CRITICAL HEALTH

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FOCUS ON HEALTH SERVICES

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EDITORIAL

Critical Health, in focusing on the political economy of health has always maintained that illness is rooted in social and economic conditions. The people who get sick, especially from preventable diseases, are also the people who earn the least money, members of the working class.

Being members of the working class determines whether you will have decent housing with sanitation and a water supply and what your nutritional status will be. The availability of these resources, food, housing, water and sanitation are very important factors in determining a person's state of health. The availability of health services also plays a role in the health status of a community.

In this issue of Critical Health we look at health care services. Health care services are not provided equally for all South Africans which tells us something about the priorities of South African society.

South Africa is a capitalist society. The driving force of capitalism is the desire to make a profit. Making a profit in production is often in conflict with maintaining health. "Most attempts to control the social production of ill health would involve an unacceptable degree of interference with the process of capital accumulation (making a profit) and as a result the emphasis in advanced capitalist societies has been on after-the-event curative medical interventions, rather than broadly based preventative measures to conserve health." (1) It is because South Africa is a capitalist society that we have a curative based health care service. The letter in this issue on the Groote Schuur hospitalillustrates the inapropriatnessof a curative based health care service.

In the present health care system there is an unequal allocation of resources and this serves to reinforce the present structure of society. Societies are characterised by the stuctures within them. In order for a society to continue in the same way these structures have to be

preserved. For capitalist society to continue it needs the workers themselves, the places where they work (eg factories) and the materials with which they work (eg coal or wool). It also needs people to have the same beliefs and relationships which hold society together. People must believe that they have to work and that some people are bosses and most people work for the bosses who own the places and materials with which workers work. Health care fits into this reproduction of capitalist society.

Health care keeps workers in a fit state to work. This explains why most health care services are in the urban areas, because that is where the workers live. Health services also play a role in ensuring the next generation of workers by controlling the sexual and reproductive activities of women. Doctors control what type of contraception women receive. The state controls the location of family planning clinics and what services they offer. As a result boththe state and the medicalprofession control an aspect of women's lives.

The other way capitalist society must reproduce itself is to prepare each individual for the part they must play in society. This is called ideological reproduction. There are many ways a society can do this. For example bantu education prepares people specifically for unskilled and semi-skilled jobs.

Health care also plays a role in the ideological reproduction of the labour force. Health care services involve a set of social relationships which are bureaucratic, hierachical and authoritarian. For people who work in the medical sector like nurses or porters "this means that their work situation both reflects and reinforces the division of labour in the wider society emphasising the differential allocation of status, power and income on the basis of class, sex and race." (1) The people in charge in the health sector are the doctors who are mostly white men from the ruling upper classes. This is true in most other areas of South Afrcan society, the people in charge are white men from the upper classes. So the health sector reflects and reinforces the status quo.

In the case of patients," their unequal relationship with the doctors, and their lack of autonomy and power within the system as a whole, means that the provision of medical care is an ideal mechanism for socialisation and social control."(1) (ie telling people how they should behave in society if they want to get on, or in this case telling people how they should behave if they want the doctor to help them.) "People come to believe that they have little control over their own bodies, just as, for example, they have so little control over the conditions in which they spend their working lives." (1) We have included an article called"Who Cares"to show just how helpless a patient can be made to feel in a bureaucratic health service and how health services are not designed with the welfare of patients in mind. To balance this the article dealing with patients' rights illustrates how people elsewhere are trying to counteract the authoritarian nature of their health service.

Health services play a part in decreasing conflict in society. When we are sick we are pleased that there is a place to go for care. The health care service which is part of, and supports a society which causes us to earn low wages and live in poor conditions,nevertheless seems to care. This confuses us, how can we be angry with a system which has, as a part of it, a caring health service. We forget about the other oppressive things the society as a whole and the health care service specifically do, especially when we are sick. In the article about the primary health care clinics we see that Soweto is the only township to have these. It is not an accident, they were begun after the '76 riots to try and pacify the community by making them think that the state really cares for their health.

Health care itself is not a bad thing, we need it and it can be used in progressive ways. In South Africa health care is not neutral. It is used in special ways for the continuation of South Afrcan society as it presently exists.

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AN ALTERNATIVE ANALYSIS OF HEALTH CARE IN SOUTH AFRICA

The following article is based on a series of lectures sucessfully used in workshops involving medical students. It provides an introductory approach to an analysis of health care in South Africa. We have decided to include this article on the basis of it's accessability to people who might be approaching an alternate analysis of health care for the first time.

INTRODUCTION

This article will discuss some aspects of how health services are organised in South Africa and why they are organised in this way.

It is important for health workers to understand the system in which they work and to realise how closely the health system is linked to other systems in South African society.

HOW ARE HEALTH SERVICES ORGANISED IN SOUTH AFRICA?

There are two major features under this heading;
-the distribution of health services
-private practice.

DISTRIBUTION OF HEALTH SERVICES

Rural areas have been neglected.

Many rural people have to travel very long distances to the nearest clinic or hospital. When they get there the treatment is often inadequate due to staff shortages and the inadequate training of health workers.For example, in most clinics, a nursing sister is left in charge and he or she has to cope with all the diseases with which the patients present. When the sister goes off duty, a nursing assistant (a person with only 6 months of hospital training) may be left in charge.

IN THEORY:

CLINIC EASILY ACCESSIBLE TO THOSE WHO NEED IT.

IN PRACTICE:

PEOPLE MUST TRAVEL LONG DISTANCES TO REACH THE CLINIC.

Althougn services for whites in rural areas are also relatively neglected (McGrath 1979.134), it is the services for blacks which suffer most. In the urban areas, there were 109 blacks for each hospital bed in 1970, while in the rural areas there 191 blacks for each bed (McGrath). In addition to the shortage of beds, doctors are also maldistributed. In the major urban areas there are 10.3 doctors per 10 000 people. In "homeland" areas there are only 0.43 per 10 000 people (McGrath 1979 134)

Thus we see that in rural areas health services have been neglected when compared with urban areas. Health services are only one aspect of this urban bias- the same pattern can be seen in the provision of water supplies, sanitation, roads, education.

IN URBAN AREAS SERVICES FOR BLACKS ARE NEGLECTED.

Health services can be provided by private practitioners and institutions or through public, government subsidised channels. Private services for blacks in the urban areas are very neglected, as shown in the table below.

DISTRIBUTION OF GENERAL PRACTITIONERS IN CAPE TOWN

NEWLANDS	1:600	white areas
WYNBERG	1:650	
MITCHELLS' PLAIN	1:3300	black areas
ELSIES RIVER	1:64000	
LANGA	1:19000	

This maldistribution of private services is understandable because most black people cannot afford the high costs of private medicine. In fact whites spend 94% of the total expenditure on private services (McGrath 1979 128)

In the public sector services are also maldistributed. For example, an analysis of two Durban hospitals showed that the white hospital had 64% of its beds occupied against 93% in the black hospital. There were only 7.2 daily patients per doctor in the white hospital compared with 13.5 in the black hospital (McGrath 1979 132).

Although it is difficult to assess what constitutes "adequate" health care, these comparisons do show that

whites in urban areas are receiving more services. It may be useful to think about whether more services always means better or relevant services.

McGrath (1979 128 129) also mentions another interesting fact. In a study of certain urban areas, it was found that white families spend only 6% of their total health budget on patent medicines (ie medicines not prescribed by a doctor, but bought in a shop), while black families spent 49% of their health budget on these medicines. He concludes. "Indeed, the relatively high level of expenditure on patent medicines by Africans in urban areas might be an indication of the difficulties in obtaining subsidised medical treatment at hospitals or clinics".

PREVENTIVE AND PROMOTIVE SERVICES ARE NEGLECTED.

In South Africa about 97% of the health budget goes to curative services. If all people get adequate preventive and promotive services on only 3% of the budget, this would not be an issue. But the examples that surround us prove that many people do not get adequate services. For example, if our health education campaigns were adequate - would mothers use dangerous and expensive bottlefeed when they could breastfeed
- would the polio epidemic have struck last year
- would cholera and typhoid be a problem
- would children still die from measles

PRIVATE PRACTICE AS A FEATURE OF HEALTH SERVICE ORGANISATION.

The majority of South African doctors (59%) work in private practice (McGrath 1979 120), and approximately one third of all beds in the country are in privately owned hospitals (McGrath 1979 120).

After this brief study of how health services are organised, we must ask ourselves why are they organised in this way in South Africa? We know that there are other ways of organising services. For example, private practice has been banned in the Soviet Union (Ryan 1978 32-33). In

Once we see how health services are bought and sold just like other goods (food) and services (plumbing) then we begin to understand why health services are organised the way they are.

It was noted previously that private practitioners are allowed. In a capitalist society which encourages free enterprise and the formation of new businesses, a doctor is seen as another shopkeeper. The doctor sells his or her skills and makes a profit of the patients (customers) illness.

Another point noted was that preventive medicine is neglected in favour of curative medicine. This is understandable in a society where the emphasis is on selling health care. When people are sick they will do anything to find help and so sick people are eager customers. When people are well however they are not always interested in learning about health education of other preventive measures.

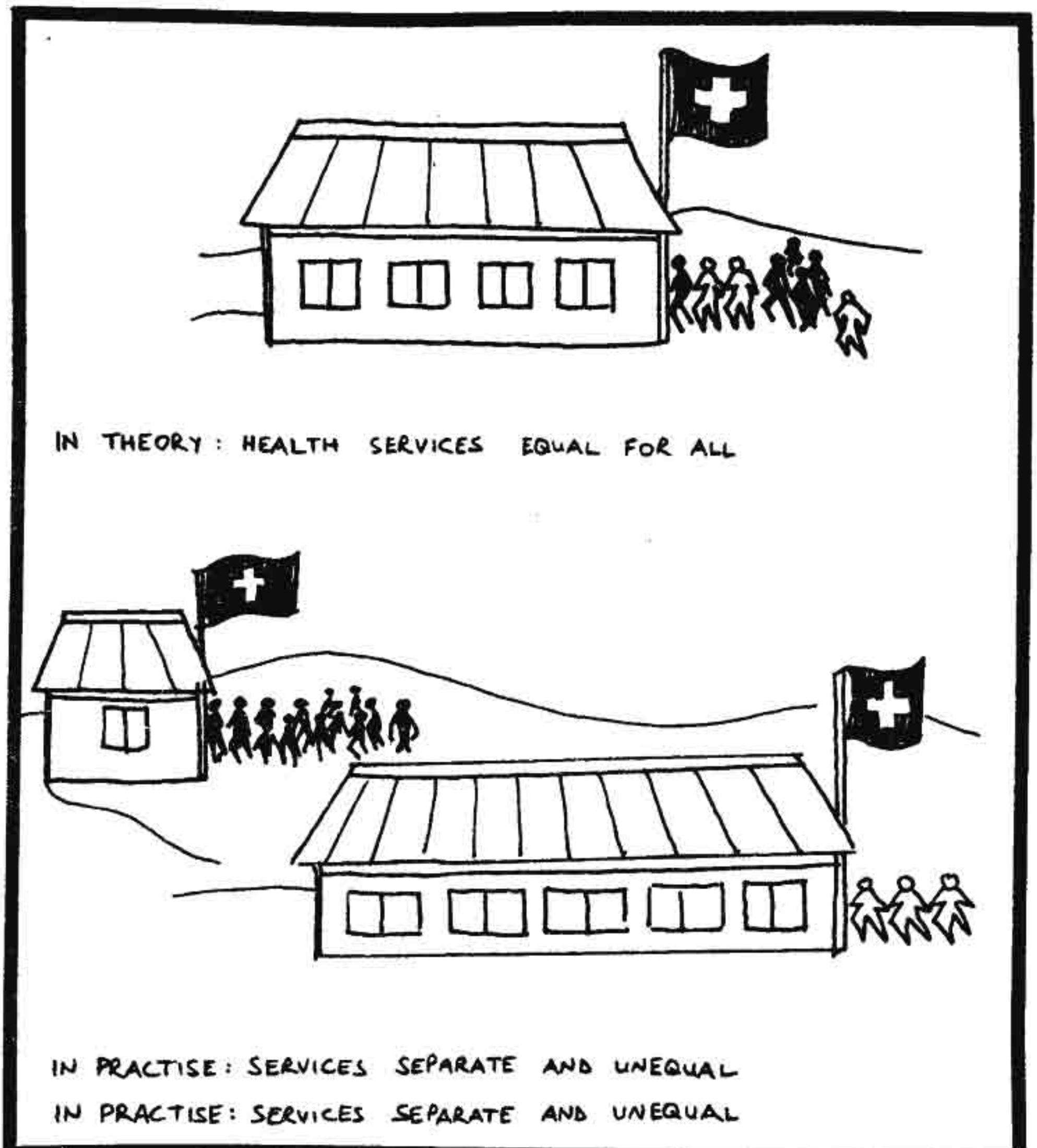
It was also noted that rural areas are neglected. If you were a shopkeeper would you rather open a shop in Soweto or Johannesburg where there are many people living close to the shop or in a rural area where your customers are poorer and live futher from the shop.

Of course you will make more profit in the city. This is one reasonwhy health services are more plentiful in the urban areas. Other reasons include the fact that most health workers prefer living in the cities, that urban dwellers are usually better organised to demand services than scattered rural dwellers, and that the workers who live in the cities must be kept fit enough to work. (The influence of the homeland system on the distribution of resources is dealth with in a separate article in this edition)

In addition to these influences of the capitalist economic system, which would apply in most capitalist countries, South Africa has some political issues which complicate the picture. The system of racial separation and the development of homelands accounts for the last item noted earlier; services for blacks are neglected. As well as

the differences in quality and quantity of services mentioned before, these racial policies account for

- separate black and white hospitals
- separate training institutions for black and white nurses
- the formation of a black medical school at MEDUNSA
- the South African Nursing Association asking for all "homelands" to form their "own" nursing associations
- separate Departments of Health being formed in each "homeland"



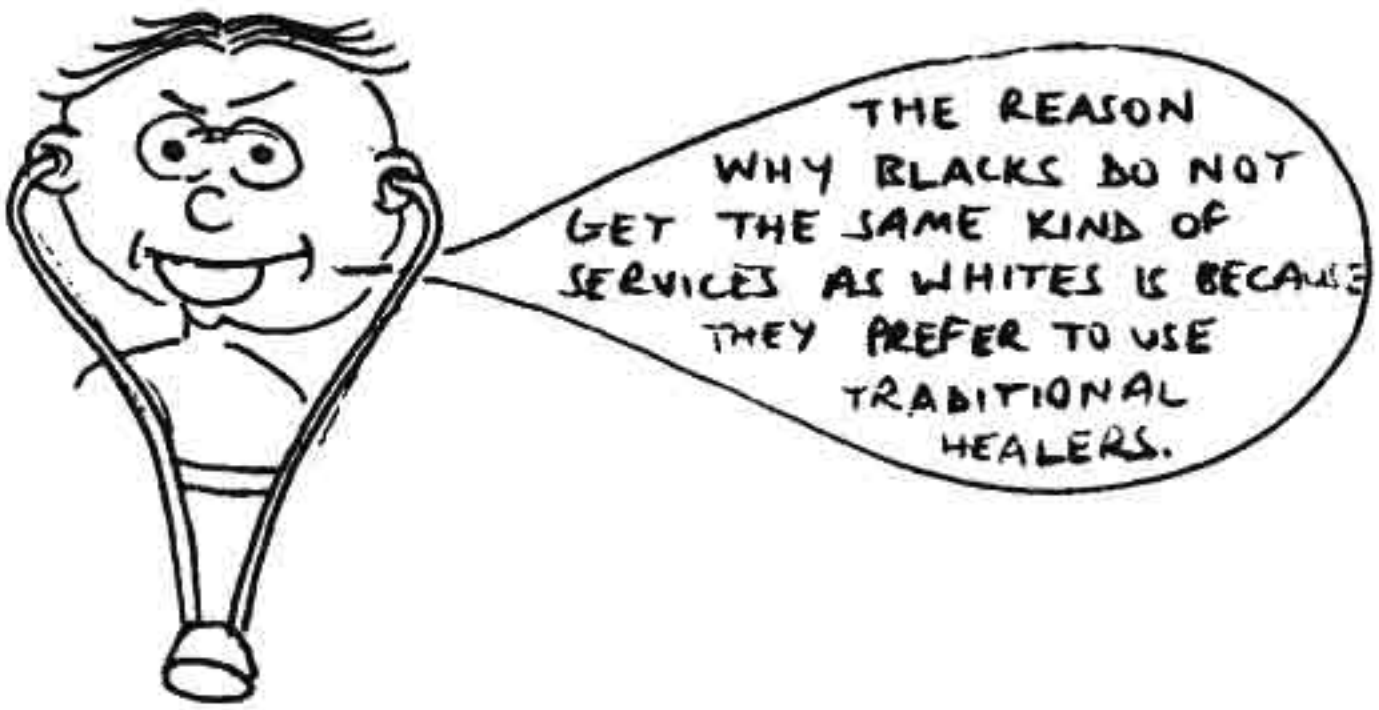
some countries, special attempts are being made to upgrade services in the rural areas. It is important to ask why these attempts are not being made in South Africa?

WHY ARE HEALTH SERVICES ORGANISED THIS WAY IN SOUTH AFRICA?

Different people have suggested different answers to this question.

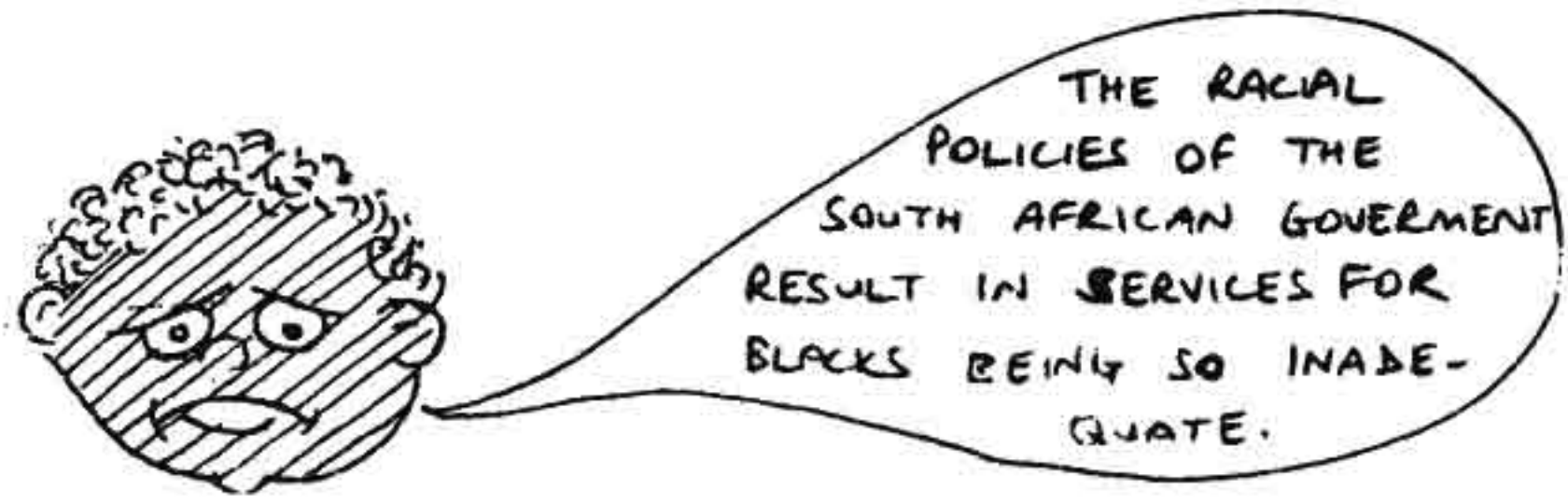
Do you believe this professor?

Even if he were right how many features does his explanation account for? Does this explain why we still allow private practice or why preventative services are neglected?



Do you believe this doctor?

Even if he were right, does his explanation account for all the features of health service organisation listed



Each of these examples explains only a part of the whole story (with exclusion of the first example which has been shown to be statistically incorrect). The following is an alternate explanation as to why services are organised the way they are.

INTRODUCTION TO A POLITICAL ANALYSIS OF HEALTH SERVICES.

A political-economic analysis begins by recognising that different societies are structured in different ways. For example, America is a capitalist country characterised by money and power being concentrated in the hands of a few while the majority of people work for the "owners", selling their labour.

In a communist country everything is owned by the government which represents the people, there are no "owners" and everyone works for a wage.

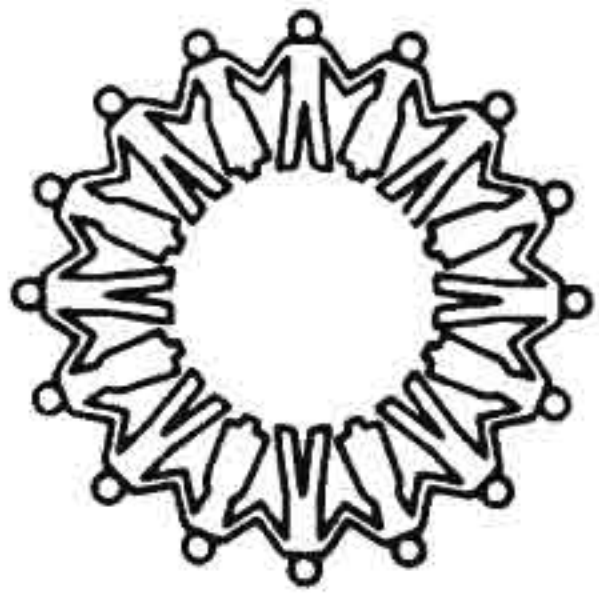
The economy and political system influences all the smaller parts of the society such as the education system, the legal system and the medical system. In capitalist countries individuals are expected to made their own provision for health care. They must pay a private doctor or pay a hospital or get an insurance scheme. In China however the government feels responsible for providing free medical care to all citizens. Health care is seen as a basic human right which the government must provide.

In South Africa the features of capitalism are reflected in the health services. Health care is bought and sold - by private practitioners, hospitals and clinics in the same way that one buys and sells clothing, furniture, and food.

Another political influence on the organisation of health care is that because South Africa has a system of government with three levels (state,provincial and local authority) health services are fragmented. This causes unnecessary expense and effort..(This issue is dealt with in the article entitled Who Cares in this issue)

CONCLUSION..

In order to understand why health services are organised the way they are in South Africa and in other countries, it is important to use a political-economic analysis. In the same way one could analyse the education or legal system. Each of these systems is a part of the South African society and are influenced by the political and economic organisation of South Africa. The problems in the South African health system cannot therefore be separated from the broader problems found in the political and economic policies of this country.



Merryl Hammond

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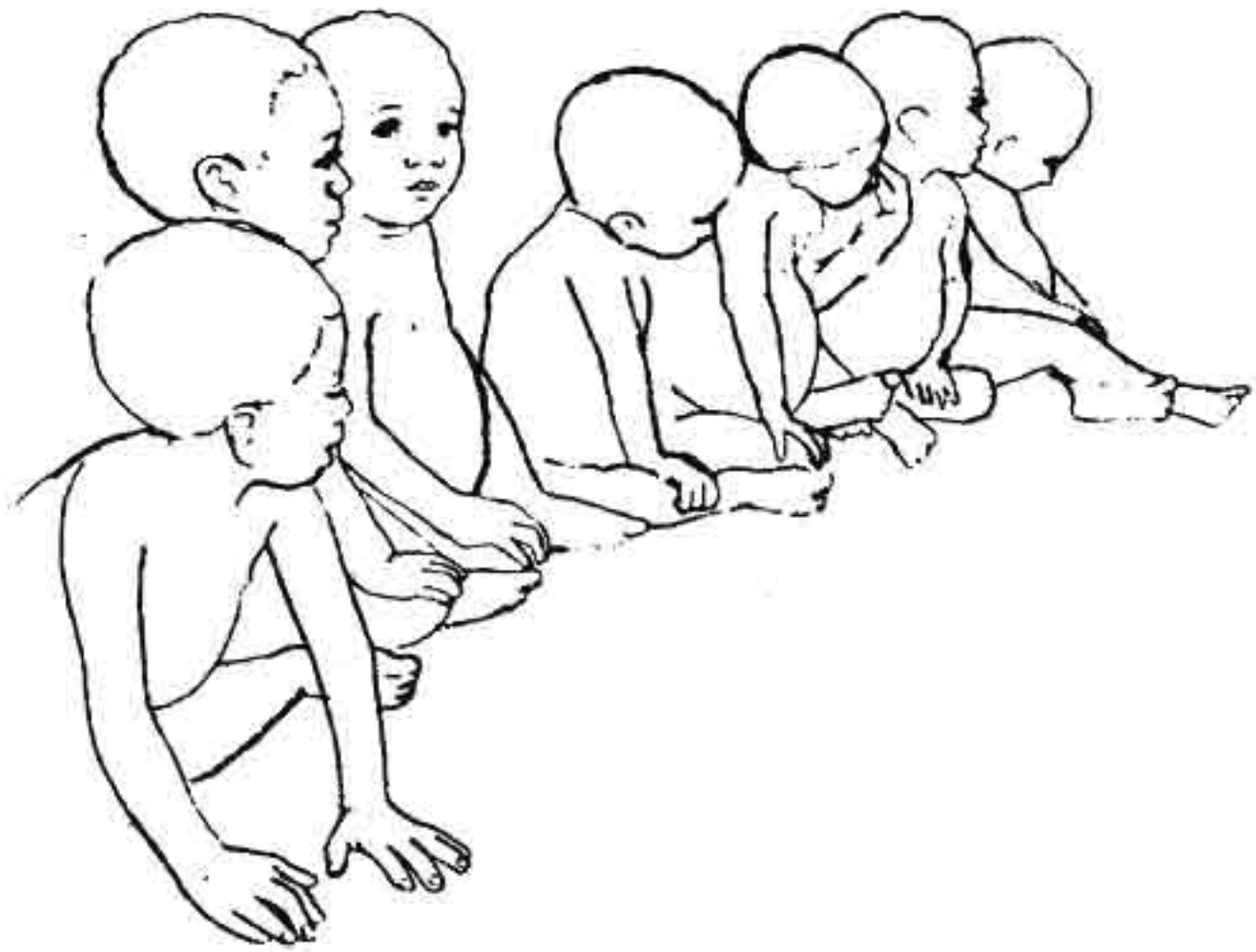


WHO CARES?

Most black people in urban areas are dependant for their health care on services run by the government. For example, although there are about 20 doctors in private practice in Soweto, and a number of others in central Johannesburg who see mainly black patients, the vast majority of people in Soweto obtain their western medical care from one or other of the clinics. Not one of these clinics however provides comprehensive care.

Responsibility for public health services is split between the Department of Health, the provincial Department of Hospital Services, and the local authority Health Department. In most areas of Soweto therefore different services are provided by different authorities, usually in different buildings. Even within one authority there is often specialisation and one service may be run quite independantly from others. This division of responsibilities gives rise to a number of problems, and one of the greatest of these problems is the failure of the health workers in the different services to communicate with each other about their patients. Doctors and nurses seeing a patient concentrate on their particular aspect of health care, and if a problem arises that is outside their sphere they then refer the patient on to someone else. The difficulties and frustration that the patient may experience being "shunted around" are illustrated by the story of Mrs Khumalo. Although the story is fictitious it is perfectly possible that all this could happen to one woman. Certainly in the area of Soweto where the health services were studied by the Community Health Centre Research Project of the University of the Witwatersrand, the different referrals ascribed to Mrs Khumalo were seen to take place many times over.

Mrs Khumalo lived in Phiri in Soweto and when she needed medical attention she went to one of the local clinics, several of which were grouped together at a health centre.

She did not want to fall pregnant and so consulted the City Health family planning clinic.

She was found to be three months pregnant and was referred to the provincial (TPA) ante-natal clinic.

There she was found to have caries in her teeth and was referred to the Department of Health dental clinic.

Back at ante-natal clinic her blood pressure was found to be raised and she was referred to Baragwanath Hospital.

After examination at the hospital ante-natal clinic she was referred back for delivery at the health centre.

She was duly delivered by the TPA midwives and referred to the TPA family clinic.

Pelvic sepsis was then suspected and she was referred to the TPA polyclinic (adult section).

Apart from the sepsis they thought she had post-puerperal depression and referred her to the Department of Health psychiatric clinic.

Three months after delivery she brought her child to be immunized to the City Health immunization clinic.

Because Mrs Khumalo had not been well, the child had been staying with its grandmother in the rural areas and at the immunization clinic was found to be sick. The City Health staff therefore referred the child to the TPA polyclinic (paediatric section).

Having examined the child and taken an x-ray, tuberculosis was diagnosed and the child was referred back to the City Health TB service.

Within a year Mrs Khumalo had been to ten different clinics, nine of them within the same grounds at the health centre, but all with seperate nursing staff and all with seperate records. The child's immunization card and TB record were filed in one pocket together with a notification from TPA of its birth, but they were seperate from the hospital record and from the other seven records scattered in different places through the health centre.

The only way for a health worker to piece together the whole picture of this mother and child was to take a full history from the mother and then to go round to all the seperate records and to transcribe all the relevant information. It was reasonably easy, although very time consuming, for a nurse to do this from the records of services run by his or her own health authority. However the nurse needed the permission both of his or her own supervisors and of the senior officials in both health authorities before the nurse could gain access to the records of services run by another authority. This came out very clearly when a request was made for blanket permission to be given to allow City Public Health Nurses to examine the TPA polyclinic records of their patients. The relevant supervisors were horrified and permission was refused.

In the urban areas many different services are often involved in providing health care for a particular patient or family. The failure of these services to communicate effectively with each other about common patients is one of the major defects of the present health services in South Africa.

Tim Wilson

THE OCCUPATIONAL MEDICINE BILL

MAIN AIMS OF BILL

The stated objectives of the Occupational Medicine Bill (OMB) are to establish an advisory committee for occupational medicine and to provide for medical measures to protect employees against medical conditions resulting from exposure to harmful substances or processes in the workplace.

The OMB is a response to the Erasmus Commission which produced its report in 1975 and showed the dismal state of occupational health services in South Africa. There are indications that this legislation has been on the drawing board for the last few years, a fact that explains many of the overlaps and lack of clarity between the OMB and the Machinery and Occupational Safety Act (MOSA) which was passed last year. As the OMB emerges after a struggle between the departments of Health and Manpower as to whom should control MOSA, this Bill can be seen as a "sop" to the Department of Health which lost that battle.

FEATURES OF THE OMB

* employers are obliged to provide an environment in which workers can not be exposed to harmful substances for greater periods of time nor in greater concentrations than laid down under MOSA.

* workers exposed to these harmful substances must be examined by a doctor and be declared fit before commencing work

* certain occupation related illnesses are to be declared notifiable (i.e. the Department of Health is to be notified if anyone is found to be suffering from one of these conditions)

* failure to comply with certain sections of the Bill will carry a penalty of up to R2 000 or 12 months imprisonnent or both

* regulations can be made on a wide variety of issues including

 * the concentration of and period of exposure of employees to harmful substances

* the labelling of containers and education of workers concerning harmful substances

* the provision by employers of facilities for the prevention and treatment of medical conditions

* the manner in which employees are to be informed of the results of medical examinations

* exemption of certain employees from the requirements of the Bill

One extremely absurd regulation enables measures to be taken to ensure that workers are adapted to their jobs, rather than that jobs be adapted to the workers.

* victimisation of workers complying with the Bill is to be forbidden

* no employee found to be suffering from an occupation-related illness can be discharged from work until suitable arrangements are made for the medical treatment and "rehabilitation" (this is not defined) of the worker.

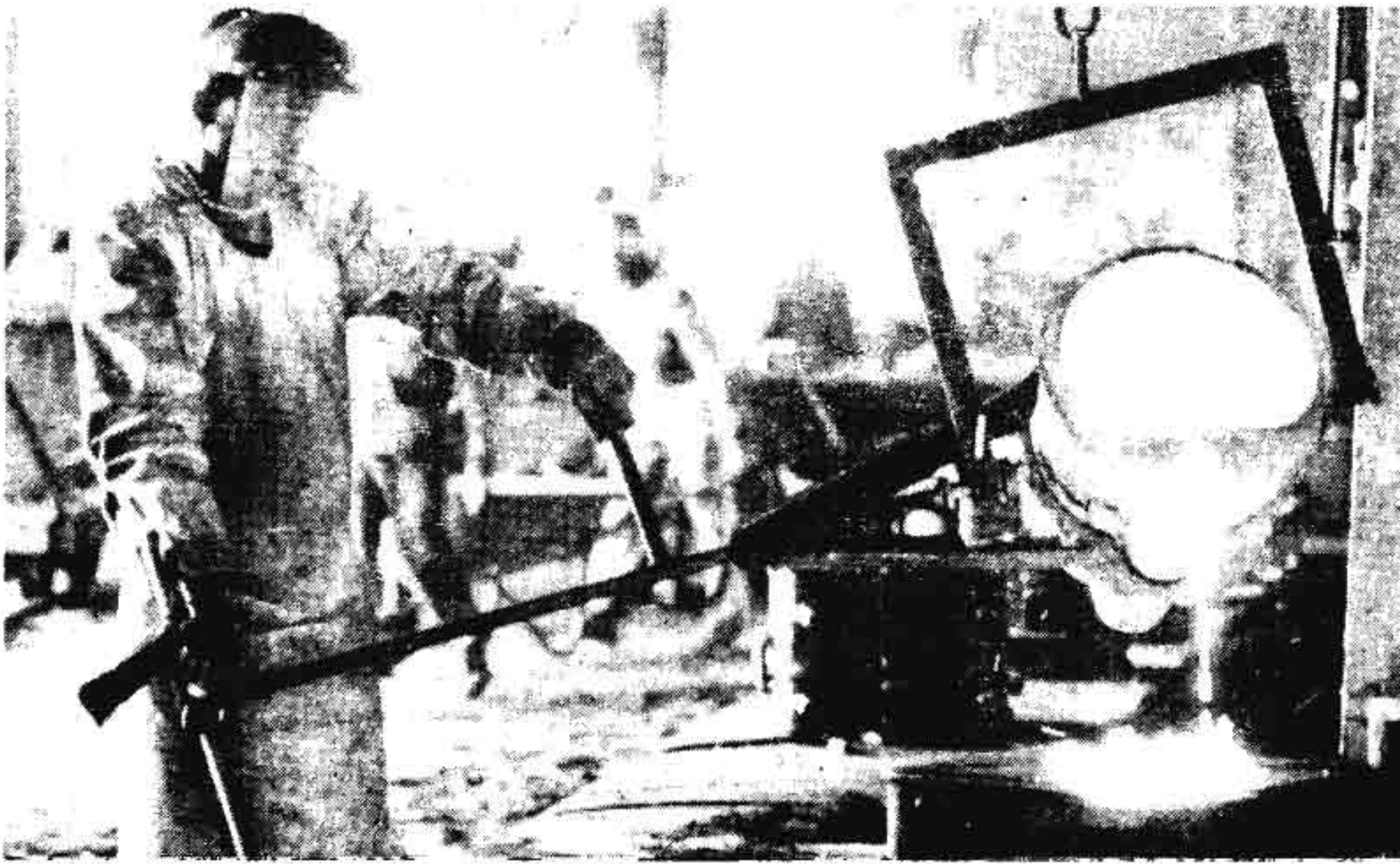
MAJOR ASPECTS OF OMB

There is clearly no attention given to the role of workers in promoting improved working conditions and health services at work. Neither individual employees nor organised workers are given a clear role in determining health and safety policy at the workplace. The only mention of employees and their role in health and safety in the work-place is the appointment by the minister of at least two representatives of employees to sit on the state-run Advisory Committee. Other than that there are again, like MOSA, heavy penalties for workers who refuse to comply with certain aspects of the Bill, for example, refusing to undergo a medical examination laid down by the Bill.

The initiative for promoting health and safety and its regulation is left with management. At this stage there is clearly inadequate machinery to police the Bill, should it become law, and management will be left more or less to exercise the degree of control that suits it in terms of economic costs.

The Bill introduces tremendous duplication between it and MOSA. In fact there is no clarity at all about the relationship between the structures set up by MOSA and those envi-saged under this new Bill. Both MOSA and OMB enable the setting of exposure limits to dan-gerous substances at work but it is not

clearly stated whom will set these threshold limit values. It is not clear who will enforce the different aspects of MOSA and the OMB. Furthermore, no link is established between the factory safety committees set up under MOSA and the present legislation.



The Bill does not go any way towards setting up an effective health service infrastructure in industry. Although the Bill will deal with matters such as how often workers in particularly dangerous industries (e.g. battery manufacturing workers exposed to lead) are to be examined, the Bill does not set up any infrastructure to ensure that this is done. No mention is made, for example, of ensuring that employers with more than fifty employees must provide some form of health service. This, like many other matters, is left to be promulgated under the regulations.

Probably the most glaring defect in the Bill is the absence of a clause on the rights of employees. This should include the right to information about the substances with which workers work and their harmful effects, the right to call in an inspector whenever workers deem it necessary and the right to obtain the results of all inspections.

In conclusion, this Bill provides for the recognition, treatment, and prevention of work-related illnesses and the monitoring of the work environment. However, little requirements are introduced with the Bill and most changes will only become apparent once the regulations are promulgated. There is tremendous overlap between this Bill and MOSA and it is uncertain how responsibilities are to be divided between the Departments of Health and Manpower. There is no clause guaranteeing the rights of employees and this could certainly form the basis for considerable dissatisfaction by workers and their unions.

Finally, it must be stressed that this is the first draft of the Bill and numerous health-related organisations and some unions put in recommendations regarding the Bill before the end of February. Particular attention was devoted to the lack of a clause guaranteeing the rights of workers to participate in all matters concerning their health and safety.

Health Information Centre

VIEWS ON A UNION CLINIC

Until recently, workers in the Paarl area went to a local general practitioner when they were ill. The consultation was paid for by a fund financed by workers and their employers. The fund also paid for drugs up to a limited amount, but this was often exceeded and workers then had to pay the additional amounts themselves.

A few years ago, the Food and Canning Workers Union and the African Food and Canning Workers Union negotiated with management so that the fund could be used to set up a clinic in the area. The fund was used to establish the clinic, pay a doctor nominated by the Union, and pay for medicines to be dispensed at the clinic.

Union members attending the clinic were asked what they felt about it. This is what they said:

"We like our clinic. We pay only twenty cents and we get our medicines for free. Also, the doctor makes sure that we get paid our Workmens Compensation money quickly."

Another worker had this to say:

"It is good that our Union helps to look after our health. It is part of our struggle for a decent living."

Another worker added:

"This clinic helps to strengthen our union - the Food and Canning Workers Union."

Many workers related their illnesses to their working conditions. One blamed his chest condition on the refrigerated air at work, and

the small, draughty, concrete room he shares with two others at his hostel. A woman blamed her muscle pains and her persistent anxiety on the hard physical work she has to do at a rate set by the machine."

The clinic run by the Food and Canning Workers Union in Paarl is a small clinic over which patients have some control through their Union. The workers there are satisfied with their Clinic. In the future, other unions may also set up clinics, and extend the control that working people have over their own health.

COMMUNITY ORGANISATION AND HEALTH

This review consists of a presentation of the overall objectives of organising around health issues, an analysis of potential contradictions within the health system, and a discussion of some practical issues involved with organising around health issues.

OBJECTIVES OF ORGANISING AROUND HEALTH

The first objective is the creation of an awareness of health within a broader context. Health must be seen as a basic human right that must be strived for politically. It must also be understood in its socio-economic dimensions. For example, the contradiction between the provision of individual curative measures, as opposed to the provision of preventative measures at a community or collective level, should be understood.

The second objective involves the mobilisation of people. It is only through unified mass action that meaningful and fundamental change is possible in any sector. Thus, programmes need to be structured so as to optimise community involvement by using local struggles as sites of challenge as well as learning experiences.

The third objective is the establishment and strengthening of community and worker organisations. It is only through such structures that development and understanding, as outlined in the first objective, is enhanced and the energies of people are focused and mobilised, as mentioned in the second objective.

POTENTIAL CONTRADICTIONS

The major contradiction in the provision of health services is an economic one. At one level, health care is a commodity subject to market forces and able to generate profits. At another level, basic health care is a necessary aspect for the reproduction of the working class.

Regarding health as a commodity, the medical profession (especially the private sector e.g. MASA), competes with the public sector (the State) against the people, to maintain profitability. This conflict is most intense at the working class level - since it conciously and deliberately pushes the burden of health care upon the private sector which the latter is reluctant to accept since it is less profitable. For middle and upper classes, both the State and the private sector are in agreement in exploiting this sector to the maximum especially through medical aid schemes.

The private sector is well organised in its "trade union" (MASA), and has a sufficiently powerful political lobby to prevent the Department of Health from embarking on any extensive public sector initiatives . It has succeeded in stopping the full implementation of the National Health Facilities Plan which proposes the creation of health centres in working class townships such as Phoenix, Mitchell's Plain and Soweto.

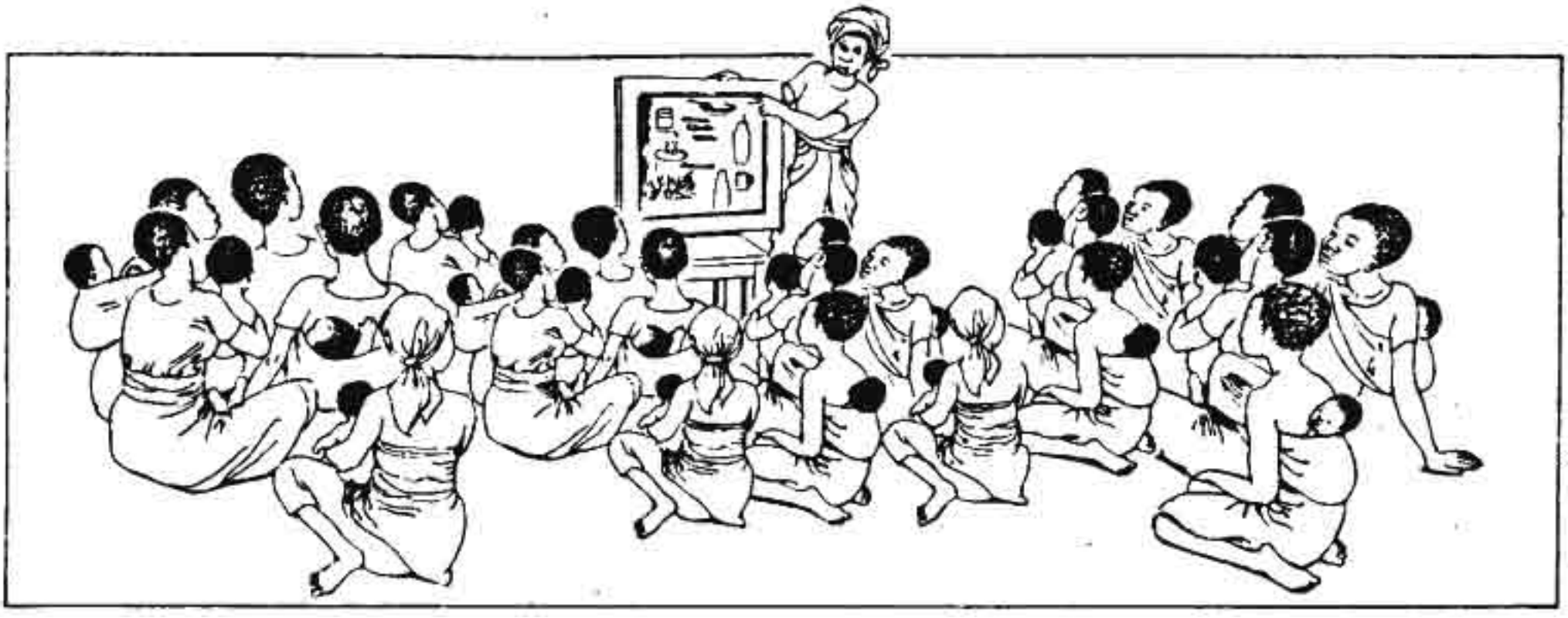
At the community level, the State has launched an extensive ideological campaign promoting primary health care, self-help in health, and village health workers in rural areas. These are all aimed at promoting the responsibility of individuals to care for their own health, and at the same time preparing people to

accept a lower standard of health care - "primitive health care".

Thus, one sees the development of a sophisticated first world type of medical system with organ transplant units in all the major centres to cater for the health needs of the urban elites, and a third world type of primitive health system promoting self-help, family planning and individual (as opposed to collective) social responsibility.

The central message throughout the typhoid, cholera, polio, and plague outbreaks in the past few years has been to emphasise the responsibility of individuals in promoting their own health and the diversion of attention away from the basic socio-economic and political factors which led to those disease outbreaks.

Apartheid permeates all aspects of health care, producing additional contradictions. Both the quantity and quality of health services for blacks and whites show gross disparities.



A variation of apartheid medicine is the attempt to impose a western high technology curative health system based on the profit motive, on a largely black working class with a different health and disease profile. Without a democratic and essentially political approach, such limitations cannot be overcome.

It must be stated clearly that organising for social and political gains through health issues has several limitations which must be considered if serious errors are to be avoided. Traditionally, health and diseases have been attributed to forces outside human control. The ideological process of showing the link between health and socio-economic and political factors therefore will involve a long process of concientization. Health, unlike wages and factory floor issues, is a "soft" issue and therefore very expendable. In the face of more pressing needs like paying for housing, transport and other costs, and obtaining better working conditions - health issues and health struggles are often not a priority in the community or on the factory floor.

In the struggle for survival, it may be more important for the sick worker to go to work rather than fight for extra health services and benefits. In addition, the provision of health services or improvements in health status are often intangible and may take a long time to materialise, unlike wage increases which are tangible, concrete gains with immediate use value.

Resistance to these issues concerning health and safety at the workplace and community have been of a limited nature. With the present economic climate it is difficult to see any significant struggles developing on their own around these issues. This is not to say that

no struggle is possible; the growing number of independent, democratic medical and health groups could play an important catalytic role in alliance with progressive trade union and community organisations. The former groups therefore have an important responsibility to focus upon these areas in an active, non-academic, and dynamic manner, providing both material and ideological input. These groups have an important role to play provided they do not get side-tracked in short term medical gains, but rather maintain a longer term perspective aimed at fundamental political changes. Likewise, the progressive trade union movement has a role to play in ensuring that these health groups have a defined and clear role that assists in broader organisation and resistance.

PRACTICAL ASPECTS

Several groups have conducted health-related programmes, including church groups, mission hospitals, union groups, community organisations, and many other more informal groupings. A common feature of most of these programmes is a sincere commitment to improving the health status of the local populations in which the organisations operate.

Implicit in some of these programmes is a commitment to working towards a just and democratic society, which is an essential prerequisite for a healthy society. A critical problem faced by these groups is the difficulty experienced in bridging the gap between an awareness of the broader issues affecting health, and a clear political understanding of South Africa. This is a problem faced by both activists in health groups,as well as community members. In other cases, as health activists become more involved in the broader political struggle, they are often

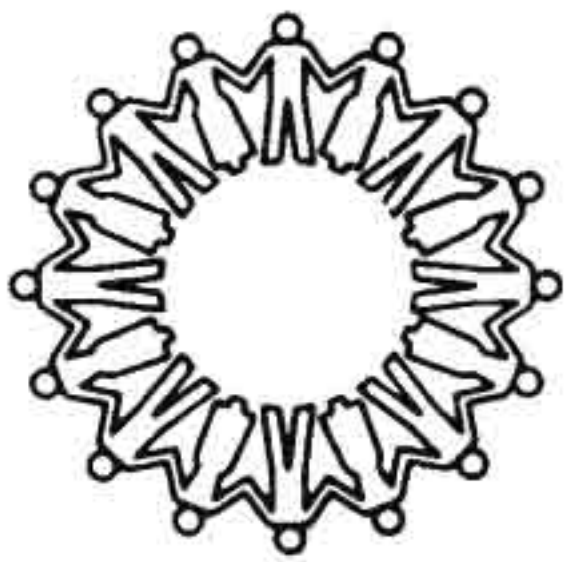
drawn into civic, union, and other sectors and out of the health sector.

Another controversial issue is whether the project should actually provide an alternative health service, in which case cash may be sucked into a bottomless pit of increasing demands, or whether it should primarily highlight the contradictions in the health sector, and persuade the masses to demand services and participation in decision-making processes affecting those services.

The latter approach lacks any short-term material benefits, and therefore demands a greater degree of mobilisation, and the creation of some organisational infrastructure ideally linked to civic, child welfare, or trade union groups in order to sustain itself.

Many readers of Critical Health are involved in some or other form of organisation around health issues. We would appreciate hearing from you about your experiences and your response to this short article.

Durban Community Worker



PATIENTS' RIGHTS

A number of overseas countries have adopted statements concerning health rights of hospitalized patients. This has been neglected in South Africa and hospital patients often suffer because they do not have a clear idea of what their rights are or what they ought to be. At present examples of the existing rights of South African patients are the right to refuse treatment and they are protected by their having to sign consent forms for various investigations and operations.

The fact that hospital patients have been singled out is not to say that hospital patients are more important. Hospital care is a small but important part of a much larger health system. It is felt that a broader charter of peoples rights with regard to health care could arise out of a charter of rights for hospital patients.

A charter of the rights of hospital patients by itself is insufficient. In each hospital the conditions should be created such that these rights are respected and adhered to. The patients must have access to some process whereby a failure to ensure these rights can be challenged. Every patient must be fully aware of what his or her rights are.

These rights can form a basis from which to work. Certain patients for eg. psychiatric patients will need additional protection of their rights.

Community groups in South Africa could demand the adoption of a charter of hospital patients rights to ensure that all people are treated properly in their local hospital.

The following is a draft of demands which could be taken up. It is based on patients' rights in other countries in Europe and America. (It must be stressed that for the purposes of this publication the list is brief and therefore incomplete).

A patient has the right

- to appropriate health care regardless of race, class, sex or religion.

-to respectful and considerate care as well as respect for and recognition of her or his religious, cultural and philosophical beliefs.

- to the protection of his or her privacy. Case discussions, consultations, examinations and treatment should take place confidentially and conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual at any examination or case discussion.

- to have all communications and records pertaining to her or his case and stay in hospital to be kept confidential.

- to receive reasonable responses to any reasonable request he or she might have.

- to have adequate continuity of care and to know that any personnel looking after the patient will inform any subsequent personnel of all the factors involved in the patient's case.

- to be advised if hospital personnel propose to involve the patient in any experimental procedures and the right to refuse to participate in such procedures.

- to complain about her or his treatment and to have the complaint investigated and to be informed as to the outcome of the investigation.

- to have access to all facilities appropriate to her or his illness.

- to know the outcome of any investigations carried out on the patient, the expected course of treatment and the prospects of recovery, and the side effects of any proposed treatment. This should be explained to a patient in an understandable way.

- to participate actively in decisions regarding his or her medical care.

- to be fully informed of the continuing health requirements following discharge from hospital.

- to recieve an explanation of her or his account regardless of the source of payment.

- to be informed of any hospital rules applying to him or her as a patient.

In conclusion the rights of patients should be drawn up by patients, paramedics and hospital staff and community organisations.

This article is intended to introduce the notion of patients' rights. Comments and personal experiences would be welcome in an effort to develop the relationship between patients and hospital staff as equal members in the health care team.

SEPARATE DEVELOPMENT IN HEALTH

This article attempts to outline the homelands policy and to show how health services in homeland areas are subject to political and ideological forces which both echo and support the homelands policy itself.

The homelands policy rests upon an identification by the goverment that South Africa is composed not of a white minority and a black majority, but of a number of culturally distinct peoples, each of which attempt to assert their own identity.

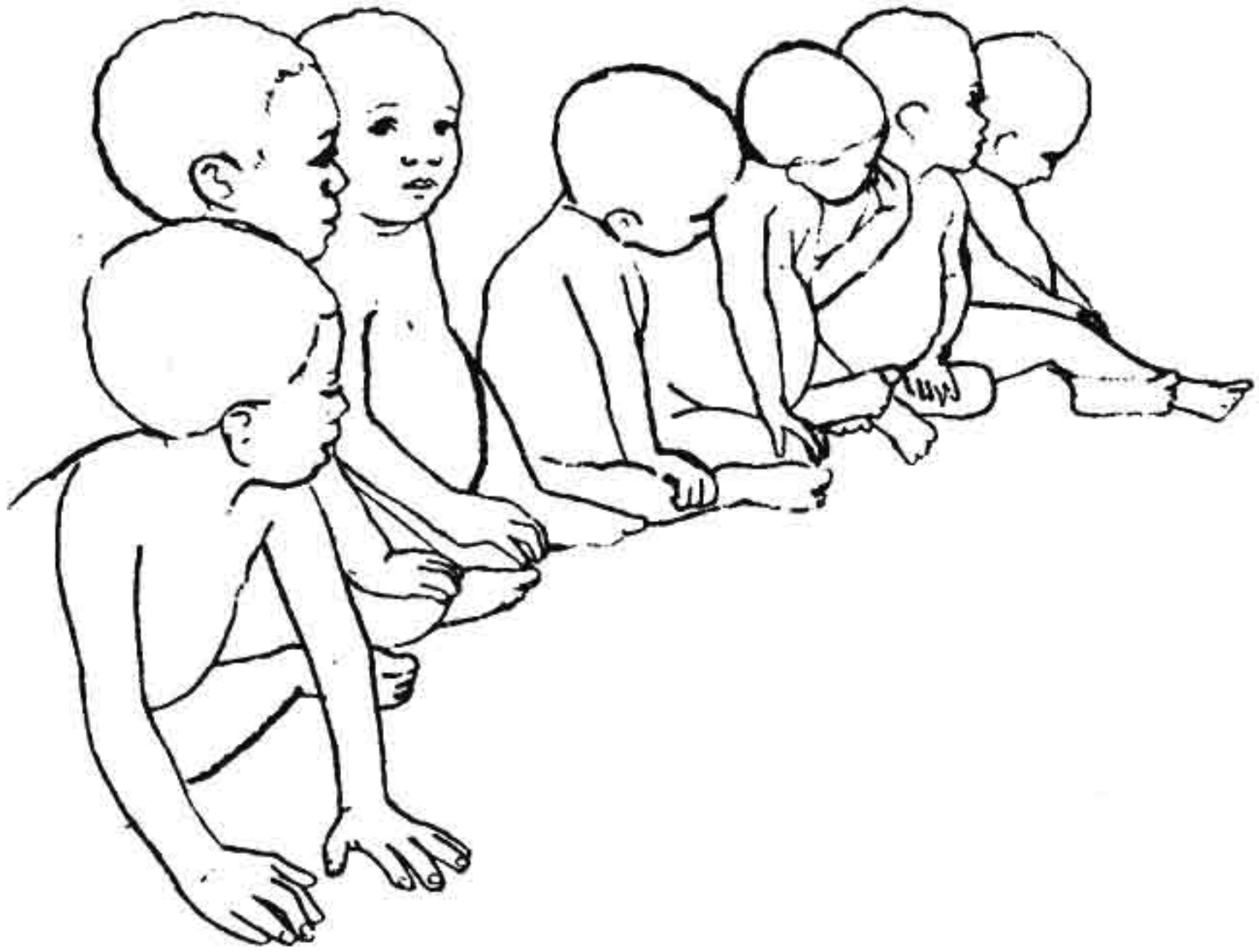
The goverment has therefore evolved a political model whereby each black "nation" can, theoretically, determine its own future. Each such "nation" has been allocated its own territorial "homeland" which constitutes a spiritual and emotional home even for those "national citizens" who physically dwell outside of it.

According to the goverment, within each homeland, official policy has given expression to the political aspirations of each people by allowing them to evolve their own self-governing institutions. As each homeland goverment gains in capability and experience, so it is encouraged to progress along the path of constitutional development until it reaches eventual "independence".

The policy states that ultimately each african "nation" will have separated from South Africa, which will then contain only white, coloured, and asian citizens. Each of the population groups will administer its own internal affairs, while all africans, even though many may be permanently resident and working in the Republic, will be expected to

exercise their political rights in their own particular homelands. The new costitution seeks to further consolidate this policy.

The homeland programme may thus be seen as a policy of divide and rule, whereby the african population which outnumbers the white population by five to one, has been redefined into ten separate ethnic minorities.



The essence of apartheid can be shown to relate to the twin goals of maintenance of white supremacy and the maintenance of the coercive labour system which ensures the cheap labour supply upon which the South African economy depends.

The South African administration has been able to relieve itself of various burdensome tasks such as the provision of education, the care of the sick, and the payment of pensions. These responsibilities have now been shifted onto the homeland goverments.

The homelands also serve to direct attention away from the political core of South Africa, deflecting protest and discontent away from the central authorities and on to the black homeland leaders.

A critique of this policy demonstrates the large number of flaws contained in it. For a start, only 13% of the land is set aside for 70% of the population. Secondly, the hopeless fragmentation of the homelands prevents them from ever becoming "countries" in any meaningful sense of the word. Thirdly, the arbitrary and racist concept of nationality ignores the extent to which the various african ethnic groups are inextricably and irreversibly interrelated. Furthermore, there is an effective denial of all political voice to blacks living in urban areas while the homelands are thoroughly impoverished, underdeveloped and dependent upon the central South African economy. (1)

Those homelands that have opted for "independence" are unviable in many respects. For example, they receive, on average, 75 percent of their revenue in direct grants from Pretoria. In the Transkei, only 15% of the labour force is internally employed. More than 70% of the economically active population is involved in the migrant labour system, while the rate of job creation in the homelands fails to absorb more than 10% of those who enter the job market every year.

The success of the homeland policy has been extremely limited in that none of the "independent" homelands has been recognised by the international community and the black population generally has not been co-opted by the policy.

HEALTH SERVICES IN THE HOMELANDS

Health services in the rural areas were originally provided by mission doctors from Europe who first started coming to South Africa in the early nineteenth century. Initially, health services were set up to cater for the needs of the missionaries and their families who were exposed to "tropical" illnesses. Later, mission health services were set up to provide medical care for the african population.

In the late 1960's, a combination of factors led to the South African state taking over these mission health services. The state was concerned about the liberalising influence of the missionary and expatriate doctors, and was also proceeding with its "separate development" policy and was eager to place homeland health services in the hands of the homeland authorities, thereby giving them credibility and respectability.

A newspaper editorial published soon after the Transkei goverment opted for "independence" pointed out that the problem of malnutrition in the area had been redefined from a problem of the South African state, to a problem of the Transkei goverment. "The Transkei malnutrition and death rate are now the worry of the Transkei goverment" it stated. "This is being done in the guise of giving freedom to blacks. Could anything be more cynical?"(RDM 30.12.77)

HOMELAND HEALTH SERVICES BOLSTER APARTHEID

There are a number of ways in which homeland health services and policies regarding the services reflect, support, and complement broader policies regarding the homelands and their relationship with white South Africa generally.

Firstly, the homeland health services reinforce the dependence of the homelands on Pretoria. Almost the entire homeland budgets derive directly from the South African goverment.

Secondly, the homeland health services give credibility to the homelands by giving the impression that these authorities are able to care for the health and social welfare needs of the population in these areas.

Thirdly, the establishment of homeland health authorities encourages ethnicity and attempts to foster a black tribal identity rather than a national identity. In Lebowa, for example, a hospital was handed over to Gazankulu, another homeland. This led to the withdrawal of nursing and administrative staff, and a large number of patients and their records, because Sotho staff refused to work under the Gazankulu authorities. (See Critical Health number 6, 1981).

Fourthly, adverse publicity is focused on the homelands and away from the South African goverment. In Kangwane, where services and amenities were very poor, the local population blamed the homeland authorities for the poor conditions and high rates of disease, rather than the South African state which is really responsible.

Fifthly, health statistics can be manipulated in order to give the impression that the

health status of people is improving. The rate of tuberculosis officially decreased markedly towards the end of the seventies and early eighties. On closer examination this can be shown to result from excluding health statistics from the "independent" homelands.

Sixthly, ethnic organisations have been established in order to promote the tribalisation of professional and other groupings. Kwazulu nurses, for example, have been prevented from joining the South African nursing association and forced to establish their own ethnic nursing organisation.

Finally, the homeland health services can be used to put pressure on the "non-independent" homelands to opt for "independence". This pressure has resulted from the dependency of the homeland health services on staff and money from the South African goverment, and the way in which the goverment is able to manipulate these in order to pressurise the homeland authorities.

CONCLUSION

This article has attempted to focus on the health services in the homelands and to draw attention to the political aod ideological roles that these services play. It has been shown that events in the homeland health services mirror those taking place in the relationship between the homelands and white South Africa generally.

It must be recognised, ultimately,,that the health care system reflects the nature of the society in which it is located. This is particularly apparent in the South African context.

REFERENCE

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Anthony Zwi

LEBOWA HEALTH SERVICES

The following are extracts from questions put to the Minister of Health of Lebowa in the Lebowa Legislative Assembly and the answers received from him. They are taken from the annual report of the Department of Health and Social Welfare, Lebowa, 1979/1980.

Q: At St. Rita's Hospital the mortuary is too small, there are too few telephones and too many patients for the available accommodation. What is the difficulty?
A: Lack of funds.

Q: Is it not time that all hospitals and clinics be supplied with two-way radios?
A: Yes, but funds are not available.

Q: Freezing of posts should be abolished if still practised by your department.
A: I agree wholeheartedly, but can unfortunately not afford to fill the vacancies at once.

Q: Jane Furse Hospital is very overcrowded, causing the patients to sleep on the floor. How can your department be so cruel?
A: We do not want to be cruel, but we are forced to accept this deficiency because of the financial state of affairs.

Q: Ambulances are too old, causing the hospital to deliver medicines by tractor.
A: This is not ideal, but is a result of the everlasting shortage of funds.

Q: Droogte and Bolahlakgomo Communities informed me to request the Hon. Minister to build a clinic within one of those places. Will it be possible?
A: Such requests should not be directed to me but to my department. I am informed by my department that a clinic has already been approved for Volop i.e. Bolahlakgomo. It will not be possible to build the clinic, however, untill (sic) funds are available.

Q: Last year I requested the Hon. Minister to enlarge the mortuary at Groothoek Hospital. What is the position now?
A: The position is the same as last year, as I have clearly indicated in my Budget and Policy speech. No funds are available for this purpose.

PHC CLINICS IN SOWETO
a comprehensive service?

It is state policy to provide blacks in urban areas with adequate health services to enable them to be productive members of the labour force. However, when it comes to providing funds for basic health services the state appears unable put policy into practice.

Health services are not comprehensive and standards vary. Clinic tarrifs, although calculated according to the patient's income, are nonetheless too high for low wage earners or the unemployed. Recently provincial hospital and clinic fees have been raised by 150%. The drop in attendence at the clinic since the latest tarrif increase has been dramatic and health personnel sit with no patients to see.

In addition people have been encouraged to seek private medical care and thereby remove the responsibility from the state.

Medical schemes are being introduced widely and their members pay private rates for doctors and hospital care. The The long term aim of these policies is clearly to make more urban blacks pay for their own health services. The existing services will cater for preventive care, immunisation, the elderly and those suffering from chronic illness, as well as family planning services. This also means that the unemployed and those who are "imformally" employed will not be able to afford good health care.

This trend parallels the trends in other social security services, for example, pensions. The working class is being called on to fund its own pension schemes.

In addition to this, standards in medical care for patients who can afford it are different for black, coloured, asian and white patients.

HEALTH SERVICES IN THE TOWNSHIPS.

Very few townships in the Witwatersrand have community clinics. Thembisa and Sebokeng, with their large populations, have no curative clinics. People living in these townships must attend the township hospital for treatment. These hospitals cannot provide comprehensive care for an entire township.

Soweto has the most sophisticated and comprehensive clinic system in the Transvaal. Although Soweto has always had clinics, after June 1976 an effort was made to upgrade the clinics and provide a standard of health care acceptable to Soweto residents in the wake of the "unrest". Below is a description of the health services offered in Soweto. Although it attempts to be comprehensive, lack of funds, inadequate staffing, a large patient load and a top heavy administration prevents the promotion of the overall health of the community.

SOWETO HEALTH SERVICES.

There are ten polyclinics in Soweto, funded by the Transvaal Provincial Administration(TPA).
Seven of these are Primary Health Care clinics and are staffed by primary health care nurses who see all the patients. The sisters take a history, examine the patient and assess and treat the problem. Complicated medical problems are refered to a doctor.

The sisters have a thorough clinical training and treat both adults and children. The approach is in theory a comprehensive one and includes checking that immunsation is up to date, health and nutrition education, screening for hypertension and a full explanation to the patient about the diagnosis and treatement of the patients' complaint.

There is a weekly physiotherapy service and one of the clinics has an Xray unit. Antenatal clinics and delivery units at the clinic are run by conventionally trained midwives under the supervision of a doctor. Only uncomplicated cases are delivered at the clinics.

The dental services see individuals for treatment and groups of school children for screening and education in dental hygiene. Familyy planning clinics provide free services and are run by state trained sisters. District nurses from Baragwanath hospital visit indigent patients at home for administration of insulin injections, changing wound dressings etc.

All the clincs are funded for curative services only. They do not immunise or trace TB contacts or follow up contacts of people with sexually transmitted disease.

Preventive aspects of health care are provided by city health or peri-urban board clinics. They run large "well baby clinics" monitoring babies weight and immunizing. Health visitors visit problem homes and follow up defaulters. Services for alcoholics, cripple care and for the mentally handicapped existt as well as a social work service. There are a few voluntary services like the Marriage Guidance Association.

Most of these services are however far too small to provide services to everyone who needs them.

FACTORS WHICH COMPROMISE CURATIVE SERVICES.

COST

Patients pay for all curative services even if they are unemployed. Only pensioners are seen for free. Pregnant women pay a R15 toR25 booking fee, to ensure a clinic delivery at their first visit for ante natal clinic and are not admitted to the ante natal clinic until they have paid which means that they often only attend ante natal clinic late in their pregnancy. This fee is payable irrespective of their having an income.

In theory every patient needing treatment should be seen and given an account if they cannot pay at the time. In practice however, people tend to visit the clinic in proportion to the availability of money so that clinics are crowded at the begining of the week and the begining of the month. This also means that patients present when their illness is at a more advanced stage because money was not at hand.

In April 1982 the clinic tarriff was doubled from R1 to R2 and a recent increase to R5 has been instituted. The number of patients attending the clinics has dropped dramatically.

Subsidies for medicines have been cut. Antibiotics are issued for four days only except in special cases.Five days and seven days, depending on the condition, is accepted as the minimum period required for effective antibiotic treatment. So even if people do get to the clinic ,in some instances, they are not getting effective therapy.Budgets for laboratory facilities have also been cut so for example blood tests for sexually transmitted diseases are not done.

STAFF.

Primary health care nurses are paid the same salary as ordinary nursing sisters although they are more highly trained. When they obtain registration and their training is recognised they will be paid more, but this is still to come. Their training involves 6 years of general nursing before they can begin their primary health care training. They see fewer patints per day than a doctor but they see each patient more thoroughly and probabily communicate with the patients far better. Although they do the same work as a doctor they are paid far less. The poor salaries have lead many sisters to look for better paid jobs.

Staff is allocated according to provincial formulas of patient-staff ratios for the entire year. These do not allow for changes in ratio during busy or quiet periods, or for time consuming problems that a sister may have to deal with.Therefore clinic staff are often under great pressure and standards are sometimes compromised. Often sisters do not have time to listen to detailed complaints, explain the diagnosis or treatment and thus the major benefit of primary health care is lost.

The obstetric staff have all been trained in hospitals for hospital conditions. They have no specific training for the clinic conditions where they do not have constant supervision and back up. In addition, as senior staff have left provincial posts for better salaried jobs, more junior staff have been drawn into responsible posts in obstetric and non primary health care posts.

CONCLUSION.

This article has made no attempt to criticise the services of the primary health care clinics in Soweto. It has been mainly descriptive. In conclusion we have added a comment from a health worker at one of the clinics as an illustration of the way some people view the services provided.

"The primary health care system exists in an ignored city in the middle of apartheids' ills. A curative system surrounded by preventable disease, staffed by an arrogant middle class dispensing tablets to cure poverty. Its administrators add up the number of patients and subtract them from a meagre budget hoping for a cheap solution. Its contribution to the health of Sowetans is minimal."

Johannesburg Medical Student

LETTER

Dear Critical Health

A comment on the new Groote Schuur Hospital.

It takes more than a few heart transplants to cause a stir amongst the residents of Observatory, and not even this concrete monster growing on their doorsteps raises many eyebrows. The projected cost of this 1700 bed hospital being built here is estimated at R200million and it is scheduled to be completed in 1990. Until then passers-by could usefully consider a few of the implications of this project.

> "It has been questioned in several countries by eminent medical authorities whether expensive and elaborate teaching hospitals are sometimes not the product of scientific fervour, careerism and lack of knowledge, coupled with the too free availability of funds, rather than real needs."

The above is a quote fron a paper on National Buildings for Health Care by Mr TL Webb, then director of the CSIR's National Building Research Institute. This is a state-funded and state commissioned research institute. So it seams that the state is ignoring its own research findings.

What are the real needs Mr Webb speaks of?
-50 000 new cases of TB are reported annually, with an estimated 4 to 5 times this number actually infected.
-the infant mortality rate in some homeland areas is more than 30%.
-25 to 30% of the rural population are malnourished.
-3950 cases of cholera and 3723 cases of typhoid were reported in 1981.
-80 000 people were victims of a range of diseases including diphtheria, leprosy, malaria, rabies, measles, polio, typhoid, tuberculosis. viral hepatitis, tetanus, cholera and trachoma.

These facts all highlight that the building of this monument is an act of short-sightedness. South Africa is a third world country with third world needs. To meet these needs we need third world health priorities. On the one hand we must provide for peoples' basic needs of housing, sanitation and good nutrition. On the other hand hand we must distibute health resources according to these real needs through decentralisation rather than futher concentration of facilities in urban areas.
As Mr Webb states futher in his report, "... the best use of our limited resources may well have to be along different lines if we are to counteract what has been described as rural hopelessness."

To limit the debate to the question of what is decided, would be toignore a more important issue, that of who decides. Health services in South Africa are controlled by the state and by the medical profession.Both are totally unrepresentative of South Africa's people, who remain passive participants in their own health care with neither the political nor the economic means to take control over their own lives.

So while we must accept that a new Groote Schuur Hospital is being built at a cost of R200million, we can draw hope from the fact that we live in a society in transition and that the society to emerge will be healthier because peoples' basic needs will be met.

<u>Cape Town resident and concerned health worker.</u>

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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