SECOND CARNEGIE INQUIRY INTO POVERTY
AND DEVELOPMENT IN SOUTHERN AFRICA

Poverty, health and health care in South Africa
by
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Introduction

This is a three part report, consisting of numerous quotes and reviews strung together to form a cohesive argument. It has been impossible to adequately cover all the authors mentioned, and I trust that they will not consider themselves to have been misrepresented. Further, it was necessary to review the arguments presented here in a very cursory manner; my intention is rather to draw the readers' attention to the literature mentioned, and hope that they will refer to the originals for a complete exposition.

Part I looks at past and prevailing conceptions of health and disease, and argues for an historical materialist approach to these issues. The emphasis here is on the development of these ideas as they occurred alongside the process of industrialisation in Britain - the lessons that this development has to offer are very pertinent to the South African situation today.

Part II consists of selected references pertaining to underdevelopment in South Africa and the third world.

Part III is an analysis of health care institutions and legislation in South Africa.

Each part is essentially a separate article, and they can read as such.

The appendix contains some statistics on death and disease rates for the RSA.
I. CONCEPTIONS OF HEALTH AND DISEASE

Modern medicine as we know it, can be dated back to the late eighteenth century. For medical knowledge, the dawning of the nineteenth century marks:

....."an ineradicable chronological threshold, the period in which illness, counter-nature, death, in short the whole dark underside of disease came to light, at the same time illuminating and eliminating itself like night, in the deep, visible, solid, enclosed, but accessible space of the human body."1.

The empirical positivist perception of the pathologist and the clinician laid the very foundations of a new medical science; and with an equally revolutionary progression of the institutions of that science, this new perception came to be located within the hospital, where disease could be isolated, studied and treated. But within this great leap forward for modern medicine there were certain latent and not-so-latent biases that remained unchecked, and were ultimately to become entrenched within the medical paradigm. We shall examine the determination of those biases in greater detail later; suffice it to say now that it was the concommitant growth of British capitalism following the industrial revolution, and the economic and ideological role the health services came to play within the new economy, that lies at the base of the distortions that took place in medical practice.

What happened within the new hospital-based science was a redefinition of the status of the sick patient as clinical 'object' - alongside the necessary detachment of the clinician goes an element of dehumanization, allowing an unclouded contemplation of the dynamics of the disease. Essentially, the disease has been removed from the social context in which it occurred. The new perception and the new institutions of the hospital go hand in hand.
"The proximate source of the clinical paradigm was the hospital base of the medical perception of reality. During the nineteenth century, the hospital became the place where diseased people were housed, diseases were identified, and a census of diseases was kept. Along with sickness, health acquired a clinical status, becoming the absence of clinical symptoms."².

Modern medicine has thus failed to provide a positive definition of health. The very basis of the new perception served to trap all future developments within its ideological limits. This bias has persisted up until today -

"..... contemporary medical definitions of health and disease are inadequate because they are abstractions derived, for specific historical reasons, from the clinical study of the individual. The definitions are inadequate expressions of the relation of medical states (illnesses) to reality, since individuals are not clinical entities. In reality, the human essence is the product of an ensemble of social relations."².

The location of disease firmly within the body of the individual is no doubt a fundamental step. It goes hand in hand with the ideology of individualism that permeates capitalist societies. But these relations became ossified - individualism served too well as the ideology of capitalism for it to be dropped. Medicine failed to move beyond this point in any significant way. In the words of Meredeth Turshen:

".....medicine's failure to develop a positive definition of health results from the individualistic and ideological bias, that pervades medical research and medical practice, structures relations between practitioners and patients, shapes the approaches selected for treatment (e.g. chemical or surgical intervention) and the technology employed, and rejects the initiation of collective social action by communities."².
Lesley Doyal\textsuperscript{3}, in 'The Political Economy of Health' takes issue with the mechanistic and individualistic biases of modern medicine. She relates these to the nature of the economy in which they occur.

"It is the medical definition, the view of the experts', which now forms the basis for the social definition of health and illness throughout the developed world....Ill health is now defined primarily in terms of the malfunctioning of a mechanical system, and treatment consists of surgical, chemical or even electrical intervention to restore the machine to normal working order..... The defining of health and illness in a functional way is an important example of how a capitalist value system defines people primarily as producers - as forces of production."\textsuperscript{3}

"...under capitalism, health is also defined in an individualistic way. It is always individuals who become sick, rather than social economic or environmental factors which cause them to be so. As Evan Stark has commented.

"Disease is understood as a failure in and of the individual, an isolatable 'thing' that attacks the physical machine or less arbitrarily from outside preventing it from fulfilling its essential 'responsibilities'. Both 'bourgeois' epidemiology and 'medical ecology'.....consider 'society' only as a relatively passive medium through which 'germs' pass en route to the individual."\textsuperscript{3}

Lancet, Vol. 2, 1976. \textsuperscript{3}

This emphasis on the individual origin of disease is of considerable social significance, since it effectively obscures the social and economic causes of ill health. The destruction of health is potentially a vitally important political issue, and the medical emphasis on individual causation is one means of defusing this."\textsuperscript{3}
Meredeth Turshen presents us with a spectrum of approaches to health:

clinical medicine \rightarrow \text{social and preventive medicine} \rightarrow \text{environmental sanitation} \rightarrow \text{medical ecology}

There are three trends detectable within this spectrum. The first is spatial, a movement from the individual outwards to encompass the whole of our environment. The second is a progression from a preoccupation with death and disease (and hence a negative definition of health) towards an increasingly positive conception of what it means to be a healthy person living within a healthy society. The third trend is chronological - each stage represents an enormous expansion of the clinical paradigm in an attempt to cope with crises in public health that have occurred over the last two centuries.

"Social and preventive medicine extended the clinical model in the direction of health, expanding its application from the individual to his or her family and immediate environment. Environmental sanitation reflects a further extension to the wider physical milieu: environmental sanitation is the study of disease based on bourgeois epidemiology, i.e. the classical triad - host, disease agent, and environment. It is in no sense a study of collectives. Insofar as these disciplines remain dominated by the clinical model, none seems to grasp the notion of collectivity, without which there can be no adequate definition of health. The discipline that comes closest is medical ecology...."

"Medical ecology "conceives of disease as a convergence in time and space and within the person of the patient of environmental stimuli (organic, inorganic or sociocultural)."

The principles of medical ecology are by no means new. They can be dated back to the Hippocratic doctrines of 400 BC....
the well being of man is influenced by all environmental factors: the quality of the air, water and food; the winds and the topography of the land; and the general living habits.

Health is the expression of harmony among the environment, the ways of life, and the various components of man's nature. (quoted in 2.)

Medical ecology fails in its task to effectively conceptualize health and disease, however, because it refuses to take cognisance of the underlying political and economic factors that in the final instance determine the nature of our environment. Meredeth Turshen proposes a 'political ecology of disease' that places these factors in perspective. The basic tenets of this approach are contained within historical materialism, and once again these ideas are not new - they were quite coherently voiced during the nineteenth century by three people whose ideas we shall examine - Frederick Engels, Rudolph Virchow, and Karl Marx.

Engels, in the preface to the first edition of 'The Origin of the Family, Private Property and the State' (1884) sums up the materialist position:

"According to the materialist conception, the determining factor in history is, in the last resort, the production and reproduction of immediate life. But this itself is of a twofold character. On the one hand, the production of the means of subsistence, of food, clothing and shelter and the tools requisite therefore; on the other, the production of human beings themselves, the propagation of the species. The social institutions under which men of a definite historical epoch and of a definite country live are conditioned by both kinds of production: by the stage of development of labour, on the one hand, and of the family on the other."4.

Rudolph Virchow, an eminent cellular pathologist writing in the 1840's, was greatly influenced by the young Engels.

"In his scientific investigations and in his political practice, Virchow expressed two over-riding themes. First, the origin
of disease is multifactorial. Among the most important factors in causation are the material conditions of people's everyday lives. Second, an effective health-care system cannot limit itself to treating the pathophysiological disturbances of individual patients. Instead, to be successful, improvements in the health-care system must coincide with fundamental economic, political and social changes. The latter changes often on the privileges of wealth and power enjoyed by the dominant classes of society and, thus, encounter resistance. Therefore, in Virchow's view, the responsibilities of the medical scientist frequently extend to direct political action. Annals of Internal Medicine 89:264, 1978, quoted in 'Embryo', issue on Primary Health Care.

A few years back Marian Jacobs described Virchow thus: "Virchow noted that the overall material condition of life created a substratcm in which neither health nor illness flourished. He argued that economic insecurity and political disenfranchisement were, through a complex chain of causality, social problems that generated disease, disability and early death. Economic stability and active political participation by the poor in Virchow's view, were necessary for good health.

For these reasons, his policy recommendations included a series of profound economic, political and social reforms such as increased employment, better wages, local autonomy in government, agricultural co-operatives and a more progressive taxation structure.

Medical solutions e.g. more clinics or more hospitals, were quite limited. Instead, because he saw the origins of ill-health in societal problems, the more reasonable approach to epidemics was to change the conditions that permitted them to occur.

To the extent that illness derives from social conditions, the medical scientist must study these conditions as part of clinical investigation.
he said, and the health worker must engage in political action. This is the sense of the connection he frequently drew between medicine, social science and politics.

"Medicine is a social science, and politics nothing more than medicine on a larger scale."

Extracted from 'The Myth of Primary Health Care' by Dr. Marian Jacobs, 1981.

Frederick Engels expounded his theoretical position in his classic work 'The Condition of the Working Class'. It was the organisation of economic production under British capitalism, he said, that inevitably created disease and early death amongst the working class. He called this social murder:

"Murder has been committed if society places hundreds of workers in such a position that they inevitably come to premature and unnatural ends. Their death is as violent as if they had been stabbed or shot. Murder has been committed if thousands of workers have been deprived of the necessities of life or if they have been forced into a situation in which it is impossible for them to survive. Murder has been committed if the workers have been forced by the strong arm of the law to go on living under such conditions until death inevitably releases them."

The three volumes of 'Capital' written by Karl Marx contain the most thorough exposition of these ideas:

"Here he (Marx) describes in simultaneously abstract theoretical and empirical observational terms medical conditions in particular places and times. He relates these to conditions of work themselves historically determined not just by the accident of a particular period but by the nature of the social relations within it.... Marx argued that the nature of all social relationships within any epoch of history was largely determined by the nature of production relations. Particularly, it depended
on the fate and mode of appropriation of the surplus to his needs that a man was capable of producing. Within the capitalist system where "free" men "freely" offered their services to an employer, surplus value was acquired by buying the time of a worker at its value: what it cost to produce it. This cost was the cost of maintaining a man at work - food, clothing, and shelter for him, as well as for his family - since it was necessary that he remain at work in perpetuity. For various reasons.... it was necessary in order for the capitalist to maintain his profit (let alone make it greater) to increase this surplus value. This could be achieved either by making the men produce more - through working harder, through longer hours, through machinery - or by reducing the cost of the man's time - by cheapening the element "needed" to keep him alive, or by employing his family. Marx explores the interrelated consequences of the pressure to increase surplus value on relations within the family, on nutrition, on rest, on morals and the relationships of the sexes, on the general physical characteristics of the population, and on the prevalence of industrial diseases."

From "Functionalism and After? Theory and Developments in Social Science Applied to the Health Field", Ronald Frankenberg.
Let us expand upon the ideas contained within this extract by beginning with the origins of the capitalist process. The industrial revolution brought on the collapse of feudal relations:

"Capitalism emerges as a distinct and separate economic formation by wrenching away working people from pre-capitalist conditions of production. Before capitalism could be established, the mass of direct producers had to be separated from the material means of production and transformed into propertyless proletarians."


The worker enters the labour market with nothing to sell other than his own labour power. He has become a commodity within the capitalist economy subject to the play of forces in the labour market.

But labour power is a rather unique commodity:

".....the value of labour-power, and the value which that labour-power creates in the labour-process, are two entirely different magnitudes; and this difference of the two values was what the capitalist had in view, when he was purchasing the labour-power. The useful qualities that labour-power possesses, and by virtue of which it makes yarn or boots, were to him nothing more than a condition sine qua non; for in order to create value, labour must be expended in a useful manner. What really influenced him was the specific use-value which this commodity possesses of being a source not only of value, but of more value than it has itself".

Karl Marx, Capital Vol. 1, pg 188. 9.

The value of labour-power, its cost to the capitalist, is determined by the working time necessary to produce the average daily means of subsistence for the worker and his family. The reproduction of labour-power is thus ensured through the payment of wages, both individual and social (such as housing, education, health care). But beyond a certain point in the working day the worker starts to produce more
value than the cost of his wages. Marx called this surplus-value. Appropriation of surplus-value by the capitalist is the basis for profit.

Marx distinguished two means of increasing surplus-value:

1) **absolute means**, by lengthening the working day of the labourer, or else decreasing the wages paid to him. This form of appropriation of labour-power generates absolute surplus-value, and as regards the consequences for the workers' health, we may speak of the absolute expropriation of health. Within underdeveloped capitalist countries this is the predominant form of exploitation.

"The extraction of absolute surplus value usually occurs in labour processes with little development of the forces of production, such as processes with low technology, elementary organizations of labour, or low specialization of labour. In these instances, there is heavy physical effort, insufficient resting time, and high caloric costs. An example of this labour process is the production of agricultural products in some underdeveloped capitalist countries. Here, with low levels of development of the forces of production, wages are the most important determinants of the amount of profit. Consequently, the capitalist aims at combining the lengthening of the working day with the lowering of wages, with subsequent low consumption by the worker and his family. This situation leads to the overwork/underconsumption pattern that typifies the condition of workers in a labour process with a low level of development of the forces of production." 10.

2. Surplus value can be increased by relative means, by increasing the productivity of labour.

"The strength of the working population increasingly limits... the ability of capitalists to lengthen the time of work. Consequently, capital is forced to increase the extraction of surplus value by either increasing the intensity of work..."
(e.g. forcing the worker to work faster) or by introducing changes in the means of work (instrument), in the organization of work, in the specialization of the worker, or in all of these. In such cases there is an extraction of surplus value, which Marx called relative surplus value, and this is the predominant form of appropriated value under advanced capitalism.10.

The loss of health that this entails is a relative expropriation of health; the introduction of new machines and products into the labour process leads to increased risks of accidents and exposure to toxic materials. The fragmentation of tasks i.e. specialization that takes place:

"allows for a devaluation of the labour power of the worker through the reduction of the level of skill required for the job. That fragmentation also lessens the degree of control which the worker has over (a) his own work and (b) the entire labour process. He is increasingly directed to the execution of tasks which are conceptualised and decided by the capitalist and his indirect workers."10.

Stress and fatigue are the end result of an alienating labour process in which

"...the most important conditions that have negative effects on workers are: (a) machine pacing of work rhythm and machine control of work methods; (b) monotonous, repetitive work, activating only a limited part of total human capabilities; (c) lack of possibilities for contact with other people as part of the ongoing work; (d) piece rates and related payment systems, which in addition to contributing to employee wear and tear, are often detrimental to the observance of safety requirements; and (e) authoritarian and detailed control of the individual, be it through foremen or impersonal systems (computer-based planning)."10.
An analysis of labour-power provides us with the key to understanding the nature of health under capitalism.

"...it is the conception of health as labour-power that leads us to what primarily determines the level of health and medical care in a capitalist society: the tendency towards maximization of the rate of exploitation."11.

The reproduction of labour-power takes place firstly within the family—the 'human factory', where the unpaid (unrecognised) labour of women takes place. The family, and on a wider scale, the community, in short the whole environment within which the worker must live and reproduce himself, is the exploited 'other half' of the capitalist economy. Wages have become their only access to the commodities that they produced.

"How is the reproduction of labour power ensured? It is ensured by giving labour power the material means with which to reproduce itself: by wages.

......this quantity of value (wages) necessary for the reproduction of labour power is determined not by the needs of a 'biological' Guaranteed Minimum Wage.... alone but by the needs of a historical minimum...i.e. a historically variable minimum.

......this minimum is doubly historical in that it is not defined by the historical needs of the working class 'recognized' by the capitalist class, but by the historical needs imposed by the proletarian class struggle (a double class struggle: against the lengthening of the working day and against the reduction of wages.)"12.

Louis Althusser

As regards the health of workers, the boss/manager/capitalist is only concerned to the extent that it affects productivity.
"Health under capitalism is an integral component of an individual's labour-power or productive capacity. The capitalist's objective interests reside only in the use-value of labour-power, that is, how much value the worker produces. A certain level of physical and mental health is thus necessary to maintain the maximum level of productivity. Below that level of health, the capacity to work falls off, and with it the amount of surplus-value that will be generated. The capitalist is simply not interested in the level of health beyond this, although the worker will be vitally interested from the point of view of quality of life, not of productive capacity. 11.

...it costs more to replace a highly skilled or educated worker than it does a worker in a relatively low-skill, low-education job. It is to the advantage of the capitalist to have the more highly skilled workers, those who are more difficult to replace, live longer than less-skilled workers who are easily replaced. In general, more units of health input (whether reflected in higher personal income, better housing, improved work conditions, more access to medical care, etc.) will be devoted to more highly skilled and educated workers and they end up healthier and live longer." 11.

Peter Schnall 13 has analysed the different 'epidemics' generated under early and late capitalism. The method of analysis he employs he calls 'historical materialist epidemiology'-

"Epidemiology is the study of the distributions and determinants of states of health in human populations. What differentiates materialist epidemiology from bourgeois social epidemiology is the attempt to relate the patterns of disease and illness in a society to the economic and social relations which are the determinants of the functioning of that society."
Materialist epidemiology is the study of disease as it spreads and involves large groups of people within the context of the social organization of any particular society. Historical materialist epidemiology maintains that the history of a particular human disease is a unique non-repetitive process; which obeys discoverable laws and results from discoverable relationships. These relationships are essentially social in nature."^{13}

Peter Schnall - Introduction to Historical Materialist Epidemiology

Schnall begins his analysis with the development of British capitalism in the nineteenth century.

The need to rapidly accumulate capital led to minimizing the cost of reproduction of labour power, i.e. the cheapest shelter, food, etc. From this arises a series of social relations culminating in the great slums of the British cities. The diseases in this epoch are uniquely due to low levels of nutrition, poor housing, overcrowding and contaminated water supplies....i.e., tuberculosis, typhoid and typhus become pandemic and epidemic diseases of the cities; they are the social products of early capitalism.

By the twentieth century this situation had improved dramatically, "with a 90% decrease in tuberculosis between 1810 and 1890 and a marked increase in life expectancy - from 45 years in 1810 to 60 years by 1910". What factors aided this improvement? They are:

1) The working class by no means remains a passive victim throughout this process. It enters into a constant process of class struggle to improve its conditions of existence, by shortening the working week and increasing real wages.

2) The incorporation of Britain into a world economic system allowed capital to trade off the skilled labour of the first world against
the unskilled and super-exploited labour of the third world.

3. The productive forces unleashed by the industrial revolution provided the material means with which the standard of living of the population as a whole could be improved.

4. It was cost-effective to improve the health status of increasingly skilled sections of the working class.

5. The epidemic diseases of early capitalism can not be limited to the working class, but continually spill over and threaten the lives of the upper classes. Intervention to control these epidemics is thus essential.

6. Scientific and technological innovations provided the state and other concerned institutions with the objective knowledge to successfully intervene in the propagation of the epidemics. This was facilitated by an already extensive infrastructure of roads and water supplies required by the growing industries.

Once the health and life expectancy of the working class reaches a certain level, they come to be afflicted with the diseases of advanced capitalism, which characteristically have affected bourgeoisie, i.e. the chronic and/or degenerative diseases such as hypertension, stroke, coronary heart disease, alcoholism, cancer, obesity and diabetes. Some general factors implicated in the aetiology of these new 'epidemics' are:

1) the prevalent patterns of consumption in industrialised society, reinforced by peer group pressure, advertising and the availability of a range of ultimately unhealthy commodities on the shelves. (Notably the penetration of capitalism into areas of food production, with consequent consumption of fast-food high-cholesterol low-fibre diets, and the promotion, through advertising, of alcohol and cigarette smoking as adaptive behaviours to the stresses of modern life).
As Cedric de Beer has said:

"The whole vast weight of a consumer oriented society drives us, like lemmings, to a fate of obesity, physical decay, lung cancer and cardiac arrest." 14.

2. Our living and working environments have become contaminated with a host of new and synthetic chemicals, plastics, toxins, drugs, pesticides, building materials, etc. whose long-term influence on our health and carcinogenic potential are often ignored or poorly understood.

3. The nature of the work process under capitalism produces stress and fatigue through a lack of control over the work process, and increasing attempts on the part of capital to increase productivity.

4. Unemployment has come to play a functional role within the capitalist economy. During 'boom' periods the unemployed can be rapidly absorbed into the production process, while during the inevitably ensuing recession their ranks are swelled, undercutting the bargaining power of trade unions to increase wages.

"Cycles of the economy resulting from the capitalist mode of production lead to periodic unemployment and re-employment with its associated stresses. Workers are no longer subjected only to the diseases directly produced at the work place, i.e. occupational poisons or accidents from dangerous equipment, but are now victimized by the progressively alienating conditions of work which extends over a lifetime of thirty to forty years." (10)
IN SUMMARY AND CONCLUSION

Historical materialist epidemiology corresponds to what Meredith Turshen calls the political ecology of disease. As a method of scientific discourse it is a minority voice in Western capitalist societies, and this corresponds to the hegemony of bourgeois ideology within those societies. It is, however, a method of unqualified value in exposing the origins and nature of disease processes in society. Various authors have employed this method in their analysis of disease in South Africa. Notable examples are "The Political Economy of Food Production and Nutrition in Southern Africa in Historical Perspective" by David Webster, "Capital, Class and Consumption: A Social History of Tuberculosis in South Africa", also by David Webster, "The Social Context of Occupational Disease: Asbestos and South Africa", by Jonny Myers.

Production is a social activity, from the toil of the worker to the consumption of the products that s/he produces. The relationships formed around production serve to structure society, such that the health or wellbeing of its individuals is ultimately determined by their relationship to that particular mode of production, i.e. their class position. In a capitalist economy the means of production are the private property of the bourgeoisie, whose profit motives have tended to take precedence over the lives of the people that work for them. Without doubt our society possesses the material means to eradicate poverty. The primary obstacle to this goal is the control of the means of production, exercised by the capitalist, and reinforced by the state. The class struggle, continuously waged by the working class, seeks ultimately to alter the nature of that control, and to usher in the era of socialism. This would bring about "the slow transformation of the very nature of labour from a coercive necessity in order to get money, income and means of consumption into a voluntary occupation that
people want to do because it covers their own internal needs and expresses their talents. This transformation of labour into an all-sided creative human activity is the ultimate goal of socialism.”

E. Mandel, "The Causes of Alienation"15.
REFERENCES

1. 'The Birth of the Clinic - An Archeology of Medical Perception'

2. 'The Political Ecology of Disease', Meredith Turshen, in 'The Review of Radical Political Economics' Vol. 9, No. 1


4. 'The Origin of the Family. Private Property and the State',

5. 'The Myth of Primary Health Care', Marian Jacobs, paper delivered at the UCT medical students conference, 1981.


7. 'Functionalism and After? Theory and Developments in Social Science Applied to the Health Field', Ronald Frankenberg,


13. "An Introduction to Historical Materialist Epidemiology" Peter Schnall - unpublished article, a copy of which can be obtained from the Health Care Trust resource centre.

14. Address by Cedric de Beer to the 1980 UCT medical students conference on "Appropriate Medicine".
The following extracts, while not overtly health orientated, are of central importance to understanding the origins of disease within South Africa. They show that the impoverishment of sectors of South African society is a historical process, occurring in the context of international capitalist relations; that conditions within South Africa's rural areas are intrinsically linked to the growth of our industrial centres, and that long-term improvements in those conditions will require fundamental changes in the prevailing power relations of our society.

1. 'Development Alternatives: Problems, Strategies, Values'

During the 1950's and 60's 'modernization' or 'capitalization' theory was popularised by many third world development planners. Traditionally development was measured in terms of gross national product per capita; the development cycle of

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investment -> production -> income
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was seen as hinging on two main centrifugal forces
1) the diffusion of capital from the metropoles towards the peripheries, allowing the accumulation of further capital, and hence increased investments
2) technological progress.

Thus the industrialized countries of the West were taken as an ideal towards which the 'backward' third world should aspire and one day attain...
(brought about by an increasing contact with these "developed" countries).
This transition was summed up by Rostow in 'The Stages of Economic Growth', 1960. He describes five stages that Henriot has summarised:

1. Traditional society - productivity limited because of insufficiently developed economic techniques.

2. The preconditions for take-off-development of a "leading sector" in the economy which positively influences other sectors; increase in agricultural productivity to support leading sector activities; improvements in transportation and other forms of social overhead capital.

3. The take-off-interval when the old blocks and resistances to steady growth are finally overcome and growth becomes normal condition for all sectors of society; main feature is increase in ratio of savings and investment to national income of 5 percent or less to 10 percent or more; also emergence of political, social, and institutional framework to facilitate impulses toward expansion.

4. The drive to maturity - long interval of sustained if fluctuating progress, with 10 to 20 percent of the national income steadily invested; new leading sectors supporting older ones.

5. Age of high mass-consumption - structural change no longer takes place at a rapid rate; leading sectors shift toward consumer goods and services."

1960-1970 was marked as the 1st Development Decade by the UN, and large sums of foreign aid were granted to third world countries to promote industrialization. But as the national debts increased, and it became increasingly obvious that poverty remained extremely widespread, if not worse, a variant of 'modernization theory', commonly known as 'dualism theory', came into vogue. In essence this theory contrasts the 'modern' industrialised, capitalist urban sector of a country's economy, with the rural peasant subsistence (and often sub-subsistence) economy.
3.

The former sector is characterised by a high turnover of capital, extensive capital accumulation, and the widespread existence of western values and patterns of consumption. The latter sector, comprising the majority of third world populations, are supposedly trapped by their cultural and economic backwardness, by their resistance to western values and methods of production, and a lack of capital accumulation.

With the realisation that their efforts were not reaching the mass of the poor in the third world, UN strategy in the Second Development Decade focussed on social goals such as education, health care, nutrition and housing, also land reforms and community organisation. However, as Henriot points out, these strategies saw the target countries in isolation, out of context of a world economic system. Further, that the problem was not the quantity of economic or social growth, but the quality of that growth.

2. THE DEVELOPMENT OF UNDERDEVELOPMENT

- Andre Gunder Frank. Chp. 8 of 'The Political Economy of Development and Undevelopment (see (1))

A review of the evidence tends to invalidate dualism theory completely, as Frank points out, and he goes further to postulate that:

"The expansion of the capitalist system over the past centuries effectively and entirely penetrated even the apparently most isolated sectors of the underdeveloped world. Therefore, the economic, political, social, and cultural institutions and relations we now observe there are the products of the historical development of the capitalist system no less than are the seemingly more modern or capitalist features of the national metropoles of these underdeveloped countries. Analogously to the relations between development and underdevelopment on the international level, the contemporary underdeveloped institutions of the so-called backward or feudal domestic areas of an underdeveloped country are no less the product of the single historical process of capitalist
development than are the so-called capitalist institutions of the supposedly more progressive areas." p.104.

Frank describes a world-embracing metropolis-satellite structure, the world metropolis draining capital or economic surplus from its satellite national metropoles in the underdeveloped world. In turn the provincial capitals feed into the national metropoles, at the same time draining their own peripheries.

Frank goes on to propose three theses:

1. "That in contrast to the development of the world metropolis which is no one's satellite, the development of the national and other subordinate metropoles is limited by their satellite status." p. 107.

2. "The satellites experience their greatest economic development and especially their most classically capitalist development if and when their ties to the metropolis are weakest." p. 108.

3. "The regions which are the most underdeveloped and feudal-seeming today are the ones which had the closest ties to the metropolis in the past. They are the regions which were the greatest exporters of primary products to and the biggest sources of capital for the world metropolis and which were abandoned by the metropolis when for one reason or another business fell off." p. 110.

These ideas have become known as 'dependency' theory. Development and underdevelopment are seen as reverse sides of the same process. Three phases can be identified:

1) An initial investment by the colonial powers that created large plantations and extractive industries in the colonies, the intention being to provide cheap exports to the first world countries.

2) The creation of a relatively wealth minority within these colonies, whose patterns of consumption demanded the local manufacture of previously imported consumer goods.
5.

3) The era of the multinational cooperatives.

"The rise of the multinational corporation (MNC) has become the most important phenomenon in the international economic order, as internal transactions of MNCs have replaced ordinary market operations. Investment in the manufacturing sector of the poor countries tends to be with capital-intensive, labour-saving technologies which accentuate unemployment problems and the maldistribution of income. The MNC's are dominant in the innovative sectors of durable consumer goods, machinery and equipment, electronics, computer, chemicals and drugs. A precondition for keeping the process of industrialization going, then, becomes dependent cooperation with their particular model of development."

Henriot p. 12.

The increasing vogue of dependency theory caused the UN General Assembly to adopt a proposal in 1974 for the establishment of a New International Economic Order (NIEO), including regulation of the activities of MNC's, and preferential trade agreements.

However 'dependency' theory has been criticised as simplistic, vague, lacking in theoretical rigour, and insensitive to the articulation of pre-capitalist and capitalist modes of production. It deviates from the classical Marxist position on underdevelopment articulated by V.I. Lenin over sixty years ago.

3. IMPERIALISM, THE HIGHEST STAGE OF CAPITALISM


Lenin's historic paper on the growth of imperialism is an excellent analysis of the origins of underdevelopment:
"Typical of the old capitalism, when free competition held undivided sway, was the export of goods. Typical of the latest stage of capitalism, when monopolies rule, is the export of capital.

Capitalism is commodity production at its highest stage of development, when labour-power itself becomes a commodity. The growth of internal exchange, and, particularly, of international exchange, is a characteristic feature of capitalism. The uneven and spasmodic development of individual enterprises, individual branches of industry and individual countries is inevitable under the capitalist system. England became a capitalist country before any other, and by the middle of the nineteenth century, having adopted free trade, claimed to be the "workshop of the world", the supplier of manufactured goods to all countries, which in exchange were to keep her provided with raw materials. But in the last quarter of the nineteenth century, this monopoly was already undermined; for other countries, sheltering themselves with "protective" tariffs, developed into independent capitalist states. On the threshold of the twentieth century we see the formation of a new type of monopoly, firstly, monopolist associations of capitalists in all capitalistically developed countries; secondly, the monopolist position of a few very rich countries, in which the accumulation of capital has reached gigantic proportions. An enormous "surplus of capital" has arisen in the advanced countries."

He continues:

"As long as capitalism remains what it is, surplus capital will be utilised not for the purpose of raising the standard of living of the masses in a given country, for this would mean a decline in profits for the capitalists, but for the purpose of increasing profits by exporting capital abroad to the backward countries. In these backward countries profits are
usually high, for capital is scarce, the price of land is relatively low, wages are low, raw materials are cheap. The export of capital is made possible by a number of backward countries having already been drawn into world capitalist intercourse; main railways have either been or are being built in those countries, elementary conditions for industrial development have been created, etc. The need to export capital arises from the fact that in a few countries capitalism has become "overripe" and (owing to the backward state of agriculture and the poverty of the masses) capital cannot find a field for "profitable" investment.

Thus imperialism emerges as a direct continuation of the development of capitalism within the first world. Lenin goes on to list 5 basic features of imperialism:

"1) the concentration of production and capital has developed to such a high stage that it has created monopolies which play a decisive role in economic life; 
2) the merging of bank capital with industrial capital, and the creation, on the basis of this "finance capital", of a financial oligarchy; 
3) the export of capital as distinguished from the export of commodities acquires exceptional importance; 
4) the formation of international monopolist capitalist associations which share the world among themselves, and 
5) the territorial division of the whole world among the biggest capitalist powers is completed. Imperialism is capitalism at that stage of development at which the dominance of monopolies and finance capital is established; in which the export of capital has acquired pronounced importance; in which the division of the world among the international trusts has begun, in which the division of all territories of the globe among the biggest capitalist powers has been completed."
It can be seen that 'imperialism' and 'colonialism' are by no means synonymous. The Spanish conquests of America, the rounding of the Cape of Good Hope and the Trade with India all occurred before the advent of monopoly capital in Britain and Europe. But it was precisely the development of monopoly capital and imperialism that was to give colonialism a world-wide impetus on a scale unknown in the history of mankind. Later, with the rise of national liberation movements throughout the third world, and the steady collapse of colonial empires, imperialism was by no means defeated. Rather it sought to entrench itself in these newly independent states through alliances with the national bourgeoisie. Colonialism became neo-colonialism. Wages remained desperately low: super exploitation generated super profits. In the trade arena, the unskilled labour of the emerging proletariat in the third world was traded off against the skilled labour of the first world proletariat.

4. UNDERDEVELOPMENT AND DEPENDENCE IN BLACK AFRICA — ORIGINS AND CONTEMPORARY FORMS

Samir Amin


Amin has described this process taking place throughout Africa. He distinguished three macro-regions on the basis of the effects of the last period of African history — colonization. These are:

1. "Africa of the colonial trade economy" comprising West Africa, Cameroun, Chad and Sudan.

2. "Africa of the concession-owing companies" comprising the Congo River basin.

3. "Africa of the labour reserves" comprising the eastern and southern parts of the continent.
Amin has identified three phases in this process. Firstly, the pre-mecantilist period extending up until the seventeenth century. This was characterized by the existence of diverse modes of production, that can roughly be divided into five types:

"i) the primitive community mode of production, the only possible one to come first, for obvious reasons;

ii) the 'tributary' mode of production which involved the persistent parallel existence of a village community and a socio-political structure which exploited the former by exacting a tribute - this, the most common pre-capitalist mode, developed sometimes from earlier into evolved forms, when the village family community lost the right of ownership of land to feudal masters;

iii) the slave-based mode of production, which was less common but scattered;

iv) the small-scale trade mode of production, quite common but never likely to form the main structure of society; and lastly,

v) the capitalist mode of production."

Amin emphasises that 'social formations are concrete structures, organised and characterised by a dominant mode of production which forms the apex of a complex set of subordinate modes.'

The mercantilist period spans the seventeenth and eighteenth centuries; in Europe two poles of the capitalist mode of production have started to emerge....

"(i) the creation of a proletariat resulting from the decline of feudal relationships, and

(ii) the accumulation of wealth in the form of money. During the industrial revolution the two became united; money wealth turned into capital, and the capitalist mode of production reached its completed stage. During this long period of incubation covering three centuries the American periphery of the Western European mercantile centre played a decisive role in the accumulation of money wealth by the Western European bourgeoisie. Black Africa played a no less important role as the
The nineteenth century saw the gradual decline of the mercantilist slave trade, and the integration of Africa into the full capitalist system.

"The partitioning of the continent which was completed by the end of the nineteenth century multiplied the means available to the colonialists to attain capital at the centre. We must remember that their target was the same everywhere: to obtain cheap exports. But to achieve this, capital at the centre—which had now reached the monopoly stage—could organise production on the spot, and there exploit both the cheap labour and the natural resources, by wasting or stealing them, i.e. by paying a price which did not enable alternative activities to replace them when they were exhausted. Moreover, through direct domination and brutal political coercion, incidental expenses could be limited by maintaining the local social classes as 'conveyor belts'."

"In the region which I have called 'Africa of the labour reserves', capital at the centre needed to have a large proletariat immediately available. This was because there was great mineral wealth to be exploited (gold and diamonds in South Africa, and copper in Northern Rhodesia), and an untypical settler agriculture in the tropical Africa of Southern Rhodesia, Kenya, and German Tanganyika. In order to obtain this proletariat quickly, the colonisers dispossessed the African rural communities—sometimes by violence—and drove them deliberately back into small poor regions, with no means of modernising and intensifying their farming. They forced the 'traditional' societies to be the supplier of temporary or permanent migrants on a vast scale, thus providing a cheap proletariat for the European mines and farms, and later for the manufacturing industries of South

Henceforth we can no longer speak of a traditional society in this part of the continent, since the labour reserves had the function of supplying a migrant proletariat, a function which had nothing to do with 'tradition'. The African social systems of this region, distorted and impoverished, lost even the semblance of autonomy: the unhappy Africa of apartheid and the Bantustans was born, and was to supply the greatest return to central capital.

5. GOLD, AGRICULTURE, AND SECONDARY INDUSTRY IN SOUTH AFRICA, 1885 - 1970: FROM PERIPHERY TO SUB-METROPOLE AS A FORCED LABOUR SYSTEM

- Martin Legassik

Chapter 7 of 'The Roots of Rural Poverty' in Central and Southern Africa' eds. R. Palmer, N. Parsons (1977), publ. by Heineman, London, quote from his introduction:

"The discovery of diamonds and gold in South Africa in the last part of the nineteenth century set in motion changes which had a profound and qualitative effect over the whole of the Southern African sub-continent. A region comparatively marginal to the world economy became transformed into the supplier of that economy's money commodity - gold. An area of the world where capital accumulation, though slow and small in quantity, was local, became rapidly dominated by metropolitan capital, which has continued to play an important role to this day. The whole tempo of economic change accelerated, reaching its peak in the South African heartland between the 1930s and 1960s: and it was change which proceeded on the basis of institutions of forced labour, already in existence in agriculture, but qualitatively transformed to meet new circumstances. The labour needs of gold-mining, of commercial/capitalist agriculture, and of secondary industry, were the basis on which emerged new social institutions and structures, new classes, new ideologies."
Moreover growth in the South African heartland was accompanied by and caused stagnation or decay in the peripheries. In a paralleled process at the international dialectic of metropole and satellite, Southern Africa proceeded from underdevelopment of the development of underdevelopment. With mining and secondary industry came the growth of cities. The Witwatersrand (the Reef, 'Goli') became the economic, social and ideological focus of a sub-continent. But alongside, in the African 'reserves', in Mozambique or Malawi, wherever the imperatives of the growing South African economy penetrated, there were also changes, and these changes were usually in the direction of rural underdevelopment, economic decay, and pauperization. In South Africa itself, moreover, the entrenchment of racialism in the institutions of the society meant the correlation of development with blackness. The correlation was not, and is not, complete, but it is cruelly strong. Thus, over a hundred years, South Africa changed from a peripheral part of the world economic system to a developed sub-metropole, generating underdevelopment and exploitation in its own periphery.

6. THE EMERGENCE AND DECLINE OF A SOUTH AFRICAN PEASANTRY


"Much of South African history revolves about the transition of a majority of her people - the rural African population - from their pre-colonial existence as pastoralist-cultivators to their contemporary status: that of sub-subsistence rural dwellers, manifestly unable to support themselves by agriculture, and dependent for survival upon wages earned in 'white' industrial regions or on 'white' farms."
13.

Bundy summarises this transition thus:

"(i) Between the discovery of gold and the First World War, the quickening economic pace and modernization of South Africa produced qualitative changes in the economy of the Transkei.

(ii) Some peasants were able to consolidate, and others to enjoy for the first time, modest economic success, as they grasped opportunities for profit, improved their agricultural techniques, and produced a surplus for sale.

(iii) At the same time, there was an acute rise in social and economic pressures; these had their origins in physical/demographic/natural causes; in aspects of the internal economy of the Transkei—especially peasant/trader relations, debt, and stratification; and in aspects of the 'external' Southern African economy—market prices, transport costs, the commercialization of white farming, the increased demand for labour, and the legislative and recruiting practices this gave rise to.

(iv) Substantial numbers of Transkei peasants lost the measure of economic independence they had enjoyed at the beginning of the period under review—i.e. they lost the ability to meet their subsistence requirements through pastoral and agricultural pursuits as they became separated from the means of production (although without experiencing the full geographical and social departure that this 'normally' entails).

(v) By 1914, a growing number of individual peasants had become proletarianized; the peasant community as a whole was less economically resilient and increasingly less self-sufficient; the peasant sector was in the process of becoming underdeveloped. The Transkei had become a structurally underdeveloped region within the developing economic system of South Africa."

Bundy isolates the following economic factors that are at the basis of this underdevelopment:
Budny isolates the following economic factors that are at the basis of this underdevelopment:

1. "The most obvious and the most far-reaching single factor is the shortage of land available to the peasantry; it is 'the key to the status of inferiority, exploitation, poverty, lack of culture, in a word the status of underdevelopment....of (peasants) who participate all too fully in the social process of capitalist development.' (A.G. Frank, 'Capitalism and Underdevelopment in Latin America, N.Y., 1969).

2. The changing character of African involvement in the money economy, from 'discretionary' spending to 'necessary' cash requirements.

3. The 'contractual inferiority' of peasant-trader relations.

4. The absence of an infrastructure that provided easy access to markets for the peasantry."

7. CAPITALISM AND CHEAP LABOUR POWER IN SOUTH AFRICA : FROM SEGREGATION TO APARTHEID - Harold Wolpe

Ch.8 of 'The Articulation of Modes of Production' (essays from ec. and soc.) Publ. by Routledge Kegan-Paul, London 1980. p289-

"The simultaneous existence of two modes of production within the boundaries of a single satte has given rise to the notion of the 'dual economy' (e.g. Hobart Houghton, 1964). As Frank (1967; 1969) and others have shown for Latin America, however, the assumption that different modes of production can be treated as independent of one another is untenable."
In South Africa, the development of capitalism has been bound up with, first, the deterioration of the productive capacity and then, with increasing rapidity, the destruction of the pre-capitalist societies. In the earlier period of capitalism (approximately 1870 to the 1930s) the rate of surplus value and hence the rate of capital accumulation depended above all upon the maintenance of the pre-capitalist relations of production in the Reserve economy which provided a portion of the means of reproduction of the migrant labour force. This relationship between the two modes of production, however, is contradictory and increasingly produces the conditions which make impossible the continuation of the pre-capitalist relations of production in the Reserves. The consequence of this is the accelerating dissolution of these relations and the development, within South Africa, towards a single, capitalist mode of production in which more and more of the African wage-labour force (but never the whole of it) is 'freed' from productive resources in the Reserves. This results in important changes in the nature of exploitation and transfers the major contradiction from the relationship between different modes of production to the relations of production within capitalism.

8. 'FROM PEASANT TO PROLETARIAN'

David Webster


Webster's article is one of the most accessible reviews of the development/underdevelopment debate in Southern Africa. The system of impoverishment, its roots lie in the system of colonialism, which ensured inequalities of development in the region. Webster describes colonialism as "usually a blatently coercive system which uses all the means at its disposal—violent, economic, political and ideological, to dominate and exploit its colonized population".
He takes issue with 'dependency theory' as articulated by Frank:

"Frank does not adequately define capitalism, for example, portraying it as a monolithic structure, without any insight into the role of different capitals, etc. His concepts are vague and lack theoretical rigour; he does not analyse capitalism as a mode of production, nor does he fully examine the pre-capitalist forms which capital exploited and destroyed. Despite these criticisms, Frank touched on many truths, and his greatest contribution was the destruction of the myth of the dual economy. Also, his assertion that indigenous societies were originally in a state of undevelopment, and that later they became underdeveloped, while the capitalist sector became progressively developed, highlighted the important insight that underdevelopment is progressive (increasing) and has a causal and concomitant link with the process of capital accumulation."

"The processes of proletarianization set in motion (appropriation of land, taxation, etc.) ensured the creation of that supply (of cheap labour) and, very importantly, it also created a surplus population, which is equally necessary to capital accumulation. The creation of a proletariat is not enough; capital needs an industrial reserve army, 'so that the mass of the unemployed can keep those in employment in a position of insecurity, keeping down wages'...."

Marx (1976 : 785)

"...once the destruction of a pre-capitalist economy has been achieved, once the process of proletarianization has begun, it is almost certainly irreversible. The underdevelopment of the rural reserve areas proceeds apace, quickly becoming unable to support even a fraction of the population inhabiting it."
17.

On the subject of migrancy, Webster concludes:

"Migrant labour, therefore, intensifies underdevelopment, the absence of the potentially progressive young and the accompanying decline in agricultural productivity means that economic self-sufficiency slips further away, ensuring the necessity of further migrant trips. Migrancy, then, contributes in no small measure to the ossification of existing (tribal) structures in Southern Africa and impedes social, economic and political change (of. Gugler 1968 :482)"

9. THE RENEWED SCRAMBLE FOR AFRICA

- A. Setdman and N. Makgetla


"... the Nationalist Party, elected to office by the white minority in 1918, asserted its determination that, in South Africa at least, while domination would remain supreme. There, the minority government pledged, transnational corporations and domestic investors need for fear expropriation or other efforts to re-orient the economy to meet the needs of the majority of the population.

The regime's policy was two-pronged. First, it reinforced the migrant labour system to ensure cheap African labour. In this context it introduced a range of direct incentives and sanctions to increase manufacturing investment. An expanded industrial sector would ensure higher living standards for white South Africans, increased military might to employ against black resistance, and reduced dependence on foreign interests.

To maintain a cheap labour force, the regime adopted apartheid, which extended and made more rigid the system of racial oppression established over the centuries of European settlement. Although it officially aimed at total segregation of Africans and whites,
the lands allocated the African population were so infertile, and underdeveloped and limited in size that black workers had no choice but to migrate to "white" areas, seeking any kind of job at subsistence wages or less. Even official commissions exposed the fact that the African lands could never support the entire African population. The fragmented, overcrowded reserves-renamed Bantustans or Bantu homelands (incorporating the incorrect and insulting Afrikaner term for Africans, "Bantu") - were never expected to be anything other than a vast labour reserve, from which unemployment and hunger would drive able-bodied men, and some women, to work as cheap contract labour for the white-owned farms, mines and factories.

The regime proceeded to systematically remove blacks from urban industrial centres, where their aspirations for liberty might trouble whites or scare off foreign investors. Many of the uprooted African families had lived in the cities for generations; now they were forced into "homelands" they had never before seen. The regime tried to break down African unity by forcing them back into "tribal" groups, although alienation of land and capitalist industrial development had long undermined the political-economic foundations of pre-colonialist society. A century of capitalist development had plunged Africans into the melting pot of proletarianization, the process could not be reversed. Yet new laws stripped Africans of even the mockery of citizenship previously permitted; they now enjoyed "citizenship rights" only in the "independent" Bantustans. If they could find a white employer, they might migrate to the prosperous "white" cities or estates. For those who remained behind - women, the unemployed, old men and children - life became a grinding round of poverty, hunger and death; a slow, less visible form of violence, which has been compared to Hitler's genocidal program."
"Employing low-paid black labour, compelled by systematically imposed poverty to migrate from South Africa and beyond, South Africa's mines produces vast profits. On this foundation, primarily with financial assistance from imperial British and German banks, a handful of mining finance houses built sprawling industrial empires. Over the years, increasingly interlinked with the South African regime's parastatals, they came to dominate and shape the nation's racist political economy. Anglo-American, by far the largest, reinvested its profits at home and abroad to weave an international network closely intermeshed with U.S. and British transnational finance capital.

Far from improving the lives of their black workers, Anglo and the other mining companies recruited migrant blacks from throughout the southern region, openly paying them wages too low to support their families. When labour unrest, spurred by the spreading liberation struggles of the 1970s, threatened their profitable business, the companies devised new approaches. They recruited increasing numbers of South African blacks who faced prolonged unemployment as the economic crisis gripped the rest of the economy, paying them slightly better wages than before - although still below the poverty line. They admitted a few to the formerly lily-white "aristocracy" at the top of the labour pyramid, but the bulk of black miners had no choice but to migrate annually from their impoverished "homelands" to earn the meager wages offered. At the same time, the companies reinvested growing shares of their skyrocketing profits to purchase sophisticated machinery and equipment sold by eager transnational corporate salesmen, to mechanize their and open new ones while reducing their dependence on increasingly reactive black workers."
"By the mid 1970s, wages constituted less than a tenth of the mining companies total income. (See Chart 5.1) Over half the wage bill went to the white miners who comprised barely a tenth of the labour force.

To hold labour costs down, the companies hired blacks almost solely as migrant workers on long-term indentures. As the manager of Wenela, the recruiting organization for the Chamber of Mines, put the issue bluntly:

Our case has always been that we want peasant farmers as labour. Our wage isn't sufficient to meet the needs of a man and his family unless it is augmented by earnings from a plot of land in the man's homeland. A family man from Johannesburg, for instance, couldn't live on what we pay.

In reality, by the '70s, many migrants and their families had no choice but to subsist almost entirely on their wages. In particular, miners from South Africa - a growing proportion of the total in the 1970s - signed on because in the Bantustans they had no alternative means of earning a living; no land, no job, no chance of either.

The mines dehumanized the migrants, breaking down their resistance to low wages and intolerable conditions. The process began in the branches of Wenela, established to recruit Africans throughout the southern third of the continent. (Many Wenela branches were closed down after South Africa's neighbours attained independence.) Responsible for feeding and transporting its recruits, Wenela typically provided food of low quality and unsanitary and overcrowded accommodations. The process of dehumanization began with the medical examination needed to obtain a job: The men had to strip naked in large groups so the doctor could examine their heartbeats. The procedure "seems unnecessary except as a way of initiating the miners into a subculture which is
deprived of any values about human dignity."

On the mines themselves the conditions were brutal:

"---it is perhaps easiest to start by thinking of a road labour
digging up pavement with a jack-hammer drill. Now imagine him
doing that work thousands of feet underground, in intensive
heat, where he cannot even begin to stand upright and where the
drill...has to be held horizontal and driven into the wall
in front. Add to this picture the noise of a roaddrill, magnified
several times by the confined space;...and the possibility that
the roof of the mine might suddenly cave in under pressure."
PART III: HEALTH SERVICES IN SOUTH AFRICA

4.1 What is wrong with South Africa's health services?

Criticisms levelled against the medical institutions of South Africa fall into two main categories,

1. the maldistribution of health services

2. the inappropriate nature of those services.

After briefly examining these criticisms, I will go on to outline various analyses that have applied to the South African health care situation, and show that fundamental changes in the level of health care distribution in our society can only take place in the context of fundamental change THROUGHOUT the institutions of our society.

Once again, these ideas are by no means new - they come from a long tradition of critical thought. I would like to summarise this tradition by first quoting three papers on the South African situation, one by Michael Savage entitled 'The Political Economy of Health in South Africa' (1), the next by Cedric de Beer entitled 'Beyond Community Medicine - the exploitation of disease and the disease of exploitation' (2), and the third by Noddy Jinabhai entitled 'The Structure and functions of the South African Health Services' (3).

Savage identifies four key characteristic features of the South African health services:

1. The bulk of services are curative rather than preventive. (It has often been stated that 2% of the health budget goes towards preventive services).

   "The decision within South Africa to commit health care resources primarily to curative medicine is at the same time a decision that medicine should be disease and hospital orientated rather than health and community orientated."

2. The health services serve primarily the white and urban populations.
In 1976 2.8% of doctors worked in the Bantustans. This follows the law of inverse medical care which states 'The availability of good medical care tends to vary inversely with the need of the population served.'

This maldistribution is indeed a reflection of an extremely widespread phenomenon. Vincenote Navarro (4) in his analysis of health in Latin America, stated:

"The highly skewed distribution of human health resources in Latin America is a symptom of the maldistribution of resources in the different sectors of the economy, a maldistribution that ... is due to the economic and cultural dependency of Latin American countries and to the control of the distribution of economic and social resources (including health resources) in those countries by a national lumpenbourgeoisie with links with foreign counterparts."

3. Ancillary services (notably those for the mentally ill, the handicapped and the elderly, as well as pharmacists, dentists, health visitors and health educators) are weakly developed, and for most of the black population are very inaccessible.

4. Control of the institutions for health care rests in the hands of a 'white' elite, and these institutions are deeply permeated by the structures of apartheid.

Savage summarises his main points:

"It has been argued first that medicine in South Africa generally has been ineffective in improving the health of the population as the important factor determining the health of the population is socio-economic develop-
ment and not the application in medical technology. Second, it has also been argued that there is a particular social organization attached to South African medicine. These two broad features conditioning and characterising South African medicine are interconnected and reinforce one another. Together they point to the existing model of medical services being in need of radical revision.

Similar criticisms were voiced against the health services in 1981 by Noddy Jinabhai (3). He lists seven features that characterise these services:

1. The discrepancy between the urban and rural areas.

2. The discrepancy between the health services in the community and workplace. There is no industrial health service.

3. The fragmentation between preventative and curative services between different authorities and between the private and public sectors. This indicates the lack of a comprehensive health service.

4. The emphasis on capital intensive technology, intensive medical care geared towards meeting the health needs of the affluent groups.

5. The lack of a clearly defined national health policy or a National Health System.

6. The present trends towards reducing the public sector and entrenching and expanding private medical practice.
7. Lastly, the undemocratic nature of the health services. To quote Prof. Savage:

"... apartheid has meant that the majority of the population are shut out from any real part in the political decisions shaping South African medicine and cannot participate in the design of services, in decisions about the distribution of medical resources or in decisions about the development and future directions that medical services are to take."

Cedric de Beer (2), writing in the late 70's provided an excellent analysis of the situation, and a few words of caution. He made the following points:

Health care in the Western World has been shaped by two interrelated forces:

1. Health care is a commodity subject to market forces

2. Medical science is mechanistic.

These have given rise to:

1. A complex and inappropriately large medical technology geared towards treating degenerative diseases of the predominantly affluent classes.

2. The inaccessibility of health care to the majority of the population due to

   a) Centralisation of resources (distance; absence from home and work)
5.

b) the cost of a cure

c) access follows the racial and class stratification of society

3. even given full access, the individualistic nature of health care delivery cannot stem the tide of third world diseases that take their origins in the social and physical environment, to which any 'cured' person must eventually return.

4. the inappropriate nature of current categories of medical personnel.

5. the importation of inappropriate 'first world' models of health care that are 'alien' to third world communities.

"Thus argue the critics, conventional, hospital based, curative medicine is too expensive for the available resources, ineffective, inaccessible, and often technically and socially inappropriate. In response to this curative approach to individual health, there has been formulated an alternative: a community approach to prevention, with cure as a secondary necessity only when prevention fails."

The major principles of this approach are:

1. We must start by tackling basic health needs
   i.e. - adequate sanitation, clean and accessible water
         - adequate housing
         - reasonable levels of nutrition

2. involving the community in planning and administering any health promotive programmes.

3. primary health care must be sensitive to the structure and functioning of communities it serves
4. the use of 'village health workers', 'barefoot' doctors, 'medical auxiliaries'.

5. a re-allocation of priorities in health care towards prevention, and a decentralisation of resources

"... there must be a change of emphasis away from complex high technology to simple means for combating the most prevalent disease, and away from bigger and 'better' hospitals to the creation of a network of clinics and health posts within easy reach of every person. Health care must cease to be a profitable enterprise and become a service."

The basic problem with this approach, as the author sees it, is that, while it is all very well to encourage people to cope with the impoverished conditions within which they live, there is a tendency to view poverty as the inescapable lot of mankind. The causes of that poverty become obscured behind a range of 'self-help' and community development programmes. The basic structures of exploitation remain untouched.

Further, the term 'community' that is so freely bandied about ignores the fact that these very 'poor communities' are themselves stratified according to class, social status, sex and other criteria; that they tend to reproduce those self same structures of domination and exploitation that are at the basis of their impoverishment. Thus community programmes frequently reinforce these structures, and have no effect on those at the every bottom of the social pyramid.

The author concludes by outlining some general guidelines for the road ahead:
"1. the link between exploitation and ill health must be fully spelt out, not only in academic journals and pleas to politicians, but in the day to day work with the victims themselves.

2. Health personnel must move beyond the superficial conception of "community". They must take sides and put their skills at the disposal of those acting with the poorest and the most powerless, in order to increase their ability to resist the threat to their existence which the present order poses.

3. In embryo form, in local projects, the practices of a just health system must be put into effect. These must be used to highlight the inadequacies of the present system, and to create expectations for the future.

4. A concerted effort must be made to build up a reservoir of politically conscious and dedicated people who will form the core of a new and just health system at some point in the future, when a just and non-exploitative society has been built."
4.2 The determination of health care structures

Let us examine the 'commodity nature of health care' argument more closely. One of the principal exponents of this viewpoint is Malcolm Segal (5), who stated his case in a 3 part series on health and health care. 'Part II: The economic basis of doctors' social practice, consciousness and education in a capitalist economy' is of particular relevance.

Commodities have an intrinsically dual nature - they are intended for consumption i.e. they are socially useful, and they are also intended for sale i.e. they have exchange value. In an economy where wages in the form of money determine one's access to commodities, a fundamental contradiction arises between their use-value and exchange-value. This has a determining effect on the nature of health care services:

1. The individual who is sick must purchase a cure. The doctor in private practice orientates his services towards the individual, more specifically towards curing that individual. The 'patient-care' model of a doctor's social practice evolved from these two characteristics.

2. The social practice of the doctor, determined by the commodity nature of health care, in turn has a determining effect on the social consciousness of the doctors, and on the nature of medical education. The very repetition of that practice reinforces the assumption that this is the way it should be, that medical solutions are the treatment of choice for disease, that ultimately the patient-care model should be extended to cover the whole of society.

3. The limitations of private practice have necessitated state intervention. The state purchases health care on behalf of the people as social wages. The state has increasingly exerted its influence over the medical profession. This, however, has done little in the way of 'socialising' medicine, and has had virtually no effect on the essentially commodity nature of health care.
4. The value of the commodity that the doctor produces is proportional to the hours of labour spent in its creation. This labour includes the years of education (i.e. invested labour) the doctor undergoes in training:

"When health care is a commodity, there is an incentive for the producers of care to obtain as long and ample an education as possible for its own sake, irrespective of the social priorities. The longer and more complex the education, the greater is the exchange-value of the commodity. Since it is always good in an abstract sense to know more, this higher education is argued for by its effect of raising the standards of individual acts of care. This, however, abstracts these standards from their effects on the distribution of resources ... ... This highest possible level is a priority for the exploiting classes, who already have adequate basic care. They also consume it disproportionately, mainly through private practice." (5)

5. The doctor, having trained for so long, now wishes to realise on the commodity he produces. He seeks a market that

a) can afford his prices

b) needs the type of sophisticated care he is offering.

For private practitioners this means gravitating towards the more affluent urban areas. Doctors in the employ of the state must climb the career ladder, obtaining increasingly specialised qualifications, and consequently expanded incomes. Ultimately many of them must emigrate to the advanced countries of the first world to realise further on their skills.
The concept of the commodity nature of health care being at the basis of the prevailing maldistribution and inappropriate nature of medical practice appears to be in contradiction to the ideas advanced by A. Schatzkin (Part I). Schatzkin argued that labour power, and the degree of skilled training attached to it, determined the level of health care meted out to sectors of society. A closer analysis will reveal that this is no contradiction. Firstly, an increasing level of skill means at the same time an increasing income, and hence increased access to all commodities, including health care. Secondly, this is precisely the area in which the state must intervene i.e. it must mediate between the demands of capital for a working class that is healthy enough to work, and the demands of the health professionals for a suitable realization of their commodity. This is the primary function of the state in a capitalist society - it must ensure "the reproduction of an economic system based on private ownership of the means of production, i.e. the capitalist economy." This entails 'smoothing over' the contradictions within that economy.

An examination of health care legislation in South Africa bears out this argument. (3) One of the greatest threats to the early workforce on South Africa's mines was occupational lung disease, especially tuberculosis. In 1902, 1907 and 1911 commissions of inquiry were held into the problems of 'phthisis', tuberculosis and dust control in the mines. In 1911 the Miners Phthisis Act made compensation for the disease compulsory. After the 1919 Public Health Act the economy swung increasingly towards manufacturing and industrialisation:

"In the 50 year interval between the 1920's and 1970's, several significant changes occurred. Firstly, the disease profiles changed from the infectious diseases to being replaced by the newer 'epidemics' of degenerative conditions of hypertension and heart disease. The conditions, related to stress and
industrialisation, had very grave economic implications since they affected largely the affluent, the managerial and executive classes. Secondly - escalating costs of all services including health services, necessitated the rationalisation of health service provision and the passing of some of these costs onto other sections of society like industry and ultimately the consumers."

N. Jinabhai (3)

The author lists some 32 Acts that have entrenched the state's control over health and health services:

1. Provision of Health Services
   - Act of Union 1910
   - Health Act 1977
   - Children's Act
   - Abortion and Sterilisation Act 1975

2. Training of Health Professionals
   - Medical, Dental and Supplementary Health Services Professions Act
   - Nursing Act
   - Pharmacy Act

3. Control of Drugs and Hazardous Substances
   - Medicines and Related Substances Control Act
   - Hazardous Substances Act
   - Abuse of Dependence Producing Substances and Rehabilitation Centres Act

4. Control of Food
   - Foodstuffs, Cosmetics and Disinfectants Act

5. Control of Air Pollution
   - Atmospheric Pollution Prevention Act
6. Control of Infectious Diseases
   - International Health Regulations Act

7. Mental Health and Psychiatry
   - Mental Health Act

8. Housing Legislation
   - Slums Act
   - Group Areas Act
   - Housing Act
   - Prevention of Illegal Squatting Act

9. Welfare Legislation
   - Fund Raising Act
   - Social and Associated Workers Act
   - Welfare Act

10. Workers' Health
    - Occupational Diseases in Mining and Works Act
    - Factories, Machinery and Building Work Act
    - Workmens' Compensation Act
    - Shops and Offices Act
    - Animal Diseases and Parasite Act
    - Animal Slaughter, Meat and Animal Products Hygiene Act

11. Miscellaneous Act
    - Births, Marriages and Death Act
    - Anatomical Donations and Post Mortem's Act
    - Atomic Energy Act
    - Criminal Procedures Act
    - S.A. Medical Research Council's Act." (3)

The 1977 Health Act and the Health Service Facility Plan of 1980, while
couched in the placatory rhetoric of 'services for the people' and
'community participation', have merely entrenched the existing inequalities. We shall return to them later - in the meantime let us proceed with the determination of health care services.

The 'health as labour-power' and 'health care as a commodity' arguments have ascribed the final determination of existing health care structures to economic factors - this is not the whole story, as Louis Althusser points out in his review of the historical materialist position:

"... Marx conceived the structure of every society as constituted by 'levels' or 'instances' articulated by a specific determination: the infrastructure, or economic base (the 'unity' of the productive forces and the relations of production) and the superstructure, which itself contains two 'levels' or 'instances': the politico-legal (law and the state) and ideology (the different ideologies, religious, ethical, legal, political, etc.)

... the object of the metaphor of the edifice is to represent above all the 'determination in the last instance' by the economic base." (6)

Althusser goes on to argue that this is no absolute determination; the superstructure itself has an 'index of effectivity':

"... (1) there is a 'relative autonomy' of the superstructure with respect to the base; (2) there is a 'reciprocal action' of the superstructure on the base." (6)

But this reciprocal action is always subject to, and in fulfilment of, its primary function - that of reproducing the necessary conditions for the continuation of the economic mode.
In the Marxist tradition the state has always been conceived as an instrument of domination of one class by another (in this instance the domination of the bourgeoisie over the working class). This domination is carried out by the apparatuses of the state; firstly the repressive apparatus, (the police, the army, etc.) which as a last resort will always intervene with violence, and secondly, the ideological apparatuses, which are far more diverse and autonomous (including such structures as the churches, the schools, the legal system, the political parties, cultural organizations, health care institutions, and last but by no means least, the family.)

Our analysis, then, of the health services would be incomplete without considering the ideological and political functions that they serve. Indeed further investigation will show that they not only reproduce the dominant ideologies and political structures of our society, but that they actively propagate and refine these functions.

There are three aspects of ideology I would like to mention. The first is empiricism and its expression within medical science as the 'germ' theory of disease. This is an essential aspect to the completed 'montage' of bourgeois ideology. The second is professionalism, which serves to protect a medical elite. The third aspect is the reproduction of the dominant / dominated relationships that occur in our society.

1. **Empiricism**

One of the most incisive critiques of ideology in medicine is provided by Vincente Navarro in "Work, Ideology and Science : the Case of Medicine". He shows that bourgeois ideology is dominant within scientific institutions and demonstrates its effects on medical science: (7)
"How does this bourgeois dominant ideology appear in medicine? By the submersion of that medical knowledge into the positivist and mechanistic ideology which typifies science created under the hegemony of the bourgeoisie, and which I would call bourgeois science ... Positivism appears in medicine in its definition of disease as a biological phenomenon caused by one or several factors which are always associated and absorbed in the existence of that disease."

The success of that ideology depends precisely on the extent to which it appears as value-free, unbiased and scientific rather than ideological. What appears as a 'natural' explanation of disease is in actuality a mystification of the political nature of disease, and a defusing of the radical potentiality latent within medical science.

2. Professionalism

In the words of Malcolm Segal (5), professionalism is:

"... based upon a concept of 'academic standards' which are defined subjectively by members of the profession. The standards are self-justifying and are divorced from the practical needs of the mass of the population. They are not, however, divorced from the wants of the guild members. Professionalism is an ideological justification for the purveyors of commodities based on knowledge and skills to promote their economic and social interests in a market economy. Amongst health workers, it is the highest expression of the distortion of their social consciousness. It is exchange-value masquerading as use-value."
In this respect we must consider a difference that has taken place between the forms of commodity production within and outside the health sector. In the broader economy there is a tendency towards deskilling labour-power, such that it becomes a component in a production line, producing ever more commodities, at an ever faster rate. Then, as mechanization takes over, the work becomes machine operated, governed by the pace of that machine. Throughout the process the capitalist has no part in the actual production of commodities.

Within the health sector, however, these tendencies are perceived as very threatening to the doctor/specialist elite. The need for a more basic health worker is obvious - in purely economical terms, it would be cost-effective. The nursing profession is increasingly making in-roads into territory that was the exclusive domain of the doctor. Why then is status of the doctor so entrenched within our perception of health care? Firstly, the medical profession holds a monopoly on knowledge and skills pertaining to health and disease. They are at the core of the propagated notion that doctors and medical science are the solution to disease. Secondly, a production line approach to health care would remove the essential element of mystification from health care; it would remove the doctor from the process, whose essential function in this regard is to reflect and reinforce the patient's conception of him as a medical 'wizard', a 'pillar of society', the final hope the patient has of a healthy existence. This leads on to the third aspect of medical ideology that we must consider, the propagation of domination.

3. Domination

Domination within the South African health services has been ever-present since the times of 'settler' colonialism. As Hoosen Coovadia (8) puts it
The assumed morality of colonialism was 'conquest for civilization'. Hospitals were built, not simply to further health care, but also to act as agents of 'civilization'. For example, Sir George Grey set up an African hospital at Kingwilliamstown in 1859, expressly to 'civilize' the African, break the influence of traditional healers and make the Eastern Frontier safe for colonial expansion."

Gooladia quotes Dr. John Fitzgerald on this subject:

"... such an Institution will draw the savage from the remotest parts of South Africa and attach him for ever to that Government which entered in spirit into his sickness and sufferings and provided a remedy. The Governor and the Government if they both unite to raise the savage from his bed of sickness or to smooth the bed of death, the assegai will be soon laid aside, and his Excellency will be the instrument in the hands providence of elevating and attaching to her Majesty in his person another Native Population ...

(in "South Africa : Its Medical History 1652 - 1898 P.W. Laidler and M. Gelfland)."

Health care institutions in South Africa have from their very inception been racially segregated. But this is not just a 'separation', it is simultaneously 'discrimination', a glaring inequality in the allocation of resources to meet health needs. Apartheid is further expressed within the composition of health worker categories, from the doctor's specialist elite to the hospital cleaners, which reflect the imbalances of the broader society. Moreover it is not simply the racial nature of these categories that reproduces domination, it is their hierarchical structure and the power relations that permeate downwards from the upper echelons, that are themselves an 'unhealthy' subordination.
These factors bear upon the nature of the doctor-patient relationship - a relationship that has been repeatedly criticised for its implicit statement of the helplessness, passivity and subjection of the sick in the face of the medical establishment.

4.3 Recent legislation in context

The proclamation of structures of domination is particularly evident in politico-legal aspects of the health service. The health services legislation that has been promulgated since 1976 must be seen in the context of changes that are taking place on the national scene. The 'new constitution' has been evolved to cope with a deepening 'organic crisis' through which the S.A. state is passing, a crisis brought on by the internal dynamics of monopoly capital. A transition from labour-intensive to capital-intensive production methods has taken place. (9)

At the same time a coherent Afrikaner monopoly capitalist class has emerged, and in conjunction with other factions of 'white' capital, allied itself with the increasingly sophisticated military arm of the state apparatus. Ever since 1976 the military has had an expanding influence on state policy, assured with the ascendancy of P.W. Botha. The strategies proposed in the March 1977 White Paper on Defence were a distinctly new approach to state security, involving a total strategy of control exercised by all state departments.

"due to the lack of co-ordinated national action the result in many countries has been total disruption of the national economy and the psychological disruption of the population ...
19.

It is therefore essential that a Total National Strategy be formulated at the highest level; it is the responsibility of the State Security Council to formulate this strategy; and this strategy requires the inter-departmental co-ordination of the complete spectrum of state activities.

extracted from the 1977 'White Paper' on Defence

A few days after the publication of the White Paper, a Symposium on National Security was held at the Institute of Strategic Studies, University of Pretoria, attended by military personnel, civil servants and academics. The papers presented once again can be seen to have had a marked effect on national policy.

M.H. Louw, Director of ISSUP, had this to say -

"While values and welfare give meaning and purpose to national existence, they are meaningless if the nation-state does not exist on an autonomous sovereign entity. It is the function of government therefore to maintain the territorial integrity of the state and the political, economic and social order, to protect the lives and property of its citizens and their organizations and to increase the influence of the state."

Economic policy was handled by Professor J. Lombard:

"A clear distinction must be drawn between the welfare functions of the economy on the one hand, and the order functions of the state over the economy on the other hand. Welfare functions ... must be decentralised as much as possible towards individuals and collective bodies of individuals who have enough common interests to make collective decisions. Order functions, on the other hand ... cannot be improved by public participation through ordinary democratic pressure."
This is the paradox of total strategy - while state control has increased in almost all sectors, welfare sectors e.g. the health services, are being used to present a facade of democratisation. The Health Act of 1977 and the National Health Facility Plan are attempts at rationalisation of services that have occurred in the context of a total strategy.

Ostensibly the function of the Health Act was to -

"create by legislation, a blueprint for the rendering of health services by the three tiers of government and in so doing to regulate the functions between the authorities in the health field. Provision is made for the co-ordination of services and the determination of health policy on a national basis so that the functions of the three health authorities can be adapted to utilize the available resources to the maximum and in so doing render the most effective health service to the population of South Africa."

(Adapted from the Health Act, 1978: 1). (10)

Chapter 1 of the Act provides for the creation of two new statutory bodies, the Health Matters Advisory Committee (HMAC), which supersedes the Central Health Services and Hospitals Co-ordinating Council, and the National Health Policy Council (NHPC).

HMAC is intended to advise the Minister of Health on all health issues. Its composition clearly shows the undemocratic nature of these recent moves, and the reproduction of state control. The committee consists of a Secretary for Health (Chairman), three directors in the Department of Health, designated by the Minister, four directors of hospital services, one from each province, two doctors employed as Medical Officers of Health (M.O.H.) in urban areas (i.e. in the local authority),
one M.C.H. from a rural area and the Surgeon-General of the S.A.
Defence Force.

One of the features of this body is the enormous number of sub-committees
it has appointed to investigate the following matters:

- Family Planning
- Health Education
- Health Services for Urban Black People in White Areas
- Health-orientated Community Involvement
- Child Health
- Nursing
- Strategic Data
- Staff Matters
- Psychiatry
- Dental Matters
- Nutrition Services
- Laboratory Services
- Health Services in Disasters
- Health Services for the Aged
- Ambulance Services
- Buildings for Health Services
- Pharmaceutical Matters
- District Surgeon Services
- Epidemiology

The NHPC is composed of the Minister of Health (Chairman), the Director-
General from the Department of Health, and four members of the Executive
Committees for Hospital Services, one from each province. Its function
is to:

- ensure that the several authorities which render health
  services in the Republic shall take all such measures as
  they may take in terms of the provisions of this Act and
any other applicable law, to promote the health of the inhabitants of the Republic so that every person shall be enabled to attain and maintain a state of complete physical, mental and social well-being ....""}

The rest of the Health Act sets about defining the functions of the three levels of government (state, provincial and local) with respect to the rendition of health services.

FUNCTIONS OF THREE TIERS OF GOVERNMENT in terms of HEALTH ACT OF 1977.

STATE HEALTH DEPARTMENT (central)

1. To co-ordinate State services with those provided by province and local authorities, and to provide any additional services needed to establish a comprehensive health service for the population of the Republic.

2. To promote a safe and healthy environment.

3. To establish a national laboratory service.

4. To promote family planning.

5. To provide for and undertake research.

6. To provide medico-legal services.

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PROVINCIAL ADMINISTRATION

1. To provide hospital facilities and services.

2. To provide ambulance services.
3. To provide facilities for treatment of acute mental illness.

4. To provide out-patient services.

5. To provide and maintain maternity homes and services.

6. To provide personal (curative) health services, sometimes in conjunction with local authorities.

7. To co-ordinate with State and local authorities to provide a comprehensive health service for the province.

LOCAL AUTHORITIES (MUNICIPALITIES)

1. To maintain the district in a clean and hygienic state.

2. To prevent nuisances, offensive conditions etc.

3. To prevent pollution of water intended for consumption.

4. To render services for:
   a) prevention of communicable diseases.
   b) promotion of health.
   c) rehabilitation.
   and to co-ordinate with other authorities.

Far from establishing the comprehensive service about which the Health Act is concerned, the fragmentation of services between the authorities (a remnant from our colonial past) has been entrenched and formalised. We are no closer to the National Health Service recommended by the Gluckman Commission in 1944. The commission's report still rings true -
"The services are NOT 'organised on a national basis' - they are disjointed and haphazard, provincial and parochial.

The services are NOT "in conformity with modern conception of Health - for they are mainly directed not to promotion and safeguarding of health, but to the cure of ill health.

The services are NOT 'available to all sections of the people of the Union of South Africa' - they are distributed mainly among the wealthier sections who, on account of their economic potentialities should need them least: and are but poorly supplied to the under-privileged sections who require them most."

The homelands policy, culminating in the so-called 'independence' of national states, has been a major mechanism of avoiding the burden of responsibility for the appalling state of health and health services in the homelands. This split that has taken place between the 'RSA' and its labour reserves was formalised in the health sector by the establishment in 1979 of a Regional Health Organization for Southern Africa (RHOSA), with its unquestioning acceptance of these homelands as separate states. The 1978 Department of Health annual report states:

"The constitutional development of the Republics of Transkei and Bophuthatswana not only brought about a new political dispensation in South and Southern Africa, but also created new administrative relations. Whereas co-operation was at national level in the past, co-operation will now have to be at international level, and the principles of international relations will come into play. It was therefore necessary that, in the sphere of public health services, the Departments
of Health of the Republics of South Africa, Transkei and Bophuthatswana, and those homelands that are either on the threshold of independence or likely to become independent, should now come together to decide on what basis co-operation is to take place."

The completely unequal nature of the relationships between the RSA and these states is masked by the euphemistic wording of the Department's 1979 report:

"The main objective of this organisation is the promotion of closer ties, assistance and co-operation in Southern Africa in the field of health. Through technical co-operation, mutual aid and advice it is envisaged to create a safe environment and healthier community in Southern Africa. The interchange of information on common and individual health problems, on preventive medicine and curative health services, the establishment of research programmes, promotion of visits by leading health specialists and establishment of health services to the mutual benefit of member states, could be regarded as some of the more important functions and projects of the organisation. Mutual assistance in the training and development of health personnel and co-operation in the utilisation of sophisticated technology on a joint basis will also be important components of the organisation's work."

In September 1980 the National Health Policy Board decided on a 'National Health Facility Plan' for the Republic of South Africa.

The following is an extract from the minutes of NHPB on 4 September 1980:
BASIC COMPONENTS FOR A HEALTH SERVICE FACILITY PLAN FOR SOUTH AFRICA

1. One Central Body must be responsible for the wider planning of Health services, formulation of Health Policy and determination of strategy.

2. With the formulation of a National Health Service Plan the starting point should be Health Services for the greatest part of the population as economically as possible.

3. With the establishment of Health Policy and rendering of health services the maximum decentralisation of services must be applied. The most suitable institution must, on certain conditions, be appointed as a service.

4. The Department of Health, Welfare and Pensions must fulfil the co-ordinating function by the compilation and revision of the National Health Plan and must provide guidance to any and all Health authorities who are responsible for the establishment of Health facilities.

5. The Department of Health, Welfare and Pensions must provide all service rendering Bodies timeously and regularly with data and information regarding any matter which may influence service rendering, e.g. Development Plans. Similarly all Health authorities must provide the Department with information which may influence any Health service facility.

6. A National Health Service Plan must bear the Health Services in Black States in mind. Liaison with RHOSA is a requirement. (Regional Health Organisation of Southern Africa).
7. Health Service facilities MUST be shared by Health authorities as far as possible. Where one body undertakes capital costs for Health Services, there will not be a contribution i.r.o. capital costs, but they can recover costs by means of rentals or other agreements. Where personnel are concerned, the Health authorities must, without recovering of costs, complement each other's services as far as practically possible with retention of legal responsibility for services that are rendered by specific authorities.

It must be emphasized that the implementation of this recommendation in respect of personnel as well as the joint use of buildings must be undertaken with the lowest possible cost.

8. The Health Service Plan will be implemented for a minimum period of 5 years, but will probably be based on 8 year periods. Periodic revision and adjustment will be done.

STRUCTURE OF A NATIONAL HEALTH SERVICE FACILITY PLAN FOR THE REPUBLIC OF SOUTH AFRICA

Six levels of service will exist:

Level 1 : Provision of Basic Needs

To maintain a very basic level of minimal health there are four conditions in order of importance:

(a) Safe drinking water
(b) Adequate food for human existence
(c) Basic sewerage and waste removal
(d) Reasonable housing

(a) DRINKING WATER

The physical provision of clean and safe drinking water is mainly the responsibility of the Department of Water Affairs, Forestry and Environmental Care, Local Authorities and Administration Boards, and is vitally important.
(b) **FOOD**

The production of food is primarily the responsibility of the Department of Agriculture and Fisheries and the private sector. Additional food to complement a protein and vitamin deficiency is the responsibility of the Department of Health, Welfare and Pensions and Local Authorities. The role of voluntary organisations and community involvement must be encouraged.

(c) **SEWERAGE AND WASTE REMOVAL**

The establishing of sewerage works and the removal of refuse and sewerage is the responsibility of the Local Authorities and Administration Boards, and is an essential function.

(d) **HOUSING**

The provision of sub-economic and economic housing to eliminate unfavourable housing is the responsibility of the Department of Community Development, Local Authorities, Administration Boards and the private sector.

The Department of Health, Welfare and Pensions must, together with the Bodies involved, act as a co-ordinating Body in order to establish guide lines for the establishment of services with minimum standards for the four basic living needs.

Private practitioners who gain first-hand knowledge of general health problems in the community and can ascertain the causative factors, will fulfil an essential function by bringing it to the attention of the authority concerned.
**Level 2 : Health Education**

In this area of health there are three facets which must be taken into account:

(a) **MINIMUM TEACHING LEVEL**

The responsibility of the various departments of education.

(b) **TRAINING AND EDUCATION**

The responsibility of the community and private sector, by means of community activities and via the media.

(c) **HEALTH EDUCATION**

Chiefly the responsibility of the Department of Health, Welfare and Pensions and local authorities and to a lesser degree, Provincial Administrations and the private sector.

**Level 3 : Primary Health Care**

This Health service will be offered to the greatest proportion of the population who need it, at the best cost advantage ratio. There are three development phases:

(a) **SELF-HELP AND COMMUNITY INVOLVEMENT**

The most elementary service in a community will be rendered by voluntary Health service organisations. The premise is that such organisations originate and develop actively as part of community activities. The community must learn to help and organise itself. This involves mainly elementary, preventative, promotive and rehabilitative services. Health authorities will co-operate purposefully with voluntary service organisations so
that those organisations can fulfil an active supplementary role in the rendering of health services. Private practitioners with their knowledge and experience can actively participate in the activities of these organisations.

(b) COMMUNITY HEALTH NURSING

This higher category of service has a preventative and curative effect and shall mainly be administered by nurses in the community. Home visits will be done under guidance of full and/or part-time practitioners. Existing and available accommodation (improvised for clinic services) will be used, e.g. school halls or any vacant room in a home, factory, etc. The financial provision for such a nursing service will be provided by the Department of Health, Welfare and Pensions and/or the Provincial Administration and/or local authorities. The service should be rendered mainly and generally by local authorities and provincial administrations, with consideration of certain services which are mainly the responsibility of the Department of Health, Welfare and Pensions, such as Psychiatry, Family Planning, Tuberculosis prevention, Geriatric Services, etc.

(c) THE COMMUNITY HEALTH CENTRE (C.H.C.)

This is the highest category of service at this level and appears to be the greatest need of that section of the population who is dependant on authority services. It will render preventative, curative, promotive and rehabilitative services in the community.

(1) The planning norm used is:

One consulting room for use by a qualified nurse per 2,500 of the population.

One consulting room for use by a medical practitioner per 5,000 of the population.
(ii) Basic facilities for at least the following services shall be provided by all Community Health Centres:

(a) Family Planning - with ante- and postnatal care as well as certain cancer tests.

(b) Immunisation

(c) Daily sick patient treatment

(d) Combating of tuberculosis, venereal and other communicable diseases

(e) Child care

(f) Geriatric Services

(g) Health Information - especially i.r.o. feeding

(h) Separate localities for meetings of voluntary service organisations

(iii) The establishment of a Community Health Centre is mainly the responsibility of Provincial Administrations and/or Local Authorities.

(iv) It is vitally important to the success of the service that where a Community Health Centre is erected, opportunity be offered for the rendering of health services by all the relevant health authorities. In order to encourage the service rendered by private doctors, the health authorities will provide consulting room facilities for private practice on a selective basis at certain Community Health Centres.

(v) The establishment of a Community Health Centre will be a joint undertaking by all the relevant health authorities. Provision of funds by the Central government will
only be done according to the norms already laid down. Where a Local Authority undertakes the erection of a Community Health Centre with a State subsidy, they must conform to norms.

(vi) Family Planning Facilities at the Community Health Centres are top priority. In order for the full utilisation of all the primary health services to take place, the support of the community and services of private practitioners are indispensable. The private practitioner will provide guidance and support to community health nurses, voluntary health service organisations in first-aid and emergency services, at family planning and sterilisations; he can undertake part-time sessions and provide advice on immunisations and healthy living standards.

Levels IV, V and V: Hospitalisation (General Guidelines)

The future need and provision of hospital beds shall mainly depend on the provision of Community Health Centres.

On condition that community health services be adequately provided for, general hospital beds will be provided on the basis 2 to 4 beds per 1,000 of the population, as community needs arise.

 Provision of beds for use by private practitioners shall also be made throughout.

The contribution of private practitioners at hospital level will be especially in the form of treatment of private patients, part-time service, training and guidance of persons in the medical and supplementary health careers.
Level IV: The Community Hospital

The main facility provided at these hospitals will be general practitioner services while certain specialist duties can also be rendered incidentally. It is envisaged that an economic unit will not be smaller than 100 general beds and will not exceed 350 beds.

Community involvement will be encouraged in all aspects.

Level V: The Regional Hospital

Besides the general practitioner services, basic specialist services such as general, surgical, internal medicine, obstetrics and gynaecology as well as paediatric services (if possible) will be available.

In order to form an economically viable unit, approximately 500 beds will be allowed, and in exceptional circumstances the number of beds may be raised to a maximum of 800 beds.

Provincial Administrations will decide which hospitals will be raised to the status of a Regional Hospital.

Level VI: The Academic Hospital

This hospital will make provision for the academic health components; that is, training, research and service rendering on an extensive and sophisticated basis. As far as possible this hospital will be limited to 800 beds. Only in unusual circumstances and with approval from the highest level may the beds be increased, in which case the beds may not exceed 1,200.
The most important criticism levelled against this new plan has been the way in which it incorporates very rational and progressive ideas into its structure, strips them of their radical potentiality, and masquerades them as an indication of a 'new dispensation'. The minimum standards set for the four basic subsistence needs is calmly passed off onto other departments; but the fact remains that these basic subsistence requirements are not met, nor is the relevant department doing anything to change the glaringly unequal distribution of the appropriate resources. The whole edifice on which these new plans is supposed to rest just does not exist.

There is much mention of the role of the 'community' in these plans; but who is the community? The state department has repeatedly demonstrated a hostile stance towards the democratic movement, and it seems unlikely to change this in any significant way. The groups that the state has identified as community leaders to be approached have, characteristically, been corrupt and elitist puppets of the state administration. We are looking for a genuine 'change of heart' in the health administration, but behind all their subtle words there lurks the same old system of domination and oppression.

There are other problems with this word 'community', and they fit in with the emphasis this plan places on health education. The emphasis for health care has been shifted onto the individuals concerned - once again a 'victim blaming' strategy is being used. The present system, whereby the affluent have access to advanced curative services, while the rest must contend with understaffed, underserviced day hospitals that can hardly cope with the enormous workload, or else have no care at all, remains unchanged.

We can fully agree with the words expressed at the 1981 conference on 'The People and the Professionals' by Julian Stern ... (11)
"This new plan is not very new, not very democratic and not very exciting. It is an attempt to streamline existing health facilities in South Africa. But with neither the money nor the ability to change the basic determinants of ill health in South Africa, the health planners have to content themselves with co-opting progressive concepts such as PHC and CHC's, and stripping them of their progressive content. Health care is to be kept in the hands of the professionals.

... ill health in our country, and any plan that tries to deal with it, are not questions of medical knowledge or expertise, but rather are political questions. The problems cannot be wished away by ministers or government planners. They can only be solved in the process of political struggle, in the struggle for a free, just and healthy South Africa."
Conclusion: THE DEMANDS OF THE PEOPLE

Basic demand for a healthy existence are nothing new to South Africa. They were clearly spelt out by the Gluckman Commission in 1944, they have been repeatedly voiced by concerned health workers and community leaders, and most of all, they are at the centre of the continuous struggle of our people for a free and just society. In 1955 at the Congress of the People, Kliptown, a broad front of progressive and democratic organisations met to draw up an historic charter of BASIC demands, the 'Freedom Charter'; not one of these demands has yet been met.

"We, the People of South Africa, declare for all our country and the world to know:

that South Africa belongs to all who live in it, black and white, and that no government can justly claim authority unless it is based on the will of all the people;

that our people have been robbed of their birthright to land, liberty and peace by a form of government founded on injustice and inequality;

that our country will never be prosperous or free until all our people live in brotherhood, enjoying equal rights and opportunities;

that only a democratic state based on the will of all the people, can secure to all their birthright without distinction of colour, race, sex or belief ..."

THE PEOPLE SHALL GOVERN
ALL NATIONAL GROUPS SHALL HAVE EQUAL RIGHTS
THE PEOPLE SHALL SHARE IN THE COUNTRY’S WEALTH
THE LAND SHALL BE SHARED AMONG THOSE WHO WORK IT
ALL SHALL BE EQUAL BEFORE THE LAW
ALL SHALL ENJOY EQUAL HUMAN RIGHTS
THERE SHALL BE WORK AND SECURITY
THE DOORS OF LEARNING AND OF CULTURE SHALL BE OPENED
THERE SHALL BE HOUSES, SECURITY AND COMFORT
THERE SHALL BE PEACE AND FRIENDSHIP
REFERENCES


5. 'The economic basis of doctors' social practice, consciousness and education in a capitalist economy', Part 2 of a three part series, by Malcolm Segal, Institute of Development Studies, University of Sussex. This is a draft copy, but as it was written some years ago I trust the author would not mind my quoting him.


8. 'The development of underdevelopment in South African Medicine', H.M. Coovadia, Department of Paediatrics, University of Natal Medical School.


10. I have extracted some of these quotes and ideas on the Health Act from a Witwatersrand Department of Community Health handout by Merryl Hammond, entitled 'Legislation affecting Health Care in South Africa'.

11. 'The National Health Services Facility Plan', address given by Julian Stern at the 1981 UCT Medical Students' Conference on 'The People and the Professionals'.

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APPENDIX

Some Statistics Pertaining to Death and Disease Rates in South Africa

Officials statistics have excluded the 'independent states' of Transkei, Venda and Bophuthatswana. The populations for these states were estimated as:

- Transkei: 2,323,650
- Bophuthatswana: 1,323,315
- Venda: 315,545

In 1980 by the Bureau for Economic Research. (Race Relations Survey 1982).

The 1980 Census estimated the population for the rest of the RSA at 24,821,000, composed of

- Africans: 16,900,000 (68.1%)
- 'whites': 4,500,000 (18.1%)
- 'coloureds': 2,600,000 (10.5%)
- Asians: 821,000 (3.3%)

Figures 1-5 present data on Incomes and Employment. My intention is to demonstrate the approximate class composition of each race category used.

Figures 6-8 are population age distribution showing the typical contrast between the 'white' (a stable pyramid until age 35-39, when the diseases of lifestyle take their toll) and black figures (a sharp fall in childhood, and another sharp fall early on in the workseeking ages).

Figures 9, 10 give patterns for morbidity and mortality.

Figures 11-17 infant mortality rates. No national figures are available for blacks. I have therefore extracted urban figures from MOH reports; we have no clear picture of the rural situation, but the few reports mentioned indicate very high figures (+ 250 per 1000 live births).

The remaining figures give incidence rates for various infectious diseases, and demonstrate quite clearly which race groups bear the burden of disease in the Republic of South Africa.
REFERENCES


2. Population Census 1980:
   Sample Tabulation
   Economic Characteristics
   Report No. 02-80-03
   Published by Central Statistical Services.

   Sample Tabulation
   Social Characteristics
   Report No. 02-80-02
   Published by Central Statistical Services.

   Report No. 07-05-01
   Department of Statistics, Pretoria.

5. Deaths Whites, Coloureds and Asians, 1978
   Report No. 07-03-17
   Department of Statistics, Pretoria.

6. Census of Hospitals and Establishments for In-Patients 1980
   Report No. 20-06-05
   Department of Statistics, Pretoria.
FIGURE 1: AVERAGE INCOMES FOR THE RSA

Source: South African Statistics 1982 (1)
FIGURE 2: % OF EACH RACE GROUP OCCUPYING SPECIFIED INCOME BRACKET

Source: 1980 Population Census Data (2)
FIGURE 3: THE SLICE OF THE CAKE

PERCENTAGE OF THE WORKFORCE WITHIN THE SPECIFIED INCOME BRACKET

INCOME BRACKET (RANDS PER YEAR)

<table>
<thead>
<tr>
<th>Income Bracket</th>
<th>Racial Composition (in Percentages) of Each Income Bracket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above R 18000</td>
<td></td>
</tr>
<tr>
<td>12000 - 17999</td>
<td></td>
</tr>
<tr>
<td>8400 - 11999</td>
<td></td>
</tr>
<tr>
<td>6000 - 8399</td>
<td></td>
</tr>
<tr>
<td>3600 - 5999</td>
<td></td>
</tr>
<tr>
<td>2400 - 3599</td>
<td></td>
</tr>
<tr>
<td>1200 - 2399</td>
<td></td>
</tr>
<tr>
<td>Below R 1200</td>
<td></td>
</tr>
</tbody>
</table>

Source: 1980 Population Census Data (2)

Legend:
- BLACKS
- COLOURED
- ASIANS
- WHITES
FIGURE 4:

SIZE % WORKFORCE BY CATEGORY

RACIAL COMPOSITION (%) OF EACH CATEGORY

<table>
<thead>
<tr>
<th>CATEGORY OF EMPLOYMENT</th>
<th>whites</th>
<th>asians</th>
<th>coloureds</th>
<th>blacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and managerial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical and related</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Production and related worker, labourer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service worker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farm and forestry, fisherman, hunter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL WORKFORCE

Source: 1980 Census Data (2)
FIGURE 5: DISTRIBUTION OF WORKFORCE AMONGST EMPLOYMENT CATEGORIES

<table>
<thead>
<tr>
<th>Percentage of workforce (for each specified race group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITES</td>
</tr>
<tr>
<td>[Chart showing distribution]</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
</tbody>
</table>

| COLOURED                                          |
| [Chart showing distribution]                      |
| 1 2 3 4 5 6 7 8 9                                  |

| ASIANS                                           |
| [Chart showing distribution]                      |
| 1 2 3 4 5 6 7 8 9                                  |

| BLACKS                                           |
| [Chart showing distribution]                      |
| 1 2 3 4 5 6 7 8 9                                  |

1. Administrative and Managerial                   6. Sales
2. Related                                         7. Production and Related
3. Professional                                    8. Service
4. Technical                                      9. Farm and Forestry etc.
5. Clerical and Related                           SOURCE: 1980 Population Census (2)
FIGURE 7: POPULATION PYRAMIDS

COLOURED

BLACKS

Source: 1980 Pop. Census (3)
FIGURE 9: PATTERNS OF MORBIDITY FOR EACH RACE GROUP

% OF PATIENTS ADMITTED FOR EACH CATEGORY OF DISCHARGE DIAGNOSIS
JULY AUGUST SEPTEMBER 1980
Source: South African Statistics 1982 (1)

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1. Infective and parasitic diseases
2. Neoplasms
3. Endocrine nutritional and metabolic
4. Diseases of the blood and blood-forming organs
5. Mental diseases
6. Nervous system and sense organs
7. Circulatory system
8. Respiratory system
9. Digestive system
10. Genito-urinary system
11. Pregnancy childbirth and puerperium
12. Skin and subcutaneous tissues
13. Musculoskeletal system and connective tissue
14. Congenital anomalies
15. Certain perinatal conditions
16. Symptoms signs and ill-defined conditions
17. Accidents poisonings and violence
FIGURE 10: PATTERNS OF MORTALITY FOR EACH RACE GROUP

(The latest comparable data is for 1978)
FIGURE 10(b): PATTERNS OF MORTALITY

ASIANS

BLACKS

Source (5)

Source (6)
FIGURE 11: INFANT MORTALITY FOR THE RSA 1930 - 1980

**Source:** (1) (JHB blacks from MOH reports)
FIGURE 12: INFANT MORTALITY - URBAN BLACKS

- 282/1000 Transkei Non-migrant (2)

? RURAL BLACKS

- 240/1000 Transkei (3)

- 227/1000 Transkei Migrant (2)

SOURCE: Urban figures - MOH reports

(2) SAMJ 51, 392, 1977
(3) Rand Daily Mail 6 October 1979
INFANT MORTALITY RATES: 1940/41 TO 1981

Deaths of infants aged under 1 year per 1000 live births

- WHITES
- COLOURED
- BLACKS

NOTE
1. Rates based on Registered Births until 1963 and from then based on Notified Births
2. Data collection changed from "mid-year" to "calendar-year" between 1955 and 1956

Source: Direct copy from Cape Town MOH report 1982
FIGURE 15: INFANT MORTALITY - PORT ELIZABETH 1968 - 1983

ASIAN (130,43)
BLACKS (112,56)
COLOURED (66,81)
WHITES (10,61)
FIGURE: INFANT MORTALITY FOR SPRINGS AND BENONI 1974 - 1982

Infant mortality rate (per 1000 live births)

150
125
100
75
50
25


Springs (urban blacks)
Benoni (urban blacks)
Springs (whites)
Benoni (whites)

Source: MOH reports
FIGURE 17: INFANT DEATHS AS A PERCENTAGE OF ALL DEATHS

Sources: (4) Deaths of Blacks 1978
(1) 1982 SA statistics
FIGURE 18: TUBERCULOSIS RATES

Source: (1)
FIGURE 19: TYPHOID FEVER

SOURCE (1)
FIGURE 21: DIPHTHERIA

DIPHTHERIA - RATE PER 100,000 POPULATION

- BLAKES
- COLOURED
- WHITES

FIGURE 22: MALARIA

Source: (1)
FIGURE 23: Puerperal Sepsis

Source (11)
These papers constitute the preliminary findings of the Second Carnegie Inquiry into Poverty and Development in Southern Africa, and were prepared for presentation at a Conference at the University of Cape Town from 13-19 April, 1984.

The Second Carnegie Inquiry into Poverty and Development in Southern Africa was launched in April 1982, and is scheduled to run until June 1985.

Quoting (in context) from these preliminary papers with due acknowledgement is of course allowed, but for permission to reprint any material, or for further information about the Inquiry, please write to:

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