HEALTH & DISEASE

GENERAL

1982

~~82~~ JAN. — DEC.

85 Sunday Times 3/1/82

Faulty phone line could mean death

By JON SWIFT

SOMEONE is going to die soon in an emergency in the Eastern Transvaal.

That's the feeling of doctors in the Lothair region, which borders on Swaziland.

And the medical men are adamant that the inadequate telephone facilities available to them in an emergency will be to blame.

These claims came tragically close to reality in the aftermath of a fatal car accident.

The station commander of the Belfast police, Adjudant Officer Janse van Vuuren, and his family were travelling on the main road near Lothair.

The car crashed and his wife and one child were killed. Another child was seriously injured.

The child was rushed to a clinic on a nearby farm and the attempt to put emergency services into operation started.

"Every time there is a thunder storm, the Escom power fails," said one of the farming community's leading medical practitioners.

"And every time the power fails, the manual exchange fails and we are out of touch with the rest of the world."

This was the case with Adj-Off van Vuuren's child.

No contact

The storm is believed to have blown out the switchboard and cancelled any hope of direct contact with hospitals at Ermelo and Amsterdam.

The manual switchboard has an emergency back-up which allows it to operate for up to 12 hours on batteries.

But when this was needed during the emergency, it was not working.

"The accident happened about 5 pm," recalled the doctor who battled to keep the child alive at the clinic.

"After an hour of struggling with terrible lines, we managed to contact Pretoria through the police in Ermelo."

The police at Lothair confirmed the timing of the accident, but they were powerless without the communication systems which could alleviate the problem.

The link to Ermelo was just enough to set a flight for life in operation.

It was this tenuous link that saw the drama take a different turn, with the despatch of a Puma mercy helicopter from the capital.

Marvellous

"The crew was marvellous," said the doctor. "They battled against the storm all the way in . . . without grid references, without lights and with no radio beacon."

But the medical men in the region are not content to let a similar tragedy happen again.

"I have been in contact with the Postmaster General," said the doctor who treated the child at the farm clinic.

"This type of communications cannot continue. Quite apart from the fact that the nearest ambulances are at Amsterdam or Ermelo, this is a high potential terrorist area.

"And every time there is a storm — and in the Lothair area, that is often — the exchange goes out."

A spokesman for the Post Office said that the department was aware of the complaint laid by the doctor.

But he pointed out that the failure of the emergency battery back-up system was "a rarity".

"The system at Lothair was found to be faulty and has since been fixed," he said.

The doctor who laid the complaint agrees that repairs have been carried out, but insists that the system is still not good enough.

"The police cannot be expected to perform the work of the ambulances.

"I have approached them in the past, but they say that they can only transport bodies.

"I told them that, in an emergency such as this, the patients could easily become those bodies."

Hospital boss puts a stop to staff party

(85) Sunday Times 3/1/82

By VAL CARTER-JOHNSON

A HOSPITAL chief who insisted on sticking to the rules caused the break-up of a multiracial New Year party this week.

When the superintendent of the Woodstock Hospital in Cape Town arrived at the hospital's annual bash, he cancelled it — because alcohol was being served to a mixed gathering.

Superintendent Dr P J W Roux and his wife were invited, but on arrival he asked that the party be stopped.

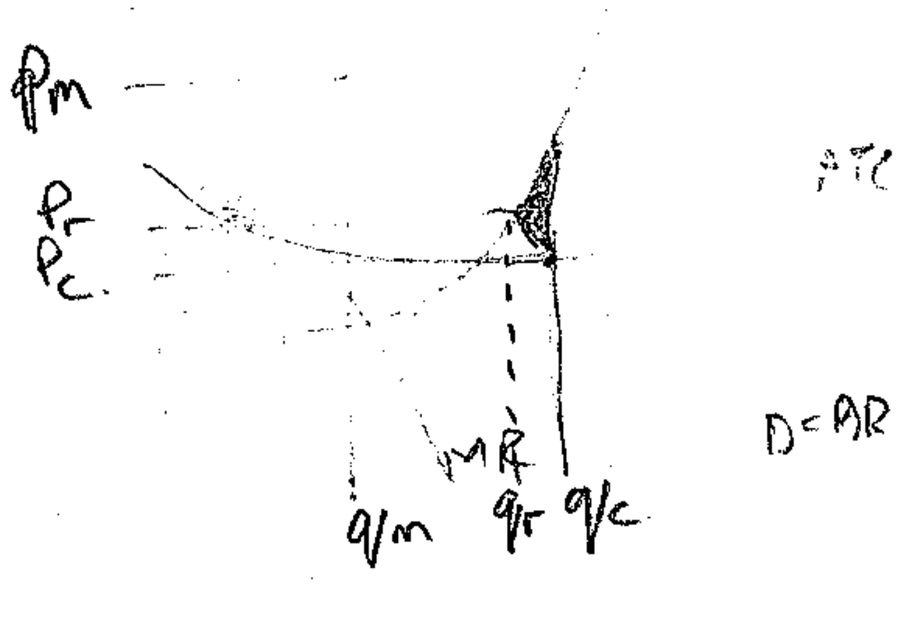
Dr Roux said afterwards he had warned the organisers it was against regulations to hold a multiracial liquor party on provincial property.

"I have handed the matter to the Director of Hospital Services and cannot comment further."

The Director of Hospital Services, Dr R L M Kotze, said the matter had been settled.

"There is a problem with having alcohol served on provincial property, and I believe that was the trouble — certainly not the race of the people who had attended the party," Dr Kotze claimed.

MC



Prof spells out poverty's heavy toll among blacks

By PAT SIDLEY

ABOUT 45% of black children admitted to King Edward VIII Hospital wards in Durban are malnourished, and 25% of those die, says the paediatric chief at the University of Natal, Professor A Moosa.

Slightly malnourished children are not admitted.

Prof Moosa blames poverty for malnutrition in South Africa and says the solution is not medical but "political and socio-economic".

Prof Moosa, head of the department of paediatrics and child health at the University of Natal in Durban, makes the disclosures in an article in the latest edition of "Sash", quarterly journal of the Black Sash.

About 80% of children who die in the children's wards are under two years old, Prof Moosa says, and most of these are under a year.

About 20% of these are in the 1-2 year age group -- and this is not reflected in the official infant mortality rate.

The death figures for black children in South Africa are comparable to those of other African countries, while the child death rate among whites compares with that of countries such as Denmark.

Children up to five years old (the most vulnerable group) make up 16% of the black population. But deaths in this group account for 55% of total black mortality.

Among whites, the 1-5 years age group makes up 11% of the population, but only 7% of total deaths.

A 1977 Soweto survey showed 45% of children aged 10 to 12 years were undernourished, and 30% of households operated below the poverty datum line.

Prof Moosa says the health priorities of South Africa should be the "provision of clean, constant water, constant, adequate supply of food, adequate sanitation and adequate housing".

The medical profession should put pressure on "policy makers and planners to deal with the roots of the problems and not the symptoms . . ."

BONTIC [illegible]

The Star Thursday April 1 1982

One clear health policy demanded

By Pamela Kleinot

RUSTENBURG — A doctor from the University of Natal yesterday slammed South Africa's health care system and called for a single government department to work out a clear-cut policy of health in Natal and kwaZulu.

Dr W Loening said sophisticated health care was available to some sections of the community while the majority of people in the region had no access to efficient primary health care.

"Health care at present is provided by six different authorities which work largely in isolation with no overriding plan or policy," he said.

Dr Loening was speaking in Rustenburg to about 50 doctors at a three-day congress on "Priorities in Perinatal Care in South Africa."

He said one of the requirements of an efficient health care system was a clear-cut policy directed by a single government department which worked in close co-operation with all related departments.

Commenting on the present system, he said that although one Ministry was responsible for the entire health care system of kwaZulu, this homeland was fragmented into about 34 areas. Some formed part of metropolitan Durban while others bordered directly on Mozambique, and efficent administration was virtually impossible.

"Hospitals are filled with patients suffering from eminently preventable diseases often requiring very costly curative care," he said.

Dr Loening said most of the children admitted to King Edward Hospital in Durban suffered from chest infections, gastroenteritis, measles and TB.

"Forty-five percent of patients admitted to the hospitals suffer from malnutrition-related diseases," he said.

Dr Loening said a substantial change in the health care system was closely involved with the political tide.

The new Health Act passed four years ago and the National Health Plan which was announced in November 1980 made no appreciable change in emphasis or direction.

"For there to be any significant improvement in the situation, primary health care will have to enjoy top priority with secondary and tertiary care providing a back-up," he said.

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NOTICE TO CANDIDATES

WAARSKUWING

1. Candidates must not use both sides of the paper for their answers. The left-hand pages may be used for rough work, but the examiners will only give credit for answers written on the right-hand pages.

2. Candidates are reminded to indicate their names on all loose sheets accompanying an answer to an examination question.

3. No candidate may have with him in the examination room any books or notes whatsoever unless specially instructed by the Registrar by written notice to bring such with him, when he may take into the room the books indicated but no other books or notes.

4. A candidate attempting to help or obtain help from any other candidate, or having any unauthorised books or notes in his possession will be liable to be disqualified and to be further dealt with as may be determined by the Senate.

5. A candidate must not take out of the examination room any examination books supplied by the University.

6. Pages must not be extracted from this book.

1. Eksamenantwoorde mag net aan één kant van die papier geskryf word. Kladwerk mag op die agterkant van 'n bladsy gedoen word, maar die eksaminator sal vir eksamendoeleindes alleen in aanmerking neem wat op die voorkant geskryf is.

2. Kandidate word herinner om hulle name op alle los blaaie wat 'n antwoord op 'n eksamenvraag vergesel, te skryf.

3. Geen kandidaat mag boeke of aantekeninge van watter aard ookal by hom in die eksamenkamer hê nie tensy die Registrateur deur skriftelike kennisgewing las gegee het om bepaalde boeke mee te bring.

4. 'n Kandidaat wat probeer om 'n ander kandidaat te help of om hulp van 'n ander kandidaat te verkry, of wat ongeoorloofde boeke of aantekeninge in sy besit in die eksamenkamer het, stel homself bloot aan diskwalifikasie en sulke verdere stappe as wat die Senaat nodig mag ag.

5. Geen eksamenskrifte deur die Universiteit verskaf, mag uit die eksamenkamer weggeneem word nie.

6. Geen bladsye mag uit hierdie eksamenskrif geskeur word nie.

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Transkeian faith healer is now a rich woman

(85)

E. Post 13/11/82

By SIMON BLOCH

TRANSKEIAN faith healer Mrs Flora Ludlolo has become so wealthy that she has bought a luxury limousine and paid R26 000 in cash for three tractors, a source has revealed.

Her husband now drives an imported R20 000 truck.

According to the informant, Mrs Ludlolo, whom thousands of people visit each week, travelling by bus to Cancele, Mount Frere from all parts of the country, has become a "very wealthy woman".

But, he claimed, the number of visitors to her home village of Cancele had decreased markedly recently.

It is said that some come from as far as Malawi and Zimbabwe.

A Kokstad, supermarket manager, Mr Billy Muller, said: "About 60 buses used to pass through here every weekend. It was unbelievable.

"I think there may have been a clampdown or something, because it's not the same anymore.

"The police also arrested a few people who filled their water containers with dagga," he said.

Another reason fewer people are visiting Mrs Ludlolo may be because there is a "fake trade" in Johannesburg and elsewhere, with people selling ordinary tap water and claiming it is "holy" water.

People visiting Mrs Ludlolo sing hymns and place large containers of water outside her house.

She then sings, and while scattering "sacred" salt over the water, assures her believers that the water has her blessing.

It is believed the water brings good luck and keeps bad away.

Some people believe that she also has powers of raising the dead.

She does not charge for her services.

Instead they leave donations — according to Mr Muller "the bigger the donation, the better the healing power".

A salesman at Oak Service Station in Kokstad said last year Mr Ludlolo paid cash for a large Mitsubishi truck, valued at approximately R20 000 — cash.

And another Kokstad businessman, Mr Jeff Rosewall, said Mr Ludlolo had bought three tractors towards the end of last year, one for R14 500, another for R6 500 and a third one for R7 000.

"He paid cash for all three," said Mr Rosewall.

He said the Ludlolos had gone into business, ploughing fields for neighbouring farmers, and Mr Ludlolo, who had the large truck, was working as a transport contractor.

Three years ago, Mrs Ludlolo was an ordinary housewife, and her husband a male nurse.

She became ill for three days and while in bed, she had a vision that she had been given the power to pray for and heal people.

She began small rites which were attended by people from neighbouring villages.

Pinetown's Red Cross service faces staff crisis

85

Mercury 16/11/82.

Mercury Reporter

PINETOWN'S Red Cross ambulance service is in dire straits — on Monday they will not have enough voluntary crew members to man their ambulance service fully.

Mrs Iolanthé Boonzaier, one of Pinetown's Red Cross committee members, said they had lost a lot of voluntary workers over the past few months.

'Most of our members are women, and I believe they have been forced to leave the Red Cross because of financial pressures.

'We need day crews for our ambulances, especially in the mornings, but several women have left because they are now working.'

The Pinetown Red Cross provides the only ambulance service in the area, sandwiched between the borders of Westville, Hammarsdale, Drummond, and Chatsworth.

The service is multiracial and all the crew members work on a voluntary basis.

Mrs Boonzaier said the Red Cross needed 100 people a month to keep the service running for 24 hours every day.

'If we don't get new members soon, we will have the ambulances but nobody to run them,' she said.

Normal light-duty vehicle licences were required for drivers, and any new members would receive first-aid training.

Mrs Boonzaier said that members could do as little as one shift a month.

It's the poverty that kills

(85)

RDM 19/2/82

By J S MOJAPELO

THE high infant mortality rate among South Africa's black children cannot be solved by medical, but by political and socio-economic solutions, a top medical academic has said.

The head of the Department of Paediatrics and Child Health at the University of Natal, Professor A Moosa — in his inaugural lecture published in the current edition of Black Sash magazine, Sash — said 8 000 000 of the 10 000 000 children in South Africa were black.

The infant mortality rate was highest among Coloured and black children. More than 8 000 children were lost a year in Natal and KwaZulu hospitals, mostly from malnutrition-related diseases.

Mulnutrition was still rife in rural areas because of black poverty.

Instead of building bigger and better "disease palaces", like the new Johannesburg Hospital, the money should be used to provide much needed basic health services in the rural areas," he said.

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MOTHER: Mrs Martha Mhlanga.

26/2/82 Sowetan

Long, long wait for ambulance

85

By CHARLES MOGALE

A MAN lay gasping for breath in Tembisa this week waiting for the only ambulance that serves the population of 140 000. The ambulance never came.

More than 24 hours after the ambulance had been called, the family ultimately hired a private car to take the man to the local hospital.

Mr Samson Mhlanga of Mthambeka Section took ill early this week. His mother, Mrs Martha Mhlanga, said he got worse on Wednesday and the family called for an ambulance.

"We waited all morning, afternoon and the following morning. Throughout the night Samson was gasping, and when we phoned the ambulance people again, they said we should try later," Mrs Mhlanga said.

Mr David Ngcobo, the relative who phoned for the family, said he was repeatedly told to "try later" as the ambulance had been taken in for repairs.

An employee of the East Rand Administration Board (Erab) said "very many" other residents had phoned for the ambulance throughout the week. All were told that it had broken down. He said three ambulances originally served the township. Two of these had been involved in accidents before the last one broke down last Friday.

"I can't say how many people called for an ambulance, but there were many. We have only one to serve the township, and last Friday it broke down. There was some trouble with the gears, and on Monday it was towed to a mechanic," he said.

The employee could not say when the ambulance — it serves 140 000 people — would be available.

The chief area director of Erab, Mr E.E Marx, said the ambulances had been "taken up in the work shop."

Mr Marx said his Board had "the normal problem which you pick up with cars.

"We are busy working to put the matter right," he said.

discipline. achievement."

Child deaths reasons

85 D. Dispatch 23/2/82

The solution to the high infantile mortality rate among black children in the country is not medical but political and socio-economic, according to the head of the Department of Paediatrics and Child Health at the University of Natal, Professor A. Moosa.

Professor Moosa made the statement in his inaugural lecture published in the current edition of Black Sash magazine, Sash.

He said out of 10 million children in the country 8 million were black. The infantile mortality rate was high in both coloureds and black children. The most vulnerable group are young children up to five years.

"We lose more than 8 000 children a year in the hospitals of Natal and KwaZulu alone and about 2 000 of these deaths occur in King Edward VIII Hospital," Professor Moosa said.

The principal causes of admissions to the children's ward at the hospital are chest infection (21 percent), gasto-enteritis (13 percent), infectious illness, especially measles, (10 percent) and TB (7 percent. And these diseases were responsible for the majority of deaths occurring amngst black children, said Professor Moosa.

"The tragedy is that these are to a large extent preventable," Professor Moosa said.

95 Star 4/3/82

NERAL NEWS

US body backing SA health effort

By Frank Jeans

America's influential Federal Drug Administration, the official controlling body for the registration and marketing of medicines has registered a Bloemfontein clinic as an FDA approved research centre.

The Hoechst Clinic for Basic Pharmacological Research is part of the University of the Orange Free State and is playing an increasingly important role in putting South Africa on the international map in the field of medical research.

The main work being carried out there, and which is drawing world interest, is in the area of pharmaco-kinetics — which is concerned with the absorption of drugs, distribution in the body, their metabolism and elimination.

Called Phase 1 research, a new drug is tested for the first time in humans — testing which normally involves a single dose and is the basic safety check.

Research of this kind is under the strict control of the Medicines Control Council, and is authorised only after the council has checked all animal tests previously carried out.

Work at the clinic is under the control of Professor F O Muller, head of the Department of Pharmacology, and who has established an international reputation in his field.

Since the clinic was founded at the beginning of 1975, it has also been closely involved in cardiovascular research and much work is currently being done in this area.

"Already we are looking for new indications in the psychiatric area, in tension headaches and in migraine," says Professor Muller.

Although a considerable proportion of the research funds is provided by Hoechst South Africa, the clinic is completely autonomous and carries out assignments for other institutions.

visions prohibit their joining such trade unions;

(2) whether an association applying for registration as a trade union under the said Act is required to have a secretary; if so,

(3) whether any requirements have been laid down in regard to the post of secretary of such an association; if so, what are they?

†The MINISTER OF MANPOWER:

(1) Yes.

(2) Yes.

(3) No.

Bathurst: Black school

*14. Mr. E. K. MOORCROFT asked the Minister of Industries, Commerce and Tourism:

(1) Whether the Black school in the grounds of the Methodist Church at Bathurst is a State-aided school; if not, what type of school is it;

(2) whether he or officials of his Department have been informed of the state of the pit latrines being used at such school; if so, when;

(3) whether these latrines constitute a health hazard; if so, why;

(4) whether steps are being taken to counteract such hazard; if not, why not; if so, what steps?

†The MINISTER OF INDUSTRIES, COMMERCE AND TOURISM:

(1) No, the school concerned which already existed before 1955, was erected by the Church in an unproclaimed township and is at present run as a community school in the original school buildings. A minimal rent is paid for these buildings.

(2) Yes, the local Circuit Inspector of my Department was informed thereof on 15 February 1982.

(3) Yes, it is unhygienic.

(4) Yes, steps are being taken to erect latrines at Departmental expense.

Bathurst: health hazards

*15. Mr. E. K. MOORCROFT asked the Minister of Health and Welfare:

Whether (a) he and (b) officials of his Department have been informed of possible health hazards in the Bathurst area;

(2) whether his Department has initiated any preventive measures to combat the spread of cholera to the Bathurst area; if not, why not; if so,

(3) whether investigations have been made into the problems caused by (a) the pit latrines in the Black township and (b) septic tanks near the Bathurst post office; if so, what steps are planned to overcome such problems?

The MINISTER OF HEALTH AND WELFARE:

(1) (a) Yes;

(b) yes;

(2) yes;

(3) (a) yes;

(b) yes; the pit latrines are being replaced and a new sewerage system to replace the existing septic tanks is being planned.

Hansard Q.61.269-370
5/3/82

(85)

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~~(b) yes;~~

(2) yes;

(3) (a) yes;

(b) yes; the pit latrines are being replaced and a new sewerage system to replace the existing septic tanks is being planned.

Two Supps

Two Supps

Dias health work hit by lack of staff

E. Post 85 22/3/82

Post Reporter

MORE money was essential to ensure community health, Dr J H Meyer, Medical Officer of Health for the Dias Divisional Council, said in his annual report.

The council's health service, which covers the area where bubonic plague has broken out, had been crippled by a lack of health inspectors, he said.

At present, only two were employed for an area of 9 000 square kilometres where 167 000 people lived, mostly blacks.

Regional health personnel prevented more disease than the number of cases treated by doctors and nurses, said Dr Meyer in pleading for the urgent review of the position of health inspectors on a nationwide basis.

He hoped that the "chronic shortage of funds" as well as the freezing of posts experienced to the end of last year, would not lead to a lowering of standards in certain fields.

"If we take another look at our priorities, I believe that almost none can be placed above that of health services.

"Only a nation which enjoys good health can generate optimal ways of thinking and top productivity," he said.

It was easier to establish and maintain sound personal relationships where individuals from all races enjoyed good health. While much had been done by the authorities to promote this end, it was "imperative that much more should be done".

When it became necessary to economise, health services should not be the first to come under scrutiny.

"We should rather economise on luxury items and unnecessary spending. The promotion of good health can neither be regarded as being unnecessary or a luxury item," he said.

On the subject of tuberculosis, he said fighting the disease remained one of his department's greatest problems.

"It must again be emphasised that noteworthy progress can only be made in this field if the socio-economic conditions of these population groups are drastically improved."

the famous Russian ballerina Galina Panova
)ite her flight from Europe the day before.

Picture:PIERRE OOSTHUYSEN

Lapa to be quizzed on camp facilities

By JOHN BATTERSBY
Political Correspondent

CAPE TOWN. — The claim by the Minister of Health, Dr L A P A Munnik, that health services in the Onverwacht resettlement camp are "as good as anything in Houghton" has precipitated a major row.

An outraged Dr Marius Barnard, chief Opposition spokesman on health, has tabled a series of questions in Parliament seeking information on conditions at the camp in the Free State.

And a community worker, who has asked not to be named, has painted a drastically different picture of Onverwacht.

Dr Munnik told Parliament on Monday that every house at Onverwacht had a tap and that it had a clinic and a health service which was "as good a health service as any of you people have in Houghton".

Dr Barnard said: "Dr Munnik has a very sad record of insensitive statements and this must rank as one of the worst."

Onverwacht is a resettlement camp, about 15km from Thaba Nchu on the SA side of the border with Bophuthatswana, housing about 120 000 people, mainly in tin shanties.

It was established in 1979 to house non-Tswanas from Bophuthatswana.

A community worker who has worked at Onverwacht said the health services at the camp consisted of a clinic staffed by 12 nursing sisters and a doctor.

The clinic gave a good service but it was quite inadequate to serve the 120 000 people, he said.

There was a tap "about every 100m or every 10 houses".

In normal conditions this did not lead to undue congestion But last November and December, when there was a water shortage, it led to serious congestion.

Work had begun on a new section at Onverwacht which appeared as though it would have running water and water-borne sewerage for each unit.

There were about 10 000 stands in the main section — about 600 were brick-and-mortar dwellings, about 50 were tents and the vast majority tin shanties.

There was no water-borne sewerage and there were bucket latrines which were supposed to be emptied twice a week but often the cart came round only once a week and "things got quite unpleasant".

SWA is a burden — PW

By JOHN MATISONN
Washington Bureau

WASHINGTON. — South West Africa has been a great financial burden which South Africa is in a hurry to end, the Prime Minister, Mr P W Botha, said in an interview published in the United States.

The Government does not stand in the way of an independent SWA, but the question was who would fill the vacuum after South Africa left.

"We are not going to allow communist forces, at the point of a gun, to subject the people of Namibia. But we won't stand in the way of independence, and we hope that the Western countries will share with us the burden of developing it," Mr Botha told Time magazine's correspondent, Mr Marsh Clark in Cape Town.

The Prime Minister said the Government was contemplating introducing measures to improve the local government system for black people outside the "national states" during the current parliamentary session.

"You cannot have development without change, though I am not for change for change's sake," he said.

Mr Botha compared the policy of "separate development" to the nations of Europe which are part of the European Common Market. Separate development was the order of the day in the Americas and Africa.

"If we carry it out here, separate development means nothing other than that the peoples have traditions, history and ideals to which they must remain true. And they must not use those traditions, histories and ideals to belittle or destroy the rights of others," he said.

alina turns TV's ok Grobler away

By ADA STUIJT

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"It was an unfortunate communication gap between SABC-TV and PACT officials. Everybody was very unhappy about it," Mr Sakkie Burger, head of TV news, said last night.

Galina Panova said: "I was very surprised and confused to see them, because I certainly didn't know of any further Press interviews.

"Since they were not accompanied by PACT representatives, I was confused about whether I should talk to them and asked them to leave instead," she said.

● Yesterday, Miss Bedelia Petzer of the SABC-TV Pretoria office conducted a news

Mulder's party bows out

Pretoria Bureau

THE executive of Dr Connie Mulder's National Conservative Party will meet for the last time in Verwoerdburg on Saturday before the party becomes absorbed into Dr Andries Treurnicht's Conservative Party.

A special NCP committee has been appointed to wind up the party's financial and other affairs. Membership files will be handed to the Conservative Party offices in Pretoria, Mr Sarel Reynecke, the NCP secretary, said yesterday.

Dr Mulder was elected to the management committee

Casinos bring a jackpot payout

Political Reporter

THE managing director of the Bophuthatswana National Development Corporation (BNDC), Mr Wynand van Graan, yesterday strongly defended the establishment of casinos in the country.

Addressing the Wits Alumni Luncheon Club in Johannesburg, Mr Van Graan said critics of gambling were unable to suggest how else to establish Bophuthatswana's tourist industry.

Casinos made other facilities available at prices people could afford.

"And contrary to popular belief, tourism to us means for a weekend of sin," he said.

The BNDC — which has half shares with Southern Sun in the Sun City and Mmabatho Sun projects — wanted people to enjoy themselves and return for future holidays.

"It will surprise you to know that a check we did last year indicated that only 20% of the guests that visit Sun City make use of the casino."

With more than 1 750 000 foreign visitors a year, tourism contributed significantly to Bophuthatswana's economy.

Tourism provided jobs for more than 3 000 people — 10% of the BNDC estimated

CAPE TIMES 10/4/82

Water needed from Palmiet

Municipal Reporter

THE Palmiet River is one of the South Western Cape's last conventional water sources that can still be developed economically for urban water supply.

And Escom believes it is essential for the river to be exploited substantially by 1991 when demand is expected to outstrip supply from existing sources in the Cape metropolitan area.

The first phase is the Palmiet hydro-electric scheme which would supplement the Steenbras Dam by 30-million cubic metres of water a year and is expected to be completed by 1988.

Competition for water in the South Western Cape between agriculture and the urban sectors is keen and a fair division must constantly be maintained.

At present, economically exploitable conventional water sources in the area are nearly exhausted.

The situation is further complicated by the scarcity of suitable dam sites for the storage in the winter months.

Smaller projects

The dependable yield capacity of the urban sector's present water sources is about 268-million cubic metres a year. According to Escom, this yield would be able to satisfy expected demand only until 1988. However, several new smaller projects already under way would increase supply sufficiently to meet demand until 1991

Apart from the proposed Palmiet scheme, other sources — including unconventional sources such as re-use of water and the desalination of seawater — are continually being evaluated.

However, these options are still considerably more expensive.

Conventional sources which can be developed include the groundwater potential of the Cape Flats.

The development of a scheme with a yield of about 10-million cubic metres a year is at present being planned. The proposed scheme would involve 27 boreholes sunk over an area of 18 sq km. The water extracted from the sand deposits would be pumped to a central point. After purification, it would be pumped directly into the urban reticulation systems.

Pipeline

Under way is a scheme to divert water from the Elands River to the Theewaterskloof Scheme via a pipeline through the Du Toits Kloof road tunnel.

Also being considered is the raising of the Voelvlei Dam — long one of the Cape's most important water sources — and the construction of a scheme to pump water from the Berg River.

Still unclear is the possible development of the Diep River which drains the southern part of the Swartland wheat producing area.

Clarke calls for more money for black health care

Mercury 21/4/82 85

Mercury Reporter

MORE money should be poured into health services for blacks in Natal because they suffered more shortcomings than whites, said Dr Fred Clarke, MEC, in Pietermaritzburg yesterday.

He was reacting to a statement in Parliament this week by the Minister of Health, Dr L A P A Munnik, that the Government should be in the dock for spending too little on health services for white people.

Dr Clarke said white people suffered few shortcomings in comparison to blacks who had not been catered for adequately in the medical field.

'The Province spends more on black health services than on whites, which is perfectly reasonable if one takes into account their masses,' said Dr Clarke. 'More people are coming into the country and increasing the population which is becoming far more aware of health care.'

Turning to the nursing crisis, Dr Clarke said Natal was still drastically short of nurses although 80 percent of the nursing posts had been filled.

He said there was a particular shortage of student nurses and that hundreds more nurses were needed to man Natal hospitals and medical institutions.

He dismissed allegations that the Province was suffering from a shortage of black nurses in black hospitals.

The only way to alleviate the present nursing crisis would be to place more black nurses in white hospitals.

Commenting on the Minister of Health's statement this week that it was 'impractical for black and white nurses to work amicably together', Dr Clarke said about 150 black nurses were already working in Natal hospitals in theatres, cancer wards and renal units

'I agree that there would be real problems with transport and accommodation for black nurses if they were taken on a full-time basis at white hospitals,' he said. 'But they are still needed.'

Meanwhile, a spokesman for Addington Hospital said the hospital was still short of student nurses.

(271) (85) (98) RDM 22/4/82

Onverwacht is no Houghton

By ADA STUIJT and ANNE SACKS

ONVERWACHT is no Houghton, despite claims by the Minister of Health to the contrary.

Dr L A P A Munnik told Parliament this week that "the health service at the Onverwacht re-settlement camp in the Free State was as good a health service as any in Houghton".

He also said every house in Onverwacht had a water tap.

An outraged Dr Marius Barnard, chief Opposition spokesman on health, has now tabled a series of questions in Parliament on the health situation in the area, a re-settlement camp 10km from Thaba Nchu in the Free State.

The camp was established by the Government to house Basothos who had to be re-settled urgently after nearby BophuthaTswana became independent.

Onverwacht houses an estimated 200 000 people, most of them young families with small children, local authorities said yesterday.

Comparisons between the Onverwacht and Houghton areas show that Dr Munnik's comparison is highly inaccurate.

For example, Onverwacht has one tap for every 50 houses.

Medical facilities at the camp consist of one clinic — only recently completed — which houses one eight-bed maternity section and a facility for 12 emergency treatment beds.

One doctor, helped by 11 nurses, sees about 300 patients a day. Four doctors alternate duty at the clinic during the week. Seriously ill patients are always transferred — by two ambulances — to Thaba Nchu, which has 250 beds in its four hospitals for blacks, said Dr A P van Dendberg, district surgeon of the area who worked at the clinic yesterday.

"We are always very busy here, and of course medical services here are never adequate. I see as many as 300 patients a day with the largest variety of complaints you can imagine."

The area is unhealthy to live in.

There are only dirt tracks to serve as roads which at the moment have big, water-filled potholes where mosquitos find a happy breeding ground.

When it rains, a small stream running through the settlement serves as the local swimming hole for thousands of children and adults.

There was a high incidence of pneumonia and TB during the rainy season, clinic nurses said yesterday.

The Government rents out 600 new brick houses to the new settlers at R30 each.

Onverwachters usually build their own shanties.

Each shanty is provided with an outdoor toilet with a bucket which is emptied once a week. The people pay R1 a year to the Government for this service.

The toilet system leaves the camp permeated with a foul odour.

Houghton's councillor, Mr Ian Davidson, yesterday described "as ludicrous as it is ridiculous" Dr Munnik's comparison of the health facilities at the camp with those in Houghton.

Mr Davidson invited the Minister to tour the area so "he might realise the folly of his words".

"It might also induce him to think before he speaks."

For example, there are only about 2 500 people living in Houghton; one Houghton family occupies an average of 4 000m² and 33 doctors live in the suburb.

All of Johannesburg's hospitals and private clinics serve Houghton. The new Johannesburg Hospital is on the doorstep, while the Kenridge Nursing Home, Park Lane Clinic, Brenthu nearby.

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316 lose jobs as VW plant trims its staff

(335) (192) (40R) RDM 22/4/82

By STEVEN FRIEDMAN
Labour Reporter

THE giant Volkswagen motor company yesterday retrenched 316 workers at its Uitenhage plant — and unionists said they feared more motor firms might retrench. Volkswagen employs 8 700 workers.

A spokesman for the National Automobile and Allied Workers Union, which is recognised by Volkswagen, said the union opposed retrenchments and believed employers could take other measures to respond to the downswing in the economy.

But he said negotiations between Volkswagen and NAAWU had reduced the number to be retrenched from around 500 and that talks were under way between the company and union shop stewards to reduce the number to a minimum.

Workers with five or more years' service were not among those to be retrenched.

The company's industrial relations director, Mr Ollie Rademeyer, said that in the light of the already severe unemployment situation in the Eastern Cape, "every effort" was made to minimise the number of workers affected.

He added that, for the first time in two years, Volkswagen dealers were "reasonably stocked" and, with interest rates at their present levels, together with economic conditions, Volkswagen needed to "adjust production".

A NAAWU official, Mr Les Kettledas, said yesterday the union had retrenched workers despite NAAWU objections.

"We are opposed to retrenchments in principle. We believe there are other measures employers could take, such as working shorter weeks and banning overtime, to meet the new economic conditions," he said.

About 30 000 workers were already jobless

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All of Johannesburg's hospitals and private clinics serve Houghton. The new Johannesburg Hospital is on the doorstep, while the Kenridge Nursing Home, Park Lane Clinic, Rosebank Clinic and Brenthurst Clinic are all nearby.

All the plush Houghton homes have water, lights and sewerage.

There is no municipal child health clinic in Houghton, but there are clinics in the surrounding suburbs, all of which are easily accessible to mothers.

Communication — by road and telephone — make health services in Houghton far more accessible than those at Onverwacht.

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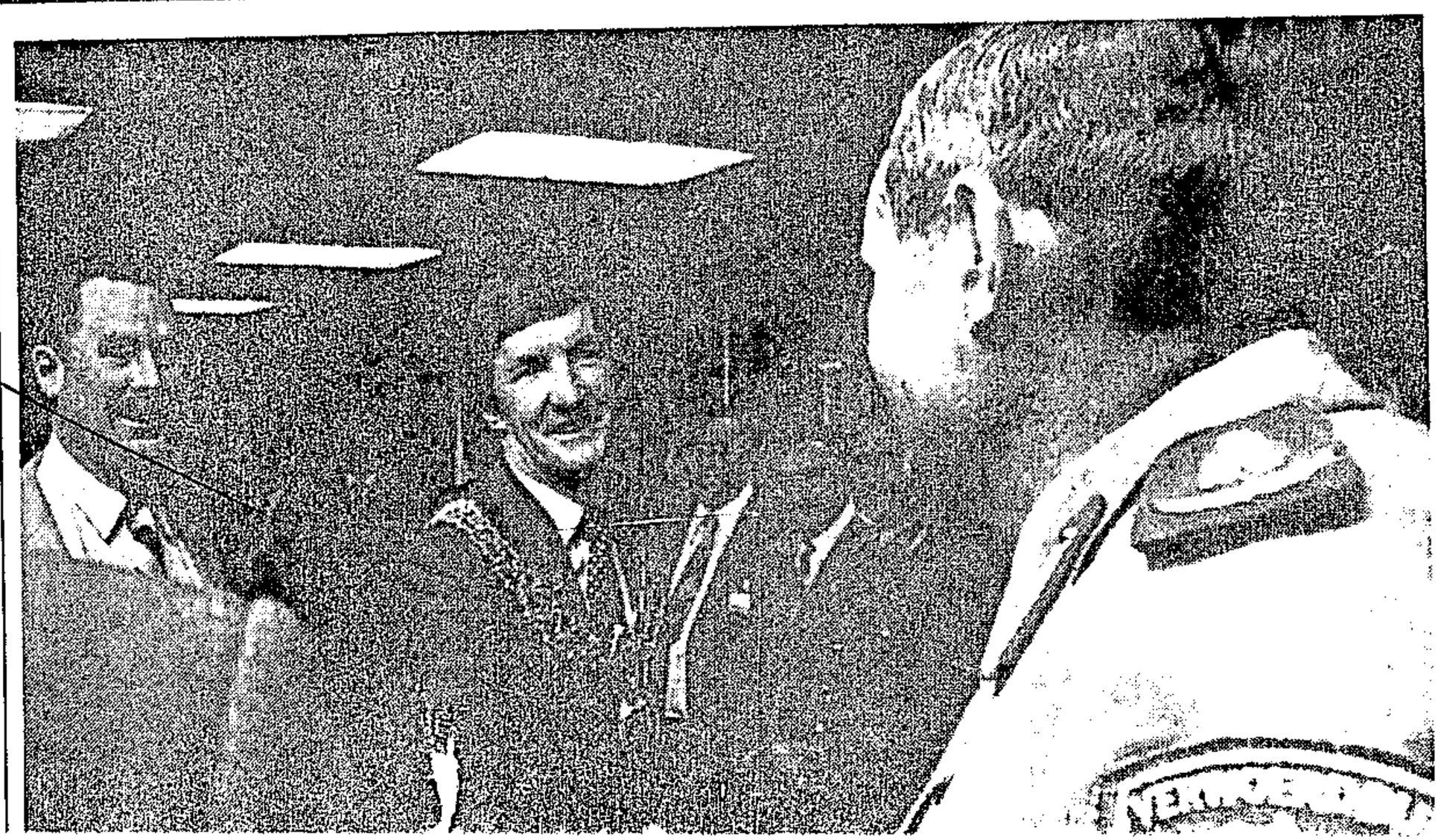
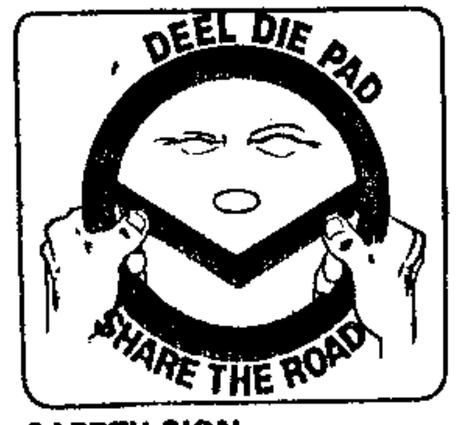


Public slack on road deaths



SAFETY SIGN
The mayor's slogan

SUNDAY EXPRESS April 25, 1982

EXPRESS CLOSE-UP VISITS THE RURAL SLUM WHICH MUNNIK

The dumping ground

THE day after Minister of Health Dr Lapa Munnik compared health facilities at the Onverwacht resettlement camp in the Free State to Johannesburg's Houghton, two children died of starvation and nearly 300 people lined up at its clinic waiting for attention by one of its two doctors.

Onverwacht — a conglomeration of despair and squalor — nestles at the foot of a chain of koppies 15km from Thaba 'Nchu and houses about 160 000 people.

Driving through the dust-bowl they call 'Botshabelo' — a place of refuge — the young and old sat outside their tin shacks and mud-houses seeking warmth from the wintry Free State sun.

There is little the clinic can do to alleviate the many seasonal health problems encountered by the residents in this resettlement camp established in May 1979.

So far the work of the 12 nurses and the two South African Defence Force doctors has hardly made an impact on the daily lives of those living at Onverwacht.

Recently they had to stand helpless as up to 70 children a day were rushed to Pelonomi hospital in Bloemfontein — 60km from the camp — during a gastro-enteritis epidemic. A nurse at the clinic said the medical staff could not cope with emergencies.

"If there are any emergencies after 4pm the patients are either taken by our ambulance to the Moroka hospital or they catch one of the buses to Thaba 'Nchu," said the nurse.

Another cause of discontent is the lack of preventive medical care at Onverwacht. Community health, said the nurse, was non-existent because of staff shortages.

Reports by LIZ VAN DEN NIEUWENHOF
Pictures by DENIS FARRELL

● Dusty squalor is the lot of 160 000 people who live in the rural slum of Onverwacht.

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Where the best is the worst

SAYS HAS HEALTH FACILITIES WHICH COMPARE WITH HOUGHTON

● One of thousands of makeshift tin shacks in [illegible] the Onverwacht residents have to live.

When the Sunday Express arrived at Onverwacht the medical staff was arming itself against the predictable outbreaks of pneumonia and bronchitis as the Free State winter approaches.

The nurse said that the health resistence of most Onverwacht children was "very low" — mostly due to malnutrition.

The day we arrived at Onverwacht six children were treated for malnutrition at the clinic.

One was 18-month-old Mavis Mgezo who was suffering from kwashiokor. Lying limply on a bed in a one-roomed tin shack and in the care of her grandmother, Mavis has been crying for the protein her body craves.

She had all the symptoms of being underfed ... skin peeling around her mouth, swollen eyes, hands and ankles.

Mavis is one of hundreds of Onverwacht children who have to make do with the little food available in their homes. As most of their fathers are either working illegally in Bloemfontein and Welkom or are migrant labourers at the mines, their mothers are left to provide for them.

'Smart alec' Munnik

HELEN Suzman, PFP spokesman on black affairs, said: "Dr Munnik is, I'm afraid, an incorrigable smart alex.

"He cannot resist making insensitive remarks such as his favourable comparison of the primitive health conditions at Onverwacht where a sad, poverty-stricken community struggles to exist, with well-endowed Houghton.

"The comparison is so absurd that it's hardly worth a comment. One can only hope that sooner or later Dr Munnik will realise that his offensive remarks reflect very badly, not only on himself but on his department which cannot dissociate itself from him."

The shortage of food is evident in the increasing number of children suffering from pellagra — vitamin B deficiency — who are fed by the clinic's feeding scheme.

The nurse commented: "We think the problem is far more widespread than we are aware of because most of the deaths are reported to the commissioner.

"We are not given the official infant mortality statistics at the clinic."

A community worker in Thaba 'Nchu said that about three out of five funerals arranged by the Roman Catholic Church are for children.

When the Sunday Express was at Onverwacht on Wednesday funeral arrangements were being made for a four-month-old baby and 17-month-old baby.

Sanitation and the inadequate water supply makes Onverwacht a health inspector's nightmare.

Most of the shacks and mudhouses are interspersed with corrugated iron pit-toilets and although officially the toilet buckets should be emptied twice a week residents said that they were being emptied once a week.

A few white-washed matchbox houses lie scattered among the tin shacks.

No official figure on the number of new houses built could be obtained but according to the community worker the Economic Development Corporation had built about 600 homes.

"These are for those who have work seekers' permits and are bought for between R4 300 and R6 000.

"But most Onverwacht residents live in one-roomed tin shacks and there are quite a number of families still living in the tents issued by the Government when they were first moved to Onverwacht four years ago," said the community worker.

Most of the people at Onverwacht were moved from the Kromdraai squatter camp in Thaba 'Nchu after Bophuthatswana independence.

Before independence the 'non-Tswanas' lived in harmony with the Tswanas.

But after independence in December 1977 conflicts with the Bophuthatswana citizens became an everyday happening and those at Kromdraai — mostly South-Sotho speaking — were harassed by the police.

They were not allowed to work in Bophuthatswana and their children were prevented from attending Bophuthatswana schools.

To 'quell resentment' they were moved to Onverwacht but had to take out Qwa-Qwa citizenship although the area is not part of the homeland.

Mrs Alice Mashode's case is typical of the many families who have been relocated.

A mother of four, she was dressed in a short yellow dress, torn and stretched through years of trying to keep making it fit despite being made for a teenager.

She took me into her tiny 3m² corrugated iron shack, its sides pasted with newspapers to keep out the dust and draught.

Her husband is a migrant labourer who works in Henneman and only sees his family once a month when he brings home a family allowance of R50.

It is a hard life for Mrs Mashode and her family. To buy their meagre groceries she either goes to the supermarket where products are sold at three times the price they are sold at in Thaba 'Nchu or catches a bus to Thaba 'Nchu.

"But there's never enough. I have a baby who is starving. I don't know what to do," she said.

SUNDAY EXPRESS April 25, 1982

CMC Times 14/5/82 85

Munnik contradicted: Resign says Barnard

Dr L A P A Munnik

Political Staff

HOUSE OF ASSEMBLY. — The Minister of Co-operation and Development, Dr Piet Koornhof, had contradicted the Minister of Health, Dr L A P A Munnik, about health conditions in the Onverwacht resettlement camp, Dr Marius Barnard, MP, said on Wednesday.

And, Dr Barnard added, information given him in Parliament on Wednesday by Dr Koornhof should leave Dr Munnik no alternative but to resign.

In April this year, Dr Munnik said in Parliament that the people in Onverwacht, a resettlement camp in the Orange Free State on the Bophuthatswana border, enjoyed "as good a health service" as any of the people in Houghton.

Yesterday, Dr Koornhof said there were two part-time doctors and three district surgeons serving the estimated population of 120 000 people at Onverwacht.

"This means, at best, there is one doctor for every 24 000 of the officially estimated population," Dr Barnard said.

Dr Koornhof said there was one dentist at Onverwacht and Dr Barnard said he had information that this dentist did not even have facilities for filling teeth and had to resort to extractions.

In April, Dr Munnik said he had visited Onverwacht and that "there is a water tap at just about everyone's doorstep and every plot has sanitation".

Dr Koornhof, however, said on Wednesday that "taps have been provided every 150 metres".

He also said there was no water-borne sewerage at Onverwacht.

A psychiatrist visited the area twice a week.

In respect of curative services, there were two senior sisters, 11 sisters, seven staff nurses and two Santa information officers.

Dr Barnard commented: "Only 20 nurses are meant to look after the health needs of 120 000."

In his reply, Dr Koornhof said there was one social worker at Onverwacht although there were three other posts for social workers.

He also said his department had built 53 houses at Onverwacht, while private individuals had erected 591 houses and 8 080 wood and iron structures had been constructed "pending the provision of permanent structures".

In addition, 61 tents had been supplied by the department, and 28 had been pitched by individuals.

He said the estimated population of Onverwacht in 1981 was 120 000 which included 66 000 people who had joined relatives and friends there.

Dr Barnard said: "I find it quite unacceptable that a statement like this should have come from the minister who is meant to be responsible for health in South Africa.

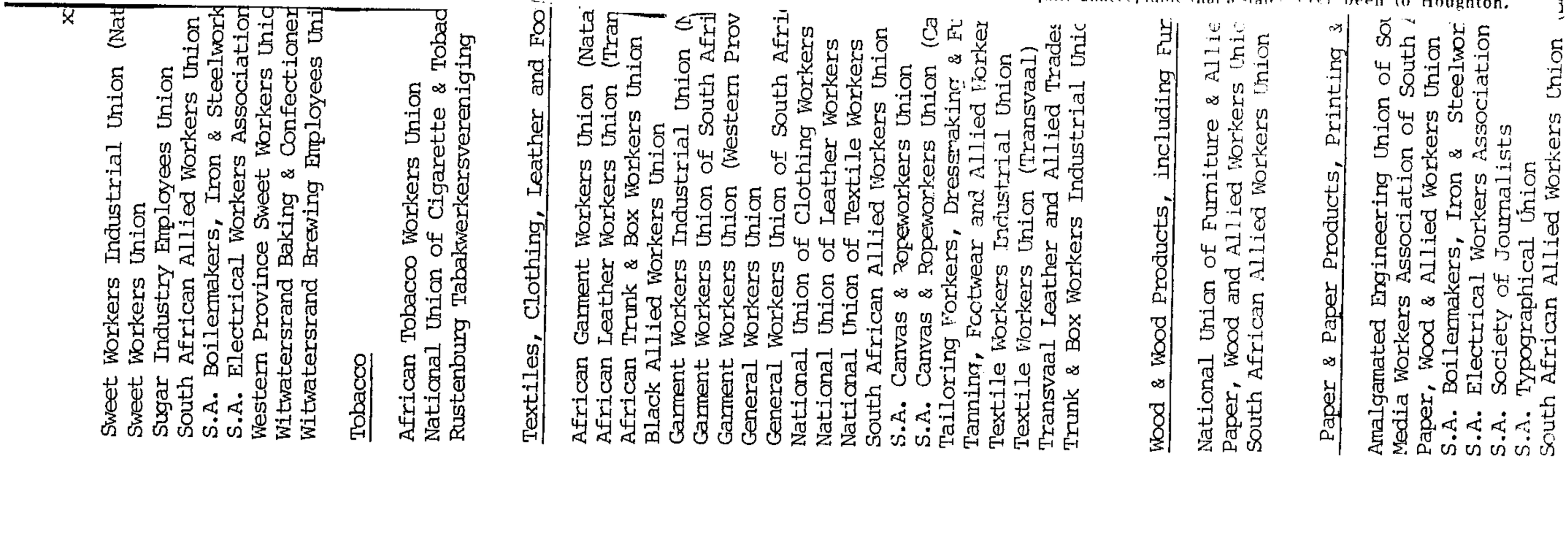
"He is obviously out of touch with the realities of the health needs of the majority of people of South Africa.

"Dr Koornhof's reply should leave Dr Munnik no alternative but to resign.

"His R20 a month blunder showed him to be out of touch with the needs of pensioners.

"His Onverwacht statement shows him to be out of touch with health needs, where the services provided are actually a health hazard.

Indeed, one is tempted to ask whether Dr Munnik has ever been to Houghton."



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S.A. Society of Journalists
S.A. Typographical Union
South African Allied Workers Union

SECTION C

Taxpayer hit by socialised medicine

Star 21/5/80

The trend to the socialisation of medicine is continuing in South Africa according to Mr John Toerien, director of Northern Transvaal Chamber of Industries.

This, he says, is bringing about a total distortion in the market place and placing an unnecessary burden on the State and taxpayer. It is also discouraging the natural development of the pharmaceutical manufacturing industry.

Mr Toerien said an estimated 65 percent of manufacturers' sales were directed through the State.

He added that about 55 percent of the medical profession and 70 percent of nurses were already employed by the State and, according to the present trend, these employment figures by the State could dramatically increase.

"There seems to be a very close correlation of volume of medicine supplied to the State and professional engagement of staff — a remarkably high figure within the philosophy of the free enterprise system," he said.

Mr Toerien said the pharmaceutical manufacturing industry was the most investigated industry in South Africa and none of the investigations carried out had found evidence of the industry "abusing its position in the market place."

Mr Toerien said there was nothing illegal or immoral in providing health services at a profit to the entrepreneur.

Referring to an accusation that the private sector was now subsidising the price of medicines to the State, he said the prices became so uneconomic that the private sector withdrew from manufacturing and promoted generic prescribing and generic dispensing.

Medicine is bought by the State through the tender system, with price the determining factor.

Mr Toerien said he did not think the present system of medical care in South Africa would be able to meet future needs. It was therefore time to pursue actively a policy of returning health care, including medicine supply, to the private sector.

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Paper No 2
(to be copied from the heading on the Examination Paper)

NOTE CAREFULLY

1. Enter at the top of each page and in column (1) of the block on this cover the number of the question you are answering.
2. Blue or black ink must be used for written answers. The use of a ball point pen is acceptable. Red or green ink may be used only for underlining, emphasis or for diagrams, for which pencil may also be used.
3. Names must be printed on each separate sheet (e.g. graph paper) where sheets additional to examination book(s) are used.
4. Do not write in the left hand margin.

WARNING

1. No books, notes, pieces of paper or other material may be brought into the examination room unless candidates are so instructed.
2. Candidates are not to communicate with other candidates or with any person except the invigilator.
3. No part of an answer book is to be torn out.
4. All answer books must be handed to the commissioner or to an invigilator before leaving the examination.

Any dishonesty will render the candidate liable to disqualification and to possible exclusion from the University

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Howard Q. Col.

Onverwacht: health services 1046 - 1049

11/6/82

Mr A GELDENHUYS asked the Minister of Health and Welfare:

What is the (a) nature and (b) extent of the health services provided at Onverwacht?

The MINISTER OF HEALTH AND WELFARE:

(a) A comprehensive health service is rendered in the area. Medical cover is provided

daily by two army medical practitioners;
three days per week by the part-time district surgeon, Thaba Nchu; and
when necessary by the part-time district surgeons, Bloemfontein,

and dental services are rendered daily by an army dentist.

Patients requiring hospitalization, are referred to Moroka Hospital and Pelonomi Hospital. All tuberculosis patients requiring hospitalization are referred to Allanridge Chest Hospital.

Primary health clinic services embody the following:

Healthy mother and child
Immunization against communicable diseases
Tuberculosis
Veneral diseases
Psychiatry
Geriatry
Dental Services
Pre- and antenatal care and confinements
Nutritional deficiency services
Health Education

Confinements were taken care of at the clinic during office hours. If a patient had not delivered by 15h30, she was transported by ambulance to Moroka Hospital. A 24-hour confinement service at the clinic is rendered from 1 June 1982.

These services are rendered by the following personnel:

2 Senior Sisters
11 Sisters
7 Staff nurses
2 SANTA educators

22

Family planning services are rendered at the clinic and from a mobile clinic by:

1 Senior Sister
4 Sisters
2 Nursing Assistants
5 Female educators
2 Male educators

14

Environmental health services are rendered by two health inspectors;

(b) the clinic facilities consist of one twelve bed ward; one maternity ward with two beds; two four bed wards; one two bed ward; two examination rooms; one treatment room; a dentist consulting room; one pharmacy; one waiting room; one admission room; one duty-room; two bathrooms; four toilets; kitchen; pantry; linen closet and medicine storeroom. Provision has been made in an iron building for psychiatric community services, family planning and the treatment of children suffering from malnutrition.

150-200 Patients on average per day receive curative services at the clinic of whom approximately 20 per week are referred to Moroka Hospital and five per week to Pelonomi Hospital. On 7 April 1982 136 patients and on 23 April 1982 76 patients were examined by the medical practitioners as part of the curative services. The attendance figure for primary health services clinics (excluding family planning) is approximately 4 250 per month. During March 1982 370 home visits were carried out by registered nurses.

The confinement figure was approximately ten per week and approximately 40 cases per month were referred to Moroka Hospital for confinements after hours.

The family planning clinic has approximately 835 clients per month.

A mobile x-ray unit was recently stationed for six weeks at Onverwacht. During that time approximately 2 400 x-rays were taken and 12 new cases of tuberculosis were located. 134 Patients receive at present out-patients treatment for tuberculosis at the clinic.

Malnutrition is combated by a nutrition scheme with P.V.M., enriched mealie meal, skimmed milk powder, soup and vegetables from the garden of the clinic. Education is performed by health personnel and with the assistance of a combi equipped with loud speakers.

A psychiatrist from Oranje Hospital renders services one day per week and psychiatric nursing services are rendered from Oranje Hospital at Onverwacht two days per week.

Dental services are daily available by an army dentist. The services of an army pharmacist has become available from 24 May 1982.

Four reservoirs receiving water from Rusfontein dam, have already been completed. A water-supply network has been constructed in the area and provision has been made for a water-tap for every five houses.

Each lot is provided with a toilet and a bucket and nightsoil is removed two times per week. During an investigation it was found that the capacity of buckets is exceeded on those premises where unlawful occupants are present. No pit-latrine is allowed and if it is located, care is taken that it is filled up.

Nyanga: health services

753. Mr. S. S. VAN DER MERWE asked the Minister of Health and Welfare:

(1) Whether there are any clinics in Nyanga; if so, how many;

(2) whether there are any (a) doctors, (b) nurses and (c) community health workers in Nyanga; if so, how many in each category?

The MINISTER OF HEALTH AND WELFARE:

(1) Yes; one Divisional Council clinic, three satellite clinics and also one day hospital which serves Nyanga and Guguletu;

(2) yes:

(a) a doctor of the Divisional Council attends clinics on a sessional basis and the day hospital has five full-time doctors;

(b) fourteen at the clinics and twenty-three at the day hospital;

(c) one social worker serving Langa, Guguletu, Nyanga and Cross Roads.

Guguletu: health services

755. Mr. S. S. VAN DER MERWE asked the Minister of Health and Welfare:

(1) Whether there are any clinics in Guguletu; if so, how many;

(2) whether there are any (a) doctors, (b) nurses and (c) community health workers in Guguletu; if so, how many in each category?

The MINISTER OF HEALTH AND WELFARE:

(1) Yes; one clinic and also one day hospital, which serves Guguletu and Nyanga;

(2) yes;

(a) municipal doctors attend the clinic for eleven sessioni per week and the day hospital has five full-time doctors;

(b) twenty-one nurses at the clinic and twenty-three nurses at the day hospital;

(c) one social worker serving Langa, Guguletu, Nyanga and Cross Roads.

Langa: health services

745. Mr. S. S VAN DER MERWE asked the Minister of Health and Welfare:

(1) Whether there are any clinics in Langa; if so, how many;

(2) whether there are any (a) doctors, (b) nurses and (c) community health workers in Langa; if so, how many in each category?

The MINISTER OF HEALTH AND WELFARE:

(1) Yes; one clinic and one day hospital;

(2) yes;

(a) there are three full-time doctors at the day hospital and a part-time doctor (eight sessions per week) at the clinic;

(b) twelve nurses at the day hospital and fifteen nurses at the clinic;

(c) one social worker serving Langa, Guguletu, Nyanga and Cross Roads

(340) (85) Hansard Q. Col. 1056 - 1057
(68) 11/6/82

Crossroads: health services

760. Mr. S. S. VAN DER MERWE asked the Minister of Health and Welfare:

(1) Whether there are any clinics in Crossroads; if so, how many;

(2) whether there are any (a) doctors, (b) nurses and (c) community health workers in Crossroads; if so, how many in each category?

The MINISTER OF HEALTH AND WELFARE:

(1) Yes; one;

(2) yes;

(a) Divisional Council doctors attend the clinic on a sessional basis twice per week;

(b) nine nurses from Nyanga clinic,

(c) one social worker serving Langa, Guguletu, Nyanga and Crossroads.

Squatter camp seen as health hazard

EAST LONDON — Conditions at a Ciskei squatter camp bordering on Arnoldton near here are believed to be unsatisfactory and a danger to health.

According to a Divisional Council of Kaffraria report, sanitation at the settlement, which consists of 60 "slum" properties and is occupied by 300 people, is "non-existent" and water is drawn from a "stagnant" pool.

The council resolved at its monthly meeting yesterday to report the matter to the regional director of State Health Services.

According to a report compiled by the council's health inspector, some of the structures at the camp are made of "wood from old motor car cases". Others are said to be wood and iron, or wattle and daub.

The report states: "Some blacks are getting water from white residents in the area. Most of the white residents, however, have disconnected their taps in the garden because blacks come on to their property at night to get water and thieving is rife in the area."

It continues: "It has been observed that the number of structures have increased and if left unchecked will eventually become a major health problem."

Giving reasons for the divisional council inspection of the squatter camp, Mr J. H. Turner, the health inspector who compiled the report, said he had not been aware at the time of the inspection that the camp fell within Ciskei territory.

"A detailed survey of the squatter camp therefore could not be undertaken," he added. — DDR

No to lower speed limit

EAST LONDON — The Kaffraria Divisional Council decided yesterday that it was not in favour of introducing an 80 km/h speed limit on the main road between East London and Macleantown.

The decision followed a recommendation from the provincial traffic department in King William's Town that the speed limit be reduced as it considered the road to be "very dangerous".

A letter from the department to the council stated that the road was "narrow and full of sharp curves" which had not been signposted. While few accidents had been reported during this year, the department said it was aware of many "single vehicle accidents which are just not reported".

The current 100 km/h speed limit, the department felt, contributed towards the "potential accident factor".

However, at its monthly meeting yesterday, the council decided that it could not support the department's recommendation. Drivers should adjust their speed to the condition of the road, the council said. — DDR

Para-medics for ambulances

EAST LONDON — Kaffraria Divisional Council ambulances will in future be manned by a team of para-medics.

The council decided at its monthly meeting yesterday to phase out non-driver ambulance assistants and to replace them with men who have both driver's licences and ambulance certificates.

Until now the senior member of each ambulance team has acted both as driver and paramedic. This has resulted in difficulties when handling emergencies.

The council also resolved to regard the ambulance units of King William's Town, Komga and Stutterheim in future as "satellites" of the East London base in order to facilitate relief services often required by these units. — DDR

Ecab health aid decision welcomed

14/7/82
D. Dispatch

EAST LONDON — The East Cape Administration Board's decision to pay towards health services in Duncan Village was warmly welcomed by the chairman of the city council's health portfolio, Mr Ivan Zulman, yesterday.

"I am absolutely delighted to hear it," Mr Zulman said.

Ecab decided on Monday to accept responsibility for the difference between the approved expenditure and the subsidy paid by the Department of Health and Welfare for Duncan Village health services.

Mr Zulman said the city council and Ecab had long been at loggerheads over the provision of health facilities in Duncan Village by the city council.

"We felt that it is not for East London ratepayers to look after an area supposed to be under the control of Ecab," Mr Zulman said.

The city council has been providing health facilities in Duncan Village without any financial contribution from Ecab who are responsible for the administration of the village.

Ecab decided on Monday to pay R186 571 for services between September 1, 1973 and December 31, 1979.

The resolution also called on Ecab to request from the city council a quarterly report on the activities of the city's Medical Officer of Health, Dr J. R. van Heerden. — DDR

Black health services need shot in arm — Azapo

85
Sowetan
20/7/82

THE recent spate of different communicable diseases on epidemic scales again highlights the lack of concern of the authorities to the basic needs of black people, says the Azanian People's Organisation (Azapo).

Issuing a statement following an outbreak of polio in the north-eastern Transvaal four months ago, Azapo said: "The irony is that in terms of mineral wealth, abundance of food and productive lands this country reigns among the richest, yet health services for 75 percent of the population compares with the poorest."

Obviously, to reserve the situation, basic needs of the people such as education, nutrition and housing should be attended to as a priority. The output of black doctors should be increased a hundred-fold.

Azapo called for the eradication of discrimination and neglect in black health services in the country.

"It goes without saying that the health services are inexplicably tied to the politics of this country," the statement said.

The statement said that this country stood alongside the First World countries regarding the advance in medical science and that the ratio of doctors to white people compared favourably with the ideal of one doctor to 600 people.

"But on the other hand, the ratio of doctors to black people is comparable to the most underdeveloped countries," said Azapo.

Need for people to care about community health

(85) Evening Post 21/2/85

Post Reporter

SOUTH AFRICA'S chief director of health promotion, Dr Howard Botha, today stressed the need for greater community involvement, self-help programmes and "people who care" in the sphere of health.

Addressing a group of representatives from various health organisations in Port Elizabeth and nearby districts, Dr Botha said the individual had a great responsibility towards both himself and the community.

South Africa's major health problems — cholera and coronary diseases — were closely related to the social, economic and general lifestyles of various communities.

Community involvement and greater self-awareness would lead to a decrease in ill-health and fewer people would be faced with the problem of expensive hospital costs.

Dr Botha said cholera was essentially an environmental problem and a plan to check cholera was being implemented. Cholera, though seldom deadly, struck at people of all ages and the symptoms were not always clear.

The cornerstones of any health care programme, he said, were community involvement, self-care and environmental care.

Dr Howard said the change taking place amongst elderly people was another important development in the community. The aged were beginning to take care of their own interests and were more self-reliant and confident.

Community involvement, he said, could save and enrich millions of lives.

...o the city to beautify Johannesburg
... interbreeding. Picture: GREG ENGLISH

...l rule, OK!

...n sands of pigeons hanging about, they haven't declared open season yet.

"A few years ago they discussed the possibility to putting the pigeons on the pill," one City Health doctor said. "They were going to spread birth control pellets around to try to cut down future pigeon population explosions."

Luckily for all these young birds strutting around our parks today, the idea was shelved because the birds' chemist bills would be exorbitant — the birth control drug costs too much.

Martin Botha, who lives in a downtown hotel, has issued a challenge to pigeon fanciers all over the country to release some of their charges and bring more natural beauty to the cities of South Africa.

"I want a new generation of city pigeon," he said.

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Pik queries US 'secret document'

Pretoria Bureau

THE SA ambassador in Washington has been told to find out from the US State Department if a document, claiming that South Africa conceals certain terrorist attacks, exists.

The Minister of Foreign Affairs, Mr Pik Botha, last night said Press reports indicated the State Department had such a "secret document".

"It will surprise me if the report is correct because it

It said the Queen had pressed an alarm bell by the ... after climbing a fence into the Palace grounds and first entering a room on the day after admitting an affair with a male prostitute. — UPI.

Medical aid scheme fees to rise 'substantially'

By GERALD REILLY
Pretoria Bureau

SOUTH Africa's financially stressed 200 medical aid schemes will have to increase members' subscriptions substantially before the end of the year, the president of the Representative Association of Medical Aid Schemes, Mr J Erntszen, said yesterday.

Some had already raised their fees to meet the alarming increases in the cost of treatment, he said.

This year alone private hospital fees had risen twice — by 15% on April 1 and again by 8.25% on June 1; provincial hospital fees had been increased; doctors' fees would go up by more than 6% from August 1; and from February 1 dentists' fees rose by 25% and physiotherapists' fees by 50%.

Dispensary fees had been increased by 32% and the costs of medicines and drugs were constantly rising.

And according to a spokesman for the South African Medical and Dental Council the council's tariffs' committee will meet in September to formulate new demands for another increase in doctors' fees.

Mr Erntszen said doctors were grossly over-remunerated for certain procedures, and the medical aid schemes were powerless to intervene.

The average member of medical aid schemes was unaware of the high costs of illness because he was financially shielded by the funds.

He stressed the funds should be freed from the burden of direct payments to doctors and for other medical and hospital services.

"Only when members are made to actually pay the acounts will they become aware of the high costs involved."

Mr Erntszen said that of the R600-million a year the funds spent in paying members' accounts, about R240-million went to doctors. The funds themselves should therefore set the maximum fees they were prepared to pay for medical services.

"It makes no economic sense that the organisations who pay the piper have no say in the level of charges which can be made by doctors and others rendering medical services," Mr Erntszen said.

THE Editor and Staff of the Rand Daily Mail wish all its Muslim readers a happy Eid.

HEALTH SPOKESMAN: Dr Abubaker Asvat.

Azapo demands equality in health

Sowetan 23/7/82

85

THE AZANIAN People's Organisation (Azapo) has called for the equal distribution of health facilities in South Africa.

By CHARLES MOGALE

Azapo's call comes shortly after its scathing attack on the Government for failing to do enough to curb the spread of communicable diseases among blacks.

The organisation's spokesman on health, Dr Abubaker Asvat, said health and politics were inextricably linked in the country.

"For the whites, everything is of the best and readily available. It is the contrary with blacks although this country ranks among the richest in terms of mineral wealth. Obviously, to reverse the situation, basic needs of the people such as education, nutrition and housing should be attended to as a priority, and the output of black doctors be increased a hundredfold," Dr Asvat said.

Until health facilities were made to be freely and easily available to all sections of the population, the problem of epidemic diseases would not be solved.

Responding to the Surf Challenge, Mrs. Mphulenyana said:

HEALTH CARE FM 23/7/82

A third area

(85)

A warning that SA will fall behind the rest of the world unless it changes its health policy has been issued by a veteran SA doctor who is an expert in the field of community health.

Sidney Kark, Professor Emeritus at the Hebrew University-Hadassah School of Public Health and Community Medicine in Jerusalem, says although there have been significant advances in clinical medicine and public health in the past century, these have grown to a point where they cost so much to implement that some other methods of health care have to be sought as well.

Kark, who was recently awarded an honorary doctorate for his work in the health field by Wits, advocates a system of community orientated primary health care (COPHC).

COPHC, as defined by him, is medicine practised outside the hospital and combines primary health care (the kind of medical care practised by GPs, nurse practitioners and public health nurses) with community medicine (which focuses on the health of populations or population groups rather than on individual patients).

According to him, it doesn't matter if the local community is a sophisticated First World one or an underprivileged Third World community. "The approach can be adapted to individual communities' health needs," he says.

"COPHC, which is a very neglected area of health care generally, is trying to wed them into the framework of primary health care. SA must adapt to COPHC if it is not going to fall behind the rest of the world. I really think it is going to be the key branch of development in the later years of this century and through the next century."

He denies that this will mean the death of clinical medicine and public health: "It won't displace them, but there is room for a third area of health care."

Kark, who worked on the first Bantu Nutrition Survey in SA, published in 1941, was formerly professor of Social and Family Medicine at the University of Natal and medical director of the Institute of Family and Community Health in Durban.

He says that in the Forties SA was on the road to setting up a system of community orientated medicine. However, when the National Party came to power in 1948, health policy changed. As a result, he left the country.

Reviewing present SA health policy and prospects for the future, Kark says politics, economics and medical schools have an important part to play in moving the country towards COPHC.

"Many people want to move towards this COPHC approach, but there is no outlet for them. The opportunities must be created through the universities to begin with, then through local authorities, government and the homeland governments."

He says he is encouraged, however, by the fact that chairs of community medicine and community paediatrics have now been established at some SA universities.

Where is SA's health education?

4/8/82 E. Post 85

Two more children died of polio last week as the epidemic continued to penetrate the North Eastern Transvaal. A Special Correspondent looks at the issues.

MODJAJI, the rain queen of the Lobedu people, was said some hundred years ago to have been responsible for the control of diseases in the North-Eastern Transvaal and their distribution to the rest of the province.

Then, as now, deadly, contagious diseases would sweep through the area devastating whole villages and sometimes moving down south to infect other communities.

The people offered tributes to Madjaji in an attempt to ward off her deadly diseases — and some developed an early form of vaccination as an added protection.

In 1982 similar epidemics — long eradicated in most Western countries — still plague the people of the North-Eastern Transvaal.

A polio epidemic broke out in Gazankulu, near Tzaneen, in May this year, killing 27 children. The epidemic has remained largely confined to parts of Lebowa and Gazankulu. Seven cases have been reported in Garankuwa near Pretoria and one case in Johannesburg.

Wards of Letaba and Shiluvane hospitals, former mission hospitals near Tzaneen now run by the Gazankulu authorities, are filled with children suffering from polio. At present there are 258 confirmed cases.

Typhoid, also supposedly a disease of the past, has recently broken out in Weskoppies, a mental hospital near Pretoria. Five people have died and a further 25 are being treated.

Why do these diseases keep recurring despite the sophisticated drugs now available to combat them?

Dr Marius Barnard, Progressive Federal Party spokesman on health, blames poor living conditions and inadequate health facilities.

A polio epidemic, which is totally preventable with vaccine, could only occur if the people were not immunised, he said. The only way to ensure people were immunised was for health authorities to provide constant immunisation drives and to educate people in health matters.

"One of the main reasons people are not immunised is, I believe, a lack of health services," he said. "There are not nearly enough health workers such as nurses, doctors, district surgeons, as well as clinics and hospitals in the rural areas."

Appropriate health education, sadly lacking in South Africa, was essential he said.

"I saw an anti-cholera poster in a black Port Elizabeth hospital which said 'Wash your hands before you eat'. Firstly, this ignores the fact that most of these people don't have anything to eat and secondly, that many of them can't read . . ."

Another problem was that South Africa's medical services were mainly of a curative, rather than a preventive nature and were city-based.

"We build monster hospitals in the cities, which are too far away to be of any use to many people and 95% of South Africa's doctors practise in urban areas," he said.

Call for boost to South Africa's basic health care facilities

ARGUS 18/8/82

THE president of the World Medical Association, Dr A G Martins of Portugal, today called for an improvement in basic health care facilities in South Africa, particularly in rural areas.

At a Press conference after a two-week fact-finding mission, Dr Martins said medical technology in the country was very advanced but a balance had to be struck between medical care in rural areas and medical care in the big cities.

TRADITIONS

He said he was very impressed with the "exceedingly good services" for blacks at Baragwanath Hospital but the Alexander Health Centre in Johannesburg lacked facilities and had a shortage of staff, especially doctors.

"South Africa has a combination of third world and first world traditions and one would have to change the attitudes of a big part of the population before the health problems could be solved," he said.

He said if the population explosion in the country continued, there would never be enough hospital beds and urged coloureds, blacks and Asians to apply family planning.

Dr Martins said he was against segregation but added that even if hospital beds for the various population groups were opened to all groups, there would still not be enough beds.

WORKING

He urged people of the "less-favoured" population groups to make an effort to better their position by "applying family planning, working hard and fighting for education".

"Everybody speaks of human rights but there is also something like human duties. People cannot expect that everything be done for them", he said.

Dr Martins, who met representatives of the Detainees' Parents' Support Commitee, said the two doctors who had seen Steve Biko, before his death in detention, had "behaved disgracefully" but the Medical Association of South Africa (Masa) could not be held responsible for it.

"Masa has changed its rules so that it can take a direct stand if that sort of thing should happen again", he said.

Atlantis houses 'health threat'

SENIOR officials of the Cape Divisional Council — including the senior health inspector, Mr J Mostert — made an on the spot investigation of several homes in Atlantis last week, which residents say are causing a health hazard.

The visit by the officials followed a call by the areas' management committee to the residents concerned to withhold payment of their housing instalments until the homes had been repaired.

A total of 66 homes had been listed by the committee for the attention of the officials, who were accompanied on the inspection tour by the project director for Atlantis, Mr Piet Burger, a representative for the areas chamber of commerce, Mr C.Alexander and Mr R Williams, a social worker from the major employer in the area.

DAMP

The homes are in a newer part of the area, which is particularly damp. The high water table is very evident in Cawdor Street, where water bubbles to the surface on the pavement and flows down the road.

A common problem being experienced by the residents due to the dampness and seemingly inadequate ventilation is mould on the ceilings and walls. In some cases the ceilings could clearly be seen to be rotting away.

AILMENTS

The deleghation was told by residents that the damp conditions were the likely cause of chest ailments.

In one case a couple and their child slept on matresses in the living room at night to avoid the "unhealthy conditions" in their bedroom.

Residents were particularly perturbed that they had to endure the conditions while paying up to R144 a month for the homes.

While welcoming the move by the Divisional Council, residents are known to be concerned that the cost of repairing their dwellings would be added to the purchase prices.

Poor health service SA's fault — Bikitsha

UMTATA — The Minister of Health, Dr Charles Bikitsha, agreed yesterday that the country's health services had deteriorated since independence and blamed this on South Africa.

Reacting to a Sunday newspaper report that Transkaians were invading hospitals in the northern border towns of Kokstad and Matatiele, Dr Bikitsha said: "They are only going where they are supposed to be going That land belongs to us and we are not a police state to tell people which medical services they should use."

"Britain has a national health service but if you want to go to a private practitioner, you are welcome to do so."

Dr Bikitsha laughed at a section of the report which said Matatiele's Taylor Bequest hospital drew 98 per cent of its patients from Transkei.

"And so it should be because that hospital belongs to us. What are they talking about. That hospital is in Transkei."

Dr Bikitsha rejected an allegation by a part-time doctor in Kokstad that white doctors had been told at independence that their services were no longer wanted.

"That's a load of rubbish. You show me a developing country that will chase doctors away.

On a claim by a doctor in private practice in Kokstad that Transkeians were happy to pay cash for his treatment although they had free services in Transki, the minister asked: "Is he complaining?

"I should think he is laughing all the way to the bank. Our people spend a lot of money in South Africa and nobody normally complains."

Reacting to an allegation that Transkei's health services had deteriorated, Dr Bikitsha said: "You know I rather like that article. The more of it we get the better it may be for us because it may open people's eyes to the poor state of health services we inherited from South Africa.

"We have tried to make do with the appalling services we took over after South Africa's more than 150 years in our country. That report is really an indictment on South Africa.

"All we have been trying to do is keep poor services running. If you run an old crock you cannot expect 100 per cent service from it."

He said that if South Africa had played the game in fulfilling its promises, things would not have deteriorated to such a state.

"The blame is entirely theirs." — DDR.

Filling a gap in S African medicine

Science this week

Bill Faill

PATTERNS of illness in blacks differ widely from those in whites, yet the great majority of health workers in this country, including almost all doctors, have been educated in ways that reflect the spectrum of diseases affecting North America, Britain and other parts of Europe.

Most of the textbooks and medical journals consulted are published abroad and the only existing medical books written by black Africans relate to areas such as Nigeria, where the pattern of disease is quite different.

There is therefore a crying need for a source of information for South African medical workers who do not belong to the black group but who at some time will have to deal with the health of blacks.

This need is even more marked for doctors and other health workers who come from the developed countries to assist in medical care in the Republic.

Need met

This need for information has now been met by a book, *Clinical Medicine and Health in Developing Africa*, edited by Dr G D Campbell — recently of Durban but now living in the Cape — Professor Y K Seedat of the University of Natal, and Dr Guy Daynes. It is published by David Philip of Cape Town.

'The multiracial team of contributors all write from experience, and we believe that they have put together a compendium of information unobtainable elsewhere,' comments the *South African Medical Journal*.

In this most comprehensive book 'the authors advise on diagnosis and management, and cover not only the various branches of medicine, surgery and psychiatry but also the administrative details that inevitably accompany any system of health care.

'The editors, who have provided us with a really worthwhile index, have been well served by their collaborators and by the publisher, who has wisely chosen to keep the price down by issuing the book as a paperback.'

A grant from Anglo American has also helped to bring the book within reach of all.

The book certainly sounds as though it would be very useful to all health workers and, in fact, to anyone — such as a farmer or factory manager — who is responsible for large numbers of blacks.

SA's medical-legal issues

Pretoria Bureau

THE Biko case and its aftermath brought to the fore a number of serious deficiencies in SA law, Professor S A Strauss of the University of South Africa said in Johannesburg last night.

Addressing a College of Medicine of SA admission ceremony, Prof Strauss said there were a number of unsettled medical-legal issues which affected less fortunate groups in society.

Among these groups were detainees and prisoners.

"The challenge to us in this country to strive towards a satisfactory system of medical care for detainees, in which ethical principles can be meaningfully realised in practice, is perhaps one of the biggest of our time," he said.

Prof Struass said the joint efforts of doctors and lawyers could achieve much in making SA society better, healthier and happier.

He said a patient's Bill of Rights had recently been widely propagated in Western countries. In part this seemed to have been inspired by a fear of "medical power" and was also a corollary of human rights movements.

Especially in the atmosphere which often characterised modern hospitals, there seemed to be widespread apprehension that the rights of the individual might become of secondary importance.

However, in 1967 Prof Strauss and a colleague had made a rough count of statutory sections directly affecting the medical profession. They had added up to 600, and had probably doubled by now, he said.

Some diseases can be prevented with modern medicines. Here, schoolkids queue for their immunisations against smallpox.

Immunisation is better than cure

Sowetan 27/10/82

IT IS a general belief that prevention is better than cure. And with a strictly supervised immunisation schedule, your child will be protected against diseases.

To safeguard the health of every child, the City Health Department has extended its services to schools and creches.

While the services at schools save working parents the trouble of taking their children to clinics, many teachers claim parents lack co-operation.

"Many parents do not submit their children's record cards when required. This is more of a problem because we have to group the children accordingly, and we often cannot interrupt classes — taking odd numbers to the clinic now and again," said one primary school teacher.

She said it was also vital that every parent or guardian followed and understood the importance of vaccines. The latter is a preparation made from germs that cause a particular disease, used to give the child's body resistance against that disease.

The vaccination could either be injected, taken by mouth, or through a scratch in the skin.

Although there are various diseases the child may be susceptible to, the Health Department has outlined the most common, and scheduled their vaccination from as early as when the baby is a month old.

The first to be given is the BCG vaccine against

By SINNAH KUNENE

tubercolosis.

At three months, the baby receives poliomyelitis, (this vaccine is also given to anyone who has been in contact with the diseases). Polio vaccine is compulsory by law and all children should be given it before they are six months old.

DPT (diphtheria, pertussis and tetanus vaccine) which is a combination of the three is given at three months. It is continued on a bi-monthly routine.

At about five months, the baby is given it's second polio and DPT and the same is provided on the sixth month. The measles vaccine is given as from seven months old or so, MMR (combined measles, mumps and rubella) is given at 15 months.

From 18 months, children are given boosters (an antibiotic dose on the above diseases) starting with the polio and DPT dose. At five years it is DT booster dose (and polio dose if not given at 18 months). Teenagers are given the DT booster dose.

N.B. Although it is not recommendable to give vaccination to feverish or rather ill children, parents should try to speed up their recovery by consulting a doctor or clinic, so that the children should not miss their vaccine for too long.

Also, parents should be aware that children react differently to the vaccines, and this should not discourage them. Instead they should seek advice from their clinic. The immunisation services are free.

Beware of your food — it may contain pesticide

Weekend Post 30/10/82

By SIMON BLOCH

HOW safe is it to sit down and enjoy a hearty meal in South Africa?

Recently the Minister of Agriculture, Mr Greyling Wentzel, said South Africa was one of the few countries where the incidence of pesticide residues in food was on the increase and a cause for concern.

Senior civil servants later excised his report from copies of Agricultural News distributed to the Press and public — but not from copies sent to farmers.

Doctors worldwide have warned repeatedly that high levels of pesticide can be carcinogenic (leading to cancer growth).

A certain level of pesticide residue is permitted in food.

It varies with the pesticide, but the levels found in South Africa are frequently twice as high as in other countries, Weekend Post learnt.

According to an official for the Department of Health, Welfare and Pensions in Pretoria, there have been instances where the levels of poisonous pesticides or fungicides on foodstuffs have been discovered to exceed the legal limits. But the facts and details were not available, he said.

Weekend Post tried this week to find out why the levels are so high and how strictly they are being monitored — and, more important, what risk they present to health.

What became clear straight away was that Government departments are now doubling their efforts to impress on farmers the need to confine crop spraying to safe levels.

Checks have been stepped up.

During the inquiries, a Port Elizabeth man who spent time working on a farm in the Robertson district, said the farmer sent his tomato crop to market only two days after spraying it with an insecticide called Metasystox.

He alleged the farmer knew this was not permitted but sent it because he stood to lose out if the crop was held back any longer.

According to a handbook, *The Guide to the Use of Pesticides and Insecticides*, crops sprayed with Metasystox must not be harvested for 21 days after spraying.

It is impossible to tell how many incidents of this kind occur and are not picked up in random official checks.

Although South Africa has strict legislation to prevent chemically-contaminated food reaching the consumer, there are hundreds of different chemical powders and sprays available to counter pests.

United Dairies carry out regular checks on milk samples from suppliers. Their tests are regarded as among the most stringent in the country. If milk is found to contain antibiotics the supplier is penalised.

But by this time any contaminated milk between checks will have been mixed with other milk in bulk carriers and passed on to the consumers.

The same flaw is found in the system of market checks carried out by State Health inspectors.

Apples, for example, taken for sampling from the Markman produce market in Port Elizabeth will not be found to be contaminated until an analysis is made in Cape Town or Durban. By this time the rest of the consignment will have been eaten.

Southern Africa is known to be an area with a high incidence of crop-destroying pests and insects carrying animal diseases.

There are general levels laid down by the World Health Organisation for levels of pesticides in foodstuffs. If these are exceeded, the foodstuffs will be banned.

But does the high incidence of pests compel farmers to over-spray to secure his crops?

According to a senior scientist at the University of Port Elizabeth, Dr John Watling, the incidence of ticks, mites, fleas and animal parasites per unit cow in the Southern Hemisphere is higher than in the Northern Hemisphere.

He said he thought it possible that more pesticides would be used in the Southern Hemisphere, but he said he had no figures to prove this.

The Department of Agriculture, in conjunction with the Department of Health, Welfare and Pensions and other authorities, have an on-going educational programme designed to eliminate the excessive use of chemicals by food producers.

Officials regularly select fruit and vegetable and milk samples from markets, cafes and supermarkets to send to laboratories for analysis.

They have denied repeatedly there is any cause for alarm.

At the University of Port Elizabeth, a team of three Government certificated analysts led by Dr Watling are regularly monitoring samples from Natal, parts of the Free State, the Eastern and Western Cape.

At this stage, samples are being taken from farms and bulk milk tankers.

But results and conclusions cannot be made available to the Press.

"There is a general comment from an international health agency that there is not a single mammal on this planet that does not have a body burden of the breakdown products of DDT, namely DDE," Dr Watling said.

DDT was a pesticide commonly used until the early 1970s, initially for the control of malaria.

Its use is now restricted, but it is not banned and neighbouring states are known to still use it.

Large areas of the world were sprayed with DDT and its breakdown products have since entered the environment and mammalian life-cycle.

Another chemical which was banned recently is Dieldrin, which is also known to remain in the ecosystem for ever.

"Any pesticides and herbicides that have chlorine in the molecule tend to get world-wide distribution via the air and air currents," Dr Watling said.

"Any level of pesticide in food is a cause for concern anywhere — that's why they're monitored."

"We have to ensure that they are still at sufficiently low levels to be harmless to man. Obviously because they are there is a cause for concern.

"What we are looking for is whether pesticides are being taken on in the food chain," Dr Watling said.

"From the levels in our food at the moment, it would appear that this was not the case to any great extent, although there are low levels of pesticides in foodstuffs.

"There have to be pesticides in foodstuffs all over the world. But the levels are low.

"Low concentrations can be toxic, but the normal levels one would find range from one part in 100 to 100 000 million parts of foodstuff, but detectable by sophisticated instrumentation," Dr Watling said.

His team is using two techniques in their search for contaminants — one is gastromatography where the sample is prepared and other contaminants like fat, protein and carbohydrate, with the exception of specific organo-molecules, is removed because they interfere with the analyses.

The other technique is mass spectrometry which is used to confirm or determine an unknown compound.

"From the results obtained from samples of milk, meat and dairy products, from Natal part of the Free State, the Western and Eastern Cape, the conclusion that the incidence of residues is on the increase does not seem to be justified.

"However, other groups in the country which are working similar projects may have reached different conclusions," Dr Watling said.

The only real conclusion Weekend Post was able to draw from its inquiries was that under the present system the ultimate responsibility rests with the first man in the chain of distribution — the farmer.

If he fails to adhere to the levels laid down, the chances are his produce will be sold and eaten just the same.

Random checks will only uncover a fraction of the transgressions and even when contaminated food is detected only the samples will have been withdrawn.

The rest of the batch will have been sold beyond trace.

New medical book for SA doctors

By TICKS CHETTY

A NEW book dealing with the treatment of the sick in developing Africa is expected to be a valuable aid to doctors.

The book — "Clinical Medicine and Health in Developing Africa" — is relevant to peculiarly South African medical requirements.

A review in the South African Medical Journal says one of the problems facing medical students in South Africa is that too much of their learning is based on the European model — while most of their clinical practice follows an African model.

Diseases

"The vast majority of our students are exposed to a broad spectrum of disease in the races that go to make up South Africa, but the textbooks and journals they consult reflect the pattern of diseases seen in North America, Britain, Holland and Germany," says the review.

The book is edited by Dr G D Campbell — formerly of Durban and now living in the Cape — Professor Y K Seedat, of the University of Natal, and Dr G Daynes of Transkei.

Mr S S B Gilder, editor of the SA Medical Journal, says in a foreword: "The overseas doctor who comes to work in developing Africa, as well as the resident medical worker, will find this book unique and essential."

Birth control jab in a storm

THE contraceptive drug injection, Depo-Provera, was at the centre of a hearing in London last week. The manufacturers of the drug, Upjohn Limited, appealed in public against the decision of the British Minister of Health, Mr Kenneth Clarke, to refuse a long-term licence for the drug.

The hearing has been adjourned but will continue in April 1983, by which time the panel of experts hearing the appeal will have investigated allegations that women in Britain are being given injections of the contraceptive without knowing precisely what it is, how long it lasts and what its possible side-effects could be.

Depo-Provera has been available in Britain since 1974, but has been licensed for short-term use only. It is approved for women whose partners have had a vasectomy (until there is a negative sperm count) and for women immunised against German measles, while the virus is active.

In practice, however, the contraceptive injection is being more widely used and there are fears that some doctors are using it on a long-term basis without informing their patients as to the ramifications of the drug.

Feminist pressure groups, including a group formed four years ago specifically to fight the long-term use of Depo-Provera, have assembled additional evidence from hundreds of women complaining about the side-effects of the drug which, they feel, should prevent it from being used on a long-term basis not only in Britain and the United States, but in developing countries as well.

The aims of Ban the Jab Pressure Group (BJPG) are threefold: to get the drug entirely banned from use all over the world; "to expose the way in which Depo-Provera has been developed, experimented with and used on women, often without their prior knowledge or consent; and to obtain free, safe and reliable contraception on demand for women".

At the core of the concern about the use of Depo-Provera is safety. According to evidence assembled by the Campaign Against Depo-Provera, there are fears that breast tumours, cervical cancer and endometrial cancer (lining of the womb) could be caused by the long-term use of the drug.

They point out that the drug has not been monitored over a long period and that it would be extremely difficult for authorities to do so.

"We believe that deaths may have occurred after medical supervision has ceased and the woman has not had an injection for months or even years, so that people do not link the death with the drug. Diseases of the endometrium do not usually occur until after the menopause," the campaign states in its report.

There is also concern at what effect Depo-Provera can have on the foetus, assuming the women is given an injection without knowing that she is pregnant, or that the after-effects of an injection given as long as 18 months previously could still be in her system, or that she is a lactating mother renewing her injections.

The side-effects of the Depo-Provera contraceptive injection are: menstrual disruption (irregular and prolonged vaginal bleeding, or no bleeding at all), headaches, marked increases in weight, nausea, dizziness and depression.

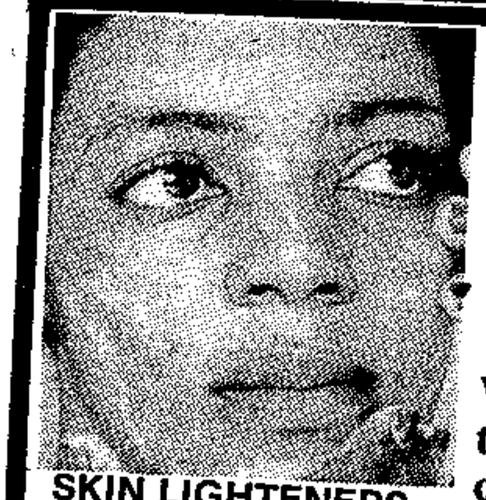
Upjohn Limited's argument (supported by the World Health Organisation, the International Planned Parenthood Federation and the Family Planning Association) is that the benefits of using Depo-Provera may well outweigh possible risks.

The company states that there is a real need for their contraceptive injection (it is as efficient as the Pill) and that it fills a gap left by existing choices and specifically states that the drug offers a significant benefit over other contraceptive methods for women "for whom other contraceptives are otherwise unsatisfactory, eg, because they may forget to take the Pill".

Depo-Provera's active ingredient is medroxyprogesterone acetate. Its progestational activity, combined with a very slow rate of dissolution, allows a single injection to prevent ovulation for at least three months and to delay fertility by almost 18.

It was first introduced in 1967 as a long-term contraceptive and is now licensed in more than 77 countries (including South Africa), involving the equivalent of 11-million women years.

Jennifer Crwys-Williams



SKIN LIGHTENERS

Dr Joshua may be sued by cream firm

WELL-KNOWN anti skin-lightening cream activist, Dr Jose Joshua, is being sued for breach of contract by a company marketing a popular brand of cream.

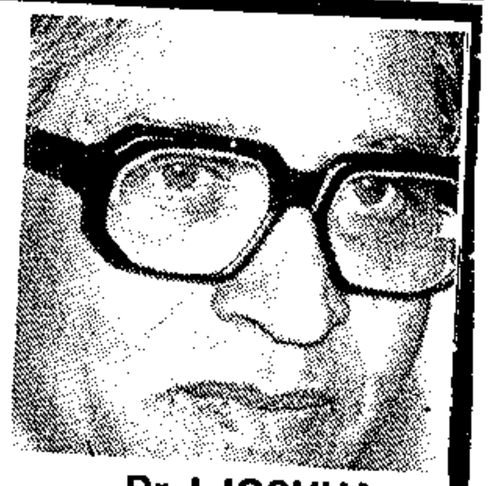
By ELLIOT TSHINGWALA

The doctor, who is president of the National Association for the Advancement of Coloured People in Southern Africa (NAACPSA), has consulted his attorney and is ready to defend the action.

Dr Joshua said a summons was served on him at the beginning of the week and he was given 10 days to decide whether he wanted to defend the case.

An organisation has recently been formed under the chairmanship of Dr Joshua to fight the use of skin lighteners. He publicly exposed the dangers of hydroquinine — an active agent in the creams.

A spokesman for Beauty Box, the company that served the summons, confirmed they were preparing to do legal battle with Dr Joshua. He, however, denied that the action was breach of promise. He said they wanted Dr Joshua to settle a debt with them.



Dr J JOSHUA

Agents unpaid for three months

INSURANCE agents at a company in Johannesburg have threatened to walk out of their jobs because they claim they have not been paid for three months.

Three of the agents, who claim to be part of a disgruntled group of 50, said they had been with the company for [illegible] the company. They were paid a commission depending on the amount of clients they recruited. He said he was not aware that they had problems concerning money, but they were always free to discuss these with him.

Health system facing breakdown — Barnard

(85)

D. Dispatch 20/1/82

EAST LONDON — The country's health system faced total breakdown if not urgently revised, Dr Marius Barnard, opposition spokesman on health, said yesterday.

Dr Barnard said it was now essential that primary health services be provided throughout southern Africa.

"We must get health services to the people," he said.

"From what I have seen, there is already a total breakdown of health services in the rural areas."

Dr Barnard said South Africa was bluffing itself with its world-renowned standard of sophisticated medical services.

"We have got a very high standard — but it is limited to a very small section of the population.

"We are training our doctors to practise in the United States of America."

Dr Barnard said that South Africa's population was exploding, and that during the next 18 years it would increase to about 60 million people.

He said second to defence, health was the government's biggest budgetary allocation.

"Over R1 000 million is being spent on health services this year. By the turn of the century, it will have to increase eight times that amount.

"Where are we going to get the money and people?

"I don't think there is an adequate realisation of the problem facing us. I don't think the problem is being faced firmly and squarely."

While he welcomed government revision of nursing salaries and working conditions, Dr Barnard said urgent attention needed to be given to the position of social workers and therapists.

"In South Africa, primary health services must be the future of medicine and here social workers and therapists play a vital role in getting health to the people.

"At present the accent on health has been on very competent diagnostic and treatment medicine. What we have to do is change our attitude to high quality community health and preventive medicine."

He said it would also be necessary to improve socio-economic conditions.

"Tuberculosis and cholera all but disappeared completely in Europe and the United States long before the arrival of modern treatment because of better socio-economic conditions.

"In South Africa, in spite of modern drugs, tuberculosis is still a major problem because socio-economic conditions have remained the same."

Dr Barnard said he would like to see new constitutional guidelines drawn up for health — unifying Southern Africa under one health service instead of fragmenting health services.

"We must also encourage the medical profession to go into the bush areas.

"Industrialists have incentives, but there are no incentives for medical people to get out into the country, and the days of missionary doctors are over." — DDR

DR BARNARD

Poisoned children

A MAJOR new probe has shown that a significant number of schoolchildren living near the centre of Cape Town have lead levels above the safety limit, and this could be adversely affecting their intelligence and causing behavioural and metabolic problems.

By LINDA VERGNANI

The startling findings are to be investigated by the Municipal Department of Health, Dr Reg Coogan, the city's Medical Officer of Health, said this week.

Miss Yasmin von Schirnding of the UCT School of Environental Studies, who carried out the survey for her master's thesis, found that 17 percent of the pupils at one Woodstock school had blood lead levels above the safety limit of 29 micrograms a decilitre.

She believes the main cause of the high lead levels may be exhaust fumes.

An international authority on the effect of lead on children, Dr Michael Moore — currently a visiting lecturer at the UCT Medical School — has warned that the findings could well indicate that there were going to be serious long-term consequences for Cape Town children from exposure to lead.

He said some of the neurological damage done to the children by high lead levels was irreparable, but for the sake of future generations "we must try to get lead out of the atmosphere through legislation or through voluntary action."

Dr Moore, who is a senior lecturer in medicine at the University of Glasgow, said: "If in a community the average intelligence drops from 100 to 95 then the ability of the people to learn, to organise, to do things for that community is vastly diminished.

"It obviously matters greatly in a large group of people and the economics of it are really stupendously significant."

The study involved more than 1 200 Cape Town schoolchildren and is the most comprehensive South African study on the effects of lead pollution.

An initial screening of 1 234 children at 19 Peninsula schools indicated that twice as many pupils in urban industrial areas had absorbed high levels of lead into their systems as pupils in outlying suburban areas.

Most of the pupils considered to be at risk came from two schools in Woodstock and Central Cape Town, but there were also individual cases of high lead absorbtion in pupils from areas like Retreat, Maitland and Athlone.

Further tests showed that at the Woodstock school, 17 percent of the Sub A pupils had blood lead levels above the acceptable limit. The average levels of pupils at this school were twice as high as those of a group of Hout Bay children. The highest level at the Woodstock school was 40 micrograms where 29 is the limit above which children are in danger of developing clinical signs of lead poisoning.

Says researcher Von Schirnding: "It is a very controversial topic but there is a lot of evidence to show that relatively low blood lead levels in children, which were previously thought of as safe, can have adverse effects on behaviour and intelligence. Any lead absorbed by humans is potentially toxic and the developing brain of a child is particularly vulnerable.

"A number of studies have shown that children with lead levels over 29 micrograms are hyperactive, easily distracted, unable to concentrate or follow simple directions and have lower IQ scores than children with low blood lead levels.

Some researchers believe adverse health effects occur at even lower levels and the current safety limit should be revised."

She believes petrol fumes may be the main culprit.

She investigated the homes of all the children with increased blood lead levels and eliminated most other possible sources of lead pollution like lead piping or flaking, lead-based paint.

Nevertheless she found "unacceptably high concentrations of lead in some paint samples" which could have been hazardous to infants and toddlers who might have chewed painted surfaces.

She found most of the children with dangerously high blood lead levels attended schools on busy roads where there was a high traffic density. She also found "significant levels of lead" in dust and soil samples at the children's homes which she believed were probably due to pollution from lead fumes from petrol.

Among her recommendations are:

● That legislation limiting lead in petrol be introduced. South Africa has a standard ,836 grams of lead per litre in petrol which is many times higher than the permissible level for lead in other countries.

"Russia banned lead in petrol in 1959. In West Germany the limit is ,15 grams of lead per litre. In America and Japan lead-free petrol is available.

"In my view it is totally unacceptable to have such high lead levels in petrol."

● That the present air pollution monitoring programme in Cape Town be expanded and that a detailed inventory of all sources of industrial exposure be taken.

"Cape Town has the highest atmospheric lead levels in the country. The three-monthly safety level for atmospheric lead is an average of 1,5 micrograms of lead a cubic metre of air. Yet in 1981 the three- monthly average in Cape Town went well above 5,5 micrograms a cubic metre.

"At particular times of the day lead levels near busy streets have been found to go up to 20 or 30 micrograms a cubic metre. The times when these levels peak is exactly when the children walk to school."

● That legislation be introduced limiting the lead content of certain paints used on surfaces likely to be chewed by children.

"In America lead in paint is limited to trace amounts of ,06 percent. In Britain all paints with lead levels higher than one percent have to have warning lables. Yet South Africa has no standards for lead in paint. Even the lead content of paint used in toys and cots is not controlled.

"Cheaper low grade paints may have lead pigments containing up to 25 percent lead. I have confidential information that in its housing schemes the City Council still uses a legal paint primer called red lead which contains a pigment with about 60 percent lead."

● That schools and creches should not be sited on roads with heavy traffic flows or next to garages, because of the health hazard.

● That a continuous screening programme be initiated to monitor the lead levels in children who may be particularly at risk.

● That a major educational programme be started to make the people of Cape Town and the authorities aware of the hazards and sources of lead exposure in Cape Town.

nate discrimination on the grounds of sex. PAT SCHWARTZ reports.

groceries, toiletries and confectionaries — these shops represent 42,4 percent of the trade country-wide.

Mr Mike Wright, Chairman of the Association of Employers (Assemp), which represents the retail [illegible]

wage gap. We're into a situation where sales generally are dropping. It's not a good time but it's the law and we must do it."

The move, said Mr Wright, was not unexpected. "We knew it was coming. The wage board

than usual, it could be that she knows that at the end of the week or the month her pay packet will be substantially plumper.

November 15 is the day when thousands of women in the commercial and distributive trade will benefit from new wage determinations which eliminate discrimination on the grounds of sex and im-

ation hands and chauffeurs, clerks and managers and include the all-important sales personnel, cashiers and till packers.

The move, coming at a recessionary time, has caused a certain amount of concern among employers — some of the increases are as high as 49 percent — but several major retailers said the increases would make

week, increas- t R20 a week f the senior

ernon Staege- ups Personnel of the Check- the increases

economic situation, but added that "one appreciates that inflation and the cost of food and rents are hitting the pockets of our workers, so it's totally necessary from that point of view."

personnel director Mr Rene de Wet were caught on the wrong foot by the gazetting on October 29 of the new determination. They had, they said, been told it was not due for some weeks.

and R5 a week ing to about R in some of the categories.

To Mr Vern mann, Groups Executive of the ers group, the

The only area in which the OK was slightly under the new minimum, he said, was in the case of sales assistants in the more qualified grades — third, fourth and fifth years of experience. But that affected only a small percentage

HEALTH AND DISEASE — GENERAL

1983 — 1984 — DEC

Oraflex . . . a possible side effect was death

Investigation by PAT SIDLEY

THE "wonder" drug for arthritis, Opren, which was reportedly marketed in Britain after it was proved the drug could kill, was available and being equally aggressivly marketed in South Africa at the same time.

Information about the drug's serious side effects was reportedly made available to Eli Lilly by its own doctors from early in the drug's marketing history, but did not reach drug control authorities in South Africa — or in the UK and United States — where the drug was also available.

The drug, known as Oraflex in SA, and was marketed by the subsidiary of the multi-national drug company Eli Lilly, which developed and marketed the drug in the UK and US.

The startling claims that information available was not acted upon, were made by BBC television's Panorama current affairs programme, by London's Sunday Times and The New Scientist in the wake of intensive media investigations on three continents, following the deaths of 96 elderly people in England who used the drug.

They have claimed that Eli Lilly doctors at a Paris conference on the drug in June 1981 (at which South African doctors spoke) warned of risks to the elderly which could lead to liver and kidney complaints which could kill.

This information, it is claimed, was not acted on for almost a year.

Investigations in South Africa have shown that:

- The drug was launched in South Africa in October 1981 after scientific data researched in the UK was presented to the Medicines Control Council, which registered the drug on the available information.
- This was some three months after the Paris conference.
- Eli Lilly told the SA Medicines Control Council (which regulates the availability of drugs in South Africa) about possible side effects in May 1982 — some months after deaths associated with the drug were first reported in Belfast, Ireland.
- A warning to reduce the dose in the elderly was then included in the package insert in Oraflex.
- In the initial months of the drug's availability in SA, the Medicines Control Council (MCC) objected to claims implying the drug could cure the disease.
- Eli Lilly had to change its advertising and disclaim editorial matter with this information.
- Editorial in the South African Medical Journal gave the impression that the drug was beneficial — but doctors have said the tests were inadequate.
- Other side effects — such as photo-sensitivity (sun-sensitivity) and oncholytis (which affects the nails) — were presented to the MCC and included in the information on the package insert.

But doctors were given additional warnings about those side effects to pass on to patients.

- Initial research leading to claims on the extent of the sun-sensitivity (in whites) was done in England, not in sunny South Africa.
- The drug was launched in a fanfare of publicity which many doctors and medical officials found offensive and largely unethical.
- The publicity proclaiming a "brand new way" of approaching the disease — which was aimed at the "lay media" — lead to countless arthritis sufferers, believing a "miracle cure" was available, demanding the new drug from their doctors and thus creating a market.
- Shortly after the warning to reduce the dose — which Lilly agreed to in the UK as well — the drug was suspended in the UK and then withdrawn worldwide by Eli Lilly. At least 96 users had died by then.
- Clinical tests in South Africa, sponsored by Eli Lilly, concentrated on reducing side effects, while the drug was on the market, pointing to the probability that Eli Lilly was concerned about the side effects.
- Information released by the public relations company hired by Eli Lilly to punt the drug to the lay and medical media in South Africa contained little mention of side effects and no mention of the liver and kidney side effects which could kill.
- Eli Lilly have claimed that in South Africa there was no reported evidence of "serious side effects".
- A South African dermatologist working with the drug, not sponsored by Eli Lilly, wrote up the painful photo-sensitivity side effects in a British medical journal.
- South African research scientists and doctors, sponsored by Eli Lilly, wrote to the South African Medical Journal after the drug was withdrawn to explain their scientifically substantiated belief that the drug was a worthwhile development.

Many doctors interviewed by the Rand Daily Mail claimed the drug was beneficial, and said it seemed to do more than most alternative drugs to alleviate (but not cure) the symptoms of arthritis.

The doctors in South Africa, who conducted scientific research for Eli Lilly, were coming up with evidence that the side effects could be controlled — until the drug was withdrawn.

But, official medical objections were raised about the claims in the advertising of the drug, as well as in editorial matter in the SA Medical Journal and in the lay press.

MCC chairman Professor Peter Folb wrote the following to the SA Medical Journal on November 14, 1981:

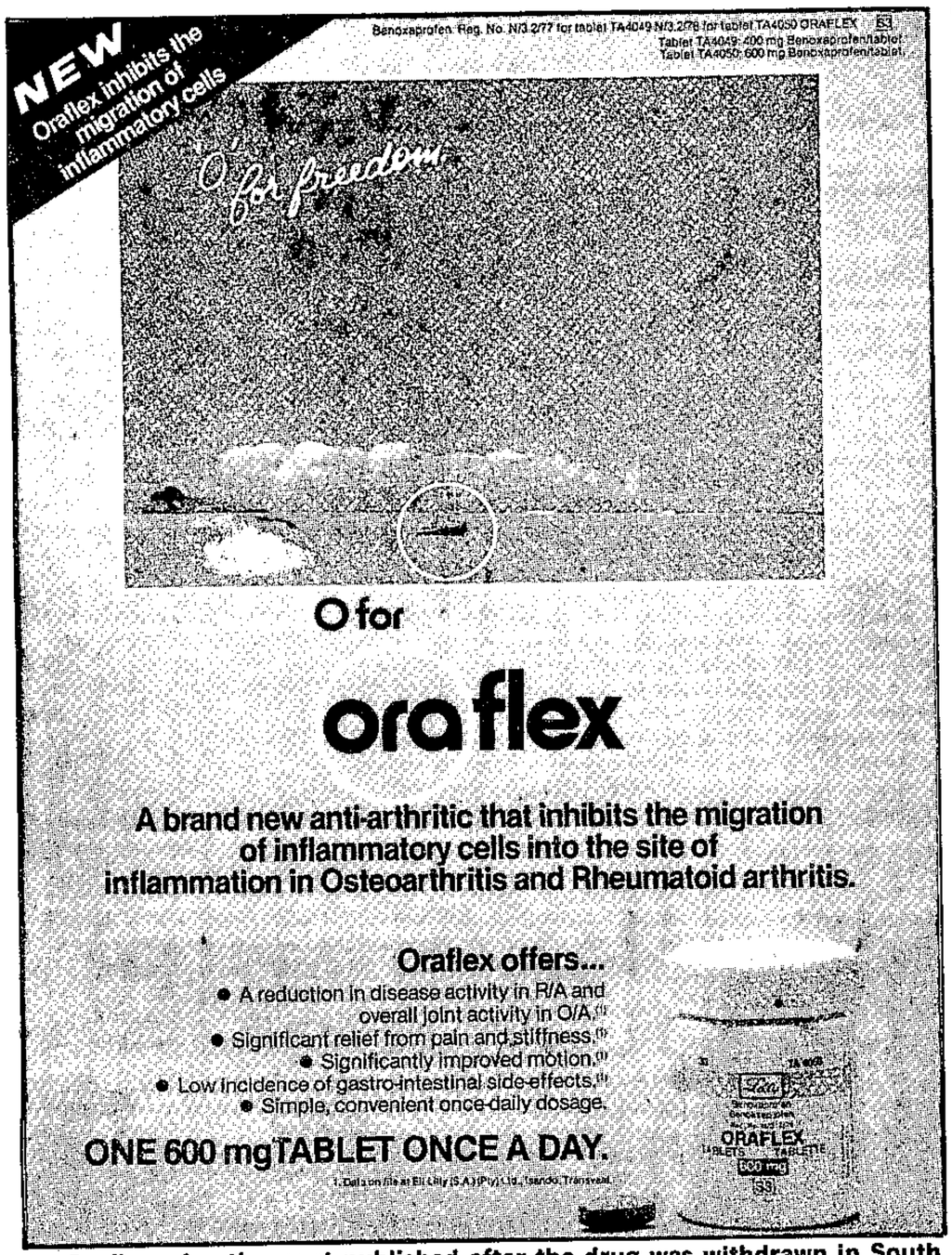
"The SAMJ of 3 October 1981 carried a 5-page advertisement for benoxaprofen (Oraflex), in which the claims were made that this new medicine offers 'a broad new way of working', providing more than pain relief in osteo-arthritis and rheumatoid arthritis, and thus it 'sets a new standard in gastric tolerance'.

"In advertising the medicine as such the drug company concerned has contravened the terms under which permission to register benoxaprofen was granted by the South African Medicines Control Council.

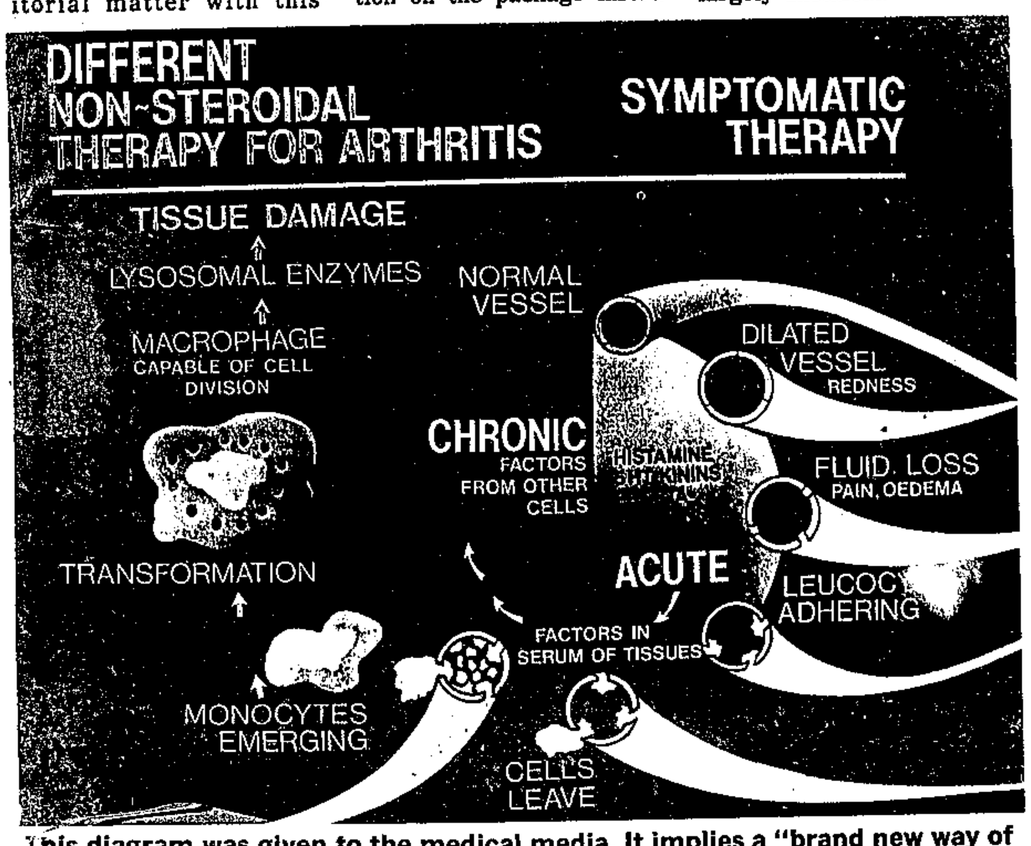
"Misleading advertising of this kind not only puts competitors of equal standing at an unfair disadvantage but, most importantly, puts patients at unnecessary risk. I am afraid that by the same token the 'News and Comment' article which appeared on page 529 of the same issue was a little incautious."

Eli Lilly SA wrote to doctors drawing "the attention of those concerned to the fact that some press reporting regarding benoxaprofen was inaccurate and potentially misleading and fell outside of the information approved by the Medicines Control Council."

"Evidence that benoxaprofen has curative and remittive actions has not been substantiated. Furthermore, it was noted that no claims were made regarding the relative safety of benoxaprofen and other agents with similar actions."



An Oraflex advertisement published after the drug was withdrawn in South Africa — but without earlier claims implying a cure.



This diagram was given to the medical media. It implies a "brand new way of working", as advertisments put it.

The extra warning which South African doctors passed on to patients using Oraflex.

> "And then all of a sudden I felt the knees are getting better . . . I could jump out of the cab . . . could walk away . . . no nonsense"

> "It means I'm able to get my own work done, keep my garden tidy, and do my bit of shopping where I never used to get out before"

● Quotes of unnamed 'users' in an advertisement in the SA Medical Journal.

In an interview last year with the Mail, Prof Folb said when the drug was registered in SA, there was experimental evidence which claimed that it might represent a new development.

"It's structure was not dissimilar to other drugs which affect symptoms, but do not control them. Therefore it came as a surprise that some experimental evidence was claimed as possibly affecting the disease process.

"Our argument was that we did not believe they had submitted evidence for humans. It was still experimental."

But, the final test, Prof Folb said, is the drug's track record.

Medical officials were unhappy that Eli Lilly "fobbed off" the Press reports disclaiming responsibility for the information contained in the reports. Some officials believed the company was not entirely "straight" about having hired a public relations firm which gave out the information.

"Patients are looking for a magic cure. Every new anti-arthritic drug which appears on the market, patients want to try. The sales of the new drug will shoot up initially," one medical academic said.

However, along with Eli Lilly, he cautioned: "All prescription drugs on the market have killed. The drug was researched and developed in good faith and drug companies are unlikely to 'conceal'."

But the BBC have noted that Lilly was "unco-operative" — an experience shared last year by the Mail.

What the US makers say

ELI LILLY'S South African subsidiary referred most of the questions put to it, to its corporate headquarters in Indiannapolis. This was their response to the questions:

"On August 5 the company announced it was voluntarily suspending the sale and distribution of its new non-steroidal, anti-inflammatory drug, Oraflex. The reasons for the company's action, which was taken in consultation with the US Food and Drug Administration (FDA), were explained in a letter to the shareholders on August 9.

"Since that time the company has thoroughly reviewed the Oraflex situation and re-evaluated the various charges levelled at us in the political arena and widely reported in the media . . .

"We are convinced that the charges questioning the scientific integrity of this corporation are without foundation. After considering all the information that was known about Oraflex at the time of its approval in the US, it is our firm opinion that the scientific conclusions on which that approval was based were correct.

"The company continues to believe that Oraflex is a unique compound that can provide relief from the pain of arthritis.

"In our opinion the risk-benefit ratio of Oraflex is clearly favourable.

"The company is involved in discussions with the FDA regarding procedure by which Oraflex may be made available on a restricted basis. The company is also continuing to co-operate with the FDA in an effort to resolve the other issues that have been raised."

Medical services 'problem' reply

GPDE Trials 28/1/83 (8) 85

Staff Reporter

CONCERN about what is claimed are inadequate medical facilities at Mitchells Plain were justified to a certain extent, but the best possible service was being given at present, the Director of Provincial Hospital Services, Dr R L M Kotze, said yesterday.

"Providing adequate medical services is like trying to fill a bottomless pit. We can never say that we have reached our goal, but I must emphasize that the problem is not only in Mitchells Plain, but over the whole Peninsula area."

Dr Kotze and three senior members of his department were commenting in an interview on concern voiced by Mitchells Plain residents that the provision of medical facilities for the 144 000 residents was being neglected.

Dr John Sonnenberg, a member of the Provincial Council and City Councillor, said this week that the medical facilities in Mitchells Plain were virtually non-existent and that the situation was "deplorable".

"There should have been a hospital out there long ago and people are dying in Mitchells Plain at nights and over weekends because ambulances have to ferry them excessive distances to the nearest hospital, which is the overcrowded Victoria in Wynberg.

"Mitchells Plain was created in a wasteland by an ideology that took the people away from places like District Six, where the Groote Schuur, Woodstock and Somerset hospitals were much closer to hand, and now they have nothing," he said.

At present there are two polyclinics run by the City Council's Health Department, and three small day-hospitals run in converted houses by the province.

John Sonnenberg

The clinics operate only during the day.

"This is the situation in quite a few communities around the Peninsula," Dr Kotze said.

"I can assure the people in Mitchells Plain that we have not forgotten them, but there are other large communities such as Belhar, Elsie's River, Kuils River, to name just a few, who are in the same position.

Dr Sonnenberg said the provincial authorities were to blame for the situation because they knew at least 10 years ago that the population of Mitchells Plain would increase rapidly to its present size, and that a total population of 250 000 people was envisaged.

"It should have been foreseen that adequate medical facilities should be made available."

Dr Kotze said his department had originally been informed that the Mitchells Plain population would be essentially middle-class, which usually generated its own private medical services.

"Nobody told us that a substantial section of the population would be on the sub-economic level, and we had to find this out for ourselves only a few years ago.

"When we realized this, it was necessary to plan the provision of medical facilities."

Besides the existing clinics, Dr Kotze said a comprehensive Community Health Centre for Mitchells Plain, which would be a combined project with the City Health Department, was in an advanced stage of planning.

"For financial reasons as well as others, I cannot say when construction will start."

Commenting on the call for a temporary round-the-clock medical facility to be established in Mitchells Plain, Dr Kotze said this was not planned for at this stage, but that it could be included in the new health centre.

He said experiments to incorporate a 24-hour casualty unit into a day hospital had been conducted before, but it had been found that the staff manning them feared for their safety in the outlying suburbs during the night.

"I would also like to point out that plans for the new Heideveld-Guguletu hospital, which will be close to Mitchells Plain, are in an advanced stage."

● Mr Basil Warner, chief of the West Cape metropolitan division of the Cape Ambulance Rescue Service (Cars), said the ambulance service to Mitchells Plain had recently been doubled from one vehicle to two for every shift.

Another two vehicles were stationed "a stone's throw away" in Grassy Park and Retreat.

He also also confirmed that an ambulance reserve unit, which would rely on volunteers to serve the area at peak times like Fridays and Saturdays, was planned.

"We hope to have something going within a month or two," he said.

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EDSON

(85) Hansard Q. Col. 704
16/3/83

Medical research

487. Dr. M. S. BARNARD asked the Minister of Health and Welfare:

(1) What was the total amount spent by his Department on medical research in the Republic in the (a) 1980-'81 and (b) 1981-'82 financial years;

(2) how many doctors are employed by his Department in the field of medical research?

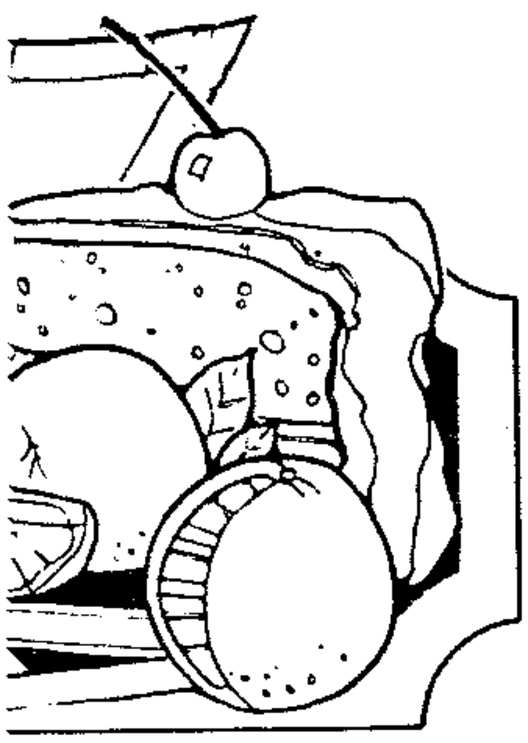
The MINISTER OF HEALTH AND WELFARE:

(1) (a) 1980-'81: R2 430 876;

(b) 1981-'82: R2 762 015;

(during 1980-'81 R7 368 800 and during 1981-'82 R8 750 800 was voted for the S.A. Medical Research Council);

(2) 16; officers of the Department holding dual or tripartite appointments who are attached to universities and who are concerned with research, have been excluded.



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'Attractions of private practice pose threat to medical care in SA'

W/L ARGUS 9/4/83 85' 93 94 95 99

Weekend Argus Reporter

SOUTH AFRICA faces a serious deterioration in standards of medical education and patient care, a top doctor warns in the latest edition of the SA Medical Journal.

"The Medical Association of South Africa and the South African Medical and Dental Council should take note that all is not well in the academic dovecote," writes Professor J W Downing, head of the department of anaesthetics at the University of Natal, in a letter to the journal.

He says provincial and State teaching hospitals and university departments of anaesthetics are suffering from a chronic and critical shortage of anaesthetists "dedicated to public, as opposed to private, practice".

"The training of future doctors in the RSA rests in the hands of a few dedicated individuals whose patience with the notion that the private practitioner is worth two to three times the full-time consultant is fast running out.

"Recently-qualified specialists in many fields, but particularly in anaesthesia, with the potential to undertake a successful full-time or academic career, have taken note of this disparity, and many are going into private practice, or emigrating.

"The final outcome will be a serious deterioration in standards of medical education and hence patient care in this country as we continue to lose many of our best and finest anaesthetists to greener financial pastures."

Professor Downing, recently returned from 13 months' sabbatical leave in the United States, says anaesthetic teaching departments there bill individual patients, raising considerable funds which are paid directly to the departments.

Further funds, running to millions of dollars, come from research grants, "interaction" with the pharmaceutical industry and the state.

The money is used to subsidise salaries in the teaching departments, to buy equipment and for book and travel allowances.

Professor Downing suggests a similar system would be feasible in South Africa. The necessary funds could come from salaries paid by the provinces or the State, research funds, donations from pharmaceutical companies and service organisations and fees charged to medical aid and Workmen's Compensation Act patients.

Patrols organised to stop 'queer bashing'

Gay vigilantes

By DIRK VAN ZYL
Weekend Argus Reporter

CAPE TOWN's only gay rights organisation, 6010, has called on members to form vigilante patrols to protect themselves from "queer-bashing".

Evidence of physical assault on homosexuals by men picked up as casual lovers has emerged recently in a number of court cases in the city.

In its latest newsletter, 6010, which has about 400 members, refers to the formation of the "Pink Panthers" vigilante group in San Francisco "in the early days of gay lib when they were at the rough end of American bashing' is an amusing pastime".

It asks: "Surely it is time for us to show these dreary men that brute force can be a two-way thing?"

The newsletter continues: "There are people at 6010 who would like to see our own vigilante force patrolling and our members trained in the art of self-defence so that next time some thug thinks he can practise for a world title fight on you, you can show him what the real meaning of Bella Bash is." (The term is gay slang for fighting.)

Publicity

A 6010 founder member, Mr Richard Griffith, salesman in a city book-

Mr Griffith, who has been assaulted three times, said the biggest problem facing gays was "lack of education and outdated, misconceived ideas in the 'normal' community, although to a degree there is now more tolerance, which, however, I find condescending".

According to Mr Griffith, "you get the situation where well-respected members of the community are not able to operate normally sexually and are beaten to death in their homes" be-

licity the gay community gets, the more homophobic reaction there is, like with AIDS" (the immunodeficient condition which has spread in gay communities).

perately needs to relate to someone in physical terms."

Being beaten up was "a basic fact of life for gays".

Mr Griffith continued: "The law in South Africa is ridiculous. It is not illegal to be a homosexual, but just illegal to do something about it. You are virtually condemned to celibacy."

The "biggest battle" facing gays was "their own apathy, which is a form of fear".

According to Mr Barry Kantor, media spokesman for 6010, the organisation "discourages members from 'cruising' — we try to alert them to the dangers involved and to what they are legally entitled to do in case of difficulty".

Urban blacks not healthy, says professor

By Pamela Kleinot

The diet of blacks in Southern Africa had deteriorated in the past 50 years, Professor Charles Isaacson, head of the department of anatomical pathology at the University of the Witwatersrand, said last night in his inaugural lecture entitled "Are Urban Blacks Healthy ?"

"They certainly do not eat nearly enough vegetables and fruit — substances which, experimentally, protect animals from many varieties of cancer," the professor said.

Cancer of the oesophagus, which was rare among blacks 30 years ago, had increased significantly, he said. Whereas only 12 cases were recorded at Baragwanath Hospital in 1955, between 250 and 300 had been reported there annually in the past few years.

He said the cause of this cancer could probably be attributed to certain protective substances lacking in the diet.

The professor said that urban blacks were not particularly healthy. There had been certain areas of improvement but urgent attention should be given to the ravages of malnutrition, particularly kwashiorkor, which exacted a heavy toll on blacks.

He added that:

● Gastro-enteritis and pneumonia were major killers of children.

● Rheumatic heart disease — associated with overcrowding and low socio-economic status — was still a scourge among blacks.

● Tuberculosis was one of the biggest killers of blacks, claiming about 20 000 lives each year.

Professor Isaacson said TB and rheumatic heart disease would be eliminated only when socio-economic conditions among blacks were improved.

The professor said South Africa was a "researcher's dream" for studying the causes and mechanisms of disease in different racial groups.

He referred to hypertension (high blood pressure), which was the commonest cause of death in blacks after violence, and said it seemed that rural blacks developed this when they moved to an urban environment.

Among other comments, Professor Isaacson said:

● There had been a significant increase in the number of blacks dying from heart attacks. Only one died in 1959 compared with 14 in 1976.

"The urban black is now developing an affluent middle-class group which smokes heavily, can afford to eat saturated fats in beef and cheese, does little exercise and frequently suffers from high blood pressure."

He added that nearly half the heart attack deaths were the result of high blood pressure.

High blood pressure, which was much less frequent in rural areas, generally killed young people by kidney failure or stroke.

"Urbanisation and Westernisation increase the incidence of high blood pressure among blacks," he said.

● Alcoholic liver disease was the biggest social disease and making Western-type liquor freely available to blacks in 1963 had produced a "medical catastrophe".

● Cancer of the liver — which was linked to the hepatitis-B virus — was probably the commonest cancer in Africa. Most cases seen at Baragwanath Hospital involved migrant labourers from rural areas.

● There was an epidemic of cancer of the cervix in black women. This was associated with frequent intercourse starting at a young age with multiple partners.

JOHN GEAR FM 29/4/83 ~~FM~~ ~~90~~ ~~95~~ 85

Bridging the health gap

The *FM* spoke to Wits Professor of Community Health, John Gear, in Gazankulu where his department is carrying out a pilot health project.

***FM:* What are the major problems of rural health care?**

Gear: The health of rural people depends on two factors. Firstly, the broader issues of housing, education, water and poverty. Secondly, the provision of an adequate health care service.

Common problems facing the health care system are malnutrition, childhood diseases, problems associated with mothers and children rather than the problems of middle-aged productive men. This disease pattern is peculiar to rural areas because of the population structure resulting from the migrant labour system and influx control. Other problems are inadequate infrastructure, distances and the scarcity of health professionals.

Is a restructuring and decentralisation of existing facilities the answer?

Yes, but only if the system isn't oppressive. A health care system can be either oppressive or liberating. An oppressive system means that people are expected to do what the health care system dictates, whereas a participatory and liberating system is developmental and the community controls decision-making.

How should resources be re-allocated?

It is widely accepted that hospital services should be decentralised, but the level of decentralisation is debatable. Many people believe a number of health centres functioning as sophisticated mini-hospitals are the solution and that the idea of very simple clinics at village level should be abandoned. I think both are required.

If we're trying to provide at least a minimum level of care for as many people as possible, then the local clinic must take precedence over the health centre. A clinic staffed by perhaps one highly trained nurse, supported by a traditionally trained nurse, and by two partially trained nurses, could run a very acceptable service for a population of about 10 000 people.

It's better to put 15 nurses in 15 villages rather than in one sophisticated centre. Staff can be trained relatively easily through centralised training programmes. Community health workers, usually women with limited education, but with supplementary training in community health work, backed up by grassroots health workers who can refer patients to a hospital, are very effective.

What are the basic health essentials at village level?

The preventive services are the most important in terms of maximum benefits for minimum input. This means ensuring there is someone with health skills in every village, that vaccines are available, that there are facilities to ensure that people who need minimal care have access to that either by providing transport to a more central point or by decentralising our traditional health service.

Where does the high technology hospital fit into this model?

The provision of high-level nodes is not justified unless an adequate basic health infrastructure exists at village level. Higher order skills and services are required when these basic needs are met.

The State's National Health Services Facilities Plan, which identifies various levels of health care delivery, acknowledges this. The first level is provision of basic amenities such as food, water, housing; whereas only the fourth, fifth and sixth levels require more sophisticated equipment and buildings.

What can be done about the inequitable spread of health benefits between urban and rural areas?

Inequality in SA is perhaps more an urban/rural differential than a black/white differential, so attention must be focused on rural areas. The health care of urban blacks is still inferior to that of urban whites but it is possible to gain access to care. In many rural areas, this is impossible because of financial constraints or distances.

The reasons for this are primarily bureaucratic. Goodwill is being obstructed and hamstrung by bureaucratic inertia. The medical and nursing profession is also to blame. I think every qualified doctor should do two compulsory years of rural service.

How does a health programme deal with the poverty factor?

Depending on how malnutrition is defined, the reality is that between 20% and 50% of children in SA's rural areas are malnourished. Poverty is the crux.

In rural areas, there is financial poverty, but also the poverty of land and water — particularly as a result of this year's drought. There are also political causes of poverty which are largely outside the ambit of health professionals. We can only tackle part of the problem.

Our responsibility is to ensure a more equitable distribution of health resources and where possible to reduce the effects of poverty through the provision of immunisation and potable water, for a start. However, we have a strong moral obligation to challenge the political predisposing factors to poverty and cannot, as health professionals, regard this as beyond our concern.

SOWETAN

Sowetan FRIDAY, APRIL 22, 1983

Family rushed to hospital after eating supper

POISON DRAMA

85

By MZIKAYISE EDOM

A KWATHEMA family of seven was almost wiped out as a result of food poisoning yesterday.

Among the nine people, seven of whom are from one family, admitted to hospital suffering from suspected food poisoning, was a three-year-old boy.

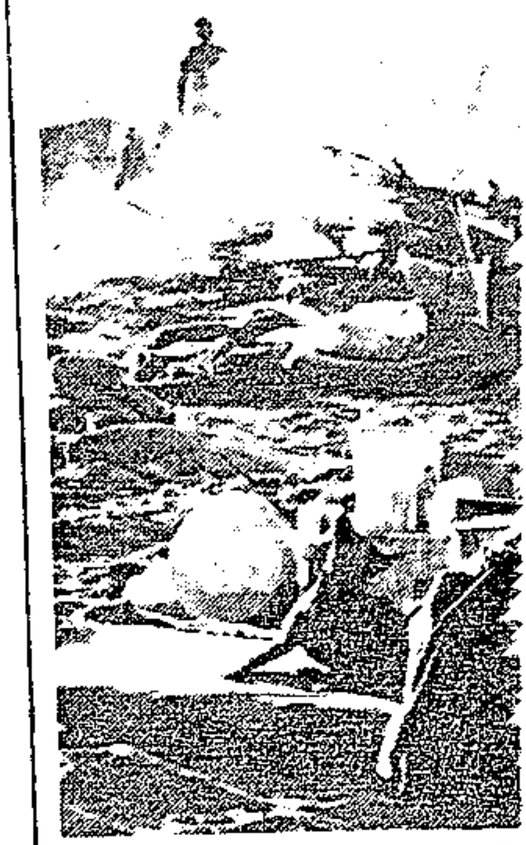
Three members of the family are in a critical condition at the Far East Rand Hospital and only one of the nine has been discharged. Those in hospital are Mr David Khumalo, his wife Georgina and their children George, William, Elizabeth, Kenny and three-year-old Nelson. They are all from 35 Mothoa Street. The two others are relatives, Mrs Thoko Nhlapo and eight-year-old Sibongile Mothoa, who both stay two houses away from the Khumalos.

A spokesman for the Far East Rand Hospital said yesterday that Mr and Mrs Khumalo and Mrs Nhlapo were still in a critical condition and that the others were expected to be discharged from hospital any day from now if their condition improved.

Mrs Sarah Mothoa, a relative of the Khumalos, told **The SOWETAN** yesterday that trouble started soon after the group had finished supper. She said that minutes later, they all started vomitting.

"We summoned an ambulance which took them to the Far East Rand Hospital. We were later told by the doctors at the hospital that the nine had eaten poisoned food," she said.

Only Sibongile has so far been discharged from hospital.



BONFIRES: Raging on th

152 Cape squatters arrested in police raid

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Fighting back against killer diseases

City Press 13/5/83

CAPE TOWN — More attention is being paid to black health needs by medical researchers in South Africa.

Although much of the research is still focused on the health needs of wealthier groups, a gradual change of emphasis is taking place.

This emerges from the annual report of the Medical Research Council which was tabled in Parliament.

Much more needs to be done — and many critics believe there will be no major change in the health profile of the majority of South Africans without major social and economic change.

But the change in research is noticeable.

Cancer

The Medical Research Council contains details of projects on cancer of the gullet — the most common cancer among black men — diabetics at Baragwanath Hospital, a disease of the joints in KwaZulu, the low priority given to TB, nutritional diseases, obesity in black women, stress among miners, and cholera.

It has been found, for example, after extensive field research in the Transkei that cancer of the gullet "is most often seen in people with a deficiency of various minerals and vitamins."

Their investigation indicates that it is not the lack of food that causes this because their findings show that these communities do have sufficient protein and energy.

Maize

But the main staple in the diet is maize, which has low levels of essential vitamins and minerals.

They say that the cancer can be prevented, or minimised, by a varied and balanced diet.

And the use of enrriched maize meal, which is now available in many parts of South Africa, would help.

They believe that the numbers of deaths from cancer of the gullet would drop by 80 percent over 20 years if the mineral and vitamin deficiencies were corrected.

The "human biochemistry unit" in Johannesburg has found that black adults and schoolchildren "do not easily detect" the difference between fortified mealie meal and unfortified mealie meal.

Medical researchers have argued for years that if mealie meal was fortified it could play an important role to improve health standards.

Compulsory

And the human biochemistry unit has pointed out that the fortification of maize was "carried out successfully in the US many years ago."

Why, therefore, is the enrichment of mealie meal not made compulsory in South Africa?

The medical researchers don't ask or reply to that question, but it is clear from their investigations that the Government should take action to compel companies to enrich all mealie meal.

The Tuberculosis Research Institute in Pretoria says the assumption that the TB problem has been resolved has led to "a sharp reduction" in research in developed countries, but despite this it has been able to extend its work.

One of the problems is the low priority given to anti-TB work by health workers, the institute says.

Another is that the procedures in TB control need to be simplified so that they can be used in different conditions

Epidemic

In its annual report, which was released this week, Santa outlined just how bad the TB epidemic in South Africa is.

It said that between 50 000 and 60 000 cases are reported every year and that about 100 000 more cases are unreported.

Ten people die every day from TB in South Africa.

Santa also said that overcrowding under "atrocious environmental conditions" such as Crossroads, coupled with malnutrition, undernourishment and rising unemployment resulted in the disease spreading over a wide area.

This finding tends to confirm the view that it is not just doctors, health workers and hospitals that will end the TB epidemic — more basic issues need to be tackled — but the research, if applied, would help.

The Institute of Biostatistics in Cape Town is evaluating the delivery of health care, particularly in Soweto. It found, for example, diabetics who were admitted to Baragwanath often had to be readmitted again later.

This was because diabetics lacked the knowledge and skills necessary to prevent another emergency, and a programme had been instituted to help this problem

There was also the problem that the treatment suggested for these diabetics was not being complied with and research was being conducted to co-develop new strategies to prevent this.

Mseleni

The institute was also looking at Mseleni joint disease which crippled both men and women of all ages in north-east KwaZulu.

It has been found that this disease exists in a larger area.

"Because of the debilitating nature of disease and its high prevalence, there are serious socio-economic implications for the inhabitants of the area."

The National Research Institute for nutritional diseases in Cape Town is researching various aspects in which important diseases have a basis or component relating to the food people eat.

It has found that there is "a high prevalence of malnutrition" among people who have kidney failure and liver disease.

Toxin

This institute also found that a popular breakfast food had more than the legal limit of toxin in breakfast food.

It discovered "unacceptably high" levels of fungus in sorghum beer malt.

Another research institute has found cholera germs survive far longer in wooden containers and to a lesser extent in earthenware pots — but disappear rapidly in plastic and metal containers.

All this research indicates that the focus of at least some of the medical research is changing.

It is about time

Health men in milk peril fight

THE Government is waging an all-out battle to contain antibiotic and pesticide contamination of dairy products throughout the country.

Since last year — when the situation was described as "disquieting" and widespread by the Department of Health — the threat has receded and officials claim they are now on top of the problem.

Of particular concern to the State health services has been a regular presence in milk test samples of the pesticide Dieldrin — banned in South Africa five years ago but apparently illegally sold and used by farmers.

Worse

Although the incidence of pesticide residue in milk is low — Health Department officials scoff at suggestions that it has ever reached life-endangering levels — nutritionists have warned that some pesticides have an accumulative effect.

The increasing presence of residues above the legal limit in milk first became noticeable about three years ago. The situation was worsened by the drought as farmers used up old stocks of fodder,

By BRIAN POTTINGER

some of which had been treated with the then legal Dieldrin.

Test samples of milk taken from milk tankers in the country turned up an alarming incidence of antibiotic and pesticide residues above the legal limit. Traces of illegal substances were also found.

Talks held

In a bid to contain the contamination the Government has set up two committees in the Department of Health and Welfare and the Department of Agriculture to monitor the problem.

Thousands of rands have been spent on an educational programme aimed at farmers, doctors, pharmacists, dentists and vetinary surgeons. Brochures, farming journals and the radio have all been used by the Government to warn farmers of the dangers of uncontrolled use of pesticides.

The department has also held talks with the South African Agricultural Union, the Dairy Control Board, the SA Dairy Products Manufacturers Association and the SA Milk Distributors Union.

In the last year between R150 000 and R200 000 has been spent by the department on the analysis of milk and other foodstuffs affected by the contamination.

By a process of elimination the department has begun zeroing in on the areas from which contaminated milk is coming and have warned farmers to change their pesticide and antibiotic programmes or face prosecution.

This week, Dr G J van Rooyen, of the Department of Health and Welfare, said the programme was paying off and the incidence of contamination was dropping.

Concern

"This is an ongoing programme. We did regard it as serious last year but samples show a drop in contamination".

Official department sources claim reductions of 40 percent have been achieved so far during the programme, with current tests being as little as four "positives" in a sample of 270.

The first public inklings of concern came last year when Mr Greyling Werntzel, Minister of Agriculture, admitted that contamination of milk by residue pesticides and antibiotics was causing grave concern.

Social change linked to improved health

By Pamela Kleinot,
Medical Reporter

Basic social change is necessary in South Africa before there can be an improvement in the health of the population, says Professor Jacques Kriel, director of the Centre for the Study of Medical Education at the University of the Witwatersrand.

"While we have a social order which is so structured that some people are doomed to poverty, no change can be brought about in the health status simply by tampering with the medical system," he said.

Addressing the Wits Alumni Luncheon Club on "Ideology and Health Care" yesterday he said a fundamental change in the social structuring was required.

Professor Kriel said health care services in South Africa were segregaged according to race — "criteria that are clearly irrelevant within a health care system".

"Not only are there separate hospitals for different racial groups but the training of health professionals is also racially segregated.".

Professor Kriel said the latest official health statistics did not include the independent states, which cut out of the calculation "large concentrations of ill-health and inadequate service".

Striking differences among the various population groups included the facts that the average life expectancy for a white man was 65 years compared to 52 for a black man, and that the neonatal mortality rate (death rate around the birth period) among whites was 21,6 per 1 000 births while for urban blacks it was 50. The rate among rural blacks could be higher than 123.

Khayelitsha health service 'inadequate'

By JO-ANNE RICHARDS

NEARLY 450 people now living at Khayelitsha — 304 of them children — are without personal health services.

Although the Divisional Council provides a preventive health service — including infant feeding, family planning and immunization — there is no curative health service for the people who began moving there on June 7.

Injured or ill residents must travel to the nearest provincial day hospital in Guguletu, either by car or by catching two buses, for which they must pay R1.23.

The first bus from Khayelitsha to the Nyanga terminus leaves at 5.30am and the last at 8.30pm. The clinic is open three times a week, although a staff member is present every day.

Both the clinic and the provincial day hospitals close at night.

The Medical Officer of Health for the Divisional Council, Dr L Tibbit, said it was not the Divisional Council's brief to provide curative health services — its clinics provided promotive and preventive services..

He said the staff at the clinic, which included nurses specializing in community health care, could deal with first-aid and minor ailments before referring the patient to the day hospital.

A spokesman for the Red Cross said staff members who visited the area last week had been so concerned about the lack of facilities for dealing with ailments and injuries that they had left their first-aid box at the clinic.

While they were there, a small child with bad burns on his legs was referred by the clinic to the day hospital without treatment, he said.

According to Dr John Sonnenberg, MPC and opposition spokesman for health, the provision of health services in Khayelitsha was primarily the responsibility of the Western Cape Administration Board.

The chief director of the WCAB, Mr J L Gunter, said the board had not asked the Provincial Administration to provide health services, but had arranged with the Divisional Council to provide a clinic.

The health services provided by Divisional and City councils were purely preventive. Personal health services for the treatment of injuries and ailments were handled by the Provincial Administration.

The Acting Director for Hospital Services in the Cape Province, Dr J L Jordaan, said he was aware of the problem and was making arrangements to deal with it. He was at present investigating the possibility of making a nurse from one of the day hospitals available for duty in the area. If a nurse was not available, a post would have to be created.

Dr Sonnenberg said the situation at Khayelitsha was clearly hopelessly inadequate. A curative presence in the area was an urgent necessity, especially as the large numbers of children were subject to illness as well as injury.

A chaotic situation should not be allowed to develop before something was done, he said.

Mr Ken Andrew, PFP MP for Gardens and opposition spokesman for black affairs in the Western Cape, said the people of Khayelitsha were promised adequate health facilities as soon as they had moved there.

These facilities should at least incorporate first-aid, community health nursing and transport to a nearby day hospital, he said.

Rural blacks ignorant about health, HSRC survey finds

(85) Star 26/7/83

Medical Reporter

A Human Sciences Research Council study shows that rural blacks are largely ignorant about general health matters.

A Department of Health statement today said the HSRC had surveyed an estimated 1 600 rural Zulus and Southern Sothos and found many of them did not know about the dangers of smoking and alcohol, or about balanced diets and immunisation.

The study requested by the Department of Health and Welfare was headed by Mr Alwyn Lubbe of the HSRC's Institute for Communication Research.

The department wanted to find out how familiar blacks are with its services, the extent to which they use the services and the best communication medium for reaching rural blacks.

The study found that radio was by far the most popular mass communication medium (reaching between 83 and 92 percent) followed by magazines (20-36 percent). Newspapers were used by five to 12 percent.

Some of the study's findings were:

- More than 25 percent believed children grew well if they ate only mealie pap.
- About half the group believed it was good to sleep next to an open fire in a room where the windows and doors were closed.
- Although most indicated that a medical doctor was able to cure mentally disturbed people, at least 49 percent believed a witchdoctor could do the same.
- More than 75 percent did not know what a balanced diet was. Those who claimed they did know particularly mentioned foods rich in carbohydrates such as sugar, bread and cereals, as well as fats and oils. Vegetables, fruit, dairy products and protein-rich foods were mentioned less frequently.
- Most respondents believe rats or mice can transmit disease, and it was necessary to keep flies away from food, but nearly 33 percent either stated the opposite or did not know.
- About 75 percent did not regard smoking or drinking alcohol as harmful or did not know what the effects were.
- Most knew what immunisation was but were unable to see the relationship with the prevention of contagious diseases. Only a small percentage believed in immunisation withinthree months of birth.
- Between 70 and 92 percent indicated that they usually preferred going to a medical doctor for treatment when they were ill. Three percent of Zulus and six percent of Southern Sothos preferred a traditional doctor.
- Two percentwho had already visited the hospital mentioned family planning as a reason.
- Asked about the causes of mental disturbance, some respondents said witchcraft, poverty, brain damage and the abuse of drugs and alcohol were responsible.
- The respondents were generally unfamiliar with the term "psychiatrist" but indicated they knew what a psychiatrist was and, almost without exception, were convinced that such a person could cure mentally disturbed people.
- Most respondents had never heard of tubercolosis, epilepsy, rheumatic fever or hypertension.When they were questioned on symptoms, causes and treatments a relatively large percentage "either gave wrong answers or really did not know".

The respondents also indicated that diseases including measles, bilharzia, malaria and venereal diseases were relatively unknown to them and that jaundice was almost completely unknown to them.

Rural blacks lack health facts

By GERALD REILLY
Pretoria Bureau

RURAL blacks are to a large extent ignorant of general health matters, such as the importance of a balanced diet and immunisation and the dangers of smoking and alcohol abuse.

Their knowledge of certain diseases is also limited, a Human Sciences Research Council survey has found.

The HSRC was asked by the Department of Health and Welfare to investigate health knowledge among rural Zulus and southern Sothos.

Mr Alwyn Lubbe, of the Institute for Communication Research, found respondents largely ignorant.

More than three-quarters of the test group did not know what a balanced diet was.

Those who claimed they did made particular mention of foods rich in carbohydrates, fats and oils.

Vegetables, fruit, dairy products and protein-rich foods were mentioned less frequently.

More than a quarter believed children grew well only if they ate maize meal porridge.

Though the majority of the respondents knew rats and mice could transmit diseases and that it was necessary to keep flies away from food, almost one-third either "stated the opposite or did not know".

Approximately half the test group believed it was good to sleep next to an open fire in a closed room.

The majority of the respondents knew what immunisation was, but were unable to see the relation between immunisation and the prevention of contagious diseases.

Some of the reasons given for mental disturbances were witchcraft, poverty, brain damage and the abuse of drugs and alcohol.

The majority believed a medical doctor was able to cure mentally disturbed people, but 49% of the test group believed a witchdoctor could do the same.

Health Fair '83 bound to receive a rousing welcome

Sowetan 6/9/83 (85)

LONG overdue; a very great need; exciting development: These are the responses from the black community whenever Health Fair '83 is mentioned.

A partial response to the Prime Minister's plea for private enterprise to play a greater role in health education, the Health Fair is being staged in the Diepkloof Hall from 17 to 25 September.

More than 20 companies will be exhibiting, demonstrating and lecturing about their health and hygiene products, and visitors will also be given free advice and examinations by Santa, Alcoholics Anonymous and other bodies.

Percy Qoboza, a well-known newspaper columnist, strongly appreciates the fact that the fair is not a covert marketing exercise purely for commercial gain.

"It is really an educational programme," Qoboza states, "in which the community will become deeply involved with health, particularly family health. We all feel it is going to be of tremendous benefit to the community.

"Private enterprise can help us enormously just by getting together with the community — there are so many problems that can be solved. In Soweto, for example, community health is bordering on a crisis."

Qoboza is also distressed by the basic lack of knowledge concerning simple hygiene. "A lot of diseases, including cholera, could be eradicated if the importance of hygiene was understood. Children are not taught this subject adequately at school, and unfortunately, many parents are ignorant of these basics too."

Joe Latakgomo, editor of **The SOWETAN,** is similarly enthusiastic about Health Fair '83, and is convinced there is a very great need for it.

"All the people I've spoken to about it feel the same, that the community has a desperate need to be exposed to this type of information, and the idea is long overdue. Because of this, the event should be received very well.

"It is interesting that these comments have been spontaneous rather than solicited," says Latakgomo.

"And as far as **The SOWETAN** is concerned, we are anxious to publicise the Health Fair so that the community knows about it and about the benefits to be gained by visiting it."

Doctors and nursing staff in the community are equally excited, the doctors being particularly keen to take the opportunity to talk to private enterprise about mutual problems and needs. They see Health Fair '83 as being a sign of a new attitude that will lead to a circle of communication helping them discover exactly what educational aids are available.

It is hoped a central pool of information might become possible. Certainly the State is keen for the private sector to produce suitable material, especially since not all overseas educational matter available is relevant to South African conditions and requirements, says a senior staff member of a local medical facility.

ARGUS 7/10/83 (85) NATIONAL

Crash project to train black doctors

Argus Correspondent

PRETORIA. — The Medical University of Southern Africa (Medunsa) will train about 200 doctors, 50 dentists, 50 veterinarians and 300 paramedical specialists a year in the next five years.

A spokesman for the university said that millions of rands have been earmarked for projects aimed at expanding and building facilities to cater for the growth of the institution. The university would accommodate about 4 500 students a year, he said.

Phased out

"In a country where there is only one black doctor for every 90 000 black people, and black dentists and veterinarians are almost non-existent, we can be proud of the work Medunsa is doing," he said.

The university, comprising of faculties of medicine, dentistry and veterinary sciences, was established on August 21 1976 to train black doctors after black students were phased out at the University of Natal's Wentworth Medical School in Durban.

The university is located about 30 km northwest of Pretoria in Garankuwa on the border of Bophuthatswana. It adjoins the Garankuwa Hospital which treats more than 20 000 outpatients and 3 000 admissions a month.

Graduation

The first batch of medical graduates was capped last November. The second graduation ceremony will be held on November 26.

Mr Louis Vogel, chief public relations officer at Medunsa, said a number of major companies and distinguished personalities have been invited to tour the campus on October 26.

The guests will visit the lecture rooms, students' residences, laboratories and other facilities on the campus.

Health services — access for poor is difficult

Medical Reporter

MANY of the poorer areas of Cape Town have two or fewer general practitioners and no hospitals, and many working class people have "problems of access" in reaching medical help.

This emerges from a working paper produced by the Southern Africa Labour and Development Research Unit (Saldru) at UCT on Access to Health Services in the Greater Cape Town Area.

The highest concentrations of general practitioners are in the wealthier suburbs such as Bellville, Claremont, Rondebosch, Sea Point and Wynberg.

The poorer areas named in the paper are Bishop Lavis, Facreton, Guguletu, Langa, Steenberg and Nyanga.

"Problems of access are created since people have to undertake inconvenient journeys to reach general practitioners, adding transport costs to the costs of consultation."

This was also a problem in the case of specialist referrals, since more than 50 percent of the private specialists worked in the city centre, the rest working mainly in other medical centres in the wealthier white suburbs.

Using 1980 figures the paper states that of the Peninsula's 936 private practitioners, 397 are specialists and 151 of these are surgeons.

This concentration was not related to the major health problems in the area — preventable diseases such as gastro-enteritis, pneumonia and under-nutrition among children, and TB among adults — but to areas of maximum profitability.

All of the 22 private hospitals in the metropolitan area of the Peninsula, with the exception of one convalescent home, were in the white areas.

Only one curative clinic, Empilisweni SACLA clinic, run by church organisations, provided primary health care facilities to a population of about 30 000 people at Crossroads.

Limited access to the services of general practitioners was a problem particularly for workers since general practitioners, apart from provincial hospital casualty departments, provided the only primary health care services available after working hours.

Provincial hospitals, with the exception of one convalescent home and one orthopaedic hospital, were all located in white group areas.

New day hospitals have been opened in three areas in the past three years, but others have been closed. Bontheuwel closed after the 1976 unrest, and areas with large populations far from the city, such as Mitchell's Plain, have no day hospitals.

"The day hospitals in Langa and Guguletu (two areas with the highest rates of TB and infant mortality) have needed extending for more than four years."

The paper concludes: "What has been found is that areas with the greatest need are areas in which there is least access to health services."

...sport services.

GS ARE:

IFF SURCHARGE OR COUNT WITH EFFECT M JANUARY 1984	EFFECTIVE TARIFF INCREASE WITH EFFECT FROM JANUARY 1984
5 % discount	6,0 %
5 % discount	6,0 %
% discount	5,8 %
% surcharge	6,0 %
% surcharge	6,1 %
% surcharge	5,8 %
% surcharge	5,7 %
	6,0 %

The 20,5 % discount to be implemented in terms of the revised tariff structures reflects the increase of 6 %. If the tariff for these two undertakings had not been revised, the increase of 6 % would have resulted in a surcharge increase from 33,5 % to 41,5 % for Rand and OFS and a surcharge increase from 36 % to 44,2 % for Eastern Transvaal.

...LIPS, BUNTON, MUNDEL & BLAKE 73215

saulting Mrs Eileen Robson."

...had alleged ... customers.

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NATIONAL Argus 11/11/83 85

Health services need urgent change — Dr Barnard

Argus Correspondent

DURBAN. — A complete revision of South Africa's health services was urgently required, Dr Marius Barnard, MP, Progressive Federal Party health spokesman, said here.

Dr Barnard, commenting on the substantial curbs imposed on private patients in Natal provincial hospitals, warned that privileged people would have to be prepared to pay more for health services in the future.

"The whole balance of health care in South Africa is wrong," he said.

"The State cannot be expected to pay for expensive curative medicine like heart by-pass operations and to ignore the needs of the underprivileged.

MALNUTRITION

"Money is urgently needed to prevent malnutrition, cholera and typhoid.

"Whether a person has a heart by-pass operation in a private hospital or in a Government hospital, the cost is still around R10 000.

"In the one case the taxpayer generally is paying, while in the other the patient or a medical aid is paying."

Dr Barnard said R10 000 could save the lives of many children in the homelands who were dying of malnutrition.

He said there were many contradictions and anomalies in South Africa's health services.

293 SOCIETIES

For instance, there were 293 medical aid societies, which themselves were pushing up medical fees because of the duplication of administrative costs.

The number of medical aid societies should be reduced.

Dr Barnard said the Browne Commission, which was investigating health care, had been appointed four years ago.

"I have asked repeatedly in Parliament when this commission is going to report.

Dr Marius Barnard

"It is extremely urgent that the commission completes its task and that the Government decides on the future of medicine.

"It must decide on the future role of private medicine and on whether South Africa requires a national health service."

He was convinced that whatever the Government decided, privileged people would have to pay more for medicine in the future, either in tax or as private patients.

He pointed out that medical costs in South Africa were a quarter of those in West Germany or the United States.

Particular attention was required for preventive medicine.

"In South Africa, for every R94 spent on curative medicine, only R6 is spent on preventive, promotional and rehabilitative medicine.

"At least 15 percent should be spent on preventive medicine to stop outbreaks of diseases such cholera and typhoid."

Dr Barnard said he supported Government moves which included the cutback on private patients, to spend less on curative medicine and more on preventive medicine.

Burglary suspects caught on the jog

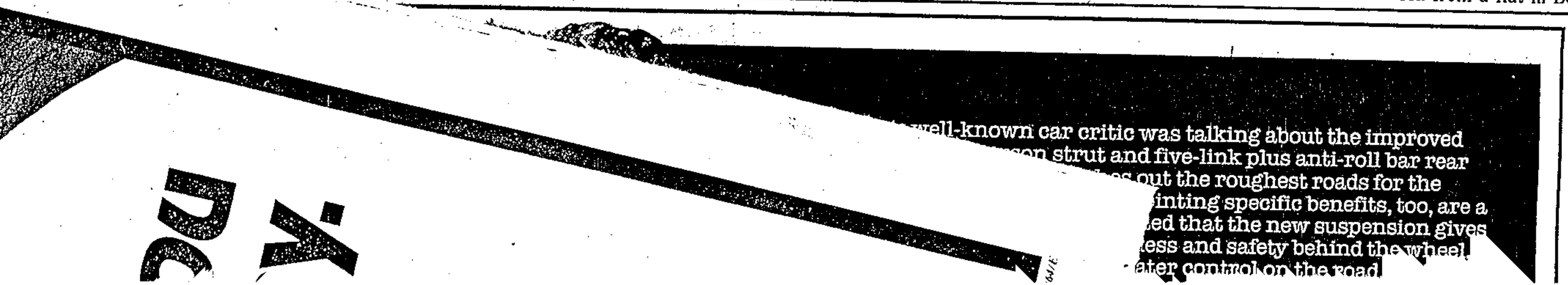
Argus Correspondent

DURBAN. — Luck wasn't in for three suspected thieves fleeing with stolen goods — they ran into three police detectives out jogging.

The head of the CID in Durban, Colonel Gert van Zyl, was jogging at lunchtime with Warrant Officer Pieter Joubert and Warrant Officer Graham Dwyer.

Near Greyville racecourse they noticed three men carrying a large quantity of property. Not wanting to scare the suspects off they quietly jogged up to them and then pounced.

They were found in possession of clothing, jewellery, radios, a tape recorder and watches believed to have been stolen from a flat in Berea.



Patients 'the victims of health care system'

CAPE TIMES 30/1/84

Staff Reporter

THE patient was the real victim of the present health care system which rewarded its primary workers, the nurses, with poor pay for long hours and a heavy workload, a group of University of Cape Town Summer School students was told on Friday.

Ms Hester van der Walt, a trained nurse who recently completed a Masters Degree in adult education and community development at Manchester University, said a group of workers as dissatisfied as nurses could not render an efficient service.

"Almost all nurses, from senior sisters to nurse aids and auxilliary nurses, feel they are paid too little," she said.

"Everyone I have spoken to rejects pay discrimination on the grounds of colour, they all feel the 12-hour 7am to 7pm shift is unnecessary and the black nurses in particular are unhappy with the heavy workload they have to cope with because of overcrowded wards."

Ms Van der Walt said nurses were also disillusioned with the South African Nursing Association (Sana).

"Sana is a statutory body and membership is compulsory for nurses, but most nurses say the organization means nothing to them and they are unconvinced about its capabilities to secure them a better deal."

"Unfortunately, few nurses realize that there is nothing to stop them from organizing outside Sana, and those who do are reluctant to do anything for fear of victimization.

"In the August issue of the official Sana magazine, Nursing News, Sana admits that nurses could form another representative body, but discourages this on the grounds that nurses would have to pay two subscriptions fees, because they would have to belong to Sana anyway, and by implying that membership of a trade union goes against the service ethic of nursing.

"As soon as anyone challenges the system, they are accused of not caring for their patients.

"The rigid rules by which wards are run breeds arrogance, pettiness and an atmosphere in which people are played off against one another," she said.

RDM 14/2/84 (85)

Asbestos in water 'no threat'

Mail Correspondent

CAPE TOWN. — Asbestos fibres in our drinking water present no health threat at all, a leading British environmental and pollution consultant, Dr B T Commins, said in Cape Town yesterday.

"Ingesting asbestos in drinking water is, at very most, an exceedingly low health risk," he said.

Dr Commins, author of many publications on pollution in air and water, was brought to South Africa by the South African Fibre Reinforced Cement Manufacturers Association, to which the major South African asbestos producers belong.

He is here on a 10-day lecture tour during which he will visit Cape Town, Port Elizabeth, East London, Johannesburg, Windhoek, Pretoria and Bloemfontein, speaking to engineers and health officials.

Dr Commins said that the negligible dangers of ingesting asbestos fibres are "in sharp contrast" to the issue of inhaled asbestos, which can over a lengthy period cause lung diseases such as asbestosis, lung cancer and mesothelioma.

"Under normal conditions, humans ingest about 0,02 micrograms per day of asbestos in water carried by fibre-cement pipes," he said. "Scientific experiments on animals have proved that massive doses of 15 grams and more a day do not constitute a danger."

		(i) Granted	(ii) Refused
(3) (a)	(i) Applications in general	10	5
	(ii) Applications in a particular case	2	0
	(iii) Applications of a particular nature	9	1

(b) Applications in general:

Five applications were refused because the applicants applied to exhibit the films in commercial theatres.

Two applications were not promoted as in one case the applicant was requested to supply further particulars which were not submitted and in the other case the provisions of the relevant Act were not applicable.

Applications in a particular case:

No applications were refused. Two applicants were requested to furnish further particulars.

Applications of a particular nature:

The application was refused because the applicant applied to exhibit the film in a commercial theatre.

In so far as the above-mentioned classification is concerned, it is assumed that applications "in general" refer to those applications in respect of which consent was requested for general permission to exhibit films on Sundays, or in respect of which consent was requested for general permission to exhibit films on one or two Sundays per month. In so far as applications "in a particular case" are concerned, it is assumed that these refer to applications to exhibit films on Sundays on specific dates. In so far as applications "in cases of a particular nature" are concerned, it is assumed that these refer to applications to exhibit films of a particular category on Sundays, for example regligious and cultural films and films in the Indian or Greek language.

Magistrates' courts: administrative posts

14. Mr D J DALLING asked the Minister of Justice:

(1) (a) How many posts are there on the establishment of his Department for administrative staff attached to magistrates' courts and (b) how many vacancies are there in respect of these posts at present;

(2) whether any of these posts are filled by persons who are not in possession of the requisite qualifications; if so, (a) how many and (b) what are their qualifications?

The MINISTER OF JUSTICE:

(1) (a) 2 171.

(b) 70.

(2) Yes.

(a) 131.

(b) Std 6 to 9.

Hansard 15/2/84
Alexandra Township
Q. Col. 180

20. Mr D J DALLING asked the Minister of Co-operation and Development:

(a) What stage had been reached as at 31 December 1983 in the development and replanning of Alexandra Township, as referred to in his reply to Question No 16 on 2 February 1983, (b) what stages are due for completion in 1984 and (c) when is it anticipated that the project will be completed?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(a) The following projects have been completed:

Leveling and compaction of the area at a cost of fifty thousand rands (R50 000), installation of water reticulation system, sewerage system, roads and storm water drainage (one comma three million rands -R1,3 million), erection of 79 houses (one comma nine million rands—R1,9 million) and construction of ring road (five hundred thousand rands—R500 000). 65 houses were built by private developers.

(b) The erection of 324 flats at a cost of six comma one million rands (R6,1 million), installation of water and sewerage systems to provide for another 1 214 houses and 104 flats—(three hundred thousand rands—R300 000) and the first phase of electrification (nine hundred thousand rands—R900 000).

(c) This will depend on the availability of funds and cannot be determined at this stage.

Hansard
Sandton/Alexandra: removals
Q. Col. 181 15/2/84

21. Mr D J DALLING asked the Minister of Co-operation and Development:

(1) How many Black persons were removed to the (a) national states and (b) independent Black states from (i) the Sandton area and (ii) Alexandra Township in 1983;

(2) how many of these persons were removed (a) voluntarily and (b) by decree or court order or in terms of other legal provisions?

The MINISTER OF CO-OPERATION AND DEVELOPMENT:

(1) (a) (i) 24.

(ii) 8.

(b) (i) 18.

(ii) 5.

(2) (a) 28.

(b) 27.

85
Infant mortality rate
Hansard Q. Col. 182

56. Dr M S BARNARD asked the Minister of Constitutional Development and Planning:

What was the infant mortality rate for (a) Blacks, (b) Coloureds, (c) Indians and (d) Whites in the Republic in 1981, 1982 and 1983, respectively?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

	1981	1982	1983
(a)	80	80	Not available
(b)	59,2	59,2	Not available
(c)	18,8	20,7	Not available
(d)	13,3	13,4	Not available

The figures in (a) are estimates based on available information.

The basic data for the calculation of rates for 1983 are not available as tabulations have not been finalised as yet.

The infant mortality rate represents the number of children who died before reaching the age of one year per 1 000 live births.

Hansard 15/2/84
Executions
Q. Col. 182

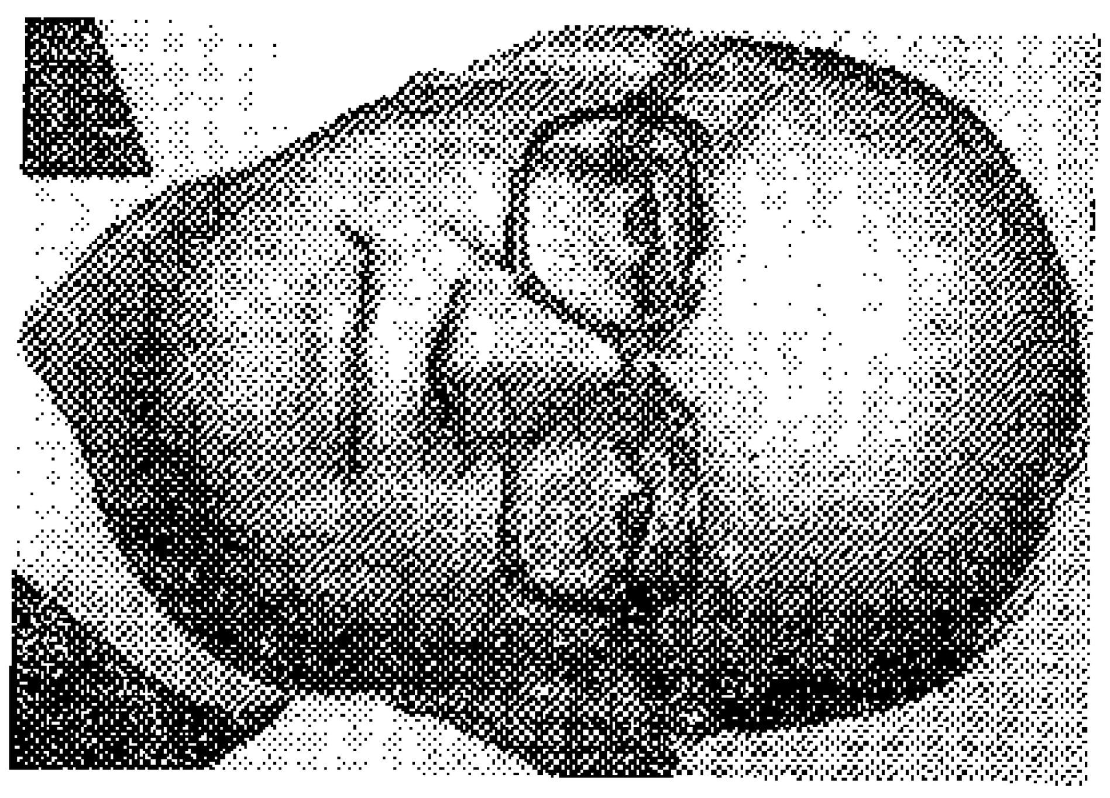
68. Mrs H SUZMAN asked the Minister of Justice:

(a) How many (i) males and (ii) females of each race group were executed in the Republic in 1983 and (b) for what crime or crimes had each death sentence been imposed?

Drugs: Patients to save millions

New deal will slash cost of medicines to public

By GRAHAM FERREIRA



☐ Van der Merwe
. . . top level talks

SWEEPING changes in the prescription of medicines which will save patients millions of rands are being hammered out at top level discussions.

Officials from the Department of Health and Welfare, the pharmaceutical industry, medical aid societies, and the medical profession, are working on the new deal. Under it:

■ Doctors will be urged to prescribe basic or "generic" drugs rather than more expensive brand name medicines. (Prescribing "penicillin" and "aspirin" instead of their specific commercial formulations are an example of this).

■ Pharmacists will have the right to substitute cheaper but equally effective drugs where doctors prescribe the more expensive brand name equivalents.

■ Market forces which currently distort the prices of some drugs will be eliminated.

An investigation by the Tribune this week revealed that in certain cases some patients are paying up to three-and-a-half times as much for exactly the same drug as other patients.

Chairman of the Pharmaceutical Society of South Africa, Mr Don Sutherland, said his organisation had been advocating a rationalisation for years.

"We have a case in point to illustrate what we are saying. There is a drug on the market which is being sold by a reputable manufacturer. But one of the sales outlets is paying R52 for a thousand capsules, while the average retailer is forced to pay R86,60 for 500 (nearly three-and-a-half times as much). Obviously this is a case where marketing principles are taking precedent over the community's health."

A source close to the pharmaceutical industry said this week that in many instances the industry gave huge financial incentives by way of cut prices to certain bulk buying groups, for example dispensing doctors, while the prices of the same drugs to other dispensers was pushed up to make up the shortfall. Some patients were thus having to subsidise others, depending on which doctor they happened to go to.

A spokesman for the Medical Association of South Africa said they were aware of the problem but could not make a further statement at this stage.

The Minister of Health, Dr C V van der Merwe, is engaged in "delicate negotiations" with representatives of pharmaceutical industry, professional bodies and Government officials, and is structuring a new deal for patients which will drastically reduce the cost of medicine.

In an interview with The Tribune this week

To Page 3

gets jail

A JAIL sentence of 12 years was imposed in a Pretoria Regional Court on a Ga-Rankuwa man who issued bomb threats to a police station.

Andrew Mokgapa (20), of Zone Three, Ga-Rankuwa, pleaded guilty to issuing four bomb threats during December last year.

Warrant-Officer J H Barnard, investigating the case, told the court how the Gezina police station had received two telephone calls from a man who warned them a bomb was set to explode in the building.

Warrant-officer Barnard testified that the bomb squad had to be called out to search the station and the Post Office was called in to help trace the calls.

He said the conversations with the man lasted for two to three hours at a time and blocked the only line to the police station's charge office.

In sentencing Mokgapa, the magistrate, Mr H F Bosman, said the law provided for a minimum three-year prison sentence for first offenders in this type of case.

He sentenced Mokgapa to the minimum three-year sentence on each of the four charges but ordered that the sentences all run concurrently. Mokgapa will serve an effective three years imprisonment.

Mrs Slabbert's paper

MRS MANA Slabbert, a criminologist at the University of Cape Town, will deliver a paper on Law and Order in an Apartheid Society, at the opening of the national conference of the Black Sash today.

The paper will be delivered at a public meeting at St Martin's in the Veld, at Cradock Avenue, Rosebank, at 7.30 pm. Mrs Slabbert is the former wife of the opposition leader, Dr Frederick van Zyl Slabbert.

Azapo looks at the people's health

THE Azanian People's Organisation, Azapo, has produced a handbook on health that is aimed at increasing health consciousness in the community.

In a foreword to the handbook, the organisation says the vast majority of blacks enjoyed no health facilities, while whites had facilities that compared well with those in first world countries.

Black urban dwellers have facilities provided so that they should be able to oil the industrial machinery that brings wealth to the country, and also because they come into daily contact with employers.

Neglected

"In rural areas the picture is totally different. These are the most neglected areas. This is because when blacks are no longer of use in the towns and cities they are sent to these dumping grounds to complete their lifespan," the foreword said.

This state of affairs will only be improved when a truly representative government was established, Azapo says.

The handbook, which is well illustrated, is mainly the work of Azapo's health secretariat and can be obtained at the organisation's offices at 208 Bree Street, Johannesburg.

New medical tariff scheme will lead to chaos — PFP

Parliamentary Staff

THE PROPOSED new system of determining medical tariffs according to free market principles will lead to "chaos", the official opposition has warned.

The Medical Schemes Amendment Bill, which was introduced in the Assembly yesterday, was slammed by the official opposition and the Conservative Party which believes it is the first step towards a Socialist medical service.

According to the Bill, doctors' and dentists' tariffs will no longer be determined by the SA Medical and Dental Council, but through negotiations between medical aid schemes and medical practitioners.

Introducing the second reading debate on the Bill, the Ministe Of Health and Welfare, Dr Nak van der Merwe, said the present system was clumsy and had been severely criticised.

The Minister was placed in an insiduous position in approving tariffs because he had to judge on conflicting evidence.

IGNORED

Medical schemes believed they were being ignored, while medical partitioners regarded the Minister as "the fly in the ointment".

With the new system, all red tape and friction would be removed. An additional advantage was that pratitioners and medical schemes had to negotiate, but each would act independently if there was a deadlock.

The market mechanism would force the parties to act realistically in determining fees, he said.

Dr Marius Barnard (PFP Parktown) said the Medical Association was not 100 percent happy with the Bill, while the association of private hospitals was very unhappy with the provisions of the Bill.

Moving an amendment that the Bill be referred to a Select Committee, Dr Marius Barnard (PFP Parktown) said the bill gave medical schemes the final power in determining fees.

There was a danger that the parties would not agree and without controls there would be chaos.

Dr M H Veldman (NP Rustenburg) said doctors and dentists were happy with the Bill. The medical profession did not want the State to meddle in its affairs.

In addition the "unsavoury" seasonal debates on tariff increases could now be done away with.

Mr W J Snyman (C P Pietersburg) said the Bill would leave medical practitioners without any bargaining power. In the final analysis, medical schemes would take a one-sided decision on tariffs.

The Conservative Party viewed the masure as a step towards a Socialist system of medical services, and this was unacceptable.

"It is unacceptable because quality and initiative will suffer and it will cost tax payers more," he said.

Mr A G Thompson (NRP South Coast) rejected earlier claims that doctors were unhappy about the system. The legal advisor of the Medical Association had told the NRP that the association was "99 percent happy" with the Bill.

The NR P would support the Bill because the free market system would be put into effect where the suplier of a service and the recipient could negotiate on tariffs without interference from the Minister.

The present system was degrading for the prefession because they continually had to haggle about tariffs.

Ultimately the new system would benefit John Citizen, he said.

Replying to the debate, the Minister of Health, Dr Nak van der Merwe said the bill did not concern more money for medical practitioners but their right to organise their own affairs.

The Bill was read a second time with the PFP and the CP voting against it.

Office ventilation hazards investigated

By MIKE JENSEN

WITH the growing tendency toward sealed, energy efficient buildings, recent studies on air quality and worker productivity have cast serious doubts on current ventilation practices.

As energy prices have grown over the last decade building designers have increasingly tended to minimise the amount of fresh air entering buildings to reduce the costs of heating or cooling it.

The effect of this on office workers is now being studied abroad and it seems the loss of office worker productivity may far outweigh any fuel savings.

While almost no work has been done on this problem in South Africa, ventilation standards are virtually the same as those in North America and concern is mounting with the rapidly increasing number of older, windowed buildings being pulled down and sealed blocks erected in their place.

The result is itchy eyes and skin, respiratory problems, headaches, nausea and a dozen other physical and psychological complaints, which have earned the syndrome a name — tight building syndrome, or TBS.

TBS appears to be shrouded in corporate secrecy. A source at the United States National Institute of Occupational Safety and Health (NIOSH) says most companies are proceeding covertly because "it threatens to become another labour issue like video display terminal emissions, or worse."

"Long-term health hazards are unknown and legal aspects are unclear."

Companies are even secretive about studies conducted on their own operations in the wake of declining productivity. Typically, research firms are sworn to secrecy, the employees know nothing about it and the public is also unaware.

In the industrial and manufacturing fields, where effects of environmental contaminants are more dramatic, most of the necessary work has been done already. Factories are typically well-ventilated and well inspected. Where there is air contamination it is usually a temporary condition.

But researchers have counted 153 airborne contaminants in sealed office buildings and suspect dozens or even hundreds more will be added to the list. Even lighting can contribute to bad air and TBS.

Most of the contaminants identified are gases of the hydrocarbon family. Varying in toxicity, these are common but pose a mystery to science as they assume complex new forms which may have long-term effects on people's health.

Such substances are emitted by office copiers (among the worst offenders), synthetic carpets, curtains, wall or ceiling furniture or fixtures.

Also, there is carbon monoxide (usually from parking garages beneath the building), carbon dioxide, nitrous and sulphurous oxides, asbestos fibres, atmospheric wastes from neighbouring industry and a host of other gases and substances.

The use of air recirculation systems to mix a small amount of fresh air with stale reconditioned air results in contaminants and toxins being recirculated through the building.

And there is the synergistic effect of the contaminants, the implications of which have scientists reeling. The contaminants recombine to form new compounds — the action of one compound precipitating a negative health effect by a second and third.

Studies at the Lawrence Berkeley Laboratory at the University of California, Los Angeles strongly suggest the synergistic effect among the large numbers of trace organics may be the key to TBS.

A study, recently published in the Canadian Journal of Public Health, showed fresh air alone was not enough to help TBS sufferers in one Vancouver office tower.

However, when this was combined with a reduction of the high ultraviolet output from office light, TBS symptoms were six times less prevalent.

'Restructuring' of health system needed

Staff Reporter

A FUNDAMENTAL restructuring of the entire medical system is needed to alleviate the current health-care crisis in South Africa, according to a study prepared for the Carnegie conference on poverty which opens in Cape Town tonight.

Mr Pundy Pillay, of the South African Labour and Development Research Unit at UCT, says the training of more doctors, nurses and dentists will not ease the chronic shortage and poor distribution of medical personnel in South Africa unless it is linked to the provision of an effective primary rural health-care system.

Pyramid-shaped system

He says the rural sector economy is unable to support a primary health-care system based on professional personnel and proposes a "pyramid-shaped" system, in which a broad base of non-professional community health workers will deal with 40 percent of the demand for care and refer the rest to progressively smaller layers of specialized institutions.

Mr Pillay describes the current health structure in South Africa as fragmented and poorly distributed in relation to health needs".

'Third World' structure

One sector of the population (urban and largely white) has a First World health system while the other (the homelands and rural areas, largely black) has a typical Third World health structure.

"The main failure of the health system is its inability to provide an adequate service to the population as a whole."

He says that only 5,5 percent of South African doctors practise in the rural areas where 50 percent of the population live.

Change in 'political control'

The situation is particularly bad in the homelands where, in 1976, the doctor-population ratio was about 1:174 000.

In his conclusion Mr Pillay concedes that it is unlikely that a more equitable distribution of resources will occur within the health sector without fundamental changes in the mechanisms of economic and political control in South Africa.

SECOND CARNEGIE INQUIRY INTO POVERTY

Bid to save Cape children, mothers

W/ARGUS 14/4/86 ~~SATURDAY~~ pg ~~1~~

Reports by DAVID BRIER
Weekend Argus Staff

AN extended scheme to supplement the food of mothers and children in the Cape has been proposed by Dr L R Tibbit, the Medical Officer of Health of the Cape Divisional Council.

In a paper presented to the second Carnegie inquiry into poverty and development in Southern Africa, Dr Tibbit proposes extended food supplements to both pre-school and schoolchildren, as well as to mothers.

The paper — written with Mr Michael Rip of the Department of Community Health of the University of Cape Town Medical School — reports low birth-weights and high infant mortality rates for coloured babies in the Peninsula.

In 1982, 68,4 percent of infant mortalities took place among coloured people, 26,1 among African people and only 5,5 percent among whites in the area studied by the Divisional Council.

Increasing mortality

Infant mortality among coloured people has shown signs of increasing, while the rate for whites and Africans is dropping.

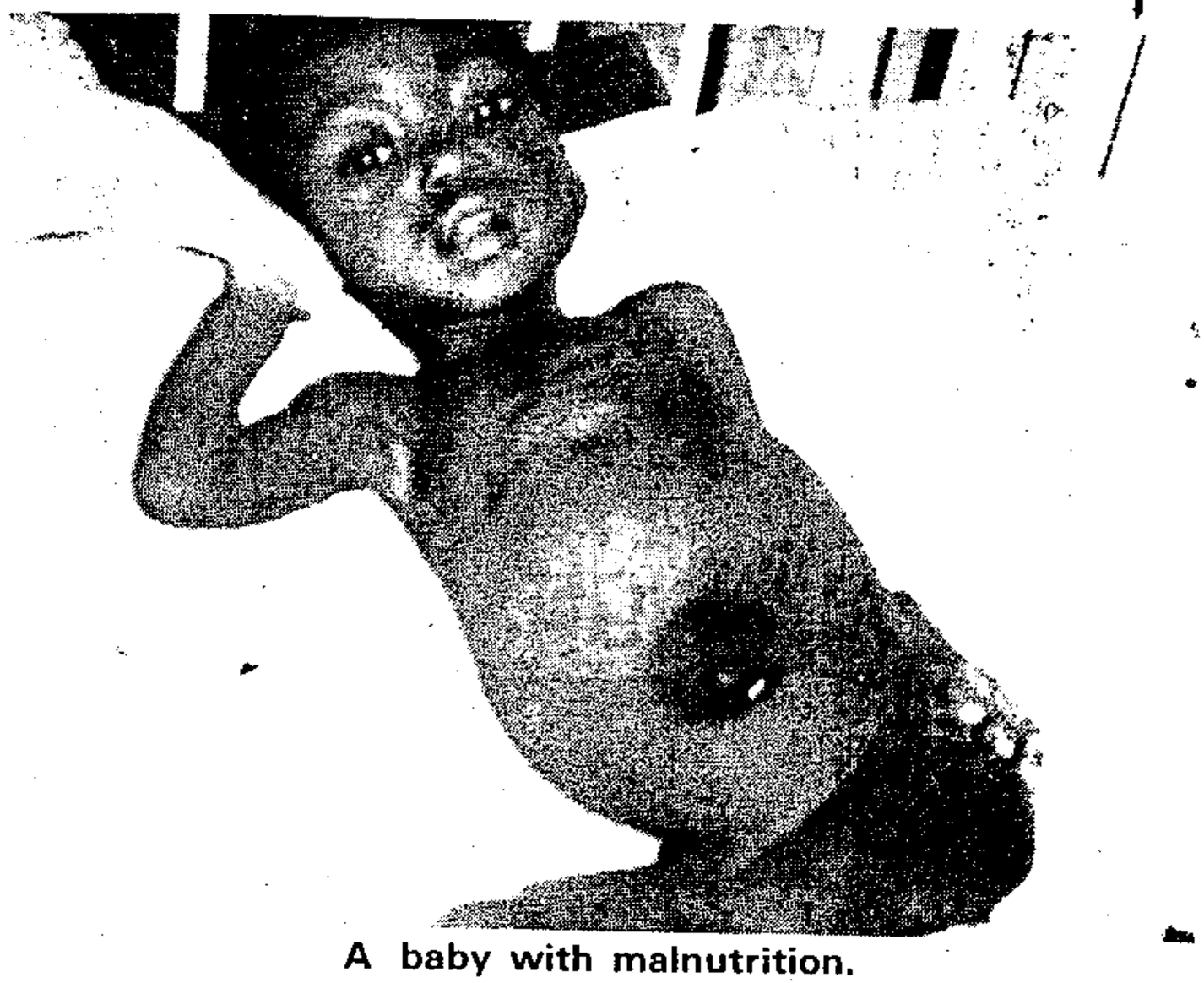
The paper shows a clear connection between low birth-weights and infant deaths.

Dr Tibbit reported that as many as a third of people born underweight due to maternal undernutrition, alcohol intake and smoking, never reach intellectual maturity.

They lack will

"This leads to the fact that they often do not have the intelligence to succeed at work later in their lives, lack the will and physical strength to win and tend to live desultory lives.

"This again leads to alcoholism and poor nutrition, which interferes with their chances of ever leading a productive life," he added.



A baby with malnutrition.

Scurvy lives on . . .

IT was incredible that a disease such as scurvy should still occur in Cape Town, Dr Stuart Saunders, vice-chancellor of the University of Cape Town, said in the city last night.

He was opening the inquiry into poverty.

Dr Saunders said he had seen children die of kwashiorkor and marasmus in Cape Town. He had seen children whose physical and intellectual development had been impeded by lack of essential nutrients.

"I have had a patient who packed apples on an apple farm and contracted scurvy. When I asked him how it was that he did not eat the apples which would have prevented him from getting scurvy, he told me the apples were for the white man.

"It is incredible that scurvy should still occur in Cape Town, a city founded to provide the fresh fruit and vegetables to prevent it," he said.

Dr Saunders said he had seen people in the city with beri-beri and pellagra.

"Every week I see the ravages of tuberculosis, which is sweeping through the rural areas and the overcrowded poor urban areas of this country like an epidemic.

"It is a preventable disease and its frightening incidence in South African blacks is a serious reflection on us all."

The dominant cause was not the tubercle bacillus, but poverty, he added.

"I have seen typhoid and amoebiasis in Cape Town, largely and almost exclusively among those people who do not have access to water from a tap, but very rarely among the citizens of Bishopscourt or Rondebosch."

Joint disease plagues Zulus

Mail Correspondent

CAPE TOWN. — A mysterious joint disease, peculiar to the Mseleni River area in northeast Kwazulu, is bringing enormous physical and economic distress to inhabitants.

The suffering caused by the disease, which is progressive and results in total immobility in its final stages, is documented in one of the papers submitted to the Second Carnegie Inquiry into Poverty and Development.

The author of the paper, the Medical Superintendent at Mseleni Hospital, Dr David Mann, appealed to the conference not to regard the disease as a "fascinating epidemiological phenomenon" but as a deep human problem affecting 3 008 sufferers.

The disease affects more women than men and is described as a "crippling multi-joint disease of unknown cause".

"The first symptom is pain, then follows progressive stiffness and limitation of movement. Pain is however always a major feature of the disease.

"The severity of the disease has been graded according to walking ability — good, limp, one stick, two sticks, crawl, immobile."

Daily tasks such as water collection become more and more difficult and sufferers must either pay others to perform these tasks or place an added burden on healthy members of the family.

Opportunities for employment in the area are negligible and households are heavily dependent on income from pensions, though less than half those entitled to financial assistance for disability and old age receive it.

In his conclusion, Dr Mann calls for a "major co-ordinated" response. He recommends that the extra R3 200 000 due to pensioners in the area be provided without prejudicing other essential health services and that more water collection points be provided.

Trained social workers should be appointed, opportunities for employment investigated and an orthopaedic centre established, Dr Mann says.

Executive stress rapped as myth

CAPE TOWN. — Executive stress was largely a myth, Dr Tim Noakes of the University of Cape Town Sports Science Centre, said yesterday.

Speaking to the Graduate School of Business Association, Dr Noakes said the myth was perpetuated by executives to justify their claims of working too hard.

"Executives are not exposed to the stress of survival," he said.

"Your stresses are largely of your own making and you can use your intelligence and finances to cope with them."

Executives had a far lower incidence of heart disease than middle and lower working levels, he said.

It had been found in the United States that the incidence among executives was one-sixth of that among menial workers.

The stress suffered by executives was not very dangerous and was caused by mismanagement, he said.

People should also remember that they could not expect to carry on their work — or sport training — at the same level forever.

"We peak for a good performance and then slack off. You have to plan for your peaks and valleys," he said.

If executives wished to work to the maximum, they should stay in good physical shape.

'Health Bonds' to be debated

Staff Reporter

A SCHEME for collecting funds for health and welfare services, similar to the current Bonus Bond system, will be proposed to the Provincial Council today at the start of its May-June session.

The opposition spokesman on health in the council, Dr John Sonnenberg of Green Point, has given notice of a motion requesting the Administrator of the Cape, Mr Gene Louw, to ask the government to investigate selling "health bonds" to raise money "specifically" for health and welfare services.

'Shortage'

In his notice of motion Dr Sonnenberg refers to the "chronic shortage of funds which militates against the provision of an adequate health-care system for all the inhabitants of the Republic of South Africa".

During the four-week session, the council will also be asked to approve a budget of R1 771-million for the Cape for the next financial year.

This figure is 16 percent up on last year's budget but this is in line with the central government's increase in estimates and most of the extra revenue is expected to be provided by the government subsidy.

Mr Louw will make his budget speech tomorrow afternoon, but the budget debate will be adjourned until Monday. He is expected to budget for a deficit in the hope that the economic situation will improve sufficiently next year to make up the shortfall.

Other items to be debated during the session include the opposition's motion of no confidence in the government, an amendment to the Education Ordinance to allow married women teachers to retain their posts, and the controversial Land Use Planning draft ordinance which was referred to a select committee for consideration after its first reading during the February session.

... was allowed. — Sapa

CAPE TIMES 15/5/84

Dept 'asked not to attend conference'

HOUSE OF ASSEMBLY. — The Department of Health and Welfare had been asked "in a very friendly way" not to attend a University of Cape Town conference on rural poverty, the Minister, Dr Nak van der Merwe, said yesterday.

Speaking during debate on his portfolio, he said he believed the findings of the Carnegie investigation could be of value if they were evaluated on scientific grounds and not used to make political points.

It worried him, however, that the department, the Medical Research Council of South Africa and the Council for Scientific and Industrial Research had not been represented at the conference.

None of the papers presented had mentioned the tremendous increase in population in South Africa and researchers had made frequent reference to "bantustans" and "the Pretoria regime".

"I don't know where they (bantustans) are in South Africa or what that (Pretoria regime) is," Dr Van der Merwe said.

He also criticized the university for deciding to send papers and related photographs from the conference to libraries worldwide.

"Do these people want to solve the problems of poverty in South Africa or are they trying to attain other goals?" — Sapa

UCT study on poverty called 'flagrantly unscientific'

Parliamentary Staff

THE University of Cape Town's Carnegie study on rural poverty has again come under fire in the Assembly.

The Minister of Health and Welfare, Dr Nak van der Merwe, and Dr Jan Grobler (NP Brits) criticised the study during the debate on the health and welfare vote.

The study was described by Dr Grobler as "flagrantly unscientific", politically one-sided and "naive".

DEPARTMENTS

He said Government departments, such as the Departments of Health and Welfare, Co-operation and Development and Internal Affairs, should have been invited to contribute to the study.

The Prime Minister also slammed the study recently.

Comparing the first Carnegie inquiry into the "poor white question" to the inquiry into rural poverty, Dr Grobler said the most important outcome of the first inquiry was the solution of the "poor white" problem.

NAIVE HOPE

But in the second inquiry, which was still being completed, there was "an almost naive hope that the problem would be solved if everyone only did their duty".

The answer to the problem of poverty lay in development: industrial and educational development.

Later, Dr van der Merwe said the researchers had not touched on the population explosion — one of the basic problems and causes of poverty.

"But they frequently referred to Bantustans and the Pretoria regime."

Dr van der Merwe said the findings of the conference could be useful "depending on whether the facts are handled in a scientific way or whether they are used for political ends".

CONSPICUOUS

Most of the papers delivered at the conference concerned health and poverty, but the department was conspicuous by its absence.

He said the department had, in fact, been asked "in a friendly manner" not to attend.

Dr van der Merwe added that neither the Medical Research Council nor the CSIR had been invited.

Increased GST on medicines extra burden for sick — PFP

Parliamentary Staff

THE increase in general sales tax (GST) would be an extra burden for sick people in the form of higher medicine prices, the Assembly has been told.

Dr Marius Barnard (PFP Parktown) said he did not think it was right that sick people should be a source of tax revenue for the Government.

Dr Marius Barnard

COMPETITION

The high cost of medicines and health services was a major theme in yesterday's debate on the Health and Welfare budget vote.

Dr Barnard said there was a need for a new health care system in South Africa similar to that in Japan, where competition among doctors and group practices was allowed.

Japan had achieved better results in health care than the United States, for example, which spent three times as much a person on medical services.

This showed that modern medicine could produce cheap health, but modern politics did not allow it to do so.

The Japanese concentrated on keeping workers healthy rather than treating them only after they became ill.

ONLY ONE

Dr J J Vilonel (NP nominated) said the cost of medicines was only one item in total medical costs. This aspect of cost should not be over-emphasised, but should be considered as part of a larger problem.

Medical costs also included hospital treatment, the training of doctors and the prevention of disease.

The Minister of Health and Welfare, Dr Nak van der Merwe, said it was the Government's intention to work towards a system under which medicines could become cheaper through a system of free competition. This could save patients millions of rands.

FAMILY PLANNING

Speakers in yesterday's debate also called for additional State action to encourage family planning.

Mr Aubrey Thompson (NRP South Coast) said ways had to be found to curb South Africa's population growth, which was one of the highest in the world.

Family planning should be made available at every level, he said.

Mr Horace van Rensburg (PFP Bryanston) said Africa's population had almost doubled in the past 25 years. Meanwhile, food production was not increasing and vast areas of grazing were being destroyed every year.

More money should be spent on publicity about family planning.

Mr van Rensburg also suggested that more people, especially men, should be encouraged to undergo sterilisation.

Health services 'dog's breakfast'

ARGUS 15/5/84

85

Parliamentary Staff

THE Government has been criticised in the Assembly for failing to spell out how South Africa's health services would be run under the new constitutional dispensation.

Mr Horace van Rensburg (PFP Bryanston) said the Government would not be able to implement the new constitutional "dog's breakfast", which provided for separate health services for the various race groups.

With the new constitutional system only about three months away, it had been expected that the Minister of Health, Dr Nak van der Merwe, would give the Assembly a comprehensive picture of how the present system would be phased out and the new health services phased in.

The Minister had not done so.

Reacting to a remark by the Minister that hospitals could not be cut up into sections for different race groups, Mr van Rensburg said the Minister should have said so when the new constitution was debated.

"It shows how impossible it is to implement the new constitution," Mr van Rensburg added.

He asked whether, under the new dispensation, there would be a Minister for "general" health services, as well as separate Ministers for coloured, Indian and black health services.

Vastly expensive

Would each Minister have his own department, hospitals, doctors and distribution of medicines ?

If so, it would be a completely impracticable and "vastly expensive" system.

Mr van Rensburg called on the Government to abandon the concept of "own" health services for the various race groups.

Instead, a system of "general" health services should be evolved.

Few coloured and Indian people were in favour of the idea of "own" health services.

Earlier, Dr Marius Barnard (PFP Parktown) said his party believed segregation in health was "totally unnecessary".

Dr Nak van der Merwe

Separate health departments for each race group in the new constitutional system would lead to further fragmentation of health services in South Africa. This would lead to greater costs in terms of money and manpower.

Opening yesterday's debate on the Health and Welfare budget vote, Dr van der Merwe said it was not possible at this stage to spell out in detail how health services would be structured under the new dispensation.

The provision of health services was divided between the three tiers of government. There was no finality on the future system because the position of provincial and local government was still uncertain.

Services were being provided to the 38 black local authorities on an agency basis.

Umbrella plan

There would have to be "umbrella" planning in the provision of services, and hospital services would have to be developed over the years.

Decisions would have to be taken on where exactly control of specific health services would be placed.

It would not be possible in the case of Tygerberg Hospital, for example, to "cut the hospital in half" and to give one section to whites and one to non-whites.

Dr van der Merwe said he could not envisage that health services would be "dismantled and divided" to a large extent under the new system.

Niehaus (297)
Spiegel and Sharp (52)
Sharp and Martiny (286)
Bank (282)
Beukes (230)

GROUP NO 15
Transvaal 2

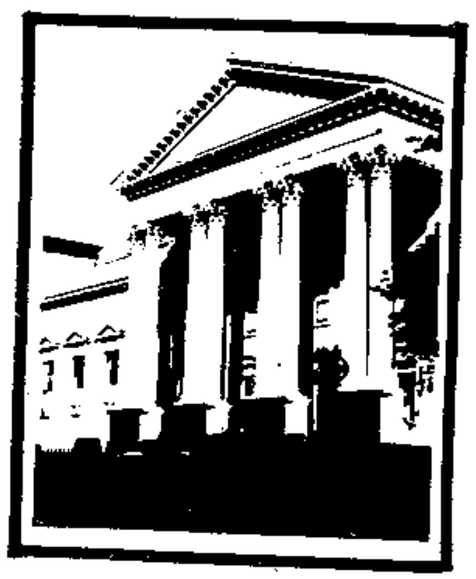
Moodie and Golino (251)
Moodie and Golino (252)
Bopape (65)
Graaff (60)
Parnell and Mabin (62)

GROUP NO 16
QwaQwa

Parliament and Politics

Minister: No finality on new-deal health system

CAPE TIMES 15/5/84 (85)



HOUSE OF ASSEMBLY. — It was impossible to give an accurate picture at present of the structure of health services in the new dispensation, but he did not foresee large-scale disruptions of the present system, the Minister of Health and Welfare, Dr Nak van der Merwe, said yesterday.

The provision of health services was divided to varying degrees between the three tiers of government, and there was no finality on the future system because the position of provincial and local government was still uncertain, he said at the start of his portfolio debate.

Earlier, the minister said South Africa was in a unique position regarding its health services.

It was a Third World country which boasted some of the world's medical firsts by top-ranking doctors, but at the same time it had problems like cholera due to under-development and poor living conditions.

His department's task was a two-pronged one, to provide personal and community health services, but this was enormously costly and projections indicated some R10 billion would be needed annually by the end of the century.

The questions obviously arose whether this could be afforded and whether suitably qualified manpower was available.

It was clear, Dr Van der Merwe said, that health services had to be taken to the people, and it had been decided to establish community health centres throughout the country.

Many were being built now, with much progress being made in the Cape.

The advantage of this system was that up to 80 percent of the patients at these centres were being attended to and treated by a nurse only — "and the patients are very happy too", he said.

This left the doctors free to attend to cases, referred to them by the nurse, at regional hospitals.

When it was considered there were more than 60 000 registered nurses in South Africa, it would be realized just how comprehensive a service could be brought to the people, the minister said. — Sapa

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ny Chauvier, said their decision to back the team fell in line with a policy of providing sportsmen with the chance of competing against the world's best.

The Worrell 1 000 was first sailed in 1976, a year after restaurant owner Michael Worrell sailed from Virgina Beach to Fort Lauderdale in a small catamaran on what started out as a 'prolonged day sail'.

Ancient tombs bulldozed

MOSCOW. — Road builders keen to keep to a construction plan bulldozed ancient burial mounds in Siberia, although they knew their historical value, a Soviet newspaper reported.

The builders, who used the mounds as hardcore for the new road bed, were an example of a growing number of construction teams who considered conserving relics an "undesirable factor" that hindered their work, Izvestia reported.— Sapa-Reuter.

UCT Carnegie inquiry: Wilson replies to Minister

ARGUS 15/5/84 p4 85

THE Department of Health and Welfare had at "no stage" been asked to stay away from a University of Cape Town conference on rural poverty, Professor Francis Wilson, director of the second Carnegie inquiry into poverty and development in Southern Africa, said.

In response to the Minister of Health's speech during the debate on his vote in Parliament last night, Professor Wilson said in Cape Town he wanted to make the following points:

"At no stage was the Department of Health and Welfare ever asked to stay away.

NOT CORRECT

"Nor is it correct that the critical issue of population growth and poverty was not touched on in the investigation.

"Indeed, an important paper on poverty and contraception was delivered by a senior medical officer of the Western Cape regional office of the Minister's own department, who played an active part in the conference.

"Moreover, a number of other papers pertaining to health and poverty issues around the country were written and delivered by medical personnel employed in one capacity or another by various branches of the country's State health services.

TWO PAPERS

"Regarding the Minister's statement that neither the Medical Research Council nor the CSIR were there, the facts are as follows:

"Two papers were written and delivered at the conference by doctors attached to the Medical Research Council.

"And as regards the CSIR, with whom the research unit responsible for organising the conference has very good links, a special invitation was extended but, unfortunately, at the last moment, the person who had accepted the invitation was unable to come.

LETTER FILED

"The relevant letter from the CSIR, dated April 11 1984 and wishing us a very creative and successful conference, is on our files.

"With regard to the distribution of conference papers as widely as possible, it is important to note that these preliminary findings of a scientific and scholarly investigation have been published with library catalogue (ISBN) numbers, which ensures that they are immediately deposited in a number of key South African libraries.

"From there it is only natural that as part of a worldwide academic community we should wish them to go further afield." — Sapa.

● UCT study "flagrantly unscientific" — Page 18.

Five bullet holes found in radiator of journalist's car

Argus Bureau

PORT ELIZABETH. — A journalist who took her car to a garage to have an overheating problem attended to was told that the radiator had five 9 mm bullet holes in it.

Miss Deirdre Moyle, 27, a sub-editor on the Eastern Province Herald, learnt of the bullet holes when the head of the Port Elizabeth murder and robbery squad, Colonel Eric Strydom, interviewed her after he had been notified by the garage owner.

Last month the brake cables on Miss Moyle's car were cut and last year the exhaust, door and boot locks were sealed with putty.

Miss Moyle said she stopped at the first garage she came to yesterday when the car's temperature gauge went into the red.

"I haven't even seen the holes yet. I learnt of them only when Colonel Strydom phoned me at work."

Miss Moyle said she had no idea who was responsible for the damage to her car.

Cuba planning big offensive, says US

Argus Foreign Service

WASHINGTON. — Cuba plans to launch a large-scale guerrilla offensive in El Salvador during the United States presidential election towards the end of this year, says President Reagan's national security adviser, Mr Robert McFarlane.

Intelligence information indicated that the Cubans planned to double the scope of the operations of the leftist guerrillas trying to overthrow the El Salvador Government, he added.

Appearing on television, he urged increased military aid to El Salvador to help beat off the guerrillas.

secure bases and infiltration routes in neighbouring countries. The nationalist leaders much closer to home.

Carnegie inquiry

CAPE TIMES 16/5/84 85

IT is curious that the Nationalist Government should have adopted a consistently negative attitude towards the second Carnegie investigation. The most recent instance was in the House of Assembly this week when the Minister of Health, Dr Nak van der Merwe, criticized the recent Carnegie conference at the University of Cape Town, which was held as part of the investigation. Dr Van der Merwe objected to the terminology of some researchers who presented papers at the conference and who had spoken about "Bantustans" and the "Pretoria regime". Dr Van der Merwe was also unhappy about the fact that conference papers and photographs had been distributed to libraries world-wide. The Carnegie Foundation has rendered such good service to South Africa in the past in sponsoring social research that it is odd that the current investigation should be so mistrusted. A scientific conference to be worthy of the name should include scholars and investigators holding varied ideological views rather than be drawn only from among those who uphold a prevailing orthodoxy. The major advances in social or technological science invariably result from the interaction between competing views, including those which are officially disapproved.

new play, unexpected spring rain

Ada

Krismis van Map Jacobs. By Ada berg)

Skaak. by M C Botha (Human &

WITH his excellent play "Kanna Hy Kô Hystoe" Adam Small pioneered a renaissance in social drama on the Cape Flats. Recently Peter Snijders' satire, "Political Joke" was published, and Melvyn Whiteboy's "Dit Sal die Blerrie Dag Wees" was performed at the Baxter.

After quite a silence Adam Small has now published a new play "Krismis van Map Jacobs". It is once again social realism with the theme of people pulled out of District Six or the homes of their birth to be flung out to the Cape Flats amid all sorts of displaced people preyed on by skollies.

This is a play of social protest, of a man working himself to the bone to be able to "buy" his family out of the degrading neighbourhood they were forced into; of a young girl; of a gang leader in jail, Map Jacobs, due to be released, a feared event; of a "political"; of a cynic, and of sundry characters.

It is a dangerous and difficult theme, that of socio-political protest in South Africa today, because it so often merely is ranting without merit. Adam Small gets past such a sterile display of revolutionary speechifying because it so often merely is ranting without merit.

Adam Small gets past such a sterile display of revolutionary speechifying because he is interested in characters, different and differing characters living the humiliation of apartheid, not tal makes Map Jac ful play show up authenti

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Civilized

Begin: a Biography. By Eric Silver (Weidenfeld & Nicolson):

ERIC SILVER was Jerusalem correspondent of the Guardian and the Observer from 1972 to 1983, and therefore well placed to study Menachem Begin at the peak of his power and in decline. He has produced a biography that is balanced without being cre ly se fai Ja on Pc 12 su of fi er Ir sp

Cape Times double puzzle

No. 16559

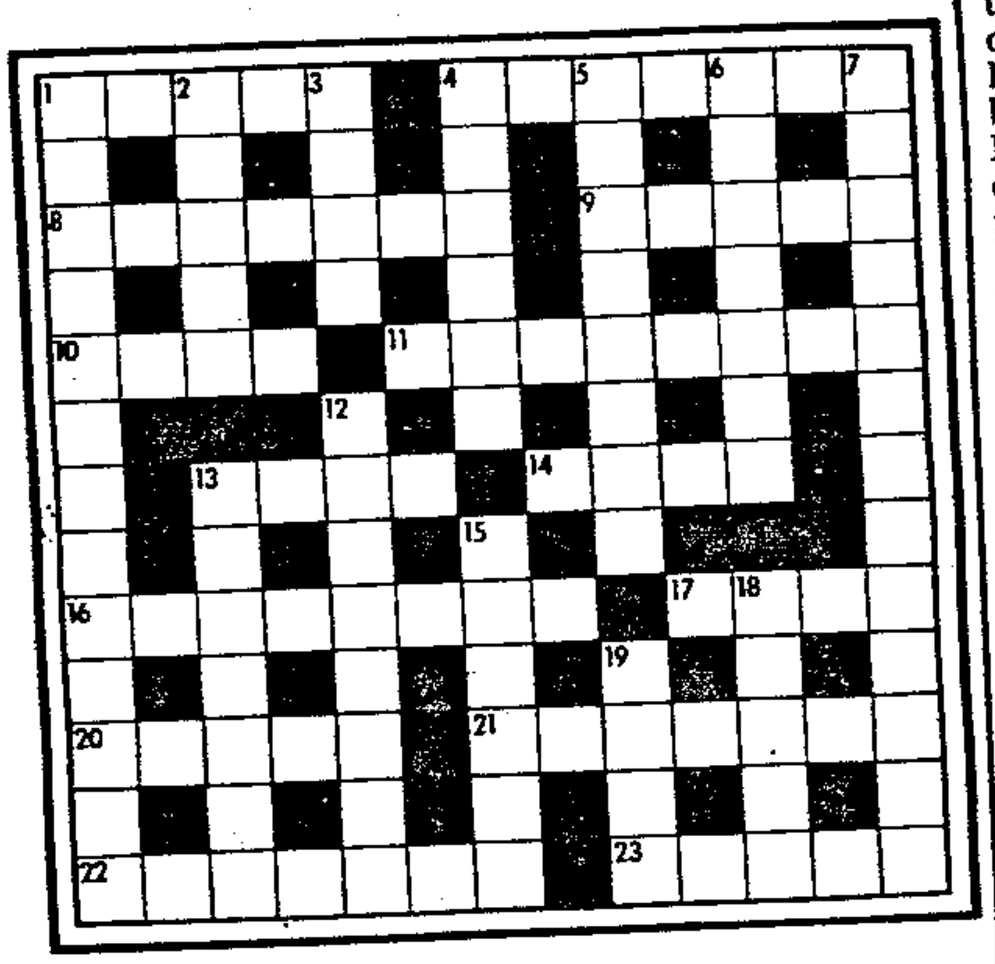
Quick clues

ACROSS

1 Profundity (5)
4 Swell (7)
8 Unhappiness (7)
9 Clothing (5)
10 Notion (4)
11 Attendance (8)
13 Dagger (4)
14 Slay (4)
16 Sleeplessness (8)
17 Tip (4)
20 Lift (5)
21 Hurricane (5)
22 Merit (7)
23 Squeeze (5)

DOWN

1 Eminent (13)
2 Chaplain (5)
3 Attention (4)
4 Wilderness (6)
5 Skid (8)
6 Everlasting (7)
7 Exemptions (13)
12 Organiser (8)
13 Sack (7)
15 Goodness (6)
18 Angry (5)
19 Support (4)



Cryptic clues

ACROSS

1 & 4 Dn. One who doesn't take the tennis tournament seriously? (5, 6)
4 Are they worn by bounders? (7)
8 They may offer to pay for lots of things (7)
9 See 2 Down
10 In the capital I raised some money from abroad (4)
11 Writer to run off with a girl (8)
13 See 17 Across
14 It should provide one with better looks (4)
16 One who works with a will (8)
17 & 13Ac. Permit to go beyond the harbour (8)
20 One that roves gracefully over eastern territory (5)
21 Beset by painful feeling, I've somehow to gain an objective (7)
22 Downtrodden machine operator (7)
23 Tries to transform religious observances (5)

DOWN

1 He'll fight with you and make the company militant (2-11)
2, 9Ac. & 18Dn. Spy protected by insurance? (5-5, 5)
3 Bound to sound like the movement of the sea (4)
4 See 1 Across
5 Each stem is destroyed by sharp knives (8)
6 It's so use being upset about Violet showing jealousy (7)
7 Not a private canteen! (9, 4)
12 Supplied with basic information, but not allowed to take the air (8)
13 Quietly tell the high priest (7)
15 Could be a lot like an ear (6)
18 See 2 Down
19 The endless fascination of tea (4)

SOLUTIONS TO QUICK CLUES No. 16558: **ACROSS:** 3 Affluence, 8 Reap, 9 Transport, 10 Ashore, 11 Teach, 14 Dozen, 15 Turn, 16 Drama, 18 Word, 20 Raise, 21 Decoy, 24 Behind, 25 Capacious, 26 Stun, 27 Statement. **DOWN:** 1 Breakdown, 2 Haphazard, 4 Fare, 5

SOLUTIONS TO CRYPTIC CLUES No. 16558: **ACROSS:** 3 Speedwell, 8 Head, 9 Foolproof, 10 Cudgel, 11 Stead, 14 Mouse, 15 Weir, 16 Round, 18 Tuft, 20 Rouse, 21 Soles, 24 Bistre, 25 Simpleton, 26 Boss, 27 Stormy sea. **DOWN:** 1 Checkmate, 2 Handcuffs, 4 Pool, 5 Eclat,

'No' to health bonds

Cape Times 16/5/85

Staff Reporter

A PROPOSAL that "health bonds" be sold to raise funds for improving and expanding the country's overtaxed health service was turned down by the Provincial Council during the first day of its current sitting yesterday.

The opposition spokesman on health, Dr John Sonnenberg, of Green Point, proposed the motion, saying that the rising demand for health care could no longer be met by the State alone.

He suggested that health bonds, like defence bonds, could be a means of raising money voluntarily from the population.

"Many people in this country who, for a variety of reasons, do not wish to purchase Bonus Bonds might be willing to invest in health bonds, knowing that the proceeds would be solely devoted to health and welfare purposes."

In reply, the MEC for hospital services, Mr P J Loubser, proposed an amendment which called for the matter of alternative sources of finance for health to be referred to the Browne Commission into health services.

Crossroads: State to control health hazard

By Staff Reporters

THE Department of Health is to investigate the hazardous health conditions at Crossroads with a view to deciding what State help can be given.

The Minister of Co-operation and Development, Dr Piet Koornhof, said today he had asked the Health Department to go into the matter.

He said his department was extremely worried about the present situation there and was in favour of everything possible being done to ward off a bad situation.

Earlier the Medical Officer of Health for the Cape Divisional Council, Dr L R Tibbit, had warned that the health situation at Crossroads was "potentially dangerous" to all the people of Cape Town.

Immunisation campaign

Dr Tibbit recommended that the population of Crossroads be drastically reduced if the city was to avoid possible outbreaks of cholera and typhoid.

While the council had not detected any cases of cholera in the camp, it had traced seven cases of typhoid — four of them in a small area of inter-related shacks.

An immunisation campaign was launched two weeks ago and 1 000 people in a particular area of Crossroads were immunised.

"We do not get typhoid in Cape Town. It is unusual and a serious matter."

Dr Tibbit said that cholera was the fastest-spreading of diseases and could get out of control within weeks if it reached Crossroads.

"This has not happened, but we would like to prevent it by getting people out of Crossroads.

"I do not control the housing situation in Crossroads. I am under contract to provide a preventive and promotional health service in the area. But the housing and sanitation are far below standard and potentially dangerous to all the people of Cape Town. I recommend that the population of Crossroads be drastically reduced."

He said that while he could foresee cholera coming to Cape Town, there was nothing more he could do as conditions in Crossroads made even the placing of additional pail toilets difficult. There was no room and lorries could not reach the pails to clear them out.

"The people must be moved out, density and overcrowding renders it impossible to do any more."

The overcrowding and poor sanitation at Crossroads had also led to "out of control" tuberculosis, gastro-enteritis and pneumonia.

"I believe the development of Khayelitsha along the lines of aided self-help housing is acceptable," he said. There would be less overcrowding because there would be more houses and more space.

A doctor at Empilisweni clinic in Crossroads today criticised Dr Tibbit's statements as "grossly unfair and sweeping, calculated to scare people".

"We don't see any cholera here and there are a few cases of typhoid. But staff do believe that Dr Tibbit has not touched on the true health problem of Crossroads — tuberculosis — which is, in fact, the duty of the Divisional Council to curb."

The doctor disagreed with the statements and said staff would meet later today to discuss a response.

● Dr Ivan Toms, who is also on the clinic staff, said: "In a community of 50 000 people an average of 12 cases of measles a month is not very bad. TB is out of control, not because of Crossroads housing but because of the apartheid system.

"Cholera is unlikely to cause a problem because we have a

(Turn to Page 2, col 10)

ARGUS 23/5/84

Warning on health

Cont from Page 1

clean water supply from the municipality and cholera is water-borne.

"And how can moving Crossroads residents to Khayelitsha stop the flow of people from the Transkei and Ciskei? When people are starving in the homelands they will come to the city.

"There is very little scientific information which links housing to health issues unless it's overcrowding. According to a study done for the Carnegie inquiry into poverty there are on average 13 people in ev-

New medical tariffs come into effect on July 1

Up go doctors and dentists fees

RDM 24/5/84 (85)

By CHRIS FREIMOND
Political Correspondent
CAPE TOWN.

THE Minister of Health, Dr Nak van der Merwe, has approved tariff increases of 8,8% for doctors and between 10% and 25% for dentists who have not opted out of medical aid schemes, it was announced in Cape Town yesterday.

Dr Van der Merwe said in a statement he had accepted the South African Medical and Dental Council recommendation that medical practitioners be granted an average tariff increase of 8,8%.

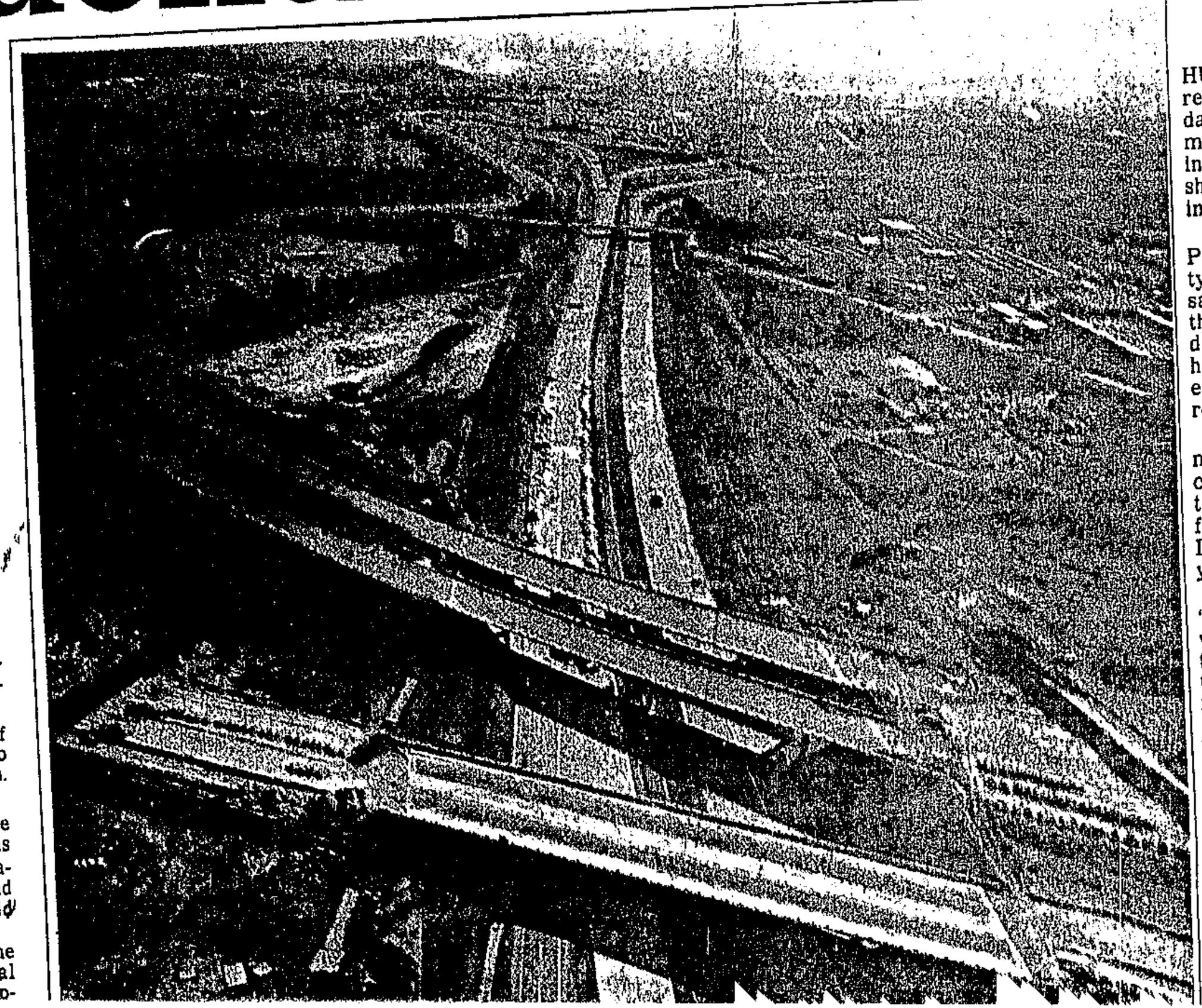
However, he was not prepared to accept the proposed 33% increase in dentists' fees.

Instead, he approved a general increase of 10% with an additional increase of 15% to general practitioners in the dental profession.

The increases are effective from July 1.

Dr Van der Merwe said in terms of the Medical Schemes Amendment Act which was passed during the current session of Parliament, provision was made for medical and dental tariffs to members of medical aid schemes and their dependents.

This will be determined in future by the Representative Association of Medical [illegible] consulting the association rep-



Human rights leaders express alarm

By DAVID CAPEL

HUMAN rights spokesmen reacted with alarm yesterday to some of the remarks made by Mr Justice Steyn in acquitting a man who shot dead a thief for stealing 63c.

Mrs Helen Suzman, the Progressive Federal Party's spokesman on justice, said it was "another one of these cases where extraordinary judgements are handed down, coupled with even more extraordinary remarks from the bench".

Mr Justice Styen's comments included that the accused, Mr Francisco Quintino, "deserved a medal" for shooting dead Mr Macks Lerutla on October 23 last year.

He said Mr Quintino "could have rendered a service to the community" as there had been no more thefts in the area since the incident.

Mrs Joyce Harris, National President of the Black Sash, said she could understand that justice had to be done, "but to encourage this type of violence, cheapens life and can only result in more violence and less respect for human life".

Mr Jo[illegible]e-Berman, Director [illegible]nstitute for Race [illegible]s, said some

'He d… a m… killi…

By NICOLA BEKH

MR FRANCISCO Q… "deserved a meda… shooting the man wh… his 63c milk money, … Supreme Court judg… yesterday.

Mr Justice Irving S… quitted the 56-year-… driver after a unanim… cision was reached … him and his two ass…

The shot which ki… Macks Lerutla on Oc… last year, was accide… absent of reckless… negligence.

He had no intentio… ing the deceased.

During evidence, … tino said several peo… neighbourhood had b… gued by milk money…

"Since the incide… have been no more … the area," the jud… "The accused could … have rendered a se… the community."

He also said he "de… medal for what he …

Mr Quintino — … tears in his eyes — h… sobbing wife after th… was passed.

Mr Justice St… housebreaking with … steal was a first se… fence.

"And if I had … somebody inside … I'd shoot him and … shoot," he said.

He said the amo… by the deceased … bearing on the m… was "completely i…

Calling for an ad… after the state had… case, Mr Justi… "I have the p… thy for the … my two … suade …

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Dr Van der Merwe said in terms of the Medical Schemes Amendment Act which was passed during the current session of Parliament, provision was made for medical and dental tariffs to members of medical aid schemes and their dependents.

This will be determined in future by the Representative Association of Medical Schemes after consulting the association representing the profession concerned.

However, because the Act had not yet become operative, Dr Van der Merwe said he was still obliged to determine a tariff on recommendations of the SA Medical and Dental Council.

The Opposition's chief spokesman on Health, Dr Marius Barnard, said last night he believed the increases were justified because of the spiralling costs of medical and dental practice.

He said that in the light of high medical costs, a strong case could now be made out for exempting medical equipment, drugs and other medically related products — including powdered milk and baby foods — from GST, which is being increased to 10% on July 1.

The increases are expected to lead to an increase in medical aid scheme subscriptions.

Meanwhile, **GERALD REILLY** reports from Pretoria that the Medical Association of South Africa (Masa) is to make a major effort to reduce medical costs.

This was decided at a meeting of the Masa's federal council in Pretoria yesterday.

The chairman of the council, Dr Rene Roex, said at a Press conference that the council had recommended to Dr Van der Merwe that doctors' prescriptions be freed from GST.

This would make a big contribution to lowering the costs of illness and relieving the financial burden on patients.

The council was also concerned about the costs of medical treatment.

It had established a "costs awareness" committee to determine guidelines and norms aimed at lowering costs of treatment.

The vice-chairman of the council, Professor N Louw, said a start had been made in training hospitals to make doctors and hospitals' staff more cost conscious.

Masa was also concerned about the incidence of malnutrition and related conditions in South Africa.

Because of this, Dr Roex said the federal council fully supported the call for a reinstatement of the food and nutrition council.

He said in time of drought the spread and intensification of the disease was aggravated.

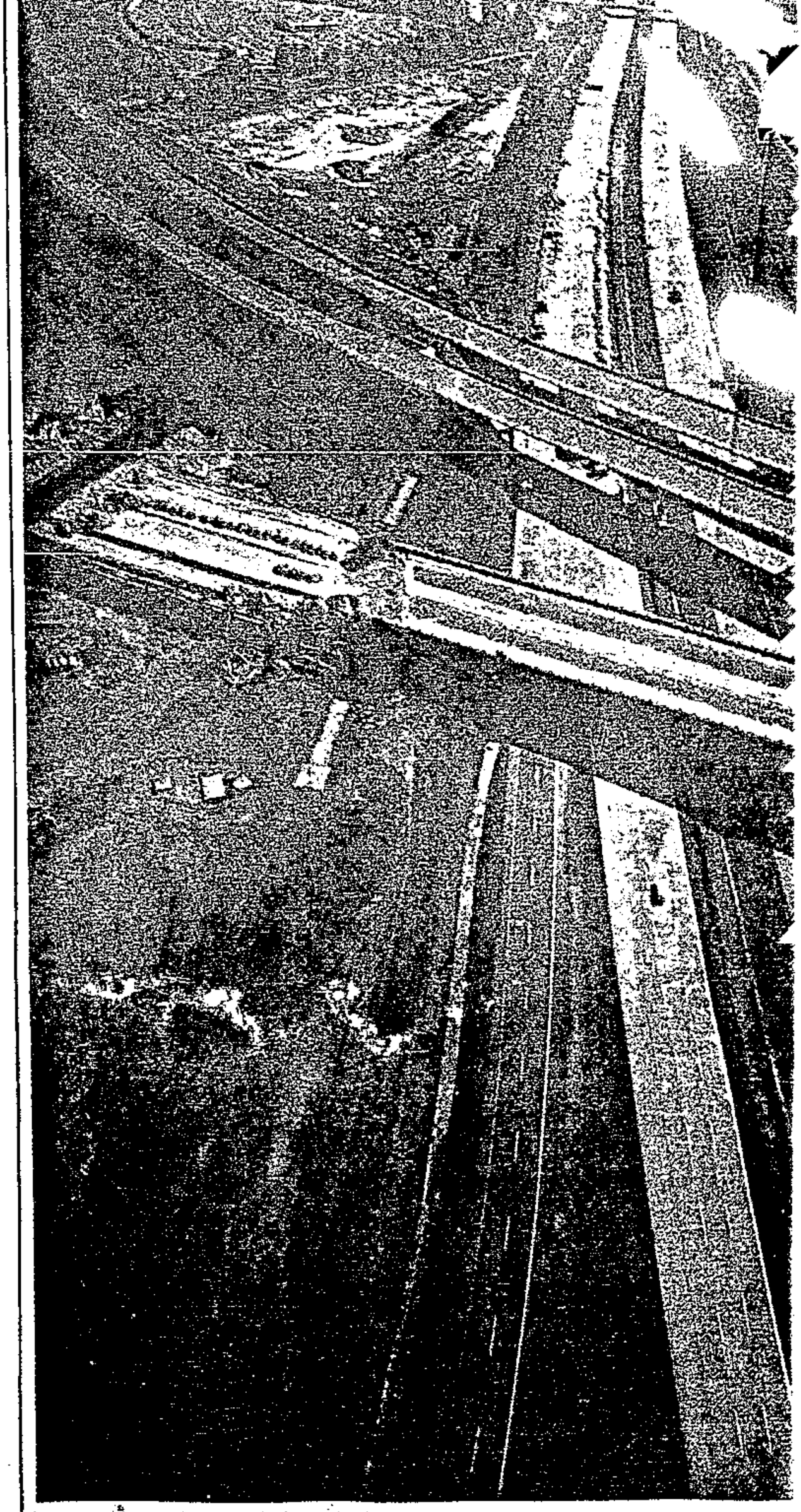
Malnutrition was one of South Africans greatest health problems and it was hoped the reinstatement of the council would contribute to better control.

On doctors tariffs Dr Roex said legislation now made it possible for doctors to determine their own fees.

He said this autonomy would be used with the greatest circumspection and responsibility.

Fees for medical aid schemes would be determined in co-operation with the Representative Association of Medical Aid schemes (rams).

The groups undertook to be reasonable in their negotiations.



The 4½km stretch of Johannesburg's new southern bypass from th the Ridgeway interchange, seen here, was handed over to the Dep road will help transport vehicles through Uncle Charlie's interse

Tobias all but boo his place in Bok te

BY GREG STRUTHERS
Mail man on Tour

STELLENBOSCH. — Caledon bricklayer Errol Tobias virtually booked his berth as Springbok flyhalf for the upcoming two-match rugby test series against England next month as he forced John Scott's tourists to salvage their second tour game with a late rally at Stellenbosch yesterday.

The 34-year-old Tobias was in brilliant form in scoring 17 points before England scraped to an unimpressive 23-21 victory after trailing 15-10 at halftime.

It was a close thing after Tobias had waved his magic wand against the English for the second time in four days with a performance that suggested South Africa may well have solved its flyhalf problem since Naas Botha left for the United States.

The England coach Dick Greenwood said Tobias was "pure gold" after his fine performance which saw the Proteas surge 21-10 ahead midway through the second half.

Veteran England fullback Dusty Hare fired home five penalties to give England their victory in front of 17 000 spectators in th rounds of the University stadi

Hare finally f ing boots after his 11 attempts the end of the da rose was bloom just when it Protea might splendid flower

However, E fered something as they prepa day's match ag Province in Cap centre Paul D field with an ank in the game. D be available fo

Medical, dental fees up on July 1

Cape Times 24/5/84

85

By PETER DENNEHY

CONSUMERS reeling from a barrage of cost-of-living increases are to suffer yet another blow when medical and dental fees rise from July 1.

The Minister of Health and Welfare, Dr Nak van der Merwe, announced in Cape Town yesterday that medical fees would increase from July 1 by 8,8 percent and dental fees by as much as 25 percent in the case of general practitioners and by 10 percent for others.

July 1 also marks the rise in general sales tax to 10 percent.

Dr Van der Merwe said in a statement that it was on the recommendation of the SA Medical and Dental Council (SAMDC) that general practitioners would get an average 8,8 percent increase.

A report before the Representative Association of Medical Schemes (RAMS) when the increase was mooted in October last year — after a 15 percent rise in medical and dental fees on September 1 — estimated the proposed medical increase would cost aid schemes R32 million a year.

RAMS president Mr John Ernstzen said at the time that aid schemes would have to raise subscriptions "substantially".

The SAMDC had proposed a 33 percent rise in dental fees, which Dr Van der Merwe said he was "not prepared to accept".

Instead, he approved a general rise of 10 percent with "an additional increase of 15 percent only to general practitioners within the dental profession".

The increases would be the last to be approved by the minister, as tariffs would in future be determined by RAMS, in terms of the Medical Schemes Act passed by Parliament this session, the statement said.

The latest increase comes in the wake of a wave of others.

- GST will rise to 10 percent on most items on the same day.
- Capetonians will pay 8 percent more in rates from July 1, electricity fees are to rise by an unspecified amount and water tariffs rose by 7 percent from April 1 this year.
- Suburban rail fares jumped 12.8 percent on average for third-class tickets on April 1, and domestic air fares rose 6 percent.
- A massive national maize price increase of 18,5 percent was announced on April 26.
- The budget seven weeks ago increased tax and duties on cigarettes and beer.
- Company tax was also raised in the budget to 50 percent of profits.
- Provincial hospital tariffs rose 50 percent from April 1.
- Postal tariffs, including the cost of telephone calls, rose 9 percent on April 1.
- Milk rose by 4c a litre from April 1 and the bread price rose 6c a loaf from February 20.
- The wholesale price of beer rose 5,5 percent in mid-February.
- Mortgage bond instalments rose in mid-February. At the beginning of the same month, GST rose from six to seven percent.

It's cheaper, but you pay more

HOW THE PEOPLES' SUBSIDISED HEALTH SERVICE COSTS THE PEOPLE TWICE THE PRICE

● This woman believed the R2 fee was obligatory

A VISIT to one of the Transvaal's provincial hospitals — 90% subsidised to provide 'inexpensive' health care — costs more than twice as much as a visit to a private doctor for some patients.

And thousands of people are being tempted into a diagnose-yourself health service.

They are opting for a private doctor — guessing or hoping that their medication will not exceed R10 — instead of for a hospital where the higher fee includes drugs.

Countless lower-income patients would do better going to a private doctor with an informal 'composite' fee structure, which includes injection and drugs, than to a hospital.

For some, the personal attention and shorter queues may make the private doctor a more attractive option in any case if it's just a rand or two difference.

These are some of the consequences of the hospital tariff increases announced by the Administrator of the Transvaal, Mr Willem Cruywagen, and which came into effect on April 1.

It is not known how many people are affected in this way, but included, for instance, are single people with a gross monthly income of more than just R210 or a couple living on R312.

Also included is any member of a family of four (black or white), with a gross monthly income of more than R520 a month.

New fees

Patients in this category pay R20 for a single out-patient visit. A private doctor charges R8,80 increasing to R9,50 when new fees for private doctor consultations come into effect on July 1.

Last year the average monthly earnings of whites was R1 128, Indians R542, coloureds R385 and blacks

● Mrs Celia Swartz — private doctor 'costs less'

Pictures: KEVIN MACINTOSH

By GRAHAM WATTS:

R289, according to the Central Statistical Services in Pretoria.

The tariff increases come with a revised patient category system based on 'computed income' — total gross family income divided by the number of household members plus one.

While the tariff system works in favour of those in the lowest income brackets, it is those in the "twilight economic zone which is above bare subsistence level — but only just" who are suffering most from the tariff increases, according to the Progressive Federal Party's provincial spokesman on health, Mrs Irene Menell.

Mrs Menell said that "a little old lady in a room somewhere living off her savings which produce an income of say R250 a month will have to spend nearly 10% of her monthly income, plus transport costs, on a single out-patient visit to a hospital".

The ordinance under which the tariffs were revised provides for reclassification procedures in the case of financial hardship.

"But," said Mrs Menell, "the people who need to use that procedure most are the people who know least about it. If they're lucky some kind person will tell them of its existence.

"It's a long, clumsy obscure and inaccessible process. There are hospitals where it is never or hardly ever used and it does not answer the problem," she said.

Satisfied

Dr Reg Broekmann, chief superintendent of the Johannesburg Hospital, said he was satisfied with the procedure for reclassification and its observance at his hospital.

"I am unaware of any case where any patient has sought reclassification and has not been satisfied," he

doctor if she had an "ordinary complaint" because it would cost her less, but her doctor had referred her to the hospital because she had "complications".

Another woman, who declined to be named, said she had to pay R25 every time she brought her daughter to the hospital. This was too much, she said, though she was on a medical aid that paid 20%.

She was not aware of any reclassification procedure.

At Hillbrow Hospital it appeared most out-patients assumed they had to pay R2 for every visit, no matter how much they earned or how many visits they made.

One woman, who would not be named because she "feared trouble" said she earned R40 a month as a domestic worker and had to bring her son to the hospital regularly.

She just paid her R2 every time, because she believed that was what she had to do.

She knew of no reclassification procedure.

In the hospital services budget before this session of the provincial council, fees are expected to bring in R79-million — R19-million (or 31%) more than last year.

About R427-million (55%) of the record R778-million hospital services budget is to go on salaries, wages and allowances.

About R24-million is to go on "other allowances" alone.

Mrs Menell told the provincial council this week the cost to society of having "inadequately treated or untreated ill health" was incalculable.

She said there were other areas in the budget where the money could be made up.

One of these was hospital management, she said.

Part of the problem lay with the "single request-type budget" in which "the more you ask for the more you are likely to get, even if it is less than you asked for".

'Socialistic'

The MEC for hospital services, Mr Daan Kirstein, asked whether the PFP "wants us to be a socialistic country".

"To say that province is chasing away patients is just untrue," he said.

Mr Kirstein said the provincial hospital service had treated 6,6-million patients last year and the figure was expected to be 8-million this year.

"And you ask whether we are facing up to our responsibilities . . ." he said.

"We are doing everything in our power to help those who are not able to help themselves. I want to give the assurance that there is nobody in this province who needs to go without medical treatment because he or she cannot afford it."

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"I am unaware of any case where any patient has sought reclassification and has not been satisfied," he said.

Dr Richard Taylor, deputy superintendent of Hillbrow Hospital, said patients were not advised in each case of their right to request reclassification.

But he was confident that every case was properly treated on its merits.

"There are, of course, ommissions, as there are in all things," he said, "but we act quickly on any complaint from a patient.

"Our main object is patient care," he said.

Out-patients spoken to at Johannesburg Hospital this week said they knew of the reclassification system, but, as one put it, "they ask you what your income is, not what you have to spend each month".

Mrs Celia Swartz of Kibler Park said she would definitely go to a private

doctor had referred her to the hospital because she had "complications".

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85 Sketch C-Herald 7/7/84

Poor have least medical facilities

A recent study by the South African Labour Development and Research Unit at the University of Cape Town showed that the people who most need health care facilities have least access to them.

Most general practitioners, it was found, were located in well-off suburbs. Sea Point had 36, Claremont, 35 and Rondebosch had 27. Areas like Guguletu, Langa and Mitchell's Plain had two or less. Of the private practitioners, 42% were specialists. The study was based on 1980 figures.

Provincial hospitals are all in "white" group areas except for one orthopaedic hospital and a convalescent home. Access to existing health care facilities in townships is difficult for most workers. Day hospitals are only open during working hours (8.00 am to 4.00 pm) but many even refuse to see patients who arrive later than 10.00am because of the large number of people who come before then.

MINIMAL

In some of Cape Town's poorest and also most densely populated areas, health care facilities are minimal. In the "New Home" — Khayelitsha — planned for "Africans", there is only one small clinic run by the Divisional Council to cater for the more than 300 families already living there. The clinic deals only with minor complaints. People with more serious illnesses must go to the Guguletu Day Hospital or to Tygerberg Hospital where journeys to both are both lengthy and expensive.

PATIENTS from all over the world come to South Africa for heart transplants, kidney transplants and other operations.

But what about Mrs Jones who coughs uncontrollably in the cold dampness of a house in Lotus River or young Janice, crying feebly in a shack in Crossroads as starvation brings her closer to inevitable death? These are the statistics we find tucked away in corners. Cape Herald staffer ESTELLE RANDALL reports ...

Mitchell's Plain with its population spilling over to 250 000 is served by four clinics, five day hospitals, 18 private doctors and two dentists. Two Provincial Administration ambulances are manned by volunteers. According to the World Health Organisation, there should at least be one doctor for every 900 people.

SPRAWLING

Mitchell's Plain residents have long been campaigning for a proper hospital to be built close to the sprawling township. This hospital, they say, should at least be as large as old Somerset Hospital but preferably as big as Groote Schuur Hospital.

The envisioned hospital would serve surrounding townships like Guguletu, Crossroads and Khayelitsha as well. But so far the authorities have not put forward any plans to build such a hospital in the near future.

Instead, they have planned a large day hospital for the Town Centre in Beacon Valley. This day hospital will have among its facilities a small operating theatre, X-ray and physiotherapy facilities, 12 maternity beds and a dental section. But the hospital will only operate during normal working hours and will be closed on weekends and public holidays. Expected to treat up to 1 200 patients a day, construction of the day hospital will start at the end of the year.

PLANNED

A private hospital, costing more than R5-million is also planned for next year. It, too, will be situated in the Town Centre.

Nearby Nyanga has one preventive health clinic run by the Divisional Council. It treats TB, children's illnesses and offers family planning assistance. The nearest day hospital is in Guguletu. People start to queue there from 6.00am. The clinic only opens at 8.00am. Too many patients — often more than 400 a day — and too few health workers force those who work at the clinic to close the gates at 11.00am. Common illnesses are TB, hypertension, diabetes and among children, gastro-enteritis.

The idea of building a hospital which would serve Guguletu and Heideveld was mooted 16 years ago. Today it has still not materialised.

. . . and they pay the most in medical expenses

PATIENTS who earn the least, pay more of their income for medical expenses than do higher income groups.

A person earning R100 a month now pays R8 per outpatient visit at Groote Schuur and R12 a day if hospitalised. This amounts to eight percent and 12 percent of the patient's income. Those earning R600 a month pay R23 a outpatient visit and R45 a day if hospitalised, amounting to 3,8 percent and 7,5 percent of the patient's income.

General practitioners have disclosed that day hospitals are increasingly turning away patients earning more than R240 a month. In most cases the patients don't get further than the receptionist and so are not assessed by a trained health worker before being referred elsewhere.

One general practitioner reported that a young mother without any money had been turned away by the clerk when she took her sick child to the local day hospital.

QUALIFY

A sister at a day hospital in the southern suburbs said that they had been instructed to allow those patients who did not qualify for treatment but who had been attending the clinic for a long time (14 years or more) to fill in forms.

These forms which require the patient to reveal details such as the earnings of all those who worked in the family, how much was spent on groceries, rent, entertainment and so forth could enable the patient to receive treatment if the authorities felt they deserved it.

The staff at the day hospital were instructed not to see those patients whose forms were still being processed. The sister herself had sent away 20 such patients in two weeks.

STRICTER

The stricter enforcement of the R240 regulation, begun in 1962, comes in the light of increased hospital fees. Fees were increased by 50% in April this year and they will probably increase again this year. A new fee structure will be presented to the the Executive Committee of the Council by the Department of Hospital Services not later than July.

In addition, fees for consultation at private dotors are high. Consultation could cost about R8,80. Treatment for a minor illness could amount to R8,75 and routine blood and X-ray tests could cost R84,73. The cost of a private hospital bed ranges from R55 to R80 a day. This excludes medication and specialist fees.

Negative effects on health in SA

Medical Reporter

SOUTH AFRICA needed an army of medical auxiliaries and doctors working in teams to overcome the combined negative effects on community health of hygiene ignorance and the excessive specialization and concentration of doctors in urban areas.

This was said by Professor R E Kirsch, Professor of Medicine at the University of Cape Town, at his inauguration at UCT last week.

Professor Kirsch covered a wide range of topics in his address, including an historical background to South African medical education, ways to improve undergraduate education, the growing public distrust of scientific medicine, the selection of medical students, and the negative impact of the government's racial policies on health care.

On this last topic, Professor Kirsch said there was a real danger that after more than 30 years of protesting about the deleterious influence which apartheid has had on health, members of the UCT medical faculty might assume that their views were known to all.

"I believe it is our duty as teachers of medicine to draw to the attention of our students any factors which adversely affect the health of our patients. Our actions will speak far louder than words," he said.

This subject touched on whether medical students were being appropriately prepared for careers as doctors in South Africa.

'Unrest'

"It is against a background of increasing knowledge and specialization, of rapidly-developing technology and of socio-political inequality and unrest that we at the University of Cape Town are called upon to educate tomorrow's doctors."

It had been found, he said, that Groote Schuur's patients commonly presented diseases in a pattern closely resembling that found in the community, and therefore the hospital allowed both students and teachers to become familiar with the major diseases seen in this part of the world.

More teaching of medicine in the community would be undertaken but for staffing and financial constraints.

'Sadness'

In conclusion, Professor Kirsch said his pride at being appointed to a Chair at UCT was tinged with sadness.

This was because he could not teach students admitted purely on grounds of merit, because he had to practise medicine and teach in a country where the "haves" and "have-nots" were distinguished by their skin colour and because, in the teaching hospitals, few doctors believed they were discriminating between patients, yet could not prove this as patients of different colour could not lie side by side in the same ward.

Express 19/8/84 85

RURAL HOSPITALS TAKE HEALTH TO THE PEOPLE . . . BY TEACHING THE ART OF PREVENTION

The barefoot doctor

IT WAS the first time the women of Zabeta village in Gazankulu had seen rice cooked without fire.

Reports by
MARION WHITEHEAD

But the wonderbox in which the uncooked rice had been placed, was no magician's prop.

The women had seen the pot of rice brought to the boil on the fire.

It had then been placed between two cushions filled with insulating material inside a cardboard box. The wonderbox cooked the food slowly, safely and economically, retaining heat in much the same way a thermos flask does.

When the lid was lifted two hours later to reveal the fluffy white rice, there was much clapping and ululating.

But the final proof was in the tasting of the food and after sampling the rice, one of the women patted the wonderbox: "Easygas," she announced with a broad smile.

Her comment summed up the impact of appropriate technology in the rural villages of Gazankulu in the North-Eastern Transvaal.

Upgrading

Under the guidance of local hospital staff, the village women have formed care groups and are taking the lead in upgrading their living conditions and developing their communities by whatever means at their disposal — including appropriate technology.

Across the way from the hut where care-group motivator Mrs Sellinah Maphorogo had just demonstrated fireless cooking, was the hut housing the village's first mud stove.

The home-made stove costs nothing to make and drastically reduces the amount of fuel used.

Behind the hut was a vegetable garden. It was a green island in a sea of grey dust in drought-stricken Gazankulu thanks to the trenching method of soil preparation.

The scheme to motivate the village women started in 1976 with a programme to treat trachoma, a common eye ailment that can lead to blindness.

Dr Erika Sutter, an ophthalmologist at Elim hospital, took up the 'barefoot medics' idea and adapted it to tackle the trachoma epidemic in Gazankulu.

The hospital provided the salaries and logistical support for care-group motivators who established groups of unpaid volunteers — called care groups — in every village.

The motivators worked with the care groups which shared their knowledge and skills with their communities.

The short-term aim was to tackle trachoma, the long-term aim to improve the general health of villagers and teach them how to take charge of their problems on a local level.

Nurse assistant Sellinah Maphorogo was one of those chosen to be trained as a care-group motivator at Elim hospital.

She is a cheerful, 'people' person, but it was tough going in the beginning when she tried to make friends in the villages.

She was chased away with knobkieries more than once and it was a year before she could start showing villagers how to diagnose and treat trachoma.

Within four years the village care groups, mostly comprising women wearing distinctive headscarves as their 'uniform', had cut the prevalence of trachoma from 33% down to 7% in some areas.

The attitude towards childhood trachoma changed from considering it a good thing to recognising it to be a threat to eyesight.

Singing

"They found a lot of trachoma, especially in the schools," said Mrs Maphorogo. "Then we got on to prevention and hygiene. The women went from house to house explaining to people and singing songs about the treatment."

There are now 120 care groups with more than 5 000 members who are in contact with an estimated 20% of Gazankulu's population.

Venda has started its own scheme and has more than 50 care groups while Lebowa, KwaZulu and Qwa Qwa are also starting schemes.

After trachoma, many wanted to know more about gastro enteritis and malnutrition — two of the most common diseases in the children's ward at Elim hospital.

This in turn has led to vegetable garden projects and the fuel-saving wonderbox cooking demonstrations. Others began building pit latrines with cheap, homecast concrete slabs as it became clear that flies spread trachoma.

In a paper at the Carnegie Conference in Cape Town earlier this year, Dr Sutter listed lack of leadership and initiative, wrong expectations and resistance to new ideas as limitations within the communities.

The main constraint, however, is the socio-economic system.

"Care groups can do something to improve life within the given limits and boost their own and the community's morale and values."

in developing countries was changing and the number of doctors practising was meaningless

He is a firm believer in delegation putting the right person in at the right level. At his hospital nurses specialising in ophthalmology manage 85% of eye cases even doing minor operations.

They see 1 363 patients a month, compared with an ophthalmologist who could take care of only 215 a month.

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● Mrs Sellinah Maphorogo shows village women how to sew a bag for a wonderb

Science says a tot or two is fine

Own Correspondent

NEW YORK — American scientists claim to have discovered the key biological causes of alcoholism.

The findings of the Alcohol Research Centre at the University of California in Los Angeles are said to explain why some people become alcoholics while most do not, and why some drinkers stay friendly while others become hostile.

The researchers concluded that the positive effects of alcohol far outweigh the negative. Alcohol, taken in small doses, was better at relieving tension and anxiety than any other known agent.

The research team is now proposing to investigate the possibility of developing a benign form of alcohol.

The effect of the alcohol molecule on the human body was once considered so complex that until a decade ago, scientists were reluctant to study it. But recent breakthroughs in molecular science have enabled them to make a far more detailed study of alcohol.

Dr Ernest Noble, director of the Los Angeles research team, said the vital breakthrough had been scientists' understanding of neurons.

TEACHING THE ART OF PREVENTION

ot doctor's magic box

go shows village women how to sew a bag for a wonderbox Picture: HERBERT MABUZA

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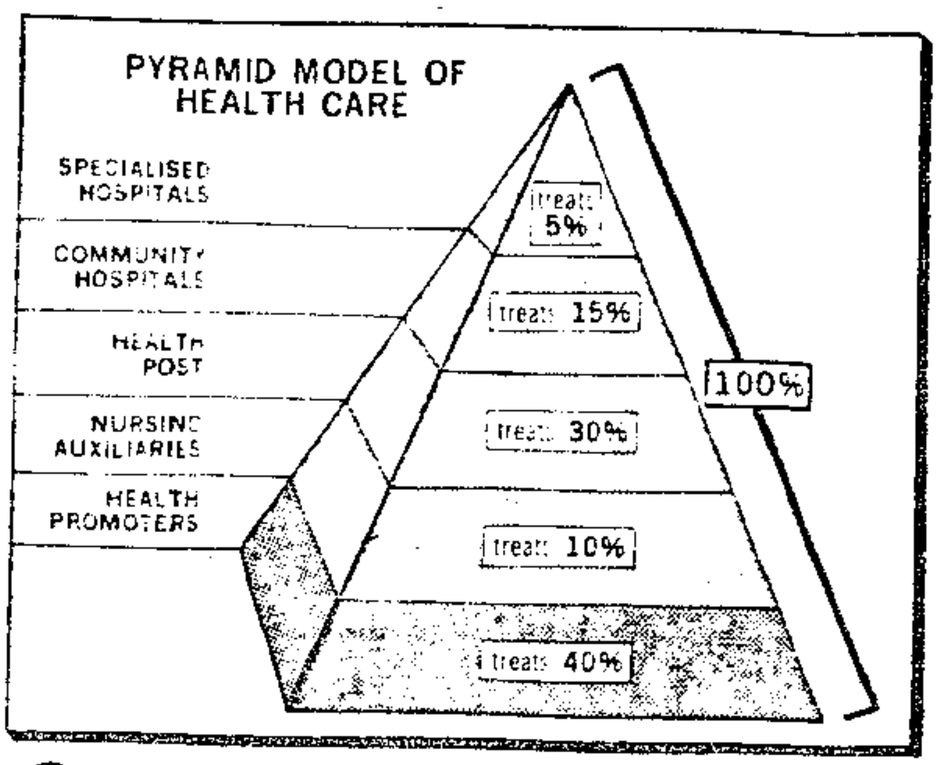
They see 1 383 patients a month, compared with an ophthalmologist who could take care of only 215 a month.

Dr Jacques said that in this system the staff had to be well controlled, the job well defined and taught very specifically.

The potential of care groups in health promotion was superior to the impact conventional health services could have on the community, Dr Sutter said in the Carnegie paper.

This was because care groups defined their problems themselves and did not compartmentalise health away from the rest of life. This made their message more real than the often dull lectures given at clinics and hospitals.



One doctor for 17 400 people

SOUTH Africa does not have enough doctors to go round. On top of this, the doctors are unevenly distributed with only 5,5% practising in the rural areas where 50% of the population lives.

Homelands account for only 3,5% of the country's total, giving a doctor-population ratio of 1:17 400.

These statistics are provided by Mr Pundy Pillay, a researcher at the University of Cape Town, in a Carnegie Conference paper entitled 'The distribution of medical manpower and health care facilities in SA'.

In Gazankulu the doctor-population ratio did not improve between 1976 and 1982, and stayed at 1:20 000.

To bring the South African ratio down to a more acceptable 1:1 300 would require 1 870 doctors to graduate every year until 1990 — but the average over the last few years has been only 748.

Mr Pillay's immediate solutions include incorporating indigenous healers into the rural health system where possible, and health teams working on a preventative health basis.

A model of the system used in Colombia shows health promoters similar to Gazankulu's care groups at the bottom of the health pyramid. Health promoters in Colombia have two to three months' training in public health and simplified medicine and meet 40% of the demand for health care.

Nursing auxiliaries supervise six health promoters each and meet 10% of the demand.

Health posts are staffed by one full-time doctor each plus a small staff who treat 30% of cases and refer 20% to community hospitals. These hospitals meet 15% of the demand and refer 5% to specialised hospitals.

In Colombia, 25 auxiliary nurses can be trained for the cost of one doctor.

But Mr Pillay says a greater use of non-professional health workers does not eliminate the need to improve the supply, distribution and effectiveness of health professionals.

iphorogo shows village women how to sew a bag for a wonderbox Picture: HERBERT MABUZA

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"Care groups can do something to improve life within the given limits and boost their own and the community's morale and values."

Effective

"They have been effective where improvements were largely unrelated to money, such as cleanliness and individual face cloths. Their effect on nutrition, however, has so far been insignificant."

She concluded that their greatest strength was that they had learnt to work together as a group, sharing their skills.

Care groups have also to some degree broken the apathy that has reigned since the removals of the 1960s when the people were forced to leave their traditional homesteads, fields and livestock and move into villages to make way for agricultural development projects.

These projects did not materialise and the people were unable to support themselves off the land.

They ended up sending their men to the cities as migrants and waiting for the money to arrive from Egoli (Johannesburg).

The disease pattern in Gazankulu is typical of that of developing countries throughout the world, and closely linked to low socio-economic standards.

The limited health personnel cannot solve the problem alone and the six hospitals, five health centres and 40 clinics serving Gazankulu's population of 500 000 provide mainly curative services

Dr Pierre Jaques, superintendent of Elim hospital, said the structure of health care in developing countries was changing and the number of doctors practising was meaningless.

He is a firm believer in delegation: putting the right person in at the right level. At his hospital nurses specialising in ophthalmology manage 85% of eye cases, even doing minor operations.

They see 1 383 patients a month, compared with an ophthalmologist who could take care of only 215 a month.

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Concern over asbestos heaps in Lebowa

By PHILLIP VAN NIEKERK

LEBOWA'S Director of Health, Dr A M Makunyane, has expressed extreme concern at the danger to people caused by abandoned asbestos dumps littering vast sections of the homeland east of Pietersburg.

Dr Makunyane told the Mail yesterday the dumps should be covered up by those responsible as soon as possible.

He said his health officials had inspected the dumps after newspaper reports on them had appeared.

"They recommended (either) that the dumps be covered with soil or the people from the schools be advised to move as soon as possible. Something has to be done."

Dr Makunyane said the companies involved — which the Mail has established include large multinationals such as United States Steel and Turner and Newall — could afford to pay.

"Unfortunately, the big fellows have done this to us. They have just come here to dig out the money, leaving the consequences with the people."

He said many people in isolated areas were assumed to have died of natural causes and simply buried. Few post mortems were performed, which meant there was no accurate record of the number of people dying because of asbestos dust.

● An entire community of people living in mobile-home trailers in Globe, Arizona, in the United States, was evacuated last year because of contamination from a nearby asbestos dump.

Local newspaper reports said the people were living near to an old mine with a dump next to it which had initially been covered with soil.

The people were moved out by the United States Environmental Protection Agency (EPA).

Experts said this was only the second time the EPA had taken this action to evacuate people at its own cost: the first time was from a dioxin spill area in Missouri.

The dump at Globe consisted of white asbestos — the least harmful — while the dumps in Lebowa and the North Eastern Transvaal consist of blue asbestos, regarded as the most dangerous.

The total number of people affected in the Globe move was 130, whereas researchers have estimated that at least 200 000 people could have been exposed to asbestos in the North-Eastern Transvaal.

Anaemia rife among children, says survey

By Pamela Kleinot,
Medical Reporter

Anaemia is prevalent among black and coloured children in South Africa because of iron deficiency.

A survey carried out by Dr Denis Derman and a group of researchers found that one-third of children in the one to two year age group were iron deficient.

The survey was carried out among 342 coloured children in Johannesburg and 378 rural blacks from Nqutu, Zululand.

"Iron deficiency is the most common nutritional deficiency in the world," said Dr Derman, of the department of medicine at the Johannesburg Hospital and the University of the Witwatersrand, who was recently awarded a PhD degree for his thesis relating to iron metabolism and absorption.

Dr Derman said that this nutritional deficiency had serious economic consequences because it caused poor work performance.

Although the iron content of most diets is more than sufficient to cover the daily requirement, Dr Derman explained that very little iron was absorbed into the body because of inhibitory factors in foods.

The most potent inhibitor of all was tea. Coffee was also an inhibitor of iron absorption. It also contains tannins. Other inhibitors include red wine, legumes, rice, maize and bran.

However, Dr Derman found that food inhibitors could be overcome with large doses of ascorbic acid (vitamin C).

He also found poor iron absorption from infant foods including proprietary milks and infant cereals when ascorbic acid was not added.

He said the department of medicine had for many years been searching for a staple food which could be used as a vehicle for additional iron or ascorbic acid.

"We had success fortifying sugar with ascorbic acid but it is costly."

Iron deficiency was uncommon in adult blacks in South Africa until recently.

Many years ago researchers found that South African black men often had an increased iron content in the body which was uncommon in other populations. It was found to be directly related to the high iron contents of traditional beers which were prepared in iron drums or pots. Traditional beers were today prepared in stainless steel pots.

Dr Derman showed that the removal of solid material, the production of alcohol and acidity were the causes of the unexpectedly high iron absorption from this vegetable product.

He also found that the lactic acid contained in the beer promoted iron absorption.

After the liquor laws in South Africa changed in 1960 iron overload became less common while liver disease increased because "Western-type liquor" is far more potent.

RDM 11/12/84 (85)

Asbestos-plagued school to be moved

By PHILLIP VAN NIEKERK

A SCHOOL housed in an old hostel next to an abandoned asbestos mine in the north-eastern Transvaal — and found to be contaminated by deadly fibres — is being moved to a new site.

The Griqualand Exploration and Finance Company (Gefco) announced this yesterday.

The school — which the Rand Daily Mail found to be contaminated by deadly asbestos fibres in the ground, air and buildings when it first publicised its existence five months ago — is situated at Kromelmboog, which is owned by Gefco.

In a Press release yesterday, Mr Pat Hart, Gefco's managing director, said the removal of the school had been decided upon with the agreement of the Lebowa authorities.

The company has decided to demolish the buildings, some of which are made of asbestos, from the beginning of the December holiday, and to cover the nearby asbestos dump and the surrounding area.

Construction of a new school being built to Lebowa Education Department standards has already started on a site off the mine property, the statement said.

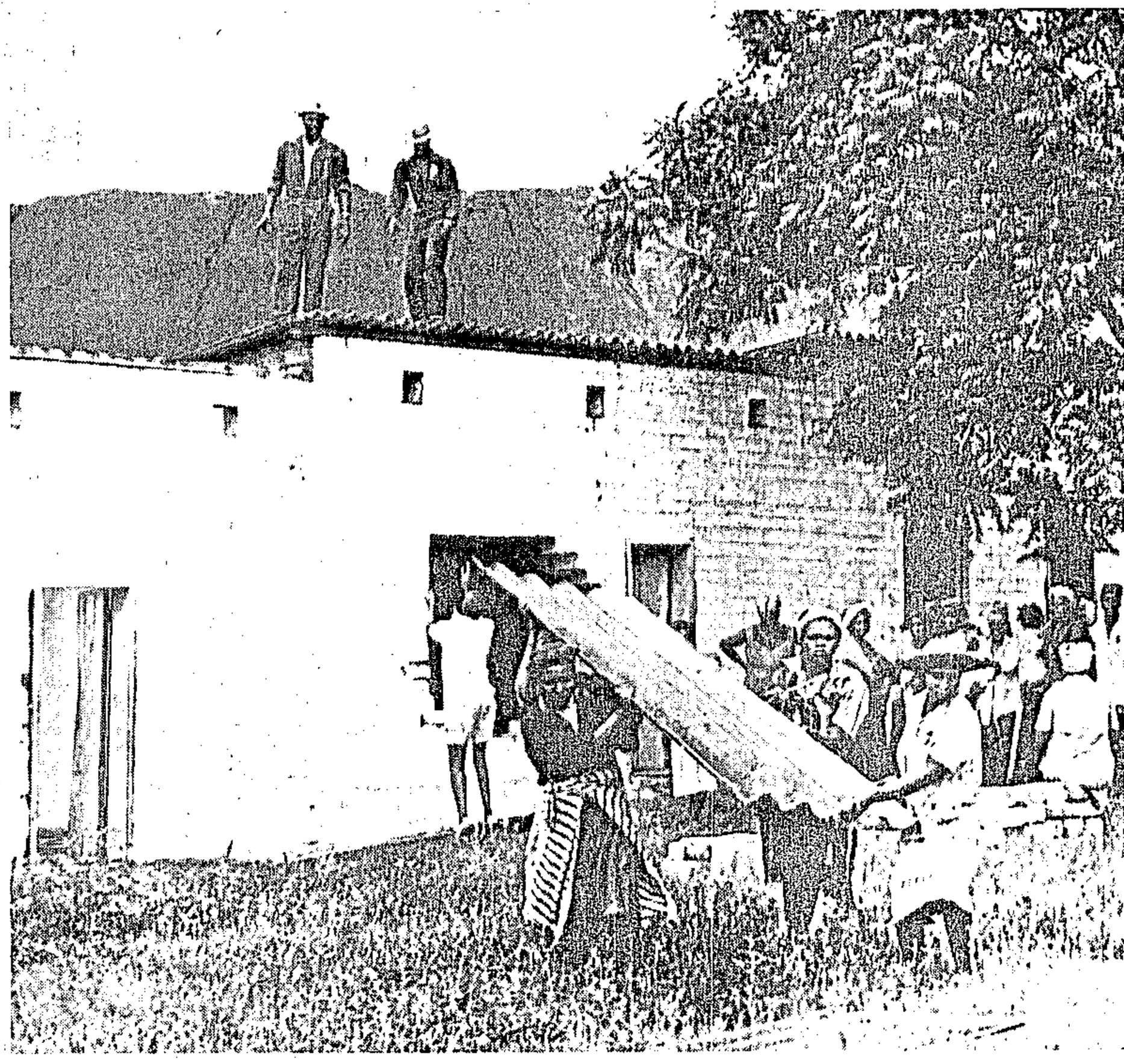
Gefco said it was assisting the school committee in the supervision of the new project, and would provide free building materials and skilled labour.

Mr Hart said the school was already housed in the hostel when Gefco bought Penge Mine from the previous owners, Transvaal Consolidated Lands, in 1981.

"We did not regard the situation we had inherited as ideal," he said, "but having taken a number of additional safety measures, and having satisfied ourselves through dust surveys that the proximity of the hostel to the dump presented no real threat to the health of the 500 pupils, we allowed it to continue."

● Gefco was yesterday condemned by the Black Allied Mining and Construction Workers' Union (Bamcwu), which has called a national anti-asbestos conference early next year to press for the closure of all South African asbestos mines.

Bamcwu said unless Gefco accepted that labour leaders had a right to represent their members in matters affecting their health and safety, such "unilateral" good intentions would not bear fruit.



Parents remove sheets of asbestos roofing from the primary school, situated at a disused mine Kromelmboog, which is being demolished and rebuilt at another site off the mine property.

Star 14/12/84 85

Children to be freed from asbestos hazard

By Kashvina Jaga

Asbestos will no longer pose a health hazard to 500 schoolchildren who study in the shadow of the dormant Kromellenboog asbestos mine, near Penge Mine in the Eastern Transvaal.

The school, previously housed in old mining quarters, is being moved and rebuilt at a site about 2 km away from the asbestos mine, said Mr Pat Hart, managing director of Griqualand Exploration and Finance Company (Gefco).

Gefco took over the mine in 1981 when the school had already been established.

Mr Hart said it was decided to move the school as its site was obviously undesirable in the long term.

The decision comes only months after *The Star* highlighted the environmental health hazard posed by disused asbestos dumps in the North Eastern Transvaal.

Asbestosis (a crippling lung disease), mesothelioma (a cancer of the lung lining), and lung cancer are three of the possible effects of inhalation of fine asbestos fibres.

Because the diseases become manifest only after a period of 20 to 30 years, the seriousness of exposure to asbestos dust is not commonly realised in the rural areas.

The new school will be ready for the 1985 school term and is being rebuilt conforming to the Lebowa education department's regulations.

Labour and building materials will be provided by the General Mining Corporation (Gencor), said Mr Hart.

He said a constructive clean-up programme at the Penge Mine and surrounding areas was virtually complete, and the company was now concentrating on the dormant mines.

"Kromellenboog, being such a mine, is receiving top priority." The extensive safety measures already in operation at the Penge Mine mill and village have reduced the dust levels to below the legal limit of two fibres per millilitre of air, said Mr Hart.

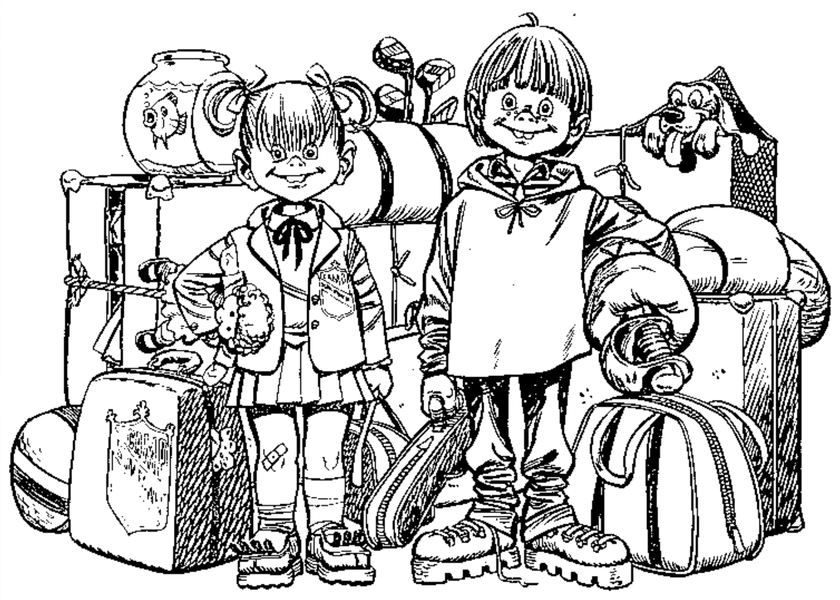
These measures include:

- Wet mining methods.
- Ore washing plant.
- Improved dust extraction and pneumatic fibre conveying in the mill.
- Dust-proof packing.
- Constant monitoring and the use of respirators in emergencies and when dust is created during repair or maintenance.

Mr Hart said that, although health risks associated with asbestos could be controlled with proper care and attention, the need to examine means of further reducing the risk could not be over-emphasised.

Health AND Disease — Alcoholism

1985.



Start shopping more with a calculator — and less with the kids, says League

by PETER FABRICIUS
Weekend Argus Reporter

THE Housewives League has urged consumers to become "more professional" about shopping to cope with the spiralling costs of basic groceries.

The League appeal is a reaction to a 91 percent increase in grocery prices over the last five years, indicated in a survey of basic items.

In the last year alone prices are up about 15 percent.

League director Mrs Franca Nardin said that shopping today had become a "profession".

"Too many housewives still shop badly because they regard it as a bind and a chore. That it certainly is. But with prices as they are today housewives can no longer afford to be squeamish about it.

"They must start shopping more with a pocket calculator and less with the kids."

The 91 percent increase in prices over the last five years is 11 percent above the official consumer price index published by the government, confirming discrepancies that the League has discerned in previous surveys.

"Our figures are consistently higher than the CPI. For instance our surveys of prices at April last year and April this year showed increases ranging from 19 to 21 percent.

"The CPI for that period was about 15 percent."

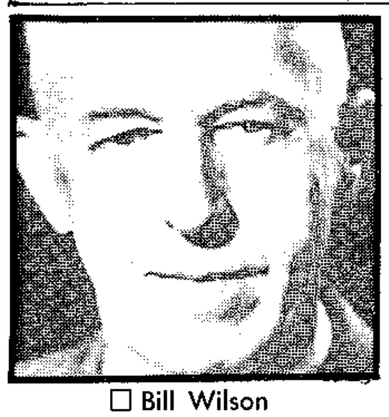
The Housewives League surveys also indicate that the well-publicised price cuts by some retailers and manufacturers, are not necessarily bringing down the overall rate of food price inflation.

"Last month we found that of 100 items surveyed in one supermarket, 88 prices had changed since the month before.

"Some prices had gone down while others had gone up. Overall, it seemed what you gained on the one side, you lost on the other.

Some examples of increases since 1980 include: Escort back bacon, 250g, up 108 percent from 89 cents to R1,85; Escort pork sausages up 97 percent from 96 cents to R1,89; first grade cheddar cheese, up 91 percent, from R2,48 a kg to R4,75; a dozen large eggs, up 86 percent from 70 cents to R1,30; margarine, 250g brick, up 91 percent from 35 to 67 cents; Dogmore dogfood chunks, 10kg, up 115 percent from R 4,09 to R8,79; and fresh whole milk up 75 percent, from 40,5 to 71 cents a litre.

About the the only product that has not shot up drstically is Bourneville cocoa which was R1,79 in 1980, R1,99 in 1984 and still the same in May this year — an increase of only 11 percent in 5 years.



☐ Bill Wilson

ALCOHOLICS ANONYMOUS NOTCHES UP A MILESTONE

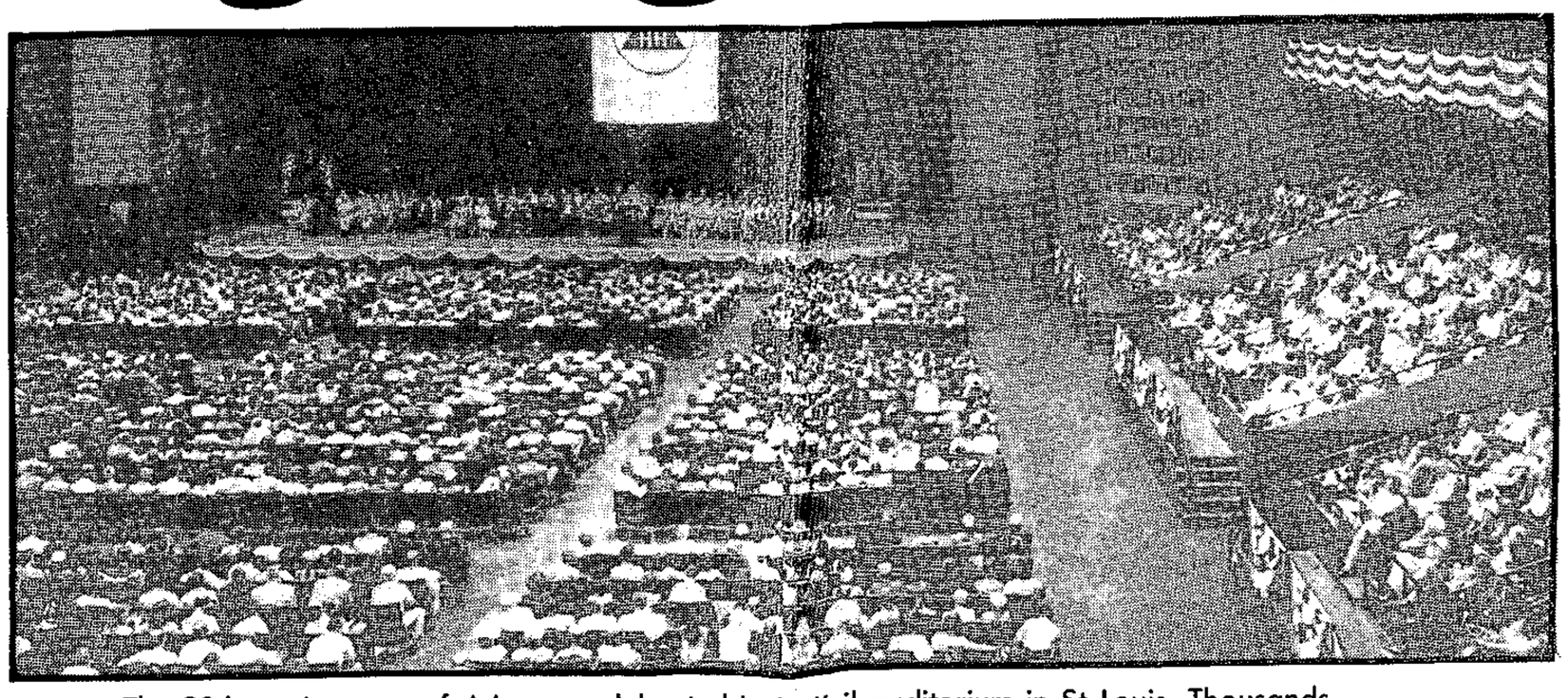
Fifty years sober — and still going strong! . . .

THIS year Alcoholics Anonymous worldwide celebrates the 50th anniversary of the founding of the fellowship by Bill Wilson and Dr Bob in Akron, Ohio on June 10 1935.

AA in South Africa will celebrate the occasion during AA Week from June 10-June 16 adopting the international theme Fifty Years in Gratitude.

The week will begin with an open public meeting at the Claremont Civic Centre at 8.15 on Monday. AA speakers will also be heard on radio

☐ Dr Bob



The 20th anniversary of AA was celebrated in the Keil auditorium in St Louis. Thousands of sober alcoholics were there.

— Reprinted with permission of AA World Service in New York.

☐ Val D

Bestseller that is never advertised

WALK into any bookstore and ask for a copy of the book. More than likely you will be met by a blank stare. Yet the book is one of the five hard-cover nonfiction best-sellers.

It is called Alcoholics Anonymous.

This year it will sell close to a million copies in the English language edition alone. It is published in 13 languages, including Afrikaans, Finnish, Icealandic and Japanese. Its original print order was some 5 000 copies. It sells that many every two days now.

It has never been advertised or promoted — but in 1983 it had sold four million copies.

Powerless over alcohol

by A Member of the As Bill Sees It Group

I AM an enigma to the non drinker. "Why is it" they always ask me, "that you can't drink?". Or they ask: "Why can only one drink do harm to you ?"

Someone once asked: "How on earth will you be able to get through life without taking another drink ?.

Good question.

But there's an answer. I only have to worry about today — I work my programme in a 12 hour spurt. Yesterday I didn't drink. Tomorrow is too far away

Those who knew me 10 years ago - before I came into Alcoholics Anonymous — still have the answer. They smile and say: Booze made him crazy. We couldn't control him".

They ought to know; they always had me to get rid of after a session.

And if you've ever tried to get rid of a persistent drunk you'll know exactly what I am talking about.

But my answer these days to the first two questions is a stock one: To drink is to die.

And for me (I speak for myself although most sober alcholics will bear me out) this is the truth.

If ever I drank again, it would kill me.

No, not at once. But an alcohlic can never take just one drink. And it is always the first one that will do the damage — set me off. Not the 15th.

This is the fact that every alcoholic must face.

And accept.

We go to AA to stop drinking — because we want to stop drinking and because we admitted that we were powerless over alcohol and that our lives had become unmanageable.

Hardest decision

This is often the hardest decision — to want to stop. To admit the messup — the apology — our lives had become.

And I knew it too. Much as outwardly the show still rolled (the happy-go-lucky good chap syndrome) inwardly, the catastrophe of what I didn't want to admit gnawed continuously, insistently. You're an alkie, the little voice that wouldn't go away used to yell. And, secretly, I knew it was so.)

But I took the decision.

And I was the only person who could.

That very first meeting remains an indellible part of me. You can imagine how I felt sitting in a strange hall with strangers all around me — worse, alcoholic strangers.

Yet it was confusing. None of them looked as if they'd spent last night on a beachfront bench.

Was I in the right place? Was I doing the right thing? Was this the answer?

I had become so used to letting myself down time and time again that the surge of hope was stifled almost before it was born.

It was an impossibility to stop, and I knew it.

What was I doing here? There was panic. I had to get out.

But I couldn't.

Fifteen minutes later I was being held spellbound by the speaker. And the amazing thing was that he seemed to be speaking to me. Directly.

I found I wasn't alone. All those things I had done — the bottles I had hidden, the insanity I had created and lived through, the deceit and lies I had practised just for one drink — why, he had done them as well.

The right place

It all suddenly made sense. I had come to the right place. At last.

I admitted I was powerless over alcohol. I admitted that my life had become unmanageable.

And in those admissions three-quarters of my own battle was won.

Some of us with inquiring minds want to know more about this killing compulsion.

I have never thought it was necessary. Sobriety at all costs is the thing that counts — not why we drank.

Alcoholism is a disease. And it cannot be cured by any medical treatment with which we are familiar.

The "cure" — abstinence — lies with the alcoholic himself. And that little sentence: To drink is to die.

One of the most important things an alcoholic learns when he joins AA is honesty — with himself.

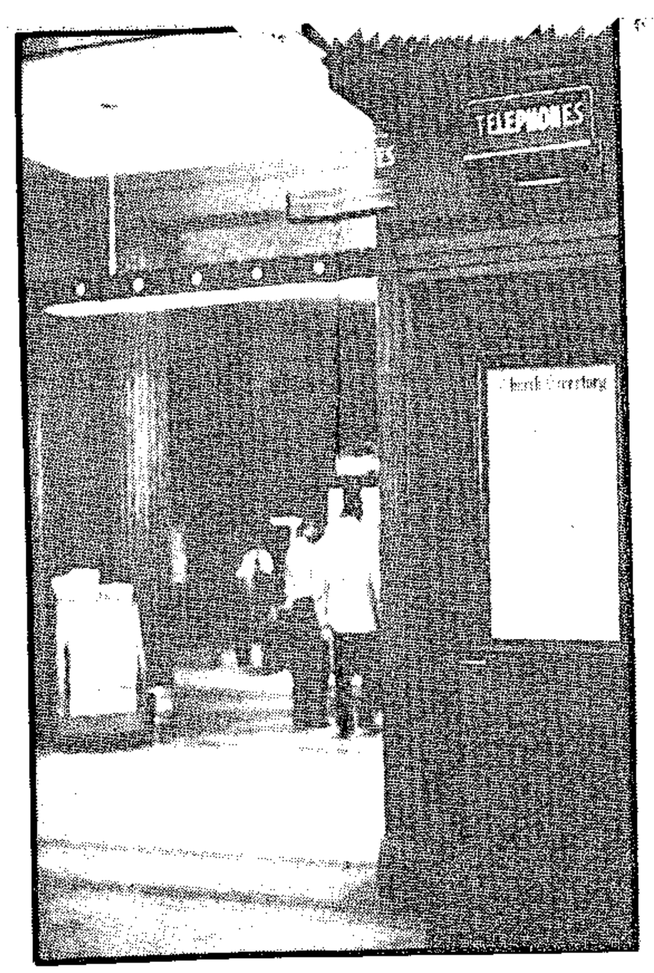
No matter who he fools — by drinking when he says he isn't — the only person he cannot fool is himself.

Twelve steps

The newcomer to AA learns immediately of the "12 Steps", which are guides to his progress along the sometimes very thorny road to sobriety.

Rarely, if ever, has an alcoholic succeeded without taking these steps or "working" the programme.

These steps are sound philosophy.



The historic decision for AA's future was made at this spot in the lobby of the Mayflower Hotel in Akron, Ohio. Here one co-founder turned away the first drink to make a phone call that led to the other co-founder, and to the chain of recovery — 50 years later — that now extends around the world.

— Reprinted with permission of AA World Service in New York.

No. 1, for instance, is the one mentioned before. We admitted we were powerless over alcohol and that our lives had become unmanageable.

than ourselves can restore us to sanity.

No. 3: We made a decision to turn our will and our lives over to the care of God as we understand Him.

No. 4: We made a searching and fearless moral inventory of ourselves.

No. 5: We admitted to God, to ourselves and to another human being, the exact nature of our wrongs.

No. 6: Became entirely ready to have God remove all these defects of character.

No. 7: We humbly asked Him to remove our shortcomings.

No. 8: We made a list of all people we had harmed and became willing to make amends to them all.

No. 9: We made direct amends to such people whenever possible, except when to do so would injure them or others.

No. 10: We continued to take personal inventory and when we were wrong promptly admitted it.

No. 11: We sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry it out.

No. 12: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practise these principals in all our affairs.

Some of the steps may appear insurmountable. They are not.

Steady progress

Steady progress makes the difficult steps easier. Some of us — until we joined AA — looked for an easier, softer way to stop drinking.

None worked. The only sure way is to quit — forever.

And, for me, that one sure way was through Alcoholics Anonymous.

I also discovered that to "join" cost me nothing. The only requirement was an honest desire to stop drinking. AA is self-supporting, relying on donations from members themselves. There are no dues or fees.

to worry about. But I know that today I won't touch it.

My years of uncertainty, indecision, remorse, fear, intolerance have gone.

The impregnable Wall I once built around myself has been finally broken down.

For once I am seeing — and living — life as it should be seen and lived. A technicolour world, exploding with love, vitality and colour.

That's sobriety.

And I can think of nothing more wonderful.

There's one other thing. To me the most important hurdle of my life has been jumped — successfully, as of today. Nothing I know of can be of more importance than my continuing sobriety. Selfish? Well it is a selfish programme — no one else can do the job for you.

It is in your hands.

Why do you drink? I was asked time and time again, by the people I loved more than anything in the world.

In truth I had no answer.

The promises I made, faithfully, that I would never drink again were broken almost the hour they were uttered. I had no desire to hurt, but a compulsion that I could not ignore.

The desire to drink left me totally at the end of my first AA meeting.

A miracle?.

Perhaps. But one I am proud to be a part of.

Permission to use Val D's photograph was granted by his wife and his son as a tribute to him or the fellowship.

HOW IT BEGAN IN SOUTH AFRICA

THE first South African to contact Alcoholics Anonymous in America was a black. His name was Solomon.

He was wandering aimlessly down the streets of Alexandra Township on the outskirts of Johannesburg one hungover morning in 1946.

He was angry at himself and puzzled by what had happened to him. More than that, he was terrified as to what was to become of his family. And his life.

He found himself resting up against a dustbin.

Looking dejectedly down, he saw a Reader's Digest someone had thrown away.

He picked it up.

Inside was a story on AA. He started to read it, suddenly aware it seemed to contain the answers to the questions he had been asking.

Solomon, his heart leaping with an undisguised hope, wrote to the General Service Office in New York.

Literature

By return of post came pamphlets and literature.

Solomon the drunk became Solomon the sober alcoholic.

But it was Val D, who celebrated 37 years sobriety last November 3, who really got things going in this country.

Val D gained his sobriety in November 1947 after reading the "Big Book", Alcoholics Anonymous, given to him by a clergyman he had approached in desperation in Springs in the Transvaal.

Answers

The book gave Val D the answers to his problems and he travelled to Johannesburg one night because he had heard an AA group — started by a stockbroker Arthur S — who had read about AA in the same edition of the magazine that had caught Solomon's attention.

50 1935-1985 ALCOHOLICS ANONYMOUS ALKOHOLISTE ANONIEM

The broker offered alcoholics "rehabilitation" money. The word got around and they rolled up to get the handouts.

It must have been a wild and bewildering night because when he arrived in Johannesburg he found Arthus S had died and the nurse who helped counsel members was on leave.

Shortly after this Val D established a group in Springs which went about helping alcoholics in a more sober fashion.

The group in fact became the hub of AA in the Transvaal.

Cape Town

It was about this time Val D met with Solomon — and about this time that Pat O'F founded AA in Cape Town.

From this point, AA in South Africa went ahead in leaps and bounds, always under the guiding hand of Val D.

Groups were established in Durban, and Pietermaritzburg. Reg C, one of the original Cape Town group, drove specially to East London to get AA going there. Port Elizabeth followed then Kimberley and Welkom and other centres.

In 1951 there were 40 groups, and a magazine had been started.

Val D died two months ago having guided AA through its formative years.

He left a legacy of some 250 groups countrywide — there are some 32 in the Cape area — and thousands of sober alcoholics.

And Solomon?

He lives on and works in Tembisa.

Argus 17/7/85

Alcohol: public enemy No 1 'no friend of business...'

Argus 17/7/85 86

Argus Correspondent

JOHANNESBURG.— Alcoholism and related illnesses are bigger killers in the industrial world than heart attacks and cancers.

Mrs Lea Wilcocks, director of the Centre for Alcohol and Drug Studies, Johannesburg, said this when commenting this week on a report in The Economist -"John Barleycorn no friend of businesss" in which it stated that by the year 2 000 alcoholism and related diseases would be public enemy number one in industry.

Today alcoholism costs business and governments across the world more than R200-billion a year.

"The scale of the problem is huge," says The Economist.

The federal government in America reckons the 10-million adults who abuse alcohol are costing R38-billion a year in lost output.

Days lost

In Britain more working days are lost annually because of alcohol abuse (10-million) than lost by strikes (2-million).

"It is estimated alcoholism costs industry, commerce in South Africa R500-million annually.

"Alcoholism and related illnesses is not only the number one cause of fatality in industry it is also the biggest single factor in deterioration of work performance and and loss of production," said Mrs Wilcocks.

She said while attending a conference in Texas recently it was stated that alcohol, its related illnesses and the consequences of alcohol abuse costs industry and commerce 17 times more than heart disease and cancer.

Rude word

In the bad old days alcoholism was a rude word and the problem, wherever it threatened to raise its ugly head, was bundled into the cupboard.

Now, however, the attitude to the alcoholic in the workplace is changing. Twenty years ago if one was discovered on the payroll he or she was fired.

"Forward thinking firms now recognise alcoholism as a disease and run programmes aimed at early intervention and treatment for alcoholics on their books," said Mrs Wilcocks.

"In South Africa Escom, which has 77 000 employees, has embarked on a national programme for the treatment of alcoholism.

Railways

"Other large establishments who recognise alcoholism as a disease and accept the need to treat it are the South Africam Railways, the Post Office, the Chamber of Mines and most multi-national companies," said Mrs Wilcocks.

There is no common denominator among alcoholics other than their dependence on alcohol — barrister or barman, solicitor or salesman, journalist or judge, company directors or train conductors are all at risk.

More likely to kill alcoholics are cancer of the oesophagus or stomach, brain haemorrhage, heart failure, a road accident, an accident at work or suicide.

"The employee assistance programme of the South African National Council on Alcohol and Drug Abuse (SANCA) is aimed at early intervention and reaching problem drinkers long before they reach rock bottom," explained Mrs Wilcocks.

Two years

SANCA's programme is a two-year one during which training in identifying and treating the problem drinker is given personnel mangagers, supervisors, on-site health professionals and co-workers.

Management, employees and unions are asked to cooperate in indentifying the problem drinker, confrontation techniques and educated in methods of treatment and rehabilitation.

"The alcoholic is no longer confronted only when he starts drinking on the job - an advanced stage of the disease.

Early symptoms of the disease are:

- Abseteeism on mondays and fridays,
- Frequent lateness for work,
- Erratic job performamce,
- Extended pub lunches.
- Frequent days off without a medical certificate.
- Frequent sick leave, and
- Change of doctors who will no longer cover for them." Mrs Wilcocks explained,

Alcoholics Anonymous, Al Anon and Alateen are reccommeded by SANCA as effective "Extra-mural" community resources for problem drinkers.

"The aim is to bring the problem into the open. It happens more and more frequently now that employees exposed to the programme come forward voluntarily and admit a drinking problem and ask for help," she said.

The alcoholics are great self-deceivers. They may recognise the symptoms but refuse to admit they have a problem. If their employer, co-workers and family do not intervene the prognosis is bleak.

If they are "lucky" death will claim them; if not, they could be left with a "wet brain" — irreversible brain damage which turns them into vegetables.

I'm just a fighter, says Malikolo

Sanca's delegate to an international conference on alcoholism and drug abuse talks to KATE McKINNELL about her work.

Mrs Malikolo Motumi tackles problems of awesome proportions.

But she would probably laugh if you told her that, and steer the conversation in another direction.

"I'm a fighter — that's all."

Her title at the South African National Council on Alcoholism and drug Dependence (Sanca) is "development adviser" — a tame description for the developer and co-ordinator of Sanca's entire service for black people in South Africa.

And the post at Sanca was offered on the strength of her work in founding the Johannesburg Childminders Association, an organisation created because of the desperate need for reliable day care for black children.

She leaves today as Sanca's delegate to an international conference on alcoholism and drug abuse in Canada, and she will be travelling around the United States and Britain, studying projects tackling alcohol and drug abuse among minority groups.

Her confidence is casual — the kind so many businesswomen tie themselves in knots to achieve, but never do. And with this strength is a genuine warmth.

Sitting in her Braamfontein office, Mrs Motumi is keen to talk about her work at Sanca.

"The need for work on alcohol and drug dependence among black people is obvious. But until recently, services for blacks were developed just by the way.

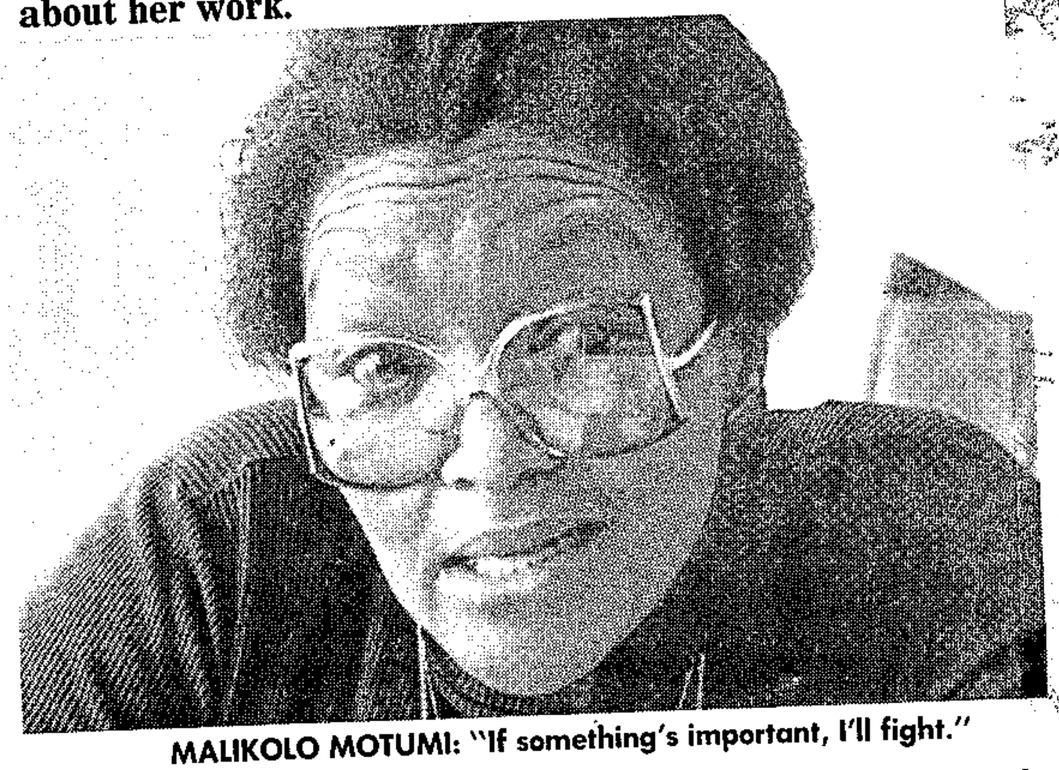
"Now we are helping local bodies to develop and run services themselves," says Mrs Motumi.

She says there are only 20 societies for black people attached to the national Sanca office — most of these are in urban areas. And there are large areas of the Free State and Natal which have no service at all.

It is a problem finding social workers, nurses and other professionals to work in the rural areas.

Influx control laws make it difficult for urban people to work in the rural communities, and some professionals fear losing their rights to live in urban areas if they move to work in outlying parts of the country.

In the year 1980/81, Sanca's out-patient facilities for alcoholics treated 657 black people — a fraction of the estimated number of people needing help.



MALIKOLO MOTUMI: "If something's important, I'll fight."

"We know alcoholism and drug abuse are widespread in both rural and urban areas — there are no statistics showing exactly how serious it is, but alcohol consumption figures are evidence enough.

"The problem is a lack of knowledge — people still do not realise that these substances can be addictive," says Mrs Motumi.

Dagga is no longer used as it was traditionally, in moderate amounts for medicinal purposes, but is smoked for the high it gives. In the townships, glue sniffing and the use of mandrax is on the increase.

"It is no use just applying services for white people to help people in the townships and rural areas — we have to develop specific services.

"This is mainly because the attitudes to alcoholism and drug dependence are different among black people," says Mrs Motumi.

Firstly, both the abuser and his family may not be aware the dependence is a disease which can be treated.

Health workers may need to point out the problem, and not wait for patients to seek help as is expected in the white population.

The black community also tends to see alcoholism as a disgrace and alcoholics and addicts may be rejected by families and friends who have the attitude that they should "pull themselves together".

Because of this, the helper needs to reach the entire family, to educate them as well as helping the addict to find other coping mechanisms.

"The central issue is a lack of education — at even primary school levels people should be made aware of the dangers of alcohol and drugs.

"And this problem is found among minority groups worldwide," says Mrs Motumi.

She says the socio-political situation in South Africa is an obvious factor behind the increasing alcohol and drug problems among black people. Poverty, frustration and a lack of recreation breed problems.

"Another point of contention is the free availability of alcohol. Why is it the provision of alcohol so often seems to take priority over other facilities?

"Why is liquor available at just about every station in Soweto? Why do local authorities grant liquor licences in areas where supplies of basic necessities are inadequate?

"It's ridiculous."

She fights, she says, for things she feels strongly about — issues which may in their nature be political, but which for her are the difference between right and wrong.

"I say what I think, and sometimes that threatens authorities. I can cope with that," says Mrs Matumi.

Her father, a Dutch Reformed minister, always predicted she would become a social worker.

"If it hadn't been social work, it would have been nursing — I love being around and caring for people — and I always have the energy," says Mrs Matumi.

After completing her social work degree, she worked for a Government health department until 1977, when she visited the US on an exchange programme.

After this, she helped compile a report on facilities in Soweto for the Urban Foundation and later spent three months studying community projects in Britain.

"I love travelling, but most important, I've found I can input into my community what I learn overseas. Programmes can't be duplicated, but they can adapted," says Mrs Motumi.

Combining knowledge she had gained overseas and her own strong feelings, she established the Johannesburg Childminders Association in 1980, and is still chairman of this organisation.

Divorced, with three children, Mrs Matumi knows the desperation of thousands of working Soweto women trying to find day care for their children.

She had to return to work when one of her children was only two months old, and battled to find adequate day care for them.

Only one pre-school centre in Soweto took children under the age of three, while there was no guarantee of the reliability of childminders.

The association trains its members in child care and sets standards of hygiene. It also helps childminders buy food and equipment at reduced costs.

Not only will mothers be sure of quality care for their children, but the childminders themselves are protected and promoted by the organisation. More women are also encouraged to become childminders, alleviating the shortage of day care facilities.

"It is still my pet project, mostly because I love children."

Mrs Motumi received an honours degree for her thesis on the childminder project, and she still takes an active part in its operation.

"I'm involved in a few other organisations, it is difficult to say no when people need help. I have far too much to do. But that's me," says Mrs Motumi.

Strike-hit bakers roll out the bread

Argus Correspondent

DURBAN. — Bakeries at shops here worked at full steam through the night to meet the huge demand for bread and rolls as a strike entered its second day.

Many customers queued long before stores opened.

At one supermarket nearly 1 000 soft rolls and 800 loaves of special bread were snapped up between 8.30 and 8.45am.

"Sales have been fantastic," said the bakery manager, Mr Geoffrey Davies. They usually baked 40 special loaves and 200 dozen rolls, but yesterday they baked 998 loaves and 2 500 dozen rolls.

He had worked through the night and hoped to keep up a steady supply today. Other stores were also baking their own bread.

"I normally do 22 bakes, but yesterday I did 86," said the manager of another supermarket-based bakery, Mr Eddie Oelofse.

However, he predicted that his supply of flour would run out today.

● Workers at the Stanger bakery failed to arrive, bringing the eighth major bakery to a standstill.

A spokesman for the employers, Mr Patrick McLaughlin, said workers were nervous about continuing to work yesterday and did not arrive for work today.

"This means that the chain is now complete, with only the Umlazi bakery still working," he said.

Alcohol a bigger killer in industry than cancer, say experts

Star 27/7/85

Medical Reporter 86

Alcoholism and related illnesses are bigger killers in the industrial world than heart attacks and cancers.

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"Alcoholism and related illnesses is not only the number one cause of fatality in industry, it is also the biggest single factor in deterioration of work performance and loss of production," said Mrs Wilcocks.

Company chiefs top of 'league'

Standard mortality rates from cirrhosis of the liver in various occupations as provided by the Office of Census and Surveys, England. Average ratio 100:

- **Company directors 2 200.**
- **Publicans and innkeepers 1 576.**
- **Seamen (officers) 781.**
- **Barmen and barmaids 633.**
- **Seamen (rating) 628.**
- **Fishermen 595.**
- **Hoteliers 506.**
- **Insurance brokers 392.**
- **Restauteurs 385.**
- **Lorry drivers 377.**
- **Cooks 354.**
- **Armed forces 350.**
- **Shunters and postmen 323.**
- **Authors and journalists 314.**

She said while attending a conference in Texas recently she had heard that alcohol, its related illnesses and the consequences of alcohol abuse cost industry and commerce an astonishing 17 times more than heart disease and cancer.

In the bad old days alcoholism was a rude word and the problem, wherever it threatened to raise its ugly head, was bundled into the cupboard.

Now, however, the attitude to the alcoholic in the workplace is changing. Twenty years ago if one was discovered on the payroll, he or she was fired.

SEEN AS A DISEASE

"Forward-thinking firms now recognise alcoholism as a disease and run programmes aimed at early intervention and treatment for alcoholics on their books," said Mrs Wilcocks.

Du Pont in America was the first business to recognise alcoholism as a treatable disease when it lauched a programme for alcoholic employees in 1942. American Airlines was another pioneer.

Among the forward thinkers in West Germany are Siemens, the electronic company, and Schering, the pharmaceutical and chemicals combine.

In Britain Debenhams, Marks and Spencer, Boots, British Airways, General Electric, the Post Office and British Rail (whose workers rank highest among deaths from cirrhosis of the liver) all run treatment courses for alcoholics.

"In South Africa Escom, which has 77 000 employees, has embarked on a national programme for the treatment of alcoholism.

"Other large establishments who recognise alcoholism as a disease and accept the need to treat it are the South Africam Railways, the Post Office, the Chamber of Mines and most multinational companies," said Mrs Wilcocks.

The simplest definition of an acloholic is somebody who, having picked up the first drink cannot predict with any certainty when he or she will stop.

There is no common denominator among alcoholics other than their dependence on alcohol — barrister or barman, solicitor or salesman, journalist or judge, company directors or train conductors are all at risk.

Cirrhosis of the liver — with company directors highest of the list of victims — is not the only killer although it is an indication of the national problem.

More likely to kill alcoholics are cancer of the oesophagus or stomach, brain haemorrhage, heart failure, a road accident, an accident at work or suicide.

EARLY INTERVENTION

"The employee-assistance programme of the South African National Council on Alcohol and Drug Abuse (Sanca) is aimed at early intervention and reaching problem drinkers long before they reach rock bottom," explained Mrs Wilcocks.

Sanca's programme is a two-year one during which training in identifying and treating the problem drinker is given to personnel mangagers, supervisors, on-site health professionals and co-workers.

Management, employees and unions are asked to co-operate in indentifying the problem drinker, confrontation techniques and educated in methods of treatment and rehabilitation.

"The alcoholic is no longer confronted only when he starts drinking on the job — an advanced stage of the disease.

"Early symptoms of the disease are:

- Abseteeism on Mondays and Fridays.
- Frequent lateness for work.
- Erratic job performamce.
- Extended pub lunches.
- Frequent days off without a medical certificate.
- Frequent sick leave.
- Change of family doctors who will no longer cover for them."

Mrs Wilcocks explained, "some doctors are loth to state the real reason for an alcoholic's inability to work."

Employers and personnel staff are warned to be wary of frequent medical certificates which diagnose nervous debility, anxiety, depression, gastritis or enteritis. These are all genuine ailments but often are medical shorthand for "too much booze".

Sanca's employee-assistance programme involves out-patient care on site, group therapy, individual therapy and medical therapy.

Alcoholics Anonymous, Al Anon and Alateen are recommeded by Sanca as effective "extra-mural" community resources for problem drinkers.

'A drink a day is healthier than none'

(86) Star 29/7/85

Own Correspondent

CAPE TOWN — Light drinkers could be more healthy than people who did not drink at all, an American cardiologist told a Cape Town symposium on alcohol and health.

Professor A L Klatsky, of the Kaiser Permanente Medical Centre in California, said population studies as far back as 1926 suggested that abstainers did not fare as well as people who drank small to moderate amounts of alcohol.

Professor Klatsky said more recent studies agreed that abstainers ran more risk of major coronary heart diseases than light or moderate drinkers.

"Belief in the existence of a possible protective effect of alcohol has been strengthened by the emergence of a hypothetical mechanism for protection via the high density lipoprotein cholesterol," he said.

Professor J E Rossouw, director of the National Research Institute for Nutritional Disease of the South African Medical Research Council, told the symposium studies had shown that in males aged 55 to 64, alcohol had a strong protective effect.

In young males, however, it had an adverse effect except at low levels of intake (about one drink a day).

"In females the effect was protective through the dose range, but no conclusion could be reached about the possible effects of high dosages," he said.

"Overall, one drink a day appears to be protective, but at a level of two or more drinks a day higher risks appear, particularly for younger males."

Smoking plus drink danger warning

Own Correspondent

CAPE TOWN — Tobacco used with alcohol has been associated with cancer of the mouth, pharynx, larynx and oesophagus, while alcohol intake sufficient to cause cirrhosis increased the incidence of liver cancer, a symposium in Cape Town has heard.

Dr J S Harington, head of the cancer research department of the National Cancer Association, said alcohol and smoking each enhanced the others' effects.

Dr D Labadarios of the metabolic unit at Tygerberg Hospital said the alcohol absorption rate could be affected by the presence of food in the stomach, the period over which ingestion occurred and the dilution and type of drink consumed.

There was powerful evidence that heart muscle damage (alcoholic heart disease) was linked to the use of large amounts of alcohol, Professor A L Klatsky of the Kaiser Permanente Medical Centre in California said.

Alcohol could also be linked to high blood pressure and a high mortality rate from cirrhosis, accidents, infections, certain malignancies and cardiovascular disease, said Professor Klatsky.

Capt Tim H
29/7/85

Beer sells best

Staff Reporter

SOUTH AFRICANS bought nearly 90-million litres of sorghum beer in 1983, nearly 60-million litres of malt beer, 30-million litres of spirits, 30-million litres of natural wines and 10-million litres of fortified wine, Dr G Loubser, head of quality control at Stellenbosch Farmers Winery, said on Friday.

He was speaking at the first symposium — on "Alcohol, Nutrition and Health" — to be held by the recently formed Cape branch of the Nutrition Society of South Africa at a City hotel.

Dr Loubser said 40,6 percent of the total South African market in 1983 consisted of sorghum beer, 27,3 percent of malt beer, 14,3 percent spirits, 13,2 percent natural wine and 4,6 percent fortified wine.

In 1984, estimates were that 75 percent of the beer sold was to blacks, 75 percent of whisky to whites, 42 percent of unfortified wines to coloureds and 35 percent of fortifed wines to coloureds.

● Maternal alcohol ingestion poses a major threat to the unborn child, with even moderate "social" drinking having harmful effects on the foetus, delegates were told on Thurday by Dr C Palmer, senior specialist at the Department of Pediatrics, Groote Schuur Hospital.

● Men can safely consume twice as much alcohol as women, and a daily intake of 500ml of beer for men and three glasses of wine for women is regarded as safe, said Dr Steve O'Keefe, of the Gastro-intestinal Clinic at Groote Schuur.

New 'cravecure' method to help beat alcoholism

Star 31/7/85

86

A new method of administering nitrous oxide and oxygen in carefully controlled doses could help alcoholics control the disease, the South African Brain Research Institute announced in a statement yesterday.

More than a million South Africans were already addicted or at risk of developing an alcohol dependency, the Sabri statement said.

The institute, in announcing its new "cravecure" method of fighting alcoholism, said the problem had reached "almost epidemic" proportions in South Africa and that the most disturbing trend was the growing number of women turning to drink.

"Although nitrous oxide and oxygen are natural substances with minimal adverse effects, they must be used in the correct proportions under professional medical provision.

"It would be a very grave mistake for anyone having access to these gases to start experimenting with them or think that by themselves they offer a quick and easy cure to drinking, smoking and other addiction problems," the statement warned.

Sabri said that alcoholism was a problem in all sectors of the community and the problem was exacerbated by the present stresses because of the recession and unemployment.

TECHNIQUES

To provide practical help for those with drinking problems, Sabri introduced the "cravecure" method, a statement said.

"We wish to extend to the community the techniques developed by Sabri during five years of research work, sponsored by the South African business community," institute director Dr Mark Gillman said.

These facilities have just become available at a day clinic in Johannesburg and apply techniques developed over the past five years by Sabri.

The same techniques have been used by Rand Aid in Johannesburg in the treatment of more than 2 000 in-patients suffering from alcohol withdrawal symptoms. The work has attracted widespread international interest.

The acute craving experienced in the early stages of withdrawal from alcohol and nicotine addiction can be eased by a short procedure involving the administration of nitrous oxide and oxygen gases in carefully calculated quantities.

The clinic has the special equipment required for the administration of the gases. Patients seek ing help to combat craving can call in as conveniently and discreetly as making a routine visit to the doctor.

Dr Gillman said one of the important benefits of the technique was that it cost less than most conventional methods. — Sapa.

100 000 whites are alcoholics, says Minister

86

STAR 21/8/85

Joe Openshaw,
Medical Reporter

There are an estimated 100 000 white alcoholics in South Africa and indications are that alcoholism is increasing among other population groups, the Minister of Health Services and Welfare, Dr D G de V Morrison, said last night.

He was addressing the annual meeting of the East Rand branch of the South African National Council on Alcoholism and Drug Addiction (Sanca), in Boksburg.

He said there were 10 million alcoholics in America and an increasing number of them were in the younger age group.

In Georgia alone, the number of teenage alcoholics is estimated to be 45 000.

According to the International Labour Organisation (ILO) there had been a steady world increase in the consumption of alcohol, the Minister said.

"The consumption of wine has increased by 20 percent in the past 20 years, spirits by 50 percent and beer by more than 124 percent.

"What is unsettling is the fast-increasing consumption of alcohol in the developing countries.

"It is estimated that if consumption grows at the present rate, the per capita consumption in developing countries will be higher than that of developed countries within a decade."

Dr Morrison said 62,9 percent of drivers and pedestrians killed in road accidents had a marked blood/alcohol content.

He said 56,9 percent of these drivers and pedestrians had a blood/alcohol content higher than the legal 0,08 percent.

The Minister referred to the educational value of the alcohol safety schools established in six centres.

MAGISTRATES

These were Pretoria, Cape Town, Bloemfontein, Port Elizabeth, Durban and Johannesburg.

"An alcohol safety school will be established on the East Rand soon," said Dr Morrison.

The success achieved with these schools is reflected by the extent magistrates made use of them — more than 2 000 people have attended the schools since the first was established in 1978.

More women are now boozers

86

2/9/85

So Wotan

By SIZAKELE KOOMA

SOCIAL workers and other community leaders say that more and more women are taking to drink, threatening the very fabric of our society.

A social worker with the South African Council for Alcohol and Drug Abuse, Miss Lonia Rashapua, believes that the reason for the increase in the number of women who drink is that many are trying to prove their equality with men by drinking.

"Some women believe that by matching men at drinking, they will be recognised as the equals of men in society," Miss Rashapua said. "It is a mistaken conception of the women's movement."

Miss Rashapua says many women drink because of the demands on their work, but the majority start drinking at social gatherings.

"Changing roles, moving from that of housewife to the professional world is a drastic step for women. Many find it difficult to cope with the transition and some of them resort to drinking, like most of their male colleagues do," she said.

Drinking at social gatherings like parties, nightclubs and shebeens has become fashionable among women.

Shebeen owners say that the number of their female customers increases by the day and some of the customers are as young as 16.

Mr Kenneth Khalimba, an assistant in an Orlando East, Soweto, shebeen, says the trend is towards shebeen entertainment.

"Most of the girls who come to our shebeen are adolescents who are crazy about nightlife. They come in groups and most of the time without male companions. Most of them prefer wine to spirits, but they take exaggerated quantities of the stuff," he said.

The Rev John Tau, director of the Soweto Society for Marriage and Family Life, says drinking is a symptom of a problem that a person may have.

Shebeens

"Children drink because they are frustrated by the lack of recreational facilities in the townships. Drinking has become the only pastime for the young generation. They are being driven to shebeens by frustration," he said.

Miss Rashapua has warned that occasional drinking can easily develop into a habit. And once it reaches this point, the descent into addiction and alcoholism is very swift.

She says that a person does not admit that she is addicted until she gets into some sort of trouble like an accident or a blackout.

"Most of alcoholics seek medical treatment when they already have health problems, when they have contracted one of the diseases caused by alcohol abuse, like cirrhosis of the liver, gastritis or stomach ulcers," she said.

About 10 patients aged between 25 and 50 are admitted to the Sanca clinic each month.

"Alcoholic women become burdens to their families. The husband always has to protect his wife and cover up for her in society.

"Children lose respect for their parents. They avoid bringing their friends home. They feel unloved. This is where delinquency starts. Children drop out of school and loiter around the townships," said Miss Rashapua.

Women we interviewed denied that they were heavy drinkers. They said their intake was relatively low compared to that of men.

"I drink just for fun, sometimes to relax and also because the liquor is there. I think I am a social drinker because I do not go out to buy it. My boyfriend loves going to shebeens and if I want to see anything of him I go too. I do not mind going there because I meet amusing people," said Miss Z of Alexandra.

Tension

Miss S said she drinks mainly to relieve tension because she has a demanding job that takes a lot out of her during the week.

"I love the tart taste in liquor. If I try to relax without a drink, I find that I am dull, restless and cannot sit on my own. I buy a six-pack of beer for the weekend. I can hold my liquor well so I drink more at parties. I usually leave when I have had enough."

Miss S said she thought women who drink too much want to be noticed or have someone take care of their problems. She said most of the women she know drink far below the dangerous level.

"I take a glass of wine to relax me if I have three unsettled nights in a row. When I was at school I liked to relax with a few glasses on Fridays. I have a limit of two glasses at parties; I drink them to relax and also to put me in a good mood," said another

Many would be ashamed of alcoholic

86

10/10/85 Medical Reporter STAR

Although 80 percent of white urban South Africans believe alcoholism is a disease and not a vice, 40 percent admit they would be ashamed to have an alcoholic in the family.

More than half the white urban population believe alcoholics merely lack willpower to stop drinking and 18 percent disagree that alcoholism is a disease.

These are among the findings of a recent Gallup Poll, conducted by the Markinor Research Group among 1 000 adults in the major centres.

A disturbing finding was that one in three respondents claimed to have relatives or friends who suffered from alcoholism.

The survey found a number of misconceptions about alcoholism:

- 54 percent believed alcoholics merely lacked willpower.
- 10 percent viewed accoholics as "bums" who slept in the park.
- 15 percent believed alcoholics were hopeless cases.
- 28 percent believed alcoholics could control their drinking and total abstinence was not necessary for recovery.

Alcoholics Anonymous was named by 62 percent as the first community resource to turn to for help and advice.

But many of these had mistaken ideas of what the organisation really was, and were unaware it was a self-supporting fellowship which did not accept contributions — the only qualification for membership being a desire to stop drinking.

- 57 percent believed it was a welfare organisation.
- 47percent thought it was a temperance society.
- 28 percent thought it was a religious organisation.
- 21 percent thought it was a group of people who taught others to drink normally.

HEALTH AND DISEASE — GENERAL

1985

40 doctors face axe

THE FATE of about 40 Baragwanath Hospital doctors, most of them senior housemen and registrars, last night hung in the balance.

This follows reports that the Director of Hospital Services, Dr H van Wyk, sent a directive to the hospital ordering that hospital costs, including the employment of doctors be cut by ten percent. The 40 doctors were employed at the beginning of this month.

The fear that the doctors may lose their jobs in this move by the Provincial Administration to cut running costs was reportedly confirmed by Professor D Moyes, deputy Dean of the University of

By SELLO RABOTHATA

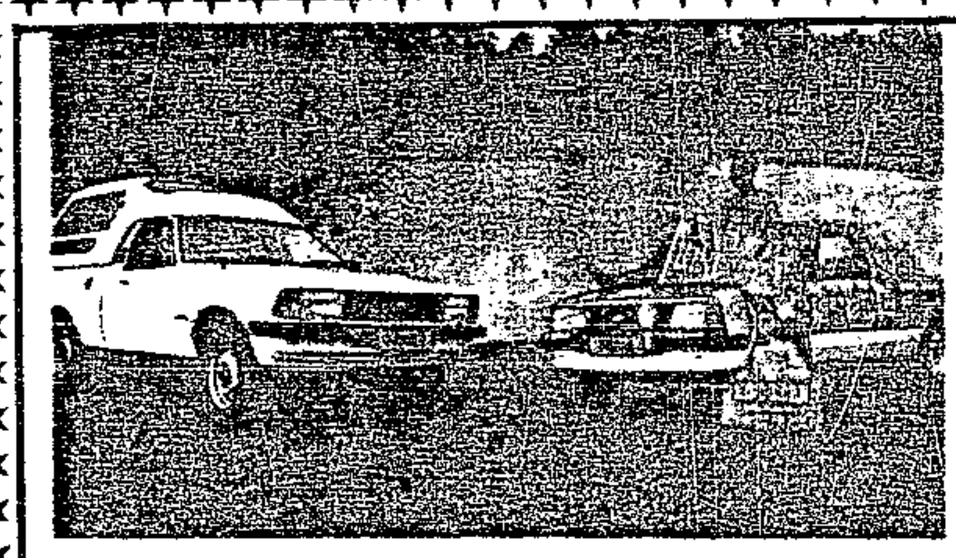
the Witwatersrand's Medical School. Talks on the issue were still being held yesterday and when **The SOWETAN** tried to get a comment from Dr van Wyk, he was said to be still in a meeting.

This decision is also seen as racially inspired as Baragwanath has always suffered a staff shortage and this reduction could seriously reduce the efficiency of the hospital, always stretched to the limit.

News of the move has not been taken lightly by the Black Health and Allied Workers' Union. The union's president, Mr Daniel Komaphe, said: "We are watching with a keen eye. It is not good to retrench people because they do not have any retrenchment procedure.

Dr Nthato Motlana said he acknowledges the fact that the economy is in a shambles but cost-cutting should be made at white hospitals, not at black ones.

"The white patient has so much at his disposal while the black one has to endure overcrowding and lack of proper medical care etc. It is therefore out of the question for costs to be cut at black hospitals. Instead, the money should be used to improve these hospitals," he said.



LETTERS

The Editor, Rand Daily Mail,
Box 1138, Johannesburg 2000.

RDM 17/1/85 ~~[illegible]~~ ~~[illegible]~~ 85

Asbestos — lack of concern for public

IN a letter published on December 21, Mr L B Lewis, the Marketing Manager of Everite Ltd, a large asbestos product company, has once again underrated the deadly hazards associated with this mineral.

Mr Lewis claims that asbestos cement products do not liberate significant amounts of respirable fibres.

Numerous studies show that the effects of the weather, pollutants such as acid rain and handling of the products do cause considerable fibre release.

For example, a concentration of 1 000 fibres per cubic metre was measured in the surrounding air of a wall faced with asbestos cement tiles (Studies in Environmental Science Vol 8).

Secondly Mr Lewis remarks that, in the photograph, the removal of the asbestos roofing from the Kromellemboog school is being done under adequate supervision. This comment further shows the lack of concern for the South African public displayed by the asbestos industry.

The only supervision shown are two men wearing overalls. No equipment for dust level measurement can be seen nor are any of the standard safety precautions visible.

While moving the school is welcomed, the ongoing presence of a large asbestos dump remains a health hazard for the nearby communities.

Finally Mr Lewis claims that consumers of asbestos products are encouraged not to do their own cutting or drilling, however there is little consumer warning of the health hazards associated with asbestos.

Nowhere in two of the catalogues issued by Everite — "A Guide to (asbestos) Container Gardening" and "Handmade (asbestos) Plant Containers" — is mention made of how deadly this dust can be.

The barest minimum exposure to asbestos can kill. A recent tragic example involved two sisters who both developed an asbestos cancer after cleaning a white asbestos cement roof. (BMJ June 1984)

Evaluation of all available human data provides no evidence for a threshold for a "safe" level of asbestos exposure (US Department of Labour). — **ASBESTOS RESEARCH GROUP, Berea, Johannesburg.**

Weekend hospital fees to rise

By SYD KHUMALO

AS FROM February 1, getting sick on weekends and public holidays will be more expensive, with hospital tariffs rising by 50 percent.

This announcement was made by Mr D P Kirstein, a member of the Executive Council (MEC) in charge of hospital services in the Transvaal. He said all paying patients are to pay a levy of 50 percent more on a normal tariff for out-patients and emergency treatment after hours between 5 pm and 7 am on Saturdays, Sundays and public holidays.

People are also going to be asked to furnish proof of income on admission to all hospitals. The annual income of the household will determine how much a family member must pay when going to a hospital or clinic.

"The department would like admission of patients to be handled without unnecessary delay for the convenience of the patient. For that purpose it is essential that information submitted by the patients for purposes of admission, be verified.

"Hospitals in future will insist on proof of income on admission of the patient. In the meantime I would like to appeal to the public to co-operate by obtaining the necessary documentary evidence before hand, in order to have it readily available when admitted to a hospital," said Mr Kirstein.

The Director of Hospital Services, Dr Hennie van Wyk, revealed that the tariffs have not gone up since March last year. The current tariffs are:

IN PATIENTS

Group	Description	Fee
H1 and H2	Special pensioners	Free
H3	Ann. income of R1 440 or more	R10
H4	Ann. income of R3 000 or more	R15
H5	Ann. income of R8 750 or more	R20 per day
	OUT PATIENTS	
H1 and H2	Special Pensioners	Free
H3	Ann. income of R1 440 or more	R2 per visit
H4	Ann. income of R3 000 or more	R2 per visit
H5	Ann. income of R8 750 or more	R7 per visit

Private patients will pay R45 per day, with Workmen's Compensation Act (WCA) patients paying R50 per day. These categories will also not receive medication from the hospital, but will have to pay extra or make alternate arrangements.

Outpatient charges for private patients are R20 per visit and WCA patients R25 per day.

Meanwhile, good news is that private doctors are not yet thinking of raising their tariffs. Dr Elset Prinsloo, the senior assistant secretary of the Medical Association of South Africa said that though it is not easy to talk of a uniform fee for private practice, "I can mention that patients who are not members of the medical aid will pay from R10 up to R15 depending on the nature of sickness and of course the kind of medicines given to the patient. Those in the medical scheme are expected to pay R9,50 for consultation and the doctor will give the patient a prescription to be taken to the chemist," she concluded.

Soweto infant mortality rate shows sharp decline

THE infant mortality rate in Soweto has declined to the level reached by black Americans as recently as 1970.

And Soweto's rate has decreased dramatically since 1950 when almost one in four black babies in the Johannesburg municipal area died before they reached the age of one year. Today Soweto's figure is one in 33.

The reason, say health experts, is that the process of urbanisation is accompanied by vast improvements in quality of life.

Clean, running water, water-borne sewerage, accessible health facilities, literacy and education, and the greater sophistication of urban life all contribute towards an improved life expectancy, the experts say.

However, the official infant mortality rate for Soweto of 32 deaths per 1 000 live births is still much high-

By PAM KRAMER

er than the 1980 figure for black Americans — 21,4 per 1 000 — and the 12 per 1 000 for white South Africa.

South Africa's overall infant mortality rate is 90 per 1 000. Botswana's and Kenya's is 80 and Zimbabwe's 70.

Deliver

Although the figures are largely accurate, Dr Les Irwig of the University of the Witwatersrand medical school said that about 20% of women who deliver at Baragwanath hospital are untraceable after a few months.

"It is reasonable to suggest that 20% of infant deaths are not reported which may result in a slight under-estimation in the statistics."

Dr Irwig said the Soweto figure could be as high as 42 per 1 000.

And Soweto is probably the most sophisticated of South Africa's black urban townships.

In a paper published in 1982, Professor Harold Stein, head of paediatrics at Baragwanath, reported that factors such as increased income, improved nutrition, sanitation, safer water, better hygiene and education all accounted for the improved mortality rates.

"The fact that a mother can read a tin to tell her how to mix food makes all the difference."

According to Prof Stein the two main causes of death — malnutrition and gastro-enteritis — are being treated far more efficiently at Baragwanath than they had been decades ago.

In 1956 one in four infants died of gastro-enteritis. In 1980 deaths due to gastro-enteritis had dropped to about 2%.

Baragwanath sees fewer extreme cases of malnutrition — 9% in 1980 as opposed to 40% in 1950.

"Mothers are becoming more aware of health and are bringing their children in much earlier. Greater earning capacity to buy the right kinds of foods is also a factor."

Improvement

Professor Cyril Wyndham of the Institute for Biostatistics at the University of the Witwatersrand, said the improvement was largely due to the "tremendous drive in the clinics to get across the message put forward by the United Nations Children's Fund concerning primary health care".

Dr Marius Barnard, PFP health spokesman, said: "Urbanisation improves health.

● To PAGE 2

Soweto infant death rate drops

The government policy to decentralise increases the population as well as the infant mortality rates."

The urban mortality rates were startlingly better than those in the rural areas, he said.

Dr Barnard said the urban figures, which could now be compared with other African and most South American

● From PAGE 1

countries, were also far more easily obtainable than those for the rural areas.

"The trouble is that we know basically very little about the rural areas. The question is: is every death reported? If you go to places like Beaufort West you'll get the fright of your life at the high coloured and black infant mortality rates there."

For Transkei the death rate in 1980 was 130 per 1 000 infants under the age of one.

A survey conducted in the rural Ciskei in the same year (one year before independence) revealed that the infant mortality rate was estimated at between 180 and 240 per 1 000 live births.

A study by the Bureau for Economic Research at the University of Stellenbosch in 1977 found that 25% of black children in the rural areas of the Transkei and the Ciskei died before they reached one year.

The man behind THE Report

● Prof Tjaart van der Walt, the man behind the controversial report on the disturbances on the East Rand is not what you might have expected. Joe Podbrey interviews him.

Turn to LIVING

Health care: sold to those who can pay

BARBARA LUDMAN

HEALTH care in South Africa is a commodity, sold to the people who can afford it, not those who need it.

The prevalence of poor health among rural blacks is a direct and logical outgrowth of the present economic and political system — making improvement unlikely.

Yet health workers who try to redress the balance by setting up community programmes in black rural areas often fail, because they don't adequately understand the communities in which they work.

So writes Cedric de Beer, research officer for the community health department at the University of the Witwatersrand medical school, in the just-published "The South African Disease: apartheid health and health services".*

The book draws a distinction between health and health care.

"The health profile of the population is very bad, particularly in rural areas, because of the extent of poverty," he says.

"And health care services are not geared to meet the health needs of the public at large.

"The link between these two things is apartheid and the economic structure, because they determine largely who will be poor and who will not — and where the social resources of the country are directed."

It's a historical phenomenon, illustrated by the introduction of tuberculosis into the country at the end of the last century by British and European miners.

Poor living and working conditions made black mineworkers easy targets; sent home when they were found infected with the disease, or when their contracts were completed, they carried the germ into the countryside.

At the turn of the century, a tuberculosis commission found the way to stop the spread of the disease was to improve living and working conditions. That did not happen.

Nor did it happen in 1944, when the Gluckman Commission — headed by the MP for Yeoville, later Minister of Health, Dr H Gluckman — proposed a health service "which might have put good, free health care within the reach of every person in South Africa".

The commission noted that services provided by private doctors were "totally inadequate for the great mass of the people, to whom they are supplied, in the main, not according to their needs, but according to their means" — a situation that, says Mr De Beer, has not changed, with health care promoted as a commodity which the individual should buy, and health services in the impoverished homelands "minimal".

"In addition," Mr de Beer writes, "the commission put the prevention of ill health above the curing of disease. This concept, very popular today, was almost unheard of at the time."

The commission noted that "first and foremost among the causes of ill health are the economic poverty and social backwardness of the greater part of the Union's population.

"Vast numbers of people in this country do not earn enough to purchase the minimum of food, shelter and clothing to maintain themselves in health ... malnutrition is rife throughout the land ... housing is a problem."

And the commission pointed out that "unless there are vast improvements made in the nutrition, housing and health education of the people, the mere provision of more 'doctoring' will not lead to any real improvement in the public health".

A partial solution was better than none at all. The commission proposed a national health service, with personal health services supplied free of charge, hospitals run by the state, not the provinces, and community health centres staffed by doctors, dentists and health visitors, with one centre for every 10 000 to 30 000 people.

The report was adopted, but its recommendations were never implemented. Mr De Beer writes that they could not have been.

"The Gluckman Commission was perceptive about many things. But it failed to come to terms with the nature of the economic system, and the political structures through which it expected its plans to be implemented.

"Only a radical change in the distribution of political power would have enabled a majority of people to enforce demands for a truly national health service."

The result Mr de Beer saw when he worked for the Environmental and Development Agency, a privately-funded group which promotes self-help projects, many of them health-oriented, in black rural areas.

It was in the late Seventies and, as part of his job, Mr De Beer toured health institutions in the Transkei and KwaZulu.

"We found health care largely restricted to fairly isolated hospitals, which were isolated also from the communities where they existed," he says.

"There was very little understanding of the social context from which their patients came, and basically no understanding of why poverty exists to the extent that it exists.

"In almost all instances the people working were very dedicated, doing the best they could to provide health care.

"But there were a number of problems: a dreadful lack of resources; in most cases, a purely curative bias, when prevention is both more cost-effective and more effective in reducing disease incidence; and the lack of an adequate understanding of the social context."

CEDRIC DE BEER ... "The struggle for social justice is also a struggle for health"

"People," he says, "are trying to launch community health programmes without adequately understanding the communities in which they work.

"For example, they will promote agriculture in a situation where up to 50% of the population is landless, or health education programmes relating to things like nutrition and hygiene which preach messages that people are simply unable to act upon."

He cites some chilling statistics. Not all are specifically attributed; but those that are include a Lebowa government survey concluding that 100 000 children in the area were malnourished, and that Kangwane, which houses less than 1% of South Africa's population, was responsible in 1980 for 20% of the notified cases of typhoid.

A survey carried out in Nqutu, in KwaZulu, found that 62% of the mothers of malnourished children knew what was necessary for a balanced diet for their children, he writes, but "they simply could not provide it. It was also found that 13% of mothers of well-nourished children ... not describe an adequate diet".

His conclusion: when a wide range of food is available "mothers will feed their children adequately without knowing exactly what proportion of protein, fat, energy, vitamins and trace elements should be in the diet."

Illness does not arise so much out of ignorance but out of deprivation.

"Injustice and exploitation are as important as germs in causing disease, and social justice is as powerful a medicine as any drug," he writes.

"Patterns of disease are related to class, standard of living and political power of different groups ... the realities of apartheid are not to be found in segregated parks and separate lavatories, but in the infant mortality rates in resettlement camps, in the cholera epidemic in KwaZulu and TB statistics of the Transkei.

"The struggle for social justice is also a struggle for health."

* The South African Disease, by Cedric de Beer (Southern African Research Service, PO Box 93174, Yeoville 2143).

Asbestos: the true perspective

DR F J WILES — Director: Medical Bureau for Occupational Diseases

IT IS widely recognised that exposure to asbestos can be a danger to health and no responsible person would wish to underestimate the risks.

It is important, however, that discussion of the problem should be scientific and objective and that sensational public statements should find no place in the debate.

Unfortunately, well-meaning enthusiasts sometimes exaggerate the dangers by quoting statistics that they have not properly understood or which have been taken out of context.

An example of this is the use of statistics extracted from the annual reports of the Medical Bureau for occupational Diseases (MBOD). Several times recently figures have been quoted that make the asbestos problem appear more serious than is actually the case if the figures are properly interpreted.

Two instances will be given:

● An article in the Rand Daily Mail of October 12, 1984 (quoting the Black Allied Mining and Construction Workers Union) stated that MBOD reports show that since 1967 a total of 5 140 miners have been compensated for asbestosis.

This figure is approximately correct. (The exact numbers are not readily available in some of the earlier reports.)

It is misleading, however, to cite this figure without some explanation of what it really means. It is essential to take three important figures into account.

(a) Diagnosis of asbestosis depends mainly on the reading of an X-ray film of the chest.

All authorities agree that the reading may be controversial and that even the most experienced X-ray readers are often in doubt as to whether asbestosis is present in a particular case.

This is recognised in the International Labour Organisation classification of X-Rays of pneumoconiosis which makes provision for two border-line categories labelled 0/1 and 1/0.

A person whose X-ray falls into one of these categories is suspected of having asbestosis but but may not actually have it.

It is the policy of the Certification Committee of the MBOD (and in keeping with the spirit of the Occupational Diseases in Mines and Works Act) to give the worker the benefit of the doubt in a border-line case.

Thus many workers are compensated for asbestosis even though there is doubt whether they do in fact have asbestosis. Of all cases compensated for asbestos-related diseases 23% are in the border-line categories of 0/1 or 1/0.

(b) The Certification Committee also compensates workers who definitely have no asbestosis in the lung itself but only asbestos-related plaques on the pleura (the lining round the lung.)

This condition is nearly always harmless and causes no disability. Of all cases compensated for asbestos-related diseases 34% fall into this group.

Taken together with the 23% mentioned in the previous paragraph this means that 57% of all compensated miners do not have a serious disease but only an abnormality on an X-ray film which is usually not associated with any disability.

(c) Of all miners compensated for asbestos-related diseases since 1967 at least 60% started work in asbestos mines before 1960. Fibre counts then were higher (sometimes as much as 50 times higher) than what is now considered safe.

Obviously the fact that pre-1960 miners have developed an asbestos related disease bears no relation to the conditons in the mines today.

It is illogical to cite compensation statistics which include such persons in any debate on the question of safety in asbestos mines now.

● The second example of a wrong interpretation of statistics is a statement in the Sowetan of October 17, 1984 that MBOD reports show that between 1967 and 1983 a total of 704 miners died from asbestos-related disease.

This statement is a serious mistake caused by a misunderstanding of the tables in the MBOD reports.

The relevant tables show the number of persons who were certified after death (compensation being paid to their next of kin). This does not mean that all these persons died of an asbestos-related disease.

On the contrary, only 19% of the deaths were caused by asbestos-related disease.

The other 81% died from an unrelated cause (heart disease, accidents etc.) and a slight degree of asbestosis was an incidental finding at the post-mortem examination.

It is clear, therefore, that the reports in the Sowetan gave a grossly distorted impression of the number of workers reported to have died as a result of exposure to asbestos.

The purpose of this article is to appeal to all concerned with the asbestos problem to make sure of the facts before they publish figures that may be quite misleading.

In the Press reports described above a lack of understanding of the MBOD statistics led to a considerable over-estimate of the risks of working in asbestos mines.

Nevertheless, even though the effects of asbestos on the health of miners are not as serious as these Press reports made them appear, this is certainly no cause for complacency.

Unrelating vigilance to ensure that safe fibre levels are strictly maintained is mandatory.

TODAY IN HISTORY

TODAY is Thursday, February 21, the 52nd day of 1985. There are 313 days left in the year. Highlights in history:

1613 — Michael Romanov, son of Patriarch of Moscow, is elected Tsar of Russia, thus founding House of Romanov.

1652 — Treaty of Hildesheim between Sweden and North German Protestant states.

1795 — Freedom of worship is established in France.

1799 — Graaff-Reinet burghers in revolt.

1849 — British forces defeat Sikhs at Gujerat in India.

1885 — Cecil Rhodes resigns his official post in Bechuanaland after offering to administer the territories with 10 policemen.

1892 — Great fire at Cape Town, destroying exhibition buildings and other places.

1903 — A deputation of the Afrikaner Bond Party under J H Hofmeyer sees the Colonial Secretary Joseph Chamberlain in Cape town.

1904 — Dr Jameson forms a new ministry with himself as Premier and also in charge of Native Affairs.

1916 — Battle of Verdun in France begins in First World War, the longest and bloodiest battle of the war with more than one million killed.

1919 — Bavarian Premier Kurt Risner is assassinated in Munich.

1922 — British protectorate in Egypt ends.

1934 — French troops combat Berbers in South West Morocco.

1943 — Britain's King George VI awards Sword of Honour to Russians for defence of Stalingrad in Second World War.

1947 — King George VI opens South African Parliament.

1963 — Soviet Union warns United States that an American attack on Cuba would mean world war.

1975 — UN Commision on Human Rights, in Geneva, Switzerland, accuses Israel of violating "basic norms of international law" in Arab territories it occupies.

1984 — US Marines start evacuating combat forces from Beirut, Lebanon, to Navy ships in Mediterranean.

TODAY'S birthdays: John Henry Newman, English cardinal (1801-1890); W H Auden, English poet (1907-1973); Leo Delibes, French composer (1836-1891). — Sapa-AP.

Sunday 26/2/85

Medical care for the poor

ABOUT 70 families living in abject poverty in the vicinity of Wheelers' Farm about 40 kilometres south of Johannesburg received free health care from a voluntary medical team at the weekend.

Men, women and children queued up in the shade of the trees where they were examined by two doctors and four nurses. Prescriptions were given in cases that needed medication.

A chart for testing eyesight was pinned on a wall and distances measured off in the grass. Some people including a woman who could not see 10 cm high letter from a distance of about 4 m, were referred to an eye clinic.

One of the families living on the farm, offered a room for private examinations. PAP smears were taken from women for tests and they were told that they will be informed of the results as soon as the slides were processed.

Azapo

The head of the Azanian People's Organisation (Azapo) health secretariat, Dr Abu-Baker Asvat, under whose auspices the preventive health clinic was run, said the team would conduct another free clinic on the East Rand next month.

The secretariat gave free preventive and curative health care to thousands of people last year when they visited areas where doctors and clinics were out of reach or not available.

Among the areas visited by the secretariat last year were the Vaal Triangle townships after the rent protests which left death and destruction in its wake.

Another important visit was to Brandfort township and the surrounding rural areas at the request of Mrs Winnie Nomzamo Mandela.

Quality of health services under fire

Staff Reporter

APARTHEID and good health care were incompatible, no matter how good the intentions of individual health workers, Dr John Sonnenberg, MPC for Green Point, said in the Provincial Council yesterday.

Speaking in the Part Appropriation Budget debate, he said the quality of health services offered under the new dispensation was likely to deteriorate.

New departments of health had been created as national states became independent, and "South Africa modelled its health services in the image of apartheid", he said.

Yet in all the national states, the ratio of people to doctors was more than 10 000 to one. KwaNdebele, with its population of 156 380, had no doctors at all.

Few dentists

In only two of the national states were there any dentists.

The ratio of people to hospital beds in metropolitan areas was 200 to 1, while in rural areas it was 600 to 1, and in some cases more that double that.

"Fragmentation of health services leads to confusion of responsibility, competition for scarce resources, inadequate co-ordination and wasteful duplication of services," he said.

"Despite this complicated fragmentation, we are now only at square one. Under the new constitution there are to be four Departments of Health where before there was only one."

the facts

THE Cape Times incorrectly reported on Saturday that the Administrator, Mr Gene Louw, said the total cost of the cancelled Capab production, "Die Walküre", was R190 000. In fact, he said the total cost would have been R190 000, but was R89 800, the cost of

RDM 9/3/85 (85)

Thalidomide used in SA

By GEOFFREY ALLEN

THE horror drug Thalidomide is being used in South Africa to treat leprosy and a chronic ulcer disease of the mouth and skin.

Yesterday Professor Peter Folb of the Medicines Control Council confirmed that the drug was being used under strict control.

In the 1960s, Thalidomide was used to stop nausea and other side effects of pregnancy.

As a result, about 10 000 babies were born with dreadful deformities — some had no limbs.

Prof Folb said the drug was strictly controlled and could only be used on women who could not fall pregnant, either because they were past child bearing age or because of effective contraception, or on men.

In June last year the British Government ordered an inquiry after it was discovered that an immunology team at the University of Nottingham, headed by Dr Richard Powell, was using the drug to treat patients suffering from Behcet's Syndrome, a painful and debilitating disease which causes skin and mouth ulcers.

The British investigation into the use of the drug is being conducted by the Committee on the Safety of Medicines, headed by Professor Sir Abraham Goldberg.

The drug cannot be manufactured in Britain by law because of its effects on unborn children.

Prof Folb said that the drug was only used in South Africa by a "small number of people".

He said that it was not readily available and that the manufacturers were extremely wary about selling it.

Thalidomide tablets cost R20 for 5 000 in Britain.

Doctors using thalidomide in South Africa have to obtain special permission from the Medicines Control Council.

"We require the patient's name, his full medical record and reasons from the doctor to motivate the use of Thalidomide.

"I can certainly allay any qualms that it may be given to pregnant women.

"Thalidomide is quite effective in curing skin and mouth ulcers and leprosy, but it has to be used very carefully," Prof Folb said.

Acording to a recent edition of Lancet, the British medical journal, Thalidomide caused about 10 000 birth deformities in West Germany in the 1960s. Five thousand of the babies lived.

In Britain 275 of 500 deformed children survived the effects of the drug.

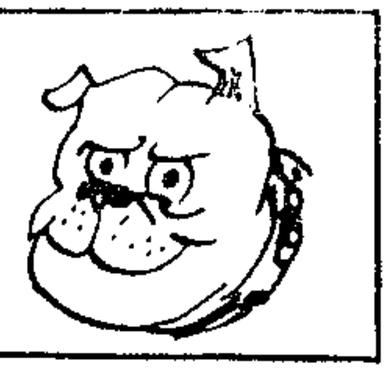
Dr Powell's team at Nottingham University has treated 20 patients, including women of child bearing age.

After the effects of the drug on children became known, the British manufacturers of Thalidomide — Distillers — paid out over R40-million in compensation.

According to Dr Powell the drug had been shown to be successful in treating chronic conditions so painful that they do not allow the sufferer to lead a normal life.

Medical schemes not responsible for those late payments

Cape Times 20/3/87 (85)



From DAVIDSON & EWING HOLDINGS (Pty) Ltd, Foreshore, Cape Town:

WE REFER to the article "Medical Aid Payments — other side of the coin", (Watchdog, Cape Times, March 12) under the editorship of Mr Molloy.

It is deplored that Mr Molloy did not see fit to refer the so-called complaints to the various organizations mentioned in order to ascertain where the specific fault lay in each case. If the complaints were indeed valid, in terms of the Medical Schemes Act, the doctors in question have the right to report such matters direct to the Registrar of Medical Schemes for action and not RAMS as suggested in the article.

For the edification of your readers, we state the following facts pertaining to the Davidson & Ewing organization: Our organization administers (not controls) 23 different medical schemes with a membership of approximately 140 000 families. Each month this organization processes in excess of 200 000 claims with a value of approximately R8,5 million.

Each society has a cut-off date for receipt of claims around about the 10th of the month and *every* account which is received by that date is either paid to the supplier, refunded to the member or returned to the member for additional details as required by the Medical Schemes Act. In order to accommodate accounts that arrive later than the cut-off date an interim payment is made to suppliers in the second week of the following month.

All liquid funds of the societies (except such amounts as may be on fixed deposits representing their reserves) are placed in a daily call account until required to pay claims. All interest earned is for the account of the society concerned and obviously assists in balancing the budget of the society.

The administration costs of every society are controlled by the Registrar of Medical Schemes and are in fact a calculated percentage of contribution income determined by the relative management committee of each society. These committees are either elected by the members from the members and/or appointed by the employer organizations.

Mr Molloy has pointed out some of the frailties of members but our experience allows us to be able to list numerous others. Such actions by the members cannot be laid at the door of a scheme or the administrators; for example a member not submitting an account; a member misusing the refund instead of payment to the supplier; delaying submission of account in order not to have to pay his portion thereon.

The medical profession is also not without blame in this respect. As was stated above, after three months the profession may submit an account direct to the society provided it is charged in accordance with the prescribed schedule of benefits. Once again, payment would be delayed if the member's name, number and society are not specified, or if the account is not in terms of the schedule of benefits, to mention only some of the requirements specified in the regulations to the Medical Schemes Act.

An invitation has already been extended to your Mr Molloy to visit our offices and to satisfy himself on the points mentioned above. This invitation was refused. A similar invitation is extended to any of your readers who wish to take the opportunity!

WATCHDOG comments: I am quite satisfied that D & E knows its business, hence there is no need for me to make an uninformed inspection of the operation.

D & E does not deny the complaints and the deafening silence from the medical aid societies in question tends to bolster them.

Perhaps more important to the hard-hit consumer is the fact that the Medical Schemes Act permits an administrative fee of 14 percent. This is paid for administration, which means the control of all subscriptions and claims.

Assuming a monthly income of R10 million, very conservative in view of claims paid out, that means D & E have a monthly cream-off of at least R1,4 million — a bit overpriced for a set-up which administers but does not control.

□ □ □

From ANCILLARY HEALTH SERVICES EXECUTIVE:

RE MEDICAL Aids: Please accept my congratulations on an interesting, analytical and objective piece of journalism.

As mentioned, however, it might be of further interest to point out that nine of the 10 named "culprits" are, in fact, unregistered schemes, falling outside the ambit of the Act by virtue of being state or quasi-state schemes. Perhaps mention of this might put a somewhat different perspective on the situation.

□ □ □

From MEDICAL DOCTOR:

I NOTICED that your article dealt almost exclusively with the length of time doctors had to wait before getting paid. While this is true, and causes a lot of frustration and anger amongst us, I do feel that you have not addressed the most important issue i.e. how is the patient affected by all this?

Mr Erntzen states that there are 240 MA societies registered with RAMS.

However, what he fails to mention is that there are 987 medical aid societies/funds in South Africa — and this figure has probably increased by now.

Only 65 of these 987 medical schemes are prepared to pay the chemist directly for the medicine dispensed by him. (This is a figure obtained from a list issued by the Pharmaceutical Society.)

With rising costs of drugs, those members of the poorer communities — who have no choice in the matter and are compelled to belong to a medical aid as part of the employment package whether their wages justify belonging to the society or not — haven't the money to buy their medicines at the chemist first and only then to claim a refund from the medical aid society.

This results in many patients not getting their medicines at the chemist.

I think that you would be doing a great service if you could establish why only 65 out of 987 medical aid societies pay chemists directly for medicines, and try to pressurize the others into changing this facet of their operation.

Sowetan 3/4/85 (85)

Fumes anger Alex residents

By MOJALEFA MOSEKI

THE furnace of a company outside Alexandra is discharging fumes that cause children to choke and cry at night while adults who come into contact with it have their eyes smart and tears flow.

And yesterday, the medical officer for Johannesburg, Dr Baldwin Richards, told **The SOWETAN** that he had sent a team of experts to investigate the effects of the gas released.

According to our investigations residents near the company, Acetico, are forced to keep their doors closed because of the fumes and the white dust that sticks to their property. But still, in some homes, the fumes and dust come in through the stove chimney opening.

A spokesman for the company, Mr Perre Marais, said as far as he knew the fumes were not harmful, but just irritating because of the concentration of vinegar. He said he realised the problem and was going to "instal a filter bag and a scrubber" to stop the fumes infiltrating the atmosphere, resulting in complaints by residents.

The company is in Bramley and is separated from Alexandra by London Road. It produces a preservative called sodium diacitate which is used mainly by bakeries in making bread. At times it operates at night.

Officials of both offices could not be reached for comment yesterday.

Mrs Florence Kubheka and her tenants at 165 15th Avenue, who are nearest to the company, said they spent sleepless nights tendering children who cried uncontrollably because of the fumes that choke them during the company's night operations.

Congo fever fears recede at Edendale

Mail Correspondent

DURBAN. — About 50 staff members at Edendale Hospital outside Maritzburg are being monitored for symptoms of Congo fever because of the death of Natal's first victim of the disease at the hospital earlier this month.

However, KwaZulu medical authorities have allayed fears of an outbreak of the highly infectious haemorrhagic fever and no-one has so far had to be isolated.

A 30-year-old construction worker, Mr Vincent Nthalane, died of the disease hours after being admitted to Edendale Hospital on April 2.

Congo fever was confirmed as the cause of death after viral cultures at the Institute of Virology in Johannesburg last Thursday proved positive.

Mr Nthalane is the first confirmed fatality of Congo fever in Natal and the fifth person to die of the disease in South Africa.

Dr Murray Short, senior medical officer in charge of communicable diseases in the KwaZulu Department of Health and Welfare, said neither the patients who shared the man's ward nor his immediate family had shown any sign of Congo fever.

Mr Nthalane's family, who live in the Mpumuza area near Edendale, had been visited by KwaZulu health staff and would be closely monitored until tomorrow, when the danger period was over.

Dr Short said the possibility that any of the contacts would have to be put in isolation was very remote.

"None of the patients who shared his ward 11 days ago has shown signs of a haemorrhagic fever as far as we are aware, and all his family are well, as are the people Mr Nthalane worked with."

Forty-six hospital staff members were "under surveillance" as a precaution.

Dr Short said the victim's body had been buried on Saturday.

While it would have been preferable for Mr Nthalane to have been cremated, this was not possible according to Zulu tradition, and the body, which had been placed in a heavy-duty plastic bag, was buried in a lime-coated grave.

Dr Short said the bag was an internationally accepted container which was normally used for the transportation of bodies from one country to another and was as efficient as the previously obligatory lead-lined coffin.

"The chances of any infection escaping are almost nil. The bag was sealed and was under observation by health staff until it was put under the ground."

Dr Short allayed fears of a possible outbreak of Congo fever, saying the disease had been around for many years. Forty-one percent of cattle herds tested in Natal were found to have been infected at one time or another, the disease being transmitted by a certain species of tick.

Praising hospital staff for their handling of the situation, he said Mr Nthalane was examined thoroughly when he first arrived at Edendale after complaining that he was not well.

A haemorrhagic fever had not been a strong enough possibility to warrant his admission and his condition had been such that the doctor who had examined him had felt he could return home with medication.

"He was asked to come back the next day for the results of blood tests.

"When he returned he was sicker and was admitted and subsequently seen by two specialists. He suddenly collapsed and died in spite of resuscitation."

Some malaria tablets said to be ineffective

~~Herald~~ 25/4/85 NM

(85)

Mercury Reporter

AT LEAST one of several types of anti-malaria tablet treatments available in South Africa does not offer an effective safeguard against the killer disease, it was disclosed yesterday.

And it was possible that the use of tablets could disguise malaria symptoms.

People living in or visiting malaria-prone areas in this country were urged by the authorities to take the necessary tablets — particularly at this time of year as it had been shown that mosquito populations increased every year before the onset of winter.

There had been no upswing of the disease in Natal to date.

But yesterday several doctors agreed that in a number of cases chloraquin tablets had proved ineffective against malaria.

But according to Dr Tol Pienaar, park warden of the Kruger National Park, visitors 'need not have any fear' of contracting malaria.

Large-scale spraying of possible breeding places is carried out regularly and the use of anti-malaria tablets was constantly advised.

'When these tablets are taken according to instructions, there is virtually no possibility of contracting malaria,' Dr Pienaar said.

A spokesman for the Department of State Health said that Darachlor anti-malaria tablets were recommended but added that no preventive measures could be guaranteed.

'Other precautions should be taken and if fever occurs a doctor should be notified immediately.

'More public awareness is needed,' she said.

Dr R McCarter, deputy superintendent of Durban's Addington Hospital, said: 'Malaria is always very dangerous. Most people take Darachlor.'

It was possible that the characteristics of malaria could remain hidden by taking various tablet treatments, he said.

Cases of malaria are known to have occurred as late into winter as the beginning of June.

Baboons in big demand for hospital experimental tables

(85)

NM 26/4/85

Mercury Correspondent

CAPE TOWN—Hundreds of baboons throughout the Western Cape are being caught by special permit and supplied to Cape Town's hospitals for medical experiments.

The vast Government animal centre in Kuilsrivier, Delft, which breeds and supplies a wide variety of animals to hospitals, alone recieves more than 300 baboons a year.

The baboons are mainly bought from farmers living along the mountain ranges of the Western Cape for prices ranging between R2 and R3,50 a kilogram. Delft has also received baboons from Humansdorp, Cradock and South West Africa.

About 100 baboons are kept in cages at Delft at any one time. They remained there for about six weeks before being sent to the medical schools at Groote Schuur and Tygerberg and other Peninsula hospitals.

Humanely

Permits to capture the baboons are issued by the Cape Department of Nature and Environmental Conservation. A quota of permits is usually obtained by Delft which then supplies the farmers. Delft also arranges collection of the animals.

This was established this week after the South African Association Against Painful Experiments on Animals voiced concern about an increasing number of reports about baboons being captured for hospitals.

The association's information is that the baboons captured are generally troublesome animals but there is also evidence that this is not always the case. They have received reports about animals being caught at Groot Constantia Estate, Hermanus, Caledon and Grabouw.

'We agree that there is a need for control if the animals are causing damage to farmlands. And if necessary they should be put down humanely but certainly not used for medical research,' said an association spokesman, Dr Janice Hoyle.

Dr Hoyle said she had written to the Cape Department of Nature and Environmental Conservation about the matter at least six weeks ago but had not yet received a reply.

When approached the deputy director of the department, Dr J Neethling, said the department was not in favour of painful experiments on animals but they realised that experiments were necessary for the good of humanity.

'That immediately creates a dilemma. But before issuing permits to Delft we try to find out how they are going to use the animals and whether the experiments will be painful. We will refuse a permit if they are unnecessarily cruel,' he said.

The head of Delft, a division of the Department of Hospital Services, Dr Albert Albertyn, confirmed that they were supplied with baboons by farmers and divisional and municipal councils.

Circulars asking for baboons had been sent to farmers unions about three years ago, he said.

Essential

'We need baboons for research which is absolutely essential. Virtually no disease has been solved without the assistance of laboratory animals,' said Dr Albertyn.

He said Delft was also against painful experiments on animals and made sure that they were treated as humanely as possible. He said the ethical principles drawn up by the S A Medical Research Council in 1979 were strictly adhered to by all people involved in animal experimentation.

'The baboons are better looked after here than they are in the wild. They have air conditioning, lots of food and water. It is essential for the experiments that we keep them in prime condition,' he said.

The manager of Groot Constantia Estate, Mr Koos Stofberg, confirmed that about 50 baboons had been caught in cages at the farm during 1980. But he said no further baboons had been caught for at least two years.

A spokesman for the Caledon Divisional Council confirmed that they had assisted with the capture of 65 baboons towards the end of 1983. He said the baboons were sent to Tygerberg Hospital.

Health problems which are not confined to SA

Dr Alexander Walker asks overseas critics to recognise the value of what has been achieved here and the immensity of what is being attempted.

The subject of Third World conditions in a largely First World environment is sensitive in South Africa since many critics, both visiting and local, maintain that the morbidity and mortality rates of our less privileged ethnic groups, particularly the black population, are a disgrace in a country famed for its mineral wealth.

None would doubt that the prevailing rates could be and will be reduced. Equally, none should doubt that the State, local authorities and other bodies are making continuous, although insufficiently appreciated, endeavours to improve the health of all population groups.

In making comparisons or allocating blame, it should be kept in mind that the non-British population in the UK (from India, Pakistan, West Africa, the West Indies, etc) is about 1,5-2 million, ie about 3 to 4 percent of the total population.

In Canada the Red Indian population is about 1,5 percent of the total, and in Australia the Aborigines constitute less than one percent.

In contrast, in SA the less privileged moiety, ie the non-white population, amounts to 84 percent and the black population to 72 percent of the country's total population.

In the face of the huge disparity, it could be conjectured that in the developed countries mentioned, with their minute minority populations, the burden of disease among the latter would in time be reduced and the rates would tend to approximate to the national averages of the huge majority populations. While this speculation has elements of plausibility, it is, alas, far from the truth.

In Birmingham in the UK, tuberculosis in Asians is 38 times the national average.

In Canada's Red Indian population, Government statistics show that native infants die from respiratory and infectious disases at a rate nearly six times the national average; that the average native life expectancy is 10 years less than the Canadian average; and that the tuberculosis rate still remains at seven times the national average.

Dr L Black, a Deputy Minister, said: "It's our own Third World right here in Canada."

At the recent Australian Medical Congress in Tasmania, Senator Peter Baume, Minister for Aboriginal Affairs, summed up very succinctly the state of health of Australian Aborgines: the average life expectancy for Aborgines was 52 years — 20 years less than for white Australians; that the infant mortality of Aborigines was 52 per thousand compared with 12,2 per thousand for white Australians; that Aboriginal children were 10 times more likely to have otitis media than non-Aboriginals; that anaemia was 10 times as common, and trachoma 15 times as common among Aborigines as among white Australians.

He referred to the high rates of intestinal and respiratory infections, malnutrition, tuberculosis and parasite infestation in Aboriginal people.

Senator Baume pointed also to the higher prevalence of cardiovascular disease and diabetes. He described the alcoholism prevalant in practically all Aboriginal communities.

As to the situation in the US, in 1972 George Burch, editor of the *American Heart Journal*, was so despondent over the continued lower expectation of life of blacks, compared with whites, that he half wondered whether the blacks were "programmed" to die earlier.

At a recent conference it was stated: "Although infant mortality rates in the US have fallen in both blacks and whites, the 90 percent excess infant mortality in blacks in 1900 remains unchanged; black men suffer an excess mortality from all major causes of death except suicide; coronary artery disease is the most common single cause of death in both blacks and whites, but blacks die from it at a much earlier age; with the exception of leukaemia and breast cancer, malignant disease is commoner in blacks than in whites; the rise in the incidence of lung cancer was delayed in black men because they began smoking later, but by 1980 the rate was twice that for corresponding groups of whites; death due to cirrhosis was double the white rate and there was a higher incidence of alcoholism; and death as a result of violence showed a greater increase among blacks."

These quotations on somewhat comparative situations elsewhere are certainly not made in the spirit of *tu quoque*. They are given simply to acknowledge that the public health problems still facing this country are gigantic; and to note that even well-intentioned, high privileged overseas countries faced with far smaller although closely analogous problems are having tremendous difficulties in combating and alleviating them.

It is therefore distressing that again and again letters are published in overseas journals which usually cuttingly, and often misinformedly, criticise our insufficiency of determination in seeking to uplift the public health situations in our less privileged populations.

In his reply to a recent letter from an Australian, the Director-General of the Department of Health, Dr F P Retief, commented, inter alia: "If the rural services have not reached a state of perfection, where in Africa (or elsewhere) has this goal been reached? Constructive suggestions in this regard would be most welcome and certainly more helpful than the vituperations to which this country has for so long been subjected."

The contents of the letter of criticism "would leave the uninformed reader with a really grotesque picture of the South African reality... Why is it that changes for the better are seldom, if ever, acknowledged?

"In the area of upliftment of developing peoples, with whom is South Africa compared? If such a comparison were ever carried out, I contend that South Africa could well claim that 'Never has so much been done by so few for so many'."

That the health problems in this country remain formidable is not at issue. All that is looked for is a measure of understanding and forbearance, and recognition of the value of what has been accomplished and of the immensity of what is being attempted.

● *This article is published with the permission of the South African Medical Journal in which it appeared on March 16.*

Cape Times 14/5/85

Question

Barnard dissects the national health service

HOUSE OF ASSEMBLY. — The future of South Africa's health services was inadequately defined and was endangered by the country's "frightening" population growth, Dr Marius Barnard (PFP Parktown) said yesterday.

Speaking in the committee stage of the Health and Welfare vote, Dr Barnard said there did not appear to be a national health policy to meet the demands of the future.

Medical training, hospitals and facilities in "developed" areas of the country equalled the best in the Western world while underdeveloped areas had to be satisfied with "the medical left-overs".

The percentage of the GNP devoted to health by most Western nations had increased over the past decade to between seven and 11 percent. In South Africa the figure had decreased from 4,2 to about 3 percent.

● Dr Barnard was called to order several times yesterday by the Chairman of Committees.

Dr Barnard said he found it "very odd" that Mr Sipho Mutsi, who died of head injuries last week after being arrested by police, had suffered an epileptic fit during interrogation.

"I've repeatedly asked the Minister of Health and Welfare about health facilities in prisons. The answer has always been that detainees are well cared for and that district surgeons visit them regularly.

"But there are never any reports by district surgeons of injury resulting from police action."

The chairman, Dr Helgaard van Rensburg, who earlier advised Dr Barnard to confine himself strictly to "the health aspect", ruled that he could not debate the merit of allowing prisoners to be seen by doctors.

Dr Van Rensburg said that prisoners' access to medical care fell under Prisons; actual medical care fell under Health. — Sapa

Call for abolition of asbestos mines

Sowetan 4/5/85

By JOSHUA RABOROKO

WORKERS all over the world have called for the abolition of asbestos mines because of the cancer threat.

Workers complain that they do not have to live in asbestos houses, send their children to abestos schools and live next to asbestos dumps.

This was said in a message from United States environmentalist, Dr Barry Castleman, to the national anti-asbestos conference called by the Black Allied Mining and Construction Workers' Union (Bamwcu) in Soweto, at the weekend.

He said: "Enough blood has already been coughed up on the alter of greed, and in the name of profit. Unions have learnt the hard way that no employer is willing to pay what your health is worth.

He also paid tribute to the Bamcwu for the strides they have taken in their struggle against asbestos mines, adding "we, who are part of the same struggle, applaud your courage and wish you good health."

He further said: "The world knows much about the economic and political exploitation of hard-working people in South Africa. But it is not so well known outside your country that many workers must also lose their health to earn their pay.

"They labour in mines, pressing machinegun-like drills into the earth. They go deaf from the artillery sound in the harsh war of survival.

"Some will come home after a long spell at the mines unable to hear their wives and children's voices. Some workers have their lungs scarred with silicosis or asbestosis.

"They become increasingly short of breath. They must watch their families become impoverished and think of themselves as a burden to their loved ones, because they will be unable to work.

Miners, construction and foundry workers with silicosis are also prone to developing tubercolosis. This lung disease can be transmitted to others in the family, especially under conditions of poverty.

"Workers handling asbestos in South Africa not only face exposure more but also work in industries that are banned in more civilised countries.

"South African varieties of asbestos have been banned from Britain and the Netherlands. The cancer threat of asbestos is so awful that construction workers all over the world have called for its abolition," Dr Castleman said.

Bamcwu is gearing to campaign for the abolition of asbestos mines in South Africa because "our people are faced with the danger of loosing their lives," declared president, Mr Letsatsi Mosala.

"We have already sent our men overseas to study various strategies we can apply to bring pressure on local mine managements. Asbestosis is a killer disease, so it is natural that we should act to protect our members.

During the conference, attended by several delegates, slides and video tapes depicting the various ways in which miners can contract the disease were shown.

After the two-day meeting, Bamcwu's general secretary, Mr Pandolani Nefolovhodwe said the conference was "a success, especially because it was probably the first of its kind."

"What remains now is for all the participants to implement what they have learnt. We are going to intensify the campaign in rural areas in the Northern Transvaal and in some parts of the Cape Province.

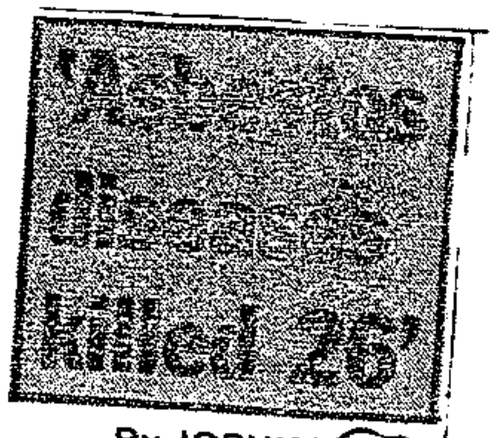
"We also want chiefs in the homelands to take part in this venture. Elected committees will be expected to work hard in the intensification and report-back meetings will be held from time to time," Mr Nefolovhodwe said.

Bamcwu will also welcome expert advice from other sources concerning the "killer disease". "We are also particularly disturbed by the fact that our members do not earn the same as their white counterparts," he said.

The campaign, if successful might have serious repercussions on workers, specially blacks who are already reeling under large scale unemployment worsened by recession and the high rate of inflation.

One factor that must also be taken into consideration is that the closure of these mines might affect other industries which are related to asbestos. Does it mean South Africa will afford to import asbestos? If so, this might mean that the country's workers will be hard-hit.

Mine managements, on the other hand, will have to take precautionary steps to avoid what could lead to serious confrontation. Unions and mine managements will have to come together to avoid "disaster".



By JOSHUA RABOROKO

A TOTAL of 26 workers have died of various diseases at Everite Limited — a major manufacturer of asbestos cement pipes and building products — 58 percent are asbestos-related deaths in the past 30 years.

In a report to The SOWETAN, the company says it has accepted a total of 103 cases of workers who are suspected to have contracted the "killer disease" at its three plants countrywide.

The report reveals that six people have died of asbestosis; nine of mosotholioma; three of lung cancer and eight of other diseases. The company has ackownledged responsibility towards employees who contracted diseases while on duty.

This report comes in the wake of an anti-asbestos campaign launched by the Black Allied Mining and Construction Workers' Union (Bamcwu) following claims that thousands of people may die of asbestos-related diseases in the mines, especially in the northern Transvaal region of Pongo.

At its anti-asbestos conference in Soweto recently, the union resolved to intensify its campaign until the asbestos mines are closed in the country, just like in other parts of the world.

Referring to Everite's report, Bamcwu's president, Mr Letsatsi Mosala, said they were concerned about the rate of deaths caused by asbestos, although the company's rate seemed to be lower compared to the number of cases in the mines.

"We have held meetings with Everite on the possibility of improving health and safety measures of their plants because many people may die as a result of asbestos-related diseases," he said.

The report says all employees who become disabled as a result of the disease continue to receive an income equal to their basic monthly salary, in addition to the money paid by the Workmen's Compensation.

"By applying this policy and granting annual increments, the company ensures that the employee will be placed in the same financial position as if he had worked in his present position until the age of 65," the report says.

This policy applies to all workers despite their race groups. But, Mr Mosala said: "We are interested in seeing our people getting the same benefits as whites. There should be no disparity.

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) Yes.

(a) (i) At the Market Street interchange at the bottom of Du Toitskloof at Paarl.

(ii) At the bottom of Sir Lowry's Pass at Strand.

(b) To determine the number of Blacks entering the Cape Peninsula from Transkei and Ciskei without authority.

(c) (i) At Paarl 202.

(ii) At Strand 212.

(d) 9 936.

(e) R426 854,53.

(f) 2 168 buses and 175 other vehicles passed the monitoring points 16 333 Black persons had authority and 64 651 Black persons had no authority to enter the Cape Peninsula.

(2) Yes.

(a) To control the movement of unauthorized Black persons from Transkei and Ciskei to the Cape Peninsula.

(b) As soon as a bus terminal at De Doorns becomes operative.

(c) Details regarding the bus terminal have not been finalised.

(3) (a) (i) Yes.

(ii) No.

(b) Yes.

(i) Du Toitskloof ..... 1 822.

(ii) Sir Lowry's Pass ... 521.

Khayelitsha

1028. Mr K M ANDREW asked the Minister of Co-operation, Development and Education:

(1) Whether, with reference to his reply to Question No 24 on 21 May 1985, his Department (a) controls and/or (b) administers Site C in Khayelitsha; if so, since what date; if not, who (i) administers and/or (ii) controls Site C;

(2) whether it is anticipated that his Department or the Western Cape Development Board will take over the (a) control and/or (b) administration of Site C; if not, why not; if so, when?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) (a) and (b) No.

(i) and (ii) The Western Cape Development Board since 4 January 1985.

(2) (a) and (b) Has always been under the control and administration of the Western Cape Development Board.

Western Cape: community councils

1030. Mr K M ANDREW asked the Minister of Co-operation, Development and Education:

How many persons of each race group were employed by (a) the Western Cape Development Board (i) prior and (ii) subsequent to the establishment of Black community councils, and (b) each specified Black community council in the area falling under the control of the Western Cape Development Board, as at the latest specified date for which figures are available?

The MINISTER OF CO-OPERATION, DEVELOPEMENT AND EDUCATION:

(a) (i) Whites 460.
Blacks 2 361.

(ii) Whites 460.
Blacks 2 349.

(b) Ashton: Whites 2.
Blacks 12.

Hermanus: Whites 1.
Blacks 11.

The three Whites involved are seconded to the two Community Councils.

Figures as at 14 June 1985.

Independent/national states: health care

1031. Dr M S BARNARD asked the Minister of Health and Welfare:

Whether his Department subsidizes any aspects of health care (a) offered by (i) local authorities and (ii) voluntary agencies and (b) in the (i) (aa) independent Black and (bb) national states and (ii) provinces; if not, why not; if so, what was the amount of these subsidies in each case in each of the latest specified five financial years for which figures are available?

The MINISTER OF HEALTH AND WELFARE:

(a) (i) Yes
1981/82 = R39 116 000
1982/83 = R48 130 000
1983/84 = R56 644 000
1984/85 = R67 414 000
1985/86 = R69 149 000

(ii) Yes
1981/82 = R 9 155 000
1982/83 = R12 808 000
1983/84 = R 9 793 000
1984/85 = R16 344 000
1985/86 = R11 663 000

(b) (i) (aa) No
Subsidized by Department of Foreign Affairs.

(bb) No
Financed by Department of Co-operation and Development.

(ii) No
Funded by Treasury.

University of Fort Hare

1032. Mr K M ANDREW asked the Minister of Co-operation, Development and Education:

(1) Whether any demonstrations took place on the campus of the University of Fort Hare during May 1985; if so, (a) when and (b) what was the cause of the demonstrations;

(2) whether any action was taken by the campus personnel as a result of the demonstrations; if so, (a) what action, (b) why, (c) by what branch of the campus personnel and (d) with what result;

(3) whether any (a) students, (b) university staff and/or (c) campus personnel were injured in the course of these demonstrations; if so, how many in each case;

(4) whether his Department took any action in connection with this matter; if not, why not; if so, (a) what action, (b) why and (c) when;

(5) whether he will make a statement on the matter?

The MINISTER OF CO-OPERATION, DEVELOPMENT AND EDUCATION:

(1) Yes.

(a) 1, 8, 9, 10, 21, 22 and 23 May.

(b) 1 May—political of nature, labours day;
8 May—demonstrations due to the arrest of seven students by the police;
9, 10, 21 and 22 May—intimidation of students by fellow students to boycott classes and stop writing of tests;
23 May—intimidation of students by fellow students and stone throwing.

Firm disputes asbestos toll

85 Sowetan 21/6/85

SIR — With reference to the article Asbestos Diseases Killed 26 (**The SOWETAN,** June 17) may we comment as follows:

1. As is clear from the article itself, 18 (not 26) out of some 24 200 people employed by Everite since 1942 have died as a result of asbestos-related diseases, including asbestosis, mesothelioma and lung cancer;

2. A further eight people who were suffering from asbestos-related diseases died from other causes such as motor accidents, homicides or unrelated diseases;

3. While these statistics were released to **The SOWETAN** "in the wake of" the Black Allied Mining and Construction Workers' Union anti-asbestos campaign, we should point out that they resulted from the Everite Health Surveillance Programme which has been in place for many many years;

4. Mr Letsatsi Mosala of Bamcwu says he is concerned about these statistics. We share his concern. This is why Everite has for many years implemented dust control measures, education programmes, health programmes and a disability pension plan for our employees. These programmes are designed to identify and take care of those who are victims of past conditions (asbestos related diseases take between 10 to 40 years to show up after initial exposure), and also to prevent any further cases among our employees. It is also important to note that our company has been seeking to develop alternatives to asbestos since 1976 and that we are making exciting progress in this area;

5. The article implies that asbestos mines elsewhere in the world have been closed. Canada, Russia, China, Switzerland and Zimbabwe, among others, remain major producers of asbestos;

6. We contacted Bamcwu, although they are not represented in our plants, as part of our policy to inform any interested party about Everite's Asbestos and Health Programme. If Bamcwu or any other organisation has suggestions on improving our Health and Safety Measures (which are to the standard set by the International Labour Organisation), we would be glad to hear from them.

May we take this opportunity to reassure your readers that the occupational health and safety of our employees is the number one priority at Everite and that the very latest scientific findings are that there is no undue risk to the occupants of buildings or schools constructed of asbestos cement where 10 percent asbestos fibres are locked into the cement.

E B CLAASEN
Personnel Director
Everite Ltd.

Bad planning erodes Tvl health care — MPC

Political Reporter

Bad planning and foolish policies at head office level were being allowed to constantly undermine the good work doctors, nurses and paramedics carried out in Transvaal hospitals, Progressive Party spokesman (on health, Mrs Irene Menell Houghton) said last night.

"It is outrageous that our hospital staff, nurses, doctors and paramedics, who work under such very trying circumstances should constantly be undermined by bad planning, foolish policies and thoughtlessness and unintelligent implementation at head office level," said Mrs Menell.

She said if at least while undermining the quality of Transvaal's curative services there had been some serious attempt to create alternative structures for health care, it would have provided some comfort.

"But that is not happening. Over the past six years this province has trained less than 200 nurses in specialist primary health care skills. It employs only 163 nurses with those qualifications," Mrs Menell added.

She said although there were a few poly-clinics in Soweto, there were very few elsewhere.

"The community-based comprehensive health care facility which is what we simply need most is simply not here and not really contemplated."

Mrs Menell said this meant that while one type of health care structure was being eroded, no serious attempts were being made to build-up alternatives.

"This can only harm our general level of health — one of our most valuable national assets."

And, according to Mrs Menell, while the health services were in such a poor state the authorities insisted on persisting with colour-segregated services.

"This is medically unsound, economically irresponsible and morally unacceptable," she said.

"At the same time we start setting up three new central government departments of health to comply with our cloud cuckooland constitution and, also at the same time, this province puts a R250 million academic hospital for the Pretoria University on its planning list.""

Mrs Menell added that these were all areas in which massive economic rationalisation could and should take place.

"I have no doubt that sheer pressure of numbers and lack of resources will eventually force the Government to abandon the system of colour-segregated hospitals. But once again it will be done on a crisis response basis and not in terms of sensible long-range planning."

Last night's report-back meeting on the provincial council session was Mrs Menell's 24th and also her last. In terms of the new legislation the system of provincial councils is to be scrapped.

Equal health care 'only when SA is a just society'

(65)

Star 9/1/85

By Mike Siluma

South Africa could only have an equitable health system once it had been changed into a non-racial and just society, the chairman of the Federation of Residents' Associations, Dr R A M Saloojee, said in Johannesburg last night.

He was speaking during a panel discussion on the problems of administering health care in South Africa. The discussion was hosted by the South African Institute of Race Relations.

Dr Saloojee described the country's new political dispensation, which provided for "own" and "general" health issues, as "absurd".

An example of this was the existence in Hillbrow of a "black" hospital which was over crowded and a "white" one which was approximately half empty, he said.

Dr Saloojee charged that the proposed new "Indian" hospital would not have all the necessary facilities.

The Minister of General Affairs would still dictate policy on health services, he said.

He compared the health system under the new dispensation to a stool with legs of different lengths. Such a stool would wobble when put on the ground, he said.

The creation of different health services for the different ethnic groups was a crumb given to those who had decided to participate in the "charade" of the new dispensation.

Dr Saloojee attacked attempts to privatise health services, describing them as a Government attempt to get rid of people who really needed the services currently provided by the State.

The Government was not alone in practicing discrimination in health services. Certain sections of the private sector also stood accused of racial discrimination.

"As far a I am concerned, we can only have an equitable health system under a society that is just and non-racial," Dr Saloojee said.

Also on the panel was Dr A J Kgomo, a Soweto medical practitioner, who said Third World conditions in South Africa, which caused diseases such as tuberculosis and malnutrition, were artificial.

He said poor nutrition, lack of proper housing and an opportunity to acquire citizenship in one's country influenced health.

Dr Kgomo appealed to the medical profession to speak out against conditions that adversely affected people's health.

It was a pity that changes would have to be brought about through coercion and pressure, he said.

Another speaker, Mr Cedric de Beer, said South Africa had used the bantustans, where no one could gather statistics, to hide the incidence of diseases such as TB.

"We must recognise that in the whole talk of reform the pillars of apartheid have not been touched," Mr de Beer said.

'Strict control on safety, efficiency'

Assurance given on generic medicines

85

STAR 10/9/85

Medical Reporter

The Medical Control Council (MCC) has to approve and register every medicine marketed in South Africa and this guarantees the theurapeutic value of generic medicines, says Mr Tony Caris, deputy managing editor of *South African Druggist.*

In a statement to *The Star*, Mr Caris says that if a generic substitute has been registered by the MCC, doctors and pharmacists can be sure it is equivalent to the medicine it is intended to replace.

Information on the medicine and results of tests have to be supplied by an independent source — normally the pharmacological department of a university — to the council's committee before registration of the generic drug.

"The MCC controls all the procedures for the manufacture and testing of medicines through approval of documentation and checks by the MCC inspectorate at regular intervals.

"Bio-availability tests which, by their nature, must involve man, are carried out on volunteers. The levels of active ingredient produced in the body are plotted graphically," says Mr Karis.

Apart from these tests and checks on the active ingredient, manufacturers have to satisfy the council about a medicine's stability — it must continue to yield the expected therapeutic dose for the lifespan shown on the label.

Local generic medicines are formulated according to latest technology ascertained from computer-based databanks and numerous technical journals.

"How can the Pharmaceutical and Chemical Manufacturers' Association (PCMA) which, to a large degree, represents the multi-national companies operating in this country, oppose the wider use of generic medicines when the multi-national parent companies are making these medicines themselves?" Mr Karis asks.

"How can the PMCA bring Professor Arnold Beckett, of the Chelsea College, London, to South Africa to speak against generic replacement when he seemed unaware of the safeguards on efficacy and safety of medicines which exist for the public here?"

Unrest 'disastrous' for health

Health services are breaking down because of rioting and unrest in the townships, says the annual report of the South African Tuberculosis Association (Santa).

The report, released in Johannesburg yesterday also says political unrest can have a devastating effect on the health of the nation.

Between 120 000 and 150 000 people are being treated for tuberculosis at any time and more than 60 000 cases are reported annually in SA.

"The recent political unrest is having disastrous effects on communications.

"Poignant appeals are being received by Santa from tuberculosis sufferers in the townships who do not know where to continue receiving treatment.

"The situation is extremely serious because any break in continuity of treatment results in drug resistance.

"Once drug-resistant bacilli have developed they convey infection which is also drug resistant, creating tuberculosis sufferers who cannot be cured," says the report.

Unrest slows flow of blood donations

STAR 17/9/85

The unrest in black townships, strikes on the mines and retrenchments have seriously affected the amount of blood being donated.

The Johannesburg-based Highveld Blood Transfusion Service, run by the South African Institute for Medical Research, is receiving less blood than usual because of the current upheavals.

The service is receiving only 200 of the 400 units of blood it needs a day.

"The unrest in the townships means that we can no longer go in there and encourage people to give blood. We find that people tend to react badly whenever they see an official-looking vehicle," said public relations officer Miss Faadiah Petersen.

Highveld's latest programme to encourage "community bleeds" at black community centres has been slowed down considerably by the unrest.

"The strikes on the mines have also stopped us from going there and getting miners to donate blood," she said. "Retrenchment has also added to our problems. We used to go to many companies around Johannesburg but because of the recession and retrenchments many of our previous donors are no longer available."

Miss Petersen said people feared they might lose their jobs if they left their jobs to donate blood or that they might feel ill after giving blood and be fired.

At the moment the Highveld service collects more than 80 000 units of blood a year, about 80 percent of which comes from mobile clinics visiting commercial and industrial premises, schools and community centres.

Visits are usually made every three to four months.

Science

Studies of heart aided by servicemen

By Pearce Wright
Science Editor of *The Times*

Regular checks on the health of servicemen provide one of the most valuable opportunities for medical research groups to assess the progress in preventive medicine.

In the latest study to be reported, a group of 377 US Air Force officers were examined for signs of heart disease.

However, this routine screening was used to compare different procedures for assessing each person's condition.

One of them was a treadmill test in which the measurements were fed directly into a computer analyser, which provided doctors with a classification showing whether an individual was at risk. The other examination was a classic electro-cardiogram analysis using standard criteria for assessing risk.

According to the conclusions of a team working with Dr Milton Hollenberg, of the Veterans' Administration Medical Centre and the University of California, San Francisco, the treadmill test is a more accurate method of assessing risk among people with no symptoms suggesting coronary artery disease.

This finding arises from a previous comparative study by Dr Hollenberg's team, showing that measurements of performance with treadmill tests were a better method of judging the degree of

Treadmill . . . still the best test.

recovery of blood vessels after coronary bypass surgery than other yardsticks.

□ □ □

In the screening of apparently healthy officers, 10 of the people were judged to have the most risk factors for coronary heart disease, including three with abnormal treadmill results. Those individuals underwent angiography, which is an examination of the blood vessels by X-rays after injection of a dye into the circulation which shows any defects obstructing the flow of blood.

Seven of the subjects had normal treadmill assessments, and all of those individuals had normal coronary arteries and normal chambers of the heart. One of three who were identified as at possible risk proved to have an observable disorder.

This detection of a case of "silent coronary artery disease" from the treadmill test is said to demonstrate a procedure with extremely high specificity for diagnostic screening.

ARGUS 15/10/85 (85) (98)

CITY/COURTS

Split control 'causing unhealthy health service'

Staff Reporter

THE splintering of control and functions of independent white, coloured, Asian and black local and regional metropolitan authorities under the new dispensation had led to inefficiency and frustration in health services and a division in the ranks of all health personnel.

This was said at the Ned Geref Synod last night by Mr A L Nyschens in his presidential address at the opening of the the Institute of Public Health's biennial congress.

He urged that all health related matters should be the responsibility of the Department of Health and Welfare.

IMPLICATIONS

"Far-reaching political, constitutional and social changes have been introduced during the last year-and-a-half, the implications of which, even at this stage, have not fully crystallised or materialised.

"It says much for the various public health services and their personnel that they have, in the face of extremely difficult situations, been more than able to maintain such high standards of service control and health generally and even to have neutralised, or considerably reduced, outbreaks of cholera and malaria that have occurred," he told the congress.

Mr Nyschens said it was a matter of urgency that clarity and details of future public health trends, planning and policy be made known to eliminate the uncertainty in public health activities and the recruitment, training and retention of staff.

FUNCTIONAL

"No final, clearcut lines of demarcation have yet been made public in regard to the final functional co-ordinated responsibilities of independent white, Asian, coloured and black local authorities, the co-ordinated duties of regional metropolitan authorities, and the possible division of health services into independent personal and non-personal sections — perhaps each under the control of of a different State department.

"It has always been accepted by health officials that planning and control of all health-related matters should be the responsibility of one central organisation — the Department of Health and Welfare.

OVERLAPPING

"The continued splintering off of control and functions has not been beneficial to health services and has led to functional overlapping by various health officials and authorities," said Mr Nyschens.

He said the inefficiency, frustrations and costs involved in splintering control and functions could not be afforded by the country and had further led to divisions in the ranks of all health personnel.

"There are inherent suspicions, jealousies, mistrust and even frustrations in regard to public health, and harmony between various members of the public health team is in doubt."

Mr Nyschens said one of the results of "this unhealthy state of affairs" is that at local government level recommendations had been made health departments inferior in status and quality.

He said this was in direct conflict with Government policy.

The congress closes on Thursday.

DISASTER PLAN

● Hospitals must have a disaster plan and develop an emergency response team capable of getting to a disaster scene rapidly to render on-the-spot medical assistance, Dr Reginald Broekmann, chief superintendent of the Johannesburg Hospital, said today.

He told the congress that one of the requirements of the disaster plan should be to reinforce the casualty department with doctors and nurses.

Hospitals should also have one or more "disaster boxes", each containing all the necessary equipment for the treatment of 10 seriously injured patients, which could be quickly loaded for transport to disaster sites.

Announcing the revised cent of total beef sales since the officials who received Premier's Awards for 40 years' service. Minister of Agricultural Eco-

Health services 'frustrated'

Medical Reporter

85

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STAR 15/10/85

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He said the continued splintering of control and functions had led to overlapping by health officials and authorities.

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● See Page 8.

Cash prizes for eight Savings Week winners

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Cape Times 15/10/85 85

State seeking health-care economy

Argus Correspondent

PRETORIA. — Fees at Government hospitals could be revised as the State juggles its health-spending in line with its tighter budget.

The Minister of National Health and Population Development, Dr Willie van Niekerk, told a meeting of the South African Medical and Dental Council yesterday that in a time of recession a more cost-effective health service was needed.

Health-care fees in general would have to be examined and the Government would be studying the possible privatisation of health-care.

"We will have a close look at the expansion or reduction of the Government's involvement in providing curative services, financing other providers of such services or performing regulatory functions," he said.

"Transferring ownership or effective control of facilities to or from the public sector is the most obvious option here, but not the only one.

"A deliberate policy to allow and encourage private services to grow in parallel with public care can alter roles through the power of the market-place, sometimes with less resistance than ownership transfers would cause."

Another option, Dr van Niekerk said, was to bring about in the public service itself certain reforms which had similar incentive effects to privatisation but did not involve overt realignment of functions.

Dr van Niekerk said another important aspect which the Government would have to consider was the structure of public subisidies.

It was of the utmost importance, he added, that South Africa should have a health-financing policy adopted by the National Health Policy Council.

This policy should encompass all the health services and should make it easier for the Department of Finance to pay for health-care.

AKE 76758

Health services disrupted

Municipal Reporter

HEALTH services in Cape Town's townships have been "seriously affected" as a result of the continuing unrest, according to the Medical Officer of Health, Dr Reg Coogan.

Dr Coogan said yesterday that clinic work in Cape Town as a whole had been reduced by 20 percent during August as a result of interruptions in the townships.

Clinic attendances had dropped and medical staff were often unable to make house calls because of rioting.

"This has affected our immunization programme and it has become difficult to treat tuberculosis patients, but we are battling on," he said.

"Doctors, nurses and health inspectors are constantly exposed to danger, and expensive vehicles like our X-ray vans are also in danger of being attacked.

"When things get really bad, we have to shut down completely, sometimes three times a day," he said.

The City Council's township clinics were "largely shut down" on Monday afternoon as a result of the unrest.

During the past couple of months, windows at two clinics had been smashed by stones and one clinic had been petrol-bombed.

Environmental health work, such as food and water control and shop inspections had also been affected.

Deputy MOH for the Divisional Council, Dr Stewart Fisher, said his department's health service was "continuing, but erratic".

"The doors, windows and furniture at our Nyanga clinic have been smashed and there has been minor damage to the clinics at Kasselsvlei and Atlantis," he said.

"If there are problems, we confine our staff to the clinic or withdraw them from the area."

Dr Fisher said fieldwork had been worst hit, with home visits to newborn babies, children, the aged and those suffering from infectious diseases the most seriously affected.

Both Dr Coogan and Dr Fisher said that although they were "concerned" about the impact of the unrest on health services, they did not believe this constituted a health hazard to the communities concerned.

The City Engineer, Mr Jan Brand, said cleansing staff were entering the townships affected by unrest "even earlier than usual" to remove refuse and clean the streets.

"We try to get it done before anyone gets up," he said.

"But its the most we can do to keep the centre of the streets clear for traffic each day. There's no such thing as sweeping the gutters or pavements."

'Preventive health care needed'

Pretoria Bureau

Only about five percent of South Africa's health budget is spent on preventive medicine, the Minister of National Health and Population Planning, Dr W A van Niekerk, said at the weekend.

Speaking to members of the Soutpansberg branch of the Medical Association of South Africa in Pietersburg, Dr van Niekerk said the amount spent on preventive medicine was well below what it should be.

But, he said: "Our good medical sense coupled with our economic situation will cause us to become more preventive health-oriented."

Dr van Niekerk encouraged the private medical sector and the community to become more involved in the provision of preventive health care.

Discussing the high population growth rate, Dr van Niekerk said the present population of 28 million would increase to about 47 million by the year 2000 and to a staggering 138 million by the year 2040.

"It is very clear that such a growth rate will place great stresses on the South African economy, the social, health and education services, agriculture and national resources," he said.

There should be a balance between the country's population and resources. South Africa could cope with a maximum of about 80 million people, he said.

The high population growth rate could be controlled only by improving the quality of life for everyone.

Dr van Niekerk urged the private sector to become more involved in the privatisation of health care.

Medical men to fight 'own affairs' move

'Ridiculous' health service plan

Mercury Reporter

THE Natal coastal branch council of the Medical Association of South Africa is unanimous that Government plans to fragment health services under 'own affairs' administrations should be 'condemned and resisted in every way possible'.

'There just isn't the money. It will all be spent on bureaucrats and health services may collapse,' said a branch council spokesman last night.

'This is one of the few issues on which the branch council is unanimous. I think everyone realises how ridiculous this system will be.'

An editorial in the latest newsletter of the Natal coastal branch criticised the 'own affairs' plans.

Provincial health services had been forced to cut back budgets, freeze posts and postpone developments for the past few years.

'One would have thought it now even more essential to curb spending. Unfortunately, to the incredulous dismay of doctors and their kindred professions in the hospital services, it has been decided otherwise.

'The decision to fragment the health services under the auspices of the new constitution has been steam-rollered through,' the editorial said.

Only a few hospitals in Natal served one race group exclusively. Hospital services were unified under the Natal Provincial Administration with central laundry, medico-technical services, ambulance services and pharmaceutical manufacturing.

'This would all have to be duplicated, triplicated or even quadruplicated,' the editorial suggested.

'With the imposition of parochial control by the "own affairs" brigade, who would run the sophisticated units such as radiography, CAT scanning, renal unit, paediatric and laser equipment at Addington which at present caters for all races?

'Would the KwaZulu Administration take over King Edward VIII Hospital? Would all the Indian doctors there have to be paid by the House of Delegates?

'This fantasy world that has been thought up by the politicians and bureaucrats in the pursuit of a crazed ideology is breathtaking in its absurdity but worse, it is morally wrong, will not benefit patients, will be astronomically expensive and will make our hospital servies the laughing stock of the world.

'Vast sums of money will now be spent in an insane proliferation of bureaucracy to achieve a more complete racial separation than was ever seen under the old apartheid.

Cape Times 7/11/85

Rise in TB among coloureds

By CHRIS ERASMUS
Medical Reporter

AN ACCELERATED tuberculosis epidemic is occurring among coloured people throughout the country and especially in the Western Cape, according to the Medical Officer of Health for the Cape Divisional Council, Dr L R Tibbit.

Addressing the TB issue in his 1984 annual report, Dr Tibbit described it as the "main infectious disease problem" facing medical authorities. He said there was an overall increase of 10 percent in the number of notifications of the disease in 1984, compared to 1983.

Since 1980 the number of annual notifications had increased by 54 percent, he said.

In all, there were 2 750 TB notifications in the Cape Divisional Council area in 1984 as against 2 500 the previous year.

Answer

"The notification rate per 100 000 has risen from 390 in 1983 to 415 in 1984 in the coloured population and it is evident that there is an accelerated epidemic of TB occurring in this population, especially in the Western Cape but also throughout the Republic," said Dr Tibbit.

"I am convinced the long-term answer to this problem is the development of community participation in the prevention, early reporting and completion of treatment of TB sufferers.

Media

"This can only be done by education. More beds for the hospitalization of TB sufferers, especially those who tend to default on treatment, is also necessary in the short term.

"However, as long as there is overcrowded housing and poor nutrition, a high prevalence rate of TB must be expected," he said.

Among steps recommended by Dr Tibbit to deal with the epidemic were the appointment of more health educators, including lay people, increased media coverage of the problem and the provision of a third mobile X-ray machine and an automatic processor for the Nyanga clinic.

● Dr Tibbit also said in his report that ischaemic heart disease (IHD) was the biggest killer overall, and especially among whites, in the Cape Divisional Council area during 1984.

IHD had accounted for 11,6 percent of all deaths and 22.1 percent of deaths among whites.

Nearly a quarter (23.5 percent) of all deaths among blacks were caused by a combination of homicides and transport accidents, with the next greatest cause of death in this group being intestinal infections, particularly among young children.

Indicators

There was little change in the infant mortality rates (IMRs) of whites and coloureds, said the report.

However, it was disturbing to note that there was a "significant rise" of more than six percent (from 32,32 to 38,36 percent) in the black infant mortality rate, particularly as IMRs were useful indicators of the efficacy of health services.

The greatest increase in infant deaths was among black neonates (new-borns) with a similar increase in the black still-birth rate.

The IMRs for the white and coloured groups were 9,62 and 24,47 percent respectively for 1984 as against 9,36 and 23,55 percent for 1983.

this year.

'Hospitals practise racism'

THE health secretariat of the Azanian People's Organisation, Dr Abu-Baker Asvat, yesterday slammed the hospital administration and accused it of practising racism in the solution of health care problems. 85

This follows The SOWETAN's disclosure about patients who [illegible] on trolleys and on the floor at the Hillbrow Hospital in Johannesburg. This happens despite reports that several beds were empty at the Indian Hospital [illegible]

[illegible] Sowetan

"For the authorities [illegible] come to grips with the overcrowding they will have to realise that racism is at the root of the problem. Blacks have [illegible] on the [illegible] floors while beds are empty at the "Indian Hospital". Patients suffer every kind of discomfort to get [illegible]

[illegible]

[illegible] mental effect on the health care service," said Dr Asvat. 3/11/85

He said Soweto [illegible] the hospital [illegible] with [illegible] beds [illegible] for the residents [illegible]

Detainee hunger strike rules

CAPE TOWN—Detainees on hunger strikes at Pollsmoor and Oudtshoorn prisons are to be treated in terms of an international convention that bans 'artificial' feeding of prisoners who refuse food.

According to the Department of Prisons, the strikers are to be treated 'strictly according to the internationally-accepted guidelines concerning the handling of hunger strikers as contained in the Tokyo declaration'.

The declaration, passed in 1968 by the World Medical Association, is an international convention on the medical treatment of prisoners.

It bars doctors from participating in the torture of prisoners, from providing facilities for the torture of prisoners, and from being present at such torture.

It also says that where a prisoner refuses nourishment and is considered by a doctor as being capable of forming an 'unimpaired and rational judgement' on the consequences of this refusal, he or she 'shall not be fed artificially'.

The decision as to the capacity of the prisoner for forming such a judgment should be confirmed by at least one other independent doctor,' says the declaration.

'The consequences for the refusal of nourishment shall be explained by the doctor to the prisoner.' — (Sapa)

Bill of health for terrorism accused

Mercury 85 09 11 85

Pietermaritzburg Bureau

DOCTORS could find nothing physically wrong with a 64-year-old woman, an alleged ANC member charged with terrorism, which could prevent her taking solid foods, the Supreme Court at Estcourt was told yesterday.

Nellie Nyawo of Ingwavuma complained last week of an irritation in her throat which allowed her to take in only liquids and maas.

She was taken to Edendale Hospital, Pietermaritzburg, at the weekend after saying she was feeling weak. A spokesman for the hospital said her condition was satisfactory.

Mr Ross Stuart, for the State, told the Court that when doctors examined Mrs Nyawo they could find nothing physically wrong with her.

Mrs Nyamo and and her 12 co-accused have all pleaded not guilty to the charges following the discovery of large caches of arms in caves in the Ingwavuma area last year.

Mrs Nyamo was excused from her trial last week after she said she was not feeling well following the complaint about her throat.

The hearing continues today.

Circular on population explosion

Municipal Reporter

UNLESS South Africa's birth rate is reduced, the country could have a population of 138-million by 2020, but only enough water for about 80-million people, says the Department of National Health and Population Development.

The department, which is co-ordinating the National Population Development Programme aimed at curbing the population explosion, says its target is a population of 80-million in 2100.

In a circular to the Cape Town City Council, the department identifies educational "bottlenecks", growing unemployment, the economic decline, rapid urbanization, rural degeneration and socio-economic problems like malnutrition, poverty and overcrowding as the major problems facing population planners.

Education is singled out as a particularly important prerequiste for slowing down the birth rate, and the government has called for priority to be given to the provision of basic education for as many pupils as possible in the short term.

More teachers will have to be trained, new educational models developed, electronic aids used more widely and literacy promoted.

Health care should be decentralized, and should focus on prevention "in contrast with a hospital or clinic-centred approach".

Education and health should be better co-ordinated and family planning expanded.

People should be encouraged to build their own homes and building standards for low-income groups revised.

The cabinet has stated that "the main objective of the National Population Development Programme is to raise the living standards and quality of life of all people in South Africa".

Cape Town's Medical Officer of Health, Dr Reg Coogan, has praised the fact that the cabinet has identified socio-economic problems as the main cause of overpopulation.

Dr Coogan said his department would give the programme its fullest co-operation.

Medics challenged on national health care

9/12/85 (85) STAR

CAPE TOWN — South African medical schools have been challenged by Professor Solly Benatar, of the University of Cape Town, to state their views on the desirability of a national health service to ensure the right of all people to basic health care.

Professor Benatar, of the department of medicine at UCT's Medical School, said the wide disparities in health and health care in South Africa could be rectified only by a national health policy.

His challenge, published at the weekend in the *South African Medical Journal*, reflects a growing concern in the medical profession about the trend towards privatisation of health care and racial division of the administration of medical services.

Professor Benatar said the practice of medicine was "a moral enterprise based on the concept of the sanctity and equality of all human life".

"This invokes the principle that all people should be treated beneficiently and with dignity."

This moral content had created the trust relationship between patient and doctor.

"The wide disparities in the health of, and health care facilities available to, different groups of people in South Africa are complex in origin, but in part are due to legislated discriminatory policies and to the lack of a national commitment to widely accepted basic human rights.

"The fundamental immorality of such policies is in conflict with the aims and ideals of the medical profession and impairs the ability of individual doctors and medical institutions to teach and practise their profession according to the basic tenets of its immorality.

"Within the framework of South African society, this can only be rectified by recognition of the right of all people to basic health care and other social services and the development of these on a national, non-discriminatory basis.

"The rising costs of medical care, the increasing trend towards privatisation and the further fragmentation of health-care services in South Africa will defeat this objective ...

"The creation and development of a national health service in South Africa, while not claimed as a panacea for all the difficulties involved in offering and delivering optimal health care to every individual, will help to establish an environment in which medicine can be taught and practised in accordance with its high moral content, for the benefit of individuals and society," he said.

"Acceptance of the proposals implicit in this proposal and their implementation, together with abolition of other discriminatory policies, are a prerequisite for the development of a just, fair and progressively civilised South African society," Professor Benatar said. — Sapa.

CAR TALKS 9/12/85

National health policy call

By BARRY STREEK

SOUTH AFRICAN medical schools have been challenged by Professor Solly Benatar of the University of Cape Town to state their views on the desirability of a national health service to ensure the right of all people to basic health care.

Professor Benatar, of the department of medicine at UCT's medical school, said the wide disparities in health and health care in South Africa could be rectified only by a national health policy.

His challenge, published at the weekend in the South African Medical Journal, reflects a growing concern in the medical profession about the trend towards privatization of health care and racial division of the administration of medical services.

Sanctity and equality of all human life

Professor Benatar said the practice of medicine was "a moral enterprise based on the concept of the sanctity and equality of all human life. This invokes the principle that all people should be treated beneficiently and with dignity.

"The wide disparities in the health of, and health care facilities available to, different groups of people in South Africa are complex in origin but in part are due to legislated discriminatory policies and to the lack of a national commitment to widely accepted basic human rights.

"The fundamental immorality of such policies is in conflict with the aims and ideals of the medical profession and impairs the ability of individual doctors and medical institutions to teach and practise according to the basic tenets of its morality.

"Within the framework of South African society this can only be rectified by recognition of the right of all people to basic health care and other social services and the development of these on a national non-discriminatory basis.

"The rising costs of medical care, the increasing trend towards privatization and the further fragmentation of health care services in South Africa will widen the gap between health care facilities available to the rich and the poor.

Threaten function of teaching hospitals

"These developments also threaten the function of teaching hospitals in their academic and clinical leadership roles — vital components of a civilized society.

"The creation and development of a national health service in South Africa, while not claimed as a panacea for all the difficulties, will help to establish an environment in which medicine can be taught and practised in accordance with its high moral content, for the benefit of individuals and society," he said.

A national health service would not impinge on the freedom of individuals to provide or purchase additional health if the right to private practice was retained.

Saunders wasteful

CAPE TIMES 14/12/85

Wasteful red tape should go

Staff Reporter

THE Vice-Chancellor and Principal of the University of Cape Town, Dr Stuart Saunders, yesterday called on the government to halt "in its tracks" the fragmentation of the country's education and health services until an acceptable constitution emerged.

Dr Stuart Saunders

Dr Saunders was addressing graduands from UCT's faculties of Law and Medicine at an afternoon graduation ceremony.

Under the present system, South Africa deserved an entry in the Guinness Book of Records in education and health as "we will have the world's greatest amount of bureaucracy and red tape per head of population and the least efficiency", he said.

Racism

"The new Constitution does not satisfy the legitimate political aspirations of those who are not white and entrenches racism and discrimination."

The division of responsibilities into "own affairs" and "general affairs" was wasteful and not in the best interests of the country's education, he said.

"We now have the Department of National Education (General Affairs), the Department of Education and Culture (House of Assembly), the Department of Education and Culture (House of Representatives), the Department of Education and Culture (House of Delegates), the Department of Education and Development Aid, and we have all the education departments of the independent and other states created as part of the Verwoerdian master plan," he said.

"It's inconceivable that any educational planner would develop such a tortuous bureaucratic system in order to serve the educational needs of a nation the size of South Africa."

Dr Saunders deplored the government's handling of the educational crisis in "coloured" schools.

"Despite our representations at the highest level, no resolution is in sight. How can police be allowed to supervise school examinations?

"How is it that scholars can be expected to show their knowledge when a whole school is arrested? Is it credible?"

Health

While the new Constitution posed problems for education, the problems they presented in the field of health were "enormous", he said.

"For years many members of the medical profession have urged that there should be a unitary administrative system for health, but now we are to have not only the three-tiered system that we have always had, but we are also going to have a horizontal differentiation of health at the second tier level into 'own affairs' so that different hospitals in the country are likely to become own affairs hospitals — white, coloured, Indian — and then also of course general affairs hospitals, while the future of the teaching hospitals remains in doubt," he said.

GENERAL

HEALTH & DISEASE — 09

1986

JAN — DEC.

Plea for one health service

Rand Times 13/1/86 85

Medical Reporter

THE further racial division of health services as envisaged under the new constitution has been criticized as inefficient, unnecessary and unwanted in a letter published in the latest SA Medical Journal.

The letter from Professor Maurice McGregor, Dean of the University of the Witwatersrand's Faculty of Medicine, says 640 faculty members have sent a petition to the Minister of Health.

The petition strongly supports the submission by deans of medicine in July last year to the Minister of Health that "all health affairs ... must be under one administration".

Professor McGregor quotes the petition which says: "We believe the present division of responsibility for health matters between provincial, national and local authorities has up to now created unnecessary inefficiency and has compromised health planning.

"To divide the administration of health services further along racial lines must increase inefficiency at a time of fiscal need, must gravely prejudice the country's ability to evolve a coherent health policy ... and is an unnecessary and unwanted extension of apartheid legislation at a time when South Africa is taking the opposite direction.

"We who work in the health care system implore the government to accept that health is indivisible and to take this opportunity to make a significant step towards a single unified health service."

Inquiry hears baby died of teargas

DISPATCH
7/2/86.

PRETORIA — The mother of a 2-month-old Mamelodi child who died four days after the November 21 shootings in the township has testified before an independent commission of inquiry by the Pretoria Council of Churches that her child died as a result of teargas inhalation.

Miss Lenah Ndlovu, whose daughter Trocia's death sparked off a controversy last year, testified before Mr A. Chaskalson, chairman of the commission, and two assessors at the Mamelodi YMCA centre on Wednesday that her child did not show any signs of illness until after she inhaled the fumes from the teargas canister fired by police who were chasing a group of youths.

She denied reports from an Afrikaans morning newspaper of December 7 last year, read before the commission, that quoted a police spokesman as saying Trocia had died of undernourishment and diarrhoea.

Events allegedly leading to Trocia's illness were recounted by the baby's grandmother, Mrs Betty Ndlovu, who said that on the morning of November 21, police in a Hippo had fired a teargas canister that landed in her yard next to the front door. The fumes penetrated the house and a bedroom where Trocia was sleeping.

"When I went into the house the child was coughing and so were we," she said, adding the child had continued coughing and her temperature had starting rising during the night.

The incident sparked a controversy between a Pretoria newspaper, the Pretoria News, and the police in November last year. The police denied the newspaper's report that the child had died of teargas inhalation.

Miss Ndlovu said she had taken Trocia to a private doctor in Waltloo, who confirmed the symptoms were those of teargas inhalation. She had been taken to Mamelodi Day Hospital on November 25 at 7.30 am, where she had started vomiting a black substance.

She had been put on the drip and transferred to Kalafong Hospital for further treatment. She had died at about 10 am at the "driproom" in Kalafong. Miss Ndlovu said the doctors who treated her at Kalafong had suggested the child had been involved in an "accident."

She had denied it and they later told her she must have been sick before she inhaled the fumes. Some authorities at the hospital "hid" the corpse before they finally released it for burial, she said.

Another witness, Mr Samson Skosana, 29, gave the commission an account of the events that led to the killing of about 15 people and the injury of scores of others.

He said thousands of Mamelodi residents gathered outside the local town council office On November 21 last year to demonstrate against high rents, and were given five minutes to disperse, but shots were fired less than a minute after the warning was given. He also said the police did not only shoot people at the scene of the demonstration. They also shot at people at different places in the township.

The commission is proceeding with the hearing. — Sapa

organised farm labour.

for farm workers.

Staff.

Scrap racist health laws — Barnard

PARLIAMENT —The South African Medical Association would be kicked out of its world body "as sure as I am standing here" if the Government persisted with its division of the country's health services on racial lines, Dr Marius Barnard (PFP, Parktown) said yesterday. STAR 13/2/86 85

Speaking in the Second Reading Debate on the Part Appropriation Bill, he said the "Own Affairs" policy as applied to health had caused members of the South African medical profession great difficulty overseas.

They were unable to "sell it" he said, and it was not in accordance with the Geneva Convention which was "totally against" racial discrimination.

Dr Barnard asked the Minister of Finance, Mr Barend du Plessis, to use his influence to ensure that the health services were united under one administration.

Dr Barnard said that with the scrapping of the Mixed Marriages Act, it was possible for a black man to marry a white woman. If she conceived, it was possible the wife would choose to go to the (white) Johannesburg General Hospital for the confinement.

It was accepted by the medical profession as desirable that the husband be present during the final stages of labour. Should this black husband faint during this process and get concussion, or cut his head, he would have to be taken to a black hospital for treatment.

And when the baby was born, as a coloured it would have to go to the Coronation Hospital.

"I ask the Minister, is apartheid outdated in South Africa?"

"Everyone" in the medical profession was against the separation of health care into own affairs, which was also very expensive.

'World body will bar SA' — Dr Marius Barnard.

Delegates laud Minister of Justice

STAR 13/2/86

PARLIAMENT — The Minister of Justice, Mr Kobie Coetsee, drew praise from both sides of the House of Delegates yesterday.

The leader of the ruling National People's Party, Mr Amichand Rajbansi, said he was proud to be part of the reformist Cabinet. Speaking during the second reading debate on the Special Courts for Blacks Abolition Bill, Mr Rajbansi said he was proud of being associated with Cabinet colleagues of the calibre of Mr Coetsee.

The actions of Mr Coetsee confirmed the independence of South Africa's judiciary, which had the greatest respect both nationally and internationally, he said.

Mr Coetsee was also praised by Mr Pat Poovalingam (Solidarity, Reservoir Hills) for the swift action he had taken following the controversial showing of a videotape depicting scenes of unrest to Durban magistrates.

Replying to the debate, Mr Coetsee said he wished to take the opportunity to thank those concerned with the videotape showing for their co-operation following the intervention of the Judge-President of Natal.

He also thanked the Press for their objective handling of the videotape issue.

Defence details misused — Malan

STAR 13/2/86

PARLIAMENT — Minister of Defence General Magnus Malan has refused to provide particulars of national servicemen who failed to report for duty.

In a written reply to a question by Mr Philip Myburgh (PFP, Wynberg), the Minister said the information supplied last year had been "misused by a certain organisation which campaigns for the discontinuation of national service".

He could not answer the second part of the question, which requested the number of prosecutions and convictions of servicemen who had failed to report for the January 1985 and 1986 intakes as the information was not readily available.

In reply to another question, the Minister said 211 white women volunteers had been accepted for national service. Of the 4 010 coloured volunteers, 1 847 were accommodated while 297 of 667 Asian volunteers were accepted. There were no black volunteers. — Sapa.

Moolla to head Indian opposition

STAR 13/2/86.

PARLIAMENT —Solidarity's Chief Whip, Mr Yunus Moolla (Stanga), has been named as the acting Leader of the Opposition in the House of Delegates.

Mr Moolla takes over from Mr J N Reddy, who was sworn in as the new Minister of the Budget on Monday.

Mr Ismael Kathrada (Verulam) took over the Health Services and Welfare portfolio.

Masa is against new black medical faculty

By JACK DEWES

THE Medical Association of South Africa (Masa) is opposed to the proposed establishment of a medical faculty for blacks in the Eastern Cape.

"Masa is against any form of ethnicity," the chairman of the East Cape branch of Masa, Dr Angus Hofmeyr, said at a Press conference in Port Elizabeth yesterday.

"The times of ethnicity are long past. We must shout against it now or fail in our duty by default.

"Merit and achievement should be the only criteria in medical education. Blacks must be assimilated with us. If blacks can mix with us they will leave their political grievances behind and go forward with us.

"In such an environment the black student can become a more complete doctor."

Dr Hofmeyr was responding to a decision by the Cabinet that if any medical faculty was to be established in the Eastern Cape it would have to be for blacks.The announcement came after the findings of the De Villiers Commission on the establishment of further medical faculties in SA were made known.

The commission recommended that medical training in Ciskei be regarded as a priority.

The Government's decision was that medical training faculty would be established in the Eastern Cape until existing faculties were "fully used".

A former Mayor of Port Elizabeth, Mr Ivan Krige, who attended the conference, said separation on ethnic grounds was "for the birds" and the idea of "medical schools in the bundu, far from facilities" was ridiculous.

This was particularly true when the University of Port Elizabeth was fighting for permission to establish a medical faculty open to all races.

(Mr Krige is a member of the UPE's board of trustees.)

Dr Hofmeyr said: "The Government must forget about politics and act for the benefit of Port Elizabeth and its university. They have concluded that the motor industry has moved out, therefore PE is dead. This is nonsense."

"Where's the money for a medical faculty in Ciskei going to come from? The taxpayer?

"If so, we want that money to be channelled to UPE, which has phenomenal potential."

Masa protested against ethnicity on humanitarian grounds, not for political considerations.

Masa hoped to maintain the efficiency of the medical profession. A faculty for blacks only would produce sub-standard medical practitioners.

Advertisements

109. Mr D J DALLING asked the Minister of Communications:

(1) What was the total amount spent by his Department in 1985 on placing advertisements for any purpose in newspapers in the Republic;

(2) what amount was paid to each specified newspaper in the above regard in that year?

The MINISTER OF COMMUNICATIONS:

(1) R826 580,86.

(2)

	R c
Audit Update	440,00
Beeld	73 999,05
Brits Pos	44,35
Business Day	42 452,53
Cape Herald	321,04
Cape Times	45 761,00
Computer Week	2 688,00
Daily Despatch	20 565,70
Diamond Fields Advertiser	8 297,40
Die Burger	51 180,11
Die Gemsbok	45,00
Die Laevelder	56,45
Die Transvaler	25 051,28
Die Vaderland	32 904,87
Die Volksblad	24 470,16
Eastern Province Herald	20 651,23
Evening Post	89,05
Karoonuus	3 550,68
Letaba Herald	45,70
Middelburg Observer	64,51
Ons Stad	1 399,44
Oosterlig	10 932,43
Pretoria News	31 003,49
Rand Daily Mail	240,00
Rekeningkunde SA	429,00
Rapport	41 462,47
SA Philatelist	533,35
Soutpansberger	48,38
Sunday Times	44 199,00
Sunday Tribune	33 009,28
Tempo	148,00
The Argus	57 817,15
The Citizen	38 549,07
The Daily News	39 844,39
The Friend	4 185,05
The Natal Mercury	40 263,23
The Natal Witness	14 395,04
The Star	110 983,36
The Sunday Star	2 955,15
Verwoerdburg News	480,48
Viva Overkruin	828,57
Western Transvaal Record	73,92
Witbank Nuus	77,95
Südafrika Rundschau	44,55

Advertisements

121. Mr D J DALLING asked the Minister of National Education:

(1) What was the total amount spent by his Department in 1985 on placing advertisements for any purpose in newspapers in the Republic:

(2) what amount was paid to each specified newspaper in the above regard in that year?

The MINISTER OF NATIONAL EDUCATION

(1) Nil.

(2) Nil.

Advertisements

125. Mr D J DALLING asked the Minister of National Health and Population Development:

(1) What was the total amount spent by his Department in 1985 on placing advertisements for any purpose in newspapers in the Republic;

(2) what amount was paid to each specified newspaper in the above regard in that year?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) R654 011.

(2) The expenditure is not kept in a format so as to identify specific newspapers.

Advertisements

128. Mr D J DALLING asked the Minister of Manpower:

(1) What was the total amount spent by his Department in 1985 on placing advertisements for any purpose in newspapers in the Republic;

(2) what amount was paid to each specified newspaper in the above regard in that year?

The MINISTER OF MANPOWER:

(1) R14382,34.

(2)

Argus	R 446,60
Burger	R 747,60
Cape Times	R 173,00
Citizen	R1513,00
Daily News	R 686,40
Diamond Fields Advertiser	R 738,76
E P Herold	R 710,00
E L Daily Dispatch	R 403,80
Friend	R 117,60
Gemsbok	R 162,00
Highveld Ridge News	R 94,08
Hoëvelder	R 83,16
Ladysmith Gazette	R 114,78
Laëvelder	R 180,00
Middelburg Observer	R 50,40
Natal Witness	R 107,35
Newcastle Advertiser	R 467,60
Noordelike Stem	R 70,40
Noord Transvaler	R 425,60
Oosterlig	R 453,60
Queenstown Daily Representative	R 102,75
Stellalander	R 48,00
Transvaler	R 249,60
Tempo	R 624,95
Vaderland	R 659,25
Volksblad	R 499,75
Vista	R 252,00
Witbank News	R 67,60
Natal Newspapers	R 833,19
The Star	R1552,32
Armed Forces	R 504,00
Beeld	R1243,20

Advertisements

129. Mr D J DALLING asked the Minister of Home Affairs:

(1) What was the total amount spent by his Department in 1985 on placing advertisements for any purpose in newspapers in the Republic;

(2) what amount was paid to each specified newspaper in the above regard in that year?

The MINISTER OF HOME AFFAIRS:

(1) None.

(2) Falls away.

Telephones: backlog

137. Mr R W HARDINGHAM asked the Minister of Communications:

What was the backlog in respect of applications for telephone services in 1985 in the (a) Howick, (b) Mooi River, (c) Underberg, (d) Hilton, (e) Kokstad, (f) Matatiele, (g) Nottingham Road and (h) Richmond (Natal) area as at the latest specified date for which figures are available?

The MINISTER OF COMMUNICATIONS:

As at 31 December 1985:

(a) 348.

(b) 78.

(c) 17.

(d) 175.

(e) 14.

(f) nil.

(g) 12, and

(h) 31.

Full consultation urged for education

AN EDUCATION policy would be forced on the rest of the country if the Minister of National Education were allowed to determine guidelines without consulting other groups, Horace van Rensburg (PFP Bryanston) said in the House of Assembly yesterday.

He was speaking during the debate on the second reading of the National Policy for General Education Affairs Amendment Bill, which provides that the general education policy determined by the Minister should be tabled in Parliament.

Van Rensburg recommended that the Minister should draw up draft policy guidelines that would then be reviewed by the Parliamentary Standing Committee on Education. — Sapa.

cial language of South Africa, the Herstigte Nasionale Party's MP, Louis Stofberg, said yesterday. Speaking during the Woordeboek van die Afrikaanse Taal Amendment Bill, he said Afrikaans could become a new symbol to bind whites in South Africa together.

Today's Business

HOUSE OF ASSEMBLY: 1. Questions. 2. Resumption of Second Reading debate — Carriage of Goods by Sea Bill. 3. Resumption of Second Reading debate — International Convention for the Prevention of Pollution from Ships Bill. 4. Resumption of Second Reading debate — Post Office Amendment Bill.

HOUSE OF DELEGATES: 1. Second Reading Debate — Carriage of Goods by Sea Bill. 2. Second Reading Debate — International Convention for the Prevention of Pollution from Ships Bill. 3. Second Reading Debate — Post Office Amendment Bill.

HOUSE OF REPRESENTATIVES: Second Reading debate — Part Appropriation Bill.

REPORTS: Sapa and Reuter.

No decision yet on running health services

HOUSE OF ASSEMBLY — The State has not yet decided who will administer provincial health services after the proposed abolition of provincial councils on July 1.

Minister of Health Services Dr Willie van Niekerk, answering a question tabled in the House by Dr Willie Snyman (CP, Pietersburg) yesterday, said he could not give "a definite reply" on who would administer the provincial health services.

By BARRY STREEK

Van Niekerk said: "The reorganisation of the health services of the provincial administrations is at present the subject of an inquiry by a project team of the Commission for Administration.

"As soon as this inquiry has been completed, a recommendation will be furnished to the Cabinet for a final decision."

Snyman had asked whether Van Niekerk's department would administer the provincial health services and when his department proposed to take over the services.

He had also asked whether his department would administer hospitals that made provision for all population groups.

The fragmentation of health services in SA

18/2/80: STAR

85

Health services in South Africa are already divided among 10 black homelands, apart from the State Department of Health.

It is now mooted that health care in the remaining 87 percent of South Africa should be classified as "own affairs".

Health matters for the great majority of South Africans will then fall under another four health departments, where today there is only one national health department.

This dismemberment of health care under 14 different authorities would give South Africa one of the most fragmented health services in the world.

In our opinion, such subdivision is not in the best interests of the people or their health. Disease respects no territorial or political boundaries: to combat it effectively and to promote positive health, the country needs a single national health service, as the Gluckman Commission concluded more than 40 years ago.

Instead of moving in this direction, the health services are being increasingly atomised. This poses dangers for the health of 30 million people.

The divisive character of the State's proposals threatens to create a health care structure that will be wasteful, inefficient and uncoordinated.

In the Transvaal alone, there are six homeland health services, apart from State, provincial and local authority services.

This means there are six ministers of health, with six secretaries for health heading six different bureaucracies, six health inspectorates, six nursing associations, six pools of health transport etc.

Can South Africa afford such a wasteful arrangement? Have we enough personnel, medical and support resources to sustain this system? We believe not. The existing position in the Transvaal is bad enough.

If the health services in the rest of the province are further subdivided — so that health care for Indians, coloured people, Africans and whites will each fall under a different ministry — the resulting skeinwork will surely provide a recipe for disaster.

The threat of further divisions in health care has elicited strong opposition from the Medical Faculty of the University of the Witwatersrand, along with the other South African medical schools.

The Medical Graduates' Association of the University of the Witwatersrand has sent the following telegram to the State President and the Minister of Health:

A DECISION REGARDING THE ADMINISTRATION OF HEALTH SERVICES IN THE REPUBLIC IS DUE TO BE TAKEN IN THE NEAR FUTURE STOP THE DEEP CONCERN OF THE MEDICAL GRADUATES OF THIS UNIVERSITY IS THAT FURTHER DIVISION IN THE HEALTH SERVICE SYSTEM MAY BE INTRODUCED STOP WE URGENTLY AND EARNESTLY REQUEST THAT ALL HEALTH SERVICES IN REPUBLIC BE ADMINISTERED BY A SINGLE DEPARTMENT STOP WE BELIEVE THIS OF CRUCIAL IMPORTANCE STOP BOTH COSTS AND QUALITY OF MEDICAL CARE WILL BE ADVERSELY INFLUENCED BY FURTHER DIVISION OF HEALTH SERVICES STOP CONVERSELY COSTS AND SERVICES WOULD BE IMPROVED BY UNIFICATION OF HEALTH SERVICES UNDER SINGLE DEPARTMENT STOP WE TRUST THIS APPEAL WILL RECEIVE YOUR EARNEST CONSIDERATION FSTP

This article, contributed by the council of the association, gives some of the reasons for its concern.

The Wits Medical Graduates' Association wishes to add its voice of condemnation to further disintegration of health services. We are aware that harm has already been done to health care in the Transvaal. Studies have revealed inefficiency and uneconomic functioning.

An example is the history of the Shiluvane Hospital between Lebowa and Gazankulu. According to a survey, in 1976 the South African Government gave it to Lebowa. In 1981 the hospital was taken from Lebowa and handed to Gazankulu.

All Pedi-speaking staff were then withdrawn, while Pedi patients were taken to other hospitals in Lebowa.

No co-ordination

Two Transvaal hospitals, it has been reported, although only 40 km apart, were unable to co-ordinate the immunisation campaigns required during the 1982 polio epidemic.

This was because the hospitals are on opposite sides of the road, one in Lebowa, the other in Gazankulu.

Co-ordination, which is vital in such campaigns, is no longer a simple matter of staff making joint plans. It has become a diplomatic event, to be negotiated between separate governments far from the scene. In the meantime epidemics run their course.

Under the "own affairs" arrangement, instead of a single State department administering health in non-homeland South Africa, health services will be divided among four different ethnic ministries.

What will be the consequences for hospitals which provide services to more than one race? Several teaching hospitals have already started moving in this direction.

The Wits family of teaching hospitals will fall under three or even four different authorities: Coronation under coloured "own affairs", Baragwanath and Hillbrow under "general affairs", J G Strijdom under white "own affairs", with the Johannesburg Hospital still to be determined.

The Medical Faculty will have to deal with three or four different authorities for clinical joint appointments, teaching facilities, patient and student admission policies, etc — a system which will be appallingly unpractical, tedious and vexatious.

We fear that the consistent application of the new system will have serious, adverse effects on the quality of clinical training our medical and paramedical students will receive.

Our association considers the proposed tricameral health system to be morally indefensible. It is based on ethnic discrimination; is wasteful of money, medical and support personnel and resources; and unworkable, if our goal is to provide good health care for the entire population.

We plead for a reunification of health care for all our people under a single national health service, cutting across region and race.

'Blacks not getting fair deal'

THE health and education of blacks was put under the spotlight at the sixth annual general meeting of the Health Workers Association held at Soweto's Funda Centre in Diepkloof at the weekend.

About 400 people, among them delegates from trade unions and civic and political organisations, attended the meeting.

The theme of the meeting was "people's education for people's health".

Miss Amanda Kwadi of the Federation of South African Women (Fedsaw) and Mr Samson Ndou of the General and Allied Workers Union (Gawu) were guest speakers.

Miss Kwadi spoke about the "inferior" system of education for blacks in "apartheid South Africa," and how much money the Government spent for children of the different race groups.

She said a survey conducted by the South African Institute of Race Relations in 1984, showed that the Government spent R1 211 for a white child per year, R711 for an Indian child, R498 for a coloured child and R146 for an African child.

AMANDA Kwadi

Looking at how "apartheid education" affects the health of workers, Miss Kwadi said it was a known fact that illiteracy, sickness, disease, malnutrition and infant mortality was high among the oppressed people.

Miss Kwadi said the country's health budget was also unequally distributed. Whites were given R679,9 million; the coloureds R395,8 million; the Indians R103 million. The amount given to the Africans was unknown, she said.

"The above clearly shows that we cannot have an effective health system in an undemocratic society," said Miss Kwadi.

Said Miss Kwadi: "We are therefore calling upon all health workers to strengthen their organisations and mobilise thus strengthening the national democratic struggle."

tained burn wounds as a result of petrolbombs.
5 injured by rioters of which one sustained a gunshot wound and four injured by stone throwers.

(3) Yes.

(a) and (b) Since 15 February 1986 increased patrols have been carried out in the townships and on 18 February 1986 concerted actions by the SAP and SADF were carried out to remove obstacles from roads and to search houses in an attempt to arrest suspects.

(4) No, not at this stage.

Own Affairs:

HANSARD 25/2/86

Committee of Inquiry into Certain Aspects of Child Care

*1. Mr R M BURROWS asked the Minister of Health Services and Welfare:

(1) Whether all the recommendations contained in the 1982 report of the Committee of Inquiry into Certain Aspects of Child Care have been implemented; if not, (a) why not, (b) which recommendations have not been implemented and (c) when is it anticipated that these recommendations will be implemented;

(2) whether he has received any representations for the implementation of all the recommendations contained in this report; if so, (a) from whom, (b) when and (c) what was his response thereto;

(3) whether he will make a statement on the matter?

†The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) No.

(a) Schools of industries do not fall under my jurisdiction and consequently I can only furnish a reply on places of safety and children's homes. In respect of places of safety the majority of the recommendations have already been implemented. These recommendations are: The appointment of multi-professional teams, upgrading of tending personnel, expansion of in-service training of personnel, appointment of experienced social workers as superintendents, determination of new standards for buildings, re-establishment of existing accommodation as good as possible as an interim measure to create a therapeutic milieu and the improvement of security measures.

Children's homes are run by private welfare organisations who are encouraged by departmental officers in the regional offices of the Department to implement the recommendations. As far as the Department itself is concerned attention has inter alia been given to: the amendment of registration of children's homes. The registration certificates of at least 80% of children's homes have been revised. Children's home liason committees have been implemented in all the regions except one. Research on the child's readaptation after discharge from a children's home has started and a guide for management of children's homes is ready for the press. Due to the financial implications which other recommendations entail, it cannot be implemented at present.

(b) Recommendations with considerable financial implications such as the erection of more places of safety and the rebuilding of children's homes according to the home unit system.

(c) In the long term as funds become available.

HoA

(2) No.

(a), (b) and (c) fall away.

(3) No.

Mr R M BURROWS: Mr Chairman, arising from the hon the Minister's reply, I should like to know whether he is convinced that the recommendations that have been accepted, as well as those that have not been accepted, will lead to the ending of the kind of conditions in places of safety that were widely reported in the media during the latter part of 1985?

The MINISTER: Mr Chairman, I think that question should be tabled. [Interjections.]

For written reply:

General Affairs:

25/2/86. HANSARD

Fuel pipelines

28. Mr B B GOODALL asked the Minister of Transport Affairs:

Q COL 209.

(1) Whether, with reference to his reply to Question No 3 on 11 June 1985, he has calculated the volume in litres of fuel lost from the South African Transport Services fuel pipelines during the period April 1982 to March 1985; of not, (a) why not and (b) when will this information be available; if so,

(2) with regard to the above-mentioned period, (a) how many litres of fuel were lost and (b) what was the cost to the South African Transport Services of (i) the loss of fuel, (ii) repairs to the pipelines, (iii) cleaning up the spillage and (iv) compensation for damage;

(3) (a) what was the position occupied by each of the persons against whom disciplinary action was taken and (b) what was the nature of the disciplinary action taken against each of them?

The MINISTER OF TRANSPORT AFFAIRS:

(1) Yes.

(a) and (b) Fall away.

(2) (a) Approximately 0,0064 per cent of the volume of product handled.

(b), (i) The divulgence of this information is prohibited in terms of the provisions of section 4A of the Petroleum Products Act, 1977 (Act 120 of 1977).

(ii) and (iii) R110 730. Separate figures are not available.

(iv) R57 650.

(3) (a) Two Controllers (Pipelines)
Assistant Controller (Pipelines)
Technical Supervisor (Electrical)

(b) Appropriate fines were imposed on the employees concerned who were found guilty of negligence.

Q. COL 210.

Commission of Inquiry into Health Matters

HANSARD 25/2/86

30. Dr M S BARNARD asked the Minister of National Health and Population Development:

85

With reference to his reply to Question No 32 on 12 February 1985, (a) what amount was spent on the Commission of Inquiry into Health Matters in the (i) latest specified financial year and (ii) current financial year as at the latest specified date for which figures are available and (b) what total amount had been spent on this commission as at that date?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) (i) 1984-85—R103 081.

(ii) 28-1-1986—R63 079.

(b) R442 558.

Decentralisation Board: applications

33. Mr A SAVAGE asked the Minister of Trade and Industry:

(1) How many applications were made to the Decentralisation Board during 1985 or the latest specified period for which figures are available;

(2) (a) how many applications (i) were approved and (ii) failed to meet the requirements and (b) what was the value of the applications in each category;

(3) (a) how many employment opportunities were created in consequence of the approved applications that had been finalised and (b) what estimated number of employment opportunities will be created in consequence of such applications;

(4) what was the total (a) number and (b) value of the applications involving foreign investors?

The MINISTER OF TRADE AND INDUSTRY:

	(1)	(2)(a)(i)	(2)(a)(ii)
1 April 1984 to 31 March 1985:	1 507	1 216	216(aa)
1 April 1985 to 31 December 1985:	1 069	965	80(bb)

Note: (aa) and (bb): 30 and 24 applications, respectively, were held over pending clearance of certain policy guidelines.

(2) (b) The proposed capital investment in respect of the applications approved is:

1 April 1984 to 31 March 1985: R1 176,7 million.

1 April 1985 to 31 December 1985: R1 043,6 million.

Note: The information is not being compiled in respect of applications refused.

(3) (a) In respect of applications approved during the period 1 April 1984 to 31 March 1985 it has been recorded that 11 351 employment opportunities had been created up to 30 September 1985. It should, however, be pointed out that it takes up to two years for a project to be physically established. Furthermore, a project can only be recorded as having been established after the industrialist's first quarterly claim is received by the Decentralisation Board. For these reasons it is also not yet possible to furnish particulars of employment opportunities created in respect of the applications approved during the period April 1985 to December 1985.

	(3)(b)	(4)(a)	(4)(b)
1 April 1984 to 31 March 1985:	77 486	44	R80,2 million
1 April 1985 to 31 December 1985:	71 556	80	R202,9 million

Substandard A

55. Mr H E J VAN RENSBURG asked the Minister of Education and Development Aid:

How many Black children were enrolled in 1985 in Substandard A in (a) each specified region and (b) the Republic?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(a)

Region	Sub A enrolment
Northern Transvaal	58 106
Highveld	46 644
Johannesburg	26 500
Orange-Vaal	40 744
OFS	40 392
Natal	37 273
Cape	46 080
TOTAL	295 739
Qwaqwa	10 972
Lebowa	89 788
Gazankulu	39 673
KwaZulu	220 841
KaNgwane	24 677
KwaNdebele	15 772
TOTAL	401 723

(b) 697 462.

Job opportunities

56. Mr K M ANDREW asked the Minister of Education and Development Aid:

(1) Whether, with reference to the reply of the Minister of Co-operation, Development and Education to Question No 935 on 4 June 1985, any portion of the R53 million has been spent by his Department on the creation of job opportunities for Blacks; if not, (a) why not, (b) what progress has been made and (c) when is it anticipated that any action will be taken in this regard; if so,

(2) (a) what amount had been spent as at the latest specified date for which figures are available, (b) how many job opportunities have been created as a result, (c) in which specified areas were they created and (d) in what areas will the remainder of this money be spent;

(3) whether he will make a statement on the matter?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(1) Yes.

(2) (a) R16 685 642,60 as at 31 January 1986.

(b) 40 981.

(c) In all the national states and on various South African Development Trust farms.

(d) All the funds allocated to the Department of Development Aid are expended on the creation of job opportunities for Blacks in the national states and on South African Development Trust farms.

(3) No.

Black spots

75. Mr R A F SWART asked the Minister of Education and Development Aid:

(a) How many Blacks were moved from Black spots to Black states in 1985 and (b)(i) from which Black spots, (ii) to which Black states, and (iii) why, were they moved in each case?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(a) None.

(b) Falls away.

KwaNdebele

78. Mr R A F SWART asked the Minister of Education and Development Aid:

(a) How many houses were built in KwaNdebele by (i) his Department, (ii)

Cancer worse in whites

PARLIAMENT — More whites died of lung cancer last year than members of the other three population groups combined, according to figures supplied by the Minister of National Health and Population Development, **Dr Willie van Niekerk**, in reply to a question by **Dr Marius Barnard (PFP, Parktown)** yesterday.

Deaths caused by primary malignancy of the lung were: whites 136, coloureds 71, Asians three and blacks 50. — Sapa.

Koeberg first the good nudes...

PARLIAMENT — A bather on Cape Town's nudist beach, Sandy Bay, would have have been subjected to hundreds of times more radiation in 1985 than if he had stood naked at the boundary of the Koeberg nuclear power station.

Even if he did so for 12 months, living off food exposed to the maximum radiation emitted there.

This claim was made yesterday in a written reply from the Minister of Mineral and Energy Affairs. Mr Danie Steyn, to a question from Mr Brian Goodall (PFP Edenvale).

The Minister said that in 1985, the maximum potential radiation dose from Koeberg was 0,5 millirem (mrem).

GRANITE OUTCROPS

"This means that if a person were to have stood at the Koeberg boundary fence for the whole of 1985 — naked and with no shelter — living off food exposed to the maximum radiation emitted from Koeberg last year, and eating seafood caught in the powerstation outfall, he would have been subjected to an additional 0,5 mrem of radiation," Mr Steyn said.

"This exposure should be compared with the 240 mrem a year a person would receive naturally on the beaches of Camps Bay, Clifton and Sandy Bay, due to the proximity of granite outcrops, or the 190 mrem a year in Johannesburg, increasing to 500 mrems a year in the proximity of certain mine dumps."

Heart disease 'robs country of R2m a day'

Preventive-medicine plan to save SA millions

(85) BUSDAY 18/4/86.

PREVENTIVE-MEDICINE programmes could save SA millions of rands in insurance and lost man-hours, says the executive director of a new Johannesburg organisation which is to research and design such programmes.

Brian Goslin, a human movement specialist from Canada, says SA's health system often stresses curing, rather than preventing, health problems. The direct and indirect costs of illness are staggering.

The SA Heart Foundation estimates that heart disease robs the country of R2m a day in insurance pay-outs and lost man-hours, he says.

DIANNA GAMES

And, he says, a reduction of only 1% in cardiovascular disease would save more than R7,5m in SA each year.

A non-profit organisation, the Institute of Preventive Medicine and Human Performance, will prescribe individual fitness programmes with the accent on prevention. It will also act as a research co-ordinating body.

The body is negotiating with the country's universities and organisations like 1 Military Hospital to form an advisory board of experts to provide input for research projects.

Its facilities will be offered to graduate students for data collection and research.

Other foundation members are:

- Professor Clive Rosendorff, head of the University of Witwatersrand Medical School's Department of Physiology;
- Professor Grenville Andrews, head of the Wits Graduate School of Business Administration;
- Dr Carmel Goodman, exercise physiologist at the Wits Medical School;
- Dr Tim Noakes, head of the Metropolitan Sports Science Centre at the University of Cape Town;
- Professor Gert Strydom, head of the Department of Biokinetics at the University of Potchefstroom;
- Dr Neil Gordon, cardiac rehabilitation specialist at 1 Military Hospital.

Doctors defy 'shunt the patients' edict

25/4/86 W. Mail

By WILMAR UTTING

ALMOST 100 doctors at Coronation Hospital, Johannesburg are openly defying a government order that patients be refused treatment and "shunted" to other hospitals as part of a drive towards "regional rationalisation".

The doctors, supported by community organisations, claim the edict is intended to separate patients, not on a regional but an ethnic basis, and is a significant move in the government's drive towards tricameral health services.

One member of the hospital board has resigned over the edict, claiming she did not want to be seen as "advancing apartheid".

And the Transvaal MEC in charge of hospitals, Daan Kirstein, said yesterday that if people did not adhere to the instructions the authorities would take steps to "make sure they do". The directive had nothing to do with politics, he said.

The hospital treats Indian, coloured and black patients.

The superintendent, Dr D Wulff, who has tried to enforce the edict through clerical staff, this week left the hospital to take what his office said was six weeks' "study leave". He could not be reached at his home.

In a statement issued this week, the Coronation Hospital Crisis Committee, backed by other organisations, condemned the directive on patient referrals and vowed to oppose it, promising that no patient would be sent from Coronation to another hospital against his or her will.

Following the directive from the Transvaal Provincial Hospital Services, an association of organisations was formed to oppose it at Coronation and "at any other hospital where the shunting of patients in furtherance of apartheid ideology is occurring".

Mass opposition to the order and the fact that doctors had completely ignored it had already resulted in a *"de facto"* suspension of the order, a doctor at the hospital said.

"And the fact that the Medical Association of South Africa supported our claim that patients should not be moved against their will was, we believe, a strong factor in the temporary suspension of the directive," he said.

"The new system was first introduced through the admittance clerks. They questioned the patients and attached little slips of paper to their files, noting "Send to Leratong" or "For New Indian Hospital" (Hillbrow Hospital). Some were even directed to Springs, he said.

"The slips were pinned to the patients' files which were sent to the doctors. Almost all of the doctors ignored the instructions."

Organisations backing the defiance of the directive include the Health Workers Association, Wits Black Students Association, Concerned Social Workers, the Federated Ratepayers' Association and the Riverlea Youth Congress.

The statement appealed to all patients, particularly those in the Lenasia area, to get in touch with any of these organisations should they find themselves "shunted" to another hospital against their will.

The government directive has led to the resignation of Dorothy Cornelius, a long-serving member of the hospital's six-member board.

"I believe the board could be seen as supporting the separation of patients on an ethnic basis, supporting apartheid.

"It is laughable but typical that this government should announce the repeal of the Pass Laws and at the same time slyly introduce apartheid in hospitals," she said.

Kirstein hotly denied there was any political motive.

"Coronation is an academic hospital and people like to go to it, saying they get better treatment there, or whatever. But it is overcrowded. Many of the people who go there practically live at the hospital. Why can't they have their toenails clipped or their tonsils out in a regional hospital, close to where they live? They don't need an academic hospital for that."

Kirstein said if people would not assist the authorities in charge, then the authorities would simply direct the hospitals "not to take this one, or this one or this one," he said. Up to now they had not done this. They had instead appealed for cooperation.

The Indians, he said, had wanted their own hospital where they could be served their traditional food.

"So we gave them the old Non-European Hospital and spent hundreds of thousands of rands putting in kitchens and bathrooms. Then just before it opened they came and complained 'this is apartheid'.

"So, after six months, when we had had only two or three patients, I said this was no good and it went to the Hillbrow Hospital."

(4) The Cabinet has recently approved the establishment of an Interdepartmental Co-ordinating Committee to effectively co-ordinate the purchasing, provisioning and distribution of medical supplies used in public health services both in the interest of the authorities rendering such services as well as in the interests of the industry.

Q Con 1491
HANSARD 30/4/86

Atmospheric lead levels

798. Mr R R HULLEY asked the Minister of National Health and Population Development:

(1) What are the latest average recorded atmospheric lead levels measured at urban locations during (a) summer and (b) winter at (i) Cape Town City Hall, (ii) Port Elizabeth City Hall, (iii) Durban City Hall, (iv) Johannesburg City Hall, (v) Munitoria, Pretoria, and (vi) Arcadia, Pretoria;

(2) in which years were these measurements taken?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1)

Site	Winter	Summer
	(units in micrograms per cubic meter)	
Cape Town City Hall	2,13	0,89
Port Elizabeth City Hall	1,96	0,64
Durban City Hall	1,03	0,50
Johannesburg City Hall	0,73	0,58
Pretoria Munitoria	1,43	0,55
Pretoria Arcadia	1,56	0,58

(2) Winter = April to September inclusive 1985.
Summer = October to February inclusive 1985-86.
March results for 1986 are not yet available.

HoA

Rock lobster

807. Mr R R HULLEY asked the Minister of Environment Affairs and Tourism:

(1) Whether any permits have been issued for the catching of rock lobster in the West Coast rock lobster sanctuary in the 1985-86 season; if so, (a) for what quantities in each case, (b) in favour of what specified persons or companies were these permits issued and (c) in respect of what specified locations are the permits applicable;

(2) whether a report has been prepared on the result of the experimental catch of 50 tons of rock lobster carried out in the 1984-85 season; if not, why not; if so,

(3) whether this report is available for public scrutiny; if not, why not?

The MINISTER OF ENVIRONMENT AFFAIRS AND TOURISM:

(1) Yes.

(a) 80 Tonnes whole mass at Robben Island and 20 tonnes whole mass at Hout Bay.

(b) SA Sea Products (Pty) Ltd, Hout Bay and Chapman's Peak Fisheries (Pty) Ltd, Hout Bay.

(c) An area adjacent to Robben Island as well as the area between "Die Josie" at Hout Bay and Oude Schip.

(2) Yes, but the total mass was 30 tonnes and not 50 tonnes.

(3) Yes.

Q Con 1492
HANSARD 30/4/86

Population numbers

850. Mr L F STOFBERG asked the Minister of National Health and Population Development:†

(1) Whether there has been a decrease in the population numbers of Whites and an increase in those of non-Whites in the past years; if so, (a) by what percentage have the numbers in respect of each population group decreased or increased and (b) in respect of what specified period is this information furnished;

(2) whether the government will have a thorough scientific investigation instituted into the causes of this state of affairs, on the basis of the investigation instituted into the poor White question in the thirties; if not, why not; if so, what State department will be responsible for (a) this investigation and (b) the financing thereof;

(3) whether he will make a statement on the matter?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) There has been an increase in the population numbers of all population groups in the Republic of South Africa.

(a) and (b)	Period 1951-1980	Period 1980-1985
Whites	1,9%	1,5%
Coloureds	3,1%	2,1%
Asians	2,8%	2,0%
Blacks	3,1%	2,7%

(2) (a) A thorough scientific investigation has been done by the Science Committee of the President's Council and a report was released on 9 March 1983.

(b) The financing was borne by the State.

(3) A statement is not necessary. The Population Development Programme is addressing this problem.

HoA

THURSDAY, 1 MAY 1986

†Indicates translated version.

For written reply:

General Affairs:

Q Con 1494
HANSARD 1/5/86

Technikons

588. Mr H E J VAN RENSBURG asked the Minister of Education and Development Aid:

How many students were enrolled in 1986 for courses in each specified department at each technikon falling under the control of his Department?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

Only the Technikon Northern Transvaal falls under this Department

(i) School for Management	:	53
(ii) School for Secretarial Training	:	55
(iii) School for Teachers Training	:	70
(iv) School for Health Sciences	:	119
(v) School for Electrical Engineering	:	35
(vi) School for Mechanical Engineering	:	9
(vii) School for Surveying, Mining and Civil Engineering	:	58
(viii) School for Physical and Chemical Sciences	:	15

Note: Information as on 17 March 1986.

Q Con 1494
HANSARD 1/5/86

Books/stationery

656. Dr W J SNYMAN asked the Minister of Education and Development Aid:†

(1) What amount has his Department spent on providing free (a) textbooks and (b) stationery for Black

for at an economic tariff rate. On this basis the following reply is furnished:

Central-Transvaal Development Board

(a) (i) 69
(ii) 752
(b) (i) 8,4%
(ii) 91,6%

As at 31 March 1986.

Highveld Development Board

(a) (i) 5 208
(ii) 6 336
(b) (i) 45,12%
(ii) 54,88%

As at 31 March 1986.

Western-Transvaal Development Board

(a) (i) 465
(ii) 12 128
(b) (i) 3,69%
(ii) 96,31%

As at 31 March 1986.

East-Cape Development Board

(a) (i) 973
(ii) 14 521
(b) (i) 6,28%
(ii) 93,72%

As at 31 March 1986.

West-Rand Development Board

(a) (i) 28
(ii) 1 097
(b) (i) 2,5%
(ii) 97,5%

As at 31 March 1986.

East-Rand Development Board

(a) (i) 2 790
(ii) 14 251
(b) (i) 16,37%
(ii) 83,63%

As at 31 March 1986.

Northern-Cape Development Board

(a) (i) 247
(ii) 6 711
(b) (i) 3,55%
(ii) 96,45%

As at 31 March 1986.

Natalia Development Board

(a) (i) 3 742
(ii) 7 629
(b) (i) 32,91%
(ii) 67,09%

As at 31 March 1986.

Eastern-Transvaal Development Board

(a) (i) 883
(ii) 6 751
(b) (i) 11,57%
(ii) 88,43%

As at 31 March 1986.

Northern-Transvaal Development Board

(a) (i) 9
(ii) 1 476
(b) (i) 0,61%
(ii) 99,39%

As at 31 March 1986.

Orange-Vaal Development Board

(a) (i) 1 075
(ii) 14 735
(b) (i) 6,8%
(ii) 93,2%

As at 31 March 1986.

Western-Cape Development Board

(a) (i) 6 934
(ii) 14 851
(b) (i) 31,83%
(ii) 68,17%

As at 28 February 1986.

Southern OFS Development Board

(a) (i) 437
(ii) 17 369
(b) (i) 2,45%
(ii) 97,55%

As at 31 March 1986.

Teargas

785. Mr P R C ROGERS asked the Minister of Defence:

(1) Whether Armscor is the sole (a) manufacturer and (b) supplier of the tear-gas used by the South African Defence Force; if not, who are the (i) manufacturers and (ii) suppliers of the tear-gas used by the Defence Force;

(2) whether any reports have been received of tear-gas causing (a) death and (b) serious injury to health; if so, (i) how many (aa) deaths and (bb) serious injuries to health had been reported as at the latest specified date for which information is available and (ii) from whom were such reports received;

(3) whether any such (a) deaths and (b) serious injuries to health resulted in (i) court action and (ii) claims against the State; if so, what are the relevant particulars in each case;

(4) whether there is an antidote available to the South African Defence Force for the treatment of persons suffering from over-exposure to tear-gas; if so, what antidote;

(5) whether such antidote is also available to South African Defence personnel in the event of accidental over-exposure, if not, why not?

The MINISTER OF DEFENCE:

(1) (a) and (b) Yes.

(2) (a) No.

(b) As far as could be established only one complaint was made where the SA Defence Force may have been involved, that tearsmoke had an injurious effect on persons. The complainant, Mr R Sonamzi, could not say whether the tearsmoke was fired by the SA Defence Force or the SA Police.

(3) (a) Falls away.

(b) No. A claim was, however, received which could possibly be linked with the use of tearsmoke

by the SA Defence Force in another case. This civil proceeding is still sub judice.

(4) and (5) No. Fresh air and clean water to wash the eyes, are all that is needed to alleviate the symptoms.

Q Cur 1531
HANSARD 2/5/86

Removals

808. Mr P G SOAL asked the Minister of Constitutional Development and Planning:

(1) Whether any persons were moved from the East Rand in 1985 to (a) national states and (b) independent Black states; if so, how many in each case;

(2) how many of these persons (a) moved voluntarily and (b) were moved (i) by decree, (ii) by court order and (iii) in terms of other specified statutory provisions?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

(1) Yes.

(a) 836.

(b) 94.

(2) (a) 862.

(b) (i) None.

(ii) 68.

(iii) None.

Q Cur 1531
HANSARD 2/5/86

Staff established

826. Mr M A TARR asked the Minister of Defence:

(1) (a) What was the authorised staff establishment of the South African Defence Force in the various grades of employment as at the latest specified date for which figures are available, (b) how many (i) Whites, (ii) Blacks, (iii) Coloureds and (iv) Indians were employed in each grade as at that date and (c) what is the policy of the South African Defence Force regarding the promotion of Blacks, Coloureds and Indians to higher grades;

(2) whether staff of different race groups belong to the same staff association; if not, why not?

The MINISTER OF DEFENCE:

(1) (a) and (b) It is not policy to divulge the authorised staff establishment and the actual strength of the SA Defence Force.

(c) Competency, qualifications, availability of a post, seniority and experience are taken into account when promotion is considered. The requirements are the same for all members of the SA Defence Force.

(2) Civilian personnel of the SA Defence Force do not have their own staff associations but they may obtain membership of those staff associations for civil servants in the public sector for which they qualify. The SA Defence Force has no influence in the formulation of policy with regard to membership of these associations. Traditionally Defence Force members in uniform do not belong to staff associations.

Economy section: occupancy

859. Mr D J N MALCOMESS asked the Minister of Transport Affairs:

What was the occupancy of the economy section of each specified South African Airways flight, during the first 15 days of March 1986, between (a) Cape Town and Johannesburg, (b) Durban and Johannesburg, (c) Port Elizabeth and Johannesburg and (d) Durban and Cape Town?

The MINISTER OF TRANSPORT AFFAIRS:

The new time-table came into effect on 2 March 1986 and the information furnished, therefore, covers the period 2 to 15 March 1986.

(a)

Flight	Sun 2nd	Mon 3rd	Tue 4th	Wed 5th	Thu 6th	Fri 7th	Sat 8th	Sun 9th	Mon 10th	Tue 11th	Wed 12th	Thu 13th	Fri 14th	Sat 15th
SA307	169	160	—	166	175	168	176	176	147	—	170	173	176	176
SA317	176	—	—	—	—	—	—	175	—	—	—	—	—	—
SA355	81	—	—	—	—	—	—	90	—	—	—	—	—	—
SA329	176	—	—	—	—	192	—	164	—	—	—	—	175	—
SA333	176	144	168	178	156	140	70	181	128	167	167	173	179	86
SA335	89	64	78	83	81	80	43	86	80	62	66	89	74	58
SA305	96	—	—	—	—	—	—	94	—	—	—	—	—	—
SA361	74	—	—	70	—	74	—	64	—	—	74	—	72	—
SA323	181	—	—	—	—	—	—	184	—	—	—	—	—	—
SA353	100	—	—	—	—	—	—	101	—	—	—	—	—	—
SA349	101	—	—	—	—	59	—	90	—	—	—	—	71	—
SA303	—	173	170	173	170	70	—	—	176	167	175	154	163	—
SA325	—	176	155	176	176	168	—	—	175	—	176	176	176	—
SA327	—	81	83	83	83	—	85	—	83	—	83	83	—	85
SA301	—	95	95	—	95	—	—	—	83	74	—	83	71	—
SA313	—	82	—	—	73	—	—	—	83	—	—	94	—	—
SA341	—	87	—	—	—	—	—	—	92	—	—	—	—	—
SA331	—	97	78	83	72	—	—	—	83	83	83	83	—	—
SA311	—	—	83	—	—	83	—	—	—	83	—	—	34	—
SA343	—	—	70	—	—	76	—	—	—	61	—	—	83	—
SA397	—	—	173	166	176	167	176	—	—	174	168	171	162	171
SA309	—	—	173	—	—	—	—	—	—	101	—	—	—	—
SA345	—	—	—	88	—	—	—	—	—	—	100	—	—	—
SA347	—	—	—	81	—	—	—	—	—	—	64	—	—	—
SA337	—	—	—	—	—	147	—	—	—	—	—	—	165	—
SA351	—	—	—	—	—	81	—	—	—	—	—	—	71	—
SA319	—	—	—	—	—	—	192	—	—	—	—	—	—	189
SA321	—	—	—	—	—	—	80	—	—	—	—	—	—	98
SA339	—	—	—	—	—	—	94	—	—	—	—	—	—	95
SA3303	—	—	—	—	—	—	—	—	—	—	—	—	83	—
SA310	192	—	—	—	—	—	—	181	—	—	—	—	—	—
SA312	180	176	—	176	164	176	—	171	163	167	172	170	176	—
SA316	176	174	—	175	163	176	176	176	173	176	176	176	176	176
SA332	160	—	—	—	—	—	—	163	—	—	—	—	—	—
SA326	166	176	—	176	176	169	143	176	170	176	176	171	168	176
SA330	180	—	—	—	—	157	—	181	—	—	—	—	169	—
SA348	71	—	—	—	—	—	—	96	—	—	—	—	—	—
SA306	89	—	—	—	—	—	—	89	—	—	—	—	—	—
SA338	87	—	77	87	—	—	—	57	—	72	42	—	—	—
SA350	96	—	—	—	—	—	—	101	—	—	—	—	—	—
SA300	—	96	57	42	79	50	—	—	68	52	81	63	74	—
SA334	—	42	—	—	—	—	—	—	46	—	—	—	—	—
SA324	—	99	62	44	52	—	—	—	86	73	64	72	—	—
SA304	—	169	—	173	174	171	—	—	174	171	169	166	174	—
SA320	—	89	—	—	83	83	101	—	82	—	—	—	101	90
SA352	—	83	—	—	—	—	—	—	81	—	—	—	—	—
SA328	—	83	—	82	83	—	—	—	83	78	79	73	—	—
SA398	—	176	173	169	176	176	—	—	174	167	164	176	176	—
SA336	—	—	75	—	57	—	—	—	—	59	—	83	—	—
SA340	—	—	—	90	—	—	—	—	—	—	86	—	—	—
SA342	—	—	—	—	42	—	—	—	—	—	—	36	—	—

Govt health policies attacked

Cape Times 8/5/86

Medical Reporter

THE government's national health policies were last night attacked for their part in causing the "disintegration and decline in the health services of the country".

Delivering his inaugural address at the University of Cape Town, Professor J M L Klopper, professor and head of the university's department of community health, said three main problems had contributed to this.

These were the lack of complete "routine health data" such as infant mortality rates for all population sectors, under-financing and inequalities in health services rendered to different population groups, and the fragmentation of services for ideological reasons.

'Cost'

The State had "divided and fragmented the health service into several systems for each of the population groups, creating a multiplicity of health departments. This in turn has added to the cost of the organization of services", he said.

"There appears to be a disruption of the system by the imposition of ideologies by politicians who apparently do not understand that in providing health care for the people there are things that can be done and things that cannot be done."

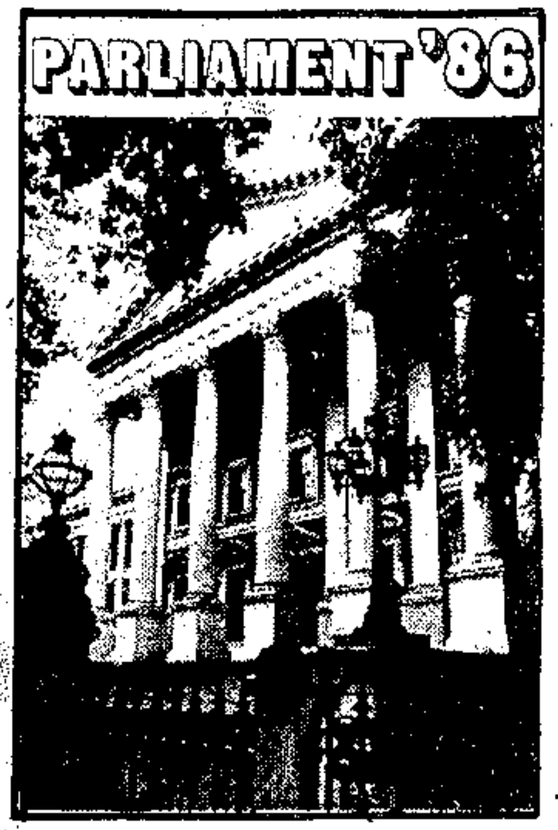
In trying to reduce costs by divesting itself of "certain services", the State health department had failed to see that the problem was not escalating health care costs, but under-financing.

Remedy

The State's answer to the problem was to have the private sector assume more responsibility, but, said the professor, "the matter of privatization has compounded the vexed problem of health care finances".

Professor Klopper said the situation could be remedied primarily by the formation of a unified, centrally controlled, national health service to provide health care for all "according to need, irrespective of locality, class or status".

Other steps that could be taken included the collection of adequate health care data on all sectors so that decisions could be made "not on the basis of racial interests", and the redistribution of finances and reallocation of resources to areas where mortality rates were highest.



'Ethnic' health care impractical, says NPP

PARLIAMENT — Fragmenting health services into ethnic compartments would result in expensive duplication of administration and materials, **Dr D Cader (NPP Montford)** said in debate on the National Health and Population Development vote yesterday.

He said he had heard that "Own Affairs" health services were to be introduced.

This should be opposed because it was impractical and expensive. "As a professional man, I am deeply concerned about dividing health services on ethnic lines," he said.

Dr Cader said country hospitals treated all colours at present and fragmentation on ethnic lines would greatly increase the costs. He also called for a single welfare board with offices placed "geographically, not ethnically".

INDIAN DOCTORS

Mr M Bandulalla (Solidarity, Havenside) said he understood that the NPP was trying to take control of health services for Indians while experts such as the Superintendent of Addington Hospital in Durban, Dr Margaret Barlow, had warned that compartmentalisation would be "suicidal".

Dr M S Padayachy (NPP North Western Cape) appealed to the Minister of National Health and Population Development, Dr Willie van Niekerk, to come to the aid of South African doctors and dentists who had studied in India but whose qualifications were not recognised by the SA Medical and Dental Council.

The Minister should do all he could to ensure that the doctors and dentists were recognised for their work "with a minimum of hardship". — Sapa.

A top-ranking TRFU official standing — however large. Northern Transvaal would never let him go. Whatever offer we made, they were

Societies seek demise of 'total cover' scheme

Call for revamping of medical aid laws

DAVID FURLONGER

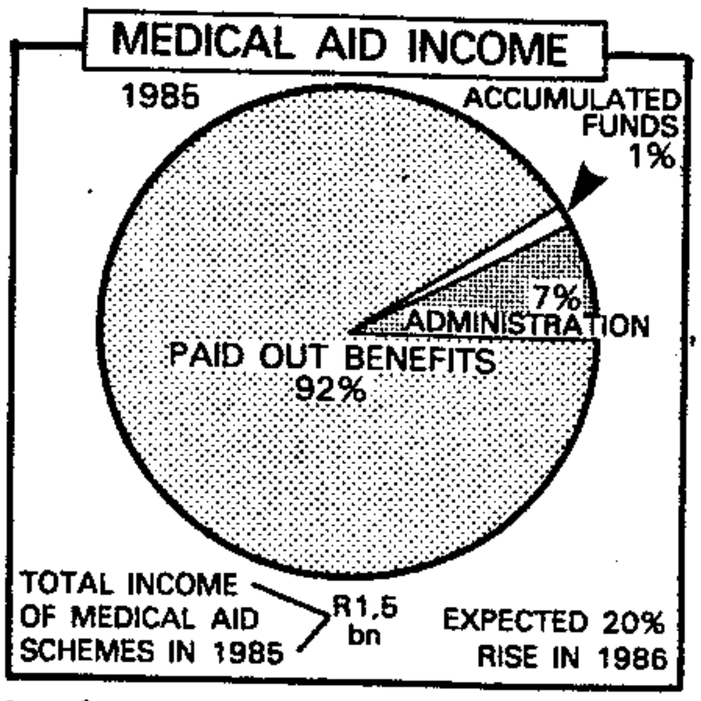
MEDICAL aid societies want government to scrap rigid legislation regulating medical cover, in favour of a more flexible system which could shift liability for minor costs — such as prescriptions — to the public.

Existing regulations force societies to provide total cover for members. The societies want to offer flexible medical packages to suit individual needs.

Options could include cover for major accidents or illness only; medical fees above a certain minimum; percentage payments and a no-claims bonus system.

Medical aid societies are awaiting the findings of the Brown Commission, which has just completed a six-year investigation into the country's health services.

Members of the commission, headed by former finance secretary Gerald Brown, say its report will be tabled in Parliament this session.



The medical aid sector made two main recommendations to the commission: No more guaranteed payments by societies to providers of medical services, and an end to their obligation to provide benefits for every service.

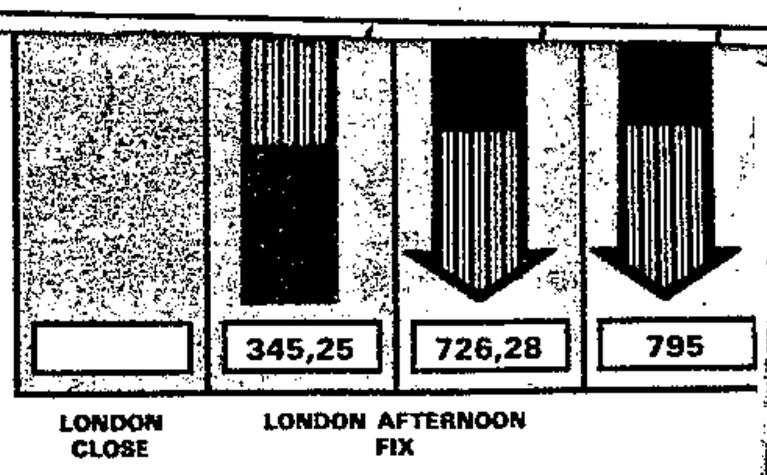
The main intention of such changes is to make members of the public liable for minor medical costs, particularly prescription fees.

An estimated quarter of all medical aid pay-outs are for prescription fees, and societies say the money would be better spent on providing cover for more costly care.

Under the 1967 Medical Schemes Act, societies are obliged to offer a minimum 70% towards the cost of services offered by GPs, surgeons, dentists and physiotherapists. The same minimum applies to hospital accommodation and prescription charges.

John Ernstzen, chairman of the Representative Association of Medical Schemes (Rams), said: "Those who want

● To Page 2



Medical aid moves

● From Page 1

socialised medicine could still buy it, but at a price. We must encourage people to reduce costs."

A medical aid spokesman for SA Druggists said: "Medical aid subscriptions are going up at a phenomenal rate. Patients should be made more aware of what costs are. Incentives have to be built in."

Ernstzen said the concept of flexible health care was accepted by the medical profession but not by the public.

"The man in the street wants socialised medicine. He doesn't care what it costs. About 80% of our members don't want a change, they want 100% cover."

Industry officials say medical aid costs are rising at an alarming rate, both in terms of medical bills and the cost of medical cover.

Total income of medical aid schemes in 1985 was about R1,5bn. This is expected to rise 20% to R1,8bn this year. In 1985, all but 8% was paid out in benefits. Another 7% went on administration, and the remaining 1% into accumulated funds.

According to Ernstzen, the present system encourages medical aid societies to be as wasteful as the public. To attract members, they must compete on the basis of pay-outs rather than efficiency or improved cover.

"The only way to compete is to keep on upping benefits in order to compete with competitors. This in itself is cost-escalating when we are talking of cost-awareness."

399-CA

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AREA A

AREA B

AREA C

Disastrous fragmentation of health services feared

15.5.86 SPAN 85

AREAS.

Pretoria Bureau

The Medical Association of South Africa (Masa) is concerned that the new tricameral dispensation could lead to further, disastrous fragmentation of health services in South Africa.

Masa's Federal Council said the association feared the allocation of particular hospitals and other health service facilities to three separate "own affairs" administrations, plus a further "general affairs" administration, would have a dangerous effect.

It would lead to unnecessary duplication — and even triplication — of basic facilities, as well as the splitting of scarce professional staff.

The efficient and cost-effective provision of health care could only be achieved through the intimate linking of all components of the health care system, said Masa.

"These include a complex range of preventive and educational services, primary health care centres and secondary, or 'regional', facilities, as well as closely integrated tertiary, high-technology 'academic' hospitals.

"Linking all these there has to be a highly developed communications and ambulance service and the training of medical, nursing and paramedical staff has to take place at all levels."

Under the new dispensation these components could be separated at both administrative and staffing level.

DISSOLVING PULP MANUFACTURING INDUSTRY

Parties	Employer Organisation: South African Industrial Cellulose Corporation (Pty) Limited. Trade Unions: Amalgamated Engineering Union of South Africa; South African Electrical Workers' Association and the Engineering Industrial Workers Union
Area	Magisterial District of Umzinto.

Footnotes

1. Overtime rates - The overtime rates for shift workers are different: the usual weekday (and Saturday) rate is 1,33, while the Public Holiday remuneration is one day off in substitution for the day worked. The rate for Sunday work is 1.5

2. Annual Leave - Shift workers are entitled to extra days leave in substitution for all statutory Public Holidays in the yearly cycle.

3. Sick Leave - Workers with continuous service working
Up to 24 months are entitled to 20 or 24 days sick leave per year
After 30 months are entitled to 40 or 48 days sick leave per year
After 36 months are entitled to 65 or 78 days sick leave per year

Sick pay is 75% of the normal wage for the first four weeks, thereafter 50%.

Doctors warn on health plans

GERALD REILLY

THE Medical Association of SA (Masa) yesterday warned of dire consequences of a further fragmentation of health services.

A statement issued after Masa's Federal Council annual meeting in Pretoria this week stressed this would be a consequence of measures to implement the tricameral political dispensation.

Masa feared the allocation of particular hospitals and other health services to three separate "Own Affairs" administrations — plus a further "General Affairs" administration — would have disastrous effects on "the remarkable developments of the past 20 years in health care services".

The federal council unanimously opposed any such measures that would threaten the welfare and health of patients and communities for whom they felt responsible.

Masa was also concerned at "renewed efforts" by the Pharmaceutical Association to question the motives of dispensing doctors.

The federal council yesterday questioned whether the continued campaign did not indicate that pharmacists had reached saturation point and if they were not now fighting for survival.

The system of doctors prescribing medicines was as old as the profession.

The federal council unanimously agreed to protect the interests of prescribing doctors.

Health services cause concern

Dispatch Reporter

EAST LONDON — Fears are being expressed about the breakdown of services in the Border corridor's black spots since Ciskei handed administration over to South Africa at the end of April.

Yesterday the PFP MP for Albany, Mr Errol Moorcroft, said he would take up the matter of health services with the Minister of National Health, Dr Willie van Niekerk, as a matter of urgency.

He was acting on information from Mrs N. Squires, of Kwelera, who said she visited the clinic in her area on Tuesday and found that despite the nursing staff being there, they did not have any medication or equipment and people who had come for medication had to be turned away. She said even the telephone had been disconnected.

The director-general for information in Ciskei, Mr Headman Somtunzi, said Ciskei had handed over the administration of the area to South Africa after administering it since 1981.

In the House of Assembly on Tuesday, the Deputy Minister of Development and of Land Affairs, Mr Ben Wilkens, announced that the black spots i the corridor would not be incorporated into Ciskei and would remain part of South Africa.

The announcement ended years of uncertainty about areas such as Mgwali, Newlands, Kwelera, Mooiplaas and Lesseyton where residents' associations have opposed incorporation into Ciskei.

But now there are fears that the interim handover period would result in a breakdown of services.

Mr K. Brennan, of the South African Embassy in Ciskei, said the takeover of services had taken place and that services would be rendered as usual.

"Obviously there will be some hassles as the takeover takes time but I know there are moves to see that all the services are rendered promptly," Mr Brennan said.

Mr Moorcroft said that the transfer of services must be swift and efficient.

"The people in the area must suffer the least amount of inconvenience," he said.

Mr Somtunzi said he did not want to comment on the announcement except that he wanted to see how long South Africa would be able to maintain stability in the area.

"We ended the administration of the area because of elements among the communities who were threatening the lives of Ciskei Government staff, such as nurses. We had to take that decision in view of the threats to our staff."

Mr Somtunzi said Ciskei still maintained that the lands belonged traditionally to that country.

Ormande Pollok reports from Cape Town that Mr Moorcroft said the decision had ended years of insecurity and heartache for the people in the black spots which needed upgrading urgently and would help defuse what could have developed into a major conflict.

"What now needs to be done as a matter of urgency is the upgrading and rehabilitation of these areas. Schools, clinics and agricultural facilities need urgent attention after years of neglect and, most importantly, adequate administrative structures need to be established.

"It is to be hoped that a speedy resolution of the Kidd's Beach trust ground dispute will now be achieved and that the squatter problem, which is still of manageable proportions, can also be solved."

15/5/86. BUS DAY.

85

Health is set up for privatisation

SUBSTANTIAL deregulation of the country's health services, opening the door to far greater participation by the private sector, is on the cards.

This is expected to be one of the major recommendations of the Browne Commission, set up six years ago to investigate SA's entire health care sector.

The report is scheduled to be tabled in Parliament within the next 10 days.

Indications of the line it is likely to take and the tack government is to adopt have been provided by government spokesmen addressing this week's annual congress of the Pharmaceutical Society (PSSA) in Cape Town.

National Health and Population Development Minister Willie van Niekerk reaffirmed the State's commitment to privatising the health services as far as possible.

And he warned the pharmacy profession to note that this could have a far-reaching impact on the future development and practice of pharmacy.

Van Niekerk said the trend for the pharmacy profession to play a more clinical role in health care was certain to be dramatically expanded and enhanced in the future.

He advised the profession to immediately set about deciding how it was to meet these future challenges, with minimum reliance on the State.

Van Niekerk observed that as privatisation began to make its mark, it could mean that many people currently being cared for by the State would be served by community health practices.

CHRIS CAIRNCROSS

Van Niekerk said that economic circumstances and a possible change in the method of financing health-care systems could place the smaller one-man practice under severe pressure.

He suggested that some thought should be given to the possibility of developing larger, more economical practices.

The chairman of the government committee investigating the privatisation of health care, G Watermeyer, forecast that pharmacists could in future play a very important advisory function to medical practitioners and the public.

Watermeyer indicated that the door was to be opened for the private sector to become directly involved in State and provincial hospitals.

This could be achieved in various ways. They could, for example, enter into partnership with a public institution for supplying a specific service or product.

Privatisation could also be brought about by negotiating agreements allowing private concerns to make use of unused capacity/facilities in public hospitals.

The establishment of health maintenance organisations by the private sector, especially by the more financially strong organisations, also appears to be a favoured proposal by government.

Watermeyer said: "This concept of health service has been growing in leaps and bounds in the US, and has proved to be cost effective if well managed."

ALL SUBSCRIPTIONS EXPIRE WITH THIS ISSUE

PLEASE NOTE

the South African disease: poverty

Injustice and deprivation cause as much illness as any virus, a medical conference was told this month. RUTH BECKER reports

THE South African disease is endemic. Its symptoms are depression, anxiety and family mistrust, together with overcrowded hospitals and discriminatory health care.

This emerged at the Apartheid and Mental Health conference organised this month by the Organisation for Appropriate Social Services in South Africa (Oassa). Formed in 1983, Oassa is committed to "appropriate" social services which meet the needs of the country's population.

Speaking at the conference in Johannesburg, Cedric de Beer from the Wits University Department of Community Medicine used tuberculosis to illustrate that "injustice and exploitation are as important as germs in causing disease".

One hundred years ago TB was rare in South Africa; today it is the country's number one killer. De Beer described it as the disease of poverty *par excellence*, as it is possible to be infected with TB but not be ill unless the body is weakened through malnutrition, overcrowding, physical or emotional stress.

The factors that shaped the disease, according to De Beer, apply to the incidence of most diseases in this country. He identified these as colonialism, land dispossession, industrialisation, the migrant labour system, homeland conditions and the lack of political rights. "Poor whites" in the 1920s, he pointed out, exhibited very similar patterns of disease to blacks today.

Because health is moulded by social and political structures, "it is not enough to play with who can eat in what restaurant; the whole history has to be undone," De Beer said.

South African health services are "divisive, wasteful, inefficient and reinforce existing political structures" he said — and they clearly discriminate against blacks.

Hospitals are overcrowded, understaffed and underfinanced and hundreds of thousands of South Africans living in the bantustans are effectively out of reach of any health service at all. Nationally, there is about one doctor to every 2 000 people — but looked at regionally, this means one doctor for every 400-500 people in the metropolitan areas, while in some of the more neglected homeland areas, an optimistic estimate would be one doctor for every 10 000-20 000 people. The (white) Johannesburg hospital spent R185 per patient per day in 1983/4. Coronation Hospital (coloured) spent about R64 per day. And in 1982, Tintswalo hospital in Gazankulu had R12,50 per day to spend on each patient.

The racial and ethnic carving of health services in South Africa means each homeland has its own department of health, minister of health, its own bureaucracy, nursing association and policies. If a patient lives in one another homeland because it's closer, follow-up visits from the clinic require a "foreign" government's permission.

De Beer recounted the story of Shiluvane hospital, on the border of Lebowa and Gazankulu, to illustrate the point. In 1976 the SA government gave the hospital to Lebowa to administer temporarily. Five years later the hospital was taken away from Lebowa and handed to Gazankulu. One Friday the Gazankulu health authorities arrived to take control. The following week, the Lebowa government withdrew all Pedi speaking staff. Pedi speaking patients were loaded into ambulances, along with their files and their drips, and taken to other hospitals in Lebowa. Thirty patients and 24 staff members (out of 38) were moved.

A cure for the national disease lies with more than increased research, improved therapeutic practice and better drugs, said Oassa chairperson Lloyd Vogelman. The science of mental health doesn't explain the large incidence of retarded development among African, coloured and Indian children. For an explanation of that malady, one must look at the causes of malnutrition and kwashiorkor, the high rate of alcohol abuse among Africans and coloureds, and South Africa's high suicide rate.

At one centre in Soweto the majority of children referred for psychiatry were under 10 years old. Information on their family histories was often sketchy and family ties were generally loose. Alcohol abuse was common and fathers were frequently uninvolved, but wanted to retain authority. Indications from the centre showed assumptions that black children are still brought up adequately in the extended family, that child abuse doesn't occur and that depression doesn't exist in black communities is mythical.

"It's difficult to say whether we still have families in South Africa," said Susan Shabangu, a trade union organiser who related her experience of family life in Soweto.

"We look upon our fathers as the providers in our families. Due to the economic situation it becomes difficult for them to provide. Fathers lose their image and the children lose respect. Most men resort to drinking ... Women live a stressful life, being mothers and workers and trying to satisfy the bosses and their children. A cleaner will get up at four in the morning and get home at six in the evening. Then she's supposed to cook and start cleaning the house and at the same time the children are looking [illegible]

Drawing: CARL BECKER

together. For most mothers it becomes difficult to discuss with their children what's affecting them. Everyone lives their own life. Families are being destroyed and no longer trust each other — the father, mother and children can't relate to each other."

Accounts from psychiatrists at the conference showed township unrest is resulting in severe depression and psychoses which are exacerbated by the economic climate and high unemployment.

Health services in Soweto are relatively "ahead" of other townships, according to Liz Floyd from the National Medical and Dental Association, but psychiatric diagnosis is neglected.

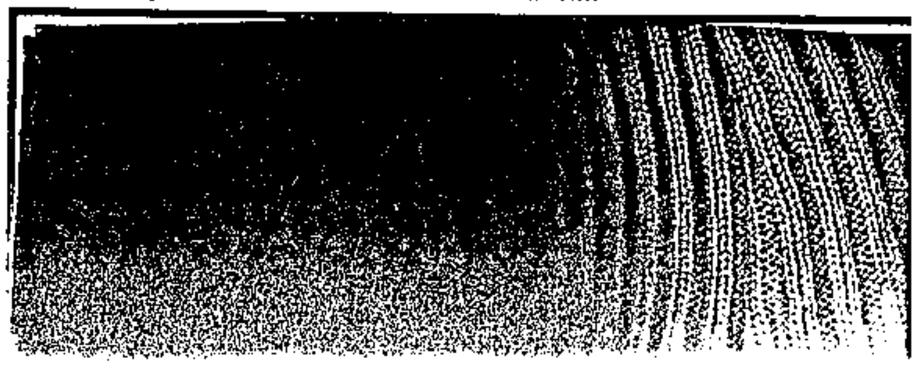
According to Floyd, a disturbed person "who has a problem to the extent that it becomes a social problem" would be admitted to a medical ward at Baragwanath, which has no psychiatric ward, treated, returned home and referred to a clinic for ongoing medication. If uncured the patient is admitted to Sterkfontein mental hospital.

But services catering for ongoing problems, such as wife battery, ar almost non-existent.

"A battered woman normally make two stops — one at the police statio and at the clinic. Doctors will see a woman on a Monday with facia injuries and won't even ask her abou it — they just treat it. I would say 8(percent of the men are drunk at the time (of the assault) and it is ofter related to unemployment. The mair response from the woman is to hide the injury — get a bit of medica treatment and stay indoors."

Floyd surveyed patients she saw a clinics to establish how many complaints were purely physical. The common disorders were hypochondriacal and social problems. Anxiety, depression, tension headache, alcohol problems and retardation were also common.

Most of the patients were women between 20-30 years of age, a number of whom had previous visits for the same problem. Few patients presented with overt psychiatric symptoms and many were epileptics coming for treatment.



Natal has 200 more hospital posts

Pietermaritzburg Bureau

THE Executive Committee had approved the creation of more than 200 additional posts in the Department of Hospital Services, MEC Fred Clarke announced yesterday.

Dr Clarke said the expansion of posts, at a cost about R3 000 000, was essential for the maintenance of an 'adequate and safe' medical, nursing and support service.

The depressed state of the economy had resulted in severe financial restraints being imposed on the administration in its attempts to expand the provision of patient care throughout Natal, Dr Clarke said.

'Although these restraints have prohibited the attainment of an ideal situation, Exco's decision is seen as a positive and encouraging step forward.'

Dr Clarke added that the creation of more posts would alleviate the situation within the department, which was having to provide experienced and specialised staff to a rapidly expanding and more sophisticated service.

Police death

...or small ...opment

necessary regulatory restrictions, to allow market forces to operate more freely and to create a benign climate in which small business undertakings could flourish and grow.

Health control set to change

Own Correspondent

JOHANNESBURG. — The government is set to back down on its plan to racially fragment the control of hospitals.

The plan, which flows out of the implementation of the tricameral constitution, came under fire from medical experts and opposition spokesmen because it would have resulted in the costly quadruplication of health service bureacracies and facilities.

Medical experts also slated the plan because they believe health services cannot be run along racial lines.

Two highly-placed sources yesterday said that after months of heated argument it is almost certain that control of hospitals will be now be vested in the new multi-racial appointed provincial executives.

A confidential document outlining the new plan has been circulated to cabinet ministers, MECs and senior health officials.

The plan has been agreed on by health ministers from the three houses of Parliament but is still awaiting cabinet approval.

The deputy director-general (administration) of the Department of National Health and Population Planning, Mr S J N Marais, said an announcement on the issue would be made in August during the second session of Parliament.

"The whole thing has not been clinched because there are certain matters which need to be clarified."

However, according to informed sources, a health policy council will be established.

The council will consist of the Minister of National Health and Population Planning, Dr Willie van Niekerk, and the three own affairs health ministers Dr George de Villiers Morrison, Mr Chris April and Mr Ismael Kathrada.

Certain functions such as epidemic control and district surgeon duties, which are at present controlled by the state Health Department, will be handed over to the provinces and own affairs departments on an agency basis.

Provincial administrations will retain control of hospitals.

A strong recommendation from the House of Delegates and House of Representatives for all hospitals to be integrated has been passed on to the cabinet for a decision.

Clinics

The own affairs health departments will be responsible for minor health services such as clinics and primary health care including school education.

To satisfy the coloured and Indian houses of Parliament the two communities will be given more representatives on the boards of hospitals at which coloured and Indian patients are treated.

Before making a decision the government considered four options on the future of hospitals. They were that:

- Any hospital that had a more than 95 percent occupancy by any one race would be hived off to the own affairs department for that race.
- Any hospital that had a more than 65 percent occupancy by any one race be controlled by the own affairs department for that race group.
- All hospitals go to own affairs departments.

'Authority'

- Hospitals remain under the control of provinces, but the authority of hospital boards be increased.

Progressive Federal Party health spokesman Dr Marius Barnard said the PFP would welcome any move that would not result in hospitals being racially fragmented.

He appealed to the government to remove now all vestiges of segregation in health services.

NATIONAL/INTERNATIONAL

Postpone 'frightening' rise in medical fees — PFP

ARGUS 15/7/86

By BRUCE CAMERON
Political Staff

"FRIGHTENING" rises in medical fees announced yesterday should be postponed until at least next year, Progressive Federal Party medical spokesman Dr Marius Barnard said today.

He called for a new look at the way the medical fees were set in the face of the announcement by the Medical Association of South Africa that fees for contracted-out doctors had been increased by between 19 and 20 percent.

Announcing the new fees, the Medical Association of South Africa (Masa) said yesterday the latest adjustment was "reasonable compensation to doctors for their services".

Dr Barnard said: "I think this is a very inopportune time to increase the fees.

"Medical schemes are running into trouble and the general public has a great burden to carry.

"The increases should at least be postponed until next year."

He felt an independent group should be brought in to assess a fair fee structure.

He warned that unless the medical profession was adequately compensated, doctors who were already leaving the country because of the political situation would also leave for economic reasons.

The Minister of Health, Dr Willie van Niekerk, would not comment on the rises, saying the matter was a private one between the medical profession and medical aid societies.

Concerned

Consumer groups believe the increase in medical costs will push up the cost of living.

Mrs Lyn Morris, president of the Housewives' League, said: "I am very concerned that people really battling with their income are going to think twice before they go to the doctor."

The Johannesburg Argus Correspondent reports that the Masa announcement said the new tariffs would not bring about an improvement in the real income of doctors, but the adjustments were based on the consumer price index.

The Federal Council of Masa said it was concerned about the possible collapse of private medical services due to spiralling practice costs.

"Even with the latest increases, doctors' incomes will continue to reflect the decrease of between five to 10 percent in the real income of the population over the past 16 months."

Masa emphasised that the new tariffs were a guide only and doctors were requested to take the financial position of their patients into account.

The new tariffs represented an increase of 19,10 percent for general practitioners and specialists, 20 percent for anaesthetists, 21,6 percent for radiologists and 20 percent for clinical pathologists.

"This represents an annual increase of 15,1 percent, which is still an average four percent lower than the consumer price index over the past 16 months," said Masa.

Specialities which were cost intensive as they were dependent on sophisticated imported equipment received special consideration because of the falling exchange rate.

(Report by B Cameron, 122 St George's Street, Cape Town).

Sowetan 15/7/86

85

RELIEF

By MONK NKOMO

AN R8-million water and sewerage system will soon be provided for Duduza township near Nigel.

Duduza to get rid of bucket system

A spokesman for the Department of Constitutional Development and Planning, in a statement released in Pretoria yesterday, said technical details of the sewerage have already been finalised by the National Housing Commission. Work on the scheme will start within three months.

The Government said that the new scheme followed years of representation by the now defunct community council.

The R8-million will be drawn from the National Housing Fund.

Buffer

"It has also just been announced that the existing buffer zones can be utilised for housing — one buffer zone has already been divided into approximately 650 housing sites. Once the services have been properly planned the full request will be presented to the National Housing Commission," the statement said.

Funds have already been reserved for this scheme and it is expected that the private sector would be fully involved in the development of the project which will result in the first elite residential area in Duduza. Employers will be given the opportunity to assist their employees with the building of houses. Private individuals will also receive the opportunity to build houses for themselves.

The City Council of Nigel has offered its assistance in the planning and the execution of development projects in the township.

Negotiations for the purchasing of additional land have been underway and it is expected that these will be finalised in the immediate future, the statement added.

20pc rise in medical costs?

Own Correspondent

PRETORIA. — An average increase of 20,1 percent in the private fees of doctors has been recommended as a guideline from this month by the Medical Association of South Africa.

In a statement released here yesterday, Masa said it regarded its latest annual adjustment of the tariff "as reasonable compensation to doctors".

The new set of private tariffs is to be used by medical practitioners as a guide only.

"Because the private tariffs are meant to serve as a guide, it creates the opportunity for negotiation between doctor and patient," Masa said.

Masa's federal council took into account the possible collapse of private medical services because of spiralling practice costs.

Masa said the adjustments, based on the consumer price index, would not improve the real income of doctors.

The increases are: General practitioners and specialists 19,05 percent; anaesthetists 20 percent; radiologists 21,6 percent; clinical pathologists 20 percent; anatomical pathology 27 percent; ultra-sound 41 percent, and computerized tomography 41,7 percent.

No decision on health, 'groups'

Staff Reporter

NO final decisions have yet been taken by the President's Council constitutional committee on whether health services are to be own or general affairs, or whether the Group Areas Act is to be replaced with a "local option".

This was said yesterday by the committee's chairman, Professor Dries Oosthuizen, after weekend press reports that his committee would in all probability recommend making health a general affair — a complete turn-around from the government's express wish to make health services under the new constitution an "own affair" issue.

Professor Oosthuizen could neither deny nor confirm a report that the committee may recommend to the government that strict residential segregation as laid down in the Group Areas Act be replaced with a "local option".

He said his committee, which was looking at the whole issue of racial segregation of residential areas and amenities, was "still making decisions on some of the really major issues".

"Much of what we decide will depend on the interpretation of what the terms 'own affairs' and 'general affairs' mean. This whole issue is still far from clear.

"I'm personally hoping for the committee's report to be finished during October but even that's speculation ..."

The four acts the committee is studying for possible revision or scrapping are the Slums Act, the Community Development Act, the Group Areas Act and the Separate Amenities Act.

Poison food suspected in death of 3

THREE people have died in the tented area of Kwanobuhle township, Uitenhage, where families removed from nearby Kabah are being accommodated.

They are believed to have died of food poisoning. Four others are in hospital, two of them seriously ill.

All seven ate mielies, rice and potatoes last night, cooked on an open fire outside their tent.

The dead are Mr Kokkerott Lappies, 30, Mr X Koyani, 25, and an unidentified woman.

Still in hospital are Edward Tshukela, 16, Mr Mzukisi Tasi, 28, Mr E Vusani, 36, and Mr S Vusani, 36.

Services at the tented area are spartan and three water tanks serve 500 families.

The Kwanobuhle Town Council has erected a large number of mobile toilets at the site.

The Administrator of the Kwanobuhle Town Council, Mr Barry Erasmus, was not available for comment about the deaths or on the removals.

People reported from the site today that health conditions were poor.

The removal of people from Kabah in Uitenhage continued this week despite an undertaking that shack dwellers would not be harassed, a community spokesman said.

Some people were voluntarily demolishing shacks because they were afraid of being forced to move.

He said that at a meeting on Tuesday, Mr Erasmus was asked to remove township "police" as well as a control point in North Street, Mosel.

Mr Erasmus had refused to move the control point but had agreed that the green-uniformed law enforcement staff would refrain from going into Kabah, except to go in with loudhailers that evening to say that people who wanted to stay in Kabah could do so.

"What happened is that they went in the middle of the night on Tuesday and again on Wednesday, and told people to demolish their shacks," the spokesman claimed.

A resident of 9th Avenue had told him today he had been unable to sleep because of the noise of shacks being demolished.

Mr Ronnie Kruger, chairman of the Midland Chamber of Industries' Uitenhage branch, was at the Tuesday meeting and confirmed today the agreement had been for law enforcement officers to be withdrawn and for loudhailers to be used to inform people they could stay.

He was later told the announcement had been made as arranged.

WIE Post 26/7/86 (85) WEEKEND POST

SA predicament 'cause of many heart attacks'

By BARBARA ORPEN

HOSTILITY, friction, stress and uncertainty are all contributing to the high incidence of death as a result of heart failure.

No country has a higher per capita death rate from this cause than South Africa.

A symposium in Port Elizabeth heard last night how the SA predicament is taking its rapid and heavy toll.

Professor Deo Strumpher, head of the Department of Organisational Psychology at the University of Cape Town, said business executives who led hard-driving lives were in a high-risk category for heart attacks.

But anger, hostility and aggression and uncertainty were factors affecting just about everyone — in all population groups at every level.

"We are living in a country in which there is a very high level of hostility and anger among all population groups — our socio-political situation is fraught with it — and it is not doing us any good," he said.

But the political situation was only part of the health hazard.

Prof Harry Seftel, of the Department of Medicine at the Univeristy of the Witwatersrand, said the main causes of heart attack were high blood cholestral, cigarette smoke and high blood pressure. Other factors included sloth, obesity, stress and heredity.

Speaking on rehabilitation after a heart attack, he said that while 10 000 South Africans died from heart attacks every year, 30 000 survived from cardiac disabilities through medication and "lifestyle changes".

The emphasis, therefore, he said, "must be on prevention — although we cannot cure a heart attack, we can help to prevent another one from occurring".

Techniques of rehabilitation included involving the patient in excercise, moderate dieting and drinking, and no smoking — "there is no such thing as moderate smoking", he said.

The benefits of these lifestyle methods were that the patient became active in participating in his or her own recovery and very often led a much better quality of life after the attack than before.

It was just as well that SA had pioneered heart transplant surgery.

Prof Chris Barnard assured the audience a tremendous future lay ahead in heart transplant surgery and said 85% of patients who had undergone a transplant had a chance of surviving after one year, and 70% a chance after five years.

Reasons for the success, he said, were that much better means of preserving the heart muscle of the donor had been discovered — a transplant could be carried out 48 hours after the heart had been removed.

New methods of diagonising rejection and treating it much earlier with better immuno-suppressant drugs had also been found.

DD 20/07/86

Cancer drug advances

Modern drugs can effect a complete cure of the commonest form of cancer in men under 30, cancer of the testicle. In young women, these drugs can cure cancer of the ovaries but this treatment is not as effective in other forms of cancer.

Breast cancer, the commonest type in women, is best treated by a combination of surgery and drugs, Dr Gareth Rees, consultant to the Bristol Radiotherapy and Oncology Centre told a conference on chemotherapy, the term used for drug treatment.

Breast cancer, ranked eighth as a cause of death among women in 1902, is now the second most common.

Most patients have had the disease for five years before consulting a doctor about it, but chemotherapy can improve their chances of survival for another five years by 10 per cent. In some cases it should be started before an operation is performed.

Drugs are most effective in cases of acute leukaemia and Hodgkin's disease. They have also proved curative in some cases of childhood cancer. But in lung cancer, the most common overall form in men, they cannot so far effect a cure, but can give a worthwhile temporary improvement.

New anti-cancer drugs are being sought throughout the world, but are extremely costly to develop. Some require five or 10 years testing before being used on patients and thousands of substances may be investigated to find one that is both effective and safe.

One problem is that drugs which can kill cancer cells may also kill normal cells, but some less toxic anti-cancer drugs are coming on the market.

A method of administering them in which the patient is fitted with a tube which remains in an artery for several weeks, with a pump to be used at intervals during the day, may reduce the toxicity by reducing the dosage required. — DDC

Only needy to have free health care — Minister

STAL 85
29-7-86

By Sue Leeman

A tariff for State health care may become the rule and only the "needy" will receive free treatment, according to the Minister of National Health and Population Development, Dr Willie van Niekerk.

Speaking at a meeting of the Medical Association of South Africa in Bloemfontein last night, Dr van Niekerk said such a tariff was a necessity.

He warned that the Government was fighting rising costs for health care.

Unless greater effectiveness and cost efficiency were achieved, the financial demands for health services could reach such proportions that they may not be attainable "within the realities of the South African economy".

Health care was a high risk, low profit business and much of it could be privatised, he said.

The private sector, he said, would be expected to provide new facilities in future, but minimum standards and quality control would have to be introduced.

Dr van Niekerk said private initiative would have to take more responsibility for training health care professionals, and promoting primary and preventive health care.

Something would also have to be done about the strong competition which had developed between private and training hospitals for the manpower and expertise needed for sophisticated medicine.

Example of Government initiative

This was detrimental to health care and to the training of health care professionals.

Dr van Niekerk believed that the country's proposed health dispensation would initiate a "new era" and was an example of the Government's initiative in trying to meet the country's changing needs.

"I am convinced that the new health policy and plan are better than any of the previous dispensations and that most worries about the new system will disappear."

He said details of the new plan would be released later.

New finding on weight gain

Women who gain 12 to 16 kg during pregnancy run a significantly lower risk of losing their child to stillbirth or late miscarriage than women who put on less than 7 kg, a US government study shows.

A STUDY by the National Centre for Health Statistics says women who gain less than 7 kg have a foetal death rate of 10,5 per 1 000 live births, compared with a death rate of 3,8 at the higher weight range.

The statistics, based on a sample of nearly 16 000 pregnancies, suggest that current obstetric guidelines for weight gain may be too conservative. Those guidelines, issued in 1983, suggest that weight gain during pregnancy should be between 10 and 12 kg.

The new figures show progressively better outcomes with weight gains up to 16 kg. Above 16 kg, the foetus is at slightly higher risk, but still is statistically safer than at any weight gain below 12 kg.

The study also showed that children born to women with little weight gain tended to be small babies, who have more health problems and higher infant mortality rates.

In spite of the value of the added weight, the study said a substantial proportion of pregnant women do not gain enough.

85 Sowetan 1/8/86

A cleaning up for Alexandra

ALEXANDRA has organised a massive clean-up for Saturday after a warning from the authorities that conditions in the township posed a "serious health hazard" to the community.

The township administrator, Mr Steve Burger, said the purpose of the campaign was to remove rubbish piles in Alexandra, clean up trenches on the roadside and dispose of litter and scraps from yards.

The clean-up campaign follows an outbreak of polio in the township at the beginning of June. Five babies were treated for the disease at the local clinic.

Doctor

The superintendent of the Alexandra Health Clinic, Dr Tim Wilson, and the doctor supervising the polio vaccination, Dr Wendy Orr, said they had discussed the health conditions in the township with Mr Burger.

The lack of a drainage system, bucket toilet system and litter posed a health hazard, they said.

DD 4/8/86

Countrywide medical aid fraud — claim

JOHANNESBURG — Members of the medical professions are allegedly perpetrating massive frauds against medical aid companies said to be between R15 million to R20 million a year, a Johannesburg Sunday newspaper said.

A front-page article in the Sunday Star says six of South Africa's medical aid administering companies, which represent 81 schemes with a total of 650 000 members and process R700 million in accounts a year, claim to have evidence of a "horrendous level of fraudulent and unethical activities".

The administration companies claim the fraud is countrywide and the extent of the racket has been uncovered by a specialised computer-backed investigation bureau, the article said.

The companies warn that if the fraud is allowed to continue unchecked, contributions to medical aids are going to be increased again soon.

The administrators also warn that if the racket is allowed to continue unchecked, a number of the smaller medical aid companies are likely to fold, leaving members with unpaid doctors' bills and no cover.

The newspaper quoted one of the investigators as saying that some doctors falsify the number of patients they see a day — with one doctor claiming that he regularly sees more than 70 patients in a normal eight hour working day. — Sapa

Poor health and its close link with poverty

By Marika Sboros and Kate McKinnell

Health was inextricably linked with politics in South Africa, delegates to the National Assembly of Women were told at the weekend.

The assembly, attended by nearly 900 delegates and observers of all races, was convened by black women's groups to formulate plans of action on the themes of equality, development and peace from now till the year 2000.

Professor Selma Browde, head of the radiation therapy department at the University of the Witwatersrand, gave a report-back before resolutions from the health workshop at the assembly.

Professor Browde said a completely new set of health services was needed if the cycle of poverty and poor health was to be broken.

Conference resolutions on the subject of health included the need to establish lobbying groups for health issues and to make use of existing groups; the provision of good day-care centres and child-minding groups; recreational schemes for children and youths.

A workshop on migration and resettlement called for ... (words deleted in terms of the emergency regulations) in solidarity with the plight of women in the TBVC areas, and to look at ways of pressurising for the ... (words deleted in terms of the emergency regulations).

The Women and Development workshop resolutions focused attention on the state of emergency and children in detention ... and the need to combine financial resources to help less-advantaged women.

Resolutions taken on education were:

● To reconfirm the efforts of the National Education Crisis Committee (NECC) by sending it the following statement:

"We women of this assembly are very aware of South Africa's present political crisis, which has virtually destroyed education for the majority of our students.

"This assembly reconfirms the resolutions of the NECC taken in March 1986. We demand the immediate release of all its members as well as parents, teachers and students held in detention. Further we demand that the Government negotiates with the NECC, the only legitimate and national educational organisation representing the interests of black students."

The assembly also resolved that action should be taken to develop informal education for students not allowed to return to school.

Important resolutions taken on women in the economy were:

● Social and other welfare benefits be equal for all races.

● It should be compulsory for maintenance payments to be deducted from men's salaries.

● Labour legislation should be updated to eradicate discrimination against women during the pre-natal and post-natal periods. Women should be granted the same work status when they return from maternity leave.

● The argument that sanctions should not be imposed because it would cause suffering among the black community was rejected as black communities felt they were already suffering.

Another resolution was that women should start by developing personal equality, and wherever possible, take stands to alter the structures under which we live and to recognise the valuable role women have in political empowerment.

New state 'is answer'

The alternative to resistance to racist oppression in South Africa was a change of government to save the country from the gathering storm, Durban sociology professor Fatima Meer said in an opening address to the National Assembly of Women at the weekend.

Professor Meer gave her view on sanctions and attacked Britain and America for refusing to implement them.

"The violence which threatens and riddles our society is directly due to racial oppression," Professor Meer said.

The only just solution to South Africa's violent crisis was a unitary state, and a single, non-racial parliament, she said.

X Report Restricted

7/8/85

DSR

Teargas 'can cause cancer'

Science Reporter

The type of teargas used by the South African Police in riots may eventually cause cancer, according to West German toxicologists.

Dr Max Daunderer, head of the Munich Toxicology Centre, has told a parliamentary inquiry by the Bavaria State Assembly that CS teargas, which is also used by the South African Police, is "more likely than not" to prove to be a cause of skin cancer.

He gave evidence on 42 victims of teargassing who were seriously ill after police battled anti-nuclear demonstrators at the proposed Wackersdorf nuclear reprocessing plant this year.

The victims had swollen joints, red patches and blisters, plus first and second-degree burns.

One victim had a clot in the lung and two suffered acute bronchitis.

Shot in the arm for health care

GOVERNMENT plans to unveil a major new national health-care policy this week.

It will move away dramatically from the racially fragmented system.

In terms of the new policy, which has Cabinet approval, control of hospital and medical services will be vested in the newly-appointed multiracial provincial executives.

CHRIS CAIRNCROSS

Officials have been quick to stress the new arrangement does not signal the immediate end to hospital apartheid but merely the desegregation of administrative controls and some services.

The new policy envisages a greater role for the private sector in the provision of health care services.

New national policy on health

Own Correspondent

JOHANNESBURG. — The government plans to unveil a major new national health-care policy this week when it moves away from the present racially fragmented system.

In terms of the new policy, which has cabinet approval, control of hospital and medical services will be vested in the newly-appointed multiracial provincial executives.

Heading this structure will be a national health policy council, chaired by the Minister of National Health and Population Planning, Dr Willie van Niekerk.

Other members will include the three Own Affairs Health Ministers, Dr George de V Morrison, Mr Chris April and Dr Ismael Kathrada.

Officials stress that the new arrangement does not signal the immediate end to hospital apartheid, but merely the desegregation of administrative controls and some services.

The new policy envisages a greater role for the private sector in the provision of health care services.

In practical terms, there is little doubt that it must eventually mean the dismantling of racial barriers at grassroots level, in hospitals and in the provision of ambulance services, for example.

The turnabout by the government is seen as a direct response to the mountain of criticism levelled at a system labelled as patently wasteful and at odds with the best interests of the country's needs.

Argus 15/8/86

Masa welcomes new plan for health services

The Argus Correspondent

JOHANNESBURG. — A move by Government to bring health services under a single authority has been welcomed by the Medical Association of South Africa.

Dr W A van Niekerk, Minister of National Health and Population Development, announced in Sandton last night that national health policy and priorities would in future fall under a single health authority, the newly appointed National Health Policy Council (NHPC).

COST-EFFECTIVE

A gathering of about 160 health-care professionals and administrators and representatives of national states were told that in future curative and preventive health services would be combined and the Department of National Health and Population Development and the provincial health services restructured to make health services more cost-effective and "reduce the fragmentation of the past".

Although whites, coloured people and Indians will be represented on the national council and self-governing national states will be consulted on health matters, blacks are excluded from it. Apartheid in provincial and state hospitals will not be dismantled.

"OWN AFFAIRS"

Dr van Niekerk said hospitals occupied by over 95 percent of people of one race would remain "own affairs", ethnic hospitals.

Hospitals occupied by less than 80 percent of one race would be classified as "general affairs" and all teaching hospitals would fall into this category.

The Medical Association of South Africa (Masa) said in a statement the plan was "in keeping with the long-standing campaign of the association against further fragmentation of health services under the present constitutional dispensation.

"Masa is still of the opinion, however, that the provision of health services should be a general affairs matter."

Major revamp on way

Govt moots national health plan

PUBLIC health services would be comprehensively restructured, National Health and Population Development Minister Dr W A van Niekerk said in Pretoria yesterday.

He said a national health plan would be created which would amalgamate the functions of the Department of Health and the provincial hospital services within the framework of the new constitutional dispensation.

The plan would make it possible to provide a dynamic, comprehensive and cost-effective health service for the first time, and would diminish the fragmentation.

A new National Health Policy Board, chaired by the Minister, would be responsible for planning, coordinating and monitoring the plan.

The ministers of health services and welfare of the Ministers' Councils of the Houses of Assembly, Representatives and Delegates would serve on the board.

Van Niekerk said the board would be assisted by an Advisory Committee for Health Affairs. The departmental chief directors of the ministers serving on the board, the surgeon-general, and others appointed by the board would serve on the committee.

Sub-committees

The committee would, in turn, function with several sub-committees.

Van Niekerk said the departments of health services and welfare of the three parliamentary Houses would be responsible for executing the plan on all three levels of government for their respective communities.

That would entail extensive responsibilities, such as providing safe drinking water, environmental health, sewerage and waste disposal services, and housing.

Health services for blacks would be provided by the Department of National Health and Population Development through powers delegated to the provincial administrations. The provinces would also act as agents for other health authorities.

The National Health Policy Board would collaborate with the self-governing black states and advise the Treasury on expenditures.

Van Niekerk referred to the high costs of private medical treatment and said families that had exhausted their medical aid scheme resources could always apply to their nearest hospital superintendent to be reclassified as hospital patients.

He said: "Everyone has access to the health services." — Sapa.

(85) DD 15/8/86 (Rep)

National health plan unveiled

PRETORIA — The functions of the Department of Health and the provincial hospital services have been amalgamated within the framework of the new constitution in terms of a new National Health Plan.

Announcing a comprehensive restructuring of South Africa's public health services yesterday, the Minister of National Health and Population Development, Dr W. A. van Niekerk, said the plan would make it possible to provide a dynamic, comprehensive and cost-effective health service for the first time and would diminish the "fragmentation" of the past.

A newly-formed National Health Policy Board, chaired by the minister, would be responsible for planning, co-ordinating and monitoring the plan.

The ministers of Health Services and Welfare of the Ministers' Councils in the Houses of Assembly, Representatives and Delegates would serve on the board, Dr Van Niekerk said in a statement.

The board would be assisted by an Advisory Committee for Health Affairs. The departmental chief directors of the ministers serving on the board, the surgeon-general and others appointed by the board would serve on the committee.

The committee would, in turn, function with several sub-committees.

Dr Van Niekerk added that the departments of Health Services and Welfare of the three parliamentary houses would be responsible for executing the plan on all three levels of government for their respective communities.

This would entail extensive responsibilities such as providing safe drinking water, environmental health, sewerage and waste disposal services and housing.

Health services for black people would be provided by the Department of National Health and Population Development through powers delegated to the provincial administrations. The provinces would also act as agents for other health authorities.

The National Health Policy Board would liaise with the self-governing homelands and advise the Treasury on expenditures.

Dr Van Niekerk referred to the high costs of private medical treatment and said families who had exhausted their medical aid scheme resources could always apply to their nearest hospital superintendent to be reclassified as hospital patients.

"Everyone in South Africa has access to the health services," he said. — Sapa

'Dynamic' new public health service plan

PRETORIA—The Minister of National Health and Population Development, Dr W A van Niekerk, yesterday announced a comprehensive restructuring of South Africa's public health services.

He announced the creation of a National Health Plan which entails the amalgamation of the functions of the Department of Health and the provincial hospital services within the framework of the new constitutional dispensation.

The plan would make it possible to provide a dynamic, comprehensive and cost-effective health service for the first time, and would diminish the 'fragmentation' of the past, Dr van Niekerk said in a Press statement.

A newly-formed National Health Policy Board, chaired by the minister, will be responsible for planning, co-ordinating and monitoring the plan.

The ministers of Health Services and Welfare of the Ministers' Councils of the Houses of Assembly, Representatives and Delegates will serve on the board.

The board will be assisted by an Advisory Committee for Health Affairs. The departmental chief directors of the ministers serving on the board, the surgeon-general, and others appointed by the board will serve on the committee.

The committee will function with several sub-committees.

Dr van Niekerk said the departments of Health Services and Welfare of the three parliamentary Houses would be responsible for executing the plan on all three levels of government for their respective communities.

Delegated

This would entail extensive responsibilities, such as providing safe drinking water, environmental health, sewerage and waste disposal services, and housing, he said.

Health services for blacks will be provided by the Department of National Health and Population Development through powers delegated to the provincial administrations. The provinces will also act as agents for other health authorities.

The National Health Policy Board will also liaise with the self-governing black states, and advise the Treasury on expenditures. — (Sapa)

New authority will control health services

By Joe Openshaw, Medical Reporter

Health policy and priorities will in future fall under a single authority — the newly appointed National Health Policy Council (NHPC).

This was the plan announced in Sandton last night by Dr W A van Niekerk, Minister of National Health and Population.

Curative services

A gathering of about 160 top health-care professionals, administrators and representatives of national states — which was also addressed by the Ministers of Health of the three Houses of Parliament — were told that in future curative and preventive health services will be combined. The Department of National Health and Population Development and the provincial health services — respectively responsible for preventive and curative services — will be restructured to make health services more "cost effective".

"The new dispensation makes it possible to provide a dynamic and comprehensive health service," said Dr van Niekerk.

Although whites, coloureds and Indians will be represented on the national council, and self-governing national states will be liaised with on health matters, the blacks of South Africa are excluded.

Aparthied in provincial and State hospitals will not be dismantled. Dr van Niekerk said hospitals occupied by over 95 percent of people of one race would remain own affairs — ethnic hospitals.

Hospitals occupied by less than 80 percent of one race would be classified as general affairs, and all teaching hospitals would fall into this catergory.

Dr G de Villiers Morrison, Minister of Health in the Assembly, announced that 44 hospital under jurisdiction of his department would are classified white own affairs.

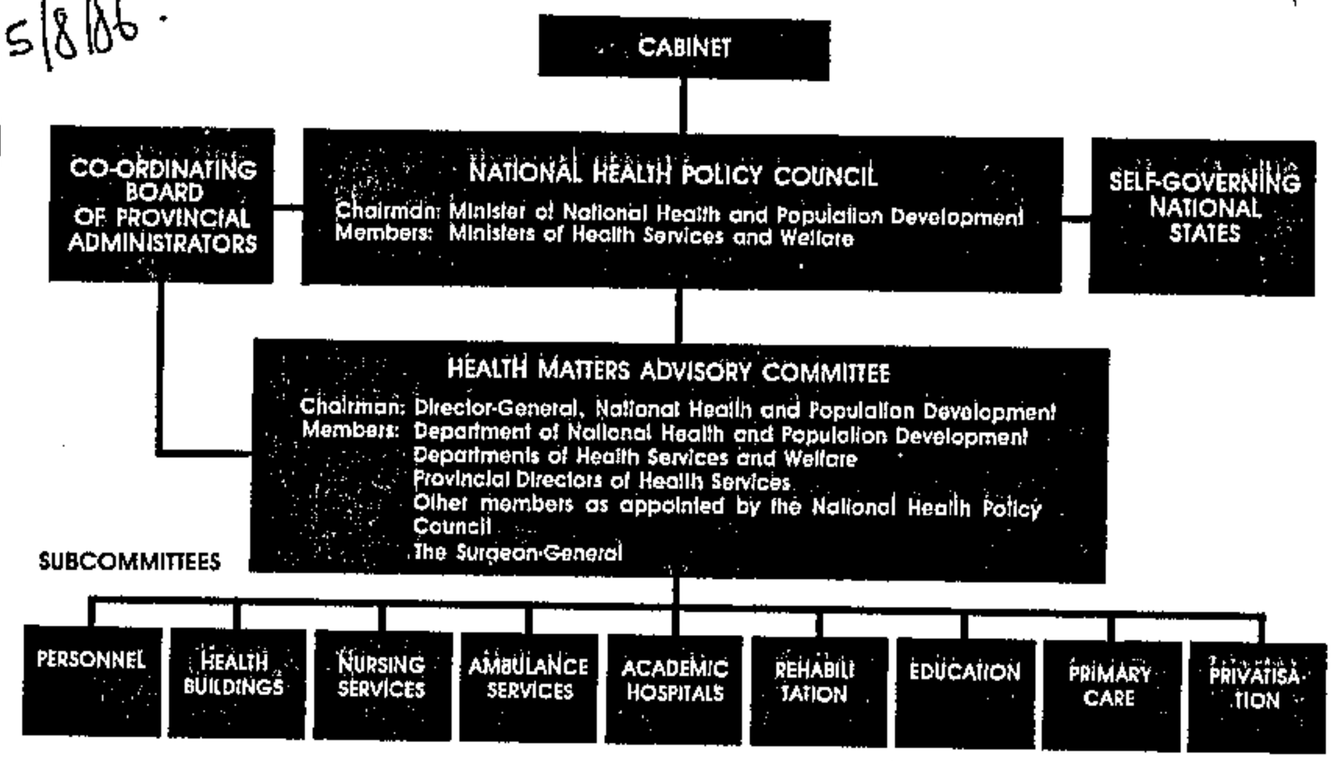
Dr van Niekerk said the national health plan would be carried out as follows:

- Policy, co-ordination and planning will become the responsibility of the NHPC under the chairmanship of the Minister of National Health and Population Development. Other members will be the Ministers of Health in the Houses of Assembly, Representatives and Delegates.
- The council will advise central Government on the provision and allocation of finance for health services.
- The Dapartment of National Health and Population Development will provide services for black communities, delegating execution to provincial adminstrations.

EXECUTION POLICY

- Community, regional and teaching hospitals will also be dealt with by the Department of National Health and Population Development with execution of policy delegated to provincial adminstrations.
- Provincial adminstration will also act as agents for other authorities within the national plan.
- Central management will be provided by a Co-ordinating Board of Provincial Adminstrators under the chairmanship of the Minister of National Health and Population develoment.
- Liaison will exist between the national health policy council and the self-governing national states.
- The private sector will have to play a greater role as teaching hospitals, providing beds for indigent State patients and the building of new hospitals.

THE FORMULATION OF THE NATIONAL HEALTH POLICY



Minister regrets blacks excluded

Medical Reporter

It was regrettable the black population had not been given the opportunity to contribute to the new health structure, Mr I Kathadra, Minister of Health Services and Welfare in the House of Delegates, said in Sandton last night.

Dr Kathadra spoke after the Minister of National Health and Population Development, Dr Willie van Niekerk, had outlined his new health dispensation plan based on input from white, coloured and Indian groups in the national Health Policy Council which will be responsible for policy, planning and monitoring the national health plan.

Mr Kathadra hoped some of the large sums spent on high-tech health services for whites would be diverted to community health care for non-whites whose hospitals were overcrowded and lacked facilities, and who had to make do with inadequate health care.

"I have visions that all other hospitals throughout the Republic will shed their tags of racialism," said Mr Kathadra.

Patients to decide on 'other race' doctors

Patients in "own affairs" hospitals will decide whether or not they are treated by doctors and nurses of other races, Dr W A van Niekerk, Minister of National Health and Population Development, said last night.

Announcing his new health plan for South Africa, Dr van Niekerk said that whether hospitals were open to all races would be decided by the newly-appointed National Health Policy Council on which the Ministers of Health Sevices of the Houses of Assembly, Delegates and Representaives will serve.

"The patients in hospitals will be polled as to whether they want black doctors and nurses.

"Black patients will also have a say as to whether they want white doctors and nurses."

Health Ministers Mr C April of the House of Representatives and Mr I Kathadra of the House of Delegates, both announced that hospitals under their ministries would be open hospitals.

Dr van Niekerk said "own affairs" hospitals would be those where over 95 percent of the patients are of one race.

"General affairs" hospitals would be those where under 80 percent of patients are of one race.

Private sector to help with hospital burden

The private sector will have to share the responsibility for erecting new hospitals, Dr De Villiers Morrison, Minister of Health and Social Welfare in the House of Assembly, said in Sandton last night.

Dr Morrison was talking of the private sector role in the new health dispensation announced by Dr W A van Niekerk, Minister of National Health and Population Development, and said South Africa was not a welfare state and did not want to be one.

He said his department was primarily concerned with the needs of the sub-economic and the aged.

He outlined three aspects which would be given urgent attention:

- **Making empty beds in hospitals available to the private sector.**
- **Making empty hospital beds available to welfare organisations for accommodating the frail aged. A pilot scheme will soon be announced.**
- **Private hospital enterpreneurs will have to shoulder a greater and increasing share in the training of nurses and other paramedical personnel.**
- **Alienating state hospitals, which are at present predominantly accommodating private patients, to the private sector. The State would then hire beds and facilities from the private sector for patients for which it is responsible. This may be more cost-effective.**

New health services plan unethical, says professor

Disappointment that blacks are excluded from a say in the new health dispensation announced on Thursday night was expressed by Professor George Dall, dean of the faculty of medicine at the University of Cape Town.

Professor Dall presided at the meeting when the Minister of National Health and Population Development, Dr W A van Niekerk, outlined his new plan. The professor said the provision of health services under a single authority was a step forward, but the exclusion of a national health policy by provincial administrations did not lead away from fragmentation of services.

Professor Dall said it was unethical that 44 of the country's white hospitals would still be run on ethnic grounds. The outside world would view it as such and consider that there had been no improvement in the country's health services, he said.

Professor Dall welcomed the fusion of preventive and curative health services into one service. The restructuring of the Department of National Health and Population Development and hospital services departments of the provincial administration was also a welcome move, he said.

A single health policy for all and integrated hospitals were justified because it was "ethical, logical and cost effective. The new health plan has not met these requirements," he said.

PFP attacks Govt's new health plan

By Joe Openshaw,
Medical Reporter

The new health dispensation should have been based on total desegregation of sevices, Dr Marius Barnard, health spokesman for the Progressive Federal Party, said in Cape Town.

"The new health plan, announced by the Minister of National Health on Friday, will be carried out by a National Party Government and therefore be based on racial discrimination in health services for which the party still stands and in consequence the country's health services remain weak," Dr Barnard told *The Star*.

He said the plan had its merits and showed the Government has at least realised that there should be one single authority for health — the newly appointed National Health Policy Council — which he hoped would lead to a total health policy.

"We should be thankful for this step. We are also thankful that own affairs have been given less responsibility and, it seems, the role of own affairs Ministers in health matters diminished," he said.

"We had feared that own affairs would have greater powers and this would result in the fragmentation of health services.

"As things now stand provincial administration affairs will still be responsibile for carrying out the national health plan.

"Although the plan is better than we had hoped for, any plan is in the end as good as the planners make it and in this instance the planners are the Nationalist Government still dedicated to own affairs," said Dr Barnard.

Administering health services in a society — unhealthy because of continued unrest — was already presenting difficulties as was evident in the treatment of tuberculosis and other infectious diseases in the townships.

Dr Barnard said the announcement by Dr G Morrison, Minister of Health of the Assembly, that 44 hospital under jurisdiction of his department would be regarded as white own affairs hospitals, was camouflage by the Government.

It was a situation

Call for urgent talks over health cost crisis

By Joe Openshaw,
Medical Reporter

A call has been made for an urgent meeting to discuss the crisis in health costs, following the steep rise in medical aid fees announced last night.

After the announcement, PFP health spokesman Dr Marius Barnard called for an urgent meeting between medical aid societies, the Minister of Health and the Medical Association to discuss the crisis.

Dr Barnard also called for a change in legislation to allow insurance companies, banking houses and financial houses to rescue medical aid schemes by bearing some of the spiralling cost of health care.

"We are gravely concerned at the ever-increasing cost of medicines and the consequent high premiums being asked of consumers," Mrs Betty Hirzel, chairman of the South African Consumer Union, said in a statement today in which she called for generic substitution of medicines.

Announcing the increase in medical aid rates, the Representative Association of Medical Aid Societies (RAMS) said last night this is the second — and in some cases the third — rise in medical aid tariffs this year.

The increase exceeded 20 percent and some members are being asked to pay as much as 90 percent more .

"RAMS realises the latest increase deals another painful blow to members who by now must be punch drunk and ready to throw the towel in, but we simply have to take this action.

"The continued overrun in claims costs — particularly where the fees of the medical profession are concerned — have left us no option," said Mr Tony Leveton, a spokesman for RAMS in Johannesburg.

RAMS this week formally asked the Minister of Health, Mr Willie van Niekerk, to intervene and, as a matter of urgency, save 43 medical funds — six of which are insolvent and 32 of which show underwriting deficits — from going to the wall by relaxing some of the provision of the Medical Schemes Act.

Minister to meet medical aid team

BUSDAY 27/8/86 (85)

CHRIS CAIRNCROSS and MICK COLLINS

HEALTH MINISTER Willie van Niekerk has agreed to see a delegation from the medical aid industry, as soon as a meeting can reasonably be arranged, to discuss the plight of certain schemes that are in danger of becoming financially disabled.

After yesterday's shock announcement that medical aid tariffs are to be increased by more than 20%, the Representative Association of the Medical Aid Schemes (Rams) has formally asked the minister to intervene.

A spokesman for Rams, Tony Leveton, said yesterday that his association had asked the minister, as a matter of urgency, to relax some of the provisions of the Medical Schemes Act.

Van Niekerk yesterday told *Business Day*:

□ He was aware of some problems experienced by certain medical aid schemes, but stressed that the industry was the domain of the private sector, and the state was limited in what it would be able to do.

□ He agreed there were several features of the medical schemes legislation which probably needed review. These were being given urgent attention.

□ He hinted last night that some of the fundamental problems in the medical aid industry would be covered in a White Paper, due to be tabled in Parliament during the current session, in response to the Browne Commission.

tioned categories of persons and (ii) estimated legal costs of the (aa) State and (bb) defendants?

The MINISTER OF LAW AND ORDER:

(1) to (3) The information is not readily available.

Emergency regulations: detentions

1194. Mrs H SUZMAN asked the Minister of Law and Order:

What total number of persons in each race group were in detention in each specified region in terms of (a) section (i) 28 and (ii) 29 of the Internal Security Act, No 74 of 1982, and (b) the emergency regulations as at the latest specified date for which information is available?

The MINISTER OF LAW AND ORDER:

(a) (i) None.

(ii) 153 persons.

Until 24 August 1986.

(b) I do not deem it in the interest of the public to make known information of this nature.

WEDNESDAY, 27 AUGUST 1986

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†*Indicates translated version.*

For written reply:

General Affairs:

HoA

SWA/Botswana: importation of beef

1156. Mr M A TARR asked the Minister of Agricultural Economics:

(1) Whether any arrangements have been made between South Africa and (a) Namibia/SWA and (b) Botswana regarding the importation of beef into the Republic; if so, (i) what are these arrangements and (ii) when were they made;

(2) (a) how many (i) carcasses and (ii) tons of beef were held in storage by the Meat Board as at the latest specified date for which figures are available and (b) what was the cost of this beef to the Meat Board;

(3) whether any plans have been made to dispose of this meat; if not, why not; if so, what plans?

The MINISTER OF AGRICULTURAL ECONOMICS:

(1) (a) Yes.

(i) SWA/Namibia may market a maximum of 280 000 cattle during 1986 in the RSA. The RSA has experienced beef shortages for many years. Import quotas are therefore negotiated in advance according to shortages expected under normal conditions.

(ii) Marketing agreements between the RSA and SWA/Namibia have been in operation for at least 40 years and are reviewed every second year, although adjustments can be made annually if necessary. The 1986 quota was negotiated during December 1985.

(b) Yes.

(i) Botswana may market a maximum of 306 tonnes of beef per week during 1986 in the RSA. The RSA has experienced beef shortages for many years. Import quotas are therefore negotiated in advance according to shortages expected under normal conditions.

(ii) Customs Union agreements have been in existence since 1910 and were renegotiated in 1969. Quotas in terms of the agreement are reviewed annually and the 1986 quota was negotiated in October 1985.

(2) (a) (i) 16 754 carcasses on 30 June 1986.

(ii) Approximately 6 174 tonnes of deboned beef on 30 June 1986.

(b) R22,72 million.

(3) Yes. The Meat Board has been selling the surpluses at cost to the trade and consumers since September 1985. As strategic stocks, the present surpluses represent only 3 to 4 days' consumption.

Medical University of Southern Africa

1187. Mr K M ANDREW asked the Minister of Education and Development Aid:

How many applications by students for admission to the first-year course in the faculties of (a) medicine, (b) dentistry and (c) veterinary science were (i) received and (ii) accepted at the Medical University of Southern Africa in respect of 1986?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

	(i)	(ii)
(a)	1 632	138
(b)	245	39
(c)	109	14

Lebowa Government: motor-cars for Cabinet members

1198. Dr W J SNYMAN asked the Minister of Education and Development Aid:†

(1) Whether his Department is involved in the provision of motor-cars to Cabinet members of the Lebowa Government; if so, how many Government cars are placed at the disposal of such Cabinet members at present;

(2) whether any motor-cars are provided for the private use of these Cabinet members; if so, (a) how many and (b) at what total cost;

(3) in respect of what date is this information furnished?

The MINISTER OF EDUCATION AND DEVELOPMENT AID:

(1) No.

(2) No.

(3) Up to 25 August 1986.

Mystery illness of 200 pupils is probed

Vereeniging Bureau

Tests are still being conducted to determine the cause of a mystery illness which affected more than 200 pupils at the Sonland Park Primary School in Vereeniging yesterday.

The children were taken to the Vereeniging Hospital in ambulances, mini buses and private cars when they complained of severe stomach cramp.

Health department tests on the school water supply showed no chemical contamination.

Hospital staff had treated about 204 pupils.

A hospital spokesman said a few children suffered nausea and vomiting as well as cramp. None of the children was in a serious condition and none was actually admitted to hospital.

POISONOUS GAS

Most of the pupils had left the hospital by noon after being given injections. But later several parents contacted the hospital after their children had started experiencing cramps again. A small number of new cases, complaining of the same symptoms, also reported to the casualty section for treatment.

The possibility that scholars were affected by some form of poisonous gas has also not been ruled out.

The school is at present being repainted and a chemical reaction could have been triggered off by the paint causing some form of poisonous gas to be given off, said the spokesman.

threat from the combined rightwing grouping seriously. NP provincial secretary and MP, Renier Schoeman, believes there is no room for complacency. He says in times of rapid political change and difficult economic circumstances, there is "always a danger that voters will act unpredictably by registering a protest vote or simply by staying away." NP strategy, says Schoeman, will be to get the message of government's reform package across "specifically and strongly, to reach voters and penetrate their consciousness."

Generally, the feeling is that the NP is in a good position to retain the seat. Political insiders say that if the CP believed there was a real possibility of victory, they and not the HNP would have fielded a candidate. Thus the chances of the HNP adding another MP to the lone voice of Louis Stofberg in parliament at this point look slim. ■

FCN MAIL

HEALTH SERVICES 85 5/9/86

Tricameral follies

The pending reorganisation of SA's health services is a matter of old wine — or medicine — in new bottles.

Representations from the medical profession aimed at having health services reorganised on a unified, nonracial basis (*Leaders* June 13) have been ignored. Instead, cleaving to ideological orthodoxy, health matters will be revamped along tricameral constitutional lines of "own" and "general" affairs.

The decision to incorporate preventive and curative services under one department is welcome and long overdue. But despite departmental rhetoric — "a new dispensation," and a "dynamic, co-ordinated and rationalised health service, cost-effectively managed to the benefit of all" — apartheid remains the guiding principle in health care.

The worst fears of the medical profession have at least been somewhat mitigated with the decision not to divide individual hospitals along racial lines. This would have meant that a hospital serving more than one group would have had separate superintendents for each race group, or one superintendent bogged down in separate bureaucracies.

Hospitals, however, have not been saved from ethnic division. They are to be allocated according to a weird formula: hospitals whose patients comprise more than 95% of a particular race group will fall under the control of the "own affairs" department of that race group; those that serve no more than 80% of one group are classified as "general affairs" hospitals under the Department of National Health and Population Development.

The department has not yet been able to explain what happens to hospitals whose patient ratio falls into the gap between 80% and 95%. Is an alarm bell triggered when the race ratio is exceeded? The system will serve to ensure that own affairs departments keep their hospitals (almost) pure racially. Presumably then, the Indian own affairs health minister, who has said that hospitals under his ministry will be open to all, stands to forfeit those hospitals that ignore the quota.

The final list of allocated hospitals is not yet available. Teaching hospitals, whatever their racial make-up, will fall under general affairs.

After the restructuring, daily running of the hospitals won't be much affected. Under the old system, hospitals were administered by the province. Under the new, hospitals fall under the jurisdiction of own affairs departments, but are immediately handed back to the relevant provincial administration to run on an agency basis.

At present the four provincial administrations are responsible to four separate administrations (see chart). Now they must work with four different budgets; how this potential bookkeeping maze will work without further costs and bureaucracy has not been clarified.

The structures of the new dispensation are not new: at the apex is the National Health Policy Council and the Health Matters Advisory Committee which were set up in terms of the 1977 Health Act. Their membership has merely been altered to reflect the tricameral fragmentation.

Under the old dispensation, preventive and curative services were split between the State, provinces and local authorities. Provincial administrations offered curative, or hospital services, while the department and local authorities were responsible for preventive services. The provinces enjoyed a large measure of autonomy, which however led to an imbalance — over 80% of the annual budget was spent on curative services.

Under the new dispensation more power is concentrated in central government. Health care *policy* is formed only by the first tier — the Department of National Health and Population Development and the three own affairs health departments. (Service for urban blacks fall under general affairs and are the responsibility of the department). Second and third tiers of government will merely implement overall policy.

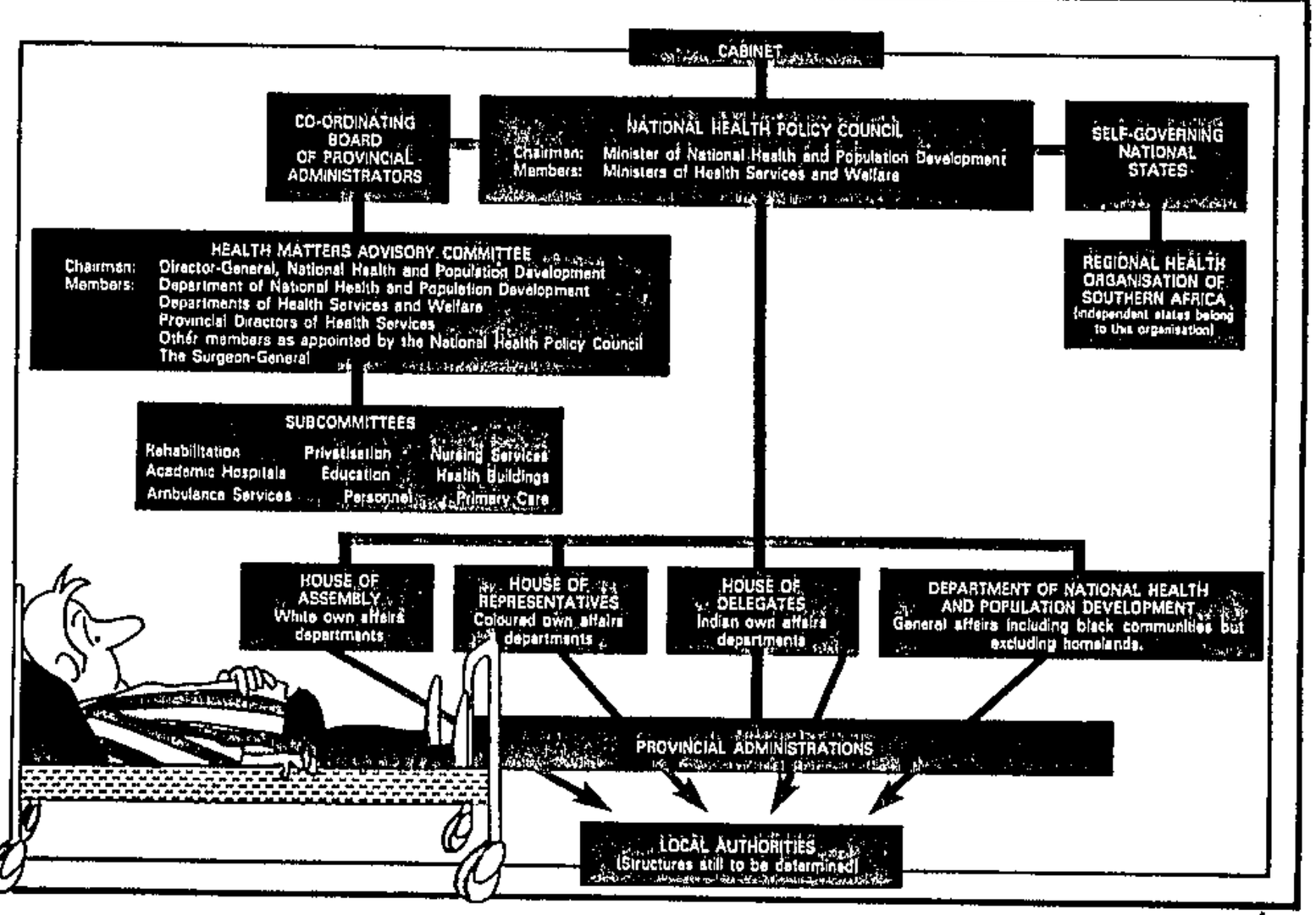
Hospital services remain a function of appointees to the new multiracial provincial administrations, in conjunction with the provincial departments. Preventive measures such as provision of safe drinking water, basic housing, environmental health, sewage and garbage disposal fall to the own affairs administrations.

Other preventive functions, such as antenatal care, children's clinics, control of infectious diseases, school services, community psychiatric services, geriatric services, family planning, immunisation and health guidance are the function of the own affairs local authorities.

In practical terms, all this means further fragmentation on the ground. In Johannesburg, for example, the city council used to provide clinics for whites, coloureds and Indians — which at least was geographically logical. Administration of these will now be split up among the own affairs departments. Consequently, for example, if a local epidemic breaks out it will now require the co-ordination of four departments.

Restructuring of the various departments is under way. Until final details are released, exactly how the health plan will work in practice remains obscure. Although preventive and curative services are being combined, fragmentation will be sustained in practice and racial divisions reinforced. For this reason the plan is unacceptable to most of the medical fraternity. ■

National health structures — sick set-up



SA hits 'false' film on health

SUNDAY TIMES FOREIGN DESK

THE South African Embassy in London is seeking legal opinion on the action of the Trades Union Council in producing and screening a commercial on health care in South Africa as part of its campaign for sanctions.

In a statement, the embassy said the film was a gross distortion of health care in South Africa.

Besides being a misrepresentation, it contained two demonstrable falsehoods relating to black infant mortality in South Africa and medical practitioners to patient ratios.

The statement said: "The ratios could only have been based on an assumption that white doctors only treat white patients and black doctors black patients. This is totally untrue."

Complaints

Facilities like those at Baragwanath Hospital were unsurpassed, and thousands of black patients from other parts of Africa came to the Republic's hospitals each year.

The doctor-to-patient ratio for South Africa, as quoted by the World Health Organisation, was 1:1 540, which compared favourably with Western Europe's 1:528. In Botswana the ratio was 1:10 476, in Angola 1:15 404, in Zambia 1:16 290 and in Lesotho 1:20 570.

The embassy is considering lodging complaints with the Broadcasting Complaints Commission and the British Advertising Standards Authority.

More health-care privatisation on the cards

GERALD REILLY

GOVERNMENT'S privatisation programme would be carried out without undue delay. This assurance was given in Pretoria yesterday by the Minister of Health, Dr de Villiers Morrison, at a symposium on privatisation of health services.

There was a need to limit or even reduce public-sector involvement in the economy, he said. The programme included possible privatisation of hospital services.

No new hospitals would be erected by the State unless there was a special need and there was proof the private sector could not provide the facility.

Privatisation of existing public facilities would be investigated thoroughly, and certain facilities could be leased or sold to the private sector.

Privatisation of existing facilities could be accomplished only if the private sector was willing to provide the full spectrum of health services at affordable cost, Morrison added.

It's a town of sick children, says report

Sasolburg air pollution shock

17/9/86 STAR

56 260 85

Pretoria Bureau

Heavy air pollution in Sasolburg has been found by researchers to adversely affect the lung functions of children living in the area.

These startling conclusions were published in the latest issue of the *South African Medical Journal* following an intensive research programme in the area. The research team was headed by Professor A M Coetzee of the University of Pretoria.

According to the article excessive air pollution by industries in Sasolburg was suspected of affecting the residents' health in general and the respiratory systems in particular.

The three-week investigation undertaken in May 1984 involved children from primary schools in Sasolburg and the neighbouring rural towns of Parys, Heilbron and Frankfort. These last three towns were chosen as control areas for their negligible air pollution levels.

Although Professor Coetzee and his team found no important differences in the incidence of respiratory illnesses, they did detect a significant difference in the lung functions of Sasolburg children.

This trend seemed to be unaffected by the smoking habits of families. However, the social class from which the children originated could have been a contributory factor, said the article.

Sasolburg, near Vereeniging, is a major industrial centre particularly as far as chemical and oil-from-coal processes were concerned. Air pollution is concentrated in this area.

Breathing worse

Questionnaires were sent to 674 children in Sasolburg and 332 children in the other three towns. Replies showed that there was no substantial difference in the incidence of respiratory diseases. However, the study showed that the breathing functions of the Sasolburg scholars is worse than those in the neighbouring rural towns.

Researchers also pointed out that air pollution was of a similar intensity in the whole PWV area.

The report has met with a mixed reception, reports *The Star's* Vereeniging Bureau.

While medical practitioners and many mothers in Sasolburg yesterday supported the conclusions of the survey, a spokesman for the town council suggested the matter was being exaggerated.

The town clerk, Mr Chris Ehlers, said a meeting on air pollution was recently held in Vanderbijlpark and proved that nobody was indifferent to the matter.

He said industries in the Vaal Triangle had spent R300 million to combat pollution.

Chest problems

Mr Ehlers said the incidence of sulphur dioxide and hydrogen sulphide in the air is "way below" the prescribed minimum standards set by the national health department.

But several mothers said yesterday at least one or two of their children were suffering from severe sinus and chest problems as well as disorders relating to the upper respiratory passages.

In more than half of the cases, the mothers — and, according to them, their family doctors — are convinced that these disorders can be linked to air pollution.

Unrest takes its toll on community health

By Joe Openshaw, Medical Reporter

Unrest is a vital community health issue, according to the *South African Medical Journal.*

Conflict and violence, says the *Journal*, have seemingly become endemic and can be expected to have immediate and long-term effects on health.

In addition, the present unrest situation with its prolonged course and uncertain future is likely to result in even more severe psychological stress than is caused by natural disasters such as floods and fires.

Further indirect and long-term effects are likely from the disruption of standard health services.

The most overt effect is the acute physical trauma arising immediately from unrest incidents, a manifestation recently studied by the community health department of Cape Town University which found that 1 percent of patients admitted each month to the trauma unit of Groote Schuur Hospital in 1984 and the first half of last year had gunshot wounds.

Between August and November last year this figure increased sixfold, says the *Journal.*

Five-hundred patients with gunshot wounds were treated at the Crossroads Clinic between February and November last year, 65 of them with wounds sufficiently serious to warrant their admission to hospital. Thirteen of these people died from the injuries.

Many of those shot were children — 11 percent were under 15 and younger — and between August and November 20 under the age of 13 were admitted to children's hospitals in the Cape Peninsula.

BOTH EYES DAMAGED

The Department of Opthalmology at Groote Schuur Hospital admitted 47 patients with eye injuries during the latter part of last year and of these two patients had both eyes damaged.

"In 41 patients the eyes had been struck with birdshot and 38 of these patients were discharged without useful vision in the affected eye; two eyes were blinded by rubber bullets.

"Although there is no comparable data, a previous study of pellet-gun wounds published is 1978 recorded only 16 cases in five years — 1,6 cases every six months — which is 1/30th of the number seen last year," says the *Journal.*

The mortality records of the Cape Town City Council show an 11 percent increase in deaths from "external causes" for the months August to November last year over those of 1984.

The *Journal* says demands for water and sanitation are unlikely to be adequately met in the near future and could precipitate the increase of gastroenteritis.

The supply and distribution of food to children already chronically malnourished has become precarious, the *Journal* adds.

Tuberculosis is already been increasing in the Western Cape.

Preventive and promotive services such as antenatal and child health programmes (including immunisation) have been interrupted and an increase in measles and poliomyelitis can be expected.

The *Journal* says there is an urgent need for a co-ordinated and realistic approach if the conflict's impact on health is to be minimised which must include, not only State-funded services but those of voluntary organisations such as Red Cross and St John's.

It also calls for a rapid means of assessing health needs and demands in affected areas and stresses that account must be taken of increased security laws which may limit the flow of health data.

SA academics face overseas publication ban

Medical Reporter

Some South African academics are experiencing difficulty in getting work published in overseas journals, says an editorial in the current *South African Medical Journal.*

"There seems to be a division of opinion among South African academics with regard to publication in overseas journals. Some say they are experiencing no difficulty in getting their work published — particularly in the US and UK — while other claim to have detected an anti-South African attitude among overseas editors and referees," says the journal.

The argument has spilt over into the columns of the *New Scientist* as a result of a letter from the president of the Zoological Society of Southern Africa, Professor B R Allanson, drawing attention to a "distressing editorial policy developing among a number of journals against the acceptance of original research papers by South African contributors".

Professor Allanson said evidence was accumulating about journals which covertly or overtly refuse the publication of papers on political grounds.

"To find that we are being subjected to a publication boycott is profoundly disturbing as it affects the free exchange of scientific thought and information."

An editorial in the *New Scientist* suggests, however, that scientists in South Africa — "if they want the scientific community of the world to take them seriously" — must openly support scientists elsewhere to bring about change.

"They cannot have it both ways: if they stay silent because they want a quiet life at home, they must expect others to add to their silence," says the *New Scientist.*

Generation of black addicts is Sanca's fear

The closure of black schools could create a generation of alcohol and drug addicts.

Welfare workers are concerned that there will be a massive upsurge in already grave social problems, particularly alcohol and drug abuse, of black communities.

They are finding it difficult to provide existing services, which are seriously inadequate. And they say there has been little progress in expanding these to deal with future demand.

Researchers are investigating the extent of drug abuse among black youth, but it is known that dagga-smoking and glue-sniffing, often practised by pre-school children, is increasing.

Alcoholism is a major problem in black urban areas. There are said to be 71 550 male and 15 222 female black alcoholics on the Witwatersrand.

Research has shown that one in every 10 urban black males consumes more than 15 centilitres of absolute alcohol a day and may be an alcoholic.

Because of this, black youths have role models which condone alcoholism, said Mrs Margeret Motumi, development adviser for the national arm of the South African Council on Alcoholism and Drug Dependence (Sanca).

Limited social services and preventive programmes as well as a general lack of awareness of the problems of dependence means there are no brakes on youth experimenting with drugs or alcohol, Mrs Motumi said.

"The youth of 16 who drinks now will be an addict in 10 years' time."

Although there are young people who reject alcholism in their parents, even they often succumb to experimenting, Mrs Motumi said.

Field work was becoming increasingly difficult for welfare workers. Their credibility was questioned and their places of contact with youth, such as schools, were being thrown into disarray.

EVENING POST, TUESDAY, SEPTEMBER 30, 1986

Suppliers in the dark over smoking health warnings

Post Reporter

PORT ELIZABETH tobacconists appear to be in the dark about when compulsory billingual health warnings must be introduced on all cigarette packets.

Tomorrow marks the start of a two-month period in which tobacco companies in South Africa have to include warnings that "Smoking is a health risk" and "Rook is 'n gesondheidrisiko" on all cigarette packs.

Local stockists and distributors said they had not heard of the new law and did not have directives or orders to start putting the warnings on the packets.

A spokesman for Cigarette Importers in PE said he had heard the move would be phased in gradually.

"Old stock without the warnings will be sold as usual until new consignments are received from the manufacturers," he said.

A spokesman for a retail tobacconist in Central said the new packets had very little to do with shopkeepers.

3 million South Africans disabled

STAR 15/10/86 (85)

By Janine Simon

More than 3 million South Africans — or 11,52 percent of the total population — were disabled, the project leader for the Year of Disabled People (YDP), Dr J F J Hattingh, has said.

This was the first record of the incidence of disability based on research in this country.

It corresponded with previous estimates based on the findings of international studies. These put the incidence of disability at between 10 and 13 percent of the total population.

"Disability" applied to 11 categories of physical, mental and sensory impairments.

Dr Hattingh said his figures were based on the research of 14 sub-committees working under the co-ordinating committee of the YDP.

Their reports, based on the population figures of the 1985 census, were completed at the end of August and concluded that:

- Epilepsy and speech impediments each affected one percent of the population or about 290 000 people.
- More than one million people or 3,5 percent of the population suffered from deafness.
- Cerebral palsy and mental disabilities each affected more than 72 000 people.
- A total of 870 000 people or three percent of the population were mentally retarded.
- 66 000 people or 0,23 percent were blind or partially sighted.
- About 5 800 or 0,02 percent of the population was autistic.
- Almost 473 000 people or 1,63 percent were physically disabled.
- Approximately 145 000 people needed care for chronic or terminal illnesses.
- More than 46 000 people were disabled by age.

Medical costs are all set to escalate

DAVID FURLONGER

THE WARNING by private hospitals that they may pull out of the medical aid system is the latest shot in a protracted dispute between the hospitals and medical aid societies.

Regularly accused of over-charging the sick and dying, the hospitals in turn accuse societies of denying them the cash they need to remain profitable. Caught in the middle, meanwhile, is the patient. One way or another, he is going to have to pay more for his medical care.

If the societies buckle in to the hospitals' threat and allow them to charge more, it will mean an increase in medical aid contributions. If the hospitals pull out of the system, the patient himself will have to pay the difference between what his treatment costs and what his medical aid is prepared to pay.

The argument is between two central bodies — the Representative Association of Medical Societies (Rams) and the Representative Association of Private Hospitals (RAPH).

RAPH officials are due to meet tomorrow to discuss pulling out of the medical aid system in response to Rams' decision to grant private hospitals an average 7% increase in benefit scales from January 1 next year. RAPH had asked for a 20% increase in the scales, which are the maximum medical aids will pay for members' treatment.

Hospitals say the 7% follows a 12% increase this year, 10% last year and 6,25% in 1984. During the same period, they claim, actual costs rose faster than inflation.

Ultimately, the dispute boils down to a difference in philosophy — between non-profit-making medical aid societies and hospitals determined to achieve maximum returns for investors.

The private hospitals sector is dominated by three groups — Rembrandt, Afrox and Clinic Holdings. Although there are several smaller investors, all are motivated by the profit factor and interests of their shareholders.

And according to RAPH chairman Dick Williamson, those shareholders are not too happy. "Returns on capital are declining and margins are coming down substantially."

He says the growing cost of building hospitals — up to R120 000 a bed — has pushed up to about 65% the minimum occupancy rate needed to break even. That, added to increasing costs — such as nursing salaries, water and power costs and imported equipment costs — have dampened profitability.

Profitable it remains, however, as the recent surge in new private hospitals indicates. And Williamson admits that bed occupancy is over the 65% mark. "So we are profitable."

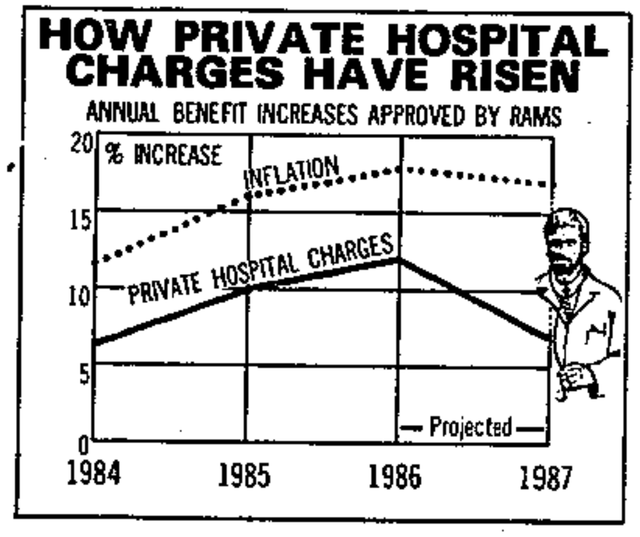
Medical aid societies, while conceding hospitals might be entitled to bigger increases, are themselves short of cash. The only way they can boost their coffers is through higher contributions from members. "We have our own cost problems," says Rams chairman Jan Fernhout.

Adding to the argument is the belief among many medical aid societies that hospitals are sometimes less than honest in the way they seek profits — by billing for drugs that were not used; by charging for reusable syringes; or even for charging for an entire roll of bandage or tape after using only a short strip.

"Every time we have queried a private hospital account we have always got a refund," says the head of a leading medical aid society. "The hospital's excuse is either 'wrong patient' or 'wrong drug quantity'. Overcharging can be as high as 20%. Hospitals get to know who is checking accounts. They will 'try it on' with a scheme which doesn't check properly."

He adds: "I can't get away from the conviction that it is deliberate."

Biggest gripe of all among critics is the "three-time-payment" system. Where clinic-based doctors used to provide their own equipment, this is often now provided by the clinics, but without a reduction in the doctor's own bill. The patient therefore is paying for the doctor, the standard hospital fee and an extra hospital fee to recover the cost of the doctor's equipment.



Williamson rejects this and says: "The hospital provides basic items of equipment. That's what we pay for it and that's what we should get back. Surely it's better to provide one set of equipment for doctors than have the need for several sets?

"In any case, if Rams doesn't want to, it shouldn't let doctors charge for the equipment they don't have. And remember — Rams has allowed doctors no increases at all for next year."

Where the two sides do agree is on the idea that most problems are caused by the existing health care system. Two main problems emerge — lack of incentive for patients to be cost-conscious and the cover-all system of medical benefits.

To most patients, their only link with health care is the monthly medical aid contribution. Beyond that, prescriptions, hospital bills and even visits to their GP mean only the receipt and handing-over of pieces of paper for others to pay.

The patient doesn't care, therefore, that any private establishment he may enter has facilities — and charges — far in excess of what he may need.

"There's no need to be so luxurious," says the medical aid society head. "I want a system of maximum payment per day. Tell the doctor: 'I can't afford this, get me a cheaper rate'. Patients have been spoiled; there is no incentive to save costs."

Williamson agrees that a system encouraging cost-consciousness would be "no bad thing".

The second complaint — that there's no variety in medical aid cover — may be rectified next month when the Brown Commission on health care is officially translated into a White Paper.

Both societies and hospitals want a system whereby people have the choice of medical cover — the option of comprehensive cover, cover for major operations or cover beyond a certain base-line.

Repeal law on striking medics plea

MEMBERS of the SA Medical and Dental Council have asked their executive committee to review an Act stating that medical practitioners involved in strikes or go-slow actions should automatically be struck off the roll.

During the SAMDC's 130th meeting in Pretoria this week, members said that when the Medical, Dental and Supplementary Health Service Professions Amendment Act was passed, the implications of coercion and intimidation in strikes could not have been predicted.

The Act provides that medical practitioners convicted of instigating, inciting or taking part in strikes or go-slow actions should automatically be struck off the roll.

One member said that, as the law stood, a doctor would automatically be struck off the roll irrespective of his own moral culpability.

Several members agreed that the council should urge that "its right to exercise its own discretion be restored in matters regarding registered SAMDC persons who had been convicted of a strike or go-slow strike". — Sapa.

Incentive schemes to be started

GERALD REILLY

INCENTIVE schemes to improve the productivity of regional industries in SA and the TBVC countries are to be introduced, Trade and Industry Minister Dawie de Villiers said in Pretoria yesterday.

This, he said, was aimed at ensuring viability. The SA-TBVC governments participating in the incentive scheme realised the need for creating permanent employment opportunities.

It was therefoer imperative that industries established in terms of the scheme should be competitive, even before short-term incentives were taken into account.

Regional industrial development authorities would subsidise 50% of the cost of productivity investigations undertaken by qualified productivity consultants.

A list of approved consultants would be compiled by the SA Centralisation Board in conjunction with regional authorities.

Private sector set to take over hospitals

Health privatisation moves

PRIVATE hospital groups are ready to take over the running of state and provincial hospitals and turn them into money-making operations.

While government officials remain cautious on privatisation plans, the private sector say it is no longer a question of "if", but of "when" and "how". Some spokesmen believe the transfer will begin within two years.

National Health and Population Development Minister Willie van Niekerk said at the weekend that no specific hospital had to date been identified for privatisation.

Health Services Minister George Morrison set the ball rolling earlier this year when he announced government wanted certain health functions to be run on private enterprise lines.

Representative Association of Private Hospitals (RAPH) chairman Dick Williamson said the Department of Health had held several discussions with hospital companies on the issue.

DAVID FURLONGER

He said private hospital groups would welcome taking over state and provincial hospitals, which had been a constant drain on public funds. He was confident they could be made profitable.

Williamson's Afrox group is one of the biggest private hospital investors, along with Rembrandt and the Clinic Holdings Group.

Clinic Holdings director Ian Bloch said his group was also interested in taking over state hospitals, but added he was still awaiting clarification rom government.

Details still to be worked out include whether private enterprise will take over all the functions of a hospital, or only certain ones.

Williamson was sure the private sector would prefer to take over the entire running of hospitals.

It is no surprise that private investors should want to take over established hospitals. When the cost of building a hospital is estimated at R120 000 a bed, there are obvious advantages in inheriting one with infrastructure.

It is unlikely, however, that the takeover would include major teaching hospitals. Private investors favour smaller provincial hospitals in the 300-to-350-bed range.

Representative Association of Medical Schemes (Rams) chairman Jan Fernhout agreed: "I would think smaller provincial hospitals could be sold to private initiative."

An alternative considered by government is that hospitals remain under present management, but be run on money-making lines.

One issue still to be resolved is that of people who cannot afford private hospital treatment.

Officials say those major hospitals the private sector does not take over will still exist to cater for the needy. Alternatives include a central health fund for those who cannot afford treatment, or the hospitals themselves claiming reduced fees from low-income patients.

Community groups attack LP project

Staff Reporter

THE planned launch of a health programme in Atlantis has earned the wrath of local community organizations, who claim the project is "an attempt by the government and its collaborators, the Labour Party, to obtain some credibility in the strife-torn Atlantis Community".

In a joint statement the Atlantis Residents Association, the Atlantis Youth Congress and the Atlantis Women's Organization, said the name of the health programme, "Give Your Child a Chance", did not reflect LP policy.

The LP had been responsible for closing down schools and its involvement in the tricameral parliament made it jointly reponsible for the detention of children and their treatment at the hands of the security forces.

The launch, which includes a procession and drum majorettes, would be a waste of taxpayers' money when the community was facing serious social and economic problems like unemployment, rental arrears and high electricity and water bills.

Mr John Majavie, parliamentary officer for the Department of Health and Welfare, House of Representatives, denied that the project was politically motivated.

"Give Your Child a Chance is aimed at bringing our health and welfare service down to the community level," he said.

"The Minister (Mr Chris April) is a community man. He is not politically motivated."

He said the launch, which begins at 9.45am at the Saxonsea Civic Centre, was "not a big expense".

Members of the local management committee, the Divisional Council and the Labour Party will speak, two schools will present entertainment programmes and drum majorettes will perform.

Red Cross boots out SA delegates

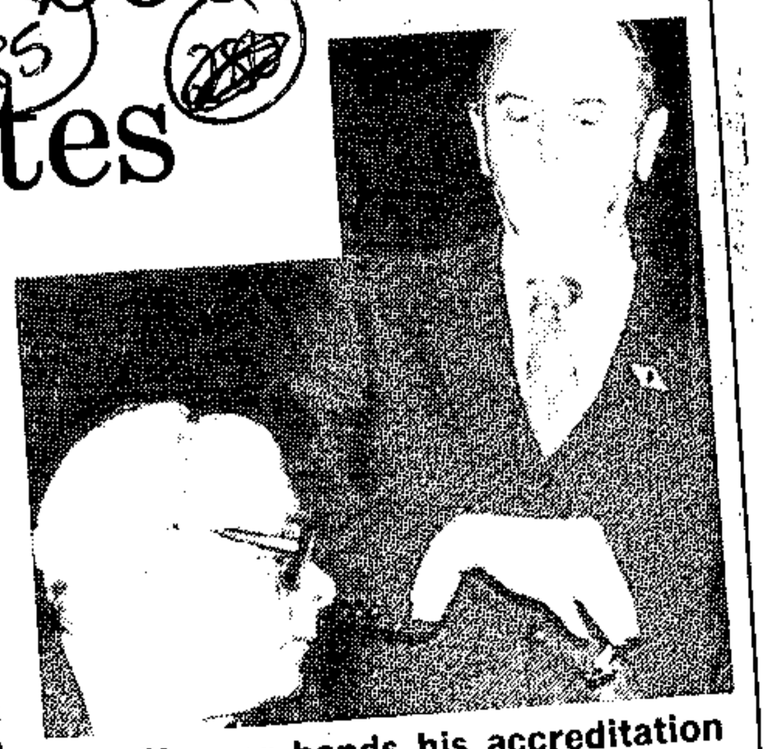
26/10/86
SUN TIMES
$5

A MAJOR International Red Cross meeting voted yesterday to suspend the South African Government delegation in protest against apartheid policies.

The SA Government representative, Mr Jeremy Shearer, ordered out of the conference hall after three days of bitter debate, said the move would send "a message of encouragement to violence".

It was the first time in the history of the International Red Cross movement, which helps victims of war and natural disasters, that a state had been suspended.

About 50 black African and communist countries forced the issue by threatening to walk out of the week-long conference unless Pretoria's delegation was excluded.



Mr Shearer hands his accreditation to conference president Bolliger

Sunday Times Reporter
Geneva

Kenyan delegate Mr Denis Afande, who led the expulsion move, said the suspension should remain in force until Pretoria abandoned apartheid. However, the South African Red Cross Society delegation was allowed to stay.

The conference voted 159 to 25, with eight abstentions, to order Mr Shearer and his colleagues to leave. More than 300 government delegations and non-government national Red Cross and Red Crescent societies were entitled to vote.

Diplomats noted almost half of those delegations refused to join the ballot, reflecting the bitter and divisive nature of the debate.

Many delegates told the conference that they felt they would be condemned, whichever way they voted — either being accused of supporting Pretoria's apartheid policies or setting a precedent which could ruin the Red Cross movement.

Mr Shearer told reporters after the vote: "What I fear is that the message this conference is sending to South Africa is a message of encouragement to violence."

Windhoek branch of Red Cross closes

27/10/86 STAR

The Star's Africa News Service

WINDHOEK — The Windhoek branch of the International Committee of the Red Cross (ICRC) has suspended its operations in Namibia, pending clarification of its future in the territory, according to representative Mr Martin Woker.

The ICRC mission in South Africa was given notice to quit the country in the wake of the weekend decision of the world body to expel the South African delegation.

When Foreign Minister Mr Pik Botha announced the retaliatory measures, however, he said the Transitional Government in Windhoek would be consulted about the future of the Namibian ICRC office, part of the main ICRC delegation in South Africa, which is based in Pretoria.

Mr Woker said that, so far, the Windhoek ICRC representatives had not had any official communication from the authorities in Windhoek about the future of the office here, nor had they yet received written confirmation of Mr Botha's weekend announcment.

The ICRC office in Namibia is comprised of four expatriate workers and five local employees.

Mr Woker said that he was "very much afraid" for the future of the people that he and his colleagues were helping.

Talks on future of ICRC in SA start today

By Sue Leeman, Pretoria Bureau

The International Committee of the Red Cross (ICRC) would do all it could to have its South African mission continue its work, the acting head of the mission, Mr Angelo Gnaedinger, said last night.

The mission's future is uncertain as a result of an announcement by the South African Government on Sunday that it intends expelling the ICRC's representatives. This follows a decision by the international conference of the Red Cross in Geneva to oust the South African Government delegation.

Vital talks between local ICRC representatives and the Department of Foreign Affairs failed to start yesterday and have been rescheduled for today.

In the interim all operations of the ICRC in Southern Africa have been suspended at the request of the department.

ICRC OPPOSED TO EXPULSION

Mr Gnaedinger stressed that the ICRC was completely opposed to the decision by the Red Cross conference in Geneva.

He said the international conference comprised all those states which had signed the Geneva Convention as well as the ICRC, the national Red Cross societies and the League of Red Cross Societies.

The ICRC had not taken part in the voting on the South African issue and believed that the decision taken by the Geneva conference was completely at odds with the conference's constitution.

"The irony is that we are fighting what happened in Geneva and yet we are a victim of it. We are hurt — we have lost a battle," Mr Gnaedinger said.

He said the ICRC was not ruling out any options which may be open. These could include arguing at the Geneva forum that the decision to expel the South African Government delegation was void.

ICRC teams both in Pretoria and Geneva were working on strategies, he said.

● See Page 19.

Red Cross holds urgent talks on SA expulsion

By Sue Leeman, Pretoria Bureau

Top officials of the International Committee of the Red Cross held urgent discussions in Geneva last night after their South African mission had been formally told to leave the country, an ICRC spokesman said in the Swiss capital.

The South African Department of Foreign Affairs yesterday told the ICRC's local representatives that they must leave the country as soon as possible.

The retaliatory move followed the expulsion of the South African Government delegation from the International Conference of the Red Cross in the Swiss capital at the weekend.

Neither the department nor local ICRC officials are commenting on the latest development, and the focus has shifted to Geneva, where the ICRC is looking for solutions.

But an ICRC spokesman said from Geneva last night that he doubted if the conference could be persuaded to change its decision to bar South Africa's Government delegation, even though the ICRC believed the ruling was unconstitutional.

African countries, notably Kenya, lobbied for the expulsion of the South Africans and the decision was ratified by a majority vote.

The ICRC has repeatedly stated that the expulsion of a government which has signed the Geneva Convention is a contravention of International Red Cross rules.

Last night the US State Department endorsed this view, but added that it also regretted the South African Government's decision to send the ICRC representatives home.

Red Cross now has tarnished image

Expulsion will leave 'a huge aid vacuum'

DOMINIQUE GILBERT

SA's decision to expel the International Committee of the Red Cross (ICRC) has not only tarnished the image of the Red Cross but will leave a huge vacuum in terms of funds and expertise used in aid programmes here, Red Cross members say.

The Geneva-based ICRC, active in SA since 1978, may have been seen by government as an unwanted independent organisation working to improve conditions in the country's trouble spots. Its most important functions have been visits to political detainees and work with Mozambican refugees.

Unconfirmed reports suggest that SA security forces have at times violated the Geneva Convention, of which SA is a signatory, by ignoring the Red Cross emblems in black areas during troubled times.

The ICRC is reluctant to comment on this saying it walks a difficult tightrope in which it has to maintain absolute impartiality and neutrality. It cannot be for or against any particular government. Its only interest is dealing with "humanitarian aid" where it is required.

By signing the Geneva Convention in 1952, the international community gave the ICRC a mandate to "take any humanitarian initiative in any country which could be useful in times of civil war or internal strife".

The local Red Cross (SARC) has already postponed major fund raising events pending clarification "of the true situation".

The SARC's dissemination officer, Neil Macaulay, said the Red Cross' image had been "sadly tarnished" by the recent involvement of politics at the international conference in Geneva. The ICRC itself was not responsible for the anti-SA vote in Geneva.

Macaulay said that while the SARC and ICRC work with one another they are separate organisations.

In terms of financial assistance at the Crossroads squatter camps alone, the ICRC allocated about R300 000 this year to assist in aid projects run by the SARC. That was used for 3 260 tents, blankets, food, medicine and other necessities.

While no official figure has been put to it yet, the ICRC has carried a large slice of the financial implications of the work carried out by the SARC, which, by its own admission, has inadequate funding necessary for the extent of its task.

Macaulay said projects already started will not necessarily be halted but funding will be more difficult.

The ICRC has sent an open letter to President P W Botha, denouncing the exclusion of SA from the world Red Cross Conference and urging SA to reconsider its retaliatory measures.

Red Cross to continue work in South Africa

PORT ELIZABETH — The International Committee of the Red Cross would continue its work in South Africa despite the Government's decision to expel its mission, Mr Gurth Walton, national president of the SA Red Cross Society, said yesterday.

Mr Walton was speaking on his return from the International Red Cross conference in Geneva at which the South African delegation was suspended.

The national organisation would have to assume responsibility for refugee relief work. Visits to political prisoners by the ICRC would continue and relief operations into neighbouring countries would not be hindered.

The expulsion of the mission meant the loss of immediate expert advice and guidance in obtaining international funds and equipment in times of disasters and conflict, such as Crossroads.

The Red Cross would continue to receive financial aid from the ICRC. This year, the committee had allocated R1,2 million to a project directed at residents of townships affected by unrest.

"The South African Red Cross delegation had established its credibility and received much sympathy from other delegates. This was largely because of a concerted information campaign before the meeting highlighting the local organisation's work in South Africa.

The ICRC was an all-Swiss organisation whose main role was to police the Red Cross conventions and to provide relief in areas of conflict.

Mr Walton said the chairman of the League of Red Cross Societies, the umbrella organisation for national societies, had bowed to pressure for a vote on the South African Government delegation's attendance.

The Government delegation had been invited as a signatory of the 1949 Geneva conventions.

The ICRC had abstained from the 159-25 vote in favour of South Africa's suspension on the grounds that apartheid was a "crime against humanity." There had been eight abstentions and 55 societies did not take part because they felt the motion was unconstitutional.

Asked whether he felt the Government's action against the ICRC was justified when the body had abstained from voting, Mr Walton said: "I'm distressed at any action which hinders the work of the Red Cross, but as a non-political organisation, I cannot comment on the Government's action." — Sapa.

Meeting in pipeline as speculation grows over ICRC's future in Namibia

The Star's Africa News Service

WINDHOEK — Speculation that the International Committee of the Red Cross (ICRC) will be allowed to remain in Namibia has arisen after the announcement this week that the transitional government in Windhoek wishes to talk to local representatives of the organisation.

The Namibian Cabinet chairman, Mr Dirk Mudge, and the Minister of Justice, Mr Fanuel Kozonguizi, are set to meet ICRC delegates, although no date has been arranged. Neither side is prepared to make a statement on the matter.

The ICRC in South Africa has been given until the end of November to quit the country, after Pretoria's retaliation against South Africa's expulsion by the international body.

When the South African Minister of Foreign Affairs, Mr Pik Botha, announced the measure, he said the transitional government in Windhoek — which has a large measure of autonomy — would be consulted over the future of the ICRC in Namibia.

HUMANITARIAN

The official transitional government statement said that the Windhoek Cabinet wanted to appraise itself of the exact role played by the ICRC in Namibia.

An ICRC spokesmen in Windhoek, who earlier this week spoke freely to the Press before being ordered to refer all queries to Pretoria and Geneva, said organisation was involved in a number of important humanitarian programmes, including work among security detainees.

Since 1981, when the ICRC office in Windhoek was set up, representatives have provided material and moral support for detainees and their families.

ICRC representative in Namibia, Mr Peter Lutoff, has said it is difficult to get a true picture of the Namibian conflict because of lack of information.

Before the suspension of its activities in Namibia, which came after Mr Botha's announcement, the ICRC's Windhoek office was running a programme for thousands of Angolan refugees, who had settled in northern Namibia.

Many of these people have not seen their Angolan relatives for years, and the ICRC is running an important tracing operation to put them in contact with their families.

The refugees are also in need of food and clothing, which the local ICRC operation helps provide.

The international body also works closely with the Namibian branch of the South African Red Cross Society helping to provide drought food aid for parts of Namibia.

The organisation has a total of nine employees in Windhoek, four of them expatriates.

AHOL

ICRC trod on toes

DOMINIQUE GILBERT

THERE is an increasing belief that government's decision to expel the International Committee of the Red Cross (ICRC) was linked to the organisation's attempts at resolving township conflict and gaining wider access to political detainees.

In its endeavours to gain credibility with all sides in township conflicts — from the authorities to the so-called comrades — the ICRC has sent numerous reports to the authorities and has been involved in talks with other affected groups.

ICRC workers have tried to set up forums for dialogue in a bid to prevent conflict.

They have been trying to negotiate with the authorities for access to all political detainees, particularly those denied access to lawyers, and more recently, to all State of Emergency detainees, immediately after their incarceration and on a regular basis after that.

Allegations by detainees of torture and abuse are said to have been made most often about their first hours and days under detention.

The ICRC has aimed at all times at maintaining an independent, neutral, impartial and unpolitical stance based solely on humanitarian grounds.

Because of this, ICRC officials, who are in the process of packing before their November 30 deadline, have declined to comment.

However, they said they hoped to release a broad statement before their departure on what they had tried to achieve in SA.

Since 1964, 14 years before the ICRC established a permanent delegation in SA, the Geneva-based organisation has been permitted to visit only convicted security prisoners and administrative detainees held under Section 28 of the Internal Security Act.

They have visited more than 300 such prisoners each year on a constant basis. At present there are no Section 28 detainees.

The ICRC's most important function in SA has been in the townships, in conjunction with the SA Red Cross (SARC). Their programmes have included development of Red Cross organisations in the townships.

First aid and disaster relief programmes have been carried out mostly by the SARC.

The ICRC's functions appear to have been aimed at a preventive rather than an operational role, although an important function has concerned the problem faced by injured who either don't dare go to hospitals for fear of reprisals by the authorities or do not have transport.

Observers agree that, as more and more restrictions are placed on the reporting of township unrest and security force counter-actions, the Red Cross has a crucial role to play. They also have a hard act to follow.

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BUSDAY

85

Major recommendations are accepted

Govt to do about-face on health service role

LACK of a central policy direction in SA's health system has led it to cater for expensive secondary and tertiary health services at the expense of preventive and primary health care.

The government, in a White Paper on the Browne Commission of Inquiry into Health Services released yesterday, said 65% of its total health services went on cost-intensive curative services with only 4,7% on preventive services. This trend would, however, be reversed.

The commission, appointed in 1980, finished its inquiry into the country's health services in March.

Recommendations made by the commission it was appointed in 1980 and finished its inquiry in March — and accepted by government include:

☐ A system of accreditation for private hospitals and unattached operating theatre units;

DIANNA GAMES

☐ The curbing of excessive and unnecessary use of medical aid services by disincentives;

☐ Establishment of a central coordinating pharmaceutical authority and the revision of the state's system of buying, storing and distributing medicines;

☐ Special assistance for trained black pharmacists to enable them to start retail pharmacies in black townships;

☐ Privatisation of patient transport services with emergency public ambulance services made available to all races on a 24-hour basis;

☐ Introduction of "catastrophic" medical aid cover in addition to the minimum service already offered — for example for cardiac surgery;

☐ Compilation by the Medicine Control Council of a list of generic equivalents it considers therapeutically equivalent to the original product. Only those appearing on the list should be eligible for substitution;

☐ Re-introduction of subsidised hospitals as a method of community involvement in the health-care system.

Recommendations not accepted by government include the marketing of medical insurance packages and greater flexibility in setting benefit levels.

The commission recommended that private hospitals set a comprehensive, all-inclusive tariff.

Government suggested that tariffs be set on a treatment/procedure/time basis instead of an item basis, and that the number of items that could be charged for be limited.

Minister of National Health and Welfare Dr Willie van Niekerk said in Pretoria yesterday that profiteering by private hospitals had been alleged but was not being investigated.

● See Page 6

BUSDAY 6/11/86 85

Way clear for publication of SA health plan

THE Cabinet has cleared the way for publication of a draft White Paper which provides for a comprehensive restructuring of SA's public health services, bringing them into line with the tricameral framework.

The aim is to provide more centralised control over health-care services, reducing racial fragmentation in the use and operation of these services, and offering the private sector a more meaningful role within this industry.

CHRIS CAIRNCROSS

The White Paper forms the basis of government's response to the Browne Commission's investigation into and report on SA's health services. Both are to be released at a Press conference on November 26.

A central feature of the proposed national health plan is an apparent amalgamation of the functions of the Department of Health with those of the provincial health services.

The aim is to create an umbrella National Health Policy Board (NHPB), chaired by National Health and Population Development Minister Willie van Niekerk.

Members of the NHPB will include the three Ministers of Health and Welfare in the tricamarel Parliament. They will be assisted by an advisory committee made up of departmental chief directors, the Surgeon-General, and other as yet unspecified appointees.

Sullivan Code firms 'show lack of interest'

A SOUTH African publisher has accused some Sullivan Code companies of being "more interested in their ratings than helping blacks" — and has appealed to the Rev Leon Sullivan for help in launching a self-help project.

The project — a health-care booklet aimed at educating blacks in basic health practices — has been approved by the local health "task force" of the Sullivan signatory companies.

It gave the go-ahead to a Johannesburg publishing company to solicit funds from the individual Sullivan signatories to produce the 150-page "SA Home Health and Hygiene Manual" — priced at R3.

Angered

To cover its costs, the publishers need to print at least 100 000 copies. And they have sent out more than 500 requests for funds, including personal approaches to the Sullivan companies.

But Mr Robert Wilson, a director of the company, Postcript Publishing, said this week: "The response has been disappointing. So far we have had only two positive replies and a number of blank refusals.

"The publication has to be completed this year to avoid

By DAVID JACKSON

substantial print price increases — but nobody really seems to care."

The lukewarm response from Sullivan Code companies has angered the publishers. They say the project is a practical example of how money could be properly spent to uplift blacks.

In a letter to Mr Sullivan, Mr Wilson wrote: "The prevailing concern seems to be more with the amount of points obtained in the Sullivan scoring system rather than in ensuring that actual benefits reach the people who need them most."

21/11/86 · FIN MAIL

THE SOUTH AFRICAN RED CROSS

FEATURE

Staying neutral

The imminent departure of the local delegation of the International Committee of the Red Cross leaves the SA Red Cross (Sarc) to carry the movement's local banner. But the Sarc will have to tread carefully to maintain the traditional image of neutrality.

After the destruction of Crossroads, the national Sarc stepped in to provide emergency shelter for the thousands of homeless. Constitutional Development and Planning Minister Chris Heunis told them to pitch the tents at Khayelitsha.

On the surface this was a reasonable enough request. But Crossroads squatters have long resisted being resettled at Khayelitsha and the burning of the squatter camps was perceived as a way to force them to move. Compliance by the Sarc would have shattered the non-political, impartial image of the organisation with the community. Following behind-the-scenes lobbying by the local delegation of the International Committee of the Red Cross (ICRC) the tents finally went up on the more neutral terrain of church grounds. This is the kind of event that a member of the ICRC delegation had in mind when he described the need to always remain neutral as "walking on a razor-sharp knife."

Ironically, it has taken the departure of the ICRC to make its presence known. Most of the members, who are all Swiss nationals by law, are already back in Geneva. The task of closing their office, a house in Church Street, Pretoria, before the November 30 deadline falls to delegation leader Michel Mordasini and his deputy, Angelo Gnaedinger. The house is not up for sale — yet. "The presence of the delegation has only been suspended," says Mordasini. "We still hope to return."

The decision to expel the ICRC came after the South African government delegation was ejected from the 25th Conference of the International Red Cross. All signatories to the Geneva Conventions, including SA, are entitled to participate in the four-yearly meeting. Other participants are drawn from the ICRC, the umbrella League of Red Cross and Red Crescent Societies, and the 144 national Red Cross and Red Crescent societies.

The main task of the ICRC is to support the observance of the Geneva Conventions and they operate only in war zones or countries where there is internal strife. Normally, the national societies concentrate on education and aid following natural disasters, but extend their work in times of conflict.

The ICRC has been here permanently since 1978 although it first began to visit political prisoners in 1964. At the time of its eviction it had access to only two categories of prisoners: sentenced security prisoners and Section 28 (Internal Security Act) detainees. Over the past few years it has negotiated, unsuccessfully, to gain the right to visit detainees held under Section 29. This covers indefinite detention for interrogation purposes, detainees awaiting trial, security prisoners condemned to death, persons convicted of public violence in connection with the internal disturbances, and all State of Emergency detainees.

The work of the ICRC is well known to families of sentenced prisoners who receive monthly food parcels and payment for a monthly ticket to visit their imprisoned relatives. For those travelling from Johannesburg to Robben Island, for example, the amount is substantial. This now ends as the ICRC funds only projects operated in an area where a delegation is present to monitor the funds. Likewise, material assistance for the Mozambican refugees in Gazankulu and KaNgwane will cease.

A fair amount of their time here has been spent informing all parties, from the South African authorities to black political groups of all persuasions, about the role of the Red Cross. A point they have been trying to hammer home is the international protection of the Red Cross emblem as a sign of impartiality and that its bearers provide relief for all casualties.

Probably the most important undertaking the ICRC will leave behind is the Community Organisers project. While this is officially a project of the Sarc, the ICRC was involved in establishing it and in the funding.

The project grew out of concern about the growing political conflict and criticism both here and abroad of the Sarc. A few years ago the Sarc was fast gaining the reputation as a whites-only organisation, which was failing in its duty to be impartial and to provide services where they were needed — the Red Cross emblem was conspicious by its absence in the troubled townships.

A total of 46 community organisers have already been recruited and trained. They are based in the townships and are working to expand the activities of the Red Cross through education, recruiting volunteers, setting up first aid centres and training township residents in first aid. Increasingly, people injured in township violence are becoming reluctant to go to state hospitals for fear of being detained. First aid workers in the townships offer an alternative — possibly without government approval. This has lent support to the theory that the expulsion was more than a mere tit-for-tat for the expulsion.

The project is still in its infancy — the first community organisers began working early this year. According to an ICRC delegate, who cannot be named, the most significant breakthrough during this time was in March during the troubles in Alexandra when more than 20 people were killed.

Sasolburg industry says reports on children's lungs 'exaggerated'

STAR 24/11/86

By James Clarke

Industry in Sasolburg is planning a counter campaign against the Press for recently publishing a medical report saying Sasolburg's air pollution was affecting children's lungs.

In a closed meeting with top government officials at the chemical town's fire station — organised by National Petroleum Refiners (Natref) — the Press was accused of "extracting from the report what they considered a good story irrespective of the bad publicity on the town and its industries".

MINUTES SENT

The minutes of the closed meeting held on October 28 — a month after Press reports appeared — have been sent anonymously to The Star's CARE campaign.

Originally, the facts appeared in the *SA Medical Journal*. The health conclusions were drawn from data collected by the Government's Department of Health.

But at the fire station meeting the department's chief air pollution control officer, Mr Martin Lloyd, apologised to the industrialists for not warning them that he had ordered the survey. He agreed with them that the medical report was "unscientific".

The Star and other newspapers last September reported that Professor A M Coetzee of Pretoria University had written in the *Medical Journal* that Sasol's air was affecting public health "particulary" people's respiratory systems.

The town council immediately said the findings were "exaggerated". But local doctors and mothers, interveiwed by The Star, supported the findings. One doctor said there was no doubt that children's upper respiratory tracts were being affected.

According to fire station minutes (received by The Star over the weekend) in apologising to industrialists Mr Lloyd said he considered the Journal of Medicine's report "unscientific", but said Professor Coetzee was denying his report "lacked scientific reliability".

Mr Lloyd told the industrialists that he believed the reason Sasolburg's children's lungs functioned differently from those in rural area was "not to be related to air pollution (but) rather to inherited characteristics".

Mr Lloyd said airborne sulphur levels were definitely going down in the area.

Two representatives from the CSIR who attented said they would help industry in its campaign to counteract the bad publicity by providing a "statistical reworking of existing results" (presumably because they consider Professor Coetzee misinterpreted the findings).

SHOULD BE APPLAUDED

Mr Geoff Craig, a spokesman for the Gas Cleaning Association (an association of clean air equipment producers) told me: "What a pity they all feel they have to be defensive.

"Those behind the survey should be applauded for at last getting down to surveying and publishing data about air pollution's effects on health. That's what it should all be about in the Department of Health.

"What a pity industry did not immediately react by supporting more searching research among the region's doctors. There is nothing unscientific about surveying doctors."

● Recently the Department of Health startled Escom by insisting on ultra-strict clean air standards for its new Letaba power station. I was told the reason was that the Vereeniging/Vanderbijlpark/Sasolburg region's air pollution had reached a level where "the slightest addition to the pollution load would be critical".

Major faults found with SA health care

PRETORIA — Major shortcomings in South Africa's health services, which include fragmentation of control and a lack of central policy direction, have been identified by the Browne Commission of Inquiry.

The major findings and recommendations of the commission, which was appointed in 1980 and finished its inquiry into the country's health services in March this year, were released in Pretoria today together with a White Paper in which the Government set out its general policy framework.

The Browne commission found that "there has been an under-emphasis on preventive and primary health care up to now, while there has been an over-emphasis on expensive secondary and tertiary health services.

This was a situation "inappropriate to the needs of the South African population in general".

While SA health services "compare well in many respects with those in other countries, there are nevethless many major shortcomings.

"There is an excessive fragmentation of control over health services and a lack of central policy direction."

It recommends consideration be given to the possibility of placing all provincial and State hospitals under one central authority and placing administration on a business footing.

The Government agrees that "cost effectiveness must receive a high priority" but replies to the central authority issue with the statement that: "Delegated provision of services in respect of hospitals will be undertaken within the total health plan by provincial administrations, also as agents for other authorities."

In its White Paper response to specific shortcomings pinpointed by the Commission, the Government acknowledges the problems and outlines its programme to solve them.

At the same time it points to the economic realities of South Africa, social and physical development demands, and the increasing population.

It warns that, as a result of these factors, the gap between funds available for health services and the needs of the population might widen.

The Commission recommends the Government should draw up and publish a National Health Policy setting out the broad framework of the health system it will seek to establish.

The National Plan for Health Services Facilities (adopted by the Cabinet in 1980) and which the Commission "wholeheartedly supports" could serve as a basis for this.

The Government believes that the way in which the various health authorities are financed is one of the factors that have given rise to the problem of fragmentation, lack of central policy direction and the resultant imbalance between primary and secondary health serives.

A total of 65% of its total expenditure on health serices is spent by the provincial authorities on cost-intensive curative services.

In practice, these services enjoyed a position of priority and the urgent demand for them imposed a strain on the financial resources of the State.

"In contrast, about 4,7% of health services budgets is applied to preventive services which, if provided and used to the optimum, could very cost-effectively reduce the need for curative services to a large extent."

According to the White paper the Government "has therefore decided to take steps with renewed force and vigour to secure a balance between curative and preventive services, hospital and community centred services, and between facilities for the provision of primary, secondary and tertiary care." — Sapa

27/11/85 · 85 SIVAC

ICRC spells out its attitude to SA's expulsion

By Sheryl Raine

The International Committee of the Red Cross (ICRC) has spelt out its attitude towards the expulsion of the South African Government delegation from its recent conference in Geneva.

In the November issue of its official journal, *Bulletin*, the ICRC made it clear it shared the feelings of African countries concerning apartheid but noted that "to be neutral for the Red Cross is not a passive and easy attitude to have".

The ICRC indicated it believed the work done at the conference and its achievements would far outweigh the crisis of the South African expulsion.

Although ICRC had not wanted to take part in a vote which resulted in the suspension of South African partcipation in ICRC work, because it considered such a move contrary to its statute of neutrality, the organisation was caught in a dilemma.

The editorial quoted Red Cross president Mr Alexander Hay on the issues which the organisation had to consider at the conference: "What the ICRC upholds in this matter is, on the one hand, the universality of international humanitarian law and, on the other hand, the respect of the rules and procedures of this conference."

The editorial said: "Although the question of the suspension of the South African Government delegation deeply affected the spirit of participants and delayed for over two days the start of the commission's work, the conference succeeded in accomplishing the tasks for which it had been convened.

"All the resolutions — more than 30 — were adopted by consensus, including those concerning respect for international humanitarian law in armed conflicts. The draft of the new statutes, prepared by the joint ICRC/League working group, was also adopted by consensus.

"For the movement as a whole, these positive results will doubtless outweigh the rest when it comes time to take stock."

In a separate article on the front page of the Bulletin, the ICRC reported it had been expelled from South Africa and would make every effort to resume its humanitarian work there.

Manufacturer defends skin lighteners after banning bid

SKIN lighteners are manufactured in SA in accordance with strict health regulations, says a large manufacturer in the R25m-a-year industry.

This comes after the Black Consumer Association and the SA Retail Pharmacists' Association called for a ban on skin lighteners.

It also follows a study published in a US medical journal this year which showed the irreversible skin disease ochronosis — a coarsening of the skin resulting in coalescent papules — was widespread among SA blacks who used skin lighteners.

The study found that up to 30% of outpatients in a dermatology department for blacks at Pretoria Hospital requested treatment for ochronosis, after using skin lighteners containing

NORMAN SHEPHERD

hydroquinone for an average of three years.

But Twins Products GM Ian Ellis said Twins' studies showed fewer users of skin lighteners were being treated for ochronosis since the law limited hydroquinone content to 2%.

He said the figures published in the US journal went back about three years — when the skin-bleaching hydroquinone agent made up 6% or 7% of many products.

Ellis said problems arose when people used lighteners with strange substances or used too much. To combat this, the industry had embarked on a campaign to educate users.

Govt backs down on Red Cross

IN A sudden about-turn, government yesterday backed down on its decision to expel the International Committee of the Red Cross (ICRC) and said it would allow the organisation to stay in SA.

The decision to stop ICRC activities in SA followed the ousting of SA from the 25th international conference of the Red Cross in Geneva.

The reversal of the decision follows a

THELMA TUCH

letter — dated November 18 — from the ICRC to President P W Botha.

The letter emphasised that the ICRC dissociated itself from the decision taken to suspend SA's right to participate in the recent international Red Cross conference.

out paying a R136 bill.

meant by the reference in the

Mr F Raymond prosecuted.

All medical staff 'under pressure', say top profs

By CHRIS ERASMUS

IT IS wrong to think that only interns are under enormous work pressure in South Africa's hospitals, according to the deans of two of the leading medical schools.

They said senior medical staff, up to and including professors, had also felt the severe effects of the freeze on new appointments compounded by burgeoning workloads.

Professor George Dall, Dean of the Medical Faculty at the University of Cape Town Medical School and a member of the executive of the SA Medical and Dental Council (SAMDC), and Professor H P Wassermann, Dean of the Medical Faculty of the University of Stellenbosch Medical School, were discussing the report on intern training by Medical Research Council, published this week, in which interns were described as overworked and undersupervised.

"It is essentially fair," said Prof Dall. "But I think it's wrong to particularly single out interns as suffering from an excess workload. Everybody working in our hospitals is suffering because, in the present economic environment, we have not been able to appoint more staff to deal with the ever-increasing workload.

"However, it is true that the situation as it affects interns has concerned the council for some time — in fact a sub-committee was appointed to look into intern training at least six months ago when it became known to us what the MRC report would be saying.

"To improve the supervision of interns during their training it has been decided to advertise for an intern supervisor or supervisors for all hospitals in the country where interns are under training. These appointments should be made very soon."

Prof Wassermann said the report was essentially accurate in pinpointing intern training problems and said that its contents were "not surprising".

"Teaching hospitals have for some years been worried about the loading of staff with increasing workloads to the detriment of research and teaching activities."

Professor Dall said that the council "is looking very carefully at the whole question of proper training for interns and trainee doctors".

Soaring heart costs stressed

WEPost 29/11/86

By YVONNE STEYNBERG

MEN over the age of 60 should step up their medical cover as they have reached a time in their lives when they could face massive bills for cardiac surgery not covered by medical aid.

The increased costs of surgery — already as high as R20 000 — have been stressed by medical aid societies, medical experts and cardiac specialists.

The highest risk factor is among white males over 60, many of whom may have retired from firms where they were covered for medical costs.

Most medical aids do not cover costs for cardiac operations in private hospitals, where many operations are performed.

Dr A Bosman, head of the department of medicine and physician in charge of the cardiac section of the Provincial Hospital, Port Elizabeth, said it was an excellent idea for medical aid societies to start drawing attention to the need for providing additional cover for cardiac operations.

"In Cape Town the costs could be anything from R15 000 to R18 000 in a private hospital, depending on the length of stay and treatment, and in Johannesburg it would be more," he said.

He said the two provincial hospitals in Cape Town often had waiting lists and patients forced to go to a private hospital would have to bear the additional costs themselves if they were not covered by medical aid for such an emergency.

"A waiting period is, of course, extremely dangerous for a patient with severe cardiac problems, as thrombosis and many other factors can complicate conditions," Dr Bosman said.

He confirmed that the high risk group was white males aged about 65.

Dr Bosman said the Provincial Hospital's recently opened cardiac section had three or four beds.

They had to serve all cardiac operations, including bypass and heart valve operations, and treatment of congenital heart disease.

A spokesman for a major medical aid society in PE said his organisation was negotiating with firms to introduce a higher medical aid cover for cardiac surgery.

He knew of a case of a man who had recently retired and had to have a bypass operation.

Because of the waiting list in Cape Town, he had to go to a private hospital where his bill was already about R14 000.

Provincial Hospital superintendent Dr L Cilliers said that depending on the length of stay of a patient, provincial hospital costs for a cardiac operation could be about R3 000 to R5 000.

But if a person was poor and needed such surgery, the cost could be as low as R50.

This showed that patients in the middle income group would suffer if they were not covered for such operations.

The Browne Commission's White Paper recommended that the introduction of "catastrophic" medical aid cover in addition to the minimum service already offered, should be increased, and cardiac surgery was specifically mentioned.

FM MARK 5/12/86

BROWNE REPORT

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Unsuccessful op

Six years ago, the Browne Commission of Inquiry was given the "urgent" task of investigating SA's health services. Last week the, admittedly voluminous, report with accompanying White Paper (WP) was finally released.

The recommendations were so long in the making that the medical profession had wearied of it all and come to expect little of consequence from it. In the event, the medical men were correct because, as Progressive Federal Party (PFP) health spokesman Dr Marius Barnard puts it, the WP is a non-event.

Broadly, the commission looked into the cost and rationalisation of health services, privatisation, provision of State health, personnel, pharmaceutical services and medical schemes.

But Barnard points out that most of the major recommendations, like the National Health Plan, have already been implemented. He says other important aspects were ignored and one of his main criticisms is that the commission did not address itself to the costly duplication of services along racial lines.

The WP endorses the National Health Plan launched in September. While this plan centralises the control of health services under one ministry, health matters are being revamped in accordance with the tricameral constitution's "own" and "general" affairs split (*Current affairs* September 5).

One of the commission's recommendations rejected by government was that all provincial and State hospitals be placed under one central authority. But in terms of the National Health Plan, hospitals are currently being allocated along ethnic lines to the "own" and "general" affairs administrations.

Nor does the WP offer any clarity on government's stated intention to privatise health services.

Another key recommendation rejected is the need for flexible medical aid cover. The Representative Association for Medical Schemes (Rams) has long been pushing for a more flexible arrangement whereby members could buy various medical aid packages. This could include anything from total cover to an optional "excess" with subscriptions adjusted accordingly. The WP thus closes the door to innovations such as low or no claim bonus schemes.

The rationale behind government's decision to reject what the medical aid schemes have long wanted was that it would subvert attempts to privatise health care. Government claims that if people were given the option they would not use it and the State would be left to look after those who had not insured themselves.

More acceptable to medical schemes is the recommendation that private hospitals move to an all-inclusive daily tarrif rate. Rams' Tony Leveton says it would ease administration and avoid the fragmentation of accounts. In terms of this scheme, says Leveton, rates are calculated on the basis of the diagnosis or ailment being treated. It has been tried in the US with some success.

But it is not as simple as it appears, he warns, and needs to be worked out very carefully.

Lower standards

Clinic Holdings MD Barney Hurwitz, however, says such a scheme would lower standards and eliminate patient choice — a view endorsed by Barnard. One example: there is a range of heart valves available, some better and more expensive. Under a tariff arrangement the tendency would be to use the cheaper varieties.

Medi-Clinic Corporation MD Edwin Hertzog says US experience of the technique has been mixed "due to factors such as enforced shortening of hospitalisation and false diagnoses."

He adds, however, that Medi-Clinic has no serious objections provided it is worked out on a realistic cost basis in conjunction with the private hospital industry. He questions, however, whether it is worth implementing because he feels greater flexibility in medical scheme cover is needed before patients will take advantage of "cost-beneficial usage of hospitals."

Overall, the hope was that the report and WP would help settle the differences which have emerged in the medical field over the past few years. As medical costs have risen and the different parties have set out to protect their financial turf, the health services have become something of a battleground in need of clearing.

Regretfully, the WP will do little to help solve the conflict.

The *FM* has been edited to comply with the emergency regulations. Information may therefore be distorted, incomplete and misleading.

RSCs countdown to early-1987 start

Final word on health role still awaited

Business Day Reporter

THE role that Regional Services Councils (RSCs) will play in the provision of health services has still not been finalised — although they are scheduled to come into operation early next year in some areas.

National Health and Population Development Community Services Acting Director Dr Pieter Henning said: "RSCs are still in a development phase.

"The role they will play in health services will become clear as the whole investigation progresses and as soon as they become functional."

Henning said a report had been compiled on how health services would fit into the new constitutional dispensation, and this would be submitted to the Commission for Administration in the new year.

Dr Rassie du Plessis said on behalf of the commission — which is responsible for the devolution of powers under the new system — "We haven't given a thought to what services are to be handed to the RSCs."

National Health and Population Development Health Services chief director Dr Jacobus Roux said, in the latest edition of *Local Government in Southern Africa*, RSCs and established local authorities would be expected to deliver an all-embracing curative and preventative service.

He said: "The services must be self-sufficient using local financial sources while subsidies will soon be phased out."

There would be privatisation of curative health services delivered to wealthy patients.

Roux said: "Rationalisation will be absolutely necessary to prevent unnecessary duplication and to guarantee optimum health services for all population groups, to maintain minimum health standards and to deliver services at a reasonable cost.

"Together with the curtailing of public sector expenditure, a limitation of the extent of services will necessarily follow."

The State's role would be to take responsibility for ensuring necessary health services complied with minimum standards, for formulating a general health policy and to guarantee necessary preventative services such as immunisation were delivered.

At the local community level, the private sector would have to contribute to the erection of community health centres in partnership with the State.

Hotel figures disappoint

Business Day Reporter

OPTIMISM from the rise in hotel occupancies in September will be tempered by October figures.

Fedhasa operations director Fred Thermann says new figures are disappointing.

October's room occupancy figures are 3,8% lower and bed occupancy figures 2% down on last year.

Only Pietermaritzburg (8,7%), Port Elizabeth (6,4%), Boland (3,2%) and Cape Town (0,1%) show increases in room occupancies.

The Garden Route hotels show the biggest drop (14,8%), with the Natal South Coast (10,1%) and Johannesburg (8,2%) not far behind.

The 24,3% drop in inflation-adjusted real income for Johannesburg shows the extent of price slashing in the city, Thermann says.

Room occupancies for the year ending October 1986 reveal steady declines. Compared with the previous year, five-star hotels show decreases of 11,5%, four-star hotels of 10,5%, three-star hotels of 8,5%, two-star hotels of 6,2% and one-star hotels of 1,5%.

Govt 'agrees' with most of Browne

STAR 27/11/86 (85)

Staff Reporters

The Government has agreed with most of the findings of the 1984 Browne Commission Report on health care services and has already implemented a number of the major recommendations, says the Minister of National Health and Population Development.

The commission, which began its work in 1980, conducted a broad investigation into the rationalisation of health services, scrutinising aspects such as personnel, pharmaceutical services, medical schemes and local and state health care. Privatisation was also dealt with.

The Government has now issued a White Paper, which it published in Pretoria yesterday.

At a Press conference, Minister of National Health and Population Development, Dr Willie van Niekerk said the White Paper was not a new health care plan, but the Government's response to the Browne Commission study.

Many of the commission's recommendations had already been put into effect, he said, and a number of others had been referred to the relevant health councils.

One pivotal finding which has already been implemented is the commission's call for a national health policy.

In August this year, the department launched a comprehensive national health policy, under the control of the National Health Policy Council.

With the publication of the White Paper, the Government has also now committed itself to taking steps "with renewed force and vigour" to rectify the imbalance between curative and preventive health services pointed out by the commission.

The commission also found that secondary and tertiary health care in South Africa had been overemphasised — to the detriment of vital preventive and primary care services. This created a situation which was "inappropriate to the needs of the South African population in general."

This finding too, would receive attention, the Government said.

The main points

Some other major findings of the commission:

● That there is an over-concentration of health personnel in urban areas and that the ratio of coloured, Indian and black medical personnel in relation to their communities is relatively low. Most qualified nurses are found to be no longer practising and the ranks of student nurses are growing very slowly.

The Government said attention had already been given to the recruitment, training and salary structures of personnel and the status and qualifications of nurses and supplementary health care staff. A new dispensation has been implemented on September 1.

● That there is a lack of medical statistics. The Government agreed in principle that local authorities should keep population statistics and said it had instructed the professional councils to compile annual data about registered members.

● That medical schemes should have greater flexibility in setting benefit levels. The commission said this left the way open for medical schemes to discriminate between types of treatment, medicines and services.

However, the Government said privatisation of medical health services could be seriously hampered if medical schemes are allowed to market different medical insurance packages, for example, only "catastrophy cover".

● That medical schemes should set up insurance schemes to cover additional medical costs.

Red Cross charities could suffer from SA's expulsion

Many people have blamed the International Committee of the Red Cross for SA's expulsion from a recent Red Cross conference. ICRC president Alexandre Hay and his committee members have been accused of jeopardising the organisation's purported neutrality, and it may suffer financially as a result. Hay also makes it clear he won't allow the Red Cross to be split into those for and against SA's continued membership.

Own Correspondent

GENEVA — Alexandre Hay, president of the International Committee of the Red Cross (ICRC), is a bit sensitive these days, and with good reason.

In the time since SA was expelled from an International Red Cross conference, hundreds of letters have landed on his desk blaming him and his all-Swiss committee members for endangering the neutrality, impartiality and universality of what is supposed to be the world's most neutral, impartial and universal organisation.

He is more than a bit anxious, too, because most of the letters threaten never to give another cent to Red Cross charities.

He is somewhat annoyed, as well, because he and his colleagues on the committee in Geneva did all they could to prevent the expulsion. They regarded it as a major mistake, and said so loudly — but in vain.

Hay took the unusual step, for a man famous for his reticence, of giving a personal interview to try to reassure the many Red Cross workers across the world that his organisation had not fallen into the hands of the politicians — nor would it in future, he implied.

Much of the anger expressed in letters to Hay and the ICRC centres on the belief that SA was ousted from the Red Cross, and with Red Cross complicity. It was not, Hay stressed.

The SA Red Cross is still a recognised member of the movement.

SA to be invited

The SA government was suspended from the 1986 conference by African, Arab and Soviet-bloc governments and Red Cross societies. But SA would be invited to the next conference, scheduled for 1990, Hay said.

Won't the same people take the same action and throw SA out again? Hay made it clear such a public split would not be permitted again.

"We have to find a solution so this doesn't happen again," he said in the interview, adding, significantly, "even if we don't have another conference again for a certain number of years."

There is no question that divisions remain between the Western nations and Red Cross leadership (which see the ousting of SA from the conference as a major political error) and the East bloc and African nations (which say SA should have been expelled long ago).

It would be possible, Hay said — indeed, it might be a requirement — for the Red Cross to delay its next conference until apartheid is no longer an issue.

Couldn't that be a very long time? Hay replied obliquely that, on the other hand, the conference could be made strictly a Red Cross affair, without the presence of governments, which have a natural bent to link humanitarian work with politics.

The Red Cross movement is made up of Hay's all-Swiss committee, which works only in conflicts and internal strife; the parallel League of Red Cross and Red Crescent Societies, which deals with natural disasters such as earthquakes, droughts and hurricanes; and the individual national societies that carry out much of the work of the League and assist the committee.

It was a conference of all these groups, over which the committee headed by Hay and the League had little power with their single, individual votes, that expelled SA.

Public reaction has been felt by the Red Cross where it hurts most. Most of the protesting letter writers pledge they will never again contribute to an organisation they now regard as sullied with the same sort of politics that has afflicted the United Nations for years.

HEALTH & DISEASE - GENERAL

1987

FEB. - ~~SEPT~~ DEC -

Site	*Summer 85/86*	*Winter 86*
Foreshore	20	24
Epping Market ...	20	24
Paardeneiland ...	20	25
Salt River	10	15
Greenpoint	10	20
Tamboerskloof ..	5	10
Edgemead	10	15

The accepted maximum allowable concentrations for the aforementioned pollutants are:

(a) Lead: 2.5 micrograms per cubic metre (monthly average).

(b) Sulphur dioxide: 80 micrograms per cubic metre (annual average).

(c) Particulates: 100 micrograms per cubic metre (annual average).

Family planning advertising

529. Mr A B WIDMAN asked the Minister of National Health and Population Development:

What was the cost of the State of family planning advertising in the 1985-86 financial year?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

R2 142 000.

Mixed marriages

530. Mr L F STOFBERG asked the Minister of Home Affairs:†

(a) How many mixed marriages between (i) Whites and Blacks, (ii) Whites and Coloureds and (iii) Whites and Indians have been entered into in the Republic since the repeal of the Prohibition of Mixed Marriages Act, No 55 of 1949, and *(b)* in respect of what specified period is this information furnished?

The MINISTER OF HOME AFFAIRS:

(a) and *(b)*:

Period: 19 June 1985 to 30 June 1986 (end of reporting period)

(i) Whites and Blacks—10

(ii) Whites and Coloureds—352

(iii) Whites and Indians—89

Period: 1 July 1986 to 29 January 1987

(i) Whites and Blacks—8

(ii) Whites and Coloureds—171

(iii) Whites and Indians—43

Group Areas Act

531. Mr L F STOFBERG asked the Minister of Justice:†

How many prosecutions were instituted by the State in each specified year from 1 January 1976 to 31 December 1986 on account of contraventions of the Group Areas Act, No 36 of 1966?

The MINISTER OF JUSTICE:

The information is only readily available for the following years:

1984—0
1985—1
1986—4.

Deaths as a result of injuries

532. The LEADER OF THE OFFICIAL OPPOSITION asked the Deputy Minister of Information:

Whether any persons reported by the Bureau for Information to have been injured since 12 June 1986 have subsequently died; if so, *(a)* how many, *(b)* in which area did each death occur, *(c)* what were the circumstances surrounding the injury and subsequent death in each case and *(d)* in respect of what date is this information furnished?

The DEPUTY MINISTER OF INFORMATION:

The authorities concerned do not keep a record of the subsequent history of all persons who are injured or wounded. After people have been treated and discharged (and are not required for further judicial investigation) further follow-up work is not carried out in all cases. The monthly statistical reviews released by the Bureau are compiled two weeks after the end of the month concerned, so that people who were initially seriously injured and later died can be reflected in the review. The two week period also gives scope to verify all the other unrest data of the previous month, so that the Bureau's monthly review contains only accurate, tested information.

(a) to *(d)*. The information as requested in the question is thus not readily available and would require an unreasonable degree of research.

Commission of Inquiry into Health Matters

533. Dr M S BARNARD asked the Minister of National Health and Population Development:

(a) What total amount had been spent on the Commission of Inquiry into Health Matters as at the latest specified date for which figures are available and *(b)* on what specified items was this money spent?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(a) R507 307,00 as at 26 January 1987.

(b) The funds were used as follows:

Salaries	R265 812
Administration expenses .	R 68 331
Members' allowances	R144 734
Publications	R 27 747
Technical services	R 683
	R507 307

Visits to detainees

534. Dr M S BARNARD asked the Minister of National Health and Population Development:

(1) Whether any visits were made by State doctors in 1986 for the purpose of examining persons detained in terms of security legislation; if not, why not; if so,

(2) whether records were kept of these visits; if not, why not; if so, what total number of visits were made in 1986;

(3) whether any reports on such visits were submitted by State doctors to his Department in 1986; if so, how many such reports were submitted;

(4) whether any action was taken by his Department as a result of such reports; if not, why not; if so, *(a)* what was the number of occasions on which action was taken and *(b)* what were the circumstances in respect of each of these cases?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) Yes.

(2) Yes = 2 898 visitors.

(3) Yes = 2 898 reports.

(4) *(a)* Yes.

(i) Hungerstrikes—40 cases.

(ii) Depression—20 cases.

(iii) Minor complaints—50 cases.

(b) (i) *Hungerstrike cases.* Consequences of such acts were explained to them by the District Surgeons. All cases were persuaded to take their food again.

Plans for a new union

THE Health Workers' Association is to join the Congress of South African Trade Unions in its aim to launch a national union of health workers this year.

An HWA spokesman yesterday said the general secretary of Cosatu, Mr Jay Naidoo, had said that the formation of a national union would be discussed in June.

Mr Naidoo was one of the speakers at the HWA's launch of the Health Charter Campaign at the weekend at Funda Centre in Soweto.

Mr Naidoo said: "It is only through mass organisation and mobilisation of the nurses, doctors and other health workers that we will begin the fight towards the transformation of health services".

The HWA spokesman said they had started organising in major centres and cities around the country. Cosatu-affiliated unions were handling regional recruiting.

COSATU secretary Jay Naidoo

In Bloemfontein the South African Allied Workers' Union (SAAWU) was handling recruitment while in Welkom the NUM office is aiding them.

In Natal the Health Workers' Organisation — a sister organisation to the HWA — is recruiting and using facilities of the Health and Allied Workers' Union, a Cosatu affiliate.

In the Transvaal the recruiting is done by HWA working with General and Allied Workers' Union.

(85) Sapa 9/3/87

Health service needs proper back-up, says Van Niekerk

CAPE TOWN — An excellent health service alone could not improve the health of the population of South Africa, Minister of National Health and Population Development Dr Willie van Niekerk said today.

Opening the 55th congress of the Medical Association of South Africa here, he said employment, housing, diet, sanitation, clean water and education were equally important.

"Although we believe the socialistic component of health services should diminish, we have a responsibility to direct our technical capability in such a way that we will not only address the sophisticated health needs of the First World, but also cater for the more basic needs of the Third World.

LARGEST PERCENTAGE

"Our aim must be to render the best, comprehensive health service to the largest possible percentage of our population with the limited resources available."

It was obvious that the private sec tor had an important role.

The academic hospital presented the apex of a pyramid based on housing, water, sanitation and primary health care. A patient should be treated at the lowest possible level of the pyramid to prevent an excessive flow of patients to the most specialised and expensive services.

"It is imperative that undergraduate students should also be exposed to less sophisticated institutions — especially the community-based health care services."

Dr van Niekerk said highly trained medical manpower was in great demand all over the world.

"Care will have to be taken to enhance the job satisfaction of these people and to lessen the influences which operate to draw them away from those services." — Sapa.

Dilemma of SA 'is demographic'

CAPE TOWN — South Africa stood accused because it could not fully comply with First World Western social and political demands, the Deputy Director General of the Department of National Health and Population Development, Dr G S Watermeyer, said today.

Delivering a paper on "Practical Uses of Mortality Profiles in the Provision of Health Service Facilities" on the opening day of the 55th Congress of the Medical Association of South Africa, he said critics generally ignored the fact that transition from tribalism to a Western style democra-

Health care 'unjust'

CAPE TOWN — The SA health care system was "blatantly unjust and inhuman" as it dealt with patients as if they were machines, Professor J Kriel of the University of the Witwatersrand said yesterday.

He said this was obvious as a hospital like the Johannesburg General stood "half empty" while black hospitals such as Coronationville were "more than 130% full."

He said modern medicine operated on a set of philosophical assumptions of what health and disease were about and did not see the patient as a person with a sociological background.

See Page 3

Foreign experts for Namda congress

Own Correspondent

CAPE TOWN — The National Medical and Dental Association (Namda) is to host a major medical conference at the University of the Western Cape in April.

Several leading academics, including three foreign medical experts, have been invited to attend. Two delegates from the Netherlands Foundation for Health and Human Rights are also expected.

Namda, a non-racial organisation with a membership of about 1 000 doctors, dentists and other health professionals, was formed in 1982 because of dissatisfaction with primary health care services in South Africa.

Matters were brought to a head by the response of the Medical Association of South Africa (Masa) to the death in detention of Black Consciousness leader Mr Steve Biko.

Namda was formed to provide a new forum for mainly black doctors.

The new body has been able to retain links with international medical organisations.

Last year Namda was offered permanent observer status at the annual conference of the Confederation of African Medical Associations and Societies.

The conference was co-hosted by the World Health Organisation, on which South Africa is not represented. No South African will in future be allowed to attend the conference unless they are bona fide members of Namda.

Namda recently won the Samuel Rubin Peace and Justice Award for its contribution to the struggle for health and human rights in South Africa. It will be presented to Dr Diliza Mji, president of Namda, in New York on May 1.

Namda has adopted the theme "Towards A National Health Service" for its April congress.

Professor Shula Marks, of the Institute of Commonwealth Studies at the University of London, has been invited to make the keynote address. She will trace the history of a national health service.

Infant's death gave life to Health Charter

Sowetan 13/3/87 (85)

THE death on June 13, 1983, of Thabiso Ndongeni, 28 days after he was born in a squatter camp in Soweto, sparked off a drive for change in the provision of health services to the black community. That drive reached a climax with the launching of the Health Charter at the Funda Centre in Soweto on March 1, 1987.

Thabiso's death came four days after he was sent to the Baragwanath Hospital by Dr Aby Asvat, who was treating the squatters at the Chicken Farm, a squatter camp near Moroka in Soweto.

Dr Asvat was later joined by other doctors to investigate the prevalence of preventable diseases at the camp.

The appalling conditions under which the 200 families lived shocked them. They examined the residents and at the end of the day all had been referred to Baragwanath Hospital for further treatment.

Four days later Thabiso (literally translated the name means "Pleaser") died. That day marked the turning-point in the lives of the team of doctors.

Thabiso's spirit haunted them and spurred them into action day after day. Today some of the doctors who went to join Dr Asvat are the brains and the backbone behind the Health Workers Association which motivated the Health Charter.

The primary demands of the Health Charter are that:

- Health services should be provided without any discrimination against any section of the South African population, and that facilities be open to all;
- Discussions and decisions on health services be removed from universities and brought to homes and streets of the townships by involving student, youth, parent, worker, political and community organisations, instead of only professors who live within the white minority community;
- The imbalance in the health budget be rectified. The budget has seen blacks who constitute 80 percent of the population, being allocated 20 percent of the available money, while whites, who are only 20 percent of the population, are allocated 80 percent.

This has resulted in South Africa failing to wipe out preventable diseases such as cholera, tuberculosis, measles and others which Mozambique wiped out in seven years.

A spokesman for the HWA says: "It is not that the Government lacks the resources to tackle these diseases and wipe them out within three years, but it has been prevented from doing that because these diseases are prevalent only in the black community — which, according to the apartheid doctrine, can be left alone to see how best to survive."

He said he held apartheid responsible for the death of Thabiso.

Relating events leading to Thabiso's death, he told of the demolition by the West Rand Development Board officials of shacks built by homeless families.

Vice-chairman of the Witwatersrand Council of Churches, the Rev Cecil Begbie, provided tents for the families, but as soon as they were pitched the Wrab officials confiscated them.

After a protracted battle to save the families they were allowed to settle temporarily at the Fred Clark Centre.

Just when everyone thought the battle to save the squatters was over Wrab dropped a bombshell: Dr Asvat himself was declared a surgery near the Regina Mundi Church in Moroka.

Although the Soweto Council was the authority in charge, Wrab controlled the land. The Government has classified Dr Asvat an Indian and Wrab said he was on land allocated for occupation by Africans.

Everyone involved in the squatter camp issue believed that Dr Asvat was victimised for his intimate knowledge of the squatter families and their problems. His surgery was reprieved after a campaign that saw Bishop Tutu visit the place for a prayer service with the families, Dr Asvat and Soweto residents.

Apartheid in the health services drove the HWA into the ranks of political organisations as it found it had no chance of fulfilling its Health Charter without enlisting the help of other organisations.

It thus joined the Congress of South African Trade Unions and at the launching of the Health Charter it announced it was affiliating to the UDF with the aim of "strengthening the democratic movement".

An HWA official said the slogan "Towards People's Health" is unattainable while apartheid exists.

The spokesman said by joining the UDF, the HWA would be able to use structures in the townships to educate people about preventable diseases and to discuss health matters.

The Government's intention to privatise health services also came under scathing attack.

"Health is a Government responsibility. Privatising health services would mean people profitting out of the illnesses of others, a situation not acceptable to us because the majority of people here are poor.

"Privatised health services have never been adequately available to those who need them most, even in America, the bastion of capitalism."

The HWA says it has about 30 000 members countrywide and it is growing rapidly. It aims at forming a health workers union affiliated to Cosatu.

CHILDREN at Fred Clark Centre gather around a brazier. The Health Charter was conceived by doctors who worked among the squatters at the camp.

FOCUS

By MOJALEFA MOSEKI

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(011) 673-4160

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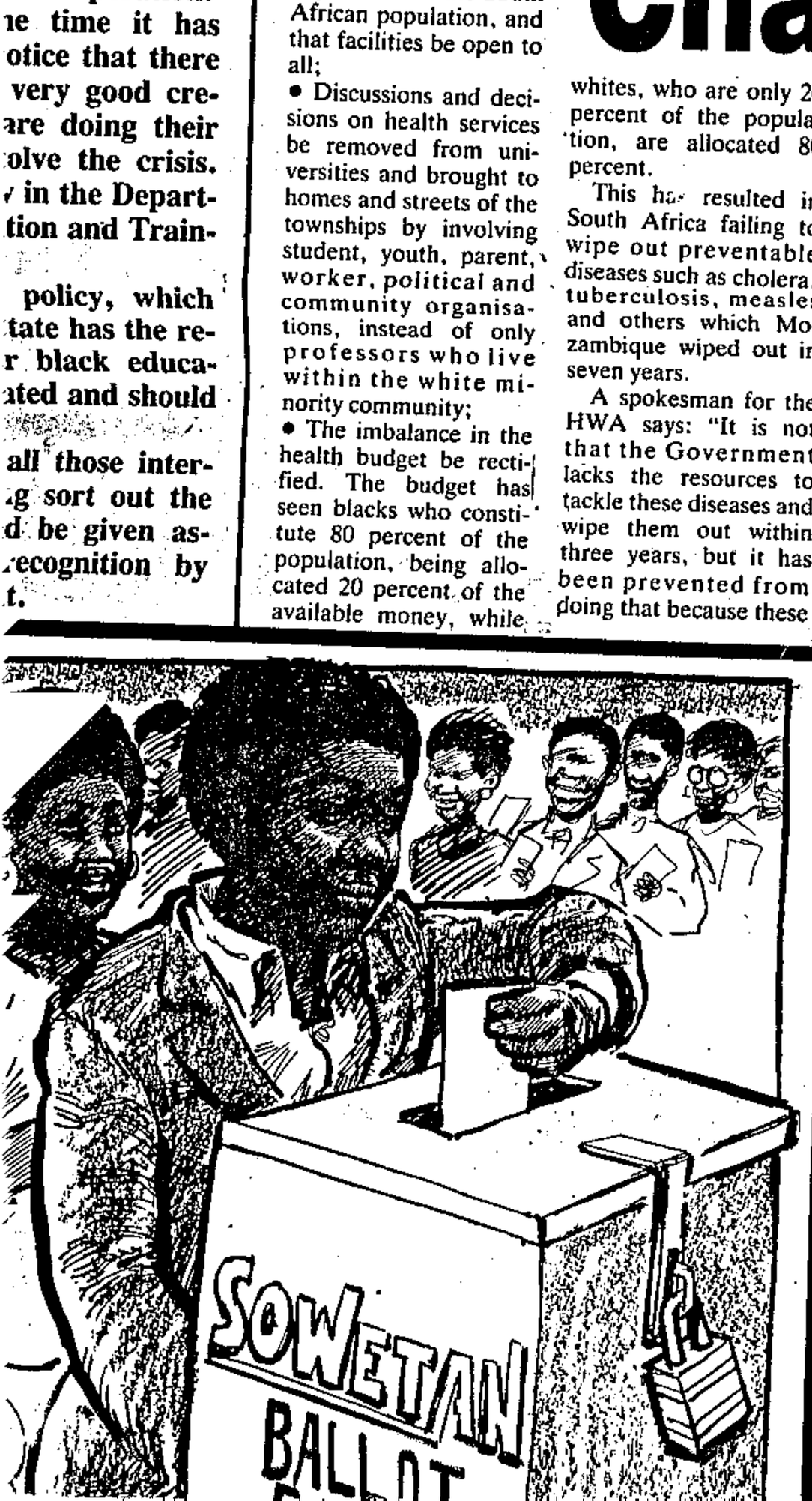
FOCUS

By MOJALEFA MOSEKI



Political comment in this issue by J Latakgomo and A Klaaste. Sub-editing, headlines and posters by S Matlhaku. All of 61 Commando Road, Industria West, Johannesburg.

Lest we forget...

THE *Sowetan* today remembers journalists around the country who are in detention:

- **Zwelakhe Sisulu, Editor of the the *New Nation*, who has been in detention under the emergency regulations for 91 days;**
- **Mxolisi Jackson Fuzile, *Veritas News Agency*, who has been detained under the emergency regulations for 274 days;**
- **Phila Ngqumba, *Veritas News Agency*, 274 days;**
- **Brian Sokutu, Eastern Cape free-**

Need for sex education

Sex education and counselling should be part of total health care in South Africa.

This was announced by the head of family planning at the University of Cape Town, Dr Esther Sapire in her address at the 55th annual congress of the Medical Association of South Africa in Cape Town last week.

Dr Sapire said that there was a need for sex education and counselling as part of the total health care in the country because sexual ignorance led to teenage pregnancies as well as sexual abuse.

Dr Sapire said 75 per cent of pregnancies were unplanned and half of South Africa's divorces were associated with sexual problems.

"Parents, teachers, the church and medical personnel all need to contribute towards sex education," she said. — Sapa

This means that to ... had traded fictitiously for 10 years. ... ing for a rethink. ... Expressed in another w... The State President's ...

Joint health care effort called for

HEALTH care in SA would become a team effort between the private and public sectors, the Minister in the Office of the State President Alwyn Schlebusch said at the weekend.

He said at the opening of the R30m Garden City Clinic extension, Johannesburg, that to judge the possible privatisation of hospital services, three types of health-service systems had to be considered:

☐ A national system where the service was rendered exclusively by the state.

MICK COLLINS

☐ A system whereby the service was rendered exclusively by the private sector.

☐ A system whereby the service was rendered by both the public and private sectors.

"The latter system, where government and the private sector divide the market between them according to the individual (a means test) is perceived as the most suitable.

"We are fortunate in SA to be able to provide health care comparable to the best in the world. There is no patient in this country, regardless of race, colour, creed or income, who cannot obtain medical care."

Competition between private and public sectors would promote cost-efficiency and allow the private sector to increase its market share by providing cheaper services.

Referring to the health plan announced by government last year, Schlebusch said planning and policy would rest with a decentralised executive on second and third levels of government.

AIRLINE MOVEMENTS

Monday Air Schedule	1300	1400	SA511	1745	1915	SA412	1945	1000	BA055
Johannesburg to Cape Town	1500	1600	SA517	2020	2150	SA417			
Dep	Arr		SA515						

Johannesburg to Gaborone

Longer life not a feat of medicine?

Attainment of a 70-year life expectancy for First World populations is not a medical but an engineering achievement, according to Professor Harry Seftel of the University of the Witwatersrand.

Life expectancy had been extended mainly by the provision of better sanitation, water and housing, Prof Seftel said in a paper on "First and Third World Catastrophes" which he delivered to the 55th Medical Association of South Africa congress held in Cape Town.

Medicine had also made great strides, he said, but its promise had not been well fulfilled, as "old plagues" had persisted and new ones emerged.

New plagues in South Africa's third world community included alcoholism, nicotinism (tobacco smoking), and hypertension, Prof Seftel said.

In discussing social, economic and political factors which contributed to the problems, Prof Seftel coined a new word: "dyscomia", or disorders of accommodation.

"This includes the Group Areas Act, the squatter camps, the removal of communities and individuals,

andof course single sex hostels which are a major cause of medical catastrophes."

Prof Seftel said the social, economic and political system was unwilling to change, as "the Mafia remains strong". This inhibited health workers from tackling the problems effectively.

A range of stresses in South Africa's first and third world communities led to addiction to chemical substances, and this was "exploited by the enormously powerful barons of the food, drink and tobacco industries with a maximum of ingenuity and a minimum of scruples," he said.

Solutions lay in correcting "dyscomia", replacing "death advertising" with messages of life, and introducing a "science of living" in schools.

"We also need a medical voice on food, liquor and tobacco boards," he said. "We must shout louder and clearer". — DDC

dens while (above) Ms Temperence Apleni-Zulu her five-month-old baby Esmina played on the grass. Left, a worker with his handcart braves the motorised madness of Market Street.

Residents told rusty water not unhealthy

By Pat Devereaux, Star Line

Discoloured household water is not a health hazard, according to water department spokesmen who responded to residents' complaints.

Commenting on Fairland residents' complaints about "rusty water", public liaison officer for the Johannesburg City Council Miss Christa Claassen said: "There is an incorrect PH balance in the Fairland reservoir. This creates acidity and could corrode water pipes over a lengthy period."

She said the problem was minor and had been corrected by the Rand Water Board adding sodium carbonate or potash.

Birdhaven resident Mr Y Adir complained the water was not filtered enough.

Another complainant, Mr I A Kolia of Lenasia, said his children had developed allergies from the rust-coloured water.

A senior plumber for the Lenasia Water Board, Mr M H Ebrahim denied the water was dangerous or unhealthy.

Zuluana the rhino is dead

The Grand Dame of the Pretoria National Zoo has died of old age.

Zuluana, the white rhino who celebrated her 60th birthday last year, arrived at the zoo at the tender age of six days and is believed to have been the first and oldest white rhino in captivity.

Zuluana had been rescued by game rangers in the Umfolozi Reserve in Natal, where she had been abandoned by her mother.

Her head will mounted and put on display at the zoo. — Pretoria Bureau.

ments deficits. Substantial fluctua- forward basis.

Homeland health plan

GERALD REILLY

SA AND the six self-governing states agreed yesterday on a plan to implement population and community development programmes.

Health and Population Development Minister Willy van Niekerk said action would be taken through a joint technical committee.

At yesterday's meeting — attended by Ministers of Health of the self-governing states — a need for an annual ministerial meeting on the issues, including health matters, was stressed.

Success would depend on combined resources, Van Niekerk said.

Ministers agreed to strengthen and expand bilateral co-operation in health and population development.

Serious health problems in the region included malnutrition and gastro-enteritis.

The threat of AIDS was also discussed, and the various health departments will exchange information on the disease.

World experts for Namda conference

MANY leading academics on Third World health care will speak at the National Medical and Dental Association's (Namda) annual conference this weekend. at the University of the Western Cape.

According to a Namda spokesperson, about 300 people are expected to attend. the conference which has as its theme, Towards a Nationalised Health System.

Dr Adrian van Ess and Ms Marijke Gurp, from the Netherlands, will represent the Foundation for Health and Human Rights as will Professor Aubrey Sheiham, an expert in community dentistry from London University.

Other visiting speakers will be Dr M Mokete, president of the Confederation of African Medical Associations and Societies (Camas) and Dr David Sanders from Zimbabwe.

Professor Shula Marks, of the Institute of Commonwealth Studies at the University of London, will give the keynote address and Namda president, Dr Diliza Mji, will open the conference.

Messages of support have been received from the Committee for Health in South Africa (Chisa), a group of representatives from Northern American countries.

"The conference theme was chosen because of the pressing need for an effective strategy to tackle the health problems of South Africa," said Dr James Davidson, medical secretary of Namda's Western Cape branch.

"Although South Africa is a wealthy country, our health services are characterised by an extremely uneven distribution. Although high technology hospitals exist in the cities where the standard of health care rivals that in developed countries, the basic level of health care for the majority of the population is very poor."

Blindness statistics available mid-year

By Janine Simon

The first comprehensive statistics about blindness in South Africa will probably be presented to the Department of National Health and Population Development by mid-1987.

Head of the Bureau for the Prevention of Blindness, Mr Sarel van der Walt, said the task was part of the increasing demand for statistics handled by the bureau since the inception of its Eye Data Bank late last year.

The data bank was one of four new services started since 1984 by the bureau — a division of the Pretoria-based South African National Council for the Blind — to complement its established and effective eye care services to rural areas.

The others are:

- An Eye Care Information Centre which offers a write-in/phone-in information service about eye conditions.
- Eye Care Awareness programmes, which draw on a wide range of professionals to educate the public about eye conditions.
- Courses in eye care, which started this year and are offered to health professionals from around the country.

Mr van der Walt added that the bureau expected its eye units — which make 75 trips each year to provide professional eye care services to isolated communities — to be needed until at least the end of the century.

Medical conference 'discussed the future'

Staff Reporter

ACADEMICS from the Netherlands, Zimbabwe and England addressed the National Medical and Dental Association's (Namda) "most successful ever" annual conference at the University of the Western Cape at the weekend.

A spokeswoman for the Western Cape Branch of Namda said it was "the first time people had discussed matters concerning a future South Africa instead of the present one".

The theme of the conference was "Towards a National Health Service".

The spokeswoman said there had been an increase in attendance by community organizations and students. Five hundred delegates from all over the country had attended the three-day conference. Three hundred people had attended the 1986 conference, she said.

Leading Third World health-care academics addressed the conference.

Dr Adrian van Ess and Ms Marijke Gurp, of the Netherlands, represented the Foundation for Health and Human Rights.

Dr M Mokete, president of the Confederation of African Medical Associations and Societies, and Dr David Sanders of Zimbabwe were two of the visiting speakers.

Professor Shula Marks of the University of London delivered the key-note address.

The conference resolved to suspend making a decision on Namda's position regarding the academic boycott because of the restrictions imposed by the state of emergency.

Hospital apartheid

Delegates will take back to regional branches a proposal to open Namda membership to all health workers. At present it is restricted to doctors nd dentists.

Namda also decided to explore ways and means of intervening in the rural areas — particularly in the homelands — and to encourage health professionals to work there.

The conference noted the discrepencies in the South African health-care system and the "appalling" doctor-patient ratio.

They have also resolved to support medical students who take a political stand and will explore ways of converting this into material support for them.

The association "would take back ideas discussed to their regional branches concerning the national health system and try and perpetrate them", the newly-appointed secretary, Dr Rob Dyer, said.

"That would mean challenging issues such as apartheid in hospitals and inadequacy of occupational health services," he said.

The new executive of Namda is: Dr D Mji (president), Dr P Owen, Dr M Maqina, Dr M Ehikko (vice-presidents), Dr W Shasha (treasurer), Dr R Dyer (secretary), Dr R Thejpahl (assistant secretary) and Professor J Reddy (publicity secretary).

National health service for SA moooted at health congress

CITY/NATIONAL

Medical Reporter

HEALTH was a right and not a privilege, delegates to a medical congress focusing on a national health service for South Africa were told.

The National Medical and Dental Association (Namda) congress held during the weekend at the University of the Western Cape (UWC) drew about 500 people. Speakers from Britain, the Netherlands, Zimbabwe and Lesotho spoke on various aspects of a national health service for South Africa.

A Namda executive said they felt it was time to do something about "a future health system for all in South Africa".

"Chewing gum"

Professor Jerry Coovadia of the University of Natal, presented "the case for an NHS" and said the essential arguments were based on moral, ethical, ideological, medical, economic, political, social and cultural foundations.

"Health is not a commodity, like a car or chewing gum," he said.

A session entitled Health Under Repression dealt with, among other things, patient care and the doctor-patient relationship in a largely authoritarian society, where doctors practising in townships could be seen as part of such authority.

Dr Stanley Levenstein, a general practitioner, said working-class people were "conditioned by society not to question those in authority" and "progressive doctors could easily fall into the trap of reinforcing the system's views" and alienating their patients.

A member of the Namda Johannesburg branch presented the results of a study by Namda doctors of 131 released detainees of whom 70 percent alleged they had been physically assaulted.

Of detainees who spent time in solitary confinement, 84 percent suffered psychological trauma, the study found, drawing the conclusion that existing acts and associated legislation did not safeguard the health of detainees.

Victims of township unrest were faced with three choices: to be treated at local (usually provincial) hospitals, to see local general practitioners, or to stay at home. Increasingly they found that to go to hospital with injuries suggestive of political involvement meant almost certain detention.

Several general practitioners in the affected areas alleged harassment by security forces and an incident was quoted where a doctor's consulting room was barricaded by Casspirs parked outside the entrance.

The emergency service group of Namda had devised a first aid training programme for township youths so that they would be able to identify injuries requiring urgent medical care.

A Western Cape spokesman for the Organisation for Appropriate Social Services in South Africa said teachers of young children were concerned that their charges would be permanently scarred through living with and witnessing violence.

At the height of the unrest, children in care centres were playing games like "Casspir, Casspir," "Witdoeke and Comrades," and later "Funerals" which were worrying and distressing for teachers.

Medical congress told of abuse of detainees

CAPE TOWN — Detainees have been physically assaulted, mentally abused and, after release, have psychological problems, a study by doctors claims.

Professor Selma Browde, of the University of the Witwatersrand, told delegates to the National Medical and Dental Association (Namda) congress here at the weekend that 72 per cent of the detainees examined by a panel of doctors alleged they had been physically assaulted while in detention.

Medical examination of 97 per cent of these bore out the allegations with evidence of bruising, lacerations, sjambok lesions, eardrum perforations and gunshot wounds.

Among the physical assaults alleged were being beaten with fists or hands, kicked, sjambokked, beaten with blunt instruments, slammed against something, suffocated and being given electric shocks.

The study of 131 released detainees by Namda doctors showed that 78 per cent had allegedly been subjected to mental abuse through interrogation, threats or humiliation, including being forced to remove their clothes and make statements.

Among the study's findings were that 32 per cent of the detainees spent time in solitary confinement, 84 per cent of whom had psychological problems after release. Of these detainees 48 per cent alleged physical deprivation, including the denial of water, satisfactory food, exercise, clean clothes and sleep.

Doctors examining the detainees found evidence of post-traumatic stress disorders, defined as being stress outside of normal human experience, with 68,7 per cent suffering sleep disturbances.

Prof Browde said the study also showed that legislation was insufficient to safeguard the health of detainees. — Sapa

3089 85 DD 7/4/87

...serious scouts as being a destabilising force.

Doctors claim detainees assaulted

A panel of doctors which treats freed detainees in Johannesburg has released a study alleging that 72 percent of those seen claimed they were assaulted in detention and 97 percent of these showed signs of abuse.
The police have said the claims are vague and unsubstantiated.

The police say . . .

The SA Police have said it "is a pity" they were expected to reply to serious allegations about the treatment of detainees "which are not substantiated in any manner whatsoever".

In reply to a study by a panel of doctors, presented at the annual conference of the National Medical and Dental Association (Namda) at the weekend, the police public relations division said:

"First of all, Professor Selma Browde, of the University of the Witwatersrand ... claims publicly that a so-called panel of doctors had found that 72 percent of detainees examined had alleged they had been physically assaulted.

"No details with regard to the 'panel' of doctors, the identity of the victims, places of alleged assault or any other relevant evidence, which could substantiate the allegations, is given.

"The SA Police .. cannot react to anonymous and unsubstantiated claims by faceless people."

The suggestion that detainees suffered gunshot wounds while in detention was "absurd and should be regarded with suspicion", the statement said.

"What seems to be conveniently overlooked is the strict code of discipline which ensures that all detainees are properly cared for, that they are not assaulted and that they receive proper medical, spiritual and other care.

"To ensure that the above is adhered to, detainees are frequently visited by district surgeons and other officials. In addition, provision is made for relatives and legal representatives to visit detainees.

"Ample opportunity thus exists for detainees who are of the opinion that they have been improperly treated, to file affidavits for investigation. All such complaints which are received are properly investigated and where proved to be true, appropriate steps are taken," the statement concluded.

The Namda study says . . .

Detainees have complained of being physically assaulted, mentally abused and, after release, have suffered psychological problems, according to a study by doctors.

Professor Selma Browde of the University of the Witwatersrand told delegates to the National Medical and Dental Association (Namda) Congress in Cape Town at the weekend that 72 percent of the detainees examined by a panel of doctors alleged they had been physically assaulted while in detention.

Medical examination of 97 percent of those bore out the allegations, with evidence of bruising, lacerations, sjambok lesions, eardrum perforations and gunshot wounds.

Detainees alleged, among other things, that they were beaten with fists or hands, kicked, sjambokked, hit with blunt instruments, slammed against walls, suffocated and subjected to electric shocks.

The study by Namda doctors of 131 released detainees showed that 78 percent of the detainess had allegedly been subjected to mental abuse through interrogation, threats or humiliation, including being forced to remove their clothing and make statements.

Among the findings of the study were that 32 percent of the detainees spent time in solitary confinement, 84 percent of whom suffered psychological problems after release.

Of those detainees reporting mental abuse, 48 percent alleged physical deprivation, including denial of water and sleep.

Doctors examining the detainees had found evidence of post traumatic stress disorders, defined as being stress outside of normal human experience, in 83 individuals, 43,4 percent of whom had recurrent dreams and 68,7 percent sleep disturbances.

The study had shown, Professor Browde said, that detention without trial was detrimental to health.

Released detainees had "special mental and physical needs to be treated by doctors who had skills in rehabilitation".

The study also showed that existing acts and associated regulations were "insufficient to safeguard the health of detainees" and that the 1983 recommendations of the Medical Association of South Africa (Masa) with regard to the treatment of detainees had "not been implemented".

Masa had to reaffirm the need in the medical profession for responsibility towards detainees. — Own Correspondent.

Namda delegates present vision of new medical structure in SA

Call for national health service

85 STAR 8/4/87

Health was a right and not a privilege, delegates to a medical congress focusing on a national health service for South Africa were told at the weekend.

The National Medical and Dental Association (Namda) congress at the University of the Western Cape (UWC) drew about 500 people from the medical and allied professions, where speakers from Britain, the Netherlands, Zimbabwe and Lesotho spoke on various aspects of a national health service for South Africa.

A keynote speaker at what has been called Namda's most successful annual conference yet, was Professor Shula Marks of the University of London. Dr David Sanders of Zimbabwe made the closing address.

Dr Adrian van Ess and Ms Marijke van Giep, of the Netherlands, represented the Foundation for Health and Human Rights. Dr M Mokete, president of the Confederation of African Medical Associations and Societies, also attended.

A Namda executive said they felt it was time to do something about "a future health system for all in a free and democratic South Africa".

Aspects such as expenditure, resources, manpower, facilities, education, privatisation, fragmentation and the role of medical and dental practitioners in such a system were discussed.

Professor Jerry Coovadia of the University of Natal, presenting "the case for a national health service (NHS)", said the essential arguments were based on moral, ethical, ideological, medical, economic, political, social and cultural foundations.

"Health is not a commodity, like a car or chewing gum," he said.

He linked the demand for a NHS to increasing resistance among workers, communities and students who demanded changes in the state and service structures, the need for an "alternative vision of health" and a national vision of "health for all".

A session entitled Health Under Repression dealt with, among other things, patient care and the doctor-patient relationship in a largely authoritarian society, where doctors practising in townships could be seen as part of the authority structure.

Dr Stanley Levenstein, a general practitioner, said working class people were "conditioned by society not to question those in authority" and "progressive doctors could easily fall into the trap of reinforcing the system's views" and alienating their patients.

A review of the emergency services offered by Namda doctors during township unrest showed that the Press curbs had affected the service because doctors outside the townships no longer anticipated meetings or funerals.

Victims of township unrest were faced with three choices: To be treated at local (usually provincial) hospitals, to see local general practitioners, or to stay at home. Increasingly they found that to go to hospital with injuries suggestive of political involvement meant almost certain detention.

Several general practitioners in the affected areas alleged harassment by police and armed forces and at least one incident was quoted where a doctor's consulting room was barricaded by Casspirs parked outside the entrance.

The emergency service group of Namda had devised a first aid training programme for township youths so they would be able to identify injuries requiring urgent medical care.

A Western Cape spokesman for the Organisation for Appropriate Social Services in South Africa (OASSSA) told delegates of the effects of repression on children and some of the work they had done in the townships.

Teachers of young children were concerned that their charges would be permanently scarred by living through and witnessing violence.

At the height of the unrest, children in care centres were instigating games like "Casspir, Casspir," "witdoeke and comrades," and later "funerals" which were worrying.

- Quotes from the conference:

"Oppressive political conditions in South Africa are highly likely to influence the mental health of the oppressed adversely." — A World Health Organisation report quoted by Dr Stanley Levenstein.

"What kind of strong sexual identity can be expected when grown men are referred to as 'boys' (or women as 'girls') by their white masters, including white children?" — Dr Stanley Levenstein.

"Detention without trial is detrimental to the health of detainees and as such can only be condemned by the medical profession." — Professor Selma Browde, Namda Johannesburg branch.

"To say that children should not be abused because they are innocent implies that the abuse of adults is all right. To protect innocent children there must necessarily be protection for adults as well." — Leslie Schwartz, OASSSA Western Cape.

- The new executive of Namda is: Dr D Mji (president), Dr P Owen, Dr M Maqina, Dr M Ehikko (vice-presidents), Dr W Shasha (treasurer), Dr R Dyer (secretary), Dr R Thejpahl (assistant secretary) and Professor J Reddy (publicity secretary).

A nation's right to national health

THE Medical Association of South Africa's inaction over the death in detention of Black Consciousness leader Steve Biko was the "straw that broke the camel's" back — a catalyst in the move of progressive doctors away from Masa.

It is nearly 10 years since Biko's death and five years since the formation of a breakaway doctor and dentist group, the National Medical and Dental Association (Namda).

Last weekend at its annual conference, Namda discussed proposals for a national health service in South Africa. SAHM VENTER reports:

"IT IS not enough for people to say that apartheid medicine is bad. People must begin to address the question of an alternative health system," the president of Namda, Dr Dilizi Mji, said.

SOUTH spoke to Mji and Professor Jerry Coovadia of the Natal University medical school's department of paediatrics about Namda and the state of health in South Africa.

"Once political power has passed into the hands of the people, they will be able to determine the nature of their society and must participate in formulating decisions about health, Mji said.

He stressed that Namda's ideas about a national health system for South Africa would not be a "blueprint", but merely "suggestions". He urged people to respond positively when Namda launched its "health charter" campaign later this year.

"In this conference we have looked at a national health service as a solution to the health problems facing South Africa."

Adamant

Health professionals are starting to discuss a national health system and Namda is encouraging its members to take the debate back to the people.

One of the problems faced by those taking over South Africa, Coovadia said, was the high level of sophistication in the health services.

"What does one do with the huge hospitals, with the highly-sophisticated apparatus, with the highly-skilled professionals? How do we transform that to a people's service?"

Solution

On the question of opening Namda membership to all health workers, both Coovadia and Mji were adament that Namda was not an elitest organisation.

"Namda must be judged by what it does and it really, sincerely and truly struggles for the health of all people," Coovadia said.

Detainees

"While Namda believes it would be a starting point to be able to see detainees, if and when they made their own choice about doctors, that question has fallen to the lot of organisation like Masa," he said

Coovadia stressed the although Masa has been involved in setting up panels of doctors whom detainees can see, they have been ineffective.

"The proof of is exists in the large number of allegations of torture, of solitary confinement and of deaths in detention since those proposals have been agreed to by the state."

NAMDA has been invited to attend the annual conference of the Confederation of African Medical Associations (Camas) in Uganda in September.

Namda was invited by Camas president Dr M Mokete, who attended the annual conference.

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DR DILIZA Mji has been elected Namda president for his third term. The three new vice-presidents are Dr Peter Owen from the Western Cape, Dr Mangaliso Maqina from the Eastern Cape and Dr Mohamed Bhikhoo from Transvaal. Dr Welile Shasha was elected treasurer, Dr Rob Dyer secretary, Dr Rajen Thejpahl assistant-secretary and Professor Jerry Reddy publicity secretary.

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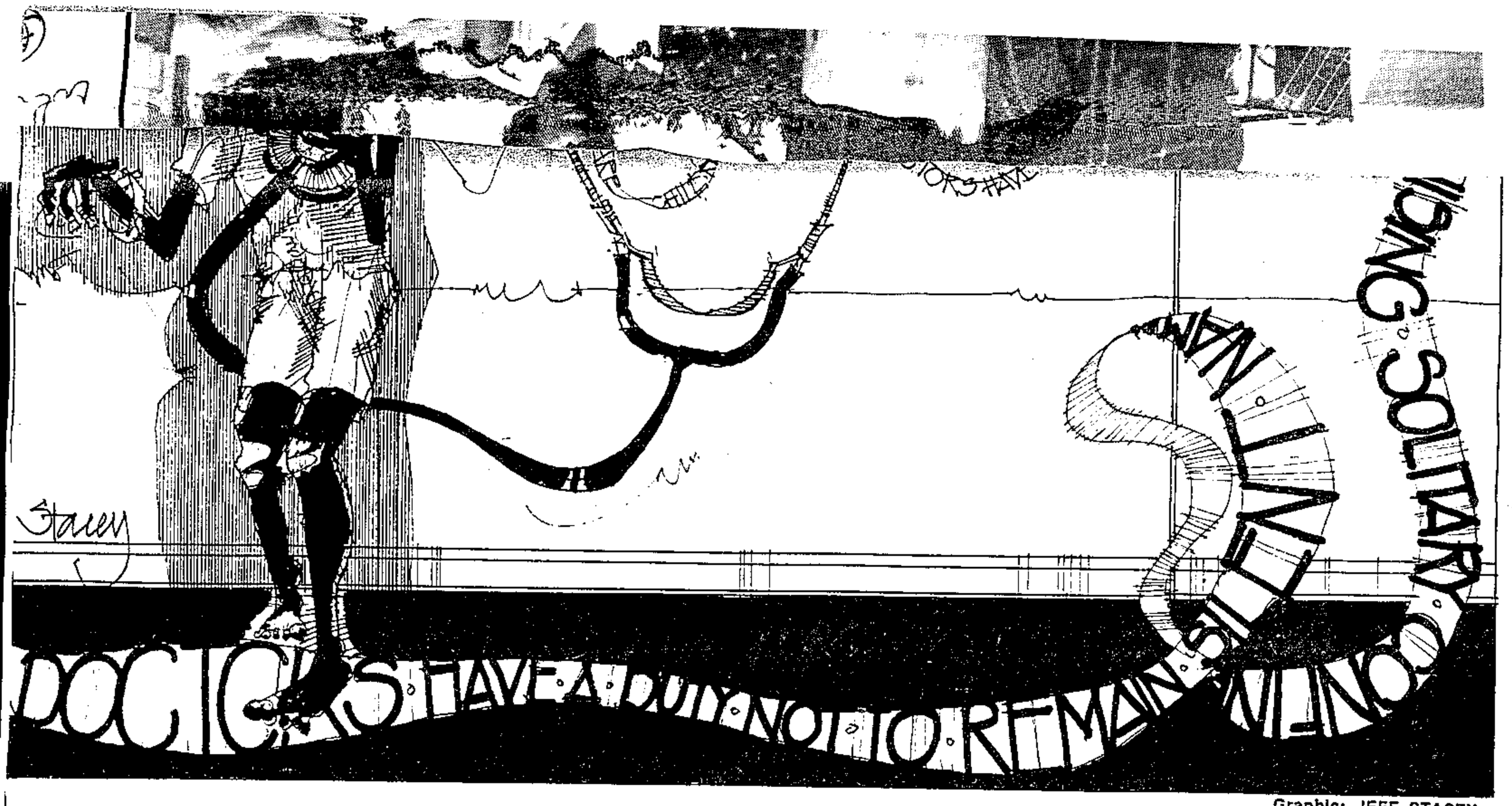
At the Namda conference this weekend were, from left, Professor Jerry Coovadia, Professor Shula Marks and Dr Diliza Mji.

Picture: RASHID LOMBARD



Graphic: JEFF STACEY

Face to face with South Africa's walking wounded — its ex-detainees

By GAYE DAVIS in Cape Town

EXISTING measures to safeguard the health of men, women and children detained in South Africa are insufficient.

This is one of the conclusions of a new study on the treatment of detainees by a group of doctors belonging to the National Medical and Dental Association. They released their report — which includes allegations of detainees' requests to see doctors being refused — in the belief that "it is the duty of doctors everywhere to bring these things to the attention of the public" and to highlight the ethical codes under which doctors should practise.

The study was based on the physical and psychological examination of 131 detainees released from detention between December 1, 1985 and June 11, 1986.

Forty percent of those seen were under 18 years old: of this group 35 percent were aged between 15 and 18 and 4,7 percent were between 10 and 14 years old.

Periods of detention ranged from one day to 490 days. More than half the detainees — 54 percent — spent up to 19 days in jail, while 18 percent were detained for more than 140 days.

Forty-three (32 percent of the group) reported having been in solitary confinement. Of these, 36,8 percent said it had lasted between one and 19 days, while 31,6 percent claimed they had spent between 120 and 279 days in solitary. Of this group, 84 percent were found to have psychological symptoms such as anxiety, depression and sleeplessness.

Of 69 individuals who alleged they had been physically assaulted, 67 were found, on examination, to have injuries consistent with the alleged assault.

These included bruises (46 percent), lacerations (45 percent), lesions consistent with being sjambokked (49 percent), five or fewer wounds (35 percent), more than five wounds (46 percent).

Nine percent showed evidence of gunshot wounds, seven percent signs of having been electrically shocked and six percent had perforated eardrums.

Mental abuse was alleged by 103 detainees (78,6 percent). Of these, 84,5 percent said they had been interrogated, 35 percent claimed they had been threatened, 26,2 said they had been humiliated, as in being forced to strip naked, 41,7 percent said they had been in solitary confinement and 48 percent alleged they had been denied basic needs such as water, satisfactory food, exercise, clothing, washing facilities and sleep.

When asked whether they had seen a district surgeon while in detention, 22,1 percent of the group said they had not.

Of the 26,7 percent (35 people) who said they had asked to see a doctor, the majority — 62,9 percent — claimed this request was refused.

Among those who were admitted to hospital during their detention (12,2 percent of the group), three said they had asked to see a doctor but said this had been either refused or not granted.

This was contrary to existing regulations regarding detainees, the report said.

The study's findings "would suggest that ... recommendations (made in 1983 by the Medical Association of South Africa to safeguard the health of detainees) have not been implemented", the report said.

Urging Masa to "reaffirm their statement" regarding the medical profession's responsibility towards detainees, the doctors said it could "no longer be restricted to a small number of concerned individuals".

In terms of internationally accepted codes of ethics, doctors had a duty not to remain silent about abuses of human rights.

A review of the work done by Namda's Emergency Services Group told how it was decided to teach township residents basic first aid skills.

Victims of political violence in the townships had three choices: to be seen at local hospitals, consult local general practitioners or stay at home.

Increasingly, victims found that going to hospital meant almost certain detention, while general practitioners found themselves inundated and subject to harassment. In one instance, a doctor's rooms were effectively barricaded by Casspirs parked at the entrance.

Responding to calls for help posed difficulties of access to areas which were often unfamiliar. Medical teams who overcame these obstacles found their role was simply that of triage — sorting out those so badly injured that there was no choice but to go to hospital.

Members of youth organisations had meanwhile devised their own ways of dealing with injured fellows. Delegates heard how attempts at removing bird shot pellets with razor blades exposed victims to massive infection.

Before the second State of Emergency, volunteer medical teams would go on standby whenever funerals or large political meetings were planned.

But the press curbs meant these events could no longer be anticipated and the service had largely fallen away.

A member of the Western Cape branch of the Organisation for Appropriate Social Services in SA, Leslie Swartz, told of the group's involvement in counselling children and reassuring teachers concerned about lasting effects of civil turmoil.

Children started playing games such as "Casspir, Casspir" "witdoeke and comrades" and "funerals" — which helped them adapt but distressed parents and teachers.

Swartz stressed the importance of focusing on children's resilience rather than on their trauma, while ensuring the well-being of those responsible for caring for them was more effective than treating the individual.

He also warned against falling into the trap of saying that children shouldn't be abused because of their "innocence" — thereby implying that abuse of others was acceptable because their actions were deliberate.

The ultimate aim is true people's health

By GAYE DAVIS in Cape Town

IT was a conference of doctors and dentists, but no drug companies touted their wares in the foyer and there wasn't a golf club in sight.

For under examination was not the well-being of the medical profession but the compelling need for health care for all South Africa's people — and how to achieve it.

With more than 500 people gathered at the University of the Western Cape, the three-day event represented the biggest annual conference ever staged by the 1 000-strong National Medical and Dental Association.

Its purpose was two-fold: to examine existing health care in South Africa critically and to prepare for a post-apartheid national health service.

As Namda president Diliza Mji said, the time had come for the organisation to move beyond the protest which first united health professionals under its banner in 1982.

Delegates heard that nothing short of a major redistribution of political, social and economic resources would adequately redress a situation in which health care was biased in favour of white over black, rich over poor, city over rural dweller, and curative rather than preventative services.

Privatisation of health and racial policies also meant a lack of central co-ordination and unnecessary duplication of facilities.

Data was either unavailable or incomplete, resulting in "hidden realities" and further hampering efforts to analyse the situation accurately.

Sociologist Cedric de Beer of Wits University's Centre for the Study of Health Policy identified obstacles in the way of a national health service as including fragmentation, which had made a "lunatic's jigsaw puzzle" of the country and its health services, and vested interests.

Corporate interests as well as private practitioners had the power to deform and distort progress towards health for all; bureaucrats might resist change for fear of losing power and control.

"But we can try and challenge the private sector, start a regional process of consultation which cuts across homeland boundaries and fight ethnic divisions such as separate nurses' associations on political grounds."

Another "first step", suggested by De Beer's colleague, Namda member Eric Buch, was for health to become an issue around which communities organised and made demands, as with housing and education.

Health workers and communities should together decide on minimum standards for acceptable health care.

"Many communities don't have facilities that are available, accessible or appropriate — especially farm workers, homeland dwellers, those in squatter settlements and those threatened by removal.

"If some of the facilities provided are accepted by communities, it is only because they are not yet in a position to judge their health services in the same astute manner in which they judge their education and housing," Buch said.

"The minimum standards programme could be a first step in both the move towards a people's health service and in the health charter campaign, later shifting attention from what is a minimum to what is desirable."

(85) W/Mail 10-16/4/87

1 in 4 in SA will get cancer

THELMA TUCH

ONE in four South Africans would develop some type of cancer, National Health and Population Development Minister Dr W A Van Niekerk said yesterday.

He was opening a two-day congress of the South African Society of Medical Oncology, which began yesterday at the Sandton Sun Hotel.

Van Niekerk said only 30% of those who would be afflicted by the disease could be cured by surgery or radiotherapy.

Among the white population, breast cancer was the most prevalent, followed by skin cancer, cancer of the colon and uterine cancer.

Among black women the highest incidence was cancer of the cervix, while their male counterparts were most susceptible to liver cancer.

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Picture: RASHID LOMBARD

I steal my children's time, says Cape's only hostel health worker

Hostel health worker Nozizwe Nyzakaza examines a patient Picture: RASHID LOMBARD

By SAHM VENTER

'I DID not even know when I was a little child that there were such things as hostels."

These are the words of Ms Nozizwe Nyakaza, who, as a young women, left her home in Cala, Transkei, to live the suppressed life of a hostel dweller's wife - illegal in Cape Town and illegal in her husband's bed in a room he shared with other men.

"When I got here I thought 'what kind of life is this? It is impossible'."

Today Nyakaza is the only health worker for the Western Cape Hostel Dwellers Association. In-between running a mobile clinic in Nyanga, Langa, Guguletu, Mfuleni, and eLwandle, she trains two in-service health workers, runs workshops . . . and looks after her five children who range in age from 18 months to 20.

When she first got to Cape Town with her husband and small children, Nyakaza shared a house (two bedrooms and a kitchen) "one of those little boxes of matches" with other families.

She was arrested several times with other "illegal" women and children, during the regular hostel raids. "It was not an easy life. Whenever it got too much, I would pack my things and go back to the Transkei for a rest."

In 1975, she was arrested yet again, for being in the Langa hostel illegally. It was 4am, she had a baby on her back and another in her arms. All the women and their children, were crowded into a truck and taken to the police station.

"A policeman suggested: 'If you are married, go to Crossroads and stay there'.

"My relatives were already there, but my husband was not in favour of squatting. It meant a lot of work for the men."

The deciding factor came later that year, when her oldest child, Xoliswa, 3 at the time, was diagnosed as having a cancerous growth in her eye. She had to have her eye removed and could not be treated in Transkei or the Ciskei.

As the child needed a lot of hospital treatment, Nyakaza decided to stay in Cape Town. She and her husband built a shack in the Crossroads bush where they were "hunted down like animals".

"I used to say to the priests they should stand up for us. I said to them: ' What did you say when I was getting married?'."

Nyakaza became involved in first aid and home nursing groups. In 1977 the only health service in the area was the Shawco mobile clinic which had health services once a week. She also worked as an interpreter for medical students in the area.

She became trained as a nutrition educationist. "Many children had malnutrition, dysentry, diarrohea and dehydration. But it was difficult for people to go out of the area for treatment, because they would be arrested."

Nyakaza worked on a voluntary basis until in 1979 the Quakers paid her a salary. In 1979/80 the Sacla Clinic opened and the temporary Shawco clinic moved out.

"We put up a little kitchen and there we got together with mothers. It ended up turning into a very big nutritional clinic - the Pulani Nutrition Clinic".

She became involved in the Hostel Dwellers Association in October last year. "I was asked to see to the nutritional status of the children. But there is so much to be done, that I have become a community worker."

In her work she comes across TB, VD, high blood pressure, malnutrition. "TB is worse among the hostel dwellers because there are so many people living there.

"People are not aware of what is happening to hostel dwellers. We are going to make it a point that everyone cares.

"Women used to have no say in the hostels. If you are a woman and you see men sitting in a hall you have to sit in the rooms. Your husband will tell you that it is not your business.

"It is a strange life, you have no rights to organise. The rules are made by the men and they get those rules from the system of migrant labour."

But through the organisation of the women in squatter camps, their position has changed. "It is wonderful," Nyakaza said.

Nyakaza works so hard at her job and organising and training other women that she sometimes feels that she is exploiting her children. "I steal my children's time". But she still lives up to her faith in women.

"Women are very strong. They must never think that they are weak. I have got great hope that the women I have come across in the hostels might take the lead. They are very brave."

Sugar campaign alarms heart body

Weekend Post Correspondent

JOHANNESBURG — The Heart Foundation of Southern Africa has expressed concern over a recent publicity campaign by the Sugar Association, saying the campaign implied that an uncontrolled sugar intake was not harmful.

In a statement, the foundation said it was well known that excess weight was a risk factor for conditions such as high blood fats, high blood pressure and diabetes — and therefore of heart disease.

Controlled kilojoule intake — which involved a limited sugar intake — was an integral part of the prevention and treatment of all these conditions, the statement said.

Generally, an individual's sugar intake should make up a maximum of 10% of his total energy requirements. But five teaspoonfuls of sugar, taken in tea or coffee during the day, could make up 4% of the energy needed by a moderately active woman, and the 10% limit could easily be exceeded by adding the sugar on cereals and in jams, sweets and cool drinks, the statement said.

Table sugar was a simple carbohydrate which was eventually broken down to glucose in the body.

Humans could usually take sufficient glucose from carbohydrate-rich foods, which contained vitamins, minerals and fibre. Gram for gram, sugar provided the same energy but gave no other nutrients.

"If you are following a well-balanced diet and exercise regularly, there is no harm in having some sugar every day, but if you are inactive or overweight, as many South Africans are, it is unwise to include too many kilojoules in the form of sugar," the statement said.

Sugar Association nutritionist Miss Nicky Ogilvie said the campaign was launched on radio and in the Press at the end of last year to counter consumer "myths" about sugar.

The association felt the campaign was ethical, educational and informative, and that if read properly, the advertisements were not misleading.

Research had shown that the only disease where sugar was a contributing cause was in dental caries (cavities), she said.

Warning to health services

THELMA TUCH

SA's health services must be prepared to deal with a population of almost 42-million by 1995, Minister of National Health and Population Development Dr Willie van Niekerk said yesterday.

He said it was essential for nurses to prepare now for a different approach to meet the needs of the communities they were to serve. The present population, he said, was about 28-million. By the end of last year there were 5 328 registered nurses with the additional qualification in community health nursing science.

Aids — and confidentiality

JOE OPENSHAW
Medical Reporter

The Medical Association of South Africa (Masa), a Department of Health's action group and an advisory committee have been locked in discussions on a recommendation that the names of Aids sufferers be revealed to health professionals.

The bodies will issue a statement soon, Professor Jack Metz, chairman of the Aids Advisory Committee, told The Saturday Star.

The three bodies are also considering a recommendation by Masa that Aids be made a notifiable disease and that immediate members of Aids sufferers' families also be informed.

Masa's executive committee issued a statement last week saying that, because of the contagious nature of Aids, doctors had a responsiblity towards the community to make information known to health professionals (like the patient's dentist) and his immediate family.

ETHICAL RULES

Masa recommended classifying the disease because of the need for co-ordinating statistics centrally in order to establish the full extent of the disease.

A Masa spokesman told The Saturday Star that the statement was an "interim" one and the recommendations of the executive would be discussed at its federal council between May 12 and 14.

The spokesman emphasised revealing information about the indentity of Aids sufferers would be subject to the Medical and Dental Council's ethical rule that "a doctor should not divulge verbally or in writing any information which ought not to be divulged regarding the ailments of a patient, except with that patient's express permission".

"This will not be a 'tell all'," she said, "notification will not entail any embarrassment for the patient because personal details will be kept confidential."

Although it is suggested that doctors should abide by the ethical rule relating to divulging information because of the important health risk of Aids to the community, Masa recommends that the "doctor do everyting possible to obtain the patient's co-operation".

investigating.

Call on doctors to reject apartheid

By SAHM VENTER

DOCTORS and health workers have been challenged to defy apartheid at the new Groote Schuur Hospital.

In a hard-hitting statement, the National Medical and Dental Association (Namda) called on doctors to either refuse to move into the new hospital unless it is desegregated or defy the implementation of apartheid there.

Namda has aimed the challenge directly at the staff of the University of Cape Town's medical faculty.

If the faculty was unwilling to make such moves, it should not be surprised if it becomes labelled a government collaborator, Namda said.

But the Dean of UCT's medical faculty, Professor George Dall, said the faculty's position was "made very clear" in a statement published in the recent issue of the South African Medical Journal (SAMJ).

The executive committee of the medical faculty's teaching staff and students said in the SAMJ they would oppose apartheid in the new hospital "with determination". Dall did not elaborate.

Namda appealed to the university as it would be "useless" to approach the authorities who "have for so long lost contact with their own humanity that it has become impossible for them to consider anybody else's".

Inciting doctors not to move into the new hospital would be detrimental to patients, vice-chairperson of the Medical Association of South Africa (Masa) Federal Council, Dr Norman Levy, said.

"I don't think that segregation is going to work, because no doctor supports it," he said.

Doctors should go about their job "quietly" and "the segregation part will look after itself, because patients will be treated", he said.

Namda said the planned segregation of the new R200-million "concrete edicfice" was not only a violation of internationally accepted standards, it is also "an insult to the patients who will attend the hospital".

Myth

The slogan 'Separate but Equal' "is not merely a myth, it is a sickening lie", Namda said.

While Namda has circulated a petition against the segregation of the hospital, the Western Cape region of the "non-political" South African Academy of Family Practice - Primary Care has also started such a petition against the segregation.

The petition which calls for the desegregation of Groote Schuur and other segregated medical institutions,is being circulated to the Academy's 300 members in the Western Cape.

"It is an ethical stand, not a political one," the chairperson of the Western Cape branch, Dr Saville Furman, said.

Last-ditch effort to save cemetery

SOUTH REPORTER

MAJOR Muslim organisations have made a last-ditch effort to save the historic High Level Road Cemetery from being destroyed in a town-planning scheme.

On the last day that objections against the proposed rezoning of the cemetery site could be lodged with the City Council, the Muslim Youth Movement, the Council of Mosques and other organisations notified the City Council that they would be filing objections to the preposed rezoning.

The public relations officer for the council, Mr Ted Doman, confirmed that objections had been lodged to the rezoning.

A spokesman for the MYM, Moulana Ebrahim Moosa, said the move should be resisted because "the bones of our ancestors will be exhumed and the cemetery will make way for an apartheid residential area under the Groups Areas Act".

Moosa said a petition was being circulated to gain support for the objections to the rezoning.

He said the cemetery was part of the heritage of the oppressed. The site was obtained by Muslims after they had fought against the British colonists in the Battle of Blaauwberg in 1805 and used as a *waqf* (charitable endowment) cemetery.

The chairman of the Muslim Judicial Council, Sheikh Nazeem Mohamed, said the MJC had also submitted an objection to the proposed rezoning.

"The community is united in its stand to save the cemetery," Sheikh Nazeem said.

The owner of the cemetery, Mr Michael Raad, of High Strand Investments, could not be contacted for comment. Raad bought the cemetery from the Muslim Cemetery Board in 1973 for R60 000.

In 1986 the MJC lost a Supreme Court application to prevent the exhumation of the bodies.

Barnard hits out at 'evil medicine'

DR CHRIS BARNARD has taken his crusade for euthanasia to the United States.

He said this week that medicine is "more evil than good" when it prolongs agony with no prospects for recovery.

"You pull the plug so that the patient will die, but sometimes when you pull the plug the patient still lingers on. What's the sense of that?" he asked last week at a medical seminar near Indianapolis.

Dr Barnard, who for six months a year is a scientist in residence at Baptist Medical Centre in Oklahoma City, has spoken out for mercy killing several times recently, on some occasions before religious audiences.

Suffering

He recounted his own mother's suffering after a stroke disabled her.

"She couldn't swallow and she developed pneumonia. The doctors said they would put a tube down (her throat) and feed her," Dr Barnard recalled. "And I knew mother wouldn't like that. She told

By PATRICIA CHENEY
Washington

me that many times."

He opted to have treatment discontinued and she died soon afterwards.

"I think the final decision must be made by the medical profession. I often say, when you fly in a plane and the pilot has problems and has to do a forced landing, he can't ask the passengers what he must do," the famous heart surgeon said.

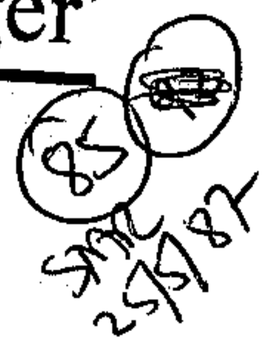
He told the Sunday Times he has received nothing but support in America for his point of view, even quoting a local pastor who told him how much he agreed with Dr Barnard's point of view.

"People tell me it is only God's work to take life, but no one has ever told me what God's definition of life is," he said.

"We accept capital punishment, war, abortion. Why can't we accept euthanasia?"

'Only sexual partners are in danger'

Masa: Aids not to be notifiable disease



By Joe Openshaw, Medical Reporter

The Medical Association of South Africa (Masa) has decided not to pursue a recommendation made by it earlier this month that Aids become a notifiable disease and the immediate family of victims of the disease, and certain health professionals, be informed of their condition.

A statement issued by Masa says it has reversed its decision to recommend that Aids be notifiable at this stage following "discussions with interested parties, locally and overseas".

Reluctant to come forward

Masa, the Department of Health Aids Action Group and the Aids Advisory Committee recently discussed the reccommdation and Masa association says "it would appear the greater part of the international medical community is not in favour of notification, the reason being that such a step may be counter productive in that sufferers would be reluctant to come forward".

"Research from various sources indicate that, except for sexual partners of an Aids sufferer, close relatives and casual contacts are not in danger of contracting the disease or becoming carriers through the use of, for example, household articles and facilities.

"Feedback on the dangers of casual exposure and the risk to health workers is very small, in fact from all the cases reported worldwide nobody involved in the treatment of Aids sufferers has contracted the disease so far.

"Aids experts advise that apart from the normal precautions taken against any form of infection (Washing hands, wearing masks and gloves and adequately sterilising instruments), it is not necessary to implement additional measures for protection," the statement says.

The danger of passing Aids by blood transfusion or the use of blood products has, for all practical purposes, been eliminated in this country by thorough testing by the Blood Transfusion Services, and by not importing blood products.

Record budget for Operation Hunger, but . . .

More and more people go hungry

By Janine Simon

Operation Hunger's mammoth R18,6 million budget for 1988 — R6 million up on last year's and treble that of 1985 — was based on the needs which should be met, executive director Mrs Ina Perlman said recently.

However, Operation Hunger, which fed 1 027 million people daily and had another 300 000 on the waiting list, would still be limited in what it could achieve.

Of the R18,6 million, more than R15 million was needed for feeding, R1,8 million for agriculture, R343 000 for other self-help projects and R842 000 for administration costs.

R625 800 had been budgeted for fund-raising costs, including the Gold Rush.

After six years Operation Hunger is moving away from family feeding as fast as possible, trying instead to concentrate on feeding schemes for children and setting up self-help projects, Mrs Perlman said.

Over the past year the number of children helped at feeding schemes rose from 650 000 to 944 966 while the number of families fed increased from 312 365 to 375 648.

Family feeding schemes were reassessed every three months and stopped if any member had started to work.

In Port Elizabeth, feeding had stopped for a month while Operation Hunger workers assessed the situation.

"We will hopefully be able to cut feeding there by about a third as temporary jobs held during the holiday period helped the unemployed," said Mrs Perlman.

Operation Hunger, which ran on a national staff of 70, was also working on a rural survey to gauge the effectiveness of their work and pinpoint future needs.

DRAMATIC

Agricultural and self-help work had expanded dramatically over the past eight months and Operation Hunger was also assessing the possibility of moving into vocational training, literacy programmes and provision of water.

Mrs Perlman said that in Ciskei, where virtually all family feeding had been phased out and a type of soup-kitchen feeding introduced — there was tighter control and only the very needy queued up for food.

In Gazankulu, where family feeding had been phased out, there had been total crop failure in the south and new appeals from the community to feed 70 000 to 80 000 children.

There had been new appeals from Venda, kwaZulu, Ciskei, Bophuthatswana, Groot Marico, the Cape and Bushmanland.

Woman dies of rabies after wrong diagnosis

DURBAN — A woman has died of rabies at her home near Pinetown after doctors had mistakenly diagnosed her illness as hysteria.

Health officials said Mrs Theresa Mkhombe, 45, was bitten by a stray dog —which was apparently rabid — on April 12 near her home in Clermont.

She had the wound stitched at the local Kwadabeka clinic.

When she became ill a month later she spent a night at the clinic on May 15, went home the next day, and on May 17 was taken by her worried family to Marianhill hospital where doctors suspected rabies and referred her to the respiratory unit at King Edward VIII hospital in Durban.

She was examined by five doctors who decided she was suffering from hysteria and sent her home.

Mrs Mkhombe died the next day.

When her family notified the health authorities a post mortem was held. The doctor who carried it out said yesterday he had been told the results showed positive for rabies.

A police probe into Mrs Mkhombe's death has been launched.

"We missed the diagnosis. She was seen by a doctor, a physician and a surgeon.

"She did not show typical clinical symptoms of rabies," the chief medical superintendent at King Edward hospital, Dr Justin Morfopoulis, said.
— Sapa

(85) ad 13/6/87 -

Health of blacks cause of concern

Weekend Post Reporter

PORT ELIZABETH's public health profile, particularly in the black areas, is causing concern to the health authorities.

"We have a high infant mortality rate compared to the other major cities, violence is extremely common, the incidence of tuberculosis is high, the socio-economic conditions are not good at all and we have high unemployment," the Medical Officer of Health, Dr Etienne du Plessis said this week.

He said 65 out of every 1 000 African babies born in the city died before they reached one year, according to the statistics for July 1, 1985 to June 30, 1986.

"Infant mortality is one of the most telling indicators of the health of any community. However, our infant mortality rate is influenced by the influx of rural people. We also have difficulty in obtaining accurate statistcis."

The infant mortality rate in the coloured community is 61,9 for every 1 000 babies.

Dr ETIENNE DU PLESSIS

In contrast the infant mortality rate for whites is 13 per 1 000 and for Indians 20,4, according to 1980 census.

Dr Du Plessis took up his post in March after practicing as a general practitioner in Hankey and Uitenhage. He holds a post-graduate diploma in community health.

He intends tackling the city's health problems by means of a wide-ranging health education programme. He stressed though that in the long-term the most important factor in improving the health of everybody was to reduce the population growth rate.

"No matter who governs this country in the future, the poor will get ever poorer unless we achieve our target of every woman having no more than two children. This is the world-wide objective of all responsible governments and health planners."

He said that it had been shown that South Africa's natural resources, particularly water, could cope with a projected maximum of 80 million people. It was expected that the population would reach this mark between the years 2020 and 2030.

"It will be easier to change our population growth rate than to increase our resources. Population growth is the one variable that is within human control."

Dr Du Plessis pleaded for greater involvement by all people in the health of the city. "The fact that you might be healthy and prosperous doesn't absolve you of the responsbility of considering your fellow man's position.

"Commerce and industry can make no better investment than to ensure that their employees are healthy and well-informed on all health matters."

The health services in the black areas had improved after interruptions caused by the unrest and three clinics, in New Brighton, Kwazakhele and Zwide, were functioning fully.

A new Zwide clinic was being built at a cost of R750 000 and the one in Kwazakhele was being upgraded and renovated at a cost of about R400 000.

He praised the dedication and professionalism of his staff and appealed to the public to allow them to go about their vital duties unhindered.

Two mobile health clinics which had been burnt out had been replaced but he said they could not be replaced if destroyed again.

SUNDAY TIMES
14/6/87

We're in a mess over stress

(85)

STRESS is scything a deadly swath through South Africa, leaving in its wake shattered lives, battered babies, debt and empty bottles.

South Africa has the unhappy distinction of being one of the leaders in the Western world in stress-related diseases and crimes — statistics that translate into tragedy.

- We rate third in divorce stakes worldwide.
- Top in heart disease.
- Top in black urban alcoholism, third for all races.

Family murders, wife and child abuse, suicides, traffic accidents and liquidations are other stress-related instances in which this country reflects killing figures.

Yet South African whites appear comfortably off.

Average annual white household incomes were R33 932, according to the Department of Statistics' 1985 survey of household expenditure.

Decline

Highest earners, with R40 050, live in Pretoria and Verwoerdburg, the lowest in East London, with R26 208 a year.

This affluent average reflects either high individual earnings — or working wives.

But, calculated at 1975 prices, the 1985 average is reduced to a mere R9 972.

In real terms, our earnings have declined — average earnings in 1975 were R10 215.

Whites also spend R185 more than they earn — an average of R34 117 a year.

We are spending 2,4 percent less on food and paying out much more on housing and income tax.

Add all these figures together and the answer equals personal stress.

More South Africans are emigrating — 1 057 during the first two months of this year compared to only 586 new settlers.

Some are taking out their frustrations behind the wheel.

There were a staggering 92 898 road accidents between November 1986 and January 1987, with 2 369 deaths — an 8,2 percent increase over last year, with fatalities 28,7 percent higher than last January.

Others turn to the bottle.

There are 52 000 white alcoholics in South Africa — a rate of 32 white male adults per 1 000.

The problem among urban black men is grimmer — 98 alcoholics per 1 000 — the highest in the world, beating the wine-imbibing countries of France (94 per 1 000) and Italy (59).

The comparative rates for other Western countries are Canada (23), United States (22) and the United Kingdom (19).

Drugs

According to Mr Mervyn Langley, research co-ordinator for the SA National Council on Alcoholism and Drug Dependence (Sanca), between 1961 and 1981 our spending on food increased five times.

On alcohol it increased 23 times.

Yet alcohol is becoming cheaper in relation to food.

Younger people are abusing drugs.

A Sanca study found that 20 percent of national servicemen had experimented with dagga; six percent with inhalants like glue, 2,5 percent with barbiturates and 2,7 percent with stimulants such as cocaine.

Others are driven to suicide — the third highest cause of death among white South Africans under 20, according to the most recent survey.

But up to 20 percent of calls from potential suicides were received from the over-60s, according to Mr Sam Bloomberg, of Suicides Anonymous — an incidence he blamed on the climate of pessimism among white South Africans, the political situation and the economic crisis.

Illness

Stress contributes to the destruction of family life.

Last year there were 23 134 divorces, with the Transvaal heading the country's toll at 60,2 percent.

Innocent victims of these divorces were 30 304 children.

Only the United States and the Soviet Union beat South Africa to the divorce courts.

Illness is the end result of stress for many.

Both heart disease and cancer are linked to stress.

Our top-of-the-world heart disease death rate for whites in the 15-to-64 age group is 224 per 100 000, with 326 Indians and 142 coloureds.

We are way ahead of the United States, which has 150 heart deaths per 100 000, and the United Kingdom rate of six per 100 000.

Half of insured South Africans die of heart disease.

Of course, much of the blame can be laid at the door of inherited high blood cholesterol, but death incidence is decreasing — possibly due to better detection and treatment.

Cancer

The decrease of heart deaths for white males between 1978 and 1984 was 29 percent, for white women 31 percent.

The most recent study of the National Cancer Association of SA, carried out by its former head, Dr John Harington, reflected all cancers at 21,6 percent for whites, 8,9 percent for coloureds, 7,6 percent for Asians and 6,5 percent for urban blacks.

Unnatural deaths account for 36 percent of South Africa's total mortality rate, according to a Medical Research Council report.

Of the 2,5-million years of potential life lost in South Africa in 1984, almost one million was lost due to traumatic injuries — motor accidents, poisoning, murder and suicide.

Third in the world in family breakups

Drink, debts a national pastime

Top of the log in heart attacks

Battered babies, murders suicides

Special report by CAS St LEGER

Prof postulates a new definition of health

Dispatch Reporter

GRAHAMSTOWN — A new definition of health was postulated by an animal scientist, Professor Val Geist, of the University of Calgary, Canada, here yesterday.

He was speaking at an international congress of zoologists and limnologists on alternative life history styles.

He said health was a state of minimum impairment which to achieve, required a maximum of competence — physical, physiological, intellectural and social — as well as the necessary resources, opportunities and motives.

Yet is was not always the "healthy" people who were survivors.

Professor Geist said large mammals were born large, grew rapidly, consumed a large supply of maternal milk, enjoyed greater maternal care, matured sexually earlier and achieved larger body size.

He said in their organs and proportions they developed disproportionately well the tissues of low growth priority.

Their social behaviour was high in frequency and intensity.

They roamed more were better at escaping predators, had a high reproductive rate and were very healthy but had a short life expectancy.

Similarly in humans body size and social class were positively related.

Professor Geist said studies in Iceland had shown that body size, population size and the amount of grazing resources fluctuated directly.

Humans' life expectancy and resource abundance might also be positively related.

Professor Geist said further data indicated that wealth and longevity were directly related.

Upper-most social classes such as independent professionals and directors of corporations spent ten to 15 per cent more time at work than did labourers.

Directors spent three times as much time in "play" as did labourers and consistently chose the more physically demanding sports.

"They also engaged in a broader range of cultural activities, saw more friends and relatives and keep more pets."

He said it appeared that data for humans fitted the model for mammals except for longevity.

"That is not too surprising since humans hardly ever procreate maximally and upper classes pass on a good part of child care to servants."

The desert-dwelling bushman had been termed the "original affluent society" because of their relative abundance of food.

The term was used to convey the notion of low work requirement, abundant leisure and choice in collecting diverse food.

But they were small, very lean, of low strength and endurance and not particularly healthy.

When working on farms bushmen grew taller, heavier and matured earlier.

The hypothesis was that a small, thin, weak diseased body was very likely to be a survivable one, while a big robust healthy body was not ideally suitable to periods of boom and bust in the desert economy — were severe and unpredictable resources were continually scarce.

Masa concerned at 'removal' of patients

The Medical Association of South Africa (Masa) expressed disquiet yesterday over "occasional reports" that patients were removed from the care of their doctors by police.

Dr Bernard Mandell, chairman of Masa's federal council, said in a statement his organisation would contact the Department of National Health and Population Development "requesting them to assist Masa in investigating such incidents when they are reported".

He said the establishment of a Masa panel, from which detainees could request a private general practitioner should they wish to obtain a second medical opinion, was "a direct result of fruitful negotiations with the department and other concerned authorities".

Dr Mandell said it was the "moral and ethical duty" of all doctors to report to Masa interference with their "clinicial independence".

"Doctors are not only entitled, but are ethically bound, to continue treating a patient until they are of the opinion that no further treatment is required," he said. — Sapa.

(95 Sowetan 23/6/87 378)

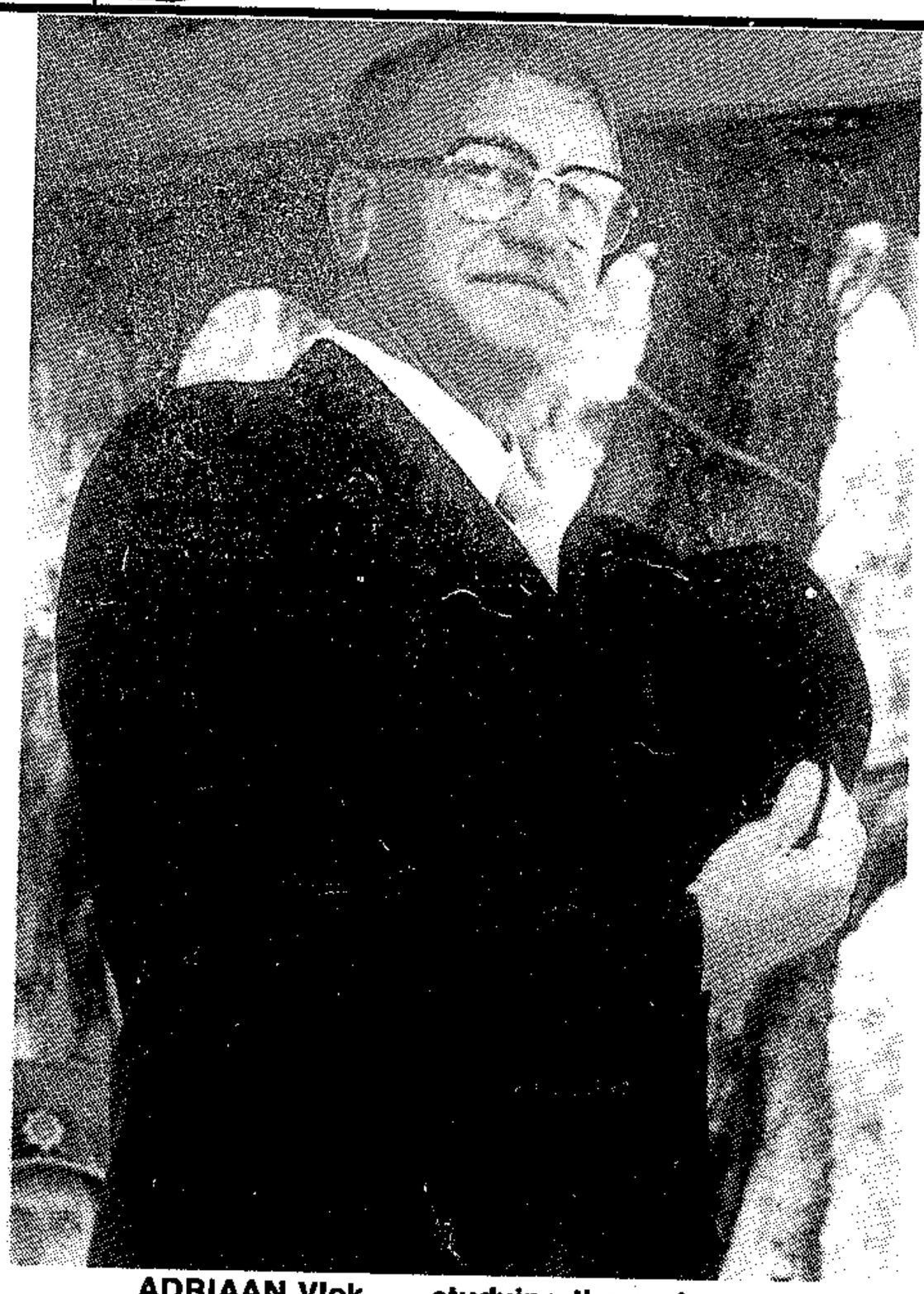
Masa guideline on detained kids

THE potential consequences for child political offenders held under the Internal Security Act are "very disturbing" as the Act makes no special provision for children, says the Medical Association of South Africa.

This is stated in a manual entitled *Children in Places of Detention: A Code for their Handling*, prepared by the South African Paediatric Association for Masa, and inserted in the latest issue of the *South African Medical Journal*.

In the preamble to the eight-page manual, Masa said the code's purpose was "to lay down a set of rules for the handling of all children in detention of which we as South Africans may be proud".

The Minister of Law and Order, Mr Adriaan Vlok, was studying the code his Press spokesman, Brigadier Leon Mellet, said yesterday.



ADRIAAN Vlok . . . studying the code.

Ideal state

Masa said it believed the code represented the "ideal state of affairs" regarding the detention of children, but realised it would take time and effort to achieve it.

The code lists four Acts: the Prisons Act, the Child Care Act, the Criminal Procedure Act and the Internal Security Act, under which children, which Masa defines as youths between seven and 18, may be imprisoned.

Of the Internal Security Act, Masa said: "This Act, which deals with 'terrorism', 'subversion', 'sabotage' and 'communism', gives wide powers to the Minister and to the police.

"Children are not granted any special protection in terms of this legislation, physically, mentally or legally.

"The potential consequences for child political offenders are therefore very disturbing."

In a section on children and detention generally, Masa said the State assumed an "awesome responsibility" when it removed children from their homes, parents and schools.

"This responsibility is the greater when one considers the possible ill-effects, including the physical, psychological, emotional and criminalising effects of detention. The purpose of this document is to emphasise and categorise these responsibilities.

"While it is most regrettable that any child should fall foul of the law, it is recognised that childhood delinquency exists and that the State is obliged to act for the protection of society.

"This obligation, however, includes that of minimising the ill-effects of detention and of rehabilitating the delinquents."

Masa said the primary purpose of detention must be to provide an environment for development which was superior, in the view of the courts, to that of the child's home.

"The juvenile delinquent must in fact be regarded as 'a child in need of care'."

It continued: "The concept of detention as a retributive punishment is totally without justification for children. Protection of society by detention of a child is only justifiable if every effort is made to return the child better able to take a full place in society."

Traumatic

On arrest procedure, Masa said: "In view of the possible traumatic consequences of arrest, consideration should be given to the creation of special police units with special training to deal with children."

No child, whatever the circumstances, should be held in detention without being charged for longer than two days unless a court order existed.

On interrogation procedure, Masa said no child should be questioned by the police without his or her parent, guardian or legal representative being present.

Masa said it was essential that magistrates and commissioners be made "fully aware" of the ill-effects of imprisonment of children. "The younger the child, the more appropriate should the sentence be with regard to the child's development."

FOCUS

Medical fees might go up

PRETORIA — The Medical Association of SA (Masa) has recommended a 20% increase in its guideline tariffs for doctors from July.

Masa's Federal Council chairman Bernard Mandell said the benefit offered by medical schemes were 50% short of a "reasonable renumeration" for doctors services.

He stressed the continually rising costs of running a practice, and warned if doctors were denied reasonable incomes the quality of services could deterroriate.

Masa's economic adviser Professor Fritz Steyn said an increase in excess of 20% could have been justified.

Mandell said about 20% of doctors charged the guideline tariffs. The others adhered to the tariffs laid down by the Representative Association of Medial Aid Schemes (Rams).

Rams tariffs were last increased in January last year by 12,5%.

During this time doctors practice costs increased from 52% of gross earnings in 1985 for GPs, to more than 60% in 1987.

In the case of high cost practices, such as pathology, costs had spiralled to 90% of gross income, Mandell claimed.

GERALD REILLY

Everything possible had to be done, he said, to keep private medical services within the reach of as many as possible. Doctors had to take into account patients financial circumstances.

Mandell asked why medical scheme members who carried a heavy load in monthly contributions did not demand increased benefits.

Last year their contributions were raised by between 40% and 112,5% — they received no increase in benefits for doctors services.

Inspite of allegations by medical schemes of an "uncontrollable" increase in payouts, total payouts had decreased from more than 40% in 1980/81 to 35,8% in 1985/86.

Mandell stressed doctors were finding it increasingly difficult to continue rendering an acceptable standard of service at Rams rate.

Rams would be urged by Masa to urgently consider a more realistic level for their scale of benefit.

(85) DD 1/7/87.

Medical cost-containment scheme to start today

Dispatch Correspondent

DURBAN — The 550 000 member Association of Medical Scheme Administrators (AMSA) is to pay dispensing doctors directly — if they agree to a new "cost-containment monitoring scheme" which starts today.

The new cost containment programme follows an agreement between AMSA and the Society of Dispensing Family Practitioners (SDFP).

The chairman of AMSA, Mr Keith Hollis, said the SDFP has agreed to develop norms for the profession "against which the prescribing and dispensing performance of individual doctors will be monitored".

These norms would be determined and measured from claims analysis provided by AMSA and only those doctors who agreed to the SDFP guidelines on cost containment would qualify for direct payment.

"By analysing the claims will be able to point out any variation in costs by individual doctors and then decide whether we wish to continue direct payment to the doctors concerned."

Mr Hollis said the procedure of doctors submitting claims directly to medical schemes for both professional services and dispensed medicines opened up "several pitfalls".

If a patient paid nothing towards such services, at the time of treatment, he had no means of recognising its true value.

"It would be unlikely that inexperienced new members would check whether the account was properly detailed, whether additional charges had been inserted subsequently or whether the scale of charges had been followed by the supplier."

Mr Hollis said the SDFP had welcomed the programme and had appealed to its members to give it their full support.

AMSA's members jointly administer 74 medical schemes.

Govt stops tests for womb cancer

Soweto
23/7/87
(85)

THE Government has discontinued routine tests for cancer of the cervix (womb) — widespread among black women — leading to fears that the disease may spread uncontrolled in black townships.

Dr Hennie van Wyk, executive director of the Department of Health Services (Transvaal), confirmed yesterday that a directive has been issued that no routine PAP smears screenings

By NKOPANE MAKOBANE

must be taken at their clinics.

He said this decision came into effect last week Monday (July 13). His department had established that other health authorities suspended the taking of PAP smears at their clinics.

This, he said, had resulted with their clinics being overburdened with patients referred by other authorities with requests for PAP smears.

The discontinuation of the tests will mean that:

- There will be a high rate of cancer of the womb;
- Less infections of the womb will be treated;
- The pick-up rate of early signs of the cancer will decrease; and
- The general awareness of the community about the disease will be affected.

The spokesman said the disease takes about a year to spread and once it has reached this stage it is difficult to treat. People, he said, may even die as quick as five years.

"The other dangers of this cancer, is that once it is diagnosed, it may cause a breakdown in the family, and cause severe depression in the woman because she would no longer be able to bear children.

● To Page 14

'Decision erosion of rights of women'

● From Page 1

In a circular sent to all medical and nursing personnel at Soweto Community Health Centres last week, the authorities say there are problems regarding the number of requests for cytological examinations on PAP smears.

They also say the tests have resulted in financial implications.

The circular states that the South African Institute of Medical Research has been requested to return all slides that they may receive from July 13 onwards to the sender.

It adds if a patient definitely needs the test she must be referred to the Gynaecological Department at Baragwanath Hospital for that purpose.

A spokesman for the Health Workers' Association (HWA) said the tests were the most simple and inexpensive method to detect cancer of the womb. This cancer was most prevalent among black women.

spokesman, a study done by an expert in the 11 primary health care clinics in Soweto during 1983, found that 41 out of every 1 000 women between the ages of 40 and 60 had cancer of the cervix. In 13 of the 41 women, the cancer was already malignant.

He said the provincial authorities could save up to R210 000 in doing the test screening as compared to treating one patient with this cancer.

"The decision by the department is a further erosion of the rights of women. The HWA urges women's organisations, including civic associations, student bodies and trade unions to halt this erosion of the rights of the black community.

"The authorities have kept on complaining there is too much . ing there is too much expenditure on the health sector. However, HWA believe that apartheid is responsible in this crisis. There are 13 ministries of health in the country and this means expenditure is 13 times more," he said.

"It is disgusting, crazy and inhuman to take away this service from black women who have the highest rate of this disease. No woman wants to have cancer when she knows it can be prevented," he said.

According to the

Hasten health privatisation call

MICK COLLINS

A MAJOR firm of management consultants has called on health care experts to follow government's lead and expedite privatisation of the industry.

It points out that the Browne Commission and the subsequent government White Paper came out in support of a more free-market system, as opposed to a national health approach.

Pim Goldby director Guy Harris says: "As far as privatisation causing an escalation of costs is concerned, overseas experience would indicate the opposite.

"The contention that it should be accompanied by firm regulatory control, I also question."

Harris says regulatory control will run contrary to government's policy of deregulation and privatisation.

"However, I do accept that there may be a need for regulation where a monoply is involved — say in the case of a small-town hospital."

Referring to a recent article in the SA Medical Journal, he says, he finds it surprising that a magazine whose readership includes a large number of doctors in private practice should infer that the private sector is a rip-off.

"I wonder if it has the support of its readers? Also, I wonder whether private practitioners would be happy with being paid only for the cost of their services and not for their capital, time, and other assets such as the years they have spent training."

Harris says the magazine speaks of the consumer paying for medical care in socialist countries through a compulsory levy.

"In fact, such levies do not care much for old age pensioners and indigent patients, so it is the corporate and individual taxpayer who ends up paying.

"While I would be the last to say that privatisation is a panacea for all ills, I do believe that it does have an important role to play in selected areas.

"Every consumer knows that health care costs are escalating — let the experts get together to find some constructive answers to the problem — and stop wasting energy on destructive criticism of options like privatisation".

Christian health care project

SOUTH REPORTER

FIFTEEN "people's doctors" with school education of between Std 3 and Std 9 have begun to give much-needed health care in Khayelitsha.

Armed with the most basic medical supplies, the community health workers, as they are properly known, are often the only health care available for people in Khayelitsha.

Khayelitsha has only two temporary state-run clinics. These are not open over weekends.

The community health workers have become crucial to the community, especially at night and over weekends, according to Dr Ivan Toms, who is training them as a project of the South African Christian Leadership Association (SACLA).

The project was started after the SACLA clinic in Old Crossroads was taken over by the SADF on June 16 last year and the staff made to leave.

At that stage, clinic staff were treating 175 medical and 65 dental patients a day, six days a week.

"Through the community health workers we can avoid a similar situation where people are deprived of essential medical attention in a situation of

"When there is unrest in the townships, outside doctors cannot always go in. These health workers live in the community and are selected by the community they serve.

"They are trained for six weeks and have regular sessions with qualified doctors afterwards," said Toms.

He felt the democratic selection by the community was essential if the programme was going to be progressive and facilitate real community development and health.

"This is a very slow and sometimes difficult process because of divisions in the community, but it is required otherwise this project will be doing things for the community which does not facilitate and give them power. We recognise and use the community structures in the areas we work in, be that street or area committees.

"Our only criterion for health workers is that they should not be linked to the power structure in the community, like the children or wives of headmen."

So far 15 community health workers have been trained and SACLA intends to have 51 working in Khayelitsha, Mbekweni and Montagu/Ashton by March next year.

Each worker is trained in both preventative and curative aspects of health and serves about 2 000 people.

Dr Ivan Toms

Toms sees the project's strength in its community base.

"It will not be withdrawn at a time of political violence, like government services normally are.

"It tries to empower the community by giving them a say in their own health care. Hopefully this will have a ripple effect and will strengthen progressive organisations in the community and their ability to make demands on the government.

"It helps to demystify health. People normally associate health care with big clinics and a doctor in a white coat who gives you an injection to make you feel better.

"Community health workers work from their homes and can explain illnesses in simple language which anyone can understand."

Church 'can't be neutral'

THE CHURCH can't be neutral in the face of the state's attempts to smash Cosatu, the country's largest federation of trade unions, the Durban-based Diakonia group has said.

Diakonia, a joint project of the African Methodist Episcopal, African Presbyterian, Anglican, Evangelical Lutheran, Methodist, Presbyterian, Roman Catholic and the United Congregational Churches in the Durban area and the Belydende Kring in Natal, outlined repression against Cosatu.

Dignity

"God's will is that worker rights and their dignity be honoured by all. A Christian concern for justice today cannot be divorced from a commitment to workers.

"If the government succeeds in destroying Cosatu then no organisation or individual is safe," Diakonia said.

It suggested various responses Christians could make to this threat against Cosatu and non-racial and democratic organisation.

- Pray for Cosatu, its affiliates and all workers.
- Discuss in groups a Christian response to attacks on the worker movement.
- Contact Cosatu offices and ask for their side of the story.
- Invite workers or trade unionists to speak to your congregation.
- Spread the facts to your social action group, Justice and Reconciliation Committee, parish council and congregation, school friends and colleagues.

Campaigns

- Encourage your friends and family to discuss how they can support Cosatu campaigns.
- Allow trade unions to use your church halls for meetings.
- Encourage workers in your congregation to share with others thoughts on working conditions and wages.
- Encourage worker participation in the running of your parish.
- If you are an employer, ensure that your labour practices are just and fair. And especially allow easy access to representative trade unions.
- If you are a worker, find out about trade unions which can represent your interests.

Uranium spillage is no health threat says AEC

SOWC 31/7/82

The uranium oxide spillage that occurred earlier this week at Majuba Pass posed no health risk to occupants of vehicles which used the road, the Atomic Energy Corporation (AEC) said yesterday.

In a statement, the AEC said that over the past two days it had monitored 54 vehicles for uranium contamination. All the vehicles had used the road shortly after the accident.

Of those 54, 52 had showed no signs of contamination and the remaining two tests revealed "small but insignificant traces of uranium".

The amounts of uranium identified were so small that they posed no risk to the occupants of the vehicles.

"The number of vehicles monitored is regarded as a representative sample and confirms that the effects of the accident pose absolutely no health risk to occupants of vehicles which used the road or to residents in the vicinity," the AEC statement said.

Examination of the vehicles was performed by qualified AEC staff at the Volksrust and Newcastle monitoring stations and at the AEC's Pelindaba site. — Sapa.

Heat's on for 'committed' doctors

Relations between two medical associations reach an all-time low amid accusations of 'harassment' of committed doctors. CARMEL RICKARD reports

NATIONAL Medical and Dental Association officials believe a "pattern of harassment" is emerging, directed at professionals who challenge the status quo in South Africa's health services.

Namda has identified several examples of this alleged harassment which includes a disciplinary case — eventually thrown out of court — brought against a "trade union doctor".

The latest issue of the *South African Medical Journal*, the official publication of the Medical Association of South Africa, was devoted to criticism of Namda. It contains a special supplement dealing with remarks allegedly made by Namda's president, Dr Diliza Mji, during a visit to the United States in May.

Mji went to America to receive a human rights award on behalf of Namda, and he allegedly made a number of remarks there, some of them critical of the state of medicine and health in South Africa, others critical of Masa.

The *SAMJ* special edition carries an official Masa reply to several of these remarks as reported in two US newspapers.

In the supplement, each comment allegedly made by Mji is followed by a paragraph headed "facts and comments" by Masa.

An example of the remarks attributed to Mji to which Masa takes exception is the following: "We don't have a death wish for Masa ... if only Masa would take up the issues we have taken up, we would close up shop and join them."

Masa complains this seems incompatible with the "repeated calls by Namda" for the expulsion of Masa from the World Medical Association and with the continuing attempts to discredit Masa, for example by describing it as "a pillar of apartheid".

Masa claims Namda "chose the path of confrontation right from the start" and assumed Masa would not agree to take up the issues espoused by Namda.

Among the issues Namda has taken up, says Masa, is a call for the unbanning of the African National Congress, an end to the State of Emergency and a statement that the House of Delegates does not represent the Indian community.

"Masa believes that issues such as (these) do not fall within the ambit of activities of a professional organisation such as Masa," the comment concludes.

Masa's criticism of Namda in this special supplement is not the first time it has slated its rival, although the issue represents an all-time low in relations between the country's two largest doctors' associations. In February, for example, the new president of the Soutpansberg branch of Masa, Dr Andre Fouche, was quoted as saying: "We know for a fact that Namda (is) sponsored by the ANC and the SA Communist Party".

Of Fouche's comments Masa's secretary general, Dr Marais Viljoen, said "Masa has not discussed the question of whether Namda is involved in the ANC or SACP or not. It can therefore neither agree or disagree with such a statement."

A Namda official, commenting on the supplement, said it was "arrogant" of Masa to issue it, as it seemed to convey the idea that no-one was entitled to disagree with Masa about health in South Africa.

"Although they claim they do not support apartheid, many of their criticisms of Dr Mji are in fact little more than apologies for the status quo in health in South Africa, and in fact give support to many apartheid practices," the official said.

"The attacks made on us by Masa officials are part of a general pattern of claiming anyone critical of apartheid is acting as a front for the ANC and SACP.

"We are not affiliated to any political organisation but the underlying reason for our existence is to draw attention to our belief that apartheid is a basic reason for ill health in this country and that it is having a detrimental effect on the health of black people especially."

Namda says another example of "harassment" of health professionals was the sudden transfer in March of Dr Krish Vallabhjee who worked at RK Khan Hospital.

"He was involved in a campaign to expose poor conditions — for workers and patients — at the hospital, and was suddenly transferred to Dundee."

Namda says they have "absolutely no doubt" that the action against Valabhjee, both in transferring him and subsequently refusing to let him move from Dundee, was "straight political victimisation".

The organisation also refers to the eight KwaZulu doctors who were "dismissed" last year from the KwaZulu government service.

Among them was Dr Joe Phaahla, a ex-president of the former Azanian Students Organisation. The doctors claimed they were being victimised because of their political convictions. KwaZulu officials said they had not been dismissed — rather their appointments had not been confirmed.

Last week, a Durban Industrial Health Unit doctor, Mark Colvin, was brought before a disciplinary committee of the South African Medical and Dental Council, the statutory body governing the profession.

Dr HE Godfrey, employed by a Pinetown factory, Pineware, claimed that Colvin had "pinched" two of Godfrey's patients and had misdiagnosed the condition of one of them.

After a brief adjournment the president and assessors agreed to throw out the case.

Commenting on the matter, a Namda official said: "People like Mark Colvin and the Industrial Health Unit — where medical help is given free of charge to workers — are providing an invaluable service and should be congratulated rather than taken to task."

W/Mail 7-13/8/87 (85)

Health centre for teenagers to open soon

(85) WPost 8/8/87

Weekend Post Reporter

THE Eastern Cape's first teenage health centre will be opened in October at the former Kolnicks building in Main Street in Port Elizabeth.

The family planning section of the Department of National Health and Population Development is leasing the ground floor of the building and conversion work will be completed by the end of September.

It will give young people of both sexes and all races a central, easily accessible venue where they can discuss their problems with understanding, trained counsellors, education or nursing personnel, with doctors available for advice and consultations.

The main purpose is to try to reduce the high number of teenage pregnancies which cut education short, lead to backstreet abortions, unwanted children and other problems.

General health education, advice on contraception and supply of contraceptives, film shows, literature and medical advice will all be on hand.

"The centre is not meant to encourage sexual licence among adolescents, but to try to create a sense of responsibility in both sexes towards themselves and the community," said a family planning spokesman.

The biggest need for family planning advice was among teenagers. Many young girls became pregnant before realising their full potential.

It was hoped, through the clinic, to get young people to defer their first pregnancy.

British statistics showed that a third of adolescents in the equivalent of Standard 8 were sexually active. The figures for South Africa were probably about the same.

It had been shown that young people who attend clinics have already become sexually active, so clinics were not encouraging sexual activity by distributing contraceptives.

Adolescents who were sexually active were already exposed to the risk of pregnancy.

Mrs Blanche Damons will be nursing system manager in charge of the programmes at the clinic and will be assisted by chief professional nurse Mrs Marie Blom and other staff.

The spokesman said that although problems should ideally be discussed at home, parents sometimes found it difficult to understand and talk about the pressures of adolescence.

Family planning work was divided into the educational side, under the control of welfare officers — university graduates trained in social work — and the nursing or clinical side, staffed by nurses with the support of doctors.

A similar health centre for the young will be opened in East London shortly, on the second floor of family planning's Oxford Street office.

She is doing her best with limited resources

By Jill Gowans

Doing the best with limited resources for the mass of the people is the kind of medicine and health care Dr Anuradha Nursingh is practising.

This Star Woman of the Year nominee is the first woman and the first Indian doctor to be appointed senior medical superintendent of the massive 1 400-bed provincial Clairwood Hospital at Mobeni near Durban. She takes charge of 1 100 members of staff.

"It is no use placing a malnourished child in hospital and giving him the best feeds, filling him with antibiotics and then returning him to the same conditions that caused his problem," she says.

"All our problems are caused by bad social conditions and we as doctors must push to educate rural people on basic hygiene and nutrition, teach them how to grow good second-class proteins and how to help themselves."

Her patients come from the whole of kwaZulu, the Transkei, Lesotho and from as far as Zambia.

Born and educated in Durban, she won a scholarship from the Indian government to study medicine.

PRIMARY CARE

It was there she saw how people were geared towards providing Third-World medicine with the emphasis on primary health care.

After doing her internship in Lesotho, Dr Nursingh worked as a medical officer at King Edward VIII Hospital in Durban and then became deputy medical superintendent at Clairwood before being appointed last year to run the hospital.

She has made dramatic changes. She is in charge of a four-month primary health care course for qualified sisters — the only province-run course in Natal — which teaches them how to examine patients and make simple diagnoses.

She has re-organised the hospital, which covers 17,5 ha, to make it more efficient and improved the outpatients' department, which handles up to 700 a day, so that patients do not have to wait for hours.

After three years of constant badgering and a very low budget, she has improved the food, acquired a full-time social worker and started an ophthalmology department.

ANURADHA NURSINGH: "Our problems are caused by bad social conditions."

She has pushed friends and colleagues to supply clothes to patients who have lost theirs, in accidents for instance. And such is her compassion that patients who have no money to re turn home after being discharged, are driven by hospital transport if they live within a 100 km radius.

She has introduced family planning talks in the pediatric outpatients department for young mothers and obtained two video machines and several television sets from which staff, including the domestic workers, and patients are taught basic hygiene and health care.

"I'm a total women's libber," she says, grinning. "I can't take men who are inefficient! A male colleague said to me: 'You females see things I would never see.'

"But I think running a hospital is like running a home. I apply the principles I would apply in my home. I know how many swabs down to the last swab we use and we have managed to contain our budget while making major improvements."

Malnutrition —no records

30/8/82

(K)

CAPE TOWN — No official records are kept by the government on the number of children suffering from malnutrition in South Africa, the Minister of National Helath and Population Development, Dr Willie van Niekerk, disclosed yesterday.

Dr van Niekerk said that "due to considerable physiological and clinical problems" regarding the definition of "malnutrition", especially of older children, no official record was kept of children under 14 years of age who suffer from this condition.

Dr van Niekerk was replying to a question by Mr Mahmoud Rajab (PRP Springfield), who wanted to know the provincial breakdown of malnutrition among children in South Africa over the past three years. — DDC

(iii) (aa) Interest is payable on reducing balance and will vary over the period of the loan. The initial amount in interest payable is R4 324 325 during November 1986.

(bb) R8 648 648 per annum.

(iv) (aa) 20 years.

(bb) November 1986.

(3) Yes.

(a) From own revenue and other sources still being investigated.

(b)

	(i) Soweto	(ii) Dobsonville	(iii) Diepmeadow
30 June 1985	R114 525 405	R 9 288 648	R49 158 919
30 June 1986	R114 525 405	R 9 288 648	R49 158 919
30 June 1987	R125 977 945	R10 217 513	R54 074 811

(4) Not applicable.

Botswana/Swaziland/Lesotho: customs revenue

411. Mr W J D VAN WYK asked the Minister of Finance:†

(a) What percentage of the Republic's customs revenue was paid over to (i) Botswana, (ii) Swaziland and (iii) Lesotho as at the latest specified date for which information is available and (b) what amount of customs revenue was paid over to each of these countries in 1984, 1985 and 1986, respectively?

The MINISTER OF FINANCE:

(a)

	1986-87
(i) Botswana	5,529%
(ii) Swaziland	2,846%
(iii) Lesotho	3,426%

Note: The precentages have been calculated on the combined income of customs duty, excise duty, surcharge and miscellaneous for the financial year 1986-87.

(b)

	1984-85
Botswana	R180 544 000
Swaziland	R130 409 000
Lesotho	R151 498 000
	1985-86
Botswana	R174 429 000
Swaziland	R136 576 000
Lesotho	R161 086 000
	1986-87
Botswana	R232 796 000
Swaziland	R119 811 000
Lesotho	R144 259 000

Newsprint imported

412. Mr W J D VAN WYK asked the Minister of Finance:†

(a) How many tons of newsprint were imported in each of the latest specified five years for which information is available and (b) what was the rand value of these imports in each such year?

The MINISTER OF FINANCE:

(a) and (b)

	Ton	*R (value)*
1982	284,8	184 183
1983	150,2	54 384
1984	441,0	202 829
1985	110,6	171 694
1986	590,9	451 697

FRIDAY, 11 SEPTEMBER 1987

†Indicates translated version.

For written reply:

General Affairs:

[Reply *bound in Annexures of House of Assembly see M/119—1987.*]

219. Dr M S BARNARD asked the Minister

of National Health and Population Development:

(1) (a) How many community health centres were there in each province as at the latest specified date for which information is available and (b) what (i) was the staff complement of each such centre and (ii) were the functions performed by the staff of these centres as at that date;

(2) whether any further community health centres are planned; if so, (a) how many in each province and (b) when are they due to be completed in each case?

Detainee: nature/cause of injuries

238. Dr M S BARNARD asked the Minister of Law and Order:

With reference to his reply to Question No 70 on 23 February 1987, (a) what was the (i) nature and (ii) cause of the injuries of each detainee which required treatment in hospital and (b) which of these injuries were sustained (i) prior and (ii) subsequent to the detention of these persons?

The MINISTER OF LAW AND ORDER:

(a) (i) A variety of injuries, *inter alia* broken limbs, arm and hand injuries, head injuries, groin injuries, eye injuries, gunshot wounds, jaw injuries and dog bite wounds.

(ii) Because these injuries are unrest-related, it is, with the exception of gunshot and dog-bite wounds, difficult to ascertain what caused these specific wounds.

(b) (i) As far as could be ascertained, all the injuries were sustained before or during arrest.

(ii) Falls away.

Group Areas Act

310. Mr S S VAN DER MERWE asked the Minister of Constitutional Development and Planning:

(a) How many notices were served in terms of section 41 of the Group Areas Act, No 36 of 1966, during the latest specified period of 12 months for which information is available and (b) (i) on what dates, (ii) in which towns or areas and (iii) in respect of what specified properties was each such notice served?

The MINISTER OF CONSTITUTIONAL DEVELOPMENT AND PLANNING:

(a) Since 1 September 1986 notices have been issued in respect of 41 premises and forwarded to the relative offices of the SA Police to be served. Confirmation has not yet been received in respect of all notices and it is therefore not known how many have already been served.

(b) (i) to (iii) Fall away.

Annual reports

384. Mr K M ANDREW asked the Minister of National Health and Population Development:

(1) (a) (i) How many annual reports were produced in 1986 by his Department and/or statutory bodies falling under his Department and (ii) in respect of what bodies were these reports produced, (b) what was the cost of producing each such report, (c) how many copies of each report were printed and (d) who undertook the printing of each report;

(2) whether the printing of these reports was put out to tender; if not, why not; if so, (a) what was the (i) lowest and (ii) highest tender submitted, and (b) what was the amount of the successful tender, in each case;

(3) whether any copies of these reports were sold; if so, (a) how many, (b) to whom, and (c) at what price, in respect of each report;

(4) in respect of each of the latest specified five years for which information is available, (a) what was the total cost to his Department of these annual reports, (b) how many copies were printed, (c) how many of these reports contained (i) full colour and

(ii) black and white pictures, (d) on what quality paper were the annual reports printed and (e) (i) how many of these reports contained a photograph or drawing of the (aa) political head and (bb) top official of his Department and/or the statutory bodies in question and (ii) how many of these pictures were in (aa) colour and (bb) black and white in each case?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

(1) (a) (i) Three.

(ii) A. The Departmental annual report;

B. The Compensation Commissioner for Occupational Diseases;

C. The Medical Bureau for Occupational Diseases.

(b) A. R48 219,75

B. R2 797,57

C. R2 614,78

(c) A. 1 800

B. 600

C. 800

(d) Government Printer.

(2) No. The procedure is in the discretion of the Government Printer.

(a) (i) (ii) and (b) Fall away.

(3) Yes.

(a) A. The Departmental annual report is not sold but distributed free of charge.

B. 20;

C. 22.

(b) The general public.

(c) A. —

B. R2,75 (excluding GST)

C. R2,80 (excluding GST)

(4) (a)

	A	B	C
1982	R45 368.84	—	—
1983	R53 784,44	—	—
1984	R61 168.92	R3 204.03	R2 187,93
1985	R56 794.30	R2 359.30	R1 982,77
1986	R48 219.75	R2 797.57	R2 614,78

(b)

	A	B	C
1982	2500	—	—
1983	2500	—	—
1984	2000	620	720
1985	2000	690	800
1986	1800	600	800

(c) (i) Five;

(ii) None.

(d) A. Dukuza Art Matt, 98 gm²

B. and C. Cream Wove, 70 gm²

(e) (i) None;
(aa) and (bb) Fall away.

(ii) None.
(aa) and (bb) Fall away.

Supplementary reply to Question No 222 on Wednesday, 29 July 1987, put by Mr R M Burrows (col 432):

Own/general affairs: hospitals

Mr R M BURROWS asked the Minister of National Health and Population Development:

(1) Whether the allocation of hospitals to

own and general affairs departments is being considered by his Department; if so, in respect of each province, which hospitals are being considered for allocation to the (a) own affairs health departments and (b) general affairs health departments;

(2) whether he will make a statement on the matter?

The MINISTER OF NATIONAL HEALTH AND POPULATION DEVELOPMENT:

In the previous reply to Question No 222, it was indicated that Riverlea, a province-aided institution, was to be allocated to the Administration: House of Delegates.

The Institution has however, already been allocated to the Administration: House of Representatives mentioned in a letter by the Minister of National Health and Population Development to the various Own Affairs Administration dated 4 February 1987.

However, this amendment must not be seen as a deviation from the guidelines, but only as an error which inadvertently crept in with the preparation of the reply.

The complete correct reply is as follows:

(1) Yes.

(a) As per the attached list.

(b) The remainder of public hospitals.

(2) No.

1. *To be allocated to the Administration: House of Assembly.*

1.1 *Transvaal*
Paardekraal, Krugersdorp
Randfontein Clinic
Vereeniging Hospital
Far East Rand Hospital
Andrew McColm
Bernice Samuel, Delmas
Bloemhof
Brits
Delareyville
Duiwelskloof
Edenvale
John Fotheringham Clinic
Elsie Ballot, Amersfoort
Evander
F H Odendaal, Nylstroom
Genl De La Rey, Lichtenburg
Groblersdal
H A Grové, Belfast
Hendrik V D Bijl, Vanderbijlpark
Kempton Park
Louis Trichardt
Discoverers Memorial, Roodepoort
Phalaborwa
Pretoria-West
Sannieshof
South Rand, Rosettenville
Sybrand Van Niekerk, Carletonville
Van Velden Memorial, Tzaneen
Ventersdorp
Voortrekker, Potgietersrus
Warmbaths
Waterval-Boven
Willem Cruywagen, Germiston

Subsidised Hospitals
Bond van Afrikaanse Moeders, Pretoria
Coligny Clinic
SAWF, Ellisras
Ottosdal Nursing Home
Pongola

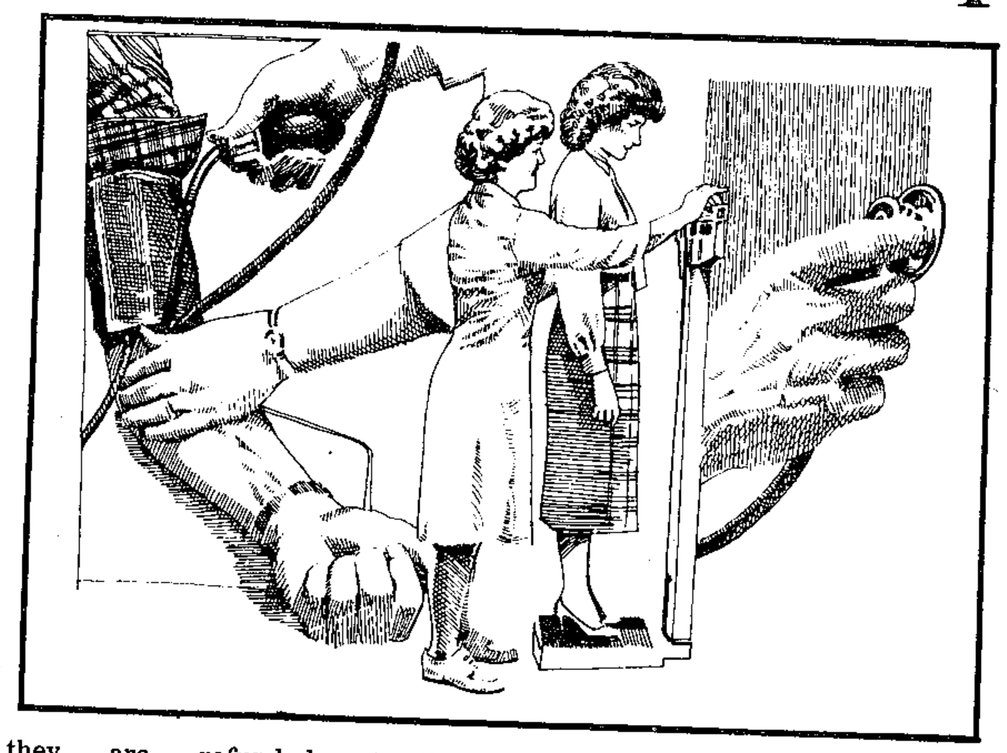
Province Aided
Zuid-Afrikaans, Pretoria
Daspoort Poll Clinic

1.2 *Cape Province*
William Slater
Volks, Cape Town
Riebeeck-West Clinic
Riebeeck Castle Clinic
Port Elizabeth Provincial
Despatch Day Hospital
Walvisbay

Day Hospitals
Deep River
Good Hope, Ysterplaat
Kraaifontein
Parow
Ruyterwacht
Goodwood

Province Aided
Corolina Maternity, De Doorns
Booth Memorial, Cape Town
Harmony Home, Kimberley
Die Wieg Maternity, Moorreesburg
Newhaven Home, East London
Regina Nursing Home, Villiersdorp

Medical profession is feeling the pinch



Medical aid contributions will soon rise to enable higher medical aid payments to doctors. Too little, too late, complains the medical profession, citing squeezed profit margins because costs are rising faster than medical aid tariff payments.

DIANA GAMES, of Johannesburg, examines the anatomy of two medical disciplines, a general practice and a large pathology laboratory.

General practitioners have not had a medical aid increase in consulting fees for two years. Their profit margins have been reduced and they place much of the blame on medical aid schemes.

Estimated costs for running a practice have risen from 50 per cent of earnings about 10 years ago to 64 per cent, leaving them with a profit margin of 36 per cent.

Doctors complain that their medical aid rates do not counteract the dent inflation has made into what they get out of the business. While this had not meant a general change of lifestyle, a doctor practising in a fairly wealthy suburb of Johannesburg said that the lower profit margins have meant larger overdrafts and a decreasing ability to save.

One doctor said that in 1970 his consulting fee was R2,50 and his 3,5-litre car cost him R4 000 new. His fee is now R13,60 and a similar car costs' R120 000.

While doctors are doing far fewer home visits than they did 10 years ago, they are spending long hours in their surgeries in an attempt to counteract the gap between income and expenditure.

His practice averages 25 patients a day, but only 30 per cent of his patients are charged scale of benefits fees paid by medical aid.

"You have to harmonise . . . you can't charge a banker the same as a labourer or a student," he maintains. But, he said, in poorer areas doctors would have a much higher percentage of patients being charged medical aid tariffs.

The control over what a doctor charges private patients is mostly determined by the fee guide devised by the Medical Association, an independent body of doctors representing about 60 per cent of the profession.

Doctors charging private fees greatly in excess of this stand to be prosecuted by the Medical and Dental Council for overcharging.

He maintains the doctor/patient relationship was ruined by the 1967 Medical Schemes Act, which made medical aid more widespread in SA and made patients, in their own eyes, no longer responsible for their accounts.

The present consulting fee, determined by the Representative Association of Medical Schemes (Rams), has been R13,60 for the past two years. In its July 1987 guide to fees, the Medical Association suggests a R27 consultation fee.

In January next year, GPs and other clinicians are to be given a 10,6 per cent scale of benefits increase by Rams, which will raise the consulting fee to R15 for a GP.

All costs of syringes, bandages and other disposable products used in a GP's practice are not refunded but built into the consulting fee.

In one hour of a doctor's time, two life insurance tests can be done costing a total of R67,50 according to Life Officers' Association scales. With R40,50 deducted for running costs, that hour's work would leave a GP with R27 profit.

In December 1984, the practice of doctors being contracted in or out fell away and now, whether they are refunded directly by medical aid depends on whether they charge the patient the medical aid tariff or a private tariff.

If private fees are charged, the patient is personally refunded the stated portion and must pay the doctor. But, said the doctor, patients are more likely to spend the cheque before it gets anywhere near him.

But even where entitled to a payment from medical aid, doctors often send first and second accounts to the patient to arrange payment. If this is not paid, the third account may be sent to the medical aid scheme.

At the outside, this means the medical aid can keep the money for 4½ months after the date of service, which allows interest build-up in their favour.

A Johannesburg pathologist claims pathologists' profit margins have been narrowed by up to 50 per cent in the past 10 years, which has led to a financial winding down in lifestyle and in perks.

Pathologists are what could be termed the backroom boys, faceless to most of their patients but engaged in highly specialised and cost-intensive work.

One of the country's largest pathology laboratories has about 35 000 patients a month, conducts an estimated 100 000 tests a month and has machinery worth a conservative R8,3 million.

A pathologist, one of several partners, said that about 10 years ago the profitability of a pathologist's practice after deducting operating costs, was in the vicinity of 27 per cent to 30 per cent. But latest estimates stood at around five per cent.

One pathologist said overdrafts have greatly increased both for the business and personally, overseas holidays and congresses have dwindled considerably and the tendency is to drive an older car instead of a new one every year.

Take-home pay has decreased both in amount and in value.

The costs of the practice have risen 34 per cent or more in the past 18 months. A pathologist's fixed cost component for tests is 65 per cent of the total. In some cases additional costs mean tests are done at a loss. The overall cost is reduced if there are a large number of patients, but the growth in patient numbers has fallen from 15 per cent a year ago to about five per cent.

Fees are primarily dictated by the boundaries of the medical aid tariff scale. Pathologists' long fight for a minimum fee per test will finally be rewarded in January with a R4,86 minimum for work in office hours and R10,20 for night work.

"This does not cover our fees, but we are happy that it has been accepted in principle and we can now fight to improve it," the pathologist said.

In the past two decades, pathology has only had a 38 per cent increase in medical aid fees.

Between September 1984 and January 1988, when a 12 per cent medical aid increase is due, there will have been no increases in scale of benefit fees, and in fact all specialists suffered a four per cent decrease in January 1986.

One of biggest loss tests is the PI, a test for the control of blood clotting, which, with administration costs, costs about R20, of which R3,20 is charged to the patient and repaid by medical aid. Because of the loss involved, this is only considered a service.

A full blood count test costs R10 and is a break-even test, while the Urea and Electrolite test for blood components is a money-spinner because of the type of instruments used and the frequency with which it is done.

Pathology laboratories are obliged to enter into a contract with medical aids, and 90 per cent of all patients are medical aid patients. The remaining 10 per cent are charged private fees in line with Medical Association guidelines, which work out to about double those of medical aid fees. The profession is thus very dependent on medical aid schemes.

A major cost factor has been the rising cost of chemicals and substances used, almost all of which are imported, and also a large rise in the cost of those made locally.

The cost of medicine has gone up about 30 per cent in the past year, while instrumentation and chemical raw products have risen over 30 per cent.

Another major expense is the fact that the intricate machines used in pathology need, ideally, to be updated about every three years, as do testing methods, and in the course of this expensive instrumentation can be rendered useless. This affects the R8 million machinery investment figure.

"Pathology is bound very much by changes in trends and requests; it has to follow what clinicians want. It doesn't lead, it follows."

Salaries and wages are also a major cost component, especially with the high number of professionals employed.

In areas like research, new test development and teaching the losses can be considerable because of little or no monetary return.

Other costs that have risen dramatically are those of textbooks — which now cost anything between R400 and R1 000 each, and journals, the lifeblood of the medical profession. The British Medical Journal cost R90 a year four years ago; it now costs R400 a year.

Priest fights to clean up streets of sewage

85

5/12/87

The bad, ugly side of town

WINNIE GRAHAM

"Will it take an epidemic of cholera or typhoid spreading into the white suburbs of Johannesburg to finally get something done about the dreadful conditions under which people live here?"

It was a cry from the heart of Father Dermot Mills, the priest in charge of St Joseph's Catholic Church in Meadowlands, Soweto, who has spent months trying to get local councils to do something about the sewage effluent flowing through the streets of the town.

After months of frustration and repeated requests to the health authorities, Father Mills invited The Saturday Star to see for itself the conditions in the township.

They were every bit as bad as he had depicted in the dossier he has compiled. And the sewer he had seen spilling over in Zone 10 was still flowing.

Residents claimed they had reported it to the Dobsonville council offices but had been told the council would not unblock it because "the residents are not paying rent".

The effluent flowed across the street, through the yards of two small houses, over a sidewalk and into the street again. The people in the houses had built little walls of mud to contain the spread of the sewage across their yards.

But the problem did not end there. As we left the scene, we saw more effluent running along Somkele Street, Zone 4, Meadowlands.

We traced it to a manhole which was literally "bubbling" with overflowing sewage. The effluent ran down the street, to be joined by yet two other streams — from a second and a third manhole. People in the vicinity claimed the spillage had started between 5 am and 6 am that day.

Around the corner in Hlala Street another manhole was overflowing. Residents said it had been flowing for several days.

The problem of getting the sewers unblocked has remained a continuous frustration for Father Mills. His records show that he reported the first overflowing manhole on Palm Sunday in April.

He recorded then: "The manhole cover had been forced open by the pressure of the flow. I reported the matter to a man introduced to me as the 'township manager'.

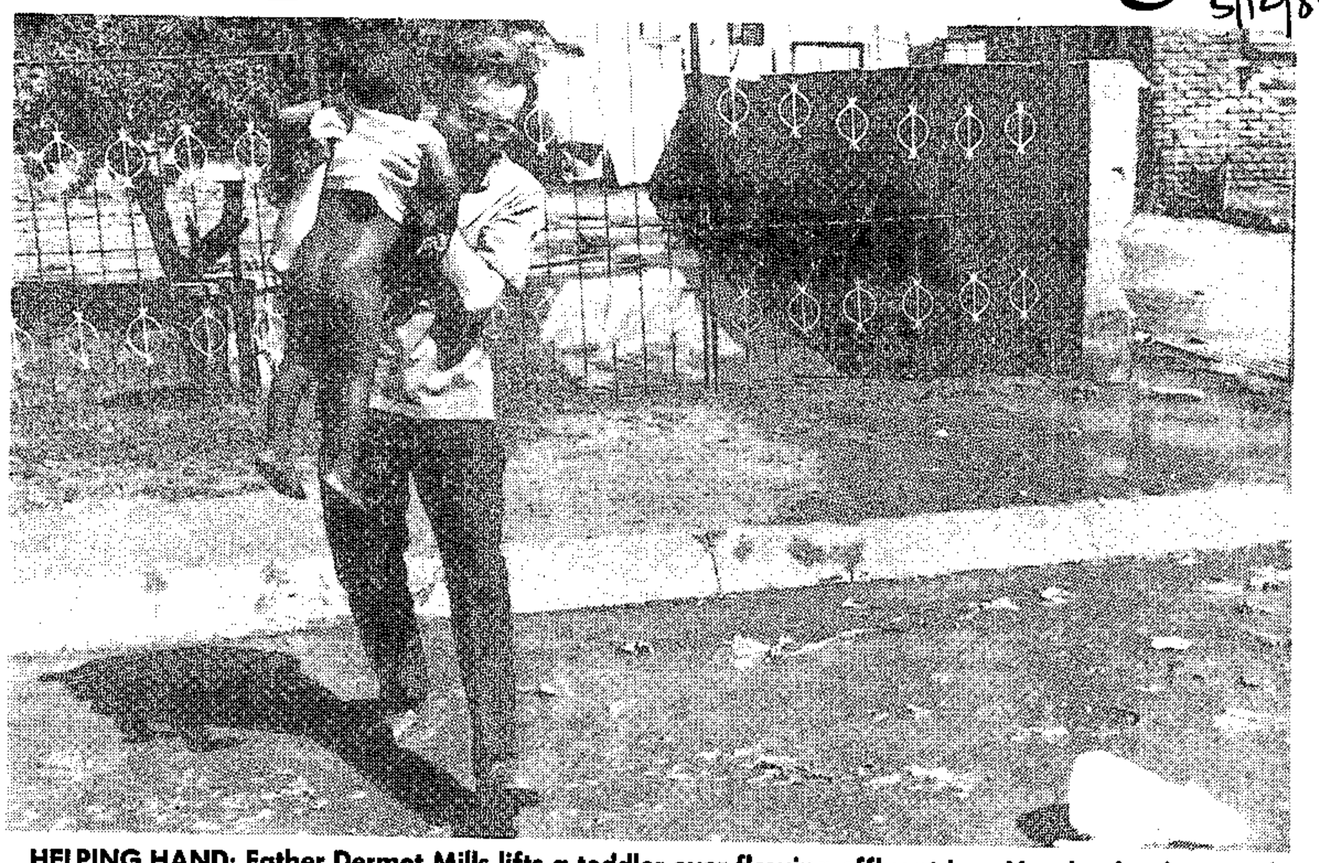
"Workmen arrived at about 11 am on the Wednesday. They spent a short while there. At noon one was still there, sleeping on the grass. The sewer continued to overflow. A 'lake' of solid sewage was in the garden and overflowing into the streets.

"On the Thursday, the workmen stopped the flow at 1 pm.

"Easter Monday (four days later): It flows again but ceases after a few hours."

Father Mills said the flow started again on May 27. He reported it to a local councillor. Workmen arrived in the afternoon and unblocked it but they did not clean away the sewage.

He records show: "On Saturday morning the sewage is still there ... solidifying.



HELPING HAND: Father Dermot Mills lifts a toddler over flowing effluent in a Meadowlands street.

"An elderly parishioner, a woman in her late 70s, tries to rake up the mess. I ask her not to as there is a health danger."

Father Mills reported again to the councillor but found her to be out. He told her husband but nothing was done.

That evening he telephoned a doctor who agreed that the effluent was a major health hazard. He said the ground would be contaminated for years, with worms being a major problem.

So the saga continued. In June the priest reported an overflowing sewer in Ngema Street. Excrement in the grounds of the church was covered with ash. He expected a health inspector but no one called and he heard nothing.

He spoke to a contact about the sewer in Ngema Street, Zone 5, and an inspector and two others arrived. They gave him a telephone number and told him: "If only people would report the overflowing manholes, they would be unblocked."

The inspector assured Father Mills that blocked sewers would be unblocked at any time, including weekends and public holidays. He continued to report blocked sewers in July, August and September.

Father Mills believes the people of Meadowlands are left to live in filth because they are black.

"That can be the only reason for the careless attitude which allows people to live in these disease-producing conditions," he added.

The chairman of the regional services council, Mr Gerrit Bornman, said this week that the reconstruction of sewerage facilities in the townships was only the "second priority".

Mr Clean learns to fight dirty — and win

MAOKENG KGWETE

When he talks rubbish, Mr Japhta Lekgetho, becomes the most eloquent person I have met.

To him, dirt is "Public Enemy No 1" and in areas served by his cleaning projects, dirt is becoming a thing of the past. The only trail he leaves behind him is cleanliness.

He fights dirty, too — giving litter no chance if he can help it.

In the bleak days of 1977, after the outbreak of the pupils' revolt, he waged a monumental one-man revolution against the squalor in the townships. It was not a complete success, but it certainly was worth an effort.

Mr Lekgetho, dubbed "Mr Clean", gave up his job as a geography teacher. He put his elegant suits away, rolled his shirt sleeves and dedicated himself to cleaner ghettos.

At the time it seemed a long, lonely and seemingly insurmountable struggle.

Today, 10 years later, rubbish mountains which used to be part of the landscape in the townships, are on the decline.

He can now afford a satisfied grin: "The struggle against squalor has been worth it, bearing in mind the awareness of cleanliness that it has instilled in our people. But I am not totally happy yet, because the problem of litter is still with us."

Mr Clean has spread his message far beyond Soweto — to Pretoria and the East Rand. He says that, to date, his National Environmental Awareness Campaign (Neac) has planted more than 30 000 trees in township schools, public places and the parks that he has personally built.

Mr Lekgetho blames township planners for the mess many black residential areas are in. "Nothing in the townships was ever planned for our recreation, or with human dignity in mind," he says.

On Kruger Day — when crowds went wild, assaulting many whites and killing two after revelry in city parks — there were 5 000 fun seekers at the park near the Dobsonville bird sanctuary. Mr Lekgetho says the people behaved very well and there was "absolutely no trouble".

If well-equipped and serviced facilities could be built right inside the townships there would not be a migration to facilities in the city on public holidays.

"People would save on transport fares, and at the same time the problem of congestion would be solved," Mr Lekgetho says.

He complains that some amenities are now being considered for the townships, but are being built on the peripheries of black areas.

He asks: "What sense of ownership does this instil in us, when facilities are being built for us outside our areas? Why can't the people who provide them bring them inside?"

Mr Lekgetho would like to develop river trails in Soweto and other townships.

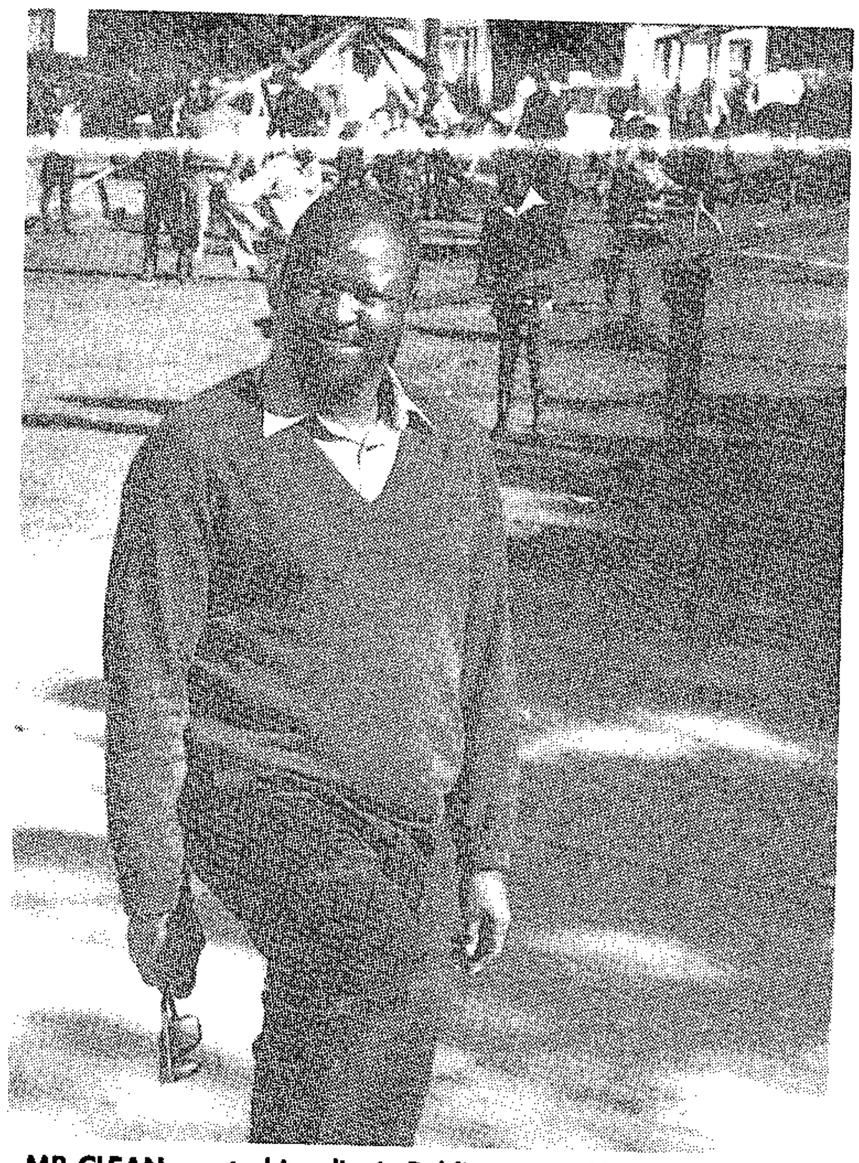
He is heartened by the fact that in the townships are hundreds of trees which daily get the attention of their "owners".

He has instilled in children a sense of pride in the trees they individually planted, so much so, that every day after school many township youngsters make it their duty to water and nurse the saplings.

Commenting on the Johannesburg municipality's move to fence public parks, he said: "The shortage of recreational facilities in black residential area cannot be judged in isolation from our political structure. Many restrictive laws of this country deny blacks the access to facilities. In almost all black residential areas facilities are inadequate."

He said a place as big as Soweto — with more than 2 million people — hardly has a park the size of Zoo Lake.

He says the solution is the total scrapping of the Group Areas Act.



MR CLEAN ... to him dirt is Public Enemy No 1. Mr Japhta Lekgetho has dedicated 10 years to cleaning up townships.

(85) SMM 10/12/87

Apartheid health care is 'unethical'

CAPE TOWN — South Africa could not afford the expensive policy of duplication, triplication and quadruplication that the Government had openly defended at recent National Party congresses, the Dean of the faculty of medicine at the University of Cape Town, Professor George Dall, said yesterday.

Speaking at the faculty's graduation ceremony, he said every cent that South Africa could afford had to be carefully spent to offset the cost of health care.

"I must oppose with every grain of my being this most expensive, cost ineffective, immoral and unethical fragmentation of our health services," he said.

"It is the greatest tragedy that has befallen all our people."

ARGUS 10/12/87

Picture: LEON MÜLLER, The Argus

The vice-chancellor and principal of UCT, Dr Stuart Saunders, and Mr Justice Pat Tebbutt, chairman of the Convocation, at a ceremony yesterday in which an honorary Doctor of Science in Medicine degree was conferred on Dr Saunders.

Apartheid in health care SA's 'greatest tragedy'

Medical Reporter

A STRONG plea for a unitary health system in South Africa has been made by Professor George Dall, Dean of the Faculty of Medicine at the University of Cape Town.

Opening the medical faculty's graduation ceremony last night, he said the country could not afford the expensive policy of "duplication, triplication and quadruplication" which the Government openly defended at recent National Party congresses.

"I must oppose with every grain of my being this most expensive, cost ineffective, immoral and unethical fragmentation of our health services.

"It is the greatest tragedy that has befallen all our people — and I mean all our people," said Professor Dall.

PRIVATISATION

"So the white Nationalist Government has decided we will afford the luxury of a tricameral system of separateness no matter the infant mortality rate or the life expectancy of the majority of South Africans."

Professor Dall said there was no place for apartheid in health care. He said there was no doubt that a unitary health system would be the most cost-effective system.

One of the key measures the Government intended using to reduce the level of inflation was privatisation. Health care had been included in the scheme in spite of the fact that the gap between the Medical Association tariff — "or so-called private fee tariff" — and the Medical Aid Scheme's tariff was widening more and more, Professor Dall said.

Privatisation of health care in South Africa would not contain costs, he said. The economic behaviour of the health care market did not, and should not, correspond to the idealised rules of the free market system.

"HUMANISTIC SIDE"

The technological explosion of the 20th century, which had resulted in unprecedented progress in scientific medicine, had tended to push the humanistic side of medicine into the background.

"There is no doubt that we need to look at the training of our students very critically and as a faculty we are constantly taking stock, evaluating our courses and planning new ones," Profesor Dall said.

Three important considerations for the future of medicine in South Africa were the maintenance and improvement of the scientific base, the adaptation of training to suit the particular needs of South Africa's kaleidoscopic society, and the importance of the doctor-patient relationship.

Blood plasma shortage hits hospitals

HOSPITALS have been hit by a shortage of dried blood plasma, particularly in the region served by the Johannesburg unit of the SA Blood Transfusion Service.

Dried blood plasma can be delivered faster, is safer to transport than frozen plasma and is used particularly in trauma cases treated in hospital casualty sections, military and field situations, medical sources say.

Confirming the shortage, medical director of the SA Blood Transfusion Service in Johannesburg Dr Maurice Shapiro said demand for dried plasma had increased "astronomically" in excess of supply.

ROGER SMITH and CHARLES PARRY

He said he did not know why this had happened.

Their stockpile was exhausted. Demand for dried blood plasma had been consistently in excess of supply for more than two years, but the level of blood procurement had remained static.

He said hospitals which insisted on dried blood plasma because of its convenience were being pressured to take frozen plasma instead, as there were ample supplies.

Shapiro said the Johannesburg unit supplied about 50% of the country's re-

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Dried blood plasma shortage hits hospitals

quirements, supplying the Transvaal, OFS and northern Cape.

There was a problem in producing more dried plasma as the unit had only a limited drying capacity and the process took time.

However, additional drying equipment was due to be installed.

Administrative director of the Blood Transfusion Service (Western Province) Malcom Kahn said there was little demand for dried blood plasma in the Cape region — the demand was for plasma products and liquid plasma.

He knew of shortages of dried blood plasma in the Transvaal and they assisted with supplies where possible.

He said it was not unusual for such shortages to occur.

A spokesman for Number One Military Hospital at Voortrekkerhoogte said the hospital was not aware of any dried blood plasma shortage.

She could not say whether any increased use of the plasma by the hospital might have contributed to such a shortage.

Another SADF spokesman pointed out the SADF had its own blood bank and he believed it was not reliant on national supplies.

17/12/87.

Asbestos is now a dying threat

Special correspondent: Johannesburg

Renowned for its non-flammable properties, it's ironic that asbestos has been instrumental in fanning the emotive fires of public health debate over the past 10 years.

The first half of the Eighties saw the asbestos/health question rage across the world. Medical and scientific researchers bandied terms such as "threshold level" and "dose-response relationships" while housewives worried about the use of fibre-cement products in their homes.

Rural communities discovered themselves to be living on asbestos mine dumps, labour unions campaigned for an outright ban on the material and mesothelioma victims encouraged the media to record their slow and agonising deaths.

While spraying the bulkheads of ships being built during the Second World War with asbestos as insulation, workers were not given respiratory protection — with the result asbestos dust accumulated in the lungs of shipbuilders, laying dormant for as long as 30 years.

There followed an outbreak of asbestosis, lung cancer and mesothelioma — termed asbestos-related diseases (ARDs).

In the Fifties and Sixties evidence began to build that it was not even necessary for workers to be exposed to the high concentration of the shipyards for ARDs to manifest themselves.

In some isolated cases, relatively low exposure of just a few years was enough to initiate a problem.

A reluctance on the part of mining and manufacturing concerns to make known the full extent of asbestos hazards saw bitter debates waged between worried health authorities and commercial interests.

"We thought it was our problem to solve and resented outside intrusion," says an executive of Everite — a company which manufactures fibre-cement building materials and pipes.

One of the key decisions by the company in the early Eighties was to try to repair the historical perception that executives had deliberately down-played the risks and were indifferent to occupational health hazards.

"I guess we were not very good at communicating our concern or our achievements to the outside world. Perhaps it was anxiety about the future of our business that caused us to be less than co-operative with outsiders," he says.

After a period of intense self-examination, and having the advantage of seeing the inevitable progress of the debate overseas, Everite agreed to regard all criticism as important and adopt an open door policy.

"In short, the industry decided to recognise anybody with even the vaguest interest in asbestos, particularly fibre-cement, as a potential partner in solving the problem."

The strategy has not only resulted in former adversaries' being seen as constructive critics but helped the industry to come to terms with the inescapable fact that the future of one of its important raw materials was uncertain.

But what of the mining of asbestos in SA? A peculiar "environmental exposure" condition exists in SA, where ARDs have been recorded among those who lived close to mines and were exposed to abnormally high concentrations of asbestos dust.

According to the mines, this situation no longer exists and environmental dust concentrations are at acceptable levels.

A study recently published by the University of Cape Town's Southern Africa Labour and Development Research Unit (Saldru), says one company — Gencor — has a monopoly of South African-produced asbestos and controls significant sectors of its mining through two partly-owned subsidiaries. The controlling shareholder of Gencor is Sanlam, through Federale Mynbou.

The two UCT researchers responsible for the study, Janine Aron and Dr Jonny Myers, say there are too many unfavourable factors for the asbestos industry to return to its productive apex in 1977, even in the long-term.

"Since the amalgamation of the two major asbestos producers in 1981, substantial cost savings have been achieved through the rationalisation of operations and through production, exploration and sales rationalisation," the researchers say.

"This resulted in the closing of uneconomic mines as market conditions required, but they could be brought back into production without incurring additional capital costs.

But asbestos comprised only 3,5 per cent of Gencor's income in 1984.

Between 1960 and 1980, production of asbestos fibres increased by 74 per cent but production rates declined in keeping with reduced world demand for fibres.

"The number of mines in operation has decreased from 43 in 1972 to seven in 1983, and the labour employed from 21 324 to 5 664," the UCT report says.

In 1984, only 7,5 per cent of the total production in SA was used locally and the bulk exported, and local sales dropped by 56 per cent between 1981 and 1984.

"There seem to be too many unfavourable factors currently and potentially influencing the SA asbestos industry to anticipate a return to the productive apex of 1977, even in the long-term.

While Gencor is the major mining concern, Everite — as the largest manufacturer — was a late starter at winning credibility.

"What progress has been made has been due to control of the facts — including acknowledgement of the uncomfortable facts — an open door policy and absolute determination to stay abreast of the state-of-the-art-of knowledge-and-control," Everite management says.

All 264 worksites at the company's factories in Kliprivier, Brackenfell and East London are below the recently-introduced statutory exposure limit of one fibre per milliletre (f/ml). Despite this, face masks are compulsory.

As a demonstration of its new policy, the company has opened its books and says in the time it has been active in SA (since 1942) 25 000 employees have been engaged.

"As of April 1987, 178 people (or 0,7 per cent) have contracted ARDs; 21 employees have died as a result of these diseases. Health records at Turnall, recently acquired by Everite, show a further 34 ARDs."

The company has now implemented a disability pension plan which allows those certified as being unable to work because of an asbestos-related disease to take early retirement and to receive a full salary (with increments) up to age 65, after which they enjoy normal pension benefits.

While there is some anecdotal evidence to suggest that environmental exposure to asbestos can cause ARDs, there is no scientific evidence as yet.

The statistics prove South Africans not to be at risk — but the asbestos debate, although dying, lingers on.

Low-cost health care for workers

13/12/85 Citizen

By ZB MOLEFE

THE provision of private low-cost medical facilities in Johannesburg's northern industrial area could benefit hundreds of workers.

The concept, introduced by a company – Community Clinics – became a reality in October. It is aimed at providing affordable, convenient health-care services for lower income people living and working in the area.

The company was formed by two experienced health-care businessmen, Don Sutherland and Brian O'Donnell.

The first Community Clinic Centre – serving Johannesburg's northern industrial areas, including Alexandra township – is planned to be the first of a network of centres that will ultimately cover South Africa's major urban areas.

Another Community Clinics feature is that employees of different firms can receive full medical treatment – including all drugs and medication – for R15 a month.

Said Sutherland: "Research indicates that the urbanisation of blacks will increase from 37 percent today to 65 percent by the year 2000.

"South Africa is faced with the prospect of its health services being incapable of supporting the demands being made on it."

He said the concept was aimed at all population groups, with special emphasis on the needs of domestic and industrial workers.

Subscription to a Community Clinic entitles the worker to:

- General consultations and treatment by a doctor or nurse.
- All medicines on the clinic's basic list.
- Light surgery, such as stiches.
- General first-aid and surgical dressings.
- Health education and counselling.
- Dental and eye care.

"The emphasis is that prevention is better than cure," said Sutherland.

"It is a move away from First World medical structures towards an affordable, essentially nurse-based system."

'Poor, unemployed and elderly worse hit'

HWA attacks rise in hospital fees

The Health Workers' Association (HWA) is bitterly opposed to the proposed increase in Transvaal hospital fees from January 1.

The HWA says the proposed increases show the total insensitivity of the authorities for the welfare of the majority of the people, particularly the elderly, the unemployed and the poor.

The HWA says the latest increases will keep people away from hospitals and clinics, as it is becoming increasingly difficult for the poor and unemployed to pay for the health heeds of their families.

150 PERCENT

No official confirmation could be obtained today of the size of the increases, but it is believed that fees will increase by up to 150 percent.

Dr J A Fourie, acting chief of hospital services in the Transvaal, said hospitals had been warned of the pending increases in a confidential document.

The HWA statement said the latest tariff increases came in the wake of severe criticism being levelled at the general deterioration of health services in the province.

It rejected the argument that increases were necessary because there was not enough money to run the health services.

It said the increases were an indication of the adverse effects of massive expenditure on defence, and maintaining the apartheid system.

"The increasing cost of maintaining apartheid at the expense of other essential services is not only further polarisation of our society but is creating further tension," the HWA said.

"People must be made aware they cannot be turned away from clinics or hospitals because they cannot pay, and we urge all community organisations, trade unions and women's organisations to oppose this issue," it said.

Doctors at Cape provincial hospitals are seething over the latest salary scales for the medical profession.

Meetings to discuss the situation and possible action were held at the Red Cross War Memorial Children's Hospital on Tuesday and the Groote Schuur Hospital yesterday.

Doctors said the problem arose with the announcement of "big" increases for consultants and medical officers, but nothing for registrars.

"We are all hopping mad about it," said a Groote Schuur source.

He said registrars were doctors who had completed their housemanship and were studying to become specialists. After at least four years' further study they qualified as consultants.

Medical officers and senior medical officers were doctors who had not specialised in a branch of medicine.

Details of these increases were not available.