APARTHEID AND MEDICAL SERVICES

by Rupert Gude

The standard of medical care available in South Africa is amongst the highest in the world—provided that one is white. The Blacks living in South Africa have limited access to this high standard, but for the most part the medical care available to them is akin to that of one of the developing countries of Africa.

This disparity is accentuated by the fact that the Blacks make up the poor of the country ("The Have nots" as Professor Phillpot of Natal Medical School describes them). Ignorance, poverty, poor sanitation and malnutrition all contribute to make this group the most susceptible to disease and the least capable of fighting debilitating diseases like tuberculosis.

In most countries of the world there is a disparity between the health care available to the urban and to the rural communities. However in South Africa this sometimes reaches gross proportions. One needs to go only 30 miles from Durban to the area known as Umbumbulu to see this glaring disparity. Umbumbulu has virtually no infrastructure of medical care. There is a District Surgeon with responsibilities there, but he can do little for the 150 000 + people who live in this area that has been virtually untouched by the wave of development that has spread around South Africa. These people have no local hospital and have to travel to Pietermaritzburg or Durban to be seen by a doctor. It is odd that a place just one hour's drive from one of the biggest cities of Africa, should have no local access to basic medical care.

Education available to the African has always been a disgrace to this country and the effect of this can easily be seen in the ignorance of many Africans as regards the relationship of good food and health. Not only is the Black community poor and lacking medical facilities but it also has limited knowledge of how to use what little it has to the best advantage.

What facilities are available to Africans?

The provision of health care for the African by the Government has traditionally been based on the building of hospitals with a medical outlook based on experience in western communities. This works well provided there is a strong infrastructure of primary medical care provided by general practitioners in the community. In the past there has been almost no primary medical care for the African community and sick people have had to travel to the local hospital. The provision of community care has been the responsibility of the bureaucrats in the regional and state centres, and until recently, very little has been accomplished in real terms.

When the Medical Faculty of the University of Natal was started in 1951, the Rockefeller Foundation founded a chair of Community Medicine. This was heralded as a great break through and it was thought that Natal would lead the rest of Africa in plans and ideas for the provision of primary medical care. Professor Kark battled for some years to provide plans for the improvement of medical care available to Africans, but his efforts were frustrated by the Department of Health, leading eventually to his resignation. Since then, and until this day, the Department of Community Medicine has not functioned. There are even offices in the new extension to the Medical School labelled "Community Medicine"—but presumably there is difficulty finding an ideologically suitable applicant.

In Natal, there are two major African hospitals—King Edward VIII Hospital in Durban and Edendale Hospital at Pietermaritzburg. These hospitals should act as specialist-referred centres for the 3½ (? 4) million Africans living in Natal, but in fact they act as the local hospital for over 1 million between them.

Spread throughout Natal there is a loose network of Mission hospitals and some provincial hospitals. The Mission hospitals are now being taken over by the State, so that Kwa Zulu can assume responsibility next year. However these hospitals are often inadequate to meet the needs of the surrounding population. In 1972 there were 3½ beds for every 1 000 people in the homelands, as opposed to 10 beds available to every 1000 white in South Africa. Some of these hospitals have achieved enormous success by the devotion of the medical staff, whilst others have been plagued by the rapid turnover of staff.

Many have suffered from the ignorance of the doctors about community health care (as opposed to hospital orientated diagnosis and treatment) and the resistance by the Department of Health in the past to innovations.

As a result the basic unit of health care in undeveloped communities—the Clinic—has been grossly neglected. Only in the last few years has the Department of Health responded to previous demands to provide clinics in the rural communities. Thus in the Nongoma District in north Zululand with a population of 75 000 people, there are only 4 clinics in addition to the hospital. The Department recognises that there should be a clinic for about every 7000 people, which means the erection of at least 300 clinics in the area of KwaZulu. This will take at least 10 years. Thus by 1987 there should be a clinic staffed by 1 or 2 nurses for every 7 000 people; in contrast to the one general practitioner available to every 2 500 whites at the moment.

When one looks at the townships of Umlazi or Kwa Mashu one cannot help being struck by the incompetance of the Department of Health. Umlazi has a population of 220 000 (as large as Pietermaritzburg) but only has one small

Mission Hospital and a clinic with 10 maternity beds. There have been plans for a new hospital there for the last 20 years but there has never been any real intent to complete it. Meanwhile the Province is spending R26 million on a new hospital for whites in Pietermaritzburg to replace an existing hospital—and it is estimated that it should be completed in 4 years. Kwa Mashu with a population of about 200 000 people was built with no plans for a hospital until it should be incorporated into Kwa Zulu. It has existed for 10 years with only a polyclinic a couple of vaccination centres and a handful of private practitioners for this huge population. Now that Kwa Mashu has been incorporated into Kwa Zulu there has been some surveying for a site for a hospital, but if the progress of the hospital at Umlazi is anything to judge by, then it will not be completed before the next century. As a result of this neglect and incompetence in health planning the patients have to trek into King Edward VIII Hospital where facilities are totally inadequate to deal with the number of patients.

King Edward VIII Hospital was founded in 1937 to treat the Africans living in and around Durban. It has expanded to 2 000 beds—though not everyone has a bed when it is crowded. It has been overwhelmed by the demands made upon it and as a result there has been a fall in standards. In the summer months between 25—35 children are admitted every day by three doctors to the hospital wards and another 40 are given intravenous infusions in the resusciatation room. The mortality runs at about 15-20. Although a lot of children are very ill on admission the mortality rate could be reduced if the pressure was not so great. This type of work contrasts strangely to the Addington Hospital for whites where only about 4 children are admitted per day by 2 doctors. Due to the huge intakes during the summer months to the limited number of beds at King Edward VIII Hospital children are often discharged half recovered when they show the first signs of improvement. However there is no organised follow up, there are no friendly private practitioners to call in at home to see how they are progressing and without doubt there is an appreciable mortality. (However this aspect of management does not interest the academics in the Department of Paediatrics. One wonders how many of the premature babies who are discharged weighing 1,8 kg survive in the cold damp and overcrowded homes in the townships. In Nigeria they found that less than half of their premature babies reached 6 months. It seems that King Edward VIII Hospital hardly recognises that there is an environment outside the hospital—that is State Health's responsibility they say as they wash their hands.)

How healthy is the African?

Health even in the most advanced communities is a very difficult commodity to measure and this is particularly so with the African where a co-ordinated health service is lacking. However one can use notifiable diseases as a rough guide . . .

TUBERCULOSIS

Tuberculosis is well known as a disease of the under privileged. The incidence in the United Kingdom was falling dramatically in the 1920's and 1930's **before** the advent of anti TB drugs, due to the rise of the socio-economic condition of the population.

However the statistics for 1975 seem to indicate that TB is on the increase for the African (3½%p.a.). There were 55 297 new notifications in 1975 for Africans as opposed to under 800 for whites. The incidence (100 000) shows dramatically that Africans are at least 17 times more likely to contract TB than whites.

Rate 1000 population	1974	1975
White	18,1	18,1
Coloured	327,7	306,9
Asian	143,0	90,2
Black	294,6	312,1

It has been estimated that at least two thirds of the 3½ million black children now at school are already infected with tuberculosis.

Once an African has contracted TB then the services available are insufficient to deal with it effectively. SANTA with limited resources has achieved limited success, but a heavily financial national organisation is needed with better overall control. The follow up of Black tuberculous patients is woefully inadequate. Almost every child that is admitted to King Edward VIII Hospital as a new case of TB had a known family contact of TB. These cases are preventable—but the services available are inadequate.

POLIOMYELITIS

Last year in Natal we had about 300 cases of poliomyelitis (notified) occurring almost completely amongst the Black population. Working in Clairwood Hospital in July 1975 we were admitting a steady stream of crippled children. However it was not until May 1976 that the Department of Health decided to mount a polio immunisation campaign. Why did it take so long for the Department to react? One wonders why it was necessary to mount the campaign at all—surely these children should be immunised as a routine. However, sadly no, there are no facilities readily available for thousands of Africans, and after this campaign has ended, there will still be the basic lack of facilities. It is odd that smallpox vaccination should be compulsory by law, when smallpox is not a problem in South Africa being confined to 4 countries in the world, and yet polio immunisation is not readily available but cripples hundreds of children every year.

MALNUTRITION

Kwashiorkor has ceased to be a notifiable disease because of under reporting—but may be it is because the Government would be embarrassed by the prevalence in the country. An article in the Sunday Tribune of June 27th claims that 3 children die every hour from malnutrition i.e. 24 000/year. I feel that this may be an exaggeration depending on what evidence is used. However in a report on nutrition published this year it was estimated that about three quarters of South African Blacks are stunted and 5—7% are "severely stunted".

In one year at King Edward VIII Hospital about 800 cases of Kwashiorkor are admitted (of which 25% die) and many more mild cases are seen in the out patients department. Over a third of all children admitted are marasmic i.e. their weight is below 60% of their expected weight. Malnutrition is a serious problem in this country which the State is not prepared to accept. Dr Stott at the Valley Trust at Botha's Hill has virtually eliminated kwashiorkor from the surrounding area by education and determination. However this is just a drop in the ocean and there seems to be no plans to extend this type of project to other areas. The withdrawal of subsidised milk has exacerbated the problem, and

together with inflation increasing the price of basic commodities the incidence will probably increase. Meanwhile evidence is accumulating that malnutrition causes stunted brain growth, and thus the Government must hold itself responsible for this group of children growing up with impaired intellectual development.

The migrant labour system is also a patent cause of illness in the community. Almost half of the economically active men in the homelands are migrant labourers. This may lead to the neglect of the wife and family in the homelands or to the neglect of children who are fostered. Promiscuity is rife since the men have to lead lives away from their wives—and veneral disease is very common.

African children often grow up as virtual orphans not knowing their fathers and suffering long periods of separation from their mothers. Inevitably this will lead to disturbances in emotional maturing with serious consequences for the future.

Access to psychiatric hospitals is limited. The Department of Health statistics show that there is gross overcrowding in the African mental hospitals.

	White	Non White
No. of patients	5 141	9 717 (+ 8611 accommodated separately)
Capacity	5 829	6 892
Overcrowded	142	3 396
Vacancies	830	

Mentally defectives have considerably greater facilities if White than if Black.

Number of white mentally defective residents	3 203
Non white	711

There are no schools for mentally handicapped African children in Natal and an attempt by Umlazi Residents' Association for the last 18 months to start a school has been rejected until recently because they were not a body recognised by the Department of Bantu Administration and Development. What arrogance!

Rheumatic Fever.

Rheumatic fever used to be the scourge of Victorian and Edwardian England, especially in the slums. A survey was conducted in Soweto and the incidence of rheumatic heart disease was about 7 out of 1000 children the rate being higher in older children. The paper concluded that the socio-economic status of the community must be improved if optimal prevention is to be achieved. In Umlazi and Kwa Mashu there must be about 500 children with rheumatic heart disease, the majority undiagnosed. Of course nothing has been done to discover these children or to prevent the disease occurring.

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What facilities are available for training in medicine?

In the 1940's it was decided to found a multi-racial medical school to train doctors who would be working primarily with Africans. Unfortunately the Nationalists came to power before it was opened and insisted that it should be a non-white school. Since 1951 it has been the major source of non-white doctors producing 612 to date. A couple of attempts were made to remove the Medical School from the control of the University and these were bitterly and successfully contested. In the last few years extensions costing R1½ million have been made to the medical school. The cynics, who said it was in preparation for the ousting of the African students, were proved right on 17 December 1975 when the Department of National Education informed the Faculty of Medicine that no more African students were to be admitted. This was done without consulting the Faculty. Since then after debate it was agreed to admit African students for one more year. However it is obvious that the Government will continue with its plans to convert the Durban Medical School into a white medical school. Apparently this decision was made in Cabinet at the end of the sixties. Mr Marais Steyn has already had talks with the Rector of Westville University concerning the establishment of an Indian Medical Faculty.

Despite assurances to the contrary it seems apparent that the policy of separate development is to be carried to the extreme despite opposition from all quarters.

So what is the future of black medical education in South Africa?

A Medical University of Southern Africa has been established at Garankuwa, 35 km north of Pretoria.

It will be under the control of the Minister of Bantu Education who has the power to vet all appointments. No doubt applicants will have to have the right kind of separate development philosophy to be appointed. This school is not yet functional and will not produce doctors before 1982. It is reputed that it will eventually produce about 200 doctors a year, but that will take many years to achieve.

How many doctors are needed? There are just about 12 000 doctors in South Africa of which just over 1000 are non white. Most of these doctors are situated in the urban areas.

In April this year Mr M. C. Botha stated that there were 84 black doctors and 398 white doctors working in the Homelands in 1975. If the population of the Homelands is taken at 9 million, this makes approximately 1 doctor for 18 000 people. This figure is slightly loaded since some people in the Homelands drain to hospitals outside. However it contrasts strangely to the ratio of 1 doctor for 1000 whites. To correct this imbalance to about 1 doctor to 2000 Africans, another 4 500 doctors would be needed. This level would take Garankuwa 22 years to reach at the minimum, i.e. 2004 by which time the population of South Africa will have doubled.

The Medical Faculty at the University of Natal is essential to supplement the output of doctors not only for the African community but also for the Indians. To close it to Blacks would be a direct attack on the future health care of Africans.

If the Government wishes to open another Medical School for whites then Pietermaritzburg is the obvious place. There is a University, a brand new white hospital is being built and there is a large African Hospital where students can get experience. (It is odd how white students get experience on blacks but black students cannot get experience on whites. It is said that non-white medical students at U.C.T. cannot attend post mortems on whites, even though the mortuary attendants are non whites. Maybe the mortuary students wash the corpses with their eyes closed!)

The standard of medical education at Natal is akin to that available at other medical schools in the country. However

since the departure of Professor Kark the Department of Community Medicine has been extinct. Community Health is the king pin to health in developing communities but at the medical school ideas along this line have not only been neglected but actively discouraged. Not until this is corrected, can the Natal Faculty of Medicine be proud of its standing in the world.

What about equality?

Racial discrimination is so rife in South Africa, that it is difficult to pinpoint examples. There are differential rates of pay in almost all fields of medicine except the Mission Hospitals, one or two independent research organisations and a few enlightened city councils. The affront to human dignity leads to very bitter feelings by the Black staff and is indefensible. It is particularly unfair since doctors, nurses, and technicians take the same examinations, have the same professional bodies and hold the same responsibility. The Government and Provinces have stated time and again their aim is to remove differentials in pay, but we still wait in vain. It is no good decreasing the differential – this is also indefensible. Only complete equality of pay for equal positions is acceptable.

An African sister earns R1740–2700 (+120) per annum and a white sister earns R3000–4380 p.a. Thus an African sister of eight years standing earns R300 p.a. less than a 1st year white sister. They both take the same examinations and I question the morality of paying a sister green from the nursing school more than an experienced sister who will have seen and learnt an enormous amount after 8 years nursing in an African hospital.

The apathy of the Nursing Council of South Africa to correct this is a glaring reminder that the wishes and rights of the Blacks are being constantly ignored. It is no wonder that they turn away from professional bodies like the Nursing Council or the Medical Association in order to obtain help.

SUMMARY

On the whole the black population is a poor, uneducated underprivileged and deprived group. Blacks have an incidence of disease considerably higher than the whites and their access to primary medical care is extremely poor. The State, which has taken on the responsibility for the health of the African, has constantly ignored the degree of illness in the African community, and many of those involved in health planning have proved ineffectual and apathetic. Little attempt has been made until the last five years to create a comprehensive service even though South Africa is the most advanced country on the whole continent. Countries like Tanzania, Nigeria and Kenya have progressed considerably further in their approach to community health care.

THE SOLUTION

1. **Hospitals.**

   There must be an urgent building programme especially in the townships. Umlazi Hospital must be completed as a national priority and the Kwa Mashu hospital started immediately. No major new township should be started without also starting a hospital for the township. One wonders how far they have got with a hospital at the new township at Mpumalanga near Hammarsdale.

2. **Clinics.**

   The Clinic network must undergo a momentous increase so that there is at least 1 clinic /7000 population. South Africa has been extraordinarily slow in providing this basic unit of a comprehensive health scheme. In the Highlands of Papua–New Guinea, where I worked for one year there was one clinic to about every 3000 people–and the first white man arrived in the Highlands in 1936!

3. **Medical Assistants.**

   South Africa will never have enough doctors for its population. Therefore in order to deliver a reasonable standard of health care Medical Assistants are a necessity. These are neither doctors nor nurses, but fulfil a different but complimentary role. An attempt was made to start a system of Medical Assistants years ago but foundered not only because of professional opposition from doctors and nurses but also because the Blacks thought that it was an attempt to preserve the status and wealth of a doctor for whites leaving the assistant grade to Blacks.

   In advanced western communities paramedical personnel are taking an increasingly active part in health care complimenting the role of the doctors. They perform duties originally, traditionally, the sole preserve of the doctor. They are not second rate doctors but complement the doctor allowing him to concentrate on more serious cases.

   Medical assistants should be trained as such and not just as "super nurses". The Nursing Association of South Africa has held by their Victorian attitudes and fought the implementation of Medical Assistants, saying that no nurse would take orders from a Medical Assistant. Such ostrich-like behaviour makes one wonder if the Nursing Association is really concerned with improving the health of the community or in maintaining an outdated status quo.

4. **Immunisation**

   There should be a massive campaign throughout the country aimed at eradicating polio, and measles. It is not good enough to have periodic immunisation expeditions or to erect a clinic here or there. A comprehensive system of clinics must be provided as a priority.

5. **Education**

   Natal University Medical School must be retained for the Blacks and Garankuwa must be completed. The ideal is that all Medical Schools should be open to all, irrespective of the colour of one's skin. The education of Medical Assistants must be started immediately. The emphasis being laid on their complementary role in medicine.

6. **The Government.**

   The apathy that pervades a lot of the people involved in the organisation of the health services must be shaken off. They must look critically at themselves and their work and realise that they are responsible for a pathetic and totally inadequate service. Although plans for a comprehensive health scheme have been laid out, little has been done to implement it.

   Considerable responsibility lies on the Department of Health for the shocking state of affairs existing at the moment, and until they realise that an adequate health service requires the injection of considerable amounts of capital and rejection of apartheid, then these injustices will remain.