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Definition. description and major policy debates
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1. DEFINING THE SECTOR
It is necessary to begin by distinguishing between health. health care and health services:
defining health
The classic World Health Organisation definition is:
Health is a state of complete physical. social and mental well being. and not merely the absence of disease.
This is a useful definition in that it points to the fact that being healthy requires more than good health care; it requires economic and political justice. housing. Clothing, food. relaxation. dignity a healthy living environment and a whole lot more.
Clearly the promotion of health within the community is a task that extends way beyond the provision of health care.
Defining health care
Health care is what happens. (or what should happen) in any interaction between the health service and individuals. families or communities. There are a variety' of ways of categorising different sorts of health care:
i. preventive. promotive. curative and rehabilitative care
Where prevention and promotion are intended to prevent disease and promote health: Under this heading falls such activities as: Immunisation against infectious diseases. screening for early warnings of serious illness (e2 pap smears). health education (smoking is bad for you. use condoms to prevent aids). the promotion of a healthy diet and life style etc.
Cure is intended help those who are sick get better. Often however, curative services are also focused on treating people with incurable diseases (asthma, diabetes. arthritis etc) or keeping alive people who are dying (of cancer. AIDS etc).
Rehabilitation is aimed at helping those who have been disabled by illness or injury to recover fully, or at least to lead fuller lives.
a
In general by far the greatest effort and most resources 20 into curative care. This is not necessarily a good thing. but relates to the medical model and the domination of the health sector by doctors.

ii. Primary, secondary and tertiary care
where
Primary care is first point of contact care (general practitioner, Clinic. hospital out patient department)
Secondary care is specialist care to which one is normally referred from the primary level. This may be ambulatory (as when one is referred to a paediatrician or a gynaecolozist) or in-patient. when one is kept in a hospital for treatment.
Tertiary care is almost always hospital based, and refers to highly specialised care normally provided only in certain hospitals (such as cancer treatment. heart surgery).
This terminology has been confused by the term "Primary health care approach". which has been adopted by the WHO and refers to all levels of health care, but tries to set appropriate priorities for ordering of the health care system. (see section 2)
iii. Physical health care and mental health care
Which distinction is fairly obvious although psychological problems often present as physical symptoms. and severe illness can adversely affect the mental health of patients and their families.
Defining the health service
The health service includes:
1 Those people who provide health care (including doctors. nurses, pharmacists. physiotherapists etc)
x The facilities in which they work (hospitals, clinics, mobile clinics. private consulting rooms)
x Logistical services (such as ambulances, laundries)
x Research services such as laboratories
t Policy formulating structures (TPA, State Health. City Health)
X Training institutions (such as medical schools. nursing colleges)
The health sector obviously includes the whole health service and the policy governing the health service and the provision of health care. From an intersectoral development perspective. a key question is: How much responsibility (and what sort of responsibility) does the health service have for social. economic. political and environmental circumstances that impinge on peoples health. but have nothing directly to do with health care.

For example. if malnutrition relates to inadequate food intake. should health workers be promoting vegetable gardening or be involved in job creating activities. Or. if inadequate shelter and consequent overcrowding contributes to the spread of tuberculosis. where does the health sector end. and housing policy begin. and how do they relate to each other?

2. THE "NEED" FOR HEALTH CARE: GAPS AND INEQUALITIES.

One of the problems in developing a health policy is that the "need" of the population for health care always exceeds the capacity of the economy to meet those needs.

This is largely because of the cost of training highly specialised health personnel. and the cost of technology, medicines and highly sophisticated institutions that are need to make use of the advances in medical science that have occurred in recent decades.

The needs and costs escalate also

x with an aging population who have long term illnesses that require expensive intervention.

X With an unnecessarily high disease burden resulting from the conditions of poverty and the unhealthy physical environment in which millions of South Africans live and work.

x with the growth of the AIDS epidemic. in which caring for AIDS related illness. and the supportive treatment for patients who are HIV positive. but do not yet have AIDS, could easily consume almost all the money currently spent on all aspects of health care.

Because needs outstrip supply. it becomes necessary to ration access to health care and to establish priorities if we are to achieve anything like equity in the health sector.

The World Health Organisation has attempted to define priorities for health care through the Primary Health Care (PHC) approach. Which states, in abbreviated form. that the goal of health services should be to

Make essential health care accessible to all in a form that is socially acceptable: This essential health care should be provided at a cost that the country and the community can provide; it should address the main health problems in the community: it should give priority to those most in need: it should provide comprehensive (promotive. preventive curative and rehabilitative) cwke. Primary health care should become the central focus of the health service. with specialist levels of the service supporting primary care.

This is hardly a solution to the problem of rationing. as it begs the questions "what is essential health care?" and what if the

country and the community cannot afford even essential health care? Nonetheless. the definition does help us to define gaps and inequalities.

Based on this definition. we can say that everyone should live within easy reach of a primary health care facility (be it DUbliC clinic or private practice) that provides comprehensive pbimary health care. and access to more specialised levels of care where necessary. Cost to the individual should not be a factor in decisions about whether to make use of these services.

gaps and inequalities

There is no need here to quote endless figures: which are available if needed:

Suffice it to say that expenditure (in the public and private sectors) on health care shows that for every rand spent on health are for African R4-30 was spent on health care for whites. That in terms of purely public sector expenditure. whereas the Cape Province spent R144-OO per capita on curative care only. the Ciskei bantustan spent R46-00 per capita on all aspects of health care, and the Transkei R44-00. At the extremes of the rich and poor communities it is probably accurate to suggest that the expenditure ratios is about 20-1.

The consequence of these gross inequalities is that there are enormous inequalities in access to health care between rich and poor. black and white. urban and rural communities.

It is fair to say that for millions of South Africans in homeland areas. in urban squatter settlements. and particularly on the white farms, essential health care is simply not available. For even such basic preventive measures as immunisation. it is probable that less than fifty percent of Children are adequately immunised against infectious diseases.

On the other hand those who are able to make use of private sector care. have ready access to good quality care which is often highly extravagant in its use of resources. In some metropolitan areas there are public sector services which have been able to provide good quality care to those within reach. The public sector has been under funded for decades. and is being progressively undermined by the private sector and is losing its ability to provide adequate care.

Some more information on inequalities is provided in, the next section.

3. EXISTING RESOURCES ANg INSTITUTIONS

i. Background information

South Africa spends just less than 6% of GNP on health care. (This is about the same as the United Kingdom. The United States and

Sweden spend about 11%, many developing countries spend about 2-3%). It is unlikely that we will be able to spend more in the near future.

However. about 50% of this expenditure takes place in the private sector, which provides health care for about 18-20% of the population. In addition about 50% of the doctors are found in the private sector. In reality. access to the private sector is dependent on having a job that has medical aid membership as a fringe benefit.

The public sector therefore has about half the money and half the doctors. to provide health care to the other 80% of the population. However. even these resources are very unevenly distributed: only about 17% of government health care expenditure goes to the homelands, where about 40% of the people live.

Per capita expenditure in the public sector has declined in real terms to below 1984 levels.

About 70% of hospital beds in the country are owned and run by the public sector. with the rest run by the private sector in a variety of contexts: many are run on a contractual basis for the state. some are corporate services such as mine hospitals. and only about 7% of beds are of the Park Lane variety. private, fee-for-service beds. (However this small (but highly profitable and expensive sector) has grown rapidly in the last few years.

South Africa is relatively well endowed in terms of numbers of doctors (about 20.000 or 1 for every 1800 South Africans and about 150000 nurses of all categories 1/250 South Africans). Similarly. there are about 4 hospital beds for every 100 South Africans.)

These are certainly adequate resources on which to base a health service. The main problems relate to their distribution. with the concentration of resources in metropolitan areas leading to a serious undersupply in many rural areas. (while personnel are theoretically moveable, hospital beds obviously are not.)

Health care expenditure in South Africa is excessively biased towards curative care. Perhaps 70% of public expenditure. and nearly all private expenditure goes to curative services. Government spokesperson frequently estimate that about 5% of expenditure goes towards preventive and promotive services. (It is not easy to determine just what an ideal balance should be. Certainly more should go to prevention and promotion than does at present.)

In order to better understand the nature and structure of health care in South Africa. it is necessary to look at the public and private sectors separately..

ii. The public sector

The public sector has a highly irrational structure, largely. but not exclusively rooted in the way apartheid has shaped health

services.
Within the single country of South Africa, there are fourteen separate departments of health (one for each of the ten "homelands" or bantustans, one each for the "whiteu. "coloured" and "Indian" "own affairs parliaments". and one for so called "general affairs").
In addition the four provinces and about 900 local authorities administer different aspects of the health service, often in racially segregated institutions. (The announcement in May 1990 that previously "white" hospitals are now open to all races has hardly made any impact on the almost universal segregation of public health facilities.)
The result of this enormously complex fragmentation of the health service is that planning is impossible. There are about four different bodies set up to "co-ordinate" health care. Not one of them has jurisdiction over all the fragments, and the four co-ordinating bodies often do hot even co-ordinate well with each other.
The situation is so complicated that it is often not possible to identify who is responsible for providing a particular service. The result is that some services are just not provided. and all authorities can deny responsibility for health service problems by suggesting that perhaps some other authority is responsible.
The duplication of bureaucracies (there are fourteen Ministers of Health presiding over fourteen departments) and of facilities (there are small towns in which the local authority runs four segregated clinics. when one or two would be plenty) leads obviously to a waste of resources which would be better spent on providing more health care to those in need.
The provinces (who provide most hospital care and run curative clinics in some areas) and the local authorities (who provide most preventive health services) between them are responsible for most aspects of health service provision (with the provinces consuming 55% and the local authorities about 6% of public expenditure.)
The homelands (17% of public expenditure) have one major advantage over other parts of the health services: all services in the homelands fall under a single authority. and are therefore potentially relatively easily co-ordinated: the problems in the homelands relate more to under financing. and to the problems of fragmentation that occur elsewhere in the health service. or that derive from the geographically fragmented nature of the homelands themselves.
The public sector as a whole displays many of the worst characteristics of an authoritarian bureaucracy. The provincial authorities in particular-hre highly centralised. allow little scope for management initiative at the different institutions. and reflect much of the mentality of the South African civil service as a whole.
The nursing staff in particular are trained and treated in almost

para military fashion: there is great emphasis on "professionalism" (meaning carrying out orders without question) and initiative is discouraged. The already authoritarian relationship between the medical and nursing professions is doubly re-inforced by the fact that most doctors are white males. and most nurses black females. The duplication of facilities. the bureaucratic management style. and the unimaginative use of trained personnel indicate that there are substantial inefficiencies in the public sector: if more effectively utilised. there seems little doubt that the public sector could provide a better spread of health care to more people, even without additional resources.

A final point about the public sector is that it is entirely unaccountable to the people it serves. By far the majority of public sector services are provided by provincial administrations run by officials appointed by the state president. There are no longer any provincial councils to whom these officials are accountable.

Thus, quite apart from the fact that the majority of South Africans have no vote, even those who do. can exercise no democratic control over health service structures at all.

ii. The private sector

The private sector is experiencing its own major crisis.

Access to private health care (beyond the occasional visit to a general practitioner (GP)) is dependent on employment which has medical aid benefit as a major benefit. About 19% of all South Africans are covered by medical schemes of one sort or another. About 80% of whites (down a little from a few years ago) and about 8% of blacks (up from 4.55% in 1980) are members of medical schemes. (The growth in black membership of medical schemes is the objective basis on which the governmentts privatisation programme has been based.)

However. cost of private health care (as measured by contributions to medical aid schemes. has risen by an average of 23% per year. Thus, over 11 years the cost of belonging to a medical aid scheme has increased ninefold. compared with a fourfold increase in the general consumer price index.

This has led to the beginnings of consumer resistance to private health care as presently structured. and to major conflicts between different sections of the private health care industry over who is LO blame, and how the funds available for private care should be shared between the different actors.

In 1988 payments by medical schemes were structured in the following way.

Payments to General practitioners 16%
private specialists 18%
Dentists 11%
Hospitals 22%
Medicines 26%
Other 7%

Although the private sector is generally perceived to provide good quality, personalised care. it is in some ways an extremely extravagant consumer of resources. If we were to provide curative care to the whole population at the present cost structure of the private sector, we would consume about 15% of GNP, which is unsupportable in any terms.

There are certain aspects of the private sector as currently structured which contribute to this great cost. and high rate of inflation. I will mention briefly just two.

The first relates to the fee-for-service system. in which health care providers (doctors, hospital etc) charge a fee for each procedure carried out. This creates a "perverse incentive" to provide more (and more expensive) services. in order to maximise profits. In the context of health care, where patients are entirely dependent on their care giver’s decision (few people. after all will tell their doctor that they do not really need that expensive test s/he has just ordered) this results in an oversupply of medical services, and therefore unnecessary costs are incurred.

The second relates to the 3rd party payment system. In a medical aid, patients choose their doctors and the medical aid fund pays these providers on a fee-for-service basis. Thus, at the time of the provision of the service, neither the supplier nor the consumer (the patient) need consider costs: - they know the medical aid will pay. This may be reassuring at the time of receiving care: however. when this system of guaranteed payment is combined with the fee-for-service system. it results in a potent source of cost escalating behaviour amongst both providers and consumers of private care.

The economics of private medicine leads to other distortions in the health care system. It focuses on curative care (which is what people will pay for) it focuses on the diseases of the wealthy (they are the ones who will pay) and it concentrates resources in the rich metropolitan area where the market is. Finally, the enormous earnings available especially to private specialists has led to a progressive flow of skilled personnel from the public to the private sector. further undermining the ability of the public sector to provide adequate services. The more flexible working conditions, and better payais also leading to more and more nurses seeking employment in private rather than public hospitals.

4. CURRENT APPROACHES OF KEY ACTORS

In this section I will deal only with the main "establishment" actors.

Government policy

Until recently government policy was clear and simple: Apartheid and privatisation.

The Apartheid bit is obvious: the health services were fragmented first into homelands. and then tricameralised with the 1983 constitution. As late as 1989 this was still in progress with the transfer of a number of white hospitals to the white "own affairs" department of health.

Privatisation had been government policy for most of the 1980’s. This had not led to the transfer of assets from the state to the private sector. To the extent that the policy was implemented. the process was more covert and opaque. Through progressive underfunding. the quality of the public sector declined, and in institutions such as the Johannesburg hospital wards were closed due to lack of funds and staff.

In addition. the cost of using public sector facilities has been continually increased. and through a process of "bracket creep" progressively poorer patients have been defined as "private" that is paying) patients. Thus it is often actually cheaper for many people to visit a general practitioner than a hospital out patients department, or a provincial clinic. So more and more people have been pushed into the private sector.

Present policy making is now totally ad hoc in nature. Apartheid is no longer legitimate. and privatisation has largely been abandoned. Policy is made largely in the context of the following variables which play themselves out at different times:

ro reform factors

X The de Klerk era has brought a "verlig" minister, and given space to some highly reform minded people at the head the National Department of Health.

t In the political context of trying to win middle ground for the Nationalist Party. there are good reasons to attempt to deracialise health care. and to make better health care available to more South Africans in the public sector.

x The enormous cost of private health care has largely been recognised, and sunk privatisation as an option.

Constraining factors

X The enormously complex administrative structure which means that any change must move through numerous structures, many of which are resistant to change for reasons of both political conservatism (such as the provincial administrations) and

bureaucratic inertia.
x The process of constitutional negotiations Which. ironically. makes it impossible for the government to dismantle Apartheid structures unilaterally. Thus decisions about appropriate structures for health services, and how to conjure regions and districts out of homelands and segregated Local authorities must, at least partially await the political settlement of broader questions of power and government
structure.
t White right wing resistance. which has certainly helped to inhibit the desegregation of hospitals.

Thus we find. on the one hand, the Minister announcing the end to hospital apartheid. and leading policy makers constructing quite imaginative and "progressive" plans. In the "national Policy for Health Act" of 1990, the Minister took upon herself the powers to necessary to force policy chenges through at all levels.

On the other hand. little actually changes. either with regard to the racist allocation of resources and access to care. or in the re-structuring of services.

This one step forward, two steps backward process probably reflects more the complexities of the present political conjunoture. than a deep seated conspiracy to appear to change while leaving everything exactly the same.

The private sector

This is complex. and the private sector cannot be seen to be a homogenous interest group speaking with one voice. There are major conflicts between the private providers (doctors. hospitals and the pharmaceutical companies) on the one hand. and the medical aid schemes on the other. At the same time, there are conflicts of interest between for example general practitioners and specialists, and between doctors and pharmacists.

However, there are also certain distinguishing features. The uncertainties of this "transitional phase" has led everyone in the private sector to attempt to define (and indeed to secure) their place in the future. This has led to greater policy flexibility than has been seen for a long time.

The mainstream professional organisations (most significantly MASA) are showing a reformist trend that is quite surprising.

The perceived threat of major intervention by a democratically elected government, together with the objective crisis in the private sector, has led to a serious consideration of new strategies and structures for the private sector which perceives a need to make a contribution to the health care of a greater number of South Africans.

In general. the lack of direction from the government, and the relative openness of the private sector. have created a unique opportunity for the progressive movement to give the lead in
restructuring health care in South Africa.

5. APPROACHES AND POLICIES IN THE PROGRESSIVE SECTOR

The progressive movement too has been rather shaken by the prospect of power. The primary demand from the progressive health organisations has been for a National Health Service (NHS). This demand has never been very specific, and the nature of the NHS demanded has not been clarified. Basically, this demand has reflected a general perception that the state should pay for health care, and that. because private care is expensive and inaccessible. that the state should also provide most health care.

As a policy for a future government. this has began to look a bit thin.Thus a major reappraisal of policy options has been under way. In this section I will discuss two of the issues currently receiving attention.

X How to finance health care/what to do about the private sector

: How to put primary care into reach of everyone

A. Financing health care for all/what about the private sector

This is a key question. We currently spend 6% of GNP on health care, yet do not provide adequate services to many. We are unlikely to be able to spend much more. but will have to create greater health service equity. How do we protect the money presently spent on health care. and make.it go further. In particular. is it possible to make better use of resources which are wastefully used in the private sector?.

Three options represent the range of opinions within the progressive sector.

option 1: Nationalise the Qrivate sector

This is the simplest option. It would involve nationalising the private hospitals. banning private practice and forcing all doctors into state employ. However. it is probably both practically and politically untenable as a course of action. Health personnel. particularly doctors would leave the health sector (and the country) in droves, and a "black market" in private care would soon emerge to undermine the pgblic sector. If all the doctors did indeed stay on. this would practically double the number of doctors on the state’s payroll - an impossible burden given that public health care is already badly underfunded.

At present nearly half of all expenditure comes out of private pockets to pay for private health care. If the private facilities.

were to be nationalised, that money would simply disappear. There would be no reason for people to pay for health care that was now provided by the state.

Thus nationalisation would greatly increase the state’s liability to pay for care. without. in any obvious way, increasing the financial resources at the state’s disposal.

Quite apart from these practical arguments, it is most likely that the state would face a sustained and powerful campaign against nationalisation from both the providers and users of private health care.

It is unlikely that any future government would seriously contemplate this option.

Option 2: Keeg Qublic and Qrivate sector separate

There is a school of thought which argues that the post Apartheid state should concentrate on’strengthening the public sector, and transforming it into an egalitarian and high quality service open to all. The private sector. so this school of thought goes. should be left alone to provide private care to those who want, and can afford, to make use of it. The sting in the tail of this approach is that the private sector should be substantially reduced in size by a series of measures aiming to make those who use private care pay the full cost and to control some aspects of private sector behaviour.

Suggested measures include:

1 Doing away with any tax rebate for health insurance contributions.

X making the private sector pay the full costs of traininz professionals who end up working in the private sector.

X Instituting a system of licensing for private hospitals. practice sites and the use of new technology.

In this way, it is argued, the private sector can be made less attractive and more expensive. thus substantially reducing its size. its influence and its ability to undermine the public sector. In addition. through doing away with tax rebates, some funds can be released to help develop and strengthen the public sector. The public and private sectors would be kept rigidly apart.

Critics of this course of action raise a number of problems. In particular, they suggest. it underestimates the ability of the private sector to adapt tq5new circumstances. In fact, they argue that it would leave in place a large and robust private sector, operating largely outside of national goals and priorities. This private sector would continue to consume a disproportionate share of resources. including doctors. entrench the two tier system of health care. and indeed continue to undermine the state’s abilit to develop an effective public health service. i

The proposed course of action would potentially release some additional funds to the public sector (the current tax rebate on medical aid contributions) but it would not provide sufficient funds to allow the rapid development of the public sector.

Option 3: Centralised financing for public and private providers

This option. seeks to draw the private sector into a national system of health care provision. The proposed mechanism is the establishment of a national health insurance system in which current medical aid contributions are replaced by a compulsory health insurance contributions for all those in formal employment. This would bring together into a single pool, controlled by the health authorities. both the public and private finances for health care. This money would then be used to pay for a package of health services for all citizens. provided by a combination of private and public sector providers.

This would lay the basis for a single system that guaranteed all Citizens access to a uniform range of essential health care that would be free, or nearly free at the point of use. Those who could afford it. would be able to buy additional care not covered by the basic package of goods.

This pooling of resources would create a powerful single purchaser of health care acting on behalf of all citizens in the country, able to ensure cost effective care by purchasing medicines cheaply, negotiating appropriate methods of payment with private providers and only paying for appropriate tests and procedures.

Such a mechanism. which has been implemented in many countries including Canada and Australia. would leave in place many of the aspects of the private sector that are attractive to both providers and users of the health service. At the same time it would create a real possibility for the state. over time. to redistribute resources towards underserved areas. to create incentives for people to use the public sector. and to attract private doctors and nurses back into to the public sector.

The major criticism of this option is that. by paying for everyone’s use of the private sector. it would dramatically expand private health care. without modifying at all the cost escalating behaviour of the private sector. The effect would be to create an enormous drain on the central pool of funds. This real danger emphasises the need to define very carefully. and cost, the package of care that would be paid for by the national insurance fund. It also points to the need to negotiate in advance with private providers over methods 0& payment, procedures and cost saving possibilities.

b. How to make PHC available to all?

As with the debate about the private sector, there’has been a

simplistic polarisation which we need to move past in order to achieve Clarity.

There has been a tendency by the proponents of a national health service to see primary care as being based in a Community Health Centre staffed by a multi-disciplinary team of salaried workers. including doctors and nurses, with other health workers such as rehabilitation therapists and mental health workers accessible if not always on tap. It is often also suggested that first contact should be with a clinically trained nurse rather than a doctor. and that GP level doctors should in fact be the first level of referral, to whom the nurses would refer the 20% of patients that they are unable to cope with adequately.

It is suggested that in this wayi the most cost effective and holistic model of primary health care will be constructed.

As with the general call for a national health service. this model lacks a s.pecific strategy to achieve its objectives. In particular. its proponents need to explain what will happen to the 9, 000 general practitioners or (1 GP for about every 4000 people in the country.) They constitute a ma.)or resource already in place for the provision of primary care. Many. probably most, of these general practitioners would at present be absolutely opposed to being employed by the public service on a salary. Many would also, on the basis of a well founded critique of existing primary care clinics, reject the idea of working in a state community health centre.

Thus the proponents of primary care through state sponsored CHCs would need a strategy based either on the forced incorporation of these GPs. (which seems politically unfeasible, and probably undesirable from many other points of view) or on their exclusion. which would mean depriving the national health system of a crucial resource.

In opposition to this nurse based, CHC based system. there are those who argue with conviction that general practitioners are the only professionals appropriately trained to provide primary care, and that anything less constitutes the provision of second class care. This argument tends to be accompanied by statements that private practice provides the greatest choice for patients, the greatest job satisfaction and autonomy for doctors, and the most conducive setting for the development of appropriate doctor patient relationships.

This argument, in turn. has its critics: Firstly. if we were to aim at a GP based primary care service there would need to be at least 1 GP per 3000 people. which would mean finding an additional 3000 GPs. or 1/3rd as many again as are presently in practice. Secondly. it is argued, OPS are so concentrated in the urban and metropolitan centres, that in many-parts of the country, there is simply no chance of basing a service around GPs. On the other hand any system which says GPs are essential in rich urban areas. but nurses are good enough for the poor, is entrenching inequality and is therefore unacceptable in terms of the basic principles stated at the outset.

Thirdly, it is suggested that any health care system centred around doctors. entrenches a medical model of health care, focuses largely on curative care. (particularly in the private sector) and underplays the need for both social intervention to improve health. and for adequate preventive and promotive services.

These two models tend to be polarised, much as the privatisation vs nationalisation debate from which they derive is polarised. Again, when it comes down to immediate policy choices. reality does not permit of any such simple solutions. We have to acknowledge that on the one hand it will be impossible to provide primary care for all without drawing CPS into the process. On the other hand, the private sector within which the general practitioners are primarily located is not. in its present form. going to provide health care to the majority of South Africans, particularly those in poor rural areas.

We believe that the solution to this dilemma may also be found in the national health insurance proposal mooted earlier.

By paying for essential health care for all (which certainly must include all primary care) such a system would make general practitioners available to all. not just those who can personally afford to pay. This would result in a whole new market for GP services in areas where no GPs can presently be found, and so lead to a wider distribution of practitioners. This tendency could be encouraged by a system of licensing practices. which would prevent excess concentration of practitioners in any single area, so encouraging new graduates to move into areas less well served by GPs. In addition the Department of Health. as the central purchaser of services could offer creative incentives aimed at encouraging practitioners to serve in poorer areas. Thus. ironically. it may prove easier (and quicker) to make primary care available. at least in some areas, by redistributing general practitioners. than by building costly community health centres and then finding public service employees to work in them.

It is also necessary to point out that the health centre philosophy is not necessarily incompatible with "private" (ie non state owned) practice. There is no reason why the state should not pay for, or even encourage. the development of group practices offering the services of nurses. general practitioners, various kinds of therapists and. even social workers. These practices could. be funded by an annual budget determined according to the number of patients served. By receiving payment fixed in advance. they would experience major incentives to provide cost effective services: to the extent that clinical care nurses could enhance this cost effectiveness. a well run practice would soon employ their services. .,

In discussing these options. it is important to bear in mind that the state is well placed to provide a large proportion of primary care through state funded and run CHCs. In the major metropolitan areas such as Cape Town and Johannesburg. there are already a

6. PROPOSED POLICIES FOR CONSlDERATION AND FURTHER DISCUSSlON

These are dealt with in the previous section. We would propose that the first step to achieving equity is the establishment of a National Health insurance System.

It is necessary over time to strengthen the public sector. to reduce in influence the private sector. to regulate the private sector and bring it into a single national health system.

The public sector needs to be managed more creatively. and made more responsive to the needs of patients.

Furthermore, it is necessary to recognise that transformation is a process not an event, and therefore there is a need to develop strategies and tactics to move Closer to the defined goals of the primary health care approach set out at the beginning of this paper.

7 AREAS FOR FURTHER RESEARCH

These are limitless. Some priority ones:

1. What essential package of health care can South Africa afford to provide to all its Citizens?
2. What possible mechanisms exist for setting Ln) a national health insurance system? How would the behaviour of the private sector be modified within such a system?
3. A detailed analysis of the policy positions (or the vested interests) of key actors in the health sector: what are their "bottom lines"? what levers exist to move them to accommodate the kinds of Changes that will be needed if we are to achieve health care for all? What compromises are possible? what would so compromise the goal of equity that it may be necessary to force changes at the expense of one or the other actors?
4. How to ensure that certain neglected areas: most notably women’s health issues and mental health are adequately incorporated into future policies.
0. The linkages (and boundaries) between the health sector. and other key "development actors (most notably welfare, education, and those government departments responsible for a clean and health living environment.)
6. What does community participation in health care mean?
I. What is the appropriate degree of decentralisation of health services: how does this link with other constitutional or administrative structures? How do we dismantle the administrative empires (in homeland and own affairs) and integrate them into a single department of health.
8. There is an enormous resource of trained personnel. How do we re-motivate them. and manage them differently in order to make best use of them.

substantial network of "polyclinics" and "day hospitals". in place. In addition most urban areas have a number of clinics 00 e . oupied by the local authority prOViding preventive service, mainly immunisation Clinic and under fives clinics. In addition, manv of the homelands also have large numbers of clinics scattered through their territories.

With appropriate staffing. infrastructural upgrading in some instances, and good support and management systems, these clinics could be transformed into cost effective institutions meetinz the comprehensive primary care needs of the communities that live around them. Major reforms to the organisation and management of the systems would also be required. There is no good reason why public facilities cannot replicate the best features of private sector care, including appointment systems. some Choice of health worker, (particularly in urban areas) and certainly continuity of care by the same health worker.

These clinics could provide a wider range of services than those provided by general practitioners in solo practice. In addition. the primary health care aphroach requires interventions in the community, and combined action with other aspects of the public service (such as the traffic department or the educational authorities). To that extent the public sector is undoubtedly in a better position to implement the approach in its full range of meanings.

It is most unlikely that South Africa will ever have a primary care system based exclusively on state employees in state health centres. or on general practitioners in private practice. General practice. private group practice and state run community health centres are all likely to be part of the immediate strategy developed by future policy makers to put primary care within reach of everyone.

The preferences of policy makers, the demands of users. and the power of private providers will all influence the longer term goals of policy. As these long term goals emerge through experience and the political process. it will be possible to drive the system in one direction or the other. Certainly it is theoretically possible to create incentives for people to use the public rather than the private sector. to encourage private practitioners to move into the public service, or to modify the behaviour of private suppliers of health care.

The possibility of a negotiated settlement to the political conflict in South Africa forced the policy discussion beyond the unproductive polarities of the debate between the privatisers and the nationalisers.

There is a need for radical changes to overcome the inequalities inherent in Apartheid aqg the present structure of the private sector. However there are also objective constraints on both the nature and extent of changes that can be introduced immediately. These constraints will, to some extent, guide the choices made by "Post Apartheid" policy makers.