CRITICAL HEALTH

DEC, 1984. NO. 11

HEALTH SERVICES

INTERNATIONAL EDITION

60c

CRITICAL HEALTH is a 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

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CRITICAL HEALTH is printed by the Central Printing Unit of the University of the Witwatersrand, 1 Jan Smuts Avenue, Johannesburg. The views do not purport to be those of the Council or the SRC of the University of the Witwatersrand.

EDITORIAL

This issue of CRITICAL HEALTH follows the issue on health services in South Africa. We have chosen to illustrate health services in other countries in this issue. The reason for this is that it is important for us to begin to develop an alternative to our health service which is appropriate to South Africa.

To do this we need to understand the short comings of other health services. The availability of appropriate articles has determined what we have included.

The article in this issue by David Werner presented at the conference on Namibia (titled Namibia need to prepare) clearly illustrates that once countries are liberated health services do not automatically become democratic and community supportive. We need to prepare in advance to ensure that this does occur and that there is a need for an ongoing struggle to ensure that such a system ultimately is born.

ACKNOWLEDGEMENTS

Doug, Jacky, Karen, Liz, Max & Merrick.

CRITICAL HEALTH is produced by an editorial collective

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NAMIBIA
NEED TO PLAN AHEAD

HEALTH WORKERS AND THEIR RELATIONSHIP TO THE SOCIAL AND POLITICAL DIMENSIONS OF A COUNTRY

by David Werner

This is a paper presented at a seminar dealing with health care in a post-independent Namibia, and which sought to illustrate health care services and their relationship with politics, in a number of different countries.

No one knows better than the people of Namibia that a declaration of independence - or even an armed revolution - is only the first step toward liberation of the people. Even after foreign invaders have been driven out, many forces of oppression will continue to operate.

The process of liberation is not primarily one of armed struggle or political decree. It is one of gradual social transformation, a group educational process in which persons learn to live and work together, both _freely_ and _fairly_:

freely in the sense that each nation, each community and each family is free to become self-reliant and to make independent or inter-dependent decisions on matters that concern their wellbeing.

fairly in the sense that groups of people, small and large, learn to peacefully prevent any member of the group (or outsider) from seeking control or privilege at the expense of others.

In short, liberation is an ongoing collective process in the defense of basic rights.

Where do health workers fit into this process? That will depend on many factors, most of which are political.

After Namibia's independence, the intention is to restructure the health system to meet the needs of all the people. This is coupled with an overall commitment toward achieving greater equity in the socio-economic and political sectors. Thus the political climate will be in favour of selecting and training health workers at every level who will serve, rather than take advantage, of the people.

But, there are many obstacles along the way - many decisions to make. Much can be learned from other countries that have recently gained independence or undergone popular revolutions.

MEXICO

The last Mexican revolution took place from 1910-1917. This resulted in the writing of the most socially progressive constitution at that time (1917). A 1934 amendment guaranteed that all Mexicans had a basic right to health.

Since then, many rural development programmes have been launched - roads, schools, and more recently agricultural and health extension work. Programme after programme to "bring health to the rural areas" has failed.

First, graduating medical students were obliged to perform a year of rural service. When this proved inadequate, a series of attempts were made to train village health aides and auxiliary nurses.

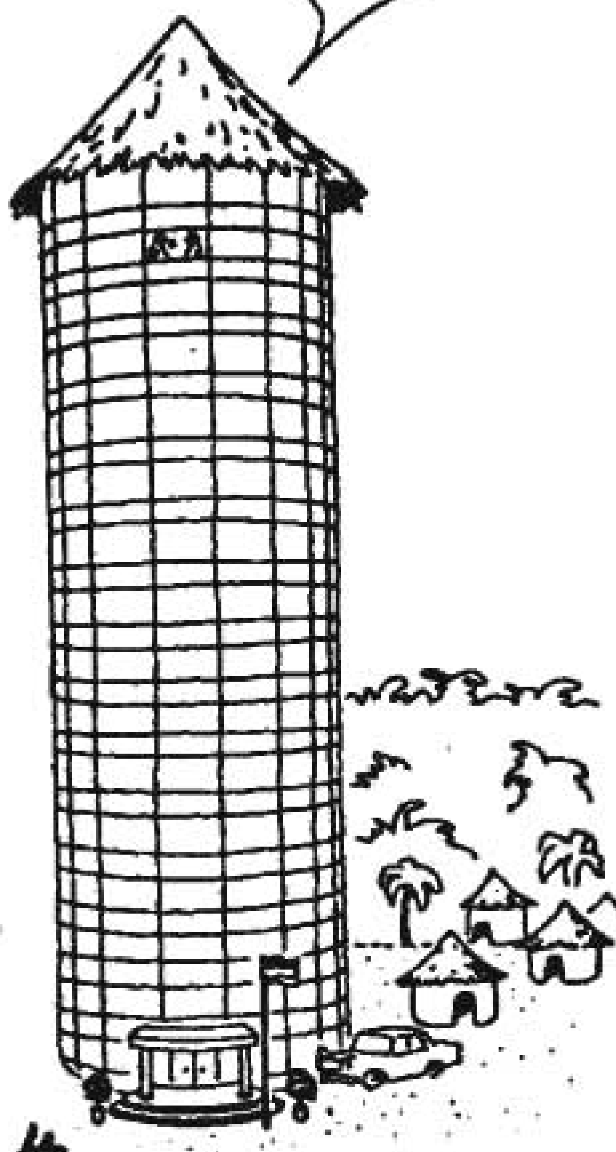
When these gave poor results, a massive effort was made to place young doctors in 2,000 prefabricated, absolutely standardised, rural health posts, which had been rapidly set up with what was imaginatively termed "community

participation". However, communities were often non-cooperative and many doctors were frequently absent, and others were extremely corrupt. The impact was marginal and in some ways negative. Preventive measures were mostly neglected, and misuse and over-use of medications was horrendous!

Today, the Ministry of Health is again about to launch a new programme with two levels of village health workers. This training will be 2 weeks long for workers from villages with less than 500 people, and 3 months long for villages of more than 500 people. But will this succeed?

Success of health workers at the community level depends on how much responsibility the people themselves take - or are permitted to take - for their own wellbeing.

In Mexico, government is tightly and centrally controlled by a single political party - the so-called Institutionalised Revolutionary Party. Although it has a strategic facade of social reform, it in fact represents the interests of a powerful minority of large land owners, industrialists, politicians and professionals - including doctors.



Effective community health work involves community awareness and decision making. It involves popular organisation. If common people join together to gain greater control over their own health, this is the beginning of such an awakening. They may begin to organise to gain more control over things such as land, production, and decisions that affect their lives.

This would be a threat to those in power. Therefore, care is taken that social reforms and agricultural or health extension work serve to create greater dgpendency on government assistance, rather than to promote true self-reliance. The goal is to placate unrest.

In this context, care is taken to select and train community health workers in such a way that they feel greater allegiance to those in power than to those in need. It is not surprising that the village health worker is often the daughter of the headman, or the dutiful servant of a land-owner.

It is no accident that the tasks of the health worker are narrowly and rigidly pre-defined, that she is required to wear a uniform that gives her the look of an outside authority, or that she spends her time filling in endless forms. Care is taken that she is kept subservient and unquestioning - a lackey, not a liberator.

If in Mexico the latest plan for reaching the rural population through the training of village health workers goes amiss, it will be because those now in positions of control are as yet afraid to redistribute political power. They fear the chain of events that might take place if rural and working people are permitted to organise and take charge of factors that determine their health.

CENTRAL AMERICA

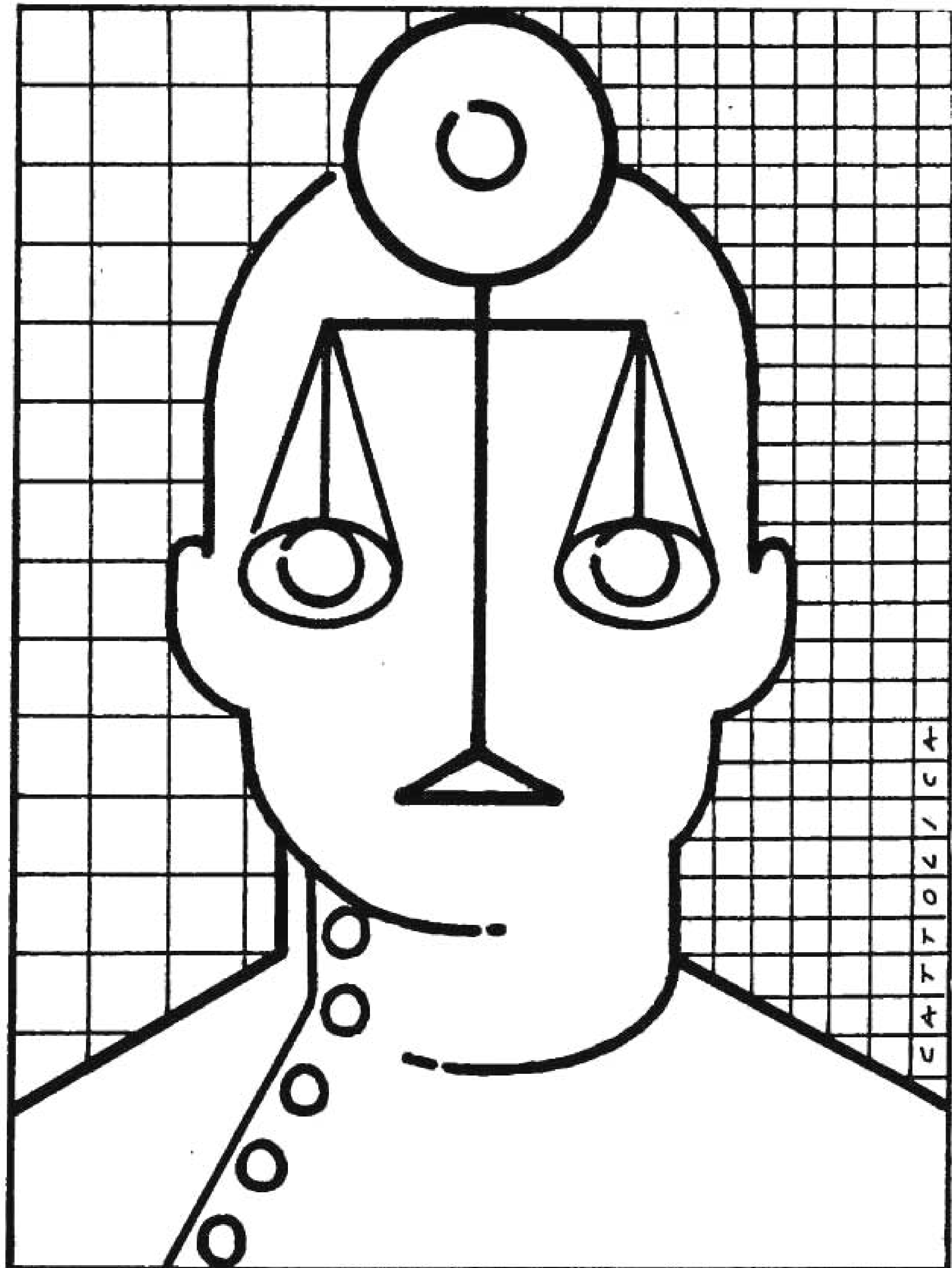
Governments that do not truly represent the people take care to form health workers that do not truly represent the people. Such precaution is strategic, for it is well known that in many countries, non-government community-based health workers have played, and continue to play, a key role in accelerating social transformation.

In Nicaragua, many courageous "promotores de salud" became village organisers in the struggle that led to the overthrow of the Somoza dictatorship.

In Guatemala and El Salvador, village health workers have become prime targets for disappearances and torture by both military and paramilitary forces. In Guatemala it has reached the point where to be caught with a first aid pamphlet can be a crime punishable by death.

Health workers at every level, from doctors to village aides, can be important political agents - either for or against the people. Following independence or a popular revolution, you would suppose that both the health ministry and its workers would work to help the people gain more power and control over their own health. However, this is not always the case.

The system of health workers that have been adopted in China and Cuba provide interesting case-studies of differing approaches to making health care more accessible to the community, but not necessarily leading to a greater degree of control over the services by the community. (These issues are discussed in more detail elsewhere in this edition of Critical Health.)

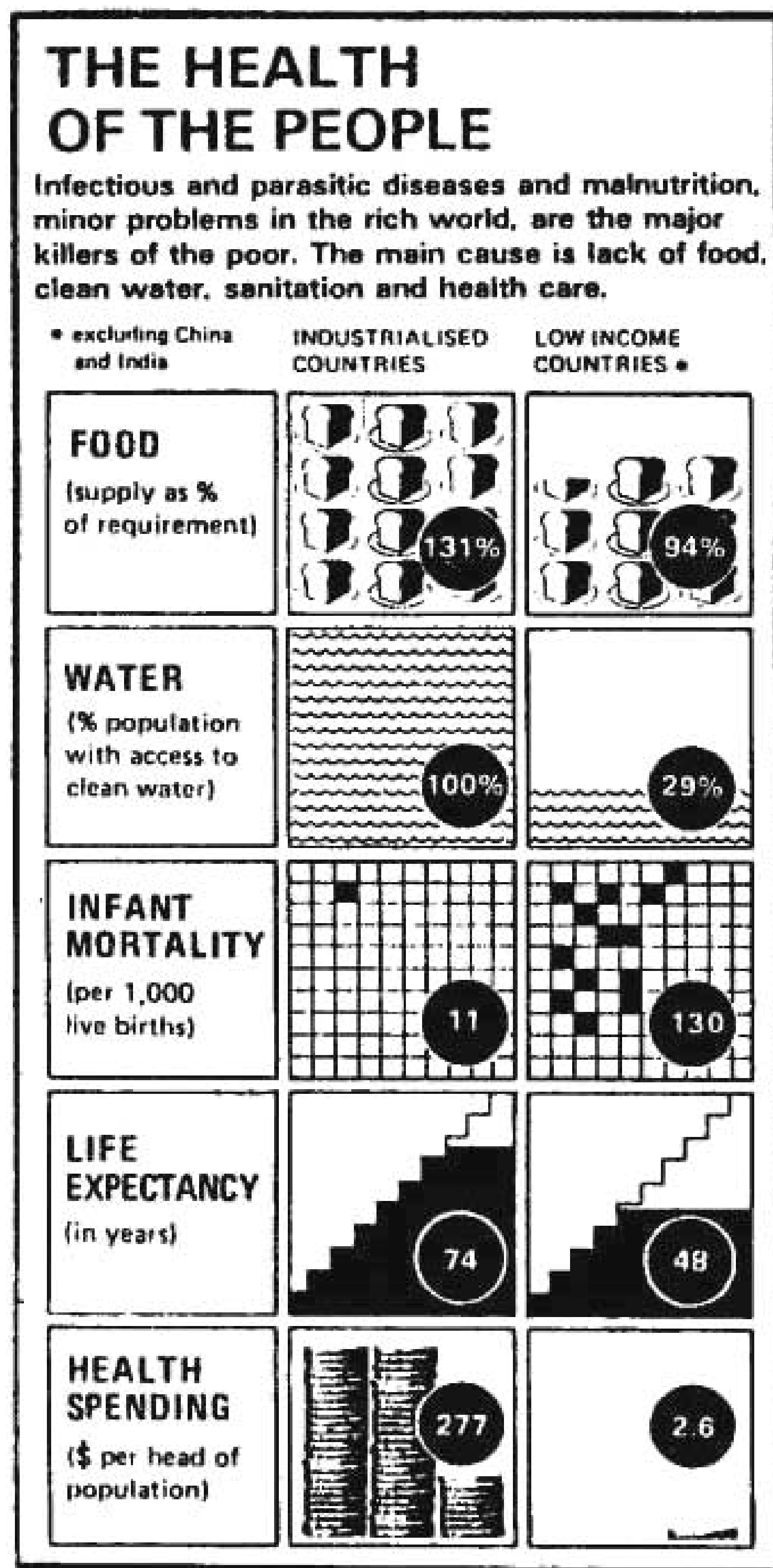


NICARAGUA

Following the overthrow of Somoza in Nicaragua, the state was faced with an exodus of physicians, and the new Ministry of Health had to, in part, be formed by leading physicians who remained. The Sandinistas were at first determined to totally restructure the health services as had been done in China, to emphasise primary care and the training of community health workers.

However, with the acute shortage of medical personnel, hundreds of Cuban doctors were invited in, not only to fill the gap, but to serve as advisers in planning the new health system. Unfortunately, the Cuban doctors recommended the same top-heavy apppoach as had been applied in Cuba. The community base of the proposed health pyramid was pulled out from under, and the focus shifted to training more and better doctors.

Fortunately, however, the community base of health brigadistas in Nicaragua was already fairly strong. Many had been popular leaders and community guerilla medics during the struggle. They continued to collaborate with the new Ministry of Health, but made it clear that they were accountable first to their communities.



For example, when a team of village health workers from Mexico was in Nicaragua in 1982 conducting a course on training methods, the local brigadistas and "multiplicadores" suddenly received orders from the Ministry of Health to change their plans and interrupt their course. The health workers replied that they would always seriously consider suggestions from the Ministry, but that they took their orders from the community. The community Committee for the Defense of the Revolution voted not to interrupt the course, and the health workers followed the community's request.

The fact that the local community and its brigadistas had the courage to stand up to the Health Ministry is impressive. The fact that the Ministry accepted thier decision is even more encouraging and gives hope that in time the Ministry of Health will move toward decentralised control and a stronger community base. In fact, within the last year this is happening; an official decision has been made to give high priority to the training of several new levels of community brigadistas.

In Nicaragua, without doubt, the social revolution is still alive. The young government is struggling to serve its people equitably and well.

ZIMBABWE

It takes a visit to post-independent Zimbabwe to realise how comparatively good things are in Nicaragua.

The so-called "independence" of Zimbabwe has done much less than was hoped for to transform the inequities of that neo-colonial state, and Zimbabwe is still very far from genuine social change.

The enormity of the obstacles was driven home by a visit to a training program - run by an elderly

German doctor - to "upgrade" the training of those who had been "medics" within the guerilla liberation army, presumably a spirited group committed to the ongoing struggle for their people's rights.

Here, a short discussion with this group is quoted:
"Are there still many people in Zimbabwe who are hungry?"
"Oh yes, many", replied the ex-guerilla health workers.
"Why?"
"Because the people are lazy," they answered. "Because they are ignorant." "Because they don't like to work." "Because they drink ..."

All typical answers of the oppressed, who have been taught to blame only themselves for their problems!

Only one feiry-eyed young women finally spoke out and said, "Not true!". Our people are hungry because all the good land is still in the hands of a few wealthy owners. The poor people have been pushed into land that that is worthless. They are forced to work on the large plantations at starvation wages. They are herded together into tiny shacks. If they drink it is because..."

At this point the feiry-eyed young woman was interrupted by the German doctor. "I'm sorry," she apologized to me. "Remember that these people are all cowards who betrayed their country, Rhodesia. But we are slowly retraining them."

MOZAMBIQUE

In contrast to Zimbabwe, Mozambique appears to have gone much farther in the direction of equity and social justice.

Soon after her liberation, the new Ministry of Health made the rural area its first priority. Roughly 70% of the health budget was allocated to setting up a network of health and dental workers to provide primary care thoughout the rural area.

As a result, the level of health of the rural population improved dramatically.

However, things are never as straight-forward as they appear. By allocating its major resources to the rural area, the Ministry of health was forced to make severe cut-backs in the urban hospitals. As a result, better-off families in the cities could no longer get all the costly secondary and tertiary care that they were used to.

There were protests, including some from the wives and families of top decision makers.

Now an increasing percentage of the health budget is again being allocated to the cities.

Whatever the case, it is indisputable that Mozambique has made great strides in the direction of health for all. Village health and dental workers have played a key role in the process. Their success has depended on the political will of the nation. (See detailed article on health in Mozambique.)

POINTS TO CONSIDER IN SOCIETIES IN TRANSITION

Perspectives from several countries that have recently become liberated have been presented. It is clear that the approach to restructuring the health systems and the roles for health personnel in these countries has varied widely.

Can anything be learnt from all this that might help countries that are about to be liberated, such as Namibia, to plan a strategy for health care, or to decide how to select, train, and assist health workers to best serve their people?

A country may become "free" suddenly, following a long struggle, but her people become free from oppression slowly. Oppression exists not only in the national and international context, but also "closer to home".

Often, each village and each family has its own oppressors and its oppressed. Even individual persons may be oppressed - or depressed- by their own low self-image, lack of confidence or loss of hope.

All this takes time to change. If it does not change, national liberation will prove hollow and short-lived.

There are always those hungry for power and privilege who await their chance to take advantage of a situation. And unless those who are weakest in the family and the community learn to organise and defend their interests, new oppressors, with new forms of oppression, will emerge.

Health workers can become "leaders of change" in helping those who are most subject to oppression within a village or family to gain the confidence, skills, understanding and unity they need to safeguard their health and rights.

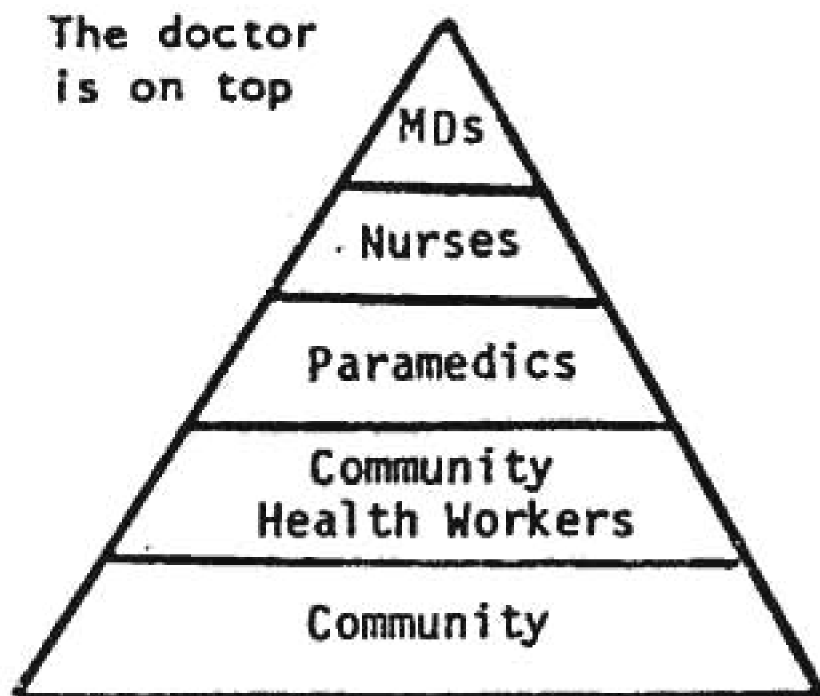
Health workers can serve this function better if the government's health system is restructured in a decentralised, people-supportive way.

Here are some suggestions for structuring a people-centred health system:

1. Tip the "health pyramid" onto its side so that the community comes first and is no longer on the bottom. Have community health workers together with mothers, school-children and

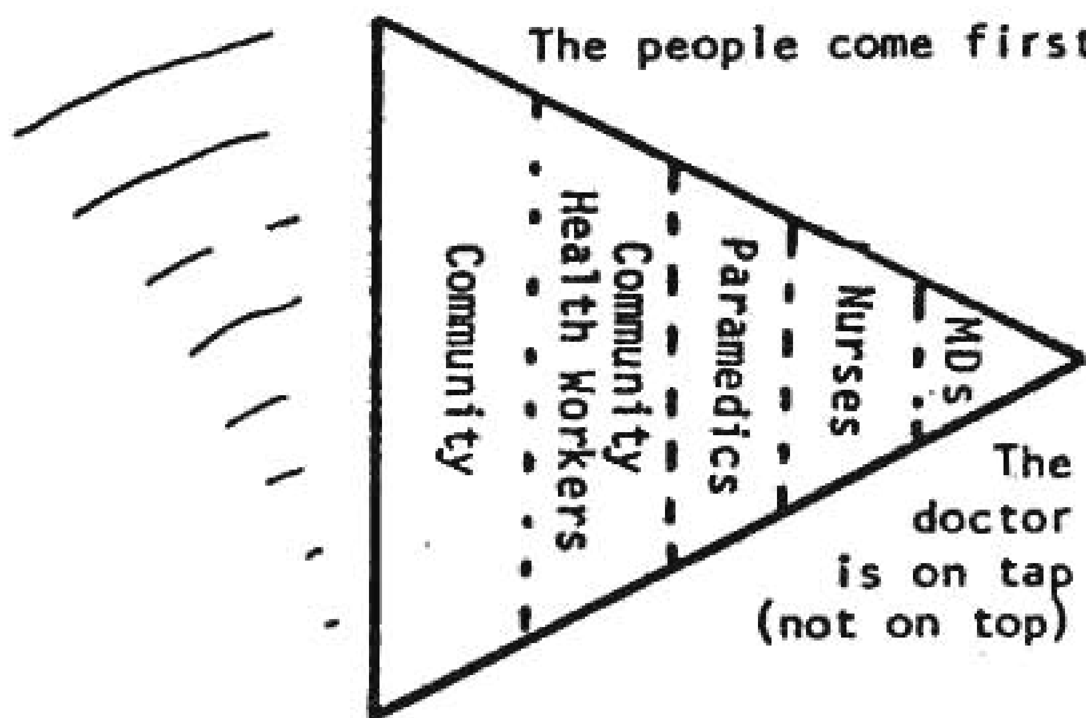
other community members play the leading role in health care, so that the medical professionals become the auxiliaries : on tap and not on top.

THE TYPICAL PYRAMID



The community is on the bottom of the stack. Each level is rigidly delineated.

THE PYRAMID AS IT SHOULD BE



The community health worker assumes the lead role in the health team.

2. The largest, most important body of health workers should be community or village health workers. Invest more in training and providing for community health workers than doctors.

3. Be sure that community health workers are selected by, and are representative of, the poorer, or more oppressed, members of the community.

4. Explore alternatives for ensuring that the health workers are accountable primarily to their own community, especially to the workers in their communities.

5. Make sure that the Ministry of Health acts as co-ordinator, supplier and adviser, rather than a "controller" of the community health workers. As much as possible, control and supervision should come from the community and involve a democratic group process.

HEALTH CARE IN CUBA REVOLUTIONISED

This is an edited version from a paper by David Werner. The editorial group has made every effort to represent Dr Werner's opinions accurately while having to cut the paper quite drastically because of lack of space to reprint the entire article. The editorial group accepts any responsibility for inaccuracies. Dr Werner prefaces his paper by stating that his visit to Cuba was brief and so his picture of the health care system is incomplete and that he had very mixed impressions and therefore "came away from Cuba with more questions than I had when I went .... questions not only about the reality of Cuba but about the very nature and needs of Man ". However Dr Werner's experience with community-based health care in Latin America has been lengthy and his impressions of Cuba are of considerable interest. This is confirmed by reading his paper; <u>HEALTH CARE IN CUBA TODAY - A MODEL SERVICE OR A MEANS OF SOCIAL CONTROL - OR BOTH."</u>

WHAT THE REVOLUTION HAS ACHIEVED.

Today, everyone in Cuba has adequate food. Everyone has access to comprehensive health care. Although sufficient housing is still a problem, a greater effort is being made to provide adequate low- cost living quarters for everyone. Primary education is compulsory and almost universal. Today there is virtually no unemployment.

To understand Cuba today one has to take into account the legacy of pre-revolutionary times. Cuba was a typical third world country where people suffered from social and physical hardships as well as poor health and inadequate health care services. Life expectancy was low, infant and maternal mortality were high. Over half of the children were malnourished. More than 50% of the doctors and 70% of the hospital facilities were in

the capital province of Havana where these costly services catered to the fortunate few.

Most of the land and industry were in the hands of a small, wealthy minority, largely under foreign (US) control. For the working people, housing, water and sanitation were inadequate; wages were low, agricultural work was seasonal only; workers' rights were minimal and unemployment was high. The government, representing primarily the interests of the rich, was corrupt and repressive.

IMPACT ON HEALTH.

Cuba's per capita income remains that of a developing country, however infant and maternal mortality have fallen to nearly that of industrialised countries.

Before 1959 the most common causes of death were those typical of poor counties; malnutrition, diarrhoea, pneumonia, malaria and epidemic disease. In recent years the major causes of death have become similar to those in industrialised countries.

The chart below shows the effect of the Cuban public health system since the revolution on several common infectious diseases. table page 7

A startling statistic of modern Cuba is the declining birth rate. Before the revolution there was a reported birth rate of 28.3 live births per 1000 inhabitants. From 1963 to the present the birth rate has steadily declined. In 1977 it was 17.7 per 1000 compared with the USA rate of 15 per 1000 and at the other end of the spectrum, Mexico with a birth rate of 41 per 1000.

This has occurred despite the fact that Cuba, unlike Mexico, has never conducted a family planning campaign. This supports the theory that "only when people achieve a certain level of economic

security will they choose to have fewer children."(1) The push towards larger families in underdeveloped countries is an economic necessity and not as a result of ignorance.

Even Cuba's adversaries admit that Cuba, through the restructuring of her social and political order, has achieved many of the commonly recognised goals of development.

THE STRUCTURE OF THE CUBAN HEALTH CARE SYSTEM.

Universal provision of health care has been one of the top priorities of the Cuban revolution and the needs of the rural areas received the greatest attention.

In 1959 more than 60% of the 6.5 million population had almost no access to modern health care. To add to the difficulties, in the first 5 years following the revolution over half of Cuba's doctors fled. In an attempt to stem the mass exodus of doctors the state compromised its commitment to equity and promised substantially higher salaries and special privileges to those doctors who were willing to stay. Many were also offered high positions in the new health ministry in spite of their privileged class background and ideological differences.

MANPOWER

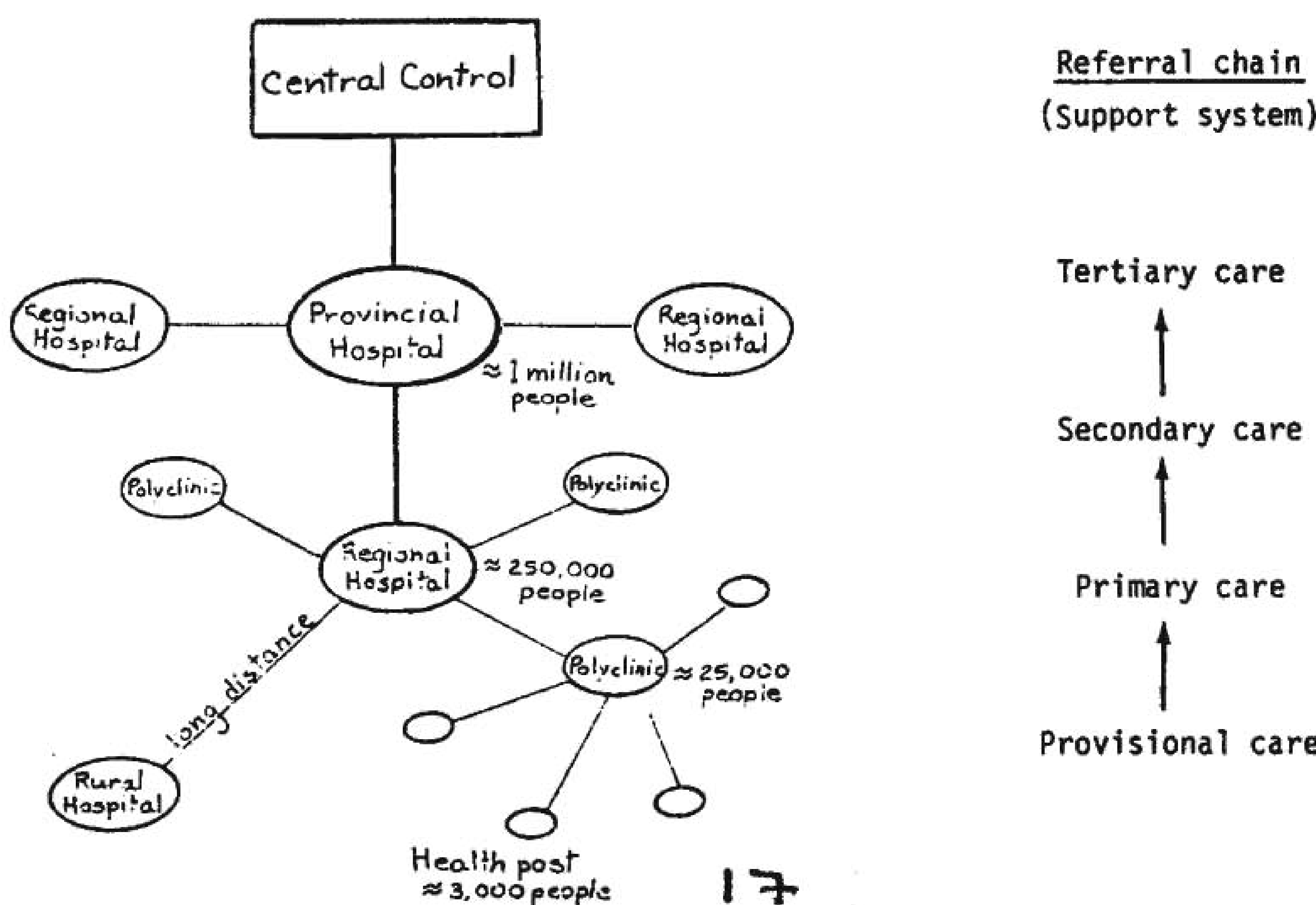
The mainstay of health manpower in Cuba is the doctor. Unlike many other developing countries, Cuba has done little by way of giving medical responsibility to paramedics or community health workers, but has rather focused on training fully qualified doctors to handle every level and aspect of curative medicine.

Following the Batista's overthrow a new ministry of health was formed (MINSAP) and the health system was re-evaluated. Increased emphasis was placed on preventive measures and on maternal and child health.

To implement some of the preventive measures help was solicited from various community organisations. With the help of these popular organisations vaccination campaigns for polio were carried out throughout the entire country in as little as 72 hours. As a result polio was completely eliminated from Cuba by 1963 - years ahead of the USA.

Today each province has a provincial hospital providing tertiary (highly specialised) care, several regional hospitals providing secondary (specialised) care and a network of polyclinics providing primary care. These are situated, geographically and in terms of referral, in a satellite formation. In rural areas, provisional care, followed by referral to the polyclinics, is provided at the community health posts. Where distances from regional hospitals are great, the polyclinic (outpatients only) is often replaced by a rural hospital (inpatients too).

Schematically it looks like this;



An effort is presently being made to shift the training of medical students away from the provincial hospitals (tertiary care "disease palaces") to the more modest regional hospitals. The revised curriculum focuses more on primary care, epidemiology and preventive and community medicine.

Senior medical students, interns and residents must spend three 4 hour sessions per week in the polyclinics.

All doctors have to spend two years of compulsory service in rural areas. In an attempt to bestow a higher value on the much denigrated field of public health, only the top 10% of each class are eligible for public health residencies. Despite this unusual status and the increased exposure of medical students to community medicine. 80% of doctors still apply for residencies in some branch of highly specialised hospital oriented curative care. Evidently the prestige linked with classical Western medicine has not greatly changed with the revolution.

POSITIVE IMPRESSIONS OF THE HEALTH CARE SERVICE.

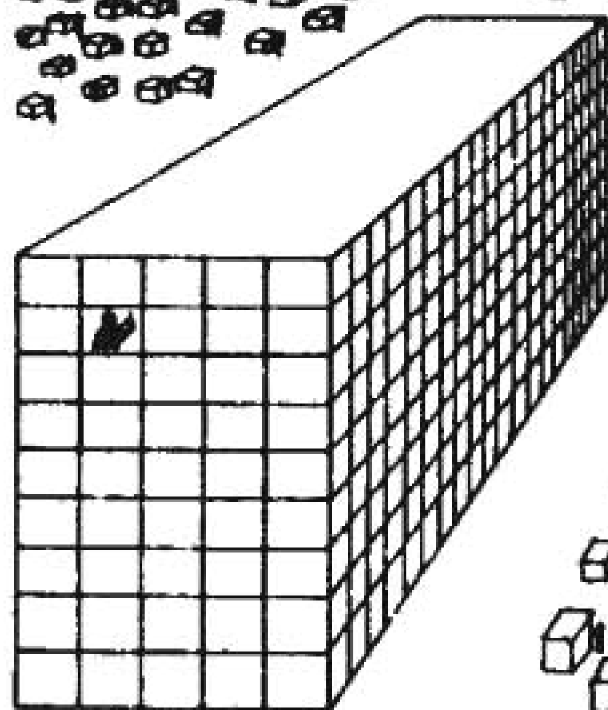
More than anything I (Werner) was struck by the obvious dedication of the personnel, above all by the friendly rapport between the doctor and the patients. When I entered a ward, the doctor would introduce the visitor to the patients, telling them something about my work in Mexico. He spoke to the patients as friends -- almost equals -- not as mere cases and "interesting pathology" as do so many doctors during ward visits in other countries I know. The friendliness of and apparent commitment of the medical staff, both to serving their patients and the goals of the revolution, was something I witnessed time and again.

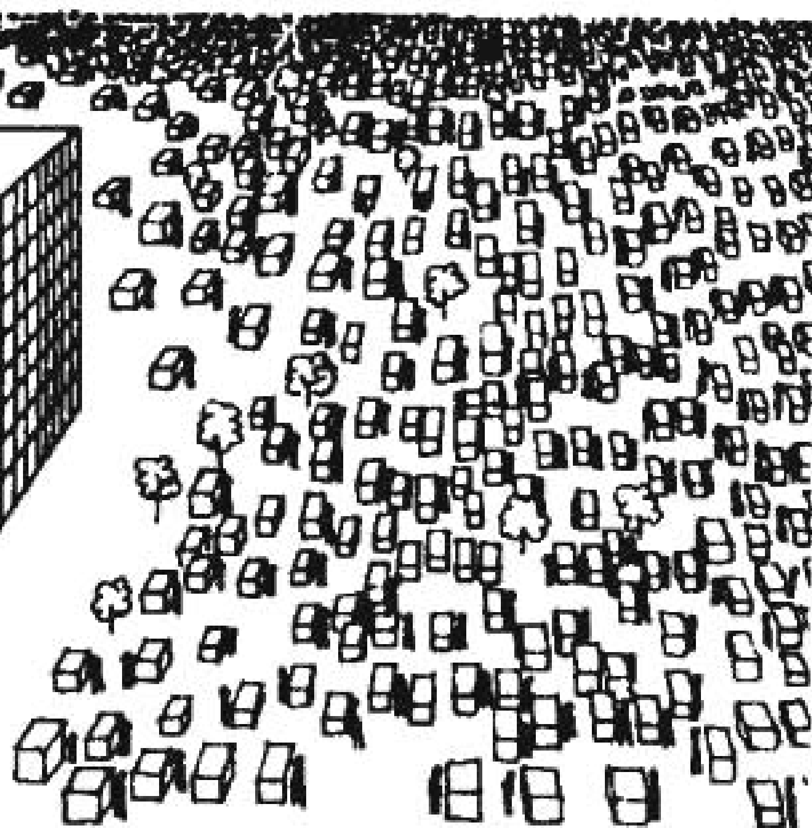
Mothers are encouraged to stay in hospital with their sick children. Whenever a child is hospi-

talised, his or her mother is given leave from work and permitted to stay with the child. The mother helps with feeding, bathing and entertaining her child, thus reducing the load on the nursing staff. Mothers are given free food and stay almost around the clock, sleeping in armchairs beside the beds.

Not only has the length of hospital stay been substantially reduced, but since mothers were permitted to stay most children stopped losing weight, whereas weight loss in hospitalised children had formerly been a major problem.

Before the revolution a mother stayed with her hospitalised child at an enormous sacrifice because hospital care was inadequate. Now she stays, in relative comfort, because the hospital recognises the importance of her presence. When mothers stay with their children they are requested to attend special sessions in which they are instructed on hygiene, safety, nutrition and disease prevention.





Primary health care workers can cost a tiny fraction of the cost of training a doctor, and are often more effective in promoting good health.

Doctors take time to explain things to their patients and this was witnessed on several occasions. However medical decision making is strictly the domain of the doctor. Even nurses, although permitted to perform a somewhat wider range of procedures than in many other countries, for eg the administration of intravenous solutions, are not officially permitted to make any decision regarding treatment. Cuban nurses pride themselves on being "the right hand of the doctor". The nurse's job is to implement decisions, not to make them.

THE HEALTH CARE SYSTEM HAS REMARKABLE OUTREACH.

Today more than 90% of the population lives within one hour's travel of a polyclinic or rural hospital. Only a few people in the most remote mountainous areas now live as far away from a health centre as three of four hours, usually on foot or mule trails.

This remarkable accomplishment has required the joint effort of different ministries and work forces; a full-scale program for extension of roads into formerly inaccessible areas - the construction of scores of polyclinics and dozens of regional rural hospitals.

DISTURBING FEATURES OF THE HEALTH SERVICE.

The people are allowed almost no medical responsibility. At the first sign of disease, however trivial, they are instructed to contact a doctor at the closest polyclinic. It is carefully explained to them that even an apparently minor symptom may be an early sign of serious disease, and that to be safe it is always better to consult a doctor. In Cuba everyone is quick to agree that a doctor always knows best.

There is an overdependency on professionals and the enforcement of a strict medical hierarchy. People are instructed to make full use of the free professional services available. Self care is actively discouraged.

For eg, diarrhoea in children, regardless of how mild, is always a cause for professional intervention. I asked if instructions were given to mothers about the importance of giving plenty of fluids to a child with diarrhoea. "Definitely not," the doctor told me, "we don't want to tell the mothers anything that might lead them to put off getting adequate medical attention at once."

This sort of concern by the state for protecting its people from "dangerous" knowledge that might lead to self care, would seem to conflict with the official policy that "the people must participate actively to assure and maintain high health levels". On the one hand people are required to participate actively in prevention. On the other hand, they are instructed to depend passively upon professionals.

This enforced, often artificial division between preventive and curative medicine is self defeating. For eg. in the August issue of the Women's Federation magazine, "Mujeres," a call was made to the people to cooperate in helping to control a current epidemic of dengue. The first request was that "All persons with real or possible symptoms of dengue report immediately to the doctor so that he can make a diagnosis and initiate treatment." However, the article provided no information as to the symptoms of dengue and one supposes that such diagnostic information is a professional, not a public domain. The article was also misleading in that it did not mention that there is no effective treatment for dengue and that it is a viral disease that goes away on its own after about 10 days.

Very little responsibility is given to the community health workers. The "bragadist sanitaria" or health brigadist is mainly an agent between the distant polyclinic and the community. Their medical skills consist of a few minimal concepts. They are permitted to bandage minor cuts and burns and issue painkillers and to inject certain medicines but only on the instructions of a doctor.

HEALTH EDUCATION APPEARS TO BE ANTI EDUCATIONAL.

In Cuba today, a great deal of emphasis is placed on "health education". However, a large part of what is called education consists of providing non-educative information (information that doesn't really tell a person how to resolve a problem himself). It constantly encourages going to the doctor for even the most minor ailment. For example, a popular health education booklet, under the heading "Eliminacion," states:

> "There are some babies who urinate each time they are fed and this worries the parents; the correct thing to do is to consult a doctor."

The absence of educative content in this sort of popular informative material is often disguised by unnecessarily complicated language. In the above mentioned booklet, section headings

read like this	when they mean this
The stimulation of language	Helping a baby learn to talk.
Buccodental hygiene	Keeping the mouth and teeth clean.

In considering the effect of such needlessly obscure language on the minds of the people, it must be remembered that the average educational level in Cuba is still about 6th grade. Much of the impact of this sort of health non-education serves to reinforce the image of medicine as a cryptic art decipherable only by an officially ordained minority -- namely doctors.

Cuban officials, of course, and many of the Cuban people proudly proclaim that the revolution still lives and that it is still in process. Some insist it is only beginning. Granted, many of the ideological changes introduced in 1959 are still being implemented. However, revolution implies radical change in policy. It entails not just reform, but transformation in the way things are looked at and done. Yet, the new centralised power structure in Cuba, far from taking steps to guarantee that basic changes (revolution) in policy can and do take place, appears to have instituted a very rigid system of enforced popular conformity which makes public questioning of policy impossible and private questioning of policy a moral as well as a civil offence; punishable in various ways ranging from social alienation to reduced material rewards, and even police harassment.

HEALTH CARE NOT COST EFFECTIVE.

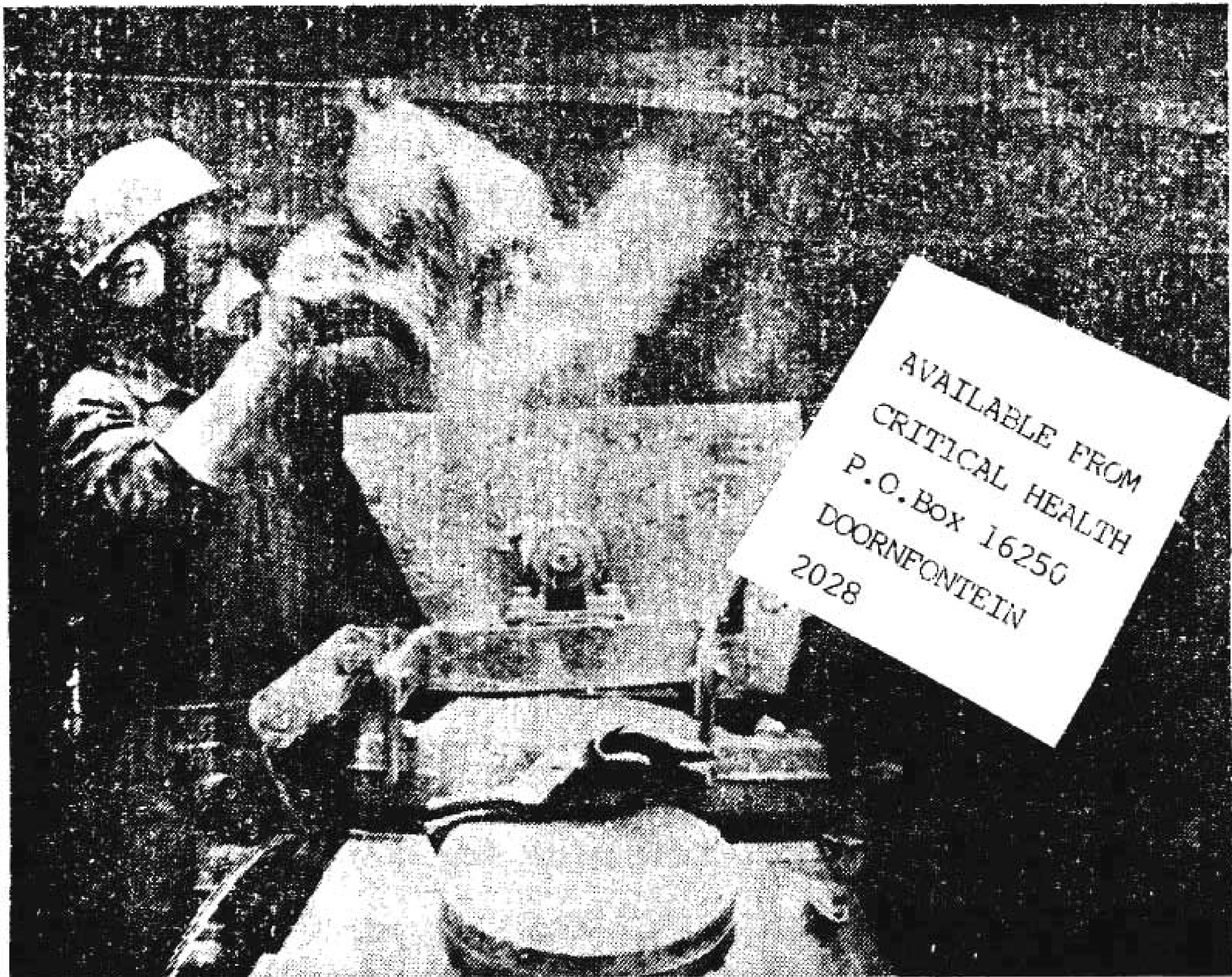
Cuba's health care system is not cost effective, but reliant on doctors who are expensive to train. The state tries to justify this approach by insisting that a completely professional delivery-oriented system guarantees the best health care for its people. But is this the case? There are indications that both quality of care and cost effectiveness can be improved by partial deprofessionalisation of medicine.

Not only has Cuba's extravagant, highly professionalised health care system resulted in growing dependency of the people on an influential minority of experts, it has also perpetuated the dependency of Cuba as a nation on massive foreign aid. Without the enormous assistance of the USSR, there is no way that a country as poor as Cuba could afford the extravagant luxury of universal health coverage provided almost exclusively by doctors.

Thus Cuba's present health care system while achieving much in improving the health of the nation, breeds a two-edged dependency; that of the people on the state and that of the state on foreign aid. It must be questioned whether such self-limiting dependencies are conducive to the optimal development or health of either a people or a state.

Dissertation Series No. 4

HEALTH AND SAFETY FOR WORKERS



A Study of Conditions of Health and Safety in the Metal Industry in the Vaal Triangle

Judy Maller

DSG/CRITICAL HEALTH

Rebuilding Health in Mozambique

INTRODUCTION

Until 1975, Mozambique was a Portuguese colony. The majority of people lived in conditions of hardship and poverty and suffered from a lack of most basic needs, such as proper housing, food, sanitation and education.

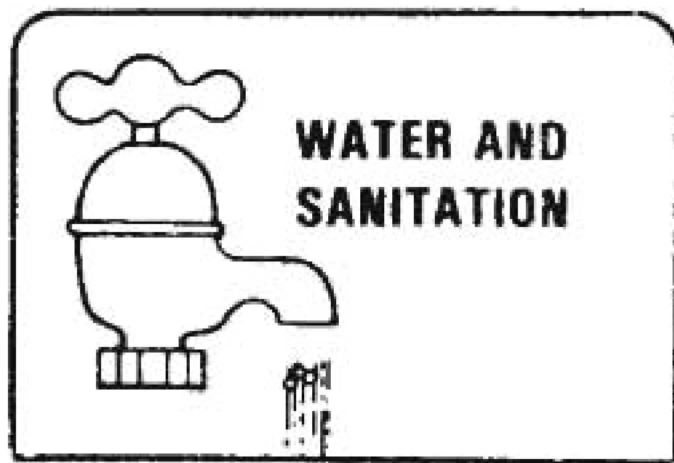
"Portuguese policy produced large scale under-development of the masses and forced people off the land. Traditional systems of communal land ownership were broken down, the local social structures of the people shattered and the caring social and cultural fabric of communities destroyed. All these can be recognised as the conditions that breed ill-health." (Africa Report, 1978:11)

HEALTH CARE UNDER PORTUGUESE COLONIAL RULE

Until 1974, medical services in Mozambique were aimed largely at the settler population. They were discriminatory on a number of levels : geographically - almost two thirds of the doctors worked in the capital city where only 5% of the population lived (Segall, 1978) and racially - hospital wards were divided into black and white, the latter receiving superior health care. Almost all care was private and had to be paid for. The majority of Mozambicans could not afford the high prices charged.

Segall (1978) estimates that 70% of the people lived beyond the reach of any health care under colonialism. Also, one third of the national health budget was spent on the main hospital in Lourenco Marques which was accessible to only 8% of the population.

Health policy and planning were not designed in order to benefit all people. Preventive health care was virtually non-existent, being limited to some immunisation and sanitation control in the urban areas (Walt, 1980). Health services were fragmented, the great majority being provided by private practitioners.



In a speech in 1974, Machel described the health situation in his country just before independence.

"In the Mozambique of the colonialists and the capitalists there are hospitals only where there are settlers. There are only doctors and nurses where people who can pay live. In Lourenco Marques there are more hospital beds, more doctors, more nurses and more laboratories than in all the rest of Mozambique. Does this mean that Lourenco Marques is the only place where people get sick?

"In the mines where we work, on the company plantations which we cultivate, on the roads that we build, in the factories, in the fields, in the villages, there are millions of people who have never seen a doctor or a nurse, who have never had any medical care when they are ill" (1974:13).

In 1975 the Frelimo goverment came to power in Mozambique, committed to establishing a democratic society and improving people's lives. From the beginning, betterment of health care was one of the main priorities of the new goverment (Korn, 1976).

In an economically poor country such as Mozambique, this is not an easy task.

HEALTH SERVICES IN POST-COLONIAL MOZAMBIQUE

National policy

The health policy adopted by the Frelimo goverment reflects its political ideology: health services are to serve the mass of the people and the emphasis is to be put on preventive care (Walt, 1980).

At Frelimo's Third Congress held in 1977, guidelines for the next three years of development were established, which outlined the ideas underlying health policy: "A fundamental task of the Party is to organise a health system that benefits all Mozambican people" (Walt, 1980).

Frelimo sees health as an integral part of the development process: better health contributes to social and economic development and this in turn generates additional resources and social energy which will facilitate further improvements in health. Goals formulated at the Congress included extending the structure and benefits of health services to all parts of the country and giving priority to the practice of preventive medicine (Programa da Frelimo, 1977).

Examples of specific steps which have been taken so far to implement policy are the nationalisation of all health institutions (in July 1975) and the banning of the private practice of medicine. These measures are seen by Gabriel and Stuart (1978) as an essential first step in the implementation of later health programmes and policies. For example, it is a necessary step in breaking down conventional beliefs that health care is a commodity and building up the idea that it is the social responsibility of the society (Gabriel and Stuart, 1978).

Legislation has also been introduced to ensure that health care is accessible to all people. For example the law on Socialisation of Medicine, passed in November 1979, provides for free emergency and preventive care and the right to free in-patient treatment. In fact, most medical care is now free, with the exception of a nominal fee (less than 25 US cents) for out-patient consultations (Gabriel and Stuart, 1978).

While Frelimo's health policy appears to be sound, there is not enough evidence at hand to judge how succesfully this policy has been put into practice to date.

Health planning in Mozambique has been criticised by Hastings (1981), a director of one of the health centres there. Hastings says : "The greatest single obstacle to advancement is the extremely low awareness amongst health care planners and administrators at Ministry and Provincial level, of the real state of affairs within the health centres and health posts. As a consequence ... if a plan is not fulfilled, the people supposed to fulfill it are blamed, but that the plan itself might be wrong is never considered" (1981).

However, since his article was published, this obstacle has, through greater contact between central and peripheral health structures, become

much less dominant. In addition, the planning process, especially at the provincial and district health levels, has undergone critical evaluation and changes, and is far more systematic than in the past.

For example, planning is based on a clearer idea of the needs in a particular area, taking into account the limitations present in the health system of the area. There is a far more systematic approach to the training of provincial and district health directors in the skills of planning and management. The annual health plans, upon which national, provincial, and district health work are based, have been simplified and priorities clearly stated (Sider, 1984).

One of the serious limitations of a health plan which devotes attention to quantity of work done, such as the number of immunisations performed, is that health workers can tend to become fixated on numbers and not on the quality of services being offered. For example, vaccinating the necessary number of people but not taking care that the vaccine is kept in conditions which ensure that it is still active when administered, gives a false sense of security against basic infectious diseases.

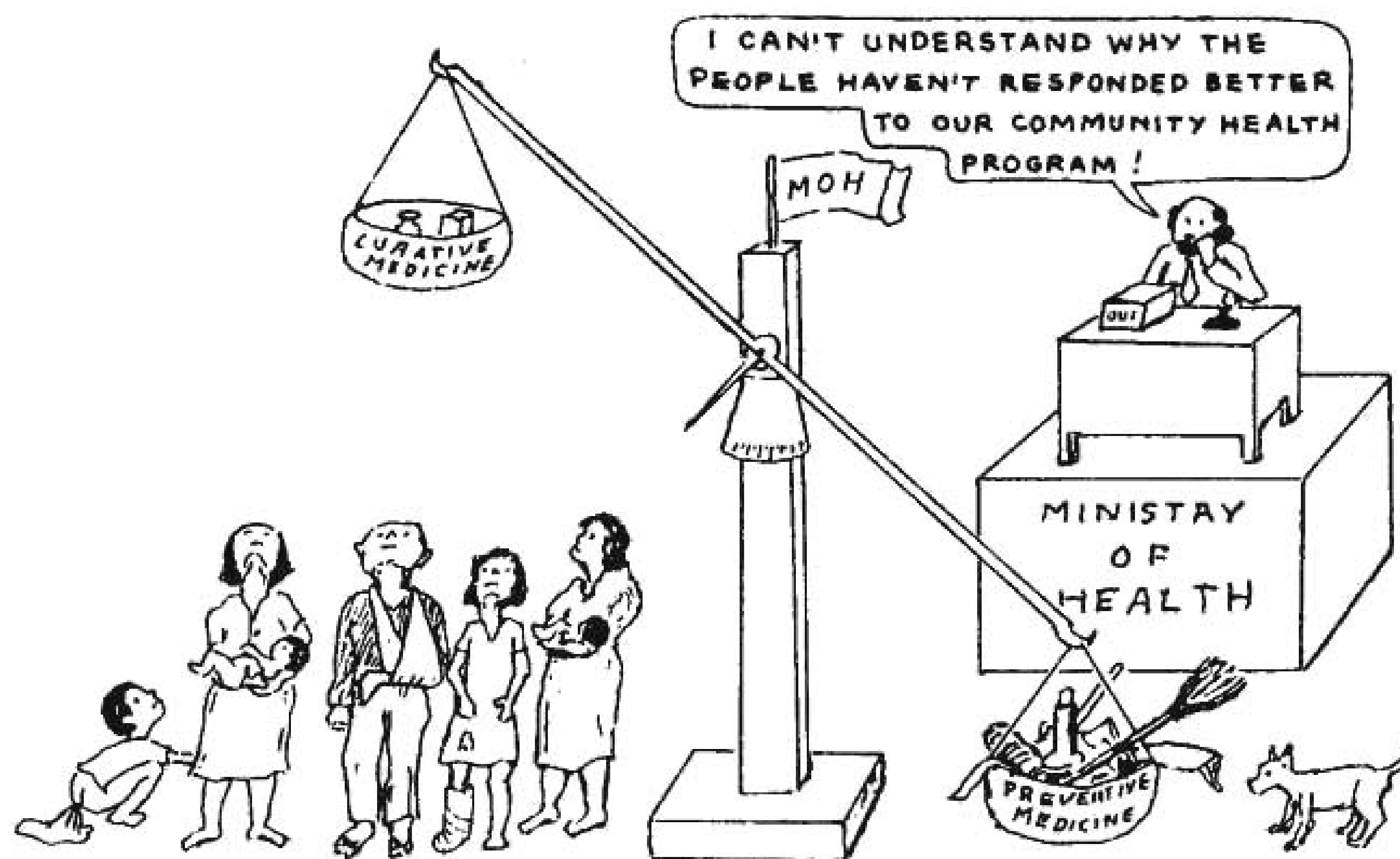
One problem identified by Hastings is the "hierarchical structure and introspectiveness" of the Health Ministry. The complexities of the enormous obstacles to changing the orientation of health care from a disease-based service, centred on large well-equipped hospitals, to preventive primary care are "ignored or glossed over".

Hastings states that he sees little evidence of a serious attempt to analyse in depth the problems of primary health care and work out a long-term strategy for their solution. However, he does

also say that the basic structure and orientation of primary care is correct and it is not over-optimistic to expect that Mozambique will one day have one of the best systems of primary care in Africa.

Sider (1984) believes that these criticisms are not accurate at this point in time.

In a community-based program, curative care cannot be separated from prevention. The first leads to the second.



A HEALTHY BALANCE BETWEEN PREVENTIVE AND CURATIVE MEDICINE MUST TAKE INTO CONSIDERATION WHAT THE PEOPLE WANT.

Priorities in health care

In Mozambique, the need to establish a correct balance between curative and preventive health care has been a major focus of attention of the health authorities (Walt, 1980). The Mozambican Health Minister, in his statement to the World Health Organization regional conference for Africa in 1975, declared that maximum priority had been given to preventive medicine through the planning of a nation-wide health programme.

However, although prevention has been made the foundation of the nationalised health service, the goverment has not ignored the curative services (Walt, 1980).

Machel, in a speech to health workers in 1974, said "... overcoming under-development does not signify only preparing for the future; it means also guaranteeing the present. In terms of health this means that, on a par with preventive action, it is necessary to develop our curative capacity according to the needs of our people..." (Machel, 1974).

Hastings (1981) identified a problem in the country's preventive health services. While there have been a number of highly succesful immunisation campaigns (in one national campaign over 95% of the population were immunised), there is still little understanding by most people that immunisation has to be given at regular intervals.

People have learnt the idea that immunisation is something a child should have only when the newspaper, radio, and other media are warning of an imminent danger. The amount of publicity to explain immunisation as a measure to be taken at definite ages has been minimal.

New emphasis is being placed on the development of integrated under-fives' clinics, where one of the principal concerns is to be the immunisation of all well and ill children brought to the clinics. This may help to overcome some of the problems mentioned by Hastings (Sider, 1984).

Resources

In 1975 the Mozambican Minister of Health described existing facilities to WHO delegates at the United Nations : "In the three main cities there was a great imbalance between one goverment department and another ... the city of Lourenco Marques where we have a neuro-surgery centre with equipment that would be the envy of many an international centre, but where in a maternity ward women give birth on a cold and bare floor, where rain leaks through, where three beds must make do for five..." (Korn, 1976).

From the beginning Frelimo attempted to rectify this imbalance in the distribution of resources. Korn (1976) sums up the objectives of the Mozambican health system as follows : "the largest possible amount of health care for the greatest possible amount of the population which can be obtained for the resources actually available".

In the first year after independence, the health budget was increased by 40-50% (Gabriel and Stuart, 1978). Even during the liberation struggle, Frelimo did more to improve the people's health in seven years than the colonial power had done in all its time of occupation.

A major priority after 1975 was the establishment of an organised rural health service (Walt, 1980).

The rising cost of health services

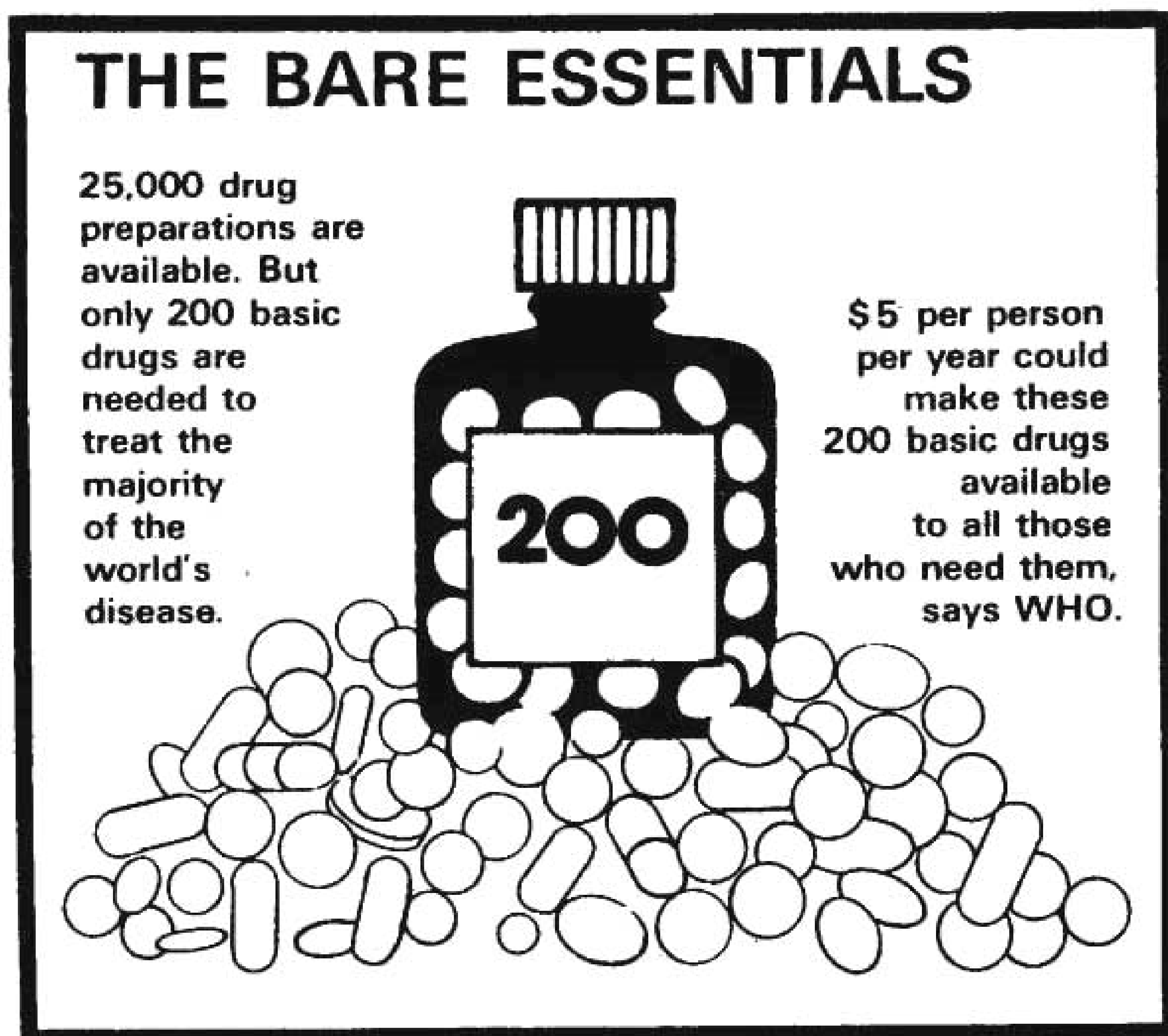
An economically poor country like Mozambique faces tremendous problems because of the shortage of resources. Areas such as the health sector are obviously affected by this.

However, there are ways in which costs can be quite substantially reduced and Mozambique is making a big effort in this direction by promoting a health service consisting primarily of paramedical and village health personnel.

Another way in which the health authorities have managed to cut down on unneccessary costs is in the supply of drugs. Between October 1975 and 1980, the number of different pharmaceutical products available in the country was reduced from about 13 000 to 340 (Contact, 1983).

Drug imports today cost the same as they did 10 years ago. Mozambique is consequently buying a lot more drugs for its money by not wasting money on useless and dangerous drugs, fancy packaging and well known trade-names.

This means that basic medicines are now available for the first time in even the most remote parts of the country. There has also been a strong attempt to educate health workers to use drugs more sensibly, training them to prescribe the least expensive and most effective drugs (Walt, 1980).



One example of this is the treatment of diarrhoea, which at one time was responsible for large amounts of drugs being wasted. Diarrhoea treatment by means of oral rehydration instead of antibiotics has been a special focus for training to form good prescribing habits. Results have been dramatic. Fewer children die of diarrhoea and less money is spent on unnecessary drugs (Contact, 1983).

Training health personnel

During the colonial period, the kind of training that health workers received was reflected in their attitudes towards their work. Medicine was seen as a professional and technical matter completely divorced from politics. Initiative on the part of the community was inhibited and corruption flourished (Africa Report, 1978). Machel described hospitals at that time as "rigid", "individualist" and "medicine monopolistic" (Africa Report, 1978).

Since independence, however, a genuine effort has been made in Mozambique to provide health personnel with the kind of training which will equip them to be effective health workers.

During the liberation struggle, Frelimo established a hospital in southern Tanzania to train health cadres. The training of these health workers reflected Frelimo's understanding of the "politics of health" (Gabriel and Stuart, 1978). Cadres were both politically and medically trained and this training emphasised community and preventive health as well as providing skills in curative medicine.

Other issues raised during training were those related to social class, the social and economic effects of capitalism and the many traditional and economic restrictions placed on women.

After independence, the medical curriculum was changed. It was orientated towards Mozambican epidemiology instead of disease patterns in Portugal as it had been previously. More emphasis was placed on paediatrics, obstetrics and gynaecology to cover the groups most at risk in the community. Medical students also have to spend two years in rural areas after graduating.

There are various levels of primary health care workers being trained at present, and the diversity and numbers of different training centres demonstrates clearly Frelimo's commitment to improving primary health care services.

Seven or eight provincial training centres have been established for the training of Agentes Polyvalentes Elementares (APEs). The APEs are trained in primary health care and one of their main tasks is to promote mother and child health. In particular, they are expected to perform ante-natal and basic child health programmes.

Most of the APEs are men. As acceptance of males within the process of child-birth is limited, there has been increasing interest in upgrading the knowledge, skills and attitudes of the traditional birth attendants.

The APEs have mostly preventive health skills, and their lack of curative health skills shows a failure to respond to the felt needs of the communal village members. The APEs have had to overcome the problem of poor credibility in the eyes of villagers, and this has necessitated some changes in their training.

The insufficiency of collective production in many communal villages has meant that the community is often unable to support the APEs, who therefore have to spend more time in the fields and less time in health-related activities. In some cases APEs have been forced to give up their health work altogether.

Over the last one to two years provincial training courses for nurses and midwives have also been set up. These courses upgrade the skills and knowledge of many health workers in the rural health posts and centres, returning these new health cadres to the areas where they worked previously.

There are also four Institutes of Health Sciences, in Maputo, Beira, Quelimane, and Nampula, plus a new course for medical technicians based in the provincial hospital of Lichinga, the capital of Niassa Province.

Here people receive a basic preventive medicine course. The growing emphasis has been that there is no such thing as a purely "preventive" or purely "curative" health worker, but that each worker should have sufficient skills in both areas. This has led to changes in the training of primary health workers.

Several older post-independence health worker categories are being phased out and substituted by the basic nursing course. These basic nurses will have an integrated training in curative and preventive skills, nursing and rehabilitation. After a period of several years service in the rural areas, new career structures give them the right to go on to more specialized training in curative, preventive, or nursing fields.

There are separate and defined career structures for midwives, basic pharmacy, x-ray, laboratory and dental personnel.

Thus, in comparison with the 12-20 doctors trained annually, literally hundreds of primary health workers and APEs are trained, all destined for the expanding rural health network.

Community involvement in health care

Since independence, there has been an emphasis on health as "... a combined effort on the part of the community" (Africa Report, 1978). This emphasis on drawing people in to take part in their own health care develops out of a broader political objective of encouraging the participation of people at all levels.

Walt (1980) sees the period of armed struggle in Mozambique as important for Frelimo in the formulation of these later principles. Through their struggle, Frelimo learned that only with the participation of ordinary people in the different spheres could any real advances be made. This ideology was obviously extended into the health sector, in which Walt (1980) sees participation as being "extensive and on-going".

Through the Frelimo Party structure, regular meetings are held between communitiies and health services. Health teams are expected to leave health centres and go into communities --villages or suburbs - to hear criticisms and problems, and exchange views.

People from the community are involved in the life of their local hospital or health centre. There are often collective work sessions in the gardens where community groups are joined by hospital staff in cleaning, planting and other necessary maintenance chores of the health facilities.

But the reality is a little more complex and sobering according to Sider (1984). He states that there is a contradiction between central health planning processes and local popular participation.

Although those health priorities that are identified are in the best interests of the vast majority of the people, they may not be congruent with people's felt needs. The main felt need is for curative health services, while the major priority is largely the improvement of preventive services. Thus the concept of community participation is problematic in this respect.

Amongst all the demands and tasks faced by health workers, communication with the community is often far down the list of their priorities, being sporadic at best.

Many criticisms that are raised in meetings with community members have to do with dissatisfaction over the type of treatment people receive from health workers. The positive results to be gained from public criticism occur only when a solid and active Party structure permeates the health unit, because this enables that criticism to be acted upon.

When, on the other hand, its members are weak, indifferent or prone to the very behaviour criticised by the people, the net effect is minimal. Thus popular criticism produces few visible results and people's willingness to be involved with, criticise and suggest improvements during these community meetings diminishes.

This dynamic is particularly severe when difficult economic conditions lead to conditions such as understaffing and drug shortages. This results in much public dissatisfaction with the health services and greater concern about more and more visible inequalities in access to and quality of treatment.

It also results in the overworked and under-supported health workers being prone to much less self-critical attitudes, poor morale, and at times desires to switch to more remunerative and less demanding work elsewhere, especially in the private sector.

In general, although there is a constant commitment to comunity participation, and given the limitations described above, a popular and representative voice in the organisation and functioning of the health services is still under-developed (Sider, 1984).

Opposition to change

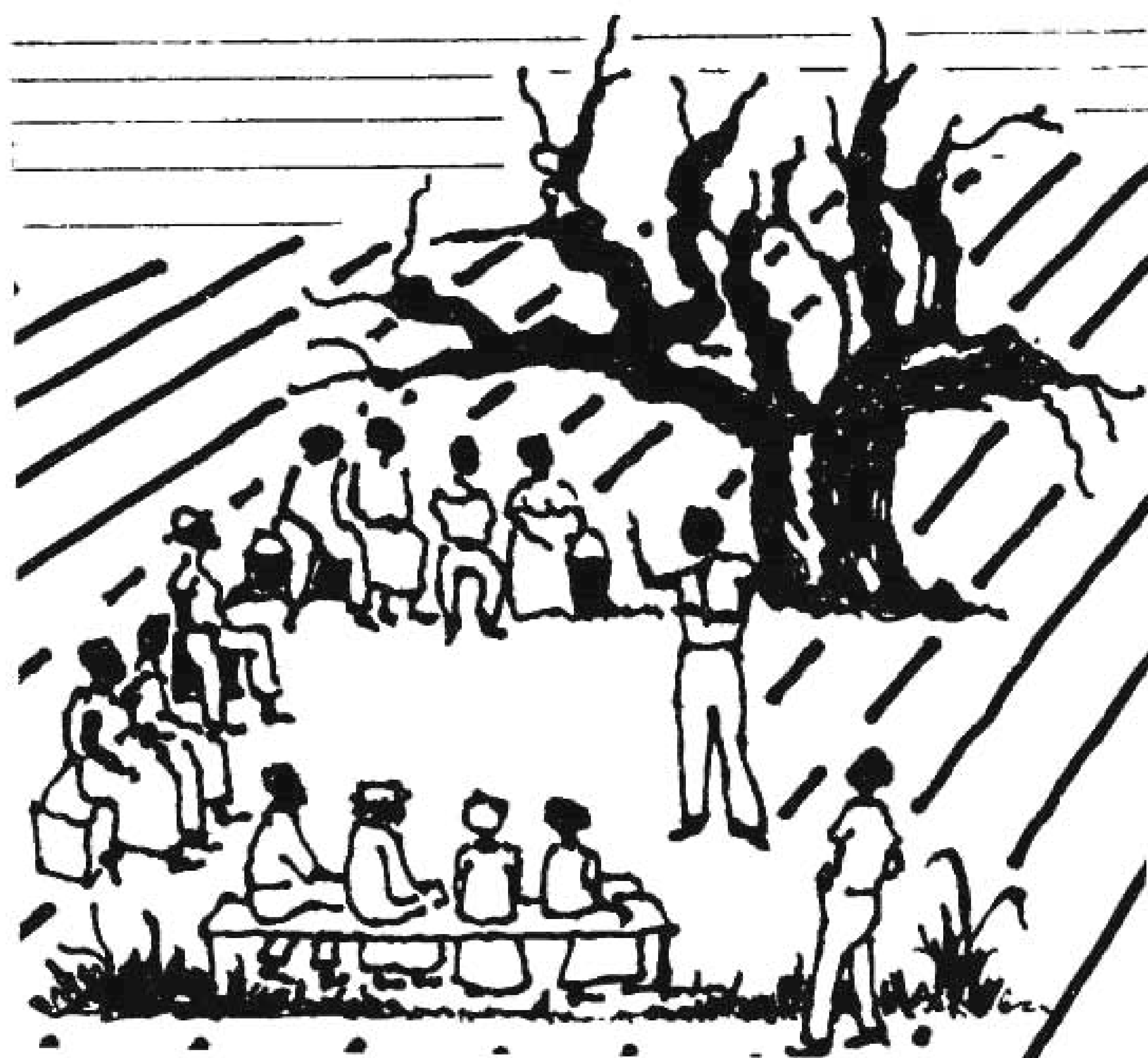
Opposition from the medical profession to progressive changes in a health care system can have serious repercussions on health plans and

programmes. In Mozambique, many doctors who were opposed to the new goverment demonstrated their opposition by leaving the country. Although this created tremendous problems in terms of staff shortages, in another sense it can be seen as a "cleansing process" (Gabriel and Stuart, 1976).

After independence, most of the 500 doctors left the country, leaving about 80 to cope with providing health care for approximately 12 million people (Walt, 1980). Many people with other technical skills also left. By May 1976, the number of doctors for the entire population had decreased to twenty (Gabriel and Stuart, 1978).

This situation was made even more difficult by the attitude of some of those who did remain : old patterns of behaviour such as racism continued.

There were serious deficiencies in the maintenance of medical standards, partly due to lack of staff, but also due to inflexibility of thought and political opposition to the new regime (Africa Report, 1978).



Mozambique has been inundated with expatriot doctors from around the world. Sider (1984) cites this as a problem :

"As a result of this 'cleansing process', Mozambique has become markedly dependent on an international polyglot of expatriate medical personnel, called cooperantes. While much useful interchange can be a positive result, the tremendous diversity in motivations, attitudes and technical and political practises of these cooperantes, makes it much more difficult to create a medical system with uniform training and practice.

"Many of the cooperantes are insensitive to the limitations, priorities, and conditions in Mozambique. Arrogance, racism, ill-treatment, incompetence are not just 'old patterns of behaviour', but are features of some of the cooperante health workers, especially doctors.

"Considering that there has been little real change in the position and power of doctors in the health system and the fact that health is such a visible and political interface between the goverment and the population, the political costs of such a dependency is worrisome."

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ASPECTS OF THE HEALTH CRISIS IN NAMIBIA

This article is based on portions of a Doctoral thesis, entitled "Aspects of Urban Change in Windhoek, Namibia, During the transition to Independence". Aspects of the health crisis in Namibia will be highlighted, with particular reference to Windhoek, due to the heavy concentration of health facilities and administrators in the urban areas. Therefore comprehensive research into central aspects of the crisis, such as the population's state of health in the rural areas, is limited to a brief overview.

INTRODUCTION

Namibian health services are in a state of crisis. Staff shortages - particularly in the rural areas - are chronic; health policies are inappropriate to local circumstances; and state - run services remain totally segregated. Political resistance to change (on a level paralelled only in education) stands out as the dominant feature and problem since 1977.

BACKGROUND

There has been no health legislation directed constructively towards socio-political change since the appointment of the first Administrator-General for the transition to independence in 1977.

The major changes relate to administrative reorganisation in terms of the three - tier government structure introduced in 1978 - 80. In practice, there has been little change other than ethnic fragmentation. By 1980/81, the differences in per capita health expenditure for each "ethnic" group had not altered, being R233.70 for whites, R56.84 for Kavangos, R37.06 for Caprivians, R24.85 for Ovambos, R15.02 for Damaras and R4.70 for "Basters".

Accurate information on the state of health and medical facilities in Namibia is almost unobtainable, because of the official blanket concealing all socio-economic data.

Official annual reports (South West Africa Administration 1977, 78 & 79 and SWA Administration for whites 1980) divulge virtually nothing of importance other than crude total occurrences of certain notifiable diseases. Semi - official sources (Africa Institute 1980) provide only crude national averages, which mask regional political and social inequalities.

Background data is therefore fragmentary. Interviews with Windhoek senior administrative and medical officials expose the levels of frustration at conditions in the health services resulting from political manipulation and the "new dispensation's" ethnic fragmentation.

ELEMENTS OF THE CRISIS

1) Physical facilities

Medical facilities are too large, prestigious and costly for the territory's population or resources, a problem exacerbated by racial duplication of facilities.

For example, plans for the Gobabis white hospital in Keetmanshoop cost R22.5m without the projected black and 'coloured' blocks. In 1980 - 81, the existing 34-bed white hospital had only 27.5% occupancy, while other population groups' beds were 37.14% full over the same period.

In view of their size, cost and segregation, the new white hospitals have been criticised as "politicians' prestige projects", inappropriate to local conditions.

Furthermore, health services are geared towards curative, not preventative medicine. Even rural clinics are inappropriate to the needs of the majority of Namibia's population because many people live up to 100km from the nearest clinic. Ambulances also remain segregated.

2) Long Term Staff Shortages:

In recent years, the staff shortage problem has worsened in the urban centres and especially in the rural areas due to poor salaries and the low standard of medical facilities.

Windhoek State hospitals and clinics are partly controlled by non - medical bureaucrats, such as the military, who also dominate services in the rural areas. In light of the ongoing liberation struggle fought by guerillas in the rural areas, who have the support of the rural population, the presence of the army - even in a civilain context - is regarded with distrust. Also, the dominant role of the SADF against the popular Namibian liberation movements cannot promote trust between rural patients and military personnel.

South Africa's presence in Namibia is regarded as illegal by the majority of the population, and therefore constitutes unwelcome interference in the internal affairs of another country.

Although there are no official records of diseases such as kwashiorkor, in the urban areas, malnutrition and child neglect is rife. This is a consequence of imbalanced diets and children having to fend for themselves in the absence of adequate creches and schools, while their parents seek employment.

Furthermore, the state hospital functions as a South African satellite training institution, because of an agreement with Stellenbosch University, under which additional medical staff and expertise from the university are employed in Windhoek.

All hospitals staff are segregated and there is a disparity between accommodation standards for the different population groups. For example, there is a severe shortage of nurses accommodation at the Katutura Hospital, but a surplus at the white state hospital.

3) The State of Health of the Population

The state of health of the population is linked directly to inequalities within the socio-economic context. These inequalities affecting the majority of the population are exposed through lower standards of housing, chronic accommodation shortages and overcrowding, inadequate sanitation and amenities, as well as poor and inappropriate health services.

Low incomes and rising unemployment also contribute to the crisis which has resulted in an epidemic of poverty-related diseases. Available mortaliy statistics reveal that TB, kwashiorkor and gastro-enteritis are major killers among the rural population, and the incidence of TB has risen annually.

People interested in knowing more about Namibia should look out for the following book

Namibia

reclaiming the people's health

The chapters following this introduction set the general scene. Chapter 2 looks at the situation in Namibia under South African occupation, providing a summary of the health statistics of the population and an overview of the health service structure which is likely to be inherited at independence. Chapter 3 then examines the role of women, their status in Namibia and their relation to the production of good health in the family as well as their predominance in the nursing services.

Chapter 4 then takes a broad look at the causes of ill-health in underdeveloped countries. It shows ill-health to be embedded in poverty, itself a product of colonial relations. Medical solutions are largely irrelevant. The emphasis is on the ability of communities to organise themselves, and relate to the formal health services through Community Health Workers, elected by and answerable to their community.

Chapter 5 considers the orientation of health workers, looking first at a range of other countries' experiences organising their health services after independence, and then asking what conclusions may be drawn about the nature of the services and the role of the professional health worker in them. Health workers' training is examined, including their political orientation and their relationship to the people they serve.

This is followed by a series of discussions of what a re-organised health service may need to consider, both the general principles involved in establishing primary care and preventive programmes, and specific experiences of such programmes in underdeveloped countries including Mozambique and Zimbabwe.

Chapter 7 concerns the health of urban residents and industrial workers, and the services available to them. These are discussed in the context of the needs of industrial management to have a healthy labour force – at least a healthy skilled labour force – as well as provide themselves with the best facilities available in western medicine. The chapter also considers how the activities of multinationals, including their exploitation of the uranium resources, affects the health of the population.

A further chapter follows, looking at medical and pharmaceutical supplies for the health services, and suggesting some areas where an incoming Namibian government might wish to focus attention. Chapter 9 then takes us back where this introduction began, with the telling of a simple story. It is one of a range of methods described for both health workers and community groups to use, in order to learn for themselves about the politics of health.

Edited by
Tim Lobstein
and
The Namibia Support Committee Health Collective

ENGLAND - THE NHS

"the National Health Service is a hotch potch of local and national interests, of old charity and modern welfare attitudes, of old professional habits and new patient's demands, all carried out without much overall knowledge of what is happening and why."

The National Health Service (NHS) employs over 1 million people and spends 12 billion pounds per annum. It is one of the cheapest (5% of gross national product, by comparison with 10% of GNP in the USA.) and the best medical service in the western world. Only 1/15 of people have private health insurance; the other 14/15 of people are completely reliant on the NHS. It provides UK citizens with the entire spectrum of medical care, from false teeth to heart transplants.

However, it provides these services in a way that discriminates against poor, working class, black and asian citizens. It is undemocratic, dominated by medical professionals and under the general influence of a high-tech, private profit ethos.

Over the past 20 years it has also been under attack from governments which have tried to curb its growth and cost, without any coherent attempt to equalise its coverage, set appropriate goals, make it democratic or reduce its dependance on private enterprise.

A QUICK HISTORY OF HEALTH AND MEDICAL SERVICES.

Between the 17th and 18th centuries, Britain changed from an agricultural economy to an industrial and trading empire. Vast numbers of people moved from the land to the mines, cities and facto-

ries. As the working class grew larger, it became politically organised. The Trades Unions and later the Labour Party, its parliamentary arm emerged. With increasing strength it won improvements in living conditions and health improved as a result.

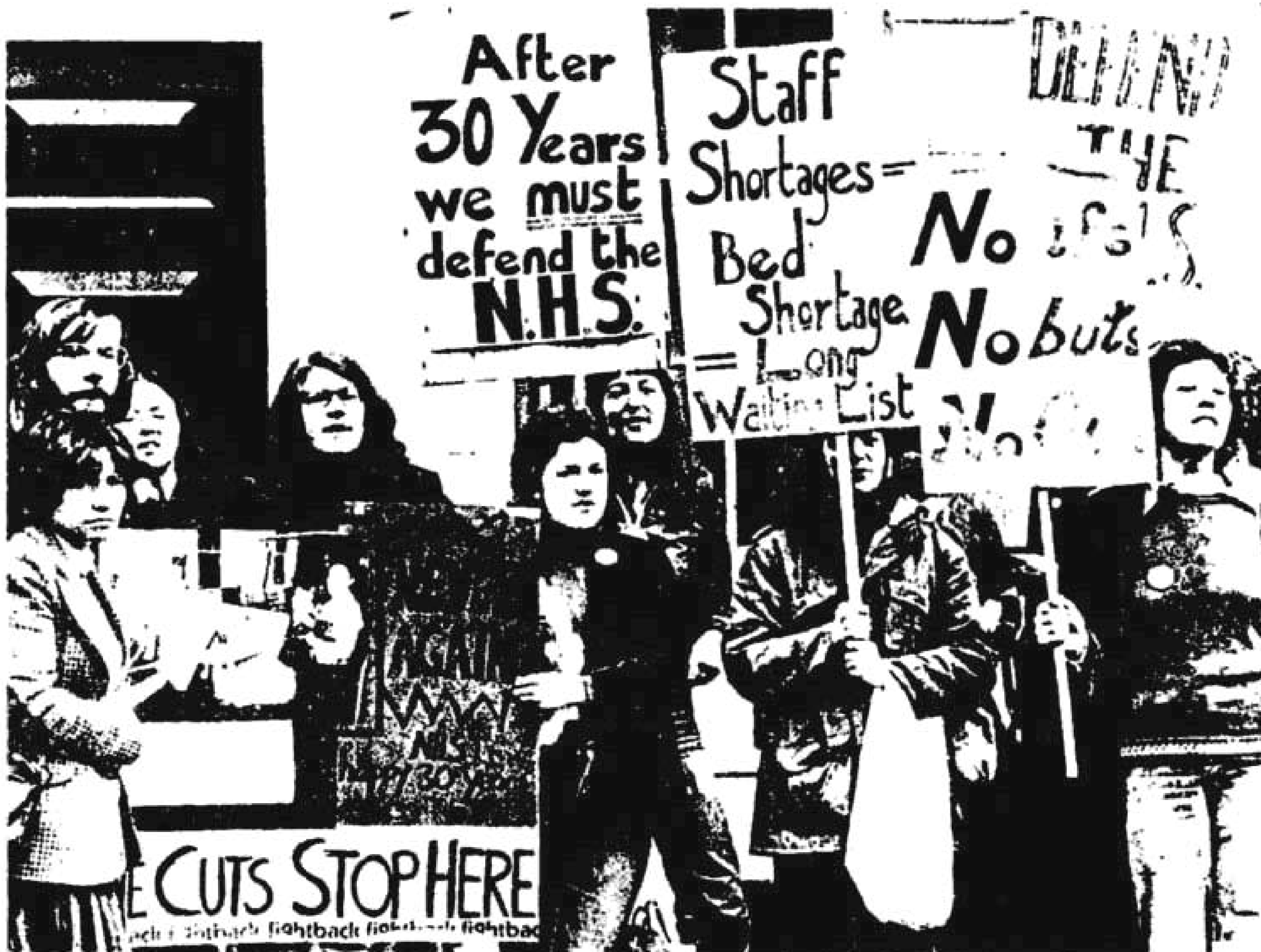
Britain was affected by several epidemics of plague and cholera, as well as endemic diseases such as scarlet fever, whooping cough, pneumonia and gastro-enteritis in children. Tuberculosis was the commonest killer of adults. All of these diseases hit the working class hardest, and the earliest interventions by the state in medical care and public health were aimed at preserving the rich from the diseases of the poor. Medical science had little to offer, and the early efforts were all sanitary. Improved water and sanitation together with rising wages, improved the health of the population substantially.

Between 1850 and 1911, medical understanding developed and with some delay was translated into medical services. The local authorities introduced a maternity and child welfare service with immunisation against several diseases like diptheria, and hospital or isolation facilities for venereal diseases, scarlet fever, smallpox and TB. Many of these advances were introduced under pressure from the Trades Union Council and organised womens' groups.

The state did not provide curative medical care, other than to declared paupers who subjected themselves to the humiliation of the Poor Law work-houses. This was the period during which the medical profession developed and organised itself into the British Medical Association. Its' higher status members, often specialists who developed their skills free consultants at the growing "charity" hospitals, saw to the needs of the rich , while the lower status general practitioner sold their services to anyone who could afford it.

Many working class people could not afford these services and under pressure from this group the state introduced the 1911 National Health Insurance Act. This used tax payers money to pay GP's to take care of workers who contributed to the fund. Although it did not cover the unemployed, the families of the workers or the lower middle class, it was a step forward, in that the insured had access to medical care when they neededit.

In many ways it was the rehearsal for the NHS, which was to be established after the second world war.Like the NHS it was established under pressure for reform and improved living conditions of the population. Like the NHS, it did not challenge the power or control that the medical profession had over the nature of medical care, and like the NHS, it did not come under control of the people it served. It was under control of the state and private enterprise in the form of the insurance companies, and to a lesser extent under the control of the medical profession.



During and after the First World War there were some serious conflicts between the working class and the poor on the one hand and the state and private enterprise on the other. With the Great Depression barely over, and the Second World War begun, it was clear to the government of the time that the population would not be wholeheartedly committed to fighting the war, unless they knew that life would improve substantially for them afterwards. In 1942 the Beveridge plan for a social welfare system for Britain was presented. It was based on a belief that every citizen has the right to a humane standard of living, which included free education, access to health care, housing and a source of income if there were no jobs. The National Health Service established in 1948,was described as the "the jewel in the crown" of the Labour Party government which took power after the war.

NHS Anatomy For Beginners.

The NHS provides medical services, and co-operates closely with local authorities in providing social welfare services. Broadly speaking, it has two parts; the hospital service and the community service.

The community service consists of general practitioners, dentists, pharmacists, optometrists and local authority services such as community nurses, child welfare clinics, a school health service, home domestic help services, social workers etc.

The GP's, pharmacists and optometrists are self employed and are not under the direction of the NHS. If the NHS wants them to do anything, it negotiates with the professional body concerned, offering inducements which are usually financial. It cannot simply issue instructions.

GP's do not charge a fee for their services, but are paid a fee by the state through their professional body according to the number of patients they have on their lists as well as for other services they provide.

Pharmacists, dentists and optometrists are paid by the state for certain services, but the patient is responsible for others. For example, optometrists test eyes at no charge to the patient, but there is a charge for spectacles, unless the patient is a pensioner, a child or very poor. The same applies to dentistry and pharmacists. Local authority services (equivalent to our municipal services) are free.

A hospital visit is free to the patient, and is paid directly out of taxes. There are about 400000 nurses who are salaried NHS staff, and 40000 doctors of whom about 1/4are qualified specialists or consultants. Several thousand of the consultants are part-time NHS staff, and are entitled to earn a portion of their income treating private patients. This is often in NHS hospitals, using NHS equipment and nurses, for the patients pay. This concession was the price the NHS paid in 1948 to win the consultants' support for the NHS.

The house officers and registrars are full time, salaried NHS staff.

This would seem to be an ideal system, however the NHS has been criticised from all sides. What follows is an analysis of some of the problems with the NHS.

SOME CRITICISMS OF THE NHS.

Patients' experience of the NHS.

These are likely but hypothetical scenarios.

Mrs. D,71, pensioner, widow of a bus driver needs a hip replacement because of severe arthritis. She

can't have one because she doesn't rank anywhere on the 7 year long waiting list in her Manchester District hospital, for this operation.

MED A 9

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by the Registration of Births, Deaths and Marriages Regulations 1968)

Registrar to enter No. of Death Entry ....

MEDICAL CERTIFICATE OF CAUSE OF DEATH

For use only by a Registered Medical Practitioner WHO HAS BEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths

Name of deceased NATIONAL HEALTH SERVICE

Date of death as stated to me 6 day of JUNE 1983 Age as stated to me 35

Place of death UNITED KINGDOM

Last seen alive by me 26 day of JULY 1948

1 The certified cause of death takes account of information obtained from post-mortem.
(2) Information from post-mortem may be available later.
3 Post-mortem not being held.

a Seen after death by me.
b Seen after death by another medical practitioner but not by me.
(c) Not seen after death by a medical practitioner.

CAUSE OF DEATH

I
Disease or condition directly leading to death† (a) CONSERVATIVE GOVERNMENT
due to (or as a consequence of)
Antecedent causes. Morbid conditions, if any, giving rise to the above cause stating the underlying condition last. (b) A THOUSAND CUTS
due to (or as a consequence of)
(c) MONETARISM

II
Other significant conditions, contributing to the death, but not related to the disease or condition causing it. RACISM & SEXISM
MEDICAL DOMINANCE

These particulars not to be entered in death register. Approximate interval between onset and death

I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature POLITICS OF HEALTH GROUP Qualifications as registered by Medical Council NONE

Residence c/o BSSRS, 9 POLAND ST, LONDON W1 Date 12 & 13 NOV 1983

*Please ring appropriate digit and letter.
†This does not mean the mode of dying, such as heart failure, asphyxia, asthenia, etc.: it means the disease, injury, or complication which caused death.

SEE BACK

Mr George P, 71, a retired banker, also needs a hip replacement for severe arthritis. He can have it done because he can afford private health insurance. It will be done by the same surgeon who would have operated on Mrs D had she have been on the hospital list.

Annie A is 19, unemployed and has one child which she did not want. In her area, the senior gynaecologist feels that working class women like herself are to blame if they don't understand their contraceptive well enough to prevent pregnancy. His department put very little money or staff into the abortion service therefor the waiting list was too long and Annie was not a priority on that list. She could not afford a private abortion and so she quietly becomes depressed in her flat on the 19th floor of a tower block in a bleak housing estate. When she sees her overworked GP, he prescribes tranquillisers.

William B was a 50 year old stevedore who died of cancer of the lung. He was a smoker, but his GP was too busy and never saw it as his job to motivate Mr B to stop smoking.Who is to blame? Mr B? His GP? The government which spent 1 million pounds a year on health education and let the cigarette company spend 80 million pounds on advertising ? Perhaps it was due to the asbestos he used to off-load at the docks.

If any of these people, rich or poor, was hit by a bus and needed emergency care, they would be assured of the best the NHS could offer. This is also true for people who have interesting diseases, as the academics in the hospitals would like to treat them.

In fact we find that the the NHS has inequalities in it that favour the rich, the services are inadequate, it is undemocratic and private health care is undermining the NHS.

Inequalities in the NHS.

There are about 25000 GP's in Britain and they are not evenly distributed to serve the entire population. As with all the services, the maldistribution is to the advantage of the middle and upper classes.

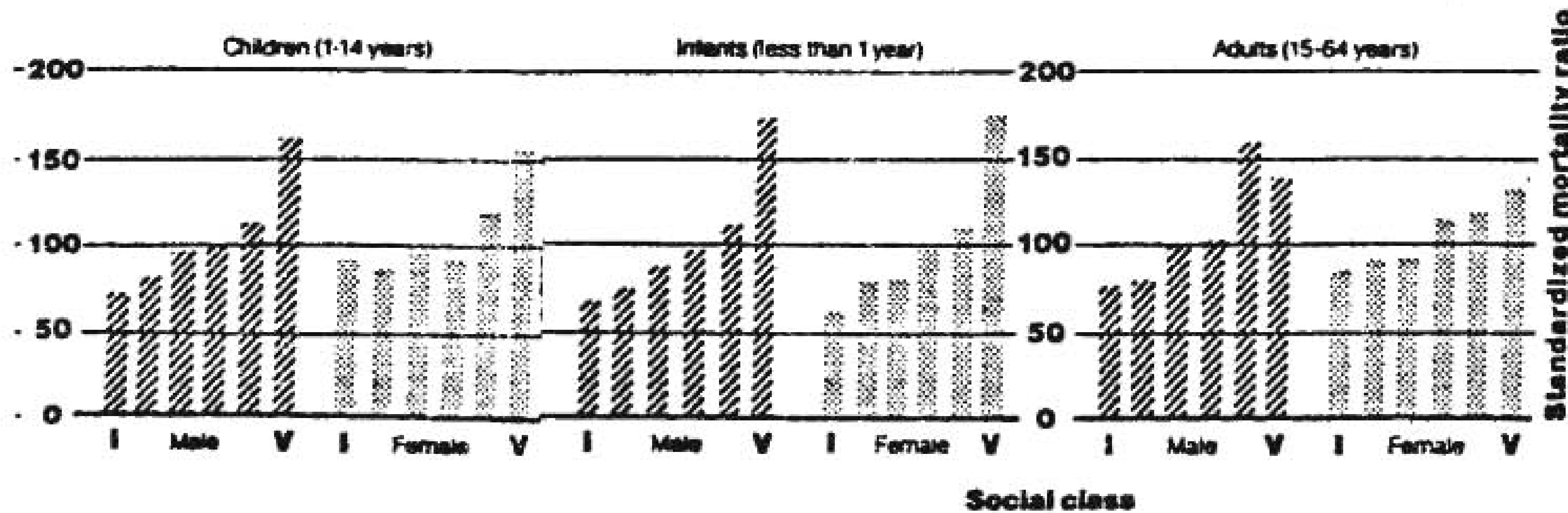
> In areas with most sickness and death, general practitioners have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation, than in the healthiest areas; and hospital doctors shoulder heavier case loads with less staff and equipment, more obsolete buildings, and suffer recurrent crises in the availability of beds and replacement staff. These trends can be summed up as the Inverse Care Law: that the availability of good medical care tends to vary inversely with the need of the population served.
>
> J Tudor-Hart, Lancet 27.2.71.

Over the last 100 years the mortality rates for all age groups up to 55 have fallen by 90% with a substantial increase in life expectancy. This improvement has not been equal for all regions, race groups or classes. It has almost always improved less for the working class, the poor and the ethnic minorities.

> If you are an unskilled,low paid, manual worker (social class 5) - you are two and a half times more likely to die before you retire than if you are in the the professional and high income bracket (social class 1). The class inequalities in health have not been erased by thirty years of the NHS.

NHS-Condition Critical; Cis report no. 26

Below are some graphs which show that no matter your age if your are in a lower social class you are more likely to die younger.



Mortality by occupational class and age. Relative mortality (%) is the ratio of rates for the occupational class to the rate for all males (or females). (Source: Occupational Mortality 1970–72, *HMSO, 1978, p. 196)*

<u>Policies are inappropriate to the health needs of the people.</u>

There is no national process of setting goals for health services, allocating resources in order of priority, evaluating the result and making required modifications.

Instead the goals and functions of the NHS are influenced to different degrees by several distinct interest groups. These are; the medical profession, the state, private enterprise, private doctors and the people themselves.

<u>The medical profession.</u>

The medical profession has as its' goal the self interested development of the profession as a whole, in terms of skills, power and wealth. This is not surprising, since that is the goal of every organised group of workers. However it becomes pro-

blematic if the group concerned is the most most powerful determinant in setting national priorities, in this case health services.

The leading figures of the profession see its aim as the understanding and treatment of diseases, particularly interesting (rare) diseases by interesting (expensive, high technology) methods. Under the approving eye of private enterprise, and with the co-operation of the state, it has been the medical profession which has exerted most influence on spending and priorities in the NHS.

The State.

Contrary to popular belief Britain has low levels of social expenditure relative to other European countries. In 1977 Britain spent 123 pounds per person on health care, in France the annual expenditure per person was 280 pounds and in Sweden it was 450 pounds. (Black report HMSO 1980) This spending is being cut further in order to reduce taxation on the rich. It is argued that this will stimulate the private sector. Thus the economy is being managed in favour of big business.

State policy is thus to cut NHS costs in any way possible. This will obviously affect those sectors least able to resist; for eg. care for the aged and chronically ill, mental health services and small non teaching hospitals. Indeed it is just these kind of services that have been closed already.

Private Enterprise.

The goal of private enterprise is profit, achieved by selling more drugs and equipment and preferably more expensive drugs and equipment, irrespective of effectiveness and efficiency, to anyone who can be persuaded to buy them. In Britain this is the state, under direction of the medical profession, who are in turn under the influence of the companies selling the drugs and equipment in the first place.

Buying drugs accounts for 10% of NHS expenditure. It has been estimated that the drug companies alone make 300 million pounds profit from the NHS per year, and that 170 million pounds of this could be saved if the the NHS introduced generic (non brand name) prescribing. Instead the Department of Health and Social Security enter into secret negotiations with drug companies.

Private medical care.

The usual argument is that by permitting some private practise draws additional resources into the health sector for those who can afford private health insurance.

There are 3 problems with this argument. Firstly paying beds (private patients paying for beds in the NHS hospitals) are still subsidised by taxes. Furthermore nurses and doctors trained in the NHS work in the private sector yet the private sector does not carry any of the cost of training these personnel.

Secondly private medicine results in queue jumping which means that non private patients experience even further delays.

Thirdly and perhaps the most important consequence of the existence of private medicine is its indirect effect on policy making. As long as most politicians, medical professors and other influential members of society receive their health care from the private sector they will be unaware of the true conditions of the NHS and unmotivated to demand improvements in it.

The people.

The people are the least influential in influencing health in the disorganised state they are now in. Obviously there are many different interest groups and they have never spoken with one voice. Nevertheless, it was pressure from the people which

It's a RIP OFF

Did you know doctors who have private patients can make use of NHS facilities at cut-price rates?

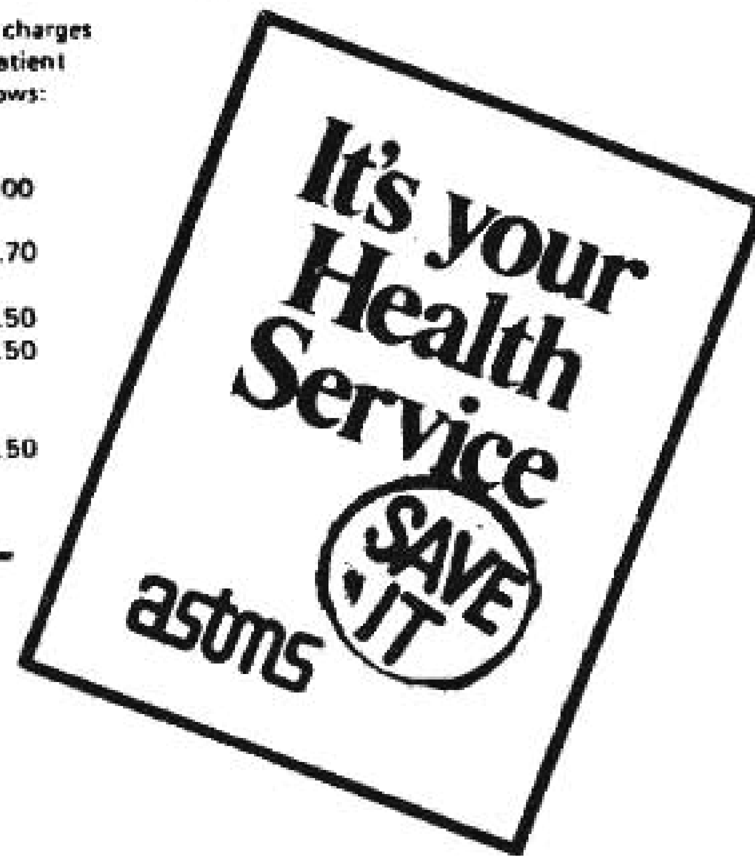
Just look at the charges for a residential private patient who could have paid to jump the queue. In a general hospital in a non-teaching district the charge is £91 a day It may seem a lot for food and accommodation but not when you consider it is meant to cover the salaries of NHS staff looking after the patient, all treatment and any operating theatre costs.

Even in an NHS exclusive hospital - a London Postgraduate Teaching hospital - the charge is only £135 per day

The daily charge is not adjusted to meet the full cost of the patient's treatment. **The balance is met by the tax-payer - most of whom cannot afford private medicine.**

Doctors treating non resident private patients get an even better deal. The charges vary according to what type of hospital provides the service. If a private patient goes to a general hospital in a non-teaching district, the charges are as follows:

Pathology: (Blood samples) - any number of tests on a single specimen	£5.00
Barium Meal: (for tracing stomach ailments)	£17.70
Radiotherapy: superficial treatment in any one day	£5.50
other treatment in any one day	£11.50
Physiotherapy and Remedial Gymnastics: for single treatment in any one day	£3.50



resulted in the formation of the NHS in the first place. It will have to be the same force which restores the NHS to its original principles of improved and equal health care for all.

The NHS needs more funding, control must be democratic with the people who use the service having control over it. The role of private medicine needs to be re-evaluated. At the same time however the re-orientation of the NHS from a mainly curative to a mainly preventative service needs to occur.

APPROACHES TO HEALTH CARE; CUBA AND CHINA

Political comparison of China's and Cuba's health care systems

Note: This comparison reflects China's health care system up until recently. Since Mao's death, the pendulum has rapidly been swinging back toward greater professionalisation and Westernisation.

CHINA.

Decentralised approach, health care is everyone's right and also everyone's responsibility. Begins from a solid base in the community and builds on pre-existing community strengths.

Barefoot doctors are the keystone of the health system, especially in rural areas. They are;
- -selected by the local community
- -accountable to the community
- -given ample medical responsibilities.

Decreased professionalisation of medicine, conventional doctors

CUBA

Centralised approach, health care is everyone's right and the state's responsibility. Begins by nationalising all medical facilities, merging big hospitals and extending professional outreach.

Doctors are the keystone of the health system, including rural areas. They are;
- -selected by the state
- -maintained by the state
- -accountable primarily to the state
- -give almost no medical responsibility to community workers.

Increased professionalisation of medicine, doctors given great

seen as members of a small, powerful elitist monopoly and an obstacle to appropriate low-cost health care that must be surmounted.

Medical schools closed down after the revolution to put full resources into training of community workers.

Traditional forms of healing valued and integrated with modern medicine. Flexible divisions of medical hierarchy; health workers who do well can readily advance to become doctors.

Self-reliance at local level encouraged, all doctors rotate to rural areas where their primary responsibility is to teach and back up local workers.

Many medicines produced locally in small cottage industry.

Medical services largely financed by local communities.

prestige, special privileges, exclusive right to make medical decisions, and power to run and plan even non-medical aspects of the health system.

Medical schools expanded after the revolution to speed up production of doctors.

Traditional forms of healing disparaged and displaced by modern medicine. Rigid divisions of medical hierarchy; lower level health workers must start over again to become doctors.

Self-reliance at local level discouraged, dependence on central system encouraged, all doctors do three years rural service. Their primary responsibility is to provide medical services.

Many medicines produced in the country, in big centralised factories.

Medical services completely financed by the state.

Result: western medical science and traditional Chinese medicine radically transformed and grafted together.

Political decision making: major policy decision centrally and undemocratically made. At times coercively implemented.

Result: conventional western medical system intensified and reformed - not transformed or joined with traditional medicine.

Political decision making: major policy decisions centrally and undemocratically made. At times coercively implemented.

David Werner. From Health care in Cuba today - a model service of a means of social control or both.

INTERESTED IN RURAL HEALTH CARE?

The **Health Services Development Unit (HSDU)** at Tintswalo Hospital (near Acornhoek in the Eastern Transvaal) is involved in the following programmes:

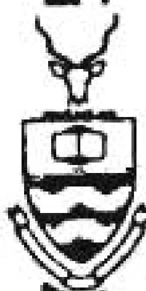
- Training Primary Health Care Nurses.
- Writing Student and Teaching Guides for PHCN training.
- Continuing Education and Support for PHCN Graduates.
- A Clinic Service Development Programme.
- Health Work with a Village Womens Group.

We have four posts that we wish to fill in 1985. Two of these will be filled by doctors. The other two are open to any health workers, including doctors.

Successful candidates will have some of the following qualities:

- Some clinical experience.
- Knowledge of the disease pattern in rural areas.
- An understanding of the social and economic causes of disease in rural areas.
- A commitment to providing good health care in rural areas.
- Some skill in adult education.

The posts are vacant from the beginning of January 1985, but can be held open for successful applicants who need to start later.



The posts will be contract posts within the Department of Community Health at Wits Medical School. Salaries will be negotiable depending on qualifications and experience.

For further information contact Cedric de Beer at (011) 647-2269 or Professor John Gear at 647-2551 or 647-2051.

Submit applications with a curriculum vitae and names and addresses of two referees Professor John Gear, Department of Community Health, Medical School, York Road, Parktown 2193.

PERSONA 303010

Occupational Health a priority in Mozambique

INTERVIEW WITH DOUG SIDER, A CANADIAN DOCTOR WHO SPENT FOUR YEARS WORKING IN MOZAMBIQUE. ONE OF HIS RESPONSIBILITIES WAS TO HELP SET UP AN OCCUPATIONAL HEALTH SERVICE IN THE AREA WHERE HE WORKED.

CH : Why is Mozambique setting up occupational health services?

DS : In the colonial period very little existed in terms of occupational health and safety for workers. Workers would lose their jobs if found to have any health problem. Factories were never designed with a view to the promotion of occupational health and safety.

When the working class came to power in Mozambique, the state began to identify occupational health and safety as an important issue, and is now beginning to tackle it.

CH : How is Mozambique tackling this issue?

DS : Since 1981, occupational health was identified as one of five or six priority areas for the health system. Infrastructure was created to enable the training of "safety monitors".

These "safety monitors" are factory workers who undergo a 45-day training course in health and safety. The course covers general health hazards such as noise, dust, chemicals and heat, as well as what should be done to decrease exposure to these factors.

In Mozambique there is often a shortage of resources. However, these shortages affect

all activities. Health and safety promotion, for example, is not affected more severely by a lack of resources than any other programme.

This is different from the case in South Africa, where health and safety may lack resources more than many other parts of the health service.

CH : Mozambique has a predominantly agricultural economy. Does this influence the occupational health and safety policies of the goverment?

DS : You are correct in saying that the economy is predominantly agricultural. The health hazards present in the agricultural system have thus also been identified as important. The problem of pesticide use, for example, has received much attention.

CH : What is the size of the industrial workforce?

DS : There are approximately 80 000 industrial workers. Industry is located mainly in Maputo, Beira, and Namphulo. The main aspects of this sector are petroleum refining, cement and textile manufacturing, and mining.

Although the industrial sector is relatively small, it is an important earner of foreign exchange and thus receives a lot of attention.

CH : Do you think that the health and safety of workers is well protected at present?

DS : The answer to that is probably "no". There are still many problems in the working environment, ranging from heat, noise, dust and chemicals, to poor nutrition and infectious diseases.

There are a number of reasons for this. Firstly, the factories were never designed

with occupational health and safety in mind.

Secondly, the poor economic position of Mozambique leads to a shortage of spare parts and the poor maintenance of machines.

Furthermore, since independence, many people with skills left the country which made the situation worse.

There is also a shortage of protective clothing such as work-clothes, boots, respirators and ear-muffs. At present the International Labour Organisation is providing some resources to rectify this.

One further problem is that Mozambique does not have the economic strength or flexibility to introduce expensive measures to improve health and safety or to substitute cheap but harmful substances with safer, but more expensive ones.

CH : What occupational health services exist at present?

DS : There is a health post or health centre in most factories. This is usually staffed by a nurse who is employed by the state health service. This health post usually deals with accidents, first aid, skin infections, gastrointestinal problems, and other common illnesses.

The health worker works with the safety monitor. The safety monitor is a worker selected from the factory and trained.

The safety monitors should also be involved in activities such as accident prevention and the control of endemic diseases in the workplace. These, however, are often neglected.

CH : What exactly were you doing in terms of health and safety?

DS : I spent approximately one and a half days per week working with my comrades to set up occupational health services. We worked mainly on setting up training courses forthe safety monitors. We helped establish pre-employment examinations for workers in industry and helped set up lung function monitoring for workers in the textile mills.

We developed mechanisms for the control of diseases such as leprosy and tuberculosis in workers. We did some research on accidents and helped to identify which workers were most affected, which shifts they worked, etc. We also spent some time looking at the particular needs of women workers, especially those in the textile and cashew nut industries.

CH : Who runs the courses for the safety monitors?

DS : There is joint responsibility for this

project. The trade unions and the Department of Health control the courses, but other groups such as the Department of Labour, the State Insurance Agency and the Red Cross also participate in them.

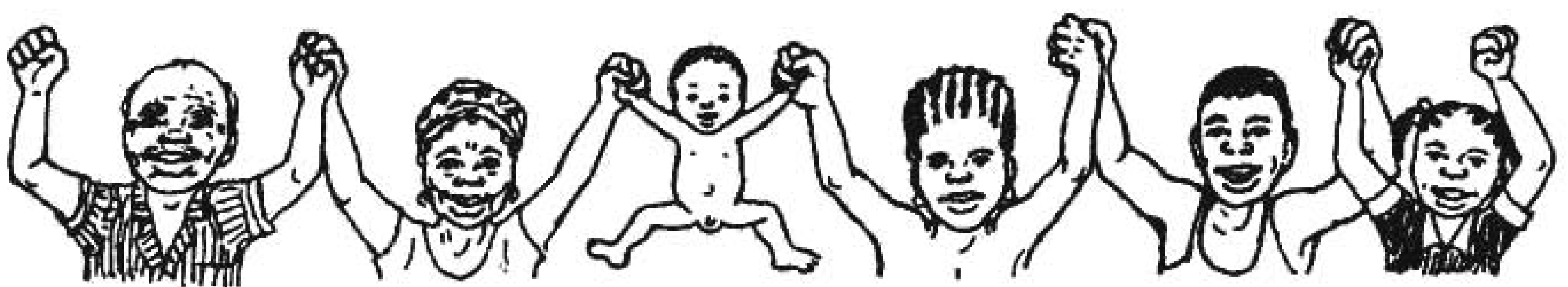
CH : In South Africa, workers and trade unions are taking up health and safety issues as workers learn more about the effects of poor working conditions on health. What is the situation in Mozambique?

DS : In Mozambique the situation is quite different. There is little technical training of workers, and little ability to identify health and safety problems.

However, there is clear recognition by the state that workers suffer from poor working conditions.

The direction of impetus is therefore different - in South Africa workers are exerting pressure to improve health and safety in the workplace while in Mozambique the state is trying to establish structures to achieve this and is attempting to train personnel to fulfil various functions in order to meet this end.

Complex questions may arise in the future, where workers may begin to identify hazards which managements or the state will be unable to remove because of the economic problems in Mozambique. How this will be resolved remains to be seen.



THE KEY TO HEALTH LIES IN THE PEOPLE THEMSELVES.

BOOK REVIEW

THE POLITICS OF GENOCIDE, by Cedric De Beer.

Reviewed by Jacky Cock.

This book makes a valuable contribution toward exposing the relationship between social injustice and ill health in South Africa. The author demonstrates a conceptual clarity, a sophisticated grasp of historical processes, and a meticulous use of evidence. These qualities linked to an extremely lucid style, make for compelling reading.

The book revolves around two central propositions: the first is that neither disease patterns nor health care services can be divorced from the social matrix in which they are embedded. This proposition underpins the validity of a social analysis of health.

The second proposition, which follows the first, is that the distribution of disease and the way with which it is dealt, reflects the major lines of division and inequality in society. The relation between inequality and health is dramatically evident in South Africa.

The book demonstrates the validity of these two propositions through five case studies.

Chapter One provides a social history of tuberculosis, with which at least ten million South Africans are infected. In tracing the arrival, spread and distribution of this disease, De Beer shows a close connection between economic and political factors and the development of TB as a major problem. He demonstrates that it is not just the presence of the TB bacillus which has caused the current epidemic:

" The conditions for this epidemic were created by the massive social upheavals which resulted from the development of large-scale industry, beginning with the mines. These changes were accompanied by the development of the migrant labour system, the creation of the bantustans, and the destruction of the rural subsistence economy."

De Beer shows how that the spread of the disease is not random and haphazard, but affects the poor, the underfed, those who live in overcrowded conditions and work at hard jobs. These are the people who hold the lowest positions in the economy and do not have the political power to improve their situation.

The author points out that medical science by itself is unable to control the epidemic. Its cure requires the eradication of poverty, unemployment and social misery.

The limitations of medical solutions to health problems is one of the themes of De Beer's second case study, the Gluckman Commission of 1942 - 1944.

He shows that the Commission was noteworthy in three respects: Firstly, it reported that throughout the country there was an unacceptable level of disease which could be attributed to social and economic conditions.

Secondly, it strongly criticised the health services of the day as inadequate, unco-ordinated and misdirected.

Thirdly, it produced a detailed blueprint for a National Health Service which might have made free health care available to all South Africans and which emphasised preventing sickness as well as curing it.

De Beer demonstrates convincingly why none of the Commission's major recommendations were implemented.

He argues that the Gluckman Commission was one of a number of commissions which represented the reformist response to the social tensions of the 1940's.

Before 1948, capital and the state proposed attempting to contain these tensions through reform aimed at undermining the growing militancy of the urban proletariat. Improvements in medical services was only one way in which it was hoped to stabilise and control the working class.

However, the Nationalist party which came to power in 1948 was unwilling to engage in the massive mobilization of resources that would have been necessary in order to implement the Commission's proposals. This unwillingness came out of the nature of the South African state, based as it was (and still is) on economic exploitation and racial oppression.

After 1948 stability was maintained through increasing political repression and a tightening of the system of labour control. This involved an increasing division between african 'insiders', living in 'white' urban areas, and those 'outsiders' restricted to the teeming rural slums termed the bantustans.

Focusing first on the health of black urban workers, De Beer shows how dangerous it is to be born into the black working class.

He documents the health hazards involved in work both through accidents and disease resulting from exposure to dust, noise and harmful substances in the workplace.

In the communities to which workers return, **"life is dangerous and often short"**. For example in Cape Town in 1981, the infant mortality rate for whites was 9,4 deaths for every thousand live births, and for africans 34,6 per thousand.

While such racial differences in infant mortality rates indicate how the burden of ill health falls on the black working class, health services for blacks are totally inadequate. This inadequacy has not been remedied by the 1977 Health Act and subsequent Health Plan, because the state (as in 1944) has not redirected resources on the scale required. For instance, the 2% of the health budget spent on preventive health programs in 1977 had only risen to slightly more than 3% by 1982.

Tighter state control has cemented divisions among the african working class. The constraints trapping people in the homelands has been termed a policy of genocide. De Beer approaches this allegation cautiously.

> **"Genocide is a strong word. It usually describes an attempt to destroy a large community of people, usually of one racial or religious group. No one is driving around the bantustans machine-gunning people, or forcing them into gas chambers. The accuracy of the word depends, then, on being able to show that conditions in the bantustans are such that forcing people to live there is, in fact, sentencing a large number of them to death by illness and starvation."**

This is precisely what De Beer demonstrates with a disciplined avoidance of empty rhetoric, linked to a sensitivity to human experience that makes moving reading.

The reality is that the 54% of the african

population living in the bantustans do not have access to means of decent survival, either through farming or jobs. The outcome is that hunger is widespread with as many as 50,000 children dying every year as a result of getting too little to eat. Among the survivors, malnutrition often stunts physical and intellectual development so that a vicious circle of deprivations across generations is put into operation.

The lack of significant agricultural or industrial resources in the bantustans behind such deprivation means that the prospects of a sound health care system are remote.

For instance, the entire KwaZulu health budget in 1982 was about R60 million, which is equivalent to the operating costs at the whites-only Johannesburg hospital.

If money is in short supply, so too are doctors and medical expertise. Only 3% of practising doctors are in the bantustans. Lebowa has one doctor for every 20,000 to 30,000 residents, compared to one doctor for every 875 white South Africans. Those hospitals that do exist are short-staffed and overcrowded.

Apartheid allows people to describe South Africa's health services as good, while acknowledging the total breakdown in health services in the bantustans, because they are not viewed as part of South Africa.

DON'T KEEP IT TO YOURSELF –

PASS IT ON !

INFORMATION IS POWER

De Beer concludes:

> **"Over two decades more than a million people, some at gunpoint, have been moved into the bantustans where there is little food and few jobs. Family members are separated by influx control and migrant labour, and the social disruption this causes contributes to illness and death. Full statistics are not available, but thousands of people die each year as a direct result of these conditions. The inadequate health services can do very little to alleviate this sickness, suffering and death. Genocide is perhaps an appropriate word to describe these conditions."**

In his final section De Beer argues persuasively for extending the strictly scientific, medical framework within which health issues are commonly viewed. This framework individualises health issues and results in a "victim-blaming" mode of thought.

> **"If people get cholera it is because they do not use 'safe chlorinated water'. If children are malnourished it is beause their parents don't feed them properly."**

The reality is that people are **"condemned by political and economic factors to live in areas where healthy living is impossible"**.

In such areas the community medicine approach to health care is inadequate because it is structured on the assumption that **"the poor must be taught to deal with the problems caused by their poverty"**, and **"ignores the truth that poverty is itself a symptom of a history of dispossession, exploitation and oppression"**. These conditions are **"as important as germs in causing disease and social justice is as powerful a medicine as any drug"**.

De Beer suggests that health professionals are in a unique position to expose the link between disease and politics and contribute to a process of change.

While the thrust of the book is to dissolve the artificial separation between health and politics, De Beer concludes by emphasising the link between the attainment of health and the building of a democratic society. He ends:

> **"As disease is of social origin, it can only be conquered when no section of the society is able to seek wealth, power or status at the expense of any other section. There is no more expressive and powerful demand than that health should be regarded as a fundamental political right."**

The final quote indicates something of the nature and scale of the issues De Beer confronts in this book.

For this reason, while it should be of special interest to health workers, his study has a much wider importance.

This study is not simply an exposure of the devastating human consequences of the extreme inequalities in our society, but penetrates behind the level of appearance and 'common - sense' assumptions to identify the structures and processes which generate these inequalities. At this level it is one of the most important explanations of the nature of South African society to appear in recent years.

Health Care Trust

41 Scott Road
Observatory 7925
Phone: (021) 47-2846

28 August 1984

COMMUNITY HEALTH WORKER

The HEALTH CARE TRUST, a resource organisation, would like to appoint a Community Health Worker to co-ordinate its COMMUNITY HEALTH PROJECT.

The job entails:

(a) Working with Community Organisations on health-related issues

(b) Development of Educational Materials and organisation of a Resource Centre

(c) Relevant Research on current community and health issues

(d) Health Education.

Applicants should apply in writing, giving details of their background and experience. Include Tel. No.

Possession of a driver's licence is preferable.

Applications should reach us by the end of September 1984. and should be addressed to:

Health Care Trust
41 Scott Road
OBSERVATORY, Cape
7925

CRITICAL HEALTH

PO BOX 16250 DOORNFONTEIN 2028

ADMINISTRATOR AND MANAGING EDITOR

HALF DAY JOB

R450 PER MONTH (BENEFITS INCLUDED)

JOB DESCRIPTION

* EDITING
* SOLICITING MATERIAL FOR PUBLICATION
* DISTRIBUTION
* ADMINISTRATION
* CORRESPONDENCE
* FUND-RAISING

THE PERSON EMPLOYED WILL WORK WITH AN EDITORIAL COLLECTIVE AND DECISIONS ON CONTENT, DIRECTION OF CRITICAL HEALTH, ETC. WILL BE MADE COLLECTIVELY.

SKILLS REQUIRED

* ADMINISTRATION
* WRITING AND LAYOUT
* TYPING AND WORD-PROCESSING (WORD-PROCESSING NOT ESSENTIAL)

APPLY IN WRITING TO CRITICAL HEALTH P.O.BOX 16250 BY NOVEMBER 30

INTERVIEWS WILL BE HELD IN THE FIRST WEEK OF DECEMBER

JOB WILL COMMENCE IN MID-JANUARY 1985

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