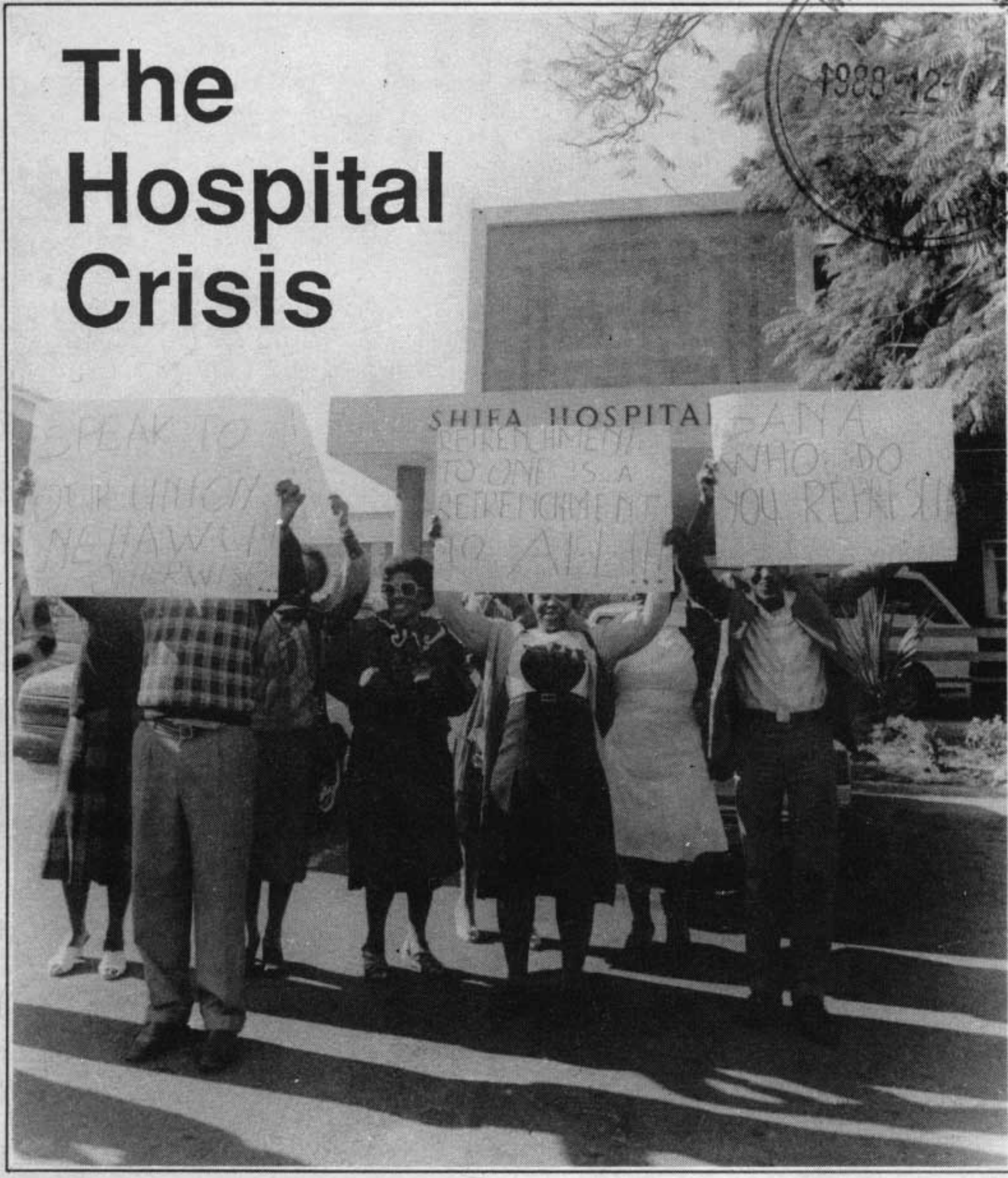
Critical Health

Number 23 August 1988

The Hospital Crisis



Areas for struggle and change

Critical Health

Number 23 August 1988

Contents

Thanks to Afrapix for photograghs, Charlotte for graphics and TOPS for layout

Critical Health is published by an editorial collective, P O Box 16250, Doornfontein, 2028.

Editorial

The service provided by South African hospitals has been in crisis for many years. The stand taken by the doctors at Baragwanath drew attention to the crisis by highlighting the prevailing conditions. Despite repeated coverage in the press over many years, the conditions remain the same and in some areas, far worse. The authorities have not adequately addressed the issue in spite of the devastating effects of the hospital conditions on people's lives. Instead, some of those who have spoken out, have been victimised.

This issue of *Critical Health* focuses on various areas of the crisis; on its causes, consequences and on areas for change. Probably the most important cause is the low priority that health care provision is given by the state. This is clearly illustrated by the distribution of the state's budget; in 1988, 2 273,2 million rand will be spent on health whereas 8 195, 5 million rand will be spent on defence. The state has claimed it has no funds to run these hospitals nor to build services in areas where there is a desparate need. This is in spite of the amount of money spent by the state in maintaining apartheid and apartheid structures (such as the tricameral parliament) that the majority of South Africans have rejected. The state has been encouraging the privatisation of health as part of a solution to the hospital crisis.

These points are dealt with in an interview with Max Price from the Centre for the Study of Health Policy. They are also mentioned in the article on mental services under apartheid. The latter article maintains that those responsible for making decisions regarding health care and hospital services, are able to get away with inappropriate planning and provision of inequitable health services, because they are in no way accountable to the community they are serving.

The articles on the campaign around the increases in hospital tariffs in Natal and the campaign launched by the Lenasia community around health care demands, illustrate the way community and health worker organisations have begun to demand this accountability from the authorities.

Until recently, health tended to be neglected as a focus of struggles within unions and community organisations. The article written by the Health Worker Organisation in Natal, emphasises the role health issues should play in the broader struggle against apartheid. It stresses the importance of health as a means to mobilise, conscientise and organise. The organisation takes this role even further by outlining the role that health should play in the transformation of society.

Interns and nurses are responsible for most of the patient care at provincial hospitals. There is a decrease in the number of health workers who are prepared to endure the poor working conditions at these hospitals. These conditions are exacerbated by drastic overcrowding. The interview with nurses from Baragwanath hospital and the study into the experience of interns, raise some of these problems and the effects they have on health workers.

Hospitals in South Africa are distributed and provided for along racial and class

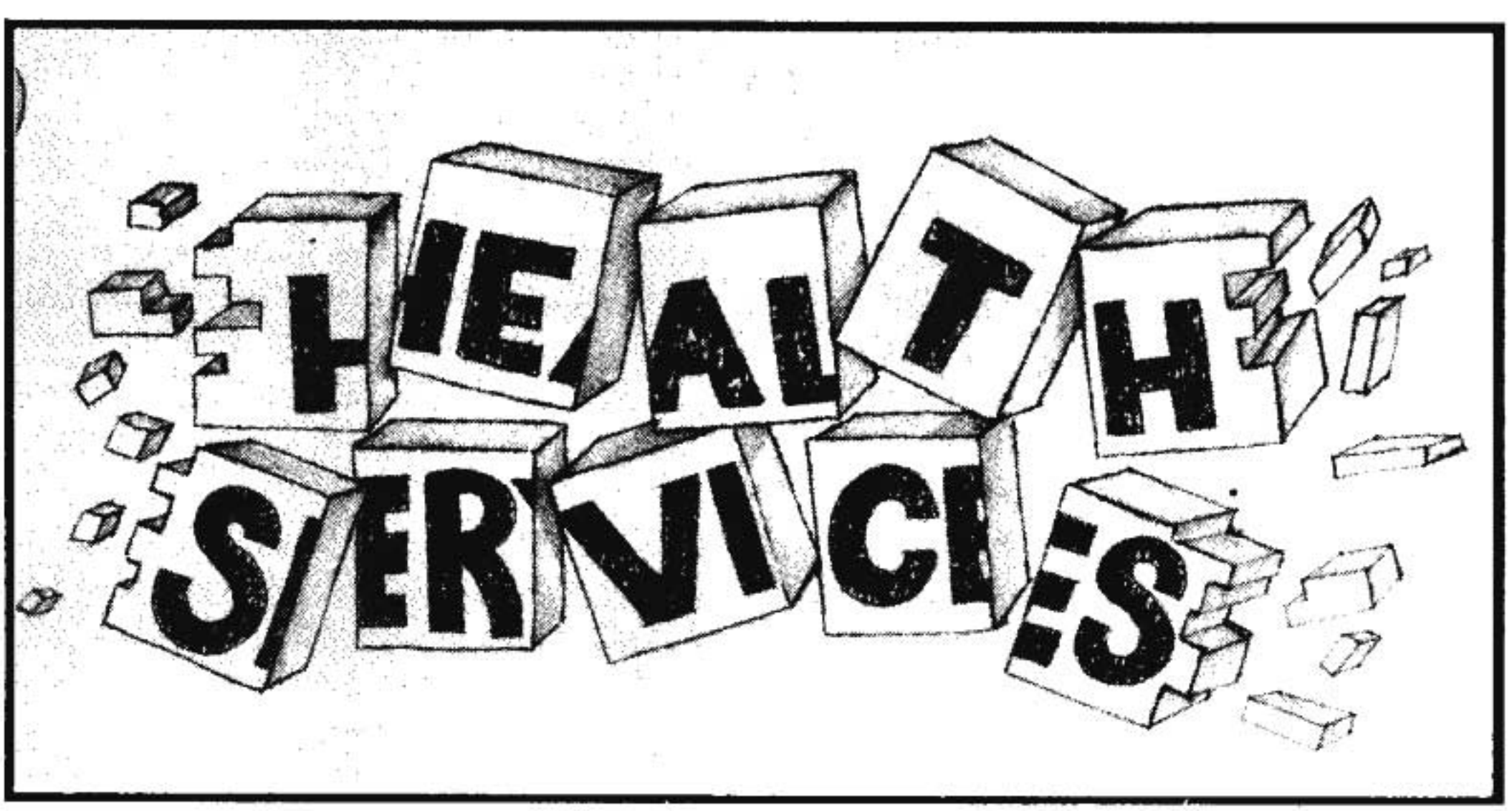
lines. *Critical Health* believes it is unacceptable for health services to be racially segregated. The practicalities of integrating Baragwanath and the Johannesburg hospitals are, however, complex. Patients and their visitors would have to travel great distances to reach the hospitals located in areas where their residence is forbidden by the Group Areas Act. There is no transport provided by the racially segregated public transport service, to take these patients from the central station to the suburb in which the Johannesburg Hospital is located. Other problems such as where to follow up discharged patients, would need to be solved. It is clear the planning of the Johannesburg Hospital was illogical and that the money spent would have been better spent building much needed facilities in areas where the people needing them are living.

In Cape Town the new Groote Schuur Hospital has been built while many of the surrounding areas remain without any health care facilities. The new hospital, however, is to be desegregated. The intention of the article on the events leading up to the desegregation is to illustrate that integration of hospitals is possible in South Africa, even under apartheid rule.

The expensive fragmentation of health into fourteen departments by the homeland policies has already been condemned by the 1986 Browne report on the Commission of Inquiry into health services. The commission found there is "an excessive fragmentation of control over health services and a lack of central policy direction". The devestating effect this fragmentation has on rural, homeland hospitals, is outlined in the article by a rural hospital doctor.

Critical Health believes that the solution to the crisis does not lie in the further fragmentation nor in the privatisation of health services. Rather, it lies in the establishment of a national health service that has the interests of, and is accountable to, all the people of South Africa.

This edition of *Critical Health* highlights the role of progressive organisations in the transformation of the hospital and health services in South Africa.



Hospitals in rural South Africa

Homelands: poor conditions, poor health

Approximately 14 million people live in the ten areas called homelands. The majority of these people live in rural areas and their health is linked to the socio-economic conditions in these areas. Diseases of poverty are reported to be the major reasons for the admission of children to rural hospitals. The attempt to make homelands independent, is an attempt on behalf of the government to get rid of its responsibility for providing a health service to meet the needs of all South Africans.

Homeland health budgets

In spite of the greater proportion of ill-health in rural areas, the homeland health budgets are very much less than for white and urban South Africans.

In 1984/5, only 12,7% of the R3,2 billion health budget was allocated to the 42,7% of South Africa's population living in the homelands.

Homeland health services

Health services and other social services that influence the health of this population, are underdeveloped. Each of the ten homelands has its own ministry of health so that South Africa has in total fourteen different departments of health. This results in a top heavy and expensive bureaucracy with duplication and inadequate co-ordination of services and costs.

Community health services come under the authority of a hospital of the same homeland. This is the reason why many clinics have no formal links with their nearest hospital, even though patients are still referred there. Sick people tend to ignore homeland boundaries, using whichever hospital is nearest. As the hospital in one homeland may not interfere in the domain of another homeland, there is often no follow up of patients who go into another homeland. A hospital is not allowed to see a sick child at a clinic, or do a home visit, if the child comes from another homeland or from non-homeland South Africa, resulting in a breakdown in patient care and cost inefficiencies.

St Barnabas - a hospital in rural Transkei

Numbers of hospital beds in homeland hospitals

The ratio of hospital beds is 1,6 per 1000 in the homelands compared with 2,5 beds per 1000 blacks and 4,8 per 1000 whites in the rest of South Africa. In 1985, twenty-four homeland hospitals ran at greater than 100% occupancy with patients sharing beds or sleeping on the floor. Facilities are often very limited with serious equipment shortages. There are also severe staff shortages.

Health worker: population ratio in the homelands

The doctor : population ratio ranges from about 1:10 000 to1:40 000. Because most medical students come from urban middle class families and their medical education does not encourage working in rural areas, most doctors opt for a more lucrative and high technology practice in urban areas. Similarly, there are 1,4 nurses per 1000 population in the six non- independent homelands compared with 6,8 in the major towns.

A day in the life of a doctor in a rural hospital

Recently over 100 doctors at Baragwanath Hospital protested the conditions endured by patients in the medical wards. The authorities tried to force these doctors to apologise for the stand they had taken. The situation received much coverage in the press and yet hospital authorities have failed to improve the situation to acceptable standards. All this in South Africa's 'showpiece' hospital serving a highly politicised community. How much more vulnerable are the 'quiet' rural hospitals that are hidden away from the public eye. These hospitals, and the rural masses they serve, are badly affected by the inequitable distribution of health care resources in our country.

Below is an outline of the daily experience of rural doctors in many of our rural hospitals.

The hospital where I work

My hospital is a typical rural hospital situated in one of the bantustans. It is situated near a conglomeration of 'little' villages (population about 25,000) and serves a health ward which comprises approximately 200,000 people. The nearest other hospital is about 45km away, a similar hospital, but administered by another bantustan health department. Our hospital has about 230 beds but this is misleading as there are approximately 400 inpatients daily.

We are 'lucky' at this hospital for we have 6 doctors. In some surrounding hospitals there are only one or two doctors and some don't have any at all.

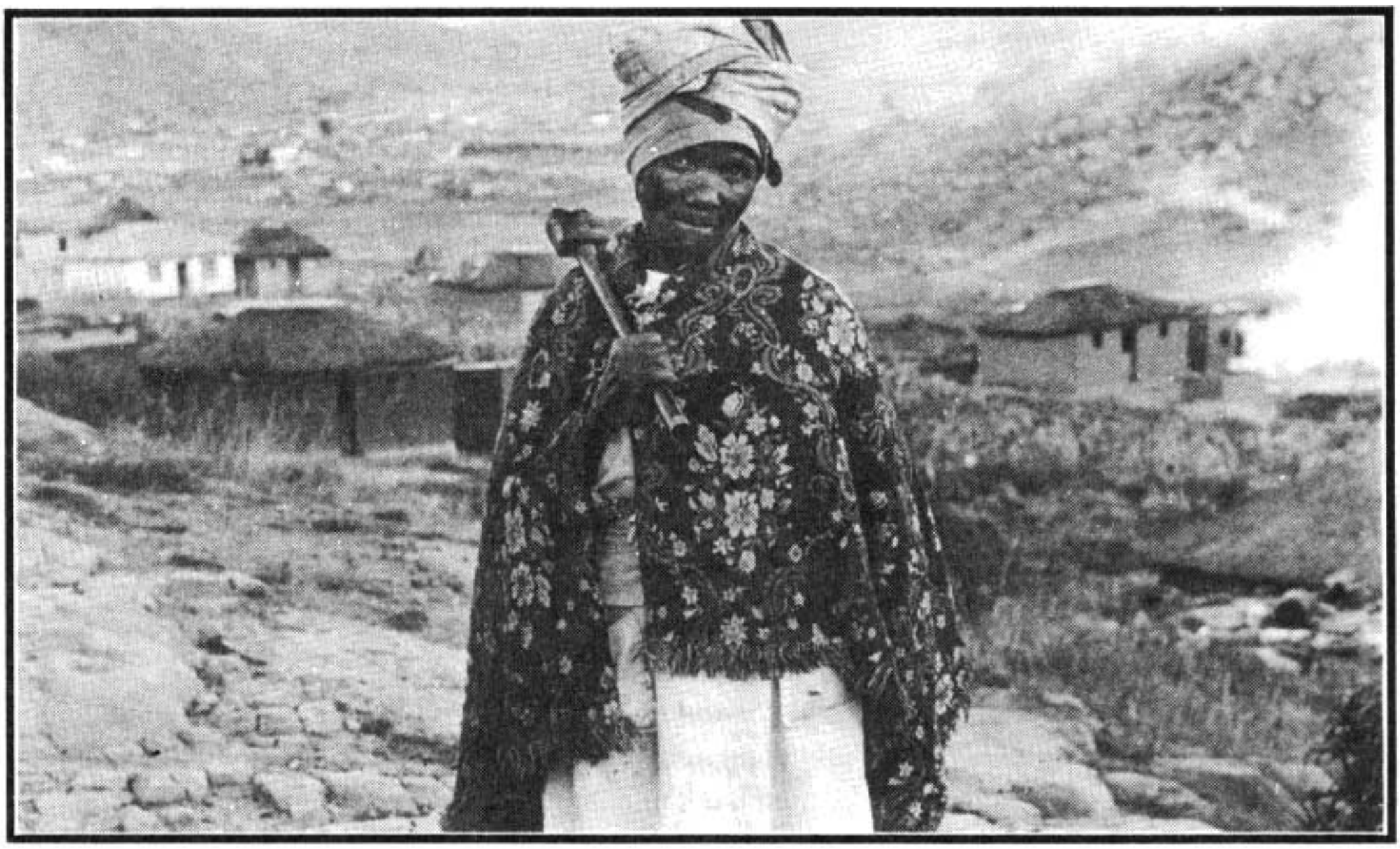
Our nearest regional hospital is 150 km away with specialists in the major medical disciplines. However, we are unable to use this referral hospital as it is not acceptable to transfer black patients to this hospital. Our 'referral' hospital is 500 km away and takes over 6 hours to get a patient to that hospital (if an ambulance is immediately available).

We have an inadequate number of nursing sisters to meet the patient's needs as the posts are based on hospital beds and not on inpatient numbers. There are two theatres, a pharmacy, and a basic x-ray and laboratory facility mainly run by untrained staff.

My day begins

My day begins at 8 o'clock in the morning.

The hospital doctors live on the grounds of the hospital. It is only a 3 - 4 minute walk to the actual hospital buildings. It is Monday morning and I am dreading the day ahead. There are going to be 250 - 400 people attending the outpatients today (depending on the time of the month). Two doctors have been on the weekend call and no doubt there will be a lot of new admissions and work remaining from the weekend. They would only have managed 'problem' ward rounds over the weekend so the wards will be bursting with patient overload and problems.



People have to travel far distances to receive basic health care

The children's ward

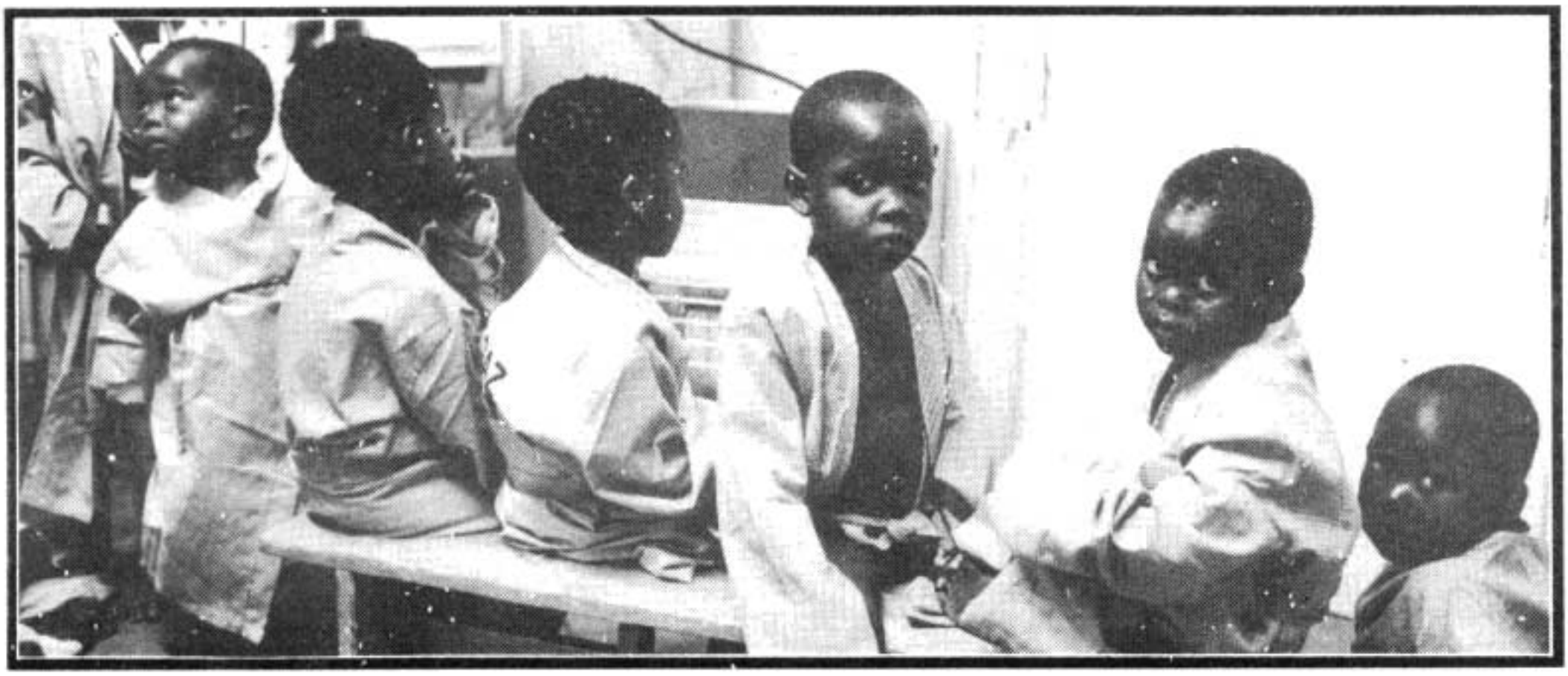
I enter the children's ward with its familiar sights and smells. We have 27 cot beds and we have a daily inpatient load of aproximately 50 - 80 children. A child in this hospital is anyone under 6 years. Any child over 6 years goes to the adult wards. There is the usual disease profile: malnutrition, gastroenteritis, pneunomia, fever, burns, paraffin poisoning, chronic ear infection, neonatal tetanus, fractures, abscesses and so on.

I begin to make my way through the 'load'. Two and sometimes three children

to a cot. Piles of patient bed records, children crying and many needing a clean nappy. Five children huddle around a gas heater. I cannot even remember half their faces let alone their names. No doubt some children have died since my previous round, but I will only find out after the ward round when it is time to sign the death certificates. There are a number of drips running and it is some wonder to know how the three nursing sisters manage to control all the drips.

I try to order only the very basic tests. The results are likely to arrive too late for decision-making or to get lost along the way. I have to rely on the sisters' impression of the children's progress.

Many of their mothers have to return home to care for their other children. Other mothers sleep on the stone floor of a small side verandah. It is freezing in winter and mosquitoe ridden in summer. We wind our way along and see the children. Many patients are discharged sooner than desirable to make way for the new admissions. The ward sometimes smells and looks like a poor children's zoo. Little somebodies, miserable and frightened peering through steel cots. There are no 'sunshine play ladies' here, no painting and playing with toys or looking at books. This is a rural hospital children's ward.



Children huddle around a gas heater for warmth

Out of stock

Today we are 'O/S' chloramphenicol and ampicillin. O/S is a daily occurence and means 'out of stock'. It is accepted as if there is no alternative. Seldom is the validity of the O/S ever questioned, but on most occasions the drug is genuinely O/S! It would not be a great shame if an odd cough mixture or analgesic was O/S, but we regualrly run out of essential drugs. Last month we were O/S of scoline, intravenous valium, syntocinon and intravenous drips!

Some hospitals issue regular weekly bulletins announcing the latest O/S's and

the new drug arrivals (celebration!). Can you imagine what would happen if the Johannesburg Hospital ran out of scoline and there was an anaesthetic accident!

I will spare you the discomfort of a more detailed description of other problems encountered in the ward.

Rural hospitals regularly run out of essential drugs

Another ward

At 12 o'clock noon, I leave the ward. I feel very sorry for my nursing colleagues who work up to 12 hours in this ward. They try their best and they see the worst, yet they keep their cool, they maintain their dignity and they are always friendly. I move next to the infectious disease ward. This ward is light relief compared to the children's ward. I will have to use the septran to treat the typhoids now, until our stocks return. I see about 30 typhoid patients and a few very sick children with measles.

The outpatients department

I go to the outpatients department. The OPD looks like the Johannesburg station at 5 pm on a weekday. There are literally hundreds of patients to be attended to. There are only four nursing sisters and two doctors. One sister 'screens' the patients into those who need to be seen by the doctors and those to be seen by the nurses. Some of the nurses have not been adequately 'trained' for this, but do the job to the best of their ability. I quickly see some of the more severe or urgent problems.

A woman is lying with a pool of blood between her legs. She is aborting a pregnancy and needs an urgent operation to stop the bleeding. The hospital has no blood to replace that which she has lost. I arrange for theatre in 15 minutes. I see another four or five patients. Some need admission so I quickly scribble down the brief history and my findings and order the necessary investigations and medication. I am hopeful that most of it will be carried out by the sister in the ward.

No ambulance available

Another patient is lying on a stretcher for urgent tranfer to our referral hospital. They are waiting for the ambulance to arrive. But the one ambulance is out on a maternity call and the other driver has 'gone to lunch'. The hospital has only two functioning ambulances and no trained paramedical staff. The ambulance man is really only a driver with absolutely no first aid skills.

Possibly the hospital nearby, 50kms away, is also sending someone off to the same referral hospital, but they are from a different homeland health department and as such we cannot co-operate with such hopital transfers. Transport is always a major problem. The hospital has no qualified mechanic, the local roads are atrocious and nearly half the hospital vehicles are out of order. The 'urgent' patient must wait and OPD gets on with its work.

Theatre

It is 13h40 and I rush off to theatre to operate on the woman who is bleeding. I call a colleague to put the patient to sleep while I clean out her womb. My 'anaesthetist' is concerned about the dangers of anaesthetising such a pale and almost shocked woman. We have no alternative, we hope for the best. I clean out her uterus which will stop any further bleeding.

All goes well and at 14h25 I go home for lunch. All is quiet and peaceful at home. I return at 3 o'clock.

The labour ward

I 'pop' into the labour ward. The doctor who normally looks after the ward is on leave. This ward has approximately 350 births a month. It is run almost entirely by midwives. There are four delivery beds. The beds are separated by a small bedside cupboard. The four beds make up the entire width of the room. There is no privacy besides some rundown plastic curtains which are seldom ever drawn. There is no incubator available. There is an old inefficient vacuum extractor and some basic

resuscitation equipment which is taken to theatre for the caesarian sections, during which time there are none left in the labour ward. The labour ward is a very small room when four or five women are in labour at the same time!

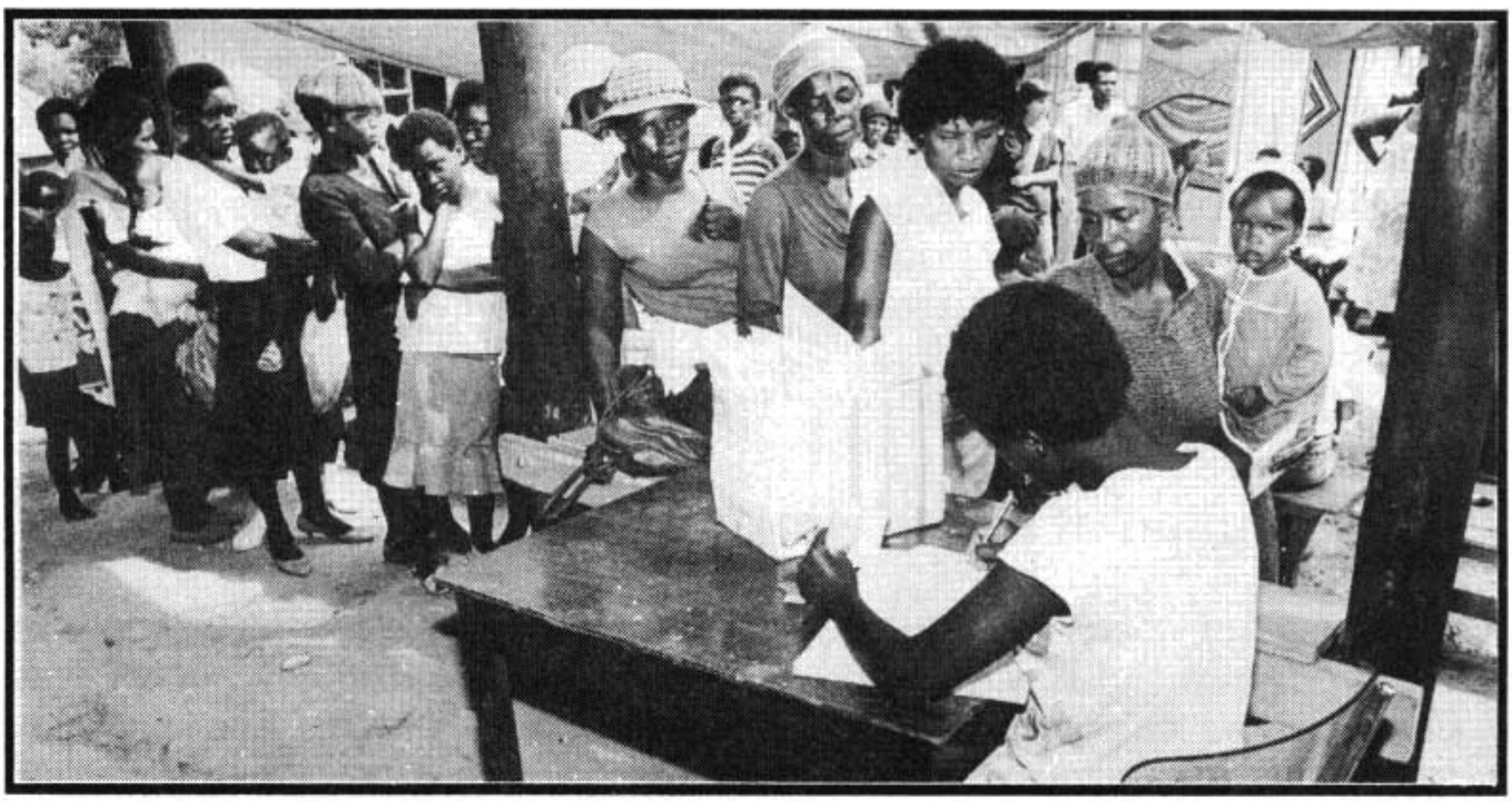
I am asked to do a breech delivery. We cannot get the rusty last third of the bed to dismantle in order to do a breech delivery. We quickly swop the bed with the one belonging to the surprised woman in the next bed. I deliver an uneventful breech. No gloves this time, in the rush of the moment the recycled 'disposable' glove split down the middle whilst I was putting it on.

In this ward there is no time or atmosphere for caring for anything else but the basic physical needs of the women in labour and even this is difficult. Again the sisters try hard, but the general load and depressing environment make it difficult to maintain a caring and sensitive approach to the women giving childbirth.

Back to the outpatients department

It is now almost 4 o'clock.

I reluctantly trudge back to the outpatient department. There are still patients everywhere. It is difficult to see the window at the end of the room. I find an assistant nurse to interpret for me and begin to see the long line of patients. Two of my colleagues are in theatre with an ectopic pregnancy and two others are 'somewhere in the hospital'. I start to see the patients again. They have been waiting for many hours. Many of them have now missed the last train and cannot afford the taxi-bus fees. Many will need to sleep over on the OPD floor and go home the following day.



Patients have to wait in long queues for many hours

I try to differentiate the 'sick' from the 'non sick'. I try to smile and greet each patient. I try to understand their frustration and I hope they might get a glimpse of mine.

The day never seems to end. There are endless complaints, pelvic inflammatory diseases, body pains, waist aches, headaches, infertility, coughs, skin sores, diarrhoea, abdominal pains, countless disability application forms (desperate people trying their luck), chest pains etc.

It is 6 o'clock in the evening. Finally the background noise seems to be fading. I dare not ask the sister how many patients still need to be seen - it is better not to know the bad news.

Fifty minutes later, I finally walk out of the OPD.

On call

I am also on call tonight. I hope and silently wish for a quiet night. My wishes are seldom granted. I fear there might be some dreadful taxi pile-up or some other horrific surgical problem which is beyond my surgical abilities. The labour ward is sure to steal any peaceful sleep. It is indeed a lonely place in the middle of the night being the doctor on call for a hospital with 400 patients and another 200,000 people not very far away ...

To sum up

I have given you a brief glimpse of a little of the day to day experience of a doctor in a rural hospital in South Africa. This was not an unusual day. Some are much worse and a few are a little better. I have colleagues who work in nearby `bush' hospitals and I am in touch with others in similar hospitals elsewhere. Our experiences are very similar. Naturally some of our rural hospitals may be quieter and better off, but very many exist as described above.

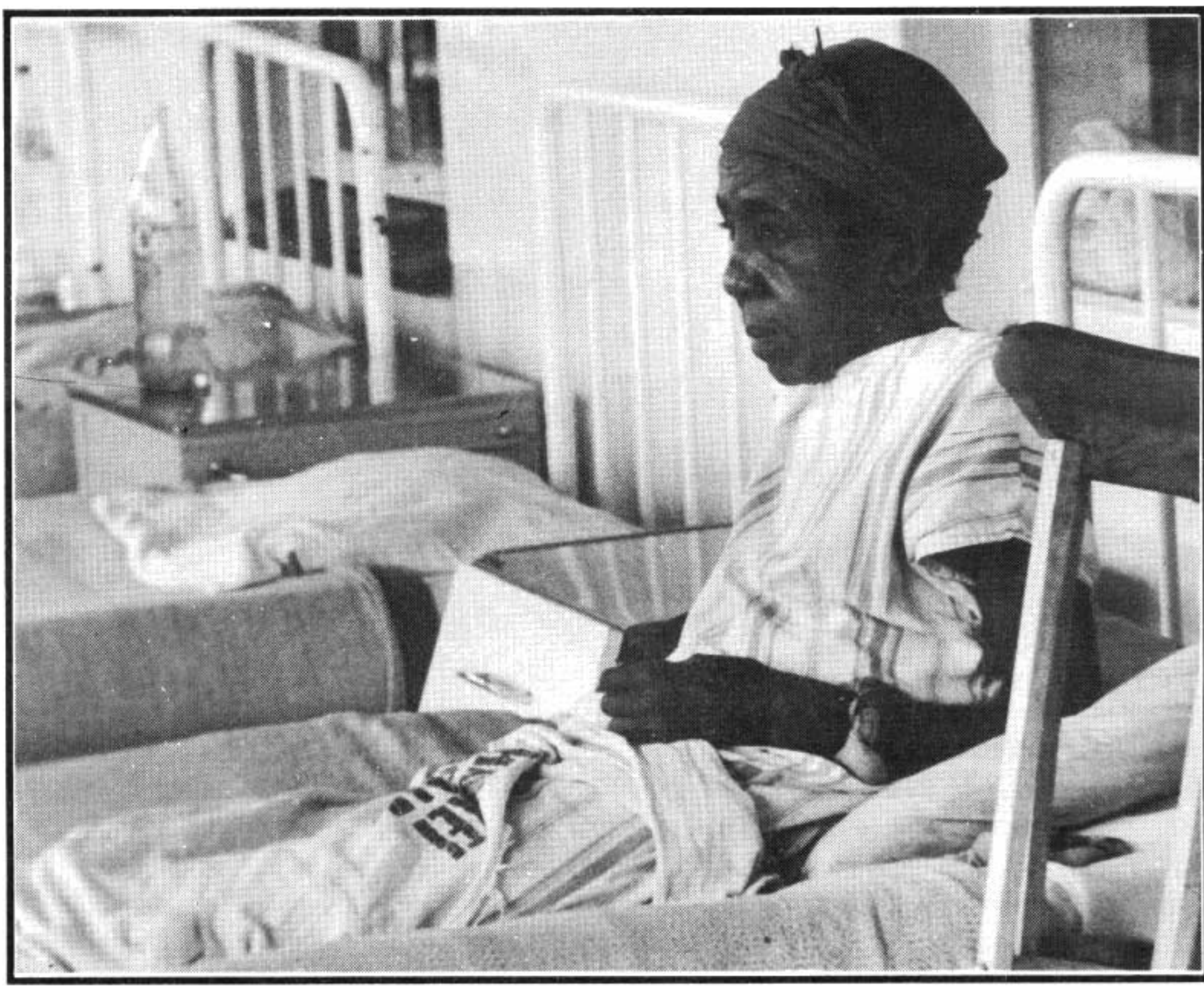
Our rural hospitals are overloaded, overstretched, underequipped and understaffed.

Maldistribution of health workers and facilities

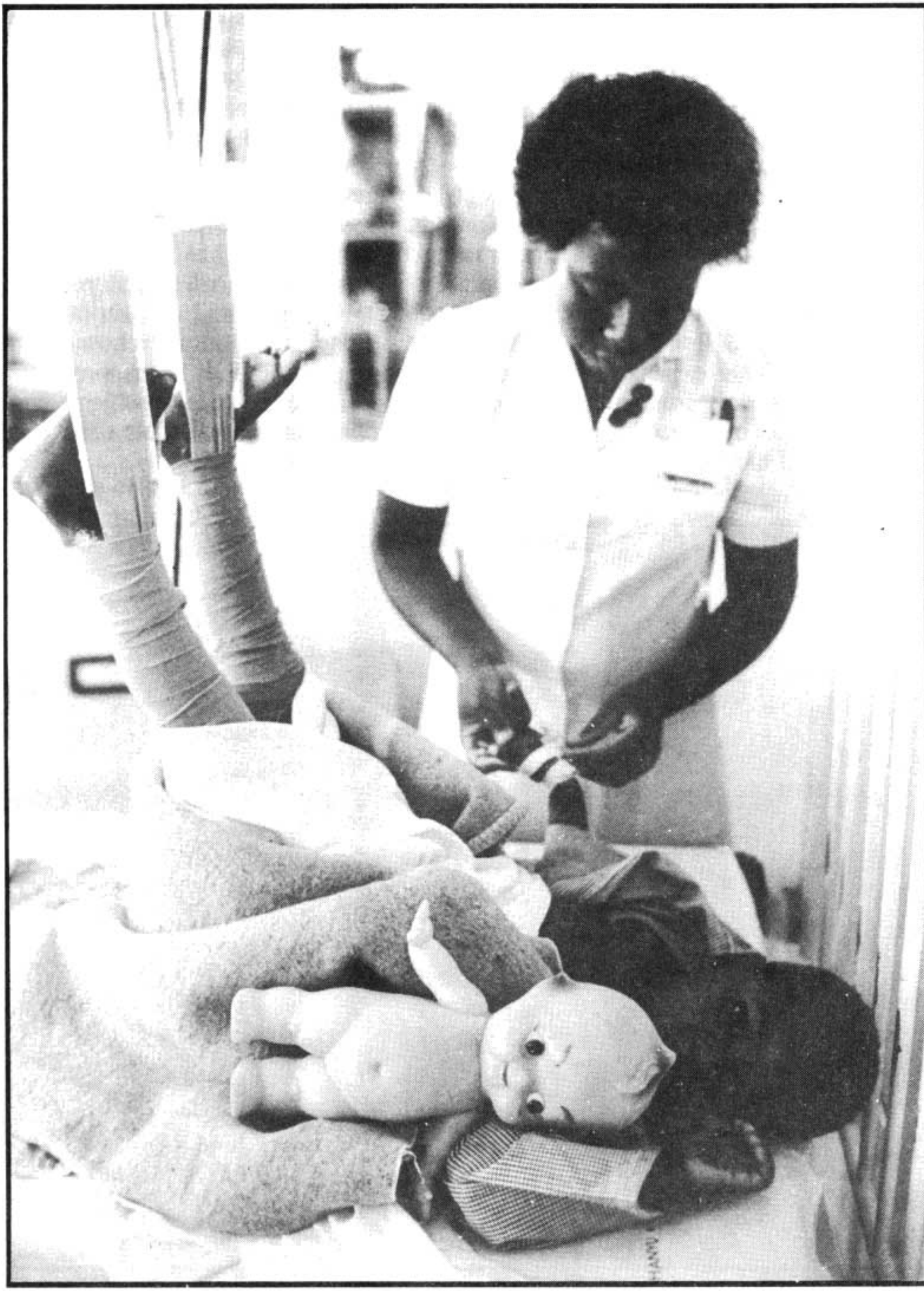
The shortage of doctors is critical in many hospitals. The previous supply of European, British and American doctors is drying up fast. The government does not seem to have the political will to streamline overseas applicants. The long delay in processing their applications often results in losing the services of such doctors. South African doctors are reluctant to work in these hospitals. There is no meaningful incentive in the form of better salaries or perks for health workers who

choose to work in these areas. There is no major effort by the central government to encourage young doctors to go to rural hospitals or even to make a rural hospital spell compulsory for all graduating doctors. The problem is not confined only to doctors - in terms of health personnel, it also involves nurses and other supplementary health service professions, administrators and skilled maintenance personnel.

The health budget for our hospital is clearly inadequate and in real terms it has been getting less each year (the situation and fate of our district clinics is even worse!). Many decisions such as the siting of new clinics, health centres and hospitals are made by politicians and not by informed health administrators and planners. We know of an extravagant new hospital recently built in a homeland (Lebowa) only 3 km from an adequate new hospital in another homeland (Gazankulu). Other expensive health centres and clinics are built in inappropriate places. It is all very frustrating and disillusioning. There are many problems and inadequacies in our rural hospitals and health services in general. This outline is only the tip of the iceberg.



Rural hospitals serve 10 - 20 million of South Africa's people: They are entitled to better health services



One of the causes of the crisis is that not enough money is allocated to health.

Interview on the hospital crisis

The following interview on the hospital crisis was conducted with Max Price of the Centre for the Study of Health Policy. It deals with the causes and possible solutions.

Q: Much publicity has been given recently to the current 'crisis' in certain of the public hospitals in South Africa. How do you view the crisis and what are your opinions of the cause of the crisis?

A: Firstly, the problem in the public sector and the reason for the crisis is that not enough money is being allocated to health. The health budget has not kept up with the population growth, increased urbanisation, the increased number of older people in the population, medical inflation, nor with people's expectations. Instead the government is spending more money on defence and on the maintenance of apartheid.

Secondly, some of the money that has been allocated has been used inefficiently. It is wasted on the upkeep of large bureaucracies, fragmentation of services into fourteen Departments of Health and on the maintenance of segregated facilities. There is the Johannesburg Hospital which is under-utilised but which still must be run. Staff, electricity and heating and loan repayments must still be paid. These expenses do not go down just because it is less occupied.

The problem is that the government is not committed primarily to the provision of health. Health needs are secondary to the maintenance of apartheid.

Thirdly, management systems of public sector hospitals are inadequate. Proper costings of operations for example, are not done and therefore the hospitals are not in a position to make proper decisions. The separation of the siamese twins at Baragwanath is an example. Was this an ethical distribution of resources in a country where people do not have access to basic life saving health care?

There are too few adequately trained people in positions of management and planning in the public sector. However, their problems of co-ordination and planning are compounded not only by the fragmentation into fourteen departments of health, but also fragmentation of curative care (which falls under the province) and preventive care (which up until April 1988 was under the state and the municipality). Resources could not be allocated from one service to the other as

they were under separate authorities.

The lack of adequate incentives within the sector to ensure efficiency and appropriate use of resources, is also problematic.

Fourthly, staff shortages are a problem. Working conditions for nurses are poor. The private sector can offer wage incentives to counter this. A vicious circle emerges where the working conditions in the public hospitals worsen as the nursing shortage worsens.

These problems are not insoluble. Yet other problems may be more complicated, such as the attitudes and incentives of some health personnel. Doctors, for example, expect to earn a large amount of money and can do so in private hospitals or overseas. Since the public sector cannot afford to spend as much on doctors as the private sector spends, this also leads to shortages of doctors in the public hospitals.

Squatters in the Eastern Cape: Health budgets have not kept up with increased urbanisation

Q: What solutions do you see to the nursing shortage?

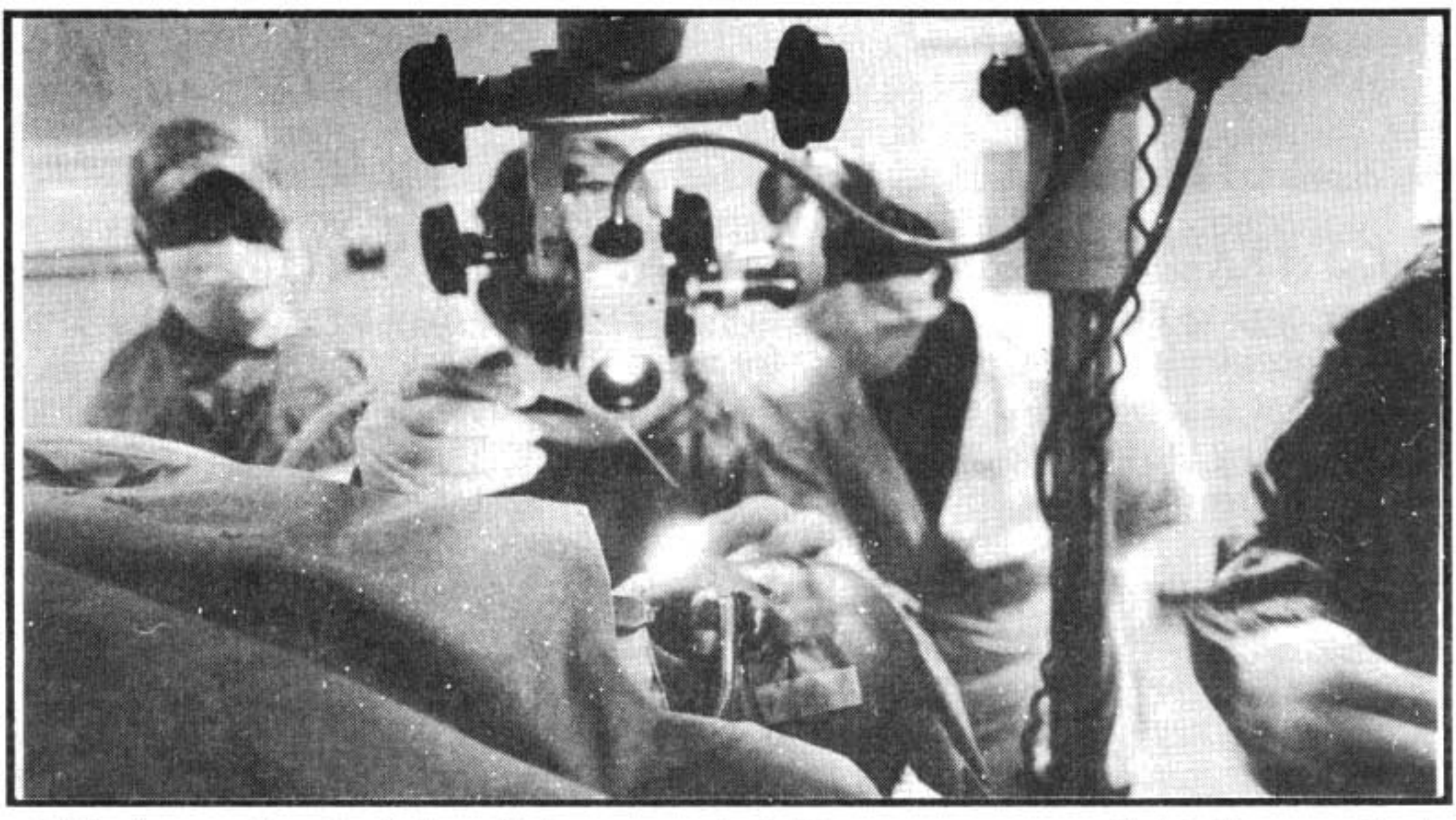
A: A solution to this is difficult. Obviously, nurses need to get paid more. One solution would be to 'de-skill' certain nursing functions or to change the qualification requirements. Nursing is becoming more professional, training is now four years as opposed to three. Perhaps some nursing work could be done by less trained people and the money saved on training and salaries could be used to pay nurses more. The large private sector actually aggravates the problem in the public

sector. Part of the difficulty in recruiting nurses to the public hospitals are the incentives provided by the private hospitals. The private sector can always maintain nurses' salaries at 10% above that of the public sector. The private hospitals however, are not involved in the training of nurses and don't carry those costs. They also do not add to the total pool of nurses.

Q: Private hospital representatives often claim their hospitals are run more efficiently than public hospitals. What evidence is there for this?

A: It is very difficult for the private hospitals to compare their running costs to those of the public hospitals. Public hospitals do not have records of amounts spent on individual operations, procedures etc. In other words there is no evidence from which a comparison could be made so I don't know on what basis private hospital representatives make these claims.

Comparing the total budgets of public and private hospitals of equal size is also hazardous. The public hospitals perform certain functions that the private sector does not provide. For example, public hospitals usually treat the most severe cases and perform most of the very 'high-tech' medicine. Also, tertiary hospitals are responsible for the teaching of health workers which is very expensive. The cost of running a public hospital includes medicines and staff salaries. The cost of private hospitals does not include this; the patient is billed separately for them.



80% of cases in private hospitals are surgical. These are more profitable than medical cases

In addition, 80% of cases in private hospitals are surgical. They tend to take on fewer medical cases which require longer periods of hospitalisation and which don't pay back as much. Most of these cases are sent to the public hospitals.

Theoretically, it is likely that private fee-for-service hospitals are less efficient and push costs up more rapidly than public hospitals. This is because it is more expensive to administer a fee-for-service system where each item is seperately billed than to administer a fixed budget fee. Also, the fact that private hospitals are there to make a profit implies that the net proportion of expenditure going to health care activities is less.

The arguments used by the private sector to defend the efficiency of the private hospitals relate to the competitive nature of the market which should force hospitals to give the best care at the lowest cost. I do not believe this argument is valid but we can come back to this later when we talk about privatisation.

Q: Do medical aid schemes provide a solution for those "non-indigent" patients who have to pay for their own care?

A: I don't think they provide a long-term solution because they contribute to rapid cost escalation and over-utilisation of the health services. The reason is that medical aids are what economists call a 'third party' method of payment. This means that when the service is used, neither the patient nor the provider is aware of the costs and so the price mechanism can't act as a disincentive at all. As a result, providers provide as much care as possible and users use as much as they can. People feel they have paid and should try to get something for it every month. Medical aid schemes are thereby fuelling the spiralling costs of medical care and some are running into financial problems because of this.

Furthermore, medical aid schemes are inequitable compared with taxes as a method of payment; someone with a low income may have to pay 10% or more of their income to the scheme, while a business executive may pay less than 2% of his/her income. It is not a good system for redistributing health resources.

Medical aids will also not cover people for treatment of conditions they had before joining the scheme and for expensive chronic conditions. Instead of being a system where healthy people pay for the sick, the high risk cases are often excluded.

At present, there are very few alternatives and the schemes, for all their faults, do have some good aspects. For example, they must continue to cover members once they become pensioners, usually at a reduced premium. They must offer a minimum package of benefits and may not discriminate on the basis of income. The schemes are, by law, non-profit services although the administration of the schemes is often performed by a profit-making company. Even then, the proportion of revenue spent on administration is restricted by law and is usually 5-7%.

Q: What do you see as possible short and long-term solutions to the present crisis?

A: In the short term, remove all subsidies of the public sector by the private sector; increase expenditure on public health services; desegregate the hospitals; combine health services into a single department of health; decentralise health service to geographically appropriate regions with more power being given to the local authorities responsible for health in the area. The local health service managers should be able to be more flexible with the given health budget; they should be able to determine pay incentives for certain areas, overtime incentives, bonuses could be introduced for clinics with good evaluations from users, etc. In the final analysis, the public health service can be changed to make it more efficient. The answer lies in this and not in privatisation.

Money that could be spent on health is used for the maintenance of apartheid

Some of the long term possibilities have already been suggested such as a form of nationalised health service. It may be appropriate that, while using the national health service, wealthier patients have to pay in order to subsidise the poorer patients. However, the state must be committed to an increase in expenditure so that any money saved does not get rechannelled into defence but is used to upgrade the health service and other essential services.

Workers who are presently thinking of going onto medical aids could also look at long term solutions which would promote alternatives to private medicine and would be consistant with a future national health service. Trade unions could run their own health services or contract with independent providers to provide services to their members. Two important conditions would be that they maintain control over their health services and that providers would not be paid on a fee-for-service basis as this leads to inefficient cost increases.

Hospital admin speak about the crisis

Critical Health spoke to public hospital administrators. The following article is a summary of these discussions.

Q: Is there a crisis in the public hospitals? If so, what is the nature of the crisis and what are its causes?

A: There are about 60 hospitals in the Transvaal. Some of these hospitals are not viable and should never have been built because there was no need in that particular area.

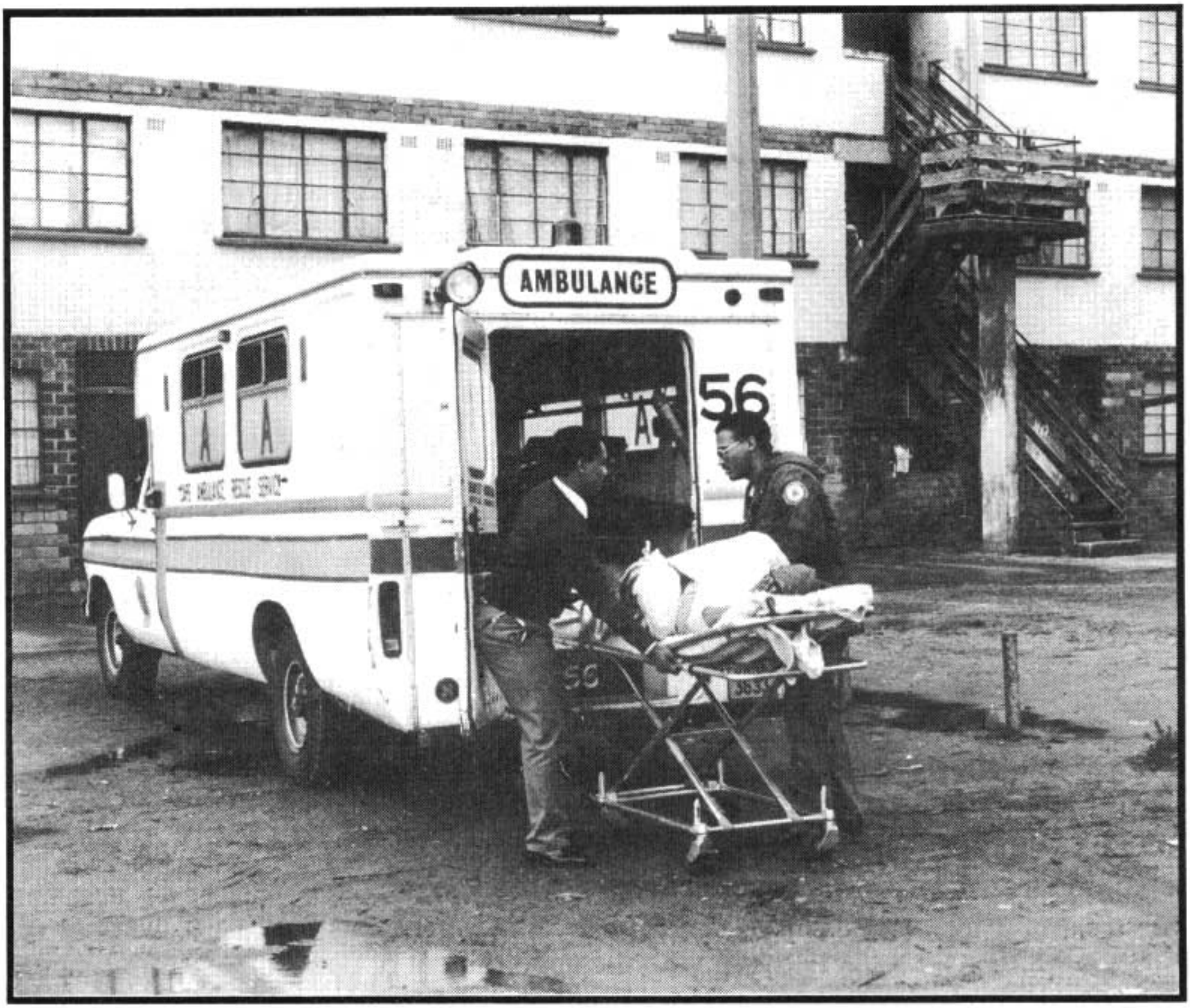
On the other hand, authorities have not expanded facilities in areas where the demand has increased due to the population growth in that area.

A large proportion of these hospitals cater for whites only and are under-utilised while those catering for blacks are inadequate and overcrowded.

To run the under-utilised hospitals is expensive and in certain smaller towns they are used practically as old-age homes for patients of local general practitioners.

The Johannesburg Hospital: Many wards have been closed due to under-utilisation

Hospitals are not planned properly, not built in appropriate areas and don't take the needs of the community into account. Patients with minor complaints in the outer suburbs of Johannesburg must travel all the way into central hospitals to be seen. In Randburg, black patients must pay R80-R90 for an ambulance to take them to Thembisa Hospital which is the hospital serving Randburg. It is far cheaper for these patients to go to the Hillbrow Hospital. White patients in the same area pay about R30 for an ambulance to take them to the J G Strydom Hospital which is closer.

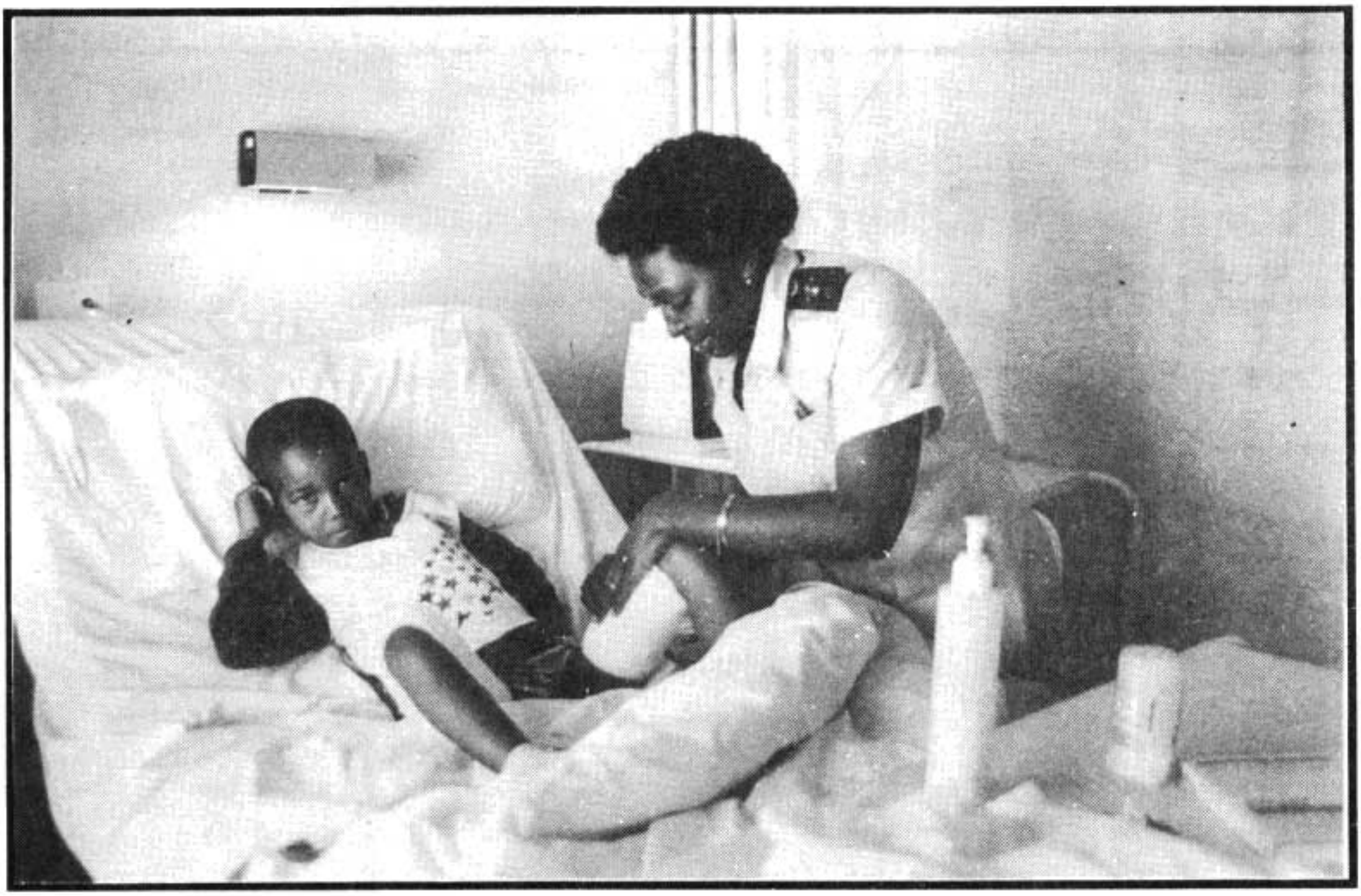


Patients often have to travel far to a segregated hospital, although a white hospital may be nearer, thereby incurring expensive ambulance costs

In certain areas, The Group Areas Act does not acknowledge the existence of permanent black residents and hence no health facility is built in that area. The hospital for blacks in central Johannesburg, for example, has no paediatric or obstetric services, as pregnant women and babies should not be residing in this area, according to the Act.

Certain hospitals have a problem with staff shortages. Nurses work under bad conditions and are badly paid. They have lost their morale. It used to be a profession with a high status, now the nurses are ordered around by clinicians who maybe over- admitting patients for their own interests.

The nurses' pay is inadequate. These are some of the reasons why the lure of private hospitals works. There the pay will be better and the hospital will not admit more patients than they can manage.



Nurses work long hours for little pay

There are also other job opportunities for nurses in the private sector, such as representatives for surgical equipment companies and drug companies.

In certain hospitals, the shortage of theatre nurses has lead to a backlog of patients waiting for surgery. Even with the appointment of new nurses, the situation will take a long time to be reversed, as the new nurses must be trained in theatre work (this can take about one year).

The Cape has a far better system of day - hospitals spread around a large area although there is still a need for more. The health services should be decentralised and major specialities should not be duplicated. The state should be establishing more clinics, appropriately located and staffed by a primary health care nurse. A doctor could rotate between these clinics on specific days to see to those problems that the trained nurse cannot deal with.This would keep minor ailments such as mild pelvic inflammatory diseases, colds, and the removal of sutures out of the main hospitals.

Q: While this may be part of an appropriate solution, is it not evading the very real need for more hospital beds in certain areas?

A: The problem is one of maldistribution of beds. At present the number of beds for white patients is far more than is necessary. Clearly, the number of beds for black patients is not sufficient. The hospitals should not be racially segregated in the first place. Also, the treasury does not distribute the money equitably between the various hospitals. The patients and the community do not have a voice.

Q: A criticism often levelled at the public hospitals is that they are not managed well. Is this true?

A: The problem is that one finds top administrators in the hospital service who have not spent any or enough time in any hospital. It is also the oldest bureaucratic game, that people get promoted well beyond their capabilities.

Q: What do you see as possible short and long term solutions to the present crisis?

A: I have already mentioned these. Feasibility studies must be done before building hospitals. Hospitals must be decentralised and non-racial. Super-specialities should be centralised to prevent duplication.

It is not sufficient to have a hospital in a particular area providing tertiary care only. Facilities for more basic health care must be made available. The present situation, where a person with a sore throat is being seen at the same casualty as a candidate for renal dialysis, is unacceptable.

Individual hospitals should be given more control over the spending of their budgets. Each department is given a certain amount to spend. If one department needs certain repairs but has no money left, it cannot receive that amount from another department with money left over.

The government must make its health policy clear to the regional hospitals. There is talk of the government prioritising preventive over curative care. If this is true, we need to know in order to plan our hospitals accordingly.

Primary Clinical Care Series

Manuals of important clinical conditions for Primary Health Care Workers in rural and developing areas

1	Basic Medical Sciences
2	Conditions of Ear, Nose and Throat
3	Cardiovascular Diseases
4	Respiratory Diseases
5	Urinary and Genital Problems (excluding sexually transmitted diseases)
6	Sexually transmitted Diseases
7	Gastro-Intestinal Conditions
8	Skin Diseases
9	Common Eye Problems
10	Trauma and Emergency
11	Infectious Diseases
12	Health Problems of Women
13	Other Important Diseases
14	Mental Health
15	Child Spacing

If you are interested in obtaining the manuals, or if you would like more information about the Primary Clinical Care Series, please write to:

The Editor,
Primary Clinical Care,
Department of Community Health,
University of Witwatersrand, York Road, Parktown,
Johannesburg 2193, South Africa.

Privatisation: In whose interests?

The government is supporting a policy of privatisation as part of a solution to the hospital crisis. *Critical Health* questioned Max Price from the Centre for the Study of Health Policy on privatisation and the financing of the hospital services. These were his comments:

People mean different things when they speak of privatisation. We need to ask what it is that the government means. I don't think the government knows what it means. But let us analyse the options.

1 Contracting out certain services

One can think of four types of privatisation. The first type of privatisation is where certain services (laundry or catering, for example) are contracted out to private companies. Some people argue that this will provide the incentive for efficiency. I don't have any strong objections to this as it would not discriminate against the poor nor would it effect the quality of health care. A problem could arise if one company gains a monopoly over the service, it may allow the company to 'hold the hospital to ransom' but this is not the major debate over privatisation.

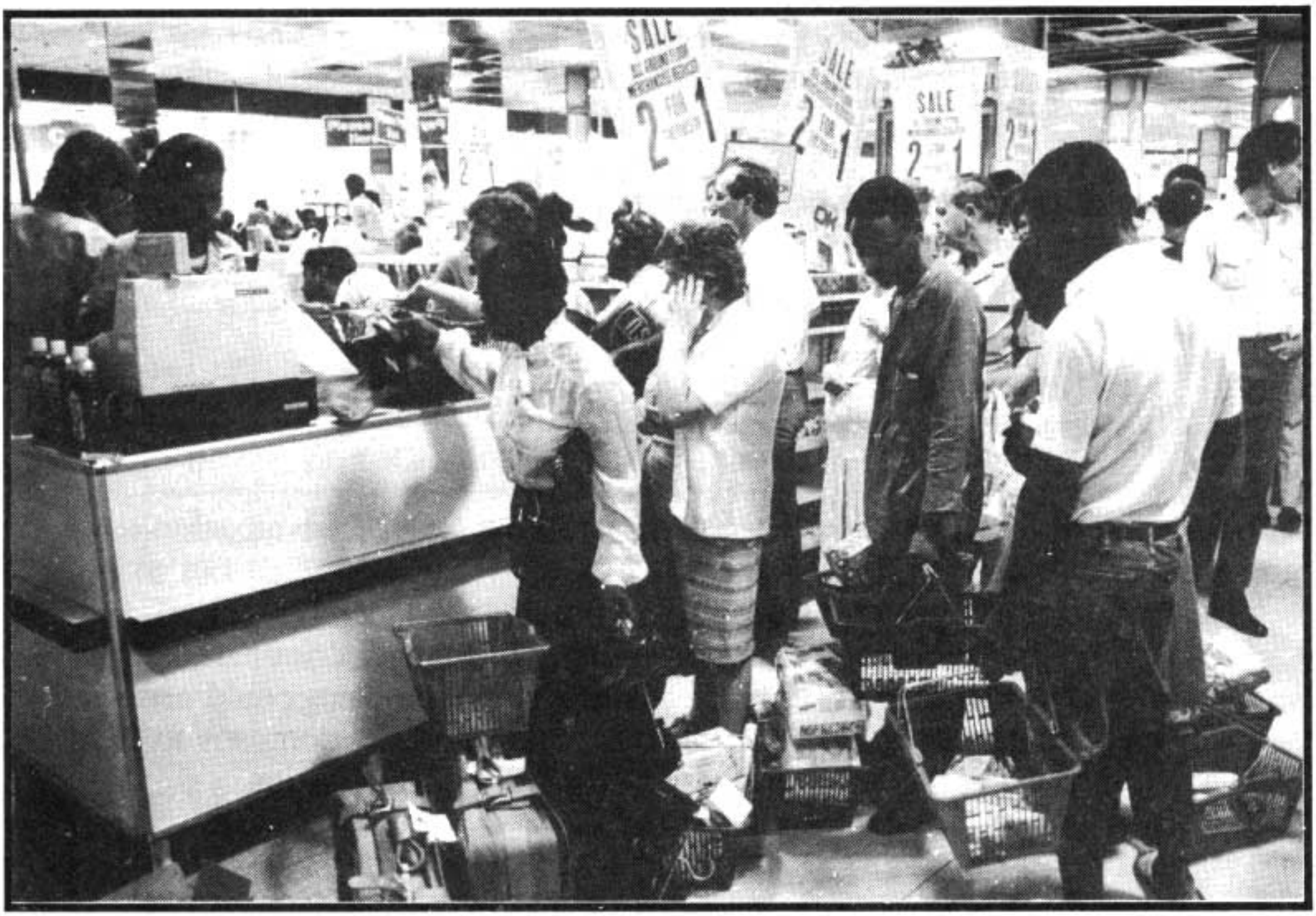
2 Fee-for-service

The second type of privatisation is when doctors and others involved in health care delivery are paid on a fee-for-service basis rather than on the salary and fixed budget system operating in the public hospitals. Supporters of privatisation argue that the freedom of the consumer to choose, forces providers to compete and to provide the best service for the lowest cost. But health care is different from other free market commodities. With any other commodity the consumers have time to search for the best option and may be relatively well-informed. However, when people are sick they usually don't have time to 'shop around'.

Furthermore, in South Africa, doctors have agreed not to advertise nor to compete and hence have fixed prices. Patients' choices are usually limited in that once they have been seen, the doctor decides on which hospital the patient will go to, according to where that doctor is working. S/he will also determine how long the patient must remain in hospital. There is no incentive for these doctors to provide cheaper drugs or to limit the number of investigations done. Many

'consumers' don't have the necessary medical knowledge to make an educated choice.

The market mechanisms therefore do not operate to keep costs down. In my opinion, it is this method of reimbursement (ie fee-for-service) that is causing cost escalation because doctors and hospitals have a financial incentive to do as much as possible.

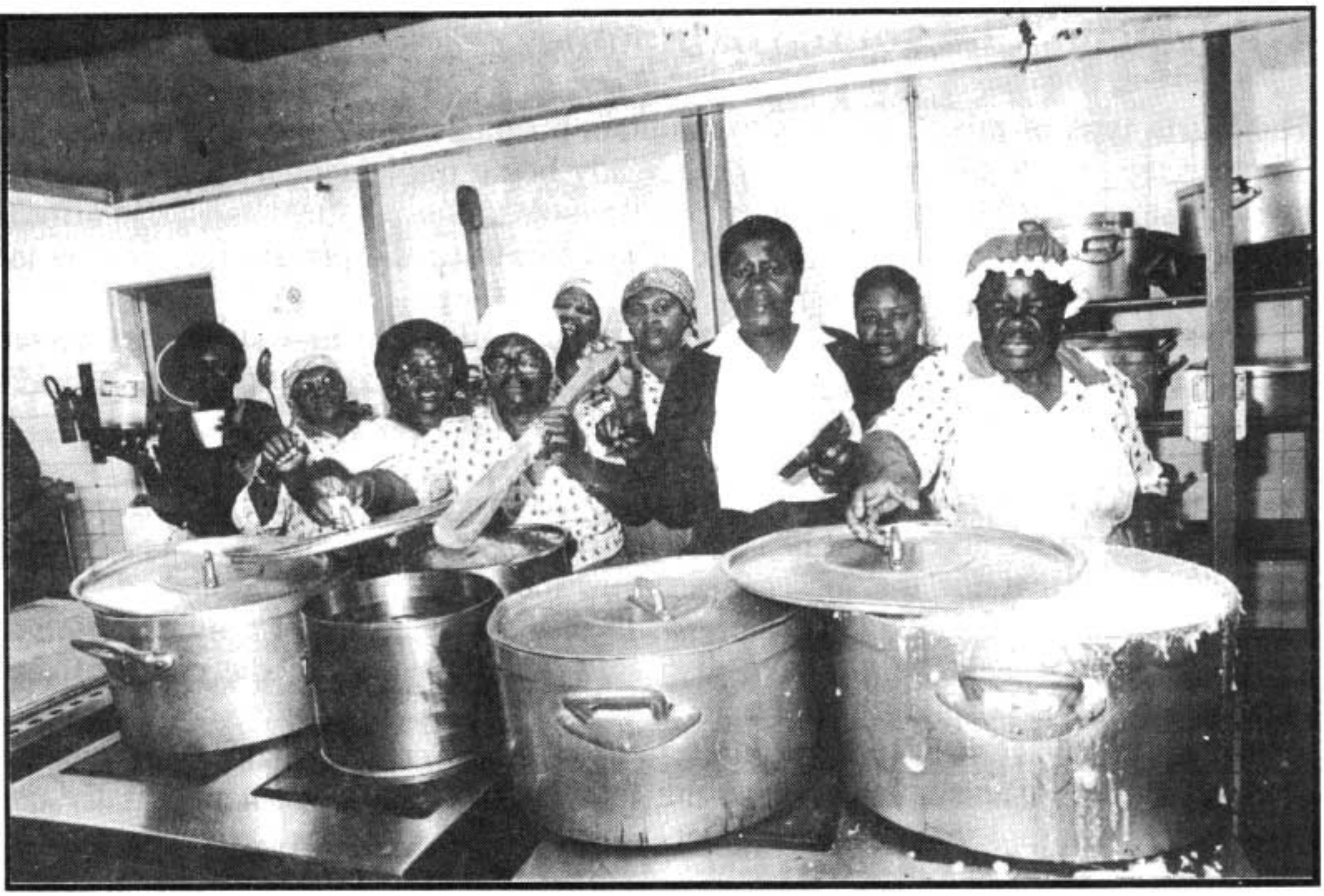


Health is not a commodity. Sick people are not able to 'shop around' for their best options

3 Selling provincial hospitals

The third form of privatisation is to sell off provincial hospitals to the private sector. People will then pay for themselves if they can afford it and if not the state will have to pay the hospital for them. Practically, the government could never afford this. The majority of people in this country probably can't afford to pay and they will remain the state's responsibility.

Another problem with selling off the provincial hospitals is that teaching and research can only be done in teaching hospitals linked to the university with a wide scope of illness.



One type of privatisation is to contract out services such as catering

I think these three forms of privatisation would be disastrous. The main reason is they would introduce a massive escalation in cost. In the private sector, medical aid premiums (which gives one a fair idea of the cost of health care per member) have increased by 600% over one decade whereas the consumer price index (which reflects the cost of living and to some extent wage increases) has increased by only 300%. In other words the cost of private medical care has increased twice as fast as the inflation rate. Public expenditure has also increased above the cost of living but not as much. The evidence indicates that cost escalation in the private sector is much greater than in the public sector.

We should note that there are some private hospitals, such as those run by the Smith Mitchell group, which do not work on a fee-for-service basis. They are paid fixed amounts by the government for patients that can't afford private care. Unlike the incentive in the fee-for- service which is to increase costs, in this service the incentive is to decrease costs as any expenses over and above the fixed rate paid by the government, must come out of the private company's profits. This discourages unnecessary costly investigations but it can also lead to a decrease in the quality of care.

In the USA, where elements of this system are found, widespread litigation acts as a safeguard against this. In South Africa, however, litigation is not common and other controls would be required.

4 Privatising the source of income

The fourth type of privatisation is to maintain hospitals in the public sector but to privatise the source of income. This is already being implemented to an extent. It involves the public hospitals charging private rates to those patients who can afford it. The intention is to encourage those who can afford the private rates to go to private hospitals.

Problems associated with this type of privatisation are that at present these patients are the most articulate and their absence may reduce the political pressure on the government for improvements within the public hospitals. Health care could deteriorate as a result.

Another problem is that if more people left for the private hospitals, the private sector would grow and possibly create a two tier and probably unequal health service. Given that for the forseeable future there will not be enough doctors, nurses and other health workers, the growth of the private sector may undermine the public sector. This, as we have discussed before, is part of the cause of the crisis in the public hospitals already.

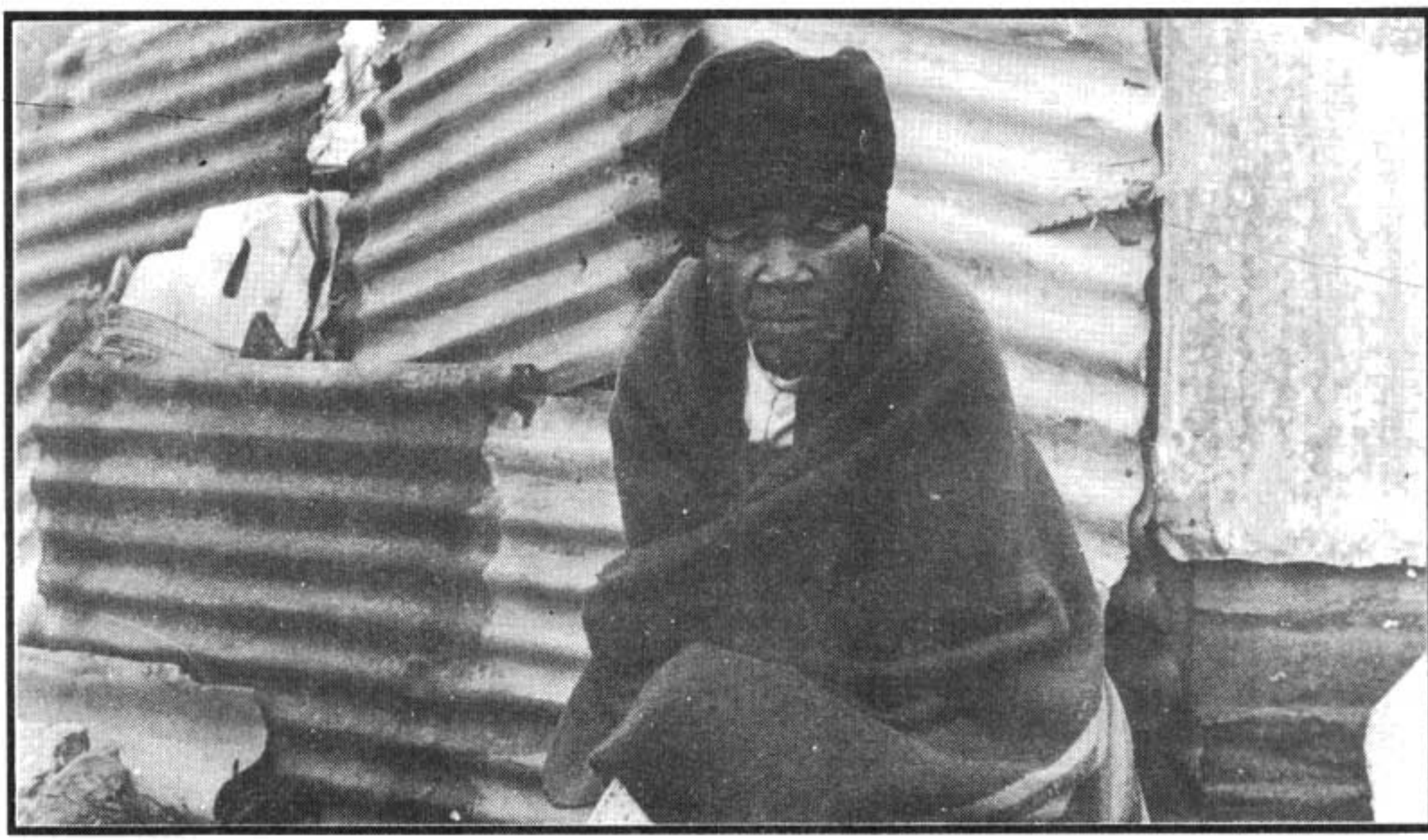
However, this form of privatisation, ie drawing on private sources of finance, does offer a mechanism to increase the total money being spent nationally on health care. A future socialist government may well have to consider a system of a unitary, government run national health service with those who can afford to, being charged private fees. These people would subsidise the health care of the poor. This would only work if the government is committed to providing good health care to the poor. If not, the extra money may well be channelled into defence or into the maintenance of regional, racial and class inequalities. A single unitary health service owned by the government (ie a national health service) but allowing for private sources of financing would not produce an unequal service for rich and poor and would eliminate the problem of competition between sectors of doctors and nurses. This system may well serve as a form of redistribution of wealth. These ideas are not definitive but are presented for debate.

The crisis and the struggle for change

The following article has been written by the Health Workers Organisation and outlines the current situation in the South African health care system. The organisation then presents broad guidelines for a future health system as well as the role that health and health workers can play in the struggle against apartheid and in the transformation of South African society.

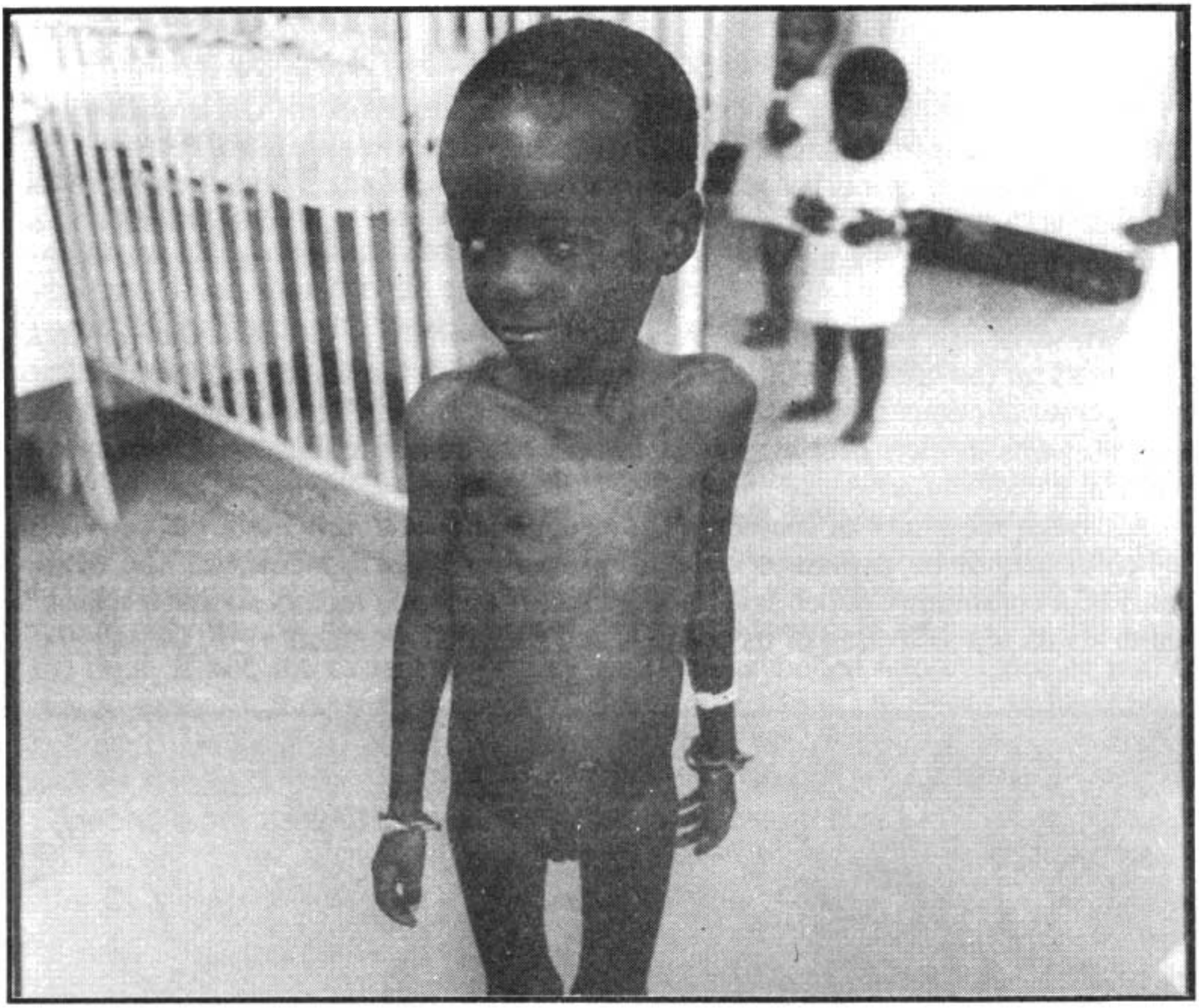
To analyse health one has to look at how and where it fits into the political framework of the country. Conflict and struggle within the health structure are part of the contradictions that exist within the larger society. People experience these contradictions in their everyday life - in educational institutions, work places and townships.

Although the study of medicine has become a specialised field, the causes of ill-health cannot be explained only in terms of scientific medicine. The health status of a community depends on political and economic factors so that a nation's health status is a reflection of its political and social environment.



A nations' health status is a reflection of its political and social environment

Therefore, the health status of a nation will only change when there are changes in its political and social policies. Food, housing, employment and other similar non-medical factors play a decisive role in determining the health status of a nation. Most diseases such as TB, will decrease only when malnutrition and inadequate housing are overcome.



Malnutrition: Diseases of poverty cannot be cured by scientific medicine alone

Health in South Africa

Health services exist to provide health care to those who need it. In South Africa, the nature of the state has left its mark on the health services. Health services and facilities in South Africa have been planned, implemented and operated along racial and class lines.

One example of this is the health care provided by individual firms to their workers. In many cases, the concern is to provide a rapid cure for the worker so

that s/he may return to the production line as soon as possible. In most occupational health services, the health status of the rest of the family, ie the wives and the children, is important only in so far as they are productive in the capitalist sector. The unemployed members of a family who are financially non-productive are largely ignored. So too are the pensioners and the grantees who have outlived their productive years.

The migrant labour and homeland systems in many cases place workers' dependents out of sight of the employer, and indeed out of sight of the urban planners and administrators. The responsibility for providing health care is often shifted to the 'homeland' governments, with the result that there is a huge backlog in both urban and rural health care services. The bulk of disease and ill-health in South Africa is found among the black population; rheumatic heart disease, for example, has been shown to have the highest incidence amongst school children in Soweto than anywhere else in the world (Maclaren et.al.1975). Disease and illness do not strike at random in South Africa but occur along very definite channels of class and colour.

In occupational health services, the emphasis is often on minimising loss of production time, rather than on the provision of comprehensive health care

Problems with the health care system

The present health care system in South Africa can be characterised as follows:
- The bulk of medical resources are devoted to a health service which is curative rather than preventative.
- The health service is organised primarily to serve the needs of whites and the urban population, yet the highest incidence of disease is amongst the rural black.
- The severe maldistribution of medical personnel is a reflection of the maldistribution of resources within South African society. Most doctors are found within the urban areas where only a small percent of the population lives.
- The health service is characterised by weakly developed ancillary services eg, dental and primary health care. According to a recent survey, the majority of practising pharmacists did not know about the concept of primary health care (unpublished data. R. Moodley et al).
- The health service is controlled by whites and is fragmented along racial lines.

The present crisis in health

The establishment of fourteen different departments of health has contributed to the inadequacies and crisis in the present health system.

The increasing fiscal crisis has manifested itself in all spheres of the SA economy. Some of the ways in which the crisis has manifested itself in the medical sector include:

1 Staff shortages

Shortage of staff is rapidly becoming an acute crisis. A number of posts within hospitals have been 'frozen'. This means that should an existing employee leave work, the post cannot be advertised without the prior consent of the administrator. Secondly, the total number of posts available have been reduced. For example at King Edward VIII Hospital, the total number of intern posts was decreased from 60 to 52, for 1988.

It is interesting to note that Groote Schuur which handles a smaller workload than King Edward VIII, but which caters for white patients as well as black patients, has 90 intern posts.

The wages paid to state employees are so poor that a number of employees are turning towards the private sector.

2 Cutback on patient care

In the name of rationalisation and economy, the quality of patient care has been compromised. This is aggravated by a shortage of staff, facilities and drugs.

3 Cutback on medicines

The number of medicines available within the provincial hospitals have been drastically cutback by almost 1000. The manner in which this was done is totally unacceptable to the staff and the particular communities; they were not consulted on this measure.

4 Increase in hospital tariffs

Recently, the NPA (Natal Provincial Administration) and subsequently Kwa Zulu, have increased hospital tariffs putting health care - especially referrals, regular checkups and preventive treatment, as well as weekend consultations out of reach of many people.

5 Increasing incidence of diseases and epidemics

This is exemplified by the recent outbreak in the Natal - Kwa Zulu area of Polio; a disease associated with poverty. Closing down of peripheral clinics: Instead of increasing the availability of medical care, the state has closed a number of the peripheral clinics.

Fawu clinic, Paarl: health workers need to organise with unions and community organisations

All these manifestations of the health crisis must be seen against the state's policy of abandoning its responsibility of providing adequate health care in favour of privatisation. Staff shortages, cutbacks in medicines and the increase in hospital tariffs have the effect of making the state health service as unattractive as possible thus forcing the community towards the private sector. The private sector, whose main aim is profit, is however, unaffordable to the vast majority of our community.

The state's attempt at providing medical care to a limited number of people, will never improve the health status of a community. For medicine to be effective, one has to address socio - economic as well as medical factors which underlie diseases. In order to promote a society with a social structure conducive to good health, health workers must become more politically involved and articulate and should direct their efforts and collective influence to changing the existing social order. Health workers need to work with existing organisations to put health onto the agenda of community organisations.

The role of health in the present struggle

The role of health in the present struggle can be divided into two broad areas:

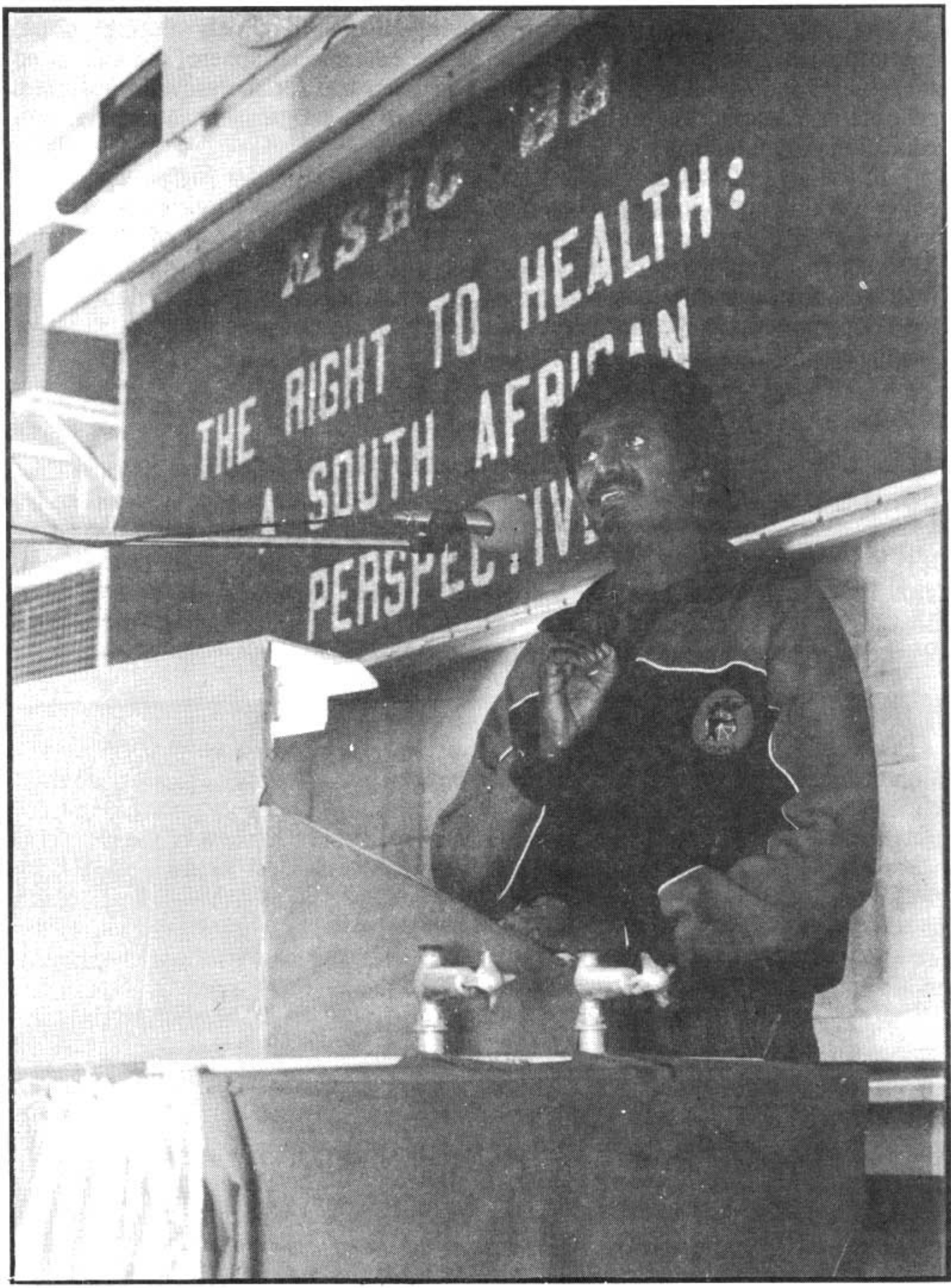
1 The role of health in the struggle against apartheid

Until recently, health has tended to be neglected as a focus of struggle both within trade unions and community organisations. Recently however, attention is being focussed on health as a means to mobilise, conscientise and organise. Community organisations are taking up issues such as overcrowding, long queues and delays at hospitals, rehabilitation of detainees, emergency treatment of unrest victims, training of activists in emergency health care, community programmes such as child health screening, primary health care projects such as St Wendolin, run jointly by the HWO and the St Wendolin community.

Even at the workplace, major unions such as the National Union of Mineworkers, have begun to seriously focus on the health and safety of workers. Alienation from work, status inconsistencies and relative deprivation economically of whole groupings of health workers are leading to an inevitable trend of unionisation, conflict and strikes. The tranquility of the health industry in South Africa has been broken and the effectiveness of health struggles as a means of mobilising the community is being highlighted.

2 The role of health in the transformation of society

In the struggle for change, we need to go beyond removing apartheid. The struggle is not only to transform the economy, but also to transform other social relations in our society.



Cosatu general secretary Jay Naidoo delivers the opening address at the 1988 Medical School Health Congress in Natal

The question of transformation is being discussed widely among people committed to change in South Africa. In the educational sphere, the call is no longer for the mere scrapping of Bantu education and for the provision of more schools and books, but rather, for an alternative, progressive, more relevant education programme.

In the area of labour - while trade unions are fighting for higher wages and better working conditions - the organisational practices and the style of democratic worker control, are laying the foundations for worker control of these very factories. Similarly health workers, together with organisations of working people in the factories and in the communities, must begin to develop democratic worker/community controlled practices in the provision of preventive and curative health care.

The future health care system - some important considerations

It is impossible at this stage to outline all the features of a new health care system. This is an ongoing debate, the important features of which will emerge with ongoing discussion. Some of the concepts which are important to the Health Workers Organisation are highlighted below.

1 A new health concept

Health cannot be viewed in isolation from the social, political and economic context within which it exists. Health care should not be a commodity, available only to an affluent minority, but rather must be placed in the hands of the people to serve the people. The monopoly of knowledge on health must be taken away from the professionals and experts and must be disseminated amongst the people. Health must be demystified. Health workers must work under the control of, and in the interests of the people and not for their own status and wealth. Mass community participation and understanding of health issues must be encouraged.

2 Health worker concept

A health worker would include any person formally employed in the health sector (doctors, nurses, laboratory technicians, radiographers, physiotherapists, cleaners etc.) or any person from the community committed to working for better health.

All health workers should be equal, irrespective of race, colour, class and sex. At present, the better paid health workers occupy the administrative positions where they in turn suppress the aspirations of ordinary health workers. This stratification denies ordinary health workers a voice in the administration of health. The strong hierarchy in health must be overcome and all barriers broken down.

3 Preventive rather than curative medicine

Although the importance of curative care is recognised, emphasis must be on preventative medicine.

4 Attitudes and education

Health workers need to shed their professional arrogance. They must be prepared to learn from and teach the people in the community. Health education should not be left to the professionals. These ideas should be incorporated into the health workers' training.

5 Accountability and control

Health workers and community organisations and their projects and programmes, must be firmly placed in the communities in which they work. These communities must be part of the informed democratic decision making process.

Health workers must be accountable to those whom they serve and not only to those in authority and power. Democratic, alternative structures must be created and strengthened to fight for and defend the interests of the poorer communities, both at present and in the future.

Mobile clinic, Daggakraal: Health workers must be accountable to their communities

6 A people-centered health system

Community health workers, together with parents, school children, workers, educators and others, should play the leading role in health care. Medical professionals should become mere auxiliaries. The largest and most important unit of health workers are the community health workers. More time and money must be spent on training them, rather than doctors. We must ensure that they are selected by and are representatives of the poorer, more oppressed members of the community. They must be accountable to their community.

7 Primary health care

Primary health care must be the main function of the health service. This would ensure better accessibility of care. More financial and material resources must be distributed to the PHC clinics. Hospitals will be needed as referral centres and support systems.

8 Distribution of resources

Health care services need to be co-ordinated by one health department, but the services must be decentralised and made easily accessible to all people. There should be an equal distribution of resources, based on the needs of the various communities, irrespective of race, colour, class, creed or sex. A reallocation of human and material resources to rural areas is necessary to overcome the urban emphasis and rural neglect under the present system.

9 Medical education

Selection criteria of students need to be reviewed. Future health workers must be selected by their community and should return to serve the same community that chose them. Students need to be trained in new values as opposed to the profit-oriented, status seeking, individualistic, purely academic, high-tech orientation of the present system. Health education and research needs to be much more relevant to the problems, illnesses and needs of the majority of people.

Conclusion

The struggle for a free society needs to be reinforced by interlocking the various struggles such as housing, sporting, education etc. What needs to be emphasised are adequate living wages, more educational and employment opportunities and more effective participation by the community in decision making processes.

An assault on our people - the increase in hospital tariffs

This article is the programme of a campaign launched jointly by the Health Worker Organisation in Natal, and other progressive organisations, to protest the tariff increases in the Natal Provincial and Kwa Zulu hospitals.

The crisis in the health sector

The ever deepening political, economic and fiscal crisis of the South African state is well established. However, what is of grave concern to us is the serious effects of this crisis in the state health sector.

The state health services have left much to be desired for a long period of time, but the continual deterioration in the quality of service has, of late, reached tragic proportions.

Working class people have been badly affected by the tariff increases

The hardest hit victims of this crisis are the black, disenfranchised, poorer, working class communities. With the increasing unemployment and inflation, they are finding it more and more difficult to survive and the health services have little if anything to offer them.

Pensioners receiving treatment after hours will have to pay R22,50

Manifestations of the crisis

The deteriorating state health services has manifested itself in many areas, some of the more obvious being staff shortages, cutbacks on drugs, cutbacks on patient care and increases in hospital tariffs.

The recent increase in hospital fees at Kwa Zulu and Natal Provincial hospitals will have a drastic effect on the community they are serving.

Facts about the tariffs

All patients will have to be reassessed in terms of how much they earn and how many 'assets' they have. It will be the patient's responsibility to prove that s/he does not have money to pay for health care. If, for example, an unemployed patient does not have a blue card, s/he is then debited for the maximum fee of R22,50.

There is no free treatment any more - even pensioners, grantees and the unemployed have to pay at least R2 each.

Those who do not or cannot fill in the assessment form, will be charged a maximum fee of R22,50.

Patients receiving treatment after hours (ie after 4 pm), on weekends or during holidays, are charged R22,50 even if they are pensioners, grantees, unemployed or earn very little. This is in spite of the fact that many patients are forced to come to the hospital at these times through the very real fear of dismissal, should they miss a days work.

Hospital staff who previously received free treatment, will now have to pay in cash.

Organising around the tariff issue - the first steps

These drastic measures have caused widespread concern amongst communities. A workshop, convened by the Health Workers Organisation (HWO) in May to discuss the issue, was attended by many organisations.

Representatives of health worker organisations, various community, youth and women's organisations, welfare and political organisations resolved to protest these increases.

A programme of action was drawn up in the workshop. It identifies four phases of the campaign to protest the tariff increases:

Phase one - groundwork: meeting with organisations
Phase two - fieldwork
Phase three - mass action
Phase four - confronting the authorities

Groundwork

An interim committee was formed. It consists of delegated representatives of various organisations. The committee is mandated to facilitate co-ordination of the 'Hospital Tariffs Campaign' spearheaded by the Health Workers Organisation in Natal.

Ever since the committee was established, various organisations, communities and mass meetings have been addressed by HWO on this issue. Attempts have been made to link up with community structures, to undertake house visits, to distribute pamphlets on a mass scale and to circulate the petition that was drawn up.

Since then, many more organisations have joined the protest. To date, about 200 thousand pamphlets have been distributed and approximately 7 000 petitions are in circulation throughout Natal.

At the last community consultative meeting held on 15 June 1988, it was resolved that the 'groundwork' phase of the campaign, ie house visiting, collection of signatures and pamphlet distribution, should draw to a close by the end of July 1988.

What has the campaign achieved thus far?

Through the campaign communities were informed of the crisis in health. The campaign has highlighted the mismanagement of public funds by the government, NPA and Kwa Zulu authorities.

It has exposed the effect of fragmentation and privatisation. Resistance to fragmentation and privatisation of health services has been building up at grassroots level. The launching and carrying out of the campaign has brought together a broad range of organisations, including trade unions, civic associations, youth, women's, sporting, health and welfare organisations in the struggle around a health issue. The campaign has shown community organisations that there are health care issues that they can mobilise around. In this way health has been put on the agenda of community organisations. The campaign has popularised the slogan 'Health is our Right' and it has challenged the authorities.

What more can the campaign achieve?

It can force the authorities to reverse some of its decisions.

It can show progressive organisations that health is no less important than rent, housing or education issues and can show community organisations that they have the most important role to play in achieving health for all.

The campaign can build a stronger link between health workers and the community and it can consolidate the resistance to fragmentation and privatisation at a grassroots level. It can show that central and local government is incapable of providing adequate, appropriate, equal and accessible health care.

Where to from here?

Because of the nature of the campaign, it cannot be dragged on for too long a time. Eventually, the gains made in the campaign must be carried through to a situation where health workers identify themselves as part of the community and take up health issues at grassroots level; where community organisations create health portfolios in their structures. This should contribute to the formation of Community Health Committees. Demands should be crystallised in a Health Charter, thereby advancing the National Democratic Struggle.

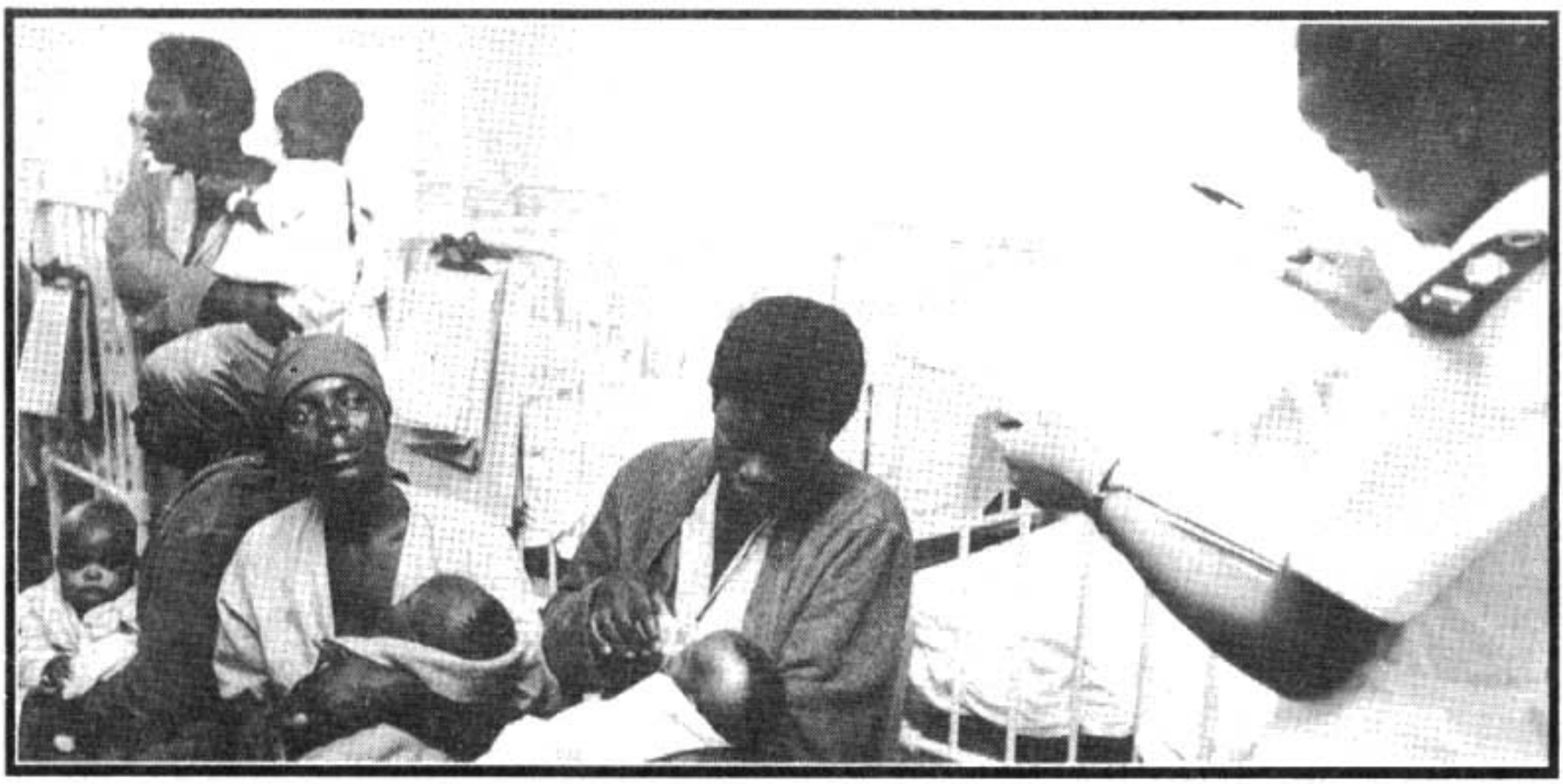
Health Worker Organisation
Natal

Interview with nurses from Baragwanath Hospital

Q: The problems occurring at Baragwanath have received extensive coverage in the local press. Can you comment on the problems?

A: Well, I think we all agree that Bara has a lot of problems. The main problem is overcrowding. A few years ago, we used to be able to predict which days would be quiet ones. We knew that at the beginning of the month, when people still have their pay in their pockets, we would be busy. Also Friday night would be busy as the start of the weekend. Now we can't predict; every day seems as busy as the one before.

We have been told to screen patients before they see the doctors. If they are not complicated problems, they should be told to go to the clinics in the location. But we find even if we do this, the patients are still many.



Nurses are expected to perform many tasks and often work under extreme pressure

A problem is always money. Sometimes people have a letter from a private doctor telling them to go to the hospital urgently but you find it is now two weeks later and their problem has got so bad that they need admission. We ask them why they didn't come at a stage when they could have been treated as an outpatient. They always say its because they did not have enough money then. People are always struggling for money.

Patients often miss their transport home after waiting in long hospital queues

At the casualty section there are usually many sick people waiting to be seen. Sometimes people wait many hours before they are treated by the doctor. The nurses try their level best to make sure that the urgent patients are seen first. Then you find that others who are not urgent but are still in pain, complain bitterly. They ask if they must be dying before they are seen. Sometimes patients come early and are only seen much later. Then the doctor shouts at them for coming with a non-urgent problem so late. The doctors don't always understand that we wait a long time. Moreover, the patients have transport problems. They can wait hours in the queue and then miss their transport home.

Q: How does the overcrowding affect your work?

A: You find that we cannot give 100% nursing care because there are too many patients. Bed-letters and X-rays go missing. Well, it is difficult. There are often over 100 patients in a ward in which there are only 40 beds. The patients are everywhere! You can find very ill patients sleeping on the floor. During the day, those that can walk go outside for the space. Then when we come around to give them their medication, we can't find them.

We know that medication has to be given at specific time intervals but sometimes we are very busy and patients get their medication late.

Other duties have to be performed regularly such as the checking of vital signs, urine outputs, blood and urine observations on diabetic patients, and so on. Of course we have to do these things in spite of the number of patients, but it is difficult.

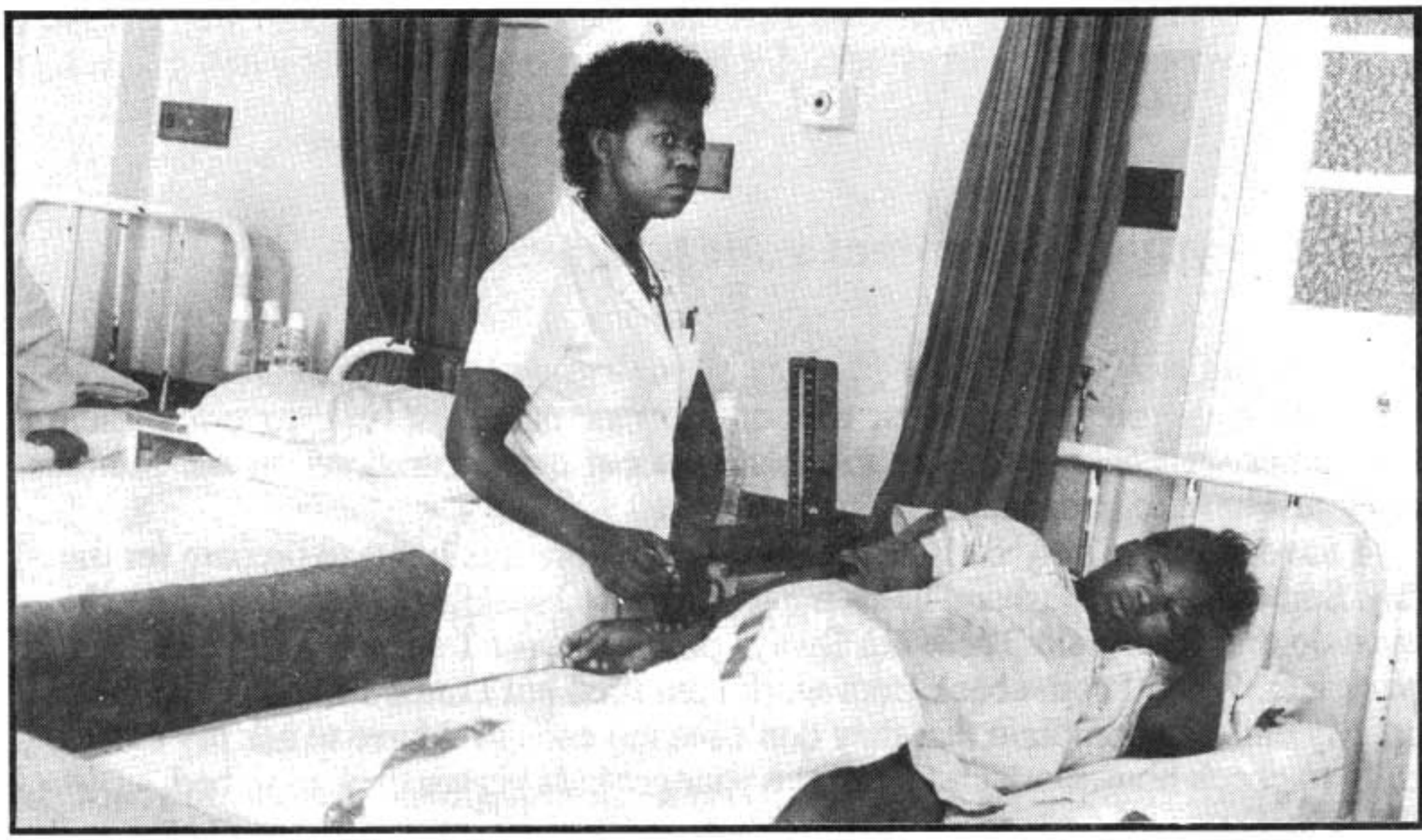
We are a teaching hospital and so we must also make time for the tuition of nurses.

One other big problem for us is the psychiatric patients. They must be given their own wards. You know some are dangerous and have actually assaulted other patients and even doctors and nurses. They also wander all over the hospital and when we need to give them their medication, they are nowhere to be found. This is a very bad situation for us.

Q: Is anything being done to alleviate or correct these problems?

A: These problems have been around for many years and they are only getting worse. Well, you can't stop people getting sick and needing the hospital but if we were more, it would help us cope.

We are told that nursing posts have been frozen, meantime we are very short-staffed as it is. You will find about 9 nurses during the day looking after 100 patients. We must change dressings, give medication, do regular observations and bed-pan parades for all these patients and we are too few.



At night there are fewer nurses on duty to do the same work as the day staff

The paraplegic patients are suffering too. They must be turned regularly, say every 2 hours, but they complain that they have not been turned the whole morning. This is a big problem, especially at night.

At night we really feel the staff shortage because there are usually only four of us on duty to do the same work as the day staff. There is a relief team to help us at night but we are still not enough. The number of patients has increased but the staff has remained the same. We are all feeling the strain.

Q: Do you find that the strain affects the way you relate to your patients and colleagues?

A: Well of course we try to maintain a good relationship with everyone but you must remember that everyone is coming to us with their complaints. Sometimes we get complaints from the patients, their relatives and the doctors all at once. To be honest, sometimes we find ourselves shouting at sick patients and also at other nurses because we are working under stressful conditions. At times we can't help ourselves. Some doctors don't understand the pressure on us. They can also shout if things are not done on time or if patients can't be found. But often it is not our fault.

There are not enough doctors and they are also working under a lot of stress. Part of our job during intakes is to translate for the doctors into the vernacular. Then we must measure the urine, take the temperature and do a blood sugar measurement. When we are under-staffed it is difficult to do this quickly and the patients are the ones who suffer, because they just have to wait until we are ready. It is true, we can get very irritable and it is hard to control tempers when you are so tired.

Q: Does your work affect your families at all?

A: Well, we are nurses to our families as well so when we leave the hospital our other nursing job begins! Just as our job can make us rude to our patients, sometimes we come home irritable and take out our frustrations on our families. They just have to understand us.

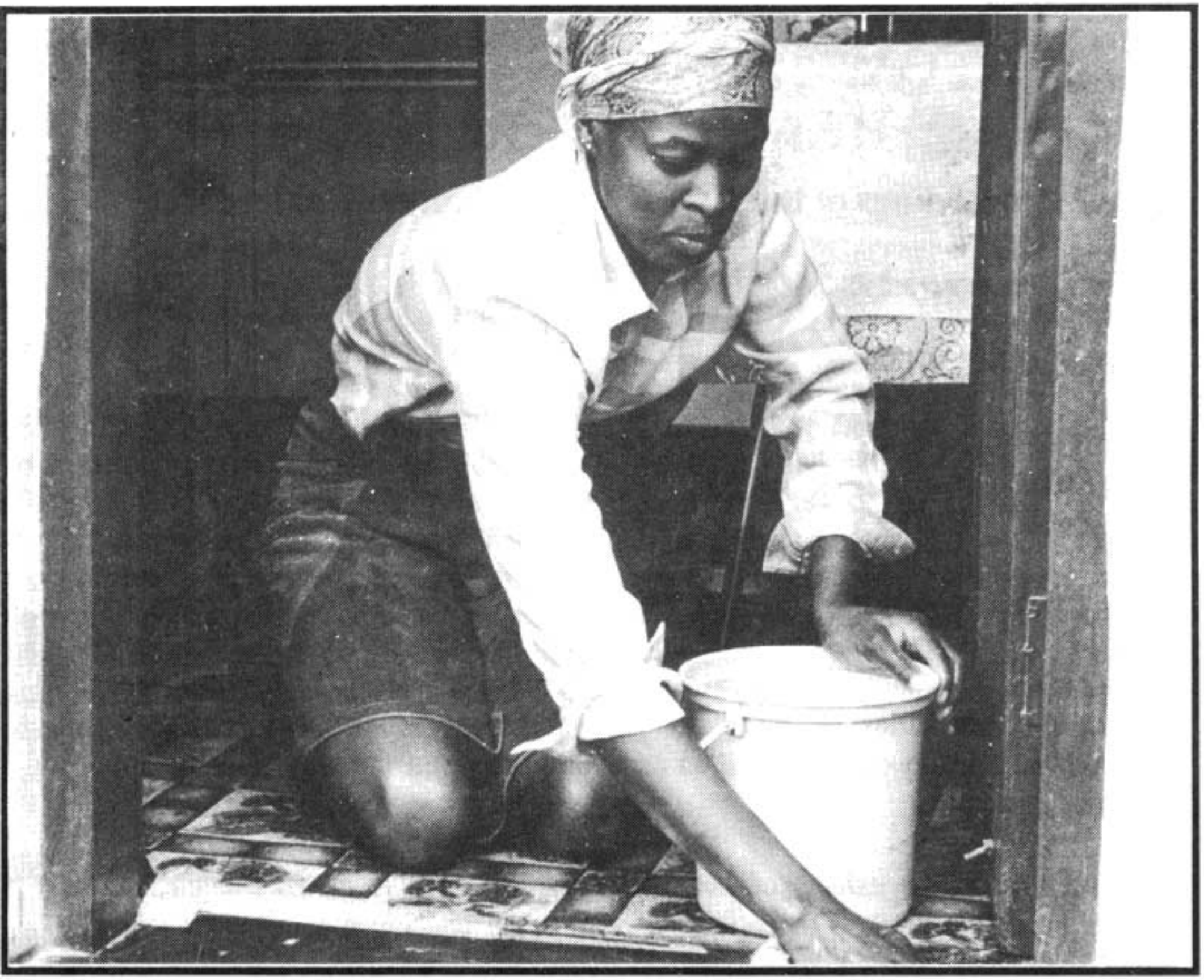
I have to get up very early in the morning (before it is light) to prepare for the day. Sometimes my husband helps me to make the breakfast but at other times I must do this all myself. There are always problems with transport and I often get to work late. When I come back from work I am tired but I must still cook and clean up. My children complain that they don't see me enough. I have to ask my older child to check homework and clean the younger kids before they go to bed.

A: I also have problems with transport and I must also drop my baby at the childminder before I set off to the hospital. This means I have to leave my home at

5.30 am to get to work at 7 am. I must still prepare my other children and my husband before this. When I knock off, it's the same problem.

A: Single parents have a lot of problems. My child gets the same transport as I do in the mornings. She must wait an hour outside the school before it opens.

A: We are all complaining about our pay. It seems that even if we get an increase, our money remains the same after deductions. It is not easy to support a family on our pay.



Nurses, like most women, work a double shift: at work and at home

Q: Are nurses discussing ways to deal with these problems?

A: Many nurses are looking for jobs in private hospitals and clinics. They say that they are paid better and there is no overcrowding. The private hospitals don't help with housing subsidies so some nurses are staying for this reason only.

A: Many nurses are joining HWA (Health Workers Association). They feel if they complain individually, they will be victimised but if they are many, they have greater protection.

Of course, many nurses were involved in the strikes at Bara and some things did change as a result. This has encouraged more nurses to join organisations because they see that this can help.

The internship year in South Africa

Interns and nurses are responsible for most of the patient care at provincial hospitals and as such, are most affected by the poor working conditions at these hospitals. The following article gives the results of a study of various aspects of the internship, including education, workload and stress, at five teaching hospitals in Johannesburg.

The internship

After six years of university study, the medical student must complete one compulsory year of practical training at a registered state hospital. Full registration as a medical practitioner with the South African Medical and Dental Council (SAMDC) is only possible when the hospital superintendent certifies that the student has satisfactorily completed one year at such a hospital. The main aim of the internship is to complete the practical part of an academic training so that the doctor can acquire sufficient medical knowledge and skills necessary for responsible, independent general medical practice. There are many problems associated with this kind of training. The aim of this study was to identify and assess the extent of some of these problems.

Education

Intern education and training is controlled by each hospital independently. There is no formal university participation. Although the SAMDC provides guidelines for the internship, such as the maximum number of patients each intern should be responsible for, these are inadequately adhered to. Academic teaching in the form of lectures, tutorials and seminars are scheduled in each of the Johannesburg teaching hospitals, but these are not sufficiently co-ordinated and are infrequent. The majority of interns felt that academic input during their internship was inadequate.

A significant proportion of the interns did not read around the medical problems which their patients presented. The reason they gave was that they did not have enough time. There is little time for self education programmes involving reading, use of the library, continuing education and postgraduate courses. The

most common form of learning appeared to be 'osmotic learning', where the intern learns by observing, participating in and performing repetitive tasks. This type of learning occurs essentially in isolation and seems to carry a high risk of error, especially when there is no feedback from senior staff.

Interns often work an 80 hour week and have little time for interests outside the hospital

Although a great deal of the intern's work appears to be uninspiring and repetitive, and even though many personal and social sacrifices are made, the study showed that interns generally seemed to appreciate the educational value of the internship year. Our study shows that most of the interns enjoyed their training year.

The year could, however, be made easier if registrars and consultants consistently provided feedback, insights and explanations to the inexperienced intern. The experience could be improved if definite objectives could be clearly defined for every clinical discipline, at each teaching hospital.

Workload

The average working week for the interns studied exceeds 80 hours. The maximum patient load of the interns studied at each hospital was 2 - 3 times the load that interns felt would be best for them to cope with. Many interns said that they could not give enough care to their patients because they had too many patients to look after and were completely overworked.

Negative effects and management errors in patient care by tired, overworked interns have been reported.

This combination of excessive numbers of patients and long working hours leave the intern with little free time and energy for study or for interests and activities outside of the hospital. A significant number of the interns studied had given up sports and hobbies, and many had expressed problems in their marriages and in relationships with other people.

Interns involving themselves in medicine only, are likely to become doctors who are culturally and socially deprived and immature. This problem of social isolation occurs long before the intern year; it begins at Medical School, where the students undergo long demanding training during which time many personal sacrifices are made. This problem worsens during the internship year and as a result, interns find it difficult to establish and maintain communication skills and relationships.

Stress and sleep deprivation

Our research confirms that the stresses experienced by interns in South Africa are the same as those experienced by interns worldwide. Sleep deprivation, time pressures and fatigue are the major stresses of intern training. Lack of sleep results in the intern being unable to function at their normal level. It has been shown that arithmetic ability, memory, performance of perceptual-motor tasks and many other tests of cognitive ability deteriorate with lack of sleep.

Sleep deprived people tend to take much longer to pick up information, to make decisions and to respond in appropriate ways. Depression, irritability, rage, listlessness, depersonalisation and destructive antisocial behaviour are common in sleep deprived interns. Such behavioural, cognitive and emotional deterioration may effect the intern badly.

What is also of great concern, are the damages that a tired and impaired doctor may inflict on the patient. Management errors by overworked, tired interns have been reported. In New York for instance, a grand jury found that the long working hours of interns contributed to the death of a young girl (the Libby Zion Case).

It may be expected that newly graduated doctors will find their internship stressful. A moderate degree of stress may even help learning and promote awareness of the critical nature of the work. Excessive stress however, brings about negative effects resulting in loss of confidence, impaired self image, damaged relationships, inefficiency, negative attitudes and withdrawal.

Our study revealed that the majority of interns found the stresses to be unbearable. The most common effects of stress reported were chronic fatigue, weight loss, inability to sleep, loss of interests outside of the hospital, abdominal pain and crying.

Dissatisfaction and disillusionment

Many interns complained of disillusionment and dissatisfaction with medicine during their training year. A high percentage said they had lost interest in medicine during their internship. This negative attitude could be attributed to the unrealistic work schedules, little guidance and supervision from experienced senior staff and excessive stresses and demands imposed on the interns.

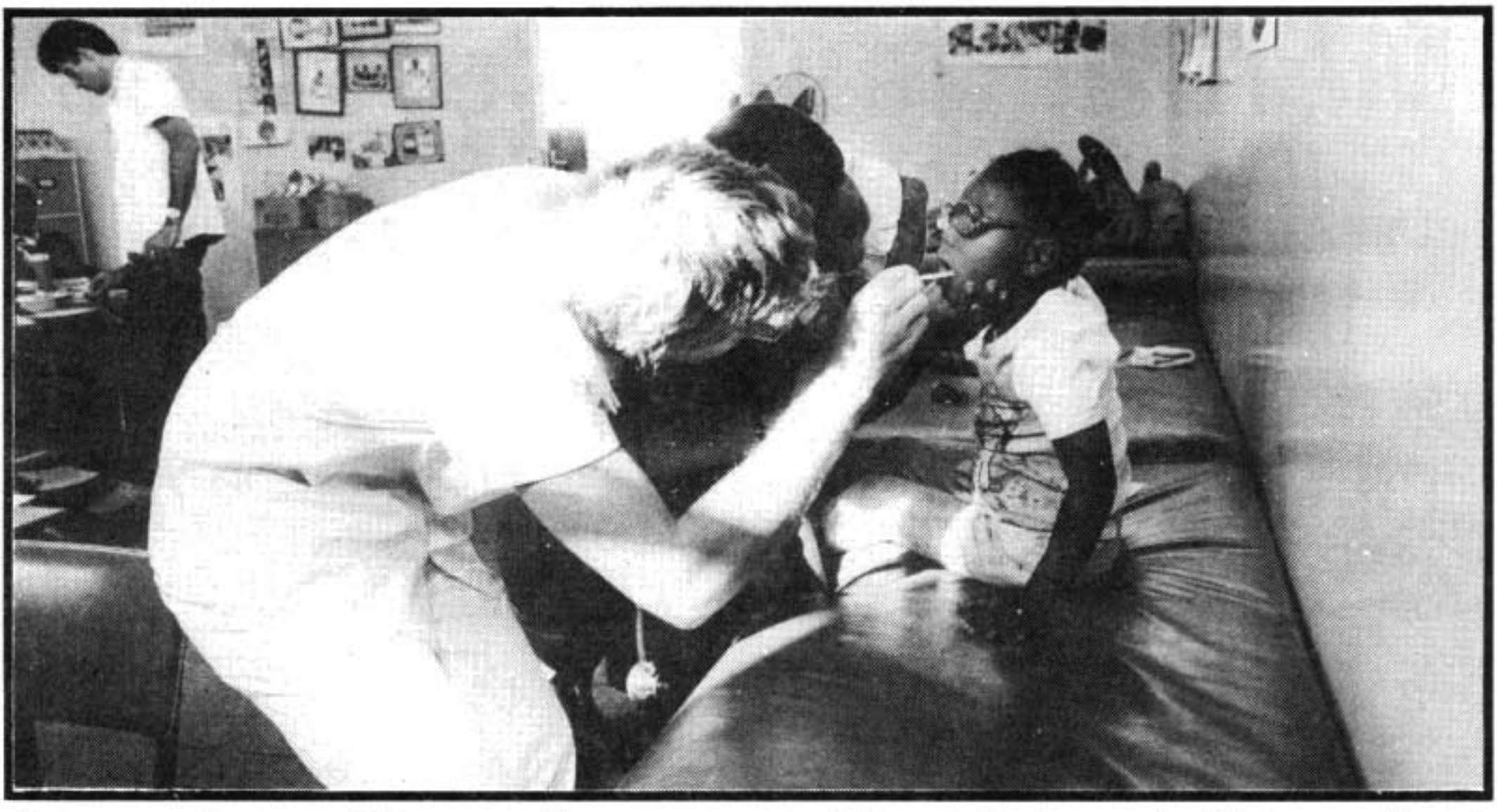
These feelings may unfortunately affect doctors' attitudes towards future careers.

Possible alternatives

Accepting that the internship year is likely to remain excessively stressful for most people in the forseeable future, we proposed the establishment of a 'support system' to help interns deal with their problems. The proposal was supported by over 75% of interns.

Other possible ways of improving the internship include early recognition of the problems, improved working conditions, formal and informal support programmes. Our study revealed a general discontent and unhappiness of the intern.

By defining and dealing with the problem areas of the internship, the year could become a more pleasant experience and patient care could be improved.



Better working conditions would ensure greater job satisfaction and a higher quality of patient care

References

1 Brink A J, Slabbert B R, Barnes J M, *The internship year in the RSA - a need for change*. SAMJ 1986; 70: 679-683.

2 Lavinsky N G, *The impact of long working hours on resident physicians*. N Eng J Med 1988; 318(12):775-782.

3 Mccue J D, *The distress of internship*. N Eng J Med 1985: 312(7): 449-452.

4 Touyz R M, Kelly A, Tollman S, Milne F J, *An assessment of the internship at the teaching hospitals of the University of the Witwatersrand*. SAMJ. In press.

5 Wilkinson R T, *After effects of sleep deprivation*. J Exp Psychol. 1963; 66: 439-442

By R M Touyz, A Kelly, S Tollman, F J Milne
Department of Medicine, University of the Witwatersrand Medical School

The complete results of this study will be published in a forthcoming issue of the SAMJ

Mental health services under apartheid

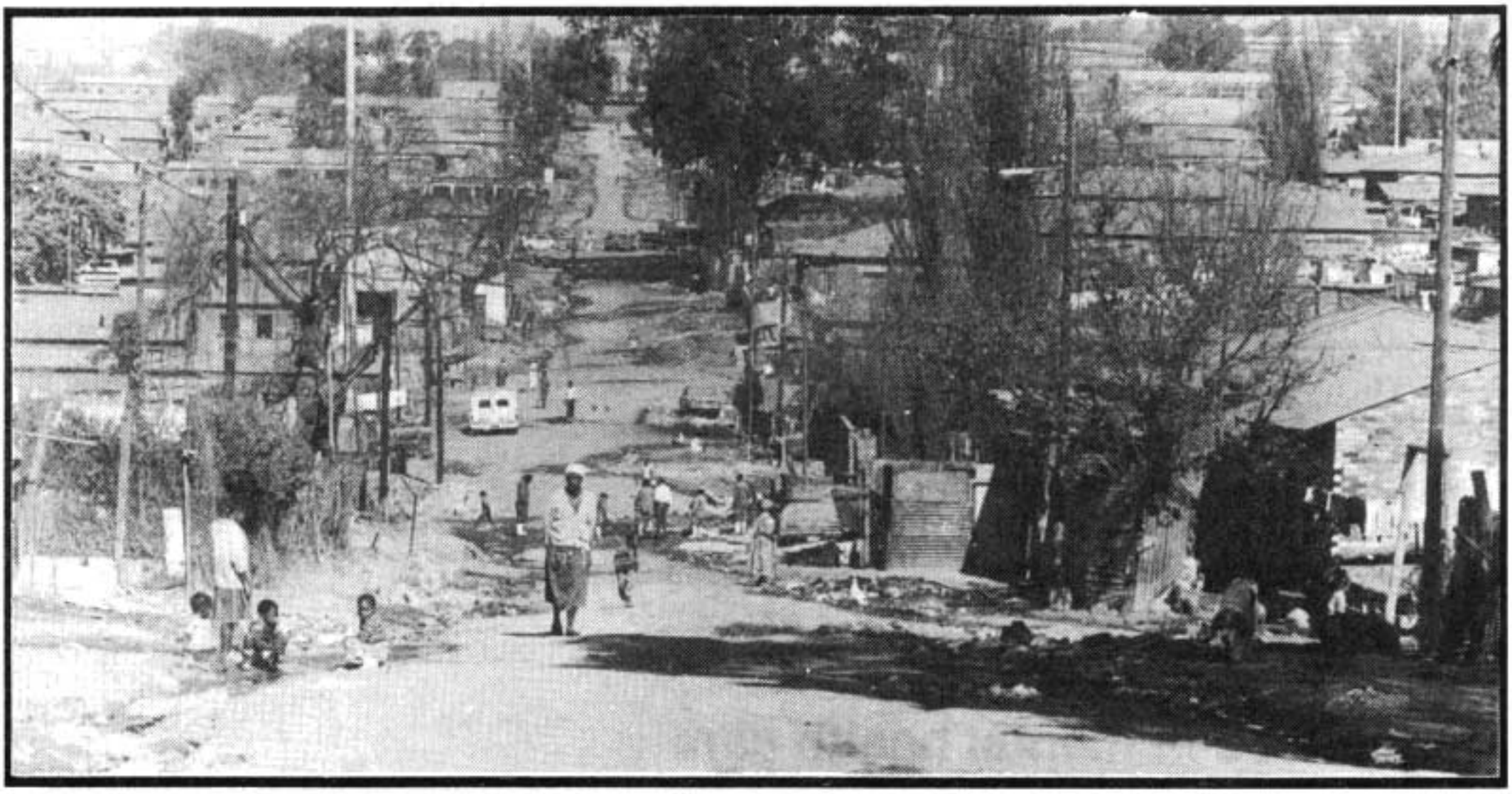
This article was written by a psychiatrist and looks at available mental health services for black and white communities. The services are grossly unequal. The article raises questions that need to be addressed to bring about change.

Discrimination In Mental Health Facilities

Mental health is not and never has been a priority in health services. Like other services under apartheid, the mental health services are provided along racial lines with a similar degree of inequality and discrimination.

In the Johannesburg area this shows itself in particular ways. In the whole of Soweto, with a population of over 2 million people, there is not a single psychiatric inpatient bed. One of the many inadequacies of Baragwanath Hospital is the fact that it has no psychiatric ward, despite a daily average of 100 psychiatric in patients. A ward is in the process of being built but will only accommodate 24 of these patients.

Health services, like most other services , have been divided along racial lines



Alexandra township: One psychiatric ward at Hillbrow Hospital serves the entire population of this township and surrounding areas

Psychotic patients admitted to Baragwanath (and other black hospitals on the Rand) will be treated in general or medical wards initially. If they do not recover soon, they stand a strong chance of being signed into one of two state psychiatric institutions in the region.

Hillbrow Hospital has a 24 - bedded psychiatric inpatient unit. This serves the black population of central and white suburban Johannesburg and Alexandra township, but Sowetans are admitted as well. This situation is in sharp contrast to the facilities for white psychiatric inpatients at the Johannesburg Hospital and the J G Strydom Hospital. These two hospitals together have over 50 beds for acute admissions.

There is no equivalent facility for black patients to Tara Hospital. Tara is essentially a whites only, medium term stay hospital which accommodates inpatients with a range of different psychiatric problems.

These include affective disorders and psychotic states, eating disorders, adolescent disorders and neurotic and personality disorders. Tara also has an active outpatient child and family unit.

The T M I hospital in Braamfontein also has a child and family unit for white outpatients. No equivalent facilities exist for the treatment of black children and families with psychiatric difficulties, inpatient adolescent, personality and neurotic disorders.

A child assessment unit for intellectually impaired black children has been developed by a team of dedicated experts which is a first of its kind for black children. It is not a full-time service and does not offer as wide a range of treatment options as are available at white child and family units.

Unequal conditions

Conditions at the white and black sections of Sterkfontein Hospital, a state psychiatric institution, differ strikingly in terms of quality of care, doctor - patient ratios, patient - bed ratios and standards of physical accommodation. All these are weighed in favour of white patients. Capital projects in the recent past have not been able to improve the conditions in the black wards or to narrow the gap between white and black facilities.

Many chronically disabled psychiatric black patients are cared for in licensed institutions such as Randwest Sanatoria near Krugersdorp. Conditions in these settings are not unlike those in the chronic sections of the state institutions. They are all characterised by shortages of facilities and spartan living conditions.

Inequalities in mental health care

Outpatient services in the black community settings (as opposed to hospitals) tend to be similar to services provided in white settings. However, the case load that the staff members have to deal with tends to be greater in black community clinics. Also, the staffing and the varieties of possible treatments, tend to be less in the black community clinics. The result is less thorough and lower quality care.

Outpatient services based at general hospitals tend to be similar for white and black patients but again, they experience the same, if not as acute problems, as those described in the community clinic settings.

Lack of personnel serving the black community

The same disparity in facilities between white and black psychiatric services can be seen in the number and availability of trained mental health workers in the white and black services. There are pitifully few black psychiatrists and psychologists; the bulk of these health workers are white and they serve mainly the white community.

The lack of trained mental health workers and facilities means that there is an insufficient range of psychiatric services - such as counselling, individual and group therapy, play therapy, family and marital therapy - within the black community whereas these facilities are plentiful in the white community.

Whatever few facilities there are for the black community, are offered by a small number of social workers who provide the mere bones of a counselling service; the bulk of their responsibilities are taken up by other social work duties such as grant applications and placement arrangements.

Thus there is a deficit in the range of psychiatric services available to the black community, as well as in the quality of services that do exist.

Whites only elections: The majority of South Africans have no say in the running of essential services

Conditions for change

It is, of course,true to say that these discrepancies, deficiencies and inequalities are a direct product of apartheid structures. The number, range and quality of psychiatric services bears a direct relationship to the amount of political power wielded by the black and white communities respectively. The number of psychiatric inpatient beds at Baragwanath Hospital is the same as the number of Sowetans in Parliament; nil on both counts. The white community, from whom parliamentarians, and other political decision makers are drawn, have the best possible facilities - which are denied those with no access to political power.

Lack of accountability

Another important aspect to be considered is that planners, decision makers, bureaucrats and other administrators responsible for the planning and maintenance of mental health facilities (and indeed all health services) are not accountable to the black communities provided with the services. Instead, they are responsible to their political masters and constituencies which are the all - white Nationalist Party and its allies. This means that any defects, problems and complaints about the services in black communities fall on the ears of people whose allegiances lie elsewhere, and are in fact opposed to those who complain.

This means that the impoverishment of the services is not only a direct result of state policy, but that attempts at improvements are bound to fail as long as the apartheid regime keeps the power to administer health services.

Piecemeal gains may be made by vigorous and sustained pressure but fundamental change and improvements are only possible when political power is exercised by people directly accountable to their communities.

The struggle for health services in Lenasia

This article was written by members of the Hospital Campaign Committee. It outlines the need for health services in their constituency and the campaign launched to assert health and health care as basic rights.

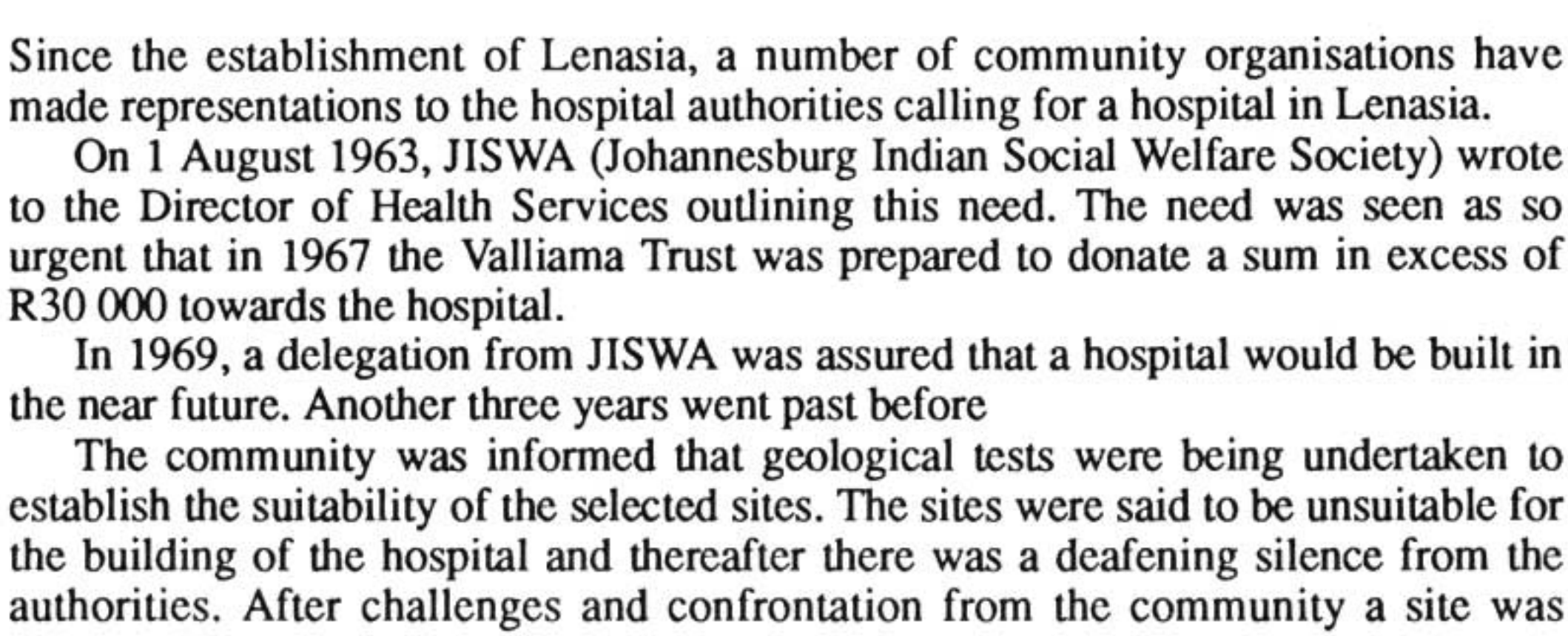
Historical background

Since the establishment of Lenasia, a number of community organisations have made representations to the hospital authorities calling for a hospital in Lenasia.

On 1 August 1963, JISWA (Johannesburg Indian Social Welfare Society) wrote to the Director of Health Services outlining this need. The need was seen as so urgent that in 1967 the Valliama Trust was prepared to donate a sum in excess of R30 000 towards the hospital.

In 1969, a delegation from JISWA was assured that a hospital would be built in the near future. Another three years went past before

The community was informed that geological tests were being undertaken to establish the suitability of the selected sites. The sites were said to be unsuitable for the building of the hospital and thereafter there was a deafening silence from the authorities. After challenges and confrontation from the community a site was finally allocated in June 1976. However, by 1980, no further steps were taken to build the hospital.



The unopened Lenasia Hospital: Parking place but no one to visit

In June 1980, a letter and petition with 13 083 signatures was sent to the Minister of Health, Welfare and Pensions stressing the urgency for health and medical services in Lenasia.

The hospital was completed in 1986 and was scheduled to have opened in October 1986. The residents were then informed that it was rescheduled to open on 1 April 1988.

The authorities are now saying that there are staffing difficulties and no funds to administer the hospital.

A meeting of a number of organisations from the community was held earlier this year. The meeting was attended by representatives from over 50 organisations. A Hospital Committee consisting of 21 people was formed.

The only available health clinic in the area is inaccessible to many elderly people and to those without their own transport

Existing health services in Lenasia

The following existing services indicate the inadequacy of the present services in meeting with the needs of the community.

One outpatient polyclinic

This clinic operates from Monday to Friday 8.00 am to 4.00 pm with no services for acute medical care outside 'office' hours. It has no provision for childbirth after hours and weekends and has no specialist service. The clinic is situated in Ext. 5, an affluent area, far away from the poorer areas such as Ext 2, 10, 11 where the greatest need exists. Furthermore, the state has failed to provide transport for the community to reach this facility.

Preventative services

For extensions 1-7, this service is provided by the City of Johannesburg and consists of a Chief Medical Officer, a Nursing Officer, 4 public health nurses and other health workers.

For extensions 8-11 and Lenasia South these services are virtually non-existent and no facilities have been built. These residents are paying more rates and taxes than Ext 1-7 residents. Presently there is 1 nursing sister for this area (8-11 and Lenasia South). Many residents are knocking at the doors of the Johannesburg Clinic for immunisations.

From the above it is clear that the present health services are grossly inadequate and in a crisis situation.

The Hospital Committee has formulated its demands around the Freedom Charter

Hardships experienced by the community

People have to travel about 32km to Coronation or Hillbrow hospitals in the event of an emergency. The only clinic is situated in an area which is inaccessible to the poorer section of the population. The following are some responses from people who were randomly interviewed about their experiences:

"My mother was in great pain and my dad rushed her to Coronation Hospital. They refused to admit her, saying that she must go to Hillbrow hospital. But we made a big fuss and they eventually admitted her. Its not the hospital staff's fault, but ridiculous government policy," Anonymous.

"I think the worst problem is emergencies at night. How does one get hold of an ambulance? By the time you get from Lenz to the nearest hospital, it may be too late," Sanjit Hari.

What the state should be providing

Curative services

These are the responsibility of the Transvaal Provincial Administration. They entail hospital services for the care of the sick and injured within 5km of residence. For a population estimated to be in the region of 300 000 (Greater Lenasia and environs ie. Klipspruit West, Mid-Ennerdale, Grasmere, Finetown, Eldorado Park, Univalle and Lenasia) the norm would be:
- hospitals: (100-400) beds, operating 24 hours per day, 7 days a week, open on public holidays and providing facilities for emergencies, accidents, intensive care and child birth;
- mental health services: provided on a 24 hour basis, 7 days a week, including provision for the hospitalisation of the acutely ill patient;
- geriatric services: health care for the elderly including a frail care centre for those who may have for eg. suffered a stroke and are unable to look after themselves at home;
- dental services: 24 hours, 7 days per week;
- ambulance services: a 24 hour service available in the area, that can respond within minutes.

Preventive and community services

- immunisation against Polio, TB and other infectious diseases;
- child health and feeding scheme for malnourished children;
- family planning service;
- screening for diseases such as cancer of the cervix, diabetes and high blood pressure;
- providing advice, health information and support services such as rehabilitation for persons having suffered a heart attack;
- treatment of patients suffering from sexually transmitted diseases.

All the above services are to be provided free, being financed from rates and taxes.

The present campaign

The present campaign began with the JISWA writing to the Director of Hospital Services inquiring about the hospital in Lenasia South which was lying unused for almost 2 years. The response from the authorities concerned was that they did not have funds to commission the hospital. The present campaign was launched at a meeting on the 24 March 1988. It was attended by at least 50 organisations within the community.

At this meeting the following demands were outlined:
- the immediate opening of the Lenasia South Hospital;
- the establishment of a comprehensive curative and preventative health service for the community, as the 98 bed hospital cannot meet the total needs of the community;
- a non-racial hospital which should serve the people of Lenasia, Eldorado Park, Ennerdale, Finetown and Grasmere;
- the rejection of privatisation.

A committee consisting of 21 persons was formed. In addition the meeting resolved that the Lenasia South Hospital be opened immediately to all the people of Lenasia and the surrounding areas.

The authorities, together with the authentic representatives of the community and relevant health worker groups, should plan and structure future health care facilities on a non-racial and non- discriminatory basis.

The first phase of the campaign was the petition calling for the opening of the hospital. The campaign slogan was "Open our hospital now! Health care is a basic right!". A newsletter, detailed coverage through the media, stickers and posters formed part of the campaign.

A mass meeting was set for 6 July 1988 where the first phase of the campaign was presented to the community for discussion and direction. At the same time, representatives of the community are exploring the suggestion that legal action be instituted against the authorities for failing to provide the community with essential health services.

Conclusion

The active participation of community organisations together with progressive health worker organisations is what we are striving for - not only for better health services but also for a non-racial, democratic South Africa.

The Freedom Charter on Health states the following:
A preventive health scheme should be run by the state.
Free medical care and hospitalisation shall be provided by the state for all, with special care for mothers and young children.
The aged, the orphans, the disabled and the sick shall be cared for by the state.
Health care is a basic right!

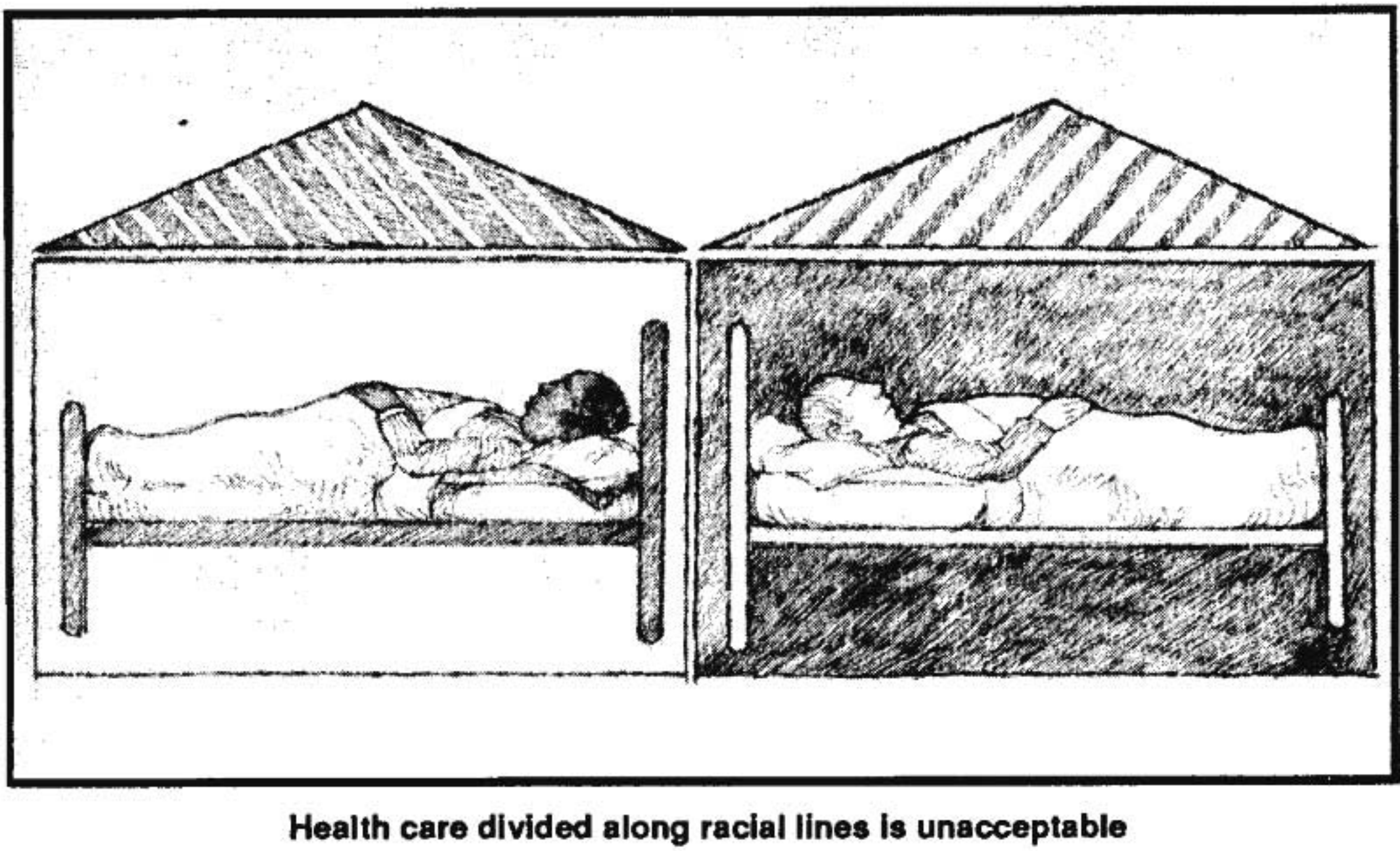
The Hospital Committee

Segregation and integration at Groote Schuur Hospital

South African hospitals are distributed according to race and class. In Cape Town, all hospitals except one convalescent and one orthopaedic hospital, are located in white group areas. In Guguletu, there is one small day hospital serving all of Guguletu, Nyanga, New Crossroads, the transition camp and Phillipi. Mitchells Plain and Bonteheuwel, do not have a day hospital at all.

The building of another large, expensive Groote Schuur Hospital in Cape Town when other surrounding areas are without adequate services, must be questioned. The new hospital will however, be completely desegregated. Although the change is welcome, there is a danger that the Cape Provincial Administration may use the desegregation of Groote Schuur Hospital to divert attention away from the continuing segregation in other Cape hospitals.

This article documents the developments at Groote Schuur Hospital in Cape Town - from segregation to integration.



Health care divided along racial lines is unacceptable

People came to the Cape to find work resulting in an increasing demand on the urban hospitals

The old Groote Schuur Hospital: an apartheid design

When the original core of the old Groote Schuur Hospital was built in the early 1930's, segregation was designed into it. There were two 'sides' - a 'white' side and a 'non-white' side, each containing approximately equal numbers of beds - 'separate but equal'. Only one nurses' home for whites was built on site. In later years a second nurses' home - for 'coloureds' was built 9 km away in the relevant group area.

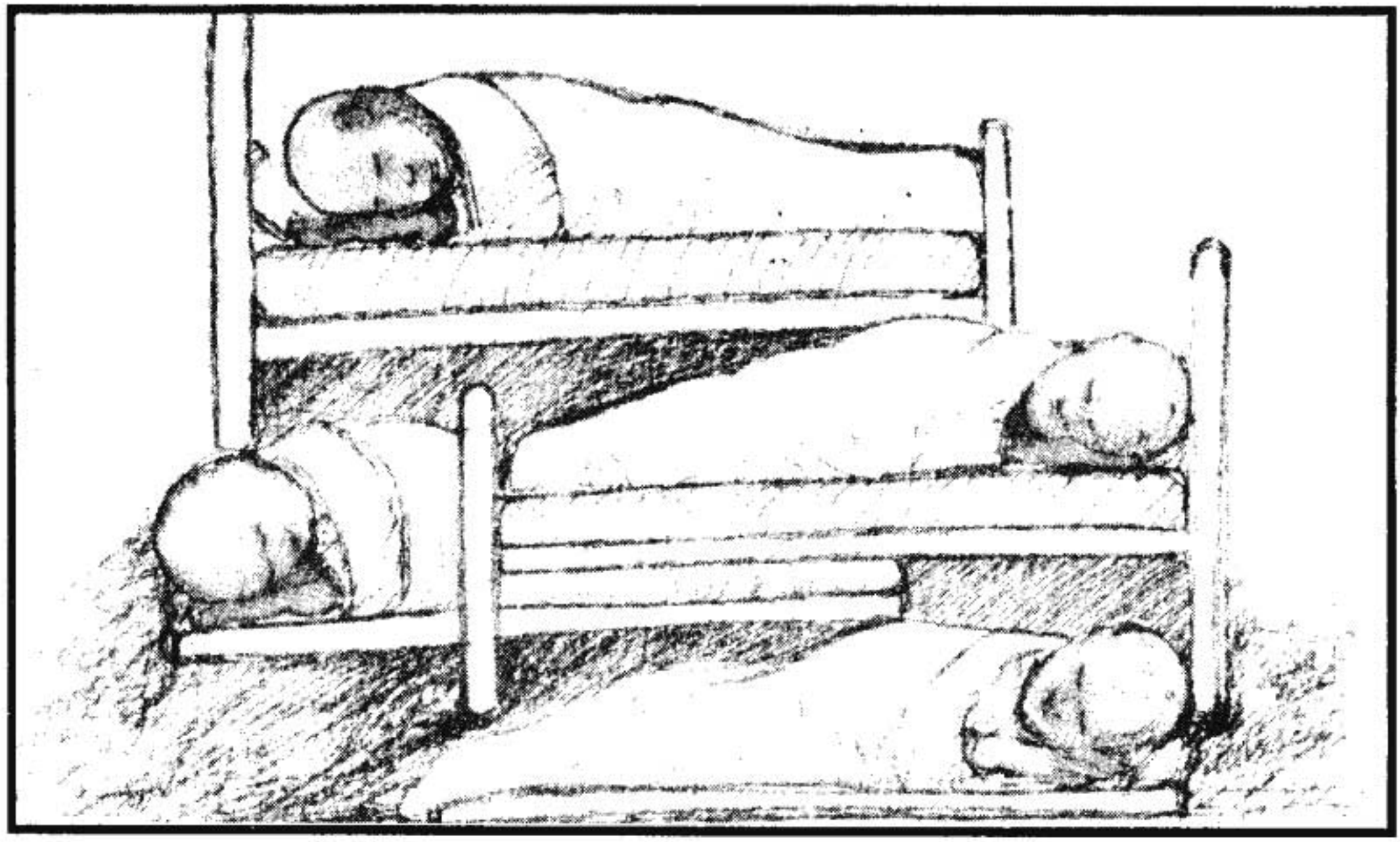
Cracks in the apartheid building design

Over the fifty years that followed, the demography and available health services of the population served by Groote Schuur has changed. There has been an increase in the provision of hospital beds for the wealthy (mainly white) by private enterprise. At the same time, there has been an increase in the proportion of the Cape Peninsula's black population. This increase, largely a result of 'rural-urban drift'has accelerated markedly during the 1980's.

The first cracks in Verwoerd-type segregation at Groote Schuur Hospital appeared in the 1970's. The duplication of intensive care units, requiring highly trained staff and expensive equipment, made segregation impractical. More

significant, however, were the declining numbers of young white women coming forward to train as nurses. Related to this were the relatively low wages being paid to nurses. Because of the shortage of white nurses for white hospitals, black nurses were employed to staff white wards.

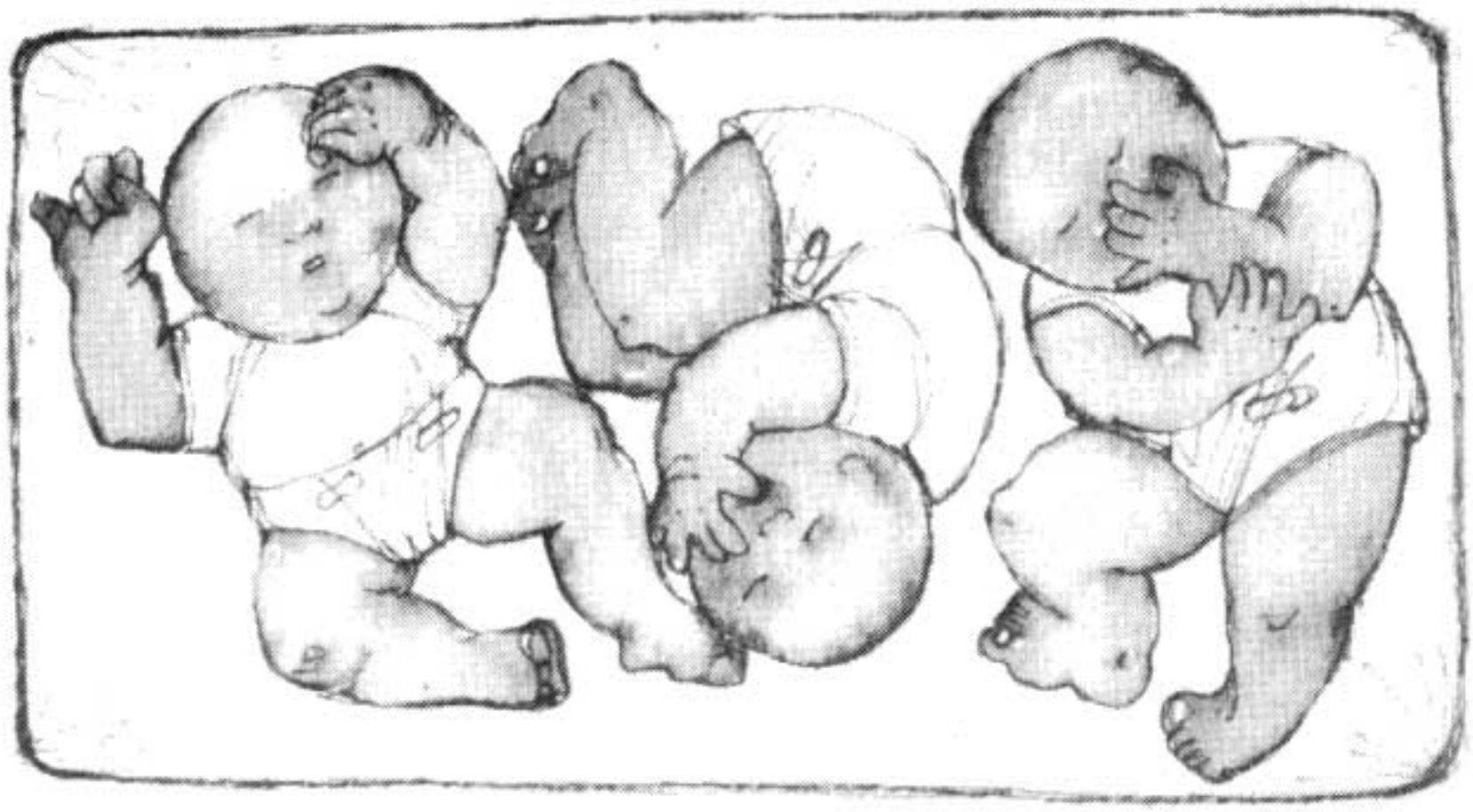
The number of black patients using the in-patient facilities at Groote Schuur Hospital increased steadily and by the mid 1980's, a crisis point was reached. On the 'non-white' side of the hospital, all the available beds and other facilities were fully used, whereas the 'white' side was under-utilised. Staffing on both sides was nearly the same. On the 'non-white' side, patients' illnesses had to be more serious to qualify for admission, hospital stays were shorter and the staff was under greater pressure.



The beginnings of desegregation

In 1985, the policy of strict segregation was relaxed. With the medical superintendents' permission in individual cases, 'non-white' patients were allowed to use vacant beds on the 'white' side of the hospital. The staff and patients made full use of this concession within the medical wards. This lead to integration in some wards. But the new policy was unevenly utilised and did not solve the problems of pressure on the staff nor the unequal thresholds for admission.

At this time, people publically voiced their discontent about the racial inequality of care imposed by segregationist arrangements. The student body was most explicit.



In 1985 an intern at the hospital documented several cases which showed that segregationist policies had resulted in a poorer quality of patient care. This information was submitted to the Faculty of Medicine's Professional Standards Committee. In a remarkable decision, evidence was ruled sub-judice and all people present at the meeting were sworn to secrecy on the committee's decision.

In December 1986, the Department of Medicine made a decision which proved to be a landmark; all medical wards and the emergency unit at Groote Schuur Hospital were effectively integrated. This courageous move had taken place after a long process of negotiation between the University of Cape Town and the Cape Provincial Administration authorities. It addressed the problems of 'unequal thresholds' for admission and uneven work loads. At first other clinical departments did not follow the lead given by the Medicine Department.

The *South* newspaper made hospital segregation a media issue

Although staff opinions have never formally been tested, there can be little doubt that the overwhelming majority of staff at Groote Schuur Hospital supported the integrationist moves. Considering how significant this change is for racist South Africa, there were very few problems expressed by patients. It became clear that with equal basis for admission, whites were a small minority of those requiring care at Groote Schuur. White admissions at the hospital have undoubtedly decreased. The reasons for this decrease are complex. They might have to do with the decision of the Cape Provincial Administration to increase hospital fees and divert medical aid members to private facilities.

The extent to which the new hospital will be desegregated will be reflected with time

In April 1987, an investigation by the *South* newspaper succeeded in making segregation at Groote Schuur, a hot media issue. On the one hand, there was the Nationalist segregationist policy as espoused by the Director of Hospital Services, Dr N Louw; on the other hand, the Faculty of Medicine reaffirmed the Cape Town university's rejection of racial discrimination (letter, SAMJ vol 71, 2/5/87). A general meeting of the Medical Faculty at this time overwhelmingly supported the university's position. People attending this meeting called for action against segregation at Somerset, Red Cross, Falkenberg and other hospitals where the university contributes to staffing.

The new Groote Schuur Hospital

The building of the new hospital has been met with much criticism. There are other surrounding areas that are in much greater need of health care services. It is not the intention of this article to condone the building of the new hospital. Rather, the intention is to acknowledge the moves within the hospital to provide a non-racial service and the example that this could set for the rest of South Africa.

In May 1988, the Department of Medicine decided to occupy wards in the new Groote Schuur Hospital. These wards are not racially segregated. There are no plans for the other clinical departments to be segregated when they occupy the new Groote Schuur Hospital. In fact racial segregation is not a part of the design of the new hospital. This is due to the determined anti-segregationist stand of the Faculty of Medicine over the hospital design in the 1970's.

Racial integration at Groote Schuur is now an established reality although the hospital still has traces of apartheid practice. There are, for example, two racially segregated nursing colleges.

Time alone will tell how far integration at Groote Schuur Hospital will be extended.

How much are you contributing to a changing South Africa?

HOW ABOUT R1·12 PER WEEK FOR STARTERS.

Isn't that a small price to pay for a more realistic perspective on South Africa?

Simply peruse the subscription details below and complete this coupon.

And put your money where your mouth is.

Subscriptions	6 months	12 months
Home deliveries in Johannesburg, Pretoria, Cape Town, Durban, P.E. & Grahamstown	R32	R59
Postal deliveries in South Africa, the homelands and Namibia	R32	R59
Airmail to Zimbabwe	R36	R70
Airmail to Botswana, Swaziland, Lesotho, Zambia, and Mozambique	R70	R132
Airmail to United Kingdom	R100	R188
Airmail to U.S.A., Europe, Australia and elsewhere overseas	R120	R225

☐ I enclose my 6-month / 12-month subscription of R _____

Name: _____

Address: _____

_____

_____

Code _____ Telephone _____

Post to: The Weekly Mail, P.O. Box 260425, Excom, 2023, South Africa

FW

The paper for a changing South Africa.

HUNT LASCARIS TBWA 8705069

SUBSCRIBE!

CRITICAL HEALTH is a quarterly publication dealing with health and politics in South Africa.

CRITICAL HEALTH aims to:

* present a critique of health in South Africa
* provide ideas for the roles that health workers can play in promoting a healthy society
* show that good health is a basic right
* provide a forum for the discussion of health-related issues
* provide insight into the political nature of health

1988 subscription rates:

<u>LOCAL:</u>			
Students, workers			R 7.00
Salaried Individuals			R12.00
Organisations			R20.00
Donor subscriptions:	R20.00	R30.00	R50.00
<u>OVERSEAS:</u>			
Individuals			UK 8.00 pounds US 12.00 dollars
Organisations			UK 15.00 pounds US 20.00 dollars

NAME: .....

ADDRESS: .....

.....

..... postal code .....

Enclosed please find R ..... for my annual subscription.
Send to: Critical Health, P.O. Box 16250, Doornfontein, Johannesburg, 2028.