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# *South Africa's Health*

## Restructuring South Africa's health care: dilemmas for planners

Rajendra Kale

*This is the last in a series of articles reporting on health care in South Africa*

Restructuring South Africa's health care involves providing care to the majority who have so far been deprived of it without destroying the excellent tertiary health care facilities and the high standards of academic medicine that exist in the country. South Africa spends 6·4% of its gross domestic product on health, which is more than the goal—5% by the year 2000—set by the World Health Organisation. But 46% of this amount is spent on the private sector, which serves 19% of the population, as was explained by Dr Nkosazana Zuma, South Africa's health minister, in her health budget speech to the parliament on 20 October 1994. Moreover, 75% of the health budget, which was 14 billion Rand for 1994-5, is spent on hospitals and academic institutions. In effect, the amount spent on health care for most of the population is much less than the 5% recommended by the World Health Organisation.

Dr Zuma said in her speech that the cornerstone on which the future health care system will be built would be a district health system offering a package of primary health care provided by a district health authority. She clarified that primary health care was not synonymous with preventive health care and that the proposed system would achieve a balance between promotion, prevention, rehabilitation, and curative services. She also outlined definite goals that the government was committed to achieve: these focused on the control of infectious diseases, an obvious priority for any developing country (box).

### Goals set by the health minister

- Increase the coverage of immunisation for each vaccine for children to 90% (from the present 70%) by the year 2000
- Eradicate poliomyelitis by the year 2000
- Reduce neonatal tetanus to fewer than one case per 100 000 live births in all districts by 1997
- Reduce the number of patients with measles to fewer than 4000 cases for five years beginning in 1996.

### Budget cuts for academic institutions

Finding the money for primary health care is difficult. Much of it will have to come from the academic institutions. Dr Zuma said that the government and the deans of the academic institutions had agreed to cut their expenditure by 5%.

Academic institutions and the big hospitals have been subjected to budget cuts in the recent past, and this further cut is not welcome. Ralph Kirsch, profesor of medicine in the University of Cape Town Medical School, said: "Some of us in the larger hospitals will suffer and there is a danger that we may get destroyed. While redistributing resources we would like the money for primary care to come from another source than ourselves, but it is coming from us.

"A hospital like Groote Schuur sees about 1·2 million patient visits, of which 80% are for primary care. We support the minister where primary care is concerned but not at the cost of destroying this. If this is destroyed, the future of medicine is destroyed. We train health care workers. Nothing has got worse so far, but the potential exists."

One possibility that is being considered is closing one or two medical schools instead of cutting the budgets of all schools.[1] Dr J P deV van Niekerk, dean of the University of Cape Town Medical School, said, "There is a threat to the educational institutions as funds may be diverted from medical colleges to finance primary health care. The important question is, can we afford to have eight medical schools, which means a medical school for every five million people. Is this number appropriate for our economy? Some feel that these are too many. On the other hand, the population is increasing rapidly and it takes 10 years to start a medical school. If you drop one medical school now, you are going to need one in the following 10 years. The danger is that the medical schools could have severe damage done to them. As medical schools generate the personnel needed for primary care, taking funds away from them is seen as a serious threat by me and my colleagues."

Dr William Pick, professor of community medicine at the University of Witwatersrand, was not perturbed by any proposed cuts: "A 5% cut in the budget of academic institutions really means that we need to improve our management, work efficiently, and save 5%."

Dr Zuma enumerated in her speech some ways in which the financial problems could be overcome but was short on detail. She hinted that doctors were not the best financial managers for a hospital but did not propose any specific alternatives. She suggested using appropriate personnel for health care, such

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as preferring midwives to obstetricians for normal deliveries, but did not describe any definite scheme. She said that the unrest in hospitals was unacceptable and emphasised the need to improve relations between workers and managers, but she did not specify any plans to improve relations, nor did she quantify the financial loss due to the unrest and strikes.[2]

### Collaboration between the public and private health sector

South Africa has a well developed private health sector. Part of the burden of public health care could be shared by those in the private sector. Dr Zuma said that she was encouraged by the overtures made by the private sector to the health ministry, and that the government was prepared to promote cooperation between the two sectors as there was a great deal of room for joint ventures. She did not, however, explain any details of such ventures, and this remains only a distant possibility.

### Prices of medicines and value added tax

Medicines are very expensive in South Africa compared with most countries in the world. Dr Zuma was unfortunately quiet on this key issue in her speech, and she was also quiet on the issue of charging value added tax on drugs. Prices of drugs in South Africa suggest that someone is profiteering. Dr J H O Pretorius, deputy director general of health services, provided data comparing the prices of drugs like Zantac and Prozac (table I). In South Africa, Zantac costs 424 Rand (for 60 tablets), which is more than four times what it costs in New Zealand. Surprisingly, the same amount of Zantac costs nearly 700 Rand in Zambia.

Dr Pretorius felt that it used to be the drug companies who were making the money: "This is the way multinationals justify the risk of being here despite economic sanctions. We were paying a price as we paid for oil, which we had to get through agents at a hell of a price. The issues are to be sorted out. The cost for the country is enormous. The same product is being exported to the neighbouring countries, where they pay half the price of what we pay here." Dr Jerry Coovadia, professor of paediatrics in the University of Natal Medical School, said that it was obvious that someone was making money. Dr J R van Dellen, the dean of the medical faculty in the same university, agreed: "Somebody was making money. Somebody is still making money."

*Cost of drugs (Rand) in South Africa, Zambia, New Zealand, and Canada*

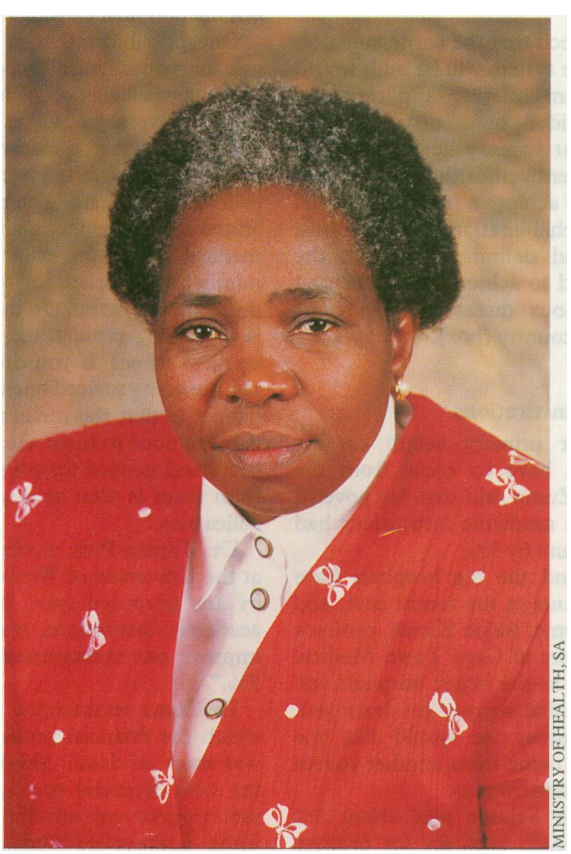
| Product | Package size | Price: South Africa | Zambia | New Zealand | Canada |
|---|---|---|---|---|---|
| Zantac 150 mg | 60 | R424·47 | R694·32<br>R252·30 (generic) | R100·08 | R179·42 |
| Prepulsid Forte | 100 | R401·41 | NA | R44·00 | R161·74 |
| Losec | 28 | R387·41 | R21·06 | R216·70 | R182·57 |
| Tagamet 400 mg | 60 | R364·61 | R47·69 | R100·10 | R173·65 |
| Tagamet 200 mg | 150 | R481·09 | R33·85<br>R3·33 (generic) | | |
| Prozac | 28 | R254·62 | NA | R194·66 | R133·22 |
| Ventolin inhaler | 1 | R58·35 | R32·31 | R11·28 | R33·48 |
| Rhinocourt Aqueos | 1 | R190·94 | NA | R54·00 | R53·95 |
| Zirtec | 30 | R99·96 | NA | R18·18 | NA |

NA=Not available.

Martin A Jennings, manager of corporate affairs in Glaxo South Africa, blamed the mark up price system in South Africa. "We had an inquiry from the ministerial department because of a letter written by somebody some months ago who went to Egypt and purchased various pharmaceuticals for a fraction of the price charged here. You cannot compare countries and countries. Take for instance a product leaving this factory at 100 Rand. In the United States it costs about 105 Rand and sells to the patient for 126 Rand; here it is 205 Rand. The mark up system all the way along the line is very high here. Pharmacies and wholesalers would dispute that. You have also got the situation where a very large share of dispensing is done by doctors."

Dr David Green, director of profession development in the Medical Association of South Africa, said: "There is no question that you can now buy drugs like Zantac and Prozac for something like 65 Rand in India and for 100 Rand in Britain, but for 305 Rand in South Africa. You can buy drugs manufactured in this country and labelled 'Made in South Africa' for much less in Zimbabwe than you can here.

"The pharmaceutical industry in this country has started publishing data to show that the drug leaves the factory with the same price in any country, whether it is Italy or South Africa or elsewhere. With that as a basis the problem must lie in the distribution system, the mark ups, and so on. South Africa, Brazil, and Paraguay are the only three countries in the world that levy a value added tax on drugs. There is some transparency about this now, and the prices of some drugs have been going down."



MINISTRY OF HEALTH, SA

*Dr Nkosazana Zuma, minister of health for South Africa*

### A politician under pressure

Dr Zuma said that the primary school feeding programme that Nelson Mandela announced in his presidental speech in May—along with free health care for pregnant women and children under 6—would not fully address the problem of nutrition in children because the problem is present at a much earlier age. As a result she had set up a committee to develop an integrated nutrition programme that would be carried out in the next financial year. This is perhaps the closest that the minister got to criticising Mandela. What she did not criticise was the manner in which

NANCY DURRELL/PANOS

*Poor schooling makes most of the population ill equipped to deal with university education—and most lack the money to pay for it*

Mandela implemented free health care for children and pregnant women by declaring it in his presidential speech. People who were to provide this care were caught unprepared by his announcement. Many hospitals were inundated with patients.[2] No extra provisions were made in advance to tackle this work load as to staff or medicines.

Said David Green: "The parents of a child born at 600 gm, who in the public sector currently would just be placed in an incubator, could now demand full life supporting intensive care and go to court demanding it. We felt that the services should have been defined a bit more than simply saying free health care. So also with pregnancy care. They could go and demand eye care, dental care, or cosmetic surgery in terms of the regulations the way they are currently placed. If we had been consulted, we could have pointed out the pitfalls."

Although everyone I spoke to agreed that these sections of society deserve free health care, the manner in which these reforms were introduced was questionable. Mandela's announcement can be interpreted as an act of a politician under pressure, or of an immature administrator, or a clever attempt to bypass the delays of getting his reforms through the bureaucracy that he inherited from the apartheid regime. If political pressures decide future health reforms and their timing, what role do health planners have?

## Political stability, financial growth and health

Many health problems—such as trauma related to violence, drug abuse, and alcohol related illnesses—are largely influenced by political and social circumstances. These are not entirely within the realm of health planners, and there is not much that health planners can do about them.

Health problems due to bad housing and sanitation are in the same category. In some townships in South Africa the houses do not have electricity. Fires lit to keep houses warm in winter can spread quickly and destroy several dwellings. Houses are so close to each other that fire engines cannot reach them. Even if they could, there is no supply of water with which to put out a fire. Such fires are due to the architecture of poverty, and eliminating mortality and morbidity due to them is a job for town planners, not health planners. Likewise, malnourishment due to poverty has no answers from health planners.

The political equation in South Africa today is fragile at best. During conversations with the various people I met it became clear that if the equation changes suddenly, a resurgence of violence and general instability can put to nought all efforts directed at improving the health of the people. Similarly, several economic reforms have been planned in South Africa, and if these reforms fail to deliver the funds required for restructuring health care it could fail miserably.

The dilemma for health planners is whether they should take into consideration the possible future political and economic scenarios and plan accordingly. Should they invest in short term plans that will provide quick gains and will be less likely to be affected by potential political and economic turmoil? Or should they make long term plans that assume political and financial stability?

## Affirmative action policy

Affirmative action is a way to address the needs of groups that were previously discriminated against—non-white people and women—and reverse their present disadvantage. It aims to reverse the effects of racism and sexism. In most countries affirmative action addresses the needs of disadvantaged minorities. In South Africa the disadvantaged population is in the majority.

Under the affirmative action policy it is now possible for a black female student from a rural area to get into a medical college in preference to a white student with higher grades. Dr Van Niekerk explained: "Among the medical schools there is a striking degree of consensus about the need and direction for change. Because of their differing background, each medical school is addressing the issues in a different way.

"Universities are autonomous entities and may largely determine their own admission criteria and ways of dealing with some obstacles. These are due to the poor schooling that the majority of the population has received, which makes them ill equipped to deal with university education. Another problem is that the majority is also economically disadvantaged and lacks the money to pay for university education."

While affirmative action corrects for the disadvantages that the black student had to face to get even those lower grades, it opens up possibilities of abuse of the system. To implement affirmative action without introducing reverse discrimination is a dilemma that health planners face.

## Conclusion

The essential dilemma that health planners in South Africa face is to restructure health care without destroying the good things that exist. Problems such as the need for more funds than are available, improving primary health care, trying to send doctors to rural areas, and dealing with strikes and unrest in hospitals are not unique to South Africa. Every democracy has to deal with them. Welcome South Africa.

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