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Private vs. Public Healthcare in South Africa

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Abstract

This paper explores the South African healthcare system in regards to the gap between the private and public healthcare sectors. Public healthcare is government funded and offered to all citizens of South Africa, but there are many disadvantages such as long wait times, rushed appointments, old facilities, and poor disease control and prevention practices. Citizens can opt to purchase private insurance in order to be treated at private hospitals and health clinics. The private healthcare sector has many perks that set it apart from public healthcare, such as short wait times, appointments are not rushed, better facilities, and proper disease control and prevention practices. South Africa's National Health Insurance (NHI) is gradually being introduced to the country over the next fourteen years. NHI strives to create a unified healthcare system by making healthcare more affordable and accessible for the South African population. This paper discusses my research findings on the South African healthcare system, as well as my personal experiences working in private and public healthcare facilities during my study abroad trip.

Private vs. Public Healthcare in South Africa

South Africa can be described as being both developed and under-developed at the same time. It is home to cosmopolitan city centers, comfortable neighborhoods and suburbs, but also to impoverished townships. I had the opportunity to study abroad in Cape Town, South Africa in summer 2015, where I explored its wide selection of foods, arts, and activities, which are all influenced by the diverse backgrounds of its people. Cape Town is a city of many identities, which I had the opportunity to discover. I took a class at the University of Cape Town on "Health and Community Development in South Africa," where I was able to learn about South Africa's healthcare system firsthand by working in South African hospitals and health clinics. While I was in South Africa, I was able to observe both private and public healthcare, and was amazed at the gap between these two sectors. South Africa's National Health Insurance (NHI) is being gradually introduced to the country over the next fourteen years and proposes to address the inequalities presented by the current private and public systems (Republic of South Africa Health Department, 2015).

Overview of South Africa's Healthcare System

"The South African health system has been described as a two-tiered system divided along socioeconomic lines" (Republic of South Africa Health Department, 2015, p.1). Government funded healthcare is offered to all citizens of South Africa for free, yet citizens can opt to purchase private insurance in order to be treated at private hospitals and health clinics. South Africa has three levels of hospitals: primary, secondary, and tertiary. Primary level hospitals include internal medicine, obstetrics and gynecology, pediatrics, general surgery, and general practice. They offer limited laboratory services and do not require referrals. Secondary level hospitals are highly differentiated by function and usually have five to ten clinical

specialties within them. Secondary care simply means a patient is referred to a professional who has more specific expertise in whatever problem the patient is having. A rehabilitation center is an example of a secondary level hospital. Specialties within the rehabilitation center include physiotherapy, occupational therapy, orthotics and prosthetics, speech therapy, dietetics, and podiatry. Secondary level hospitals typically have 200 to 800 beds. Tertiary level hospitals offer highly specialized equipment and expertise in areas such as coronary artery bypass surgery, renal or hemodialysis, neurosurgeries, severe burn treatments, and other complex treatments and procedures. Patients are transferred to tertiary level hospitals when primary and secondary level care is not adequate for their condition. Tertiary level hospitals range in size from 300 to 1,500 beds (Jamison et al., 2006).

Public Healthcare

The South African government funds its public healthcare, which gives it many advantages and disadvantages. The advantages of public healthcare include free care to all citizens, including pharmaceuticals, wheelchairs, crutches, toilet seats, etc., and home care visits. Because of the high amount of impoverished communities in South Africa, free healthcare benefits those who could not otherwise afford healthcare. The disadvantages of public healthcare are long wait times, poor quality of care compared to private healthcare, rushed appointments, old facilities, and poor disease control and prevention practices.

My Observations

During my study abroad trip, I was able to experience public hospitals firsthand. I worked as an international health studies intern at Lotus River Primary Hospital where I was able to observe, interview, and shadow health professionals. I found public healthcare to have significant disadvantages, such as long wait times, poor quality of care compared to private

healthcare, rushed appointments, old facilities, and poor disease control and prevention practices. My observations and impressions follow.

Wait times. There was a long line of people that extended outside of the hospital building each morning before it opened at 8:00am. At 8:00am, everyone entered and waited in line to get checked in. There were four different waiting rooms that filled up instantly. Each morning around 8:30am, the Lotus River staff sang a song called the "Ghoema Song." The staff went to each of the four waiting rooms and sang this to the patients. Whichever patient in each waiting room danced the best won the "golden ticket," which meant they got to skip the line to be seen by the doctor ahead of the others. Once the doctor saw them, they were also able to go to the front of the line at the pharmacy. My impression was that it was basically a fast pass and a method to cheer up patients and staff before the day started. The "Ghoema Song" tradition appeared to be a way to decrease the wait time for a few fortunate patients. Patients participated in this tradition because of the risk of not being seen by a doctor that day due to long wait times.

Urine analyses. I observed many issues with disease control and prevention in the South African public hospitals. The first problem I observed was in the preparation room at Lotus River. I observed what the nurses do with patients before they are sent to see their doctor or department in the hospital. They took patients' weights, temperatures, and did urine analyses for each patient. For the urine analyses, each patient was given a small glass cup to urinate in. At first, I saw nothing wrong with this. After observing for a longer time, I realized the urine cups were not cleaned after each patient used them. Instead, the patient brought the urine to the nurse, and the nurse dipped a test strip into the cup. After that, the patient dumped out the urine into a toilet and rinsed their cup. After rinsing their cup out with water, the patient brought the urine cup back to the preparation room and set it on the table. I witnessed the next patient come in and

pick up the same exact cup to use for their urine analysis. The urine cup was not cleaned with soap or sanitized in any way. Another observation I made with the urine analyses is that the nurses did not wear gloves. They used their bare hands to dip the test strips into the urine cups, and placed the urine soaked test strips onto the counter. After the test strip results were recorded, the test strips were thrown out, but the counter was not wiped down or cleaned. I observed doctors and nurses coming in and putting their pencils and patient charts onto the counter where the urine strips were placed. There was one instance where a doctor came in and put her pencil down in a puddle of urine. She picked her pencil back up and wiped the urine on her smock, and kept using it. It was unclear if she knew the wetness on her pencil was urine or if she thought it was just water. Clearly, this high risk behavior could be avoided through the use of disposable containers at best and sanitation of the glass cups at the very least.

Glove usage. I was quite shocked at the lack of glove usage in the public hospitals. When I asked about the lack of glove usage, nurses explained that they choose to wear gloves or not. Consequently, if a nurse becomes ill or injured, they assume responsibility. I observed a nurse applying dressing to a man with an ulcer on his leg. In the middle of the procedure, she was called to another room. She was still wearing her gloves from the ulcer patient, and went from the dressing room to across the hall. She did not take off her gloves. She touched door handles, cabinet handles, and one other patient. When she came back, she did not change her gloves or wash her hands. Instead, she continued with the ulcer patient from where she left off. Clearly, this patient was exposed to potential infections from the nurse having encountered many contaminated objects.

Hand washing. Hand washing is also a significant problem in South African public hospitals. I interviewed Lotus River's manager, who reported that there was not a hand washing

policy in hospitals (S. Jones, personal communication, July 2, 2015). Hand washing is optional, but encouraged, especially after employees use the restroom. The facility's custodian provided a tour of the facility's storage room which was well stocked with soap and gloves, yet there was minimal use of these supplies. At first I assumed that the lack of hand washing was due to an inadequate amount of resources, but after talking with the custodian and seeing ample amount of supplies, it was clear the resources were available.

Bed linens. I observed multiple patients using the same bed linens. After one patient got off a bed, the next patient would sit on the same bed linens. When I was shadowing the physiotherapist, she had multiple patients come in and lay on her table while she did massages. These patients would put their faces face down on the bed linen, and the next patient would come in and do the same. In the trauma room, I observed blood on the bed linens which were not changed between patients. Rather, a paper towel was placed over the blood before the next patient. The custodian reported that bed linens were changed after each patient and the beds were also wiped down with cleaner after each patient (Anonymous, personal communication, July 2, 2015). When I asked Lotus River's manager about when the linens were changed, she indicated they were only changed at the end of each day unless bodily fluids got on the linens. If bodily fluids got on the linens, she noted that they were changed immediately before the next patient comes in to sit on the bed (S. Jones, personal communication, July 2, 2015). Given my observations, it was clear that policies were not being followed regardless of there being evidence of ample supplies of bed linens in the storage areas.

Medical instruments. Medical instruments were used with many different procedures. I observed a nurse treating a man with an open wound, and the medical instrument dropped to the hospital floor. She retrieved it and began using it again without it being sanitized. I spoke with

Lotus River's manager about the process of sanitation of medical instruments, and she indicated that there were no guidelines (S. Jones, personal communication, July 2, 2015). They have only two autoclaves in the hospital. With the amount of medical instruments used in the hospital, two autoclaves are definitely not adequate.

Occupational Therapy Shadowing

During my study abroad trip, I shadowed an occupational therapist named Graham Clark at Elsie's River Hospital. Each day Graham had numerous appointments with patients of different conditions. He also took walk in patients as he could. If someone did not show up for an appointment, Graham would see as many other patients as he could since he was so in demand. The therapy room had four beds and an open space in the middle that was used for pediatric therapy and group therapy sessions. The physiotherapist shared the room with Graham, so it was usually quite noisy. The beds were sectioned off with curtains to give each patient privacy during their appointments, however, conversations from each table could still be heard clearly throughout the room. Graham was only able to spend fifteen to thirty minutes with each patient because of the high patient demand. He was forced to rush through appointments and not spend adequate time with each patient. Many of his patients needed resources to take home after their appointments, such as wheelchairs and crutches. In public hospitals, these resources are provided to patients for free, however, there was always a lack of resources within the stock room and Graham was forced to send many patients home empty handed. This was a significant problem for the therapy department because many treatment plans depended on the use of resources that were out of stock. Graham explained to me that despite his numerous orders for more items, he rarely ever received his shipments before stock ran out.

Graham took me on a home visit with him in Elsie's River, Cape Town. The neighborhoods surrounding Elsie's River Hospital were impoverished and dangerous. Stray animals wandered the streets and trash was piled everywhere. The home we visited had dirt floors, scrap metal walls, and housed multiple families. The man we saw had a spinal cord injury due to gunshot wounds. The patient was extremely skinny and could not move on his own. He was in a lot of pain and could barely talk. Graham was able to provide him with a wheelchair during our visit so that he would not be forced to be bed ridden anymore. When I came to Elsie's River the next day, Graham told me there had been a shooting later that night only two blocks away from the house we went to on our home visit. Most Cape Town townships have high crime rates and gang problems. Patients with injuries due to gunshot wounds are common in public hospitals.

Private Healthcare

Private healthcare is much different than public healthcare. The government does not fund private healthcare, so citizens must purchase their own private insurance in order to be treated at a private healthcare facility. Private health insurance is expensive, and there are fewer facilities than the public healthcare sector has. The advantages of private healthcare are short wait times, quality care, better facilities, adequate resources available, appointments are not rushed, and proper disease control and prevention practices are utilized. The disadvantages of private healthcare are that it is expensive, there are fewer facilities, patients are responsible for paying for healthcare visits, pharmaceuticals, and additional resources such as wheelchairs or crutches. Citizens who can afford to pay for private insurance use private healthcare. The majority of South Africans cannot afford private insurance, so the demand is lower than the demand for public health facilities. The lower demand is the reason there are fewer facilities, so

even if someone has private insurance, there may not be a private healthcare facility nearby for them to use.

Occupational Therapy Shadowing

During my study abroad trip, I was able to experience private hospitals firsthand. I worked at The Quadrant Wellness Centre, a secondary hospital in Claremont, Cape Town. Here, I shadowed an occupational therapist named Carmelita Barron. The Quadrant Wellness Centre was a modern building with a large fountain out front. The building was securely locked and required patients to get buzzed in after pressing the doorbell and speaking to the receptionist through an intercom system. There was another fountain in the reception area and the waiting room had high-end furniture. There was only one other person in the waiting room when I arrived. The facility was quiet, clean, and richly furnished. The public hospitals in South Africa appeared more warehouse-like than hospitals, and the private facility felt more like a fancy hotel than a wellness center. Carmelita greeted me and we started seeing patients. She only had three patients to see this day and explained that this was normal because she blocks out at least one hour for each patient. This way, each patient got the attention and care they deserved. She was able to spend adequate time with each patient and document their appointments thoroughly afterwards. After each patient, she wiped down the equipment that was used with cleaner and washed her hands. The patients that came in were very different than those seen at the public facilities. They were all dressed in nice clothing and well groomed. They asked educated questions and had high-end accessories such as watches and smart phones. Part of the therapy was performed using an iPad. These vast differences made me realize that private healthcare is solely for the wealthy and entitled population of South Africa, and public healthcare is for the

poor. There is no middle ground. The wide gap between these two sectors is a significant problem in South Africa.

Carmelita took me on a home visit with her to a wealthy neighborhood in Claremont, Cape Town. The neighborhood the patient lived in was a gated community with fancy houses. It was clean, well kept, and quiet. When we arrived at the patient's home, his child's nanny answered the door. There was also a housekeeper cleaning the kitchen when we arrived. The home was large with elegant features such as granite countertops, tile flooring, a fireplace, and high-end electronics such as a flat screen TV and a video surveillance system. The man we saw had been a patient of Carmelita's since he had a major stroke one year prior. He was a successful businessman before the stroke, but now cannot stand up or talk. He had Carmelita as his in-home occupational therapist, and also had a physical therapist and speech-language pathologist. He was able to have in-home treatment since he could afford to pay for private insurance.

Personal Reflections

The "Ghoema Song" was eye opening to me because the entire hospital shut down for at least thirty minutes each morning in order to sing the song to each waiting room. Every health professional was expected to stop working and participate in the singing and dancing. Although this was a great way to cheer up patients and staff at the beginning of the day, it caused wait times to become even longer for the majority of patients who did not receive the "golden ticket." At 10:30am each morning, all the staff at Lotus River stopped working and went on a break called "tea time." This break was thirty minutes long and its purpose was to have a break between the beginning of the day and lunch. All staff took this break at the same time, so the hospital shut down once again. At 12:00pm was lunch break and every staff member took this break at the same time as well. Lunch break was an hour long and caused yet another shut down

of the hospital. All these breaks combined caused two hours of time where no patients were seen. Instead, patients had to keep waiting and by the time the hospital closed at 6:00pm, many patients remained unseen and were told to come back the next day. Clearly, the long wait times at Lotus River could be avoided by not participating in the "Ghoema Song," and by cutting down on tea time and lunch break. Perhaps to avoid entire hospital shut downs during the day, staff could take their tea time and lunch break at different times so the hospital can continue seeing patients without long periods of being shut down.

Initially, I thought my urine analyses observations were an issue of low budget and not having available resources. However, after speaking with the hospital's manager I was informed the hospital has all essential resources and their budget is flexible (S. Jones, personal communication, July 2, 2015). After learning this, I was confused about the urine test in particular because the solution is quite simple. Using the same urine cup for multiple patients without proper sanitation increases the risk of disease between patients. It also makes it impossible to have an accurate urine analysis because the urine cup is contaminated with the prior patients' germs. The cups should either be disposed of after each patient, or should be thoroughly sanitized after each patient. Nurses should always wear gloves in the preparation room too because they are working around bodily fluids all day.

Lack of glove usage is a significant problem in South African hospitals. Not wearing gloves and not changing gloves between patients can result in infection. If someone is admitted with a leg fracture, for example, the risk for infection is high, as well as acquiring additional illness because of poor disease control and prevention. It is clear that healthcare professionals in South Africa are not properly trained in disease control and prevention.

Employees would treat patient after patient without washing their hands or using hand sanitizer. Employees were also observed rubbing their eyes with their hands, licking their fingers before turning pages in patient charts, and blowing their nose without washing their hands afterwards. Given these observations, it is evident that staff is not well informed on universal precautions to prevent spread of disease and illness.

Townships in Cape Town are impoverished communities where people live in shacks made of scrap metal and dirt floors, do not have running water, and have nothing but porta potties to use for a bathroom. This is the environment the majority of public healthcare professionals live in. This impacts the way healthcare professionals act at work in regards to disease control and prevention. Many public healthcare professionals live in communities where running water is not available, and I feel this affects their hand washing habits at work. They bring these unsanitary habits to the workplace and unintentionally put others at risk. Proper disease control and prevention practices are not taught in South African public hospitals. Many citizens of South Africa are afraid to go to the hospital for fear of getting sicker while they are there. Many patients I spoke to at public hospitals explained that they had many friends who went to the hospital for one health problem and left with multiple other health problems. There have not been many significant studies done on hospital-acquired infections in South Africa, so there is not concrete proof of the widespread issue. However, citizens of South Africa trust word of mouth information on the issue and choose to stay home and get sicker instead of going to the hospital and risk falling more ill.

South Africans who live in townships often trust traditional healers more than a medical doctor. Traditional healers treat patients in their own homes and use natural healing methods. The problem with this is there are no scientific findings to backup the methods used by

traditional healers. Healthcare professionals are concerned about the work of traditional healers because many patients come to the hospital after having adverse reactions to the treatment they received. The most significant problem with this is that healthcare professionals can rarely figure out what causes the adverse reactions because traditional healers use such a vast realm of healing methods. I experienced this situation firsthand when a one year old child came in with an extremely bloated stomach after seeing a traditional healer. She had an ultrasound of her stomach and her doctors were puzzled at what could have caused the bloating. Her mother said the traditional healer wrapped her stomach in herbs to cure a stomach ache, but she did not know what the herbs were. The doctors could not accurately diagnose or treat her since they did not know what the traditional healer's treatment entailed.

South Africa's Healthcare Outlook

South Africa's National Health Insurance (NHI) is being gradually introduced to the country over the next fourteen years. It is expected that NHI will create a unified health system by making health care delivery more affordable and accessible for the South African population (Republic of South Africa Department of Health, 2015). The government claims that NHI will ensure equity, address the inequalities presented by the current private and public health system, and present an ambitious plan to change the face of the South African healthcare system over the next fourteen years.

Prior to 1994, South Africa's health system was divided along racial lines. " One system was highly resourced and benefitted the white minority. The other was systematically under-resourced and was for the black majority" (Republic of South Africa Department of Health, 2011, p. 5). Post 1994, a two-tiered health system developed. The current system is based on socioeconomic status. The attempts to reform the health system have not gone far enough to

bring about equity in healthcare. The NHI will address the burden of disease in South Africa. The country has been plagued by four clear health problems: HIV/AIDS and TB, maternal, infant and child mortality, non-communicable diseases, and injury and violence (Republic of South Africa Department of Health, 2011).

Despite significant improvements since 1994, there are still significant quality problems. "Among the commonly cited and experienced by the public are: cleanliness, safety and security of staff and patients, long waiting times, staff attitudes, infection control and drug stock-outs" (Republic of South Africa Department of Health, 2011, p. 9). Over the next fourteen years, the NHI will be gradually introduced to the country. See table 1 for details of the first five years of phasing-in the NHI.

Table 1: Phasing-In of National Health Insurance – The First 5 years

Key features	Time-frames
1. NHI White Paper and Legislative Process • Release of White Paper for Public Consultation • Launch of Final NHI Policy Document • Commencement of NHI Legislative process	 10 August 2011 December 2011 January 2012
2. Management reforms and Designation of Hospitals • Publication of Regulations on Designation of Hospitals • Policy on the management of hospitals • Advertisement and appointment of health facility managers	 August 2011 August 2011 October 2011
3. Hospital Reimbursement reform • Regulations published for comment on Hospital Revenue Retention • Development of a Coding Scheme	April 2011 January 2012
4. Establishment Office of Health Standards Compliance (OHSC) • Parliamentary process on the OHSC Bill • Appointment of staff (10 inspectors appointed)	 August 2011 January 2012

5. Public Health Facility Audit, Quality Improvement and Certification
• Audit of all public health facilities
  ◦ 21 % already audited (876 facilities)
  ◦ 64% completed (2927 facilities)
  ◦ 94% completed (3962 facilities)
• Selection of teams to support the development and support of quality improvement plans and health systems performance
• Initiate inspections by OHSC in audited and improved facilities
• Initiation of certification of public health facilities
	
	End July 2011
	by end of
	December 2011
	by end March
	2012
	
	October 2011
	February 2012
	March 2012

6. Appointment of District Clinical Specialists* Support • Identification of posts and adverts • Appointment of specialists • Contract with academic institutions on a rotational scheme	 August 2011 December 2011 February 2012
7. Municipal Ward-based Primary Health Care (PHC) Agents • Training of first 5000 PHC Agents • Appointment of first 5000 PHC Agents • Appointment of PHC teams	 December 2011 March 2012 April 2012
8. School - based PHC services • Establish data base of school health nurses including retired nurses • Identification of the first Quintile 1 and or Quintile 2 schools • Appointment of school-based teams led by a nurse	 August 2011 October 2011 November 2011
9. Public Hospital Infrastructure and Equipment • **Refurbishment and equipping of 122 nursing colleges** First 72 nursing colleges by end of financial year 2011-2012	 March 2012

• **Building of 6 Flagship hospitals and medical faculties through PPP's**
  • King Edward VIII Academic (KZN)
  • Dr George Mukhari Academic (Gauteng)
  • Nelson Mandela Academic (E. Cape)
  • Chris Hani Baragwanath Academic (Gauteng)
  • Polokwane Academic (Limpopo)
  • Nelspruit Tertiary (Mpumalanga)
• Refurbishment of public sector facilities
	Commence 2012
	
	Ongoing

10. Human Resources for Health (HR) • Launch of HR Strategy • Short to medium term increase in supply of medical doctors and specialist • Increase in production of nurses • Increase in production of pharmacists • Increase in production of allied health professionals	 September 2011 2012 – 2014 2012 – 2014 2012 – 2014 2012 – 2014
11. Information Management and Systems Support • Establishment of a **National Health Information Repository and Data Warehousing** (NHIRD) • Provincial and District roll-out of the NHIRD • Appointment of Information Officers and Data Capturers	 July 2011 November 2011 November 2011
12. Build capacity to manage NHI through the strengthening of District Health Authority • Creation of NHI district management and governance structures • Selection of Pilot Sites (First 10 districts) • Development and test the service package to be offered under NHI in pilot sites • Extension of Pilots from 10 districts to 20 districts	**April 2012** June 2013
13. NHI Conditional Grant to support piloting of initial work in 10 districts • Piloting of the service package in selected health districts • Piloting fund administration	**April 2012**
14. Costing model • Refinement of the costing model • Revised estimates	 2012 2013
15. Population registration • Partnership between Departments of Science and Technology, Health and Home Affairs on: ▪ Population identification ▪ Population registration mechanisms	**Commences April 2012**
16. ICT • Scoping exercise with Department of Science and Technology and CSIR • Design of ICT architectural requirements for NHI	**April 2012**
17. Establishment of NHI Fund • Appointment of CEO and Staff • Establishment of governance structures • Establishment of administrative systems	**2014**
18. Accreditation and contracting of private providers by NHI Fund • Establishment of criteria for accreditation • Accreditation of first group of private providers	 2013 2014

(Republic of South Africa Department of Health, 2011, p. 48-49)

It is stated that the NHI is not being implemented to abolish private healthcare, but it will help make quality healthcare more affordable. According to Health Minister Aaron Motsoaledi, "…quality private healthcare is no longer affordable in the country and that is why the country needs universal health coverage" (Gqirana, 2015, p. 1). The efforts of the NHI include reduced waiting time because that is one of the large problems with South Africa's current public healthcare system. South Africa has a massive lack of doctors and nurses, so community health workers are used to address the shortage. The problem with these community health workers is that their job descriptions and employment contracts have not been standardized. A large amount of community health workers are not registered anywhere. Many of them started out as volunteers and have a wide range of skill levels. Community health workers are important members of the South African healthcare system because they "…help with time-consuming tasks of professional health workers, such as following up on HIV or TB patients to ensure they take their medication correctly" (Gqirana, 2015, p. 1). The NHI will work to produce a community health worker policy to ensure they are trained appropriately since there are such a large number of community health workers in South Africa.

The NHI will ensure universal health access to all legal residents of South Africa. High-income citizens will be taxed to support payment for the NHI. It has not been decided how much extra this tax will be, or at what income threshold the tax will kick in at (Child, 2011). The NHI will be implemented in three stages. The first stage began in 2012. This stage focuses on "…improving public health service delivery, strengthening of management and governance systems, particularly to improve the quality of health services" (Moodley, 2015, p. 1). Stage two will begin in 2017/2018 and focuses on registering and issuing NHI cards to all South African citizens. A fraud management system will also be set up during stage two. Stage three will begin

in 2019/2021 and "…will focus on ensuring that the NHI fund is fully functional" (Moodley, 2015, p. 1). Many health professionals I worked with in South African hospitals had significant doubts about the NHI. The NHI began its first implementation stage in 2012, but the healthcare system has not seen any major changes thus far. Because of this, many health professionals and citizens doubt the timeliness of implementing the NHI. Many believe South Africa's healthcare system is too complex to fix within just fourteen years, especially since there have been no major changes in the first four years of implementation. South Africa has high hopes for the NHI, but only time will tell how successful the implementation will be.

Conclusion

There is a major gap between private and public healthcare in South Africa. Public healthcare is government funded, but there are many disadvantages such as long wait times, poor quality of care, rushed apppointments, old facilities, and poor disease control and prevention practices. Private healthcare is much different than public healthcare. It is expensive, not funded by the government, and there are fewer facilities. The advantages of private healthcare are short wait times, quality care, better facilities, adequate resources available, appointments are not rushed, and proper disease control and prevention practices are utilized. The NHI is being introduced to the country to address the issue of inequality between the private and public healthcare sectors. Over the next fourteen years, the South African healthcare system will go through many changes and the gap between private and public healthcare will hopefully close.

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