Lessons from the Frontline States and the UK

Representatives from the Ministries of Health of the following Frontline States shared their experiences with the delegates: Namibia, Mozambique, Angola and Zimbabwe. All these countries inherited some common features in their health systems post independence. This included a discriminatory health system based on racial, economic and geographic grounds, and one which had little or no preventive aspects.

Some of the common problems faced the incumbent governments were:

- The loss of skilled personnel: this was a major drain on the country's resources, often crippling the health services, and was difficult to replace in most instances. The loss was either to other countries or to the private sector and was a result of ideological or economic reasons.
- The dominance of the private sector, which served to undermine the public sector. This was an important power base in society and was not always easy to challenge.
- The emphasis on urban-based curative health care.
- The effect of destabilising reactionary groups on the health services and economy. This was most clearly seen in Renamo's destabilising effect on Mozambique.

In order to redress some of the historical imbalances and maintain a cost-effective health service, certain recommendations were made. These included:

- having an accurate assessment of the country's health and welfare status at the point of transition. This would be invaluable in planning any future health service;
- giving priority to rural areas;
- emphasising preventive and promotive health, whilst recognising the need for tertiary care;
- creating a national health service (NHS);
- training of health personnel e.g. village health workers, medical auxiliaries. This would be cheaper than training doctors and should be designed to meet the health demands;
- legislating state intervention into the private sector in order to serve the needs of the people;
- the formulation of an essential drugs list for the NHS, and possibly a non-essential drugs list for the private sector;
- compulsory community service for all graduates. This would help to keep newly-trained staff in the public sector and to serve the underdeveloped areas. Preparation for this would have to be attended to in the curriculum and training;
- a political commitment to primary health care;
- mass campaigns for health education;
- a system of referral from the health post to the provincial hospital to the teaching hospital;
- the incorporation of allied sectors into the health care delivery system e.g. the church, traditional healers, mining companies;
- adopting a multidisciplinary approach to diseases.

From this session it became apparent that there are many lessons to be learnt from our colleagues in the Frontline States. ❑

Experiences from the UK have shown that health services as such are not the major determinants of good health. A lack of knowledge of available services, language problems, insensitivity to cultural values and child care problems, as well as a host of other obstacles, inhibit free access to health services even when they are available.

Lessons from the UK

The National Health Service (NHS) in the United Kingdom united both a fragmented and unequal health system, since its establishment by the Labour Government in 1948.

The services are free at the point of delivery, available to all and provide a high standard and uniform level of health care for the rich and poor alike.

The funding of the NHS predominantly from general taxation is part of a political commitment to an NHS. Originally the intention was to finance it largely from a national insurance system, with contributions taken from wages of employees and supported by contributions from employers - the system covering employees for both health and welfare benefits. In practice, however, this makes up only about 10% of NHS funding.

Academics and doctors were the major obstacle in setting up the NHS. Support for the NHS was rewarded with financial merit awards, in addition to their salaries, in exchange for not undertaking private practice. This approach, though not politically ideal, worked in terms of limiting private practice.

General practitioners play a referral role, are paid a flat fee based on patient list sizes and a fee for service component based on preventive activities.

Consultants have clinical autonomy and a job for life. They engage in some private practice but rely on their NHS posts for patient referrals. This is problematic in many ways but ensures the consultants remain within the NHS.

Positive aspects

- National planning and rational decision-making over the provision of facilities and the planning of personnel has reduced duplication of expensive high-tech services, established appropriately located facilities, introduced primary health care workers and established a national drug policy and an essential drugs list.
- Although underfunded, the NHS has proven to be cost efficient and to provide a high standard of health care for all through the referral system. Only 6% of total funds goes towards administration.
- Staff support - even in the recent attacks on the NHS, staff from all political persuasions have been united in their support for the NHS.

Staff morale is essential. Real problems such as poor wages and working conditions must be addressed.

Problems

- The power of doctors.
- The power of consultants to freely introduce new, often unevaluated technology, leading to soaring costs.
- Hospital-based care dominates over preventive care.
- Access to services is not necessarily made equal by establishing a free and available service. Lack of knowledge about available services, language problems, insensitivity to cultural values, all inhibit free access. Also, certain groups such as women need to have their specific needs addressed.
- Lack of community participation: attempts at community participation were made through the Community Health Council (CHC) structure. These are made up of nominated community members as well as fulltime workers. Legally, the CHC must be consulted about plans of a district health authority, for example, a decision to close a hospital. In practice, however, they only have the power to delay and refer back patients.

A further attempt at community participation was made through the District Health Authorities. They have a trade union and an education representative as well as local authority representatives on them. In practice, however, this does not work as real community participation - the lack of which has helped facilitate political manipulation of the NHS as we have seen in the UK recently. ❑