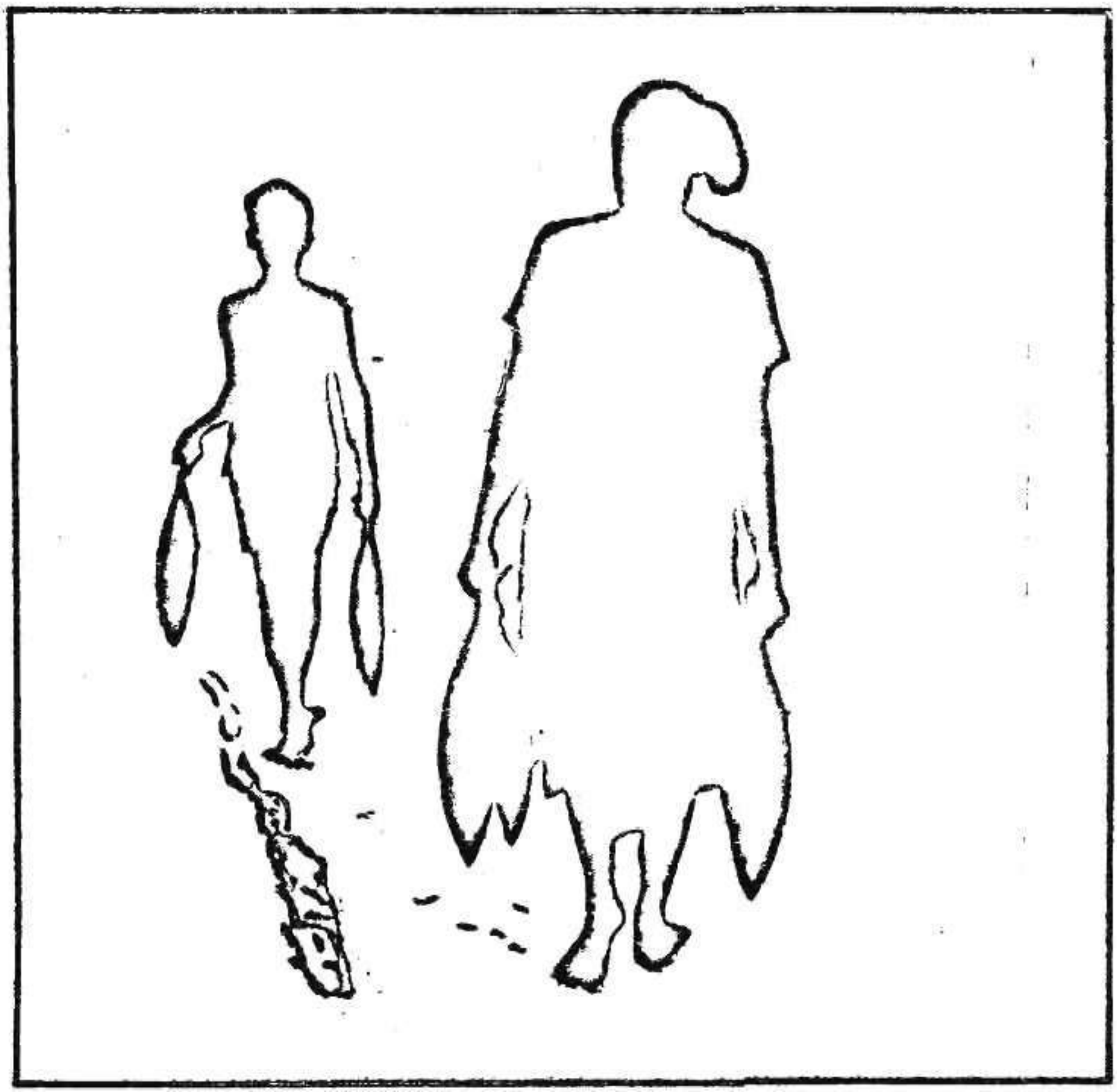
THE CONTRIBUTION OF MISSION HOSPITALS TO MEDICAL CARE IN SOUTH AFRICA.

BY: GREG WELLS



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

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

EARLY DEVELOPMENT:

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

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

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

The other and initially less common tendency was

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

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

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

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

MISSION HOSPITALS AND THE DEPARTMENT OF HEALTH.

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

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

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

Of course there were unresolved problems:

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

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

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

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

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

ACHIEVEMENTS AND FAILURES.

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

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

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

3. They showed the effectiveness of community

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

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

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

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

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

THE FUTURE:

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

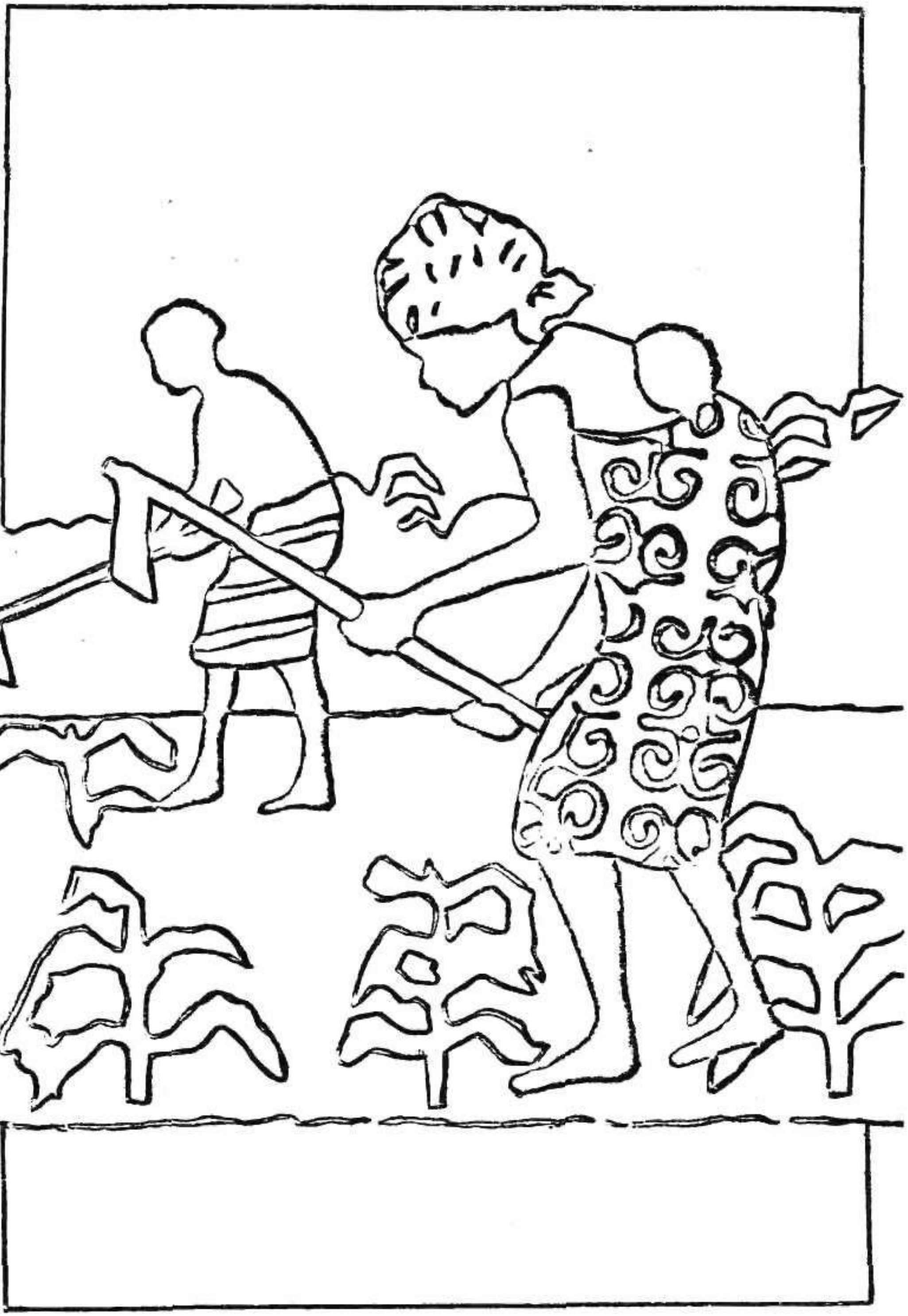
cannot say it has improved health care in KwaZulu. This is a problem of the past, and should not concern doctors now considering working in the homelands.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

NOTES:

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

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

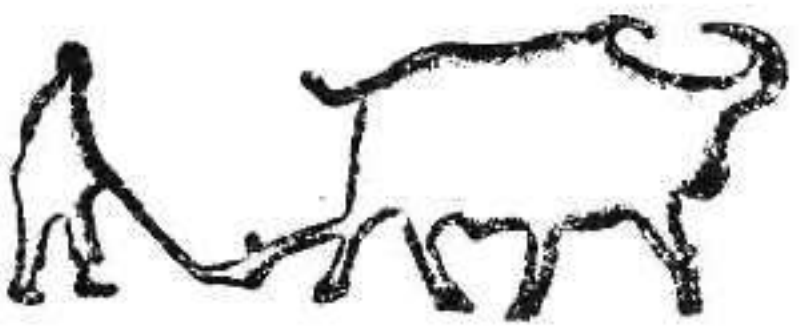
2. Why did direct community involvement start later? Is this related to the concept that *health is something which is given to people* by doctors?

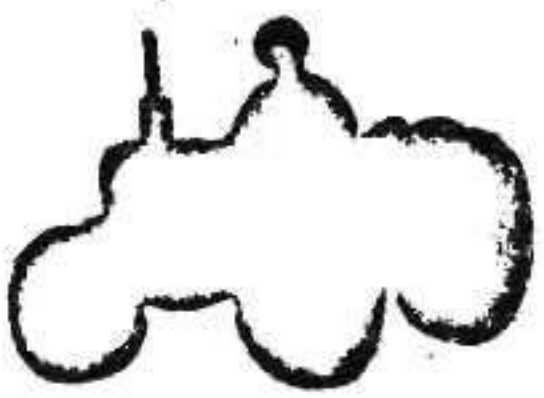
3. Why is there a dilemma between providing a "good" service for a few, and some service for many? Should one not have in mind a "good" service for all?

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

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

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





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Ideas and Action

Basics

South African Labour Bulletin

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