HEALTH + DISEASE

GENERAL

1975 — JAN 1977

HANSARD 1 Q. Column 2

4 February 1975.

1.89

2. 101

Medically-trained Bantu serving in homelands

*3. Mr. L. F. WOOD asked the Minister of Bantu Administration and Development:

How many trained Bantu (a) doctors, (b) dentists, (c) chemists and druggists, (d) veterinarians and (e) nurses are serving the Bantu people in the Bantu homelands.

The DEPUTY MINISTER OF BANTU DEVELOPMENT:

(a) Doctors—72.

(b) Dentists—0.

(c) Chemists—19.

(d) Veterinarians—0.

(e) Nurses—16 510.

Health and Diseases

General

HANSARD 2 Q column 130..

14 February 1975.

89

Closing gap in salaries paid to White and non-White doctors and nurses in State employment

*29. Mr. R. M. DE VILLIERS asked the Minister of the Interior:

What progress has been made in closing the gap in salaries paid to White and non-White doctors and nurses, respectively, in State employment.

The DEPUTY MINISTER OF THE INTERIOR:

The Government's policy in regard to the narrowing of the gap has been clearly stated on various occasions in the recent past. Apart from the salary improvements which were granted to non-White officials over the past few years - the most recent of which became effective as from 1 July 1974 the matter is continuously receiving the attention of the Government with a view to implementing its policy.

HANSARD 2 CL 130
14 FEB 1975

89

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HANSARD 3 Q. column 145-148.
17 February 1975.

89

Salary scales for doctors/dentists/ pharmacists

17. Mr. L. F. WOOD asked the Minister of the Interior:

What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services.

The MINISTER OF THE INTERIOR: (a) to (d)

(i)

Rank	Salary scale (R per annum) White	Coloured/Indian	Bantu
Specialists			
Professor/Chief Specialist	15 600 (fixed)	13 200 (fixed)	11 250 (fixed)
Principal Specialist	14 400 (fixed)	12 150 (fixed)	10 350 (fixed)
Senior Specialist	13 200 (fixed)	11 250 (fixed)	9 540 (fixed)
Specialist	12 600 (fixed)	10 800 (fixed)	9 180 (fixed)

Rank	White	Coloured/Indian	Bantu
Government Medical Officers			
Chief Government Medical Officer	13 200 (fixed)	11 250 (fixed)	9 540 (fixed)
Principal Government Medical Officer	12 600 (fixed)	10 800 (fixed)	9 180 (fixed)
Government Medical Officer	7 740 - 360 - 9 900 - 450 - 11 700	6 300 - 300 - 9 900	5 340 - 240 - 6 300 - 360 - 8 460
Intern	5 100 (fixed)	4 050 (fixed)	3 360 (fixed)

(ii) Dentists: As in respect of Government Medical Officers.

(iii) Pharmacists: Rank and salary scale (R per annum)

White	Coloured/Indian	Bantu
Chief Pharmacist 9 900 - 450 - 11 700	8 100 - 360 - 9 540	Principal Pharmacist 6 060 - 240 - 6 300 - 360 - 7 380
Principal Pharmacist 7 740 - 360 - 9 540	6 060 - 240 - 6 300 - 360 - 7 740	Senior Pharmacist 4 740 - 180 - 5 100 - 240 - 5 820
Pharmacist 5 340 - 240 - 6 300 - 360 - 7 380	4 380 - 180 - 5 100 - 240 - 5 820	Pharmacist 3 450 - 150 - 4 200 - 180 - 4 560
—	1 740 - 120 - 2 700 - 150 - 3 300	Pharmacist (Unqualified) 1 530 - 90 - 1 620 - 120 - 2 700 - 2 850
—	3 000 (fixed)	Trainee Pharmacist (Male) 2 460 (fixed)
—	2 850 (fixed)	Trainee Pharmacist (Female) 2 340 (fixed)

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Question
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Hansard. Q. 194-95-
19 February 1975.

(1) 89
(2) ~~Educ. University~~

Medical and dental students ×

81. Mr. L. F. WOOD asked the Minister of National Education:

(1) What is the present enrolment at each university in respect of (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) medical and (ii) dental students;

(2) (a) whether he intends to extend the training facilities for medical and dental students; if so, in what manner;

(3) what is the projected output of trained (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) medical practitioners and (ii) dentists for 1980, 1985 and 1990, respectively.

The MINISTER OF NATIONAL EDUCATION:

(1)	(a) (i) and (ii)		(b) (i) and (ii)		(c) (i) and (ii)		(d) (i) and (ii)	
U.O.F.S.	222	—	—	—	—	—	—	—
U.P.	1 203	404	—	—	—	—	—	—
U.S.	617	115	—	—	—	—	—	—
U.C.T.	850	—	75	—	51	—	—	—
Wits	946	258	12	3	124	15	3	9
Natal	—	—	41	—	295	—	217	—

(2) (a) no;

(3)	(a) (i)* and (ii)*		(b) (i)* and (ii)†		(c) (i)* and (ii)†		(d) (i)† and (ii)†	
1980	587	68	19	—	54	—	—	—
1985	685	75	21	—	63	—	—	—
1990	783	83	24	—	73	—	—	—

Notes: *Calculations based on five year trend since 1960.

†No projection could be made since there is no trend.

Names submitted for consideration in appointment of committees in terms of Publications Act

85. Mr. J. D. DU P. BASSON asked the Minister of the Interior:†

What (a) bodies submitted names of persons or (b) persons submitted their own names to him in response to his request to the public last year to submit names to him for consideration in the appointment of committees in terms of the Publications Act, 1974.

The MINISTER OF THE INTERIOR:

(a) See the attached schedule.

(b) It is not in the interest of the persons concerned that their names be made known.

SCHEDULE

S.A. Association of Theatrical Managements.
Nederduitse Gereformeerde Kerk.
St. Andrews Presbyterian Church.
Aksie Morele Standaarde.
Federasie van Bonde van Jongeliedeverenigings op Gereformeerde Grondslag in Suid-Afrika.
South African Theatre Union.
Vrouehulp van die N.G. Kerk.

HANSARD 3 Q. column 241

21 February 1975.

8-9

Inspections in respect of doctors/dentists/ chemists/druggists

33. Mr. L. F. WOOD asked the Minister of Health:

How many inspections were carried out by his Department during 1974 on (a) doctors, (b) dentists and (c) chemists and druggists in connection with their responsibilities as defined in sections 65 and 65*bis*, respectively, of the Medical, Dental and Pharmacy Act and the regulations promulgated thereunder.

The MINISTER OF HEALTH:

(a) 379.

(b) 28.

(c) 1 404.

HANSARD 3 Q. column 245-246
21 February 1975.

Medically trained non-Whites

89

90. Mr. L. F. WOOD asked the Minister of Health:

How many (a) Bantu, (b) Indians and (c) Coloureds have been registered as (i) midwives, (ii) health visitors, (iii) radiographers and (iv) sister tutors in each year since 1970.

The MINISTER OF HEALTH:

(i) Midwives as at 31 December of each year:

(a) 1970—9 096, 1971—9 681, 1972—10 371, 1973—11 188, 1974—12 014.

(b) & (c) Up to 1972 a combined register for Indians and Coloureds was kept and the figures are as follows:

1970—1 904, 1971—2 103, 1972—2 324.

The particulars for the period since 1972 are as follows:

Indians: 1973—198, 1974—263.
Coloureds: 1973—2 186, 1974—2 362.

(ii) Health visitors as at 31 December of each year:

(a) 1970—371, 1971—374, 1972—450, 1973—545, 1974—666.

(b) 1970 to 1972—nil, 1973—3, 1974—9.

(c) 1970—103, 1971—103, 1972—137, 1973—161, 1974—182.

(iii) Radiographers are not registered according to racial groups.

(iv) Sister tutors as at 31 December of each year:

(a) 1970—48, 1971—51, 1972—65, 1973—89, 1974—106.

(b) 1970 to 1974—nil.

(c) 1970—39, 1971—51, 1972—56, 1973—63, 1974—66.

Question.....
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HANSARD 5. Q. column. 342-3.
4 March, 1975.

Medical facilities/staff in homelands

*5. Mr. R. M. CADMAN asked the Minister of Bantu Administration and Development:

(1) How many (a) mission hospitals, (b) other hospitals and (c) clinic centres are there in the homelands in (i) the Republic and (ii) South West Africa;

(2) how many hospital beds are there in hospitals in the homelands in (i) the Republic and (ii) South West Africa;

(3) how many (a) White and (b) Bantu (i) medical practitioners, (ii) nurses and midwives, (iii) dentists, (iv) chemists and druggists, (v) physiotherapists, (vi) radiographers, (vii) health inspectors, (viii) health assistants and (ix) pharmaceutical assistants, are serving in the homelands in the Republic and South West Africa, respectively.

The DEPUTY MINISTER OF BANTU DEVELOPMENT:

(1) (a) (i) 92.

(ii) 22.

(b) (i) 16.

(ii) 5.

(c) (i) 549.

(ii) 67.

(2) (i) 30 518.

(ii) 3 639.

(3) (a)

	Republic	South West Africa
(i)	595	51
(ii)	340	118
(iii)	7	1
(iv)	38	7
(v)	28	3
(vi)	43	6
(vii)	2	11
(viii)	- -	19
(ix)	7	1

(b)

	Republic	South West Africa
(i)	72	1
(ii)	16 510	732
(iii)	1 (Student)	
(iv)	19 (16 Students)	
(v)	34	—
(vi)	58	- -
(vii)	15	3
(viii)	32	9
(ix)	16	—

1989

~~2101~~

HANSARD 6

Q. column 479

14 March 1975.

Health - Dis - General

Infective hepatitis

*24. Dr. E. L. FISHER asked the Minister of Health:

(1) Whether infective hepatitis is a notifiable disease; if so, how many cases of the disease have been notified between 1 December 1974 and 1 March 1975; if not,

(2) whether he has any knowledge of an outbreak of the disease in the Cape Province; if so,

(3) whether the source and cause of the outbreak have been established; if so, what are they;

(4) whether he will make a statement on the matter.

The MINISTER OF PLANNING AND THE ENVIRONMENT (for the Minister of Health):

(1) Yes; 127.

(2) and (3) fall away.

(4) No.

Full aid for new Black varsity

STAR 7/5/75

59

Political Staff

The University of Pretoria and the University of the Witwatersrand medical, dental and veterinary faculties will be closely associated with the new Black medical university to be established at Ga-Rankua near Pretoria.

This is clear from a statement issued by the Minister of Bantu Administration and Development, Mr M C Botha, following inquiries about the university.

The decision to build was announced earlier this week.

In his statement, Mr Botha said the University of Pretoria's three faculties would be asked to assist in the preparation of syllabuses and to provide lecturers, on loan if necessary. The University of the Witwatersrand would be involved in the same way. The two universities would be represented on the council of the new institution.

HOMELANDS

In addition, the three existing Black universities would serve on the new council and would assist with the training of first-year students.

The various homeland governments would also have representation on the council to ensure that the interests of all homelands were provided for.

Mr Botha also revealed that the new university would be a statutory institution. Empowering legislation would have to be introduced in Parliament.

INDEPENDENT

"In other words, it will be an independent institution with three faculties and will not be a branch of any other university," Mr Botha said.

Medical men would also serve as part-time lecturers as was the case in similar faculties.

Mr Botha said that he

89

'Training defects' in medical schools

STAR 19/5/75

Science Editor

Present-day medical education is not designed to provide optimum health service to a changing society and far-reaching changes are necessary if the situation is to improve.

This is the view of two overseas health experts who are to be guest speakers at the Wits Medical Students' Congress this week.

They are Professor J D E Knox, head of the department of general practice, University of Dundee, and Professor Moshe Prywes, on authority on medical eduction, of Jerusalem.

There was a new world emphasis on community and preventive health as opposed to hospital-based curative medicine, but up to now the knowledge and attitudes which students acquired were less appropriate for the provision of health care and preventive medicine within a community.

DEFECTS

Students were aware of the defects in their training and thus the reason for the conference which was entitled "The GP Dilemma," Professor Knox said.

The specialist emphasis in student teaching sometimes "played hell" with diagnosis, he added.

For example, his students would probably not regard a stomach ache in the same light if asked to make a diagnosis by a psychiatrist and a gastroenterologist in turn.

DECLINE

Professor Knox said the explosion of medical knowledge in recent years had caused universities to abandon 'urning out safe all-rounders — the general practitioners — who were the most important members of the team providing primary health care.

The decline in general practitioners was further aggravated. They were paid less than specialists. The GP was also being increasingly excluded from hospital practice.

Therefore, doctors went into general practice, "by default rather than by intent."

But with the new curricula and departments of community and family medicine being formed at many universities (both have been established at Wits), Professor Knox saw the GP of the future as a doctor prepared by his education for a tough job.

He would find professional satisfaction as an essential part of the total health team, including hospital doctors.

Science Editor STAR 22/5/75

89

It was not the policy of the Department of Health or the Government to introduce a State-controlled national health service in South Africa, Dr James Gilliland said in Johannesburg yesterday.

Dr Gilliland, the co-ordinating director of health services in the department, was addressing the Wits medical students' conference.

He said health services would continue to be provided by two separate, but interrelated modes —private practitioners and the various health authorities.

Where these two modes existed side by side, the patient could decide which he wished to use.

"But I must also emphasise that the health authorities must organise their services in such a fashion that, on account of their presence and availability, no one shall be significantly financially embarrassed as a result of illness."

While a national health service was not envisaged, there was an increasing awareness that co-ordination of health services was long overdue. This could be done without diminution of the functions and responsibilities of each authority.

This had, in fact, been achieved by sharing physical facilities so that State, province and local authority provided a "one-stop" health service with each sector retaining its identity.

HOMELANDS

Outlining the development of health services in the homelands, Dr Gilliland said responsibility for comprehensive health services would gradually be transferred to the Black governments.

The first of these Homelands Departments of Health and Welfare was established in the Transkei in 1973 and in Bophuthatswana last month.

The Ciskei would follow in September, Lebowa, Gazankulu and Venda next year and kwa-Zulu in 1977.

Regular liaison between the South African and the homeland governments in health matters had been assured and highly technical services would be provided on request through such bodies as the Medical and Dental Council.

To be sick in Soweto...

Science Editor

A Black doctor outlined the frustrations he experienced practising in Soweto when he addressed the Wits medical students' conference in Johannesburg yesterday.

He said the Black patients could not afford to pay for treatment or medicines, private GPs could do little but provide "first aid" or refer them to Baragwanath Hospital.

Attempts by the private doctors to help provide total health care in Soweto in association with the hospital authorities had failed. They had been told there was no place for them.

The doctor said he had been asked by a Bantu Affairs official when he was going to leave town. He was not welcome in Soweto, although he had practised there for 18 years.

Asked where he should go, the official said: "Where you came from." (He was born near Pretoria).

The GP deplored recent moves by "orthodox" medicine to gain the co-operation of the witchdoctor in the treatment of disease. It was because of the witchdoctor's hold over the people that doctors often saw a patient only when his illness was far advanced.

Hansard 17 25/6/76

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1089.

3. Students doing medical training

Mr. N. J. J. OLIVIER asked the Minister of Bantu Education:

How many students in the Republic, including the homelands, (a) were enrolled as at 31 March 1975 in each of the years of study for training as and (b) qualified at the end of that year in each of the years of study for (i) health assistants, (ii) health inspectors, (iii) public health nurses, (iv) medical laboratory technologists, (v) dental therapists, (vi) radiographers, (vii) physiotherapists and (viii) other para-medical personnel with specification of each type of course.

The MINISTER OF BANTU EDUCATION:

	(a) Year of study 1st	2nd	3rd	(b) Year of study 1st	2nd	3rd
(i) Health Assistants	33			30		
(ii) Health Inspectors	—	141		—	131	
(iii) Public Health Nursing	53			45		
(iv) Medical Laboratory Technology	24			462		
(v) Dental Therapy	17	—	—	13		
(vi) Radiography	7	4		6	4	
(vii) Physiotherapy	10	8	—	8	4	—
(viii) National Diploma in Public Health	253	—	—	23	—	—

1 Final enrolment. Course is being discontinued.

2 Private candidates studying at hospitals included.

3 Introduced in 1975 and supersedes the course for Health Inspectors.

Statistics are in respect of Departmental centres only.

ng your talk:

and HORIZONTAL PLAN

an

1) Take a ... paper. Think about your subject. Jot down 20 to 30 words associated with it.

2) Working on a 5 minute talk, ring the three words you think are the most important on your list.

3) What do these words say to you? What specifically do you want your audience to think and do at the end of your talk? Now, write the aim of your talk in one short sentence.

4) Write your aim at the top of a clean sheet of paper.

The Body

5) Leave about six lines for the introduction. Write your three main points down leaving a few lines in between each.

6) Go through your list of ideas again. Underline those points that support your three main points.

7) Write two sub points under each main point.

8) At this stage you should refer to books, interview specialists, check figures and statistics, find quotations, apt examples or demonstrations.
Your talk should be an expression of your own ideas on the subject, backed by outside opinion.

(1) 89
(2) 3

89

Bikitsha: Fight illness with food

DD 27-6-72

UMTATA — Agriculture should be treated as a branch of medicine, the medical superintendent of the Butterworth Hospital, Dr C. L. Bikitsha, told students at the Tsolo College of Agriculture yesterday.

"With antibiotics and drugs I can only patch up sick people," Dr Bikitsha said. "But if you give me milk and meat I will wipe out tuberculosis in the Transkei."

Dr Bikitsha, who was guest speaker at the college diploma day, said he looked forward to the day when the beds in his hospital would be empty because diseases like tuberculosis, kwashiorkor, malnutrition and sepsis had been wiped out not by drugs but by good food.

He mentioned one disease, cancer of the gullet, of which the Transkei had the highest incidence in the world. It had been shown that the cause was deficiency in certain trace elements, which resulted in diseased crops.

"Using fertiliser laced with trace elements we shall be able to produce maize which will not poison us."

Dr Bikitsha, himself a farmer, said land in the Transkei was static and unproductive, while the population was growing, although the Transkei had a wonderful climate and plentiful water. It should become the granary of Africa, exporting a massive surplus every year.

"The concept of an agricultural country which works three months of the year during the rainy season and sits back for the rest is so ludicrous I cannot imagine why we have allowed it to go on so long.

"This pattern will have to be changed. We will have to train agriculturists who will go out and motivate people to see the importance of agriculture."

The 31 final-year students at the college were all given their diplomas yesterday. Not one had failed the principal, Mr John Parmiter said.

Mr Parmiter said in his address, plans were afoot for expansion and complete rebuilding of the college. New classrooms were to be built soon, as well as a workshop.

The college would also have a soil-testing laboratory which would serve the whole Transkei.

Rainfall for the past season had been low, Mr Parmiter said, and Tsolo had had only 385mm, compared with the average 600mm. As a result the maize crop was down by about a third and grazing was scarce. — DDR.

'5000 more hospital beds' call

(89)

STAR 14/7/75

About 5 000 extra hospital beds would be needed every year and another 6 000 doctors would have to be trained within the next 10 years if existing health standards were to be maintained, Dr Johan de Beer, Secretary for Health, said in Johannesburg today.

At the jubilee congress the Medical Association on "Health services of the future," he said that 4 000 of these doctors would be needed for hospitals. The other 2 000 were unlikely to fill the additional need outside hospitals. This lent greater urgency to the extension of medical training facilities, particularly for Blacks.

"UNFORTUNATE"

Dr de Beer called for a new, rationalised relationship between his department and the hospitals and health departments of the provinces and homelands.

The object was co-operation in the national interest, in contrast to the present "unfortunate climate" in which each authority sought to gain as much as possible in terms of setional interests and autonomy.

The rationalisation he sought would not affect the autonomy of the homelands departments of health.

Dr de Beer stressed that he was not seeking unification of the different health and hospitals authorities, but co-ordination between them.

"AN EPIDEMIC"

There were, however, some aspects which so closely overlapped or were so delicate that a centralised structure and control was indicated.

Additional medical training facilities were urgently needed, particularly in respect of the Black population, said Dr de Beer, who outlined specific health areas in which targets had to be set and programmes devised. These included:

- Tuberculosis, which was running at epidemic rates;
- Malnutrition, in which milk powder schemes and enrichment of mealie meal were called for;
- Family planning, in which big thinking and effective action were needed to create a national network of services;
- Psychiatric services, in which outpatient and community services would reduce the number of inpatients.

A medical look ahead

Science Editor

Professor Phillip Tobias today gave a prediction of man, society and medicine 50 years from now.

In summary, he said, the goal of medicine of 2025 would be survival of the whole species of man, not only as an individual or as a society.

Professor Tobias, Wits anatomist and physical anthropologist, was addressing the opening session of the 50th congress of the Medical Association of South Africa in Johannesburg.

SCHOOLS

This is how he sees mankind and medicine of the future:

- If present trends continue, the world population will be 10 000-million, and 5 000 medical schools will be needed. Africa alone will need 750, as against the present 41. South Africa — already lagging behind international optimum standards with only six medical schools — will need 45.
- It may be assumed that inadequate standards will still be a feature of the less-developed world, as they are today.
- The world will still be carrying an enormous burden of preventable disease in the "inadequately medicalised" parts. Man will still be grappling with an appalling load of illness, malnutrition and starvation in some areas.

INSUFFICIENT

Birth control was only part of the solution and sharing of wealth was also insufficient. Without more and better education no solutions would work.

The greatest threat to mankind's survival was in such spheres as in overcrowding, overpollution and an ever-increasing growth of the city.

By 2025 these problems must have been solved and this would need the active participation of the medical profession.

(89)

Medical care position 'at crisis point'

STAR 15/7/75

Marais Malan, Science Editor

Medical care in South Africa is at a crisis point and fundamental changes to the entire system are imperative if the needs of society are to be met, says the president of the Medical Association, Dr Jonathan Gluckman.

In his presidential address at the official opening of the association's jubilee congress in Johannesburg last night he said: "I believe that we as a profession have failed to play an adequate role in the health service to the people as a whole.'

Dr Gluckman said it was difficult to see how a tremendous shortage of doctors and paramedics could be met in the next 20 years. To meet it, the patterns of medical education should be reconsidered. Preventive and promotive health and nutrition problems must come much more to the fore.

PERSPECTIVES

Present teaching tended to emphasise specialisation, the esoteric rather than a direct, positive involvement in health. Doctors must also acquire proper perspectives of their function and responsibility in society — an aspect to which students, with rare exceptions, were not being exposed.

Dr Gluckmann said doctors would have to accept compromises in the face of the shortage of staff "no matter what our historic attitudes have been."

At present they routinely performed many tasks which could be handled better by people trained less broadly but more intensively.

He referred to the training of anaesthetists' assistants and said he believed this development inevitable.

"We have no hope of providing sufficient doctors in the short time available to us to put our medical services on to a better footing. I believe it inevitable that we shall have to use partly trained people — veltschers, or so-called 'barefoot doctors' — to serve large sections of our population, and I believe this is of pressing urgency.

With few exceptions,

To Page 3, Col 5

Medical 'crisis point'

(From Page 1)

doctors were conscientious and dedicated to providing the best possible care for their own patients, but many were unwilling to recognise the basic flaws in the system and the unmet needs of many of their fellow citizens.

"We are at a crisis point in the development of medical care in this country and there is need for fundamental changes in the nature of our system.

"In spite of the millions being spent in the medical aid sector, many middle-class people today, in a good financial position, could be destroyed by a prolonged and serious illness in the family — a virtual impossibility in countries such as West Germany, Sweden or Britain, despite the faults in their national health services."

As one solution, Dr Gluckman suggested that medical council rules be amended to permit group practice by doctors. Rules which made group practice illegal were "archaic and out of tune with modern developments in medicine."

89

Havemann's call on equal pay

16/7/75

Mercury Reporter

PIETERMARITZBURG—The Administrator of Natal, Mr. Ben Havemann, has asked the Minister of the Interior, Dr. Connie Mulder, to bridge the wage gap between Black and White medical staff.

And Natal's MEC in charge of hospitals, Mr. Frank Martin said yesterday: "If the Government gave us the money we would give Black medical staff equal pay now."

And the Minister of Health, Dr. Schalk van der Merwe said in a telephone interview last night that the Cabinet was committed to narrowing the wage gap for Black medical workers.

"Parity in wages will eventually be reached," he said, but he would not expand.

In a letter to Dr. Mulder, the Administrator, acting on instructions from Exco said Natal supported the elimination of the wage gap and he asked for Dr. Mulder's comments.

Natal has for years fought the other provinces represented on the Medical Co-ordinating Council for higher pay for Black medical staff.

The council considers wage recommendations for civil servants made by the Public Service Commission.

"There is nothing legally stopping us from paying equal salaries. It would mean breaking the council agreement on wages, and we would do this if we had the money," Mr. Martin said.

"We just haven't the revenue to start paying them equal salaries. Our provincial subsidy is calculated from the salary recommendations made by the Public Service Commission and there is nothing we can do about it.

"We believe that people with equal qualifications and responsibilities should be paid the same," he said.

The Durban City Council recently reversed a decision on Black doctors' wages and agreed to pay equal salaries.

Sex clinics plan in city

STAR 15/7/75

Science Editor

The establishment of clinics to help people with sexual problems at Johannesburg hospitals, particularly the General and the Strijdom, is being considered.

This was announced today by Professor L A Hurst, head of the department of psychiatry at the University of the Witwatersrand, at a sex therapy "workshop" conducted as part of the jubilee congress of the Medical Association of South Africa.

The lecturer was Dr Domeena C Renshaw, University of Cape Town graduate, director of the sexual dysfunction clinic and associate professor of psychiatry at Loyola University of Chicago.

The object of the proposed clinic, Professor Hurst said, would be to enhance marital happiness. The advice of Dr Renshaw was being sought in their introduction.

Dr Renshaw said it had been estimated that half of the married couples in the United States suffered from some form of sexual dysfunction, and from her experience many in South Africa were similarly affected.

"Anyone who expects to find Hollywood, Playboy type of sex in marriage will be disappointed. Sexual harmony has to be worked for," said Dr Renshaw.

'Disease of human relations'

21/7/75

Cape Times Correspondent

GENEVA. — An open attack on apartheid and public health in South Africa has been made in a publication of the World Health Organization.

The article is entitled "The disease of human relations." It was written by Thomas J. Gray who is described by the WHO as a South African writer living in Europe.

The article says: "South Africa today has one White doctor for every 400 Whites, one Indian doctor for every 900 Indians, one Coloured doctor for every 6 200 Coloureds, and one African doctor for every 44 000 Africans.

"Given the shortage of Black doctors, medical training facilities for non-Whites should, logically be extended. In reality, Africans find it difficult to study medicine and are effectively barred from all but one medical school.

ETHNIC ORIGINS

"Health professionals with identical qualifications and skills receive differing rates of pay based on their ethnic origins.

"When the country's Medical Association protested, it was given official assurances that the salary gaps between Black and White would be reduced. In fact, they have increased.

"Low incomes and living standards for Blacks, who form 70 percent of all South Africans, leave them vulnerable to disease. More than 55 000 died from tuberculosis in one year compared to 824 Whites — who form about 18 percent of the population. Because malnutrition is a major problem for the Black majority, babies in the African homeland reserves are reported to have only a 50 percent chance of reaching the age of five."

(89)

Too much sickness among Africans—professor

RDM 29/7/75

Staff Reporter

PROFESSOR H. Seftel, professor of African Medicine at the University of the Witwatersrand, said yesterday there was far too much sickness among Africans.

He was speaking at the jubilee congress of the South African Society of Physiotherapy at the Institute for Medical Research in Johannesburg.

He said there was no precise figures for disease among Africans, but there was no doubt a good deal of sickness. He pointed out that in the rural and homeland areas the infant mortality was 140 in every thousand people. The figure for the rest of South Africa was 20 in every thousand.

SURVEY

Prof Seftel said one survey in the Transkei showed that eight per cent of adults X-rayed showed some evidence of tuberculosis.

In the urban areas hygiene among Africans was higher, but the incidence of malnutrition and other infections was still too high.

Even in the cities the incidence of diseases among Africans was still four times that of Whies.

Africans in cities were plagued by disorders associated with the Western way of life, "or better, the Western way of death".

In some cases Africans suffered more from these diseases than Whites. These included high blood pressure and strokes, and heart and kidney failures.

Hypertension was the principal cause of death among Africans in Johannesburg, he said.

The deplorable lack of amenities and outlets for Africans left two avenues open to them — sex and drink. Sex resulted in the spreading of gonorrohea and illigitimate babies.

Tobacco and alcohol swallowed a major proportion of the city African's income, he said. The consequences were that the worker's family suffered poverty, especially among migrant labourers.

FACTORS

Social and economic factors were the root cause of disease, including the maldistribution and inequality of income, schooling and housing.

The bulk of the suffering was among Africans, but the medical services were concentrated on Whites. Most of the disease was in rural areas, while most of the doctors lived in the cities.

In the homelands, with a population of about eight million there was only one doctor for every 14 000 people, said Prof Seftel. Compared to this there was one doctor for every 400 Whites.

National health 'to be major issue'

RDM 29/7/75

89

Staff Reporter

THE Major issue of the next general election will be the introduction of a national health service, predicted Professor C. Searle, head of the Department of Nursing at Pretoria University, yesterday.

Professor Searle was speaking at the jubilee congress of the South African Society of Physiotherapy which opened at the Institute for Medical Research in Johannesburg yesterday.

Professor Searle said leading figures in the medical profession were pointing to failures in health services, and that State intervention would soon be necessary.

"At the moment the average citizen has to go to the private sector for his medical needs, and cannot enjoy the State services which he pays taxes for.

"Health is rapidly becoming a luxury for White citizens, and their demands will make the introduction of a national health scheme a burning issue at the next election.

Professor Searle said a comprehensive health service for Blacks was already a "fait accompli", but that the needs of Whites were not being looked after. She stressed the need for combining private services with a comprehensive State health service which would improve the quantity and quality of health services and suit the pocket of the middle class.

Health care comes under fire

STAR 30/7/75

(89)

Science Editor

The health care system in South Africa which costs taxpayers millions of rands a year, yet excluded most of them from benefiting, was vigorously criticised at the jubilee congress of the South African Society of Physiotherapy in Johannesburg yesterday.

Professor Charlotte Searle, president of the South African Nursing Association, said that, inevitably, public murmurings would grow to a clamour and Parliament would have to take note of the disatisfaction of the people.

She warned: "This could lead to the introduction of a national health service scheme. Anything is possible in a situation where the White citizen is forced into a situation where health is fast becoming a luxury."

Professor Searle said that for some extraordinary reason the present system denied John Citizen, the mainstay of the tax-supported system, the opportunity to use the services which he had provided.

When he was sick he had to have recourse to the private sector for hospital treatment. The financial implications of this crippled him and his family while his taxes were steadily rising to pay for more and better State health services.

"As the citizen has an inalienable right to demand health services which are within his means without the fear of financial crippling, the policies in regard to health care are increasingly being debated as evolving political issues.

"Over and over it is being said that the escalation in the cost of health care, particularly for the White section of the community, must inevitably force the State to intervene to a greater extent in the organisation and delivery of health care.

"It is claimed that it is unrealistic for health care to be left to the laws of supply and demand and that the State should interfere on social and economic grounds.

Professor Searle said that the present system diverted a large share of the nation's income to coping with health dropouts.

The cost of providing hospital beds was staggering, provision of extra-institutional, health services owing to maldistribution of manpower was inadequate, while prevention of ill-health among the White section, denied the benefit of a comprehensive health service, was a "costly patchwork system."

"Time is running out for private health practice unless there is a re-organisation in the way services are provided and unless the pockets of the middle-class people are considered to a greater extent," she added.

Patients 'in the wrong hospitals'

Science Editor

Many patients being treated in general hospitals should not be there at all but should be in rehabilitation hospitals where they could be treated more efficiently and economically, an orthopaedic surgeon said at the physiotherapy congress in Johannesburg yesterday.

The trouble was that the number of rehabilitation programmes worthy of the name could be counted on the fingers of one hand, he said. Many more were urgently needed.

The establishment of separate rehabilitation centres was economically sound. At present the chronic sick requiring rehabilitation received highly skilled nursing care and attention in acute diseases hospitals — "five-star breakfast-in-bed service" — which, apart from wasting skilled nursing, denied the patient the opportunity to become independent.

The number of patients who required rehabilitation was enormous. Also enormous in terms of time and money was the cost of not providing such care.

What was needed was effective legislation if rehabilitation were to become really effective, the surgeon said. On any rehabilitation programme today it might be necessary to deal with as many as seven different government departments, without apparent machinery for liaison among them.

This "lumbering administrative oxwagon" was inherited by the present Government and its predecessor and it was high time that it was replaced by a "1975 model with an internal combustion engine."

The solution appeared to be that rehabilitation should be handled by a single portfolio, only then would it prosper.

Minister suggests probe of medical profession

ARGUS 4/8/75

The Argus Correspondent

PRETORIA. — The Minister of Health, Dr S. W. van der Merwe, has suggested that the South African Medical and Dental Council conducts an inquiry into professional malpractices.

Addressing the first meeting of the council in its newly constituted form, the Minister warned that:

- The medical profession was becoming increasingly materialistic.
- The number of cases of malpractice was rising out of proportion to the numerical increase in doctors.
- Relations between doctors and pharmacists needed urgent attention.

Dr van der Merwe said the composition of the council had been changed to meet changing demands, but the council itself had been evenly divided on whether it should be increased or reduced in size.

GOING WRONG

A problem of primary concern was the image of the profession. The traditional doctor-patient relationship was in the process of serious erosion and, in the eyes of the public, the profession was becoming more and more materialistic.

The Minister said the increasing number of disciplinary investigations was becoming a source of concern. It appeared that the number of cases of malpractice was rising disproportionately and that 'somewhere something is going wrong.'

'I am forced to ask myself whether the time has not com... to und... the... shou... aspects... both.'

(8c)

Doctors seen as too greedy, says Minister

Rand Daily Mail 5/8/75

Staff Reporter

THE Minister of Health, Dr Schalk van der Merwe, warned doctors and dentists yesterday that the public believed they were becoming "more and more" materialistic.

Addressing the first meeting of the newly elected South African Medical and Dental Council in Pretoria, the Minister said the image of the profession in the eyes of the community had become a problem of primary concern.

"In this matter we will have to be entirely realistic. In South Africa the medical and dental professions have developed in a way which in the scientific field deserves admiration nationally and internationally."

In the process of this development, however, "something somehow got lost" and this was damaging the image and status of the profession.

The traditional doctor-patient relationship was in the process of serious erosion.

The council, Dr Van der Merwe said, would have to give increasing attention to the profession's materialistic image.

Dr Van der Merwe said another serious problem was discipline.

The increasing number of disciplinary investigations was becoming a source of concern. It appeared that the number of cases of malpractice investigated was rising out of proportion to the numerical increase of practitioners.

"The only conclusion is that somewhere something is going wrong.

"I am forced to ask myself whether the time has not come for the council to undertake an inquiry to determine the causes of this phenomenon."

The medical association was doing its utmost to maintain self discipline in its own ranks. The association however had no statutory powers.

The new Act made provision for people outside the council to be involved in its work, and it was now possible to establish a more active co-operation with the association.

Another aspect demanding urgent attention, Dr Van der Merwe said, was the relationship between the different professions and the maximum utilisation of all registered persons.

The pharamaceutical profession was dissatisfied because doctors dispensed in competition with chemists and even entered the marketing field, and doctors were dissatisfied with the so-called "counter prescribing" by chemists.

Chemists were particularly dissatisfied with the control exercised by doctors over the medicines they handled.

Dr Van der Merwe pointed out that the two professions were supposed to work together in the interests of the patient.

They should act jointly to encourage a more harmonious relationship between the doctor and the pharmacist, the Minister said.

Professor H. W. Snyman, Dean of the Medical Faculty of the University of Pretoria, was yesterday re-elected president of the South African Medical and Dental Council.

Munnik calls for Coloured birth control

ARGUS 5/8/75

89

THE Coloured population of the Cape would have to co-operate with the Provincial Administration by practising family planning if they hoped to have facilities equal to those given to Whites, the Administrator, Dr L. A. P. A. Munnik, said today.

Speaking in the Budget debate in the Provincial Council, he said the myth that the Government encouraged family planning to deplete Black populations was "the biggest nonsense ever."

The Government was concerned with the welfare of the Coloured people, but it could not afford to cater for the population explosion, he said.

He called on Coloured leaders to encourage birth control among their own people. Only in this way could the shanty-towns of the Cape be eliminated.

Referring to an Opposition call for the elimination of influx control, Dr Munnik said the Coloured migration to the Peninsula showed what could happen without this sort of control.

Influx control was not an ideology but an economic necessity. People poured into the Peninsula area to live in shanties without jobs or income, and this had to be curbed.

Referring to a call for equal wages for Black and White teachers and medical staff, he said this was not a new idea and the principle had been accepted by the Administration.

SALARIES

However it could not be put into effect overnight. 'If you say we must put everyone on equal salaries tomorrow, South Africa could just not afford it.

'Attack us if you think we are not doing it fast enough, but realise that we cannot do it overnight. The Whites, the Coloured and the Africans know this,' he said.

Coloured nurses in South Africa received higher wages than White nurses in Britain and African nurses received higher wages than nurses anywhere else in Africa.

The effect of equal wages on inflation should also be considered, Dr Munnik said.

A top-level Cabinet committee had been appointed to look into the financial problems of small municipalities following discussions he had had with the Government.

However, all South African municipalities would have to be prepared to 'tighten their belts' in view of the expenditure

89

Dental chief slams the Minister

Sun Times 10/8/75

SUNDAY TIMES REPORTER

THE PRESIDENT of the Dental Association of South Africa, Dr H. van Rensburg, has sharply attacked the Minister of Health for his call this week for an urgent inquiry into gross misconduct in the medical profession.

"I cannot allow these incredible unsubstantiated Press statements to pass without comment," he said.

"These statements refer to greediness, dishonesty and materialistic and undisciplined behaviour by members of my profession."

Only two disciplinary inquiries relating to dentists had been held by the Medical and Dental Council in the past year. One of these inquiries had related to a dentist of 80 who had moved premises and had failed to inform his patients of the right address.

Dr Van Rensburg said that if these two cases were related to the services rendered by the 1 800 dentists in South Africa then the call for an inquiry was totally unjustifiable.

At the inaugural meeting of the new Medical and Dental Council in Pretoria this week the Minister of Health, Dr Schalk van der Merwe, said that instances of misconduct in the medical profession were increasing disproportionately to the numbers of those qualifying.

"The only conclusion that can be reached is that something serious is happening in the medical profession," said Dr Van der Merwe.

On the question of tariffs, Dr Van Rensburg said that the dentists had opted out of the medical aid schemes because these had allowed for an increase of only 12 per cent over seven years. A system of tariffs had been devised by the Medical and Dental Council and agreed to by his association.

This system included measures to hold practitioners responsible for "unrealistic charges in excess of this tariff" in cases where these had not been discussed beforehand with patients.

Dr Van Rensburg said that the only guarantee of payment by medical aid societies was payment of the restricted amounts up to the amount of benefit allowed by the societies.

Soweto heart disease rate 'formidable'

2578/73

The Argus Bureau

LONDON. — An extraordinarily high rate of heart disease among schoolchildren in Soweto has been blamed chiefly on overcrowding and poverty there, in a survey published in the latest issue of the British Medical Journal.

The survey found that in one age group about 20 out of every 1 000 children suffered from rheumatic heart disease. The researchers conclude: 'The socio-economic status of the community must be improved if optimal prevention is to be achieved.'

Yet, they say, the survey figures do not represent the full extent of the problem in the Black townships near Johannesburg. The survey was conducted among schoolchildren, a relatively privileged group, and rheumatic heart disease would be more prevalent in poorer children who do not attend school.

Widespread rheumatic heart disease is usually associated with impoverished communities. The incidence of the disease has been declining throughout the world with the emergence of wealthier societies.

FORMIDABLE

The researchers say the disease remains a formidable health challenge in South Africa in spite of the declining incidence in other economically advanced countries.

It would take a long time for conditions in Soweto to improve sufficiently and so the survey calls for a comprehensive preventative campaign.

The cost of instituting and maintaining such a campaign, it claims, would be less than the cost of treating sufferers in hospitals.

In all, 12 050 children from 2 to 18 years were tested between May and September 1972. The disease was found in 6,9 out of every 1 000.

The rate is much higher in older children. The incidence in the group from 6 to 18 years old was 7,1 in every 1 000.

The highest figure in a comparable survey was a rate of 5,3 in 1 000 in the Rocky Mountains in the United States. That survey, however, was conducted between 1956 and 1961 among predominantly 18-year-olds.

Other comparisons given reveal an incidence of 3,8 in 1 000 in Japan nine years ago; 1,4 in Northern India; 1,7 in Denver, U.S; and 1,0 in Barbados.

A survey five years ago among 500 children in one school in Teheran, Iran, showed a rate of 22 in 1 000.

The Soweto rate of 19,2 in 1 000 was found in children in the seventh school grade. The age group of highest occurence was 15 to 18 years, and girls were slightly more suspectible than boys.

Of all the children found to be suffering from rheumatic heart disease, for 82,5 percent it was the first diagnosis.

The most prevalent contributing factor to the high rate of the disease in Soweto, in the view of the researchers, was overcrowding. Families of eight children recorded an incidence of nearly 15 in 1 000.

The survey was conducted by 10 senior cardiologists representing several medical institutions in South Africa, including the Department of Medicine at the University of the Witwatersrand and the Johannesburg General Hospital.

CHRISTIAAN

We've lost a 20-year war on malaria

(89)

MERCURY 5/9/75

THE pesky mosquito has got man licked. A full-scale war lasting 20 years has failed to eradicate the menace of the flying carrier of disease.

The World Health Organisation, in a frank admission, says that even little gains that have been made will be lost for ever unless man makes a greater effort immediately.

This year, in Africa alone, one million children will die of malaria, the W.H.O. estimates.

Underestimated

Despairingly, a survey made at the end of the 20-year campaign says: "W. H. O. was under the illusion that eradication was possible in practice. But this was to underestimate such major stumbling blocks as the impracticability of an international organisation acting as a substitute for the absence of a national medical infrastructure."

Which means, in simple language, that if a country's own health organisations don't fight the war against mosquitoes, nobody will.

W.H.O., as an unknown and untrusted foreign body, found it hard to get anything done in underdeveloped countries.

They couldn't convince the natives of the need to move their furniture out of their homes while the walls were sprayed, for example.

That is one of the basic essentials of the mosquito war, because the mosquitoes, after tanking up with blood from a sleeping human, settle on these walls.

Down drain

It has cost about R105-million to take on the mosquito in serious battle, and it looks like R105-million down the drain.

Malaria is on the upsurge again in Africa, India, Pakistan, Sri Lanka and Thailand, for a start.

W.H.O.'s survey highlighted another lamentable aspect of the losing battle by pointing out that it was the smell of victory that, paradoxically, contributed to failure.

"All too often the marked progress that had been made in mosquito eradication lulled national health authorities into a false sense of security," it said.

"They have relaxed their efforts . . . and malaria has re-established itself."

So be on guard. Do your bit, little as it might be. Next time you see a skeeter, donder him!

(1) 89

(2)

Dispatch

Focus on dental health

(89) 6/9/75

EAST LONDON — The Dental Association of South Africa is aiming to reach every single primary school teacher in the Republic and South West Africa during their annual dentistry health week which begins next week.

Their motto will be "plaque, the tooth enemy," and their aim will be to discipline children in the correct and regular ways of brushing teeth.

The South African Medical Journal points out that dental diseases could be eliminated if teeth were brushed regularly and in the correct way, and if dental floss was used to clean between the teeth where the brush could not penetrate.

According to a dental surgeon in East London, 90 per cent of school children were in need of dental care.

"If they were taught self-discipline in caring for their teeth, the percentage of tooth decay would most certainly drop," he said.

The doctor said the programme would explain that it took 24 hours for bacteria to organise in plaque to produce acids and toxins which were responsible for two major dental problems, caries and periodontal disease, and that the aim of all dentistry was to remove the plaque.—DDR.

A poolside risk of cancer

(89)

MERCURY 4/9/75

Science Correspondent

SWIMMING pool owners who use the chemical known as OT for testing the chlorine in the water are exposing themselves to the risk of developing bladder cancer in later years.

Local experts — they included a professor at the University of Natal Medical School, a consulting chemist and a manufacturer of pool chemicals — were unanimous in their recommendations.

OT should be treated with caution, a glove or some other protection should be worn when shaking the tube and clear labelling is desirable, they said.

A recent report from the U.K. Government's Health and Safety Executive said that OT—its full name is ortho tolidine — is linked with bladder cancer, with an interval of as long as 40 years before the disease develops after exposure.

In the very few British factories licensed to use OT, strict regulations are enforced, with compulsory urine tests twice a year.

The U.K. concern arises from the fact that factory regulations do not apply to pool owners.

The Durban experts were all agreed that the fact that OT was very dilute by the time pool owners used it did not necessarily make it any safer to use.

OT kits used in this country sometimes have a cancer warning printed on them, but many do not.

The pool chemical manufacturer said that an alternative was available called DPD which carried no cancer risk.

"But it would cost the pool-owner about R50 a kit instead of R4 that the OT outfit costs him," he said.

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(2) 89

89

Black medical varsity planned

Natal Mercury 24/10/75

Mercury Correspondent

PRETORIA — Draft legislation is being prepared for the establishment of a university at Garankuwa for the training of African doctors, dentists and veterinary surgeons, the Minister of Bantu Education, Mr. M. C. Botha, said in Pretoria yesterday.

Attention would also be given to training for certain auxiliary health services.

The Minister said the university would be an autonomous institution and to ensure academic standards it was intended to work closely with the universities of Pretoria and the Witwatersrand.

For training the university would make use of the Garankuwa Hospital which would form an integral part of the university in which its control would be vested.

In this respect the Minister said the university would be unique in South Africa.

Mr. Botha said because the purpose was to train students from the ranks of all the African population groups, and the specialised nature of the training, it was essential that the proposed medical university should have the co-operation of all State departments concerned, the homelands Governments, the three existing African universities as well as the neighbouring universities of Pretoria and the Witwatersrand.

"It goes without saying that the homeland Governments would have to be involved in the university."

The Minister said arrangements had been made with the University of Pretoria to obtain the expert assistance of Professor H. W. Snyman, Dean of the Faculty of Medicine. He would act as chief adviser in setting up the medical university.

Mr. Botha said Prof. Snyman had extensive knowledge and experience and as an acknowledged expert had served in various commissions of inquiry. He

RDM 24/10/75

HEALTH - General

~~1 [illegible] - General~~

2 HEALTH - General

African medical university planned

Staff Reporter

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"It goes without saying that the homeland governments will have to be involved in the university."

It was intended that first-year training would initially be undertaken at the three universities for Africans and that the medical university would provide training from the second year.

89

No race bias in SA Red Cross—report

Star 27/10/75

Own Correspondent

GENEVA — There is no evidence that the Red Cross Society of South Africa practices racial discrimination, according to a report by the deputy secretary general of the League of Red Cross Societies.

The report, by Mr Bertil Petterson, is the 16th item on the agenda of the annual meeting of the league's board of governors, being held in Geneva from tomorrow to Saturday, November 1.

Mr Petterson, Swedish-born but now a Mexican national, based his report on a personal visit to South Africa.

He was instructed to go as the personal representative of league secretary general Mr Jose Barroso as part of the programme adopted in 1973 "against racism and racial discrimination."

His report to the board of governors is expected by officials of the league, which has 90 member Red Cross, Red Crescent and Red Lion societies, to remove pressure from some of them for the expulsion of the South African Red Cross.

The league also made it clear that it firmly opposes any expulsion action by moving the board of governors meeting to Geneva from Rabat. The Moroccan Government said it would refuse visas to South African Red Cross officials and the league promptly stated that this would violate its fundamental principle of universality.

Mr Petterson's report said in part:

"I made a study of the (South African) society's constitutional documents, ie their memorandum (mandates) and articles of association. In neither of these documents could I find any reference to race or colour.

"It is quite clear that any member of any race, and for that matter of any age, sex, religion or political conviction, may legally become a full member of the society and will thereupon be entitled to full participation in its affairs.

"The society owns 76 ambulances and one aircraft which is used exclusively for ambulance purposes. These services are available to all races and are provided free of charge. Donations in reimbursement are accepted from those who can afford them.

"The society provides bursaries from an established fund for the post-graduate training of nurses. During the past five years 36 of the 40 bursaries granted were to Blacks.

"The Geneva Conventions, printed in English and Afrikaans, are used in schools for all races. To promote teaching, the society has now translated this pamphlet into Xhosa and Zulu, the languages of the two main Black ethnic groups in South Africa."

City's new MOH

ARGUS 31/10/75

89

DR R. J. COOGAN, Cape Town's new Medical Officer of Health, believes — in the face of 'a daunting challenge' — 'that we will succeed in developing in South Africa a comprehensive community health service second to none in the world today.'

The Minister of Health, Dr S. W. van der Merwe, has approved Dr Coogan's appointment. He takes over as MOH at the end of November when Dr R. M. Langerman retires. Dr Coogan has been Deputy MOH since 1972.

He said yesterday the city's health services were undergoing complete reorganisation to meet present challenges.

DISEASES

This included consolidating advances in the control of killer child diseases, controlling food, water and sanitation services and maintaining maternal and child welfare services 'to the point where infant mortality and maternal mortality are reduced to the minimum.'

Cape Town provided an 'interesting and challenging' microcism of world health.

'We have both a developed society and an under-developed society.'

On one hand, said Dr Coogan, there was an increasing death rate due to heart and circulatory diseases, cancer and the 'stress syndromes.'

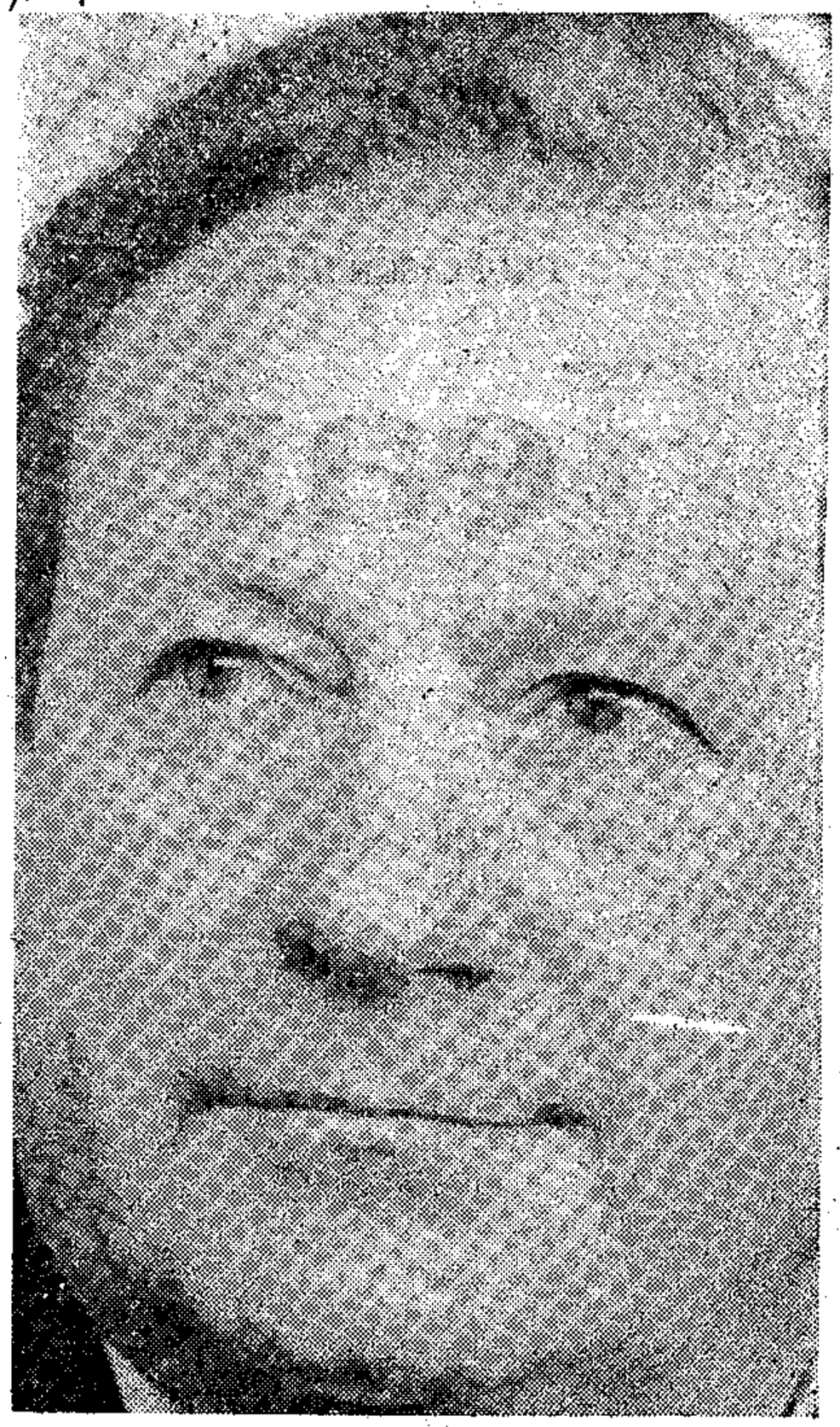
On the other hand were the 'old socio-economic enemies' of malnutrition, tuberculosis and the population explosion. Venereal disease was also on the upsurge in all groups.

POLLUTION

But there was another facet: 'Modern life poses a new awareness of environmental pollution, air pollution, noise pollution, and the possibility, in the not too distant future, of pollution by nuclear radiation.'

Dr Cogan said the city's health service would aim at closer co-operation with the Provincial Hospital Service and the Day Hospital Organisation.

'This is necessary to provide a cohesion between our preventive services, the curative services of the hospitals and a rehabilitative service which has still, largely, to be developed.'



DR R. J. COOGAN, Cape Town's new Medical Officer of Health.

Dr Coogan qualified at the Royal College of Surgeons in Ireland in 1944 while serving with the Army Medical Corps and subsequently served for eight years in the merchant navy.

In the early 1950s he developed a hospital and a series of casualty clearing stations in an Arabian oil field being developed by American magnate Jean Paul Getty. He also looked after the oil multimillionaire in America and Europe.

HOSPITAL

He was appointed Medical Officer of Health to the Government of Jamaica in the mid-1950s and came to South Africa in 1960, as senior medical officer at the Chamber of Mines Chest Hospital near Johannesburg.

Dr Coogan came to Cape Town in 1967 as medical superintendent of the Brooklyn Chest Hospital, and in 1970 became superintendant of the City Hospital.

At the same time he was senior lecturer in infectious diseases at the University of Cape Town. He became Deputy MOH in the city in 1972 and in May this year was admitted a Fellow of the Royal Society of Health.

Dr Coogan is married and has four children. He has been a keen boxer and fencer, and was three times a national sabre champion and finalist for the British and Empire Open title.

He gave up rugby after a game on stony Kenyan ground at the age of 34.

'I spent the following 10 days treating the other members of the team, and myself, for multiple injuries,' he said.

Health crisis hits Durban

(1) ~~262~~ - Natal

(2) 89

Star 3/11/75

Own Correspondent

DURBAN — Durban's municipal health service is nearing breakdown point with the city paying some of the lowest salaries in South Africa and smaller authorities in Natal attracting away staff with offers of better pay.

Astounding figures released today by the chairman of Durban City Council's health and housing committee, Mr Clive Herron, show that the third largest city in South Africa is at the bottom of the money ladder, resulting in a critical shortage of medical officers, health inspectors and community nurses.

Of the 31 health inspectors trained by the city last year more than half have already left for better paid posts.

The shock figures have been released a few days after a special council meeting to consider the situation. Members heard a report by Durban's medical officer of health, Dr Colin MacKenzie, that the critical manpower shortage would leave the city unable to cope with an outbreak of epidemic disease.

A Government circular instructing local authorities to cut back on spending and putting a freeze on employing more staff has dashed hopes of relieving the crisis.

Mr Herron said today: "This has caught us at a time when we have the most vacancies."

Among the vacancies for senior posts are two for assistant medical officers of health, one senior clinical medical officer and four clinical medical officers.

R3 000 LESS

There are 11 vacancies for health inspectors. At present the maximum number of these posts is 67, but Mr Herron believes that the figure should be 126 as Durban is a large industrial, residential and holiday area.

A chief health inspector in Durban is getting R3 000 less than his opposite number in Johannesburg, R2 000 down on Pretoria and R1 000 lower

But many inspectors did not have to go so far afield for better money. Smaller local authorities in Natal, such as Stanger, Greytown and New Germany, have attracted away staff with offers of R100 a month more plus fringe benefits.

Another section of the service to suffer is the community nursing. At the moment there are 66 community nurses working in Durban — one for every 12 000 of the population.

Mr Herron reckons the city should employ about 200 of these nurses. Home visits over the last four years have dropped from 83 000 to 43 000.

Change of life-style could beat disease

Own Correspondent

CAPE TOWN. — Some diseases caused by modern man's life habits could be prevented "by radical changes in our way of life such as altering our eating habits, and by withdrawing ourselves from the environment of city life and occupational exposure," according to Professor A. J. Brink, president of the South African Medical Research Council.

He said research had shown in part that such changes could prevent some diseases, but "the practice of this knowledge might make life hardly worth living."

Medical research today must fight disease by defining its cause and removing this if feasible. Research must furthermore provide in-depth knowledge so that in cases where it was not feasible to remove the cause researchers could change or defeat its effects.

"We are more and more in need of in-depth knowledge in order that we may also enjoy life," Professor Brink said.

"Therefore it is likely that research in all fields would become more sophisticated and require more and more trained researchers and better facilities." — Sapa.

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both sides of the paper

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Marburg: SA woman's role

23/12/76 STAR

Science Editor

The top role a Johannesburg woman doctor played in containing the serious outbreak of Marburg disease in Zaire in October was disclosed today.

Another strictly kept secret now also revealed is that she contracted a disease similar to Marburg virus disease and was, in fact, in the Johannesburg Fever Hospital until recently.

She is Dr Margaret Isaäcson, head of the epidemiology department of the South African Institute for Medical Research, and a world expert on epidemic diseases.

Dr Isaäcson was a prominent member of the team which dealt with the Marburg cases in Johannesburg last year. When the outbreak in Zaire occurred, she was asked to go there with serum — the only form of specific treatment — taken from the two Johannesburg patients who recovered.

DEATH TOLL

The disease broke out in the north of Zaire and exacted a heavy death toll.

When Dr Isaäcson arrived there, she found a frightening situation. Practically everyone who had been handling or nursing the patients in hospital was dying of the disease, which has a mortality rate of some 95 percent.

Without thought for her own safety, she began treating the patients and teaching the staff how to handle them without getting the disease themselves.

She started a surveillance scheme to locate the contacts of patients in an effort to bring the epidemic under control.

"We were successful," she said today. "If the disease had spread beyond the hospital into this city of 2-million people, I don't know what we would have done."

Dr Isaäcson was a member of a 50-member international commission formed to combat the outbreak. After three weeks she and other members of the team went to the epidemic area in the north and field teams visited 30 000 families in 500 villages to establish the extent of the epidemic and to find cases that had recovered.

So far only 15 survivors have been found and they are being bled regularly to provide a serum stock.

DR MARGARET ISAACSON

Cape Times white/pink

Medicine: Blacks to lose school

Own Correspondent

DURBAN. — White medical students will be admitted to Durban's Black medical school within the next few years following the Cabinet's decision to phase out African — and later Indian and Coloured — students at the school.

A new medical school for Africans is being built by the Government at Garankuwa Hospital near Pretoria and Indian and Coloured medical schools are likely to be established at the Durban-Westville and Western Cape universities.

These facts emerge from the Cabinet's instruction last week to Natal University's Medical Faculty not to admit first-year African students as from next year.

The Dean of the Faculty, Professor P M Smythe, has issued a statement condemning the decision for destroying the institution in its present form.

And last night Dr Batchelor, president of the Natal Coastal Branch of the Medical Association of South Africa, said: "There is little doubt that in the next few years Whites will be admitted to the Durban medical school — but at a price.

"That price will be the phasing out of Black students in line with the Government's policy of separate development."

Dr Batchelor said the Cabinet's instruction to close the school to African first-year students in 1976 and second-year students in 1978 meant the end of the only Black medical school in the country at present.

"The Cabinet's decision has come as a great disappointment to most of the staff at the medical school who enjoy a good reputation both here and overseas" he said.

He added that there had been rumours for about a year that Blacks would be phased out of the school [illegible] but

kuwa Hospital opened within the next few years.

Durban medical school will now have to turn away 40 to 60 would-be African first-year students next month, but although there is now no African medical school at which they can enrol they can do their first two years at any African university.

It is only in third year when clinical subjects are needed that medical students have to enrol at a medical school.

No deadline has been set for the medical school for accepting third-year African students.

It is expected that the university council will make every effort to have the Cabinet's decision revoked following the board of the Medical Faculty's announcement that it is "totally opposed" to the decision.

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TOESPRAAK GELEWER DEUR SY EDELE DR. SCHALK VAN DER MERWE, MINISTER VAN GESONDHEID, TYDENS DIE JAARLIKSE DINEE VAN DIE WORCESTER AFDELING VAN DIE KAAPSE WESTELIKE TAK VAN DIE MEDIESE VERENIGING VAN SUID-AFRIKA IN DIE KERKSAAL VAN DIE WORCESTER OOS N.G.-GEMEENTE, WORCESTER OP VRYDAG 28 NOVEMBER 1975 OM 21h00.

EMBARGO VRYDAG 28 NOVEMBER 1975 OM 21h00.

MR. PRESIDENT, COLLEAGUES, LADIES AND GENTLEMEN, AS REQUESTED BY YOU, I GLADLY ACCEDE TO YOUR WISH TO EXCHANGE SOME THOUGHTS ON THE SUBJECT "PRESENT PRIORITIES IN HOSPITAL AND MEDICAL CARE FOR THE COLOURED PEOPLE OF SOUTH AFRICA."

VIR MY AS GENEESHEER EN MINISTER VAN GESONDHEID EN VAN KLEURLINGBETREKKINGE, IS DIT DUIDELIK, UIT HIERDIE ONDERWERP WAT U GEKIES HET, DAT DIE MEDIESE PROFESSIE EN IN BESONDER HIERDIE TAK VAN DIE MEDIESE VERENIGING, INTIEM EN DIEPGAANDE BELANGSTEL IN DIE WEL EN WEE VAN ONS BEVOLKING, IN AL SY SKAKERINGS EN OP ALLE VLAKKE.

SUID-AFRIKA IS 'N DINAMIESE LAND MET 'N GROEIENDE EKONOMIE EN ALHOEWEL DAAR TANS 'N INFLASIE PROBLEEM IS, IS EK OORTUIG DAARVAN DAT MET ALMAL SE HULP EN SAMEWERKING DIT SLEGS TYDELIK VAN AARD IS, OMDAT ONS GROOTSTE BATE IN DIE GEHALTE VAN ONS BEVOLKING AS 'N GEHEEL Lê.

DIE VERSKILLENDE BEVOLKINGSGROEPE, BLANK, KLEURLING, ASIëR EN SWART, IS IN STAAT OM HULLE PROBLEME, VAN WATTER AARD OOKAL, AFSONDERLIK EN OF GESAMENTLIK OP TE LOS, IN DIE GROEPSBELANG, ASOOK IN DIE BELANG VAN DIE LAND AS 'N GEHEEL.

DIT SYNDE SO, IS DIT VAN OWERHEIDSWEë NOODSAAKLIK DAT DIE MEGANISME, DIE INSTRUMENTE EN DIE FASILITEITE GESKEP WORD OM AAN ELKE BEVOLKINGSGROEP DIE GELEENTHEID TE BIED OM SY GEHALTE STEEDS TE VERBETER EN DAARDEUR HOMSELF TE DIEN EN

DEUR/....

DEUR SY EIE BEDIEN TE WORD OP SOVEEL VLAKKE AS MOONTLIK. DIT VORM IMMERS DIE HOEKSTEUN VAN DIE BELEID VAN AFSONDERLIKE ONTWIKKELING. DEUR HIERDIE BELEID SO TOE TE PAS, SAL ONS TOEKOMSTIG STERKER BEVOLKINGSGROEPE VERSEKER, WAT VIR SUID-AFRIKA VAN ONSKATBARE NASIONALE EN INTERNASIONALE BETEKENIS SAL WEES.

OM HIERDIE IDEAAL TE VERWESENTLIK, IS DIT NODIG OM OP BAIE TERREINE VAN DIE VOLKSHUISHOUDING, GELEENTHEDE EN DIE NODIGE FASILITEITE DAARVOOR TE SKEP. SULKE GELEENTHEDE EN FASILITEITE MOET TEN VOLLE DEUR DIE MENSE VIR WIE HULLE GESKEP IS, BENUT WORD. OPLEIDING OM DIENS TE KAN VERSKAF IS 'N BASIESE NOOD= SAAKLIKHEID. EERS WANNEER OPLEIDING OP 'N HOë PEIL, WERKERS EN AKADEMICI VAN GEHALTE LEWER, KAN KWALITEITSDIENSTE VERWAG WORD. DIT IS DAN OOK ONS STREWE TEN OPSIGTE VAN DIE KLEURLING= BEVOLKING EN HIERAAN KAN ONS ALMAL SAAMWERK OM DIT TE VERWESENLIK.

LAAT MY TOE OM 'N PAAR ASPEKTE WAARIN U BELANG SAL STEL, NADER TOE TE LIG.

'N GEMEENSKAPSGESONDHEIDSDIENS WAAROP DIE DEPARTEMENT VAN GESONDHEID GROOT KLEM Lê EN WAARAAN JAARLIKS R9 MILJOEN SPANDEER WORD, IS DIE ALLESOMVATTENDE BUITEPASIëNTE-DIENS WAT AS 'N GESUBSIDIEERDE DIENS, DEUR PLAASLIKE OWERHEDE, AAN AL DIE INWONERS IN HULLE REGSGEBIEDE GELEWER WORD.

HIERDIE DIENS WAT BEKEND STAAN AS 'N ARTIKEL 17 DIENS EN WAT GELEWER WORD INGEVOLGE DAARDIE ARTIKEL VAN WET 51 VAN 1946, MAAK VOORSIENING VIR 'N 7/8STE SUBSIDIE OP SEKERE KAPITALE EN BEDRYFSUITGAWES DEUR 'N PLAASLIKE OWERHEID AANGEGAAN OM DIE DIENSTE TE KAN LEWER.

DIE OPRIGTING VAN KLINIEKGERIEWE MET MEUBILEMENT EN INSTRUMENTASIE, SOWEL AS SEKERE KATEGORIë VAN MEDISYNE, KWALIFISEER VIR HIERDIE SUBSIDIE. GROTER WERKE VAN OOR DIE R25 000,00 SOWEL AS KLEINER WERKE ONDER HIERDIE BEDRAG,

KOM/...

KOM IN AANMERKING VIR DIE SUBSIDIE. AFSONDERLIKE GERIEWE VIR DIE VERSKILLENDE RASSEGROEPE WORD OPGERIG, AFHANGENDE VAN HULLE BEHOEFTES. SO WORD DAAR TANS 'N GROOT EKONOMIESE BEHUISINGSKEMA OP DIE KAAPSE VLAKTE VIR KLEURLINGE GEBOU, WAAR 'N KLINIEK IN DIE BURGERSENTRUMKOMPLEKS INGESLUIT SAL WEES TEEN 'N BEDRAG VAN R180 000,00.

DIENSTE WAT HIER GELEWER SAL WORD IS ONDER ANDERE KRAAM= VERPLEEGDIENSTE, VOOR-EN-NAGEBOORTE SORG, KINDERSORG, BUITEPASIëNTEBEHANDELING VAN TUBERKULOSE EN VENERIESE SIEKTE GEVALLE, IMMUNISERINGS- EN GESINSBEPLANNINGSDIENSTE, SOWEL AS DIE BEHANDELING VAN KLEINER ONGESTELDHEDE.

TERWILLE VAN EKONOMIESE OORWEGINGE EN VIR DIE WELSYN VAN DIE GEMEENSKAP, IS DIT NOODSAAKLIK DAT HIERDIE DIENSTE BINNE MAKLIKE BEREIK VAN ELKE INDIWUDU IN DIE GEMEENSKAP SAL WEES.

MISTER PRESIDENT, IN ACCORDANCE WITH THIS POLICY, THE LOCAL AUTHORITIES OF WORCESTER, CAPE TOWN, CALEDON, CERES, TULBAGH, CLAN WILLIAM, FRASERBURG, KUILSRIVER, STELLENBOSCH, GEORGE, GRABOUW, HEIDELBERG AND KNYSNA, ALL RECEIVED SUBSIDIES, IN THE RECENT PAST, TO ENABLE THEM TO ERECT THE NECESSARY CLINIC BUILDINGS WHERE THESE SERVICES COULD BE RENDERED TO THE COLOURED POPULATION GROUPS WITHIN THEIR COMMUNITIES.

AS INDICATED EARLIER ON, A SERVICE CANNOT BE RENDERED WITHOUT SUITABLY TRAINED PERSONNEL. MY DEPARTMENT, THEREFORE, SUBSIDISES POSTS ON THE ESTABLISHMENT OF LOCAL AUTHORITIES, WHICH ENABLE THEM TO RENDER SUCH SERVICES AS ARE NEEDED BY THE COMMUNITY, WITHIN THE SCOPE OF THE ESTABLISHED POLICY. THIS MAKES IT POSSIBLE FOR LOCAL AUTHORITIES TO APPOINT: MEDICAL OFFICERS, HEALTH INSPECTORS, NURSES AND SUCH OTHER CATEGORIES, OF WORKERS, PROVIDED FOR UNDER EXISTING HEALTH LEGISLATION.

BEARING IN MIND THE SPARSELY POPULATED RURAL AREAS OF OUR

COUNTRY/...

COUNTRY, WHERE PEOPLE ARE ALSO IN NEED OF BASIC MEDICAL, NURSING AND OTHER SERVICES, SUPPLIED UNDER THE COMPREHENSIVE OUTPATIENT SCHEME, MY DEPARTMENT MAKES MOBILE CLINICS, COMPLETE WITH PERSONNEL, AVAILABLE TO SUCH LOCAL AUTHORITIES AND ALSO UNDER THE 7/8 THS SUBSIDISED SCHEME.

DURING THE FINANCIAL YEAR 1976/77 A NUMBER OF BURSARIES HAVE BEEN EAR-MARKED BY THE DEPARTMENT OF HEALTH TO BE MADE AVAILABLE TO SUITABLY QUALIFIED COLOURED NURSES TO OBTAIN POST-BASIC TRAINING FOR THE DIPLOMA IN PUBLIC HEALTH, THUS ENABLING THEM TO PROVIDE A BETTER QUALITY SERVICE TO THE COMMUNITIES WHICH THEY WILL SERVE.

IT SHOULD NOW BE APPARENT, THAT AT ALL GOVERNMENT LEVELS I.E. CENTRAL, PROVINCIAL AND LOCAL, EVERY EFFORT IS BEING MADE TO PROVIDE SUCH HEALTH SERVICES TO THE NATION AS A WHOLE. THE PARTICULAR NEEDS OF ALL SECTIONS OF THE COMMUNITY ARE ALWAYS CONSIDERED IN DETAIL AND GREAT STRIDES HAVE BEEN MADE RECENTLY, TO SATISFY DEMANDS FOR BETTER SERVICES, WITH PARTICULAR EMPHASIS ON OUR COLOURED POPULATION, COUNTRY WIDE.

MENEER DIE PRESIDENT, BENEWENS AL HIERDIE ASPEKTE, WAT VOORUITGANG BETEKEN, WAS EN IS DAAR NOG ALTYD DIE HUNKERING NA 'N EIE MEDIESE FAKULTEIT VIR DIE UNIVERSITEIT VAN WES-KAAPLAND MET 'N AKADEMIESE HOSPITAAL WAAR KLEURLING MEDIESE STUDENTE OPGELEI KAN WORD. HIERDIE WAS NOG ALTYD ONS STREWE EN DAARVOOR IS HARD GEWERK.

VANAAND KAN EK U DIE GOEIE NUUS, IN HIERDIE VERBAND MEEDEEL. DIE KABINET HET SO PAS BESLUIT, DAT 'N MEDIESE FAKULTEIT VIR DIE UNIVERSITEIT VAN WES-KAAPLAND, EN DIE GEPAARDGAANDE OPLEIDINGSHOSPITAAL AS 'N GEÏNTEGREERDE EENHEID BEPLAN EN OPGERIG MOET WORD. DIE AKADEMIESE HOSPITAAL SAL OP DIE TERREIN VAN DIE UNIVERSITEIT WEES, OF SO NA AS MOONTLIK DAARAAN.

HIERDIE/...

HIERDIE BESLUIT HOU GROOT EN BELANGRIKE VOORDELE VIR DIE HELE KLEURLINGBEVOLKING IN EN IS WEER EENS 'N BEWYS, DAT VAN OWERHEIDSWEë, ELKE BEVOLKINGSGROEP IN ONS LAND SY REGMATIGE DEEL SAL KRY ASOOK SY PLEKKIE IN DIE SON.

HOSPITALE IN DIE BOLAND, SOOS DIE WAT U HIER IN WORCESTER HET, SAL MOONTLIK KAN INSKAKEL BY DIE FAKULTEIT VAN GENEESKUNDE VAN HIERDIE UNIVERSITEIT. SULKE HOSPITALE SAL KAN DIEN AS SATELLIETE OM KLINIESE OPLEIDING TE VERSKAF AAN STUDENTE IN HUL KLINIESE JARE. EKONOMIES SAL DIT OOK GEREGVERDIG WEES OM STUDENTE NA DIE KLINIESE MATERIAAL EN DIE PASIëNTE TE BRING LIEWER AS OM PASIëNTE NA DIE STUDENTE TE BRING. 'N ANDER ASPEK WAT GROOT SIELKUNDIGE WAARDE HET, IS DAT PASIëNTE IN HUL TUISOMGEWING HOSPITALISEER KAN WORD, WAT DIE MINIMUM ONTWRIGTING VAN HUISHOUDINGS-, GESINS- EN FAMILIEBANDE SAL MEEBRING.

WAT VIR U, DIE PRAKTISERENDE GENEESHERE MET AANSTELLINGS BY HIERDIE TIPE HOSPITALE VAN BELANG IS, IS DAT U GEWILLIG SAL MOET WEES OM IN U EIE DISSIPLINES AS LEKTORE EN LEERMEESTERS VIR DIE STUDENTE OP TE TREE.

IT IS MY CONSIDERED OPINION, THAT AMOUNGST OUR COLLEAGUES IN CITIES AND TOWNS, THERE ARE SOME OF OUR BEST TUTORS IN THE MEDICAL PROFESSION. PEOPLE, WHO BY EXPERIENCE AND TOIL, HAVE MASTERED THE PRACTICAL ASPECTS OF MEDICAL PRACTICE. THEY ARE ADMIRABLY SUITED TO TEACH THE PRACTICAL, BASIC AND OTHER ALL IMPORTANT ASPECTS OF PREVENTIVE, PROMOTIVE AND CURATIVE COMMUNITY MEDICINE AND HEALTH SERVICES TO DOCTORS IN THE MAKING. IT IS ESSENTIAL TO HAVE THIS BASIC KNOWLEDGE AND KNOW HOW, BEFORE BRANCHING OFF INTO A SPECIALISED FIELD.

MAY I APPEAL TO COLLEAGUES, BOTH GENERAL PRACTITIONERS AND SPECIALISTS, THAT SHOULD THE POSSIBILITY BECAME A REALITY, YOU WOULD BE WILLING TO ASSIST IN THIS PROJECT AND MAKE IT A TREMENDOUS SUCCESS, IN THE INTEREST OF OUR COUNTRY AS A WHOLE. I THANK YOU.

VRYGESTEL DEUR DIE DEPARTEMENT VAN INLIGTING OP VERSOEK VAN DIE MINISTER VAN GESONDHEID EN VAN KLEURLING-, REHOBOTH- EN NAMABETREKKINGE.

AA 24/12/75

Dagga grab in court

EAST LONDON — A scuffle broke out in the magistrate's court here yesterday when a man awaiting trial for possession of dagga made a dive for the prosecutor's table and swallowed a dagga zol there as a court exhibit.

Although the man, Mr Dries Long, 33, could not be forced to cough up the zol, despite the efforts of four policemen who struggled with him for about five minutes, he had not destroyed the evidence against him — the zol was to have been used as evidence against a 16-year-old youth, also charged with possession of dagga.

The whole incident happened so fast that the magistrate, Mr F. C. Smith, who immediately adjourned the court for a few minutes, said afterwards he thought the man was suffering From a fit as he was struggling violently.

Mr Long was charged with obstructing the course of justice.

The magistrate ruled that he could not hear the charge of obstruction and ordered that both cases be heard in another court.

Mr Long, a casual labourer, was allowed R30 bail and warned to appear again on February 16.

The youth, who pleaded guilty, pleaded that a that a "muti man" had given him the dagga for a chest ailment.

The magistrate remarked that it was strange that "so many of your people" (referring to the youth) had chest problems for which they took dagga.

The youth was found guilty and sentenced to three months' imprisonment, suspended for three years. — DDR.

F. M. 21/1/76

(1) Editorial
(2) 89

Apartheid lunacy

Another piece of apartheid madness will be set in motion this year.

SA's Black medical education, centering on Natal University's Black medical school, is on the point of being phased out and replaced by a system which will see Africans graduating from the Medical University of Southern Africa (Medunsa) at Ga Rankuwa, about 22km from Pretoria, and Coloureds and Indians graduating from schools attached to the universities of the Western Cape and Durban-Westville respectively.

As from 1976 first-year African students will attend African universities before going on as sophomores to Medunsa, while as from 1978 Natal University will be altogether debarred from taking in any more new African students in second-year and beyond. Coloureds and Indians are to be phased out at the discretion of the Ministers concerned.

The plan seems to be based on the report of the Committee of Inquiry into Medical Education. Though government appointed the committee in the late Sixties, its report has never been tabled, so many medical academics are still completely ignorant of its contents.

More recently, Natal University's medical school authorities have pressed, to no avail, for a clear answer from Pretoria about the school's future. Having lately seen R1,4m of extensions almost completed and authority granted for extensions to African students' hostel accommodation, the school hoped and expected it would be allowed to remain as it is and that the only debate would be over its size.

Natal University's argument is that the school should be expanded to allow an intake of 160 new students a year (now 120, with about 50-50 Africans and Indians and a smattering of Coloureds) of which 100 should be Africans.

That would help cope with the significant increase in the last five years of Africans matriculating with mathematics. This development has pushed up first-year applications to Natal University medical school (from 70 in 1970 to around 200 last year).

Natal University believes once there's a 160 intake a second Black medical school would be justified. Moreover, it's reckoned it would cost a mere R430 000 to provide for its extra intake.

Instead, Pretoria has now disclosed it is to spend R30m over six years on establishing Medunsa. At the same time it will be busily destroying a well-established Black school, which not only has an excellent academic record, but whose celebrated atmosphere of racial accord has drawn a host of dedicated teachers.

It's not as if Medunsa is going to turn out a great many more African doctors than Natal University. It's projected intake is 160 a year. Yet expectations are that by 1980, only two years after Medunsa's start-up, there'll be around 320 applications. So it'll be saturated almost from its inception.

Pretoria, apparently, aims to transform the Natal University into a White institution. Undoubtedly there's a good case for another such school in the country. But that's still no reason for closing Natal University down for Blacks.

As Professor John Reid, Dean of Natal's Faculty of Medicine, points out, Natal University could easily run two medical schools with the same staff: the existing Black school attached to King Edward as at present, and a White school attached to Addington.

Certainly Pretoria's latest lunacy can hardly improve SA's standing in the outside medical world. Recently, the World Medical Association wanted SA out of that body because of apartheid.

Black protest at N.U.

NM 7/2/76

Mercury Reporter

BLACK medical students at the University of Natal are planning a series of meetings to protest against the Government's decision to bar Africans from the university.

The students are also against a move to bar Coloureds and Indian medical students later in a phasing-out programme.

Students spoken to yesterday said that the Medical School Council, in conjunction with the Students Representative Council (Blacks) has arranged for a number of meetings to decide what actions to take.

"We are not going to let the matter rest there," said a student member of the Medical School Council.

Professor J. V. O. Reid, acting Dean of the Medical School, said yesterday that he was not aware of any student meetings.

Professor Reid added that he was pleased that the Government had a second look into its previous decision.

"We have written to the Minister of National Education and still awaiting a reply," he said, adding that they hope to have an interview with the Minister in the "very near future".

In the meanwhile work has started on the first phase of the massive R30-million Medical University for Southern Africa at Ga Rankuwa near Pretoria. The first phase

University fights for its Blacks

NM 24/8/76.

(1) Ethic = University

(2) 8/9

Science Correspondent

AN appeal has been made to doctors throughout South Africa to help persuade the Government to change its mind and allow all non-White students to continue to attend the University of Natal Medical School.

The appeal takes the form of a letter published in the S.A. Medical Journal which has been signed by the professors of every department in the University's Faculty of Medicine.

Beginning this year, Africans are being phased out over a two-year period and the University has been informed that it must be prepared to phase out Indian and Coloured students some time in the future.

The Government plan is that all African medical students will in future be trained at the Medical University of South Africa, near Pretoria, which still has to be completed.

The letter reads in part: "This decision means the destruction in its present form of an institution which we and our colleagues have so patiently built up over the past 25 years, believing that we were making a contribution of national importance.

"While we certainly welcome the establishment of another medical school in South Africa, charged with the task of training African doctors who are at present in desperately short supply, we question the wisdom of simultaneously excluding Africans from entry to a well established and reputable institution such as ours."

Cases of notifiable diseases

63. Dr. A. L. BORAINE asked the Minister of Health:

(1) How many cases of each notifiable disease were notified in respect of (a) Whites, (b) Asians, (c) Coloureds and (d) Bantu in 1974 and 1975, respectively;

(2) how many deaths from each disease occurred in each race group during 1974 and 1975, respectively.

The MINISTER OF HEALTH:

(1) Cases notified—1974.

	Whites	Asians	Coloureds	Bantu	Other
Anthrax	—	—	1	—	—
Asiatic cholera	—	—	—	—	—
Brucellosis	4	—	3	1	—
Diphtheria	39	3	43	417	—
Encephalitis	186	5	13	90	—
Erysipelas	4	—	—	7	—
Glanders	—	—	—	—	—
Insecticidal Poisoning	—	—	4	48	—
Lead Poisoning	—	—	—	14	—
Leprosy	4	5	5	150	—
Malaria	169	4	3	1 436	10
Meningitis	159	21	278	827	8
Ophthalmia Neonatorum	7	3	84	118	—
Plague	—	—	—	—	—
Poliomyelitis (acute)	5	11	25	373	—
Puerperal fever	3	4	13	95	—
Rabies	—	—	—	2	—
Relapsing fever	—	—	—	—	—
Scarlet fever	188	2	9	8	—
Sleeping Sickness	1	—	—	3	—
Smallpox	1	—	—	—	—
Tetanus	1	17	19	211	—
Trachoma	—	—	—	541	—
Tuberculosis	754	1 014	7 557	50 564	179
Typhoid fever	45	59	103	3 302	6
Viral Hepatitis	646	114	152	342	4
Yellow fever	—	—	—	—	—
Typhus	—	—	—	—	—
Total	2 216	1 262	8 312	58 599	207

Grand Total 70 596

Cases notified—1975:

	Whites	Asians	Coloureds	Bantu	Other
Anthrax	2	—	—	—	—
Asiatic cholera	—	—	—	—	—
Brucellosis	—	—	—	1	—
Diphtheria	24	2	28	384	2
Encephalitis	150	7	8	115	1
Erysipelas	4	—	1	3	—
Glanders	—	—	—	—	—
Insecticidal Poisoning	—	—	1	31	—
Lead Poisoning	1	—	—	3	—
Leprosy	—	—	4	155	3
Malaria	110	9	4	1 680	2
Meningitis	139	5	253	808	5
Ophthalmia Neonatorum	6	—	56	117	2
Plague	—	—	—	—	—
Poliomyelitis (acute)	4	9	31	526	—
Puerperal fever	16	—	6	117	—
Rabies	—	—	—	1	—
Relapsing fever	—	—	—	—	—
Scarlet fever	401	—	10	30	1
Sleeping Sickness	1	—	2	2	—
Smallpox	—	—	—	1	—
Tetanus	—	7	15	300	—
Trachoma	1	—	—	539	2
Tuberculosis	746	551	7 054	50 675	127
Typhoid fever	53	27	195	3 298	4
Viral Hepatitis	914	150	128	497	5
Yellow fever	—	—	—	—	—
Typhus	—	—	—	—	—
Total	2 572	767	7 796	59 283	154

Grand Total 70 572

(2) Deaths—1974:

	Whites	Asians	Coloureds	Bantu	Other
Anthrax	—	—	—	—	—
Asiatic Cholera	—	—	—	—	—
Brucellosis	—	—	—	—	—
Diphtheria	2	—	5	35	—
Encephalitis	4	—	2	8	—
Erysipelas	—	—	—	—	—
Glanders	—	—	—	—	—
Insecticidal Poisoning	—	—	—	—	—
Lead Poisoning	—	—	—	—	—
Leprosy	—	—	—	3	—
Malaria	2	—	—	14	—
Meningitis	9	3	28	60	—
Ophthalmia Neonatorum	—	—	—	—	—
Plague	—	—	—	—	—
Poliomyelitis (acute)	—	—	—	9	—
Puerperal fever	—	—	—	1	—
Rabies	—	—	2	1	—
Relapsing fever	—	—	—	—	—
Scarlet fever	2	—	—	—	—
Sleeping Sickness	2	—	—	8	—
Smallpox	—	—	—	—	—
Tetanus	—	1	9	51	—
Trachoma	—	—	—	—	—
Tuberculosis	43	30	603	1 960	6
Typhoid fever	—	—	2	55	—
Viral Hepatitis	1	1	10	14	—
Yellow fever	—	—	—	—	—
Typhus	—	—	—	—	—
Total	65	35	661	2 219	6

Grand Total 2 986

Deaths—1975:

	Whites	Asians	Coloureds	Bantu	Other
Anthrax	—	—	—	—	—
Asiatic Cholera	—	—	—	—	—
Brucellosis	—	—	—	—	—
Diphtheria	1	—	—	32	—
Encephalitis	2	—	4	7	—
Erysipelas	—	—	—	—	—
Glanders	—	—	—	—	—
Insecticidal Poisoning	—	—	1	3	—
Lead Poisoning	—	—	—	—	—
Leprosy	—	—	—	2	—
Malaria	1	—	1	2	—
Meningitis	9	1	22	36	—
Ophthalmia Neonatorum	—	—	—	—	—
Plague	—	—	—	—	—
Poliomyelitis (acute)	—	—	3	2	—
Puerperal fever	—	—	—	5	—
Rabies	—	—	—	—	—
Relapsing fever	—	—	—	—	—
Scarlet fever	—	—	—	—	—
Sleeping Sickness	—	—	—	—	—
Smallpox	—	—	—	—	—
Tetanus	—	1	2	42	—
Trachoma	—	—	—	—	—
Tuberculosis	30	21	488	1 504	2
Typhoid fever	1	1	3	58	2
Viral Hepatitis	4	2	4	16	—
Yellow fever	—	—	—	—	—
Typhus	—	—	—	—	—
Total	48	26	528	1 709	4

Grand Total 2 315

Hansard 3
col 173
11/2/76
85

Burns backs new medical school

26/2/76
DP

EAST LONDON — The leader of the Ciskei National Unionist Party, Chief S. M. Burns-Ncamashe has come out in support of the proposed establishment of a medical school near Pretoria where black students will be given medical, dental and veterinary training.

Beginning this year, blacks are being phased out over a two year period from the University of Natal medical school.

The present government plan is that all black medical students will in future be trained at the medical school near Pretoria, still to be completed.

In a statement Chief Ncamashe said: "The more urgent issue is the sound and adequate training of black students as medical practitioners, as dentists and as veterinary surgeons.

"We highly appreciate the fact that at this varsity institution all black South Africans will gain admission irrespective of their ethnic origin.

"We hope the medium of instruction will be the universal language for higher learning, English, and that the tone of the varsity will be correspondingly cosmopolitan," Chief Ncamashe said.

Chief Ncamashe said it would be more appreciated if lecturers and professors were not only drawn from inside the Republic but also from abroad.

"We entertain the fear that if such a varsity institute on were to be staffed almost entirely by products of South African universities the teaching and research in the specified fields might be in danger of being limited by racial bias or ethnic myopia," Chief Ncamashe said.

Chief Ncamashe said the black people of South Africa were now marching forward along the road towards independence and self-sufficiency and all training should of necessity take this fact into account.

"Our youth should on no account be trained for subordinate roles but specifically for full responsibility in their future independent country.

"It would therefore be to the discredit of the Republican government for expenditure to be incurred on a project viewed by its sponsor as being no more than an institution for producing 'kaffir' doctors, all of whom are to be treated as members of a subordinate caste in contrast to those of the ruling caste," Chief Ncamashe said. —DDR

Education Universities

(2) 59

Spending on health

R182-m

ARGUS 27/8/76

THE Cape Provincial Administration will have spent an estimated R182-million on hospital services and public health during the year ending on March 31 1976. This is the highest single amount shown on a statement published this week.

The original estimate for the hospital services vote was R176-million. The additional sum is included in the additional appropriation passed by the recent sitting of the Provincial Council.

The revised total amount to be spent on roads and bridges in the province is about R137,5-milllon, almost R16-million more than the original estimate.

ESTIMATE

The estimate of expenditure on education remains unchanged at R134-million.

One of the unforseen amounts that had to be paid by the Provincial Administration during the current financial year was the sum of R520 000 for disaster damage following the floods in the north eastern Cape.

Natal University

3:84

NM 28/2/76

Black students in protest

Mercury Reporter

MORE than 200 Black medical students with raised fists symbolising Black power (above) assembled outside the Durban Medical School yesterday to protest against the Government's decision to phase out Black students from the school.

Mr. R. E. Mhlanga, president of the Black medical students representitive council, hit out at the Government's decision.

"We have every right to study at this medical school as it was built on the sweat and blood of our forebears."

He said that it was a pity that while South Africa was making every attempt to improve relationship with neighbouring states, very little was being done to "build bridges" between Whites and Blacks in South Africa.

He said a series of meetings were being planned for each African township "to make our parents aware of our problems."

Mr. Sam Malevse, said the removal of Blacks from one place to another was nothing new.

"As Blacks of this country we should be allowed to study at the institution we choose."

Time was running out for Whites in

No limit on research Transkei society told

EAST LONDON — Medical and other types of research should have no boundaries when lands such as the Transkei and Ciskei gained their independence.

This was what Prof A. J. Brink, the president of the South African Medical Research Council, told delegates at the opening of the biennial meeting of the Transkei and Ciskei Research Society here yesterday.

Medical research in South Africa was peculiar because the country had a different environment to other countries, physically, geographically and medically. We also had a multi-national structure.

Prof Brink said: "No two cases of a disease are exactly alike. Multiply this from the individual to the group, from the group to the community, from the community to the race and from the race to the nation and you have one of the most challenging anomalities the mind of man can encounter."

He said the types of disease most prevalent in each race group varied widely.

"Ischaemic heart disease has become virtually the biggest single killing disease among South Africa's whites. It is a part of our way of living and working and is related to the technological environment of the day.

"The blacks — or more correctly the rural or recently urbanised blacks — hardly suffer from this disease at all until they come to the cities and adopt a Western way of life — and death," Prof Brink said.

The blacks, however, suffer from a different heart disease called cardio-myopathies.

Prof Brink pointed out differences other than heart diseases, and these included the greater longevity of black people, their virtual immunity to cancer of the bowel and the high incidence of cancer of the oesophagus which is found among Transkei blacks, where it had reached the highest incidence in the world.

He said the view that "the mind is capable of eradicating any disease" was hopelessly incorrect,

Yesterday talks ranged from the agricultural potential of the homelands, obstacles to this development and the ecology of the area to literacy and future planning.

Today's talks will cover medical subjects including diseases most prevalent in the Xhosa people and as widely diversified as the complications of ritual circumcision and studies on premature babies.

Tomorrow's talks will be on psychological problems and diseases. — DDR.

Prof A. J. Brink

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Apartheid blamed for poor health

STAR
21/9/76

Pretoria Bureau

The United and Progressive Reform Parties in the Transvaal agree that health care implies not only hospital services for the sick, but a full reappraisal of community conditions to prevent people from falling ill in the first place.

Their views are contained in separate articles published in the university of the Witwatersrand medical students' journal, "Auricle".

The United Party's contribution was prepared by Mr Dave Epstein MPC, and the PRP one by Dr Selma Browde, MPC and Dr Alex Boraine, MP.

Although their views were worded differently, both parties agreed that:

- Social conditions attributable to apartheid were responsible for malnutrition, which was a big cause of ill health.
- Health care was hampered by the fragmentation of responsibility between State, provincial and municipal institutions and functions.
- Apartheid in even the curative sector caused wasteful duplication of manpower and expense.
- Medical posts in hospitals and other institutions had to be more attractive.
- And equal pay and opportunities for non-White doctors and nurses, and the right for nurses to work in White hospitals and medical students to study at all medical schools, was needed to meet the demand.

The UP wanted free hospitalisation, and free health care as an ultimate objective, recognising [illegible] body [illegible] the b[illegible]

Both essenc[illegible] popula[illegible] health [illegible] within [illegible] means.

200/85

Look after black workers, warns professor

Sunday Tribune 14/4/85

Finance Reporter

THE South African system of black migrant labour has been attacked on medical grounds by Professor A. Solomon, professor of diagnostic radiology at Johannesburg's Baragwanath Hospital.

He said migrant labour pools defeated any hope of industrial health control, and added: "Permanency in registered employment, inducements to encourage permanency, protective legislation and central medical monitoring together with continuously improving working conditions will safeguard an economy which leans heavily on black workers."

He said black workers, particularly those in high-risk industries like asbestos mining and manufacture should be registered and regularly checked for such industrial diseases.

Professor Solomon pointed out that 90 percent of the 21 000 workers employed on asbestos mines are black.

He said the high turnover of labour in the asbestos industry and the absence of a central records establishment for blacks made impossible an accurate long-term follow up on the health hazards.

He also called for trained medical officers to be appointed to factory inspectorates.

"The factory inspector is no longer sufficiently competent or able to recognise the insidious undermining of the workers' well-being."

He suggested in addition that the Workmen's Compensation Act be enlarged to include inhalents as a cause of injury.

85

CT - 20/11/76.

SA quits world medical body

PRETORIA. — The Medical Association of South Africa has resigned from the World Medical Association.

Announcing this yesterday, the chairman of the South African association's federal council, Professor J N de Klerk, said there was a strong possibility that the world body would soon be completely dissolved.

Professor De Klerk said the federal council had decided to withdraw for two reasons, none of which was political.

He said the council had no "quarrel" whatsoever with the basic philosophy of the world association but was tired of the system of double standards that were applied.

While some principles applied to certain member countries, different principles were used in other countries.

"Expediency has become the motivating force behind the association's decisions," he said.

The second reason for South Africa's withdrawal was financial.

He said the world body's finances were in "a complete mess".

For instance, 18 of the 55 member countries had not paid their subscriptions of about R6 000 a year. — Sapa

85.

'No health care in industry'

22/11/76
STAR

The Erasmus commission on occupational health found there was a lack of awareness of occupational health and hygiene in industry, industrialists have been told.

Addressing a National Occupational Safety Association (Nosa) seminar on the commission in Kempton Park, Mr Bunny Matthy, general manager of Nosa, said the commission had found management did not care enough about health in the factory.

NO CONTROL

No one in a firm was responsible of occupational health. Those who were doing something were not properly trained. There was no control knowledge or responsibility in the use of toxic materials.

There were no statistics. The majority of the inspectorate was not trained or fully qualified.

The commission found 12 Government departments responsible for occupational health. These included the departments of Health, Labour, Mines, Water Affairs, Agriculture, Community Development and Forestry.

It suggested that the Department of Health bridged the activities of the inspectorate and the recommendations.

Safety in factories would fall under the Department of Labour and safty underground would fall under the Department of Mines. Municipal employees would carry out the inspectorate functions.

85

19/12/76 ST

Medical aid may soon pay the lot

MEDICAL aid schemes will in future be allowed to pay doctors' fees in full for their 800 000 members. At present schemes may pay only 80 per cent of fees.

By NEIL HOOPER

A spokesman for the Department of Health confirmed this week that the law had been amended to allow medical aid schemes to pay doctors in full from the beginning of next year. The 80 per cent maximum has been in operation since 1973.

The spokesman said that another important change was that in future medical aid schemes would be able to pay in full doctors who have opted out of medical aid schemes. At present medical schemes paid to their members only a portion of the fee of doctors who had opted out.

Restricted

"The present Act applies only to doctors who are members of the scheme and who charge prescribed tariffs It does not apply to doctors who have opted out," the spokesman said.

The Medical Association made representations to the Minister of Health for the present arrangement to be amended.

"The aim of amending the present legislation is to see if more patients will now go to doctors who have opted out, even if they are charging more than the prescribed medical aid tariffs.

"It will not be up to each of the 250 medical aid schemes in the Republic to decide whether they wish to pay the additional fees."

Another important change in the Act was that maternity fees would become part of a member's general fees. At present medical schemes have a prescribed fee for confinements.

One of the few controversial aspects of the new regulations in the ruling that medical aid schemes are not obliged to pay for drug addiction.

"Some South African municipalities recognise alcoholism as a disease, but the State does not, and therefore cannot allow medical aid schemes to pay for treatment for alcoholism. Nor can it agree to pay for sick leave to people suffering as a result of alcoholism," the spokesman said.

85

Donors urged to give holiday blood

24/12/76 Star

Science Editor

Blood donors have an important duty to see to before taking off for the Christmas and New Year holidays.

Those due for a bleed are asked by the South African Blood Transfusion Service in Johannesburg to give their regular donation.

"We are not short of blood at present but we must be prepared for the 10-day period when little bleeding is done," Mr Frank A Browne, secretary of the service, says.

"There may be a disaster or a spate of accidents where blood is needed in large quantities.

"Over the holidays surgeons usually confine their activities to emergencies. But the normal programmes get under way again after the New Year and then there is usually a heavy call on the blood bank. We must have enough in stock."

There are also a substantial number of patients suffering from leukaemia and other disorders who need a constant supply of fresh blood, said Mr Browne.

85

Drop in 'natural deaths' in 10 years

Cape Times 28/12/76

Chief Reporter

WHILE violence and accidents are displacing certain diseases as major causes of death in the Cape Town municipal area, the latest report of the City's Medical Officer of Health reflects a marked decrease in the death-rate from natural causes over a 10-year period.

In the period 1965 to 1975 the death-rate dropped from 10,20 to 8,44 for every 1 000 Whites and from 10,61 to 7,18 for every 1 000 members of other race groups.

In 1975 the overall death-rate fell to 7,56 for every 1 000 people from 8,31 in the previous year, which represents a decrease of seven percent for all races — 6,7 percent among Whites and nine percent among other races.

The MOH, Dr R J Coogan, says in his report that the White death-rate decrease has been "fairly general" and that among other races the decrease has been most pronounced in the senility gastro-enteritis and "ill-l'defined causes" categories.

The report shows that cardiovascular (heart) diseases continue to head the list of principal causes of death among all race groups. Among Whites, accidents and violence have displaced "other respiratory diseases", and diseases of the nervous system have displaced diseases of the genito-urinary system. Among people of other races accidents and violence have displaced bronchitis and pneumonia as principal causes of death.

In a classification of causes of death among Black and Coloured people in 1975 — the year under review in Dr Coogan's annual report — accidents and violence are shown as the third-biggest cause, after heart diseases and cancer. Among Whites, accidents and violence are shown as the sixth biggest killer, after heart diseases, cancer, senility, arterial diseases and bronchitis and pneumonia.

Suicide up

Home accidents, as a cause of death, increased from 56 in 1974 to 67 in 1975, and the suicide rate increased from 0,04 in every 1 000 people of all races in 1974 to 0,06 in 1975. Dr Coogan notes that males continue to predominate in each racial group, while 39 percent of all suicides "occurred among persons in the prime of life — that is in the age-group of 25 to 44 years".

The MOH says the infant mortality rate is of special significance because it is regarded as one of the most sensitive indexes of health conditions of the general population. In 1975, he adds, infant deaths fell by 191, or 22 percent, compared with the previous year.

85 154

Ambulances are for all, councils told

Star 5/1/77

Pretoria Bureau

The Government has again reminded municipalities that there should be no racial discrimination in ambulance services and official conferences.

At a management committee meeting of the Pretoria City Council last night, a circular from Mr Eric Uys, Transvaal Director for Local Government, was tabled.

Mr Uys said it was Government policy that there should be no racial discrimination in ambulance services during emergencies.

In accidents or disasters the first available ambulance should be used to transport patients, irrespective of whether the ambulance is manned by whites or blacks.

He also reminded that there should be no racial discrimination at congresses, meetings or symposiums at academic level.

ACCOMMODATION

Mr Uys said local authorities should also help organisers obtain accommodation for people of other races attending such meetings.

A Pretoria City Council spokesman said today that it had been the practice for years to put injured people into the first available ambulance at accidents.

85

6/11/77

Blacks are worst hit by cancer

WASHINGTON — Blacks, Asians and American Indians in the United States suffer a proportionately higher death rate from cancer than whites, a major study has revealed.

The study, released yesterday, also shows that certain cancers strike some races with greater frequency than other races.

The occurence of different cancers among non-whites varies throughout the United States, says the study, which was based on death certificate figures for 35 types of cancer compiled by the National Centre for Health statistics from 1950 to 1969.

The latest report written by National Cancer Institute scientists said the geographical studies bolstered medical theories that a relationship existed between environmental factors and cancer risks.

LOCAL FACTORS

The reasons for the varying rates and distribution of cancer were unknown. But the geographical differences should spur investigators to look for local factors that might contribute to the disease, the scientists said.

The non-white study of more than a half-million deaths included blacks, Americans, Indians, Chinese and Japanese, with blacks forming 92 percent of the group.

The scientists said the combined death rate for all forms of cancer for non-whites as a group was slightly higher than for whites.

Compared to other racial groups, blacks have proportionately higher rates for cancers of the mouth and throat, aesophagus, stomach, pancreas, larynx, lung, bladder, cervix and a kind of bone marrow cancer called multiple myeloma.

Whites have higher mortality rates than blacks for cancer of the colon and rectum, breast, ovary, testes, kidney, skin, brain and lymph system, as well as leukemia. — Sapa-AP

85

Anti-rape dart man optimistic

Own Correspondent

DURBAN — The Durban inventor of the dart-firing anti-rape device, Femeprotect, is expecting a decision from the Departments of Health and Justice this week following a call for the total banning of the product by Mr Horace van Rensburg, Progressive Reform Party spokesman on health.

Mr Jac Coetzee said today that he had left 20 samples of the device with the departments for their inspection. He had been promised a decision early this week.

Mr Coetzee accused Mr van Rensburg of trying to torpedo his invention without taking the trouble to examine a production sampie.

Mr Coetzee said he was still very optimistic that his product would be accepted. It would not be put on the market until the safety, legal and health aspects had been fully investigated and approved.

Mr Coetzee said the controversy his advertisements had generated made it impossible to gauge how the product had been received by the average woman.

(85)

XERAY

MAY

(85)

Caught in the middle on medical care

820 19/11/77

Pretoria Bureau

People in the middle-income groups in South Africa are hardest hit when it comes to medical expenses.

Households with an annual income of between R4 000 and R10 000 will be most seriously affected by increasing medical tariffs. This is shown in recently published findings of the Department of Statistics on household expenditure of whites in 1975.

Households in this income bracket are paying 3,5 percent of their average annual expenditure on medical services and requirements for each person, as opposed to 2,7 percent at the bottom end of the scale, and 2,4 percent at the top.

Correspondence from the Department of Comprehensive and Community Medicine at the University of Cape Town and Groote Schuur Hospital in the latest issue of the South African Medical Journal emphasises the need to review income criteria on medical care.

The correspondence points out that while middle-income people may not benefit from provincial medical care, those in lower-income groups have expenses kept low by subsidised services, and upper income groups are better able to absorb increasing medical costs.

85

The Cape Times, Wednesday, January 19, 1977

Squatter hazard

THE DEPARTMENT of [illegible]
on Modderdam Road [illegible]
spokesman for the Minister [illegible]

The spokesman said that the Minister of Health, Dr [illegible] W van der Merwe, had received a telegram from Mr Lolly Adams, Chief Whip of the Labour Party, and was expecting a report on the investigation in a day or two.

Dr Frank Mitchell, the Medical Officer of Health for eight municipal areas including Pelgrim's, said the squatters had become a hazard because of the lack of sanitation and a good water supply.

"The only way that I could [illegible] into this is in my executive capacity as [illegible] assist Squatco, but I have asked for [illegible] to [illegible]

the Government [illegible]

[illegible]

Soon

Heath + Dis - Gen

Black toilets a city problem

The lack of toilet facilities for blacks in Johannesburg is giving city health officials grey hairs and causing health problems.

But, they claim, nothing can be done about the situation until the council provides more money.

One problem area is Wolhuter Street, Jeppe. CARE continually receives complaints about the filth on the pavements from people living and working on what one resident, Mr M Devabhai, calls "sewage street."

Opposite Mr Devabhai's house is a black hostel and a beerhall, but the drinking goes on long after the beerhall has closed, he told CARE, and because the drinkers have no place to relieve themselves they use the pavements.

"I know the area is heavily fouled," Mr J A Oxenham of the City Health Department told CARE, "but when the West Rand Administration Board took over the hostel and beerhall they closed down a public convenience nearby."

Mr M Wilsenag of the board assured CARE they had "at no time closed down any toilets.

Miners' lack of faith in Bureau'

Politicol Staff

THE ASSEMBLY — Miners have a lack of faith in the Bureau for Occupational Diseases and this is causing considerable concern.

In the Bureau's report for 1975/76, just tabled in Parliament, this is described as an unhealthy state of affairs, both for the bureau and the miners.

While having existed for a considerable time, the situation persists "partly because of exaggerated stories and propaganda which have so moulded public opinion that many miners regard the Bureau as an enemy, and partly because of the Bureau's failure to disseminate information."

COMPENSATION

Many miners, probably most of those with long service, believe they are entitled to medical compensation. If they do not receive it, they think it is due to incompetence of the Bureau staff, or even to deliberate obstruction.

One of the main misconceptions, regarded as responsible for lack of faith in the bureau, is that conditions underground are such that anyone with more than 25 years service must suffer from a disease caused by his work.

Health & Dis
General
85

Talks on medical fees

Representatives from medical aid societies and private hospitals met today to discuss the proposed 16 percent increase in fees.

Subcommittees of the Representative Association of Medical Aid Schemes and the Representative Association of Private Hospitals were formed in January to consider the issue.

The results of their studies was discussed at a meeting of the two bodies today.

The increase in fees at private hospitals for medical aid patients could rise by 16 percent which would mean a rise in the standard surgical tariff from R17 to R20.

CANCER LINKS FOUND

Mercury Correspondent

JOHANNESBURG — An important breakthrough in cancer research by two Johannesburg doctors has shown a definite link between primary cancer of the liver, a form of the disease with a high incidence in South Africa, and a virus which causes serum hepatitis, a serious liver disease.

Following on research by Dr. Gwen Macnab, head of the serology laboratory of the S.A. Institute of Medical Research, Dr. Jennifer Alexander, cell biologist of the S.A. Institute of Virology, has established that liver cancer cells produce a large quantity of Australia Antigen, a type of virus particle found in many patients suffering from hepatitis.

Dr. Alexander was successful in keeping alive liver cancer cells in tissue cultures in test tubes and has been able to isolate a pure form of the cells.

Her findings have opened the way for further research into both serum hepatitis and liver cancer and will greatly assist scientists experimenting with new drugs against both diseases.

Instead of trying new drugs out on patients one at a time without knowing side effects, doctors will be able to carry out multiple experiments in the laboratory.

Dr. James Gear, consultant in virology to the State Health Department, said yesterday that the discovery was of particular importance in South Africa, where there was a high incidence of liver cancer, especially among non-Whites.

He said: "Serum hepatitis is known to be transmitted through innoculations which contain human blood, a serious problem in blood transfusion.

Dr. Gear said Dr. Macnab had undertaken a study of patients suffering from liver cancer and had found that about 80 percent showed signs of Australia Antigen virus in the blood.

Dr. Alexander will be going to a New York congress soon to deliver a paper on the subject.

85

Cancer breakthrough in SA

26/1/77 Star

Marais Malan,
Science Editor

A suspected link between a virus and primary cancer of the liver has been confirmed through a finding of world significance by a Johannesburg medical research worker.

This has opened new horizons, not only in cancer research, but also in the study of an important and potentially lethal disease in Africa, serum hepatitis.

The scientist is Dr Jennifer Alexander, cell biologist at the SA Institute of Virology.

The discovery has already evoked world-wide scientific and medical interest and she has been invited to read a paper on the subject at a congress in New York next month.

The Nobel Prize winner for medicine in 1976, Dr B S Blumberg, discoverer of the virus, or virus particle causing serum hepatitis, the so-called Australia antigen, has been invited to Johannesburg to study the work at first hand.

FIRST TIME

And Professor O W Prozesky, director of the institute, comments "This ranks as a scientific advance which merits international recognition."

Dr Alexander's research involves a cell culture of liver cancer cells which she obtained from a patient about three years ago. Although the patient died long ago, she achieved the "almost impossible" of growing the cells in culture and keeping them alive.

Now she has shown, for the first time in the world, that the cancer cells produce large quantities of Australia antigen, thereby establishing direct evidence of an association.

Cancer find stays at home. — Page 23.

What do you do about snakebite?

EAST LONDON — Last week a Steynsburg woman, Mrs Barendina Vorster, died after being bitten by a cobra. With this in mind many are asking. "What action should be taken when someone is bitten by a snake?"

This is the question I posed to an East London doctor who is a recognised expert on snakebites and their treatment.

"Get the patient to a doctor," was the crux of his reply.

But there are certain steps which can be taken to increase the patient's chances of survival and here are some of the do's and don'ts of treating snakebites.

Do try and find out what type of snake it was by killing or capturing it. This will help the doctor.

If you are reasonably sure the snake was some type of adder don't apply a tourniquet as this will only cause irritation.

Do apply a tourniquet if the bite was from a cobra or ringhals or if you are uncertain what type of snake it was.

Don't leave the tourniquet on for longer than 55 minutes without loosening it for five minutes. This could cause the limb to go gangrenous.

Do apply the tourniquet to the top of the leg or arm. On the bottom half of either it will fail to stop the circulation.

Do inject snakebite serum. If you have more than one ampoule use it. The required dosage is three to four ampoules in the case of an adder bite and nine in the case of a cobra bite.

Don't think that by injecting serum you have cured the patient. The normal snakebite kit contains only one or two ampoules of serum and this is not enough, especially if injected into the muscle by a layman.

Do insist on getting the patient to a doctor, who will give serum intravenously if necessary.

Don't cut the victim to bleed the bite or try to suck the venom from the bite. Don't rub potassium permanganate (Condy's Crustals) into the bite. This will only cause a burn.

Once you have observed these do's and don'ts what are the snakebite victim's chances of survival?

It appears they are excellent. In the case of 100 consecutive snakebite cases treated at the Frere Hospital over a period of two years not one died and only two suffered a serious reaction.

"Only half the bites were from venomous snakes, and half of these needed treatment," the doctor who treated the snakebites told me. Snakebites were only treated if the symptoms appeared serious enough.

The venomous snakes are divided into two distinct classes, adders and the cobra—ringhals type.

Adder bites caused intense pain and local irritation, but though they could cause the loss of a limb they were not likely to seriously endanger life. Cobra or ringhals bites caused nervous paralysis, which caused the muscles to relax and could result in respiratory failure and death. The symptoms become visible in about half an hour and are drooping eyelids and a lolling head.

The doctor said it was easy to tell the difference between adders and types of cobra as the adders were short, fat and slow, while cobras were long, thin and fast.

There are two exceptions to the above groups, the berg adder which causes nervous paralysis like the cobra group and for which there is no known effective serum, and the boomslang, which causes excessive bleeding and eventual death. Boomslang serum is available in Johannesburg and can be flown to East London to treat a boomslang victim.

Though boomslangs are common, there was not one boomslang bite recorded among the 100 cases treated and the doctor told me it was probably because of the shy nature of this snake and the fact its fangs were situated far back and it could only bite a human on an extremity such as a finger or the side of the hand.

The polyvalent serum in the common snakebite kits is effective against all snakes found in this area with the exception of the boomslang and berg adder.

And something else to set your mind at rest is the fact the non-poisonous snakes are usually the more aggressive.

In addition to this if you are bitten by a poisonous snake it may not inject venom. How much venom it injects, if any, depends on how angry or excited it is. — DDR.

85

Cancer breakthrough

JOHANNESBURG — A significant breakthrough in cancer research has been achieved in South Africa.

A suspected link between a virus and primary cancer of the liver has been confirmed through a finding of world significance by a Johannesburg scientist, Dr Jennifer Alexander, cell biologist at the South African Institute of Virology, and her main associate, Dr Gwen Macnab of the South African Institute for Medical Research.

The breakthrough has opened new horizons, not only in cancer research, but also in the study of an important and potentially lethal disease in African serum hepatitis.

The discovery has already evoked worldwide interest and Dr Alexander has been invited to read a paper on the subject at a congress in New York next month.

The Nobel Prize winner for medicine in 1976, Dr B. Blumberg, discoverer of the virus, or virus particle, causing Serum Hepatitis, the so-called Australia Antigen, has been invited to Johannesburg to study the work at first hand.

Dr Alexander's research involves a cell culture of liver cancer cells she obtained from a patient three years ago. Although the patient died long ago, Dr Alexander achieved the "almost impossible" of growing the cells in culture and keeping them alive.

Now she has shown that the cancer cells produce large quantities of Australia Antigen, thereby establishing direct evidence of an association.

The director of the Institute of Virology, Prof O. Prozesky, said scientists could now try to establish whether the material coming from this line of cancer caused serum hepatitis and whether the cell stopped being cancerous if it was cured of the virus.

He said the discovery gave doctors a chance to evaluate drugs against both serum hepatitis and liver cancer without having to expose humans to the drugs.

"What is important is that for the first time one can study the association between a virus and a cancer cell in a laboratory — what the virus does to the cancer and what happens if you clear the cell of the virus."

It also was now possible to "culture the hepatitis virus in the laboratory."

Several scientists in various parts of the world have already asked Dr Alexander for specimens of her liver cancer line.

But as her own investigations are at a crucial stage, she will not be able to comply until later this year.

Some overseas scientists have already indicated their desire to work at the institute.

Malnutrition goes up with price of food

By TONY ROBINSON

THERE ARE clear indications that malnutrition is increasing in the Cape Peninsula and this appears to be directly related to rising food prices.

No statistics are available on the problem, but Professor M D Bowie, acting head of the Department of Paediatrics at the University of Cape Town, said a good indicator was the number of patients admitted to the "drip room" at the Red Cross War Memorial Children's Hospital.

During the first five months of this year the number of patients was about 20 percent higher than for the corresponding period last year. The number of deaths has almost trebled.

The "drip room" is used to treat patients suffering from diarrhoeal diseases, a condition clearly associated with malnutrition.

During the first five months last year, 2 376 patients were admitted to the drip room and there were 19 deaths.

During the first five months of this year 2 893 patients were admitted — an increase of 517 — and there were 52 deaths. This is nine more than the 43 deaths recorded during the whole of last year.

Professor Bowie said this seemed to indicate that there were more cases of malnutrition and that they were more severe.

He said there had been no change in the method of treatment and the running of the drip room was progressively improving.

Dr Frank Mitchell, Medical Officer of Health for the Divisional Council of the Cape, said the problem could be a result of rising food prices.

Even the price of heavily subsidized skimmed milk powder had gone up, and during the past six months there had been a lower distribution of the powder by the council, he said.

This situation exists in spite of the fact that there is a huge surplus of skimmed milk powder in the country.

Mr T J H-Maree, manager of the Dairy Board, said the surplus was world-wide, and in South Africa it amounted to 9 000 tonnes.

One of the reasons for this was substitute known as PVM which had been promoted in competition with skimmed milk powder.

There was no export market for it and the board was looking for ways to get rid of it. One possibility was to use it in animal feeds.

But Mr Maree emphasized that the board did not want to do this and would rather use it for human consumption.

"If anyone can come to us with an outlet for human consumption that does not affect our existing markets we will be happy to co-operate. But it must be an additional market."

He said the board could not give away the surplus, but it would sell it at a considerably reduced price.

At present skimmed milk powder sold to local authorities is subsidized by about 50 percent by the Public Health Department as part of a programme to fight kwashiorkor.

Mr N Freeman, organizer of the Peninsula School Feeding Scheme, said he would like to co-operate in helping the Dairy Board reduce the surplus.

The important point to note in the previous table is that while the number of Matriculants shows a strong rising trend, the number of NTC passes, particularly at the higher levels, is extremely small. The principal

dians encounter difficulty in be-
irms wishing to indenture an Indian
o the local Apprenticeship Committee
willing to be indentured.

lone in Cape Town, L.C. Johnson in
Elliott in Kimberley and Bethelsdorp
College for Advanced Technical Edu-

ich will offer courses leading to
or the first time in 1977, is as

-time students at the Peninsula

ment excluding entices	Apprentices
138	262
159	302
177	383
483	531

ed Affairs, Annual Reports.

jump in 1972 figures is mainly the
wly-introduced businessmen's course.
ment for 'technical' courses only
courses) is not available.

ntial supply of technicians, the
e number of Coloured matriculation

HEALTH
and
DISEASE

GENERAL

APRIL 1977 - 1978

Hansard 2 col 146 4/2/71

85

Trained Bantu medical staff and veterinarians in homelands

2. Mr. L. F. WOOD asked the Minister of Bantu Administration and Development:

How many trained Bantu (a) doctors, (b) dentists, (c) chemists and druggists, (d) veterinarians and (e) nurses are serving the Bantu people in the Bantu homelands at present.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

(a)	Doctors	19
(b)	Dentists	0
(c)	Chemists	0
(d)	Veterinarians	0
(e)	Nurses	3 518

The above figures are applicable in respect of those Homeland Governments who have not yet taken over health services. Figures in respect of the Homeland Governments who have already taken over health services are not readily available.

Hansard 2 col 148 4/2/77

85

Salary scales for staff in State/provincial hospital services

14. Mr. L. F. WOOD asked the Minister of the Interior:

What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services.

The MINISTER OF THE INTERIOR:

(a) to (d).

(i)

Rank	Salary scale (R per annum) White	Coloured/Indian	Bantu
Specialists			
Professor/Chief Specialist	15 600 (fixed)	13 200 (fixed)	11 250 (fixed)
Principal Specialist	14 400 (fixed)	12 150 (fixed)	10 350 (fixed)
Senior Specialist	13 200 (fixed)	11 250 (fixed)	9 540 (fixed)

Rank	Salary scale (R per annum) White	Coloured/Indian	Bantu
Specialist	12 600 (fixed)	10 800 (fixed)	9 180 (fixed)
Medical Officers			
Chief Medical Officer	13 200 (fixed)	11 250 (fixed)	9 540 (fixed)
Principal Medical Officer	12 600 (fixed)	10 800 (fixed)	9 180 (fixed)
Medical Officer	7 740 × 360–9 900 × 450–11 700	6 300 × 360–9 900	5 340 × 240–6 300 × 360–8 460
Intern	5 100 (fixed)	4 050 (fixed)	3 300 (fixed)

(ii) Dentists: As in respect of Medical Officers.

(iii) Pharmacists: Salary scale (R per annum).

Rank	White	Coloured/Indian	Bantu
Chief Pharmacist	9 900 × 450–11 700	8 100 × 360–9 540	6 060 × 240–6 300 × 360–7 380
Senior Pharmacist	7 740 × 360–9 540	6 060 × 240–6 300 × 360–7 740	4 740 × 180–5 100 × 240–5 820
Pharmacist	5 340 × 240–6 300 × 360–7 380	4 380 × 180–5 100 × 240–5 820	3 450 × 150–4 200 × 180–4 560
Trainee Pharmacist	4 020 (fixed)	3 150 (fixed)	Male: 2 100 (fixed) Female: 1 980 (fixed)

The above-mentioned scales do not include allowances payable to the personnel.

Hansard 6 Q cols 551-552 3/3/77

Bantu Homelands Constitution Act: Health matters

(504) Mr. L. F. WOOD asked the Minister of Bantu Administration and Development:

Whether health matters have since 31 March 1975 been transferred to any Bantu homelands in terms of the provisions of the Bantu Homelands Constitution Act, 1971; if so, (a) to which homelands and (b) when did such transfers become operative.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

Yes.

(a) and (b)

Bophuthatswana . . .	1 April 1975
Ciskei	1 September 1975
Lebowa	1 April 1976
Gazankulu	1 September 1976
Venda	1 September 1976

85

Hansard 7 Q cols 589-590 9/3/77

(85)

Medical staff in Homelands

443. Dr. F. VAN Z. SLABBERT asked the Minister of Bantu Administration and Development:

How many (a) White and (b) Black (i) doctors, (ii) dentists, (iii) nurses and (iv) chemists were practising in each Bantu homeland as at 30 June 1976.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

It cannot be readily ascertained how many White and Black doctors, dentists, nurses, etc., are practising in each Homeland. The particulars given below are only applicable in respect of the persons in the categories concerned who are employed in the Homelands who have not taken over health services as yet. Figures in respect of the Homeland Governments who have already taken over health services, are not readily available.

		QwaQwa	Swazi	KwaZulu	Garankuwa Hospital
(a)	(i)	2	17	169	93
	(ii)	1	0	2	3
	(iii)	3	10	89	2
	(iv)	0	2	9	7
(b)	(i)	1	1	11	5
	(ii)	0	0	0	0
	(iii)	55	320	2 679	464
	(iv)	0	1	0	0

186
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SCHOOL OF ECONOMICS Harvard 9 Q cols 678 - 682
ECONOMICS 1A
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85

Notifiable diseases

419 Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

(1) How many cases of each notifiable disease were notified in respect of each race group in 1976;

(2) how many deaths from each disease occurred in each race group during that year.

* * * * * * *

The MINISTER OF HEALTH:

Cases notified—1976.

	Whites	Asians	Coloureds	Bantu	Other
Anthrax	—	—	—	1	—
Asiatic cholera	—	—	—	—	—
Brucellosis	4	—	—	15	—
Diphtheria	10	1	24	303	—
Encephalitis	183	7	9	92	1
Erysipelas	13	—	3	7	—
Glanders	—	—	—	—	—
Leprosy	3	1	8	124	—
Malaria	136	6	1	1 601	—
Meningococcal inf.	142	6	339	739	1
Plague	—	—	6	—	—
Poliomyelitis	3	2	60	254	1
Poisoning, lead	—	—	—	3	—
Poisoning, pesticidal	3	—	25	71	—
Puerperal sepsis	6	—	4	71	—
Rabies in man	—	—	—	—	—
Relapsing fever	—	—	—	—	—
Scarlet fever	625	2	23	36	1
Smallpox	—	—	—	—	—
Tetanus	—	3	20	288	—
Trachoma	—	—	—	737	—
Trypanosomiasis	4	—	—	1	—
Tuberculosis	737	508	7 046	45 414	124
Typhoid fever	101	25	65	2 868	4
Typhus fever	—	—	—	—	—
Venereal disease gon. ophthalmia	5	—	24	151	1
Viral hepatitis	696	216	166	643	4
Yellow fever	—	—	—	—	—

Notified Deaths:

Anthrax	—	—	—	—	—
Brucellosis	—	—	—	—	—
Diphtheria	—	—	1	19	—
Encephalitis	5	—	5	9	—
Erysipelas	—	—	—	—	—
Hepatitis	3	—	17	21	—
Leprosy	—	—	1	—	—
Malaria	3	—	—	3	—
Meningococcal inf.	5	—	41	34	—
Plague	—	—	—	—	—
Poliomyelitis	—	—	1	5	—
Poisoning, lead	—	—	—	—	—
Poisoning, pesticidal	2	—	1	4	—
Puerperal sepsis	—	—	—	—	—
Rabies	—	—	—	—	—
Scarlet Fever	—	—	—	—	—
Smallpox	—	—	—	—	—
Tetanus	1	—	7	27	—
Trachoma	—	—	—	—	—
Trypanosomiasis	—	—	—	—	—

Cases notified—1976	Whites	Asians	Coloureds	Bantu	Other
Tuberculosis	38	21	566	1 614	5
Typhoid Fever	2	—	2	33	—
Typhus Fever	—	—	—	—	—
Venereal disease Gon. ophthalmia	—	—	—	—	—

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Herbalists' revival

21/4/85

Zambia has embarked on a scheme to incorporate traditional medicine into modern medical practice.

The scheme has received support from university lecturers and doctors who feel that herbalists have a vital role to play in the treatment of certain diseases.

The move follows thorough research by the National Council for Scientific Research, which has analysed certain herbs and found them to have medical properties.

Research employees toured the countryside and collected roots from herbalists for examination in laboratories. Scientists were able to determine their structures and write up a pharmacopoeia for various herbs.

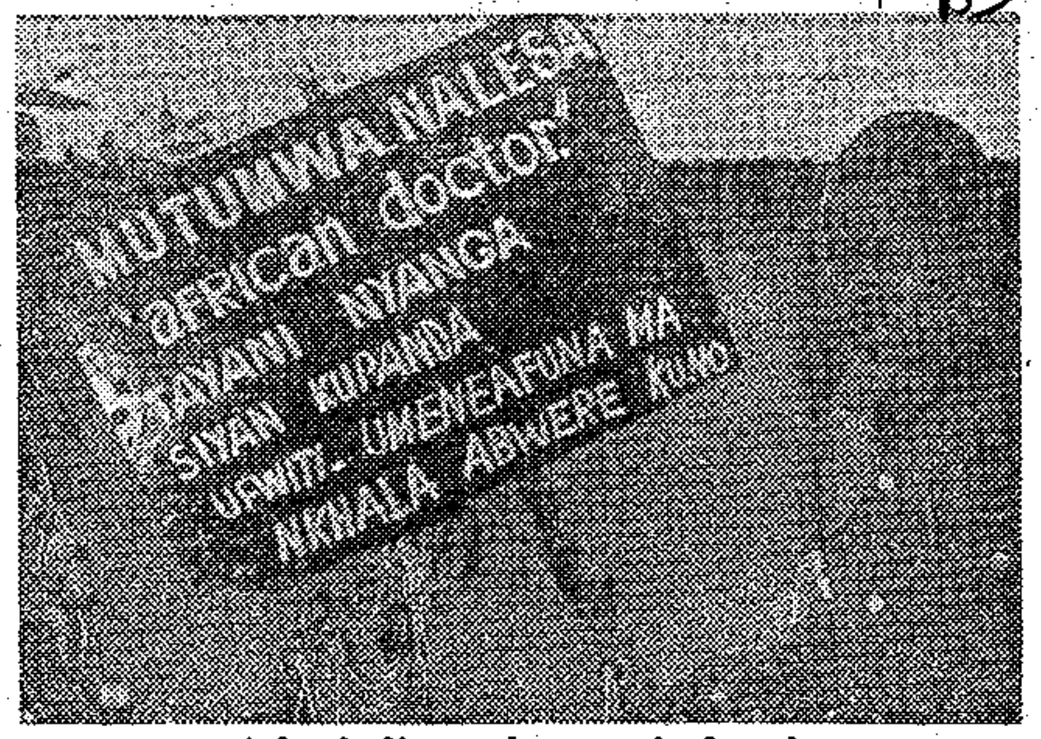
One herb which interested the medical profession is being used in the treatment of bilharzia with good results. In fact, it was this herb which attracted the National Council for Scientific Research to study traditional notions.

Two pure alkaloids were isolated from the plant used by villagers and these were tested chemically and found valuable. The other herb which interested researchers was one used for fertility by women. The concoctions were collected and analysed by chemists and doctors.

Zambian herbalists have given the scheme encouraging support. The research has been found to be of tremendous importance because it looks at new compounds to cure disease.

According to the late Dr Dawson Nkunika, who was secretary-general of the National Council for Scientific Research, penicillin has losts its miracle cure reputation as some strains of bacteria are now resistant to it.

Dr Nkunika, who initiated the scheme, was of the opinion that some of the herbs could replace penicillin. Dr Dewan Mohinder Nath Nair, former head of the department of botany at Zambia University, has strongly defended herbalists and medicinal plants.



A herbalist and wares in Lusaka

He said there was no truth in claims that plant medicine administered to people suffering from certain diseases made them worse.

Dr Nair has personal proof of the effectiveness of plant medicine. His wife, who suffers from asthma, "sleeps like a log" when she takes certain plant medicine powders and he says her difficulty in breathing is instantly relieved.

No matter what some people may say, traditional healers [illegible] vital role to play in the treatment of some diseases. Some people now realise that the approach to a patient by both modern doctors and traditional healers is similar.

It is well known that there are certain diseases today which modern science has failed to cure, but which some of the herbalists have dealt with successfully.

To enhance the programme, the Ministry of Health has been organising workshops for doctors and traditional healers. Soon there will be special training programmes for traditional midwives throughout the country.

The programmes are enabling the herbalists to express themselves freely. It is not certainly everyday that a medical scientist in Africa has good things to say about African medicine men. Call them herbalists or what you will, they have a vital role to play. — GNS

— Tim Chigodo

85

FACT Six out of ten urban black children are illegitimate

24/4/77 Times (85)

Misery of a baby boom

By Suzanne Vos

TO THE black militants, people are power. Strength, they say, lies in numbers. Family planning is a Government plot.

To the urban black housewife and mother, effective family planning means keeping a job and food in the kitchen cupboard. Modern contraception means a better way of life.

But the black tribal chief, husband or lover doesn't see it that way — at least, he didn't until recently.

Then tentative signs began suddenly emerging that he was slowly changing his thinking.

This change of heart could be crucial to South Africa because male opposition is seen by many as an important stumbling-block in the way to the general black acceptance of family planning.

FACT

● In 1960 the white South African birth-rate was 24 per 1 000 people. The African figure was 40-45 per 1 000.

In a survey conducted only a few weeks ago in KwaZulu, chiefs previously vehemently opposed to contraception of any kind suddenly began voicing their approval.

"Times are changing," the chiefs told an investigating team of Family Planning Association counsellors.

No longer are children a source of wealth when growing unemployment means there is not enough food to go round, when urbanisation means they are no longer a source of cheap labour on the land; and when a large brood is no longer a guarantee of a comfortable old age.

FACT

● In 1975 whites had lowered their birth-rate to 18,9 per 1 000. The African rate of 40-45 was unchanged.

In the old days, illegitimacy was not a problem, said the chiefs. "Our daughters did not have children who grew up with no fathers."

Every month throughout South Africa more than half a million black woman visit 2 000 clinics set up to provide them with free contraceptives.

For many of these woman the fact that they have chosen to control their own fertility is a secret to be kept from their men.

But their men — especially those who are forced by the migratory labour system to live apart from their wives — have other reasons to be wary of contraception.

An unfaithful wife on the Pill cannot be caught out.

Research also shows that many black men feel the use of contraceptives destroys the pleasure of sex and that children are a proof of virility.

FACT

● Two years ago 6,4 per cent of all white births were illegitimate. The figure for urban African births was 63 per cent.

And not only that . . . family planning is the white man's idea.

However, in spite of the underground call for "people power" since last year's unrest, the State Health Department reports no drop in attendance at clinics.

FACT

● Only 15-18 per cent of urban African women aged 15 to 45 are thought to use contraceptives. The figure for white women is 58-60 per cent, for coloureds 50 per cent and Indians 48 per cent.

With a budget of R6-million a year — criticised by many working in the field as a mere drop in the bucket — the Department is trying to encourage black participation in the programme.

More than 300 blacks are employed in senior supervisory posts. Many are university graduates.

But even with slowly-changing attitudes, the black family planning programme has its problems.

One is the current thinking of the black man. Another is the sensitivity of black thinking in South Africa generally.

Dr J. M. Mbere, of Soweto, vice-chairman of the Family Planning Association of South Africa, told me:

"Many blacks feel the Government is pushing black birth control while neglecting to motivate the idea of planned parenthood.

"Blacks know the Government wants them to reduce their numbers while, at the same time it encourages whites to increase theirs — naturally and by white immigration."

Dr Elin Hammar, chairman of the Transvaal region of the Family Planning Association, says: "There is a strong feeling among many blacks that family planning is being imposed by a different culture on a people who are capable of controlling their own needs.

FACT

● In the homelands, only 11,7 per cent of women use modern methods of contraception.

"It is an intrusion by a Government body into the last vestiges of privacy when there are so many other intrusions into individual freedoms and choices."

The previous comments are by and large personal observations by people working in the field.

However, the Human Sciences Research Council recently completed a comprehensive survey into attitudes of black South African men towards fertility and family planning.

Their conclusion: "Black males could prove to be a serious obstacle in the way to a more general acceptance of family planning."

FACT

● Figures obtained from a black hospital on the Reef show that 70 per cent of the deaths in its gynaecological wards are due to complications following incomplete illegal abortions.

The research findings, published this month by Dr J. Lotter, were from a study conducted among Zulu, North Sotho, South Sotho, Tswana, Xhosa, Tsonga and Venda.

Four children was the most popular single choice of men questioned in the survey, but when asked for an ideal number, more than half chose either six or eight.

It is interesting to note that a third of white South African women (and more than half of the English-speaking subgroup) now consider two children the ideal.

Many blacks regard children as a gift of God and the number of children a parent has as something that was decided by God alone.

More than half the men questioned felt contraception to stop women having too many children was wrong but — a sign of hope for family planning — half the urban men questioned thought contraception was acceptable.

FACT

● An Institute of Race Relations survey showed that the reason most given by schoolgirls for failing examinations — 37 per cent — was pregnancy.

On the positive side again, half of the sample population felt that the black people in South Africa would develop more quickly if fertility declined.

Contrary to expectations, however, a considerable number were uncertain whether a man with a large progeny would in fact have fewer financial worries in old age than the man with few children.

The men revealed that they were not convinced that families with few children would have a higher living standard than those with many.

FACT

● The same survey showed that when African children said they had left school for financial reasons, most said: "My mother could no longer afford to send me" — with emphasis on "mother"

Dr Lotter concluded that black men today have high fertility orientations: A strong belief in the value of high fertility, a considerable amount of opposition to the practice of contraception and a widespread lack of awareness of the population problem.

Which all adds up to a lot more work for family planning.

And continuing infant mortality, illegal abortions and illegitimacy.

Hansard B col 946 26/4/77

(85)

Inspectors appointed in terms of legislation

*17. Mr. L. F. WOOD asked the Minister of Health:

How many inspectors are appointed in terms of legislation administered by his Department.

The MINISTER OF HEALTH:

Approximately: 446.

Hansard 15 col 1062 9/8/77

(85)

Medical training for Bantu

908. Mr. N. J. J. OLIVIER asked the Minister of Bantu Education:

How many Bantu students (a) were enrolled during March 1976 in each of the years of study for training as and (b) passed their final examinations during 1976 in each of the years of study for (i) health assistants, (ii) health inspectors, (iii) public health nurses, (iv) medical laboratory technologists, (v) dental therapists, (vi) radiographers, (vii) physiotherapists and (viii) other para-medical personnel with specification of each type of course.

The MINISTER OF BANTU EDUCATION:

	(a) Year of study			(b) Year of study		
	1	2	3	1	2	3
(i)	48			33		
(ii)	31	23	—	21	21	—
(iii)	47			30		
(iv)	23			13		
(v)	15	13	—	12	12	—
(vi)	4	6		4	5	
(vii)	8	8	4	7	3	4
(viii) Occupational Therapy	6	—	—	5	—	—
Dietetics	3	—	—	3	—	—

Hansard 17 Q cols 1190 - 1192 25/5/77

(85)

Medical facilities/staff in homelands

(883) Mr. R. M. CADMAN asked the Minister of Bantu Administration and Development:

(1) How many (a) mission hospitals, (b) other hospitals and (c) clinic centres are there in each of the homelands in (i) the Republic and (ii) South West Africa;

(2) how many hospital beds are there in each of the homelands in South West Africa;

(3) how many (a) White and (b) Bantu (i) medical practitioners, (ii) nurses and midwives, (iii) dentists, (iv) chemists and druggists, (v) physiotherapists, (vi) radiographers, (vii) health inspectors, (viii) health assistants and (ix) pharmaceutical assistants are working in each of the homelands in South West Africa;

(4) how many (a) White and (b) Bantu (i) physiotherapists, (ii) radiographers, (iii) health inspectors, (iv) health assistants and (v) pharmaceutical assistants are working in each of the homelands in the Republic.

The MINISTER OF BANTU ADMINISTRATION AND DEVELOPMENT:

The particulars given below in respect of the homelands, are only applicable in respect of those homelands who have not yet taken over health services. Figures in respect of the homelands who have already taken over health services are not readily available.

(1) (a) (i) KwaZulu 27
Swazi 1

(b) (i) KwaZulu 8
Swazi 1

(a) (ii) 20.

(b) (ii) 5.

(c) Due to the fact that all clinic matters are now the responsibility of the Homeland Governments, the required information cannot be readily obtained.

(2)

Kaokoland	44
Hereroland	148
Kavango	1 088
Damaraland	142

(3)

	(a) Whites	(b) Bantu
(i) Kaokoland	4	0
Hereroland	3	0
Kavango	10	0
Damaraland	3	0
(ii) Kaokoland	1	16
Hereroland	0	24
Kavango	31	75
Damaraland	3	13
(iii) Kaokoland	0	0
Hereroland	0	0
Kavango	0	0
Damaraland	0	0
(iv) Kaokoland	0	0
Hereroland	1	0
Kavango	1	0
Damaraland	1	0
(v) Kaokoland	0	0
Hereroland	0	0
Kavango	1	0
Damaraland	0	0
(vi) Kaokoland	0	0
Hereroland	1	0
Kavango	1	0
Damaraland	1	0
(vii) Kaokoland	1	0
Hereroland	1	0
Kavango	1	0
Damaraland	1	0
(viii) Kaokoland	0	3
Hereroland	1	2
Kavango	3	38
Damaraland	3	4
(ix) Kaokoland	0	0
Hereroland	0	0
Kavango	0	0
Damaraland	0	0

In addition 9 Army Doctors are rendering services to the general public as and when necessary in Kavango (5), Kaokoland (2), Hereroland (1) and Damaraland (1).

(4)

	(a) Whites	(b) Bantu
(i) KwaZulu	5	6
Swazi	2	0
(ii) KwaZulu	13	13
Swazi	0	4
(iii) KwaZulu	1	16
Swazi	1	5
(iv) KwaZulu	0	120
Swazi	0	6
(v) KwaZulu	1	28
Swazi	2	2

12. Which of the following is most likely to have a high price elasticity of demand ?

    1. Cigarettes.
    2. Motor car tyres.
    3. Chocolate ice cream.
    4. Food.
    5. Shoelaces.

13. Given two straight line demand schedules, the coefficient of price elasticity of demand at point B (on the same horizontal line as A) is

30/6/77 N/MERCURY (85) P 1

Cancer check on cured meat

14 **WASHINGTON — A senior Agricultural Department official said it was time for a closer look at the potential cancer risks of using sodium nitrite to cure meat.**

Bacon, hams, hot dogs and many other meat and poultry products are treated with nitrite to prevent the growth of bacteria that can cause botulism, a deadly food poison. It also is added to give the products an appetising rosy colour.

But under certain conditions, such as in frying bacon with high heat or in the normal human digestive process, nitrite can combine with other substances to form a nitrosamine, which some authorities say is among the more potent of cancer-causing agents.

A panel of experts originated by the Agriculture Department nearly three years ago will meet on Monday to examine evidence relating to nitrites and cancer.

Assistant Agriculture Secretary, Mrs. Carol Tucker Foreman, heads the panel.

Mrs. Foreman said she expected "some clashes" among panel members regarding nitrite and cancer.

"It's very hard. The industry people are upset and the consumers — if you start saying to them 'eat bacon and you're going to get cancer' are going to be upset," she said.

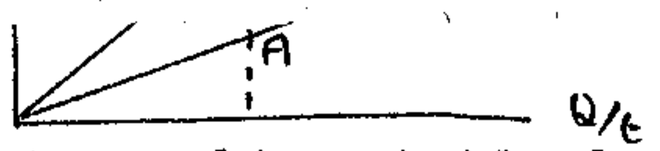
Up to now the panel had not faced the cancer issue squarely. It had focussed on benefits of nitrite in preventing botulism.

Even if the panel made a firm recommendation on use of nitrites, it would be months before the department made a decision on reducing or eliminating the chemical in meat and poultry. — (Sapa.-AP.)

15

is

5. None of the above.



16. A rise in the price of refrigerator components would probably lead to

    1. A fall in the demand for refrigerators.
    2. A rise in the supply of refrigerators.
    3. A leftward shift in the supply curve of refrigerators.
    4. A rightward shift in the demand curve of refrigerators.
    5. A leftward shift in the demand curve of refrigerators.

17. Income elasticity of demand is defined as

    1. $Y/Q \times \Delta Q/\Delta Y$
    2. $\Delta Q/Y \times \Delta Y/Q$
    3. $Q/\Delta Q \times Y/\Delta Y$
    4. $Q/Y \times \Delta Q/\Delta Y$
    5. $\Delta Q/\Delta P \times P/Q$

6. The law of increasing (relative) cost is <u>incompatible</u> with

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   4. A p
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9. The law of
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   5. Increasi

10. In an economy
    of resources,

    1. To increas
       increase
    2. To decrease
       decrease
    3. To increase
    4. To increase the production of capital goods a decrease in the production of consumer goods is needed.
    5. None of the above.

11. Price elasticity of demand is

    1. Measured by the slope of the demand curve.
    2. A measure of the responsiveness of the quantity demand to changes in price.
    3. The ratio of the change in price over the change in income.
    4. None of the above.
    5. Two of the above.

30/6/77 N/MERCURY (85)

New view of cholesterol

CARRY ON RUNNING

... and drinking

CHOLESTEROL, the fatty constituent of the blood which has been blamed for the spread of heart disease, is not such a dietary villain after all, American medical researchers have established.

Studies at Stamford University, California, and the Framingham Laboratories, Massachusetts, have shown that cholesterol, which accumulates excessively — clogging arteries — with high fat diets, is not a simple substance, but is carried in the blood by several chemicals, called lipids.

Tests have shown that these vary in density and that the high - density lipids not only do not promote heart disease, but can positively prevent it. The dangers of excessive low - density lipids remain.

People with an inherited excess of high - density lipids in their blood tend to live longer than average, free of heart disease. Women, who also have a low heart disease risk unless they smoke, also carry more high - density lipids in their blood than men.

One way in which men can increase their proportion of beneficial cholesterol is to take up running. A British - born researcher at Stamford, Dr. Pat Wood, who is a marathon runner, has shown that regular exercise converts low - density lipids to high - density lipids.

Healthy diet

Other ways of improving the blood make-up are nutritional. Doctors at Stamford now believe what would have been laughed at only a few years ago — that a vegetarian diet is among the most healthy it is possible to have.

By contrast, diets rich in fatty meat, eggs and dairy products raise the level of harmful low-density lipids.

There is consolation for drinkers. Whatever the effects of alcohol on the liver, it does not seem bad for the heart, beause it promotes the formation of high - density lipids.

the price system

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Page 3 / .....

Jeans can make you ill

BONN — The fad of wearing tight jeans is believed responsible for an increase in skin disease, the West German Health Ministry said yesterday.

The Ministry secretary, Mr Fred Zander, said the tight jeans caused heat and moisture to build up on the wearer's legs, creating what one German official called "jeansitis." — SAPA-AP.

85

N.D. 23/7/77

Medical fees going up?

JOHANNESBURG — Higher doctors' fees are expected to come into effect in early October following the report of the Remuneration Commission handed to the Department of Health this week.

The commission's chairman, Mr Justice Erasmus, has completed a three-month investigation into doctors' and physiotherapists' tariffs at the request of the Medical Association and the Central Council for Medical Schemes.

His confidential report, to be placed before the Minister of Health, Dr Van der Merwe, lays down the new scale of fees which must be implemented within three months.

The last determination of fees was stipulated in January 1975. — DDC.

This shows an uncritical attitude and has, Grant maintains, contributed to the chauvinistic brands of history which have had such effect in our own times.[50] Livy's account of the earlier Republic is one long narration of traditional Roman virtues[51] and the mention of the savageries perpetrated by the Romans for century after century. On several occassions Livy distorts history for national reasons.[52] He portrays all national types as stereotypes,[53] and almost all individuals are either heroes or villains.[54] His characters are black or white.[55] The purpose of these simple presentations of character was to illustrate certain moral traditions and to show their impact on events.[56] Livy glosses over the less desirable features of the personalities of his heroes,[57] concentrating rather on their glory and achievements.[58] With regard to Rome's neighbours, Livy's patriotism can be seen to exercise a strong influence.[59] In his view Rome's subjects tolerated her rule because it was fair and moderate and because they accepted the Romans as their superiors,[60] clear evidence of his belief that Rome was morally entitled to rule other nations.[61] Livy's patriotism warped his judgement of Rome's enemies who are often described as cruel and treacherous,[62] whereas those who took Rome's side are glowingly portrayed.[63] Livy's partiality for the Roman aristocracy[64] and for political conservatism[65] is also apparent in the way he tends to condone the misdeeds of the upper classes,[66] while he is unwilling to tolerate the slightest deviation from the mos maiorum.[67] These inherited prejudices, his views on internal politics and his attitude towards the popular elements manifests itself through the words which he uses, to describe their behaviour.[68]

Livy (and Tacitus) exploited to excellent effect the ancient device of the speech, which was an integral and carefully planned feature of classical historiography,[69] even though crammed with anachronisms,[70] unnatural and objectionable sentiments,[71] and obviously invented[72] for the occasion.[73] Livy used speeches to moralise about[74] and to clarify obscure[75] situations.

(50) DJ 144/1 - 3/778/12, Statement by Tomboek Umfanawenduku, 19 June 1912.
(51) This picture is reconstructed from scattered material contained in DJ 144/1 - 3/778/12.
(52) See generally DJ 144/1 - 3/778/12, and especially Memorandum by Secretary for Justice, 6 Sept. 1911.
(53) Ibid., Statement by Nkuku, 16 June 1912.
(54) Ibid., Deputy Commissioner of Police to Sec. Tvl. Police, 28 Aug. 1912.
(55) Ibid., Statement by Tomboek Umfanawenduku, 19 June 1912.
(56) The status of Roma and its relationship are best described in the statement by Tomboek Umfanawenduku, ibid., and in another statement by Hoffman (age 13), dated 17 June 1912, and contained in the same file. That this was not always the case is evident from Rex v. Mkosi Mkemeseni, op. cit.
(57) DJ 144/1 - 3/778/12, Statement by Tomboek Umfanawenduku, 19 June 1912.
(58) For various punishments, see ibid., "Statement as to the Position of Native Detaining Gangs in Prison", and Statement by Johnson Johannes, 19 June 1912. For "nails", see also Diamond Fields Advertiser, 25 May 1919.
(59) ENQUIRY RE STUDY AT THIS UNIVERSITY
DJ 144/1 - 3/778/12, Statement by Tomboek Umfanawenduku, 19 June 1912.
(60) "Rex v. Mkosi Mkemeseni", op. cit. p. 25.
(61) Cape Times, 20 Aug. 1915.
(62) DJ 144/1 - 3/778/12, Det. A. J. Hoffman to Deputy Commissioner, CID, 12 Oct. 1911.
(63) I wish to inform you, however, that it would be necessary for you to obtain the written consent of the Director of Native Labour, Department of Native Affairs, before you can interview any Native Criminal Gangs in Prison. 13
(64) Ibid., Det. A. J. Hoffman to Inspector in Charge, CID, 12 Aug. 1912. See also ibid., Statement by Tomboek Umfanawenduka, 19 June 1912.
(65) For "Scotlanders" see DJ 144/1 - 3/778/12, Statement by Tomboek Umfanawenduku, 19 June 1912. For a certain political prejudices. Native Criminal Gangs in Prison", 1912. For an example of conflict between what the position is the yourhear Parliament, see Diamond Fields Advertiser, 25 May 1919.
(66) For which Livy is taken to task by Tacitus, see Ogilvie, op. cit., p. 32. For a description of the Ninevites at the University of Cape Town, see Cape Times, 20 Aug. 1915. For an example of conflict between these early Ninevites as being of the "vagrant type" and the Native Criminal Gangs in Prison, see DJ 144/1 - 3/778/12, Statement by Johnson Johannes, 19 June 1912.
(67) See "Rex v. Mkosi Mkemeseni", op. cit.
(68) See DJ 144/1 - 3/778/12, Statement by Det. Prob. H. G. Roy, 19 June 1912. Roy's observations are borne out by an examination of "Rex v. Mkosi Mkemeseni", op. cit.
(69) See, especially, "Rex v. Mkosi Mkemeseni", op. cit., p. 31.
(70) See DJ 144/1 - 3/778/12, Statement by Det. Prob. H. G. Roy, 19 June 1912.
(71) DJ 144/1 - 3/778/12, Det A. J. Hoffman to Inspector in Charge, CID, 12 Aug. 1912. See also ibid., Statement by Det. W. Futter, 19 June 1912. Futter described these early Ninevites as being of the "vagrant type".
(72) For evidence of the early [illegible] for unqualified [illegible] had this day b[illegible] altogether is, nee[illegible] order, and the sar[illegible]
(73) DJ 144/1 - 3/778/12, Deputy Commissioner to Secretary, Transvaal Police, 28 Aug. 1912.

N. Mercury 28/7/77

Health fees report

(53)

Mercury Correspondent

CAPE TOWN — A remuneration commission under the chairmanship of Mr. Justice R. P. B. Erasmus has submitted a report on doctors' fees to the Minister of Health, Dr. S. W. van der Merwe.

A Department of Health spokesman confirmed this yesterday and said the minister would give his decision on the report before October 15.

Any alterations to present schedules of fees would affect medical-aid tariffs only, including physiotherapists' tariffs.

A new unit system on which to base the tariffs is expected to be introduced similar to that already in operation for anaesthetists.

In this system certain procedures would be valued according to the degree of expertise, the scope of the service and risks involved.

Tacitus concentrated on happenings at Rome which were the source of constant
of political power. He was not seriously concerned with "exotic
and although he included a number of anecdotes about provincial governors,
economic factor. He was primarily concerned with Roman politics. He
wrote about politics and politicians from experience.
Tacitus contributes little to our knowledge of the economic history
of the period and tells us even less about the provinces, mentioning
them only when war or rebellion breaks out in them. Tacitus conceived
the history of the times as tracing the fortunes of the emperors and
the governing class, and this further limits his sphere.
The question of Tacitus' sources is hotly disputed. Some scholars
think that Tacitus did a great deal of independent research in the
archives, finding information which he supplemented from the recollections
of friends and his own contemporary reminiscences. Some think Tacitus
was too much of a novelist to dig in dreary papers and that
he relied for information on the works of memoir writers during
period concerned. Yet others believe that Tacitus derived much of
his material from Greek historians of the Augustan period.
problems when collecting material since the periods about which he
wrote were far back in the past and had happened in
controversial in character. From the earlier times he probably
depended largely on [illegible]
who had written contemporary accounts. Few of the historians of that
era have left any checks on what he says.
can identify three groups
doubt that Tacitus made
believe that he depended
detraction, for his sour
rumour and scandal in
a charge.

(16) These wage robberies and inadequate state protection were the source of constant complaint by the mine owners. See, for example, [illegible] Report of the Chamber of Mines for 1896, pp. 170-171 and passim.

(17) Newspapers throughout the 1890s abound with reports of such thefts by state officials. For a selection of examples, see the Standard and Diggers News (4 Dec. 1894, 4 Jan. 1895 and 7 Jan. 1895 (Portuguese border officials). Since such robberies hampered labour flows, the Chamber of Mines complained bitterly about them, see Report of the Chamber of Mines for 1896, pp. 170-171 and passim.

(18) This geographical location compares favourably with the European case studies. See, for example, [illegible]

(19) [illegible] Standard and Diggers News, 19 Feb. 1895.

(20) This, of course, was also the era during which other historians, such as Livy, concentrated on the early years of the Roman republic.

(21) From "Statement by Jan Note", op. cit. (Author's emphasis) The book on Nahum Levi Carlo: Christ stopped at Eboli, Lopresti Schneider, Pantheon, 1947 and Davis Fiedler Chapman, C.: Milocca, a Sicilian Village, Allen & Unwin, 1964 are two which he supplemented from the recollections of friends and his own contemporary reminiscences. Some think Tacitus was too much of a novelist to dig in dreary papers and that he relied for information on the works of memoir writers during the period concerned. Yet others believe that Tacitus derived much of his material from Greek historians of the Augustan period.

(22) Statement by Jan Note, op. cit.

(23) Standard and Diggers News, 19 Feb. 1895.

(24) Standard and Diggers News, 19 Feb. 1895 and 7 Jan. 1895.

(25) Standard and Diggers News, 2 Aug. 1894 and 7 Jan. 1895.

(26) See, for example, Standard and Diggers News, 30 March 1895.

(27) Standard and Diggers News, 31 Jan. 1895.

(28) [illegible]

(29) [illegible]

(30) [illegible]

(31) [illegible]

(32) [illegible]

(33) [illegible]

(34) Peter Warwick, "African [illegible]

(35) [illegible] 29 Nov. [illegible] reference available to me.

(36) See, for example, the case histories quoted in S.A. Annual Report of the Dept. of Justice 1914, p. 235. More generally, Napier Devitt, Memories of a Magistrate (London, 1934), p. 144.

Cripple Care profit

D.D. 35
30/7/77

EAST LONDON — The East London Cripple Care Society made an all-time record profit of R6 796 at their annual fete last month.

This was announced by the Mayoress, Mrs J. A. Yazbek, when she cut the ribbon officially to open a gift shop at the Margaret and Harry Fuller cripple centre at 7 St Luke's Road.

Mrs Yazbek said the fact that the society had recently acquired the house next door to add to the existing premises was a tribute to the inspiration of two devoted and dedicated people. — DDR

Clearly, both firms are best off if both increase prices. But suppose you were firm A: would you do it? Remember that you would thereby run the risk of losing $50,000 if your opponent stood pat. There are two circumstances under which you would not increase your price : (1) if you were a conservative manager for whom the hope of gaining $100,000 wasn't worth the risk and worry of possibly losing $50,000; and (2) if you believed that firm B was under conservative management and would not assume the risks of a price increase. Indeed, there is a third circumstance that leads to the same decision, and that suggests how subtly one has to reason when money is at stake. It is (3) if you believe that firm B believed that you were a conservative firm and would therefore not raise your price. So it is far from certain that the firms would make mutually advantageous decisio llowed to communicate.

These two trivial gam dient of life in an oligopoly; the strategic interpl In practice, the games oligopolists play are . Each firm may have to contend with the acti eres rather than only one, and each will have a s with respect to prices, product design, merch many other things, instead of only a single dich at, the inevitable uncertainties of business make it in wn a sure-fire matrix, as we have done.

2/8/77 WITNESS

Bilharzia may create vitality

Science Correspondent

BILHARZIA, far from making children lethargic, may make them more energetic.

This is a preliminary conclusion drawn by Mrs. J. Kvalsvilg of the Department of Psychlology at the University of Natal.

She was speaking at a biological symposium held in Durban yesterday.

Fifty children from schools at Adam's Mission, near Durban, were studied in both classroom and playground situations.

Although the full results have not yet been analysed, it has emerged that the children with bilharzia were more energetic.

Mrs. Kvalsving, however, said it was possible that more energetic children explored more and thus exposed themselves to bilhazia.

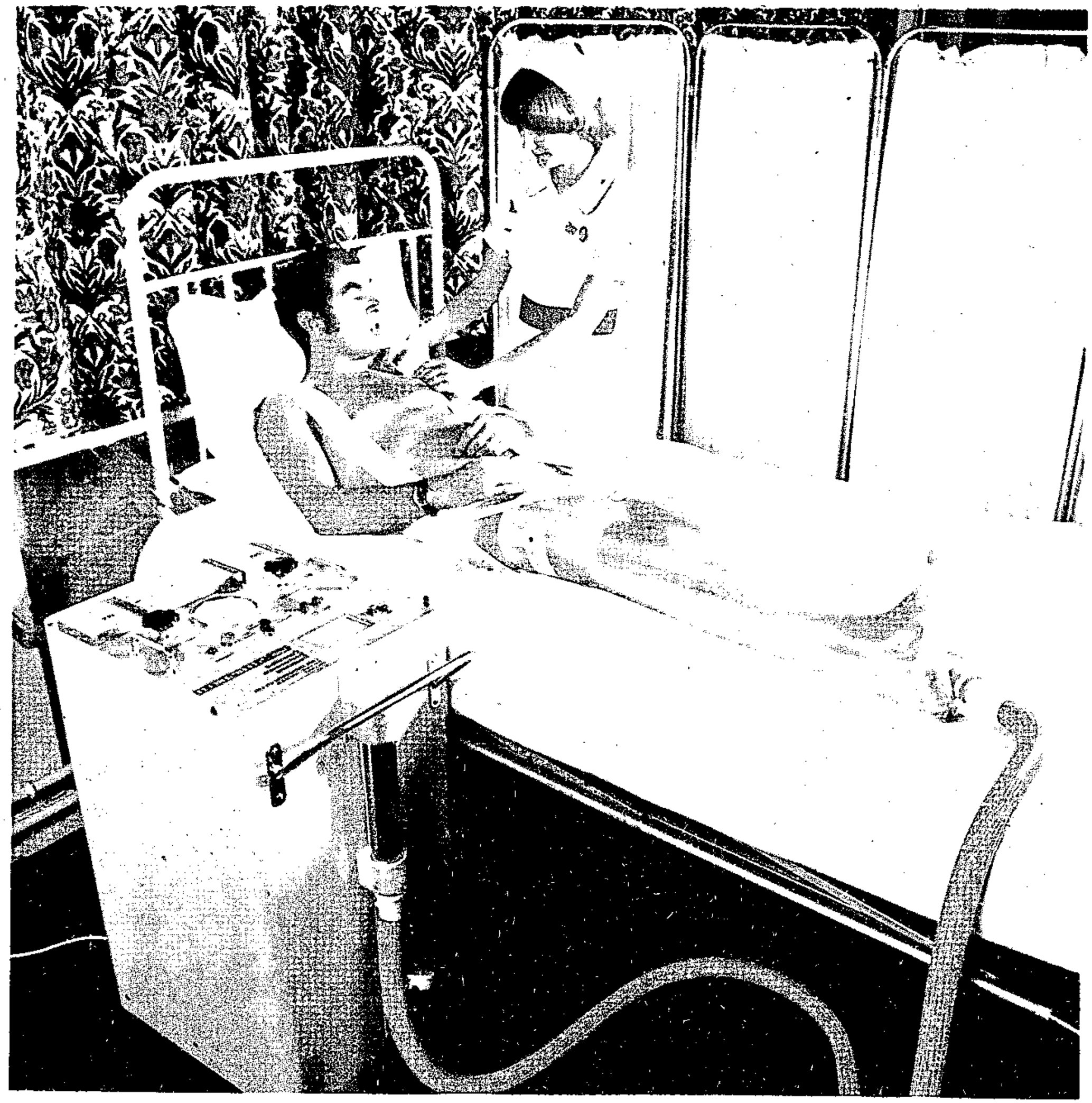
85

SIZE GROUP (HECTARE)	ECONOMIC REGION									
	46		47		48		49		50	
	No.	Area	No.	Area	No.		No.	Area	No.	Area
TO 1,9	-	-	8	8	4				-	-
2 - 4,9	9	32	45	132	43				2	7
5 - 9,9	99	867	55	454	92				1	9
10 - 19,9	87	1 334	65	1 020	108				-	-
20 - 49,9	400	11 912	194	6 411	164				8	299
50 99,9	331	24 265	219	16 558	137				98	7 706
100 - 199	430	64 503	477	73 009	231				88	13 034
200 299	330	81 349	509	126 719	161				139	33 833
300 - 499	595	233 187	888	347 790	222	85 487			189	74 079
500 - 999	839	613 078	942	663 585	215	149 007	505	353 423	328	236 770
1 000 - 1 999	671	934 423	422	574 787	71	97 643	233	303 862	198	275 879
2 000 - 4 999	405	1 206 500	124	350 497	29	80 743	78	208 834	86	274 046
5 000 - 9 999	72	471 806	9	52 770	3	17 645	2	10 930	6	43 868
10 000 - oVER	20	335 900	3	40 321	-	-	-	-	-	-
TOTAL	4 288	3 979 156	3 960	2 254 061	1 480	520 754	2 727	1 255 634	1 143	959 530

D.D. 2/8/77

Healing with plastic bags

(85)



East London is getting worked up about using plastic bags for refuse collection. But the much-maligned bags have many other uses — one of them being in hospitals.

Known as the Cape Sterishield Controlled Enviroment Treatment System, conventional dressings or plaster casts are replaced by enclosing damaged limbs in transparent plastic bags.

The enviroment inside the bag is controlled, keeping the bacteria count low, and the humidity, temperature and pressure at the degree calculated to produce the best conditions for healing.

Among major advantages are the elimination of changing of dressings, maintaining a sterile enviroment, the ability to see how the limb is progressing and improved control of swelling and other post-operative or injury symptoms.

The concept, developed by a British company, has been progressing for seven years and its full possibilities still have to be realised. In future both burns and plastic surgery may be treated within plastic bags.

ARGUS 1/9/77

TABLE 21. NUM

BE IN THE CITY

AREA	S.A.R. MEN
1. Milnerton Munic (farm labourers Kilarney area) Stable 'boys' M	4,315
2. Bakoven to Port (domestics, car etc.)	own 1,719
3. Portwsood Road Gate (domestics takers, etc.)	
4. Toll Gate to Ne (includes Clare Athlone, Lands	
5. Kenilworth to H	
6. Retreat to Kalk	
7. Salt River Brid Paarden Island- Industries	
8. Fishhoek Munici	
9. Pinelands Munic	
10. Simonstown Muni	
11. Thornton	
12. Bergvleit	
13. Bishops Court	
14. Constantia	
15. Kirstenhof	
16. Ottery	
TOTAL	L 6,034
CITY COUNCIL TOTAL:	9,409

'Bonding' urged to retain SA doctors

The Argus Correspondent

JOHANNESBURG. — Bonding medical graduates immediately after qualification for 10 years' service in health care should be introduced to curb South Africa's alarming brain drain, a Wits University medical professor said in Johannesburg today.

Professor H. Seftel, Professor of African medicine at the University of the Witwatersrand, was speaking at a seminar at the university's medical school.

He said medical students were privileged people who were committed to serving community suffering. The community paid for the students to study at a medical school.

'I have no hesitation in calling for a system of bonding for graduate students to a period of 10 years' service in health care,' Professor Seftel added.

'Bonding graduate students might be the best way of selecting medical students who really cared,' he said.

Dr George Beaton, director of the division of continuing medical education at the university, said two surveys were conducted in 1973 and 1976 to find out how many Wits medical graduates had remained in South Africa.

The survey showed that about 46 percent of students who graduated between 1960 and 1973 had left South Africa and South West Africa.

Most had gone to the United States, Australia, New Zealand, Israel and Britain.

Since last December when the second survey was carried out, the brain drain had worsened.

IV

Elles baragouinaient des choses à demi exprimées, le regard perdu et comme suivant intérieurement un sentiment subtil et délicat qu'elles semblaient ne pouvoir traduire.

Il les pressait: «Et pourquoi? et pourquoi? Pourquoi suis-je donc un égoïste? Pourquoi un misanthrope?* Pourquoi cela? Dites, dites?»

Au fond d'elles-mêmes, elles le savaient, elles jouaient un jeu, elles se pliaient à quelque chose. Il leur semblait parfois qu'elles ne cessaient de regarder en lui une baguette qu'il maniait tout le temps comme pour les diriger, qu'il agitait doucement pour les faire obéir, comme un maître de ballet. Là, là, là, elles dansaient, tournaient et pivotaient, donnaient un peu d'esprit, un peu d'intelligence, mais comme sans y toucher, mais sans jamais passer sur le plan interdit qui pourrait lui déplaire.

air furieux, grognon, il va leur dire quelque chose d'avilissant, les rendre (elles ne savent comment) conscientes de leur bassesse, sinon maintenant, du moins à la moindre occasion, sans qu'on puisse lui répondre, de sa manière détournée, si mauvaise.

Quel épuisement, mon Dieu! Quel épuisement que cette dépense, ce sautillement perpétuel devant lui*: en arrière, en avant, en avant, en avant, et en arrière encore, maintenant mouvement tournant autour de lui, et puis encore sur la pointe des pieds, sans le quitter des yeux, et de côté et en avant et en arrière, pour lui procurer cette jouissance.

Rand Daily Mail 29/9/77

The older blacks best 'survivors'

Science Editor

Middle-aged South African blacks have a better chance of reaching old age than South African whites and both whites and blacks in the United States.

This little known fact emerged from a lecture last night by Dr Alex Walker, head of the Medical Research Council's biochemistry research unit at the South African Institute for Medical Research.

He was speaking at a meeting of the Institute for the Study of Man in Africa on "Colour and health — contrasts in nutrition and health patterns in South African blacks and Indians."

Dr Walker said calculations had shown that 39,5 of South African blacks who were 50 in 1951 were alive 20 years later.

But for US Negroes the figure was 34,8, for US whites 37,4, for South African whites 32,7, and for South African Indians 21,6.

INDIANS

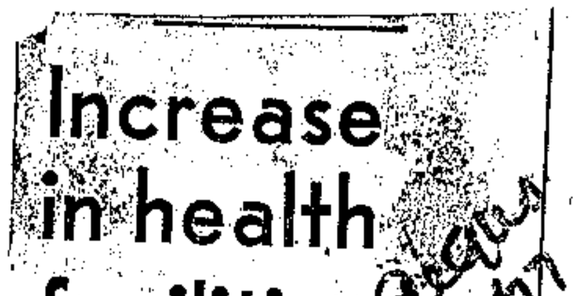
The higher values for South African blacks was due to their lower mortality after middle age from degenerative diseases — coronary heart disease, cancer and diabetes.

The surprisingly low survival figure for Indians, he attributed partly to the principle of "programming."

It was believed, Dr Walker said, that Indians were destined or "programmed" to have shorter lives than some other races which neither improvements in living standards nor in medical services were likely to change significantly.

Mortality figures of black children under five tell a different story, however. In rural and urban areas figures of between nine and 19 percent have been obtained.

The figure for Indians in Durban is eight and in rural India, 10 to 25. White South Africans have a figure of 2,5 percent.



Increase in health facilities

THE object of the new health law was to provide a comprehensive basic service for the entire public, Dr J. L. Jordaan, assistant director of hospital services, said today.

Dr Jordaan was addressing the 21st anniversary meeting of the South African National Council for the Aged.

The aim of the law was to provide a basic health service for the public which would consist of simple but effective and easily accessible facilities.

The service would provide preventive treatment.

The CYL, showing negro inf t Africans must determine their own future . It looked beyond S. A. 's borders towards Pa ressing the co-operation of all Africans in establis ghout Africa and freedom from colonialism. Reports West Africa and the appointment of Africa's fir ter, Nkrumah, carried in the South African press, r . (13)

The CYL was suspicious of , Firstly, it was a white evolved doctrine. nist class diagnosis was in direct contradictio belief that Africans were oppressed because of their race. (14) The Africanists of the CYL did not reject the CP out of hand. In fact they found themselves drawn together because of a common radicalism of method in creating a mass movement.

The ANC 's interracial policy reached its climax in the meeting of the Congress of the People (COP) in 1955. The COP was supported by the ANC, the South African Indian Congress, the South African Congress of Democrats, the Coloured People's Organization and the South African Congress of Trade Unions. The COP drew up a Freedom Charter in which it was stated that " S. A. belongs to all who live in it, Black and White. " It advocated the establishment of a multi-racial democratic state based on the principle of sharing power. Such declarations were an affront to the Africanists, denying the concept of " Africa for the Africans. " Interracial ideology, the interracial composition of the COP and the influence of non-African leadership constituted, to the Africanists, a betrayal of African nationalism. After the failure of the Western areas and Bantu Education Campaigns, the ANC lost a great deal of prestige. Africanists seceded in 1958 and formed the Pan-African Congress under Sobukwe in 1959. (15)

The Pan-Africanist Congress (PAC) was an extension of the CYL outside the ANC. The PAC, like the CYL in the 1940's, maintained that it was returning to the ANC 's original nationalism. It censured the ANC

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(13) Walshe, pp. 335-336 (14) Wilson & Thompsom, p.459

(15) Wilson & Thompson, p.464.

Aqus. 11/10/77

Call to promote health

85

TWENTY-TWO professors at the University of Cape Town Medical School have called on members of the medical profession to use their influence to promote a healthier community life.

'Our responsibility for human welfare insists that we draw attention to the dangers of social disorganisation, inadequate housing and disruption of the family unit,' the professors say in a letter in the South African Medical Journal.

The letter says that medicine has turned its back on treating diseases only. The emphasis is now on diagnosis and therapy.

'Students are taught to pay attention to the total background of the patient — his home circumstances, economic considerations and cultural and hereditary factors.

'Comprehensive medicine is taught in every medical school in the Republic and community care, with its emphasis on preventive medicine, is highlighted.

'Surely it is time for members of the medical profession to use their influence collectively to promote a healthier community life throughout South Africa.'

First health panel named

STAR 31/10/77

85

John Patten,
Political Correspondent

The Minister of Health, Dr van der Merwe, announced today the appointment of the first Health Matters Advisory Committee in terms of the Health Act passed earlier this year.

The 12-member committee under the chairmanship of the Secretary for Health, Dr J de Beer, will meet for the first time in Pretoria on November 2 and 3.

Dr van der Merwe said today the realisation of the Health Act had been an exceptional event in the field of health, but the constitution of the advisory committee was equally important.

The committee has to investigate, consider and make recommendations on all, and also on particular, health matters.

Decisions taken on the recommendations would be applied as health policy and would be implemented on a national basis.

For the first time, health matters pertaining to State, provincial and local authorities, would be co-ordinated by a single body.

DIRECTORS

"I trust, and believe, health services will be rationalised and the overlapping and confusion which at times arose will now be eliminated," he said.

Besides Dr de Beer, the committee includes three directors in the department of health, four directors of provincial hospital services, two representatives of urban local authorities, one representative of a local authority in a rural area, and a representative of the Defence Force.

Department of Health representatives on the committee are Dr J Gilliland, Dr J P Roux and Dr H P Botha. Those from the Provincial services are Dr H Grove (Transvaal), Dr W K Botha (Natal), Dr J Kruger (Free State and Dr R L Kotze (Cape).

Urban local authority representatives are Dr J P A Venter, of Pretoria, and Dr R J Coogan of Cape Town and the rural representative is Dr J Allen of Stellenbosch.

The Surgeon-General, Major-General N J Nieuwoudt, represents the defence force.

The committee's secretary is Deputy-Secretary in the Department of Health, Mr M H Raath.

31/10/77

Carbohydrate diet 85 augus. 'easiest to follow'

THE low carbohydrate diet was from a practical point of view the easiest diet to follow and doctors and patients would find it was the most effective way of losing weight healthily and possibly permanently, a doctor writes in the latest issue of the South African Medical Journal.

The doctor says slimming diets had value only when they were nutritionally adequate to maintain health, calorically deficient to reduce weight, socially acceptable to ensure that boredom did not destroy the continuity of the diet, economically feasible and potentially permanent.

He says the reduction of carbohydrates reduced the nutritional value of the diet little, if at all. It had the advantage that once the patient had learnt the approximate carbohydrate content of the foods he was allowed, he did not have to worry about the amounts of the wide range of foods available to him.

These foods included lean meat, white poultry, veal, most fish, fat-free cheese, eggs and most leafy vegetables.

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ders and agriculturalists rather than on the more recent large scale flowerings of civilizations such as those in Greece, Egypt and the near East. Although these are legitimate branches of archaeology, they are not taught at present within the Department of Archaeology.

Archaeology III was introduced for the first time in 1976, changing the Archaeology major from two years to three. The course is offered in both the Arts and Science faculties and focusses on the investigative techniques of the archaeologist in the field, in the laboratory, and in writing prehistory. The course includes some practical training in museum methods, photography, mapping, and the like, but has a heavy emphasis on the applied science techniques employed by archaeologists. Fieldwork is required.

In Additional Archaeology (taken simultaneously with or subsequent to Course III) students with exceptional aptitude and interest pursue individual original research projects involving scientific applications in the analysis of archaeological materials, and participate in a research seminar. Laboratory and fieldwork are carried out as each project requires.

COMPARATIVE AFRICAN GOVERNMENT AND LAW I:

The material for this course is derived largely from Southern Africa with comparative reference to case studies in the political systems of East and Central Africa. The course includes an introduction to the comparative study of the politics of race, class, and ethnicity.

Comparative African Government and Law I may not be taken in the first year and Political Science I must be completed beforehand. It is suggested that the following course or courses should be taken prior to or concurrently with Comparative African Government and Law I. The suggested courses and their times of meeting are given below:-

Political Science I meets at 9.25 a.m.
Economics I meets at 10.20 a.m.
Sociology I meets at 11.15 a.m.
African History I meets at 8.30 a.m. (this course cannot be taken by a first year student)
Social Anthropology I meets at 8.30 a.m.

New health committee is chosen

Staff Reporter

HEALTH matters concerning State, provincial and local authorities would for the first time be coordinated by a single body, the Minister of Health, Dr Schalk van der Merwe, said in Pretoria yesterday.

Announcing the constitution of the first Health Matters Advisory Committee, he said the committee would investigate health matters and make recommendations.

The members of the committee, which will meet in Pretoria on November 2 and 3 are: Dr J de Beer, the Secretary for Health, chairman; and Dr J Gilliland, Dr J P Roux and Dr H P Botha, who are directors in the Department of Health.

Representing provincial administrations will be the Directors of Hospital Services in the four provinces.

Representatives of local authorities in urban areas are Dr J P A Venter of Pretoria and Dr R J Coogan of Cape Town; Dr J Allen of Stellenbosch and the surgeon-general of the Army, Major-General N J Nieuwoudt, are also members. Mr M H Raath, deputy secretary in the Department of Health, is the committee's secretary.

(85)

MEDICINE AND STATE ON COLLISION COURSE

Medical Schemes Act now a 'dead letter'

The Argus Correspondent

JOHANNESBURG. — Unless extreme wisdom prevails, a stormy time in medical politics is in the offing with the possibility of open confrontation between the Government and the medical profession.

Until now the Medical Association of South Africa has merely made rumbling noises in its opposition to the Medical Schemes Act.

Now it has irrevocably thrown it overboard by officially advising its members to contract out, in protest against the latest tariff of fees laid down by the Remuneration Commission.

This means that the Act has become, theoretically, a dead letter.

UNSATISFACTORY

If all doctors contract out they may charge all patients whatever they like, provided fees remain within the bounds of what is regarded as reasonable by the South African Medical and Dental Council.

The Government has, of course, realised that the Act, in its present form, is unsatisfactory.

Recently the Minister of Health, Dr Schalk van der Merwe, said that a different method would have to be found of determining a tariff of fees for medical aid patients.

Since then proposed amendments to the Act have been published.

SOCIALISED

They do away with the Remuneration Commissions appointed to lay down a tariff and this function is to be transferred to the Medical and Dental Council.

But another amendment abolishes the right of doctors to contract out in terms of the Act.

And while, in spite of their misgivings, they are prepared to live with a Medical Council tariff, the removal of this right is placing the Government and the profession on a collision course.

In effect, doctors say, this provision introduces a form of socialised medicine in a time-honoured free enterprise system and further bedevils the traditional patient-doctor relationship.

The Act, it is said, has already driven a wedge between doctor and patient by introducing a third party — the medical schemes.

But at least doctors could get out of it by contracting out.

Enforce the tariff and doctor-patient relations can only deteriorate.

One cannot help sympathising with both Government and doctors in their predicament.

The Medical Schemes Act was a sincere attempt on the part of the State to regularise private practice with the interests of both doctors and patients in mind.

It has not worked out that way.

Unless a medical aid tariff can be enforced and doctors retain the right to contract out, the Act remains basically ineffectual.

If it is enforced, as the amendment seeks to do, the democratic right of doctors to run their practice as they see fit is taken away.

This they will not accept.

PAYMENTS

But many doctors need the medical aid schemes, which ensure regular payment of accounts.

So only about 2 000 of the 7 000 or so doctors in private practice have contracted out so far.

It is significant, though, that an independent survey has shown that most contracted-out doctors still charge their medical aid patients the preferential rates, which suggests that their opposition to the Act is not based entirely on financial considerations but that ethics play a significant role.

Whether the Government should allow the present situation to reach a point of confrontation is debatable.

Enforcing medical tariffs will provide a better deal financially for the medical schemes and their patients and end once and for all the unseemly bickering that has followed each remuneration commission report.

On the other hand it will leave in its wake a medical profession seething with resentment.

And this will do neither the patient nor professional medical standards any good.

The solution is for the Government to scrap the 'no contracting out' clause in the new Bill but to retain the provision whereby the Medical Council would fix the tariff.

Provided representation of the private medical sector is increased on the council — which seems a fair compromise — the chances are that a tariff may be worked out that will satisfy both doctors and medical schemes.

It is worth a try for a year or two anyway.

The alternative, as embodied in the Bill, may lead to chaos.

'Brain drain' to Dallas

DALLAS (Texas). — A 'brain drain' of South African doctors to Texas has re-settled an estimated 30 white families in Dallas, most arriving during the past year.

The Dallas Morning News says the doctors are mostly responding to enticing offers published in South African medical journals, some offering more than R50 000 in gross income annually plus various fringe benefits.

Texas is one of the few states in America where foreign doctors may practice with a temporary licence while they study for the State's medical exam.

Although Texas has no current shortage of doctors in the big cities, there is an acute lack of general practitioners in some remote rural areas.

Several of the state's 254 counties have no doctors at all. — Sapa-AP.

[illegible] (Couriers Day)

13th September — Options

20th September — Options

27th September — Vacation

4th October — Options

[illegible] — Options

The medics' bill FM 13/1/78

(85)

J J van Rensburg, Pretoria:
It was with interest that I read "The doctors' dilemma" (*FM* December 2) with your article on "Doctors' fees — How big an increase?" (*Current affairs*, October 14) and the subsequent letter from "Sick of it" still in mind.

Surely it would be the utmost "medical-aid bureaucracy" if your statement that the Bill aims, *inter alia*, at "giving power to the Medical Schemes Council" to determine a tariff of fees were correct. In fact the Bill proposes that a tariff of fees will be determined by the Medical and Dental Council appointed under the Medical, Dental and Supplementary Health Service Professions Act, 1974, comprising the following members:

- The Secretary of Health;
- Ten persons appointed by the Minister, of whom four shall be medical practitioners; one shall be a dentist; one shall be attached to a faculty of medicine or dentistry; three shall be persons who are not registered under the Act; and one shall be a chairman of a professional board;
- One medical practitioner who is a director of hospital services;
- Four medical practitioners representing the universities;
- Nine medical practitioners and four dentists;
- One person designated by the SA Nursing Council; and
- One person designated by the SA Pharmacy Board.

It is clear from the above that the medical profession will have all possible control over the determination of tariffs.

The question should, however, be asked whether it could be expected that medical schemes would continue guaranteeing payment to doctors if they have no say in the "agreement" according to which they guarantee payment in exchange for lower tariffs for their members.

Should the Bill become enforced, surely the doctors would be in a position to determine their own fees without giving medical schemes any chance of objecting — since medical schemes are not allowed to contract out? This must be the juicy carrot referred to in your article, which should leave all doctors happy to forget about contracting out for the rest of their lives.

Despite this most favourable proposal (made by the Minister of Health), Professor De Klerk and the rest of the Medical Association (the doctors' and dentists' trade union as you have called them) still have an incomprehensible, arrogant approach. The question still remains whether or not their views are shared by a majority of doctors and dentists.

Star 7/3/78

Children die in malaria outbreak

Two black children have died of malaria and 27 other people are being treated for the disease at Pongola on the Transvaal-Natal border.

It is believed most patients came from across the Swaziland border where they presumably contracted the infection.

The Department of Health is waiting for further information from its regional office in the area.

Apparently local health authorities are concerned about an increase in the numbers of malaria-carrying mosquitoes in the region. Spraying is in progress on both sides of the border.

The Health Department was told of 2 909 malaria cases in South Africa last year. Most were in the Northern Transvaal, with only 147 in the Southern Transvaal and Natal.

Hansard 6 col 380 10/3/78

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123

Gross national product

28. Mr. N. B. WOOD asked the Minister of Statistics:

(1) What was the gross national product for the latest year for which figures are available;

(2) what was the (a) percentage and (b) amount allocated to (i) health in the Republic and the homelands, respectively, and (ii) social welfare services;

(3) what was the (a) percentage and (b) amount allocated to (i) education and (ii) housing in respect of each race group.

The MINISTER OF STATISTICS:

(1) R27 729 million for the calendar year 1976 and estimated at R28 668 million for the 12 months ended 31 March 1977.

(2) (3)

	(a) Percentage of Gross National Product	(b) Amount R Million
(i) Health:		
Republic	2,61	749,6
Homelands	0,30	85,8
(ii) Social welfare services	1,51	433,1
(i) Education:		
Whites	2,88	824,3
Coloureds	0,53	152,9
Asians	0,22	62,1
Bantu	0,70	199,7
(ii) Housing:		
Whites, Coloureds and Asians	0,69	196,7
Bantu	0,54	155,2

In the case of (3)(ii) separate figures in respect of Whites, Coloureds and Asians are not available. Transkei is excluded.

23/4/78 (85)

CANCER SCARE OVER PLASTIC FOOD PACKAGES

Sun. Tribunes 23/4/78 (85)

By TONY SPENCER-SMITH

HOUSEWIVES may be carrying poison into their homes with every basketful of food.

This is the shock finding of two University of Cape Town researchers who say that PVC, used in the packaging of many foodstuffs, may cause cancer and other diseases.

They are Cape Town Medical School biochemist Dr Kathryn Ivanetich and Mrs Rosemary Estment who published their claims in the latest issue of the distinguished Journal of Science.

And Minister of Health Schalk van der Merwe disclosed this week that his department is investigating possible health hazards from food packed in PVC and "will not hesitate to take action if necessary."

The two scientists say America is now considering a wide-ranging ban on PVC (Polyvinyl Chloride) food containers and that only urgent independent research will show whether there is any cancer threat.

Dr van der Merwe said his department would certainly study the paper as part of its ongoing research.

A carcinagenic chemical called VCM (Vinyl Chloride Monomer) which is used to make plastic has been proved to cause liver cancer in humans, according to Dr Ivanetich and Mrs Estment.

Their work is given considerable weight by its publication in one of South Africa's most respected scientific journals.

Dr Ivanetich told the **Sunday Tribune** there was legimate cause for concern and research was vital. Her report says no cognisance appears to be taken by the Government or industry in this country of American restrictions.

Schalk van der Merwe . . . we will take action if the need arises

measured, everything depends on this, and there is no doubt VCM is a dangerous substance."

She told me the thin film used in supermarkets to seal punnets of fruit and vegetables and to package meat, and bought by housewives to use in thousands of ways in the home, was made of PVC.

Vast range

She says PVC — used in South Africa for the packaging of a vast range of foodstuffs from dried peas to cooking oil — has been shown in overseas studies to have caused a number of serious health problems including liver cancer among people working in PVC factories.

The leading producer of PVC in South Africa, African Explosives and Chemical Industries, said that while the controversy about PVC was obviously taken seriously by the company, which was financing research into the matter, no health hazard had yet been proved.

Mr Michael Blizzard, the company's national PRO, said America tended to be hysterical in medical matters and to overreact and Dr Ivanetich seemed to be "leaping onto the bandwagon a little."

He said the company complied with stringent VCM maximum level standards laid down in Europe in manufacturing PVC for foodstuff packaging.

But Dr Ivanetich replied: "This sort of assurance doesn't satisfy me. The levels of VCM in actual foodstuffs should be

And when supermarket packers used hot metal to cut the film, the heat caused fumes of VCM, hydrochloric acid and carbon monoxide — all toxic substances — to come off, posing possible health hazards to workers.

She said there was no doubt VCM got into foods from PVC containers.

Goods where 100 percent of the plastic containers are of PVC include vinegar, cooking oil, salad oil and non-vacuum-packed cheese.

The plastic is also used widely for other dairy products, sauces, bacon, chicken portions, dried peas and beans, margarine and many other foods including some health foods.

(85)

Hansard 12 28 April 1978.
Question 13 Cols. 715 & 716

Legitimate traders resent the activities of the meat sellers as they can get away with unhygienic methods at markets like these

By MARION COX

SICKNESS FOR SALE

We can't control these bad-meat hawkers, says city health inspector

ILLEGAL trading in contaminated meat and offal flourishes in Durban in spite of efforts to stamp it out.

A health inspector for Durban City Council said they were helpless to do anything.

"The hawkers openly defy us when we visit them," he said. "Health inspectors have no power of arrest and because they are unarmed they are frightened to go to some areas without police protection."

Durban City Police and South African Police regularly raid the worst trouble spots, but the inspector said: "As soon as the police arrive, the hawkers scatter and unless they can be caught actually selling the meat even the police are powerless to do anything."

Intestines, stored in filthy containers, soon become a health hazard, and can give the customer food poisoning and gastro enteritis

Every day African hawkers set up business in Dalton Road, near the abattoir, selling offal from filthy hardboard tables supported by crates and wrapping the fly-blown and often rotting meat in newspaper or used potato bags.

"The health hazards are obvious," said Dr Neville Becker, Durban deputy medical officer of health. "No checks are made on the fitness of the meat for human consumption and the practice is illegal. We would like to clean up the area but as fast as we catch one set of traders another crowd replace them."

Difficult

Brigadier Hennie de Witt, police commissioner for Port Natal, said the police had difficulty stamping out the hawking but he intended to take up the matter personally.

"This practice cannot be allowed to continue," he said. "I intend taking the matter up with the chief magistrate and the town clerk in an effort to eradicate this illegal trading. We must try to get increased fines — at present offenders get away with paying a R10 admission-of-guilt fine, which is absurd."

By-laws make it an offence to sell raw meat without a licence. Licenced traders have to comply with regulations on refrigeration, storage, wrapping, staff facilities and hygiene. Dalton Street's illegal traders do not.

"You can imagine how much the registered trader resents these hawkers who

City health inspectors say they are afraid to go to Dalton Street alone and need police protection when on a raid

are getting away with filthy practices for the price of an occasional fine," said a spokesman for the health department.

The source of the meat and offal sold by the hawkers is not known, but because the abattoir is only a few metres away the meat is probably bought from offal dealers there.

There is nothing to stop the hawkers buying offal from the abattoir and reselling it but, although the offal is probably uncontaminated when they buy it, storage in the open in filthy dustbins can make it dangerous to humans in a few hours.

Because the source of the meat is not checked, it could be from the carcasses of diseased animals and full of parasites such as tapeworms, liver flukes and TB-carrying organisms.

"Even abattoir-bought meat, when sold in the unhygienic conditions of the Dalton Street traders, can soon give the buyer food poisoning," said Dr Becker.

Alcohol: hope for damaged brain cells

8S Star 21/6/78

WASHINGTON — Brain damage suffered by chronic alcoholics, long thought to be permanent, may be partially reversible with abstinence from liquor, researchers say.

The new Canadian findings indicate some damaged brain cells may rejuvenate and regain some of their function when alcoholics stop drinking.

And the University of Toronto researchers say they could help explain why many severe alcoholics who quit drinking recover some of their memory, learning abilities and ability to think abstractly and learn new tasks.

However, no changes were noted in the two other abstaining subjects either, but the researchers said both showed marked improvements in function tests.

Dr Carlen said there were no data to show if alcoholics with brain damage who drank less were more likely to recover some impaired mental function than others.

"But we have evidence that all chronic alcoholics who drink for 10 years or more have signs of cerebral atrophy," he said. — Sapa AP.

"This is the first time anyone has shown reversible cerebral atrophy (wasting) in adult human beings," Dr Peter Carlen, one of the chief investigators, said.

In a report in the journal Science, the researchers say they are not suggesting that entire brain cells, called neurons, regenerate and grow. It is generally believed that these nerve cells do not reproduce in adult mammals.

But they theorise that tiny threads called dendrites, which carry impulses into nerve cells, can recover and possibly grow if not damaged too badly by alcohol. Along with dendrite growth they also may be increased in other nerve fibres, supporting tissue and small blood vessels, they said.

The researchers base their theory on a series of special brain X-rays taken of eight chronic alcoholics treated at the Addiction Research Foundation Clinical Institute of Ontario. The patients all with more than 10-year histories of heavy drinking, received no special treatments. As part of the study, six patients stopped drinking while two continued.

The first X-ray scans, which electronically recreate cross section brain slices, showed a loss of cerebral tissue and large cavities in the brains of four abstaining subjects.

MORE TISSUE

Scans taken months later showed smaller cavities and appear to be more brain tissue, the study said.

The two subjects who continued to drink

It should be noted that the term 'technical' is misleading when referring to the above institutions, since they do in fact offer a wide range of courses commercial and a

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Table 2. NTC 1 - V p

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1972	3 10
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Health care . . . not enough

HEALTH

(85)

Plenty wrong

FM 29/9/78

The little-explored, possibly neglected, field of the economics of health care in developing countries, such as SA, came under scrutiny in Cape Town this week at an international conference organised by UCT's Labour and Development Research Unit and the SA Medical Scholarships Trust.

In an uncommon get-together of economists, medics and sociologists, 140 delegates pondered and discussed 75 papers and concluded that SA, for all its wealth and economic leadership in Africa, did not have the highest standard of health.

Opening the conference, Professor Marius Barnard said that after numerous visits abroad, even those behind the iron curtain, he had come to the conclusion that although SA had modern hospitals and sophisticated medical facilities, the Republic came off second best after comparing the medical infrastructure with the incidence of malnutrition, infant mortality and diseases related to poverty and deprivation.

Professor Bernard Pimstone of UCT medical school, who has gained international recognition for his research work into "man's biological adaptation to nutritional deprivation" in the Western Cape said: "I have often been disturbed by the recurring question: would my research funding not have been better channelled into preventing rather than studying malnutrition?"

Other speakers concluded that there is something wrong with the allocation of resources within medicine, and in the community it is supposed to serve, because the prevalence of malnutrition and other preventable diseases remains unacceptably high.

Pimstone says the problem goes deeper than the provision of medical facilities or the pursuit of health statistics. It involves social and dietary mores and adaptations to urbanisation. One example is the abandonment of breast-feeding at an early stage of a child's life, leaving it indoors with surrogate parents while the mother tries to boost family income.

This sets in motion the vicious circles of rickets, marasmus and kwashiorkor. "The problem can't be controlled by diet replenishment alone — it is part of a devastating social phenomenon of wider implications, and the cure has to be seen in a broader perspective," says Pimstone.

SA delegates at the conference agreed there was a need for a wide overview of health requirements in the country.

Referring to possible distortions in the allocation of resources for health care, it was suggested that a start could be made by examining medical faculties at SA universities — such as the system of admitting medical students exclusively on their academic pretensions and little else. "How," asked Pimstone, "can we expect the bourgeoisie we create at university to physically work in the desplate areas where doctors are needed most? Should teaching hospitals be more physically integrated into the community? We should also consider the question of doctor substitutes — why not have the 'barefoot doctor' system in SA? Why not make extended use of medical auxiliaries to bring medical care to rural areas?"

Professor Alan Sorkin, Professor of Economics at the University of International Health at Johns Hopkins university, Baltimore, perceives four major advantages in broadening the base of allocating health care funds.

- Increased manhours by the work force;
- Increased productivity;
- Increased habitability of the land area by overcoming diseases such as malaria; and
- Changes in the attitudes of people to their own destiny (healthy people are less fatalistic, docile, more self-confident).

Sorkin showed there was a close correlation between health care and development, in which the latter could not move without the former. His experiences while working with the World Health Organisation had shown that, while improvement in the general standard of health care was inevitably followed by a short-run population explosion, a substantial fall in the birth rate invariably followed a drop in the death rate after a lag of 10-15 years.

The question many delegates were asking after digesting evidence produced by Third World health economists like Sorkin was: as a major food exporter with a persistently high rate of malnutrition can SA afford space-age hospitals like the new Johannesburg Hospital, put up at a capital cost of R150m (R52 000 per bed) and which will cost R30m-R50m a year to run?

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Shocking details of rural health care revealed

By Barry Streek

CAPE TOWN — Alarming, indeed shocking, details of the inadequacies of health care in South Africa, particularly in the rural areas, were given at an international conference in Cape Town last week.

And a radically different medical system — which could be implemented in terms of the 1977 Health Act — is urgent: a system which takes cures and prevention to the people rather than one based on expensive hospitals and doctors, once people are sick.

Central to the new approach is the concept of a medical community assistant in those areas where the health indices are worst.

The medical assistant system is already functioning in neighbouring states — in Rhodesia, Mozambique, Botswana, Lesotho and Swaziland — but not in South Africa, expect on a limited scale.

In the Republic the Westernised, hospital-based system, based on the needs of developed countries, is followed, with some effect in the Durban areas but with disastrous results outside the cities and towns.

A delegate at the conference from Gazankulu said that R10 a year for every person could be adequate for health care in some poor countries, but this was totally inadequate in areas, like Gazankulu, where expensive structures had been inherited. Even the health laws prevented the introduction of new methods.

The need for a new health care system was summed up by one of the international delegates who told me: "The statistics from the rural areas in South Africa have not really surprised me. What has shattered me are your health policies. They are so out of date. They are ten years behind Botswana."

At the conference, which was sponsored by the Southern Africa Labour and Development Research Unit (Saldru) and the South African Medical Scholarships Trust (Samst), it was revealed in the 75 papers and discussion that:

"Malnutrition and other diseases in the rural areas was more extensive than in the Crossroads squatter camp in Cape Town — the incidence of protein calorie malnutrition in Crossroads was 1,9 per cent while at Nqutu in Kwazulu it was 7,3 per cent.

"A sample survey of children under the age of five in Transkei has revealed an infant mortality rate of 240 per 1 000 — compared to figures of 12 per 1 000 for whites 38,1 per 1 000 for Coloureds, 29,1 per 1 000 for Asiatics, and 68,7 per 1 000 for urban black people.

"For every 4,82 births in the rural areas of the Ciskei, there was 3,84 children alive — 203 out of 1 000 children died — and 3,27 children were alive for every 4,28 born in the urban areas of the homeland — 236 out of 1 000 died.

"Malnutrition is still extremely common in South Africa, tuberculosis is still rampant despite the apparent slight decrease in incidence recently and malaria seems to have escaped from control . . . malaria, malnutrition and heart attacks are all visible failures of our health care system while heart transplants and the treatment of pneumonia and of gastro-enteritis are visible succes." (Dr Tim Wilson).

"In 1977, businesses in the greater Cape Town area lost an estimated total of R33 million due to problem drinking among their employees," according to Mr Wynand Louw, of the University of the Western Cape.

"While there is one doctor for every 969 people in the 13 principal areas, the ratio is 7 612 per doctor in the rest of the country. The average in the homelands was 23 037 people per doctor (Mr Mike McGrath, of the University of Natal).

"South Africa spent 3,6 per cent of its gross national product of health expenditure in 1974/5, a decline from the 4,2 per cent in 1959/60. Even in 1960 this proportion was lower in South Africa than for some countries with lower per capita incomes. This placed South Africa below Western countries, below Czechoslovakia, Hungary and Poland but above Russia, Bulgaria and Rumania.

"With medical graduates leaving South Africa in increasing numbers — 80 per cent of the university of Witwatersrand's medical graduates over last fifty years are now overseas —, the increasing need for doctors in military service and the expected return of expatriate doctors to their countries of origin, health facilities are likely to suffer in future, particularly in the rural areas.

"The South African pharmaceutical industry spends about four times as much on promotion as on research." According to Mr Jonathan Brodie, the figure spent by the industry on promoting their products was almost as large as the entire cost of manufactuing.

This depressing picutre of the state of South African health was improved somewhat by the proof of success at a number of projects in Southern Africa where health workers, clinics and day hospitals appear to have had a marked impact.

The senior medical superintendent of the day hospitals organisation in the greater Cape Town area, Dr J. A. Smith, said: "Unless there is a sound primary level of health care, the rest of the system will be wasted, expensive and inefficient, no matter how skilled or how expert or highly specialised it is."

With the introduction of trained health care teams in purpose-built units in areas of the Cape, where people were concentrated, had shown "a dramatic improvement in health standards."

Although the day hospitals had started only in 1969, one and a half million items of service are being handled a year (all of which would have been handled in more expensive hospitals previously) at 16 centres.

Only two per cent of the patients were referred to established hospitals at a cost of four per cent of the Cape hospitals budget — and the high birth rate has dropped to 23 per 1 000

In Soweto, according to Professor Lucy Wagstaff, 40 primary health care nurses have dealt with over 130 000 patients since the latter half of 1976, and the doctor has a new role as "consultant, evaluator and monitor."

And a pioneering health centre service at Pholela in Natal reduced infant mortality from 27,5 per cent in 1942 to 10,06 per cent in 1952, but the experiment was, regrettably, not extended to other areas for a number of reasons.

Clearly, projects which have taken health and preventive care to the people have met with some success although, equally clearly, social and economic (essentially political) factors have a significant bearing on the level of health. This point was confirmed in a number of the research projects discussed.

As UCT's Michael Savage said: "If medicine is to be effective it must produce stable family life, adequate wages, promote educational and employment opportunities, better agriculture and more effective participation by communities in decision-making processes . . . the bulk of specific medical resources are devoted to health services which are curative rather than to those which are preventative and inhibit the occurrence of illness or in some way remove the situation in which illnesses are likely to occur."

With a new health policy, given lighter priority by all sections of the government, using medical assistant and community programmes in all areas of South Africa, a much happier situation could be created.

But, while 200 delegates from Kenya, Denmark the United States, Britain, Rhodesia, Swaziland, Gazankulu, Ciskei and KwaZulu, as well as all parts of South Africa, grappled with this serious problem, the South African Government was noticeable for its absence. The Department of Health did not send a single representative to even listen, let alone explain and elaborate on its view.

One trusts that its absence was a bureaucratic oversight. Or must people like Professor Ralph Kirsch continue to say, a little pathetically, "I work in a university where many academics including myself, wake up too late, and criticise actions when they could possibly have used their influence to prevent these, but didn't because they believe politics should be kept out of medicine. This despite the fact that health development is a political and social process."

28/11/78 W 85

Safety tips

Accidents do not happen — they are caused.

Matches must never be left withn the reach of children. Playing with matches has caused fires from which many children have been badly burned and sometimes died.

Never leave a young child playing on a bed near an open window. Children like to see what is going on outside. They have been seriously hurt or even killed by falling out of an open window.

Occasionally it is necessary to bring tools into the house to repair broken things. Take great care to see that dangerous tools such as saws and screwdrivers are NEVER allowed to become toys.

WORD MEANINGS

- **SERIOUSLY:** Badly.

OCCASIONALLY: Not often.

- **REPAIR:** Make good or mend.

Clean food prevents disease

GASTRO-ENTERITIS is an infection of the intestinal tract (gut). The symptoms are soft watery stools which may contain blood or slime, cramping pains in the stomach, vomiting and sometimes a fever. The younger the child with gastro-enteritis, the more serious is the disease. It is also more serious in underfed children.

The symbol of the Department of Health.

The child loses water and body salts in the vomit and large liquid stools. If this fluid is not replaced the child becomes very ill and may die. When these symptoms develop, especially if the eyes look sunken, the child must be taken to the hospital immediately.

The doctor may have to give special fluids into the blood if the vomiting continues. Diarrhoea (many watery stools) and vomiting are seen with other illnesses such as kwashiorkor (badly fed children), measles, and infections of different parts of the body.

The child should always be taken to the hospital when these symptoms occur so that the doctor or nurse can find out what is the cause.

Gastro-enteritis is caused by germs which are eaten with dirty food. The germs are spread by flies, dirty hands, dirty water and dirty feeding bottles or teats. The infection can be spread to babies by other children or adults.

To prevent this disease the house must be kept clean and insects kept off the food. Hands must be washed after visiting the toilet, after changing nappies and before making or giving food to the family.

Gastro-enteritis is uncommon in breast fed babies because breast milk is the best food and is germ free. Therefore all babies should be breast fed for as long as possible.

If the baby is bottle fed the feeds must be prepared with boiled water and all the equipment kept clean.

By keeping the food clean a mother can reduce the risk of gastroenteritis in her family.

Next week the subject will be Tuberculosis Part I.

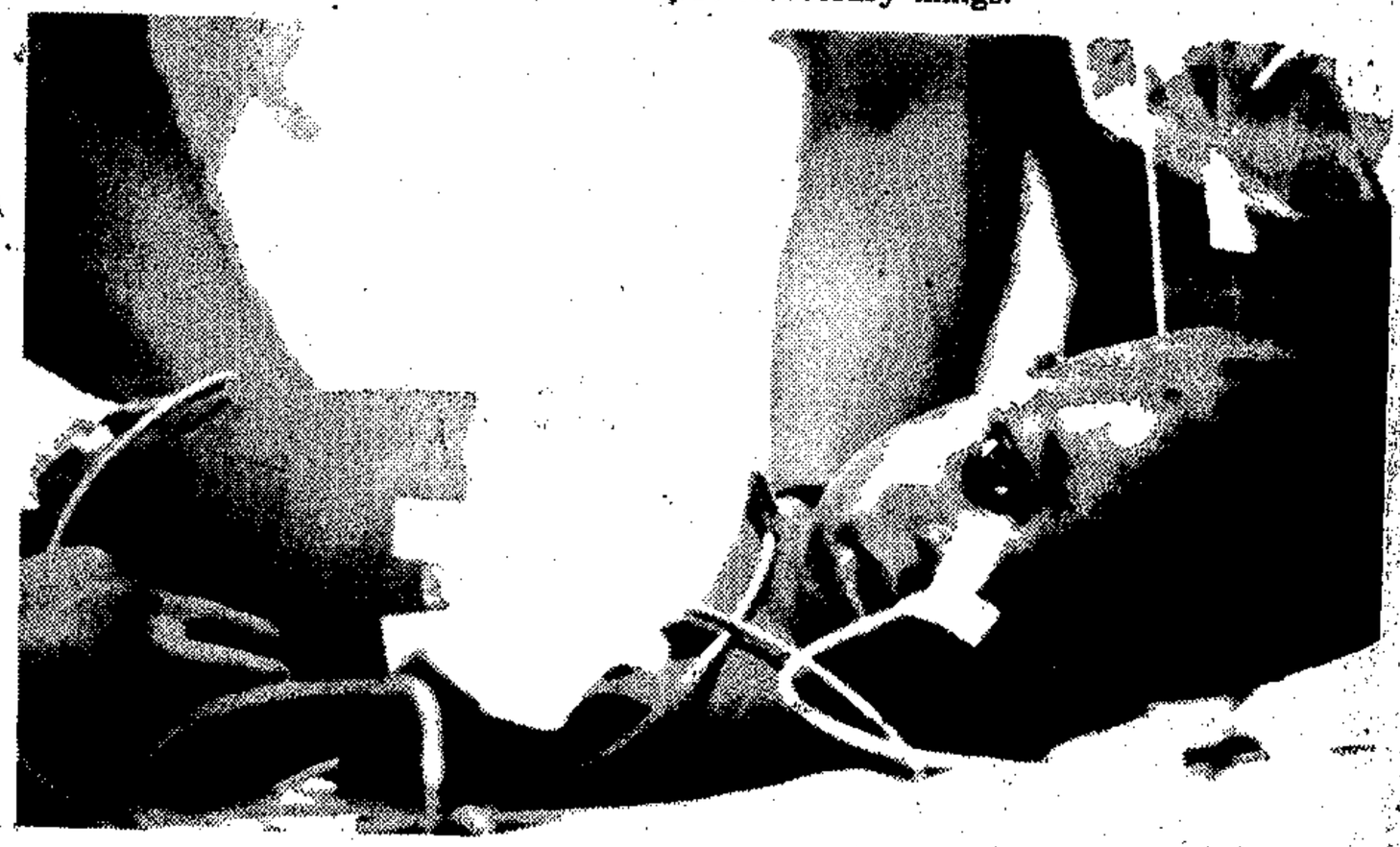
WORD MEANINGS:

- **STOOLS:** Waste matter thrown out of the body from the bowels.
- **SLIME:** Sticky fluid.

VOMITING: Bring up food from the stomach.
SERIOUS: Not slight.

- **DEVELOP:** Start to happen.

SUNKEN: Set deeper (in the head) than is usual.
GERMS: Tiny living organisms causing disease.
TEATS: Rubber top on a baby's feeding bottle.
INSECTS: Small creatures, e.g. beetles, ants and bees.
EQUIPMENT: Necessary things.



A child being treated for gastro-enteritis in hospital

Conclusion

The paper has argued that Botswana can afford and would benefit from a more organic, more experimental, more locally determined approach to rural development than the apparent inappropriate drive for greater precision. The two proposals used as examples of such an approach, the upgrading of the traditional rights to graze to a right over communal land under a communal land company concept and a regular employment guarantee scheme, are both wonderful laborato[ry] [for] improve budgetary rules, local government capacit[y] [re]lations, individual and group security and initi[ative]. At the same time they are effective instruments fo[r] [t]or the management of common assets and for the provi[sion] [st]ructure.

Wool Board Administration
Board in Mamlhlope Hos-
tel moved.
The families are among
the more than 100
moved to the hostel after
their houses were des-
troyed or damaged by
floods two years ago.
Their plight is under-
lined by the inability of
Wrab to do anything to
help because of an acute
shortage of funds.
The families are housed
in hostel rooms built for
single men and they are
paying up to R7 a month
for each occupied bed.
Toilets, bath[rooms] and
many [other] facilities
are shared.
Wrab Chairman Mr [illegible]
said there was a
strong [illegible] with any health
[illegible] welfare offi-
cer [illegible] at the hostel
[illegible] looked after the
[illegible] of the people.
Dr [illegible] Black doctors worried
by conditions in the hos-
tel are changing together
to plead to the malnutri-
tion which has been
found among children
[illegible] two years ago.
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For children under 16
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hostel.

Doctors
move to
aid hostel
families

Sewerage and
poverty are hampering
the health of scores of
families housed by the
Wool Board Administration
Board in Mamlhlope Hos-

committees and were employing 16 625 [illegible] the following sectors of the economy:

TABLE 3

Sector	Industria[illegible] of [illegible] / Number of [illegible]
Manufacturing	
Services	
Commerce	

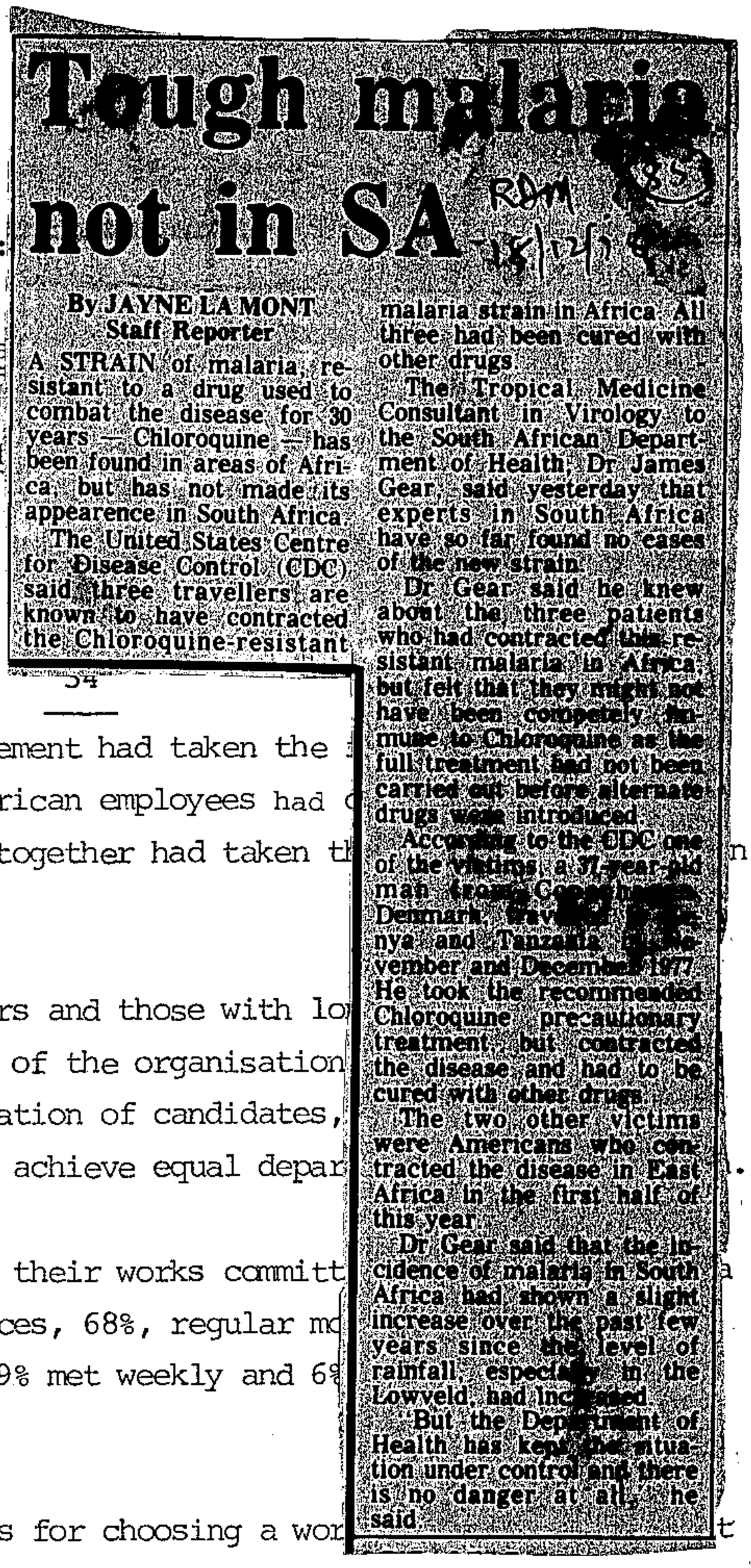
In fifteen organisations (44%) management had taken the [illegible] establishing the committee, while African employees had [illegible] (15%), and management and employees together had taken th[illegible] (41%).

There was a tendency for older workers and those with lo[illegible] elected to these committees: in 80% of the organisation[illegible] restrictions whatsoever on the nomination of candidates, [illegible] were certain requirements, mainly to achieve equal depar[illegible].

82% of the respondents reported that their works committ[illegible] period of one year. In most instances, 68%, regular mo[illegible] meetings were held, while a further 9% met weekly and 6[illegible] intervals.

The most frequently mentioned reasons for choosing a wor[illegible]t they were more effective than liaison committees, that they were more representative and acceptable to African workers, and that the workers preferred them.

In 1973 only three co-ordinating works committees[39] had been established.



Tough malaria not in SA

By JAYNE LA MONT
Staff Reporter

A STRAIN of malaria, resistant to a drug used to combat the disease for 30 years — Chloroquine — has been found in areas of Africa, but has not made its appearence in South Africa.

The United States Centre for Disease Control (CDC) said three travellers are known to have contracted the Chloroquine-resistant malaria strain in Africa. All three had been cured with other drugs.

The Tropical Medicine Consultant in Virology to the South African Department of Health, Dr James Gear, said yesterday that experts in South Africa have so far found no cases of the new strain.

Dr Gear said he knew about the three patients who had contracted this resistant malaria in Africa, but felt that they might not have been competely immune to Chloroquine as the full treatment had not been carried out before alternate drugs were introduced.

According to the CDC one of the victims, a 37-year-old man from [illegible] Denmark, was [illegible] nya and Tanzania [illegible] vember and December 1977. He took the recommended Chloroquine precautionary treatment, but contracted the disease and had to be cured with other drugs.

The two other victims were Americans who contracted the disease in East Africa in the first half of this year.

Dr Gear said that the incidence of malaria in South Africa had shown a slight increase over the past few years since the level of rainfall, especially in the Lowveld, had increased.

"But the Department of Health has kept the situation under control and there is no danger at all," he said.

Recognition of African Trade Unions

The Verster investigation indicated that while the majority of participating organisations with liaison committees (56%) were opposed to the recognition of African trade unions, the majority of those with works committees (68%) were in favour of recognising them.[40]

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37. Op.cit. pp.91-4.
38. Ibid, pp.97-101.
39. Hansard 3 columns 160-1, 22 August 1973.
40. Op.cit. pp.66-8, 108.

find out

how your clinic can help you

MANY people do not know what a clinic can do for them. We hope to give them some idea of the clinic's functions.

Large areas will have one or more fixed clinics, while smaller towns may have a mobile clinic (a travelling van) which visits them on particular days of the week.

Some villagers in the country may have to travel to the clinic in a nearby village.

It is the duty of each person in the community to find out where the clinic is, when it is open, who works at the clinic and what services they supply.

Information about clinics can be obtained from the local authority, and from the hospital in the area.

The clinics are usually run by nursing sisters, assistants and health workers who make up the health team. This team is advised by a doctor who visits the clinic on particular days to see the patients whom the sister sends to him.

The clinic staff provides a comprehensive service, that is, they help prevent [illegible] ill-

[illegible] homes to make sure that sick people are getting better and to remind them about the clinic.

An important service is the "mother-and-child" clinics. Pregnant women are cared for and taught about breast-feeding and child care. Young children are weighed and measured often to make sure that they are developing well, physically and mentally.

Immunisation (vaccination) protects the children from "killer" diseases like diphtheria, measles and TB.

Some clinics have maternity nurses who help with births at home. For those women who want to plan their families and have healthy, well-spaced children, the clinics provide advice on family planning.

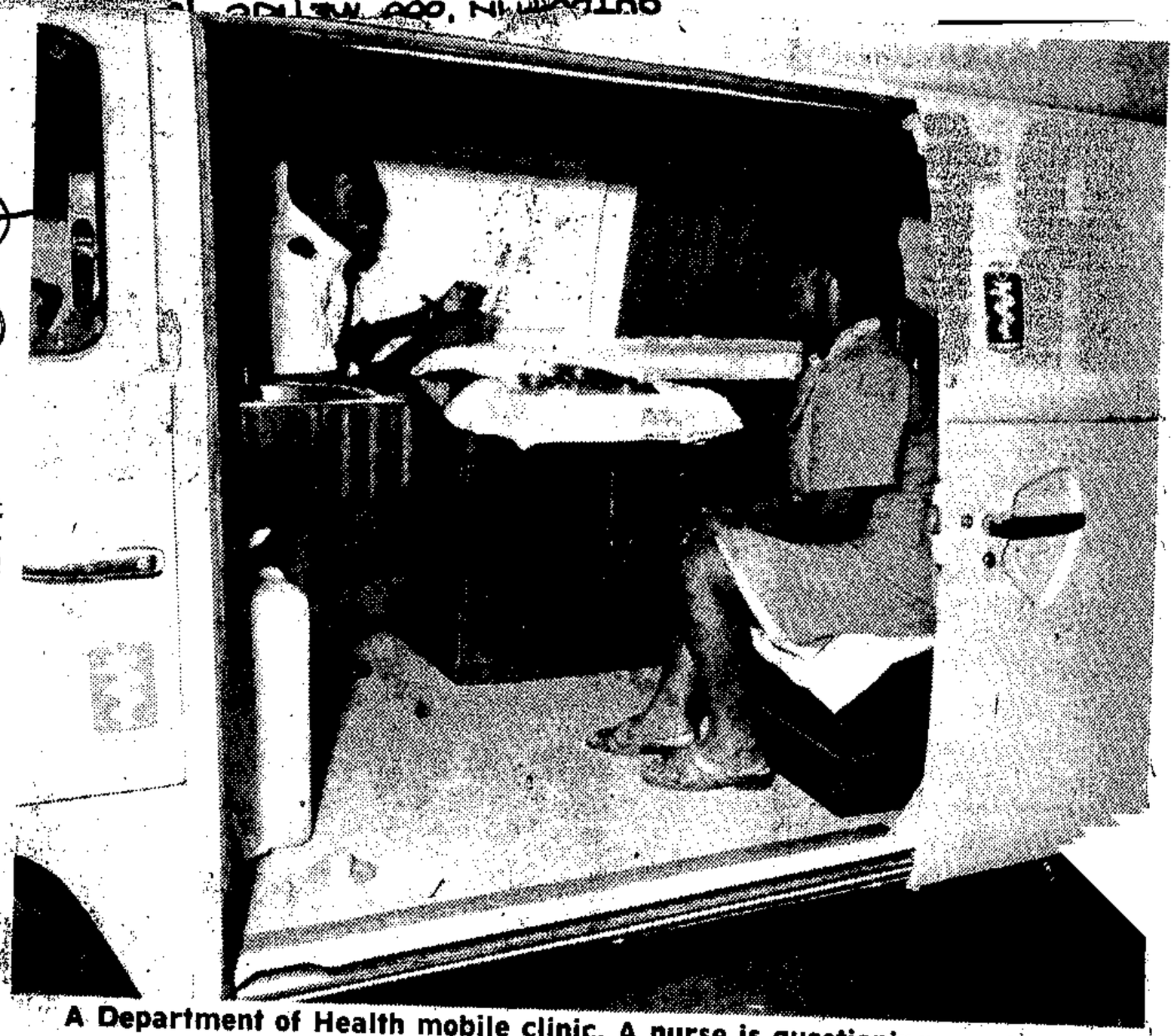
Clinics give treatment for minor ailments and injuries and treat or follow up patients with TB and venereal disease.

Some clinics give dental care and the nurse can give advice about other health problems. Many of the services are free.

WORD MEANI[illegible]

duty: What o[illegible] o[illegible]

[illegible] as important.



A Department of Health mobile clinic. A nurse is questioning a patient

Lesotho may soon become abortion refuge for SA women

Weekend Argus 23/12/78.

185

Weekend Argus Correspondent

JOHANNESBURG. — South African women might soon be able to drive to Lesotho for a legal abortion, according to the country's Medical Association.

The association is campaigning for a revision of Lesotho's abortion laws and wants to introduce abortion on demand during the first three months of pregnancy.

If the plan succeeds — and the indications are that it will — it will create serious problems for the country's small medical service if hundreds of South Africans flock to Lesotho for abortions.

And doctors registered in South Africa will not be able to go to Lesotho to do operations which are illegal in this country, said a local authority.

The secretary of the Lesotho Medical Association, Dr Mercy Mlotywa, said: 'No final decision has been taken about legalising abortion on demand. We are to discuss the matter in January.

'If the majority of doctors agree with our plan, we will try to have the law changed,' she said.

The association plans to introduce a system with three categories.

During the first three months abortion will be obtainable on demand. From the third to the sixth month of pregnancy abortion will only be possible if the mental or physical health of the mother is endangered.

Abortion will not be allowed during the last three months of pregnancy unless the physical health of the mother is in danger or it is likely a deformed child will be born unless the abortion is performed.

It is understood the new plan has the support of many Lesotho doctors and leading members of the Lesotho Medical Council.

CLASSICAL AS[S]OCIATION OF SOUTH AFRICA — VERENIGING VAN SUID AFRIKA

All members[hip] of the Association are hereby notified that the ANNUAL GENERAL MEETING which will be held on Wed[nesday] 6th September 1978 at 1.10 p.m. in the Michaelis Building (Room 114), Unive[rsity of Cape Town, Rondebosch] will be fol[lowed by a lecture. Business of this business meeting

Profess[or Dr. Ernst Gombrich, Director of the Warburg Institute, London, and Slade Professor of Fine Art, Oxford, and Visiting Professor, Michaelis School of Fine Art, U.C.T. will be in CAPE TOWN AND JOHANNESBURG (illustrated by slides)

Professor D[r. Gombrich was born in Vienna but moved to the Michaelis School where he won renown for his lectures on the history of art, and became Director of the School in 1971. Under his leadership the School has been vibrant with new activities.

AGENDA for the AGM/SAKELYS vir die Algemene Jaarvergadering

1. Personalia
2. Minutes of the AGM held on 7th September 1977/Notule van die Jaarvergadering van 7 September.
3. Chairman's report/Verslag van die Voorsitter.
4. Matters arising from the Minutes and Chairman's Report/ Sake wat van die Notule en Voorsitter se Verslag voortspruit.
5. Financial statement for the year ended 10th September 1978/ Finansiële verslag vir die jaar geëindig 10 September.
6. Motion: The Western Cape Branch requests the chairman of the Classical Association to transmit to the biennial conference of the Association the proposal that the portion of the subscription remitted to the local branches for each registered member should be increased from 50 cents to R1.

   Proposed: J.E. Atkinson; Seconded: Mr. J. Sang.
7. Election of office bearers and committee members for 1978-9/ Verkiesing van ampsdraers en komiteelede vir 1978-9.

   Huidige lede: Voorsitter/Chairman: John E. Atkinson
   Sekretaris/Tesourier//Secretary/Treasurer: Mr. J. Sang
   (Vice: Miss P. le Roux)

   Sekretarisse vir die Skole/ Schools' Secretary: Miss B. Keeson
   (not available for reelection)

   Committee members: Dr. S. Bruwer, Mrs. M. Mezzabotta, Mr. Thom Mr. P. Collins, Miss S. Armstrong, Dr. R. van Stekelenberg.

   Coopted members: Mej. D.J. Blokbergen, and student representatives from U.S., U.W.C. and U.C.T., namely Messrs. M. Sahd and C. Yon and Miss J. Frater.
8. Any other business/Algemeen.

J. Sang.
Department of Classics, U.C.T.
Phone: 698531 Extn. 213.

Health

General

85

2 . 3 . 79

12 . 12 . 79

Persons poisoned by poisons used for agricultural purposes

Hansard 3(96) 20/2174

8. Mr. N. B. WOOD asked the Minister of Health:

(85)

(1) How many persons (a) died and (b) were admitted to hospital as a result of poisoning by poisons used for agricultural purposes during the last 12 months for which figures are available;

(2) in respect of what dates are these figures given.

The MINISTER OF HEALTH:

(1) (a) 21.

(b) 73.

(2) 1 January 1978 to 31 December 1978.

3

For written reply:

Salary scales for doctors/dentists/pharmacists

23/2/79 Hansard 3 169

17. Mr. N. B. WOOD asked the Minister of the Interior and Immigration:

(a) to (d) What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Black (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services.

The MINISTER OF THE INTERIOR AND IMMIGRATION:

Rank	Salary scale (R per annum) White	Coloured/ Indian	Black
(i) Specialists			
Chief Specialist/Professor	17 490 (fixed)	14 850 (fixed)	12 870 (fixed)
Principal Specialist	16 170 (fixed)	13 530 (fixed)	11 910 (fixed)
Senior Specialist	14 850 (fixed)	12 390 (fixed)	10 950 (fixed)
Specialist	14 190 (fixed)	11 910 (fixed)	10 560 (fixed)
(ii) Medical Officers			
Chief Medical officer	14 850 (fixed)	12 390 (fixed)	10 950 (fixed)
Principal Medical officer	14 190 (fixed)	11 910 (fixed)	10 560 (fixed)
Medical officer	8 610 × 390–10 950 × 480–12 870	7 440 × 390–10 950–11 430	6 630 × 270–7 440 × 390–10 170
(iii) Dentists: As in respect of Medical Officers.			
(iv) Pharmacists			
	White	Coloured/ Indian	Black
Chief Pharmacist	10 950 × 480–12 870	9 390 × 390–10 950	7 830 × 390–9 390
Senior Pharmacist	8 610 × 390–10 560	7 170–7 440 × 390–9 000	6 090 × 270–7 440
Pharmacist	6 090 × 270–7 440 × 390–8 220	5 010 × 270–6 900	4 110 × 180–5 010 × 270–5 820

The above-mentioned scales do not include allowances payable to the personnel.

HEALTH YEAR

A sick society

(85) FM 2/3/79

The problems of disease are inseparable from those of society. Nowhere is this more true than in SA — Harry Seftel, Professor of African Diseases, University of the Witwatersrand.

Indeed, as a close look at the vital statistics reveals, the relationship between ways of living and ways of dying in SA is stark. While medical technology churns out intricate and expensive cures, the real solution may lie in improved socio-economic conditions.

The link between health and wealth is most striking when infant mortality rates are compared. There were only 18,5 deaths per 1 000 white infants under the age of one in 1976. This compares well with the best figures in the world — the US recorded 16,4 infant deaths per 1 000 that year.

For black babies, life is far more hazardous. Infant mortality among coloured people, according to Department of Statistics figures, was 112,2 per 1 000 in 1976, more than six times that of whites.

African figures are just as high. In the 1970 census, the African infant mortality rate was 123,9 per 1 000. This actually represents an increase from 101,2 in 1960. More recent figures are problematic; accurate data are only kept for selected magisterial districts, covering 3,4m Africans in 1976, when the figure was down to 100,2.

Department of Health epidemiologist Horst Kustner puts the African infant mortality rate somewhere in a wide range between 80 and 120. He adds, however, that it is dicey to compare white and black figures, since although all African infant deaths must be registered, not all births are.

Peter Bundred, senior lecturer in Community Medicine at UCT, estimated recently that infant mortality among rural Xhosa in Transkei is a shocking 282 per 1 000. (India's figure was 122 in 1973, Thailand's as low as 26.)

Whatever the exact figure, the discrepancy between white and black infant mortality rates is undeniable. The causes are clear. Census data show that over half of African infant deaths in 1970 were caused by enteritis and pneumonia, neither of which represents a grave danger for a well-nourished baby. But to a child whose resistance has been corroded by poor diet and living conditions, both are highly likely to prove fatal.

Surprising killer

Nor have conditions changed significantly over the past four decades. The Department of Statistics' Report on Deaths points out that there has been no improvement in mortality figures from enteritis and diarrhoea for coloured people since 1937.

One surprising and totally avoidable killer is measles. Even among white children, says paediatrician Max Klein, the risk of dying from measles is 30 times greater than in the US. The solution is fairly simple — a measles vaccine. In the US, measles vaccination sliced mortality from 40 000 deaths in 1960 to a mere 30 in 1976. The campaign in SA has been less effective; doctors and the authorities disagree on why.

Better living standards have protected whites from many disease hazards facing the poorer classes. But the good life has its own risks, chiefly heart disease.

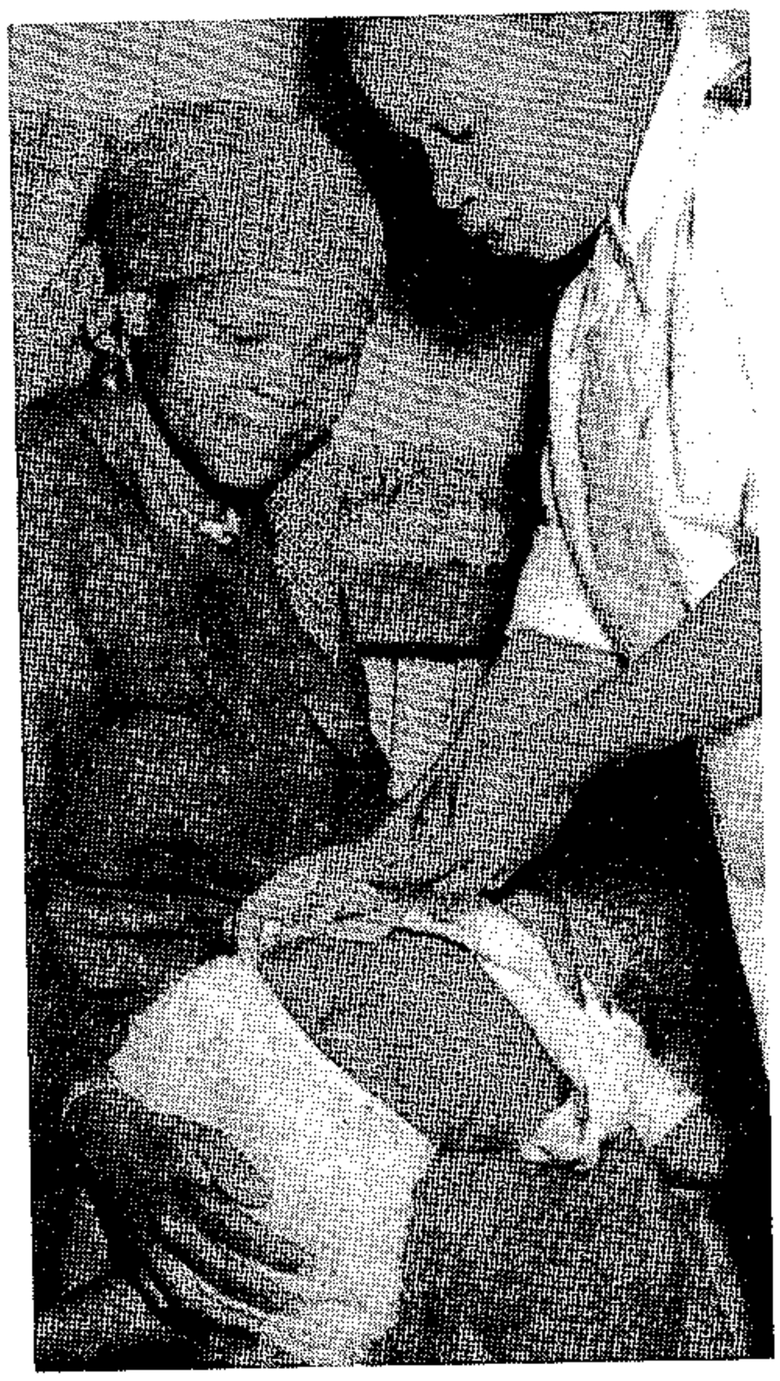
In 1976, over 25% of all white deaths were caused by coronary thrombosis. Most alarming is the incidence of heart disease in young white males. Epidemiologist Cyril Wyndham pointed out recently in the *SA Medical Journal* that SA white males between the ages of 25 and 34 in 1970 were seven times more likely to suffer from heart disease than their Swedish counterparts. The danger to South Africans is 2,5 times greater than even their fast-living American coevals.

The flood of joggers on to the streets may be having an effect. Wyndham shows that the incidence has dipped slightly since 1970.

Many medical authorities attribute the high incidence of heart disease to Western lifestyles, in particular smoking, obesity, hypertension, and a sedentary way of life. Seftel refers to Western man's "unnatural gastronomic extravaganza," and his "dietary intoxication." Also on the upsurge is cancer, which caused 15,6% of all white deaths in 1976.

An interesting side-effect of better health among whites is that the percentage of whites over 65 has nearly doubled over the past 50 years, reaching 6,7% in 1970. In a number of countries, people over 65 account for over half the requirements of hospital bed and long term care facilities.

The disease pattern emerging from the statistics is clear. But health planning scarcely tallies. The Secretary for Health,



Help at Bara . . . but what when she gets home?

Jan de Beer, has said that the ultimate purpose of health services is to meet the health needs of the total population.

Yet Johannesburg, despite its 15 private nursing homes and three provincial hospitals, has just been endowed with a new R156m General Hospital. This despite the average bed occupancy in 1976 of only 69% in the old General Hospital, a drop of 4% from the 1973-74 figure.

The old General Hospital was, to be sure, in poor condition. But neighbouring Soweto has only the 2 500-bed Baragwanath Hospital, plus a trickle of patients treated in the 233 beds of Johannesburg's Non-European Hospital. In deciding to build the new General, was the Transvaal administration motivated purely by medical considerations, or did it want to emulate the Cape's medical showpiece at Tygerberg?

Worse off

Rural areas are even worse off. Bundred points out that while urban areas have one general practitioner to every 2 000 people, in rural areas the doctor/population ratio is one to 10 000. "Many deaths in rural areas could be prevented at low cost, yet 98% of the medical budget is spent on curative services, usually supplied to the urban elite at high cost."

There were 58,9 registered nurses per 10 000 whites in 1975, against 9,2 for Africans and only 5,8 for Asians.

More hospitals and doctors would, however, go only some of the way towards solving the problems. Hundreds of malnourished babies are helped back to health at Baragwanath Hospital only to go home to the same conditions that precipitated their malnutrition.

The key, community health doctors point out, lies in the old adage that prevention is better than cure. Better education and adequate inoculation are essential. Studies have shown that many illnesses begin to disappear even before new therapies are introduced to remedy them, simply because of improved standards of living.

Health planning should be better balanced with the incidence of disease. Some medical establishments are obsessed with expensive treatment of uncommon, and sometimes almost incurable diseases, while little is spent on highly preventable diseases widespread among blacks.

Another proposed solution is the Chinese precedent of "barefoot doctors," villagers trained to meet rudimentary health needs of rural Chinese. The SA version would involve highly skilled nurses, trained to examine patients, treat common conditions, and refer serious cases to doctors. About 80% of all patients can be handled by primary health care nurses alone. The idea has been implemented to a limited extent in Soweto.

The focus of National Health Year is on greater public involvement in promoting health. De Beer has spoken of the need for a better balance between hospital and community-based services, and his department has taken tentative steps in that direction. But health authorities need to go much further if they are really to ensure a healthy society.

DEPARTMENT CULTURAL HIST[illegible]PE 1979

LECTURE SCHEME 1st [illegible]

E	26th Feb.		Man [illegible]	-religious problems; social structure
L	27th "		Mesop[illegible]	& socio-economic struct. religion,
S	28th "		Mesop[illegible]	rature
E	1st March		Egypt[illegible]	
	2nd "	T		
E	5th "		Anato[illegible]	s
L	6th "		Aegea[illegible]	cultures) Myceneans
S	7th "		Troy	be handed in 2nd April)
	8th "		[illegible]PPEAL	
E			Greece	onication) from Dorians to archaic
			period	
L			reece	& archaic art
S			trusc	
E			reece	theon
				.
E			reece	losophy & Solon & Democracy &
			itera	ht.
L			he Pe	to the Greeks - wars & culture
S			reece	5th c.
E			Greece	Literature, Rhetoric, Historiogr.
	23rd "	T		
E	26th "		Alexan	are, reformations & Seleucids
L	27th "		Socrat	le
S	28th "		Helleni	
E	29th "	Test	The las	uscans (600) beginnings of Rome
			till th	e 400 B.C.
	30th "	T		
E	2nd April		Roman [illegible]	riata, the Civis, legions, nobility,
			Punic w	the east
L	3rd "		Roman c	ch of Caesar
			Helleni	hilosophy
S	4th "		Celts	
E	5th "		The Rom	e archaic period 250 - 80
				classical " 80 - 14 A.D.
				imperial " 14 A.D. - 300 A.D.
	6th "	T2		

TO GO AHEAD

The City Council decided at last week's meeting to go ahead with the scheme.

The matter came up late in the afternoon, when a third of the council members had already left the meeting. Voting was 11 in favour of going ahead with the scheme and 11 in favour of carry-

"There are many factors to be taken into consideration including the possibility, suggested by authorities at the University of Cape Town, that the council may be spending a great deal of the ratepayers' money to create a health hazard.

This would be put to the association at its annual meeting, when members would decide which solution they favoured.

"This is a very serious decision which the city fathers are called on to make," he said.

It was also a fact that some local residents were worried at the prospect of losing sportsfields and possibly part of the golf course if a sewer works was built.

Mr Joubert said he had been very concerned to read in The Argus that authorities at the University of Cape Town thought the new outfall was a potential health hazard.

HEALTH FACTOR

In an interview, Mr Joubert criticised Sea Point representative, Mr J S Rabinowitz, for telling the council at its last meeting that the association was not in favour of a sewer works on Green Point Common.

He said the association had appointed a committee, on which two doctors were serving, to look into the matter and was still awaiting its final report.

Municipal Reporter

Further study on plan urged

GREEN and Sea Point Ratepayers' and Residents' Association wants further investigation to be carried out before the City Council starts work on a R6,2-million scheme to build a sewer outfall, Mr Chris Joubert, the chairman of the association, said today.

In an interview, Mr Joubert criticised Sea Point representative, Mr J S Rabinowitz, for telling the council at its last meeting that the association was not in favour of a sewer works on Green Point Common.

He said the association had appointed a committee, on which two doctors were serving, to look into the matter and was still awaiting its final report.

The Department of Water Affairs and Department of Health have given the City Council permission to go ahead and build a new outfall pipe at Green Point after "exhaustive research carried out by the University of Cape Town and the Council for Scientific and Industrial Research".

ENGINEER'S VIEW

Cape Town's City Engineer, Mr J G Brand said today that raw sewage has been dumped into the sea at Green Point for the past 300 years.

The Mayor, Mr Ted Mauerberger, who is a Sea Point representative, used his casting vote in favour of the outfall scheme.

Hansard 6 Quest Col. 414

KC/3/79

85

Research on accumulation of lead in animal/human tissue

*19. Mr. N. E. WOOD asked the Minister of Health:

Whether there has been any research in the Republic on the accumulation of lead in animal and human tissue; if so, what are the results.

†The MINISTER OF HEALTH:

No research *per se* has been undertaken in the Republic. Dr. E. R. Steyn wrote a scientific review on the problem. The National Research Institute for Occupational Diseases performed a very limited survey of the lead content in the blood of children at the Baragwanath and Coronation Hospitals in order to obtain data about the normal levels of lead in blood. The Institute also renders a monitoring service to industry which incorporates the determination of the lead content in the blood of exposed employees in order to enable industry to take the necessary steps to safeguard the health of such employees.

Hansard 6 Quest Col - 426

85

14/3/79

Malaria

231. Mr. N. B. WOOD to ask the Minister of Health:

(a) How many cases of malaria were reported in the Republic in the last 12 months for which figures are available and (b) how does this figure compare with that for the previous period of 12 months.

The MINISTER OF HEALTH:

(a) 6 125.

(b) 3 512.

were not abated by the various politico-economic crises which forced down real wages in Rhodesia in the 1906-39 period : e.g. the agricultural product price slump in 1923-4 and the agrarian labour supply crisis in 1924-28, the Great Depression of 1929-33, the effect of the Maize Control Act (1931) on peasant production and a continuous process of involution in the peasant economy throughout the period. 3/

By 1933 the R.N.L.B. ceased to function. The inflow of
workers was sufficient to meet most employer demands at
pre-Depression wages. In 1934, however, W.N.L.A. negc
establishment of a depot in Salisbury for the purpose c
recruitment in its non-Southern Rhodesian 'tropical' ca
Another Agreement in 1939 gave W.N.L.A. facilities for
roads, stations and rest camps in exchange for an unde
would not attest contractees from Southern Rhodesia. 4/
Manager of W.N.L.A.'s Tropical Division (W. Gemmill) mo
in 1940. Stations were set up at Msasa (Salisbury), B
Wankie and Inyazura. The Rhodesian railway network w
to transport recruitees in and out of South Africa and
were also established en route. To some extent these
with a similar network established by Ulere (a Cewa te
the free migrant labour transport service operated by
Rhodesian government from 1938-58 in the two Rhodesias
But because the latter network operated in a distincti
catchment area, direct competition with W.N.L.A. was m

Despite having to acquiesce to a 'labour market-sharin
primarily founded upon the political power of Southern
in excluding W.N.L.A. from 'their domain' - W.N.L.A. w
substantially its recruitment of 'Tropicals' (those wo
North of Latitude 22°S.), from 3 000 (1,1 percent of t
black labour force) in 1936 to 32 000 (10,6 percent) i

At this stage (circa 1936-) W.N.L.A.'s preoccupation i
was with recruitment in Barotseland and Nyasaland, a r
having been obtained for the latter which by 1939 all
take-off of 10 000 contractees. 7/ In this area Southern Rhodesian
and W.N.L.A. interests clashed strongly and were 'resolved' through
open competition. The Southern Province of Nyasaland was a prime
source of 'free flow' labour to Rhodesia. In a challenge to W.N.L.A.
/ intrusion .....

NOTES

1/ For historical perspectives see G. Arrighi, Labour Supplies in Historical Perspective, Journal of Development Studies, 6, 3, 1970: Charles van Onselen, Chibaro, Pluto Press, 1976: Peter Scott, Migrant Labour in Southern Rhodesia, Geographical Review, vol. 44, 1954: and D.G. Clarke, Contract Workers and Underdevelopment in Rhodesia, Mambo Press, Gwelo, 1974.

2/ Data for the period up to 1933 are drawn from Charles van Onselen, Op. cit.

3/ On these issues see G. Arrighi, op cit; M.C. Steele, The African Agricultural Labour Supply Crisis 1924-1928, Labour Research Seminar [illegible] of Rhodesia, 1973 (mimeo)

Spinal injection kills pain of childbirth

By Marais Malan, Science Editor

The Baragwanath Maternity Hospital has built up one of the biggest series in South Africa of the controversial "spinal injection" to kill the pain of childbirth. And the doctors are thrilled with the results.

The procedure is technically known as epidural anaesthesia. The patient remains fully conscious and last year about 250 caesarean sections were done with epidural as the only anaesthesia.

An advantage in normal childbirth is that while pain in the womb is blocked, motor function is retained and contractions are not impaired.

Backbone

In addition, babies are less affected by the anaesthetic agent than with inhalation anaesthetics and are therefore in better condition after birth.

The injection, which is given into the space which separates the backbone from the spinal cord, is almost painless.

"The method has come into use in South Africa only in the past 10 years or so," explained a senior obstetrician at the hospital.

It is being used in about 15 to 20 percent of births, but the patients are carefully selected.

The most common use is in women who have or develop chronic high blood pressure as a complication of the pregnancy or labour. Usually it succeeds in bringing down the blood pressure.

Belief

The second is severe pain, particularly in women who give birth to their first baby.

Although there was a common belief that black women had a small and sometimes slightly deformed pelvis which might make birth difficult and painful. In such cases epidural anaesthesia was ideal.

The method was also indicated in a host of other conditions. Out of a total of nearly 3 000 epidurals given last year, 74 were for twin deliveries, 43 for premature delivery and 142 for breech deliveries.

Bonding

It was used when forceps delivery was necessary and in 51 cases when the mother suffered from heart disease and as much strain as possible had to be kept off the heart.

The obstetrician said he liked doing a caesarean under epidural because it allowed the mother to see her baby born and to hold it immediately afterwards. This helped mother-baby bonding, he said.

Usually the mother experienced nothing but a little discomfort during the operation, but she had to be mentally prepared beforehand so that she knew what was going to happen.

"I am impressed with the safety and efficacy of epidural anaesthesia," the obstetrician said.

Journal of Economics, 4[illegible]

17/ Roger Leys, op. cit.

18/ ....

we had not unsaddled The only course was to retire to the shelter of the kopje en to the front to lie down and try ıld see, but they only fired a f including myself, led our hor face rather a hot fire though i ght sides that faced it. We had or the greater part of the way ov

Soon afterwards th red. They started at a trot t canter so young Seymour, who was in command of the Squadron, ordered them to walk. The Carabiniers and I were safe behind rocks by this time, so we could watch them. To our amusement we heard the Sergeant-Major roar out 'dress back on the left' when they were walking across. It was a good instance of the power of discipline to see the men so obedient under such fire.

We soon learned that the firing was caused by two troops of the Carabiniers going down to water their horses. The Boers waited patiently hoping that we would try to take the Nek. When the watering party moved off they thought we were all going away and so fired. We estimated that they fired over a thousand rounds as us and yet they only hit one horse. The

Hansard 13 (814) 9/5/74 85

Abortions

727. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

(1) How many abortions in accordance with the provisions of section 3 of the Abortion and Sterilization Act were carried out during the period 1 January to 31 December 1977 and 1978, respectively, on (a) married and (b) unmarried women in each race group who were (i) under 14 years, (ii) 14 to 18 years, (iii) 18 to 25 years, (iv) 25 to 35 and (v) over 35 years of age;

(2) how many of these abortions in each case were procured in terms of paragraphs (a), (b), (c), and (d), respectively, of section 3 (1) of the Act.

The MINISTER OF HEALTH:

(1) and (2) See annexures 7 and 8 of the Department's annual reports for 1977 and 1978, respectively.

Millions wasted as medicines go down the drain

Bevis Fairbrother

AT LEAST R56-million worth of prescribed medicines are washed down the drain annually in South Africa, a Mercury investigation has revealed.

The White population was responsible for almost half of this figure in spite of there being 13 078 000 more Blacks than Whites in South Africa, according to the latest population figures released by the Department of Statistics.

The majority of a cross-section of the public interviewed over the past few weeks admitted to wasting a third of the medicines prescribed to them.

Medical aid societies estimated the average family spent about R8 a month on medicines.

From these facts, coupled with a survey by the Johannesburg General Hospital that 70 percent of their patients did not "comply sufficiently as per instruction" on prescriptions, and a White population figure of 4 408 000. the Mercury estimated Whites wasted almost R25-million worth of medicines.

Inquiry

The Steenkamp Commission of Inquiry into the pharmaceutical industry released its findings in January 1978. It claimed the consumer spent R240-million on prescribed medicines annually.

Professor Harry Grant-Whyte a Durban expert on drugs, said medical practitioners were largely to blame for the situation as they prescribed more than was needed.

Professor Grant-Whyte suggested that prescriptions be in triplicate to control the situation.

One copy would be for the pharmacist, one retained by the doctor and the third posted to a central department to be processed.

Control

"This will be the first step in controlling irrational, injudicious prescribing of excessive quantities of drugs, especially sedatives and tranquillisers.

"Certain patients should be counselled and given placebos and be monitored rather than subjected to vast amounts of medicines," said Professor Grant-Whyte.

Other doctors blamed patients for the "staggering" wastage figure.

"Patients sometimes feel better prematurely and do not complete a prescribed course of medicine. A large amount is thrown away and then they return shortly afterwards for more medicine for the same complaint," said one doctor.

Background

112 out of 1000 black babes die

8S
15/5/79
Argus

CONCERN at the high black and coloured infant mortality rate in South Africa — but with the promise of a steadily improving situation — has been expressed by the State Health Department and child health authorities.

Figures just published show the rate for coloured and black to be seven times higher that that of whites in the birth-to-one-year age group, and 13 times higher in the one-to-four-year group.

Dr Howard Botha, Director of Strategic Planning for the Health Department, said it was accepted that many of these deaths were preventable. That was why the department was concentrating on community medicine — bringing primary health care to as large a section of the population as possible.

'As yet primary health care and our health education programmes do not reach everyone. But this is the direction in which we are working within the limitations of available funds.

'Adequate immunisation against some of the infectious diseases will already make a great difference. For example measles predisposes towards gastro enteritis and pneumonia — some of the main baby killers.

'Subcommittees of community leaders already exist to deal with various aspects of child health, including infant mortality.

'We are also reviewing our hospital building programme, with the possibility that there will be fewer new hospital beds but more mobile health services, clinics and day hospitals which can bring health care to the people wherever they are.

'There would also be an extension of the role of the primary health care nurse who is proving such a success in Soweto'.

Professor Harry Stein, head of the Paediatric Department at Baragwanath Hospital, said the infant mortality figure of 112 per 1 000 live births for coloured and black (white rate 18) given in an article in the latest SA Medical Journal, did not apply to Soweto.

In 1956 it was 150 in Soweto — in 1977 it had dropped to 42.

In 1956 (population of Soweto estimated at 300 000) 2 400 children were treated at the hospital for gastro enteritis. In 1978 it was 3 261 (population estimate more than a million). In the same period the number of deaths from gastro enteritis dropped from 650 to 53.

The infant mortality rate for black babies is 13 times higher than for whites in the one-to-four-year-old group, reports MARAIS MALAN. But the black infant death rate is decreasing.

'We have a long way to go in Soweto, but a good deal of progress has been made', Professor Stein said.

A prominent paediatrician said it had been shown by studies in Cape Town that there was a close association between the incidence of gastro enteritis and poverty.

Through co-ordination of provincial and local health and community health services the infant mortality rate among the coloured in the area was down to 25,9 per 1 000 live births. In addition, coloured people in Cape Town had better housing, clean water and received higher wages.

He advocated the following measure to curb the high infant mortality rate among coloured and black elsewhere.

- Good ante- and post-natal care.
- Greater support of breast feeding and family spacing. So that the small child can get better maternal care.
- A comprehensive investigation into the problems of the working mother. Maternity allowances should be paid for at least three months after the birth of a baby so that it can receive a good start in life. At present mothers usually take off two months before and one month after the birth.
- There should be more creches for the babies of working mothers and child-minders should be adequately trained.
- The rural mother should be care for while her husband is working in the city.
- There is a need for more pre-school clinics. Subsidies are available but local authorities often do not make use of them.

Young blacks to get vaccine for liver virus

Science Editor

A new vaccine against a virus causing a potentially serious liver disease will soon be used in South Africa on black children in the hope of preventing the development of liver cancer in later life.

This was announced in Johannesburg last night by Professor Michael Kew of the department of medicine at the University of the Witwatersrand, during his inaugural lecture. He specialises in diseases of the liver.

The so-called hepatitis-B virus, which causes an infection of the liver, is now believed to be associated with primary liver cancer. Blacks from certain regions are particularly prone to this form of cancer, which is nearly always fatal within six weeks of diagnosis.

The results of treatment of liver cancer in South African blacks had been dismal, Professor Kew said.

"Clearly when a tumour runs such a rapid course and the results of treatment are so poor, one must direct one's attention to prevention."

Liver cancer had a peculiar geographical distribution which suggested that one or more environmental agent was responsible.

There were two possible culprits. One was a poison, aflatoxin, produced by a mould growing on grain products stored in warm, moist conditions. Studies had shown a direct association between aflatoxin intake and the incidence of liver cancer.

The second was the hepatitis-B virus, which usually caused infection in early life and often persisted in the blood, thus leading to a chronic carrier state.

Southern African blacks had a high incidence of chronic infection with the virus and virtually every liver cancer patient was also a carrier.

If a clinical trial showed that a vaccine against the virus protected against liver cancer it would be proof that the virus was the cause, Professor Kew said.

group could have hived off, and, each group had the potential to act as a nucleus for further expansion, the present model can account for divergent lines of evolution within a tradition.

In the description of the two models used in the present study, it was pointed out that group fission could have resulted from two different processes: (1) social stress as a result of overcrowding, and (2) increased mortality and lowered reproductive fitness due to the scarcity of a particular resource. Group fission would appear to have been associated with social conflict

(Legassick, 1969; Monnig, 1967; Turner, 1954). This association

the results cannot be used as an absolute confirmation of the validity of the discontinuous spread model.

The major problem with the radiocarbon chronology is the small sample size. Only four Silver Leaves sites have been dated and one of these Eiland is a specialised activity area (Evers, 1975). Kwale and Urewe have more dated sites but again samples are very small. In the discontinuous spread model it was suggested that the overall rate of spread would have been faster than the expansion of an individual culture. Therefore, the regression for the overall rate of spread was calculated from the earliest known dates for each culture and this reduced the sample size. It is possible that the sample sizes are so small that they do not reflect the real population of dates. Because of the sample size problem an independent evaluation of the two mechanisms of dispersal is necessary.

The data used in the present study were derived from only one tradition, the flutted and bevelled complex, and therefore the analysis would seem to be tied to the validity of a particular culture-historical reconstruction. While this is true, the rapidity of spread associated with the simulation of the discontinuous spread model would seem to indicate that this is the most likely mechanism of dispersal.

ACKNOWLEDGEMENTS

I would like to thank Professor T.N. Huffman for reading and commenting on the numerous drafts of the paper. Miss C.S. Harcourt helped edit the manuscript and Mrs J. Howard-Tripp typed the final drafts.

I would like to express my special thanks to Dr D.S. Wilson who introduced me to evolutionary ecology and helped to debug the programmes.

Preventive health aid 'insufficient'

(85)
27/7/79
Argus

THE State was not directing enough resources towards preventive health care, Dr T MacCorry, regional manager of the Urban Foundation for the Western Cape, said yesterday.

He was speaking at the 50th annual meeting of the Care Committee for Tuberculosis Patients, held at the City Hall.

Mr MacCorry said 98 percent of the State's Health budget was spent on curative services, and a change of direction was needed.

He said the Urban Foundation's aims was to improve the quality of life for all and among its projects was that of community health.

In Cape Town the foundation had assisted with the formation of the Child Safety Centre at Red Cross Children's Hospital —the first of its kind in the country.

Another project was the dessemination of community health with the help of St John's Ambulance organisation, which was training lay health workers in basics who took their knowledge into the community.

Each trained person visited families to spread the knowledge, and in turn trained others.

He said he felt that to maintain interest the health workers should be paid by the State, even if it were only R20 a month.

The health workers would save the State millions of rands by preaching prevention before cure was necessary.

c) Ander lede:

may (45) Star 11/8/79

Being ill also cost more soon

Science Editor

By the end of the month another cost-of-living blow is expected to fall when the South African Medical and Dental Council meets in Johannesburg to determine a new medical aid tariff for doctors and dentists.

Whatever the outcome, the public covered by medical aid are not likely to have much to rejoice over.

Medical practice in South Africa schemes in South Africa deal with 6 000 to 7 000 practices. Some are solo but many are partnerships, so the number of contracted-out doctors form a clear minority.

The allegations that contracted-out doctors charge up to 100 percent more than the medical aid tariff has been denied by both the Medical Association of South Africa and the manager of a large privately run medical aid scheme.

The true figure has been placed at five to 31 percent, with an overall average of about 22 percent.

Informed sources believe the entire medical aid movement is due for a major rethink. The total cost of health care is still lower here than in most developed countries, but costs are escalating and the public will have to prepare itself for devoting a larger percentage of their income to medical expenses.

A higher tariff may entice some contracted-out doctors back into the medical schemes' fold, but it will have to be substantially higher to have this effect. The result — probably increased medical aid subscriptions.

If the tariff is not high enough, more doctors may contract out, so more patients will have to pay the difference between their medical scheme benefits and the doctors' private tariff.

In either instance health services will cost more.

In spite of beliefs to the contrary, the percentage of contracted-out doctors is not high at the moment. In December the figure was 3 806 out of about 15 000 on the medical register.

Of the 3 806 the medical aid tariff applies only to about 2 000 doctors in pri-

Friends (Quakers) en van die American Friends Service Committee deurgebring. Hy het 'n aantal konferensies in verskillende dele van die land bygewoon, baie vergaderings toegespreek en senior beamptes van die Carnegie Corporation, van Community Relations Services van die Departement van Justisie van die Amerikaanse regering, van die American Friends Service Committee en kollegas verbonde aan verskeie universiteite besoek.

Gedurende Augustus en September het die Direkteur Engeland, Nederland, Switzerland, Swede, Israel en Zambië besoek. Hy het vooraanstaande joernaliste, Suid-Afrikaanse diplomate, senior amptenare van die Suid-Afrika-Stigting en verskeie regerings betrokke by Suid-Afrikaanse belange ontmoet. Hy het besprekings gevoer met stigtings, trusts en opvoedkundige verenigings. As gevolg van sy besoek aan Nederland het hy 'n toelae vir die Konstruktiewe Program ontvang van die Algemeen Diakonaal Bureau van die Gereformeerde Kerken in Holland.

Professor J.L. Boshoff, ere-Fellow van die Konstruktiewe Program, het met 'n aantal instansies, wat universiteite in Natal en Transvaal insluit, en met verskeie handels- en industriële firmas in Natal, kontak opgebou.

(b) Konferensies

...ktеur die volgende konferensies

...asionale Uitvoerende Komitee- ... die Suid-Afrikaanse Insti- ...ge, Kaapstad (Januarie).

... Vergadering van die Religious ...tterheim (April).

... Sosiologie, Uppsala, Swede. ... Werkgroep 6 en vergaderings ...an die Internasionale Sosio- ...ng as die amptelike afgevaardigde van Suid-Afrika (Augustus).

DEPARTEMENT VAN GESONDHEID

No. R. 1802 24 Augustus 1979

VERKLARING VAN MEDIESE TOESTANDE AS AANMELDBARE MEDIESE TOESTANDE KRAGTENS ARTIKEL 45 VAN DIE WET OP GESONDHEID, 1977 (WET 63 VAN 1977), OOR DIE HELE REPUBLIEK VAN SUID-AFRIKA

Kragtens die bevoegdheid my verleen by artikel 45 van die Wet op Gesondheid, 1977 (Wet 63 van 1977), verklaar ek, Schalk Willem van der Merwe, Minister van Gesondheid, hierby die ondergenoemde mediese toestande as aanmeldbare mediese toestande oor die hele Republiek van Suid-Afrika, met ingang van die datum van publikasie van hierdie kennisgewing:

Antraks.
Brucellose.
Cholera.
Difterie.
Geelkoors.
Hemoragiese Koorssiektes van Afrika (Denguekoors, Ebolakoors, Kongokoors, Lassakoors, Marburgkoors, Slenkdalkoors).
Hondsdolheid.
Lepra.
Leptospirose.
Loodvergiftiging.
Malaria.
Masels.
Meningokokkale meningitis (insluitend meningkokemie).
Paratifoïede koors.
Pes.
Pokke (alle vorms).
Poliomiëlitis.
Primêre maligniteit van die brongus, long en pleura.
Psittakose (insluitende Ornitose).
Tetanus.
Tifoïede koors.
Tifuskoors (epidemiese luistifuskoors, endemiese rotvlooitifuskoors).
Toksoplasmose.
Tragoom.
Tripanosomiase.
Tuberkulose (alle vorms van tuberkulose is aanmeldbaar, behalwe gevalle gediagnoseer slegs op grond van kliniese tekens en simptome en/of 'n positiewe tuberkulientoets.).
Vergiftiging weens enige landbou- of veemiddel wat kragtens die Wet op Misstowwe, Veevoedsel, Landboumiddels en Veemiddels, 1947 (Wet 36 van 1947), soos gewysig, geregistreer is.
Virus Hepatitis A en B en ongedifferensieerd.

S. W. VAN DER MERWE, Minister van Gesondheid.

DEPARTMENT OF HEALTH

No. R. 1802 24 August 1979

DECLARATION OF MEDICAL CONDITIONS AS NOTIFIABLE MEDICAL CONDITIONS IN TERMS OF SECTION 45 OF THE HEALTH ACT, 1977 (ACT 63 OF 1977), THROUGHOUT THE REPUBLIC OF SOUTH AFRICA

Under and by virtue of the powers conferred upon me by section 45 of the Health Act, 1977 (Act 63 of 1977), I, Schalk Willem van der Merwe, Minister of Health, hereby declare the undermentioned medical conditions as notifiable medical conditions throughout the Republic of South Africa, with effect from the date of publication of this notice:

Anthrax.
Brucellosis.
Cholera.
Diphtheria.
Haemorrhagic Fevers of Africa (Congo Fever, Dengue Fever, Ebola Fever, Lassa Fever, Marburg Fever, Rift Valley Fever).
Lead Poisoning.
Leprosy.
Leptospirosis.
Malaria.
Measles.
Meningococcal meningitis (including meningococcaemia).
Paratyphoid Fever.
Plague.
Poisoning from any agricultural or stock remedy registered in terms of the Fertilizers, Farm Feeds, Agricultural Remedies and Stock Remedies Act, 1947 (Act 36 of 1947), as amended.
Poliomyelitis.
Primary malignancy of the bronchus, lung and pleura.
Psittacosis (including Ornithosis).
Rabies.
Smallpox (all forms).
Tetanus.
Toxoplasmosis.
Trachoma.
Trypanosomiasis.
Tuberculosis (all forms of tuberculosis are notifiable, except cases diagnosed solely on the basis of clinical signs and symptoms and/or a positive tuberculin test).
Typhoid Fever.
Typhus Fever (epidemic lice typhus fever, endemic ratflea typhus fever).
Viral Hepatitis A and B and undifferentiated.
Yellow Fever.

S. W. VAN DER MERWE, Minister of Health.

INDIRECT COMMAND

THE GAULS AT ROME

After massacring the old men, the Gauls sacked the city and attacked the Capitol. Beaten off, they besieged it until the garrison was ready to [illegible] gold. At the critical moment the great general Camillus, [illegible] vengeance on

Medical fees up 52 per cent

85 DD
29/8/79

JOHANNESBURG — Massive increases in doctors' and dentists' fees were announced yesterday.

Hard-hit South Africans will have to pay a shock overall increase of 52,4 per cent in doctors' fees and 33,3 per cent in dentists' fees from November 1.

The increases were granted by the South African Medical and Dental Council at a special meeting in Johannesburg yesterday and will be gazetted in November.

Yesterday, the Secretary of Health, Dr J. de Heer, said it was the largest increase ever granted by the council.

The increases mean:

Doctors will be paid out R68 million more by medical aid schemes. If the patient's share of the account is added, doctors will receive about R76 million more a year.

South Africa's 1 578 897 members of medical aid schemes will have to pay an average of nearly R7 more per month on subscription fees.

Each doctor will collect an estimated R12 436 more a year from medical aid societies.

The new minimum statutory fees mean that:

The GP consultation fees will rise from R4 to R6,60 and specialist consultation fees from R16 to R23,10.

Fees for a doctor's visit to a private home, hospital or nursing home will increase from R6,88 to R13,20.

An adult tonsillectomy performed by a surgeon will increase from R38,40 to R52,80.

Removal of the appendix by a surgeon will increase from R72 to R99.

The council defended its decision to grant the increases by accepting a submission from the South African Medical Association that the costs of running a medical practice had escalated while statutory tariffs did not compensate doctors for the general increase in the cost of living.

The 60-page report submitted to the council stated: "From verified statistics it is clear that the financial position of doctors has, over the past few years, lagged behind the consumer price index and inflation rate."

The 64,4 per cent increase in statutory tariffs granted to general practitioners is seen as a move to narrow the gap between statutory and private tariffs.

Statistics show that contracted out doctors charge an average of 19 per cent more than fees laid down in the statutory tariff.

The representative Association of Medical Aid Schemes said in objection to the doctors' remuneration increases: "Increases in earnings of this magnitude could never be justified to the man in the street who has had his income eroded by inflation and enormous increases in prices of all commodities in recent times."

The president of the Border Coastal Branch of the Medical Association of South Africa, Dr D. Kayser, said: "We expected the increase because our fees have hardly gone up in five years."

Labour leaders last night expressed shock and dismay at the "appalling and unreasonable increases doctors propose to grant themselves".

Claims were made that the South African Medical and Dental Council had recklessly used its powers and that the council should be rapped by the government.

The general secreatry of the Trade Union Council of South Africa, Mr Arthur Grobbelaar, said last night: "There's no use us appealing to the government to curb these increases. The government has shown itself to be ineffectual in similar situations in the past.

"The time has come for us, the general public, to take up the fight.

"These ridiculously excessive demands by the Medical Council must be stopped, and it is us who must oppose them."

verjaarsdag op 1 Apr
in 1977 vervang de

DIE OORSPRONG EN D

Die Sentrum word groc
Bailey-Trust wat inge
Bailey gestig is. Di
Institute of Inter-Ra
Garansie) - 'n maatska
'n aandele-kapitaal
Nr. 61 van 1973).

And, Mr Grobbelaar said, the government must not favour the medical profession. It must stand aside.

And the Pharmaceutical Society falls into the same category as the doctors and must also be opposed.

"We just cannot rely any more on the government. The fight is ours and we must organise to oppose," Mr Grobbelaar said.

The national president of the Housewives' League, Mrs Joy Hurwitz, said: "This is an extremely hard blow for the consumer, who, unfortunately, cannot dictate whether he falls ill or not. The increases are extraordinarily high — one wonders if anybody at all is taking any notice of the inflation rate — old age pensioners will be hardest hit, also young families, who have to cope with gynaecologist and hospital fees, and then attention and medication for their children's many illnesses.

"The consumer can cut out luxuries, but if your child is ill you have no option but to call in the doctor.

"They've got a captive consumer body paying through the nose." — DDC-DDR.

New Act will have adverse effect on welfare work

Star 3/9/79. (85)

By Elizabeth Wilson

The massive bureauracy set up to implement the new National Welfare Act could severely hamper welfare organisations and treble their costs.

Mr Lage Vitus, acting director of the National Council for Mental Health said welfare organisations could not afford the fragmentation into many regional and racially-segregated boards envisaged by the Government from this month.

"Instead of spreading resources to the people who need them, this legislation will put an impossible strain on welfare services," said Mr Vitus.

The National Welfare Act requires all welfare organisations to be re-registered.

First they must register as fund-raising organisations. Then, if they wish to operate as welfare organisations and qualify for Government subsidies, they must also register as welfare organisations.

The new Act allows a two-year registration period.

It requires that welfare activities be dealt with by four different departments: Social Welfare and Pensions, Coloured Relations, Co-operation and Development and Indian Affairs.

Each of these departments must now set up their own welfare boards on a regional basis.

TEN REGIONS

"The Department of Social Welfare has indicated that it will have ten different regions; other departments could have more", said Mr Vitus.

This could mean that a national council could have to correspond and deal with 40 different regional welfare boards all working independently and with their own policies and processes.

"Twelve people will be required to work on each board which makes for a lot of people and a lot of time.

"In addition to this, social welfare organisations will have to split into four racial groups and divide their services. Some national councils have more than 100 branches.

"If we are to do justice to each group this will treble our expenses. At the moment we are sharing facilities and staff."

Mr Vitas predicted the new system could also cause national councils to lose their international affiliations.

CONFUSION

Mrs Geraldine Schoeman, director of the South African National Epilepsy League commented: "This Act was intended to promote better control of welfare agencies, but the way it has been drawn up it is going to cause tremendous confusion. There are going to be serious problems in implementing it. Already there is confusion even among Government departments as to how the Act will be put into practice."

Dying is the great leveller

85/247 STAR 23/9/79

Is Apartheid Dead

Vestiges of apartheid still exist in the Reef's ambulance services, but fall away in emergencies.

"When someone is dying, we do not worry about the colour of the person's skin," seems to be the general feeling among fire officers canvassed.

Mr R Hansen, fire officer, said Krugersdorp ambulances served the town as well as parts of Pretoria, Rustenburg and Hartbeespoort Dam.

The black locations in the area, Kasigo and Munsieville, are served by the West Rand Administration Board.

Ambulance services for all Reef townships are run separately by the boards.

Krugersdorp station has five ambulances for whites and three for blacks all similarly equipped. Only the white staff, however, are qualified as paramedics, and are sent out to emergencies involving all races.

"In emergencies, no notice is taken of the colour of the patient's skin, and white staff can be sent to blacks, or vice versa," Mr Hansen said.

Mr A F Cloete, Benoni platoon officer, said his station had separate ambulances for blacks and whites but, depending on what ambulances were available, a non-racial emergency service would be provided.

This man was knocked over by a car. In the emergency, a white team came by ambulance to the rescue.

ONE SERVICE

Mr C Emery, of the Johannesburg Fire Station, said Johannesburg's 42 ambulances were fully integrated as one service, but, where possible staff of one race were sent to serve patients of the same race.

Station officers on the Rand generally agree, blacks serve blacks and whites whites, but when a woman is in labour and time is short, the nearest ambulance must help.

INTENSIVE

Sandton is served by six ambulances and an intensive care unit.

To upgrade the service, Sandton would also soon be aided by voluntary civil defence units, staffed by trained people, Mr R F Schmidt, chief officer, said.

There, white patients are taken to white hospitals and blacks to black hospitals, regardless of which hospital is closest in the emergency.

Better Living

Award-winner

The popular Prof who cares

195 Sunday Express 14/10/79

Story and pics by PENNY SWIFT

THE smile on Professor Lucy Wagstaff's face reflects her pleasure at getting a prize awarded to lecturers who have done the most for their students.

But it isn't because she's won the award. It's because the students have recognised a need for the kind of work she's doing.

Head of Community Paediatrics at the University of the Witwatersrand, she was one of two winners of the annual Daubenton Prize given to lecturers whom students consider to have shown the most interest in their welfare.

This year seven lecturers were nominated by the students — and Professor Wagstaff and Professor Trevor Jenkins, head of the Department of Human Genetics at the Medical Research Institute's School of Pathology, shared the award.

Interest

"I don't think it's me in particular," she said this week. "I think it's the kind of things I'm involved in that interests them. Present student leaders see a need for health services in South Africa.

"I think the award reflects their appreciation of these services. I'm thrilled that in the International Year of the Child, they wanted to focus on the needs of children, and that they chose somebody who works in the community."

Most of Professor Wagstaff's work is in Soweto and she feels strongly about people's attitudes towards Whites working in the townships.

"We aren't cranks or do-gooders or drop-outs from academic medicine. And we aren't trying to impose ourselves on other communities. Our emphasis is on partnership and teamwork. We have a common problem and we're trying to find a solution."

Her smile broadens when she says that student interest in community work has grown.

"In the past interest was predominantly in high-powered hospital medicine. Now they are recognising the value of positive health rather than just disease.

Disease

"Disease is something you can treat and in doing so, make an individual healthy. But it doesn't make a community healthy."

As a professor, it's her function, she says, to make it easier for students to get involved in community paediatrics.

"I take students into Soweto to see the health problems that exist. But we don't go on zoo trips. Students can only go if they are going to do something useful so that both they and the community benefit."

For instance first year students might help with weighing babies in homes, while final year students will actually examine and treat the children under supervision, she says.

"Community paediatrics covers the health needs of children in the broadest possible sense. It looks at the *total* health of children and ways of providing health services."

One of her current projects is an extension of the health network into homes in Soweto.

Two years ago, a University grant made it possible for her to recruit concerned women living in the township and give them basic training in nutrition and hygiene.

"Now they go into the homes and see what they can do to help. If they find a problem family — perhaps with children who have scabies — they refer them to the clinic or arrange the necessary help.

"It's difficult to measure the benefit but I hope we will find there is a permanent place for these lay health workers in the Government Health Services.

"In modern medicine we've become too quick to run to a 'professional' every time something goes wrong. We need to promote self-help again."

Praise

Quick to praise others and shift the limelight from herself, Professor Wagstaff says it is Mrs Stella Lowenstein's family trust which finances the chair of Community Paediatrics created two years ago, that makes her work possible.

Probe a bit more and she says she is also director of the Primary Health Care Education Centre, also funded by donations. Based at Baragwanath Hospital, it functions as a resource centre.

"We are interested in primary health care country-wide and in neighbouring countries," she says.

And then, having worked as a paediatrician at the hospital for 14 years, she now has an honorary appointment there.

She also teaches at a Soweto night school for adult matriculation students.

And she's in charge of Harry's Angels — the flying medical team which goes to Swaziland monthly.

On top of that she's patron of the Johannesburg Clinical Study Group, a group of Black and Indian doctors who aim to continually increase their clinical experience.

A full and busy life indeed. Little wonder the students decided Lucy Wagstaff is the professor who really cares.

● Professor Lucy Wagstaff, at home with her dogs.

● Professor Wagstaff and the University combi she uses to take students into Soweto.

RDM 23/10/79

LETTERS

The Editor, Rand Daily Mail
Box 1138, Johannesburg 2000

It's a question of medical priorities

THE ARTICLES, "Government seeks compromise in medical fees rise" and "Unions slam medical fees rise", (RDM Oct 13, 16) confuse the "Medical Council" with the doctors. Whereas the Medical Council is the public's watchdog to check, inter alia, on doctors overcharging, it now seems the Council are accused of overcharging for the doctors!

Legislation was not passed by Parliament "to give doctors full authority to determine their own fees". It was foisted on the Medical Council against their will and I am sure the Council will be only too glad if "legislation is passed during the 1980 Parliamentary session to strip it of its fee fixing powers" and they have apparently now asked for such a motion.

When the Medical Schemes Act became law in 1967, the first scheme's tariff was the tariff that the Medical Association (the doctors' trade union) had drawn up years ago for Medical Aid Societies. Society members were individuals in the lower income bracket who normally qualified as hospital cases. There was an income ceiling for members of these societies and the tariff was generally two thirds of normal fees. These societies came about to save industry many manhours that would otherwise have been wasted by their employees having to go to public hospitals for treatment, where the large attendances meant the loss of a whole day's work.

Medical Aid Societies represented a small percentage of the population. To aid and protect these schemes, there were also various general rules. Thus overtime fees (night visits) were chargeable only for calls received and made before 6 am and after 6 pm. (This was altered some years ago to 7 am and 6 pm). Thus if a doctor received half-a-dozen calls between 5.30 and 5.50 pm, but could not get around to the last case until 8.30 pm or later, it was still a day call; or a surgeon might see a case at 5 pm but have to wait and treat the case until 11 pm before operating. It was also a day call. What do Mr Arthur Grobbelaar of the Trade Union Council, Senator A Scheepers of the Garment Workers' Union and Mr A Niewoudt say to those hours?

Another general rule was that if two operations were done by the same surgeon under the same anaesthetic but not through the same incision, eg double rupture, the fee that could be charged for the second

[illegible] sual

then the fee for the second operation was R15. This has since been increased to R25.

Thus at a corneal grafting operation, the surgeon after removing the opaque cornea, might have noted that the patient had a cataract as well. He could have completed the corneal graft and let the patient suffer for another six months and then received a fee of R120. Instead he would remove the cataract during the same session as a graft and be paid a munificent R15 extra.

This Medical Aid Tariff with all its general rules was in one swoop adopted by the Government and applied to the Medical Schemes where there was no income ceiling to membership. There was thus already a 33 1/3 reduction on standard fees for those doctors who contracted in. Fortunately, doctors could contract out if they wished, but many doctors dared not do so because the regulations made the schemes pay the patient its share of any fee if the doctor was contracted out, even if he charged tariff rates. And of course some patients would pocket the money and forget the doctor.

The original Act provided for the tariff to be reviewed every two years. This was done by the Remunerations Committee presided over by Mr Justice Erasmus of Info fame.

He soon ruled that the period be increased to every three years and on one occasion he notified doctors that they should not ask for an increase in fees but should increase their productivity if they wished to earn more!

So, from 1967 to 1979, the tariff fees were grudgingly increased 10% and 5% and some items even decreased but never making up the 33 1/3 chop introduced in 1967 and not taking into account the rising CoL and the expenses of starting and running a practice and the general spiral of inflation.

The Government also had a few rules especially for themselves. Thus members of the Police Force and other categories of Government employees were to be seen at Medical Scheme rates less 10%. This had latterly been modified but still applies to police pensioners etc.

Under Government, one also includes Province. Thus doctors who do part-time work in the hospitals (and part-time workers form the majority), receive no paid leave and no pension. Thus, for 30 years, I have given hospital services equivalent to 3/11 of the time of a full-time employee.

Surely [illegible]

The so-called 52,5% increase for doctors is not a perfectly honest assessment. Some doctors might receive a 50% increase but not all.

To help assess the value of any consultation, procedure or operation that a doctor might render, all items have been broken down into units so that fees amongst the various groups of doctors and specialists would be equitable. Thus, whereas a GP's consultation was considered equal to 5 ½ units, a specialist physician was considered to be worth 20 units for the additional expertise and time that he devoted to a consultation.

The present value of a unit is 80c. The latest Medical Council determination, taking into account the various increases in CoL and the expenses of medical practice, is that the unit should now be 110c. This is a 37,5% increase, so where is the 52,5%. The difference is that it is now considered that the GP consultation is assessed six units (5 ½) and the physician 21 (20). These two groups had been underpaid in the past. The representatives of Medical Schemes have, no doubt, computed that the extra units for the GPs and physicians will cost them so much more and they found it would mean a 50% increase in their disbursements. An extra 2 ½% I believe was added for extra administration and thus all doctors, it was intimated, are to receive 52,5% more!

Not many doctors have retired by the age of 60 or 65 but are still working (if fit) till over 70, so how well off can they be? If the Government wants to help keep fees down and prevent inflation, they would do better to grant doctors a realistic income tax rebate. After all, MPs and Cabinet Ministers have done that for themselves.

On the other hand, if the medical tariffs are to be reduced and doctors prevented from contracting out, I am sure many working part-time in the hospitals will have to reconsider their position and resign, following Mr Justice Erasmus' advice to increase their productivity to earn more. The time now given to hospital work could then be devoted to private work and earn about six to 10 times their hospital pay, at medical scheme rates.

Lastly, the private fee that I could charge for a consultation 30 years ago was 3 guineas (R6,30). Today the private tariff fee is R12 (Medical Schemes R9,60). What other costs have increased less than 50% over [illegible] Even the Rand [illegible] gone from 1,5 [illegible]

[illegible] of the proportional contribution of selected [illegible] 'coloured'

RESULTS

For Africans, the proportional mortality was the only index calculated.

(iv) Proportional Mortality, accounted for by specific conditions.

(v) Expectation of Life. This was calculated both at birth (e_0) and at 45 years of age (e_{45}) for both males and females. It expresses the average number of additional years an individual would be expected to live beyond birth and 45 years.

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62

by 1970, this figure had decreased to 15,7%, indicating that the whites had improved disproportionately to the 'coloureds'. Similarly, for children 1 to 4 years of age, during the period 1941 to 1970, the white mortality experience as a percentage of the 'coloureds' had decreased from 15,2% to 7,1%. It should be noted that the 0 year age specific death rates are higher than the corresponding IMRs. This is because the denominator for the former is the number of live births whilst for the latter it is the mid-year populations under one year of age.

Table II. It will be noted that the mortality experience of the

Medical Aid—succour or sucker schemes?

85

By PAM KLEINOT

IT'S A multimillion rand industry, financed by nearly 2-million people and run on a "non-profit basis" — but its books are not open for scrutiny to its members.

This is South Africa's network of medical aid schemes which has been under the spotlight in recent weeks.

Old antagonisms between the medical profession and medical schemes were sparked off by the 52% increase in medical tariffs — described by medical schemes as "unjustified". Doctors said they had complaints about medical schemes.

It is against this background that Consumer Mail investigated medical schemes and found:

- It costs the public an estimated R40-million a year to run, averaging out at R1,66 for each member every month.
- Of the subscription income paid to these schemes, 25% is set aside in a reserve fund and about 10% is used for administrative costs.

And as more and more doctors and dentists opt out of medical aid schemes, the consumer loses out. While the benefits remain the same, members have to pay in substantial sums.

Earlier this year one of the country's 38 entrepreneur schemes was in the news when more than R200 000 went missing.

The event focused attention on the entire industry and the claims and counter claims that revolve around it.

But just what safeguards are built into these schemes to prevent misuse or misappropriation of public money?

Members of the medical profession claim that entrepreneur schemes are a "high-powered business game" and accuse the administrators of the schemes of "profiteering".

These allegations are denied by spokesmen from medical schemes who claim that medical aids are run on a non-profit basis.

Mr J Ernstzen, vice-chairman of the Representative Association of Medical Aid Schemes (Rams), denies that funds are being misused or mismanaged.

Asked why the books are not open for public scrutiny, he said: "It's utterly ridiculous to suggest that they should be. No one walks into the OK Bazaars to look at their books."

He said members were supplied with audited balance sheets annually.

"Medical aid funds are strictly controlled and there is adequate legislation to ensure this," he said.

He said safeguards included:

- Subscription income may only be used for benefits and administration costs.
- The registrar of medical aid schemes inquires into administration costs and controls the amount allowed.

Reacting to the doctors' call for medical aids to throw open their books, Mr Ernstzen slammed them for "interfering" and compared the members/medical aid scheme relationship to that of the patient/doctor — which was considered to be sacrosanct.

"This sort of statement is made to divert attention from their own association and the recent increase."

Commenting on the missing R214 000 from a medical aid scheme, Mr Ernstzen said: "Theft cannot be legislated against."

In recent weeks Professor J N de Klerk, chairman of the federal council of the Medical Association of South Africa, has expressed concern about the large profits made by entrepreneur medical aids, claimed to be more than R1-million a year in some instances.

"Anyone who tells you these schemes are not in it for the money is talking nonsense," he said.

During a month-long investigation Consumer Mail established that:

- South Africa's 210 medical aid schemes — 38 of which are entrepreneurial — are ostensibly run on a nonprofit basis, but critics claim their administration allowance makes them the "finest business enterprise in the world".
- Substantially more than half the country's dentists and about 32% of the doctors have opted out of medical aid because they feel they are not earning a reasonable income from the lower medical tariffs.
- Of the total annual subscriptions received by medical schemes, 25% is set aside in a reserve fund and about 10% used on administrative expenses.

Mr Ralph Stocker, an authority on medical aid schemes, said while medical aid was initially welcomed when it was first introduced, it had subsequently deviated from its original role as a "debt collecting agency" and "assumed the role of dictator of what doctors should earn".

"Gradually entrepreneurial interest filtered into the schemes and today there are few medical aids not controlled by a (Pty) Management Company," he said.

Mr Stocker said only 65% of a member's subscription money "can work for him" because 25% is set aside in a reserve fund and about 10% for administration expenses.

Mr Stocker said that for maximum effeciency the present medical aid schemes should be rationalised.

"This would cut down on administrative costs — and there are too many for them to be a viable proposition," he said.

Doctors interviewed by Consumer Mail said they resented the fact that their earnings were being dictated to them by a group of businessmen with vested interests.

Other gripes about medical aids include:

- The arbitrary way in which medical aids pick and choose what they cover. For example, while some cover remedial education hardly any cover infertility and contraception.
- Members benefits are reduced correspondingly with the drift by medics to opt out of medical aids.
- Patients often have to fork out large amounts because medical aids in some cases pay as little as 50% of fees of members of the medical profession who have opted out. There are many more dentists who have opted out than have opted in.
- Many doctors contracted out of medical aid last year following a recommendation by the federal council of the Medical Association of South Africa because of dissatisfaction with the findings and tariffs laid down by the fifth remuneration commission.
- Although there is a low debt rate for doctors contracted into medical aids, they are not paid out for up to three months.
- Medics who have opted out claim that there is no guarantee they will be paid once their patients have been paid out by their medical aid scheme.

They also said the increase in medical aid tariffs in the past decade had not kept up with the cost of living

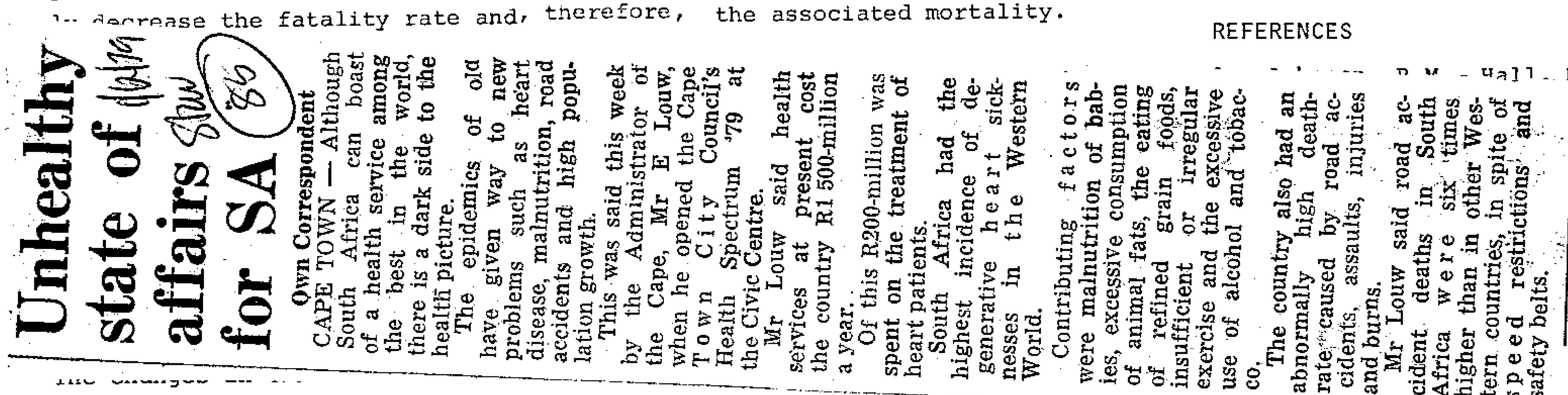
While their gross profits have remained more or less the same in the past few years, their net profits have lagged miserably behind because of increased expenses

A breakdown of medical aid schemes shows:

- 31,7% of medical aid members belong to 100% medical aids.
- 47% belong to schemes giving between 80% and 100% cover.
- 20,6% belong to schemes giving only 80%.
- There are 172 in-house medical aid schemes which cover 80% for all services except surgical procedures, hospitalisation, theatre fees and medicine supplied in hospitals — for which they give 100% cover.
- There are 38 entrepreneur schemes. Members pay higher subscriptions but get 100% cover.

is consistently worse than that of the whites. The 'coloureds' have higher mortality rates for all the major causes of death apart from cardiovascular diseases and neoplastic diseases in men over 65 years of age, neoplastic diseases in women in this group, and cardiovascular disease in men 45-64 years of age during 1960 and 1970. Clearly the rate of 5/1 000 which has been chosen is entirely arbitrary but a similar pattern of mortality emerges if lower or higher levels are selected.

Two aspects of these age-cause specific mortality rates require emphasis. Firstly, whilst being affected by the incidence of the diseases in question, these rates are also influenced by their fatality rates, for example, a decrease in the mortality related to Tuberculosis will not only be influenced by a decreasing incidence of this disease but also by improved prevention at primary, secondary and tertiary levels of intervention which will consequently decrease the fatality rate and, therefore, the associated mortality.



Unhealthy state of affairs for SA

Own Correspondent
CAPE TOWN — Although South Africa can boast of a health service among the best in the world, there is a dark side to the health picture.

The epidemics of old have given way to new problems such as heart disease, malnutrition, road accidents and high population growth.

This was said this week by the Administrator of the Cape, Mr E Louw, when he opened the Cape Town City Council's Health Spectrum '79 at the Civic Centre.

Mr Louw said health services at present cost the country R1 500-million a year.

Of this R200-million was spent on the treatment of heart patients.

South Africa had the highest incidence of generative heart diseases in the World.

Contributing factors were malnutrition or abnormally high consumption of animal fats, the eating of refined grain foods, insufficient or irregular exercise and the excessive use of alcohol and tobacco.

The country also had an abnormally high death-rate caused by road accidents, assaults, injuries and burns.

Mr Louw said road accident deaths in South Africa were six times higher than in other western countries, in spite of speed restrictions and safety belts.

for the purposes of the present study, of relative unimportance.

The expectations of life for 'coloureds' and whites are presented in Fig. 6. Although data has been published for Africans[5], this is speculative and is not considered to be of sufficient reliability to warrant inclusion. Two different expectations of life have been included: (1) e_o - the expectation of life at birth, and (2) e_{45} - the expectation of life at 45 years of age. Characteristically women have a better expectation of life than men, and Fig. 6 indicates that this is so for both whites and 'coloureds'. In fact, so marked is this difference that at e_{45} 'coloured' females have a better expectation of life than white males. What is perhaps of some concern is that the gap between the expectation of life for males and females is widening. This trend is apparent in both the whites and the 'coloured' communities, although it is particularly marked in the latter for whom Male:Female deficit of 1,0 years in 1941 at e_o has become 6,9 years in 1970. For whites a deficit of 3,7 years in 1929 has increased to 7,0 years in 1970.

Both white and 'coloured' females have shown an increasing life expectancy at the age of 45, and although this has been small, it contrasts with the downward trend of both white and 'coloured' males.

Although it is apparent that the Expectation of Life at birth for the 'coloureds' has shown a marked improvement between 1941 and 1970, it is salutary to note that neither 'coloured' males nor females, at either e_o or e_{45}, have reached expectations of Life in 1970 which are as high as the whites were in 1929. What also gives some cause for concern is that although the expectation of Life cannot be expected to improve indefinitely, it would appear that the 'coloured' life expectancy is levelling off at a much lower age than has occurred in the white community.

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Star 3/12/79 (85)

The challenge to Health: adapt

The ability of man to adapt to a rapidly changing environment is the biggest challenge facing the nation's health in the next decade, writes Secretary for Health DR JOHAN DE BEER, in the continuing series of articles, A Glimpse into the 80s.

The objective of South African health authorities is not only to prevent and combat disease but also to increase life expectancy and to enhance the quality of life of all people in South Africa.

In the past, policy was determined and health services were rendered by the Department of Health, the provincial administrations and local authorities with very little co-ordination. In recent years, however, the foundation has been laid for a closely co-ordinated and comprehensive health service. The establishment of a co-ordinated national health policy in which all the statutory health authorities and the private sector can participate, remains a very high priority and is already firmly established.

In order to achieve the desired physical, mental and social wellbeing for all the peoples of South Africa, particular attention will have to be paid to a number of aspects.

One of the major objectives of the Department is to inform the public on health matters. A Health Education programme aimed at making the advantages of family planning better known is one example; the role that breast-feeding can play to decrease infant mortality, is another.

Healthy living habits for the young, the not-so-young and the aged, will be promoted. It is also the intention to enlighten the public regarding the optimal use of existing health services and facilities. In this respect the proper use of facilities offered by the private sector, as well as public facilities, is essential.

The importance and desirability of preventive and promotive measures as against the disadvantages of prolonged and expensive curative procedures is a basic health educational theme.

A number of transmissible diseases can be prevented effectively and economically by means of immunisation. Were the population at risk to be effectively immunised against infectious diseases, these would, like smallpox, disappear from the South African scene. Measles is a major cause of death and infants can be completely protected by immunisation.

Diphtheria, whooping cough, polio, tetanus, smallpox, German measles, typhoid and tuberculosis are some of the diseases which can be prevented by means of immunisation.

Many people in South Africa suffer from the effects of diseases which are either directly or indirectly associated with nutritional disturbances. Under-nutrition as well as over-nutrition will be receiving attention.

An important aspect of nutrition is, of course, the availability of basic foodstuffs at prices which can be afforded by the less privileged members of society. It would seem as though protein from meat — particularly red meat — will have to be replaced by, or at the very least be augmented by, protein from other sources, such as beans.

It should be anticipated that a malnourished person would not be able to realise his full potential in the community. The effects of malnutrition on the physical and mental development of the child, however, is particularly important because it will determine the performance of the individual for the rest of his life.

As a result of urbanisation and technological progress, age-old social systems are disrupted. The need to adapt to new conditions and the persistent demands for change, place increasing stress on the individual. The time saved by sophisticated machines allows or forces the individual to become involved in a multitude of new activities. Many people cannot cope with the new responsibilities and the result is psychiatric breakdown.

It is important to realise that many psychiatric conditions can be effectively treated. Semi-permanent hospitalisation can no longer be supported — nor is it necessary. The care of these patients in the community, with the help of the community, will receive ever-increasing attention.

A similar approach will have to be evolved for the growing numbers of elderly people.

In this, as well as in making health policy, the participation of the community will have to be obtained. It is unacceptable that the statutory health authorities should be held solely responsible for all the decision-making and the delivery of health services. Involvement to the extent of participation in the rendering of services is a very real objective of the Department of Health. The field for community participation and involvement is wide open, particularly for the coloured, Indian and black communities.

In this respect the involvement of neighbouring independent or self-governing states in the planning of health services is also considered to be essential. The health of a community can never be seen in isolation.

With this in mind an organisation known as the Regional Health Organisation for Southern Africa (Rhosa), has recently been established. A secretary general has been appointed and it is anticipated that a number of standing committees will soon be instituted.

When one considers the threat posed by the pollution of our environment from industrial and human sources, it becomes clear that firm counteraction will be necessary. The world's technological progress and the population growth, as well as urbanisation which compounds the problems, exploit and diminish a wide variety of natural resources. The health hazards which arise because of man's demands for more and more energy and subsequent production of waste materials can be serious. Coal, oil, and nuclear pollutants are capable of influencing our ecosystems to such an extent that food production could be jeopardised.

The challenge of the 1980s for the Department of Health, in close association with the other health authorities at provincial and local authority level, will be to ensure that man will be able to adapt to his rapidly changing environment. His level of mental and physical fitness, and therefore his ability to earn an adequate income, will be crucial.

Good housing, good food, the availability of a sufficient quantity of clean water, efficient disposal of refuse and a reasonable supply of fuel for cooking and washing are the basic necessities for physical health.

The health of the community is probably as important as that of the individual. A community can only develop if demands are addressed to it — if it has specific responsibilities.

GENERAL EXPLANATORY NOTE

[ ] Words in bold type in square brackets indicate omissions proposed by the Minister on introduction.

Words underlined with solid line indicate insertions proposed by Minister on introduction.

See Acts for full text

BILL

To amend the Anatomical Donations and Post-Mortem Examinations Act, 1970, relating to definitions; to provide for control over the importation and exportation of tissue; relating to the powers of the Minister of Health to make regulations; and to provide for incidental matters.

BE IT ENACTED by the State President, the Senate and the House of Assembly of the Republic of South Africa, as follows:—

1. Section 1 of the Anatomical Donations and Post-Mortem Examinations Act, 1970 (hereinafter referred to as the principal Act) is hereby amended— Amendment of section 1 of Act 24 of 1970.

(a) by the substitution for the definition of "dentist" of the following definition:

"'dentist' means a [person] dentist registered or deemed to be registered as such under the Medical, Dental and [Pharmacy] Supplementary Health Service Professions Act, [1928] 1974 (Act No. [13] 56 of [1928] 1974);";

(b) by the insertion after the definition of "dentist" of the following definition:

"'export' means to export from the Republic by any means;";

(c) by the insertion after the definition of "hospital" of the following definitions:

"'import' means to import into the Republic by any means; and 'importation' has a corresponding meaning;

'importer' includes any person who, whether as owner, consignor, consignee, agent or broker, is in possession of or is in any way entitled to the custody or control of any tissue imported;";

(d) by the substitution for the definition of "medical practitioner" of the following definition:

"'medical practitioner' means a [person] medical practitioner registered or deemed to be registered as such under the Medical, Dental and [Pharmacy] Supplementary Health Service Professions Act, [1928] 1974;";

(e) by the insertion after the definition of "regulation" of the following definitions:

"'Secretary' means the Secretary for Health;

'this Act' includes any regulation made thereunder;";

12/12/1985

Commission of inquiry into medical schemes

PRETORIA — A commission of inquiry would investigate all aspects of medical aid schemes, as part of a full inquiry into health services, the Minister of Health, Dr L. A. P. A. Munnik, said yesterday.

The Hon Mr J. W. Haak, has been appointed chairman of the commission, which will issue an interim report on medical schemes within three months of its appointment.

As an interim measure, until the commission reported, draft legislation will be gazetted today, concerning the present tariff of fees for services, as the SA Medical and Dental Council has decided to review tariffs.

Dr Munnik said he hoped the commission would be able to remove the unpleasantness that has accompanied the determination of tariffs.

"I hope they will be able to find an acceptable formula to calculate the cost of health services, so that suppliers receive reasonable incomes and patients were assured that they were paying reasonable fees."

The commission will make recommendations regarding the scope and cost structure of health services in both public and private sectors.

"This is with a view to rationalising services and making them more effective, as well placing costs on a sound and firm basis," Dr Munnik said.

He said the tariff of fees for services by medical practitioners and dentists, to members of medical schemes, had made it an appropriate time to appoint such a commission.

Some of the terms of reference of the commission are:

- The rationalisation of medical schemes. An investigation of their administrative costs, assets and reserves, profits and/or compensation of entrepreneurs, use of manpower, the extent of coverage.
- The investigation into the extent to which the recommendations of a previous commission of inquiry into the pharmaceutical industry, have been implemented.
- To determine what influence pharmaceutical manufacturers have had on the cost of medicine.
- To investigate the implementation of the recommendations of a previous commission of inquiry into private hospitals and unattached operating theatres.
- To investigate the provision of medical services by state, provincial and local authorities.
- The incomes and fringe benefits of medical practitioners, dentists and supplementary health service personnel.
- Excessive use by patients of medical services.

The commission will publish an interim report of medical schemes three months after its appointment. It will issue interim reports on various facets of its terms of reference and will appoint committees to investigate these various facets.

Professor J. N. de Klerk, chairman of the Federal Council of the Medical Association of South Africa, MASA, said last night he welcomed the appointment of the commission "with open arms."

"We have stated all along we would support a commission and are only too happy it has been appointed." — DDC.

GENERAL EXPLANATORY NOTE

[ ] Words in bold type in square brackets indicate omissions proposed by Minister on introduction.

Words underlined with solid line indicate insertions proposed by Minister on introduction.

BILL

To amend the Medical, Dental and Supplementary Health Service Professions Act, 1974, so as to do away with the prescribing of qualifications obtained by virtue of examinations conducted by any examining authority situated outside the Republic, entitling any holder thereof to registration under the said Act as a psychologist; to provide for the temporary registration, for training purposes, in respect of supplementary health service professions, of persons not permanently resident within the Republic; to make new provision for the registration with the said Council of persons practising supplementary health service professions; to prohibit the use of certain names by certain unregistered persons; to bring certain expressions of the said Act into line with others; to further regulate the effect of tariffs of fees for medical practitioners, dentists and psychologists and in respect of supplementary health service professions; to effect a change in relation to the power to make regulations; and to further define the powers of the Minister of Health; and to provide for matters connected therewith.

BE IT ENACTED by the State President, the Senate and the House of Assembly of the Republic of South Africa, as follows:—

Amendment of section 11 of Act 56 of 1974, as amended by section 3 of Act 52 of 1978.

1. Section 11 of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (hereinafter referred to as the principal Act), is hereby amended by the deletion of paragraph *(b)* of subsection (2A).

Amendment of section 24 of Act 56 of 1974.

2. Section 24 of the principal Act is hereby amended by the substitution for subsection (2) of the following subsection:

"(2) No qualification obtained by virtue of examinations conducted by a university, or other examining authority, situated outside the Republic shall be prescribed under this section unless—

(a) such qualification entitles the holder thereof to practise as a medical practitioner or dentist [or psychologist], as the case may be, in the country or state in which such university or other examining authority is situated;

(b) by the laws of that country or state, persons holding qualifications granted after examinations in the Republic and entitling them to practise in the Republic as medical practitioners or dentists [or psychologists], as

Govt to probe medical costs

By WILLIAM SAUNDERSON-MEYER
Pretoria Bureau

A COMMISSION of Inquiry would investigate all aspects of medical aid schemes, as part of a full inquiry into health services, the Minister of Health, Dr L A P A Munnik, said yesterday.

Mr J W Haak, former Minister of Ecomomic Affairs, has been appointed chairman of the commission, which will issue an interim report on medical schemes within three months of its appointment.

Because the SA Medical and Dental Council had decided to review tariffs of fees for services, and the commission's report would not be ready for the next Parliamentary session, as an interim measure draft legislation on the present tariffs would be Gazetted today.

Dr Munnik said that he hoped the commission would be able to remove the unpleasantness that has accompanied the determination of tarif...

The commission will make recommendations about the scope and costs of health services in both public and private sectors.

This is with a view to rationalising services and making them more effective, as well as placing costs on a sound and firm basis," Dr Munnik said.

The commission will also investigate:

- How far the recommendations of a previous commission of inquiry into the pharmaceutical industry have been implemented;
- What influence pharmaceutical manufacturers have had on the cost of medicine to the consumer and on the supply prices to retailers, wholesalers and doctors;
- The implementation of the recommendations of a previous commission of inquiry into private hospitals and unattached operating theatres;
- The provision of medical services by State, Provincial and local authorities;
- The costs of conducting a pharmaceutical practice, profit margins on dispensing and on other commodities and prescription patterns, and
- The incomes and fringe benefits of doctors, dentists and other health service personnel, patient loads, private practices and their running expenses.

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HEALTH & DISEASE - General

1-1-80 - 31-12-80

Minister's plan to control medical fees 'monstrous'

The Minister of Health's plan to control medical fees by getting the power to amend or set aside decisions of the Medical and Dental Council has been described as "monstrous" by a professor of forensic medicine.

Professor H Shapiro of Unisa was speaking at a special Johannesburg meeting of the council called to discuss draft legislation which gives the Minister extensive powers to control medical fees.

The meeting was requested by at least six members of the council.

Two Bills which are to amend the Medical, Dental and Supplementary Health Service Professions Act and the Medical Schemes Act are being discussed.

In terms of the draft law, the Minister will be empowered to amend or set aside any decision by the Medical Council and substitute new tariffs.

Professor Shapiro also strongly objected to another amendment which gave the Minister powers, after consultation with the executive committee of the council, to amend or set aside any decision or determination by the council.

The amending legislation makes it clear that any amended or new decision or determination "shall be deemed to be the decision or determination of the council."

Professor Shapiro said the proposed amendment by the Minister to the Medical, Dental and Supplementary Health Service Professions Act was unnecessary and undesirable.

He asked for the amendment to be rejected. He said the amendment was in conflict with the letter of the council in all respects and it rendered the statutary authority of the council as nominal and superfluous.

The amendment thus undermined the exercise of that authority.

A motion that the Minister be advised not to proceed with the amendment was seconded.

Professor Shapiro described the amendment as a "kiss of death; the kiss of a deadly mamba. This is a monstrous amendment to the Act."

He said that the effect of the amendment was that the Minister could do no wrong and "we (the medical profession) can do no right."

Professor A J Brink, Dean of the Faculty of Medicine at Stellenbosch, dissociated himself from the tirade made by Professor Shapiro against the Minister, but said he had sympathy for the motion itself.

Professor H Snyman, president of the council, said the amending law which gave the Minister powers to veto the decision of the council was unacceptable and he would not be associated with it.

Professor Shapiro's motion, condemning the amendment, was carried by a vote of 27 to one with four abstentions.

Quant il oï Guillelme ledengier,
Molt fu dolanz, n'i ot que corrocier.
Isnelement avale le planchier,
Vint a Guillelme, sel sesi par l'estri
Et par la resne de son corant destrier
"Sire, dist il, molt es buens chevalie
Mes el palés ne vaus tu un denier.
- Qui dit ce donques? dit Guillelmes
- Sire, dit il, ge nel vos doi noier:
Foi que doi vos, ç'a fet Aymes le vie
Envers le roi vos pense d'empirier."
Et dit Guillelmes: "Il le comparra ch
Lors se regarde dans Guillelmes arrie
En mi la sale choisi Aymon le vieil.
Quant il le vit, sel prist a ledengie
"He ! gloz, lechiere, Dieus confonde t
Por quoi te paines de franc home jugi
Quant en ma vie ne te forfis ge rien?
Et si te peines de moi molt empirier?
Par saint Denis a qui l'en vet proier,
Ainz que t'en partes le te cuit vendre chier."
Il passe avant quant il fu rebraciez,
Le poing senestre li a mellé el chief,
Hauce le destre, enz el col li asiet,
L'os de la gueule li a par mi froissié;
Mort le trebuche devant lui a ses piez...
"Looÿs sire, dit Guillelmes li fiers,
Ne creez ja glouton ne losengier,
Que vostre peré n'en ot onques un chier.
Ge m'en irai en Espaigne estraier;
Vostre iert la terre, sire se la conquier."

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Hours

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Commission of Inquiry into Health Services

14(799) 23/5/80 (85)

624. Mr. N. B. WOOD asked the Minister of Health, Welfare and Pensions:

What are the respective qualifications of the members of the Commission of Inquiry into Health Services?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

Mr. G. W. G. Browne—Former Secretary for Finance.

Prof. H. S. Breytenbach—B.Ch.D., M.Ch.D., Ph.D.: Head: Clinical Dental Training: University Stellenbosch.

Mr. W. M. C. Davidson—F.C.I.S.: Managing Director of a group of medical schemes.

Dr. J. N. du Plessis—M.B.B.Ch.: Deputy Director of the Department of Health, Welfare and Pensions.

Dr. P. J. Klopper—M.B.B.Ch., M.D., M.R.C.P., F.R.C.P.: Specialist Physician.

Mrs. H. M. Lessing—Member of the S.A. Consumer Council.

Prof. N. S. Louw—M.B.Ch.B., M.Med.: Professor of Gynaecology and Obstetrics: University Stellenbosch.

Prof. G. Marais—Ph.D. (Economics), B.Com., M.Com.: Director of the Management School: Unisa.

Prof. F. P. Retief—M.B. Ch.B., M.R.C.P., M.D.: Rector: Medunsa.

Mr. J. J. van der Spuy—B.A. L.L.B.: President of the Transvaal Municipal Association.

Mr. D. J. de Villiers—B.A. L.L.B.: Chairman of the Central Council for Medical Schemes.

14(770) 19/5/80 (85)

Notifiable diseases

514. Mr. H. E. J. VAN RENSBURG asked the Minister of Health, Welfare and Pensions:

How many cases of each notifiable disease occurred among (a) Whites and (b) Blacks in (i) Randburg and (ii) Sandton during 1977, 1978 and 1979, respectively?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

			1977	1978	1979
(a)	(i)	Tuberculosis	4	2	0
		Typhoid Fever	0	1	2
		Scarlet Fever	1	0	0
		Meningococcal Infection	0	2	0
		Viral Hepatitis	4	5	0
		Encephalitis	1	2	0
(b)	(i)	Typhoid Fever	0	1	0
		Tuberculosis	8	12	18
		Viral Hepatitis	0	1	2
(a)	(ii)	Typhoid Fever	0	2	0
		Tuberculosis	0	1	3
		Scarlet Fever	5	1	0
		Meningococcal Infection	3	0	0
		Viral Hepatitis	3	10	1
		Malaria	1	4	0
		Encephalitis	1	0	1

Hansard 14(768) 19/5/80 (85)

Patients: expenditure

508. Mr. H. E. J. VAN RENSBURG asked the Minister of Health, Welfare and Pensions:

What was the national average *per capita* expenditure on (a) White, (b) Asian, (c) Coloured and (d) African (i) in-patients and (ii) out-patients in the Republic during 1977, 1978 and 1979, respectively?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

(a), (b), (c), (d), (i) and (ii) this information is not available, as all Provincial Administrations do not keep separate figures for in and out-patients and for the different population groups.

23/4/80

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Medical Schemes amendment
Bill

See 3. Hansard 5 cols 1094 - 1130

2214/80

85

Anatomical Donations & Post mortem examinations amendment Bill

See S. Hansard 5 cols 1058 - 1064

Homeopaths, Naturopaths, osteopaths & Herbalists amendment Bill

See S- Hansard 5 cols 1064 - 1073

2/4/80

85

Medical Dental & supplementary
Health Service Professions
Amendment Bill
(3rd Reading)

See Hansard 10 Colsm 4412-4424

18/4/80

85

Medical Dental + supplementary
Health service - professions
amendment Bill

(committee Stage).

See Hansard 9 ~~Question~~ Qs

4298 - 4351

Hansard 7 Quest. Col. 382/383
17/3/80 85

Registration of drugs
7(382/383) 17-3-80 85

76. Mr. N. B. WOOD asked the Minister of Health:

(1) How many applications for the registration of drugs were dealt with dur-

ing 1979 in terms of the Medicines and Related Substances Control Act, 1965;

(2) how many applications (a) were approved, (b) were rejected and (c) are pending;

(3) what amount was collected during 1979 in respect of (a) registration fees and (b) renewal fees?

The MINISTER OF HEALTH:

(1) 471

(2) (a) 227

(b) 11

(c) 666

(3) (a) R31 020

(b) R58 500

Cooper also offers information on services and fees (both in-patient and out-patient) at provincial hospitals for comparison purposes. In conclusion, she makes the following points:

(i) In general, more concern is shown for skilled workers, who are difficult to replace, than for unskilled workers (that is, there is a skill and a race bias in the provision of services).

(ii) Medical aid schemes, and to a lesser extent medical benefit schemes emphasise curative rather than preventive medicine.

(iii) The benefits extended by medical benefit schemes are much less comprehensive than those extended by medical aid schemes.

(iv) Contributions to the former are generally lower.

(v) The benefit of a sick pay fund to workers is often dubious. Most of the trade unionists interviewed by Cooper suggested that a sick pay fund increased employer control as workers had to get a certificate from a doctor whose interests might be closer to those of employers than to those of workers. Furthermore, sick pay funds are made up of equal contributions from worker and employer, while under the Factories Act the employer would have to pay sick pay in full, and the leave and pay provisions in sick pay funds are not always better for workers than those in the Factories Act.

(vi) It may not be in the interests of unskilled workers (often contract workers) who move frequently from one industry to another, to contribute to medical schemes. Most schemes require contributions for 13 to 16 weeks before a member is eligible for benefits and benefits often increase with length of membership.

6. NUTRITIONAL STATUS AND POLICY

Two papers dealt with nutritional status indicators in South Africa - those of Du Plessis *et al* (*30) and Neil White (Vol.2). In addition, a condensation of statistics on child nutrition in various parts of the country was provided as background and material. These studies show that there is a far greater proportion of children who are malnourished in rural areas than in urban ones, even among children in urban squatter areas. White shows that, using the arm circumference test, the proportion of malnourished children aged 1-5 years was 1,9% in Crossroads compared with 7,4% in Nqutu in KwaZulu, and he quotes other studies which find an incidence of 12% in Tsolo, Transkei, and 13,8% in the Muldersdrift farming area near Johannesburg. (The arm circumference method is an extremely conservative measure of malnutrition. In Tsolo, over 30% were malnourished by reference to the

Medical chiefs reject Munnik veto

By BRUCE STEPHENSON

THE SOUTH African Medical and Dental Council has rejected outright an attempt by the Minister of Health, Dr L A P A Munnik, to have veto power over its decisions.

At a special meeting in Johannesburg yesterday, the council voted 27-1 against a provision in the Medical, Dental and Supplementary Health Service Professions Amendment Bill, which is soon to be considered by Parliament, which gives Dr Munnik the right to set aside any council decision.

The council was also strongly against allowing Dr Munnik further right of veto on increases in medical tariffs.

Dr Munnik's move follows the 52% increase in doctors' and dentists' fees last November which he publicly disapproved.

A four-man delegation from the council is to see Dr Munnik "as a matter of urgency" in an attempt to persuade him to change his mind on the unprecedented legislation.

The council president, Prof Hennie Snyman, said it had been the tradition in South Africa for the Medical and Dental Council to have near-autonomy in its affairs.

"The members of the council do not serve for financial gain, but for the love of their profession. I do not find this intended legislation acceptable and will not be associated with it."

The Secretary for Health, Dr Johan de Beer, said he had not been opposed to the November increase, but he had been opposed to it going into effect in one fell swoop, as the public could not absorb it.

22.1.80 Kom - 85

defect; although association has been found in Durban between height for age and school performance, and Thomas (Vol.2) found that children below the Boston third percentile in weight for age deteriorate if untreated whether or not they have normal body proportions. Again rural children were worse off than urban ones in the older age groups and the proportion with low weight for height increased with age.

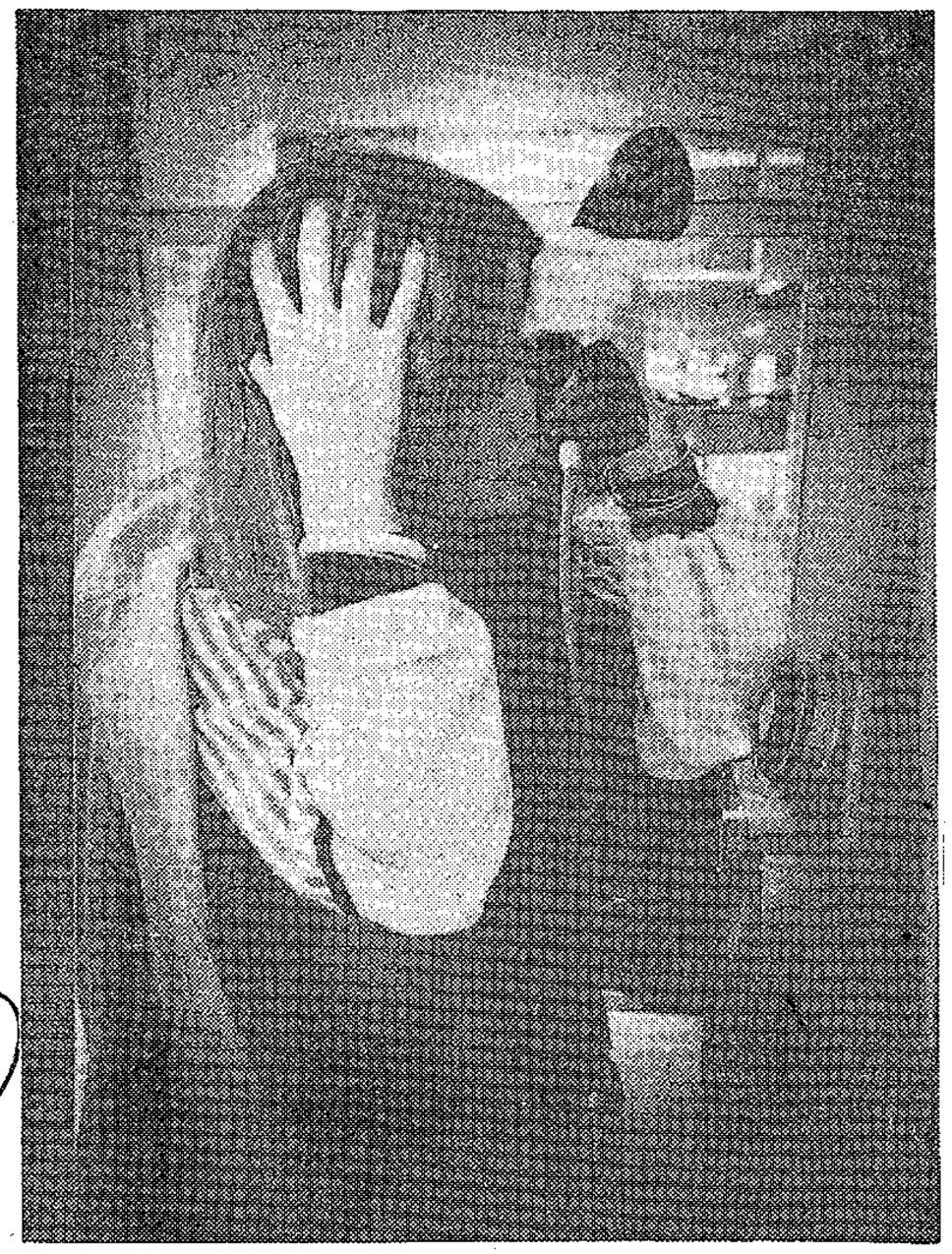
Du Plessis *et al* attribute this poor nutritional situation to non-recognition of nutritional disease and the ignorance of healthy feeding patterns.

Statistics on malnutrition from other surveys confirm the rural-urban discrepancy, although there are very few random studies which give a true picture of nutritional status of the community (clinic and hospital samples are useless for this purpose).

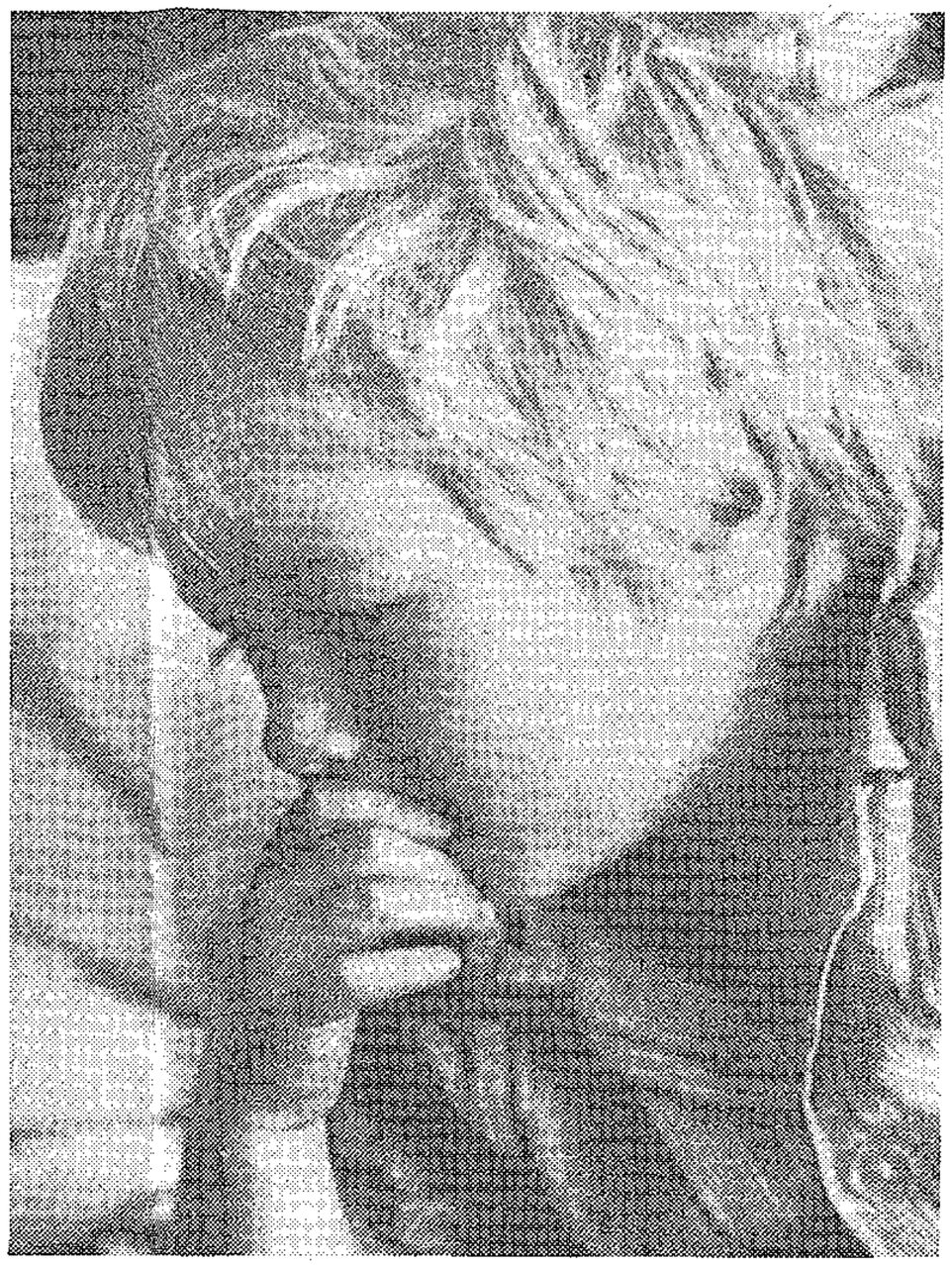
What happens to children who are malnourished? In East London, Trudy Thomas (Vol.2) followed up a sample of children with mild malnutrition (below the third percentile but without clinical signs) who were not admitted to hospital but were treated as outpatients with supplementary food, advice and bus fares where necessary for follow-up, and found that 51% of them had died within 6 weeks. But hospitalisation too is often ineffective. 14% of children hospitalised died within 6 weeks of discharge. Hospitalisation with follow-up and milk after discharge offered the best chances of

The traumas and guilt of an unwanted pregnancy

REPORT BY
SHEILA STEVENS



The unwanted pregnancy . . .



The unwanted child . . .

In Johannesburg last week, a woman was sentenced to two years' jail on six counts of abortion. Since 1970, she had been found guilty on a total of 15 counts of illegally performing abortions, the court heard.

She was evidently not the only person performing back street abortions. In 1978, State hospitals and institutions dealt with 19 818 incomplete abortions compared with 541 legal abortions.

The reasons for the discrepancy are not hard to find. Grounds for abortion under the Abortion and Sterilisation Act of 1975 are very limited indeed.

They are:

- Where the continued pregnancy endangers the life of the woman concerned or constitutes a serious threat to her physical health;
- Where the continued pregnancy constitutes a serious threat to the mental health of the woman (two doctors have to certify in writing that the continued pregnancy creates the danger of permanent damage to a woman's mental health);
- A serious risk that the child to be born will suffer from a physical or mental defect of such a nature that it will be irreparably mentally handicapped;
- In the case of alleged rape or incest, after interrogation of the woman concerned;
- In the case of alleged unlawful carnal intercourse in contravention of section 15 of the Immorality Act.

ABORTION research conducted in civilised First World countries during the early 70s shows that the psychological effects of having an abortion are far less damaging to a woman than the effects of being forced to continue an unwanted pregnancy.

And, according to Professor James Gardner, head of the department of applied psychology at the University of the Witwatersrand, it is largely as a result of these findings that abortion has been legalised in the United States, Britain, Australia and parts of Europe.

"South Africa is a good 10 years behind the times as far as abortion is concerned," said Professor Gardner.

Most of the research, he said, was done on unwed mothers where the psychological trauma resulting from an unwanted pregnancy was largely associated with the social or personal stigma of being unmarried.

Because abortion is illegal in South Africa, except in special circumstances, many women are forced into a social role which is highly undesirable, he said.

Professor Gardner considers it presumptuous of the State to legislate on personal feelings and says women should be able to have abortion on demand, be it for physical, psychological, social or personal reasons.

"The death rate by abortion is far lower than the death rate by pregnancy," he said.

Where a woman goes through with an unwanted pregnancy, one of the alternatives after the birth is to put the child up for adoption.

"But there is always guilt associated with giving up the child — even if it's not wanted," said Professor Gardner. "It can lead to a lifelong series of self-recriminations."

In the first 11 or 12 weeks of pregnancy, however, the foetus "is not an identifiable human being", he said.

"The idea of guilt and recrimination is not associated with abortion in the early stages."

Illegal abortion, he said, poses the risk of infection and injury and opens up new sets of problems for people who are forced to break the law in order to do what they feel is right.

But where abortion is legal, there is far less danger of physical injury to the mother.

Professor Gardner was involved in abortion counselling in the United States in the 1960s when abortions were still illegal in that country.

"Our role then was largely to make sure that the woman, and sometimes the man as well, had considered all other alternatives and whether the effects of abortion were not worse than having the child, and to refer them to places where abortion was legal.

"In most cases, the effects of abortion are therapeutic. It's the termination of an unpleasant experience which results in psychological relief.

"Many women fall pregnant in an unloving, unfulfilling relationship. Abortion is a way of wiping the slate clean.

"It is presumptuous of the State to step in at a point where the foetus is still not an identifiable human being," he said.

Speaking in his personal capacity, Professor Abe Rubin, head of the department of gynaecology and obstetrics at Baragwanath Hospital, said modern day medical expertise made legal abortion eight times less hazardous than childbirth.

If performed in the early stages of pregnancy (the first seven weeks), a legal abortion could be done as an outpatient procedure "with almost no morbidity or mortality", he said.

Thereafter, the risk of complications increased 20 to 30% for every week's delay. South Africa's restrictive abortion legislation, however, inevitably resulted in delays for women seeking legalised abortion, he said.

Professor Rubin said a woman who wants an abortion is not usually psychologically disturbed — "there is very little change in her psychological outlook after abortion".

But he pointed to the dangers of backstreet abortion which, he said, included death, haemorrhaging, permanent sterility and chronic infection.

Professor Rubin does not, however, advocate legalised abortion on demand.

"Abortion should be a matter between the doctor and the patient. If a doctor believes it is right for the patient, he should do it. He should not be dictated to by the law."

He believes abortion can reasonably be considered where:

- a woman already has a large family;
- a girl is young and unmarried;
- a woman has made a valid attempt at contraception but this has failed;
- an older woman, whose children are grown up, falls pregnant again in the pre-menopausal phase.

There is a growing body of opinion that the Abortion Act of 1975 is a failure and must be amended. It has not had the desired effect of reducing illegal abortion figures.

Mrs Helen Suzman, Progressive Federal Party MP, plans to continue pushing for the liberalisation of South Africa's abortion law this parliamentary session to bring it into line with practices in other parts of the world.

"I'll bring it up in the Health Vote," she said. "The clause allowing for illegal abortions is far too stringent and should be relaxed."

Mrs Suzman also proposes that:

- Where a girl falls pregnant under the age of 16, age should be the only factor in determining whether she can have a legal abortion.
- A girl who falls pregnant after being raped should not have to undergo interrogation to determine whether or not she is entitled to an abortion.

Doctors reject Minister's fees prescription

By Bob Kennaugh

Doctors have rejected draft legislation that would give the Minister of Health extensive powers to control medical fees and veto decisions of the Medical and Dental Council.

The Bills were gazetted last month. In terms of the draft legislation any tariffs or fees will not be effective until approved by the Minister. The tariff, once approved by the Minister, will be a maximum tariff binding on all medical practitioners.

At a special Johannesburg meeting of the council members decided that the draft law was unnecessary and undesirable because it was in conflict with the spirit of the statutory objects of the council. The amendment usurped the functions of the council in all respects and rendered the statutory authority of the council nominal and superfluous.

TARIFFS

Doctors also approved a motion that the amendment was prejudicial to the good order and conduct of the business of the council. The council advised the Minister not to proceed with the proposed amendment.

Members also opposed an amendment which seeks to prevent doctors from contracting out of the Medical Schemes Act.

A four-man delegation from the council, headed by Professor H Snyman, the president, is to meet the Minister to discuss the draft legislation.

Professor J N de Klerk of Stellenbosch University, chairman of the Federal Council of the Medical Association, proposed that tariff changes should be submitted to the Minister after the council had approved the recommendation.

If the submission were acceptable, the Minister should publish it as soon as possible in the Government Gazette but not later than three months from the date on which he received it.

If the recommendation were not acceptable he should send it back to the council for reconsideration. It should then be resubmitted to the Minister within three months in a revised acceptable form.

The Minister should then publish the tariff change within three months.

	WHITE Male	WHITE Female	ASIAN Male	ASIAN Female	COLOURED Male	COLOURED Female	BLACK Male	BLACK Female
Rheumatic Heart Diseases (390-398)	115 1.2%	121 1.5%	28 2.5%	15 1.9%	120 3.9%	139 4.4%	49 2.1%	56 2.9%
Hypertensive Diseases (400-404)	212 2.2%	389 4.9%	115 10.1%	127 15.8%	190 6.1%	276 8.8%	273 11.4%	212 11.0%
[illegible]	9752 100%	7926 100%	1135 100%	804 100%	3114 100%	3140 100%	2390 100%	1921 100%
[illegible]	750 38.0%	[illegible]	[illegible]	28 26.9%	572 26.3%	161 24.7%	282 15.1%	59 18.2%
[illegible]	485 24.6%	[illegible]	[illegible]	13 12.5%	84 3.9%	18 2.8%	76 4.1%	11 3.4%
[illegible]	59 3.0%	41 6.1%	41 12.3%	2 1.9%	680 31.3%	167 25.6%	806 43.1%	89 27.5%
[illegible]	1973 100%	677 100%	333 100%	104 100%	2175 100%	652 100%	1868 100%	324 100%

... and self inflicted poisoning by motor vehicle exhaust gas" is a code used in South Africa which does not appear in I.C.D. (8th revision). See Ref. 13.

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DEPARTEMENT VAN GESONDHEID

1 Februarie 1980

No. R. 156

WYSIGING VAN DIE REGULASIES BETREFFENDE ANATOMIESE SKENKINGS EN NADOODSE ONDERSOEKE

Kragtens die bevoegdheid my verleen by artikel 13 (1) (dA) van die Wet op Anatomiese Skenkings en Nadoodse Ondersoeke, 1970 (Wet 24 van 1970), wysig ek, Lourens Albertus Petrus Anderson Munnik, Minister van Gesondheid, hierby die regulasies afgekondig by Goewermentskennisgewing R. 889 van 24 Mei 1974, soos gewysig by Goewermentskennisgewings R. 2348 van 13 Desember 1974, R. 1112 van 6 Junie 1975, R. 1879 van 3 Oktober 1975, R. 258 van 13 Februarie 1976, R. 185 van 11 Februarie 1977, R. 187 van 11 Februarie 1977, R. 1027 van 10 Junie 1977, R. 239 van 10 Februarie 1978, R. 2124 van 27 Oktober 1978, R. 1572 van 20 Julie 1979 en R. 1573 van 20 Julie 1979 deur die voorgeskrewe weefsel, die voorgeskrewe gemagtigde inrigting en die voorgeskrewe doel vermeld in die Bylae hiervan in onderskeidelik kolom I, kolom II en kolom III van Bylae II in te voeg:

BYLAE

Kolom I Voorgeskrewe weefsel	Kolom II Voorgeskrewe gemagtigde inrigting	Kolom III Voorgeskrewe doel
Niere.....	Wentworth-hospitaal, Durban	Oorplanting.
Niere.....	Greys-hospitaal, Pietermaritzburg	Oorplanting.
Niere.....	Northdale-hospitaal, Pietermaritzburg	Oorplanting.

DEPARTMENT OF HEALTH

1 February 1980

No. R. 156

AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATIONS REGULATIONS

By virtue of the powers vested in me by section 13 (1) (dA) of the Anatomical Donations and Post-mortem Examinations Act, 1970 (Act 24 of 1970), I, Lourens Albertus Petrus Anderson Munnik, Minister of Health, hereby amend the regulations promulgated by Government Notice R. 889 of 24 May 1974, as amended by Government Notices R. 2348 of 13 December 1974, R. 1112 of 6 June 1975, R. 1879 of 3 October 1975, R. 258 of 13 February 1976, R. 185 of 11 February 1977, R. 187 of 11 February 1977, R. 1027 of 10 June 1977, R. 239 of 10 February 1978, R. 2124 of 27 October 1978, R. 1572 of 20 July 1979 and R. 1573 of 20 July 1979 by inserting the prescribed tissue, the prescribed authorised institution and the prescribed purpose named in the Schedule hereto, in column I, column II and column III, respectively, of Schedule II:

SCHEDULE

Column I Prescribed tissue	Column II Prescribed authorised institution	Column III Prescribed purpose
Kidneys....	Wentworth Hospital, Durban	Transplantation.
Kidneys....	Grey's Hospital, Pietermaritzburg	Transplantation.
Kidneys....	Northdale Hospital, Pietermaritzburg	Transplantation.

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No. R. 157 1 Februarie 1980

WYSIGING VAN DIE REGULASIES BETREFFENDE ANATOMIESE SKENKINGS EN NADOODSE ONDERSOEKE

Kragtens die bevoegdheid my verleen by artikel 13 (1) (dA) van die Wet op Anatomiese Skenkings en Nadoodse Ondersoeke, 1970 (Wet 24 van 1970), wysig ek, Lourens Albertus Petrus Anderson Munnik, Minister van Gesondheid, hierby die regulasies afgekondig by Goewermentskennisgewing R. 889 van 24 Mei 1974, soos gewysig by Goewermentskennisgewings R. 2348 van 13 Desember 1974, R. 1112 van 6 Junie 1975, R. 1879 van 3 Oktober 1975, R. 258 van 13 Februarie 1976, R. 185 van 11 Februarie 1977, R. 187 van 11 Februarie 1977, R. 1027 van 10 Junie 1977, R. 239 van 10 Februarie 1978, R. 2124 van 27 Oktober 1978, R. 1572 van 20 Julie 1979 en R. 1573 van 20 Julie 1979, deur die voorgeskrewe weefsel, die voorgeskrewe gemagtigde inrigting en die voorgeskrewe doel vermeld in die Bylae hiervan in onderskeidelik kolom I, kolom II en kolom III van Bylae II in te voeg.

BYLAE

Kolom I Voorgeskrewe weefsel	Kolom II Voorgeskrewe gemagtigde inrigting	Kolom III Voorgeskrewe doel
Hart.....	Groote Schuur-hospitaal, Observatory, Kaap	Oorplanting.

No. R. 158 1 Februarie 1980

REGULASIES BETREFFENDE PRIVATE HOSPITALE EN LOSSTAANDE OPERASIETEATEREENHEDE

Die Minister van Gesondheid het kragtens die bevoegdheid hom verleen by artikel 44 van die Wet op Gesondheid, 1977 (Wet 63 van 1977), die volgende regulasies uitgevaardig:

WOORDOMSKRYWING

1. Vir die toepassing van hierdie regulasies, tensy uit die samehang anders blyk, beteken—

"afgebakende area" die steriele gebied wat deur 'n skeidslyn geskei word van die nie-steriele gebied;

"behandeling" 'n diagnostiese of terapeutiese prosedure wat uitgevoer word vir chirurgiese, mediese, verloskundige of tandheelkundige doeleindes, met inbegrip van die verskaffing van die nodige verpleegdienste, akkommodasie, toerusting en aanvullende fasiliteite, en het "behandel" en "behandelde" 'n ooreenstemmende betekenis;

"Direkteur" die Direkteur van Hospitaaldienste van die provinsiale administrasie van 'n provinsie waarbinne 'n bepaalde private hospitaal of losstaande operasieteatereenheid gelee is of gaan wees;

"eienaar" die persoon, of die benoemde in die geval van 'n maatskappy of vereniging van persone (met of sonder regspersoonlikheid), wat 'n private hospitaal of losstaande operasieteatereenheid instel, uitbrei, bedryf of onderhou;

"geventileer", in verband met 'n vertrek, dat sodanige vertrek geventileer word deur 'n doeltreffende kunsmatige ventilasiestelsel of deur een of meer vensters wat regstreeks na die buitelug oopmaak en wat heeltemal of gedeeltelik oopgemaak kan word en so geplaas is dat dit 'n doeltreffende deurtrek of kruisventilasie bewerkstellig;

No. R. 157 1 February 1980

AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATIONS REGULATIONS

By virtue of the powers vested in me by section 13 (1) (dA) of the Anatomical Donations and Post-Mortem Examinations Act, 1970 (Act 24 of 1970), I, Lourens Albertus Petrus Anderson Munnik, Minister of Health, hereby amend the regulations promulgated by Government Notice R. 889 of 24 May 1974, as amended by Government Notices R. 2348 of 13 December 1974, R. 1112 of 6 June 1975, R. 1879 of 3 October 1975, R. 258 of 13 February 1976, R. 185 of 11 February 1977, R. 187 of 11 February 1977, R. 1027 of 10 June 1977, R. 239 of 10 February 1978, R. 2124 of of 27 October 1978, R. 1572 of 20 July 1979 and R. 1573 of 20 July 1979, by inserting the prescribed tissue, the prescribed authorised institution and the prescribed purpose named in the Schedule hereto, in column I, column II and column III, respectively, of Schedule II.

SCHEDULE

Column I Prescribed tissue	Column II Prescribed authorised institution	Column III Prescribed purpose
Heart.....	Groote Schuur Hospital, Observatory, Cape	Transplantation.

No. R. 158 1 February 1980

REGULATIONS GOVERNING PRIVATE HOSPITALS AND UNATTACHED OPERATING-THEATRE UNITS

The Minister of Health has, by virtue of the powers vested in him by section 44 of the Health Act, 1977 (Act 63 of 1977), made the following regulations:

DEFINITIONS

1. For the purposes of these regulations, unless the context otherwise indicates—

"approved" means approved by the Secretary;

"central sterile supply department" means a room or rooms in which instruments, dressings, basins, containers, water and other items which are required to be sterile for the treatment of patients are sterilised, and are for this purpose received, cleaned, packed, sterilised and stored;

"demarcated area" means an area which devides sterile from non-sterile areas;

"Director" means the Director of Hospital Services of the provincial administration of a province within which a particular private hospital or unattached operating-theatre unit is or is to be situated;

"inspecting officer" means a Government officer as defined in section 1 of the Public Servants Act, 1957 (Act 54 of 1957), authorised in writing by the Secretary to carry out an inspection;

"lighted", in relation to any room, means that such room is effectively lighted by means of an approved artificial lighting system or that the total unobstructed window area is equivalent to not less than 15 per cent of the floor area of such room;

"operating-theatre" means a room in which a registered medical practitioner or dentist carries out operations;

"goedgekeur" deur die Sekretaris goedgekeur;

"herstelkamer of -ruimte" daardie gedeelte van 'n operasieteatereenheid wat spesiaal gehou word en ten volle toegerus is vir onmiddellike na-operatiewe herstel, resussitering, verpleging en spesiale versorging van pasiënte tot tyd en wyl sodanige pasiënte geag word genoegsaam herstel het dat hulle met veiligheid vanuit voormelde gedeelte verwyder kan word;

"inspeksiebeampte" 'n beampte omskryf in artikel 1 van die Staatsdienswet, 1957 (Wet 54 van 1957), wat deur die Sekretaris skriftelik daartoe gemagtig is om 'n inspeksie uit te voer;

"losstaande operasieteatereenheid" 'n operasieteatereenheid wat nie in besit is van of bestuur word deur die Staat, 'n provinsiale administrasie, 'n plaaslike bestuur, 'n private hospitaalowerheid, 'n hospitaalraad of enige ander openbare liggaam nie, wat nie verbonde is aan 'n hospitaal of verpleeg- of kraaminrigting nie, en waar 'n pasiënt wat in sodanige operasieteatereenheid geopereer word, hoogstens 12 uur mag vertoef, bereken vanaf die tydstip waarop hy die eenheid binnegaan onmiddellik voordat hy geopereer word;

"oorbewoon", in verband met 'n vertrek of akkommodasie, dat daar minder as 4 m² vloeroppervlakte en minder as 12 m³ lugruimte is vir elke persoon wat in sodanige vertrek of akkommodasie werk of gehuisves word, of dat daar minder as die helfte van hierdie oppervlakte en ruimte vir elke sodanige persoon van jonger as 10 jaar is: Met dien verstande dat die vloeroppervlakte en die lugruimte van 'n enkelkamer nie kleiner mag wees as onderskeidelik 10 m² en 30 m³ nie;

"operasieteater" 'n vertrek waarin 'n geregistreerde geneesheer of tandarts operasies uitvoer;

"operasieteatereenheid" 'n plek waar chirurgiese werksaamhede uitgevoer word en waarin voorsiening gemaak is vir die fasiliteite soos in hierdie regulasies uiteengesit;

"private hospitaal" enige hospitaal of enige ander inrigting, gebou of plek waar voorsiening gemaak word vir die behandeling en versorging van gevalle wat geneeskundige of chirurgiese behandeling en verpleegsorg nodig het, maar met uitsluiting van—

(a) 'n hospitaal of enige sodanige inrigting, gebou of plek wat bedryf word deur die Staat, 'n provinsiale administrasie, 'n plaaslike bestuur, 'n private hospitaalowerheid, 'n hospitaalraad of enige ander openbare liggaam;

(b) 'n spreekkamer, operasiekamer of apteek van 'n geneesheer of tandarts wat nie bedakkommodasie verskaf nie;

(c) 'n losstaande operasieteatereenheid; en

(d) 'n hospitaal of ander inrigting wat gelisensieer is vir die opneming en aanhouding van geestesongestelde persone ingevolge artikel 46 van die Wet op Geestesgesondheid, 1973 (Wet 18 van 1973);

"sentrale sterieleverskaffingsdepartement" 'n vertrek of vertrekke waarin instrumente, verbande, komme, houers, water en ander items wat vir die behandeling van pasiënte steriel moet wees, gesteriliseer word, en vir hierdie doel ontvang, skoongemaak, verpak, gesteriliseer en geberg word;

"spoelkamer" 'n vertrek waar bedpanne, urinale, sputumbekers en soortgelyke houers geberg word en geledig, uitgespoel en ontsmet kan word en waar vuil bedlinne, verbande en dergelike artikels geplaas kan word voor verwydering;

"operating-theatre unit" means a place where surgical activities are carried out and in which provision is made for those facilities as set forth in these regulations;

"overcrowded", in relation to any room or accommodation, means that there is less than 4 m² of floor area and less than 12 m³ of air space for each person working or accommodated in such room or accommodation and less than half of this area and space for each such person under 10 years of age: Provided that the floor area and air space of a single room shall not be less than 10 m² and 30 m³ respectively;

"prescribed procedures" means the surgical operations and medical procedures listed in Annexure A;

"private hospital" means any hospital or any other institution, building or place at which provision is made for the treatment and care of cases requiring medical or surgical treatment and nursing care, but excluding—

(a) a hospital or any such institution, building or place conducted by the State, a provincial administration, local authority, private hospital authority, hospital board or any other public body;

(b) any consulting room, surgery or dispensary of a medical practitioner or dentist which does not provide any bed accommodation;

(c) an unattached operating-theatre unit; and

(d) a hospital or other institution licensed for the reception and detention of mentally ill persons in terms of section 46 of the Mental Health Act, 1973 (Act 18 of 1973);

"proprietor" means the person, or the nominee in the case of a company or an association of persons (whether corporate or incorporate), who establishes, extends, conducts or maintains a private hospital or unattached operating-theatre unit;

"recovery room or area" means that section of an operating-theatre unit specially set aside and fully equipped for the immediate post-operative recovery, resuscitation, nursing and special care of patients until such time as such patients are considered to have recovered sufficiently to be safely removed from the aforementioned section;

"sluice room" means a room where bed pans, urinals, sputum mugs and similar containers are kept and can be emptied, washed out, disinfected and stored, and where soiled linen, dressings and similar items can be deposited prior to removal;

"treatment" means any diagnostic or therapeutic procedure carried out for surgical, medical, obstetrical or dental purposes, and includes the provision of the necessary nursing services, accommodation, equipment and ancillary facilities, and "treat", "treating" and "treated" have corresponding meanings;

"unattached operating-theatre unit" means an operating-theatre unit not owned or managed by the State, a provincial administration, a local authority, a private hospital authority, a hospital board or any other public body and not attached to a hospital or nursing home or maternity home, and where a patient operated on in such operating-theatre unit may remain for a period not exceeding 12 hours, reckoned from the time he enters the unit immediately before being operated on; and

"verlig", in verband met 'n vertrek, dat sodanige vertrek afdoende verlig word deur 'n kunsmatige verligtingstelsel of dat die totale onversperde vensteroppervlakte gelykstaande is met minstens 15 persent van die vloeroppervlakte van sodanige vertrek;

"voorgeskrewe prosedures" die chirurgiese operasies en mediese prosedures wat in Aanhangsel A gelys word.

Enige ander uitdrukking wat in hierdie regulasies gebruik word, het, tensy uit die samehang duidelik anders blyk, dieselfde betekenis as dié wat daaraan geheg word in die Wet op Gesondheid, 1977 (Wet 63 van 1977).

REGISTRASIE

2. Behoudens die bepalings van regulasie 8, mag niemand 'n private hospitaal of 'n losstaande operasieteatereenheid oprig, instel, uitbrei, bedryf, onderhou, bestuur of beheer of 'n diens daarin lewer of die verskaffing van behandeling daarin toelaat of reël nie, tensy sodanige private hospitaal of losstaande operasieteatereenheid of beoogde private hospitaal of losstaande operasieteatereenheid geregistreer is ooreenkomstig die bepalings van hierdie regulasies en die eienaar in besit is van 'n geldige registrasiesertifikaat wat die Sekretaris ten opsigte daarvan aan hom uitgereik het.

3. Elke sodanige registrasiesertifikaat wat ingevolge regulasie 14 (1) of 14 (3) uitgereik word, is van krag vanaf die datum van uitreiking tot en met die 31ste dag van die eersvolgende Desembermaand, wanneer dit verval, of vir sodanige gedeelte van bedoelde tydperk as wat in die registrasiesertifikaat vermeld word. 'n Aansoek om hernuwing van sodanige registrasiesertifikaat moet minstens 90 dae voor die vervaldatum en ooreenkomstig regulasie 11 gedoen word: Met dien verstande dat wanneer sodanige registrasiesertifikaat ná 30 September uitgereik word, dit sodanig uitgereik word dat dit geldig bly tot die 31ste dag van Desember van die daaropvolgende jaar.

4. 'n Private hospitaal of losstaande operasieteatereenheid word nie as sodanig geregistreer nie en geen registrasiesertifikaat word ten opsigte daarvan uitgereik nie, tensy—

(1) die perseel waarop die private hospitaal of losstaande operasieteatereenheid bedryf word of gaan word en die toerusting wat in sodanige private hospitaal of losstaande operasieteatereenheid gebruik word of vir gebruik aldaar bestem is, geskik en toereikend is vir die doeleindes van genoemde private hospitaal of losstaande operasieteatereenheid;

(2) die private hospitaal of losstaande operasieteatereenheid nie bestuur word of bestuur sal word op 'n wyse wat vir die liggaamlike, geestelike of sedelike welsyn van die pasiënte of personeel nadelig is of sal wees nie;

(3) die personeel van die private hospitaal of losstaande operasieteatereenheid voldoen of sal voldoen aan aanvaarde norme vir die doeleindes van sodanige hospitaal of eenheid;

(4) die persoon in beheer van sodanige private hospitaal of losstaande operasieteatereenheid as 'n geneesheer, of, in die geval van 'n uitsluitlike tandheelkundige diens, as 'n tandarts geregistreer is of sal wees ingevolge die bepalings van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsberoepe, 1974 (Wet 56 van 1974), of, in die geval van 'n algemene mediese verplegingsdiens of 'n verloskundige diens, as onderskeidelik 'n verpleegkundige of 'n vroedvrou geregistreer is of sal wees ingevolge die bepalings van die Wet op Verpleging, 1978 (Wet 50 van 1978);

"ventilated", in relation to any room, means that such room is ventilated by an effective artificial ventilation system or by one or more windows opening direct to the outer air and capable of opening wholly or partly, and so placed as to make possible an effective through draught or cross-ventilation.

Any other expression in these regulations has the same meaning, unless the context clearly indicates otherwise, as that assigned to it in the Health Act, 1977 (Act 63 of 1977).

REGISTRATION

2. Subject to the provisions of regulation 8, no person shall erect, establish, extend, conduct, maintain, manage, control or render any service in a private hospital or an unattached operating-theatre unit or permit or arrange for treatment to be provided therein unless such private hospital or unattached operating-theatre unit or proposed private hospital or unattached operating-theatre unit has been registered in accordance with the provisions of these regulations and the proprietor is in possession of a valid certificate of registration issued to him in respect thereof by the Secretary.

3. Each such certificate of registration issued in terms of regulation 14 (1) or 14 (3) shall be effective from the date of issue up to and including the next succeeding 31st day of December, when it shall lapse, or for such portion of the said period as may be specified in the certificate of registration. An application for the renewal of such certificate of registration shall be made in accordance with regulation 11, not less than 90 days before the date of expiry: Provided that whenever such registration certificate is issued after 30 September, such registration certificate shall be issued for a period up to 31 December of the following year.

4. A private hospital or unattached operating-theatre unit shall not be registered as such and no certificate of registration shall be issued in respect thereof, unless—

(1) the premises on which a private hospital or unattached operating-theatre unit is or is to be conducted and the equipment which is used or is intended for use in such private hospital or unattached operating-theatre unit are suitable and adequate for the purposes of the said private hospital or unattached operating-theatre unit;

(2) the private hospital or unattached operating-theatre unit is not managed or will not be managed in a manner which will be detrimental to the physical, mental or moral welfare of the patients or staff;

(3) the staff of the private hospital or unattached operating-theatre unit comply with, or will comply with, accepted standards for the purposes of such hospital or unit;

(4) the person in charge of such private hospital or unattached operating-theatre unit is or will be registered as a medical practitioner or, in the case of an exclusively dental service, a dentist, in terms of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), or in the case of a general medical nursing service or a midwifery service, is or will be registered in terms of the Nursing Act, 1978 (Act 50 of 1978), as a registered nurse or midwife, respectively;

(5) daar 'n verpleegkundige wat ingevolge die Wet op Verpleging, 1978 (Wet 50 van 1978), geregistreer is, in bevel van die verplegingsdiens is of sal wees indien die persoon in beheer 'n geregistreerde geneesheer of tandarts is soos in subregulasie (4) beskryf;

(6) sodanige registrasie in die openbare belang is.

5. (1) In sy aansoek moet die eienaar 'n beskrywing gee van die perseel; besonderhede verstrek aangaande die ligging daarvan, die aard van die behandeling wat daar verskaf sal word, die bevolkingsgroepe van die personeel wat aan die private hospitaal of losstaande operasieteatereenheid verbonde sal wees en die bevolkingsgroepe wat van die private hospitaal of losstaande operasieteatereenheid gebruik sal maak; en enige verdere inligting verstrek wat die Sekretaris nodig ag om hom in staat te stel om die aansoek te oorweeg.

(2) Die eienaar moet die Sekretaris onverwyld skriftelik in kennis stel van elke verandering in die besonderhede wat hy ingevolge subregulasie (1) verstrek het, of wat aangedui word op die huidige registrasiesertifikaat wat ooreenkomstig regulasie 12 van hierdie regulasies uitgereik is.

6. Die eienaar van 'n geregistreerde private hospitaal moet aan die Sekretaris, aan die Direkteur en aan die pasiënte en personeel van sodanige hospitaal ten minste drie maande kennis gee van die voorgenome sluiting daarvan: Met dien verstande dat die Sekretaris in oorleg met die Direkteur in buitengewone omstandighede 'n korter tydperk van kennisgewing kan magtig.

OPRIGTING VAN PRIVATE HOSPITALE EN LOSSTAANDE OPERASIETEATEREENHEDE

7. (1) Niemand mag sonder die vooraf verkreë skriftelike toestemming van die Sekretaris 'n gebou oprig, verander, of toerus of enige perseel op enige ander wyse gereedmaak vir gebruik as 'n private hospitaal of losstaande operasieteatereenheid nie.

(2) (*i*) Iemand wat voornemens is om 'n private hospitaal of losstaande operasieteatereenheid op te rig, moet vooraf skriftelike toestemming verkry van die Sekretaris, wat hom, in oorleg met die Direkteur, van die nodigheid of onnodigheid van so 'n private hospitaal of losstaande operasieteatereenheid moet vergewis alvorens hy toestemming verleen of weier.

(ii) Nadat die aansoeker sodanige toestemming verkry het, moet hy Vorm I (Aanhangsel B) voltooi en planne tesame met die nodige inligting voorlê vir goedkeuring deur die Sekretaris en sodanige bykomende inligting verstrek as wat die Sekretaris mag verlang.

(3) Toestemming en goedkeuring ingevolge regulasie 7 is nie oordraagbaar nie.

8. In die geval van 'n private hospitaal of losstaande operasieteatereenheid waarvan die gebou nog opgerig of omgebou staan te word, moet 'n aansoek om registrasie vergesel gaan van planne van die gebou of beoogde gebou. Sodanige planne moet die aard en konstruksie van die gebou of beoogde gebou of die aard van die ombouings, na gelang van die geval, duidelik toon. Die benamings van die kamers, afmetings en vierkante afmetings moet by die planne aangeheg word in die vorm van 'n skedule.

9. Indien die pasiënte in 'n meerverdiepinggebou gehuisves word, moet daar voorsiening gemaak word vir 'n toereikende aantal hysers of opritte: Met dien verstande dat behoorlike voorsiening gemaak moet word vir hysers wat geskik is om 'n pasiëntebed of -trollie te neem en dat voorsiening gemaak moet word vir die afsonderlike verwydering van vuil linne, afval en vullis.

(5) a nurse registered in terms of the Nursing Act, 1978 (Act 50 of 1978), is or will be in charge of the nursing service if the person in charge is a registered medical practitioner or dentist as described in subregulation (4); and

(6) such registration is in the public interest.

5. (1) In his application the proprietor shall give a description of the premises and also furnish particulars regarding their location, the nature of the treatment to be rendered there, the population groups of the staff attached to the private hospital or unattached operating-theatre unit and the population groups that will make use of the private hospital or unattached operating-theatre unit, and shall furnish any further information required by the Secretary in order to consider the application.

(2) The proprietor shall immediately report to the Secretary in writing any change in the particulars furnished by him in terms of subregulation (1) or indicated on the current certificate of registration issued in terms of regulation 12 of these regulations.

6. The proprietor of a registered private hospital shall give not less than three months' notice in writing of the intended closure of such hospital to the Secretary, the Director, patients and staff: Provided that, in exceptional circumstances, the Secretary, in consultation with the Director, may authorise a shorter period of notice.

ESTABLISHMENT OF PRIVATE HOSPITALS AND UNATTACHED OPERATING-THEATRE UNITS

7. (1) No person shall erect, alter, equip or in any other way prepare any premises for use as a private hospital or unattached operating-theatre unit without the prior approval in writing of the Secretary.

(2) (i) Any person intending to establish a private hospital or an unattached operating-theatre unit shall first obtain permission in writing from the Secretary, who, in consultation with the Director, shall satisfy himself as to the necessity or otherwise for such a private hospital or unattached operating-theatre unit before granting or refusing permission.

(ii) Having obtained such permission, the applicant shall complete Form I (Annexure B) and submit plans for approval by the Secretary, together with the necessary information, and shall supply any additional information which the Secretary may require.

(3) Permission and approval in terms of regulation 7 are not transferable.

8. In the case of a private hospital or unattached operating-theatre unit of which the buildings are still to be erected or converted, plans of the buildings or proposed buildings shall accompany the application for registration. The plans should show clearly the nature and construction of the buildings or proposed buildings or the nature of the conversions, as the case may be. Room names, dimensions and square measurements shall be attached to the plans in the form of a schedule.

9. A sufficient number of lifts or ramps shall be provided where patients are housed in a multi-storey building: Provided that adequate provision shall be made for lifts suitable for taking a patient bed or trolley and for the separate removal of soiled linen, waste and refuse.

10. Alle planne moet op 'n skaal van 1:100 geteken en in tweevoud ingedien word.

11. Die aansoeker moet aan die Sekretaris skriftelike bewys lewer dat nòg enige staatsdepartement nòg die betrokke plaaslike bestuur beswaar daarteen het dat die private hospitaal of losstaande operasieteatereenheid op die betrokke perseel bedryf word. In die geval van 'n gebou wat nog opgerig of omgebou staan te word, moet die aansoeker skriftelike bewys lewer dat die plan deur die betrokke plaaslike bestuur goedgekeur is.

AANSOEK OM HERNUWING VAN REGISTRASIE

12. Minstens 90 dae voor die datum waarop 'n registrasiesertifikaat verval, moet die eienaar aansoek doen om die hernuwing van sodanige registrasie.

13. Elke aansoek om hernuwing van die registrasie van 'n private hospitaal of losstaande operasieteatereenheid moet aan die Sekretaris gerig word wesenlik in die vorm van Vorm I in Aanhangsel B.

HANTERING VAN AANSOEKE

14. By ontvangs van 'n aansoek besluit die Sekretaris in oorleg met die Direkteur—

(1) om die beoogde private hospitaal of losstaande operasieteatereenheid te registreer en 'n registrasiesertifikaat ten opsigte daarvan uit te reik behoudens sodanige voorwaardes as wat hy goeddink; of

(2) om registrasie te weier, in welke geval hy geen registrasiesertifikaat uitreik nie; of

(3) om die registrasie van die private hospitaal of losstaande operasieteatereenheid te hernien en 'n registrasiesertifikaat ten opsigte daarvan uit te reik behoudens sodanige voorwaardes as wat hy goeddink; of

(4) om hernuwing van die registrasie te weier, in welke geval hy geen registrasiesertifikaat uitreik nie.

15. Die Sekretaris kan vir die doel van regulasie 14 die perseel waarop die aansoek betrekking het, inspekteer of deur 'n inspekterende beampte laat inspekteer en die aansoeker moet ten opsigte van sodanige inspeksie aan die Ontvanger van Inkomste inspeksiegeld van R30 betaal, wat vervoergeld insluit.

HERAANSOEK OM REGISTRASIE

16. Enige eienaar wat om die registrasie van 'n private hospitaal of losstaande operasieteatereenheid aansoek gedoen het en wie se aansoek geweier is, of enige eienaar wie se aansoek om hernuwing van registrasie geweier is of wie se registrasiesertifikaat ingevolge regulasie 18 gekanselleer is, of enige eienaar wat versuim het om betyds om die hernuwing van registrasie aansoek te doen en wie se registrasiesertifikaat verval het, of enige eienaar of voornemende eienaar wat ingevolge regulasie 55 appèl aangeteken het teen die weiering deur die Sekretaris van registrasie of hernuwing van registrasie of teen die kansellering deur die Sekretaris van 'n registrasiesertifikaat en wie se appèl afgewys is, kan te eniger tyd heraansoek doen om die registrasie of hernuwing van registrasie van dieselfde private hospitaal of losstaande operasieteatereenheid: Met dien verstande dat indien registrasie of hernuwing van registrasie geweier is of die registrasiesertifikaat gekanselleer is onrede versuim deur die applikant om aan die voorwaardes en die vereistes te voldoen wat die Sekretaris ingevolge regulasie 14 (1) of 14 (3) gestel het, sodanige verdere aansoek nie gedoen kan word nie totdat en tensy daar aan al sodanige voorwaardes en vereistes voldoen is.

10. All plans shall be drawn to the scale of 1:100 and submitted in duplicate.

11. The applicant shall furnish the Secretary with proof, in writing, that neither the Government departments concerned nor the local authority concerned have any objection to the private hospital or unattached operating-theatre unit being conducted on the premises concerned. In the case of a building still to be erected or converted, the applicant shall furnish proof, in writing, that the plan has been passed by the local authority concerned.

APPLICATION FOR RENEWAL OF REGISTRATION

12. Not less than 90 days before the date on which a certificate of registration expires, the proprietor shall apply for the renewal of such registration.

13. Every application for renewal of registration of a private hospital or unattached operating-theatre unit shall be made to the Secretary substantially in the form of Form I in Annexure B.

HANDLING OF APPLICATIONS

14. Upon the receipt of an application the Secretary shall, in consultation with the Director, decide—

(1) to register the proposed private hospital or unattached operating-theatre unit and issue a certificate of registration in respect thereof, subject to such conditions as he may deem fit; or

(2) to refuse registration, in which event he shall not issue any certificate of registration; or

(3) to renew the registration of the private hospital or unattached operating-theatre unit and issue a certificate of registration in respect thereof, subject to such conditions as he may deem fit; or

(4) to refuse the renewal of registration, in which event no certificate of registration shall be issued.

15. The Secretary may for the purposes of regulation 14 carry out or cause to be carried out by an inspecting officer an inspection of the premises in respect of which the application was made and the applicant shall pay to the Receiver of Revenue in respect of such inspection an inspection fee of R30, which shall include transport fees.

RE-APPLICATION FOR REGISTRATION

16. Any proprietor who has applied for registration of a private hospital or unattached operating-theatre unit and whose application has been refused or any proprietor whose application for renewal of registration has been refused or whose certificate of registration has been cancelled in terms of regulation 18 or any proprietor who failed to apply timeously for renewal of registration and whose certificate of registration has expired or any proprietor or prospective proprietor who lodged an appeal in terms of regulation 55 against the refusal by the Secretary of registration or renewal of registration or against the cancellation by the Secretary of a certificate of registration and whose appeal has been dismissed may at any time re-apply for registration or renewal of registration of the same private hospital or unattached operating-theatre unit: Provided that, if registration or renewal of registration has been refused or the certificate of registration has been cancelled because of failure by the applicant to comply with all the conditions and requirements imposed by the Secretary in terms of regulation 14 (1) or 14 (3), such further application shall not be made until and unless all such conditions and requirements have been complied with.

VRYSTELLING VAN VEREISTES TEN OPSIGTE VAN REGISTRASIE

17. Die Sekretaris kan te eniger tyd, op dié voorwaardes en vir dié tydperk wat hy in oorleg met die Direkteur bepaal, aan 'n eienaar vrystelling verleen van enige vereistes ten opsigte van registrasie ingevolge hierdie regulasies.

KANSELLERING VAN REGISTRASIE-SERTIFIKAAT

18. 'n Registrasiesertifikaat kan te eniger tyd gekanselleer word—

(1) deur die Sekretaris indien die eienaar—

(i) versuim om aan enige voorwaardes en vereistes te voldoen wat ingevolge regulasie 14 (1) of 14 (3) gestel is; of

(ii) versuim om die opgawes, [illegible]ede of inligting te verstrek wat hy ingevolge regulasie 28 moet verstrek; of

(iii) skuldig bevind word aan 'n misdryf ingevolge die bepalings van hierdie regulasies;

(2) deur die Sekretaris of die Minister, indien hy dit in die openbare belang ag dat die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan sodanige registrasiesertifikaat uitgereik is, gesluit word.

19. Indien die Sekretaris of die Minister, na gelang van die geval, kragtens regulasie 18 'n registrasiesertifikaat kanselleer, gee hy aan die eienaar skriftelik kennis dat hy die registrasiesertifikaat aldus kanselleer en dat die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan dit uitgereik is gesluit moet word voor of op 'n datum in sodanige kennisgewing vermeld.

20. By die kansellering van 'n registrasiesertifikaat kragtens regulasie 18, verval die registrasie van die private hospitaal of losstaande operasieteatereenheid ten opsigte waarvan sodanige registrasiesertifikaat uitgereik is, op die datum vermeld in die skriftelike kennisgewing bedoel in regulasie 19.

BOUVEREISTES VIR LOSSTAANDE OPERASIETEATEREENHEDE

21. Die vertrekke van 'n losstaande operasieteatereenheid moet aan die volgende vereistes voldoen:

(1) Behalwe waar daar in hierdie regulasies 'n ander vereiste gestel word, moet alle mure minstens 2,6 m hoog wees, gemeet van die vloer tot by die plafon, en gebou wees van baksteen, klip, beton of ander ondeurlatende materiaal en, tensy anders goedgekeur, moet die buitemure minstens 225 mm dik en die binnemure minstens 89 mm dik wees.

(2) In die operasieteater, die spoelkamer, die toilette en stortbokkies moet die voeg tussen die muur en die vloer gerond wees.

(3) Alle gange wat vir pasiëntetrollies bedoel is, moet minstens 2 m wyd wees.

(4) Alle deure wat toegang verleen tot vertrekke waar pasiënte gehuisves sal word, moet minstens 2 m hoog en minstens 1 m wyd wees.

(5) Alle vertrekke moet bevredigend geventileer en verlig wees en ruim genoeg om te verseker dat hulle nie oorbewoon is wanneer die maksimum getal persone wat gewoonlik op enige tydstip daarin sou wees, teenwoordig is nie.

(6) Alle vertrekke, gange en teaters moet voorsien wees van 'n gladde, stofdigte plafon.

EXEMPTION FROM REQUIREMENTS IN RESPECT OF REGISTRATION

17. The Secretary may at any time, on such conditions and for such period as he may determine in consultation with the Director, grant a proprietor exemption from any requirements in respect of registration in terms of these regulations.

CANCELLATION OF CERTIFICATE OF REGISTRATION

18. A certificate of registration may at any time be cancelled—

(1) by the Secretary if the proprietor—

(i) fails to comply with any conditions and requirements imposed in terms of regulation 14 (1) or 14 (3); or

(ii) fails to furnish the returns, particulars or information which he is required to furnish in terms of regulation 28; or

(iii) is found guilty of an offence in terms of the provisions of these regulations;

(2) by the Secretary or the Minister if he deems it to be in the public interest that the private hospital or unattached operating-theatre unit in respect of which such certificate of registration has been issued be closed.

19. Whenever the Secretary or the Minister, as the case may be, cancels a certificate of registration in terms of regulation 18 he shall give notice in writing to the proprietor that he is so cancelling the certificate of registration and that the private hospital or unattached operating-theatre unit in respect of which it was issued shall be closed down on or before a date specified in such notice.

20. Upon the cancellation of a certificate of registration in terms of regulation 18, the registration of the private hospital or unattached operating-theatre unit in respect of which such certificate of registration was issued shall lapse on the date specified in the written notice referred to in regulation 19.

BUILDING REQUIREMENTS FOR UNATTACHED OPERATING-THEATRE UNITS

21. The rooms of an unattached operating-theatre unit shall comply with the following requirements:

(1) Save where otherwise required in these regulations, all walls shall not be less than 2,6 m high, measured from the floor to the ceiling, and shall be constructed of burnt brick, stone, concrete or some other impervious material and unless otherwise approved, the external walls shall be not less than 225 mm thick and the internal walls not less than 89 mm thick.

(2) In the operating-theatre, sluice room, toilets and shower cubicles, the joint between the walls and the floor shall be rounded.

(3) All corridors taking patient trolleys shall be not less than 2 m wide.

(4) All doors giving access to rooms in which patients are to be accommodated shall be not less than 2 m high and 1 m wide.

(5) All rooms shall be satisfactorily ventilated and lighted and spacious enough to ensure that they are not overcrowded when the maximum number of persons that would normally be in them at any time are present.

(6) All rooms, corridors and theatres shall be provided with a smooth, dustproof ceiling.

(7) Die vloere van alle vertrekke en gange moet van goedgekeurde materiaal wees en bedek wees met 'n wasbare, ondeurlatende materiaal: Behalwe dat waar vlambare materiaal gebruik, gehou of gebêre word, die vloer van die operasieteater en van die vertrekke waar sodanige vlambare materiaal gebruik, gehou of gebêre word, asook alle vloere binne 'n afstand van 1 m van die deure van die operasieteater en van sodanige vertrekke waar vlambare materiaal gebruik, gehou of gebêre word, bedek moet wees met 'n ondeurlatende, wasbare, antistatiese tipe materiaal en dat 'n opvallende waarskuwingskennisgewing 'n vereiste is ingeval die vloer nie antistaties is nie.

(8) Die oppervlakte van die mure moet glad gepleister wees en moet, behalwe waar hierdie regulasie anders bepaal, met 'n ligkleurige wasbare verf afgewerk wees of met 'n wasbare, ondeurlatende materiaal bedek wees; Met dien verstande dat in die geval van spoelkamers, toilette, storthokkies, operasieteaters, sentrale sterieleverskaffingsdepartemente en steriliseerkamers, die mure tot 'n hoogte van minstens 2,1 m van die vloer af, in plaas daarvan om met 'n ligkleurige wasbare verf geverf te word, bedek kan word met wit of ligkleurige glasuurteëls of met 'n ander wasbare, ondeurlatende materiaal: Met dien verstande, verder, dat die mure agter alle handewasbakke tot 'n hoogte van 500 mm bokant en 500 mm aan weerskante van sodanige handewasbakke bedek moet word met wit of ligkleurige glasuurteëls of ander wasbare, ondeurlatende materiaal.

(9) Behoorlik geplaaste en toereikende brandkrane, brandslange, brandblussers, branduitgange en nooduitgange moet verskaf word en bevredigend in stand gehou word.

(10) Indien die operasieteatereenheid nie op die grondverdieping van 'n meerverdiepinggebou is nie, moet die gebou voorsien wees van 'n brandtrap sowel as van 'n hyser wat groot genoeg is om 'n pasiënte-draagbaar te neem.

(11) Genoegsame water moet aangelê word na alle krane, storte, spoelapparaat en sanitêre geriewe in die operasieteatereenheid en alle vuilwater van die handewasbakke, spoelkamers, spoelbakke en toiletpanne moet doeltreffend dreineer in 'n goedgekeurde rioolstelsel.

(12) 'n Goedgekeurde verbrandingsoond of ander geskikte stelsel moet verskaf word vir die doeltreffende verbranding of wegdoen van vuil verbande en chirurgies verwyderde weefsels sonder om enige oorlas te veroorsaak.

VERTREKKE WAT NODIG IS

22. 'n Losstaande operasieteatereenheid moet bedryf word in akkommodasie waar voorsiening gemaak is vir—

(1) 'n operasieteater met 'n aangrensende steriliseerkamer, herstelruimte en saalakkommodasie wat so beplan of bedryf moet word dat die manlike en die vroulike pasiënte doeltreffend geskei sal wees: Met dien verstande dat indien sodanige herstelruimte so ingerig is dat dit voldoende is om die saalakkommodasie te vervang, geen sodanige afsonderlike saalakkommodasie vereis word nie;

(2) 'n skropruimte buite die operasieteater: Met dien verstande dat indien die operasieteater ruim genoeg daarvoor is, sodanige skropruimte verskaf kan word op enige geskikte plek binne die operasieteater; en

(3) 'n spoelkamer, spoelfasiliteite, dienskamerfasiliteite vir verpleegkundiges, 'n linnekamer of -kas vir skoon linnegoed, opbergruimte vir vlambare materiaal, voldoende kleedkamer- en toiletfasiliteite vir

(7) The floors of all rooms and corridors shall be of approved material and covered with impervious washable material: Save that where flammable materials are used, kept or stored, the floor of the operating-theatre and the rooms where such flammable materials are used, kept or stored, as well as all floors within a distance of 1 m of the doors of the operating-theatre and of such rooms where flammable materials are used, kept or stored, shall be covered with antistatic material of a washable impervious type and that a conspicious cautionary notice is a requirement if the floor is not antistatic.

(8) The surfaces of the walls shall be smoothly plastered and, save where otherwise provided in this regulation, be painted with washable paint of a light colour or clad with a washable impervious material: Provided that in the case of sluice rooms, toilets, shower cubicles, operating-theatres, central sterile supply departments or sterilising rooms, the walls up to a height of not less than 2,1 m from the floor may, instead of being painted with washable paint of a light colour, be covered with white or light-coloured glazed tiles or other washable, impervious material: Provided further that the walls behind all wash-hand basins shall, up to a height of 500 mm above and 500 mm on either side of such wash-hand basins, be covered with white or light-coloured glazed tiles or other washable, impervious material.

(9) Properly placed and adequate fire-hydrants, fire-hoses, fire-extinguishers, fire-escapes and emergency exits shall be provided and satisfactorily maintained.

(10) If the operating-theatre unit is in a multi-storeyed building and not on the ground floor, the building shall be equipped with fire-escape stairs as well as a lift of sufficient size to take a patient stretcher.

(11) Sufficient water shall be laid on to all taps, showers, sluicing apparatus and sanitary conveniences in the operating-theatre unit and all waste water from wash-hand basins, sluice rooms, sluice pans and toilet pans shall effectively drain into an approved sewerage system.

(12) An incinerator or other suitable system shall be provided for the effective incineration or disposal of soiled dressings and surgically removed tissues, without causing any nuisance.

ROOMS REQUIRED

22. An unattached operating-theatre unit shall be conducted in accommodation in which provisions is made for—

(1) an operating-theatre with adjoining sterilising room and recovery area and ward accommodation so planned or conducted that male and female patients shall be effectively separated: Provided that if such recovery area is so arranged as to provide adequate substitute ward accommodation, no such seperate ward accommodation shall be required;

(2) a scrubbing-up area outside the operating-theatre: Provided that if the operating-theatre is sufficiently spacious for the purpose, such scrubbing-up area may be provided at a suitable place within the operating-theatre; and

(3) a sluice room, sluicing facilities, nurses' duty-room facilities, a linen room or cupboard for clean linen, storage space for flammable material, adequate change-room and toilet facilities for staff and

personeel en pasiënte afsonderlik (toilette kan onafhanklik van kleedkamers vir mans en vroue afsonderlik verskaf word), 'n wagkamer vir pasiënte en hulle besoekers, kantoorruimte en, waar toepaslik, 'n spreekkamer.

AKKOMMODASIE

23. Die vertrekke wat in regulasie 22 bedoel word, moet aan die volgende vereistes voldoen:

(1) Die wagkamer moet 'n vloeroppervlakte hê van minstens 12 m², met 'n minimum muurlengte van 3 m: Met dien verstande dat indien daar binne die wagkamer voorsiening ook vir die kantoorruimte gemaak word, die vloer van die wagkamer 'n oppervlakte moet hê van minstens 18 m², met 'n minimum muurlengte van 3,6 m.

(2) Die kantoorruimte moet—

(i) minstens 6 m² vloeroppervlakte beslaan indien 'n gedeelte van die wagkamer vir hierdie doel ingeruim is; of

(ii) verskaf word in die vorm van 'n afsonderlike vertrek met 'n vloeroppervlakte van minstens 10 m² en met 'n minimum muurlengte van 2,4 m.

(3) Die spreekkamer moet, indien dit verskaf word, buite die operasieteater-area wees en moet 'n vloeroppervlakte hê van minstens 12 m², met 'n minimum muurlengte van 3 m, en moet toegerus wees met minstens een handewasbank met voldoende warm en koue water aangelê.

(4) Die operasieteater moet 'n vloeroppervlakte hê van minstens 20 m², met 'n minimum muurlengte van 3,6 m. Die mure moet minstens 2,6 m hoog wees, gemeet van die vloer tot by die plafon, en moet 'n aaneenlopende gladde oppervlak hê wat bedek is met harde glans-epoksihars- of 'n soortgelyke verf of met 'n ander geskikte wasbare, ondeurlatende materiaal; die plafon moet met 'n ligkleurige emaljeverf geverf wees. Die mure, die vloer en die plafon moet bestand wees teen herhaalde reiniging en ontsmetting.

(5) Warm en koue water moet aangelê word na elmboog-beheerde krane in die skropruimte bokant twee handewasbakke of trôe.

(6) Die operasieteater moet doeltreffend geventileer en verlig wees: Met dien verstande dat vensters, as daar is, stofdig moet wees. Die minimum vereiste vir lugreëling is dat 'n kantoortipe lugreëlaar met 'n 10-mikron-stoffilter geïnstalleer moet word.

(7) Die operasieteater moet van elektriese krag voorsien wees, wat aangelê is na minstens drie vonkvrye muurproppe, 'n geskikte elektriese operasieteaterlamp wat van die plafon of van 'n vrydraende balk aan die muur hang, goedgekeurde fasiliteite vir noodverligting in geval van 'n kragonderbreking, 'n goedgekeurde operasietafel wat die pasiënt ten minste in die Trendelenburg-posisie kan plaas en, waar toepaslik, ook in ander posisies, na gelang van die operasies wat uitgevoer gaan word.

(8) Die operasieteater moet toegerus wees met 'n geskikte suigapparaat (vir gebruik deur die chirurg en die narkotiseur afsonderlik) wat minstens twee suigpunte het en wat in staat is om slym en bloed tegelykertyd effektief te verwyder. Daar moet ook voorsiening gemaak word vir noodfasiliteite van hierdie aard wat gebruik kan word ingeval die apparaat wat gewoonlik gebruik word, buite werking raak.

(9) Die operasieteater moet voorsien wees van geskikte pypleidings om suurstof en laggas vanaf 'n gasbank te lei, tensy sodanige gasse in silinders verskaf word. 'n Boyle-apparaat of 'n ander geskikte tipe

patients separately (toilets, independent from change-rooms may be provided, for males and females separately), a waiting-room for patients and their visitors, office space and, where applicable, a consulting room.

ACCOMMODATION

23. The rooms referred to in regulation 22 shall comply with the following requirements:

(1) The waiting-room shall have a floor area of not less than 12 m², with a minimum wall length of 3 m: Provided that if the office space is to be provided inside the waiting-room the floor of the waiting-room shall have an area of not less than 18 m² and a minimum wall length of 3,6 m.

(2) The office space shall—

(i) have a floor area of not less than 6 m² if a portion of the waiting-room is set aside for this purpose; or

(ii) be provided in the form of a separate room, with a floor area of not less than 10 m² and a minimum wall length of 2,4 m.

(3) The consulting room, if provided, shall be outside the operating-theatre area and shall have a floor area of not less than 12 m² and a minimum wall length of 3 m and shall be fitted with at least one wash-hand basin with sufficient hot and cold water laid on.

(4) The operating-theatre shall have a floor area of not less than 20 m², and a minimum wall length of 3,6 m. The walls shall be not less than 2,6 m high, measured from the floor to the ceiling, and shall have a continuous, smooth surface and be painted with hard glossy epoxy resin or a similar paint or covered with any other suitable washable impervious material; the ceiling shall be painted with a light-coloured enamel paint. The walls, the floor and the ceiling shall be capable of withstanding repeated cleansing and disinfection.

(5) In the scrubbing-up area, hot and cold water shall be laid on to elbow-operated taps over two wash-hand basins or troughs.

(6) The operating-theatre shall be effectively ventilated and lighted: Provided that windows, if any, shall be dustproof. The minimum requirement for air conditioning shall be the installation of an office type conditioning unit with a 10 micron dust filter.

(7) The operating-theatre shall be provided with electric power to at least three flashproof wall plugs, a suitable electric operating-theatre lamp suspended from the ceiling or cantilevered from the wall, approved facilities for emergency lighting in the event of a power failure and an approved operating table capable of placing the patient at least in the Trendelenburg position and, where applicable, in other positions as well, depending on the operations to be carried out.

(8) The operating-theatre shall be provided with suitable suction apparatus (for use by the surgeon and the anaesthetist separately) with at least two suction points capable of effectively removing blood and mucus simultaneously. Provision shall also be made for emergency facilities of this kind which can be used if the apparatus that is normally used fails.

(9) The operating-theatre shall be provided with suitable piping for conducting oxygen and nitrous oxide from a gas bank, unless such gases are supplied in cylinders. A Boyle's apparatus or other suitable type of

narkoseapparaat met al die noodsaaklike aansluitings vir die pasiënt se asemweë moet verskaf word. 'n Gasabsorberingsapparaat is verpligtend.

(10) Die steriliseerkamer moet 'n vloeroppervlakte van minstens 9 m² hê, met 'n minimum muurlengte van 3 m. Behalwe dat waar 'n losstaande operasieteatereenheid voor die afkondiging van hierdie regulasies op dieselfde perseel bedryf is en 'n steriliseerkamer wat 'n kleiner vloeroppervlakte het alreeds vir hierdie doel gebruik is, sodanige steriliseerkamer verder gebruik kan word.

(11) Die instrumente, komme, verbande, verbandtrommel/pakke, houers, water, ens., moet in die steriliseerkamer gesteriliseer word in 'n goedgekeurde steriliseerapparaat, wat van een of meer van die volgende metodes gebruik kan maak:

(i) Stoom onder druk;
(ii) kookwater;
(iii) droë hitte;
(iv) 'n steriliseergas;
(v) enige ander goedgekeurde metode:

Met dien verstande dat indien 'n stoomoutoklaaf gebruik word, die apparaat gemonteer moet word in 'n toereikend geventileerde masjienkamer buite, maar direk langsaan, die steriliseerkamer en dat die outoklaaf in die steriliseerkamer moet inwys: Met dien verstande, verder, dat indien gebruik gemaak word van 'n proses wat stoom, waterdamp of ander gasse voortbring, 'n geskikte apparaat vir die verwydering daarvan verskaf moet word.

(12) In plaas van 'n ingeboude steriliseerapparaat kan geskikte reëlings getref word dat 'n goedgekeurde sentrale sterieleverskaffingsdepartement voldoende steriele verbande, handdoeke, komme, bakke, instrumente, spuite en steriele water verskaf vir alle operasies.

(13) (1) Die herstelkamer of -ruimte moet binne die afgebakende area wees, met 'n vloeroppervlakte van minstens 12 m² en 'n minimum muurlengte van 3 m. Dit moet toegerus wees met minstens een handewasbak met warm en koue water elmboog-beheerde krane oor die handewasbak aangelê; minstens een vonkvrye muurprop; 'n draagbare lig wat na elke bed geneem kan word; 'n suigapparaat wat bloed en slym kan suig en wat elke bed kan bereik; 'n suurstoftoevoer wat op so 'n wyse aangelê is dat daar by elke bed suurstof gelewer kan word; en geskikte resussiteer-apparaat. Verder moet daar fasiliteite wees om, indien nodig, die pasiënte af te skerm.

(2) 'n Storttregter en opwasbak moet in 'n geskikte area verskaf word.

(14) Die kleedkamer moet 'n vloeroppervlakte hê van minstens 7 m² met 'n minimum muurlengte van 2,1 m en moet toegerus wees met vonkvrye muurpropne en met minstens een handewasbak met warm en koue water aangelê. Daar moet in elke kleedkamer spoeltoilette verskaf word op die grondslag van een vir elke agt persone, en die spoeltoilette moet afgeskort wees van die res van die kleedkamer. Die kleedkamer moet oor voldoende fasiliteite beskik waar klere en skoon en vuil teaterdrag afsonderlik gehou kan word. Die kleedkamer moet een deur hê wat binne die afgebakende area oopmaak en moet 'n aparte ingang van buite die afgebakende area hê.

(15) Die saal moet 'n vloeroppervlakte hê van minstens 8 m² vir elke bed. Dit moet toegerus wees met minstens een vonkvrye muurprop en met 'n handewasbak, met warm en koue water aangelê na elmboogbeheerde krane.

anaesthetic apparatus with all the necessary connections for the patient's airways shall be provided. A gas scavenging apparatus shall be mandatory.

(10) The sterilising room shall have a floor area of not less than 9 m² and a minimum wall length of 3 m. Save that where an unattached operating-theatre unit was conducted on the same premises prior to the promulgation of these regulations and a sterilising room with a smaller floor area was used for this purpose, such room may continue to be so used.

(11) The instruments, basins, dressings, dressing drums/packs, containers, water, etc., shall be sterilised in the sterilising room in an approved sterilising apparatus which may use one or more of the following methods:

(i) Steam under pressure;
(ii) boiling water;
(iii) dry heat;
(iv) a sterilising gas;
(v) any other approved method:

Provided that if a steam autoclave is used, the apparatus shall be mounted in an adequately ventilated machine room outside but immediately next to the sterilising room, with the autoclave facing into the sterilising room; Provided further that if the process used involves the production of steam, water vapour or other gases, a suitable apparatus for the effective removal thereof shall be provided.

(12) Instead of built-in sterilising apparatus, suitable arrangements may be made for an approved central sterile supply department to provide sufficient sterile dressings, towels, bowls, basins, instruments, syringes and sterile water for all operations.

(13) (1) The recovery room or area shall be in the demarcated area and shall have a floor area of not less than 12 m² and a minimum wall length of 3 m. It shall be fitted with at least one wash-hand basin to which hot and cold water shall be laid on to elbow-operated taps over the wash-hand basin; at least one flashproof wall plug; a portable lamp that can be taken to every bed; a suction apparatus which can effectively draw off blood and mucus and can reach every bed; a supply of oxygen so laid on that oxygen can be supplied to every bed; and suitable resuscitation apparatus. In addition, facilities shall be provided for the screening-off of patients if necessary.

(2) A slop hopper and sink shall be provided in a suitable area.

(14) The change room shall have a floor area of not less than 7 m² and a minimum wall length of 2,1 m and shall be fitted with flashproof wall plugs and at least one wash-hand basin to which hot and cold water is laid on. Flush toilets shall be provided in each change room on the basis of one for every eight persons, and such flush toilets shall be partitioned off from the rest of the change room. Such change room shall have adequate facilities where clothes and clean and soiled theatre clothing may be kept separately. Such change room shall have one door which opens inside the demarcated area and a separate entrance from outside the demarcated area.

(15) The ward shall have a floor area of not less than 8 m² for every bed. It shall be fitted with at least one flashproof wall plug and a wash-hand basin to which hot and cold water is laid on to elbow-operated taps.

(16) Die spoelkamer moet 'n vloeroppervlakte hê van minstens 5 m² met 'n minimum muurlengte van 2,1 m. Daar moet voldoende koue water aangelê wees na 'n spoelpan. Die spoelkamer moet toegerus wees met geskikte rakke van ondeurlatende materiaal vir skoon en ontsmette bedpanne en urinehouers, asook met houers van ondeurlatende materiaal met digsluitende deksels vir vuil linnegoed.

(17) (i) Die opbergruimte vir vlambare materiaal moet 'n vloer hê wat met 'n washare, ondeurlatende materiaal bedek is;

(ii) voorsiening moet gemaak word vir 'n geskikte linnekamer of linnekas vir skoon linnegoed; en

(iii) fasiliteite vir steriele opberging moet verskaf word.

(18) Die dienskamer moet 'n vloeroppervlakte hê van minstens 10 m² met 'n minimum muurlengte van 2,4 m. Dit moet langsaan die herstelkamer of -ruimte wees en tussen laasgenoemde en die saal (as daar 'n saal is), met 'n venster in die muur tussen die dienskamer en die herstelkamer of -ruimte en 'n venster in die muur tussen die dienskamer en die saal. Dit moet toegerus wees met warm en koue water aangelê na elmboog-bebeerde krane oor 'n handewasbak, asook met 'n tafel met 'n blad van ondeurlatende materiaal, 'n koelkas, en tensy dit elders in die gebou verskaf word, ook 'n spoeltoilet en genoegsame rakke en kaste sodat klere, skoene en vuil oorklere afsonderlik gebêre kan word: Met dien verstande dat in plaas van 'n dienskamer, daar binne die herstelkamer of -ruimte of die saal 'n diensstasie vir die verpleegkundige verskaf kan word, welke diensstasie toegerus moet wees met sodanige fasiliteite as wat vir hierdie doel nodig is. 'n Alarmstelsel moet geïnstalleer wees om alle personeel in geval van noodgevalle te waarsku.

MEUBELS EN TOERUSTING

24. (1) In akkommodasie waar 'n losstaande operasieteatereenheid bedryf word, moet daar benewens die meubels en toerusting ook die volgende fasiliteite verskaf word:

(i) Fasiliteite vir die toediening van binne-aarse vog en bloed;

(ii) bloeddrukmeters;

(iii) 'n stetoskoop;

(iv) spuite en naalde;

(v) 'n afsonderlike sluitkas vir Bylae 7-stowwe;

(vi) 'n afsonderlike sluitkas vir alle ander Bylae 1-6 ongeskeduleerde medisyne;

(vii) 'n afsonderlike sluitkas vir gevaarhoudende stowwe;

(viii) 'n instrumentekas vir die operasieteater.

(2) Verder moet die operasieteatereenheid apparaat en instrumente bevat, met inbegrip van minstens twee laringoskope, McGill-tipe klemme vir volwassenes en kinders, geskikte endotrageale buise met die nodige verbindings, tongklemme, lugweë, 'n trageostomiestel, 'n hartmasseringstel en defibrillator, asook middels om die pasiënt te ventileer ingeval die suurstoftoevoer onklaar raak, en ander toerusting en middels wat tydens 'n noodtoestand nodig mag wees.

PLIGTE VAN EIENAAR

25. Die eienaar moet sorg dat—

(1) die akkommodasie waarin hy sy losstaande operasieteatereenheid bedryf, altyd in 'n skoon en netjiese toestand is;

(2) alle toerusting en instrumente altyd skoon en in 'n goeie en veilig werkende toestand is en, wanneer dit nie in gebruik is nie, netjies in die toepaslike bêreplek of kas gehou word;

(16) The sluice room shall have a floor area of not less than 5 m² and a minimum wall length of 2,1 m. Sufficient cold water shall be laid on to a sluice pan. The sluice room shall be fitted with suitable shelves of impervious material for clean and disinfected bed pans and urine containers, as well as receptacles of impervious material, with tight-fitting lids, for soiled linen.

(17) (i) The storage area for flammable material shall have a floor covered with a washable, impervious material;

(ii) a suitable linen room or cupboard for clean linen shall be provided; and

(iii) facilities for sterile storage shall be provided.

(18) The duty room shall have a floor area of not less than 10 m² and a minimum wall length of 2,4 m. It shall be next to the recovery room or area and between the latter and the ward, if any, with a window in the wall between the duty room and the recovery room or area and one in the wall between the duty room and the ward. It shall be equipped with hot and cold water laid on to elbow-operated taps over a washhand basin and a table with a top of impervious material, a refrigerator, and, unless provided elsewhere in the building, a flush toilet and sufficient shelves and lockers for keeping clothes, shoes and soiled gowns separately: Provided that instead of a duty room, a duty station may be provided for the nurse within the recovery room or area or the ward, and such station shall be equipped with such facilities as may be necessary for this purpose. An alarm system shall be installed to alert all staff of any emergency cases.

FURNITURE AND EQUIPMENT

24. (1) In accommodation in which an unattached operating-theatre unit is being conducted the following facilities shall be provided in addition to the furniture and equipment:

(i) Facilities for the administration of intravenous fluids and blood;

(ii) sphygmomanometers;

(iii) a stethoscope;

(iv) syringes and needles;

(v) a separate lockable cupboard for Schedule 7 substances;

(vi) a separate lockable cupboard for all other Schedule 1–6 unscheduled medicines;

(vii) a separate lockable cupboard for hazardous substances;

(viii) an instrument cupboard for the operating-theatre.

(2) In addition the operating-theatre unit shall contain sufficient suitable apparatus and instruments, including not less than two laryngoscopes, McGill forceps for adults and children, suitable endotracheal tubes with the necessary connections, tongue forceps, airways, a tracheostomy set, a cardiac massage set and defibrillator, as well as means to ventilate the patient if the oxygen supply fails, and other equipment and materials that may be required for emergencies.

DUTIES OF PROPRIETOR

25. The proprietor shall ensure that—

(1) the accommodation in which he conducts his unattached operating-theatre unit is always in a clean and tidy condition;

(2) all equipment and instruments are always clean and in good and safe working order, and are kept tidily in the appropriate storage place or cupboard when not in use;

(3) die steriliseerapparaat of -toerusting vir geen ander doel as sterilisering gebruik word nie, dat ander die gebruik daarvan vir enige ander doel ook nie toegelaat word nie, en dat sodanige apparaat of toerusting gereeld getoets word vir doeltreffendheid en dat die bevinding aangeteken word in 'n register wat hy vir hierdie doel moet byhou;

(4) die operasieteater vir geen ander doel as dié van 'n operasieteater gebruik word nie en dat die gebruik daarvan vir enige ander doel ook nie toegelaat word nie;

(5) 'n register bygehou word van alle snykundige ingrepe wat uitgevoer word en van alle monsters wat vir patologiese ondersoek weggestuur word;

(6) 'n gelyste stof ingevolge die Wet op die Beheer van Medisyne en Verwante Stowwe, 1965 (Wet 101 van 1965), en 'n gevaarhoudende stof ingevolge die Wet op Gevaarhoudende Stowwe, 1973 (Wet 15 van 1973), gebêre word slegs in sluitkaste wat vir dié doel aangehou word;

(7) daar geen gordyne in die operasieteater of steriliseerkamer opgehang word nie;

(8) daar geen tapyte of enige los bedekkingsmateriaal op die vloer van die operasieteater of die steriliseerkamer of enige saal of dienskamer of pasiëntevertrek is of geplaas word nie, en dat geen plakpapier teen mure van pasiënte- of behandelingsruimtes gebruik word nie; en verder dat sodanige mure vry bly van aangeplakte kennisgewings, papier en soortgelyke materiaal wat skoonmaak belemmer;

(9) geen kamer waarvan die mure, vloer of plafon tekens van klammigheid toon, as pasiëntekamerkommodasie gebruik word nie;

(10) instrumente en toerusting te alle tye skoon, netjies en in goeie en veilig werkende toestand is en, wanneer dit vir die behandeling van pasiënte gebruik word, vóór gebruik behoorlik, soos wat nodig is, ontsmet of gesteriliseer word;

(11) solank daar 'n pasiënt in die operasieteatereenheid is, geen deure wat toegang tot die eenheid verleen, gesluit word nie;

(12) die spoelkamer nie gebruik word of die gebruik daarvan toegelaat word vir enige doel nie, behalwe vir die bewaring en skoonmaak van bedpanne, urinalebottels en soortgelyke houers, en die uitspoel en opberging van vuil linnegoed, verbande en ander afval, totdat dit verwyder word; en dat geen ander plek behalwe die spoelkamer vir die opberging en skoonmaak van sodanige artikels gebruik word nie en dat die gebruik van geen sodanige ander plek vir sodanige doel toegelaat word nie;

(13) daar in elke spoelkamer altyd behoorlike houers van ondeurlatende materiaal en met digsluitende deksels beskikbaar is vir vuil linnegoed, verbande en ander afval;

(14) die inhoud van houers vir vuil verbande en afvalweefsels minstens twee keer per dag verwyder en doeltreffend weggedoen word;

(15) alle bedpanne en urinalehouers, nadat dit gebruik is, sonder versuim geledig, skoon uitgespoel en dan ontsmet word;

(16) 'n toereikende aantal vuilgoedhouers van ondeurlatende materiaal en met digsluitende deksels in goeie toestand beskikbaar is; dat hulle nooit oopstaan nie; dat die inhoud van sodanige houers minstens een keer per dag doeltreffend weggedoen word sonder om 'n oorlas te veroorsaak; en dat die houers nadat hulle leeggemaak is, behoorlik gewas en ontsmet word;

(3) any sterilising apparatus or equipment is not used or permitted to be used for any other purpose than sterilisation and that it is regularly tested for effectiveness and the results recorded in a register which he shall maintain for this purpose;

(4) the operating-theatre is not used or permitted to be used for any other purpose than as an operating-theatre;

(5) a register is kept of all surgical operations performed and all specimens forwarded for pathological examination;

(6) any scheduled substance in terms of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965), and any hazardous substance in terms of the Hazardous Substances Act, 1973 (Act 15 of 1973), shall be stored only in lockable cupboards kept for the purpose;

(7) no curtains are hung in the operating-theatre or the sterilising room;

(8) no carpets or any loose covering materials are on or are laid on the floor of the operating-theatre or the sterilising room or any ward or duty room or patient area; that there is no wall paper against the walls of patient or treatment areas and further that all walls are kept free from affixed notices and paper or similar material which impedes cleaning;

(9) any room showing dampness in the walls, floor or ceiling is not used for patient accommodation;

(10) instruments and equipment shall at all times be kept clean, tidy and in good and safe working condition and, if used in the treatment of patients, shall be effectively disinfected or sterilised, as may be required, prior to use;

(11) while there is a patient in the operating-theatre unit, no doors affording admission to the unit are locked;

(12) the sluice room is not used or permitted to be used for any purpose other than the storage and cleansing of bed pans, urine bottles and similar containers, and the rinsing and depositing of soiled linen, dressings and other waste, until their removal, and that no place other than the sluice room is used for the storage and cleansing of such items;

(13) in each sluice room proper receptacles of impervious material, having tight-fitting lids, are always available for soiled linen, dressings and other waste;

(14) the contents of receptacles for soiled dressings and waste tissues are removed at least twice a day and effectively disposed of;

(15) after use, all bed pans and urine containers are immediately emptied, rinsed clean and then disinfected;

(16) an adequate number of refuse receptacles of impervious material, with tight-fitting lids in good condition, are available; that they are never left open; that the contents of such containers are effectively disposed of at least once daily, without causing a nuisance, and that such containers are properly washed and disinfected after they have been emptied;

(17) die vloere van die vertrekke wat vir die losstaande operasieteatereenheid gebruik word, minstens een ker per dag skoongemaak word en dat alle vuilgoed in vuilgoedhouers geplaas word;

(18) ingeval die vloere nie antistaties is nie, 'n toepaslike waarskuwing op 'n opvallende plek vertoon word;

(19) benodigdhede soos seep, 'n geskikte naelborsel en handeafdroogfasiliteite altyd beskikbaar is by elke handewasbak in die losstaande operasieteatereenheid;

(20) 'n geregistreerde verpleegkundige óf geneesheer of tandarts altyd teenwoordig is (afgesien van die geregistreerde verpleegkundiges of geneeshere of tandarts in die operasieteater) solank daar in die herstelkamer of -ruimte 'n pasiënt is wat nie by sy volle bewussyn is nie;

(21) solank daar 'n bedpasiënt binne die gebied van die losstaande operasieteatereenheid is, die dienste van ten minste 'n ingeskrewe verpleegkundige geredelik beskikbaar is;

(22) dat die onderskeie kamers of ruimtes gebruik word vir slegs die doeleindes waarvoor hulle goedgekeur is;

(23) dat alle dienste en maatreëls wat oor die algemeen vir die toereikende sorg en die veiligheid van die pasiënte nodig is, gehandhaaf en nagekom word;

(24) aseptiese beginsels ten volle nagekom word by die behandeling van pasiënte;

(25) alle handewasbakke vir pasiënte, personeel en besoekers bevredigend toegerus is met skoonmaakmateriaal en afdroogfasiliteite;

(26) doeltreffende plaagbeheer toegepas word;

(27) die rioolstelsel en die stormwaterdreineerstelsel onderhou word in ooreenstemming met die vereistes van die betrokke plaaslike bestuur;

(28) die kosware op die perseel gehanteer, gehou, opgeberg en berei word in ooreenstemming met openbare gesondheidstandaarde en die regulasies van die betrokke plaaslike bestuur;

(29) genoegsame noodfasiliteite vir verligting en vir die instandhouding van essensiële toerusting en dienste verskaf en onderhou word;

(30) geen ongemagtigde persone toegang het tot die pasiënterekords nie en dat die privaatheid en belange van die pasiënte beveilig word;

(31) daar by die operasieteatereenheid 'n "Geen toegang"-teken aangebring word; en dat

(32) 'n afskrif van hierdie regulasies in 'n leesbare toestand, en behoorlik bygehou, op die perseel beskikbaar gehou word.

26. Die eienaar moet ondergenoemde afsonderlike registers, waar toepaslik, bylhou of laat bylhou:

(a) 'n Register, wesenlik in die vorm van Aanhangsel D, van die algemene mediese en chirurgiese pasiënte wat toegelaat word;

(b) 'n register, wesenlik in die vorm van Aanhangsel E, van die bevallingspasiënte wat toegelaat word en van die geboortes;

(c) 'n register, wesenlik in die vorm van Aanhangsel F, van alle pasiënte wat in enige operasieteater behandel word;

(d) 'n register, wesenlik in die vorm van Aanhangsel G, van alle buitepasiënte of ongevallepasiënte wat behandel word;

(e) 'n register, soos die Sekretaris verlang, van alle pasiënte met aansteeklike siektes en van enige ander spesialeklaspasiënt; en

(17) the floors of the rooms used for the unattached operating-theatre unit are cleaned at least once a day and that all refuse is emptied into refuse receptacles;

(18) in the event of the floors not being antistatic, an appropriate warning is prominently displayed;

(19) requisites such as soap, a suitable nail brush and handdrying facilities are always available at every wash-hand basin in the unattached operating-theatre unit;

(20) A registered nurse or medical practitioner or dentist (apart from the registered nurses, medical practitioners or dentists in the operating-theatre) is always present as long as there is a patient not fully conscious in the recovery room or area;

(21) whenever there is a bed patient on the premises of an unattached operating-theatre unit the services of at least an enrolled nurse is readily available;

(22) the various rooms or areas are used only for the purposes for which they have been approved;

(23) all services and measures generally necessary for adequate care and safety of patients are maintained and observed;

(24) aseptic principles are fully observed in the treatment of patients;

(25) all wash-hand basins for patients, staff and visitors are satisfactorily provided with cleansing materials and drying facilities;

(26) effective pest control is exercised;

(27) sewerage and storm-water drainage systems are maintained in conformity with the requirements of the local authority concerned;

(28) foodstuffs are handled, kept, stored and prepared on the premises in conformity with public health standards and the regulations of the local authority concerned;

(29) adequate stand-by facilities for lighting and for the maintenance of vital equipment and services are provided and maintained;

(30) no unauthorised person has access to patient records and that the privacy and interests of patients are safeguarded;

(31) a "No Entry" sign is affixed to the operating-theatre unit; and

(32) a copy of these regulations, in a legible condition and up to date, is kept available on the premises.

26. The proprietor shall keep or cause to be kept in the following separate registers, where applicable:

(a) A register of general medical and surgical patients admitted, substantially in the form of Annexure D;

(b) a register of maternity patients admitted and of deliveries substantially in the form of Annexure E;

(c) a register of all patients treated in any operating-theatre, substantially in the form of Annexure F;

(d) a register of out-patients or casualty patients treated, substantially in the form of Annexure G;

(e) a register, as required by the Secretary, of patients with infectious diseases, or any other special class of patient; and

(f) 'n register, wesenlik in die vorm van Aanhangsel H, van die verpleegkundige personeel.

27. Geen eienaar mag in enige private hospitaal meer pasiënte opneem of behandel of die opneming of behandeling aldaar toelaat van meer pasiënte as die getal waartoe daar in die registrasiesertifikaat magtiging verleen word nie. Die Sekretaris kan toestemming verleen om meer pasiënte op te neem of te behandel in gevalle van nood of waar hy daarvan oortuig is dat ander hospitaalfasiliteite nie beskikbaar is nie.

28. Elke eienaar moet binne 15 dae na die einde van elke maand aan die Sekretaris 'n opgawe verstrek of laat verstrek waarin aangedui word met welke getal pasiënte die getal waarvoor daar in die registrasiesertifikaat magtiging verleen is, daagliks gedurende die maand oorskry is en wat, in elke geval, die redes vir sodanige oorskryding is.

29. Elke eienaar moet sonder versuim aan die Sekretaris sodanige opgawes en inligting verstrek as wat die Sekretaris van tyd tot tyd vereis met betrekking tot die beheer oor en bestuur van die betrokke private hospitaal, die gerieve, voorrade of personeel waaroor dit beskik, die dienste wat daarin gelewer word en die pasiënte wat daarin behandel of verpleeg word.

PRIVATE HOSPITALE

30. *Akkommodasie en fasiliteite.*

'n Private hospitaal moet bedryf word op 'n perseel waar daar genoegsame en bevredigende voorsiening gemaak is vir—

(a) een of meer verpleegeenhede, met inbegrip van—

(i) beddens in sale of kamers vir die behandeling van pasiënte;

(ii) 'n dienskamer of diensstasie vir verpleegdiendiges wat so gelê is dat die fisiese toegang tot geen pasiënt wat versorg moet word, verhinder of vertraag word nie;

(iii) bad- en toiletfasiliteite vir pasiënte;

(iv) 'n behandelings- of verbandkamer;

(v) afsonderlike opbergplek vir linne, farmaseutiese benodigdhede, saaltoerusting, die besittings van die pasiënte en sodanige diverse items as wat nodig is vir die bestuur van die verpleegeenheid;

(vi) 'n spoelkamer;

(vii) fasiliteite vir die skoonmaak en opberg van reinigingstoerusting en -materiaal;

(viii) 'n saalkombuis; en

(ix) verbindingsgange;

(b) 'n kamer of kamers wat toereikend vir administratiewe beheer, navrae, die toelating van pasiënte en die opberging van rekords is, wat afsonderlik is van die dienskamer van 'n verpleegeenheid en wat aan die personeel toegang bied sonder dat hulle deur die pasiëntevertrekke hoef te beweeg;

(c) 'n hoofkombuis;

(d) pakkamers vir massa-opberging;

(e) 'n ruskamer en toiletfasiliteite vir die personeel;

(f) 'n wagkamer en toiletfasiliteite vir besoekers;

(g) steriele voorrade;

(h) fasiliteite vir die onmiddellike beskikbaarstelling van alle benodigde farmaseutiese produkte;

(i) 'n wassery of die verskaffing van skoon linne;

(j) 'n lykhuis of vir die onmiddellike verwydering van 'n lyk; en

(f) a register of the nursing staff, substantially in the form of Annexure H;

27. No proprietor shall admit to or treat in or allow to be admitted to or treated in any private hospital more patients than the number authorised by the certificate of registration. The Secretary may give permission for more patients to be admitted or treated in emergencies or if he is satisfied that no other hospital facilities are available.

28. Every proprietor shall within 15 days of the end of each month furnish or cause to be furnished to the Secretary a return showing the number of patients exceeding daily during the month the number authorised by the certificate of registration and the reasons for such excess in each case.

29. Every proprietor shall without delay furnish to the Secretary such returns and information as the the Secretary may from time to time require in relation to the control and management of the private hospital concerned, the facilities, stores or staff at its disposal, the services rendered therein and the patients receiving treatment or nursing care therein.

PRIVATE HOSPITALS

30. *Accommodation and facilities.*

A private hospital shall be conducted on premises where adequate and satisfactory provision has been made for—

(a) one or more nursing units, including—

(i) beds in wards or rooms for the treatment of patients;

(ii) a duty room or duty station for nurses so placed that physical access to any patient requiring care is not impeded or delayed;

(iii) bathing and toilet facilities for patients;

(iv) a treatment or dressing room;

(v) separate storage space for linen, pharmaceuticals, ward equipment, patients' belongings and such sundry items as may be necessary for the management of the nursing unit;

(vi) a sluice room;

(vii) facilities for the cleansing and storage of cleaning equipment and materials;

(viii) a ward kitchen; and

(ix) connecting corridors;

(b) a room or rooms, adequate for administrative control, enquiries, admission of patients and storage of records, which shall be separate from the duty room of a nursing unit and accessible to the staff without their having to pass through the patient areas;

(c) a main kitchen;

(d) store-rooms for bulk storage;

(e) a rest-room and toilet facilities for staff;

(f) a waiting area and toilet facilities for visitors;

(g) sterile supplies;

(h) facilities for the immediate supply of all necessary pharmaceutical products;

(i) a laundry or a supply of clean linen;

(j) a mortuary or for the immediate removal of any dead body; and

(k) 'n verbrandingsoond of ander geskikte stelsel vir die doeltreffende en onskadelike wegdoen van besoedelde verbandmateriaal en van chirurgies verwyderde weefsels.

31. *Addisionele fasiliteite.*

Enige van of al die ondergenoemde fasiliteite kan, na gelang van die behoeftes van die pasiënte wat in sodanige hospitaal opgeneem of daar behandel word, ooreenkomstig hierdie regulasies verskaf word, en moet aldus verskaf word indien die Sekretaris dit as onontbeerlik beskou of dit vereis:

(a) 'n Operasieteatereenheid;
(b) 'n afsonderlike verloskundige eenheid;
(c) ontvangs- en behandelingsfasiliteite vir buitepasiënte en/of ongevalle;
(d) sentrale steriliseerfasiliteite;
(e) akkommodasie en fasiliteite vir werknemers;
(f) fasiliteite vir—

(i) radiologie en verwante diagnostiese doeleindes;
(ii) fisioterapie;
(iii) arbeidsterapie;
(iv) elektrokonvulsiewe behandeling;
(v) psigoterapie;
(vi) enige spesiale ondersoek of behandeling;
(vii) die opleiding van verpleegkundiges, geneeshere en lede van aanvullende mediese gesondheidsberoepe;
(viii) die mediese ondersoek van werknemers;
(ix) die opleiding van werknemers in noodhulp;

(g) enige ander goedgekeurde fasiliteite.

32. *Algemene strukturele vereistes.*

Behalwe waar hierdie regulasies 'n ander vereiste stel, is die volgende strukturele vereistes van toepassing op alle private hospitale:

(1) Die mure van die operasieteatereenheid en van die verloskundige eenheid moet minstens 2,6 m hoog wees, gemeet van die vloer tot by die plafon, en moet gebou wees van goedgekeurde ondeurlatende materiaal.

(2) Die voeg tussen die vloer en die mure moet in die operasieteatereenheid, in die verloskundige eenheid en in alle toilette, badkamers en spoelkamers, asook orals anders waar dit nodig is, sodanig gerond wees dat doeltreffende skoonmaak moontlik is.

(3) Elke gang of deurgang wat vir pasiënte gebruik word, moet minstens 2 m wyd wees en waar pasiënte binne die operasieteatereenheid of verloskundige eenheid verskuif word, moet die gang minstens 2,5 m wyd wees.

(4) Al die vertrekke moet voldoende verlig en geventileer wees.

(5) Stofdigte plafonne van 'n gladde, ondeurlatende materiaal en geverf met 'n geskikte wit of ligkleurige wasbare verf, moet aangebring wees in alle pasiënteakkommodasie- en behandelingsruimtes.

(6) Die vloere van al die kamers en gange moet van beton of soortgelyke ondeurlatende materiaal wees, met 'n gladde afwerking, en, tensy hierdie regulasies anders bepaal, bedek wees met 'n wasbare, ondeurlatende materiaal.

(7) Al die binnemuuroppervlaktes moet bedek wees met 'n gladde, harde pleisterafwerking met geronde hoeke en moet geverf wees met 'n ligkleurige, duursame, wasbare verf of, so nie, bevredigend bedek wees met 'n soortgelyke wasbare, ondeurlatende materiaal: Met dien verstande dat waar die mure geverf is, die mure agter die handewasbakke spesiaal met glasmurteëls of 'n spesiale wasbare, ondeurlatende materiaal bedek moet

(k) an approved incinerator or other suitable system for the effective and innocuous disposal of soiled dressings and surgically removed tissues.

31. *Additional facilities.*

Depending on the requirements of the patients admitted or treated at such hospital, any or all of the following facilities may be provided, in accordance with these regulations, and, where deemed indispensable or required by the Secretary, shall be thus provided:

(a) An operating-theatre unit;
(b) a separate maternity unit;
(c) reception and treatment facilities for out-patients and/or casualties;
(d) central sterilising facilities;
(e) accommodation and facilities for employees;
(f) facilities for—

(i) radiology and allied diagnosic purposes;
(ii) physiotherapy;
(iii) occupational therapy;
(iv) electro-convulsive treatment;
(v) psychotherapy;
(vi) any special investigation or treatment;
(vii) the training of nurses, medical practitioners and members of supplementary health service professions;
(viii) the medical examination of employees;
(ix) the training of employees in first aid;

(g) any other approved facilities.

32. *General structural requirements.*

Save where otherwise required in these regulations, the following structural requirements shall apply to all private hospitals:

(1) The walls of the operating-theatre unit and of the labour unit shall be not less than 2,6 m high, measured from the floor to the ceiling and constructed of approved impervious material.

(2) In the operating-theatre unit, the labour unit, all toilets, bathrooms and sluice rooms, and wherever else necessary, the joint between the floor and the walls shall be so rounded as to permit effective cleaning.

(3) Each corridor or passageway used for patients shall be not less than 2 m wide and where patients are moved within the operating-theatre unit or labour unit the corridor shall be at least 2,5 m wide.

(4) All rooms shall be satisfactorily lighted and ventilated.

(5) Dustproof ceilings of smooth, impervious material, painted with a white or light-coloured suitable washable paint, shall be provided throughout all patient accommodation and treatment areas.

(6) The floors of all rooms and corridors shall be of concrete or a similar impervious material brought to a smooth finish and, except where otherwise provided in these regulations, covered with a washable, impervious material.

(7) All interior wall surfaces shall be given a smooth, hard plaster finish with rounded corners, painted with a light-coloured durable washable paint or alternatively satisfactorily covered with a similar washable, impervious material: Provided that, where walls have been painted, the walls behind wash-hand basins shall be specially clad to a height of at least 500 mm above, and to a distance of at least 500 mm beyond the sides

wees tot 'n hoogte van ten minste 500 mm bokant, en 'n afstand van ten minste 500 mm aan weerskante van sodanige handewasbakke, sodat op hierdie wyse 'n ondeurlatende afwerking verkry word wat met die verfwerk aaneenloop.

(8) Doeltreffend geplaaste en toereikende brandkrane brandslange, brandblussers, brandtrappe en nooduitgange moet verskaf en bevredigend onderhou word.

(9) Handewasbakke moet in die onmiddellike nabyheid van elke toilet, urinaal en spoelfasiliteit verskaf word.

(10) Die vertrek waarin medisyne geberg word moet toegerus wees met 'n lugreëlaar sodat 'n konstante kamertemperatuur verseker word.

33. *Pasiënte-akkommodasie.*

(1) In hierdie regulasie word elke vaste toebehoorsel vir die doeleindes van die bepaling van die minimum afmetings, gereken as 'n muur of gedeelte van 'n muur van 'n kamer waarbinne 'n pasiënt geakkommodeer word.

(2) Geen pasiënt mag gehuisves word in enige vertrek met 'n vloerruimte van minder as 10 m² nie of in 'n enkelvertrek waar daar nie die volgende minimum ruimte is nie:

(a) 0,9 m tussen elke sykant van die bed en die naaste muur aan sodanige sykant; en

(b) 1,2 m tussen die voetenent van die bed en die teenoorgestelde muur.

(3) Geen pasiënt mag gehuisves word in 'n kamer met meer as een bed nie, tensy daar voorsiening gemaak is vir 'n minimum ruimte van—

(a) 0,75 m tussen elke sykant van elke bed en die naaste muur;

(b) 0,9 m tussen die sykante van alle aangrensende beddens; en

(c) 1,2 m tussen die voetenent van elke bed en die teenoorgestelde muur of 'n minimum van 1,5 m tussen die voetenent van 'n bed en die teenoorgestelde bed.

(4) Geen kind mag in 'n kinderkamer gehuisves word nie, tensy daar 'n minimum ruimte is van—

(a) 0,75 m tussen alle aangrensende bababedjies;

(b) 0,6 m tussen elke sykant van elke bababedjie en die naaste muur; en

(c) 0,9 m tussen die voetenent van elke bababedjie en die teenoorgestelde muur.

(5) Geen pasiëntekamer mag gebruik word vir die akkommodasie van sowel manlike as vroulike pasiënte nie, tensy al die pasiënte kinders is van 'n leeftyd van hoogstens 10 jaar: Met dien verstande dat 'n pasiëntekamer gebruik kan word vir die gelyktydige akkommodasie van 'n man en sy vrou.

(6) Uitgesonderd die geval van 'n moeder en kind, moet kinders en volwassenes altyd in afsonderlike kamers geakkommodeer word: Met dien verstande dat waar afsonderlike akkommodasie van volwassenes en kinders onder 10 jaar onprakties is met die oog op behandeling, daar voldoende tussenskotfasiliteite beskikbaar moet wees.

34. *Pasiëntkamers.*

(1) Elke pasiëntekamer in 'n private hospitaal moet direk verbind wees met 'n gang of deurgang.

(2) Deure wat toegang verleen tot kamers waarin pasiënte gehuisves is of sal word, moet ten minste 1,2 m wyd wees.

of such wash-hand basins in glazed tiling or a special washable, impervious material so as to form an impervious finish continuous with the paintwork.

(8) Effectively placed and adequate fire-hydrants, fire-hoses, fire-extinguishers, fire-escapes and emergency exits shall be provided and satisfactorily maintained.

(9) Wash-hand basins shall be provided in the immediate vicinity of all toilets, urinals and sluices.

(10) An airconditioning system shall be installed in the room provided for the storage of medicine in order to ensure a constant room temperature.

33. *Patient accommodation.*

(1) In this regulation any fixture shall, for purposes of determining minimum measurements, be regarded as a wall or part of a wall of a room in which a patient is accommodated.

(2) No patient shall be accommodated in any room with a floor area of less than 10 m² or in a single room where there is not a minimum space of—

(a) 0,9 m between any side of any bed and the nearest wall on that side; and

(b) 1,2 m between the foot of any bed and the opposite wall.

(3) No patient shall be accommodated in a room with more than one bed unless provision is made for a minimum space of—

(a) 0,75 m between any side of any bed and the nearest wall;

(b) 0,9 m between the sides of any adjacent beds; and

(c) 1,2 m between the foot of any bed and the opposite wall or a minimum of 1,5 m between the foot of any bed and the opposite bed.

(4) No infant shall be accommodated in a nursery unless there is a minimum space of—

(a) 0,75 m between adjacent cots;

(b) 0,6 m between any side of any cot and the nearest wall; and

(c) 0,9 m between the foot of any cot and the opposite wall.

(5) No patient room shall be used for the accommodation of both male and female patients, except when all patients are children not older than 10 years: Provided that a patient room may be used for the simultaneous accommodation of a husband and wife.

(6) Except in the case of a mother and child, children and adults, shall always be accommodated in separate rooms: Provided that, where separate accommodation for adults and children under the age of 10 years is impractical for reasons of treatment, proper screening facilities shall be available.

34. *Patient rooms.*

(1) Each patient room in a private hospital shall communicate directly with a corridor or passageway.

(2) Doors giving access to rooms in which patients are or are to be accommodated shall be at least 1,2 m wide.

(3) Elke pasiëntekamer moet voorsien wees van 'n handewasbak toegerus met elmboog-beheerde krane met warm en koue water aangelê.

(4) Elke pasiëntekamer moet geïdentifiseer word deur die volgende by die ingang aan te bring:

(a) Die nommer van die pasiëntekamer; en
(b) die getal goedgekeurde beddens daarin.

35. *Bykomende fasiliteite.*

(1) (a) Waar verskeie pasiëntekamers toiletfasiliteite deel of waar 'n pasiëntekamer met sy eie fasiliteite meer as agt beddens bevat, moet die volgende verskaf word:

(i) Ten minste een bad of stort per 12 pasiënte of gedeelte van sodanige getal: Met dien verstande dat die getalsverhouding van die baddens tot die storte in ooreenstemming moet wees met die funksie van die verpleegeenheid;

(ii) ten minste een toilet per agt pasiënte of gedeelte van sodanige getal, maar in mansale kan elke derde toilet vervang word deur een urinaal; en

(iii) ten minste een handewasbak per agt pasiënte of gedeelte van sodanige getal.

(b) Vir babas moet toereikende spesiale badfasiliteite verskaf word in direkte aansluiting met die kinderkamers.

(2) (a) Die grootte en tooerusting van die saalkombuis moet voldoende wees vir die grootte en funksie van die verpleegeenheid en vir die stelsel waarvolgens voedsel verskaf word.

(b) Die saalkombuis moet so geplaas wees dat dit geen oorlas veroorsaak nie.

(3) (a) Na gelang van die stelsel waarvolgens voedsel verskaf word, moet voldoende voorsiening gemaak word vir—

(i) fasiliteite vir die ontvangs van aflewerings, vir die opberging en bereiding van warm en koue voedsel en die bediening daarvan aan pasiënte en personeel;

(ii) fasiliteite vir die verwydering, opwas en opberging van breekgoed en messegoed; en

(iii) fasiliteite vir die effektiewe uitlaat van stoom, rook, damp en hitte.

(b) Voldoende en geskikte voorsiening moet gemaak word vir—

(i) vullisdromme wat behoorlik leeg- en skoongemaak kan word en toegerus is met digsluitende deksels; en

(ii) handewasbakke vir kombuispersoneel.

(4) Geskikte kleedkamer-, ruskamer- en toiletfasiliteite moet vir die werknemers verskaf word en sodanige fasiliteite moet wees volgens die standaard soos dit bepaal is in die Wet op Fabrieke, Masjinerie en Bouwerk, 1941 (Wet 22 van 1941), soos gewysig.

(5) Geskikte en afdoende wagkamers, toilette en handewasbakke moet vir besoekers verskaf word.

OPERASIETEATEREENHEID IN 'N PRIVATE HOSPITAAL

36. *Algemene vereistes.*

'n Operasieteater moet die volgende insluit:

(a) Een of meer operasieteaters met toegang slegs deur 'n kamer, area, deurgang of gang wat duidelik binne die afgebakende area is en wat so beplan en ingerig is dat toereikende beheer uitgeoefen kan word oor alle persone en materiaal wat sodanige kamer, area, deurgang of gang binnegaan;

(3) Each patient room shall be provided with a wash-hand basin fitted with elbow-operated taps to which hot and cold water is laid on.

(4) Each patient room shall be identified by displaying at the entrance—

(a) the number of the patient room; and
(b) the approved number of beds in such room.

35. *Ancillary facilities.*

(1) (a) Where several patient rooms share toilet facilities or where a patient room with its own facilities contains more than eight beds, the following shall be provided:

(i) At least one bath or shower per 12 patients or part of such number: Provided that the proportion of baths to showers shall correspond to the function of the nursing unit;

(ii) at least one toilet per eight patients or part of such number, but in male wards a urinal may be substituted for every third toilet; and

(iii) at least one wash-hand basin per eight patients or part of such number.

(b) Adequate special bathing facilities for babies shall be provided in direct conjunction with nurseries.

(2) (a) The size and equipment of the ward kitchen shall be adequate for the size and function of the nursing unit and for the system of supplying food.

(b) The ward kitchen shall be so placed that it does not cause a nuisance.

(3) (a) Depending on the system of supplying food, adequate provision shall be made for—

(i) facilities for taking delivery of, storing and preparing hot and cold food, and serving such food to patients and staff;

(ii) facilities for the removal, washing-up and storage of crockery and cutlery; and

(iii) facilities for the effective extraction of steam, smoke, vapour and heat.

(b) Adequate and suitable provisions shall be made for—

(i) garbage bins which can be properly emptied and cleaned and which are provided with close-fitting lids; and

(ii) wash-hand basins for kitchen staff.

(4) Suitable change room, rest room and toilet facilities for employees shall be provided and such facilities shall be of the standard laid down in the Factories, Machinery and Building Work Act, 1941 (Act 22 of 1941), as amended.

(5) Suitable and adequate waiting rooms, toilets and wash-hand basins shall be provided for visitors.

OPERATING-THEATRE UNIT IN A PRIVATE HOSPITAL

36. *General requirements.*

An operating-theatre unit shall include the following:

(a) One or more operating-theatres with access only through a room, area, passageway or corridor which is clearly within the demarcated area and so planned and equipped that adequate control can be exercised over all persons and materials which enter such room, area, passageway or corridor;

(b) en verder binne die afgebakende area—

(i) toereikende kamers vir steriele pakke en stelkamers;

(ii) 'n skrop-area buitekant die operasieteater maar aangrensend daaraan en met bevredigende toegang daartoe: Met dien verstande dat, behoudens die aanbeveling van die Direkteur met betrekking tot spesiale dienste in die operasieteater, die Sekretaris toestemming kan verleen dat sodanige skrop-area binne die operasieteater geleë kan wees;

(iii) 'n herstelkamer of -ruimte waar pasiënte toereikend geakkommodeer kan word vir na-operatiewe verpleegwaarneming, wat onmiddellik toeganklik is vir 'n geneesheer en wat beskik oor voldoende resussiteer- en noodfasiliteite;

(iv) 'n sterieleverskaffingseenheid: Met dien verstande dat 'n gedeelte van die fasiliteite van sodanige eenheid so afgeskort kan word dat dit buite die afgebakende area is;

(v) 'n spoelkamer wat slegs die operasieteater of operasieteaters bedien: Met dien verstande dat, indien 'n spesiale gang ingerig is waarvandaan die operasieteater of -teaters skoongemaak kan word, sodanige spoelkamer nie binne die afgebakende area mag wees nie maar so geleë moet wees dat dit 'n toegangsdeur slegs vanaf sodanige gang het;

(vi) voldoende verkleekamerfasiliteite, met direkte toegang tot die afgebakende area, vir geneeshere, verpleegkundiges en huishoudelike personeel: Met dien verstande dat daar vir pasiënte wat nie gebruik maak van saalakkommodasie nie, bykomende verkleefasiliteite verskaf moet word;

(vii) 'n oorplaasarea, vir die oorplasing van pasiënte vanaf saaltrollies na teatertrollies, oorkant die afgebakende area;

(viii) 'n dienskamer vir verpleegkundiges of 'n diensstasie vir verpleegkundiges wat so geleë, gebou en toegerus is dat dit vir die verpleegkundige personeel moontlik is om die pasiënte regstreeks waar te neem en om, waar nodig, bystand aan die pasiënte te verleen;

(ix) indien ligte verversings voorgesit gaan word, voldoende fasiliteite vir die opberging, bereiding en bediening van sodanige verversings:

(x) skoonmakersfasiliteite; en

(xi) afsonderlike opbergkamers, of voldoende geskikte bergingskaste in die plek daarvan, vir die opberging van skoon linne, medisyne, toerusting en diverse items.

37. *Afmetings.*

'n Operasieteater moet beskik oor—

(a) 'n vloeroppervlakte van minstens 30 m²;

(b) 'n muurhoogte van minstens 3 m;

(c) 'n wydte van minstens 5,1 m; en

(d) 'n area, direk by die operasieteater, waar die instrumente gestel kan word.

38. *Vloer.*

(1) Die vloer van enige operasieteater moet van 'n ondeurlatende materiaal wees, gelê sonder oop tussenruimtes en met alle voeë opgevul ten einde 'n aaneenlopende, ondeurlatende bedekking te verskaf, en so afgewerk dat die muurbedekking en vloerbedekking saamgevoeg is in 'n aaneenlopende gladde oppervlak sonder tussenruimtes.

(2) Tensy daar 'n antistatiese vloerbedekking gelê is en in stand gehou word in ooreenstemming met die spesifikasies van die Suid-Afrikaanse Buro vir Standaarde, moet daar by die ingang van 'n operasieteater

(b) and further within the demarcated area—

(i) adequate sterile pack and setting rooms;

(ii) a scrubbing-up area outside but adjacent to the operating-theatre, with satisfactory access to such operating-theatre: Provided that, subject to the recommendation of the Director with regard to any special services offered in the operating-theatre, the Secretary may permit such scrubbing-up area to be situated within the operating-theatre;

(iii) a recovery room or area where patients can be adequately accommodated for post-operative nursing surveillance, which is immediately accessible to a medical practitioner and which has sufficient resuscitation and emergency facilities;

(iv) a sterile supply unit: Provided that a portion of the facilities of such unit may be screened off so as to fall outside the demarcated area;

(v) a sluice room to serve the operating-theatre or operating-theatres only: Provided that, where a special corridor is provided from which cleaning of the operating-theatre or operating-theatres can be effected such sluice room shall not be situated within the demarcated area, but shall be so situated as to have an access door from such corridor only;

(vi) suitable change-room facilities, with direct access to the demarcated area, for medical practitioners, nursing and domestic staff: Provided that additional change facilities shall be provided for patients not utilising ward accommodation;

(vii) a transfer area, for the transfer of patients from ward trolleys to theatre trolleys, across the demarcated area;

(viii) a nurses' duty room or duty station which is so situated, constructed and equipped that it is possible for the nursing staff to observe patients directly and render assistance to patients where necessary;

(ix) if light refreshments are to be served, suitable facilities for storing, preparing and serving such refreshments;

(x) cleaners' facilities; and

(xi) separate store-rooms, or sufficient suitable storage cupboards in lieu thereof, for the storage of clean linen, medicines, equipment and sundry items.

37. *Dimensions.*

Any operating-theatre shall have—

(a) a floor area of not less than 30 m²;

(b) a wall height of not less than 3 m;

(c) a width of not less than 5,1 m; and

(d) an instrument setting area immediately off the operating-theatre.

38. *Floor.*

(1) The floor of any operating-theatre shall be of impervious material, laid without open interstices and with jointing filled in so as to provide a continuous impervious covering, and so finished that the wall covering and the floor covering are joined in a continuous smooth surface without interstices.

(2) In an operating-theatre, unless anti-static flooring has been laid and maintained in conformity with the specifications of the South African Bureau of Standards, there shall be affixed and prominently displayed at the entrance to such theatre a cautionary

'n waarskuwingskennisgewing aangebring word en op 'n opvallende plek vertoon word ten effekte dat die vloer van sodanige teater nie antistaties is nie en dat plofbare narkosemiddels, gasse of skoonmaakmiddels nie binne die teater gebruik mag word nie.

39. *Installasies.*

By elke teater moet daar die volgende verskaf word:

(a) 'n Toereikende pypleidingtoevoer van suurstof en distikstofoksied;

(b) 'n voldoende verligtingstelsel;

(c) 'n lugreëlingstelsel toegerus met filters wat doeltreffend is vir deeltjies met 'n grootte van vyf mikron en wat 'n toereikende vermoë het om 'n temperatuur van ten minste 10 °C asook 'n relatiewe voggehalte van ten minste 45 persent te handhaaf;

(d) 'n toereikende en bevredigende meganiese suigstelsel met ten minste twee suigpunte;

(e) toereikkende fasiliteite vir 'n noodtoevoer van suurstof en distikstofoksied, noodverligting en noodsuiging in die geval van 'n meganiese, elektriese of ander onderbreking tydens 'n operasie;

(f) elektriese krag by ten minste drie vonkvrye muurproppe met 'n aardlekkasie-apparaat op 'n minimum hoogte van 1,5 m;

(g) 'n goedgekeurde operasietafel waarop 'n pasiënt geposisioneer kan word na gelang van die vereistes van die operasie wat uitgevoer moet word.

40. *Gange binne operasieteatereenhede.*

'n Onbelemmerde wydte van minstens 2,5 m moet vir die pasiëntetrollies gehandhaaf word in die gange en deurgange van 'n operasieteatereenheid.

41. *Skrop-areas binne operasieteatereenhede.*

(1) Enige skrop-area moet minstens 2,1 m wyd wees en moet so toegerus wees dat dit ten minste twee persone in staat stel om, voordat hulle die teater binnegaan, tegelykertyd onbelemmerd en afsonderlik te skrop onder warm en koue water uit elmboog-beheerde krane oor spatwerende wasbakke of 'n dreineertrog, en om teaterdrag aan te trek.

(2) Waar die gebruik van die operasieteater beperk word tot die prosedures gelys in Aanhangsel A, word bevredigende voorsiening vir die gelyktydige, afsonderlike skrop van slegs twee persone beskou as voldoende vir die doel van hierdie regulasie.

42. *Herstelareas binne operasieteatereenhede.*

(1) Die herstelkamer of -ruimte moet binne die afgebakende area wees en met 'n vloeroppervlakte van minstens 12 m² en 'n muurlengte van minstens 3 m hê en moet voldoende spasie verskaf vir ten minste een pasiënt uit elke operasieteater wat bedien word, bereken op 'n basis van 9 m² onbelemmerde vloeroppervlakte per pasiënt.

(2) Die herstelkamer of -ruimte moet toegerus wees met—

(a) 'n handewasbak voorsien van warm en koue water deur 'n elmboog-beheerde kraan;

(b) 'n voldoende suurstoftoevoer vir elke pasiënt wat geakkommodeer word;

(c) 'n genoegsaam verstelbare vaste of draagbare lamp vir elke herstelbed of trollie;

(d) 'n toereikende en bevredigende meganiese suigstelsel met een suigpunt vir elke herstelbed of trollie;

(e) twee vonkvrye elektriese kragpunte vir elke herstelbed of trollie; en

(f) fasiliteite om pasiënte af te skort.

notice to the effect that the floor of such theatre is not anti-static and that explosive anaesthetic agents, gases or cleaning agents are not to be used inside such theatre.

39. *Installations.*

At every theatre there shall be provided—

(a) an adequate piped gass supply of oxygen and nitrous oxide;

(b) an adequate lighting system;

(c) an air-conditioning system fitted with filters effective for five micron particles and with sufficient capacity to maintain a temperature of at least 10 °C and a relative humidity of at least 45 per cent;

(d) an adequate and satisfactory mechanical suction system with at least two suction points;

(e) adequate facilities for an emergency supply of oxygen and nitrous oxide, emergency lighting and emergency suction in the event of mechanical, electrical or other failure during an operation;

(f) electric power to at least three flash-proof wall plugs with an earth leakage device at a minimum height of 1,5 m;

(g) an approved operating table on which the patient can be positioned according to the requirements of the operation to be performed.

40. *Corridors within operating-theatre units.*

An unobstructed width of not less than 2,5 m shall be maintained for patient trolleys in corridors and passageways within any operating-theatre unit.

41. *Scrubbing-up areas within operating-theatre units.*

(1) Any scrubbing-up area shall have a width of not less than 2,1 m and shall be so equipped as to permit both unhindered and simultaneous scrubbing-up by at least two persons under hot and cold running water from elbow-operating taps over splash-limiting basins or a drainage trough, and gowning prior to entering the operating-theatre.

(2) Where the use of the operating-theatre is limited to the procedures listed in Annexure A, satisfactory provision for simultaneous separate scrubbing-up by two persons only will be deemed sufficient for the purposes of this regulation.

42. *Recovery areas within operating-theatre units.*

(1) The recovery room or area shall be inside the demarcated area and shall have a floor area of not less than 12 m² and a wall length of not less than 3 m, and shall provide sufficient space for at least one patient from each operating-theatre which it serves, calculated on the basis of 9 m² of unobstructed floor area per patient.

(2) The recovery room or area shall be fitted with—

(a) a wash-hand basin to which hot and cold water is laid on to elbow-operated taps;

(b) a sufficient supply of oxygen for each patient to be accommodated;

(c) a sufficiently adjustable fixed or portable lamp for every recovery bed or trolley;

(d) an adequate and satisfactory mechanical suction system with one suction point for every recovery bed or trolley;

(e) two flash-proof electric power outlets for every recovery bed or trolley; and

(f) facilities for screening off patients.

43. *Sterieleverskaffingseenheid.*

(1) Die vloeroppervlakte van die sterieleverskaffingseenheid moet minstens 12 m² wees, die muurlengte daarvan minstens 3 m, en dit moet 'n toereikende vrye vloerruimte hê.

(2) Die sterieleverskaffingseenheid moet toereikend toegerus wees om die instrumente, materiale, verbandpakke, bakke, houers, water en diverse items vir gebruik in verband met die behandeling wat verskaf word, afsonderlik te ontvang, skoon te maak, te verpak, te steriliseer en op te berg.

(3) Indien 'n stoomoutoklaaf gebruik word, moet dit gemonteer wees in 'n toereikend geventileerde en toegangklike masjienkamer buitekant die steriliseer-area en onmiddellik aangrensend daaraan en moet die outoklaaf in sodanige area oopmaak: Met dien verstande dat indien 'n steriliseerproses wat gebruik word die voortbrenging van stoom, waterdamp of ander gasse behels, 'n geskikte metode verskaf moet word vir die doeltreffende verwydering daarvan.

(4) Die bepalings van hierdie regulasie belet nie die eienaar om, met die toestemming van die Sekretaris en behoudens sodanige voorwaardes as wat die Sekretaris vasstel, 'n goedgekeurde sentralesterieleverskaffingsdepartement op te rig en te onderhou nie, om sodoende toereikende steriele voorrade aan alle pasiënte-akkommodasie- en behandelingsareas van die hospitaal te verskaf.

44. Dienskamers binne operasieteatereenhede.

(1) Die vloeroppervlakte van die teaterdienskamer moet minstens 10 m² wees met 'n minimum muurlengte van 2,4 m en moet so geleë en gebou wees dat die doeltreffende bewaking van die pasiënte moontlik is: Met dien verstande dat in plaas van 'n dienskamer 'n toereikende diensstasie verskaf kan word.

(2) Die teaterdienskamer of -stasie moet toegerus wees met sodanige fasiliteite as wat nodig is vir die doel waarvoor sodanige dienskamer of -stasie gebruik word.

45. Spoelkamers van operasieteatereenhede.

Die vloeroppervlakte van 'n teaterspoelkamer moet minstens 5 m² wees met 'n muurlengte van minstens 2,1 m en moet toegerus wees met—

(a) 'n spoelpan;

(b) toereikende rakke vir die opberging van skoon houers;

(c) 'n vlekvryestaal-opwasbak met warm en koue water; en

(d) 'n handewasbak met warm en koue water.

46. Kleedkamers van operasieteatereenhede.

'n Teaterkleedkamer moet van toereikende grootte wees, met 'n vloeroppervlakte van minstens 9 m² en 'n muurlengte van minstens 2,1 m en moet toegerus wees met—

(a) 'n handewasbak met warm en koue water;

(b) geskik afgeskorte toilette op die basis van een toilet vir elke sewe lede van die teaterpersoneel of gedeelte van sodanige getal;

(c) toereikende fasiliteite vir die afsonderlike bewaring van persoonlike klere en besittings, skoon en gebruikte teaterdrag; en

(d) 'n storthokkie met 'n droë aantrekarea.

43. *Sterile supply unit.*

(1) The sterile supply unit shall have a floor area of not less than 12 m², a wall length of not less than 3 m and adequate free floor space.

(2) The sterile supply unit shall be adequately equipped separately to receive, clean, pack, sterilise and store instruments, materials, dressings, basins, containers, water and sundry items used in connection with the treatment provided.

(3) If a steam autoclave is used, it shall be mounted in an adequately ventilated and accessible machine room outside and immediately adjacent to the sterilising area, with the autoclave opening into such area: Provided that, if any sterilising process used involves the production of steam, water vapour or any other gases, a suitable means for the effective removal thereof shall be provided.

(4) The provisions of this regulation shall not preclude any proprietor from establishing and maintaining, with the consent of the Secretary, and subject to such conditions as the Secretary may impose, an approved central sterile supply department in order to provide adequate sterile supplies to all patient accommodation and treatment areas of the hospital.

44. Duty rooms within operating-theatre units.

(1) The theatre duty room shall have a floor area of not less than 10 m² and a minimum wall length of 2,4 m and shall be so situated and constructed as to make effective patient surveillance possible: Provided that an adequate duty station may be provided instead of a duty room.

(2) The theatre duty room or station shall be equipped with such facilities as may be necessary for the purpose for which such theatre duty room or station is used.

45. Sluice rooms of operating-theatre units.

A theatre sluice room shall have a floor area of not less than 5 m² and a minimum wall length of 2,1 m and shall be fitted with—

(a) a sluice pan;

(b) adequate shelving for storing clean containers;

(c) a stainless steel wash-up basin with hot and cold water; and

(d) a wash-hand basin with hot and cold water.

46. Change rooms of operating-theatre units.

A theatre change room shall be of adequate size and shall have a floor area of not less than 9 m² and a minimum wall length of 2,1 m and shall be provided with—

(a) a wash-hand basin to which hot and cold water is laid on;

(b) suitably partitioned off toilets on the basis of one toilet for every seven members of the theatre staff or part of such number;

(c) adequate facilities for the separate storage of personal clothing and effects, clean and used theatre clothing; and

(d) a shower cubicle with a dry change area.

VERLOSKUNDIGE EENHEID

47. *Algemene vereistes.*

'n Verloskundige eenheid sluit in—

(a) een of meer verpleegeenhede ooreenkomstig hierdie regulasies;

(b) toereikende babakamerfasiliteite, insluitende—

(1) 'n afsonderlike kamer waar voorsiening gemaak is vir spesiale versorgingsfasiliteite, insluitende—

(i) ten minste een broeikas;

(ii) resussiteringstoerusting met suiging en suurstof; en

(iii) suurstof- en suigingvoorsiening in die hoofeenheid;

(2) resussiteringstoerusting in die bevallingskamer, insluitende—

(i) 'n tafel van geskikte hoogte; met

(ii) oorhoofse verhitting; en

(iii) voorsiening vir suurstof en suiging;

(c) 'n melkkombuis, indien meer as 15 beddens vir moeders verskaf word;

(d) 'n pasiëntevoorbereidingskamer, indien meer as 15 beddens vir moeders verskaf word;

(e) 'n kraamkamer bestaande uit—

(i) 'n bevallingskamer of -kamers volgens die basis van een bevallingskamer vir elke 10 beddens vir moeders, of een bevallingskamer plus 'n kamer vir pasiënte in die eerste stadium van bevalling vir elke 15 beddens vir moeders;

(ii) bykomende dienste, met inbegrip van—

(aa) 'n spoelkamer met voorsiening vir die bewaring, ondersoek en wegdoen van plasentas; en

(bb) afsonderlike opbergfasiliteite vir steriele pakke en instrumente, linne, medisyne en diverse toerusting.

(f) waar meer as 15 beddens vir moeders verskaf word en geen operasieteaterfasiliteite geredelik beskikbaar is nie, voorsiening vir 'n operasieteatereenheid wat voldoende geskikte teaterfasiliteite bied.

48. *Bevallingskamers.*

(1) Die vloeroppervlakte van elke bevallingskamer moet minstens 16 m^2 wees met 'n wydte van minstens 3,7 m.

(2) 'n Bevallingskamer moet ook beskik oor—

(a) toereikende skropfasiliteite;

(b) 'n geskikte, verstelbare lamp, vas of draagbaar;

(c) 'n antistatiese vloer indien plofbare verdowingsgasse gebruik word;

(d) toereikende voorsiening vir suurstof; en

(e) toereikende fasiliteite vir die ressusiteer van babas.

VERANDERINGS

49. Geen gebou van 'n private hospitaal of losstaande operasieteatereenheid of gedeelte van sodanige gebou mag uitgebrei, gesloop of andersins struktureel of funksioneel verander word sonder die skriftelike goedkeuring van die Sekretaris in oorleg met die Direkteur nie. 'n Eienaar wat sodanige goedkeuring verlang, moet skriftelik daarom aansoek doen en elke sodanige aansoek moet—

(1) vergesel gaan van gedetailleerde planne en spesifikasies; en

(2) die redes vir die beoogde uitbreiding, sloping of verandering volledig uiteensit.

MATERNITY UNIT

47. *General requirements.*

A maternity unit shall include—

(a) one or more nursing units, in accordance with these regulations;

(b) adequate nursery facilities which shall include—

(1) a separate room where facilities for special care shall be provided, including—

(i) at least one incubator;

(ii) resuscitation equipment with suction and oxygen; and

(iii) oxygen and suction supply in the main nursery;

(2) resuscitation equipment in the delivery room shall include—

(i) a table of a suitable height; with

(ii) overhead heating; and

(iii) oxygen and suction supply;

(c) a milk kitchen, if more than 15 mother beds are provided;

(d) a patients' preparation room, if more than 15 mother beds are provided;

(e) a labour unit consisting of—

(i) a delivery room or rooms on the basis of one delivery room for every 10 mother beds, or one delivery room plus a room for patients in the first stage of labour for every 15 mother beds;

(ii) ancillary services, including—

(aa) a sluice room with provision for storing, examining and disposing of placentas; and

(bb) separate storage facilities for sterile packs and instruments, linen, medicines and sundry equipment;

(f) where more than 15 mother beds are provided and no operating-theatre facilities are readily available, provision shall be made for an operating-theatre unit with sufficient suitable theatre facilities.

48. *Delivery rooms.*

(1) Each delivery room shall have a floor area of not less than 16 m^2 and a minimum width of 3,7 m.

(2) Each delivery room shall also contain—

(a) adequate scrubbing-up facilities;

(b) a suitable adjustable lamp, fixed or mobile;

(c) an anti-static floor if explosive anaesthetic gases are used;

(d) adequate provision for oxygen; and

(e) adequate baby resuscitation facilities.

ALTERATIONS

49. No building of any private hospital or unattached operating-theatre unit or any portion of such building shall be extended, demolished or otherwise structurally or functionally altered without the written approval of the Secretary in consultation with the Director. Any proprietor wishing to obtain such approval shall apply in writing and every such application shall—

(1) be accompanied by detailed plans and specifications; and

(2) set out in full the reasons for the proposed extension, demolition or alteration.

VERTONING VAN REGISTRASIESERTIFIKAAT BY PRIVATE HOSPITALE EN LOSSTAANDE OPERASIETEATEREENHEDE

50. Die houer van 'n geldige registrasiesertifikaat moet sodanige registrasiesertifikaat wat in regulasie 14 (1) of 14 (3) vermeld word, op 'n opvallende plek op die perseel waarop dit betrekking het, vertoon of laat vertoon.

INSPEKSIES

51. Die Sekretaris kan 'n private hospitaal of losstaande operasieteatereenheid te eniger tyd en so dikwels as wat hy dit nodig ag, inspekteer of deur 'n inspekterende beampte laat inspekteer.

52. Die eienaar van 'n private hospitaal of losstaande operasieteatereenheid of 'n ander persoon wat vir die bestuur daarvan of beheer daaroor verantwoordelik is of wat in bevel van die verplegingsdienste daarvan is, moet aan die persoon wat ingevolge hierdie regulasie as inspeksiebeampte optree, alle inligting verstrek wat sodanige beampte verlang betreffende die organisasie en bestuur van sodanige private hospitaal of losstaande operasieteatereenheid en betreffende die akkommodasie, verpleging en behandeling van pasiënte. Al die registers, kliniese rekords en ander rekords in verband met pasiënte en personeel moet vir die doel van sodanige inspeksie beskikbaar gestel word.

53. Niemand mag 'n inspeksiebeampte in enige opsig in die uitvoering van sy inspeksie dwarsboom nie; of weier om inligting wat deur sodanige beampte gevra word, na sy beste wete te verstrek nie; of weier om enige apparaat of plek of ding te wys of om enige kas oop te sluit nie.

54. Die Sekretaris kan te eniger tyd die eienaar van sodanige private hospitaal of losstaande operasieteatereenheid by skriftelike kennisgewing aansê om, binne 'n redelike tyd wat in die kennisgewing vermeld word, sodanige strukturele veranderings of sodanige verbeterings in verband met die organisasie of bestuur van voornoemde private hospitaal of losstaande operasieteatereenheid aan te bring of sodanige toerusting aan te skaf of te vervang of sodanige gebreke reg te stel as wat in die bedoelde kennisgewing vermeld word.

APPÈL

55. Die eienaar of voornemende eienaar van 'n private hospitaal of losstaande operasieteatereenheid kan skriftelik by die Minister appelleer teen enige besluit wat die Sekretaris ingevolge 'n bepaling van hierdie regulasies geneem het met betrekking tot sodanige eienaar of voornemende eienaar, na gelang van die geval, van 'n private hospitaal of losstaande operasieteatereenheid.

56. 'n Appèl ingevolge regulasie 55 moet aangeteken word binne sewe dae nadat die besluit waarteen geappelleer word, onder die aandag van die eienaar of voornemende eienaar, na gelang van die geval, gekom het en moet duidelik vermeld—

(1) teen watter besluit sodanige appèl aangeteken word; en

(2) op watter gronde sodanige appèl aangeteken word.

57. 'n Appèl ingevolge hierdie regulasies word ingelewer by die Sekretaris, wat dit, tesame met sy redes vir die besluit waarteen daar geappelleer word, aan die Minister voorlê.

DISPLAYING OF CERTIFICATE OF REGISTI TION AT PRIVATE HOSPITALS AND UN TACHED OPERATING-THEATRE UNITS

50. The holder of a valid certificate of registra shall display or cause to be displayed in a cor cuous place on the premises to which such certifi relates, the certificate of registration mentioned in r lation 14 (1) or 14 (3).

INSPECTIONS

51. The Secretary may at any time, and as o as he may deem necessary, inspect or have inspe by an inspecting officer any private hospital or u tached operating-theatre unit.

52. The proprietor of a private hospital or u tached operating-theatre unit or any other pe responsible for the management or control thereo who is in charge of the nursing services thereof s render to the inspecting officer in terms of these r lations all information the said officer may requir regard to the organisation and management of s private hospital or unattached operating-theatre and the accommodation, nursing and treatment of patients. All registers, clinical records and any o records in connection with patients and staff s also be available for inspection.

53. No person shall in any way obstruct any insp ing officer carrying out his inspection or refuse to nish to the best of his knowledge any informa requested by such officer or to show any appar or place or thing or to unlock any cupboard.

54. The Secretary may at any time direct the p prietor of such private hospital or unattached ope ing-theatre unit by notice in writing to effect, wi a reasonable period stated in the notice, such st tural alterations or such improvements in regard the organisation or management of the said pri hospital or unattached operating-theatre unit or acquire or replace such equipment or to remedy s defects as may be specified in the said notice.

APPEALS

55. The proprieter or prospective proprieter o private hospital or unattached operating-theatre may appeal in writing to the Minister against any d sion made by the Secretary in terms of any provi of these regulations in respect of such proprieto prospective proprietor, as the case may be, of a vate hospital or unattached operating-theatre unit.

56. An appeal in terms of regulation 55 shall lodged within seven days of the decision appe against having come to the knowledge of the propri or prospective proprietor, as the case may be, and s clearly state—

(1) against which decision such appeal is lod and

(2) the grounds on which such appeal is lodged.

57. Any appeal in terms of these regulations s be lodged with the Secretary, who shall submit i the Minister together with his reasons for the d sion against which the appeal is being lodged.

58. Die Minister kan die besluit wat die Sekretaris ingevolge die bepalings van hierdie regulasie geneem het, bekragtig, wysig of herroep, en moet die eienaar of voornemende eienaar van 'n private hospitaal of losstaande operasieteatereenheid skriftelik van sy besluit in kennis stel.

MISDRYWE EN STRAFBEPALINGS

59. 'n Persoon wat—

(1) 'n private hospitaal of losstaande operasieteatereenheid instel, uitbrei, bedryf, onderhou, bedryf of beheer of 'n diens daarin lewer terwyl sodanige private hospitaal of losstaande operasieteatereenheid nie ingevolge die bepalings van hierdie regulasies geregistreer is nie; of

(2) die bestaande geboue van 'n private hospitaal of losstaande operasieteatereenheid of 'n gedeelte van sodanige geboue uitbrei, sloop of struktureel verander of die gebruik daarvan wysig sonder die voorafverkreë skriftelike goedkeuring van die Sekretaris; of

(3) die eienaar is van, of in diens is by, 'n private hospitaal of losstaande operasieteatereenheid en wat—

(i) versuim of weier om aan die Sekretaris, of aan 'n persoon wat namens hom handel, toegang tot sodanige hospitaal of losstaande operasieteatereenheid te verleen vir die doel van 'n inspeksie ingevolge regulasie 52; of

(ii) versuim om aan die bepalings van regulasie 54 te voldoen; of

(iii) die Sekretaris, of 'n persoon wat namens hom handel, in die uitvoering van sy pligte ingevolge regulasie 53 dwarsboom of hinder of versuim om aan sodanige bepalings te voldoen, of in stryd met sodanige bepalings optree;

is aan 'n misdryf skuldig en strafbaar—

(a) by 'n eerste skuldigbevinding, met 'n boete van hoogstens R500 of met gevangenisstraf vir 'n tydperk van hoogstens ses maande of met sowel daardie boete as daardie gevangenisstraf;

(b) by 'n tweede skuldigbevinding aan 'n soortgelyke misdryf, met 'n boete van hoogstens R1 000 of met gevangenisstraf vir 'n tydperk van hoogstens een jaar of met sowel daardie boete as daardie gevangenisstraf; en

(c) by 'n derde of daaropvolgende skuldigbevinding aan 'n soortgelyke misdryf, met 'n boete van hoogstens R1 500 of met gevangenisstraf vir 'n tydperk van hoogstens twee jaar of met sowel daardie boete as daardie gevangenisstraf.

60. Alle provinsiaalondersteunde hospitale is uitgesluit van hierdie regulasies.

61. *Vorms.*

Vir doeleindes van die Wet op Gesondheid, 1977 (Wet 63 van 1977), en die regulasies daarkragtens uitgevaardig, moet gebruik gemaak word van vorms wat wesenlik ooreenstem met dié wat in die aanhangsels hiervan gespesifiseer word.

HERROEPPING VAN REGULASIE R. 1071 VAN 25 JUNIE 1971

62. (1) Die bepalings van die regulasies vir losstaande operasieteatereenhede (Regulasie R. 1071 van 25 Junie 1971) word hierby herroep vir sover dit van toepassing is op losstaande operasieteatereenhede of daarop betrekking het.

58. The Minister may confirm, amend or revoke a decision taken by the Secretary in terms of the provisions of these regulations and inform the owner or prospective owner of a private hospital or unattached operating-theatre unit in writing of his decision.

OFFENCES AND PENALTIES

59. Any person who—

(1) establishes, extends, conducts, maintains, manages, controls or renders a service in any private hospital or unattached operating-theatre unit which is not registered in terms of the provisions of these regulations; or

(2) extends, demolishes or makes structural alterations to the existing buildings of a private hospital or unattached operating-theatre unit, or any portion of such buildings, or alters the purpose for which such buildings are used, without the prior approval in writing of the Secretary; or

(3) is the proprietor of or is employed at a private hospital or unattached operating-theatre unit and who—

(i) fails or refuses to allow the Secretary, or any person acting on his behalf, access to such hospital or unit for the purpose of an inspection in terms of regulation 52; or

(ii) fails to comply with the provisions of regulation 54; or

(iii) obstructs or hinders the Secretary or any person acting on his behalf in the performance of his duties in terms of regulation 53, or who contravenes or fails to comply with such provisions,

shall be guilty of an offence and liable—

(a) upon a first conviction, to a fine not exceeding R500 or to a term of imprisonment not exceeding six months or to both such fine and such term of imprisonment;

(b) upon a second conviction for a similar offence, to a fine not exceeding R1 000 or to a term of imprisonment not exceeding one year or to both such fine and such term of imprisonment; and

(c) upon a third or subsequent conviction for a similar offence, to a fine not exceeding R1 500 or to a term of imprisonment not exceeding two years or to both such fine and such term of imprisonment.

60. All provincial-aided hospitals are excluded from these regulations.

61. *Forms.*

Forms essentially as specified in the annexures hereto shall be used for the purposes of the Health Act, 1977 (Act 63 of 1977), and the regulations made under the Act.

REPEAL OF REGULATION R. 1071 OF 25 JUNE 1971

62. (1) The provisions of the regulations in respect of unattached operating-theatre units (Regulation R. 1071 of 25 June 1971), are hereby repealed in so far as they apply or relate to unattached operating-theatre units.

(2) 'n Kennisgewing, bevel, besluit, goedkeuring, toestemming, magtiging, inligting of dokument uitgereik, geneem, verleen of verstrek en 'n ander handeling wat ingevolge 'n bepaling van hierdie regulasies uitgevoer is of by hierdie regulasies herroep is, moet, indien dit nie teenstrydig is met die bepalings van hierdie regulasies nie, geag word uitgereik, geneem, verleen, verstrek of uitgevoer te gewees het ingevolge die ooreenstemmende bepalings van hierdie regulasies.

63. Hierdie regulasies tree in werking op 1 April 1980.

AANHANGSELS

Aanhangsel	Vorm	Onderwerp
A.....	—	Omvang van voorgeskrewe prosedures uitgevoer in losstaande operasieteatereenhede.
B.....	I	Aansoek om registrasie van 'n private hospitaal/losstaande operasieteatereenheid.
C.....	II	Registrasiesertifikaat.
D.....	III	Register van pasiënte opgeneem.
E.....	IV	Bevallingsregister.
F.....	V	Operasieteaterregister.
G.....	VI	Ongevalle- en buitepasiënteregister.
H.....	VII	Register van verpleegkundige personeel.

AANHANGSEL A

OMVANG VAN VOORGESKREWE PROSEDURES UITGEVOER IN LOSSTAANDE OPERASIETEATEREENHEDE

In losstaande operasieteatereenhede mag geen voorgeskrewe prosedures uitgevoer word nie tensy die nodige fasiliteite, toerusting en assistensie vir sodanige prosedures, vir resussitasie en vir na-operatiewe sorg beskikbaar is.

A. TANDHEELKUNDE

(1) Herstellende tandheelkunde.
(2) Verwydering van tande.
(3) Geringe mondprosedures.

B. ALGEMENE CHIRURGIE

(1) Vratte.
(2) Besnyding.
(3) Hegting van wonde en pese.
(4) Insnyding van oppervlakkige absesse.
(5) Dreinering van hematoom.
(6) Verwydering van vingernaels en toonnaels.
(7) Verwydering van oppervlakkige voorwerpe, maar slegs waar metodes van akkurate lokalisasie beskikbaar is.
(8) Sigmoïdoskopie en kolonoskopie.
(9) Verwydering van eenvoudige oppervlakkige tumors.
(10) Inspuiting van hemoroïede en spatare.
(11) Abdominale parasentese.
(12) Anale dilatasie.
(13) Spierbiopsie.
(14) Lediging van getromboseerde eksterne hemoroïede.
(15) Behandeling van anusspleet.
(16) Laterale sfinkterotomie.

(2) Any notice, order, decision, approval, permission, authority, information or document issued, made, granted or furnished and any other action taken under any provision of these regulations or repealed by these regulations shall, if not inconsistent with the provisions of these regulations, be deemed to have been issued, made, granted, furnished or taken under the corresponding provisions of these regulations.

63. Date of commencement of regulations is 1 April 1980.

ANNEXURES

Annexure	Form	Subject
A.....	—	Scope of prescribed procedures carried out in unattached operating-theatre units.
B.....	I	Application for registration as a private hospital/unattached operating-theatre unit.
C.....	II	Certificate of registration.
D.....	III	Register of patients admitted.
E.....	IV	Maternity register.
F.....	V	Operating-theatre register.
G.....	VI	Casualty and out-patients register.
H.....	VII	Register of nursing staff.

ANNEXURE A

SCOPE OF PRESCRIBED PROCEDURE CARRIED OUT IN UNATTACHED OPERATING THEATRE UNITS

In unattached operating-theatre units no prescribe procedures shall be carried out unless the necessar facilities, equipment and assistance are available f such procedures, for resuscitation and for post-operati care.

A. DENTISTRY

(1) Restorative dentistry.
(2) Removal of teeth.
(3) Minor oral procedures.

B. GENERAL SURGERY

(1) Warts.
(2) Circumcision.
(3) Stitching of wounds and tendons.
(4) Incision of superficial abscesses.
(5) Evacuation of haematoma.
(6) Removal of finger-nails and toe-nails.
(7) Removal of superficial foreign bodies, but o where methods for accurate localisation are availa
(8) Sigmoidoscopy and colonoscopy.
(9) Removal of simple superficial tumours.
(10) Injection of haemorrhoids and varicose ve
(11) Abdominal paracentesis.
(12) Anal dilatations.
(13) Muscle biopsy.
(14) Evacuation of thrombosed external haem hoids.
(15) Treatment of fissure *in ano*.
(16) Lateral sphincterotomy.

C. PSIGIATRIE

(1) Elektrokonvulsiewe terapie.
(2) Narkoanalise.
(3) Elektrostimulasie.
(4) Lumbale en sisternale punksie.

D. ORTOPEDIE

(1) Reduksie van eenvoudige frakture.
(2) Reduksie van eenvoudige ontwrigtings.
(3) Manipulasies.
(4) Aspirasie van gewrigte.
(5) Inspuitings in gewrigte.
(6) Arteriografie.
(7) Karpo-tonnelvrylating.
(8) Peeshegting.
(9) Senuweehegting.
(10) Ganglionverwydering.

E. OOR, NEUS EN KEEL

(1) Laringoskopie.
(2) Proefpunksie en sinusspoeling.
(3) Parasentese, met inbegrip van die installering van plastiekbuisies en die skoonmaak van ore onder algemene narkose.
(4) Kouterisering.
(5) Verwydering van vreemde voorwerpe en poliepe.
(6) Reduksie van neusfraktuur.
(7) Tonsillektomie en adenoïdektomie.

F. GINEKOLOGIE EN OBSTETRIE

(1) Ondersoek onder narkose.
(2) Insnyding van Bartholiniese kieste.
(3) Uitwendige kering.
(4) Insit van intrauteriene-voorbehoedmiddel.
(5) Kouterisering van serviks.
(6) Endometriumbiopsie.
(7) Histerosalpingogram.
(8) Verwydering van servikale poliep.
(9) Vulvabiopsie.
(10) Hormooninplanting.
(11) Himenektomie.
(12) Dilatasie en kurettasie.
(13) Diagnostiese laparoskopie.
(14) Sterilisering.
(15) Shirodkar-operasie.
(16) Radiologiese ondersoekprosedures wat algemene narkose vereis.
(17) Ander kleinere prosedures wat nie binne 12 uur 'n X-straalondersoek binne die eenheid sal vereis nie.

G. OOGDEELKUNDE

(1) Ondersoek van kinders onder narkose.
(2) Verwydering van vreemde voorwerpe in kornea.
(3) Sondering van traanbuise.
(4) Insnyding van Meiboom-kieste.
(5) Verwydering van Pterigium.

H. VELSIEKTES

(1) Diatermie en kurettasie van vratte.
(2) Diatermie en kurettasie van soolvratte.
(3) Diatermie en kurettasie van *verrucae acuminatae.*
(4) Biopsie van vel of slymvlies deur middel van 'n insnyding of met behulp van 'n pons.
(5) Verwydering van goedaardige oppervlakkige letsels.
(6) Verwydering van kwaadaardige oppervlakkige letsels.
(7) Insnyding en dreinering van oppervlakkige abses.

C. PSYCHIATRY

(1) Electroconvulsive therapy.
(2) Narcoanalysis.
(3) Electrostimulation.
(4) Lumbar and cisternal puncture.

D. ORTHOPAEDICS

(1) Reduction of simple fractures.
(2) Reduction of simple dislocations.
(3) Manipulations.
(4) Aspiration of joints.
(5) Injections into joints.
(6) Arthrography.
(7) Carpal-tunnel release.
(8) Tendon suture.
(9) Nerve suture.
(10) Ganglion removal.

E. EAR, NOSE AND THROAT

(1) Laryngoscopy.
(2) Proof puncture and sinus irrigation.
(3) Paracentesis, including insertion of grommets and toilet of ears under general anaesthetic.
(4) Cauterisation.
(5) Removal of foreign bodies and polyps.
(6) Reduction of fractured nose.
(7) Tonsillectomy and adenoidectomy.

F. GYNAECOLOGY AND OBSTETRICS

(1) Examination under anaesthetic.
(2) Incision of Bartholin's cyst.
(3) External version.
(4) Insertion of intra-uterine contraceptive device.
(5) Cauterisation of cervix.
(6) Endometrial biopsy.
(7) Hysterosalpingogram.
(8) Excision of cervical polyp.
(9) Vulva biopsy.
(10) Hormone implantation.
(11) Hymenectomy.
(12) Dilatation and curettage.
(13) Diagnostic laparoscopy.
(14) Sterilisation.
(15) Shirodkar operation.
(16) Investigative radiological procedures requiring general anaesthetics.
(17) Other minor procedures which will not necessitate an X-ray within the unit within a period of 12 hours.

G. OPHTHALMOLOGY

(1) Examination of children under anaesthetic.
(2) Removal of corneal foreign bodies.
(3) Probing of tear ducts.
(4) Incision of Meibomian cysts.
(5) Removal of Pterygium.

H. DERMATOLOGY

(1) Diathermy and curettage of warts.
(2) Diathermy and curettage of plantar warts.
(3) Diathermy and curettage of *verrucae acuminatae.*
(4) Biopsy of skin or mucous membrane by means of incision or punch.
(5) Removal of benign superficial lesions.
(6) Removal of malignant superficial lesions.
(7) Incision and drainage of superficial abscess.

I. UROLOGIE

(1) Sistoskopie.
(2) Uretradilatasie.
(3) Vasektomie.
(4) Testisbiopsie.
(5) Meatotomie.
(6) Besnyding.
(7) Verwydering van uretra-karunkels.
(8) Verwydering van spermatokeel.

J. TORAKSCHIRURGIE

(1) Plurale-aspirasie en naaldbiopsie van plura en long.
(2) Interkostale blok.
(3) Verwydering van oppervlakkige gewasse.
(4) Brongoskopie } met of sonder verwydering
(5) Esofagoskopie } van vreemde voorwerpe.
(6) Dilatasie van esofagus.

K. NEUROCHIRURGIE

Soos by B, plus, waar van toepassing:

(1) Ondersoek onder narkose.
(2) Lumbale punksie en gepaardgaande prosedures soos intratekale fenol- of alkoholtoediening, spinale wortelblokkering, lugenkefalogram, miëlogram, medisyn toediening en spinale dreinering.
(3) Senuweeblokkering soos van Gasser-ganglion, oksipitale senuwee, ens.
(4) Angiografie deur middel van naald of kateter.
(5) Trageotomie.
(6) Aftap van ventrikels deur bestaande beengat (boorgat) of fontanelle of beenpunksie vir doel van dreinering of toediening van kontrasmedia of geneesmiddel.

L. PLASTIESE CHIRURGIE

Soos by B, plus, waar van toepassing:

(1) Plastiese reparasie van klein wonde.
(2) Manipulasie van neusfraktuur (onder plaaslike verdowing).
(3) Klein veltransplantate.
(4) Uitsny en herstel van littekens (onder plaaslike verdowing).

M. INTERNE GENEESKUNDE

(1) Gastroskopie en duodenoskopie.
(2) Sigmoïdoskopie.
(3) Rektale biopsie.
(4) Sternale punksie.
(5) Diagnostiese parasentese van plura en peritoneum.
(6) Inspuiting in senuweewortels en ganglia.
(7) Lumbaal punksie.

AANHANGSEL B

Vorm I

Departement van Gesondheid

Aansoek om registrasie as 'n *private hospitaal/losstaande operasieteatereenheid ingevolge Regulasie R. 158 van 1 Februarie 1980.

Die Sekretaris van Gesondheid
Privaatsak X88
PRETORIA
0001

Hierby word aansoek gedoen om die registrasie van 'n *private hospitaal/losstaande operasieteatereenheid, ten opsigte waarvan besonderhede vir die jaar eindigende op 31 Desember 19..... hieronder verstrek word.

1. Naam van *private hospitaal/losstaande operasieteatereenheid .....
2. Ligging van perseel (straat, lokaliteit, dorp).....
3. Naam en posadres van geregistreerde eienaar van die eiendom (perseel).....

I. UROLOGY

(1) Cystoscopy.
(2) Urethral dilation.
(3) Vasectomy.
(4) Testis biopsy.
(5) Meatotomy.
(6) Circumcision.
(7) Removal of urethal caruncles.
(8) Removal of spermatocele.

J. THORACIC SURGERY

(1) Pleural aspiration and needle biopsy of pleura lung.
(2) Intercostal block.
(3) Removal of superficial tumours.
(4) Bronchoscopy } with or without removal
(5) Oesophagoscopy } of foreign bodies.
(6) Dilatation of oesophagus.

K. NEUROSURGERY

As under B, plus, where applicable:

(1) Examination under an anaesthetic.
(2) Lumbar puncture and similar procedures as intrathecal phenol or alcohol administration, sp root block, air encephalogram, myelogram, drug a nistration and spinal drainage.
(3) Nerve block, e.g. Gasserian ganglion, occi nerve, etc.
(4) Angiography—needle or catheter.
(5) Tracheotomy.
(6) Drainage of ventricles through existing burr or fontanelle or bone biopsy, for purposes of drai or administration of contrast media or drugs.

L. PLASTIC SURGERY

As under B, plus, where applicable:

(1) Plastic repair of small wounds.
(2) Manipulation of nasal fracture (under l anaesthetic).
(3) Small skin transplants.
(4) Excision and repair of scars (under local anaes tic).

M. MEDICINE

(1) Gastroscopy and duodenoscopy.
(2) Sigmoidoscopy.
(3) Rectal biopsy.
(4) Sternal puncture.
(5) Diagnostic paracentesis of pleura and peritone
(6) Injection into nerve roots and ganglia.
(7) Lumbar puncture.

ANNEXURE B

Form

Department of Health

Application for registration as a *private hospital/unattac operating-theatre unit in terms of Regulation R. 158 of 1 Febr 1980.

The Secretary for Health
Private Bag X88
PRETORIA
0001

Application is hereby made for the registration of the follo *private hospital/unattached operating-theatre unit, details which are supplied below for the year ending 31 December 19....

1. Name of *private hospital/unattached operating-theatre .....
2. Situation of premises (street, locality, town).....
3. Name and postal address of registered owner of the prop (premises).....

4. Naam en adres van eienaar (in die geval van 'n maatskappy of vereniging van persone, sy benoemde verteenwoordiger) wat die *private hospitaal/losstaande operasieteatereenheid sal bedryf.....
5. Naam en adres van die geneesheer of geregistreerde verpleegkundige en vroedvrou wat in beheer sal wees.....
6. Indien 'n geneesheer in beheer sal wees, die naam en kwalifikasies van die geregistreerde verpleegkundige en vroedvrou wat in bevel van die verpleegdiens sal wees.....
7. Getal en toewysing van die beskikbare beddens vir pasiënte (sien notas hieronder).....

4. Name and address of proprietor (in the case of a company or association, it's nominee) who will be conducting the *private hospital/unattached operating-theatre unit.....
5. Name and address of the medical practitioner or registered nurse and midwife who will be in charge.....
6. If a medical practitioner will be in charge, name and qualifications of the registered nurse and midwife who will be in charge of the nursing services.....
7. Number and allocation of beds available for patients (see notes below).....

	Algemeen		Verloskunde		Aansteeklike siektes	Ander (spesifiseer)	Totaal
	Volwassenes	Kinders	Moeders	Babas			
Blankes.....							
Nie-Blankes.....							

8. Getal:
   (a) Operasieteaters.....
   (b) Bevallingskamers.....
9. Verandering (as daar is) in beskikbare pasiënte-akkommodasie/-beddens gedurende die huidige jaar (spesifiseer).....
10. Getal geregistreerde personeel *in diens op datum van aansoek/wat in diens sal wees op datum van nuwe registrasie waarom aansoek gedoen word:

		Praktisyns		Verpleegkundiges	
		Geneeshere	Tandarste	Geregistreer	Studente
Voltyds.....	Blank.....				
	Nie-Blank.....				
Deeltyds.....	Blank.....				
	Nie-Blank.....				

11. Getal voltydse ingeskrewe verpleegkundige personeel *in diens op datum van aansoek/wat in diens sal wees op datum van nuwe registrasie waarom aansoek gedoen word.

		Ingeskrewe verpleegkundiges	Ingeskrewe student-verpleegkundiges	Ingeskrewe verpleeg-assistente	Ingeskrewe leerlingverpleeg-assistente
Voltyds.....	Blank.....				
	Nie-Blank.....				

	General		Maternity		Infectious diseases	Other (specify)	Total
	Adults	Children	Mothers	Babies			
Whites.....							
Non-Whites.....							

8. Number of:
   (a) Operating-theatres.....
   (b) Delivery rooms.....
9. Changes in the patient accommodation/beds available during the current year, if any (specify).....
10. Numbers of registered staff *employed at date of application/to be employed at date of new registration applied for:

		Practitioners		Nurses	
		Medical	Dental	Registered	Student
Full-time.....	White.....				
	Non-White.....				
Part-time.....	White.....				
	Non-White.....				

11. Number of full-time enrolled nurses *employed at date of application/to be employed at date of new registration applied for:

		Enrolled nurses	Enrolled student nurses	Entolled nursing assistants	Entolled pupil nursi assistants
Full-time.....	White.....				
	Non-White.....				

12. Ander voltydse geregistreerde personeel in diens (as daar is) (spesifiseer).....
.....

13. Ander deeltydse geregistreerde personeel in diens (as daar is) (spesifiseer).....
.....

14. Indien die Suid-Afrikaanse Raad op Verpleging die hospitaal erken as 'n goedgekeurde opleidingskool vir verpleegkundiges, vroedvroue of ingeskrewe verpleegkundiges of ingeskrewe verpleegassistente:

(a)

Algemene verpleeg-kundiges	Vroedvroue	Ingeskrewe verpleeg-kundiges	Ingeskrewe verpleegassi-stente

(b) Indien die hospitaal erken word as 'n goedgekeurde opleidingskool vir een of meer van die kategorieë van personeel in (a) hierbo vermeld, moet ondergenoemde inligting ook verstrek word:

Kategorie	Nommer van registrasie- of inskrywingsertifikaat deur die S.A.R.V. uitgereik	Datum van uitreiking
(i) Student- algemene verpleegkundiges.....		
(ii) Studentvroedvroue.....		
(iii) Leerlingverpleegkundiges		
(iv) Leerlingverpleegassistente		

Registrasie by die S.A.R.V. (spesifiseer):

	Nommer van oorspronklike sertifikaat	Datum van uitreiking	Jaarlikse registrasie	
			Kwitansienommer	Datum
Algemeen...				
Vroedvrou...				
Ander.....				

(c) Ander opgeleide personeel, met uitsluiting van die persoon in beheer:

(i) Geregistreerde verpleegkundiges/vroedvroue:

Naam	Kwalifikasies	Nommer van oorspronklike sertifikaat	Datum van uitreiking	Jaarlikse registrasie	
				Kwitansienommer	Datum

(ii) Ingeskrewe verpleegkundiges.....
Totaal.....

(iii) Ingeskrewe verpleegassistente.....
Totaal.....

12. Other full-time registered staff employed (if any) (sp
.....

13. Other part-time registered staff employed (if any) (sp
.....

14. If the hospital is recognised by the South African Nu Council as an approved training school for nurses, mid or enrolled nurses or enrolled nursing assistants:

(a)

General nurses	Midwives	Enrolled nurses	Enrolle nursing assistan

(b) If the hospital is recognised as an approved tra school for one or more of the categories of nursing referred to in subsection (a), the following inform should also be given:

Category	Number of registration or enrolment certificate issued by the S.A.N.C.	Date iss
(i) Student general nurses...		
(ii) Student midwives.....		
(iii) Pupil nurses.....		
(iv) Pupil nursing assistants..		

Registration with the S.A. Nursing Council (specify):

	Number of original certificate	Date of issue	Annual registr	
			Receipt number	D
General.....				
Midwifery..				
Other.....				

(c) Other trained staff, excluding person in control:

(i) Registered nurses/midwives:

Name	Qualifications	Number of original certificate	Date of issue	Annual registr	
				Receipt number	D

(ii) Enrolled nurses.....
Total.....

(iii) Enrolled nursing assistants.....
Total.....

15. Reëlings vir die opleiding en onderrig van elk van ondergenoemde kategorieë, soos toepaslik:

(i) Studentverpleegkundiges.....
(ii) Studentvroedvroue.....
(iii) Leerlingverpleegkundiges.....
(iv) Leerlingverpleegassistente.....

Ek verklaar hierby dat bostaande gegewens waar en korrek is.

Plek.....

Datum.....

Handtekening van eienaar

L.W.—Indien die beskikbare ruimte onvoldoende is, heg 'n skedule aan.

Notas:

(a) *Woorde wat met 'n sterretjie aangedui word, moet deurgehaal word indien hulle nie van toepassing is nie.
(b) Hierdie vorm moet gebruik word vir die eerste en elke daaropvolgende aansoek om registrasie.
(c) Item 7: Die getal beddens, bababedjies en wiegies wat werklik beskikbaar is om pasiënte te akkommodeer, moet vermeld word, maar sluit die volgende uit—

alle trollies;

alle wag-, voorbereidings-, eerstestadium- en bevallingskamerbeddens en bababedjies in die verloskundige eenheid;

die hersteltrollies en herstelbeddens van 'n operasieteatereenheid van 'n private hospitaal maar nie dié van 'n losstaande operasieteatereenheid nie.

AANHANGSEL C

Vorm II

Sertifikaat No.....

Verwysing No.....

DEPARTEMENT VAN GESONDHEID

REGISTRASIESERTIFIKAAT

Hierby word gesertifiseer dat die.....
.....
gelee te.....
geregistreer is as 'n *private hospitaal/losstaande operasieteatereenheid ingevolge die bepalings van Regulasie R. 158 van 1 Februarie 1980 vir 'n tydperk van.....maande eindigende.....
Naam van eienaar of besturende liggaam.....
.....
Adres van eienaar of besturende liggaam.....
.....
Naam van persoon in beheer.....
Maksimum getal pasiënte wat tegelykertyd geakkommodeer kan word:

Pasiënte wat tegelykertyd geakkommodeer kan word	Maksimum getal geakkommodeer	
	Blank	Nie-Blank
*Geneeskundig en chirurgies:		
(a) Volwassenes.....	.....	.....
(b) Kinders.....	.....	.....
Bevallings:		
(a) Moeders.....	.....	.....
(b) Babas.....	.....	.....
Aansteeklike siektes.....	.....	.....
Ander (spesifiseer).....	.....	.....

Met uitsluiting van bogenoemde aktiwiteite, word die werksaamhede van bogenoemde *private hospitaal/losstaande operasieteatereenheid soos volg beperk.....
.....
Geteken te....., op hede die.....dag van.....19.....

.....
Sekretaris van Gesondheid

Hierdie sertifikaat is nie oordraagbaar nie en moet jaarliks hernieu word.

* Skrap indien nie van toepassing nie.

15. Arrangements for the training and teaching of each of the following categories, as applicable:

(i) Student nurses.....
(ii) Student midwives.....
(iii) Pupil nurses.....
(iv) Pupil nursing assistants.....

I hereby certify that the above particulars are true and correct.

Place.....

Date.....

Signature of proprietor

N.B.—If available space is insufficient, attach separate schedule.

Notes:

(a) *Words designated by an asterisk to be deleted if not applicable.
(b) This form is to be used for the first and every subsequent application for registration.
(c) Item 7: The numbers of beds, cribs/cots actually available for accommodating patients are to be stated, but these exclude—

all trolleys;
all waiting, preparation, first stage and labour room beds and cots in maternity units;
the recovery trolleys and recovery beds of an operating-theatre unit of a private hospital, but not those of an unattached operating-theatre unit.

ANNEXURE C

Form II

Certificate No.....

Reference No.....

DEPARTMENT OF HEALTH

CERTIFICATE OF REGISTRATION

It is hereby certified that the.....
.....
situated at.....
is registered as a *private hospital/unattached operating-theatre unit in terms of Regulation R. 158 of 1 February 1980 for a period of..... months, ending.....
Name of proprietor or managing body.....
.....
Address of proprietor or managing body.....
.....
Name of person in charge.....
Maximum number of patients who may be accommodated at the same time:

Patients that can be accommodated sumultaneously	Maximum number accommodated	
	White	Non-White
*Medical and surgical:		
(a) Adults.....	.....	.....
(b) Children.....	.....	.....
Maternity:		
(a) Mothers.....	.....	.....
(b) Babies.....	.....	.....
Infectious diseases.....	.....	.....
Other (specify).....	.....	.....

With the exception of the above-mentioned activities, the activities of the above-mentioned *private hospital/unattached operating-theatre unit are restricted as follows.....
.....
Signed at..... this..... day of.....19.....

.....
Secretary for Health

This certificate is not transferable and must be renewed annually.

* Delete if not applicable.

AANHANGSEL D

Vorm III

REGISTER VAN PASIËNTE OPGENEEM

Reeks No.	Pasiënte-registrasie No.	Datum opgeneem	Volle naam van pasiënt	Ouderdom	Geslag	Woonadres	Diagnose/ Rede vir toelating	Naam van geneesheer wat die pasiënt behandel	Finale diagnose	Datum van		In geval van dood	
										Ontslag	Dood	Gesertifiseerde oorsaak	Deur wie gesertifiseer

ANNEXURE D

REGISTER OF PATIENTS ADMITTED

Form III

Serial No.	Patient registration No.	Date admitted	Full name of patient	Age	Sex	Residential address	Diagnosis/ reason for admission	Name of medical practitioner treating the patient	Final diagnosis	Date of		In case of death	
										Discharge	Death	Certified cause of death	By whom certified

AANHANGSEL E

Vorm IV

BEVALLINGSREGISTER

Reeksnommer van geval.....
Datum opgeneem.....
Naam van pasiënt.....
Ouderdom.....
Bevolkingsgroep.....
Adres.....
.....
(a) Getal vorige bevallings.....
(b) Getal vorige miskrame.....
(c) Datum van bevalling.....
(d) Datum van miskraam .....
Volle termyn, vroeggebore of miskraam? Indien miskraam, vermeld benaderde getal maande.....
Ligging.....
Duur van bevalling.....
Geslag van baba.....
Dood of lewend by geboorte.....
Komplikasies (as daar is) gedurende of na die bevalling.....
.....
Naam van geneesheer (blokletters).....
Handtekening.....
Naam van vroedvrou (as daar is).....
Datum van vroedvrou se laaste besoek of datum van ontslag.....
Toestand van moeder op daardie tydstip .....
Toestand van kind op daardie tydstip .....
Opmerkings.....

.....
Handtekening

ANNEXURE E

F

MATERNITY REGISTER

Serial number of case.....
Date admitted.....
Name of patient.....
Age.....
Population group.....
Address .....
.....
(a) Number of previous confinements.....
(b) Number of previous miscarriages.....
(c) Date of confinement.....
(d) Date of miscarriage.....
Full-term, premature or miscarriage? If miscarriage, state approximate number of months .....
Presentation .....
Duration of labour.....
Sex of infant.....
Born alive or dead.....
Complications (if any) during or after labour.....
.....
Name of medical practitioner (block letters).....
Signature .....
Name of midwife (if any).....
Date of midwife's last visit or date of discharge.....
Condition of mother then .....
Condition of child then .....
Remarks.....
.....
Signature

AANHANGSEL F

Vorm V

OPERASIETEATERREGISTER

Reeksnommer.....
Datum.....
Naam.....
Toelatingsregister No.....
Geslag.....
Ouderdom.....
Saal.....
Narkose.....
Naam van narkotiseur.....
Naam van chirurg.....
Naam van assistent-chirurg.....
Operasie.....
Duur van operasie: Van..... tot.....
Dreinering, ens.....
Teater.....
Handtekening van verpleegkundige by operasie.....
Handtekening van nasiener.....
Opmerkings (komplikasies, ongelukke, ens.).....
.....

ANNEXURE F

OPERATING-THEATRE REGISTER

Serial number.....
Date.....
Name.....
Admission register No.....
Sex.....
Age.....
Ward.....
Anaesthetics.....
Name of anaesthetist.....
Name of surgeon.....
Name of assistant surgeon.....
Operation.....
Duration of operation: From..... to.....
Drains, etc.....
Theatre.....
Signature of nurse taking operation.....
Signature of co-checker.....
Remarks (complications, accidents, etc.).....
.....

AANHANGSEL G

ONGEVALLE- EN BUITEPASIËNTEREGISTER

Reeks No.	Register No.	Datum	Tyd	Naam	Ouderdom	Geslag	Adres	Klagte/ Besering	Ontslag	Na ge
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

ANNEXURE G

CASUALTY AND OUT-PATIENTS REGISTER

Serial No.	Register No.	Date	Time	Name	Age	Sex	Address	Complaint/ Injury	Discharge	N pr
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....

AANHANGSEL H

Vorm VII

REGISTER VAN VERPLEEGKUNDIGE PERSONEEL

Volle naam.....
Nooiensvan (indien toepaslik).....
Identiteitsnommer.....
Geslag..... Geboortedatum.....
Bevolkingsgroep..... Nasionaliteit.....

ANNEXURE H

REGISTER OF NURSING STAFF

Full name.....
Maiden name (if applicable).....
Identity number.....
Sex..... Date of birth.....
Population group..... Nationality.....

PROFESSIONELE KWALIFIKASIES

Graad/Diploma/Sertifikaat	Registrasiesertifikaat	
	Datum	No.

Kwitansie van lopende registrasie/inskrywing by S.A. Raad op Verpleging:

Datum.....
Nommer.....

Kwitansie van lopende lidmaatskap van S.A. Verpleegsters-vereniging:

Datum.....
Nommer.....
Datum van aanstelling.....
Datum van diensbeëindiging.....

1 Februarie 1980

No. R. 165

WYSIGING VAN DIE REGULASIES BETREFFENDE ANATOMIESE SKENKINGS EN NADOODSE ONDERSOEKE

Hierby word vir algemene inligting bekend gemaak dat die Minister van Gesondheid kragtens die bevoegdheid hom verleen by artikel 13 (1) (dA) van die Wet op Anatomiese Skenkings en Nadoodse Ondersoeke, 1970 (Wet 24 van 1970), voornemens is om die regulasies uitgevaardig by Goewermentskennisgewing R. 889 van 24 Mei 1974, soos gewysig, verder te wysig deur die voorgeskrewe weefsel, die voorgeskrewe gemagtigde inrigting en die voorgeskrewe doel vermeld in die Bylae hiervan, in onderskeidelik kolom I, kolom II en kolom III van Bylae II in te voeg.

Belanghebbendes word hierby versoek om binne drie maande na die datum van hierdie kennisgewing gemotiveerde kommentaar in te dien by die Sekretaris van Gesondheid, Privaatsak X88, Pretoria, 0001 (vir aandag: mnr. L. A. du Pisanie).

BYLAE

Kolom I Voorgeskrewe weefsel	Kolom II Voorgeskrewe gemagtigde inrigting	Kolom III Voorgeskrewe doel
Gehoorsenuwees	Departement Neurochirurgie, Universiteit van Pretoria	Navorsing.

PROFESSIONAL QUALIFICATIONS

Degree/Diploma/Certificate	Registration certificate	
	Date	No.

Receipt of current registration/enrolment with S.A. Nursing Council:

Date.....
Number.....

Receipt of current membership of S.A. Nursing Association:

Date.....
Number.....
Date of appointment.....
Date of termination of service.....

1 February 1980

No. R. 165

AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATIONS REGULATIONS

It is hereby notified for general information that the Minister of Health, in the exercise of the powers vested in him by section 13 (1) (dA) of the Anatomical Donations and Post-Mortem Examinations Act, 1970 (Act 24 of 1970), intends to further amend the regulations promulgated under Government Notice R. 889 of 24 May 1974, as amended, by inserting the prescribed tissue, the prescribed authorised institution and the prescribed purposes named in the Schedule hereto, in column I, column II and column III, respectively, of Schedule II.

Interested parties are hereby invited to submit substantiated comments to the Secretary for Health, Private Bag X88, Pretoria, 0001 (for attention: Mr L. A. du Pisanie), within three months of the date of this notice.

SCHEDULE

Column I Prescribed tissue	Column II Prescribed authorised institution	Column III Prescribed purpose
Auditory nerves	Department of Neurosurgery University of Pretoria	Research.

ET 6/2/80 (85)

Warning on medical control

Science Reporter

WARNINGS against State-controlled medicine and a call to doctors to stand together against official "disregard and disrespect" of the medical profession appear in the letter columns of the latest edition of the South African Medical Journal.

In strongly-worded attacks on the proposed Medical Schemes Amendment Bill and the Medical, Dental and Supplementary Health Professions Bill, a Cape Town doctor and a Pretoria doctor warn that if these come into effect the result would be:

- The practice of medicine would "to all practical purposes" become State-controlled.
- The medical, dental and allied professions would lose "such autonomy as they still have".
- The State would have the power to set ethical standards, train and register doctors and take disciplinary action without consulting the Medical and Dental Council; and be able to determine fees for both medical aid schemes and private patients.
- Such legislation would "influence the quality and pattern of medical practice very considerably", would give the public inferior medical services at no reduction in cost, increase their dissatisfaction, cause the personal relationship between patient and doctor to disappear, and encourage more doctors to leave the country.

It was "of the utmost importance" that every member of the medical, dental and supplementary health service professions "resolutely resist, individually and collectively, all these proposals and that they make their views clear to the authorities in no uncertain manner".

On this matter there could be "no compromise, no deal and no appeasement", the letter said.

The second letter said it was "hard to believe that this legislation emanates from a doctor who was once a colleague in the practice of medicine".

"I trust that Parliament will not be so unwise as to give the Minister of Health (Dr L A P A Munnik) such unfettered and unfair power."

The writer added that the members of the Medical and Dental Council should not allow themselves "to be treated like kindergarden infants and urged them to oppose "this iniquitous piece of legislation" vehemently.

"If it should ever reach realization it calls for the resignation of the whole Medical and Dental Council."

	B		M	
	F			
0-1	0,48	0,49	533	
1-4	0,05	0,05	0,25	0,20
5-24	0,05	0,05	1,44	0,91
25-44	0,22	0,23	0,80	0,68
45-64	0,05	0,05	0,23	0,22
65+	0,05	0,05	0,05	0,05
ALL	0,08	0,08	0,49	0,48
NO.	130	203	329	533

	B		M	
	F			
0-1	0,06	0,04	203	
1-4	0,04	0,02	0,10	0,08
5-24	0,08	0,06	0,73	0,56
25-44	0,02	0,03	0,34	0,25
45-64	0,04	0,02	0,06	0,08
65+	0,02	0,03	0,02	0,02
ALL	0,06	0,04	0,04	0,06
NO.	130	203	130	203

XIV CONGENITAL ANOMALIES 91

	W		A		C		B	
	M	F	M	F	M	F	M	F
0-1	1,57	0,76	0,60	1,03	1,24	0,79	0,89	0,74
1-4	0,05	0,04	0,05	0,05	0,05	0,02	0,04	0,05
5-24	0,01	0,00	0,01	0,01	0,01	0,02	0,00	0,00
25-44	0,00	0,00	0,00	0,00	0,00	0,01	0,00	0,00
45-64	0,01	0,00	0,00	0,00	0,00	0,00	0,00	0,00
65+	0,02	0,01	0,00	0,00	0,00	0,03	0,00	0,00
ALL	0,04	0,02	0,03	0,04	0,04	0,03	0,03	0,00
NO.	87	43	9	14	50	33	54	47

XV CERTAIN CAUSES OF PERINATAL MORBIDITY AND MORTALITY

	W		A		C		B	
	M	F	M	F	M	F	M	F
0-1	12,46	9,07	16,92	11,55	29,22	24,78	23,16	22,23
1-4	0,02	0,02	0,02	0,02	0,02	0,04	0,04	0,00
5-24	-	-	-	-	-	-	-	-
25-44	-	-	-	-	-	-	-	-
45-65	-	-	-	-	-	-	-	-
65+	-	-	-	-	-	-	-	-
ALL	0,25	0,17	0,48	0,32	0,83	0,67	0,55	0,67
NO.	519	359	170	113	942	785	1143	1075

KENNISGEWING 98 VAN 1980

WYSIGING VAN REGULASIES BETREFFENDE ANATOMIESE SKENKINGS EN NADOODSE ONDERSOEKE

Hierby word vir algemene inligting bekendgemaak dat die Minister van Gesondheid kragtens die bevoegdheid hom verleen by artikel 13 (1) (dA) van die Wet op Anatomiese Skenkings en Nadoodse Ondersoeke, 1970 (Wet 24 van 1970), voornemens is om die regulasies uitgevaardig by Goewermentskennisgewing R. 889 van 24 Mei 1974, soos gewysig, verder te wysig deur die voorgeskrewe weefsel, die voorgeskrewe gemagtigde inrigting en die voorgeskrewe doel vermeld in die Bylae hiervan, in onderskeidelik kolom I, kolom II en kolom III van Bylae II in te voeg.

Belanghebbendes word hierby versoek om binne drie maande na die datum van hierdie kennisgewing gemotiveerde kommentaar in te dien by die Sekretaris van Gesondheid, Privaatsak X88, Pretoria, 0001 (vir aandag: mnr. L. A. du Pisanie).

BYLAE

Kolom I Voorgeskrewe weefsel	Kolom II Voorgeskrewe gemagtigde inrigting	Kolom III Voorgeskrewe doel
Hart	Tygerberghospitaal	Oorplanting.
Temporale bene	Tygerberghospitaal	Opleiding en navorsing.
Larinks	Tygerberghospitaal	Opleiding en navorsing.
Lewer	Tygerberghospitaal	Navorsing.
Milt	Tygerberghospitaal	Weefseltipering.

(8 Februarie 1980)

(85)

NOTICE 98 OF 1980

AMENDMENT OF THE ANATOMICAL DONATIONS AND POST-MORTEM EXAMINATIONS REGULATIONS

It is hereby notified for general information that the Minister of Health, in the exercise of the powers vested in him by section 13 (1) (dA) of the Anatomical Donations and Post-Mortem Examinations Act, 1970 (Act 24 of 1970), intends further to amend the regulations promulgated under Government Notice R. 889 of 24 May 1974, as amended, by inserting the prescribed tissue, the prescribed authorised institution and the prescribed purposes named in the Schedule hereto in column I, column II and column III, respectively of Schedule II.

Interested parties are hereby invited to submit substantiated comments to the Secretary for Health, Private Bag X88, Pretoria, 0001 (for attention: Mr L. A. du Pisanie), within three months of the date of this notice.

SCHEDULE

Column I Prescribed tissue	Column II Prescribed authorised institution	Column III Prescribed purpose
Heart	Tygerberg Hospital	Transplantation.
Temporal bones	Tygerberg Hospital	Training and research
Larynx	Tygerberg Hospital	Training and research
Liver	Tygerberg Hospital	Research.
Spleen	Tygerberg Hospital	Tissue typing.

(8 February 1980)

GG6840

The Chief

DD 9/2/80 $5

Don't light up!

If you're a smoking addict take a long, hard look at these facts provided by the Southern Africa Council on Smoking and Health. The statistics are based on 1976 figures and exclude blacks:

The risk of lung cancer in heavy smokers is 15 to 30 times greater than that of non-smokers.

The World Health Organisation says the control of cigarette smoking would contribute more to improving health and prolonging life than any other single action in the field of preventive medicine;

The rate of coronary heart disease, of which cigarette smoking is a main cause, is the highest in the world among white South African men and women;

One in four white South African children are smokers before they reach the age of 15 and many are regular smokers at the age of 11;

In Britain it is estimated cigarette smoking is responsible for 50 000 premature deaths a year and that more than 30 million working days a year are lost due to smoking-related diseases;

Babies born to women who smoke during pregnancy tend to have a lower birth weight and be more susceptible to infection than babies born to non-smokers;

Deaths from cardio-vascular diseases resulting from smoking are more than three times higher than the number of fatal car accidents in South Africa.

Considering those facts I'm not surprised South Africa is to hold a "National Smokeless Day" on April 2 as part of a worldwide anti-smoking thrust emanating from the World Health Organisation in Geneva.

Smokers throughout the country will be asked to abstain from smoking on April 2, but the main purpose of the campaign will be to alert the public to how seriously smoking has been and is affecting the health of South Africans.

The Council on Smoking and Health is hoping the entire South African population — smokers and non-smokers — will actively support this promotion and help build up a healthy nation of all race groups.

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Hansard 2Q col 66 13/2/80

(1) How many (a) Whites, (b) Coloureds, (c) Indians and (d) Blacks in the different professions associated with health services emigrated from South Africa during the last 12 months for which figures are available;

(2) what is the number of each race group in each such profession?

Emigrants: persons in professions associated with health services

166. Mr. N. B. WOOD asked the Minister of Statistics:

The MINISTER OF STATISTICS:

(1) (a) 358

(b), (c) and (d) 15 (separate figures not available).
Figures are for the period December 1978 to November 1979.

(2)

	(a)	(b), (c) and (d)
Medical doctors	103	3
Dentists	14	—
Pharmacists	30	1
Professional nurses	150	9
Other nursing personnel	1	—
Optometrists and opticians	6	—
Physiotherapists, etc.	30	—
Radiographers	16	1
Osteopaths, chiropractors, etc.	8	1
Total	358	15

'Govt narrow on abortion'

Political Staff

THE ASSEMBLY — Mrs Helen Suzman (PFP, Houghton) lashed out in the Assembly yesterday at Government attitudes to abortion in South Africa.

Speaking in the second-reading debate on the Abortion and Sterilisation Amendment Bill, she said the abortion legislation had been debated by men with narrow minds who knew nothing of the agony of women.

Referring to arguments put forward by a speaker on the Government side, Mrs Suzman said: "He might take a different attitude if his own 16-year-old daughter became pregnant."

This was something that could happen to anybody's daughter.

One of the manifold difficulties of women — pregnancy after rape — was made a little easier by the proposed legislation.

The Bill, among other things, empowers a magistrate to grant consent in certain circumstances for the sterilisation of persons who cannot themselves consent to it.

The second reading of the Bill was supported by all parties in the Assembly.

Mr H E J van Rensburg (PFP, Bryanston) said exaggerated restrictions in the existing law were causing much misery.

Experts had said that victims reported to the police in only five percent of rape cases.

A large percentage of illegitimate births, especially among the coloured people, occurred as a result of rape.

The Minister of Health, Dr L A P A Munnik, said South Africa's abortion law was based on Christian principles and these would be maintained.

Dr Munnik said he was prepared to consider proposals for improvements from Mr van Rensburg, but abortion on demand would never be accepted.

Hansard 2 Quest Col 93 15/2/80

85

Commission of Inquiry into Fluoridation

*16. Mr. A. B. WIDMAN asked the Minister of Health:

Whether he intends to introduce legislation to give effect to the recommendations of the Commission of Inquiry into Fluoridation; if so, when; if not, why not?

The MINISTER OF HEALTH:

No, not at this stage.

The Department of Health has been receiving additional information from various sources which is being evaluated. When this has been finalized, a decision shall be taken.

Hansard 2 Cols 769 → 15/2/80

85

never been the intention of the association to imply that the draft Bills had any political connotation.

After thorough consideration of all the representations I decided to amend certain provisions in the Bills to be introduced in Parliament. These amendments will have the following effect—

1. As regards the right of contracting in and contracting out in terms of section 29 of the Medical Schemes Act, 1967, the *status quo* will be preserved, but it shall be provided that if, after consultation with the S.A. Medical and Dental Council and the profession concerned, it is deemed to be desirable in the public interest, the right of contracting in and contracting out may be rescinded, or that it may only be allowed under certain specific circumstances, which will be prescribed by regulation.

2. The draft provision by means of which the Minister may set aside any decision of the S.A. Medical and Dental Council will be restricted to tariffs of fees applicable to services rendered to members and dependants of members of medical schemes, after the Minister has consulted with the executive committee of the council.

3. The tariffs of fees will have to be approved by the Minister prior to publication, and shall relate only to services rendered to members and dependants of members of medical schemes.

4. The tariffs of fees so published shall be maximum fees only in respect of services rendered by providers of services to members and dependants of medical schemes who have contracted in.

5. As regards the constitution of the tariffs committees, the *status quo* will be maintained for the present.

The professions will in this way, at their request, be afforded an opportunity of adopting measures and applying self-discipline to ensure that the right of contracting out will be in the public interest and will not be abused. Every possible malpractice with regard to the application of the tariff of fees will also be

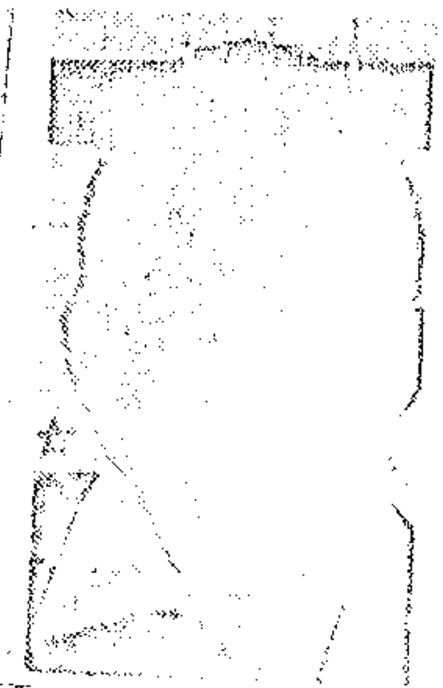
DRAFT LEGISLATION RELATING TO THE MEDICAL PROFESSIONS AND MEDICAL SCHEMES

(Statement)

*The MINISTER OF HEALTH: Mr. Speaker, a draft Medical, Dental and Supplementary Health Service Professions Amendment Bill and a draft Medical Schemes Amendment Bill was published for general information in the *Gazette* on 12 December 1979 with a view to obtaining comment on the provisions of the measures from interested parties.

For general information, and to prevent further harmful publicity, I want to announce that I have in the meantime held talks with the representatives of the S.A. Medical and Dental Council, the Medical Association of South Africa, the Dental Association of South Africa and the Private Hospitals' Association. I shall now request the Representative Association of Medical Schemes to discuss this matter with me.

With reference to newspaper reports in this connection, the Chairman of the Federal Council of the Medical Association stated categorically during the interview that it had



Has anyone seen Jovan?

Jovan Bouchal (14) has been missing from his Bowling Avenue primary school in Newclare, Johannesburg, since January 22. His family has been searching for him without success. Anyone who knows his whereabouts should contact his parents at 2301 Derick Flats, Newclare (phone 673-3779) or their nearest police station.

State warns on skin lightening

By Bob Kennaugh

The Department of Health is to crack down soon on shops which sell skin lightening cream containing mercury or more than two percent of the chemical hedroquinone.

This was disclosed by Dr Pieter Swanepoel, the department's sub-director of environmental health, who was commenting on a finding that skin-lightening cosmetics are responsible for an epidemic of chronic poisoning of the skin of black women in the Transvaal.

The findings of Professor G H Findlay and Dr H A de Beer, of the dermatology division at the University of Pretoria, were published in the SA Medical Journal

They found that there was widespread use by black women of bleaching preparations containing hydroquinone. "The products act efficiently as bleaching agents, but chronic overexposure of the skin with hydroquinone eventually produces ochronosis (which is the result of chronic poisoning)," they said.

New legislation limits the use of this chemical in skin lighteners to two percent.

"We will soon send out inspectors who will buy supplies of creams. These will be analysed to see whether they contain mercury or more than two percent of hydroquinone. If we find that the law is being broken, the distributors will be prosecuted."

The Fair Deal first investigated the sale of illegal skin lighteners last year. It found that many shops were selling skin lighteners containing dangerous amounts of mercury or hydroquinone.

A Fair Deal survey conducted last September, found that 60 percent of bleaching cream from two companies tested showed traces of illegal quantities of mercury.

lokugala logwayimbo indoda imele icala losebenzi ezame ukubo[illegible] abamnyama xa bebemengaphandle kweFektri. Abasebenzi balile ukwahlulwa, omnye wabo uthe "Silapha sonke yaye iinjongo zethu zinye."

Ayanda amanani abantu abazibandakanyileyo nabasebenzi kwiveki ephilileyo kubekho abafundi base University nakwano Kolegi abangaphezu kwe - 500. Abafundi bavelu kwezi zikolo U.W.C., Hewat, Peninsula Training College ne Bellville Technical College.

Abafundi bathe abasebenzi mabaphinde baqeshwe kungenjalo yonke imveliso yakwa Fattis & Monis ingathengwa.

Umbutho oyi Western Province Traders Association uthe uza kuxelela onke amalungu awo ukuba angayithengi imveliso yaleFektri de bavume uthethwathethwano.

Umbutho oyi South African Council of Sports SACOS ucele onke amalungu awo nazo zonke izikolo ezinonxibelelwane kunye nabo ukuba zixhase abo bagxothiwyo de baphinde bageshwe. Yaye akufuneki bayithenge imveliso yale fektri.

Abafundi base U.C.T. bayenzile eyabo intlanganiso bebona kalisa ubunye nabasebenzi. Bacele ukuba imveliso zakwa Fattis & Monis zingathengwa okanye zingasetyenziswa.

Umbutho oyi Women for Peace Movement ucele ukuba efektri yenzi uphando nothethwathethwano kunye nabasebenzi.

Umbutho walapha eKapa oyi National African Federated Chamber of Commerce ubhalile wakhupha istatement uxhasa abasebenzi abagxothiweyo.

UFattis & Monis uphikele ukuthi akukho ngxabano nakungevani kulefektri. Kodwa ke lowo ungumphati wefem le uthi, ukhathazekile xa kusithiwa imveliso yabo mayingathengwa ngabamNyama njengoko inkxaso enkulu ivelo kwabo bamNyama. Abaphathi bale Fem baqashe abasebenzi abangabanye ukuba basebenze endaweni yabo bagwayimbileyo ukuze kubekho imveliso, kodwa imveliso yehlile

Ngubani uFattis & Monis? UFattis & Monis yiFektri enezimveliso zilandelayo:
Record Self Raising Flour, Record Cake Flour, Record Bread Flour, Record Sifted Flour, Record Unsifted Flour, Record Wheatie Treat Flour; Philadelphia Flour; Koelberg Mille pack Mealie Meal; Fattis & Monis icecream cones, wafers and cake cups; Fattis and Monis Macaroni, spagetti, shells, ribbons, rings, dilatines; Princess macaroni, spagetti, shells, rings, ribbons, dilatines; Checkers, Poto' Gold, Pick 'n Pay macaroni, spagetti, rings, ribbons, shells, dilatines; Wrench Town Bakery, Observatory ; Good Hope Bakery, Elsies River; Ultra Bakery, Somerset West.

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SA may rejoin world group

By PETER BAYER.

THERE is a strong likelihood that the Medical Association of South Africa will return to the World Medical Association (WMA) later this year.

South Africa resigned in 1976 from the organisation it helped to found in 1948.

The resignation was prompted by the fact that the WMA was becoming an anti-apartheid platform for its increasing Third World members.

The Secretary-General of the WMA, Dr Andre Wynen, said yesterday that after touring the country, visiting hospitals and meeting with top officials, he felt it necessary for South Africa to return to the WMA.

He said he had succeeded in amending the WMA's constitution two years ago and Third World nations now wielded less power in the association.

Dr Wynen said what he had seen showed that South Africa had a great deal to contribute to world medicine and had the most sophisticated medical care on the continent.

Secretary-General of MASA, Dr Marais Viljoen, who invited Dr Wynen to the country, agreed that South Africa should rejoin the WMA as an exchange of ideas was necessary to maintain a high standard.

"This does not mean we have already agreed to rejoin WMA," Dr Viljoen said.

"However, after Dr Wynen has presented his report, MASA will reconsider rejoining. At this stage, I see no reason why we should not go back."

● The American Medical Association which resigned from the WMA shortly before South Africa, for the same reason, has rejoined since the amendment.

Canada, which also resigned, has also rejoined and the Rhodesian delegation is apparently reconsidering rejoining. However, the Scandinavian delegation resigned after the amendment was made.

Hansard
4(224)
27/2/80

85

Notifiable diseases

44. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

How many cases of each notifiable disease were notified in respect of each race group in 1979?

The MINISTER OF HEALTH:

	White	Coloured	Asian	Black	Other	Total
Anthrax	0	0	0	0	0	0
Asiatic Cholera	3	0	0	0	0	0
Brucellosis	12	0	0	5	0	17
Diphtheria	5	16	2	59	6	88
Encephalitis	99	3	8	15	0	125
Erysipelas	4	0	0	3	0	7
Glanders	0	0	0	0	0	0
Gonorrhoeal ophthalmia	2	25	0	105	0	132
Lead poisoning	3	1	1	4	0	9
Leprosy	1	4	2	123	2	132
Malaria	101	10	11	1 648	1	1 771
Meningococcal infect	115	788	9	315	0	1 227
Pesticidal poisoning	6	26	1	39	0	72
Plague	0	0	0	0	0	0
Poliomyelitis	1	3	0	80	0	84
Puerpural fever	1	3	2	53	0	59
Rabies in man	1	0	0	5	0	6
Relapsing fever	0	0	0	2	0	2
Scarlet fever	81	6	0	5	0	92
Smallpox	0	0	0	0	0	0
Tetanus	5	7	0	240	0	252
Trachoma	0	0	0	22	0	22
Trypanosomiasis	0	0	0	0	0	0
Tuberculosis	606	8 326	673	35 094	299	44 998
Typhoid fever	47	107	39	3 253	6	3 542
Typhus fever	2	0	0	0	0	2
Viral hepatitis	729	246	140	497	8	1 620
Yellow fever	0	0	0	0	0	0
Total	1 824	9 571	888	41 567	322	54 172

Hansard 4 (229) 28.2.80 ~~3(gen)~~

85

~~B(gen)~~

~~3(gen)~~

poisoning by poisons used for agricultural purposes during the last 12 months for which figures are available;

(2) in respect of what dates are these figures given?

The MINISTER OF HEALTH:

(1) (a) 103.

(b) 72.

(2) 1 January until 31 December 1979.

THURSDAY, 28 FEBRUARY 1980

†Indicates translated version;

For written reply:

Persons poisoned by poisons used for agricultural purposes

3(gen) (229) 28.2.80

3. Mr. N. B. WOOD asked the Minister of Health:

(1) How many persons (a) died and (b) were admitted to hospital as a result of

C UNRESOLVED ISSUE

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uction which provide for
with (3), evidence on
wage 'subsidies' upon
deficiencies in these

mists will probably
do not rid themselves
explain social reality.
lism or praxiology, the
ias of received doctrine
ch the Classical school

Mothers' over-diluted the feeds partly because of ignorance and partly because they could not afford the cost of the feed, he said.

But now, he said, mothers had a much better idea of how to use a formula feed and there was greater awareness that breastfeeding was still the best method of feeding a baby.

Had advertising encouraged mothers to use these products?

Professor Stein said it seemed to have done so.

It was very common in the past, he said, to see an advertisement for one of these preparations showing a big, bonny baby.

● In terms of regulations under the Foodstuffs, Cosmetics and Disinfectants Act, foodstuffs intended for babies 12 months of age or younger must bear a label indicating in both official languages that "breast feeding should be the first choice."

The new slogan is 'breast is best'

South African manufacturers of baby foods say they have stopped advertising breast milk substitutes in the non-medical Press.

The practice of advertising these products to the general public has been condemned by doctors and nutritionists.

They say there is a danger that mothers, through ignorance or poverty, will over-dilute these products to the detriment of their babies' health. As in most cases, they say, "breast is best."

In Washington a House of Representatives subcommittee on international policy and trade is investigating the marketing practices of American Home Products Corporation and Nestle Incorporated, both of which have subsidiaries in South Africa.

The investigation follows claims by an American organisation called the International Nestle Boycott Committee, which alleges the marketing practices of multi-national giants contribute to massive infant mortality in the developing world.

It was revealed at the subcommittee hearing that American Home Products Corporation had ordered its South African subsidiary to stop using a particular baby food advertisement.

An executive of the subsidiary company, Wyeth Laboratories, said it was given this instruction by its parent company about the middle of last year.

Since then, all advertising to the public had been discontinued. While the company continued to advertise in the medical press, its last advertisement directed at consumers (an advertisement in the magazine "Living and Loving for 26 dollars) appeared about September last year.

A spokesman for Nestle said they had not advertised any baby formula products to the general public for over two years. Now they advertised only in medical journals, which were directed at doctors who knew what was best for mothers and their babies, he said.

A spokesman for the Department of Health said the department held a meeting with all baby food manufacturers about two years ago, at which they agreed on a code of practice.

He said Wyeth Laboratories' advertising to the public last year had not constituted an infringement of this agreement because it was not "aggressive" advertising.

Wyeth's spokesman said the code of practice did not prohibit advertising to the public, but his company had decided, on its own, to limit its advertisements to the professional Press only.

Professor H Stein, chief paediatrician at Baragwanath Hospital, said Baragwanath had been trying very hard for many years now to promote breastfeeding. He said it was only in very few cases that mothers could not breast feed.

He said that in the past many of the cases of malnutrition in babies brought to the hospital were the result of over-diluting of formula feeds by mothers.

Tar and nicotine laws (85) rdm 6/3/80. possible soon

By BRUCE STEPHENSON

THE Secretary of Health, Dr Johan de Beer, said in his annual report, tabled in Parliament yesterday, that legislation would be introduced soon as part of a comprehensive programme to curtail smoking.

He is aiming for January 1, 1982, as the date for this legislation to be effected.

The Government wants cigarette manufacturers to disclose the tar and nicotine contents of cigarettes on each packet from January 1, 1982.

Cigarette manufacturers said they were strongly opposed this.

The Government is also planning an education programme, aimed mainly at schoolchildren, to warn of the dangers associated with high tar content in cigarettes.

Adults will be encouraged to moderate their smoking.

Dr De Beer said from Cape Town yesterday that he was consulting manufacturers on the form of the warning that would appear on each packet.

"We have looked at what America and Britain are doing in this regard and I am not sure that their methods have had any effect.

"But we are learning from their campaigns and I am sure that we will find some sort of solution."

Arch anti-smoking campaigner Mr Alf Widman, MP for Hillbrow, has welcomed the move and wants the Minister of Health to ban smoking in "any public place".

Mr Widman said he was "delighted" at the department's plans.

This was "covered completely" by his Smoking Control Bill, which proposes that:

- Tar and nicotine content, plus a warning "Smoking is dangerous to your health", be displayed on every cigarette packet;

While appaling health

Uplift in Alex

(85) (90) (343) (341) STAR 6/3/80

Residents in Alexandra township stir in their sleep and wrinkle their noses when the Baca tribesmen from 21st Avenue start work at 4 am.

Appalling health hazards in Alex

ing health conditions prevail in Alexandra, a critical shortage of funds threatens the 40-year-old clinic providing essential health services to the Johannesburg township. ROB MEINTJES reports.

The Bacas' job: To empty by hand the bucket toilets used by 50 000 residents in the old black township adjoining Sandton.

The stench of human excrement fills the morning air as the Transkeian Bacas trudge from toilet to toilet.

On bad days when the buckets are full their contents slop on to the workers' overalls.

The buckets — left standing by the roadside — are often overturned before they can be emptied into the sewerage truck as it inches through the streets behind the workers.

An ideal breeding ground for a host of diseases, the toilets themselves consist of open outhouses and the buckets are easily toppled by residents and their animals.

A sewerage system was in fact built for Alex during the pre-administration board era of the Peri-Urban Board — but it was never connected to township homes earmarked for demolition by a Government determined to convert Alexandra into a hostel city.

Even now that Alex has been "saved" by the Government as a family township the costs of connecting houses to the old sewerage is prohibitive — at least until plans for upgrading Alexandra have been finalised, according to a spokesman for the West Rand Administration Board.

Seepage

In the meantime an emergency R200 000 has been obtained to improve sanitation at schools in Alex by installing mobile toilets of the type used in aircraft and by connecting some schools to the sewerage system.

But seepage from adjacent bucket toilets at homes will continue to threaten health conditions at schools.

And the schools host worms and gastro-enteritis — rare diseases in the well fed white child but extremely dangerous for undernourished black babies.

Two-month-old Ethel Siko was one such victim. Severely dehydrated by gastro-enteritis, malnourished and with a congenital heart condition, the baby was beaten a drip at the Alexandra Clinic for two days while mother Sylvia kept a constant vigil at her side.

Feeding

Staff had tried and failed to persuade Sylvia Siko to take Ethel to Tembisa Hospital because of the baby's critical condition. The tearful mother insisted on treatment at the Alexandra Clinic with its dedicated staff and 40-year record of service to the community.

Gradually the baby was coaxed away from death. When admitted to the clinic her weight was 2,5 kg. After two days on the drip and a week of special feeding she was back to her expected weight of 4 kg.

"She was nearly finished," the relieved mother said once her baby was on the road to recovery.

"Our biggest problem is the underweight child," said one of the doctors at the clinic. A combination of gastro-enteritis or worms and poor diet led often to kwashiorkor, she said.

Services

But "kwash" resulted mainly from poverty and ignorance — not through lack of care by Alex mothers.

Their responsiveness to instruction is illustrated by excellent attendances at the "Well Baby" clinics on Mondays, Wednesdays and Fridays by mothers keen to learn about health care from Sister Mary Thema, a veteran with 41 years' service at the Alex Clinic.

Other services provided by the clinic cover family planning, antenatal care, a maternity unit, paediatric, eye and dental clinics, adult care, community visits a busy casualty bay and social work.

Costs for the average 500 patients a day are half the consultation fees asked by the Provincial Administration.

But the clinic is struggling to make ends meet.

The University of the Witwatersrand and the students' rag make large grants to the clinic.

Final-year medical students supplement the permanent staff by day and run the casualty bay at night.

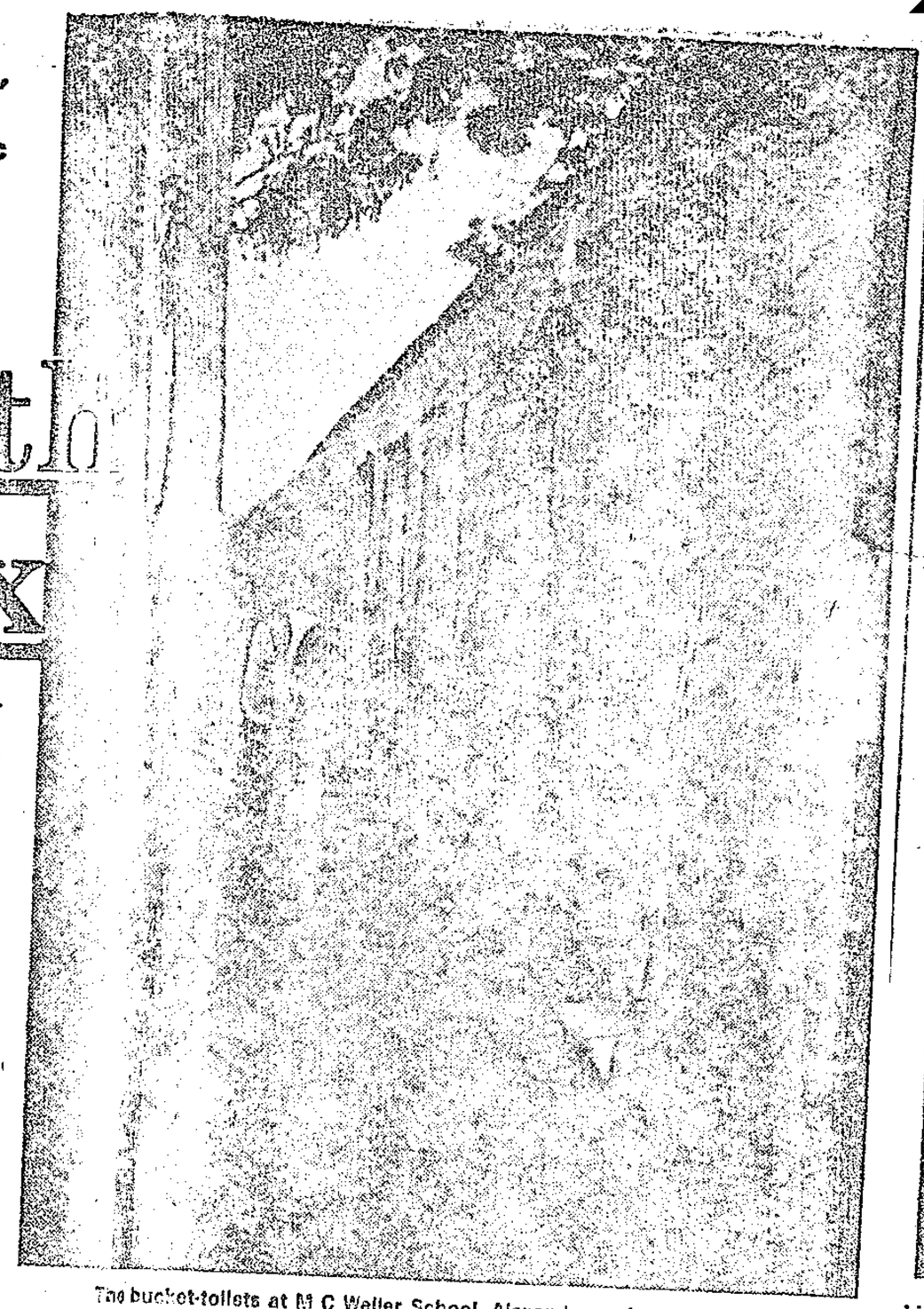
Some of the services may have to be discontinued, however, unless an extra R30 000 a year can be raised.

The Medical Students' Council of the university is planning a competition to help the clinic over its immediate financial difficulties. The council hopes prizes will be gi by business concern Johannesburg.

People interested in competition should c tact Mark Hersch, c veners of the 1980 "W for-Alex" Appeal, af medical school in Joh nesburg (Telepho 724-3561, extension mornings only).

But the clinic nee long-term financial sistance as well if it is survive.

Alexandra has been "saved" as a family township. But the babies of Alex run the gauntlet of diseases such as gastro-enteritis and worms — rare in the white suburbs.



The bucket-toilets at M C Weller School, Alexandra — front ....

... and back. Bucket toilets at schools and houses in Alex are easily overturned by dents and their animals — the contents flow into pools of excrement.

Photographs by ERIC HEINZE.

NM 13/3/80 (85) ~~3/11~~

All-out battle to beat typhoid crisis

Mercury Reporter

TYPHOID in Inanda has reached epidemic proportions and the Department of State Health has launched emergency plans to try to bring the situation under control.

High-ranking State health officials are holding top-level discussions with 'various other authorities' to decide what course to take in the stricken area where there had been 30 cases this year, compared with eight cases for the same period last year.

Inanda is a massive supplier of labour for Durban and other urban centres.

Brig Charles Lloyd, Officer Commanding Natal Command, said last night he was involved in joint discussions with the Department of Health and the Department of Co-operation and Development about the supply of water to Inanda.

'We were approached in connection with the problem but no decision has been taken. We will be having final discussions tomorrow,' he said.

Dr M G Gregersen, Deputy Regional Director of Health, yesterday said the negotiations were 'extremely delicate'.

It is believed that a main concern is to supply the area with piped, purified water.

Dr Gregersen said the cause of the outbreak was a culmination of factors, particularly the fact that the district had no sewerage and 'almost no running water' and had been gripped by severe drought.

Campaign

So far, 19 291 people have been inoculated in a massive immunisation campaign in the area most severely affected — a 30 km² block between the Inanda police station and the borders of Phoenix and Ntuzuma townships, including the Amaoti district.

Senior Medical Officer of Health Dr Murray Short said yesterday he had been notified of three deaths in the area but added that more, unreported, were possible.

Inanda reported 150 typhoid cases in 1979.

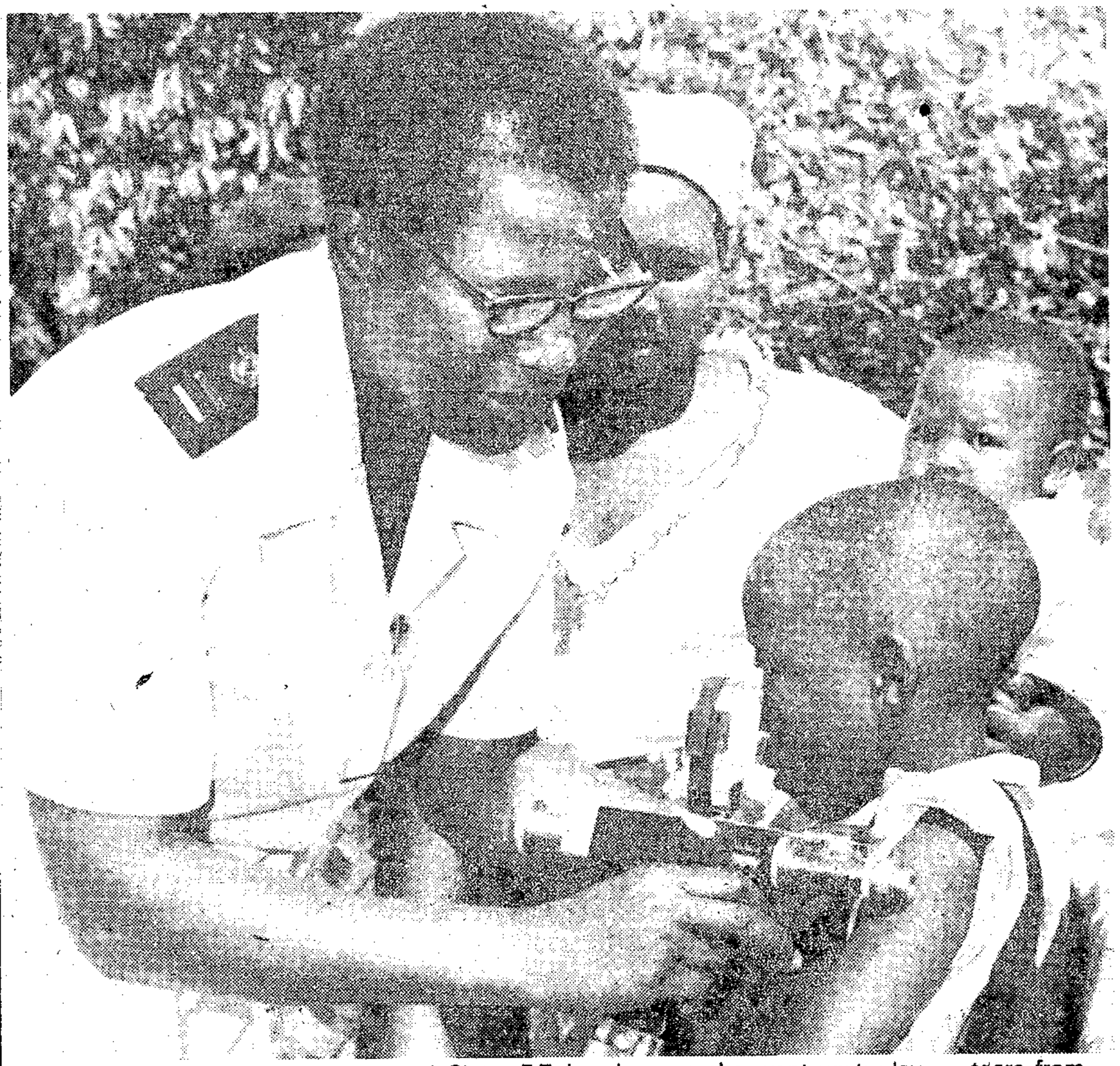
Speaking of the 30 cases reported so far this year Dr Short said: 'These are cases which reach the hospitals. There could be a lot more that never reached them.'

Four clinics and a mission hospital serve the estimated 60 000 residents of Inanda, most of whom are informal settlers.

'Lack of water and proper sanitation facilities, aggravated by the area's dense population, are to be blamed for the spread of the disease,' Dr Short said.

Durban's Medical Officer of Health, Dr Colin Mackenzie, said last night that although there had been three cases of typhoid reported in Durban in the past month — one related to the outbreak in Inanda — there was no cause for alarm.

To the rescue



LAUGHTER and tears accompanied Sister E Zulu wherever she went yesterday — tears from those on the receiving end of the vaccination gun, laughter from those who were watching. Their turn soon came, however. More than 20 000 people have been inoculated so far.

Tankers to help in relief of typhoid-stricken Inanda

Mercury Reporter

TANKERS carrying thousands of litres of much-needed water will be in Inanda from Monday, Brig Charles Lloyd, Officer Commanding Natal Command and chairman of the emergency committee formed to organise relief of the typhoid-stricken township, announced yesterday.

Sites for the tankers will be levelled today and it is hoped water distribution will start on Monday.

At a Press conference held immediately after the emergency committee's final meeting, Brig Lloyd said the prime concern had been to plan emergency measures to defuse the immediate problems of the water shortage and the typhoid epidemic, and not to attempt any solution of long-term problems.

'The immediate problems in Inanda — drought and the consequent typhoid epidemic, aggravated by the fact that it lacks the basic services of an organised community — required emergency action by various departments and for that reason an inter-departmental committee was formed.'

The committee had drawn up plans for short-term relief and had formed a management committee, chaired by the District Magistrate and Commissioner of Verulam, to implement them.

Seventeen tankers had been loaned free to the Department of Co-operation and Development by the Port Natal Administration Board, Department of Water Affairs, NPA Road Services, the S A Development Trust at Ntuzuma, two civil engineering contractors and the Stellenbosch Farmers' Winery.

According to Mr James Rivett-Carnac, an engineer for the Urban Foundation and member of the management committee in charge of water, the tankers will be filled at five bulk-supply points in Phoenix and Ntuzuma townships and water will be distributed from 17 points along Inanda's main road.

Water will be free and there will be no rationing, although residents will not be allowed to fill more than one 25l container at a time.

Mr R N Blumrick, chief commissioner of the Department of Co-operation and Development for Natal, said his department had sent R10 000 with which to foot fuel and water bills.

'This is the amount I estimated would be needed,' he said.

'If more funds are required I have only to ask.'

The Regional Director of State Health, Dr Johann van Rensburg, said his department had been aware it was 'heading for a disaster situation' when the typhoid epidemic showed signs of accelerating instead of diminishing.

While 158 cases had been reported there last year, 30 cases had already been reported this year whereas only nine were reported for the same period last year.

'Inanda's proximity to Durban, and the fact that typhoid only reaches its peak in the winter months, added to our concern.'

A massive immunisation programme had been initiated last week as a 'last resort' and teams of workers had systematically swept through the area.

'Immunisation is not considered an effective way of dealing with typhoid but it does keep the disease at bay.'

Dr Van Rensburg said the programme had been extended for another day and would end this afternoon.

So far, more than 20 000 residents had been inoculated, he said.

In response to a Mercury question, Brig Lloyd said long-term solutions of Inanda's water problems could only be dealt with at ministerial level.

According to Mr Blumrick, the Department of Co-operation and Development was already investigating the complex land ownership system in Inanda.

'If it was decided to lay a reticulated water system in the area, we would have to know who the land owners were,' he said.

The Urban Foundation completed a feasibility study into laying such a system in part of Inanda in June last year and submitted its findings to various authorities, including the Department of Co-operation and Development.

Durban's Deputy Medical Officer of Health, Dr Muriel Richter, said yesterday that while the situation in Inanda gave cause for concern, the threat to Durban was not as great as might have been expected.

Although Inanda adjoined Durban and supplied it and other urban centres with labour, there was no reason to panic, she said.

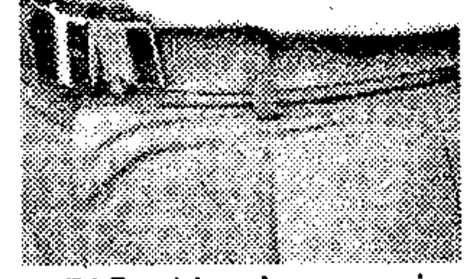
'Our Department has been inundated with calls from commerce and industry inquiring about this, but apart from those industries concerned with the sale and distribution of food there is no cause for alarm.

'Most major industries in Durban have highly effective medical services on the premises liaising with their medical officers.'

Typhoid, or enteric fever, is endemic in South Africa and Natal has the highest incidence. It is caused by an organism that breeds in human waste and has an incubation period of about 14 days.

Although difficult to diagnose, general symptoms to watch out for are a steadily-rising temperature, severe headaches and stomach discomfort — either constipation or diarrhoea.

'It is impossible to contract the disease if one is careful about personal hygiene,' Dr Richter said.



BRIG Lloyd . . . in command.

Medical secrecy: Doctors blamed

Staff Reporter

DOCTORS were "very greatly to blame" for surrounding their profession with a mediaeval mystique and an air of unapproachability, the president of the World Healing Federation, Dr Ian Pearce, said yesterday.

Addressing the Medical Students Council at Groote Schuur Hospital, Dr Pearce said true communication between doctor and patient was distressing in its rarity.

The prime need was to convince the general public that self-healing was an inherent property of the human being. This should be believed in, strengthened and trusted.

Dr Pearce, who is visiting South Africa from England, said that the present generation of orthodox doctors was handicapped by the barriers of their own training, which was heavily over-biased towards drugs and surgery.

The health establishment itself also emphasized acute, high-cost, hospital-orientated and drug-orientated medicine.

This "interventionist" concept of therapy was further strengthened by the influence of the pharmaceutical industry which was more concerned with selling its drugs than keeping people healthy.

'Disease service'

Three quarters of the physical disease which he himself had seen was due to faulty patterns of emotion and wrong attitudes of mind.

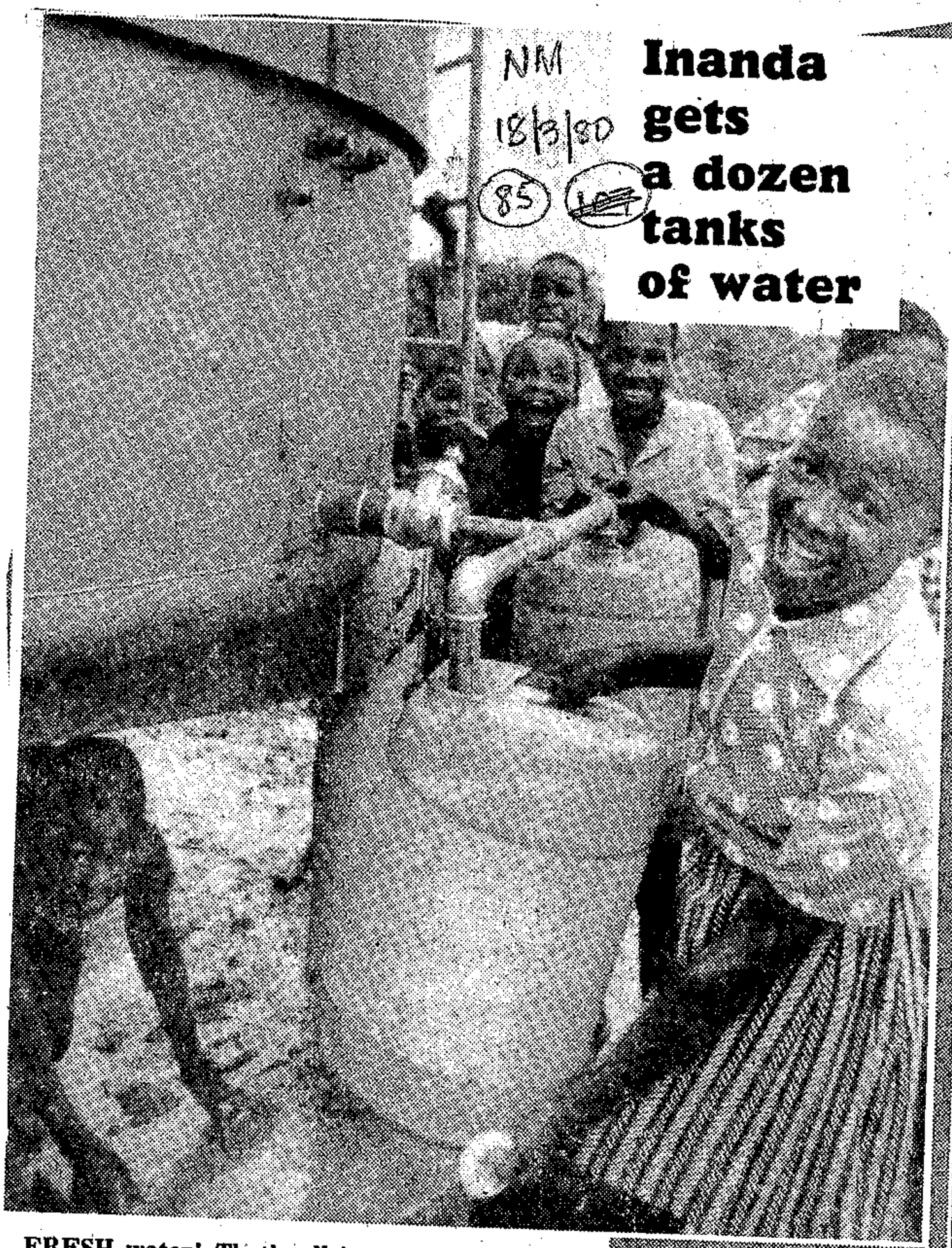
Not recognizing this, the Western medical system was dealing only with a fraction of health and its problems, and becoming less and less effective. The system itself frequently produced disease.

The whole system — research, education, medical schools and universities, and the way hospitals were run — was in fact not a health system at all, but a "disease service".

Not only did the system only recognize a few of the physiological factors influencing health and ignore the rest, but it used destructive techniques such as drugs, surgery and radiation as its main methods.

NM
18/3/80
(85)

Inanda gets a dozen tanks of water



FRESH water! That's all it needs to bring out the biggest smiles in Inanda where typhoid recently reached epidemic proportions.

Twelve water tanks went into operation yesterday for the first time and hundreds of happy residents queued up with containers of all shapes and sizes at various points in the township.

According to Mr Charles Pervis, District Magistrate of Verulam, who has been appointed head of the operation to get fresh water to Inanda, the residents may receive 25ℓ of water a day.

Officials have been appointed at the base depot in Inanda to ensure the conservation of as much fresh water as possible.

Most of the water tanks were installed in the north of Inanda where the typhoid epidemic seems to be at its worst.

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UCT

Inanda helped because it made people take notice'

NM 19/3/80

(85) (10?)

Mercury Reporter

THE potentially explosive situation at Inanda was now being defused but only because its seriousness and the health threat to Durban had caused the authorities to 'sit up and take notice', the Regional Director of State Health, Dr Johann van Rensburg, said yesterday.

He said departmental records showed that typhoid in Inanda had in fact showed a marginal improvement over recent years but that it nevertheless had presented a 'continuous health problem'.

Contaminated

He said: 'A recent survey showed that without exception, every natural source of water in Inanda is contaminated with human waste, which is no good at all.

'A proper water system, a refuse removal scheme, better roads — Inanda has been crying out for these for years but nothing could be done because there was no local authority to take charge.'

Gravity

Now, however, the authorities had been forced to realise the gravity of the situation and were looking into effecting a long-term solution of Inanda's problems.

One area to be improved soon is the health service in the area, for years hopelessly inadequate.

'The Department of Co-operation and Development has granted us funds to establish a permanent clinic there. Until now we have been able to run only a basic service from a mobile clinic based at Kwa Dabeka,' Dr van Rensburg said.

New clinic

Discussions were presently underway with community leaders to decide the best site for the new clinic.

'We hope to extend the service to health education,' Dr van Rensburg said.

'The recent rain also gave cause for concern, as it caused a run-off from polluted sources which in turn contaminated reservoirs and boreholes that were not properly sealed.

'But the people know now that there is fresh water freely available and I doubt they will be getting supplies from elsewhere.'

How to check for typhoid symptoms

(85)
NM 19/3/80

WITH 30 cases of typhoid already reported in Inanda this year doctors say that women at home can play an important part in assisting in the arrest of the disease by keeping on the look-out for symptoms of the disease among their domestic workers and by telling them how to spot signs of the disease among their children.

The symptoms to watch for, according to a spokesman for the Durban Medical Association(DMA), are:

* Fever.
* Excessive perspiration.
* Explosive diarrhoea — pea-soup stools.
* Abdominal pains due to infection. These can be continuous or spasmodic.
* Dehydration — thirst, dry mouth and tongue.
* Mental confusion.

Because of the high mortality rate of typhoid, it is important to get the patient to a doctor or a hospital as soon as possible. The disease can only be treated successfully by the administration of antibiotics or intravenous rehydration.

There are, however, a few things that can be done to ease things for the patient until she can be taken to a doctor.

* Give fluids since rehydration can to some extent be done orally.
* Keep the patient lying down — walking around can spread the toxin more rapidly through the body.
* Sponge the patient down when she is feeling hot or perspiring.

The DMA warns that typhoid is a highly infectious disease. People could be infected before it becomes visible and to prevent the disease from spreading, it will be wise to follow the following precautions.

* Keep domestic workers out of the kitchen.
* Prevent them from handling any food for consumption by other members of the household, without washing their hands with an anti-septic soap.
* Care should be taken not to wash their dishes with those of the rest of the household. The best precaution would be to boil their dishes and cutlery.
* It would be wise to use a disinfectant in the toilet but even more importantly to supply domestic workers with disinfectants to use in their homes if water-carrying sewerage-systems are not in use.

E.B.

Best schools

Settled for more than 100 years, the area boasts some of the best African schools in the Durban area, a number of shops and other local businesses, a police station and a new post office.

The land ownership of the area is complex. There are perhaps 400 black private landowners and 200 Indian landowners, while a certain amount of land is owned by the S A Development Trust.

Because it is so-called released land, it may be sold only to blacks. However, should it be necessary, the Department of Co-operaton and Development could buy it back.

The whole area apparently is earmarked to be incorporated into KwaZulu in terms of the proposed Homelands Consolidation Bill.

When asked who the local authority responsible for Inanda was the Chief Commissioner of the Department for Co-operation and Development for Natal, Mr R N Blumrick, said there was none.

Health matters

Asked why, he said as far as health matters were concerned, the Department of Health assumed responsibility for the area.

However, the Regional Director of State Health, Dr Johann van Rensburg, said yesterday the Department of Co-operation and Development had already implied its responsibility for Inanda by supplying funds for the emergency relief of the area.

'In a released area the Department of Co-operation and Development supplies the funds and we act merely as their agents,' he said.

'The department now has to make a decision whether it is going to act as a local authority in the area or not.'

Dr van Rensburg said his department had no power to collect taxes, lay sewerage, build roads or houses in Inanda, and therefore there was a desperate need for a bona fide local authority in the area.

of Natal, said in his inaugural lecture last night.

Prof Spencer is the first incumbent of the newly created Chair of Community Medicine and is regarded as the most highly qualified South African in his field.

'Insufficient attention has been focused on the medical needs of communities in rural areas such as KwaZulu,' Prof Spencer said.

'In 1979 the South African Medical Association

PROF Ian Spencer

issued a form to 1 200 members asking for volunteers for one month's service to the desperately pressed hospitals and clinics of KwaZulu. Two replied,' he said.

The King Edward VIII Hospital in Durban was grossly overloaded because of the lack of primary health care in the rural areas.

'The education of a single doctor costs South Africa approximatley R30 000. It should become law that before a doctor can be registered he does a stipulated period of service among those communities such as KwaZulu which are in great need of medical attention.'

NM 20/5/80 (85

Tragedy of the typhoid-stricken

The unwanted

Mercury Reporter

THE tragedy of Inanda's situation was that no one was prepared to take the responsibility of being the local authority for the area, the Regional Director of the Urban Foundation, Mr Alan Mountain, said yesterday.

Although action had been taken to remedy Inanda's immediate problems, 'a long look' needed to be taken at the long-term solutions.

'No upgrading of the area can take place until a local authority assumes control,' he said.

The Urban Foundation, prompted by Inanda's lack of water and proper sanitation facilities, had investigated laying a reticulated water system in Inanda as early as March last year, and after its completion had submitted a report to various departments, including the Department of Co-operation and Development, for consideration.

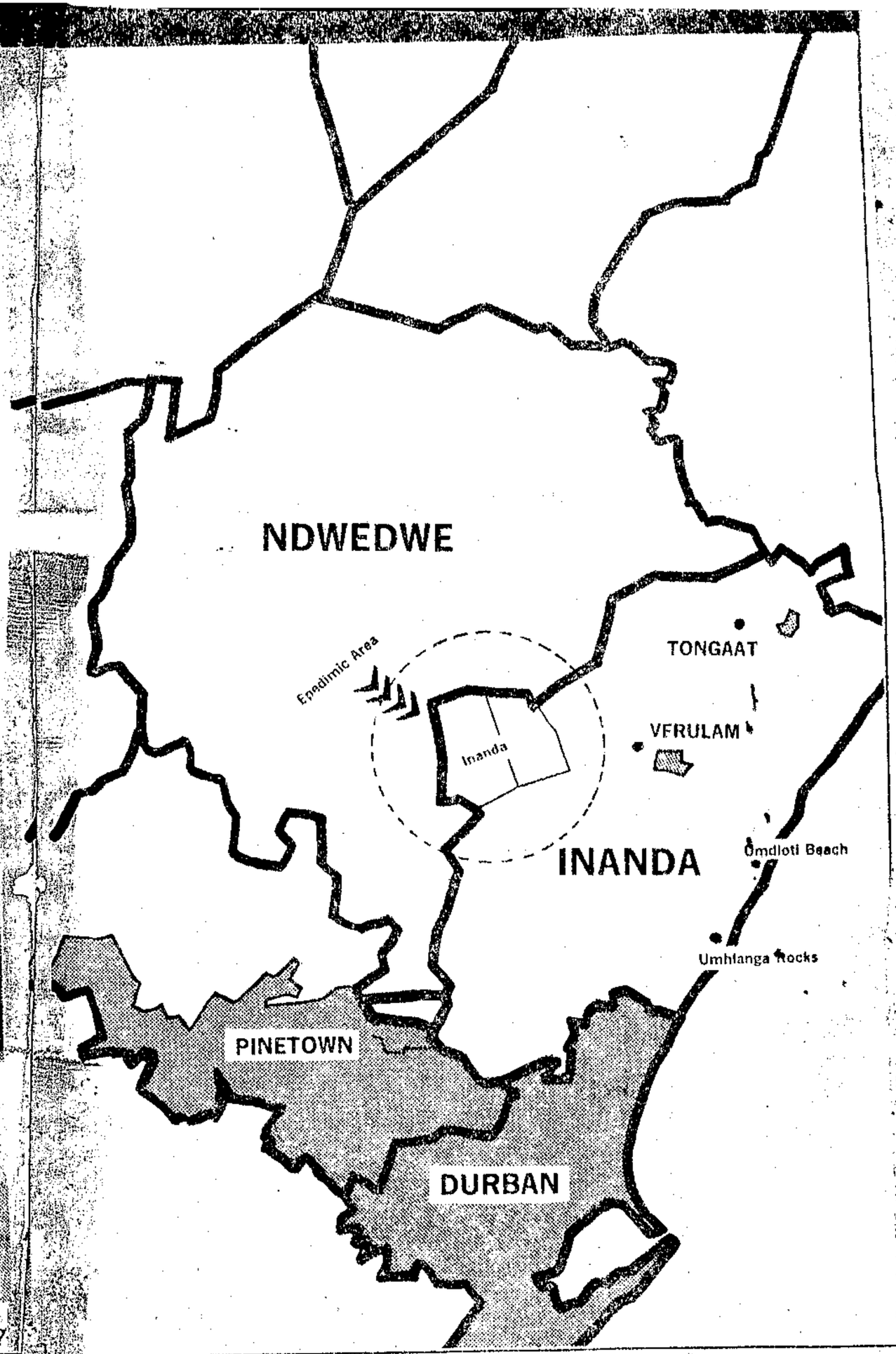
However, nothing was done.

This was because there was no local authority to which money for the scheme could be loaned. The cost of the scheme, taking into consideration inflation, would be about R2,5 million, he said.

According to Mr James Rivett-Carnac, who conducted the feasibility study for the foundation, the operating costs of supplying Inanda with water by tanker would be in the region of R144 000 a year.

'As it is, the costs of

ALAN Mountain . . Whose responsibility?



Rand pumps will soon switch to gasohol

STAR 21/3/80 55 183

By Harvey Thomas, Motor Editor

Premium pumps on the Rand will switch over to gasohol — 10 percent alcohol, 90 percent petrol — in July or August.

And in Johannesburg today the Automobile Association said that its tests of the mix had been "positive."

The new blend is a direct result of Sasol 2 coming on stream and will initially be sold on the Rand. But further gasohol areas will be designated and gradually introduced.

The 10 percent blend is a combination of ethanol (a light alcohol) and other heavier alcohols. When gasohol is freely available in different parts of the country the saving to South Africa in foreign exchange will be upwards of R200-million.

The AA's tests proved that vehicles tuned to optimum economy with exhaust C O levels of less than 1,5 percent actually used 1,7 percent more fuel when filled up with gasohol.

"But the change in power output at maximum throttle openings was negligible," said Mr Fred Botham, the Association's Technical Services executive. He added that a recent survey had established that fewer than two percent of the vehicles on the Rand were tuned to such optimum economy.

When vehicles tuned to optimum economy were detuned by fitting larger jets to the carburettors the switch to an alcohol blend had improved consumption marginally.

The move to gasohol does, however, bring new implications for the motor trade.

Special care will be needed by service station operators to keep water out of tanks; filler caps and dipsticks will have to be closed meticulously and repair checks run.

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Officer blasts dagga dealers

KIMBERLEY. — Dagga dealers who sold to military servicemen in their camps were affecting South Africa's defence, Mr P B Koekemoer was told in the Kimberley Magistrate's Court yesterday.

The magistrate was told that servicemen who smoked dagga were unable to go to the operational area.

Lieut H Boshof, of 11 Commando, giving evidence against two Kimberley men on a charge of selling dagga to two servicemen, said that he was in charge of a company of about 400 medically unfit servicemen and these men were a target for dagga dealers.

He said that since 1978 many servicemen had appeared in court on possession charges and that dagga smoking was a great problem in the army as it meant that soldiers who smoked dagga were sent to rehabilitation centres instead of operational areas.

Klaas Riet, 18, of the Bentfontein district in Kimberley, and Jood Kaas, 48, of Saviera Street, Galeshewe, were found guilty of selling dagga to two servicemen and sentenced to five years in jail. They denied the charges.

Mr J de Lange and Mr L van der Walt, two servicemen, giving evidence for the State, said that on February 6 they were approached by Riet and Kaas in their camp and asked if they wished to buy dagga.

They told the court that they agreed to meet Riet and Kaas the next day at a certain place for the transaction. They (Mr De Lange and Mr Van der Walt) said they went to report the incident to Lieut Boshof immediately and the three of them worked out a plan to trap the men.

Mr Van der Walt said Lieut Boshof gave Mr De Lange a marked R2 note to pay for the dagga and gave him a set of browns — army pants and shirt — to use in his part of the transaction.

Corporal G Miller of the Military Police said that on February 7 he and other MPs, on instruction from Lieut Boshof, grouped themselves where the transaction was to take place.

He said he saw Riet take R2 from Mr De Lange and hand him a matchbox full of pure dagga.

Although Riet had no previous convictions, the magistrate said that because they were involved in this serious crime together, he should receive the same sentence. He wished to make an example of them. — Sapa.

Bureau to aid child welfare

Staff Reporter

THE Child Care Information Centre at the University of Cape Town's Child Health Unit is to establish a voluntary aid bureau to co-ordinate the efforts of individuals and service organizations involved in child welfare throughout the Peninsula.

The Urban Foundation has granted the university R9 600 over the next two years for a co-ordinator to run the bureau.

Professor Maurice Kibel, professor of child health, said the bureau would play an important part in child welfare. This was because many individuals and separate bodies were doing valuable work among the underprivileged but there were many gaps and duplication. This wasted time, money and effort in work that was largely unco-ordinated.

Impetus for the establishment of the bureau had come from Dr Isobel Robertson, former head of the Child Welfare Society in the Peninsula and part-time lecturer in paediatrics at UCT.

UCT

AS AT 29 02 80

DESCRIPTION SYMBOL

REGISTRAR

EXAMINATION RESULTS IN FACULTY ARTS

YEAR : N/A COURSE

FIRST NAMES

BARBARA LOUISE 911101

NUMBER OF STUDENTS 1

EXAM

10000 MISCELLANEOUS APTS.

STUD NO SURNAME

152327Y VAN DER MERWE

* TOTAL NUMB

DEAN

STU13-9 EXAMINATION RESULTS IN FACULTY ARTS AS AT 29 02 80 PAGE 1

12010 LOWER DIPLOMA IN LIBRARIANSHIP YEAR : 1 12010

STUD NO	SURNAME	FIRST NAMES	COURSE	DESCRIPTION	SYMBOL		
~~1409808~~	~~BUHRING-UHLE~~	~~URSEL~~	~~118101~~	~~CULTURAL HISTORY OF W.E. I UP~~	~~(50)~~	~~1~~	~~1409808~~
159075H	ELEERS	CHARLES PETER	118101	CULTURAL HISTORY OF W.E. I UP	(50)	3	159075H

* TOTAL NUMBER OF STUDENTS 2

DEAN REGISTRAR (ACADEMIC)

ET 28/3/80 (137) (85) (163)

Black workers retire earlier

BLACK employees in an oil company contributed to the incidence of early retirement through ill-health in a ratio out of proportion to the number employed, a doctor told the general practioners' congress in Cape Town.

In a paper based on figures issued by a Cape-based oil company, Dr A Spratt said blacks formed 52 percent of all early retirements, while they made up only 32 percent of the work force. Second were coloured employees then whites, with Indians in the lowest group.

Labourers formed the largest grouping among the prematurely-retired, accounting for 37 percent. Average age on retirement was 53 and the main cause was hypertension (23 percent) followed by chronic lung disease (13 percent) and heart disease (10 percent).

Health Dept's new assault on smoking

(85) RDM 28/3/80

By MARILYN ELLIOTT

THE South African Government collects R240-million annually in tax on the R1000-million tobacco industry, a spokesman from the Department of Health said in Johannesburg yesterday.

But while the Treasury collects money from the cigarette industry, another section of the Government — the Department of Health — is spending money on campaigns to halt smoking.

The Department's latest campaign, beginning with a "Smokeless Day" on April 2, is aimed at both smokers and non-smokers.

The campaign was born from a policy statement by the Minister of Health in Parliament last year. It is aimed at educating the public about the dangers of smoking by means of posters, pamphlets, films and media coverage. The department hopes to dissuade teenagers from smoking and persuade smokers to smoke less or smoke cigarettes of low tar and nicotine content.

At a Press conference in Johannesburg yesterday, the deputy secretary for the Department of Health, Mr Martin Raath, said the campaign was designed to inform South African smokers of the hazards of smoking and to try and halt beginner smokers.

"Surveys in SA and the UK show that more than 80% of smokers want to stop and 87% do not want their children to smoke," he said.

Mr Raath said negotiations are well under way between the Department of Health and cigarette manufacturers to introduce compulsory tar and nicotine content statements on cigarette packs. He said it appeared to him that manufacturers were not particularly concerned about the nation's health — "they want to sell as many cigarettes as they can. It's business."

The Department of Health has also launched a counter-propaganda programme to offset the effects of cigarette advertising in the country — a R17 100 000 a year business.

A hard-hitting film, directed at youngsters, has been compiled by the Department in a fresh attempt to discourage smoking. The film — entitled "Smoking — An Illusion of Maturity" — attacks the main appeal of the advertising: that smoking will improve your image.

The slide and sound show presents a horrifying medley of dirty ashtrays, nicotine-stained fingers, butts drooping from mouths and blackened lungs as the real results of dedicated smoking.

Professor Harry Seftel, chairman of the Council on Smoking and Health, yesterday hailed the film as the most effective stop-smoking message he has seen.

"This is a film all South Africans should see. Our country has the highest number of heart attacks in the world. We also manufacture cigarettes with the highest tar and nicotine content in the world. While no association has been proved, it's an interesting point."

So far, public response to the "Smokeless Day" has been tremendous, Mr Raath says.

"Factories, business houses and private individuals have stuck up our posters. The Council on Smoking and Health gets a huge mailbag everyday from concerned people. We hope that April 2 will be the beginning of a much stronger attack on smoking," he said.

This is the second "Smokeless Day" held in South Africa. The first, in November 1978, was organised by the SA Cancer Association.

'A constant battle against virulent disease'

● Field officer B P Mocke: 'If the smear is positive, the patient is given further treatment.'

"THE children all have bilharzia — and it's hardly worth treating them until they are old enough to know they must stay out of the water. And TB, malaria and typhoid are common. Thirty beds in this 150-bed hospital are occupied by typhoid cases at the moment."

The speaker was Dr Russell Hlekane, medical superintendent of the Douglas Smit Hospital at Shiluvane in Lebowa, about 25km from Tzaneen. He left his patients to talk to us briefly — a tired young man, heavily bearded, who puffed at a cigarette as he spoke.

His patients queued patiently on the stoep outside the surgery — old men, pregnant women, runny-eyed children, mothers suckling sickly babies, people in wheelchairs and on crutches. Others hobbled painfully up the steep hill. A woman wrapped in blankets lay flat on the ground at the bus stop. She had just been discharged from her hospital bed.

By JEAN LE MAY

Pictures: Doug LEE

The Tzaneen area is deadly. Decades ago, its Letaba-Letsitele Valley was known as the Valley of Death because of the danger from malaria. Malaria is still endemic, although a massive control programme organised by the National Institute for Tropical Diseases at Tzaneen has done much to make the area safer, reducing deaths from malaria by thousands.

Other tropical diseases are rampant there, too.

Nearly all the rivers carry bilharzia. Typhoid is endemic, with sporadic epidemics. Trachoma, a dangerous eye disease, occurs frequently, as well as a tropical form of venereal disease which resists normal methods of treatment.

Dr Hlekane, the only medical man in his considerable section of this diseased paradise apart from the banned Dr Mamphela Ramphele, wages an unceasing war against ignorance as well as against disease.

"Malnutrition should not be a problem, but it is," he said. "Well-dressed women bring their malnourished children to me in hired cars. In many cases it is a matter of negligence rather than poverty — it is the unwanted child who is malnourished," he said.

"This could be prevented by family planning, but there is resistance to birth control. I frequently deliver the babies of 13-year-old girls."

● Dr Russell Hlekane
. . . unceasing vigilance

Dr Frank Hansford, chief medical officer at the NITD at Tzaneen, gave us a complete run-down of the anti-malaria campaign run by the institute in which more than 500 field workers are permanently employed and close on a million houses are sprayed yearly.

Although the health departments of four Governments are involved — Venda, Lebowa, Gazankulu and South Africa — cooperation is excellent, said Dr Hansford. But problems and delays arise in co-ordinating plans when any new project is on the drawing-boards, such as water supply or sewage schemes.

We watched a team of malaria control officers move swiftly thorough a compound on a timber estate. The men sprayed the wooden houses inside and out, then lined the people up for blood smears to be taken.

Many of the children, remembering earlier typhoid inoculations, screamed and fought. The team, burly men in overalls and gumboots, handled them gently, picking up the toddlers wth soothing words, while field officer B P Mocke deftly pricked their fingers and made the smears.

"Anyone who is sick or has been sick is given anti-malaria tablets and a note is made on the record," explained Mr Mocke. "If the smear is positive, we come back to the patient who is either put in hospital or given further treatment by a district nurse."

Apart from malaria, the institute makes a special study of bilharzia, in collaboration with the SA Institute for Medical Research in Johannesburg. In some parts of the North Eastern Transvaal, particularly around Tzaneen, up to 90% of Black children of school-going age have urinary bilharzia.

Only education and adequate sanitation can curb bilharzia, said Dr Hansford, but some rivers around Tzaneen at present carry a greater potential danger — typhoid.

"Most of the rivers from which people in these areas draw their water are highly suspect," said Dr Hlekane. "But if the infection is not in the water, it can also be carried by flies. Nobody is particular about using latrines — if there are any latrines."

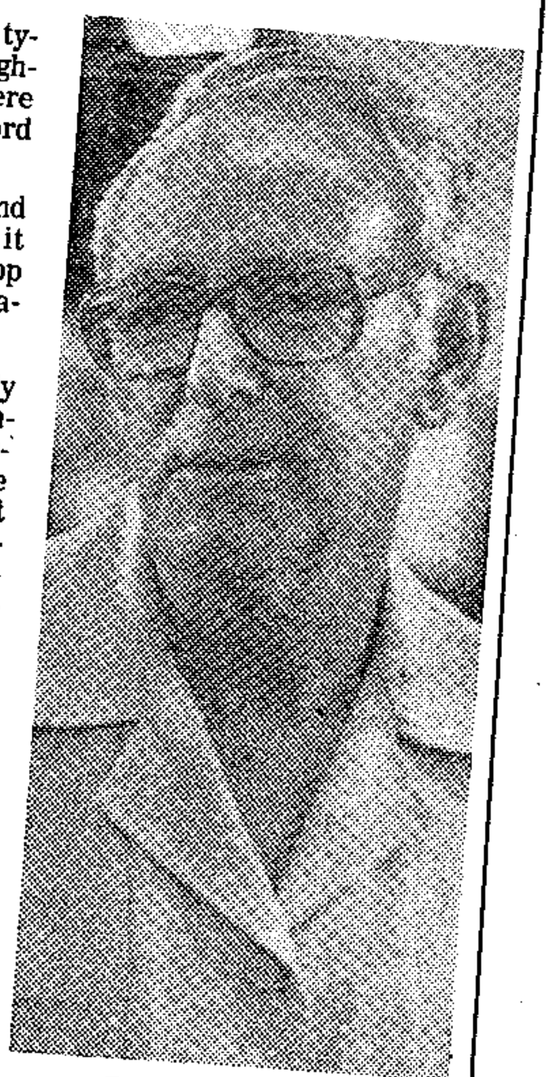
About 80% of the 5 000 typhoid cases reported throughout the country in 1979 were from this area, Dr Hansford said.

Boreholes had been sunk and pipelines built, he added, but it was virtually impossible to stop people from using the river water.

Later we drove up a lovely valley which runs from Lenyenye towards the Drakensberg. The Thabina River, one of the headwaters of the Great Letaba, brawled down the valley between thatched-hut villages and fields of grain sorghum. When we stopped at a flooded drift a group of children swarmed out of the fields and mugged for the photographer, prancing around in the water.

They swam and played "all the time" in the river when it was hot, said an elderly woman fondly. Yes, the people had been told there was sickness in the river, but what could they do about it?

"You can't keep children out of water," she said firmly.



● Dr Frank Hansford
. . . 'problems and delays'

WHO's yes to Star virus stock (85)

1/4/86.

Own Correspondent

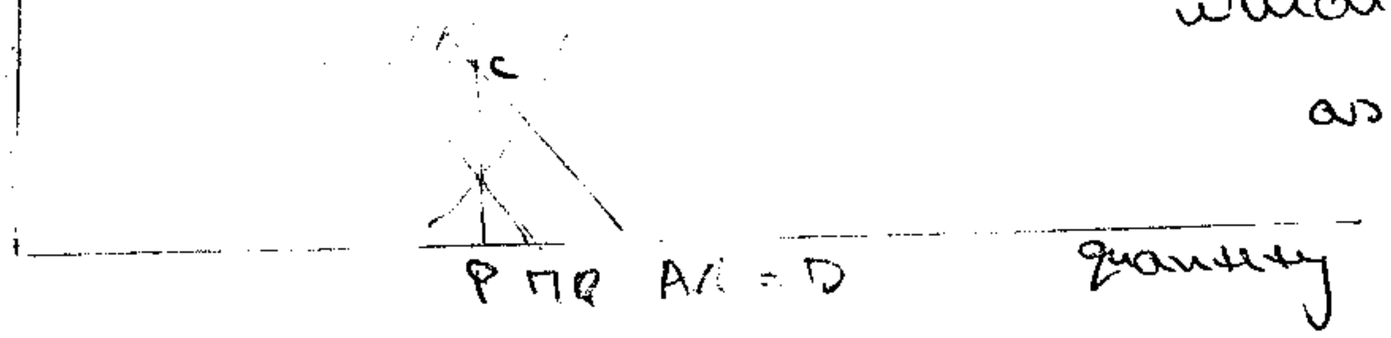
A Department of Health spokesman today denied South Africa holds stocks of smallpox virus contrary to instructions from the World Health Organisation.

Commenting on a report from New Delhi that India was to demand from the WHO that South Africa destroy its stock, Dr James Gilliland, co-ordinating director of the Department of Health, said: "We are keeping these stocks with the full knowledge of the WHO."

MC

ATC

ATC Average Total cost
MC Marginal cost
MR Marginal Revenue
AR average revenue
which = Demand curve
as $TR = \frac{P}{Q} = D$



Before Price discrimination the firm was making a loss of PBCD & a (ATC − AR) of
If price discrimination is introduced output is at Q_1 where MC = MR and price is equal to D
The Area PDEC is part of the consumer surplus and the revenue lost made by the firm. Hence if the revenue achieved by price discrimination in area APE is greater or equal to the loss EBC the firm will be producing profitably.
Hence in this case the introduction of price discrimination enabled a good to be produced which otherwise may not have been available as firms were not prepared to produce it at a loss.

11

SA to produce new cancer drug

(85)

C.T. 10/4/80

Own Correspondent

DURBAN. — Durban will start producing by the end of the month a rare anti-viral drug which could be used against some forms of cancer.

The medical director of the Natal Blood Transfusion Centre, Professor Peter Brain, said Durban could become one of the world's largest producers of the newly-developed drug, Interferon, which would eventually be used to fight a variety of viral infections from the common cold to chronic hepatitis.

Professor Brain said it was planned to establish a plant similar to that in Finland which was the world's biggest producer of the drug.

The work was being done in collaboration with the National Institute for Virology in Johannesburg, which would carry out research under Professor Barry Schoub of the University of the Witwatersrand.

Professor Brain said Interferon — which was produced in small quantities in the human body — was being tested on cancer sufferers in the United States.

The initial five batches of the drug were produced by Mr S H McMemamin, of the National Blood Fractionation Centre at the Paradise Vally laboratories, near Durban.

Research

Bob Molloy writes that Interferon research is being carried out by a small group at the University of Cape Town.

Professor W du T Naude, head of the department of bacteriology at UCT medical school, said that work on the mechanisms of the production of Interferon in living cells was under study.

It had been found that Interferon could be produced by introducing an "arbo virus" into a culture of chicken cells. The virus, carried by ticks and certain flying insects, caused fever and skin rash in humans.

There were several means of producing Interferon. These included the work on white blood cells carried out at Durban; use of tissue cultures, and the employment of genetic engineering techniques in which the genetic code for Interferon was inserted into a bacterial cell, causing it to become a living "factory" producing the anti-viral drug.

temporary measure but which, like so much else in South Africa, is likely to remain for a long time.

On the other side of Durban, in the area adjoining Kwa Mashu work has already begun on building the new township of Ntuzuma which in addition to family housing will include hostel accommodation for between 40 000 and 50 000 men. Like Umlazi the services for Ntuzuma - streets, water etc. - are to be financed by the Durban Municipal serices levy even though the townships lie technically within the homelands.

Another major hostel [illegible] is Clermont, the township that is being develo[illegible]letown/New Germany/ Westville industrial com[illegible]s include hostel accommodation for

(Note: Information on [illegible]l to come)

Summarizing the sit[illegible]ban the following table shows the overall pictur[illegible] accommodation.

Table 14: Singel Accom[illegible]rban 1971.

Type	No. [illegible]
Municipal Hostels	27
Municipal Compounds	
Railway and other Govt. Compounds	6
Private Compounds	24
Other Licensed Premises	
Umlazi Hostel	8 5[illegible]
Building sites (Temporary)	2 0[illegible]
Ntuzuma Hostel	--
Clermont Hostel	--
Total	68 848

[illegible] except for 677 in [illegible] women hostel. Plans for [illegible] 19 500 beds for males.

[illegible]ineer Dept: [illegible]
[illegible]y gangs etc.

[illegible] premises housing 50 or [illegible]ple each

[illegible]ess than 50 people each.
[illegible]g domestic servants)

Built 1967-1971. Not all as necessary still being [illegible]971.

40 000-50 000 beds

further [illegible] beds

[illegible] over

THE ASSEMBLY. — Government spending on preventive medicine would be stepped up during the next few years, the Minister of Health, Dr Lapa Munnik, said in the Assembly yesterday.

He was replying to the debate on the third reading of the Medical, Dental and Supplementary Health Service Professions Amendment Bill, which among other things makes the Minister the final arbiter in determining fees for medical services.

He said that if only 1% more of the Health Budget was spent this year on preventive medicine, it would amount to R15-million. This would have to be achieved by reducing spending on curative medicine.

The Bill was supported by the Official Opposition and opposed by the New Republic Party.

Mr Nigel Wood (NRP Berea) said that if the Minister had the final say in the determination of medical fees and declined to approve an increase, he could alienate a large section of the medical profession. They could in turn take on less patients and do less work with the result that more people would turn to provincial hospitals for treatment. This could lead to a socialisation of medical services.

Dr Munnik described Mr Wood's argument as "an Alice in Wonderland story with a medical connotation".

He pointed out that he only had the final say as far as the statutory tariff was concerned, and that he had nothing to do with private tariffs.

More money for preventive medicine

RAND DAILY MAIL, Tuesday, April 22, 1980

More money promised for preventive medicine

CT 22/4/80

in Parliament

HOUSE OF ASSEMBLY. — Government spending on preventive medicine would be stepped up during the next few years, the Minister of Health, Dr L A P A Munnik, said yesterday.

He was replying to the debate on the third reading of the Medical, Dental and Supplementary Health Service Professions Amendment Bill, which among other things makes the minister the final arbiter in the determination of fees for medical services.

He said that if only one percent more of the health budget was spent this year on preventive medicine, it would amount to R15 million. This would have to be achieved by reducing spending on curative medicine.

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Dr Munnik described Mr Wood's argument as "an Alice in Wonderland story with a medical connotation".

He pointed out that he had the final say only as far as the statutory tariff was concerned and that he had nothing to do with private tariffs.

"A doctor's first duty is to his patients and many of them have received no pay at all for services rendered. It is unlikely that they will go on a sort of a go-slow strike.

"I have no intention of socializing medical services in this country.

"If any one does this it will be the medical profession itself, by for instance doing less work and pricing themselves out of the market."

The bill was read a third time and the objection of the NRP was recorded. — Sapa

Maize clue in cancer incidents

RDM 25/4/80.

Staff Reporter

THERE are indications that deficiencies of the trace element manganese in the soil of certain areas of Transkei, which has been found in maize plants, eventually could be responsible for the high incidence there of cancer of the oesophagus.

These are the findings of a soil scientist, Professor M C Laker, who delivered a paper at the second South African conference on fundamental molecular and cellular cancer research in Johannesburg yesterday.

Prof Laker, one of a team of experts who has spent four years working on this research, said that although it had not been proved that manganese deficiencies were responsible for the cancer, scientists were considering the possibility of adding small amounts of the trace element to soil in high incidence areas to document results.

Since early 1976, scientists have been intrigued by statistics which showed that in certain areas of Transkei, the incidence of oesophagal cancer was high, while in other areas it was comparatively low.

A team of experts, drawn from many scientific disciples, began to examine the environment in high and low incidence areas to pinpoint a factor which was present in one area and absent in the other.

The scientists have examined the proportion of trace elements in maize leaves from both high and low incidence areas and have found that levels of manganese absorbed by the plants seems to be a vital factor.

Prof Laker said that while it was too early to draw conclusions from information gleaned from these experiments, it would be "immoral" for scientists to ingore the results and not continue with research.

Police test lethal spray to destroy dagga

A herbicide described as "highly dangerous" has been used by the South African Police in an experiment to destroy dagga plants in a remote region of the country.

Paraquat, the trade name for paradipryridyl dimethochloride, was used on one occasion in an experiment conducted by the SAP in conjunction with the Council for Scientific and Industrial Research to test its effectiveness on immature dagga plants.

The same herbicide was used in an American-funded programme to wipe out dagga plantations in Mexico.

But, according to a spokesman for the National Institute on Drug Abuse in Washington, the programme was halted and paraquat withdrawn when it was discovered that contaminated dagga could cause severe lung damage.

By WYNTER MURDOCH

"Paraquat was withdrawn in the summer of 1978. We regard it as a highly dangerous substance," it was stated.

Professor D A H Taylor, of the department of chemistry at the University of Natal, said he had been astounded to learn that paraquat had been described as a "harmless" herbicide.

"It is anything but harmless. It is a nasty, vicious substance that can kill in nasty, vicious ways."

According to his files a lethal dose of paraquat was about 15 g. In lesser doses there was a "delayed toxicity" that became apparent about two to three weeks after absorption.

"Basically paraquat attacks the lungs. It makes them grow. The substance can be absorbed through the skin, inhaled or taken by mouth.

"The only time that paraquat is harmless is when it has come into contact with the ground. It is a highly ionized chemical and is deactivated when it comes into contact with the earth."

It was widely used by the agricultural sector because of this property.

Professor Vic Leary, head of the department of pharmacology at the University of Natal medical school, said that if paraquat was absorbed in a toxic quantity "within 48 hours the person would experience symptoms of kidney and liver disfunction".

He cited a case of a 15-year-old boy who accidently swallowed a mouthful of 20 per cent paraquat solution and died.

In lesser doses a person who absorbed paraquat could develop lung trouble after a latent period of about two weeks.

"Scarred fibrosis may occur and lead to death, while with very heavy doses the brain is affected and convulsions may occur."

Test

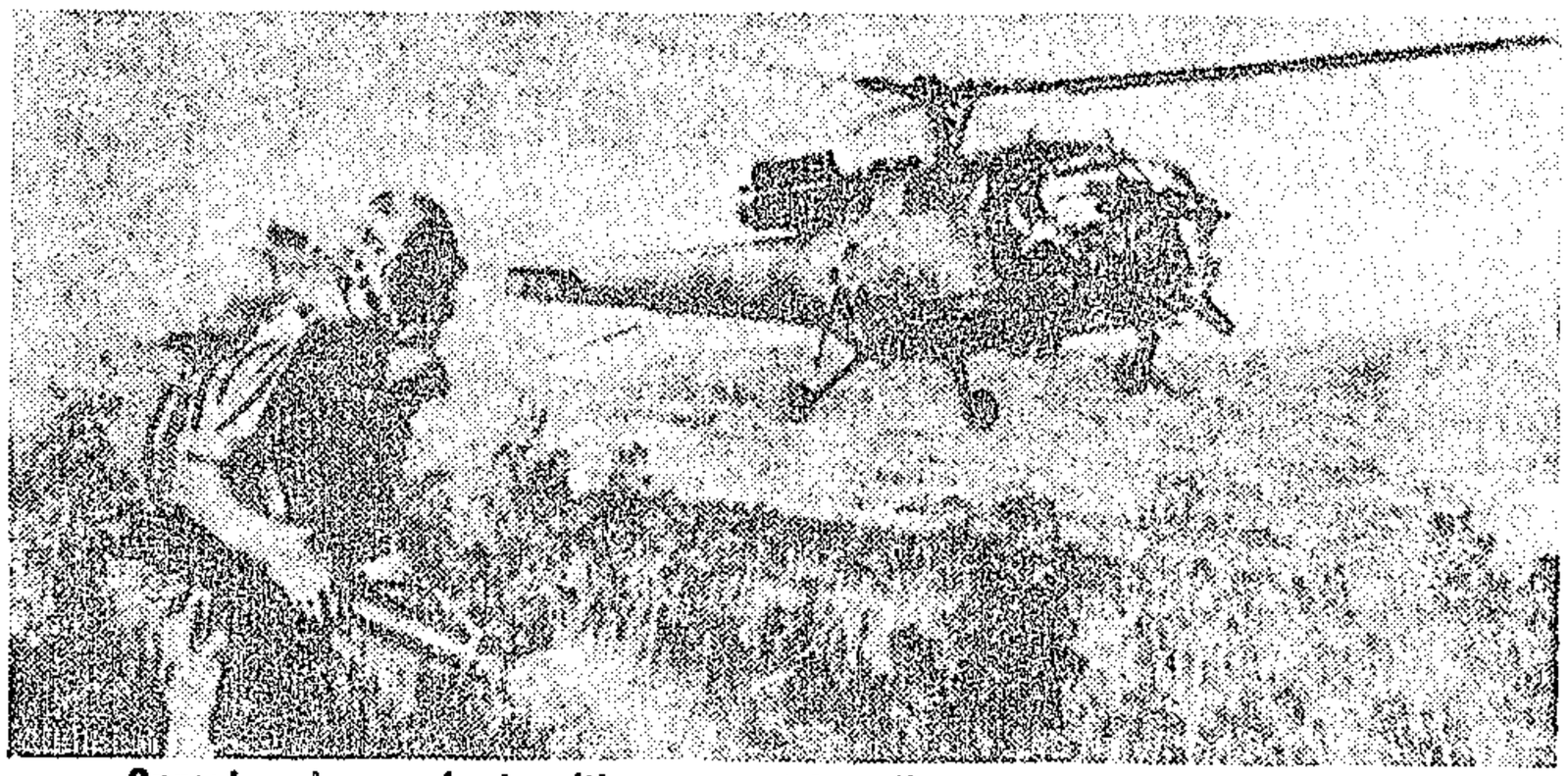
According to the statement released by the Police Directorate of Public Relations "a herbicide containing 200 g/litre paraquat was used on one occasion only in an experiment conducted by the SAP in conjunction with the CSIR to test its effectiveness on immature dagga plants. The herbicide has not as yet been put to use.

"The dosage effectively used in the experiment is 50 ml of the herbicide dissolved in 10 litres water and applied under pressure.

"As all herbicides can be regarded as harmful in one or another way this experiment was conducted in a remote spot on a small scale with the necessary precautionary measures.

"We are aware of the fact that a herbicide was used in Mexico to destroy dagga plants but we are unaware that it has been recently withdrawn.

"The herbicide used by the police in the experiment is locally obtainable in the trade. It is unknown whether it is imported or not."



Spraying dagga plants with paraquat in a "remote part of South Africa"

Police grab R100 000 drugs

Sunday Times Reporter

NARCOTICS Bureau detectives scored a major success yesterday when they intercepted 16 809 Mandrax tablets en route from Swaziland.

Two detectives, acting on a tipoff from a police informer, arrested a 26-year-old man and his 35-year-old woman companion close to the Oshoek border post in the Eastern Transvaal and confiscated the consignment of habit-forming drugs.

The consignment, worth more than R100 000 at black market prices, is one of the largest hauls netted by police.

Both suspects are being held in custody at Carolina and are expected to appear in court early next week.

(85)

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

No. R. 902 2 May 1980

APPOINTMENT OF COMMISSION OF INQUIRY INTO HEALTH SERVICES

It is hereby notified for general information that the State President has been pleased to appoint a Commission of Inquiry as follows:

COMMISSION

by the State President of the Republic of South Africa

To:

Gerald William Gaylard Browne
Hermanus Steyn Breytenbach
William Matthew Charles Davidson
Daniel Johannes de Villiers
Jean Nathaniel du Plessis
Phillippus Johannes Kloppers
Hilda Margaret Lessing
Nicolaas Salomon Louw
Georg Marais
Francois Pieter Retief
Johannes Jacobus Steyn van der Spuy

Greetings!

Whereas I deem it expedient to appoint a commission to inquire into and report on the matters mentioned hereinafter;

Now, therefore, by reason of the great trust I repose in your learning, judgement and ability, I hereby authorise and appoint you, Gerald William Gaylard Browne to be Chairman, and you,

Hermanus Steyn Breytenbach
William Matthew Charles Davidson
Daniel Johannes de Villiers
Jean Nathaniel du Plessis
Phillippus Johannes Kloppers
Hilda Margaret Lessing
Nicolaas Salomon Louw
Georg Marais
Francois Pieter Retief
Johannes Jacobus Steyn van der Spuy

to be members of a commission with the following terms of reference:

With a view to the rationalising of services, the promotion of more effective services and the placing of the costs of the services on a sound and firm basis, to inquire into, to consider and to report and make

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

No. R. 902 GK 6969 2/5/80 2 Mei 1980

AANSTELLING VAN KOMMISSIE VAN ONDERSOEK NA GESONDHEIDSDIENSTE

Hierby word vir algemene inligting bekendgemaak dat dit die Staatspresident behaag het om 'n Kommissie van Ondersoek aan te stel soos volg:

OPDRAG

van die Staatspresident van die Republiek van Suid-Afrika

Aan:

Gerald William Gaylard Browne
Hermanus Steyn Breytenbach
William Matthew Charles Davidson
Daniel Johannes de Villiers
Jean Nathaniel du Plessis
Phillippus Johannes Kloppers
Hilda Margaret Lessing
Nicolaas Salomon Louw
Georg Marais
Francois Pieter Retief
Johannes Jacobus Steyn van der Spuy

Saluut!

Nademaal ek dit dienstig ag om 'n kommissie aan te stel om ondersoek in te stel na en verslag te doen oor die aangeleenthede hieronder vermeld;

So is dit dat ek, omdat ek groot vertroue in u kennis, oordeel en bekwaamheid stel, u Gerald William Gaylard Browne as Voorsitter en u

Hermanus Steyn Breytenbach
William Matthew Charles Davidson
Daniel Johannes de Villiers
Jean Nathaniel du Plessis
Phillippus Johannes Kloppers
Hilda Margaret Lessing
Nicolaas Salomon Louw
Georg Marais
Francois Pieter Retief
Johannes Jacobus Steyn van der Spuy

hierby magtig en aanstel as lede van 'n kommissie met die volgende opdrag:

Om, met die oog op die rasionalisering van dienste, die bevordering van doeltreffender dienste en die plasing van die koste van die dienste op 'n gesonde en vaste grondslag, ondersoek in te stel na, oorweging te skenk aan, en verslag en aanbevelings te doen oor die

REPUBLIC OF SOUTH AFRICA

GOVERNMENT GAZETTE

STAATSKOERANT

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Vol. 179] PRETORIA, 2 MAY MEI 1980 [No. 6969

PROCLAMATIONS

by the State President of the Republic of South Africa

No. R. 80, 1980

COMMISSION OF INQUIRY INTO HEALTH SERVICES IN THE REPUBLIC

Under the powers vested in me by section 1 of the Commissions Act, 1947 (Act 8 of 1947), I hereby declare that the provisions, except the provisions of section 4, of that Act shall apply to the Commission of Inquiry into Health Services and I hereby make the regulations contained in the Schedule with reference to the said Commission.

Given under my Hand and the Seal of the Republic of South Africa at Cape Town this Second day of April, One thousand Nine hundred and Eighty.

M. VILJOEN, State President.

By Order of the State President-in-Council:

L. A. P. A. MUNNIK.

SCHEDULE

REGULATIONS

1. In these regulations, unless the context otherwise indicates—

"Chairman" means the Chairman of the Commission;

"Commission" means the Commission of Inquiry into Health Services referred to in this Proclamation;

"document" includes any book, pamphlet, record, list, circular, plan, placard, poster, publication, drawing, photograph or picture;

"Inquiry" means the inquiry conducted by the Commission;

"member" means a member of the Commission;

"officer" means a person who has been appointed or designated to assist the Commission in the performance of its functions;

"premises" includes any land, building or structure or any part of a building or structure, any vehicle, conveyance, vessel or aircraft.

PROKLAMASIES

van die Staatspresident van die Republiek van Suid-Afrika

No. R. 80, 1980

KOMMISSIE VAN ONDERSOEK NA GESONDHEIDSDIENSTE IN DIE REPUBLIEK

Kragtens die bevoegdheid my verleen by artikel 1 van die Kommissiewet, 1947 (Wet 8 van 1947), verklaar ek hierby dat die bepalings, uitgesonderd die bepalings van artikel 4, van daardie Wet van toepassing is op die Kommissie van Ondersoek na Gesondheidsdienste en vaardig ek hierby die regulasies in die Bylae vervat met betrekking tot genoemde Kommissie uit.

Gegee onder my Hand en die Seël van die Republiek van Suid-Afrika te Kaapstad, op hede die Tweede dag van April Eenduisend Negehonderd-en-tagtig.

M. VILJOEN, Staatspresident.

Op las van die Staatspresident-in-rade:

L. A. P. A. MUNNIK.

BYLAE

REGULASIES

1. In hierdie regulasies, tensy uit die samehang anders blyk, beteken—

"beampte" iemand wat aangestel of aangewys is om die Kommissie by die uitvoering van sy werksaamhede behulpsaam te wees;

"dokument" ook 'n boek, pamflet, aantekening, lys, omsendbrief, plan, plakkaat, aanplakbiljet, publikasie, tekening, portret of prent;

"Kommissie" die in hierdie Proklamasie bedoelde Kommissie van Ondersoek na Gesondheidsdienste;

"lid" 'n lid van die Kommissie;

"ondersoek" die ondersoek wat deur die Kommissie ingestel word;

"perseel" ook grond, 'n gebou of bouwerk of enige gedeelte van 'n gebou of bouwerk, 'n voertuig, vervoermiddel, vaartuig of vliegtuig;

"Voorsitter" die Voorsitter van die Kommissie.

Shock findings at mental home

CAPE TOWN — Shock findings in a University of Cape Town study of a state-run Peninsula home for the retarded, show that half the child inmates were abandoned by parents and that 27 who died within a three-year period were given pauper burials because relatives could not be traced.

The home, a former TB hospital at Westlake, known as the Dr A. J. Stals Care and Rehabilitation Centre, is administered by the Department of Health. It is described in the study as "barrack-like and linked by long colourless passages". Visitors complained of "absence of colour, pictures and arcitectural variation."

The study adds that it is "an apartheid institution catering for persons statutorily designated as Coloured and in need of residential care." There were 930 adults and children in the care of the centre with another 800 on the waiting list from the Cape Town area alone.

After admission it was found that there appeared to be "a total or near total breakdown in the relationship between parents/guardians and their children" of which the most severe form showed in loss of contact "arising from either falsification of addresses supplied to Dr Stals or charges of address without keeping the institution informed."

Only about seven per cent of the parents or guardians visited their children on a regular basis. "As a conservative estimate, about 50 per cent of the children at Dr Stals may be regarded as having been largely or totally abandoned by their parents or guardians," the report said.

The findings are reported in a survey by Mr Ken Jubber, a senior lecturer in the department of sociology.

"When one child died during the research period, the burial was long delayed in an attempt to trace the parents. Even the police failed to find them. Eventually the child was buried an unclaimed pauper.

"That such burials of mentally retarded children at Dr Stals is common was confirmed by figures supplied by the centre. Between March, 1977, and August, 1979, the centre had given 27 deceased children pauper burials either because their parents or guardians could not be traced, or because they refused to claim the body," Mr Jubber said.

A previous study of severe mental retardation in the Coloured community had found the prevalence to be "slightly less than for the white group". At present, more than 9 000 Coloureds may be mentally retarded as against a 1967 maximum estimate of 14 000 whites.

The UCT study also found that comparisons between facilities for white, Asian, Coloured and African mentally retarded showed "sharp inequalities".

In 1976 there was one bed for every 4 296 blacks, one for every 3 286 Asians, one for every 989 Coloureds, and one for every 488 white mentally retarded persons. In addition, the grants available to parents and guardians who cared for seriously mentally retarded persons at home, "proved a clear example of discrimination".

According to figures provided by the Department of Health in its 1978 report, whites were paid R88, Coloureds and Asians R47.75, and blacks R23.75.

Mr Jubber warned against applying social welfare type solutions favoured in Western countries — such as the move to de-institutionalise care centres and return patients to their family with a State subsidy.

Under-privileged groups in South Africa were "quite different from those in advanced countries". Up to 70 per cent of the children at the home were there because their parents "cannot or do not want them at home even with good prospects of some form of caring or assistance."

"The implementation of home care programmes at the expense of institutions does not seem advisable, only social change on a grand scale would make it advisable."

"Since this form of change is slow in emerging, it appears that "total" institutions for the mentally handicapped children of the poor will continue to be needed and must hence be provided," Mr Jubber said. — DDC.

Puffers won't be pressured

Political Staff

THE ASSEMBLY. — The Government disclosed this week that it planned no major propaganda campaign to discourage smoking, and revealed that in 1979 it derived R12 500 000 in customs duty and R269-million in excise duty on tobacco products.

The information was released by the Minister of Finance, Senator Owen Horwood, and the Minister of Health, Dr Lapa Munnik.

Replying to questions tabled by Mr Alf Widman (PFP Hillbrow), Dr Munnik said his Department had no specific counter-propaganda programme to offset the effects of cigarette advertising, although it was pressing on with its health education programme to discourage smoking.

Asked how much was being spent on the project, Dr Munnik said that because it formed part of a general health education drive, it was impossible to determine annual expenditure on this part of the project.

Fm 16/5/80 (85)

=> 70%

(24)

CLIVE ROSENDORFF

On the heart beat

Totally relaxed in a rocking chair, Professor Clive Rosendorff, Wits University Medical School's head of the department of physiology, hardly fits the label of gung ho alarmist.

But this cardiologist, who has just received the rare honour of being elected a fellow of the Royal College of Physicians at the tender age of 42, has some alarming things to say on coronary heart disease in SA, with special reference to executives.

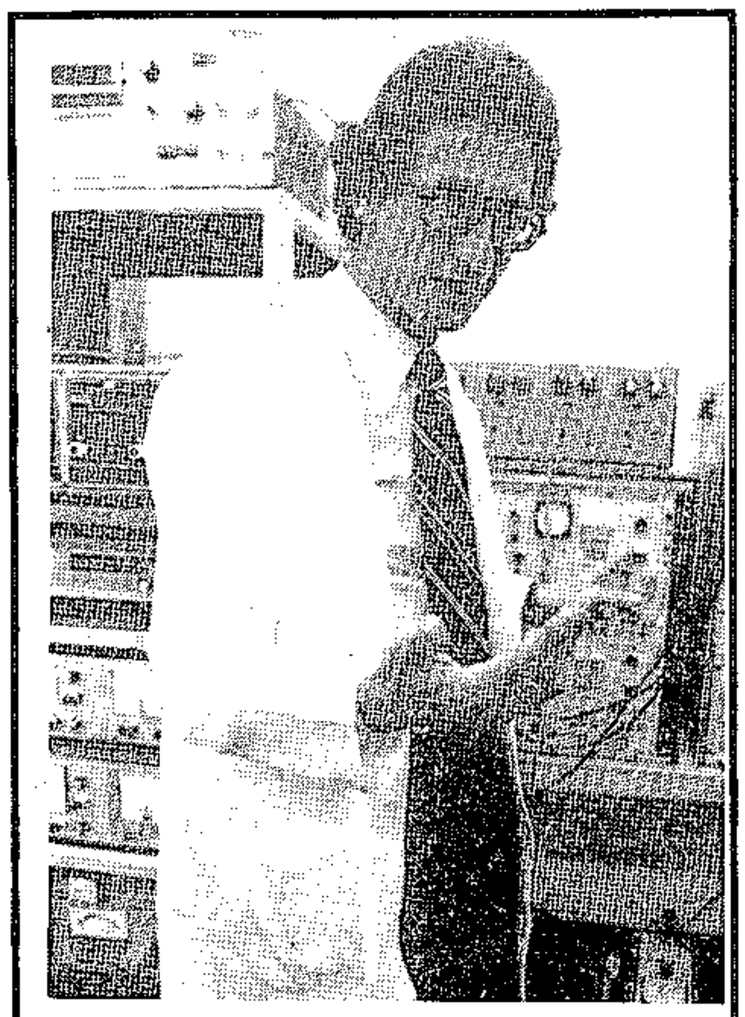
Rosendorff, also director of the university's Circulation Research Unit and a senior physician in the department of medicine, is co-director of the Johannesburg Hospital's hypertension clinic.

The research unit, which claims some pioneering discoveries in the fields of hypertension and coronary heart disease, researches diseases of affluence: cardiovascular diseases like heart attacks and hypertension, as well as diabetes and obesity.

Says a lean and fit looking Rosendorff, somewhat sadly,"The health of white South Africans is poorer than that of comparable groups in England and Wales, particularly in two areas — coronary artery disease and strokes, of which we have the highest incidence in the world. We beat the Finns, the Americans and the British into a cocked hat."

Cigarette smoking is heavily implicated, he says. And the cigarette smoking rate is "extremely high in SA where cigarettes have a higher nicotine tar content than overseas."

Other factors implicated are blood fats or cholesterol in the blood which tends to be high in SA males, and the very high incidence of hypertension.



Rosendorff . . . SA whites are a slothful, slobby lot . . .

Rosendorff: "We have an appalling track record of coronary heart disease in the prime productive years. Heart attacks are occurring in men in their thirties, are very common in the forties and extremely common in the fifties."

Unfortunately, hypertension, long implicated in heart disease, gives no warnings "until all the organs like the kidneys and heart collapse or the person gets a stroke."

Regular check- ups — annual for men in their forties, twice-yearly in the fifties, are essential to determine hypertension. It affects over 30% of adult SA males, black and white. However, drug therapy today is both effective and has few side effects.

Rosendorff graduated as a medic at Wits in 1962, then lectured in the Department of Medicine at St Thomas' hospital in London and "picked up a MRCP" (membership of the Royal College of Physicians — a pretty tough hurdle to cross as any medic knows) while he was there.

At the same time he gained a PhD from the University of London in cardiology, channelling his research into "how hypertension affects the blood flow through the brain and the heart muscle".

White SA males have a major problem with alcohol. "We have four times the cirrhosis rate here compared with the UK. White South Africans are a pretty slothful, gluttonous, slobby lot. We don't exercise, we all eat and drink too much."

Business people, especially, tend to poor eating habits. They skip breakfast, have vast business lunches, and often big dinners. Some advice handed out at random: Cut down on super and prime grade meats, dairy products, saturated fats, liver, kidneys, shell fish, imported cheeses and chocolates. Whole grain breads are allowed, so are fruits, vegetables and lean meat and fish.

Rosendorff obviously doesn't over-indulge. He's lean as a pike staff and only puffs cigars — without inhaling.

Right now his research focuses on "spasm in the coronary artery." It can be triggered off by emotional upheaval or severe exercise in somebody who is not fit. It's worsened by high cholesterol levels."

Says Rosendorff: "Most of the really big advances in drug therapy are made by the drug companies with huge financial resources and not by universities."

The word "breakthrough" makes him laugh. "It's the most over-worked word in the media. The time taken to repudiate a 'breakthrough' used to be a month, now it's two days . . ."

In published research, 98% is not original work."It's embellishment of someone else's work. It's repetition, it's dull. Nine out of every 10 ideas come to nothing."

What is the panacea for today's health problems? His hawkish features break into a sardonic grin before he answers. "It helps to choose your parents . . . "

ANDIDATE MUST enter in the number of each question (in the order in which it has ered); leave columns (2) and

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Vervaardig in Suid-Afrika

Call for funds for medical research

20/6/80

By MARILYN ELLIOTT

MORE State money had to be pumped into medical research if the SA Medical Research Council was to enter new and necessary fields, the MRC president, Professor A J Brink, stated in the annual report of the MRC tabled in Parliament yesterday.

Prof Brink pointed out that manpower was not being utilised and the MRC could not provide sufficient posts for qualified people who wanted to make medical research their career.

"In spite of 10 years of steady development, the MRC's major problem remains the availability of sufficient funds to satisfy the need for urgent research and provide facilities for researchers," Prof Brink said.

Annual parliamentary grants to the MRC have increased from R2 080 000 in 1970/71 to R5 200 000 in 1979/80. This reflects a budget growth of about 5% a year.

At a Press conference in Johannesburg yesterday, a member of the MRC and director of the Witwatersrand Dental Research Unit, Prof P E Cleaton-Jones, said a lack of funds would result in medical research not reaching its full potential in South Africa and a brain-drain of medical researchers.

Studies show that South Africa spends 33% less per capita on medical research than countries like Canada and Australia.

Despite the crippling shortage of funds, the MRC has made major breakthroughs in many fields. Some of the highlights include:

- The two major cancers affecting black males in Southern Africa are cancer of the oesophagus and primary liver cancer.

The MRC's National Research Institute for Nutritional Diseases was able to show a close relation between the level of the intake of a toxic mould, aflatoxin, and the appearance of primary liver cancer.

The aflatoxin fungus grows on peanuts, cassava and maize and communities using these types of food are exposed to high levels of the toxin.

The study has had important implications for industry and led to the introduction of control measures to ensure that processed food is not contaminated with this toxic mould.

The MRC, in collaboration with other research organisations, has found that plant deficiencies almost certainly influence the occurrence of oesophageal cancer.

- Using American studies as a guideline, the MRC's transplantation research unit found that a specific type of irradiation on experimental primates has improved tolerance of transplanted organs.
- The National Research Institute for Nutritional Diseases embarked on a pilot study of coronary risk factors in the South-western Cape. The institute examined 7 350 whites and found a high prevalence of risk factors. High blood cholesterol was found in 33%, high blood pressure in 27%, 22% of the population between the ages of 16 and 65 smoked more than 10 cigarettes a day and 35% was overweight.

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(85)

MM 20/5/80.

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Mother claims she was 'kicked out'

A CAPE TOWN mother has alleged that she was ordered out of an ambulance in which her son lay dying because it was "for whites-only" and that it took an hour for the ambulance to deliver the child to hospital where he was certified dead.

The allegations have been strongly denied by the Cape Town ambulance service which claims there was no delay, that there was no race discrimination in transporting patients and that Mrs Salie of Athlone was not ordered off the vehicle by any of its men.

Mr J B van Zyl, deputy ambulance chief for Cape Town said his station's records were open to inspection by the public.

Abduragmaan Salie, a nine-year-old pupil at Surrey Primary School in Athlone, was critically injured by a bus in Hein Road, Athlone on Wednesday evening after he and friends visited a shop.

Mrs Miriam Salie, the boy's mother who lives with her seven remaining children in an old bus off Pluto Road, Surrey Estate, said she arrived at the accident about half an hour after it happened.

The ambulance was at the scene and Abduragmaan was in the back of the vehicle.

"I got in the back and my boy was still breathing. However an ambulanceman told me he did not think he was still alive," Mrs Salie said.

"A man — I don't know if he was a policeman or an ambulance man — then shouted "get that woman out of here, this is a white ambulance" she said.

"I don't know why they didn't take him to hospital. It was nearly an hour after the accident happened and he was still lying there. The ambulancemen would not tell her to which hospital they were taking her son.

She had to 'telephone around' to find out that Abduragmaan had been taken to the Red Cross Hospital and then the mortuary.

Mr Basil Warner, chief of the Provincial Administration's Cape Town Ambulance Service, said there were no race barriers when patients were transported to hospital.

His men were aware of this.

"There was an ambulance on the spot when the accident happened. I can assure you that there was no delay and not one of my men told Mrs Salie to get out because the vehicle was for whites only.

"Another ambulance nearby with two ambulance medical assistants was radioed for help. They took four minutes to get there and saw the boy was dead."

The second ambulance left because they had a woman in convulsions on board and the ambulance with the boy pulled out immediately, he said.

"The boy was taken to the mortuary an hour after the accident happened. In that time the procedure at the hospital where the boy was certified dead was also completed.

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system.

26 April :

Student representatives meet throughout the country and resolve to continue their boycott 'until there is tangible evidence that our grievances will be redressed'.

29/05/80 ARGUS

Interns protest at 'agitation' label

Medical Reporter

THE Interns Committee of Groote Schuur Hospital is circulating a petition protesting against a statement made by the Minister of Health, Dr L A P A Munnik, that certain doctors were involved in agitation about nurses' salaries.

The petition has so far received a good response, not only from interns but from doctors and professors at all levels attached to Groote Schuur Hospital and the University of Cape Town's Medical School.

In Parliament this week Dr Munnik said a few doctors were involved in agitating about nurses' salaries. 'But we know who they are and I want to very seriously warn them to leave the nurses alone and practise their own profession,' he said.

The Interns Committee told The Argus the petition was aimed at making the point that the position was not as Dr Munnik said.

Doctors supported the nurses' pay demands, and had made no secret of the fact, but they were not acting as agitators.

The committee began circulating the petition yesterday, and when it is complete it will be sent to Dr Munnik.

HEALTH CARE FM 30/5/80

First, third world (85)

Detention

So prevention is better than cure? But what of those who take charge of health care in countries — and SA is one — in which the health backlog is massive? Resources have traditionally been channelled into providing expensive, essentially middle-class curative facilities. But at last SA is recognising that existing systems fail to meet the needs of its populations. So, aided by the 1977 Health Act, SA is rethinking public health policy.

For example, says Health secretary Dr Johan de Beer: "This year the Department of Health is spending 20% of its budget on prevention and health promo-

health pattern similar to the white group."

All this points to the important role to be played by the private sector in assisting employees with housing, transport, day care facilities, and wages that are adequate to allow employees to provide for their own health care.

All developing countries are faced with a thorny problem. Is it better to provide some health care to *all* or total health care to a *few* — and nothing to the remainder? "The choice which Ghana faced in 1976 was typical of this dilemma. A 300-bed hospital at Timali cost £2,4m with running costs of £600 000. For the same cost it would be possible to build 240 health centres at West African standards," according to Dr David Whittacker of the SAIMR.

It seems that the Department of Health is well aware of this. Says Health secretary De Beer: "SA faces a very complex problem. On the one hand we are a developed country and on the other a developing country. And the problems of developing countries in providing health care are different from those of developed countries.

"We are trying to maintain a balance between providing primary health care for all and the need to maintain and extend tertiary health care particularly with regard to research facilities. We are aware of the fact that we can't do one without the other and there is always the danger of channelling more into tertiary than primary services."

tion, whereas five years ago, it was well below 10%.

He adds: "In the past too much money has been channelled into sophisticated health care facilities in relation to the amount of money available for primary health care."

The latest health policy paper released by the World Bank reveals some interesting facts:

SA has one physician per 1 970 people, compared with Britain's 760, US 610, Yemen 32 380, and Israel which has one for every 350 people (the highest ratio of doctors in the world).

However, says Dr Tim Wilson, director of Wits Community Health Centres research project: "The geographical distribution of doctors within a country is as important as the distribution of doctors per capita."

In 1962 it was estimated that SA's doctor:patient ratio varied from 600:1 in Durban to 4 600:1 elsewhere. Says Wilson: "Nearly 20 years later the ratio is reportedly unchanged."

Health and poverty

According to the report, SA has one hospital bed for every 150 people — the same ratio as the US; and Britain has one for 120. Wilson comments: "The SA figures could be misleading. Baragwanath has 2 500 beds and we assume Soweto's population to be 1,5m; this gives a bed-to-population ratio of 1:600. Again it's a question of the distribution of resources."

Infant mortality is generally regarded as an index of a population's health, and SA's high infant mortality rate for black and coloured children indicates an urgent need for a reassessment and re-evaluation of the allocation of health resources.

According to Dr Les Irvig, epidemiologist with the Medical Research Council of SA: "The mortality rates for black and coloured children between one and four are 13 times as high as those for white children — and 50% of deaths among Africans and coloureds occur in the under five age group."

However, as Michael Savage, assistant Professor of Sociology at UCT has pointed out: "The institutionalised health care system is not the only or most important determinant of health care in a population. It is a well known fact that TB declines in a population when malnutrition and inadequate housing are overcome. Rheumatic fever declines when poverty and overcrowding are effectively attacked, typhus declines when sanitation and inadequate water supplies are improved."

According to Greg Wells, author of *Health, Healing and Society*: "When a large white group lived in poverty in SA during the depression in the Thirties, their health was more like that of the present blacks than whites. Those blacks who have attained a high standard of living show a

Health and school linked

(85 RDM 6/6/80)

THE home environment often made school health education almost useless, a speaker at a health conference in Pretoria said yesterday.

Speaking on the second and last day of the South African National Council for Health Education conference at the CSIR conference centre, Dr F Auerbach said there was "deep scepticism in educational circles about the trend towards asking teachers to take over the parents' role."

Dr Auerbach, organiser at the Teacher Centre of the Transvaal Teachers' Association, said: "Classroom instruction can't remedy deep-seated social ills".

However, he said, it was worthwhile to have health education in schools, because medicine and education had to join forces. "It could even affect the survival of mankind."

Dr Auerbach stressed four priorities in health education: housing, family life, nutrition, and the control of stress.

He said that without adequate housing as the first foundation it was difficult to embark on any successful programme of health education. Bad family life, too, was a disruptive influence on possible improvement in health education.

He appealed for a restarting of the school feeding programme to combat the effects of malnutrition — so badly felt in the black community.

The number of young suicides stemming from poor school results and modern stress was also worrying, said Dr Auerbach.

"We must extend children, but not stretch them on the rack of ambition," he said.

When asked in a panel discussion following his speech, whether he thought teachers were qualified to give health education, Dr Auerbach said: "Let's not fool ourselves, teaching is in a crisis. There are white schools with five teachers short. In some Indian and coloured schools there no pupils, or if there are, they are unwilling to be taught."

He said that unfortunately this type of classroom situation adversely affected health education.

"If only we could properly educate a single generation of adults," he said. — Sapa.

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Munnik inquiry team meets

Cape Times 10/6/80

85

Staff Reporter

Mr Gerald William Gaylard Browne, former Secretary of Finance, has been appointed chairman of the Commission of Inquiry into Health Services.

The commission, appointed by the Minister of Health, Dr L A P A Munnik, met for the first time in Cape Town yesterday.

Other members are Professor Hermanus S Breytenbach, Mr William M Davidson, Mr Daniel J de Villiers, Dr Jean N du Plessis, Dr Phillipus J Kloppers, Mrs Hilda M Lessing, Professor Nicolaas S Louw, Professor Georg Marais, Mr Francois R Retief and Mr Johannes van der Spuy.

The terms of appointment are to rationalize health services, promote effective services and put costs on a firm basis.

Special attention will be paid to:

- Administrative costs, profits and remunerations.
- The extent to which recommendations of the inquiry into the pharmaceutical industry have been implemented and their effect.
- The extent to which the recommendations of the inquiry into private hospitals and unattached operating theatres have been implemented and their effect.
- Services and facilities supplied by the State.
- Range of cost of services provided by local authorities.
- Costs of conducting a pharmaceutical practice.
- The average taxable income of doctors, dentists and supplementary health staff.
- Patients over-use of services, possibility of disincentives to over-use, extra payments by members of medical aid schemes and contributions by employers.
- Any related matters.

Study traces history of disease

Science Reporter

A UNIVERSITY of Cape Town human genetics study has traced a mentally debilitating disease back through 14 generations of Afrikaners to its first arrival in the early Cape and found that over 200 individuals in more than 50 families were affected.

A total of 491 persons, of whom 153 are still living, have been identified. A racial analysis showed that this represented 355 Whites, 115 coloured people and 11 people classified as Africans.

The disease is Huntingdon's Chorea, which occurs in adult life as psychiatric or neurological symptoms and appears as personality change, violent anti-social behaviour or abnormal movements. It has been described as "a slow killer which slowly and inexorably disintegrates the mind and body".

Other descriptions are "insanity with a tendency to suicide". Sufferers have been implicated in assaults, stabbings, shooting, theft, murder and other crimes, such as offences against property, sexual aberrations, prostitution, rape and indecent exposure.

Every child of an affected parent has an even chance of inheriting the fatal gene. The inability to escape from the unacceptable reality that they may be "passive victims of a totally random genetic accident" was devastating for all concerned. "It's like living under a cliff, waiting for a landslide," was the way a 33-year-old woman described her feelings.

The minimum direct cost to the State of a single affected person is estimated at R33 000 and the lowest total estimate for the whole of South Africa is about R3,7m annually.

"For every affected individual there are approximately 10 people in the immediate environment, including those at risk, the unaffected spouse and other members of the family, who suffer from the far-reaching social consequences of the disorder.

"Although expenses vary with socio-economic and family circumstances the above total can be regarded as a gross understatement of the real figure," the study said.

The affected group was found to stem from a common ancestor, Sophia van der Merwe, whose father, Willem Schalk, came to the Cape on the sailing vessel "Dordrecht" in 1658.

The study, carried out by the Department of Human Genetics and reported in in several articles in the latest issue of the South African Medical Journal, showed that the 50 affected families link up with four very large Afrikaner families. The north-western Cape was found to have a large concentration of affected families.

Researchers used family interviews, government archives, historical libraries, genealogical works, Jan van Riebeeck's journal, family bibles and even gravestones to build up their information.

"Approximately 210 affected persons have been traced over 14 generations to the two marriages of Sophia van der Merwe in the 17th century. Accepting that affected individuals have descended from both these marriages, it is highly likely that Sophia carried the gene for Huntingdon's Chorea," said the authors.

They added that "at the present time there is no cure or reliable method for recognizing the carrier for the gene of Huntingdon's Chorea. However, it is possible that a combination of careful ascertainment of affected individuals and their families, together with appropriate genetic counselling, will play some part in reducing the prevalence of the diseases."

Bosses are asked: pay workers' medicines

A JOINT committee of the Medical Association of South Africa and the South African Pharmaceutical Society yesterday asked employers to help low-income workers who can't afford vitally-needed medicines when they have been injured.

A statement issued in Pretoria said: "The associations have asked employers to provide company orders to accompany Workmen's Compensation Act prescriptions, accepting responsibility for payment. Accounts for prescriptions would then be sent directly to the employer, who would then claim the amount back from the WCA Accident Fund."

A Masa spokesman said: "Some workmen incur considerable financial hardship after injury. This usually affects those in the lower-income groups.

"The main financial problems include not only loss of salary, but also that he must pay for his own medicines before, and even after, the Workmen's Compensation has accepted his claim. Obviously, the workman deprived of his income — and often without savings — is unable to purchase the drugs he needs."

At present, employers sometimes help, and often the doctor supplies drugs from his own stock, but no proper system has been set up to handle the problem.

"In less than 2% of WCA claims is liability by the scheme not accepted, so the MASA believes few employers would be risking loss by underwriting the cost of medicines in these needy cases." — Sapa.

A-plant in SA to sterilise medical supplies

RDM 14/7/80

By HENRY HARINGTON
Pretoria Bureau

AN ATOMIC plant for sterilising South Africa's medical supplies is being built at the Isando industrial complex near Johannesburg.

The process will also be used to improve the quality of cable insulation used in the electronics industry.

The plant — the first commercial undertaking in South Africa based solely on the use of nuclear technology — will be run by Isoster Ltd, and is owned on a 60-40% basis by Federale Volksbeleggings and the Industrial Development Corporation.

The installation, costing R3,5-million, will be operating by the middle of next year.

Since 1971, a pilot plant at the headquarters of the Atomic Energy Board (AEB) at Pelindaba has been used to sterilise disposable syringes, surgical gloves and instruments, bandages and swabs.

Mr A J van den Berg, chairman of the IDC, said last week: "The Atomic Energy Board found the pilot plant so successful that they invited the IDC to tackle it on a commercial scale. There was great interest from overseas concerns, but the IDC decided to form a wholly South African consortium for the project."

Mr A S Barnes, general manager of Federale Volksbeleggings, said yesterday: "In the process, pre-packed medical supplies pass through a chamber where they are exposed to the electro-magnetic energy released by Cobalt 60 in the form of gamma rays.

"Unlike atomic materials used in nuclear power reactors, Cobalt 60 does not leave any residue of radioactivity in an object which has been subjected to its rays.

"The saving in manpower through gamma-radiation has led to increased demand for disposable medical products in hospitals throughout the world," Mr Barnes said.

Plastic disposable equipment melts in steam sterilisation, while the use of potentially explosive ethylene oxide gas is dangerous and not entirely reliable.

Mr Barnes added: "It is accepted throughout the world that if disposable medical products are exposed to a certain amount of radiation, they are unequivocally accepted as sterile.

"The goods are placed in containers and the radiation goes right through them, killing any microbes, so they remain sterile until the seal is broken.

"The process is virtually identical to that used in hospitals when cancer cells in a patient are killed by exposure to a controlled amount of electro-magnetic energy from a 'cobalt bomb'.

"The energy also strengthens the rubber and plastic in disposable equipment. For example, surgeons' gloves are made 10% stronger, and artificial limbs, besides being sterilised, have their abrasion resistance reduced by 30%.

"We will also be able to make cable insulation for the electronics industry stronger and more heat resistant, so the industry will be able to use thinner and lighter cable," Mr Barnes said.

An Atomic Energy Board spokesman said that though South Africa was a leading country in the development of food radurisation, it was premature to discuss its commercialisation.

Discussing the safety aspect of the plant, Mr Barnes said: "There are more than 80 plants like this round the world, but to my knowledge there has never been an accidental emission of radiation. We have to provide a detailed evaluation of the project to the AEB, who will only licence us to operate when they are satisfied it is completely safe. We are also in contact with the Department of Health.

"The cobalt is stored in a concrete structure with 2m-thick walls which significantly exceeds the safety margin required."

Mr Barnes added that there was export potential for gamma-sterilised disposable medical supplies.

(85) RDM, 17/7/80

Doctors reject plan for 'health profile'

By MARILYN ELLIOTT

A HEALTH programme for executives being planned by the National Development and Management Foundation of South Africa has been severely criticised by the Medical Association of South Africa.

The association believes the NDMF programme has little medical value, no scientific basis, and is not economically justifiable.

A spokesman for the association said in Pretoria yesterday: "We firmly believe in the value of approved preventive and community health services. But the evidence gleaned by the association, including a round-table discussion with the NDMF at which we put forward our views, suggests that the programme is unsuitable for South African needs."

The association has made its views known to the registrar of the SA Medical and Dental Council, and the director of the NDMF.

According to the association, the scheme will prove to be extremely expensive, and it argues that studies overseas, including views expressed in "Lancet" (the British medical magazine), suggest that the value of a battery of tests being suggested for executives will prove to be marginal.

Yesterday, the executive director of the NDMF, Mr P W Penzhorn, said he was amazed and disappointed by the association's criticism.

"Although I do not wish to comment at this delicate stage, I feel I must. I think the association has thrown this programme out on spurious grounds. The reasons given for dismissing it are ludicrous, vague, and contradictory. It is not true that this programme will be costly. We have already conducted surveys among executives which show that they want the service and are prepared to pay for it.

"With the present cumbersome system, an executive may have to go to four different doctors or specialists to find out what his various health problems are. With this programme, he has one stop, finds out exactly what his 'health profile' is, and takes it to a doctor for appropriate treatment.

"The plan to start such a unit has been backed by both the past and present Ministers of Health," he said.

At a conference four years ago attended by Dr Schalk van der Merwe, then Minister of Health, the NDMF was asked to explore the possibility of a special health service for executives and others in commerce and industry who have to deal with a lot of stress.

Mr Penzhorn said that although the programme has not yet been formally submitted to the SA Medical and Dental Council for approval, this will be done in the near future. Nothing about the programme will contravene medical ethics, he says.

"At a discussion with the Medical Association a while ago, it was agreed that we should go ahead with the programme. Now the association has decided against it. I hope that we can discuss this again and come to some suitable arrangement. We would like the association's co-operation."

Meanwhile, the association's spokesman said yesterday: "Time and again, the most effective form of screening and preventative medicine has proved to be a regular check-up by a person's own family doctor, who has regular contact with the person and family. In this manner the doctor can take a long-term view of any individual's health. The programme being put forward by the NDMF will not have these advantages."

Cost of services soaring — Louw

THE COST of South Africa's medical services was astronomical and was increasing annually, the Administrator, Mr Gene Louw, said last night.

Speaking at the Carinus Nursing College graduation ceremony in the City Hall, Mr Louw said that the Cape had a proud record in the fields of intensive care, nuclear medicine and organ transplants.

These services, however, cost a great deal. Figures for 1978, the latest available, showed that the Cape Province's hospital services dealt with 531 020 in-patients and 6 776 682 out-patients.

Last night saw the graduation of 312 nurses, 70 having completed a 3½-year course in general nursing and midwifery, 182 having passed a three-year course in general nursing and 60 a two-year course for enrolled nurses. This represented a pass-rate of almost 100 percent — 28 percent with distinctions — with a 40 percent honours pass-rate in social sciences.

Govt attacked over medical services

(85) RDM 22/7/80.

By ARNOLD GEYER

THE Government has been accused of feeding wrong information overseas about the quality of South Africa's medical services.

Two physiology professors at the University of the Witwatersrand have strongly criticised Scientific Progress — a journal published on behalf of the Prime Minister's Scientific Advisory Council — for drawing "unjustified and misleading" conclusions from reports on the ratio of doctors to population.

The Government-sponsored publication claimed satisfactory medical services were available for most South Africans.

But Professor D Mitchell and Professor C.H Wyndham, writing in the latest issue of the South African Journal of Science, said:

- QwaQwa — with a population of 250 000 — had only two doctors;
- If the total estimated population of the country were divided by the estimated number of economically-active doctors, there was an overall doctor/patient ratio of one to 1 900, but for the black homelands there was only one doctor to about 50 000 people;
- Although the average ratio was one to 1 900 in 1975, only 28% of South Africans lived in area where the ratio was one in 2 000 or better; and

These privileged areas contained the majority of the white population.

The two academics said they based their conclusions on the same survey — by the Human Sciences Research Council in 1975 — as Scientific Progress did.

"Even if one accepts as a crude index of the quality of medical services the ratio of doctors to population, the conclusion drawn by Scientific Progress is unjustified and misleading," they wrote.

The rural areas of South Africa, particularly the homelands, had a ratio of doctors to patients which, even if estimated optimistically, was typical of Zambia, Ghana and other Third World countries.

"And few would consider such a complement satisfactory.

"As Scientific Progress is circulated internationally from the Prime Minister's Scientific Advisory Council, the publication has a special obligation to be both circumspect and credible," they said.

Prof Mitchell and Prof Wyndham also quoted from the most recent report on the distribution of doctors in South Africa, by the University of Cape Town and the University of the Witwatersrand.

Findings of the survey, which are to be printed in the next edition of the South African Medical Journal, include:

- The ratio of doctors to patients in rural areas, including "white" areas and homelands, was one to 12 800.
- More than 90% of the listed graduates from UCT and Wits and more than 80% of those from the Pretoria and Stellenbosch campuses worked in urban areas; and
- Since 1946, there had been a progressive gravitation of doctors towards the urban areas.

The discrepancy in medical care for blacks and whites also emerged in a recent survey conducted by the Southern African Labour and Development Research Unit of the Universi-

Heart still No 1 killer, say insurers

CAPE TOWN. — Cardio-vascular diseases accounted for nearly half the deaths recorded in South Africa last year by the eight largest life insurance companies, says the Life Offices' Association of South Africa.

In its annual review of life insurance, released yesterday, it says coronary disease is the most common of these diseases.

The association adds: "Another cause for public concern is the number of deaths due to road accidents, particularly among younger people."

The association represents 38 insurance companies who transact more than 98% of South African life assurance business.

It lists the main causes of death as:

- Cardio-vascular diseases 48,8%;
- Violent causes — including road accidents — 15,4%;
- Cancer 14,2%;
- Respiratory diseases 6,8%; and,
- Other causes 14,8.

The review says these figures can be expected to differ from those for the entire public as they are in respect of insured people only.

Insurance and benefit payments were made last year at the rate of R2 500 000 every working day of the year, the association said.

Total pay-outs for the year were R616-million compared to R551-million in 1978.

Payments — including bonuses — on death and disability (R240-million) and policy maturity (R138-million) increased steadily, as did payments on annuities and other pension benefits (R149-million).

Total income for the companies was R2 496-million — against R1 927-million in 1978 — with premiums making up R1 705-million of this amount.

The offices held assets totalling R9 199-million against their liabilities to pay future claims under policies still in force.

This meant assets were up 24,1% on the previous year.

Total net additional money that became available for investment through life insurance was R1 497-million. — Sapa.

Surgeon backs Nyangas

Sun 24/7/80

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The Star's Africa
News Service

SALISBURY — One of Zimbabwe's top surgeons, Mr Ian Rosin, has added his full support to the campaign to include nyangas (traditional healers) in the country's National Health Service.

Mr Rosin said that between 40 and 50 percent of the illnesses in the country were psychosomatic, and could be dealt with only by nyangas.

"These illnesses cannot respond to pathological treatment," he said.

He praised the Minister of Health Dr Herbert Ushewokunze for his stated intention of amending the Medical and Dental Act to allow nyangas to take part officially in the health service.

5. Die Raad kan goedkeuring verleen vir die installering van enige fabrikaat, tipe, klas of model huishoudelike brandstofverbruikende toestel, met dien verstande dat die Raad oortuig is dat sodanige toestel voldoen aan die vereistes van klousule 2.

6. Hierdie Bevel tree in werking op 7 April 1981.

7. Hierdie Bevel heet die Agtste Rookbeheerstreekbevel.

BYLAE

Die gebied begrens deur Queens Park-laan, Victoriaweg, Soutrivierweg, Voortrekkerweg, Swartrivierparkweg, Setlaarsweg, De Waal-rylaan en Oostelike Boulevard, tot by 'n punt oorkant Queens Park-laan.

No. R. 1550 25 Julie 1980

WET OP MEDIESE SKEMAS, 1967

Kragtens artikel 30 (3) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), soos gewysig, kondig ek, Joseph Petrus Hermanus Steyn, Registrateur van Mediese Skemas, hierby die geldetarief in artikel 1 (1) van genoemde Wet bedoel en deur die Minister van Gesondheid, Welsyn en Pensioene goedgekeur, soos volg af:

GELDETARIEF TEN OPSIGTE VAN PRIVATE HOSPITALE

1. Die tarief wat in Bylae A hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blankes met hoogstens 70 geregistreerde beddens.

2. Die tarief wat in Bylae B hiervan uiteengesit is, geld ten opsigte van private hospitale vir Blankes met meer as 70 geregistreerde beddens.

3. Die tarief wat in Bylae C hiervan uiteengesit is, geld vir beide sodanige kategorieë hospitale.

4. Die tarief sluit algemene verkoopbelasting in, behalwe op items met betrekking tot medisyne, verdowingsmiddels en verbandgoed.

5. 'n Komitee van vyf lede, van wie die Verteenwoordigende Vereniging van Mediese Skemas drie benoem en die Verteenwoordigende Vereniging van Private Hospitale twee benoem, word saamgestel om aansoeke van private hospitale met minstens 61 geregistreerde beddens vir Blankes, om by die toepassing van die tarief in Bylae B geag te word hospitale te wees wat meer as 70 sodanige beddens het, te oorweeg. Bedoelde komitee bepaal die prosedure wat by die aanhoor van sodanige aansoeke gevolg moet word, en die beslissing van bedoelde komitee is afdoende.

6. Hierdie tarief is ter vervanging van die tarief wat by Goewermentskennisgewing R. 2853 van 28 Desember 1979 gepubliseer is en tree in werking op 1 Augustus 1980.

BYLAE A

Saalgelde

Hospitale moet die presiese tyd van toelating en ontslag op alle rekenings aandui.

Saalgelde word gehef teen die volle daaglikse tarief indien toelating vóór 12h00 geskied en teen die helfte van die daaglikse tarief indien toelating ná 12h00 geskied. Saalgelde word gehef teen die helfte van die daaglikse tarief indien ontslag voor 12h00 geskied en teen die volle daaglikse tarief indien ontslag ná 12h00 geskied: Met dien verstande dat die minimum bedrag wat gevra word, gelyk is aan die tarief vir een volle dag.

	Algemene saal	R
57001	Chirurgiese gevalle, per dag	24,00
57002	Toraks-chirurgiese gevalle, per dag	25,00
57003	Neurochirurgiese gevalle, per dag	25,00
57004	Mediese en neurologiese gevalle, per dag	25,00

5. The Council may give approval for the installation of any make, type, class or model of household fuel-burning appliance, provided it is satisfied that such appliance is capable of complying with clause 2.

6. This Order shall come into effect on 7 April 1981.

7. This Order shall be called the Eighth Smoke Control Zone Order.

SCHEDULE

The area bounded by Queens Park Avenue, Victoria Road, Salt River Road, Voortrekker Road, Black River Park Way, Settlers Way, De Waal Drive and Eastern Boulevard, to a point opposite Queens Park Avenue.

No. R. 1550 25 July 1980

MEDICAL SCHEMES ACT, 1967

In terms of section 30 (3) of the Medical Schemes Act, 1967 (Act 72 of 1967), as amended, I, Joseph Petrus Hermanus Steyn, Registrar of Medical Schemes, hereby publish the following tariff of fees, as referred to in section 1 (1) of the said Act and approved by the Minister of Health, Welfare and Pensions:

TARIFF OF FEES IN RESPECT OF PRIVATE HOSPITALS

1. The tariff set out in Annexure A hereto shall apply in respect of private hospitals with no more than 70 registered beds for Whites.

2. The tariff set out in Annexure B hereto shall apply in respect of private hospitals with more than 70 registered beds for Whites.

3. The tariff set out in Annexure C hereto shall apply in respect of both categories of such hospitals.

4. The tariff shall include general sales tax except on items in relation to medicines, drugs and dressings.

5. A committee of five members shall be established, and shall consist of three members nominated by the Representative Association of Medical Schemes and two members nominated by the Representative Association of Private Hospitals, to consider any applications from private hospitals having no fewer than 61 registered beds for Whites to be regarded for the purposes of the tariff in Annexure B as if they were hospitals with more than 70 such beds. The procedure for hearing such applications shall be laid down by the said committee and the decision of the said committee shall be final.

6. This tariff is substituted for the tariff published in Government Notice R. 2853 of 28 December 1979 and shall come into effect on 1 August 1980.

ANNEXURE A

Ward fees

Hospitals shall indicate the exact times of admission and discharge on all accounts.

Ward fees shall be charged at the full daily rate if admission takes place before 12h00 and at half the daily rate if admission takes place after 12h00. Ward fees shall be charged at half the daily rate if discharge takes place before 12h00 and at the full daily rate if discharge takes place after 12h00. Provided that the minimum amount charged shall be equal to the tariff for one full day.

	General ward	R
57001	Surgical cases, per day	24,0
57002	Thoracic cases (surgical), per day	25,0
57003	Neurosurgical cases, per day	25,0
57004	Medical and neurological cases, per day	25,0

DDT banned, but Dept of Health goes on using it

By Hannes Ferguson,Farming Correspondent

The State's Department of Health sprays hundreds of tons of DDT in the Transvaal and Natal Lowveld every year although the poison has been banned in South Africa since 1976.

An investigation has revealed that the department uses up to 500 tons a year.

The department is the only body in South Africa legally permitted to use DDT, and the active ingredients of the otherwise banned insecticide are specially imported for the department.

Scientists allege that the continued use of DDT by anti-malaria teams in northern Natal and parts of kwaZulu is contaminating Kosi Bay.

Mr G Begg, a senior officer of the Oceanographic Research Institute at Durban, said malaria-spraying units were responsible for a build-up of the DDT level in the Kosi Bay estuary. This was a threat to marine life.

This was confirmed by a spokesman for the Council for Scientific and Industrial Research in Durban, who added that as recently as last year a tanker used for carting DDT concentrate had been cleaned by using local river water.

The DDT was subsequently washed into the river by rain. This led to DDT being identified in the top layer of the ocean floor near Kosi Bay.

SAMPLES

The CSIR took extensive samples in a country-wide survey of marine pollution.

Dr J W J van Rensburg, regional director of health for Natal, confirmed that DDT was used intensively in the hinterland of Kosi Bay to stem the advance of malaria from Mozambique

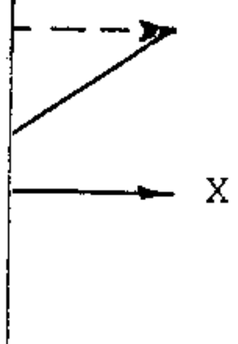
It was mainly used for spraying the inside of huts. Dr van Rensburg said he was not aware of any negligent cleaning of containers or tankers.

A spokesman for the National Institute for Tropical Disease at Tzaneen, which is a part of the Department of Health, said there were useful substitutes for DDT but they were much more expensive and not as long-lasting.

The Star's CARE campaign comments: DDT is almost universally banned and has been for years. It is a broad spectrum killer which not only kills useful non-target insects but also affects higher forms of life. DDT is a long-lived poison which gets washed far from its target areas and can go on killing for years. Throughout the world there are increasing signs that numbers of insects are produeing strains which are immune to its effects.

Figure 2.3

; b) axial loading.



Figur

International lab congress in Durban

85
RDM
29/7/80

DURBAN. — The concept of medical technology had changed considerably over the past 30 years and continuing education in this field was an absolute necessity, the Minister of Health Dr L A P A Munnik said yesterday.

Dr Munnik opened the 14th Biennial Congress of the International Association of Medical Laboratory Technologists here yesterday.

This is only the second congress of the association to be held outside Europe since the first was held in Switzerland in 1954.

Addressing more than 500 local and overseas delegates, Dr Munnik said that originally a qualification in clinical pathology, embracing microbiology, chemical pathology, haematology and histology, had been sufficient.

"In South Africa, because of the wide geographical spread of hospitals and laboratories, this broad general knowledge was essential.

"However, with the advances in medical science during the past two decades, more and more technologists are becoming specialists in one of the disciplines", Dr Munnik said.

Today an aspirant technologist could qualify in 16 different categories, and to aid continuing education, an advanced school of medical technology has been established at the South African Institute for Medical Research in Johannesburg.

"The demand for laboratory services all over the world continues to grow and this, coupled with the shortage of pathologists in areas away from main centres, places a greater emphasis on the role played by the technologists in the health team, he said.

Several workshops and more than 120 scientific lectures will take place during the congress, which will go on until Friday.

There will also be a trade exhibition, put on by 40 companies.

Dr Munnik will attend a state banquet tonight, and the mayor of Durban, Mr Haydn Bradfield, will host a civic reception for the delegates. — Sapa

Close care gap, doctors urged

By MARILYN ELLIOTT

SOUTH African doctors were urged yesterday to insist on quality care for everyone, to remedy the present imbalance of high-quality care in some fields and disturbing neglect in others.

The call came from Professor D J du Plessis, vice-chancellor and principal of the University of the Witwatersrand, in the opening address at an international cardiology congress in Johannesburg.

Prof Du Plessis said although South African doctors were highly skilled in the most modern treatment of coronary artery disease, the country's incidence of rheumatic heart disease equalled that of most undeveloped countries.

"There is, therefore, evidence of great advances — concern for the welfare of some people — and also of distressing neglect and a disturbing lack of interest in a disorder which is producing immense disabilities in another section of the population.

"It seems that individuals under certain circumstances cannot expect the same concern from our medical profession.

"While it is easy to blame the authorities, the profession must accept part of the blame for what has taken place."

Dr Du Plessis said it was time the medical profession in South Africa demonstrated it was aware that it operated in an unique society.

A new era of medical investigation and endeavour was required to fulfil the increasing expectations of many people who did not yet benefit.

In a paper delivered yesterday, Dr M E Edginton, of the Department of Community Medicine at Wits, drew attention to the high incidence of rheumatic heart disease in Soweto.

American delegation of doctors for SA

THE American Medical Association has accepted an invitation from the Medical Association of South Africa to send a delegation to the Republic in February to examine medical practice in South Africa.

It will be the second Ama team to visit South Africa, where US doctors will examine the structure of medical practice.

The invitation was issued to the American Medical Association (Ama) by Dr Marais Viljoen, secretary-general of Masa, during the recent annual meeting of the Ama in Chicago.

The delegation will include senior Ama members, Dr Lowell Steen, chairman of the American Medical Association's board of trustees, and the president of the American Medical Association Dr Robert Hunter.

"Throughout the recent Ama meeting, which was attended by delegates from many other overseas medical associations, Masa received a warm welcome and at no stage was reference made to alleged discriminatory practices in South Africa or the Steve Biko case," the statement said.

"Masa was undoubtedly as heartily welcomed as any of the other overseas associations and it is clear the South African medical profession is still highly regarded by the world medical community.

"The only false note sounded during the meeting, as far as South Africa was concerned, took place during a meeting of the American Medical Association's board of trustees which had been requested by the secretary of the Nigerian Medical Association, Dr Beko Ransome-Kuti. During this meeting he criticised South Africa for its alleged policies of discrimination against blacks in general and black doctors in particular.

"The criticism, however, was short-lived when the Ama trustees pointed out to him that many of them had been to South Africa and that his facts were incorrect," the statement added. — Sapa.

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KENNISGEWING 563 VAN 1980

KOMMISSIE VAN ONDERSOEK NA GESONDHEIDSDIENSTE

Hierby word vir algemene inligting bekendgemaak dat die Kommissie van Ondersoek na Gesondheidsdienste se aanstelling op 2 Mei 1980 in *Staatskoerant* 6969 aangekondig is, en dat hy reeds sy eerste sitting op 9 Junie 1980 in Kaapstad gehou het.

Die Kommissie gaan sy voorlopige ondersoekwerk deur middel van vier deskundige komitees aanpak wat die volgende hoof onderwerpe van die opdrag sal dek:

1. Hospitaal- en owerheidsgesondheidsdienste;
2. farmaseutiese dienste;
3. mediese skemas; en
4. gesondheidsdiensberoeps-aangeleenthede.

Belanghebbendes wat graag getuienis aan die Kommissie wil voorlê, word uitgenooi om beknopte memoranda oor bogenoemde onderwerpe aan die Sekretaris: Kommissie van Ondersoek na Gesondheidsdienste, Privaatsak X63, Pretoria, te rig.

(15 Augustus 1980)

NOTICE 563 OF 1980

COMMISSION OF INQUIRY INTO HEALTH SERVICES

It is hereby notified for general information that the appointment of the Commission of Inquiry into Health Services was published in Government Gazette 6969 on 2 May 1980, and that it held its first meeting in Cape Town on 9 June 1980.

The Commission will undertake its preliminary investigations through four expert committees which will deal with the following main subjects contained in the terms of reference:

1. Hospital and public health services;
2. pharmaceutical services;
3. medical schemes; and
4. health services professional matters.

Interested parties who wish to submit evidence to the Commission are invited to submit concise memoranda relating to the aforementioned subjects to the Secretary: Commission of Inquiry into Health Services, Private Bag X63, Pretoria.

(15 August 1980)

Why Natal has to care for KwaZulu sick

Mercury Reporter

IT WAS highly unlikely that KwaZulu could run its hospitals on the R35 million allocated, Mr Frank Martin, MEC for hospitals, said yesterday.

'That budget is probably one of the reasons why Natal is caring for most of KwaZulu's patients — and we don't have enough money either. A big hospital like King Edward VIII takes R27 million to R30 million a year to run.'

Natal has a R96 million budget for hospitals alone while half KwaZulu's R88 million health budget goes on pensions. Natal theoretically serves a population of about 4 200 000, compared with KwaZulu's estimated 3 200 000.

'But we are catering for far more than the number of people registered as Natalians — there are also KwaZulu Zulus, Transkeians and Basotho,' Mr Martin said.

'Co-ordinating Natal and KwaZulu hospital services would save money of course but we are all trying to find out how far we can go before the Government steps in.'

According to Mr Martin, all aid Natal might give to the homeland is governed by the Financial Relations Act. This lays down what the Province is allowed to spend — and that doesn't include looking after patients from KwaZulu. The Government doesn't provide money for that, said Mr Martin.

'In the interests of South Africa, Pretoria should take heed of the Province and KwaZulu's suggestions,' Mr Martin said.

Health hazard rears before your very eyes

A NEW health hazard is rearing its ugly head in the office.

The ubiquitous video display unit — the keyboard and television screen connected to a computer — is considered by some experts to be potentially damaging.

And if the use of computer terminals grows at the rate which some pundits would have us believe, it is a health hazard to which increasing numbers of the population will be exposed.

In the US more than 1 600 000 video display units (VDUs) were in use last year and the number is expected to increase dramatically in the near future.

Again in the US many top executives run their own personal computers in their offices. VDUs, therefore, represent a health hazard to all ranks of worker.

In the past there have been several scares about possible risks of ionising and non-ionising radiation being emitted from the screen, particularly because operators sit only a few feet away, and for much of the working day. But no proof has been found.

However, a survey conducted in the US has found that VDU operators suffer far more than do other colleagues from a wide range of health problems and stresses.

The study, conducted by the National Institute for Occupational Safety and Health, looked at three major sites where there were a number of operators using VDUs and compared them with other workers on the same sites.

A much greater number of the VDU operators suffered from eye strain, blurred vision, irritated eyes, sore shoulders and wrists and hand cramps than did the other groups with whom they were being compared.

Not only that, in all three sites the VDU operators reported more general health complaints than did the control groups. They also seemed to suffer more noticeably from stress and reported irritability, depression and anxiety.

The National Institute for Occupational Safety and Health study — found that the use of the VDU alone was not the sole cause of higher stress and health complaints from the users. It found that the different working conditions, reflected in the amount of control the operators had over their jobs, was a marked factor.

In other words, those operators who worked to high production demands and tight deadlines, but had a great deal of control over how these demands were met, reported a lower lever of complaints about their jobs.

On the other hand, where work was carried out under pressure at a fast pace and it was boring or repetitive, and where the operators had little control over how it was done, more stress was caused.

The study suggests that ergonomic solutions to improve the design of work stations — as academics are given to call the place where a VDU operator works — and which might solve problems like eye strain, pains in the neck and shoulder and sore wrists, are not enough.

It concludes that any ergonomic solution must be supplemented with a proper design of the actual tasks which VDU operators are to carry out if they are not to go on suffering from more illnesses and stresses than workers in conventional jobs.

Looking at future of medicine in SA

MORE than 1 000 doctors, including delegates from Europe and the United States, are expected to attend the biennial congress of the Medical Association of SA (Masa) to be held in Pretoria from July 6 to 11 next year.

Speaking at a Press conference in Johannesburg yesterday, the chairman of the organising committee, Professor Frans Geldenhuys said:

"The congress theme will be to look at the future of medicine in South Africa in the next decade — a period which is expected to see many major developments.

"New and exciting medicines will be coming into use in the next 10 years, medical research will be pushing further into seeking the causes of diseases such as cancer and the role of the doctor as the leader of a multi-disciplinary health team will be taking on greater emphasis."

Prof Geldenhuys, who is president-elect of Masa, said that medicine also had to face the challenges of a population with an increasing percentage of old people.

The conference, to be held at the University of Pretoria, would act as a forum for the discussion of these challenges as well as bringing together many leading figures from the local medical profession. A number of important international authorities from the US and Europe will speak at the conference.

Medical and dental fee review

The medical tariffs committee of the SA Medical and Dental Council this week reviewed doctors' fees and will make recommendations whether or not increases are justified.

The Medical Association and the Representative Association of Medical Schemes replied to requests to consider medical tariffs and on Tuesday and Wednesday this week the tariffs committee dealt with the written recommendations.

Last week the dental tariffs committee considered recommendations.

Medical aid schemes are opposed to further tariff increases requested by doctors and dentists.

There was a storm of protest last November when doctors were granted a massive 52,45 percent increase.

Chemists issue drug warnings

Staff Reporter

MANY pharmacists throughout South Africa are now handing out instructions on the risks and side effects of drugs when they dispense them to the public.

There is no law stipulating written information, but Mr Frans Eckard, the president of the South African Retail Chemists' and Druggists' Association, said many pharmacists were supplying the instructions because they recognised the need for the public to have the information.

"At the moment, it is entirely up to the individual pharmacist to decide whether he wants to do so. Many pharmacists are providing instructions on a trial basis because they recognise the need. I think we will go ahead with it," Mr Eckard said.

When drugs are dispensed in small quantities, written information about side-effects are not provided. Pharmacists provide verbal information on drugs, but they recognise that this is not sufficient.

Mr Rupert Lorimer the Opposition spokesman on consumer affairs, yesterday congratulated pharmacists.

"I hope this information will be extended throughout the country. It is highly commendable in the light of the misuse of drugs."

Gesondheidsprojek kom vir almal in SA

RAPPORT 2/11/80 (85)

Deur THINUS PRINSLOO

'N OMVATTENDE nuwe gesondheidsplan vir alle rasse in Suid-Afrika word vandeesweek aangekondig. Dit gaan onder meer om die oprigting van verskeie gemeenskap-gesondheidsentrums.

'n Wye reeks dienste — van basiese tandheelkunde tot sekere psigiatriese behandelings — gaan verskaf word by die sentrums wat in die onderskeie gemeenskappe in Suid-Afrika opgerig sal word.

Die nuwe benadering gaan veral om die verskaffing van voorkomings-en basiese gesondheidsdienste. Daar gaan nou met Suid-Afrika se buurstate geskakel word.

Dr. L. A. P. A. Munnik, Minister van Gesondheid, begin die week al om met die leiers van swart nasionale state te beraadslaag om beter koördinering van gesondheidsdienste te bewerkstellig.

Die nuwe gesondheidsentrums gaan met die eenparige goedkeuring van al vier provinsies opgerig word. Die Departement van Gesondheid sal die bou van die sentrums koördineer.

RAPPORT verneem die sentrums sal tussen R500 000 en R1 miljoen elk kos. Daar word beoog om die eerste van die sentrums binne 'n jaar te open.

Na verneem word, gaan dr. Munnik so gou moontlik verdere samesprekinge met belanghebbende partye voer. Daarna sal hy 'n voorkeurlys aan die Kabinet voorlê vir die oprigting van die sentrums.

Die volgende dienste gaan onder meer by die sentrums verskaf word: gesinsbeplanning, voor-en na-sorg van kraamgevalle, voedingsadvies, die immunisering wat plaaslike besture op die oomblik behartig, spesiale psigiatriese dienste soos die verligting van spanning, en ook tandheelkunde.

By die sentrums gaan groter gebruik gemaak word van susters wat spesiaal opgelei sal word.

SA's health care system — don't criticise the science that saves

PROFESSOR Savage's comments (Inside Mail Oct 13, 15) on the ill effects of the philosophy of apartheid, the urgent need for improvement of the socio-economic political lot of the black people and the need for improvement in the health services should receive wide support.

But his diagnosis as to how this has come about with the emphasis on medical technology and his prescription for alleviating the situation is open to question and is not helped by factual misrepresentation.

Historically the medical system he attacks largely derives from the famous Flexner report on medical education to the Carnegie Foundation in 1912. It was Flexner who introduced the basic sciences into medicine which in the end not only produced the means of preventing the killer diseases of diptheria, measles and poliomyelitis etc, but also provided the antibiotics to control pneumonia, meningitis etc, as well as the remarkable advances in medicine which have been achieved over the last 40 years.

Now, secure from the ravages of these diseases, Prof Savage attacks the discipline of medicine and fails even to mention that it is the very efficiency of medical control of the germs he derides that is at the root of the major problem facing not only South Africa but the rest of the world — the population explosion. Nor is recognition given to the pill — also a product of medical technology as a major contribution to the solution of this problem.

Apparently tuberculosis has little to do with the tubercle bacillus. The reason why tuberculosis declined in the 1930-40 era was in part due to better socio-economic conditions, but mainly due to the isolation of all "open" or active carriers of tuberculosis in sanatoria (when the sanatoria were emptied to take war casualties in Britain, tuberculosis increased widely in prevalence).

It was medical 'technology' that produced the anti-tuberculous drugs Streptomycin, INH etc, which for the first time ever controlled "the Captain of the hosts of death — the consumption" to the enormous relief of mankind and destroyed the tubercle bacillus, so allowing patients an early escape from the often fatal experience of year-long (or more) isolation in a sanatorium.

Nobody would possibly deny that malnutrition in poor, overcrowded surroundings aids the spread of tuberculosis. But to say that the control of the tubercle 'germ' is of no importance is nonsense. The World Health Organisation claims to have eradicated small pox off the face of the earth by no other means than eradicating the 'germ' from human carriers by vaccination. Furthermore, the recognition of the germ cause of disease has had a profound influence on crop production and, through veterinary science, on animal husbandry, increasing and ensuring food supplies.

It is the very success of the methods it has developed, coupled with the urgent public demand for control of these diseases, that has delayed medicine in giving due emphasis to the community approach.

Action is being taken to improve the training of students, who, despite their meetings of protest about the state of and training in community health, are generally poorly motivated once they have tasted the excitement of dealing with sick patients.

Curricula have been altered emphasising preventive and community health and development in the first two years of training so it can have maximum impact on optimum development. Concern also centres around the method of selection of students solely on scholastic attainment. Currently selection of some students has taken into account their personality, motivation, concern and compassion — very difficult to assess and even more difficult to avoid charges of bias in selection, but well deserving of a trial.

Medical people in South Africa have not been unaware of the need to improve community health. Thirty years ago Kark, at Polela, developed preventive and community health services, now being hailed as novel, which were ahead of anything in the rest of this world. Subsequently, he was first Director of the Institute of Community Health in the Faculty of Medicine of the University of Natal.

Disillusioned by the total lack of State support, he eventually moved to Israel where he built up what is probably the top institute in the world in community health founded on his medical experience and the system he developed in Natal.

Subsequently, the Rockefeller Institute, similarly disillusioned by State lack of interest and restrictions and the shelving of all the recommendations of the Gluckman Commission, withdrew its financial support, so the institute closed.

The Faculty of Medicine of the University of Natal has since then repeatedly sought permission to establish community health centres in Umlazi township specifically to help in training black students, but has been unable to get State permission.

The College of Medicine of South Africa devoted its second symposium to the health services in Southern Africa. It was widely acclaimed by visitors from many parts and by the paramedical disciplines and welfare services which participated. One of its many recommendations was that health should be linked with education and that in the black areas the health clinics should be built adjacent to the schools — so that adults, school children and infants could all be involved in a single concept of health education and prevention.

The centre of gravity of the problem is that health services, the control of tuberculosis and other communicable diseases is the responsibility of the Department of Health as laid down in the Act of Union and nothing can or will be done without its concurrency or consent.

Recently State Health, rightly concerned by the state of health of much of the community for which it is responsible, has established Chairs of Preventive and Community Health using the prestige of the Medical Schools to add authority to the Chairs and to attract staff.

But what is disturbing is that State Health subtly continues to exercise control by keeping to themselves the finances, the right of veto of staff appointments and by denying to the staff university conditions of service. Similar control has been extended to all psychiatric services (despite strong protest from Afrikaans as well as English-speaking universities) and to pathological services.

South African medicine is not "deeply permeated with apartheid". In fact the separation of medical facilities and training is generally deplored. In many ways it is in the forefront of opposition to apartheid with a common register, equivalent standards of training and of medical care in the teaching hospitals, but it is prevented from widening its facilities for blacks by State legislation and control of finances — facts widely recognised and which explain its acceptance by responsible circles overseas.

Recently much concern has been expressed as a result of Mr Justice Didcott's comments on the Trojan horse being used to undermine the Court of Appeal. There is considerable concern in medical circles that the Government intends a wider take-over of faculties of medicine of the universities, divorcing them from their university ties and allegiance and establishing a Medunsa-like system under the control of State Health.

If this is so, it will be the Department of Community Health which will provide the necessary Trojan horse, aided and abetted by adverse publicity in the Press. —

P SMYTHE (Emeritus, Professor of Paediatrics, University of Natal), Nottingham Road.

RAND Daily Mail

WEDNESDAY, November 5, 1980

This is the way to a healthy nation

AT LAST — a relevant national health plan! Dr LAPA Munnik's announcement of a health service which will put the emphasis on preventive and primary health care, instead of the present curative hospital services, is splendid news. And it is no less welcome for being decades overdue.

It is at last a recognition that this country has an inappropriate bias in its health services — what Professor Michael Savage has termed a white, urban hospital-centred bias rather than a black, rural, preventive bias.

Prof Savage's views, the subject of much argument in this newspaper's letters columns, coincided with the cholera outbreak in the Eastern Transvaal. It is precisely that epidemic, and its frightening spread to reach 279 reported cases in one month, that has underlined the inappropriate bias of our health services, and the importance of the Minister of Health's announcement.

Cholera is, as we pointed out at the onset of the epidemic, a Third World disease out of place in a country which boasts expensive, ultra-modern hospital-based medicine. The reality in South Africa is a situation in which conditions of poverty, ignorance and impure water supplies are conducive to the spread of diseases such as cholera.

As Dr Tim Wilson, a community health expert put it: "If I have typhoid I want a decent doctor, but if I have a clean water supply in the first place, I am unlikely to get typhoid."

The Government has finally grasped this need for a basic level of minimum health covering safe drinking water, sufficient food, housing, sewerage and waste disposal. Dr Munnik's department will coordinate the work of other Government departments in this respect — we hope with the minimum of bureaucratic hold-ups.

Dare we hope this will mean a stop to the indiscriminate dumping of blacks in inhospitable areas for ideological reasons?

And health centres staffed by nurses will take preventive medicine — family planning, TB detection, child feeding, care of the aged — to the adults and children before they become candidates for those "disease palaces" of past hospital planning.

Of course, problems abound. But this is a start.

Matanzima warns against 'quacks'

By WILMAR UTTING

THE State President of Transkei, Paramount Chief Kaiser Matanzima, this weekend called on the territory's citizens to seek medical treatment only from properly-trained people — and to shun homoeopaths, naturopaths, "quacks" and other "impostors who are doing all in their power to draw your minds into the dark ages".

Chief Matanzima's attack on homoeopaths, herbalists and naturopaths was the theme of his speech to 2 500 members of the Mampondomiseni tribe.

The occasion was the official handing over of a R100 000 clinic to Transkei by Johannesburg Consolidated Investments. The company employs more than 12 000 Transkeians at the Rustenburg Platinum Mines.

The chief called on his people to place their trust only in trained medical personel and to use the clinics to their fullest advantage.

"The Government of South Africa recognises these homoeopaths. I disagree with them," he said.

"Medical impostors" felt they could move round willy-nilly in Transkei, trying to take the place of those who had spent many years training and were dedicated to improving the health of the Transkei people, he said.

A Transkei Department of Health spokesman later explained that Chief Matanzima felt strongly about unqualified practitioners. So do members of the department since their operations were seriously jeopardised recently by the arrival in Umtata of two South Africans.

The department, with few clinics and a scant staff, was fighting ill-health on many fronts — a rising TB and infant mortality rate, alcoholism and malnutrition — and ignorance, the spokesman said. Recently another problem was added to the list: care of the mentally ill.

The two South African men had taken rooms in the centre of Umtata, claiming to be "naturopaths" and saying they could cure patients for R10.

They had operated with financial success, "treating" 400 to 500 people a day.

The Department of Health said the South Africans had operated fraudently. Patients were asked by a receptionist what their symptoms were. The descriptions were relayed to the men through a microphone. Then the patients were ushered in for a consultation.

The men, dressed in long white robes, threw bones and then described the patients' symptoms. Impressed, they paid R10.

But patients with pneumonia were merely given a few vitamin pills or injections. Patients with diseases of the eyes actually lost their sight and then went to the Department of Health in despair.

The men were finally deported.

"We actually don't object to them if they come with proper qualifications and are kept under control," the spokesman said.

He said the government's criticism of untrained people dabbling in medicine did not extend to witchdoctors.

They operated within the tribal structure and were invaluable in that they actually sent people to the clinics when they believed they were ill, he said.

The doctor said that in spite of the growing number of clinics and doctors, TB, the scourge of the homeland, was still rife and "well-nigh uncontrollable".

Official statistics of the prevalence of "open" or infective tuberculosis are 4% of the 3 000 000 population, but practising doctors believe this figure is an optimistic one. Also optimistic, they say, is the official infant mortality figure of 300 in every 1 000.

"People have babies in the bush. They don't register them. When they die they are buried with no official notification. Official statistics are just guesswork", one doctor said.

GENERAL EXPLANATORY NOTE

[ ] Words in bold type in square brackets indicate omissions proposed by the Minister on introduction.

Words underlined with solid line indicate insertions proposed by Minister on introduction.

for full text see GG. 7344

BILL

85 89

To amend the Medicines and Related Substances Control Act, 1965, with respect to certain definitions; so as to provide for the amendment of entries in the medicines register; to provide for the transfer of certain certificates of registration; and to alter certain designations; and to provide for incidental matters.

BE IT ENACTED by the State President and the House of Assembly of the Republic of South Africa, as follows:—

Amendment of section 1 of Act 101 of 1965, as amended by section 1 of Act 17 of 1979.

1. Section 1 of the Medicines and Related Substances Control Act, 1965 (hereinafter referred to as the principal Act), is hereby amended—

(a) by the substitution in subsection (1) for paragraph *(a)* of the definition of "advertisement" of the following paragraph:

"*(a)* appearing in any newspaper magazine, pamphlet or other publication; or";

(b) by the insertion in that subsection after the definition of "approved name" of the following definition:

"'certificate of registration' means a certificate of registration issued under section 15 (4), 15A (4) or 15B (4);";

(c) by the insertion in that subsection after the definition of "dentist" of the following definition:

"'Director-General' means the Director-General: Health, Welfare and Pensions;";

(d) by the substitution in that subsection for the definition of "Minister" of the following definition:

"'Minister' means the Minister of Health, Welfare and Pensions;";

(e) by the insertion in that subsection after the definition of "prescribed" of the following definition:

"'public' includes a section of the public concerned in manufacturing, dispensing, selling or administering, or the issue of prescriptions for, medicines or a Scheduled substance;";

(f) by the deletion in that subsection of the definition of "Secretary"; and

(g) by the substitution for subsection (2) of the following subsection:

"(2) A medicine shall, notwithstanding the fact that its components are identical to those of any other medicine as to physical characteristics, quantity and quality, for the purpose of this Act not be regarded as

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PRESS STATEMENT BY DR, THE HONOURABLE, L.A.P.A. MUNNIK, MINISTER OF HEALTH, WELFARE AND PENSIONS ON A HEALTH SERVICE FACILITIES PLAN FOR THE R.S.A.

This plan is one of the most important developments in Health Services during the past decades. It shall promote the accent on preventitive and basic primary health care instead of the present curative hospital services.

Embargo: Monday 3 November 1980 at 19h00

Pretoria

3 November 1980

1. One central body will be responsible for the overall planning of health services, the formulation of health policy and determining of strategy.

2. The Department of Health, Welfare and Pensions will serve as co-ordinator in the compilation and revision of the national health plan and will guide all and every health authority responsible for the establishment of health service facilities.

3. The Department of Health, Welfare and Pensions will timely and regularly provide information concerning any matter which may have an influence on service rendering, for example development or resettlement plans, to all service rendering bodies. All the health authorities will, in the same manner, provide the Department with information which may have an influence upon any health matter.

4. The health service plan will be cognisant of the health services in the National states. Liaison with the Regional Health Organisation of Southern Africa (RHOSA), will be maintained and extended.

5. Health service facilities will, as far as possible, be shared by health authorities. Where one body incurred capital expenditure for health services and such services are shared with another body, there will not be a contribution regarding capital expenditure, but expenditure may be recovered by means of recovery of rent or other agreements. With regard to personnel all health authorities will, without recovering of cost, supplement each others' services as far as is practically possible with retention

..../2

(b) Food

The production of food is primarily the responsibility of the private sector under guidance of the Department of Agriculture and Fisheries. The provision of food to supplement in protein and vitamin deficiencies for indigents, is the responsibility of the Department of Health, Welfare and Pensions and local authorities. The role of voluntary organisations is just as important and community involvement and participation must be encouraged.

(c) Sewage and waste disposal

The disposal of sewage and waste as well as the establishment of sewerage plants is an essential function of the local authorities and administration councils.

(d) Housing

The provision of sub-economic and economic housing to eliminate undesirable housing is necessary to create a minimum level of health.

In conjunction with the authorities concerned, the Department of Health, Welfare and Pensions will act as co-ordinator to introduce guidelines for the establishment of services with minimum standards for these four basic subsistence needs.

Private practitioners who obtain first-hand knowledge of general health problems related to the community, and who can determine the leading causes, will have a very important function in this field by bringing it to the attention of the authorities concerned

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will on purpose enact co-operation with voluntary service organisations for these organisations to play an active supplementary role in the rendering of health services.

The private practitioners as well as other health professions are members of a community, and on account of their training and knowledge, have the expertise to guide and actively particpate in such service organisations' activities.

(b) Community health nursing

The following higher category service has preventive and curative tendency and will mainly be rendered by nurses in the community to that part of the population depended on this service. Home visits will be done under guidance of fulltime and/or part-time physicians. Existing and available accommodation, improvised for clinic services for example school hall or any other vacant room in a house, business centre, etc., will be used. The financial provision for such a nursing service will be provided by the Department of Health, Welfare and Pensions and/or the provincial administrations and/or local authorities. The service should in general and mainly be rendered by local authorities and provincial administrations with consideration to certain services like psychiatry, family planning, combating of tuberculosis, geriatric care, etc. which are primarily the responsibility of the Department of Health, Welfare and Pensions.

(c) The community health centre (CHS)

This is the highest category service on this level and seems to be the largest present need of that part of the population dependent on public health services. Preventive,

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(iii) The establishment of a CHC is primarily the responsibility of provincial administrations and/or local authorities.

(iv) For the service to be a success it is important that where a CHC is erected, opportunity will be given for the rendering of services by all the health authorities concerned. In order to encourage the rendering of services by private practitioners, the health authorities will have to consider consulting room facilities for private practice on a selective basis at certain CHC.

(v) The establishment of a CHC will be a joint undertaking by all the health authorities concerned. Provision of funds by the central government will only be made available in terms of the norms already expressed. Where a local authority undertakes the erection of a CHC with government subsidy it will comply with the said norms.

(vi) Family planning facilities at CHC are the greatest priority. For the full development of all the primary health services the support of the community and service of private practitioners will be essential. The private practitioner will provide guidance and support to community nurses and voluntary health organisations, in first-aid and emergency services and with family planning and sterilisations; he will also be able to undertake part-time sessions and give advice on immunisation and a healthy life-style.

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In order to obtain an efficient and economical unit, bed provision will consist of 500 beds and in exceptional cases it will be allowed an increase to a maximum of 800 beds.

Provincial administrations themselves will determine which hospitals should be promoted to the status of a regional hospital.

Level VI - The academic hospital

This hospital will provide for the academic health components; that is, training, research and service rendering on a comprehensive and sophisticated basis.

As far as is possible these hospitals will be limited to 800 beds. Only in unusual circumstances and with approval from the highest level may the beds be supplemented in which case it may not exceed 1 200.

Issued by the Department of Foreign Affairs and Information at the request of the Department of Health, Welfare and Pensions.

PRETORIA

3/11/80

Health services to be changed

17/10/80

CAPE TOWN — South Africa can expect a major announcement inthe next few weeks on the reshuffling of the country's health services, the Minister of Health, Dr L. Munnik said here yesterday.

Dr Munnik was speaking at the official launching luncheon of South Africa's first national heart week.

He said it had become increasingly obvious that health services had to be streamlined to emphasise the role of preventative rather than curative aspects.

Dr Munnik told an audience that the 18-month-old national heart effort had grown into a "magnificent campaign" to try to prevent cardiovascular disease, a condition for which South Africa — with the highest heart attack rate in the world — is notorious.

Citing obesity, smoking, high blood pressure, tension and lack of exercise as the main risk factors associated with heart disease, Dr Munnik said the control of such bad habits was not only the responsibility of the individual but the whole community. — DDC.

Govt censured for 'neglect' of health services

NM 20/10/80

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Mercury Reporter

SOUTH Africa is in the grip of its third crisis in health services this year and the Government deserves 'severe censure' for its neglect of basic services, Mr Nigel Wood, MP for Berea and NRP health spokesman, said in a statement at the weekend.

'First there was typhoid in Inanda, then rabies in Natal and now the cholera outbreak in the Eastern Transvaal,' he said.

Vacancies

Quoting from the latest annual report of the Department of Health, he said there were 1 149 vacancies for white health personnel alone. Health inspectors were 22 percent below strength, district surgeons 28 percent and nurses 57 percent.

'Clearly these facts have a significant bearing on the crises we have suffered this year. The Government must take urgent and decisive action to fill the vacancies.'

'Marxist' medicine is not healthy for South Africa

RDM 21/10/80 (82)

AS A member of the paramedical profession since 1978 and now as a medical student at Pretoria University, I was disappointed to read Prof Michael Savage's articles "The development and underdevelopment of South African health" and "Diagnosis of failure and a new prescription" (Inside Mail Oct 13 and 15). I found them very negative and stereotyped.

I worked at the World Health Organisation (WHO) in Geneva for two years as a research assistant for a study of the health and psycho-social implications of apartheid. My work entailed the collecting of all available information on South Africa's health and disease patterns and health services and I researched scores of papers written by all sorts of experts and quasi-experts who attempted to examine these factors.

I found there were basically two broad categories of papers. Firstly, those written by laymen, usually academic, Marxist/Socialist influenced social scientists whose motives are all too clearly purely political and aimed largely as an attack on the "evils of the apartheid-capitalist system". The papers in this category are basically a re-hash of each other and barely distinguishable one from another.

The other broad category consists of articles written by professional medical personnel who have worked or are working in South Africa. These articles are reports of results of scientific research which has highlighted certain undeniable differences in health patterns, growth patterns and health services for the various race groups in South Africa. It should however be born in mind that some disease pattern differences between blacks, Asians, coloureds and whites can be attributed to genetic differences and not only to differences in health services.

Prof Savage's article falls very clearly into my first category of attacks on South African health services. His criticism of the biological model of medicine can only be described as simplistic, narrow and inaccurate. His arguments are not original, not well-founded and are straight parrotry of views of people like Ivan Illich (author of "Medical Nemesis").

All his criticisms of the health care system seem to be based on the belief that the answer to the so-called "crisis" he describes would be the implementation of some sort of socialist health care system in which the State would plan and determine the allocation of health care resources on the basis of absolute equality for all — this would inevitably result in great regressions in areas like research and training of skilled medical personnel.

No knowledgeable health official in South Africa can deny that more emphasis should be placed on preventative health care — and this is being done. In the same way the State together with the South African medical profession is making every effort to improve the health care system through better and more relevant training, development of ancillary health and welfare services creating awareness of the different health and psycho-social problems facing different race groups, increasing the number of health personnel and the elimination of all discrimination based solely on race.

Even some of the most dogmatic anti-SA researchers at WHO admitted that in comparison with the rest of Africa, the health services for blacks in South Africa could only be criticised by a hypocrite. The contribution by South Africa to fighting disease and to WHO projects in the rest of Africa, for example immunisation, should not be overlooked.

Obviously economic, social and political factors contribute to mortality and morbidity rates in many societies, however the Marxist-influenced argument that a clinical and biological attack on sources of disease is therefore inadequate is a non-sequitur. The Marxist solution would be to implement a centralised system which would dispatch doctors to where the bureaucrats found them to be needed according to statistics. They would also re-allocate research and hospital construction funds to rural development schemes, based on the belief that the majority of diseases in South Africa would not occur under different political and economic circumstances.

Michael Savage must bear in mind that South Africa is in a unique stage of development hovering between Third and Industrial worlds. This places particular demands on the health system and requires a delicate balance of emphasis placed on the varied services provided. We must be able to satisfy the demand for sophisticated technological medicine and we must be able to supply primary health care where needed.

For example, our health care system must be able to cope with malnutrition of the Third World — marasmus and kwashiorkor — and malnutrition of the industrial world — obesity — and their accompanying aggravating factors and complications. These are medical problems and can be treated as such. Social, economic and political problems such as poverty, overcrowding, inadequate sanitation, must likewise be treated as social, economic and political problems. Where these overlap with or cause medical problems the solution must be a joint one.

The Marxist viewpoint, that medical problems of a society such as this can only be solved by a total restructuring of the political and economic system along socialist lines, is a fallacy. As one who has knowledge of health care systems in various African and socialist states, I am convinced of the inherent superiority of the free enterprise system to provide for its people's health care needs.

Finally I must reject Prof Savage's assertion that "health is far too serious a matter to be left solely in the hands of the health professionals". There must of course be democratic control of the activities of medical professionals but we must at all costs avoid the health care system becoming a socialist political football.

What is needed in SA's health care system is more constructive contribution to its improvement and less Marxist influenced negativism. — Mrs I E WILLIAMSON, Sunnyside, Pretoria.

Apartheid and health don't mix

(85)

RDM 23/10/80

MRS I E WILLIAMSON'S attack (RDM Oct 21) on Professor Savage's articles on health in South Africa cannot be allowed to go unanswered.

Mrs Williamson presents herself as a medical student and a "member of the para-medical profession". She omits to mention that according to newspaper reports (Beeld Jan 25 and RDM Mar 6) she was a South African spy within the World Health Organisation.

Thus it is not surprising that she indulges in South Africa's most pervasive traditional sport: that of labelling all unwelcome comment and criticism as Socialist/Marxist.

The absence of fact or rational argument makes her letter difficult to contradict. Nowhere does she tackle the substance of Prof Savage's arguments. Nonetheless the following points need to be made:

● She argues that some of the differences in disease patterns between different population groups "can be attributable to genetic differences". The diseases responsible for the majority of deaths amongst African children are: parasitic/infective, respiratory, and nutritional/metabolic. None of these are genetically related. According to Wyndham and Irwig, the mortality rate of children below the age of one year is 135/1 000 amongst Africans, and 22/1 000 amongst whites. Presumably Mrs Williamson does not believe that African children are genetically predisposed to die.

● On the one hand she says that Prof Savage's arguments are "straight parrotry of views of people like Ivan Illich". On the other hand she says that Prof Savage wants a centralised, socialist health care system. If she had ever read Illich, she would know that this is the last thing that Illich wants. He regards all health care systems, be they capitalist or socialist, as being evil in themselves.

● Mrs Williamson argues that the "State, together with the medical profession is making every effort to . . . eliminate all discrimination based solely on race. Perhaps an examination of the relative amounts spent on, eg Baragwanath Hospital and the Johannesburg Hospital would disabuse her of this fantasy. The laudable aim of equality can never be achieved within segregated facilities.

● She argues that health services for blacks compare favourably with those of the rest of Africa. Mitchell and Wyndham state that QwaQwa, with a population of 250 000, has only two doctors. This figure should be compared with a figure for urban areas of one doctor per 875 people, rather than with figures from other countries.

These misleading statements aside, Mrs Williamson's letter consists of little other than unsubstantiated generalisations and personal opinions such as "the inherent superiority of the free enterprise system to provide for its people's health care" and that socialist health systems "inevitably result in great regressions in areas like research and training of skilled medical personnel".

Mrs Williamson is, of course, entitled to her own opinion. If she wishes to convince others of her correctness she should rely on reasoned argument rather than smear.

The words "socialist" and "Marxist" appear no less than eight times in her letter, as if mere repetition of these tedious slurs were sufficient to disprove any argument. In fact her letter tackles none of the basic themes of Prof Savage's articles. These are that apartheid and poverty in South Africa must carry substantial blame for much of the ill-health that exists in South Africa; that the current practice of health care is inadequate to deal with these health problems; that some of the most exciting attempts to provide social justice in health are to be found in countries that white South Africa regards with suspicion because they are black, or socialist, or both.

Mrs Williamson states that "there must, of course, be democratic control of the activities of health professionals". This laudable aim will surely not be achieved until all the people of South Africa are able to exercise democratic control over all aspects of their lives. — **P C DE BEER, Mayfair, Jhb.**

Secret of healthy diet simple, says doctor

Medical Reporter

HEALTHY eating does not mean eating health foods, according to Dr D Labadarios, senior nutrition researcher for the Medical Research Council and head of Tygerberg Hospital's metabolic unit.

At a Heart Week lecture on diet at the Golden Acre centre yesterday, he said the secret for a healthy diet was a simple formula — energy intake (in the form of food) should equal energy output.

Dr Labadarios said South Africans were 'digging their graves with their knives and forks.'

In a recent Medical Research Council study in the South-Western Cape, 62 percent of women and 32 percent of men aged between 56 and 65 were overweight.

BABIES

Parents had the mistaken idea that fat babies were healthy babies, and that overweight in children could be ignored.

They thus perpetuated bad eating habits in their children, causing a vicious circle.

The dietary aspect of the risk factors for heart disease was overwhelming. The body could not stand an imbalance in the diet, and eventually was forced to complain — usually by means of a heart attack.

The main risk factors were high cholesterol levels, high blood pressure and smoking.

The study had shown that one in three people had abnormal cholesterol levels.

HIGHEST

South Africa's cholesterol intake was the highest in the world, corresponding to the fact that the country also had the highest number of deaths from heart disease.

South Africans ate too much saturated fat, animal protein and salt (proved to cause high blood pressure).

Saturated fats were necessary, but should be take in balance with polyunsaturated fats.

The ideal cholesterol intake each day was a maximum of 300 milligrams. One egg contained this amount.

FORMULA

Dr Labadarios said the formula for a healthy heart was to keep cholesterol low, stop smoking, control blood pressure, take exercise, relax, and have a moderate alcohol intake (half a bottle of wine or the equivalent alcohol value a day.

A small portion of good food was good, but thinking that a little more of the same food would be better was a fallacy.

 RDH 31/10/80

The Editor, Rand Daily Mail, Box 1138, Johannesburg 2000.

McCarthy medicine is also no solution to SA's health problems

BEING located in a university, I am used to critics who attempt to be rational and accurate in their arguments. It is an interesting experience therefore to be exposed to a different type of critic, none other than Mrs Craig Williamson whose letter (October 21) attacks my articles on South African health care (Inside Mail, Oct 13, 15).

By means of carefully worded smear and innuendo, Mrs Williamson's letter appears to engage in an attempt to label me a Marxist and thereby to avoid the substance of my argument. This I believe to be a crude McCarthyite technique. But first let me turn to the overt thread of her argument.

Mrs Williamson creates two broad categories of papers on health, those written by "academic Marxist/socialist-influenced social scientists whose motives are all too clearly political and aimed largely at the evils of the "apartheid-capitalist system", (the latter phrase, significantly, she puts in quotes in spite of the fact that it is not mine).

The other category she creates is that of papers written on health "by medical personnel who have worked or are working in South Africa".

Her simple division of writings on South African health not only reminds one that there are two categories of readers of writings on South African medicine (those who divide the writings into two types and those who don't) but should leave many people puzzled as to how she would classify papers, published in reputable journals like the SA Medical Journal, on such important topics as malnutrition but written by social scientists.

On the basis of her argument one can only assume that what she really wishes to propose is that all writings on South African health care not written by professional medical personnel are Marxist/Socialist influenced.

Her simplistic classification system inevitably leads her specifically to classify me as being "Marxist/Socialist-influenced" and she then asserts that parts of my arguments are "inaccurate". In spite of failing to specify even one factual inaccuracy, she charges unknowingly into creating an inaccuracy of her own by accusing me of "straight parrotry" of the views of Ivan Illich.

As Mrs Williamson writes that she has "researched scores of papers" on South African health, I can only assume that she would have come across a valuable collection of such papers ("The Economics of Health Care in South Africa", edited by Gill Westcott and Francis Wilson) and seen in Volume I that I devote two pages specifically to rejecting the views of Illich. I suggest that it is Mrs Williamson's claims and standards of accuracy that need to be called into question.

By smear, innuendo, spurious classification and inaccuracy, she lays down a particular ideological framework of criticism, spawning many red herrings. Her letter then edges toward what she views as the substance of my arguments (not however before demonstrating that peculiar South African passion for an ill-written racial sideline "some disease pattern differences between blacks, Asians, coloureds and whites can be attributed to genetic differences").

Specifically she states that I would "seem" to argue for a socialist health care system" in which the State would plan and allocate health care resources on the basis of absolute equality for all". The fact that I do not argue this in my articles is of no bother to her (to save her the work and because I am doubtful of her ability to interpret my writing accurately, I add that nowhere have I argued it). This foolish debating trick leads her into a weak attempt to destroy arguments I never made and I can see no reason to reply to her statements.

Mrs Williamson then develops her style of argument by writing "Even some of the most dogmatic anti-SA researchers at WHO admitted that in comparison to the rest of Africa, the health services for blacks in South Africa could only be criticised by a hypocrite."

Here she sails dangerously close to labelling as hypocrites a range of distinguished South Africans such as those who have served on Government commissions that have been critical in their evaluation of health services for blacks in South Africa.

Finally, it is most interesting to note that Mrs Williamson, according to the Rand Daily Mail (Mar 6), has admitted to being a spy working for the SA Police while employed at the World Health Organization in Geneva.

In that report she was quoted as saying, "My real aim was to get as much information as possible on activities in the medical world while working as a secretary at WHO."

One is led to ask what was her real aim in writing such a letter. Her use of the term Marxist (five times), Socialist (four times) and her classification of me as a "Marxist/Socialist influenced social scientist", suggest that someone is studying those dark days of American history dominated by Senator Joe McCarthy's witch-hunts and attempting to apply similar techniques in contemporary South Africa. These techniques were decisively rejected by the American people and so too will they be rejected in South Africa.

Crude smear, innuendo and inaccuracy do not form a response to serious issues concerning the current state of health care in South Africa but they are, however, a sad commentary on Mrs Williamson. — **MICHAEL SAVAGE, Associate Professor, University of Cape Town.**

Argument on health care problems is confused

WHILE Michael Savage's article on the development and underdevelopment of South African health services (Inside Mail Oct 13, 15) attempts to uncover the failings of the South African system of health care, there are certain confusions in his argument not unfamiliar to those who have followed the debates over the British National Health Service.

On the one hand there is the view that medical science and the health services can make little contribution to the overall health of the population, and yet so much effort is spent revealing the inequalities of health care in relation to the health needs of the people.

To quote from Prof Savage's article in your pages, "South African medicine is skewed towards providing services for the affluent . . . it is skewed away from providing adequate health care coverage for the poor and for workers."

Either the health services do matter, in which case their organisation and distribution is a matter of considerable public concern, or else they are irrelevant to the health of the population and we need only find out how we have succumbed to such a pervasive conspiracy perpetrated by the medical profession and the state.

Between conspiracy theories and moral rectitude, it would be more apposite to consider disease as the complex outcome of the historical development of South Africa, and understand the role of the health care services in that light. — D N UNTERHALTER, Trinity College, Cambridge, England.

UCT study critical of health and nutrition

C. Times 1/8/80

85

Science Reporter

HIGHLY CRITICAL studies of the mining industry, occupational health, nutrition, the pharmaceutical industry, medical education and mental health were published this week in a collection of papers from the Southern Africa Labour and Development Research Unit (Saldru) of the University of Cape Town.

The collection, the second of two volumes covering a conference on the economics of health in South Africa, among other things criticizes the Erasmus Commission of Inquiry on Occupational Health for praising the mining industry while failing to pay attention to the high number of victims of dust-induced diseases.

It also points out, at a most embarassing time of industrial unrest, that the commission "sees a constructive role for white trade unions, but does not see this role extended to all workers".

"On the contrary," says the report, "it ascribes industrial peace to the absence of black trade unions in the Republic and a striking absence of industrial organization in certain factories."

Migrant labour

A backhander for migrant labour appears in a paper on malnutrition which states that "no claim is made that migrant labour, *per se*, causes malnutrition — rather, that the extensive physical disruption of family life which it causes, fosters extensive desertion by menfolk of their dependants and an illegitimacy explosion whom nobody wants, nor can provide for. When this occurs on a wide scale in a poverty situation, widespread malnurition occurs."

The treatment of long-term psychiatric patients is covered in a number of papers on mental health, one of which criticizes the Smith Mitchell "empire" of privately-run institutions.

This group, which embraces more than 80 companies and operates 13 mental institutions in addition to 15 TB, geriatric and surgical-medical sanatoria, receives a daily tariff per patient from the Department of Health. The report says that "despite the fact that Smith Mitchell is a private profit-making enterprise, their links at the Smith Mitchell institutions are seconded from the Department of Health. Although the situation has changed since 1963, the department still employs key staff at these institutions."

Because of the wide-ranging activities of Smith Mitchell "it was not possible to refute the claim (made by a Swedish newspaper) that the company had made a profit of R10,5 m in 1973".

"It is clear that Smith Mitchell do profit; otherwise they would not operate. They have no competition in the field of mental health. The extent of profitability in this area remains a secret," the paper added.

The pharmaceutical industry comes in for its share of criticism in two extensive papers on the manufacturing of ethicals and the economics of prescribing such drugs.

Profits are shown to be higher than average for all manufacturing industries. A breakdown of costs brings out the fact that the drug companies spend almost four times as much on promotion as they do on research, and almost as much as on the entire cost of manufacturing, while at the same time maintaining that one of the reasons for high prices is the high cost of research.

'Priorities'

One paper points out that "criticism has often been levelled at the fact that detailmen (medical reps) are not knowledgeable enough to give doctors adequate information (on new products). Adverts aimed a recruiting medical representatives require only a matriculation certificate, but stress that selling experience is essential. This may indicate the priorities of drug firms."

It refers to the controversial use of free gifts, samples and bonuses. "Gifts are given to doctors to encourage them to prescribe a particular brand of drugs. Doctors may also be given a bonus for prescribing drugs, or are often able to get a free sample with every package of drugs ordered. The result is that doctors can gain by prescribing (and selling) the higher-priced items."

The editors of the collection are Dr Francis Wilson of the UCT School of Economics and director of Saldru, and [illegible]

"Initially [illegible]

INSIDE MAIL RDM 15/10/80 (85)

● The crisis in South Africa's health system

Diagnosis of failure ... and a new prescription

In his final article on South Africa's health system, MICHAEL SAVAGE, Associate Professor of of Sociology at the University of Cape Town*, suggests a three-point plan for the creation of an effective model to combat disease and illness in the Republic.

THE South African system of health is critically weak and is failing to provide adequate health care to the mass of citizens in this country.

This is one result of the wrong model of medicine being adopted both because it "fits" in well with the existing political system and, probably more importantly, because it grew out of and was shaped by the needs of the economic system.

What can be done to develop South African health care?

As a first step a systematic analysis and evaluation of the current efficacy of the existing health care delivery system is needed.

Such an evaluation should have as its prime task not the noting of the failures of the existing system but the unravelling of the roots of why these failures have occurred and continue to do so.

To my knowledge the last comprehensive attempt to analyse the South African health care services and make concrete proposals for their future development was that of the Gluckman Commission of Inquiry into the National Health Services, which reported in 1944.

This commission recommended the establishment of a national health service and proposed detailed changes, such as the creation of a network of local health centres that would promote health and deal with illness by using teams of medical workers in which the doctor would only form one segment of the team.

Other members of the health centre team would include health assistants, who were to undertake health education, provide first aid and to assist at clinics.

Subsequently a limited implementation of this proposal to establish a health assistant programme was undertaken, particularly by Dr Kark who established training courses for such assistance.

The major recommendations of the Gluckman Commission, with the change of government in 1948, were never fully acted upon and the health assistant scheme failed due to poor funding and a variety of other factors unconnected with the need for, or the adequacy of, these workers.

Subsequent to this 1944 commission, medical evaluation appears to have taken place only on a departmental basis and other than the setting up of a weakly-developed comprehensive health scheme in the "homelands" no significantly new national plans for the health care system in South Africa have been implemented or considered.

Consequently there has been no systematic evaluation of the South African medical system.

Yet such an evaluation is needed to probe the roots of disease in this society and then to examine how medicine and health care can help attack these roots.

Among the difficult questions that would have to be answered in this task is probing beyond the trite statement that poverty causes disease, and raising the question of what causes poverty in the first place?

What has caused not the undevelopment of black rural areas but their continuing underdevelopment that has produced such widespread poverty in these areas?

Similarly, in probing the roots of disease, one will have to go beyond linking childhood malnutrition to such things as migrant labour, and raise questions about the causes underlying the perpetuation of the migrant labour system itself.

Only when a clear understanding of the roots of ill-health and disease are displayed can it be understood how medicine can best play its proper role of striking at the heart of disease. Only then can an adequate examination of the existing system be made and disciplined thinking start about constructing a health care delivery system to meet the needs of the South African population.

As a second step there should be an examination and evaluation of the experiences of other countries in implementing and experimenting with new models of health care delivery.

One need only look to states nearby South Africa — such as Mozambique, Tanzania, Botswana, to view a variety of attempts to reshape or create new health care systems. Many of these experiments are extremely challenging and have direct relevance to South Africa.

Mozambique, for instance, is in the process of establishing a health care system that focuses on preventative medicine and rural health. It has engaged in mass immunisation campaigns and is busy attacking the three most common sources of disease — mosquitoes, contaminated water and the lack of adequate sanitation.

To help in this attack and to help deliver medicine to the population, Mozambique is in the process of building up a core of health workers who come from the areas they are to serve and who are given a nine-month training which enables them to engage in simple preventative medicine, health education and basic therapeutic treatment.

Likewise one could examine the Tanzanian system of rural medical care and village health workers; or one could examine the Botswana family welfare educator programme which is attempting to build up a network of village health workers under the supervision of nurses.

In short, there are many experiments that are taking place in creating new health services, which could have direct relevance to our society.

Such experiments need careful evaluation, for a naive enthusiasm about them is widespread, and some people seem to suggest that the experiments are without major problems and should be transferred to South Africa.

Not only does this attitude indicate a naivety about how health planning should take place but it fails to pay attention to the fact that there are very considerable problems that are associated with many of these much enthusiased about innovations — some of them have failed to achieve such things as a redistribution of doctors into the rural areas, other experiments may have opened up gaps between sections of the population by giving certain people access to doctors and hospitals while trapping other people into an experimental system.

There is also the danger that, in the enthusiasm for such experiments, people will fail to recognise that the experiments that have taken place have usually occurred within the framework of a significantly changed political and economic environment and that it is more than probable that most effective health care experiments elsewhere, cannot be transplanted into an unchanged South Africa.

Nevertheless it is possible to learn from these new models of health care delivery, and even to implement some parts of them in embryonic form in local projects. This examination and evaluation of new projects is a second constructive area in which work can begin.

Thirdly, and most briefly, there is an important need for the whole practice of medicine to become integrated into a multidisciplinary community development programme.

The TB of the Ngutu area and the malnutrition around Cape Town cannot be eradicated by doctors and nurses acting in a hospital setting.

What is needed to attack these problems is a multidisciplinary approach to disease in which medicine, housing, agriculture, education and economic programmes co-operate to build up community facilities to combat such disease.

South African medicine appears to concentrate excessively on treating disease in isolation from the setting and environment in which it occurs yet, at the same time, teaches that most disease in South Africa will only be overcome once people are better paid, better fed, better housed and better schooled.

A real effort on the part of the medical profession needs to be made to close the gap between its teaching and its deeds, such a gap can only be closed in this area by the medical profession actively involving itself in community development programmes as one segment of a total response to disease.

However, again caution needs to be exercised in working out how best this can be done. As De Beer has pointed out several community development schemes have helped obscure the roots of disease, either by encouraging survival strategies that ultimately only make the existing social order more palatable, or by engaging in projects, such as India's "Green Revolution" which benefited the richer peasants so much that they pushed the marginal farmers off the land.

These then are three positive steps:

- **An analysis and evaluation of the current medical system;**
- **An examination of the experiences of other countries and**
- **An involvement in community development that can be begun now.**

If South Africa is to become a health-promoting and healthy society, it needs both new social structures and new medical structures.

This means that medicine must reject the belief, unfounded in fact, that its technology by itself can improve the health of any large population.

Wage levels, patterns of income distribution, employment opportunities, housing, agricultural production, nutritional programmes all affect the health of any population more than technological medicine can.

To be effective, medicine must be directly involved in the promotion of health-producing social structures.

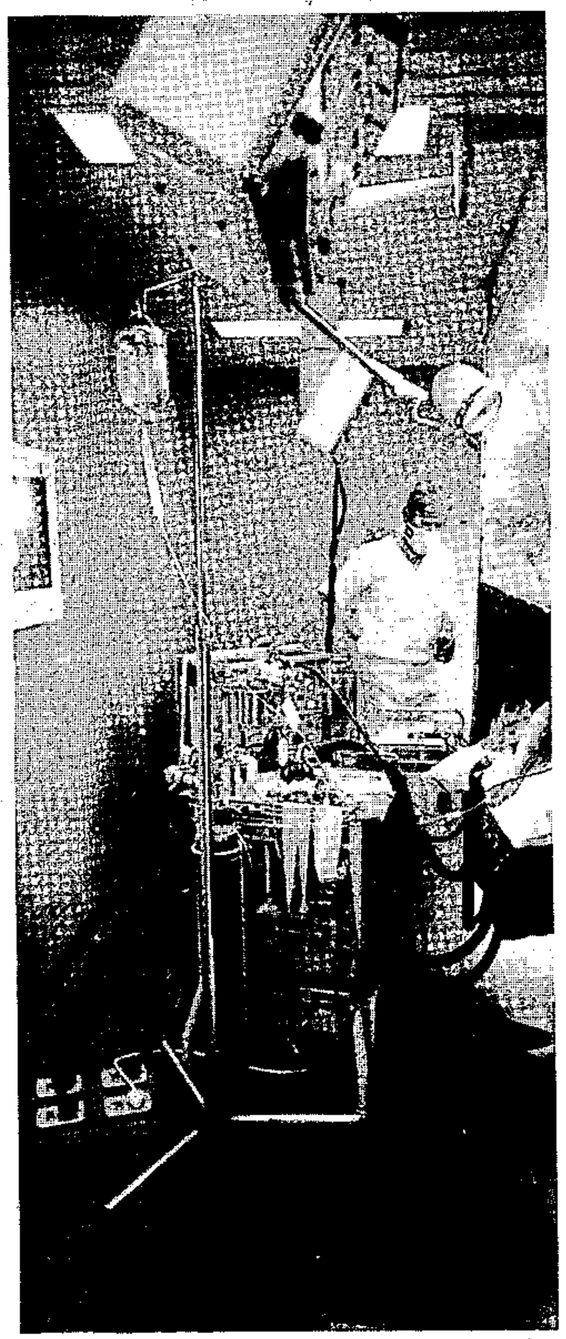
In South Africa this results in an immediate obligation on the medical profession to combat all aspects of apartheid that have institutionalised a range of political and social constraints denying the opportunity of good health to large sections of the population.

At the same time, the medical profession and members of the society should be working towards creating a new and innovative model of health care delivery. Neither task will be easy. The challenges facing South African medicine are great but no greater than its potentialities.

*** In Part One of this series Professor Savage was mistakenly referred to as a member of the academic staff of the University of the Witwatersrand.**

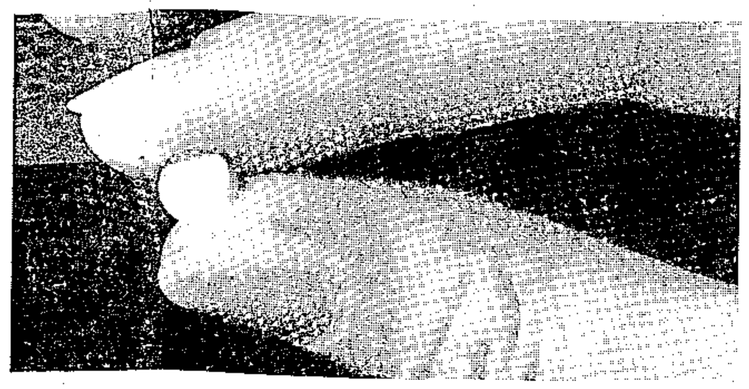
THE DEVELOPMENT AND UNDERDEVELOPMENT OF SOUTH AFRICAN HEALTH

RDM 13/10/80 (85)



South African medicine has adopted a technological and physiological approach to the promotion of health. To become effective medicine must become involved in combating social policies which are associated with widescale poverty and malnutrition.

South African medicine has concentrated on attacking symptoms instead of the ultimate causes of disease and ill-health, says **MICHAEL SAVAGE**, Associate Professor of Sociology at the University of the Witwatersrand. In the first of a two-part series he criticises the biological model of medicine and argues that the fundamental causes of disease and illness in South Africa are to be found in the structure of apartheid.



For others the crisis facing modern medicine is not a technological one but an economic one as health care costs escalate at an increasing pace and as evidence mounts that countries that spend the most on health do not necessarily have the best health.

For yet others the crisis in modern medicine involves the maldistribution of health resources, with the bulk of these resources being devoted to curative medicine, so much so that 50% of the health care expenditure in the Western world is being spent on people who will die within the next 12 months.

In addition, medical resources have been distributed so that they are concentrated into areas where health needs are the lowest and conversely are most sparse where death and disease are the greatest.

However specified, it is increasingly evident that medicine is having to face a critical appraisal of its effectiveness, and that health is far too serious a matter to be left solely in the hands of the health professionals.

In my view, the critiques of medicine such as those above, have generally been far too narrow and simplistic and have failed to reach into the heart of the complex issue of what accounts for the development and underdevelopment of health, particularly within South African society.

The particular failings of the South African system of health care are not hard to discover, indeed many of these failings have long been recognised. One can briefly enumerate the chief of these failings (not in any necessary order of importance) that have helped produce the current crisis in South African medicine.

1 Medical resources are devoted to curative medicine rather than to preventative medicine, or to health services which inhibit the occurrence of illness or remove the situation in which illness is likely to occur.

It has been estimated that only 2% of expenditure on health care in South Africa is devoted to preventative medicine.

2 South African medicine is organised primarily to serve the needs of white population and the urban population, although the bulk of disease and suffering is among the black population and occurs in rural areas.

One reflection of this white urban bias, in place of a needed black rural bias of South African medicine is found in the distribution of doctors in South Africa.

Recent figures indicate that some 81% of all doctors live in urban areas where only slightly more than a third of the population live, while only 2,8% of all doctors work in the so-called bantustans.

One consequence of this is that some 39% of all registered doctors serve the metropolitan areas of Johannesburg and Cape Town while an area such as QwaQua, with a population of 250 000, has only two doctors.

3 South African medicine has concentrated its resources on technological medicine and has become hospital-centred rather than concentrating its resources on primary health care.

Its medical system has spent R156-million to erect the central disease palace of Johannesburg General Hospital which is a sum greater than that able to be spent on primary health care services annually by most of the so-called black states.

4 South African medicine is characterised in its organisation by having weakly developed ancillary services.

The dental services in South Africa have been described by a Minister of Health as being "so inefficient, unbalanced and unco-ordinated" that they fail to meet the needs of the country. Similarly, within the three black townships of Cape Town there is not one pharmacy for the use of the population and residents have to leave the townships to obtain drugs if clinics are not open.

One does not have to quantify the obvious: the number of qualified dentists, pharmacists, ophthalmologists, or more importantly, the number of health visitors and health education is severely limited, as is the number of institutions available, particularly to the black population, to serve the needs of the mentally ill, the handicapped or the elderly.

In sum, ancillary medical services are in chronically short supply and are weakly developed.

5 The education and training of doctors has been oriented toward the curricula of developed Western countries, rather than designed to train doctors for their role in this country and equip them to mount an assault on the major diseases found in this society.

Clear illustrations of this are found in medical curricula in the de-emphasis on the teaching of community health, the fundamental disregard of teaching of social science subjects, and the lack of integrating teaching in both a rural and an urban setting.

6 There is a heavy expenditure on pharmaceuticals, with an estimated 21% of total health expenditure in South Africa being used to purchase pharmaceuticals.

Many of these pharmaceuticals appear to be artificially priced by monopolies.

In addition, there is a tendency for medicines to be wastefully and inappropriately used; polypharmacy is rife with a result that 25% to 30% of hospitalised patients suffer complications as a result of adverse drug interaction.

8 South African medicine is skewed toward providing services for the affluent and the rich, and dealing with the diseases of opulence and, conversely, it is skewed away from providing adequate health care coverage for the poor and for workers.

One indication of this is provided by the relative emphasis placed on care for victims of heart disease as opposed to the lack of emphasis placed on the promotion of industrial health.

8 South African medicine is dominated and controlled by whites and is deeply permeated by the structure of apartheid.

Medical professionals are trained in different institutions according to their skin colour and generally are paid differently — thus, for instance, South Africa pays its nurses according to their colour, although the Minister of Health has indicated that it would only cost R51-million per year to give equally qualified nurses the same pay.

Similarly, gross segregation runs throughout the bulk of medical facilities available to the population and thus inevitably many, if not most, of these facilities are not equal either in terms of their physical capacities, physical quality, or in terms of the quality of care that they are able to offer.

There can be no other country in which the duplication of expensive services on the ground of colour is the norm.

Most vitally, though, apartheid has meant that the majority of the population is shut out from any real part in the political decisions shaping South African medicine and cannot participate in the design of services, in decisions about the distribution of medical resources, or in decisions about the developments and future directions that medical services are to take.

That a few blacks in some "homelands" can help decide about the framework of medicine in limited geographical areas merely gives emphasis to the far more important feature of the general exclusion of blacks in the control and design of the national health policies.

9 One cumulative result of the previous characteristics is that South Africa cannot be said to have a health system.

Instead it has a disease service, and one which concentrates on the diseases of the affluent and on curing those diseases found in the septic fringes of its large cities.

The South African system of medicine is thus not organised in order to promote health but rather organised around the attempt to deny disease.

All of these nine features of South African medicine severely limit its growth as well as attempts to develop health in this society. Because these features did not somehow miraculously descend from above to dictate the form of medicine in our society, we must now ask why is it that South African medicine has such characteristics?

In large measure the answer to this question is found in the way in which health has been defined in this society.

Crudely put it can be said that the dominant definition of health has asserted that health is the absence of disease.

While at first glance such a statement might seem tautological, it is not; for contained within it is the critical assumption that the primary determinants of health and illness are predominantly biological. If disease is what causes ill-health, then according to this definition of health, it is disease that should be removed in order to promote good health.

From this proposition flows the belief that the medical professions should engage in a clinical and biological attack on the sources of disease for their task, and the task of scientific medicine, is to mediate between people and disease.

Implicit in this orthodox medical approach are a range of assumptions, mainly assembled around a germ theory of disease. The germ theory of disease has long occupied the central part of the medical stage and it has been believed that to prevent or treat disease it is only necessary to break the most important link in a causal chain.

However, the correct model for interpreting disease is more that of an interconnected web than that of a chain.

Medical technology can only play a limited role in affecting some of the factors in this causal web, as can be seen by the fact that such technology has not been markedly successful in reducing morbidity or mortality rates in any large population.

If medicine separates itself from attempting to influence those other factors in the web not directly amenable to its technology then it cannot be effective in promotion health.

To attack germs is only one severely limited way of mediating between people and disease.

Increasingly it has come to be realised that economic and political factors are the major contributors to the rates of morbidity and mortality in all societies. Much, if not most, of the progress in any nation's health status is provided when alterations in its political and economic environment occur.

TB declines when malnutrition, inadequate housing and wages improve; rheumatic fever declines when overcrowding and poverty are effectively attacked; typhoid declines when sanitation and water supplies are improved; in short, most diseases are best combated not by medical technology but by significant alterations to the political economy of society.

All this then points to the fact that it is exceedingly difficult to demonstrate that resources spent in South Africa on medical care could not be more effectively spent in an effort to improve the general health of a population by providing adequate houses, living wages, stable family conditions and in general by creating an environment in which constructive economic and social development can occur.

However, South African medicine is not organised in a manner which recognises this. Instead it has adopted a technological and physiological approach to the promotion of health.

It is precisely the adoption of this biological-medical model that has resulted both in the tremendous stress placed on curative medicine in South Africa and also in the emphasis placed on the provision of hospitals, doctors and drugs.

South African medicine thus has concentrated on attacking symptoms instead of the ultimate causes of disease and ill-health.

Recently the director of the Charles Johnson Hospital in KwaZulu stated that he believed TB to be on the increase in the area of this hospital due to the combined effects of resettlement, poverty, malnutrition, overcrowding, which he described as "a positively lethal combination", particularly when coupled with the factors of family breakdown, migrant labour, poor agricultural development, non-existent labour opportunities, limited land resources and the efforts of people to support themselves on reduced remittances from migrant labour.

Against such a background there was, he believed, no possibility for a decrease in TB.

Similarly, other doctors in rural areas have reported that their medical work against such a background has little impact on the incidence of the predominant diseases, which are associated with malnutrition, in their areas.

Also within urban areas it can be asked whether there is any real hope of removing typhoid from among the 50 000 residents of Alexandra, one of the oldest black townships of Johannesburg, when this area has no water-borne sewerage system for its householders and operates on bucket system for the removal of human waste?

Likewise, is it possible to combat a broad spectrum of ill-health in Soweto when recent estimates indicate that some 43% of Soweto households fall below the primary poverty datum line and an estimated 80% of households fall below what can be termed the human standard of living?

Clearly medicine cannot become effective and adequately promote health in this society until it goes beyond dealing with the symptoms of ill-health and beyond pumping "magic bullets" and potions into individuals who are ill.

In short, medicine will only promote health in a society if it acts on the recognition that the primary determinants of health and illness are social and political phenomena.

To become effective medicine must become involved in combatting social policies in South Africa which are associated with widescale poverty, malnutrition and join in the promotion of stable family life, adequate wages, employment opportunities, better agriculture and effective participation by communities in decision-making processes.

No amount of technological medicine will be able to stem an increasing tide of illness until such time as this technology is associated with efforts to promote a just social system.

INSIDE MA

IT IS widely agreed that modern medicine is going through some sort of a crisis.

The precise nature of this crisis is a source of considerable debate. For some the crisis stems from a growing realisation that medicine is technically ineffective in improving the health of large populations, for most major improvements in health have not been due to medical technology or the intervention of trained medical personnel.

Thus, for instance, the reduction in TB rates in the developed world took place long before the drugs of the 1930s and 1940s, and even since them it is doubtful that medical intervention has been the decisive factor in any decline of this disease.

The technology of medicine likewise has been ineffective in combatting the major killers of mankind — malnutrition, heart disease, cancer and so forth — and increasing doubt is being expressed about the efficacy of medical treatments (so much so that a recent commission in the United States found that only 10% to 20% of treatment has been validated by the hard test of a controlled trial).

HEALTH AND DISEASE —

GENERAL.

10/1/81 — 31/12/81

STAATSKOERANT

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ALGEMENE KENNISGEWING

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

Die volgende konsepwetsontwerpe word hierby vir algemene inligting en kommentaar gepubliseer.

Kommentaar daarop en vertoe daaromtrent moet voor of op 4 Februarie 1981 aan die Direkteur-generaal: Gesondheid, Welsyn en Pensioene, Posbus 3879, Kaapstad, 8000 gerig word:

(a) Wysigingswetsontwerp op Gesondheid, 1981;
(b) Wysigingswetsontwerp op Voedingsmiddels, Skoonheidsmiddels en Ontsmettingsmiddels, 1981;
(c) Wysigingswetsontwerp op Gevaarhoudende Stowwe, 1981;
(d) Wysigingswetsontwerp op Geestesgesondheid, 1981.

GENERAL NOTICE

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

The following Draft Bills are hereby published for general information and comment.

Any comment and representations thereanent should be forwarded to the Director-General: Health, Welfare and Pensions, P.O. Box 3879, Cape Town, 8000 on or before 4 February 1980.

(a) Health Amendment Bill, 1981;
(b) Foodstuffs, Cosmetics and Disinfectants Amendment Bill, 1981;
(c) Hazardous Substances Amendment Bill, 1981;
(d) Mental Health Amendment Bill, 1981.

● If drug tests true —a 'catastrophe'

● 11 000 000 are at risk

● People follow doctors' advice

Argus 10/1/81

(85)

Cancer scare

A REVOLUTIONARY drug tested on South Africans and prescribed by millions throughout the world with digestive trouble since it was first marketed in Britain four years ago is strongly linked to stomach cancer in a study by a leading British gastroenterologist.

The drug, Cimetidine, is made by the international pharmaceutical firm Smith Kline and French (SKF) under the trade name Tagamet.

The study was undertaken by Dr Peter Reed, consultant physician and senior lecturer in medicine at the Royal Post Graduate Medical School, Hammersmith, and East Berkshire Hospital.

If the suspicions raised are confirmed, it would be, in the words of a member of Britain's drug 'watchdog', the Committee on Safety of Medicines (CSM) 'a major catastrophe.'

Unlikely

He added that if SKF was seeking marketing approval for cimetidine today, 'the doubts raised by Reed and others would make it extremely unlikely for approval to be granted.'

Cimetidine, the result of eight years' research at SKF's laboratories at Welwyn Garden City, Hertfordshire, was the first of a new series of drugs named H2-Blockers and was hailed as a 'pharmacological revolution.'

With a pill, doctors could achieve what only the surgeon's knife could do before — cut down the stomach's production of acid and maintain it at that level, thus doing away with the chief cause of peptic ulcers.

The Reed study reinforces another serious doubt about H2-blockers disclosed last summer, when Imperial Chemical Industries announced that it had ceased research on its version (tiotidine) because, the company said, tumours had been found in the stomachs of rats given the drug.

A quarter

Dr Reed agrees that cimetidine has its uses. He prescribes it for short periods to patients 'for whom alternative treatment is not possible or has failed — about a quarter of all ulcer patients.'

But he is deeply worried by its use for digestive ailments far less serious than ulcers. Although SKF cites one study showing that 70 percent of prescriptions are given to ulcer sufferers, one enthusiastic doctor has described cimetidine as 'the ultimate cure for bellyache.' Such sentiments most concern gastro-enterologists such as Dr Reed.

Bleeding

SKF scientists began research in 1964 for a drug effective against peptic ulcer, a disease that affects up to 90-million people and can result in fatal bleeding.

Treatment then consisted mainly of antacids, or, in severe cases, surgery. But the best antacids are taken in such high doses that people often give up before their ulcers heal, and surgery has its problems.

The acid

It involves either removing the ulcerated part of the stomach or severing the vagus nerve fibres, which 'tell' the stomach to produce the acid needed to facilitate digestion. Too much stomach acid has long been known to play a key role in causing ulcers.

Both surgical procedures expose patients to increased risks of developing cancer years later.

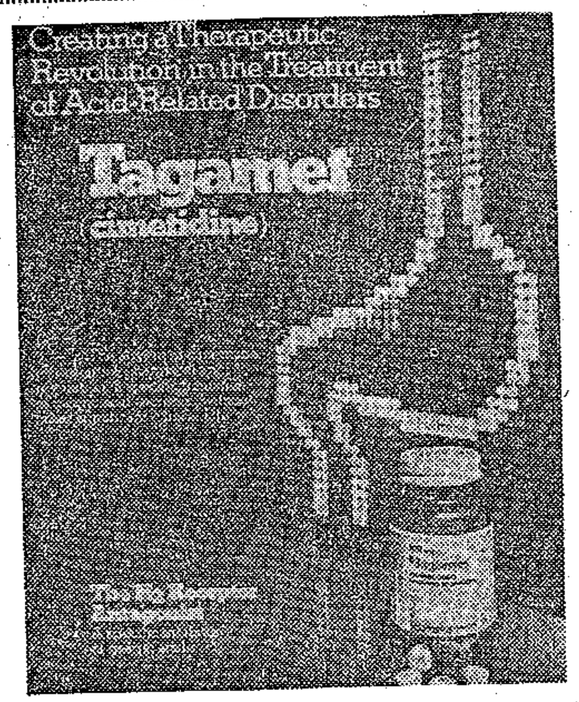
Initial tests showed that cimetidine reduced gastric acid secretion by over 80 percent. Treated rats and dogs, SKF reported, showed no signs of malignancy in the digestive tract. And among the first 3 000 patients given the drug in tests in the UK, Europe, and South Africa, the only side-effects reported were diarrhoea, tiredness, dizziness and rash — in too few patients to be considered significant.

Effective

In 1976 Britiain's Committee on Safety of Medicines (CSM and America's Federal Drug Administration (FDA) declared cimetidine effective and safe.

Over the next three years, of the one-million people treated with cimetidine in Britain alone, only about 3 000 (0,03 percent) complained of side-effects, most of them minor.

Reports from doctors described the drug in glowing terms.



IN an exclusive report, JOHN MAURICE lifts the lid on a medical controversy. Millions of ulcer sufferers take a prescribed drug which might plant the seeds of cancer. . . . Tests are inconclusive, but the medical profession is seriously concerned by the implications of sober, scientific research.

gastroscope and saw something suspicious in her stomach. We took a biopsy. To our surprise the diagnosis came back: 'Very early cancer.'

Part of the surprise was the fact that the patient had been suffering from ulcer in the duodenum, whereas the cancer developed in the stomach.

animals. This pushed Mr Elder into making his worries public.

A paper by Dr Elder and his co-workers in 1979 raised the possibility that cimetidine might contribute to the development of gastric cancer. It sparked off a lively controversy.

field. One must treat the elder hypothesis seriously and investigate it, but it's certainly not scientific to make extrapolations from such a hypothesis.

'I don't think we should duck the problem or pretend that it's not an issue, but I do think that the technology and knowledge of this field are so poor and the relationship between the test-tube and the live human being so distant, that what we should be doing is investigating the problem and not speculating.'

Situation

And Dr Bill Burland, SKF's director of clinical research and development, UK, said: 'We would certainly like to clarify the whole situation. But it is very difficult to determine what is happening in gastric juice, not just in cimetidine-treated patients but in other conditions in which nitrosamines have been implicated.'

Meanwhile, Dr Reed was presenting the early results of his studies. Since Hamburg he has been analysing and completing his findings.

Using a new method developed by Dr Clifford Walters to measure N-nitrosamine levels in gastric juice, Dr Reed tested over 300 individuals.

He found that:

● In the group as a whole, the lower the stomach acid levels, the higher the N-nitrosamine concentrations and vice versa;

● When the individuals were grouped by the 'state of their stomachs' — from healthy people, to patients with pernicious anaemia, who have a high risk of stomach cancer and virtually no stomach acid — there was 'a close relationship' between low stomach acidity and high N-nitrosamine levels, and a high risk of stomach cancer; and

● For the patients as a whole, those who had been treated with cimetidine (about half) showed significantly higher N-nitrosamine levels than those who had not been treated with the drug.

Dr Reed and Dr Elder agree that their researches do not prove cimetidine is carcinogenic — and certainly do not suggest that every patient who has taken the drug is at risk. However, they believe the evidence is disturbing.

How worried are the drug supervisory bodies?

Happy

Professor Dennis Parke, professor of biochemistry at the University of Surrey, says: 'The manufacturers have been very responsive and have done excellent studies. We were very happy with these studies . . .'

A year

Within a year of its launch, the drug had been given to 1 300 000 people. Now about 11-million sufferers have taken it in more than 100 countries. The manufacturers tell doctors in their advertising: 'Tagamet is so effective, it has become part of your daily routine.'

A standard, one-gram daily course of treatment costs R63. World sales for 1980 have been estimated at over R360-million.

Smouldering

Fears that cimetidine may have carcinogenic (cancer-causing) potential have been smouldering for the past two years. But partly because so many cancer 'suspects' have been alleged, the doubts have not been investigated.

By mouth

Cimetidine taken by mouth, stops the stomach producing too much acid. The cells on the stomach wall do not begin secreting acid until they get a message from the body 'delivered' mostly by a substance called histamine. This latches on to a slot or 'receptor' on the surface of the cell. If these receptors are 'blocked' less acid is produced.

SKF tested about 1 000 compounds before coming up with cimetidine.

No trigger

Its molecule is similar enough to histamine to fit the histamine-receptor (known as H2-receptor) slots and prevent true histamine from latching on. But the cimetidine molecule does not trigger off acid secretion.

Daily dose

After four to six weeks on a daily dose of four or five cimetidine tablets (one g in all), 70 to 95 percent of patients showed healing of their ulcers. It also proved extremely effective in relieving ulcer pain.

SKF was happy. Doctors were happy. Millions of patients were happy.

The first clouds appeared early in 1979.

'When cemetidine came out, I, like many others, was keen to try it on my patients with long-standing peptic ulcer disease,' recalls Dr James Elder of the University of Manchester and consultant at the Manchester Royal Infirmary.

Two pills

'One patient I gave cimetidine to had been having recurrent duodenal ulcers for five years. She responded fantastically to a 12-week course of cimetidine and I put her on a maintenance regimen of two tablets (400 mg) at bed-time.

'Eight months later we examined her with a

Two more

After two other Manchester Infirmary patients treated with cimetidine were found to have gastric cancer, Dr Elder consulted Professor Allan Foster of the Chester Beatty Research Institute in London.

Professor Foster examined cimetidine's chemical structure and declared that it 'could nitrosate' — meaning it could be converted by the body into Nitrosocimetidine, one of a class of substances comprising some of the most powerful known cancer-producing agents — the N-nitroso compounds.

Structure

Foster also found that N-nitrosocimetidine bore a close resemblance, in structure and activity, to MNNG, discovered in 1967 by Professor Takashi Sugimura of Tokyo's National Cancer Research Institute to be the most potent gastric carcinogen identified in

Conference

In January, 1980, the three firms in the H2-Blocker field — SKF, ICI and Glaxo — sponsored an international conference on the safety of nitrosatable drugs in London.

But the conference settled nothing. Most speakers in fact agreed nothing could be settled until adequate techniques were developed to identify individual N-nitroso compounds, particularly N-nitrosocimetidine, in humans — if it were indeed present.

Five months later the issue was discussed again at the ninth International Congress of Gastro-enterology in Hamburg — but again was left undecided.

Confused

In Hamburg Dr Roger Crossley, vice-president of clinical research and development at the headquarters of SKF's parent company in Philadelphia, said: 'It's a very confused, poorly understood

However, he says, the CSM is 'very concerned' over doubts being raised about the drug.

'But as yet we have no evidence to say it is unsafe.

'I and many of us hope that this whole business turns out to be a red herring — with all the millions of people who have taken the drug. If not, it would cast doubt on the whole basis on which we determine drug safety.'

Restrictions

In the US the FDA's approval of the drug in 1976 was for short-term use only. Last April the FDA authorised its use in long-term therapy, although, as the FDA's Dr Thomas Q Garvey points out, restrictions have recently been added. 'We have instructed the manufacturers to state on the label that the drug is to be used for long-term therapy only in patients in whom recurrence of the ulcer might require surgical intervention and does not exceed 400 mg a day.

Ailments

But what about uses of the drug for less serious ailments?

Dr Garvey agrees that cimetidine is used 'for a whole batch of diseases of varying severity caused by over-production of pepsin and acid,' but not, he says, 'on a long-term basis, and after only a month of two of the treatment it's highly unlikely that anyone will develop a cancer, although it's not impossible.'

Results of tests now being carried out by SKF and in other centres in animals will be crucial. Most are continuing and those which have been completed have produced contradictory results.

While the doubts persist, experts are deeply divided on how cimetidine should be used.

Dr John Alexander-Williams, consultant surgeon at Birmingham General Hospital, sees no cause for alarm or even worry over the drug.

'It's the equivalent of surgery with the advantage of being reversible. And if a physician gives it to a patient for life, he's only doing what an operation does.'

A purpose

However, on the reasonable assumption that 'God put acid in our stomachs for a purpose and it's generally a bad thing not to have acid there,' Dr Alexander-Williams is planning a study comparing a time-honoured drug like carbenoxolone, which increases the resistance of the stomach to damage from acid, with an H/H2-blocker.

A more worrying view is put by Dr Reed and Dr Elder, who are particularly concerned over the use of the drug for uninvestigated digestive complaints.

An ulcer

Dr Reed says: 'Time and again I see patients who come to me with a note from their doctor, saying: "This patient has dyspepsia. I have started him on cimetidine. Please see if he has an ulcer."

Dr Reed also feels over-zealous use of cimetidine could lead to delays in diagnosing stomach cancer, since, as SKF agrees, the drug may alleviate symptoms of malignancy.

Dr Elder says Cimetidine is 'an excellent drug — it's the way it's being used that's dangerous. And it's not like cigarettes, where an individual can take it or leave it.

The way

'Most people follow a physician's advice. It's the accolade given by the medical profession to this drug that worries me. Perhaps we haven't been critical enough of the way we use Cimetidine.

'And remember,' he adds, 'it took many years before a cast-iron link was established between cigarettes and lung cancer. Are we just to sit back and wait for evidence while our patients take part in what may amount to human experiments?'

Poisoned bread in Natal: 2 die, 23 ill

C.T. 24/11/81 (166) (85)

Own Correspondent

DURBAN. — Two people have died and 23 have been admitted to hospital after eating suspectedly poisoned bread sold in the Richards Bay/Empangeni area of Natal.

A dock worker at Richards Bay went into convulsions while working on a ship, fell into the bay and drowned before he could be reached.

A second dock worker had convulsions and died before he could be taken to hospital.

Twenty-three people were admitted to the Ngwelezane hospital near Empangeni suffering from convulsions and doctors treated other people at home.

Panic spread through the Zululand area yesterday when it was discovered that 2 400 loaves of brown bread possibly containing a dangerous poison had been sold on Thursday.

Shops were inundated with telephone calls and residents flocked to stores to return bread.

Tests on the samples of bread, which was sold out at the Zululand outlets, are being carried out by International Consulting Laboratories in Durban. A spokesman for the laboratories said the results might not be known until Monday.

The first indication of the suspected bread posioning appeared on Thursday morning when a driver working for a Richards Bay bakery complained that he was feeling ill.

At 1 pm on Thursday a worker painting the deck of a ship at Richards Bay suddenly had convulsions and drowned after falling into the sea.

Soon after, another worker in the harbour area showed similar symptoms and died before he could be taken to hospital. Post-mortems are being held.

said: "We immediately contacted local radio stations to warn Zululand residents once we suspected that the batch of 2 400 loaves might contain poison."

It is suspected that the bread was contaminated by flour transported by train from a company in Durban to Richards Bay.

Railways authorities and the Railways Police are investigating the possibility that the truck used to carry the 270 bags of flour may have previously carried poison and that 'the flour may have been contaminated in transit

'Against policy'

A spokesman for the SAR in Richards Bay said it was strictly against their policy to use for the transportation of foodstuffs trucks which had carried any other goods, but the possibility that this had happened was being investigated.

Although all cargo records were computerized, the trucks' contents of the past few weeks would not be known until about Wednesday, he said.

Convulsions

The medical superintendent of the Ngwelezane hospital, Dr M Girdwood, said 23 people had been admitted on Thursday night suffering from convulsions, apparently caused by a chemical poison which attacked the central nervous system. However, all had recovered during the night and some were discharged yesterday morning.

Doctors in the Zululand area reported that they had treated a number of people with diarrohea symptoms, possibly caused by a mild form of poisoning.

The manager of the Richards Bay bakery which baked the suspect bread, Mr Cliff Webb, The owner of the transport firm which carried the flour from the railway depot to the bakery said their lorries were used only for the transportation of foodstuffs and clothing. There was no chance that the flour had been contaminated while it was in his company's care.

A spokesman for the group of which the Richards Bay bakery is a member said it was believed that the poisoning was caused by their bread.

"One of our bakers smelled the flour early on Thursday and suggested it might be contaminated. We informed the public," he said.

Staff of the Empangeni War Memorial Hospital are on stand-by, but by late last night no victims of suspected poisoning had been admitted there.

Tests on samples of the bread are being done by International Consulting Laboratories in Durban, but a spokesman said the results might not be known until Monday.

On Thursday morning a driver for Richards Bay Bakery complained he was feeling ill.

At 1pm, a dock worker on a ship at Richards Bay had convulsions — and fell overboard and drowned.

Shortly afterwards, another worker in the harbour area also had convulsions — and died before he could be taken to hospital.

Post mortems are being done.

The medical superintendent at Ngwelezane Hospital near Empangeni, Dr M Girdwood, said 23 people were admitted on Thursday night with convulsions, apparently caused by a chemical poison which had attacked the central nervous system.

All recovered during the night and some were discharged yesterday.

Doctors in the Zululand area said that a a number of people with symptoms of diarrohea — caused possibly by a mild form of poisoning — had been treated.

An SAR spokesman at Richards Bay said it was strictly against Railways policy to transport foodstuffs in trucks which had carried other goods — but the possibility that this had happened was being investigated.

Though all cargo records were computerised, the contents of trucks for the past few weeks would not be known until about Wednesday, he said.

The owner of Enselni Transport, which carried the flour from the Railways depot to the bakery, said their trucks were used only for transporting foodstuffs and clothing. There was no chance it had been contaminated while it was in his company's care.

A spokesman for Sasko — Richards Bay Bakery is part of the Sasko Group — said he believedthe poisoning was caused by their bread.

"One of our bakers smelled the flour early on Thursday and suggested it might be contaminated. We informed the public," he said.

Poisoned loaves fear after two die

RDM 24/1/81
(85)

Own Correspondent
DURBAN.

TWO people have died and 23 been given medical treatment on the Natal North Coast after eating suspected poisoned bread.

Panic spread through the Richards Bay-Empangeni are of Zululand area yesterday when it was discovered that 2 400 loaves of brown bread — possibly containing highly dangerous poison — had been sold on Thursday.

Mr Cliff Webb, manager of Richards Bay Bakery, the company which made the bread, said: "Once we suspected that the batch of 2 400 loaves might contain poison, we immediately contacted local radio stations to warn Zululand residents."

It is suspected that the flour used to make the bread was contaminated while being transported by train from the Sasko company in Durban.

Railways authorities and SAR Police are investigating the possibility that the truck used to carry the 270 bags of flour might have carried poison previously.

FINE ART & ARCHITECTURE

Cape Provincial Institute of Architects' Prize
For the best student in :-

Sixth Year
P F Dunckley

Helen Gardner Travel Prize
For a student who has satisfactorily completed 1st, 2nd and 3rd major courses.
P A Rappoport

Molly Gohl Memorial Prize
For the best woman student in third year.
Miss C Tredgold

David Haddon Prize
For the best student of Architecture (or Quantity Surveying) in the subject of Professional Practice.
D H Pryce Lewis

General J B M Hertzog Prize
For the best final year student.
S A Read

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D H Pryce Lewis

General J B M Hertzog Prize
For the best final year st

S A Read

Osbourn Prize
For the best work in fourt year.

D H Pryce Lewis

John Perry Prize
For the best work in third year.

R A van Rosenveld.

Hunt to find poison source

By RAY JOSEPH

CHEMISTS in Durban are working round the clock analysing samples of suspected poisonous bread after two people died and another 53 were admitted to hospital in the Richards Bay-Empangeni area.

A spokesman at the laboratory conducting the tests said yesterday that tests were "proceeding at the moment, but we do not have a positive result as yet."

Mr Cliff Webb, manager of the Richards Bay bakery which made the bread, said yesterday that 2 400 brown loaves had been sold from the suspect batch.

"But today (Saturday) many of our trucks are coming back with full loads. People are not accepting the bread," he said.

The two dead men were both dock workers at Richards Bay harbour.

One suffered convulsions and fell into the harbour and drowned, while the second went into convulsions and died before he could be taken to hospital.

Discharged

Panic spread through Zululand on Friday as people converged on shops to return bread.

Railways police are investigating the possibility that a truck which transported flour to Richards Bay may have earlier carried poison and that the flour was contaminated in transit.

Dr M Girdwood, superintendent of the Ngwelezane hospital — where 53 people were treated — said the last admittances were at 10 pm on Friday.

All those treated had eaten bread and came from the area between Richards Bay and Empangeni. Most had now been discharged, and none were serious.

"The symptoms were fairly alarming. They were all suffering from convulsions, which were apparently caused by a chemical substance attacking the nervous system," he said.

The bakery manager said the affected flour had been isolated and "there is nothing wrong with the flour we are using now."

Panic as hundreds of loaves of bread are dumped

VICTIMS . . . 17-year-old Ntomiza Sithole (left) suffered stomach pains and felt nauseous and Nkosini Majola, 36, blacked out

S. Tribune 25/1/81 (85) (184)

By TICKS CHETTY

PANIC-STRICKEN white and black families in the Empangeni and Richards Bay areas in Natal have dumped hundreds of loaves of bread after two people died and 45 were admitted to hospital after eating suspected poisoned bread.

Authorities are baffled as to why the bread which is sold to all races, affected only blacks.

Those who were hospitalised on Thursday and Friday, suffering from convulsions, have all been treated and discharged.

Ten more admitted yesterday are being kept for observation.

The bread dumping started after two Richards Bay dock workers died after suffering severe stomach convulsions.

It is suspected the bread was contaminated by flour which was transported by train from the Sasko company in Durban to Richard's Bay Bakery, which is part of the Sasko group.

Tests on samples of the bread which were sold at outlets in Empangeni and Richard's Bay, are being conducted at a laboratory in Durban.

Analysts are presently working flat out on the tests but the results are expected to be known only by Mon-Monday.

Mr Webb, the Richards Bay Bakery manager, said the panic had caused stores in the Empangeni and Richards Bay areas to stop buying their bread.

"We haven't assessed our losses yet but we know that hundreds of loaves of bread have been dumped by people. Several shops have also returned their supplies to us."

He urged people not to fear that the bread now being delivered was affected in any way because new stocks of flour were now being used by the bakery.

Dr M. Girdwood, superintendent of Ngwelezane Hospital in Empangeni, said yesterday that although the symptoms displayed by those admitted to hospital suggested poisoning, he could not say for sure that the bread was responsible.

"Until we know the results of the tests being carried out on samples of bread and the post-mortem findings on the two dock workers who died, we cannot speculate about the causes."

Railway Police are investigating.

Thornton White Prize
the best work in
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M F J Sandilands

rick Association Prize
he student who has made
use of bricks in his
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irkman

bbs Award
he best project in
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R W Kohne

Second Year
C S Jones

Third Year
B de Jong

First Year
J A L C

Call for stricter firearm laws

Own Correspondent

CAPE TOWN. — The principal surgeon and clinical head of surgery at Johannesburg's J G Strijdom Hospital, Dr G A G Decker, has called for a tightening up of laws regarding possession of firearms.

In the latest South African Medical Journal, he says that during the first 11 months of 1980, 18 whites were admitted to his hospital's general surgical wards for treatment of gunshot wounds.

"In only two cases were the wounds sustained as a result of armed robbery. Seven were shot because of a dispute with a member of the patient's family, or as a result of a brawl in a bar. In eight of the patients the injuries were self-inflicted as a result of attempted suicide or accidental firing of the firearm.

"One of the patients was a 17-year-old girl who happened to be in the line of fire of a drunken 24-year-old man brandishing a pistol while allegedly trying to help a relation who was being assaulted in a bar lounge of a hotel. The girl sustained a penetrating abdominal wound with injury to the right kidney and stomach.

"The man who fired the pistol was found guilty of being in illegal possession of a firearm and ammunition. He was cautioned and discharged."

Dr Decker said it was obvious that too many South Africans owned firearms. Many of these people were emotionally unstable and untrained in their use.

"Is it not time the laws concerning the possession of firearms were changed to ensure that only carefully selected applicants are granted a licence to possess a firearm?" the doctor asks, saying our laws do not offer an adequate deterrent sentence that will prevent the irresponsible use of firearms.

Dr Decker believes the experience of gunshot wounds at the J G Strijdom Hospital is probably not unique and that most urban hospitals could produce similar figures.

Unfortunately, he says, many victims never reach hospital, but go directly to the mortuary.

RDM 26/1/81

Thousands of loaves dumped in poison fear

Own Correspondent

DURBAN. — Thousands of loaves of bread have been either dumped or returned to shops in Empangeni and Richards Bay in Natal, following the discovery that 2 400 loaves of brown bread sold on Thursday might have contained poison.

Two people have died and thirty-six others have been admitted to hospital with suspected food poisoning.

It is thought that the flour used to bake the bread was contaminated with poison while being transported by train from the Sasko company in Durban to Richards Bay Bakery.

Dr M Girdwood, superintendent of Ngwelezane hospital at Empangeni, has appealed to people living in the area not to panic. He said the situation was under control.

He said more than 65 people had been in hospital for observation, many with stomach cramps or headaches, but that the bread had not yet been proved to be the cause of poisoning.

People were over-reacting, he said, and attributing all kinds of symptoms to poisoned bread.

"The whole thing is getting out of hand — I think everyone should calm down."

The first sign that the bread might have been poisoned appeared on Thursday morning, when a Richards Bay Bakery driver complained he was feeling ill.

Hours later, two dock workers died, both as a result of convulsions.

A spokesman for the State Health Department in Durban, who are monitoring the situation, said most of those admitted to hospital had already been discharged.

"The bread is being analysed in Durban and the results are expected to be released early next week," he said.

Meanwhile, bread sales at Richards Bay Bakery have dropped dramatically, with people either baking their own bread or buying from other outlets.

The area manager for Sasko, Mr Rob Bradbury, said the bakery had suffered a substantial loss of trade.

He said there had been "a lot of consumer resistance, and quite big cuts in orders from our retailers".

He said: "Our main concern is that if something was wrong with the bread it should be put right.

"We will continue to give top service as in the past and we hope our business will come back."

D H Pryce Lewis

of Professional Practice.

For a student who has
satisfactorily completed
1st, 2nd and 3rd major courses.

P A Rapoport

Molly Gohl Memorial Prize
For the best woman student
in third year.

Miss C Tredgold

David Haddon Prize
For the best student of
Architecture (or Quantity
Surveying) in the subject

Helen Gardner Travel Prize

FINE ART & ARCHITECTURE

ARCHITECTURE

Cape Provincial Institute
of Architects' Prize
For the best student in :-

Sixth Year

P F Dunckley

†Indicates translated version.

For written reply:

Emigrants

2. Mr. N. B. WOOD asked the Minister of Statistics:

(1) How many (a) Whites, (b) Coloureds, (c) Indians and (d) Blacks in the different professions associated with health services emigrated from South Africa during the last 12 months for which figures are available;

(2) what is the number for each race group in each such profession?

The MINISTER OF STATISTICS:

Preliminary figures for 1980 are as follows:

(1) (a) 227.

(b), (c) and (d) 24 (separate figures not available)

(2)

	(a)	(b), (c) and (d)
Medical doctors	59	4
Dentists	18	1
Veterinarians	10	—
Pharmacists	12	1
Dietitians	2	1
Professional nurses	96	16
Nursing personnel not elsewhere classified	1	—
Optometrists and Opticians	3	—
Physiotherapists	8	—
Radiographers	10	1
Osteopaths	9	—
Total	227	24

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

(1) (a) 111.

(b) 93.

(2) 1 January until 31 December 1979.

Doctors/dentists/pharmacists: salary scales

18. Mr. N. B. WOOD asked the Minister of State Administration:

What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Black (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services?

The MINISTER OF STATE ADMINISTRATION:

(a) to (d)

Rank	Salary Scale (R.P.A.) White	Coloured/ Indan	Black
(i) Doctors			
Chief Specialist/ Professor	26 700 (fixed)	26 700 (fixed)	26 700 (fixed)
Principal Specialist	24 000 (fixed)	24 000 (fixed)	24 000 (fixed)
Chief Medical Superintendent	23 100 (fixed)	23 100 (fixed)	23 100 (fixed)
Senior Specialist			
Senior Medical Superintendent	22 200 (fixed)	22 200 (fixed)	22 200 (fixed)
Principal Medical Officer			
Specialist			
Medical Superintendent	20 400 (fixed)	20 400 (fixed)	20 400 (fixed)
Senior Medical Officer			
Medical Officer	11 550-18 840	11 550-18 840	10 650-18 180
Registrar			
(ii) Dentists			
Chief: Dental Services	24 000 (fixed)	—	—
Principal Dentist	22 200 (fixed)	22 200 (fixed)	22 200 (fixed)
Senior Dentist	20 400 (fixed)	20 400 (fixed)	20 400 (fixed)
Dentist	11 550-18 840	11 550-18 840	10 650-18 180
(iii) Pharmacists			
Chief: Pharmaceutical Services	22 200 (fixed)	—	—
Chief Pharmacist (Provincial Services)	17 520-20 400	—	—
Principal Pharmacist	14 220-17 520	13 560-16 860	12 450-15 540
Senior Pharmacist	11 550-14 220	10 650-13 560	9 750-12 450
Pharmacist	7 740-11 100	7 080- 9 300	5 745- 8 070

For written reply:

Black states: doctors/dentists/chemists and druggists/ veterinarians/nurses

10. Mr. N. B. WOOD asked the Minister of Co-operation and Development:

(1) How many trained Black (a) doctors, (b) dentists, (c) chemists and druggists, (d) veterinarians and (e) nurses are serving the Black people at present in the Black states whose governments have not taken over health services;

(2) which governments have not taken over health services?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(1) (a) Nil.

(b) Nil.

(c) Nil.

(d) Nil.

(e) 700.

(2) kaNgwane and kwaNdebele Government Services.

FACULTY OF ENGINEERING

Corporation Medals
For the best student in each of the 2nd, 3rd and final years.

Second Year (Bronze Medal)

Miss G C Littlewort

Third Year (Silver Medal)

Miss N C Davidson

Fourth Year (Gold Medal)

P M Salmon
T J Cumming
D P Weeks
J H Rens
B F McCleland

Professor George Menzies Prize
Awarded on results of final examinations to the best male student in Land Surveying or Civil Engineering.

J H Rens

Sammy Sacks Memorial Prize
Awarded to the student with the best classwork in Engineering Drawing.

L Menegaldo

CHEMICAL

A E & C I Prize
For the first year student obtaining the highest average mark.

G L Cragg

S. Tribune 22/2/81 (85)

PREGNANCY DRUG FEARS

BRITISH doctors are to be warned against prescribing debendox, an anti-nausea drug widely used among South African women during pregnancy.

The warning to all GPs will recommend that the use of any drug, including debendox, be avoided "if at all possible" during pregnancy.

The warning reflects the continuing conflict of scientific opinions over whether the drug increases the possibility of deformity in babies.

The warning begins: "There have been a large number of epidemiological studies of debendox. Although there have been some formations associated with pregnancy, a casual relationship has not been established."

A spokesman for the drug's manufacturers in Britain said in future the company would not be promoting the drug, but it would be available to any GP who wanted to prescribe it. — Observor News Service.

Notifiable disease

208. Mr. H. E. J. VAN RENSBURG asked the Minister of Health, Welfare and Pensions:

How many cases of each notifiable disease were notified in respect of each race group in 1980?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

	WHITE	COLOURED	ASIAN	BLACK	OTHER	TOTAL
All forms of tuberculosis	564	8 365	644	36 164	158	45 895
Typhoid	49	54	76	3 530	12	3 721
Leprosy	2	2	3	85	1	93
Diphtheria	3	7	1	37	0	48
Meningococcal infection	87	654	7	349	1	1 098
Tetanus	2	10	5	238	0	255
Poliomyelitis	0	15	1	68	0	84
Measles	994	1 415	266	13 631	148	16 454
Viral Hepatitis	5	3	0	4	0	12
Type A Viral Hepatitis	1	5	0	19	0	25
Type B Viral Hepatitis	2	0	0	0	0	2
Non A Non B Viral Hepatitis	730	243	133	596	5	1 707
Malaria	126	3	10	2 858	3	3 000
Cholera	0	0	0	546	0	546
Parathyphoid	1	0	0	0	0	1
Plague	0	0	0	0	0	0
Anthrax	2	0	0	1	0	3
Brucellosis	12	0	0	2	0	14
Small Pox	0	0	0	0	0	0
Yellow Fever	0	0	0	0	0	0
Haemorrhagic Rift Valley Fever	0	0	0	0	0	0
Rabies (Human contacts)	—	—	—	—	—	181
Psittacosis	2	0	0	0	0	2
Trachoma	0	0	0	48	0	48
Typhus Fever—Lice	0	0	0	0	0	0
Typhus Fever—Ratflea	1	0	0	4	0	5
Trypanosomiasis	0	0	0	0	0	0
Leptospirosis	1	0	0	0	0	1

	WHITE	COLOURED	ASIAN	BLACK	OTHER	TOTAL
Toxoplasmosis	17	0	0	20	0	37
Primary Malignancy of Bronchus	158	66	6	94	1	325
Primary Malignancy of Lung	52	9	5	37	0	103
Malignant Neoplasm of Pleura	1	0	0	0	0	1
Poisoning from agriculture and stock remedies	5	33	1	71	1	111
Lead Poisoning	0	0	0	4	0	4

Lead content in petrol

*3. Mr. N. B. WOOD asked the Minister of Mineral and Energy Affairs:

Whether steps have been taken to reduce the lead content in petrol; if so, what steps; if not, why not?

The MINISTER OF MINERAL AND ENERGY AFFAIRS:

No, because the lead content of petrol conforms to the specification of the South African Bureau of Standards.

Lead poisoning

303. Mr. H. E. J. VAN RENSBURG asked the Minister of Health, Welfare and Pensions:

How many cases of lead poisoning were reported in 1980?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

4.

STAATSKOERANT

VAN DIE REPUBLIEK VAN SUID-AFRIKA

GOVERNMENT GAZETTE

REPUBLIC OF SOUTH AFRICA

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VOL. 189] KAAPSTAD, 4 MAART 1981 [No. 7449
CAPE TOWN, 4 MARCH 1981

See full text sa Gg

85

KANTOOR VAN DIE EERSTE MINISTER

No. 423. 4 Maart 1981.

Hierby word bekend gemaak dat die Staatspresident sy goedkeuring geheg het aan die onderstaande Wet wat hierby ter algemene inligting gepubliseer word:—

No. 20 van 1981: Wysigingswet op die Beheer van Medisyne en Verwante Stowwe, 1981.

OFFICE OF THE PRIME MINISTER

No. 423. 4 March 1981.

It is hereby notified that the State President has assented to the following Act which is hereby published for general information: —

No. 20 of 1981: Medicines and Related Substances Control Amendment Act, 1981.

Medical care in SA 'excellent'

(85) Argus 6/3/81

Medical Reporter

THE quality of medical care in South Africa was excellent, the executive vice-president of the American Medical Association (AMA), Dr James Sammons, said yesterday.

Dr Sammons is a member of an AMA delegation that is taking 'a hard look' at the health manpower situation in South Africa in a follow-up to its visit here two years ago.

The delegation has also reaffirmed its support for the SA Medical Association's return to the World Medical Association.

RESIGNED

South Africa resigned from the world body in 1976 because its finances were 'in a complete mess' and because different principles were applied to different countries.

Dr Sammons said that South Africa's approach to health manpower solutions were 'very good' and equal to any in the world.

He added that the United States and South Africa shared similar problems regarding shortages of doctors and nurses and the high cost of medical care.

The AMA delegation consists of the association's president, Dr R B Hunter, chairman Dr L Seen, deputy executive vice-president Dr J Miller, and legal adviser Ms Betty Jane Anderson.

They will leave for Australia tomorrow, where they will continue their investigation into health services.

New black medical trade union to be formed today

BY MARLAN PADAYACHEE

THE Medical Association of South Africa (Masa) — criticised for its handling of the Steve Biko Affair — faces opposition from a new black medical trade union to be formed in Durban today.

And the organisers of the new health workers' association which will include doctors, nurses and hospital workers as members, strongly believe that Masa's handling of the inquiry into the death in detention of the Black Consciousness leader is the major catalyst in the launching of the new body.

Two similar associations have already been formed by doctors in Cape Town and Johannesburg and efforts will be made to co-ordinate the formation of a national body which will eventually supplant Masa.

Leading medical men will gather at the Medical School in Umbilo Road this afternoon at 2pm to officially launch the association which will dedicate its efforts to underprivileged people in rural areas.

Acting president of the Natal Coastal Branch of Masa, Dr John Hamilton said yesterday: "Splits are not desirable. We welcome a special body to provide health care in rural areas which is of great need."

STAATSKOERANT

VAN DIE REPUBLIEK VAN SUID-AFRIKA

REPUBLIC OF SOUTH AFRICA

GOVERNMENT GAZETTE

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CAPE TOWN, 11 MARCH 1981

Jan Jull tax + see SG

KANTOOR VAN DIE EERSTE MINISTER

No. 498. 11 Maart 1981.

Hierby word bekend gemaak dat die Staatspresident sy goedkeuring geheg het aan die onderstaande Wet wat hierby ter algemene inligting gepubliseer word:—

No. 31 van 1981: Wysigingswet op Gevaarhoudende Stowwe, 1981

OFFICE OF THE PRIME MINISTER

No. 498. 11 March 1981.

It is hereby notified that the State President has assented to the following Act which is hereby published for general information:—

No. 31 of 1981: Hazardous Substances Amendment Act, 1981.

85

STAATSKOERANT

VAN DIE REPUBLIEK VAN SUID-AFRIKA

REPUBLIC OF SOUTH AFRICA

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Vol. 189] KAAPSTAD, 11 MAART 1981 CAPE TOWN, 11 MARCH 1981 [No. 7479

See full text see SS

KANTOOR VAN DIE EERSTE MINISTER

No. 500. 11 Maart 1981.

Hierby word bekend gemaak dat die Staatspresident sy goedkeuring geheg het aan die onderstaande Wet wat hierby ter algemene inligting gepubliseer word:—

No. 33 van 1981: Wysigingswet op Gesondheid, 1981.

OFFICE OF THE PRIME MINISTER

No. 500. 11 March 1981.

It is hereby notified that the State President has assented to the following Act which is hereby published for general information.

No. 33 of 1981: Health Amendment Act, 1981.

85

It appears then, that either farmers' es
payment in kind in the agricultural census
actual payments,(8) or that many of the farr
this survey pay high wages relative to the
area. This question will be further exami
section.

c) Total payment.

The addition
terms) and paymen
payment made by f
The distribution
is shown in the t

Distribution of work

Total payment (F	
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5,01 - 7,50	
7,51 - 10,00	
10,01 - 12,50	
12,51 - 15,00	

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He listed the following impairments: deafness, blindness, defective eyesight, impaired hearing and grave mental retardation, porphyria, haemophilia, muscular dystrophy, marble bone disease, hair-lip and cleft palate, spina bifida, cystic fibrosis, Huntington's chorea, Huntington's syndrome, Klinefelter's syndrome and Turner's syndrome.

For example, he said, one child in every 50 suffered from hypergliadaemia, one in 300 from porphyria and one in 2 000 from spina bifida.

Other recommendations in the report include that the existing genetic services section of the Department of Health be expanded, counselling programmes for parents and teachers of handicapped children in respect of care and education should be compiled, research should be undertaken into the education of handicapped children and significant tax concessions should be given for parents of handicapped children.

In his report, Dr Urbani said the occurrence of genetic impairments should not be underesti-
mated.

There was more than a 50 percent chance that a child might be genetically impaired, it was better for the parents to adopt one or to resort to artificial insemination.

An additional factor was that often when a genetically impaired child was born, the parents could not cope. This led to divorces and further hardship and expense.

In an interview, he pointed out the wisdom of a medical examination for a couple before they married and cited the example of Prince Charles's fiancee, Lady Diana, who had been declared medically fit to carry the heir to the British throne.

Dr Urbani said that if there was more than a 50 percent chance that a born with genetic diseases. The register would also record the names of the parents.

Dr Giovanni Urbani, of the Human Sciences Research Council, who undertook the investigation, said he knew the recommendations would be controversial but pointed out that there was tremendous hardship for all concerned when a genetically impaired child was born.

Own Correspondent

Urban

All couples intending to marry may have to be medically examined first to determine whether they are likely to have genetically impaired children.

This recommendation is contained in a 198-page detailed research report commissioned by the Department of Health.

The report also recommends keeping a central register on all children born with genetic

Genetics costs for future parents urged

Giving birth in poverty or in wealth

JANET RYAN

WHAT EXACTLY is the Third World?

Prof R H Philpott, head of the gynaecological and obstetrical departments of the University of Natal, suggests one definition may be considerable poverty in the midst of considerable wealth.

Speaking at the international symposium of midwifery held in Johannesburg recently, he said such wealth and such poverty is characteristic of South Africa.

"We see the results of poverty in our wards in complications of birth and pregnancy" — pathological conditions which are not often seen in places where there is no poverty and where adequate health services are available.

In South Africa, birth happens in extreme conditions: palatial hospitals on the one hand; the primitive hut on the other.

In Zululand, three to four years ago, a survey showed that at least 300 more clinics specialising in primary health care were needed.

Until recently, this was being realised at the rate of only three or four clinics a year.

Rural clinics particularly, the professor says, are suffering because of the policy of separate development. Homelands can hardly meet the immediate needs of the population with venues for decentralised primary health care.

Decentralised medicine is not new. The professor, himself has been involved in its evolution for the last eight years.

Previously, he worked in a hospital in Zimbabwe where gross overcrowding resulted in the expansion of hospital care to clinics already established in township areas.

Once the clinics proved to the communities they served that they were part of the hospital, these "birth-units" handled all normal deliveries.

This cut down hospital intake by 50%, says the professor.

The midwives staffing these clinics received regular in-service training to upgrade their skills.

A consultant from the hospital visited the clinic every week, helping the staff to screen patients for complex obstetrical problems which needed referring to the hospital. And the consultant provided a regular exchange of information between the clinic and hospital staff.

After a normal birth, mother and baby were kept under observation for six to eight hours before their discharge. Daily post-natal visits by the midwife in the days following birth ensured patients received efficient after-care.

This is the system the professor chose to alleviate overcrowding in the King Edward Hospital in Durban in 1975.

He increased the number of urban black maternity clinics and the upgrading of the midwives' skills is continuously appraised.

Three consultants oversee the clinics. Every clinic is visited weekly. The midwives receive in-service training at the hospital for two weeks of every year.

Some of the clinics are enormous, says Prof Philpott — some register 2 000 births annually.

Should an unexpected complication occur during birth or labour, each clinic is equipped with a two-way radio link to the senior registrar of the obstetrical ward at the hospital.

Since the clinics and birth units were established, perinatal deaths have dropped considerably.

Dr J V Larsen, previously a superintendant of the Charles Johnson Memorial Hospital, a large hospital near Dundee, is one of the consultants.

He has extensive experience of the needs for improved perinatal care in rural areas.

Dr Larsen is also in charge of the newly introduced advanced midwifery course — a diploma recognised by the Nursing Council in 1979.

This course, says Professor Philpott, qualifies a midwife to deal with all obstetrical complications, short of abdominal surgery.

Twelve midwives from KwaZulu and Natal are trained every year. As post-graduates they are based at rural hospitals.

Though working under a doctor, they are virtually in charge of the obstetrical department including outlying clinics which might be attached to the hospital. Training involves management skills and relates to all aspects of maternity care, before and after birth.

Some rural areas have no hospital at all, a fact discovered when Professor Philpott's department conducted a survey a few years ago.

It also showed, he says, that many patients at the hospital were coming from areas up to 80km away for a normal delivery.

Regarding clinics, he gave the example of an area with a large population of about 200 000 people, between Scottburgh and Ixopo, which is only served by two small clinics.

In some areas, because of the lack of either clinic or hospital, many babies are delivered — and pregnancies monitored — by "alternate birth attendants".

These are women who, traditionally, are chosen by their communities to serve as midwives. Illiteracy might be a problem but, says the professor, these women possess incredible midwifery and mother-craft acumen.

With increased on-the-spot instruction, Prof Philpott and his associates believe, these women have an important part to play in the care and safety of pregnant mothers in remote rural areas.

They need to learn, for example, how to anticipate or diagnose an obstetrical problem in advance; how to refer patients for specialised care.

But first the training programme — already formulated — must be accepted by the Nursing Council. The professor says negotiations are already underway and the council is acutely aware of the health needs of all the

No. R. 774 10 April 1981

CUSTOMS AND EXCISE ACT, 1964

AMENDMENT OF SCHEDULE 1 (No. 1/1/744)

Under section 48 of the Customs and Excise Act, 1964, Part 1 of Schedule 1 to the said Act is hereby amended to the extent set out in the Schedule hereto.

D. W. STEYN, Deputy Minister of Finance.

No. R. 774 10 April 1981

DOEANE- EN AKSYNSWET, 1964

WYSIGING VAN BYLAE 1 (No. 1/1/744)

Kragtens artikel 48 van die Doeane- en Aksynswet, 1964, word Deel 1 van Bylae 1 by genoemde Wet hierby gewysig in die mate in die Bylae hiervan aangetoon.

D. W. STEYN, Adjunk-minister van Finansies.

SCHEDULE

I	II	III	IV
Tariff Heading	Statistical Unit	Rate of Duty	
		General	M.F.N.
85.21 By the substitution for subheading No. 85.21.40.10 of the following:			
".05 Diodes, of a value for duty purposes not exceeding 50c each	no.	25% or 60c per 100	
.07 Diodes, of a value for duty purposes exceeding 50c each	no.	5%"	

Note.—The rate of duty on diodes of a value for duty purposes not exceeding 50c each is increased from 5% to 25% or 60c per 100.

BYLAE

I	II	III	IV
Tariefpos	Statistiese Eenheid	Skaal van Reg	
		Algemeen	M.B.N.
85.21 Deur subpos No. 85.21.40.10 deur die volgende te vervang:			
„.05 Diodes, met 'n waarde vir belastingdoeleindes van hoogstens 50c elk	getal	25% of 60c per 100	
.07 Diodes, met 'n waarde vir belastingdoeleindes van meer as 50c elk	getal	5%"	

Opmerking.—Die skaal van reg op diodes met 'n waarde vir belastingdoeleindes van hoogstens 50c elk word van 5% na 25% of 60c per 100 verhoog.

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

10/4/81 No. R. 777 GG 7542 10 April 1981

MEDICINES AND RELATED SUBSTANCES CONTROL ACT, 1965 (ACT 101 OF 1965)

85

The Minister of Health, Welfare and Pensions has, in terms of section 35 (1) (xxiv) and (3) (b) of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965), made the regulations in the Schedule hereto.

SCHEDULE

1. In this Schedule, unless the context otherwise indicates, the expression "the regulations" means the regulations published under Government Notice R. 352 of 21 February 1975.

2. The following regulation is hereby substituted for regulation 32 of the regulations:

32. (1) Any person registered as a midwife, in terms of the Nursing Act, 1978 (Act 50 of 1978), who wishes to purchase, acquire or keep for administration in a midwifery case, the scheduled substances set out in Annexure C shall apply, in writing, to the Regional Director: Health Services, of the area concerned for a permit, giving the following particulars in such application:

(a) The type of midwifery service for which the scheduled substances are required.

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

No. R. 777 10 April 1981

DIE WET OP DIE BEHEER VAN MEDISYNE EN VERWANTE STOWWE, 1965 (WET 101 VAN 1965)

Die Minister van Gesondheid, Welsyn en Pensioene het kragtens artikel 35 (1) (xxiv) en (3) (b) van die Wet op die Beheer van Medisyne en Verwante Stowwe, 1965 (Wet 101 van 1965), die regulasies in die Bylae hiervan uitgevaardig.

BYLAE

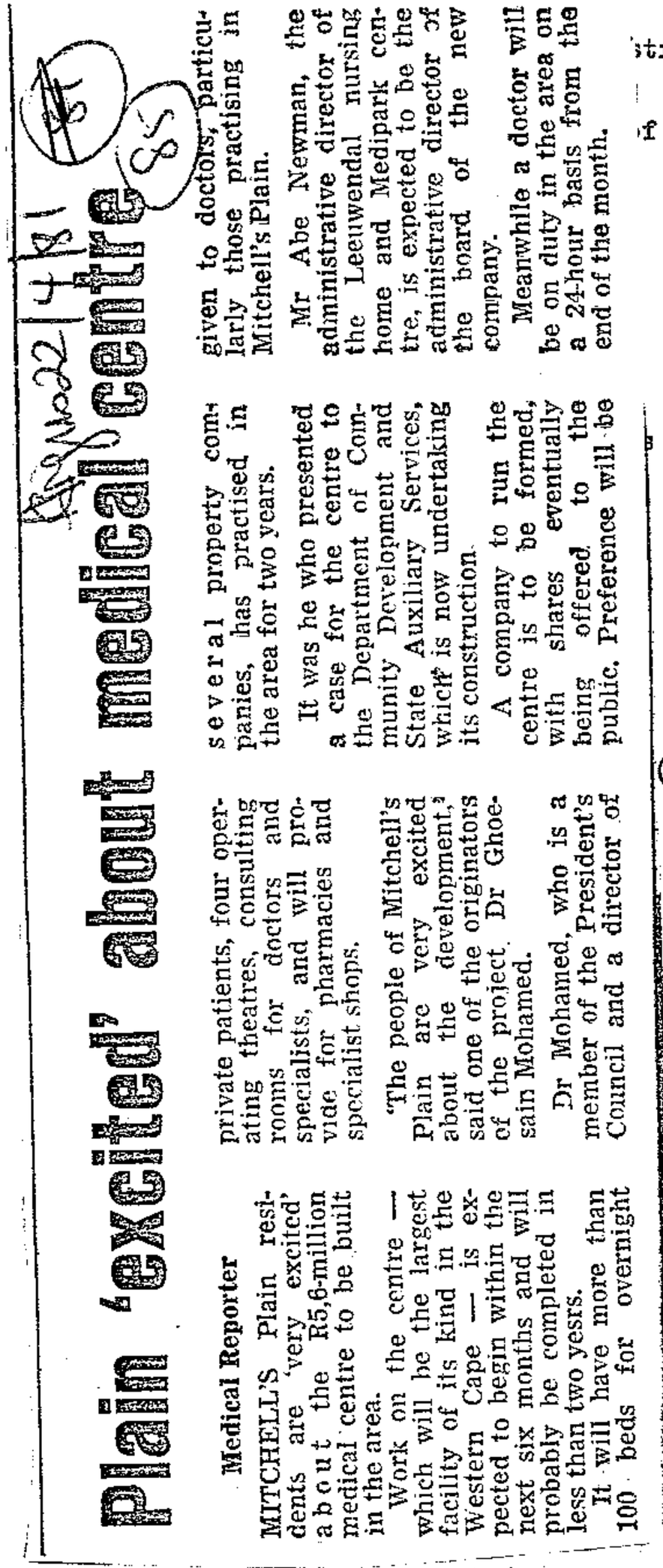
1. In hierdie Bylae, tensy dit uit die samehang anders blyk, beteken "die regulasies" die regulasies uitgevaardig by Goewermentskennisgewing R. 352 van 21 Februarie 1975.

2. Regulasie 32 van die regulasies word hierby deur die volgende regulasie vervang:

32. (1) Iemand wat ingevolge die Wet op Verpleging, 1978 (Wet 50 van 1978), as 'n vroedvrou geregistreer is en wat gelyste stowwe soos uiteengesit in Aanhangsel C vir toediening by 'n verloskundige geval wil koop, verkry of aanhou, moet skriftelik by die Streekdirekteur: Gesondheidsdienste van die betrokke gebied aansoek doen om 'n permit en in sodanige aansoek die volgende besonderhede verstrek:

(a) Die tipe verloskundige diens waarvoor die gelyste stowwe benodig word.

for full text see GG.



Plain 'excited' about medical centre

Medical Reporter

MITCHELL'S Plain residents are 'very excited' about the R5,6-million medical centre to be built in the area.

Work on the centre — which will be the largest facility of its kind in the Western Cape — is expected to begin within the next six months and will probably be completed in less than two yesrs.

It will have more than 100 beds for overnight

several property companies, has practised in the area for two years.

It was he who presented a case for the centre to the Department of Community Development and State Auxiliary Services, which is now undertaking its construction.

A company to run the centre is to be formed, with shares eventually being offered to the public. Preference will be given to doctors, particularly those practising in Mitchell's Plain.

Mr Abe Newman, the administrative director of the Leeuwendal nursing home and Medipark centre, is expected to be the administrative director of the board of the new company.

Meanwhile a doctor will be on duty in the area on a 24-hour basis from the end of the month.

stries and farming per month

	f Total	Percentage malnutrition	Percentage non-maln.
		57%	43%
		50%	50%
		22%	78%
		100%	

s monthly (Table Thirteen)

	48%	52%
	57%	43%
	75%	25%
		100%
	63%	37%

(Table Fourteen)

	53%	47%
	67%	33%
	25%	75%
	63%	37%
	50%	50%

Table Fifteen)

	50%	50%
	80%	20%
	100%	
	57%	43%
	40%	60%
	40%	60%
	44%	59%

me: (Table Sixteen)

	75%	25%
	66%	34%
	43%	57%
	28%	72%
	100%	

R8-R11	14%	
R11+	2%	

No. of horses and donkeys (Table Nineteen)

Nil	82%	51%	49%
1-2	14%	57%	43%
3-4	4%	50%	50%
4+			

No. of sheep (Table Twenty)

Nil	68%		
1-10	16%	75%	25%
11-20	8%	75%	25%
21-30	8%	25%	75%

No. of pigs (Table Twenty one)

Nil	66%	45%	55%
1-3	34%	64%	46%

No. of goats (Table Twenty Two)

Nil	64%	56%	44%
1-10	22%	36%	64%
11-20	10%	60%	40%
21-30	4%	50%	50%

No. of chickens (Table Twenty Three)

Nil	18%	44%	56%
1-15	38%	63%	37%
16-30	30%	47%	53%
31-45	12%	60%	50%
45+	2%		100%

ownership of
Other than a few chickens, a few head of cattle and maybe a pig - there was little evidence that active farming was contributing much to the economic life of the households investigated. The figures for ownership reveal a greater incidence of malnutrition in those households that owned little or nothing in the way of livestock.

A REVIEW OF THE SOUTH AFRICAN HEALTH-CENTRE EXPERIMENT

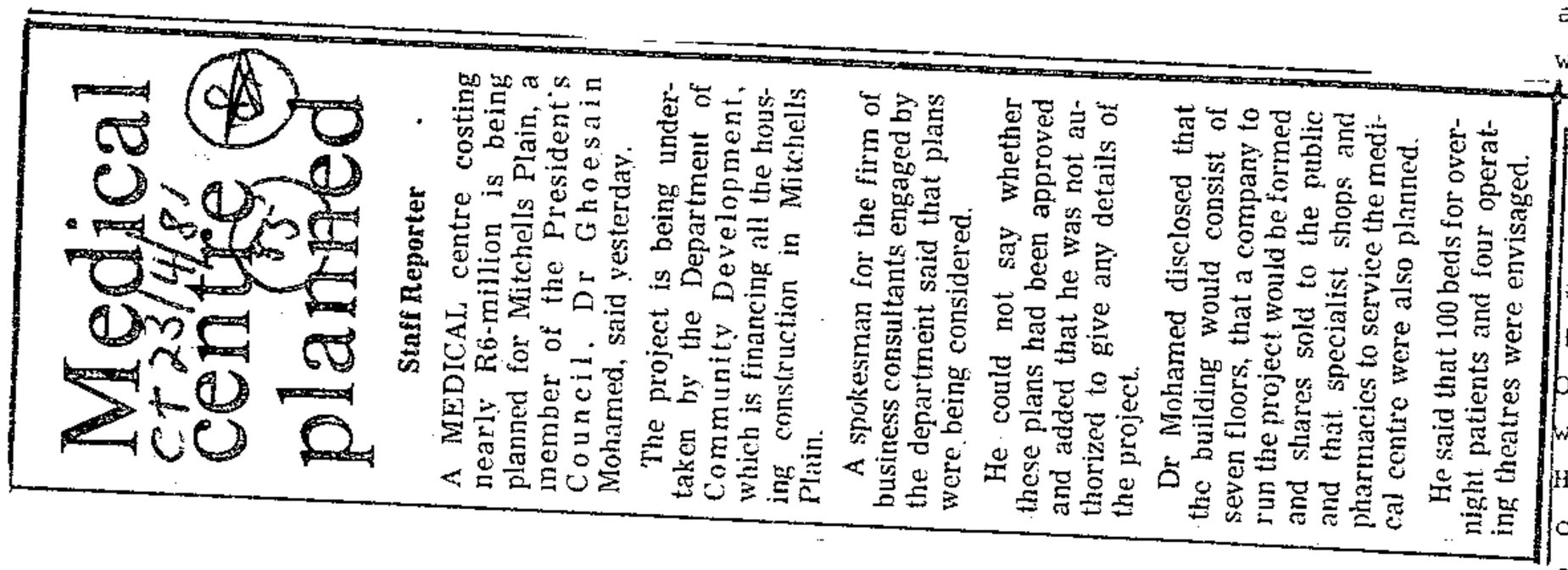
I. Intrcduction.

2. The National Health Services Commission.

3. Implementation problems with the recommendations of the NHS Commission.

4. The Health-Centre Experiment.

5. Epilogue.



Medical centre planned

Staff Reporter

A MEDICAL centre costing nearly R6-million is being planned for Mitchells Plain, a member of the President's Council. Dr Ghoesain Mohamed, said yesterday.

The project is being undertaken by the Department of Community Development, which is financing all the housing construction in Mitchells Plain.

A spokesman for the firm of business consultants engaged by the department said that plans were being considered.

He could not say whether these plans had been approved and added that he was not authorized to give any details of the project.

Dr Mohamed disclosed that the building would consist of seven floors, that a company to run the project would be formed and shares sold to the public and that specialist shops and pharmacies to service the medical centre were also planned.

He said that 100 beds for overnight patients and four operating theatres were envisaged.

Introduction

With the present day renewal of South African interest in primary health care, community oriented health services and health education, it seems worthwhile to look back in the past and see what has been done in this field already.

South Africa fortunately provides a very fruitful example in this respect, as there has been a lot of rethinking, discussion and experimentation about a community oriented health service some 35 years ago. Particularly between 1940-1950, there was a real search for a new approach to the many health problems within South African society of those days.

The highlight of this period is the work of the National Health Services Commission which sat from 1942-1944, under the chairmanship of Dr H. Gluckman. (1) This National Health Services Commission advised the establishment of a National Health Service (NHS) based on Health-Centres, as its foundation. On the recommendation of this Parliamentary Commission a start was made with a nationwide scheme of Health-Centres. To these Health-Centres, the function of an integrated preventive and curative grassroot level health service based on a team approach was allocated.

The fruits of this approach were anticipated to be:

a) an equal distribution of health services for all sections of the people of South Africa;
b) a National Health Service based on a modern conception of health;
c) the prevention of further wastage of health resources through unification of all personal health services under the direct administration of one single authority (the Department of Health).

The first 'Health-Centre' was actually established in 1940 under the very able leadership of Dr Kark, as part of an experiment of the Union Department of Public Health to determine the most useful kind of health service for the numerous health needs of the African people in the 'Native Territories', health

./ ...

Health services 'facing collapse'

STAR 27/4/81

85

Own Correspondent

Nearly a quarter of the posts in the Department of Health are vacant and some services run the risk of collapsing.

The department's 1980 annual report, issued in Pretoria, reveals that sufficient personnel could not be trained or retrained to keep the department's essential services operating efficiently.

The general revision of salaries last year had not brought any improvement and the recruitment of staff in the Witwatersrand area had virtually ceased, because the department could not offer competitive salaries.

The staff shortage was so serious that the department could not meet its commitments even on the basis of minimum efficiency, the report said.

NURSING

The worst affecter services were the nursing of state patients, health inspections, medico-legal examinations as evidence in courts and information services for pensioners.

The report showed a shortage of nearly 30 percent of nursing staff in posts from sister to nursing assistant, and a similar lack of medical officers.

A total of 2 341 people resigned from the department last year and a further 176 has retired or left because their contracts had ended. In the same period 3 629 people joined the staff.

"As a result of the staff situation essential services for which the department is responsible are being rendered unsatisfactorily and certain services run the risk of collapsing," the report said.

"On other levels the quality and extent of service is handicapped by a shortage of staff."

Medical indaba

4/5/81 By LEN MASEKO (85) Sowetan

A THREE-DAY conference titled "South African Health - History of the Main Complaint" which intends looking at the political, social and economic history of this country is to be held at the University of Witwatersrand between tomorrow and Wednesday.

The conference, an annual event organised by the Wits Medical Students' Council, is also aimed at striving for an effective and equal health system in the country.

Topics which will be discussed at the conference include malnutrition; labour and health; food as a weapon of war; overpopulation; the development of the health care system in this country and the introduction of white man's diseases in South Africa.

The aims of the conference are

- to give the public and the students a new approach to health and disease and broaden the narrow perception of health held by health workers.
- to show that causes of illness — psychological, sociological and economic cannot be dealt with within the realms of purely scientific medicine.

It will be held at the G R.Bozzoli Sports Centre, University of the Witwatersrand in Braamfontein.

Doctor slams medicine 'swindle'

CISKEI MINISTER SAYS PYRAMID COMPANY WILL BE BANNED

S. Tribune 5/7/81 85

SUNDAY TRIBUNE, JULY 5, 1981

THOUSANDS of desperately ill and dying people may be being ripped off through the sale of bogus medicines.

And now medical practitioner turned politician Dr B. Maku has said he wants to stop the abuse in the soon-to-be-independent Ciskei, where he is Minister of Health.

The company to incur his wrath is the Kempton Park-based Golden Chemical Products, headed by Brian Murray, which he accused in the Ciskei Legislative Assembly of unmitigated swindling through the sale of spurious substances and palpably dishonest merchandise.

Dr Maku said the company's products would be banned after independence and warned pedlars of the goods to "wind up their perfidous practices."

Tribune Reporter

A **Sunday Tribune** investigation showed there were scores of agents throughout the country for this pyramid company, which is netting thousands of rands through its products, which it claims:

- Can cure asthma, TB and other lung disorders through its vitamin tablets.
- Can cure a stroke or paralysis through its vitamin tablets.
- Can heal sores and can control skin disorders through a substance called Care, which is also used to control insects and as a household cleanser. It can also be used for toothache and earache and costs R6,98 an undiluted litre.
- Can regulate weight through its protein supplements, which come in powder form and look like icecream when mixed with water.

None of the products is sold in chemists or shops but entirely through its agents, who have ranks according to the quantity of good they order each month. An area distributor must take R1 720 worth of goods; a direct distributor goes on to R2 000; and a general distributor R4 000.

I spoke to a general distributor — one of the 120 agents who went on a company perk last year to Tel Aviv for a nine-day lecture course on how to market the company's products.

"I was invited to a meeting and became interested in the products and started off with goods valued at R1 720, which took about two weeks to sell, and later went up until I became a general distributor," says the woman who works in a bank during the day and sells her goods in the township of Mdantsane near East London at night.

How does her merchandise work?

"I tell you, our stuff is real good. Take Care, for instanse. It heals sores, which disappear in about a week. It can be used for toothache and earache."

She admits that their vitamins for polio takes a bit of time.

"When people suffer from polio for a long time, it can take up to six months but our vitamin tablets for things like coughs and asthma work in no time."

She also says the slimming course must be taken religiously to work and costs R21,95 a kilogram. "You dilute this protein powder with water and have it at lunch-time and for breakfast, but for dinner you have a solid meal. I've seen it work for people who use it according to instructions. But it can also be used for people convalescing who require additional nutrition beside their meal. It is supplementary. It depends entirely on the person, like all other slimming stuff."

She said the cleansing product was "super" and was used extensively in hospitals.

Mr Murray, managing director of Golden Chemical Products at Kempton Park, told the **Tribune** he was aware of Mr Maku's statements in the Legislative Assembly but would not comment.

Govt orders tough health care curbs

RDM P 18/7/81

85

By ADA STUIJT

THE Government has issued a tough directive to curb spending in major State health services — retroactive to the beginning of the year.

The memorandum sent this week to all regional health directors and medical superintendents countrywide outlines steps to cut back services and freeze personnel levels in the TB prevention, mental and family health service programmes.

Dr J de Beer, Director-General of the Department of Health, Welfare and Pensions, says in the memo that inflation problems have prompted the department to take strong action to curtail spending.

He says services are being cut back or ended "only in those departments in which damage would be minimal".

Yesterday Dr Marius Barnard, Progressive Federal Party spokesman on medical affairs, slammed the curbs and said the nation's health services were deteriorating rapidly.

"It is rather foolish to make cuts in preventive care programmes, as these specifically save money for the State in the long run. For instance, in the TB prevention programme, the cuts will cause more expense to the State later on in having to treat more TB patients," he said.

The cuts will also have a serious effect on the mental health services, where the Government's measures include cutting off applications for the rest of the year for financial aid to support mentally-handicapped patients at home.

In the Johannesburg area alone, an average of 200 black homes a month will not receive this aid unless they applied for it before last March.

Thousands of these "single-care" applications for mentally-retarded patients have been held back since March because the Department of Health has frozen funds, according to an executive member of the Mental Health Society in Johannesburg.

Single-care funds are R109 a month for white guardians, R33 for blacks, and R62 a month for coloureds and Indians.

In addition, psychiatric outpatient levels are frozen at the 1980 level — meaning no new psychiatric out-patients may be accepted except when previous patients vacate programmes.

In the TB prevention programme, the Government has ordered that:

- The "wonder" drug rifampicin may only be dispensed at the same level as last year;
- No mobile X-ray units may be bought except to replace existing units.

Family care programmes will be hampered, because visits from District Surgeons to outpatient clinics and to individuals will be curtailed.

In the dental care services, information and preventive services will be kept to a minimum.

All present vacancies for health inspectors at local level are frozen and may not be filled without prior Department approval.

The memo asks regional directors to advise local health authorities of the cutbacks 'in the most tactful way possible''.

Govt cost cuts seen as hazard to health

W. Post 18/7/81 (85)

By CLIFF FOSTER

ALL regional health directors are being ordered by the Government to enforce spending cuts in major services, and the Eastern Cape, which has escaped the worst of the hospital crisis so far, is going to be affected along with all the rest.

Services to feel the axe are TB prevention, mental care, and family health programmes.

Blacks are likely to suffer most.

The cuts are retroactive to the beginning of the year.

Col W E Hawkins, secretary of the Port Elizabeth branch of Santa, the TB association, said the cuts would prove to be a false economy because reducing preventive care would result in a rise in the number of cases.

"People suffering from TB will be passsing it on to others all the time," he said.

The branch's Santa hospital at Bethelsdorp is "bursting at the seams", he said. "We are a 320-bed centre and we are running at an average of 400 patients.

"This is caused to some extent by the country districts sending us patients they can't handle for proper treatment."

The branch, he said, had applied recently for Government funds to expand the hospital but this had since been rejected.

The regional health director for the Eastern Cape told Weekend Post today he had not yet received a copy of the directive.

When he does he will learn that in the TB prevention programme the Government has ordered that:

- The "wonder" drug, rifampicin, may only be dispensed at the same level as last year.
- No mobile X-ray units may be bought except to replace existing ones. (Santa in Port Elizabeth does not have a mobile unit.)

Family care programmes will be hampered because visits from district surgeons to outpatient clinics and individuals will be curtailed.

In mental health services, measures include cutting off applications for the rest of the year for financial aid to support mentally-handicapped patients at home. (Single-care funds are R109 a month for white guardians, R33 for blacks and R62 for coloureds and Indians.)

In addition, psychiatric outpatient levels are frozen at the 1980 level, meaning no new psychiatric out-patients may be accepted except when previous patients vacate programmes.

In dental care services, information and preventive services will be kept to a minimum.

All present vacancies for health inspectors at local level are frozen and may not be filled without approval.

The cuts have drawn a sharp reaction from Dr Marius Barnard, PFP spokesman on medical affairs. He slammed the proposals and said the nation's health services were deteriorating rapidly.

"It is foolish to make cuts in preventive care programmes, as they save money for the State in the long run. For instance, in the TB prevention programme, the cuts will cause more expense to the State in later having to treat more TB patients."

State's health spending cut

CT 18/7/81
(85)

Own Correspondent

JOHANNESBURG. — A memorandum received on Thursday by all regional health directors and medical superintendents in the country advises large financial cuts to be made — retroactive to the beginning of the year — in the nation's TB-prevention and mental and family health service programmes.

Dr J de Beer, Director-General of the Department of Health, Welfare and Pensions, warns in his memorandum A3/2/1/B dated July 16 that because of the country's inflation problems, the department is taking strong steps to curtail government spending.

"Only in those departments in which damage would be minimal, are services cut back or ended," he said.

Dr Marius Barnard, PFP spokesman for medical affairs, criticized the cuts and said the nation's health services were deteriorating rapidly.

He said: "It is rather foolish to make cuts in preventive-care programmes, as these specifically save money for the State in the long run. For instance, in the TB-prevention programme, the cuts will cause more expense to the State later on, having to treat more TB-patients."

The most serious effect — besides the TB-prevention programme — will be felt in mental health, where the government has, among other measures, stopped financial applications for support of mentally-handicapped patients cared for at home.

In the Johannesburg area, a monthly average of 200 black mentally-handicapped will be not be able to receive financial aid for their home care unless they applied for it before March 1981.

Thousands of these "single-care" applications have been held back since March because the Department of Health has frozen funds, according to an executive member of the Mental Health Society in Johannesburg.

In addition, personnel vacancies have been frozen for the following health services:

TB prevention.

● In this programme, the successful drug Rifampicin may be dispensed only at the same level as last year.

● No mobile X-ray units will be purchased unless they replace existing units.

Mental Health.

● No new psychiatric out-patients may be accepted until a previous patient has vacated a place at the clinic. The psychiatric out-patient figures are to be maintained at the same level as in 1980.

● No psychiatric patients' single-care funds to support retarded patients at home will be considered for the remainder of the year (these are paid to guardians of patients for home care instead of hospitalization).

● Psycho-therapeutic drugs must be dispensed under strict controls.

Family Health Care Clinics.

● All family-care programmes will be hampered because visits from district surgeons to out-patient clinics and individuals will be curtailed.

Dr J de Beer

Dr Marius Barnard

Dental Care.

● Requests for dentures will be considered only in the most necessary cases.

● Information and preventive services will be kept to a minimum.

Health Inspectors.

● All present vacancies for health inspectors at local level are frozen and none can be filled without prior Health Department approval.

In a final warning, all regional directors and medical superintendents are "seriously requested to personally see to it that these measures are strictly followed".

The memo states that regional directors will have to advise local health authorities of these cutbacks "in the most tactful way possible".

An executive member of the Mental Health Society in Johannesburg said the directive was "ridiculous" because it was issued in the second half of 1981, when most departments had already overspent the budgets for the first half.

"Especially in mental-health care, we work on a preventative basis, because our goal is to prevent mental patients from being hospitalized.

"This cut-down completely negates our service. We deal with at least six certifiable, white mentally-ill patients a week in the Johannesburg area alone who walk into the out-patient clinics for help.

"In black areas, an average of 16 severely mentally-ill patients daily are certified for hospitalization at out-patient clinics in the Johannesburg area.

No reply

"What is even worse is the complete curtailment of the single-care grants. In March, the 219 applications for single-care of black patients weren't even replied to, and only in June did we hear that the money supply for these mentally-handicapped patients had dried up."

Dr G Viljoen, secretary-general of the Medical Association of South Africa, said last night that he could not comment on the directive before studying it.

No Department of Health officials could be reached for comment last night.

'Horror births' row over drug on sale in SA

S. Express 19/7/87 (85)

BUT DOCTORS SAY 'DON'T WORRY' AFTER UK STUDY

● Debendox ... could it cause deformities in babies?

A "PRETTY INNOCUOUS" anti-nausea drug, said in Britain to be the cause of horrible deformities in unborn infants, is freely available over the counter from South African chemists.

The medicine is a Schedule Two drug, Debendox, which is used to control morning sickness.

It is featuring in a Thalidomide-type row in Britain in spite of assurances from doctors and the findings of a medical study that it is "not specifically" the cause of malformation in babies.

A petition with 8 000 signatures has been sent to Prime Minister Mrs Margaret Thatcher urging that the drug be banned. Many parents in the UK and America have started boycotting the drug, which opponents claim has crippled 2 000 babies worldwide.

By CHRISTINA PRETORIUS

However, tests carried out by doctors and reported in the *British Medical Journal*, found that of 620 pregnant women given the drug only eight — or 1,3% — gave birth to a malformed infant. Of 22 357 women not given the drug, 445 — or 2% — gave birth to malformed babies.

Nevertheless, a Debendox Action Group has been started in England to get the drug banned. It has been reported that another 300 British parents are suing the American manufacturers for R300-million following the births of their malformed infants.

The British Committee of Safety in Medicine feels that prospective mothers "are probably safer not using Debendox".

"Although there is no proof that the drug is directly responsible for the babies being born deformed some people believe there is a connection," said a spokesman for the committee.

"Doctors are probably better not prescribing it during pregnancy."

But the South African manufacturers of the medicine, Merr-National, claim the drug to be 100% reliable.

"There's absolutely nothing wrong with it," said managing director, Mr Jack Lipworth. "All this fuss about babies being born crippled is a load of nonsense.

"We don't have a high turnover in the drug but neither have we received any complaints about it."

A spokesman for South Africa's Pharmaceutical Society felt the drug was "pretty innocuous". "When all the fuss broke out over the drug in England and America we went into its merits very carefully and couldn't find a single reason to ban it in South Africa," he said.

"It is absolutely reliable and has a proven track record. We simply can't consider taking it off the market," he said.

Mrs Valerie Alexander, chairman of the British Debendox Action Group, took the drug and gave birth to a child whose arms ended at the elbows.

Mrs Alexander is responsible for the petition which has been sent to Mrs Thatcher.

"A lot of people have suffered because of the drug and we want to put an end to the horror by having it banned," she said.

SUNDAY EXPRESS July 19, 1981

Death lurks on the back of those transport trucks

S. Express 19/7/81 (85)

By SAVVAS GEORGIADES

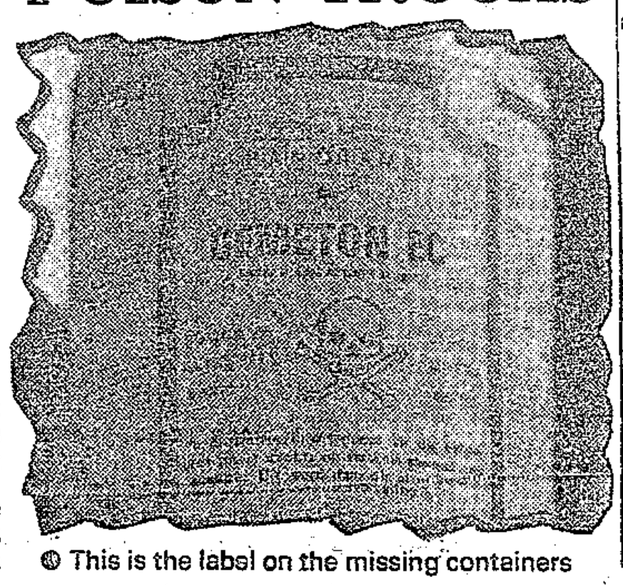
DANGEROUS chemicals which could wipe out whole cities are being transported on South African roads without any regulations to control their movement.

Fifty containers of an extremely deadly insect poison. Dematon, disappeared last week from the back of a truck, near the Ben Schoeman Highway. More than 10 containers are still missing.

One millilitre of this substance could prove fatal. The poison can be absorbed orally, through the skin, or by inhalation.

But in spite of the highly dangerous implications of such a situation, the Sunday Express found, effective safety controls for the transport of poisons are totally lacking — although experts have been campaigning for them for years.

THERE ARE NO SAFETY LAWS FOR THOSE POISON TRUCKS



© This is the label on the missing containers

Mr J C Hillman, senior research officer at the Institute for Transport and Road Research, said the institute had been fighting for years for legislation to control the transportation of hazardous substances.

He said there were insufficient controls and legal requirements to restrict such transportation to competent, properly equipped and responsible operators.

Independent ombudsman Mr Eugene Roelofse said the loss of the 50 poison containers highlighted the need for stringent controls.

"Tons of poisonous chemicals are transported on South African roads and nothing is done to regulate how they should be transported," he said.

Mr Roelofse said one truck carrying hazardous substances could destroy a city if the truck was involved in an accident.

"Poisons in terms of the Hazardous Substances Act should be transported only in a locked truck," he said.

"The Minister of Health, or his office, has had the chance to draft regulations since 1973.

"This hasn't been done and I think the minister should be asked to give thought to why huge amounts of poison can be shipped in whatever fashion the movers or transporters wish without protection being given to the public."

Mr Roelofse said manufacturers should apply voluntary controls.

A spokesman for Panorama Chemicals said 13 of the 1-litre containers which fell off the truck were still missing.

As far as the company was concerned everything had been done to ensure the safety of the containers. A White supervisor had seen that they were securely packed and that a tarpaulin had been properly fastened over the load.

Mr Ray Hose, head of the Automobile Association's road traffic affairs section, said: "We are not very happy about the transportation of chemicals and have made representation about badly stacked goods in the past."

He said a Hazchem code placard displayed on the side of a truck helped minimise the danger as the series of symbols and numbers could be translated by Police, fire or traffic officers enabling them to take the necessary action in the case of accidents.

A spokesman for the Department of Health admitted there were no regulations controlling the transportation of poisons.

The department, in conjuction with the transport companies, was however, considering regulations and their enforcement, he said.

In a document published in April this year, Mr Hillman warned: "The increasing use of dangerous chemicals and petroleum products by South African industry makes it necessary for some form of control to be introduced to regulate transport before a major disaster occurs, such as has happened overseas.

"Many of these substances are hazardous to man or his environment and the quantities currently being transported by road through our cities have exposed our society to the very real risk of a major disaster."

Proposals were put to the Department of Health in September 1978 by the institute's projects advisory committee concerning new regulations to cover labelling and routing of hazardous loads as well as requirements for incident reporting and driver health examinations.

"The proposals were accepted in principal but to date nothing has been published," Mr Hillman stated.

The transport of two classes of hazardous substances is controlled by South African law.

These are explosives and radio-active materials, which are subject to the Explosive Act No 26 of 1956 and the Atomic Energy Act No 90 of 1967 respectively.

The Acts strictly control manufacture, storage, handling and transportation of the substances and are actively enforced.

Flammable liquids are subject to control by municipal bye-laws.

Mr Hillman said the Road Transportation Act of 1977 and the growth in industrial demand for transport services had increased the likelihood of amateurs becoming involved in this field of transportation.

"Any member of the public can buy a vehicle and operate a restricted haulage business, including the carriage of hazardous materials except flammable liquids," he said.

"Legislation intended to minimise the possibility of a disaster is necessary to demonstrate to the general public that the authorities are aware of their fears and are taking action, and to minimise the possible loss of life and property damage.

"Specially trained and equipped personnel would be needed if spot checks on suspect loads were to be made and laboratory facilities would be needed for analysis.

"Staffing problems, complexity of the task and difficulties in demarcating areas of responsibility are likely objections to these requirements, but they should not be allowed to delay the introduction of any measures."

Mr T E Olivier, deputy chief, operations, of the Johannesburg Traffic Department, said the department was well geared for any emergencies.

Each traffic officer has a copy of the Hazchem code and if there was any mishap he was able to decipher the code and call in the necessary people to deal with the situation.

Health services stifled by shortage

Chief Reporter

A chronic shortage of qualified professional people is stifling growth and health services in South Africa.

Professional associations, including engineers and doctors, are struggling to find ways to stretch limited manpower resources to cope with the country's growing needs.

South Africa's brain-drain, which peaked in the late 1970s, has slowed down, while the trickle of professional immigrants has increased slightly without reaching the pre-1976 level.

Despite this improvement, professional bodies report rising demands for professional manpower, which cannot be met.

Dr P J Lloyd, chairman of the manpower commission of the Federation of Societies of Professional Engineers, said there was a demand for 2 400 engineers a year, and only 1 000 graduates — creating a shortfall of 1 400.

The shortfall would limit the growth of the country, and with a lower growth-rate, the demand for engineers would be limited, he added.

The worst shortage was in the civil engineering field, with a yearly demand for 700 engineers, and a supply which has dwindled from 500 to 250.

Dr Lloyd said there were about 15 agricultural engineers for 50 posts yearly; 90 chemical engineers for 200 posts; 250 or 300 electrical engineers for 650 posts; 250 or 300 for 600 mechanical engineering posts; and 30 for 90 min-metallurgical engineering posts; and 30 for 90 mining engineering jobs.

The federation has proposed:

- A short-term solution by encouraging immigration;
- A medium-term solution by encouraging women, coloured people and Indians to become engineers;
- A long-term solution by producing more black engineers.

Dr Lloyd warned that official statistics which showed that 863 engineers immigrated to South Africa last year, were misleading.

Many of these were not professionally qualified, and only one in 10 stated to be an electrical engineer was, he said.

The federation believed in open engineering faculties to all races, he said, and was helping black engineering students study at the University of the Witwatersrand.

Professor Guy de Klerk, chairman of the federal executive of the Medical Association of South Africa (Masa), predicted a huge increase in demand for private practitioners by the year 2000.

He said that, at present, about six to eight percent of blacks belonged to medical aid societies. But by the end of the century this would increase to 80 percent.

The private medical sector must be geared to cater for the huge demand.

Professor De Klerk proposed:

- That available medical practitioners be used more optimally;
- That greater use be made of nurses and other para-medical staff who were not fully-trained doctors;
- That greater use be made of technology such as computers and television.

He said that small rural towns needed fewer doctors than cities, which experienced violence and disease caused by stress.

Dr Nthato Motlana, chairman of the Soweto Committee of 10, said there were only 12 or 13 private medical practitioners for Soweto's population of more than a million. Other black doctors were employed by the authorities at Baragwanath Hospital or clinics.

In black rural areas, doctors were almost unknown, he said. Dr Motlana blamed the Government's separate education policy for the reduction in the training of black doctors.

He proposed that all medical faculties, including those at Afrikaans language universities, be opened to blacks.

Affirmative action and bridging courses for blacks with an inferior matric should be given, he said.

The Medical University of Southern Africa (Medusa), which will produce its first black graduates soon, was not enough to cope with the shortfall, he said.

Professor Cyril Wyndham, of the Wits Medical School, said white areas in Johannesburg, Cape Town and Durban had one doctor to every 600 patients — a ratio comparable to that in cities such as New York and London.

But South Africa's homeland areas had one doctor to every 20 000 patients.

Professor Wyndham proposed that instead of trying to train as doctors those who would be reluctant to practise in rural areas, more effort should be put into training para-medical staff — as had been done in the Third World.

65 down with typhoid at mine

Sixty-five people were taken to hospital after an outbreak of typhoid fever at the Kloof gold mine near Westonaria.

Doctors say the disease was prevented from spreading.

Goldfields's public relations officer, Mr Joe Moller, told The Star: "The outbreak started at the beginning of this month but has been brought under control and the source of infection has been removed."

Mr Moller declined to name the source of infection but said 18 of the 65 people had since been discharged from hospital.

Mining sources said the most likely source of typhoid fever would be unpurified water from the Vaal, which is used underground as service water.

While clean drinking water was provided at all levels on gold mines it was not unusual for workmen to drink the service water because it was more easily available, they said.

Although chlorinated the service water was not sterilised and germs could find their way into underground working places.

Doctors at the mine said the disease was prevented from spreading because it was contained within the mining compounds and the hospital.

Health cuts will save only R2m

RDM 21/7/81 (85)

CUTS in the Government's health budget will affect more than 900 000 patients, yet the savings will amount to no more than R2-million, say spokesmen for the various services affected.

The cut-back directive created a stir at local and Government levels and the Department's officers are holding an urgent meeting in Pretoria this morning to discuss its implications.

By ADA STUIJT.

According to a Department of Health memorandum — sent to regional health directors and medical superintendents country-wide — health jobs in TB prevention, mental and dental health services and family service programmes are frozen.

Services have been frozen at 1980 levels despite the effects of inflation.

Dr Marius Barnard, Progressive Federal Party spokesman on medical affairs, called the curbs "rather foolish".

Thousands

"It would be better if the Government concentrated savings attempts on fields where only a few patients were affected. The present cuts will affect many thousands of patients of all races," he said.

"For instance, they should avoid duplication of services in the same area — such as the additional R1 500 000 heart unit at J G Strijdom, when one is already available at the Johannesburg Hospital."

In mental health, the total amount spent for single care grants for home care of mentally handicapped patients was R1 620 000 in 1980.

Mental health clinic officials said more than 2 000 black patients in the Soweto area alone were on an application list for these grants — now frozen for all who applied after March this year.

By freezing these grants R132 000 was saved.

Last year's total of 467 892 psychiatric out-patient visits may not be exceeded, alyhough more patients were treated in the first six months of this year than last year.

In the TB programme the drug Rifampicin — used extensively for last year's 11 528 patients — may not be used in greater quantities than it was in 1980.

Doctors

Doctors prefer this drug. Although it costs three times as much as other drug combinations, it sterilises lungs much quicker and therefore saves money in hospitalisation costs.

A TB specialist at the Medical University of Southern Africa, Professor E Glatthaar, said a 3-drug-combination must usually be given for not less than four to six months, as patients quickly developed a resistance.

"That's why Rifampicin is so marvellous. It sterilises the lungs much quicker — within six months or less — as opposed to other drugs taking perhaps six to nine months.

"The cost for rifampicin is R300 per patient cure as opposed to the total cost of R100 for the other kinds," he said.

But these figures do not take into account the longer hospitalisation required.

D H Pryce Lewis

of Professional Practice.
Surveying) in the subject
Architecture (or Quantity
For the best student of
David Haddon Prize

Miss C Tredgold

in third year.
For the best woman student
Molly Gohl Memorial Prize

P A Rapoport

1st, 2nd and 3rd major courses.
satisfactorily completed

FINE ART & ARCHITECTURE

ARCHITECTURE

Cape Provincial Institute
of Architects' Prize
For the best student in :-

Sixth Year

P F Dunckley

Helen Gardner Travel Prize
For a student who has

A headache at an eighth of the price

By Caroline Braun,
Consumer Reporter

A South African tourist in Italy bought a box of six Cafergot suppositories to relieve her migraine headache. She was amazed at being charged only 80c; the same product in South Africa costs R6,44 — more than eight times the price.

A random survey comparing the prices of seven drugs in South Africa with the identical products in three overseas countries showed that, in most cases, South African drugs were by far the most expensive.

Health is an emotive issue, and a look at the accompanying chart is enough to make the average South African consumer's blood pressure rise.

But although South Africans do pay more for drugs at retail level than many overseas consumers, the matter is not quite that simple.

In fact, as local pharmaceutical companies are at pains to point out, drug price comparisons are not ones.

When comparing local with overseas prices one must also take into account whether the entire drug is made overseas and then imported to South Africa, whether only the active ingredients are imported, or whether the drug is made entirely in South Africa.

Drugs which are imported in their complete state (as is the case with most of those in our survey) are subject to substantial customs duties, freight costs and, often, insurance costs. The registration fee for an imported drug is double that for a locally-made drug, and the retention fee (to keep it registered), can be up to three times that for a local drug.

Mark-ups along the drug distribution chain vary from country to country, which further contributes to price differences.

In South Africa, the manufacturer's price represents about 55 percent of the retail price. The wholesaler receives a 21,2 percent markup, and the retail pharmacist a 50 percent mark-up.

A country's state of economy also influences its drug prices. In Italy, for example, where the economy is shaky, drug prices were "frozen" for 20 years. Prices were increased last year for the first time since 1960, but only by 20 percent.

There is a further important factor to account for the large drug price discrepancies between Italy and South Africa.

In Italy, drug patents are not guaranteed or respected, and there are a host of pirate companies which flood the market with generic equivalents as soon as a new drug is introduced.

An example of this was when the Roche company put Valium on the market, 24 copies were produced within months.

This lack of respect for patents is a serious deterrent to research. Drug companies are disinclined to spend millions of rands (usually 10 to 15 percent of their turnover) on research only to have other companies jumping on the bandwagon.

In South Africa, there are no pirate companies, and patents are guaranteed for their entire period.

In many European countries, the public is reimbursed by the government for medicine purchases. It is, therefore, in the Government's interest to keep drug prices as low as possible.

It must also be remembered that residents in these countries often pay a percentage of their salaries to Social Security or National Health schemes. Part of this money is used to subsidise drug costs, which results in lower retail prices.

South Africa's Medicines Control Council sets very high safety and quality standards when deciding whether to accept a product for registration.

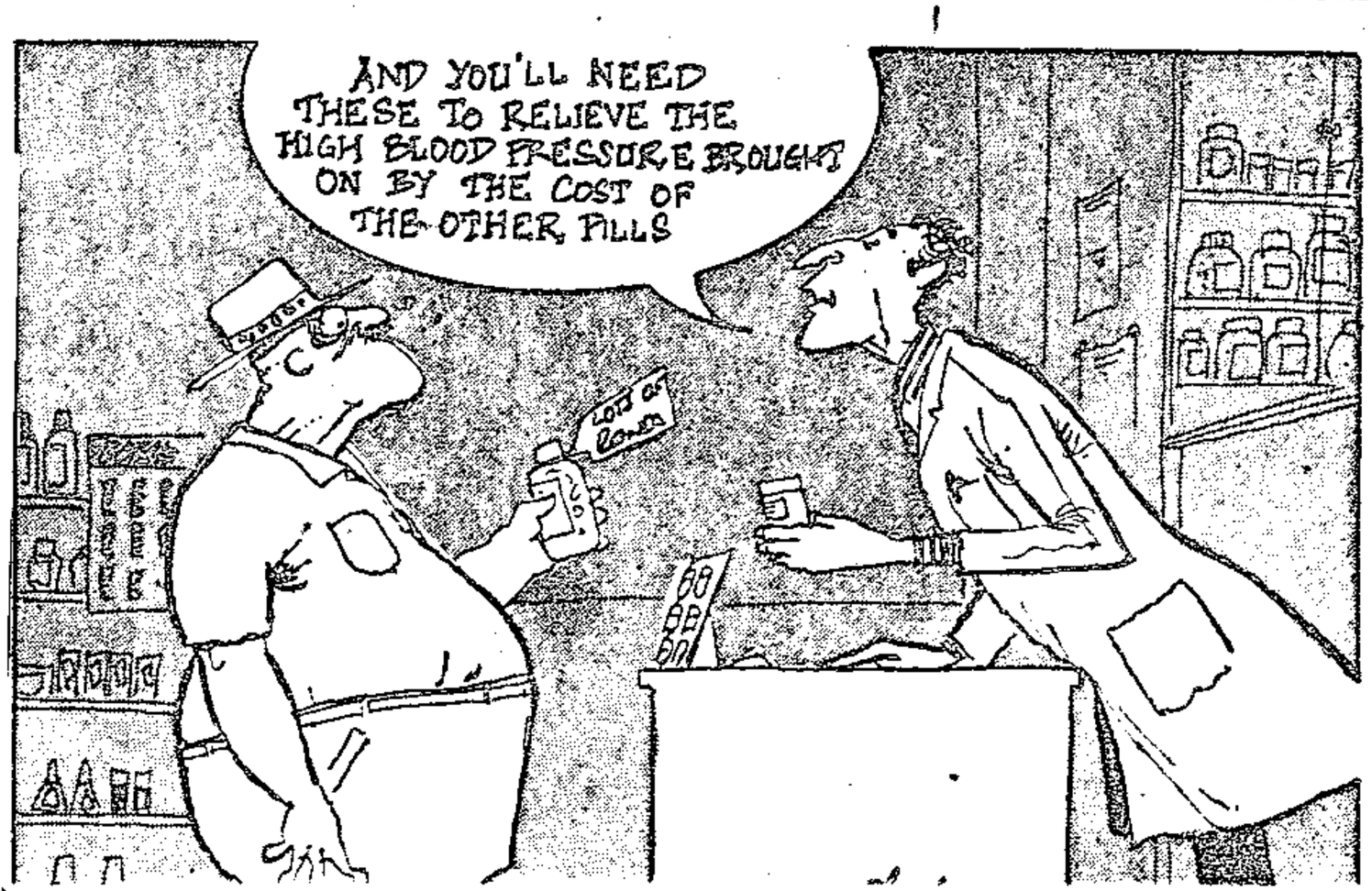
There is no direct price control on drugs in South Africa, but the pharmaceutical industry is subject to a profit control. A manufactuer may not increase or introduce a new product price without the approval of the Price Controller — and the Controller does not allow a company's profits before tax to exceed 15 percent.

The question of whether South Africa's pharmaceutical industry overcharges the consumer is a thorny and emotive one.

The industry has come under public scrutiny time and time again. In the past 18 years there have been four Commissions of Inquiry to investigate whether pharmaceutical companies make excessive profits. None has found evidence of this.

	South Africa	Britain	France	Italy
Cafergot Suppositories (6) (Sandoz)	6,44	2,13	1,11	80c
Stugeron Forte (30 pills) (Janssen)	8,16	8,79	5,04	2,37
Feldene 10 mg (60 pills) (Pfizer)	26,34	16,02	10,82	—
Sectral 400 mg (28 pills) (Maybaker)	18,00	20,61	10,44	—
Opterom Eyedrops 10 ml (Fisons)	10,81	8,00	4,67	—
Diamicron 80 mg (60 pills) (Servier)	19,50	10,68	12,51	8,16
Uticillin 500 mg (30 pills) (Beecham)	18,26	14,73	—	—

● Retail prices of drugs



29/7/81

STAATSKOERANT

VAN DIE REPUBLIEK VAN SUID-AFRIKA

85

GOVERNMENT GAZETTE

REPUBLIC OF SOUTH AFRICA

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Vol. 193] KAAPSTAD, 29 JULIE 1981 [No. 7684
CAPE TOWN, 29 JULY 1981

ALGEMENE KENNISGEWING

GENERAL NOTICE

DEPARTEMENT VAN GESONDHEID, WELSYN EN PENSIOENE

DEPARTMENT OF HEALTH, WELFARE AND PENSIONS

Die volgende konsepwetsontwerpe word hierby vir algemene inligting en kommentaar gepubliseer.

Kommentaar daarop en vertoë daaromtrent moet voor of op 31 Augustus 1981 aan die Direkteur-generaal: Gesondheid, Welsyn en Pensioene, Posbus 3879, Kaapstad, 8000 gestuur word.

(a) Wysigingswetsontwerp op Gesondheid, 1982;
(b) Wysigingswetsontwerp op Vrugafdrywing en Sterilisasie, 1982;
(c) Wysigingswetsontwerp op Apteekers, 1982.

The following Draft Bills are hereby published for general information and comment.

Any comment and representations thereanent should be forwarded to the Director-General: Health, Welfare and Pensions, PO Box 3879, Cape Town, 8000 on or before 31 August 1981.

(a) Health Amendment Bill, 1982;
(b) Abortion and Sterilization Amendment Bill, 1982;
(c) Pharmacy Amendment Bill, 1982.

QUANTITY SURVEYING

(Continued)

Bell-John Prize
For the best all-round student in any year of study.

P C Key

The Committee of the Western Cape Chapter of Quantity Surveyors' Prize
For the student obtaining the highest marks in Professional Practice.

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URBAN & REGIONAL PLANNING

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Mail Reporter

THE Minister of Health, Dr L A P A Munnik, has rejected the South African Medical and Dental Council recommendations for increases of 25% in dental fees and 50% in physiotherapist fees.

The recommendations, made in April, have been referred back to the council for further consideration. The Minister, it is understood, was not satisfied that the motivation for the increases was strong enough.

According to a spokesman for the medical council, the dentist and physiotherapist tariff committees will meet to review the extent of the increases.

They would report to a full meeting of the council in October after which a representation would be made to the Minister.

This means that increases in the tariffs could be delayed until the end of the year, as the Minister is given three months to respond to any application for fee hikes.

Last month Dr Munnik approved increases of 9,9% in doctors' fees. But here, too, the Minister was not satisfied and referred the application back to the council.

Not only did the Minister question the extent of the increases asked for, but after having agreed to them, he delayed their implementation until September 1.

Thursday, July 30, 1981

Minister rejects medical fees hike

Let us be honest and state clearly that better health through preventive health education lies in the hands of those members of a health team who have cared for and cured the patient in the past, they are the people that have the credibility and the trust and the confidence of the patient. Consequently increased expenditure in the preventive field should be to those people in the community who practice comprehensive medicine curative and preventive and can apply it. Dr. David Sone's essay on 'Pri Prevention' by Nuffield Provincial Hospitals Trust concludes that isolated schemes are unproven and expensive except immunisation.

THE FUTURE

What of the future ?

I would like to see our new and highly enlightened Health Act fu implemented as soon as possible with a unified curative and preventive service run from community health centres.

I would like to see medical administrators who were health and community orientated as well as disease and hospital orientated. I would like to see medical administrators who were trained in this field and not just failed clinicians. I would like to see proper training facilities for those who work in the community. In our free contraceptive services, mankind now, for the first time, has the power to control his destiny. I would like to see communities accountable for their population growth and those that show responsibility receive the benefits due to them.

IN CONCLUSION

The role of modern medicine should be to help us safely into this world and comfortably out of it and during life to protect the well and care for the sick and disabled.

It has been said that historians of 20th century medicine might easily be overwhelmed by the spectacular break-throughs and technical wonders wrought by the fruitful marriage of medicine and the scientific method, and overlook some of our human and equally difficult accomplishments in the organisation and

/delivery of health ....

delivery of health care. The use of health teams may well come to rival our brightest technological triumphs by the way they have gone about changing attitudes to health, by mobilising communities at the grass roots, activating them in decision making and self care.

Our society now believes, amongst other things in the probability of [illegible] through systematic organization of

DAILY DISPATCH, FRIDAY, JULY 31, 1981 — 5

Concern over rise in forced circumcisions

UMTATA — The Justice Department was perturbed at the increase of forced circumcision of men, especially elderly people, in the Matatiele District.

The secretary of the department, Mr J. Zeka, said his department was going to take steps against the perpetrators. He said there were known cases of victims who were ill-treated and subsequently died.

"The Department of Justice is charged with the maintenance of law and order and is perturbed by the breakdown of law and order in the Matatiele District," he said.

"The district is inhabited by Sotho-and Xhosa-speaking people. Both of these tribes practise the circumcision custom.

"In recent years it has become apparent that some members of these tribes are overstepping the normal tribal bounds in the exercise of this custom".

If a man evaded the custom until he was over 60 years these men did not think he was too old.

They caught him and dragged him into the circumcision school and circumcised him without his consent.

"It is significant that in all these cases chiefs will turn a blind eye and will not report to the police". The Department of Justice could not sit back and pretend that all was well when lives were lost in this manner.

"Steps are to be taken to prefer criminal charges against those who are responsible for the perpetration of this barbaric behaviour". — DDR.

Political changes 'key to SA health'

Anglo 11/8/81

Medical Reporter

THE health of people would not improve unless South Africa saw political and economic changes, the organisers of the University of Cape Town's medical students' conference said last night.

'Ill-health in South Africa is not simply a result of invasions by bacteria, it is a product of the country's economic development,' they said in a paper presented by one of the conference organisers, fourth-year student Mr David Goldblatt.

South Africa's two biggest health problems were tuberculosis and malnutrition, with black people contracting 98 percent of TB cases.

'Black South Africans bear the brunt of all diseases,' said Mr Goldblatt.

DEATH RATE

The pro rata death rate for black babies was up to six times higher than that of white infants, he said.

Another speaker, Dr Noddy Jinabhai of the Durban Medical School's community health department, said local health services were divided artifically and fragmented by complex legislation.

The Health Act of 1977 had aggravated this fragmentation.

Both Dr Jinabhai and Dr John Frankish, of Heideveld Day Hospital, agreed that South Africa's health services had been affected by a majority of patients not having a say in political decision-making processes that affected such services.

MORE STAFF

'I am sure that if local communities were consulted they would want more medical personnel at day hospitals,' said Dr Frankish.

Day hospital doctors each usually saw between 70 and 80 patients daily which meant on average consultation could last five minutes only.

'One never feels that one has spent enough time with a patient and this leaves both patient and doctor feeling dissatisfied,' he said.

There were not enough doctors however, to meet the country's health needs; additional paramedical staff would have to be trained.

The public conference, which was opened last night by UCT's principal and vice-chancellor, Dr Stuart Saunders, ends tomorrow.

LIFE ASSURANCE (85)

Hearty gains

FM 14/8/81

The contributions of the life assurance companies to campaigns combating premature death from heart disease could be reaping rewards.

Fewer insured people died of heart diseases in 1980 than in 1979. According to the Life Offices' Association of South Africa's annual review of life insurance cover, there were 7 756 claims for death resulting from cardio vascular disease, which is 2,4% fewer than 1979.

A possible reason for this slowdown in heart deaths is the greater public awareness of the contributory factors to coronary disease. The review points out that "considerable financial and other support to the campaigns to fight heart disease has been provided on an individual basis by member companies."

The main causes of death recorded by the eight largest life offices during 1980 (with 1979 figures in brackets) are as follows:

□ Cardio-vascular diseases 46,4% (48,8%); violent deaths 14,9% (15,4%); cancer 13,4% (14,2%); respiratory disease 8,1% (6,8%); and other causes 17,2% (14,8%).

As the table shows, the rate of increase in group and pension business dropped back sharply to 16,2% from 44,1% in 1979. The Association says that the 16,2% is closer to real growth in new pension business. In 1979 and to some extent in 1978, numerous private pension funds came into the ambit of the assurance industry thus grossly exaggerating the growth figures. A spokesman from the Association says that in future the review will probably separate the two figures.

The marked increase in individual ordinary premiums of 25,3% (13,4%) is attributed by the Association to the growing popularity of life insurance policies as a means of investment.

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Medical research

*17. Dr. M. S. BARNARD asked the Minister of Health, Welfare and Pensions:

(1) What is the total amount spent annually by his Department on medical research in the Republic;

(2) how many doctors are employed by his Department in the field of medical research;

(3) whether his Department co-ordinates medical research in order to prevent duplication?

†The MINISTER OF HEALTH, WELFARE AND PENSIONS:

(1) The following amounts were spent during the previous financial year:

By the Department	R2 728 195
By the S.A. Medical Research Council	7 368 800
	R10 096 995

(2) Full-time 11
Part-time 16
27
(Excluding the MRC)

(3) Yes.

EXTRACT FROM LETTER FROM THE INDUSTRIAL DEVELOPMENT CORPORATION TO MR A. MENDELSOHN

. . . Should you wish to move your factory to Darling, where the Industrial Development Corporation are planning to erect a set of factory flats, you may qualify for the decentralization concessions of the Board for the Decentralization of Industry, Pretoria.

Whereas Darling is at present not officially classed as a decentralized growth point by the Department of Planning, the Decentralization Board may consider granting you concessions on an ad hoc basis, with your case being considered on its individual merits. You should in the first instance, therefore, apply to the Decentralization Board for decentralization concessions, which to our knowledge of the policy of the Board, are likely to comprise the following:

1. INCOME TAX CONCESSIONS

Your income tax payable will be reduced by amounts equal to the following percentages:

(i) 40 per cent of total wages paid to all or additional Blacks employed by you over the first two years after establishment at Darling.

Small families first priority, says Loubser

Argus 13/8/81 (85)

Provincial Staff

THE quality of life of all people in South Africa will have to be improved on a broad front if the authorities envisage health for everyone, the MEC in charge of hospital services, Mr P J Loubser, said yesterday.

Speaking on the Provincial budget vote on hospitals, Mr Loubser argued that South Africa's first priority was the promotion of family planning.

'To what extent can we succeed in our striving if the population continues to increase at the currently excessive tempo?' he asked.

'It can also be said that no authority with the best medical services in the world can bring health to people if the numbers of dependants continue to become greater and greater in comparison with the breadwinners.'

MOVE AWAY

Mrs Di Bishop (PFP, Gardens) said she believed no one would dispute the importance of family planning.

She appealed, however, to the Administration to move away from statements by former MP, Mr M C Botha and Mrs Bettie Scholtz, MP for Germiston District, about the need to produce more white babies.

'If the Administration is earnest about promoting family planning, I appeal to them to have regard to the political milieu in which family planning must take place,' Mrs Bishop said.

BEST WAY

Mr Frank van der Velde (PFP, Wynberg) said: 'The best way to encourage family planning is to improve a man's standard of living.

'As soon as a man lives above the breadline, he's very conscious that his living is eroded by more children.'

In reply, Mr Loubser said family planning should not be seen merely as birth control.

He invited every woman of child-bearing age to use his department's services for advice on planning a family, ante-natal care, birth and post-natal care.

V.C. Maine...

Introduction

These notes are based on a preliminary e late
Mrs Anne (Bailen) Zurne on 15th April terviews
(30th April and 20th May 1980) and a s she wrote
during this period. The tapes have be l
material deposited with the Department rsity of
Cape Town. The tapes give insights in District
Six, its shops, streets and celebratio at
happened to Russian Jewish immigrants

Anne Zurne was born in 1907 - second o n of Hyman
and Esther Bailen. What is told here r parents'
story. Hyman Bailen - born in Omsk i orporal in
the Tsar's army, who left Russia for ere he
became a seller of carpets - arrived during
the 1890s. Anastasia (known as Esthe in this
country) was also a Bailen, a cousin and. She
was born in Tomsk in 1881, became sew gymnasium
in Siberia, and was sent by her paren around
1900, when their community was threat

Had the way been paved by other famil ly so, for
the Bailens were connected to the Pol tore
renown, and others. In time to come, nother and
sister followed, but lived in Lourenc ne sister's
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to District Six, or what employment he took up on his arrival.

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TRIBUNE REPORTER

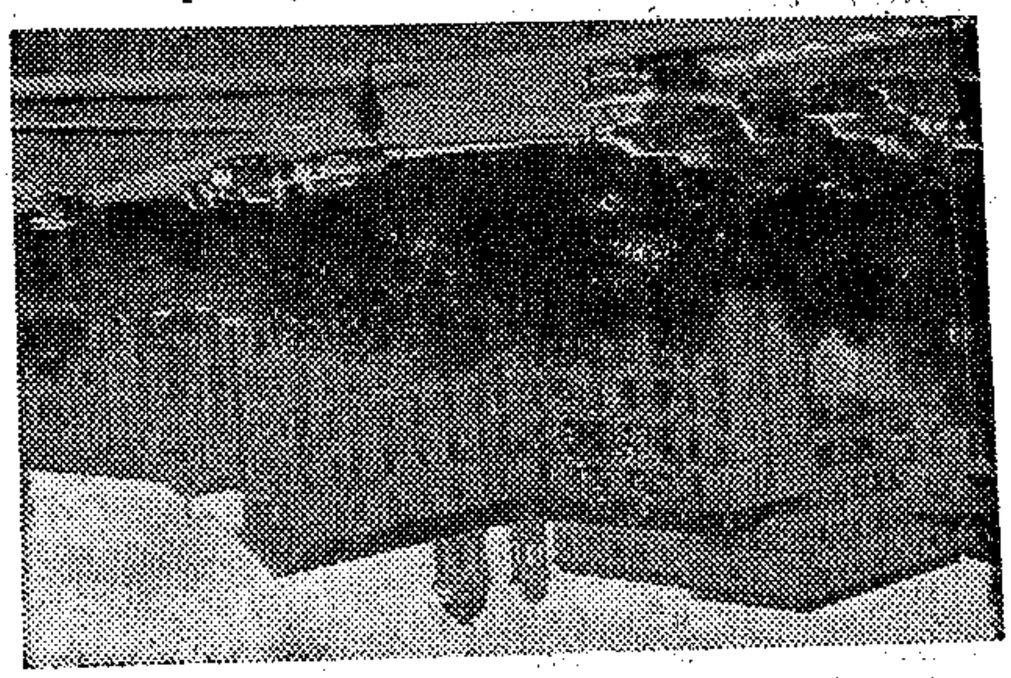
Groote Schuur Hospital . . . serious damage was done by inadequate budget increases

EVERY second African can and coloured person who dies in South Africa is a child under five, says one of the country's top medical men, Professor Solly Benatar.

This striking statistic has been revealed by Professor Benatar in his inaugural address as head of the University of Cape Town department of medicine, as part of a devastating analysis of the state of health care in the country.

It reflects a trend in developing countries where over-promotion of drugs, many of them with little therapeutic value, attracts expenditure on these by people who often do not even have enough money to feed themselves.

"In 1979 only 2,2 percent of the allocated health budget was spent on preventive medicine and this was increased to 2,85 percent last year. This was still highly inadequate, but additional funds alone would not solve the problems," he



TO DIE
CONTINUE
YOUNG ONES
IN CRISIS
MEDICINE
... AND
THE

S. Tribune 18/8/81

SUNDAY TRIBUNE, AUGUST 16, 1981

He is also head of the division of medicine at Groote Schuur Hospital.

He says the high number of black and coloured children dying is a "cause of great concern", especially as the figures for whites compare favourably with those in America.

Other important points he made include:

● The percentage of the Gross National Product spent on health declined from 4,2 percent in 1976 to 3,4 percent last year, and is now only a third of the percentage spent in America, Germany and Sweden.

● Serious damage was done to Groote Schuur Hospital by "clearly inadequate" budget increases in the late Seventies and while the Cape Provincial Administration had realised the serious consequences of the cutback, this would take a long time to repair.

Morale dropped, and many senior staffers left for more satisfying and financially rewarding work in the private sector or overseas, and had had to be replaced by more junior staff, whose further training would take a considerable amount of time.

● While only 7 percent of Government expenditure went to health services, 16,9 percent went to defence.

The cost of one tank could provide a thousand classrooms for 30 000 children and that of a modern jet fighter could be used to finance 40 village pharmacies.

Professor Benatar said the majority of resources were spent on curative services in the towns, so many people in the lower socio-economic groups, living beyond the immediate confines of major cities, were still dying prematurely of infective and other preventable diseases.

"Less than 2 percent of health expenditure in South Africa was on research and development, compared to 19 percent in America, while a disproportionately large 21 percent was spent on drugs and pharmaceuticals in this country, compared to 8 percent in America.

"This high percentage of the health budget spent on drugs and pharmaceuticals

"Dr Johann de Beer, Director General of the Department of Health, Welfare and Pensions, has recently announced that this percentage will be steadily increased annually over the next 20 years and by the year 2 000 will constitute 15 percent of the health budget.

"Within a few days of his announcement a memorandum was received by regional health directors and medical superintendents throughout the country, informing them that large financial cuts would be made in the nation's tuberculosis prevention programme as well as in mental and family health service programmes.

"In view of the very high incidence of tuberculosis in South Africa this is not only totally inappropriate, but also irreconcilable with the apparent increased expenditure being devoted to preventive medicine."

Professor Benatar says that if we continue to spend less and less of our Gross National Product on health and at the same time increase the proportion of the total preventive medicine, we must recognise that our curative health services will inevitably deteriorate.

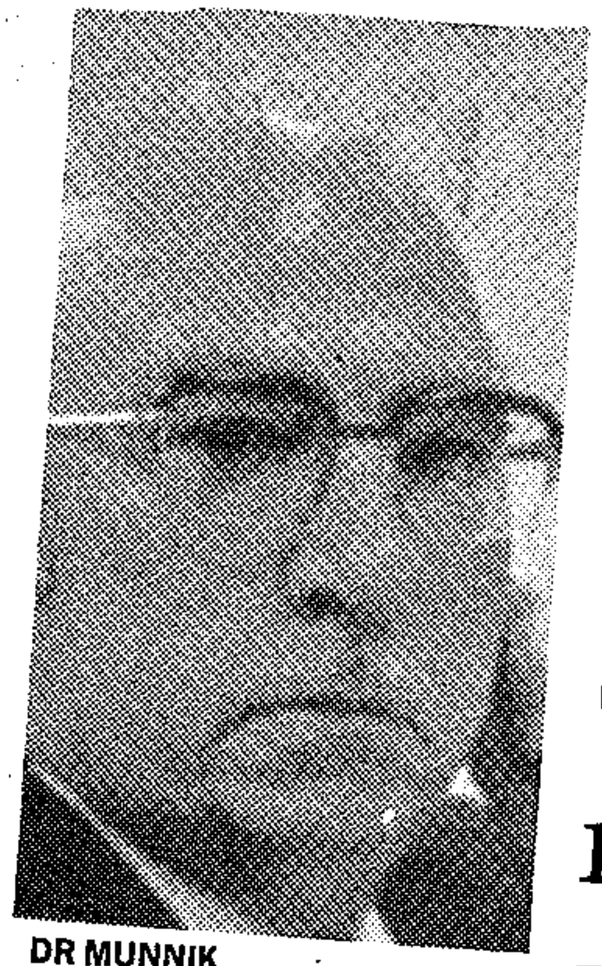
"New district hospitals will not be built at the rate required to cope with the growth in population and teaching hospitals will have to take on an even greater work load, and thus function more and more as service district hospitals.

"Teaching standards will be eroded, the quantity and quality of research work being done in our medical schools will fall, and the quality of special care, which has been notable in our teaching hospitals, will also deteriorate.

"A careful look at the use of our currently available curative facilities in Sotuh Africa will show that these are already being stretched to their limits."

He adds: "There is no doubt that the medical profession, particularly in the modern westernised society, is facing a crisis characterised by rising costs of health care and criticism of doctors lack of compassion and humanity, their arrogance and narrow education."

There IS a crisis, Dr Munnik!



DR MUNNIK
"Is this a crisis?"

Health services facing collapse, Govt report warns

By HELEN ZILLE

SOME health services are threatened with collapse by serious staff shortages, the Department of Health, Welfare and Pensions warns in its annual report tabled in Parliament yesterday.

The warning comes less than a week after the Minister of Health, Dr L A P A Munnik, denied there was a serious shortage of nurses and described the situation as a "so-called" crisis.

In sharp contrast, the report of his department for the past year warns it will not be able to meet its commitments "even on the basis of minimum efficiency", because of the serious staff shortages.

Shortages of nursing staff and health inspectors have reached serious proportions, it says.

"As a result of the staff situation, essential services for which the department is responsible are being rendered unsatisfactorily, and certain services run the risk of collapsing."

The report says staff shortages reached "dramatic proportions" towards the end of last year — and Dr Marius Barnard, Opposition spokesman on health, said yesterday that according to his information, the situation had deteriorated since then.

Dr Barnard attacked Dr Munnik for "devoting a large portion of his speech in Parliament last week to attempting to show there was no serious nursing shortage".

"Instead, he said the position was due to surplus hospital beds for whites," Dr Barnard said.

"Either the Minister is wrong, or his department and the country's leading doctors are wrong.

Prove it

He said it was up to Dr Munnik to prove his competence — "and if he cannot, he should resign or be replaced."

During his speech last week during the Censure Debate, Dr Munnik said he wished to analysethe "so-called crisis".

In the Cape Province, 90% of the existing posts were filled.

"Is this a crisis?" Dr Munnik asked the House.

In Natal, 96% of the vacant posts were filled, in the Free State 86% and in the Transvaal 76%, he claimed.

After rejecting allegations of a critical nursing shortage, Dr Munnik said: "One of our biggest problems in this country today is that we have too many (hospital) beds for whites ...

"We cannot build more hospitals and then wonder why we have a shortage of nurses, for then the shortage is on paper and in terms of the buildings we have erected."

Dr Barnard noted that Dr Munnik's statements had been repudiated by leading medical specialists and the Medical Association.

"Either the Minister's facts are incorrect or the situation has improved dramatically recently. My information is that matters have actually deteriorated," Dr Barnard said.

The department's report gives no statistics of countrywide staff shortages. However, it gives a table of vacancies in "representative entry posts".

This table shows a 40% shortage in the "health nurse" category, a 54% deficit in the "male staff nurse/staff nurse" category and a 70% shortage of "student nurse/student male nurse" personnel.

expressed as a fixed amount plus a percentage of the retailer's turnover. The exclusion of such amounts is understandable since they do not represent a firm commitment.

ED22 notes that if lease payments are charged against income as incurred this may result in a failure to match costs against revenue, and cites the following examples -

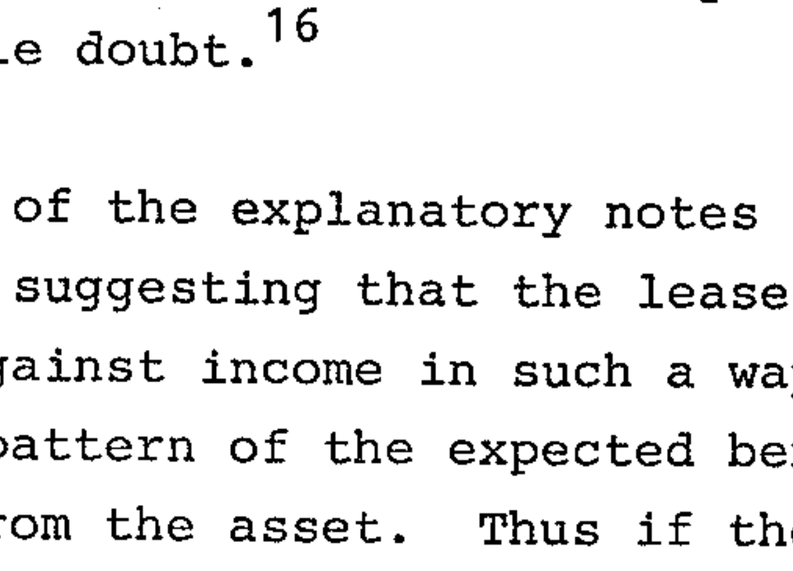
(a) where the lease payments are not spread equally over the term of the lease.

(b) where the lessee has to make payments prior to bringing the leased asset into use.

(c) where the initial term of the lease is significantly shorter than the period over which benefits will be derived from the asset and a renewal option exists, the exercise of which is assured beyond reasonable doubt.[16]

This section of the explanatory notes to ED22 continues by suggesting that the lease payments be charged against income in such a way as to reflect the pattern of the expected benefits to be derived from the asset. Thus if the lease payments were front-end loaded, portion of the payments would be deferred, and vice versa. This problem does not arise if the leased asset is capitalised and depreciated systematically.

Example 2 : Defe



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lease is 6 years. per month
for the first year after. At

High medical cost a health 'threat'

Science Reporter

THE nation's standard of health is threatened by soaring costs of medical care, the heavy workload on health-care personnel and the lack of facilities in rural areas, according to Professor A J Brink, president of the Medical Research Council, in his annual report.

The report, tabled in Parliament yesterday, said that medical research in the past had made real contributions to the prevention and treatment of physical illnesses.

This expertise could also be successfully directed to improving the ability of the medical profession to help the patient in need.

The Tuberculosis Research Council was currently testing a number of new drug combinations aimed at the reduction of treatment time. About 1 000 patients had taken part in a trial of the drugs and the majority had been cured within four months. Seen against the annual state budget of R39m, this represented a major saving.

The problem of relapse and readmission to psychiatric hospitals in South Africa was being investigated by the MRC's unit for research into clinical psychiatry based at the University of Cape Town.

This was a national health problem as readmissions to psychiatric hospitals were about 60 percent. Factors such as family pressures, psychological and social problems and failure to take prescribed drugs had already been identified but more information was needed to enable specific action to be taken.

At Garankura Hospital an MRC-supported project was investigating a nutrition education programme for mothers of under-nourished pre-school children admitted to hospital. It was hoped that the education programme, tailored to the family's resources, would help to lower the readmission rate.

Other studies which had looked at outpatient waiting times in large hospitals had identified bottlenecks in patient flow.

Links aid research

Science Reporter

INTERNATIONAL co-operative agreements arranged by the Medical Research Council have proved of great benefit to medical research in South Africa.

An agreement with the Israeli National Council for Research and Development is working well — so far three scientific meetings in cardiology, immunology and disease epidemiology have been held with prominent scientists from both nations taking part. A further meeting has been arranged for March, 1982 in Cape Town.

The theme of the meeting will be the medical care of children, with emphasis on the newborn — an area of mutual concern in both countries. According to Professor A J Brink, the MRC president, a joint research programme particularly in coronary heart disease would be of great advantage.

Other agreements with overseas agencies have enabled the MRC to provide sophisticated services for medical research which would not have been possible because of high costs.

A computerized biomedical information service, which at the press of a button gives access to thousands of medical publications throughout the world, is an example.

Centre aiding cancer studies

Science Reporter

CONSTRUCTION of the R16-million Nuclear Accelerator Centre in the Cape has reached an advanced stage and is already an aid in cancer research, Dr P D R van Heerden of the Medical Research Council said yesterday.

According to the MRC report, the Nuclear Accelerator Centre at Faure, on the outskirts of Cape Town, is one of six similarly sized centres in the world but is unique in that it has a triple function — basic research in nuclear physics, manufacture of radio-isotopes for use locally and abroad, and applications in the biomedical sciences. The centre will give new hope to cancer sufferers and a 30-bed hospital is to be built nearby.

Preliminary tests at the centre are expected to begin in 1984, the report said.

Hypertension a big killer in the townships

SEVERE malignant hypertension is "extremely common" among urban blacks, says the Medical Research Council.

The findings of a study undertaken in Johannesburg were contained in the council's 1981 annual report tabled in Parliament yesterday.

The study, done by Dr R J Milne of the renal unit at the University of the Witwatersrand, documented the prevalence of hypertension in black patients admitted to a Johannesburg hospital.

A quarter of the patients taking part in the test died and 40% needed kidney dialysis.

Sapa.

Shift is to preventive medicine, says MP

CT 28/8/87 85

HOUSE OF ASSEMBLY. — The government intended solving most of the country's health and social welfare problems through good co-ordination, planning and the establishment of community health-care centres, Dr W J Snyman (NP Pietersburg) said yesterday.

He said during the debate on the budget vote of the Minister of Health, Welfare and Pensions, Dr L A P A Munnik, that the intention was to shift the accent from curative to preventive medicine, and this year's budget showed an increase of R130 000 for the treatment of diseases related to malnutrition.

He said that in an earlier speech in the Assembly, Dr Marius Barnard (PFP Parktown) had stated that 50 000 people were dying every year from diseases related to malnutrition.

"These figures are wrong and are clearly an effort to bring South Africa's medical services into discredit in the eyes of the world."

The official figure for all population groups in the country was 3 195, and Dr Barnard could have obtained these figures had he approached the Department of Health.

Dr Snyman said he favoured the fluoridation of drinking water in South Africa, pointing out that there was proved evidence that it prevented tooth decay.

Arguments that the fluoridation of water resulted in diseases such as cancer, loss of concentration and intelligence and an increase in the incidence of mongols, were unfounded, he said. — Sapa

BYLAE

1. In hierdie Bylae, tensy dit uit die samehang anders blyk, beteken "regulasies" die regulasies afgekondig by Goewermentskennisgewing R. 2276 van 3 Desember 1976, soos gewysig by Goewermentskennisgewings R. 1830 van 16 September 1977, R. 444 van 10 Maart 1978, R. 812 van 20 April 1979 en R. 1098 van 22 Mei 1981.

2. Regulasie 1 van die regulasies word hierby gewysig deur na die omskrywing van "algemene tandheelkundige praktisyn" die volgende omskrywing in te voeg:

"'die Wet' die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974);".

3. Opmerking (3) van die opmerkings by regulasie 4 (3) word hierby gewysig deur die woord "drie" in die derde reël te vervang deur die woord "ses".

SCHEDULE

1. In this Schedule, unless the context otherwise indicates, "regulations" means the regulations published under Government Notice R. 2276 of 3 December 1976, as amended by Government Notices R. 1830 of 16 September 1977, R. 444 of 10 March 1978, R. 812 of 20 April 1979 and R. 1098 of 22 May 1981.

2. Regulation 1 of the regulations is hereby amended by the insertion of the following definition after the definition of "general dental practitioner":

"'the Act' means the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974).".

3. Note (3) of the notes to regulation 4 (3) is hereby amended by the substitution for the word "three" of the word "six" in the first line.

No. R. 1839 28 Augustus 1981

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD.—REGULASIES BETREFFENDE DIE GELDE BETAALBAAR

Die Minister van Gesondheid, Welsyn en Pensioene het, op aanbeveling van die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, kragtens artikel 61 (1) (e) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974), die regulasies in die Bylae hiervan uiteengesit, uitgevaardig.

BYLAE

1. In hierdie Bylae beteken—

"die Wet" die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974), en het enige uitdrukking waaraan 'n betekenis in die Wet geheg is, daardie betekenis en tensy uit die samehang anders blyk, beteken—

"artikel" 'n artikel van die Wet.

2. Registrasiegelde betaalbaar kragtens die bepalings van die Wet is soos volg:

(a) Deur 'n geneesheer of tandarts wat voldoen het aan die bepalings van artikels 24, 25, 26 of 30: R75.

(b) Deur 'n student, student-intern, intern, sielkundige, intern-sielkundige of 'n lid van 'n aanvullende gesondheidsdiensberoep: R10.

(c) Deur 'n geneesheer of tandarts vir die registrasie van 'n spesialiteit: R100.

(d) Deur 'n persoon wat kragtens artikel 35 'n addisionele kwalifikasie registreer: R10.

(e) Deur 'n geneeskundige tegnoloog, radiografis, psigotegnikus of sielkundige vir die registrasie van 'n addisionele kategorie in die betrokke beroep: R10.

3. Gelde betaalbaar kragtens die bepalings van die Wet vir terugplasing van 'n naam op 'n register, is soos volg:

(a) Deur 'n geneesheer of tandarts—

(i) naam teruggeplaas kragtens artikel 19 (5): R50;
(ii) naam teruggeplaas kragtens artikel 42 of 51: R75;
(iii) spesialiteit of addisionele kwalifikasie teruggeplaas kragtens artikel 35: R10.

(b) Deur 'n sielkundige of lid van 'n aanvullende gesondheidsdiensberoep—

(i) naam teruggeplaas kragtens artikel 19 (5): R10;
(ii) naam teruggeplaas kragtens artikel 42 of 51: R10.

No. R. 1839 28 August 1981

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL.—REGULATIONS RELATING TO THE FEES PAYABLE

The Minister of Health, Welfare and Pensions has, on the recommendation of the South African Medical and Dental Council, in terms of secion 61 (1) (e) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), made the regulations set out in the Schedule hereto.

SCHEDULE

1. In this Schedule—

"the Act" means the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), and any expression to which a meaning has been assigned in the Act shall bear such meaning and, unless inconsistent with the context—

"section" means a section of the Act.

2. Registration fees payable under the provisions of the Act are as follows:

(a) By a medical practitioner or dentist who has complied with the conditions of sections 24, 25, 26 or 30: R75.

(b) By a student, student-intern, intern, psychologist, intern-psychologist or member of a supplementary health service profession: R10.

(c) By a medical practitioner or dentist for the registration of a speciality: R100.

(d) By a person who in terms of section 35 registers an additional qualification: R10.

(e) By a medical technologist, radiographer, psychotechnician or psychologist for the registration of an additional category in the relative profession: R10.

3. Fees payable under the provisions of the Act for restoration of a name to a register are as follows:

(a) By a medical practitioner or dentist—

(i) name restored in terms of section 19 (5): R50;
(ii) name restored in terms of section 42 or 51: R75;
(iii) speciality or additional qualification restored in terms of section 35: R10.

(b) By a psychologist or member of a supplementary health service profession—

(i) name restored in terms of section 19 (5): R10;
(ii) name restored in terms of section 42 or 51: R10.

Brain drain warning

Political Staff

HOUSE OF ASSEMBLY. — Professor A J Brink, chairman of the Medical Research Council, has said that the health of all South Africans is being affected by critical problems connected with the provision of health services.

Writing in the council's annual report tabled yesterday, Professor Brink said there was "an overwhelming need to undertake research on the delivery of health care".

He also said the country had lost "numbers of our best scientists". However, younger scientists were showing considerable ability and commitment to research concerning specifically the health problems of South Africa.

"The soaring costs of medical care, the growing need to provide health facilities in many rural communities, the increasing workload placed on the available health-care personnel are critical problems affecting the standard of health of all South Africans," Professor Brink said.

He believed that the involvment of the council and researchers would help to ensure that the health needs of South African could be met.

In an interview, Professor Brink said it was worrying that South Africa was losing so many of its best scientific researchers because of limited professional structures and research fields.

It was heart-rending, he said, to travel overseas and encounter so many top researchers who had left South Africa. Most of them had left for professional and not political reasons.

It was a great blow to South Africa, to lose this brain power and at the same time it was costing the country a lot of money.

We can estimate $\bar{X}$ for the workforce by $\bar{x} = 1,296$
and s^2, the sample variance, is calculated to be 2,397.
Using a normal approximation, the 95% C.I. for $\bar{X}$ is:

$$1,296 \pm 1,96\sqrt{2,397\left(1-\frac{1000}{36000}\right)\cdot\frac{1}{1000}}$$

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HOUSE OF ASSEMBLY. — The Budget vote on Health, Welfare and Pensions was passed yesterday after heated debate over the government's pension policy.

The minister, Dr L A P A Munnik, said during the debate that in future his department would try to bring home a total health concept to the population.

He announced that his department would be distributing a booklet to the aged in October dealing with healthy diets and the promotion of health in general.

"The question of how we eat is important and we must tell the people that they can eat well and healthily at a reasonable price.

"We must base our dietary needs on the requirements laid down by the World Health Organization.

"If we eat better there will be less chance of coronary and other diseases."

The minister said that the booklet, which would be distributed to the aged, would be followed up by regular pamphlets on health.

He had also had talks with the Minister of Foreign Affairs and Information, Mr Pik Botha, who was the minister in charge of the SABC, with a view to promoting the health of the nation on the second television channel to be introduced soon.

"The aim will be to have documentaries on better diets, health education and cleanliness."

The minister said alcohol, drug abuse and excessive smoking were evils which could be overcome.

If South Africans continued to smoke and drink at the present rate, which was extremely high, "the evil of these deeds will overcome the people of South Africa before the evil of communism".

Moderation, he said, was the key word.

Dr Munnik said that many of the problems of health, welfare and pensions were at present being investigated by a commission.

The report of this commission, expected by the middle of next year, would probably be the most important in the medical history of the country.

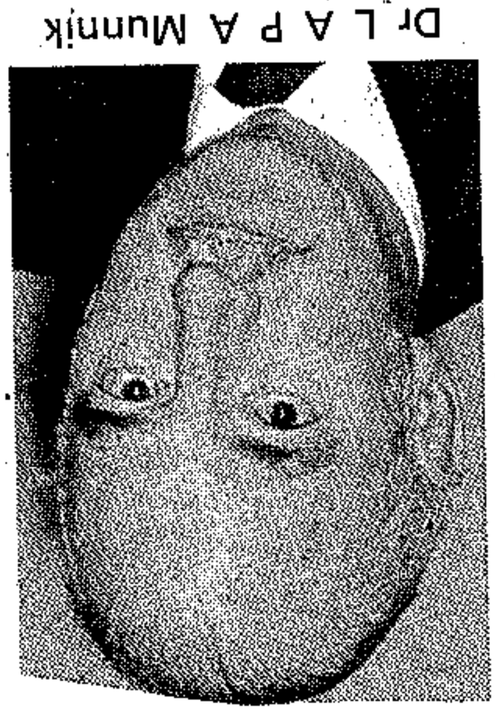
He had asked the commission to bring out its report in sections and had already received the first. Details would be released as soon as he had studied them.

The government was concerned about the plight of pensioners who had been caring for themselves for years, but due to inflation, were finding it increasingly difficult to make ends meet.

"A country which does not care for its aged has no future," the minister said.

The vote was approved. — Sapa

Munnik talks of 'total health idea'



Dr L A P A Munnik

Mr Ken Andrew

Crackdown by health authorities

Sta 2/9/81

East Rand Bureau

A canteen at a Wadeville glass factory, four butcheries, a cafe, a fish and chip shop, a bakery and a land development company have been fined for contravening Germiston's public health laws.

Consul Glass, Rossouw Road, was fined a total of R155 for:

Not keeping the premises and cooking utensils in a sanitary condition. Failing to stock goods to allow adequate access for cleaning. Failing to provide filters in the canopy above the cookers. Failing to provide approved towelling at the wash basin and disregarding a statutory notice.

Four Germiston butcheries were fined a total of R330 for contravening the Food, Cosmetics and Disinfectants Act.

They are Olympia Butchery, Haley Street, Parkhill Gardens (R200); Farhan Butchery, Germiston South (R40); Checkers Meat Market, Klippoortjie, (R40) and Central Butchery, Oosthuizen Street (R40).

Harris Fish and Chips, Railway Street was fined R200 for failing to keep its premises in a clean condition and for disregarding a statutory notice.

Musical Cafe, Geldenhuys Road, Malvern East, was fined R70 for storing goods so as to preclude effective cleaning, employees failing to wear protective clothing and failing to keep protective clothing in lockers.

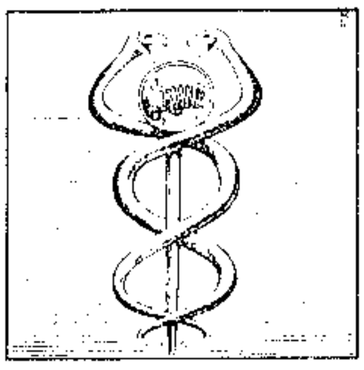
Allorto Bakery, [illegible] Street, Johannesburg, was fined R40 for not protecting food from contamination.

Tuckers Land and Development Corporation was fined R50 for disregarding a statutory notice.

All paid admission of guilt fines.

STATE MEDICAL SERVICES (85) FM 4/9/81

A burnt out case?



Government health services in SA are in a sick and sorry state. In the Transvaal alone, 20% of the 10 353 available white hospital beds are empty because of acute staff shortages, whilst all but the seriously ill are being turned away. Health services throughout the country are in a state of similar crisis.

Despite Health Minister Lapa Munnik's protestations to the contrary, the annual report of his own Department of Health, Welfare and Pensions warns that staff shortages have reached such serious proportions that "essential services run the risk of collapsing."

Yet private hospitals, where there are no staff shortages, are by no means full although their bed occupancy rates have increased sharply over recent years. In the Seventies, there was a boom in the building of private hospitals but probably not a profitable one. Nearly all new clinics built claim they lost money as bed occupancy rates were not as high as they had expected. For example, the original owners of the Park Lane in Johannesburg, built at a cost of about R5m, were forced to lease it to another group.

At present, 60 private surgical and medical hospitals offer 24-hour service nationally — supplying between 6 000 and 7 000 beds — but exact occupancy rates are unobtainable. Neither Mannie Finger, chairman of listed Amalgamated Medical (AMMED), owners of five clinics, nor Bunny Bloch of Clinic Holdings, owners of 13 clinics, is willing to disclose them.

However, according to John Randall, chairman of the Representative Association of Private Hospitals (RAPH), "private hospital bed occupancy rates now average 70% in direct contrast to 55%-60% occupancy rates of the past few years."

This indicates that private hospitals *are* increasingly becoming alternatives to State institutions. Some believe that they offer a better service than the State, others are compelled to use them simply to obtain treatment. According to Dr Neville Howes, chief superintendent of the Johannesburg Hospital "only the most serious patients are being admitted, others are being referred to private nursing homes and hospitals."

There is also a cost dimension to the issue. According to one clinic owner: "The average stay in a private nursing home is now four days, whereas in a State hospital it is 9,2 days. Private hospitals are definitely more cost-efficient than State hospitals."

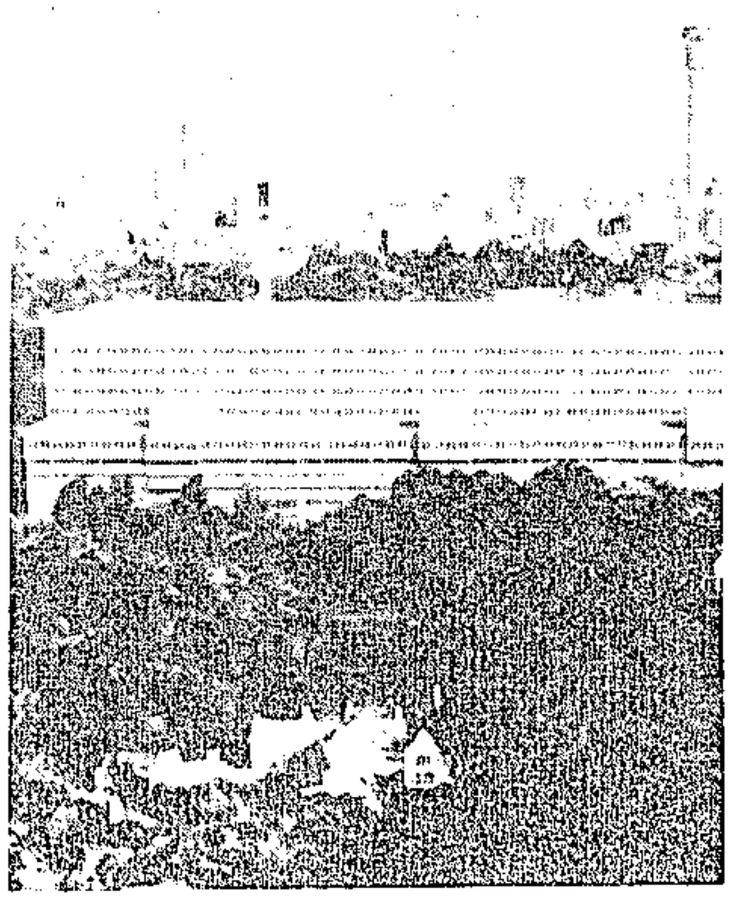
But a shorter stay cannot simply be attributable to the high costs of private hospitalisation forcing a need for greater efficiency. The rapidly growing membership of medical aid (MA) schemes means that increasing numbers of people can in fact afford private hospitalisation. Presently, approximately 80% of whites, 20% of coloured people and an increasing number of blacks are members of such schemes.

The demand for private medical facilities can be expected to increase due to rising incomes, a growing number of firms expanding fringe-benefit programmes to include black members and a drop in the standards of State-supplied medical services.

Middle-income black patients or MA members will no longer put up with the 200%-300% overcrowding at Soweto's Baragwanath Hospital with its consequent delays in care and attention. After a directive earlier this year by the Minister permitting private hospitals to admit black patients, they have been swift to respond.

Says Joseph Steyn, Registrar of MA schemes: "There are 251 registered MA schemes in SA, with 1 291 909 white members and 287 962 dependents. There are 416 191 black, coloured and Asian members with 493 143 dependents — 909 334 people."

A study undertaken by the PE Consulting Group SA — a private sector management consultancy — reveals sufficient demand from private paying black patients in Soweto to fill at least 100 beds and maintain a minimum of three operating theatres.



Johannesburg's General . . . only for the seriously ill?

The survey estimates that at least 8% of all black patients treated can afford private hospitalisation. This suggests that if Soweto has a population of 1m, 80 000 can afford private treatment. So a 100-bed private facility there could in fact be underestimating demand.

The relative cost of private medicine has long been the focus of heated public debate. Yet Munnik has approved an increase of 9,9% in doctors' fees and a 10% increase in the costs of private hospitalisation from September 1. In addition, it is likely that contributions to medical-aid funds will increase between 12%-15% before the end of the year to keep pace.

The fact of the matter is that the cost of private hospitalisation is approaching market clearing levels. Therefore costs appear high mainly in relation to heavily-subsidised State facilities which in turn bear little relationship to true cost. Fees at provincial hospitals are calculated according to a sliding scale determined by income. The average fee paid by a hospital patient is R8 per day, the top rate being R25 all-inclusive. Some patients without MA membership pay as little as R2 a day. However, a recent survey revealed that the actual cost of hospitalisation on a daily basis was R72,39 (a figure calculated over the period April 1980 to end-January 1981).

In private hospitals, where the cost of treatment has increased 26% since last year (and is due to increase a further 10% from September 1) the daily bed rate alone is R31,50, excluding medication.

The cost of a bed is just the beginning. According to Medschemes' Keith Hollis: "At present, a three week to one month stay at a private hospital for treatment of a coronory thrombosis costs between R1 000 and R1 500. This would include a possible one to five days in intensive care costing R60 a day. If the patient has had no surgery and is placed in a general ward, this would cost R33 a day for two to three weeks. Drugs are the major additional cost and could amount to R600 for a person hospitalised for one month."

These tariffs compare well with the cost of hospitalisation in other countries. For example, hospitalisation in Canada costs R194 a day, Netherlands R144, US R144, and Britain R141.

Last week Munnik announced that an investigation into the possibility of a differentiated salary scale for nurses was underway and that nurses might be given special salary treatment similar to that recently given to teachers.

That may help. But at present white provincial hospitals continue to cut ser-

Medical malpractice in South Africa: Patients struggle to get compensation

THE BIG COVER-UP

S. Tribune (85) 20/9/81

VICTIMS of medical malpractice in South Africa face tremendous difficulties in receiving compensation because of claimed cover-ups by doctors.

That is the opinion of private and provincial doctors and provincial nurses who spoke to the **Tribune** this week and told disturbing stories of wrong amputations and needles left inside patients after surgery.

But the secretary-general of the Medical Association of South Africa (Masa), Dr Marais Viljoen, said through his secretary he was "too busy" this week to speak to the press about these allegations.

Dr Viljoen is the South African representative for both the Medical Protection Society and the Medical Defence Union which provides professional liability coverage for 80 percent of South Africa's 10 000 doctors.

Through the public relations company that acts for Masa, Dr Viljoen said the bodies provide full liability coverage and legal assistance. He did not give requested statistics of litigation in South Africa and refused to take calls from the **Tribune**.

But the latest report of the Medical Protection Society refers to a number of cases in which doctors in South Africa were successfully sued by patients.

In one case a GP operated on the wrong foot of a boy to remove a needle stuck under a bone. Only when he failed to find the needle and had sewn up the incision did a colleague notice that the doctor had operated on the left instead of the right foot. The boy was awarded damages of R650.

By Marion Whitehead

"Some cover for others — it's really always the patients' fault. Like they'll say the patient swallowed the needle, not that it was left in after the surgery."

The Tribune was told of disturbing cases. They ranged from wrong amputations and untreated internal haemorrhaging that resulted in death, to needles and swabs left inside patients after operations.

A bereaved husband told how his wife had died in hospital after being treated for cancer of the lungs and secondary cancer of the brain. He claimed the postmortem report showed only a small tumour on the lung and believes she died after choking on her own mucous as nurses turned her to wash her.

He has complained to the hospital who are investigating the case.

The editors of Criti-Health, a journal put out largely by medical students at Wits University, said cases of malpractice frequently came to their attention.

The 1980 report warns doctors that between 1977 and 1979, they settled 29 claims arising from wrong operations. The figure includes cases from Britain, South Africa, Australia and a number of smaller countries.

A provincial authority paid a young boy R12 000 damages after his leg had to be amputated below the knee because a plaster had been put on too tight. The leg went gangrenous, problems with communication were indicated as the doctor did not speak Zulu and it was not clear if the boy had been given post manipulation plaster instructions.

A record amount of R34 000 damages was awarded last year to a polo player who broke his arm. The appeal court judge said that post-operative care had been negligent, reducing the man's arm to "a shrunken claw like appendage of extremely limited value" and which may still have to be amputated.

The case dragged on for eight years before the award was made, underlining the difficulties encountered by patients trying to sue.

"People don't sue in this country. They're totally ignorant about their rights and how to go about suing," said a nurse.

"And unless you're pretty clued up, it's difficult to put together a case against a doctor.

These included doctors who charged for TB treatment, who told patients they would be charged more if they continued complaining about treatment and who performed unnecessary operations, such as tonsil removals and caesarian sections.

"No one is looking after people's interests in this respect. And there's no backup for people who feel they've been messed around".

They said they would be prepared to publicise cases of abuse and promote awareness of patients' rights but could not actively take up cases.

To bring a case to court, a complainant needs not only a lawyer — an expense many cannot afford — but a doctor who will substantiate the case. But not many medics are prepared to give evidence against a colleague.

As far back as 1976 Prof S. A. Strauss of Unisa, a medical law expert and author of Doctor, Patient and the Law, alleged there was a conspiracy among doctors to protect each other in cases of negligence. Masa denied this.

The Protection Society report contains a number of tips to doctors to help avoid mistakes in their practice.

Curbs set on local health services

DD 23/7/81 (85)

PORT ELIZABETH — A drastic curtailment of the expansion of health services run by local authorities has been recommended by the Department of Health.

All vacant health posts with local authorities and subsidised by the department have been frozen and no additional staff may be taken on to run new clinics completed during the 1981/82 financial year.

Last night the Director-General of Health, Dr J. de Beer, said the money allocated to health this year was sufficient to maintain health services but not to expand them.

The purchase of medicines is to be strictly controlled and expenditure on high protein diets for tuberculosis patients is to be cut.

These are among the money-saving measures to be adopted in the Eastern Cape according to a circular distributed to local authorities by the regional director of health in Port Elizabeth, Dr J. D. Krynauw.

The cutback on funds for the Department of Health is in terms of the government's broad policy to curtail state spending as an anti-inflationary measure.

The measures to be adopted in the Eastern Cape, and which will vary only slightly nationally according to regional needs, came under sharp attack from the Progressive Federal Party's health spokesman, Dr Marius Barnard, who said the decision was a cause for great concern.

He warned that by freezing all vacant posts the already serious nursing staff shortage would be aggravated.

The circular says no vacant subsidised posts may be filled without the prior approval of the department. If this occurs subsidies will be forfeited.

The posts to be frozen include those of nurses and health inspectors.

Dr De Beer said last night that existing health services would not suffer.

The freezing of posts would affect "a few hundred jobs" nationally.

Referring to diets for tuberculosis patients, he said that while a diet needed to maintain the general health of patients would be administered, high protein diets could to some extent be eliminated because of the advent of the new and highly effective TB drugs.

Dr Barnard questioned a health policy which cut back on expenditure affecting largely low-income groups, terming them "preferential cuts".

State Health has provided funds for a subsidised feeding scheme as a stop-gap measure until tuberculotics receive disability grants, which can sometimes take several months to come through.

Because of employer prejudice tuberculotics invariably lose their jobs and have no other source of income. Concerned people have therefore condemned the cutbacks as self-defeating.

Doctors, nursing sisters and Santa officials were adamant that correct feeding was vital in TB treatment. One said: "There is little benefit from pumping drugs into a malnourished body." — DDC.

It's the toddlers who die — professor

By Pamela Kleinot

Half of all deaths of South African coloured people and blacks occurred before the age of five, Professor Lucy Wagstaff, head of Community Paediatrics at the University of the Witwatersrand, said this week.

Delivering her inaugural lecture at Wits she said only seven percent of all white deaths happened at this early age.

Professor Wagstaff suggested that medical graduates who chose to have exclusively white practices should opt for geriatrics because more than half all white deaths occurred after 65.

She said doctors needed to become experts in health education because destructive life styles were at the root of half white deaths.

In her lecture — entitled "Child Health — Who Cares" — Professor Wagstaff said infection and nutritional deficiencies were the major health hazards for the vast majority of children in southern Africa.

Although admissions to Baragwanath Hospital of children with malnutrition had fallen by more than a fifth in the past 25 years there was cause for concern about child health in rural areas.

But there was a wide spectrum of malnutrition in southern Africa, ranging from overindulgence among the affluent to deficiency states in the disadvantaged.

She said while nutrition education was important it would achieve little without the availability of adequate food.

Fines for breaking health laws

East Rand Bureau

Two restaurants and a bakery have been fined for contravening Germiston's public health laws.

Vienna Forrest Restaurant, Cross Street, was fined R50 for contravening the Food, Cosmetics and Disinfectants Act.

Hokaai Restaurant, Dekema Road, Wadeville, was fined R20 for littering a vacant stand.

Olympic Bakery, McAlpine Road, Malvern East, was fined R80 for failing to protect food from contamination.

Other Germiston companies which have paid admission of guilt fines for contravening local public health laws are:

Germiston Transport, Brug Street, Elsburg (R50); Caledonian Iron and Brass Foundry, Van Lingen Street (R100); Turnsteel Precision Engineering (Pty) Limited (R100); and ASA Scrap Iron and Metal Group, Stanley Road (R10).

Town's health threat confirmed

Argus 30/9/87

Argus Correspondent

HERMANUS.—Senior officials of the State Health Department have confirmed that conditions in the Zwelihle township here are appalling.

The conditions were described as a health hazard for the whole of Hermanus by the senior inspector of health in his report last month.

In a letter tabled at the town council's monthly meeting, the Health Department states that officials visited Zwelihle on September 2 and found that conditions were as described. They have assured the Hermanus Municipality of their support and they have also taken up the matter with the Western Cape Administration Board.

The minutes of a meeting held between senior officials of the board, the Hermanus Municipality and councillors early this month were also tabled.

According to the minutes, the senior health inspector, Mr H Rossouw, said the township had received considerable attention since his report and was 'looking better.'

The council's clinic medical officer, Dr J Tate, said there was still a danger of an epidemic if present conditions continued.

It was agreed that the only way to solve the health problems in the township was to provide water-borne sewerage which, according to the regional director of the administration board, Mr B Breunissen, would cost about R200 000 — an amount which would be impossible to recover from the residents. The State would therefore be requested to finance this scheme.

The chief director of the Western Cape Administration Board, Mr A A Louw, said if there was a health hazard in Zwelihle, it was no worse than in 1973 when the board took over from the municipality.

He said the board could not agree that 'little or no attention' — as reported by the senior health inspector — was paid to repairing facilities. The word 'inadequate' would be more appropriate.

The bucket sewerage system had always been inadequate. Informal quotations for additional toilets were asked for and, if approved, provision for one toilet for every six people would be made, he said.

Mr Louw admitted that the condition of the toilets was poor but new doors and frames were being provided. The board also admitted that the toilets did not 'look good' but, according to Mr Breunissen, they were cleaned every 14 days.

Premature deaths deplete work force

By Pamela Kleinot

Premature deaths of black and coloured people from preventible diseases are a serious loss to South Africa's workforce, says Professor C H Wyndham of the South African Medical Research Council.

Writing in the SA Medical Journal, Professor Wyndham said the proportion of man-years lost due to death in 1970 and 1976 was twice as high for coloureds and blacks as it was for whites.

Causes of death contributing to the difference in rates included tuberculosis, respiratory disease, "ill-defined" diseases and homicide. Many of these are associated with underdeveloped communities where undernutrition, lack of proper sanitation and overcrowded housing is found.

Professor Wyndham pointed out that, according to mortality rates, South African whites were less healthy than the population of England and Wales.

More than half of all deaths in the economically active age group among whites and Indians resulted from destructive lifestyles, involving dietary excess, cigarette smoking, alcohol abuse, fast and reckless driving and the social stresses of modern living.

Professor Wyndham said entirely different health strategies were needed for white and Indian communities on the one hand, and coloured and black groups on the other.

Among whites one-third of man-years lost in 1970 was due to circulatory diseases, with 29 percent attributable to ischaemic heart disease. A further one-third was lost due to accidents, 20 percent due to motor vehicle accidents.

The situation was different for coloureds and blacks. One-third of man-years lost was due to accidents. Among blacks 15 percent was due to homicide. Infective and parasitic diseases accounted for 11 percent — with 8 to 9 percent due to tuberculosis — and respiratory diseases accounted for 11 percent.

MoH hits at low wages, poor housing

CT 3/10/81
85

By NEVILLE FRANSMAN
Municipal Reporter

FARMERS in the Greater Cape Town area have been criticized by the Cape Divisional Council Medical Officer of Health, Dr L R Tibbet, who says in his annual report that poor living conditions and low wages continue to contribute to serious health problems among farm labourers.

He also warned that "we appear to be losing ground in the battle against tuberculosis in the non-white population groups".

In his 1980 report on the Combined Health Control Scheme — which covers a vast area stretching from Cape Point in the south to Mamre in the north (excluding the Cape Town municipality) — he said the farming population of Philippi was one of the most depressed, with no community resources whatsoever because of the scattered nature of the relatively small population.

Alcoholism and poverty were rampant, with poor nutrition and a very low quality of life.

Dr Tibbet added: "An attempt to motivate the employers (in Philippi) has not been successful and requires the right person."

Referring to Constantia, he said: "Poor housing and low wages of much of the farm labour continues to contribute towards the problems of alcoholism, tuberculosis, child-abuse and neglect and malnutrition, all problems in one of the country's wealthiest areas."

'Alarming' VD

In the Durbanville area nearly 5 000 visits to clinics were made during the year because of venereal disease. A VD survey there had indicated "a most alarming incidence of 15,7 percent in the farming population of this area". All steps had been taken to institute appropriate treatment and preventive measures.

Earlier in his report, Dr Tibbet said the untoward incidence of syphilis in Durbanville was not surprising when taken in conjunction with the housing report on the farming areas.

though one wonders what has become of the labourers."

As regards TB, Dr Tibbet remarked that as it appeared that ground was being lost in the battle against this disease among coloured and African people, it was obvious that housing and economic betterment were priorities. He also expressed the hope that the State financial cuts this year would not curtail the supply of drugs used in treatment of TB.

Other points made by Dr Tibbet were:

● If salary structures were not improved "Medical Officers of Health will become a dying breed".

● Infant mortality rates — "the most sensitive index of the efforts of the total health team in any given area" — had dropped in 1980 when compared to those of the previous year.

● Transport accidents were the principal cause of death in the age group five to 14 years. This showed the necessity for increased efforts in road-safety training in schools.

● Unless the nursing-staff establishment was considerably increased in the near future, the health service was likely to falter as result of sheer numbers of clinic attendances and the resultant volume of work.

● Nearly 61 300kg of foodstuffs had been condemned during routine inspections of establishments such as shops and cafes which handled foodstuffs.

● In Atlantis, with its rapidly-growing population, the clinic venues (a house and part of Wesfleur Hospital) had become far too small and inadequate and new clinic buildings were urgently required.

"Overcrowding was apparent in 45 out of 76 dwellings and with poor hygiene and sanitation, the ideal conditions for endemic syphilis and other diseases arise. Infestation of flies can only complicate matters.

"It appears that much more thought, work and finance must be put into housing and socio-economic conditions of farm labourers, not only in the Durbanville area," he said.

Referring to the southern areas such as Noordhoek, Sun Valley and Kommetjie, he stated: "The poultry farms, with much poverty and malnutrition, have fortunately been closed down, although

● Kasselsvlei was a particularly socially-depressed area with many problems, including a high incidence of TB.

● Ravensmead was one of the most depressed areas and this was reflected in the high incidence of TB, meningitis and measles. A clinic venue in the Stonehill area was an urgent priority and there was a "crying need" for creches and pre-school centres.

● Elsie's River was "beginning to take shape" and "the fruit of long years of planning and industry is at last being borne, and community activity is coming more and more to the fore".

Political acts of terrorism: financial assistance to passers-by

*12. Mr. G. B. D. McINTOSH asked the Minister of Health, Welfare and Pensions:

Whether any provision is made for financial assistance to be provided to passers-by who are injured as a result of political acts of terrorism; if not, why not; if so, what form of assistance is rendered in these circumstances?

The MINISTER OF HEALTH, WELFARE AND PENSIONS:

No, the matter falls outside the scope of functions of the Department.

Mr. G. B. D. McINTOSH: Mr. Speaker, arising out of the hon. the Minister's reply, is he not aware that there is at least one known case where as a result of a bomb exploding in Durban a family has been seriously distressed financially, and would he not consider working out something to assist innocent people who are injured as a result of such explosions?

†The MINISTER: Mr. Speaker, as the hon. member knows, the necessary machinery exists in my Department. If somebody becomes unfit for work for some reason or other—e.g. if he is run over by a car or injured by a bomb explosion or whatever—he can apply for a disability pension in the usual way. I think that is what the hon. member has in mind, but I do not intend to make special arrangements to protect people who happen to be in the vicinity when a bomb explodes.

New healthscheme for all SA

RDM 15-10-81 (85)

Mail Correspondent

A SIX-TIER health facilities plan has been instituted to provide a comprehensive health service to all South Africans, the Minister of Health, Dr L A P A Munnik, said yesterday.

He was speaking at the opening of the Second Technocratic Exhibition at Groote Schuur Hospital. Cape Town. The exhibition was organised by the South African Association of Hospital Engineering Technicians.

The Minister said the health facilities plan comprised services such as the provision of basic needs — clean water, adequate food, clothing and housing — as well as health guidance and primary health care.

Other levels of service were provided by community, regional and academic hospitals. In the immediate future, more attention would have to be given to community-orientated health services, Dr Munnik said.

He called on the private sector to help provide health facilities to the country's people.

"The role of the private sector in providing facilities is of cardinal importance in our comprehensive health planning. The finance and manpower needs of our services in relation to our resources precludes a State-controlled service," he said.

Dr Munnik said the cost structure of the private sector should be such that an increasing proportion of the population could make use of their facilities while the State (and consequently the taxpayer) would have a decreasing financial burden.

Discussion

The cost and cost effectiveness of medical and technological progress was the subject of discussion throughout the world and steps had to be taken to curtail cost escalation, Sapa quotes the Minister as having said.

"In South Africa we are committed to a system of norms including need and cost norms. These norms also aim at matching the needs of the community with the facilities to be provided.

"The role of the private sector in providing facilities is of cardinal importance in our comprehensive health planning," he added.

"However, in South Africa we are in a unique position. Our needs range from the very basic to the most sophisticated and our services have to be spread proportionately in order to cover the entire field.

"The private sector has an important responsibility to fulfil in making services available to the population," said Dr Munnik.

"In considering the various aspects of the health facilities plan, I know of no more significant development than the involvement of the private sector in our planning," the Minister said.

Delicate

"The delicate inter-relationships between the responsibilities of the private sector and the State and the consequences of policy changes could be far reaching.

"It is my considered opinion that the cost structure of the private sector should be such that an increasing proportion of the total population could make use of their services while the State, and consequently the taxpayer, would have a decreasing financial burden.

"In such a system, the need for mature financial discipline is essential," Dr Munnik said.

POLITICAL STAFF

How can four men look after 5 719 f...

THE parliamentary session ending in Cape Town today has again underlined the parlous state of occupational health for the country's 5,5-million industrial workers.

That much has emerged in replies by the Minister of Health, Dr L A P A Munnik, to a series of probing questions in the House by the Opposition spokesman on health matters, Dr Marius Barnard, on the outcome of the Erasmus Commission of Inquiry into occupational health.

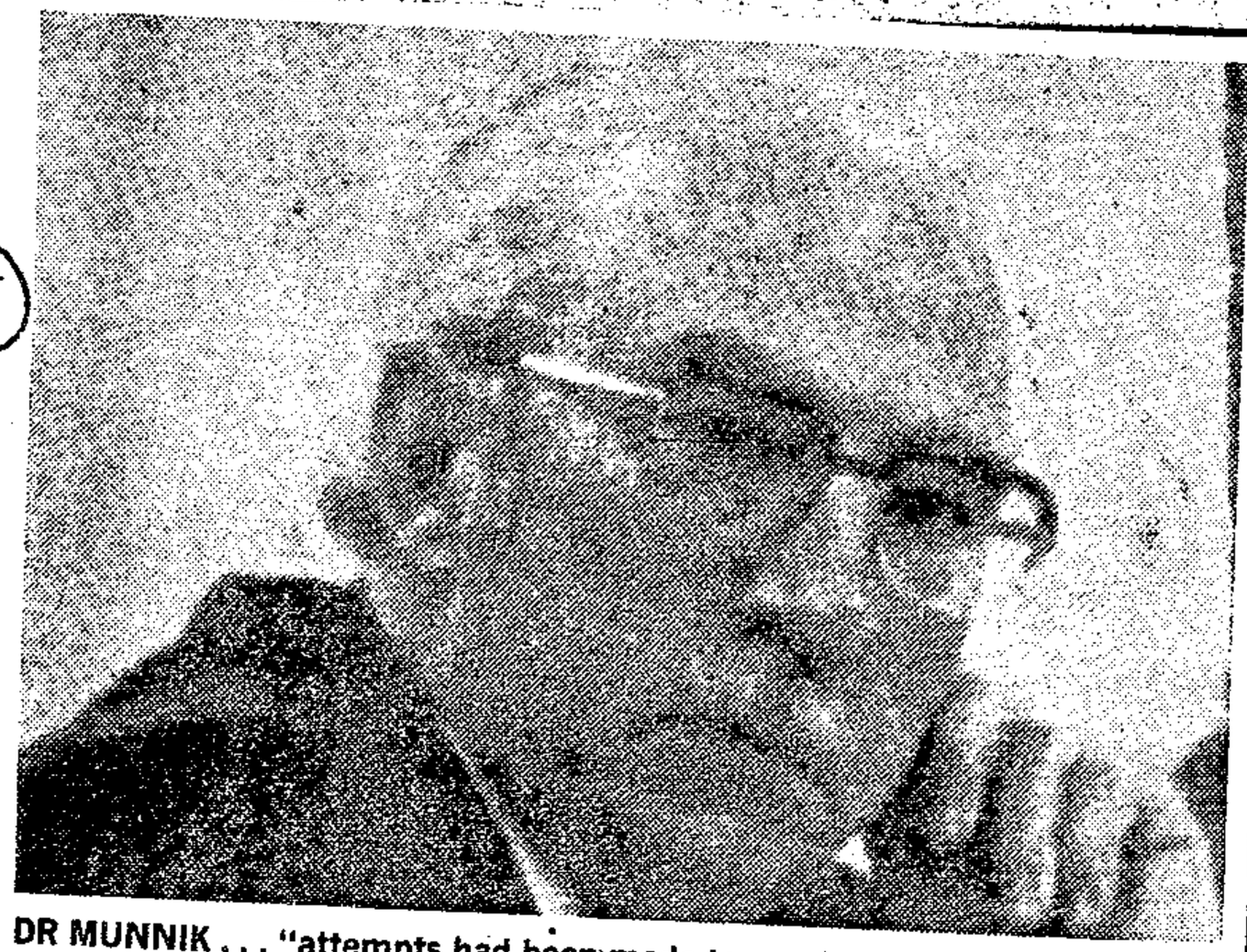
Nearly six years ago, the commission, which was chaired by the same judge who headed the inquiry into the former department of information, Mr Justice Rudolf Erasmus found that there was an alarmingly high rate of occupational disease in industry and on the mines.

Although some of its comments were placatory to management, the Erasmus commission report revealed extremely dangerous working conditions and an increasing rate of occupational disease.

Comprehensive

It found that 5,78-million (71,9%) of the eight million economically active people in Sout Africa were not covered by le islation relating to occupation disease. It also found that ma agement was not industriall health-orientated.

The commission pointed o that South Africa was one of th few industrially developed cou tries without a comprehensiv health system for the protectio of all industrial workers and th



DR MUNNIK . . . "attempts had been made to resolve the areas of disagreement 'at high level' and were continuing"

MEDICAL SERVICES (85) FM 23/10/81

Appropriate treatment

There is consensus that SA's medical services are in need of radical restructuring. The *FM* recently recorded the extent to which public facilities are under strain. But that is only part of the problem.

The Federated Chamber of Industries (FCI) recently set up a study to consider the increasing demand for health services that is being placed on the manufacturing sector. It was particularly concerned at trends towards the centralisation, and socialisation, of medicine. It now argues that free enterprise principles should be applied to the system in the search for solutions.

The basis of the argument is that health, like low-cost housing, education, and social pensions, would benefit from this process.

In all sectors of social welfare, the FCI says, "the fundamental problem is similar. The State has accepted for itself a primary (and often exclusive) responsibility for the provision of basic services funded from tax revenues. These services are often of a high standard (and) the fact that these services are free or heavily subsidised stimulates demand. The demand for medical services is massively augmented by the rapidly growing black populations in both urban and rural areas."

So: "Increasingly the basic health services face the burden of providing relief from the effects of poverty, malnutrition, overcrowding and ignorance. Differentiation in the provision of health services also threatens to become a political issue."

The policy of cheap, freely available state services depresses the overall supply of such services, not only in state but also in private institutions. There is a shortage of doctors and nurses in state hospitals, affecting even essential facilities. Worsening the situation is the fact that pay differentials between SA and overseas have led to a brain drain. But there is an ever-rising demand that a high level of services be extended to the public on a non-discriminatory basis.

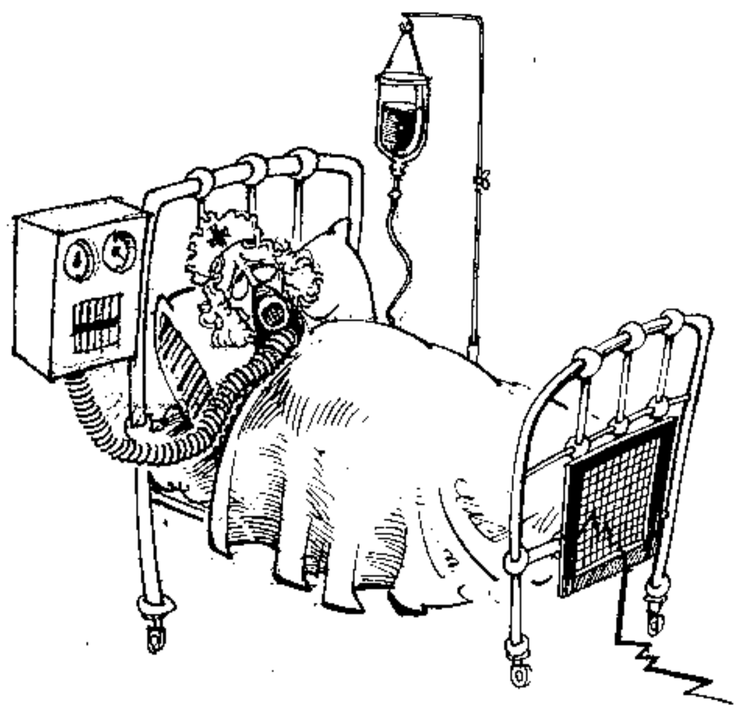
Between 1973-1979, the amount spent on health in SA and the homelands rose more or less in line with inflation from R508m to R1 112m — though this amount, as a percentage of gdp, actually declined from 2,7% to 2,4%, especially after 1976. In the homelands the figure was 0,3% of gdp up to 1976, but fell to 0,15% in 1980 with an absolute decline in the amount spent on health services in that year.

Government health services are either free, or the scale of fees is scheduled according to the patient's means — excepting communicable diseases like tuberculosis, leprosy, typhoid, malaria and VD. No patient is barred from treatment because of inability to pay; a tradition which makes sound long-term social and economic sense, considering the potential for a build-up of resentments over inadequate services for blacks, and the actual loss of man-days once disease takes hold beyond the preventable stage.

This access to medical facilities should not be interfered with, though restructuring would mean a greater allocation of funds at the lower end of the spectrum.

There is evidence of a considerable imbalance between the amounts spent on whites, coloureds, Indians and blacks. And a further imbalance exists between services available in rural as against urban areas. The doctor/patient ratio for urban whites is less than 1:1 000; in some black rural areas it is 1:20 000.

In addition, there is a complicated institutional framework for the services, with the Department of Health controlling six decentralised services; the involvement of the Department of Education and Training; while the provinces and homelands, both independent and non-independent, have



their own health functions.

The major structural division, of course, is between the public and private sectors. Co-ordination tends to be on an *ad hoc* basis, and the state health services carry a heavy burden of care for those who present themselves for treatment whether or not they are in a position to pay the market rate for these services. To this extent, SA's medical services are socialised, and private health services operate largely on a parallel basis.

A certain amount of what can be called cross-subsidisation occurs. This applies not only to richer patients being treated in subsidised state institutions. In some cases public health services are directly subsidised by the private sector, as in the supply of pharmaceuticals. About 60% of medical drugs are supplied through the state health services under a tender and code list system. Direct state intervention in the production of pharmaceutical products and medical equipment is widespread — and threatens their long-term supply.

The system therefore faces certain critical choices. There can be:

☐ Increased centralised control over medical services, including the supply of drugs; or

☐ The re-establishment of market disciplines so that prices can play a primary role in regulation.

The second option diminishes, but does not eliminate, the role of the State. The maintenance of essential standards in training and practice, the control of harmful drugs, and surveillance of malpractices and the abuse of market power would remain in the public domain.

But, in arguing that free market principles should be given greater sway, the FCI points to the debilitating effects of centralisation — the placing of industrial health facilities under the DOH, with factory inspectors reporting to the department, is one example. The process contributes to a gross loss of efficiency in public health services.

To achieve an acceptable level of health services the following reforms are suggested:

☐ The first line of defence should be effective suppression of major communicable diseases;

☐ There should be an adequate geographical spread of primary health care services;

☐ The balance between preventive and curative elements of health care should take into account the cost of delays — the burden on the taxpayer of therapy for those who have to be hospitalised because of failures of early diagnosis or preventive treatment;

☐ Co-ordination between the private and public sectors, and involvement of the private sector in industrial health;

☐ Control of standards and institutional care which permits access by the needy to *appropriate* health care facilities;

☐ Adequate training facilities for doctors, dentists, nurses, paramedics and health care workers as well as pharmacists; and

☐ The construction of acceptable community clinics.

These can all be secured within a less centralised system.

The existing structure of state hospitals and clinics is fundamental to the system, and a central authority is needed for the effective operation of health care services at all levels. But the *management* of this structure should be more sophisticated and subject to disciplines normally thought of as the preserve of the private sector.

The structure must become more responsive to the needs of users. This would mean matching various levels of health care requirement to the appropriate institutional

levels — for example, greater use of home nursing, community and industrial health clinics, education for prevention, and responsible self-medication.

A fundamental reform would be to adopt a market-related pricing structure which takes income differentials into account. Those who can pay the market rate for services should not be subsidised. To secure this, facilities, services, and medicines should not be specified above the optimum level dictated by medical needs.

The objective must be to work towards integration of the services. But if state institutions have to function more as private institutions they must be given greater autonomy to specialise, set scales of tariffs and remuneration levels for different staff skills, and actually compete with other state-owned and private institutions.

The basic problem remains that of the poor — how to subsidise those who cannot afford market-related tariffs. There are three possible approaches: subsidising the individual; subsidising an institution; and a medical insurance/medical aid solution.

All three must be used, the FCI argues, though there should be no automatic subsidy for institutions. Subsidisation here should be contingent upon proof that a particular patient can pay only a specified amount.

As state subsidisation is diminished, resources would be diverted to primary remedial and educative medical systems aimed at malnutrition, the diseases of poverty, and ignorance of basic health care.

Here, too, the private sector has a role. It should be encouraged to establish its own primary health care centres — in particular, industrial health facilities. These should be eligible for government subsidies on the same basis as state institutions.

There should be no health levy on employers, and "to avoid double taxation the subsidisation of welfare services must be channelled through the State Revenue Fund as the taxation system is the only equitable base for subsidisation."

Such greater co-ordination between the services, and the setting up of market mechanisms, would represent "a complete break with the present system of differentiated, subsidised and over-utilised medical services concentrating on curative rather than preventative medicine."

This would indeed be a radical restructuring of the present system. A large number of representative bodies would have to be consulted. But it would certainly assist in arresting the deterioration of services.

'Government must act to prevent diseases'

RDM 7/11/84

By ADA STUIJT

A SENIOR paediatrician in Natal says the Government should be spending more money on primary health care rather than on sophisticated health care in towns.

And Dr Walter Loening, senior paediatrician at Natal's King Edward VIII Hospital who has completed a survey on primary health care facilities in four Natal communities, revealed that the Government does not have reliable statistics on black infant mortality, one of the criteria on which a country's quality of primary health care is judged.

Doctor slams lack of data on infant deaths

Primary health care directs attention to the root causes of diseases, such as unsafe drinking water, lack of sanitation and poverty.

"Most of the public money is spent on sophisticated health care in towns to cure patients, with the result that many people still die prematurely from infectious and other preventable diseases," he said.

Four deaths

Only a month ago, a major cholera outbreak in BophuthaTswana, 40km north of Pretoria, was traced to the heavily-polluted Apies River, used as the only water source for the hundreds of thousands of people living along its banks. Four deaths resulted and hundreds of victims were treated on an emergency basis.

Five ways of evaluating the quality of a country's primary health care are the availability of enough clean, treated water and safe sanitation, the infant mortality rate, prevalence of preventable diseases, nutrition of children in particular and the community at large, and how important the Government rates primary health care facilities in its budget.

But the major problem — and primary health care's first concern — is the availability of clean water. Among the communities on which he based his study, Dr Koening noted that two of them relied almost completely on a stream for their water source and the earth's surface for their sanitation.

In only one community — KwaMashu — there were outside taps and toilets available. Hlabisa, Inanda-Ndwedwe and Mawela have pit and surface sanitation exclusively.

"It is thus not surprising that water-born diseases (typhoid, cholera, malaria) continue to be a major problem."

Dr Koening attacked the Government for not providing reliable statistics on black infant mortality, quoting from the Department of Health's latest publication which said that "data on blacks for the outlying rural areas were not available because of the customs, mores and level of education of those communities concerned".

"It is interesting to note how the blame has been placed on the shoulders of the community and no mention is made of the task of health care facilities," Dr Koening said.

HEALTH SERVICES

A primary problem

Large numbers of people living in rural KwaZulu are still succumbing to diseases which could quite easily be prevented, according to Dr Walter Loening, senior paediatrician at the King Edward VIII hospital in Durban.

According to Dr Loening, the hospital took in 2 000 tuberculosis patients last year. Of the children admitted, 74% had a respiratory infection or gastro-enteritis while 45% were malnourished. Studies carried out on infant mortality rates show that in the Inanda/Ndwedwe area as many as 134,1 deaths/thousand are recorded. In other areas like Mawela, the figure is around 111,4. This compares with the national rate of 122/1 000 for coloureds, 35 for Indians and 20 for whites.

Loening says there is a direct correlation between high infant mortality rates and poor primary health care. For example, in the Inanda Ndwedwe district and Mawela, almost 100% of the inhabitants draw their drinking water from streams. At the same time, there are no proper facilities for the disposal of excreta. Consequently, debilitating water-borne diseases are a danger.

Loening criticises government for spending money on sophisticated institutions like Tygerberg, Johannesburg General, and Groote Schuur hospitals, without treating the root cause of the problem. He points out that Groote Schuur has just been allocated R140m for expansion, yet the KwaZulu government cannot obtain 1% of that figure for the provision of primary health care. He argues that this hardly makes sense as it is obvious that a small sum of money spent on primary care could obviate the need for vast hospitals for tertiary care.

(85) Sowetan 29/12/81

A stinking health hazard

THE refuse dump on the western side of Atteridgeville/Saulsville township is a smelly health hazard and an eye-sore say angry residents living nearby.

By MONK NKOMO

The dumps are situated near the Bathokwa Lower Primary School and Flavius Mareka Secondary School and the people staying around Lephora, Lekekeke, Lenong and Lefsedi streets have to put up with the offensive smells which have "been haunting us for almost eight years," a resident said.

The SOWETAN visited the area and found the stench unbearable in the nearby houses despite all the windows and doors being closed in an effort to prevent the large swarm of flies from the dumping ground.

Mrs M Mabaso, who suffers from high blood pressure and lives right opposite the dump was found with a piece of paper hitting at the numberless flies.

"I'm tired of this set-up, these deadly things even drop into our pots on the hot stove. Now that I have a week-old baby, I cannot use an insecticide and the doors and windows are always closed. I suffer from high blood pressure and I sweat like hell," she said.

Mr B Mkhonza, an inventory control manager of Checkers in Johannesburg, condemned the authorities for turning a blind eye to their complaints about the "terrible smell and the flies breeding in the rubbish."

He added: "We have tried to use various insecticides in an effort to clear our homes of flies, but to no avail. I have a metre-long fly catcher in every room, but these are smeared with flies after only two days. There are millions of flies breeding in that dirt."

His wife, Miriam, said she cooked their lunch and supper at about 5am to avoid "the rush". "These flies are a real menace, they even fall into our food."

Asked how she coped with washing outside, Mrs Mkhonza said, "Man, they crawl all over my body. It's terrible".

Mr J Plaattjie said he was particularly scared about the potential health hazard, "especially for the children".

"The authorities should do something to prevent this terrible stench. There are also some whites who came and dumped rotten meat which creates an awful smell," he said.

Mr A F Aap, director of technical services for the administration board of central Transvaal said he had not yet received complaints about the refuse.

"I can assure you that the matter will be attended to as from today," he said.

UNBEARABLE: That's what we found about the stink coming from this dump.

Training

The cost of training a new worker mu
heading.

Overtime

Overtime may have to be worked in or
tion loss.

First aid

Instead of members of the first aid staff
cidents, they could check on health p

Investigation

There are costs involved by the super
the accident and completing the neces
easy to ascertain, but cognisance mus
other work will possibly be neglected.

Required clerical control

The claims on the Accident Fund requi
and this naturally costs time and mone

Equipment repairs

The cost of repairing or replacing t
damaged, the clean-up and the re-set
equipment.

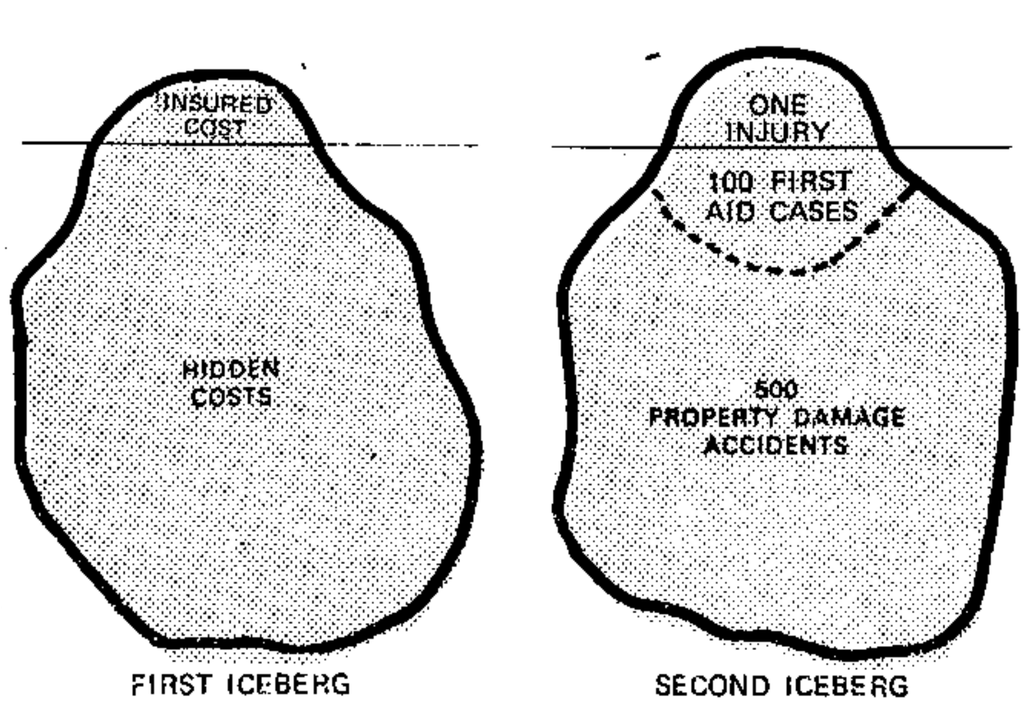
Like all icebergs, the mass below the surface is the most dangerous, especially when we consider what these hidden costs could add up to. Some writers maintain that the ratio of insured costs to hidden costs should be 1:4. Others maintain that no definite ratio can be arrived at. It is suggested that each firm does its own exercise and calculates the total costs of its accidents - if necessary on a sampling basis. This was done recently at a certain firm and it was found that the medical and other insured costs came to about R600,00. The hidden costs in loss of production and contract penalties amounted to more than R6 000,00 - a 1:10 ratio!

It may be said that because of an accident, no actual difference in production is noticed. It may be true that the output from the plant is the same whether accidents take place or not but what must be very obvious is that if the output is to remain the same it must be produced at a higher cost. NOSA is extremely anxious for more firms to introduce systems whereby the total cost of an accident can be determined in their works. A draft accident report form can be supplied by NOSA together with suggested methods for collecting data.

SECOND ICEBERG EFFECT

If one iceberg were not enough to emphasise the terrific amount of avoidable waste which is taking place in South Africa, there is a further iceberg which relates the frequency of injuries to the number of accidents which take place.

It should be made quite clear what an accident is. It is an unplanned, uncontrolled event that interrupts or interferes with the orderly process of the production activity or process.



FIRST ICEBERG — SECOND ICEBERG

Report leads to clean-up operation

Mercury 31/12/81

Mercury Reporter

DURBAN City Engineer's Department workmen were yesterday busy cleaning up the refuse at a disposal site in Chatsworth after a report in the Mercury yesterday of 'unhygienic conditions' there.

Mr Eric Norman, Durban's Deputy City Engineer, told the Mercury yesterday that his department was clearing the site and warned that anyone caught dumping refuse there would be prosecuted.

'We have asked the Police and the City Health Department to keep a close watch on the site,' he said, adding that it was illegal to dump refuse there because the site, which was run previously by the Durban Corporation, had been closed as a refuse dump.

'We have inspectors watching the place, but because dumping is done at night and over weekends, it is impossible to catch the culprits,' he said, appealing to local residents to help by recording the registration numbers of vehicles seen at the site.

'Only this way will we have concrete proof of the offenders and so be able to prosecute them,' he added.

Several local residents expressed alarm at the 'unhygienic conditions' at the site, saying they feared that if it were allowed to continue unchecked there was a likelihood of the outbreak of cholera in Chatsworth.

accident may cause damage to
iction delay without necessarily
njury may or may not result from
n the smooth flow of production

ch cause accidents, these being
e physical conditions. Either of
if them may cause the accident.
by F.E. Bird and G.L. Germain, it
000 accident cases was made
elationship between an accident
that on an average there were
ut damage to property and 100
nature for every disabling injury.
gures, which we have no reason
of facts, we come to the shock-
bly 224 000 multiplied by 600
our statistics in total and which
attention of management. The
idents may vary from very minor
age to machinery and only minor

the injury-causing accidents we have only tackled 16% of the problem.

OUR PROBLEM

According to the Workmen's Compensation Commissioner's figures we experience over 333 675 injury-causing industrial accidents a year. This excludes those injuries requiring first aid treatment only. These accidents, which exclude home and road accidents' involving private vehicles, result in some 31 000 people being permanently maimed each year. The estimated potential and actual loss of man-power is 29 000 000 man-days.

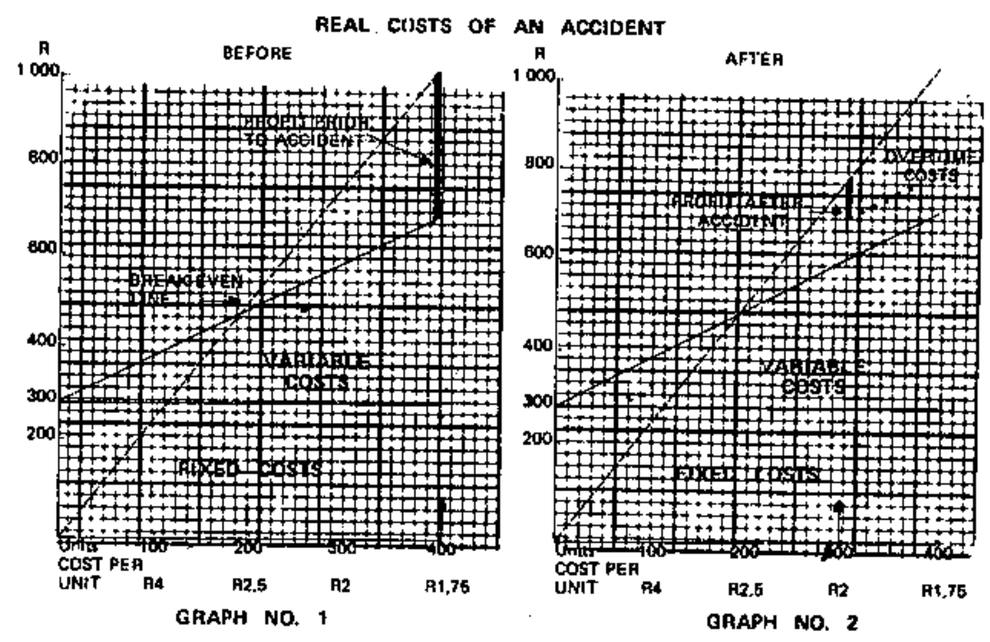
This latter figure is equivalent to about 100 000 workers lying idle every working day and this far exceeds our present effective immigration growth.

The Workmen's Compensation Commissioner and the accident funds approved by him pay out approximately R26 200 000 a year by way of compensation, rehabilitation and medical expenses because of injuries.

CHALLENGE

This surely must be one of the greatest challenges for South African management to plan their efforts of accident prevention on scientific lines dovetailing into their day-to-day managerial activities.

There is no doubt that with NOSA's guidance and expertise the injury and accident rate can be greatly reduced.



GRAPH NO. 1 — GRAPH NO. 2

Industrial accidents are costing South Africa about R100 million a year, through loss of productive time. In addition, more than 2 000 people are killed and 30 000 are permanently disabled. In the above graphs, the real costs before and after an accident are measured in terms of a fall in production and the overtime expenses required to maintain production levels. The effect on profits is dramatic, with a drop from R300,00 to R75,00 as a result of inadequate safety precautions.