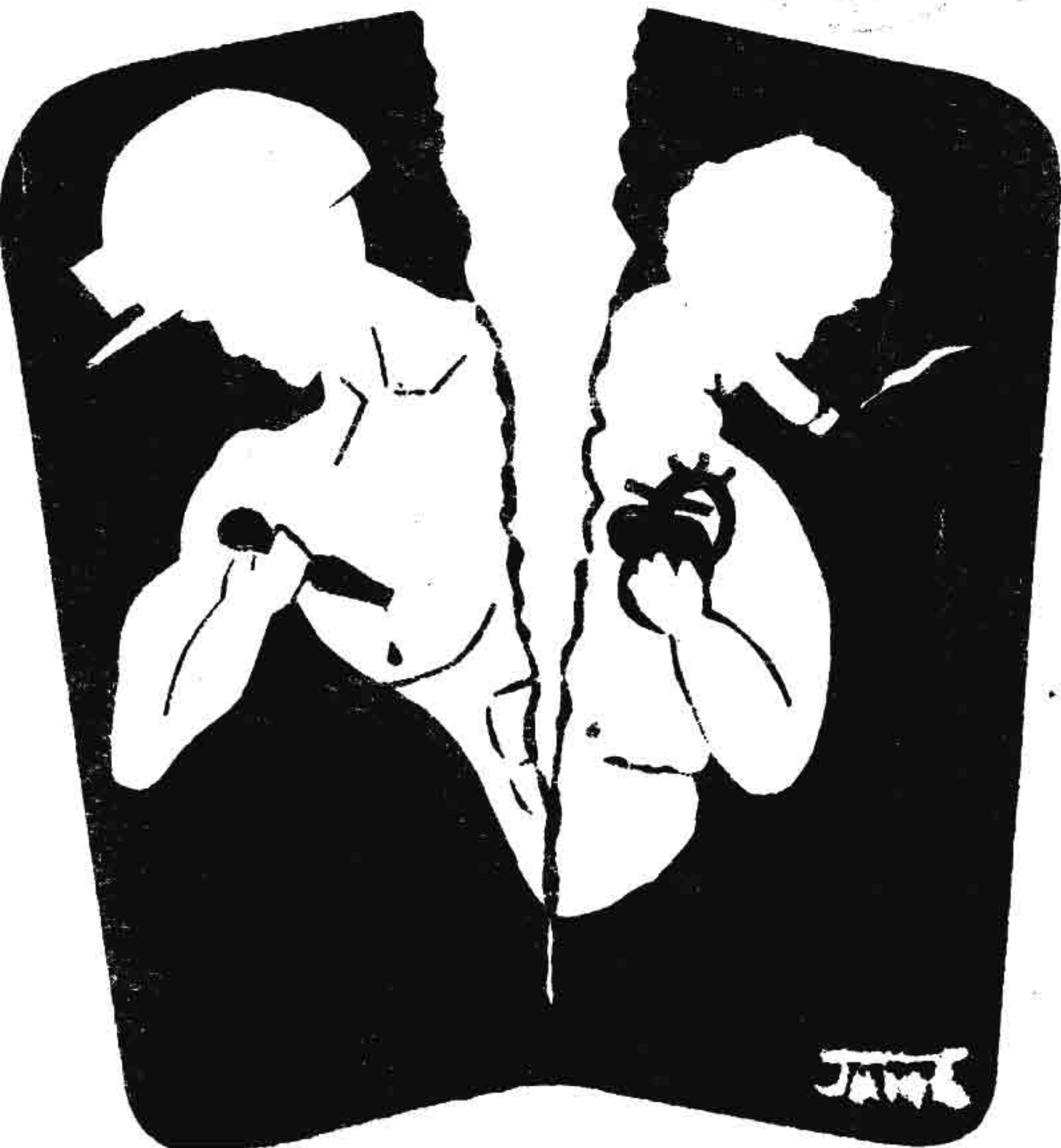
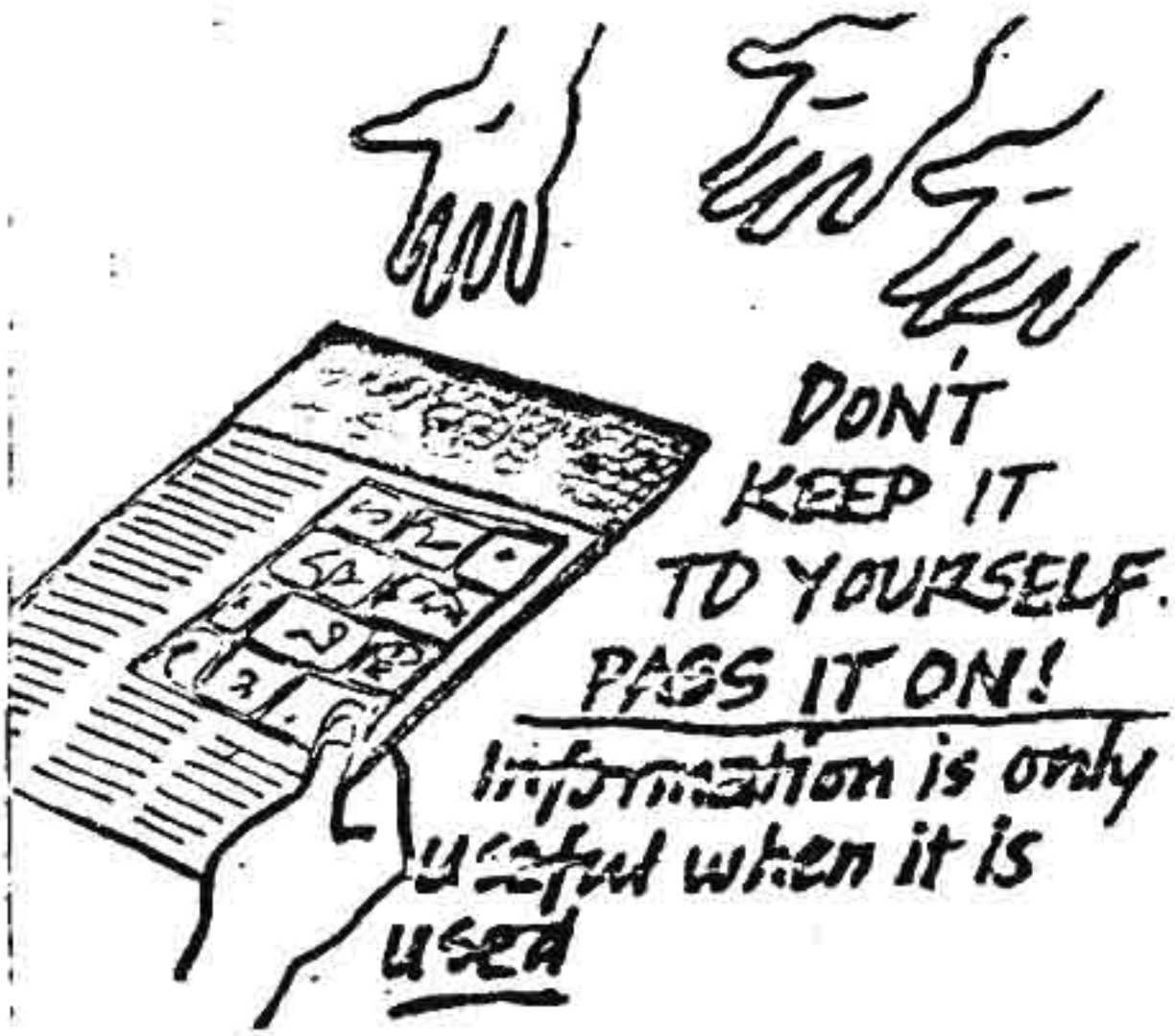
CRITICAL HEALTH

No 1



CONTENTS



EDITORIAL.

South Africa cannot claim to be a country in which most of its inhabitants enjoy good health. In fact, South Africa's health problems range widely from the diseases of overindulgence to those of extreme poverty. The health services are largely orientated towards meeting the needs of only some sections of the population, while others are totally underserved. The peak of medical technology and expertise is found alongside a total lack of any basic health services in other areas. These contrasts are as clearly apparent in health as in all other aspects of life in South Africa.

We believe that health is not only related to medicine. It is determined by numerous factors which exert differential forces on the health statu of people. The factors involved are varied and include socio-economic, political cultural, educational, and others. We believe that medicine and doctors play a limited part in determining the health of the people - in fact many other factors play far more important roles.

CRITICAL HEALTH therefore arises as an attempt to present information and views on health in its broadest context. It arises as an attempt to balance the vast amount of literature which deals with disease and medicine in isolation, and not in the context of society as a whole. The corporate body of medical practice and knowledge today is powerful. It is so all embracing that its critics cannot give voice to their opposing views. CRITICAL HEALTH, offers that opportunity.

Our objectives are thus to stimulate an interest in health-related matters in the context of South African society. We hope to provide a forum for the discussion of a wide range of topics.

In this issue we look at aspects of Community Health, Industrial Medicine, Medical Education, History of Health Care in South Africa, and the Role of Women in Medicine. We also introduce a section of this booklet that will deal with specific theory related to alternate types of health care and which will appear in future editions. We hope also to publish brief reports on any current events affecting health.

We would like all people who are interested in health (and health is the concern of everybody) to contribute to and criticize this publication.

EDITORS:

CLIFFORD GOLDSMITH
SUSAN GOLDSTEIN
KEITH KLUGMAN
ANTHONY ZWI

This is the first issue of CRITICAL HEALTH. We intend to bring out four issues in 1980. If you are interested in receiving them, please send R1-00 to CRITICAL HEALTH, care of Medical Students' Council, Wits Medical School, Esselen Street, Hillbrow, 2001.

This issue of CRITICAL HEALTH was printed by the Printing Unit, Wits Medical School, Esselen Street, Hillbrow.

A STORY FROM TOLSTOY.

I see mankind as a herd of cattle inside a fence enclosure. Outside the fence are green pastures and plenty for the cattle to eat. While inside the fence there is not quite grass enough for the cattle. Consequently, the cattle are tramping underfoot what little grass there is and goring each other to death in their struggle for existence.

I saw the owner of the herd come to them, and when he saw their pitiable condition he was filled with compassion for them and thought of all he could do to improve their condition.

So he called his friends together and asked them to assist him in cutting grass from outside the fence and throwing it over the fence to the cattle. And that theycalled Charity.

Then, because the calves were dying off and not growing up into serviceable cattle, he arranged that they should each have a pint of milk every morning for breakfast.

Because they were dying off in the cold nights, he put up beautiful, well-drained and well-ventilated cowsheds for the cattle.

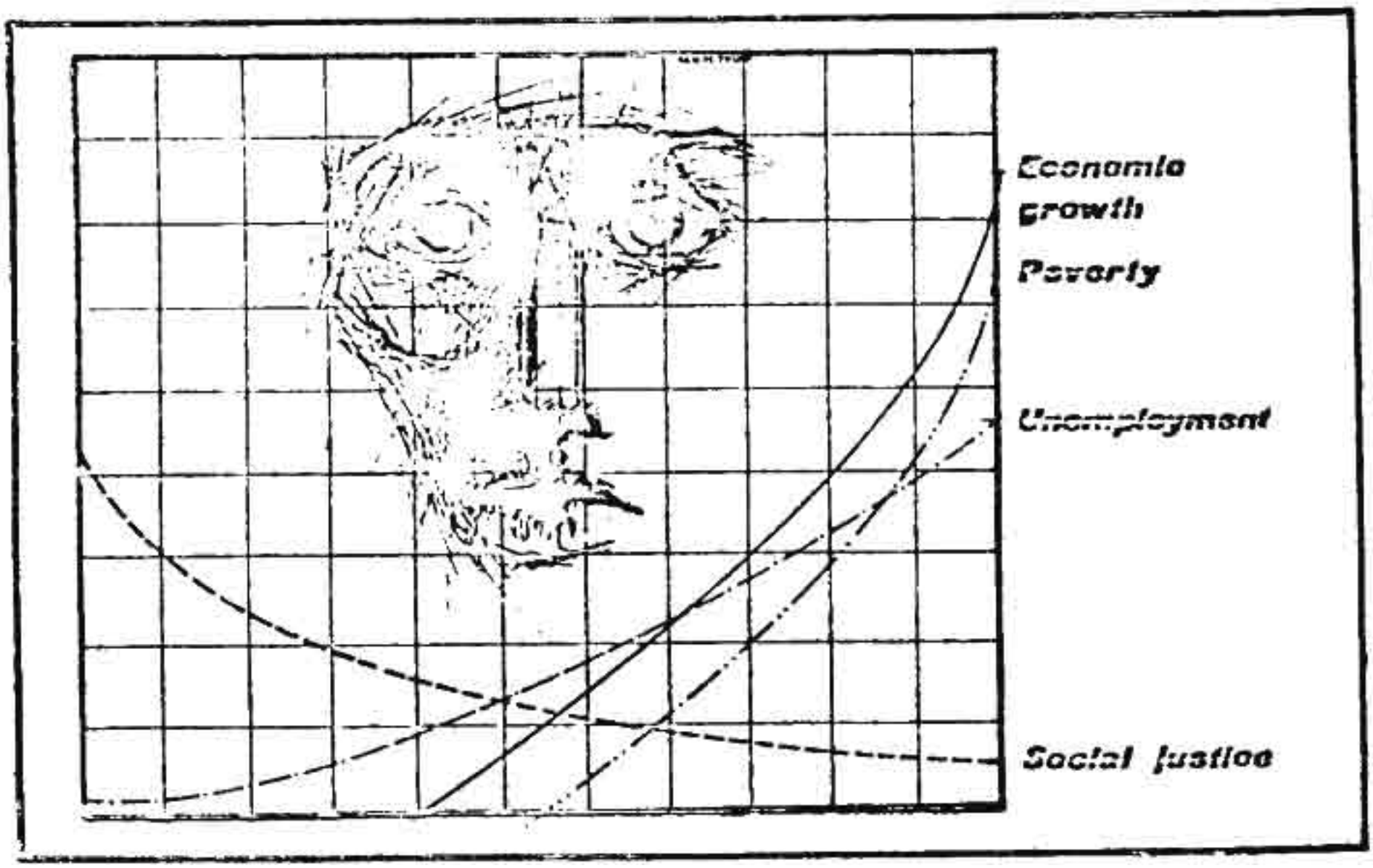
Because they were goring each other in the struggle for existence, he put corks on the horns of the cattle, so that the wounds they gave each other might not be so serious. Then he reserved a part of the enclosure for the old bulls and the old cows over 70 years of age.

In fact, he did everything he could think of to improve the condition of the cattle, and when I asked him why he did not do the one obvious thing, break down the fence, and let the cattle out, he answered, "If I let the cattle out, I should no longer be able to milk them."

BEYOND COMMUNITY MEDICINE:

THE EXPLOITATION OF DISEASE

AND THE DISEASE OF EXPLOITATION.



BEYOND COMMUNITY MEDICINE: THE EXPLOITATION OF DISEASE AND THE DISEASE OF EXPLOITATION

In the past decade or so, concern about the prevalence of ill health in the face of apparently significant advances in medical treatment has led to a reassessment of health care priorities and the nature of health care delivery. The result has been an assault on the old order. It is, say the critics, incapable of providing adequate health care to all the people of the world. A new set of health care principles has been created.

These principles, with slight variations, are expounded by progressive bodies such as the World Health Organisation, the Christian Medical Commission, and, lately, have even taken root in South Africa. Put together under such names as "Community Medicine", "Primary Health Care" and "Preventive Health Care", these principles have come to be the accepted wisdom of that part of the medical world which is concerned to do something about the poor, and often deteriorating health of the masses who live (or often only exist) upon this planet.

In this paper I hope to give some words of caution. It seems that this new dogma is in danger of entrenching the very things that is claims to be combating; that it is a potentially powerful weapon for change that may become, albeit unintentionally, a prop to the existing order. In order to demonstrate this, I have given this paper the following structure:

PART 1 outlines the criticisms which have been levelled against the old medical order by the proponents of Community Medicine, and looks at the alternatives that they present.

Part 2 looks at the conservative tendencies contained within the new school.

Part 3 tries to look for a way to make the critique of the old order true to its own premises. I try to look for a real role for health care in an unjust social order.

Although I believe that the argument presented here has general relevance, I have tried to situate the paper in the South African context. This is because of the nature of this publication, but also because I believe that all theoretical debate only has meaning if grounded in a social reality.

PART 1 - THE ASSAULT ON THE CITADEL.

Health care throughout the Western World has been shaped by two dominant and connected factors. The first is that health care, like almost everything else, has been turned into a commodity to be bought and sold. This means that the nature of health care is largely determined by the effective market: by those who can afford to pay. The second factor is that medicine, along with almost all other branches of science, has taken an extremely mechanisitic direction. It puts the emphasis on the purely physical processes of the individual body. Thus,as long as the physiology of the organism is understood, it is possible to analyse any malfunction and to take the body apart and to put it back together again, or to intervene in some other, purely technical way, in order to correct what has gone wrong.

These two elements are linked. If health care is something which an individual buys, then it is logical that those who sell the care will concentrate on the body of the buyer, rather than on the relationship between people and the physical and social environment in which they live.

It is the consequences of these two factors that give rise to much that the community medicine

school criticises (although the critics themselves often do not realise the roots of these aspects of modern medicine that they so vehemently reject).

Arising out of these factors comes a tendency towards ever more complex and expensive types of medical technology which are, it is claimed, necessary to deal with the degenerative diseases of opulence. The cardiac unit, with its own South African pinnacle, the heart transplant, is perhaps the most extravagant example. (Whether these forms of treatment are in fact successful, or whether they rather constitute a form of modern witchcraft to ease the troubled mind of the patient is itself a subject of some debate). This technology requires ever more specialised training, and this, in turn, raises the cost of providing health care.

Thus this increasingly technical approach to medicine re-inforces another consequence of the commodity nature of health care: its accessibility to the masses. Our society is stratified along lines of race and class. It follows logically that access to health care, as a commodity to be bought, will be similarly stratified. But if the technical nature of health care has this direct effect on its accessibility, it also has an indirect effect. The very expense of modern equipment requires it to be centralised to an ever greater extent, in one or two national and provincial hospitals, thus rendering it not only economically, but also geographically inaccessible to the majority of people. These factors are not really separable. The cost of long distance travel, extended separation from family and crops, or absence from place of work are prohibitive to those living on the very margins of survival. So, say the critics, conventional western medical practice is rendered inaccessible to those who need it the most: the poor. (It is as well to anticipate the thrust of my argument by pointing out that it is at least as much the division of the

society into rich and poor, as it is the nature of the technology that renders access so difficult).

The "engineering", mechanical nature of medical practice ensures that, even discounting its inaccessibility, it would still be ineffective. This is because trying to treat the major contributors to morbidity and mortality on an individual level is like trying to hold back a tidal wave with a mechanical teaspoon: it does not matter how sophisticated the device, there are inexorable forces that are going to swamp it.

The major diseases to be dealt with are various forms of diarrhoea, pneumonia, T.B., measles, worms, malaria, etc. and, of course, the greatest killer of them all, in that it is often a fatal complicating factor in all the others, protein energy malnutrition. The problem is that these diseases, or at least their prevalence, is directly related to the social and physical environment. So, although drug and other treatment may be extremely effective in individual cases, two problems arise. The first is that not enough people have access to this treatment. The second is that even where there is access, the success of the treatment is, in time, negated when the victim returns to the environment which is itself pathogenic.

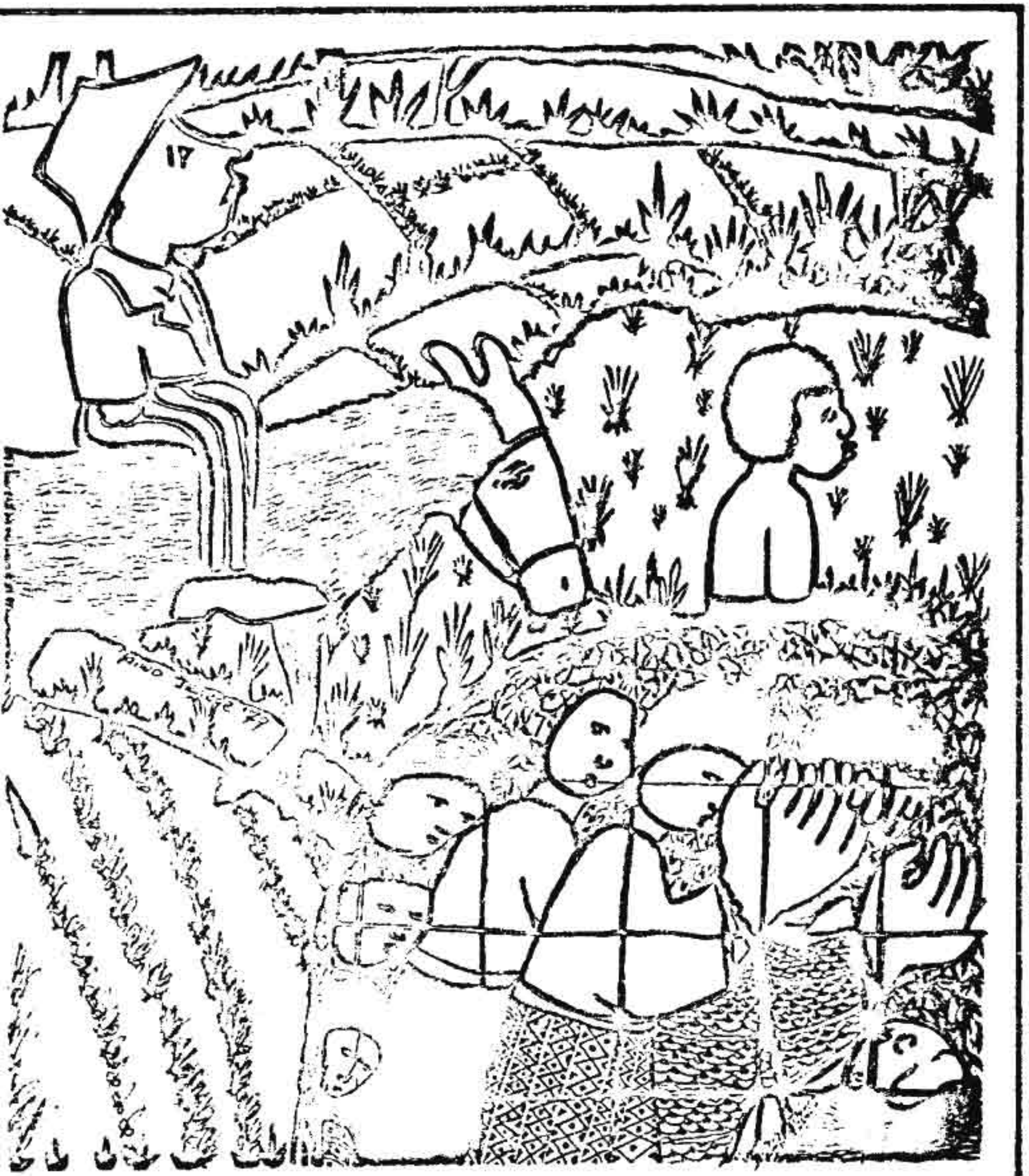
It has been documented on numerous occassions (1) how in Europe, deaths related to these diseases had dropped to almost their present levels before the introduction of antibiotics and immunisation on a mass scale. The conclusions are inescapable. The effects of these diseases are reduced or negated when the standard of living rises, when sanitation is improved, and when nutritional status rises. Thus, social, economic and environmental factors are far more important determinants of health than is the discovery of a new drug.

The commodity nature of health care ensures that current medical practice is not only inaccessible

and ineffective but also, in terms of the effective utilisation of resources, wasteful. The fact that health care has to be purchased ensures that it is a profitable undertaking. So, in order to protect their exploitation of disease, doctors have established, with offical backing, a monopoly over the provision of health care. This monopoly is dressed up in the guise of "maintaining professional standards", "protecting the public", and so on. The effect of this monopoly is that when doctors do reject the careers for which their background and training prepare them, and try to practice amongst those who have the least access, the rural poor, they find that a good 80% of their time is spent on treating cases that could be adequately dealt with by people with considerably less training than themselves. Thus is the scarcity of resources made even greater, and much money is spent on imparting substantial skills to people who then spend much of their time as glorified dispensers of first aid.

Furthermore, argue the critics of conventional medicine, western medicine is developed in the "advanced" first and second worlds, and is often foisted, with very little explanation, onto a population with customs and social practices very different to the society in which the system of medicine was developed. This is exacerbated by the fact that medical practice is undertaken by doctors who, almost by definition, have difficulty in communicating with the people that they are serving by reason of cultural, class, and often language differences. Furthermore these doctors, being arrogantly sure of their scientific superiority, tend to ignore indigenous forms of healing and care, or to regard it as superstitious claptrap, thus not making use of a significant local resource.

Thus argue the critics, conventional, hospital-based, curative medicine is too expensive for the available resources, ineffective, inaccessible,



and often both technically and socially inappropriate. In response to this curative approach to individual health, there has been formulated an alternative: a community approach to prevention, with cure as a secondary necessity only when prevention fails. What follows is an attempt to outline briefly (and non-exhaustively) the major principles of this formula.

THE FIRST PRINCIPLE is that if social, economic and environmental factors are decisive in deciding the overall health of a community, then it is on the level of these factors that decisive health interventions will occur. More specifically, basic health needs are: adequate sanitation including a clean and accessible water supply; adequate housing; and a reasonable level of nutrition and hygiene. Thus, all attempts to improve the health of impoverished communities must combine medical care with a general programme of community development to provide these facilities.

According to this principle, the following are integral to health programmes: attempts to improve the agriculture of the target population, or at least to promote vegetable gardening as a nutritional supplement; nutrition education in order to teach people how to improve their food intake on very small amounts of money; other types of health education to encourage hygenic practices and the building and usage of latrines; and a wide variety of "appropriate technology" hardware to ensure that basic water requirements. cooking facilities and the other necessities of life are met.

THE SECOND PRINCIPLE is that every effort must be made to involve the community in both the decision making and the implementing of programmes aimed at improving health. This principle has a number of different roots that I think should be spelt out. First, such things as vegetable gardening schemes and improved sanitation are only going to work if the community thinks that they

are a good idea, works hard to create them and continues working to maintain them. Secondly, people will only participate willingly and effectively if they feel that they have a stake in the programme, and involving them in the beginning is a good way of ensuring that this happens. Thirdly, "outsiders" often have misconceptions about the most pressing needs of a community. It is only by means of involving the communities that these problems can be overcome.

A THIRD PRINCIPLE grows out of the belief that conventional medicine takes no account of established patterns of life and the existing cultural beliefs and paractices within communities. So the principle is espoused that primary health care should not disrupt established community relationships, and should have the approval of all elements of the community. This is a tactical question as well as an ethical prinicple, for if powerful elements within a community are opposed to particular programmes, then the chances of these programmes getting off the ground are reduced.

A FOURTH PRINCIPLE is that extensive use should be made of people called cariously "village health workers", "barefoot doctors", or "medical auxiliaries". It is felt that doctors are overtrained for much of the work that they do, and that at any rate it would be prohibitively expensive to train sufficient doctors to provide health care to all. Furthermore, these auxiliaries, coming from the communities that they are to serve, understand local customs and would not carry a foreign aura around with them.

THE FIFTH AND FINAL PRINCIPLE that I want to mention is that there is a need for a re-allocation of priorities in health care and a decentralisation of resources. It is necessary to direct most efforts at prevention rather than cure; there must be a change of emphasis away from complex high technology to simple means for

combating the most prevalent diseases, and away from bigger and "better" hospi-als to the creation of a network of clinics and health posts within easy reach of every person. Health care must cease to be a profitable enterprise and become a service.

There can be no doubt that this school of thought, in its critique, and in some of the suggestions that it makes for reforming health services is a progressive one. Contained within these ideas is part of the solution to the problems of health and disease. In the next section I try to show how this school of thought, by not taking its own principles to their logical conclusion is in danger of betraying them. The criticisms are severe, but I have no intention of calling into questions the goodwill or integrity of any practitioner or theoretician of community health programmes.

PART 2 - THE UNFINISHED REVOLUTION:

My argument in this section has the following elements:-

1. The proponents of community medicine have not sufficiently analysed the social reality in which they are trying to intervene. As a result, when seeking the social and economic causes of disease they tend to focus on the wrong things.

2. This means that their actions, and those towards which they guide others, tend to come to grips with the wrong things.

3. The overall consequence is that they create a false reality and course of action, while at the same time directing both attention and effort away from the crucial aspects of society that need tc be changed, while at the same time claiming that they are combating disease at its very roots. Thus, like those they criticise, they become guilty of treating

symptoms not causes.

It is commonly accepted by the proponents of community medicine that the overiding factor in the major diseases contributing to South Africa's mortality and morbidity statistics is poverty. There is an undeniable correlation between poverty and malnutrition, poverty and lack of hygiene and education, sanitation, housing and so on. Therefore, goes the reasoning, we must teach the poor how to grow vegetables, how to feed their children. We must teach them basic hygiene. In addition, we must engage in community development programmes so that people will do these things for themselves. We must teach people to overcome the apathy and lack of initiative that comes with poverty and ignorance. We must develop simple health technologies so that they can look after themselves, and be looked after more cheaply and easily. We must engage in "relevant research" to discover who is most "at risk", most liable to fall prey to the various diseases that the indigent are prey to. Thus we can help people to help themselves to counteract the effects of their poverty.

These responses are understandable. They come from people who, on a day to day basis, have to deal with the effects of poverty on those amongst whom they work. Furthermore they often meet with some success in this type of work, and this can only reinforce the feeling that they are on the right track, that if only enough people thought and acted as they do, health problems of the poor would soon be dealt with

I believe that these responses are based on an inadequate understanding of poverty. They derive from a world view that sees poverty as a stable state from which people can be helped, if only the right tools, techniques and push buttons can be found. Poverty is seen as the problem of the poor. Something from which they must be taught to escape.

This view, the rest of this section will argue, is erroneous and extremely patronising. By and large the poor are pretty resourceful people, who manage to survive under conditions to which most of us would succumb. In contrast I will argue that poverty is not simply a condition from which people can lift themselves, but rather a situation imposed on people by a historical process, and to which they are bound by forces which have been unleashed during that process. I will argue that the poverty of the broad mass of people does not merely co-exist with the wealth of the elite, but that the two are inextricably linked; that the wealth of the rich is in fact built on the exploitation of the poor; that to talk about overcoming the effects of poverty without seeing it as necessary to change the social structure that gives rise to it is to admit the permanence of the structure, and thus of the diseases of poverty.

I have said that analysis only has meaning if it takes place in the context of a concrete reality. I want briefly to outline this process of exploitation, and the political domination that accompanies it, as it has developed in South Africa. Although it is not possible to undertake a detailed historical analysis here, I feel that it is important to gain at least some insight into the processes which have created mass poverty and malnutrition and the associated diseases in South Africa.

When the European settlement of South Africa began, the settlers did not find that the local population were agriculturally incompetent, that they were unable to look after and feed their children, nor that they suffered from mass malnutrition.

If this is the case, then the poverty and, in some cases, near endemic malnutrition, currently found in South Africa cannot be put down to an original state of underdevelopment. Rather it must be sought in the progressive underdevelopment

which has resulted from the interaction of an indigenous economy in which the surplus produced was redistributed to the community, and an intruding, colonial cash economy, backed in the final instance by the guns of the settlers. It must be sought in the driving of people off their land, ending in the bottling up of the black population on 13% of the land by the Land Acts of 1913 and 1036. It must be sought in the compelling of large portions of the male population into the cities to work on the mines and later in the factories. This was achieved by the imposition of taxes such as hut, dog, or poll taxes: the only way to earn the white man's money was in the white man's mines. Resistance was sharply crushed. (In 1922 General Smuts dealt with a refusal by the Bondelswarts to pay a tax on their dogs. He ordered that the village be bomed from the air, and then sent in a column of men armed with machine guns. More than 100 people died in the attack). Increasingly the reserves and their indigenous economy degenerate, unable to cope with the strains and limitations imposed on them. Too little land resulted in overgrazing, overstocking and overloading.

South African History of the 20th Century is taught as the history of the white political parties, their changing alliances and policies. These are only the surface facts. The underlying realities are the growth of a black labour force, driven to the mines and industry as their traditional livelihoodcrumbled. This labour force is controlled by a migrant labour system that breaks up homes and families and gives the rural male no choice as to his place of work. The real South African history is the growth of political control and the repression of attempts by blacks to break out of the cycle of exploitation in which they found themselves. This has involved the suppression of black trade unions and political movements. Finally it is the history of the consolidation of the reserves into "homelands" where are dumped the growing number of

unemployed, and where the highest morbidity and mortality rates are to be found.

There is of course another side to the story. Out of this same process has emerged the powerful South African economy, and with it a white middle and upper class with one of the highest standards of living in the world. Here are found the degenerative diseases of superabundance. White prosperity has of course not merely happened at the same time as the exploitation of the black population. It is a consequence of it.

It is against this background that the proponents of community medicine must judge whether they have faced up to, let alone begun to answer the most important questions in which they should be involved: if poverty is the most important cause of disease, then what are the most important causes of poverty? If actions in the health sector are aimed at eradicating disease, then how effective are these actions in eradicating the causes of poverty?

And these are the crucial questions. If community medicine, in its theory and practice, is dealing only with the effects of poverty, and is leaving the basic structure of exploitation untouched, while at the same time claiming to deal with the very roots of disease, then it is doing a very conservative thing. For not only is it accepting that the causes of poverty cannot be done away with, thus giving the current social structure the status of a law of nature, it is also giving the system credibility by claiming, against all the available evidence, that the effects of poverty can be overcome within the very system that has created that poverty.

There is a second, closely allied misconception which is propagated by the conventional truths of "community medicine". This is the belief in "community". It is widely held that there are a series of "poor communities" which need to undergo a process of community development.

This assumes that there is a common interest amongst all members of the community. If however one examines these communities in the light of historical processes of underdevelopment, then a different picture emerges. There are the ordinary people and there are chiefs; there are those with land, and there are the landless; there are the unemployed, the traders and the transport riders. There are those who have been given some kind of a stake in the system of "homeland government". The communities are in fact divided by class, status, sex, and a variety of other criteria. We find that the structures of domination and exploitation are reproduced right throughout South African Society, and into these very "communities". In fact the concept of community is a myth of the unperceptive outside eye.

This raises serious questions about the principles of "community participation" and "community involvement in planning". These "democratic processes of decision making" are often simply a way of smoothing the way for the richer, the better educated and the more powerful to hi-jack any particular project for their own ends.

This is not the only way in which programmes can have the effect of increasing economic discrepancies.

One of the common attitudes found among people working in rural areas, is that if people are starving it is important to increase food production. As a result, extension officers are brought in, co-operatives are established to help people acquire implements, seeds are provided, and often a range of "wonder" crops such as soya beans are promoted for their high yields and nutritional value. These programmes, because they rest on false assumptions, are likely to fail. It is not that there is not enough food in South Africa to feed everybody. Farmers allow tons of food to rot weekly because

they cannot get a high enough price for it. It is rather that the poorest people cannot afford to buy it. Secondly, the poorest people are precisely those without money or land. That is why they are starving. This means that all the "wonder crops" in the world will not help them. Thus only those a few runds up the economic ladder can benefit.

A devastating example of how these programmes can make things worse comes from India and the Green Revolution of a few years back. Here it was commonly believed that improved grain varieties were going to solve the malnutrition problem. What in fact happened was that only the comparatively well off could afford to buy the new grain and the fertilizer and equipment necessary to use it. They benefited so much that they pushed the marginal farmer off the land, and the overall incidence of poverty, landlessness and starvation has in fact increased. (3)

This kind of result is reproduced wherever "community development" programmes proliferate (4). The fact of the matter is that people learn very quickly from such experiences, and are unwilling to participate in such programmes a second time. This leads to the rural poor having gained a reputation for being "anti-development", "apathetic" or even "lazy". They understand well enough that they are kept poor by certain forces, and that until these are tackled at their roots, there is little point in trying to combat the mere symptoms that they give rise to.

There is another aspect of the emphasis on community and preventive medicine which is in danger of bolstering existing inequalities. There is a danger that it can provide an excuse for "making communities responsible for their own health" when the resources within that community are patently inadequate - not because of the communities inherent inadequacy, but because of its history of deprivation. Thus it becomes a respectable

reason for the authorities to wash their hands of responsibility for a situation which they, and the exploiting classes which they represent, have created.

In this light the enthusiasm with which some people have regarded the new South African Health Act as being a progressive step because it allows for the implementation of many of the basic principles of community medicine should be treated with some caution. This is the case particularly in view of the discrepancies in the allocation of health resources. For example, the new Johannesburg Hospital has cost something in the region of 100 million rands to build, and will cost about a third of that per year to maintain.

There are other bizarre consequences of the refusal to recognise that lack of resources is socially determined rather than a law of nature. one of these is the emphasis placed on "family planning" and nutrition education amongst the poor. The assumption here is that if people are hungry, there are simply too many of them for the available food supply. The other side of the "grow more with the wonder bean" coin, is the "lets have smaller families with less mouths to feed" syndrome.

On the surface all these things seem reasonable enough. But no-one tells the rich to have fewer children lest they starve. No-one insists that the mothers of Houghton or Constantia feed their children so many grammes of protein carefully balanced against so many milligrammes of minerals, vitamins and trace elements.

It is not even as if these evangelists for birth control say to the poor: "we know that you are exploited and oppressed. We will fight with you to achieve freedom, but in the meanwhile here is a survival recipe for your children". Or, "we know that you cannot farm because you are landless while the majority of the land is in the hands of

the white farmers. We will fight with you for a redistribution of land and power. In the meantime, here are ways of growing vegetables to keep yourself alive."

Rather, these techniques are put forward as solutions in themselves to the problems of the exploited. The only inference is that exploitation is part of the natural order, and people are going to have to learn, literally, to live with it.

Similar flawed reasoning lies behind the continuing search for an Appropriate Health Technology. If one asks the question "appropriate to what?", the only reasonable answer is "appropriate to survival in conditions of extreme exploitation and poverty." This research ignores the fact that the technical possibilities already far outstrip the social and political ability to use them. If this is the case, the continued search merely reinforces the myth that a social and political problem will have a solution, if only we can find the right bit of technological magic. A word about other types of research is opposite at this point. In order to make preventive outreach programmes more effective, it has become fashionable to conduct extensive research programmes into, for example, what it is that makes certain children in a rural slum suffer from malnutrition while others do not. Typically these programmes come up with the answer that it is not so much economic status, as the fact that the child comes from a broken home, or his mother has deserted him or some other fact of social dislocation that is responsible. This is fine. No one knows who is most at risk, and can maximise one's efforts to minimise the effect of malnutrition amongst that particular target group, during the continuing phase of oppression. Unfortunately much more is read into these surveys. Suddenly broken homes become the cause of malnutrition - which can then presumably be prevented by a timely bit of marriage guidance or social work. Yet the children of Hollywood divorcees do not

starve, nor do the offspring of Johannesburg's jet-set broken homes. The most that can be deduced from this research is that where everyone is living below the breadline, survival tends to depend on the stability of the home environment, rather than exactly how far below the breadline one is.

One could go on in this vein indefinitely. I hope that I have given sufficient illustrative examples to make my case. In brief, I have argued that the theory and practice of community medicine often tends to obscure the roots of disease which are to be found in exploitation and political oppression; that this is done by providing inadequate explanations, by portraying survival strategies as ideals, thus accepting the permanence of the social order which makes survival difficult; by creating the myth of community where none exists, and so creating in the name of democracy, avenues for the rich and the powerful to pursue their own interests; by giving government an excuse to evade its responsibilities in providing health care to all; in short, in obscuring the truth that health care can only provide care, whereas health can only be provided by a political solution to the inequities inherent in our society.

PART 3: THE ROAD AHEAD.

The first step is to undertake a careful evaluation of all the principles of community medicine, and particularly their application in specific programmes.

The critical understanding of the role of health care must begin with putting the interaction of the social structure as a whole, and the "communities" with which the system of care is concerned, into the correct perspective. Many of the false attitudes that I have described stem from a tendency to generalise an approach to the world out of immediate experiences in a small part

of the world. Thus it may be true that a family has more children than it can feed. A village may be able to overcome a number of its health problems by acquiting a cheap water supply. This is very different from saying that the answer to the world's malnutrition problems is better family planning, or that the right technology would do away with water-related diseases.

Rather, one must undertake a thorough analysis of the dynamics and structures of a society as a whole, including a careful understanding of its history. Then one must examine how this or that "community" reflects these dynamics and structure, and how our actions will affect them. Will they reinforce domination and exploitation or help to challenge them?

There is nothing wrong with assisting people to survive when they are down and out. It only becomes reprehensible when it distracts from the more important work - eradicating the evils of malnutrition and other diseases of poverty at their roots.

I have said that health care can only provide care, that it is essentially in the realm of politics that the health of the nation will be determined. It is only when we stop trying to "help the poor", and join with them in the struggle for political and economic freedom that we can be truly said to be striking at the heart of ill health.

I am not suggesting that those concerned with health care should lay down their scalpels and take up arms or that nothing can be done in the field of health until a just political and economic order have been created. That would be both negative and impractical. It is simply that we must take care not to reinforce the existing imbalance of power in order to achieve short term goals.

On the other hand care should be taken not to fall into a paralysis of disillusionment and hope-

lessness. I cannot spell out in detail what people should do. I can only outline some general guidelines.

1. The link between exploitation and ill health must be fully spelt out, not only in academic journals and pleas to politicians, but in the day to day work with the victims themselves.

2. Health personnel must move beyond the superficial conception of "community". They must take sides and put their skills at the disposal of those acting with the poorest and the most powerless, in order to increase their ability to resist the threat to their existence which the present order poses.

3. In embryo form, in local projects, the practices of a just health system must be put into effect. These must be used to highlight the inadequacies of the present system, and to create expectations for the future.

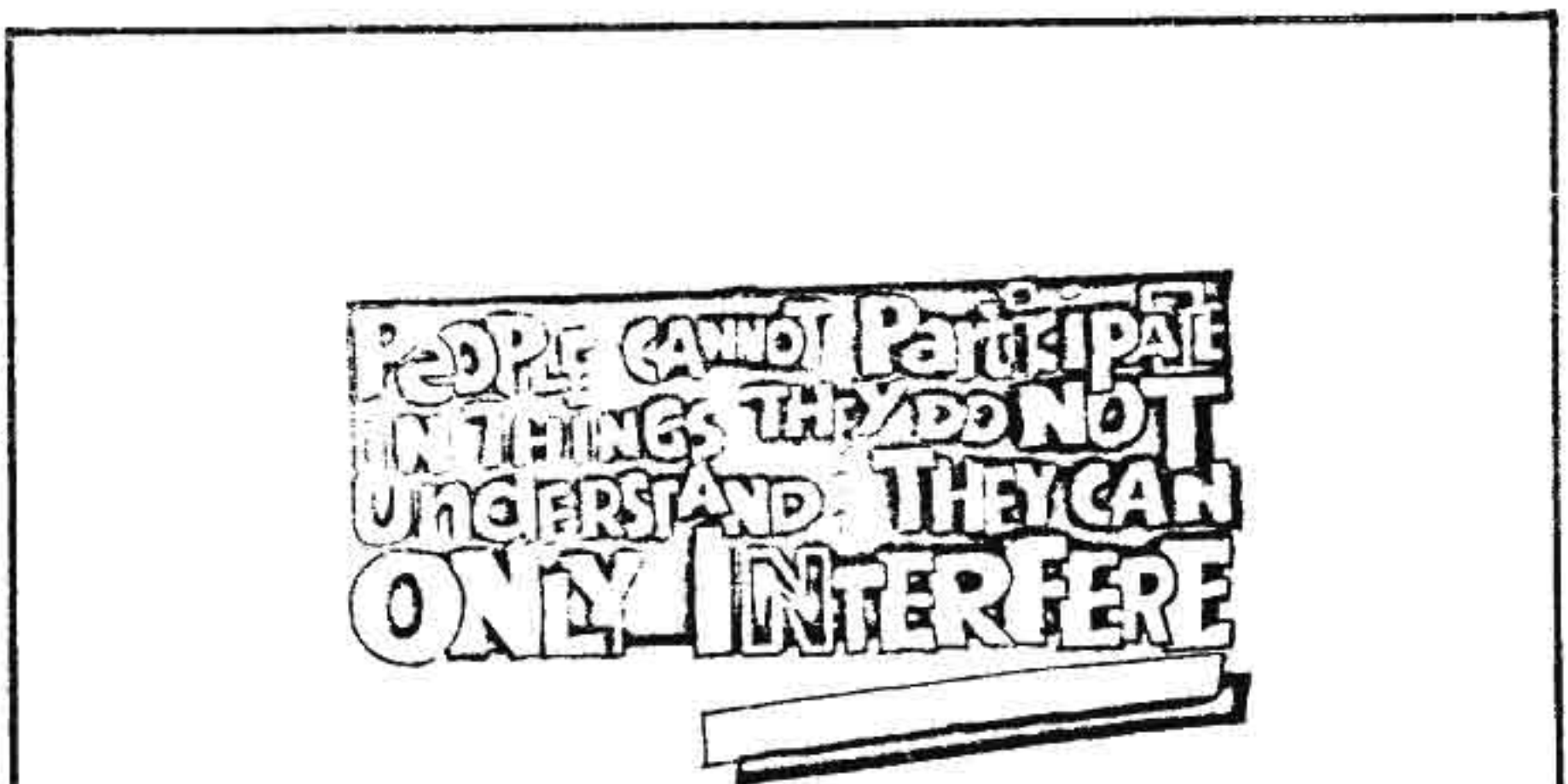
4. A concerted effort must be made to build up a reservoir of politically conscious and dedicated people who will form the core of a new and just health system at some point in the future, when a just and non-exploitative society has been built.

Western medicine, despite the good intentions of some of its practitioners, has become a huge industry. Its practices, its structures, its professional organisation and the society in which it exists have made sure of this. It has more to do with the exploitation of disease than the provision of health care.

What I have tried to show in this paper, is that understanding this, and the attempt to look for alternatives within the present system is only half the task. If medical practitioners, and others, wish to see the creation of a truly

healthy society, then they must examine carefully what role they can play in ridding society ofthe disease of exploitation.

PTO for NOTES on this article.



NOTES:

1. See for example. Mckeown T. A Historical Appraisal of the Medical Task, in Mclachlan, Gordon and Mckeown (eds) Medical History and Medical Care.

2. This kind of unfounded optimism can be found even in those programmes which have gone furthest in understanding the types of criticisms that are levelled in this paper. So for example Berhorst C. The Chimaltanago Development Project in Health by The People. World Health Organisation 1975.

3. For a good introduction to the relationship between hunger and social injustice see: Powers J. and Holenstein A.M. World of hunger Temple Smith 1976.

4. For a detailed and devastating account from the Transkei see: Claassens A. An Assessment of Self Help Projects in a District of the Transkei. A paper presented to a conference on The Economics of Health Care in Southern Africa. Cape Town September 1978.

A Comprehensive bibliography would be overpowering. What follows is simply a guide to some of the reading available.

For the seminal works on the community medicine approach see: King M. Medical Care in Developing Countries OUP 1966 Bryant J. Health in the Developing World Cornell University Press, 1969.

L.G. Wells. Health Healing and Society Ravan Press 1974 is an instructive booklet applying the principles of community medicine to South Africa.

A concise statement on appropriate technology for health and the use of medical auxiliary is to be found in:

Gish O. (ed) Health Manpower and the Medical Auxiliary Intermediate Technology Publications 1971.

An interesting publication in which most of the issues raised here arise from time to time is CONTACT a bulletin published by the Christian Medical Commission in Geneva.

The most comprehensive critiequ of the structure, organisation and function of western medicine can be found in:

Navarrro J Medicine Under Capitalism

A somewhat eccentric, sometimes devastating, sometimes conservative attack on the entire medical world is to be found in Illich I. Medical Nemesis. This should be read in conjunction with Navarro's critique of Illich.

For descriptions of alternative health care services and projects the logical starting place is

Newell K. (ed) Health by the People World Health Organisation 1975.

The commonest case study is China. Short introductions are

Health Care in China Christian Medical Commission 1974.

Chabot HT. The Chinese System of Health Care published in Tropical and Geographical Medicine 28 1976.

A fascinating personal account is Horn J. Away with all Pests. Hamlyn 1969.

Apart from the above other articles which I have found interesting are:

Powles J. The Medicine of Industrial Man Published in the Ecologist of October 1972 and

Kromberg M Health Care - New Music old Harmony. This is printed elsewhere in this publiscation.

Readings on South African History are difficul because they are often locked away in academic journals. As a general reference see:

Wilson M. and Thomson L. (ed) The Oxford History of South Africa. Published by Oxford University Press in 2 volumes.

An interesting paper on the interaction betwee the colonial and the indigenous economies is

Bundy C. The Rise and Fall of the South Afric Peasantry in Journal of African Affairs Vol. 7 October 1972.

For an understanding of the impact of mining on South African History Johnstone F. Class, Race and Gold. Routledge & Kegan Paul 1976.

An interesting anecdotal history of South Africa is Roux E. Time Longer than Rope University of Wisconsin Press, 1968.

WOMEN IN MEDICINE.

by SUSAN GOLDSTEIN.

WOMEN IN MEDICINE by SUSAN GOLDSTEIN.

The position of women in medicine is very similar to the position of women in society in general. Women are exploited and oppressed. The worst paid jobs are seen as women's jobs, for example, nursing, occupational therapists and physiotherapists. Nursing in particular is badly paid and the hours are long. It has been said that nursing is a woman's job because it is similar to housekeeping and mothering - and in the same way very little recognition is given to nurses.

Salary rises in the above jobs are much lower than the salary rises of doctors (proportionally) There is very little consideration for the child bearing function of women - i.e. if a nurse becomes pregnant she has to leave her job (and the same applies to a female doctor who is more than four months pregnant). There are very few crêche facilities. For women doctors to work and have a family, they are forced to specialise.

In this virtually all female medical team (with the male doctor at the head) - the women have no power and are usually forced to abide by the decisions of the doctor, and what is more they hold little power in the overall covering body - the Medical and Dental Council.

Before one can change the situation, one must examine the form exploitation takes, and only then can one move against it.

Research on women in health has been largely inadequate through two basic mistakes. Firstly, the focus has been largely on women themselves, as if they were responsible for the present situation, whereas one should focus on social and economic systems which are controlled largely by men of defined class positions. Secondly,

the health sector is usually seen in a vacuum, instead of looking at society in general to see how the structure of the health sector came into being.

If one looks at the class composition of the United States population, one sees that a relatively small number of people own a disproportionate amount of personal wealth, and whose income is derived from ownership; the Corporate Class of which 0,1% are women.

Then one gets the upper middle class of which 11,3% are women.

The lower middle class can be divided into:

(a) clerical and sales workers - 82,6% of which are women, and

(b) self employed, shop keepers, craftsmen and artisans - 28,6% are women.

The working class can be divided into three sections:

(a) manual labourers - 20% women.

(b) service sector - 83,3% women.

(c) farm labourers - 3,3% women.

Moreover 50% of the lower middle class women are married to working class men.

The position in South Africa, although clouded by race is essentially very similar.

There are numerous reasons for this sex discrimination in the labour force. Two of the important reasons are:

(i) The system of the family, whereby the woman (housewife) does a large amount of necessary labour with no recognition of this labour spent. The Employer pays the husband as one person,

while he is actually benifiting from the labour of two people. This is upheld by socialising women into the emotional rewards system -- that is that the woman is emotionally fulfilled by working and caring for her family. It is also assumed that because of the emotional rewards of the family, a woman can "enjoy" a lower salary than men.

(ii) Women are kept as a reserve labour force for states of crisis such as war.

The class composition of the health sector is similar to that of the labour force in general. There are upper class white male physicians - the unquestioned leaders of the health team, and the lower middle class female nurses who are appendages to and dependant on the physicians. The auxillary and ancillary personel are females of working or lower middle class origin.

More important than the class composition of the health sector is the control and leadership of the sector. We find here (both in S.A. and the U.S.A.) that although about 80% of workers are women (nurses and auxillaries) total control is exerted by the 20% who are physicians.

In Russia the situation is slightly different - 80% of physicians are women, yet the control of the health is still in the hands of males. Less than 10% of the National Health Board are women, and only once in 50 years has the Minister of Health been a woman.

An interesting point to note is that even though there has been an increase in women admitted to medical schools to train as physicians, the class composition of physicians has not changed at all.

At this point an important question to ask is - who is the health sector supposed to serve?

The answer must be - the entire population,80% of whom are lower middle and working class people, and 50% of whom are women. Yet the control of the health sector is in the hands of a few upper middle class males.

For health services to be effective the interest of all the people must be represented and thus the people to whom the service is directed must have control of that service.

From the above one can see that a strategy for change would be to change the sex and class composition of the government and to have the government representative of and accountable to the majority of the population.

"The Women's Liberation Movement will be ended when and only when --- the process of the social transformation of society as a whole is completed".

(Soong Ching-ling).

Hospital nurses and a pay gap

Pretoria Bureau

There is a gap of more than R112 a month between starting salaries paid to white and black nurses in Transvaal provincial hospitals.

The Administrator, Mr Sybrand van Niekerk told Mrs Irene Mennell (PFP Houghton), in the Provincial Council yesterday that whites receive R310 a month, blacks R197,50 and

RAND DAILY MAIL

31-04-1979.

questions

of a worker

reading history

Who built seven-gated Thebes?
Books list the names of kings.
Did kings haul the blocks and bricks?
And Babylon, destroyed so many times
Who built her up so many times? Where
Are the houses where the construction-workers
Of golden-gleaming Lima lived?
Where did the masons go at nightfall
When they finished mortaring the Wall of China?
High Rome is full of victory arches.
Who put them up? Whom did the Caesars
triumph over?

Did chronicled Byzantium build only palaces
for its inhabitants? In fabulous Atlantis
the drowned bellowed in the night when the sea
swallowed them up after their slaves.

Young Alexander conquered India
Just he?
Caesar beat the Gauls.
Didn't he at least have a cook with him?
Philip of Spain wept when his Armada
Went down. Did no one else?
Frederick the Great won out in the Seven Years' War.

Who won besides?

A victory on every page.
Who cooked the victory feast?
A great man every decade.
Who paid the bills?

Lots of facts.

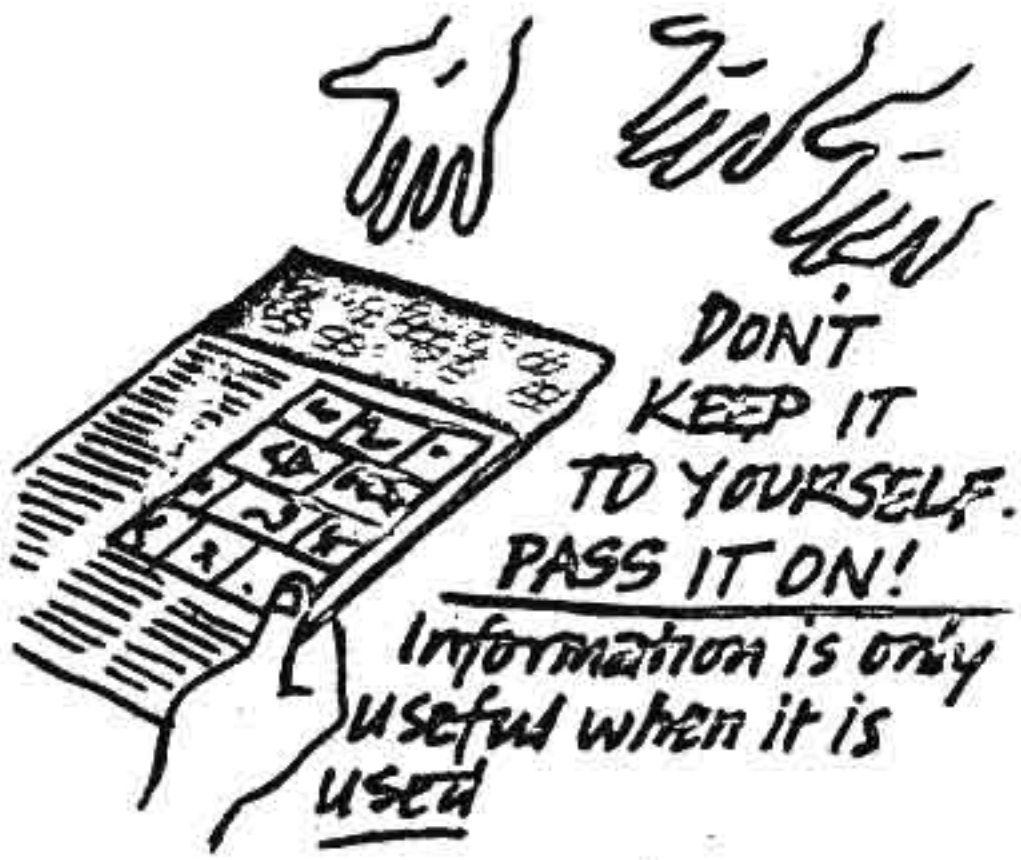
Lots of questions.

berthold brecht

UNDERSTANDING

COMMUNITY

HEALTH.



UNDERSTANDING COMMUNITY HEALTH.

INTRODUCTION.

The editors of "Critical Health" believe that there is a serious lack of awareness of the concepts and principles involved in community health in Southern Africa. This extends from the specific health worker to community workers in other fields, to academics and research workers, and to the people of Southern Africa, in general. A paucity in the application of these community skills to the health problems of Southern Africa and an inadequacy in the present health care system is apparent. This fact is hardly surprising when one considers that there is a conspicuous absence of institutions, groups or even individuals to provide a relevant education in Community Health Care.

It is the belief of the editors that the totally inadequate present system of providing health care in South Africa will steadily worsen unless fundamental changes are introduced which will allow us to break out of this vicious cycle. Despite these limitations, it is believed that reading material can be of value to those people who are able to perceive the present failings of our health care system and who desire knowledge of alternatives. It may even have a small part to play in effecting a change in attitudes.

It is in response to this educational gap in the field of community health that this section is to be included as a regular feature in this quarterly publication. Through "Understanding Community Health", we hope to develop an awareness of the basic concepts and principles essential to the field of community health.

The aims of this series of articles are thus:

(a) to provide:

(i) the community worker or potential Community worker with a starting point for reading in the field of Communtity Health.

(ii) people working in other spheres with the concepts in Community Health, which they can consider and apply in their daily tasks.

(b) It is not hoped to provide any more than the broad concepts or principles, but through reference lists, appended to each article, an attempt shall be made to help the reader to acquire an in-depth understanding of the subject.

(c) the practical application of the skills shall be continually shown by way of concrete Southern African examples, and by the selection of authors who have practical experience in the field.

(d) at all times, the articles shall be pertinent to the needs and problems of Southern Africa, including as far as possible the references selected.

(e) in addition, it is hoped to cultivate in the reader, a critical awareness towards the problems of Southern Africa, an attitude believed to be essential to adequate health care.

A draft of the topics to be covered in the programme are :-

1. Introduction - What is Community Health?

   including, definitions of concepts and a discussion of the relationship and differences between

   "Medicine in the Community" and
   "Community Medicine".

2. The Political Economy of Southern Africa (Development and Underdevelopment)

   The political economy of Health in Southern Africa.

4. Community Development.

5. Epidemiology and demography - The basic principles.

6. Disease distribution patterns in Southern Africa.

7. Health and the State
   including, South Africa at present, and its health legislation.

8. Design and management of Health Care Systems including examples from other third world countries.

9. Indigenuous health resources, in Southern Africa.

10. Priorities and constraints in health care in South Africa.

11. Health problem-solving
    including data analysis,
    Community diagnosis,
    and the "Community Syndrome Concept" (Kark).

12. The Health Care Team.

13. Primary Health Care in Southern Africa.

14. Medical Sociology
    including customs, groups, families, and traditional practitioners, as they influence Community Health.

15. Specific, major health problems of Southern Africa - The challenges we face: including Tuberculosis, Malnutrition, Coronary Artery Disease, Alcoholism, Violence Rheumatic Heart Disease and others.

Each topic will be dealt with over one or more articles. Two articles covering diverse topics, will appear in each edition.

P.S. The editors would greatly welcome and appreciate critical responses from readers on this section, as we would for the rest of the booklet.

TRANSKEI - A FLOURISHING HOMELAND ?

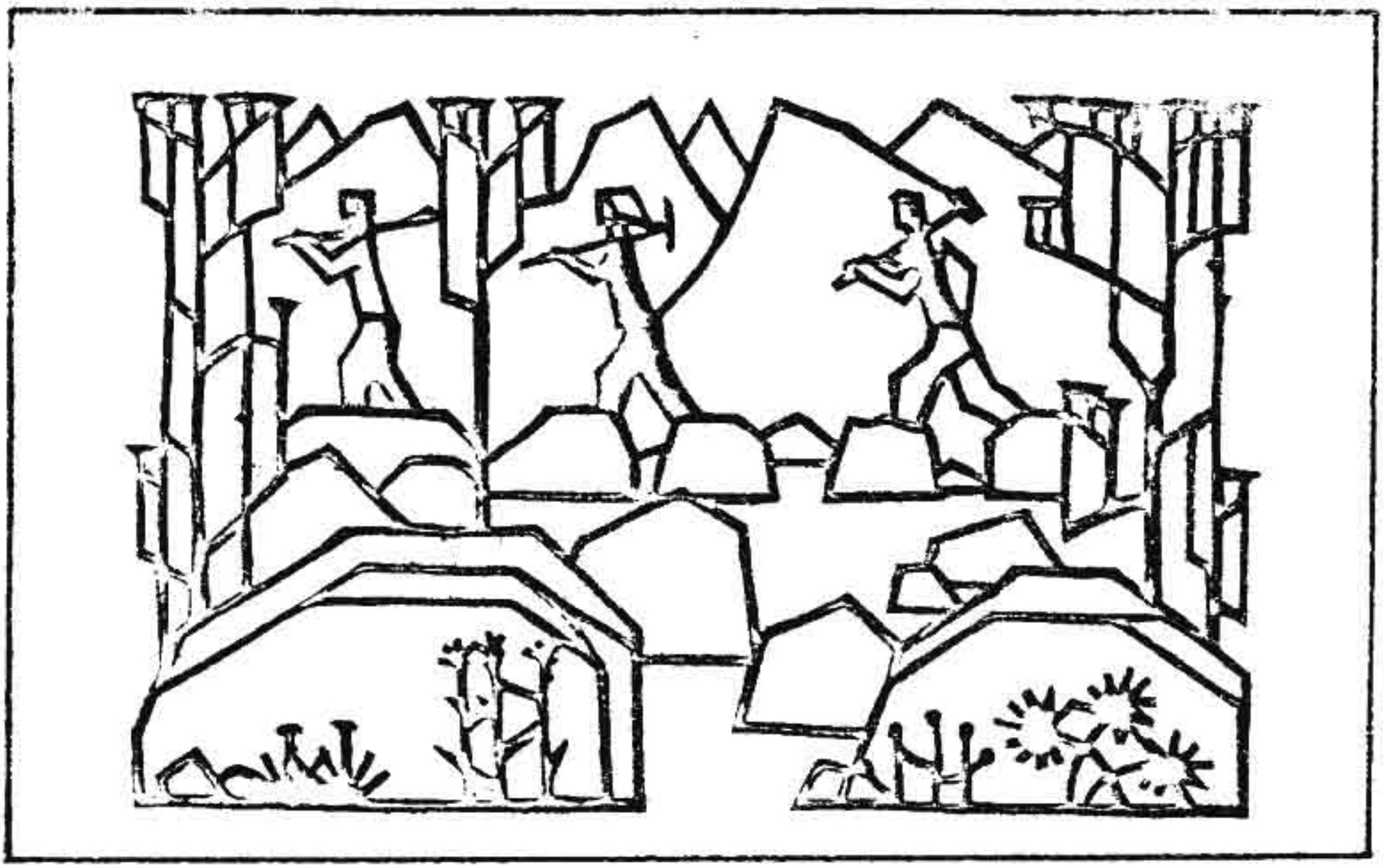
In a survey of the Tsalo area of the Transkei the following results were revealed:

36% of all children under 5 years old were found to be malnourished.

60% of these between 18 and 30 months suffered from malnutrition.

The infant mortality rate was high and poverty extreme.

The Nationalist Party may be attempting to promote the viability of its homeland policy but "the attractiveness of the independent homelands policy will inevitably be judged by blacks in terms of their own experience" (Professor J. Dugard, 1979).



INDUSTRIAL HEALTH CARE

BY

A GROUP OF JOHANNESBURG DOCTORS.

INDUSTRIAL HEALTH CARE.

A Group of Johannesburg Doctors

Following the publication of the findings of the Erasmus Commission of Enquiry into Industrial Health in 1976 and the SALRDU/SAMST conference on the economics of health care in Southern Africa (Cape Town, September 1978) attention has been focused on industrial health care in South Africa. Studying these proceedings it becomes clear that the state of industrial health in South Africa is very unsatisfactory and that very little has been done either on a practical or a theoretical level in this respect. Enforcement of such legislation as does exist is inadequate and we contend that it cannot improve unless there is direct worker participation in the control of industrial health. As long as the onus for industrial health falls on management and the state, it will be governed by the motives of profit and productivity and not by real health interests as perceived by workers.

THE UNSATISFACTORY PRESENT SITUATION.

1. At present, legislation covering industrial health is largely inadequate and implementation severely limited. There are at least 32 Acts governing industrial health which fall under 12 different government departments. Because of a lack of co-ordination of the laws, there are workers who are unprotected by any legislation; maximum concentrations of noxious substances are not standardized etc. Also there is an inadequate staff to implement and police

these laws - e.g. 32 factory inspectors for 30 000 factories in 1974.

2. There is a tendency in South Africa to narrow the concept of industrial health to that of occupational disease and not to include industrial accidents. Such a separation was made by the Erasmus Commission. This is in opposition to international trends - as shown by the Occupational Safety Health Act of 1970 (USA) and the English Health and Safety at Work etc. Act of 1974 - which aim to provide for one comprehensive and integrated system of law dealing with health and safety of the public as affected by work activities. What has developed in South Africa is a false complacency about industrial health in certain spheres. For example, the Erasmus Commission felt that the position with regard to health.on the mines was satisfactory while it was aware that in 1974 there were 500 deaths and 22 222 workers injured in accidents on the mines.

3. One consequence of the lack of representation of workers' interests in respect of industrial health is that good industrial health schemes are rare. One example is the service run by AE&CI at their Modderfontein factory. It comprises:-

(a) A well equipped hospital able to handle acute and elective medical and surgical problems.

(b) Clinics dealing with industrially-related health problems e.g. hypertension. Patients are identified mainly by "on-the-job" screening done by nursing sisters throughout the complex.

(c) Surveillance of toxic substances amongst "at risk" workers.

(d) Several first aid stations.

(e) Emergency rooms in every plant; emergency training drills are mandatory throughout the complex.

Regular environment health and safety inspections are carried out by representatives of management.

Although this scheme is far superior to other industrial health programmes in South Africa, and very few such programmes exist, it can be criticized on the following ground:-

i. The absence of worker-representation on safety inspections.

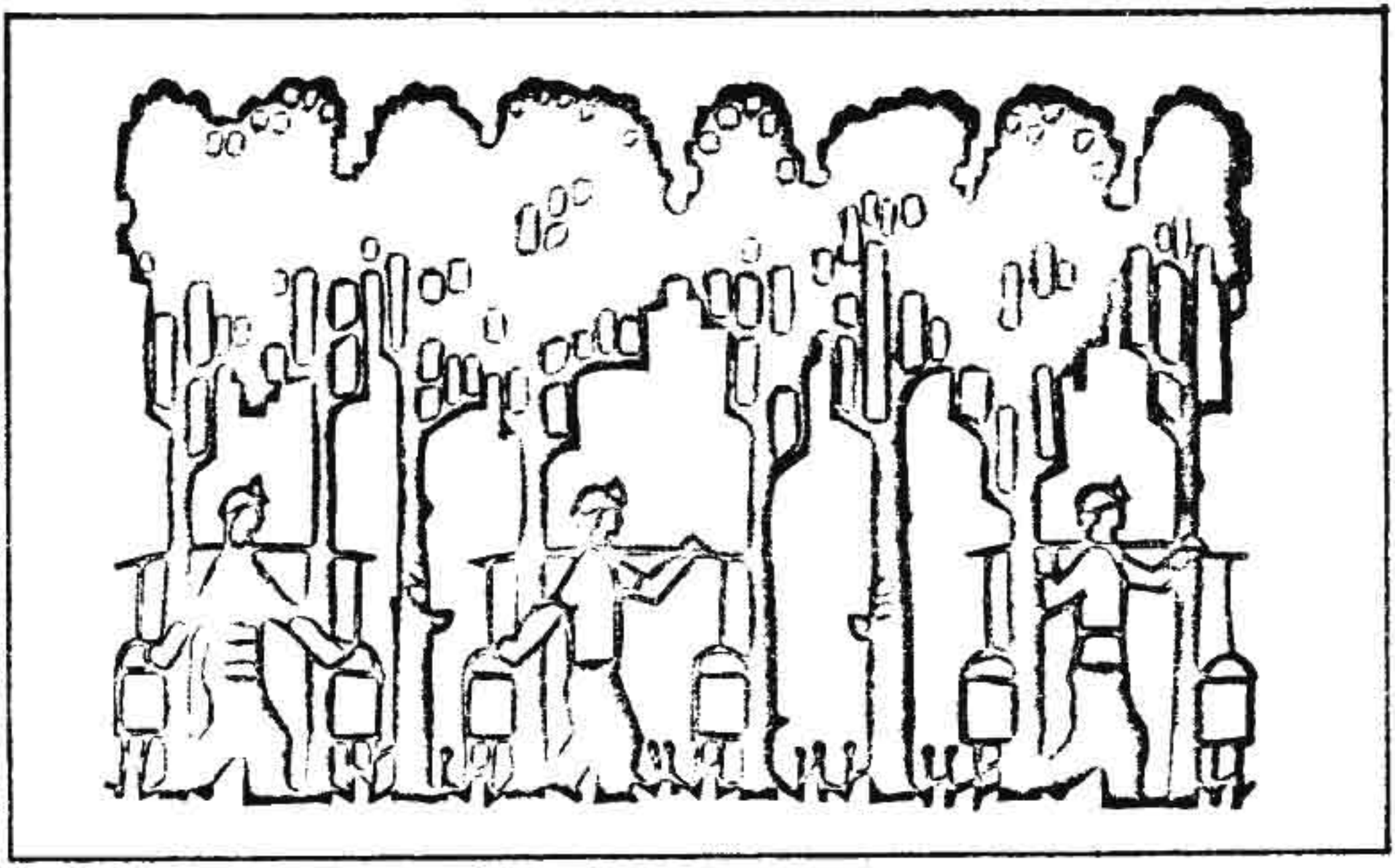
ii. The absence of channels through which workers can register complaints about working conditions and hazards.

iii. The lack of formal worker-education programmes on factory health dangers.

iv. The lack of direct control by workers of the medical scheme. The scheme is under the control of and dependent on management.

WORKER PARTICIPATION IN INDUSTRIAL HEALTH.

As a result of the Erasmus Commission new legislation dealing with industrial health will be enacted. This legislation can only be effective if it provides for workers'-participation, a principle accepted by the Erasmus Commission in only a limited measure: "After all if mutual trust is to be achieved, there must be some level at which employer and employee may meet to consider the employee's work environment and health. How these committees are constituted may for the time being be left to the discretion of management. Whatever the organisation may be that is created, it should be capable of discharging the legal obligation which the commission proposes to impose upon employers, namely that of consulting their workers on industrial health



matters."

Normally this role is fulfilled by trade unions. Where trade-unions are recognised for all workers, participation can be ensured in the following ways:-

1. Health officers or committees in factories are elected by the workers themselves.
2. These officers or committees have free access to factories, workers and records.
3. They work in co-operation with doctors and experts appointed by the trade-unions who also have access to factory workers.
4. These committees have powers of inspection and enforcement recognised by law.
5. A national organisation representing workers has the power to lay down standards and conditions in relation to industrial health.
6. Worker -organised preventive industrial health education makes workers aware of the hazards to which they are exposed.
7. Worker-controlled health schemes deal not only with specific occupational diseases and industrially related health problems such as TB, hypertension and mental health.

The recognition of trade unions for all workers is unlikely in South Africa in the near future. This consideration must be given to the nature of the bodies which can fulfil the recommendations of the Erasmus Commission that the management of any industrial undertaking should be obliged to consult workers or their representatives on industrial health issues and working conditions and to grant them a hearing when they have complaints.

One suggestion is that there be worker-elected committees, working with the advice of suitably

medically qualified people, which could:

(a) Negotiate with management on industrial health issues and on the enforcement of industrial safety measures.

(b) Help in the education of workers about the problems of safety and occupational diseases.

(c) Form the basis of a general co-operation between workers on health matters.

The success of such committees would depend on:-

i. The awareness of workers of the health problems they face in the factory.

ii. The extent to which the committees are truly representative of the workers and their support amongst workers.

It is possible to envisage the establishment of these committees within the present legislative framework.

**

This article has been reprinted from the South African Labour Bulletin, Vol. 4, No. 9 and 10, March 1979.

HOW NEUTRAL ARE MEDICAL SCHOOLS ?

BY

ANTHONY ZWI.

HOW NEUTRAL ARE MEDICAL SCHOOLS ?

BY ANTHONY ZWI.

The Medical Schools do not tackle or confront the root causes of ill-health in South Africa. They prefer to concentrate only on disease and the technology required to limit or eradicate it. No attempt is made to isolate the causes of poor health and to alter these causative factors. Instead the Medical Schools produce graduates who are capable only of functioning in a narrow sphere of medicine and one which makes little or no impact on the overall health status of all the people of South Africa. Thus, the Medical Schools, part of a totally inadequate health care system, function to perpetuate that system without altering it.

Although doctors and medical schools are by no means the major influence on the health status of people, they do have a limited role to play in the improvement of the health of the people. In this article, I would like to briefly look at the present role of medical schools in South Africa, how they play their part in preserving the status quo, and to what extent their role could be altered. *

The Medical Schools train doctors who are expected to meet the health needs of the people. The Medical Schools are therefore required to produce sufficient doctors of sufficiently high technical ability to meet the health needs of this country.

* The author's views are based on Wits Medical School and it is assumed that the issues raised are common to the other Medical Schools in South Africa. If this is not the case, the editors would be pleased to learn of this - Editors.

No attempt, however, is made to produce doctors who will attempt to influence the causes of illness and will try to reduce the reliance of people on the medical profession. Efforts are rather directed at increasing the number of doctors to enable them to deal with an increasing population with increasing amounts of diseases. It is difficult to estimate what actual effect doctors have on the picture of ill-health in South Africa. However, one can look at where doctors are found and how they function. At present, 65½% of all doctors in South Africa practise in metropolitan areas, and a further 29% practise in cities or towns, while only 5½% practise in rural areas. (Beaton and Bourne, 1978). Of those in rural areas many are expatriates. The vast majority of doctors (90% in 1973) are Whites who practise mainly amongst the White sector of the population and this further increases the disparity in the distribution of doctors. The doctors produced in South African medical schools are largely devoted to curative medicine and their influence on health is limited to the numbers of individual patients they see and minimal if any influence is extended on the community at large. Of the active doctors in South Africa, approximately 25 per cent are specialists and of these only about 2 per cent are specialists in preventive medicine. Only a small proportion of doctors are involved in industrial health care and the care of workers.

Very few South African doctors understand the social and political milieu in which they function, and even fewer perceive their role as one which may have important social and political consequences. They therefore prefer to fit in neatly with the established social elites in South Africa and play their part in ensuring the smooth and efficient functioning of society in its present form.

Yet the medical schools claim to be attempting to meet the needs of <u>all</u> the people of South

Africa. But, in this country dominated by inequality, oppression, and exploitation, can the medical schools actually separate themselves from society and function in the interests of all, rather than only in those of the elite? Can the medical schools be neutral or do they take sides? I believe that the medical schools cannot possibly claim to be neutral institutions. Rather, they play a strong part in ensuring the continuation of society in the way it functions at the present time. In this way it echoes the role of the university - to produce graduates who will ensure optimal functioning of society in the form that the government (and not the majority of the people) have decided as being in the "best interests of the people" (i.e. some of the people).

The medical schools support the status quo in a number of ways. To a large extent this is by default, i.e. by what the medical schools do not do. Do they ever confront the real issues behind ill-health in South Africa? Do they ever talk about the distribution of wealth or power or land? Do they ever discuss the origin of the homelands, underdevelopement, and migrant labour?

Are the medical schools neutral if they produce doctors who accept all that they see around them without critically looking at society or the causes of ill-health? Are they neutral if the products of medical education are usually doctors who readily become part of the elite and reinforce the unjust status quo? Is medical education neutral if it does not even ensure that students and doctors are able to communicate with the majority of their patients, even if they do not speak either English or Afrikaans? Is it neutral if students are taught their skills in highly sophisticated institutions, and are not taught to function without this highly technical backup, while a large proportion of patients will be seen in areas where this backup is not available?

Are medical students taught that health is not determined only by medicine and doctors but by

numerous other influences? Are they taught that they should be concerned with the health of their patients and the communities from which they come, or are they taught that doctors are there only to deal with disease? Are students taught about the other health workers who are essential parts of the health team if the health of the majority of people is to be improved? Are they taught how to teach and how important it is to learn to teach, whether it be for the benefit of individual patients, communities, or colleagues?

Do the medical schools teach students how to analyse a health problem, assess what is influencing the health status of the people concerned, implement appropriate programmes and evaluate them? Do the medical schools ever question the role of doctors or the distribution of health care in South Africa? Do the medical schools condone the building of large disease palaces in preference to the erection of Community Health Centres?

All the medical schools would answer that they are attempting to deal with these issues, but that is true to such a limited extent as to make no impact on prospective doctors.

There are a number of reasons for failing to confront these issues. First of all, the Medical School is but a section of the University, and as mentioned earlier the university is responsible for producing graduates who will fit into the present structure of society without disrupting it. They will help to ensure the perpetuation and smooth-running of society in its present form. Doctors contribute by supporting the elite and allowing to suffer those who have been oppressed and dispossessed.

Secondly, doctors as a group are tremendously conservative and there is an amazing reluctance to change, an avoidance of anything new. They work together as a group to maintain their own

interests. The profession is far more important than the public.

Thirdly, doctors are generally ignorant of the causes of ill-health in South Africa. They have never been made aware of the history of disease in South Africa. Why is malnutrition such a major problem in the homelands? Are rural communities stupid or is there something else influencing the high incidence and prevalance of disease? Doctors generally do not bother to isolate the causes of ill health in communities. Malnourished children are treated (if the doctor finds himself in a hospital not only treating the upper and middle classes) and then they go home. What is at home and what is in the community generating that disease is left for other people to tackle.

The medical schools do not encourage a look at the causes of health problems. Nor for that matter, do they encourage students and staff to generate solutions to South Africa's health problems. They prefer to casually fit into the structure of health services as they presently exist.

Is it surprising that the majority of students aim to practise in cities and towns? In their training, do they ever leave the vast teaching hospitals? Do they learn about the health problems in the most isolated communities with little or no access to sophisticated medicine? It is surprising that the graduates follow the example of their teachers and stay in the comfortable surroundings of the city? Is it surprising that doctors wish to stay in the urban areas and to serve the elite, even though the medical school and its teachers do all they can to encourage their students to work in rural areas or with other communities and groups in urban areas. Is it surprising that students do what their teachers <u>do</u> rather than what they <u>say</u>?

RELEVANCE

IS THE ESSENTIAL QUALITY

OF EDUCATIONAL OBJECTIVES

*

OBJECTIVES WHICH HAVE EVERY

QUALITY EXCEPT RELEVANCE

ARE POTENTIALLY DANGEROUS

It is not surprising that students do not involve themselves in innovative approaches to meeting the health needs of communities, because their teachers know so little about them. Our teachers rarely leave their vast teachnological master-pieces and rarely if ever come into contact with the realities of ill-health outside these institutions. It is hardly surprising that what we are taught about reflects the interests and pre-occupations of the teachers rather than the needs of society (Simpson, 1976).

The medical schools do not teach students that health is interrelated with numerous other disciplines such as social anthropology, politics, sociology, agriculture, social work, psychology, and others. Doctors are always spoken of as being at the head of the team. Yet, to what extent do the students ever even work with members of these allied disciplines? Do they ever actually work together as a team during their training? Would they know how to work with people who are not doctors or nurses?

Medical schools are not neutral but reflect a set of ideologies and assumptions predetermined by the elite of society. If the medical schools wanted to attempt to become neutral, or even to play a positive role in the pursuit of justice in this country, what would they have to do?

First of all, the medical schools must draw up a set of objectives for their educational programme. The medical schools must state what sort of doctors they wish to produce. The public should debate this and influence the direction in which the medical schools move. At present the medical schools produce the sort of doctors they graduate, knowing and ensuring that they have trained the sort of doctor not wanted and needed by the people.

The medical schools must critically analyse the role they presently play in South African

health care and must attempt to ensure that they are not producing doctors who merely accept and condone the present unequal distribution of health care, but rather analyse critically and then act according to their findings.

The medical schools should stimulate an awareness of the relationship between health and socio-economic, political, cultural, and other factors. These relationships are complex and unclear but only through analysis and debate can a clearer understanding of the relative importance of these different influences be arrived at.

The medical schools should engender in their staff and students a commitment to all the peoples of South Africa. This can best be facilitated by enabling students to interact and communicate with a broad spectrum of South African Society and encouraging them to participate actively in the improvement of health in communities. The more students learn about South Africa and its problems, the more willing they will be to accept the challenges of working for change, and the improvement of health care of all the people.

The medical schools must analyse the health problems of South Africa and establish priorities for the provision of health care. Courses should ensure that students are taught thoroughly of these problems and the alternative methods of how best to deal with them. At present there is no clear understanding of what exactly are the major health problems in South Africa or how best to attempt to solve them. Yet, the amount of time and emphasis devoted to the teaching of particular health problems is almost inversely related to the frequency with which these problems are seen outside of the teaching hospitals (Simpson).

The medical schools must see themselves as part of society with a responsibility to it. The orientation of the medical curriculum must clearly

be directed towards teaching students to cope with the most prevalent health problems by using the most appropriate methods of solving them. This is in contrast to emphasising the highly sophisticated techniques required to influence the course of extremely rare diseases, as is done presently.

The medical schools must involve themselves in actually providing the health services needed by society. At present, the medical schools all help in the provision of urban curative services, but they should also become far more involved in providing alternative forms of medical services. The medical schools should run community hospitals and clinics in rural and urban areas to teach their staff and students about the problems encountered in community setting and the derivation of that ill-health. The medical schools should become involved in training health workers in urban and rural communities and should devote attention to the health needs of workers. Where else are doctors influenced but during their training? If the course gave students a broad awareness of the problems of society and the techniques required for solving them, then doctors would be much more willing to devote their lives to serving communities rather than only serving their own personal interests.

The medical schools must become more involved in researching health systems and aspects of health care. Attention must also be devoted to critically evaluating present methods of meeting health needs. Medical schools must advocate those solutions that would be most appropriate, and must not be bound by precedence and conservatism. Students should be part of a dynamic search for solutions to health problems, rather than silent supporters of the present inadequate approaches.

Of course it is highly unlikely that the medical schools would actually contemplate radically changing medical education towards something far more relevant. Medical Education will probably continue to benefit and pepetuate the interests of the elite, and the majority of people will continue to suffer. There is little pressure for the present approaches to change, and they will continue until circumstances force us to confront the alternatives.

REFERENCES:

BEATON AND BOURNE, Some Notes on the Distribution of Doctors in South Africa 1975, paper presented at SALDRU/SAMST Conference on the Economics of Health Care in Southern Africa, September 1978.

GUILBERT, J.J., Educational Handbook for Health Personnel, W.H.O. Offset Publication No. 35, Geneva, 1977.

SIMPSON, M.A., The Uses of Objectives, notes.

SIMPSON, M.A., Medical Education - A Critical Approach, Butterworths, London, 1972.

CENSUS OF HEALTH SERVICES (1972-1973), Medical Practitioners and Dentists, Government Printers, Pretoria, 1976.

SOME PERTINENT FACTS ON ABORTION.

Abortion is controlled in terms of the Abortion and Sterilization Act No. 2 of 1975.

It has been estimated that between 50000 and 100000 illegal abortions are performed annually in South Africa, and that most of these are performed by untrained personnel.

About 20000 women die annually from illegal abortions and about another 30000 women will be sterileas a result of complicating infections of illegal abortions.

Whites in South Africa spend apprcximately R7 million annually to have abortions performed, both inside and outside this country.

Baragwanath Hospital alone sees about 30 complications of abortion per week i.e. 1500 per year.

Is it not time we reviewed the Abortion and Sterilization Act No. 2 of 1975?

THE CONTRIBUTION OF MISSION HOSPITALS TO MEDICAL CARE IN SOUTH AFRICA.

BY: GREG WELLS

THE CONTRIBUTION OF MISSION HOSPITALS TO MEDICAL CARE IN SOUTH AFRICA.

This article is based on experience mainly with mission hospitals in Natal, and most of those in KwaZulu, but should be relevant at least in outline, elsewhere in South Africa.

EARLY DEVELOPMENT:

Medical missions usually started with a small hospital where a doctor could have his base. Often the hospital followed the establishment of church, school, and other mission work, and this would affect siting and policy.(1) Hosiptal care was often nearly all that could be offered: vaccines and effective out-patient treatments were often not available, bad roads made it difficult to leave the hospital, or to refer seriously ill patients.

There were two possible trends, not unique to South Africa, which a hospital might follow. Until recently these were the results of implicit and little-discussed assumptions, not of expressed policies.

The hospital might serve only those who came to it for help. Its Christian concern was shown by caring for these individuals at the highest possible level, using State and private services as the yardstick. This led necessarily to a concentration on curative medicine at the expense of all else. This attitude has been common in South Africa but never carried to such extremes that only the wealthy could afford such "excellent" treatment. Almost all the mission hospitals were rural, serving poor and scattered populations without the elite to demand and support such a service.

The other and initially less common tendency was

to try to reach people outside the hospital with some minimum level of care. In some places the mission doctor was also the district surgeon and so responsible to the government for providing vaccinations, and minor curative care to indigent patients. Co-operation could develop into a regular mobile clinic service from the hospital, and later give rise to permanently staffed clinics. Direct community involvement started later and has always been rarer (2).

Isolation meant that hospitals depended very much on individual leadership to attract funds and staff. Some hospitals grew larger than other even though they served populations and areas of similar size. A large hospital would if the staff were inclined that way be able more easily to start a clinic network. Thus until recently there have been large hospitals with many, few, or no clinics, and small hospitals with few or none.

The mid-sixties brought many changes to mission hospitals around the World. Newly independent countries wanted co-ordinated national health services, at a time when rising costs made interdependence and co-operation more attractive to the missions. One result of this has been a slow swing towards providing some service for as many people as possible, rather than a "good" service for a few (3).

South African hospitals were never instigators and innovators to any degree. The one truly indigenous experiment was introduced, and later abandoned, by the Union Department of Health in the 1940s. This was Kark and Gale's health centre concept, which was very advanced for its time. It was nearly thirty years later that similar ideas were again practiced locally.

MISSION HOSPITALS AND THE DEPARTMENT OF HEALTH.

By the early 1970s the mission hospitals and the South African Department of Health were finding

ways of co-operating to some degree. The Department of Health, as agent for the Department of Bantu Administration, was responsible for health care in the homelands, where the missions were already providing nearly enough hospitals, and some clinics. It made more sense for the Department to subsidise them than to duplicate services. Most of the missions certainly needed the financial assistance, though many saw it as a first step towards complete government control - as in fact it turned out to be (4).

The introduction of the "Comprehensive Health Service" was another practical co-operative step. Each hospital was to be responsible for providing and co-ordinating health care in a defined district round it. All clinics within a district, whether government, tribal, or private, would form an integrated service with the hospital though retaining their independent administrations. Hospitals and clinics would provide curative, preventative, and rehabilitative care at their appropriate levels - at last formally abolishing the division between curative services (Provincial) and preventative and infectious disease control (State) which has bedevilled South African health care.

Of course there were unresolved problems:

1. The integration of hospitals and clinics was accepted reluctantly by those hospitals which wanted to concentrate on in-patient care.

2. There was insufficient discussion and preparation beforehand, so that clinics and hospitals often had conflicting ideas about their relationships. For instance, some clinic staff resented the imposition of hospital authority, which seems unjustified because it was not explained. This would seriously hinder co-operation.

3. The Department of Health and hospitals could and in some cases did disagree about the scope

of the new service. Was it to stop at creating a network of clinics and hospitals, or to extend into community organisation and involvement? Were, for example, resettlement schemes a preventable cause of ill-health to be opposed from the start, or did concern for health only begin after resettlement had taken place?

The debate on these and other issues was hampered by the arrangement which made the Department of Bantu Administration responsible for policy and funding, and the Department of Health only their agent. However, there did seem to be a mutually beneficial framework within which the Department of Health and the hospitals could share what each had to offer. Unfortunately the opportunity for voluntary co-operation was lost almost as it began: the government decided that all mission hospitals in homelands should be taken over by the South African department of Health and in due course be handed over to the newly-created homeland health departments.

ACHIEVEMENTS AND FAILURES.

What, could one say, have been the main contributions of the mission hospitals to health care in South Africa?

1. They provided the only health care available to the enormous number of people living in rural areas of the homelands. Even after the government take-over, the quality of care in an area depends on what had been achieved by the mission rather than on present government initiatives.

2. They pioneered the idea of a comprehensive service with preventative and curative care being provided by the same staff from the same building.

3. They showed the effectiveness of community

> care practiced by a clinician and springing from his concern for his patients.

The first two contributions have been taken over by the government - in itself a tribute to their success. The third still depends on the individual doctor and for many reasons is likely to become more important.

On the other hand, an important failure of the mission hospitals had been their inability to attract sufficient South African Doctors. I can only comment on this as I have seen it in KwaZulu in recent years, but it is important as it seems probable that fewer overseas doctors will choose to come to the South African homelands in future.

The number of doctors with a specially religious mission motivation has always been small. Most of the doctors have come for generally humanitarian reasons, and to experience a different health system and way of life. More overseas doctors than South Africans return after visiting a homeland as a student - often expressing a feeling that they owe something to the people for what they learnt, and want a chance to repay it. Overseas doctors have seemed less concerned for their immediate career prospects, and more prepared simply to serve people without worrying how this will affect their own future. South African students do sometimes give the impression that they are interested in the homeland hospitals for the possible benefits to themselves, without fully appreciating the opportunity of serving other people (5).

Having said this I must add that these are generalisations, and that many South African doctors have served long and unselfishly in mission hospitals.

THE FUTURE:

It is not pleasant to be taken over by the government from the church, and looking back I

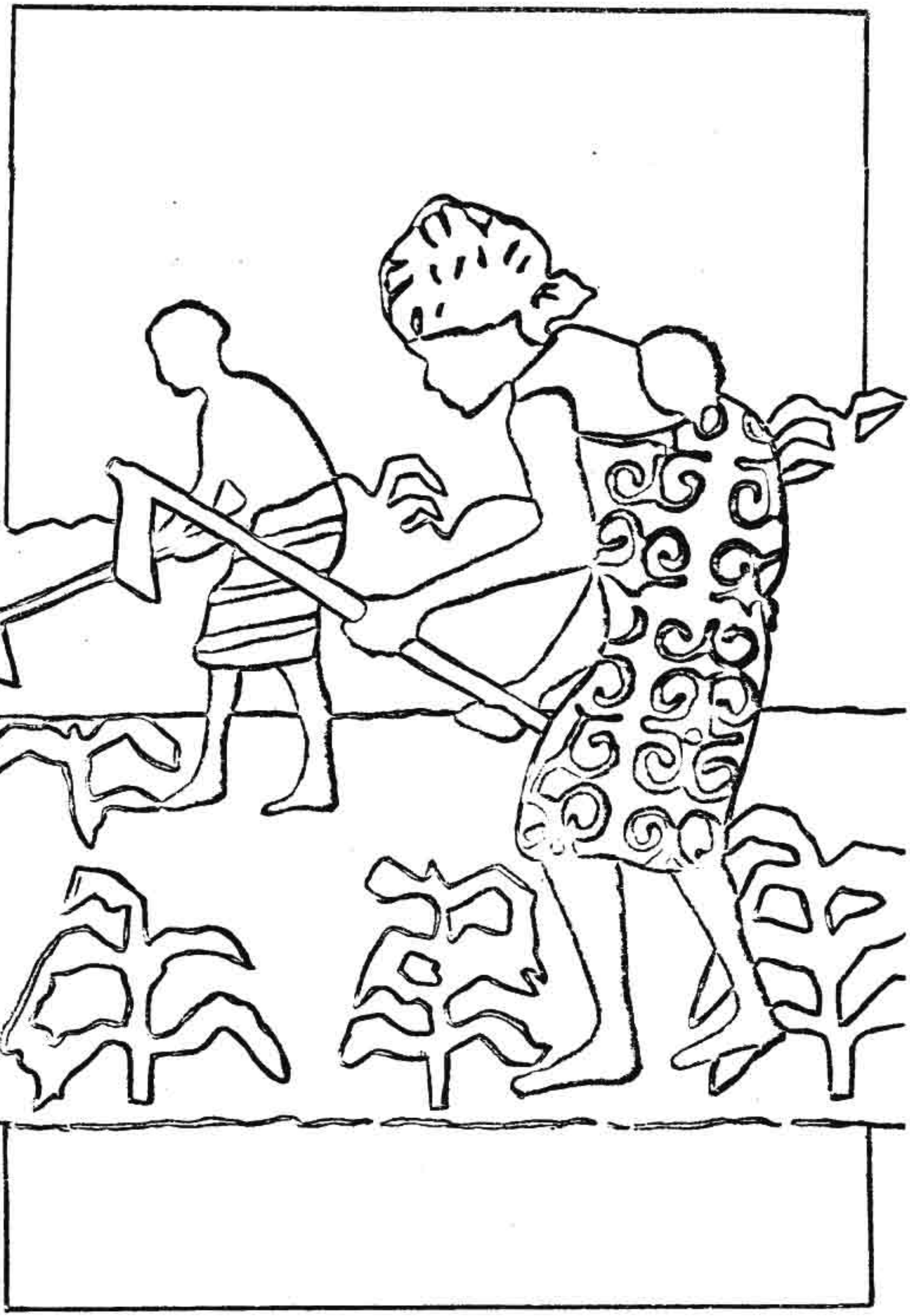
cannot say it has improved health care in KwaZulu. This is a problem of the past, and should not concern doctors now considering working in the homelands.

I believe it is right that doctors should work in the homelands (at least the non-independent ones) at present, and that they should be South Africans - preferably with some postgraduate experience but not with specialised training or qualifications. A few such doctors, coming for only a few years, could have a significant effect. They will need three broad approaches to their work - to support government policy where it is beneficial, to activate government policies which are potentially beneficial but in practice not applied, and to oppose policies which are obviously harmful.

Put like this it may sound as though medical care is secondary - but it is precisely in clinical medicine, with constant feed-back on how policies and actions are affecting individuals, families, and communities, that broader approaches are possible.

Rural KwaZulu, for example, has one doctor for between ten and one hundred-thousand people, depending on the district. Delegation and decentralisation are vital to serving as many people as possible, but nursing staff are often hesitant to take on extra responsibilities even though this is official policy. It will take tact and patience and understanding to change this, but the more a doctor can train other staff for health education, treatment of minor ailments, routines such as ante-natal care, the more time he will have for more serious problems. A doctor's presence is essential if this training is to proceed smoothly and if nursing staff are to have confidence in their new roles

Paradoxically it is easiest to delegate when the need is least - that is, two or three doctors can together plan and run a training scheme which one alone could not manage. There are more hospitals



with one overworked doctor needing help than there are hospitals with no doctor at all.

Some government policies are so contradictory that it is easiest from an official point of view to ignore them. An example is the South African Department of Health's recent discovery of the importance of community involvement in health. This is a hopeful sign of change, but in practice is likely to cut too sharply across other policies such as migrant labour and resettlement to stand much chance of being vigorously implemented. District doctors can use the policy to justify involving themselves with communities though, and can put pressure on officials at higher levels to follow through the implications.

Many young doctors and students are now interested in community medicine, without wanting to cut themselves off from clinical medicine. Herein lies the great opportunity of the homelands, that successful community work springs most directly and effectively from a clinician's concern for his patients. Experiencing a measles epidemic leads to organising mass vaccination campaigns; typhoid and gastro-enteritis show the need to improve water supplies; the inadequacy of seeing several hundred out-patients alone, to training nurses for primary health care. The problems are appallingly obvious, and likely to yield as well to well-informed common -sense and enthusiasm as to specialised knowledge.

Small hospitals have an advantage now, having fewer fixed commitments to maintain, and can more easily experiment with new ideas. For instance a small hospital without clinics might be able to introduce village health workers as an alternative.

A homeland doctor sees the problems of resettlement and migrant labour as it affects patients and friends, and is in a privileged position to have some small influence on them. He is to a large extent irreplaceable, has the immunity of an official position, and has access to others who

can bring influence to bear. The confusion of policy often allows for fairly wide freedom of action.

Medical work in the homelands is no longer so separate from the rest of South Africa. It is easier materially to work there: salaries are equivalent to those in Provincial hospitals, and it is possible to transfer to a homeland and back again without losing benefits.

Secondment from military service now allows doctors who might not otherwise consider it to work in a homeland. The present system is inefficient (from everyone's point of view), being a by-product of military service rather than true national service. It is hindered by uncertainty about the length of postings, and often by short spells in several places rather than a longer period in one place. However for most doctors military service is now a fact of life, and if it must be done it is certainly more constructive to spend the time in a homeland than anywhere else. Its main benefit though will be those few doctors who like what they find, and return after completing their service.

The question which seems most to concern doctors actually thinking of the homelands is, "Will I be adequate for the demands made on me?". It is a valid question, and indeed the right one. A doctor who does not ask it is unlikely to be flexible enough to recognise the whole range of needs which exist.

The answer is certainly, "No". No one doctor, indeed no number of doctors as such, is or will be adequate for all the needs. On the other hand, there are more doctors needing help than hospitals without a doctor at all, and no one need fear being too far from clinical support. But it takes time to learn one's true inadequacies and one's inability to change deep-rooted social problems single-handed; it takes longer to learn that what people want, and need, is not heroic

measures and desperate operations, but care for themselves and their communities, expressed by individuals simply doing their best, whatever that may be.

NOTES:

When reading this article, we found it important to read it critically.

1. When and where were these Mission Hospitals set up? and what was their purpose? This should be obvious but is it? If the mission hospitals intended as a primary aim to care for the health of the people, then why was the siting dependant on where the school and church were, and not on the needs of the people?

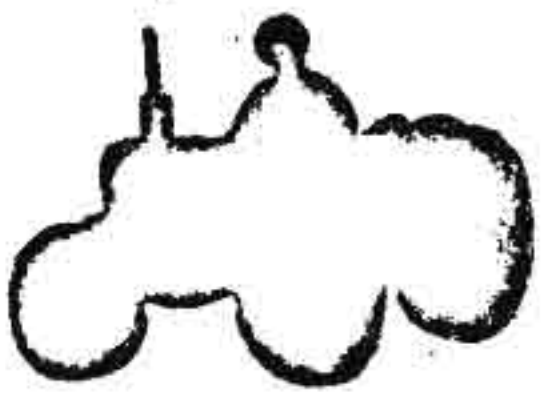
2. Why did direct community involvement start later? Is this related to the concept that health is something which is given to people by doctors?

3. Why is there a dilemma between providing a "good" service for a few, and some service for many? Should one not have in mind a "good" service for all?

4. Why did the government take over the mission hospitals? The answer is: so that they could control the mission hospitals, and doctors. Why was this control necessary? Did they see Mission Hospitals as a threat? Did tney want to prevent any political involvement of doctors?

5. A doctor's attitude depends on many things - his background, his training and education. Aren't most (if not all) the doctors trained in South Africa middle and upper class people from urban areas?

Finally, one should always keep in mind the difference between health and medical care, and even more important is to remember the causes of ill health in the "homelands"



ACKNOWLEDGEMENTS

Ideas and Action

Basics

South African Labour Bulletin

Students' African Movement