UNITED NATIONS

CENTRE AGAINST APARTHEID

DEPARTMENT OF POLITICAL AND SECURITY COUNCIL AFFAIRS

NOTES AND DOCUMENTS*

No. 18/77

June 1977

IMPLICATIONS OF APARTHEID ON HEALTH AND HEALTH SERVICES IN SOUTH AFRICA

by

A group of black doctors in South Africa

77-12282

A disease permeates the entire fabric of South African life, the disease of apartheid, segregating health services by race and resulting in drastically disparate levels of disease incidence and life expectancy between black and white groups. This is a system which metes out an inferior socio-economic and educational status of varying degrees to black people and is, hence, responsible for the high incidence of other diseases and low life expectancy that blacks experience.

In order to provide viable alternatives, we must first take a close look at the wrongs in the organization of health services in South Africa today. Although we are daily witnesses to racism, its insidious ramifications in the delivery of health services may be less obvious and have been increasingly obscured by a powerful state propaganda machine.

It must be stated at the outset that information on the health situation in South Africa, particularly for blacks, is not very easy to come by. Morbidity and mortality statistics are inadequate in many instances, and sometimes totally lacking. Information contained in the present report was drawn from the various sources cited as well as from personal work experience.

Having stated the problems, we shall then attempt to outline the principles of an alternative system of health care which will be rooted in concepts of equality and justice.

Implications of apartheid on health

1. Mental health

Concern and care for the mental health of the community, no less than for its physical health, is a vital social responsibility of the medical profession.

Besides the easily observable manifestations of mental ill health, subtle forms of mental disease occur in South Africa as a consequence of the migrant labour system. There can be no doubt that the migrant labour system is damaging to the mental well-being of black people. This enforced separation of migrant labourers in city hostels from their families in the "homelands" has destroyed the fabric of traditional African society and robbed Africans of the fundamental human right of working and living within the security and comfort of their own families.

Mothers and children in the ethnic 'homelands' are denied the fulfilment provided by the presence of the husband and father. The emotional and intellectual deprivation of this enforced and totally inhumane separation must result in incalculable harm to the family unit.

Pass laws have made criminals of millions of blacks and continue to do so at the alarming rate of 2,000 every day. 1/ Men in the soulless

---

1/ Cluver, Richard, quoted in Daily News, 8 April 1976.

hostels of urban townships are driven to alcohol and illicit sex which leads to the inevitable increase in incidence of venereal disease. Evidence of the latter is seen in the rising rate of congenital syphilis in Durban and the fact that 10 per cent of randomly assessed factory workers, and a similar proportion of Soweto neonates have positive serological tests for venereal disease. 2/ Violence as well as mental ill health is bred in the monotonous streets of African townships such as Soweto.

The cumulative effect of poor prospects of obtaining employment or promotion, insecurity of tenure, possiblity of banishment to an 'ethnic homeland', lack of recreational facilities and the paucity of material benefits in ghetto life - in pointed contrast to the almost vulgar display of white affluence - creates a burden of stress which becomes intolerable and culminates in tragic explosions of uncontrollable wrath.

The implications of the finding that protein calorie malnutrition retards intellectual development are profoundly disturbing and make prevention of malnutrition imperative. The recently published findings of Stoch and Smythe, 3/ based on a 15-year developmental study in Cape Town of the effects of severe undernutrition during infancy on subsequent physical growth and intellectual functioning, confirm that there is gross, permanent retardation of intellect in malnourished children when compared with children in control groups. This powerful argument lends a sense of urgency to this problem.

One is forced to the conclusion that the framework of social existence imposed by apartheid could hardly fail to be inimical to mental and social well-being.

2. Physical health

(a) Infant mortality

It is generally accepted that one of the best indicators of levels of health in a society is the rate of infant mortality. The following tables give the figures for different national and race groups:

2/ Symposium on Health Services in South Africa (the 2nd Interdisciplinary Symposium of the College of Medicine of South Africa 1975), p. 9.

3/ Stoch, M.B., and Smythe, P. M., Archives of Disease in Childhood (1976), vol. 51, no. 5, p. 327.

Table 1. Infant mortality per 1,000 births [a]

Industrialized countries	1901-5	1921-25	ca.1973	Africa	ca.1973
Belgium	148		17.0	Angola	24.1
Canada		98	15.5	Ghana	63.7
England/Wales	138		16.9	Kenya	55.0
France	139		15.5	Liberia	159.2
Sweden	91		9.2	Lesotho	114.4
Switzerland	134		12.5		
U.S.A.		74	17.6		

a/ World Health Statistics Annual, 1968 and ibid., 1973-76.

Table II. Infant mortality per 1,000 births, South Africa

	South Africa [a] 1971	Johannesburg [b] 1970	Durban [c] 1972	Transkei [d] 1969
Whites	20.9	20.26	17.72	
Asians	35.6	29.30	35.05	
Coloureds	122.1	66.07	38.72	
Africans	?	95.48	77.39	216

a/ World Health Statistics Annual, 1973-1976.
b/ Johannesburg Health Department, Medical Officer of Health's Report 1969/70 (Johannesburg, 1970), Appendix D.
c/ Annual Report of the City Medical Officer of Health of the City of Durban, 1972 (Durban 1973).
d/ Connor, B. H., Lancet (1970), vol. 1, p. 768.

These figures are a clear and telling indictment of the racial orientation of paediatric services in South Africa, with the worst off getting the least that society has to offer. As infant care is an area of special concern in community medicine, priority in the South African context must be directed at the root causes that result in such disparate services. There can be no compromise with a system of social,

political and economic arrangement which lavishes the benefits of the civilization and knowledge of mankind on some of its inhabitants while abandoning the rest to pitiful neglect and shameful abuse.

(b) Malnutrition

Malnutrition has assumed crisis proportions in South Africa and, with the price of essential daily food such as bread and milk rising, there is every possibility that hunger will rage through the deprived black community of South Africa like a dreadful scourge. Indeed the prospect for blacks is grim and forbidding. Many will have read that 75 children (African and Coloured) are dying every day from lack of proper and adequate food. 4/

Our experience in Durban, at one of the largest hospitals which serves black people in South Africa, is summarized in Table III, which shows the high incidence of malnutrition among patients admitted in Natal.

4/ Fehrsen, S., quoted in Sunday Tribune, 27 June 1976.

Table III. Malnutrition in Natal [a]

Year	Total admissions	Per cent admissions malnourished	Kwashiorkor and Maramas with or without infection				
			African	Indian	Total	Deaths	Mortality (%) [b]
1959	5774	32	1975	76	1871	698	37
1960	5073	35	1675	95	1770	620	35
1961	4248	38	1516	101	1617	540	33
1962	5251	34	1687	102	1789	565	32
1963	5555	40	2090	111	2201	692	31
1964	6685	51	3206	206	3412	997	29
1965	5517	48	2490	152	2642	825	31
1966	5257	45	2162	182	2344	765	33
1967	5075	45	2110	167	2277	657	29
1968	5625	42	2236	153	2389	757	32
1969	5336	45	2227	186	2413	662	27
1970	5421	43	2212	133	2345	595	25
1971	5091	45	2152	153	2305	518	22
1972	5688	44	3745	257	2517	655	26
1973	7027	49	3222	219	3441	845	25
1974	7907	45	3422	119 [c]	3541	764	22
1975	7590	51	3717	128 [c]	3845	851	22

a/ Annual Report of the City Medical Officer of Health of the City of Durban 1972 (Durban 1973), pp. 22, 33.

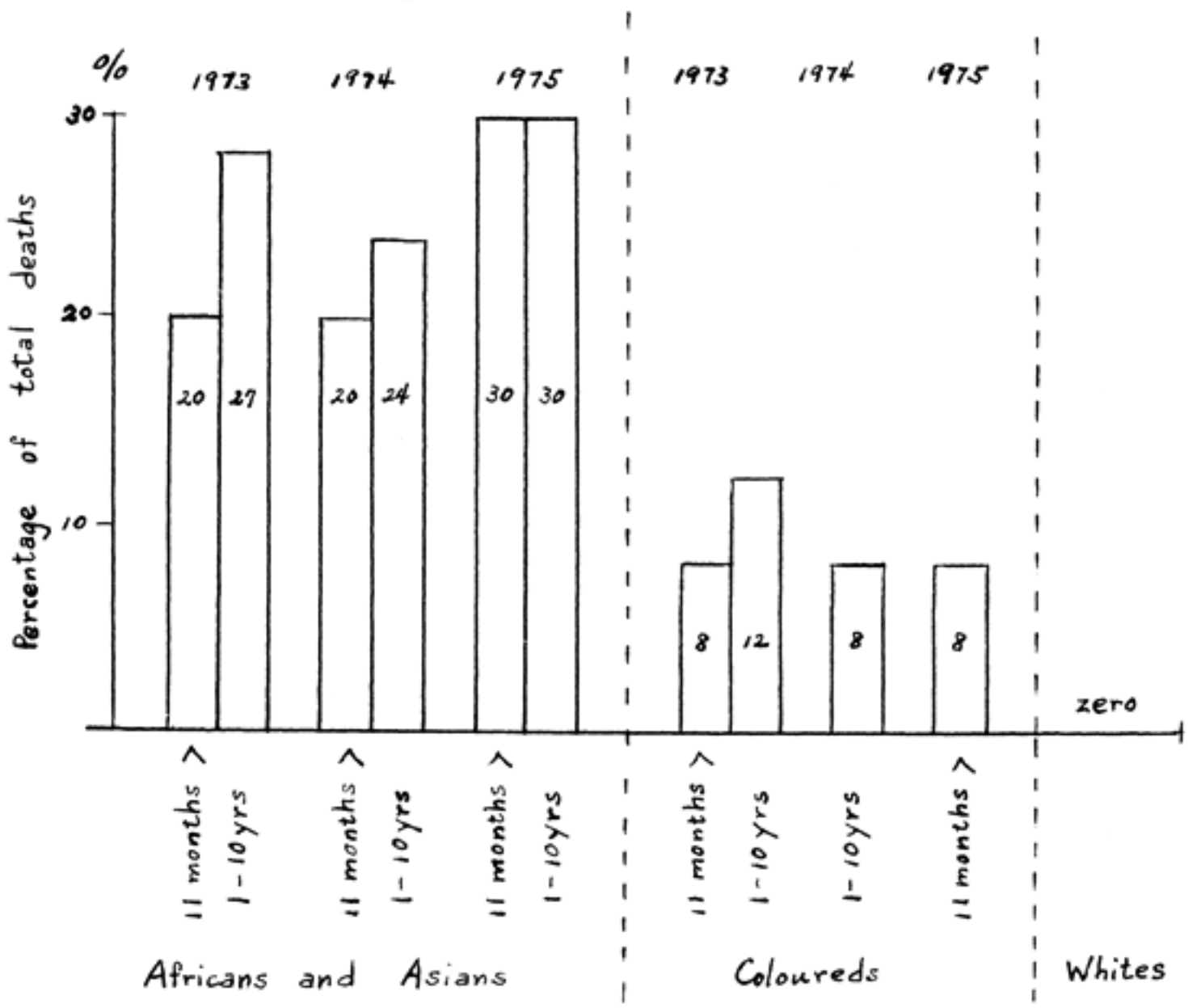
b/ Nutritional state largely contributing to high mortality rate.

c/ Fall in numbers accounted for by marked reduction in Indian admissions with opening of R. K. Khan Hospital.

An analysis for the period 1973-1975 of post-mortems of children under 10 years of age performed at King Edward VIII Hospital (for Africans and Asians) and Addington Hospital (mostly for whites) in Durban reveal the following results:

Figure 1

Post-mortem records of percentage deaths due to malnutrition of children under 10 years of age at King Edward and Addington Hospitals



This figure reveals the extent to which malnutrition was found at post-mortems to be the major pathological diagnosis in children under 10 years of age. From these results we infer the following:

a) Malnutrition assumes serious proportions in the Republic amongst blacks, especially in the African population;

b) Whites do not suffer malnutrition.

Reports from the Transvaal and Cape 5/ suggest that the problem is a national one of enormous magnitude. The most common forms of nutritional deficiency are protein calorie malnutrition and pellagra; less common are scurvy, beri-beri, anaemias and rickets.

Malnutrition is due to poverty. According to World Bank figures, South African blacks had a yearly per capita income of $150 in 1974, a figure which placed them well below at least seven independent African States. Associated factors which may contribute to malnutrition are prejudice against certain articles of food and ignorance of proper use of existing facilities. Infections predispose to malnutrition. It must be reiterated, however, that the root cause of malnutrition is poverty.

It is important that this point be clearly understood, for there is a body of opinion in South Africa 6/ which would attribute to ignorance an equal, if not larger, role in the aetiology of malnutrition. The indissoluble link between poverty and public health has been amply demonstrated by the work of Boyd-Orr, 7/ M'Gonigle and Kirby 8/ and Mitra. 9/ They have confired what should now be self-evident: that people who do not have enough money cannot buy food - these people become malnourished. In their authoritative work on human nutrition, Davidson, Passmore, Brock and Truswell 10/ state emphatically that the unequal distribution of food caused by poverty is by far the most important factor responsible for malnutrition, and that these relationships are "often such a feature of everyday life that both the people and Government become accustomed to the facts and blind to the consequences".

In the wealthiest country in Africa, poverty can only have one cause: the grossly unequal distribution of wealth - the appropriation by an

---

5/ Bowie, M. D., quoted in Sunday Tribune, 27 June 1976.
6/ Symposium on Health Services in South Africa, (1975) p. 17.
7/ Boyd-Orr, J. B., Food, Health and Income (London: MacMillan, 1936).
8/ M'Gonigle, G.M.C., and Kirby, J., Poverty and Public Health (London: Gollanz, 1936).
9/ Mitra, K., in Indian Journal of Medical Research (1941), vol. 29, p. 143; and ibid. (1942), vol. 30, p. 91.
10/ Davidson, S., Passmore, R., Brock, J. F., and Truswell, A. S., Human Nutrition and Dietetics, 6th edition (Churchill, Livingstone), p. 555.

avaricious elite of the goods so plentifully produced by all - with the result that Africans who constitute 70 per cent of the population receive 19 per cent of the country's cash income, [11] and 66 per cent of Africans in industrial centres live below the Poverty Datum Line. [12] Furthermore, social evils of the migrant labour system, the disruption of family life, and the paucity of cultivable land with very little irrigation and much soil erosion in the rural African areas have all led to the impoverishment of black people.

(c) Communicable diseases

Communicable diseases are prevalent among the underprivileged blacks. Tuberculosis, typhoid, tetanus, measles, polio, diphtheria, infectious hepatitis and pertussis are not uncommon. More children die from measles in South Africa in three days than in the United States in one year. [13]

If the nutritional status of blacks in South Africa is deplorable, the situation with respect to communicable diseases is no better. It is widely recognized that malnutrition predisposes to communicable diseases, and that the interaction of these two factors results in an alarmingly high incidence of illness and deaths.

Table IV shows the racial distribution of incidence of tuberculosis and venereal disease in Durban. These infectious diseases can easily be eradicated by adequate nutrition, housing, sanitation, immunoprophylaxis and domiciliary chemotherapy. There is little need for costly hospitals and equipment. For example, it has been calculated that R9,000 ($12,600) per annum would pay for immunization of 15,000 black children against measles, whereas it would cost R150,000 ($210,000) per annum to hospitalize 514 patients with complications arising from measles infection. [14]

11/ Gray, T. J., in World Health (July 1975), p. 3.
12/ Ibid.
13/ Symposium on Health Services in South Africa (1975), p. 8.
14/ ibid.

Table IV. Tuberculosis and venereal disease in Durban [a]

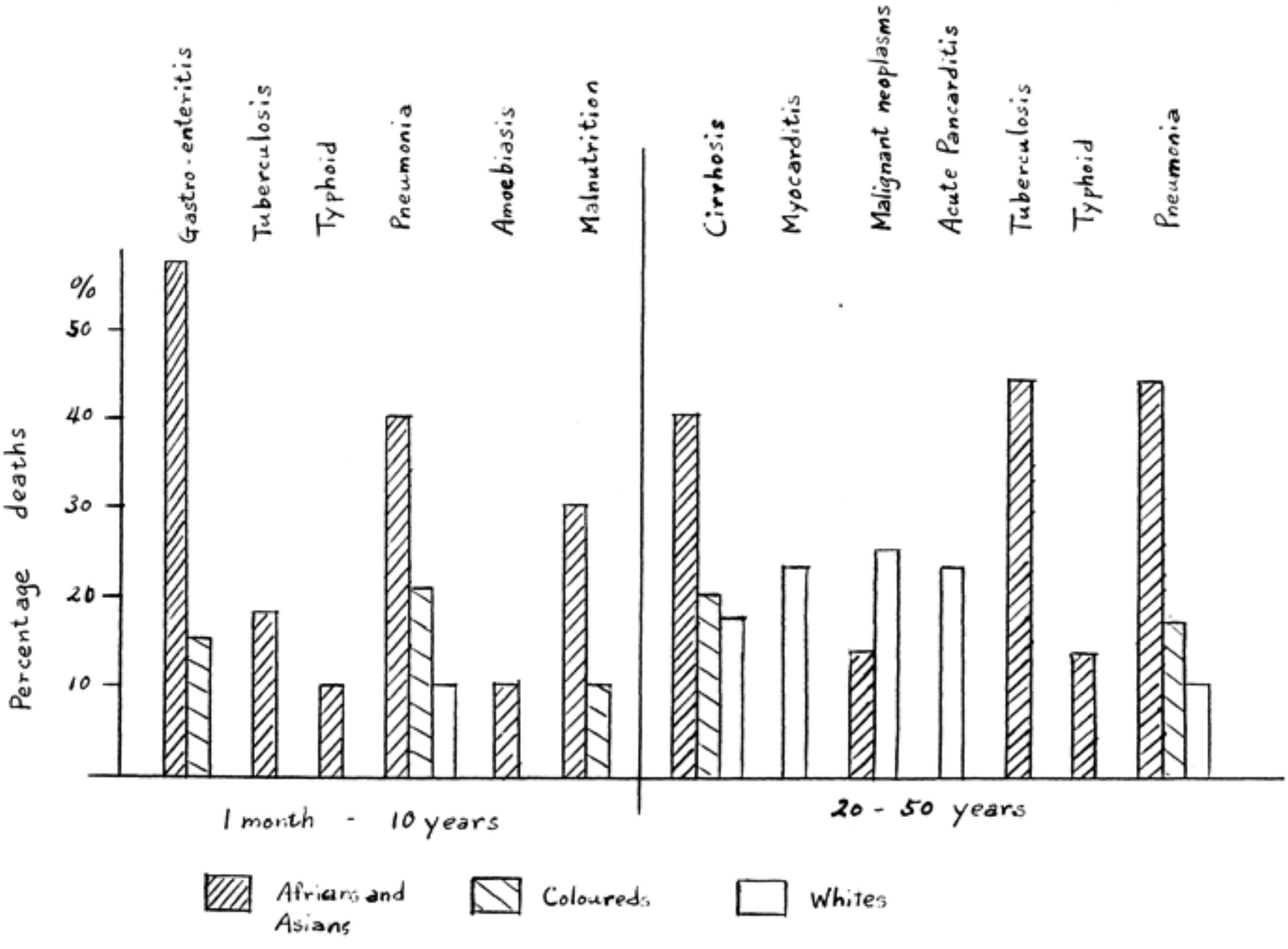
	Year	White	Indian	Coloured	African
Tuberculosis					
Attack rate per 1,000 population	1964	.69	1.96	3.91	6.43
	1968	.42	1.83	3.27	6.11
	1973	.29	1.11	2.24	4.08
Venereal disease					
Attack rate per 100 population	1964	.28	.35	1.77	5.82
	1973	.21	.28	.34	6.50

a Annual Report of the City Medical Officer of Health of the City of Durban, 1972 (Durban 1973), p. 22 and 33.

Figure 2 illustrates the results of a study into the causes of death among the different racial groups in Durban.

Figure 2

Post-mortem records of causes of death at King Edward VIII and Addington Hospitals, 1973-1975



Note: In the 1 month to 10 years age-group among whites, deaths, other than for pneumonia, were due to non-infectious diseases such as cvs abnormalities.

These results point towards the following:

a) the fact that the two outstanding causes of ill health and early death amongst blacks are nutritional deficiency and communicable diseases;

b) the gross discrepancy between the state of health of whites and blacks;

c) the disparity in the level of health of the various black population groups, the most adversely affected being the African.

(d) Health care:

Health care is delivered, not according to need and availability of best resources, but against a system of ethical values enunciated by an entrenched and uncaring minority. The following table outlines the discrepancies between the various groups.

Table V. Health care

	Whites	Asians	Coloureds	Africans	Year	
Physician/population	1:400	1:900	1:6,200	1:44,400	1972	a
	1:400			1:40,000	1975	b
Nurse/population	1:256		1:1,202	1:1,581	1970	c
Medical students	3,710	445	142	202	1970	d
	3,838			220	1974	e
Number of medical graduates per 1,000,000 population	145			0.8		e
Dental students	708	16	6	7	1970	d
Pharmacy students	1,660		104	66	1972	d
Pay scale	100%	76-81%	76-81%	61-74%	1973	f
		80-90%	80-90%	65-80%	1976	g
Hospital beds	10:1,000		5.57:1,000		1972	h

a A Survey of Race Relations in South Africa 1972 (Johannesburg, Institute of Race Relations, 1973), p. 404.
b Personal data, 1975.
c A Survey of Race Relations in South Africa 1972, p. 405.
d A Survey of Race Relations in South Africa 1973 (Johannesburg, Institute of Race Relations, 1974), p. 353.
e Tobias, P., in South African Medical Post, (May 1976), p.2.
f Berhardt, I., in British Medical Journal (1973), vol. 3, p. 632.
g Personal data.
h A Survey of Race Relations in South Africa, 1973, p. 352.

Toward an alternative system of health care

These facts make it evident that, in South Africa, politics and social life cannot be divorced from the practice of medicine. Medicine implies a commitment to the equal promotion of health throughout a community. These alarming statistics confirm, however, that the delivery of health care in South Africa is dominated by the principle of racial segregation, different ethnic groups being allotted different hospitals or sections of hospitals with different facilities. The least provision is made for those with the greatest needs. This system of delivering health care not according to need or to the availability of the best resources is in flagrant contradiction to the system of ethical values that has prevailed in the medical profession since Hippocratic times.

The starting point, therefore, must be national liberation - in the widest sense of the term: a liberation of the black man from the bonds of poverty, ignorance and disease and his release from political, economic and social subjugation, as well as a national awakening of the white man towards a realization of his social responsibility and a rejection of his unrelenting pursuit of personal profit and privilege.

Apartheid must be recognized for what is is - "a crime against humanity". With the democratization of South Africa, the reins of power will pass into the hands of all its people; the country can then be guided to a new social order, which would not only distribute wealth more evenly and improve the social and cultural lives of its impoverished black people, but also ensure them protection against ill health and a positive promotion of their well-being.

In this broad scheme of things for the betterment of our society the doctor in community medicine works alongside everyone else, his special task being the protection of the health of all its people. One hopes that no group will then have to suffer from a succession of preventable diseases, and all will benefit from the best health care society has to offer.

Within the context of Africa, concepts of social and community medicine, especially in relation to private and nationalized forms of health care, may require fresh examination. The fierce individualism of the West which has become so much a part of our national psyche may have to be reoriented towards some of the ideals of traditional African society with its emphasis on the consideration of the common good.

Our own beliefs in this regard are simple: at the very heart of the issue is our conviction that health is one of the benefits of life to which every man, woman and child has an inalienable right. It is a belief that the community as a whole has the responsibility to provide those health services which its individual members cannot provide for themselves.

It is rooted in the recognition that social services are not a charity, but one of the natural benefits available to the citizens of a civilized State.

Medicine must be organized according to a clear, rational and humane plan, where resources are directed to need and the anarchy of present-day South Africa is reversed. The mainstay of our health services must be the adoption of the principle that medicine is meant for the masses of our people and therefore must be free and available to all.

Unlike the orientation of these services in present day South Africa, the prevention of disease must be in the foreground of all health activities. Take the case of malnutrition: malnutrition is preventable by money. The death toll due to malnutrition is high. The real toll, however, is in the quality of the lives of our black people.