**Letter from Johannesburg**

**SUB-SAHARAN AFRICA HEALTH OUTLOOK: IS IT TOTALLY SOMBRE?**

Every now and then we have good news. In 1995, Rajendra Kale showed that the mean life-span of Africans in South Africa was 61 years, only 9 years less than that of the white population. Recently, it was reported that the infant mortality rate of African infants in parts of Soweto (3 million population), adjacent to Johannesburg, had decreased and is now 4.1–27.5/1000 live-births, and the under-5-year mortality rate is 21.1–27.5/1000—needless to say, the best for sub-Saharan African populations.

In contrast, as described in a previous Letter, in the past few years we have had to face the devastating news that in South Africa nearly a quarter of Africans are now HIV infected. AIDS will cause early death in as many as half the teenagers living in the hardest hit countries of Southern Africa, and in Botswana, half of all deaths are now attributable to the infection.

To keep a balance, or at least to lessen our despondency, it is appropriate to keep in mind two points: first, that other countries, which are socio-economically far better off than African countries, have their own problems of ill-health; and second, that with intense determination even poor countries can make excellent progress despite highly adverse social and other circumstances.

Regarding the first point, a fitting example was given in a recent editorial in the BMJ on ‘Joining together to combat poverty’, in which several striking statements were made on the current health/ill-health situations. Worldwide, of the 4.4 billion people in developing countries, nearly three-fifths lack access to sanitation, a third don’t have clean water, about a fifth have no health care, and a fifth do not have enough dietary energy and protein. At the same time, ‘even among rich nations there are many examples of growing socio-economic inequalities in health over the past 20 years’. Health inequalities in Britain have just been declared the worst ever. The life expectancy gap between professional and unskilled workers is now 9.5 years for men and 6.4 years for women. Of particular concern is the fact that so many children are robbed of their physical and mental potential through poverty. Even in the USA more than one in four children below twelve years of age have difficulty obtaining all the food they need.

Turning to the second point, outwardly, among the huge majority of the world’s population, prospects for the promotion of meaningful improvements in health would seem well nigh hopeless. In a recent editorial on ‘Health systems: More evidence, more debate’, an extremely important issue was raised concerning ‘spending more and spending better’. As to spending more, it was stated that ‘one can find poor health outcomes even in the context of adequate expenditures and substantial aid’. However, in respect of the urge made for ‘spending better’, there are many examples of success. Perhaps the most outstanding example is that of the state of Kerala, in India. This state, one of the poorest, with a population of 60 million, has a per capita Gross National Product (GNP) of about one-hundredth that of the UK. Yet, the total fertility rate is 1.7, the mean survival is 69 years for men and 74 for women, and the infant mortality rate is 13/1000 live-births. These statistics are superior to those in many western countries. Interestingly, even in the latter, there is the favourable situation of Albania, perhaps the poorest of countries in Europe with less than a tenth of the per capita income of the UK; yet the life expectancy of those over 15 years of age is the same, a situation which is indeed ‘surprising and deserves attention’.

Attention has recently been drawn to the situation in Oman, where child mortality has been reduced tremendously from 230 to 15 per 1000 in the past 20 years. Surely, as stressed in a recent review, it would be of enormous value for an international body such as the World Health Organization (WHO) to set out in some detail the health expenditures and practices of a number of countries, which, at great socio-economic odds, have been able to secure better health statistics than would be expected.

How best can South Africa spend the money allocated for the health care of our inter-ethnic populations? The proportion of GNP budgeted for health care (8.4%) is relatively large (USA 13.7%, France 9.8%, UK 6%) although in Russia it is 4%, where the life expectancy of men has fallen to 57.6 years. However, while the amount spent on health care in the UK amounts to US$ 1297 per individual, the corresponding amount in South Africa is only US$ 130. In the South African Health Review 1999, the overview emphasized that apart from the major impact of HIV/AIDS—up to 35% of hospital beds are now occupied by those with HIV-related infections—transformation is hampered by many factors. There is the difficulty of redistributing resources and also the shrinking of public sector budgets. A major problem concerns the poor relationship between the public and private sectors. In this respect, the principal problem is that in 1992–93, the private sector spent 60% of the total health care budget on less than 20% of the population, with 40% of the resources being spent on 80% of the almost wholly African population. The disproportion had decreased slightly by 1995. Other problems to be addressed are the wide variations between provinces in the infant and maternal mortality rates, as well as in levels of child immunization coverage, e.g. 50% in the Eastern Cape and Kwa-Zulu Natal but 80% in the Northern Cape.

From a recent analysis of health/ill-health situations in various developed countries, it was concluded that, ‘If you are going to be ill, the best place is France—the country ranked first in an analysis of the world’s health care systems carried out by WHO’. How intensely we in South Africa envy such a commendable ranking! However, when compared with the situation in other countries in sub-Saharan Africa, South Africa probably held this first place until 5–10 years ago before, alas, the onslaught of the HIV/AIDS epidemic with its numerous countrywide ramifications. Yet, although the outlook for the African population is indeed sombre, this situation could still be improved if there were greater application of the knowledge of health/ill-health, by both the individual and the State, coupled with more effective spending of the limited health care money available.

REFERENCES

4. Gottlieb S. UN says up to half of the teenagers in Africa will die of AIDS. BMJ 2000;320:67.
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The government brought all for the students, and it seemed to be an excellent idea. The institutions together under what it called a 'single window', so enter the college of his or her second preference while awaiting the results of the application to the first. The government brought all the institutions together under what it called a 'single window', so there was a common entrance test. Candidates were called in order to interfere with admissions to these deemed universities. The Court directed the government to admit the petitioner in place of the selected candidate who had fewer marks than the petitioner. Ruling in his favour, the Court declared that the Supreme Court held that merit alone should be the criterion for admission to superspecialty courses, and no special provisions were permissible. The Court directed the government to admit the petitioner in place of the service candidate who had been admitted. It is reassuring to think that we will have people of quality to treat serious ailments.

The Managing Director of the Tamil Nadu Medical Services Corporation (TNMSC) recently sent a circular to all practitioners of the city, informing us that the TNMSC had made available MRI and CT scans at a number of centres in government hospitals. The public could utilize these facilities at rates much below those charged by private operators. Plain CT scans are done for Rs 500 and those with contrast for Rs 700; MRI charges vary from Rs 3500 to Rs 4500 for plain, and Rs 5000 to Rs 6000 with contrast. Many patients take advantage of this facility, which is working well now. One hopes it will endure. One criticism has been that fewer cuts (I use the word in its radiological and not its financial sense) are taken than in the scans done at private centres, so smaller lesions may be missed.

Water, or its absence, is now the dominant topic of conversation in the city. The Madras Metropolitan Water Supply and Sewerage Board (commonly known as Metrowater) has given up all pretence of supplying us with water. There is none in the supply pipes, there is none in the supply pipes, and Metrowater refuses to accept any fresh applications for supply by lorry. People either buy water from the many private suppliers, or queue up on the road to get a meagre bucket or two from the corporation water lorries. This supply is supposed to be covered by the water rates we all pay to Metrowater, but one usually has to pay the driver of the lorry and the attender Rs 0.50 per pot of water. A tanker holds 12 000 L, and the average domestic container may hold 10–12 L, so one lorry load could fetch the lucky staff Rs 500 per load. Obtaining water from the Metrowater lorries is a time-consuming business, for there are long queues, and those who can...