New directions in health care: from apartheid to democracy

This article attempts to examine health resources under the current set of political, economic, social and cultural conditions, still most accurately described as "apartheid", and proposes a health care system for a democratic South Africa.

Expenditure on health

Reliable estimates of total expenditure on health are extremely difficult to obtain. Figures compiled by different researchers at different times range from 2% to 4,6% of the GNP.

Between 1971 and 1982 there was a declining central government expenditure on health and education with more funds flowing into defence and housing. This was not offset by increased expenditure on welfare which could have had a positive impact on health.

South Africa spends far less proportionately on health than do developed countries which utilise about 6% of GNP on average, and less also than many third world states, including those in Africa. And it has been estimated that a mere 2,2% of this small total health budget is directed towards preventive programmes.

The expenditure on health in Bantustans, where need is greatest, is far less than that in neighbouring provinces. There are gross discrepancies in the distribution of resources between black and white, whichare exacerbated by the large role of the private sector.

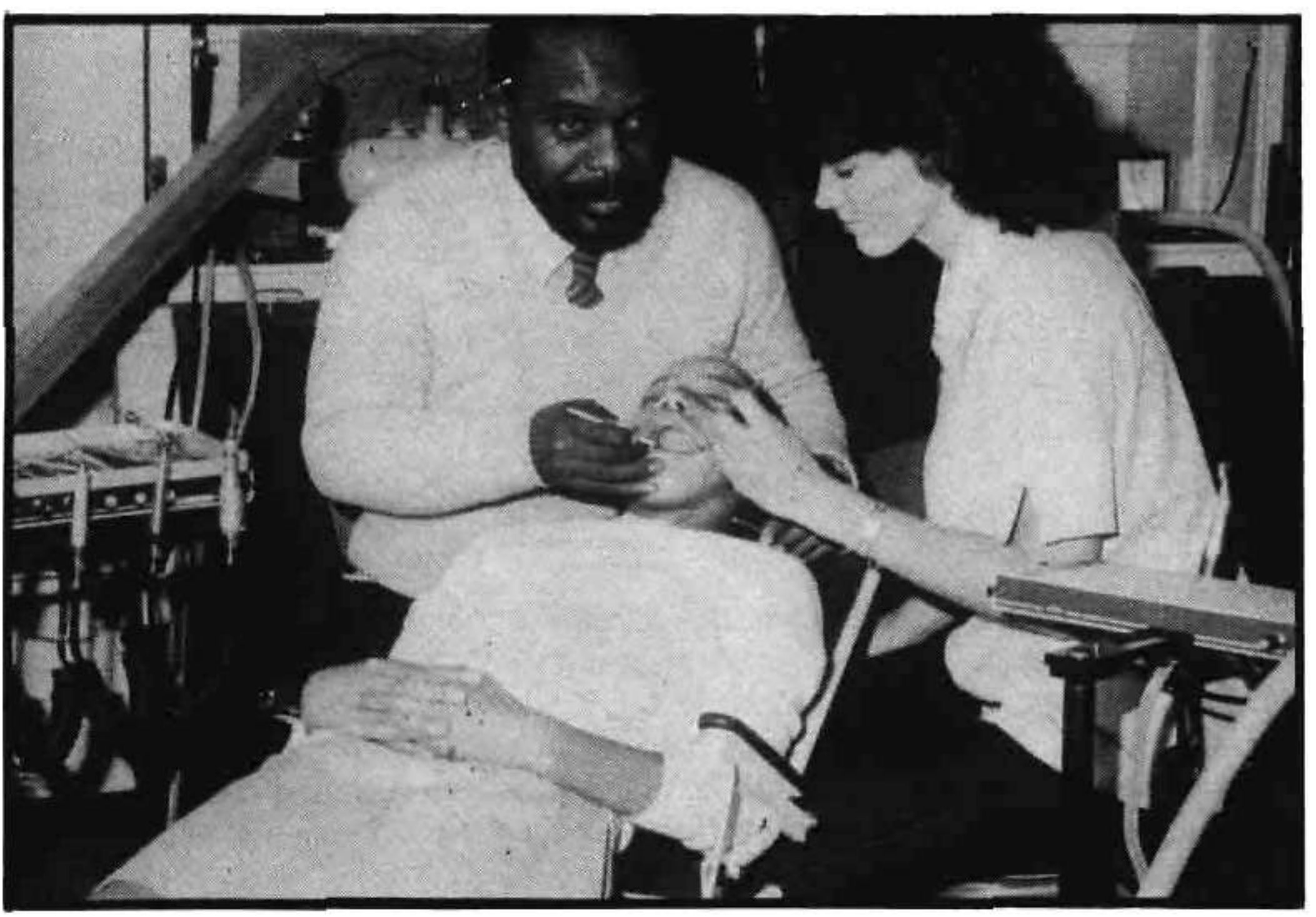
However, the distribution of health services is not only determined by race, class and geography but, in its present state, it contributes to the deepening of these divisions.

Composition of the health sector

Medical and dental faculties

There are seven medical faculties in South Africa, giving a ratio of about one faculty per 4,4 million people. The majority of students at these faculties are white. In addition, these medical faculties have not been utilised to their full capacity because of the shortage of facilities, academic staff and training patients.

A similar position obtains in dentistry. There are five faculties and only a tiny fraction of the more than 1 000 students are African, coloured or Indian. Over the years these faculties have produced an overabundance of white dentists, sufficient Indian dentists and hardly any coloured or African dentists.



There are not enough coloured or African dentists

Thus there is an oversupply of white doctors and dentists and no need for the establishment of any new faculties for training doctors.

The De Villiers Committee stated that there are enough Medical and Dental faculties to cater for this country's needs up to the year 2000 and that any rise in demand can be met by optimising use of existing capacity. If this were done, South Africacould produce 1 300 doctors and 260 dentists every year. It recommended that no new medical or dental faculties be created at present.

Training and Ideology

There are serious constraints in the structural framework and ideological content of the training process of all health professionals, which limit the value of these individuals for the needs of the community.

The selection of students, the curriculum content, the methods of teaching, learning and assessment, the definition of objectives for the type of professional required and the metropolitan siting of all faculties reinforce and deepen the divisions in society between urban elites and rural poor. The class position of doctors and dentists in both the public and private sector, ensures that health remains a commodity for purchase by those able to afford it.

There is also considerable inflexibility in the training of nurses, who form the largest group of health professionals, coupled with rigid control over their professional lives by the ruling nursing association. This places them in an ambiguous position in health and social struggles. Their training has the effect of endowing them, socially and ideologically, with class interests which contrast with those of their low-income patients. A critical awareness of these hierarchical, divisive structures, and of the need for more democratic practice was created in the process of mass action such as the King Edward and Baragwanath Hospital stayaways. Even though these events had a ripple effect, the overall organisation of work at hospitals has not changed significantly.

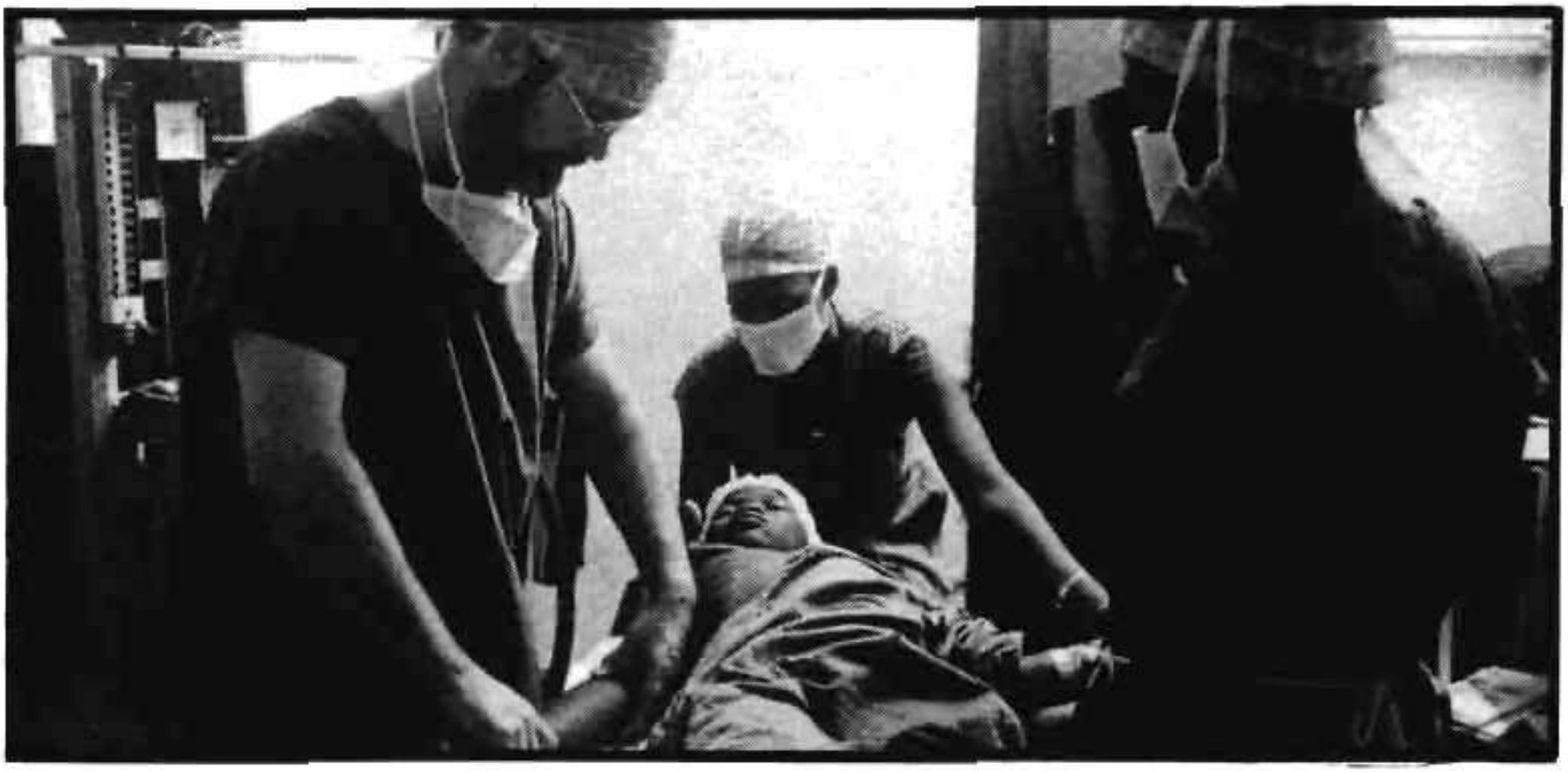
Medical supplies

In the production aspect of the health sector the role of multinationals and other companies in the manufacture and distribution of drugs, drug-related products and medical equipment, requires careful research. These companies have considerable influence over the practice of medicine by determining the cost of health care through their profit motives. While in developed countries drug costs are a small part of the health budget, in poor countries they can account for about 30% of government health expenditure.

Distribution of health professionals

Doctors

Health professional to population ratios are relatively crude indices for the provision of, and inequalities in health care. There can be no ideal or fixed ratio which is optimal for health. Indeed, too many doctors increase the cost of health care and in some instances, may pose an obstacle to health attainment. In the case of South



The present total number of doctors is sufficient for the needs of this country

Africa, however, these ratios demonstrate that training is racially biased, that community needs have not been matched with appropriate services, and that there are specific deficiencies in supply.

The present total number of doctors is sufficient for the needs of this country. However, there is an overwhelming concentration of doctors in urban areas with 80% being in towns and cities while 66% of the black population live in rural areas. KwaZulu, for example, is short of about 300 doctors at present.

Specialist Doctors

The popular fields of specialisation such as Internal Medicine, Anaesthetics and Surgery bear little relation to national needs. In a country where under-nutrition and infection are widespread and serious, there are few experts in these fields. The degree of specialisation is excessive in specific disciplines, and occurs at the cost of primary care physicians. Furthermore, there is a drainage of manpower. In any new dispensation, this laissez-faire policy will have to cease and priorities will have to be set according to need, through centralised planning.

Dentists and Dental Specialists

Research indicates that 75% of services rendered by dentists could be done by dental therapists whose training is one-eighth the cost of a dentist and whose charges reduce cost by 30%. There are too many white and Indian dentists. Too few dentists work in rural areas. More African and coloured dentists, dental therapists

and oral hygienists should be trained. Readjustments, without expansion, of existing facilities in white and other faculties would meet these requirements.

Nurses

There are racial and urban-rural disparities in the number of nurses, with the most favourable ratios among coloureds and whites. Black nurses suffer poor status, meagre salaries, racial discrimination and inadequate training opportunities. Despite this, there are a sizeable number of African nurses.

The World Health Organisation's recommendation for the third world is that there should be one nurse for 500 people to provide comprehensive service. By such reckoning South Africa will require about 64 000 nurses for this purpose alone. There is certainly scope for expansion of training for nurses even under the present set up. However, if they are to fulfil a primary health care function, their selection, curriculum and control and possibly even their designation will have to be profoundly altered. In combination with a suitably trained doctor, a few trained nurses can provide comprehensive care to about 20 000 persons. This formula will mean the provision of about 1 500 doctors and roughly 6 000 nurses for this country.

Distribution of health facilities

Hospitals

Except for some rural areas and Bantustans, South Africa has an adequate number of hospitals. The proviso on maldistribution remains and it must be emphasized that gross discrepancies exist between facilities for black and white, even when one considers only the best served hopitals for blacks (teaching hopitals). In many cases these differences stagger the imagination.

Clinics

There are a total of 2 094 clinics in South Africa providing services such as immunisation, antenatal care, maternal and child care, family planning, dental care, tuberculosis treatment, venereal disease therapy and psychiatric care. The distribution of clinics averages out to about one clinic for 15 000 to 16 000 persons; the World Health Organisation's norm is 1 clinic for 10 000 persons.

There are shortages in terms of numbers of clinics but more importantly there are serious deficiencies in the functioning of existing clinics. They have been found to meet only a small percentage of health care needs (home visits, family planning,

deliveries, illness, child health, and antenatal care).

These clinics, like the health services in general, mirror the social relations of a dominated and segregated community. Therefore they cannot fulfil the requirements of the Alma Ata declaration which firmly locates the practice of primary health care in the context of mass participatory democracy.

The lack of representative organisations at local level, the power of tribal authorities and village elites, nepotism, arbitrary and dictatorial control by Bantustan administration, land restriction, limited employment opportunities, inadequate transport and little monetary support ensure that many of these clinics are "community oppressive" and render "second class care to second class citizens".

Primary health care therefore remains an important focus for health struggles for a changing society. The implications are that numbers will have to be increased and content revolutionised.

There are serious deficiencies in the functioning of existing clinics

Nationalisation /socialisation of health services

Socialised health care will affect the production of professionals, health workers, institutions, distributive units, machines, instruments, tools and drugs.

Nationalisation of health services involves about 9-10 000 doctors, the medical

aid schemes and private hospitals. Medical aid schemes and private hopitals will be nationalised, and the former replaced by a state-run national health insurance scheme which will have its terms and financing determined by negotiation. The national health insurance scheme will cover everyone.

Doctors will have the right to work within or without the national health service. A number of different options can be offered to induce doctors to support the national health service either totally or partially.

Private hospitals are not part of an integrated comprehensive planned health care system. They contribute little to training of health professionals, they compete unfairly with public sector hospitalsfor staff and patients, they offer services which are primarily profit-making, they do not support preventive/promotive health care, and finally, they support only a small section of the public which in South Africa has access to medical aid schemes.

Conclusion

An alternative health care system in a liberated South Africa should be interwoven with the fabric of social development. It should contain ten essential features:

1. The transformation of the state.
2. Private and public sector health care delivery, with gradual decay of the former and progressive expansion of the latter.
3. Health as a basic human right.
4. Research into the production and distribution aspects of health care.
5. A single, central co-ordinating National Council for Health Development which will determine priorities and strategies.
6. A nationalised health service.
7. Nationalisation of the purchasing and distribution of drugs and medical supplies.
8. Restructuring the training of health professionals.
9. A nationwide network of primary care clinics based on unified health teams, fused organically into local community and worker organisations through health committees, serving as the core of the new health service and as a crucial link between needs at the periphery and policy at the centre.
10. Regional and tertiary hospitals with allocations for high technology care and research being influenced by the needs of the majority.

This is a shortened version of a paper presented at the Institute of Social Studies, Transnational Institute, Amsterdam, December 1986. By H. M. Coovadia of the National and Medical Dental Association (Namda).

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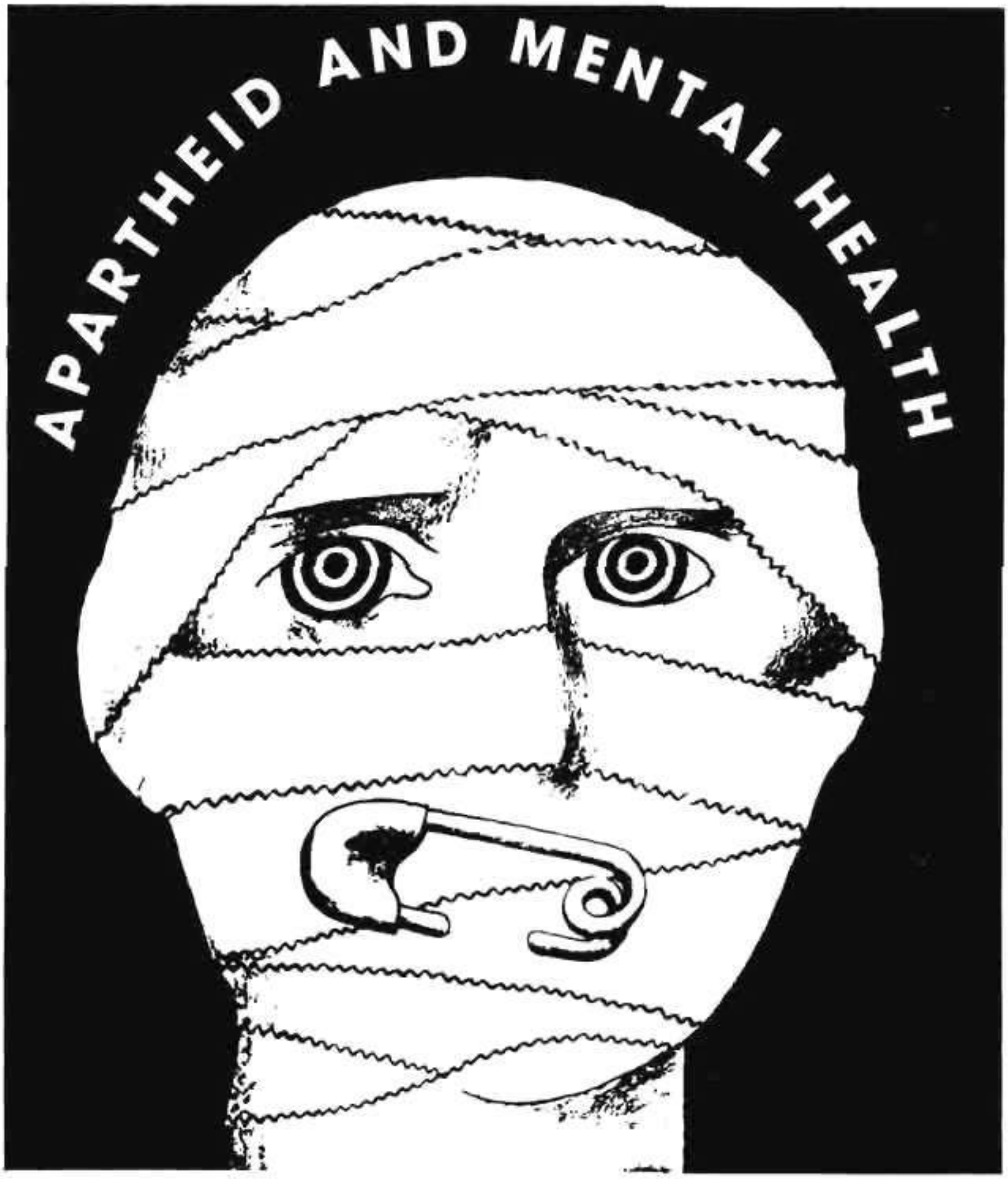

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