



Globalisation and local power: influences on health matters in South Africa

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Abstract

This paper reviews some of the multiple influences on health issues in South Africa, placing them in the context of globalisation. By examining the complexity of factors, both domestic and global, which impact on these issues, it questions the extent to which global patterns in areas such as health policy, HIV/AIDS, health care pluralism, and neo-liberal macroeconomic policy have played out in South Africa.

The identification of some of the multiple and complex forces in each case reveals a relatively consistent story of global pressures interacting with domestic realities, with some recognizably local results. There is no doubt that a full and nuanced understanding of health in South Africa requires an appreciation of developments in the global political economy, international organizations such as the WHO and World Bank, and forces which operate outside of institutions. In each case, however, the specific opportunities available to actors within the country, as well as the relative power of those actors, should be given their due consideration in analysing their potential impact on health matters.

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1. Introduction

In the last decade, South Africans have seen profound political transformations in their country; at the same time, they have also been confronted with a wide range of challenges to their health. This paper reviews some of the multiple influences on these issues in South Africa, placing them in the context of the disparate group of international trends and pres-

ures commonly described as globalisation. The paper examines the web of factors, both domestic and global, which impact on South African health matters, and questions the extent to which global patterns in areas such as health policy, HIV/AIDS, health care pluralism, and neo-liberal macroeconomic policy have played out in South Africa.

This paper is not a quantitative study examining changes in life expectancy, infant mortality or any other direct or indirect measures of population health as a result of globalisation. Instead, it sets out some of the key elements of the South African health and healthcare landscape, focussing on those

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areas in which international forces are seen to play a substantial role. In each case the paper traces out the interplay of various trends and tensions, drawing on the qualitative evidence available to understand the drivers behind the various health matters considered.

1.1. *Historical context*

Pressures on the health of South Africans from outside the borders of the country started even before those borders were created. The establishment in 1652 of a Dutch settlement in what was later to become Cape Town, the arrival within two centuries of British settlers and laws, and the explosion of the mining industry in the late 19th century with the discovery of gold and diamonds all came with associated costs and benefits to the health of people living at the southern tip of the African continent. Each of these developments was driven by the expansion of international trade, travel, and communication; at the same time, they brought with them influences on health as diverse as war, diseases, allopathic medicine, methods of food production and preservation, and new working environments and conditions. In addition, insofar as they shaped the structure of what was to become South African society, global forces had a profound impact on the distribution of health and disease within the country through the links between social position and health [1,2].

However, while South Africa has in the past been influenced by events outside its borders, ‘Globalisation’—with a capital G—suggests something more than this. The ubiquitous use of the term in the last decade reflects a widespread perception that we are living in a world where people are progressively more dependent on, and aware of, events in distant geographical regions. Economies in particular are seen as being increasingly interdependent, with massive growth in world trade and the spread of financial markets, an unprecedented dominance of market forces, and the transformation of production systems and labour markets. The spread of liberal democracy and its values of freedom of speech and association, the expansion of international media empires, and the growth of the Internet and other technological innovations, are also commonly associated with globalisation [3].

This perception of ever-widening global links also suggests the corollary: that the ability of individual nation-states to determine their own policies and maintain their own distinctive identities is steadily declining as international pressures become increasingly powerful.

The international economic trends of the last few decades must, however, be viewed with a sense of historical perspective. In a wide-ranging examination of three aspects of the world economy—world trade, foreign direct investment, and the expansion of all capital flows—Hoogvelt [4] argues convincingly that developments in the recent decades point to a ‘deepening’, rather than ‘widening’ of economic integration. She shows, for example, that although it has grown tremendously in absolute terms, world trade currently forms a smaller proportion of world output than it did in 1913. Also, the respective share of trade which takes place between and within the ‘core’ countries in Europe, North America, East Asia and Australasia has grown over the same period. If anything, she suggests, countries in the ‘periphery’ are less involved in world trade than they were in the early part of this century.

To a large extent, however, technological innovations have enabled social and economic interaction across spaces that previously generated far more friction. Contrary to Hoogvelt [4], Goldblatt et al. [5] argue that today’s global economic system links national and global economies more closely than ever before. Acknowledging that this is not the first historical period in which international trade has been important, and allowing for the fact that contemporary trade may be uneven, they nevertheless maintain that trade today is more extensive and intensive than in previous periods, leading to increased international competition between countries and firms.

Goldblatt et al. [5] provide a useful framework for understanding globalisation and its impact on nation-states, while maintaining some sense of historical context. They point out, firstly, that the power of nation-states should be examined in relative terms. Governments have always had to operate within the framework of international politics and economics, and we should be interested in the extent to which the balance of power shifts between individual states and international forces. They argue, similarly, that international forces seldom remove absolutely any options—they tend rather to increase the costs and

decrease the benefits of any policy that may be contrary to the interests of powerful international players.

The preceding discussion suggests that an examination of these relative shifts in power between international and domestic forces is central to a nuanced understanding of South African health issues in an era of globalisation. This necessitates a review, firstly, of some of the most important global influences on these issues. This non-exhaustive list includes: international health policy; macroeconomic pressures; the expansion of multinational companies in the pharmaceutical industry; HIV/AIDS; and “health care pluralism” or “medical pluralism”. In each case this is followed by an evaluation of the multiple and complex interactions between these global forces and other domestic conditions.

1.2. International health policy

The origin of what today can be characterized as a ‘global’ health policy can be traced back to the late 1970s and early 1980s [6]. The *Health for All* (HFA) principles introduced by the World Health Organisation (WHO) and endorsed at international conferences (most notably the Alma Ata Declaration of 1978) made it clear that governments were responsible for the health of their citizens [6,7]. There were several critical threads to these principles: first, health was defined in a positive and holistic sense, rather than simply as the absence of disease. Secondly, the importance of equity in the distribution of health, both within and between countries, was stressed. Thirdly, multiple determinants of health were recognised, including social, economic, lifestyle and environmental factors [7]. One of the practical outcomes of these and other similar principles was the emergence of the Primary Health Care (PHC) approach, which stressed early, holistic, preventive care and the promotion of health, rather than more expensive curative medicine.

These principles marked a fairly radical shift from earlier thinking, which had focused simply on disease and medical solutions. This new, broader approach placed a much greater emphasis on socio-economic determinants of health, and in so doing helped to make health a central issue in development. The HFA principles dovetailed perfectly with moves within the development community to expand measures of countries’

progress from simple measures of income per capita to incorporate factors such as health and education [8]. The intertwining of health and economic growth suggested that progress would not be sustainable unless it improved the health and welfare of the citizens of poorer countries.

However, the new-found prominence of health and health care on the development agenda in the following decades meant, somewhat ironically, that WHO began to lose ground as the international institution responsible for health policy. To begin with, WHO’s more radical and broadly based strategy brought it into conflict with powerful international players. In two well-documented cases, both in the mid to late 1970s—the regulation of international marketing of baby foods, and the establishment of an Essential Drugs Policy for developing countries—WHO came up against extremely powerful opposition from massive multinational companies (in the food and pharmaceutical industries, respectively). In both cases, these companies received the full support of their home governments. The US government was particularly vocal in its objection to the perceived interference of the WHO in global trade practices, where it was seen as having no legitimate jurisdiction [9,10].

In addition to this opposition from powerful vested interests, WHO’s position in guiding health policy in developing countries has slowly been usurped by the institutions of the World Bank [11,12]. From the late 1960s, the Bank had been concerned with population growth and its perceived relationship with poverty. By 1980, the Bank began direct lending for health services, on the grounds that it could provide technical expertise and analytical skills, and with an understanding that health was a vital factor in determining productivity and poverty levels. By the end of the decade, the World Bank had become the largest international funder of health sector projects [12]. The Bank is also extremely influential in guiding other bilateral and multilateral aid, with the result that Bank-approved projects are likely to receive additional funding from other sources.

The significance of this shift in power has been immense. In keeping with the World Bank’s wider neo-liberal programme of privatisation, liberalisation of trade, and rolling back of government, its policies have overwhelmingly favoured reductions in government health expenditure and greater opportunities

for private providers of medical care and drugs [13]. Evidence suggests that reductions in health spending have been closely related to a country's degree of indebtedness and participation in World Bank and IMF adjustment programmes [14]. Expenditure on health in Zambia fell 22% in real terms from 1982 to 1985, with a similar drop of 70% in Bolivia from 1980 to 1984. These reductions brought with them declines in child immunisation programmes, shortages of health supplies, and the re-emergence of manageable diseases such as typhoid, tuberculosis and hepatitis [14].

The limitations and imperfections in the private market for health care are well documented: asymmetric information between doctors and patients, incentives for providers to over-prescribe, the status of health and health care as a public good, and the existence of externalities are the most commonly noted economic reasons for government intervention in health care markets [15]. These problems must be kept in mind when considering the increased influence of the World Bank on health policy, considering its preference for free markets and minimal government regulation.

In South Africa, however, this process has operated almost in reverse. Before 1990, the National Party government had dedicated most of its health care resources to tertiary, curative care catering primarily for the white minority, which held political and economic power. While most white South Africans had access to health care which compared well with the United States and Europe, others were dying of curable diseases such as tuberculosis and malaria [16]. Unsurprisingly, the WHO's push for PHC in the early 1980s did not meet with much interest in the apartheid government of the time.

However, when the African National Congress (ANC) took power in 1994, the principles of HFA and PHC were a central feature of their health policy [17]. The party's election mandate was largely about redressing the wrongs of the past, and providing basic health care, education and other social services to those who had been previously deprived of such access. Between 1994 and 1999, a host of health policy reforms were introduced in keeping with these principles. These included the introduction of free health care for children under 6 years of age and pregnant women, the establishment of an essential drugs list,

national immunisation campaigns for polio, measles, and hepatitis B, and school-feeding programmes [18].

In addition to reforms within the public health sector, the Department of Health also aimed to restructure the private health sector in such a way that all those who could afford private care would be covered privately, freeing up public resources for those who could least afford care. In 1994, approximately 23% of South Africans (the majority of them white) relied on the private health sector for health care; they accounted, however, for over 60% of the country's health care expenditure. The financing for the vast majority of this care came from private medical schemes and health insurance companies [16].

A series of reforms to the Medical Schemes environment in 1989 and 1993 had substantially deregulated the private health financing industry, allowing for the introduction of age-related premiums, stricter underwriting and a much wider range of product designs. After 1994, the Department of Health attempted to reverse these trends with the introduction of community rating and guaranteed issue, meaning that medical schemes could not charge different premiums based on a member's age, nor could they refuse cover to someone because of their health status. The aim of this legislation, in keeping with the Department's wider mandate, was to extend private cover to the old and the sick that were currently being excluded [19].

There has been extensive and on-going opposition to this legislation and the regulation surrounding it from the private health financing industry, with the main stated concern being a likely increase in the costs of private care and the ensuing destabilisation of the market.

One clear message which can be drawn from this story is that the South African government (at least as far as the Department of Health is concerned) has the desire and ability to move in directions which conflict both with international trends in terms of deregulation of the private health care sector and with the powerful interests of local providers and funders. Global pressures and policies do not appear to be the drivers of reform in South Africa: strong domestic imperatives to be seen to be providing health care to all seem to dominate thinking within the Health Department (at least in this particular case).

There does seem to be an underlying conflict between the government's redistributive health policy

(which is bringing it into direct conflict with big business) and the government's more conservative macroeconomic strategy. This points to the importance of influences on health matters operating outside the health sector, and in particular those which operate through macroeconomic factors. Weil et al. [20], for example, examine the impact of development policies in five areas outside the health sector: macroeconomic policies; agricultural policies; industrial policies; energy policies; and housing policies. It is clear that policy and practice in each of these areas can have fairly direct impacts on the health of South Africans; for the sake of space, however, we will expand on only one of them—macroeconomic policy.

1.3. *Macroeconomic policy*

The section above alluded to some of the impacts of macroeconomic strategies on health, primarily through their influence on government expenditure on health and attitudes towards the privatisation of health care services. Weil et al. [20] enumerate some of the multiple and dynamic links between macroeconomic variables and health status. These links operate in two main channels: (1) through the impact of macroeconomic policy on government spending, particularly on health and education; and (2) through the effect of policy on household income and how this translates into food consumption and nutritional status of an individual. Tracing one path through, the link might work as follows: a country's exchange rate and balance of payments will to some extent shape the structure of the local economy, and in turn the wages of individuals working in a particular export market, for example. This will in turn determine the real income of that worker's household, which (depending on the relative power of individuals within the household) will affect individual food consumption and consequently nutritional status and health. In a similar way, levels of external borrowing, domestic and foreign investment, and credit availability all have some impact on individual health.

A cursory examination of South African macroeconomic policy in the last decade shows many of the familiar features of Structural Adjustment Programmes, and it would be relatively simple to tell a story of redistributive social policies being abandoned in favour of market-friendly economic liberalisation programmes.

In 1994, the ANC was voted into power in the country's first inclusive democratic elections on a broadly based Redistribution and Development Programme (RDP). As the RDP evolved, it drifted away from policies such as extending public ownership in critical industries and strengthening the role of organised labour in policy-making, towards a paradigm which protected property rights and would require the rationalisation of the public sector. However, in spirit, it remained true to its commitment to some form of substantive redistribution and redress of historically entrenched social and economic inequalities [18].

This redistributive and restorative programme lasted only 2 years before being taken over by a new macroeconomic strategy: Growth, Employment and Redistribution (GEAR). Although the RDP had technically been internalised rather than abandoned, GEAR's main focus was on economic growth through a familiar set of market liberalising reforms which aimed to increase private investment (especially foreign), enhance export competitiveness, and achieve improvements in productivity. These aims translated into deficit reductions, strict controls on public spending, tight monetary policy to maintain currency stability, the removal of tariffs and exchange controls, and reductions in corporate taxes. It was hoped that these measures would lead to sustainable economic growth, bringing with it more jobs (especially in labour-intensive industries) and therefore economic redistribution [18]. In essence, it called for a structural adjustment programme which would make the local economy attractive to foreign investors, create jobs, and improve the welfare of the poor both by providing jobs and by using the extra public resources generated by economic growth.

This narrative, however, misses some key local developments. In many ways, the government has remained true to its mandate of widespread structural reform and spending on social services. Since 1994, spending on community and social services (including health, education, housing, and welfare) has grown consistently in real terms. In 1998/1999 and 1999/2000, for example, total spending in these areas grew by 29% and 10.6% respectively, while inflation over the period was only 5.6% per annum [21]. In addition, there have been significant attempts to correct massive discrepancies in the distribution of resources within these sectors. The emphasis has

partially shifted from high-level tertiary services, which historically catered for a predominantly white, urban minority to primary services aimed at the majority of the population (this is true for both the health and education sector). Also, since 1994, 1.2 million houses have been built, hundreds of thousands of additional toilets have been provided, and almost four million houses have been electrified [22].

It is almost impossible to determine how all of these policies have impacted on health. Public spending on health, education and housing should all translate into some benefits, yet the failure to create new jobs may have the biggest impact on individual health [23]. In addition, the government has failed tragically and publicly to deal with the threat of HIV/AIDS in any meaningful way. In terms of human life and quality of life lost, it is possible that mistakes here could easily outweigh any positive reforms in other areas. Also, even in areas where the Department of Health has been praised for its actions—e.g. in providing free care for young children—policy declarations about improving basic health services have not always been matched by systematic implementation and sustainable programs.

A final problem may be the effect of increasing and changing inequality on population health. As Jenkins and Thomas [24] illustrate, although between-group inequality (i.e. differences between racial groups) has been decreasing in South Africa since the 1970s, within-group inequality has been increasing, resulting in little overall reduction in inequality. There is also growing evidence that inequality itself has an independent impact on population health in an international setting [25], and some initial evidence confirms this pattern in South Africa—it is likely that the gross inequality entrenched by apartheid laws and structures is largely responsible for the poor health status of many South Africans [23]. A conservative macroeconomic strategy favouring the emergence of a black middle-class without any wide-scale redistribution can only exacerbate the growing within-group inequality, with likely harmful effects on population health.

The government's macroeconomic policy since 1994 does not suggest any straightforward conclusions. GEAR's conservative foundation may be in keeping with the preferences of global business and international institutions, yet the government has nevertheless maintained a commitment to substantial, and

possibly increasing, spending on health. It is true that this has sometimes been marred by poor implementation, and that the lack of a coherent approach to deal with HIV/AIDS has been disastrous and tragic. Also, it is likely that macro factors such as the creation of jobs and the spread of inequality could have a greater impact on peoples' health than the provision of hospitals and doctors, even if this is at a primary level.

Yet a key question is whether the changes described above have been driven primarily by globalisation (whether this relates to the increasing power of capital and decreasing power of labour, pressure from international financial institutions, or the spread of liberal democracy and market forces) or by domestic politics.

We have alluded previously to possible incompatibilities between a wide-scale redistributive health policy and a more conservative macroeconomic policy. There have, for example, been hints of conflict between the Departments of Finance and Health: during meetings of the Health Care Finance Committee in 1994 to discuss proposals for national or social health insurance, “[Department of Finance representatives] were particularly concerned that some of the health care financing approaches considered as options for tackling the funding gap, such as a dedicated payroll tax, would be inconsistent with policy” [18, p. 58].

There is evidence to suggest, however, that these potential contradictions do not represent a conflict between a redistributive domestic agenda and neo-liberal international pressures. Rather, pressures on both sides are coming primarily from local, rather than global, sources. Clearly, the pressure for redistribution comes from a domestic electoral support base of millions of people who were historically deprived of access to jobs, health care and education. Yet the forces pushing in the other direction—i.e. for a more conservative macroeconomic policy—are also predominantly local. Several authors have argued convincingly that the peaceful transition to democracy after 1990 was the result of an “elite pact” between white political and economic elites and their black counterparts who saw a mutually shared interest in ensuring a peaceful future where property rights, the potential for profitable business, as well as rapid advancement for the fortunate few who had emerged from the apartheid years with a decent education and political contacts would be ensured [26,27].

As we go on to argue in the following section, the ANC government has been prepared to resist the pressures of large international companies—and their governments—when this has been in keeping with their domestic agenda.

1.4. Multinational companies

Multinational companies in a wide range of industries are seen by many as embodying the worst of the dangers posed by globalisation to the health of people in developing countries. Dangerous working conditions and child labour are obvious culprits; when they occur in factories which produce goods in developing countries for companies and consumers based predominantly in the wealthier countries, they are doubly destructive. Similarly, pharmaceutical companies which devote their research and development budgets to treatments for high cholesterol, ulcers and depression rather than malaria, tuberculosis and HIV/AIDS, are easy targets (at least in terms of rhetoric). Multinational tobacco is also slated for targeting young and poorly educated potential customers in eastern Europe, Africa and Asia [11].

The relationship between the South African government and some of these multinationals has been especially interesting. Most notably, in the pharmaceutical industry, there have been various confrontations since 1998 over the parallel importation of drugs to South Africa, especially for the treatment of HIV/AIDS. In 1998, the Minister of Health, Nkosazana Zuma, championed legislation which would allow for the importation of generic drugs from the cheapest international source. This legislation was fiercely opposed, both by the pharmaceutical companies, and, initially, by the US government—South Africa was placed on a trade watch-list for potential violations of intellectual property rights. Thirty-nine pharmaceutical companies brought a case against the government for infringement of international trade law, and only after a wide-ranging public campaign following the start of the trial did the pharmaceutical companies withdraw their case [28,29]. Several of the companies have since offered to provide anti-retroviral drugs at little or no cost to the public sector and HIV/AIDS NGOs (this offer has not as yet been taken up by the government, but an extensive discussion of this is well beyond the scope of this paper).

This seems to suggest that power of multinationals might not be as overwhelming as some believe. It is unlikely that the companies would have dropped their case without substantial publicity and pressure from civil society in their home countries, and the influence this might have had, in turn, on the home governments in the West. Yet it does show that there are means available for the governments of relatively small countries to manage the risks posed to the health of their citizens by multinationals, without sacrificing their international standing.

1.5. HIV/AIDS.

In 1997, *World Health*—the magazine of the World Health Organisation—devoted an issue to globalisation and infectious diseases. It brought to the fore the new health problems exacerbated by processes linked to globalisation, with a special emphasis on HIV/AIDS [30]. There is full agreement that HIV/AIDS is a global phenomenon. Bancroft [31, p. 89] states that this does not . . . “imply that it is the same everywhere. Rather, the spread and impact of the virus and the disease are delimited by the differential access to resources, power and control of different groups of people in different parts of the world”. He further argues that “[t]hese inequalities and differences can be understood in terms of globalisation, in the sense both of global flows of power and resources, and of a changing, rapidly evolving relationship between the global and the local” [31, p. 89]. The development of the HIV/AIDS epidemic in South Africa, as well as the government’s response to it, provide clear support for the argument advanced above [32].

The dramatic spread of HIV/AIDS in Southern Africa has been facilitated by globalisation, partly through the impact of modernity and modern nation-state structures on the region. The economic development of Africa brought with it rapid urbanisation and cheap, fast transport; factors such as the creation of roads and urban centres, social conflict and the general mixing of people, social liberalisation and growing sexual freedoms, have all contributed towards the dramatic spread of the disease. This has been further fuelled in South Africa by the aberrant social structure created by the system of migrant labour and the separatist policies of the apartheid regime.

Since globalisation is conceptualised as an exchange which often creates and reinforces inequalities between and within countries, it can help to explain the global pattern of the epidemic along the traditional lines of social inequalities such as geographic location, class, race and gender. In South Africa, race and gender are the most significant determinants of vulnerability in the context of the epidemic [33]. This is true not only with regard to the spread of the infection, but also when it comes to access to treatment. In terms of Bancroft's argument, then, the "disease is filtered according to local inequalities of race, class and gender" [29, p. 94].

A paradox of globalisation is that the availability of allopathic medicines or treatments for HIV/AIDS in developing countries can widen inequalities between people. This is definitely the case in South Africa—most of the white population has access to the latest available treatments, while these same treatments are beyond the reach of those most in need. The now famous confrontations of the Treatment Action Campaign (TAC) with the South African Government (over the provision of anti-retroviral drugs to pregnant mothers) are an example of attempts to reverse this perverse situation [34].

Global forces have also had an impact on lifestyles and social relationships which have been shaped by, and have continued to adapt to, the tensions between local and global in ways that have significant implications for health. One such example is the dramatic improvements in communication, which have enabled transmission of information and images that transcend national and cultural boundaries. However, the mass communication networks and the growing use of computers have brought the latest available medical technologies closer to home in a differential manner; for most of the population they remain out of reach physically and culturally (particularly with regard to the prevention and treatment of AIDS). This helps to create a global culture which is often in conflict with local social realities, values, and mores. The refusal of the government in South Africa to provide anti-retroviral drugs on the one hand, and the uncritical emphasis on the use of condoms in health promotion campaigns on the other, provide the necessary evidence that reliance on global information and efforts is problematic in the local context and needs to undergo further scrutiny [35].

1.6. *Health care pluralism*

One of the impacts of globalisation on health—the existence of pluralism in health care—is, as Cant and Sharma [36] point out, nothing new. A multiplicity of choices of health practitioners, treatment modalities, and ways of understanding and explaining health and disease have always featured in non-western as well as western societies [37] although the nature of the various healing systems and their relations to each other differed. The dominance of allopathic medicine in the western world has not been fully reproduced in non-western countries, in which indigenous healing systems have been prominent [38–41]. In much of the non-western world, allopathic medicine (or western medicine) is associated with the colonial state and linked to control and surveillance of local populations. Although, according to Cant and Sharma [36, p. 177] "... the colonial state was, in general, either indifferent or actively hostile to indigenous forms of healing", they have continued to flourish to this day [42].

In 1977, the World Health Assembly of the WHO passed a resolution promoting the development of training and research related to traditional medicine, followed by the introduction of the HFA principles in Alma Ata (1978). These principles included resolutions to promote the incorporation of both practitioners and useful elements of traditional medicine into national health systems [43]. Following this, many developing countries have taken action to develop policies and programmes for the integration of traditional systems of medicine into national and Primary Health Care systems [44], despite the problems associated with the potential collaboration between bio-medical and indigenous health practitioners [45].

According to Janes [13, p. 1805] ... "The health transition encompassing growing populations, increasing social inequality, globalisation and structural adjustment at the hands of international financial institutions and a consequent decline in government investment in health care services, will likely create a new rationale and a potentially vast market, for alternatives to expensive and increasingly inaccessible (and arguably ineffective) biomedicine." In addition he argues that ... "the epidemiological force of the health transition, the political goals of government and the economic impetus of the marketplace each

have the potential to have a profound transformative effect on indigenous medical systems [13, p. 1810].

In the last 20 years, the hegemonic position of allopathic medicine in western-countries has been threatened due to diminished public belief in its ultimate abilities to cure diseases and treat the sick. This has also been interpreted as symptomatic of the shift towards the post-modern and its emphasis on a plurality of cultures and acceptance of multiple discourses [46]. In most of the western-world there is a growing tendency to use complementary and alternative medicine (CAM), among both consumers and providers of health care. This trend is accompanied by a process of professional and institutional 'legitimation' of CAM [47].

The South African case of 'medical pluralism' or 'health care pluralism' presents an example in which the global forces and processes discussed above are manifested in a unique context linked to the formation of local alternatives.

There is evidence to suggest that in the second half of the 19th century western-white healers did not treat traditional indigenous healing and healers with the disdain and arrogance apparent in later years. To the contrary, there was a degree of recognition and mutual exchange [42]. This co-operation disappeared during the apartheid years due to a marked government bias towards western/allopathic medicine, which in the South African context was (and to a degree still is) considered as medicine of and for white people (mainly because most allopathic practitioners have been white and bio-medicine has been less accessible to the African population).

Although, according to the global trends outlined above, new attention has been given to indigenous healing and its potential benefits in the context of PHC and HFA, the South African apartheid health services did not adopt these recommendations immediately after the Alma Ata declaration as did other African countries. In so doing, they succeeded in maintaining the hegemony of allopathic medicine, while at the same time keeping it inaccessible for the majority of the African population. The political transformation process that started in the early 1990s and culminated in the new political dispensation in 1994 has sought to change this scenario.

There are an estimated 150 000–200 000 traditional healers in South Africa, but there is no single regula-

tory body (they are presently licensed by about 100 organisations). Despite the fact that the government has set the necessary procedures in motion to legitimise these practitioners, very little has changed on the ground. Since traditional healers as yet have no statutory position, government does not financially support their services [48].

However, despite the lack of official organisation and legal recognition, indigenous healers continue to occupy a significant place in the list of choices of healing systems available to the majority of the population. It seems that in the public health arena, they have been included as important partners in many collaborative PHC projects initiated by some local health care authorities as well as non-governmental entities [42,48]. In the private sector, mainly due to pressure from employees, some companies have recognised the need for the inclusion of traditional healing (as well as CAM) in their health and medical insurance packages [48].

The situation seems somewhat paradoxical—indigenous healers used by the majority of the historically disadvantaged communities do not form part of the nationally financed health care system; yet this system prides itself on its unequivocal support of the Primary Health Care approach as articulated in the Alma Ata declaration. Only when their official recognition materialises (this seems unlikely to happen in the near future) will the indigenous healers be able to fulfil their designated role as envisaged by the WHO in a similar way to indigenous healers in other countries who participate formally in providing a nation's health service [43,49].

The HIV/AIDS epidemic and its rapid growth in South Africa has added an additional dimension as well as a certain urgency to the processes outlined earlier. The high rates of infection and the inability of the government and its health services (or bio-medicine) to curtail the rapid spread of the disease [50,51] have attracted renewed attention to the potential contribution of indigenous healers towards the efforts to curb the epidemic. Indeed, many local and provincial programmes rely on the training and participation of traditional healers, mainly due to their physical availability and cultural accessibility to the communities mostly in need. It is also the result of a lack of sufficient funds and resources within the official health services, as well as the cultural barriers they have been confronted with in their health promotion campaigns. Thus many

HIV/AIDS programmes have been initiated with the active participation of indigenous healers, the support of government, and funding from non-governmental organisations and foreign agencies [48].

Globally, the control of HIV/AIDS has been driven mainly by the official public health services. In South Africa, it seems, indigenous, complementary and alternative medicine are playing an important role in the epidemic, depicting the local social and cultural context. However, further exploration of this issue is beyond the scope of this paper.

2. Discussion and conclusion

This paper has identified and sketched some of the multiple and complex influences on health issues in South Africa. In each case, a relatively consistent story has emerged of global pressures interacting with domestic realities, with some recognisably local results.

In the international arena, the most powerful voices in health policy have shifted from the holistic strategies of the WHO to the broader rationalisation programmes of the World Bank. The principles of Primary Health Care are still given due priority, but they must now be implemented in the context of a shrinking public health sector. We have seen that in South Africa, most of the movement has been in the opposite direction—from an apartheid-era emphasis on self-sustaining private health care, predominantly at a tertiary level, to a focus on broad-based public health care, provided through an equitable government health sector. This shift has occurred in the face of a recognisably neo-liberal macroeconomic policy, again driven by local alliances. And in an era where many question the power of small states against multinational capital, the South African government has successfully challenged one of the most powerful industries—the pharmaceutical industry—with the help of both local and international pressure groups.

The HIV/AIDS epidemic, South Africa's most pressing health issue, has again shown how local history—in the form of inequalities along the fault lines of race and gender, and the impact of migrant labour—has shaped the development and spread of the disease, as well as access to both preventive and curative care. The importance of complementary and alternative medicine, in line with international trends,

is also shown up in its specifically South African manifestation. Its co-existence with allopathic medicine is not new in the country, and it has adapted and grown from old tensions.

There is no doubt that a full and nuanced understanding of health issues in South Africa requires an appreciation of developments in the global political economy, international organisations such as the WHO and World Bank, and forces which operate outside of institutions (most dramatically, the spread of diseases such as HIV/AIDS). In each case, however, the specific opportunities available to actors within the country, as well as the relative power of those actors, should be given their due consideration in analysing their potential impact on health. Most importantly, the constraints and possibilities created by the domestic social and economic context must not be forgotten whenever the forces of globalisation are considered.

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