Critical Health

Number 35 November 1991

Luqubo Yezempilo u Hulumeni afanele ayinikeze kuZwelonke

Inkgubo ka Hulumente Yezimpilo kwizwe Lonke

Nazionale Gesondheidsdiens

National Health Service

Tirelo ya Maphelo a Setshaba ya Mmuso

Tshebeltso ya Bophelo ya Setjhaba ya Mmuso

Tirelo ya Boitekanelo ya Bosetshaba ya Mmuso

Contents

Typesetting by *Critical Health*

Thanks to the Citizen for the photograph. Thanks to UDUSA for the use of their computer. Thanks to Ant Philbrick for doing the graphics for the section breaks and Max Price's article. Thanks to Aphrophone for the translations.

Critical Health is published by an editorial collective. P.O. Box 16250, Doornfontein, 2028. Tel: (011) 484 3078

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Editorial

It is over a year and a half since progressive health and welfare workers met in Maputo to discuss this crucial period of transition in South Africa. At the Maputo Conference, there was general agreement around the need for a comprehensive national health service (NHS) as the means of attaining a better and more equitable standard of health care. The conference recognised the number of obstacles we need to overcome and began to debate realistic goals and how to achieve them. We left the conference realising the amount of work still necessary in this area.

This edition of *Critical Health* attempts to take the debates forward by looking at the issues involved in this transformation.

We begin by looking at the way the state and various political parties see the way forward. In the first article, *Critical Health* interviews Coen Slabber, Director General of the Department of National Health and Population Development. In this interview he clearly acknowledges the department's past mistakes and indicates an intention to move towards a single department of health as opposed to current divisions along racial lines. He maintains that the state is shifting its focus onto primary health care in rural and squatter areas.

Critical Health comments on the interview suggesting that the image projected by the state hides the reality of its attempts to diminish its responsibility for health care. It is doing this in the face of deteriorating health status as evidenced by increasing infant mortality rates, incidence of TB and deaths from malnutrition.

In the next article *Critical Health* approaches various political parties to assess their views on the future health care system. The nature of these replies varies, leaving the impression that much work is still to be done in this area. Very few have clearly thought out programmes of action that go beyond rhetoric and criticism of the current system.

It cannot be taken for granted that health workers and patients automatically favour moves towards an NHS. Historically, in South Africa, the public sector has been racially based, and has provided a poor quality of service and poor working conditions in comparison to the private sector. This has left a legacy of negative perceptions of state services and the impression that an NHS will perpetuate a cumbersome bureaucracy with long queues, irritable health workers and poor salaries.

Recognising that a move towards an NHS will also involve the need to win support for it, *Critical Health*, in the final article in this section, looks at people's expectations of the health care system.

The next section looks at issues relating to the financing and control of health services. Max Price's article addresses the confusion around terms such as privatisation and nationalisation. He points out that the role of the private and public sectors must be defined in each of the areas of financing, ownership and control. These areas, he argues, are in effect distinct from one another. It is necessary, therefore, to develop particular strategies in each of these areas.

The Centre For Health Policy argues that national health insurance (NHI) is the best method of financing an equitable health service.

It is interesting that both the CHP and the government (see the interview with Coen Slabber) motivate for NHI. It is clear, however, that the restructuring towards a comprehensive, progressive health service involves more than its financing. The issue of community control and democracy is central to the agenda of the progressive movement in South Africa. But is it possible to have community participation in health? *Critical Health* reports on the development of a democratic health committee in the squatter community of Tamboville. This represents a practical attempt at answering this question.

The next three articles look at primary health care (PHC) and the role of personnel in an NHS. Drawing on the experience of the Alexandra Health Centre, the first article by Grant Rex looks at a number of issues relating to the development of PHC services. Amongst other things, Rex's article motivates for a strong emphasis to be placed on the role of PHC nurses in the provision of PHC. Helen Rees, however, questions the assumption that PHC nurses should replace general practitioners in the provision of PHC. She maintains a lot more research is needed in this area before policy decisions can be made.

A second contribution by Grant Rex emphasises that occupational health services will have to be an important component of primary health care in an NHS. In Critical Health No.33 an article motivated for management to bear the full responsibility of occupational health services. Rex maintains that this will leave workers in smaller businesses without occupational health care. He argues that occupational health services should be the responsibility of the state with capital making a financial contribution.

The first article in the next section, an interview with Professor Milton Roemer, provides a valuable international perspective on some of the pressing questions facing South Africans in the restructuring of the health services. Roemer supports NHI, and argues for a strengthening of the public health care sector as a method of dealing with the private health sector. He also raises issues around drug lists and personnel.

Rachel Jewkes and Anthony Zwi focus specifically on the British NHS. They

describe its structure and functioning as well as the changes made to the NHS during the Thatcher era. It is interesting to note that the NHS survived this era. This is in part a reflection of popularity of the NHS amongst the British public as well as the fact that the NHS has the support of many of the nurses and doctors who work in it. This indicates that the international move away from state socialism does not imply a rejection of the NHS model.

Nevertheless, Jewkes, Zwi and Lesley Doyal point out that the British NHS has shortcomings of its own. Doyal argues that the British NHS still perpetuates fundamental inequalities. A rigid, male dominated hierarchy persists, as does discrimination of the working class, of women in general and of minority race groups.

Health and welfare services are closely related and cannot be planned in isolation from each other. For this reason, the editorial collective of *Critical Health* felt that we needed to cover the debates on restructuring in both the health and welfare sectors. However, at least two editions were necessary to adequately deal with the issues. This edition on health will be followed by an edition on welfare early next year.

SECTION a

Strategies and expectations: the government, political parties and the people

In South Africa, we have entered a crucial period of transition in which we can genuinely transform the nature of our society. Restructuring the health services forms a critical part of this transformation. A National Health Service has become a potential reality. In this section the state's current strategy, as well as, the vision of a number of political parties are documented. We also examine some of the prevailing attitudes and expectations of both users and providers with regard to health care.

The Winds of Change? an Interview with Dr. Coen Slabber.

by Critical Health

It is important to understand current state thinking with regard to health in order to be able to discuss the potential for moving toward an NHS. Critical Health spoke to Dr. C.F. Slabber, Director-general of the Department of National Health and Population Development, to get his views on the role of the department in delivering health care as well as his ideas on a future health care system in South Africa. The following are edited extracts from the interview.

Critical Health (CH): What are the department's priorities in terms of providing for the health needs of South Africans?

C.F. Slabber (CS): The major priority for the department is the expansion of our primary health care services. It's essential that in each community there must be primary health care services. The areas that we are concentrating on are the squatter areas and the deep rural areas because that's where we find our major problems.

CH: In what way would you see yourself as providing those services?

CS: Within the department we've got a project specifically for squatter areas. Last week I visited the project that we've just erected in Khayelitsha. It will be run by the Regional Services Council but we've supplied the funds for the clinic and we subsidise it. To that must be added the Independent Development Trust (IDT) of Jan Steyn. The IDT will supply funds for capital for building. We supply funds for running that building, the equipment, the staff, medicines and so on. The third one: the State President in his budget speech in parliament announced a project where money from the selling off of the strategic reserves will be made available. We've applied for 180 clinics specifically in deprived areas.

Dr. Coen Slabber: the department's priority is to expand primary health care services for all. Picture courtesy of The Citizen.

CH: Would you say that by building these 180 clinics you've started to tackle the problem or more or less covered the backlog in need for clinics?

CS: I cannot see that 180 clinics will cover the backlog, especially with rapid urbanisation. It's a start, it's most definitely not the final answer.

CH: This particular fund is a three year fund. What do you see happening after three years?

CS: I think it we can succeed with these programmes of PHC we can convince the professions and the politicians that this is the way to go, and I foresee that more funds will be made available. What we're trying to do here is get a kick-start, and then, once it is accepted by everybody, funding will be much easier.

CH: What do you see as the major obstacles in developing the health care system in South Africa?

CS: I would say rapid urbanisation with, in many cases, inadequate basic services, things like clean water, sanitation, waste removal, housing. I think the second

problem is that within the professions there is a certain resistance to PHC. The doctors are threatened because nurses do some of the things that they feel should be done by doctors. The nurses are threatened by community health workers. So the attitude of professions must be changed. That takes time. And the third obstacle: we need funds, especially for running these clinics.

CH: In an input you gave this year at a PHC conference you talked of the importance of inter-sectoral collaboration. Could you expand on that a bit?
CS: Yes. What I said there is that, if a department like the department of housing or, for example, the Urban Foundation develops a new housing project, there should be very close collaboration with our department so that we can provide the necessary services. The other department that's very important is agriculture, producing the correct food that is necessary.

CH: If you see the importance of intersectoral collaboration, what would be your response to, for instance, the TPA cutting off electricity supplies to townships or Conservative Party local authorities cutting off water supplies, given that we presumably accept that doing those things can create a health hazard?
CS: It's not a straight forward answer. Where must they get funds to supply those services if people don't pay for those services? Even if you look at health care, it's accepted by the World Bank, it's accepted by WHO, people must pay for curative services. If people don't pay for services it becomes very difficult to render those services.

CH: As a health department, have you in any way discussed these issues with the TPA or Conservative Party local authorities to stress to them that the way they are approaching these things could actually affect the health of those communities?
CS: In every case where electricity or water is cut off we, as a department, will go and inspect the health hazards and help the community there to overcome those health hazards as far as possible. So, certainly, in every case we go to see what the health hazards are and are educating the community to try to see to it that no serious problems develop.

CH: What would be your feeling on the bread subsidy and price control of bread?
CS: I think the bread subsidy is an inefficient way of doing it because we are also subsidised and we don't need that subsidy. Yes I'm in favour of helping people who really need help but subsidising everybody across the board, I think, is a bad way of doing it. What the government has decided is that a fund will be made available for nutritional help to people who really need it.

CH: Have you been part of those processes, part of the consultation when the bread price subsidy was cut back and when price control on bread was abolished? Have you been part of the process of discussing this fund?
CS: Yes.

CH: What have your inputs been?
CS: Our input has been that we accept the rationale for cutting the subsidy on bread but we feel very strongly that nutritional problems is one of the major health problems in South Africa and for the needy there must be an alternative.

CH: Do you think the fund is big enough and that the money will be channelled to the correct areas?
CS: I don't think it has been decided exactly what the fund will be. With VAT coming in, it must be in place by October. Whether it will reach the targeted areas, that's always very difficult because the targeted areas are usually those that are to a certain extent inaccessible, but we're going to try our utmost to reach all the needy. And we will not be able to do it as a department but we're going to get the help of welfare organisations and local authorities.

CH: Would you not have thought it more reasonable if this money targeting the poor was established and if there was an analysis of whether the money was being spent effectively before the bread subsidy got cut?
CS: Well, the bread subsidy was just not affordable any more. You must remember we are still living in a period of sanctions and the economic growth of South Africa is inadequate.

CH: What has been your response to the imposition of VAT on basic foodstuffs as well as on medical services?
CS: Let's look at it the other way round. For the success of value added tax it is important that there should be as few exceptions as possible. It's better to use the income of your taxes to alleviate definite needs than to use your tax structure to address the problems.

CH: Would you as a department have gone along with the idea that basic food stuffs and medical services should be charged VAT?
CS: As long as part of the additional income is made available for addressing the needy.

CH: In a document from your department, namely the "1990 health trends in South Africa", it is reported that the infant mortality rate, the rate of notification of TB

and deaths from malnutrition are all increasing. Can you comment on whether you feel that what you've said so far will start to address those problems?

CS: If the economic situation deteriorates, if unemployment increases, you'll always get an increase in malnutrition, tuberculosis and so on. So those factors are, we feel, more an indication of the present economic situation of South Africa. If we don't improve the economy I think it will be very difficult for the health services to improve the health status of our people because everything is interlinked; the economy, your income, your education and health status.

CH: There was a boom in the South African economy between 1986 and 1989, yet the health figures in 1986 were better than the figures in 1989. If the figures for infant mortality, malnutrition and TB notifications were getting worse in a period when the South African economy was actually growing what do you foresee happening now that we're back into a recession?

CS: The Gross National Product (GNP) per capita is the most important indicator. There's been no growth in GNP per capita even since 1986, because the GNP grew but its always been lower than the population growth. The second thing is, if I remember correctly, 1986 was more or less the end of influx control and since then we've had this massive urbanisation that caught the health services totally unaware.

CH: Would you agree, therefore, that in periods of recession these figures would actually be accentuated?

CS: Certain figures must be accentuated in periods of recession because malnutrition and infectious diseases are more common and the impact of these infectious diseases is more serious.

CH: So would you say that with the increasing incidence of infectious diseases there's an increasing need for health services?

CS: But then again, as I said, nutrition does not strictly fall within the ambit of the health department but nutrition is a very important aspect of good health and we must address the nutritional problems of our people.

CH: Would you say that the health department is actually pushing strongly enough at central government's door for enough funds?

CS: At present the health budget of South Africa is a bit more than 11% of total government expenditure. If you compare that with other countries, 11% is a very high percentage in respect of health care services and it is unlikely that the government will spend much more. If we can increase the total budget then of course 11% will become more than it is at present.

CH: Has that total amount increased or decreased in real terms?
CS: It's up and down. In the last year the total amount has decreased in real terms. Of course, it's a problem if there's no real increase in health funds. But the increase in the health budget is more than the increase in the total budget of the government.

CH: There are a large number of different departments of health in South Africa. Do you envisage a unified health care system being provided in this country?
CS: The State President has made it quite clear that there'll be one central national health department and, of course, regional and local authorities. The question is what will be included in the new South Africa, and that is part of the constitutional negotiations. For instance, will Transkei be part of the new South Africa? That I cannot tell you.

CH: What is happening with the own affairs health departments?
CS: The own affairs health departments are written into the present constitution. It's the constitution until we've negotiated a new constitution, but if you look at the own affairs health departments, they run no hospitals. All three own affairs departments have decided that local authorities will do their PHC services. So it's a small set up that they've got.

CH: The House of Representatives actually wants to dissolve.
CS: It was discussed in parliament where the house asked for abolition of its departments. The State President said that legally its not possible.

CH: What is the department's policy on racial discrimination and racial inequality?
CS: The department and the minister are quite adamant that there should be no racial discrimination. We've got five principles on which we feel a health care service must be built, and equity is one of them. We feel very strongly that there should be no racial differences.

CH: In a large number of hospitals, wards are still kept entirely separate. What is the department's attitude to the segregation of wards?
CS: I think the Minister has made it quite clear that all hospitals are open to all people. Segregation of wards according to health needs, say segregating surgery from medicine, that's fine, but segregating purely on race is not acceptable. Separating people, if they so wish, on a cultural basis, is fine, for example, Moslems because of their eating habits.

Segregation has to be removed, as well as, ensuring that resources are distributed more equitably. Photo: Suzy Bernstein

CH: There's quite a lot of resistance to desegregation from within the hospitals. What is one's response to that resistance?

CS: Well I think the department accepts that there will be resistance. On the other hand you know we've got overcrowding of black hospitals, we've got empty beds in white hospitals, there's no way that we can build new hospitals with all those empty beds in the white hospitals so we must get all the beds made available to all the people.

CH: What is the government's attitude with regard to the privatisation of health services?

CS: The whole concept of privatisation in the broad sense is not a bad one. When it comes to health services it is, of course, more problematic, it's more emotional. What we must get clarity on as soon as possible is how we are going to finance our health care in future. Are we going to use a private system or a mixed system as we have at present? Are we going to go for a national health system as they have in Britain, or for national insurance? The department feels that a national health insurance scheme is the best model to develop. Privatisation and the future financing of health care go together, and I don't think you'll see any privatisation of health care services before that is sorted out.

CH: What are the range of things that you are privatising?

CS: The things that are being looked at are especially catering services because you can lose a lot of money if it's not done very well. Laundry services and gardening

services can be done privately, as can cleaning services. As long as it's cheaper and as efficient.

CH: Have you done studies into whether it is as efficient? Quite a lot of empirical research has been done in other countries showing that private contractors have done a poorer job then the previous hospital staff.

CS: The provinces have done the studies and they're quite satisfied that they are more cost effective and more efficient.

CH: Are there any studies available?

CS: You'd have to ask them but they've done their studies.

CH: In terms of poorer patients, hospital tariffs over the last fifteen years have escalated quite dramatically. The amount that hospitals recover from tariffs is actually a very small percentage of the total hospital costs. If increasing those tariffs results in a diabetic going into coma, for example, is that a cost effective way of looking at the financial set up?

CS: I think the principle is quite clear that people must pay for their hospital care, but you cannot withhold hospital care because he hasn't got the funds. If he hasn't got the funds he'll still receive hospital care and he'll still receive his medication in a hospital.

CH: What if a clerk at administration actually demands the funds to the point where the patient turns away from the hospital?

CS: Any patient can go to the superintendent immediately if he's not satisfied with what the clerks have done to him. The superintendent must see to it that all patients that need care must be treated.

CH: The cost of medical services have increased roughly at the rate of inflation, whereas the cost of medicines has been well above that. The cost of medical aid contributions has also increased way above inflation. What would be your comments on the status of the private sector and the medical aid sector?

CS: South Africa has got one of the highest claim rates in the world. So its very obvious that the system is being abused to a certain extent. The private sector has to build in disincentives to eliminate overuse of the system. For instance, there must be a co-payment. Medical schemes cannot cover you one-hundred percent. Say it covers 80% of medicines, the other 20% you must pay.

CH: To get back to the question of national insurance, within that framework, what would be the role of the public sector and the private sector?
CS: At present, I think there are about two hundred medical aid schemes. What we foresee is a central fund run by either the government or a consortium of private medical aids or insurance companies. Contributing to that fund will be the government, the employers and the employees. It will be one big fund that can be distributed. That will cover your basic health care services for everybody. That's the Canadian system, everybody is insured.

CH: Within your insurance scheme, what percentage of health care do you think will be provided by the private sector?
CS: The private sector at present is catering for about 21% of the total population. I cannot see that that will increase rapidly. There is an increase in the number of people belonging to medical schemes but, as a percentage of the total population, it's more or less stuck at 21%.

CH: The private sector is using about 45% of resources. In the new national insurance scheme that you are talking of, would more funds be distributed to the public sector?
CS: Oh yes, you must have equitable distribution there. The central fund, the distribution thereof, would be on an equitable basis. For instance, with exactly the same need you'll get the same amount of money. But there will always be additional spending, the Harry Oppenheimers will always buy additional insurance cover.

CH: Do you envisage that, in this coming period, policy will strengthen the public health sector at the expense of the private sector?
CS: The model that we are going to put on the table is a national health insurance scheme. We know that there are other people who will come with the model of a national health service, there are other people who feel very strongly for the fee for service, so that will have to be discussed. It's not a decision that we want to take unilaterally. We want to get all the role players together and sit round a table.

CH: Are you trying to initiate that consultation?
CS: We are trying to initiate that and from our side we've got no problems. We talk with anybody who is involved in the health care field, whether it's left or right or centre.

CH: To what degree will different parties have a say in final decision making.
CS: We try and involve everybody, we try and get to a consensus decision.

CH: Whilst appreciating the obvious need to direct finances into primary health care, do you think that justified the decision to put a moratorium on building hospitals? There was a hospital planned for New Canada in Soweto and Baragwanath is clearly overcrowded.

CS: The moratorium is for two reasons. One is that we feel that we need the primary health care service urgently, the other is that the moratorium was put on at the same time that the Minister announced that all hospitals are open to all races. Will the people at Baragwanath go to, for instance, Johannesburg Hospital? How can somebody from Soweto get to Johannesburg Hospital? It's the most stupid place where they built that hospital. It's in a rich area but it's for poor patients. But we have to see what the impact was of opening up the hospitals. The moratorium is just to give us time to evaluate the impact, to evaluate the cost of PHC. It's not a permanent one.

CH: And in terms of the private sector, you also put restrictions on whether they can build new hospitals or not. Why have two hospitals, one in Randburg and one in Goodwood, which are overserviced areas, been granted?

CS: Those would be House of Assembly decisions, not our decision.

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A Response to Dr. Coen Slabber

by Critical Health

The following article briefly assesses changes in the approach to health care by the health department and looks at these changes within the context of broader political and economic developments.

We have seen the government move away from the 1980s strategy of reform coupled with brutal repression. It has recently unbanned political organisations, committed

itself to a process of negotiations and started to consult on a wide range of issues with the same progressive structures it openly repressed a few years ago.

These new developments cannot, however, be understood in terms of a change of heart by the government. By the end of the 1980s, it succeeded in temporarily weakening opposition to its rule, but the economic crisis that has gripped this country since the 1970s was getting more severe. The government began to feel that it has the political strength to shape future developments in a particular way and, at the same time, win internal and international approval. It also started to see this acceptance as necessary to resolve the economic crisis. (It is important to note that these recent changes have taken place within the context of increasing levels of violence, even though the government no longer overtly supports repression.)

This new political strategy is clearly reflected in the different state departments and the health department is no exception. It is more accessible than before and it is more open about the mistakes it has made in the past. The department recognises that the standard of health of the poor in South Africa is getting worse and it admits that health services in existence today are both inappropriate and inadequate. It is now talking of a single central national health department and suggesting a national health insurance for this country. It is expressing the need to consult with all structures in the health sphere before reaching a decision as to future health policy. The department is, in fact, trying to distance itself from its past mistakes, as if it is a different health department in a "new South Africa".

Despite this, the department continues to slavishly adhere to the government approach to the economic crisis, instead of taking adequate steps to overcome the problems it has identified. This approach, as it relates to health, is as follows: it is an absolute priority that the economy must grow at a faster rate then the population. This will lead to more jobs and a better standard of living, which, in turn, will lead to an improved health status in South Africa. It will also allow for a larger budget and more money to be spent on health services. In order to achieve the required economic growth, the role of the private sector must increase and that of the state must decrease. State health services must, therefore, suffer in the short term.

There are a number of flaws to this argument. First, a decrease in the role of the state has not been shown to be necessary for rapid economic growth. Secondly, it is far from guaranteed that an adequate growth rate will be achieved with current economic policies and, thirdly, a growing capitalist economy does not necessarily lead to an improved standard of living for the poor. In short, the top officials in the health department are merely ensuring that government economic policy is being carried out, without any guarantee that this will lead to an improvement in health standards. They are showing a lack of concern about the immediate effects of this policy on health and health services.

The total health budget decreased in real terms last year in the face of a rising infant mortality rate, an increasing incidence if TB, and a growing number of deaths from malnutrition. The department has committed itself to primary health care, but it does not have the money to build clinics and, as a result, it is forced to rely on ad hoc sources of funding for new clinics. It also uses progressive concepts, such as primary health care and community participation, to shift its financial responsibilities on to individuals, communities and welfare organisations.

The department has repeatedly stressed the relationship between health and nutrition, as well as that between health and basic services. It has spoken often about intersectoral collaboration. Within this context, it could reasonably be expected that the department would point out the negative aspects arising out of the activities and proposed policies of other departments.

Here again, the health department has assigned more importance to economic motivations than effects on health. In relation to the cutting off of electricity and water supplies in the townships, it has argued that the people cannot expect services if they do not pay for them. The department has been a willing partner in the decision to terminate the bread subsidy and abolish the price control of bread. It has agreed to the imposition of VAT on basic foodstuffs and medical services without having ensured that the poor will be adequately compensated for the increased prices they will be forced to pay.

In summary, the department is trying to shed its history and portray itself as a new department. This is in keeping with the general political developments in the state. It is also, however, pursuing policies which are directly in line with the economic perspective of central government. These policies are having a negative impact on health, which is already suffering under the impact of the economic crisis.

Political parties and a national health service

by Critical Health

Six major political parties were approached by Critical Health for details of their health policies. Of the six, only the Conservative Party had adopted a policy in final form. The Democratic Party (DP), the Inkatha Freedom Party (IFP), and the South African Communist Party (SACP) supplied us with draft health policy documents. The Pan Africanist Congress's (PAC) draft national health policy was not available for us to have a look at. From the African National Congress (ANC) we received a national health policy discussion document prepared for their July conference, as well as, health policy documents from their PWV and Border regions.
What follows is a brief survey of party policies on the issue of an NHS. An edited version of one of the documents, the proposals on health policy of the Border region of the ANC, has been selected from the documents received, for publication. The Border health policy discussion was one of the more interesting and original health policy documents received by us. It was chosen not only because of this, but also because it has emerged from a process of in depth consultation in the Border region.

African National Congress: the ANC's national health policy discussion document states that health is a basic human right and that the right to "free essential health care" should be entrenched in the constitution. The government should be responsible for making the funds available to ensure that essential health care is available to all South Africans. Funds for the financing of health care should be raised through taxation. There should be a preferential allocation of resources to promote health care within the most vulnerable sectors of the community. It is accepted that a large private sector will continue to exist in a future mixed economy. Nevertheless most health care must be provided by the public sector, which the document states, needs to be strengthened, improved, and made accountable to the community (an edited version of the draft health policy of the ANC's Border region is reproduced below).

Conservative Party: Official CP policy envisages " the necessary emphasis being placed on preventive and decentralised community health services" whilst "avoiding the total socialisation of these services".

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Democratic Party: the DP's draft health policy asks the question " does South Africa need a privatised health care system or a National Health System"? A final health policy document is the process of being drawn up.

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Inkatha Freedom Party: the IFP's draft health policy document makes no direct reference to the creation of a national health service, or for that matter, to the role of the private sector. The document states: " the IFP recognises the crucial need for the future government to provide health care facilities for all South Africans". Furthermore, "in an attempt to maintain the essential health care services needed in this country in the face of limited funding, these services must be directed into activities deemed more appropriate to the needs of the majority, rather than a rigid adherence to standards dictated by the First World".

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Pan Africanist Congress: a spokesperson for the PAC said that the PAC regarded the present health care system as a colonial one which serves the interests of whites while neglecting those of blacks. The PAC is in the process of formulating an official health policy. The spokesperson said that the PAC was looking into the possibility of developing a democratic community based health care system which was decentralised and de-bureaucratised.

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South African Communist Party: its draft health policy states that the existing health care system in South Africa has its roots in capitalism and colonialism. The document states that these "foundation stones" need to be broken otherwise health care in South Africa "could remain the same forever". The document goes on to state that health care is a basic human right, that health care provision is the responsibility of the state, and that health care must be free, that is, no fee-for-service.

ANC Border Region Health Commission: Draft Health Policy - 18/05/91

The Border Health Commission was formed in November 1990 by the Border Regional Executive of the ANC in order to draw up a draft health policy. The Commission consists of individuals and not representatives of organisations and is free to co-opt people with expertise in the health field. In April a regional health workshop was held. Those invited included; all ANC branches in the Border region, the National Medical and Dental Association (Namda), Industrial Health and Safety Education Project (ISHEP), Progressive Primary Health Care Network (PPHCN), the National Education, Health and Allied Workers Union (Nehawu), medical superintendents of all hospitals in the Border region, and interested individuals who were not necessarily ANC members. Some 60 delegates took part.

The commission felt that the general principles of ANC health policy in the booklet, "Towards developing a health policy", were acceptable and needed little further discussion. It was therefore felt that the commission should focus on specific aspects of health policy in more detail. The following topics were chosen:

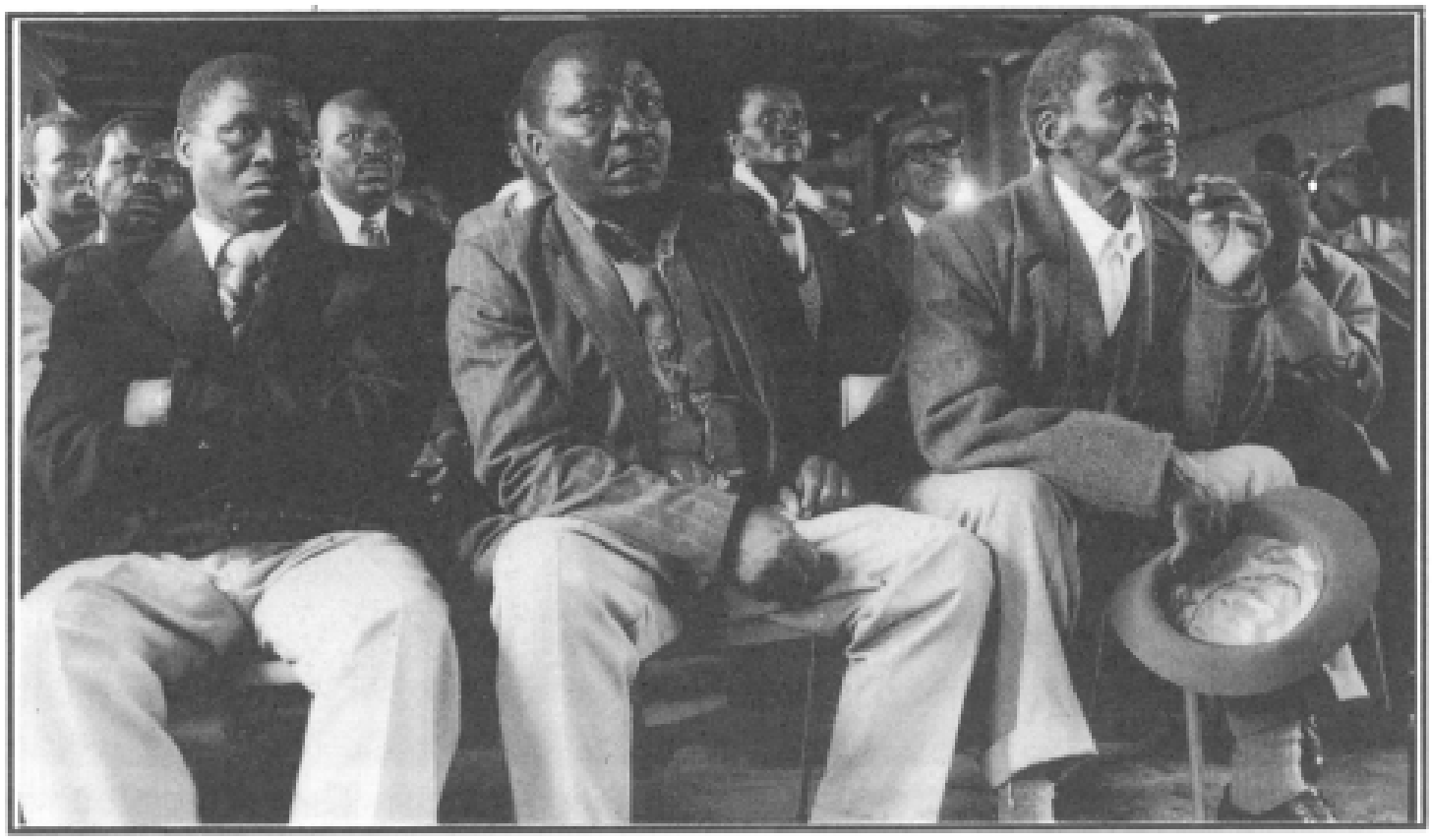
1. Structure and function of the National Health Service.
2. The future position of private health care.
3. The nature of the ideal primary care unit.
4. The role of traditional healers.
5. Training of health workers.

1. The National Health Service: Structure and Function

A national health service (NHS) is needed and must be accessible, affordable, and accountable to the community.

Organisational structure

The NHS should consist of a number of organisational levels, including national, regional, district, and primary care (a detailed outline setting out the structure and



The NHS management structures must facilitate accountability to the communities it serves. Photo: Cedric Nunn

functions of national, regional and district health authorities, regional and district hospitals, and community health centres is provided in the original document).

The pyramid shaped health service structure as exemplified by the present arrangement in the Ciskei area was seen as the best structure for the hospital service. This involves regional hospitals supervising a larger number of smaller district hospitals. There would be a free flow of patients, staff, teaching and expertise between the different levels of service.

Community accountability

Participatory democracy involves the participation of health workers and the community in decisions which affect them. The structure and management of the health service should be decentralised to allow for direct accountability to the community being served.

Each level of health authority will be directed by a management committee constituted in such a way as to form the basis for accountability to the community. Such committees must meet regularly and their meetings must be open to the public whose input should be welcomed.

Local authority health services and environmental health services

The non-personal health services at present dealt with by the health departments of local authorities would stay with these authorities. These include monitoring of water supplies, sewerage disposal and the licensing of business premises, especially food supplying facilities. On the other hand, the personal health services at present with the local authorities would pass to the district health authority. These would include immunisation, antenatal care, TB, sexually transmitted diseases, etc.

Finance

Funding for the NHS should be raised centrally and allocated to regions and thence to districts in proportion to size and health status of the population. Funds would be raised either by tax or by a national health insurance scheme. Their allocation would be by region and by district within each region.

At the primary care level remuneration should be on the basis of a capitation, that is, a fixed amount per patient per year. This would encourage preventive work as a healthy patient demands less medical care. Higher capitation fees for working in remote or otherwise less desirable areas will allow the NHS to promote the service in such areas. The system of payment by a fee for each item of service rendered is not desirable as it tends to lead to doctors providing more treatment than patients actually need.

2. Private Health Care

In accordance with the ANC's policy of a mixed economy the private sector will be allowed to operate but it will be regulated to conform to national standards. General practitioners (GPs) who are doing private work should not be able to work for the NHS. The large number of medical aid schemes should be phased out to leave one central scheme.

3. Nature of the primary care unit

The basic unit of primary care service would eventually be the group practice model as typified by the British NHS. This involves several GPs working together in company with nurses, community health nurses, village health workers, rehabilitation

Traditional healers can play a useful role. The formal health sector should investigate ways and means of utilising their skills. Photo: Medico Health Project

workers, pharmacists, etc. The group practice would be responsible for the health of a fixed number of patients. It would not play a curative role but more a comprehensive one including prevention.

The present primary care comprehensive clinics, for example, those in the Ciskei, would gradually be transformed into the group practice model by increasing the number of doctors serving them and by adding other categories of health care workers. During the transition phase it might well be that several community health centres would be served by a single doctor who acts to support the nursing staff at each centre.

4. Traditional medicine and traditional healers

The NHS should have a positive attitude to the "good" aspects of traditional medicine and incorporate these into the service. The formal health sector should undertake research into the methods and therapies (especially herbal) used by traditional healers as it seems likely that effective and economical remedies would be brought to light. Formal health personnel should be educated to appreciate the nature of traditional medicine.

The problem of registration of traditional healers is a very difficult one. The

profession is not very organised and registration has been problematic in African countries where it has been attempted. It was seen as important that traditional healers should form a professional structure. It is financially impractical to incorporate the roughly 150 000 traditional healers into the NHS or to provide state assistance to patients consulting traditional healers.

5. Health worker training

(a) It was felt that a number of difficulties in health worker training stemmed from problems in the present school education system. These include the present low quality of secondary school education, particularly, in the scientific area.

In addition many children get little or no career guidance at secondary school. As a result the paramedical professions, such as physiotherapy, occupational therapy, and dietics, are not considered by students when they make career choices.

(b) Training will need to be established for a number of newer health worker categories, including village health workers and rehabilitative workers.

(c) The location of training facilities should be structured so as to make training more appropriate and should be community based.

Most health workers are trained in institutions located in areas very different to those where they will eventually practice. If the practical side of training takes place in facilities and communities similar to the communities similar to the eventual working situation of the health worker, the more fully equipped he/she will be to provide appropriate health care.

Training needs to be decentralised. Much of the practical training of medical students should be carried out by the local staff of the health service at all of the following levels: regional, district, and community health. The implication is that at all of these levels there will be a need for teaching staff.

(d) At present medical and nursing curricula particularly, are heavily oriented towards curative care. Training needs to be made more appropriate and emphasise primary health care.

It is necessary to get genuine community representation at a national level where the basic policies for curricula are defined. The same would be true at all subsequent levels, including the medical and nursing faculties at universities.

(e) Training should be problem oriented. This should also mean that a topic or clinical problem is taught in a multidisciplinary way.

(f) The following should be considered in the selection of student health workers:
1. The prospective student's social value system. Health workers need to be concerned for and involved in the welfare of their community.
2. Selection boards should include academics, practitioners at each level of the service, and community representatives.
3. The high cost to parents of medical education effectively limits entry to medical school to the middle class child whose identification with the needs of the masses may be very limited.
4. One suggestion is for a system of state scholarships or bursaries for health care students. The process of allocating these scholarships to suitable candidates will enable the wider community to have a say in who should benefit from expensive training. For example, local community organisations might be asked to approve candidates. A candidate record of community service could play as large a role as academic achievement.

Conclusion

The above submissions are made out of a desire to contribute to the debate on the development of a democratic health service which will deal not only with the problems of sickness and disability but also make a significant contribution to the health and hence the wealth and prosperity of the nation.

Border Regional Health Commission
May 1991

How much support is there for an NHS?

by Critical Health

In this article, an attempt is made to assess what users and providers of health care in South Africa expect from a health service. The article is not exhaustive and it does not deal with the attitudes and feelings of health personnel and patients in a comprehensive way. The intention is merely to highlight the very different expectations that various people may have. This suggests that it can not be assumed that there is overwhelming and unqualified support for an NHS and, when moving toward this goal, it will be necessary to take the range of different views into account.

Introduction

South Africa is a fragmented society. This fragmentation is reflected in the diverse experiences that people have had of the various health services that have been provided. Workers and the unemployed have had different experiences to those of the middle and upper classes. The same can be said of women and men, people of different races and people living in rural and urban areas. This has resulted in a wide range of perceptions of the existing health care system. These views have undoubtedly played an important part in shaping peoples' attitudes towards and expectations of health services.

Most existing services have been provided by the private and public sectors. The private sector includes general practitioners, specialists, chemists and private hospitals. It caters only for those who can afford private care, that is, approximately 20% of the population. It consumes about 45% of the resources spent on health care.

The public sector includes state clinics and hospitals. The remaining 80% of South Africans receive health care from this sector. It only accounts for 55% of the total expenditure on health.

From these figures, it is clear that the public sector spends far less on each individual than the private sector. The public sector, moreover, services the poor and the unemployed, in other words, those parts of the population who are more prone to disease and in greater need of health care.

The state health sector in South Africa has, furthermore, developed along racial

lines. After coming to power in 1948, the National Party developed a reasonably comprehensive public health service for white South Africans for which they had to pay only minimal user charges. The majority of whites have been able to afford private care, but even those whites who have made use of public health services have received a reasonably high level of care.

Inadequacy and dissatisfaction

Black South Africans have, on the other hand, been provided with an inadequate health service. Black patients have suffered as a result of shortages of doctors, nurses, hospitals and hospital beds. They have experienced endless queues, overcrowded hospitals and impersonal care from overworked staff.

This has led to widespread dissatisfaction with the public sector, as well as, an increasing awareness of the excessive privilege enjoyed by a minority which has access to private services. Many black users of the state sector may be hoping that the political changes currently taking place will lead to easier access to private health care.

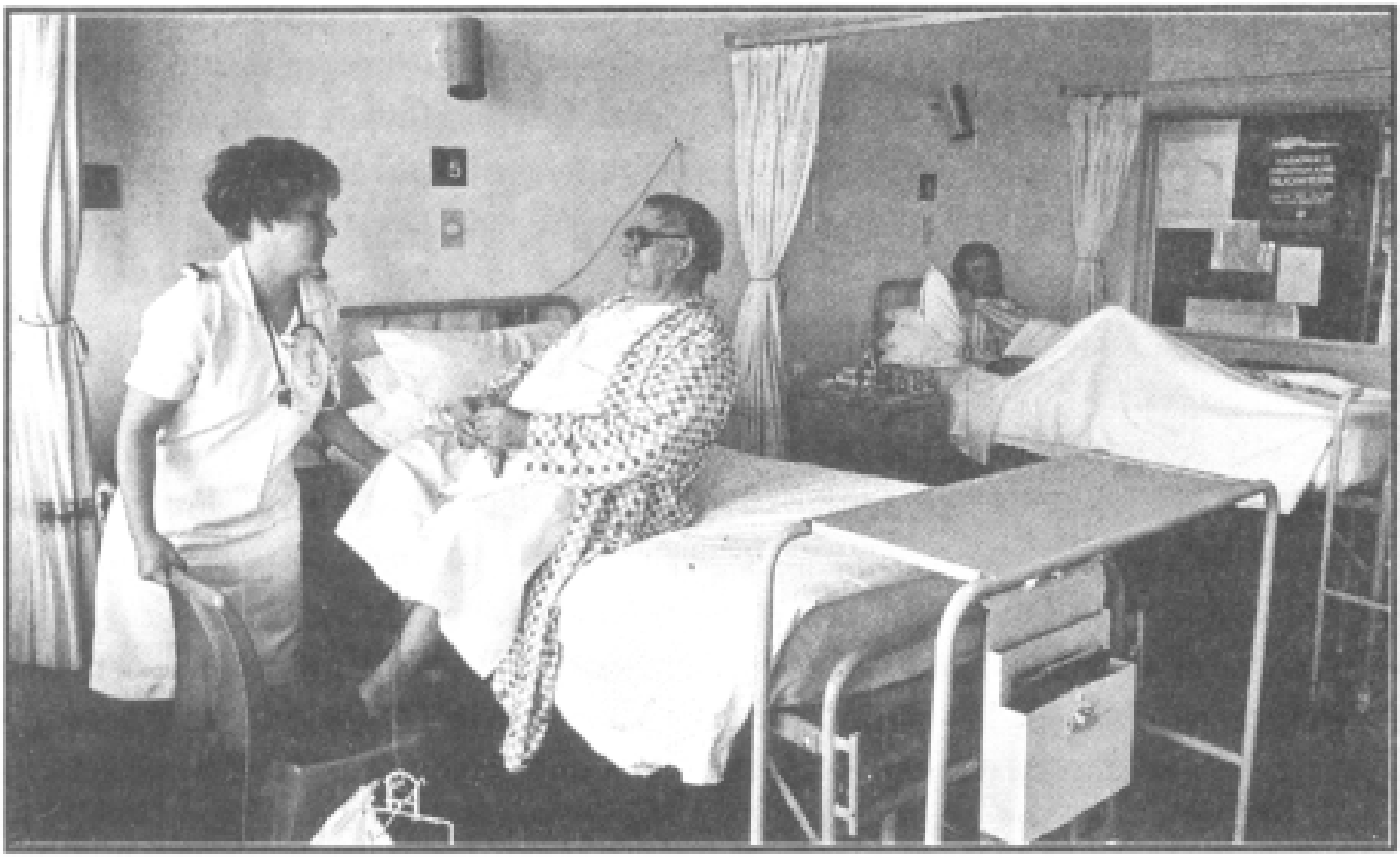
The majority of South Africans are, however, unlikely to be predisposed against state services or in favour of private health services, as the private sector has always been and will continue to be out of their reach.

The new rhetoric of the Department of Health suggests that state health services are improving, but in reality these services are deteriorating. The state is failing to carry out its responsibility in the face of an ever growing number of people who are in need of health care. The state is also forcing people to pay more for public health care. User charges have escalated to the point where some rates are now comparable to those in the private sector.

Limited access to the private sector

The decline in the quality of service in conjunction with the increased costs of public care is putting pressure on potential public sector patients to go to private sector. It is also probably leading to increasing disillusionment with the public sector amongst people of all races, including white users of the public sector.

The majority of white South Africans have a long history of being serviced by the private sector. The emerging black middle class has increasingly turned to the private sector as well. Most users of this sector expect a reasonably high standard of medical treatment provided in a convenient and comfortable way. They can make appointments with their family doctor instead of waiting in queues. They have access to private hospitals with fairly luxurious standards and these hospitals also have a



Users have a vested interest in the private sector and will be against any changes which could limit the role of this sector. Photo: Medico Health Project

comparatively high ratio of medical personnel to patients. The care received in the private sector is also likely to be less impersonal than that in the public sector. These users therefore have a vested interest in the private sector and will be against any changes which limit the role of this sector.

Unions and an NHS

In the last few years, there has been a big increase in the number ofunionised black workers that have joined medical aid schemes. They have thereby gained access to the private sector and, as such, also have a definite interest in this sector. This does not necessarily mean that these workers have an allegiance to the private sector in the long term.

Asked to comment, a spokesperson for the Congress of South African Trade Unions (Cosatu) said that he believed that union members will support a national health system. Unionists acknowledged that participation in medical aid schemes might be interpreted as an endorsement of the privatisation of health services and the federation recognised that it needs to start taking the struggle for health much more seriously.

At its recent national conference, the South African Commercial, Catering and Allied Workers' Union (Saccawu), a Cosatu affiliate, passed a resolution calling for the full nationalisation of health services.

The National Union of Metalworkers (Numsa), another affiliate, has recently withdrawn from the metal and engineering industries' medical aid fund. A Numsa official, Geoff Schreiner, said that, before it became a member of the fund, Numsa fought for it to be restructured. In particular, the union pushed for the fund to become a voluntary scheme because it was aware that workers had diverse views on medical aid membership. He said that workers felt that it was too expensive and, when given the opportunity, most members stopped paying their contributions. Workers were demanding that it is the state's responsibility to ensure that all citizens have access to proper health care.

Crisis in the private sector

We should not assume that the private sector necessarily provides a higher quality of service than the public sector. Racist practices, for example, also exist in the private sector. Poorer patients who cannot afford full rates are often made to wait in segregated waiting rooms and may receive lower standards of treatment.

The entire private sector is, furthermore, in a severe and growing crisis. The cost of private care is increasing well ahead of the inflation rate. Medical aid schemes are responding in a number of different ways. They are increasing their premiums and this is putting the cost of monthly contributions out of the reach of many potential members. The schemes are not necessarily paying out the full cost of medical care. For example, the Medical Association of South Africa recommends that doctors charge a maximum of R55.20 for a consultation, but medical schemes only pay R24.80 per consultation. Patients have to pay the difference between the amount charged and the medical aid rate. Medical schemes are also limiting the types of medical care which they are prepared to cover. In this regard, they are being assisted by the government which is changing laws in ways which will allow schemes more discretion in defining the content of their medical aid packages.

As a result of this crisis, the percentage of people in the country covered by medical aid is no longer increasing. The private sector will thus continue to cater for a small minority. Many of those who do have access to this sector are no doubt becoming increasingly disillusioned with the spiralling cost of private care.

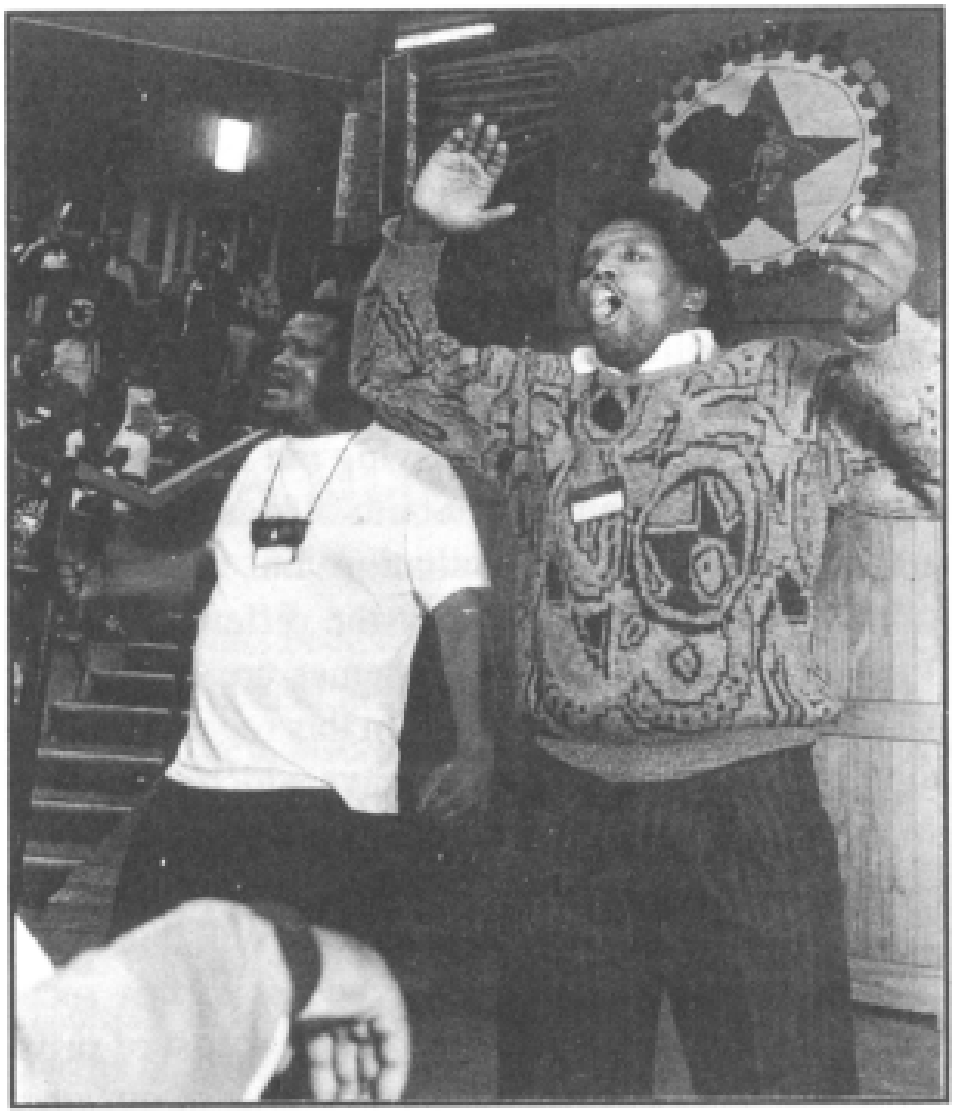
From the above, it is clear that users have a number of different perceptions of the public and private sectors and there will be varied responses to the establishment of an NHS based on a large public sector. Many people currently also have a number

of other attitudes which are not necessarily in keeping with an NHS.

Emphasis on curative care and the fears of doctors...

At present, medical care in both the private and public sectors is primarily curative. There is a reliance on drugs and technology and there is little in the way of holistic, preventative or promotive medicine. Most patients place their faith in pills, injections and curative medicine in general, but, if an NHS is to improve health status, it will need to focus on prevention. Most patients also prefer and many even demand to be treated by doctors and other highly qualified personnel, but an NHS may need to rely on other categories of health workers.

Various health personnel also have widely differing interests and attitudes with regard to health services. The majority of doctors work in private practice and almost all of these doctors oppose an NHS. They see an NHS as a threat to their incomes and their independence. Many doctors may also fear competition from other health workers in an NHS.



Workers' demand that the state take responsibility for the provision of proper health care for ALL the citizens of the country. Photo: cedric Nunn

These attitudes are, by and large, based on the assumption that doctors in an NHS will work under the same conditions as doctors presently working in the public sector. Doctors in private practice have not given enough thought to the potential role of doctors in an NHS and progressive structures have not done enough to stimulate debate along these lines. It has been suggested that general practitioners should be involved in a teamwork approach in family care clinics and that they should be encouraged by various incentives to work in underserviced areas. However, even the suggestion of these relatively minor changes have been met with opposition by doctors.

... and nurses

As a result of deteriorating conditions in the public sector and the offer of better salaries in private employment, an increasing number of nurses have been leaving to work in the private sector. While it may seem that these nurses would be antagonistic towards the public sector, it appears that the overall perception is that there are distinct advantages and disadvantages in both.

Many nurses feel that the most significant disadvantage of the private sector is the lack of job security. The impression amongst nurses is that relatively minor issues such as differences between nurses and doctors can lead to immediate dismissal. There is also a strong feeling that racist practices still persist in the private sector. Many black nurses feel they will not be promoted to top positions and will have to take orders from white nurses who may not be as qualified as themselves.

Another serious disadvantage of the private sector is the lack of opportunities to advance one's career. Conversely, the public sector provides study leave after certain periods of service and encourages nurses to further their training. Nurses in the private sector also often find themselves doing work which, in the public sector, is reserved for those still in training.

A central advantage of the private over the public sector is that it offers better salaries, but this is partially offset by the lack of housing subsidies. The flexible hours and the fact that p73 each nurse is responsible for fewer patients than in the public sector both add to the favourable perception of the private sector. Jobs are less strenuous both physically and mentally and this means that nurses can provide a better service to their patients. Nurses in the public sector feel they may end up giving the incorrect treatment as a result of exhaustion and stress rather than through negligence.

Many nurses are threatened by the possibility of different categories of health workers performing nursing tasks, mainly because they feel that this will undermine the process of closing the gap in professional status between nurses and doctors.

While this attitude is highly prevalent, other nurses also recognise the urgency need for the provision of health care to all. These nurses seem to feel that such workers could take the strain off public sector nurses and doctors. If their training was good and if they knew their limitations, they would be beneficial.

Conclusion

It can be said that there are a wide range of attitudes on a number of issues which are central to the establishment of an NHS. There are different opinions about the public and private sectors. These include negative perceptions of the state sector and assumptions that an NHS will perpetuate the faults of the current state sector. People are not sufficiently aware of the need for prevention and there are also different views on the roles of various types of health personnel.

As such, the practical task of developing an effective national health service carries with it the task of addressing people's different expectations and fears. If an NHS is to succeed, it needs to have the support of health providers as well as receivers of health care.

SECTION **b**

Financing and control

In moving towards an NHS, it is important to specifically address the changes that will need to be made in each of the areas of financing, ownership and control. In this section an argument is made in favour of national health insurance as the best way of financing health care. In addition, the hitherto unrecognised role of civil society is raised with regard to the control of health services. Together with progressive elements in the health sector, organised civics are challenging authorities to make health services accountable to the communities they serve.

A Framework for Understanding the Financing of Health Care

by Max Price

In talking about the private sector, the public sector, nationalisation and privatisation, people often use the same terms when they actually mean different things. Using some simplified models of the health sector, this article will attempt to illustrate some of these different meanings in order to clarify the terms of the debate.

The main point of this article is to show that the economic structure of the health sector must be understood in terms of three different questions:

· Where does the finance come from and how is it channeled into health care?
· Who provides the health services?
· Who owns the health services and who employs the health careproviders (HCPs)?

This paper is therefore not about the consequences of different types of health services and is not intended to pass judgment on the pros and cons of the different models.

Sources of finance

There are a number of ways in which health care can be paid for. One method is that of users or consumers of health care paying for services when they are ill. There is a

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Note: the term "health care providers" (HCPs) which is used in this article refers to doctors, nurses, dentists, and others whose job involves the provision of health care.

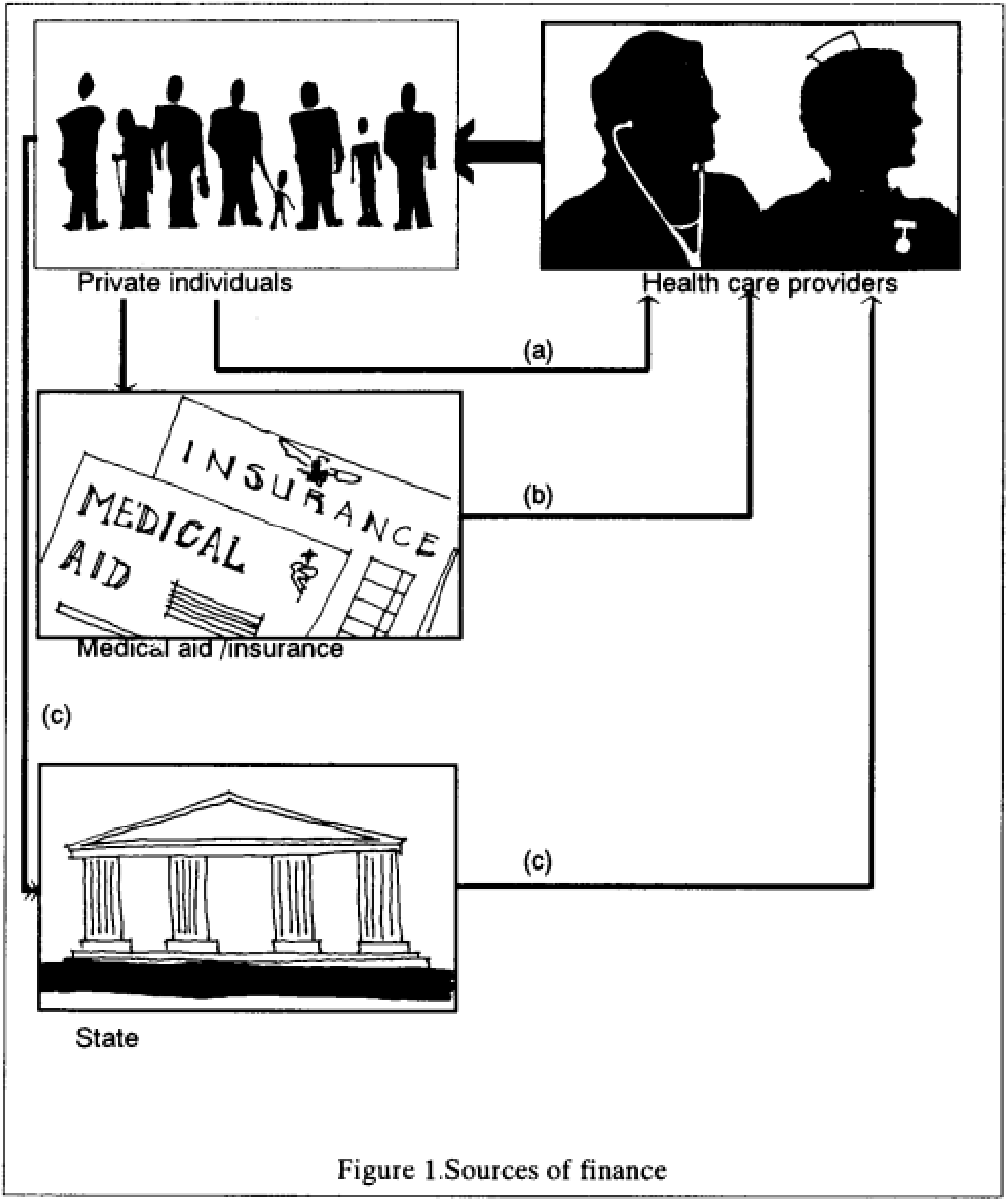


Figure 1.Sources of finance

direct exchange of money paid by the consumers to the health care providers who in return provide health care services, medicines, etc. **(See fig 1, arrow (a)).**

Individuals may need very expensive health care at any time and they may not have enough money available when they need it. So, many people get together, pool their money each month, and that money goes to the few that are sick. In other words, by paying a little every month, even when they are healthy, they are receiving the

security of knowing that if they need it, they would be able to pay for an emergency. This "risk sharing" is formalized into institutions such as burial societies, stokvels, and medical insurance/aid schemes **(see figure 1, arrow (b)).**

People also pay taxes to the government and government pays the health care providers, hospitals, and pharmacists to provide care and medicines to the people **(see figure 1, arrow (c)).**

In South Africa all these levels co-exist. For example, in insurance systems, the patient often has to pay the first R5.00 or 20% of the bill directly to the health care

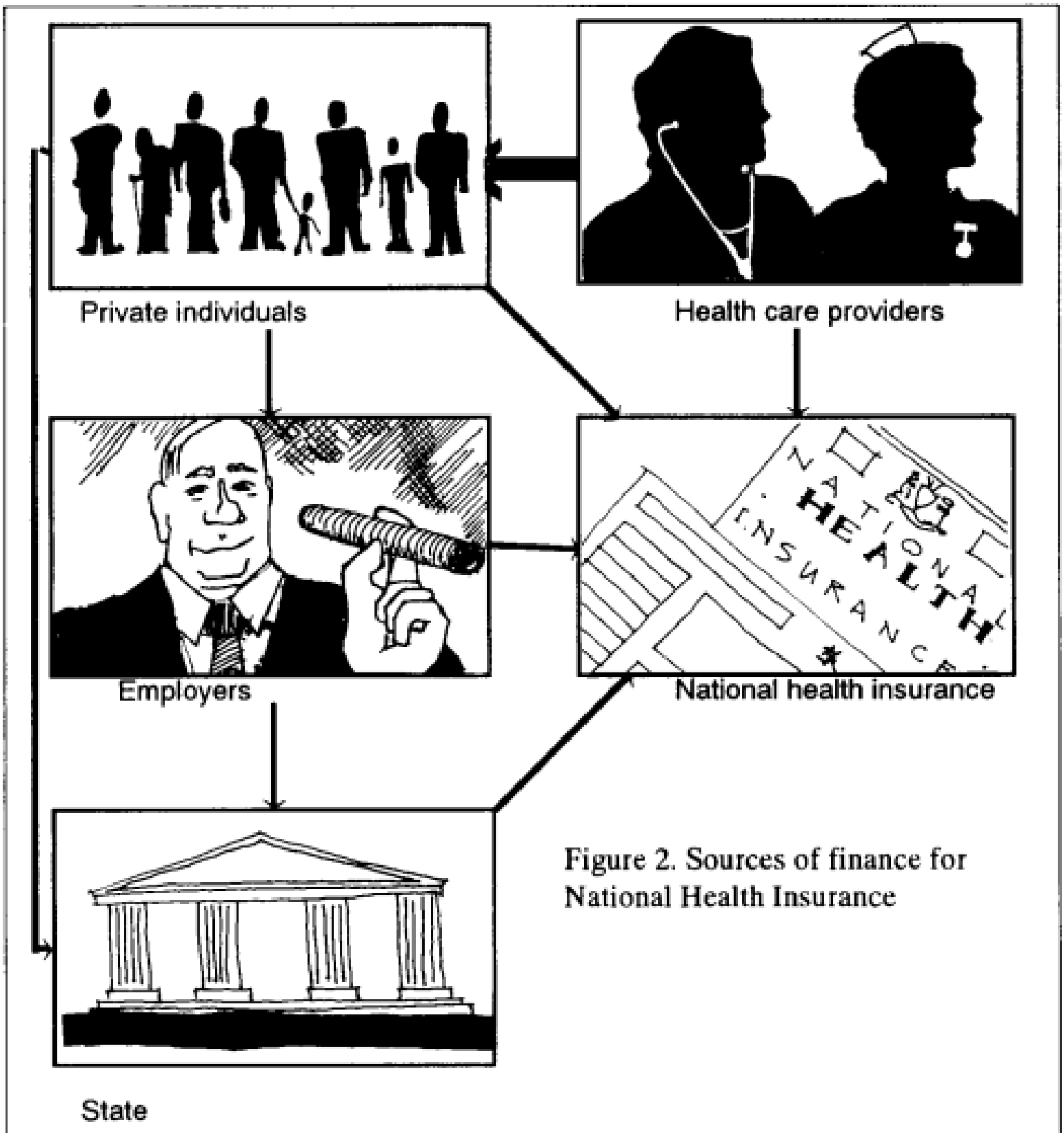


Figure 2. Sources of finance for National Health Insurance

providers. Patients receiving treatment at state hospitals also have to pay some of the costs.

In some countries health insurance is closely linked to the state, and is referred to as "national health insurance". The state subsidises the insurance on behalf of people who are unemployed and cannot afford to contribute to the scheme directly **(see figure 2).**

In talking about these SOURCES OF FINANCE we should bear in mind that all finance ultimately comes from individual people (or from their employers), but that it may be channeled in different ways. In general, some options are public **(figure 1, arrow (c))** and others private **(figure 1, arrows (a) and (b))**.

One of the meanings of "privatisation" is the shift from public sources to private sources of funding. For example, this is usually what the International Monetary Fund (IMF) and World Bank mean when they push for privatisation in health - the introduction of "user charges" or direct payment by the patient to the provider. Conversely, a National Health Service requires the channeling of finances through government or a national health insurance.

The different ways of financing health services have implications for equity, efficiency, redistribution, preventive/curative biases etc. For example, taxation may allow for easy redistribution of health services, while direct (private) payments by individuals may lessen the overuse of scarce health resources. There are many debates about the consequences of different financing arrangements. Unfortunately space does not allow a discussion of all these consequences.

Ownership and employment

Let us now look at the HCPs - i.e. the doctors, nurses, psychologists, pharmacists, etc. - as well as the hospitals, clinics, etc where they work. We discover that there are another 3 models reflecting their relationships with these different sources of finance. These are models of OWNERSHIP AND EMPLOYMENT **(figures 3, 4 &5)**.

First, HCPs may be self employed, independent providers, choosing whom they wish to treat, where to work, how hard to work, etc. Secondly, HCPs may be employed by the state, for example in provincial hospitals or the Soweto primary care clinics. Hospitals may of course be owned by the state. Thirdly, doctors may be neither self-employed nor state employed. They may be employed by a non-state organisation such as the Alexandra Clinic or a Health Maintenance Organisation (HMO), or one of the other private hospitals, or they may be contracted to the state.

In Britain the General Practitioners (GPs) have considerable autonomy and are almost self employed, but they are contracted to the state and get paid a fixed amount

per patient by the state. They also may not care for more than a certain number of patients and may not work in an area where there are too many GPs.

When some people talk about "privatisation" they are referring to privatisation of ownership, such as selling off publically owned hospitals, or doctors moving away from public employment into private practices. Conversely "nationalisation" is taken to mean the abolition of privately owned hospitals and private practitioners, in other words, state ownership of all hospitals and state employment of all health care

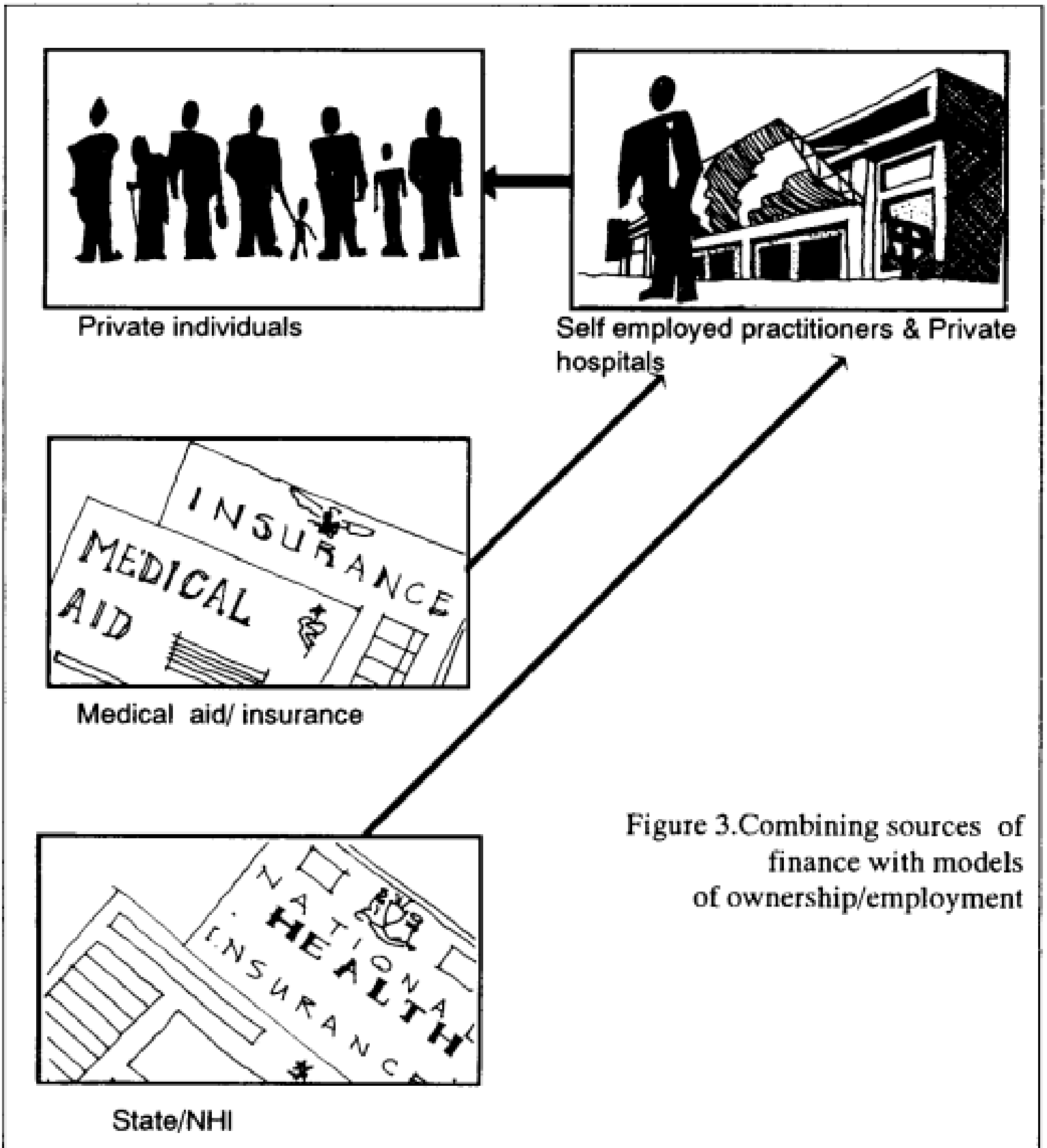


Figure 3.Combining sources of finance with models of ownership/employment

providers.

This is where a lot of the confusion arises. The different levels of financing are NOT tied to the models of ownership and employment. In discussing these issues we need to seperate out the consequences of policies regarding ownership from those regarding financing.

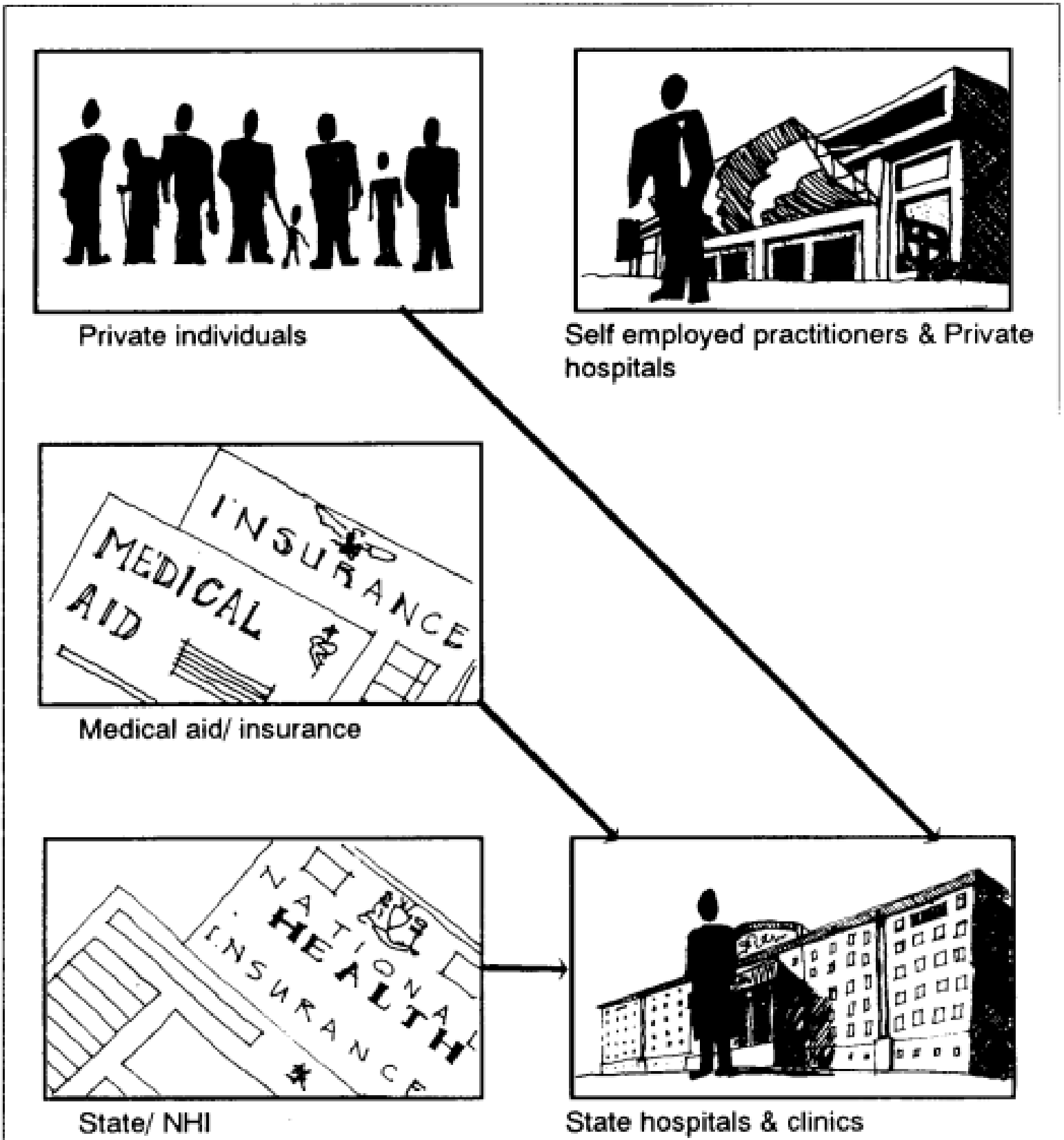
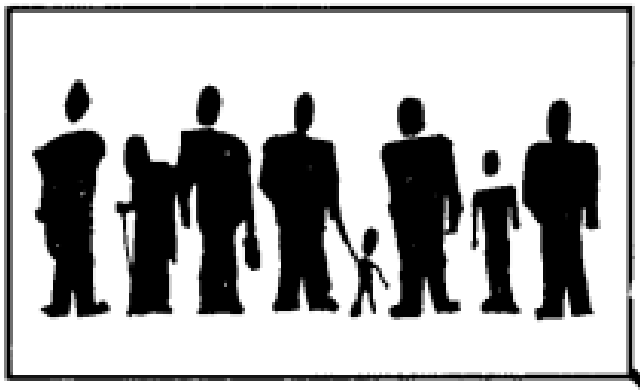


Figure 4. Combining sources of finance with models of ownership/employment

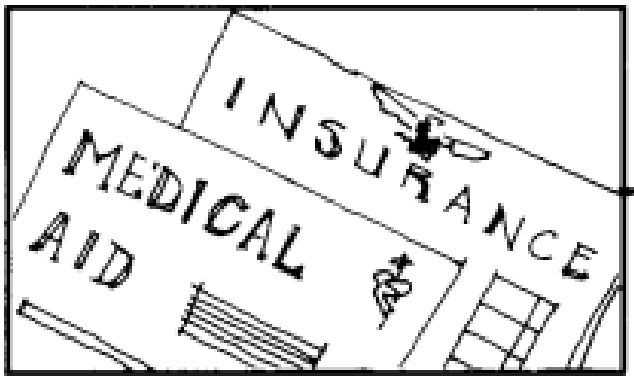
Ownership, employment and sources of finance - different combinations

Figure 3 shows that private, self-employed health care providers can be financed out of private, quasi-public or fully public finance sources. For example, the elderly in the



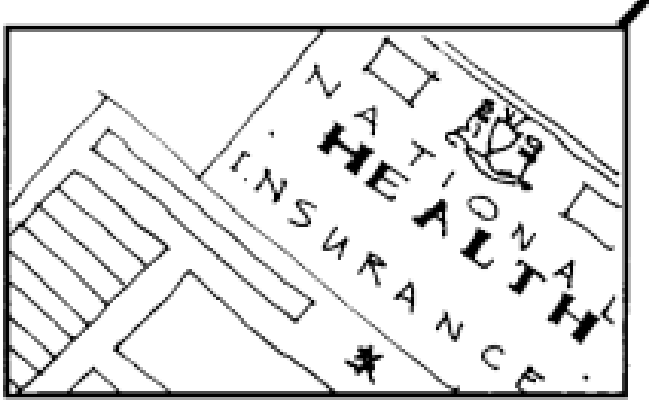
Private individuals

Self employed practitioners & Private hospitals



Medical aid insurance

Some HMOs, NGOs, British GPs *(1)*



State/ NHI

State hospitals & clinics

Figure 5.Combining sources of finance with models of ownership/employment

(1) Health Maintenance Organisation, Non-governmental Organisation

USA are financed by the government Medicare system but go to private, self employed providers. The public source of finance in this case means that private ownership is not, in itself, an obstacle to receiving health care (of course, there may be other reasons for not liking private ownership, but we must be clear what these reasons are).

Figure 4 shows how, even with public ownership and employment of HCPs, there can be many different methods of financing. The World Bank's adjustment policies are forcing many countries to charge individuals to use the public health services ("user charges"). This may well create obstacles to health care for the poor, in spite of the nationalised ownership of the health services in these countries.

Figure 5 shows again that all 3 levels of financing can be matched with non-profit private, and quasi-public forms of ownership and employment.

Conclusion

Although these models obviously simplify the situation, we see now that privatising or nationalising sources of finance can leave the ownership patterns unaffected. On the other hand, nationalising or privatising ownership need not in itself change the accessibility of health care.

There are clearly complex interactions which must be teased out if we are to go beyond slogans and engage in meaningful debate. But it also means that, in order to achieve our objectives of affordable, accessible and equitable health care for all, there are more subtle instruments available than nationalisation.

Max Price works at the Centre for Health Policy

A National Health Service and the future of the private sector - the case for a National Health Insurance

by the Centre for Health Policy

Debates about how the future economy will have to tackle entrenched inequalities are forthcoming and necessary. However, there has been a neglect in debating how to restructure the disproportionate public and private sector health services. This article examines a number of options concerning the financing of health services and, in particular, examines the future role of the private sector.

The Need for Debate on Social Policy

The economic policy of a future "Post-apartheid" government is one of the most hotly contested issues at present. Some of the main opponents in the debate do however share some common ground. They agree that a future economy will have to combine both:

i. Sustained economic growth and
ii. The reduction of the massive social inequalities that have resulted from

apartheid. There will need to be rapid social and economic development for previously dispossessed communities.

Development, it is agreed, cannot occur without growth. Growth cannot occur without the stability brought about by development.

While there has been intense debate about the broader economy there has been little public debate about the future organisation and funding of social services such as health, welfare and education. This absence of debate is also worrying because it may reflect the mistaken belief that the elimination of apartheid will itself correct the deep inequalities that apartheid has brought about in our social services.

This paper aims to examine some issues relating to the financing of health care, and most particularly to the future role of the private sector.

The size and impact of the private health sector

The private sector is a crucial part of the present health care system. Total health care expenditure in South Africa was about R12 Billion in 1989 (nearly 6% of the Gross National Product). The private sector consumes nearly half of this amount.

Furthermore, the private sector employs about 50% of the doctors, 90% of dentists, many nurses, and the vast majority of pharmacists. About 25% of hospital beds are found in the private sector. The private sector also enjoys the loyalty of many of its "consumers" (that is, patients) because of high standards of personalised care, continuity of care and the freedom to choose ones doctor.

There is little doubt, however, that the private sector in its current form is a major obstacle to the creation of an equitable, efficient, and appropriate health service.

The private sector and inequality

Despite consuming nearly half of all resources available for health care, the private sector provides (largely curative) care to only 20% of the population. Due to the fact that the private sector operates in response to market forces, private health care delivery is heavily concentrated in the densely populated wealthier urban areas.The private sector contributes little to alleviating the desperate shortage of resources in rural areas.

The growth of the private sector has also contributed to the deterioration in public sector care, by attracting many highly skilled doctors and nurses away from the public service, and towards the more highly paid jobs in the private sector.

The private sector and inefficiency

In an economic sense the private sector is highly inefficient. Measured by medical aid contributions, the cost of private care to the consumer has risen by 23% a year for the last decade. This is several points above the general rate of inflation, and is a trend that appears to be escalating.

The uncontrollable cost increases are evidence of the excessive, and often unnecessary use of services in the private health sector. This results from the nature of incentives in the private health sector: there is an incentive for hospitals and doctors to do too much, and for patients to demand too much, and neither the users nor the consumers are concerned about the costs since "the medical aid is paying"

As the costs of belonging to medical aid schemes increase, medical aid schemes are paying for a smaller proportion of medical costs. Proposed changes to the law, if passed, will even enable medical aid schemes to withhold cover entirely from high-risk individuals, such as the elderly and chronically ill.

Medical aid schemes, attempting to control the costs of medical care, are increasingly involved in bitter disputes with private health care providers - general practitioners, private specialists and private hospitals. A full-blown crisis in private health care seems likely if the medical aid schemes and the providers of private care remain deadlocked while costs relentlessly escalate. Indeed, it is arguable that the crisis has only been prevented by the major subsidy which the state provides to employers in the form of tax concessions for their contributions to employee's medical aid. (The value of this subsidy in 1988 was about R1.5 billion).

How the crisis will manifest itself is difficult to predict. At best, private care will become inaccessible to all but an even smaller elite - the young, healthy and wealthy. At worst, the private health care market may collapse completely. Either extreme would push many additional patients into the underfunded public sector.

The private sector and inappropriate priorities

People will "buy" health care when they are sick. There is little incentive to pay for preventive services when healthy. As a result, market forces tend to ensure that private care emphasises high technology curative care, and tends to neglect appropriate preventive and promotive services. These latter services do not generate enough

revenue to justify their provision by private sector entities in search of profit: left to itself, the private sector will inevitably focus on providing curative care and ignore preventive and promotive services.

The debate about health service options

The debate thus far:

Before February 2 1990 the battle lines in the health sector were clearly drawn. On the one hand, the government and most of the private health care establishment were promoting the privatisation of health care. On the other hand, "progressive" voices in the health sector, including anti-apartheid organisations and a wide range of academics, vigorously opposed privatisation and called for the building of an equitable and affordable National Health Service.

Today the distinctions are both less obvious and more complex. On the one hand, everyone professes to favour equitable and appropriate health care for all and no-one, least of all the government, publicly defends the notion of health care privatisation. On the other hand, the proponents of a National Health Service (NHS) face a very difficult question: what is a National Health Service, and how do we create it? More specifically, what do we do about the large and powerful private sector? The essential question is how a future government should intervene in the health sector so as to ensure increasing equity, without destroying the system it is trying to improve?

Three forms of state intervention are commonly mentioned. We discuss each in turn. Each obviously has a number of possible variations with different implications. It is not possible to discuss these subtleties here.

Option 1: Nationalise the private sector

This is the simplest option. It would involve nationalising the private hospitals, banning private practice and forcing all doctors into state employ. However, it is both practically and politically untenable as a course of action. Health personnel, particularly doctors would leave the health sector (and the country) in droves, and a "black market" in private care would soon emerge to undermine the public sector. If all the doctors did indeed stay on, this would practically double the number of doctors on the state's payroll - an impossible burden given that public health care is already badly underfunded.

At present nearly half of all the money spent on private health care comes out

of private pockets. If the private facilities were to be nationalised, that money would simply disappear. There would be no reason for people to pay for health care that was now provided by the state.

Thus nationalisation would greatly increase the state's liability to pay for care. There are also additional demands on state revenue that will be made by post-apartheid education and welfare services. Alternative funds could only be raised through the application of higher taxes, a move that would hardly be popular.

Quite apart from these arguments it is likely that the state would face a sustained and powerful campaign against nationalisation from both the providers and users of private health care. It is unlikely that any future government would seriously contemplate this option.

Option 2: Keep public and private sector separate

There is a school of thought which argues that the post-apartheid state should concentrate on strengthening the public sector, and transforming it into an egalitarian and high quality service open to all. The private sector, so this school of thought goes, should be left alone to provide private care to those who want, and can afford, to make use of it. The sting in the tail of this approach is that the private sector should be substantially reduced in size by a series of measures aiming, firstly, to make those

Strengthening the public sector will make health care more accessible to more people. Photo: Medico Health Project

who use private care pay the full cost, and secondly, to control some aspects of private sector behaviour.

Suggested measures include:

· Doing away with any tax rebate for employer contributions to medical aid.

· Making the private sector pay the full costs of training professionals who end up working in the private sector.

· Instituting a system of licensing for private hospitals, private practices, and the use of new technology.

In this way, it is argued, the private sector can be made less attractive and more expensive thus substantially reducing its size, its influence and its ability to undermine the public sector. The public and private sectors would be kept rigidly apart.

Critics of this course of action raise a number of problems. In particular, they suggest, it underestimates the ability of the private sector to adapt to new circumstances. In fact, they argue that it would leave in place a large and robust private sector, operating largely outside of national goals and priorities. This private sector would continue to consume a disproportionate share of resources, including doctors, entrench the two tier system of health care, and indeed continue to undermine the state's ability to develop an effective public health service.

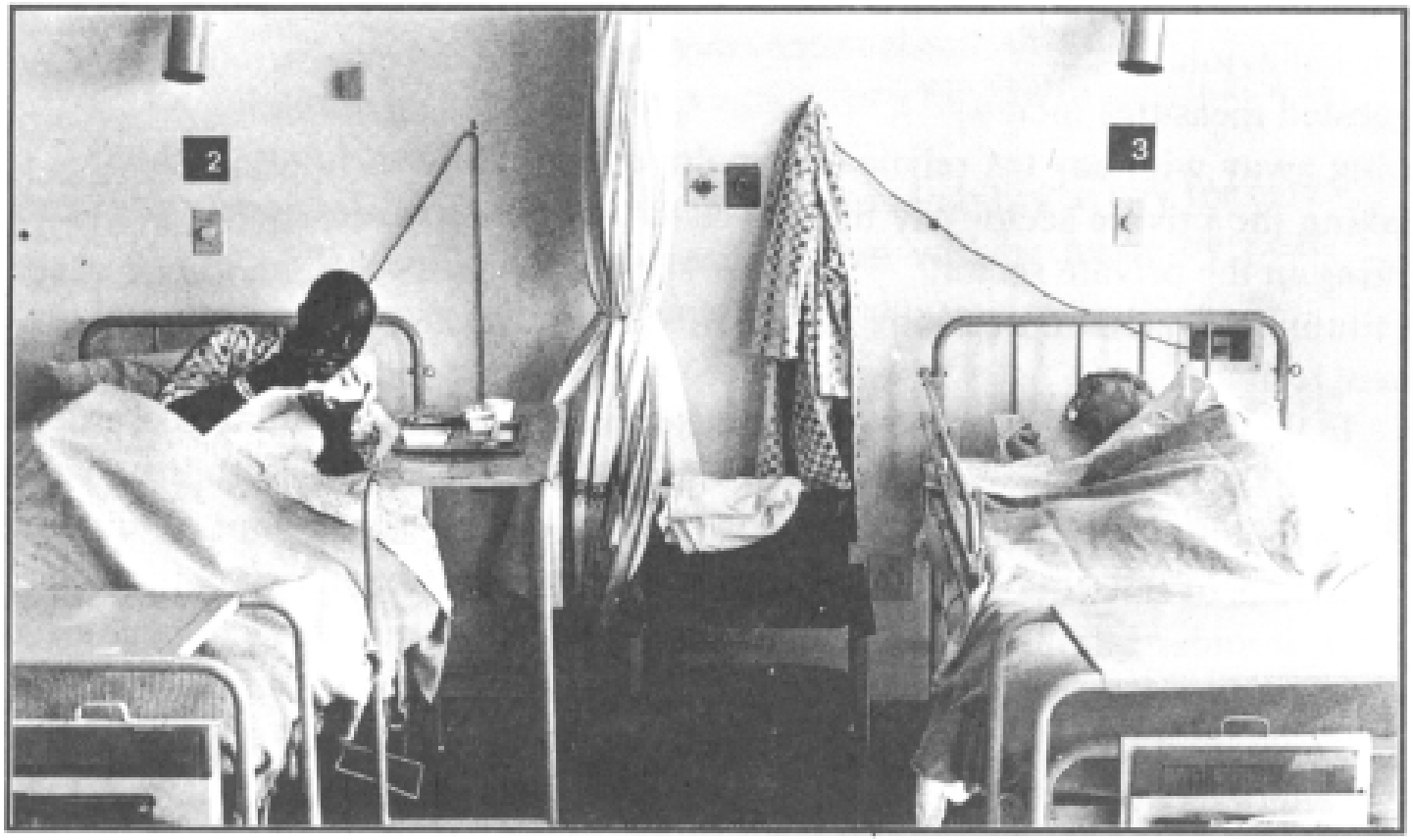
This proposed course of action would potentially release some additional funds to the public sector (the current tax rebate on medical aid contributions) but it would not provide sufficient funds to allow the rapid development of the public sector.

Option 3: Centralise financing for public and private providers

This option seeks to draw the private sector into a national system of health care provision. The proposed mechanism is the establishment of a national health insurance system in which current medical aid contributions are replaced by a compulsory health insurance contribution for all those in formal employment.

The national health insurance system would bring public and private finances for health care into a single fund controlled by the health authorities. The money would then be used to pay for a package of health services for all citizens, provided by either private or public sector providers.

The national health authority would be involved in the development, and enforcement, of norms governing the private sector. Such norms would include, for example, methods of practise and payment that reduce inefficiency. Also, the private sector would be obliged to participate in the training of health personnel, thereby contributing to the national pool. This amalgamation of resources would create a powerful single purchaser of health care which would act on behalf of all citizens in the country. The health authorities would ensure cost effective care by purchasing medicines cheaply, negotiating appropriate methods of payment with private providers and only paying for appropriate tests and procedures.



National Health Insurance could guarentee adequate access to health for all.
Photo: Medico Health Project

Such a system would guarantee all citizens access to a uniform range of essential health care that would be free, or nearly free, at the point of use. (Health care, over and above what is defined as essential, could be purchased by those who could afford it.) National Health Insurance, as a sum earmarked specifically for health care, tends to be more acceptable to people than an ordinary tax increment.

Such a mechanism, which has been implemented in many countries, including Canada and Australia, would leave in place many of the aspects of the private sector that are attractive to both providers and users of the health service. At the same time it would create a real possibility for the state, over time, to redistribute resources towards underserved areas, to create incentives for people to use the public sector, and to attract private doctors and nurses back into the public sector.

The major criticism of this option is that, by paying for everyone's use of the private sector, it would dramatically expand private health care, without modifying at all the cost escalating behaviour of the private sector. The effect would be to create an enormous drain on the central pool of funds. This real danger emphasises the need to define, and cost, very carefully the package of care that would be paid for by the national insurance fund. It also points to the need to negotiate in advance with private providers over methods of payment, procedures and cost saving possibilities.

Conclusion

Like so much else about South Africa today, the future of health care will have to be negotiated. What is clear is that the present structure is detrimental to the goals now espoused by all parties in the health sector.

To the extent that the needed fundamental changes can be achieved with a broad consensus, this would be a good thing, and should be the aim of negotiations.

It is our opinion that nationalising the private sector would make that consensus impossible, and that maintaining the private sector as a separate and elitist service would make it impossible to meet the social goals of the new South Africa.

A National Health Insurance system may provide precisely the correct mix of state guidance and private initiative and choice.

This article was jointly written by members of the Centre for Health Policy

Community participation in health - the Tamboville Health Committee.

by Critical Health

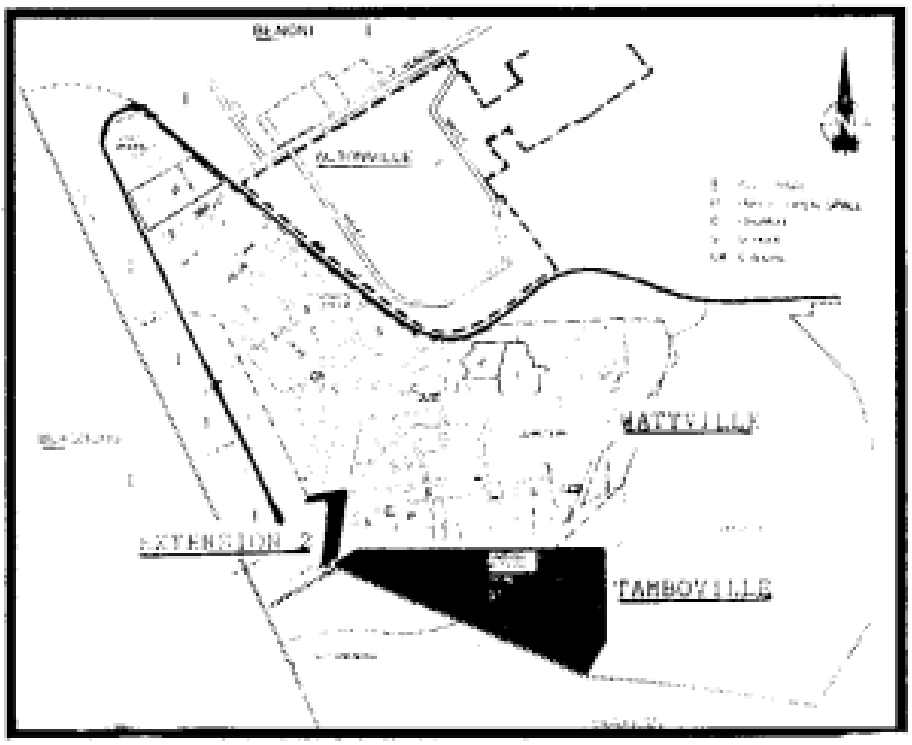
In the past community organisations in South Africa have not given much attention to the issue of health. It has been argued, however, that community participation in health services is a requirement if there is to be a genuine improvement in people's health. How community participation in health is to be achieved is, however, not clear and there are some who say that it is not really practically possible.

This article looks at the establishment of Tamboville, a low cost housing settlement, by residents of the township of Wattville. It focuses on the formation of the Tamboville health committee and looks at some of the problems facing the committee. The article provides a motivation for community participation in health. It concludes with a proposal aimed at defining more clearly the role of the health committee in encouraging community participation in health.

The struggle for land, housing, and health in Tamboville

Wattville and Tamboville

On a boot shaped piece of land bordered on three sides by the "white" towns of Benoni, Boksburg, and Brakpan lies the township of Wattville. Wattville is a typical



Location of Wattville & Tamboville (courtesy Planact)

South African township. There is widespread poverty and unemployment, and a shortage of land, housing and health facilities. But in certain respects Wattville is fairly unique. For one thing the crime rate is relatively low. Unlike many other South African townships, most of the people who stay in Wattville have been staying there for more than 10 years. Also in Wattville there are more adults (over 18) than children (under 18) while in most South African townships it is the other way round.

Running along the south side of Wattville lies another smaller piece of land which until quite recently was open veld. In June 1990 the community of Wattville, under the leadership of the Wattville Concerned Residents Committee (WCRC), decided to occupy this area which is owned by the Benoni Town Council (BTC). The land invasion was carried out in a planned and orderly manner. Numbered plots were laid out and these were each allocated to a family from within Wattville. The invaded land was named Tamboville after the national chairperson of the ANC and former resident of Wattville, Oliver Tambo.

The main motivation for the land invasion was the land and housing shortage in the township. A recent survey of the housing situation in Wattville has revealed that over 40% of stands in Wattville have at least 1 outbuilding, while 17% have 3 outbuildings. On average there are more than 7 people inhabiting each of the houses while the average outbuilding served as a shelter to 5 people. As many as 30 people stay on some of the stands.

The initial response of the BTC to the land invasion was to have the WCRC leadership arrested by the police. The community reacted with a march to the police station to demand the release of its leaders. After the WCRC leaders had been released, an emergency sitting of the BTC listened to representations from the

WCRC on the right of people from Wattville to remain in occupation of Tamboville.

The outcome was an agreement between the WCRC and the BTC that, not only could settlement on the land continue, but the BTC would allocate R2 million from its Capital Development Fund for the provision of basic services in the area. It was further agreed that a low-income housing development would be established at Tamboville under the direction of a Joint Technical Committee made up of representatives of the WCRC and the BTC.

Since then the WCRC has been playing a direct role in planning the development of Tamboville. The Joint Technical Committee has been working in co-operation with members of the planning organisation Planact. Because a systematic programme of workshops and reportbacks has been maintained, this has permitted the needs, aspirations and opinions of the future residents of Tamboville to be incorporated in the planning process.

The clinic

In the past Wattville residents have been largely reliant on the health services provided in neighbouring Actonville. However the staff and services provided at the clinic are inadequate to provide for the combined health needs of the populations of the two townships.

The initial plans for the development of Tamboville made provision for a clinic site. Planact then approached the Department of Community Health at Wits Medical School who drew up a proposal for the development of a comprehensive primary health care service in Tamboville. As part of the service the Community Health Department put forward guidelines for the running of the clinic. The envisaged clinic was to provide both curative and preventive services but not in-patient or delivery facilities.

The health committee

At about the time of the land invasion, a health committee was also appointed by Wattville residents to look into the health issues facing prospective Tamboville residents. Initially the committee consisted of five members but some of the committee members did not participate in the activities of the committee.

Community health problems

Asked about the health issues facing the community, committee members indicated

that in one area adjacent to Wattville there was no running water or toilet facilities. Another problem was the disposal of rubbish. People throw rubbish almost anywhere, they said. In particular people who had recently moved into an area are often unconcerned about the cleanliness of their environment.

One major problem is that people in the community often tend to be secretive about health problems facing themselves or members of their families. People appeared to fear public ridicule even for fairly common health problems such as TB. So as to keep a disabled child hidden from other members of the community, parents will keep the child confined in their homes.

Another problem relates to the quality of treatment received from doctors. This applies particularly to doctors operating from practices in the surrounding areas. One complaint is that doctors will supply medicine to a patient without fully examining the patient first. Committee members are of the opinion that it is mainly black patients who receive this kind of treatment. Hospital and ambulance fees are also a source of difficulty. At the nearby Boksburg-Benoni hospital people are required to pay a minimum of R15 per consultation. Ambulances will not take people to hospital even in an emergency unless an amount of R26 is first paid.

Winning people's trust

Committee members said that they had initially attempted to pay door to door visits in the community but people had generally been suspicious of them and seemed not to be interested in health. Some people had become angry at what they saw as interference by health committee members in their personal affairs. Since then the health committee has been trying to work through the street committees.

The committee acknowledged that it was a problem getting community members to take an active interest in health issues."People just want to go to the doctor and that's it," said one committee member. Nevertheless it was felt that people would begin to appreciate the committee. For example the committee felt that they would be able to provide guidance to community members about what kind of treatment it would be reasonable to expect from doctors. Furthermore if people had problems with the kind of treatment they were receiving at the clinic they would be able to take these up with the committee.

Defining community health needs

In September a meeting was held with the purpose of defining the most important health needs of the community. Members of the WCRC, the health committee, and

representatives from the BTC Health Department, the Wits Community Health Department, and Planact, attended the meeting. Those at the meeting identified a number of important areas which would require attention:

1. The meeting felt that there was need for education on topics such as first aid, alcoholism, drug addiction, parenthood, oral re-hydration of babies, violence. Other suggestions provided by the health committee are information on strokes, back-ache, smoking, breast-feeding and nutrition.
2. Education about and treatment of AIDs and other sexually transmitted diseases.
3. Children's health services - immunisation etc.
4. Health services for women, including family planning, pap smears, maternity and ante-natal care.
5. Emergency services - for accidents and childbirth.
6. Chronic care for diabetes, high blood pressure, hypertension, arthritis, and TB.
7. Care for special groups such as the aged, disabled, and those requiring psychological services.
8. Dental care.

Why do we need community participation in health care?

Under the present system people have become accustomed to receiving health care as a commodity. This means that, like other goods which are bought in a shop, health care is received in exchange for money. But when we leave the doctors rooms we may have received some medicine or a prescription but usually we have learnt very little about what is actually wrong with us or what we can do to avoid the same problem in the future.

One reason for encouraging people to participate in addressing the health issues which face their communities is to provide them with knowledge so that they can better look after their own health. This doesn't mean that doctors will not be necessary. But if people understand more about their own health it is believed that they will become less dependent on doctors and be able to avoid many of the simple health problems which are related to the way that people lead their daily lives.

One very good example of this is in relation to nutrition. The kind of food that one eats has an important effect on ones health. However, when one goes to the doctor it is very rare for the doctor to sit down with one to talk about ones diet. What would be of use to people therefore is if they could be provided with information about things like nutrition. But people need to involve themselves in

health issues if they are to empower themselves with the knowledge to take more responsibility for the health of themselves and their families.

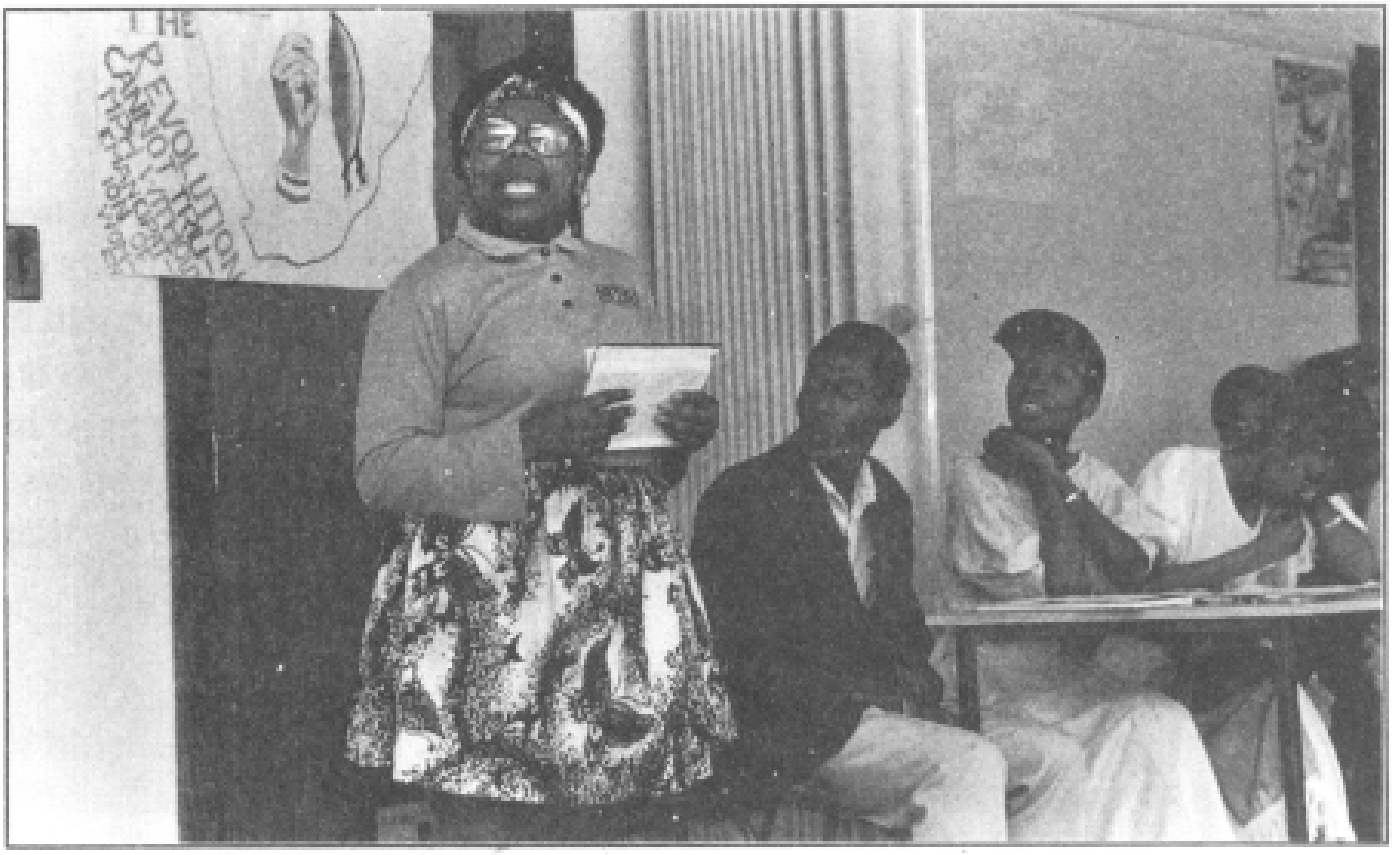
An additional reason for encouraging community participation in health is related to the present way in which health care is structured. Doctors have become accustomed to attending to the health problems of wealthier people in our society as it is mainly wealthy people who have been able to afford the high costs of health care. However, all people do not suffer from the same health problems. A community based health committee can act as a means whereby doctors are put in touch with people's real health problems so that they can provide a positive service to all their patients and not simply to the wealthier ones.

A Township Residents Health Committee - a proposal compiled by the Tamboville Health Committee and Critical Health

Aims and objectives

To promote the health of the community and to encourage community members to participate in the promotion of health.

To promote awareness amongst community members about health.



Health committees can act as a means whereby doctors are put in contact with the communities real health problems. Photo: Medico Health Project

To provide health information and advice to people in the community.
To ensure that appropriate health services are provided for the community.
To facilitate community participation in the running of the clinic in order to ensure that full and proper use is made of resources and facilities

Responsibilities

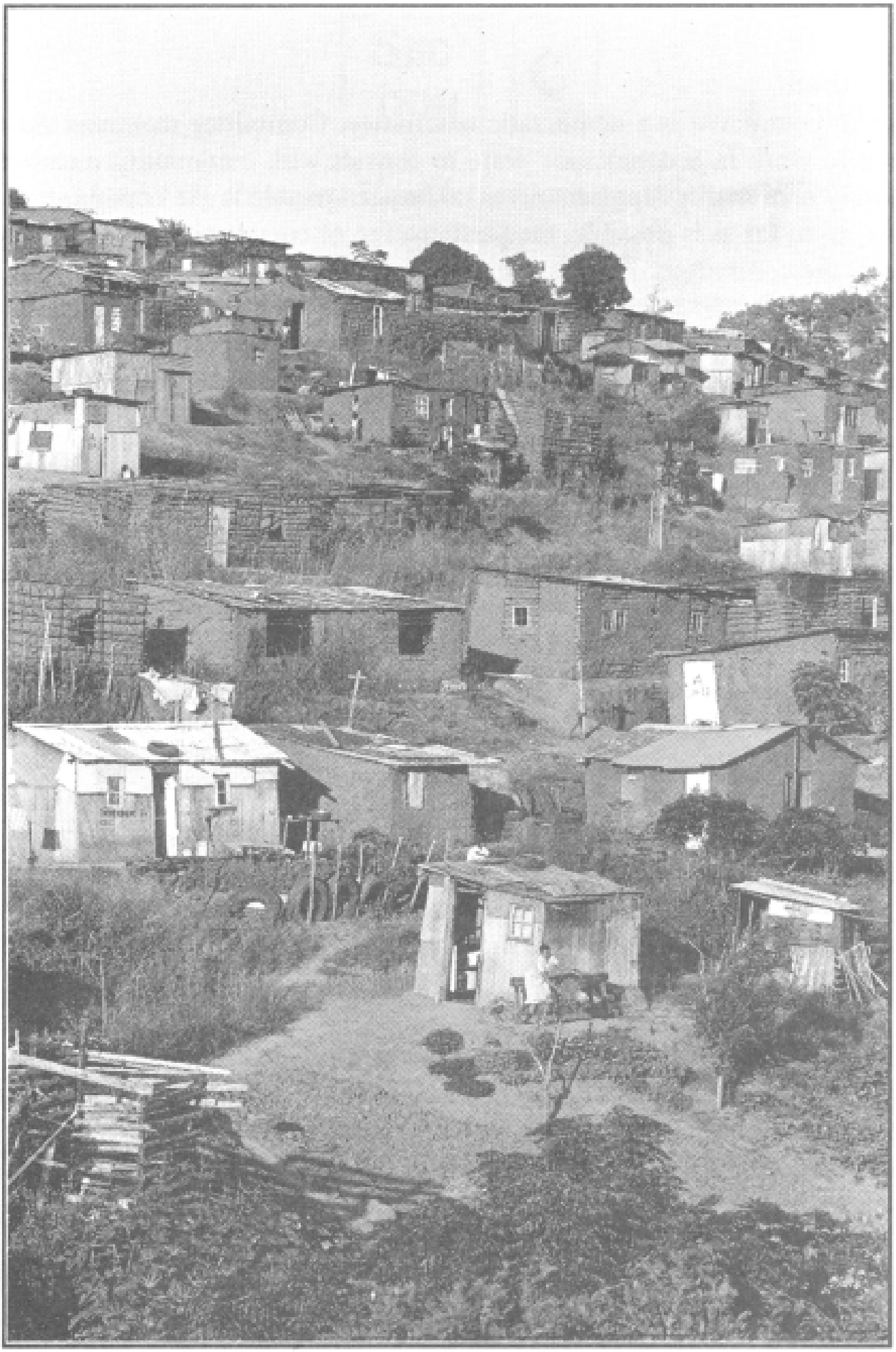
In consultation with the staff at the local clinic and the community the committee should:
Decide clinic opening and closing times.
Advise the health workers at the clinic about what health services need to be provided.
Decide what health education topics are important to the community.
Communicate "health messages" to the community.
To coordinate provision for community care of the seriously ill and others in need of assistance.
To encourage members of the community (particularly health workers) to become involved in the activities of the committee.
Liaise with relevant local authority (the feeling was that in Tamboville the BTC was preferable to the Wattville Town Council. However once a democratic and accountable local authority is elected in Wattville/ Tamboville, this would be the body through which the health committee conducted its affairs).
In conjunction with the town council, to implement participatory research programmes in the community.

Composition of the committee

At present health committee members in Wattville are involved in the committee on a voluntary basis. It is suggested that one or two of the committee members could eventually be employed either in a full-time or part time capacity. This would have to depend on an assessment of what the actual workload of committee members is and of whether the committee is making a real practical contribution to the improvement of health in the community. Furthermore, even if some committee members are employed, the committee should nevertheless encourage voluntary participation by community members in its activities.

Requirements for participation

Committee members should be resident in Tamboville/Wattville. They should have a commitment to the community and be interested in the health and welfare of the community. It is not necessary that they have any medical or health related qualifications but it may be necessary to provide basic training in community health issues to them. Committee office bearers should not be employed at the community



Informal settlement - a community based health committee can act to put health workers in touch with people's real health problems. Photo: Cedric Nunn

clinic.

Appointment

The health committee is a democratic committee. Committee members should be prepared to work in a democratic way, to consult with community members and particularly community representatives, to be accountable to the community, and to promote, in so far as is possible, the participation of community members in the ac tivities of the committee.

Committee office bearers could be directly elected by the community. However, due to financial and time constraints, it may be preferable for the office bearers to be appointed by a democratically elected local authority/town council.

Tamboville and Wattville

The clinic has been built in Tamboville but will also be used by Wattville residents. In the same way the committee that has been formed has been formed to promote the health of Tamboville residents but could potentially be developed into a health committee for the Tamboville/Wattville area.

(Thanks to Planact for advice and assistance)

References

1. Planact Annual Report - 1989/90.
2. Wattville Concerned Residents Committee - Briefing document prepared for the Benoni Town Council. 10 July 1990. In History in the Making, November 1990, vol. 1 no. 2 pp56-62.

VNS have produced a video dealing with the struggle for land and housing in Tamboville. The video stresses the important role of democratic participation by people in the community. Contact VNS for further details at P.O. Box 16455, Doornfontein, Jhb, 2028. Tel: (011) 23-5668. Fax: (011) 23-5353.

SECTION C

The NHS, Primary Health Care and personnel

Articles in this section are united in their motivation for an emphasis on PHC in the provision of health services, but question who should provide that care. The provision of occupational health services is related to the provision of PHC. This section continues the debate initiated in a previous edition as to who is responsible for these services.

PHC, the Alexandra Health Centre and some implications for an NHS in South Africa

by Grant Rex

A National Health Service in South Africa would require the extensive development of primary health care as the point of entry for people. The author, Grant Rex believes that in interpreting the Alma Ata declaration, the Alexandra Health Centre can serve as a useful point of reference for an NHS in South Africa

Introduction

In this article an attempt is been made to identify some of the areas in which debate and, more importantly, research needs to move if PHC is going to be properly integrated into a future NHS. Of particular importance are the questions of financing the training of PHC personnel; budget allocation to a PHC network; the problem of standards for a nursing based service; and the challenge of deepening community participation in decision making. On the basis of the framework outlined it would also seem that rather than neglecting PHC as a basis for the future NHS, this should form the mainstay of current research agendas.

In 1978 the World Health Organisation hosted a major intergovernmental conference at Alma Ata in the Soviet Union.The Alma Ata declaration, which emerged from the conference, outlined the basic principles of primary health care (PHC).

Underlying the concept of PHC is the idea that the main roots of poor health lie

in living conditions and the environment, and particularly, in poverty.

A PHC service must provide not only curative care, but also incorporate preventive, promotive and rehabilitative interventions such as health education, proper nutrition, and basic sanitation. Furthermore, PHC involves encouraging people to play a greater part in the protection and improvement of their own health. A PHC based approach therefore involves combining and integrating a range of strategies for the improvement of health. The provision of basic services for the whole population is emphasised, rather than highly specialised and technologically sophisticated medical care.

Central to PHC are the principles that:

· the first line of contact between populations and their health services should be the provision of PHC;

· that PHC should be practical, scientifically sound and socially acceptable;

· that a health team approach rather than a doctor based service should be relied on.

Subsequent to Alma Ata there has been widespread international acceptance of the PHC approach. However, the achievements of many PHC services in terms of improving health, have not lived up to the expectations of many of those who were originally committed to the idea.

In South Africa the debate around developing an adequate national health

Existing large hospitals are inaccessible to most people. A well developed PHC network would substantially relieve that problem. Photo: Anna Zieminski

service (NHS) has focused on a variety of issues such as the respective roles of public and private health sectors, the financing of health services, the need to deracialise services, and the issue of privatisation. While these issues are fundamental to the provision of decent health services, there is an important need to place Alma Ata and PHC back on the agenda.

This article will address certain issues related to the development of PHC services as the "first-line" component ofan NHS. Where applicable, the experience of the Alexandra Health Centre (AHC), the largest non-governmental organisation (NGO) health service in South Africa, will be used as a point of reference.

PHC and existing state structure

The implementation of a PHC based approach would necessitate the creation of a national network of comprehensive PHC centres, providing the first line of contact between the community and the NHS. At present, tertiary hospitals see 30% of all outpatients treated by the government health services. If a PHC network were to be established, it would substantially relieve the load on the tertiary hospitals.

However, ultimately the relationship between PHC centres and tertiary hospitals, should be a mutually supportive one. The PHC service would have to provide an integrated referral system. Developing such a system would require the thorough deracialisation and rationalisation of existing government services.

The budget for secondary and tertiary care should be allocated to the primary level which would then purchase tertiary hospital services on a market related basis. This "democratisation" of finances would discourage the tertiary hospitals from wasting scarce resources on problems with low social relevance.

With regard to the training of nurses and doctors, the acceptance of a PHC based approach would require a reorientation towards emphasising the social relevance and appropriateness of medical education. Medical schools, and nursing colleges, for example, should also be under pressure to provide appropriate training. Anomalies like language illiteracy, rural neglect, and sexism, must be addressed with more urgency, not only in curricula, but also via other means such as the nature of student selection criteria.

Relationship to the private sector

Despite the fact that it consumes a disproportionately large amount of the total financial resources spent on health in South Africa, it is unlikely that we will be able to do away with the private sector. For one thing it is likely that people will assert that patients should retain the right to buy medical services if they so choose.

In view of this, the question of the relationship of the private sector to an NHS arises. Linked to this is the question of the standard of care which can be delivered by an NHS, and especially by a nursing based service as is the case in a PHC network.

For many, a doctor based service is a prerequisite for adequate standards of scientific health care delivery and cannot be compromised. For others, if due attention is paid to the relationship between doctors and PHC nurses (PHCNs), adequate standards can be maintained in a nursing based service.

There are obviously conflicting views around the question of the quality of care provided by PCHNs in comparison to that provided by doctors. However, the benefit of having a PHCN, who speaks the language of the patient and is not profit orientated, undeniably diminishes the importance of whatever difference there may be in standards of health care delivery.

There have been points in its history when the AHC has been substantially dependent on PHC nurses (PHCNs) and functioned adequately. In Alexandra township a large proportion of residents, if they can afford it, make use of both private services and the AHC. Private doctors and the AHC co-exist on a competitive basis. There appears to be no reason why a PHC service should not function effectively in a competitive relationship with the private sector.

However, for the PHC service to be truly competitive, the private sector will have to take fuller responsibility for paying their own costs. One aspect of this is the cost of training health personnel. A tax on the private sector for health personnel used could be one way of getting the private sector to carry more of this burden.

Financial implications of the Alex experience

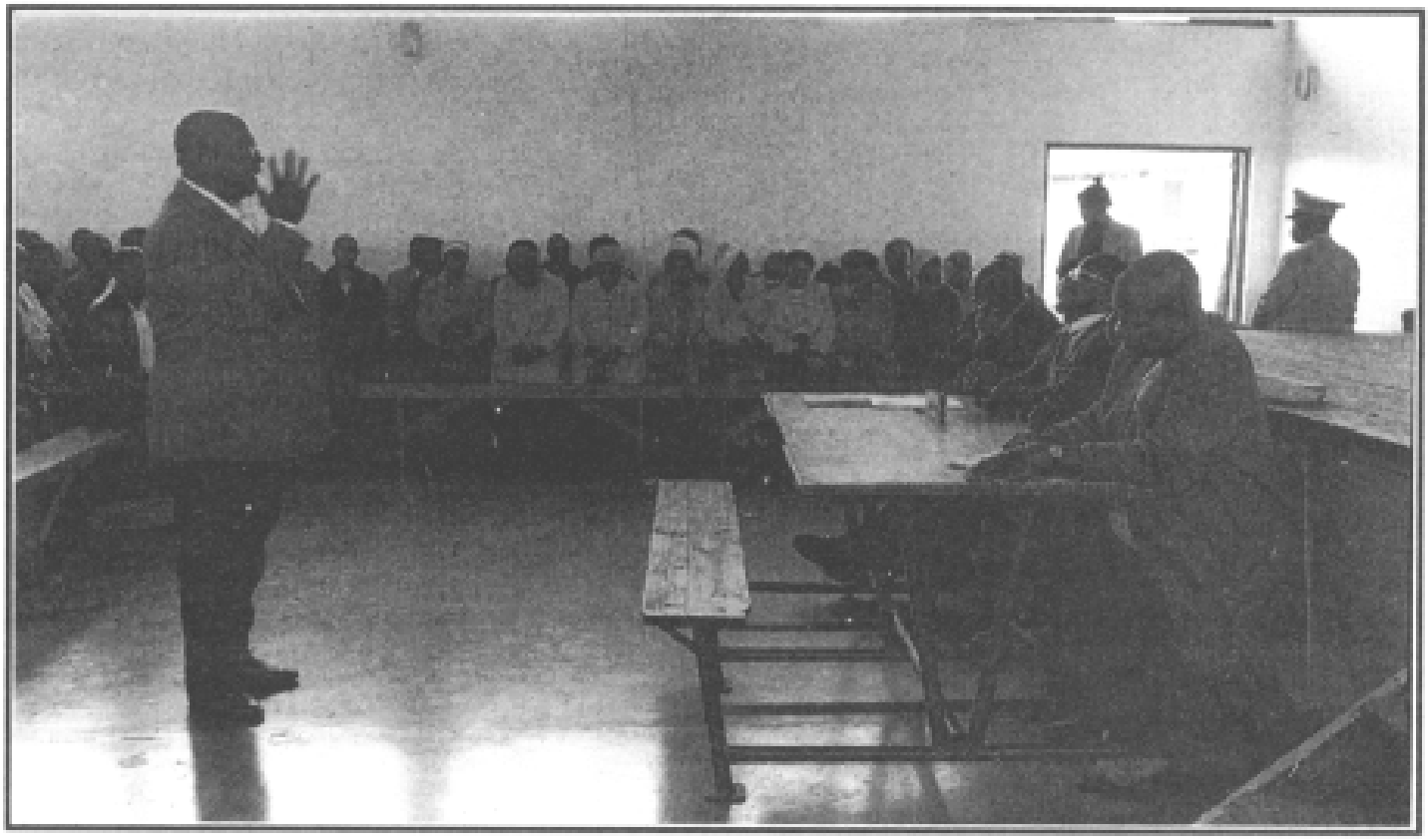
The AHC is located in the largest urban area in South Africa. It has a close working relationship with Wits University medical school, including the contribution of final year students. Due to its unique nature at present, it also manages to secure various

other benefits. These factors would obviously not operate to the advantage of PHC centres in a nationwide network. Nevertheless the AHC can still be seen to provide us with a basis for generalising about the financing of PHC nationally.

In 1988/ 89 South Africa spent R242.00 per capita, 5.8% of its GNP, on health care. Roughly half of this money was spent by the government and half in the private sector. This means that in 1988/89, the South Africa government had in the region of R120.00 to spend on health care for every man, woman and child.

The World Health Organisation recommends that each government spend 25% of its health budget on PHC. If the South African government were to allocate 25% of its health budget to PHC, this would imply that, using the 1988/89 figures, there would be R30 for PHC for each person in the country.

Population estimates for Alex vary between 200 000 and 250000. A 25% allocation from the state health care budget (that is, R30 per person) would therefore provide R6-7.5 million for PHC in Alex. In 1989/90 the AHC spent R4 million apart from capital development. The implication is that an allocation of 25 % of present governmental expenditure to PHC would be easily sufficient to finance a national



Accountability of the service to the community has to take into account the size of the community, the technical nature of management of a clinic, as well as the legacy of undemocratic local authoritues. Photo: Cedric Nunn

network of comprehensive PHC centres.

This would require long term planning with particular attention to the financing of human capital development, such as the training of PHCNs, health educators, administrators, and other technical staff. These challenges would require an additional financial commitment from the state.

The question of accountability

In the absence of a strong democratically elected local authority, the AHC has been controlled by a management board, 6 of the 13 members of which are elected at an Annual General Meeting (AGM) at which all Alexandra residents are entitled to vote. Of the remaining 7 places on the board, 1 is elected by the AHC staff, 3 are carried over from the previous board, and 3 are appointed by Wits University for historical reasons.

The AGMs are advertised through the local civic association. Advertising includes a mass distribution of 10 000 pamphlets and adverts in the Sowetan. While this has worked reasonably well with increasing attendance at AGMs to over 500 in 1990, there are obvious limits to this type of control. In particular, it does not extend to participation in day to day management or to decisions of a more technical nature.

The size of the Alexandra community obviously places restrictions on democratic participation. However, the experience of the AHC seems to indicate that this is not the only obstacle to more thorough going involvement. For one thing the organisation of a modern technological service is made more cost efficient by serving a fairly large community. Furthermore because of a shortage of management skills the number of PHC centres would have to be restricted. By implication the basic PHC unit would have to be a certain minimum size. Economic factors might therefore determine the size of PHC units. This may undermine the possibility of more democratic community participation.

In addition, community control may conflict with democratic management of health workers employed by the board. The AHC experience has highlighted the conflict of interests between health workers and the community they serve. This confirms the need for management to be accountable to the community, and for worker interests to be protected by union organisation.

The present form of community participation at the AHC is an interim arrangement, a response to undemocratic Apartheid based local authority. The AHC experience suggests that democratically elected representatives can develop expertise in health policy, and thereby have a more meaningful say in the actual direction health care delivery moves in. The onus then shifts onto local authorities to deepen democracy by mechanisms such as regular report backs, recall, etc. While this in no

should form the mainstay of current research agendas.

Grant Rex is a general practitioner working for the Alexandra Health Centre

Non-Government Organisations (NGOs)

In South Africa NGOs are those organisations - unions, civics, research, service, religious, educational - outside of the private sector, that receive no support, financial or otherwise from the government. The role that NGOs have played traditionally has been to mobilise or channel resources, material and non-material, to those sectors of society that have been deprived as a result of apartheid and economic exploitation.

Overseas, on the other hand, NGOs remain independent of governments but can still receive aid or funding from governments. They have begun to challenge governments by pressing for macro policies that are relevant and sensitive to the poor. They network around key social issues such as gender, the environment, social services, and fairer economic relations between the advanced capitalist countries and the Third World. *(Frank Meintjies, Weekly Mail, 2.8.91)*

A Note on Personnel

by Helen Rees

Central to the current debate around the role of Primary Health Care (PHC) in a future health service is the question of what kind of personnel are required to provide such a service? This article briefly raises some questions relating to the role of PHC nurses and general practitioners (GPs) as providers of PHC.

Introduction

There is a broad range of opinion which supports the development of Primary Health Care (PHC) services in South Africa. Both the government and the ANC, amongst others, have expressed their support for PHC. Before an effective PHC service can be developed, certain questions about the kind of personnel required to deliver such a service need to be answered.

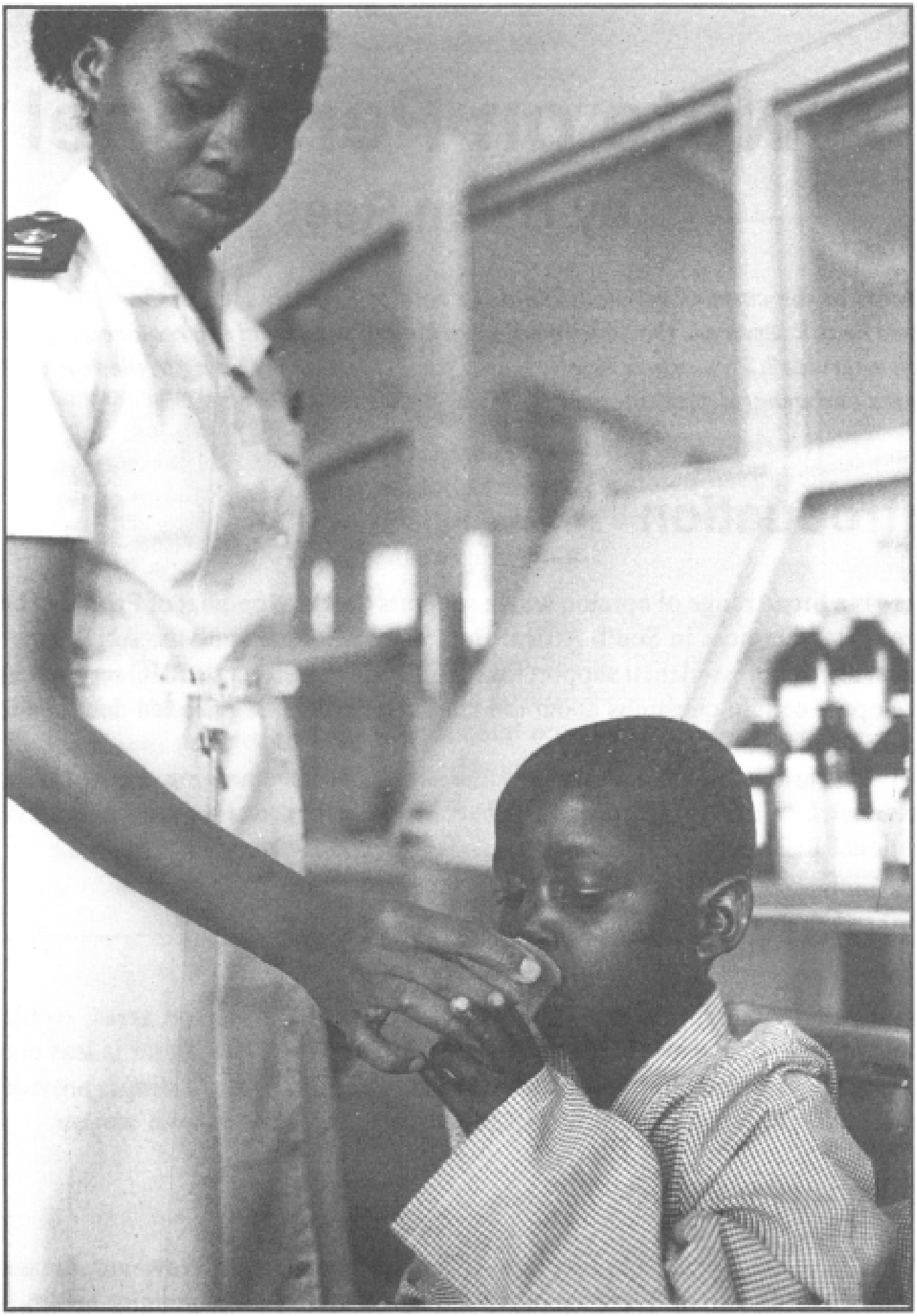
This article briefly focuses on some aspects of the emerging debate on health personnel. Its aim is to raise questions that need to be looked at before we can develop a national PHC policy.

Primary health care nurses

It is a shared assumption that PHC services, particularly in rural areas, would be provided by PHC nurses (PHCNs). The exact role of the PHC doctor is less clearly defined, but one model proposes changing the PHC doctor from a simple provider of clinical care, into that of clinical consultant, manager, and research worker.

Content of training

PHCNs have been practising in South Africa for several years. However, the nature of their training varies. Some centres train PHCNs with a community health bias, whereas, others train them primarily as PHC clinicians (that is, examining patients, making diagnoses and providing treatment) in the belief that this is the major service



What is the role of the Primary Health Care Nurse? Photo: Medico Health Project

they provide once they are practising.

In their most recent recommendations the South African Nursing Council has weighted the PHC training heavily towards community health skills with very little emphasis on clinical skills. They imply that nurses require little training to develop the necessary skills after their basic nurse training to allow them to work as clinicians. Some people involved in the training of PHCNs would argue that PHCNs are, in fact, family practitioners and not community health specialists and that their training should be orientated towards the discipline of family health rather than community health.

This then raises the first question: what is the present role of PHCNs, and what training would best support this role?

Support structures for PHCNs

Apart from the problems of the content of PHCN training, there are also problems for them in terms of support structures. Their job has no prospect of promotion unless they move back to the traditional nursing hierarchy. They are neither nurse nor doctor, although still subject to nursing structures. The result is that there is often conflict between PHCNs and their nursing peers and conflict with their nursing superiors.

On the other side, there is professional rivalry between PHCNs and PHC doctors. Doctors feel threatened by the movement of PHCNs into their territory, and increasingly uncertain of what their role as a doctor ought to be. If the role of the two professionals is similar, then why should doctors get paid so much more than PHCNs?

Cost benefit

To add to this confusion, is the question of cost benefit. When PHCNs were first trained, the aim was to have a PHC practitioner who was locally based and trained, and who would be cheaper to train and more effective than a doctor. Whilst the former point is often true for PHCNs, the latter two points may not be. A primary health care nurse has 3 years of basic nurse training, after 1 year of midwifery and a final year of PHC training.

With basic nursing training expanding to 4 years, PHCN training will become 6 years in length, and hence very expensive, although still cheaper than a doctor's training. Secondly, PHCNs often work more slowly than doctors and have to refer more cases for second opinions. This means that in terms of cost, a PHCN consultation is potentially more expensive than one with a doctor, as was recently shown in a study done at Diepkloof Clinic in Soweto.

A different type of PHC clinician?

With all these problems attached to PHCNs as the model of a mid level health worker, some people are now suggesting that it may be better to train a different type of PHC clinician. Community members could be given a 3 year community based training in both family medicine and community medicine skills. This would qualify them as a PHC clinicians, with a career option that would later allow them to qualify, if they wanted to, as doctors. Much more research has to be done into the role of the PHCN before we can assume that they are the model health workers for a future PHC service.

General Practitioners

When we talk of future health services and the development of a multi-disciplinary health training, we include in that team a PHC doctor. But where do we find these doctors, and what training do they need?

In addition, those who are motivating for the expansion of PHC services need to be more specific about what will happen to the private sector and, in particular, to general practitioners (GPs).

We have 7 000 - 9 000 doctors practising as "generalists" in South Africa, who are thought to give about 12 million consultations every year. Although drug companies may know where all these GPs are, the progressive health sector and probably the government does not know much about this work force. We don't know where they are, what functions they fulfil, what their skills are, or whether they would be interested in joining a multi-disciplinary health team.

More and more doctors are choosing private general practice as a career option. We need to look carefully at the reasons for this and at the nature of the service they are providing to the community. The image of a GP is that of a high income earning doctor, with a large patient load. In some cases, this is a fair assessment. Some doctors choose to go into private practice because they believe that they will be able to give a better quality of care to patients than can be given in a public sector, renown for bureaucracy, long queues and lack of continuity.

Some people argue that GPs are serving the `first world' component of the population. This is only partially true. Although GPs over cater for the urban areas, many work in peri-urban and rural areas. Many of their consultations are to "cash" patients (that is, poorer, non-medical aid patients). As PHC clinicians, GPs have also become aware of the PHC team approach, and of the limitations of their predominant

curative practices. Financially, GPs are feeling the squeeze. Medical aids are increasingly in conflict with GPs over their remuneration. Dispensing may become prohibited for many urban GPs, and this would eat into their profits.

Under these circumstances increasing numbers of GPs may be interested in integrating their practices into a comprehensive state run PHC model. Can we afford to ignore GPs? The state certainly couldn't afford to provide services for 12 million consultations per annum and at the same time cannot ignore 8 000 skilled health workers working in the field.

Finally, do we really know what kind of health service is acceptable to South Africans? It seems that many people prefer to spend more money and see a "special doctor" rather than seeing a PHCN in a clinic. Is our intention to develop a `third world' nurse based service, whilst allowing a `first world' or doctor based service to continue in parallel. Isn't this just more of the fragmentation that we are all so keen to escape from? And how does this challenge an oft held view that health care begins and ends with doctors?

Before committing ourselves to a model for PHC services in SA we first need to have a better understanding of what is happening in presently in health services. The feasibility, costs, and potential impact of any model put forward must be assessed. Decisions about a PHC model should not be made by politicians and community health specialists alone. The debate must be broadened to include all PHC clinicians, and the communities they serve.

Helen Rees is a general practitioner involved in the Women's Health Project at Wits Medical School

Post-Apartheid Occupational Health Services: What about small industry and the informal sector?

by Grant Rex

This article acknowledges the need for business to contribute to the provision of ccupational health services (OHSs). The author,however, also stresses the need for OHSs to be based on comprensive PHC principles in line with the broad development of an NHS. The model that is argued for here points to a distinction between the need for business to finance OHSs and the need for the state to manage this important service.

The contribution by Fareed Abdullah to discussion about future occupational health service (OHS) provision is extremely welcome(1). It identifies a number of important needs, in particular, the need for employees to finance occupational health services,and the need for state funding to focus on prevention, training, evaluation and monitoring. In addition it makes valuable proposals around future OHS provision and even goes on to listshortcomings with the proposed model.

However, there are additional shortcomings which were not mentioned and which need further discussion. The most important of these arises from the problem of providing services to smaller industry and the informal sector. The model proposed by Abdullah will result in either the neglect of these sectors, or else, the state will have to bear the financial burden of providing OHSs single-handedly. The stress in the

article on links with comprehensive primary health care (PHC) services is also contradicted by a conclusion which favours management based OHSs. A management based service parallel to a state based comprehensive PHC network, lays the basis for division as these services develop, even if managements subscribe to comprehensive PHC. A third problem with the model relates to the failure to distinguish between financing, provision, and the location of health services. The distinction between financing and provision of the service is drawn initially, but is lost in the rest of the discussion. Instead, if an approach to OHS provision is made witht his distinction in mind, then the option of capital financing the OHS without controlling it, becomes possible, and an alternative model becomes viable.

A State controlled Primary Health Care based Model

The strength of a factory based model can largely be retained,and the weaknesses eliminated, with a PHC based OHS model which is controlled by the state and financed by capital. This separation can be achieved by way of charging each workplace on a capitation basis for a service located at a local PHC centre as part of the state controlled PHC network. The model which will be presented, is based on the experiences of an OHS recently launched at the Alexandra Health Centre and which is currently functioning along these lines.

While the success of a state controlled model depends in part on a state more sympathetic to worker interests, this is a far cry from the control which management could assert over a service entirely under their control. And while worker organisation is ultimately the only guarantee of a safe and healthy workplace, a state sympathetic to workers' interests can bring valuable weight to bear in favour of this process of democratisation. Well motivated health workers employed by such a state would also have the space to engage in activities without fear of harassment, and without the danger of being ignored and deprived of resources.

However, the most important features of a state controlled model are the advantages which result from economies of scale, especially for smaller workplaces. What is meant by this, is that the coordination which results from services which are larger in size or scale, allows for cheaper provision of infrastructure, including buildings, transport, lab facilities, and other special investigations, referral systems, drug supply, environmental and biological monitoring and, importantly, research. While it is easy to assert that employers must provide OHSs, and that smaller workplaces must combine resources, unless this is organised by the state, the capacity of small workplaces are not part of any organisation or federation and are poorly

covered by legislation. PHC based services also have the option of reducing costs by increasing scale in more ways than do private employers.This can take place even if the PHC deals with the same number of workers, but simply focuses on a wider spectrum of diseases.The potential to serve more people simply by being PHC based and offering services to nearby communities is also possible.

By being part of regional health care delivery the OHS also benefits from a functioning referral system. Even more important may be access to basic special investigations and drug purchasing and distribution. The cost of these services is significantly reduced by being part of an established national network.

However, it is not only the cost of running such facilities, but the cost of setting them up that also needs to be taken into account. If a regional service with capacity to accommodate OHS demands is in existence, then there is no risk of duplicating such services if the OHS is PHC based and plugs into this facility.

The need for research is also met more easily if the OHS is PHC based. Rather than relying on national and regional centres which, with likely increase in demand are going to be even more overextended than they are now, a PHC based service has the potential to conduct at least some basic research of relevance. In contrast, management based services are currently conducting little if any research even in large factories.

Occupational health services should be provided at even the smallest of worklaces. Photo: Medico Health Project

There is also more potential for formal on-going training. This is important for a developing service, and is also unlikely to take place if the service is management based.

Potential Problems

Several problems are associated with a PHC based OHS. Two of these are identified by Abdullah. The first relates to the advantages of a service actually located at the workplace. This is clearly important. However, a PHC controlled service can also be permanently located at those factories large enough to use the services of a permanent health worker and provide premises. Some of the advantages of a factory based service in terms of early detection of occupational disease, can even be retained in a PHC located service which conducts regular on-site medical examinations and appropriate screening.

Secondly, there is the problem of existing management based OHSs. This has political dimensions and obviously needs to be dealt with sensitively. Initially they can simply be maintained alongside state based OHSs. Later with a flexible approach and a process of negotiation, they can be incorporated to a greateror lesser extent appropriate to each circumstance.

The most serious potential problem identified by Abdullah, however, is that of OHSs "being lost in a sea of general health" if they are part of comprehensive health care delivery. Rather than detract from OHS, however, PHC may in fact assist development by contributing resources. In the case of theAlexandra Workers Health Outreach, surplus skills and technical resources which were available at the Alexandra Health Centre (AHC) were put at the disposal of the fledgling service. This made for an easy start to the service, and helped to overcome the significant inertia associated with developing OHSs, especially for small workplaces, and relates back once again to the size of the PHC and economies of scale which it allows.

Conclusion

The initial experience of the Alexandra Workers Health Outreach which has been described elsewhere (2), therefore points strongly in the direction of a state controlled service with a PHC network. While there is a financial imperative to involve management, ways need to be found of ensuring that the OHS is not under their

control. Although this depends ultimately on strong worker organisation, the location of OHS under state control allows for economies of scale, national coordination, and diminishes management influence, while affording to health workers not directly involved in the acquisition of profits, the chance to make a contribution.

Grant Rex is a general practitioner working at the Alexandra Health Centre

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SECTION d

International perspectives

It is clear that, in South Africa, we still have a long way to go in terms of both popularising an NHS and developing coherent policies in order to move towards a comprehensive NHS. The international context highlights the range of problems faced by those countries with an NHS. This raises the question of whether an NHS can operate to the best of its potential in a capitalist society. It also points to the need to understand the dynamics of health and health services within the context of broader society.

Everything you wanted to know about health systems, but were afraid to ask

an interview with Milton Roemer

Professor Milton Roemer of the University of California, Los Angeles is an expert on national health systems around the world. He is also a consultant to the World Health Organisation (WHO). The interview was conducted by Laetitia Rispel of the Critical Health collective around issues of the financing of health care, the different levels of service provision between the private and public sector, and policy decisions around drug lists and personnel.

Q. One of the features of the health care system in South Africa is that we have a large and powerful private sector. In 1987, for example, South Africa spent 5.8% of the gross national product (GNP) on health. Of this, 44% was spent in the private sector which serves only about 20% of the total population. Could you comment on the challenge we face in dealing with the private sector?

MR: The ideal system of health care financing would be that everything be based on taxes which are progressive, so that high income people pay more, and low income people pay less. But that kind of financing has never been achieved, except after many years of financing by insurance. Even in the case of the British and the Swedish and Norwegians, they had many years of insurance before they shifted to relying principally on taxes.

The other way is if you have a revolution, as in Russia, where they organised health services under general taxation. Even in Russia, though, they continued insurance for 20 years from 1917 to 1937, when they unified everything under a

national government tax-supported system.

I think it would be wise to draw up a financing system by insurance which would be politically acceptable. This would require everyone who is employed, any kind of employment - government or private, industry, agriculture or mining - to pay into the insurance system. The insurance would be paid partly by the worker and partly by the employer. The self-employed, for example, shopkeepers and small peddlers, could also pay into the insurance, but they would have to pay for everything since they have no employer. They might be able to get some protection if they earn below a certain income. Then for the low income people, who must always be supported by government revenues, it would be good to have the revenues paid into the insurance system on behalf of the low income people, so that there is not a separate system for the poor.

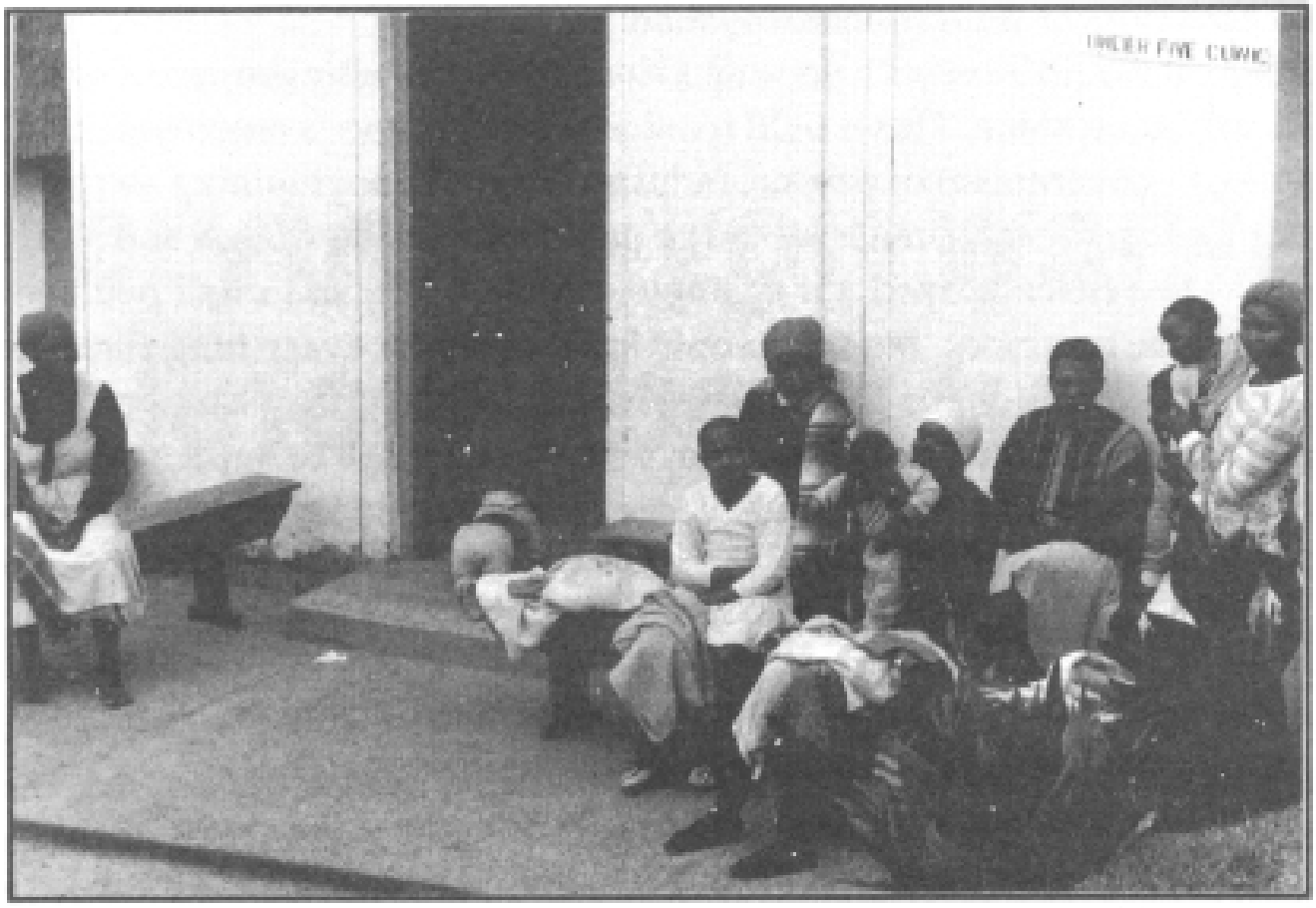
After many years of compulsory insurance or social insurance, (which I think is a better term) support for medical care and public health, it could take the course which was taken in Great Britain or in Canada. In Canada they had insurance on a province-by-province basis and then gradually each province shifted from insurance (earmarked payments by individuals and employers) to general tax revenues of the province and of the federal government. So after a number of years, the system became essentially tax supported. In Britain it is about 85% from general taxation with a little bit still from insurance.

I think that insurance is a politically acceptable form, because it is earmarked for health and it is payment by both the employer and the employee. Compulsory insurance for every wage earner in South Africa could be controlled by government nationally or by the provinces. The latter could be administratively responsible for collecting insurance contributions and for paying doctors. However, insurance is not the most equitable system. The most equitable system is to have health care paid by general tax revenues.

Financing is important, because it gives you power to do other things. Not that money is every thing, but if you have control over money you can effect how the money is used. For example, more organised services could be provided. So I think it would be wise to first develop National Health Insurance (NHI) and at the same time strengthen the delivery side by organising health centres and polyclinics.

I think the best medical care can be given by teams of personnel working together in health centres. You have a history of wonderful health centres in South Africa, but they were not sufficiently financed by the apartheid government. These primary health care centres that were started back in the 1930s - where doctors, nurses and others worked together - you most probably want more of these, where people can get health care from a team of personnel and not just from a private doctor in a private office which I know is preferred by many upper middle-class people. But this is wasteful and does not necessarily give good quality care.

So I think there should be as much development as possible of organised



The best medical care can be provided by teams of personnel working together in health centres or polyclinics. Photo: Medical Health Project

delivery of general medical care and preventive services by teams of personnel in health centres or what some countries call polyclinics. These health centres or polyclinics could have a number of different specialists, for example, paediatricians, obstetricians/gynaecologists, and maybe sometimes specialists in dental care or psychiatry as well as general practitioners.

Q. In South Africa we face the challenge of dealing with a large private sector. Opinion ranges from those favouring total nationalisation of health care to those in favour of leaving the private sector alone to collapse under the weight of its own limitations. Can you comment?

MR: I guess for some time you may be stuck with hospitals under private auspices, but I don't think the politics of South Africa, from what I know, would permit the new government to take over all the private hospitals as they did in Great Britain. In Britain the government did take over the private hospitals, but that was after 30 years of compulsory insurance. There was a critical situation in the British private hospital system after World War II. Hospitals in debt were taken over by the government. I think, after a certain number of years, the government could take over the hospitals, as they did in Britain and the Scandinavian countries.

Q. Could you comment whether it is possible to avoid a two tier system (that is, a private sector and a public sector providing different quality health care) in South Africa?

MR: A two-tier system is most likely to continue until there is complete integration under a democratic system of government. It would take time to get rid of it. I don't think there is a revolutionary situation in South Africa where power would be seized as in the case of the Bolsheviks in Russia or as in the case of China where a unified system could be established immediately.

Q. Some people in South Africa have suggested some form of centralised policy-making in health care, with decentralised flexible programme development. For many people that conjures images of a centralised bureaucracy. How does one overcome the tension between an overcentralised bureaucracy and too much decentralisation so that overall national priorities can still be devised and implemented?

MR: I have found it very hard to make generalisations, given the situation in different countries. The ideal, it seems to me, is to have a central authority to set standards and to provide money. The money, in the form of grants, should attempt to equalise different local areas which differ in natural resources and wealth. The local authorities should be responsible for implementation. In fact, there seems to be quite a world movement towards decentralisation and government at local level (be it county, municipality or district) being strengthened to be capable of managing all the health services within a local area of say 50 - 100 000 people.

Q: Assume we have NHI in South Africa. We can neither take over the individual private practitioners, nor can we prevent people from going to individual private practitioners. How does one encourage people to go to community health/ primary health care centres?

MR: The answer lies in strengthening the public sector. If you make the public sector attractive, people will be less likely to go to the private sector. Many countries have a dual system of private/public care, but there is an extra price to pay for use of the private sector. Many Latin American countries have social security (similar to NHI), but if a person wants to see a certain private practitioner, because they like the attitude of the doctor or his sense of humour, they can do so, but they have to pay out-of-pocket, whereas they don't in the public sector. That means that the private sector will be used by people with more money. If it is only going to affect 10% of the population, I don't think it is such an inequity.

Gradually that will be reduced I think. As a matter of fact, the experience in the Scandinavian countries has been that, as the public sector has been strengthened with good health care personnel and enough doctors and nurses, more people have used the public sector. Why should they pay more if they can get perfectly good care in the

public sector? In Sweden and Finland, the private sector has almost disappeared, but it is a gradual process.

Q: If national health insurance is implemented more than 200 private medical aid schemes will come to an end. How does one deal with the competing vested interests of this strong private sector lobby?

MR: In Australia there was a period when Australian NHI was carried out through subsidies of the private health insurance companies. Then the law was changed and it was made a government scheme with one big national fund. The private insurance still exists but on a much smaller scale. It only covers child-birth and elective (non urgent) surgery. Perhaps there is a role for private insurance, but only to serve the small percentage who are willing and who can afford to pay twice - taxes or social security and then to pay extra to private insurance for a private room in a hospital instead of a ward with 6-8 people or who want fast access to elective surgery for which there is a waiting list. No matter how many personnel one puts in a public system, the demand is usually high. The waiting lists for hernia and varicose vein operations are long, and people can break through the waiting lists if they have private insurance. The question is, of course, whether it is a serious inequity. Granted it does mean that people with money have a service which is a little better, but if the public system is made strong enough, the private sector gets smaller and smaller.

Q: You have written a lot about personnel issues. There is a lot of debate in South Africa about community health workers (CHWs) as part of the primary health care team. They have mainly been trained and used in rural areas and peri-urban areas. Some people have suggested that programmes should be implemented on a national scale, while others have said that South Africa is a middle-income country and could train higher level health workers.

MR: The use of community health workers with limited training is tricky. I feel they could be abused in a system which is not democratic, for example, when you say that those who live in cities or have enough prestige can see a doctor, but those who are poor and who live in rural areas should go and see a CHW. In my opinion, CHWs should be used in every system but as part of a team. If the team has doctors and professional nurses on it, there could also be CHWs for handling simple problems - not just for rural people but for everybody.

When it comes to a poor country in Africa, for example, Ghana, there are so few doctors, it may be necessary for everybody to be served by CHWs until they can build up an adequate supply of doctors. But these countries should have laws as were passed in Mexico and even Iran, to require that new medical graduates must serve in rural areas. Everyone then has access to at least young doctors, and gradually one can build up the supply. So I think we have to be careful that we don't just supply CHWs in rural

The most important freedom to ensure is that of people's access to medical care, not the freedom of doctors to practice where they like. Photo: Medico Health Project

areas or in slums, on the grounds that we can't get doctors to go there. Doctors should be provided where they are needed. The important freedom to ensure is that of people's access to medical care, not the freedom of doctors to practice where they like. The medical associations usually think that the most important freedom is for doctors to practice in a city where every thing is comfortable.

Q: There is also a debate in South Africa about the method of payment for doctors. Could you comment on the appropriateness of fee-for-service, salaries and capitation forms of payment?

MR: I think the capitation method has a great deal to be said for it, because it gives the doctor the incentive to have more patients choose him or her, and at the same time it does not give extra payment for extra procedures or services. It is interesting that in the Soviet system, one of the corrective actions that the new Minister of Health under Gorbachev is taking, was to introduce capitation payments on top of the salaries that the doctors get in a polyclinic. The doctor gets an additional monthly capitation payment for all the people that choose to be served by that doctor, and this makes the doctor careful to be nice to people.

I think that salaries are reasonable, but they should be elastic, they shouldn't be absolutely fixed. Even with a salary, you can have incentives for diligent work. Combining salaries and capitation has a lot of advantages.

Q: Drugs are another potential cost-saving area in health care. Could you comment firstly on essential drug lists, and secondly on how to deal with the vested interests of the multinational drug companies?

MR: The WHO has been promoting the idea of lists of essential drugs, that is, limiting the number of drugs that may be imported into a country, but only a few countries have adopted it for the total health system. Norway had a strict policy on something like 2000 drugs that could be sold in the country. About 50 countries have developed a list of essential drugs for public facilities. Usually a committee of top physicians and pharmacists selects about 200 - 300 drugs, usually the cheaper generics. That has been a real source of savings. One of the few countries that have done this for all drugs is Bangladesh, and it has achieved even greater savings. It was found that the companies that thought they were going to lose money did not lose money; there was just a trivial change in their profits.

The USA only spends about 8-9% of its national health expenditure on drugs, which is very high of course, whereas in the developing countries, where they have to import drugs, it may be 20 or 30% of national health expenditure. An essential drug policy is particularly important in these countries.

Q: In South Africa, as in the United States most of the pharmacists are in private practice and they run these pharmacies like supermarkets. What kind of role should pharmacists play?

MR: The pharmacy is a useful public resource for health care. I would like to see pharmacists being trained in health education, and maybe doing lab tests in an area, which could be convenient to people. All too often pharmacists are concentrated in cities and there is a shortage in rural areas, just like for other personnel. A demonstration of how the situation can be corrected was in Cuba, where they closed down the pharmacies in cities and built them up in rural areas.

Q: Community participation is one of the key components of the WHO Declaration of Primary Health Care. From your travels around the world, are there any countries where community participation is operative, and what lessons could we learn in South Africa?

MR: I'm afraid there has been much more talk about such participation than action. There are not many countries where citizen groups have played a significant part. One I happen to know about, and they take a lot of pride in it, is Cuba, where committees of consumers - people in the neighbourhood around each of its polyclinics and hospitals - have been organised. I don't know how effectively this has been done in other countries. The average consumer, I guess, even if he or she is a natural leader, feels a little hesitant to give advice on health issues, because they do not feel they know

enough about them. A lot more work needs to be done on community participation, and how citizens can participate in policy making at a local level.

A National Health Service - the UK experience

by Rachel Jewkes and Anthony Zwi

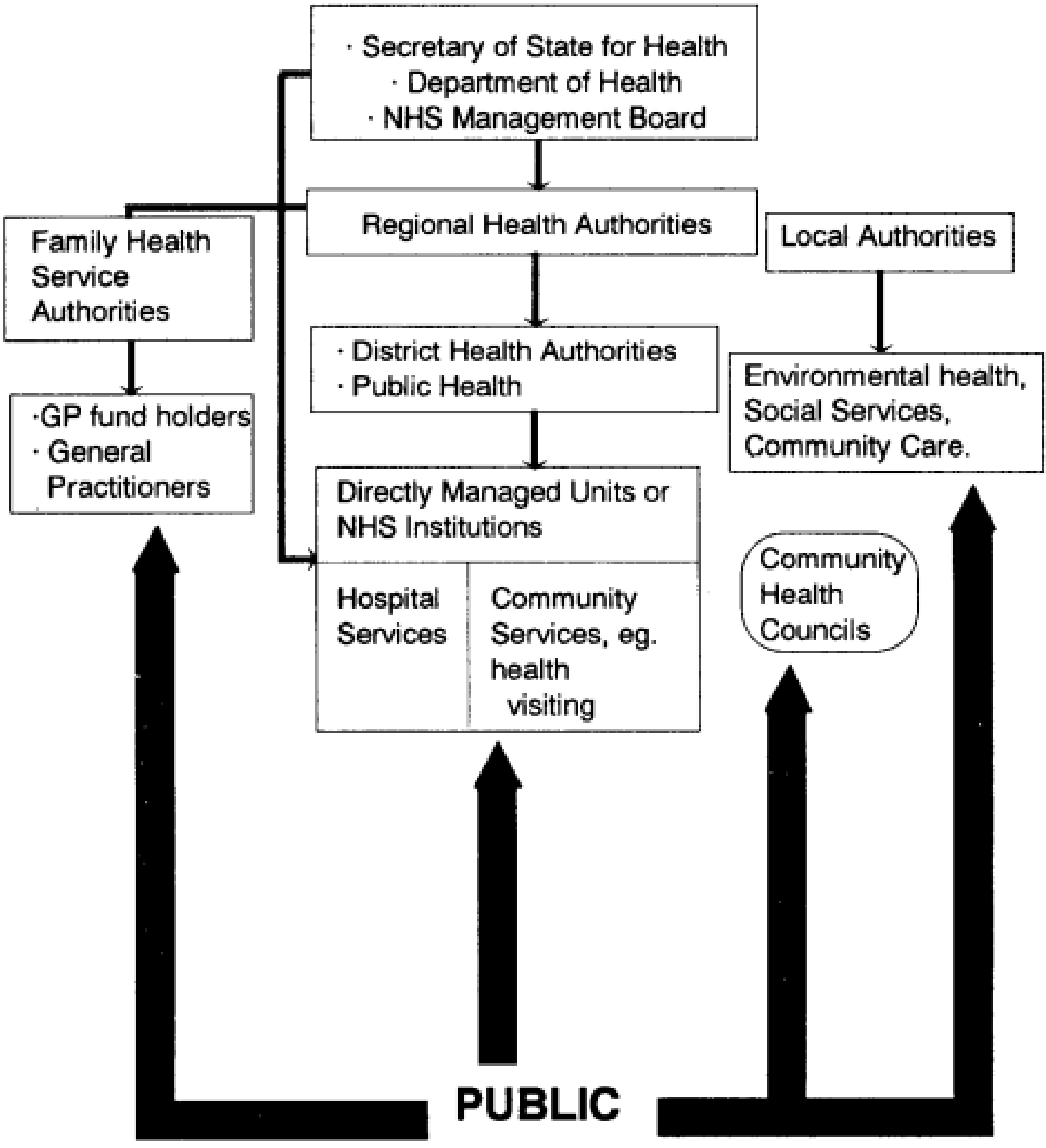
This article provides a broad overview of the British National Health Service. It describes the structures of control, as well as the role of Community Health Councils, Directors of Public Health and General Practitioners. The article briefly examines "the NHS reforms" introduced by the Conservative Party government to create an "internal market" within the NHS. Positive and negative aspects of the NHS are assessed and the author concludes by suggesting what some of the lessons of the British experience have been.

The British National Health Service (NHS) was established by the Labour Party government in 1948 as part of the programme of national reconstruction following World War II. Its aim was to provide "a comprehensive health service designed to secure improvement in the physical and mental health of people in England and Wales by prevention, diagnosis and treatment" (Ministry of Health, 1946).

Before the War the health care delivery system was fragmented (partly private for profit, partly charitable, partly local authority, and partly insurance scheme), and haphazard, and excluded many people from access to appropriate treatment (Morgan, et al; 1985, p.178). The NHS provides high quality care across the broadest range of services and is free at the point of delivery, available to all on the basis of need, and of one standard for rich and poor alike.

Structure of the NHS

(arrows indicate lines of responsibility & access to services)



Structure of the NHS

Regional Health Authorities and District Health Authorities

The NHS is an hierarchical organisation ultimately accountable to the Secretary of State for Health. The national controlling body for the NHS is the Department of Health. Powers for administration and running of the service are delegated to the 14 regional health authorities (RHAs) and 189 district health authorities (DHAs).

RHAs cover populations of 2-5 million people; DHAs serve a population of about quarter to half a million. Both types of health authority are composed of executive (employees) and non-executive (lay) members; they are not elected and may therefore be appointed on a political basis and are not accountable to the local communities (Ham, 1991).

Community Health Councils

Community Health Councils (CHCs) were set up in 1974 to represent the views of consumers of health services. Their members are nominated by voluntary organisations, local authorities and the RHA. They too are not elected. The Secretary of the CHC is a paid employee of the RHA. They have access to public information, the right to visit hospitals, access to senior managers and, prior to the latest NHS reorganisation, had rights of attendance at health authority meetings. They have few formal powers and in practice do not amount to real community participation (Doyal, 1979 p.185).

Directors of Public Health

Each district has a Director of Public Health who is the chief medical advisor to the DHA. The role of the Director includes determining the health status of the local population and the factors influencing it, assessing the health care needs of the population, monitoring the effectiveness and efficiency of services, providing public health advice to local agencies, communicable disease control and health promotion.

General Practitioners (GPs)

General practitioners (GPs) are independent practitioners who contract with Family Health Service Authorities (previously called Family Practitioner Committees). They undertake to provide primary health care (PHC) to 2 000 - 3 500 people who are on

their "list". Everybody in Britain is entitled to be "on the list" of a GP and receive care from him/her; about 98% of the population are.

GPs are paid from the Family Health Service Authorities according to their list size, items-of-service, preventive activities like immunisation and health promotion. Historically, they have not had to worry about the costs of treatment or prescribing, although this is now changing.

Some of the large general practices (group practices with more than 9 000 patients) are given a budget from the RHA from which to purchase hospital care and drugs, except for emergency care, for their patients.

The distribution of GPs is controlled centrally to ensure that all areas of the country are served; some incentives are provided to encourage GPs to work in under-served and more needy communities. GPs are the gate-keepers to secondary care in the NHS and can refer patients on for treatment to the hospitals with which the local district health authority (or in the case of fund-holding practices, they themselves) have contracts. There are some private GPs but their numbers are so small as to be negligible.

The NHS Reforms

Prior to 1 April 1991 the acute care hospitals (with the exception of a few specialist hospitals) were all managed and funded directly by DHAs. After the introduction of the latest reforms, the NHS was split into those who purchase health care and those who provide it, in an attempt to introduce a competitive "internal market" in health care.

"Providers"

In most cases the "providers" are the same hospitals units (now called "directly managed units") that have been delivering health care for years. The most notable differences are that they are no longer directly funded and all the resources they need to provide a service come through winning contracts from the "purchasers".

Some hospitals have taken an option of "self-governing" status. These remain broadly within the framework of the NHS but are accountable to the Secretary of State for Health and not the health authorities, they are run by a board of directors, and can establish their own management structure, employ their own staff and set their own terms of employment. In all these respects they differ from the directly managed units. They can also choose to provide the services they wish and find most profitable.

"Purchasers"

There are two types of purchasers in the new system. The main purchasers are the DHAs. They have a budget provided by the RHAs from which they are expected to purchase the health care needed by their communities. They can purchase from directly managed units, self-governing trusts or private hospitals (of which there are very few) depending on where they can get the quality they require at the lowest price.

Fund-holding GP practices make their own contracts with providers, and account for approximately 10% of purchasing power.

Finance

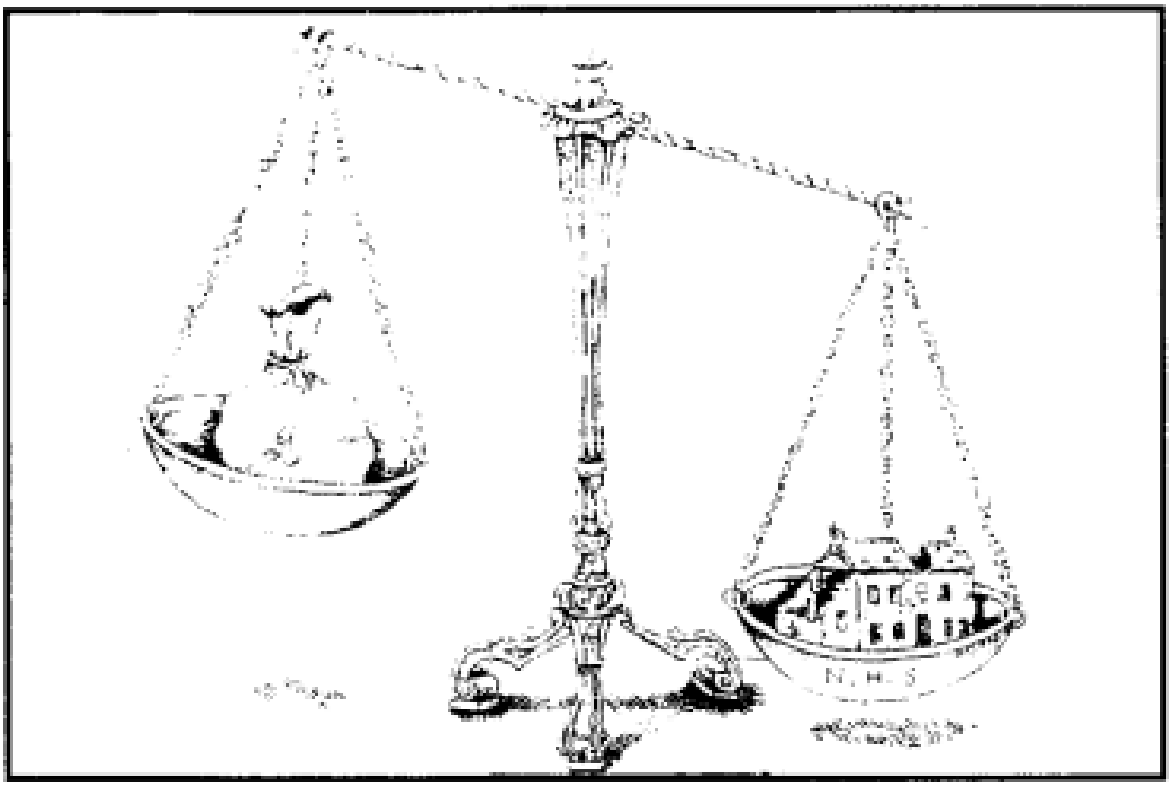
The NHS is 96% funded from central government revenue. Of this 81% is from general taxation and 15% from National Insurance contributions which are deducted from employee salaries with an employer contribution. The remaining 4% of NHS funding is from direct charges for prescriptions (a flat rate per item paid only by the employed, currently 3 pounds), dentists and opticians (Ham, 1991).

Some Positive Features

A high standard of health care is available to all. Access to hospitals is either through GP referral or through casualty departments.

· The NHS encourages health promotion activities, although most activity is treatment orientated. Community services, such as community nursing and psychiatric services, also form an important part of available care supporting and maintaining people in their homes: some complimentary services are provided by local authorities.

· Although the NHS is frequently criticised for being inefficient, only 6% of the Gross Domestic Product is spent on health care compared to 9% in Sweden and nearly 12% in the USA (1987 figures) (Ham, 1991). Services provided are acknowledged to be as good as or better than those in similar countries. Pharmaceuticals are purchased at centrally-agreed prices which are lower than in other countries. Until the latest NHS reforms, all staff where employed on a nationally agreed basis which meant that the salaries of the most skilled professionals were kept much lower than those of colleagues in comparable countries.



Underfunding is always a problem. (Source unknown)

· Administration in the NHS is very efficient. Until the NHS reforms were introduced only 5% of the NHS budget was spent on management (Donaldson and Donaldson, 1988). Resources intended for health care were not wasted on invoicing and charging.

· National coordination is relatively easy in the NHS. Health policy issues, such as drug policies, can be decided nationally and implemented locally. Prior to the latest NHS reforms, services were centrally planned and there were attempts to ensure that resources were allocated and services available nationwide according to need.

· The NHS is supported by most of its staff, even those who are politically Conservative. Much of the success of the NHS has been due to its ability to harness this support as well pride in the service amongst local communities.

· Private practice is kept to a minimum. Only 200-300 doctors work solely in the private sector (Griffiths et al, 1987). Over 90% of consultants work at least 80% of their week for the NHS and use their NHS practice as a "shop-window" for their private practice (DHSS Annual Census, 1985). Although there are important criticisms to be made about private practice in Britain, consultants in the UK work many more hours in the state sector than they do in many comparable countries.

Unfortunately most of the above features are threatened or directly undermined by the latest NHS reforms and attempts to subject health care to market forces. A critique of these reforms is not provided here.

Some Negative Features

· Community participation and control is insufficient. With no local accountability, the system is vulnerable to party political manipulation.
· There has been too much professional autonomy. Prior to the NHS reforms consultants were not accountable and they had unlimited budgets for the introduction of new, often untested, technologies leading to escalating health care costs (Morgan et al, 1985, p.189). One positive feature of the NHS reforms is that they attempt to limit the power of professional and make them accountable. Consultants are being made to account for expenditure in their departments; they must agree to timetables with their managers and must account for their clinical practice through medical audit.
· In reality there is still overwhelming hospital dominance of the system. Health promotion and prevention of disease is severely underfunded.
· The NHS suffers from chronic underfunding, which has resulted in dissatisfaction with some areas of the service, notably the long waiting lists for surgery.

Lessons Learned

· Restricting the power of doctors is essential if any new health system is to avoid some of the mistakes of the British NHS. Clinical practice must be subject to peer review and appropriate clinical audit.
· The availability of free primary health care and health promotion is possible through the general GP system. This is by far the greatest strength of the NHS and is the key to the service being cheap, comprehensive, acceptable, and accessible to the total population.
· Communities should have real power over local health services, although this should be balanced by a strong central policy and overall health strategy.
· New technology, new drugs and new treatment should be introduced only after proper evaluation.
· Staff support is essential and real problems such as poor wages of less skilled staff grades should be addressed. Junior doctors should not have working conditions which other workers and their unions would not accept. Career planning and training should be available, to make the best use of junior medical staff.
· NHS experience of minimum private practice indicates that private practice should be controlled so that the state sector does not lose the benefit of these doctors training and skills.
· Equality has to be worked at. Access to services is not made uniform by simply removing tariffs. Certain disadvantaged groups, such as minority ethnic groups, the

elderly, women, the unemployed and unskilled, and the homeless have specific needs which have to be addressed first. These needs include interpreters and advocates, help with transport, play areas for children, appropriate clinic hours, and information about services and health in general.

· There are limitations to any health care system. A national health service does not solve a country's health problems on its own. Despite 40 years of the NHS in Britain wide class-based and geographical-based inequalities in health persist (Townsend and Davidson, 1982). Radical changes are needed in society tackling the social determinants of ill health before radical improvements in health will be seen.

Conclusion

The NHS has provided an excellent service to the people of Britain, which unfortunately is now declining due to years of underfunding and recent moves by the government. Although clearly the NHS system cannot be transferred directly to South Africa, many features of the service may be relevant to those planning a future health system and there are many important lessons to learn.

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Women, class, racism and the British NHS

by Professor Lesley Doyal

The creation of the National Health Service (NHS) in 1948 brought considerable benefits to the majority of the British people. Women, in particular, appeared to benefit from the new system because of their special health needs connected with fertility and reproduction, and because many of them had only limited access to medical care. As the health service expanded it also became an important new source of jobs for women. The NHS is now the single largest employer of women in the country.

It would seem, then, that British women should be well satisfied with the NHS. Yet if we look more closely it becomes apparent that these achievements have been limited. Most notably the NHS seems to have played little role in lessening class and race inequalities in health and the utilisation of health services. Furthermore, it has contributed to the emergence of new forms of control over women's lives and perpetuated the domination of men in the health care system.

Class Inequalities and the Treatment of Women

Mortality variations

Mortality statistics show that the average British woman can expect to live about six years longer than her male counterpart. However, it can be misleading to treat men and women as homogeneous groups, since there are also marked differences in mortality rates within gender groups - differences relating to marital status, to region of residence, to race and especially to social class.

On the basis of evidence drawn form the early 1970s, the ratio of male to female deaths in roughly 2:1 within each social class. In social class I (professional and managerial) the death rate for men aged 15-64 is 3.98 per 1 000, while for women it is only 2.15. The comparable figures for social class V (unskilled) are 9.88 and 5.31,

showing not only a marked difference between the sexes but also a steep social class gradient. Thus women and men in different social classes have continued to have different mortality rates. These differences are significant because they show that for women as well as for men, the potential benefits of the NHS have been limited by the basic inequalities that still characterise British society.

Patterns of female sickness and ill-health

Despite their greater life expectancy, women continue to report more sickness than men and make more visits to their doctors. But again these sex differences mask the very different experiences of women in different social classes. Annual figures for self-reported sickness taken from the General Household Survey 1976 show that the rate of "limiting long-standing illness" is about three times greater for women in social class V than for professional women (Townsend, Davidson and Whitehead, 1988).

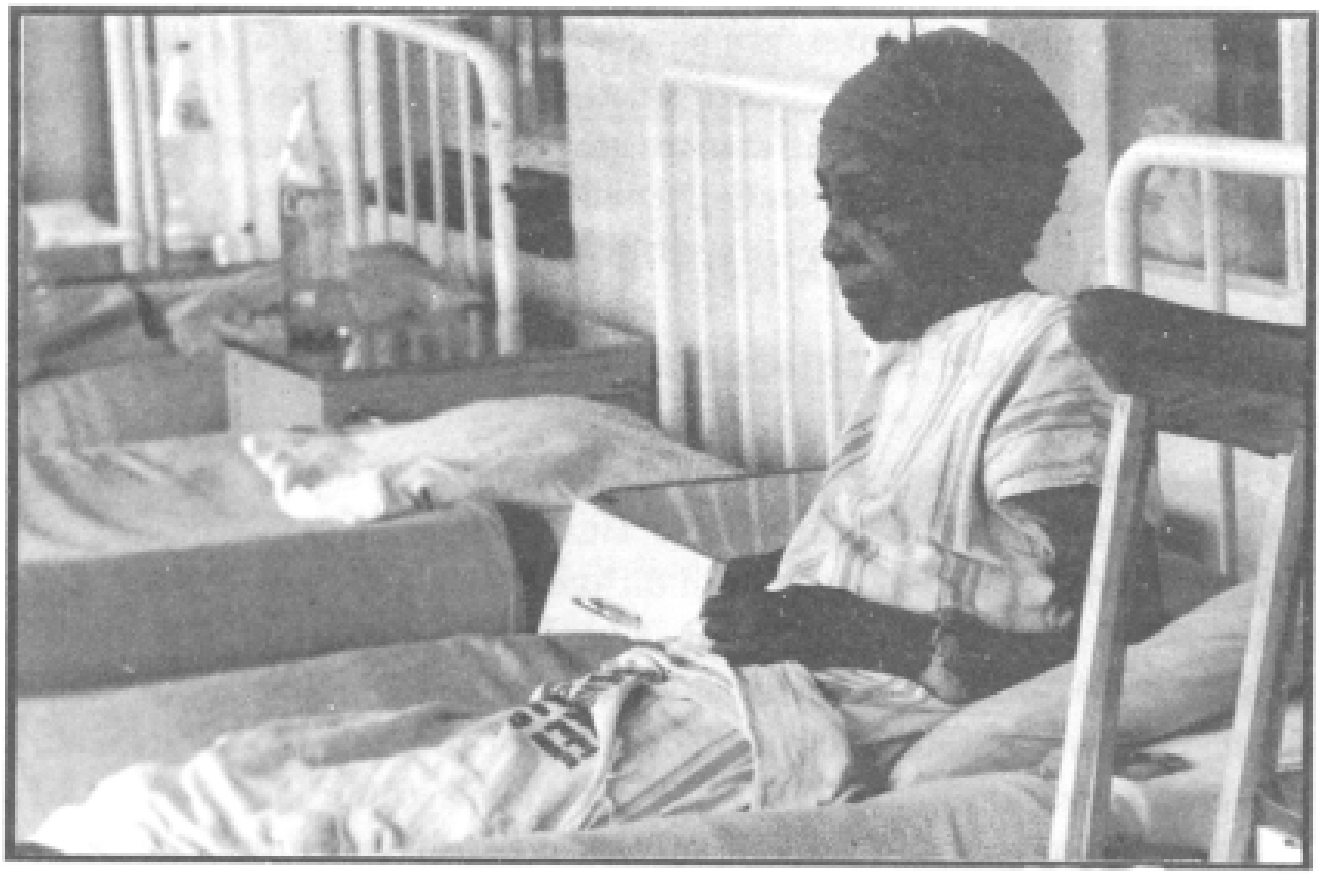
Thus the creation of the NHS has not equalised the life chances of British women, nor their standards of health. The reasons for this are complex and stem in part from continuing inequalities in living and working conditions. But the reasons are also related to the fact that the NHS has not equalised access to medical care. While women as a group make greater overall use of the health service than men (due to their reproductive longevity) there are still very marked differences in utilisation of general practitioner services, of inpatient and outpatient hospital facilities and of preventive services.

Official statistics show that both the number of women consulting a doctor and the average number of consultations for each individual tend to increase with falling social class. This is not surprising given the much higher rates of mortality and morbidity we have already identified in social classes IV and V.

However, researchers have now measured utilisation in a more sophisticated way, by comparing consultation rates, not simply against the numbers in the population, but according to the need for care (Le Grand, 1978). This shows that women in the semiskilled and unskilled groups make relatively less use of general practitioners (GPs) services than other groups when their higher rates of sickness are taken into account.

Quality of care

However, even these relatively sophisticated measures of use and need are still only partial since they do not take into account the quality of care provided. The technical standard of care is difficult to assess but there is evidence that GPs in working class districts tend to have fewer facilities for diagnosis and treatment compared with their



Working class women tend to have shorter consultations than middle class women.
Photo: Medico Health Project

colleagues in more affluent areas.

Moreover, the quality of the personal relationships that are so important in health care also vary between social classes. Several studies have shown that middle-class patients (both male and female) tend to have longer consultations with more extensive discussion of their problems than their working class counterparts. Surveys suggest that these variations in the subjective experience of health care are even more important to women than to men (Cartwright and Anderson, 1981).

Part of the reason for this is that women are more likely to visit their doctors when they are not "sick" - when they are seeking advice about contraception, for instance, or when they need reassurance in a state of depression or anxiety. They appear to bring different expectations to the medical encounter and working class women, in particular, frequently find that their need for communication and for information is not met (Roberts, 1985).

Utilisation of preventive services

One of the main advantages of the NHS for women as a group was their improved access to preventive services and to techniques of fertility control, in particular. However, it is important to determine how far these services have been made equally available to all. This poses considerable methodological problems, since no regular

statistics are collected on the utilisation of preventive services. However, most of the research in this area suggests that women in social classes IV and V make markedly less use of most of these services than those higher up the occupational hierarchy (Townsend, Davidson and Whitehall, 1988).

Cervical screening, for example, is an important service that has been of genuine value in identifying potential cancers in women and in preventing their further development. Yet it is clear that the working class women are much less likely to obtain cervical smears than their middle class counterparts. This class differential in the utilisation of cervical cytology is highlighted when seen against the background of class differentials in death from cervical cancer. The standardised mortality ratio (SMR) for deaths from cervical cancer in 1970-72 was 42 for women in social class I compared with 140 in social class IV and 161 in social class V (Registrar General's Decennial Supplement, 1978). This makes cancers of the cervix one of the most class-linked of all female cancers, yet those women most at risk are still the least likely to obtain smear tests.

Control over fertility

If we look at the areas of control over fertility there appears to be a marked class differential in use of services, with middle class women being more likely to attend a family planning clinic or discuss birth control with their GP. There is also evidence of a higher proportion of unwanted pregnancies among working class women.

In the case of abortion, there is little evidence available to indicate the class origin of the women using such services. However, we do know that the NHS does not meet current needs and that the women with fewest resources are most likely to lose out. The NHS now performs less than 50% of all abortions carried out in the UK, the rest being performed within what is called the "charity sector". These providers are not profit making but charge a "reasonable" sum for their services (currently about 160 pounds).

Thus for many women, the ability to obtain an abortion (especially a quick and easy one) may still depend on whether or not they have the means to pay. In addition the standard of abortions performed (as measured by subsequent mortality and morbidity rates) is considerably better in the charity sector than the NHS, thus bestowing an even greater benefit on those who can pay.

As with abortion and contraception, sterilisation continues to be an issue where women's rights and ability to choose are not always taken seriously. There is, however, something of a reversal in class patterns of use in that childless (often middle class) women frequently have difficulty obtaining sterilisation on the NHS while those (usually black and/ or working class) defined by doctors as "ignorant" or "feckless"

will often be persuaded to do so. In 1973, 10.8% of all abortions (and 20.6% of NHS abortions in England and Wales) were accompanied by sterilisation.

Thus poor women who cannot "opt out" of the NHS are more likely to be coerced into a sterilisation they would not have freely chosen, while those with more resources can pay to obtain the treatment they would prefer.

Race and Health Status

In recent years it has increasingly been recognised that these class differences are exacerbated by racial factors, leading to a situation of double discrimination for many of the most deprived women in the British population. Claims of this kind are extremely hard to substantiate in any quantitative way since British official statistics do not include any racial breakdown (Radical Statistics Race Group, 1980).

However, most black women are to be found at the bottom end of the occupational hierarchy and this inevitably affects their health. Although some ethnic groups have a higher incidence of particular problems (sickle-cell anaemia among blacks being a case in point), patterns of morbidity among black women are broadly similar to those of other women in social classes IV and V, reflecting their low income and unhealthy living and working conditions.

However, black women also have to bear the added burden of the racial discrimination that still permeates many aspects of the functioning of the NHS. In some cases this is manifested by a lack of concern by health workers for the needs, desires and lifestyle of the patient, or even a straightforward attack on values and practices perceived to be alien. This can be a particular problem when the patient's native language is not English, and Asian women receiving obstetric care have often suffered in this way. But it can also amount to a more institutionalised form of racism as recent writers have documented (Mares, Henley and Saxler, 1985).

New Forms of Control over Women's Lives

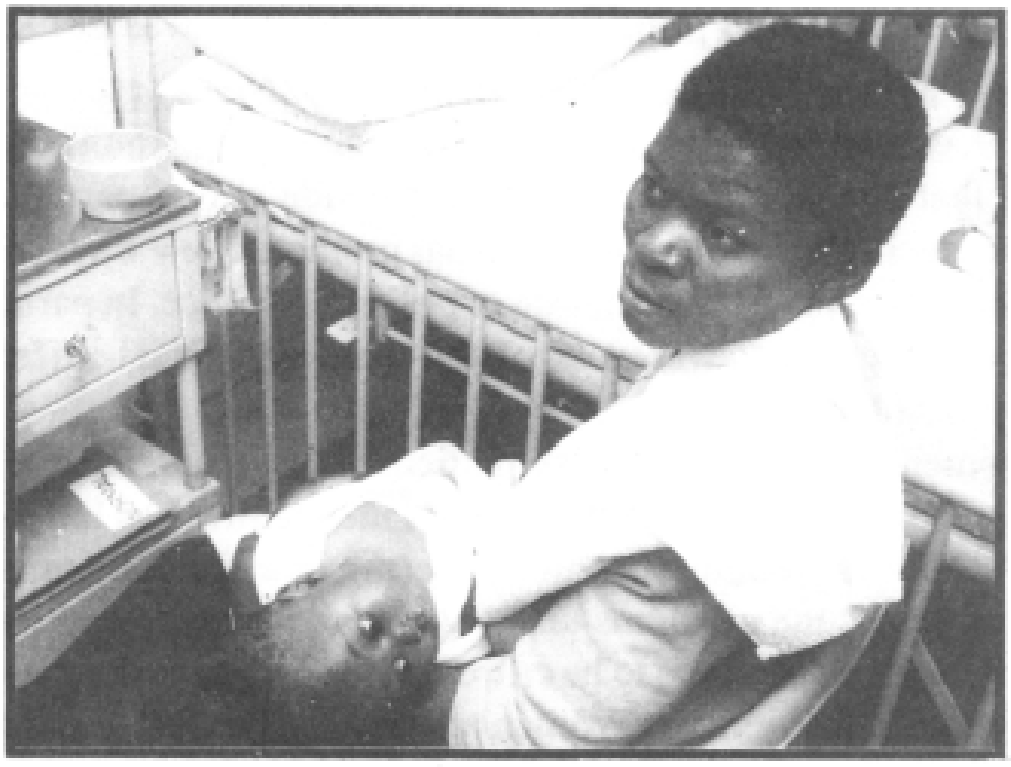
As feminists have pointed out, many of the gains women have made in access to medical care have been accompanied by a growth in the degree of control doctors are able to exert over fundamental aspects of their lives (Leesom and Gray, 1978; Roberts, 1981; Doyal and Elston, 1986).

This is particularly clear in the case of medical control over reproductive technology. Perfectly healthy women are still dependent on doctors for information, advice, and sometimes even physical access to contraception, while abortion, in particular, remains firmly in medical hands. Doctors increasingly control not just the means to prevent pregnancy but also the conditions under which women give birth.

While medical intervention has played some part in improving rates of infant and maternal mortality, its importance has often been greatly overestimated. In fact, there is a growing belief that the medicalisation of childbirth in Britain goes beyond what is necessary. Attempts by administrators to cut the costs of maternity services and to increase bureaucratic efficiency and the desire of doctors to develop more sophisticated technology have often been allowed to override the interests of mothers and babies. Indeed there is a real sense in which doctors whose job satisfaction often lies in high technology intervention have been able to appropriate much of the satisfaction of childbirth from the woman concerned.

Male Domination

Women continue to experience discrimination and disadvantage (Beechley and Whitelegg, 1986) and are seen as inferior to men, whatever, their social and economic status. This general denigration of women has been reflected in the functioning of the



Women have increasingly less control over issues of their reproductive capacity and childbirth. Photo: Medico Health Project

health service.

As users women have little say in the running of the NHS. Just as importantly, the majority of health workers who are women have very little control over their own working conditions. Power has remained firmly in the hands of white middle class men and as a result the NHS has continued to reflect their interests and priorities.

Thus the NHS has failed to live up to its potential for improving women's health or for providing equal opportunities in the workplace. Moreover, it has facilitated the development of new sources of control over women. As a result, women have become involved not just with defending the services as provided, but also with the formulation of proposals for qualitative changes in their organisation and control (Doyal, 1983).

Women and Organisation around Health Care

With the development of the contemporary women's movement in the 1960s medical care became an important focus for political action (Doyal, 1983). The earliest of these feminist health campaigns were concerned primarily with medical sexism. Women began to discuss their experiences of health care, to identify the particular forms of sexism encountered in medical practice, and to formulate strategies for their elimination. The emphasis was on women taking care of themselves and each other; challenging the policies and priorities of the NHS itself was not seen as a major priority.

However, economic and political developments during the Thatcher years have demonstrated that strategies of this kind can provide only a partial solution to the health problems facing British women. This has prompted new ways of thinking about women's health needs and a reorientation of political practice. In particular, it has led women to a much greater awareness of the class and racial differences in their experiences of health care.

Thus women have become active participants in the defence of the NHS and their growing recognition of the race and class inequalities has led to the forging of important links between feminist health strategies and wider political campaigns. Not surprisingly, however, the problems many women have experienced with the health service have sometimes led them to be critical of the orthodox defensive strategies of the male dominated trade unions. Women are seeking not just to defend the NHS as it is, but to make it more responsive to the needs of the consumers.

In its early stages the feminist critique of the NHS concentrated on the treatment

women received at the hands of doctors, and the development of health problems was given little attention. However, attention has now shifted towards an exploration of what it is that makes women sick. British feminists have begun to examine the illnesses and disabilities that bring women into the medical care system and to explore the ways in which these problems can be explained by particular aspects of women's lives. They have recognised that the National Health Service is in reality a National Sick Service because while it provides a certain level of medical care for women, it plays only a very small part in the active promotion of their health.

In theoretical terms this has meant the beginnings of a socialist feminist understanding of health and health care and in more practical terms it has led to campaigns to improve the living and working conditions of women.

Lesley Doyal is Professor of Health Studies at Bristol Polytechnic. This is a shortened version of an article which appeared in Lewin and Oleson, (1985). Women, Health and Healing: Toward a new Perspective. Tavistock.

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RESOURCE LIST

Please note that this list is not exhaustive. We have tried to provide the most relevant articles and books available in the country concerned with the development of a National Health Service.

CENTRE FOR HEALTH POLICY PUBLICATIONS LIST

Books

1. A National Health Service for South Africa. Part I: the case for change

Monographs:
Number in brackets indicates CHP list number

1. (no. 2) Buch E. 1987. *Towards a national health service - forward from the current situation: current resources and their development - facilities.*

2. (no. 3) Buch E. 1988. *Health services in the South African homelands.*

3. (no. 4) de Beer C; Buch E & Mavrondis J. 1987. *Introducing a national health service: obstacles to be overcome.*

4. (no. 5) de Beer C. 1988. *A health service for the future: some utopian thinking.*

5. (7) Buch E & Rispel L. 1989. *How will a national health service affect general practitioners in South Africa?*

6. (10) de Beer C. 1989. *How many beds does Baragwanath Hospital need?*

7. (11) Price M & Tshazibane P. 1989. *Dilemmas posed by medical aid schemes for the labour movement.*

8. (12) Broomberg J & Price M. 1989. *Evaluating a medical aid scheme proposal.*

9. (13) Price M & Broomberg J. 1990. *What's wrong with medical aid schemes?*

10. (14) Broomberg J & Price M. 1990. *Towards an integrated health care financing and delivery scheme.*

11. (20) Freeman M & Motsei M. 1990. *Is there a role for traditional healers in health care in South Africa?*

12. (21) de Beer C & Broomberg J. 1991. *Financing health care for all: is National Health Insurance the first step on the road to health care for all?*

Briefing Documents
Number in brackets indicate CHP list number

1. (1) *Medical aids and the cost of health care: what happens next?* November 1989.

2. (2) *Privatising hospitals is bad for your health.* November 1989.

3. (3) *The cost of private health care: explaining the crisis.* November 1989.

4. (4) *Policy studies for political change an immediate priority.* August 1990.

5. (6) *Dismantling apartheid in health care.* September 1990.

6. (7) *Mending the fragments?: the national policy for health act.* November 1990.

7. (8) *The great nationalisation debate: the case of private health care.* November 1990.

8. (9) *An end to hospital apartheid: a case study of progress towards non-racialism.* March 1991.

Technical Reports
1. Broomberg J & Rees H. February 1991. *The costs of public sector primary health care: a case study of the Diepkloof community health centre.*

All the above as well as the full list is available from:
CENTRE FOR HEALTH POLICY
DEPARTMENT OF COMMUNITY HEALTH
WITS MEDICAL SCHOOL
7 YORK ROAD
PARKTOWN 2193

Journal Articles

South African Medical Journal (SAMJ)

Square brackets indicate CHP reprint number.

The future of medical aid schemes in South Africa - towards national insurance or the American nightmare?
Broomberg J. [25]
April 1991 (79) p415-18

The need to democratise the health services - a challenge to doctors.
Njikelana S; Price M & Jeppe C. [13]
Jan. 1991 (1) p4

The 1983 distribution of hospitals in the RSA by area, race, ownership and type.
Zwarenstein MF & Price M. [14]
Aug. 1990 (78) p130-33

The impact of the fee-for-service reimbursement system on the utilization of health services: Part I. A review of the determinants of doctor's practice patterns.
Broomberg J & Price M. [14]
Aug. 1990 (78) p130-33

The impact of the fee-for-service reimbursement system on the utilization of health services: Part II. A review of the determinants of doctor's practice patterns.
Broomberg J & Price M. [15]
Aug. 1990 (78) p133-36

The impact of the fee-for-service reimbursement system on the utilization of health services: Part III. A review of the determinants of doctor's practice patterns.

Broomberg J & Price M. [16]
Aug. 1990 (78) p136-38

The private health sector in South Africa - current trends and future developments.
Broomberg J; de Beer C & Price M. [17]
Aug. 1990 (78) p139-44

Financing health care for all - is national health insurance the first step?
de Beer C & Broomberg J. [18]
Aug 1990 (78) p144-48

Reducing health care costs - potential and limitations of local authority health services
Ijsselmuiden CB & de Beer C. [19]
Aug. 1990 (78) p161-64

Achieving health care for all
de Beer C & Broomberg J. [20]
Aug. 1990 (78) p119-20

A comparison of prescribing patterns and consequent costs at Alexandra Health Centre and in the private fee-for-service medical aid sector.
Price M. [21]
Aug. 1990 (78) p158-60

Problems with privatisation (letter)
Simpson MA.
Aug. 1990 (78) p168

A unitary health service for South Africa
Benatar SR
Department of Medicine, University of Cape Town
May 1990 77 (9) p441-7

A Methodology for resource allocation in health care for South Africa, Part I: rationale and prerequisites.
Klopper JM; Bourne DE; McIntyre DE; Pick WM; Taylor SP: Department of Community Health, University of Cape Town.
Sept. 1989 76 (5) p209-11

Health funding - the writing on the wall: a personal view (editorial).
Benatar SR.
July 1989 76 (2) p43-4

Aanvalle op die privatisering van gesondheidsdienste
{Attacks on the privatisation of health services}
Hertzog ED & de Villiers JN.

May 1988 73 (9) p511-2

Use of indicators in achieving "Health for All" in South Africa.
Yach D & Klopper JML.
1987 72 p805-7

South African health care expenditure, 1975 - 1984 .
Taylor SP & Klopper JML.
1987 72 p802-4

Privatisation of South African health services - are the underlying assumptions correct?
Naylor CD, Department of Medicine, University of Toronto, Ontario, Canada.
Nov. 1987 72 (10) p655-6

The health and wealth of South Africa.
Klopper JML & Taylor SP.
1987 72 p799-801

A National Health Service for South Africa.
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