The provision of hospitals and clinics in South Africa

Some steps to redress the problems

A number of papers have demonstrated the harmful effect that apartheid has on the mental and physical well-being of an individual and society as a whole. The racial inequalities between the black and white, as well as urban and rural, distribution of hospital beds and clinics is also well known.

This paper by Kamy Chetty focuses on the distribution of fixed health facilities (hospitals and "stationary" clinics) in South Africa for the different levels of health care and analyses some of the problems with the present distribution. Steps that can be taken to redress the problems are suggested.

Distribution of facilities for primary, secondary and tertiary care levels

The South African government often argues that health care delivery for blacks in South Africa is better than other countries in East Asia and Africa, by comparing the total of all available hospital beds. A more coherent analysis of the present health care delivery system is provided by assessing the distribution of facilities according to the type of care that is delivered at primary, secondary and tertiary care levels. (Figure 1)

1. The Primary Care level - embraces all general health practice services offered to the population at the point of entry into the system. This includes health workers based in communities, clinics and health centres as well as the general practitioner. This paper will concentrate on fixed clinics and health centres.

2. The Secondary Care level - comprises the more specialised services to which people are referred by the Primary Care services.

These are the hospitals which provide general medical or surgical care, and institutions which cater for specific categories of patients. In this paper, this level has been sub-divided into:

a) general hospitals which provide general medical and/or surgical care;

b) special hospitals which provide long term care for psychiatric or TB patients, and maternity, nursing or geriatric hospitals and/or homes.

3. The Tertiary Care level - includes highly specialised services not normally found at the secondary level. It includes the referral hospitals, highly specialised units and academic teaching hospitals.

The pyramid approach (figure 1) suggests that most of the facilities should be focused at the primary care level with least emphasis at the tertiary level in order to deliver appropriate health care.

Figure 2 illustrates the distribution of hospital beds in the metropolitan areas in the provinces, for the tertiary and secondary (shown as general and special) levels. The graph shows that most of the care in metropolitan areas is delivered by tertiary care hospitals, and that a disproportionately low number of hospital beds provide general care. Further analysis shows that of the hospitals that provide general care in these areas, a large proportion are in the private sector and are "private for profit". This implies that they are mainly accessible to private fee paying and medical aid patients. The following table indicates the percentage of these beds.

Area	% Private for profit
Cape	65
Natal	38
Orange Free State	26
Transvaal	26

Figure 3 shows the distribution of beds at the tertiary and secondary levels in the homelands. This illustrates that greater emphasis is placed on general beds but there still exists a disproportionately high number of tertiary beds in Bophuthatswana, Kwazulu and QwaQwa.

Figures 4 and 5 illustrate the distribution of clinics in the homelands and provinces. These indicate that, with the exception of Venda and Ciskei, there is also a poor distribution of clinics at both provincial and homeland level. The WHO recommendation is 10 000 people per clinic.

The above analysis shows:

1. A bias towards tertiary beds in the provinces.
2. A poor distribution of facilities at the primary care level.

What are the solutions?

Immediate removal of racial segregation at all facilities within provinces will only partially redress the problem of racial inequality.

However, dramatic improvement in the number of beds for the homelands and for blacks within provinces will result if the fragmentation that is created by the homelands system is abolished. This will be achieved through incorporating homelands into the geographical area of the provinces, (i.e. Ciskei and Transkei into the Cape, Kwazulu into Natal, QwaQwa into OFS and the rest of the homelands into Transvaal).

The following tables describe the consequences in terms of hospital beds per thousand population and population size per clinic in each of the provinces.

Despite the improvement after desegregation and the incorporation of the homelands, there still remains a deficiency of clinics at primary care level for most of the country.

Analysis of total numbers alone, however, is insufficient as there are many other factors that affect equity in the provision of health care. Three of these factors are financial access, geographical access and socio-economic access.

Area	Number of beds per 1000 population
Cape	4.8
Natal	4.5
Orange Free State	3.4
Transvaal	4.3

Area	Population per clinic
Cape	11 015
Natal	21 878
Orange Free State	17 958
Transvaal	19 133

1. Financial access

As has been shown, a large proportion of the general hospitals in the metropolitan areas are private, fee for service institutions which are mainly accessible to the majority of whites and a minority of blacks (i.e. those on medical aids). Blacks in the metropolitan areas therefore are heavily reliant on tertiary care institutions for general medical care. This is not cost effective for the health system, as tertiary beds are more expensive than general beds.

The questions this conference needs to address are:

1. Should we build more general hospitals within the public sector, or should the tertiary care hospitals be converted to general care hospitals?
2. Should the private hospitals be made more accessible and if so, how should this be done? For example, do they remain within the private sector, which means the number of consumers within this sector must be increased; should these hospitals become publically owned; or should other options be pursued (e.g. National Insurance Schemes)?

If planning for additional hospitals, the need for primary care level facilities, for referral from these institutions and the ability to equip and provide human resources for them, must be taken into account.

An appropriate balance needs to be sought between different levels of health care. Creating additional hospitals without improving referrals will disproportionately increase the benefit to the urban population.

2. Geographical access

Desegregating all hospitals does not lead to immediate accessibility. Access depends on the location of the facilities, the distance people have to travel, and the availability of transport and communication. In planning for the future, these factors must be taken into account and appropriate solutions found.

3. Socio-economic access

Equity is a social phenomenon and need is based on socio-economic factors. Health and health care delivery therefore cannot be seen in isolation. Social factors such as housing, education, sanitation and an individual's right to an economically viable life is the basic underlying tenet to equity.

Conclusion

This brief analysis shows that enough hospital beds can be made available through redistribution for a future South Africa. However, a micro analysis at regional and sub regional levels will have to be carried out in order to assess the facilities available for the different levels of health care. Fundamental to such an analysis is the question of access to health care facilities. Other factors such as the provision of other facilities (general practitioners, community health workers, and mobile clinics) must be taken into account.

In future planning resources need to be deployed according to population needs and resources available. It is appropriate to concentrate on the primary care level as this will create the conditions for an equitable health system. In this way the imbalances within the present system will start to be redressed. ❑

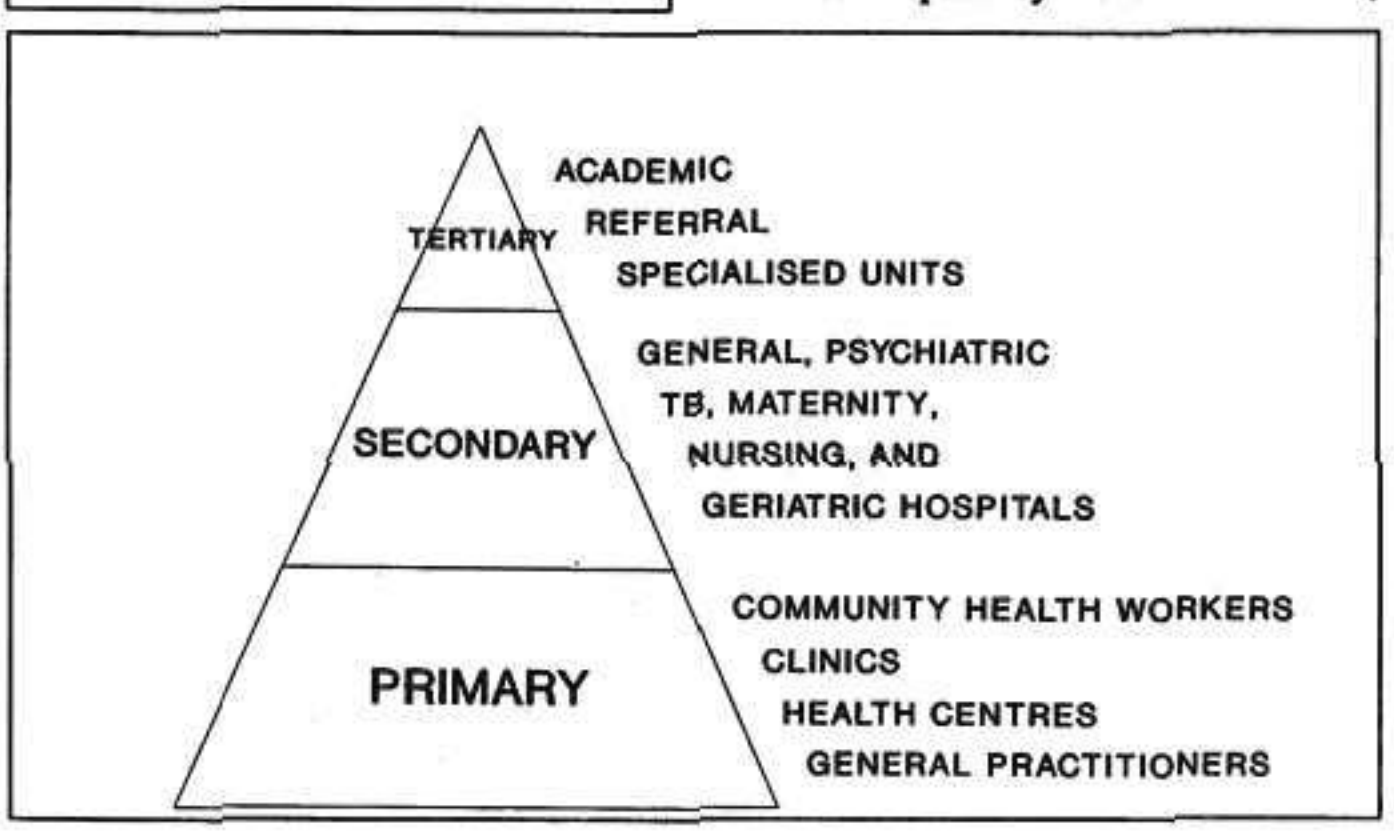


Figure 1. The health pyramid

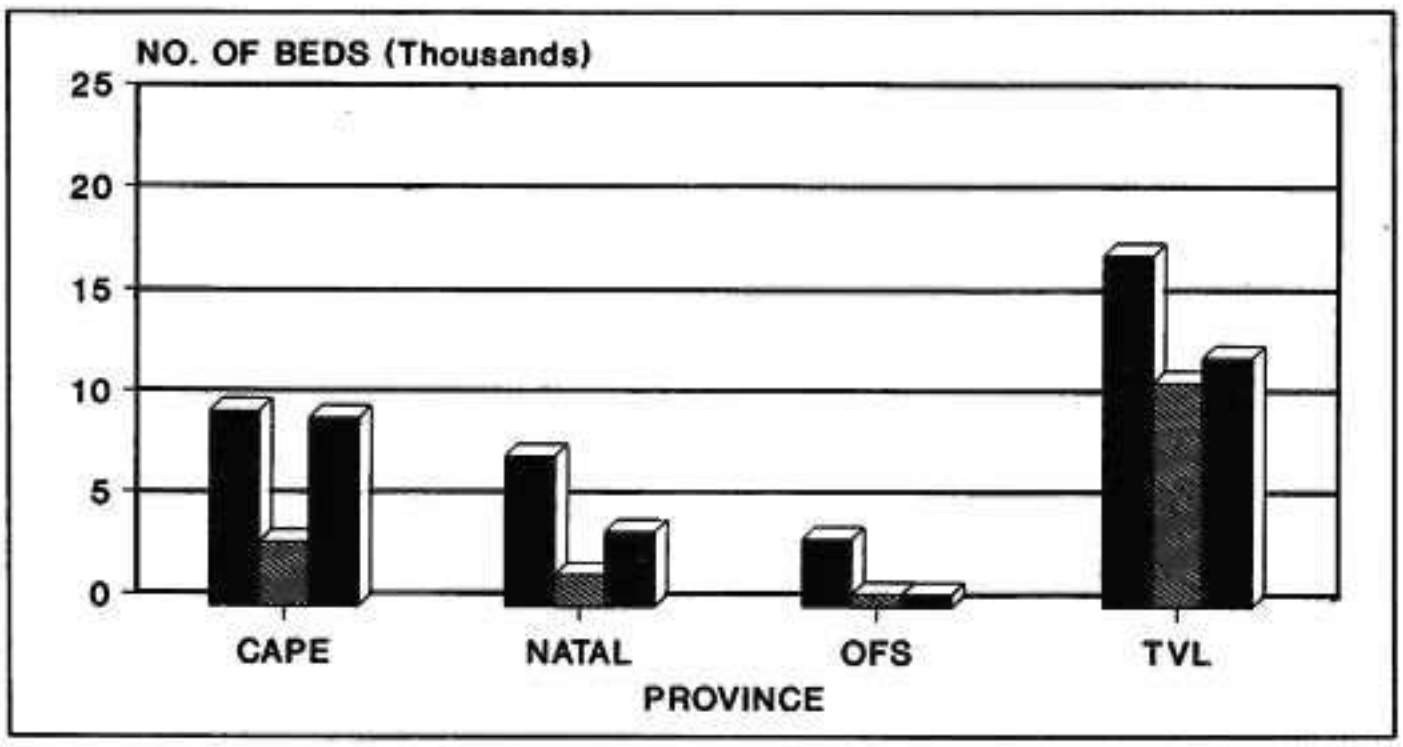


Figure 2
Distribution of beds
Tertiary / secondary level
Metropolitan areas

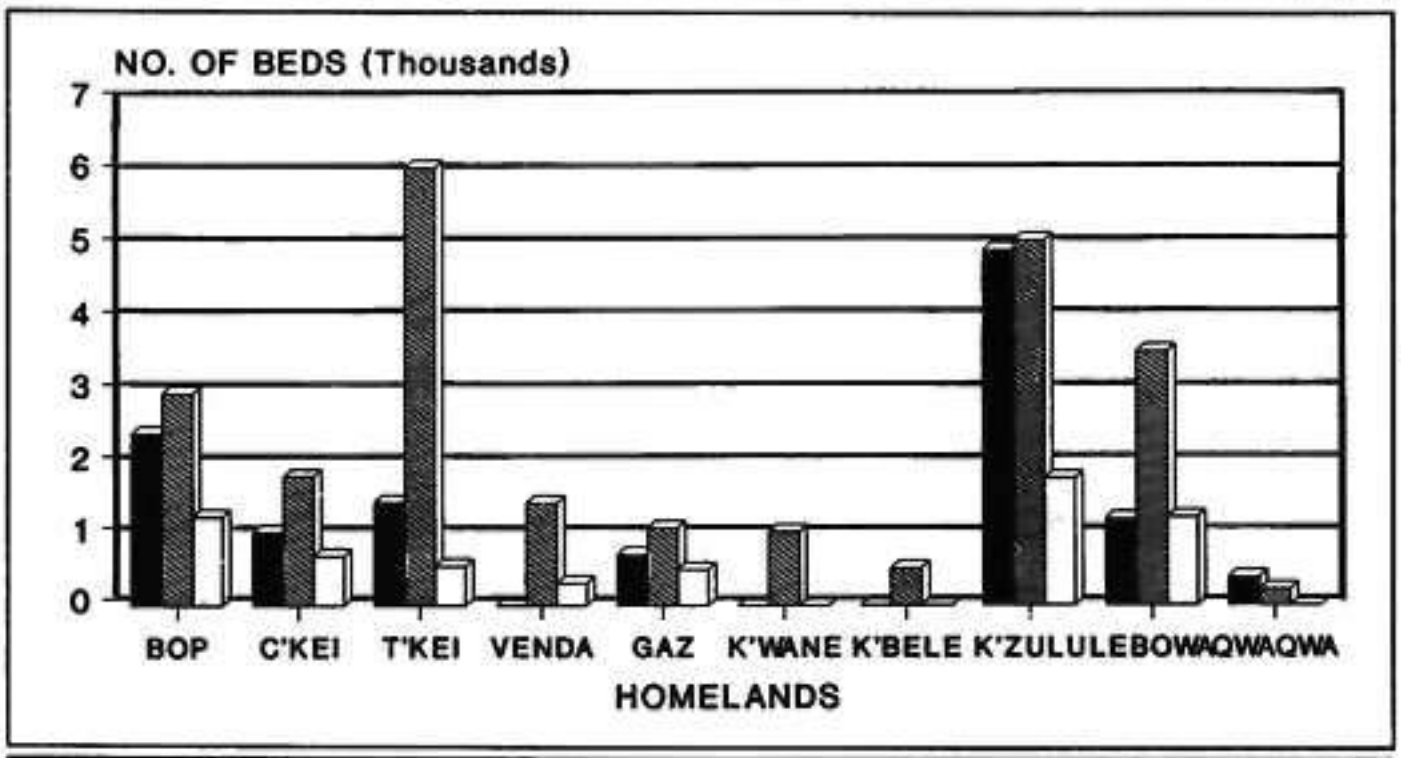
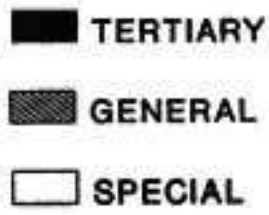


Figure 3
- Distribution of beds
Tertiary / secondary level
Homelands



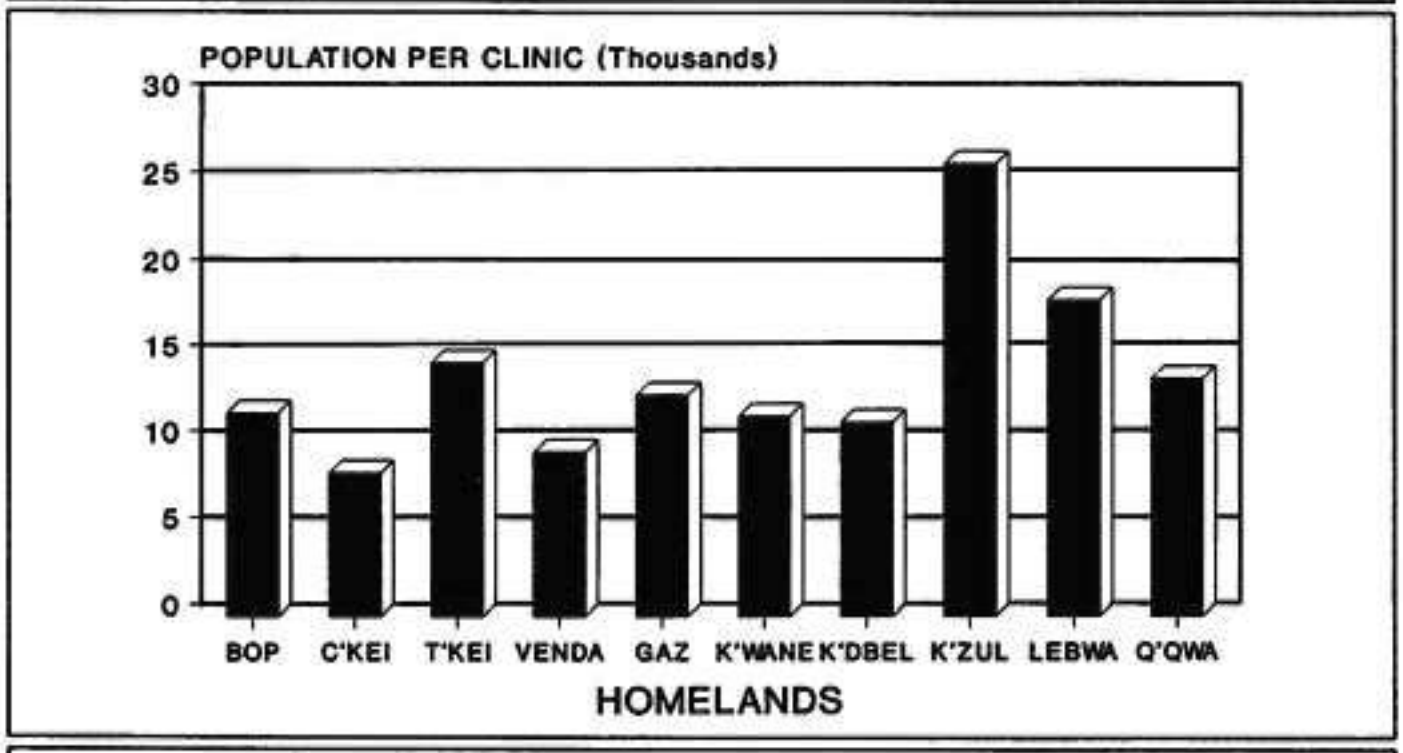


Figure 4
Primary level
Distribution of clinics
Homelands

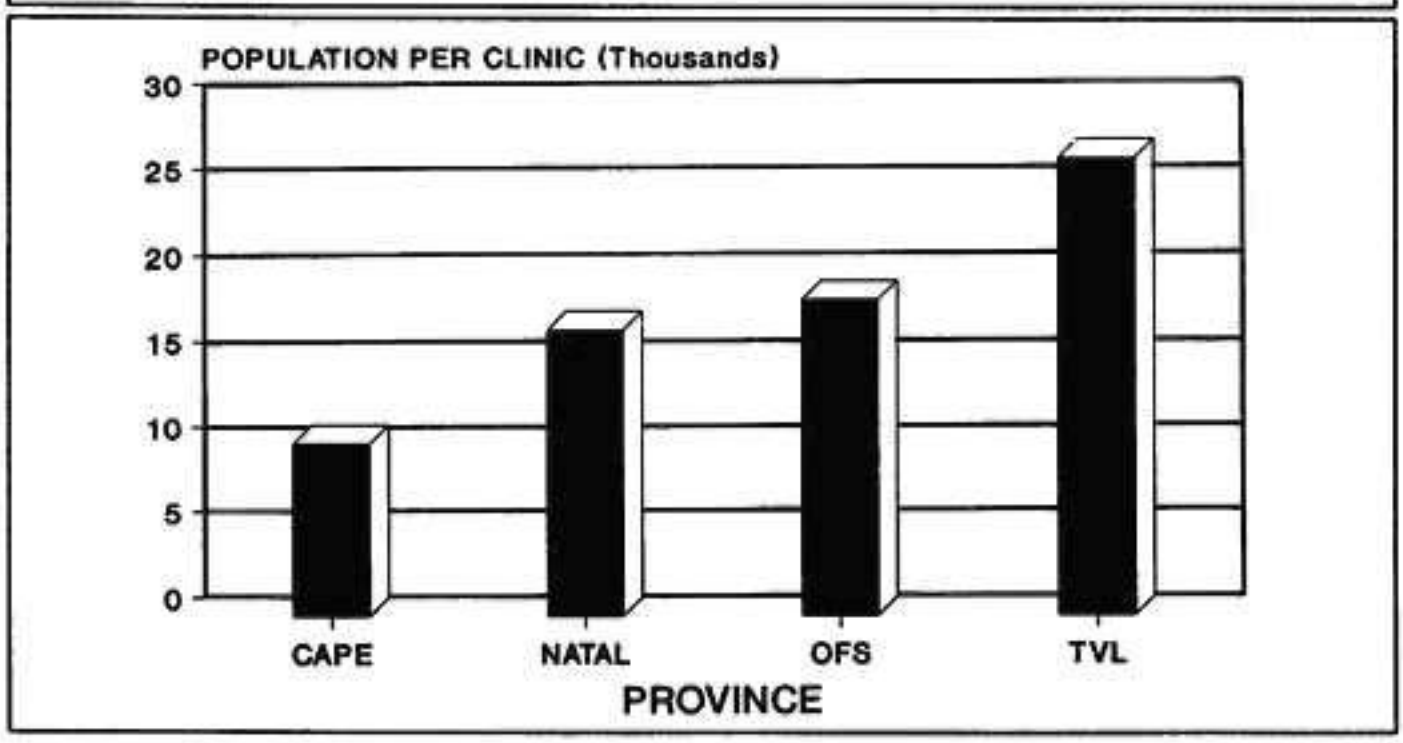


Figure 5
Primary level
Distribution of clinics
Provinces