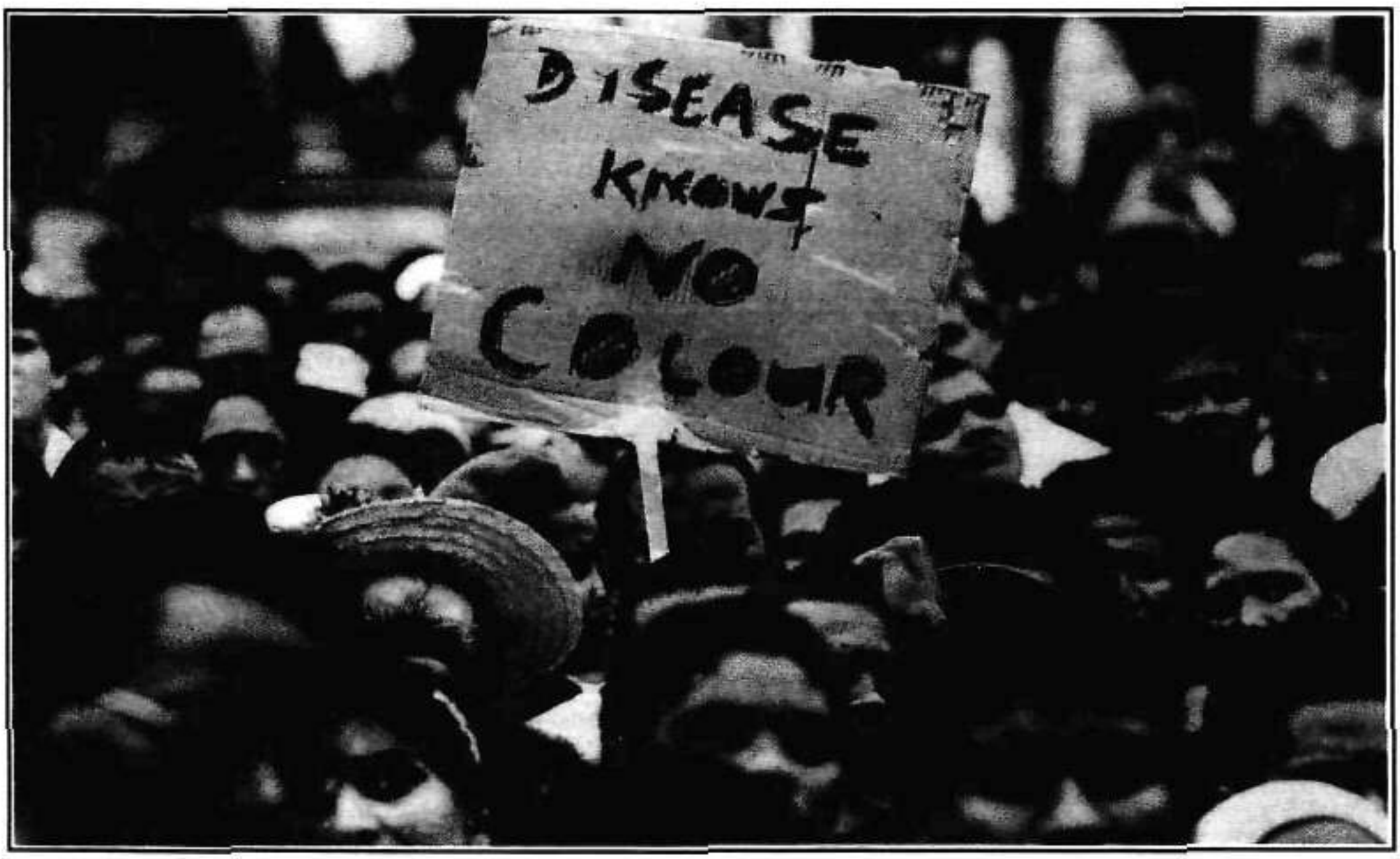
Transforming health and welfare services

Problems and prospects



*This paper by **Leila Patel** and **Cedric de Beer** begins with a brief discussion of the changing political environment and in this context, identifies some of the questions that will have to be answered in the transformation of the health and welfare services in a future South Africa. It highlights the need for equity in service provision and access, explaining how decisions regarding nationalisation will influence the health and welfare sector.*

The authors express the need to move away from the present emphasis on high technology care to more appropriate interventions while recognising the possible costs of such decisions.

The paper raises important questions regarding the concept of community participation in decision making and identifies some of the problems faced with attitudes of personnel towards the transformation of health and welfare sectors.

This conference on health and social services in transition takes place at a time when the entire political scenario in South and Southern Africa has changed dramatically. The unbanning of liberation movements and the possibility of a political settlement through negotiations may be within reach. These changes have brought a renewed urgency to the debate about a post-apartheid society and pose particular challenges for the liberation movements and for health and social welfare workers in particular.

The government has begun to engage the liberation movements around their proposed social policies and programmes for the future. Two issues have become central to this debate:

- The future economy and economic policy measures and their effect on productivity, employment and standards of living.
- Health, education, social welfare and housing policies and programmes aimed at improving black socio-economic conditions. The national budget presented in parliament this year made provision for a 40% increase in allocations to social services. A further R3 billion has since been earmarked for this purpose.

Clearly the government is embarking on an aggressive strategy to challenge the liberation movements in relation to how a post-apartheid society will work. It is preparing to strengthen its hand at the negotiating table and enhance its image at a mass level and in the international community.

How to improve the quality of life in a post-apartheid South Africa has become one of the central political questions. Lessons from Eastern Europe and Nicaragua indicate that if a post-apartheid government cannot improve people's living standards, then the broad support base of the liberation movements can easily be eroded.

This conference is faced with the stark realities of "what is possible given limited resources".

The challenge of unification

If a political settlement through negotiations is possible it can be assumed that we will inherit a fairly intact health and welfare system. To our advantage we will inherit a workable infrastructure which will continue to operate while the process of transformation is taking place. But it is this very apartheid-ridden, fragmented infrastructure which we are trying to change. Thus we have the more difficult task of unifying the health and social services and building a new system of service delivery while at the same time, dismantling the old. We need to set a time frame for this process and carefully explore all the ramifications.

Some principles of social justice

Equally difficult will be the construction of health and welfare services that meet the social goals laid down in the Freedom Charter, the constitutional guidelines of the ANC and demands, resolutions and declarations of democratic organisations. We suggest equity, appropriateness and community participation as a set of principles to guide our critique of the present health and welfare system and future post-apartheid policy makers and planners as they move towards reconstruction.

'In reality we will not be able to do away with dual standards in health and welfare service provision immediately.'

Equity

Racial discrimination in the allocation of resources has been widely documented. If we are to provide health and welfare services to all - that is, in the way these are currently provided to whites - then the allocation of resources for these services would have to increase three fold.

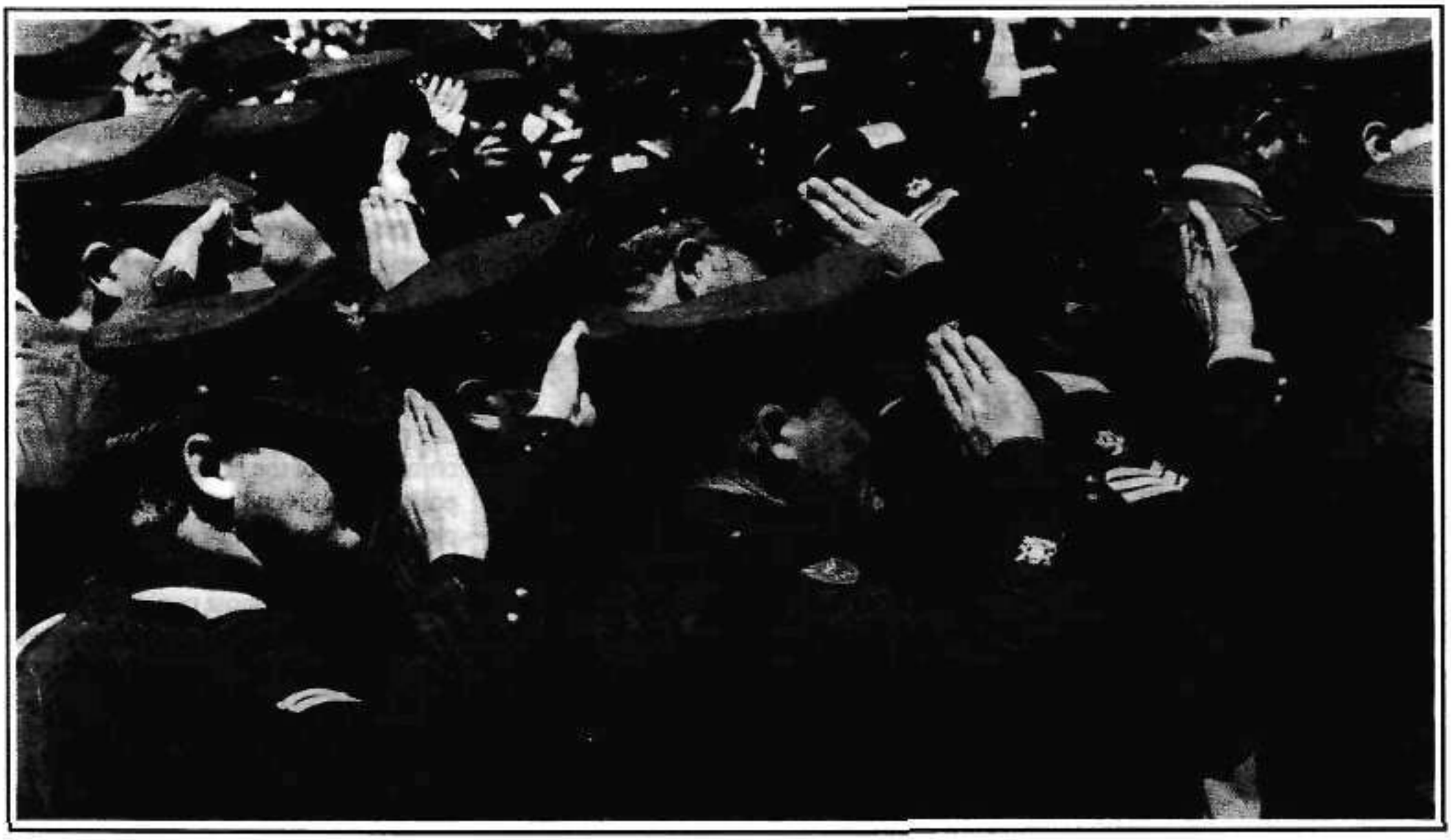
We continually use the comfortable slogan that by dismantling apartheid and through slashing the military budget, we will generate sufficient extra funds to pay for these improvements. But given the needs for housing, job creation and the provision of water and electricity, there is no doubt that the funds will not be available to allocate substantial extra resources to health and welfare. Thus in reality we will not be able to do away with dual standards in health and welfare service provision immediately. Within this reality we will have to devise means to ensure that any additional resources are directed towards those in greatest need: the unemployed, children, women, senior citizens, the disabled, rural communities and so on.

The existence of a large private health sector is a major contributor to inequalities in health care at present. Half of all money spent on health care in South Africa is spent on the private sector which caters for the care of only about 20% of the population. Privatisation remains a cornerstone of the present government's policy, yet, given the millions of unemployed, and the fact that most black people earn a quarter of the income of whites, it is impossible for most people to provide for their own health and welfare needs. Clearly, privatisation coincides with racial differentiation in order to reinforce inequalities in these areas.

The post-apartheid government faces difficult questions with regard to the private sector. Will it be appropriate to nationalise private health services; to take over private hospitals; to force private practitioners into state employ; to nationalise medical aid schemes, pension funds and the various forms of private death and disability insurance that middle class people have stored up for themselves?

A decision that a process of nationalisation is undesirable or impossible will have far reaching implications for how we evolve a system of state social security. It seems inevitable, for the foreseeable future, that the state social security system will be a mixture of contributory (e.g. contributions from employers and workers) and non-contributory (tax funded) benefit systems. This in turn has implications for our capacity to promote equity, as it is likely that existing inequalities such as those between the employed and unemployed, may be reinforced. It is from such inequalities that political opposition to a future democratic government may develop.

Certain inequalities will, however, remain with us for many years. Hospitals and other health care facilities are mostly concentrated in white areas. This is a serious problem where patterns of settlement have been distorted by the Group Areas Act and the homeland system. We will have to address questions such as: should we close the white Johannesburg Hospital and move the medical school to Baragwanath Hospital where it will be



Contrary to popular belief, dismantling apartheid and slashing the military budget will not generate sufficient extra funds to pay for an equitable health and welfare service for all.

able to serve the people of Soweto more effectively? Also, there are other barriers to access to health and welfare services such as language, age, sex and the cultural background of health and welfare workers. Welfare workers, for example, are predominantly white, while the population they serve is generally black.

Creating appropriate services

Our present services are fashioned on outmoded colonial or present first world models of service delivery. This approach is essentially curative and relies on highly trained professionals to render services. Similarly, in the welfare sector, the case work model is the dominant mode of intervention in social problems. This excessive focus on individual disorders has the effect of ignoring and concealing the social causes of illness as well as the causes of social problems that are dealt with by social workers and welfare agencies.

We need to develop new models more appropriate to South African conditions. In health care this means that we must give priority to the provision of comprehensive preventive, promotive and curative primary health care in the communities. In welfare, the importance of preventive interventions means redirecting our focus towards community and social development. Specialist services are obviously still necessary, but specialists should be used to provide support and training for community-based primary services, which must be our priority.

While specialist services are obviously necessary, difficult choices will have to be made in order to generate the funds necessary to spread primary and comprehensive services to all those communities currently deprived of them.

In reality, the implementation of these approaches involves the making of difficult choices. For instance, will we have to close some hospitals or some specialist services such as organ transplant units? Should we leave high technology research to scientists of North America and Western Europe? Should we be shutting down marriage counselling services and move away from labour intensive forms of intervention such as psychotherapy? Such drastic steps will have their own negative consequences but if we do not make these choices, then it is unclear how we will generate the additional funds and extra personnel to spread primary and comprehensive services throughout all those communities which are currently deprived of them.

Making community participation work

Much rhetoric abounds with regard to the concept of community participation in the planning and implementation of health and welfare services. There are a number of obstacles to confront if we are to give life to this crucial principle.

Firstly, technically complex decisions have to be made. Given the lack of familiarity with these issues and the enormous backlog in education, it is not clear how we expect people to participate in making such decisions. Secondly, participation is costly in terms of both money and the participation of personnel in the process of consultation. There are also important questions to answer regarding appropriate structures through which people should participate in the

planning and implementation of health and welfare policies and whether people will have the time or the inclination to participate in such a wide range of structures and forums, eg. education, local civic matters etc.

Also, there is a large voluntary sector of religious and other organisations involved with social services and welfare. Burial societies and stokvels are based right inside the communities. We need to ask how they will be included into the planning and decision-making processes and whether they should receive funds from the state for their services.

The strength of the mass democratic movement has developed models of participation through separate local community and trade union based structures in which grass-roots participation can occur.

However, as these structures tend to be politically aligned, we must ask whether participation would depend on the political affiliation of individuals. This may result in political allegiance becoming the criterion for access to resources which in turn, may result in the emergence of new forms of privilege and consequent elitism.

Failure to address all these questions could lead to token participation and misuse by political factions, bureaucrats and other emerging elites.

Assuring adequate personnel

Winning the support of personnel

A political challenge facing a post-apartheid health and welfare ministry is whether it can win the support of existing health and welfare workers for its new policies and programmes (focused around a primary care, community-based approach within a unitary system).

We must recognise that there are administrators and other personnel who believe that their jobs or status depend on the existing fragmented structure.

Highly skilled and influential people in the private (particularly health) sector will mobilise substantial opposition to attempts to reduce the size of the private sector and to attempts to exercise greater control over the provision of private services. Also, our training institutions and their graduates emphasize specialist and curative skills and tend to regard community-oriented preventive and promotive work as second class, and essentially irrelevant to professionals. In addition, professional jealousy, within and between the professions, results in specialists objecting to lesser qualified workers doing work they think belongs within their empire. Professional groups tend to regard lay workers as constituting a dangerous invasion of their territory.

These workers will either implement or sabotage post-apartheid policies.

Training personnel

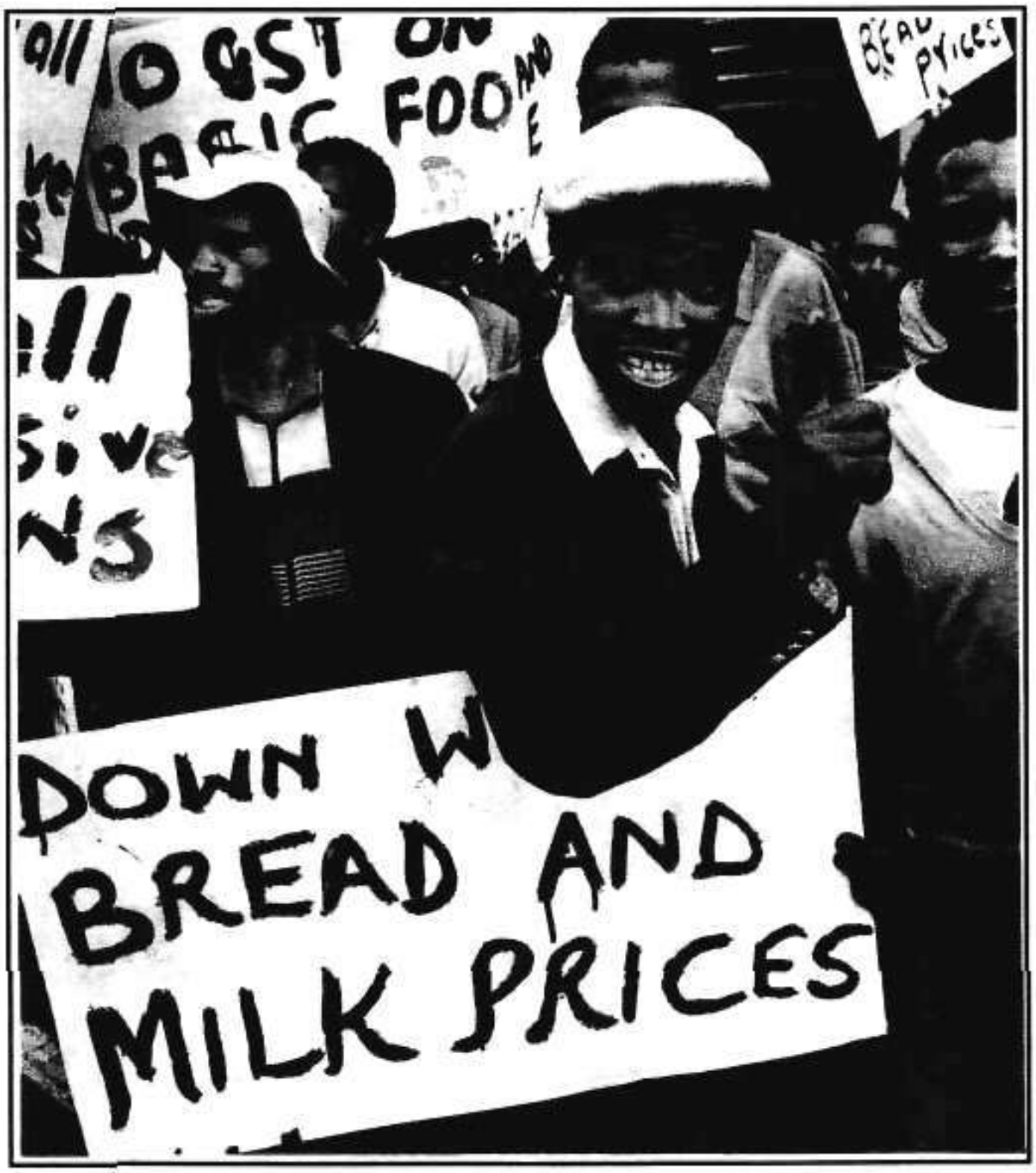
On a technical level, we need to define how many health workers we need and with what level of skill. We will then have to train or retrain large numbers of health and welfare workers with more appropriate skills. Ways of encouraging them to work in underserved areas must be found.

Finally, we will have to find ways to redress the enormous racial imbalance in the numbers of health and welfare service providers. To do away with racial biases in the services we will have to change the current situation where most managers, planners and policy makers are white.

Conclusion

A post-apartheid government will have to make decisions with far reaching implications for the social services in general.

Restructuring will involve the dismantling of apartheid at every level and the development of a unitary system combined with democratising of local, regional and national structures will be paramount. Restructuring must promote equity with regard to racial, class, gender and geographic divisions. ❑



Privatisation remains the cornerstone of the present government's policy, yet given the fact that many South Africans cannot even afford basic foodstuffs, how will they be able to pay for their own health care?