GOVERNANCE OF THE PUBLIC HEALTH SECTOR DURING APARTHEID: THE CASE OF SOUTH AFRICA

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Abstract

The healthcare system that the African National Congress (ANC) government inherited in 1994 can hardly be described as functional. Indeed the new government had inherited a combination of deliberate official policy, discriminatory legislation and at times blatant neglect. This paper presents an overview of the evolution of the healthcare system in South Africa. The structures set up under apartheid had implications for provision of public healthcare to South Africans and reveals how governance structures, systems and processes set up during apartheid had implications for the provision of public healthcare to South Africans.

Keywords: Apartheid, Democracy, Discrimination, Health Services

1. INTRODUCTION

The passage from apartheid to democracy has been tainted by unjust laws and a wide range of human rights violations. It is not possible to appreciate the history of apartheid and to understand what South Africa went through and is still going through without some reference of how White minority rule influenced present political structures and economic patterns. Any assessment of South Africa's predicament, and any effort to recover from its past, must acknowledge the weight of history. Here we follow Coovadia, Jewkes, Barron, Sanders, and McIntyre (2009: 817) who point out that South Africa's history has had a marked impression on the health of its people, health policies and services of the present day. These limitations can be attributed to a diverse combination of factors such as: the elevated level of medical migration, critical health worker shortages, imbalance of resources, inequities in the recruitment of staff, an evolving burden of disease and inadequacies in managerial capacity.

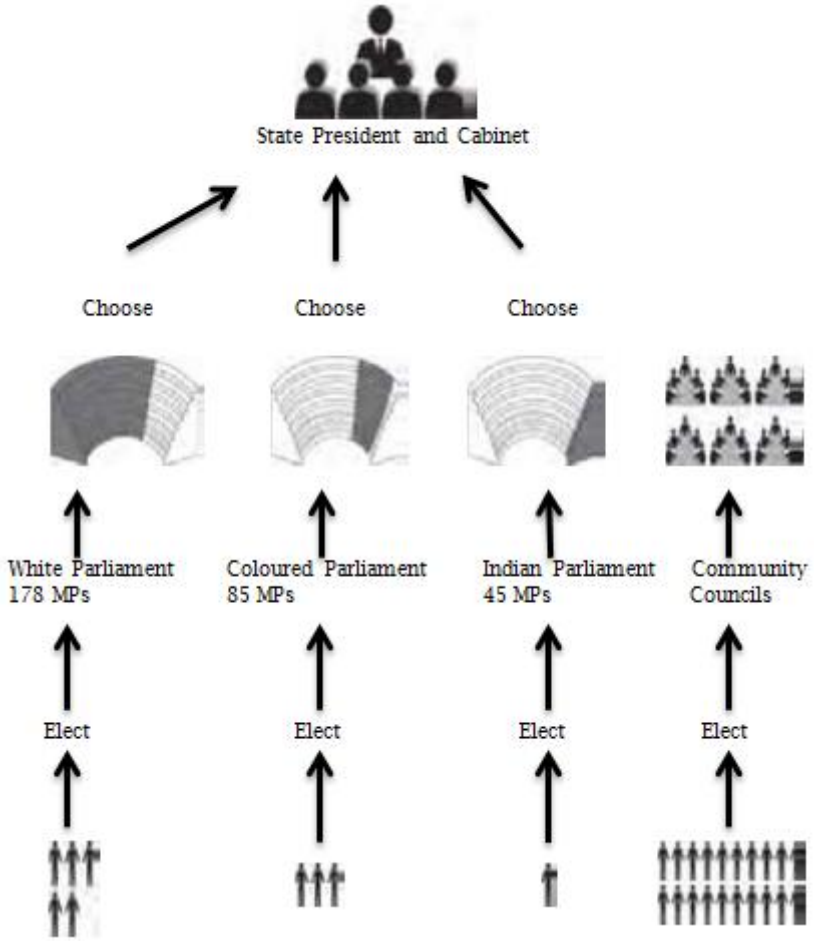
The American Association for the Advancement of Science and the Physicians for Human Rights Organisation (1998) state that the apartheid healthcare system restricted access to healthcare for Blacks and often ignored quality-of-care standards. It established an environment in which abuses such as the denial of emergency care treatment, falsification of medical records and limitation of Blacks' access to continuous medical care were prevalent.

2. THE HISTORY OF APARTHEID IN SOUTH AFRICA

South Africa's history is engulfed in discrimination, segregation and unjust laws. This racism was demonstrated in every aspect of health such as: 1) rigid segregation of health facilities; 2) disproportionate spending on the health of Whites as compared to Blacks - resulting in world-class medical care for Whites while Blacks were usually referred to congested and dirty facilities; 3) public health policies that disregarded diseases primarily affecting Black people; and 4) the denial of basic sanitation, supply of clean water and other components of public health to rural areas and townships. Moreover, people with mental illness and retardation were locked away in institutions, deprived of human rights and access to community-based programmes that would enable them to recover (The American Association for the Advancement of Science and the Physicians for Human Rights Organization, 1998).

Apartheid, a system which endured from the late 1940s to the early 1990s, was a system of institutionalised racial segregation created by the government of South Africa, which gave preference to a very small minority of White South Africans. It also created class divisions, forcing people to migrate to "homelands" which were divided along ethnic grounds. Prinsloo, Jansen and Vanneste (1999) note that in terms of the institutionalised state structures on the national level, the 1983 Constitution provided for legislative authority lodged with Parliament. Separate, racially segregated houses were created: the House of Assembly (178 white representatives), the House of Representatives (85 Coloured representatives) and the House of Delegates (45 Indian representatives). Not only was the tricameral parliament racially segregated, but it excluded Africans altogether. In addition, the new proposals were not commonly accepted by either Coloureds or Indians, many of whom rejected the subordinate status afforded to them in the new system. The executive authority was vested with the State President, the Cabinet and three Ministers' Councils (one for each of the Houses Parliament). The judiciary was executed by a connection of courts, including the Supreme Court as well as lower courts. The figure below indicates how Botha's new tricameral parliament was supposed work.

Figure 1. How Botha's new tricameral parliament was supposed to work



Source: Culpin (2000: 114)

The provincial level of government, consisted of four provinces (Natal, Cape, Transvaal and Orange Free State) was made up of a Provincial Council, an Administrator and an Executive Committee (all white). Second tier government was not limited to the four provinces, given the existence of four independent (black) homelands (Transkei, Bophuthatswana, Venda, Ciskei) and six self-governing territories (Lebowa, Qwaqwa, Gazankulu, KaNgwane, KwaNdebele and KwaZulu). However, like the four provinces, these homelands and self-governing territories remained accountable to central government. Separate racially based establishments were created for Blacks, Whites, Indians and Coloureds on the local level of governance. Residents of the non-white areas generally dismissed these autonomously elected local bodies. Added to this separation was the significant advantage that white local authorities had in terms of resources, facilities and services (Prinsloo, Jansen and Vanneste 1999).

Political processes and organisations that shaped the political arena during the apartheid era were of both a conventional and an unconventional nature. According to Janda, Berry and Goldman (2009: 193) conventional participation can be defined as a relatively uncommon behaviour that uses institutional channels especially campaigning for candidates and voting in elections. Conversely, unconventional participation is regarded as a relatively uncommon behaviour that challenges or even defies established institutions and dominant norms. Because most conventional channels of political participation were limited to Blacks, their resistance to White domination took on the form mainly of unconventional political participation. The ANC is probably the best known organisation associated with resistance to apartheid. Many examples of defiance and unrest mark the apartheid years. Yet, it was possibly the Soweto uprising of 1976 that can be regarded as a turning point. What began as a student protest to compulsory education in the Afrikaans language, soon extended to the rest of South Africa (Prinsloo, Jansen and Vanneste 1999).

It was not only the general population that endured racial discrimination. Few Blacks were permitted into the medical field. Those who were accepted were subjected to schools with limited resources and, when admitted to White institutions, were demeaned by practices like prohibitions on Black medical students wearing white coats and stethoscopes in White hospitals. In addition, Black nurses were denied adequate training resources and the opportunity to use their skills in an appropriate manner (The American Association for the Advancement of Science and the Physicians for Human Rights Organization, 1998).

According to Van Rensburg (1991) in Ngwena and Cook (2005: 128) at the height of apartheid,

Whites disproportionately enjoyed the bulk of public expenditure on healthcare and received four times more per capita than their African counterparts, while Coloureds and Indians received a somewhat intermediate share. According to Van Rensburg, Fourie and Pretorius (1992) there was also racial fragmentation of services which was taken to absurd heights by the creation of separate departments of health for each of the ten 'Bantustans' serving the African population under the homelands policy of the Bantu Authorities Act, (Act No. 68 of 1951) subsequently renamed the Black Authorities Act, 1951. Frankental and Sichone (2005: 146) describe the Bantustans as being dependent on the South African state for their administrative, economic and security operations and were excluded from all international political, cultural and economic life. The main function of the Bantustans according to Frankental and Sichone (2005: 147) was to provide cheap labour to South African mining, manufacturing and agricultural industries. Williams (2010: 61) notes that under this legislation the government established a hierarchy of authorities consisting of tribal authorities, regional authorities and territorial authorities. However, at the top of this hierarchy were the White officials from the Department of Bantu affairs who supervised their activities. The lack of financial resources within the Bantustans was crippling. According to De Beer (1984: 57) no system of healthcare could cope with the epidemic of ill health in the Bantustans. There was a constant shortage of doctors and healthcare resources had serious consequences for the people living in the Bantustans. Van Rensburg and Benatar (1993) maintain that it was not until 1990 that social amenities such as healthcare were desegregated. But by then the dye of pervading and lasting socially engineered inequality in healthcare had been firmly cast.

Following the creation of the Bantustans, Lengfeld and Pienaar (2006: 52) state that the government began to force Black people who lived in so-called White areas to move into the homelands. Their land was taken away from them and sold to White farmers at very low prices. Subsequently, between 1960 and 1983 over three and a half million people were deliberately uprooted from their livelihoods, and plunged into poverty and hopelessness in the barren Bantustans. De Beer (1984: 49) states that the relocation of 'surplus people' into independent and self-governing Bantustans meant that the worst political problems associated with unemployment, housing shortages and squatter camps were experienced in the homelands. De Beer (1984: 51) substantiates this view by maintaining that the reserves were unable to provide an adequate subsistence for the population. As the population increased, forced settlement and overuse of natural resources continued to deteriorate.

De Beer (1984: 60) recounts three instances where the attitudes of health officials show how the poison of ethnic thinking has seeped into health services:

- It was reported in November 1982 that two student nurses at Sebokeng Hospital in Vereeniging were told to leave the hospital when it was discovered that they had Bophuthatswana and Transkei travel documents. A spokesperson for the hospital said that it was common knowledge that student nurses from 'foreign countries' could not be accepted without prior consent from their government;
- Dr G de Klerk, head of the Medical Association of South Africa is on record as blaming the spread of epidemics in South Africa on the breakdown of health services in the 'Black states'. South African health services, according to Dr de Klerk, compared with the best in the world. However, the health services of the neighbouring states and of the homelands were either in a state of collapse or totally inadequate; and
- In the White areas of Natal, an estimated 60 percent of African patients come from the homelands. This influx was at its greatest at the Taylor Bequest Hospital in Matatiele, where 98 percent of patients came from the Transkei. This led Dr Clark, in charge of hospital services in Natal to complain: "Natal's biggest health problem is that every one of our hospitals is burgeoning with foreign Blacks".

De Beer (1984: 62) states that health services in the apartheid era were not an attempt to meet the needs of the people; rather their operations reflected the needs and policies of the apartheid state.

Table 1 reflects the differences between White and African populations in Johannesburg in 1968.

Table 1. Rates per 1 000 of population

	White	***African***
Birth	21,63	46,46
Infant mortality	19,41	101,11
Maternal mortality	0,22	2,66
Tuberculosis incidence	0,28	4,56
Tuberculosis deaths	0,03	0,36
Death	8,12	11,95

Source: Report by the medical officer of health (1968). In Wells, L.G (1974:1)

Wells (1974: 2) draws a distinction between the common causes of death amongst Whites and Africans in Johannesburg where the most common causes of death among Whites were:

- Heart disease;
- Neoplasm's (e.g. cancer);
- Diseases of the nervous system;
- Diseases of the respiratory system; and
- Accidents, poisonings and violence.

Amongst Africans the most common causes of death was:

- Accidents, poisoning and violence;
- Diseases of the respiratory system;
- Heart disease;
- Diseases of early infancy; and
- Diseases of the digestive system.

Seedat (1984: 23) mentions that the economic, social and political status of Africans under apartheid ensured that the vast majority lived in conditions of great poverty and depravation. The effect that these conditions had on their health and well-being is evident in the severe morbidity and death of the African population. Seedat (1984: 31) takes up the argument by stating that Tuberculosis (TB) was rife in the Bantustans. The medical journal, the Lancet reported in 1970 that TB was present in 20 percent of babies under six months and that the majority of adults in the Transkei showed evidence of TB. Over 27 percent of notified cases of TB in

1981 were in the Bantustans. The South African institute of race relations (1982: 526) in Seedat (1984: 31) suggests that while the incidence of TB was halved amongst Whites since the beginning of the late 1970s it had increased by more than 40 percent amongst Blacks. In 1980 a total of 2 050 deaths were officially attributed to TB. De Beer (1984: 11) makes it clear that in the rural areas TB was flourishing and even possibly spreading. With sparse health services those with TB could possibly affect others or a person remained infected for life if malnourished or strained through over-work or some other illness.

Amongst the Black population, particularly the Coloured and African groups Seedat (1984: 11) maintains that unnatural deaths through homicide and violence took a major toll on adult lives. Disease of the respiratory system notably pneumonia, enteritis, diarrhea and heart diseases were an important cause of death. Hypertension was the second most common cause of heart failure amongst African adults, particularly found among the urban population. This form of hypertension was extremely rare in rural Africans – suggesting that stress in the urban areas under apartheid conditions, might have been a factor.

The country's health system remains unequal and ineffective – a lasting legacy of the apartheid system that still has an effect on its people and services of the present day. The notion of White supremacy and racial segregation were central pillars of the apartheid ideology that continue to hinder the government's attempts to restructure its healthcare system. This persistent inequality in the delivery of healthcare is illustrated in the nation's distribution of HIV/AIDS where Black South Africans bear the highest burden of disease.

The next section analyses how the health sector was governed, highlighting apartheid ideologies and how this has impacted the way in which health services are delivered today.

3. HOW THE HEALTH SECTOR WAS GOVERNED DURING APARTHEID

Although apartheid ended over 20 years ago, the country is still grappling with massive health inequalities. The HIV/AIDS pandemic for example emerged into prominence during the period when South Africa was striving to build a new dispensation based on non-racialism. It is argued that HIV/AIDS is a disease of poverty since various colonial and apartheid-era policies left the majority of the Black population impoverished. The problem with this argument according to Kenyon and Zondo (2011: 52) is that there is little available evidence in refuting the relationship between high levels of poverty and HIV/AIDS in South Africa. According to Coovadia et al (2009:8) there are marked differences in the rate of disease and mortality between the different races in South Africa. In their study on national HIV/AIDS prevalence among the different race groups, Shisana and Simbayi (2002: 46) conclude that the observed national prevalence among Africans is significantly higher as compared to other race groups. Some features of the apartheid healthcare system were:

- The health needs of the majority of South Africans were ignored;
- Most resources benefited Whites in Whites-only facilities;
- Some health services were developed in the 10 'homelands' but they were inadequate;
- Services for the Black population were extremely under-funded, and health workers battled to deal with the overwhelming need for healthcare. Patients, including young children and the elderly, commonly queued for hours to receive care;
- Hospitals serving the Black population were notoriously overcrowded with patients often sleeping on mattresses on the floor;
- By the 1980s, there were 14 health departments, each serving a specific area or racial group;
- Altruism on the part of private individuals and missionary societies went some way towards improving the plight of the Black population;
- Urban services were far better funded than underdeveloped rural services (Horwitz 2009: 1).

According to Coovadia et al (2009: 826) the backbone of the health system in the Bantustans were non-profit, missionary-run hospitals. Similarly Wells (1974: 20) suggests that a large part of the health services of rural South Africa was founded by missions. Wells (1980) builds on his previous statement by maintaining that mission doctors first started arriving in South Africa in the early nineteenth century. O'Reagain (1970) proposes that originally, health services were established to provide for the needs of the missionaries and their families, who were subjected to new tropical illnesses and required hospital services for this purpose. Subsequently, mission health services were set up to provide medical care for the African population, and also to play a part in the educational and religious uplift of the Bantu.

Roux, (1974) writing about mission hospitals in South Africa states that after the Second World War there was an expansion of mission stations in South Africa. By 1962, as many as 77,2% of the total of 14 976 hospital beds in homeland areas were administered by over 100 mission hospitals, while 10,7% were controlled by the Department of Health. Doyal (1979) noted that in many rural areas the mission hospitals provided the only health care services in the vicinity. Initially the state supported the activities of the mission hospitals as they clearly provided a valuable service at little direct cost to the state.

But by the late 1960s Van Rensburg and Mans (1982) wrote that a combination of factors led to the introduction of a policy by the South African state to take over rural mission hospital services. The state began this process of take-over by providing subsidies to these hospitals, initially on a 50-50 basis. This involved a certain degree of control being handed to the state by allowing the hospitals to be inspected by the provincial administrations. Wells (1980) was of the opinion that most of the missions certainly needed the financial assistance although many saw it as a first step towards complete government control.

3.1. Segregation of health services

According to Dookie and Singh (2012: 1) the historical inequalities of healthcare delivery in South Africa have placed a huge strain on an already over-

burdened public health sector. South Africa has a legacy that is deeply entrenched in racial discrimination; in fact this subject has received widespread attention where researchers have long described the various ways in which the deeply entrenched differential allocation of privileges based on race have had adverse consequences on the health of Black individuals. Extensive research suggests that there is constant interest in the degree to which perceptions of discrimination are stressful life experiences that can adversely affect health. Gilson and McIntyre (2002) maintained that the disparities of South Africa are largely attributable to the racially discriminatory economic and social policies of apartheid - regarded as unacceptable inequalities.

Williams, Gonzalez, Williams, Mohammed, Moomal and Stein (2008: 4) suggest that there is limited population-based studies in South Africa that have assessed the levels of perceived discrimination and its potential health consequences, and there is reason to believe that assessing perceived racial discrimination will be challenging. Hunt (2006: 204) observes that discrimination and stigma amount to a failure to respect human dignity and equality by devaluing those affected, often adding to the inequalities already experienced by vulnerable and marginalised groups.

Table 2. Medical staff in selected Bantustans, 1981

Bantustan	*Medical and dental staff*	*Nursing staff*	*Paramedical staff*	*Pharmacists*	*Other*
Lebowa	95	1	13	12	5
Gazankulu	40	6	6	5	7
Venda	17	15	5	3	4
Ciskei	81	12	17	6	12
KwaZulu	265	23	28	21	184
QwaQwa	3	2	1	1	5
Bophuthatswana	90	46	8	7	20
Transkei	124	18	4	2	6

Source: Survey of race relations in South Africa, (1982: 541)

3.2. Private practise

De Beer (1984: 19-20) explains that services provided by private doctors were totally inadequate – not according to need but according to means. In other words, the best medical care was available to those who could afford it. One of the consequences of private medical care was that doctors congregated where affluent people lived. During this time there was one doctor for every 308 White person in Cape Town as compared to one doctor for every 22 000 people in Zululand and one doctor for every 30 000 people in the Northern Transvaal.

Thus the provision of private care accelerated inter-racial health inequalities. According to Muiu (2008: 163) as a result of unequal access to health services, Whites lived longer than Africans, a pattern that has continued in the new South Africa. As a result of apartheid Whites only hospitals were empty while hospitals that catered for Africans were poorly staffed, poorly equipped and over-crowded. Apartheid health services ensured full provision for the minority and prejudicial services for the majority. These services did not emphasis preventative medicine, such as immunisation, nutrition and sanitation. Instead they focused on curative medicine. Most people who could not afford to pay for health services were forced to depend on over-the-counter medicine, which, in most cases, worsened their situation. Privatisation of health services served as an economic need for the wealthy because it reinforces interest groups that influence government medical policy.

3.3. Hospital apartheid

Seedat (1984: 64) states that being a patient of the public health sector in the apartheid era meant spending an entire day including the evening waiting for treatment at some busy major hospital. Although some clinics were set up in townships to provide a quicker service, these were badly staffed, often only with nurses, and possibly a doctor coming in for a few hours per day. Worst off were the inhabitants of rural areas where the population was served only by mission hospitals to which many patients had to travel long distances. In contrast White patients had better access to better facilities. This included less crowded hospitals, speedier referral and better equipped surgeries. All facilities were segregated, those for Whites being amongst the best in the world and those for Blacks being greatly inferior.

According to Seedat (1984: 64-66) an investigation by journalists who visited Baragwanath Hospital in 1983 revealed that in one ward 40 beds were occupied by 89 women. Stickers marked 'urgent' were stuck on the foreheads of critically ill patients because it was the only way that doctors could identify urgent cases. At night more than half of the patients slept on the floor. Similar conditions existed in other hospitals. Coronation Hospital which only had 505 beds was supposed to serve the entire Coloured and Indian population of Johannesburg, which included outlying areas such as Lenasia. In Natal, King Edward Hospital was supposed to serve the entire Black population of the province with 2 000 beds. Statistics revealed that the hospital dealt with 600 000 out-patients per year. In 1977, the Livingstone Hospital in Port Elizabeth demonstrated appalling conditions where women in labour were subject to laying two to a bed, on mattresses on the floor and on trolleys in the corridors. Meanwhile there were empty beds in the White section of the hospital. In 1976 Black patients at the Groote Schuur Hospital in Cape Town slept on trolleys – sometimes for weeks. During this time bed occupancy in the Black section was 110 percent and in the White section 75 percent.

Discriminatory attitudes according to Seedat (1984: 12) were evident in family planning services, which were largely concerned with controlling the

size of the Black population. Whites feared being swamped by a numerically larger Black population, evident in Whites increasing the size of their families. The state spending on family planning in 1976 was increased to R5.3 million. In 1971, the Director-General of the Department of Health, Welfare and Pensions, DR Johann De Beer, warned that sterilisation and abortion might have to be made compulsory unless certain ethnic groups accepted family planning measures. During this time White and Indian birth rates both stood at 16 percent per 1 000, the Coloured birth rate was 26 percent per 1 000, and the Africans 35 percent per 1 000.

3.4. Health workers

Seedat (1984: 84) explains that by the end of 1981, a total of 3 920 medical specialists and 16 787 general medical practitioners were registered with the South African Medical and Dental Council. The doctor patient ratio was 1: 330 for White people, 1: 730 for Indian, 1: 12 000 for Coloured and 1: 91 000 for African. Medical practitioners were unequally distributed. While approximately 60 percent of the population lived in rural areas, only 5percent of doctors practised there. The distribution of doctors by universities also illustrates the bias of skills and expertise towards the urban areas. For example, 30 percent of all doctors operating in rural areas came from non-South African universities. Immigration also led to the shortage of medical practitioners. Between 1970 and 1975 it is estimated that 14 percent of all medical graduates left the country permanently. Since then, emigration by doctors from South Africa for financial and political reasons has continued. A total of 123 doctors have left South Africa permanently in 1979, 59 doctors in 1980 and 55 doctors in 1981.

One factor which affects the distribution of doctors according to Wells (1974: 32-33) is that they are unreasonably disqualified from entering the profession. Educational opportunities for Africans, from primary schools upwards, were controlled by Whites through the restraint of finances for education. There was only one medical school in the country which would admit African medical students, and in 1972 only 15 Africans qualified as doctors against 440 Whites. Yet, even if all medical schools were open to Black students; the numbers would be restricted based on the limited education available to Africans.

Table 3. The South African school applications received and accepted by race 1986

University	*White*	*Asian*	*Coloured*	*Black*
Cape Town	260/116	43/20	81/7	53/37
MEDUNSA	-	-	-	1495/180
Natal	0	25/2	334/39	153/37
Orange Free State	447/123	0	0	0
Pretoria	838/224	0	0	0
Stellenbosch	693/169	124/18	0	0
Witwatersrand	792/142	53/13	371/33	332/2

Source: Survey of race relations in South Africa (1987/88)

According to O'Reagain (1970: 89) there were also marked differences in the salary scale of Whites and non-Whites. A White medical officer, for example, received a salary by the end of his/her fourth year equal to that of a Coloured or Indian senior specialist. In 1966, salaries paid to White doctors were increased by about 20 percent while those paid to non-Whites remained the same. According to Baldwin-Ragaven, De Gruchy and London (1999: 40) African doctors were paid even less than their Indian and Coloured counterparts and African females less than African males. In addition Black doctors did not receive annual bonuses - only Indian and Coloured doctors received bonuses. It was only when Indian and Coloured doctors threatened to return bonuses that the authorities agreed to grant bonuses to all doctors.

O'Reagain (1970: 89) goes on to argue that Black doctors were granted less leave that White doctors. Black junior doctors were given one-and-a-half days leave per month worked compared to two days for their White colleagues. Postgraduate training, particularly in the subspecialties, was limited for Black doctors. In order to become a cardiologist for example, Black doctors had to leave the province, or even the country, to receive training. Other difficulties experienced by Black doctors included obtaining housing subsidies, qualifying for pension schemes, withdrawal of special travel/inconvenience allowance and difficulty in successfully pursuing and academic career.

The humiliation of medical personnel on the grounds of skin colour was also experienced by nurses. According to Baldwin-Ragaven et al (1999: 167-68) the Nursing Amendment Act which was passed in 1957 stipulated that all members of the South African Nursing Association (SANA) had to be White and could only be elected by White nurses. Different registers were maintained for different race groups, and the SANA Board was to be elected and controlled by Whites only. The act also stipulated that Black nurses could not give orders to White nurses; Black doctors could however give orders to White nurses. However, this practise was not well accepted by many White nurses and, up until 1979, there were reports of White nurses refusing to work under non-White doctors. In the 1970s Black nurses were prohibited by law for attending to White patients. Marks (1994: 190) states that private hospitals faced losing their registration if they allowed Black nurses to attend to White patients.

Wells (1974: 40) states that Black nurses received less pay that White nurses, they were often blocked from promotion and had very little contact with nurses visiting from overseas. In addition they worked in overcrowded understaffed wards, with sicker patients than their White counterparts dealt with. Remarks about Coloured nurses were expressed openly in their hearing. – seen as Coloured first and nurses second.

4. CONCLUSION

Change especially in the health sector has been profound and yet it seems as though nothing has changed. Agreed – apartheid no longer exists, society has been desegregated and inequality has been deracialised. However old patterns of segregation and inequality persist where old hierarchies reach into the present.

Twenty years into democracy, many features of apartheid still plague the health system. Whilst the fourteen health departments of the apartheid era were problematic, the sharing and co-ordination of responsibilities between the present national, provincial and local levels of government remains a complex process. Although the new health system is based on the concepts of primary healthcare, the health status of much of the Black population remains poor, reflecting the level of poverty and other factors, both social and educational, which impact negatively on the health of communities. Judged on these criteria apartheid was a failure.

Despite these obstacles, progress has been made. Apartheid healthcare systems have been eradicated. All South Africans have constitutional protection of the right to healthcare and there is a commitment among the medical fraternity to provide high-quality health services for all. The professional bodies: the Health Professions Council of South Africa and the Medical Association of South Africa have been transformed. There is improved access to healthcare and greater attention to healthcare priorities including the present AIDS epidemic.

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