:179), it is “the principles and values which help guide the values among public health system actors designed to promote health and prevent injury, plus disease in the population”.

secondary, tertiary]” right through human life cycle, the field of public health started to gain momentum both in “public and legislative” domains (Ibid).

Although there was not yet a formal field of study of public health ethics, from around “the 1980s, a Forum on Bioethics [now called the Forum on Ethics] was consummated by the American Public Health Association as a primary interest group that catalysed the discussions and networking of public health ethics scholar” (Callahan & Jennings, 2002:170). According to Callahan & Jennings (2002), continued persistence of certain factors such as the inequality of “health status of race and ethnicity, the arising need for universal health care, and the significance of background social and economic factors caught the attention of the many,” a need for change in the field of bioethics was inevitable. From around the middle of 1990s, there was proliferation of “interest in population health and the ethical dilemmas that were facing the public health programmes attracted attention” (Callahan & Jennings, 2002: 170). As such, “courses on ethics, and public health and ethics began to surface with greater frequency within the public health curriculum of public health schools.” In year of “1997 CDC formed an ethics subcommittee of the Director’s Advisory Committee” (Ibid). Currently, public health ethics is a full-fledged field of study assisting public health practitioners and policy makers in making principle-based decisions when needing to launch and implement a public health programme for the good health of communities or societies.

As earlier alluded to, public health ethics is related to bioethics, clinical and research ethics. However, public health ethics possess features that make it different. According to Ortmann *et al* (2016), what sets it apart are “the defining characteristics which focus on achieving social goods for the populations while respecting individual rights and recognizing the interdependence of people”. Public health ethics applies “principles and norms that guide the practice of public health and it identifies, analyses and resolves ethical issues inherent in the practice of public health” (Ortmann *et al*, 2016). Public health ethics is more concerned with communal health than just individuals, yet at the same time respecting individual rights. These features seem to have some similarity to Ubuntu ethics which also has focus on what is good for the people at community level than just paying attention to individuals. Integrating Ubuntu moral theory would be more beneficial to the disadvantaged population as it offers more positive characteristics, which, if embraced and fostered stand to bridge some of the disparities between public and private; and within the public health care sector.

### 3.4.2 Public Health

It is almost impossible to elaborate on public health ethics without first touching on public health discipline to which the moral values and principles discussed refer. Public Health is one of the old science-based disciplines whose definitions are multiple. Attempts have been made to provide definitions although some of these definitions fall short as they only address the health aspect without including the public aspect. Dawson's and Verweij's (2007) approach to the definition of public health has been developed such that its authors state that, public health is "the epidemiologically measured health of a population or group, or the distribution of health in a population, or the underlying social and environmental conditions causing an impact on everyone's health, requiring a collective and concerted actions" usually effected by governments to promote health and prevent disease or injury before manifestation, "with involvement of the public to realize the improvements of health" of a population. Winslow (1920) defines public health as

"...the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, and the organization of medical and nursing service for the early diagnosis and preventative treatment of disease."

From both the definitions stated above, it comes to the fore that public health efforts are collective in nature, involving multiple actors such as governments, public health practitioners, other stakeholders, including the community members. Public health is concerned with dealing with masses of people on a preventative and promotive basis before a disease manifests or before an injury occurs. Gauging by the high level of operations and functions, it becomes hard not to foresee ethical challenges that may arise when a certain programme is being planned for implementation with particular reference to South Africa's Constitution which is seemingly elevating protection of individual human rights at its core, provided that one poses a threat of violating the rights of others.

Ortmann *et al* (2016:5) concurs that traditionally, public health's "emphasis is on preventative measures which focus on addressing the root or core cause" of a disease or an illness before symptomatology manifestation, and on "promotion of health and well-being of

the population across a range of interventions.” However, authors such as Marmot & Wilkinson (1999), Syme (1998), and Gostin (2003) acknowledge that, public health officials are widening their scope of practice by tackling issues related to even-handed allocation of socio-economic resources since “social status, race, and wealth are important influential factors on the health of populations.” By focusing on these factors including the “social capital” seems to be the way forward as governments in different parts of the world are exploring to find ways to reduce the persistent health and socioeconomic disparities.

According to Ortmann *et al* (2016), public health is more of an empirical field and most often than not, “its definition takes an enumerative form of identifying key activities [such as, surveillance, sanitation, maintaining food and workplace safety, disease prevention and control, and promoting healthy behaviour].” To illustrate this enumerative approach, Public Health Functions Steering Committee (1994) developed a schematic diagram illustrating ten enumerative essential services of public health presented below in Figure 4.1.



Figure 4.1 Essential Public Health Services.<sup>5</sup>

<sup>5</sup>(1) Monitor health status to identify community health problems. (2) Diagnose and investigate health problems and health hazards in the community. (3) Inform, educate, and empower people about health issues. (4) Mobilize community partnerships and action to identify and solve health problems. (5) Develop policies and plans that support individual and community health efforts. (6) Enforce laws and regulations that protect health and ensure safety. (7) Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable. (8) Assure competent public and personal health care workforce. (9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services. (10) Research for new insights and innovative solutions to health problems. From Public Health Functions Steering Committee 1994. Essential Public Health Services. Available at <http://www.cdc.gov/nphpsp/essentialServices.html>, accessed on the 24/08/2017).

These ten essential services serve as a framework for public health initiatives and “fall under three overarching functions of assessment, function, and assurance that construct an integrated cyclic process” (Ortmann *et al*, 2016:5). Rendering of services at “local, regional, or national public health agencies consequently defines public health practice,” and although “research is an integral to all public health services,” however, it “is a distinct practical service that provides insights and innovative solutions” (Ibid). From the preceding discussion, it surfaces that community is at the core of public health practice and services. According to Jennings (2007), community is not a statistical concept based on abstraction and it is not an absolute assemblage of individuals, but more of a “network of relationships and emotional bonds between people sharing a life in common, organized through a political and moral order.” Jennings’s definition of a community brings out some of the core values shared by Ubuntu. Forming an integral part of Ubuntu ethics are the relationships amongst people sharing a life and a common humanity.

As it currently stands in South Africa, the Public Health Sector is not only about public health that is focused on individuals alone, but it is rather far reaching and targeted at communities. Primary health care facilities have almost doubled in number, from just about 67 million to being more than 120 million since after 1994, making health care services accessible to many who were previously disadvantaged. With new health programmes introduced such as school health, child and maternal health, rehabilitation and mental health, HIV & AIDS treatment programme and so forth, more communities are able to access services that were previously limited. In the current state, South Africa’s public health system is not only concentrated on preventative services as it previously was before amalgamation of segregated healthcare, it is now rather extensive and inclusive of curative services as well which are offered at various levels of health care facilities.

All these developments and programmes form part of policies that are geared towards achieving equitable access to health care services and redressing the existing disparities. These are in line with the proposed enumerative essential services offered by public health sector as illustrated on the schematic diagram in figure 4.1 above.

With all the efforts by the government, quality of health services remains poor in South Africa as a result various contributing factors such as, poor governance with failing management health systems, poor staff morale compounded by lack of support from

management and health personnel shortages. These contributing factors that hinder deliverance of good quality services to poor are referred to as fault-lines by Prof Rispel. These negatively contributing factors make the public health sector efforts fall short of what it intends to offer to the South African population.

By adopting and incorporating Ubuntu moral theory, some of the contributing factors could be addressed since this concept or theory offers some positive values, which, if instilled not only on public health policy, but also as part of professional ethics and code of conduct, could have far more reaching outcomes in as far as improving quality of health services.



## CHAPTER 4: THE SOUTH AFRICAN HEALTHCARE SYSTEM

### 4.1 INTRODUCTION

As previously explained, the South African healthcare system is a two-tier system divided between private and public sectors, like in many developed and some underdeveloped countries. The previously fragmented public health system was dismantled in post-colonisation era. “A new politico-administrative structure was established post 1994 elections,” giving birth to “nine new provinces” and one National Department of Health, versus the “previous structure of four provinces and ten ‘homeland’ administrations” (Wadee, *et al*, 2003). However, the two-tier system has proven difficult to dismantle. As such, legal instruments were adopted to provide frameworks for continued work of accommodating and providing for basic, equal and equitable rights for all within the public health system. Within the provinces, for service delivery, Primary Health Care [PHC] makes the bedrock for “District Health System [DHS] policy” (Twenty-year review South Africa, 2014). Despite the provision of frameworks meant for continued equitable service delivery for all, equitable access to health care services is far from reality. Not only there is inequity between private and public health care sectors, but there are “substantial inequities in health between provinces and also within provinces” (Day, Monticelli, 2006; Development indicators, 2008; & Coovadia *et al*, 2009). This means that inequities exist within public health sector alone.

Within the two-tier system that exists in South Africa, the greatest burden of disease is carried by the public sector. Given that the State is the guardian of every individual person living in South Africa and with the South African Constitutional provision of everyone having a right to access to healthcare, members of the private health insurance cannot be denied services in public healthcare sector. When private health insurance funds are exhausted, members of these private health insurance seek health services from the public sector. With this current scenario, the public healthcare sector remains over-burdened and will continue taking strain until implementable solutions beneficial to most have been established. The public health system has an inherent duty to adopt an approach that rests on societal interests seeking to provide the greatest good health for the greatest number of people, whereas the private health system focuses on individuals with financial ability to pay for services rendered.

## 4.2 HISTORICAL ORIGINS

The South African history is laden with a legacy of apartheid, a regime which treated people differently based on colour of their skin and gender. The unequal treatment that people of different race and gender were subjected to not only affected them on a societal level, but it was rather transmitted to all spheres of their lives, including the health care system. It has been over two decades since the end of apartheid regime, yet “the South African healthcare system continues to be faced with significant challenges” (Arhete & Erasmus, 2016). Efforts, such as increasing the number of primary health care facilities, have been made by the South African government to try and ameliorate the unequal and poor access to health care by some people. However, the system is said to be “performing below standard” (Ibid).

According to Coovadia, *et al*, (2009), “the origin of a dysfunctional health system and the clash of the epidemics of communicable and non-communicable diseases” results from policies that were put in place during the apartheid government; the effects of such policies are still visible under the democratic government. Coovadia, *et al*, go on to say that South Africa’s anguished past was formed by a combination of policies that were enforced by the ruling government of the time. Policies such as “discrimination against gender and race, the forced migration that led to disruption of family life, huge income disparities, and extreme violence, have all contributed to the health status and health services” rendered to non-White South Africans. As a result of policies that were implemented by the apartheid government, Charasse-Puoele and Fournier (2002) concur that, “differences on poverty levels and on health care supply, including difference in education opportunities, were created between racial groups,” which impacted on the health status of Blacks<sup>6</sup>. “The apartheid policy encouraged separated development for each of the racial groups, ultimately working to the greater benefit of Whites” (McIntyre, *et al*, 1995).

Before the 1994 election, “South Africa was divided along the lines of race into four independent states, six self-governing territories and four provinces of White South Africa.”

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<sup>6</sup>South African History Online quotes a paper of 1971 in which Steve Biko defined “Black” “...as those who are by law or tradition politically, economically and socially discriminated against as a group in the South African society and identifying themselves as a unit in the struggle towards the realization of their aspirations.” For Biko, therefore, being black was not a matter of skin pigmentation, but a reflection of a mental attitude.

Source: <http://www.sahistory.org.za/archive/definition-black-consciousness-bantu-stephen-biko-december-1971-south-africa>, accessed in August 2017.

As a consequence of the division, there was “approximately 800 local government authorities whose roles differed greatly depending on race and location [urban or rural areas]” (McIntyre, *et al*, 1995).

Coovadia *et al* go on to say that, the apartheid regime further caused division of health care when the Bantustans were established, each with its own health department. The Bantustans were created after the Nationalist Party government assumed office in 1948. Jobson (2015) concurs and says, other than the division leading to the duplication of local government authorities, the fragmentation also resulted in “fourteen separate health departments being created, one for each racial group and one for each nominally independent apartheid homeland.”

The system not only resulted in duplication and fragmentation, it also led to “racial inequalities in access to health care due to a differential funding” system that was put in place (Jobson, 2015). The Public Health Act amended in 1897 promoted the “racial segregation by separating the curative and preventative services, and in 1910, the Union for South Africa was established, further fragmenting health care services amongst the four provinces of the time” (Coovadia *et al*, 2009). The “1919 Health Act gave the hospitals in the four former provinces the responsibility of curative care, and preventative and promotive healthcare to the local authorities” (Ibid.). The Act, which was “drafted in response to high mortality rates from 1918 influenza outbreak, created a divided three-tier health service – national, provincial and municipal system.” (SAHR, 2016). This three-tier health system was agreed upon as a political means to an end, to have the “Boer Republic agree to union with the British Colony” (Ibid.).

As far back as around 1880s, private hospitals already existed and “private health care was funded from out of pocket payments until 1889 when the first voluntary health insurance organization was introduced. The organization was called medical schemes, and was meant to benefit the health care needs of White mine workers initially” (Coovadia, *et al*, 2009). According to Tollman and Pick (2002), “apartheid years were at their high in periods from late 1950’s till the late 1980’s. Around this time period, urban hospitals were developed, and although they were publicly funded, these newly built hospitals added to the expansion of private health sector;” and were meant to be for profit, versus the initial trend of “mission hospitals and industry-specific on-site hospitals” (Coovadia, *et al*, 2009). According to Coovadia *et al* (2009), the extension of private hospitals was escalated by a distinct policy of government to make hospitals private for the purpose of profit-making and, to catch on with

international trends geared towards “an increasing role of private sector.” The benefits and services of private hospitals could only be afforded by the “privileged White minority” (Ibid.). The development of these private hospitals was greatly “stimulated by corporate capital, especially the mining houses” (Coovadia *et al*, 2009). Many authors such as Tollman and Pick; Bac, (1986); Van Rensburg, (1995); Health Systems Trust & Henry Kaiser J. foundation, (1995) are of the view that, health care services to population groups occupying rural areas was largely provided, at times, effectively by “networks of mission-sponsored hospital and clinic system”. The “Bantustans health system’s backbone emerged from non-profit organizations and hospitals run by missionaries” (WHO, 1983; & Coovadia *et al*, 2009).

Around early 1940s, Community-Oriented Primary Care [COPC] surfaced when Sidney and Emily Kark founded and established Pholela Health care centre in 1942 nearby a poverty-stricken area of KwaZulu Natal. COPC emerged after the Republic of South Africa was faced with “health challenges resulting from development of urban slums and the growing TB epidemic that was affecting mine workers”. As a result of widespread movement of Black people from rural areas to the cities, “overcrowding, poor sanitation, diets and social disintegration ensued” (Coovadia *et al*, 2009; & SAHR, 2016). The Pholela Centre’s staff members serviced the area not only with medical care, they instead worked to “improve the housing, sanitation, and access to food” ([apps.nlm.nih.gov](https://apps.nlm.nih.gov)), that way addressing the social determinants of health in that area. The purpose of the Pholela health centre was to render primary health care services to one of the needy communities at the time. It is reported that, between

“...1942 to 1944, Gluckman Commission was established and it advocated for unitary national health services. Following the first Pholela health centre being established, Gluckman commissioned for more community health centres to be set up from 1945 when he became the Minister of Health. The Commission was a response to “government’s recognition of the health problems of ‘poor Whites’, who had minimal access to health care, a phenomenon that grew during the war” (Carnegie Commission, 1932; & SAHR, 2016).

The centres were purposed for the “community-based primary health care, with the health of the population being the prime concern” (Coovadia *et al*, 2009). Following the Gluckman Commission, over forty “clinics were established in Natal and elsewhere in South Africa” (Ibid)

between the 1940's and 1950's However, with Gluckman's reign lasting only three years before implementation, his vision was not fully realized at the time. When "the Nationalist Party [NP] assumed power in 1948, Gluckman's recommendations were rejected" by the new government (Buchman, Kunene, & Pattison, 2008; Coovadia *et al*, 2009). The rejection of the Gluckman proposal came along with more stringent apartheid policies that later led to formation of Bantustans, as already mentioned above. This caused a further divide and inequalities amongst the different racial groups in South Africa, not only in health care sector, but also on the socio-economic sphere.

### **4.3 THE CURRENT HEALTH CARE SYSTEM**

After the 1994 elections, the health care system maintained a two-tier system, that is, the public and private sectors. The private sector is "funded primarily from individual and employer contributions, out-of-pocket payments and government tax subsidies, whereas the public sector is almost fully funded by the taxes, with a small portion funded by NGO's" (Mutymbizi, UCT).

The public sector was transformed into nine provinces whose administration is housed only under one Department of Health at National level. Within each province, health care services are rendered via DHS whose foundation is rested upon primary health care services which form a port of entry into health care system at district level before accessing regional hospitals and thereafter, tertiary and specialized level hospitals for super-specialized health care services. Regional and tertiary levels of hospital care are for those patients requiring special care beyond the level of a district hospital usually run by General Practitioners [GP] employed by State on a full-time or part-time basis.

Primary health care is encompassed within the District Health System [DHS]. According to South African Health Review (SAHR, 2016), "the Primary Health Care [PHC] forms the cornerstone for service delivery within the District Health System [DHS]." In 2003, "the DHS was incorporated into the National Health Act [NHA], thereby formalizing and legalizing it" (NHA, 2003). The DHS has its own district hospitals which act as a point of referral for patients from primary health care facilities whose health care needs require more than PHC services can actually offer.

In 2011, South African's DHS introduced "District Clinical Specialist Teams [DCSTs], which was incited by escalating pressure to achieve the Millennium Development Goals

[MDGs] for maternal and child health before and after 2015” (SAHR, 2014/15). The role of DCSTs is to “provide ongoing education and clinical guidance to the staff in healthcare facilities, and must possess basic competencies that will make it possible for them to provide leadership in clinical governance” (Handbook for DCST’s, 2014). In addition, DCST’s are expected to adequately govern resources allocated to DHS meant to intensify favourable health outcomes in communities. The introduction of “DCST’s is part of the strategy to re-engineer PHC along with introducing Ward-Based Outreach Teams [WBOT’s], School Health Teams [SHTs] and contracted General Practitioners [GP’s]” (SAHR, 2014/15). The “PHC re-engineering strategy is part of the broader health system goal of moving towards the realization of UHC” (Ibid).

In preparation for NHI, there has been a paradigm shift towards remodelling primary health care facilities into Ideal Clinics. According to SAHR of 2014/15, the introduction of Ideal Clinics is one of the many strategies modelled to respond to the current deficiencies in the quality of PHC services. Its purpose is to “provide a community-based comprehensive range of integrated diagnostic, curative, preventative, promotive, rehabilitative and palliative services” (Ibid.), a model not far from the original “Kark model” of Community-Oriented Primary Care [COPC].

“(The) implementation of this model is grounded on the 2011 findings of the Baseline Audit that was commissioned by National Department of Health [NDoH], which showed that the South African public health facilities collectively scored less than 50% compliance with vital measures, 34% in patient safety and 30% in the area of positive attitudes” (SAHR, 2014/15).

By implementing the Ideal Clinic model, the South African government is aiming at improving the quality of health care service at primary health care level. Judging from the intent by the government, it comes to the fore that the Ideal Clinic initiative is viewed to be the way forward in improving the quality of care in primary health, along with all the programmes that have also been implemented, that is, WBOT’s, SHT’s and so forth.

South Africa’s “health system has a strong provincial government structure” which is positioned to allow “a certain degree of decentralization to address the political, managerial and operational issues in terms of systemic efficiency and cost-effectiveness” (SAHR, 2014/15). To strengthen the health system and improve services delivered to communities,

“transfer of authority and responsibility from National government to provincial and further on to local government is a strategy that has been adopted by some other countries, and South Africa should be well on its way in following this strategy in preparation for NHI implementation” (SAHR, 2014/15). But the country still has some steps to undertake in decentralizing the health system. However, in undertaking the necessary steps required to decentralize the health system, careful designs and strategies for effective implementation need to be followed in order to avoid further “worsening the existing disparities and inefficiencies.” (Ibid).

Despite the efforts and strategies being adopted by government to improve quality of health care and service delivery, there are still gaps and obstacles hindering delivery of good quality health care services to the poor. On her inaugural lecture delivered on September 28, 2015, at the University of Witwatersrand, Professor Rispel identified three areas of hindrance in delivery of good quality health care to the poor population groups in South Africa. Rispel refers to these hindrances as fault-lines. The first fault line is poor leadership where government has allowed unskilled managers to occupy positions of power that require tact as well as will to execute and implement policies. Lack of leadership skills and poor governance has been compounded by overall deficiency of culpability. The second fault line is poor quality service delivery at primary health care facilities because of partially functioning DHS which is thought/known to be a bedrock for service delivery at primary health care level. Restrictions preventing a fully functional DHS stems from poor conspicuousness of who plays what role between national, provincial and local government departments of health leading to strained working relationships. This is further exacerbated by issues or challenges related to funding and sufficiency which are escalated by feeble and disorganised management systems. The third fault line which she identified is the health care personnel crisis. As highlighted in previous chapters, the clinician/patient ratio is higher in South Africa, including the nurse/patient ratio. This is affirmed by the World Health Organisation in its comparison with other countries. According to Rispel (2016: 20), although the South African government has a five-year strategic plan for human resource within the Department of Health, the health care labour force crisis persists because the plan is deficient of detail and fails to pay attention to “lower levels of government,” which according to the DHS establishment should be playing a vast role in ensuring delivery of good quality health care services in primary health care. The public health sector workforce crisis is further compounded by unequal and uneven

distribution of health care personnel in rural and urban areas, additional to unequal distribution between private and public health care sectors. Furthermore, on her study, Prof Rispel found that there is poor morale amongst staff, coupled with questionable behaviour and exceptionable attitudes. To add more strain to the already existing challenges is having staff deficiencies. Further assault to injury is rooted at healthcare service providers being met with an uncondusive work environment deficient of not only the necessary equipment to properly function, but they are also confronted with lack of support from management. Corruption is also noted to be amongst the contributing factors that cripple or compromise health care service delivery. In an audit done between 2009 and 2013, it was found that there was “irregular spending in provincial health funds” (Auditor General of S.A, 2014; Rispel, 2016: 19).

All these factors combined lead to poor health care services delivery to the neediest in South Africa

#### **4.4 Prevailing Inequities and their Implications**

Despite transformation strides such as increasing the number of primary health care facilities and improvement of socio-economic situations for some so as to improve the lives of South African people by the democratic government, and regardless of “government interventions to redress health inequalities” (Khaoya, Leibbrandt & Woolard, 2015), inequality and inequity amongst the population groups remain persistent according to the study reports by different authors such as Zere and McIntyre (2003), Case (2004), Bradshaw (2008), and Ataguba (2013). From historical origins of our health care system it has been alluded to that “human developmental inequalities in South Africa are largely attributable to racially discriminatory economic and social policies of apartheid” (Gilson & McIntyre, 2002). Because of “the principle of separation” (Charasse & Fournier, 2004) in South African history, inequalities to access to good education, health care, good housing and sanitation persist. And for this reason, these man-made intentional inequalities are considered to be unacceptable. Therefore, more needs to be done to rectify or reverse the consequences of these ill-intentions of the apartheid system even if it takes decades to get the desired results of equality, and even if it is relative equality.



As Khaoya points out, “good health is at the core of happiness and well-being to human beings, and is ascertained by one’s socioeconomic status such as income and education” (Khaoya, *et al*, 2015). Because health outcomes are closely intertwined with these socio-economic factors, so, if there is uneven allocation of these factors, then, the expectation is that of uneven health outcomes. Because of continuing uneven distribution, Mayosi and Benatar (2014) note that, “the health and well-being of most South Africans remains afflicted by the adamant burden of infectious and non-communicable diseases, persisting social disparities, and inadequate human resources to provide care for the growing population combined with a rising tide of refugees and economic migrants.” It is acknowledged and appreciated that “reversing both local and global complex factors causing adverse effects in health of the people is immensely difficult and will take many decades” (Ibid.). Gill and Bakker (2011) emphasize that the difficulty in reversal process is compounded by pervasive challenges that emerged during the “global economic crisis in 2008.”

A considerable number of people in South Africa are still living below poverty line. Directly or indirectly, “links between health and wealth exist at some level, although the relationships are complex. Therefore, it would be of considerable benefit to tackle health improvements along with putting in place measures alleviating poverty” (Mayosi & Benatar, 2014). Decreasing the number of the unemployed drastically would most probably contribute to the alleviation of poverty and therefore improve the health status of the many in South Africa. With still high unemployment rate which is currently remaining at about 27%, a considerable number of people are living below poverty line. Without tackling the social determinants of health, socio-economic and health inequities will continue to widen. Health status of some will continue to be “predominantly affected by a lack of access to the basic requirements for life – clean water, adequate nutrition, effective sanitation, reasonable housing conditions, access to vaccination, good schooling and childhood nurturing [including adolescent nurturing] that, with availability of jobs, set the scene for improved health and longevity” (Mayosi & Benatar, 2014).

It is noteworthy to acknowledge that poverty – both absolute and relative – are of relevance and importance as it has been observed that “in societies with relative poverty [as indicated by lower Gini coefficient of income inequality ranging from 0 to 1, with 0 indicating total equality], disparities in health and well-being are less marked” (Wilkinson & Pickett, 2009; Mayosi & Benatar, 2014). Causes and symptoms of South Africa’s “relative and absolute

poverty are not any different from those noted in global communities” (Benatar, 1998; Schreker, 2011; & Mayosi *et al*, 2014). According to Stats SA (2006/2011), “relative poverty has worsened as shown by the Gini coefficient increasing from 0.6 in 1995 to almost 0.7 in 2009.” According to Mayosi and Benatar (2014), only “10% of the South Africans are top earners, earning about 58% [combined] of the total annual national income, with 70% of earners on the bottom end earning a mere 17% combined. These inequalities, which are the widest in the world, are associated with diseases of poverty, such as tuberculosis [TB] and HIV & AIDS”. The manifestation of diseases associated with poverty suggest that addressing poverty and other determinants of health would bring about a better health status and improved quality of life amongst South Africans.

As it was earlier alluded to in preceding chapters, “the annual per capita expenditure on health ranges from 1400 USD in private sector to 140 USD in public sector” (Coovadia *et al*, 2009). To further highlight the prevailing disparities in health care sector, Mayosi and Benatar (2014), note that “the public health care sector is staffed by only 30% of doctors in the country, which provide for an approximately 84% of the national population and 70% of doctors are in private sector catering for 16% of the South African population”. With the stated figures above, it comes to the fore that, even in “provision of health care” as far as human and economic resources are concerned, disparities remain persistent and “continue to widen” (Coovadia *et al*, 2009). Prof Rispel, in her 2015 inaugural lecture at the University of Witwatersrand, as discussed earlier, also noted the persistent uneven and unequal distribution of health care workforce between private and public sector; and further “maldistribution between rural and urban areas” (SAHR, 2016: 20).

As reiterated by Wadee, Gilson, Thiede, Okorafor & McIntyre (2003), on a study done by Gilson and McIntyre published in 2002, it was established that “income is a mediating factor in the relationships between race and health status. For African and coloured populations, infant mortality rate tended to decrease with rising income.” Charasse (1999) and Fournier & Charasse, (2004) concur with Gilson and McIntyre as they have noted that, it seems “racial and economic discrimination have a significant impact on infant mortality rate.” As far as income and health are concerned, Smith (2016) concurs that “inequalities in health outcomes are both a cause and consequence of income disparities since health outcomes are influenced by multiple inputs outside the health system,” that is, the social determinants of health such as education, housing, sanitation and so forth. On another study conducted by

Gilson and McIntyre (2007), evidence suggests that there was “increasing disparities among the low-income groups and the high-income groups in comparison to the uninsured group [without medical aid] and the insured group [with medical aid]” based on data gathered between 1992 to 2003. Those of low-income group without health insurance tend to not seek medical attention even when they feel sick. It was noted that those “people within the category of low-income group are likely to take longer to seek medical care until it is severe” (ibid). On their study, it was established that, “non-use among the poorest income quintile was 27% without health insurance versus 15% of those with insurance.” The non-use for both groups could be attributed to lack of money for transportation to a health care facility [whether public or private] and for any other costs that could be incurred, considering that the location of some people is more than 5km from the health care facilities, and that some people who are of low income are forced by their employing companies to take private health insurance. Cost burdens to the user of a health care facilities need to be taken into consideration by policy makers because, for a low-income household, even a “low cost burden levels may be enough to tip poor households into poverty” (Gilson & McIntyre, 2007).

Therefore, in formulating a policy, using a different approach, such as incorporating Ubuntu ethics in policy-making, in addition to the existing, that takes into consideration the needs of a person from low income group which are likely to be different from those of a person from high income group, could be a way forward for South Africa. With time spent understanding the determinants of health for rural and urban population could give a clearer indication of where these population groups differ and what their needs are, and therefore be able come up policies which would need to be slightly different so as to able accommodate the needs of people in a rural setting and those in an urban setting. A one-size fits all approach for healthcare policy-making, is seemingly designed to cater more for the urban population needs than of the people living in rural areas. This contributes to the persistent inequality to access to healthcare facilities within the public sector, even before addressing the inequality between private and public health sectors.

#### **4.5 THE PROPOSED SOLUTIONS THROUGH NATIONAL HEALTH INSURANCE [NHI]**

##### **4.5.1 Introduction**

The World Health Organization (WHO 2010) has proposed a shift towards Universal Health Coverage [UHC] for all countries in order to have equal and equitable access to health

care services. In response to WHO recommendations and in committing to and realizing the Constitution of the country of individuals' right to health care, the South African government proposed NHI. The first draft proposing NHI was released in 2011 and the White Paper was released in July of year 2017. In June 2018, the NHI Bill was released. According to the NHI Bill's opening statement, NHI is seen to be one of the keys which will assist in healing the divide of the yesteryears, a tool to help bridge the "socio-economic injustices, imbalance and inequities" through application of "democratic values, social justice and fundamental human rights" as per the Constitution of South Africa (NHI Bill, 2018).

NHI is defined as "a financing system for health care designed to pool funds for the purpose of actively purchasing and providing access to quality and affordable personal health care for all South Africans based on their needs, not their socio-economic status" (NHI White Paper, 2017). NHI is proposed as a solution to the existing inequalities and inequities to the access of health care services by many South Africans. It is said to be the way forward towards improved health outcomes as set by MDG and UHC for all South Africans, meaning that "people will be able to access healthcare services to where they live for free at the point of care" (Ibid). NHI is seen as a representation of a "policy shift towards massive reorganization of the existing healthcare system between both public and private sectors" (Ibid). In reorganizing the current health care system, it is envisioned that NHI will break the boundary walls preventing the poor population groups within South Africa from accessing quality health care services offered by the private health care sector, and through NHI implementation, it is envisioned that the burden of disease will be reduced.

#### **4.5.2 NHI Overview**

Health care financing proposals and attempts, amendments and implementations in South Africa date as far back as "90 years ago when the 1928 Commission of Old Age Pension and NHI were effected" (NHI White Paper, 2017). Following that, a series of proposals have come to the fore with failed implementation attempts for many. On the basis of Sections 9, 10, 12, 27 and 28 of the Bill of Right of the Constitution of South Africa and the RDP vision, the current government has sought to take "reasonable legislative measures" through the approval of and implementation of the NHI over a specified period of time, "to ensure greater equity between people living in rural and urban areas, those served by the public and private health sectors, thereby promoting equity, accessibility, as well as utilization of health

services” (Ibid). The government action is supported by the fact that South Africa is a signatory to many international charters and instruments, such as, “Universal Declaration of Human Rights [adopted by the UN in 1948] and the International Covenant on Economic, Social and Cultural Rights [ICESCR – adopted in 1966 by the UN General Assembly and effected in 1976]” (NHI White Paper, 2017). Additional to Section 27 and RDP vision, it is in compliance with these charters that the South African government is adopting and implementing NHI, and also to fulfil the most recently adopted “Sustainable Development Goal [SDG’s] adopted by the UN at its 7<sup>th</sup> General Assembly in September of 2015” (Ibid).

As per NDP proposal, NHI will be implemented in stages with a vision of relatively reducing medical care offered by private sector, also to improve quality and the capacity of health care workers, through training programmes meant for upskilling personnel, employed by the healthcare sector, both private and public. By implementing NHI as proposed by NDP, it is envisioned that by 2030:

“South Africa will have a life expectancy of at least 70 years for men and women; the generation of under-20 should be largely free of HIV; the quadruple burden of disease will have been radically reduced compared to the two previous decades, with an infant mortality rate of less than 20 deaths per 1000 live births, and the under 5 mortality rate of less than 30 per 1000 live births, accompanied by a significant shift in equity, efficiency, effectiveness and quality of healthcare provision, and significant reduction of social determinants of health” (Ibid).

Implementation is key to the realization of these objectives in order that South Africans may enjoy more efficient healthcare, assuming that all other issues, some of which are raised in this research, will have been addressed.

#### **4.5.3 Key features, Principles and Finance of NHI**

On its planned implementation, NHI will entail certain features that will work as a roadmap to achieving and fulfilling the intended objectives or goals. NHI will be a “single publicly administered fund” owned by State for the benefit of its population, with a “responsibility to pool and purchase health services through structures that will be responsible for contracting accredited health care providers to provide services to the entire population” (NHI White Paper, 2017). Furthermore, it will be a “single-payer for all health care

costs, for services rendered, on behalf of its population” (Ibid). Some other features that will be encompassed are: a) “Progressive universalism” where NHI is intended to open free “access to needed promotive, preventative, curative, rehabilitative and palliative services without exposing them to financial hardships” (Ibid), despite a person’s socioeconomic background. b) “Comprehensive services” intended to cover an all-inclusive set of health services with a vision to provide a sequence of care envisaged to be achievable through community outreach, health promotion and prevention programmes run at various levels of care. c) “Financial risk protection” where NHI is intended to protect individuals and household from suffering financial hardships and prevent people from being deterred to access and utilize the needed health services, through elimination of user-fees, co-payments and other direct out-of-pocket payments. d) Creation of a “Single fund which will integrate all sources of funding into a unified health financing pool for the benefit of the health needs of the population” (Ibid). e) “Strategic purchases where NHI is envisaged to buy services for all and intends to actively use its power as a single purchaser to proactively identify the needs of the population” (Ibid).

As it was earlier alluded to, NHI is premised on the principle of “right to access health care by ensuring fair and just health care system for all, by offering affordable health services” (NHI White Paper, 2017). NHI is geared towards achieving “social solidarity through provision of financial risk pooling that will enable cross-subsidization between the young and old, the rich and poor as well as the healthy and sick”, thereby removing the notion of health care being treated as a commodity, and shifting towards the concept of health as a “social investment” (Ibid). NHI is envisioned to deliver services at “appropriate levels of care tailored to local needs while ensuring that health systems meet acceptable standards of quality and achieve positive outcomes on everyday settings, through efficient resource allocation and efficient healthcare interventions” (Ibid).

Finance for NHI will come from “mandatory prepayments” from all people [tax-payers] who are able to contribute towards the ‘Single Fund’. The financing method or plan drawn out on the draft does not give a conclusive detailed layout except for detailing different scenarios through which revenue can possibly be raised from various forms of tax. The figures given on the White Paper for projected health expenditure under NHI are based on 2010 prices for public sector costs with inflation factored in. This is both confusing and unsettling because it means that the projections are more than 5 years behind.

#### **4.5.4 Strengths of NHI**

The proposed NHI has a number of strengths worthy of pointing out. To begin with, it promises an ideal health system where all South Africans will gain access to quality healthcare services thereby removing inequalities and inequities. The removal of unfairness and unjustness is not only limited to accessing a point of health care service, but it is rather inclusive of removing financial barrier which are seen as one of the big barriers to health care access. When NHI is implemented, it will bring about significant improvement on past policies.

Primary health care and district health care will be improved through re-engineering with major decision making and governance responsibilities given to District Health Authorities [DHA] as well as the District Clinical Specialist Teams [DCST's]. The re-engineering not only applies to this level, but also extends to regional and tertiary healthcare facilities where state of the art diagnostic and technological instruments are installed for easy patient management and easy flow of data between different facilities.

It is also proposed that there will be free health care services at the point of care. Although the services are already accessible for free of charge at PHC level, NHI will remove all form of fees or co-payments at all levels of care, except for when a patient bypasses the referral point, which is designated to be the PHC facility or a contracted private primary health care provider.

A stronger public-private partnership will be established through contracting a number of private health care workers for service delivery to the public. This will help boost or strike a balance on apparent human resource disparities currently existing.

Standard medical treatment protocols will be applied throughout the country and up-skilling of service providers, with particular reference to doctors where all will be required to know the current protocols used to treat various conditions.

#### **4.5.5 Weaknesses of NHI**

Notwithstanding the strengths discussed above, NHI as presently drafted reveals a number of serious weaknesses which should be addressed before its implementation. For instance, it promises to deliver people-centred services that will contribute towards reduction of poverty. Without feasible and implementable multi-sectoral strategies already in place for the purpose of addressing and alleviating poverty, NHI cannot possibly alleviate poverty single handed. Depending on implementation of NHI to mitigate poverty on its own is ambitious and

far from reality. Proper strategies addressing other social determinants of health need to be designed and implemented for NHI to achieve its intended goals such as, reducing the burden of disease, improvement of quality of life.

Equal access to health care services for all South Africans is at the core of NHI goals. However, some people live far away from health care facilities, both public and private. This is especially true for those living in the rural areas. This directly translate to having this group of people carrying a high cost burden to access health care, something that is in conflict with and counterproductive to NHI's intended goal. Without realistic implementable plans and strategies to address distance factor for the poor and unemployed living in the faraway establishments of healthcare, an obstruction to access to health care services due to socio-economic circumstances will remain a reality for some people. For the rural provinces of South Africa such as the Eastern Cape, a slightly different implementation approach of NHI policy and strategies may need to be considered and actioned in order to realise the core goals of NHI, considering many community members live in villages where healthcare facilities are situated more than five kilometres away. Taking into consideration the geographical differences of our provinces would assist in bridging the gap of inequalities in accessing healthcare services.

Reengineering of health care facilities has been ongoing in preparation for NHI. Even though the health care infrastructure has been undergoing an overhaul to a great degree, not much attention has been focused on improving staff attitudes. Without due consideration, plans and motivational strategies in place to address and improve staff attitudes, the expected reasonably improved health outcomes based on NHI implementation alone rather seems enthusiastic since rendering of good quality service is, to an extent, linked to human resource strengths, and probably positive virtues as well.

With implementation of NHI, there is a great possibility of having increased waiting periods for those seeking health services, especially where elective surgical procedures are to be carried out by the private hospitals contracted to deliver services to the South African population for free. The number of people serviced by these private hospitals will increase, therefore leading to increased waiting periods. With that said, however, it must be noted that the waiting period will still be less than what is currently experienced by patients in the public sector.



Amongst some of NHI goals is to improve or reduce burden of disease. However, without addressing the living conditions which act as the source of spread of some communicable diseases, and without having focused programmes that are targeted at improving lifestyles of people, thereby reducing some of the non-communicable diseases, achievement of improved burden of disease seems rather shaky and threatened.

The current health system has poorly coordinated occupational health services. On NHI White Paper, there is no clear mention or commitment in improving this part of healthcare services.

Some authors, such as Gilson and Daire (2011), Coovadia *et al* (2009), Mayosi *et al* (2009) and Rispel (2016), have made reference to poor leadership and governance, leading partly, to poor service delivery and failing public health system. Efforts have been made by the government to impart good leadership and governance, however, the knowledge and skills of some managers remains depleted. This is cause for concern because amongst some of the NHI plans is to have power and responsibility delegated from national to provincial and district governments despite the apparent hiatus currently existing in leadership and governance capacities.

Inequality and inequity in distribution of health workforce does not only exist between public and private health sectors, but it also exists between urban and rural areas within the public health sector itself. There's no provision made on the NHI White Paper concerning plans and strategies to deploy health care workers, especially doctors, to rural primary health care facilities, considering that currently, PHC are mainly operated by nursing staff. Though there will be private GP contracted to render services, the provision does not guarantee that rural PHC facilities will have doctors visiting consistently for improved quality of care.

NHI financing plan is not clearly indicated, except for mention of probable financing scenarios. Missing on the White Paper is the costing of the proposed NHI. Reflected on the draft are costs that are based on 2010 figures when the first draft was being prepared. Raising more concerns about the costs and affordability is that, the estimated figures are based on country's economic growth projected at 5%, 3.5% and 2% starting from period 2013/14 to 2025/26. The projected figures are furthest from current reality of South Africa's economic growth which has progressively plummeted to 0.3% in 2016.

#### 4.6 NHI EVALUATION AND CONCLUSION

NHI proposal and subsequent planned implementation is rooted on a theory of social justice seeking to address unfair and unjust resource allocation between public and private health sectors, and between urban and rural settings within the public health sector itself. NHI implementation is also based on the “right to access to health care”, a provision made under Section 27 of the Bill of Rights in the South African Constitution.

Human Rights are, by nature, protective of the rights of individuals from being exploited or taken advantage of by the State or government. Most often than not, individual rights collide with actions advanced by government for the public good. This becomes apparent with the intended implementation of NHI where all [affluent and impoverished] South African citizens are seemingly coerced to becoming beneficiaries of a single fund system, even for those who can afford and willing to pay for access through private health insurance. Dr Serfontein ([www.businesslive.co.za](http://www.businesslive.co.za)) affirms this by stating that, “the Minister intends to provide access to quality healthcare for everyone, free of charge. The question remains whether the affluent truly need free healthcare, as they are clearly in a position to pay for access.” The approach adopted for NHI implementation therefore seems to be in collision with individuals’ rights, [in this case, the affluent] to choose.

The State has opted for social solidarity approach in its advancement of public health for the public good. This approach is, according to Last (2007), Stuttaford *et al* (2012a) and London *et al* (2015), of use for rights to health since it puts insistence on collated actions towards collated health by society and is fundamental to the “art and science of promoting and protecting good health.” In this research, it is hereby proposed that, Ubuntu moral theory be incorporated into the NHI drafting and implementation so as to ameliorate the notion that individuals’ rights are being overlooked for the greater good. This is because, as much as Ubuntu puts emphasis on “communal and interdependent living, however it does not imply anti-individualistic” (Letseka, 2014:548). Contrary to that, “Ubuntu respects the particularity of the other, which means articulation for its respect for individuality” (Louw, 2006:168). Louw (2006) and Letseka (2014) go on to say that, “Ubuntu defines the individual in terms of his/her relationship with others”. In other words, “self or individual is constructed by its relationship with others”, hence the maxim “*a person is a person through others or umuntu ngumuntu ngabantu*”. Ubuntu’s perception is holistic in its view of a person, rather than diminishing him/her to a “specific characteristic, conduct or function” (Letseka, 2014:548).

Ubuntu's perception is contrary to social solidarity perception of a person which its basis is rooted on functions, and specific characteristics.

Ubuntu "demonstrates high levels of self-government, accountability"; something which currently is one of the major challenges amongst managers at different levels within the public health sector; and "mutual interdependence" (London, Himonga, Fick & Stuttford, 2015:942). Ubuntu incorporates "ideas of group solidarity and interdependence, responsibility, compassion, respect human dignity, conformity to basic norms and collective unity" (Ibid). At the core of Ubuntu is the striving for some form of equality through sharing, because when a person progresses more compared to others in terms of material, then the excessive gets to be shared with the under-resourced or disadvantaged within the community. And this is not done out of coercion, but rather voluntarily since a person's identity is deeply and tightly interwoven with community.

In my opinion, Ubuntu ethics has much to offer as a moral theory, and its incorporation into NHI and public health policy as a whole is likely to benefit many and maybe, it would resonate better with the majority of South Africans. I propose the adoption of an African ethic for an African people-centred policy to make it work better for the South African society and nation, rather than adopting a completely Western approach exclusively. After all, there is not one moral theory which provides answers for every challenge. Therefore, an adoption of Ubuntu and incorporating it along with taking cognisance of various relevant theories in the same context, a favourable resolution can be reached.

## CHAPTER 5: UBUNTU ETHICS - OPPORTUNITIES AND CHALLENGES

### 5.1 INTRODUCTION

African societies are diverse and multicultural, gilded with history and heritages that have been moulded over the centuries. Embedded in its heritage and history are the negative views associated with traditional beliefs and practices. Gebre and colleagues are of the view that Africa is wealthy with doctrines, “philosophies and institutions that are African”, which have been carved and re-carved over time. However, the African continent has been depicted under a negative light, with African people being considered as “incapable of addressing their problems on their own”. African countries are viewed as having “a multitude of problems, such as: famine, conflict, coups, massacres, corruption, disease, illiteracy and so forth” (Gebre, *et al*: 2017). The stated problems associated with “African societies are viewed as being the result of greed and dishonesty by the inflictors of suffering and oppression” (Ramose, 1999) during colonisation. Because of these negative reflecting views, African leaders and general population have resorted to adopting Western-based solutions for addressing their challenges arising in Africa. This is done as a way of seeking to fit within the global worldview of norms and practises that are generally viewed as the “correct way” of doing things. The adoption of Western-based solutions is rooted to the oppression of Africans that took place during the colonization era. During the period of colonization, western belief systems and values were foisted on African people. The indoctrination process took place under compelling circumstances leaving minimal room for choice. This was coupled with the undermining of the indigenous people’s belief systems and values, not only by the westerners, but by the very African people resulting in Ubuntu philosophy and practices being lost in translation overtime. It is therefore not surprising that some, if not most African people, including South Africans, are not aware of Ubuntu way of life, hence the deficiency in application in daily living and implementation in public policy.

Generally, there are governance challenges in most, if not all African states which are associated with corruption. These governance issues are implied to expose a “moral depravity and badness of the perpetrators”, says Broodyrk, (2005); Moloketi, (2009); and Nyarwath, (2002). Corruption is said to be caused by a “lack of commitment to moral beliefs by perpetrators, which is in turn due to weak moral will of an individual towards other people” (Khomba, 2011: 145, <https://repository.up.ac.za>). The association of African societies with corruption should not be equated to Ubuntu moral theory as being invalid or lacking thereof.

As it can be deduced from the above statements, it comes to the fore that the issues or challenges in governance are rather associated with individuals' moral status, and not necessarily related to the credibility of Ubuntu as a moral theory. In my view, the lack of commitment to a moral belief is a consequence of loss of identity of the perpetrator as he or she cannot truly identify with the western way of doing things yet unacquainted with the African way of life, that is, Ubuntu moral values and practices.

Despite these various views about Africa and its people, from Africa emerged an ancient philosophy that views human beings as being equal, "sharing a collective interest with others". As a consequence of the nature of "interactive relationships between human beings, humans exist as autonomous and independent individuals" (Gebre, *et al*: 2017:13). It is precisely this "relational view of human existence based on mutual and complex networks with others" (Ibid) that Ubuntu stands to offer a different approach to solutions of challenges arising not only in health care sector, and not only in Africa, but globally in most spheres or sectors of life.

## **5.2 OPPORTUNITIES OF UBUNTU**

Human relationships are important in Ubuntu worldview and are therefore protected. Ubuntu morality is based on the premise of reciprocal acknowledgement of "personhood in any human parties in relationship with each other" (Chuwa, 2014: 36). In relationships, people get to mutually benefit from one another. The existence of "individuals as human beings within Ubuntu" gets realised by being in a "relationship with other humans" (Macquarrie, 1972: 104). According to Macquarrie, "individual therefore implies or denotes a plurality of personalities corresponding to the multiplicity of relationships in which the individual in question stands." He goes on to say that "being an individual by definition means being with others." Chuwa further explicates the meaning of "being with others" as "defining the nature of the relationship as either good or bad, right or wrong" (2014: 37). The reference to actions [earlier mentioned in chapter 4] based on Ubuntu moral theory as per Metz' construct, "actions are wrong not merely in so far as they harm people [utilitarianism] or degrade an individual's autonomy [Kantianism], but rather just to the extent that they are unfriendly or, more carefully, fail to respect friendship and or capacity for it" (2011: 540). The ideas of morality in African societies are, according to Metz (2011: 538), construed as comprehending of "communal relationships as a desirable type of interaction that should serve as a guide of

what majority want and which norms become dominant". The actions executed by an individual gain them a moral status under Ubuntu, which can either portray them as good or bad, right or wrong. The implied actions of individuals get to establish or destroy harmonious living shared by people living in a particular society.

One of the key pillar's that is central to African values and systems is the culture of living in "harmony and sharing amongst Africans" (Gebre, *et al*: 2017). Broodryk captures this phenomenon of harmonious living more elaborately when he states that "harmonious thinking, talking and behaviour are embraced by Ubuntu" (Broodryk, 2006:21). Harmoniousness tends to ease tensions. Mandela concurs with the view that there is tendency to feel and or see less tensions when harmony exists amongst people. As reiterated by Broodryk, Mandela states that, "it never helps to take a morally superior tone to the other person or opponent, for superior tone and attitudes increase tensions. Kindness should prevail". Harmonious living goes hand in hand with one of the wisdoms that comes to the fore in Ubuntu. This wisdom is captured by Broodryk, along with other opportunities that are offered by Ubuntu ethic on a paper he presented at the CCEAM Conference in October 2006 in Cyprus.

### **5.2.1 Live to be the best that one can be**

According to Broodryk, this piece of wisdom confronts what life is about and encourages one to be peaceful and comfortable with one's capabilities or abilities, be content with who one is. In Ubuntu, a person is encouraged to excel in what they do and not be concerned much about irrelevant issues which do not affect his/her performance, irrespective of one's social and economic standing in a community. This wisdom stems from the knowledge that, in Ubuntu, we are all equal, and complement each other in the works we do. It forms part of the African personality earlier mentioned in the previous chapters, where one strives for living in peace and harmony with another person.

To be able to live in peace and harmony with other persons, one needs to be in a position to accept and be gratified with their abilities. Generally, life has its own challenges, "but it is the harmonious person who finds solutions to daily problems" (Broodryk, 2006:19). Therefore, if each person strives to be their best within their communities based on the values of Ubuntu, we would achieve "a new worldly order to the benefit of all," suggests Broodryk.

In Ubuntu, it is appreciated that, each person has a different role to play in their communities regardless of how mundane the role may seem to be. Though competition exists amongst people, however its encouragement is to the benefit of the community, not for individual enrichment. Therefore, within a group, compete to do your best for the benefit of all. In essence, practising “Ubuntu is indeed, about applying non-critical attitudes for increases in harmonious living”, says Broodryk. With regards to harmony, Tutu states that harmony, friendliness, community are great goods, describing social harmony as the *summum bonum* – the greatest good. “Anything that subverts or undermines this sought-after is to be avoided like the plague” (Tutu, 1999:31). Metz (2011:539) suggests that, “Ubuntu ethic can be termed anti-egoistic as it discourages people from seeking their own good without regard for, or to the detriment of others and the community.”

### **5.2.2 My neighbour and I have the same origins, life-experience and a common destiny<sup>7</sup>**

According to Broodryk (2006), by virtue of being neighbours, people have similar life experiences, with similar origins and colloquial destiny because we are all human. My understanding of originality from his perspective does not necessarily imply a place of birth and upbringing, but rather more about the origins of human beings generally. And I understand commonality of human destiny [within this context] as being about the eventuality of each human being here on earth, not necessarily meaning a specific location.

From an Ubuntu perspective, it is on the pre-eminence of closeness and benevolence that ‘we’ as human beings are able to live cooperatively in a community, headed towards a similar direction with similar or common goals. Broodryk states that, “being together, we can share what we have”, not only our thoughts and daily experiences, but our resources as well

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<sup>7</sup> This phrase is directly borrowed from Broodryk, (2006:5), but was originally used in I am A. Freeman. *Seeds of Revolution: A Collection of Axioms, Passages, and Proverbs*, Volume 1. Bloomington: World Harvest Press, 2014:190. The phrase is from a poetic section which has the following stanza:

My neighbor and I have the same origins;  
 We have the same life-experience and a common destiny;  
 We are the obverse and reverse sides of one entity;  
 We are unchanging equals;  
 We are simultaneously legitimate values;  
 My neighbor’s sorrow is my sorrow;  
 His joy is my joy;  
 He and I are mutually fulfilled when we stand by each other in moments of need;  
 His survival is a precondition of my survival;  
 That which is freely asked or freely given is love...

- *Zulu Personal Declaration*

for the benefit of all, including those who do not have much socioeconomically. As earlier mentioned, in Ubuntu, human beings are viewed as equals, and therefore, by sharing what we have with those who do not have, we can in some way reach some level of equality with regards health and other resources. Metz (2011:538) consolidates Broodryk's view of togetherness into two themes. He refers to these themes as "identity and solidarity."

These themes fall within the context of what he calls the "typical African discussion of the nature of community as an ideal" (Ibid). To explicate the identity theme, Metz is of the view that, for a person to identify with another person, it is more about people thinking of themselves as a 'we' in order to take "pride or feel shame in the group's activities, as well as for them to engage in joint projects, coordinating their behaviour" (2011:538) to achieve the shared goal or vision.

Solidarity is exhibited when "people's attitudes such as emotions and motives are positively oriented towards each other, coupled with engaging in mutual aid, acting in ways that are reasonably expected to benefit each other" (Metz:538). Metz goes on to clarify that, although solidarity and identity are notionally different, however, in Ubuntu, "the characteristic African thought includes that they ought to be actualized together". By actualizing identity and solidarity simultaneously, harmonious living is also achieved.

### **5.2.3 We are the obverse and reverse sides of one entity<sup>8</sup>**

As much as we are different as individuals, the reality is, on the other hand we are the complement of one another. Ubuntu encourages development of or a move towards the spirit of commonness by sharing. This becomes clear from Broodryk's view when he states that, the "meaning of life stems from the social and physical interdependence of people" (Broodryk, 2006:6). From this notion, a sense of comradeship is established. Under the spirit of comradeship, people strive to achieve similar goals or to at least reach a common ground, thereby achieving a certain level of equality regardless of our different socioeconomic and or racial backgrounds. Broodryk noted or observed that, amongst those practising Ubuntu "if a person is progressing materially and receiving more than others, the extras are shared with the underprivileged. Africa does not allow that some eat while others go hungry or that some sleep warm whilst others are left out in the cold." As such, "there is an absence of material class forming"

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<sup>8</sup> This is taken directly from I am A. Freeman. Seeds of Revolution: A Collection of Axioms, Passages, and Proverbs, Volume 1. Bloomington: World Harvest Press, 2014:190.



amongst African communities, states Broodryk. From this perspective, incorporation of Ubuntu into public health policy would be beneficial for the disadvantaged or less fortunate since the financially able would share a certain portion of their fortune. Such sharing of resources would assist in redressing the disparities currently existing in resource allocation in health sector, between public and private healthcare sectors.

The South African Constitution has some of its roots on Ubuntu values. The Constitution “demands that the human dignity of all people be respected and protected”. This is exactly “in line with the notion that all people are significant and equal” (Broodryk, 2006:8). Though in reality we are not all equal and or can never be too equal, however, through sharing of the resources we have, a certain level of equality would be reached with regards access to health care, for instance.

#### **5.2.4 Sharing**

Sharing in African communities is at the core of its values. It is one of the values that can be adopted in public policy making, not limited to public health only, but in other sectors as well. As earlier alluded to, people have “different talents and resources, sharing these in a spirit of cooperativeness” (Broodryk, 2006:8), and of uplifting each other would be a mutually fulfilling complementary activity. According to Ramose (1999), the principle of sharing is the “regulative element of social organisation”. He goes on to say that, this principle is responsible for bringing to life African communalism, which is further explicated by Gyekye:

“Communalism is the doctrine that the group constitutes the main focus of the lives of the individual members of that group, and that the extent of the individual’s involvement in the interests, aspirations, and welfare of the group is the measure of that individual’s worth. This philosophy is given institutional expression in the social structure of African societies” (1987:208).

As reiterated by Gebre *et al* (2017: 19), (Nyamnjoh, 2015a) states that “African society understands self as something incomplete with potential power to create a symbiotic order of interdependence, free from mutual exclusion of the others”, thus creating an agreeable atmosphere which “links, combine and complement dissimilar things”. Through sharing of ideas, experiences, resources, African societies are enabled to co-habit in a community harmoniously, regardless of where the other person hails from. This is what Gebre *et al* refer to as an interface function.

Through this characteristic feature and principle of sharing amongst African communities, a neighbour's pain or loss is shared by the other members of the community based on the underlying premise of Ubuntu that "one is through the other person". Not only in times of pain that communities share each other's pain, but also in times of joy and happiness, because, "by standing together, enjoying and celebrating together, a spirit of cohesiveness is established. This is also referred to as togetherness, warmth, and cheerfulness" (Broodryk, 2006: 10). This principle of sharing not only brings people together within communities; it extends to creating a sense of belonging and security, with lesser burden to be carried by one person or family in times of difficulty. Similarly, through sharing of resources with those who do not have as much resources within the health care sector, a sense of security and belonging would be created. The existing gap of resource allocations within the public health care sector alone, and of access to health care facilities, would be reduced.

#### **5.2.5 Empathy**

African societies thrive on, and are "mutually fulfilled when they stand by each other in moments of need, by being able to put oneself in another person's place and situation" (Broodryk, 2006: 12). This quality not only allows one person to experience another person's needy circumstance[s], but it also allows one to derive satisfaction from overcoming the challenging experience. It is through possession of this quality that one is able to have empathy which is acquired through being able to "listen actively to the problems and words of others", says Broodryk.

#### **5.2.6 Compassion**

Since "a person is a person through another person", this adage denotes an interdependence of people to each other, and therefore an ability to survive through the support of each other, "an interpersonal bond of care and love is created". In "challenging times of natural and unforeseen disasters, and poverty, man is dependent on the survival of all" (Broodryk, 2006:14) since no one can exist alone and thrive. This characteristic feature of Ubuntu comes forth as an Ethic of Care. Caring for each other is at the core of human survival, something that is also expressed in Gilligan's Feminist Ethics of Care. Therefore, the application of Ubuntu ethics in public health policy would not only instil a sense of caring and solidarity amongst South Africans, but it would also bring us together towards achieving gap

minimization in health disparities through sharing of resources with the less affluent by the affluent group of people in South Africa.

### **5.2.7 Reciprocity of Care**

Ubuntu encourages a give and take principle not only in caring, but it rather extends to other spheres of life. As far as care is concerned, Ramose (1999) is of the view that “reciprocal care for another human being goes beyond the accumulation and safeguarding of wealth as an end in itself”. He illustrates this by giving a narrative of “when one is faced with a decisive choice between wealth and preserving the life of another human being, he says the latter should be chosen”. Preservation of human life seems to be of utmost importance in Ubuntu and for any human being faced with a similar situation. When faced with a particular situation, it is expected of them to put a person first above all things. According to Richard (1980) and Chuwa (2014: 39), it is the interchange that makes it easy for an individual, a society and “the biospheric survival and progress, and proper reciprocation brings about harmony while failure to do so may generate violence” and resentment.

### **5.2.8 Respect**

In Ubuntu, as an expression of respect for another person or community, “no community or person has a right to prescribe a destiny for any other” (Broodryk, 2006: 15). This expression of respect goes beyond that of person. It also extends to respect for a person’s “religion, spirituality, political affiliation, socio-economic status, beliefs and customs” (Ibid). Respect for persons is central and important to Ubuntu, as such, respect for rights of persons is enshrined in South African Constitution. The application of this important Ubuntu characteristic should go beyond the scope of Bill of Rights in South Africa. The application Ubuntu in public health policy would assist decision and or policy makers to be cautious not to infringe on rights of others when implementing policy, such as is indicated in NHI white paper document where the affluent citizens of South Africa are seemingly given no choice but to be covered by the proposed Single Fund for health insurance, although they can afford to buy private health insurance, not as a supplementary, but as the only health insurance for them.

### **5.2.9 Tolerance**

Alongside respect, tolerance is another characteristic feature in the midst of Ubuntu. In Ubuntu, it is appreciated that no person is the same as the other person though we all

thrive through each other. Therefore, Ubuntu embraces pluralism and tolerates each person's differences so long as there is no disruption of harmony within a community. Ubuntu's tolerance of pluralism is, in some way in keeping with parts of Isaiah Berlin's writings in *Four Essays of Liberty*. This Ubuntu feature of tolerance comes to the fore in "management of diversity – a situation where people with different backgrounds [ethnic, religion, language, occupational and so forth] reside in the same integrated neighbourhood respecting and tolerating each other's religions, traditions and choices" (Gebre *et al*: 2017:21-2). By stating that tolerance is one of Ubuntu features, it is not to imply that "conflicts between different ethnic groups do not arise, however, African societies employ diplomacy to resolve conflicts and establish normalcy. This strength of Ubuntu is an expression of "unity in diversity" (Ibid). With differences surrounding and existing amongst people within a community, tolerance of each and every person's difference/s brings about peace and harmony.

South Africa is diverse and multicultural in its construction, and the pluralistic feature of Ubuntu is complementary to our current socioeconomic status. Therefore, by applying Ubuntu to public policy would help in closing the gap of disparity not only in health care sector, but in other sectors as well.

#### **5.2.10 Redistribution of wealth**

The word wealth not only applies to material assets, but to other forms of abundance, such as knowledge, wisdom to name just a few. In some parts of Africa, it was a common practice to give someone a 'start up' [such as a cow], to those who did not have, for their own wealth building in the spirit of sharing what was available by those who had more. As there was not much written about Ubuntu, knowledge, wisdom and morality was passed on from generation to generation through oral transmission. That way 'wealth' was redistributed amongst Africans within various societies.

#### **5.2.11 Corporate Governance and Leadership**

Khomba (2011: 135; <https://repository.up.ac.za>) has precisely noted that amongst African societies, each and every geographic setting possesses its own differentiating characteristics of which amongst is culture. Khomba goes on to say that, the culture of Africans is distinct in nature from "Western cultures in some ways." According to him this is indicative of how closely intertwined the social and cultural aspects are in an African structure, and are "considered to be a key determining factor for the success of any organisation that operates

on the continent". The concerns of the African framework denote that "people must be put first, given priority and treated well, before products, profits and productivity" (Khomba, 2011:135; <https://repository.up.ac.za>). An Ubuntu-centred management system acknowledges the connotation of group solidarity, as well as unity in diversity. Its leadership characteristics incorporate group and "community supportiveness, sharing of burdens in difficult times, and cooperation. By sharing the burdens, suffering is minimised" (Ibid). Incorporation of Ubuntu philosophy in public policy, leadership and governance seems to be a promising option that will instil African-based leadership skills that are considerate of people's needs first, rather than individual needs or rights [as it currently stands with South African Constitution, which is focused more on individual rights than groups or community].

Ubuntu ethics has some grounding principles such as harmony, kindness, solidarity, caring, love and sharing that are also the "founding principles of business ethics and corporate governance" in modern day business practice. These business principles are inclusive of all "organisational members as part of the community" (Khomba, 2011: 145, <https://repository.up.ac.za>). In modern day business practice, matters of corporate governance are more conspicuous and therefore good grounding of business practice on incorporative ethical principles are "critical to corporate productivity and organisational practice, since corporate governance is directly interwoven with business ethics" (Rossouw, 2005: 105). Through Ubuntu philosophy, good corporate governance is possible since its morality is strongly based on "awareness of moral rights and wrongs" (Khomba, 2011: 146, <https://repository.up.ac.za>). Through instillation of Ubuntu moral theory via education, corruption can be uprooted. As reiterated by Khomba, Moloketi (2009:243, 247) is of the view that, since the principle is community-based, "Ubuntu philosophy must be the essence of a value system that underpins a commitment to eliminate corruption". This implies that leaders need to be sensitive to the needs and good of people in a community or country at large, and be accustomed to putting people first, not only by verbal transmission, but must be coupled with evidence resulting from positive actions.

### **5.3 UBUNTU CHALLENGES**

#### **5.3.1 Introduction**

It was earlier indicated that, embedded in Africa's heritage and history are the negative views associated with traditional beliefs and practices. As such, Ubuntu as a moral theory is

believed to be vague with prominent features that are failing to recognize “the value of individual freedom, fitting only traditional, small-scale culture more than a modern, industrial society” (Metz, 2011: 532). According to Gebre *et al*, “the word traditional is sometimes used to connote backwardness as well as absence of change in the form of knowledge or institutions that people have possessed since long ago”. Therefore the view about Ubuntu ethics being traditional has contributed towards it being viewed under negative light of backwardness, not fitting the modern society. However, in reality, “human beings follow a certain manner of customs and cultures that are constantly renewed and created over again through transformations arising from within or as a result of contact with the outside world, resulting in a state of dynamic change” (Gebre *et al*, 2017: 11). Therefore, to deflect from “misunderstanding and confusion” caused by use of the word ‘tradition’, “the term indigeneity is preferred” (Ibid) by some philosophers. It “refers to customs, culture, ideologies and norms that have been created and used by people in a particular society” (ibid). Since human beings are, by natural process, remodelled through transformations resulting from interactions with the world, therefore, “the knowledge and institutions possessed by African people exist in a state of dynamic change” (Ibid). It then follows that, to say Ubuntu only fits within a “traditional, small-scale culture” (Metz, 2011:532) is misleading and detracts from its value and contribution to the inevitable evolution of a way of life for the human kind, on a global scale.

In the preceding chapter, I alluded to the minimal availability of written literature about Ubuntu philosophy until recent years. Afro-centric Alliance (2001) and Khomba (2011: 147, <https://repository.up.ac.za>) concur that, “one major challenge of African indigenous knowledge is that it is not written down and mostly transmitted verbally from one generation to the next through story-telling.” Because of minimal written old African tradition[s], it therefore makes it difficult for the younger generations to understand and fully practice Ubuntu. This is compounded by minimal or no efforts to sensitize and spread the information about Ubuntu philosophy, about an old African way of life. Since there is minimal awareness about African philosophy amongst the African people themselves, incorporation and implementation of this moral theory and a way of life poses a challenge. This concern is compounded by the democratic and capitalistic backdrop of South Africa as a country, of which most, if not all South African are accustomed to. As it is well known, democracy and capitalism are almost equivalent to saying “each man for his own.”

### 5.3.2 Breach of human rights

Amongst the criticisms against Ubuntu is the infringement of individual human rights through the “limitation of personal autonomy and freedom” (Chuwa, 2014: 36) of choice. Some authors such as Chuwa are of the view that individual rights do not amount to a level greater than that of a society since individual members of a society are an articulation of, and capacitated by a society. Rights of individuals are not elevated above those of the community. Senghor states that, “community and its needs are more important with its needs preceding those of the individuals who make up the community” (1964). Nkrumah shares a similar view with Senghor and articulates the impeding tug-of-war and tension existing within the ideal of global unity in Ubuntu. Gyekye took note that the community or society is essential for the process of self-actualization and that of personhood realization. Nonetheless, he emphasizes that “individuality is not obscured by the membership in a human community” (1997: 40) since ethnicity, originality, belief systems, and so forth remain respected for each individual human being. Respect for individuality comes to the fore when we talk of, and in the form of unity in diversity.

To further explicate and argue against the claim of emphasis of society rights over individual rights, Weil (1973: 182, 188-9), as reiterated by Chuwa, points out that “it is not true that freedom of one man is limited by that of other men since freedom of a man is always relative to the freedom of others”. Weil goes on to say that, “man is really free only among the equally free men.” To further put emphasis on the argument against society versus individuals, Kasenene (1994) argued that, generally, human beings have an inherent ability to think and act independently at an individual level and capacity, so long as their actions do not harm others. Therefore, as much as an individual is independent in thoughts and actions, however, the individual has to always keep in mind that excessive exercise of individualistic approach is regarded as being contradictory of one’s corporate existence. From Kasenene’s viewpoint it comes to the fore that, as much as individuals are given leeway to act independently, however, their actions are limited to the extent of securing another person’s safety, which is in keeping with the principle of non-maleficence in biomedical ethics. This point highlights that not only public health ethics are an extension of biomedical ethics, but it also highlights that Ubuntu ethics are not necessarily based and limited to the traditions and culture of a small group of people. Ubuntu ethics are rather global in their approach, hence the need to not only acknowledge but to incorporate and apply them in public health policy

for the benefit of societies and individuals forming these societies. Elevation of individual rights way above those of a group or community at large can be to the detriment of societies, therefore impeding community growth and evolution. Although Ubuntu thrives on open dialogues between its community members, however, “Ubuntu respects individual autonomy” (Macquarrie, 1972; & Chuwa, 2014). Even though in Ubuntu the rights of individuals do not supersede those of a community, but individuality of a person is taken into account and each person’s belief system respected.



## CHAPTER 6: UBUNTU AND PUBLIC HEALTH POLICY

### 6.1 Introduction

Having deliberated on various facets of Ubuntu ethics, it is important that I discuss how it should relate to the subject matter at hand, that is, public health policy in South Africa. Given that Ubuntu ethics exhibits values that are fundamental for various communities that form the modern nation-state of South Africa, and given the foregoing deliberations on the benefits of Ubuntu, I will now use this chapter to not only explain the link between Ubuntu and public health policy, but will also delve into the possibility of developing an integrated approach between Ubuntu ethics and public policy with a deliberate focus on NHI.

Ubuntu principles also encapsulate and complement principles and ethics of business, one of the fields whose association with Ubuntu has prolifically been written about. Ubuntu's positive characteristics or virtues and core elements give the African philosophy a robust potential to contribute towards economic growth and social development through incorporation into the policy making and implementation thereafter, nationally. As a people-centred philosophy premised on caring, sharing, living in harmony, hospitality and respect, Ubuntu promises to offer a moral theory whose values are focused on benefitting not only individuals, but communities at large.

Just over a decade ago, the former South African President Thabo Mbeki made a call to convey Ubuntu principles into heart of "national reconstruction and development policies". This advance was purported to conjoin Ubuntu with the commands of "political power and democracy" (Nkondo, 2007: 88). Thus far this call has been acknowledged only to the extent of policies in South Africa being privy to the advancement of human kind, but it has not come to a point where they make Ubuntu principles dominant to the basis of development of economic growth and social development, nor are they made to be of chief importance within the "context and focus of the business of the State" (Ibid) as far as inclusion into policy is concerned. When the Reconstruction and Development Programme [RDP] document was drafted the most prominent feature was about bringing change on the material status of South African people. Nowhere in the draft were "matters of the soul" (Mbeki, 2006) explicitly referenced to.

Although the Republic of South Africa is capitalist in its construction, however, there has been attempts by the government to intervene in domestic economic affairs such as BEEE,

land reclaim and redistribution, and so forth, so as to encourage some degree of ‘levelling out’ between the socioeconomic groups in South Africa. Despite these attempts, Ubuntu philosophy has not been applied as a way of life or way forward in leadership and governance of the State, nor has it been applied in resource allocation in health care and other sectors. As an outcome of this research in the field of applied ethics, it is my intention to attempt to apply Ubuntu philosophy to public health policy, inclusive of resource allocations, so as to try to bridge the gap of inequality between public and private sectors. However, this is not an easy task as Ubuntu philosophy has not been given the meticulous attention it deserves and no conceptual framework for Ubuntu exists for integration into public health policy and resource allocations.

## **6.2 The Essential Link between Ubuntu and Public Health Policy**

It is the view of this researcher that Ubuntu ethics is appropriate for not only discussing public morality, but also for formulating public health policy that is morally tenable for South Africa. This is more significant for the public health sector, which is the focus of this research. Establishing a clear link between Ubuntu and public health policy is crucial for the development of a better society in South Africa. As Metz (2011: 536) points out, it is dependent to “those living in contemporary Southern Africa to refashion the interpretation of *Ubuntu* so that its characteristic elements are construed in light of our best current understanding of what is morally right.” This is a call to apply Ubuntu in proper context in order to enhance societal well-being for the benefit of all. The good of the community is as important as the good of every member of the community. Metz summarizes it as follows:

“...to seek out community with others is not best understood as equivalent to doing whatever a majority of people in society want or conforming to the norms of one’s group. Instead, African moral ideas are both more attractively and more accurately interpreted as conceiving of communal relationships as an objectively-desirable kind of interaction that should instead guide what majorities want and which norms become dominant” (2011:538).

In other words, Ubuntu ethics does not merely seek to fulfil what benefits the majority, as would be the case in a utilitarian society; instead Ubuntu seeks to build consensus on common good. In this context, common good is understood to imply not just what is good

for everyone in the community, but also what is good for the continued well-being of a community as a single unit.

The positive attributes of Ubuntu must come into play in order to establish the essential link with public health policy. To begin with, peaceful coexistence and harmonious living is likely to be built up and enhanced among South Africans of diverse backgrounds when public health policy integrates Ubuntu ethics. Modern South Africa is a unitary state whose people, in an Ubuntu sense, are expected to view themselves as one community with diverse qualities. These diverse qualities include economic strength, intellectual acumen, ethnic diversity, institutional capacity, political cohesion, social strata, and population growth. Various individuals in the population participate and hold shares in these ingredients of life in various magnitudes. In order to establish and propagate Ubuntu ethic of peaceful coexistence and harmonious living, public health policy has to take cognisance of the interests of population groups, not just in terms of ethnicity and race, but also in terms of levels and variances of participation in national life. In other words, public health policy has to facilitate peaceful coexistence among the various communities. No part of South African community should be left on their own to suffer the debilitating effects of disease while others simply watch on the side-lines, for in Ubuntu, *"your pain is my pain"*, therefore, sharing of resources available to us as South Africans for the benefit of even those who lack would be in cognisance of and in corporation with Ubuntu philosophy.

The idea gets firmer when considered in the context of common origins, life experience, and destiny, which Metz (2011:538) consolidates into themes of "identity and solidarity." By implication, a good public health policy should recognise and strengthen the common origins, experience, and destiny of South Africans as one people. All South African people should strive to live together as a collective, united in their actions and harmonious in their coexistence. These efforts can be reinforced by having governmental buy-in through programs that will create more awareness about Ubuntu philosophy across all sectors, for a uni-sectoral approach, application and or implementation would not yield much of desirable results. From the multi-sectoral approach perspective, allocation of resources to take care of diseases or health issues that affect only a segment of the population would be accepted and dealt with, not as "their" problem, but as "our" collective burden. And this multi-sectoral approach would also assist not only in curative care medicine, but also in identification of,

and addressing social determinants of health before getting to cause disease [preventative medicine].

There are certainly diverse socio-economic groups of the South African population which designate lower income-earners to exclusion from certain aspects of health care, and an integration of Ubuntu into policy formulation would address them to a certain degree. As a result, the equitable sharing of health resources would lead to better access for the poor. This is supported by a research carried out by Harris, *et al*, (2011:162) in which they concluded that “...understanding social relationships, identities, and shared meanings is important for any reform striving toward universal coverage.” Such understandings of social relationships have the potential of helping develop better policy and practice of health care.

The interdependence of members of a community as portrayed in Ubuntu philosophy provides an opportunity for sharing of talents and resources, and public health policy should endeavour to provide and build up such sharing. For instance, volunteers serving as Community Health Workers (CHWs), are actually sharing their talents with the community in which they live. The same goes for birth attendants within the villages, or holders of first aid kits in an institution. A public health policy that endeavours to support such existing structures finds strong roots in Ubuntu. These may appear mundane to some; yet they form a crucial component of initial and basic health care in a community. In any discourse regarding the concept of sharing as found in Ubuntu ethics, it is important to take keen note of the difference between Ubuntu ethic of sharing in health matters and a human rights-based approach to health care. Before going into the differences, it is worth mentioning that human rights charter is open to various interpretations, which amongst them is the notion of individual rights being elevated above those of a community. Whereas a human rights approach seeks and require government to take reasonable measures to ensure access of health care by the individuals without an explicit consideration of the responsibility or role of an individual person towards achieving this right, Ubuntu seeks to acknowledge and establish the responsibility of each individual within a society along with the responsibility of government to ensure access to health care services. This approach does not only hold government responsible, it also calls upon individuals to join together in taking care of the sum of individuals which make up a community. In Ubuntu, the individual rights are not above those of a society even though an individual’s particularity is respected. Therefore, actions that would benefit an individual through the efforts of only an individual, which is only

government in this case, would not be embracing Ubuntu philosophy. Even though in Ubuntu a society takes precedence, an individual is an indispensable member and component of a society with inherent value and moral worth, thus, respect for individual particularity remains maintained in Ubuntu despite the nuance of collaborative efforts for the benefit and betterment of people in various communities.

So, rather than encouraging the individual to seek his or her right to access health care service, the society is encouraged to extend care beyond self because any lack of care by an individual towards another individual brings about negative impact to the whole society which is made up of individuals. In this regard, matters of disease prevention, establishing community monitoring mechanisms, and engagements in community health education are all issues that need to be addressed in a public health policy from Ubuntu ethics perspective under discussion. Rather than viewing health matters as government concerns, communities should be encouraged to begin to see them as their own too, especially if they have been engaged in policy formulation and approval as well. In this way, rather than violating individual interests and preferences, Ubuntu ethics is responsive to these interests and preferences, while at the same time it is enhancing communal cohesiveness. Both the public and private sectors can actively engage in the process of policy formulation and approval in a broader sense, before legislature completes the process.

### **6.3 Integration of Ubuntu Ethics and Public Policy in NHI**

The Ubuntu principle of pooling resources together for mutual security of members of the community in time of need is one that should find expression in modern policies such as NHI. In Ubuntu, when an illness strikes an individual, it is not just the sick person who suffers, but the whole community suffers with him or her. Diseases, like other calamities, are an attack on the well-being of the whole community and its posterity. Disease undermines the continued existence of not just one sick person, but of the entire group of people, whether that group is a family, a clan, a tribe, a race, or even a whole nation. Conversely, well-being is not evidenced by the health of only one individual, but the health of the whole community. When all the members of a community are healthy and are not experiencing any effects of calamities or diseases, then the whole community is healthy and is assured of continuity into the future. When all members of a community are healthy, they, in turn work towards

improving their own circumstances and contributing towards economic growth of the country.

So, what happens when sickness strikes? How should healthy members behave towards the one who is sick? Going by the principles of Ubuntu as discussed earlier in this thesis, as soon as members of a community learn that one of them is sick, they would ordinarily visit him or her to assess his or her progress or otherwise. They would evaluate what kind of help is needed and how best such help may be obtained, and act to bring this help to reality. Saving the life of one person is viewed to be an act that saves the life of the whole community. Since NHI is designed to pool funds in order to help members gain access to treatment when they get sick, its formation into a national policy falls into the rhythm of Ubuntu in a form of, or as a form of social justice. Everyone should contribute to this fund, not merely as a version of commercial insurance for each individual, but as a communal means by which the nation deals with the common adversity of illness whenever it strikes. In Ubuntu principle, the many contribute to accumulate a resource that can rescue the few who will be unfortunate enough to get sick. Their sickness is a concern of the whole national community because without them, the rest of the nation is not complete.

Rather than looking at Ubuntu ethics as rights-based, I look at it as an ethic of human responsibility in caring for fellow human beings. In Ubuntu, it is not an individual's right to advance certain claims, such as healthcare, that count. Instead, it is the responsibility of each member towards the wholesomeness of the community that is highlighted as fundamental. We take care of each other better when we are each holding our responsibility to the community seriously.

In previous chapters, it was mentioned that amongst the contributing factors to high burden of disease is consequent to lifestyle and behavioural choices. Ubuntu ethics encourages individuals to modify his/her lifestyle and behavioural choices in order to curb unnecessary spending on disease burden consequent to negative behavioural/lifestyle choices.

#### **6.4 Justice theories in Ubuntu context and Public health policy**

As earlier alluded to in previous chapters, it is almost impossible to utilise only one moral theory to solve arising challenges within the health care sector. Health care is vast with multiple divisions that are required to work synergistically to achieve identified goals of public

health care. To have a smooth-running health care system that's able to deliver and meet targets, it may be necessary to explore various moral theories in the context of drafting and implementing of ethical and broadly accepted, tenable public policies.

For the purpose of this research, various moral theory concepts other than the one under research were discussed. Of the theories discussed were certain theories of justice and public health ethics which are necessary for policy development process. Justice theories cannot be done away with because they form an integral part of and are at the core of social justice, and public health is thought to be one of the ways or platforms utilised to address social injustice and redress inequalities.

Generally, theories of justice seek to illuminate the meaning of reasonable distribution of resources or goods amongst members belonging to a community or society. Theories of justice support the rights of individuals to their freedom, acquisition and holding of goods. From the few justice theories discussed, it can be appreciated that there are various views with regards what is just or unjust.

One of the theories that has been discussed earlier is Communitarian justice theory, it has minimal or no room for individual rights. It is a community-based theory concerned with the well-being of individual members who make up a community, something that is also shared by Ubuntu moral theory. Communitarian justice theory underscores the importance of community and common good for all, a characteristic which is also similar to Ubuntu. This theory appreciates the extent to which people are connected and interdependent. This interdependence and interconnectedness is necessary for continued existence, something that has been affirmed almost 400 years ago by John Donne in his famous poem titled, "No man is an Island" where he appreciates how connected and interdependent human beings are. Sharing of social and economic resources that are available and at a disposal of a society is just and fair and these must be distributed in a manner that is beneficial to everyone, though not necessarily equally, because no one exists alone. In Ubuntu, sharing of available resources is at the core of the theory though it does not necessarily imply equally because in reality, "laws of nature" determine who is in a better position to generate and acquire more income and wealth. As much as it may be so, everyone must have a role to play and in the process be able to benefit from these socio-economic resources. Both Ubuntu moral theory and Communitarian justice theory are inclusive in their approach and concerned with sharing of resources to benefit everyone in a community, hence my proposal of incorporating Ubuntu

into public health policy to augment or complement the existing theories already in use in an attempt to bridge the gaps within healthcare.

One might be concerned about the rights of individuals, however, as much as Ubuntu is concerned about the good of the community at large, but it does respect individuals and individuality. While promoting solidarity for the good of the community, Ubuntu takes into account values and belief systems of other people who do not necessarily subscribe to the Ubuntu way of life. Amongst other characteristics, Ubuntu calls for tolerance and unity in diversity in its pursuit for achieving a common goal that benefits all persons in a community. Therefore, adopting and incorporating Ubuntu into public health policy would be valuable and of benefit for some.

Another theory that was discussed earlier is Egalitarian justice theory, of which one of the most popular is that of John Rawls whose first principle of justice is based on all persons having an equal right to the most basic freedom congruent with alike freedom for other persons. Differently applied within the context of this research, the implication is that all persons have an equal right to access equal health care services appropriate to their needs, without prejudice which may be based on socio-economic status or background. This is further affirmed by Edmonds (2017) who is of the view that one should not be subject to different treatment or service based on individual attributes and it is in line with section 27 of the South African Constitution which promotes right to access to health care by all persons. Having mentioned equal freedom or access to basic needs, Egalitarian justice theory is not necessarily advocating for “equal sharing of all social benefits to all persons” (Beauchamp & Childress, 2009:256). Equality is applicable as far as basic needs such as access to health care because equal sharing or access to such a freedom is just as his first principle clearly states. Ubuntu offers a variety of values which may not necessarily exist in egalitarian justice theory which would strengthen public health policy and probably improve health outcomes. I am of the view that by adopting Ubuntu and aligning it with public health policy, including NHI, would be of added value in servicing human kind and in ensuring that some ground of equality is achieved, insofar as health care access is concerned, thereby dissipating, to some extent, the long existing inequalities, one of the things that is intended to be addressed through implementation of NHI. If Ubuntu moral theory could be incorporated into NHI, it would assist in bridging the end results of socio-economic gaps within the health care sector which resulted in part, from past injustices.



From libertarian perspective, protection of individual rights is the primary role of the State. Those who firmly believe in libertarianism are of the view that distribution of goods or resources is just and fair so long there is no forcible interference from the state whose key role is to ensure access to resources and or goods by those who can afford to pay for them. This theory of justice is far from Ubuntu moral theory. Ubuntu moral theory believes in sharing of resources for continued existence of humankind. On the surface, it may seem that this theory of justice is not far from the Rights Charter of the South African Constitution, which seems to elevate the rights of individuals above those of community, but on a closer look, the individuals protected by the Constitution make up the communities.

For an extended period of time, not much has been achieved in realising the equal right to access to health care for approximately 86% of the population who depends on public health care for services. From this viewpoint, it would seem that the Constitution has been more in favour of the affluent group, therefore libertarian to some extent.

In the face of high levels of unemployment, a number of people living below poverty line and with added strain from the quadrupled burden of disease in South Africa, the Constitution seems to have been tilting more towards the elite group, which constitutes a minute group of people within the population, who have the means to access superior private health care services, acquire and keep resources or goods. This moral theory is in complete opposition to Ubuntu philosophy which advocates for sharing of resources, elevating equity in accessing basic goods and services without socio-economic prejudice.

With the move towards realisation of Universal Health coverage through implementation of NHI, the Constitution seems to be on the right path in realising the right to access health care services equally by everyone, when looking at the proposal and the intentions put forth on the NHI white paper. NHI is intended to bridge the gap of resource disparities between private and public health care sector. Whether the NHI's intent is achievable under the current economic climate and the crisis of staff shortages in public health care sector is a question to be raised on another research. What may have seemed to be a libertarian approach to healthcare may have led some people, especially those in the private sector, to adopt an attitude that their own medical well-being is all that matters, as long as their medical insurance or aid functions well. With that attitude, there grows a careless view of what goes on in public healthcare sector in our country. This attitude has been previously predominant

in promoting healthcare policies and practices that, while attempting to promote the principles of individual rights, freedom and autonomy, end up relegating and ignoring the principles of community, care, and human responsibility.

### **6.5 Public Health and Public Health Ethics within the context of Ubuntu**

At the core of Ubuntu is solidarity, that is, unity towards achieving a common goal, which in this case would be bridging disparities that exist between public and private health care sector. To at least come close to bridging the gap and improving the health status of the members of our community, something that is of primary focus and responsibility of public health authorities, a moral theory that is all inclusive in its approach is necessary. To incorporate such a moral theory into public health policy would, to a certain extent, bridge the existing inequalities within the public health care sector; and between public and private health care sectors.

The ultimate goal for public health is to ensure that the well-being of the population is safe guarded by utilising measures that promote a healthy nation. By taking measures that promote health brings to the fore a caring characteristic, something that is one of the salient characteristics of Ubuntu. A healthy nation cares better for its fellow human beings and stands to build an economically viable society through combined efforts and various role-playing for the benefit of everyone.

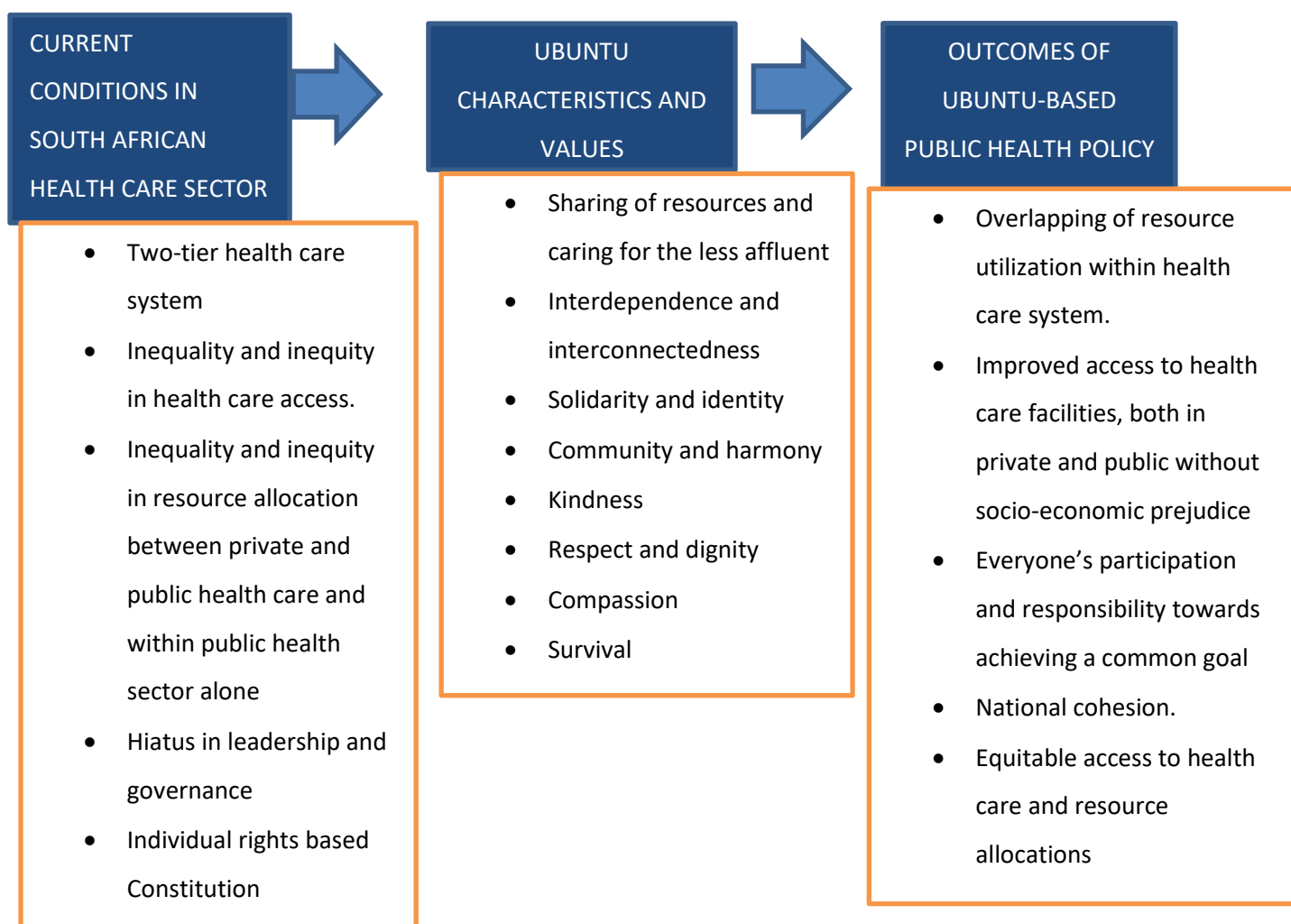
Characteristic of public health ethics is its need to promote what is good for the community or society while it also seeks to respect singularity and at the same time acknowledges how interdependent people are. These features are also something that Ubuntu values and seeks to promote. Therefore, including Ubuntu as part of public health policy would be of added benefit as it brings with it some other values that may not be necessarily prominent or offered by public health ethics.

### **6.6 A CONCEPTUAL FRAMEWORK: THE ROLE OF UBUNTU IN REDRESSING RESOURCE DISPARITIES IN HEALTH CARE**

South Africa is a multicultural and multiracial country which has many talents and resources that, if pooled together, can be made useful for the benefit of South African citizens through incorporation of Ubuntu philosophy into public health policy and resource allocations, not only within health care sector, but right across all sectors. Before delving into

the conceptual framework, it is worth defining Ubuntu for the purpose of this section. From the researcher's viewpoint, Ubuntu is a people centred value system with a permeating character of communal sharing and caring, coupled with harmonious living and mutual reliance on each other for survival as individuals coexist in a community or society. Embedded in Ubuntu philosophy are values such as respect and dignity, kindness, compassion, survival as well as identity and solidarity. Below is a flow chart which illustrates a conceptual framework that depicts the role of Ubuntu in redressing the disparities that exist in health care sector insofar as access to health care facilities and resource allocations is concerned.

The conceptual framework is divided into three categories. The first category of the conceptual framework explores the current conditions within the health care sector. This is followed by the characteristics and values of Ubuntu in the second box of categories. In the last flow chart of the box are the probable outcomes which could be achieved over time if Ubuntu moral theory is incorporated into public health policy. I say over time because the end result would not be achievable overnight. A lot of work and effort to have the buy-in of all the stakeholders is a pre-requisite to achieve success and to have desired outcomes. Amongst the stakeholders whose buy-in is of significance is that of health care professionals who are solely practicing in private health sector without much moral drive and or commitment to social responsibility targeted towards betterment of the health status of all South Africans. In Ubuntu, solidarity, one of the core values, is essential if a common goal for the common good is to be achieved. Uniting in adversity as people of South Africa irrespective of social class, race or gender is primary if disparities currently existing between private and public health care sector are to be minimized. The conceptual framework has been developed in order to give a visual presentation of the flow of how Ubuntu can influence the existing state of health care and transform it into a viable and sustainable communal cohesiveness, with resultant benefits overflowing to the life of the whole nation. Each variable in this diagram relates to the succeeding one in interdependence that illustrates the positive outcomes of Ubuntu visually.



**Figure: 6.1** An Ubuntu conceptual framework in redressing disparities in healthcare access and resource allocation.

### 6.6.1 Current Challenges in the Public Health Sector

The problem of resource allocation in public health sector brings out various ethical viewpoints through which deliberations may be done. Although each ethical theory has a strong point that can be helpful in the discourse, most of them are limited in scope in terms of suitability to resolve issues of equity and access. In this research, Ubuntu ethics is proposed as the most suitable theory for the ethical discourse under research. In South African context, health matters are as much a communal matter as they remain private. Access to health care can be discussed as a matter of social justice and be viewed in terms of virtue ethics or utilitarianism, or some other ethical theory. But these theories alone will not address the need to enhance community values in the face of adversity or calamity. It seems feasible that

Ubuntu ethics can easily set the people on a path leading to a comradeship and communal mindset, as well as instil an ethic of care which demands that each person is able to identify with the other since “I am because you are” from the Ubuntu perspective. This will in turn, lead to the strengthening of health systems in the country through sharing and caring.

Hiatus in leadership and good governance is one of the other challenges facing not only the public health care sector, but rather extends to other sectors as well. To establish adequate service delivery demands that a different approach and a way of doing State business be explored. Ubuntu philosophy is people-centred and at its core it holds values that put forth respect and dignity, welfare and health, safety, caring and compassion, advancement of human being. In Ubuntu perspective, these values come before all other factors such as “politics, economics and financial factors” (Nzimakwe, 2014: 31) are taken into consideration. Therefore, Ubuntu seems to promise a different moral theory laden with values that can contribute to improved leadership and good governance if incorporated and implemented in public health policy.

The Rights Charter in the South Africa Constitution is mainly rooted on the rights of individuals than of communities. Community interests and or rights are not explicitly addressed. Rights of individuals seem to be taking precedence over communities and there seems to be minimal space for responsibilities that are placed upon individuals. As such, individuals have less interest in partaking for the benefit of a community. Ubuntu is an inclusive moral theory. Therefore, by promoting Ubuntu through education and awareness initiatives or programs in a bid to sensitize South African citizens about the Ubuntu way of life, and incorporating the ethos of Ubuntu into public policy generally, not only in public health, would be of benefit for the nation. It would assist to imbue back a moral fibre, not only amongst leadership, but amongst the members of the public, that overtime has been eroded as a result of various factors.

#### **6.6.2 Ubuntu Characteristics and Values**

Ubuntu philosophy is ingrained with characteristic virtues and values that, if adopted and applied holistically in public policy, assert to build a nation which would be able to stand together and rely on members of the population, both in times of adversity and aid. As it currently stands now, much responsibility lies with government to make provision for its citizens without much participation by the citizens. This has created a ‘dependency syndrome’

by the members of the public without much participation and or sharing responsibility for the uplifting of communities that people live in.

#### **6.6.2.1 Caring and sharing**

To care from an Ubuntu perspective means or translates to having a person's welfare, safety, health, dignity and advancement into full capacity being conscientiously considered and having efforts put in place to realize care. Fox (2010) and Nzimakwe (2014:31) concur on the view that "Ubuntu's emphasis is placed on the human aspect and teaches that the value, dignity, safety, welfare, health, beauty, love and development of the human being are to come first and should be prioritized before all other consideration, specifically in modern days, before political and financial factors" are justified. Ubuntu carries with it the value of compassion, a capacity to understand another person's difficulties and a feeling that allows one to sympathise and empathise with another person's misfortune. With compassion springs out care which enables one to exert efforts and actions that make life more tolerable and humane for the other person. With combined efforts and actions, a sense of being and or life is established for all involved, because in Ubuntu "a person is a person through another person." In Ubuntu philosophy, no person can become self-realised in isolation without other persons being involved in one way or the other. A policy in resource allocation that adopts Ubuntu philosophy as a guiding principle, especially when it comes to allocating resources to the disadvantaged or less economically able, that kind of policy would be in a position to embrace a person holistically, to recognize their value and worth, ensure of their safety, welfare, health and development.

Sharing is one of the key elements that characterise Ubuntu philosophy. Not only do human beings share amongst themselves, but they also share with the rest of the ecological system. Sharing almost always goes together with caring in Ubuntu because one would not be able to share any of his or her resources without caring and having compassion for others first. From Ubuntu worldview, each person is interconnected and interdependent to another person. Because of this interconnectedness and interdependence, in policy making, sharing of resources would form part of our being and it would be fulfilment of this synergistic coexistence.

### **6.6.2.2 Solidarity and identity**

In Ubuntu perspective, 'I' exists in so far as it is related to, or associated with another person. In other words, 'I' is because we are. Through another person, 'I' gets to be. Except through identification with another human being, one person cannot be fully able and or capable of surviving alone or in isolation. By virtue of human beings being human, they are therefore members belonging to the group. Metz (2011: 538) explains this concept of identity more succinctly. He states that, "to identify with each other is largely for people to think of themselves as members of the same group, to conceive of themselves as 'we', to engage in joint projects, coordinating their behaviour to realise shared ends." This core element of Ubuntu would play such a significant role in resource allocation policy if adopted. It challenges each person realign their way of thinking and behaviour so as to contribute towards realisation of the end goal. In this research, one of the end-goals is to minimize the gap of resource allocations between private and public health sectors through application of Ubuntu philosophy in health policy. Secondly, it is to minimise gaps of resource allocations within the public health care sector, between provinces and between urban and rural setting. Thirdly, it is aimed at equipping leadership with a moral theory that is intended to put people first, not just in words, but in actual act. With Ubuntu possessing this key feature, it is a possibility that, the gap could be minimized when this moral theory is incorporated into policy, coupled with political and other leaders not only being educated and oriented with Ubuntu, but also practicing Ubuntu.

Comradery or solidarity is another key element of Ubuntu philosophy that enables people to come on board in reciprocal efforts and actions for the benefit of other people. For people to form comradery or be in solidarity, a mind-set positively acclimatized towards others is of significance. This translates to one being able to care and have compassion towards others, for without these qualities, it is almost impossible to sensibly work with others for the benefit of another person towards a common goal. Without these virtues, it would be almost as though one is duty-bound [Kantianism]. Being duty-bound with no sense of emotional connectivity would not be embracing of Ubuntu because in this philosophy, being connected to emotions is also fundamental. Ubuntu ethics also comes across as the ethic of care. From the above discussion, it is easily appreciated that the Ubuntu key features are closely intertwined in the application of daily living and they work synergistically for goal

achievement and for benefiting others. Similarly, with incorporation of Ubuntu into policy, all these key features and values would have to be employed simultaneously.

#### **6.6.2.3 Community and harmony**

A person's existence is bound up with that of a particular community where his or her identity has been formed, in Ubuntu philosophy. One's identity is constituted in a particular community in Ubuntu philosophy and the community or society comes first before any person. The good of a community or society at large is superior to that of a person. From Ubuntu perspective, a person cannot become without belonging to a community which helps moulds them into beings that work towards uplifting their community for the benefit of everyone living in it. In this way of life, one is dejected from advancing their own interests to the detriment of other community members. With direct application of Ubuntu, then it would mean that as a nation, all persons belong to the same group, living and working towards achieving the same end-goal of equity and equal resource allocation, which would in turn bring harmony. Harmonious living is another characteristic feature of Ubuntu. In Ubuntu, one should strive to live harmoniously with his or her fellow community members by obliging to do what is good for the community. Disruption of harmony would result from one's acts that disregard the good of the community, unfriendly towards others and self-serving.

#### **6.6.2.4 Respect and dignity**

Giving respect and dignity to others based on inherent worth or value one possesses by virtue of being human forms part of humaneness, that is, Ubuntu. This is achieved by having a non-discriminatory ability to converse and or relate with others without prejudice while maintaining high regard for another person's values and beliefs. Additionally, by having an ability to love others as one shares a way of life allows one to be able to identify and maintain comradery with others. In Ubuntu, human life is priceless. By sharing resources at our disposal, not only as South Africans, but as human beings on a global scale would be a sign of valuing human life and contributing towards maintain this valuable asset.



## 6.7 Summary and conclusion

This thesis proposes that the nation of South Africa should integrate Ubuntu ethics into policy making and civic education with regard to healthcare in order that the economic middle class in the country can be motivated into accepting and participating willingly in the new NHI policy. The deliberate focus on the middle class here is not intended to leave out the rich and the poor, but meant to capture the largest segment of the country's economic profile in terms of how they function in the socio-economic life of the nation. It is my strong proposal that the acceptance, adoption, and participation of the middle class in an Ubuntu-based NHI will help South Africa establish equity in healthcare whose benefits will easily trickle up and down to both the rich and the poor respectively. The motivation must take shape through regular civic education to be deliberately rolled through the Ministry of Health before and after approval. Those who currently access health care through medical aid or insurance must not be complacent in believing that they can escape either harm or responsibility arising from it. They must grow into believing and practising the Ubuntu ethic of humanness and solidarity in order to build a stronger nation and society in which each person cares for everyone and everyone cares for each one, especially with regard to health.

In conclusion, though South Africans have rights to access healthcare, the quality actually varies due to poor economic status of portions of the population who are forced to survive with less than optimum services in the public sector. In the process of the ethical study, a deeper understanding of Ubuntu is gained and applied in addressing disparities in resource distribution. In the context of considering other ethical theories such as distributive justice and public health ethics, the study evaluates the suitability of Ubuntu ethics as a framework in which the problem can be adequately addressed in South Africa. The findings of the study establish that citizens of South Africa are one large extended family, in an Ubuntu sense, and are capable of living in a communitarian society in which each individual is an integral component and participant in the life of one composite whole.

Ubuntu is a philosophy which calls each one of us to participate within his or her community. Within the context of this research, Ubuntu is calling and encouraging every South African to participate in alleviating the disparities that exists in health care sector. The hiatus is more prominent in the public health care sector when compared to the private health care sector. This moral theory expects and encourages each person to be of service to

others one way or the other, and take responsibility for own actions. As Nzimakwe puts it (2014:32), “Ubuntu is a call to service and participation which serves humanity in a practical way.” In the current South African setup where the burden of quadruple disease and unemployment is at a plight, it would be of significance and embracing of Ubuntu if resources are pooled together, and as a nation strive for some balance in allocating the resources for the benefit of the less or least economically able. The way Ubuntu has been practiced, lived and experienced in yesteryears, as it has been written by various authors aforementioned and quoted in this research, it can be appreciated that the way of life portrayed by Ubuntu philosophy offers support to those who are vulnerable, whether physically or socioeconomically. Ubuntu encourages a person to be groomed into a ‘whole’ person by encouraging one to be connected to their feelings and emotions [compassion, care, sympathy, empathy and so forth], connected to spirituality for the benefit of everyone involved. Because in Ubuntu exists a principle of collaborative act for improvement and advancement of the vulnerable people within communities, it therefore brings about a sense of being to the lives of others. To adopt Ubuntu philosophy and incorporate it into public health policy would be a first step towards healing some of the gaps that currently exist in health and other sectors.

In this research, Ubuntu ethics is proposed because a tolerant and compassionate value system that treats all people equally as human beings regardless of race or place/ country of origin. The positive virtues of Ubuntu as described in chapter three, together with the values encourage each person to partake towards the good of the nation within the context of this research. It would be of significance and bring about change, if leaders, at various levels of leadership in government who are called to service the South Africans, were to adopt Ubuntu, making it a central moral and value system that they live, practice and promote. Owing to its positive virtues and values, inculcated into each leader or manager, corruption would be curbed and most likely, service delivery would be improved. From the previous chapters, it was mentioned that corruption partly stems from an individual’s lack of moral fibre or standing. By instilling an Ubuntu moral fibre into governance personnel where another person is put first and where it is believed “an injury to one is an injury to all”, maybe, corruption levels could be decreased. Also, at the core of Ubuntu is accountability. Accountability is something that is currently lacking within managers across various levels in public health sector. By indoctrinating Ubuntu in public health policy and including it as part

of training for those in management positions, maybe, a certain degree of accountability and improved service delivery would be achieved.

Ubuntu philosophy is well captured in Batho Pele principles which are found in every government department, but hardly put into actual practice in leadership.

In view of the above discussion, this thesis proposes that public health policy should integrate Ubuntu ethical values such as community, sharing, care, solidarity, identity, harmony, respect, and dignity into policy documents and legislation. Government policies such as NHI must not only be based on grounds of justice and rights to access, but must deeply get the principles of Ubuntu discussed above to build a foundation for an integrated society wherein all South Africans care for one another, regardless of race, or gender, or ethnicity, or socio-economic status.

From the discussions on previous sections and chapters, it has become clear that what Ubuntu moral theory offers or stands for is not something necessarily new or unheard of, but rather, it is a concept of a way of life which is said to be mainly associated with Africans. However, from literature it emerges that Ubuntu is a human phenomenon experienced by many, regardless of one's origin or nationality. By incorporating Ubuntu into public health policy, it would not be something that is just about Africans, but rather, it would be about incorporating positive values and or virtues that are of human in nature and origin, which stand to benefit all the disadvantaged within health care regardless of one's race or ethnicity and socio-economic background.

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