Political parties and a national health service

by Critical Health

Six major political parties were approached by Critical Health for details of their health policies. Of the six, only the Conservative Party had adopted a policy in final form. The Democratic Party (DP), the Inkatha Freedom Party (IFP), and the South African Communist Party (SACP) supplied us with draft health policy documents. The Pan Africanist Congress's (PAC) draft national health policy was not available for us to have a look at. From the African National Congress (ANC) we received a national health policy discussion document prepared for their July conference, as well as, health policy documents from their PWV and Border regions.

What follows is a brief survey of party policies on the issue of an NHS. An edited version of one of the documents, the proposals on health policy of the Border region of the ANC, has been selected from the documents received, for publication. The Border health policy discussion was one of the more interesting and original health policy documents received by us. It was chosen not only because of this, but also because it has emerged from a process of in depth consultation in the Border region.

African National Congress: the ANC's national health policy discussion document states that health is a basic human right and that the right to "free essential health care" should be entrenched in the constitution. The government should be responsible for making the funds available to ensure that essential health care is available to all South Africans. Funds for the financing of health care should be raised through taxation. There should be a preferential allocation of resources to promote health care within the most vulnerable sectors of the community. It is accepted that a large private sector will continue to exist in a future mixed economy. Nevertheless most health care must be provided by the public sector, which the document states, needs to be strengthened, improved, and made accountable to the community (an edited version of the draft health policy of the ANC's Border region is reproduced below).

Conservative Party: Official CP policy envisages " the necessary emphasis being placed on preventive and decentralised community health services" whilst "avoiding the total socialisation of these services".

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Democratic Party: the DP's draft health policy asks the question " does South Africa need a privatised health care system or a National Health System"? A final health policy document is the process of being drawn up.

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Inkatha Freedom Party: the IFP's draft health policy document makes no direct reference to the creation of a national health service, or for that matter, to the role of the private sector. The document states: " the IFP recognises the crucial need for the future government to provide health care facilities for all South Africans". Furthermore, "in an attempt to maintain the essential health care services needed in this country in the face of limited funding, these services must be directed into activities deemed more appropriate to the needs of the majority, rather than a rigid adherence to standards dictated by the First World".

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Pan Africanist Congress: a spokesperson for the PAC said that the PAC regarded the present health care system as a colonial one which serves the interests of whites while neglecting those of blacks. The PAC is in the process of formulating an official health policy. The spokesperson said that the PAC was looking into the possibility of developing a democratic community based health care system which was decentralised and de-bureaucratised.

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South African Communist Party: its draft health policy states that the existing health care system in South Africa has its roots in capitalism and colonialism. The document states that these "foundation stones" need to be broken otherwise health care in South Africa "could remain the same forever". The document goes on to state that health care is a basic human right, that health care provision is the responsibility of the state, and that health care must be free, that is, no fee-for-service.

ANC Border Region Health Commission: Draft Health Policy - 18/05/91

The Border Health Commission was formed in November 1990 by the Border Regional Executive of the ANC in order to draw up a draft health policy. The Commission consists of individuals and not representatives of organisations and is free to co-opt people with expertise in the health field. In April a regional health

workshop was held. Those invited included; all ANC branches in the Border region, the National Medical and Dental Association (Namda), Industrial Health and Safety Education Project (ISHEP), Progressive Primary Health Care Network (PPHCN), the National Education, Health and Allied Workers Union (Nehawu), medical superintendents of all hospitals in the Border region, and interested individuals who were not necessarily ANC members. Some 60 delegates took part.

The commission felt that the general principles of ANC health policy in the booklet, "Towards developing a health policy", were acceptable and needed little further discussion. It was therefore felt that the commission should focus on specific aspects of health policy in more detail. The following topics were chosen:

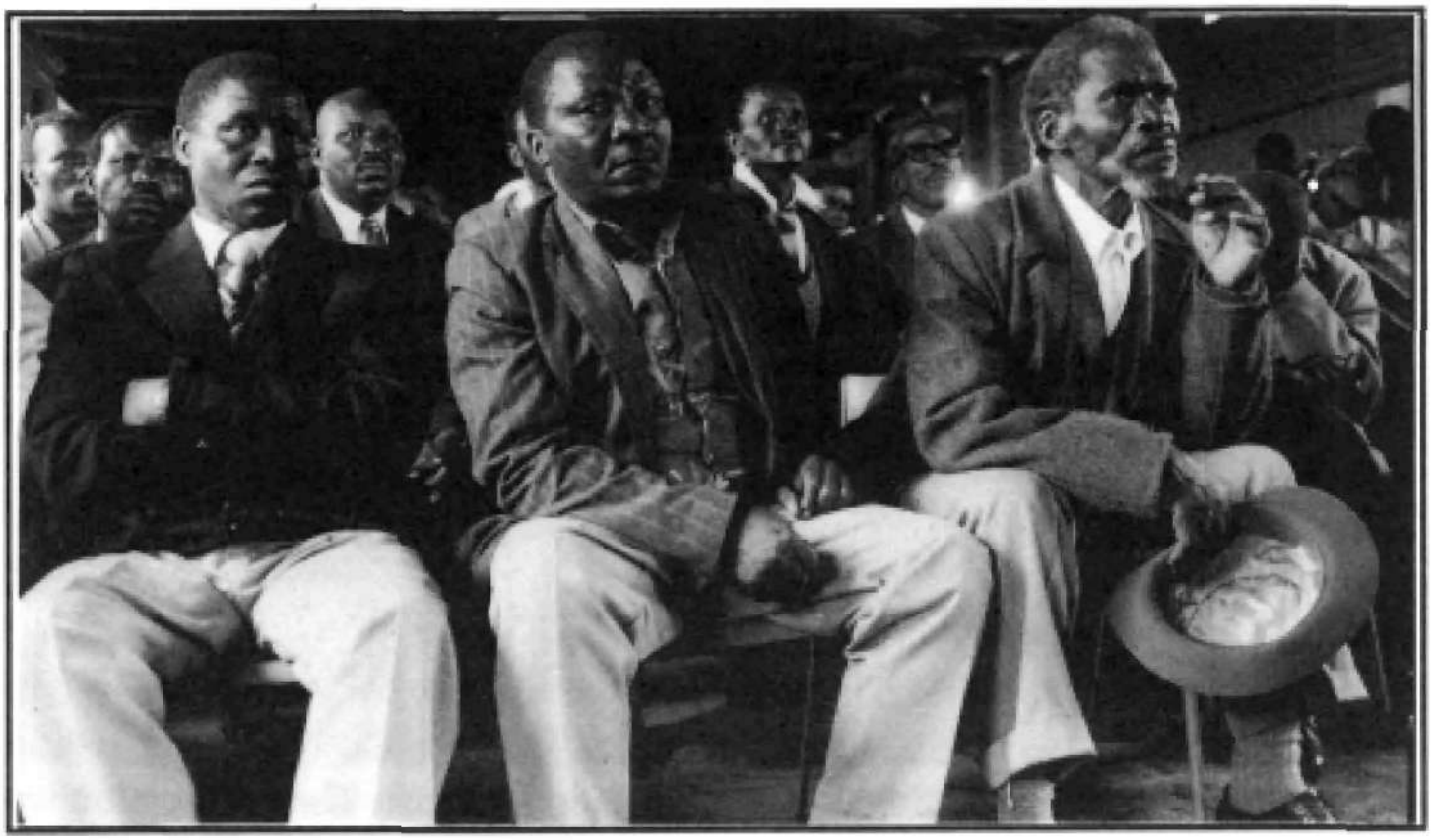
1. Structure and function of the National Health Service.
2. The future position of private health care.
3. The nature of the ideal primary care unit.
4. The role of traditional healers.
5. Training of health workers.

1. The National Health Service: Structure and Function

A national health service (NHS) is needed and must be accessible, affordable, and accountable to the community.

Organisational structure

The NHS should consist of a number of organisational levels, including national, regional, district, and primary care (a detailed outline setting out the structure and



The NHS management structures must facilitate accountability to the communities it serves. Photo: Cedric Nunn

functions of national, regional and district health authorities, regional and district hospitals, and community health centres is provided in the original document).

The pyramid shaped health service structure as exemplified by the present arrangement in the Ciskei area was seen as the best structure for the hospital service. This involves regional hospitals supervising a larger number of smaller district hospitals. There would be a free flow of patients, staff, teaching and expertise between the different levels of service.

Community accountability

Participatory democracy involves the participation of health workers and the community in decisions which affect them. The structure and management of the health service should be decentralised to allow for direct accountability to the community being served.

Each level of health authority will be directed by a management committee constituted in such a way as to form the basis for accountability to the community. Such committees must meet regularly and their meetings must be open to the public whose input should be welcomed.

Local authority health services and environmental health services

The non-personal health services at present dealt with by the health departments of local authorities would stay with these authorities. These include monitoring of water supplies, sewerage disposal and the licensing of business premises, especially food supplying facilities. On the other hand, the personal health services at present with the local authorities would pass to the district health authority. These would include immunisation, antenatal care, TB, sexually transmitted diseases, etc.

Finance

Funding for the NHS should be raised centrally and allocated to regions and thence to districts in proportion to size and health status of the population. Funds would be raised either by tax or by a national health insurance scheme. Their allocation would be by region and by district within each region.

At the primary care level remuneration should be on the basis of a capitation, that is, a fixed amount per patient per year. This would encourage preventive work as a healthy patient demands less medical care. Higher capitation fees for working in remote or otherwise less desirable areas will allow the NHS to promote the service in such areas. The system of payment by a fee for each item of service rendered is not desirable as it tends to lead to doctors providing more treatment than patients actually need.

2. Private Health Care

In accordance with the ANC's policy of a mixed economy the private sector will be allowed to operate but it will be regulated to conform to national standards. General practitioners (GPs) who are doing private work should not be able to work for the NHS. The large number of medical aid schemes should be phased out to leave one central scheme.

3. Nature of the primary care unit

The basic unit of primary care service would eventually be the group practice model as typified by the British NHS. This involves several GPs working together in company with nurses, community health nurses, village health workers, rehabilitation

Traditional healers can play a useful role. The formal health sector should investigate ways and means of utilising their skills. Photo: Medico Health Project

workers, pharmacists, etc. The group practice would be responsible for the health of a fixed number of patients. It would not play a curative role but more a comprehensive one including prevention.

The present primary care comprehensive clinics, for example, those in the Ciskei, would gradually be transformed into the group practice model by increasing the number of doctors serving them and by adding other categories of health care workers. During the transition phase it might well be that several community health centres would be served by a single doctor who acts to support the nursing staff at each centre.

4. Traditional medicine and traditional healers

The NHS should have a positive attitude to the "good" aspects of traditional medicine and incorporate these into the service. The formal health sector should undertake research into the methods and therapies (especially herbal) used by traditional healers as it seems likely that effective and economical remedies would be brought to light. Formal health personnel should be educated to appreciate the nature of traditional medicine.

The problem of registration of traditional healers is a very difficult one. The

profession is not very organised and registration has been problematic in African countries where it has been attempted. It was seen as important that traditional healers should form a professional structure. It is financially impractical to incorporate the roughly 150 000 traditional healers into the NHS or to provide state assistance to patients consulting traditional healers.

5. Health worker training

(a) It was felt that a number of difficulties in health worker training stemmed from problems in the present school education system. These include the present low quality of secondary school education, particularly, in the scientific area.

In addition many children get little or no career guidance at secondary school. As a result the paramedical professions, such as physiotherapy, occupational therapy, and dietics, are not considered by students when they make career choices.

(b) Training will need to be established for a number of newer health worker categories, including village health workers and rehabilitative workers.

(c) The location of training facilities should be structured so as to make training more appropriate and should be community based.

Most health workers are trained in institutions located in areas very different to those where they will eventually practice. If the practical side of training takes place in facilities and communities similar to the communities similar to the eventual working situation of the health worker, the more fully equipped he/she will be to provide appropriate health care.

Training needs to be decentralised. Much of the practical training of medical students should be carried out by the local staff of the health service at all of the following levels: regional, district, and community health. The implication is that at all of these levels there will be a need for teaching staff.

(d) At present medical and nursing curricula particularly, are heavily oriented towards curative care. Training needs to be made more appropriate and emphasise primary health care.

It is necessary to get genuine community representation at a national level where the basic policies for curricula are defined. The same would be true at all subsequent levels, including the medical and nursing faculties at universities.

(e) Training should be problem oriented. This should also mean that a topic or clinical problem is taught in a multidisciplinary way.

(f) The following should be considered in the selection of student health workers:
1. The prospective student's social value system. Health workers need to be concerned for and involved in the welfare of their community.
2. Selection boards should include academics, practitioners at each level of the service, and community representatives.
3. The high cost to parents of medical education effectively limits entry to medical school to the middle class child whose identification with the needs of the masses may be very limited.
4. One suggestion is for a system of state scholarships or bursaries for health care students. The process of allocating these scholarships to suitable candidates will enable the wider community to have a say in who should benefit from expensive training. For example, local community organisations might be asked to approve candidates. A candidate record of community service could play as large a role as academic achievement.

Conclusion

The above submissions are made out of a desire to contribute to the debate on the development of a democratic health service which will deal not only with the problems of sickness and disability but also make a significant contribution to the health and hence the wealth and prosperity of the nation.

Border Regional Health Commission
May 1991