OVERSEAS OBSERVER

Letter from South Africa

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THE LEGACY OF THE OLD SOUTH AFRICA—four decades of apartheid oppression and neglect and their consequences—lies like a heavy hand on the new South Africa, and in no fields more than public health, health status, and health care. To make sense of the struggles for change that are occurring now, and their relatively modest yield, it is essential to remember the starting point. The same appalling data that once served primarily to fuel the anti-apartheid effort are now items on a national agenda, enormous problems and inequities that must visibly begin to be resolved.

Consider: when Nelson Mandela and the African National Congress (ANC) became the national government of reconciliation, this was (and in many respects still is) the situation:

- A sophisticated, first world health-care complex, as good as most in the industrialized nations, served one-fifth of the population and consumed nearly half of all health care dollars.
- The nonwhite four-fifths (African, mixed-race, and Indian) were consigned mainly to an underfunded, bizarrely fragmented, often inaccessible public sector within which the nation's seven teaching hospitals alone got 30 percent of all public-sector health dollars and all primary care services got 15 percent.
- Total per capita health expenditures (in U.S. dollars) were $201 for whites, $111 for mixed-race people, $109 for Indians, and $51 for Africans. Per capita public health expenditures followed a similar pattern.
- A recent International Monetary Fund study estimated the African infant mortality rate at 52.8 per 1,000 live births; for the mixed-race population, 39.4; for Indians, 10.6, and for whites, 8.6 (*1*). The operative word is "estimated"; in some rural and urban shantytown communities, half of all African deaths are believed to be unreported.
- Classic third-world diseases continue to be the major killers of Africans, but the explosive rural-to-urban migration over the past several years threatens to turn an epidemiologic transition into an epidemiologic trap: continued high rates of measles, tuberculosis, pneumonia, malnutrition, gastroenteritis, typhoid, and dysentery, together with rising rates of urban lifestyle diseases—cancer, pulmonary disease, diabetes, cirrhosis, and heart disease.
- Of all black South Africans, one in every four is a squatter, mostly crowded into squalid tin and cardboard shacks that sprout on vacant land and often coalesce into huge, sprawling communities of hundreds of thousands. In these urban "informal settlements"—an almost ludicrous euphemism for the homes of more than 7 million people—40 percent have no clean water or sanitation, 50 percent have no electricity, 50 percent live in poverty, and only 1 child in 40 goes to school.

Underlying these health disasters, of course, are social disasters. Whites—13 percent of the population—occupy 87 percent of the land. Eight percent of whites have 90 percent of the nation's personally owned wealth. The Africans, 75 percent of the population, get only 27 percent of the earned income. Only 5 percent of new African entrants to the job market find work. Some 73 percent of African teachers are underqualified, and 46 percent of Africans are illiterate.

The African National Congress and its health sector personnel knew all of this, of course, long before the elections that brought them to power, and they came prepared. In exile in Zambia and elsewhere, and with the cooperation of supporters within South Africa, they collected and analyzed the data, estimated the resources, debated alternative strategies, and began to draw up an agenda, a process that intensified during the several years of political negotiation with the old government.

The result was not one plan but two. A massive Reconstruction and Development Program (RDP), not nearly enough to meet the need but a definitive

beginning, takes aim at the social and environmental infrastructure—to build housing, provide sanitation and clean water, increase nutrition, establish environmental controls, and above all, create jobs (*2*).

And the ANC's "National Health Plan for South Africa," a 57-page manifesto that is now the centerpiece of the government's health reforms, calls for a total restructuring and rationalization of the 11 national, 4 Provincial, and more than 800 local health authorities, a massive shift from tertiary to primary care, a district health system built on a core of more than 1,200 (and eventually, 2,500) new community health centers and clinics, the integration of public and private sectors into a single national health system, a reorientation of all medical and other health personnel schools from hospital-based tertiary care training to community and regional hospital-based primary care, the development of a national health care financing system, elaborate mechanisms for community participation at all levels, and a fixed set of priorities beginning with maternal and child health.

In the context of this huge agenda, what's happened so far? Not much, at first glance, but glances can be misleading. Dr. Nkosazane Zuma, the National Minister of Health, grew up in Pholela, one of the poorest and sickest rural areas of Natal Province, but the site of the pioneering 1950s health center that became the model for the U.S. community health center network. She has not forgotten. In the face of financial constraints, she has ordered the construction of the first several hundred clinics in the most desperately underserved rural areas.

Earlier, she pushed through legislation providing free care for all pregnant women and children younger than age 5. With good reason: in addition to the dreadful infant mortality rates, the African maternal mortality rate is 58 per 100,000, more than seven times the rate for white women. In coordination, roughly 450 million Rands (about $150 million in U.S. dollars) has been allocated recently under the RDP to provide 3 million school children with one meal three days a week.

After fierce negotiations, the academic hospitals (which are funded primarily by the central government) accepted a 5-percent budget cut so those funds could be redirected to primary care.

And in what is surely the most important recent development, a committee of health economists has recommended a National Health Insurance plan, linked with social security, that would guarantee three free clinic visits a year and limited hospitalization for the entire South African population. (Since most whites and many middle-class nonwhites are already enrolled in private health insurance plans, the benefits would accrue mostly to the poverty-stricken black majority.) The plans would be financed by a 3-percent annual income tax. In the South African context, that is a significant redistributive measure.

Given the needs, these are small steps indeed. But behind the scenes, and often out front, there is a virtual frenzy of planning, discussion, debate, and efforts to flesh out the details of further change, carried on by a bewildering variety of public health authorities, provincial and national "forums" involving private, nongovernmental and nonprofit sectors, national commissions, and "strategic management teams."

In a recent 58-page document (one page longer than the draft ANC National Health Plan!) the government recently set out its health priorities for reconstruction and development. They are the work of no less than 10 committees, covering areas from national health legislation, health financing, and a national health information system to human resources, academic health complexes, and drug policy, to nutrition, maternal and child health, and oral health. In turn, health priorities have been elaborated in 22 separate categories—the largest number, significantly, in the area of "restructuring and shifting of

The Public Health Service and South Africa

Recognizing both the needs and the opportunities in South Africa, the Public Health Service is working with the Government and other institutions, focusing both on public health issues and on research in the health sciences. Interchanges on health policy, food and drug regulation, and on health service issues are growing as well.

The Centers for Disease Control and Prevention is in the forefront, collaborating in the development of epidemiology and surveillance systems to identify provincial and national program priorities and to strengthen the overall public health infrastructure.

Activities include training epidemiology and public health management and use of health information systems for decision making. Public health problems of particular concern include tuberculosis control, HIV–AIDS prevention, substance abuse and demand reduction, maternal and child health, occupational health and safety, and oral health.

South Africa wants to develop a comprehensive research program within a coherent national agenda. Efforts are being made to assure access by South African scientists and academicians to U.S. funded research grant opportunities and to existing information systems.

As described by Dr. Geiger, South Africa is determined to bring its public health and medical care systems rapidly into the 21st century.

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resources.'' In each category (''Fragmentation, for example, or ''Rural Health Services'') the document presents a detailed statement of the problem, a single specific objective, and an elaborate list of proposed interventions. In eight steps, for example, the document traces the pathway to replacement of the present byzantine public health structure by a district health system, based on units of 50,000 to 750,000 people, and linked rationally to provincial health authorities and the national health department. (But the old government's legions of (mostly white Afrikaner) civil servants, including those in all the health authorities, are remaining in their jobs as part of the deal struck for transition, making change more difficult.)

Given the needs, and the time it will take to institute all these changes, what has happened so far seems modest indeed. And even this early progress is threatened by two looming epidemics, HIV–AIDS and tuberculosis. In the worst-affected areas, HIV seroprevalence is close to 1 percent and the doubling time is 8.5 months. Among women appearing for preventive and prenatal care in the former ''homeland'' of KwaZulu, 1.6 percent were seropositive in 1990; the 1993 rate was estimated to be 9.6 percent. By the year 2,000, it is projected that 4 to 7 million people in South Africa will be seropositive and that AIDS will account for 60 percent of all deaths. By the year 2005, it is estimated that 18 to 24 percent of the population will be infected, cumulative deaths will have totalled 2.3 million, and there will be 1.5 million AIDS orphans. (This year, the budget for AIDS education, research, and treatment was doubled.) There is hope of significant help from the Centers for Disease Control and Prevention and the U.S. Agency for International Development, but that is clearly threatened by the new Congress. U.S, Canadian, and European foundations and aid agencies helping South Africa are already stretched thin.

In HIV-afflicted areas, tuberculosis rates are rising; in the Cape Province, a raging TB epidemic, apparently unassociated with HIV, now is estimated to total 80,000 cases. And violence, now more criminal than political but sometimes a mix of both, is endemic—at rates that would be called epidemic in the United States. In the first 8 months of 1994, for example, 183 policemen were shot.

No list of problems, long bureaucratic agendas, and plans, however, can adequately convey the *feel*, the emotional tone of life in South Africa now. On a 5-week assignment as a consultant on the future development of an academic complex in Durban a few months ago—my first post-election visit—the same old inequities and disparities were obvious, the crumbling public hospitals serving nonwhites were just as overcrowded as in the past, the rigidly segregated apartheid-area townships (tiny concrete-block houses, mostly) were just as dusty, smoky, and polluted. The micro-shantytowns, erupting everywhere like scabs on the metropolitan and peri-urban skin, were vastly increased in number and in degrees of misery.

But in the city proper, on the streets and in the stores and parks and restaurants where all the races mingle, there was something new—with some exceptions, an astonishing civility, and among many conservative urban whites what I perceived as a mixture of relief, trepidation, and the very tentative beginnings of a pride in the political (not economic) transition that has been accomplished. (Rural white farmers and small-town residents, I am sure, are a different story). And in the academic centers and the upper levels of government, despite a healthy barrage of criticism flowing from the white and black press alike—there is, along with the fatigue, headaches, and constraints, a constant buzz of discussion and innovation.

Here too, it is important to be modest; South Africa has only begun to change, and the continuity of change is not assured. There have been and will be bitter strikes, restless and impatient townships, frictions among the nonwhite population groups, white resistance, and internal ANC disputes. Long-running arguments are still simmering. In 1991, the nation had no schools of public health, now it has three. The need for public health training is obvious—in all of South Africa there are only a handful of PhD epidemiologists, but many voices argue that the country, at this stage, can only support one. Similarly, there has been outrage (joined more gently, by Archbishop Desmond Tutu and President Nelson Mandela himself) at the high salaries and generous perquisites the new African civil servants and members of Parliament originally drew.

Despite these and other recurring crises, the overriding feeling in South Africa, I thought, was hope. And in the decade that has brought us Bosnia, Rwanda, Chechnya, Kashmir, and East Timor and Guatemala, South Africa at the moment may be the most hopeful place on earth.

References

1. Lachmann, D., and Bercusan, K., editors: Economic policies for a new South Africa. International Monetary Fund, Washington, DC, 1992.
2. African National Congress: The reconstruction and development programme: a policy framework. Umanyano Publications, Johannesburg, South Africa, 1994.