experience of challenging intubations, and material for at least two more publications.

I make a plea to managers of NHS trusts to give active support and encouragement to health professionals who wish to spend time in the developing world.

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1 Christie B. NHS staff should work in developing world, says princess. *BMJ* 1995;311:77-8. (8 July.)

South Africa's health

Apartheid cut both ways

EDITOR,—Some of the points that Rajendra Kale raises in his article giving his impressions of health in the new South Africa tell only part of the story.[1] Kale falls into the trap of many commentators on South Africa, whereby he gives us the example of a "white" ambulance picking up a white patient at the scene of an accident while leaving behind a black patient to die. Nobody would argue that this is an unacceptable manner in which to conduct affairs, but it is seldom mentioned that the situation was identical for any person who tried to use facilities provided for members of another racial group.

While living in Johannesburg in 1984 I came across a pathetic scene late at night. An elderly black man was walking along the street leading by the hand a distressed white adolescent, who was calling rather ineffectually for help. The adolescent had been mugged and repeatedly stabbed; the black man had found him in a doorway and had been trying to get him to a hospital without success. They had been turned away from a private white clinic with no accident and emergency facility and from the local black hospital. The adolescent was discharged from the white hospital that I drove him to the next day: he had been stabbed in the back 27 times.

Kale describes how pregnant women and children under the age of 6 have been entitled to free health care since May 1994. Although he gives examples of the huge increase in the numbers of patients attending a hospital, he does not mention preparations or funding that were made for this increased activity. It is odd that this increase in hospital attendance with no apparent additional funding is not connected with the strikes that are described as being for better pay and conditions. These strikes may be viewed as "completely irresponsible behaviour" by Dr Docrat, but does he not consider the extremely difficult working conditions that the staff have now been placed in to be a result of irresponsible behaviour? It would be understandable for health care workers to feel indignant (to the point of conducting a lawful strike) at not being given funding to cope with the changed circumstances in their hospitals.

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1 Kale R. Impressions of health in the new South Africa: a period of convalescence. *BMJ* 1995;310:1119-22. (29 April.)

Ethnic differences in health are seen in other countries

EDITOR,—Rajendra Kale's article giving his impressions of health in the new South Africa has limitations in terms of both accuracy and perspective.[1] Kale is critical of the progress made, but his table gives detailed data on health and disease for a decade ago; surely such data for 1990 or later could have been obtained. He cites South Africa as exhibiting "the worst of Third World medicine." This is not correct. Infant mortality in Ethiopia is 130/1000 live births, which is double that cited for local Africans (61/1000). Referring to Baragwanath Hospital in Soweto, Kale reports the high frequency and severity of malnutritional diseases (for example, "scurvy in florid form") as though these prevail at present. The report by Blumsohn that he cites is a reprint of one published a decade previously. In 1978—nearly 20 years ago—paediatricians at that hospital reported details of "substantial improvements in child care" and that "we no longer see either the severe chest deformities of rickets or tetany"; scurvy was not even mentioned.[2]

We agree with Kale that health in Africans could be improved but doubt whether it could be improved considerably. In our big cities (where about 40% are urbanised, not 25 % as Kale states) infant mortality is 20-25/1000 live births[3]; in comparison, infant mortality in Afro-Americans is 17/1000.[4] Interestingly, as another comparison, the infant mortality among poor single mothers in Switzerland is 21/1000. The maternal mortality of Africans is given as 22/100 000. The figure reported for Afro-Americans is 18/100 000 and for white Americans 6/100 000; the figure for white South African mothers given by Kale—1/100 000—is surely a misprint. The average percentage of African infants of low birth weight is 13%; that of Afro-American infants is also 13%.[5] Regarding survival, that of Africans is given as nine years less than that of white people; the difference in survival between Afro-Americans and white Americans averages seven years.[6] In Aborigines in Australia the gap is 20 years.

A further consideration is that the vital statistics for minority populations in prosperous countries—for example, Maoris in New Zealand and indigenous Indians in Canada—are considerably inferior to those of the respective white populations. Accordingly, Kale's urging that we should narrow the wide gap between Africans and South African white people, while well meant, lacks realism. Pragmatically, can South Africa with its small white and very large black population be expected to accomplish what rich Western countries have found to be impossible?

We are emphatically not defending the unfairness of past state health practices and measures and do not dispute that the health data of Africans could be improved. Our concern is simply that in making judgments and setting goals it is imperative to have an accurate appraisal of current morbidity and mortality and of what can be realistically accomplished.

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2 Stein H, Rosen EU. Changing trends in child health in Soweto. *S Afr Med J 1980*;58:1030-2.
3 Medical Officer of Health for the City of Cape Town. *Annual report 1993-4*. Cape Town: City of Cape Town, 1994.
4 Current trends. Infant mortality—United States, 1992. *MMWR* 1994;43:905-9.
5 Increasing incidence of low birthweight—United States, 1981-1991. MMWR 1994;43:335-9.
6 Current trends. Mortality patterns—United States, 1992. *MMWR 1994*;43:916-20.

According equal status would help integration

EDITOR,—Rajendra Kale exaggerates in his generalisation that in India graduates with the degree of bachelor of ayurvedic medicine and surgery set up in general practice and dispense allopathic medicines without having received any training in their use.[1] No doubt a small proportion of the graduates resort to this bad practice, just as a proportion of graduates with the degree of MB, BS dispense homoeopathic or ayurvedic medicines.

I am a great believer in the integration of different systems of medicine. Integration is more likely to be viable, however, if the different systems are accorded equal status. For example, in India, though different systems of medicine (ayurveda, siddha, unani, and homoeopathy) are officially recognised, the salaries offered to allopathic doctors and the "other" doctors differ greatly. As the granting of equal status to doctors from other "well recognised" and "organised" systems of medicine has not been possible, the integration of traditional healers is a long way away.

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1 Kale R. Traditional healers in South Africa: a parallel health care system. *BMJ* 1995;310:1182-5. (6 May.)

Psychiatric data are questionable

EDITOR,—Rajendra Kale's overview of health care in South Africa is a report on a large country sectorised through years of prejudice.[1] Epidemiological data (in traditional apartheid style) supply us with an alarming yet not unexpected discrepancy in the health profile of white people compared with black people, which is ascribed to "the best of First World and the worst of Third World medicine."[1] Audit of community psychiatric clinics, however, showed strange figures: "Schizophrenia was diagnosed in 68% of black patients compared with 19% of white patients; mood disorders were diagnosed in 9% of black patients compared with 41% of white patients."[2]

The international pilot study of schizophrenia showed that a reliable diagnosis of schizophrenia was made by local psychiatrists in nine different countries, including India and Nigeria; the prevalence was similar in all countries.[3] The large epidemiologic catchment area study of depressive epidemiology in the United States found few differences in the ethnic or racial presentation of mood disorders.[4]

I agree that it is difficult to interpret Kale's data. What criteria have been used to make the diagnosis? By whom were the diagnoses made? Could there have been racial prejudice? Did patients always understand questions about "depression" (in most South African languages there is no direct translation for the word)? Is it not a sign of wisdom for rural black people to "hear voices" or "see vision" of their forefathers? And were socioeconomic factors considered?

One thing is certain: South Africa's mental health urgently needs structured, statistically meaningful epidemiological research. Perhaps then we will know whether Kale has presented us with a fallacy of psychiatry in South Africa or with an internationally unique transcultural phenomenon.

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