DETERMINING PRIORITIES: THE CASE FOR ESSENTIAL NATIONAL HEALTH RESEARCH

C C Jinabhai
H M Coovadia

Introduction

South Africa stands on the threshold of moving from an era of racial domination and exploitation to one of democracy, peace and social justice. This transition is pregnant with a number of opportunities, contradictions and challenges.Within the social service sector, the health sector is one of the sectors in which these inequities are most gross, and these are analyzed in the first part of the paper. The tremendous challenges and opportunities that exist to facilitate a smooth transition to democracy and the contribution that health research can make is then explored.

The Commission on Health Research for Development has identified health research as the essential link to equity in development. This paper explores the potential contribution of Essential National Health Research (ENHR), in addressing these constraints, establishing priorities for the new government, the progressive health organisations and the mass movement; and enhancing health and development.

ENHR is essentially a set of strategies for harnessing the power of research to accelerate health improvements and to overcome health disparities.

Its particular goal is to improve the overall health and socio-economic status of the people of the developing world.

Key issues in the dialogue among researchers, policy makers and communities are to:

- establish links between researchers, decision - makers and communities with respect to health;
- create mechanisms for turning health research into action and policy;
- develop information systems as tools for use in decision making;
- maximise use of scarce resources;
- evaluate country programmes of health for their effectiveness;
- build local research capability in health and strengthen local institutions with mandates to solve local health problems through epidemiological and social science research.

Through this process ENHR moves towards equitable, effective and sustainable systems of health.

Traditionally the World Bank and International Monetary Fund (IMF) prescription for development has focused narrowly on economic growth while leaving the delivery of social services to the market forces with minimal state intervention. This

conventional wisdom is increasingly being challenged as the market has failed to deliver social goods and services, economic growth has failed to trickle down to the masses, and the health status of the masses has deteriorated. Countries which invested in both economic growth and social services perform demonstrably better on social indicators than similar countries which did not.

The 1990 State of the World's Children Report makes a strong plea for developing both health and social indicators to measure progress.

The Human Development Reports of the U N Development Programmes (1990 and 1991) go further and propose the Human Development Index (HDI), based on life expectancy, literacy and real GDP per capita. The UNDP notes that perceptions of development have shifted from economic development to socio-economic development, and now to human development. This emphasises the development of human choices and the centrality of people. It is reflected in measuring development not as the expansion of commodities and wealth but as the widening of human choices.

Health and Development in South Africa

Disparities at the level of health policy, status, services and expenditure clearly indicate the need for a radically new approach to determine priorities for the health and development agenda. A substantial body of evidence exists which documents these disparities.

Table 1 below reflects the extent of disparities in health status by considering basic indicators. The major burden of disease, death and disability falls upon black people.

Policy formulation in South Africa faces a number of constraints - some of which are general while others are specific to an apartheid society.

The first problem is that in an undemocratic society with high levels of repression, significant polarisation occurs between planners and policy makers on the one hand and the oppressed majority. This had reached a state of paranoia where information about health services, status and financing was almost regarded as classified information, and the state went out of its way to distort, misinform and even not collect data, as in the case where malnutrition notification was discontinued.

Currently we do not have basic vital statistics such as the number of children who are born and die. A comprehensive national Health Information System is the cornerstone of any sound planning or policy framework.

A particular feature of democracy is the ability of people to change the government and policy makers through the electoral process, to directly influence policy and to open up the policy making process to public debate and scrutiny. Within South Africa this process is shrouded in secrecy, behind a plethora of laws and regulations, creating a high level of antagonism towards the present policy makers. Current methods of priority setting and policy formulation are based on outmoded and discredited systems and processes.

A further consequence of this is the mystification of the policy making process including the assumption that only highly specialised people and academics can undertake policy formulation. A favourable policy climate will have to be estab-

lished to dispel the notion that only whites, doctors, males and specialists can make policy. In addition a massive education and information campaign will have to be undertaken to empower and skill black people in all aspects of governance.

Transforming Health Policy, Status and Services

A number of problems exist in formulating health policy in the context of social transformation. The following are some of the issues that will have to be addressed.

While a number of racial laws have been repealed, the Republic of South Africa Constitution Act still fragments health, welfare, education and culture in terms of 'own and general affairs' to be administered by different ethnic and racial groups. This basic constitutional framework needs to be replaced, by one based on the Guiding Principles adopted at CODESA and which recognises South Africa as a unitary state, in which democratic principles and practises will be enshrined.

A single health act, encompassing comprehensive health care delivered through a National Health Service, and emphasising inter-sectoral collaboration - will have to be promulgated.

The SA Medical and Dental Council (SAMDC), the S A Nursing Council, the other para-medical bodies, will have to be restructured and focused on promoting a whole new ideology and objectives in health based on the concepts of Primary Health Care. With the adoption of a new constitution, these bodies would be democratised. They would then reflect the aspirations and the needs of the majority, and fundamentally influence the shaping of new policies.

In terms of the Health Act of 1977, and the National Health Policy Act of 1990 the National Health Policy Council (NHPC) and the Health Matters Committee formulates policies in terms of existing norms and guidelines. New policy making structures and Community Health Committees (CHC's) will have to develop a Health Care Delivery System based on Primary Health Care (PHC). Considering all the demands that will be placed on communities, innovative means will have to be found to obtain adequate community participation, to ensure that the more organised and articulate sections do not dominate and that the needs of the marginalised and the most inarticulate are considered.

The organisation and delivery of services through both the public and private sectors, the roles of health auxiliaries, the optimum mix of public and private sector financing, and fundamentally the extent of national or state funding and co-ordination will require major debates. Particular attention will have to be paid to the multi-national pharmaceutical companies, the private medical industry and the academic sector - all of whom have enormous power and the ability to either subvert national health objectives or to blackmail the new government into making major concessions.

Financing of health services will remain a major area of contestation and debate. Internationally the monetarist policies of Reagan and Thatcher still dominate macro-economic debates. Privatisation is still seen as the best means for distributing goods and services. At the macro-economic level, the nature of the growth path, the extent economic growth that will be possible and the prospects of sustainable development

will have a direct and profound bearing on the form and content of the social service sector.

Like the private and academic sectors, - the massive and predominantly white civil service and health administration - has the potential to frustrate and subvert social transformation in all sectors. All the different options - retrenchments, early retirement or their retention has serious economic and political implications. At the same time skills and capacity in the democratic movement to administer the social system is extremely limited. Can sufficient consensus be reached between the two groups to facilitate social transformation in the best interests of all social forces?

The critical factor missing in many development programmes is the human dimension. Education and training is required not only in the management and administration of the health system, but policy and economic sciences, epidemiological and statistical sciences. Fundamentally the task is to establish a whole new ethos, culture and style of civil administration that promotes efficiency, effectiveness and the national interest. All the contradictions of gender, race and class are deeply ingrained in the current human resources distribution. The lag time in training health workers is between 4 to 7 years - hence transforming selection criteria, curricula, teaching methods would require a 10 to 20 year time frame. In the meantime massive pressures to deliver social goods immediately - will put tremendous pressure on the new government either to radically rethink current human resources development models (and introduce health auxiliaries) or to maintain the status quo.

Specifically in South Africa the Convention for a Democratic South Africa (CODESA), made up of all the major political organisations from the democratic and governmental sectors, is discussing issues such as an Interim Government, a new democratic constitution and major social issues such as poverty, unemployment, economic growth and the provision of social services. The transformation of all the institutions, policies and structures that have shaped the lives of millions of people for centuries, and fundamentally the emergence of a new 'Development Paradigm' to replace the apartheid paradigm is high on the political agenda.

All the intellectual, human, technical, material and institutional resources of, university and academic groups; the MRC, HSRC and CSIR; IDT, Development Bank and other agencies involved with interventions; and the progressive non-governmental organisations, await a democratic political milieu to, make their contribution.

ENHR Relevance for South Africa

ENHR is seen as both a 'set of strategies' to accelerate health improvements and as a unique self-evaluative process of Research, Policy and Action. The process empowers researchers, policy and decision makers and community representatives in setting priorities for planning, promoting and implementing research and action programmes.

It includes participatory research with communities to identify and prioritise community health problems, to rationalise epidemiological data with health needs

defined by communities; policy analysis and economic research to establish appropriate health and research policies; and operational research to improve health systems management and resource allocation to achieve Equity in Health.

ENHR has relevance for South Africa at this particular juncture in our history for a number of reasons.

Currently South Africa is undergoing one of the highest levels of mass mobilisation in its entire history. A key feature of ENHR is community involvement in all facets of life - the high levels of expectations, while perceived by some as a threat, is likely to ensure a direct and sustained input into all aspects of social and health policy.

Furthermore, most sectors of civil society are organised into mass based structures - labour, business, church, sport, professionals (doctors, health workers, lawyers, social workers, teachers) etc. This organised character will ensure that they will not be easily disarmed ideologically or demobilised.

A qualitatively unique feature of this mass mobilisation is its political character. The relationship between legislative and constitutional measures and policy is being sharply debated in numerous forums around the new constitution, the demand for a Constituent Assembly and the CODESA talks.

According to the World Bank South Africa is classified as a middle income country with a per capita income of US$ 2290 (UNICEF 91). Hence unlike many other developing countries, the material and economic resources for implementing the results of ENHR can be mobilised, and realistically applied.

A reflection of this economic reality is the substantial scientific research capacity. This capacity is highly organised, productive, well connected to the international community and has successfully addressed the technical, scientific and human needs of the white community and the business and industrial sectors. While major problems exists in turning this capacity around to addressing the needs of the majority, the potential nevertheless exists for a new government to transform its research priorities. Thus both the technical, human and material resources for a significant ENHR process, potentially exist.

The last decade has seen the emergence of an organised and articulate progressive health movement. This movement is in the process of restructuring itself as the Unity Health Forum. This organised sector in alliance with other mass based groups and in close collaboration with a democratic government would provide the subjective conditions for transforming the existing research capacity and for promoting the principles and practise of ENHR.

During the period of resistance both the external and the internal movements established an extensive international network, including links with the major UN agencies, foundations, philanthropic agencies and research groups. While links with Africa are still weak, this international collaboration would facilitate a process of learning and sharing ENHR experiences.

In conclusion the critical policy issues for social transformation in the health sector have been identified. In addition the potential contribution that the strategy has to offer in this process of social transformation has been highlighted.

TABLE 1 BASIC INDICATORS FOR HEALTH IN SOUTH AFRICA

	AFRICAN	WHITE	COLOURED	ASIAN
Population (Million)(a)	29.0	5.0	3.2	1.0
Percent of Population(a)	75.5	13.5	8.6	2.6
Total Fertility 1988(a)	3.9	1.8	3.0	2.4
IMR (1000) 1988(a)	80.0	11.9	46.3	19.0
Percent of Population Under 5 years(c)	15.9	7.9	11.9	10.3
Per Capita Health Expenditure 1987(a)	R95	R596	R339	R356
Per Capita Child Welfare Expenditure 1988(b)	R22	R176	R227	R171
Per Capita Educational Expenditure 1988(a)	R276	R3,080	R1,358	R2,226
Life Expectancy 1985(c)	62	71	61	67
Percent of Death Before 1 year 1987(c)	15.7	1.3	10.8	5.4
Percent of Death Before 5 years 1987(c)	22.5	2.11	6.3	7.3

(a) *SAIRR Survey 1989/90*
(b) *SAIRR Survey 1988/89*
(c) *Health Trends in South Africa, Department of National Health and Population Development, 1988*