Demographic Transition, Health Care and Social Security
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Demographic Transition, Social Security and Health Care: The South African Case*

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I. Introduction

My task is to present an overview of population transition, social security, health and health care as these sublimate in South African society. Due to both the magnitude and the diversity of this topic, I necessarily have to limit myself to fragments and flashes of the real situation only. By doing so, I knowingly run the risk of presenting an incomplete, selective and overgeneralised picture, thus portraying a somewhat simplistic, unbalanced and even dramatised view of the extremely complicated and multifaceted South African

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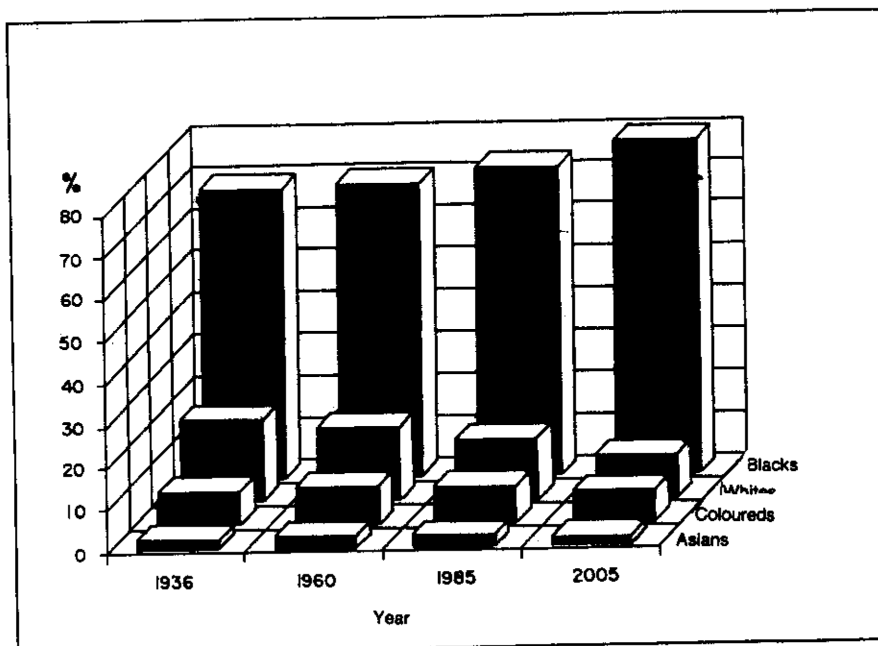
reality. In order to touch on the numerous important aspects contained in the theme, I am also obliged to present the relevant material rather fragmentarily, summarily and too briefly, nevertheless trying to illuminate the interrelatedness and coherence among the different components at stake, as well as to highlight those aspects which deserve particular attention in social and health policies and programmes.

In sequence I shall:

- reflect on the South African population, with special reference to its composition and those trends, changes and transitions which pose explanations for problems and complicate possible solutions;
- present some selected data reflecting aspects of social security which, however, rather portray a conspicuous lack of or grave deficiencies in social security in South Africa, and obviously stemming also from the general population situation;
- reconstruct the health and health status of the people, with reference to prevailing morbidity and mortality profiles and discernible trends in these;
- review the health care supply in South Africa, with concentration on the problematic features and deficiencies of the existing dispensation;
- in conclusion, I shall share some views on prospects of the future.



Source: Van Rensburg et al., 1992: 98

Figure 1: Trends in the Race-Ethnic Composition of the South African Population, 1936-2005

II. The Population: Structures, Trends and Transitions

With regard to the South African population, the demographic data to follow, summarise the prevailing characteristics of this population, illuminate the important trends and transitions, and touch on the dominant, related problems facing the country. The focus is primarily on the situation and changes, rather than on explanations and causes.

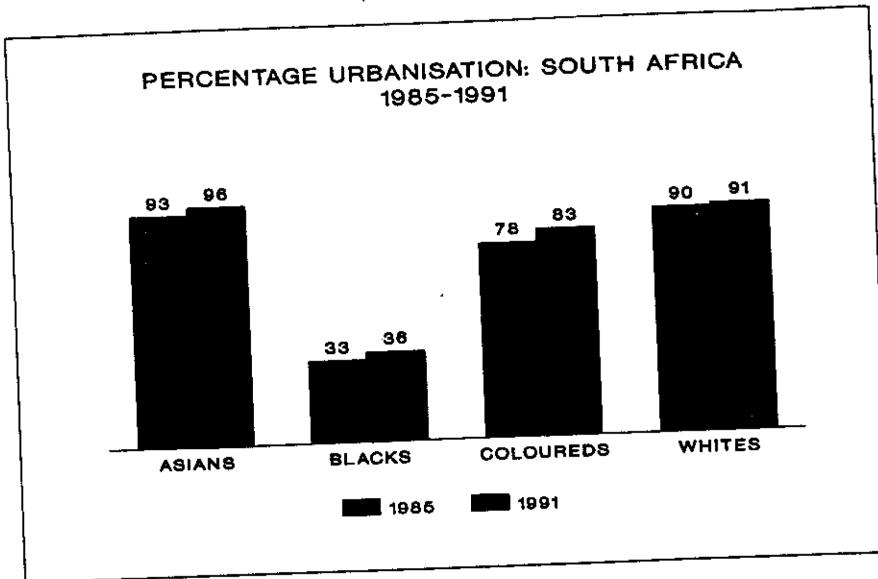
1. The race-ethnic composition of the South African population

One of the more noticeable features of the South African population is its distinctive race-ethnic composition, more specifically its racial and ethnic heterogeneity and diversity. The larger South Africa is inhabited by a population which in 1990, amounted to an estimated 37 million, at present growing at a rate of 2.4% per annum. The current composition of the population in terms of its broad fourfold division is shown in percentages in Figure 1. Owing to different growth rates — 0.8% whites, 1.5% Asians, 1.7% coloureds, 2.8% Africans (Cooper et al., 1993: 256) — this composition has significantly changed and will further change over time.

In 1990 Africans constitute an approximate 75%, whites 13.5%, coloureds 8.6%, and the Asians 2.6% of the larger South African population. A systematic trend towards the increasing Africanisation or blackening of the population is conspicuous.

2. The rural/urban distribution of the South African population

In 1990 an estimated 22 million people or 63% of the population of South Africa (including the ten homelands) were urbanised (note: in the South African context "urban" is defined as any populated area with some form of local authority); by the year 2000 it will probably grow to a projected 75% (Cooper et al., 1993: 45). Figure 2 presents more detail on the level of urbanisation in South Africa, especially as this trend manifests in the respective population groups in recent years.



Source: Department of National Health and Population Development 1992: 23

Figure 2: The Level of Urbanisation (Percentage) of the South African Population 1985-1991

Despite the many advantages urbanisation holds for the South African population, amongst other things, improved education services, job opportunities, transport facilities, water supply, sanitation, and more accessible and available health care, the scope and rate at which urbanisation is presently taking place, especially among the black population, present several problems and disadvantages for the health and social security of the population. In this regard Yach (1990: 22) is quite specific when saying that the major disadvantages regarding health include the possibility of exacerbating poverty and slum conditions—particularly in the peri-urban areas of the cities — giving rise to increasing nutritional deficiencies, declines in child survival and increase in conditions

associated with overcrowding, such as tuberculosis. A second group of conditions related to the pace of industrialization as well as consumerism that accompanies urbanization, result in urban pollution — particularly increases in air and marine pollution with consequent detrimental effects for health. Consumer pressures during urbanization increase the consumption of tobacco, alcohol, and high-fat food and are associated with a decline in physical activity resulting in increases in ischaemic heart disease and lung-cancer rates. A third major group of adverse health conditions includes the effects of high levels of social and political instability that often accompany unplanned and rapid urbanization, particularly in developing areas. This has been seen to give rise to substance abuse, increases in sexually transmitted diseases (including AIDS) and a high level of assault.

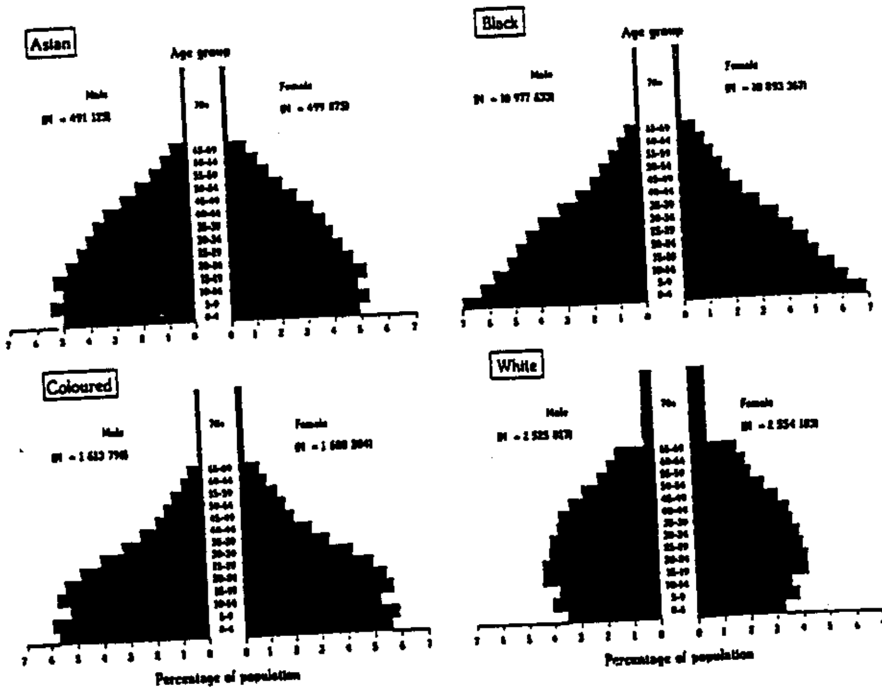
3. The age structure, birth rate and life expectancy of the South African population

In 1991 the general age structure of the South African population was as follows:

< 15 years	34.64%
15-64 years	61.07%
> 65 years	4.29%

(Department of National Health and Population Development 1994: 23).

The age structures of the different population groups are quite divergent, as explicated in Figure 3.



Source: Department of National Health and Population Development 1994b: 25.

Figure 3: The Age Structures of the Different Population Groups in South Africa, 1991

Demographically whites clearly constitute the oldest of the four population groups. In 1985 this population group had contained an elderly component of 8.5%, while white youths (under the age of 15) represented 25.2%, which almost matches the 25% notch of societies with aged populations. The three remaining population groups could at that time still be classified as predominantly young populations: the relevant percentages being for Asians 2.8% and 34.1% respectively, for coloureds 3.3% and 37.0% respectively, and for Africans 3.0% and 42.9% respectively. In 1985 the median ages

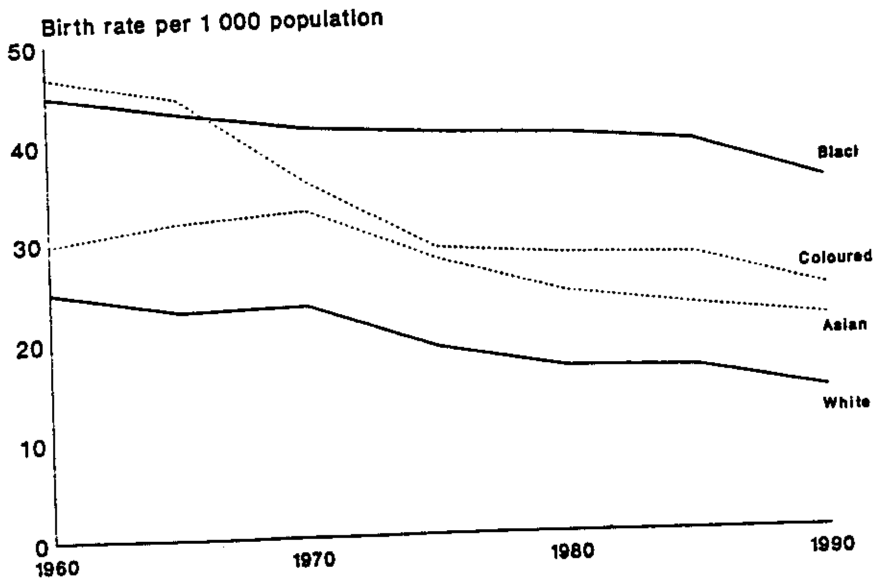
of the respective population groups were in descending order: whites 29.5 years, Asians 23.3 years, coloureds 21.3 years and a particularly low 17.9 years for Africans (Hofmeyr and Ferreira, 1990: 92). Furthermore, indications clearly are that all four population groups are systematically aging, and that the white population will have reached a very high degree of elderliness by the year 2005, while more than 3% of the total South African population will be 65+ years of age.

As a matter of fact this particular age structure poses an immense dependency ratio which in 1990 amounts to a child dependency ratio of 63 and an elderly dependency ratio of 6; for the different population groups the total dependency ratios amount to the following: whites 50.1; Asians 56.0; coloureds 64.4 and Africans 76.6 (Department of National Health and Population Development 1992: 8, 9).

Birth rate is also an important demographic factor, which normally has significant effects on prevailing social and health problems. In addition, birth rate — and trends therein — is an important determinant of the age structures of populations. In 1990, the birth rates of the different population groups were: whites, 1.37%; Asians, 2.04%; coloureds, 2.22%; and Africans 3.5%. Figure 4 depicts the recent state of the birth rate of the South African population, differentiated for the four population groups, as well as trends over the longer term.

As regards life expectancy in 1992 the average for the entire South African population was 64 — whites 73, Indians 67, coloureds 63 and Africans 63 (Cooper et al., 1993: 258). Moreover,

the trend is clear: the life expectancy of all the population groups shows a consistent increase. However, the rise in life expectancy did not take place uniformly in all the groups; nowadays, the greatest gains are noticeable in the non-white groups.



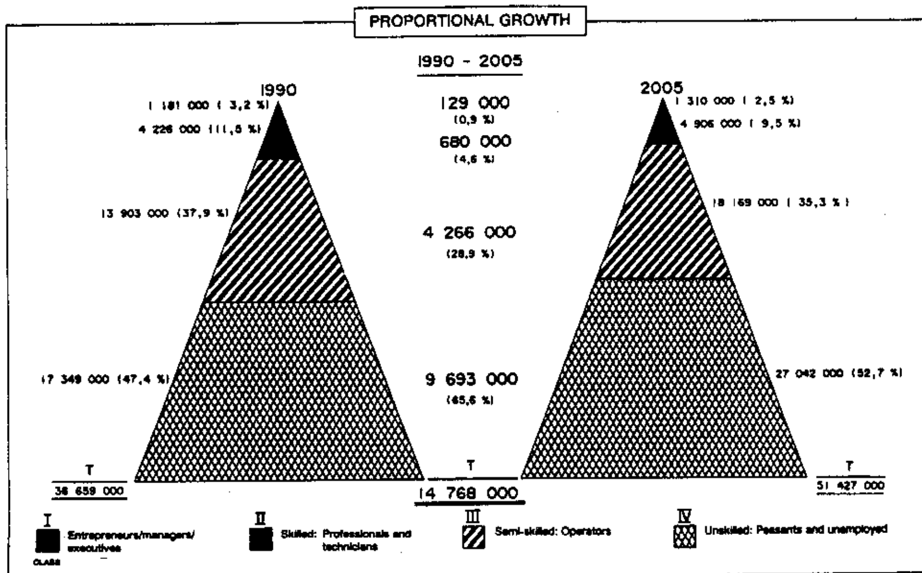
Source: Department of National Health and Population Development 1992: 12

Figure 4: The Birth Rate of the Different Population Groups in South Africa, 1960-1990

4. The socio-economic division/class structure of the South African population

People's socio-economic status is of direct importance to the risks of poor health, disease and death they are exposed to. Their class position is closely linked to the measure of education their children receive, the house in which they live, the occupations they

pursue, and the income they earn; it co-determines their life expectancy, their life chances, and the nature of the diseases to which they are exposed and the severity with which they are struck. In as far as the total South African population is concerned, Sadie (1991) constructs the following illuminating class division (Figure 5), with a projection of how the proportional share of each class will change in future. Bear in mind also, that the socio-economic status division in this country noticeably concurs with the special internal race-ethnic differentiation of the population. The white/non-white divide therefore coincides with the preponderance of "haves" among



Source: Adapted from Sadie 1991

Figure 5: The Class Composition of the South African Population and Trends in this Respect, 1990-2005

whites and that of "have nots" among non-whites. For long the inherent rigidity of the existing socio-economic division has largely tended to a caste-like partitioning.

On grounds of his projection, Sadie (1990: 194, 195) sketches a rather sombre demographic and economic, and by implication also health and social security picture for the future. Says Sadie: "[T]he greatest offence perpetrated against the generations to come is that millions of children are being brought into the world without any prospect of enjoying a decent life. Within Class IV the chances are one in four that they will be born to a mother who would not harbour the necessary nutrients in her body—because of poverty and the high birth rate coupled with inadequate spacing of children—to produce a healthy child, who, because of inadequate nutrition and informal education on mother's lap, will not enter school as an alert child who could benefit maximally from education, and who, when he or she reaches the age of entry into the labour market, will have no more than one chance in four to obtain a job in the modern sector. He or she is doomed to eking out a precarious existence in self-eremployment in the informal sector or to living on charity. And he or she is unlikely to have the drive, energy, perseverance, achievement, motivation, etc, to move into the entrepreneurial/ managerial class. It can be shown that the economic value of a person in Class IV is negative. One cannot conceive of an attribute in a postapartheid society that will dispel the gloom or lay the ghost."

III. Social Security in South Africa

The foregoing highlights of the South African population and its transition already foreshadow some of the demands put to the social security armament of the country. One logical deduction is that these demographic conditions create a climate in which the social security system will in all probability be overtaxed, with subsequent large-scale insecurity for scores of people in most dimensions of social life. In this section we review data which portray this rather fragile fabric of social security in South Africa. Though not presented in a complete and systematic way, the selected information nevertheless leaves us with little doubt as to the relatively to highly insecure social reality within which many South Africans are at present living. In this regard, it must be emphasised that South Africa has never represented a good example of social security — especially not in those dimensions of the population where economic, social and political deprivation has always been rife, due to the well-known and prolonged atrocities of colonialisation and apartheid. Furthermore, there is sufficient evidence that the recent social-political transition has also rendered social security in the country extremely fluid, and has in many respects overburdened the safeguards of the social security system.

To reflect this sad situation, a series of statistical data portraying social security in South Africa, or rather the lack thereof, specifically among certain sectors and groups of the population, is presented here, again in an all too selective and fragmented way. From these flashes the complete picture can be filled in without much effort, especially bearing in mind the aforementioned

demographic conditions and trends. Poverty, crime and violence, and accidental disaster receive more extended attention in this consideration of social security in South Africa, due to the critical scope and escalation of these problems in recent years.

1. Poverty

(1) *Status of poverty*

Poverty takes on an enormous scale in South Africa, with sure indications of a continued and gradual impoverishment of the population. In 1985, 15.5 million people were considered poor; in 1990 the estimation was 17,1 million, with a projected 18.4 million in 1995. In 1992 it was estimated that about 50% of the total population and 66% of the African population lived below the Poverty Datum Line (PDL = estimate of the income needed by any individual household if it is to attain a defined minimum level of health and decency) (Cooper et al., 1993: 169, 197, 199). Regarding the black population in particular, Simkins (*Sunday Times*, 22.09.1991) reported that about one-third of black households in cities live below the Minimum Living Level (MLL = the minimum income needed for subsistence in the short term), though this proportion rises to just over 50 per cent on the fringes of cities under homeland jurisdiction. Poverty levels in smaller towns are slightly higher, and in the homeland rural areas 84% of the people were termed "in poverty" in 1985, 82.6% in 1990. Despite the enormous magnitude of poverty, according to an estimate, 300,000 people in South Africa may be unaware of their right to receive welfare grants.

It must be emphasised that poverty in South Africa is closely linked to race, geography, age and gender; it is also related to the high population growth; furthermore, poverty concerns not only income, but also implies dirty drinking water, malnutrition, poor housing and dismal health prospects.

(2) *Unemployment*

It was estimated that in 1991 about 5.4 million people, representing 40% of the Economically Active Population (EAP = all persons, irrespective of age, who are employed, both formally and informally, or self-employed) in South Africa (including the ten homelands) were without formal employment. Of this figure 2.5-3 million were active in the informal sector, while another 2.5-3 million (18.3% of the EAP) were unemployed. Unemployment by race indicates that it was the highest among Africans, at 25% of the African EAP (1.6 million people), while the coloured unemployment rate as a proportion of EAP was 17% (202,000 people), the Indian rate, 13% (43,000 people), and the white rate, 4% (83,000 people) —the latter figures excluding the independent homelands. Furthermore, about 70% of unemployed Africans were under the age of 35 (Cooper et al., 1993: 43, 178, 179).

(3) *Housing*

South Africa experiences a severe housing crisis. To eliminate the existing housing backlog, it was estimated in 1992 that 198,000 houses needed to be built each year for the next ten years. As a result of this backlog, but also due to large-scale and rapid urbanisation, squatting occurs countrywide and has grown to a tremendous social problem. There is approximately 7 million people in South Africa living in informal settlements, as squatters and

backyard dwellers. To qualify this housing situation in South Africa further, the following observations are applicable (Cooper et al., 1993: 47, 48, 105, 189, 210, 234, 237, 238):

- In 1991 only 33% of the rural population (excluding the homelands) had housing of an acceptable standard (the structure provides health protection and enough sleeping space); 42% of houses surveyed were structurally inadequate for health protection (the structure is a risk to health and sleeping space is overcrowded), while 50% of the rural population had inadequate sleeping space (is overcrowded).
- In 1992 23 million people (approximately 57% of the population) in South Africa (including the homelands) did not have access to domestic electricity; there were 208 townships in South Africa (excluding the independent homelands) where at least 70% of the households were without electricity; in the homelands less than 10% of the population had access to electricity.
- Early in 1992 some 12 million people (approximately 30% of the population) in South Africa had no access to a water supply of reasonable quality; furthermore, 61% of the rural population of South Africa (excluding the ten homelands) had no access to safe drinking water.
- Seven million, i.e. 33% of the South African population (excluding the independent homelands) had minimal sanitation provision, and only 24% of the rural population of South Africa (excluding the ten homelands) had access to adequate latrine facilities.

(4) *Malnutrition*

Operation Hunger estimated that 12 million people in South Africa are unable to acquire sufficient food to maintain themselves at an adequate nutrition level; some 4 million are in a critical and potentially life-threatening situation. Another source revealed that 31% of rural pre-school children had been underweight owing to poor nutrition.

2. Crime and violence

(1) *Crime*

According to Ramphele, communities undergoing social disintegration displayed the following behavioural patterns: low job participation with both high unemployment and high rates of unemployability; high alcohol and drug abuse; low performance in all spheres of life, including school education and skills training; high crime rates and endemic violence at all levels of social interaction; and despair and acceptance of the "victim image". In addition, poverty, overcrowding, migrant labour and a general sense of worthlessness had weakened the ability of the family to face the challenge of coping with politicised and rebellious youth or the "lost generation", as it had become known (Cooper et al., 1993: 199-200; Ramphele, 1992). Such is precisely the situation that has arisen in many communities in South Africa. There is widespread disrespect for the law, and crime in its many diversified forms has become important survival strategies or coping mechanisms for scores of people living in desperate conditions. An alarming and ever-escalating level of crime is the result, as explicated in the following reported cases of crime (Table 1)—the real level certainly several times higher.

(2) *Child rape*

Reported cases of child rape increased from 1,707 in 1988 to 2,915 in 1991, i.e. by 71%.

(3) *Political violence*

Owing to its political history, South Africa has had a long and at times ferocious history of political violence. In the last three decades this kind of violence has taken on alarming proportions, and most recently it escalated to the extent that it jeopardises the fragile fibre of the social security system of the country. In comparing violence of the 1970s, 1980s and 1990s, the following pattern of escalation is observable: During the 1976 uprisings (June 1976 to October 1977) an average of 40 people died monthly. During the 1980s (from September 1984 to the end of 1989) this monthly average increased

Table 1: The Incidence of and Short Term Trends in Crime in South Africa, 1989/1990

Category	1989	1990	% change incidence
Burglary	187,946	225,158	+19.80
Assault with the intent to do bodily harm	128,887	124,030	-3.77
Malicious damage to property	82,487	91,378	+10.78
Robbery	50,636	61,132	+20.72
Allfraud, forgery misappropriation, embezzlement, etc.	43,321	49.644	+14.60
Rape	20,458	29,321	+43.32
Murder	11,750	15,109	+28.59
Arson	4,563	7,717	+57.16

Source: Republic of South Africa 1992: 50

September 1984 to the end of 1989) this monthly average increased to 86, and on four occasions exceeded 200 political fatalities. From December 1989 to May 1990 it was consistently above 200. In March 1990, for the first time ever, the level rose to not only above 300, but also above 400 to 458 per month (South African Institute of Race Relations 1993). The pattern of deaths due to political violence for the period 1987-1993 is expressed by the following figures (Center for Socio-Legal Studies 1987-1993):

Year	N deaths
1987	661
1988	1,149
1989	1,409
1990	3.699
1991	3,167
1992	3,467
1993	3,716

From the beginning of 1987 to the end of 1993, political violence had thus claimed 17,268 lives.

3. Accidental disaster

(1) *Accidents at work*

In 1991, 604 miners had been killed on mines, while 9,103 miners had been injured on mines. This meant that an average of about two workers were killed and 25 injured every day of the year.

(2) *Accidents on roads*

Fatalities due to traffic accidents in 1992 amounted to 10,142. This represented 4-5% of all deaths among South Africans (10% of all deaths in the 15-59 age cohort) and a rate of 3.19/10,000 of the

population; 43.8% of these fatalities were pedestrians. Serious casualties counted 32,792 in that year (Cooper et al.,1993; Department of National Health and Population Development,1992: 73; National Road Safety Council, 1994).

(3) *Disability*

About 3.5 million people, or 12.7% of the South African population are disabled in some way.

IV. Morbidity and Mortality in South Africa

1. Profile of diseases and deaths in the population

In the extension of the general demographic profile, and originating from the described social miseries—manifesting mainly in violence, crime, poverty, instability, unemployment and squatting—also lie the peculiar mortality and morbidity profiles of the South African population. In this regard the following general remarks and data sufficiently summarise the present situation and discernible trends: South African society is pre-eminently a society in transition, and this is also true of its disease and death profiles. Stated simplistically, there is an ever-increasing share of the so-called "diseases of civilisation" or "chronic diseases of lifestyle", i.e. a shift towards a typically chronic-degenerative disease and death profile. At the same time, there is a proportional decrease in the typical "social diseases", and therefore a shift away from the erstwhile acute-infectious disease and death profile. Also evident in the South African situation is that the various population groups find themselves in different stages of this transitional process, as the various population sectors are exposed to risk factors on a

differential basis. Certain groups of the South African population have advanced conspicuously more than others in the processes of development, urbanisation and industrialisation, and this is particularly noticeable in the broad and complex spectrum of needs in the various sectors of the population. Certainly, one cannot speak of a pure, uniform and stable profile of diseases and deaths, and concomitant care needs, but rather of a highly mixed, varied and variable need profile.

The disease and death profiles of the South African clientele obviously contain elements of both First and Third World countries, in which there is a high incidence of gradually out-phasing infectious and contagious diseases amidst an increasingly in-phasing pattern of chronic-degenerative diseases and pathologies of ageing. Table 2 presents more detail in this regard.

When data (for 1988) are compared to the corresponding information for 1976, a series of important observations come to light (Van Rensburg, 1992; Van Rensburg et al., 1992):

- Most important, are the drastic changes regarding the main causes of death in the different population groups, and therefore also in the disease and death profiles of the South African population during the 1976-1988 period. In particular, virtually a complete phasing out of infectious and parasitic diseases from the five most important categories of causes of death is discernible. Whereas in 1976 this category was still first in order of importance among coloureds and Africans, it only featured among the first five for Africans in 1988 and also at half the rate.

Table 2: Prominent Features in the Mortality/Morbidity Profile of the South African Population

Indicator	Year	Whites	Asians	Coloureds	Africans
Diseases of the circulatory system					
deaths/100,000	1988	312.1	201.2	189.0	80.0
as % of all deaths	1988	38.4	34.1	21.8	13.2
Neoplasms					
deaths/100,000	1988	150.2	51.4	104.9	48.3
as % of all deaths	1988	18.5	8.7	12.1	8.0
Diseases of the respiratory system					
deaths/100,000	1988	100.3	56.1	104.7	57.7
as % of all deaths	1988	12.3	9.5	12.1	9.5
Infectious/parasitic diseases					
deaths/100,000	1988	18.1	19.5	101.0	77.7
as % of all deaths	1988	2.2	3.3	11.7	12.9
Accidents/poisoning/violence					
deaths/100,000	1988	84.6	72.6	136.9	114.8
as % of all deaths	1988	10.4	12.3	15.8	19.0
Notifiable diseases (notifications per 100,000)					
Tuberculosis	1990	16.5	59.2	599.7	183.4
Measles	1990	9.3	3.4	9.2	33.9
Typhoid	1990	0.4	1.1	0.2	7.1
Nutritional deficiencies (deaths per 100,000)	1988	0.4	1.0	9.7	9.8

Source: Van Rensburg et al., 1992

- Equally striking, even dramatic, is the upward shift of the position of accidents, poisoning and violence in the death profile of the South African population. It moved from second to first position among Africans, from fourth to second among coloureds, from third to second among Asians, while among whites it retained fourth position. However, it seems that the heightened prevalence and prominence of accidents, poisoning and violence in the total death profile were not due to increases

in the rates of these figures, but rather to the considerable levelling out of the rates of erstwhile more prominent causes of death. Such decreases in rates occurred in all the population groups — especially with regard to diseases of the circulatory system, contagious and parasitic diseases, and diseases of the respiratory system.

- In general, the death intensity with regard to most causes and conditions in all the population groups decreased, and in many cases the decrease was considerable to dramatic. The general levelling out in gross mortality, and especially in infant mortality in all the population groups, must have played a meaningful role in this.
- When weighed in terms of the aforementioned morbidity and mortality trends, one must reach the conclusion that the health of the South African population is nowadays considerably better than a decade or two ago. This does not, however, mean that it has necessarily reached an acceptable level. On the contrary, many problem areas are still pertinently on the foreground, while several new threats and insecurities have appeared in the health profile of the South African population.

Note also, the conspicuous differences in the disease and death profiles of the different population groups. These may be ascribed to divergent factors, amongst others, differences in life style, demographic variables, climatic differentials, general living conditions, etc. In addition, notable trends in the disease and death profiles can also be explained in terms of these factors.

Some other universal indicators of health status regarding the South African population are worth mentioning in this section.

2. Infant mortality, under 5 mortality, and maternal mortality

The recent situation and trends in South Africa for these indicators of health status (per 1000 live births), specifically within the different population groups, are as follows:

Infant mortality

Year	Whites	Asians	Coloureds	Africans
1980	13.1	24.4	60.7	70.0
1990	8.6	10.6	39.4	52.8

Under 5 Mortality rate

Year	Whites	Asians	Coloureds	Africans
1980	17	30	85	36
1990	12	13	49	20

Maternal mortality

Year	Whites	Asians	Coloureds	Africans
1980	4	10	38	21
1990	3	15	30	23

(Department of National Health and Population Development, 1992: 18, 19; 1994a: 28, 29).

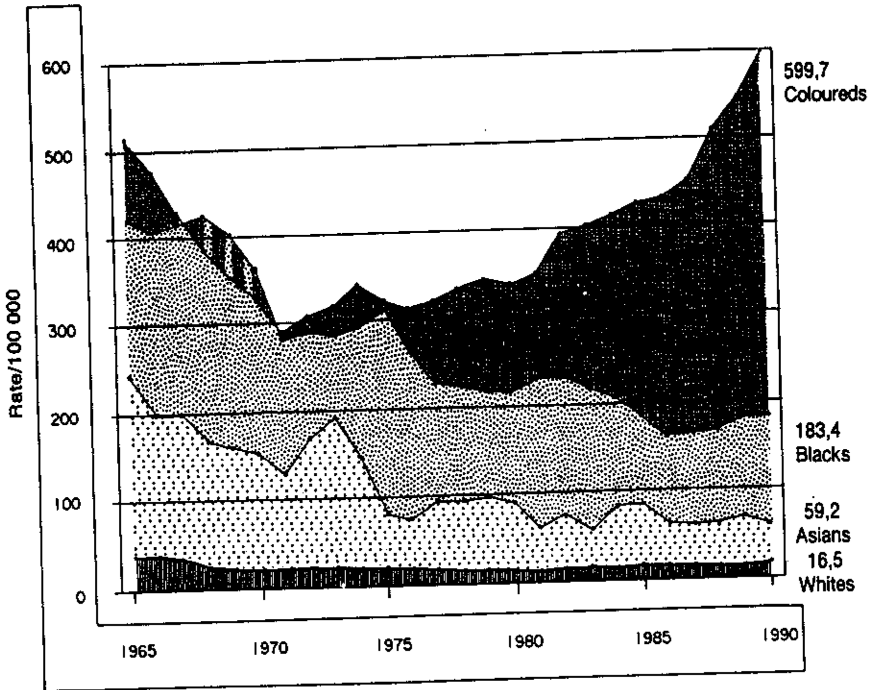
Of particular interest, are the wide discrepancies among the different population groups, and the high vulnerability of the Africans and coloureds. Although the general trend in these groups seem to be downwards, the situation still remains serious.

Bearing in mind the previously described demographic characteristics, social conditions and specifically the health statuses of the

more vulnerable groups and sectors of the population, it may be said that certain diseases in particular pose a tremendous threat to social security in the country by burdening our resources to the utmost. In this regard, tuberculosis and AIDS deserve special mentioning.

3. Tuberculosis

For decades now, tuberculosis has been the most important notifiable disease in South Africa. The growing mine industry and the rapid industrialisation, together with poor living and working conditions, large-scale poverty, the enormous movement of Africans brought about by the migrant labour system and the escalating incidence of TB in the black reserves, helped to make the disease the largest public health problem in South Africa. The immensity of the situation is such that one could actually speak of a continued TB epidemic in South Africa, despite the noticeable developments in detection, control and treatment during the past decades. In 1990 80% of all notifications were for cases of TB; more specifically TB had a known case-load of 71,861, a notification rate of 192.6/100,000, 1,955 deaths and a death intensity of 5.24/100,000 in the entire South African population in that year. The highest notification rate for tuberculosis was that among coloureds (599.7/100,000), a rate which more than triples that of Africans (183.4/100,000) and is more than ten times that of Asians (59.2/100,000). The notification rate among whites 16.5/100,000) is remarkably lower. These significant differences result particularly from the poorer living conditions among the coloured and African populations. Note also, hospital and medical costs incurred by TB alone exceed and estimated R200 million annually. The longer term trends in the incidence of TB are shown in Figure 6.



Source: Van Rensburg et al., 1992: 183

Figure 6: The Incidence of Tuberculosis According to Race/Population Group (Notification Rate/100,000) in South Africa for the Period 1965-1990

4. Aids

The HIV/AIDS epidemic in South Africa is currently entering a period of explosive growth. By February 1994, 3,071 AIDS cases had been reported. The majority of these are Africans (79.3%), followed by whites (15.2%), coloureds (4.9%) and Asians (0.2%) (Department of National Health and Population Development, 1994: 41). A similar pattern applies to HIV-positive cases: in February

1993 43,413 such cases had been reported, the majority of which occurred among Africans (90%), followed by whites, coloureds and Asians with 4%, 2% and 0.4% respectively. Initially South Africa experienced pattern-I AIDS (with a peak in 1989), but since 1990 pattern-II AIDS dominates. Pattern-II transmission is typical of the African population group, whilst Pattern-I transmission typifies the other three groups. Paediatric AIDS accounts for 23.2% of all reported cases. Furthermore, urban areas experience much higher AIDS case reporting than rural areas; rapid urbanisation and accompanying factors such as the disruption of the more stable traditional lifestyles, social, behavioural and economic changes, unemployment and economic insecurity are undoubtedly important contributing factors in the spread of HIV-infection and AIDS in South Africa. Based on the generally accepted assumption of the WHO that there are approximately 10 unknown HIV-positive cases to every known case, the estimated cumulative number of HIV-positive individuals currently in the country stands at about 440,000, with a doubling time of 10 to 11 months. This sombre picture regarding the escalation of the AIDS/HIV epidemic in South Africa is emphasised in the following projections (Table 3):

Apart from its severe social costs in all spheres of life, the AIDS/HIV epidemic places an enormous burden on the South African economy, both in terms of direct and indirect costs. According to Broomberg et al. (1991: 53) the total direct costs will increase from approximately R94 million in 1991 to R7.4 billion in the year 2000. This amounts to a 79-fold increase. By the year 2005 health expenditures on AIDS/HIV could reach 34-75% of total health expenditures. As to indirect costs, lost production in both the

formal and informal sectors is projected to increase from approximately R296 million in 1991 to R9.3 billion in the year 2000.

Table 3: The Projected Number of HIV-Infections and AIDS Deaths in South Africa: 1991, 1995, 2000

Doubling Time	Year		
	1991	1995	2000
HIV-Infected:			
6 months	77,734	7,416,964	12,695,303
9 months	49,049	1,874,966	12,130,825
12 months	38,931	666,025	8,591,348
15 months	33,867	342,836	4,348,887
AIDS-Deaths:			
6 months	11,324	1,417,942	6,324,998
9 months	7,882	354,988	4,481,577
12 months	6,668	140,841	2,440,391
15 months	6,064	80,626	1,154,630

Source: Whiteside, 1990: 32

V. Health Care and Health Coverage in South Africa

1. The South African health care system and its deficiencies

Linking the above-described health situation of the South African population — as expressed in terms of morbidity and mortality—to the health supply in the country, it must be emphasised that this unique, transitional disease and death profile poses a number of important, yet problematic consequences for the care system in South Africa. The country's care system must obviously provide for a far broader and more complex spectrum of needs as a result of these transitional circumstances. Such a mixed and widely varying disease and death profile—and need profile—consequently

demands a far broader spectrum of services and facilities than is the case in societies with a relatively uniform profile. This brings with it the difficult question of the synchronisation of care supply with care need, which is certainly far more difficult to align in South Africa than in societies with more uniform and stable need profiles. Furthermore, determining priorities and distributing health care fairly in South African conditions are far more difficult to accomplish owing to the multitude of competing needs in the different population sectors. The danger in such a situation is that equal distribution and fair dispensation *vis-á-vis* the diverse care needs of the various population sectors might not necessarily be realised in policy, but that priorities are often assigned in favour of one facet of care to the detriment of another. This could also happen at the expense of certain sectors of the population in which the needs lie differently from dominant priorities.

In this section the main objective is to present a synoptic reconstruction of the health care system as an important part of the larger social security system in South Africa. Note that the general health care supply in the country is a relatively favourable one, as is confirmed by the following data on health care provision. Despite an overall favourable situation, however, provision and distribution of health resources reveal a highly distorted picture. South African health care is notoriously known for its internal inequities, discrepancies and deficiencies. Looking at health care in South Africa historically, it may be concluded that over centuries a strong structural drift has manifested itself in South African health care which eventually resulted in the present rigid health care structure, continuously strengthened by a series of mutually reinforcing trends.

The main features of this evolution may be summarised in six statements (Van Rensburg et al., 1992): Dominance of Western-scientific, curative and medico-professional health care; intensification of colour segregation, racial apartheid and racial fragmentation in health care; expansion of the pluralistic structure of health care; continuation of structural, functional and geographic fragmentation of health care; deepening of rural-urban discrepancies and inequalities in health care; and emergence of contradicting health policies and contending interest and power groups in health care.

Due to these historical developments, health care and health care coverage in South Africa up to now would be best described and evaluated in rather negative terms, which boil down to the following:

(1) *Shortages*

Shortages of both a primary and secondary nature, the former referring to real lacks of finance, personnel and facilities, while the latter refer to maldistribution, poor provision, malutilisation, even squandering of available health resources—all symptomatic of the inefficient management of health care.

(2) *Fragmentation*

Fragmentation, including the diverse forms of structural, racial, functional and geographical fragmentation of the health care system, leading to deficient co-ordination of services and conspicuous gaps and overlaps in the provision of health care.

(3) *Inequalities*

Inequalities of a wide range, relating especially to material wealth, employment and purchasing power, to membership to

specific race or colour groups, and to location in rural, urban and peri-urban areas, each variable generating grave disparities and inequalities in the distribution, provision, accessibility, attainability, affordability and quality of health care.

(4) *Lack of synchronisation*

Lack of synchronisation between the supply of and the need for health care, due to services and facilities which are neither geared to nor organised towards optimal provision for the real needs of the South African population, because policy, priorities and organisation in health care favour certain population sectors and certain need categories within the clientele more than—and even at the expense of — others.

(5) *Escalating costs and the unaffordability of health care*

Escalating costs and the unaffordability of health care, *inter alia* originating from the fragmentation of health care and the numerous bureaucratic structures, the changing population structure, greater incidence of chronic-degenerative diseases, increasing use of high technology in health care, rising expectations among the clientele, the free-market health care sector, *etcetera*.

The following information substantiate to a large extent the aforementioned argumentation.

2. Health care financing

Between 1985 and 1990 public health expenditure as a percentage of total state expenditure remained between 11 and 12%; the latest available data show an increase to 12.7%. Expenditure on health as a percentage of the GDP 1990/91 amounted to a total of 6.65% - the public sector 3.54% and the private sector 3.11%

(Department of National Health and Population Development, 1992: 26, 28). Proportionately speaking, the public sector has been responsible for 55-60% of all expenditure on health in South Africa in recent years, while private expenditure on health care constitutes the remaining 40-45%. Bear in mind, however, that the public sector is responsible for the comprehensive provision of care to approximately 80% of the South African population. On the other hand, the private sector focuses its attention mainly on curative care for the remaining 20% of the population who can defray the cost of private health care directly from personal resources and/or by means of health insurance. In 1987 the average per capita expenditure in the public health sector was R159 as against R555 in the private sector. It goes without saying that these disproportionate expenditure rates will surface in the incomparable quality of services rendered within each sector. Taking into account the distortions caused by maldistribution of health insurance — the total per capita expenditure on health care for the various population groups in 1987 were R138 for Africans, R340 for coloureds, R356 for Asians and R597 for whites (Van Rensburg et al., 1992).

3. Health insurance

In 1989, 250 medical schemes were in operation in South Africa; an.. approximate 20.1% of the total population were beneficiaries of some or other medical scheme at that time. Obviously medical aid schemes failed to secure medical care for the majority of South Africans; in 1989 the following percentages of the different population groups were covered: Whites 69.3; Asians 53.3; Coloureds 39.5; and Africans 6.5. Apart from this, the medical insurance system in South Africa seems to be not a particularly

healthy one: it was disclosed that during 1990 nine medical aid schemes had been declared insolvent and a further 88 had incurred financial losses. During 1991 three medical aid schemes were declared insolvent (Cooper et al., 1993: 273; Van Rensburg et al., 1992).

4. Hospitals and clinics

In 1990 the number of hospitals amounted to 201, with a bed capacity totalling 67,784. The provision of hospital beds (all types) per 1,000 of the population was quite varying. In the homelands it varied in 1991 from a low of 1.3/1,000 to a high of 5.3/1,000. In the rest of South Africa it was 6.4/1,000. During the era of racial segregation in hospitals, the bed provision varied from a high of 6.5/1,000 for whites as against 2.23/1,000 for non-whites. More recently, there were numerous reports of deteriorating conditions at government hospitals owing to shortages of funds, leading to overcrowding and poor quality of care (Department of National Health and Population Development, 1992; Van Rensburg et al., 1992).

In 1992 there were about 3 000 health clinics in South Africa, including primary health care, maternal, psychiatric and general clinics. This amounted to an approximate ratio of 1:12,700 of the population (Department of National Health and Population Development, 1994a: 85).

5. Health personnel

In 1991 the provision of health personnel was as follows:

Category	Number	Ratio
Physicians	24,614	1:1,389
Dentists	3,944	1:8,333
Pharmacists	9,280	1:3,704
Nurses (all categories)	151,610	1:246
Additional health personnel	27,912	1:1,220

Note however, that in recent years serious disparities occurred still, particularly in relation to the private-public divide, geographical area and racial grouping, with the private sector, metropolitan areas and whites throughout and in all categories better provided by far. For example, 41% of all practising doctors were employed in the private sector, which served only 20% of the total population, as against 59% in the public sector serving 80% of the population; the ratio of registered medical practitioners ranged from 1:6,666 in one region to 1:710 in another; the ratio of practising doctors according to race distribution varied from 1:282 for whites to 1:53,543 for Africans (Department of National Health and Population Development, 1994a: 76; Van Rensburg and Benatar, 1993; Van Rensburg and Fourie, 1994).

6. Immunisation coverage

At the beginning of the 1990s the immunisation coverage rates for certain infectious diseases in the total population, as well as in the different population groups, were as follows:

	Whites	Asians	Coloureds	Africans	Total
BCG	93	95	98	84	85%
DPT3	85	87	84	64	67%
Polio3	86	87	87	66	69%
Measles	73	87	82	60	63%

The coverage rate was consistently higher in urban areas, while in all cases remarkably lower in the African population group (Department of National Health and Population Development, 1992: 32-34).

VI. Conclusion

In recapitulating the more salient features of the South African situation, the following may be highlighted once again: The general posture of the population seems to be a highly fluid one, revealing significant changes and transitions in several dimensions. Alas, these are in most respects of a problem-generating nature and spelling a rather discouraging future. Most conspicuous are the trends towards increasing Africanisation or blackening of the population; towards sweeping urbanisation, to a large extent manifesting in distressful slum conditions; towards gradual ageing of certain sectors amidst youthfulness and high virility in others; and towards creeping impoverishment as the poor classes threaten to engulf the self-sufficient and entrepreneurial ones. At the very roots of several of these trends lies an explosive population growth which tends to systematically devour any capacity of economic growth, human upliftment and socio-economic development, thus neutralising most

of the dear gains in health and social security. Superimposed on these demographic transitions are the social and political transformations which are fiercely and profoundly sweeping our country. Together these demographic and socio-political changes prepared a fertile bedding for instability, insecurity and a series of social problems to thrive in. In recent years poverty, unemployment, crime and political violence have indeed escalated to reach unsurpassed heights, while subjecting many South Africans to unbearable living conditions. In the end these circumstances took a high toll in terms of ill-health, premature death, undue insecurity and stress, all most costly in financial, social and human terms.

To conclude this rather sombre version, let us take a few steps back into history in order to gain a better perspective on present and future developments in the health and social welfare spheres. To start with, bear in mind that social and health policies are precisely the mechanisms to deal with the kind of conditions described above. In general, social policies have as their ultimate aim to address and combat social problems and insecurities in societies. Seen positively, such policies strive to secure a minimum standard of living, and to promote independence, self-sufficiency and human dignity. In turn, the main objective of health policies is to allay the fears, insecurities and suffering caused by disease, disability and death; their main function is to create safeguards for health, sanity and security for those they intend to serve.

Up to now—and as was clearly demonstrated in the previous sections—social and health policies in South Africa had at best had a questionable record, at worst a tragic history abundantly characterised by unfreedom and domination, discrimination and

privileging, inequity and injustice. For the larger part South Africa's health care and social welfare history there existed a sharp divide which in broadest terms relates to opposing ideological, socio-political and economic ideals and strategies (Van Rensburg, 1991; Van Rensburg et al., 1992). On the one hand, the Nationalist government of yesterday, along with its powerful allies in the private sector and in state bureaucracies, for many decades pursued the explicit policies of apartheid and privatisation in the field of health care, primarily based on the principles of racial segregation, entrepreneurialism and health care as a privilege. In this process the South African health care system acquired its typical pluralistic structure, accompanied by the afore-mentioned series of structural and functional deformities, discrepancies and deficiencies.

Directly opposed to this dispensation, however, there simultaneously and systematically evolved a multifaceted progressive or patriotic health front, which over decades—in particular since the early 1940s—positioned itself even stronger against the prevailing policies and structures in the health sphere, agitating for a unitary, democratic, non-racial and non-sexist health system, preferably in the form of a National Health Service, undeniably leaning on the socialist principles of collectivism, statism and equalitarianism, vehemently furthering the Primary Health Care approach and propagating health care as a basic human right.

More important than lingering on this past, however, is a view to the future and the prospects it holds for us. Most encouraging in this regard, is that in recent times, and seemingly in accordance with the greater processes of negotiation and reconciliation, there apparently emerged in the health care sphere a marked shift away

from the hard-core ideological and political extremities of the past towards a new balance in which moderation, compromise and realism become highly rated in health policy. In particular it appears that health policy formulation will in future be characterised by open debate, wide consultation, community involvement, and genuine efforts to accommodate the needs and interests of all. Although it cannot as yet in all certainty be predicted in what exact direction health policy will develop in future, a clear and genuine commitment towards approaches favouring public health care, primary health care and health care as a basic human right has already taken root firmly (ANC, 1994a; 1994b; Mgijima, 1994). In combination these indeed harbour the potential to bend future health care in South Africa towards greater equity, greater affordability, greater justice and less fragmentation. Also most encouraging, and with direct implications for future developments in the health sphere as well, is the kind of visionary approach contained in the **Reconstruction and Development Programme** recently launched by the African National Congress. This Programme will henceforth also serve as a main fount of future policy directions and strategies in the health and social welfare spheres. Six well-motivated principles are in particular isolated and emphasised, namely an **integrated programme, based on people**, that **provides peace and security for all** and **builds the nation, links reconstruction and development** and **deepens democracy** (ANC, 1994a: 7). Regardless of justified criticism of different kinds and origin on this Programme, it nevertheless contains sufficient visionary ingredients which are essential to guide us into our newly discovered future, but for the rest so uncertain a future.

However, be cautioned: despite the shifts towards moderation, compromise and new balances, and regardless of promising dreams and visions, the road ahead remains long and steep, and our walk will still be an uneasy one. In addition to guiding dreams and ideals, for the years to come we shall in particular be in urgent need of a determined political will, sustained legitimacy of governance, continued consultation and involvement, deepening loyalty, and sacrificing hard work in order to convert our ideals and expectations into healthy realities, gratifying and rewarding to all our people.

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