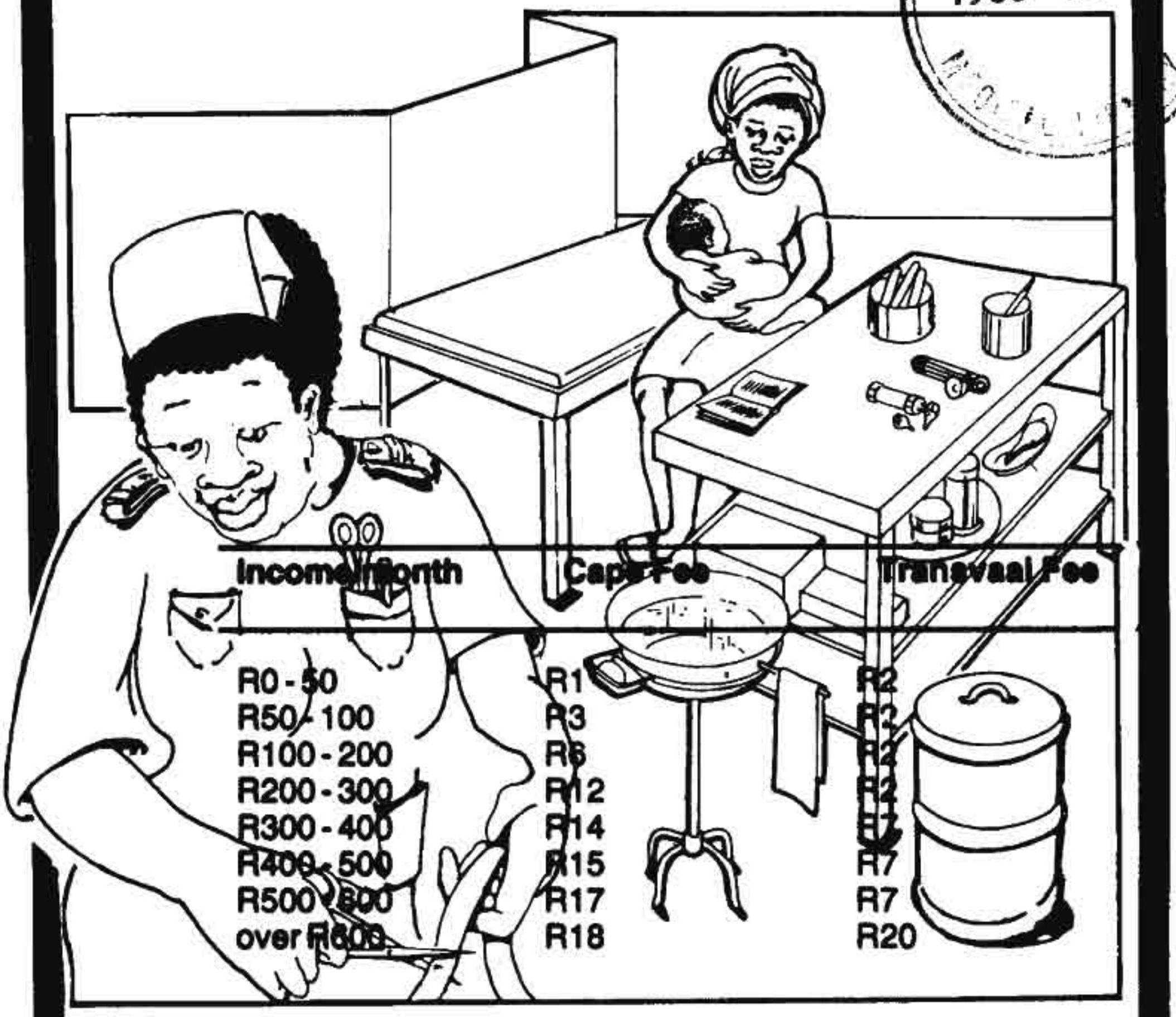
CRITICAL HEALTH

number 14 october 1985



health care: who can afford it?

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Thanks to EDA, Learn and Teach, Afrapix, HWA, Mike

People's Workbook

EDITORIAL

In April 1984, the outpatient fees at the provincial hospitals in the Cape and Transvaal were increased by up to 250%.

Government spokespersons on health have come up with reasons for these increases. They are concerned about cutting back government expenditure on public institutions like education and health. They argue that peoples' standard of living has gone up, and that people can therefore afford to pay more for their health needs.

But, in fact, this is not correct. A closer look at black working peoples' incomes shows that their wages have gone down in real terms over the years. This is what the article on "Income, Unemployment and the Cost of Living" in this issue of Critical Health explains.

In the mean time, health workers have seen the effects of the increases in public health fees. They see many patients who come only when they are seriously ill, and patients who do not come for check-ups and follow-up treatment, simply because they cannot afford the cost of transport and treatment.

Health care is becoming a commodity that only few people can afford. This is borne out by the fact that there is hardly any difference in provincial hospital fees and private doctors' fees. The government is encouraging the private sector to take over more of the health care expenses. Already, private clinics are being built in and around the townships. They provide mainly curative services for those who can afford it. The privatisation of health care takes attention away from the state's responsibility to see to the health problems which it produces with its policies of division and inequality.

The article on "Raising the Price of Provincial Health Care" shows the effects of the increases. This article, furthermore, shows how the fees are structured and makes

suggestions for a different, more fair fee structure that is more in line with peoples' real income and health needs.

The following article, "Health and Health Care in Mhala", shows the poverty in one of South Africa's rural "homeland" areas. That is where the diseases of poverty are even more rampant than in the cities, and people have even less access to health care. This article looks at ways of improving health care even within the unsatisfactory conditions caused by apartheid divisions.

As unrest and police violence in the townships continue, more and more people get detained. More evidence is coming to light about the conditions in which detainees are being kept. The affidavit by Dr Wendy Orr concerning the torture and ill-treatment of detainees in the Eastern Cape has highlighted the role of district surgeons. It has shown, once more, that state health officials, such as district surgeons, tend to put their obedience to the orders of the state before the duty to their patients. The same is true of many provincial hospitals who allow the unrest victims to be treated under police guard and released into detention. The Detainees' Counselling Service is one of the organisations which is concerned with the rights and health of detainees. The article on the "Psychological Effects of Detention" describes the post-traumatic stress disorders from which many detainees suffer, and suggests ways of dealing with these problems.

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INCOME, UNEMPLOYMENT, AND THE COST OF LIVING

The Official Figures

Many people who support government policies believe that the standard of living of urban black people has improved over the past five to ten years. Government officials and employers argue that therefore black people are able to pay for their own education, housing, and health services.

When these people put forward these arguments, they often use figures from the government's Central Statistical Services. The Central Statistical Services give figures on average earnings of each race group. Also, there are a number of studies which show that the income gap between whites and blacks is becoming narrower since 1970.

A Second Look at the Statistics

The picture that these statistics and studies paint, is regarded by many people as a fact. But nothing is further from the truth. The real picture of black peoples' standard of living looks rather different. This is not to say that the Central Statistical Services are telling lies. Rather, the problem with these statistics is that they are measuring something different from what many people think or would like to think that they are measuring.

When the Central Statistical Services talk of 'earnings', they mean the aggregate wages, bonuses, allowances, overtime pay, medical aid and pension scheme contributions.

Much of the increase in African earnings between 1978 and 1981 was taken up by increased contributions to pension schemes. These cannot be called 'income' in the correct sense of the word. The greatest contribution

to the rise in earnings during this time period came from the high level of overtime work which workers were putting in. At that time, overtime pay made up a great deal of workers' wages, especially of workers in the manufacturing sector. While this was happening, the actual wages of workers (including allowances and bonuses) fell in real terms.

Now this applies only to the sample of employees which the Central Statistical Services based its figures on. The real situation was even worse, because these figures do not include the lowest paid sectors, namely agriculture and domestic service, nor the independent bantustans. Once people have been removed to the bantustan areas, they no longer appear in the South African statistics. In this way, the South African government gets rid of its responsibility for the welfare of these people.

Another problem with the figures from Central Statistical Services is the fact that they do not consider the distribution of income. They ignore the many people who do not get any income, who are dependent on the people who do have an income.

From this, we can conclude that the real African wage rates, household incomes and individual incomes, have remained more or less the same or have even gone down during the period 1976 to 1981.

Between 1917 and 1970, the income gap between whites and Africans has widened. Many data have been put forward to show that this inequality in income distribution has lessened markedly since 1970.

But these data only look at the distribution of income between people who actually receive income. The data ignore those people who do not get an income - that is, the unemployed, whose numbers have more than doubled during this period. If we include these and look at income distribution on a 'per capita' basis, we find that the per capita income distribution of income between Africans and whites has not improved.

Unemployment

But not only has the inequality between white and black South Africans increased. There is increasing inequality amongst africans themselves - between Africans living in urban areas and those living in the bantustans, and between those who have an income and those who do not have any income at all. One reason for this inequality can be found in the increasing unemployment of Africans, which has doubled since 1970; and another reason for this inequality is the fact that subsistence farming in the bantustans is virtually impossible and that social security services are non-existent. The number of people in the bantustans living below the bread line has, from 1960 to 1980, almost doubled from 5 to 8,8 million. The number of people in the bantustans without any source of income has increased sixfold from 0,25 million to 1,43 million from 1960 to 1980.

Soweto households: "We cannot win"

In the urban areas (notably Soweto), households have responded to low income and rising prices by sending out more people to work. These people were almost exclusively women. This caused hardship and suffering to the people concerned. At the end of the 1978-1981 upswing in the economy, there were more households below the poverty datum line than before that period.

The hardship of the people affected in this way did not even ease with a real increase in wages during 1981 and 1982. For with the beginning of the recession in 1981, more people became unemployed. Many of the household members who took up employment between 1978 and 1981, were retrenched. In this way, Soweto households could not win. In the 'boom' period 1978-1981, they were affected by the high rate of inflation. In the "downswing" period which started in 1981, they were affected by increasing unemployment.

This article was adapted from a paper presented by Jeremy Keenan to the NAMDA Conference "Towards Health Care for All", January 1985

UNEMPLOYMENT AND INCOME DISTRIBUTION IN A "HOMELAND" AREA

The findings given below come from research that was done in the Pilanesberg area of Bophutatswana. This area is one of the best off homeland areas. It is close to industrial growth points, to the platinum mines, to Sun City, and to the Bophutatswana government administration and services. That means that people living in the Pilanesberg area have access to jobs and transport.

Nevertheless,

- more than 40% of people who would be able to work in a job are unemployed.

- The income in the area is very unequal:
  10% of households get 33% of the cash income in the area
  50% of households get 17% of the cash income in the area

- 55% of households live below the minimum living level (that is, below the level of what a family needs to survive in the short term, not including clothing, transport, etc.)

- 75% of households live below the effective living level (that is, below the level that is calculated at 50% more than the minimum living level and includes money for transport, clothing, etc.)

- The main reasons why people lost their jobs and became unemployed were illness and ill health caused by poverty and malnutrition.

- 40% of the people who lost their jobs are between 20 and 29 years old.

RAISING THE PRICE OF PROVINCIAL HEALTH CARE: UNWISE AND UNFAIR?

In this paper, John Frankish and Merrick Zwarenstein from the NAMDA Tariff Group look at the rise in fees for medical services. This paper focuses on the medical service fees in the areas of the big cities which fall under the Cape and the Transvaal Provincial Administrations.

In looking at the rise in fees, it turns out that it is higher than the general rate of inflation.

The new tariff fees do take income and family size into account; but still, they put poorer patients at a disadvantage, and the price of health care would prevent many people from getting the medical care that they need.

In this way, the Provincial Administrations are not fulfilling their duty and their obligation to provide medical services to all who need them, at a price that people can afford.

This paper would, further, like to make some suggestions on how to improve the situation, so that the Provincial Administrations can carry out their tasks more fully and fairly.

Provincial Health Care Services in the Past

The provincial departments of hospital services always used to be responsible for providing curative health services to people in lower income groups. The Health Act of 1977 for the first time makes this a legal obligation. The provincial authorities have to provide for "personal health services". A "personal health service" is defined as any health service for examining and treating any person's physical or mental condition which

needs attention. The law does not specifically say that such services are to be provided for low income patients. But, in the past, provincial authorities and private medical services always had an agreement to lay down an income limit for patients to be treated in provincial health care. This agreement prevented competition between provincial and private health services for patients able to afford private, unsubsidised health care.

Conditions for appropriate provincial health care

If the provincial authorities are to fulfil their obligations to provide curative health services, they must not only have the facilities for medical care (such as hospitals, clinics, medical staff, facilities for examining, diagnosing, and treating patients, drugs, etc.); but they must also make sure that people in need of medical care can have access to the health care services.

The Tariff Fee Increases

Outpatient fees at the provincial hospitals in the Cape and Transvaal were increased greatly in April 1984 - in the Cape by 50% for all income groups and in the Transvaal by up to 250% for certain income groups.

Despite those very large increases, provincial authorities say that medical treatment is still accessible to all, because patients who cannot afford medical treatment can appeal to have their fees reduced. But if one looks at the fee increases more closely, it becomes clear that it is the average patient, rather than the exceptional patient, who cannot afford the fees of the provincial hospitals. According to official figures for 1980, more than half of Soweto households earn less than R300 per month. In the Cape Peninsula working class townships, the average income lies between R150 and R290 per month.

Results of the Increases

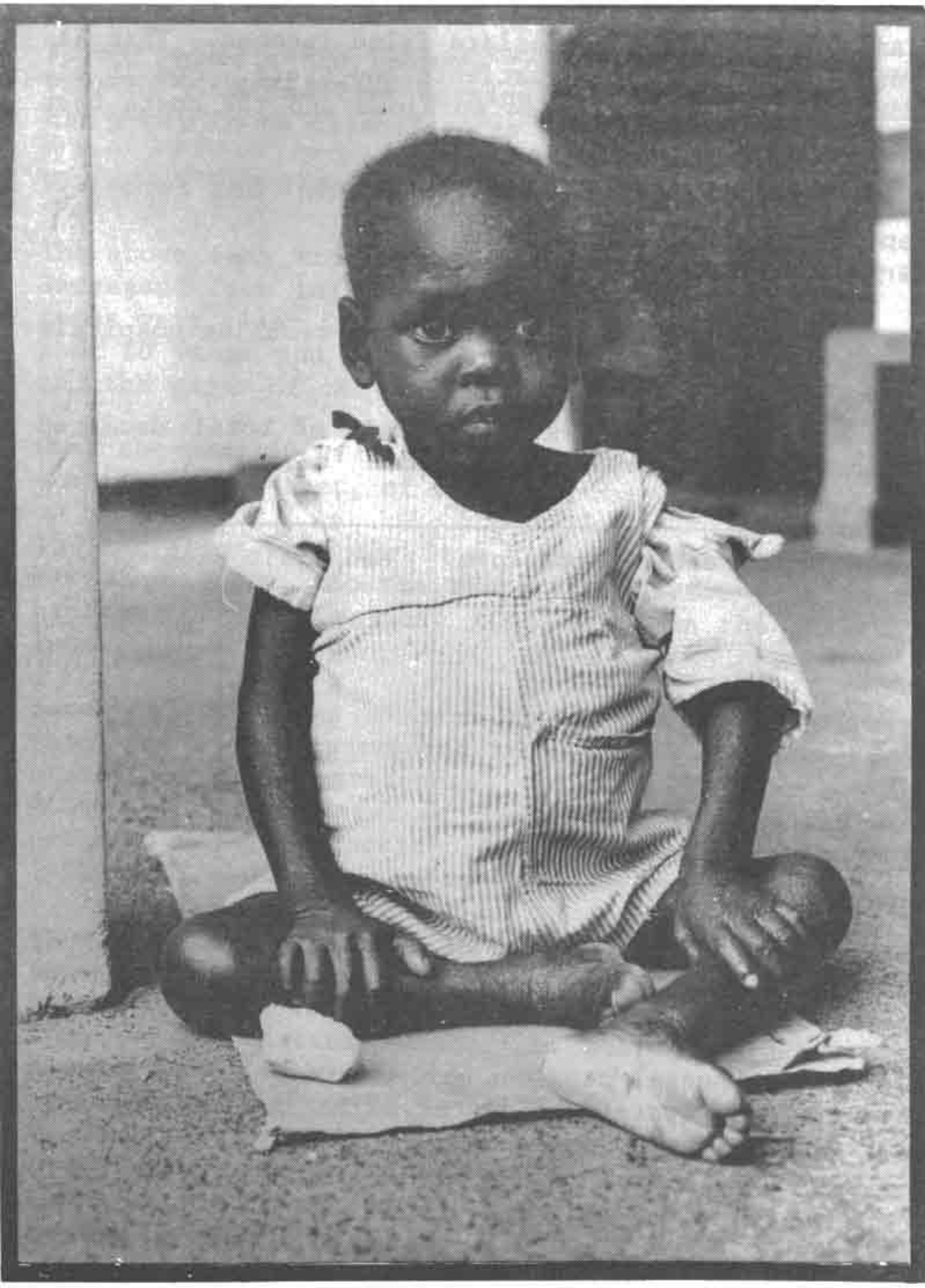
After the fees were increased last year, many patients could not afford to pay for medical treatment. As a result, the number of patients seeking medical treatment has gone down. The provincial authorities have not released any figures on this; but doctors in provincial health services confirm this drop in patient numbers.

There are many patients with chronic illesses such as hypertension, diabetes, asthma, and epilepsy who have stopped coming to hospitals regularly for follow-up treatment and medication. Now they often only come for treatment when their condition is completely out of control, or has become so bad that they do not have any other option but to come back for treatment. After they have been treated, they do not come back for regular check-ups.

The number of patients coming for dressings has also gone down. Meanwhile, it is very important for them to come to hospitals for getting wounds, chronic ulcers, burns, etc. dressed.

What is most disturbing is the fact that patients who have suffered from an acute illness hesitate to come back for follow-up visits, because they are charged for that return visit. So, for instance, it is uncommon today to have a child return for a Heaf reading, because patients are charged full rates even for that. Also, people hesitate to return for hydration checks, for circulation checks after they have had a Plaster of Paris cast, for follow-up of middle ear or of urinary tract infections in children, of pneumonia and jaundice, of anaemia, and so on. And as a doctor or health worker, it is difficult even to make a decision whether to ask a mother to return with her malnourished child when one knows that she cannot afford food for the family, let alone the costs of another hospital visit.

Apart from these immediate problems, the new fee structures have had other results which cannot be pinpointed so easily. The new fee structures have generally had



Child suffering from Marasmus and TB

the effect of undermining the relationships between hospital staff and patients. Many patients, for instance, feel forced to declare false incomes. This has caused embarrassment to patients and staff. And it has increased the bureaucratic workload and the costs that go with it.

Cape Provincial Administration Tariff Structures

The present outpatient tariff at non-teaching hospitals in the Cape is as follows:

Fees are payable on a sliding scale of total declared family income irrespective of family size:

Family income p.m.	Fee/visit
R 0- 50	R 1
R 50-100	R 3
R100-200	R 6
R200-300	R12
R300-400	R14
R400-500	R15
R500-600	R17
over R600	R18

Patients pay for a maximum of two visits per calendar month. Visits thereafter during that calendar month are free.

Patients on social pensions are seen free. (Unemployed patients on private pensions or with incomes less than that social pension are charged.)

Patients earning more than R600 a month are classified as private and are asked to go to a private doctor. (This ceiling was, in fact, R240 at the time of the tariff increases on 1 April 1984, and was increased on 3 August 1984 after representations to the authorities.)

Accounts are levied for any amount owed of R12 or more (including accounts from previous visits.)

Formal appeals can be made to have accounts reduced. Persons from families earning more than R600 per month can apply to be classified as hospital patients.

Fee Rises and Inflation

The above fees are very high. The true burden of the increased fees falls on low income patients. This becomes very clear if one looks at the increases over the past 10 years and relates these to the inflation rate and the wages of the average patient.

Over the past 10 years, there has been an increase, for each income bracket, of 500%.

The inflation rate for Cape Town over the same period was about 300%. So the hospital fees for each income bracket increased almost 60% more than the inflation rate.

Secondly, the rate of increase in subsidised hospital fees needs to be compared to the rate of increase in private general practioners' consultation fees as approved by the Minister of Health over the same 10 year period. General practitioners' fees increased by only 140% - well below the inflation rate for that period.

At one stage (during the period 1977-1979), the private fees were, in fact, increased by more than the inflation rate. But this increase was followed by such an outcry from private patients (who, in most cases, have the necessary political muscle), that the law was changed to give the Minister of Health final say over increases in the private tariff. He has never, since then, granted an increase more than the prevailing inflation rate.

Bracket Creep

So far we have considered only the fee increases for each income bracket over the past 10 years. This, unfortu-

nately, shows only part of the real fee increase which has taken place. The major effect of the fee increases is hidden in the so-called "bracket creep". While the fee for each income bracket has been increased (supposedly to take account of inflation), no corresponding adjustments have been made to the income brackets themselves. This means that patients find themselves moving up through the income brackets as their wages increase with inflation (but not with spending power), and so they find themselves in even higher fee brackets.

Other Problems

There are also other problems in the present fee structure which need to be mentioned.

Patients in the lower income brackets are asked to pay relatively more than patients in the upper income brackets. It would be more fair if all income brackets would pay roughly the same proportion of their income, or that the scales be weighted in favour of the lower income brackets.

The Cape Provincial Administration encourages patients to make use mainly of day hospitals. But patients who attend and pay at a day hospital and are then referred to a teaching hospital, are expected to pay a full fee yet again at the teaching hospital. This double fee can hardly encourage anyone to go to a day hospital first.

The Transvaal Provincial Administration Tariff Structures

The NAMDA Transvaal tariff study group has prepared a similar analysis focusing on the inpatient services of the Soweto Primary Health Care Clinics and Baragwanath Hospital which are run by the Transvaal Provincial Hospital Services.

"Computed Incomes"

In the Transvaal, the tariff category for a patient is decided on the basis of the computed income. This is

derived by dividing the total annual income by the number of family members plus one, for instance:
Five family members, total income per year - R2400
Computed income = R2400 6 (5 family members + 1) = R400

The method of adding one to the family size discriminates against larger families, tending to categorise them in higher fee brackets.

For instance: Two families, with the same income per person per month, but different in size, will have a different computed income and will often pay different tariffs.

Table: Family Size and Computed Income

Family Size	Annual Income	Income/ Person/ Month	Computed Income	Tariff/ Outpatient Visit	Class
2	R1800	R75	R600	R2.00	H4
4	R3600	R75	R720	R7.00	H5

Present Out-Patient Tariffs and Tariff Categories

There are four common paying categories, namely H3, H4, H5, and P3. Other categories are less common - these include social pensioners, persons with certain rare diseases, scholars from school clinics, long serving staff and patients whose fees are paid from other sources, such as Workmen's Compensation Act patients, prisoners, and so on. The present fees and tariff categories are as follows:

Current Tariff

Tariff Class	Computed Income(in Rands)	Outpatient Tariff Per Visit	Inpatient Tariff
H3	R 0-R 480	R 2.00	R10/admission
H4	R 480-R 600	R 2.00	R15/admission
H5	R 600-R1250	R 7.00	R20/day
P3	R1250 plus	R20.00	R45/day

Tariffs as a Proportion of Income

These tariffs take a large bite from the monthly income of patients who seek provincial medical care, particularly those in the lower income groups.

For example: A family of five with an annual income of R4800 (R80 per person per month) is classified H5. If two children each need one visit, and one return visit to a hospital doctor, the total cost is R28.00. That is 7% of that family's income. In addition, one child may be admitted to hospital for five days. In that case, at R20.oo per day in hospital, a further 25% of the monthly income is spent on medical care.

Comparison of Cape and Transvaal Provincial Administration Fee Structure

It is difficult to directly compare the fee structure of the Transvaal and the Cape Provincial Administrations; for the income brackets are different for the Transvaal and the Cape respectively. The Transvaal income brackets take into account family size, while the Cape income brackets do not do so. But if we take the family size to be five, we can compare the fees that patients from such families have to pay:

Income/month	Cape Fee	Transvaal Fee
R 0-R 50	R 1	R 2
R 50-R100	R 3	R 2
R100-R200	R 6	R 2
R200-R300	R12	R 2
R300-R400	R14	R 7
R400-R500	R15	R 7
R500-R600	R17	R 7
over R600	R18	R20

In both provices, fees have increased above the inflation rate.

In the Transvaal, an attempt has been made to adjust for bracket creep. This is the main reason why fees are so unequal between the two provinces. But the overall picture shows the totally arbitrary standards for setting fees. This calls for a nationally determined fee structure.

Why were the fees raised? - Refuting the myths

It has been argued that the tariffs could be raised because people are able to pay more. This would mean that real income rises have matched the 300% to 700% real rise in tariffs over the last 10 years. But studies have shown that this is not true. In the last few years, most household incomes have gone down in real terms. This can be expected to get worse in the current depression.

Another reason for raising the tariffs is the assumption that more Africans are members of medical aids, and that therefore people can afford the higher fees. But, in fact, only a very tiny proportion of Soweto residents are on medical aid. This is therefore no justification for raising the fees. The medical aids of which they are members often make people pay a part of the bill, and the patient usually has to pay an initial amount.

It has also been argued that many patients have factory health services provided by their employers. This, too, is only true for a small number of Soweto residents. In any case, these services are not always staffed by a doctor. These services are available to workers only, not to their dependants.The factory health services are closed outside of factory hours.

The health authorities have argued further, that many patients have switched to private general practitioners. There is no evidence to show that this includes all or even most of the patients who can no longer afford provincial health services. The fees range from R7 to R15 at the dispensing doctors whom most lower income patients would use. Therefore many of these patients are not able to afford this fee either. General practitioners usually do their best, but they cannot do investigations, or give patients expensive drugs for hypertension, diabetes, asthma, or other chronic illnesses.

The private profit sector cannot provide affordable health care to low income groups in the same way that the Primary Health Care clinics or Day Hospitals can. Therefore raising the tariffs and lowering the number of patients in the provincial sector is a contradicition, not a transfer of health services.

Even though the state might, in the short term, save money by raising the tariffs, it will not be able to cut down expenses in the long run. It will be overcome by the hidden economic and social costs of delayed medical attention for unnecessarily complicated illnesses.

Officials of the state health services say that those who use the service should pay for it. In 1983, only 6% of the total costs of the Transvaal health service was recovered in fees. Administration officials estimate that the fee increase of 1984 will pay for 9% of the overall costs of the health services. Does this estimate take into account the fall off in attendance, which lies anywhere between 8 and 80%? Does it take into account that there are going to be many more cases of se-

rious illnesses, because people cannot afford to get medical care as often and as early on in illness as they need it? And even if state health officials do take these things into account, is the extra burden of death and disease on low income groups worth the drop from 94% to 91% in the state subsidy?

Conclusion

The medical services are putting up barriers to keep patients out - to discourage people from using the services. In this way, they hope to reduce costs. They do this without considering the health of the patients, or their legal obligation to provide adequate medical care for those who need it and cannot afford to buy it privately. As a result, those in greatest need, those who are least able to afford illness, or health care, are affected most.

There are four reasons why the Provincial Administrations are doing this:

Firstly, there is a clear central government policy to reduce state expenditure, particularly social welfare expenditure.

Secondly, there is an unfounded belief that the private profit sector can provide for basic needs of low income groups.

Thirdly, the state is out of touch with the plight of the majority of the people, who do not have democratic control over state actions.

Fourthly, the state has no commitment to plan for the rational allocation of resources to priority health needs first.

Suggestions for Alternatives

The NAMDA tariff group would like to make the following suggestions, with the aim of encouraging patients to attend hospitals and clinics early in illness, and come for follow-up visits.

The first suggestion would be to reduce outpatient tariffs. NAMDA proposes a nominal outpatient fee for all patients from low-income groups. But the authorities are unlikely to put this into effect immediately. Realising this, NAMDA offers the following scheme for immediate national implementation:

Annual Income per household member	Proposed Fee/ Outpatient Visit
R 0-R 600	R 1
R 600-R1100	R 3
R1100-R1500	R 6
R1500-R1800	R10
over R1800	R15

The proposed fee structure would make for a progressively increasing fee as a proportion of income. It would also bring fees, both in the Cape and in Transvaal, more into line with inflationary trends since 1974.

In determining the tariff class, the household size shoud be taken into account fully. For the Transvaal, this means that the definition of "dependant" should be widened. "Dependants" should include unemployed adults dependent on that household, unofficial forster children, and rural non-resident dependants. All such people draw on the family income, and this should be taken into account when setting payment categories. For the Cape, the whole concept of household size should be introduced.

The cost of return visits should be lowered. The maximum number of visits paid for in a calendar month by any patient should be reduced from the Transvaal's present five to the Cape's two. Patients returning for results of tests or referred from a peripheral centre to a central hospital should not pay again. In general, doctors and sisters providing care should be entitled to issue free return cards to patients in need of follow up for a single acute illness episode. Patients with sexually transmitted diseases should not pay when returning for treatment; contacts should be treated a a low or nominal fee. Sufferers from chronic diseases, a list of which should be prepared and recognised nationally, should be charged a low or nominal fee for regular visits; those patients who are stable should be allowed three months' supply of medication.

NAMDA believes that people will willingly pay fees that they can afford and that they had a part in determining, for decent, polite health care. A reasonable fee structure will increase clinic incomes, improve relations in the health services, reduce the clerical and social work load, and also reduce misrepresentation, frustration, and authoritarianism. Most important, it will ensure that people seek care early rather than too late.

This article has been prepared in the belief that an issue as important as fees should be debated openly in the health service and in the communities served.

NAMDA therefore urges the health authorities to consult with legitimate community representatives, and with patients and staff.

While recognising increasing health service costs, NAMDA does not believe that these should be paid for with hardship and even more death and disease.

This article was adapted from a paper presented by Merrick Zwarenstein and John Frankish to the NAMDA Conference "Towards Health Care for All", January 1985

HEALTH CARE FOR ALL

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RESOLUTIONS

The following resolutions were passed at a joint meeting between the Health Workers' Association (HWA) and the Federation of Transvaal Women (FEDTRAW) in April 1985.

- This meeting noting with grave concern:

a) the drastic increase in the hospital and clinic fees and the 50% surcharge on after hour services
b) the limiting of drug prescriptions and surgical appliances
c) the fact that, despite the increases in hospital tariffs, no attempt has been made by the hospital authorities to improve services and facilities
d) the glaring inequalities in services for the different race groups

hereby resolves

a) to mobilise the community through progressive organisations in a campaign to protest against these measures
b) to work jointly with progressive civic organisations, trade unions, women's groupings and student bodies to bring about a just and equitable solution to the above problems and the establishment of fully integrated, non-racial health services.

Proposed by HWA
Seconded by the Soweto Women's Group.

- This meeting noting that:

a) 60% of the people in our land are forced to live in the backyards of apartheid. Here they are faced with poverty, hunger and starvation. They are denied the basic facilities for e.g. proper housing, sanitation, education and health facilities;
b) death due to starvation is a common event;
c) diseases relating to poverty, e.g. malnutrition, gastro enteritis, tuberculosis menengitis are rampant;
d) the effect of the migratory labour system and the resettlement of thousands of people have led to deterioration in family life and health status;

hereby resolves

a) to highlight the plight of our brothers and sisters in the rural areas
b) to work through our organisations to try and alleviate the problems of these people.

Proposed by HWA
Seconded by the Soweto Women's Group.

HEALTH AND HEALTH CARE IN MHALA

Gazankulu is one of South Africa's so-called "black states". The Mhala district is an isolated island mid-way between Nelspruit and Tzaneen. It is typical bushveld with limited water and poor agricultural potential. 152 000 people live in Mhala's 57 villages which vary in size and infrastructure. Health services are underdeveloped and comprise one 260-bed hospital (Tintswalo), one health centre, eleven clinics and a mobile clinic.

This paper focuses on the day to day realities of health and health care in Mhala.

Mhala is a "homeland" area like many others. The people who live there are poverty-stricken and, therefore, peoples' state of health is poor. The health service cannot do anything to do away with this poverty; and the health service does not give good quality health care that is in reach of everyone. The homeland policy brings about more problems because it breaks up the services and forces divisions between people. This article looks at the problems of health care in this area. Similar problems can be found with health and health care in other "homeland" areas. The writers of this article would like to show that it is nonetheless worthwhile to try and develop health services within the limits of the policies that cause social ills in this country.

This paper was written at the beginning of 1984. The figures in this paper give a picture of the conditions at the time. Even though slight changes might have happened between then and now, the general problems and the conclusions that can be drawn from the figures, have not changed fundamentally.

Socio-Economic Conditions

A study done by the "Institute for Development Studies of the Rand Afrikaans University" has shown just how

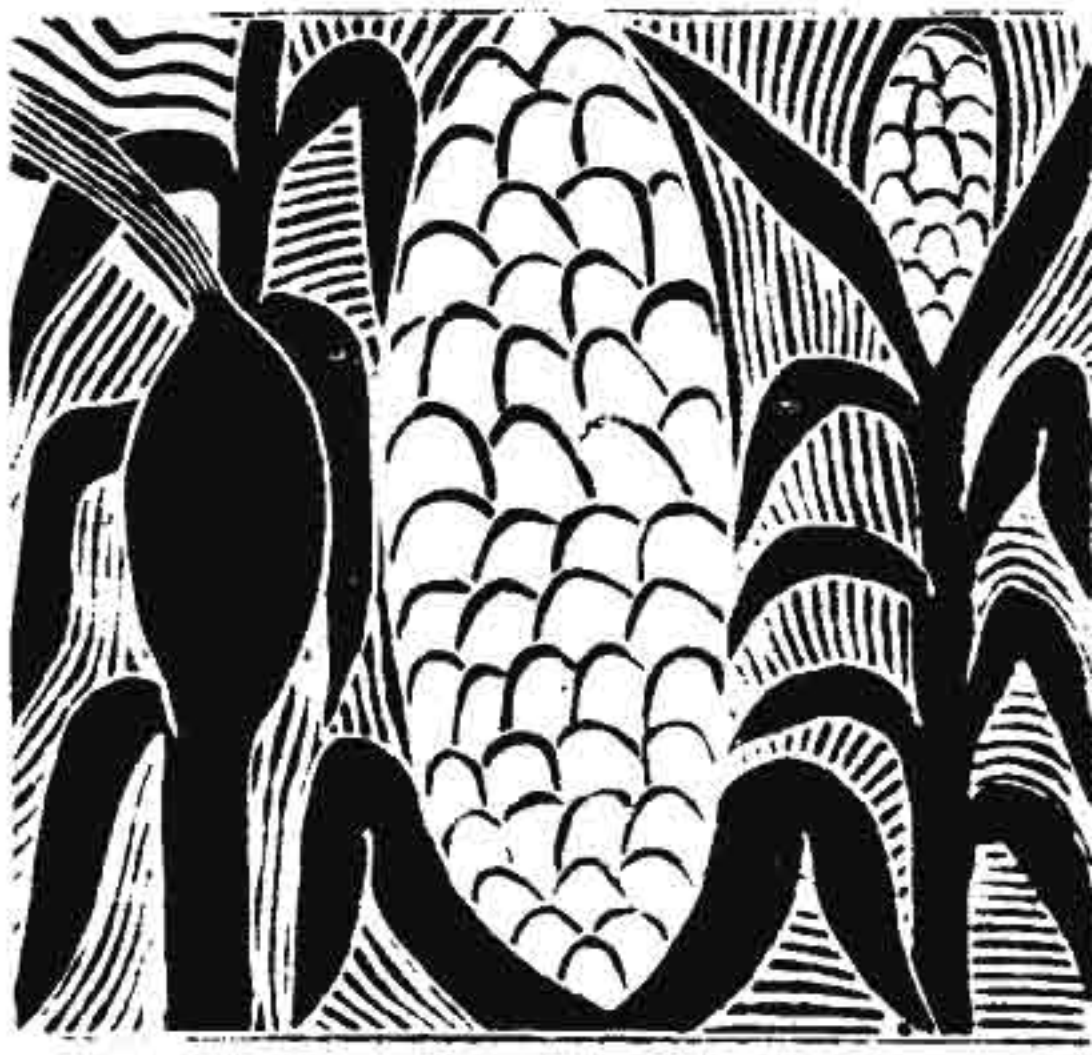
widespread and far-reaching the poverty in Gazankulu is. How do the problems of land, food, water, transport and education affect the people in their daily lives?

Land

There are 152 000 people living in the 1 204 square kilometer area of Mhala. On average, 126,2 people are living on one square kilometer of land. Most people live in closely spaced villages. They have limited access to land. The average plot is 1/4 hectare. People are given a further two hectares if this is available.

Food

People are not able to produce enough food on their land and do not have enough money to buy it. The result is malnutrition.



Even in the best years, a harvest will not provide food for more than five months. It is only in the few special development projects that fields can be watered.

The average family gets between R40 and R50 per month. This, in most cases, is what migrant workers send home. This money has to cover everything the family has to buy, including food. (The average family size is 5.) This is not enough under any circumstances, but it is made worse by the high cost of food in rural areas. (For any goods bought in the local shops, people from Mhala have to pay up to 44% more than in a supermarket in Nelspruit.)

Water

165 boreholes are the main source of water in Mhala. 31 boreholes have engines and 29 have reservoirs. Most boreholes feed into a single standpipe, but some have

more than one outlet. On average, one tap is used by 760 people.

The water situation is made worse by the distribution of boreholes and by inadequate maintenance. In April 1982, seven villages (with altogether 15 582 people) had no boreholes, and a further six villages (with altogether 16 846 people) had all their boreholes out of order.

This means that 32 428 (48,6%) of the 66 615 people in the 25 villages of Mhala South could not get clean water.

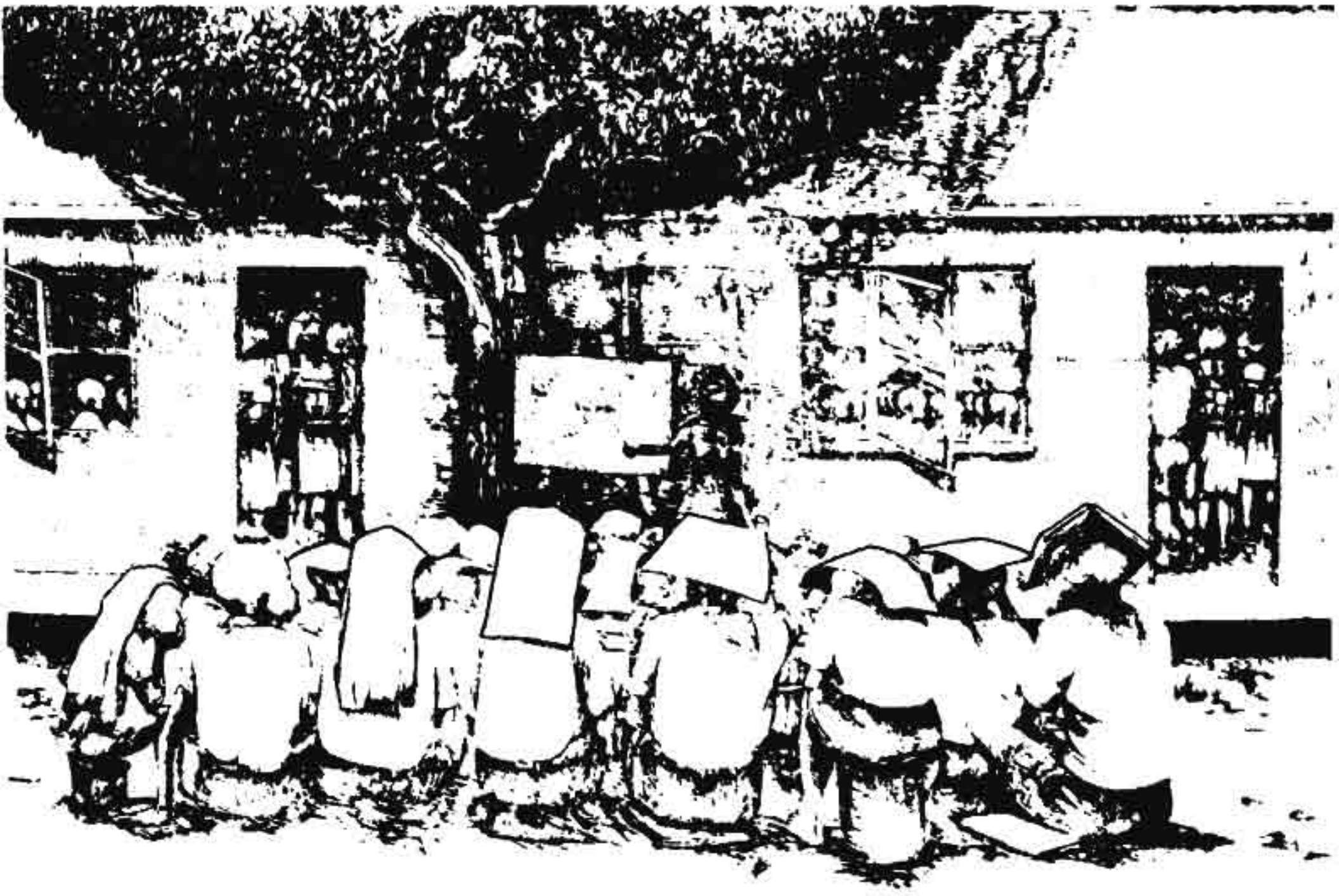
Transport

There is no bus service and only 6 kilometer of tarred road in Mhala. Transport is possible by means of taxis. But the taxi fares are so high that most people cannot afford them. People have to pay 80 cents for a return trip from the nearest village to the hospital, and R16.00 from the furthest village. At night, this increases to R10.00 for a return trip from the nearest village to the hospital, and to R80.00 for a return trip from the furthest village to the hospital.

Education

The primary schools in Mhala have one teacher for every 53 pupils. Many teachers are not qualified. There are shortages of classrooms and textbooks. Often, there are as few as five textbooks for a class of 60.

Given these poor socio-economic conditions, the disease patterns in Mhala are not surprising.



The Diseases

The diseases of poverty

Malnutrition

At least 5 021 (26,3%) of 19 021 children under five years are malnourished. 804 (4,3%) of them are seriously malnourished. The school health service found that 39,6% of 2 609 school children had not had any food before coming to school.

Communicable Diseases

Communicable diseases are diseases that spread from one person to the next. They spread particularly quickly where people are living without adequate food, and without proper sanitation facilities.

In 1983, 279 people were admitted to Tintswalo for TB. The number of people admitted to Tintswalo for Typhoid has steadily gone up from 111 in 1976 to 830 in 1982. Typhoid is endemic in the Mhala area. Cholera struck Mhala in 1981. 41 cases were confirmed.

Diseases in the children's ward

Tables 1 and 2 show that diseases that come with poverty are the main reasons for admissions to the children's ward, and for deaths. 63,9% of admissions are caused by 7 diseases. All of them are diseases of poverty. 69,7% of the deaths were due to 3 causes that have to do with poverty.

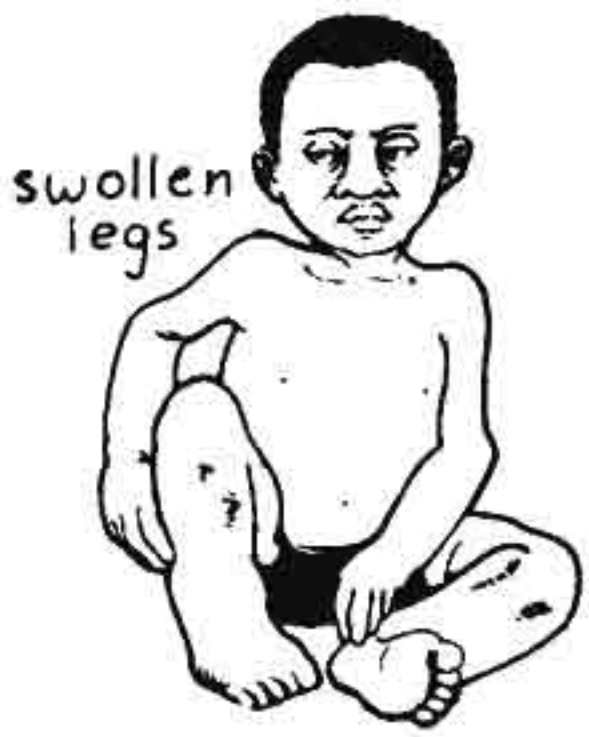
Table 1:Causes of Admissions to Tintswalo Hospital Children's Ward

Cause of Admission	Number of Admissions	% of Total
Gastroenteritis +/-dehydration	271	20,4%
Kwashiorkor and/or marasmus	175	13,2%
Pneumonia	153	11,5%
Typhoid	64	4,8%
Skin infections	64	4,8%
Paraffin ingestion	62	4,7%
Burns	59	4,4%
All other causes	479	36,1%
Total admissions	1 327	100,0%

Table 2: Causes of Death in Tintswalo Hospital Children's Ward (January - December 1983)

Cause of Death	Number of Deaths	% of Total
Gastroenteritis and dehydration	26	34,2%
Kwashiorkor and/or marasmus	17	22,4%
Tetanus	10	13,2%
All other causes	23	30,3%
Total deaths	76	100,0%

marasmus



kwashiorkor

marasmic-kwashiorkor

Harmful Health Behaviour

There are more and more things that people buy and use which may be harmful to health. Nowadays, many people eat refined foods. Also, people have come to rely on infant formula foods, alcohol, cigarettes and skin lighteners. Using these products is harmful in any society, but more so in poor communities, because they misdirect scarce resources and because people have not been warned about the harm that may befall them.

Diet

The staple diet used to be unrefined maize, with peanuts and dark green leafy vegetables as relish. Now only refined maize is available, which people eat with sugar, cabbage or tomatoes; and so proteins, roughage and vitamins are lost.

The traditional diet is not being encouraged and people do not realise that the changes they are making are for the worse. For example, only 22% of 46 mothers interviewed in an infant feeding study believed that peanuts were an important food.

The same study found that 80% of mothers had given their children fizzy drinks, 96% "chips" and 92% sweets.

Alcohol

The alcohol trade is flourishing and is supported by radio advertising. Bottle store owners do not give ex-

act sales figures, but say that business is "very good". This is probably true when one looks at the number of powerful people who get into the bottle store business. 8 of the 14 bottle stores in Mhala are owned by chiefs, headmen or ex-members of the Gazankulu parliament.

Cigarettes

Cigarette sales are going up all the time. Shop-owners say that people have changed from single cigarettes to buying packets and that the demand for new brands of cigarettes is increasing. Many people prefer status brands, such as "Benson and Hedges Gold" and "Dunhill".

Skin lighteners

The skin lightener market has grown very fast over the last few years. Sales have jumped and more and more products are becoming available on the rural market.

This is the picture of the diseases of poverty, and of the things people buy and use which may be harmful to their health. The next section looks at how adequate the health services are to deal with these problems.

The Health Services

This section shows that resources for health care are scarce. It also shows how this affects peoples' access to health care, and the quality of health care.

Accessibility

An "accessible service" would be one that is less than 5 kilometers away from where people live, and that provides care at all times, at a cost that people can afford. Health service policy and the behaviour of health workers should not alienate people.

Distance

About half the people of Mhala live more than 5 kilometers away from their nearest health facility. Tintswalo Hospital (the only hospital in Mhala) is situated in the north-west corner of the district. It has already been mentioned that transport is inadequate and expensive.

Those people who live further away are not likely to come to the health service as often and as regularly as they would need to. Although Tintswalo serves more than 50 villages, in February 1984 70,7% of outpatients came from only 8 villages. The three Gazankulu villages make up 13% of the population of Mhala. The same 8 villages mentioned earlier made up 59,9% of the deliveries at Tintswalo in 1983. The distance of the villages from the clinics also affects clinic attendance. About half the ill patients and children at child health clinics come from the village that the clinic is in; attendance goes down as the distance between the villages and the clinics or hospital increases.

Cost

Many outsiders think that health care in Mhala is "cheap". But in actual fact, it is beyond the means of the people living in Mhala. This can be shown by the results of statistical studies. In October 1982, the hospital and clinic fees were, on average, doubled. As a result, there was a drop in attendance in all but the free services.

There are more figures to show that people cannot afford health care. 65,8% more outpatients are seen at Tintswalo during the first week of every month than in each of the other three weeks. This is because people have more money at this time. December is the exception. The hospitals and clinics have equal attendance in all four weeks of the month of December, probably because migrant workers are home, bringing with them their Christmas bonus payments which allow people to go for treatment.

Time

Health workers at the hospital see far fewer patients at night than at urban hospitals. This does not mean that at night, fewer rural people need treatment. It is much more likely that people who need treatment at night cannot afford the high cost of night transport. At that time, also, patients cannot go to the clinics any more because the clinics close at 5 o' clock in the afternoon.

Alienation

If people feel unhappy with the health service, they are less likely to seek help from it. Health workers should therefore develop good relationships with their patients and give them all the information that they need. Health workers should show respect for traditional beliefs and practices. Some health workers, by their behaviour towards the patients, tend to make the patients turn away from the health service. For instance, a nurse might scold a mother who brings a dirty-looking child for treatment, not considering that the mother and the child had to walk a long distance to get to the hospital or clinic.

There are good reasons for health workers getting in touch with traditional healers. This is not allowed at Tintswalo - a policy dating from the time of mission control. Many patients choose to seek care only from traditional healers, or to get care from both traditional and modern sources. Care from traditional healers is readily available in Mhala. There are even training schools for traditional healers in the area.

How many in need of health care do actually get treated?
The problems of distance, time, cost and alienation are the reasons why only few of those people who need care, actually get it. Statistical studies have shown that the need of people for care is mostly met in the case of ante-natal care and delivery of babies. But other needs for health care like child health, family planning, home visits, and care for sick people, are far from being met.

It is important to realise that patients' needs for health care are real. It is wrong to believe that people in rural villages "don't want health care". If ways are found to give more people access to the health services, more people will come to the hospital and the clinics. This can be shown by the much higher rates of attendance when people have money and when they live near to the health services. When a mass immunisation campaign was held, more children came to be immunised than were believed to be in Mhala. This was because the service was available for free in every village; and informing the people had helped to overcome alienation.

Quality of care
The inadequate resources for health care in Mhala make for poor quality health care. Health workers have learnt to accept and work within this inadequate system. That is why standards and practices that would be queried elsewhere, are the norm in Mhala. For example:

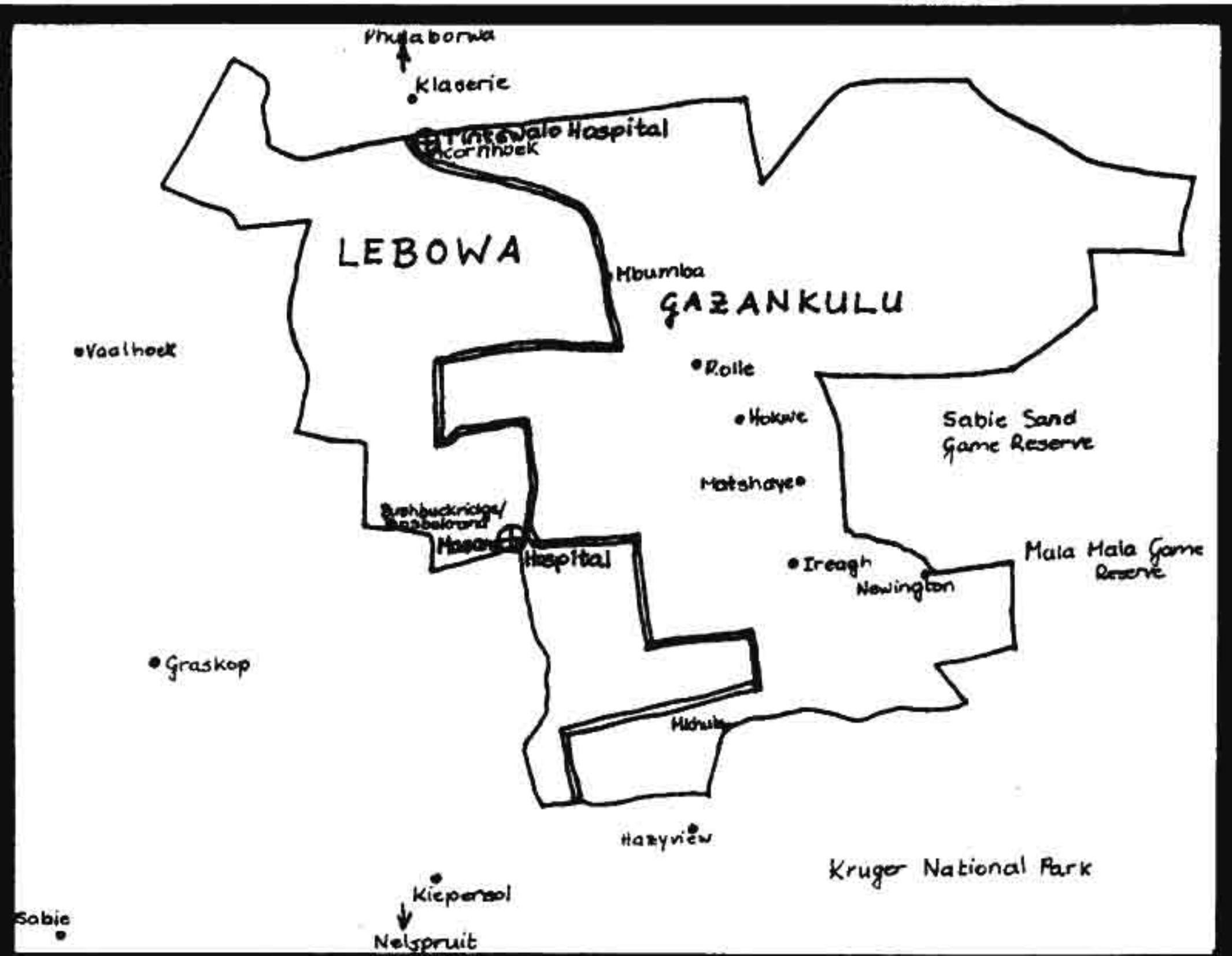
- It is acceptable that patients may be treated without having been examined.
- Workers function in areas where they have inadequate skills.
- Patients are not always explained what is happening to them.
- Patients die because there is no adequate referral system.
- It's "too bad" if things are out of stock or supply is short - patients just do without.

None of these shortcomings are planned or deliberate. They happen because of the inadequate framework in which

health care is delivered.There are not enough nurses and doctors to treat people in need of medical help; there is only a small amount of money available for hospital and community services; and health workers do not get adequate training for the work they are expected to do.

The Effects of the Homeland Policy

Tintswalo hospital and its neighbour, Masana, were previously responsible for the care of the communities around them. Tintswalo now serves the Mhala district of Gazankulu, and Masana the Mapulaneng district of Lebowa. The implementation of homeland policy has led to fragmentation of health services and divisions between people.



Fragmentation of health services

Before homelands were introduced, health services had the policy of serving nearby communities, of co-ordinating the services, and of communicating with each other. Now the Mhala district of Gazankulu is Tintswalo's responsibility, and the Mapulaneng district of Lebowa is Masana's responsibility. Each is now responsible for community health services on each other's doorstep. This wastes scarce staff-time and transport, and weakens an already inadequate support system.

The hospitals no longer co-ordinate policy. For example, when health workers at Tintswalo approached Masana for working together in the care of TB patients, they were told, "Gazankulu can do what it wants to, but Masana will follow Lebowa's policy". During the polio epidemic, health workers at Tintswalo wanted to run a joint immunisation campaign with Masana. But they were told that they should run their own immunisation campaign, and Masana, in turn, would run its own. Even in the face of an epidemic, the fragmentation of health services was carried on.

In the meantime, however, co-operation between the two hospitals has improved. The senior staff saw the bad effects of homeland divisions in health care and have co-ordinated some of their efforts. But there are limits to co-ordination and co-operation as long as the homeland policies remain.

Divisions between people

The health services do not officially distinguish between people whom they treat. Nonetheless, people are beginning to understand that Masana belongs to the "Sothos" and Tintswalo to the "Shangaans". For example,

- Some patients have been told by Masana staff to go to "that Shangaan hospital".
- Patients referred from Tintswalo's clinics to Masana have had to pay again, unnecessarily.
- Ambulance drivers from Tintswalo have refused to take patients to the "Lebowa hospital".

These are just a few of the results of the division be-

tween people. Others can be seen in the fact that Tintswalo only accepts "Shangaan speakers" for nursing training; that Sotho speakers in the Mhala district are beginning to feel that they should go to "the Sotho hospital" and not to Tintswalo; and that polio, when it broke out in Gazankulu, was regarded as a "Shangaan disease", and so many "non- Shangaan speakers" did not see the need to immunise their children.

Developing Health Services Under Apartheid

We have seen in this article what kinds of problems result from health services which function in a society based on inequality. People in most South African rural areas, especially in the "homelands" are poverty-stricken and find it hard to survive. They are in poor health, and the diseases which break out among them are the diseases of poverty.

Added to this are the problems of the health services themselves. The health care system is far away from the community, not only in kilometers, but also because of the time and money that it takes people to get to the health service. Also, many health workers cannot talk to and understand their patients well enough. All of these problems are responsible for the fact that only a small number of those people who need care, actually get it.

Many of these problems could be overcome with enough finance, staff, facilities and equipment. There is no hope that these will be forthcoming, given the unequal allocation of resources under the apartheid system. Health workers should not accept the poor quality of care as a norm. Finally, health workers should combine and co-ordinate their efforts to work against the bad effects of apartheid health services, so that health care will be better and more accessible to people.

Looking at all these problems, the question arises: Why try and develop health services if their chances for providing good care are so small? Why not wait for major changes in the structures of society that will remove

the barriers of apartheid and allocate resources in a more equal way?

We would like to argue that it is still worthwhile trying to develop health services in Mhala today. The reasons for this are:

- Health services are important in rural areas.
- It must become clear that what is seen as good enough in terms of the quality and accessibility of health care in rural areas, does not, in fact, meet standards of good health care.
- Alternative methods of delivering health care have hardly been explored in South Africa. This needs to be done.
- People need to develop an understanding of what is needed for setting up adequate health services.

In these ways, we can help the process towards and prepare for an improvement in the health services under changed social and political conditions.

This paper was presented by Cedric de Beer and Eric Buch
to the Second Carnegie Inquiry Into Poverty in Southern
Africa, April 1984

+ BATANDWA NDONDO +

Batandwa Ndondo, a young community worker from a well known Transkeian family, was murdered on Tuesday morning, 24 September, in the little Transkeian village of Cala.

That morning, five people came to Ndondo's house. After they had spoken to him, Ndondo agreed to go with them. Shortly thereafter, he was shot repeatedly in front of several villagers. Ndondo's body was taken directly to the police station, and then to the hospital. Ndondo's brother established at the hospital that the Transkeian police were involved. Later this was confirmed by the head of Transkei CID, General D.K. Nkalitshana.

The people living in Cala know that the van in which Ndondo was taken away belongs to the security police. The drivers of this van are known to people as the 'death squad'.

A murder enquiry was opened. Sworn statements by witnesses were taken by Ndondo's brothers, Dumisa Ntsebeza, a lawyer, and Lungisile Ntsebeza. However, key witnesses have been detained. Ndondo's friends and colleagues have been harassed by the police.

The police stopped Ndondo's colleagues from Cape Town from attending the funeral. All white people who came to attend the funeral were ordered to leave. There were more armed police than mourners at the funeral. Many youths, who were wearing T-shirts commemorating their comrade, were arrested at the funeral.

The post mortem has shown that Ndondo was shot eight times. At least six of the eight shots were fired after he had fallen to the ground.

At the time of his death, Ndondo was employed by the Cape Town-based Health Care Trust to co-ordinate a village health worker project at Cala. He was working with villagers on a community spring protection project to provide clean water for the village.

In 1984, Ndondo was an executive member of the Unitra (University of the Transkei) Students' Representative

Council. Following student action for representation, Ndondo was detained, released, suspended by the university authorities, and then refused re-admission in 1985.

A student boycott at Unitra was held in response to Ndondo's death. A number of students were arrested by police after demonstrating in protest against Ndondo's death.

Ndondo's killing happened against a background of widespread disruption and repression of youth organisations by the police. While people at Cala have lost a son and a community worker, this action implicitly threatens all those trying to work in local communities.

Since the Transkei took 'independence' in 1976, there has been an almost continual state of emergency. Recently, a 10.00pm to 5.00am curfew has been imposed, which has been harshly enforced.

The world focuses its attention on police action in the townships; but we must not forget the suffering of those living elsewhere in South Africa, in the backyard of apartheid.

BATANDWA NDONDO

THE PSYCHOLOGICAL EFFECTS OF DETENTION

People who are detained, interrogated, and tortured often suffer many unhealthy psychological effects. The conditions of detention make people suffer bad pain, humiliation, degradation, and fear. Detainees often cannot sleep, eat, or exercise in their normal way. They cannot carry on with their normal, day to day relations with people. They are not allowed to enjoy their normal comforts.

People in detention therefore have no control over the most basic functions of their lives. This loss of control, together with the pain, discomfort, deprivation, and fear, make people very prone to become psychologically disturbed. These disturbances can come about while in prison, or even some time after leaving prison. The symptoms and psychological disability can carry on for many years if the person does not get treatment.

Post-traumatic stress disorders

It is possible that, under bad pressures, people may completely lose touch with reality and become psychotic (mad). Other people may become withdrawn, depressed, feel helpless about themselves, and even become suicidal. The most common disturbance that people get once they have left prison, is a state of anxiety called post-traumatic stress disorder. People who are suffering from post-traumatic stress often remember the traumatic experiences in detention, especially torture. These memories return at any time of the day or night in the form of nightmares, or even when the person is fully awake. The fear and fright which the person felt during the actual torture, come up again when the person remembers the events during detention. This is very disturbing to the person concerned. The people suffering from post-traumatic stress will find themselves suddenly and unexpectedly trembling, crying, and becoming very anxious. These memories come back on their own, or during normal daily events which in some way are similar to the situations that the person has experienced in detention. Events such as hearing a door slam, hearing someone shouting, waiting in a queue, reading a

headline can bring back the memories of detention. The person is often unable to control these memories and they become very distressing. They make people anxious about being together with other people. They often shy away from contact with other people because they fear that they might break down in company, which can be embarassing and humiliating. They may also become withdrawn from family and friends for fear of showing their anxieties to others. They often become short-tempered and irritable when they are with others, even or especially with close family or friends. Often, they find it difficult to concentrate on work, or on reading, or on specific tasks. This kind of behaviour comes about because the person concerned is affected by the memories of detention, and by the fear that these memories may return. People who are suffering from post-traumatic stress disorders often get a fright at unexpected events like sudden loud noises (cars hooting or back firing, doors banging), seeing shadows, lights suddenly being switched on bright, or seeing unfamiliar people in familiar places.

Their sleep is often disturbed by bad nightmares and by fears of going to sleep in case the nightmares might come back, or in case they will not wake up again. The sleep problems can be very serious. They may make it even more difficult for people to concentrate on their work the next day because they are very tired.

Sometimes the symptoms of fear and worry may be so bad that people will feel unreal, as though they are not in touch with their bodies or the world around them; instead, they may experience everything as if they were in a bubble, cut off from the rest of the world.

People showing these signs of stress have difficulty working efficiently in their jobs or in their families, with friends, comrades, or in their leisure time.

Experiences of detainees in other countries

While all these effects are common, they are not always to be found in all people suffering from post-traumatic stress disorders. How bad the signs of stress are depends mostly on how bad the torture was which these people experienced. It has been shown in many different countries that all people who are tortured have their

breaking point, no matter how strong they are , and no matter how committed they are to the struggle. Torturers know that if they continue increasing the pressure on detainees, even the toughest will eventually reach this breaking point and crack. It follows from this that when people do develop these signs of stress, it means only that they were pressurised and tortured very badly. People who have been detained and tortured by oppressive governments in South America, Indochina, Asia, and Europe have reported similar conditions and symptoms. This shows that the kinds of reactions to detention, pressure, and torture which we have shown, are very common. Sometimes as many as 70% of all detainees will develop the symptoms of this state.

As far as treatment is concerned, medicines often help to relieve some of the symptoms, like difficulty in sleeping. But medicines alone do not cure the condition; the signs of stress often come back once the medicines are stopped. It has been found that the best and most reliable cures result from talking treatments with trained (psycho-) therapists. This form of treatment can be done individually, or in groups of fellow-sufferers. The treatment usually is successful when sufferers come to understand that the behavior which they show is a completely normal response to barbarous and inhuman cruelties. People usually recover when they are able to have faith in themselves and in the rest of the world again.

People who suffer from these difficulties and need help, can contact the Detainees' Counselling Service in Johannesburg at (011)23-6664. The service is given free by trained therapists for anyone suffering the psychological effects of detention. It is important to remember that these effects may not go away on their own, and that they will carry on disturbing and handicapping the sufferers for many years, unless they get the right treatment and help.

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