CHAPTER 14

Health for all?

Towards a national health service in South Africa

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At its landmark conference in Polokwane in December 2007, the African National Congress (ANC) adopted a resolution to implement a National Health Insurance (NHI) as part of a broader ten point plan to address the key challenges facing the health system.

In the Government Gazette of 11 September 2009, Health Minister Aaron Motsoaledi established a ministerial advisory committee to advise on the development of policy, legislation and implementation of the NHI. The Gazette declares: 'The introduction of a National Health Insurance System is founded on three principles. Firstly, that it is a Constitutional right that the public has access to affordable and acceptable quality health services; secondly, that it is the responsibility of the State to ensure the progressive realisation of the right to health for all South Africans that is premised on the objective of universal coverage; and thirdly, that it is important for health services to be funded in an equitable manner that promotes social solidarity' (Department of Health 2009).

Motsoaledi said the committee would release a draft white paper on the NHI for public comment in due course but by mid-March 2010 the white paper had not been released, and very little is known about the proposed NHI apart from the three fundamental principles outlined above.

The available information indicates that the NHI will pool all the money currently spent on health into a single National Health Insurance Fund (NHIF). This includes money allocated through the health budget, together with a 'mandatory contribution' from everyone over a certain income threshold. The mandatory contribution will increase progressively according to income but the unemployed and those below a defined income threshold will be exempt. The NHIF will pay for all health care services in South Africa. Citizens and permanent residents will be able to choose either a public or a private health care facility. There will be no user fees or co-payments for health care (Department of Health 2009).

Reynolds, L (2010): New South African Review 1. Wits University Press. http://witspress.wits.ac.za

The rationale for the NHI is made clear in the Gazette: 'The South African health care system is ... fragmented and inequitable ... due to ... huge disparities ... between the public and private health sectors with regards to the accessibility, funding and delivery of health services ... To address these imbalances in access and utilisation of health services as well as health outcomes ... the health care system requires the creation of a National Health Insurance System that transforms the health system into an integrated, prepayment-based health financing system that effectively promotes the progressive realisation of the right to health care for all' (Department of Health 2009).

In addition to the NHI, the proposed ten point plan includes the following:

- Stronger leadership (the number one priority)
- Improving quality of care
- Upgrading health system management
- Increasing human resources for health
- Revitalising infrastructure
- Accelerating an anti-AIDS strategy
- Creating mass mobilisation for better health
- Tackling policies on access to medicines
- Strengthening South Africa's research and development community.

Thus the proposals for the NHI are envisaged as located within a broader thrust to promote an affordable national health care system which be equally accessible to all South Africans.

The highly respected journal, *The Lancet*, has taken a special interest in these developments, and recently commissioned a special series of articles on health in South Africa, written by researchers, physicians, and public health specialists with intimate knowledge of the situation (Kleinert and Horton 2009).

An accompanying editorial expresses a mixture of caution and optimism:

> Is Motsoaledi's strategy deliverable? The past decade has seen Nelson Mandela's Rainbow Nation stripped of some of its brightest colours: thanks to escalating unemployment, deepening inequalities within the black population, emigration of some of the country's most skilled professionals, rapid declines in domestic food production, regressive tax policies, the collapse of the education system, a bloated welfare dependency culture, falling life expectancy, violence and social instability, and eroded standards of public service provision. Worse, The Economist has put South Africa at the top of a league table of vulnerable emerging market economies. The global financial crisis has severely limited the country's room for reform.
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> Despite these broader economic uncertainties [there is a sense of] unprecedented opportunity. A new coalition for national health renewal – between government, professionals, scientists, and activists – has been born. There are outstanding examples of excellence across South Africa's health service to learn from. And despite the past, as Aaron Motsoaledi pointed out, there is no predetermined future ahead. The outlook for South Africa can be different. As *The Lancet* continues to follow South Africa's progress, we believe it will be different – and better (*The Lancet* 2009).

The Lancet is correct: there is a palpable sense of optimism among a wide range of health professionals, civil society actors, scientists and health department officials.

However, excellent proposals and plans to improve health and health care have cropped up in the past in South Africa and internationally. Some have been inspirational, filling people with enormous enthusiasm and goodwill and commitment, only to falter and fail because of lack of political will and the power of vested interests. Three examples are particularly relevant to the NHI.

The first emerged in South Africa in 1944 when a national health services commission recommended the establishment of a single tax-funded national health service for all citizens irrespective of race or class. It was inspired by the concept of Community Oriented Primary Health Care (COPHC), developed under the leadership of doctors Sydney and Emily Kark in the 1930s and 1940s. COPHC based itself firmly in local contexts, provided comprehensive promotive, preventive and curative care through a team-based approach, and relied on a continuing cycle of local epidemiological research to guide practice. This departed from existing health care models, and was later to influence public health understanding internationally, notably in the USA and Israel. The second example was the almost universal adoption by many countries of the 1978 Declaration of Alma Ata with its commitment to health as a fundamental human right and its vision of 'Health for All' by the year 2000. Finally, in 2004, the Reconstruction and Development Programme and the ANC's national health plan for South Africa provided a vision for a just and equitable health

system for the new democracy. All three, however, failed to meet their potential, largely because of a deadly combination of a lack of political will and the power of vested interests.

This article gives an overview of why and how these historic opportunities emerged and why they failed. Against this background, it then explores what it would take for the NHI and associated reforms to contribute to making universal health care for all South Africans a real possibility. It argues that unless the lessons of history are learned, powerful vested interests grounded in neoliberal orthodoxy may attempt to shape the NHI in their favour. If they suc- ceed, the NHI is unlikely to contribute to the transformation of the health system in a way that effectively promotes the progressive realisation of the right to health care for all.

SOUTH AFRICA IN THE 1940s: Community Oriented Primary Health Care and the National Health Services Commission

An experiment with social medicine in South Africa six decades ago provides particularly trenchant lessons for today's attempts to improve the country's health and establish an excellent and equitable health system. In the late 1930s and early 1940s, new thinking around public health, community medicine and family practice emerged in South Africa, challenging prevailing ideas and creating great excitement. Progressive pioneering doctors, notably Raymond Dart, Eustace Cluver, Harry Gear, George Gale, David Landau, and Sidney and Emily Kark, developed a highly sophisticated and holistic understanding of the causal influences and roots of disease. They recognised the need for community participation and intersectoral coordination in health promotion and actively ensured that health and agricultural workers, for example, worked closely together to reduce malnutrition in people, animals and the soil (Yach and Tollman 1993).

At Pholela, along the Umkomaas river valley, the Karks employed and trained local community health workers who compiled detailed maps drawn from the local population. These maps provided a basis for the first population census in the area. The resulting report, compiling information gleaned from 887 inhabitants of the 130 homes adjacent to the centre, stressed the need for village planning in the areas of basic sanitation, soil erosion and nutritional status.

There was, therefore, early recognition of the importance of the environmental and agricultural sectors, and of community involvement. Annually thereafter, the initial defined area was expanded and served as a practice site for more intensive study and service. An annual household health census, administered by the health assistants, was introduced. 'In this

way,' Kark wrote, 'we hope[d] to lay the foundation for accurate epidemiological studies, for measuring movements of the population, and for assessing the influence of various environmental factors on people' (Yach and Tollman 1993). These steps laid the basis for what later became known as community oriented primary care which strives to link community wide interventions with primary medical care, using community epidemiology as its base.

The results were remarkable: crude mortality rate decreased from 38.3 in 1942 to 13.6 per 1000 in 1950; infant mortality dropped from 275 to 100 per 1000; and the incidence of severe malnutrition declined sharply. These improvements were accompanied by increasing interest and active cooperation on the part of the people served by the project (Kark and Cassel 1952).

In 1942, the South African government under the prime minister, Jan Smuts, appointed the National Health Services Commission (NHSC). Its task was to make recommendations for an organised national health service to ensure 'adequate medical, dental, nursing and hospital services to all [sic] sections of the people' (Jeeves 2005).

The Commission's chair was Dr Henry Gluckman, United Party MP for Yeoville. Gluckman had been prominent in parliamentary debates on South Africa's poor health status in the late 1930s. Sydney Kark was appointed the commission's technical adviser (Yach and Tollman 1993: 1043-1050).

The Commission proceeded with a comprehensive survey of the health conditions and needs of 'the people as a whole' and tabled its report two years later. It declared that the health of the people was 'far below what it should be and could be', and blamed this upon the poverty of the black population and large sections of the white population, as well as on the primitive health and educational facilities then available. It further argued that the medical system was not using its resources effectively. Its services were not available to large sections of the population, not organised on a national basis, and not up to modern standards. It needed a complete reorganisation.

The NHSC made it clear that reform of the health system on its own could achieve little unless the country addressed the underlying social origins of much of the preventable disease affecting it. Furthermore, rather than relying on individual doctors, health care should be delivered by teams made up of doctors, nurses and auxiliary personnel. Their mandate would be the 'promotion and preservation of health', rather than reliance on curative medicine (Jeeves 2005: p.91).

Over three and a half months of fieldwork the commissioners gathered evidence and testimonies from more than 1 000 witnesses. They described how service provision was disjointed, haphazard, provincial and parochial, and thus 'very inadequate'. Services did not conform with 'the modern conception of health' but were curative rather than promotive, and were 'poorly supplied to the under-privileged sectors who require them most'.

The Commission insisted that a national health authority's efforts should be directed not towards 'the provision of more and more hospital beds, but towards the provision of more and more health centres with periodic examination of all members of the population'. It therefore proposed the establishment of 400 health centres under twenty regional health organisations, each looking after roughly 25 000 people. These centres would provide 'personal health services for all sections of the people as a citizens' right . . . according to needs rather than means'. They were to be 'the basic unit' in the national health scheme where 'the actual personal health service will be rendered'. The entire country would be served, and every family would have a health centre to which it would look for health services which would replace the system of uncoordinated private practice (Digby 2008).

It concluded that adequate health services for all sections of the population required national uniformity under a centralised authority. This implied a single national health service that would reach all the people of South Africa, and would be paid for by a graduated tax assessed as part of general taxation.

The pioneering work of Sidney and Emily Kark and their colleagues at Pholela served as a model for the centres. The healthcare team there developed an intensive family health service in which the home visit, and not the clinic, was seen as the basis for activity. Health assistants acted as field workers in compiling detailed records of domiciliary visits. Preventive and curative healthcare gradually merged into 'a more comprehensive outlook best described by the title of social medicine'.

The future work of staff in Gluckman's health centres more generally was envisaged as being 'to act as the practitioners of social medicine'. Training the personnel who would practice social medicine in health centres had started at Pholela.

In 1945 Kark and others established the Institute of Family and Community Health at Clairwood in Durban. The Rockefeller Foundation helped the Institute with generous funding. The Institute offered public health training to a wide range of professionals from doctors to community workers.

The NHSC's innovative idea of health centres challenged the existing order, both in South Africa and Britain. As a doctor, Gluckman was well aware of the medical profession's

sensitivities. Anticipating opposition, the Commission spelled out patients' rights to a free choice of doctor in the new health centres, as well as the fact that there would be no compulsion for medical practitioners to enter the national health service. In its turn, the Medical Association of South Africa (MASA) made it clear that its 'preparedness to cooperate wholeheartedly in a national health service for the prevention and treatment of disease' was conditional on the preservation of personal relationships between doctors and patients, and on the right of doctors to engage in private practice.

The Commission decided to make 'a practical beginning' by rolling out the health centres, before 'delicate and important negotiations' had been accomplished and a 'comprehensive solution' had been reached. Meanwhile, the Smuts government, which turned out to be luke-warm about the Commission's recommendations, was signalling that reform would be introduced by a series of measures and not by major legislation as was to be the case in Britain with the establishment of the National Health Service in 1948.

The first 'Gluckman' health centre began in December 1945 at Grassy Park, in Cape Town, followed by Lady Selborne and Tongaat in 1946. Cradock and White River were set up in 1947. By 1953 there were more than thirty centres, and by 1960 the number had grown to more than forty. Most stressed promotive health education (through ante-natal clinics, mother and baby clinics or the examination of schoolchildren), as well as preventive measures (through improved nutrition, immunisation and vaccination), but the importance of curative medicine in the treatment of disease (through the outpatient clinic or district nursing station) varied considerably.

The extent to which health centres offered curative care threatened private medical practice. When Gluckman became minister of health in November 1945, he had thought it necessary to reassure the profession by stating that those receiving curative care at health centres would not have been able to afford a private doctor, and that centres had only been set up 'in those areas where there are large numbers of people so poor that they cannot afford to engage the services of private practitioners' (Digby 2008).

When the National Party (NP) won the elections in 1948, the political environment changed drastically, closing 'the window that had briefly opened for a more innovative approach' (Jeeves 1998). The multiracial health teams embedded in the health centres were antithetical to the NP's programme of apartheid. Staffing problems became endemic since more than one in five staff left, were transferred or had their services terminated, whilst major difficulties were experienced in staffing rural or remote centres. Within a few years, peripheral centres closed or had been handed over to provincial administrations.

Discouraged by hostile government policies, the Karks, and many of South Africa's most progressive doctors, emigrated.

But, as Shula Marks has pointed out, the hostility of the apartheid state to the health centre movement and what it stood for was not the only, or even the main, reason for the ultimate failure of the health centre approach. The Smuts government had been lukewarm to the proposal, and allowed the powerful authorities of the then provinces (Transvaal, Orange Free State, Cape and Natal) to retain control over publicly funded curative services and hospitals. The direct tax by which the system was funded was unpopular, and the government agreed to refund 50 per cent of provincial expenditure. Ironically, the provinces used this subsidy to provide free hospital services. However, the result of the political failure to bring all publicly funded health services under unified administrative control was that from the outset the health centres were starved of resources and the hospitals were favoured. In 1944/45, for example, the vote for health centres was only £50 000 – less than 4 per cent of the state health budget.This set up a vicious cycle (not unlike that being experienced today) in which the neglect of preventive and local curative services led to an urgent demand for hospital beds from a growing number of desperately ill people, driving up health care costs (Marks 1997: 456).

Furthermore, with the changed political climate and because the medical profession became more hostile to any notion of 'social medicine', district surgeons and private doctors also felt encroachment on their territories. Health centres became located only in areas where local authorities were unable to provide personal health services or where people were too poor to pay for private health care. Contrary to the original intention, the health centre idea became associated with the poor and progressively marginalised (*ibid*).

This shift of the health centres from the centre to the margins undermined the non-racial vision of the NHSC. By the early 1950s, when the apartheid government was implementing increasingly rigorous racial segregation, the majority of the centres were located in black areas. In 1952 the standing committee of the Commission resolved that 'the time has come for the official acceptance of the health centre as the means for improving the health of the non- European population and reducing the costs of health care.' As Marks points out 'health centres were finally reduced to being a cheap option for black health care' (*ibid*).

THE 1978 DECLARATION OF ALMA ATA

The concept of primary health care re-emerged in the late 1960s when it became clear that western-based colonial models of 'development' foisted on the colonies and based on the

idea of modernisation and progress and of 'helping them be like us' were failing. This included the transplantation of hospital-based health care systems that had evolved in England and Europe to the colonies with their vastly different climates, cultures and health environments.

Cueto (2004) has reviewed the historic strands and events that led to the establishment of the global goal of 'Health for All' by the year 2000 (HFA2000). The main historic strands were the work of missionary doctors in poor communities in different parts of the world, the success of 'barefoot doctors' during the cultural revolution in China, and the emergence of strong anticolonialist movements in Africa and elsewhere.

Missionary doctors working among poor people in underdeveloping countries discovered the value and importance of involving local people actively in their own health care. In the late 1960s they established the Christian Medical Commission (CMC), a specialised organisation under the auspices of the World Council of Churches and the Lutheran World Federation. The CMC emphasised the training of village workers at the grassroots level, equipped with essential drugs and simple methods. In 1970, it created the journal *Contact*, which probably used the term 'primary health care' for the first time. The offices of the CMC in Geneva were close to the WHO headquarters, and there were personal links between John Bryant and Carl Taylor of the CMC and Halfdan Mahler, then director general of the WHO. In 1974, collaboration between the CMC and the WHO was formalised. Influential books such as Newell's *Health by the People* (Newell 1975), cited examples of CMC programmes, while others were brought to the attention of the WHO by commission members (Cueto 2004).

Meanwhile, news had spread from communist China of enormous health gains achieved by 'barefoot doctors'. The barefoot doctors, whose numbers increased dramatically between the early 1960s and the cultural revolution of 1964–1976, were a diverse array of village health workers who lived in the communities they served – thus rural rather than urban health was stressed (Cueto 2004).

While the progressive health community debated PHC, a new political context favourable to it emerged with the spread of national, anti-imperialist, and leftist movements in decolonised African nations and other underdeveloping nations. These changes led to new proposals on development made by some industrialised countries. Modernisation was no longer seen as the replication of the model of development followed by the United States or Western Europe (Cueto 2004).

In 1975, the WHO and UNICEF produced a widely discussed joint report, Alternative Approaches to Meeting Basic Health Needs in Developing Countries. The term 'alternative ' underlined the shortcomings of traditional vertical programmes concentrating on specific diseases. According to the document, the principal causes of morbidity in developing countries were malnutrition and vector-borne, respiratory, and diarrheal diseases, which were 'themselves the results of poverty, squalor and ignorance' (Djukanovic and Mach 1975). The report also examined successful primary health care experiences in Bangladesh, China, Cuba, India, Niger, Nigeria, Tanzania, Venezuela and Yugoslavia to identify the key factors in their success. Again, the assumption that the expansion of 'Western' medical systems would meet the needs of the common people was highly criticised (Cueto 2004).

The landmark event for primary health care was the international conference on primary health care that took place at Alma Ata, the capital of the Soviet Republic of Kazakhstan, from 6 to 12 September 1978 – more than three decades after the Karks pioneered the concept at Pholela.

The conference was attended by 3 000 delegates from 134 governments and 67 international organisations from all over the world. Its main document, the Declaration of Alma Ata, which was already known by many participants, was approved by acclamation (Cueto 2004). However, despite the initial enthusiasm, it was difficult to implement primary health care after Alma Ata. About a year after the conference took place, a different interpretation of primary health care appeared, and once again the concept challenged vested interests.

Werner and Sanders have described the strong socio-political implications of the Alma Ata concept of PHC (Werner and Sanders 1997). First, it explicitly stated the need for a comprehensive health strategy that not only provided health services, but also addressed the underlying social, economic, and political causes of poor health. Specifically, it called for a more equitable distribution of resources. Political commitment to primary health care implied more than formal support from government and community leaders. For developing countries in particular, it implied the transfer of a greater share of health resources to the under-served majority of the population. It therefore recognised that there was a need for increases in national health budgets until entire populations had access to essential health care. Furthermore, it required affluent countries to commit themselves to a more equitable distribution of international health resources to enable poor countries, and especially the least developed, to apply primary health care. Finally, Alma Ata also emphasised the close link between health and development of the poorer sector of the community (although, unfortunately, to make the declaration palatable to the politically diverse governments represented at the gathering, a precise statement of just how 'development' was to be achieved was omitted) (Werner and Sanders 1997).

In line with three decades of experience, the Declaration also called for participation of the people affected, asserting that 'self-reliance and social awareness are key factors in human development', and emphasising the importance of 'community participation in deciding on policies and in planning, implementing, and controlling development programmes'. Strong community participation had clearly been a common feature of the successful community-based programmes which had been studied in the process of formulating the Declaration. The participants at Alma Ata recognised that PHC itself can contribute to development and serve as an arena for awareness raising and organised action. At the same time, they realised that the dynamic unleashed by greater awareness and mobilisation was potentially revolutionary, and was therefore likely to meet with opposition from those wanting to maintain the *status quo* (Werner and Sanders 1997).

This realisation of the socio-political implications of PHC may have been the reason for the imprecise language of the Declaration and for its subsequent reinterpretation to suit a range of agendas and interests. At a meeting at the University of the Western Cape in 1992, Dr Ofosu-Amaa of UNICEF acknowledged this lack of clarity: 'Unfortunately the use of the term 'primary health care' for so many themes and features of the basic idea has been the source of endless confusion'. This lack of clarity is arguably one of the reasons for the failure of the Declaration to lead to HFA2000 (Reynolds 2009).

In the narrowest interpretation, PHC was merely a place of health care delivery, the site of first contact between people and the health service, usually the local clinic. This, and the fact that local primary care facilities had for many years been functioning inadequately (mainly because disproportionate amounts of money were being spent on central hospitals) gave the impression that PHC was a cheap and inferior form of health care. However, others saw PHC as a changed philosophy of health care delivery, a reform of the health sector to provide comprehensive care at all levels 'from the small health post to hospitals and even the ministry of health'. This broader view included all levels of health care, but it ignored the necessity for inter-sectoral collaboration and community participation.

What, then, was the basic idea? The themes mentioned above are part of it, but there is more. The missing theme, implied in the document but perhaps not stated clearly enough, is often spoken of as '*the spirit of PHC*'. The spirit of PHC is its premise that health is a social, economic and political issue, and above all a fundamental human right. It addresses the under- lying determinants of health and is based on the concepts of equity, sustainability, and community empowerment (see, for example, Spirit of Alma Ata 1978; Caucus 2006). The Alma Ata Declaration states that ' ... primary health care is *essential health care* based on practical, scientifically sound and socially acceptable methods and technology *made universally accessible* to individuals and families in the community through their *full*

participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part *both of the country's health system*, of which it is the central function and main focus, and of the *overall social and economic development* of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

People have the right and duty to participate individually and collectively in the planning and implementation of their health care [italics added for emphasis]'. PHC 'requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources'.

In essence, the PHC approach seeks to empower people through a bottom-up notion of human development, controlled by people at the community level. Starting with local knowledge and resources, it promotes self sufficiency, and should be sustainable.

These ideas imply redistribution not only of resources but also of power and control. Instead of being at the top of a hierarchy, doctors would work in teams with other levels of health workers, including community health workers. They would learn to avoid professional jargon and to demystify technology and other aspects of care, seeking to empower people to understand more and take more responsibility and control over their lives. The voices of previously marginalised people would be heard and respected. They would become central actors in their own health and development (Reynolds 2009).

The most serious reinterpretation of PHC came with the emergence of s*elective* PHC (SPHC). In 1979 the prestigious *New England Journal of Medicine* published a paper by Julia A Walsh and Kenneth S Warren under the title 'Selective Primary Health Care: an interim strategy for disease control in developing countries' (Walsh and Warren 1979). The idea behind SPHC was that better health outcomes would be achieved more quickly in poor countries if groups of people who were at risk from major diseases were targeted with well chosen and cost-effective preventative measures and treatments. This shifted the focus from the overall social and economic development and empowerment of the community as a means of achieving health to technical interventions aimed at the prevention and cure of diseases.

The cartoon encapsulates the arguments that led to the advent of SPHC (Werner and Sanders 1997, with permission).

This narrow focus on disease was a fundamental departure from the values of the comprehensive PHC approach of Alma Ata, and to many it represented the demise of PHC. Where comprehensive PHC necessitated changes not only in the health sector but also in other social and economic sectors and in community structures and processes, SPHC involved the health sector on its own, leaving out other government sectors that are important for health. Furthermore, it ignored the emphasis on the overall social and economic development of the community and on social justice. More fundamentally, it ignored the all-important principle of involving the community in the planning, implementation and control of PHC. This de- politicised PHC, stripping it of its potential to transform people's lives and their place in the world (Reynolds 2009: 309-336).

But to others selective PHC was an attractive idea. Some public health experts felt that the broad, comprehensive PHC approach did not have clear targets. Selective PHC, on the other hand, made it possible to set clear, attainable short-term targets and to measure progress relatively easily. And because it removed the political dimension of health care it was attractive to governments closely allied to privileged minorities, elites with vested interests and corporate groupings (Reynolds 2009).

As an example of SPHC, UNICEF adopted the 'Child Survival Revolution' in 1983, with the goal of reducing by half the number of children in the Third World who die before their fifth birthday by the year 2000, at a cost that poor countries could afford. To meet this goal it prioritised four important health interventions under the acronym 'GOBI':

1. Growth monitoring – weighing growing children regularly to identify those at risk of malnutrition.

2. Oral rehydration therapy–to prevent children with diarrhoea from dying of dehydration by giving them a carefully prepared mixture of water, sugar and salt to drink.

3. Breastfeeding – because of its many beneficial effects on child health.

4. Immunisation – to prevent some of the major infectious diseases.

Responding to criticism that the programme was too narrow, UNICEF expanded it to 'GOBI-FFF' by including in the package the three Fs: Family planning, Food supplements and Female education.

Governments that had shown little support for comprehensive PHC welcomed GOBI enthusiastically. USAID and the World Bank pledged major financial support. By the mid-1980s, many poor countries were promoting some or all of the GOBI interventions. These interventions are excellent in themselves, and there have been many successes since the Alma Ata Declaration. Immunisation and oral rehydration have saved many children's lives and will continue to do so. Around the world, mothers and children are, on average, healthier than they were thirty years ago. But SPHC did not prove to be the interim programme it was sup- posed to be. In most poor countries it failed to transform into a broad comprehensive approach with universal coverage, intersectoral collaboration and community participation. As a result, the improvements in health it delivered were not sustainable.

This is not difficult to understand. Although immunisation prevents some of the major infectious diseases, it does not prevent other common diseases that flourish in poor socioeconomic conditions: gastroenteritis, pneumonia, tuberculosis, malaria, HIV/AIDS and malnutrition. Countless children whose lives were saved by oral rehydration became sick again and many died because they continued to live in conditions that made them sick, and because many were malnourished (Reynolds 2009). The health measures of the child survival initiative can only realise their full potential to save children's lives in a sustainable

way if health is seen as a fundamental human right and the underlying social and economic conditions in which poor people live change.

HEALTH CARE UNDER THE ANC: A road to crisis

In the run-up to the first democratic election in April 1994, the ANC adopted the Reconstruction and Development Programme (RDP) as its election manifesto in return for the support of the Congress of South African Trade Unions (Cosatu) in the elections. Through the RDP, labour hoped to commit the state to 'beginning to meet the basic needs of people: jobs, land, housing, water, electricity, telecommunications, transport, a clean and healthy environment, nutrition, health care, and social welfare' (Visser 2004: 6).

In May 1994, five decades after the NHSC had tabled its report, the ANC published its national health plan for South Africa, drawn up with the technical support from the WHO and UNICEF (ANC 2004). The plan stated clearly that:

> A single comprehensive, equitable and integrated National Health System (NHS) will be created and legislated for. A single governmental structure will coordinate all aspects of both public and private health care delivery and all existing departments will be integrated. The provision of health care will be coordinated among local, district, provincial and national authorities. Authority over, responsibility for, and control over funds will be decentralised to the lowest level possible that is compatible with rational planning, administration, and the maintenance of good quality care. Rural health services will be made accessible with particular attention given to improving transport.
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> Within the health system, the health services provide the principal and most direct sup- port to the communities. The foundation of the National Health System will be Community Health Centres (CHCs) providing comprehensive services including pro- motive, preventive, rehabilitative and curative care. Casualty and maternity services will be available as 24-hour services. Community health services will be part of a coordinated District Health System, which will be responsible for the management of all community health services in that district.

However, the RDP soon ran into trouble. It had considerable success in social security and welfare as well as access to healthcare, but there were huge backlogs in housing and access to basic services. Then, in 1996, the ANC-led government effectively abandoned it and replaced it with GEAR – the neoliberal Growth, Employment and Redistribution macroeconomic policy.

GEAR was not the product of consultation with Cosatu and the ANC's own broader constituency but was developed by a technical team of fifteen policy makers made up of

officials from the Development Bank of Southern Africa, the South African Reserve Bank, three state departments, academics and two representatives of the World Bank.

The ANC health plan did not last long either. Although it was never explicitly changed, the emphasis on private health care implicit in GEAR totally removed the vision of a national health plan from practical reality.

Nevertheless, it is important to acknowledge that there has been substantial progress since the dawn of democracy, notably in access to sanitation, water, and social grants and welfare. The proportion of households with access to sanitation increased from 50 per cent in 1994 to 73 per cent in 2007. In 2007, 60 per cent of all households had access to a flush or chemical toilet (an increase from 51 per cent in 1996). Households with access to the RDP standards of a minimum of 25 litres of potable water per person per day within 200 metres increased from 62 per cent in 1994 to 87 per cent in 2007. But the largest gains have been in the area of social grants. Between 1996/07 and 2007/08, beneficiaries of social grants increased from 2.4 million to 12.4 million. The new child support grant reached 8.2 million beneficiaries; recipients of the disability grant, which is payable to people with AIDS, doubled to 1.4 million, and old age pensioners rose from 1.6 million to 2.2 million (Coovadia *et al* 2009). Meanwhile, the government has provided the poorest households with free minimal access to water and electricity to meet their most basic needs, although many households are still unable to afford adequate access to either (Coovadia *et al* 2009: 817–834).

In the health sector, the aim has been to reduce inequities in health and health services through free primary care for pregnant women and children and a one-year community service programme for newly graduated health professionals. The racially segregated and fragmented homeland health care systems have been drawn into one national public health care system. Anti-tobacco legislation has been promulgated in spite of resistance from the tobacco industry. The Choice on Termination of Pregnancy Act of 1996 has resulted in a reduction in abortion- related deaths of between 51 and 96 per cent. There has been a reorientation of services towards primary care, and more than 1 300 clinics have been built (Chopra *et al* 2009) .

Concurrently, the government has had to resist the vested interests of corporate companies in South Africa and worldwide that could cause harm to health, especially the tobacco and pharmaceutical industries. User fees were removed for maternal and child primary health care services, and abortion was legalised. Government policy to remove discrimination and promote wealth redistribution has led to improved pensions, a burgeoning number of social

grants, and a social expenditure programme to build houses, and provide clean water, sanitation, and electricity (Chopra *et al* 2009; Harrison 2010).

Despite these gains, in 2010 the South African health system remains divided into public and private sectors, and the distribution of resources is inequitable. For example, using 2006 data from PERSAL, PCNS and Statistics South Africa, Wadee and Khan calculated that the number of people per doctor was 4 219 in the public sector and 601 in the private sector. The number of doctors per 100 000 dependents was 23.7 and 166.3 in the public and private sectors respectively (Wadee and Khan 2007).

Furthermore, both systems are in a crisis. As health economist Gavin Mooney points out, 'the public sector is grossly underfunded and overworked; the private sector is grossly inefficient and inequitable. This is a disastrous combination for health and for health care' (Mooney 2009).

The public health system is facing arguably its deepest crisis in history. It is fragmented, inequitably distributed across and within the new nine provinces, and even between sub-districts at local level. It remains hospital and doctor centred, and concentrated in the larger urban areas and cities. It is plagued by chronic staff shortages, low morale and a persistent brain drain. On the other hand, the private sector is plagued by spiralling costs of technology and medicines, a shrinking client base, now exacerbated by increasing unemployment arising from the global crisis of capitalism, and an ageing population.

This dysfunctional health system has to deal with one of the largest disease burdens in the world, including an estimated 4.9 to 6.6 million people living with HIV infection (making South Africa the country with the highest proportion of infected people in the world) (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance 2008); rampant and uncontrolled tuberculosis with growing numbers of patients with multi- and extreme drug resistant strains; the emergence of new epidemics such as avian influenza and the H1N1 virus; the re-emergence of 'old' epidemics such as measles; persistent childhood malnutrition; and a creeping epidemic of non-communicable disease including high levels of homicide and violent trauma, predominantly affecting poorer communities. Nutritional deficiencies and maternal and child health problems continue to affect large numbers of poor people.

Alarmingly, life expectancy at birth is estimated to have declined from 57 in 1996 to 50.5 in 2004. In 2004, life expectancy still showed significant racial differences. For example, the lowest life expectancy was for African males (47.8) and the highest was for Indian females (66), followed by white females (65.6) (Day and Gray 2008). The disease profile (and

therefore life expectancy) reflects the socio-economic situation in the country, where the more affluent live a healthier and longer life and the economically disadvantaged have a lower life expectancy (Day and Gray 2008; SAIRR 2008/9: 483).

South Africa is very unlikely to achieve the health-related Millennium Development Goals (MDGs). With respect to MDGs one and four (eradicate extreme poverty and hunger; reduce deaths in children under five years old) the country is showing 'reversal of progress'. Goal five (reduce maternal deaths) shows 'no progress', while goals two and six (achieve universal primary education; combat HIV, AIDS, malaria and other diseases) show 'insufficient progress' to meet the goals (Chopra *et al* 2009).

The massive burden of disease stems largely from neoliberal orthodoxy and the failure under GEAR, with its focus on growth rather than employment and redistribution, to deal effectively with the underlying social determinants of health, including growing inequality, deep poverty, inadequate housing, sanitation and domestic water in the home. South Africa has one of the largest burdens of disease in the world.

It is as true today as it was in the 1940s that realising the right of all South Africa's inhabitants to health cannot be achieved without dealing adequately with the underlying social and economic determinants of health.

THE NHI AND THE TEN POINT PLAN: Towards health for all?

Whether implementation of the ANC's proposed NHI and its accompanying Ten Point Plan will lead to the progressive realisation of the right to health, as envisaged by the PHC experiment of the 1940s, Alma Ata and indeed, the country's constitution, depends fundamentally on the nature of the society we want to build. More specifically it depends on the model of health care that the Ministerial Advisory Committee (MAC) agrees to promote and particularly on the human resource policy it adopts.

It is clear that attempting to extend the doctor-centered, hospital-based system focused on curative care such as that currently operating in the private sector to a wider section of people will be unaffordable. Yet unfortunately this seems to be the assumption that underpins current thinking as shown, for example, by the recent Econex study, commissioned by the Hospital Association of South Africa (HASA), a body representing the private hospital industry (Van der Berg *et al* 2010). The study finds that the healthcare sector is performing poorly by inter- national standards and that there is growing dissatisfaction with the service. It points out that free care at the point of service delivery will increase

demand for doctors' services, especially among those who currently cannot afford such care. Demand for private visits and hospital services will increase, while demand for public facilities will fall.

Then it examines 'the supply side' and concludes that about 10 000 extra general practitioners and 7 000 to 17 000 specialists will be needed to meet the increased demand. It shows that apart from the costs of employing such a large number of extra doctors, the country is simply not training enough doctors and nurses to meet the demand 'in the short-term'. It argues that South Africa's large disease burden means that utilisation of services will be higher under a NHI than most other countries. In addition, a properly designed system for South Africa should 'take cognisance of ... the high unemployment rate, the prevalence of poverty, the shortage of doctors and the relatively small tax base'. After considering a range of scenarios, the report concludes that the NHI is simply unaffordable (Van der Berg *et al* 2010).

Although it has been criticised by the unions, there is no reason to doubt the quality of the Econex report. Rather, its major problem is that it assumes a doctor-centered, hospital-based model, which, it has shown, is manifestly unaffordable. The argument that the NHI is 'unaffordable' favours those that benefit from the *status quo*. Though it has dominated the NHI debate, it is essentially a red herring. A country needs a health system that it can afford. According to Alma Ata, 'Primary health care is *essential health care* based on practical, scien- tifically sound and socially acceptable methods and technology *made universally accessible* to individuals and families in the community through their *full participation and at a cost that the community and country can afford* to maintain at every stage of their development in the spirit of self-reliance and self-determination'. Mooney points out that 'all countries can afford an NHI if they place enough weight on social cohesion and equity'. He estimates that an NHI will increase health care costs by about 15 to 20 per cent.

An alternative conception of how a South African health system should function, and the human resources it would need, has been provided by Sanders and Lloyd (2010) in a study for the National Health and Allied Worker's Union. In this, they are critical of the continuing focus on the medical model, and argue for a much wider concept of health worker than the one currently in favour. In essence, they go back to many of the ideas which were originally put forward in this country in the late 1940s.

Sanders and Lloyd argue that Community Health Workers (CHWs) can assist in service delivery at the community level. While there are thousands of Community Based Health Workers (CBHWs), there is no defined scope of practice, standardised training or model of working. Many are working on single issue or vertical programmes; there is no career

progression; and despite carrying out essential health services, the CHWs (who are most often women and usually from the most disadvantaged communities), are often paid a stipend, or expected to volunteer.

The health system should focus on 'task shifting' and proper recognition of existing and new cadres of health workers; redefining their scope of practice and ensuring that there is no duplication of roles; revising the training curriculum of health professionals; increasing production of all categories of health workers (old and new); and initiating effective mechanisms to ensure retention of health professionals in the public sector.

Comparing Brazil and Sweden, Sanders and Lloyd feel that the success of the Brazilian model offers lessons for South Africa. The Brazilian government takes responsibility for health service delivery, including prevention and promotion, and uses teams of professionals, which include paid CHWs, as essential members of the health teams. Doctor-centered curative services such as that offered in Sweden would cost significantly more than the family health team model of Brazil.

In South Africa, where a relatively small number of people would be contributing to the NHI fund relative to the number of people using it, it is very unlikely that a doctor-centred curative model would be able to address the broader health needs of the majority of the population. Extreme maldistribution of doctors results in large sections of the population being unable to access their services. Moreover, even if an NHI scheme could enrol the services of doctors currently working in the private sector, it is highly unlikely that they would relocate to rural or peri-urban areas.

By contrast, lower level health workers, CHWs and mid level workers (MLWs) are much more likely to remain in rural and peri-urban areas and are capable of undertaking many of the functions of doctors in dealing with common illnesses and injuries. They require to be supported by nurses and must be able to refer complicated cases to higher levels of the health system. In the short-term, the skills gap must be primarily filled by CHWs and MLWs while simultaneously the training of nurses and doctors must be accelerated and their skills base adapted to low-resource settings.

CONCLUSION

Without knowing more about the thinking of the Ministerial Advisory Commission (MAC) on the NHI about the nature of South Africa's health service it is not possible to know

whether the NHI will help bring about health for all. Although the members of the committee are there in their capacity as experts and not organisational representatives, it is inevitable that they will bring considerations related to their own backgrounds and prejudices, their occupations, lifestyles, preoccupations and other extraneous considerations to bear on the proceedings.

It is dangerous to speculate, but it is reasonably safe to say that given the diversity of their backgrounds, it is likely that the members of the MAC will not see eye to eye on some of the issues on which they must deliberate. Those who benefit from the current system will defend it, and it is highly likely that a range of vested interests will come to bear on the proceedings of the MAC. Apart from essential arguments about the distribution and mix of human resources, there will be disagreements about the right to health and universal access to equitable services versus health as a marketable commodity. What is clear, however, is that meeting the constitutional requirement of the progressive realisation of the right to health will require learning the lessons of South Africa's rich history of innovations in health care and a shift away from the current biomedical hospital- and doctor-centered system.

The underlying socio-economic inequality and underdevelopment that spawned community oriented PHC in the 1940s and made the PHC approach necessary in the 1970s still exist. A growing number of progressive health workers and activists in civil society believe that now, more than ever, a comprehensive and progressive PHC approach adapted to the South Africa of today is the key to health for all. It will require community participation and intersectoral action to tackle the social and economic determinants of health. Improving the health service on its own is not enough.

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