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

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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