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TO MEDICAL PROFESSIONALS IN
SOUTHERN AFRICA.

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MEDICAL PROFESSIONALS IN SOUTHERN AFRICA

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IMPERIALISM AND THE CHALLENGE TO MEDICAL PROFESSIONALS IN SOUTHERN AFRICA

R. Loewenson & J. Sachs

INTRODUCTION:

Southern Africa is infected with a parasite, imperialism, that swallows our human and material resources. How do health professionals respond to this attack on the regions health? Do they ignore the parasite and prescribe tonics to ease the pain? Do they describe it with great precision and do nothing to eliminate it? Do they ride on its back, swallowing some of its half digested leftovers? Do they join the broad struggle to eliminate it altogether?

To look at this question we draw specifically from the examples of our own countries in the region - Zimbabwe and South Africa. These are clearly at different stages of the anti imperialist struggle. South Africa is under a colonialism of a special type, where blacks are oppressed as a race, and where black workers are further subjected to class oppression. This produces a health profile which borders on genocide. In post-colonial Zimbabwe, imperialism is less mediated by race and gives evidence of the extent to which the demands of foreign monopoly capital undermine democratic aspirations towards health and the delivery of a comprehensive system of health care.

THE IMPACT OF IMPERIALISM ON HEALTH

Imperialism produces a bitter contradiction between scientific advance and social degradation, best described by Cde Gorbachev, General Secretary of the CPSU, in his address to the 27th CPSU party congress,

"On the one hand the swift advance of science and technology has opened up unprecedented possibilities for mastering the forces of nature and improving the conditions of life of man. On the other, the 'enlightened' twentieth century is going down in history as a time marked by such imperialist outgrowths as the most devastating war, an orgy of militarism and facism, genocide and the destitution of millions of people. Ignorance and obscurantism go hand in hand in the capitalist world with lofty achievements of science and culture."

Foreign capital in Zimbabwe and South Africa has reaped huge surpluses through low wage labour living in inadequate, overcrowded living environments, with hazardous workplaces. The technological development of imperialism, which could produce advanced machinery for removing and processing gold, could not build decent housing for workers on the mines. This resulted in

high and often fatal levels of nutritional and communicable disease. Tuberculosis, unknown in Southern Africa prior to colonisation rose to its current (under)reported level of 10 million cases in South Africa. (3) Silicosis, asbestosis and coal miners lung followed the development of the mining industry; 75-80% of black South African miners are reported to have suffered industrial accidents or disease in the past decade with a permanent injury rate in mining of 100/1000. (2) Company liability is restricted to minimal contributions to workmens compensation, in which payment to black workers is less than one tenth that to white workers. (2) Despite the high level of industrialisation in South Africa, 72% of formal sector employees are not even covered by legislation for these minimal benefits. (2) Irrigation schemes expanded agricultural production raising levels of bilharzia and malaria in the working populations. The large scale farms, the so called 'bread baskets', became the areas of greatest malnutrition, with children starving in the shadow of mountains of grain. (6) Under conditions of extremely low wage labour, it was cheaper to hire more workers to make up for productivity losses than to raise payments or rations. Without any form of guarantee of employment security, employers simply removed unfit workers.

Malnutrition was the direct physical expression of the disruption in food supplies, and of the poverty of wage labour, persisting throughout the decades of colonialism. Food has been used as a weapon to undermine class struggle. During the liberation struggle in Zimbabwe, the Rhodesian forces attempted to starve the freedom fighters out through Operation Turkey, burning crops, limiting food supplies to protected villages into which people were rounded and preventing peasant crop production. As a result there was a 38% increase in infant mortality in the protected villages, largely due to undernutrition. (5)

The colonial racism of Rhodesia and South Africa resulted in a white population with amongst the highest standard of living anywhere in the world, and a black population living in sub-human conditions. The ratio in Infant Mortality in 1980 in Zimbabwe was 1 : 3,5 : 10 between whites, urban blacks and rural blacks corresponding to a 39 : 5 : 1 ratio in income in the same groups respectively. (7) In South Africa, the double oppression of race and class produces large differentials in mortality based on both factors.

Institutional separation of areas of poverty disguised in official 'national' statistics the burden of disease resulting from imperialist policies. The fragmentation of the homeland areas in South Africa in which 11 million people have been forced to live provided an institutional form to this segregation. Segregation within national populations allowed for administratively separate and technologically different forms of care to emerge: Extensive measures for environmental protection, drainage and sanitation were taken for the white community; nothing was done for resident black workers, who were

segregated at a distance to avoid the spread of disease , as they were regarded "as a serious menace to the health of the European community." (4)

In colonial Rhodesia and in South Africa ,Imperialism established a pattern of production in which the accumulation of wealth and the expansion of production was based on the physical wasting of the working people- farms,factories,mines and cities built out of the bones of its workers.

THE IMPACT OF IMPERIALISM IN POST INDEPENDENT ZIMBABWE

The removal of racist structures in Zimbabwe under conditions of continuing foreign economic domination removes only a part of this disease burden . Foreign ,private economic control is a conduit for the export of national wealth and continued peasant and working class poverty. Monopoly control over market prices and protectionism in decaying advanced capitalist economies produces declining terms of trade for Southern African goods, inflating prices on capital inputs in production and raising national debt .In Zimbabwe , this reached Z\$590 million in 1985 , with a debt service ratio of 28% . (8) Health is threatened by unemployment , and static or falling real wages . IMF and World Bank loan conditions call for wage freezes,reduced social expenditure and support of private production, robbing the masses of the means to better health.

These material conditions result in persistent levels of ill health.Mortality has clearly declined in Zimbabwe , but there is no evidence of declines in disease rates ,except in the group of immunisable diseases.(9) Targetted health interventions , such as immunisation and expansion of PHC and of accessible curative care are suggested to have had the major role in producing the observed reductions in mortality. (7,11) Reductions in undernutrition between 1980 and 1982 of up to 50% coinciding with rising wages and increased expenditure on social services appeared from surveys to plateau in the 1982-86 period of rising unemployment,static wages and rising food prices.(9) Unemployment and seasonal underemployment have been associated with raised levels of ill health and food insecurity.(12) Increasing capital intensity of production through import of foreign technologies is associated with a 2,5 fold rise in reported occupational accidents from 1975 to 1984 (11) , mostly of mechanical and chemical causes.

As imperialism intensifies the contradiction between corporate wealth and social squalor , attempts to improve the health status of the population to take on vital development tasks is seriously compromised. The experience of countries in Africa,Asia and Latin America is that despite targetted health interventions to improve survival, levels of child mortality and social disease are rising. (1) These inhuman consequences of imperialist policies have led UN agencies such as UNICEF to call for less painful ways of practising imperialism :called 'adjustment with a

human race, UNICEF avoids the source of the problem by calling for a more gradual imposition of the same policies ~~aiming~~ protection for the poor. Little specification of how that protection is to be achieved is given, apart from regularly monitoring the extent of their starvation. (1)

Sustained improvements in health poses the challenge of taking health out of the arena of medical curative interventions, and into an attack on the underlying imperialist structures producing deepening problems of ill health.

MILITARY AGGRESSION

Private monopoly interests have not been slow to use violence to protect their interests anywhere in the globe, and Southern Africa is a brutal example of that. Inside South Africa, state brutality engages in daily assault on citizens of all ages, with over 15 000 in detention since June 1986, subjected to physical assault, gunshot, electric shock, mental abuse and other forms of torture. In 1985, 1000 people were murdered by the state. (13) Doctors attempting to treat military abuse have practices surrounded by Caspers and police have been reported to have followed patients into surgery to continue interrogation. (15)

South African military aggression backed by funds and weapons from the United States of America and Western Europe, has destroyed economic and service infrastructures in the whole region. This has been most marked in the socialist economies of Mozambique and Angola. In these countries, South African aggression has undermined the economic progress which produced marked improvements in health. Infant mortality rates in Mozambique and Angola, which declined by 30% in the first years after Independence, have now risen to pre Independence levels. In Mozambique, 4 million people were reported to require food inputs, 2 million had lost access to health care and 25% of the primary health care network was reported to have been destroyed or forced to close. The direct death toll from destabilisation in Mozambique was estimated in 1986 to be 100 000. This does not include the indirect mortality due to undernutrition and disease arising out of the economic effects of war. (14) Destabilisation has also affected provinces in the south and east of Zimbabwe. Health workers are often the target of such attacks; the murder in August 1987 of health workers in Matabeleland, Zimbabwe is witness to this South African assault on people's health, backed with weapons and funds from imperialist countries.

The expenditure on the military industry globally of about US\$1 trillion every year represents "...conspicuous misuse and abuse of resources in the midst of poverty, hunger and disease." (R. Mugabe in 36) Every second, the United States spends US\$25 000 on arms. With 12 hours worth of this expenditure, all children in the world could be immunised against disease. The imperative for private profit directs skills and resources towards manufacturing weapons rather than towards solving social

problems.

EXPLANATIONS FOR ILL HEALTH

Health professionals have an important role in using knowledge and skills to explain the sources of ill health in this broad based attack on health problems. As imperialism robbed the region of its material resources, however, bourgeois scientists and policy makers consistently avoided or distorted the social and economic causes of ill health. Medical questions are answered from a mechanistic and depoliticised framework, looking towards individual cure rather than social causes for disease. Illness is explained as arising due to individual practices. This leads to a victim blaming approach to ill health, where ill health is seen as the consequence of peoples poor hygiene or incorrect lifestyles, rather than the social conditions producing those environments or lifestyles.

The history of health care under colonialism and apartheid is full of examples of this perception of ill health. Malnutrition has been attributed to incorrect eating habits and lack of 'home budgetting'. Dr C.S. Garbers, president of the Council for Scientific and Industrial Research blamed the 1982 cholera outbreak in South Africa on the blacks 'preferring to drink dirty water out of muddy pools, rather than the safe chlorinated water supplied by the authorities'. He ignored the political and economic conditions in which people did not have such facilities. (3)

One of the strongest of the victim blaming arguments is that of overpopulation. Ignoring the economic roots of unemployment, the global maldistribution of resources, and the social and economic factors which determine family size, poverty in developing countries is attributed to overpopulation, and overpopulation is blamed on the overbreeding and incorrect decisions of the poor. Massive promotional and contraceptive distribution programmes are mounted, often funded by United States AID. The USA, with 10% of the worlds population, swallows 50% of its resources, pays its producers millions of dollars to burn food mountains and keep land idle, and spends US\$25 000 per day on military weapons. It then points to the productive populations of Asia, Africa and Latin America as the threat to global resources. In South Africa, racism adds to the stereotype of the poor, so that black people are portrayed as the cause of their own poverty by breeding hordes of unkempt children. (3) Family planning services in South Africa have therefore continuously expanded, where other health facilities have been cut back. (3) Overpopulation is also given as the reason for the disparity between need and provision of services.

Victim blaming in occupational health blames accidents on the 'accident prone' worker. Protection against injury is often limited to the provision of protective clothing (essentially a last line of defence rather than the sole protection) and the

education of the worker , with limited action in changing the work environment and in workers rights to screening of new technologies..

Thus bourgeois medicine acknowledges the role of material factors in ill health as elements of individual responsibility:As the British Health Education campaign calls out to its citizens in the midst of the advanced capitalist crisis of growing homelessness,unemployment ,pension cut backs,and social service cut backs -

"Look after yourself!"

HEALTH CARE UNDER IMPERIALISM

Advances in science and technology have produced the skills to eliminate most of the communicable disease currently causing the bulk of our mortality . How are these skills used under imperialism ?

Medical professionals serving colonial companies used their skills to ensure that health problems such as malaria did not pose an obstacle to imperialist expansion . They also served their own interests in acquiring property. Dr L Jameson, a famous member of the colonial loot committee , used his medical skills to treat King Lobengula's gout after he withdrew the mining concessions ceded to the colonisers . Lobengula's decision after treatment to reassign the mining rights may or may not have had something to do with the large doses of morphine Jameson is reported to have used .(16) Health care was used to build the support of the local population. Flemming , in 1909 , referred to it as "...one of the methods adopted for attracting the natives" (16). One doctor commented in 1924, "The care of the sick is in most cases one of the most popular methods by which the missionary effort amongst native races endeavours to bring the native under their influence ."(16)

The reluctance to make any serious changes to the underlying factors to disease- wages,living environments ,social conditions and diet -and the search for rapid ,selective interventions together with premedical screening and some level of curative care developed as a relatively typical feature of health care provision in working class areas. Health care was carefully balanced against the cost effectiveness of introducing new labour and against the relative loss in surpluses due to ill health. Undernutrition ,for example, was important in so far as it undermined productivity.The theme of a Zimbabwe government film in 1948, "Dividends from diet" , emphasised "the economic return in efficient labour to be gained from the employer who feeds his native labourers properly".(17) In the 1970's multinational food companies were still advertising grain beverages for workforces with the slogan .."Watch your profits grow!" (18)

Strategies for dealing with the control of communicable diseases

often focused exclusively on the white population , regarding the black communities as the source of disease ."The native is the reservoir of infective tropical disease from which the European and his family is subject to invasion. Unfortunately the native carrier is commonly a perfectly healthy looking individual so that the European may not have the opportunity of realising until too late the danger to which he is being subjected." (19) The major forms of health care intervention in the black population were restricted to epidemic control and the provision of a limited level of curative care, particularly for the workforce. (20)

Health facilities were targetted at the propertied classes first, and then the urban working class population . For the rural and urban poor, inadequate poorly staffed facilities were rationalised by promise of referral to higher levels of care, usually inaccessible due to distance or cost. The provision of care was therefore highly fragmented ;missions provided services in rural areas, large mines and estates had their own industrial facilities, some government facilities serviced periurban areas and private health care providers existed in the main centers. Services were poorly planned and unco-ordinated .In South Africa, local authorities are responsible for sewerage, installation of electricity and other environmental services falls under the supervision of the central Department of Public Health , hospitals are run by Provincial authorities and control of infectious diseases is run by the Central Government Public Health Programmes.

The greatest fragmentation of services in South Africa was established in the 'homelands', where the responsibility for the provision of care was discharged by the Central government. The new tripartite system of government intensifies this isolation , with the responsibility of health in the 'Own Affairs Department' and the budget met by the 'homeland' authority without any source of revenue. In Kwazulu, for example , the entire health budget in 1982 was R60 000 000, the same as that spent in one white hospital in Johannesburg. (3) A third of the South African population reside in these areas , suffering amongst the highest levels of ill health, with the least provision for health care.

The rationalisation for this inverse care was summarised in the Rhodesian case by Dr Webster , the Secretary for Health in 1973, stating

"...we have a relatively small, advanced population with sophisticated demands for modern and therefore expensive medical facilities. At the other extreme we have a massive and increasing demand for simpler facilities , and between the two we have an emergent class who mainly need the latter , but tend to demand the former." (20)

Curative care for the few dominated , drawing up to 90% of health budgets .(21) Curative care was sold as a commodity, linking the interests of medical professionals to those of multinational drug

and medical technology companies and to the private sector ,who paid generously for their support and service .By 1980, of all the doctors in Zimbabwe, 42% were practising in private , with 80-90% of these in the two main urban centers,Harare and Bulawayo. (24)This private sale of medicine provided practitioners with power,prestige and wealth.They looked first to opportunities for promotion outside the country ,rather than in underserved national areas,draining the subsidies on their training away from their home countries. Only 11% of doctors in colonial Rhodesia were practising in rural areas. (20) In South Africa ,only 3% of practising doctors are in the 'homelands'.

This unequal distribution of health services was strongly supported by the system of health care financing .In Zimbabwe ,80% of whites and a small proportion of blacks comprised the 220 000 people covered by private medical aid at Independence.

(7) This paid for high cost private care with about \$4,5 million subsidy from the government per year. Medical Aid society members were estimated to obtain 25% of the health budget .(7) With strong company subscription and support of private sector care , medical aid societies linked with the National Medical Association (of doctors) to become the spokesmen for business interests in health policy. (23)The ratio of expenditure on health care per capita in the Medical aid : urban public sector : Rural Public sector in Rhodesia was \$144 : \$31 : \$4 respectively. (7) The state used public resources to subsidise private care for the wealthy .Patients at Parirenyatwa received in 1979 state subsidies per person 55 times higher than those in rural hospitals serving the rural peasants, and twice as high as the comparable facility serving the black urban working class. (27)In South Africa in 1984/5, 40% of the health budget was spent on private care. (3)Gross overcrowding of public facilities was matched with underutilisation and high per capita expenditure in the private sector.

The distorted pattern of health care delivery allowed the sale of expensive technology to a minority of the population : non essential drugs at high cost under the control of the private multinational drug industry, laboratory test procedures and curative technologies unavailable to the majority of the population. Private medical care , and its funding through medical aid , meant that these resources could be made available to a limited section of the population at high cost , maintaining the profits of the related industries. At the same time , companies such as Nestle's,producing breast milk substitutes , and pharmaceutical products like Mr Strong (a tonic), analgesics like aspirin and cafenol, anti diarrhoeal agents like kaolepectin and long acting injectible contraceptives like Depo Provera were marketted to the working class and peasantry , despite their known side effects. In many cases ,these were distributed through unregulated traders . This shifted the costs of care onto the working classes and peasantry , freeing public resources for use by the elite.

The restriction on education for blacks under colonialism and apartheid meant that few blacks could become medical professionals, being allocated to technical or service posts at much lower rates of pay. In South Africa, one in every 350 whites is a doctor; in the black population the ratio is one in 45 000. This job reservation, initially based on colour and increasingly based on class coincided with the distribution of medical manpower and the rates of pay. In Zimbabwe, for example, medical assistants, often from poorer backgrounds, tended to staff (unassisted) rural primary levels of care. They received salaries less than half that of SRN's in 1980 although often in sole responsibility for frontline health facilities. (7) Doctors salaries were 13 times that of medical assistants and 66% of those in state service worked in the main referral center. (23)

Medical professionals served monopoly interests in the pay of or on the boards of directors of multinationals, ignoring occupational health problems. Medical studies carried out by the companies (using foreign expertise, as in the case of Turner and Newall on asbestos) are private property, and inaccessible to workers. Workers do not have rights to compulsory information on the production processes or approval of any new processes. These are fertile conditions for the export of hazardous technologies, particularly as rising import costs and demand for increased productivity places increased pressure on capital imports.

These inadequate provisions were noted in the 1942 Gluckman commission in South Africa, which reported the failure of the South African health care system to deal with the high levels of disease, its inadequate and unco-ordinated nature, and the adverse effect of private care in distorting resources away from need. (3) This commission proposed state responsibility for health care, the adoption of primary care, centered around the establishment of community health centers and the provision of free services. Special taxes were advocated to meet the costs of such a service. A co-ordinated National Health Service would employ curative and preventive staff, so that all doctors would in time become state employees. This proposal, which attacked some of the fundamental bases of bourgeois health was sabotaged through a number of means:

- the provincial governments refused to hand over health care to the state, thus denying financial resources for implementing the plan.
- the government refused to implement a health tax.
- the medical profession opposed it on the basis of interfering with their independence and lucrative private practices.

The Gluckman commission represented an attempt to implement a national health service in the context of a society built on division, oppression and exploitation. Policy recommendations for broad based integrated care proposed to state institutions serving narrow minority interests could not succeed without a base in democratic organisations and the force of class struggle. The Nationalist government of 1948 used more extreme coercive tactics

to control black struggle than health care and it was not until 1977 following the popular uprisings that even lip service began to be paid to preventive care , as in the Public Health Act of 1977.

In the 1970's , the impact in Zimbabwe of regional political changes , and the growing force of the national liberation struggle , made it an urgent priority for the propertied classes to maintain the skewed distribution in health care in the face of nationalist, anti racist struggles, and thereby maintain their own high level of health care provision. This produced a series of attempts in the period immediately before 1980 to remove the racial elements of the old health system , and establish some compromises for the higher income sections of the black working and petit bourgeois classes. As one of the medical aid society representatives stated,

"In 1976, when Dr Kissinger met Mr Vorster and Mr Smith in Pretoria , it became apparent to medical aid societies that majority rule would shortly become a reality. The national Medical Aid Societies therefore began to work with the medical profession on ideas as to how the private enterprise system could adapt itself to cater for the new demands of the majority rule government. In working with the medical profession it became clear that the great fear among practitioners was that the health service would be nationalised."
(Handley V. Quoted in 20)

The attempt to defend against nationalisation and the withdrawal of private practice included the integration of hospitals to remove the racial barrier on treatment , and maintain the barrier on a fee paying/state patient basis . This would imply greater class definition in health care provision. The removal of barriers to the practice of African doctors and an increase in medical aid coverage to include certain sections of the black working class was also proposed to co-opt aspirant black medical professionals into supporting a model of health care in which class , rather than race , would continue to maintain minority privilege . Independent of , although highly subsidised , private care could thus expand at its own pace. (20) The Medical Services Act 1979 provided the legal basis for medical aid societies and established their right to construct and control private hospitals with corporate share ownership. (20) The Cohen report makes no mention of rural health care . The major theme of the report was thus an attempt to avert a national health service addressing inequalities in care .

In South Africa, a Commission of Inquiry into the Health services in 1984/5 , the Browne Report, examined the health services . Like the Cohen report, it excluded the bulk of the rural population, by excluding the 'Bantustans'. The commission pointed to the lack of central policy direction and the negative effects of fragmentation of care. The over emphasis on tertiary care and

insufficient primary and preventive care was noted ,along with inadequate training of black health personel. The minimum requirements for health are listed as drinking water,sufficient food,sewerage and adequate housing.(25)

These 'minimum needs' applied only to labour working in white areas,and not to the 'Bantustan' populations. In addition expenditure would have to be "...discharged with regard to the economic realities,the demands of the social and physical development and the ever increasing population which could lead to a disparity between what is required and the funds available." (25)

The major area of uptake on the commissions report in the black population was in the question of family planning,bypassing questions of improvement of care and referring improvement of living conditions to the local authorities. The Orderly Movement and Settlement of Black Persons Bill and the Black Communities Development Bill excluding blacks from central government placed the responsibility for health services for urban and rural black communities on locally raised resources.(25) Thus the verbal recognition of the importance of primary care was made while abrogating all financial responsibility for that care.At the same time a firm commitment was made towards expanding private care and contracting out ancilliary services to the private sector.

These policies in both pre-Independent Zimbabwe and in South Africa in the 1980's,represented an attempt to divorce health professionals from the broad national struggle of the masses , and to preserve a private and distorted provision of health care. They encouraged an elite core within the local medical profession to serve monopoly capitalist interests,against the needs of the mass of the population.

Such attempts to entrench inequalities in health care provision met the conflicting and popular thrust for a national,integrated and comprehensive health care system from the national liberation movements and the popular struggle.

HEALTH IN THE STRUGGLE FOR NATIONAL LIBERATION

The national liberation struggle in Zimbabwe demanded the removal of racial barriers to property and professional status .Access to adequate health care was identified as a 'basic human right'. (26) The emphasis was on a democratic approach to health care ,with people as the main protagonists and the main beneficiaries.The social organisation of health care was seen as the primary framework,within which technical inputs would be made. (Cde Ushewokunze,27)Professionals , not all "...immune from the occupational disease of paternalism " were encouraged into active collaboration with the community and a wider involvement in health than curative care.(27)Total coverage of the population with acessible care implied a restructuring of the health

services away from the private, curative trickle-down approach of the colonial period. It meant an increase in the rural primary care share of the health budget (7) and the adoption of the primary health care policy of accessible care for all. (2,7,31)

Popular struggle pushed for more however than a reorientation of public sector resources. Workers and peasants in the struggle called for land, and the restoration of national wealth to the people. The reduction of ill health and the organisation of comprehensive health care would demand not only a redistribution of social resources in health care, but changes in the control over production of those resources. Health planners at every level would link with the sociopolitical structures in order to ensure responsiveness to popular initiatives and accountability of the service. The political manifestoes of the liberation movements, ZANU and ZAPU, both stressed the role of popular control of Zimbabwean resources. The scientific socialist manifesto of ZANU(PF), adopted at its first congress in 1963 indicated the need for socialist transformation of the economy to give expression to real democratic demands, including those for a healthy existence.

The force of worker and peasant action pushed these social and economic issues into the health arena. The freedom fighters, some trained in health care, responded to and further mobilised this force. Guerilla medics dealt with peoples' expressed health needs with whatever skills and material resources were available, at the same time linking their explanations of ill health to the broad political and economic struggle. The weapons of medical knowledge and skill were used in the service of the broad population, to meet their immediate needs and to support their consistent anti-imperialist struggle.

The level of anti-imperialist struggle in South Africa has reached an advanced stage, with popular mobilisation in almost all areas against the state structures supporting imperialism issues as instruments of struggle, so that health workers have been challenged to redefine the bourgeois role, and join in the broad democratic struggle. Hence, in South Africa, democratic professionals have organised the National Medical and Dental Association (NAMDA) contrasting with the minority interests of the Medical Association of South Africa, to expose the health consequences of apartheid, and to use their skills to support democratic struggle. This linkage of health skills to the broad political struggle of the masses is evident in the liberation movement. It is embodied in the Freedom Charter, propounded at the Congress of the People in 1956, and adopted by the African National Congress (ANC) and the majority of the people of South Africa. In respect of health care the charter calls for a preventive health service, run by the state and free medical care for all, with special attention to mothers and young children. It also provides that the aged, the orphans, the disabled and the

sick shall be cared for by the state. This social responsibility for health is seen as part of an overall economic strategy which places national resources in the hands of the people.

THERE SHALL BE HOUSES, SECURITY AND COMFORT-the right to live where one chooses in comfort and security
THE DOORS OF CULTURE SHALL BE OPEN -free compulsory, universal education
ALL SHALL BE EQUAL BEFORE THE LAW; THE PEOPLE SHALL GOVERN-every man and woman shall have the right to vote
THE PEOPLE SHALL SHARE IN THE COUNTRY'S WEALTH-the mineral wealth, the banks and monopoly industry shall be transferred to the people as a whole, and other industry and trade be controlled in the interests of the people.

The struggle for health is thus viewed as involving all material and social sectors, linking engineers, doctors, industrial workers, lawyers, agricultural workers and so on. The popular and vanguard forces within the liberation struggle demanded comprehensive democratic health care resting on the transformation of ownership of productive resources in the societies away from private foreign ownership. Their health actions were in conflict with those imposed by imperialism, through its local allies. Productive resources would be used towards social well being, so that health became a social, not an individual responsibility. They attacked the material base to ill health, so that individuals could have the means to take action to improve their health. They demanded that all those with knowledge and skills use them in the service of these ends, accountable to democratic structures. This meant that health would be the responsibility of many inputs, and not just that of medical services.

HEALTH CARE IN ZIMBABWE, POST 1980

Post Independent Zimbabwe gives evidence of the continued attack by imperialism on these aspirations of the masses. Popular demand for economic change in Zimbabwe has been frustrated by current de facto reconciliation with capitalist relations of production and continued foreign domination of the economy. This has placed fundamental economic barriers on the application of progressive health policies.

In September 1980, in the climate of expectation post Independence, free medical services for those earning less than Z\$150 per month and free primary schooling were announced. In February 1981, the discriminatory Medical Services Act 1979 was repealed, abolishing the racial segregation of facilities.

The major change in health practice has been the adoption of primary health care, with its objective of reorienting the health sector towards accessible curative care and community mobilisation over the spread of disease. Primary Health care

expanded greatly ,mainly in the peasant areas , mobilising social resources through the state (financial) or community (human). (9)

Curative and preventive structures were integrated into the district and provincial health team structures , accountable both to higher levels of the health structure and to the relevant local government structures. Targetted interventions , such as immunisation , growth monitoring and the promotion of oral rehydration solution increased in coverage. (30)

This expansion in certain elements of primary health care required an expansion in government expenditure. In current price terms , there was an immediate increase of 44,7% (27,5% in real terms)in the Ministry of Health Budget , increasing its share of the budget to 5,1% . This growth increased into the next budget year , so that by 1982 , the MoH actual expenditure had almost doubled.The integration of services implied an increased burden on Ministry funding . In addition,while the medical services share of the budget declined, the preventive share increased ,reflecting changed Ministry of Health philosophy.(31)

The expansion in real health sector expenditure occurred during the period of high economic growth and wage increases of 1980-82 Expanded facility coverage , free health services and rising real wage rises increased utilisation rates of health care by 2 to 3 fold .

In 1983 , the IMF loan agreement signed by the Zimbabwe Government resulted in reduced public sector expenditure and a reduction in wage increases .(32)Declining terms of trade and private,foreign expropriation of surpluses and export of capital led to increasing fiscal deficit and increased goevernment borrowings . From 1983 , the state raised its credit worthiness by following an orthodox IMF-type stabilisation programme .This turned the real increase in expenditure on social services in 1981/2 into a real decrease of 9,1% in the 1982/3 fiscal year. (31)This restraint on expenditure continued into 1985/6 ,so that at a national level between 1982 and 1985 ,less funds were available for expenditure on health within the public sector. (31)Important legal and administrative measures have been taken to control the private sector , such as the requirement for public service in graduating doctors, the removal of private practice in goverment doctors , the establishment of an essential drugs list for the country and abolition of the free use of state facilities by private doctors. The public sector however continues to subsidise prive care through tax abatements to the amount of about Z\$17 million per year.(33)The essential drugs list does not apply to the private sector , and drugs imports still compete in foreign exchange with luxury pharmaceuticals .A high proportion of doctors remain outside the public sector, compared to other grades of health manpower, working in facilities which are underutilised in relation to the crowding of public services. The wastage in subsidised training and practice of this loss of manpower undermines adequate care in the public sector.

Changing the conditions underlying ill health and organising health care to meet national needs become increasingly difficult under current conditions of export of capital, of national debt, of rising unemployment in the formal sector and of command of national productive resources by foreign companies. As is evident in the national liberation struggles of the region, meeting the force of imperialism which undermines both the material and social conditions for health requires the marriage of the skills of regions health professionals and the mobilisation of its masses. Imperialism, which tries through professional elitism, through bourgeois education, through material incentives and through military force to divorce health professionals from the masses poses a historical challenge to progressive forces within the region, including health workers and medical professionals. It is a challenge in which we can make one of two broad responses :

We, as health professionals, can retreat into narrowly defined, vertical, technological practices of health care. We can use health as a means of accumulating private wealth, treating the few and ignoring the masses. We can work for imperialism, searching for cheaper 'fixes' to use within the narrowing boundaries of socially available finances. We can ignore the causes of ill health and the maldistribution of health care. We can define our role as technicians and scientists, sold to the highest bidder, and divorced from the broad social and economic struggle. We can shun working within the sociopolitical struggle, and using the skills we have to develop political organisation and understanding through health issues. We can pretend to be apolitical, while in fact we act on behalf of imperialism in the region.

We also have the choice to recognise the contradiction between imperialism and improved health and to use our science in the class struggle. We can address and teach about health problems from their social and economic roots upwards; We can identify and demand accountability in production processes for the ill health caused; We can demand a social responsibility for meeting health care, and contribute in restructuring the whole health service towards meeting national needs; We can bring popular mobilisation into health care by working in the context of mass democratic organisations, and push for social control of the productive resources needed to meet health needs. We can broaden our contact with progressive health workers, particularly from socialist countries which have advanced the anti-imperialist struggle, and exchange experience and expertise in recognition of our common grounds.

In the struggle in South Africa, it is obvious that a health service which responds to the needs of the masses cannot be built under conditions of apartheid, so that the immediate challenge to medical professionals is to fight to remove apartheid at all levels. Health workers who have the respect and attention of the

community they serve have a role in raising political awareness of the causes behind the health problems experienced and the lack of health care. Medical skills can be used to mobilise at union and community levels. Within the region, health professionals have a role in raising the understanding and awareness of apartheid's attack on the whole regions health, as it acts for imperialism to undermine our economies and to destabilise us militarily, socially and economically, and our demand to remove this diseased system.

These challenges, in the national liberation struggle in South Africa and the continued struggle against imperialism throughout the region, cannot be met by individual health workers. It requires a collective organisation both within and beyond the health profession. Health professionals need to build democratic organisations which link health workers at all levels to contribute to and promote progressive health policies. These organisations need to work with sociopolitical structures, with other national democratic organisations of lawyers, engineers, builders and so on, and with democratic health worker organisations in other countries. In our struggle against imperialism, health professionals have to take the bullet of knowledge and skills to the machine gun of popular struggle, to mortally wound imperialism.

Health workers in the region have already shown this commitment. Like Comrades Samora Machel, Vijay Ramlakan, Sibongiseni Dhlomo and other liberation cadres, when the moment demands, the medical kit is used in one hand and the gun in the other. Like Steve Biko and Neil Aggett, the struggle is taken into the frontlines of the mass organisations, and remains uncompromising in the face of state brutality. Like the countless health workers in Mozambique, Angola, Zimbabwe and other frontline states who do not leave their posts in the face of military aggression the commitment to the struggle for health is unwavering.

The vitality and organisation of the intellectual, social and political forces daily gaining momentum will be the treatment which expels the parasite from our region for once and for all.

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