RESTRUCTURING AND FINANCING OF HEALTH AND WELFARE SERVICES

The Maputo Conference devoted a number of days to the challenge of restructuring and financing of health and welfare services, tackling policy issues broadly and more importantly, looking at some of the practical issues as well.

Papers presented covered both aspects - financing and restructuring. Delegates initially divided into four "buzz groups" to highlight what participants perceived to be key issues to consider.

Two separate workshops were then held - one on financing and the other on restructuring. Inputs were given from both the health and the welfare sectors.

THE BUZZ GROUPS

Participants identified the following areas for further examination:

- urban-rural bias
- the nature of financing health and welfare services both at present and in the future
- community involvement and community financing
- identification and redistribution of fixed resources
- determining minimum welfare needs
- mechanisms for restructuring
- the role of the private sector
- the relationship between primary health care and tertiary care
- the role of the worker organisations in restructuring health and welfare services

The fact that resources available to redress the inequalities in health and welfare would be limited (one paper gave a figure of R10 billion to achieve instant parity in welfare alone!) highlighted the need for realistic expectations to be put forward to people's organisations. This need underpinned much of the discussion and papers at the conference.

THE WELFARE SECTOR

The input from N. Hlatshwayo of the ANC, emphasised the existence of welfare as an integral part of any socialist system. A people's government will intervene and dismantle the racist welfare system, provide a national health service and free welfare. The importance of the role of people's organisations was stressed. Mass participation in the mobilisation of the working class for services, facilities and benefits, is a tradition that would strengthen and deepen a genuinely democratic people's welfare system.

A. Letsebe and J. Loffel presented a paper on restructuring welfare services providing practical, effective and immediate steps for restructuring.

They raised the advantages and disadvantages in a separate as opposed to a unitary ministry of health and welfare.

Welfare workers maintain a need to increase the number of registered social workers from the present 6 000 to 21 000 by the year 2000. Training programmes of social workers and other welfare personnel need to be reviewed and should contain a political content.

The distribution of resources amongst different authorities - "racial" and geographical - that a future post-apartheid government will inherit, will be the backlog against which we will have to move towards equity. What extra resources are available for redistribution after eliminating fragmentation? What welfare services can the country actually afford on an equitable basis? These questions were dealt with in a paper by F. Lund.

THE HEALTH SECTOR

The first paper, by H.M. Coovadia, detailed the important aspects of a new health policy for South Africa. The need to involve organisations, build equity and concentrate on prevention, was emphasised. The paper argued that a new health policy must have:
- an affirmative action programme
- a statement of principles including a bill of rights
- a single ministry of health with central planning but decentralised functioning. This must include participation of grassroots organisations.

The second input, by B. Kistnasamy, addressed the practical steps that can be taken to decrease morbidity and mortality from common diseases. The authors argue that the major intervention will involve the use of Primary Health Care (PHC) but maintain that PHC will fail if it concentrates only on providing essential health services. Rather it should envelop a militant concept aimed at redistributing power and resources.

As a first step, the Progressive Primary Health Care Network (PPHCN) and the National Emergency Service Groups (NESG) need to be strengthened as they are currently involved in work of this nature.

Mass-based campaigns (including media and involving key members of the liberation movements) are needed as is the involvement of civics in health so that mass based struggles can make a firm input into health campaigns such as mass immunisations.

Setting targets (e.g. 75% of population immunised in first year; 90% in second) and the creation of a pool of human and material resources during the transition phase was highlighted as an important interim measure.

The third paper, given by Rob Davies, of the Department of Economics and

Delegates discuss issues raised at the conference.

Planning of the ANC addressed the socio-economic framework within which restructuring could take place. The paper argued that there can be no equitable health service without a democratic transformation of the economy while recognising that productivity cannot be raised and people's creative energy unleashed unless the population is healthy. Thus an equitable system is an essential element of a programme of economic transformation.

There is a need for democratic transformation with affirmative action aimed at redressing economic problems facing those disenfranchised by apartheid.

While the goal of transferring the existing monopoly industry to the ownership and control of the people remains a long term aspiration, the degree of state intervention necessary to redress the current problems cannot be reduced simply to nationalisation. The ANC is committed to promoting economic growth, but this must benefit the majority. The mixed economy approach means that the movement recognises the private sector to have an important role. However, companies should respond to the interests of stakeholders other than shareholders - this includes workers, consumers and the community. The ANC is committed to the establishment of democratic structures which will permit a broad national debate on economy and other aspects of policy.

In group discussions that followed the papers, the need to link health and welfare was emphasised. Welfare workers indicated that they felt marginalised by the medical orientation of large parts of the proceedings. The groups felt that greater emphasis should be given to welfare research.

RECOMMENDATIONS

1. The space provided by the present political situation should be used to "engage" the state and the conservative professional bodies such as The Medical Association of South Africa (MASA) and the South African Nursing Association (SANA).

State facilities should be used on condition that regular mandates are obtained from community organisations. The agenda of the progressive organisations should guide such engagement.

2. Develop the PPHCN. Draw social workers into the structure.
3. Restructure training of health and welfare personnel and look at ways to redirect personnel to rural areas.
4. Place health and welfare on agenda of mass organisations. Work with a wide range of community organisations and trade unions. Mobilise against new welfare legislation, intensify the defiance campaign. Mobilisation should take place at a local level around concrete, realisable demands.
5. Address the hegemony of medical over social services. Progressive health projects to start incorporating welfare issues into their programmes.
6. Redirect more research towards welfare issues.
7. Support progressives working in voluntary welfare organisations, eliminate racism in welfare structures.
8. Integrate our short-term programme for transition with a strategy for the future, in one process.

"Primary Health Care should not concentrate only on the provision of services. Rather it should envelop a militant concept aimed at redistributing power and resources."

The impact of workers' demands around health and welfare issues needs to be carefully examined.

AREAS FOR RESEARCH

- What formulas can be used for determining welfare (and other) subsidies?
- What alternative models exist in other parts of the world?
- What mix of private and public sector health care is appropriate for South Africa?

FINANCING HEALTH AND WELFARE WORKSHOP

The papers and discussion in this workshop focussed primarily around two areas: the role of the privately owned health sector and the responses to the privatisation strategy of the state.

M. Price presented a paper that outlined the different sources of funding for, and ownership of, health services and clarified the meaning of terms such as "privatisation" and "private funding", so that discussions could revolve around a common understanding of the terms used.

The paper, by C. de Beer and J. Broomberg argued for a national health insurance as the first step towards financing health care for all. The centralised control of health financing would be the best mechanism to integrate privately owned facilities and private practitioners into a National Health Service (NHS).

The next paper by M. Zwarenstein suggested there was no place for the private sector in the NHS. He argued that the private sector was found wanting when evaluated against standard indicators of health care and in the process of transformation, the strategy should be directed towards strengthening and building the public sector, while leaving the private sector untouched. Legislation should, however, be introduced to prohibit the entry of future medical students into private practice and to control unnecessary procedures being performed - such legislation, together with the ripening of the internal contradictions of the private sector would lead to its eventual demise. The underlying assumption of the position was that direct measures against the private sector would result in major political battles which a new state would be in a poor position to take on.

The participants in the workshop were in agreement with the notion that there was no place for the private sector in a future NHS. There was, however, general disagreement with the strategy proposed, namely that of leaving the privately owned sector to "die out", for the following reasons:

1. The private sector would continue to undermine the public sector.
2. A large percentage of health workers are in the private sector and serving only a small section of the population. Measures must be taken so that they begin to serve the needs of the majority.
3. From a financial point of view, resources currently in the private sector (50% of the total health expenditure) needed to be appropriated for general use in a common pool. This was felt to require centralisation of financing and the proposal of doing this through taxation or a National Health Insurance Scheme was reiterated. The process would necessitate curtailing and

regulating private medical insurance.
4. It was felt that the experience of many countries in Africa had shown that coercive measures directed at private practice would not work (e.g. banning entry would increase the brain drain and stimulate a parallel black market).

The discussion then turned to ways of incorporating and controlling the private sector. It was agreed that the main instrument of control should be incentives. These could be financial and other, e.g. improvement in working environments. The style and quality of the public sector would have to be improved so that health workers are attracted to work in this sector. It was agreed that while some regulation would be needed, these should be used with care.

A period of compulsory rural/community service for graduates was seen to be a useful strategy.

RESPONSES TO PRIVATISATION STRATEGY

The second major area of discussion was around the responses to the privatisation strategy of the state.

An input by J. Broomberg pointed out that the aim of the privatisation initiative by the state was to "off-load" responsibility for health/welfare provision onto capital/individuals.

The increasing demand for medical aids via the trade union movement and the dilemmas it posed, were outlined:

On the one hand, offering such benefits contributed towards addressing the material needs of workers and strengthening the unions. But, the provision of such benefits to workers only (by excluding the unemployed, etc) is leading to a stratification of the working class.

Participants agreed there was no easy solution to the problem. A number of different views with regard to how it could be addressed emerged. These included:
1. That workers should be educated to see their long term interest, and be urged not to join the medical aids.
2. That workers health schemes be seen as victories for the labour movement, and that it should be up to the future NHS/state to compete and provide more attractive alternatives.
3. That workers should set up their own health services in the form of benefit schemes. Such schemes, controlled by the workers could be more easily manipulated in the interim to minimise the stratification effect, and in the long term would provide an infrastructure which would be easier to transform into an NHS.

Views expressed against the last proposal included the fact that workers would acquire vested interests in their schemes and resist incorporation into a future NHS. A counter view to this was that unions should, for the interim, concentrate on the material needs of workers, and that it would be possible to inform the workers at the same time of long term political interests so that they would not resist incorporation into an NHS. Such education should be taken up by the workers' organs of political power such as the South African Communist Party (SACP).

The workshop did not resolve the issue, but highlighted some of the contradictions involved. The workshop further recognised that these contradictions were not specific to health but were seen in the social and welfare sector too.

Strategies aimed at strengthening the public sector and making it more attractive for both patients and personnel must be found.

THE WAY FORWARD

The workshop did not set out to develop definitive strategies for the future. It served primarily to deepen understanding of the problems faced in trying to transform the health sector and to identify areas for research and debate.

The following areas were identified:
1. The impact of workers' demands around health and welfare issues in terms of satisfying the needs of the working class in the interim and long term.
2. The development of strategies which would minimise/avoid stratification of the working class, and direct worker initiatives in keeping with the development of a national health service.
3. The applicability of various models of private facilities and private practice to the South African context.
4. Levers of control (economic, legislative, and other) which could be exercised over the private sector.
5. Development of strategies aimed at strengthening the public sector and making it more attractive for both patients and personnel.
6. Effectiveness and cost-effectiveness of various health care interventions.
7. Is a National Health Insurance the first step to financing health care for all?
8. The implications of foreign aid and programmes and possible problems involved.

RECOMMENDATIONS

1. A period of compulsory service to the state should be introduced for all health workers.
2. Debates on health financing must be contextualised in terms of the ANC's general economic thinking, and more specifically, in terms of the mixed economy debate.
3. The anti-privatisation campaign and the campaign for the NHS needs to be intensified by all political, worker, welfare and health organisations.

No final agreement was reached on the following resolution: 'In order to finance health for all, control of funding needs to be centralised, and financial resources currently in the private sector should be brought under control of the state'. ❑