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Health and Health Care in South Africa Against an African Background

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Basic to medical sociology, or the sociology of health and health care, is the premise that the health of populations is profoundly influenced and determined by society, in particular by the social, cultural, political, and economic contexts. In similar vein, health care systems closely reflect the broader societal environments in which they nestle. The opposite also holds: societies are in significant ways influenced by health and disease in their populations.

This chapter sets out to describe and explain the nature and development of health and health care in South Africa. It does so against the background of health and health care on the African continent. In particular, we focus on the main features, trends, and deformations of health and health care in Africa, as well as the underpinning historical forces. When it comes to South Africa, our focus is mainly on the current transformation of the health system, against the backdrop of inequalities, disparities and distortions entrenched in the South African health system over three and a half centuries of exposure to colonialism and apartheid. In particular we assess the current reforms of, and constraints on, the health sector. We also glance at some of the main features of morbidity and mortality in South Africa, as well as at the daunting challenges these pose to the health system and the current reform process.

Historical Forces Shaping Health and Health Care in Africa

The Main Historical Shapers of African Health Care

Some of the earliest evidence of medical practice comes from Africa. Ancient Egyptians were known, over 5,000 years ago, for their advanced knowledge of medicine. Imhotep (3,000 BC), the "historical father of medicine," instructed

Greeks in medicine, possibly built the first hospital, and wrote about medicine and surgery. Two renowned documents reveal the achievements of the ancient Egyptians: the Code *of Hammurabi*, possibly the first code of medical practice, and the *Ebers Papyrus*, summarizing knowledge about several disease categories and offering advice on diagnosis, prognosis, and treatment (Weiss and Lonnquist 1994; Zoneraich et al. 1996; David 1997; Miller 1997). Again around 300 BC, Alexandria became the world's intellectual center where the scientific basis of modern medicine was laid. Thereafter, the African continent remained silent and did not contribute to modern medicine until the mid-twentieth century.

The spread of Islam by the Arabs in the seventh century, brought new nuances to health care on the African continent. The Arabs' intense interest in medicine is reflected in the famous teaching hospitals they built which served as links between Greek and Renaissance medicine (Weiss and Lonnquist 1994). The influence of Islam on African medicine, resulted in mixed African–Islamic medical systems, and the conversion of magico–religious African medical beliefs and practices to scientific principles fundamental to western medicine – thus paving the way for the acceptance of western biomedicine (Kirby 1993). Even in present-day Islamic Africa, there are strong influences toward the Arabization and Islamization of medicine (Kandela 1993).

Western medicine in Africa was predominantly pioneered by Christian (Protestant and Catholic) missionary societies during the last quarter of the nineteenth century and early decades of the twentieth century, mostly in advance of health services provided by colonial governments (Waite 1987; Brown 1998). Hundreds of mission hospitals and dispensaries were established, with healing eventually seen as an essential element of the missionary mandate. The nature of the missions (e.g. Protestant or Catholic) and the country of origin of the missionaries (Britain, France, Germany, Switzerland, Belgium, with smaller cadres from Italy, Spain, and Portugal) influenced the organization of health care and the orientation of health practitioners. Even today, many African countries still rely heavily on missionary hospitals and health services, with church-related health care services accounting for 25 percent to 50 percent of services (Good 1991; Fyle 1993; Banda and Walt 1995).

Though European colonization of Africa coincided to a large extent with missionary initiatives on the continent, it was only after World War I that colonial governments accepted some responsibility for the health care of indigenous populations (Van Heyningen 1990; Good 1991; Comoro 1993). Prominent among the factors affecting the shape of health systems in colonial Africa, was the relationship of domination–exploitation between imperial powers and the colonized peoples. As a result, typical structural deformations were ingrained on the emerging health systems. Among these, doctor-orientated, hospital-centred, urban-concentrated, and curatively-biased policies and systems featured most strongly. Also recognizable was the creation of segregated structures in which the colonial population was treated preferentially to its "native" counterparts (Good 1991; Fetter 1993; Alubo and Vivekanando 1995). In South Africa this "apartheid in medicine" grew to the fullest extremes (van Rensburg et al. 1992; van Rensburg and Benatar 1993). However, the benefits brought to health care in Africa by western countries should not be underestimated.

Most notable were the introduction of western allopathic medicine to the continent, control of epidemics, and strong traditions of management and administration, especially by British colonial regimes (Burrows 1958; Laidler and Gelfand 1971; Fetter 1993). In many cases, colonial powers provided the first modern health facilities.

Liberation from the colonial heel in the mid-twentieth century set in motion new trends in health care in Africa. Mass emigration of colonial personnel left a great void in postcolonial African health systems that was gradually filled by expatriate professionals, graduates from newly established local training institutions. Progressive Africanization of health systems and indigenized cadres of health personnel gave rise to less doctor-dependent models of care, especially nurse-based health services (Last and Chavunduka 1986; Alubo and Vivekananda 1995). However, to varying degrees, mother countries remained influential in sustaining western health care in the postcolonial Africa, and in the process reproduced and perpetuated the distortions inherited from the colonial period (Comoro 1993; EIU Country Profiles 1997–8).

Western Allopathic and African Traditional Health Care – A Pluralism

For centuries health care in Africa was confined to traditional medicine. The appearance of western influences on the African scene inaugurated a pluralism in health care where western allopathic medicine came to exist side by side with African traditional medicine. Colonial governments and missionaries generally despised, discouraged, and even suppressed traditional medicine. As a result, traditional medicine was relegated to an officially inferior and often covert position. Subordination of traditional medicine was carried further by organized professions in the western-scientific mold. In time, four broad varieties of relationships crystallized (Stephan 1983; Last and Chavunduka 1986; Pretorius 1995, 1999): (1) *exclusive (monopolistic) systems*, recognizing only the practising of scientific medicine; (2) *tolerant systems*, characterized by *laissez-faire* policies which virtually ignore traditional medicine, yet allow its existence; (3) *inclusive (parallel) systems*, recognizing traditional health systems alongside scientific medicine; and (4) *integrated systems*, tending to unite allopathic and traditional medicine in a combined system of training and practice.

Political emancipation and to an extent, the Alma Ata Declaration in 1978, have been instrumental in propelling governments toward strong support of traditional health care, in particular toward either parallel or integrated systems. Policies in several African countries have moved a long way toward establishing beneficial coexistence and cooperation of the two systems, and even incorporating traditional health care into modern systems. African traditional healers have also gone a long way toward organizing themselves in somewhat autonomous local and national organizations (Abdool Karim et al. 1994). However, despite such strides, an anti-traditional medicine attitude still prevails generally, with the two systems still interlocked in a relationship underpinned by mistrust, prejudice, and even antagonism (Last and Chavunduka 1986; Comoro 1993). The grounds for supporting or opposing traditional medicine in Africa are varied,

ranging from political ideology and religious doctrine to scientific and practical reasons. In terms of the essential qualities of professions, African traditional medicine remains marginal and has a long way to go before it can achieve the stature of an organized profession.

The Current Shape of Health and Health Care in Africa

It is not possible to speak of one common history or one common format of African health care. Rather, health care in each country is shaped by a combination of unique historical and societal circumstances. Despite this limitation, some broad observations can be made regarding the nature and status of health care in Africa.

Africa's Population, Health, and Burden of Disease

Africa comprises 53 independent states, harboring an estimated population of over 600 million. An average annual growth rate of between 2.2 percent and 3.3 percent between 1950 and 1990, resulted in an explosive increase from 170 million to 500 million. The majority of this population can still be classified as non-urban (Sparks 1998). In the mid-1990s, life expectancy averaged 53 years; in only nine African countries it exceeds 60 years; while in many countries it is still well below 50 years (e.g. Zambia, Burundi, Guinea, Malawi, Mali, Niger, Somalia, Uganda), and even lower in Sierra Leone (35 years for females, 32 for males) (*Africa at a Glance* 1998; *EIU Country Profiles* 1997–8/1998–9).

Although infant mortality rates have fallen spectacularly during the past century – from levels exceeding 200–300/1,000 IMR – it remains high in Africa, with the highest rates recorded in Rwanda (145), Mali (156), and Sierra Leone (200), and the lowest rates in Mauritius (17), Tunisia (41), South Africa and Algeria (51). Under-5 mortality often exceeds 200/1,000, reaching exceptional heights in Mozambique (275), Sierra Leone (284), Angola (292), and Niger (320). Only in Botswana, Cape Verde, Mauritius, Namibia, South Africa, most of the northern African countries, and Seychelles, are both the infant and under-5 mortality rates below the developing world's averages of 64 and 95/1,000 respectively (compared respectively to the developed world's of 14 and 18/1,000) (Fetter 1993; Vogel 1993; World Bank 1996; UNDP 1997; *Africa at a Glance* 1998). In sub-Saharan Africa, maternal mortality amounts to 971/100,000 live births; is more than double the rate of 471/100,000 in the developing world as a whole. For the 1980–90 period, rates were highest in Ghana, Somalia, and Mali: 1,000, 1,100 and 2,000/100,000 respectively (Vogel 1993; UNDP 1997).

Africa's burden of disease is very high especially in the communicable and preventable categories. In earlier times it was smallpox, and now it is TB, measles, malaria, and HIV/AIDS, and many other infectious diseases. Tuberculosis is the leading single killer and is on the increase, aggravated by the HIV epidemic. Of the world's 30 million people infected with HIV 21 million live in sub-Saharan Africa, and of 12 million deaths 83 percent occurred in Africa

(Lachman et al. 1999). Malaria is endemic in many African countries; annually there are 300–500 million clinical cases of malaria and between 1.5 and 2.7 million deaths, 90 percent present in Africa (WHO Report 1996). A disease burden of this magnitude profoundly impacts on health and continuously taxes African health systems as well as social services to their limits. However, there have been significant achievements: Treatment for leprosy increased from 7 percent in 1987 to 27 percent in 1990 and to 63 percent in 1993, reducing the prevalence of the disease from 483,000 cases in 1990 to 159,000 in 1993. Vaccination programs have markedly reduced the incidence of neonatal tetanus in several African countries, and poliomyelitis is on the decrease. With the upsurge in malaria in recent years, and in particular the development of widespread resistance to chloroquine, malaria control programs are being given high priority through a WHO global malaria strategy which includes 17 African countries (WHO Report 1997).

Africa's health status, burden of disease, and health care needs are conspicuously shaped by poverty, malnutrition, infectious diseases, armed conflict, drought, famine, inadequate access to primary and secondary education, lack of safe water, sanitation, and a range of socioeconomic factors propelling inequitable distribution of resources. To understand the causes of this sad state of the continent requires focused attention on exploitation in the past, its continuation in the present, aggravated by the burdens imposed by the "curse of the nation-state" and progressive marginalization of Africa by the industrialized world (Gill 1986; Davidson 1992; Benatar 1995; Logie and Benatar 1997).

Economic Realities, Living Standards, and Social-Economic Well-Being

Africa has a veritable history of political instability which has dislocated large numbers of people, with devastating effects on health and health systems. The European colonial legacy left serious voids and instabilities that threatened the emerging independent nations in the 1960s. In many cases, conflicts were initiated by withdrawals of colonial powers. In others, independence triggered bitter conflict battles among contending internal factions and fuelled a sequence of ruinous wars, military regimes, and authoritarian one-party states. The establishment of a range of socialist/collectivist political power structures has molded and reformed national health systems into centralized systems, which jeopardize the already inadequate private health care sectors. Man-made catastrophes (civil wars and sporadic genocide), as well as natural disasters (droughts, floods, and famine) have dislocated millions of people, profoundly disrupting their health and health systems. Cases in point are Rwanda where the ethnic massacre in 1994 claimed the lives of 1 million people within three months, and Malawi, which in recent times has absorbed about 1 million Mozambican refugees.

On the Human Development Index (HDI – measuring human progress on a 0 to 1 scale), African countries fare dismally. According to recent grading, only three African countries (Seychelles, Mauritius, and Libya) rank in the "high category", and then only in the 52nd, 61st, and 64th positions respectively. Thirteen African countries are in the "medium category" (South Africa 90th),

while the majority (35 of them) in the "low category" of the HDI – with the last 19 positions in the index filled by African countries, the very last being Niger, Rwanda, and Sierra Leone (175th) (UNDP 1997; *Africa at a Glance* 1998). Compared to Seychelles' relatively favorable score of 0.845, Sierra Leone has the most unfavourable score (0.176) on the scale – and the "worst quality of life" and the "poorest health services in the world" (Fyle 1993a: 60). Sub-Saharan Africa has the highest proportion of people in – and the fastest growth in – human poverty. The Human Poverty Index (HPI – reflecting the combined basic dimensions of poverty) is 40 percent for the whole of sub-Saharan Africa, and exceeds 50 percent in seven countries in the world, of which six (Niger, Sierra Leone, Burkina Faso, Ethiopia, Mali, and Mozambique) are in Africa. Some 220 million people in the region are poor, and it is estimated that by 2000 half the people in sub-Saharan Africa will live in poverty. Women and children, and more so those in rural areas, are disproportionately poor. However, despite the depressing performance of Africa, the HDI of sub-Saharan Africa as a whole has nevertheless improved during 1990–4 from 0.200 to 0.380 (UNDP 1997).

Economic indicators show that Africa's annual per capita GNP in 1996 ranged from a minimum of $80 in Mozambique to a maximum of $6,280 in the Seychelles, with a mean of less than $500. Africa's economic plight is further aggravated by debt-ridden economies, which are supported by almost valueless currencies. The majority of initially defined Heavily Indebted Poor Countries (HIPCS) – 33 of 41 – are in sub-Saharan Africa (Sparks 1998); the subcontinent's debt stands at $300 billion (Oxfam 1997), which is about $370 for every man woman and child on the continent (UNDP 1997; *Mail and Guardian* 1998a; Williams 1998). Niger exemplifies Africa's plight: it has a per capita GNP of $200; 92 percent of its population lives on $2 a day or less; the debt burden comprises 88 percent of the GNP; and three times more money is spent on international debt repayments than on health and education (*Mail and Guardian* 1998a). Rwanda, Burundi, Liberia, the two Congos, Sierra Leone, and Somalia grapple with similar mountainous debts in the aftermath of military conflicts. These facts have a profound effect on the nature of health care in all its dimensions.

The Variety of National Health Systems and Health Policies in Africa

Africa's national health systems are variable. They range from predominantly socialist/collectivist (Tanzania), socialized/national health service (Kenya), to strongly inclined private/free market dispensations (South Africa) (Field 1989). Although most African countries do entertain a private health sector, private health care is generally weakly developed. Western-style health care is primarily provided by the state. Many factors militate against private health care; and foremost are restrictive national economies, poor populations served by the free public health services, weakly developed insurance, the absence of large numbers of self-paying patients, and the typical disease and mortality profiles of Africa's populations. Despite these constraints, there have been significant strides toward private health care in several African countries, albeit more often the result of negative propellers such as recent economic reforms, declining health budgets

accompanied by decreasing expenditure on government services, collapsing public health services, and unavailability or poor quality of drugs and medical equipment (Banda and Walt 1995).

Featuring prominently in the African context, but certainly not unique to Africa, is the regional and rural–urban maldistribution going hand in hand with absolute shortages in the health corps, leaving sizeable proportions of rural populations without access to doctor services (Comoro 1993; Fyle 1993; Alubo and Vivekananda 1995). For instance, although 85 percent of Kenya's population live in rural areas, less that 10 percent of its physicians are located in rural settings (Cockerham 1998). Country wise, doctor: population ratios vary greatly, Libya (1:962), Seychelles (1:1,064), and South Africa (1:1,500) are most favorably supplied, while Malawi (1:50,000), Chad and Mozambique (both 1:33,333) are in the least favorable situations. Generally, the provision in sub-Saharan countries is poor to very poor – an average of 1:18,514. Although there have been improvements (some impressive) during the past 20 to 25 years in many African countries (1:97,000 to 1:33,333 in Burkina Faso, 1:86,100 to 1:33,333 in Ethiopia, 1:50,000 to 1:7,692 in Guinea, 1:30,400 to 1:2,500 in Lesotho), it should be clearly noted that during the same period this ratio has deteriorated in several countries. Most notable is the worsening ratio in Uganda from 1:9,200 to 1:25,000; in Ghana from 1:14,894 to 1:22,970; in Kenya from 1:8,000 to 1:20,000, and in Mozambique from 1:18,900 to l:33,333 (World Bank 1996; UNDP 1997; *EIU Country Profiles* 1997–8).

African countries have devised a variety of strategies to overcome the pronounced maladies in the provision and distribution of health services, especially to attract or compel staff to undeserved rural areas or disadvantaged sectors. Among these measures are the introduction of a variety of less expensive and less qualified medical and clinical auxiliary staff categories. In particular, nurses have come to constitute throughout the African continent the backbone of health services in the delivery of both ambulatory and institutional-based health care. As primary health care (PHC) is making headway, African health systems are becoming less accommodating to, and less concerned about, sophisticated medical services.

Health Reforms in Africa

Amidst worsening economic conditions and often as part of structural adjustment programs, many African countries have recently embarked on either piecemeal or major health reforms, particularly to achieve greater efficiency and equity in public health (Gilson and Mills 1995). These measures manifest in cost-cutting, curbing of government expenditure on health, strides toward privatization, and the introduction/reintroduction of user-charges and cost-recovery policies. However, they also surface in changes in health and health-seeking behavior (reduced health care, reduced clinic and hospital attendance, decline in illness episodes), changes in health outcomes (increase in malnutrition) (Bijlmakers et al. 1996), the resurgence of epidemics (yellow fever and tuberculosis), skin infections (due to the unaffordability of soap and detergents) (Alubo and Vivekananda 1995) and, in general, a negative effect on welfare (Costello

et al. 1994). Such health reforms are often spear-headed or supported by a multitude of international multilaterals and bilaterals from the developed world extending technical and financial assistance for strengthening national health care systems, and with particular emphasis on PHC. In addition, health programs launched by the World Bank and the IMF often came to the rescue of many African countries, but at the same time, created dependency and subscription to the interests and agendas of these agencies (Banda and Walt 1995).

Health and Health Care in South Africa – A Study in Transition

Although South Africa's health and disease profiles, as well as its health system, in many respects resemble that of Africa at large, and perhaps more so that of sub-Saharan and southern Africa, we can in no way conclude that the South African health system and health profiles are typically African or a typical reflection of the African scene. Major differences prevail, both of qualitative and quantitative nature. Quantitatively, South Africa has more than other African countries – more health staff and health facilities, and generally a larger health budget. Qualitatively, South Africa has a different make-up of health issues, and generally a far more sophisticated health care system.

Legacy of Colonialism and Apartheid – The Need for Reform

For the greater part of the twentieth century, income, geographical location, and most importantly, race or ethnicity have been the arch determinants of the quantity and quality of health care received by South Africans. The health care system that the ANC-led government inherited in 1994 following the first democratic elections, can scarcely be described as functional and much less egalitarian. The new government came to power at the tail-end of a long period that through a combination of deliberate official policy, discriminatory legislation, and at times benign neglect had managed to firmly imprint on the country's health care system a number of structural distortions. These distortions can be subsumed under five main headings (Savage and Benatar 1990; MRC 1991; van Rensburg et al. 1992; ANC 1994b; van Rensburg and Fourie 1994; Benatar and van Rensburg 1995; van Rensburg and Harrison 1995).

First, is the dominance of curative-oriented health care. On the one hand, the exponential growth of allopathic medicine in the twentieth century has been a boon to the country and has witnessed phenomenal gains in the health of the populace, including the eradication of many infectious diseases. On the other hand, it has exerted some negative consequences. In the main, modern medicine has become a victim of its own success. It has led to overdependence on massively expensive hospital-based care at the expense of more affordable preventative and community-based care, e.g. for the 1992/3 financial year, 81 percent of public health expenditure was toward curative hospital-based care of which 44 percent was allocated to tertiary or academic hospitals (Health Systems Trust and World Bank 1995).

Second, is the intensification of racial segregation in the provision of services. Race or ethnicity rather than need has indubitably been the most important variable determining quantitative and qualitative access to health care (De Beer 1984; van Rensburg and Benatar 1993). In colonial and apartheid South Africa in particular, health care also became an instrument for maintaining white supremacy (Price 1988). At the height of apartheid, whites disproportionately enjoyed the bulk of public expenditure on health care and received four times more per capita than their African (black) counterparts, whilst Coloureds (mixed race) and Indians enjoyed a somewhat intermediate position (van Rensburg 1991). Racial fragmentation of services was taken to absurd heights under the homelands policy which began in the fifties, and since 1983 under the tricameral dispensation (van Rensburg et al. 1992).

Third is the functional fragmentation of services, which has its origins in the *Public Health Act* of 1919, which bequeathed to the country a three-tiered, uncoordinated and uncomplimentary system of organizing and dispensing health care services. It created a national Department of Public Health, provincial authorities and local authorities, each with its own domain and jurisdiction in health matters, but also leading to gross deficiencies in coordination of responsibilities and functional areas. Provincial authorities unduly concentrated on the provision of urban curative hospital-based care, while primary and community health care were grossly neglected. Despite sporadic attempts toward transforming the system in later years, the paradigm of a fragmented system lacking cohesion and a community-based care focus continued largely unmitigated (Gluckman Commission 1944; Browne Commission 1986).

Fourth, is the accentuation of rural–urban discrepancies and inequalities in the provision of services. For two reasons, urban areas have historically consumed a preponderant share of health care services, but at the expense of rural areas. One, the establishment and location of health care facilities essentially adhered to the country's pattern of urbanization, which in turn was a consequence of the development of the mining industry and industrialization. Two, successive governments were primarily preoccupied with establishing health facilities to serve and secure the health of the white population concentrated in urban areas. The "homelands" policy further deepened the chasm between rural and urban areas, as more and more resources were channelled into (white) South Africa.

Fifth, is the growth of a pluralistic structure of health care in which the private sector was repeatedly augmented at the expense of the public sector. A perverse asymmetry has for decades existed between the private and the public sector in terms of resources and health coverage (Price 1986). The private sector commands 60 percent of the resources that are spent on health care, and yet it provides coverage for a mere 20 percent of the population (van Rensburg et al. 1992). The proliferation of the private sector was particularly facilitated by the National Party government during the seventies and eighties as part of a shift from Keynesian economics to monetarism (Price 1988). Privatization was regarded as indispensable to devolving responsibility to the individual, downsizing the public sector, and reducing the state's financial burden. This resulted in a strong, competitive, and lucrative free market in the health sector, proliferation of high-tech medicine, phenomenal growth of the pharmaceutical

industry, and generally inflated costs (Naylor 1988; van Rensburg and Fourie 1988).

Current health sector reforms are driven by the desire to rectify these structural distortions in the health sphere and in particular are aimed at unifying the fragmented health services into a comprehensive and integrated National Health System; reducing disparities and inequities in service delivery and health outcomes; and extending access to an improved health service (Department of Health 1996a, 1996b, 1997a, 1997c). Note however, that health sector reforms in South Africa have not only to do with internal restructuring. Reform also fits into a broader reform process in Africa and further afield – that is reform to cope with rising demand, and to render more accessible and more affordable care, especially for the deprived.

Reform of the South African Health System

CONSTITUTIONAL AND LEGAL REFORMS – THE RIGHT TO HEALTH SERVICES

The present health reforms in South Africa are not entirely the initiative of the new government. Several reforms, some anticipating those of the current government, had been introduced by the previous government. However most of these were nullified by the confines of an unchanging sociopolitical order which left little leeway for fundamental reform of the health system (van Rensburg et al. 1992; van Rensburg 1999). The new political order changed it all. The ANC (African National Congress)-led government embarked on fundamental reform, encompassing both the broader societal order and the narrower health sector. Since 1994, the reform frameworks have been detailed and mandated by a series of official policy papers and legislation at both national and provincial levels (Department of Health 1997a, 1997c). More fundamentally, the new *Constitution* lay the basis for the reform of the health sector.

Prior to the current reforms, health care services were a privilege rather than a right and the main beneficiaries were whites. The *Constitution of the Republic of South Africa* of 1996, which replaced the interim *Constitution* of 1993, gives conspicuous expression to the idea of a fundamental right to health care for all. It translates to the health care sector the values of social justice, equality under the law, and respect for human rights that were not priorities under colonial and apartheid dispensations. By doing so the Constitution clearly lays the foundation for both a liberal and egalitarian health care system and thereby signals a break with the legacy of gross inequality and guarantees everyone the right of access to basic health care services. At the same time, it enjoins the state to take reasonable measures within its available resources to achieve the progressive realization of such a right of access to health care (De Waal et al. 1999).

Outside the Constitution, there are a number of other measures which have been taken with a view to achieving equitable access to health care. Noteworthy are the provision of free health care to mothers and children under six, the *Choice on Termination of Pregnancy Act*, which gives women easy access to

legal abortion, the *Medical Schemes Act*, which extends medical-aid coverage to the elderly and chronically sick, and the *Medicines and Related Substances Act*, which permits parallel importation of medicines and promotes the use of generic medicines which are more affordable. Plans are also underway to introduce a social health insurance scheme so as to require those in employment to purchase for themselves more stable and reliable medical cover. In short, the new reforms, if efficiently implemented and sustained, should provide the substance for rectifying not only racial, but also equally significant, income and geographical impediments to access to health care services.

Reforms in the Structure and Content of the Health System

UNIFYING FRAGMENTED HEALTH STRUCTURES

Note again, that in the previous dispensation health care was geographically, structurally, racially, as well as authority-wise, fragmented to the extreme, consisting of 14 health authority structures – 1 national ("white" South Africa), 10 homeland (per ethnic group), and 3 own affairs (based on race) ministries. Prime among the achievements of the new government is the dismantling of this fragmentation by unifying the segregated and divided structures. Health is now consolidated under a single national ministry supposed to oversee, support, and coordinate the entire health system of the country. The nine newly established provincial governments (PHAs) embody a "federal-like" decentralized system, with more powers entrusted unto the provinces than before. In turn, these PHAs are now developing, coordinating, and supporting the emerging district health authorities (DHAs). In this respect, the *White Paper on Local Government* (1998) introduced an entirely new phase in the restructuring of health, intending to shift the responsibility for PHC increasingly onto local authorities and communities. In turn, this implies that the current, still fragmented, provincial and municipal authority and service structures are to be integrated into consolidated district structures underscored by cooperative government structures.

DISMANTLING APARTHEID IN HEALTH

The new government decisively succeeded in dismantling apartheid structures and racially discriminatory laws and measures in the public health sector in a relatively short period of time. As part of such a de-racializing process, stern affirmative action measures which pertinently encompass a striking Africanization of the public health system and a pronounced sensitivity for gender to ensure representivity, have been introduced. The once almost "all-white" and "all-male" top management structures (prior to 1994, whites accounted for 90.2 percent of management staff at national head office, while 87.8 percent of all managers were male) has been systematically revised to reflect the race and gender composition of the population more accurately. Hence Africans, Indians, and Coloureds and women now figure prominently in the executive and management positions in the public health sector.

RECTIFYING DISTRIBUTIVE DISPARITIES IN HEALTH PROVISION

There are no quick fixes to the pronounced discrepancies and inequalities in the apportionment and distribution of health resources that have been entrenched over centuries. Current reforms aim to redress these gross inequities in a two-pronged approach implying, firstly, large-scale resource reallocation and redeployment of personnel and facilities to smooth out gross disparities, and secondly, controlling the referral and flow of patients to the various public providers and facilities to ensure a more even and appropriate spread. Among the specific redistributive measures contemplated to encourage staff to deploy and redeploy in underserviced areas are; retraining of personnel; providing incentives for staff to work in rural areas; introducing contractual obligations for those receiving subsidized training; importing Cuban doctors to serve in underresourced facilities and communities; and strengthening the public sector in order to attract staff from the private sector. Regarding the flow of public patients to providers and facilities, various measures are being devised to effect more appropriate and cost-effective referral flows. Foremost are: making PHC the first point of entry for patients utilizing the public health sector; introducing penalizing payments to restrict the bypassing of PHC facilities, and thus deterring the unjustified use of public hospital facilities; and regionalizing health care, i.e. deploying health facilities and workers in such a manner and in such numbers that patients would be able to receive the appropriate services in their respective health regions and districts, except for services of a tertiary nature.

Expanding Free Health Services to Deprived and Vulnerable Groups

A major step toward equity and accessibility in health care, and particularly to remove financial barriers to access for vulnerable groups, was the introduction and expansion of free health services. Such socialization of health care stands in sharp contrast to policy under the previous government where the deliberate strengthening and expansion of the private sector in health care was one of the mainstays in health policy. Since mid-1994, formidable strides have been made toward free health services by broadening the groups eligible for such care. In tandem with these measures, and in particular to limit the expansion of the private health sector, a number of regulatory measures have been proposed to reform the private health sector and to limit its expansion, and these apply to private providers, private hospitals, and the health insurance industry. Amongst others, are the authorization of the construction of new private hospitals by the minister; cutting of state subsidies to private hospitals in order to discourage their growth; barring doctors from share-holding or having other financial interests in private hospitals; regulating the importation of expensive technology in both the public and private sectors; controlling the dispensing of medicines by medical practitioners; introducing mandatory health insurance coverage for a defined hospital benefit package; ensuring cross-subsidization and risk-pooling in health insurance; and enhancing efficiency of and cost-containment in the health insurance market (Department of Health 1996b).

INVOLVING COMMUNITIES IN GOVERNANCE OF HEALTH

After a protracted history of undemocratic, authoritarian, and top-down government – excluding in particular the "non-white" population from decision-making processes – it became one of the prime dictates of the new government to create a people-driven culture and restore democratic involvement. In public health, the focus is on participatory health care, i.e. empowering communities to participate actively in planning, prioritizing, and monitoring health care in their specific areas and to take greater responsibility for their own health (Department of Health 1996b, 1997a, 1997c; Ministry of Provincial Affairs and Constitutional Development 1998). As a result, South Africa is witnessing the emergence of numerous novel governance structures at all levels of health, pertinently representing and involving civil society (Levendal et al. 1997). Decision-making in public health is intended to become a participatory affair and devolved to the lowest levels of the district and community.

Constraints and Negative Outcomes of Health Reforms

The aforementioned reforms have in many ways transformed the South African health care system in fundamental ways, and with effects for the good of equity, accessibility, and efficiency. These positive outcomes for the health system and for health care relate to steady moves away from discrimination and domination in the public health sector; greater accessibility of health care for disadvantaged groups; significant strides toward interprovincial equity and intraprovincial parity; unifying erstwhile racially and homeland fragmentation and greater integration of formerly segregated facilities and services; initiating health programs targeting in particular the most acute health problems (HIV/AIDS, TB, MCWH, nutrition), as well as protecting the most vulnerable groups in society; and refocusing the training of health personnel to become less hospital and high-tech bound and dependent, to render them more efficient and effective in delivering care in PHC settings, also in remote rural areas.

However, transformation has not been an altogether smooth process, and in many respects it is accompanied by negative outcomes and constrained by other factors militating against full and effective reform (van Rensburg 1999). Amongst the more important failures thus far is the absence of a national legislative framework – toward the end of 1999 there is still no National Health Bill published – leaving much in the field in a vacuum, unarticulated and uncertain, resulting in a disjointed restructuring process amongst provinces (Stuurman-Moleleki et al. 1997). But there are other negative outcomes and failures.

The broader transformation process inaugurated a process of never-ending change in the public health sector that has left few structures and staff members unaffected and unconfined. It has led to large-scale restructuring of departments and divisions, to myriad of novel codes and regulations, to mass redeployment and reshuffling staff. Irrespective of major gains for equity, fairness, and representivity, affirmative action measures started rapid and large-scale introduction

of less experienced and inexperienced personnel and managers into key positions in state bureaucracies, and triggered voluntary severance packages, resignations, and dismissals of senior and experienced staff in significant numbers. These developments have had detrimental effects on continuity, career security, and staff morale. They have also led to concerns that standards are dropping (Ruff 1997; SAIRR 1997).

Despite the dismantling of apartheid, race and gender distortions in health care are bound to persist for decades to come, partly due to the backlogs created by the previous system, and partly as a result of the continuation of typically race-based provision in a class-segregated system, with the more wealthy catered for by the private sector, while the less wealthy have to rely on a less effective public health sector. The introduction of free health care was in many respects not adequately planned and budgeted for, and has led to patients flooding public health facilities and services, in many cases resulting in severe overcrowding, shortages of supplies and equipment, poor working conditions at clinics, low morale among public health staff, deterioration in the quality of care, and even abuse of scarce resources (McCoy and Barron 1996; McCoy and Khosa 1996; SAIRR 1997).

Budgetary mechanisms toward equalizing interprovincial inequity at central government level had been suspended in favor of provincial autonomy. The achievement of interprovincial equity in health has thus become uncertain, compromised, and is slipping down the agenda – more so in the light of ever more stringent budgets confronting the provinces (Barron et al. 1997; Buthelezi et al. 1997; Robb et al. 1997; Ruff 1997; Van den Heever and Brijlal 1997). There is widespread public perception that access to health services and quality of care is no better than it was (Naidoo 1997; Robb et al. 1997; Gaigher 1998).

Little has as yet materialized of the intention to rid the health system of its notorious two-class character, i.e. a weak public sector that caters "second-class" services to that majority of the population dependent upon the state, and a strong private health sector providing "first-class" services for the wealthy and insured minority. Current developments and trends point to the expansion and strengthening of the private sector, and along with this, the perpetuation of those notorious structural distortions and disparities, as well as persistent market- and provider-driven initiatives leading to excessive health spending and resultant cost-escalation. There are few signs of a strong and strengthening public sector. The trend is rather in the opposite direction, i.e. a weakening public sector. Deep inroads are being made into the public sector as the influx of profits, staff, and patients to a flourishing private sector is surging and valuable resources are increasingly lost as a result of the emigration of health professionals to other countries. Broadened access to the resources of the private sector appears unlikely. Instead, the shifting of private-sector patients (with concomitant cost-shifting) onto the already overstretched public sector appears likely (Van den Heever and Brijlal 1997; Wolvardt and Palmer 1997).

The new government is not succeeding in creating unity amid crippling pluralism in the health sector. There is a growing split, estrangement, and open

conflict of interests between the public and private sectors; confusion among national, provincial, and local spheres of government; conflicting relationships between local government structures and civil organizations; unfulfilled expectations of traditional healers; frustrated interests of private health providers, medical professionals, and of pharmaceutical companies; and clashes between government, the health professions, labor unions, and the private sector on matters such as compulsory community service, parallel importation of medicines, importation of foreign (Cuban and other) doctors, stances on free health care and generic medicines, and many more.

The pending devolution of control in health care to District Health Authorities certainly poses questions regarding the competence of current local governments to assume responsibility for comprehensive primary health services. These questions become more daunting if one considers the present state of local governments, many of them weak in management capacity, poor in infrastructure, and virtually in states or on the brink of bankruptcy, further fuelled by shrinking intergovernmental grants and persistence of the culture of non-payment for services. In such circumstances, the wholesale transfer of current provincial responsibilities to local governments would in most cases be risky in the extreme (Naidoo 1997).

Table 21.1 Private–public divide in the health sector, mid-1999

CATEGORY	*Total*	*Public sector 1999 Estimated dependants: 34,611,781 82%***	*Private sector 1999 Estimated dependants: 7,597,709 18%***	*Public–Private RATIO*
General practitioners	**19**	5,398	14,331*	**1 : 2.65**
	729	*27.4%*	*72.6%*	
Medical specialists	**7,826**	1,938	5,888*	**1 : 3.04**
		24.8%	*75.2%*	
Dentists (including specialists)	**4,269**	316	3,953*	**1 : 12.51**
		7.4%	*92.6%*	
Pharmacists	**4,410**	1,047	3,363*	**1 : 3.21**
		23.7%	*76.3%*	
Physiotherapists	**3,406**	463	2,943*	**1 : 6.36**
		13.6%	*86.4%*	
Occupational therapists	**1,986**	388	1,598*	**1 : 4.12**
		19.5%	*80.5%*	
Speech therapists and audiologists	**1,388**	119	1,269*	**1 : 10.66**
		8.6%	*91.4%*	
Dental therapists	**306**	121	185*	**1 : 1.53**
		39.5%	*60.5%*	
Psychologists	**3,808**	222	3,586*	**1 : 16.15**
		5.8%	*94.2%*	

Sources: PERSAL Establishment Administration 1999; *Board of Healthcare Funders of South Africa 1999; **Chapter 13, *South African Health Review* 1998.

In spite of every effort to realize the set ideals during the past few years, the general performance record of civil society in terms of large-scale community participation and involvement in matters pertaining to health care is not always encouraging and is even disappointing (Levendal et al. 1997). Also such involvement and consultation often comes at a price in terms of protracted delays and even derailment caused by lengthy consultation in legislative and decision-making processes (Stuurman-Moleleki 1997). This is not ascribed to reluctance and apathy only, but is also due to lack of leadership, support, capacity, and material resources.

Devised to deal with the most acute problems and to look after the needs of the most vulnerable groups, several health and health-related programs (especially for HIV/AIDS, TB, immunization, nutrition, MCWH) had been introduced. One could say that many policies with clear objectives and targets have been set. However, the extent of health problems still to be addressed suggest that widespread implementation is far from adequate and that performance records leave much to be desired. The intent has been provided; what is needed, is the transformation of good intentions into practices which can make an impact (Floyd 1997; Jacobs et al. 1997; SAIRR 1997).

The health reforms also brought major reforms and restructuring to health care training and education, especially a determined shift toward emphasis on PHC. Medical training and specialized health care came under severe pressure as medical schools, which offer the best prospect of retaining the best of modern medicine within the public sector, are "dismantled" under the thrust of the PHC drive and financial stringency. It is questionable whether the narrow perspectives of political decision-making in this respect really understand the long-term implications (Benatar 1997).

In the final analysis, one could then say that the health reforms in South Africa opened vast potential and numerous new avenues for better, easier, accessible, and more equitable health care. However, reforms have not been altogether effective and beneficial. The overhasty pace and the political thrust of the transition in many respects also confused matters and introduced unintended negative results detrimental to the effectiveness and efficiency of the system, the well-being of staff, as well as the quality and user-friendliness of the services for patients.

Health and Disease Profiles – Daunting Challenges for Reform

Main Determinants of Health, Disease, and Death in South Africa

Health and disease are not primarily matters of health care. They are as much the result of prevailing environmental influences, cultural patterns, and behavioral risks. Therefore they do not necessarily respond to biomedical and health care interventions. Also health reforms play but a small part in the improvement of health. More important for health are the general living and working conditions of that population and the lifestyles of its members.

The prevailing socioeconomic conditions in South Africa do not spell encouraging prospects for the health and well-being of the majority of the population, especially not for the disadvantaged who are at the same time the most vulnerable to disease and death. Furthermore, there is not enough evidence to convincingly conclude that the general living and working conditions of the majority of South Africans have improved significantly over the past four to five years as to reflect positively in health indicators – despite the major strides in health reform. Poverty and unemployment are high, large proportions of the population remain undernourished and illiterate, disruption of family life is escalating, levels of crime, violence, and trauma are rising, backlogs in housing, pure drinking water and sanitation persist, mass labor migration and the influx of illegal migrants continues, and South Africans are smoking more (Bradshaw 1996; SAIRR 1997). Amid such broader trends in the environment, improvements in health care would have minor effects, if at all, on the health of South Africans. In addition, current health reforms cannot swiftly react to, or compensate for, historical neglect and backlogs in health and health care in the short term.

From the foregoing emerge a picture of gross inequalities. In fact, among the middle-income countries, South Africa of recent has the highest income inequalities in the world. The inner layers of this inequality leave particular groups within the South African society highly vulnerable (Mokaba and Bambo 1996): First, Africans carry most of the burden of poverty, and bear the highest negative and the lowest desirable indicators. Secondly, women bear most of the brunt of inequality and poverty, and constitute an ever-larger proportion of people in poverty. Thirdly, serious disparities exist among provinces and between rural and urban areas, with rural areas and provinces (especially the former homelands) with larger percentages of rural settlements faring worse than urban areas.

Table 21.2 Socioeconomic inequality: select social indicators

Indicator	*African*	*Coloured*	*Indian*	*White*	*South African*
Human Development Index	0.500	0.663	0.836	0.901	0.677
Gini coefficient	0.53	0.44	0.47	0.45	0.58
% Individuals in poverty	57.2	19.8	6.8	2.1	45.7
% Households in poverty	47.2	18.5	6.2	2.1	35.2
Annual household income (ZAR) urban	17,900	22,600	40,900	59,800	
% Unemployment	41	23	17	6	33
% Household with piped water in dwelling	32.7	72.2	96.8	96.9	51.4
% Household with sanitation facilities	90.1	96.8	100	99.9	92.3
% Electricity for lighting from grid	51	84	99	99	65

Source: Bradshaw 1998; Mokaba and Bambo 1996; Møller 1998.

Like the prevailing living conditions of the population, so is lifestyle and risk behavior among different groups and categories of the South African population highly variegated phenomena. In their turn, these phenomena have determining effects on health status and burden of disease. The prevalence of smoking, obesity, sexual practices, and preferences among different ethnic, gender, and age groups illustrate the vast divergence in risk-taking behavior and practices. Recently it was estimated that 56.5 percent of adults (15–64) need to change to a healthier lifestyle and that 16.5 percent fall into a high-risk category that need to be diagnosed and managed (Fourie and Steyn 1995). Results of the *South African Demographic and Health Survey 1998* show that there is almost universal knowledge (97%) of HIV/AIDS and the population is generally well-informed about how the disease is transmitted. However, this does not translate into safe sexual behavior as reflected in high rates of STD symptoms. Also the types of contraceptives most popular among women – injection, pills, and female sterilization – suggest that knowledge of HIV and STD transmission does not always synchronize with prevailing sexual practices.

Table 21.3 Burden of disease in different races – select indicators

Indicator	*African*	*Coloured*	*Indian*	*White*	*South African*
Crude mortality rate (1994)	10.2	7.2	7.3	6.7	9.4
Infant mortality rate/1,000	54.3	36.3	9.9	7.3	48.9
Maternal mortality rate (1992)	58	22	5	8	
Female life expectancy at birth	67	65	70	76	68
Male life expectancy at birth	60	59	64	69	62
Cervical cancer/100,000	34.6	30.4	15.1	12.3	30.5
AIDS total number					
AIDS (1996)					
females	5,219	202	6	25	5,452
males	4,606	172	13	492	5,283
Tuberculosis notifications (all forms)/100,000 (1996)	137.4	530.3	50.4	14.3	154.3
Measles notifications /100,000 (1995)	14.3	27.5	4.6	5.5	14.7
Measured hypertension (1998)					
men >15	10.3	12.4	9.9	15.2	11.0
women >15	13.0	17.1	9.3	12.0	13.2
Prevalence of symptomatic asthma (1998)					
men > 15	6.4	6.2	8.9	8.5	6.7
women > 15	8.5	8.1	12.5	8.1	8.6

Sources: *South African Health Review* 1998; Department of Health 1997b; *Epidemiological Comments* Dec. 1996/Jan. 1997; V. Møller 1998; *South African Demographic and Health Survey* 1998.

Mortality and Morbidity Profiles of the South African Population

South African society is preeminently a society in transition, and this fact is clearly reflected in its disease and death profiles. In general, mortality rates have declined mainly as a result of improved incomes, diet, and living conditions, and access to medical technology and health care (Bradshaw and Buthelezi 1996). Equally characteristic of South Africa's profiles of health and disease, are the gross differences and diversity which hinge in particular on the parameters of race/ethnicity, age, gender, and geographical location, but foremost on socio-economic conditions, cultural patterns, and resulting lifestyles and deprivation. Typical of the health and disease profiles of South Africans are the high and consistently rising prevalence of chronic and degenerative conditions such as ischaemic heart disease, cancer, hypertension, diabetes, etc., amid widespread incidence of so-called "social diseases" associated with poverty and poor living conditions, such as tuberculosis, pneumonia, measles, nutritional deficiencies, STDs, gastro-intestinal diseases, etc. To these are to be added the high prevalence of trauma caused by motor vehicle accidents, violence, assault, rape, and murder. Rightly Bradshaw (1998) refers to the "triple burden of disease" prevailing among South Africans, comprising chronic diseases of lifestyle, communicable diseases, and trauma.

Morbidity and mortality in South Africa are further characterized by extensive variations between the provinces, along the rural–urban divide, and among the ethnic groups, the latter closely linked to socioeconomic class disparities. A number of these variations in the morbidity and mortality patterns are depicted in table 21.3 according to racial/ethnic affiliation and provincial location.

Outcomes of the Reforms for Health and Health Status

Apart from the above-described outcomes of the health reforms for health policy and the health care system, it is also important to reflect on the outcomes of these reforms for the health of the population. Theoretically, the commendable gains of the past years, especially in terms of accessibility, affordability, and attainability of public health care, should also reflect in concomitant benefits for the health and well-being of the people. Whether this has been the case, remains difficult to determine for several reasons.

Firstly, it is difficult, and even impossible, to monitor the outcomes of health care reforms over the short time span of four years, and as explicated in terms of improved health status and quality of life, fulfilment of health needs, decreases in mortality and morbidity rates, higher life expectancy, etc. Second, improvements in health status indicators since 1994 (if any) are part of longer-term trends noticeable for the past decade or two – IMR between 1960 and 1994 almost halved, from 80/1,000 in 1960 to 43.1/1,000 in 1994. Despite this general decrease, enormous differentials in IMR remain for the various population groups – for Africans 54/1,000, for Coloureds 36, for Asians 9.9, and for whites 7.3/1,000. Trends in IMRs are inextricably linked to trends in socioeconomic improvement, but note that infant mortality has lately begun to increase with the

impact of the HIV/AIDS pandemic. This situation is illustrated in the two scenarios depicted in table 21.4.

Table 21.4 Projected trends in infant mortality rate by race – two scenarios

Year	*1990–95*	*1995–2000*	*2000–5*	*2005–10*	*2010–15*	*2015–20*
African ***(A)***	53.4	39.0	26.7	20.6	16.9	15.1
African ***(B)***	53.4	49.5	46.7	43.9	41.7	40.8
Coloured	42.4	36.5	30.7	24.8	18.9	15.5
Indian	13.4	11.1	9.7	9.7	9.7	9.7
White	10.2	9.7	9.7	9.7	9.7	9.7

Notes:
A = improvement in quality of life because of better housing, electricity, clean water, and a drop in the unemployment. Rate – IMR for Africans would drop to 15/1,000, i.e. by 72% in the 30-year period.
B = general living conditions would not improve markedly. Rate – IMR for Africans would not drop below 40/1,000, i.e. by 24% only in the 30-year period.
Source: J. Catlitz 1996.

Third, the lack of information, and more specifically, the inconsistency and unreliability of current health status indicators (in particular for the African population), rules out any reliable deductions on short-term trends in health status at this point of time (Bradshaw 1997). Fourth, there is indeed ample evidence that in recent times trends in several important indices of mortality and morbidity are on the increase rather than declining – Tuberculosis and HIV/AIDS are examples. Fifth, recent gains regarding mortality, morbidity, and life expectancy could in coming years be eroded dramatically by the AIDS pandemic (SAIRR 1997). Sixth, health and disease are not matters of health care only; but are as much the result of prevailing socioeconomic conditions and lifestyle, and thus do not necessarily respond to health care interventions.

All things being equal, more accessible and affordable services should have soothing effects on the health of the population, especially those sectors of the clientele previously seriously disadvantaged and deprived. The Presidential-led programs of nutrition, free health services, mother and child health, clinic building and upgrading, certainly also have immediate effects, for example on the alleviation of hunger and undernutrition, accessible mother and child care, etc. However, looking at the outcomes of the health reforms on health, matters appear not all that promising. Three broad areas suffice to illustrate this gloomier side.

HIV/AIDS shows the fastest growing rate of contagion in the world (Williams 1998). The proportion of the sexually active population that is HIV+ has been increasing drastically. In 1994 it was approximately 5 percent of the sexually active population or half a million people, with a doubling of numbers every 13 months. In 1996 it was between 12 percent and 16 percent of the sexually active or up to 2 million people, and the doubling time was 5–12 months. The evidence of the 1998 HIV survey confirms that the epidemic continues to grow at an alarming rate with 3.6 million people infected (Department of Health 1999). South Africa could expect to accumulate between 5 and 7 million HIV-infections

and about 1.5 million cases of AIDS by 2005. Unless the epidemic is turned around, expenditure on HIV/AIDS could hypothetically take up at least a third and possibly as much as 75 percent of the health budget within the next decade (Floyd 1997; SAIRR 1997) with major distorting effects on the general provision of and access to health services.

Table 21.5 HIV-infection rates in women attending antenatal clinics

Year	*1993*	*1994*	*1995*	*1996*	*1997*	*1998*
Percentage infected	4.01	7.57	10.44	14.17	17.04	22.8

Source: Bradshaw 1997:10; Department of Health 1998; Floyd 1997; SAIRR 1997.

South Africa is facing one of the worst TB epidemics in the world, with disease rates more than double those observed in other developing countries (Weyer 1997). In 1994 the incidence of TB in South Africa stood on 300/100,000 of the population, with 2,000 reported deaths for that year. More recent figures show that the incidence rate of TB has increased by 6 percent between 1995 and 1996 – from 340 to 362/100,000 of the population. An investigation by the WHO showed that South Africa had the worst TB epidemic out of 150 countries investigated. If trends continue, some 3.5 million people would become infected with TB by 2006, while multidrug-resistant TB is on the increase (SAIRR 1997; Weyer 1997). Worst is the situation in the mining industry where recently the incidence of TB is given as 3,000/100,000, as over a national rate of approximately 350/100,000 (SIMRAC 1999). The spread of TB within the mining context is grossly facilitated by an extensive migrant labor system within South Africa, as well as between South Africa and several neighboring countries. Note also that the magnitude of this bleak scenario is deepened by TB being so closely linked to HIV infection; in 1995, an estimated 23 percent of all TB cases were HIV+, increasing to 27 percent in 1996.

Ours is also a society of exceptional high levels of violence with few signs in recent years that a declining curve is emerging. During the decade 1987 to 1997, political violence alone has claimed 21,438 lives (SAIRR 1998). Trauma and fatalities as a result of road traffic accidents, assault, and murder also pitch at alarming heights with few signs of abating trends. Bradshaw (1997) records that in 1996 9,790 people died through road traffic collisions; a further 38,159 sustained serious injuries, and 86,291 slight injuries. During the period 1990–6, the average number of casualties per collision increased from 1.2 to 1.6. Furthermore, amid a relatively poor record of safety over the years, fatalities and injuries in South African mines adopt alarming proportions: between 1988 and 1995 fatalities in a total workforce of approximately 400,000 amounted to 5,005 and injuries to 75,001. Recent downward trends in figures are more ascribed to a decrease in the workforce than to improvements in the state of occupational safety (SIMRAC 1999).

A last point, with the strong emphasis on primary health care and the concomitant de-emphasizing of sophisticated hospital and specialized care, it is to be expected that certain disease conditions and patients categories will receive less

attention from a treatment point of view – expensive treatment procedures and free option to utilize these have certainly diminished.

Regarding the outcomes of the health reforms on the health and well-being of the people, one could then conclude that the reforms over the past five years in all probability contributed constructively to improving the health of the population and alleviating the heavy burden of disease and ill health of the deprived and vulnerable. However, areas remain where the new policies and structures of health care as yet do not in practice make any significant difference. Only an improved standard of living and changed lifestyles would render such a difference.

Conclusion

Africa's heavy burden of disease, scarce health resources, and ailing health systems are unenviable. However, in South Africa's case, there are some hopeful signs. In the short period since 1994, transformation of the health system has been remarkable. The country's constitution, health policy, health structures, and contents of health care have changed fundamentally. The constitution is categorical about the commitment toward recognizing the injustices of the past and effecting redress so as to establish a society based on social justice, improve the quality of life for all citizens, and free the potential of each person. It thus frowns upon the historical lottery of race, income, and geographical location as the major determinant of access to health care. Instead, access to health care is cast in egalitarian terms as a right for everyone. It is apparent, however, that there are formidable obstacles to the realization of equitable access to health care. Though the transformation of the South African health care system is on track and in numerous ways irreversible, it is far from complete. Moreover, the implementation of the new policies has been slow and tardy, hampered by many difficulties, not least by forces with different convictions, aims, and interests.

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