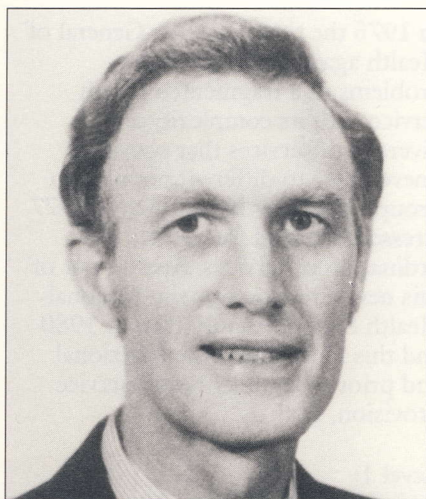
Whither Primary Health Care in SA Today? * – Dr Daryl Hackland



Dr Daryl Hackland
MB ChB; DCH (SA)
Dept of Health KwaZulu
Private Bag X10
Ulundi 3838

Curriculum vitae

Dr Daryl Hackland's academic preparations as teacher and minister as well as physician have suited him uniquely for his present position as Secretary for Health of KwaZulu. In 1970 Dr Hackland was appointed Medical Superintendent at Bethesda Hospital, Ubombo, where he remained until 1981. In 1976 he took study leave taking up a post in Paediatrics at King Edward VIII Hospital and Addington Hospital which culminated in his obtaining the DCH (SA). While at Bethesda Hospital he established a comprehensive rural community medical service and commenced the training of health professionals. In 1981 Dr Hackland was appointed Director of Health Services for KwaZulu and in 1984 Secretary for Health. He serves on numerous regional and national committees concerned with medical services and community health provision and has published and lectured widely in South Africa on these subjects.

**Opening Address: 7th GP Congress, June 1990*

Summary

In this Opening Address at the 7th GP Congress Dr Hackland identified 4 important areas of development which impact directly on the future of health care in South Africa: National Policy, Manpower, Training, and Population Development and Planning Processes. All these point strongly in the direction of primary health care, and after giving an historical overview of the situation in SA, he concluded by making a strong plea for the maximal use of all resources to achieve the goal of Health for All.

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Primary Health Care; Population Growth; Health Planning; Policy Making; Education, Medical

Introduction

Mr Chairman, Honoured Guests, Colleagues in the medical and allied professions, it gives me great pleasure to be with you today and to share with you a few thoughts as we all prepare to focus our minds on the Congress theme – the General Practitioner as "the Vital Link".

In looking closely at the Congress programme, there is no doubt that the sub themes of the Patient Link, the General Practitioner in action, the Team and the Vital Link have been planned to address issues and questions which impact on the critical interface between the doctor and the health care system.

This interface is an intricate network of factors surrounding the patient, the general practitioner and Health Care. It is not a simplistic model surrounding ailment, treatment and support service, but rather a series of links in a chain which must remain intact if it is to be effective in meeting the health needs of communities.

Some of the links surrounding the *patient* are beliefs, life style, family, attitudes, environment; those around the *General Practitioner* are vocation, sense of service, training, knowledge skills, practice management; and the links around *Health Care* being the systems, cost effectiveness, facilities, team approach and administration.

Whilst recognising these interdigitating factors one is lead to the point where a question begins its formulation in our minds. Some of the papers during the final day ask questions namely:

The GP as a vital link in the South Africa of the future –
Grow or bust?
Who knows best?
What is the role of the Family Practitioner?

I put the question to you this morning in the context of the theme of this Congress, "Whither Primary Health Care in South Africa today?"

I ask the question conscious of the many issues which relate to Health Care in this country.

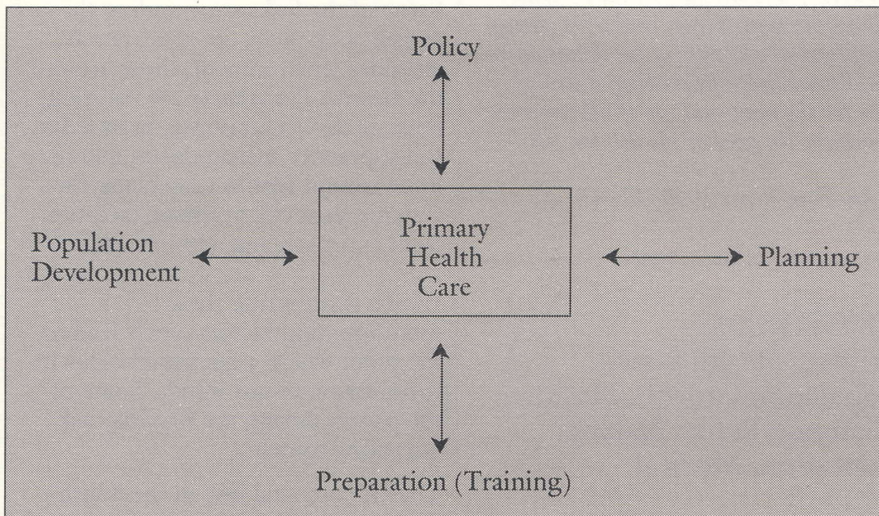
I am mindful for instance of the debate between nationalisation and privatisation. I consider as well, recent trends and developments within the health care scene and am encouraged that what is filtering out would appear to be, at last, a realisation that a commitment to Primary Health Care as the nucleus

... Whither Primary Health Care?

of Health Care, is essential if the system is to succeed.

I highlight for you some of these developments.

Table I



Firstly, Policy

During most of this century, health policy in South Africa has been directed by two major pieces of public Health legislation, namely the Public Health Act No 36 of 1919 and the Health Act No 63 of 1977.

It is interesting to note that following the influenza epidemic of 1918 which took a toll of approximately 150 000 lives in South Africa and led to a re-orientation and reorganisation of health services, the 1919 Public Health Act laid down the establishment of a central independent health authority: the Department of Health with its own ministry.

The 1918 influenza epidemic had highlighted two aspects of health service provision in the country which remain important problems to the present time.

Health Services were found to be *fragmented* and the second problem related to the unequal distribution of services on a national basis.

The time has now come for National Policy to address these problems for they have bedevilled Health Care provision for too long.

Slowly, slowly catch a monkey seems the strategy, for in spite of the 1944 Gluckmann Commission proposal to solve the problems of the lack of co-ordination (considerable fragmentation) and the shortage of health services in those sectors particularly relating to the great number of disadvantaged citizens in urban and rural areas by the institution of a National Health Service, the recommendations remained unimplemented.

In 1975 the then Director-General of Health again highlighted the problems of a fragmented health service with its complexity and diversity of services that provided uneven care to different population groups. The new Health Act of 1977 stressed the need for greater co-ordination of services. Arising out of this new direction was the National Health Service Facility Plan of 1980 and this highlighted the functional and priority levels of health service provision, ie

Level 1:

Basic services: clean water, housing, sanitation, nutrition.

Level 2:

Provision of education, and specifically health education

Level 3:

Provision of Primary Health Care that is acceptable and appropriate to the needs of communities.

Level 4-6:

Provision of Community, regional and training hospitals.

During the last year a National Health Policy and National Health Aims document has served before the Conference of Health Ministers of various self governing regions and Minister of National Health and Population Development.

In this document it is again encouraging to note the central role being given to the provision of Primary Health services. Focal attention is given to comprehensive health services for the entire population of South Africa. Equal importance is therefore given to

maintaining the health of those who are well and to treating those who are ill. Services for the promotion of health, the prevention of disease and the treatment and rehabilitation of patients must consequently be community-oriented and of equal importance to available sources.

The trend of such a national policy points strongly at Primary Health care as the key to the provision of an equitable health service for all and the assurance of an acceptable level of health care, thus ensuring a lifting of the health status of communities so desperately in need thereof.

> A survey in 1918 found that South African health services were fragmented and they were unequally distributed: still the situation in 1990!

Secondly: Population Development

There is in the country today a programme being implemented which takes cognisance of the issue of population growth in South Africa and attempts to address this from a developmental perspective. That population growth is a critical issue, there is no doubt, but such growth relates intimately to the status of politico-socio-economic development of South Africa and its peoples.

The South African population is presently growing at an average rate of 2,3% per year. If this growth rate were to continue, the necessary balance between population size, socio economic capabilities and available resources of South Africa could be seriously compromised thus jeopardising stability, progress, and health.

Projections suggest that the South African population can increase from the present 31+ million to approximately 47 million in the year 2000, 79 million in the year 2020 and 138 million in 2040.

The main aim of the Population Development Programme is to increase the standard of living and quality of life of all people in South Africa for it has been shown that with this increase in the quality of life, there is a concomitant decrease in fertility.

Here again it is noted that the promotion of primary health care for all population groups is one of the 5 specific objectives of the programme and that special emphasis is placed on the acceleration of social and economic development especially with regard to education and training, job and prosperity creation, informal sector development, satisfaction of basic needs, development of rural areas, orderly urbanisation and Primary Health Care.

> The Gluckmann Commission's proposal in 1944 to solve the problem of fragmentation: still unimplemented!

Success of such a programme can only be achieved if each community, each interest group (medical fraternity), each individual (doctor), becomes actively involved in actions to ensure the upliftment of the quality of life of all people in South Africa. I see our action surrounding the implementing of an effective primary health care service whose achievements can be measured and evaluated against set indicators and targets.

> The Health Care Act of 1977 asked for greater co-ordination: still unimplemented!

Thirdly the provision of appropriately trained manpower is vital to the cause of Primary Health Care

The present situation in many rural areas of this country is that doctors are just not available, let alone being appropriately trained.

I illustrate this fact by indicating that in the rural areas (of KwaZulu) the percentage of posts filled at the beginning of 1989 was 35%. This rose to 53% during the later part of the year following a concerted recruiting drive but this has once again fallen to a critical level of 43%.

One is informed that South Africa trains sufficient doctors, as some 900 qualify each year. Whether this is so or not, is debatable.

What is acknowledged is that South Africa has a serious maldistribution problem and many factors impact upon this unacceptable state of affairs. Academicians need to seriously address this crisis area and

one is encouraged to see emerging alternative strategies for medical training such as the problem oriented community based models. Medical education must produce a doctor suited to and capable of providing appropriate primary health care. At present the general medical

> The main aim of the Population Development Programme is to increase the standard of living and quality of life for all

manpower situation in South Africa is similar to that found in other middle income developing countries.

Comparisons with the WHO world regions for doctors revealed that South Africa had 7,1 doctors per 10 000 population, Latin America 7,3, North America 18,2 and Europe 21,1.

However the modern trend is for health care provision to be based upon the services of teams of health professionals rather than on being purely doctor-oriented. In 1985 there were 55 health team members per 10 000 population in South Africa. In developed countries the figure is 102 /10 000 and in underdeveloped countries it drops to 9,8 (WHO manpower 1975).

The role of the nurse and the supplementary health professions is becoming more important in modern health care, but such roles cannot exclude the part that must continue to be played by the medically trained doctor. Here I would pause to make a plea that serious attention be given by decision makers to drastically increase the number of black students completing medical training. It is pitiful that the number qualifying in 1979 being 38, had only risen to 105 in 1986.

The practice of family medicine must be seen to be moving away from the densely populated urban areas into the high risk poorly served rural areas and policy makers are challenged to make this happen by way of the creation of attractions to such areas. One such important strategy could be the acceleration in the provision of opportunities for Vocational Training in areas where doctors will eventually settle and practice.

Fourthly: Primary Health care is seen to be facilitated by planning which addresses directly the problem of the fragmentation of Health Services

Here encouraging initiatives are seen emanating from Medical Association proposals and those proposals made by such organisations as NAMDA in the Progressive Primary Health Care network.

Recently, MASA in a memorandum prepared by the President of the Natal Inland Branch, stated "It is

> With the increase in quality of life comes a concomitant decrease in fertility

unfortunate that the many good ideas outlined in the National Health Service Facilities Plan cannot be adequately implemented because of the multitude of different health departments, each with their own priorities, for provision of health care for their particular community".

Of great significance then is the very recent resolution (26/4/90) of the KwaZulu Natal Joint Executive Authority that reads "to permit the

> The multitude of different health departments each with its own priorities, hamper medical progress in our country

effective co-ordiation of Health Care Services in the Natal/KwaZulu region, it is desirable that at least the health services component of two major authorities namely, the NPA and KwaZulu Government be integrated and become one single health care authority."

Only when this is achieved and a unitary health service comes into being can proper and adequate planning be done to implement a primary health care strategy that must of necessity take into consideration the vital role to be played by the private sector.

I have identified 4 important areas of development which I believe impact directly on the future direction of health care in South Africa: National Policy, Manpower Training, Population Development and Planning Processess all point strongly in the direction of Primary Health Care.

That Primary Health Care is being

practised in this country is evidenced by this Congress and can also be demonstrated in most regions in South Africa. I illustrate this second point by highlighting but a few important facts. Before doing this, may we be reminded that what we see happening, *independently* at this point in time, are the actions of the private sector on the one hand, that of the public sector on the other.

Within the region to be referred to Primary Health Care has been the strategy for the past 2 decades. Some facts will illustrate what is presently happening.

Table II: Primary Health Care Facilities

Attendances	1987	1988	1989
OPD (26)	692274	681289 ▼	665798
Clinics (174)	3140743	3745233 ▲	3658203
Mobile points (431)	618036	689931 ▲	590449

Objectives - to▼ OPD attendances and ▲ clinic and mobile point attendances

Costs

What proportion of the total health budget for the region is spent on Primary Health Care?

Table III: Provision of Comprehensive Care

	22,79%	
Cost/attendance	R14,78	
Breakdown of Costs	Fixed clinics	57%
	Mobile clinics	5%
	Malaria control	4%
	Health Inspectors	3%
	School Nursing	2%
	Training Resource/Research centre	1%

Table IV: Health Ward Experience

	Patients Seen	Hospital Admissions
Doctors Nil	4387	1318
Doctors 2	7900 ▲	1193▼

From this experience, although it remains to be proven statistically significant, the doctor remains a vital member of the Health Care team operating within comprehensive national primary health care service - cost effectively.

The vision for the future and in answer to the question "Whither PHC in SA today?" there is no doubt that Primary Health Care is the key and must be the nucleus around which all other levels of care operate.

As the private sector family practitioners interact and interdigitate meaningfully with the public sector in the provision of primary health care for all the peoples of South Africa, a system will emerge that will be the answer of an equitable service that meets the health needs of all, a service that is accessible, available and affordable and provided with full participation of those the system serves.

In conclusion I make the plea for the maximal use of all resources in this country towards achieving the goal of Health for All, but in particular, that doctors in both the public and private sectors, functioning as they do at the Primary Health Care level, be optimally utilised. Furthermore, that PHC be accorded high priority by Government, health authorities and Universities.

It gives me great pleasure in declaring this Congress open and wish you, your fellow organisers and those attending, a most fruitful and stimulating time.