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PRIVATE HEALTH CARE IN TIMES OF PANDEMICS IN SOUTH AFRICA: DOES AFFORDABILITY AND CLASS MATTER?

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Abstract. This paper argues that class and the affordability of healthcare do not matter during times of pandemics. The class and affordability of private healthcare are a privilege only when there are no reported healthcare crises on earth. The middle class believes that private healthcare, which is mainly achieved through the affordability of medical aids, secure employment, and service by exceptional nursing professionals, is an everlasting privilege. This paper utilises secondary data (books, articles, and government documents) to argue that the privilege of private healthcare is often limited by the natural instability that humanity may face at any time in its lifetime, when unexpected pandemics emerge. This paper concludes that private healthcare affordability and class are temporary privileges that can be limited at any time by unstable factors, such as natural disasters and pandemics. This paper contributes to policy in that it highlights significant pointers for public administration and the middle class to understand that, in the context of pandemics, full privileges can be limited, and that public healthcare staff and facilities may play a more significant role in mitigating the pandemic.

Keywords: affordability; private health care; pandemic; crisis; medical aid

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JEL Classifications: I10, I18

1. Introduction

South Africa’s healthcare system is two-tiered, with a large public sector and a smaller private sector. In 2022, 15.7% of South Africans were covered by private medical aid (Cowling, 2025). In South Africa, the private hospitals play a significant role in the health system. However, private hospitals are supported by a few middle-class citizens and some self-funded business individuals. In 2022, 73.1% of households utilised public healthcare, while 25.4% opted for private care (Statista, 2025).

The private hospital's health services are said to be unique and are serviced by ethically grounded nurses providing quality healthcare, which is assumed to exceed the public sector's healthcare standard. Dunga (2019:61) argues that in developing countries, there is a consistent link between income and health, in the sense that higher income levels correspond to greater access to quality healthcare. Individuals with lower incomes have no choice but to go to public hospitals, where healthcare services are generally of extremely low quality (Maphumulo & Bengu, 2018), which has led to a particular extent to South Africans losing trust in the ruling elites and their public administration. South Africa’s public health system is characterised by poor leadership, corruption, a lack of medical resources, staff shortages, and long waiting times (Abrahams, Thani & Kahn, 2022). Based on such anomalies, private healthcare becomes an option for a few, mostly middle-class and affluent individuals. Those who cannot afford quality healthcare and have no other option are faced with the difficulty of receiving low-quality public service at public hospitals. The question raised in this paper is: Does the privilege of private healthcare matter during pandemics? In answering this research question, this paper will look at the following

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objectives: 1) to provide literature and a theoretical context of the paper; 2) to characterise context of the South African nursing during pandemic; 3) to analyse the different professional ethics between private and public health care nurses; 4) to evalaute the capacity of hospitals during COVID-19 pandemic, 4) to conclude whether affordability and class mattered during the COVID 19 pandemic?

2. Literature Review and Theoretical Perspectives

This paper tackles a crucial area of human challenges in the event of disasters. Both epidemics and pandemics are considered unforeseen crises that are often beyond the capacity of humanity to deal with immediately at first occurrence. While many authors have written about COVID-19 issues, little to nothing has been written about how these unplanned events often create barriers to middle-class benefits and ultimately put everyone on an equal scale. The COVID-19 literature has focused mainly on health effects, the role of nurses and healthcare practitioners, and how governments have contained it. I decided to pursue the argument of this paper through the lens of the Crisis Theory. The emergence of COVID-19, which disrupted the global health system, showed the world that no class could be better than the other when such an unplanned event occurs. In addressing such gaps in the literature and practice, this paper offers a new perspective through an analytical approach and the Crisis Theory lens, arguing that class and affordability among the middle class did not matter during the COVID-19 pandemic. The Crisis Theory was developed as an intervention or a response to the growing demand for services in situations where immediate assistance was required for large numbers of individuals (Poal, 1990). Walby (2022:499) defines it as " an event that has the potential to cause a large detrimental change to the social system and for which there is a lack of proportionality between cause and consequences". Therefore, this creates the need for crisis intervention. The theory is primarily applied across various disciplines, depending on the angle of scholarship in social science pursued (Baumgardt & Weinwann, 2022). A pandemic such as COVID-19 caught the entire globe by surprise, in which instance some measures were taken in a panic mode. Even though humanity lives in a state of panic during pandemics, a need arises for action to be taken to deal with the event itself. The COVID-19 crisis led to millions of deaths worldwide (Walby, 2022). Careful background information on this issue itself is important for successful intervention in a crisis. According to Wang & Gupta (2025:1), the best available intervention model is SAFER-R (which consists of stabilisation, acknowledgement, facilitation of understanding, encouragement, recovery and referral). The successful application of this model ultimately helps people return to a state of normalcy after a crisis has been resolved. The application of this model in this discussion is crucial for understanding the limitations and behaviour of individuals, state organs, and institutions during times of crisis. Crises are mainly traumatic, and they leave emotional scars in people; others find it difficult to recover after such a crisis. The COVID-19 pandemic had not only left an emotional crisis in humanity, but it had also left others with chronic ailments that were not previously detected. To some medical practitioners, the pandemic remains a mystery even after it has passed.

2. Methodology

This paper is a qualitative study. The paper used secondary data sources (books, articles, and government documents) to argue that the privilege of private healthcare is often limited by the natural instability that humanity may face at any time in their lifetime, when unexpected pandemics emerge. The author sampled the materials for use in the study, ensuring that the materials used are relevant to issues related to South African COVID-19-related concerns, the roles and ethics of the nursing profession, private healthcare, health professionalism, and the capacity of South African hospitals during the pandemic. The author used the deductive analysis approach in analysing data obtained through secondary data sources.

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3. Results and Discussions

The results and discussions are based on the primary research question raised in the paper. The question was: Does the privilege of private healthcare matter during pandemics? In answering this research question, this paper will look at the following objectives 1) To give context of the South African Nursing during pandemic, 2), To analyse the different professional ethics between private and public health care nurses,3) To evalaute the capacity of hospitals during Covid 19 pandemic,4) and to conclude whether Affordability and really Class Mattered during the COVID 19 pandemic?

3.1 The South African Nursing during the COVID-19 Pandemic

Generally, both public and private sector nurses became heroes of the health sector during the COVID-19 pandemic worldwide, as more attention was paid to them and the medical doctors. However, doctors remain slightly behind the scenes. Some traditional and spiritual healers also took a hit at the time, as their spiritual superiority was doubted in the face of scientific advancements. The nursing profession has become so complex that nurses must take care of patients, attend to patients' families, perform their administrative duties, and adhere to their demanding work shifts (Alguwez, 2022). They were seen as the frontliners of the COVID-19 pandemic in comparison to other healthcare workers (Fawaz, Anshasi & Samaha, 2020), in the sense that they continuously had to interact with the patients. Pires, De Oliveira, Siqueira, Feldmann, Oliveira, & Gasparino (2018) posited that the nursing team is mainly responsible for 95% of healthcare in patients. Although that was ignored in Africa, these continuous interactions caused many nursing staff to experience high burnout, depression, anxiety, fear and exhaustion (Gohentsemang, Coetzee, Botha & Fourie, 2024). At that stage, there were no narratives of the separation of public and private sector nurses in this role, as the health sector remained the critical sector responsible for providing care, curing illnesses, managing health, and attempting to save lives for all. While universities, colleges, schools, markets, and other workplace sectors were closed, hospitals remained open to safeguard humanity from harm (Peiro, Lorente, & Vera, 2020). However, it is acknowledged that the work ethics of nurses in the public and private sectors are not seen from the same professional perspective. Arguments of quality associated with private and poor service, as well as those associated with the public sector, were temporarily averted during the COVID-19 pandemic, implying that the argument of quality and quantity of healthcare is a time-phased matter controlled by events.

South Africa faced numerous healthcare challenges before the emergence of the COVID-19 pandemic (Ngobeni & Dhanpat, 2022), which may primarily be administrative and political in nature. However, the critical ones include human resources and access to quality health care (Abrahams et al., 2022). COVID-19 was therefore adding to the already ailing challenges of the South African healthcare system. Although facing those challenges, in South Africa during the COVID-19 pandemic, both public and private hospitals were seen as one arm responsible for a significant contribution to and delivery of the country's healthcare system, facing the same challenges of capacity to deal with the pandemic, with insufficient available resources. That was in the sense that they were all overcrowded to the limit and had staff whose performance was not limited by a self-attitude of not performing, but rather by the availability of resources to cope with the overall deteriorating public healthcare facilities even though South Africa itself is short of healthcare workers, with 213 people for one nurse (Abrahams et al., 2022) in public hospitals.

Generally, both nurses in the private and public health care sectors faced various risks associated with their calling, which in some instances have exposed them to the risks of infections and potential loss of life. During the COVID-19 era, there was little to be concerned about in terms of which sector, private or public, offered higher-quality healthcare in South African hospitals. Collectively, in their various sectors of healthcare, they pursued their calling to save lives, even where it meant losing their own. Although the public attaches no little significance to how many lost their life in their line of duty, emanating from their calling, we know that it happened. Tlotleng,

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Cohen, Made, Kootbodien, Masha, Naicker, Blumberg & Jassat (2022) noted that no such data exists or has been explored regarding the healthcare workers admitted during the COVID-19 illness. No nurses of each of the sectors worked for the purpose of being motivated by the incentive scheme of any sector, but by the desire to save lives.

3.2 Different Professional Ethics Between Private and Public Health Care Nurses

Generally, South Africans differentiate between the ethical duties of those in the private and the public hospitals on different scales. The staff of private hospitals are better rated than those in public hospitals, creating a disparity in unequal healthcare within the South African public healthcare system. The ethical responsibility of nursing is based on four fundamental principles: promoting health, preventing illness, restoring health, and alleviating suffering (Stellenberg & Dorse, 2014). While both public and private healthcare nurses are produced by the same health qualifications and registered under the same professional healthcare bodies, public healthcare workers are viewed as of slightly lower quality in comparison with their counterparts in private healthcare provision. It is argued that this is mainly due to the relaxation of the service ethos in the public sector, where it is not in dispute that codes of conduct and ethics exist. However, it is acknowledged that the enforcement of those codes of ethos is relaxed. Even with the existence of the Batho Pele Principles (People First Principles), both patients and family members are reportedly not treated with courtesy.

According to Torkaman, Heydari & Torabizadeh (2020:1), the nurses' professional and ethical performances are influenced by the health organisation's environment, quality, and holistic ethical commitment within the organisation. Private healthcare hospitals are primarily driven by profit and therefore strive to appear as if they are providing first-class healthcare to their clients (Choonora & Eyles, 2015:1), as opposed to the less caring attitudes often associated with public hospitals. More often, they adopt a customer-focused model guided by high ethical standards. Therefore, it implies that public health organisations that adopt a laissez-faire attitude promote a lack of appropriate commitment from their nursing staff. The ethical climate is critical within the healthcare environment (Okumoto et al., 2022) in ensuring that the public's health is in the hands of health professionals guided by professional ethics. In the public healthcare environment, there is a massive problem of staff and resource shortages that causes nurses to develop poor attitudes, which compromises their professional commitments to their profession (Abrahams et al., 2022). Neither are private healthcare providers angels of ethical practices, since at times they have to use unqualified healthcare workers as a way of saving costs (Choonara & Eyles, 2015:1-3). A thin line between these two can be based on a rationale for non-compliance with ethical principles. Private healthcare, even with unqualified healthcare workers, may claim to achieve the goal of serving clients effectively. In contrast, a public healthcare worker in the same situation may fail to deliver service to a client due to a lack of resources.

3.3 The Capacity of South African Hospitals during the COVID-19 Pandemic

Generally, the COVID-19 pandemic caught all nations by surprise. South Africa was no exception to the rule, with a significant loss of life expected (Le Grange, Dickison & Davis, 2020). Significant concern in South Africa was the anticipated shortage of critical care beds, which posed a worrisome factor in managing the surge. Although numerous modelling efforts emerged, South Africa relied on the South African COVID-19 Modelling Consortium, which regularly publishes short- and long-term projections (Solanki, Blecher, Cornell, Crisp, Engelbrecht, Manning, Morar, Myburgh, & Patel, 2021). According to Ngobeni, Breitenbach & Aye (2020), as of 2018, the South African healthcare system consisted of 813 hospitals, comprising 404 public hospitals and 409 private hospitals. The public sector hospitals accounted for 49.7% of beds, while the private sector accounted for 50.3% of the beds. At this juncture, there is also a problem with dysfunctional public hospital facilities compared to the better facilities in private hospitals.

The figures mentioned above indicate that the South African government has placed a significant responsibility for its healthcare in the hands of private healthcare providers, which is only accessible to a few (Hlafa, Sibanda & Hompashe, 2019; Malakoane, Heunis, Chikobvu, Kigozi, Kruger, 2020). The health system continues to be

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characterised by social exclusion between the haves and the have-nots (Ndebele, Mlambo & Molepo, 2021). Those without medical insurance are likely to have their health expectations not met or compromised promptly (Moeti et al., 2023), resulting in a shortened life expectancy. This explains why public hospitals are often overcrowded with long queues and are unable to accommodate ailing patients. Public healthcare supports 84% of the population, while private healthcare supports only 16% of the middle-class insured population (Mokhele et al., 2021). The inequality in these percentages indicates that poor South Africans are far from receiving quality healthcare, which threatens the economic productivity of the society (Mhlanga & Ndhlovu, 2021).

On the other hand, private hospitals' beds, with only 16% of the population to serve, will never be full at any time except during pandemics, which therefore means that they always have available beds, while public hospitals are always full. Since medical insurance is not a compulsory policy in any South African employment contract, government hospitals still take full responsibility for the uninsured professionally employed population in the country. Thus, overburdening the poor and the unemployed to enjoy such a right.

According to Alavinenejad et al. (2022), 75% of the Intensive Care Unit (ICU) beds in South Africa are located in private sector hospitals, while only 25% are in public hospitals, which can't accommodate 80% of the population that required this service during the pandemic. According to McQuid-Mason (2021:304), South Africa's three largest private hospital group "reported that a surge in COVID-19 cases had filled their ICUs' capacity, and some of the hospitals were diverting ambulances to other facilities". This implies that even the middle-class citizens could not be accommodated in the so-called selected few health access. Other resource-providing provinces in the country entered into Service Level Agreements (SLAs) with private health hospitals to accommodate referrals from public hospitals for critical care in ICU wards (Solanki, Bletcher, Crisp, Engelbrecht, Morar, Myburgh & Patel, 2021). The capacity of the South African health system in providing healthcare is below par by any standard of measurement, due not only to physical resource constraints but also to the inequitable distribution of health workers between the two sectors (Ashmore, 2013). In reality, the public health system is not capable of handling the available health-seeking population, even without the threats of pandemics at play. Notably, the current healthcare system in South Africa does not fund private healthcare providers, such as private hospitals and clinics (Young, 2016:9), which some proponents accuse of being market-oriented, thereby prohibiting access to specific categories of citizens (Basu et al., 2012). The government can resolve this issue by introducing the National Health Insurance (NHI) scheme, which promises to fund both the private and public healthcare sectors.

The same government is often failing to provide itself and deliver services efficiently to the public (Pillay, 2007; Sebola, 2023). Corruption and poor leadership are making it difficult for the political administration to achieve its service delivery objectives (Sebola, 2023; Sebola, 2025). Many will agree with me that the NHI will not resolve the ailing public healthcare crisis as long as the complex issues separating private from public healthcare are not carefully addressed. The government environment, which creates fertile ground for corruption through manipulated supply chain management processes, will collapse the private sector's healthcare within a short space of time if the NHI is implemented carelessly. It is not known why the government wants to resolve the ailing public healthcare system by attempting to replace it with an effective system of private healthcare rather than building more hospitals with beds that can at least cover 50% of the population. It will be important in the future for the South African government to consider subsidising private hospitals without interfering in their operations, except through regulation. If the government provides support to private health care providers, they can invest in infrastructure and offer more affordable healthcare to South Africans. Thus far, they have demonstrated that, despite their limited resources, they can provide more and better healthcare facilities than the government (Ngobeni et al., 2021; Solanki et al., 2021; Alavinenejad et al., 2022). It requires hard work, dedication, and moral commitment for the South African government to gain the public's trust in the imagined benefits of merging the former two-tier health systems. Mokhele et al (2021:389) reported that "in India, some people escaped from public hospitals and quarantine due to trust deficit in the public health care system in many parts of the country. Yet, even in South Africa, during the COVID-19 pandemic, some wealthy individuals who contracted COVID-19

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have preferred to be cared for by private doctors and nurses at home rather than in hospitals. Some argued that, despite loss of trust in the health system, there was a possibility of more risky infections at hospitals than at home.

3.4 Did Affordability and Class Really Mattered during the COVID-19 Pandemic?

Literature demonstrated that almost all hospital facilities were over-subscribed during the pandemic (Solanki et al., 2021; McQuid-Mason, 2021:304). Nursing services were required simultaneously in all sectors. There was, therefore, a continuous exchange of human resources, skills, and facilities among the various sectors to save lives, as the workforce shortage became apparent (Chen, Lai, & Tsay, 2020). Although there were Service Level Agreements (SLAs) for facilities and human resource skills in private healthcare, it does not seem that there were any for the exchange of human resource skills from public to private healthcare. The Private nurses who provided services to the public healthcare sector in such a capacity were probably on a part-time basis (Solanki et al., 2021). The SLA primarily focused on sharing both human resources and facilities with the private healthcare sector through an agreed-upon payment model and rates. The SLA and model rate were developed by the Western Cape Provincial Government and adopted by the National Government for all provinces (Solanki et al., 2021). This arrangement was only an indication that South Africa's public healthcare system is severely under-capacity to serve the health needs of its majority population.

Although there is insufficient data available about the capacity of the private healthcare sector during pandemics, the sector also faces a staff shortage. In this instance, they most cases rely on contract nurses working in public sector hospitals. Gohentsemang et al (2024:3) have noted "the demand-supply imbalance for nurses, which has grown because of the interaction of several demand-side factors". It is generally acknowledged that the nursing profession is in demand due to a labour force shortage in the sector (Aiken et al., 2022). With this in mind, we acknowledge that not only is one sector exclusively better in terms of health care workers' capacity. The issue of middle-class citizens enjoying the privileges of private health care is a matter of time and stability. We have experienced during the COVID-19 pandemic, as no evidence exists that private healthcare providers sent some of their patients to public healthcare. Still, we have proof that the public healthcare sector signed SLAs with public sector hospitals to care for some of their patients in instances where their hospitals are at full capacity. In this instance, the poor share private sector resources with the middle class. The privileges of the middle class become limited, not only through sharing their benefits with people experiencing poverty, but also because, during this time of pandemic, private hospitals contract many nurses from public hospitals to help them meet their hospital capacity workload. The situation itself, as it currently stands, has also created a perception that private healthcare is losing its efficiency and effectiveness, as it must involve employees with less understanding of their work ethics and culture in its health system contracts. During the pandemic, it may have been challenging for health sector institutions to address complaints of poor work ethics and performance, as capacity was limited.

Conclusions

This paper is based on a new perspective on COVID-19 literature, which has been trending in health science perspectives in public health journals. The novelty of this paper lies in its unique approach to addressing COVID-19 literature from the perspective of social class benefits. This paper argues that class and the affordability of healthcare do not matter during times of pandemics and disasters. The class and affordability of private healthcare are privileges only when there is no reported healthcare crisis on earth. The paper aims to dispel the myth that the middle class believes private healthcare, which is primarily achieved through the affordability of medical aids, secure employment, and is serviced by exceptional nursing professionals, is an everlasting privilege. The contribution of this paper to knowledge production is not only limited to the middle-class understanding of their limited privilege during pandemics, but also to policymakers in the healthcare sector, who need to understand that pandemics and disasters are unplanned, and therefore, a need arises for the government to invest more in health infrastructure. Although from a health perspective, some medical practitioners reject the relationship between COVID-19 and the new health problems suffered by post-COVID-19 victims, COVID-19

have indeed left new chronic illnesses in the lives of many, which they previously did not have. It is indeed risky for the South African government to place more than 50% of its healthcare responsibility in the hands of the private healthcare sector, which it is not even subsidising. Indeed, the paper's argument is not comparable to previous writings, as many authors did not approach the COVID-19 discussions from an unequal social class perspective.

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