HEALTH & DISEASES — GENERAL

1992

HEALTH MATTERS

THE ROUTE TO HEALTH FOR ALL

New Nation [Learning Nation] 20/3-27/3/92 (85)

The health system in South Africa is characterised by a health care system which mainly serves the urban white people, while the majority of the population is served by a fragmented and inadequate health service, and in some areas none at all. Apartheid capitalism has entrenched the fragmentation and poor distribution of existing health facilities. This has resulted in a scarcity of doctors and nurses throughout the country. Poor distribution can be seen in the understaffed, overcrowded conditions in some areas and the under-usage of services in others.

Against the background of the existing inequalities in the South African health care system "Health for All South Africans" seems a distant dream. Primary health care has been proposed as a way of transforming Health for All from a mere dream to a fact of life.

Liki Mokoena gets up at 4 o'clock every morning to fetch water

What is Primary Health Care (PHC)?

In 1978 in Alma Ata, a city in the now dissolved Soviet Union, the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) convened a conference where the governments of 134 countries and voluntary agencies endorsed the concept of Primary Health Care (PHC) as a way to achieve Health for All by the year 2 000.

The Alma Ata declaration describes PHC as health care that is made **accessible** to all individuals and families in the community in a way that is **acceptable** to them through full community participation and at a cost that the community can **afford**. Many aspects of this declaration arose from the realisation that the world's health problems cannot be solved by medical science alone when the vast majority of people in the world don't have access to this science.

PHC represents a relatively new approach to health care provision. One of the most important aspects of PHC is **equity**. Equity does not mean equality, whereby everybody, irrespective of their needs, gets equal services. It means providing health care and health facilities according to the needs of the people. Those who are most in need will thus be provided with more services and in this way the imbalances of the current health system will be addressed. But, PHC must not be seen as merely health care for the poor. Through a policy of equity, health care will be provided in a way that will be less wasteful and more cost-effective. In an equitable health care system the health needs of those who have been neglected by the health system under capitalism will be a priority - for example people in rural areas and squatter settlements.

In this declaration, the purpose of health care was considered to be to improve the health of the people through social and economic development. Health is thus seen as a tool for development in the spirit of **self-reliance** and **self-determination**. Although the central focus of PHC is within the health system, it also forms an integral part of the overall upliftment of the community. It aims to bring health care as close as possible to the homes of people and their workplace. This further stresses the need for health services to be accessible to the people.

PHC thus has implications for both the health system and other sectors of the state and the economy such as housing, sanitation, electrification etc. Because development is such an important aspect of PHC it is evident that this approach to health supports the definition, discussed in our article **"What is Health?"**. This definition extends much further than merely the absence of disease.

What PHC is Not!

People have various perceptions of what PHC truly means. For example, many people think of PHC only as a form of inferior health care for the poor. Because of the wide range of misunderstandings of the true meaning of PHC, it is essential to address some of the most common misconceptions.

PHC is **not** an inferior form of health care for the poor in the community, nor is it only for the Third World countries. This is illustrated by the fact that PHC was endorsed by 134 countries, which included **both** First and Third World countries, and the declaration that PHC should be based on **scientifically sound** and socially acceptable methods.

PHC is not health care that is delivered by Community (Village) Health Workers and nurses only. Although Community Health Workers and nurses form an important part of the PHC personnel, **all** health workers (including doctors and nurses) have a role to play in a health system based on PHC. The role of the people in the community as key players and active participants in the PHC system should also not be overlooked.

PHC in South Africa

In South Africa many health workers argue that it is impossible to implement PHC under Apartheid, which has denied many people access to health services and ignored calls for community participation in addressing people's health. These difficulties, together with differences in the interpretation of the concept PHC have led many health workers to coin the term **"Progressive PHC"**.

PHC is being implemented by a wide range of Service Organisations especially in the rural areas of the country. But, when considering the health needs of all people, it is clear that a co-ordinated national initiative is necessary.

More than 10 years ago the government introduced the **National Health Service Facilities Plan** and endorsed the concept of PHC. However it still separated the responsibility of housing, water, sanitation etc from health and failed to propose a model for community participation in health. This "plan" remains an empty promise, more than a decade later. Some steps are being taken towards the implementation of PHC. But even PHC cannot be achieved with the top-down approach used by the government. All the people affected by PHC need to be involved in the various phases of planning the programme. In July 1990 when the government adopted the **National Policy for Health Act**, it claimed that this act was going to "radically change the face of health care implementation". Yet to this day these changes are not yet evident. The government has made some sort of commitment to PHC but it will take a long time before all the people of South Africa will feel the benefits of PHC. This is in part because of the fragmentation in the health system and the nature of health training - which does not equip health personnel to meet the challenge of PHC - namely to provide equitable, accessible and socially acceptable health services for all.

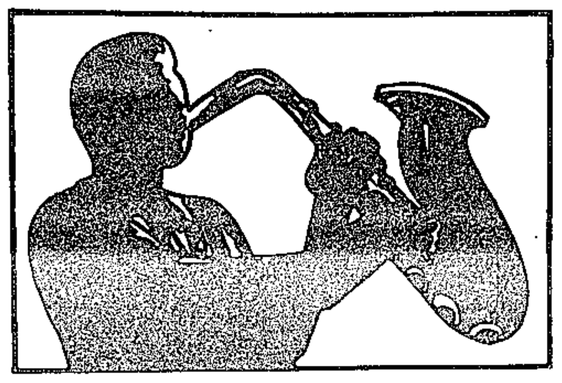
PHC Policy

For PHC to be implemented it needs to be incorporated into health policy. Because of the all-encompassing nature of PHC, it is no longer possible for doctors, nurses and other experts to sit together and formulate health policy on their own. PHC demands an integrated approach to the planning and policy-making process so that all the people involved in sectors that have an impact on health and development - for example **housing, sanitation, water, agriculture** etc - are also consulted.

Many groups and organisations are currently in the process of policy formulation or modification.

In future editions of Learning Nation the concept of Progressive Primary Health Care will be addressed as well as current debates on *health policy*, for example *health personnel training*, *health financing* and other topics. This will enable readers to view critically policies relating to health that are currently being proposed and debated at various forums.

CULTURE



...ts of Soccer in South Africa

the interest of business owners and officials in South Africa. They were interested in the game as a means of controlling workers.

As Reverend Sivetya recalls: "Many European gentlemen who were in business soon saw the need of having football played by their workers because it kept them in Durban. That is why some firms always took those who could play."

This also happened on the mines. **Dan Twala** (who co-founded both the Johannesburg F.A. and the **South African Soccer Federation**) notes that the game was encouraged by mine and compound managers: "It helped the mine keep their staff busy over weekends and it helped their recruiting programme."

Next week we will look a little closer at this site of struggle between the white authorities and the emerging black working class in the urban areas.

ne, the first Black tball in Europe.

Can you recognise the player on the left in the last row? It is a youthful Dan Twala, then playing for Highlanders in 1935.

Letters

This is a letter received from Mr Radebe in response to a recent article on the culture page. He is responding to the following quotation by the Japanese novelist Natsume Soseki:

An artist is a person who lives in the triangle
which remains after the angle which we
may call common sense has been removed
from this four-cornered world

My Honourable

I wish to air my views towards Natsume Soseki's quotation. According to my views, I will name Mobile and Immobile. I do agree with the artist. In that there are people who lives in the triangle. In this four-cornered world, where the angle is taken away which is common sense I name it the art or culture

The way we talk and way we live to our daily routines, all the things we do and that happened around us, token angles, presents, suffering. Intimidations and deprivation of emotions, failings to express yourself in any form. It is all art of living to four cornered people. They also enjoy Love and Peace. Romance and full of Hate, most not trustworthy through selfishness and greediness, because of their ignorance to life in the triangle, while the gates are open to all. There is nor discrimination of colour or sex or culture.

Immobile are four-cornered people. Mobile are people who live in the Triangle. They belong to four cornered world, but able to move in the Triangle world and come to tell us all about what they explored or findings, most of the discoveries are fascinating.

The artist, is the person of many words, many ways, observing things done by humans and animals. He or she can make his or her day-dreams and dreams to come in life or life like. He or she may be able to describe God's appearance in many forms, and convince four-cornered people.

Four cornered people, some of them consider trianglers mentally disordered. Because they are able to pull themselves out and in four cornered world.

When Trianglers pull out of four cornered world he or she discard common sense now, he or she adopts a highly intellectually sophisticated sense. Then she or he come back to four cornered world to expose his or her findings. First his or her findings will be unfamiliar, then becomes fascinating and spreads into cultured activities.

Triangle is the infamous land, but famous to all thinkers and life lovers and to all who do not take life for granted. Because life has no guarantee, there are people around us who are born and gifted to see the land of triangle. I will make an eg with Mr Ray Charles, American blind singer. He sings songs that people who has eyes to see but can't see or dream what Ray Charles have seen or dream about, Mr Ray sings in his record Tilted she was born to love me every night and day. Let us find out how he did come to see that, and I think this will give us a torch to find the core of Mr Natsume quotation. I wish I was not awaiting trial prisoner, maybe I would given enough sheets to write down my views. But I will now try to collect scrap sheets from the rubbish bins of the officials and I will sell my ration for the sake of getting money to buy New Nation weekly so that I will be able to get the sun I saw in the Nation paper. Learning Nation the sun to all who wants to feel warm. Look at the flowers in early morning before sun rise Tell me what you see. I see illitrates or flowers. Look at the flower after sun rise. I see smiling faces. Attending graduate ceremony, I will buy New Nation to get the sun, I am cold and poor but New Nation Learning Programme will help not for the moment but the rest of my life.

I wish to write this. In this space which I've suppose to have write my views. But promise to write very soon as I get sheets.

I see God is crying
Through prison window
I see God coughing
I see God sneezing
I see God striking matches
Through prison window
I see God smoking
I ask My God
Lord why crying
My Lord said
My people are thirsty
My tears your water
My coughing and sneezing
your oxygen your fresh air
Smoking my bad habit
Let my people kill themself
I help everybody
Who wants to kill himself and herself
Who wants to go in and out in prison
Who wants to be loved and be hated
I love my people I love my precious toys
I love you all four corners world
I love you all Trianglers I love all my creatures

If there is any common sense in my word above I would like to hear from all reader. Please include me in this debate. The world I am living on it at this stage, is 2 1/2 corners, But consider me as Human on Humanisms grounds

Yours obediently
Mandla Radebe

Health care in crisis

STAR 4/1/92 (85)

MAGNUS HEYSTEK
Finance Editor

SPIRALLING health care costs escalating at an annual 25 percent in recent years, are threatening to put adequate medical care out of the reach of all but the very rich.

Already a large part of society, particularly blacks, coloureds and Asians are not covered by any medical aid and this situation is expected to worsen unless rocketing medical costs are brought under control.

Medical costs have become the fifth largest expense in the consumer price index (CPI) for the average person, with a weighting of over five percent, according to the latest figures supplied by the Central Statistical Service.

It has overtaken fuel as a major expense item and is only topped by housing (with a weighting of 14 percent), food (18 percent), transport (14 percent) and clothing (seven percent).

As a result of the sharp increase in medical aid contributions many lowly-paid employees are opting out of medical aid funds.

According to the latest available figures from the Registrar of Medical Schemes 68,8 percent, or 3,4 million, out of the total white population of 4,9 million people are currently covered by medical aid schemes.

However, for the other racially-defined groups the picture looks even worse. Only 33,8 percent (313 000) of an estimated 928 000 Asians have medical aid cover, with the percentages for coloureds and blacks even lower at 30,2 and 5,5 percent respectively.

Company cost

For most companies too the cost of medical aid schemes is becoming a major expense.

According to Leon Lewis, joint managing director of actuaries Alexander Forbes and the chairman of Medicaid Administrators, medical aid costs to companies could soon overtake pension fund costs if current trends continue.

Pension fund costs are generally escalating in line with the average rate of inflation of 15 percent, but the burden of health costs as a percentage of the total payroll will double in less than ten years.

For companies the escalation of medical aid costs has a number of consequences, Mr Lewis says:

● As the medical aid system relies on a great deal of cross-subsidisation, younger employees who present a better risk are increasingly reluctant to continue to subsidise older members with a poorer risk portfolio.

● Companies have to reassess their commitment to employees in terms of the extent to which they are prepared to finance healthcare.

● Healthcare programmes are absorbing an ever increasing percentage of total renumeraton. As this trend continues lower paid members will not be able to afford their contributions and will be forced to withdraw from the medical aid.

● Despite the significant increase in the cost of and benefits provided by medical aid schemes, many providers of healthcare services are charging rates far in excess of tariffs.

Medical aid members are therefore forced to pay an ever-increasing portion of the medical aid costs out of their pockets due to the "gap" between the scale of benefits used by medical aids and the costs charged by doctors, hospitals and specialists.

Topping up insurance

Insurance companies have recently entered this particular field in a big way, marketing "top-up" health insurance schemes.

Mr Lewis points out that the medical aid industry has historically provided cover for pensioners at significantly subsidised rates.

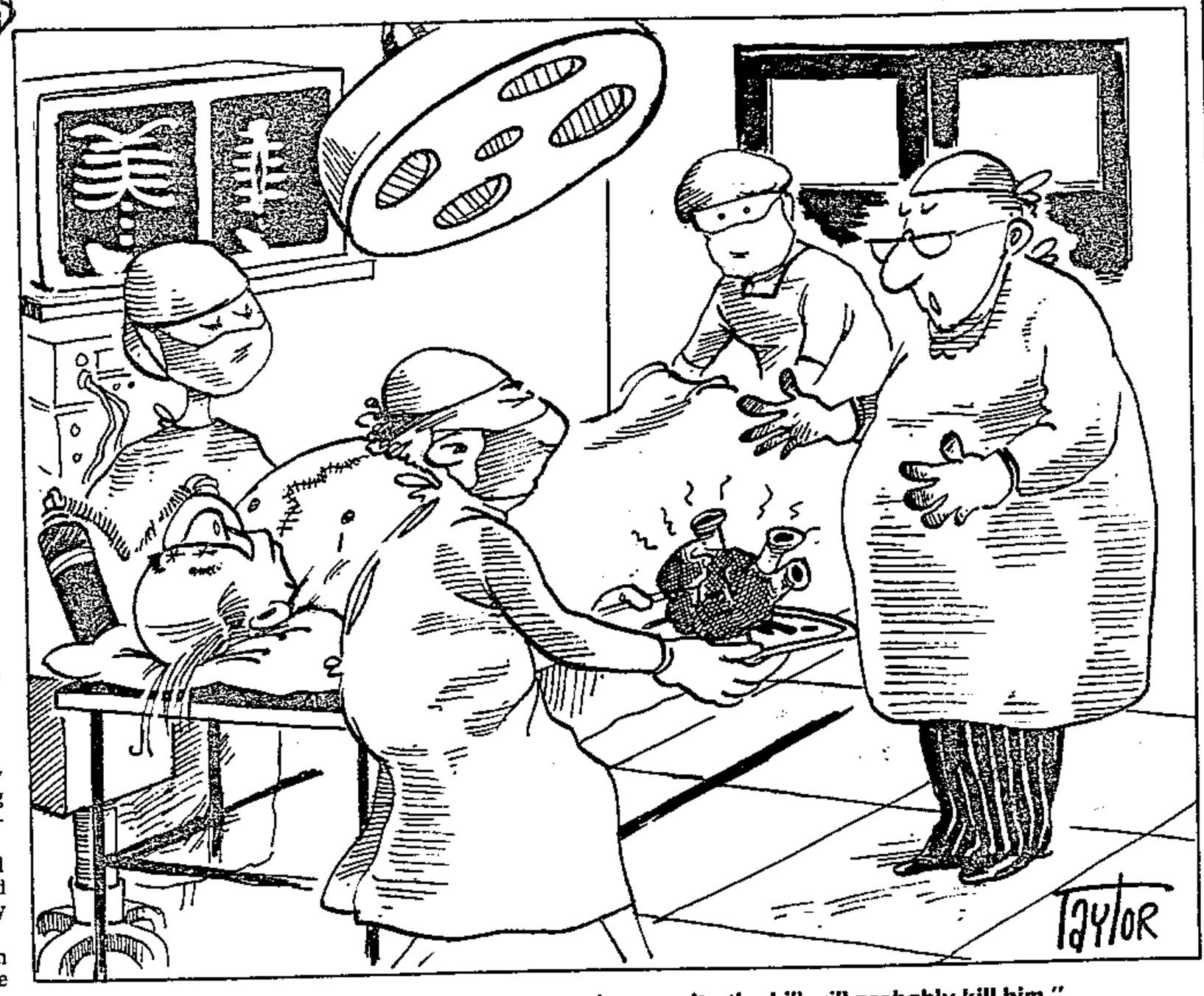
"The growing cost pressures within the industry are likely to reduce the extent of the subsidy applicable to pensioners and will force many pensioners to leave the system," he says.

The rapidly emerging Aids disease is also likely to cause enormous problems. Conservative models for the likely spread of Aids in in this country suggest an HIV infection rate of about 25 percent among active employees by the year 2010.

Studies based on this assumption conclude that about 50 percent of all expenditure on healthcare will be for Aids-related problems by that stage. Current expenditure on Aids is zero.

Proposed changes to the Medical Aid Schemes Act, which include the removal of scale of benefits, could alter the situation positively, Mr Lewis says.

It would enable medical aid schemes to have greater flexibility as far as benefits, design and limits of the system are concerned and could reduce the widespread abuse of the system.



"Well, Mr Jones survived his heart transplant — pity the bill will probably kill him."

Clean out portfolio rubbish

MR JGM of Witbank writes: Recently you advised Mrs RF of Johannesburg to sell "bad" shares and to "put the money to better use in other areas".

Attached is a list of shares obtained by us on the advice of some "expert stockbroker". I shall be obliged if you will provide me with your recommendations on which shares to keep and which to sell.

If you have any other share suggestions please feel free to advise which shares to purchase.

The shares are (with quantities held in parentheses): Eersteling (4 200), Ergo (100), Joel (100), Spescom (10 000), Rand Leases (1 500), Samancor (500), Hiveld (500), RC's (10 000), Osprey (21 000), retiring in about four year's time. Both my husband and I are sixty.

At the current exchange rates the above sum would be more than R60 000.

As the Bank rate in England is now 9 to 9,5 percent, I don't think it is such a good idea to invest for such a small return while the properties in the Cape are going up in price and the interest received on the money won't cover the expected increase in prices.

I think this is a sound idea but meanwhile my husband dithers and cannot make up his mind and all the while prices are going up in the Cape.

If we ask our London Bank to transfer the above money to our bank in

Personal Finance:

Questions and answers

DO you have any queries on financial and investment matters? Do you feel that you are not getting objective financial advice? If so, then write to MAGNUS HEYSTEK, c/o Money Matters, The Saturday Star at P.O. Box 1014, Johannesburg, 2000. All letters will be treated in confidence.

Health care in crisis

MAGNUS HEYSTEK (B5 ARG 6/1/92)

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DEPARTEMENT VAN NASIONALE GESONDHEID EN BEVOLKINGS-ONTWIKKELING

No. R. 173 **10 Januarie 1992**

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

REGULASIES BETREFFENDE DIE SAMESTELLING, WERKSAAMHEDE, BEVOEGDHEDE EN PLIGTE VAN DIE BEROEPSRAAD VIR NOODSORGPERSONEEL

Die Minister van die Nasionale Gesondheid het kragtens artikel 15 (5) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974), die regulasies in die Bylae hiervan uiteengesit, uitgevaardig.

BYLAE

1. In hierdie regulasies beteken "die Wet" die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974), en het 'n uitdrukking waaraan 'n betekenis in die Wet toegeken is, daardie betekenis en, tensy uit die samehang anders blyk, beteken—

"artikel" 'n artikel van die Wet;

"beroepsraad" die Beroepsraad vir Noodsorgpersoneel ingestel kragtens artikel 15 (4);

"lid" 'n lid van die Beroepsraad vir Noodsorgpersoneel.

Samestelling van die beroepsraad

2. Die beroepsraad bestaan uit sewe lede en word soos volg saamgestel:

(a) Een persoon wat lid van die raad is, word deur die raad aangewys;

(b) vyf noodsorgpersoneellede word verkies deur ambulansnoodsorgassistente en ambulansnoodsorgtegnoloë;

(c) drie persone wat geneeshere of tandartse is en wat besondere kennis van noodsorg dra, word deur die raad aangewys.

3. Behoudens die bepalings van regulasie 4 is die dienstermyn van lede van die beroepsraad vyf jaar, gereken vanaf die datum van die verkiesing of aanwysing bedoel in regulasie 2 (b) of (c): Met dien verstande dat sodanige lede herkiesbaar is of weer aangewys kan word, na gelang van die geval.

4. (1) 'n Lid ontruim sy amp—

(a) as hy insolvent raak of van sy boedel afstand doen ten voordele van sy skuldeisers of met hulle 'n skikking aangaan; of

(b) as hy sonder die toestemming van die beroepsraad afwesig is van meer as twee agtereenvolgende gewone vergaderings van die beroepsraad; of

(c) as hy ingevolge die Wet onbevoeg geword het om sy beroep te beoefen; of

(d) as hy, as 'n verkose lid, sy bedanking skriftelik aan die beroepsraad meedeel; of

(e) as hy, as 'n aangewese lid, ophou om aanwysbaar te wees of skriftelik aan die raad kennis gee van sy wens om uit sy amp te bedank en sy bedanking aangeneem word.

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

No. R. 173 **10 January 1992**

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

REGULATIONS RELATING TO THE CONSTITUTION, FUNCTIONS, POWERS AND DUTIES OF THE PROFESSIONAL BOARD FOR EMERGENCY CARE PERSONNEL

The Minister of National Health has, in terms of section 15 (5) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), made the regulations set out in the Schedule hereto.

SCHEDULE

1. In these regulations "the Act" means the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), and any expression to which a meaning has been assigned in the Act shall bear such meaning and, unless the context otherwise indicates—

"member" means a member of the Professional Board for Emergency Care Personnel;

"professional board" means the Professional Board for Emergency Care Personnel established in terms of section 15 (4);

"section" means a section of the Act.

Constitution of the professional board

2. The professional board shall consist of seven members and shall be constituted as follows:

(a) One person who shall be a member of the council, shall be designated by the council;

(b) five emergency care staff members shall be elected by ambulance emergency care assistants and ambulance emergency care technologists;

(c) three persons, who shall be medical practitioners or dentists and who shall have special knowledge of emergency care, shall be designated by the council.

3. Subject to the provisions of regulation 4, the period of service of members of the professional board shall be five years, reckoned from the date of the election or designation referred to in regulation 2 (b) or (c): Provided that such members shall be eligible for re-election or redesignation, as the case may be.

4. (1) A member shall vacate his office—

(a) if he becomes insolvent or assigns his estate for the benefit of, or compounds with, his creditors; or

(b) if he is absent from more than two consecutive ordinary meetings of the professional board without the professional board's leave; or

(c) if he has been disqualified under the Act from practising his profession; or

(d) if, as an elected member, he notifies the professional board, in writing, of his resignation; or

(e) if, as a designated member, he ceases to be eligible for designation or gives notice, in writing, to the council of his desire to resign from office and his resignation is accepted.

(2) Elke vakature wat in die beroepsraad ontstaan, word aangevul deur aanwysing of verkiesing, na gelang van die geval, en elke aldus aangewese of verkose lid beklee sy amp slegs gedurende die onverstreke gedeelte van die tydperk waarvoor die lid wat sodanige amp ontruim, aangewys of verkies is.

Bevoegdhede van die beroepsraad

5. Die beroepsraad kan—

(a) vertoë tot of deur bemiddeling van die raad rig vir die uitvaardiging, wysiging of intrekking van 'n regulasie of reël wat op die beroepsraad of op ambulansnoodsorgassistente of op ambulansnoodsorgtegnoloë van toepassing is;

(b) deur bemiddeling van die raad vertoë tot die Minister rig betreffende die omskrywing van die omvang van die beroep van ambulansnoodsorgassistent of ambulansnoodsorgtegnoloog indien die raad kragtens artikel 33 (1) by die Minister sou aanbeveel dat die omvang van die beroep van ambulansnoodsorgassistent of ambulansnoodsorgtegnoloog omskryf word deur die handelinge te bepaal wat vir die doeleindes van die Wet geag word handelinge te wees wat by die beroep van ambulansnoodsorgassistent of ambulansnoodsorgtegnoloog tuishoort.

Werksaamhede en pligte van die beroepsraad

6. Dit is die plig van die beroepsraad om—

(a) 'n hoë peil van professionele onderrig en professionele gedrag by ambulansnoodsorgassistente en ambulansnoodsorgtegnoloë te bevorder;

(b) aan die raad verslag te doen oor enige aangeleentheid rakende ambulansnoodsorgassistente of ambulansnoodsorgtegnoloë wat deur die raad na hom verwys word;

(c) die raad te adviseer oor die skrapping, kragtens die bepalings van artikel 19 of artikel 32 (2), van die naam van 'n persoon uit die register van ambulansnoodscrgassistente of dié van ambulansnoodsorgtegnoloë wat kragtens artikel 32 gehou word; en

(d) aanbevelings by die raad te doen betreffende die erkenning van inrigtings vir die voorgeskrewe praktiese opleiding van ambulansnoodsorgassistente of ambulansnoodsorgtegnoloë en betreffende die erkenning van kwalifikasies van ambulansnoodsorgassistente of ambulansnoodsorgtegnoloë wie se name kragtens artikel 32 in die toepaslike register ingeskryf word.

No. R. 174 **10 Januarie 1992**

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

INSTELLING VAN 'N BEROEPSRAAD VIR NOODSORGPERSONEEL

Kragtens die bevoegdheid my verleen by artikel 15 (4) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974), en na oorweging van 'n aanbeveling van die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, stel ek, Elizabeth Hendrina Venter, Minister van Nasionale Gesondheid, hierby 'n beroepsraad in wat

(2) Every vacancy on the professional board shall be filled by designation or election, as the case may be, and every member so designated or elected shall hold office only for the unexpired portion of the period for which the member vacating such office was designated or elected.

Powers of the professional board

5. The professional board may—

(a) make, to or through the council representations for the making, amendment or withdrawal of any regulation or rule that applies to the professional board or to ambulance emergency care assistants or to ambulance emergency care technologists;

(b) submit, through the council, representations to the Minister in regard to the definition of the scope of the profession of ambulance emergency care assistant or ambulance emergency care technologist should the council recommend to the Minister, in terms of section 33 (1), that the scope of the profession of ambulance emergency care assistant or ambulance emergency care technologist be defined by specifying the acts which shall, for the purposes of the Act, be deemed to be acts pertaining to the profession of ambulance emergency care assistant or to ambulance emergency care technologist.

Functions and duties of the professional board

6. It shall be the duty of the professional board to—

(a) promote a high standard of professional education and professional conduct among ambulance emergency care assistants and ambulance emergency care technologists;

(b) report to the council on any matter affecting ambulance emergency care assistants or ambulance emergency care technologists referred to it by the council;

(c) advise the council on the removal under the provisions of section 19 or section 32 (2) of the name of any person from the register of ambulance emergency care assistants or that of ambulance emergency care technologists kept under section 32; and

(d) make recommendations to the council in regard to the recognition of insitutions for the prescribed practical training of ambulance emergency care assistants or ambulance emergency care technologists and in regard to the recognition of qualifications of ambulance emergency care assistants or ambulance emergency care technologists whose names are entered in the appropriate register kept under section 32.

No. R. 174 **10 January 1992**

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

ESTABLISHMENT OF A PROFESSIONAL BOARD FOR EMERGENCY CARE PERSONNEL

Under the powers vested in me by section 15 (4) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), and after considering a recommendation of the South African Medical and Dental Council, I, Elizabeth Hendrina Venter, Minister of National Health, hereby establish a professional board to be known as the Professional Board for

Seminar to focus on medical costs

STAR 10/1/92

Pretoria Bureau

Health Minister Dr Rina Venter has invited the medical fraternity to discuss ways in which the cost of medicine and medical services can be curtailed.

Interested parties are to take part in a forum in Pretoria on February 28 to discuss the following matters:

- Whether the substitution of medicines registered by the Medicines Control Council should be allowed under certain conditions.
- Whether a system of maximum medical aid pricing should be accepted and implemented.
- Whether the principle that the patient is responsible for part-payment of the cost of medicine at the time of dispensing should be accepted and implemented by the medical scheme.
- The principle of a single exit price based on volume purchased being accepted by the pharmaceutical manufacturers.
- Whether the remuneration of the pharmacist and dispensing medical practitioner should be by way of a dispensing fee and not a percentage mark-up.
- Whether the principle of pharmacist-initiated therapy should be accepted.
- Whether greater professional discretion should be granted to pharmacists by the rescheduling of certain schedule 3 and 4 medicines.
- Whether the parallel importation of certain medicines should be implemented.

Shake-up in health care

ET 10/1/92 (85)

Own Correspondent

JOHANNESBURG. — National Health Minister Dr Rina Venter yesterday unveiled radical new plans to halt rampant medical inflation and restructure the national health-care system.

Dr Venter's proposal yesterday for a "medical Codesa" at which the proposals will be discussed drew a positive response from all sections of the health care sector, including her staunch opponents such as the National Medical and Dental Association and the Medical Association of SA, which recently spearheaded calls for her resignation.

A broadly constituted forum is to discuss Dr Venter's wide-ranging proposals on February 28.

They include allowing pharmacists to supply schedule three and four drugs without doctors' prescriptions.

Another proposal is to introduce a single exit price on sales by pharmaceutical manufacturers.

Single exit prices would restrain manufacturers from giving certain medicine suppliers an unfair advantage by preventing them from offering medicines to various suppliers at different prices.

If implemented the proposals would accelerate the move to a primary health-care orientation by making medical care more cost effective and more readily available to lower-income groups.

Lukewarm welcome for 'medical Codesa' call

(85) CT 11/1/92

Staff Reporter

NATIONAL Health Minister Dr Rina Venter's call for a "medical Codesa" to discuss proposals to combat the rocketing medical costs and to restructure the national health care system has been welcomed — with reservations.

The influential Medical Association of South Africa (Masa) which recently spearheaded calls for her resignation, is in favour of the conference but some members feel that pharmacists may be given too much leeway to initiate therapy which could endanger patients' lives.

Dr Tony Berman, secretary for Masa in the Western Cape, said he applauded the awareness Dr Venter had shown of the high costs of health care in South Africa, but urged that before she made any unilateral decisions she should consult with Masa in the interests of further health care.

He said pharmacists were not fully trained in clinical skills and could not examine the patient to ascertain physical signs of illness. He was reacting to the proposal to allow pharmacists to supply Schedule 3 and 4 drugs without doctors' prescriptions.

Mr Gus Fergusson, director of the Pharmaceutical Society of South Africa in the Western Cape, said the society welcomed the proposed changes, which could stimulate competition and bring prices of medicines down.

The executive director of the Representative Association of Medical Schemes (RAMS), Mr Rob Speedie, said any steps which could reduce the costs of medicines to the consumer must be welcomed and pursued.

Dr Venter's wide-ranging proposals are expected to revitalise the now chaotic state of health care in South Africa and make medical care more cost-effective and more readily available to lower income groups.

A broadly constituted forum will discuss the radical new plans in Pretoria on February 28.

ANC wants a say in health system

THE ANC yesterday asked Health Minister Dr Rina Venter to place a moratorium on current attempts by her department to unilaterally restructure the health system.

In the statement Venter was also asked to accept that "others should participate in the process of restructuring and that the NP cannot unilaterally decide which isolated aspects of the beleaguered health system should be addressed".

(85)

2/12/92

ANC call to Venter

The ANC has called on Health Minister Dr Rina Venter to place a moratorium on all current attempts by her department to unilaterally restructure the health system. STAR 13/11/92

Venter health care move criticised

85

CT 13/1/92

Own Correspondent

JOHANNESBURG. — The ANC has criticised Health Minister Dr Rina Venter for acting unilaterally in her initiative to bring down the cost of health care.

It called for her to place a moratorium on her department's efforts to restructure the health system and to accept the right of other organisations to participate in the restructuring.

Dr Venter has announced she plans to call a health care convention.

Two policemen gunned down

Business Day Reporter

NATAL police are investigating the possibility that two 19-year-old constables were murdered because they were members of the force.

The bodies of the policemen were found in the veld next to the Bulwer/Howick road on Saturday. Both had been shot twice at point blank range in the back of the head.

A police spokesman yesterday confirmed that one of the constables had his SAP appointment certificate hidden inside his underpants in an apparent bid to conceal the fact that he was a policeman.

The constables were identified as Jacques Wilken and Wybrand Smit. They were hitchhiking from Durban to Newcastle at the time.

Sapa reports a team of top detectives is working around the clock to trace the murderers.

In another incident directed at the SAP, a handgrenade was thrown at a policeman on patrol in Sharpeville, Vereeniging, on Saturday night. B|Day 13|1|92

The grenade detonated near a private dwelling. The policeman sustained slight injuries.

Police said yesterday a man was killed when an RDG 5 hand grenade was thrown at a private vehicle in Kagiso near Krugersdorp.

Two men were wounded when a gunman fired a number of rounds at a beerhall in Daveyton on the East Rand, and extensive damage was caused when a shack and a private vehicle were set alight in Gugulethu in the western Cape.

ANC lashes out at health plan

B|Day 13/1/92

85

Business Day Reporter

THE ANC has criticised Health Minister Rina Venter for acting unilaterally in her initiative to bring down the cost of health care.

It called for Venter to place a moratorium on her department's efforts to restructure the health system and to accept the right of other organisations to participate in the restructuring.

The ANC was responding to the minister's announcement last week that she would convene a meeting of key players in the industry to discuss plans to cut costs of medicines and move towards more primary health care.

The ANC said itself, Cosatu and the SACP had already called for the establishment of a forum of political groups, trade unions, community organisations and government to address health and other social services during the period of transition to a new government.

High medical costs were only a symptom of a system "which has been constructed to protect the interests of the white minority and big business", said the ANC statement. It said many fundamental flaws of apartheid remained in place, including apartheid in hospitals.

While the involvement of all interested parties in discussions to curb the cost of health care was long overdue, Venter had to realise that the NP could not unilaterally decide which isolated aspects of the health system should be addressed.

The Pharmaceutical Manufacturers' Association (PMA) said at the weekend that while it welcomed the planned talks on health care, it was inappropriate to use the title High Cost of Medicines for the forum.

"It would have been far better if the forum concentrated on the high cost of the medical bill rather than to select one item of the medical bill which, indeed, is the most cost-effective one," said PMA executive director John Toerien.

He said it appeared SA was "once again falling into the same trap as in the past by addressing only one facet of the health bill.

Toerien said the forum's recommendations flowed mainly from the De Villiers investigation into health care, which was completed four years ago and the results of which have never been made public.

The investigation was carried out by Wim de Villiers, who was later appointed to the Cabinet.

The PMA believed that the broader approach for the forum was substantiated when the De Villiers investigation began in November 1987.

Its terms of reference also covered privatisation of hospital services, especially in terms of cost-effectiveness; involvement of the state in rendering hospital services and methods to reduce this systematically; and any other matters which could lead to the reduction of state spending on health services.

● Comment: Page 4

New State health policy

Sowetan 17/1/92

THE ANC and an influential welfare lobby group, the Co-ordinating Committee on Welfare Policy, are expected to react today to a far-reaching working document on the State's welfare policy.

The document, released by National Health Minister Dr Rina Venter this week, contains two significant concessions - racial parity and a single welfare authority - long demanded by progressive lobby groups.

It was drawn up after discussions with various interest groups and individuals over the past two years.

Comments on the working document will be accepted up to April 30.

The document states that equal social welfare grants for all races will be phased in by April 1 1996.

The document proposes one umbrella body to control all welfare departments.

On the contentious issue of finance, the document urges the State to allocate more funds for welfare.

Sowetan Correspondent

It says the business sector should be involved in welfare programmes and a comprehensive strategy must be developed to obtain maximum financial help from communities.

Donations

The State should be urged to exempt welfare donations from tax, according to the discussion document entitled "Points of Departure in Developing a New Social Welfare Dispensation for the Republic of South Africa".

It stresses that the development of an appropriate welfare dispensation is the joint responsibility of the State and the private sector and not the sole task of the Government.

RINA VENTER

City has the best 'sun hat'

(85) ARCT 18/1/92

PATRICK FARRELL
Weekend Argus Reporter

THERE is more ozone protection against the sun's ultra-violet rays in Cape Town than anywhere else in South Africa, in spite of its nearness to the Antarctic's ozone hole.

But Cape Town's relatively thick layer of protection in the spring dwindles as the summer wears on, dropping to a seasonal low in autumn.

This is the finding of the Space Research Institute at the University of Natal, whose figures show that the Mother City gets the highest levels of ozone in early summer.

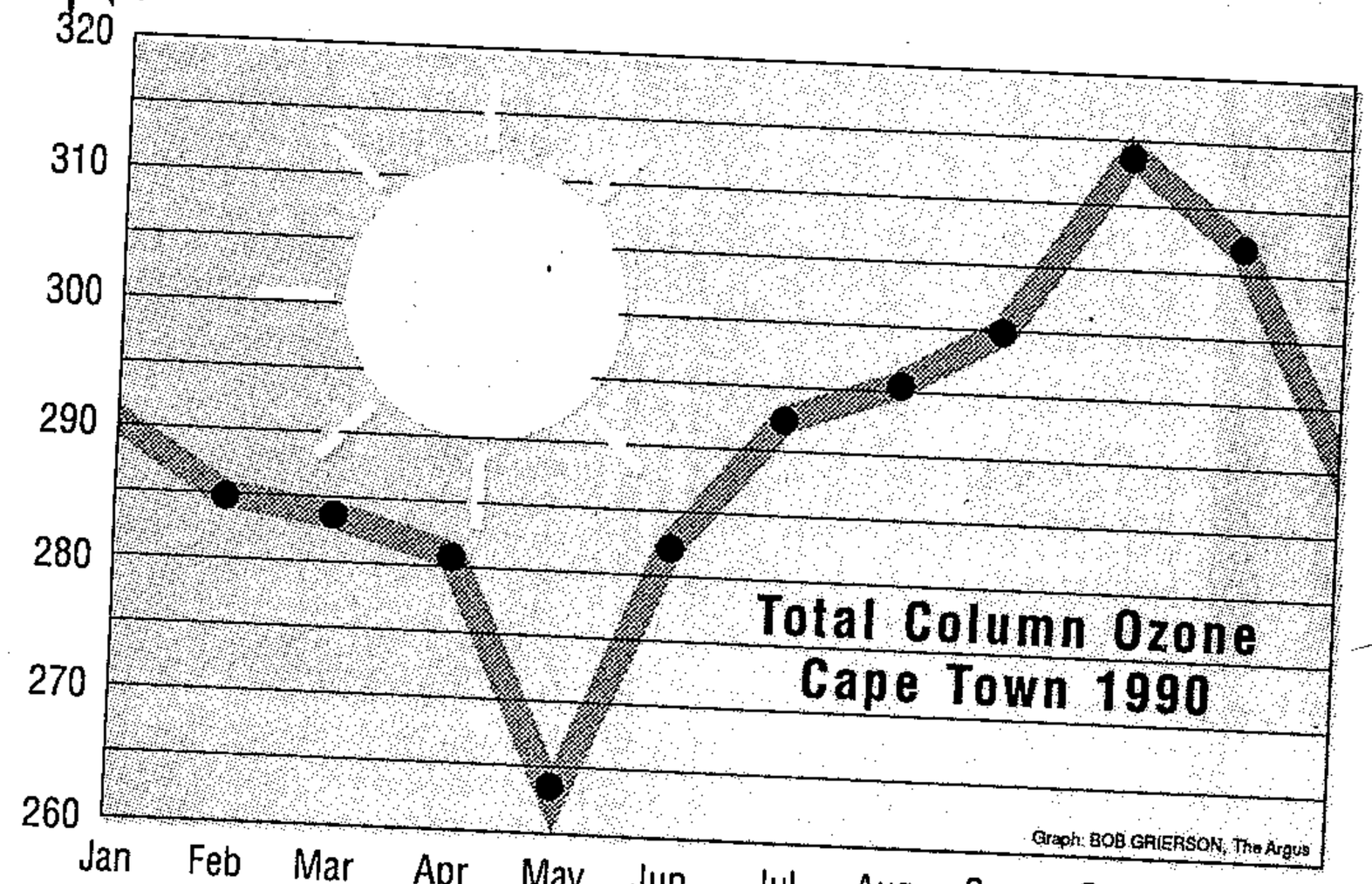
By midsummer the levels begin to drop until they are at a low in May when the whole cycle begins again.

The institute's Dr Erhard Mravlag said the reason for these changes is the circumpolar vortex, a wind system unique to Antarctica which influences the mid-latitudes.

"Ozone is produced in the tropical stratosphere but is stopped from moving down to the polar regions by the vortex, which forms a type of barrier in the late winter.

"The result is a build-up in ozone levels above Cape Town in October," he said.

The vortex breaks up in late October and ozone-rich air then rushes down to fill up the ozone hole over Antarctica, leaving Cape Town with much lower ozone levels at the height of summer in January.



☐ **DANGER LEVELS:** This graph shows the ozone levels above Cape Town for 1990 in Dobson Units. A Dobson Unit figure divided by 100 will give the thickness of ozone at sea level, eg 300 DU equals 3mm of ozone, although in the stratosphere this figure increases to a thickness of a few kilometres.

While the levels are very low in May, there is no major cause for alarm, say experts. This is because the sun is then much lower on the horizon in winter and therefore much weaker, although people should still take precautions against sunburn.

The ozone measurements were taken by the American Nimbus 7 satellite, launched in 1978.

Data from the spacecraft is first sent to Nasa in the United States to be processed and from there to the University of Natal.

Although the data for 1991 has not been released by Nasa, it is expected to be similar to that of 1990.

Recently a R350 000 French-made SAOZ (System for the Analysis of Observations at Zenith) instrument was installed at the University of Natal.

The instrument, the first in the country, will measure UV rays from the sun as well as the ozone level.

Call for better food labelling

(85)
CT 20/1/92

JOHANNESBURG. — Leading nutrition advisory groups have called for strict food labelling legislation to combat the soaring incidence of heart disease, strokes and cancer in South Africa.

The need for improved food labelling is outlined in an editorial in the latest issue of the South African Medical Journal, and endorsed by the Heart Foundation of Southern Africa, the Association for Diabetics in Southern Africa, the National Cancer Association and the Allergy Society of South Africa.

The recommendations include enforced labelling of kilojoules and specific nutrients such as fat, salt and fibre content of all processed foods.

Substances which could cause intolerance reactions such as caffeine and lactose should be quantified, while foods containing eggs and wheat — both commonly associated with allergies — should be clearly marked.

"Marketing buzz words such as 'lite' and 'diet' should be defined and standardised."

The recommendations stem from the high incidence of diseases which can be attributed to increasing urbanisation and the low fibre and high fat and salt content of the average South African diet.

The groups believe disease prevention through nutritional education is futile without comprehensive food labelling.

Legislation currently requires compulsory nutrient labelling only for baby foods and foodstuffs claiming a health or diet function.

Law amendments are currently under review by the Food Legislative Advisory Group (FLAG) of the Department of National Health and Population Development.

The editorial expresses concern that the advisory group consists almost exclusively of members from the food and allied industries. — Sapa

Venter rejects plea to broaden forum scope

CT 24/1/92 Own Correspondent (85)

JOHANNESBURG. — National Health Minister Dr Rina Venter yesterday rejected proposals by the National Medical and Dental Association (Namda) to broaden the scope of her proposed medical forum, planned for February 28, to encompass the major issues facing health care.

Namda and the ANC's health department yesterday criticised Dr Venter's forum — which will focus on the cost of medicine — saying it was too narrowly defined and what was needed was discussion on the restructuring of health services.

Namda spokesman Dr David Green said his organisation viewed the forum as "a bit of a con" as it was not consultative. He said to discuss the restructuring of health care in a haphazard way was "ineffectual and could even be damaging".

Medical TV service coming

JOHANNESBURG. — A medical cable television network service is due to start on April 2 this year.

The Medical Television Network, MTN, which will be introduced by JSE-listed Publico Limited — South Africa's largest specialist publishing company — will be linked initially to about 1 000 hospital wards and private waiting rooms. CT 24/1/92

"Our programme aims at informing, educating and entertaining viewers, with topics ranging from health care to children's features, travel, lifestyle, sport and comedy," Publico chairman Dr Jack Shapiro said yesterday.

He said research had shown the project would be "commercially attractive". — Sapa.

Medical associations reject Venter's forum

(85)

B Day 24/11/92

KATHRYN STRACHAN

NATIONAL Health Minister Rina Venter yesterday rejected proposals by the National Medical and Dental Association (Namda) to broaden the scope of her proposed medical forum to encompass the major issues facing health care in SA.

Namda and the ANC's health department yesterday criticised Venter's forum — which will focus on the cost of medicine — saying it was too narrowly defined and what was needed was discussion on the restructuring of health services.

Namda spokesman David Green said his organisation viewed the forum as "a bit of a con" as it was not consultative. He said to discuss the restructuring of health care in a haphazard way was "ineffectual and could even be damaging" as each reform had far reaching ramifications. He added that Namda would reassess whether it would attend the forum on February 28.

ANC secretary for health Ralph Mgijima said yesterday the ANC's health department would not attend the forum as it had not been consulted. He disagreed with the way in which Venter had called the meeting, saying she should have consulted other players in the health field from the outset.

In a letter to Venter, Namda requested that the meeting be jointly convened by the National Health Department and the ANC, and possibly Namda and the Medical Association of SA (Masa).

Masa secretary general Hendrik Hanekom said the forum appeared to be "yet another attempt to discuss specific problems in isolation". He said the items on the agenda centred around the provision of medicines and that other factors contributing to rising health care costs would not be addressed. Hanekom said, however, that they would attend the forum.

Representative Association of Medical Schemes (Rams) official Rob Speedie said he still believed the forum represented a step in the right direction and hoped it would deliver positive results.

Wits University's Centre for Health Policy Studies director Cedric de Beer criticised the limits of the agenda. While the forum was called to discuss drug policy, only one aspect of that policy would be tackled. De Beer said the agenda outlined by Venter focused entirely on the private sector while 80% of people in SA depended on the public sector for health care. The main question facing health administrators was making drugs more accessible.

Although the issues on the agenda were important, they focused largely on the vested interest of business medicine: "It is about squabbles over the market share." He added that doctors, pharmacists and the pharmaceutical industry were the only actors involved in the proposed forum and what was needed was a meeting which would involve consumers and deal with the problem of making drugs more accessible.

NSL rejects Bhamjee's offer of R2m

THE National Soccer League (NSL) re-

THEO RAWANA

Health study in cash crisis

SHARP cuts in funding and a soaring import bill have left South Africa's primary medical research body, the Medical Research Council, in a critical condition.

Yet without the MRC research input, South Africa's scientific brain drain would increase, the country's health care system would be left directionless and academic medicine, already in crisis, could be paralysed.

"The government should give us more money," says the MRC's deputy president, Dr Walter Prozesky. "The government says health and education are priorities, and we work in both fields. I believe the government should put its money where its mouth is and give us greater funding."

For many years the MRC's budget was inflation-linked, but for the past three years the council has had to cope with a five-to-seven percent cut every year in rand terms, as well as face an inflation rate of 20 to 30 percent for imported goods such as chemicals, equipment, computers and books.

A changing South Africa meant a change in the MRC's research priorities. The focus on a Western-oriented thrust to be part of the sophisticated international scientific world had shifted to South Africa's own health problems.

The MRC would continue to spend about 50 percent of its budget on research grants for people in other research bodies and academic hospitals . . . "where basic scientific and laboratory research is done best. It is important to maintain our capacity for this type of work."

The rest of the budget would fund the MRC's own programmes, particularly its six new national research priorities: Aids, tuberculosis, malaria, urbanisation, nutrition and trauma.

The financial cuts and the rationalisation had made about 20 MRC posts redundant, and the council was still negotiating with individuals about their jobs.

"We're not whining for more money for ourselves," said Dr Prozesky. "The point is that if the health services do not get the necessary information they will not be able to solve South Africa's health problems, and we'll all suffer.

"The health services can't afford to run blind. It's like driving a car without headlights in the dark — it'll go for a while, but it won't be long until it hits something."

The academic hospitals, where the country's new crop of doctors, nurses and other medical personnel were trained, were already staggering under a the double load of increasing demand and shrinking resources.

"If we get a cut in funds and pass it on to the academic hospitals a large part of their capacity is paralysed. And this would have a direct negative effect on the whole medical situation in South Africa.

"We could lose some of our best people; they will leave the country if we don't create structures in which they can continue their research."

The MRC received money from the Department of National Education, and was administered through the Department of National Health, a split that did not make life any easier.

"We've been trying to influence the decision makers, but to no avail," said Dr Prozesky.

"Budget cuts by national education seem to be passed on indiscriminately, based on precedent, without any proper setting of priorities.

"The situation we find ourselves in is critical. We can't expand, yet South Africa has a growing population and growing health needs."

The Medical Research Council, a statutory research body that contributes information on which major decisions on health policy are based, has watched its budget shrink sharply over the past three years. As rationalisation progresses, deputy president Dr Walter Prozesky speaks to VIVIEN HORLER of Weekend Argus about his concerns:

Health care debate must look beyond the private sector

(85) (90) (98)

BFDay 29/11/92

CHERILYN IRETON

THE need for a new health care system and national drug policy is being overshadowed by a tussle for a greater share of the private sector medicine market.

Players outside government and quasi-government health services who are keen to extend their influence include drug manufacturers, drug wholesalers, pharmacists, dispensing doctors and private clinics and hospitals.

Official statistics are hard to come by, but it seems this "private sector market" accounts for only 30% to 40% of drug sales in volume terms while drawing about 80% of total expenditure.

In spite of the size and significance of the public sector drug market, its problems — particularly in the availability and distribution of medicines — receive little public attention. Instead, the debate on high medicine costs has centred around private sector issues — such as the role of the pharmacist, generic substitution and the misuse of medical aid funds — many of which are underscored by considerations of turnover and market share.

Powerful lobbying by players in the medicine market has meant many of these issues have remained deadlocked over the past five years. But government, attempting to address rising health care costs, plans to discuss them next month at a national forum hosted by National Health Minister Rina Venter.

There are mixed feelings about the forum. Several parties, including the ANC, say it is not the time for government to be moulding new policies, particularly those that address only one small facet of health services. Others are impressed that Venter has moved away from autonomous decision making and is actually negotiating future policy.

The success of Venter's forum could, however, rest on the profile of delegates. Venter has issued a blanket invitation to interested parties and several organisations are already reassessing their attendance in light of the restricted agenda. Wits University Centre for Health Policy director Cedric de Beer warns that those who eventually sit around the table may represent only narrow interests; there may be no one to represent the interests of the consumer and to raise issues that lie outside the private sector debate. These include the integration of government's 14 departments of health and the privatisation of services, which appears to have been put on ice.

Drug policy matters include the question of distribution of medicines to rural areas, homelands and squatter camps. "Although there is the infrastructure to buy the drugs there doesn't seem to be the infrastructure to distribute them," De Beer says.

Fellow Wits researcher Bada Phasari argues that any forum looking to make health care cheaper and more accessible to low-income groups should, by definition, be looking at the interests of the consumer. "This forum seems to be based on the interests of the providers of health care services such as the pharmaceutical manufacturers, drug wholesalers, pharmacists and dispensing doctors."

He believes the so-called crisis in the retail market is not only about the cost of drugs but also about the fact that many players' profit margins are under pressure. This could distort any debate.

Venter has identified eight issues for her agenda. They are that:

- ☐ Substitution of prescribed drugs by cheaper "generic" alternatives be allowed under certain conditions;
- ☐ Pharmacists be given a wider role and be allowed to dispense schedule three and four drugs without a doctor's prescription. Schedule three includes drugs that need to be repeated for chronic cases of illness like epilepsy while schedule four are those not allowed to be repeated without another prescription;
- ☐ Pharmacists be allowed to initiate therapy;
- ☐ Pharmacists and doctors be given a fixed fee for drugs dispensed and not a percentage markup;
- ☐ Medical aid patients be responsible — at the point of sale — for part of the bill for dispensed medicines;
- ☐ Manufacturers have only one sale (or exit) price for their products, thus preventing huge discounts to selected parties;
- ☐ Medical aid schemes accept a system of maximum medical aid pricing; and
- ☐ Imports of products already produced locally be allowed.

The state tender system is not up for discussion but it is unlikely that Venter will be able to keep it from being debated. The same applies to transfer pricing — a practice where multinational companies pay their offshore affiliates inflated prices for active ingredients used in the local manufacture of their products.

The agenda may also still be influenced by the contents of a document, "Your options on health care", to be presented to government next month by the Pharmaceutical Manufacturers' Association (PMA). The recommendations were drawn up after a forum on the health care delivery system held by the PMA in November. Delegates included the ANC.

The PMA's suggestions are likely to focus on ways of making health care more cost-effective and will include input on restructuring medical aid schemes — which it believes encourage overusage and abuse of the health care system — restrictions on free health care, the scrapping of the tender system and the need for one state health department.

This last point is one which the ANC argues strongly. It foresees a unified, nonracial health system where all services fall under the responsibility of a single authority. Central to its proposals is that all services be accessible and affordable.

An extension of this is the belief that a national drug policy is needed to deal with problems of availability, distribution and the price of drugs. The ANC believes an essential drug list needs to be drawn up to ensure there are enough medicines at every health care facility. It also envisages maximum use of generic drugs.

Government has already been formulating a national medicines policy and says good progress has been made. It sees next month's forum as one step towards a broader, national medicines policy.

But once the forum is over, Venter will have to consider whether to risk drawing up and implementing the new policy while Codesa is busy negotiating political and economic dispensations. If she does press ahead, the challenge, particularly on the medicines front, will be to bring together the private and public health sectors — those players that prosper from providing health services to those South Africans that can afford it, and those players who battle to serve those who cannot.

ANC unveils its national health service plans

B1 Day 29/1/92

KATHRYN STRACHAN

THE ANC's health department has launched a campaign for a halt to all restructuring of health services by the state, the organisation's health director Ralph Mgijima said yesterday.

He accused government of being undemocratic and of acting unilaterally in restructuring health facilities. He expected the campaign to have widespread support.

Mgijima said the organisation had adopted formally the principle of a national health service with a single Department of Health which would regulate the private sector.

Although the private sector was a vital part of health care, Mgijima said that in the future it would become less necessary as the service provided by the public sector improved. Attempts would also be made to draw private practitioners into the public sector.

At present the private sector used almost 50% of health care resources but provided care for only 20% of the population. These resources were heavily concentrated in urban areas.

Mgijima added that the ANC had resolved that essential health services would be free at the point of delivery and that ways of providing additional funds for public health services would be established.

One of the methods being considered was a national health insurance scheme. There would be a health tax kept separate from other taxes.

All employed people would make a compulsory monthly contribution and contributors could claim free medical attention from both the public and the private sectors.

To further alleviate the burden the organisation intended implementing dedicated taxes — taking a percentage off alcohol and cigarette taxes, for example.

US Speaker unfair — Schwarz

STAR 3/11/92

By Hugh Roberton
Star Bureau

WASHINGTON — A brief reference to South Africa by the Speaker of the US House of Representatives, Thomas Foley, has drawn a sharp reaction from the South African ambassador to the US, Harry Schwarz.

Mr Foley, a member of the Democratic Party, made the remark in his response to President Bush's State of the Union address to Congress.

Criticising Mr Bush for having evaded the health care crisis, he said: "Few Americans realise that the US and South Africa are the only economically advanced nations that do not guarantee the health care of their people."

History

In his response, Mr Schwarz said that presumably because of its apartheid history, South Africa had been brought into the US domestic political debate, "to my mind most unfairly and irrelevantly".

South Africa could not be described as an economically advanced country to be equated with the US.

South Africa devoted "vast resources" to meet the health needs of its people — in fact more than 6,4 percent of the country's GNP, Mr Schwarz said.

"Many other countries which could have been quoted by the Speaker do not compare favourably with South Africa," he said.

'They must be given the right to choose'

(85) ARG 1/2/92

THERE was a time when it was so rare to find a dead baby in the sewers around Durban that it was always reported to the police.

Now it has become so common that the drain cleaners at Kwadabeka near Pinetown merely dump the little bodies in a pit with rags, rotting food and other rubbish that blocks the drains.

What should be done about these unwanted babies? Is abortion the answer?

Pro Life supporters say it is not the answer and that abortion is murder. But its members do not offer a solution to the problem of unwanted babies.

The countless little scraps of human life found in the sewers outside Pinetown were flushed down toilets. It is not known whether they were from miscarriages or abortions.

"At first when we found them in the sewers we used to tell the police. Now there are so many we don't worry any more. They look like foetuses younger than five months. They get trapped in the screens that catch anything bigger than a table tennis ball," said Umgeni Water Board superintendent Mr Vic Maynes.

"We dig a hole next to the screens and dump anything that gets caught there. All we have time to worry about is treating the water. We don't have time to bury the babies," he said.

At the heart of the Pro Life argument is the Christian belief that a foetus in the womb is a human being who has a soul.

However, Dr Marg Dyer, chairman of the Abortion Reform Action Group, said the Pro Life argument did not help women in desperate circumstances who are prepared to risk their lives rather than continue with their pregnancy.

"They want the right to take responsibility for their lives," she said.

"They should be given the right to choose."

But then why does the church not perform a proper burial after a miscarriage?

Pro Life leader Dr Claude Newbury said this was according to legal precedent, which named a foetus under the age of 28 weeks as an "abortus". In practice, nurses in hospitals incinerate foetuses which have miscarried.

Dr Newbury said Pro Lifers in the United States gave burials to babies found in rubbish bins behind clinics where abortions were performed.

"There are no unwanted babies. Only unwanting parents," said Dr Newbury.

"And if you are unwanted — does that qualify you for death?" he asked.

He said the state should provide welfare programmes to solve the problem.

'Front-street' doctors charge R3 500

ARG 1/4/92

IN clean white clinics and behind closed doors there are a number of doctors allegedly making a commercial killing by performing "front-street" abortions on desperate women.

The relatively safe suction procedure takes about 10 minutes and doctors are allegedly demanding as much as R3 500 in cash.

Meanwhile, poorer women are risking their lives resorting to the often unsanitary conditions of backstreet abortionists who can be found "on every street, in every township" in the country, according to Dr Marg Dyer, the Abortion Reform Action Group's Cape chairman.

Dr Dyer is leading the fight for women to be able to obtain a safe, cheap abortion within three months of falling pregnant.

Her chief opponent is the leader of Pro Life, Dr Claude Newbury, who says abortion is murder and cannot be condoned by a Christian society.

"The pro-abortionists are saying it is all right to kill human beings, provided they are little and voiceless and defenceless," he says. Dr Newbury equates abortion with the genocide of Jews in nazi Germany.

But Dr Dyer says it is a matter of philosophical debate at which stage a fertilised egg becomes a human being.

"This is an endless argument. And it does not help the pregnant woman to solve her problems.

"The reality is that we end up with unwanted children who sleep in doorways and beg in car parks. What quality of life is that?"

Dr Dyer called for a commission to investigate the present Abortion Act, which she says has never benefited women.

Dr Newbury says his opposition to abortion stems from the Hippocratic oath as well as his religious beliefs.

"As a doctor I have sworn an oath to preserve human life — a pagan oath that dates back to 350 BC."

Dr Newbury maintains that abortion should not be performed in any circumstances — not after a rape or if the child is deformed.

"It is not a medical procedure. People use it under the guise of medicine."

He said he was told by an anxious young boyfriend last week that a specialist gynaecologist in Johannesburg had agreed to perform an abortion for R3 500.

"It's blood money," says Dr Newbury, who reckons the "minor procedure" would take about 10 minutes and should cost a maximum of R300.

Most of these illegal "front-street" abortions are done by doctors and nurses in consulting rooms and clinics.

"It happens all the time. There are doctors who do it under the guise of a D and C."

Most perform a suction abortion if the pregnancy is under 12 weeks.

"They open the mouth of the womb with a range of dilators, from very small to large, which are a bit thicker than the thumb.

"When the womb has been forcibly opened, they insert a suction tube, usually made of steel with whistle tips at the other end. This suction is about 30 times stronger than a powerful vacuum cleaner.

"The suction tears apart the insides of the womb and disrupts the contents. You can identify little arms and legs," he says.

Women who cannot afford the high costs charged by a local doctor (he could be struck off the register and brought to trial) or who cannot afford to travel overseas where abortion is legal, are stuck with risky options.

"Sometimes 'backstreet' abortionists use primitive instruments and 'operate' in unsterile conditions," said Dr Newbury.

Says Dr Dyer: "The Abortion Act discriminates against poor women.

"The majority of backstreet abortions are performed in the townships by a nursing sister and women pay whatever they can. They literally go begging for help.

"Conditions are not aseptic. The abortionists take some sort of instrument into the uterus to stir up the contents. They sometimes use knitting needles or pieces of wire. It is extremely dangerous and the woman can die.

"The sad part is that we are not only looking at young unmarried girls, but women with other children. They can kill themselves in this way and leave their children without a mother."

Girls who have an abortion that becomes septic might have to have a hysterectomy and never be able to have children.

"Pro Life has no answer to these problems," says Dr Dyer.

"We believe that in the first 12 to 14 weeks a woman should be able to consult her own doctor and make her own decision."

This is the case in all the European Community countries, except Ireland, says Dr Dyer.

Physical, mental damage can be forever

(85) ARG 1/2/92

BACKSTREET abortion is not only one of the leading causes of maternal death in South Africa but for every woman who dies there are many who endure permanent physical or psychological trauma.

Weekend Argus spoke to Professor Ronald Green-Thompson, head of the Natal Medical School's obstetrics and gynaecology department, to discuss the most common methods of illegal abortion and what can go wrong.

"If someone tries to induce an abortion by inserting a catheter (one of the most common methods) only, without injecting any agents, then the danger is sepsis (and trauma to the local area). The insertion could result in the perforation of the uterus and bladder or injury to the genital tract, causing bleeding and possible sepsis," he said.

"If the abortionists inject a fluid (which is often done as they think it increases the chances of the foetus aborting, and is usually an irritant or toxic substance) then the result may be an air embolism and sudden death."

An air embolism is caused by bubbles of air entering the bloodstream.

"Depending on what is used, the substance can also cause major chemical damage to the uterus and other tissues, resulting in necrosis, or active death of the tissues, and often gangrene," said Professor Green-Thompson.

He said that if the abortificant liquid was injected too forcefully, it could enter the abdominal cavity via the open ends of the Fallopian tubes. If an infection was passed into the abdomen in this way it could become well-established. The liquid could also cause necrosis of other major abdominal organs.

One of the best-established complications of backstreet abortion is what doctors term DIC (Disseminated intra-vascular coagulopathy).

Professor Green-Thompson explained: "In DIC the chemical agent and/or septicaemia interferes with the clotting factors in the blood, causing widespread bleeding.

"Micro-embolisms disseminate in the blood, causing respiratory distress syndrome and other organ failure.

"The lungs are unable to maintain the blood gases at their correct levels and the red blood cells also become haemolysed — they lose their ability to carry sufficient oxygen and carbon dioxide.

"The blood pressure may drop right down, leading to renal failure, resulting in septic shock."

"For every woman who dies, there are many who don't," said Professor Green-Thompson. "Many suffer infertility, blocked or partially blocked Fallopian tubes, ectopic pregnancies, uterus damage, chronic renal failure, chronic pelvic pain, sexual dysfunction, psychological disturbances from the trauma and guilt, and difficulty sustaining good relationships."

Tens of thousands of SA women desperate to abort their pregnancies risk death and disability under the hands of unskilled abortionists

Backstreet slaughter!

(85) ARG 1/2/92

BETWEEN 42 000 and 200 000 South African women risk death, injury and permanent disability at the hands of backstreet abortionists every year.

The Department of National Health and Population Development, in its *Epidemiological Comments* report, said that estimates varied widely, depending on which model was used to determine them — the higher figures being chosen on extrapolations from other countries, particularly the United States.

The report says that in 1989, 40 or more women were known to have died as a result of complications arising from "illegally induced abortions", although many such deaths go unreported.

Shocking they may be, but these figures cannot put a value on the emotional, mental, physical and spiritual suffering that accompanies many of these illegal procedures, and the estimate of the number of women who submit to backstreet abortions is only a conservative, educated guess. The figures could be up to 10 times as high.

Before 1975 it was an offence to procure an abortion under any circumstances, including after rape or incest. And, as the report states, "it was all but impossible to gain exemption from this rule and anecdotes abound of the human hardship this caused".

The Abortions and Sterilisations Act (Act No 2 of 1975) legalised abortions under certain stringent conditions. Four criteria are used to determine whether a woman is eligible for a legal abortion, 818 of which were performed from July 1 1990 to June 30 1991.

These criteria include:

- Where there is a serious threat to the woman's physical health;
- Where there is a serious threat to the woman's mental health;
- Where the unborn child is declared incurably ill; and
- Where the pregnancy has resulted from "illegal intercourse" (for example, rape or incest).

The cases are assessed by a committee comprising a state psychiatrist, a gynaecologist, the superintendent of the registered local hospital and in some instances a social worker.

Minister of Health Dr Rina Venter's recent report that 98,6 percent of the respondents who wrote in to her department giving their views on abortion were against any change in the law, and that no "well-motivated" pro-abortion suggestions were received, has caused great controversy.

"Even Hitler couldn't claim to have had 98 percent support," said Dr Michael Ewart-Smith, senior state psychiatrist at Sterkfontein Hospital, who is known for his outspoken views on abortion.

A woman's magazine which ran a survey on abortion last year found that 86 percent of respondents were in favour of legalised abortion.

"We are out of step with the rest of the world," said Dr Ewart-Smith.

"It is a ridiculous indignity that women have to ask someone like me whether they can have a legal abortion. I believe a woman is herself the best judge — clearly better than any committee in this country or, for that matter, the world.

"The question of backstreet abortions just adds horror to the whole situation and, combined with the population explosion, makes it clear that the law must be changed.

"What surprises me is that South African women aren't more militant about this. Perhaps they are getting the law they deserve.

"After consulting to make sure that a woman is not being forced into having an abortion by a guy or by her parents, the procedure — which is a very easy and safe operation — should be available speedily, safely and with the minimum of guilt," he said.

The African National Congress's Women's League has called for abortion to be made freely available, stating that most black women do not have private doctors or the financial means to go through the expensive process of trying to secure a legal abortion.

Because of inadequate family planning and sex education, unwanted pregnancies arise and then the state makes criminals of women who attempt to do something about them, the league says.

Mary Rodrigues, director of Birthright in Durban, an organisation which counsels mothers on alternatives to abortion — adoption or foster-care — says: "Birthright's position is that abortion is never right — that there are alternatives."

Every mother has the right to have her baby, and every baby has a right to be born."

She says she is not anti-abortion in the strict sense of the word, and that Birthright, on occasion, counsels women after abortions.

"We let them talk and try to help them get beyond the event. There is often a lot of guilt involved," she says.

The often acrimonious debate on the moral, ethical, social and legal implications surrounding abortion will in all likelihood never cease, and while it continues, in the words of one young woman: "The violence perpetrated against women in the form of having to resort to backstreet abortions will continue to maim and kill."

40 women died last year at hands of illegal abortionists

National Transport Commission

*4. Mr J CHIOLÉ asked the Minister of Transport:†

(1) Who are serving on the National Transport Commission at present;

(2) whether the composition of this commission changed recently; if so, (a) what was the nature of the changes and (b) (i) who served on the previous National Transport Commission and (ii) for what length of time did each of the permanent members serve on it;

(3) whether members of the previous commission whose services were terminated were furnished with reasons for the termination of their service; if not, why not; if so, what reasons?

B6E

The MINISTER OF TRANSPORT:

(1) The following eight members presently serve on the National Transport Commission:

Dr M F Mitchell: Chairman and Acting Director-General: Transport
Mr R G Meyer
Mr H J Claassens
Mr J J Smit
Mr G R Pauw
Mr S Petersen
Mr P P M Chetty
Prof S J Zondi

Dr C F Scheepers who has been appointed Director-General: Transport as from 1 March 1992, will from that date be appointed chairman of the Commission.

(2) Yes; the composition of the Commission has changed with effect from 1 January 1992.

(a) The membership has been decreased from ten to eight members. The powers, functions and duties of the Commission have been scaled down over the past year to such an extent that it now concerns itself primarily with matters regarding civil aviation and commuter subsidies.

(b) (i) The following members served on the previous Commission:

Mr R G Meyer: Chairman and Director-General: Transport
Mr J J Smit
Mr H C van Zyl
Mr B Slabbert
Mr E F Niksch
Mr G R Pauw
Mr J J S Germishuys
Mr A M Brynard
Mr H J Meyer
Mr C J Grové

(ii) The permanent members served on the previous Commission for the following periods:

Mr R G Meyer — 1 October 1987 until 31 December 1991
Mr J J Smit — 1 May 1987 until 31 December 1991
Mr H C van Zyl — 1 October 1976 until 31 December 1991
Mr B Slabbert — 1 October 1971 until 31 December 1991
Mr E F Niksch — 1 June 1977 until 31 December 1991

(3) Yes; the members were informed that their periods of service expired on 31 December 1991 and that the demands of the changing transport environment have necessitated the re-composition of the Commission.

Letter: Acting Judge President, Natal

*5. Mr D J DALLING asked the Minister of Justice: Hansard 4/2/92

(1) Whether in July 1991 he received a letter from the Acting Judge President of Natal in connection with the release of criminals from prison; if so,

(2) whether he will disclose the contents of this letter; if not, why not; if so, what was (a) the content of the letter and (b) his response thereto?

B11E

The MINISTER OF JUSTICE:

(1) Yes.

(2) No. It is not practice to disclose the contents of correspondence addressed to me. In fact, the Honourable Member may wish to reflect whether his question, referring to the action of a court official, to wit a Judge President, is in order in terms

of Parliamentary convention. The Honourable Member is referred in this regard to *E May, Parliamentary Practice* (21 st Ed.), p 291 and also p 288

The matter of release of prisoners, both under the amnesties announced by the State President and in terms of normal policy, was subsequently discussed at a conference held with the Chief Justice and all the Judges President.

Hansard 4/2/92

A mutual understanding was reached in respect of both the concerns voiced on behalf of the administration of justice and the particular demands on the Executive at a crucial stage in South Africa's development, when exceptional steps had to be taken in order to deal with the question of political prisoners and the necessity of an evenhanded approach as far as other prisoners were concerned.

(a) and (b) Fall away.

Certain person: potential threat

*6. Mr P G SOAL asked the Minister of Defence:

Whether, with refererence to his reply to Question No 26 on 19 February 1991, a certain person, whose name has been furnished to the South African Defence Force for the purpose of the Minister's reply, was identified by the Civil Co-operation Bureau as a potential threat to State security; if so, (a) when, (b) for what reasons and (c) what is the name of this person? Hansard 4/2/92 B16E

The MINISTER OF DEFENCE:

As was indicated in the reply to question number 26 of 19 February 1991, the findings of the Harms Commission had been referred to the Attorney-General for further investigation. The Attorney-General has indicated that the matter is still being investigated and it is therefore *sub judice*. (a) (b) and (c) fall away.

SABC: educational television service

*7. Mrs C H CHARLEWOOD asked the Minister of Education and Training:

(1) Whether, since the reply to Question No 23 on 9 April 1991, his Department has taken any further steps to establish, through the South African Broadcasting Hansard 4/2/92 Corporation, a full-scale educational television service to Black schools throughout the country; if not, why not; if so, (a) what further steps and (b) when is it anticipated that this service will commence;

(2) whether he will make a statement on the matter?

B19E

The MINISTER OF EDUCATION AND TRAINING: Hansard 4/2/92

(1) No

(a) The establishment of a fullscale educational television service to Black schools country-wide cannot be afforded by the Department at this stage.

The department is currently planning a project in co-operation with the SABC to assist standard 10 candidates with the aid of television broadcasts for two hours per day from 1 April 1992 to 30 September 1992.

Furthermore the Department and the SABC are jointly planning a pilot television programme project which will be directed at pupils from standard 5–7, parents and teachers. The programmes will be broadcast during 1992.

An interdepartmental committee is currently investigating all aspects of distance education. This includes, inter alia, educational radio and television.

(b) Falls away.

(2) Not at this stage.

Single health department

*8. Mr M J ELLIS asked the Minister of National Health: Hansard 4/2/92

(1) Whether, since her reply to Question No 15 on 12 March 1991, her Department has taken any further steps to consider the administrative, financial and national health implications of a single department of health for South Africa; if so, what further steps; if not, why not; cont—D

(2) whether she will make a statement on the matter? B26E

The MINISTER OF NATIONAL HEALTH:

(1) The Department of National Health and Population Development has developed a model for the restructuring of health services in co-operation with the various role-players. The key aspects of the model constitute the following:

- Devolvement of primary health care services to local authorities. This implies that the functions rendered by the six authorities be rationalised to one authority.
- Granting of maximal management autonomy to academic hospital complexes.
- Transfer of academic hospitals to the Department of National Health and Population Development. This implies the financial and administrative consolidation of the function which at present vests with five authorities, under the control of the Department of National Health and Population Development.

Meaningful progress has already been made with the implementation of the new health dispensation.

Discussions are presently being conducted in respect of the rationalisation of the functioning of the Department and own affairs administrations within the terms of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983). It is envisaged that a model will be established within the near future;

(2) various statements relating to the new health dispensation have already been made by the Minister.

Aids: free air-time

*9. Mr M J ELLIS asked the Minister of National Health:

(1) Whether she has approached the Minister of Home Affairs with a request for free air-time on radio and television for anti-Aids advertisements of any form and/or Aids information or education programmes; if so, what was the response; if not,

(2) whether she intends making such a request; if not, why not? B27E

The MINISTER OF NATIONAL HEALTH:

(1) No,

(2) an Interdepartmental AIDS Committee was established at the beginning of 1991 and consists of departments that are directly or indirectly involved in AIDS prevention. These departments are contributing to the National Strategy for AIDS Prevention, as well as to internal AIDS prevention activities within their respective departments. Each department was requested to indicate via the Interdepartmental AIDS Committee in what ways departments will utilise resources at their disposal in the prevention of AIDS.

The SABC is outonomous and decides for itself on its advertisement policy. The AIDS Unit approached the SABC for free transmissions but the request was not granted.

Van den Heever Commission: report

*10. Lt-Gen R H D ROGERS asked the Minister of Education and Training:

(1) Whether, with reference to his reply to Question No 28 on 20 February 1991, the fourth report of the Van den Heever Commission has been received; if so, when;

(2) whether any action is contemplated against persons named in that report; if so, (a) what action and (b) against whom? B34E

The MINISTER OF EDUCATION AND TRAINING:

(1) The Fourth Report of the Van den Heever Commission, dated November 1991, was submitted to the Government and is at present being studied.

(2) (a) and (b) fall away.

Pensions: widows of SADF members

*11. Lt-Gen R H D ROGERS asked the Minister of Finance:

Whether, with reference to the reply by the Minister of National Health and Population Development to Question No 280 on 26 April 1990 and his reply to Question No 140 on 13 March 1991, further consideration has been given to raising the pension of a widow of a deceased member of the South African Defence Force to 75 per cent of the pension paid to her late husband; if not, why not; if so, with what result? B35E

The MINISTER OF FINANCE:

No. As previously stated such a step is not affordable.

Police recruits

*12. Mr P H P GASTROW asked the Minister of Law and Order:

(1) Whether, in comparison with 1991, there is to be any reduction during 1992 in the number of recruits being trained for the South African Police at police training colleges in the Republic of South Africa; if so, (a) why and (b) how many police recruits (i) will the South African Police train at such colleges during 1992 and (ii) were so trained in 1991;

(2) whether he will make a statement on the matter? B36E

The MINISTER OF LAW AND ORDER:

(1) (a) and (b) (i)

It is not possible to reply to the question at this stage, as the number of students to be trained during 1992 depends on the amount of money approved to the post of Law and Order in the Main Budget by Parliament.

(b) (ii)

6 442 students were trained during 1991.

(2) No.

Additional teaching posts: Cape Peninsula

*13. Mr K M ANDREW asked the Minister of Education and Training:

Whether any additional teaching posts have been created at primary and secondary schools in the Cape Peninsula in 1992; if not, why not; if so, (a) how many were created at such (i) primary and (ii) secondary schools and (b) what are the names of the schools involved? B41E

The MINISTER OF EDUCATION AND TRAINING:

Yes.

(a) (i) 70

(ii) 43

(b)

Primary	*Posts*
Nkazimlo	1 Principal
	1 Head of Department
	10 Teachers
Chuma	1 Principal
	1 Head of Department
	10 Teachers
Ilifa	1 Principal
	3 Teachers
Sosebenza	1 Deputy Principal
Emithini	1 Deputy Principal
	1 Teacher
Ebulumkweni	7 Teachers
Kukhanyile	2 Teachers
Ntwasahlobo	1 Teacher
Vuzamanzi	1 Teacher
Sobambisana	1 Teacher
Mkhangeli	1 Deputy Principal
	10 Teachers
Hlengisa	1 Head of Department
	1 Teacher
Mfuleni	1 Head of Department
	4 Teachers
Linge	1 Teacher
Langabuya	4 Teachers
Mkhanyiseli	1 Teacher
Walter Teka	3 Teachers

Secondary	*Posts*
Intlanganiso	1 Principal
	1 Head of Department
	17 Teachers (new school)
Mvuzemvuze	2 Heads of Department
	5 Teachers
Masiyile	1 Head of Department
	1 Teacher
Luhlaza	1 Teacher
Malizo	1 Teacher
Thandokulu	1 Teacher

'Medical Codesa' call

STAR 5/2/92

Medical Reporter

South Africa needs a "medical Codesa" to address the problems experienced in the health sector, Society of Dispensing Family Practitioners executive member Dr Eddie Sarlie says in the body's latest newsletter.

Medical politics was out of step with mainstream politics and needed a forum for negotiation and consultation.

"While Parliament remains an important platform for policy statements by the Government, its function is now little more than technical. The real decisions on key issues will undoubtedly be taken by Codesa." Dr Rina Venter wanted to effect major changes to health care and to impose her will on the medical fraternity.

Dr Sarlie was writing in reference to the forum the Minister has called to discuss the rising cost of medicine and medical services, as well as amendments to the Medical Schemes Act.

"We cannot and will not accept any major restructuring of health legislation in SA without proper consultation and negotiation," he said.

To address problems like fragmented health services, lack of facilities, high cost of health care, and VAT on medical services, a "medical Codesa" was needed.

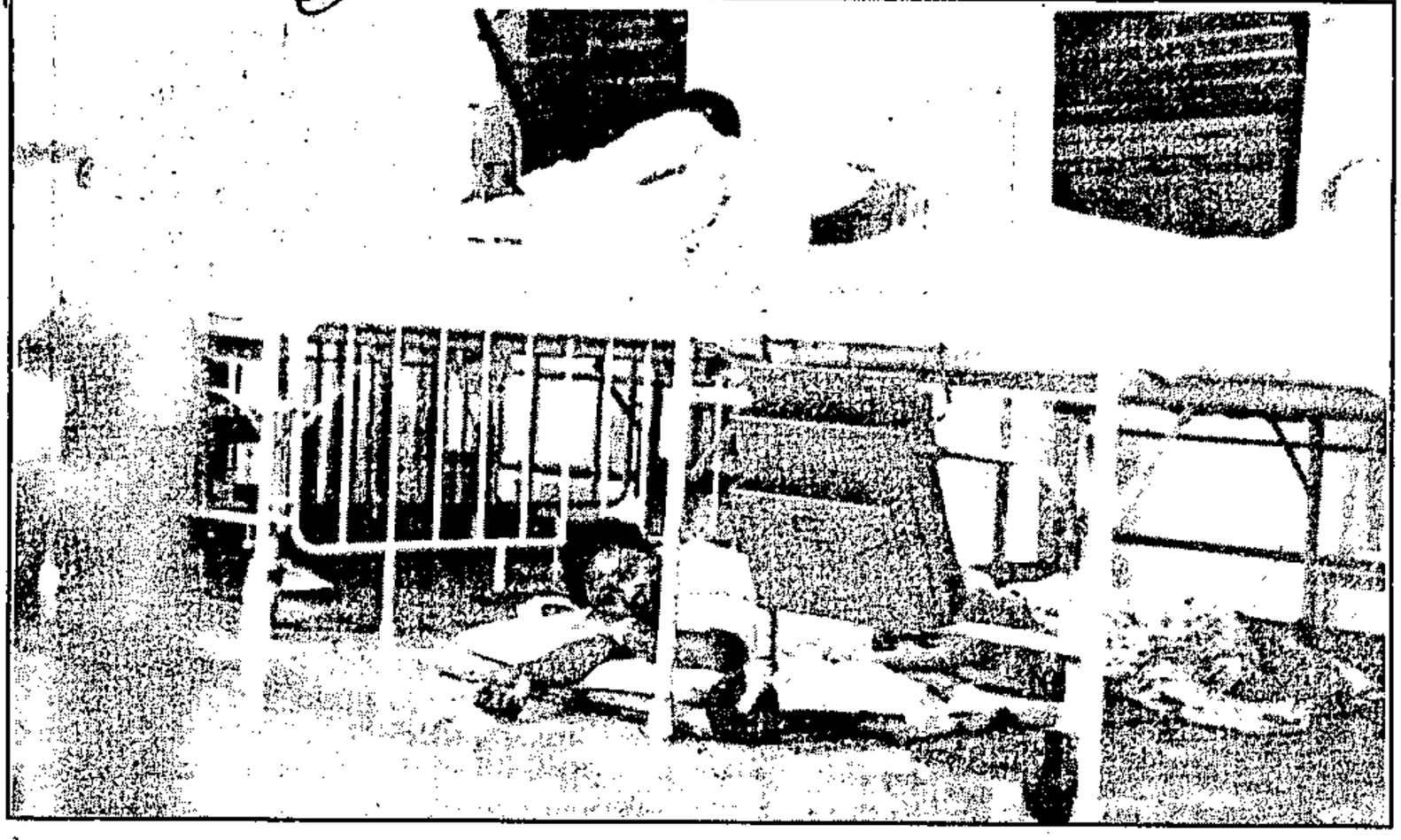
HEALTH MATTERS

HEALTH AND HEALTH CARE

New Nation (learning Nation) 7|2|-13|2|92 (85)

Welcome to the Health Matters page for 1992. Many of our readers have told us that they like the health page and find it very interesting. Thank you for your support.

In 1992, we are going to try to make our health page more interesting. We are having a meeting with a large number of health organisations to identify what the important issues are. We also need your help. We want you to write to us and to tell us what you think are the important health issues and what you want to learn or debate about.



Privatisation

Health and health care have become topics for much debate in many countries. Health and access to health care are major problems for many people in the world. The trend in many capitalist countries is to move away from state health services and towards privatisation. This means that these governments want to relinquish responsibility for health care, and hand this over to the private sector. Privatisation has resulted in many people being without adequate health care in many places. This trend is particularly strong in the USA and many European countries.

Health and health care in South Africa

South Africa is a very unhealthy place to be. Many people live in poor conditions and do not have access to the resources which make people healthy.

People are unhealthy because they do not have enough food to eat, they often do not have jobs, and they are often paid very low wages. Many people live in overcrowded townships, with poor housing and without clean water and sanitation. All of this means that people get sick.

When people get sick, they do not have access to decent health care. They do not have access because health services are expensive and unequally divided in a number of ways. This means that when people get sick, they often get worse because they either can't afford, or are too far away from health care services.

Why do people not have access to good and affordable health care?

There are more services available in the urban areas than there are in the rural areas. People who live in rural areas are often very far away from health care services. There are also more hospitals, clinics and doctors in the cities than anywhere else, because the government does not provide free health care for people. Health services which the government does provide are inadequate and overcrowded and are often very far away from where people live.

People also get sick because much more money is spent on curing rather than preventing disease. The government talks a lot about being committed to primary health care, but we see very little evidence of this.

Apartheid and Health

There are more and better services available to whites and rich people. This is because the government spends more money per person on health care for whites, which means that whites have always had access to better quality public services than anyone else. Public services for blacks are often overcrowded and do not have the same quality of equipment and services as the white hospitals.

Health care is also inadequate because the government spends a lot of money on maintaining apartheid in health. A few years ago the government announced that all facilities were to be opened to all. This is not what is happening. Public services throughout SA are still largely operating on the basis of race.

Money is also wasted because the government spends a lot of money maintaining 14 different departments of health, one for each homeland, whites and the tricameral system of "own affairs". This wastes an extraordinary amount of money which could be used to provide better care for everyone.

Capitalism and Health

Rich people are able to get better care, because they are able to pay for Medical Aid schemes. Medical Aid schemes help them pay for private health care. Private care is often better than the care the government provides. This is because the government has for a long time now, tried to reduce its responsibility to provide health care for the people. The government has allowed public sector services to deteriorate and has kept raising the costs of care in public hospitals. They have been trying to force people out of the public sector and into the private sector. This has all been part of their privatisation initiative.

Private services are very expensive and out of the reach of most people. The only way that adequate, affordable and accessible care can be provided for people, is through a National Health Service, provided by the state. A service which provides free care for all the people in a democratic and accountable way.

Women and Health

There are not adequate services for women and children. Women, especially black women, do not have access to appropriate health services for themselves or their children. Family planning services have usually provided inadequate and inappropriate care. They offer a limited range of contraceptives and women are often given unsuitable contraception which can affect their health and their ability to have children in the future.

Women do not have free access to simple cancer tests of the breasts and the womb; tests which can save thousands of lives. Many thousands of women also risk their lives and their health every year in SA, by having illegal, backstreet abortions, because the law only allows very few women to have safe abortions.

The government also does not meet its commitment with regard to the needs of children. Many black children get sick and die because they do not get immunised against certain diseases such as polio. Children get sick and die from simple diseases which can be cured. They die because their parents do not have access to health services for their children. Thousands of children die every year from starvation.

Workers and Health

Workers often get sick at work. Many workers are exposed to dangerous substances such as lead and asbestos. Very few workplaces have medical services on the premises. Even when these do exist they are often more concerned with productivity than the health of the workers. The law is inadequate as it doesn't provide enough protection for workers.

AIDS is a disease we hear a lot about. This new disease will make many people sick and die. We need to tackle this problem now. There are a number of problems related to this, one of which is literacy. Many people cannot read or write and they do not have access to education or the media. This makes mass education about AIDS very difficult. The government has not done enough to combat the spread of AIDS in ways which people can understand. During the year we hope to debate these issues and also run articles on AIDS education.

These are just some of the problems. There are many others. Learning Nation will try to address many of these issues during the course of 1992. We need your help. Please write to us and tell about the health problems you have experienced. Also tell us about the things you would like us to write about on the health page.

Patients may lose the right to choose their own doctors

Medical Reporter STAR 11/2/92

Patients may lose the right to choose which doctor they go to for treatment if the Government passes the amendments to the Medical Schemes Act, the chairman of the Dispensing Family Practitioners Association (DFPA), Dr Robert Rapiti, said yesterday.

He was speaking after his organisation and other medical bodies had placed an advertisement this weekend concerning "shocking health care news".

The group included the Dental Practitioners Association, the SA Dispensing Practitioners Association and the Islamic Medical Association.

He said the organisations paid for the advertisement with the assistance of some drug companies which did not want to be named.

The establishment of Health Maintenance Organisations (HMOs) was only one of the aspects of the amendments to which they objected, he said.

Among other medical bodies which have rejected the amendments is the Medical Association of South Africa. Medical schemes have, however, "unequivocally" welcomed the amendments to the Act.

All the statements made in the advertisement referred to the implications of the provision to establish HMOs contained in the amendments to the Medical Schemes Act which is yet to come before Parliament.

These include the loss of choice of doctor.

HMOs allow medical schemes to establish practices which would employ among others doctors, specialists, dentists, pharmacists and nurses and to have their own hospitals.

This would provide a single point of health care delivery which would be more cost-effective, medical schemes have claimed.

Patients would be obliged to use the services of the HMO — or would have to pay out of their own pockets if they chose to go for private medical care.

If a medical aid established an HMO, members would have to see doctors on the HMO panel.

This could force private practice doctors — who often subsidised the care of the indigent and poor through care of the richer patients — out of existence, Dr Rapiti said.

The care of the poor would then be thrown back to an already over-extended public health service.

He said doctors employed in HMOs would have dual responsibility — to the patients as well as to the company. The latter would expect their doctor to contain costs and would provide the incentives for doctors to use cheaper medicine or to con- tain costs in their own ways. This was not in the interest of the patient.

"Private doctors only do what is the best for the patient," he said.

A spokesman for the Representative Association for Medical Schemes could not be reached for comment yesterday.

'Health Codesa' call to Venter

(85)

ARG 13/2/92

Political Correspondent

HEALTH Minister Dr Rina Venter will face demands for a comprehensive "health Codesa" when she meets representatives of the medical fraternity for talks this month.

She will also face strong criticism from the country's drugs manufacturers who believe the government has adopted an "ad hoc" approach to problems in health care.

They want a new health care delivery strategy to be drawn up by an all-inclusive political and professional forum along the lines of the constitutional negotiations at Codesa.

These points emerged in a briefing yesterday by the Pharmaceutical Manufacturers' Association (PMA).

The PMA is strongly critical of the limited terms of reference of the February 28 summit, describing Dr Venter's approach as "seeking an ad hoc fix instead of looking at health care as a whole and trying to find a solution".

The terms of reference include discussion on the implementation of, among other things, generic substitution, compulsory medical aid pricing, parallel imports and the re-scheduling of medicines.

PMA spokesman Mr John Toerien said: "We need to discuss a new health care delivery strategy."

The PMA also took umbrage at the fact that the invitation indicated that the discussions would focus on "implementing" rather than debating the recommendations of the De Villiers report.

Details of health plan will be released today

(85) CT 14/2/92

Staff Reporter

PROVINCIAL authorities will today announce plans to provide a better, more affordable, effective and accessible health service for the city and the metropolitan area.

The plan is aimed at easing the load on academic hospitals and providing better health services for the whole community. It is also intended to provide better health services in townships and outlying areas.

Reacting to the proposed plan revealed by the Cape Times yesterday, Dr George Watermeyer, CPA hospital and health services deputy-director, said no worker's job would be jeopardised by the rationalisation and it would not place an extra burden on the CPA's health budget.

"Though the plan is aimed at rationalising hospital services in the greater Cape Town metropolitan area, it is in line with planning for hospital services in the whole province," he said.

Dr P J W Roux, superintendent of Somerset Hospital, said he was "delighted to hear" that the trauma unit at the hospital would be extended.

"There have been rumours for some time that the hospital may be closed down, but now it seems its future is assured and it will be utilised to its full capacity," he said.

Dr Alan McMahon, director of emergency services for the CPA, said the emergency services would now be able to provide a better service to the community — especially in the townships.

He was pleased there would be no retrenchments, which usually accompany rationalisation.

● Details of the plan will be released at a press conference in the city today.

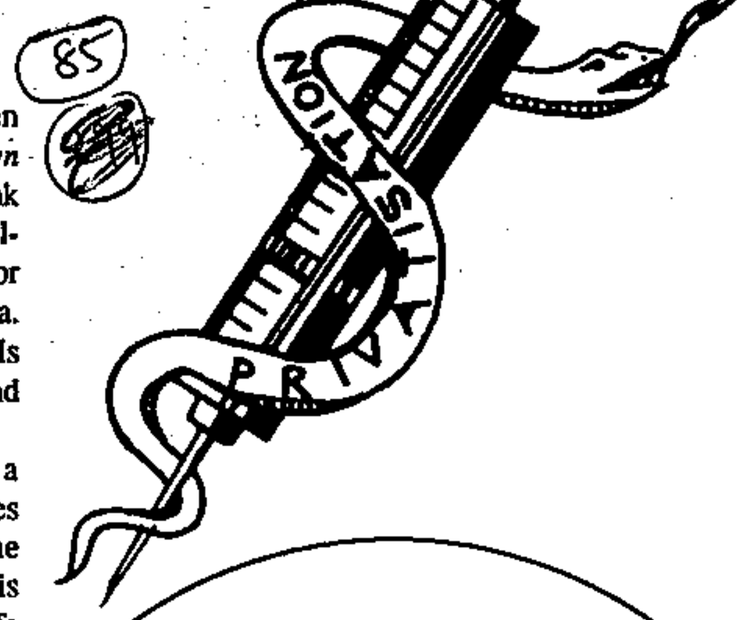
HEALTH MATTERS

WHAT IS HEALTH?

New Nation 14/2 - 20/2/92
(Learning Nation)

When we think of such a question we often relate our answer to ourselves directly and our *own* experience of combating disease. As a result we think of health as something to do with the **absence of ill-health** and something that is solved for us by a doctor or a hospital or a traditional healer such as a sangoma. This sense of health is important for us as individuals and as people concerned about our families and friends.

When however we think of the population as a whole, of countries and regions then health becomes a concept that expresses something much more - **the state of well-being of the people as a whole.** In this broader sense health is an index of the quality of life of a people and not only the absence of disease. The term, health, as used on this page will therefore include looking at individual health problems, but will mainly look at health as a measure of **the quality of life of the people.** In this sense health includes everything from the quality of people's housing, to their diet, to conditions in the workplace as well as the extent to which widespread diseases such as TB and gastro-enteritis have been eradicated.



Health and the Development of Society

The key to understanding the development of society lies in looking at how society is **organised to produce the goods necessary to sustain life** (food, shelter, travel etc). In the struggle to produce these goods people have to enter into some relation with one another and with nature. The struggle amongst people and between people and nature produces different forms of organisation. In the process of these struggles the health of the people changes and is a measure of the quality of the organisation of society.

At the same time improvements in the struggle against diseases have a direct bearing on the organisation of society as these improvement can, for instance, decrease the rate at which people die and thus cause **population increases** which require changes in society to accommodate these increases.

So, for instance, the changes brought about by the **second industrial revolution** in capitalist Europe at the end of the 19th century such as the development of the **refrigeration** of food and the invention of new **medicines** and vaccines caused major changes in people's lifestyles. Although the fact that capitalist Europe had vast discrepancies of wealth, meant that different classes experienced these improvements unevenly, overall the standard of living of millions of people improved. Most importantly, **the death rate (mortality rate)** dropped dramatically and the population of the cities of Western Europe and North America went up by millions. These increases in turn forced people to emigrate to new countries which pushed up the European population in other countries in Asia, Africa and America.

We can see, therefore, that to speak of health in the wide sense involves looking at things like mortality rates, population increases, the changes in eating habits of the people, changing residential patterns, as well as, of course, the changes in disease patterns.

Health and the Inequality of life in Capitalist Society

When we look at the spread of diseases in capitalist society we find that different strata and classes have different disease experiences. In the main the rich suffer from diseases associated with **over-rich eating habits** and the tensions of running businesses or offices and professional work. They therefore are prone to heart problems, ulcers, gout etc. The working class and the poorer people suffer from widespread social diseases such as kwashiorkor, tuberculosis and rickets which are associated with **bad eating habits housing and sanitation.**

But more than this, look at the relation between the spread of particular diseases and class is the fact that the broader definition of health we are employing here includes the fact that the rich have access to better air (their houses are mostly in suburbs away from the city pollution); they have the means to spend on health foods; they can afford gyms for exercises and they have more leisure time to either exercise or just relax. In addition to the fact that health care in capitalist society is a **commodity** which can best be afforded by the rich, the quality of life of the rich, and therefore their health, is better.

Earlier on we spoke about the great changes and improvements in health brought about at the end of the 19th century in Europe and North America. Today we however have the strange situation that further developments in health technology - from food storage and processing to the inventions of new medicines and advances in medical science - **are not improving the overall quality of life of the people as a whole.** In fact in the country which has won more Nobel Prizes for medicine than any other, the USA, the scale of epidemiological diseases (those brought about by poor environment and living conditions) is increasing. This look at health illustrates one of the major contradictions of capitalism - as a society it has the **capacity** to improve the quality of life of all its people dramatically, and yet the need to make **private profit** for the rich makes that capacity unrealisable.

Health and the Question of Policy

The political changes which are taking place in South Africa today will not only impact on health and health services, but health will be an important measure of just how much these changes have really improved the quality of life of the people of South Africa. Questions such as: how do we ensure that all South Africa's people have access to good quality and free/affordable healthcare? will have to be combined with questions about living standards, wages, housing and the environment to ensure that the quality of life which has been enjoyed by a small class can be attained by all. Proposals about a **National Health Service** are being put forward at the same time as calls for free, compulsory education and a Macro-economic Forum to ensure that the economy can guarantee jobs for all. For this reason there is much attention being paid to questions of policy in the mass movement in South Africa today; in other words what strategy should the people's organisations follow to ensure that the demands of the struggles over the last 40 years are realisable at the level of political power, housing, education, jobs and health services.

To the extent that health is the measure of the overall quality of life of the people, the issues raised on this page in our future editions will not only help our readers deal with current health problems but with the all the proposed policies that organisations are putting forward in South Africa.

Learning Nation would like to hear from you about questions you would like to raise on this page and issues you feel should be raised around the broad view of health. Write your views/questions in the space provided and send them to Learning Nation, PO Box 11350, Johannesburg, 2000.

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Nairobi medics invited in

A CONFERENCE between the Medical Research Council (MRC) and the African Medical Research Foundation (AMREF) was held yesterday to investigate possible areas of co-operation.

AMREF, a Nairobi-based organisation presently helping to develop community-based health-care programmes for Namibia, was invited to South Africa by the MRC. (85) ET 13/2/92

AMREF director-general Dr Michael Gerber said that AMREF, which did a lot of work in remote areas, tried to train illiterate people to take responsibilty for health care in their villages.

Venter's info was 'incorrect'

(85) CT 15/2/92

Staff Reporter

SOME of the information which Health Minister Dr Rina Venter placed before Parliament this week was incorrect, according to well-placed medical sources.

She was answering questions tabled by DP MP Mr Mike Ellis concerning the extent of racial integration in hospitals. According to her reply, three hospitals in the Free State, one in the Cape and six in the Transvaal had admitted only white patients last year.

She added that "one such hospital, the William Slater in Cape Town, had an average occupancy rate of 19,12%".

Dr Frank Bowey, one of the medical superintendents of Groote Schuur Hospital, said that William Slater was in fact a totally non-racial institution in respect of both patients and staff, and had been so since April last year.

Before that it had been an under-utilised whites-only alcoholics-only hospital, he said. In April it had been converted into a non-racial psychiatric hospital for adolescents and young adults, and from the moment it re-opened it had been 100% full.

Middelburg (Tvl)	71,0

(The erection of a new prison at Witbank will also alleviate this situation.)

Piet Retief	6,8
Witbank	1,2

(The erection of a new prison has been included in the major works services programme.)

Apart from the new prisons and alterations to existing prisons as mentioned above, the erection of a new prison at Secunda is included in the major works services programme.

Northern Transvaal

Prison	*% over-populated*
Baviaanspoort Maximum	42,5
Baviaanspoort Medium	38,9

(The erection of a new prison at Baviaanspoort has been included in the building programme. Civil engineering works have been completed.)

Louis Trichardt	48,8

(Re-building of the prison will commence during the 1992/1993 book year.)

Nylstroom	42,2
Pietersburg	63,1

(The erection of a new prison has been included in the major works services programme.)

Tzaneen	53,7

(Possibility of a new prison is being investigated by the Regional Commissioner.)

Apart from the new prisons and alterations to existing prisons as mentioned above, a prison farm at Alldays as well as the modernisation/extension of the existing prison at Louis Trichardt is included in the major works services programme.

Western Transvaal

Prison	*% over-populated*
Christiana	9,7

(Modernisation is included in the building programme of the Department of Correctional Services.)

Klerksdorp	41,7
Potchefstroom	28,9
Rustenburg	7,6
Wolmaransstad	27,2

(Modernisation is included in the building programme of the Department of Correctional Services.)

Apart from the prisons mentioned above, the erection of new prisons at Lichtenburg and Zeerust are included in the major works services programme.

Natal

Prison	*% over-populated*
Bergville	22,6

(Modernisation is included in the building programme of the Department of Correctional Services.)

Bulwer	65,8

(Modernisation is included in the building programme of the Department of Correctional Services.)

Dundee	28,7
Durban Medium B	12,9
Empangeni	52,7

(The erection of a new prison at Richards Bay which is being planned, will replace this prison.)

Eshowe	23,6

(The erection of a new prison has been included in the major works services programme.)

Estcourt	18,7

(The erection of a new prison has been included in the major works services programme.)

Greytown	6,6

(The erection of a new prison has been included in the major works services programme.)

Ixopo	30,4

(The erection of a new prison has been included in the major works services programme.)

Kokstad	38,6

(The erection of a new prison has been included in the major works services programme.)

Matatiele	45,9
Melmoth	25,0
Mtunzini	9,7

cont →

Pietermaritzburg	43,2
Port Shepstone	23,4

(The erection of a new prison has been included in the major works services programme.)

Sevontein	13,9
Stanger	13,2

(Modernisation is included in the building programme of the Department of Correctional Services.)

Umzinto	54,8

(Civil engineering works for a new prison have been completed. Tenders for the erection of the prison will be requested during the 1992/93 book year if funds are available.)

Utrecht	30,0
Waterval Medium A	18,2
Waterval Medium B	18,8

Apart from the new prisons and alterations to existing prisons as mentioned above, new prisons at Bergville, Estcourt, Greytown, Ixopo and Pongola are included in the major works services programme. Extentions, alterations and improvements at Nongoma prison is also being planned.

The Department of Correctional Services annually provides a priority list of identified building projects to the Department of Public Works with a view to incorporating them in the Department of Public Works' five year building programme according to which building work is programmed for a term of five (5) years.

This programme is revised annually according to the availability of funds. The fact that a specific project appears on the major works services programme does not imply that it will be executed within five (5) years.

The average rate of over-population in South African prisons on 31 December 1991 was 15,67% in comparison with 8,8% on 31 December 1990.

ANNEXURE A

Analysis of the prison population as on 31 December 1991

Sentenced	1991-12-31
Up to and including 6 months	5 254
More than 6 months to under 2 years	9 360
2 years to 5 years	25 758
Longer than 5 years to 10 years	20 026
Indeterminate sentences	4 081
Longer than 5 years to 10 years	7 059
Longer than 20 years and imprisonment for life	1 350
Unsentenced	23 694
Others	326

(Psychopaths, periodic, corporal punishment, persons sentenced to death)

TOTAL	96 908

Pietermaritzburg: autopsies

40. Mr M A TARR asked the Minister of National Health: (85)

(1) (a) How many persons are qualified to perform autopsies at the Pietermaritzburg medico-legal laboratory and mortuary and (b) what are their names;

(2) how many autopsies on victims of political violence were performed by each of these qualified persons in 1990;

(3) in how many such autopsies (a) was death attributed to (i) assault wounds and (ii) stabbing and (b) were no abnormalities found?

B126E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Two and (b) Dr R J Ingles and Dr D E Maney;

(2) separate statistics with regard to victims of political violence are not kept by the Natal Provincial Administration;

(3) falls away.

National Health: budget (85)

45. Mr M J ELLIS asked the Minister of National Health:

(1) What amount of her Department's Budget was spent by (a) her Department itself and (b) (i) local authorities and (ii) other agencies for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures for the period 1 April 1991 to 31 March 1992?

B86E

Continued →

The MINISTER OF NATIONAL HEALTH:

(1) (a) R460,244 million and

(b) (i) R185,551 million and

(ii) R 18,087 million;

(2) Department itself R409,920 million
local authorities and R204,640 million
other agencies R 18 153 million

Please note that the Department's budget was reduced due to the fact that the Chief Directorate Pensions was transferred to the Department of Finance with effect from 1 September 1990.

SAP: current strength

59. Mr A J LEON asked the Minister of Law and Order:

(a) What is the current strength of the South African Police Force, (b) how many persons have joined the Police Force for the first time since 1 June 1991 and (c) in respect of what date is this information furnished?

B147E

The MINISTER OF LAW AND ORDER:

(a) 96 947

(b) 4 581

(c) 6 February 1992.

Wendy Orr Interdict: settlements

66. Mr E W TRENT asked the Minister of Law and Order:

With reference to the out-of-court settlements resulting from civil actions taken against the Minister of Law and Order and the South African Police following disclosures relating to what was commonly known as the Wendy Orr Interdict, what were the (a) amounts paid to each applicant, (b) costs paid by the State as compensation for the legal costs of the applicants and (c) State's costs in this matter?

B156E

The MINISTER OF LAW AND ORDER:

(a) R120 500,00 was paid to 82 applicants. Compensation varies between R200,00 and R8 000,00 per applicant.

(b) R21 993,71 (provisionally).

(c) R8 425,00 (provisionally).

White population group: births

74. Dr W J SNYMAN asked the Minister of Home Affairs:†

How many births were registered in respect of the White population group in each calendar year from 1960 to 1991?

B185E

The MINISTER OF HOME AFFAIRS:

1960	76 300	1976	78 513
1961	75 725	1977	73 998
1962	76 581	1978	73 183
1963	75 569	1979	73 079
1964	76 781	1980	74 760
1965	77 342	1981	79 058
1966	79 426	1982	77 686
1967	81 635	1983	81 139
1968	84 100	1984	81 534
1969	85 758	1985	79 863
1970	88 368	1986	72 955
1971	89 115	1987	70 431
1972	89 890	1988	69 189
1973	89 965	1989	70 964
1974	83 224	1990	69 649
1975	79 811		

1991 Not available. (Since the repeal of the Population Registration Act, 1950, statistics in this regard are not kept on the basis of population groups.)

Own Affairs:

Teachers/promotion staff: services terminated

4. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether any teachers and/or promotion staff falling under his Department had their services terminated with effect from 31 December 1991; if so, (a) how many and (b) for what reasons;

(2) whether any of the above persons received additional pension benefits as a result of having their services terminated by his Department; if so, (a) what additional benefits, (b) who funded the additional benefits and (c) what total sum is involved;

(3) whether he will make a statement on the matter?

cont

B45E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes, the information, however, applies as from 1 January 1992,

(a) 1 769,

(b) attainment of retirement age, medical reasons and rationalisation;

(2) yes,

(a) full pension benefits in terms of the pension regulations which state that in respect of abolition of posts and retirement on medical grounds, a maximum of 5 years may be added to a person's total years of service,

(b) Department of Finance,

(c) the information may be asked from the Department of Finance;

(3) no.

National Senior Certificate examinations: results

5. Mr R M BURROWS asked the Minister of Education and Culture:

(1) How many pupils at schools falling under the control of his Department (a) wrote, (b) passed, (c) failed, and (d) obtained matriculation exemption in, the 1991 National Senior Certificate examinations;

(2) how many of these pupils obtained (a) A, (b) B, (c) C, (d) D, (e) E, (f) F and (g) other aggregate symbols in these examinations;

(3) how many of these pupils passed in (a) Mathematics and (b) Physical Science in the above-mentioned year? B49E

The MINISTER OF EDUCATION AND CULTURE:

(1) (a) 509,

(b) 383,

(c) 126,

(d) 22;

(2) (a) 0,

(b) 6,

(c) 45,

(d) 163,

(e) 219,

(f) 43,

(g) 33;

*(3) (a) 174,

(b) 95.

* Higher Grade, Standard Grade and Lower Grade included. Information refers to full-time candidates only.

Departmental schools utilised for other purposes

6. Mr R M BURROWS asked the Minister of Education and Culture:

Whether any schools owned or controlled by his Department are unutilised or utilised for purposes other than education; if so, (a) how many as at the latest specified date for which information is available and (b) for what other purposes were they being utilised?

B50E

The MINISTER OF EDUCATION AND CULTURE:

Yes,

(a) 11 as on 11 February 1992,

(b) ten schools are presently in the process of being alienated. One school is being considered for education purposes.

Non-White teachers: appointments

7. Mr A GERBER asked the Minister of Education and Culture:†

Whether any non-White teachers have been appointed at schools under the control of his Department; if so, (a) at what schools, (b) how many and (c) in respect of what date is this information furnished?

B61E

The MINISTER OF EDUCATION AND CULTURE:

Yes,

(a) Dale College Boys' Primary School (King William's Town)

Rondebosch Boys' High School

The Settlers High School (Bellville)

The Grange Primary School (Pietermaritzburg)

North Crest Primary School (Durban)

Cont →

tion and begin to create consequent judicial uncertainty in connection with the matter. In general such a step should contribute towards a successful transition from the present system to that of a *Rechstaat* or constitutional state in which the rule of law prevails.

Cape Peninsula: pollution level of sea

*20. Mr C W EGLIN asked the Minister of Environment Affairs:

(1) Whether any tests were conducted recently to determine the level of pollution of the sea around the Cape Peninsula; if not, why not; if so, (a)(i) when and (ii) where were these tests conducted and (b) what was the finding in respect of the pollution level;

(2) whether this pollution constitutes or at any stage constituted a hazard to human and marine life; if so, what are the relevant details?

B207E

The MINISTER OF ENVIRONMENT AFFAIRS:

(1) Yes.

(a) (i) — Heavy metals in black mussels every six months since 1985

— Radioactivity weekly in sea water and quarterly in biota since 1980

— Faecal coliform levels are measured every two weeks in sea water

(ii) — Heavy metals at 30 positions between Bloubergstrand and Pringle Bay

— Radioactivity measurements made in sea water at Silverstroom Strand and Melkbos and in biota at Yzerfontein, Dassen Island and Melkbos

— Faecal coliform measurements made at 55 sites around Cape Peninsula between Milnerton and Monwabisi.

(b) — Heavy metal concentrations in black mussels were in most cases below those set internationally for human consumption.

— Radioactivity levels were well within internationally acceptable limits.

— Faecal coliform levels at most sites complied with EEC bathing water standards. EEC levels were exceeded on occasions in Hout Bay, Mouille Point, Rocklands, Three Anchor Bay and at some sites in False Bay (mainly in the winter).

(2) — No. None of the monitored pollution levels pose a threat to marine life.

— Faecal contamination has the potential to impact on human health in some areas, at times. Comprehensive information is obtainable from the Department of Environment Affairs.

Union buildings: partially vacated

*21. Adv J R DE VILLE asked the Minister of Public Works:†

Whether any section of the Union buildings is to be vacated; if so, (a) when, (b) for what reasons and (c) who and/or which State department is accommodated in this section at present? B209E

The MINISTER OF PUBLIC WORKS:

No, (a), (b) and (c) fall away.

SADF: certain organization financed

*22. Mr P H P GASTROW asked the Minister of Defence:

(1) Whether a certain organization, the name of which has been furnished to the South African Defence Force for the purpose of the Minister's reply, was at any stage financed or otherwise supported by the Defence Force; if so, (a) for what (i) purpose and (ii) period was it so financed or supported and (b) what is the name of this organization;

(2) whether such financing or support was provided through front organizations?

cont - - - B210E

The MINISTER OF DEFENCE:

(1) and (2)

This matter is presently being investigated by the Commission of Enquiry into the Prevention of Public Violence and Intimidation (also known as the Goldstone Commission). I, therefore, do not consider it advisable to anticipate the findings of the Commission.

SADF: training of two persons

*23. Lt-Gen R H D ROGERS asked the Minister of Defence:

(1) Whether two persons, whose names have been furnished to the South African Defence Force for the purpose of the Minister's reply, have at any stage undergone training by the Defence Force or any of its associated companies; if so, what are the names of these persons;

(2) whether the Defence Force or any of its associated companies provided training at any stage for Transvaal members of or persons sympathetic to a certain organization, the name of which has also been furnished to the Defence Force; if so, what is the name of this organization?

B211E

The MINISTER OF DEFENCE:

(1) and (2)

This matter is presently being investigated by the Commission of Enquiry into the Prevention of Public Violence and Intimidation (also known as the Goldstone Commission). I, therefore, do not consider it advisable to anticipate the findings of the Commission.

SADF: financing of secret camp at Mkuze

*24. Lt-Gen R H D ROGERS asked the Minister of Defence:

(1) Whether the South African Defence Force financed, through front organizations, the establishment and equipping of a secret camp at Mkuze in Northern Natal; if so, what was the cost of this project;

(2) whether, at this camp, Caprivi trainees were housed and front organizations trained leaders and activists of a certain organization, the name of which has been furnished to the Defence Force for the purpose of the Minister's reply; if so, what is the name of this organization;

(3) whether the trainers were linked to the South African Defence Force; if so,

(4) whether the Defence Force's involvement in the Mkuze project was discussed with and agreed to by the leader of the organization referred to in paragraph (2) of this question;

(5) whether this project has been suspended; if so, why?

B212E

The MINISTER OF DEFENCE:

(1) to (5)

This matter is presently being investigated by the Commission of Enquiry into the Prevention of Public Violence and Intimidation (also known as the Goldstone Commission). I, therefore, do not consider it advisable to anticipate the findings of the Commission.

Targeted aid schemes: spending of amount budgeted

*25. Mr K M ANDREW asked the Minister of National Health:

With reference to the R220 million originally budgeted for the targeted aid schemes, as well as any further allocations that may have been budgeted for this purpose, (a) how much of the budgeted amounts has been spent, (b) by which Government Departments or organizations was it spent and (c) in respect of what date is this information furnished?

B217E

The MINISTER OF NATIONAL HEALTH:

(a) R94 550 000,00 is in the process of being paid out,

(b) *State Departments and State infrastructures*

* Clinics operated by local authorities and provincial administrations

* TBVC States
* Self-governing Territories

Non-governmental organizations

Southern Transvaal:

* Imqualife
* Food Gardens Foundation
* Street-wise

cont - - - -

* Mes-aksie
* Save the Children Fund
* Kupugani

Natal:
* Kupugani
* Feed the Babies Fund

Eastern Cape:
* South African Ministers Unity Independent Churches Association
* Port Elizabeth, Uitenhage and District School Feeding Fund
* Valley Welfare
* Port Alfred Psychiatric Work Group
* East London Psychiatric Work Group
* Grahamstown Blind Workers Self Help Group

Northern Transvaal:
* Hluvukani
* Kerklike Aksie Noodhulp
* Living Waters Development Foundation

National Councils:
* SA National Council for the Aged
* SA National Council for Child and Family Care and

(c) 13 February 1992.

Disability pensioners: date of pension

*26. Mr B B GOODALL asked the Minister of National Health:

(1) Whether the date or dates on which disability pensioners of all race groups receive their pension have been changed; if so, why;

(2) whether the pensioners concerned were given any notice of this change; if not, why not; if so, what notice?

B213E

The MINISTER OF NATIONAL HEALTH:

(1) Dates of payment of social allowances are determined annually and it is possible that the dates of payment may not be the same each year.

The dates of payment of black people in Natal will be changed again as from 1 April 1992 due to a new payment system;

(2) yes, pensioners are informed in writing of the dates of payment. Black people are also informed verbally at the different points of payment.

Prisoners transferred to mental institutions

*27. Mr D J DALLING asked the Minister of Correctional Services:

How many sentenced prisoners were transferred to mental institutions in 1991?

B214E

The MINISTER OF CORRECTIONAL SERVICES:

Thirty-one (31). This figure includes one (1) prisoner who was admitted to a hospital prison for psychopaths in terms of section 30 of the Mental Health Act, 1973 (Act No 18 of 1973) as amended.

St Lucia: conservation of wetlands

*28. Mr R F HASWELL asked the Minister of Environment Affairs:

(1) Whether he intends tabling, during the current session of Parliament, legislation on the conservation of wetlands for the specific purpose of preventing mining at St Lucia; if not, why not;

(2) whether he will make a statement on the matter?

B215E

The MINISTER OF ENVIRONMENT AFFAIRS:

(1) No, it is not considered necessary and appropriate to table an Act specifically to prevent mining at St Lucia. Adequate legislation already exists and therefore this matter will be dealt with on merit in terms of the existing applicable legislation and conventions.

(2) No.

Boxing and Wrestling Control Act: representations

*29. Mr R F HASWELL asked the Minister of National Education:

(1) Whether he recently received any representations in regard to amending the Boxing and Wrestling Control Act, No 39 of 1954; if so,

(2) whether, in response to these representations, he intends tabling amendments to the said Act during the current session of Parliament; if not, why not; if so,

(3) whether such amendments will be aimed at (a) making boxing safer and (b) making it possible for members of the South African National Boxing Control Board to be elected?

B216E

The MINISTER OF NATIONAL EDUCATION:

(1) Yes.

(2) No, negotiations are still in progress between the interested parties.

(3) (a) No. This aspect has received detailed consideration in 1991.

(b) It will depend on the results of the negotiations that are in progress between the parties concerned.

INTERPELLATION

The sign * indicates a translation. The sign †, used subsequently in the same interpellation, indicates the original language.

Own Affairs:

Teachers: termination of services

Mr R M BURROWS asked the Minister of Education and Culture:

Whether he intends to terminate the services of any teachers during the 1992-93 financial year as a result of the abolition of posts; if so, what are the relevant details?

B197E.INT

The MINISTER OF EDUCATION AND CULTURE: Mr Chairman, the hon member for Pinetown would have taken note of the joint media statement issued on Monday by me and by the hon the Minister of National Education. In this statement I announced a new education plan which would ensure that thousands of teaching posts were retained in the Department of Education and Culture, Administration: House of Assembly, and give significant self-determination to communities. I also indicated my intention to consult the advisory bodies of the department. This will take place early next week.

The hon member is aware of the fact that since the allocation to my department has been cut for the 1992-1993 year it will be necessary to terminate the services of teachers, since our personnel costs constitute 83% of our Budget. The exact figures are not available at this stage, because this depends on certain variables, but there is a starting point.

The new staffing provisions for schools will come into effect on 1 August 1992 and will result in approximately 4 000 teaching posts being abolished. The uncertain factors, however, relate to the number of teachers who will avail themselves of the opportunity of early retirement, and also the number of schools which will convert to model C. The more schools there are which retain the status quo, the more teachers would have to be retrenched. I am, however, confident that the overwhelming majority of schools will appreciate the advantages of the model-C option and grasp the opportunity of achieving significant self-determination and of maintaining standards.

It is significant that the Teachers' Federal Council has given its support to the proposed plan. In a statement Mr Allan Powell, chairman of the TFC, said the following, amongst other things:

> The Teachers' Federal Council would have preferred to avoid these measures, but the realities are inescapable.

The council is convinced that, under the circumstances, the best package has been obtained for teachers and for education in general. Posts will only be abolished where absolutely necessary. On account of the variables and uncertainties, it serves no purpose to speculate on the numbers involved. However, I can assure the hon member that staff whose posts may have to be abolished will be sympathetically handled and that they will be entitled to benefits as stipulated in the various Acts applicable to their conditions of service. This has been my department's policy in the past and will remain its policy in the future.

Mr R M BURROWS: Mr Chairman, the hon the Minister said on TV the other night that I had to be patient. He knows that I am not patient when it comes to the children of South Africa and what they should be getting from everybody.

Cont----

The MINISTER OF NATIONAL HEALTH:

(1) (a) R460,244 million and

(b) (i) R185,551 million and

(ii) R 18,087 million;

(2) Department itself R409,920 million
local authorities and R204,640 million
other agencies R 18 153 million

Please note that the Department's budget was reduced due to the fact that the Chief Directorate Pensions was transferred to the Department of Finance with effect from 1 September 1990.

SAP: current strength

59. Mr A J LEON asked the Minister of Law and Order:

(a) What is the current strength of the South African Police Force, (b) how many persons have joined the Police Force for the first time since 1 June 1991 and (c) in respect of what date is this information furnished?

B147E

The MINISTER OF LAW AND ORDER:

(a) 96 947

(b) 4 581

(c) 6 February 1992.

Wendy Orr Interdict: settlements

66. Mr E W TRENT asked the Minister of Law and Order:

With reference to the out-of-court settlements resulting from civil actions taken against the Minister of Law and Order and the South African Police following disclosures relating to what was commonly known as the Wendy Orr Interdict, what were the (a) amounts paid to each applicant, (b) costs paid by the State as compensation for the legal costs of the applicants and (c) State's costs in this matter?

B156E

The MINISTER OF LAW AND ORDER:

(a) R120 500,00 was paid to 82 applicants. Compensation varies between R200,00 and R8 000,00 per applicant.

(b) R21 993,71 (provisionally).

(c) R8 425,00 (provisionally).

White population group: births

74. Dr W J SNYMAN asked the Minister of Home Affairs:†

How many births were registered in respect of the White population group in each calendar year from 1960 to 1991?

B185E

The MINISTER OF HOME AFFAIRS:

1960	76 300	1976	78 513
1961	75 725	1977	73 998
1962	76 581	1978	73 183
1963	75 569	1979	73 079
1964	76 781	1980	74 760
1965	77 342	1981	79 058
1966	79 426	1982	77 686
1967	81 635	1983	81 139
1968	84 100	1984	81 534
1969	85 758	1985	79 863
1970	88 368	1986	72 955
1971	89 115	1987	70 431
1972	89 890	1988	69 189
1973	89 965	1989	70 964
1974	83 224	1990	69 649
1975	79 811		

1991 Not available. (Since the repeal of the Population Registration Act, 1950, statistics in this regard are not kept on the basis of population groups.)

Own Affairs:

Teachers/promotion staff: services terminated

4. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether any teachers and/or promotion staff falling under his Department had their services terminated with effect from 31 December 1991; if so, (a) how many and (b) for what reasons;

(2) whether any of the above persons received additional pension benefits as a result of having their services terminated by his Department; if so, (a) what additional benefits, (b) who funded the additional benefits and (c) what total sum is involved;

(3) whether he will make a statement on the matter?

cont

B45E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes, the information, however, applies as from 1 January 1992,

(a) 1 769,

(b) attainment of retirement age, medical reasons and rationalisation;

(2) yes,

(a) full pension benefits in terms of the pension regulations which state that in respect of abolition of posts and retirement on medical grounds, a maximum of 5 years may be added to a person's total years of service,

(b) Department of Finance,

(c) the information may be asked from the Department of Finance;

(3) no.

National Senior Certificate examinations: results

5. Mr R M BURROWS asked the Minister of Education and Culture:

(1) How many pupils at schools falling under the control of his Department (a) wrote, (b) passed, (c) failed, and (d) obtained matriculation exemption in, the 1991 National Senior Certificate examinations;

(2) how many of these pupils obtained (a) A, (b) B, (c) C, (d) D, (e) E, (f) F and (g) other aggregate symbols in these examinations;

(3) how many of these pupils passed in (a) Mathematics and (b) Physical Science in the above-mentioned year? B49E

The MINISTER OF EDUCATION AND CULTURE:

(1) (a) 509,

(b) 383,

(c) 126,

(d) 22;

(2) (a) 0,

(b) 6,

(c) 45,

(d) 163,

(e) 219,

(f) 43,

(g) 33;

*(3) (a) 174,

(b) 95.

* Higher Grade, Standard Grade and Lower Grade included. Information refers to full-time candidates only.

Departmental schools utilised for other purposes

6. Mr R M BURROWS asked the Minister of Education and Culture:

Whether any schools owned or controlled by his Department are unutilised or utilised for purposes other than education; if so, (a) how many as at the latest specified date for which information is available and (b) for what other purposes were they being utilised?

B50E

The MINISTER OF EDUCATION AND CULTURE:

Yes,

(a) 11 as on 11 February 1992,

(b) ten schools are presently in the process of being alienated. One school is being considered for education purposes.

Non-White teachers: appointments

7. Mr A GERBER asked the Minister of Education and Culture:†

Whether any non-White teachers have been appointed at schools under the control of his Department; if so, (a) at what schools, (b) how many and (c) in respect of what date is this information furnished?

B61E

The MINISTER OF EDUCATION AND CULTURE:

Yes,

(a) Dale College Boys' Primary School (King William's Town)

Rondebosch Boys' High School

The Settlers High School (Bellville)

The Grange Primary School (Pietermaritzburg)

North Crest Primary School (Durban)

Cont →

linked to Codesa.
Sapa (ZEP) CT 17/2/92

Medical Codesa urged CT 17/2/92 (85)

Own Correspondent

DURBAN. — A "medical Codesa" has been called for by the Society of Dispensing Family Practitioners (SDFP).

Health costs have soared while the government "decided unilaterally" on health matters, the SDFP said in a full-page newspaper advert.

"We cannot and will not accept any major restructuring of health legislation in South Africa without proper consultation and negotiation."

Oil sale to aid schools, health

Political Staff

AT least R426 million of the R1 billion obtained from the sale of stockpiled crude oil had already been earmarked, Minister of State Expenditure Mr Amie Venter said in Parliament yesterday.

He said R138m would go to education, R204m to roads and R84m to health.

The rest would be allocated to welfare services, hostels, community facilities, the job creation programme, the police and the maintenance of government buildings. ET 20/2/92

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Number of taxpayers

20. Mr K M ANDREW asked the Minister of Finance:

What was the (a) number of individual taxpayers in each income category, (b) tax assessed in each income category expressed as a percentage of total tax assessed, and (c) total amount of tax assessed in each income category, in respect of the 1988-89, 1989-90 and 1990-91 tax years, respectively?

B40E

The MINISTER OF FINANCE:

(a), (b) and (c) See attached schedule under cols. 233 and 234.

Capital gains/tax-free income

36. Mr G C ENGEL asked the Minister of Finance:

In respect of the latest specified tax year for which information is available, (a) what is the amount of capital gains recorded by (i) individual and (ii) corporate taxpayers and (b) what is the total amount of tax-free income or allowances, by category, granted by the Government?

B105E

The MINISTER OF FINANCE:

(a) (i) Individuals: The information is not available.

(ii) Corporate taxpayers: R1 770 171 694

(b) Tax-free Income: R11 259 500 187

Allowances granted in terms of the Income Tax Act, 1962:

Marketing allowance (section 11*bis*) R879 260 109

Economic Development (section 21*ter*) R31 169 927

Films (section 24F) R50 371 727

Sponsorships (section 18B) R16 249 117

Leasehold Improvements (section 11(g)) R40 177 484

Note:

(1) The allowances represent only those granted to companies and close corporations. Allowances granted to individuals, are not available.

(2) All the amounts (excluding the sponsorship allowance) relate to the 1990-tax year, and represent 55% of the total number of companies and close corporations, registered for tax purposes.

(3) The allowance in respect of sponsorships represents allowances approved during the 1989/90 financial year.

Total budgetary allocation: National Health

46. Mr M J ELLIS asked the Minister of National Health:

(1) What was the total budgetary allocation for health matters, including additional appropriations and amounts recovered from other Government Departments for agency work, for (a) each province, (b) each of the self-governing territories, (c) each of the own affairs administrations, (d) the South African Development Trust and (e) the Department of National Health and Population Development for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures in each case for the period 1 April 1991 to 31 March 1992?

B87E

Continue p 2351 6

ANALYSIS OF THE NUMBERS OF TAXPAYERS AND TAX ASSESSED IN INCOME GROUPS

Taxable Income Group R	TAX YEAR 1991 Number	% Total	Tax R'000	% Total	TAX YEAR 1990 Number	% Total	Tax R'000	% Total	TAX YEAR 1989 Number	% Total	Tax R'000	% Total
LOSS	9 921	1,19	0	0,00	23 062	1,31	0	0,00	28 116	1,25	0	0,00
0 – 5 000	92 214	11,08	1 263	0,01	218 236	12,38	3 479	0,02	225 958	10,03	5 525	0,04
5 000 – 10 000	5 608	0,67	4 657	0,05	25 866	1,47	12 560	0,08	68 622	3,04	23 648	0,17
10 000 – 15 000	18 401	2,21	13 362	0,14	79 293	4,50	53 494	0,36	344 415	15,28	241 596	1,73
15 000 – 20 000	31 241	3,75	42 539	0,45	122 928	6,97	180 601	1,21	348 167	15,45	552 710	3,96
20 000 – 25 000	41 162	4,94	86 305	0,90	221 147	12,54	603 924	4,03	254 812	11,31	749 746	5,37
25 000 – 30 000	43 617	5,24	141 377	1,48	197 133	11,18	847 852	5,66	212 805	9,44	952 022	6,82
30 000 – 35 000	42 198	5,07	203 099	2,13	175 599	9,96	1 067 565	7,12	173 634	7,70	1 079 842	7,74
35 000 – 40 000	49 358	5,93	326 613	3,42	149 054	8,45	1 185 407	7,91	139 477	6,19	1 133 740	8,13
40 000 – 45 000	82 170	9,87	697 792	7,31	121 147	6,87	1 201 123	8,02	104 812	4,65	1 052 511	7,55
45 000 – 50 000	82 964	9,97	855 544	8,97	95 975	5,44	1 144 753	7,64	81 044	3,60	976 596	7,00
50 000 – 60 000	127 081	15,27	1 665 726	17,46	127 731	7,24	1 901 011	12,69	103 045	4,57	1 541 797	11,05
60 000 – 70 000	78 912	9,48	1 349 629	14,15	72 227	4,10	1 374 603	9,17	56 966	2,53	1 091 731	7,83
70 000 – 80 000	47 133	5,66	1 001 993	10,50	40 814	2,31	952 635	6,36	33 770	1,50	791 021	5,67
80 000 – 90 000	27 122	3,26	693 092	7,26	25 119	1,42	696 297	4,65	20 913	0,93	582 514	4,18
90 000 – 100 000	16 210	1,95	483 267	5,07	16 513	0,94	530 006	3,54	13 322	0,59	428 786	3,07
100 000 – 150 000	27 157	3,26	1 077 181	11,29	32 661	1,85	1 394 960	9,31	27 842	1,24	1 196 460	8,58
150 000 – 200 000	5 570	0,67	345 735	3,62	9 373	0,53	616 357	4,11	8 271	0,37	545 544	3,91
200 000 – 250 000	2 054	0,25	171 915	1,80	4 057	0,23	357 774	2,39	3 404	0,15	300 277	2,15
250 000 – 300 000	932	0,11	97 861	1,03	1 892	0,11	208 693	1,39	1 608	0,07	178 519	1,28
300 000 – 350 000	495	0,06	61 799	0,65	983	0,06	129 951	0,87	889	0,04	117 048	0,84
350 000 – 400 000	290	0,03	42 725	0,45	675	0,04	104 592	0,70	547	0,02	83 783	0,60
400 000 – 450 000	181	0,02	30 185	0,32	422	0,02	74 996	0,50	319	0,01	57 018	0,41
450 000 – 500 000	104	0,01	19 854	0,21	281	0,02	55 960	0,37	221	0,01	44 545	0,32
500 000 +	403	0,05	127 071	1,33	846	0,05	285 791	1,91	677	0,03	222 600	1,60
	832 498	**100,00**	**9 540 584**	**100,00**	**1 763 034**	**100,00**	**14 984 384**	**100,00**	**2 253 656**	**100,00**	**13 949 579**	**100,00**
	Data I.R.O. 53,61% of all registered taxpayers are reflected in this table				Data I.R.O. 83,34% of all registered taxpayers are reflected in this table				Data I.R.O. 94,02% of all registered taxpayers are reflected in this table			
	Statistics in respect of taxpayers of earning less than the applicable standard income tax on employees (SITE) limit are not available and therefore not reflected in these figures.											

The MINISTER OF NATIONAL HEALTH:

	R'000	R'000
(1) (a) Provincial administrations:		
Provincial Administration of the Orange Free State		
Provincial Administration	473 576	
Additional Allocation	53 418	
Department of National Health and Population Development	16 585	
Administration: House of Assembly	27 030	
Department of Education and Training	550	
Department of Development Aid	18 933	
Total		590 092
Provincial Administration of Natal		
Provincial Administration	972 167	
Administration: House of Assembly	48 854	
South African Development Trust Areas	54 294	
Department of National Health and Population Development	17 892	
Total		1 093 207
Provincial Administration of Transvaal		
Provincial Administration	2 295 022	
Administration: House of Assembly	198 611	
Department of National Health and Population Development	50 000	
Department of Development Aid	11 348	
Total		2 554 981
Provincial Administration of the Cape of Good Hope		
Provincial Administration	1 953 300	
Administration: House of Assembly	71 767	
South African Development Trust Areas	2 331	
Department of National Health and Population Development	42 024	
Total		2 069 422
(b) Self-governing territories:		
KaNgwane		61 513
GaZankulu		104 667
KwaZulu		436 898
QwaQwa		60 865
Lebowa		156 458
KwaNdebele		9 407,
(c) Own affairs administrations:		
Administration: House of Representatives		107 814
Administration: House of Delegates		36 454
Administration: House of Assembly		534 072,
(d) South African Development Trust Areas		91 399
		and
(e) Department of National Health and Population Development		486 895;
(2) (a) Provincial administrations:		
Provincial Administration of the Orange Free State		
Provincial Administration	552 879	
Additional Allocation	38 320	
Department of National Health and Population Development	18 450	
Administration: House of Assembly	29 230	
Department of Education and Training	1 105	
Department of Development Aid	19 362	
Total		659 346

	R'000	R'000
Provincial Administration of Natal		
Provincial Administration	1 082 214	
Administration: House of Assembly	54 427	
South African Development Trust Areas	59 721	
Department of National Health and Population Development	21 805	
Total		1 218 167
Provincial Administration of Transvaal		
Provincial Administration	2 506 997	
Administration: House of Assembly	254 312	
Department of National Health and Population Development	54 000	
Department of Development Aid	14 599	
Total		2 829 908
Provincial Administration of the Cape of Good Hope		
Provincial Administration	2 135 189	
Administration: House of Assembly	71 545	
South African Development Trust Areas	4 128	
Department of National Health and Population Development	44 000	
Total		2 254 862
(b) Self-governing territories:		
KaNgwane		79 142
GaZankulu		137 003
KwaZulu		504 000
QwaQwa		71 585
Lebowa		206 005
KwaNdebele		17 831
(c) Own affairs administrations:		
Administration: House of Representatives		169 851
Administration: House of Delegates		41 553
Administration: House of Assembly		623 630
(d) South African Development Trust Areas		115 570
(e) Department of National Health and Population Development		693 268

Hospitals: total amount allocated

57. Mr M J ELLIS asked the Minister of National Health:

(1) What total amount, inclusive of the original amount and all additional allocations, did the responsible province allocate to the (a) Groote Schuur Hospital and its satellites, (b) Tygerberg Hospital, (c) Universitas Hospital, (d) Witwatersrand hospital complex, (e) H F Verwoerd Hospital, (f) academic hospital falling under Medunsa and (g) King Edward VIII Hospital for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures for the period 1 April 1991 to 31 March 1992;

(3) how many authorised so-called academic beds are available to each of the universities associated with the above hospitals?

B145E

The MINISTER OF NATIONAL HEALTH:

(1) *Provincial Administration of the Cape of Good Hope*

(a) R359 192 076,

(b) R319 409 501,

Provincial Administration of the Orange Free State

(c) the information regarding the Universitas Hospital cannot be given separately from the National Hospital because these two hospitals are seen as a unit.

The total amount allocated to the two hospitals for the period 1 April

Continued —>

SADF: suicide attempts/suicides

68. Lt-Gen R H D ROGERS asked the Minister of Defence:

How many (a) members of the Permanent Force, (b) national servicemen and (c) members of the Citizen Force/Commandos (i) attempted to commit and (ii) committed suicide in 1990 and 1991, respectively?

B158E

The Minister of Defence:

1990

	(a)	(b)	(c)
(i)	40	163	3
(ii)	7	20	2

1991

	(a)	(b)	(c)
(i)	43	129	18
(ii)	10	5	4

Black townships: actions of troops

69. Lt-Gen R H D ROGERS asked the Minister of Defence:

(1) Whether any official complaints were lodged with the South African Defence Force in 1991 regarding the actions of troops in any Black townships; if so, (a) how many, (b) on what dates and (c) what was the nature of the complaints in each case;

(2) whether these complaints have been investigated; if not, why not; if so, what were the findings in each case;

(3) whether any action has been taken as a result; if not, why not; if so, what action?

B159E

The MINISTER OF DEFENCE:

(1) Yes.

(a) 24.

(2) and (3) Yes.

(b)	(c)	
18 Jan 91	Alleged assault.	Member tried in civilian court. Found not guilty.
20 Jan 91	Alleged assault.	Plaintiff instituted claim of R500.
12 Feb 91	Alleged assault	Case investigated and withdrawn due to a lack of evidence.
7 Mar 91	Seven members charged with murder and attempted murder.	Case postponed until 26 Mar 92.
1 May 91	Two members charged with murder and assault.	Member tried in civilian court. Found not guilty.
1 May 91	Shooting incident. Civilian wounded in the foot.	Member tried in civilian court and found guilty.
4 May 91	Three members charged with attempted murder.	Case postponed until Mar 92.
4 May 91	Shooting incident. One civilian kiled and one wounded.	Trial date has not been determined as yet.
5 May 91	Alleged assault.	Lebowa Police investigated the case. No prosecution.
24 May 91	Three members charged with attempted murder at Hazyview.	SA Police still investigating the case.
24 May 91	Three members charged with attempted murder at Marite.	SA Police still investigating the case.
21 Jun 91	Alleged disturbance of the peace.	Case investigated by Lebowa Police. Plaintiff withdrew the charge.

5 Jul 91	Alleged assault.	Lebowa Police investigated the case. No prosecution.
14 Jul 91	Alleged rape and pointing of a firearm.	Member tried by civilian court and found not guilty on both charges.
19 Jul 91	Injury sustained after tearsmoke had been fired.	Plaintiff instituted a claim of R5 000. Claim is still receiving attention.
20 Aug 91	Seven members charged with 18 cases of assault.	Case tried by civilian court and postponed until 23 Jul 92.
25 Aug 91	Three members charged with alleged robbery, pointing of a firearm and theft.	Members tried by civilian court and found not guilty.
25 Aug 91	Civilian allegedly wounded.	Lebowa Police investigated and found that the person was not shot by a member of the SADF.
25 Sep 91	Alleged assault.	Members tried in civilian court and found guilty.
12 Oct 91	Complaints received that members searching a hostel, broke doors, windows and lockers. Charges of theft, assault and general vandalism were also made.	Matter investigated. Complaints found to be groundless.
14 Oct 91	Alleged assault.	Lack of evidence. Charges dismissed in court due to lack of evidence.
20 Oct 91	Shooting incident. Civilian wounded.	SA Police investigated case and referred it to the Attorney-General for decision.
29 Oct 91	Alleged murder.	Case dismissed in court due to lack of evidence.
15 Nov 91	Alleged assault.	Plaintiff withdrew the charge.

Own Affairs:

Budget for health services: amounts spent

17. Mr M J ELLIS asked the Minister of Health Services and Welfare:

(1) What amount of her Department's budget for health services and welfare was spent by (a) her Department itself and (b) other Government Departments as agents for her Department for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures for the period 1 April 1991 to 31 March 1992?

B85E

The MINISTER OF HEALTH SERVICES AND WELFARE:

Vote 8: Health Services

(1) (a) R172 020 047

(b) R362 051 509

(2) (a) R204 683 000

(b) R418 947 000

(In respect of Vote 7: Welfare, the Department does not make use of the services of agents.)

White pupils: African languages

24. Mr K M ANDREW asked the Minister of Education and Culture:

(a) How many White pupils at Government schools (i) wrote and (ii) passed the Standard

continued

This may hurt a little, says Dr Venter

Outrage has met nearly every major policy decision by Minister of Health Dr Rina Venter. In a wide-ranging interview with **GAYE DAVIS**, *she responds to her critics*

NEEDLESS to say, the offices of the ministry of health in the Hendrik Verwoerd Building in Cape Town are a smoke-free zone. "You can smoke, but you must do it somewhere else," a staffer informs a visitor who has unwittingly lit up a cigarette.

By the time Minister of Health Dr Rina Venter sweeps in, not a trace of blue smoke lingers to taint the air. She apologises for being late: there are too few hours in the day. The interview will have to be brief.

As we speak, welfare agencies in Durban and Johannesburg are preparing to add their voices to the chorus of criticism which has met virtually every major policy announcement she has made since assuming office.

This time, the issue is the draft Social Assistance Bill. Underpinning welfare agencies' criticism of it is their complaint that Venter failed to carry out her promise of conducting wide-ranging consultations before making her move.

It's a recurring motif, one that has resounded in the wake of most of the 44 major policy decisions Venter has taken so far in her efforts to reconstruct South Africa's health delivery system. Almost every interest group in the health care sector has erupted in outrage at proposals emanating from her office — though not all have gone as far as the Medical Association of South Africa (Masa), which recently called for her resignation.

For the record, she's not about to vacate what she describes, with demure understatement, as "rather a hot seat. I'm not even considering it," she says.

"If you go back in history, you will find that no minister of health was ever praised, or even very well liked. But I cannot do things to be popular. I cannot do my job just to serve the interests of one specific interest group.

"I want to develop an effective health system and I have the responsibility of seeing it meets the needs of the total population of the country."

She is faced with the task of redressing a situation in which health care has traditionally been biased in favour of white over black, rich over poor, city over rural dweller and curative over preventative services.

When President FW de Klerk handed her the portfolio, these imbalances had stretched the system to breaking point. It was common cause that the country's health system was seriously ill, if not in terminal decline.

Venter maintains that every policy decision she has taken has been in strict accordance with the five basic principles identified by the World Health Organisation as crucial to any adequate health service: accessibility, affordability, acceptability, cost-effectiveness and efficiency.

Opting for what she calls "the total approach", she has tried to tackle the problem from both ends. She has acted to free teaching hospitals from a welter of bureaucratic red tape and grant them unprecendented autonomy, as well as the opportunity to generate their own funds.

At the same time, she has tried to lay the ground for a primary health care network aimed at meeting the needs of the majority of the population. A spin-off of this is that health care provision at local level will ease the load on overburdened teaching hospitals in the major centres. She's about to tackle the high cost of medicine and she has intervened in the crisis faced by cash-strapped medical aid schemes.

But everywhere she has gone, she's stepped on toes. You don't radically restructure a country's health delivery system without coming up against powerful vested interests.

Her critics contend that the remedies she has applied so far are founded on an ad hoc assessment of the nature of the complaint, instead of a profound diagnosis and a carefully thought-out course of treatment, decided on only after extensive consultation of expert opinion.

Total approach ... Dr Rina Venter

Venter denies this. She says she doesn't want to sound presumptuous, but it wasn't all that difficult to analyse the situation and see where the problems lay. She announced her health policy intentions in budget vote speeches before parliament in 1990 and 1991; but "apparently, the message didn't get through".

Now she's being accused of failing to consult — in her view, an unjust charge. She cites the 16 forums so far held with various health sectors and says another 19 are planned. She has tackled the problems systematically and, above all, objectively, she says.

But as she speaks, it becomes clear that she and affected health sectors are using different dictionaries when it comes to defining the meaning of the word consultation. It also becomes clear that at the heart of this semantic dispute lies the very real issue of political power and who controls the process of restructuring the health service.

Venter believes that every move she has made has been for the good. She also believes that the government "is serious about bringing about an equitable situation" and that it is objective in taking decisions, predicating them on whether or not they will be for the benefit of the "total population".

Not everyone shares her faith, least of all the National Party's political opponents. The African National Congress has accused the government of acting unilaterally and of being undemocratic in restructuring health facilities at a time when a future constitution is being negotiated — a charge that has echoed from various groupings.

Venter acknowledges that "all political parties have their own ideas of what the health system should be like" and claims to be open to suggestions. She says she is prepared to listen to anyone with a vested interest in making the ailing health system better.

But what she is not prepared to do is commit herself in some outside forum to the wishes of any one interest group. "The core issue is, I consult but I do not commit myself," she says. "My duty lies with the public and I have a duty to judge whether what we are doing will serve the interests of the total population and not only one group's interests."

The discretion lies with her and the cabinet: at the end of the day, she is not only minister of health, but also an NP politician. It's no wonder, then, that her stance is construed as a determination to ensure that the government remains the chief physician at the patient's bedside, with the final say over not only the course of treatment to be decided upon but also its implementation.

She pleads for "the co-operation of all" in making "the health reconstruction process easier". She also says she believes it's possible, and that it should be based on "a totally objective evaluation of what needs to be done — without (interest groups) putting their own concerns first".

She acknowledges that "until we have a new constitution in place and a new government, this will be a difficult process to manage", but points out that politics will still play a role even after a new political dispensation is reached.

She doesn't think she's naive about the difficulties she faces in achieving "the co-operation of all". Under the circumstances, perhaps that's just as well.

HOUSE OF DELEGATES

QUESTIONS

†Indicates translated version.

For written reply:

Own Affairs:

Telephone rental: House of Delegates

1. The LEADER OF THE OFFICIAL OPPOSITION asked the Minister of the Budget and Auxiliary Services:

What amount was paid by the Administration: House of Delegates for the use of telephones by each of the members of the Ministers' Council in their (a) residences and (b) offices in (i) Cape Town and (ii) Natal during the period 1 January 1991 up to the latest specified date for which figures are available? D3E

The MINISTER OF THE BUDGET AND AUXILIARY SERVICES:

PERIOD: JANUARY TO DECEMBER 1991

	RESIDENCE		OFFICES		TOTAL	MTH.AV.
	Cape Town	Natal	Cape Town	Natal		
	R	R	R	R	R	R
Chairman of the Ministers' Council and Minister of Housing	452,73	1 457,82	5 147,32	2 766,79	9 824,66	818,72
Minister of Health Services and Welfare	1 740,64	2 093,54	3 211,89	1 729,85	8 775,92	731,33
Minister of the Budget and Aux. Services	2 564,05	1 251,72	2 911,57	1 181,21	7 908,55	659,05
Minister of Local Govt. and Agriculture	1 885,69	4 704,64	3 478,01	1 419,31	11 487,65	957,30
Minister of Education and Culture	2 631,02	5 322,33	4 406,39	4 731,62	17 091,36	1 424,28
Deputy Minister of Local Govt.	3 303,90	3 156,70	2 897,91	1 797,20	11 155,71	929,64

Note:

1 The above amounts *include* rentals.

Cognisance must also be taken of the fact that the above accounts is inclusive of the Ministers' role as Members of Parliament.

2. Monthly telephone usage allowed to Members of Parliament and Office bearers against vote of Parliament:

Members of Parliament : 2250 units = R371,25 per month
Office Bearer (eg. Leader of Official Opposition) : 5625 units = R928,12 per month

These latter amounts *exclude* rentals.

Department's budget

2. Mr M ABRAHAM asked the Minister of Health Services and Welfare:

(1) What amount of his Department's budget for health services and welfare was spent by (a) his Department itself and (b) other

continued

Government Departments as agents for his Department for the period 1 April 1990 to 31 March 1991;

(2) what are the estimated figures for the period 1 April 1991 to 31 March 1992? D12E

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) (a) R251 013 834
(b) R12 452 672 — Department of Local Government, Housing and Agriculture.

(2) (a) R312 193 000
(b) R11 300 000 — Department of Local Government, Housing and Agriculture.

Parent-teacher associations

3. Mr M RAJAB asked the Minister of Education and Culture:

(a) How many schools under the control of his Department (i) have and (ii) do not have parent-teacher associations and (b) in respect of what date is this information furnished? D25E

The MINISTER OF EDUCATION AND CULTURE:

(a) (i) 204
(ii) 254

(b) information furnished is as at 1992/02/14.

policy of the Department on the release of people is a well-tried one which has been in position for a very long time and it is being applied strictly.

†Adv C H PIENAAR: Mr Speaker, further arising out of the hon the Minister's reply I want to know whether his predecessor, when he released the prisoners, acted in accordance with that well-tried policy.

†The MINISTER: Mr Speaker, I arrived there six months ago, and I am applying that policy strictly. I want to give the hon member the assurance that as far as I know my predecessor applied the policy of the Department in respect of the release of prisoners with due regard to all the circumstances that prevailed in the country and in the Department.

†Adv C H PIENAAR: Mr Speaker, further arising out of the hon the Minister's reply, may I just ask him why the Attorneys-General protested against the releases if his predecessor applied that policy?

†The MINISTER: Mr Speaker, I am really not aware of the Attorneys-General having protested against the policy. [Interjections.] There is dissatisfaction, but . . .

†An HON MEMBER: That's a bull's-eye.

†The MINISTER: The hon member should just keep calm and not fight the referendum now already. We shall fight it later.

I repeat, my predecessor applied the policy with due regard to all the circumstances prevailing in the country. At the moment there is much anxiety about crime. That is a factor that is being taken into account. That is why we are again looking at the whole policy regarding release. It is a well-tried policy that has been in force for many years and has worked very well.

Business interrupted in accordance with Rule 180C(3) of the Standing Rules of Parliament.

Certain person who left the RSA

*11. Mr L FUCHS asked the Minister of Foreign Affairs:

(1) Whether a certain person, whose name has been furnished to the Minister's Department for the purpose of his reply, has left the Republic of South Africa; if so, (a) for what period of time did he stay in the Republic and (b) what was the total cost to the State of keeping him in the Republic;

(2) what is the name of this person?

B255E

The MINISTER OF FOREIGN AFFAIRS:

(1) (a) The person and his spouse resided in Pretoria from 10 March 1990 until 8 November 1991. Since the latter date he has been residing in his own home in the Bisho/King William's Town area.

(b) The person and his spouse were accommodated in an available house in Pretoria, where they paid their own living expenses.

(2) Mr L L W Sebe.

Health of certain prisoner

*12. Mr L FUCHS asked the Minister of Correctional Services:

(1) Whether he will make a statement on the state of health of a certain prisoner, whose name has been furnished to the Minister's Department for the purpose of his reply; if not, why not; if so, (a) what is this prisoner's name and (b) what are the relevant details;

(2) whether the State intends releasing this prisoner on humanitarian or other grounds; if not, why not; if so, (a) when and (b) on what grounds?

B256E

The MINISTER OF CORRECTIONAL SERVICES:

(1) No.

The privacy of prisoners as well as the professional independence of the medical practitioners who are responsible for their health care, is respected. It is therefore policy not to make details available or to comment on the state of health of individual prisoners. However, it can be confirmed that he has access to adequate medical and psychiatric treatment.

(a) and (b) Fall away.

(2) The release of a patient of the State is addressed statutorily in the Mental Health Act, 1973 (Act No 18 of 1973) and continue

takes place according to the mechanisms and qualifications as stipulated by the above-mentioned Act. My department has no decision-making powers regarding the release of this category of persons.

(a) and (b) Fall away.

Medicines and Related Substances Control Act

*13. Mr M J ELLIS asked the Minister of National Health:

(1) Whether the Appellate Division has ruled that the provisions of the Medicines and Related Substances Control Act, No 101 of 1965, are not applicable to the State;

(2) whether she has received representations that steps be taken to make the Act applicable to the State; if so, (a) from whom and (b) what has been her response to these representations?

B257E

The MINISTER OF NATIONAL HEALTH:

(1) Yes;

(2) yes,

(a) the Chief Directorate of Procurement Administration of the Department of State Expenditure, the Medicines Control Council as well as the Pharmaceutical Manufacturing Association, and

(b) I accept the decision of the Appellate Division but wish to add that it is the policy of the Government that the State must observe the laws on medicine. Medicine provision by the Government must be orderly and good dispense practice must be maintained. The proper way to ensure and organise this is by means of the National Policy for Health Act, 1990 (Act 116 of 1990).

Report by Dr Wim de Villiers

*14. Mr M J ELLIS asked the Minister of National Health: 85

(1) Whether she has any intention of releasing the full text of the report by the late Dr Wim de Villiers on medicine; if not, why not; if so, when will the contents of this report be made available;

(2) whether she will make a statement on the matter? 85

B258E

The MINISTER OF NATIONAL HEALTH:

(1) No, as Dr Wim de Villiers passed away before the report had been completed, the Cabinet decided not to make the contents of the report available;

(2) no.

Office of the Surveyor-General: price increases

*15. Mr K M ANDREW asked the Minister of Regional and Land Affairs:

Whether there have been any increases since 1 January 1988 in prices charged by the Surveyor-General's Office for (a) prints of micro-filmed diagrams and (b) copies of township film; if so, (i) what increases and (ii)(aa) when and (bb) why were the prices increased?

B259E

The MINISTER OF REGIONAL AND LAND AFFAIRS:

Yes, the fees that the office of the Surveyor-General charges for

(a) prints of "micro-filmed diagrams" and

(b) "copies of township film"

increased since 1 January 1988.

The order of the increases was as follows:

(i) The fees for prints of diagrams on microfilm were increased from R1,00 in 1987 (GST excluded) to R2,00 (GST excluded) in 1990 and finally to R3,50 in 1991.

The fees for paper prints of plans on film were increased from R2,00 (GST excluded) in 1987 to R3,00 (GST excluded) in 1990 and finally to R5,50 in 1991.

(ii) (aa) The increases came into operation on 1 September 1990 (Government Gazette No 12715 of 31 August 1990) and on 1 October 1991 (Government Gazette No 13482 of 30 August 1991).

(bb) The reasons for the increases are the following:

In view of the accepted principle to evaluate the functions of all Govern-

Forum focus on medicine price drop

Own Correspondent (85) (S) CT 27/2/92

JOHANNESBURG. — The government's senior representative at the medical summit said the forum's main achievement was agreement that deregulation of medical-aid schemes would help bring down the prices of medicines.

Dr Coen Slabber, the director-general of the Department of National Health and Population Development, said South Africa's medicine prices were the highest in the world.

Delegates attending yesterday's forum said the talks, despite the non-participation by several prominent organisations, were a successful step towards a national health care policy.

Dr Slabber said deregulation would allow employers and trade unions to negotiate their own package for their employees, within certain parameters.

He said 101 delegates attending the forum had failed to reach consensus on whether pharmacists should be allowed to initiate therapy in response to certain patient illnesses, but had agreed the pharmacist was one of the most under-used health care professionals.

Other points discussed by the delegates included compulsory patient part-payment of the cost of medicine and the rescheduling of certain medicines.

The ANC's department of health and the National Health Unity Forum (NHUF), whose members include the National Medical and Dental Association and the South African Health Workers' Congress, withdrew from the talks on Wednesday saying they were undemocratic.

Forum facilitator Mr Guy Harris said he believed there would be behind-the-scenes talks to get the ANC and NHUF to participate in further medical forums, which will culminate in a forum in October.

Forum boycott

HEALTH organisations yesterday repeated their resolve not to attend Health Minister Rina Venter's forum on costs of medecines. The ANC health department and the National Health Unity Forum objected to the lack of consultation and the narrow focus of the agenda. Venter has said previously the forum was to one of a series.

BID 27/12/92 (85)

Medical bodies shun health summit

'Venter ignoring our proposals'

STAR 28/2/92 (85)

By Helen Grange
Pretoria Bureau

Several medical bodies have publicly distanced themselves from today's Department of Health summit addressing the high cost of medicine.

Their absence is expected to seriously undermine the Government's efforts to gain unity in a bitterly divided medical fraternity.

The ANC's department of health, the National Health Unity Forum (NHUF) and the Dispensing Family Practitioners Association have refused to attend on the grounds that the topic is too narrow and that the State unilaterally convened the forum and set the agenda.

The NHUF is an umbrella body for the National Medical and Dental Association, the National Progressive Primary Health Care Network, the Organisation for Appropriate Social Services in SA, the Health Workers Society and the SA Health Workers Congress.

The ANC and NHUF, in a joint statement this week, said National Health Minister Dr Rina Venter "appears consistently to ignore definitive proposals made by ourselves regarding the future health dispensation of our country".

In addition, the statement said, the agenda for the forum had been predetermined by the State, with an inadequately narrow focus.

The venue, date and participants had also been determined solely by the State.

Any restructuring in the health care system needed the necessary approval of Codesa, and the notion of a "piecemeal approach" to solving the health crisis was therefore rejected.

"To this end, we propose a meeting between all the key players to jointly determine the terms of reference for an envisaged forum addressing the crisis," the statement said.

The Dispensing Family Practitioners Association criticised the forum for not addressing the issue of a health care system, saying the cost of medicine was only one aspect of the whole question.

Valuable time was being wasted by not addressing the other aspects.

Despite the refusal by these organisations to attend, there has been an overwhelming response by individuals and other medical bodies to the forum, a Department of Health spokesman said.

The Pharmaceutical Association would attend the forum, but would express serious reservations about its structure and purpose, a spokesman said.

"The most important question of medicine cost-effectiveness doesn't appear on the agenda, and we believe that apart from being unrepresentative, it will be a waste of time. We will however be there to put our views across," the spokesman said.

Topics to be discussed today include:

- A maximum medical aid price for certain drugs.
- A part payment/levy by a member of a medical aid scheme on medicine purchases.
- Pharmacists being given greater professional discretion in prescribing palliative drugs for self-limiting illnesses, such as flu.

Call to deregulate the health sector

B Day 2/3/92

KATHRYN STRACHAN

PROPOSED amendments to the Medical Schemes Bill would go a long way towards containing the soaring cost of medicines, National Health Department director-general Coen Slabber said at the weekend.

Addressing a forum convened by National Health Minister Rina Venter to discuss the cost of medicines in the private sector, Slabber said there was considerable support for deregulation in the health sector.

Representative Association of Medical Aid Schemes executive-director Rob Speedie said the expenditure of medical schemes had increased by 34% last year, and that the only way to contain these costs was to allow more deregulation.

Deregulation is seen as the answer to escalating costs in health care as it promises to give medical schemes greater flexibility to negotiate packages with doctors, pharmacists and clients and to tailor programmes.

The Bill aims to do away with fixed fees and amend the scale of benefits and maximum and minimum benefits payable as these are seen as contrary to free market principles.

Slabber said the forum had also accepted that pharmacists, despite being the most accessible health care practicioners, were the most underutilised and that they could provide a lot more in terms of primary health care. It was agreed they should be given more authority in terms of diagnosing and dispensing medicines.

The main discussion at the forum centred around granting pharmacists greater professional discretion by allowing them to supply schedule three and four drugs without prescriptions. Pharmacists can supply only unscheduled and schedule one and two ng dispensers greater freedom to sell cheaper generic drugs in place of brand name equivalents was also agreed on.

Another issue discussed was introducing single exit prices on sales by pharmaceutical manufacturers. Single exit prices would restrain manufacturers from giving certain medicine suppliers an unfair advantage by preventing them from offering medicines to suppliers at different prices. At the moment some dispensing doctors can obtain medicines more cheaply than pharmacists.

Venter proposed removing restrictions on parallel importing. Current legislation prevented importation of medicines manufactured in SA. Anomalies existed where, for example, SA-manufactured medicines are available more cheaply in Gaborone than in SA.

Slabber said it was unfortunate that left wing health organisations had elected not to attend as they would have made a positive contribution, but admitted the Department were on a "learning curve" in dealing with consultation. It is expected there will be more "talks about talks".

Medical Association of SA secretary-general Hendrik Hanekom said that if the department wanted to affect change it needed the support of all parties involved. He said the department needed to take greater care in the process of arranging such forums to ensure all groups were represented.

Slabber said proposals to reduce the high cost of medicines would be circulated to all groups concerned for consensus, including those which stayed away from the forum.

The recommendations would then be put to Venter and discussed at a meeting in October. Then the recommendations could be incorporated into a National Medicines Policy.

'Deregulate health care to cut costs'

er 2/3/92

(85)

Own Correspondent

JOHANNESBURG. — Proposed amendments to the Medical Schemes Bill would go a long way towards containing the soaring cost of medicines, National Health Department director-general Dr Coen Slabber said at the weekend.

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City's infant death rate falls

(85) CT 4/3/92

Municipal Reporter

INFANT mortality statistics in the city indicate that black and coloured people in the city have better health services than those available to black people in some major American cities a decade ago.

Dr Michael Popkiss, the Medical Officer of Health, notes in his annual report for 1990/91 that Cape Town's overall infant mortality rate for the year was 16,91 (per 1 000 births), an improvement on the previous year's 18,04.

Mortality in the very young, he points out, is a sensitive index of the efficiency of health services and the health status of communities.

"Comparison with four major American cities is interesting," he says.

Infant mortality rates for whites and other race groups, which were available for some American cities in 1982, showed that Boston had a rate of 11,6 for whites and 26,1 for blacks; Chicago 12,3 and 25,8 respectively; Detroit 9,4 and 26,9; Washington 7,5 and 24,1.

Dr Popkiss says he had to do some soul-searching before deciding to use race-specific statistics in his report — the first since the Population Registration Act was scrapped.

"The matter has been debated within academic and non-governmental organisational fields, and a wide consensus is that, where broad use of group designations is of help in securing the resources necessary to improve living conditions, it remains justifiable," he says.

Dr Popkiss notes that in some areas it was no longer possible to get statistics which are specific about race. For example, notifications of births no longer carry racial designations of the parents or child.

Cape Town smoggier

Municipal Reporter

AIR pollution guideline levels for nitrogen oxides were exceeded on 28 occasions last winter for a total of 50 hours, according to the latest report of the Medical Officer of Health (MoH), Dr Michael Popkiss.

The period covered is for the months April to September.

One of the nitrogen oxides is nitrogen dioxide (NO_2), which is measured separately, because it is an indicator of photochemical activity — new processes caused by interaction between pollutants in the air and ultraviolet sun rays.

Graphs show that the NO_2 level rises as the number of cars coming into the city increases.

If present trends continue, the report says, a 36% increase in the number of vehicles (140 000 to 190 000) will double the amount of photochemical smog over the city.

Elsewhere in his report on pollution in the city, Dr Popkiss notes that the guideline for hydrocarbons "is exceeded on most days of the year, and for most of the day. Doubt has thus been expressed as to the aptness of the guideline."

The MINISTER OF FINANCE:

(1) (a) ± 20 700 according to the report of the curators;

(b) and (c)

The investments were invested by Masterbond Participation Bond Trust Managers (Pty) Ltd which acted as agent in participation bonds, debentures, the money market and syndicated property projects. (The company is not a registered financial institution.)

	Million
Participation bonds	R70,1
Short-term debentures	R400,5
Money market	R26,8
Property syndication	R96,9

(2) (a), (b)(i) and (ii)

No. In the report of 12 February 1992 submitted to the Cape Supreme Court the curators confirmed that a full accounting can be given of all funds which were received on an agency basis by the Masterbond Group from investors. Those investers whose funds have not yet been repaid by the curators and are currently at risk, are invested in high risk pleasure resort projects. The development companies involved herewith are not financial institutions and no supervisory authority is responsible for supervising whether the projects are viable. Investors themselves are responsible for evaluating the risks of projects.

(3) (a) and (b)

Registered deposit-taking institutions (formerly referred to as banks and building societies) are statutorily in terms of the Deposit-taking Institutions Act, 1990, and Regulations made in terms thereof, compelled to submit the following statutory returns at the stipulated periods and in respect of the following matters and risks indicated in the table hereunder, to the Registrar of Deposit-taking Institutions:

Return Form No.	*Name of Form*	*Intervals*
DI 099	Declaration in respect of statutory returns submitted	Monthly
DI 100	Balance sheet	Monthly
DI 110	Off-balance sheet activities	Monthly
DI 120	Asset-becked securitisation	Annually
DI 130	Return regarding investments and interests held	Annually
DI 140	Return of shareholders of DI or controlling company	Annually
DI 200	Income statement	Monthly
DI 210	Analysis of net non-trading income and reserves transfers	Biannually
DI 300	Liquidity risk—maturity ladder	Monthly
DI 310	Minimum reserve balance and liquid assets	Monthly
DI 400	Capital adequacy	Quarterly
DI 410	Interest rate risk	Monthly
DI 420	Price risk	Monthly
DI 430	Trading risk	Monthly
DI 500	Credit risk	Quarterly
DI 505	Reporting of large exposure	When necessary
DI 510	Large exposures	Quarterly
DI 520	Assets bought in	Annually
DI 600	Currency risk	Monthly
DI 700	Restriction on investments, loans and advances	Annually
DI 900	Institutional and maturity breakdown of liabilities and assets	Monthly
DI 910	Institutional breakdown of issuers of and transactions in selected assets	Monthly
DI 920	Analysis of instalment sale and leasing transactions	Quarterly
DI 930	Interest rates on deposits, loans and advances at month end	Monthly

The information provided to the Bank Supervision Department of the South African Reserve Bank in these returns conforms *inter alia* to the guidelines and standards of the Bank for International Settlements in Basel, Switzerland, which lays down international standards for supervision of banks and in certain cases the risk management orientation is more advanced than the rest of the world's bank supervision authorities.

Total expenditure on health

79. Mr M J ELLIS asked the Minister of National Health:

(1) What was the total expenditure on health by the State for the period 1 April 1990 to 31 March 1991;

(2) what is the estimated total expenditure for the period 1 April 1991 to 31 March 1992? B224E

The MINISTER OF NATIONAL HEALTH:

(1) R7 036 906 378

No particulars were received from the Lebowa Government;

(2) R7 997 164 990

No particulars were received from the Lebowa Government.

Own Affairs:

White schoolchildren: number enrolled at Government schools

22. Dr W J SNYMAN asked the Minister of Education and Culture:†

How many White schoolchildren were enrolled at Government schools for the White population group in each year from 1960 to 1992? B186E

The MINISTER OF EDUCATION AND CULTURE:

1985: 938 214
1986: 926 415
1987: 911 439
1988: 891 933
1990: 884 119
1991: 879 478

The figures are in respect of public ordinary schools. The pupil enrolment for 1991 is preliminary, while those for 1992 will only be available after 10 April 1992. The information is provided from the SANEP information system for education statistics which has been in operation since 1985. Prior to 1985, education statistics were collected by the Central Statistics Service and are not available in the required format.

Lecturer/student ratio

27. Mr R M BURROWS asked the Minister of Education and Culture:

(a) How many (i) students and (ii) lecturers are there at each of the colleges of education falling under his control and (b) what is the applicable lecturer/student ratio for each such college? B244E

The MINISTER OF EDUCATION AND CULTURE:

Residential Colleges	(a)(i)	(a)(ii)	(b)
Bolandse Onderwyskollege	417	51	1:8,2
Cape Town College of Education	372	43	1:8,7
Port Elizabeth College of Education#	140	26	1:5,4
Edgewood College of Education	628	76	1:8,3
Durban College of Education	206	53	1:3,9
Bloemfonteinse Onderwyskollege	294	41	1:7,2
Johannesburg College of Education	1 172	102	1:11,5
Pretoria College of Education*	150	19	1:7,9
Goudstadse Onderwyskollege*	227	36	1:6,3
Onderwyskollege Pretoria	1 380	114	1:12,1
Potchefstroomse Onderwyskollege	628	65	1:9,7

* Close at the end of 1992.
\# Closes at the end of 1993.

HEALTH CARE (85)

Cutting drug prices

Health Minister Rina Venter has been accused of offering only piecemeal solutions to health-care problems. But her latest proposals to contain medicine costs in the private sector — largely by deregulating the pharmaceutical industry — have elicited a surprising degree of consensus among key players in health care.

Even her staunchest critic, the Medical Association of SA, was satisfied that the proposals taken at last week's forum "were arrived at in a responsible manner." But it has expressed serious reservations about Venter's lack of an overall action plan and the absence of some interest groups.

Likewise, the Pharmaceutical Manufacturers' Association, which before the forum suggested the conference would be nothing more than an "ad hoc fix," stayed for the discussions. – FM 6/3/92

Venter's latest proposals come after her recent recommendations to deregulate the Medical Schemes Act. If implemented, they would allow schemes to provide health-care services, employing doctors, nurses and practitioners. It is believed such a move would cut health-care costs by as much as 40% and end

doctors' absolute discretion in providing health care. Not surprisingly, many of her recommendations were not well received by doctors.

The reforms she proposed to the pharmaceutical industry are just as far-reaching. Based largely on the findings of the Browne Report, published in 1986, Venter's recommendations to curb medicine costs include the greater use of generic substitutes, maximum medical aid pricing, patient responsibility for part-payment of medicines, greater pharmacist-initiated therapy and parallel imports of certain medicines.

There is no doubt that Venter is delaying proposing a new national health-care policy, at least until October. In his opening address at the forum, Health Director-General Coen Slabber stressed that the department was dividing the problem into smaller units, to be managed at individual forums.

But the cost of medicine in the private sector warrants urgent attention. Slabber says medicine prices are high compared with the main Western countries. "It is distressing that pharmaceutical expenditures are decreasing as a percentage of all health expenditures in developed countries. This is not the case in SA," he adds.

There was general consensus at the forum that substituting medicines with generic equivalents is an option to curtail costs.

While participants stress that the responsibility for substitution rests with the practitioner, pharmacist and patient, no consensus was reached on whether the doctor would have the final say in allowing substitution.

A proposal is that the Medical Council should list medicines that cannot be substituted. The pharmaceutical association suggests cost-effectiveness rather than the price of a medicine should be considered when making the decision to use a substitute. For example, it suggests a brand or patent medicine could keep you out of hospital whereas a cheaper generic might only ease symptoms.

No agreement could be reached on a system of "maximum medical aid pricing" which would see medical schemes limit the amount they would pay for certain substances. Delegates concurred that Venter's proposed amendments to the Medical Schemes Act would resolve this issue.

Consensus was reached on the concept of a single exit price based on the volume purchased, but it was agreed that such a policy would be difficult to police.

This recommendation is geared primarily towards pharmaceutical companies that give massive discounts to doctors who buy only small quantities of drugs, compared with the far higher prices paid by retail and wholesale chemists for larger quantities. The Competition Board says this practice encourages doctors to push certain brands solely for their own gain.

The forum rejected Venter's proposal that pharmacists should be remunerated by way of a professional fee and supply medicines to the public at cost. Here it was felt that advertising would keep down prices.

The Pharmacy Council recently allowed pharmacists to charge a "reasonable fee" while the Pharmaceutical Society of SA (the professional body) set this amount at a maximum of R7,62 per item plus an additional amount to recover costs (rent, salaries).

The belief in the sector is that people will shop around for the best prices. Representative Association of Medical Schemes CE Rob Speedie, however, questions whether this will in fact happen. He suggests it is difficult to shop around for medicines.

Venter's proposal to give pharmacists more opportunities to initiate therapy was also accepted. But it was decided that medical schemes should be free to choose whether to allow such claims as part of their scale of benefits to members.

The forum decided that rescheduling medicines should not be the way to grant pharmacists greater professional discretion, but access to certain schedule three and four medicines should be allowed under stipulated conditions.

The forum was willing to consider the parallel import of certain medicines provided costs could be lowered and passed on to consumers. The need for strict quality control was stressed in view of the increasing incidence of counterfeit medicines.

Speedie emphasises that more work needs to be done on the Pharmaceutical Act: "It is meaningless to free medical schemes without allowing pharmacists to work with people other than pharmacists. You cannot have fully fledged health maintenance organisations while schemes cannot employ pharmacists. Until then, pharmacists will hold a monopoly over medicine prices." ■

Health officers launch new professional organisation

S/Times (Cty) 8/3/92 85 226 208

By KURT SWART

HEALTH officers in the Western Cape plan to launch a professional body this month to represent their interests, following the launch of a national health officers' association late last year.

Mr Johnny Slingers, chairman of the steering committee, said a preliminary meeting was held at the Peninsula Technikon in Bellville last Saturday to discuss the launch of the new organisation.

This followed the formation of the Southern African Association for Environmental Health Officers (SAAEHO) at Soshanguve in Pretoria on September 30 last year.

Said Mr Slingers: "The first national council meeting was held in Kimberley at the end of November last year and was attended by delegates from all over Southern Africa, including the Western Cape.

"The meeting last week served as a report-back to fellow health inspectors as well as a forum to discuss the formal launch of a Western Cape region of the SAAEHO."

The local SAAEHO steering committee is calling on all health officers in the Western Cape and neighbouring areas to register and attend the launch at the Peninsula Technikon at 2pm on Saturday, March 21.

For further information call Mr Johnny Slingers and Mr Emmanuel Rusford on ☎ 952 7640 and 959 6366 respectively.

The new body will be the first organisation of its kind run on a non-racial basis, said Mr Slingers.

Environmental health officers, or health inspectors, are responsible for disease control, hygiene, environmental health and "community involvement and upliftment".

The association, "a professional body for professional people", will be a rival grouping to the predominantly white Health Officers' Association of South Africa.

City ranks 3 for baby death rate

(85) CT 10/8/92

Staff Reporter

CAPE TOWN has the third highest infant mortality rate among cities countrywide — with Khayelitsha among the worst areas for baby deaths in the country.

A survey done by the Cape Times showed that Cape Town's infant mortality rate was higher than those of Johannesburg, Durban and Pretoria but lower than Bloemfontein and Port Elizabeth.

Cape Town's Medical Officer of Health, Dr Michael Popkiss, said in his annual report for 1990/1991 the infant mortality rate was an indication of the efficiency of health services.

Figures from the Medical Officers of Health for the various cities are measured for deaths under the age of one year per 1 000 live births.

Dr Popkiss said there had been a drop in Cape Town to 16,91 in 1990 from 18,04 in 1989.

He said a comparison between cities was not very accurate since statistics depended on the population mix and the number of births in a city.

Dr Popkiss said that one needed to see Cape Town having a higher infant mortality rate than Johannesburg against the fact that Johannesburg had a large affluent white population, which would automatically result in a lower figure. He said that the drop in Cape Town's figures was what was important.

The infant mortality rate for Khayelitsha in 1990 was 33,3, with the total rate for the Western Cape RSC area for the same year being 22,4 according to Dr M Tatley, deputy chief director of health for the Western Cape RSC.

The 1990 infant mortality rates for other cities were:

- Durban: 10,17;
- Johannesburg: 13,6;
- Soweto: 26,05;
- Pretoria: 15,46;
- Bloemfontein: 30,36.
- Port Elizabeth: 41,25.

SA warned of high heart disease risks

CT 12/3/92 (85)

Staff Reporter

MORE than half of South Africans are at risk of heart disease unless they change their lifestyles — while a quarter of South Africans suffer from hypertension or high blood pressure.

This is according to the director of the Heart Foundation of Southern Africa, Mrs Rika de Ruiter, speaking at the end of a three-day medical symposium in Cape Town on hypertension convened by the Heart Foundation and the Medical Research Council.

Experts on hypertension from South Africa and overseas decided at the conference on guidelines for the treatment and management of hypertension in South Africa.

Mrs De Ruiter said hypertension was one of the major risk factors for heart disease.

Other risk factors included smoking, stress, excess weight, lack of exercise and a high cholesterol intake.

She said there had been total agreement among delegates at the conference on the need for non-pharmacological treatment of hypertension which would mean extensive lifestyle modification programmes.

The incidence of hypertension was very high, particularly among black South Africans. Increased urbanisation had made people very inactive.

"The high level of alcohol consumption among black males is very worrying. However, getting the compliance of hypertension patients is one of the biggest problems we face," she said.

Mrs De Ruiter said that one of the problems with high blood pressure was that it could often go undetected. She emphasised that mild hypertension needed to be treated as early as possible so as to avoid the cost of treating strokes and heart attacks.

The conclusions reached by the symposium will be tabled into guidelines for treating hypertension and used in the hypertension education programme to be run by the Heart Foundation.

UK health expert warns against fall in standards

(85) ARG 13/3/92

ANDREA WEISS
Medical Reporter

UNLESS primary health care is an integral part of community upgrading, it is merely a cost-cutting exercise, an international expert in tropical medicine has warned.

Professor Ralph Hendrickse, in Cape Town to visit family, was head of the Liverpool School of Tropical Medicine until his retirement last year.

He said that when hospital services were allowed to run down, people were left worse off than before in spite of government pledges to primary health care.

"The grand design of primary health care is marvellous in theory but it is missapplied if it is not part of community development."

And where services were allowed to deteriorate, the consequences were a drop in morale and doctors "voting with their feet", he warned.

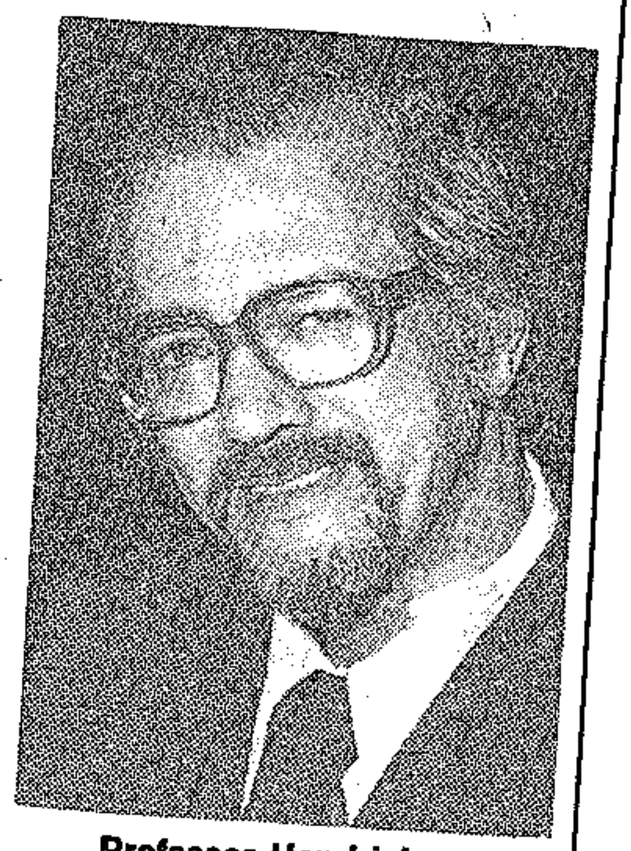
Professor Hendrickse said he believed medicine in South Africa was following the privatisation trend seen in the United States to the detriment of both patients and doctors.

On the one hand patients were having to pay high prices for health care while doctors were compelled to practice "defensive medicine" for fear of litigation.

He was appalled by the price of drugs in South Africa. "I can't escape the feeling there is an element of rip-off. It is not what the profession can take pride in. People must be feeling extremely vulnerable."

● Professor Hendrickse is the son-in-law of the late Dr A Abdurahman, one of the first black doctors in South Africa.

A graduate of UCT, he worked in Nigeria for a number of years before settling in Liverpool.



Professor Hendrickse

Mrs Hunadi Mateme obtained a PhD in pharmacy at the graduation ceremony at Medunsa. Pic: PAT SEBOKO

Plea for more money for medical research

Sowetan 16/3/92 (85)

THE Government must stop spending billions of rands on defence and instead use that money on medical research, Medunsa chancellor Bishop Stanley Mogoba said at the weekend.

Speaking at a graduation ceremony at the Medical University of South Africa near Garankuwa on Saturday, the newly appointed chancellor said if the Government could spend R10 billion on defence, "why can't it treble this figure in the education of our children and particularly in medical education and research?"

A record 109 doctors graduated as compared to 46 last year. A total of 297 degrees and diplomas were conferred.

A senior pharmacist in Lebowa's department of health, Mrs Hunadi Mateme, received a PhD in pharmacy.

She is married to Dr Mabu Mateme, Lebowa's director of education.

Mr Pieter van Wyk, a lecturer at Medunsa, also got a PhD in biochemistry.

Mogoba, the guest speaker, said it was "foolhardy to pour our resources into military hardware and military science and win questionable victories when our medical schools and research are battling to survive on shoe-string budgets".

He added: "I call upon our country to reallocate to medical research the money now being used for military defence."

Mogoba said those who fought decisive wars against diseases such as malaria, leprosy, tuberculosis, heart and venereal diseases were the real heroes.

"Today we face the challenge of Aids. The most cautious and conservative prognosis of Aids indicates that by the year 2000, we could have our modern hospitals and clinics rendered completely inadequate so that our hotels will have to be converted into hospitals in which we wait for death."

More contacts for Medical Research

Sowetan 19/3/92

85

By MOKGADI PELA

THERE was increasing contact between the Medical Research Council and its counterparts in Africa as a result of the country's reforms, outgoing president Dr Philip van Heerden said this week.

He cited the visit by the delegation of the African Medical and Research Foundation as testimony. Based in Nairobi, Amref is known for its Flying Doctor service in Eastern Africa.

Van Heerden said community health programmes were Amref's strength and the MRC could learn much from the organisation's experiences in Africa.

He said on the other hand, the MRC could offer research and consultation services, particularly in epidemiology, nutritional and tropical diseases. Both organisations aim to establish collaborative projects.

"We wish to see their approach towards Aids, malaria and TB," van Heerden said.

He said due to many years of isolation, South Africa had suffered a lot. He wished for the renewal of links between South Africa and the World Health Organisation. WHO has very advanced programmes in many areas which could benefit South Africa.

Health services to increase by 22pc

CAPE TOWN — Health services will cost more than R9,9 billion, a rise of 22 percent on last year. But this does not include provision for salary improvements.

The steadily rising cost of health services has meant that the structure and nature of health delivery must be urgently reviewed, said Barend du Plessis. STAR 19/3/92

The provision of all primary health care services will be transferred to local authorities to secure greater community involvement.

Academic teaching hospitals are to operated on "a business basis" and each institution will be run by a business manager.

Relief over increase in health care

STAR 19/3/92

By Carina le Grange

The 22 percent increase in spending on health — amounting to R9,93 billion — was a much needed increase, Centre for Heath Policy director Cedric de Beer said yesterday.

Mr de Beer said "on the face of it" he welcomed the increase since the increase in the previous Budget was very low.

"What is important, however, was how the funds were targeted. One hopes it would improve services to the most needy and not simply disappear into administrative costs."

The transfer of primary health care services to local authorities should be with the proviso that they should not be expected to provide all the finance, Mr de Beer said.

Dr Ralph Mgijima of the ANC health secretariat said the increase in health spending was welcomed, depending on how it was spent.

The ANC said in an official brief response that allocations to health, education, housing in this year's Budget speech appeared to be "broadly appropriate".

The organisation added however that the central issue was the way these allocations were spent and managed.

"We have no faith in the ability of the departments responsible for these areas to deliver the services in an effective and efficient way," the ANC said.

● The Medical Association of SA said it welcomed the shift in emphasis towards community oriented expenditure.

Masa secretary general Dr Hendrik Hannekom said he trusted the health services allocation of R9,928 billion would contribute towards increased access to health care by the estimated 40 percent of the population not taken care of by the current system.

Spending on health services rises by 22%

B|Day 19/3/92

Own Correspondent (85)

CAPE TOWN — Spending on health services, excluding the TBVC states and salary improvements, has been increased by 22% to R9,928bn. Much of this increase has been allocated for National Health, which rises to R1,169bn from R634,2m.

Finance Minister Barend du Plessis said the steadily rising cost of health services had meant the structure and nature of health delivery had to be reviewed urgently.

Notwithstanding the existing constitutional limitations still influencing reforms in the health service system, certain important functional adjustments in service delivery were already being made, focused particularly on the expansion of primary health care and a partnership service between the public and private sectors.

Considerable progress, he said, had already been made in transferring the provision of all primary health care services to local authorities and the necessary funds for these services would be supplied to local authorities by the Department of National Health and Development.

He said that as academic hospitals accounted for a significant portion of the health budget, it had become urgently necessary that the cost effectiveness of these services be improved.

To this end, the task of operating each of these institutions on a business basis would be entrusted to an executive manager with the necessary management and financial expertise.

☐ A further R440m has been budgeted for special targeted aid schemes under the Nutrition Development Programme.

Of the R220m allocated last year, R110m has been paid or is in the process of being paid — a total R35,6m has been paid to non-government organisations. Applications totalling R59m have been approved by the Department of National Health and Population Development and are in the process of payment, with applications for a further R5,4m now being processed, and R10m has been budgeted for state clinics operated by local authorities.

Medical services VAT to stay

STAR 20/3/92 (85)

Representations from organisations for Value Added Tax on medical services to be removed were not being considered at this stage, Minister of Finance Barend du Plessis said in the House of Assembly yesterday.

Replying to a question by Mike Ellis (DP Durban North), he said the representations did not appear to relate specifi cally to medical services for pensioners alone.

Mr du Plessis said more than 80 percent of the population received treatment in State-funded hospitals, where pensioners and others paid nominal charges which were exempt from VAT.

Pensioners in the higher income bracket were entitled to income tax relief for their medical expenses.

People aged 65 and older could claim all medical expenses as a tax deduction.

Mr Du Plessis said the Medical Association of South Africa (Masa) had initially requested a zero-rating on all medical services. This could not be accommodated because it would have reduced the tax base, and general practitioners, who previously paid GST on purchases, would be placed in a better position.

Masa then indicated that it preferred the standard VAT rate to an exemption and this course of action was accordingly followed. — Sapa.

Contact lens — beware of tapwater

(85) ARG 21/3/92

VIVIEN HORLER
Weekend Argus Reporter

CONTACT lens-wearers who make saline solution with tapwater run the risk of blindness.

This warning has been issued by the opthalmologist who runs the corneal clinic at Groote Schuur Hospital.

The doctor, who cannot be named for professional reasons, goes further and says he no longer recommends that contact lens-wearers make up their own saline.

In the United States the Food and Drug Administration has withdrawn salt tablets from the market so that people are forced to buy commercially prepared saline.

Saline is used for cleaning and storing contact lenses.

The ophthalmologist says there have been five or six cases of blindness in South Africa in the past year resulting from a corneal abscess caused by the use of tapwater saline.

The culprit is a protozoa called acanthamoeba which lives in tapwater.

"Acanthamoeba is all around us. We drink it regularly and usually it doesn't cause problems in the eyes or anywhere else."

But the minor scratches on the cornea caused by the routine insertion and removal of lenses can give the acanthamoeba access, and infection, followed by a corneal abscess, can result.

The infection is eventually controlled by drops, but the scarring of the cornea can leave the patient unable to read the letters on the top row of an eyechart. A corneal transplant is the only way to restore sight in the affected eye.

"In an ideal world people who make up their own saline use distilled water, and make up a fresh batch every day. But people cheat. They use tapwater and they don't bother to make it up fresh, and this provides an ideal opportunity for the acanthamoeba to flourish."

The doctor said more and more people were using disposable lenses, and it had been found these people were 12 times as likely to develop corneal infections of various kinds as people using ordinary lenses.

"In theory these lenses are safe because you're supposed to throw them away after a week or two, but again, people cheat and often only buy a new pair when the old lens starts getting uncomfortable.

"And that discomfort is actually the result of damage to the cornea.

"According to a Moorfields Eye Hospital study in London, people who wear extended-wear lenses, which you can leave in your eyes for some time, have 18 times the chance of corneal infection.

"Contact lenses, both hard and soft, are perfectly safe but you have to be scrupulous about caring for them. It is safe to leave them in for most of the day, provided they are cleaned and disinfected daily. We recommend any of the hydrogen peroxide cleaning systems.

"Lenses should also be cleaned of protein about once a week, or a build-up of protein can also cause minor abrasions on the cornea."

All you need to know about medicines

Sowetan 24/3/92

By SELLO RABOTHATA

THE *Reader's Digest* has published a book which is aimed at helping the ordinary family understand the everyday use of medicines and drugs.

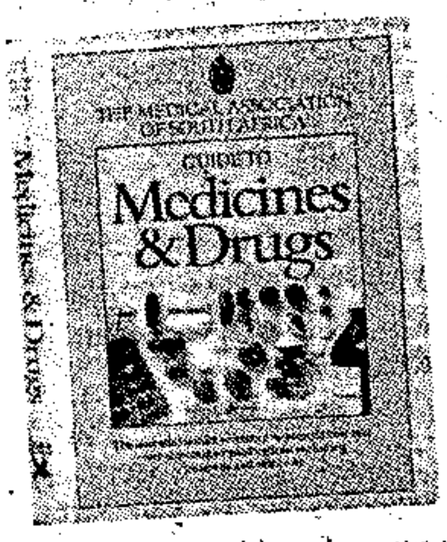
The Digest says research shows that 10 percent of all admissions to hospitals is for the treatment of drug-related conditions.

The book says it is largely due to the misuse of drugs and medicine through lack of knowledge of how they work and also, more often, how they react when taken in conjunction with alcohol or other treatment.

Information

"Guide to Medicines and Drugs", a new complete family reference book, was compiled by *Reader's Digest* in conjunction with The Medical Association of South Africa. It aims to tackle the issue of drug information.

Drugs are not only effective substances, but are also powerful chemicals that can have harmful effects if not used correctly.



Mr Christopher Walton, the books division editor-in-chief, said the guide was compiled by experts under the supervision of Dr Nick Lee, editor of the *SA Medical Journal*, and double-checked by doctors and pharmacists to ensure that information given was factually correct.

He said: "We wanted to ensure we presented the layman with a clear, easy-to-use guide. There was a definite gap in the market for a book such as this one. This is the first of its kind and we are confident it will become an essential family reference - a lifesaver."

The book is divided into four sections, the first two give an account of how drugs affect the body systems and how the main classes of drugs work.

Dosage

The main section gives in-depth information about 199 widely-used drugs, including the effects the drug has, potential problem areas, and what to do in the case of a missed dosage. Other sections include an index of drug and propriety names, a colour identification guide to commonly prescribed tablets and capsules, as well as information on vitamins and drugs of abuse.

The book is available from *Reader's Digest* or through major retail outlets and costs R94,58.

Squatter bottle-fed babies 'in danger'

ANDREA WEISS, Medical Reporter

PUTTING a baby on a bottle and returning it to a squatter camp is tantamount to a death sentence.

This emerged from a Press briefing on a Cape Provincial Administration plan to curb stillbirth and newborn deaths.

University of Stellenbosch obstetrician Dr Gerhard Theron said babies on bottles were 25 times more likely to die than breastfed babies if their mothers lived in squatter areas.

He said a bottle-fed baby would probably not live a year in an area where clean water, fuel and milk powder were hard to come by.

The promotion of breastfeeding at every opportunity is part of a five-point plan to curb the 27-in-a-1 000 perinatal mortality rate in the Cape. The first week after birth is seen as crucial to the success of breastfeeding.

The rest of the plan is to:

- Ensure that every woman is examined at least twice during pregnancy;
- Test all pregnant women for sexually transmitted diseases, especially syphilis which is responsible for 25 percent of all preventable stillbirths in Khayelitsha;
- Teach women about Aids; and
- Promote the use of a labour graph during the first stage of labour.

HOUSE OF ASSEMBLY

QUESTIONS

† Indicates translated version.

For written reply:

General Affairs:

Citizenship certificates

132. Mr P G SOAL asked the Minister of Home Affairs:

How many citizenship certificates (a) (i) had been issued and (ii) remained to be issued as at 31 December 1991, and (b) were issued in 1991, to citizens of each self-governing territory?

B333E

The MINISTER OF HOME AFFAIRS:

	(a) (i)	(a) (ii)	(b)
KwaZulu	1 611 543	2 009 960	312
Lebowa	278 321	1 362 363	0
QwaQwa	173 250	1 007 079	1 428
Gazankulu	98 444	487 198	0
KaNgwane	4 574	610 945	0
KwaNdebele	47 430	374 772	240

The figures furnished under (a) (ii) are projections based on the latest adjusted 1985 Census figures as supplied by the Central Statistical Service. The results of the 1991 Census Survey, adjusted for undercount, are not yet available.

Black home-owners

137. Mr P G SOAL asked the Minister of Local Government and National Housing:

(a) How many Black home-owners are there in the Republic, (i) including and (ii) excluding the self-governing territories, and (b) how many such home-owners have mortgages?

B345E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

(a) (i) and (ii) No statistics are available because, in so far as it concerns registration of land and other real rights, no distinction was made in respect of the various population groups even prior to the abolition of racially-based legislation.

(b) Falls away.

Departmental schools: number of classrooms

159. Mr R M BURROWS asked the Minister of Education and Training:

(a) What is the (i) total number of classrooms in schools administered by his Department and (ii) average number of classrooms for such (aa) primary and (bb) secondary schools and (b) in respect of what date is this information furnished?

B389E

The MINISTER OF EDUCATION AND TRAINING:

(a) (i) 54 428

(ii) (aa) 5,5

(bb) 23,4

(b) 5 March 1991.

PE/Uitenhage metropole: population figures

165. Mr E W TRENT asked the Minister of Home Affairs:

How many (a) male and (b) female (i) Whites, (ii) Coloureds, (iii) Asians and (iv) Blacks were there in the Port Elizabeth/Uitenhage metropole as at the latest specified date for which information is available?

B395E

The MINISTER OF HOME AFFAIRS:

	(a)	(b)
(i)	82 094	86 365
(ii)	84 770	92 372
(iii)	4 175	4 168
(iv)	208 443	243 457

The 1991 Population Census information, as at 7 March 1991, is furnished. This information has not yet been adjusted for possible undercount. The information refers to the magisterial districts of Port Elizabeth and Uitenhage as data on the metropole is not available.

Electricity supply: PE metropole

166. Mr E W TRENT asked the Minister of Local Government and National Housing:

(a) How many houses are supplied with electricity in (i) the metropole comprising Port Elizabeth, Ibhayi, Uitenhage and Kwanobuhle and (ii) each of these four areas and (b) in respect of what date is this information furnished?

B396E

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING:

(a) (i) 88 496

(ii) Port Elizabeth 65 366
Ibhayi 7 698
Uitenhage 12 800
Kwanobuhle 2 632

(b) 16 March 1992.

Health: amount budgeted

170. Mr M J ELLIS asked the Minister of National Health:

(a) What total amount has been budgeted for health in South Africa in respect of the latest specified 12-month period for which figures are available and (b) how much of this amount has been earmarked for (i) primary health care, (ii) secondary health care, (iii) tertiary health care and (iv) any other specified division?

B400E

The MINISTER OF NATIONAL HEALTH:

Department of National Health and Population Development

(a) 1991/92 financial year: R714 464 000 and

(b) (i) R197 059 000,

(ii) not applicable,

(iii) not applicable and

(iv) Health: R517 405 000.

Provincial Administration of the Cape of Good Hope

(a) 1992/93 financial year: R2 065 342 000 and

(b) (i) and (ii) separate amounts not available. A total amount of R1 062 441 000 has been provisionally voted,

(iii) R813 120 000 and

(iv) Head Office Administration: R189 781 000.

Provincial Administration of Natal

(a) 1991/92 financial year: R1 014 063 000 and

(b) (i) R326 923 000,

(ii) R345 141 000,

(iii) R175 221 000 and

(iv) Administration and auxillary services R13 436 000
Ambulance and emergency services R45 541 000
Supporting and specially controlled services R91 805 000
Central medical stock account R1 000 000
Government motor transport R655 000
Capital works R14 341 000

Provincial Administration of the Orange Free State

(a) 1991/92 financial year: R659 346 000 and

(b) (i) R70 712 000,

(ii) R184 650 000

(iii) R320 900 000 and

(iv) R83 084 000 for:
Management;
Capital and minor works;
Emergency medical services;
Auxilliary and specially controlled services.

Provincial Administration of Transvaal

(a) 1991/92 financial year: R2 388 161 000 and

(b) (i) R308 073 000,

(ii) R773 764 000,

(iii) R1 306 324 000 and

(iv) not available.

Administration: House of Assembly

(a) 1991/92 financial year: R623 630 000 and

(b) (i) R83 143 200,

(ii) R537 364 800,

(iii) R3 122 000 and

cont . . 2

(iv) not applicable.

Administration: House of Delegates

(a) 1991/92 financial year: R32 946 000 and

(b) (i) to (iv): according to the Administration's distribution, this information is not available.

Administration: House of Representatives

(a) 1991/92 financial year: R156 652 000 and

(b) (i) R98 720 000,

(ii) R45 832 000,

(iii) R12 100 000 and

(iv) none.

KwaZulu

(a) 1991/92 financial year: R508 000 000 and

(b) (i) R116 000 000,

(ii) R306 000 000,

(iii) none and

(iv) R86 000 000 for:

Administration etc.

KaNgwane

(a) 1991/92 financial year: R82 191 699 and

(b) (i) to (iv): according to the KaNgwane Government's distribution, this information is not available.

KwaNdebele

(a) 1991/92 financial year: R13 577 000 and

(b) (i) not available,

(ii) not available,

(iii) not available and

(iv) not available.

GaZankulu

(a) 1991/92 financial year: R137 662 568 and

(b) (i) to (iv): according to the GaZankulu Government's distribution, this information is not available.

Lebowa

(a) 1991/92 financial year: R233 683 000 and

(b) (i) R2 505 000,

(ii) R231 177 000,

(iii) none and

(iv) not available.

QwaQwa

(a) 1991/92 financial year: R60 865 000 and

(b) (i) R10 580 000,

(ii) R39 860 000,

(iii) R4 090 000 and

(iv) R6 335 000.

HOUSE OF ASSEMBLY

QUESTIONS

† Indicates translated version.

For written reply:

General Affairs:

Gross domestic product: deficit/expenditure

51. Mr K M ANDREW asked the Minister of Finance:

What was the (a) deficit before borrowing, (b) total actual expenditure, and (c) deficit before borrowing as a percentage of the gross domestic product, in each of the past five financial years?

B106E

The MINISTER OF FINANCE:

	Deficit R million	Actual expenditure R million	Deficit as % of GDP
1987/88	9 557,3	47 449,8	5,6%
1988/89	7 855,0	55 926,4	3,8%
1989/90	4 358,0	65 459,3	1,8%
1990/91	7 145,2	73 947,3	2,6%
1991/92*	13 160,8	86 387,8	4,3%

*Estimated

Deductibility of moneys paid for educational purposes

124. Mr R M BURROWS asked the Minister of Finance:

(1) Whether, with reference to his reply to Question No 74 on 27 February 1991, he or his Department has initiated further investigations into the deductibility of moneys paid by individual taxpayers for educational purposes at school or college level; if not, why not; if so, (a) what matters are being investigated and (b) by what body;

(2) what is the current tax policy regarding individuals and/or companies making donations to (a) tertiary institutions, (b) pre-primary schools, (c) primary schools and (d) secondary schools;

(3) whether there have been any changes in the above policy during the past five years; if not, why not; if so, what changes?

B318E

The MINISTER OF FINANCE:

(1) and (2) Yes. An interdepartmental committee, consisting of representatives from the Department of Finance, the Department of National Education together with other interested parties, have conducted extensive discussions regarding the extension of the deductibility of donations to, especially, primary schools. As a result of practical problems that are being experienced, not only with the extension, but also with the current deductions, no solution has as yet been found. In the light of this, the committee has considered various alternative suggestions for State assistance in respect of education costs and proposals in this regard will be submitted to the Government shortly.

(3) Yes, notwithstanding various technical amendments, the only substantial amendment which has been made to section 18A of the Income Tax Act over the past five years, is the introduction of provisions allowing donations made by companies to certain special funds which are to be utilized for educational or training purposes for the advancement of primary and secondary education, to also be deductible for income tax purposes.

Consolidation: purchase of land/cost

160. Mr P G SOAL asked the Minister of Regional and Land Affairs:

(a) What was the cost of purchasing land for the purpose of consolidation in respect of each (i) self-governing territory and (ii) independent Black state as at 31 December 1991 or the latest specified date for which figures are available and (b) how much land was added in each case?

B390E

R8,6 billion for health budgets

CT 27/3/92 (85)

Political Staff

MORE THAN R8,6 billion had been allocated for the health budgets of the four provincial administrations, the three own affairs administrations, the six non-independent homelands and her own department, the Minister of National Health, Dr Rina Venter, said yesterday.

The Transvaal Provincial Administration had been allocated the largest amount, R2 338 161 000, she said in reply to a question tabled in Parliament by Mr Mike Ellis (DP, Durban North).

The Cape was to get R2 065,3m, Natal R1 014m, the Free State R659,3m, the House of Assembly R623,6m, the House of Delegates R32,9m, the House of Representatives R156,7m, KwaZulu R508m, KaNgwane R82,2m, KwaNdebele R13,6m, Gazankulu R137,7m, Lebowa R232,7m, QwaQwa R60,9m and the Department of National Health R714,5m, Dr Venter said.

PROGRESSIVE PRIMARY HEALTH CARE - (PPHC)

WHAT MAKES IT DIFFERENT?

85

New Nation [Learning Nation] 27/3 - 2/4/92

Last week we looked at Primary Health Care as a possible route to "Health for All".
We take this issue forward this week by looking at the idea of Progressive Primary Health Care.

The belief that improvements in health are solely due to improvements in medical care has been disproved on numerous occasions. Yet, a purely **medical approach** to health is still the basis of health systems in many countries as well as our own. The aim of health care under such a system is only to treat disease as it appears through doctors and medicine, and not to uplift the community as a whole.

There is another approach to health, called the **health services approach**. With this approach, the community participates actively in the delivery of health services. It focuses on health services and assumes that improvement in health service provision will result in improvement in health.

But, as we saw last week, it is clear that improvement in health demands a much broader participation of the people. In this country we therefore need an approach to health that places health squarely in the hands of the people; one that sees health as resulting from collaboration and cooperation between various sectors, for example the medical sector, agriculture, education, housing, water services etc. And so we have **the community development approach** which defines health as the result of social, economic and political development. It therefore believes in the involvement of people in the planning and delivery of health **and other services** for the advancement of health and development. This approach identifies the community as a key participant in the decision-making processes and bases itself on what the **community** wants and not on needs identified by medical experts alone. It further stresses the need for a **bottom-up** approach rather than the **top-down** approach which we are all used to.

Progressive Primary Health Care (PPHC)

Last week, we looked at the emergence of the idea of **Primary Health Care**. Interpreted correctly, Primary Health Care would involve two main types of activity; firstly, a focus on health problems within the community; and secondly, attention to education and the improvement of social and economic conditions.

But, this dual function of health work within a health system based on Primary Health Care is a source of conflict. **Many health workers do not see it as part of their duty to promote social change.** Health workers also find themselves in **institutions** where the possibilities of working with the poor and most powerless is limited. They may then find themselves in a position where, instead of being part of the solution, they are part of the problem.

From this there arises the need for **Progressive Primary Health Care workers** who are committed to bring about social change in South Africa.

Progressive Primary Health Care workers are, then, a distinct and separate grouping within Primary Health Care. They believe that *"social activists should mount and sustain a political campaign to promote the practical realisation of the PHC approach on grounds of both equity and efficiency in the allocation of resources"* (from Article 1 of the Haikko declaration).

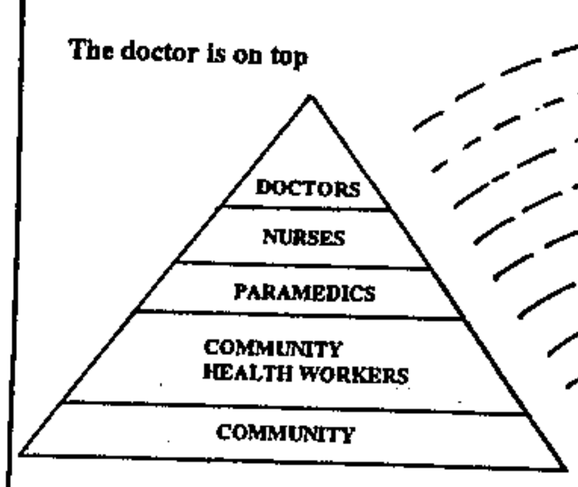
From this, it makes sense that many of those who subscribe to the philosophy of Progressive Primary Health Care are members of progressive democratic organisations - which actively address a range of social issues around labour, economics **and** health.

The Role of Community Health Workers in PPHC

Traditionally the doctor has been the head of the health team. This situation has increasingly been questioned. As we move towards a more community development oriented **(continued below the diagram)**

(Diagram 1)

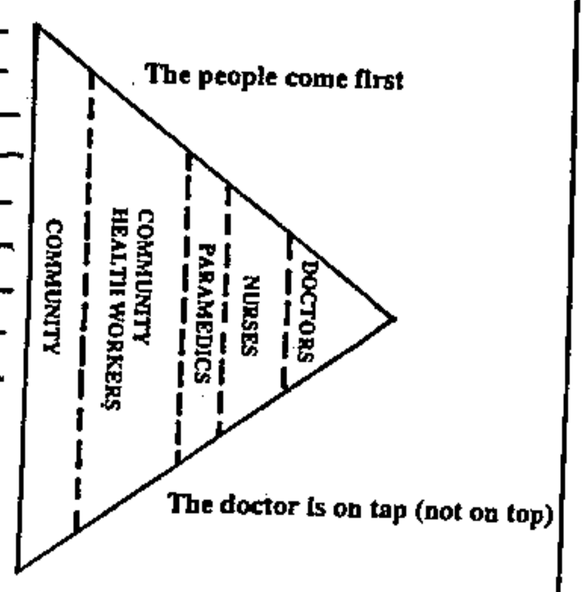
The typical pyramid



The community is at the bottom of the pyramid. Each level is rigidly separated from the next.

(Diagram 2)

The pyramid as it should be



The doctor is on tap (not on top)

The community health worker assumes the lead role in the health team.

approach to health, the conventional health skill pyramid (see diagram 1) should topple to make the community the head of the pyramid. This is one of the changes that are essential for an equitable health care system. Until this happens health experts will continue to dominate the field of health.

In a new structure (see the toppled pyramid in diagram 2) the community health worker would assume a leading role in the health team. Currently community health workers are seen as people who will be **replaced** once enough funds are available to employ a doctor. As a result they are being exploited. They are also regarded as having very little influence on the effectiveness of health care delivery. But, in a Primary Health Care system the community health worker programmes will form a key element of the health service. The limited training of these workers is even, in some sense, an advantage in that they are closer to the people and often more acceptable and credible to the community.

The National Progressive Primary Health Care Network

In September 1987 the **National Progressive Primary Health Care Network** (NPPHCN) was formed. It consisted of a non-governmental grouping of health organisations, health and development projects, community-based organisations and individuals committed to the concept of Progressive Primary Health Care. This was at a time when health activists were under close surveillance by the state. The Network currently consists of members from 5 main regions namely Eastern and Western Cape, Southern and Northern Transvaal and Natal, with each region being represented on a national co-ordinating committee.

The aim of the NPPHCN is to promote the development of Progressive Primary Health Care in South Africa by, amongst other things;

- creating a forum through which health and development projects, as well as other organisations and individuals can share experience and expertise.
- providing assistance for those involved in existing Primary Health Care programmes.

Other NPPHCN issues that have a high priority are:

- community accountability
- improvements in health worker practice
- improving the conditions in which people live.

In the progressive sector there are numerous health and welfare organisations that for years have all worked towards the health and welfare of all South Africans. Many of these groups are represented at the NPPHCN, but still as different organisations. The question that then arises is: **How can progressives criticise the fragmented health system while the progressive sector itself is fragmented?**

In July 1991 a national conference was held with the aim of promoting unity within the health and welfare sector and to initiate health policy development. At the conference a unified organisation was proposed consisting of national and regional health and welfare organisations, namely the South African Health Workers' Congress (SAHWCO), the National Medical and Dental Association (NAMDA), the Organisation for Appropriate Social Services of SA (OASSSA), the National Education, Health and Allied Workers Union (NEHAWU), the Health Workers' Society (HWS), and recently the NPPHCN. At the moment, various Regional Unity Forums are working towards a unified progressive health structure to be launched during 1992.

Conclusion

When looking closely at the structure of the South African health care system it is clear that it is not designed for community participation and consultation. It also does not have community development and health as its ultimate goals. The current system has an unacceptably high potential for exploitation of people by doctors and nurses. Clearly, if we want to implement a participatory approach to health, we urgently need to restructure our current health system. In view of limited financial resources in the country it is reasonable to assume that there will not be a huge increase in the health budget. A more realistic approach, then, would require the redistribution of health expenditure in order to support the transition to Primary Health Care.

Researchers find anti-cancer algae

(SE) 30/3/92 MRG

GRAHAMSTOWN. — Researchers at Rhodes University have found that an algae they are using to treat effluent also contains an anti-cancer agent.

Environmental Biotechnology research group leader and senior biochemistry lecturer, Mr Peter Rose, says his group has been looking at the environmental impact of effluent and salinity levels of public water systems.

They have found that by growing large amounts of the algae — Dunaliella — in saline water, they can control effluent and salinity levels in the country's water systems.

"And we've also found that the algae contains products of high value."

Mr Rose says the organism produces beta-carotene and glycerol.

"Beta-carotene has anti-cancer properties and where people consume dark-green vegetables which have beta-carotene there is a low incidence of cancer, particularly lung-cancer."

Previous tests show beta-carotene helps prevents cancer especially among high-risk groups such as smokers.

"Beta-carotene can also be used to replace tartrazine which causes problems in children."

Mr Rose says the effluent treatment process used by the group is low cost, "environmental friendly" and competes well with the "capital intensive process" used by larger municipalities.

The research group has now been awarded R750 000 by the Water Research Commission and Sasol.

According to Mr Rose the money will be spent largely on funding students and on capital equipment needed.

"We have six postgraduate students and a full-time research officer involved in the research so we will be spending a large section of the money in funding them," he said. — Ecna.

Minister makes the most of health

ARGT 30/3/92
(35)

Me and My Health

The only woman member of the Cabinet, Dr Rina Venter, Minister of National Health and Population Development makes crucial decisions affecting the social and health needs of the country. CHARLENE CLAYTON spoke to her about her own health and lifestyle and how she copes with reactions to the unpopular decisions she sometimes has to make.

Elegantly dressed in a yellow and black tailored suit, Dr Rina Venter's outward image is one geared for the role she plays — that of Cabinet Minister holding the portfolio National Health and Population Development.

As such, she is friendly and professional, but somewhat guarded.

Inwardly, a side that only occasionally emerges, she is a true *boerevrou* with her feet firmly on the ground.

She has enjoyed good health most of her life, dubs herself "lucky" and accepts it as one who has yet to suffer a severe health problem.

At present her goal is to fulfil the task she has to perform to the best of her ability and timewise, this means her family life has been set aside.

"I cannot change our family life to fit in with my schedule, but I know, this is not a permanent position and it won't last forever.

"I don't find it difficult to manage a healthy lifestyle because I am well disciplined: I generally eat well and get enough rest.

"In the past, when I was president of the Vrouefederasie, it was difficult to maintain my weight with all the nice things they prepared at every meeting.

"But I believe one has to have your own objectives and stick to them."

When it comes to food choices, Dr Venter says she loves food and does not have preferences.

"I'm easy, I think I grew up in a house where you ate what was put in front of you — there was no time for 'grille'.

"When I was a mother, there was breakfast,lunch and supper, but now that I have my own programme, I only eat when I'm hungry.

"I'm not an exercise person — I have tried aerobics, but that is not my style and I have come to the conclusion that the best exercise for me is to walk.

On the issue of stress, she says: "When I started this job, I used to get terrible headaches which my husband (a medical practitioner) attributed to stress, but once I recognised it as such, I learnt to control it.

"When I work with a difficult problem, I tackle it as objectively as possible. I go into all the details and once I've made my decision, I can relax, even if it is unpopular — and I've made many unpopular decisions in the past two years.

"If people attack the issue at hand, that's fine — but what I have found in the past is that they go further and attack my person."

She deals with this kind of reaction by staying out of a debate.

As far as the ordinary stresses of being in the public eye is concerned, she says "I've been in public life for about 10 years now and I've become used to peforming in front of people."

On tackling illness, Dr Venter believes in consulting doctors when she encounters a problem.

"I tend to develop cysts in the breast and have suffered from this since 1968.

"I go for regular mammograms and have had two operations but the principle I think is that women should go for regular checkups..

On her beauty routine, she says: "I love a hairdresser. I have been going to the same one in Pretoria for the past 25 years.

"I have my hair done once a week and if I can fit it in, twice a week, but that is as far as my beauty routine goes."

Dr Venter starts the day at six in the morning and leaves the office around six or seven in the evening. On the days when Cabinet is in session, she dosen't get home till after eight, and the social programme is busy.

"We usually have social commitments of some sort every evening and in the past I was a little soft on that and got my programme overloaded, but now I try not to go to more than two social occasions a week.

Spending six months of the year in Pretoria and the remainder in Cape Town is not a problem for Dr Venter.

"I started this lifestyle when I was elected to Parliament way back in 1985 and at the time it was quite something to adjust to, but I've arranged my circumstances so that I can cope.

"I have clothes and make-up in Pretoria and another set down in Cape Town so I just hop on the plane."

In her younger days, Dr Venter used to do embroidery and knitting for the family and she used to play the piano regularly.

But with the limits on her time, she only really gets to doing occasional reading and international history is her favourite literary topic.

Firemen's lift for ambulances

CT 31/3/92 (85)

Staff Reporter

CAPE Town's ambulance service is easing its staff shortage by leaning on its friends in the fire brigade — especially on busy weekends.

Mr Rod Douglas, head of the ambulance service, said yesterday the ambulance service was "a bit short" of personnel, but there was a great deal of co-operation with the fire departments.

"Our vehicles stand by at Milnerton, Bellville and Goodwood fire stations. We provide the vehicle and an ambulanceman, and it links up with the firemen, who have to spend time on the road in the ambulance service to qualify in their field anyway."

Goodwood municipality had developed its rescue section to the extent of getting its own emergency vehicle, he said.

"If they get to a scene before us that is fine."

Close co-operation between the ambulance service and the fire brigades had been going on for four or five years, he said.

Manning problems were especially acute on the weekends, but several firemen spent time at the ambulance depot on weekends "working with our reservists".

Mr George Wright, second in charge of Goodwood Fire Station, said that ambulances stationed at fire departments were still very much under the command of the ambulance service.

ANC joins call for new health policy

STAR 16/4/92

(85) (28/8) (88)

By Zingisa Mkhuma and Shirley Woodgate

The ANC has added its voice to the growing number of bodies concerned about the appalling state of the public health services, saying that it had warned a long time ago that there was a "health crisis" in the country.

South Africa is suffering a major breakdown of public health services and there have been calls for urgent action to alleviate the situation which is being aggravated by political violence and the horrific road accident rate.

The ANC yesterday reiterated its call for the Government to do away with the two tier health system which, it said, had made it possible for health workers to run away from public hospitals because of falling standards and low wages.

Democratic Party health spokesman Carole Charlewood said yesterday the situation was untenable when a country that called itself civilised had to decide which of its sick would live or die.

She called for an immediate round-table conference to fashion a new health policy.

PAC secretary for health Dr Selva Saman said the private sector consumed half of the national health budget, but served only 20 percent of the population. "The private cost of health is increasing at about twice the rate of inflation," he added.

The Department of National Health and Population Development this week said that the crisis was being aggravated by violence and the high number of accident victims being treated at provincial hospitals.

At the same time, about 35 percent of the most skilled nurses between the ages of 26 and 35 years have left the service for the private sector.

But the Transvaal Provincial Administration denies that any intensive care unit (ICU) beds in its five major hospitals have been closed.

However, chief director for advanced health-care services Dr Harm Pretorious acknowledged there was a shortage of resources which was felt in the ICU wards of some State and country hospitals. Patients in ICU wards were sometimes "pushed aside" by critically injured people, he said.

Dr Pretorius was responding to an earlier report from the Critical Care Society of Southern Africa, which stated that up to 20 percent of ICU beds in South Africa had been closed. The president of the society, Dr Dick Burrows, said that the crisis had reached a point where critically ill patients had had to be turned away.

The ANC said that, in its health policy document, it had proposed steps to attract nurses and doctors back to public hospitals.

A spokesman for the ANC's health department said it was a fallacy that the National Health budget had gone up by 22 percent this year.

"We think at the most it went up by about 16,6 percent, because the Government included the R440 million set aside for the Nutritional Development Programme in it," he said.

Bid to rob poverty fund

By Paula Fray STAR 1/4/92

Within a week of the Poverty Relief Programme's launch, someone tried to steal R1,7 million from it, Finance Minister Barend du Plessis told a press conference in Pretoria yesterday.

A spokesman for the Department of National Health confirmed that a charge had been laid and a case was expected to come to court soon. He would not comment further.

Yesterday Mr du Plessis said one of the delays which occurred towards the end of last year was due to the fact that within the first week someone "attempted to steal more than R1 million from the poverty assistance programme", which led to a review of the administration of the funds. (294) (85)

Mr du Plessis said the attempt was thwarted through the diligence of National Health Minister Dr Rina Venter and Deputy Finance Minister Dr Theo Alant.

He said Dr Venter would have to appear in court ... "on the witness stand".

HEALTH MATTERS

FINANCING HEALTH CARE

New Nation (Learning Nation) 3/4-9/4/92 (85)

Today's article looks at various health financing options and the debates around them.

In the foreseeable future, South Africa won't be able to allocate sufficient resources to the health sector to satisfy basic needs. Therefore it is important that resources should be used in the most effective way possible.

Many different factors have contributed to the poor state of South African Health Services: Apartheid policies, inadequate planning, and little coordination between health policy making and financing.

In South Africa, there is a mixed private and public health sector. This has led to problems, since the private sector provides health care to about 21% of the population, yet uses nearly half the resources allocated to health care. This inequality between the private and public health services immediately leads to the question of how a new health system's finances should be arranged.

Curative vs preventative Health Care

People have immediate need of health care which cures and rehabilitates (To rehabilitate means to bring back to a normal life.)

However, such a service needs to be accompanied by preventative services. If not, the demands on the curative services will remain as heavy as they are now and make demands on the financial resources of the country. There is never a clear limit to peoples' health needs. However, there is always a limit to what a country is willing or able to finance. Thus, realistic health resource planning must take into consideration economic as well as health factors.

Who should finance health services?

The two sources of financing for health care are the private and public sectors.

The most important private sources are the individuals who pay for services, either directly to the service provider or indirectly through medical aid schemes that are supplemented by contributions from employers. But in a country with a high rate of unemployment, this method cannot fund health care for an entire nation.

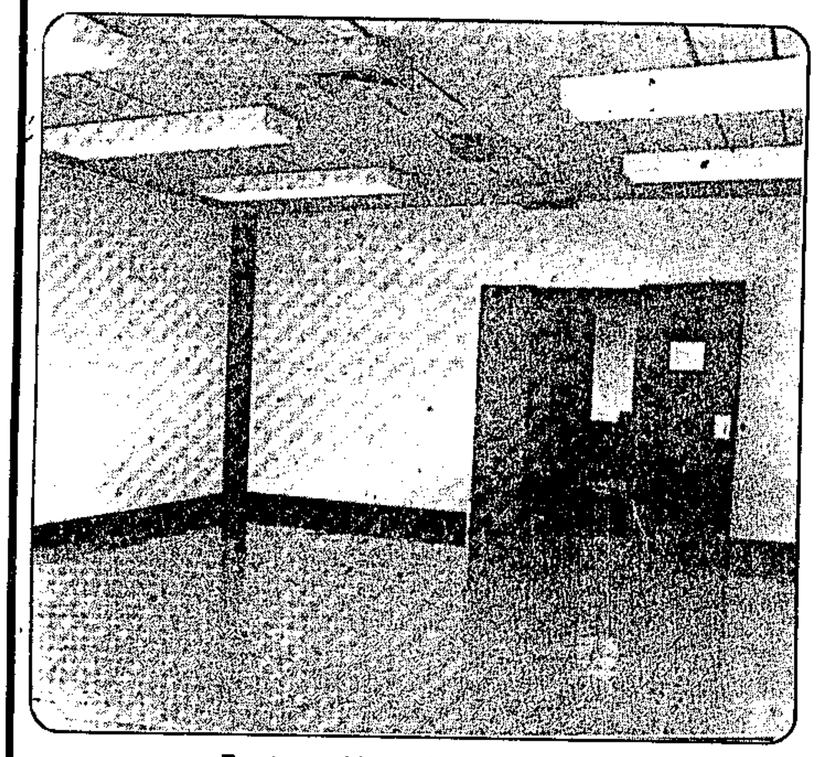
Insurance companies have also recently started providing financing to cover certain medical expenses, but, again the majority of people are unable to participate in this because their income is too low.

The public sources of financing are tax revenue and a national public health insurance system that is regulated by the government.

Exploring the options

The options for financing health can thus be divided into three categories:

1. **maintaining the social system as it is now and keeping the private and public sectors separate;**
2. **implementing a national health service;**
3. **financing the private and public health system through a centralised financing system.**



Empty ward in a private hospital

1. Separate private and public health services

One option is to maintain the separate private and public health sector. With this option, the private sector will be competing with the public health services. But, because the present private sector is so powerful, it will undermine the public health sector. There are many problems with this option because it will continue the present system of unequal services, with the private sector catering for a mostly white minority, while using most of the health resources.

2. National Health Service

Under a national health service, the private and public sector are 'employed' by the state. People practising in the private sector are paid a salary according to the number of patients they see. An advantage of this is that health care is more equitably distributed. In some neighbouring countries, banning of private practice has resulted in a 'black market' in private health care.

Another result could be that many health professionals may leave the country. It is argued that if a national health system is implemented immediately in South Africa, these two possibilities are likely to result. This would then undermine the health service sector as a whole. If they do not leave, the employment of all the health professionals by the state will place an almost impossible burden on the public health budget.

However, there are many advantages to a national health service. A national health system increases the possibility of community participation and control. Because of decentralised decision-making there is more accountability to the people. It ensures that a high standard of health care is available to all people and that affordable medicines are made available (often cheaper than in many other countries). Community services and health promotion activities are encouraged by this system.

Another very important advantage is that the administration costs of the National Health Service will decrease.

3. National Health Insurance

In this system, the public and private sectors both contribute to a central fund that is managed by a national body, usually the health authorities. The health authorities will have control over the development and functioning of both the public and private health sectors. This system is commonly known as the national health insurance system.

It is claimed that through this system, each individual will then receive equal health services, but this applies only to the most basic health services. Other more costly care is often available only to people who have extra private medical insurance cover.

The Way Forward

Many progressive health organisations have supported the call for a national health system. There are also others in the non-progressive, traditional health sector who share the view that in the end a national health system would have the most benefits for the health of the nation. However, when considering the organisation of current health care structure, the National Health Insurance system has been proposed as an interim measure that would make transition to the national health system easier.

In this period of planning and policy development, many political parties are actively engaged in debates such this one around health policy. Politicians are beginning to realise what an essential and important role health plays in the well-being of a nation, and that health and health-related issues feed into other areas of public life.

SA-Mauritian medical accord

PORT-LOUIS — Mauritius has signed an agreement with South Africa on medical co-operation, Prem Nababsin, the Deputy Prime Minister and Health Minister, said yesterday.

The agreement provides for patients who cannot be operated on in Mauritius to be taken to SA, training for Mauritian health workers in South Africa and for SA specialists to give seminars. — Sapa-AFP.

'Rethink health services'

ARG 7/4/92

CLIVE SAWYER
Municipal Reporter

PROVINCIAL administrations, and city and town councils, must generate their own income to guarantee their effectiveness and independence, the Administrator, Mr Kobus Meiring, said today.

Opening the annual debate on provincial affairs in parliament, Mr Meiring also called for a rethink on changes to health services, and called for commercialisation of nature reserves.

Mr Meiring said it was "unsatisfactory" that the provincial administration was an extension of central government instead of a government institution in its own right.

This caused unnecessary duplication of functions, and confusion among the public and officials, he said.

Regional and local government bodies should be highly autonomous, and should generate their own income supplemented by government grants according to a set formula.

City and town councils should have final decision-making powers over matters of local interest, Mr Meiring said.

Provincial hospital and health services had to take account of increasing urbanisation and demand for services, limited finances, and legitimate demands for community participation in the services.

A crucial shift of emphasis was to be made from hospital to primary health care services, but this should not allow a breakdown in standards, Mr Meiring said.

He criticised government plans to remove academic hospitals from the control of provincial authorities and give them to the Department of National Health and Population Development.

Health services should be left in the hands of the provincial administration, which had a proven track record, he said.

It was doubtful whether local authorities were able to give effective primary health care — "and even if they were, there is no way in which it can be provided cheaper than by the provincial administration".

Changes were needed in the running of the CPA department of nature conservation.

Image-boosting plans for the department included increased access to nature reserves, creation of affordable accommodation facilities, and commercialisation of the service.

Commenting on recent speculation about the future of the Cape Peninsula Protected Nature Environment, Mr Meiring confirmed that R100 000 had been set aside for updating existing management plans.

An announcement would be made in due course, he said.

ARG 7/4/92

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Many health jobs 'could go'

ET 8/4/92 (85)

Political Staff

A LARGE number of posts in the Cape Provincial Health Services could be scrapped as part of a rationalisation programme, the MEC in charge of hospital services, Mr Dawie le Roux, said yesterday.

Many of the posts are currently filled.

A similar warning was issued by Natal MEC Mr Peter Miller, who warned that 2 500 jobs would be lost if more money was not made available for health services.

Speaking during the provincial budget Mr Le Roux said his department was starting the year R130 million short of what was required to maintain services at last year's levels.

The proposal to cut posts had come from an investigation conducted by his department and a private sector company whose brief had been to produce a more streamlined and appropriate system, with a leaner and more efficient service structure.

'Beat the budget'

Undertaking to make cuts in the best and most sympathetic manner possible, Mr Le Roux said this would be done in consultation with staff associations, the commission for administration and department of state expenditure.

Mr Le Roux said a management plan had been drawn up and he believed that if it was approved by the cabinet, hospital services would be in a position either to beat the budget or come close without affecting the quality of services.

Earlier, Cape Administrator Mr Kobus Meiring expressed serious concern about the government's plan to strip the provinces of responsibility for some hospitals and primary health care services.

Mr Meiring said it was common knowledge that the vertical fragmentation of health services in terms of the concept of own affairs had failed, and that the end was in sight.

"This to our minds is a positive development."

Health 'murdered in cradle', warns Stellenbosch dean

ARG 14/4/92 (85)

JOHN VILJOEN
Education Reporter

CUTBACKS on spending at academic hospitals by provincial authorities amount to "murder in the cradle" of the medical profession, according to the Dean of Stellenbosch University's medical faculty.

Professor H P Wasserman said he looked forward to when academic hospitals were administered separately and allocated funds at a national level.

The Cape Provincial Administration's moves to cut posts in academic hospitals would harm teaching and research.

While the CPA did an excellent job providing health services, the situation would deteriorateas as long as this policy continued.

Staff cutbacks had a domino effect on the whole academic structure, he said.

This was a national problem and the long-term effect would be to lower health care standards.

The relationship between academic hospitals and the CPA was "certainly strained" at the moment, and he described the CPA's planning as "rather haphazard".

A result of recent cutbacks had been the drop in the number of temporary positions filled by doctors and specialists from the private sector, he said.

These "sessional positions" were valuable to teaching and their reduction, while not unexpected, had had a negative effect on teaching.

But he felt cutbacks in nursing staff were more serious as they began a chain reaction by reducing the number of teaching beds.

The CPA was guilty of "murder in the cradle" by cutting back at the source of all doctors, nurses, occupational therapists and physiotherapists.

For this reason he looked forward to the proposed implementation of a new dispensation for academic hospitals in terms of which they would fall into a separate group under a supervisory board administrated by the Department of National Health.

Funding would be allocated on a formula based on the productivity levels (for example output of graduates and research achievements) of the hospitals.

He was confident conditions at academic hospitals would improve with this system.

Tygerberg was the most cost-effective teaching hospital in the country and would benefit from a fairer budget policy set at a national level, he said.

"Local politics" would no longer play a role if academic hospitals were administered centrally.

Teaching functions at Tygerberg also suffered because the hospital was "smothered" by trauma cases. This placed an increased burden on those responsible for health care and education.

Chief Medical Superintendent at Tygerberg Dr J G L Strauss said there was a gradual reduction in the number of patients at academic hospitals.

Owing to rationalisation, some temporary posts had become redundant and those holding them were not replaced when they left, but posts had not been terminated.

Stellenbosch University rector Professor Mike De Vries said it would be an exaggeration to suggest that the medical faculty was in dire financial straits.

Stellenbosch had financial limitations, just like any other university, he said.

New health plan mooted

Bloem 15/4/92 (85)

KATHRYN STRACHAN

AS THE state once again comes under attack from all sides for its increasingly expensive and deteriorating health services, the idea of a national health insurance scheme is gaining in popularity as the best solution.

Wits University Centre for Health Policy director Cedric de Beer believes that the state would best be able to raise funds for health care by combining an allocation from general tax revenue with funds raised through a statutory national health insurance scheme.

This system, which is used in many countries including Canada and Australia, involves replacing current medical aid contributions with compulsory health insurance for all those in employment.

ANC health department head Dr Ralph Mgijima says his organisation believes that drawing the private sector into a national health insurance scheme would be a logical step.

De Beer explains that there are only three possible options for central financing of health services. The money has to come out of general tax revenue, it must be raised from some form of statutory health insurance, or from some combination of the two.

The principle of a national health insurance scheme is that all those in formal employment pay a compulsory health insurance premium, which is usually matched by employers. As the scheme develops, self-employed groups can be brought into the scheme.

This revenue is then used to pay for a package of health services provided by either the public or the private sector. In many countries the funds are used only to pay for the health care of contributors. However, it is also possible for these funds to be pooled with government revenue set aside for health care, and used to pay for services for all. The state would pay the full costs of an agreed comprehensive package in any appropriate facility whether privately or publicly run.

Different countries have excluded specialist dental services, cosmetic surgery and the provision of glasses other than the most basic ones available. In Australia, the health insurance system will pay for medical services received in private hospitals, but those choosing to use private hospitals have to pay for the frills.

De Beer believes health insurance is merely a politically acceptable way of mobilising additional resources for health care from those groups which can afford to pay. It is easier to convince those better off to make additional payments earmarked specifically for health, than to pay the higher tax needed to pay for the subsidisation of health care from general revenue.

Linked to this argument is the notion that tax funding for health is relatively vulnerable. During periods of economic recession government can easily reduce the health budget. It is more difficult to do so with an earmarked allocation.

The development of a national health insurance scheme would not establish equity in health care overnight, warns De Beer. However, as the state gains control over extra funds, so it should become possible to direct funds for capital development to the areas at present under-serviced, and to create incentives for doctors and nurses to work in these areas.

Major opposition would be expected from a number of sources, most obviously the medical aid schemes and doctors and private hospitals that want to operate outside the state-financed health system.

The Medical Association of SA (Masa) is looking also at a national health insurance system, but remains concerned that it could undermine the role played by medical aid schemes. "If such a system were to be introduced it would be essential to find a way of synchronising it with the existing medical scheme system, so as to enhance rather than potentially to destroy the existing system," says Masa secretary-general Hendrik Hanekom.

De Beer believes medical aid schemes should be used only for services not included in the basic package provided by the national scheme. If they were allowed to operate in place of a national health insurance system for individuals who chose them, this would simply reproduce the existing exclusive private sector system which consumes 50% of resources while serving 20% of the population, and undermine the whole national health system.

There would also be the danger that medical aid would "skim off" better risk groups and offer them lower premiums, which would seriously undermine the national scheme.

He concedes that the expertise needed to operate such a system lies with medical aid administrators, and ways of incorporating them into the system could be discussed.

De Beer would also expect opposition from private sector doctors and hospitals in that a national health insurance system could reduce their earnings or profit margins.

This is because the state, being by far the largest buyer of health care, would be in a powerful bargaining position in negotiations with private hospitals and practitioners over rates of payment.

IF THERE is an identifiable financial

change rate mechanism parity – to be

of the Service and the amount is therefore not supplied per Arm of the Service.

	1989-90	*1990-91*	*1991-92*
State Funds:	R 700 000	R1 526 000	R 889 500
Contributions by members:	R4 597 811	R3 972 309	R4 200 347

Note:

Contributions by members are used for affiliation and entry fees, equipment and clothing, financial assistance to members representing the SA Defence Force or national teams, hiring of facilities and new facilities.

Dora Nginza Hospital: staff complement

204. Mr E W TRENT asked the Minister of National Health:

What, in respect of the Dora Nginza Hospital, was the complement of (a) nursing staff, (b) medical practitioners, and (c) pharmacists, in each grade as at 31 December 1991?

B461E

The MINISTER OF NATIONAL HEALTH:

(a)	Senior Nursing Service Manager	1
	Chief Professional Nurse	5
	Senior Professional Nurse	18
	Professional Nurse	112
	Senior Staff Nurse	1
	Staff Nurse	122
	Nursing Assistant	69
(b)	Medical Superintendent	1
	Principal Medical Officer	3
	Medical Officer	14
	Specialist	4
	Part-time Specialist	3
(c)	Principal Pharmacist	1
	Senior Pharmacist	3
	Pharmacist (Intern)	1.

Elizabeth Donkin Hospital: staff complement

206. Lt-Gen R H D ROGERS asked the Minister of National Health:

What, in respect of the Elizabeth Donkin Provincial Hospital, was the complement of (a) nursing staff, (b) medical practitioners, and (c) pharmacists, in each grade as at 31 December 1991?

B463E

The MINISTER OF NATIONAL HEALTH:

(a)	Senior Nursing Service Manager	1
	Nursing Service Manager	3
	Chief Professional Nurse	5
	Senior Professional Nurse	28
	Professional Nurse	24
	Senior Staff Nurse	2
	Staff Nurse	8
	Senior Nursing Assistant	17
	Nursing Assistant	40
(b)	Chief Specialist	1
	Senior Specialist	1
	Specialist	2
	Medical Officer	2
	Part-time Medical Officer	1
(c)	Pharmacist	1.

Livingstone Hospital: staff complement

207. Lt-Gen R H D ROGERS asked the Minister of National Health:

What, in respect of the Livingstone Hospital, was the complement of (a) nursing staff, (b) medical practitioners, and (c) pharmacists, in each grade as at 31 December 1991?

B464E

The MINISTER OF NATIONAL HEALTH:

(a)	Senior Nursing Service Manager	1
	Nursing Service Manager	3
	Chief Professional Nurse	14
	Senior Professional Nurse	45
	Professional Nurse	480
	Senior Staff Nurse	20
	Staff Nurse	380
	Nursing Assistant	120
(b)	Medical Superintendent	1
	Medical Officer	60
	Part-time Medical Officer	1
	Intern (Medical)	31
	Senior Specialist	6
	Part-time Senior Specialist	1
	Specialist	19
	Part-time Specialist	12
(c)	Principal Pharmacist	1
	Senior Pharmacist	4
	Pharmacist	12
	Pharmacist (Intern)	4

Legal abortions

213. Dr Z J DE BEER asked the Minister of National Health:

(1) Whether any applications for legal abortions were made to her Department in 1991; if so, how many (a) such applications were made and (b) legal abortions were performed as a result;

(2) how many of these legal abortions were authorized in respect of (a) statutory rape, (b) rape and (c) incest?

B492E

The MINISTER OF NATIONAL HEALTH:

(1) No, applications are made to the medical practitioner in charge of a provincial hospital or a few private hospitals designated for this purpose.

(a) unknown and

(b) 981 legal abortions were reported for the year 1991 as at 31 January 1992;

(2) abortions may be procured by a medical practitioner in terms of sections 3(1)(a)–(e) of the Abortion and Sterilization Act, 1975 (Act 2 of 1975) and the statistical returns only specify the categories accordingly.

During 1991 a total of 46 abortions have been procured in terms of section 3(1)(d)—pregnancy in consequence of unlawful carnal intercourse.

Abortion/sterilization: legislation

214. Dr Z J DE BEER asked the Minister of National Health:

(1) Whether, with reference to her reply to Question No 13 on 9 April 1991, she intends to introduce any legislation in regard to abortion and sterilization during the present session of Parliament; if not, why not; if so, (a) what legislation and (b) when;

(2) whether she has received any representations in this regard during the past 12 months; if so, (a) from whom and (b) what was (i) the nature of and (ii) her response to these representations?

B493E

The MINISTER OF NATIONAL HEALTH:

(1) No, since public opinion is against any amendments to the Act;

(2) yes,

(a) 1 318 representations from individuals and organizations were received from which all but one were against any amendments and

(b) no amendments are envisaged.

Mercury in tooth fillings

215. Mr M J ELLIS asked the Minister of National Health:

(1) Whether she has received any requests from individuals and/or organizations to ban the use of mercury in tooth fillings; if so, from whom;

(2) whether her Department is investigating the possibility of banning the use of mercury in tooth fillings; if so, why;

(3) whether she will make a statement on the matter?

B494E

The MINISTER OF NATIONAL HEALTH:

(1) No;

(2) no;

(3) no.

Immunization programmes: amount allocated

216. Mr M J ELLIS asked the Minister of National Health:

(1) (a) What sum of money was allocated to immunization programmes in the 1991-92 financial year and (b) what immunization programmes were undertaken;

(2) whether these programmes could be implemented fully out of the sum so allocated; if not,

(3) whether additional funds were allocated for this purpose; if so, from what source?

B495E

The MINISTER OF NATIONAL HEALTH:

(1) (a) R4 766 000 and

(b) the expanded programme on immunisation consists of sustained vaccina-

cont →

Health-care costs come under worldwide scrutiny

STAR 23/4/92

No government, whether rich first world or poor third world, can accept sole responsibility for the health care delivery system in its country.

A World Bank report states: "The conclusions argue that present policies need to be substantially re-orientated in many countries. The conventional and still growing faith that health care should be totally paid for and administered by governments needs to be vigorously challenged."

The subject of an ever-increasing health care bill and how to fund such costs is receiving the highest priority internationally.

Eugene L Step, chairman of the board of the American Pharmaceutical Manufacturers Association (PMA), summed it up at the 14th IFPMA Assembly held in Washington in 1988:

"In the more than a century since Otto von Bismarck first established the German social security programme, we have seen not only a revolution in the science of health care, but a revolution in the politics of health care. The simple and primitive care that was once considered the privilege of the few has become the sophisticated, expensive care considered to be the right of all."

For decades governments have been making health care promises without realistically calculating the costs. Historically, rapidly growing economies have permitted governments to fund these promises.

With the slowing of economic growth, health care costs have come under increasing scrutiny.

"The confluence of a rising tide of health care expectations, expensive new technologies, longer life expectancies, and an ageing population have brought a world-wide focus on health care costs."

The position in South Africa is therefore no different to that in the rest of the world.

Strategy

This is the conclusion of the PMA (South Africa) who have written a strategy document entitled "A cost-effective, equitable and durable health care delivery system for South Africa", outlining its attitudes towards health care.

The PMA supports a health care scenario of economic growth coupled with a free enterprise economy within which privatisation and deregulation play a decisive role. This is essentially what the Government has committed itself to.

It does not support the idea of a national health system because this puts the onus of funding such a scheme on the fiscus with little or no responsibility on the individual.

The Government's own declared philosophy of a free enterprise economy and the long-term economic needs of South Africa would make such a national health scheme unaffordable.

The PMA acknowledges that currently the economic growth rate in South Africa is unacceptably low, thus limiting the creation of job opportunities and consequently there is an increase in the unemployed and underemployed.

This places additional and unnecessary burdens on the fiscus at a time when pressure is being exerted on the Government to reduce expenditure.

South Africa cannot afford for health care costs to increase in an uncontrollable manner and the PMA feels there is a need to adopt an equitable, cost-effective and durable health care delivery system.

The PMA outlines the following major problems facing South Africa's health care delivery system:

- Lower econonomic growth rates
- Population explosion (with minor exceptions) mainly in what is internationally termed the third world population
- Higher employment and underemployment
- A greater percentage of the total population moving into the category of the aged
- The overtaxation of the working population with such negative results as reducing personal private expenditure, eliminating entrepreneurial initiatives;
- Misuse and overuse of health care delivery services both in the public and private sectors
- Inhabitants who are loathe to accept greater responsibility for health care including preventative and curative health care services in that the perception has been cultivated since World War 2 that health care is a right and not a privilege
- Modern but more cost-effective techniques in treating patients
- More "expensive" but more cost-effective medicines.

The PMA warns that unless an orderly structure is designed to define the role and responsibility of the Government, the employer and the individual, a credibility gap will develop between Governments and the private sector health care delivery system, the Government and the patient, the private sector health care delivery team and the patient and even between members of the health care delivery team.

Furthermore, unless such structures are designed within the broad economic scenario defined, the demand on the fiscus will ultimately become unbearable because of other priorities.

One of the most important factors affecting the future of health care in South Africa is population growth.

This will effectively determine the quantity, quality and distribution of health care services.

A study by the University of South Africa's Bureau of Market Research found that the total population in South Africa would increase to more than 47 million by the end of this century and would double in the next 28 years.

Several factors should help to limit population growth.

These include education, promotive and preventive health education, improved housing and the securing of a stable job opportunity.

The PMA document quotes parts of the report by the Science Committee of the President's Council on Demographic Trends in South Africa of 1983.

On the subject of health care the report recommends that no elderly person should have to forego reasonable treatment because of an inability to pay but that in future every individual would have to become more responsible for the financing of his/her own medical and health care.

"This means the State will provide reasonable medical treatment for those who need it, while those who demand more, will have to be prepared to finance it themselves", the President's Council report concludes.

The report also recommends that the "greatest possible encouragement must be given to the private sector by means of public education programmes and tax incentives to ensure that adequate medical aid and/or insurance schemes are available and are utilised in South Africa".

The PMA points out that the growth of the population will lead to increased competition for scarce financial resources in the fields of economic investments such as job creation, the raising of per capita income (through training people), capital formation (in plant and infrastructure) and of demographic investments (education, health services, housing, energy, water supplies and social infrastructure) in addition to the requirements of the army and police.

According to the Earthscan Institute, 80 percent of the world's diseases are linked to inadequate water and sanitation in the form of waterborne diseases, water-based diseases and infections because of defective sanitation.

Globally, over 1 000 million people are affected.

Inadequate shelter and poor education all contribute to general morbidity. (There is a direct correlation between education and general wellness).

Other factors such as social and physical security and inadequate policing also contribute to South Africa's health problems.

The PMA feels that it is important that the Government expenditure is reduced (with consequential tax relief), as it has "been shown internationally that the greater the share of the Government in a national economy, the less chance there is to induce growth in that economy."

In conclusion the PMA argues that the principles of a cost-effective, equitable and durable health care system are:

- The individual is responsible for his/her own health
- Health care is a privilege and not a right, but the indigent and aged must be cared for
- There must be one health care system
- The individual should be funded rather than institutions. (There is widespread consensus that the direction for a solution for the indigent, the disabled, the chronically ill, the terminally ill and the social pensioner must be sought in the subsidisation of the needy individual. The underlying assumption is that this is more cost-effective than creating a subsidised delivery structure for these target populations.)
- The real costs of public sector facilities must be calculated so that the costs of public and private facilities can be compared realistically; the same rules regarding conditions, codes of practice, cost calculation, standards, controls etc, will have to be applied to both public and private institutions.
- Principle of co-payment (the patient being charged in relation to his income)
- Promotion of self-medication
- Restructuring of medical aid/insurance schemes
- Using the free market concept to supply medicines and professional services

The PMA believes the adoption of these principles is essential for a health care delivery system, which will be cost effective, equitable and durable and which will offer sustained implementation in future.

Package

The philosophy expressed must be seen as a package.

Unless this principle is adopted, a situation can once again be reached that loopholes will be promoted to misuse and abuse both the private and public health care delivery systems.

The adoption of these principles, will be cardinal in developing a strategy for privatisation of the health care delivery system.

The PMA also recommends appropriate deregulation in order to facilitate privatisation.

'This is the way to provide best health system'

STAR 23/4/92

85

The subjects of health, and the system for the delivery of health care, are emotional and politically sensitive, all over the world.

At the same time it is impossible to look at such issues in isolation from South Africa's economy.

Unless there is economic growth there will not be sufficient profits or income to tax for state-supplied health care, or to contribute the medical aid for health care provided within the private sector.

The PMA believes in a free enterprise economic system and a dual system to provide health care.

The debate on this topic is complicated by a severe lack of accurate, comprehensive and unbiased health economic data and especially data relating to cost-effectiveness of health care.

South Africa has, however, a lot of information on cost which is used by everybody to "prove" the inefficiencies of the other side's system.

It would indeed be "magic" if South Africa could provide free or almost free and limitless high quality health care to all, but this of course is totally unrealistic and even wealthier countries that have tried to move in that direction have failed miserably.

Health care provision must also be seen in conjunction with other competing socio-economic needs that exist including housing, education, sanitation and water.

The PMA believes that all accept that socio-economic upliftment in South Africa is urgently necessary and must be given a high priority.

However, one cannot support the viewpoint that the immediate need for socio-economic development must be addressed separately from the fundamentals of a future economic and health care delivery strategy or system.

Scheme

It further seems that the World Health Organisation slogan, "Health for all by the year 2000", is being deliberately misinterpreted to mean that this should be the sole responsibility of a government. This is not so and to adopt this would be contrary to the conclusions reached in international studies.

It is, however, common knowledge that many see a possibility in financing a national health scheme similar to the one applicable in the United Kingdom. Recent changes to the scheme indicate that the original objective has not been successfully achieved.

It seems to be more correct for South Africa to continue with its dual system — but that a greater growth rate in economy is necessary to create more job opportunities in the private sector, particularly if cognisance is taken of the population explosion which is being experienced.

This conclusion should be associated with the address by Robert Dole, Republican leader in the US Senate in October 1988:

"My topic is about responsibility, and I believe that the Government's responsibility to control costs and avoid waste is no greater than its responsibility to encourage industry to continue to search for new and improved medicines.

"What I am suggesting is that the manner in which this health care is provided can have a significant impact on health care now — and most importantly — in the future."

The term "manner" naturally also includes not only the physical provision of health care but indeed the financing of health care.

The demand for health care for all population groups in South Africa currently exceeds the State's ability to meet this demand. It is likely that the extent of this inability will continue to increase.

The PMA believes it to be imperative for the State and private sector to co-operate to the fullest extent to bring about the most cost-effective use of scarce resources available to meet the demand for health care.

Call for nurses to handle primary health care

STAR 24/4/92

Staff Reporter

Capable nurses could easily handle 80 percent of the primary health care traffic now done by general practitioners, according to Ray Leigh, convener of the Lay Health Lobby which calls for the introduction of health maintenance organisations (HMOs) to alleviate the growing health crisis.

Mr Leigh believes registered nurses should be allowed to examine, diagnose, prescribe and treat patients up to the level of their expertise.

"Highly qualified doctors have no need to waste time on minor complaints.

"These doctors have more important work to do," said Mr Leigh.

He was speaking after the launch of a Lay Health Lobby booklet entitled "HMOs: Solution to the health-care crisis" which attacks legislation restricting the establishment of HMOs.

Vaalmed in Vanderbijlpark is a good example of an HMO, said Mr Leigh, which although restricted, managed to deliver health care services at no less than 40 percent below the costs of a medical aid society.

The Lay Health Lobby is now recruiting business support for converting medical aid schemes to HMOs.

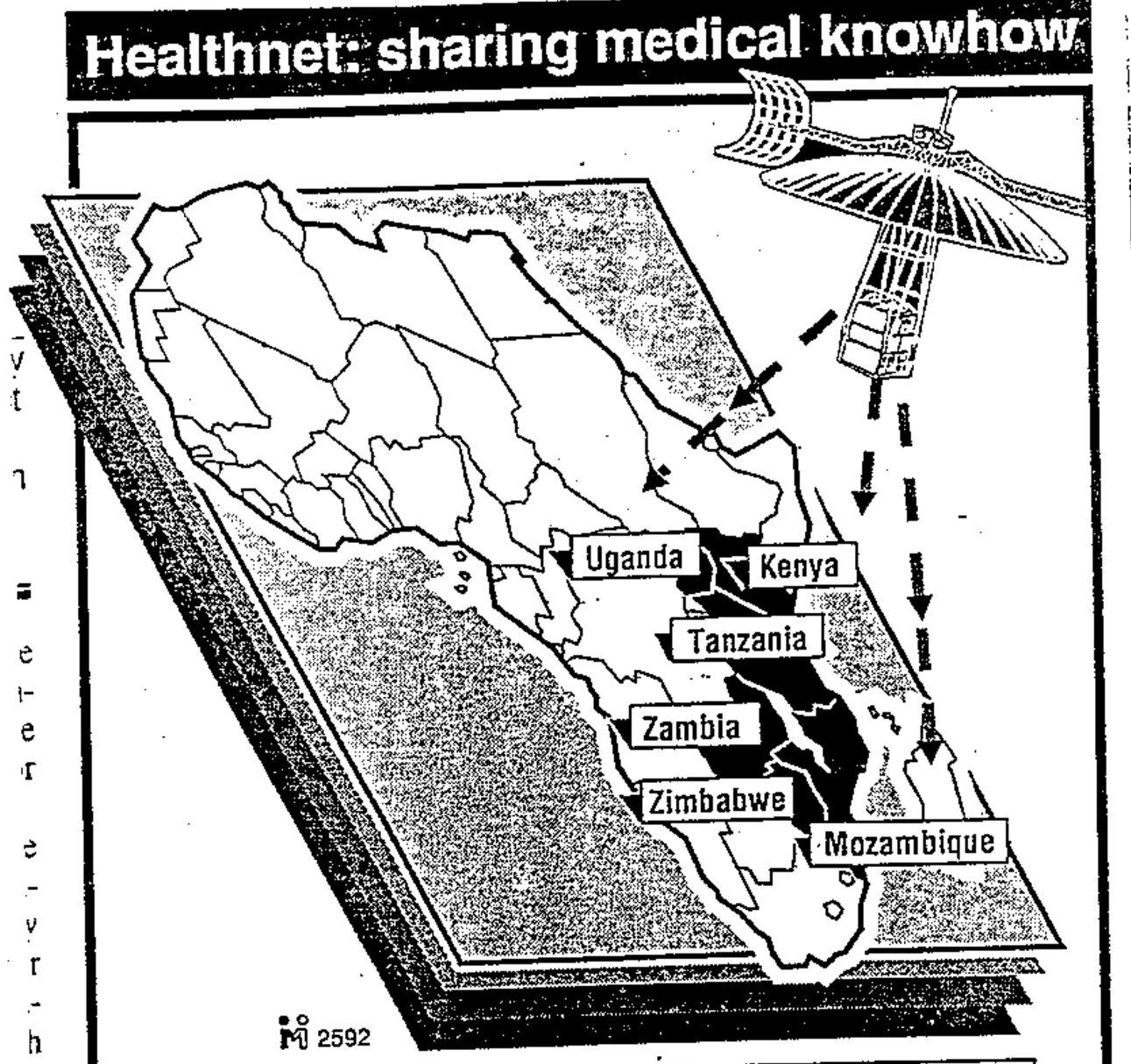
"Until now, HMOs providing full hospital services could only be established in one-industry towns," said Mr Leigh.

"Apart from these, no single company can establish an HMO for its employees.

"A company's employees live in widely-dispersed suburbs and HMOs must be situated where employees and their families live," he said.

According to Mr Leigh the answer is clear: Companies can establish multi-company HMOs by pooling the numbers of their employees living in the same residential areas.

According to Mr Leigh HMOs could reduce the cost of health by more than 40 percent when restrictive legislation is removed.



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Zambia	7.8m	7,150	1.2
Zimbabwe	9.5m	6,700	2.9
Tanzania	23.8m	26,200	1.2
Kenya	24m	9,970	1.7
Uganda	16.8m	21,900	0.2
Mozambique	15.3m	37,960	1.8

Source: Human Development Report, World Bank

Healthnet will help doctors in Africa share medical knowhow

Harare's a step ahead

w\Mail 24/4-29/4/92. (85)

By ANDREW MELDRUM: **Harare WHILE work is progressing to get the SatelLife's Healthnet system up and running throughout southern Africa, the University of Zimbabwe's medical library already has in place a computer system to retrieve information for staff and students at the Medical School, and a newsletter to bring rural hospitals and clinics up to date.**

"It's an amazingly quick, easy way of getting instant access to the current literature in the international health field," said Helga Patrikios, the medical library's director. "And then it is relatively easy to get that information out to our doctors and other health-care personnel in the rural areas."

Three microcomputer workstations have been funded by the Carnegie Corporation of New York to bring optical disc databases to Zimbabwe's health professionals — in particular Medline, the index to 3 500 biomedical journals. CD-ROM (Compact Disc Read-Only-Memory) is the medium — it combines enormous storage capacity (over 400 MB per disc) with user-friendly retrieval software. The world's most comprehensive biomedical database, Medline is stored on seven discs and updated every month.

According to Zimbabwean professionals the CD-ROM system is fully appropriate to the country's needs, indeed, appropriate for use throughout southern Africa and the developing world.

"More and more doctors, nurses and students are coming to us for literature searches," said Patrikios. "Last year we were doing about 120 searches a month — this year, with two extra work stations, it's up to about 190 or 200 a month. We're pleased that for the first time we can deliver really current information to our users."

One of the important spin-offs of the CD-ROM service is the news digest that is produced and sent to health workers throughout the country. Doctors choose articles from the monthly update discs that focus on the major health issues in Zimbabwe and the region. The digest, *Current health information Zimbabwe (CHIZ)*, is printed by the Zimbabwe Ministry of Health and is circulated to health professionals throughout Zimbabwe and to the World Health Organisation and Ministry of Health offices in neighbouring countries.

Beaming health to starved Africa

w/mail 24/4-29/4/92

For doctors in Africa it is prohibitively expensive to get details of the latest medical developments. Now a health satellite will beam information to Africa every month.

By **ALLAN THOMPSON**

A NEW health satellite project will help doctors and academics in southern Africa to get access to vital medical information and to communicate better with their counterparts in other developing countries.

Through the Healthnet satellite network, information from libraries, hospitals and universities in the industrialised countries will be beamed directly to medical research facilities and hospitals.

The lack of foreign exchange makes it often extraordinarily expensive to receive the latest medical information in countries like Zambia, Tanzania and Zimbabwe.

Because of limited resources, the University of Zambia was forced a decade ago to cancel its subscriptions to medical journals. In Tanzania, it can cost the equivalent of two-thirds of a week's salary for a doctor to send a fax message, and nearly as much to receive one. And telephone and mail services are often poor. In Uganda, where an estimated 24 percent of the population is HIV positive, current information about the Aids-causing virus is scarce.

Healthnet hopes to ease communication between doctors in Africa. Its organisers say innovative use of satellite technology will help them receive journal articles and communicate with medical centres around the world.

The Healthnet project was begun by SatelLife, a United States-based international non-profit agency. SatelLife was conceived by the International Physicians for the Prevention of Nuclear War, in a reaction to President Ronald Reagan's Strategic Defence Initiative, known as Star Wars. It got off the ground in 1989.

Last July, SatelLife's low-earth orbit satellite was launched to transmit information and receive messages from ground stations based at medical institutions in the developing world.

Said Julia Royall, deputy director of SatelLife: "The idea is to facilitate transmission of medical information in Third World countries, for doctors to enhance communication not only with each other, but with colleagues in the rest of the world."

The satellite, no bigger than a beachball, revolves around the earth at an 800km orbit twice a day. Initially, ground stations have been set up in six countries: Zambia, Tanzania, Uganda, Kenya, Zimbabwe and Mozambique. Each has an IBM-compatible computer, a type of ham radio and a modem to connect the computer and radio.

The satellite sends and receives messages using radio waves. Its continuous signal is picked up by the radio attached to the computer. Once the signal is recognised, a message transfer takes place at the ground station. The information can either be stored in the station's computer or printed out.

Doctors and academics will be able to make requests for specific information from libraries and university databases. Tanzania's station, for example, has established an information-sharing arrangement with Massachusetts General, John Hopkins Hospital and Massachusetts Library.

The satellite stays within range of each ground station for about 15 minutes, transmitting a page every second. It can deliver about 50 000 pages of electronic mail each month to Africa. Included in the transmissions will be literature from the *New England Journal of Medicine*, which is donating its articles for the project.

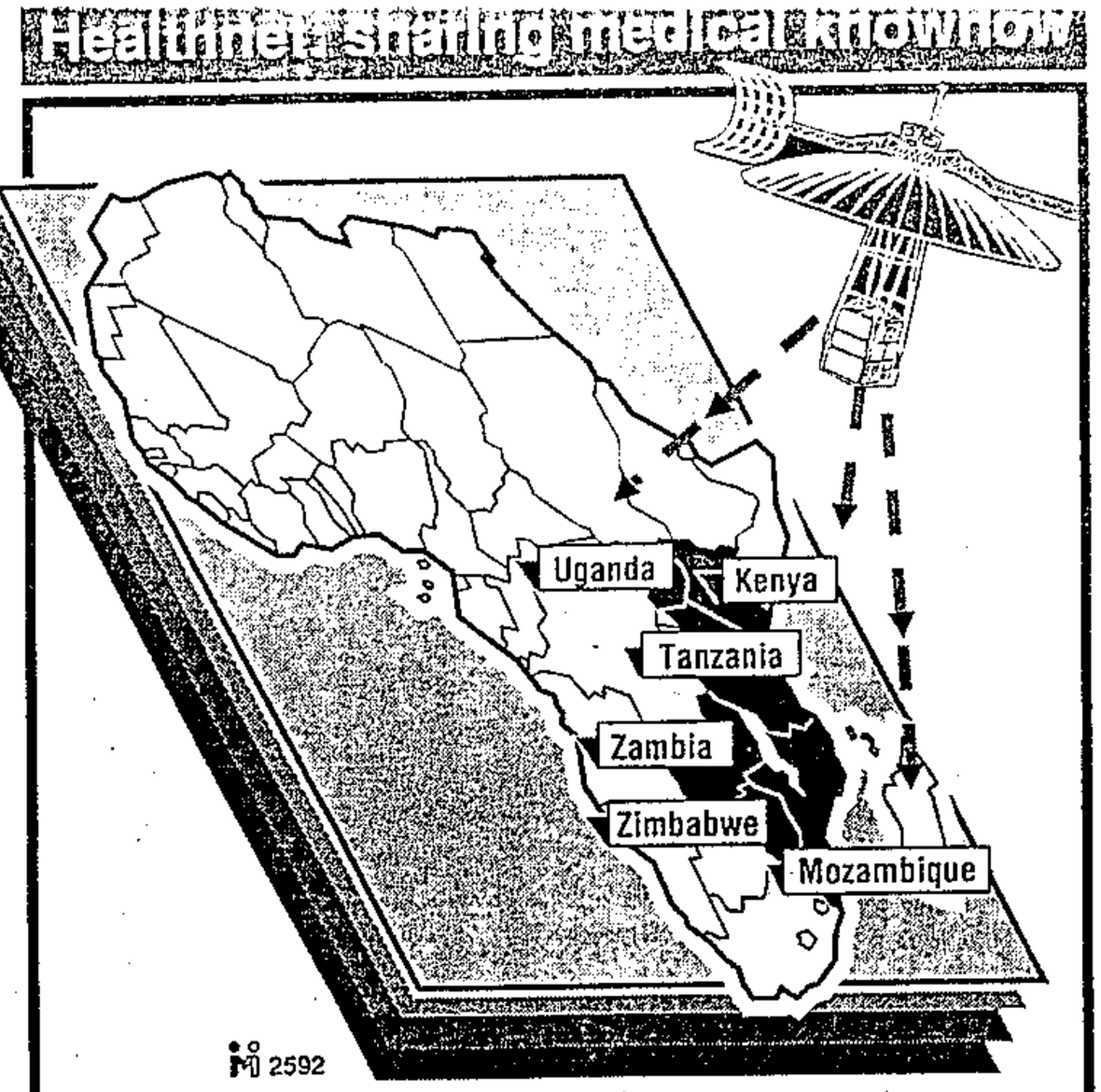
Organisers hope to set up stations in 15 African countries and, if successful, will expand the system to other parts of the world. Within each country, it is hoped the ground stations will act as a hub for the distribution of medical information by telephone or through special computer software.

The host countries must provide a secure location for the ground station and an operator to be trained to run the equipment. A user council is established in each country with representatives from a variety of medical and scientific organisations.

SatelLife does not own the satellite; it bought the operating capacity from Survey Satellite Technology, the British company that launched it into orbit.

The cost of the ground stations — about $7 500 each for the experimental stage — has been covered by such sources as the McArthur and Rockefeller foundations in the US. Canada's International Development Research Centre has helped by buying 10 percent of the satellite's air time. The operating capacity, a million-dollar item, has been funded by a grant from NEC Corporation, of Tokyo.

There have already been twinning arrangements between some libraries in Canada and Zambia, for example. And the Aids Network, a group established in east Africa to help spread information about the disease, will also be able to make use of the satellite. — Gemini News.



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Publicity shy . . . Siphiwe Nyanda, the sports writer turned guerilla leader, is the man most likely to succeed former MK chief of staff Chris Hani. Picture: Karen Fletcher

'Comrade Joe' set to lead MK

STAR 24/4/92

By Thabo Leshilo
Political Staff (84A)

South Africans can be forgiven for not knowing Siphiwe Nyanda, the man tipped to take over the reins from the fiery Chris Hani as Umkhonto we Sizwe chief of staff.

The acting MK chief simply hates the limelight.

Mr Nyanda (41) was asked by the ANC to fill the void after Mr Hani resigned three months ago to concentrate on his duties as general secretary of the SA Communist Party.

"I have neither the stomach, heart or desire to follow in his footsteps," Mr Nyanda told The Star yesterday.

"I just want to do my job," he added, stressing that addressing political rallies was not on his list of duties.

The father of two believes his jump to the top echelons of MK was fortuitious — he was not even on MK headquarters staff when he was chosen by the National Working Committee of the ANC to fill in for Mr Hani.

Mr Nyanda was a prolific sports writer on the World and an underground ANC activist before he left South Africa to join MK in 1976.

After receiving training in the Soviet Union and east Germany, he was MK commander for the Transvaal urban region from 1983 to 1987. During this time, his name featured frequently in terrorism trials.

Known by his MK name, "Tebogo Kgope", the elusive Mr Nyanda was responsible for coordinating the infiltration of MK guerillas as well as establishing arms caches and safe houses.

He would not be drawn into discussing the several missions he claimed to have carried out for the ANC. Legend, however, has credited him with such spectacular attacks as the Sasol bombing of 1981.

"General Gebuza", as his friends call him, was seconded to Operation Vula in 1988 — a key SACP project led by then-ANC president Oliver Tambo and designed to strengthen MK structures in South Africa.

Mr Nyanda attracted huge media interest as "Comrade Joe", leader of the alleged May 1990 SACP plot to overthrow the Government if constitutional negotiations failed.

He went underground, was arrested in Natal, but released after an agreement between the ANC and the Government.

Mr Nyanda speaks in glowing terms about the strength, training and ability of the ANC's guerilla army, and flatly denies that MK is disorganised, demoralised and needs upgrading.

"I am loath to use the word 'upgrade' when talking about MK because it implies that we're inferior to the SADF," he said. "The greatest challenge facing MK is to reorientate it from an irregular army to a conventional army — not to upgrade it," he said.

Consultants advise CPA on health service cuts

SI Times (Cape Metro)
26/4/92
85

By GLENDA NEVILL

THE Cape Provincial Administration has hired a private management consultancy company to advise on cutbacks and on streamlining health services.

This was disclosed by the deputy director general of Hopital and Health Services, Dr George Watermeyer, who said Byrne Fleming Consultants would make their recommendations next month.

He could not say where cutbacks would take place until their report had been studied.

But, he said, expensive and sophisticated services and medicines, as well as research laboratories, would have to cut back on their services as part of the CPA's cost-cutting measures — which are the result of several factors which have forced the CPA to rationalise.

These included an increasing demand for health services caused by accelerating urbanisation and a rapid growth of the population in the Cape, which has resulted in longer waiting lists for operations for state patients and longer queues of sick people in local hospitals' waiting rooms.

The CPA's Hospital and Health Services department began this financial year R130-million short of the funds required to maintain last year's levels as a result of further cutbacks in government allocations to provincial hospitals.

Earlier this week Mr Dawie le Roux, Member of the Executive Council in charge of hospital services, announced a 14 percent increase in hospital fees from May 1.

In February Mr Le Roux announced the outline for a rationalisation programme.

The CPA's programme was aimed at easing the load on academic hospitals and providing better health services in townships and outlying areas by changing the nature of services in certain hospitals.

This would include an extension of the operating hours of day hospitals and community health centres, arranging for a fleet of satellite and mobile clinics and making use of some hospitals which were underutilised in the past — resulting in an increased burden on teaching hospitals like Groote Schuur, the Red Cross Children's Hospital and Tygererg.

During a debate earlier this month, Mr Le Roux said that a large number of posts in the CPA's Health Services could be scrapped or frozen. His statement was greeted with outrage by medical authorities, who said these cuts would harm teaching and research and lead to lower health care standards.

Food for thought on labelling

THE question of compulsory and comprehensive food labelling needed examining, Health Minister Dr Rina Venter said.

She was replying yesterday in the debate on the Health vote to a call by Mrs Carole Charlewood (DP Umbilo) for legislation to enforce labelling on all food. (85) ARG 29/4/92

"I will certainly make recommendations to the task group that is looking at this at the moment," she said. — Sapa.

Ill health a luxury, warns Venter

CAPE TOWN — South Africans can no longer afford to be ill, Minister of Health Dr Rina Venter said in Parliament yesterday.

Introducing debate on the health budget vote, she said payments by medical aid schemes to private hospitals had risen by 55 percent between 1989 and 1990.

South Africans were among the highest claimants for health services in the world.

"The increase in payments exceeds the inflation rate by far. South Africans can no longer afford to become ill."

There would have to be a revision of the "established interests and consumer patterns" if the survival of the private sector in the health dispensation was to be ensured.

Dr Venter said she planned to table draft legislation this session to amend the Medical Schemes Act by increasing the power of medical schemes to manage their own affairs, and help them to develop cost-saving measures and counter malpractice effectively.

The Bill would set out a maximum medical aid tariff in benefit structures and ensure regular actuarial investigations for the funding of schemes. — Sapa.

SA's health 'duplication' slated

Political Staff

SOUTH AFRICA's 14 ministers of health and 18 health-delivering authorities had resulted in duplication, higher costs and a lack of co-ordination, the Deputy Minister of National Health, Mr Fanus Schoeman, said last night.

This complex structure had led to a multiplicity of divided responsibilities, he said at a function to mark the publication of the department's annual report.

This included the duplication of health services and resources, unco-ordinated delivery and development of health services, obstruction to management efficiency, higher organisational and administrative costs, a lack of uniform and appropriate management information systems, the creation of a variety of different co-ordinating structures and bodies, and disparities in the division and delivery of resources.

"The result of these deficiencies is that the health services are not accessible to everyone, the services are all the more unaffordable, equality in delivery cannot be meaningfully addressed, the effectiveness of the services is detrimentally affected and that existing health services are not generally accepted."

Mr Schoeman said the department had taken various initiatives to address these problem areas.

(85) CT 12/5/92

Health care to be decentralised

BIDay 12/5/92

LINDA ENSOR

CAPE TOWN — The creation of regional government with responsibility for health services in a circumscribed geographical area under a new constitution would form the foundation for the restructuring of health care in SA, Deputy National Health Minister Fanus Schoeman said last night.

"A single authority will be responsible for the delivery of specific health services within the borders of each of these geographical areas," Schoeman said at a Medical Research Council function following the tabling of the council's report in Parliament yesterday.

Schoeman said the referral of health functions to central, regional and local government levels was the principle departure point for the restructuring of health services which would be decentralised on a regional and not an ethnic basis.

Local authorities would be responsible mainly for primary health care services in their own areas.

A central health department will be involved mainly with national policy formulation, development of national strategies, setting of national norms and standards, national co-ordination and monitoring of service delivery.

Schoeman said the basic guidelines for the financing of a new health service should include the principles that:

☐ The health service which must be delivered and funded must be clearly described;

☐ Effective disincentives for excessive provision of services must be built into the system;

☐ The individual must remain responsible for the maintenance of his own health;

☐ Appropriate quality and cost control must be implemented;

☐ High technology services must be rationalised; and

☐ The option to purchase additional services must be maintained.

Sapa reports that Heath Minister Rina Venter told Parliament yesterday that all state hospitals would be made accessible to private patients in future as a first step toward deregulating the licensing of private hospitals. She said diagnostic centres would also be introduced at academic and regional hospitals to give private patients a "second opinion".

Government was convinced that the market for private hospital services had reached saturation point. The development of more facilities entailed higher costs for financiers and developers, which in turn were passed on to the consumer.

Medical group talks to WHO

A DELEGATION from SA's Medical Research Council has had discussions with the World Health Organisation's regional office in Brazzaville, Congo.

The meeting was the first since the suspension of SA's membership from the WHO in 1974.

The council's co-ordinator of community health research, Dr Derek Yach, said WHO membership was dependent on political developments in SA.

Yach said SA could make a significant contribution in the training of African medical practitioners and researchers.

SA could also provide its neighbours with laboratory facilities. — Sapa.

Unequal distribution of medical resources

85

STAR 14/5/92

Nearly three quarters of all South Africans rely on the State to pay for their health care and the majority of them suffer diseases associated with poverty and instability.

Some 2,3 million South Africans have been classed as "nutritionally vulnerable", but the bulk of South Africa's health budget and services is not directed at them.

Instead the unequal distribution of health care means a bias towards urban rather than rural areas and to diseases associated with industrialisation.

Although South Africa has an aggregate gross national product six to seven times that of China and Sri Lanka, life expectancy is only four-fifths that of these much poorer states.

And the growing incidence of Aids may lead to a "potentially catastrophic" diversion of resources away from the problem, health care professionals have warned.

A major study, "Changing Health in South Africa: Towards New Perspectives in Research" was published in South Africa recently.

Comprising interviews with 354 leaders in the health care field, it was conducted by the Medical Research Council under the leadership of Dr Derek Yach on behalf of the California-based Henry J Kaiser Family Foundation.

The report argues that state efforts to liberalise the system have merely "resulted in superimposing flawed policy-making structures on a fundamentally flawed system of health services."

The study, which is aimed at facilitating the restructuring of the country's health services, sketches a bleak scenario. South Africa combines the worst health consequences of industrialisation and poverty.

There is a high incidence of heart diseases and cancers, mainly among whites but also rapidly increasing among urban blacks, and endemic patterns of preventable diseases, particularly among rural and peri-urban blacks.

The authors point out that the lack of basic public health conditions such as adequate housing, safe water and sanitation are the major causes of ill health.

The study says problems include health policy decisions being made on a political basis and an emphasis on curative urban health care.

Ending the fragmentation of health services — there are 14 departments of health in South Africa — and forming a unitary health service is the first important step.

Fragmentation of health services is inefficient and wasteful.

And the report recommends a move towards community-based primary health care.

Industry grows at amazing rate

85

STAR 14/5/92

Health care is the fastest growing industry in the world and escalating costs go hand in hand with an aging population.

Secretary of the South African Day Clinic Association Carl Grillenberger says:

"Much of the problem is due to the new technology which has entered the health care arena over the past 15 years.

Technology is keeping people alive longer, but costs escalate.

"The present health-care cost hikes are felt particularly in South Africa where many people are faced with affording higher bills but their incomes remain static.

"There is also a strong shift into private-sector health care as the Government does not have the financial resources to fund new technology or, in many cases, replace existing equipment.

"Maintaining and upgrading services is essential in a good health-care service."

He believes that cost cutting is merely being given lip service and that there is a lack of effective action.

Surgery

He says the Government seems reluctant to make the necessary changes via the Amendment to the Medical Schemes Act of 1967 to allow free market principles to prevail.

He points out that in the USA almost 50 percent of surgery is carried out on an out-patient basis.

"I estimate that in South Africa only 10 percent of surgeries are on this basis. If this is changed there will be immediate cost savings.

"However, the medical aid societies are required to pay for any procedures which meet the rates published in the government gazette, regardless of whether there are more cost-effective ways.

"Therefore many procedures are carried out with hospitalisation that could be done far cheaper in a day clinic. If patients had to foot the additional costs themselves they would have an incentive to take the more cost effective route," says Grillenberger.

He argues that the Department of Health Services should also facilitate the granting of licences to day clinics as they tend to be around 40 percent cheaper than using a hospital and, in many instances, match the costs of provincial and government hospitals.

Politics dominates abortion issue

Backstreet ops cause for concern

HENRIËTTE GELDENHUYS
Staff Reporter

SAFE abortion on demand will probably not be a right in the new South Africa.

The main political parties, still dominated by men, either refuse to stick their necks out on the issue — or condemn abortion outright.

The ANC Women's League, regarded as one of the most progressive women's organisations, is not prepared to support the liberalisation of abortion laws.

They are "under pressure from our constituencies not to take sides" and "fear we will alienate the church women," says Western Cape ANC Women's League general secretary Ms Nomatyala Hangana.

Neither the African National Congress nor the Democratic Party have policies on abortion.

DP spokeswoman Ms Caroline Knott said abortion was a "highly emotive and religious issue" of which everybody had a personal view.

Asked what their policy was, the Inkatha Freedom Party's only response was that the issue "has not been discussed on central committee level".

The government opposes changes to present legislation and the Conservative Party believes abortion is a sin.

CP spokesman Mr Chris van der Heever said his party was Christian and nationalist and "absolutely against abortion".

The PAC believes the high occurence of backstreet abortions means legislation should be reviewed.

The PAC's secretary of health, Dr Saman Silva, said: "The PAC is concerned about the complications of backstreet abortions. The legislation should be replaced by new legislation that will have to reflect a balance between the moral value system of the historically indigenous people and the hard, clinical facts of backstreet abortions."

Dr Rina Venter, left, the Minister of Health, who does not intend introducing any new abortion legislation, and Mrs Adrienne Koch, right, NP President's Councillor, who says, in her personal capacity, that she supports abortion on demand.

But the PAC would make a policy decision only after "further discussion at branch level".

Azapo supported abortion on demand and criticised other political parties for their lack of interest in women's reproductive freedom.

The president of the Azapo women's organisation, Imbeleko, Ms Nobantu Nguenya, said: "Men must stop deciding for us. We have to come out in support of abortion. If we don't, we are not helping the very people we are trying to represent.

"Backstreet abortions and women struggling to cope with unwanted children affect the day-to-day lives of women. We cannot shy away from an issue which affects women directly," she said.

In private, many politicians support the liberalisation of abortion laws.

Even a National Party president's councillor, Mrs Adrienne Koch, said recently she supported the right of women to abortion on demand before the 10th week of pregnancy.

She was speaking in her private capacity during a University of Cape Town debate on abortion attended by about 600 students.

In parliament, the Minister of Health, Dr Rina Venter, said she did not intend submitting new legislation because public opinion was against it.

She said she did not know how many applications there were for legal abortions in 1991, but 981 were performed.

According to a 22-year-old UCT student who had an abortion at Groote Schuur Hospital in February, there were 30 women in the queue on H-floor of the outpatients department the day her application was the only one to be approved.

"I was lucky. I managed to prove that I was mentally sick enough," the woman said.

But it is estimated that nearly 250 000 women risk their lives in backstreet abortions annually — and an average of three black women die from them daily.

Those with enough money, mainly white and coloured women, have abortions in the United Kingdom.

A spokeswoman for the Leigham Clinic in Streatham, said at least one South African woman a week had an abortion at the clinic.

London gynaecologist Dr Sydney Alstadt said about 500 South African women have abortions in London annually.

Khayelitsha women to march on hospital

ANDREA WEISS, Health Reporter (35) ARG 15/5/92

WOMEN from the ANC are to march to the Khayelitsha Day Hospital today to demand better health services.

Doctors this week said the day hospital was in a crisis because of staff shortages, but the Cape Provincial Administration's regional health department has said the hospital "is maximally staffed for its size".

There are seven doctors at the hospital serving an estimated population of 700 000.

The CPA also said there was no space for more doctors and two more centres were being planned. But doctors have said that if one doctor is on leave the burden of work causes a crisis.

The ANC Women's League, which has organised the march and will hand over a memo addressed to Minister of Health Dr Rina Venter, said it was regularly sent complaints about "long queues, sordid conditions in which women have to give birth and the bad treatment they get from the staff.

Nazareth House	42	"
President Kruger Kinderhuis (Johannesburg)	91	"
President Kruger Kinderhuis (Pretoria)	63	"
Princess Alice Adoption Home	16	"
SAVF Kinderhuis	50	"
St George's Home	70	"
St Mary's Children's Home	60	"
Strathyre Girls' Home	60	"
The Guild Cottage	18	"
Villa Lubet Kinderdorp	220	"
Coloureds		
Cape Province:		
Annie Starck Village	60	29 April 1992
Habibia Children's Home	18	"
Boys' Town Macassar	60	"
Bruce Duncan House	70	"
Christine Revell Kinderhuis	49	"
Holy Cross Children's Home	120	"
Leliebloem House	72	"
Herberg Kamieskroon	100	"
Herberg Pofadder	132	"
RK Sending Kinderhuis Kamieskroon	74	"
GC Williams Children's Home	60	"
St Francis Home	60	"
Margarets House	10	"
St George's House	40	"
St Mary's Children's Home	40	"
The Homestead	24	"
James House	20	"
SOS Children's Village Port Elizabeth	120	"
Steinthal Kinderhuis	644	"
Heatherdale Children's Home	60	"
Patricks House	30	"
Moria Kinderhuis	40	"
Ons Plek	16	"
Kidshelter	15	"
Highway Home	12	"
Natal:		
Bethshan Children's Home	30	"
St Monica's Home	84	"
St Philomenas	80	"
St Theresa's Home	105	"
St Thomas' Home	60	"
Transvaal:		
St Joseph's Home	118	"
SOS Children's Village Johannesburg	160	"
St Nicolas Home	65	"
Asians		
Natal:		
Aryan Benevolent Home	102	"
Lakehaven	80	"
Motala Children's Home	15	"
Darul Yatam-maWal Maskaeen	66	"
Sunlit Gardens Children's Home	60	"
Boys' Town —Genazzano	55	"
Boys' Town —Verulam	10	"

Places of safety

246. Mr M J ELLIS asked the Minister of National Health:

(a) How many places of safety are there for each population group in each province of the Republic, (b) what are their names, (c) how many children can be accommodated in each and (d) in respect of what date is this information furnished?

B579E

The MINISTER OF NATIONAL HEALTH:

(a) and (b)	(c) and (d)	
Whites		
Transvaal:		
Norman House	85	29 January 1992
Tutela	90	"
Jubileum	75	"
Cape Province:		
Protea	50	"
Tenderden	60	"
Natal:		
Excelsior	78	"
Orange Free State:		
Monument	50	"

(a) and (b)	(c) and (d)	
Asians		
Natal:		
Greenfields	80	29 January 1992
Valley View	120	"
Blacks		
Transvaal:		
Tsosoloso	*200*	*30 May 1991*
Van Ryn Deep	*140*	"
Cape Province:		
Nomzamo	20	"
Siyakathala	140	"
Koelenhof	115	"
Galeshewe	100	"
Lorato	100	"
Enkuselweni	100	"
Siyalinga	100	"
Natal:		
Pata	100	"
Bayhead	370	"
Orange Free State:		
Tshirelesong	160	"

(a) and (b)	(c) and (d)	
Coloureds		
Transvaal:		
Witwatersrand	65	30 April 1992
Cape Province:		
Bonnytown	200	"
Vredelus	90	"
Rosendal	80	"
Erica	100	"
Nerina	50	"
Mimosa	80	"
Outenikwa	100	
Natal:		
Oceanview	75	"

Positions occupied in top five post levels

258. Mr M J ELLIS asked the Minister of National health:

(a) How many persons from each race groups occupy positions in the top five post levels of the Department of National Health and Population Development and (b) in respect of what date is this information furnished?

85 B617E

The MINISTER OF NATIONAL HEALTH:

(a)

Top five post levels	*Population Group* *White*	*Indian*
Director-General	1	—
Deputy-Director-General	2	—
Third post level e.g. Chief Director	16	—
Fourth post level e.g. Director	26	—
Fifth post level e.g. Deputy Director	73	1

(b) 4 May 1992.

***Per capita* allocation of health funds**

259. Mr M J ELLIS asked the Minister of National Health: (85)

What was the *per capita* allocation of health funds in each of the four geographical regions of the Republic for the (a) 1991-92 and (b) 1992-93 financial years?

B619E

cont-d

The MINISTER OF NATIONAL HEALTH:

(a) Cape Province: R355 *per capita*
Orange Free State: R246 *per capita*
Transvaal: R217 *per capita*
Natal: R191 *per capita*

(Department of National Health and Population Development's allocation has not been included in these figures.)

(85)

(b) Cape Province: R395 *per capita*
Orange Free State: R277 *per capita*
Transvaal: R250 *per capita*
Natal: R23 *per capita*

(Department of National Health and Population Development's allocation has not been included in these figures.)

INTERPELLATIONS UNDER NAME OF MEMBER

Botha, Dr W J—
General Affairs:
Finance, 841

Burrows, Mr R M—
Own Affairs:
Education and Culture, 185, 436, 1004

Carlisle, Mr R V—
General Affairs:
Public Enterprises, 917
Transport, 848
Own Affairs:
Housing and Works, 619

De Beer, Dr Z J—
General Affairs:
State President, 981

Ebrahim, Mrs R—
Own Affairs:
Housing and Agriculture, 1021

Gerber, Mr A—
Own Affairs:
Education and Culture, 291, 537

Gibson, Mr D H M—
Own Affairs:
Education and Culture, 864

Haswell, Mr R F—
General Affairs:
Law and Order, 272
Local Government and National Housing, 527

Hoon, Mr J H—
General Affairs:
National Education, 911

Jacobs, Adv S C—
General Affairs:
Home Affairs, 725

Langley, Mr T—
General Affairs:
National Intelligence Service, 1

Leon, Mr A J—
General Affairs:
Law and Order, 129
Transport, 732

Le Roux, Mr F J—
General Affairs:
Foreign Affairs, 123

Momberg, Mr J H—
General Affairs:
Mineral and Energy Affairs, 7
National Education, 611

Padiachey, Mr D K—
Own Affairs:
Housing and Agriculture, 951

Paulus, Mr P J—
General Affairs:
National Health, 267

(85) ARCT 16/5/92

On the march for improved service

SEVERAL hundred ANC women from the organisation's Khayelitsha branch braved the rain to march to the local day hospital to demand a better health service in the area.

On hand to receive a memo addressed to Health Minister Dr Rina Venter were Dr Arthur Rosenberg, Cape Provincial Administration medical supervisor for black day hospitals, and Dr Jocelyn Kane-Berman, medical supervisor of Groote Schuur Hospital, who said she hoped a joint committee of ANC women and hospital personnel could be formed to address the problems "within the financial constraints" that existed.

demanding better treatment at the day hospital

WHO's Health for all thwarted by poverty

South 16/5 - 21/5/92

WORLD Health Organization (WHO) campaign to guarantee basic health care for everyone by the year 2000 is being thwarted by poverty, an African official said.

Botswana's health minister, Mr Bahiti K Temane, said the target "has become unattainable in many parts of the world — definitely in Africa" because Aids is spreading and the gap between rich and poor countries is widening.

In 1978 member states of WHO, a UN agency, set themselves the goal to promote "Health for All by the Year 2000". It includes ideas like providing safe water, immunization against childhood diseases and enough nutrition for mothers and children.

"There is no way the poverty in Africa can be eliminated in eight years," Temane told WHO's annual assembly recently. "Furthermore, Aids will reverse even the little achievements that had been attained to date."

Future efforts to widen health care "will founder ... as long as the rich nations are getting richer and the poor nations are getting poorer," Temane told a nearly empty meeting hall.

He asked rich countries to provide technology and help market reforms through investments.

WHO delegates are reviewing the global health programme, the framework for much of the agency's current work.

An example of how poverty overrides medical progress is cited in a WHO report to the meeting.

Treatments exist for diarrhoeal diseases like cholera — a major child killer — but little progress can be expected if people return to live in germ-infested conditions, it says.

While people are living longer everywhere, "improvements in life expectancy do not necessarily mean a healthier life," the report says.

Many scourges — cancer, cardiovascular disease, tropical sicknesses and the deadly immune system destroyer Aids - are spreading in the Third World, it says.

It admits "the expectations of health for all by the year 2000 will not be realized in most countries".

Since the end of the Cold War, developing countries have worried that western aid — already tight in an economic recession — will shift to rebuilding eastern Europe and the former Soviet Union.

Temane said "euphoria has now cleared" after the wave of democracy in eastern Europe and signs of economic hope for Africa that ended the 1980s.

Botswana, with close economic links to neighboring South Africa, is one of Africa's richer countries. — **Sapa-AP**

Health funds higher in Cape

Political Staff 85

HEALTH fund allocations in the Cape over the past two financial years were higher per capita than in the other provinces, the Minister of National Health, Dr Rina Venter, said yesterday. CT 16/5/92

During 1992/3, R395 per capita had been allocated in the Cape, R277 in the Free State, R250 in the Transvaal and R223 in Natal.

5 young lives saved each minute

70% of children now vaccinated

(85) ARG 20/5/92

ANDREA WEISS
Health Reporter

MORE than 70 percent of the world's children under a year old are now vaccinated against preventable diseases, according to a visiting international pharmaceutical expert.

Professor Patrick D'Arcy OBE told 250 delegates at a Pharmaceutical Society of South Africa conference in Somerset West that he attributed the improvement to a drive by the World Health Organisation that began in 1974.

Vaccination throughout the world in 1990 reached 72 percent for diptheria, pertussis and tetanus, 81 percent for TB and 68 percent for measles.

This effectively saved five young lives every minute of every day from the ravages of these killer diseases, and prevented about 2,6 million cases a year.

The WHO was intent on eradicating polio by 2000, and reducing measles by 90 percent and eliminating neonatal tetanus by 1995.

He said there had also been developments in the battle against hepatitis B. There were an estimated 2 000 million people infected with the virus, 350 million of whom were chronically infected carriers and at high risk of death from cirrhosis and primary liver cancer.

The WHO now recommended routine infant vaccination in countries where more than 8 percent of the population carried hepatitis B. The cost of the hepatitis B vaccine had dropped to about R5,20 a dose.

Professor D'Arcy said that apart from Aids, the biggest killers in the world were diarrhoea, tropical diseases such as malaria, acute respiratory infections, tuberculosis and cancer.

● Mr Reg Magennis, Medical Association of South Africa director on health policy, told the congress medical aid schemes were facing a financial crisis.

The annual increase in benefits paid out between 1975 and 1990 had risen about 25 percent.

During this time, medicine prices rose about tenfold, compared with an eigthtfold consumer price index rise.

The volume of medicine consumed rose 16 percent between 1975 and 1982, but dropped to below 1975 levels in 1991, indicating a growing resistance to price increases.

The higher percentage of pensioners claiming from medical aid societies was beginning to burden active members. Estimates showed that active members were contributing up to 19 percent more to cross-subsidise pensioners.

know that the function of paying out pensions to Whites, does not fall within my sphere of responsibility. Dragging Whites into this is therefore totally irrelevant.

Furthermore I want to tell the hon member that between R14 million and R18 million have been saved and recovered during the past few months because it has been established by way of proper control that payouts had been made within and across the borders and that people had been receiving pensions in two places. [Interjections.]

It is the CP's policy which causes these problems. [Interjections.] Owing to the failed homeland policy people receive pensions in the Transkei, Ciskei, Venda and Bophuthatswana, and after they have claimed their pensions over there, they claim pensions here as well. We have identified this problem and that is why we are busy centralising these matters as well.

†The most valuable contribution from the DP came by way of an interjection from the hon member for Bryanston when he said this was a disgrace. I wish to say to that hon member that that comment actually highlights the predicament we are faced with.

We are dealing with old people, people who should be treated with compassion. I have had several discussions with various Directors-General, and I wish to assure him that, first of all, there is no malice on the part of any of the officials involved on that level and secondly, that that does not mean that we condone negligence, if there was negligence. I want to give the hon member the assurance that the various administrations dealing with this are training the officials who are dealing with this aspect at the communication centres. They want to address this particular problem. [Time expired.]

Mr B B GOODALL: Mr Speaker, the social old-age and the disability pensions are of critical importance, both to the individual who receives them and to the community. If one looks at an area such as Gazankulu one will find it estimated that half of the people who receive a regular income receive it from pensions.

We know that in rural Zululand 32% of household income comes from pensions. Therefore the delivery system is of critical importance. In South Africa we have two delivery systems. The one works relatively well for the urban area or more sophisticated element of the population. But for the rural segment of our population the delivery system is not working. South Africa's problem is similar to that of many other developing countries.

The World Bank made recommendations with regard to input, saying that one ought to improve the social service delivery system, have better targeting of services, more co-ordination between the various agencies involved, more involvement of the poor and more use of non-governmental agencies. It seems to me that that is where the solution lies.

The solution is to use the very sophisticated financial structure that South Africa has, and we need to give them an incentive to do that. We have to pay them. It is better to pay them than to build up the bureaucracy. However, we also have to give another incentive. We have to give an incentive to the people who receive the pensions to encourage them to use that financial services sector.

In other words, one needs a two-tier social old-age pension. I think we have every right to do that, because that money comes from the taxpayers of South Africa and they have the right to know that the people who need the money are receiving it in the cheapest and most efficient manner possible.

Mrs C H CHARLEWOOD: Mr Speaker, it is also vital for all pensions and grants that were cancelled through this recent bungling to be restored immediately—plus arrears, plus interest.

All those currently in receipt of old-age pensions should continue to receive them, irrespective of the birth date shown on their IDs. They should not be penalised for the errors made by bureaucracy in the past.

Future review dates should be staggered and the pensioners informed clearly and timeously as to what they need to do by local officials who have been adequately trained.

The system should contain provision for permanent disabilities that do not require review—those that are obviously incurable—and only classify for review those conditions that can be cured. The district surgeons at present cannot

cope with the demand. Their offices are being flooded. Appointments are being made months ahead for people. How are they to survive in those months until a new medical certificate has been submitted and the paperwork processed? [Time expired.]

The MINISTER OF LOCAL GOVERNMENT AND NATIONAL HOUSING: Mr Speaker, I want to compliment the DP. They are working as a team. The one member came down hard on the problem and the other member came down hard on the solution. I want to thank the hon member for Edenvale who made a valuable contribution. I think the points he raised related to some of the sentiments I expressed, and I believe they are worth looking at in my future deliberations with the Provincial Administration. I want to thank him for that.

I want to put the hon member for Umbilo's mind to rest. We are aware of the magnitude of the problem. We know the problem ought to be addressed. Furthermore, I want to tell that hon member that we were threatened with legal action by the Legal Resource Centre in the Transvaal in particular. We said that instead of having an argument in court, we should discuss the matter and solve it amicably amongst ourselves. What we did was to solve each and every case they had registered and cited peacefully out of court so that each was settled to the satisfaction of the Legal Resource Centre.

As far as I am aware, the Administrations do have the open-mindedness to install toll-free telephone numbers, etc. They have exactly that in mind.

I want to thank hon members for this debate, but I must add that it would be grossly unfair to imply that the Provincial Administrations are dealing with this matter in an insensitive manner. Although the results were devastating to those old people and therefore do create that impression, I can assure each and every hon member that people in the highest echelons of the Provincial Administrations want to deal with this matter with compassion.

Debate concluded.

QUESTIONS

†Indicates translated version.

For oral reply:

General Affairs:

Additional allocation for health care services: Natal

*1. Mr M J ELLIS asked the Minister of National Health:

(1) Whether an additional allocation of approximately R50 million was made available to the province of Natal for health care services in a previous financial year; if so, when;

(2) whether a similar allocation is to be made available to this province in the current financial year; if not, why not; if so, (a) what will be the amount of this allocation and (b) when is it expected to be made available?

B507F

The MINISTER OF NATIONAL HEALTH:

(1) Yes, on 20 November 1990;

(2) no, the above-mentioned allocation was not recurrent. Recurrent expenditure must be funded out of the annual allocated amount.

Document on financing of education: local authorities

*2. Mr A GERBER asked the Minister of Local Government and National Housing:†

(1) Whether the Co-ordinating Council for Local Government or any person in his Department has drawn up a document containing proposals for the financing of education by local authorities; if so, (a) by whom and (b) when was this document drawn up;

(2) whether he will make the document available to members of Parliament; if not, why not; if so, what are the main recommendations;

(3) whether he will make a statement on the matter?

B600F

Silence on water 'to avoid panic'

CT 22/5/92

85

By GLYNNIS UNDERHILL

THE city council kept quiet about the leakage of an excessive quantity of chlorine into the Cape Town water supply this week to avoid panic, Mayor Mr Frank van der Velde said yesterday.

The overchlorinated water, piped into homes on the Cape Flats and in the southern suburbs, had resulted in a few complaints of mild diarrhoea but no hospital cases.

Acting city engineer Mr Henk Beekman said yesterday that the water supply was back to normal.

The overchlorination was detected on Tuesday night when Cape Flats residents complained of a burning sensation after drinking water.

Mr Salie Hendricks of Mitchells Plain unwittingly changed the water in his fish pond on Wednesday afternoon. By yesterday morning all his Koi and goldfish were dead.

"I wouldn't have changed the water if I had been warned about the problem," he said.

Mr Van der Velde said the council had allowed overchlorinated water run to waste from mains in affected areas.

Mr Beekman said the council had received 200 complaints on Tuesday, 150 on Wednesday and only a handful yesterday. Samples taken at some homes fell within the chlorine limit of up to 0,5 milligrams a litre — but others had shown more than 3,0 milligrams a litre.

The Medical Officer of Health, Dr Michael Popkiss, said that on Wednesday the chlorine level was 10 times normal in places. This level caused irritation but was not dangerous.

"It could cause a burning sensation in the mouth and on the lips and could cause vomiting in babies," he said.

Mr Beekman said the water problem had not been caused by human error.

A chlorinator pipe had leaked into water at the Blackheath water treatment plant, and the "plug" of water with a high concentration of chlorine had been distributed to other water pipes.

The council was now inserting further sampling points along the pipeline to give an "early warning".

'Rushed' medical Bill stirs up controversy

ANDREA WEISS
Health Reporter

A STORM is brewing between the medical establishment and Health Minister Dr Rina Venter over the "last-minute" tabling of the Medical Schemes Amendment Bill in parliament this week.

The Bill, which was printed for comment in the Government Gazette last year, makes sweeping changes to the system of medical schemes and seeks to address some of the abuses of the past, according to the government.

It is understood that Dr Venter wants to have the Bill approved by parliament by the end of this session, probably towards the end of June.

But the Medical Association of South Africa (Masa) and the DP spokesman for health, Mr Mike Ellis, have warned against "rubber stamping" of the Bill without proper consideration.

Mr Ellis said the Bill was obviously "highly contentious" as it was the piece of legislation that had led Masa to call for Dr Venter's resignation last year.

Dr Bernard Mandell, chairman of Masa's Federal Council, said Masa was "deeply perturbed by the tabling of a Bill which may have far-reaching implications on access to health care in the 11th hour of the current parliamentary session".

He said Masa understood the need for a review on deregulation of the health insurance system.

But it regarded it as "totally unreasonable" to expect the joint committee to consider the amendments before the end of this session. It took the Department of Health almost six months to review comments on the draft legislation.

Dr Mandell said the Parliamentary Joint Committee on Health should not be pressurised into having to "rubber stamp legislation".

The Bill proposes sweeping changes to medical aids, including making membership of the Representative Association of Medical Schemes (Rams) compulsory. Provision is also made for Rams to act as a corporate body.

This move was criticised by Masa last year as giving "monopolistic power" to Rams without protecting patients.

Other provisions in the Bill include:

☐ Repealing the statutory requirement for a scale of benefits to be published in the Government Gazette, giving Rams the right to recommend scales of benefits;

☐ Allowing married women to become members of medical aid schemes in their own right. Either spouse would be allowed to be a member of the medical scheme or a dependent;

☐ Providing for regular actuarial checks of medical aid schemes to ensure they are financially buoyant; and

mother, Miss Bie ok, of
rville, who was una re that she
give birth to twin
fusion of the babies re, but
s are hopeful that e dicate
ion will be successl.
uled teams of surgon from
berg and the Red ros Chil-

...ate on them. We need to use procedures to stretch the skin to give us enough skin to cover the defects," he said.

Doctors and nursing staff say the babies have each developed their own personalities and say that Catherine smiled for the first time yesterday.

TINY TOTS . . . Siamese twin and Helena.

Battery acid 'used as cure'

(85) CT 23/5/92

SOMERSET WEST. — Many residents of Katlehong, near Germiston, use battery acid, dog excrement and floor polish to treat open wounds, a pharmaceutical researcher, Ms Herlinde van der Walt, told delegates at the national congress of the Academy of Pharmaceutical Science here yesterday.

Her research had also shown that 42% of Katlehong residents perceived witchcraft as a source of illness and that many still relied on traditional healers and medicines.

Ms Van der Walt was reporting on her study of self-medication by residents in the township.

While 80% of respondents recognised "germs" as the main source of illness, five percent also attributed ill-health to not attending the funeral of a relative.

"For ailments such as headaches self-medication was adequate. But there is a disturbing general lack of knowledge of disease medication and causes of illnesses. Only two percent of respondents, for example, thought disease could be sexually transmitted," Ms Van der Walt said. — Sapa

HONOUR . . . US First Lady Mrs Barbara Bush is hooded with an honorary Doctorate of Humane Letters on Thursday from Louisiana University

Café burglary

Sentence date set

AID TO VENDA (Continued)

	1986/87 R	1987/88 R	1988/89 R	1989/90 R	1990/91 R	1991/92 R
D. Technical and other assistance						
Manpower provision	9 307 295	9 254 836	11 551 110	14 549 855	10 964 806	19 081 000
Flour subsidy	1 861 605	2 033 652	1 762 451	1 130 893	921 744	—
Technical assistance	641 579	1 080 985	928 541	545 222	197 296	2 083 820
Salaries of judges	196 801	162 659	191 541	401 041	204 729	398 000
TOTAL	12 007 290	12 532 132	14 433 643	16 627 011	12 288 575	21 562 820
GRAND TOTAL	256 053 964	331 413 872	428 311 714	508 117 017	591 822 288	743 749 774

1) Actual figures
2) Estimates

NOTE: Transfer payments in respect of customs union share and common monetary area appear on the budget vote of the Department of Finance.

AID TO CISKEI

	1986/87 R	1987/88 R	1988/89 R	1989/90 R	1990/91 R	1991/92 R
A. Direct financial assistance						
Budgetary aid	221 789 034	301 692 499	384 930 928	440 033 134	561 934 117	708 431 700
Incentive scheme for industries	29 871 423	23 516 112	31 310 570	16 098 888	35 324 135	28 371 959
Non-recoverable financial assistance	603 262	—	99 278	—	—	201 308
Relief of distress	—	—	—	—	—	—
Job creation	14 770 105	10 830 000	6 457 660	4 995 317	—	—
TOTAL	267 033 824	336 038 611	422 798 436	461 127 339	597 258 252	737 004 967
B. Transfer payments						
Tax compensation	24 386 346	24 563 000	33 141 862	40 523 332	53 000 000	64 886 000
Customs union	107 291 000	156 117 000	180 489 000	221 776 000	265 989 000	265 989 000
Common monetary area	2 999 893	3 702 400	4 794 133	6 561 400	7 993 440	9 869 600
TOTAL	134 677 239	184 382 400	218 424 995	268 860 732	326 982 440	340 744 600
C. Loans from RSA (Project aid)	7 638 332	7 585 000	11 544 730	20 359 114	11 649 000	9 323 272
D. Technical and other assistance						
Manpower provision	9 697 851	24 758 130	17 570 022	17 122 280	13 786 329	22 998 000
Flour subsidy	611 092	498 723	454 278	322 036	117 755	—
Technical assistance	243 572	305 377	432 276	573 049	473 421	3 715 448
Salaries of judges	214 424	232 754	345 508	726 976	382 505	790 000
TOTAL	10 766 739	25 794 984	18 802 184	18 734 341	14 760 010	27 503 448
GRAND TOTAL	420 116 134	553 800 000	671 570 345	769 081 526	950 649 702	1 114 576 287

1) Actual figures
2) Estimates

NOTE: Transfer payments in respect of customs union share and common monetary area appear on the budget vote of the Department of Finance.

SA Medical and Dental Council: disciplinary cases

265. Mr L F STOFBERG asked the Minister of National Health:† (85)

(1) Whether members of the South African Medical and Dental Council are required in considering disciplinary action to adjudicate on colleagues who are or have been involved in suspected irregularities; if so,

(2) whether any of these members have the necessary legal knowledge and experience to perform such a task; if so, what are the relevant details;

(3) whether consideration is being given to having disciplinary cases of this nature heard by magistrates or judges in courts; if not, why not;

(4) whether she will make a statement on the matter?

B630E

The MINISTER OF NATIONAL HEALTH:

(1) No, it is required of members of the South African Medical and Dental Council, in the consideration of disciplinary action, to pronounce judgement on the professional acceptability of the conduct of colleagues involved in suspected irregularities;

(2) falls away;

(3) no, because the South African Medical and Dental Council, as constituted, was established to perform this function. Disciplinary cases of the South African Medical and Dental Council are not criminal or civil cases which are judged in the courts and require the knowledge and experience of the ethical norms of the medical and dental professions, which the members of the Council possess. The Supreme Court has referred to the South African Medical and Dental Council as the body, *par excellence*, to take decisions on disciplinary cases. Every colleague has the right to take decisions of the Council on revision to the Supreme Court which will ensure that such a person is not wronged by a possible legal error on the part of the Council; (85)

(4) no.

Own Affairs:

Social old-age pensioners: amount of pension

68. Mr L FUCHS asked the Minister of Health Services and Welfare:

(1) What was the amount of the pension received by a social old-age pensioner (a) during the 1991-92 financial year and (b) as at the latest specified date in the current financial year;

(2) whether this pension is to be increased in the current financial year; if not, why not; if so, (a) when and (b) by how much;

(3) whether the amounts paid monthly to pensioners are in step with the rise in the rate of inflation; if not, what is the rate of growth of the amounts paid monthly to pensioners?

B659E

The MINISTER OF HEALTH SERVICES AND WELFARE:

(1) (a) 1 April 1991 to 30 September 1991 = R304 pm
1 October 1991 to 31 March 1992 = R314 pm

(b) R345 per month.

(2) Yes.

(a) Pensions have been increased as from 1 April 1992.

(b) R31 per month.

(3) No.
Pensions have been increased by 10% as from 1 April 1992.

Chlorine water scare is over

CT 25/5/92

Staff Reporter

The chlorinated municipal water scare is over, says deputy city engineer Mr Henk Beekman.

He said tests taken on Friday had shown that the water was back to normal chlorination levels. The problem began when a chlorinator pipe leaked last Tuesday (~~215~~) (85)

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Total number of children in children's homes

239. Mr M J ELLIS asked the Minister of National Health:

(1) (a) What total number of children of each population group (i) can be and (ii) is accommodated in children's homes in the Republic and (b) in respect of what date is this information furnished;

(2) whether capitation grants are paid annually in respect of children residing in such homes; if not, why not; if so, (a) by whom and (b) what capitation grants in respect of each population group? B552E

The MINISTER OF NATIONAL HEALTH:

(1)(a)	(i)	(ii)	(b)
Blacks	1 639	1 459	31 March 1992
Whites	6 449	5 234	31 October 1991
Coloureds	2 648	2 229	1 April 1992
Asians	403	378	29 April 1992

(2) no, capitation grants are paid monthly/quarterly in respect of every child committed to a children's home in terms of the Child Care Act, 1983 (Act 74 of 1983),

(a) by the welfare departments of the Administrations: House of Assembly, House of Delegates and House of Representatives as well as by the four provincial administrations and

(b) *Blacks:*
R378 per child per month.

Whites:
R639,80 per child per month.

Coloureds:
R564 per child per month.

Asians:
R976,61 per child per quarter.

The reaching of parity is planned for 1 August 1992 with effect from 1 April 1992.

Aids programme: total amount budgeted

268. Mr M J ELLIS asked the Minister of National Health:

What total amount (a) was budgeted for her Department's Aids programme for the 1991-92 financial year and (b) was spent by her Department on this programme during the said financial year? B655E

The MINISTER OF NATIONAL HEALTH:

(a) R12 928 000 and

(b) R10 264 000

This is not the final expenditure as certain adjustments may still occur prior to the closure of the Department's books ± end of June 1992.

Professional forum on health services

269. Mr M J ELLIS asked the Minister of National Health:

(1) What are the names of the 40 professional associations participating in the professional forum on health services to which she referred in a speech on 27 March 1992;

(2) whether there are any professional bodies which are not participating in the forum; if so, what are their (a) names and (b) reasons for not participating;

(3) (a) what are the names of the three representatives appointed by the forum to serve on the committee that determines policy and (b) what is the (i) name and (ii) function of this committee;

(4) whether there are similar structures for non-professional bodies to advise the Minister on policy issues; if so, (a) what are these structures called and (b) what are the names of the representatives serving on them;

(5) whether the professional forum (a) is obliged to consult or (b) does consult such non-professional bodies before making a recommendation? B656E

The MINISTER OF NATIONAL HEALTH:

(1) The names of the professional associations who established a liaison forum are the following:

The Dental Association of South Africa
The Pharmaceutical Society of South Africa
The Chiropractic Association of South Africa
The Medical Association of South Africa
The Psychological Association of South Africa
The South African Association of Occupational Therapists
The South African Homeopathic Association
The South African Association of Hospital and Institutional Pharmacists
The South African Association of Radiographers
The South African Nursing Association
The Social Workers Association of South Africa
The Health Officials Association of South Africa
The South African Society of Physiotherapy
The South African Society of Medical Laboratory Technologists
The Association for Dietetics in Southern Africa
The South African Speech-Hearing-Language Association Health Unity Forum
The Association of Ambulance and Emergency Care Personnel (SA)
The South African Association of Medical Scientists
The South African Society of Clinical Technologists
The South African Dental Laboratory Association
The South African Association of Oral Hygienists
The South African Registered Optical Dispensers Association
The South African Optometric Association
The Orthotics and Prosthetics Association of South Africa
The South African Podiatry Association
The South African Association of Biokinetics
The Society of Dispensing Family Practitioners
The Academy of Family Practitioners;

(2) yes,

(a) their names are unknown and

(b) the liaison forum determines its own criteria for membership;

(3) (a) Mr R Magennis
Dr A Bruwer
Professor M Concha and

(b) (i) Executive Committee and

(ii) handling of day to day issues and the preparation for meetings. Attending scheduled meetings of the Health Matters Committee unless the liaison forum decides otherwise;

(4) no;

(5) (a) no, the liaison forum decides for itself

(b) no.

HEALTH CARE INDUSTRY

Taking a scalpel to high prices

Health Minister Rina Venter finally appears to have realised that she will never be able to appease the vested interests in the healthcare industry as she tries to halt spiralling medical costs for the public.

Certainly, introducing the Medical Schemes Amendment Bill in parliament last week, despite continued strong opposition from the Medical Association of SA, shows a resolve few of her critics could have anticipated. With only a month to go before parliament closes, Venter seems determined to deregulate the industry. Her proposed changes will give medical schemes more scope to keep costs in check and halt doctors' sole discretion in dispensing health care.

If passed, the Bill will put an end to guaranteed payments and scales of benefits. It will allow schemes to provide healthcare services, by running hospitals and clinics and employing doctors, nurses and pharmacists, a move that has lowered costs by as much as 40% elsewhere in the world.

In cutting medicine costs, the Minister's resolve to deregulate the pharmaceutical industry will have to be just as unflinching. SA drug prices are among the world's highest.

Last week's annual conference of the Pharmaceutical Society of SA showed little initiative in addressing the costs issue. The debate merely depicted an industry wracked with internal tensions and lacking direction. While retailers, wholesalers and manufacturers battled to define their roles in the industry's apparent identity crisis, little consensus was reached on containing spiralling medicine costs.

The industry is not short of suggestions. Several recommendations — based on the findings of the Browne Commission and believed to contain many of the recommendations of the uncompleted Wim de Villiers report — were canvassed earlier this year at a forum convened by the Minister.

Generic substitution, ending the ban on imports of medicines that could compete with locally made ones, pharmacist-initiated therapy, rescheduling some medicines so that you would not need prescriptions to get them, and allowing other retailers to compete with pharmacies are all proven cost-cutting mechanisms that have dropped medicine prices in other countries. But vested interests — mostly doctors and drug manufacturers — continue to prevent their being implemented in SA.

The heated debate on generic substitution is a case in point. Manufacturers and doctors are still debating the efficacy and safety of generic drugs in SA. Yet generic drugs have been used safely for 30 years in State hospitals, resulting in huge cost-savings. The anomaly is that, legally, the widespread use

of the drugs remains prohibited.

Still, there has been some progress on the issue of generics. In February, Venter's department tabled a list of 36 substances that could not be substituted by generics, implying that all other medicines could be. Considering the discord on the issue, she is expected to table legislation allowing the widespread use of generics long before consensus is reached.

Medical administrator David Boyce says: "While the pharmaceutical industry broadly favours generic substitution, the multinational drug companies do not." Boyce, a former retail pharmacist who heads TPS, a claims processing arm of Medicredit, says the multinationals are preoccupied with protecting the market share of their patented drugs and with recouping their research investments. International studies suggest manufacturers secure a return of more than 45% on capital investment.

The conference did resolve to investigate allowing the parallel import of cheaper medicines. In the UK, parallel imports accounted for £250m in medicine purchases last year. But local manufacturers have already begun to stress that these imports could pave the way for counterfeit medicines, lowered standards and lost jobs.

The call for volume-based prices from manufacturers remains a great source of controversy in the industry. Wholesalers and retail pharmacists have persistently criticised manufacturers for giving big discounts to dispensing doctors, who buy only small quantities of drugs compared with the far higher prices paid by retail and wholesale chemists for larger quantities.

"This encourages doctors to drive the product through the (prescription) pen," says Len Keating, CE of wholesalers ACA and PDC. "They get deals for buying a thousand rands worth of merchandise that a pharmaceutical wholesaler could not secure when buying even a million rands worth of the identical product." The matter is now before the Competition Board.

Rescheduling schedule two and three medicines to allow pharmacists more room to initiate therapy would lower prices and sometimes save on a doctor's consultation fee. Tom Carse, past president of the Pharmaceutical Society of SA, says a list has been compiled by Potchefstroom University detailing no less than 96 ailments that could be treated by a pharmacist without any need to consult a doctor.

Venter has indicated her support for such a move but the powerful Medicines Control Council appears to be the stumbling block to implementing this reform.

The council's director, Johan Schlebusch, asks why too little has been done to familiarise pharmacists with the clinical aspects of medicines in higher schedules "in anticipation of the day when these schedules become a reality." However, many argue that the council, a scientific body, must consider the economic needs of a Third-World population rather than apply unsuitable First-World standards.

Regrettably, nothing was said at the conference about dropping the ban on pharmacists working for nonpharmacists in retailing. Such a move would certainly pave the way for large retail chains such as Pick 'n Pay and Clicks to enter the market and challenge the manufacturers' drug-price stranglehold, described by a conference observer as "obscene and inappropriate to the needs of the country." ■

THE DROUGHT

Fuelling the price spiral

Government says food prices have soared by nearly 30% over the past year, while Pick 'n Pay's Raymond Ackerman and the Premier Group's Peter Wrighton put the figure at around 15%. But, whatever the increase, food prices are sure to rise faster in the months ahead as the effects of the drought kick in.

With much of the maize crop wiped out, downstream users of imported yellow maize will be hit hard, sending a ripple effect of higher prices through the food chain. In

Free-market co-operation 'needed to prevent disaster'

BD Day 29/5/92 (85)

THE health care industry needs a critical change of direction and application, without which the country is doomed to spiralling costs and inadequate services, says AMA CE Timothy Gelman.

AMA, a Southern Life company, is SA's second largest medical scheme administrator.

"The days of bureaucratically based funding in the industry are over. The situation demands a market-driven approach, a range of services which caters for tailor-made solutions and an awareness of the costs of treatment at every point in the chain."

Gelman says the problems facing members, medical providers and suppliers include restrictive legislation and medical ethics, spiralling costs and a lack of understanding of their implications.

"We have a system in which abuse by a few — members and practitioners alike — can cause major problems in containing premiums," says Gelman.

"Abuse of medical aid ... has become second nature, with a complete disregard for consequences to the consumer."

AMA believes deregulation is essential and the private sector must be allowed to use free market principles if costs are to be contained. Services must be tailored to the customer's requirements, not the other way around.

"Unfortunately the Medical Schemes Act regulates the nature and price of our product and while recently proposed amendments reflect a move towards free market principles, much remains to be done."

Solutions require flexibility, education on preventative health care and the establishment of value chains which place the emphasis on health not on sickness. Managed health care, which includes health maintenance organisations, can also increase the cost-efficiency of medical services and share responsibility for cost effective health care.

"The system will work effectively at all levels when members stop seeing medical aid as an open cheque book, and providers start working according to sound business practice. If these issues are not addressed, the future scenario is one of health care which will be financially out of reach of all but the very wealthy," he says.

Nationalisation debate still rages in health circles

WHILE protagonists for the nationalisation of the mines and major industries are increasingly less vocal in the ANC and the trade union movement, the same cannot be said for the health sector.

The Progessive Health Unity Forum, which includes the ANC, Cosatu and organisations of medical professionals, takes as its starting point the need for a strong national public health service in a future government.

The debate centres on what kind of public health service is needed and what — if any — the public and private sector mix should be.

The SA Communist Party is focussing its energy on a "triple H" campaign — health, housing and hunger. It believes people are entitled to free health care provided by the state.

The ANC believes the private sector should be involved in a national health insurance scheme paid for by tax revenue and compulsory health insurance for all those in employment.

Contributions to such a scheme would replace current medical aid contributions, and medical aids could only be used to pay for those services the national insurance scheme did not provide for — possibly, specialist dental services and cosmetic surgery.

Many supporters of the ANC-SACP-Cosatu alliance believe the health sector should be nationalised completely by taking over the private hospitals and compelling all doctors to work for the state.

Obstacle

According to the Health Policy Unit at Witwatersrand University, which argues that the private sector as currently constituted is the biggest obstacle to the creation of an equitable, efficient and appropriate health service, full scale nationalisation is not a practical solution and it is "unlikely" to be seriously considered.

"Health personnel, particularly doctors, would leave the sector and the country in droves and a black market in private care would soon emerge to undermine the public sector."

The unit also says that even if all doctors stayed, it would more than double the the state's already underfunded payroll.

Currently over half of all health expenditure is privately generated and this would disappear with wholesale nationalisation.

The unit favours the ANC's idea of a national health insurance system. "This would bring together into a single pool, controlled by the health authorities, both the public and private finances for health care. The money would then be used to pay for a package of health services for all citizens, provided by a combination of private and public sector providers."

Nehawu is a major player in the sector

BD aug 29/5/92.

WORKERS in the health sector are organising to fight "health for profit and the unilateral restructuring of services," says the assistant general secretary of the 50 000-strong National, Education, Health and Allied Workers' Union (Nehawu), Neal Thobejani. (85)

Thobejani says the union is involved in a Progressive Health Unity Forum — that includes organisations like the ANC and the National Medical and Dental Association — where policy for a future health system in SA is being discussed.

He says the bottom-line is that the state must take responsibility for the health of people — especially the young, old and unemployed.

This month tariffs at public hospitals were increased by 12% and the union is "consulting with the community" about action against the increase. Nehawu sees the increase as part of the "commercialisation" of health services which is putting health out of reach of most people.

Dispute

Nehawu and three other unions are in dispute with the Commissioner of Administration over wages and working conditions.

Thonejani says industrial action — including sit-ins, demonstrations and strikes — is certain in the industry if the commissioner does not improve on the wages offer.

On private hospitals Thobejani says the conditions are slightly better. "But our main struggle is for centralised bargaining in the private hospitals."

The Nurses Forum has called on Codesa to decide the status of the SA Nurses Association (Sana), which, with about 150 000 members, has a majority of black members. Membership is compulsory.

Thobejane says many black nurses are also members of Nehawu and the referendum is a response to pressure on Sana to be a trade union. If Sana accepts union status the prospects for unity will be better.

Nehawu and Sana are at loggerheads on issues like the right of nurses to strike, whether health is an essential service or not and whether health workers should be covered by the Labour Relations Act.

Nehawu has been organising in hospitals for the past seven years, but it was only after the nationwide hospital strikes in 1990 that it was taken seriously by the health authorities and other unions in the sector.

Merging

Now Nehawu is on the brink of merging with four other unions in the sector — the Cape-based Health Workers Union, Northern Transvaal Public Sector Union, Venda Public Sector Union and the Kwa Ndebele Public Sector Union. This will increase its membership by a further 12 000.

In addition, Nehawu is discussing unity with Nactu's 30 000-strong Public Sector Union (PSU) under the auspices of the joint Cosatu-Nactu Workers Summit this weekend.

Outside the staff associations, Nehawu and the PSU are the main players in the health sector.

If they unite, the new union will be the major force among health workers.

KARIN SAKS

National health service mooted to cure the legacy of apartheid

(85) (EP1)

South 30/5 – 3/6/92

'In line with the ANC commitment to a mixed economy, the provision of health care by the private sector will continue to be acknowledged and regulated'

HEALTH Minister Dr Rina Venter's startling assessment that South Africans can no longer afford to be ill starkly highlights the crisis in health care.

The crisis is a result of the government's emphasis on high-tech and private health care and fancy and expansive drugs, but it points to the need for a radical re-think on health care policies.

The ANC guidelines stress that for people to be healthy, they need to earn enough to live comfortable lives and work in safe conditions.

The guidelines emphasise the primary health care approach adopted by the World Health Organisation and the United Nations Children's Fund (Unicef).

The ANC proposes one comprehensive, integrated national health service (NHS).

There will be a single department of health for the whole country, which will co-ordinate all aspects of health care provision, and will be accountable to the people through democratic structures.

The homeland and own affairs departments of health will be integrated into the NHS, and there will be no segregation and racial discrimination in health services.

Health care

"In line with the ANC commitment to a mixed economy, the provision of health care by the private sector will continue to be acknowledged and regulated."

The responsibility for health care will be divided between national, regional and district authorities. Where possible, these will coincide with regional and local government boundaries.

The ANC stresses co-operation between the health service and government authorities responsible for sanitation, water supply, housing and other social services.

Also envisaged is a national drugs policy. This is needed because "there are many parts of the health service where there is not enough medicine in store, or where medicines run out from time to time. On the other hand, in the private sector, there is little doubt that too much money is spent on medicine."

It is also envisaged that strong affirmative action programmes will be needed to ensure that more black people, especially women, are trained as doctors.

But there is no doubt that better health care, even expanding primary health care facilities to all South Africans, will be expensive in a new South Africa.

It is difficult to determine how health care will be financed because there is a lack of statistics which show what the majority of South Africans need in terms of health care and how much government is spending on what at the moment.

This reflects the lack of systematic planning for health programmes.

The government has now set up a working committee to collect data on what is needed, and it is expected to report in October.

Several ideas have been put forward by the ANC and others about how the health cost will be met, but there is no consensus yet.

Some would like to see the defence budget channelled into a national health insurance scheme to provide good primary health care to the neediest South Africans.

The better-off could, if they wanted, still have access to private, high-tech treatment with the help of medical aid schemes.

But why should the better-off benefit from the national health insurance scheme? And should they not pay for everything themselves without the state reimbursing employers for their contribution to medical aid schemes?

On financing health care, the guidelines say it is "the responsibility of the government to mobilise sufficient funds to ensure a service of free and equal access to essential health care for all South Africans. No-one should be excluded from a public health facility because they cannot afford it. Only when this is achieved will it be possible to reduce the gap in access to health care between rich and poor; black and white; and urban and rural people.

"Since, however, government resources are limited, those who can afford to, will have to contribute to the cost of health care, either through general taxation, or by contributing to a national health or social insurance fund, or both. The costs of medical care should be kept down by careful accounting and the rational use of resources."

All this could be easier said than done. The World Bank warns that while most African countries have endorsed primary health care and "health for all", the influence of urban and upper-class elites have skewed the distribution of resources away from the rural poor and more preventative services.

The World Bank also warns the emphasis should not be on building more hospitals. It should be on running what there is more efficiently and on ensuring rural outreach programmes particularly to serve women who have no access to transport.

represent some form of subsidy to agriculture. These are loans, consolidation of debt, purchase of land and subsidised interest rates, the subsidies on interest, conversion of land to farming patterns and we also have emergency assistance.

There are two points that the DP would like to make here, and the first is that we believe that over the longer term subsidies to agriculture should be phased out altogether. They have not achieved the objectives they were installed for, namely to help farmers in trouble and to make access to agriculture easier for aspiring farmers. Instead, subsidies have often been capitalised into land values, and they have helped to give distorted price signals resulting in wrong patterns of production. High land values have, in fact, made entrance into farming more difficult, and the wrong production patterns have made farming more risky. To the extent that the Department is responsible for the administration of subsidies, we believe these should fall away.

Secondly, with regard to the purchase of land and loans for the purchase of land, we believe the Land Bank as a specialist institution should handle this and should have overall responsibility. Subsidised loans for land should also be phased out and hence another function of this Department.

We therefore do not foresee the functions of the Land Bank and the directorate being combined, because we would hope that over time most of the functions of the directorate would fall away. They should continue to perform those which they do keep, like drought relief and assistance in situations like that.

The MINISTER: Mr Chairman, with regard to what the hon member for Pietermaritzburg North said about the question of subsidies, we are in the process of phasing out subsidies. On the other hand, with the difficult farming conditions we have and the erratic climate in which farmers operate there are times when one has to ensure food security by means of subsidies keeping farmers in production, or else we will end up without a sufficient supply of locally produced food. We would then have to rely on imported food, which is usually expensive. In that regard we cannot totally disregard the role that subsidies can play in facilitating this action.

With regard to the purchase of land, the department no longer funds the purchasing of land and we do not intend doing so in the future, because that is the function of the Land Bank. I agree with what the hon member has just said.

*With all due respect, I do not think the hon member for Ladybrand listened carefully to my explanation. We have not created a new body but have just brought about a rationalisation between the two activities so that certain functions that are the responsibility of the Land Bank do go to the Land Bank, as I mentioned in respect of various transactions where money for production loans is involved and in respect of the consolidation of debt, and that on the part of Agricultural credit, relief is only granted in respect of the interest. However, I have already explained this.

I do not think the hon member need worry about the fact that the Land Bank has been so unapproachable, as he says. Indeed, the experience that we have is that the Land Bank acts in an extremely responsible way and in fact only in cases where it cannot do otherwise, does it proceed to take action in terms of the provisions of its Act.

In this regard the Agricultural Credit Board plays a important role. That is why it should also keep functioning separately, as he says. [Time expired.]

*Mr J M BEYERS: Mr Chairman, we on this side of the House are in favour of the Agricultural Credit Board being incorporated into the Land Bank and that the Land Bank takes over all the functions of the ACB. We have been appealing for a long time, together with the formal agricultural sector, for a one-stop financial assistance service for farmers where the farmer's total financial package can be addressed and meaningful and streamlined decisions taken on it. For the farmer the important advantage is in this sense that his total financial planning can then be finalized at one place. A further advantage, especially in view of the future constitutional dispensation that the Government is planning, is that the farmer's financial service will not then be so closely associated with the Government than is the case at present with the ACB.

However, from this side of the House we impose two important conditions for the incorporation of the ACB—which in any case is apparently not going to take place, in view of the hon the Minister's reply. In the first place we state that all category 3 farmers that receive assistance from

the ACB at present should still be assisted by the new body or combined body, with the same advantages and the same conditions as they enjoyed at the ACB.

In the second place we feel—and we feel strongly about it—that the Directorate: Financial Assistance should not disappear, but should be available to render State assistance to farmers through particular channels, during emergency- and disaster-related conditions.

In a country such as South Africa, with our particular climatology and fluctuating natural conditions, the State will always have to play an important role to keep agriculture healthy.

A further aspect that I believe has now become urgently necessary and on which we should like to ascertain the Minister's opinion, is whether it will be possible in such a possible new dispensation, for commercial banks to be responsible for agricultural debt, which as a result of excessive interest rates, at present constitutes about 39% of the total debt burden of farmers . . . [Time expired.]

*Mr C E HERTZOG: Mr Chairman, it is of the utmost importance that certain functions of these bodies be combined. We have great understanding for the idea that the Directorate: Financial Assistance should remain in existence to be of assistance to farmers in cases of disaster, but just as a train driver cannot accept financial responsibility for a train disaster, so the farmers cannot accept financial responsibility in the present conditions for a disaster in agriculture. That is why we on this side of the House would really like to see certain functions combined, but that the Directorate: Financial Assistance remains in existence in order to be of assistence in emergencies.

*The MINISTER: Mr Chairman, I can give the hon member for Ladybrand the assurance that that is exactly what we envisage in respect of certain functions that must be combined and that should logically fall under a financing institution and not the State. But in respect of the functional arm that should deal with disasters, and remain the responsibility of the State, we must keep the Agricultural Credit Board and the directorate in place in order to be able to evaluate it at grassroots level. We cannot do without it, and that is exactly one of the reasons why we cannot combine the two. It therefore remains as is.

The hon member for Virginia asks for one-stop service in respect of financing. It is going to be transferred to the Land Bank, or we are going to try to do it. The other functions then remain with the Agricultural Credit Board.

The existing conditions in respect of category 3 farmers will be maintained. Under the auspices of the Agricultural Credit Board they can move in and out, not only at the Land Bank, but also at commercial banks in order to subsidise agricultural debt on a sliding scale for one year with low interest rates, and can then phase it out slowly.

The directorate will not disappear. Commercial banks that deal with agricultural debt are therefore also being incorporated here. As far as the Agricultural Credit Board is concerned and farmers that serve on agricultural credit committees . . .

*The CHAIRMAN OF THE HOUSE: Order! The hon member must resume his seat. The hon the Minister may proceed.

*The MINISTER: They perform an important function and provide an unselfish service to farmers. I should like to express my gratitude on this occasion for the functions that they perform. It is one of the important things at grassroots level that should remain intact for the sake of agriculture. In order to do this we need to have the financial assistance arm and also the Agricultural Credit Board.

We are not planning to change radically, but we should like to make the whole process more streamlined with a view to a healthy financing policy.

Debate concluded.

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Feeding scheme: amount distributed/available

270. Mr M J ELLIS asked the Minister of National Health:

(1) (a) (i) What total amount (aa) has been distributed in terms of the Government's

feeding scheme since it was introduced in 1991 and (bb) is still available for this scheme and (ii) in respect of what date is this information furnished and (b) what are the names of the persons or organizations responsible for distributing these funds;

(2) whether any problems have been encountered in the distribution of these funds; if so, what problems?

B657E

The MINISTER OF NATIONAL HEALTH:

(1) (a) (i) (aa) An amount of R110 million from the Nutrition Development Programme (NDP) was spent during the 1991/1992 financial year and R14,7 million in the 1992/1993 financial year, and

(bb) from the R440 million allocated to the NDP for the 1992/1993 financial year, an amount of R425,3 million is still available, and

(ii) 20 May 1992, and

(b) regional committees were established by the regional offices of the Department of National Health and Population Development (NHPD) to investigate and evaluate the infrastructure and credibility of the programmes of non-governmental organizations, that apply for funding. Recommendations for the funding of these organizations are then forwarded to the Head Office of NHPD for processing, final approval and payment.

Regional offices of NHPD allocate funds according to needs to clinics operated by local authorities, provincial administrations and regional services councils. These clinics may apply to the nearest regional office of NHPD for funding from the NDP, for the extension of the existing state-subsidized scheme for combating protein-energy malnutrition.

Funds were made available from the NDP by the NHPD to the TBVC states and self-governing territories with the proviso that these governments assume full financial accountability for the judicious allocation and spending of the funds, as well as full responsibility for implementing, co-ordinating and monitoring of programmes;

(2) yes, because of misapplication of funds by a non-governmental organization, stringent financial control measures had to be introduced to prevent further misapplication. Approval of these measures was only granted by the Department of State Expenditure on 20 December 1991 which led to delayed payments to organizations. These delays should, however, be overcome shortly.

A National Interim Committee has been established to *inter alia* compile the policy, criteria and guide-lines for the NDP, which have now been completed.

Shortage of sufficient manpower especially at regional level has also jeopardized the progress of the NDP. This matter is receiving urgent attention.

HOUSE OF REPRESENTATIVES

QUESTIONS

†Indicates translated version.

For oral reply:

Own Affairs:

Appointment of Indian teachers: withdrawal of circular

*1. Mr W J DIETRICH asked the Minister of Education and Culture:

(1) Whether, with reference to the reply to Question No 3 on 21 May 1991, Circular No 45/89, which was issued by his Department on 23 October 1989 and dealt with the appointment of Indian teachers, has been withdrawn by his Department; if not, why not; if so, (a) when and (b) by whom;

(2) whether, in withdrawing this circular, the normal procedure was followed; if not, why not;

(3) what procedure was followed in this case;

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

C28E

†The MINISTER OF EDUCATION AND CULTURE:

(1) Yes.

(a) On 27 December 1991.

(b) By the Chief Executive Director: Education and Culture.

(2) Yes.

(3) A circular was issued to rectors of colleges, principals of schools, Inspectors and Regional Chief Inspectors of Education, the Inspectorate at Head Office, Regional Representatives of the Department of Budgetary and Auxiliary Services and Teachers Associations wherein the open policy of the Department with regard to the appointment of CS-Educators on an equal basis was confirmed.

(4) No. A statement is not deemed necessary.

Mr W J DIETRICH: Mr Chairman, arising from the hon the Minister's reply, I want to ask him a question. I do not want to quarrel with the hon the Minister, but I have a problem. On Tuesday, 21 May 1991 the former Minister of Education and Culture stated that the circular under discussion here had been withdrawn on 25 March 1991. Now we are told that the circular was withdrawn on 27 December 1991. I would like to know which is the true version.

The MINISTER: Mr Chairman, I do not want to enter into a debate on whether the statement was withdrawn or not, or what is true or untrue. I am merely stating the case according to information supplied by my Department.

I can read out the statement of 27 December 1991 if the hon member for Bethelsdorp wants to listen to it. The circular, No 70/91, dated 27 December 1991, is addressed to the Directorate: Staff Education and reads as follows:

APPOINTMENT OF CS-EDUCATORS

It is herewith confirmed that the Department has accepted the policy whereby all CS-Educators may compete on an equal footing for posts under the control of the Department.

The appointment of CS-Educators in the service of other education departments will, however, first be confirmed by this department with the education departments concerned. This measure is necessary in order to clarify any contractual commitments, the transfer of service benefits etc.

Nominations for the appointment of CS-Educators who, at the time of nomination are in the employ of other education departments or who at some time in the past were in the service of other departments, must therefore be submitted at least one month before the appointment becomes effective. This measure does not apply in the case of advertised posts.

The contents of this circular must be brought to the attention of all concerned.

The House knows that we have an open policy in our education section. We accept applications from the whole community. Any child is entitled to apply for a place in a school if it is available. Anyone with the right qualifications is entitled to be appointed to our Department.

I admit that the previous circular that was issued when this matter came under discussion created

cont ... p

Doctors call for child-proof cans to help stop paraffin poisoning

(8) ARG 15/6/92

Health Reporter

RESEARCHERS have called for child-proof paraffin containers to stop the high rate of paraffin poisoning in areas without electricity.

Red Cross Children's Hospital figures show that 30 percent of all poisoning cases treated there are due to paraffin poisoning, mostly in children under three.

Dr Blanche de Wet of the Medical Research Council's trauma programme studied paraffin poisoning in 436 children in the Peninsula.

She found that most children were poisoned in summer — a fact she attributed to thirst and the paraffin being decanted into cooldrink bottles.

Because children have an under-developed sense of taste, it took several sips before they realised what they were drinking.

Most of the children had to be admitted to hospital for at least one day, with treatment costing an average of R256 per patient.

Dr De Wet said the ultimate solution was a "child-proof returnable paraffin container".

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Forums/conferences/discussions on health care

274. Mr M J Ellis asked the Minister of National Health:

(1) Whether, prior to holding a forum, conference or discussion on any matter relating to the health care rendering service, she consults with interested role players in regard to the holding of such a forum, conference or discussion; if not, why not; if so, how is this consultation effected;

(2) whether the items on the agenda for such a forum, conference or discussion form part of the consultation with interested role players; if not, why not;

(3) who makes the decision on who constitutes the relevant role players that should attend such a forum, conference or discussion;

(4) whether groups are consulted on this matter to ensure full representation of all interested role players, including extra-parliamentary groups; if not, why not;

(5) whether she will make a statement on the matter?

B680E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, depending on matters to be discussed at such a forum, important role players are consulted. It takes place either by inviting interested parties to pre-forum discussions to plan the agenda and approach and to decide on objectives for the forum, or through individual contact;

(2) yes — see point one;

(3) the Department of National Health and Population Development, subcommittees of the Health Matters Committee and those consulted re the forum;

(4) yes;

(5) no.

Aids and Lifestyle Education Programme kit

275. Mr M J ELLIS asked the Minister of National Health:

(1) (a) (i) How many and (ii) which education departments have requested that her Department's Aids and Lifestyle Education Programme kit be made available to them, (b) with effect from what date is this information available and (c) how many such kits have been distributed to each of these departments;

(2) whether her Department has received any feedback concerning the effectiveness of this education programme; if so, what is the nature of the feedback;

(3) whether there has been any international response to this programme; if so, what has been the response;

(4) whether she will make a statement on the matter?

B681E

The MINISTER OF NATIONAL HEALTH:

(1) (a) (i) 13

(ii) the Department of Education and Training, the Department of Education and Culture, House of Representatives; the Department of Education and Culture, House of Delegates; the Department of Education and Culture, House of Assembly as well as the Departments of Education of Lebowa, KaNgwane, Ciskei, Transkei, KwaZulu, KwaNdebele, Qwa-Qwa, Venda and GaZankulu,

(b) 27 April 1922 and

(c) there have already been 2 000 requests for the school package;

(2) although formal research as to the efficacy of the programme will only com-

cont —D

HOUSE OF ASSEMBLY

QUESTIONS

†Indicates translated version.

For written reply:

General Affairs:

Adjustments/cut-backs: health services

257. Mr M J ELLIS asked the Minister of National Health:

Whether, in terms of the budgetary allocations to each of the provinces, the provincial hospital services have had to make any (a) adjustments to and (b) cut-backs in the provision of health services; if so, what is the extent of these adjustments and cut-backs in each province?

B616E

The MINISTER OF NATIONAL HEALTH:

Provincial Administration of the Cape of Good Hope

(a) Yes, during March 1991 certain emergency measures were introduced to stay within the limits of the 1990/91 budget allocation. At the beginning of the 1991/92 financial year some of these measures were retained, ie:

— Out-patient visits to specialist and academic hospitals are limited to referred cases and/or emergencies, where possible.

— Limitations on laboratory services and special investigations.

— Curtailment of ambulance and other patient transport services and visits by specialists to rural areas.

— Filling of vacancies only after individual consideration.

— Cessation of subsidized transport of staff and free teas.

— Curtailment of overtime renumeration and

(b) further steps to implement adjustments and cut-backs (1991/92):

— Replacement of the system of dispensing by private pharmacists to district surgeons.

— Optimization of provisioning administration.

— Management optimization: Savings made possible by the Directorate: Management Advisory Services and private management consultants (Byrne Fleming).

— Privatization of catering services and incineration services.

— Streamlining of staff establishments.

— Savings measures were also introduced at province aided hospitals.

Provincial Administration of Natal

(a) and (b) Yes, the Health Services Branch requested an allocation of R1 069 708 767 and was given an allocation of R983 608 000.

In order to remain within this budget the following measures were introduced:

— The purchase of new medical equipment and the replacement of ageing, and obsolete equipment has been restricted to the absolute minimum. In some instances essential services have had to be stopped, or severely curtailed, as a result of inadequate equipment and facilities.

— Certain essential services have been limited to the smallest number of patients possible, eg kidney dialysis, bypass operations and the treatment of cancer.

— General measures have been implemented to reduce usage of official transport and electricity, restriction of the prescribing of expensive medicines and limitation on the types of foodstuffs given to patients and staff members.

— In spite of an increased workload, essential post expansion in respect of medical, nursing, ambulance and administrative personnel has had to be held in abeyance.

— HIV testing has been limited to an absolute minimum.

Provincial Administration of the Orange Free State

(a) and (b) Yes, the adjustment was in the form of a cut-back of ±R24 724 000 in the 1991/92 financial year. This amount was primarily necessary for the commissioning of the new intensive care unit and theatre complex at Pelonomi Hospital.

Provincial Administration of Transvaal

(a) and (b) Yes, the actual requirement of the Branch: Health Services of the Provincial Administration of Transvaal was R2 685 959 000 against an allocation of R2 336 764 000 which caused a deficit of R349 195 000 for the 1991/92 financial year.

The following adjustments and cut-backs have been made:

— No expansions, including ambulance services.

— Curtailment of Initial Equipment.

— A cut-back of 9,29% on the remaining portion of the need.

Certain person: requests for financial compensation

276. Mr M J ELLIS asked the Minister of National Health:

(1) Whether she has received any requests for financial compensation from a certain person, whose name has been furnished to the Department of National Health and Population Development for the purpose of her reply; if so, (a) what is this person's name and (b) what is the basis of his request for compensation;

(2) whether any other (a) individuals and (b) organizations have supported this person's request for compensation; if so, what are their names;

(3) whether any other persons have requested compensation on similar grounds; if so, (a) how many and (b) what was her Department's response to these requests;

(4) whether she will make a statement on the matter?

B682E

The MINISTER OF NATIONAL HEALTH:

(1) (a) Yes, Mr Gawie Stoltz and

(b) he became infected with HIV as a result of receiving HIV-contaminated imported Factor VIII. This happened before 1985 when all Factor VIII was heat treated and before an approved test for HIV was commercially available;

(2) (a) no and

(b) yes, ACT UP and the South African Haemophiliac Foundation;

(3) no;

(4) no.

Additional flat: Addington Hospital

292. Mr M J ELLIS asked the Minister of National Health:

(1) Whether an additional flat is available on the fourteenth floor of Addington Hospital; if so, (a) how long has this flat been in existence, (b) what is the (i) nature and (ii) size of the flat and (c) what was the cost of (i) developing and (ii) equipping it;

(2) from which provincial vote were the funds for this development obtained;

(3) (a) for what purpose is this flat being used and (b) what was the original purpose of the flat?

B730E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

(a) since 1971,

(b) (i) it is a small bedsitter with ablution facilities and adjoining office and

(ii) Original area: 39,5 m^2
Additional room: 19,04 m^2
Total area: 58,54 m^2 and

(c) (i) and (ii)

the office/bedsitter and ablution facilities have been in existence since 1971. During 1992 the flat was renovated and extended by one room to separate the bedroom and office. The total cost of extending the flat by

cont—D

FM 19/6/92

HEALTH CARE

A prescription all can afford

85

Rina Venter's firm deregulation has antagonised a number of vested interests

Finding solutions for the ailing health-care system hasn't made Health Minister Rina Venter very popular. Her first two years in office have seen her holding steady under fire from a huge array of vested interests which, of course, want protection from competition.

Her aim is to halt the upward spiral of medical costs — making health care affordable and accessible. That is why she has set about deregulating the entire sector. Since her proposals offer sound and well-tested mechanisms for cutting costs, introducing competition and improving standards, she has become a consumers' Minister. Yet these proposals challenge doctors, drug manufacturers, private hospitals and bureaucrats; so they resent her.

For its part, the ANC has dismissed her efforts as merely part of "government's unilateral restructuring programme." In other words, it wants to be consulted in decision-making. At present, too, Venter is in a wage conflict with striking hospital workers in the Transvaal. It comes as no surprise, then, that the anti-Venter lobby is strong.

The Minister will soon know whether she has won the first round — a measure which will take effect in the private sector. Parliament is due to vote on the controversial Medical Schemes Amendment Bill, which, if passed, will give medical schemes greater scope to check costs. In a nutshell, the Bill would end guaranteed payments and scales of benefits, ultimately curbing tendencies towards over-servicing by doctors and abuse by patients. It would also pave the way for schemes to run their own hospitals and clinics and employ doctors, nurses and pharmacists — a move that has lowered costs by up to 40% elsewhere.

Venter's intention is to save the sector — which serves around 20% of the population — from collapse. The schemes are struggling to contain claim costs within the limits of subscription revenue; in 1990, almost half reported operating losses, with the red ink totalling R100m.

Doctors don't like it. Nearly a year after the proposed reforms were formally laid on the table for discussion, they are still attempting to stop the Bill as it stands. Last week, a group of about 30 doctors staged a demo outside parliament — and Johan Vilonel, chairman of the standing committee investigating the Bill, himself a physician, is said to be under particular pressure from his profession to delay a vote.

Off the street, the Medical Association of SA (Masa), which represents doctors, is in the forefront of anti-Venter agitation. The essence of the recalcitrance is that doctors believe the Bill is a threat to their professional discretion in dispensing medical services. They are concerned that the medical schemes could grow too powerful — acquiring virtually unchecked power to control the use and provision of services. A Masa spokesman puts it crisply: "Health professionals in the employ of medical schemes may be subjected to interference with their clinical judgment and might be pressured to compromise patient care because of cost considerations."

Venter

The Bill's supporters argue that the current fee-for-service system offers doctors and patients no incentive to be cost-effective. It is assumed that some faceless medical scheme will foot the bill; and the upshot is that some doctors push their patients further up the treatment scale than they need to go and some patients camp out in surgeries.

This is why Rob Speedie, executive director of the Representative Association of Medical Schemes (Rams), argues that health maintenance organisations run by medical schemes would actively discourage the oversupply of services. In addition, they would offer a number of options: "A medical scheme could provide its beneficiaries with total health care at a hospital staffed by specialists, nurses, paramedics, radiologists and pharmacists, etc — at ordinary contribution rates. If a member chooses to seek treatment outside this framework, he would probably have to pay some sort of penalty."

Speedie

Speedie says that this model — successfully applied for some time in SA by Vaalmed — would cut costs for medical schemes because of economies of scale. Treating 80 people rather than eight gives the scheme greater buying power and enables a more cost-effective use of equipment and information resources.

The Bill could well usher in the US-style "preferred provider organisation." This means that a group of health-care professionals joins forces to provide for the needs of a community for a fixed time, usually a year. They contract out their services to a medical scheme but payment would be based on the number of clients rather than a fee-for-service arrangement.

Wits Commerce dean Duncan Reekie, a medical economist, says such schemes would make doctors wary of under-providing services — because patients would just keep coming back. "This would increase costs and lower profits and employers would take their business elsewhere. The incentive must, therefore, be not to overprovide or under-provide."

But even if the Bill passes parliament intact, Speedie says sophisticated health maintenance organisations will take some time to develop in SA: "The Bill merely seeks to achieve a larger measure of freedom to enable medical schemes and doctors to compete. Market mechanics don't adjust overnight to new trends."

Masa would like to see the scrapping of regulations prohibiting professionals from forming multi-speciality group practices. But it expresses concern that allowing medical schemes to control services could end the cross-subsidisation practised by many doctors who serve both the affluent and the poor. This would throw the poor into the grossly inadequate public sector. It also believes that the Bill would pave the way for less risk-rating — whereby health packages are designed to suit individual needs. Speedie says cross-subsidisation will continue, though "claims will be assessed with more care."

Masa has other demands:

- ☐ It wants the Minister to retain a system that guarantees minimum payments determined by the professional health-care associations;
- ☐ It wants medical schemes to be obliged to pay for what the doctors regard as certain essential services — such as basic consultations; and
- ☐ It believes that all payments by medical schemes should go directly to the provider of

cont'd

FM 19/6/92.

85

health care — the doctor — and not to the member. This would prevent the member from "using such benefits for his own purposes instead of paying the provider."

Masa apparently fears that the Bill would give medical schemes the opportunity to create a monopoly in the private health-care sector. "Patients' freedom of choice in respect of providers of services will be restricted," it argues. It also wants certain guarantees from government before it will support the Bill: "For example, to what extent would the State be prepared and capable of caring for patients who are not covered by health insurance, or who require services for which their schemes offer no benefits?" asks Masa's Bernard Mandell.

There is some validity in these points — but if costs are to be checked, there can be no hard-and-fast guarantees, particularly when it comes to minimum payments. This principle has been fully grasped by Venter.

The Minister's efforts to deregulate the pharmaceutical industry — that huge repository of vested interests — have further angered the doctors as well as manufacturers. When, earlier this year, Venter convened a forum to address the escalating costs of medicine, SA drug prices were pinpointed as among the world's highest. Yet there are simple ways to bring them down.

Venter would like to:

- ☐ Extend generic substitution;
- ☐ End the ban on medicines that would compete with locally made ones (so-called parallel imports);
- ☐ See the introduction of certain forms of pharmacist-initiated therapy; and
- ☐ Reschedule some medicines so they can be sold without a prescription.

Venter may well have to push ahead with her reforms long before any sector consensus is reached: "I simply can't accede to a massive anti-reform lobby, especially when the reforms are based on principles accepted around the world."

But discord runs deep. While the pharmaceutical industry broadly favours generic substitution, the multinational drug companies do not. Manufacturers — and some doctors — continue to question the efficacy and safety of these drugs whereas State hospitals have, in fact, been using them for the past 30 years with huge cost savings. Venter's department has listed 36 substances that could *not* safely be substituted by generics — which means that all other medicines could well be substituted. It could easily be done.

The multinationals' objections are understandable — they are not about to pave the way for cheaper medicines even though the bulk of the population can't afford patented brands. David Boyce, chairman of Medicredit's TPS, accuses these companies of being obsessed with protecting market share and recouping research investments, though international studies suggest that manufacturers secure a return of more than 45% on their capital investment.

Allowing the parallel import of cheaper medicines is another thorny issue. Local manufacturers have already begun to stress that such imports could pave the way for counterfeit medicines, lowered standards — and lost jobs. A familiar protectionist refrain. Yet in the UK, parallel imports accounted for £250m in medicine purchases last year.

Rescheduling certain prescription medicines to allow pharmacists greater freedom to initiate therapy could well lower prices by saving a consultation fee. A recent study by Potchefstroom University details 96 ailments that could be treated by a pharmacist without a doctor's intervention. And on this issue, Venter has some support: pharmacists are eager to extend their services to include limited clinical work, especially at the primary or preventive health care level.

But doctors and the all-powerful Medicines Control Council are dubious. Council director Johan Schlebusch has suggested that pharmacists could be required to undergo further clinical training before a rescheduling is allowed. Against that, many argue that the council — a scientific body — needs to apply standards more appropriate to a Third-World population than in the past.

Another simple cost-cutting exercise would be to drop the ban on pharmacists working for retailers such as Pick 'n Pay and Clicks, which could then enter the market and challenge the drug manufacturers' stranglehold on prices. Government is considering scrapping professional bars on freedom of association — and one result has been that SA embassies abroad have been inundated with visits from international drug companies threatening to pull out of SA if their operations are subjected to deregulation.

Venter comments: "I don't want to make things difficult for the multinational companies — but I do need to serve the interests of the public as a whole."

That is why, in addressing the gross imbalances and funding crisis in public health, Venter has opted to deregulate extensively. Her actions follow closely the SA Chamber of Business recommendations.

Formal racial barriers have been lifted and hospitals are required to treat all races. In practice, however, here as elsewhere, bureaucrats often frustrate reform. Added to this problem is the financial burden of maintaining 14 health departments while everyone awaits the final shape of the new political order.

Against such structural impediments Venter has made considerable progress. Her chief concern has been to reduce the gulf between preventive and curative services. She started by dedicating at least 5% of her budget to primary health care — and her intention is to increase this allocation to a sector which has been "particularly inaccessible to blacks."

Lack of adequate financial provision at this level is largely responsible for the overcrowding at provincial and academic hospitals. In the past two years, Venter has spent R80m on building 141 clinics and a further 60 have been sponsored by business. She has also set about reforming the top stratum of the public health system and is in the process of giving these hospitals complete autonomy in running their budgets and making their own decisions. Cape Town's Red Cross and Groote Schuur hospitals recently appointed accountants Ernst & Young to revamp their administrative and business practices.

Venter would also like to end licensing for private hospitals. She believes this would open the market to greater competition by giving developers greater responsibility for ensuring a viable project. And she believes the private sector should be more involved in optimising the use of facilities at State hospitals. At regional and local government levels, some hospitals will now fall under the local authorities and facilities are to be streamlined.

While finances are limited, Venter believes that good, lean, decentralised and autonomous administration will deliver the best health-care system in an imperfect world. She wants to "lay a good foundation for a future government to reach the needs of the population at an affordable level" — an ambition that indicates how far she has moved from the closed, overly protective and costly medical world of the past. ■

(2) how much (a) had been spent on aid in terms of the above (i) scheme and (ii) programme as at the latest specified date for which information is available and (b) is it estimated will be spent on each in the current financial year?

B842E

The MINISTER OF NATIONAL HEALTH:

(1) (a) (i) and (ii) A minimum and maximum amount do not apply,

(aa) R40 per adult per month
R35 per child under 1 year per month
R40 per child over 10 years per month
R25 per child 2-9 years per month;

(bb) (i) R20 per person per month;

(ii) R30 per person per month;

(b) The financial circumstances of the farmer is evaluated to qualify for assistance of (aa). With regard to (bb) it is a supplementary scheme that provides for one third of a person's energy and protein need.

(2) (a) (i) 31 May 1992: R2,5 million and

(ii) 8 June 1992: R88 million awarded/spent;

(b) (i) R20 million and

(ii) R440 million.

Banquet facilities at home of Administrator of Natal

347. Mr M J ELLIS asked the Minister of Regional and Land Affairs:

Whether banquet facilities have been established at the home of the Administrator of Natal in Pietermaritzburg; if so, (a) at what cost, (b) who authorized it and (c) from which vote or votes was the cost of establishing these facilities drawn?

B845E

The MINISTER OF REGIONAL AND LAND AFFAIRS:

No. (a), (b) and (c) Fall away.

HOUSE OF ASSEMBLY

Forum on curtailment of cost of medicine

348. Mr M J ELLIS asked the Minister of National Health:

(1) Whether a forum on the curtailment of the cost of medicine was held on or about 28 February 1992; if so,

(2) whether a record was kept of the proceedings of this forum; if not, why not; if so,

(3) whether this record is available to the public; if not, why not;

(4) whether she has commissioned any investigations as proposed at this forum; if not, why not;

(5) whether she will make a statement on the recommendations made at the forum?

B846E

The MINISTER OF NATIONAL HEALTH:

(1) Yes,

(2) yes,

(3) no, because all organizations which showed an interest were accommodated at the forum. A copy of the record has been made available to them for submission of further comment;

(4) no, not at this stage, because all comments has not yet been received. The comments must be studied further and be considered before further decisions concerning investigations can be made;

(5) no.

SAP: issuing of bullet-proof vests

351. Mr E W TRENT asked the Minister of Law and Order:

With reference to his statement on 3 June 1992 on bullet-proof vests (a copy of which has been furnished to the South African Police for the purpose of the Minister's reply), (a) which branches and/or units of the Police are as a matter of policy issued with bullet-proof vests, (b) on what basis are priorities determined, (c) which of these units had been issued with such vests as at the latest specified date for which information is available and (d) when is it anticipated that all units will have been issued with bullet-proof vests?

B849E

The MINISTER OF LAW AND ORDER:

(a) There is no fixed policy whereby specified branches and/or units are given preference when issuing bullet-proof vests. The issuing of bullet-proof vests is determined by priorities.

(b) The circumstances of each of the eleven (11) police regions are unique and priorities to establish to whom the vests will be allocated, are determined at a regional level.

Any branches and/or units of the Force may apply to be issued with bullet-proof vests. Reasons must be given in support of the application. Vests are then issued on a priority basis dependent on the available stock.

(c) As has been mentioned in paragraph (a) *supra*, preference is not given to any specified units in respect of the issue of vests. There is virtually no unit or branch that does not have bullet-proof vests at its disposal.

(d) As the suppliers cannot meet all demands, it is not possible to give a target date by which all units or branches will have been issued with bullet-proof vests.

Total amount spent on decentralization benefits

354. Mr W U NEL asked the Minister of Regional and Land Affairs:

(a) What total amount was spent on decentralization benefits in the 1991-92 financial year, (b) how much of this amount is related to new projects commenced during the said financial year and (c) how many new employment opportunities were created by way of such new projects (i) countrywide and (ii) in (aa) Phuthaditjhaba and (bb) Industriqwa in the 1991-92 financial year?

B852E

The MINISTER OF REGIONAL AND LAND AFFAIRS:

(a) 1982 RIDP—R629 928 789

(b) 1991 RIDP—R 1 242 608

(c) (i) 1982 RIDP—new projects which realized in the 1991-92 financial year—666 employment opportunities.
1991 RIDP—approvals from 1 August 1991 until 20 May 1992—17 035 employment opportunities.

(ii) (aa) 1982 RIDP—new projects which realized in the 1991-92 financial year at Phuthaditjhaba—None.
1991 RIDP—approvals from 1 August 1991 until 20 May 1992 at Phuthaditjhaba—None.

(bb) 1982 RIDP—new projects which realized in the 1991-92 financial year at Industriqwa—40 employment opportunities.
1991 RIDP—approvals from 1 August 1991 until 20 May 1992 at Industriqwa—258 employment opportunities.

Registered medical technologists: private practices

355. Mr W U NEL asked the Minister of National Health:

(1) Whether regulations permitting the establishment of private practice by registered medical technologists have been approved; if not, why not; if so, with effect from what date will such persons be permitted to enter into private practice;

(2) whether any qualifications and conditions have been set for such persons to be able to practise; if so, what (a) qualifications and (b) conditions?

B853E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, regulations permitting private practice by medical technologists were pub-

Cont'd

Gambling Bill on hold

Political Staff

CAPE TOWN — Government failed last night in its bid to ram controversial anti-gambling legislation through Parliament before going into recess today.

Justice Minister Kobie Coetsee called a special meeting of the parliamentary justice committee yesterday to process the Gambling Amendment Bill. However, matters were not concluded during last night's session.

The Bill is intended to close the loophole in the Gambling Act which has given rise to the establishment of hundreds of hard-gambling casinos in cities around the country.

Committee chairman Gert Myburgh denied yesterday that the Bill was being rushed through Parliament to protect the horse racing industry or homeland casinos.

He said the rate at which casinos were mushrooming had sparked fears that the situation would become uncontrollable.

The proposed legislation changes the definition from "games of chance" — the loophole exploited to set up the casinos. Instead it specifically outlaws popular forms of gambling by name and the mechanisms used for gambling.

It is understood Coetzee could soon announce a commission of inquiry into gambling, as well as lotteries for welfare, health and education purposes.

Venter outlines sweeping cutbacks

B/Day 19/6/92

Political Staff

CAPE TOWN — Health Minister Rina Venter yesterday outlined sweeping cutbacks in the provision of health services in all four provinces during recent months.

In Natal, budget-trimming measures included the limiting of HIV testing "to an absolute minimum". Visits by state specialists to Cape rural areas had been stopped because of cutbacks in provincial hospital services.

Sapa reports that Venter, replying to questions in Parliament, said certain essential services in Natal hospitals — such as kidney dialysis, bypass operations and treatment of cancer — had been limited to the smallest number of patients possible.

In some cases in Natal essential services had to be stopped or seriously curtailed because of inadequate equipment and facilities.

The Natal Health Services Branch had requested an allocation of R1,09bn, and been given R983,6m.

In the Transvaal, cutbacks included stopping expansion of ambulance services.

Transvaal provincial health services suffered a deficit of R349,19m for 1991/2, after asking government for a R2,69bn allocation and receiving R2,34bn.

In the Cape, outpatient visits to academic hospitals had been limited to referred cases and emergencies where possible, and laboratory services and special examinations had also been cut back.

Visits by specialists to rural areas had been ended.

Ambulance and other patient transport services had been stopped.

Vacancies were filled only after individual consideration and subsidies for staff transport and free tea had been scrapped.

Overtime payment had been stopped.

District surgeons in the Cape had taken over dispensing from private pharmacists.

Catering and incineration services had been privatised.

The measures in the Cape included cutbacks imposed in March last year, plus additional steps for 1991/2.

Vacancies in Cape hospitals and state health clinics were being filled only after individual consideration.

Attention had also been paid to the streamlining of staff establishments.

In the Free State, cutbacks totalled about R24,72m in the 1991/2 financial year.

This amount was necessary primarily for the commissioning of the new intensive care unit and theatre complex at Pelonomi Hospital.

Govt slated for late Bills

Beer-swilling women not for SA

TV visuals of women sipping beer are still a no-no for local viewers.

According to recent research, beer-swilling women are not acceptable to black South Africans, who account for 80% of the R4,5bn-a-year beer market. As a result, advertising agencies have excluded women from their campaigns, account executives say.

SA Breweries (SAB) public affairs manager Adrian Botha says black and white women account for an estimated 20% of beer drinkers in metropolitan areas but there is no advertising directed at this market.

A recent Markinor survey commissioned by SAB found that most blacks objected to advertisements showing women drinking beer.

Of respondents, 52% said they found it unacceptable for women to drink.

Asked if they found it acceptable for women to be shown drinking in advertisements, 56% said they did not while 13,4% said they did.

Partnership account executive Marc Spriestersbach says there has never been any deliberate intention to exclude women from beer advertisements.

Spriestersbach, who handles the account for SAB's Castle Lager, says traditional values have dictated that women should be excluded and introducing them into advertisements might mean sales being adversely affected.

Botha says the situation could change as SA women became more liberated. "But the change so far has been much slower than I would have expected."

Another account executive says a further reason for not showing women in advertisements is that beer is a masculine drink. "We do not want to compromise on the masculinity of beer."

The executive, who did not wish to be named, said his agency had already introduced an advertisement that shows women in a social environment. But the woman is not actually drinking beer nor is she as prominent as the males in the advertisement.

UK publication Advertising Age says most beer campaigns use blatantly sexist advertising to titillate male beer drinkers. This is especially so in the US, it says.

DUMA GQUBULE

HEALTH BRIEFS

Cape Town tops the danger list

SOUTH 2016-24/6/92.

Cape Town is the most dangerous city in the world.

A study of trauma here by the Medical Research Council (MRC) last year shows that one person in 10 requires medical treatment for a fresh injury annually.

This trauma rate is "considerably higher than anything recorded elsewhere in the world", according to the head of the MRC's National Trauma Research Institute, Dr Johan van der Spuy.

WHO at health indaba

AN international conference on community health, to be held in Johannesburg next month, will be addressed by three World Health Organisation officials.

The WHO delegation will be visiting South Africa in their personal capacity.

The conference of the Community Health Association of South Africa will be held at the Nasrec exhibition centre outside Johannesburg from August 4 to 8.

More than 1 200 delegates from the United Kingdom, Israel, Chile, Belgium and participants from all parts of southern Africa are expected to attend the conference.

Topics to be discussed include Aids, tuberculosis, health care, preventable diseases, urbanisation, environmental health, low-cost housing and education.

- *Sapa.*

Plan for health reform

ST Times 28/6/92.

(85)

By PETER MALHERBE

A NATIONAL health scheme for all races, covering basic medical services and financed by taxpayers, has been drawn up by the Medical Association of SA.

The plan to reform the system was approved at a federal council meeting earlier this month.

It was proposed as a solution to the country's inefficient, unfair and expensive health care system, a doctor told the Sunday Times.

Higher

He said details would be released next month.

The present system resulted in an inequitable, two-tier state and private health system, with the state unable to pay for the higher level of service for all its patients.

The doctor, who wished to remain anonymous, said the health plan would be funded from income tax.

Medical practitioners saw it as the state's responsibility to ensure affordable core health care at all levels.

Additional medical insurance could be paid for by private patients' insurance cover.

The national health plan would:

- Be run by a single ministry of health;
- Finance the purchase of core health services for the entire population;
- Be financed from general taxation;
- Provide the greatest assistance to people least able to provide for themselves.

Masa has long demanded a non-racial, single health service for all citizens. The insurance would cover all South Africans needing essential medical procedures. Private medical aid schemes would be used merely as a "topping up" facility.

People covered by private medical aid schemes would be free to seek treatment under the state fund or their own scheme.

People could buy extra, non-tax deductible insurance to provide cover for additional services which would allow them to choose their own doctors or hospitals.

Then, should they require any treatment under the state "core medical services" list, they could apply for a cost contribution from the state fund, subject to a means test and government guidelines.

Injury

Those unable to afford medical services would be covered by the government scheme. Medical services would be required to apply means tests to their patients.

Core medical services — to be defined by an advisory committee with community representation — would include pregnancy and maternal care, child care, emergency treatment, and medical and surgical treatment of injuries or illnesses.

Such a system would be funded to encourage cooperation between the private and public health care sectors, leading to the more efficient use of resources.

The state and private schemes would form part of a national health network to provide comprehensive data for planning budgets and designing facilities.

Jacobsohn said.

provinces.

Masa calls for single health ministry to be set up urgently

B1Day 2/7/92

(85)

GERALD REILLY

PRETORIA — The Medical Association of SA has called for the urgent establishment of a single health ministry to get its health care system on a more equitable and efficient basis.

Masa secretary-general Dr Henrik Hanekom confirmed yesterday Masa had drawn up a blueprint for a core health service funded by government from general revenue.

Hanekom said the proposals would ensure everyone had access to core health services.

The blueprint was based on co-operation between public and private sectors and was aimed at eliminating the duplication encountered under the existing system, he said.

Masa's plan was appropriate and attainable against a background of the social, political and economic realities facing the country.

Core health services should be defined by government in consultation with a national advisory comittee of experts and funds for these services would be allocated to regions on an agreed formula.

The services could be provided by either private or public sectors.

Hanekom said in terms of Masa's plan individuals would be free to obtain supplementary insurance for additional services.

The role of government in financing services not defined as core services should be reviewed.

Hanekom said it was government's responsibility to ensure that all had reasonable and affordable access to core health services.

Meanwhile, the SA Nursing Association yesterday came out in favour of a so-called Health Maintenance Organisation as opposed to the traditional "fee for service" practice, saying prepayment for medical services would lead to better cost control and efficiency, Sapa reports.

The association said any health maintenance organisation should offer a multi-disciplinary service.

Employers, labour unions, medical schemes, government or private groups should have the freedom to start such an organisation.

Foreign jurists in SA to draft report

TIM COHEN

PRETORIA — A group of leading foreign jurists had arrived in SA to draw up guidelines for the orderly conduct of mass action, the Goldstone commission said yesterday. B1Day 2/7/92

Although the multinational panel was appointed earlier this year, it will make its report in the midst of the ANC's mass action campaign and is expected to influence how the campaign is conducted.

The panel will publicly report back to a committee, established by the Goldstone commission, next week in Cape Town.

After this the committee and representatives of interested parties would be free to debate any relevant issue with the panel, the commission said in a statement yesterday.

The commission will then report to President F W de Klerk and make recommendations about legislation on mass demonstrations.

Health care bodies unite

By BEATHUR BAKER

PROTRACTED attempts to unite health care organisations are set to bear fruit at the launch this weekend of the South African Health and Social Services Organisation.

Sahsso will bring together five major bodies, including the National Medical and Dental Association (Namda), the Organisation for Appropriate Social Services in South Africa (Oasssa) and the South African Health Workers' Congress.

A politically non-aligned organisation, its chief aims will be to provide primary health care to communities and to lobby for improved health services.

Unity talks, which began several years ago, are known to have been complicated by the differing character of the organisations. The constituent organisations have been duplicating services.

Melvyn Freeman, an Oasssa member from the Wits Community Health Centre, says the uniting of health care and social services under one umbrella allows the organisation to look not only at the provision of medical services for illness, but also at the social conditions in which disease occurs.

Sahsso membership will make it possible for health professionals such as doctors to join the same organisation as other workers in the health sector. Previously unorganised workers, such as those in mental health, can also be represented.

Call for state health scheme

By REG RUMNEY

THE conservative Medical Association of South Africa (Masa) has advocated a radical reshaping of the way health care is provided and paid for in South Africa.

This week it proposed that a state health plan under the control of a single ministry of health should assume responsibility for providing a basic set of medical services for all South Africans, "in the shortest possible time".

Its new approach stands in contrast to a policy that in past years concentrated mainly on defending doctors' incomes against what it regarded as insufficient payment by medical aid schemes.

As the medical schemes come under pressure and the political democratisation process gathers momentum, it has come to be accepted that the way health care is provided in South Africa has to change.

Against that background Masa this week released a wide-ranging working document to be used to develop health policy.

In advocating a form of national health scheme, it rejects the notion that the market alone can provide medical treatment for all South Africans.

"It's a recognition that Masa's always stated goal of providing good health care can only be achieved with extensive state intervention and state financing," notes a health policy researcher.

The key concept in the document is "core health" services, such as treatment for illnesses. Everyone should have reasonable, affordable access to these, and the state must help pay for those who can't provide for themselves. Masa proposes that such core services be defined by the government in consultation with informed community representatives.

How much the individual would pay, if anything, would depend on how much he or she earned. Masa suggests a "means test".

It would not depend on whether the individual had "top up" medical insurance or a medical aid scheme for services which are not "core". On the other hand, supplementary medical insurance would not be tax-deductible.

Masa proposes a "national health care financing system" funded from general tax revenue as opposed to funding from a special tax on employees, such as the special social insurance taxes common in European countries.

Masa acknowledges the current funding system, which it describes as a "voluntary system with a state-provided safety net", is insufficient.

Now the health system promotes multiple standards of service, where income, insurability and geographic location all determine the quality and range of access to health services, according to Masa.

The state health plan will have important consequences for the players who now dominate the health scene.

For instance, the document poses the question whether medical aid cover for core services will actually be necessary if the state does extend its health involvement. Masa also suggests the role of the state in financing non-core services should be reviewed.

Masa admits using general tax as a source of funds for this purpose has the weakness of not providing incentives for cost-effective use of medical services but it believes this is the best route.

There is no clear definition of the scope of the government's responsibility in providing health services. It proposes that state spending on core health services be budgeted for, and reported on, separately from other health services.

Pink bag problem? Phone the council

Staff Reporter (85) ARG 13/1/92

MEDICAL practitioners wishing to dispose of pink bags containing hazardous medical waste should telephone the City Council cleansing division to arrange for its collection, says Medical Officer of Health, Dr Michael Popkiss.

This follows statements from several doctors in the Southern Suburbs that Council workers handle the hazardous pink bags no differently from the ordinary domestic black ones.

"The pink bags are primarily for the protection of the workers who handle them," Dr Popkiss said. Merely being aware that the pink bags contain hazardous waste serves to protect these workers.

"Final disposal of hazardous waste is in the same trenches as other waste. I would however prefer that it was handled and disposed of entirely separately," Dr Popkiss said.

Practitioners experiencing difficulties or who wish to make queries about the pink bag service should contact the office of the director of cleansing at ☎ 400 3020.

Khayelitsha health awareness campaign

85 ARG 16/7/92

EDWARD MOLOINYANE
Staff Reporter

A WEEK-LONG health awareness campaign, aimed at improving the quality of life through health care, has been launched in Khayelitsha.

The campaign, at Nolungile Health Centre in Site C under the auspices of the Khayelitsha Health Care Forum — a grouping of more than 20 organisations — started on Monday.

The project was officially launched by the director general of the Department of National Health and Population Development, Dr Coen Slabber, last year.

A number of activities, among them slide shows on child health, pre-school programmes, drama, stalls selling baby food, cooking demonstrations and family planning presentations have been lined up for the week.

Hundreds of children, accompanied by workers from the Western Cape Regional Services Council and the Lingelethu Town Council took part in a clean-up operation in Site C on Tuesday.

The project is financed by the RSC through the South African Christian Leadership Assembly (Sacla).

The RSC is responsible for several services in Site C, including health care and night soil collection.

According to projects co-ordinator Mrs Koleka Lubelwana, about 20 community health care workers have been employed and trained to provide primary health care services to the community.

The workers are paid by Sacla, which oversees projects.

Mrs Lubelwana said the workers made door-to-door visits and the project was popular in the community, with people from as far as Macassar using the services.

She said the project was so far confined to Site C but depending on this week's campaign, more such projects could not be ruled out.

Masa may help in health dispute

CHARLIE PRETZLIK

THE Medical Association of SA (Masa) looks increasingly like being drawn into helping resolve the dispute over health workers' pay and conditions.

There were indications in discussions last night that Masa, together with the newly formed SA Health and Social Services Organisation and other health groups, would be brought in as a mediator in the dispute between Nehawu and the authorities. The talks continue today.

The parties hope that Masa will be able to encourage intervention "at the highest level". BIDAY 16/7/92.

A solution to the six-week-old hospital workers' strike also appeared closer after a meeting between Nehawu and the Cape Provincial Administration (CPA) in Cape Town yesterday.

Nehawu secretary-general Phillip Dexter said he was "optimistic and hopeful" any agreement reached in the Cape province would influence the outcome of strike talks in other provinces.

The CPA displayed a more progressive approach than the TPA, he said. His union had begun urging strikers in Natal and the Cape to return to work.

The CPA said yesterday that 2 387 hospital, roads, community service and conservation workers were still on strike, LINDA ENSOR reports.

Striking workers marched through the Kimberley Hospital, while at Valkenberg strikers from surrounding hospitals gathered in the hospital and allegedly forced non-striking workers to join them.

Frere Hospital in East London announced that 90% of its work force had resumed work.

Prescription to tackle apartheid

STAR 20/7/92 (98) (85)

The South African Health and Social Services Organisation, which aims to unite progressive health groups into a powerful component of civil society, was launched virtually unnoticed earlier this month amid the ongoing hospital strike, reports PAULA FRAY.

WHILE media attention was focused on the ongoing hospital strike, a broad range of professional and community-based health and social service workers joined forces to launch a unique and potentially powerful group on July 4.

The unification of various progressive health organisations follows the emergence of a number of small groups during the past decade — with similar aims but divergent approaches — to fight the effects of apartheid in health.

The progressive health and social services organisations had a political, not labour, approach, says SA Health and Social Services Organisation (Sahsso) publicity secretary Dr Aslam Dasoo.

"The move to unity has been a long process, particularly because of the differing political backgrounds of the organisations. The first act in the unity process actually took place in March 1989 when health and social service workers' associations and organisations merged nationally to form the Health Workers' Association.

"There was an acceptance of the principle of unity in action ... that the organisations would take apartheid on jointly but would each retain their autonomy."

A closer relationship was urged and unity was finally endorsed at a meeting in the western Cape last year. Groups which have already joined include the SA Health Workers' Congress, the National Medical and Dental Association, the Organisation for Appropriate Social Services in SA, the Overseas Medical Graduates' Association, and the Health Workers' Society.

People's power . . . the new national health and social service says it will have as its principal pillars accountability, affordability and accessibility.

"What we saw (officially) launched on July 4 this year is possibly the third largest force of the emergent independent organs of civil society," says Dr Dasoo. "If one accepts that the labour sector will be an independent organ of civil society alongside the national civic sector, then this forms the third most organised formation in civil society."

Dr Dasoo belives the notion of civil society is one borne out of decades of struggle and the need for civil society to be protected from the government ... whichever government that may be.

It will need its own, independent, organs in order to empower the people. This is what is emerging in South Africa, says Dr Dasoo.

"Cosatu has given notice to the tripartite alliance of the ANC-SACP-Cosatu that in the instance of a democratic government, Cosatu will remove itself from that alliance formally and constitute itself again to take care of the interests and demands of the workers and therefore of civil society."

In this, says Dr Dasoo, lies the biggest strength of the organs of civil society: "They don't become bland, toothless tools. They must remain organs of people's power, and therefore the principal aim and demand of Sahsso is the empowerment of our communities — the political, social and economic empowerment of our communities."

The launch of Sahsso, says Dr Dasoo, means that the struggle in the health and social services sector has moved to a qualitatively higher level. "Whereas before, in the 1980s particularly, the accent was on the politics of protest, now the accent is, and should be, the politics of development and empowerment."

In this light Sahsso has already begun a process of establishing the organisation at grassroots level. "Once the community is in control it can effectively act as an organ of people's power. It forms, together with the trade unions and civic movement, the shatter-belt which will protect civil society from any government of the day, whoever that government might be."

But, without political empowerment, even the "most fancied, most advanced health policy will be meaningless and worthless".

"Sahsso sees itself as an independent organ of civil society which will seek to empower our communities in the health and social service sector through the establishment of a nonracial, non-sexist and a democractic national health service in the country.

"This national health and social service will have as its principal pillars accountability to the communities it serves, affordability and accessibility." □

Hospitals' emphasis on cost criticised

BIDAY 2/7/92

LINDA ENSOR

CAPE TOWN — A doctor's role at academic hospitals had changed from one of saving lives to one of saving cents, departing head of UCT's cardio-thoracic surgery department at Groote Schuur Prof John Odell said yesterday.

He said preoccupation with cost-saving techniques at these hospitals had overtaken concern about clinical work and research.

It had become impossible, without compromising patient care, to make further cost savings, but this was repeatedly being demanded. He said that since announcing his resignation and planned emigration, a number of his colleagues had told him they were also planning to leave SA.

"Financial restrictions forced upon hospital administrations have resulted in an over-zealous and overbearing attitude in the application of cost-containment measures.

"The attitude is that 'rationalisation, cost containment and a new approach' justifies the means, and if someone falls by the wayside, it's 'part of the new SA'.

"It must be realised that the future health of the country's people is dependent on medical schools and teaching hospitals. It is through them that all future medical doctors and health-care workers are trained."

Homicide probe over dead boys

(85)

CT 24/7/92

THOHOYANDOU. — The police are to investigate two charges of culpable homicide after the deaths of two boys, aged 11 and 13, at the Tshilidzimi Hospital in Venda last week, police spokesman Captain Cas Jones confirmed yesterday.

The two boys, from Venda villages, were taken to hospital from a traditional circumcision school near Levubu, outside Venda.

A Department of Health and Welfare spokesman in Venda said the boys had been in a critical condition and had bled profusely. They died on admission.

According to the director-general for health and welfare, Dr John McCutcheon, traditional circumcision schools in Venda are banned, and that had helped in reducing the number of casualties related to the practice. — Sapa

Hospital strike was avoidable — Masa

By Paula Fray

The tragic consequences of the ongoing labour disruptions at hospitals could have been prevented if adequate dispute resolution mechanisms existed, Medical Association of SA (Masa) federal council chairman Dr Bernard Mandell said yesterday.

Masa called for the urgent establishment of a negotiation structure in accordance with accepted international labour relations practice.

The call came as the Transvaal Provincial Administration (TPA) said in a statement that all dismissals of strikers were final.

National Education, Health and Allied Workers' Union (Nehawu) general-secretary Phillip Dexter said the union was "obviously disturbed, but not surprised" at the TPA action. "It just means we will have to intensify our actions," he said, adding that Nehawu's programme of occupation of hospitals would continue.

The TPA yesterday reported several violent strike-related events in the Transvaal at the weekend. It said dismissed Ga-Rankuwa Hospital workers threatened to burn down the houses of several hospital employees.

Phillip Dexter . . . disturbed, but not surprised.

Two hospital workers were treated for burns on Saturday after their houses had been petrol-bombed, the TPA said.

● A 44-year-old Johannesburg man underwent an emergency heart transplant operation at Cape Town's Groote Schuur Hospital at the weekend, despite pressure on resources due to the strike.

● About 600 members of the health workers' union were still on strike at eight Cape Peninsula hospitals yesterday.

Plea for blood

PEOPLE may die in Natal next week if additional blood donors do not give blood this week.

The shocking situation has arisen because the shortage of blood for the Natal Blood Bank has worsened since yesterday's appeal for people to come forward and help. Blood stocks are dwindling rapidly.

This week it was reported that if supplies were not boosted urgently it could mean a life-threatening situation for people in need of transfusions.

Mrs Janis Chapman, public relations manager for the Natal Blood Transfusion Services, said: "If we do not get more donors this week, we could have deaths on our hands within the next few days."

- *Sowetan Correspondent*

New health school set to change medical education

Health Reporter

A NEW Western Cape School of Public Health, based at the University of the Western Cape, is set to transform traditional medical education.

The school will offer participatory in-service training for people in the health arena to encourage them to influence health policy from grassroots upwards.

It is headed by returned exile Dr Olive Shisana who is a social epidemiology graduate of the John Hopkins University in the United States.

Two similar schools are in the pipeline in Natal and the Transvaal and could play an influential role in future planning of health services.

Professor Caroline Ntoane, head of nursing at UWC, said the underpinning philosophy of the school was that there was a crisis in the health-care system and that medical training was not geared towards solving that crisis.

Workshops, discussions, role-plays, brainstorming and case studies will be the mainstay of the school's educational approach and courses will be offered at times which suit working adults.

The school, which will be in full swing by 1993, kicked off its activities with a winter school focusing on primary health-care and the restructuring of the present system.

Professor Ntoane said the "highlight" of the winter school was a course led by four consultants from Kenya's African Medical Research Foundation on the training of facilitators.

The end result of this particular module was a booklet produced by people who had worked in the field of health showing the way to tackle training of community workers.

The group felt communities had "enormous potential in identifying and facilitating the solution to their problems". This contrasted with common practice in health planning where outside agencies have handed down would-be solutions to problems.

"This approach has created a serious dependency syndrome," the participants felt.

Professor Ntoane said: "The whole notion is to empower people who in turn will go out and empower communities. The key words are transformation, empowerment and collaboration for community development."

Natal short of blood

(86) G 31/7/92

NATAL Blood Transfusion services have made an urgent appeal to all other provinces for blood, saying they faced a "critical shortage" because of serious flu epidemics and next week's threatened mass action.

Reports by Staff Reporter, Own Correspondent, Sapa-Reuter-AP and UPI.

A woman adds a tyre to a burning barricade in Khayelitsha, near Cape Town, as hundreds of thousands continued a nationwide strike yesterday. Picture: AP

Witnesses 'were informers'

PRETORIA — Counsel for the Weekly Mail and the ANC conceded yesterday that two witnesses who testified against the police on "safe houses" gave unreliable evidence to the Goldstone Commission.

Frans Rautenbach in his argument told the Goldstone Commission committee inquiry into allegations of police involvement in underground operations to kill ANC activists that the committee should accept part of the evidence of Solly Mngomezulu while that of Daniel Kolisang was totally unreliable.

Kolisang told the committee he first had contact with the police on December 7 last year before he was promised a job with the Transvaal Provincial Administration by Sgt J Seago. BIDAY 5/8/92.

On January 2 1992 he was taken to a police safe house in the Vaal Triangle where he was interviewed by a white policeman called Brian who told him he (Kolisang) would be employed as an informer and he was to kill certain activists.

Kolisang said he reported the matter to ANC officials in Sebokeng. But police argued that the man was an informer on their payroll who seemed to have got scared and decided to report the matter to the organisation.

Mngomezulu claimed that after he returned from exile he was approached by a policeman known as Robert who promised him employment with a cosmetics company, but he was taken to a safe house near Parys were he was told to be an informer.

He said he was kept at the smallholding for several days until he escaped. He reported to the ANC and later pointed out the house to Weekly Mail reporters. Police denied the house was a safe house.

Police said Mngomezulu had agreed to work as an informer and had told them he was connected to the police before he went into exile.

Following the submission of counsel for the police, Flip Hattingh, on Monday, Rautenbach agreed the witnesses were unreliable in many instances. — Sapa.

tionally the total extra court time hours.

Who's WHO in health

KATHRYN STRACHAN

FOUR UN World Health Organisation (WHO) officials are to speak at a local health conference which begins outside Johannesburg today, for the first time since the organisation broke off relations with SA.

The four-day conference has been organised by the Community Health Association of SA (Chasa).

The event will include an exhibition of medical equipment at Nasrec Centre near Soweto.

Conference organiser Jackie Swart said the conference would be addressed by more than 100 speakers, including 12 international experts. BIDAY 5/8/92

It was intended to bring about a unified strategy for improving health in southern Africa.

Truth on violence

New health bill causes an uproar

PRETORIA. — The Patients' Rights Organisation of South Africa (Prosa) has strongly opposed certain sections of the Medical Schemes Bill.

Prosa said yesterday the bill, which was heard by the Parliamentary Committee on Health here last week, contained sections which could allow medical schemes to run their own Health Maintenance Organisations (HMOs) with their own hospitals and pharmacies, where they would employ their own medical practitioners.

CT 10/8/92

In evidence to the committee last week, Prosa said it felt HMOs would stifle competition and infringe the rights of patients who belonged to medical schemes. — Sapa

'Mass medicine' may spell transplants' end

ANDREA WEISS
Health Reporter

SOUTH AFRICA celebrates 25 years of heart transplants this year — but, the future of the operation which put the country on the international medical map is in the balance.

Dr Ralph Mgijima, health secretary for the ANC, said it was "very, very possible" after an evaluation of health policy that heart transplants would be suspended in future.

He said the ANC was looking at reorganising the whole of the health service with emphasis on primary and preventative care.

It had not yet reached the stage of evaluating the cost of free, basic care for all South Africans. Once this had been done, it would be possible to see what was left to spend on "heart transplants and other exotic operations", he said.

Dr Mgijima said the weighing up of costs had to be looked at in the context of whether, for instance, it was better to improve living conditions in Soweto, thus preventing diseases like rheumatic heart fever, or to spend the money on expensive operations.

Countering this argument is Professor John Odell, head of the University of Cape Town's heart surgery department which pioneered heart transplants in the world. Professor Odell leaves for the United States at the end of the year, but is optimistic about the future of transplant surgery.

"I don't think this country can afford to stop it. Heart transplants put South Africa on the map.

"If we do stop the operation, what will happen is that patients will go overseas. There will be emotive appeals in the newspapers, money will leave the country and everybody will be reminded of what is happening to the health system."

He added: "There have been a lot of spinoffs. We have learned a lot more about immune response and tolerance which can help with the management of Aids."

In an editorial written for the Southern African Journal of Critical Care, Professor Odell acknowledged that heart transplantation was under "intense pressure" because of the perception that it was expensive and only benefited a few.

"If the results were not as good as they are, one would have no hesitation in reconsidering the service. We have shown that with paediatric heart transplants the costs are comparable with the management of childhood leukaemias and intensive neonatal care.

"We have reduced the costs of immunosuppressive therapy by 72 percent by combining cyclosporin and ketoconazole (drugs used in post-operative care).

"The long-term costs are now comparable to the other costs of chronic diseases. The procedure has brought immense credit to Groote Schuur Hospital, the University of Cape Town and South Africa.

"It has shown the rest of the world that the standard of medicine practised here is comparable to the best in the world. We must not make the mistake of stopping transplantation."

Professor Chris Barnard believes the choice is simple: "We have to decide whether we want medical treatment to reach the standard of Third World countries. If we decide to take the Third World route, there is no place for heart transplants.

"If we want to maintain the high standards for which we are recognised, we must continue to do transplants."

He said there was no doubt there was a need to concentrate more on "medicine for the masses", but it would be a pity if this was allowed to cancel out other aspects of medicine.

He said the notion that transplants were expensive implied that not doing them cost nothing.

"But, if you don't do the transplant, you have a patient with chronic heart failure who needs expensive medication, frequent hospitalisation and who can never go back to a productive life."

Professor Barnard added that people who made decisions to suspend this kind of treatment had probably never had a loved one with chronic heart failure and were "disqualified by their non-involvement".

"It would be a great pity if we deteriorated to the state where we treated only measles and mumps."

FLASHBACK: This was how The Argus covered the historic heart transplant operation on Mr Louis Washkansky in December 1967, an operation that catapulted Dr Chris Barnard, Groote Schuur Hospital and Cape Town to instant fame.

The Cape Argus
CAPE TOWN, MONDAY, DECEMBER 4, 1967
PRICE 5c

Patient's condition 'first class', Groote Schuur doctors say

CRISIS AFTER 7 DAYS

MAN WITH A NEW HEART

Three years' work on 'op'

Louw tells of key factor in heart transplant

Thirty-two hours after his historic heart transplant in Groote Schuur Hospital, Mr. Louis Washkansky is maintaining his satisfactory condition. Dr. J. C. Burger, Medical Superintendent of the hospital, said this afternoon that the 55-year-old patient's condition was unchanged since this morning.

THE critical part in the heart transplantation would be in about a week's time, Prof. J. H. Louw, head of the Department of Surgery at the University of Cape Town Medical School, said today.

MISS DENISE ANN DARVALL — fatally injured in a road accident — for whom her lover Mr Louis Washkansky, a new lease of life.

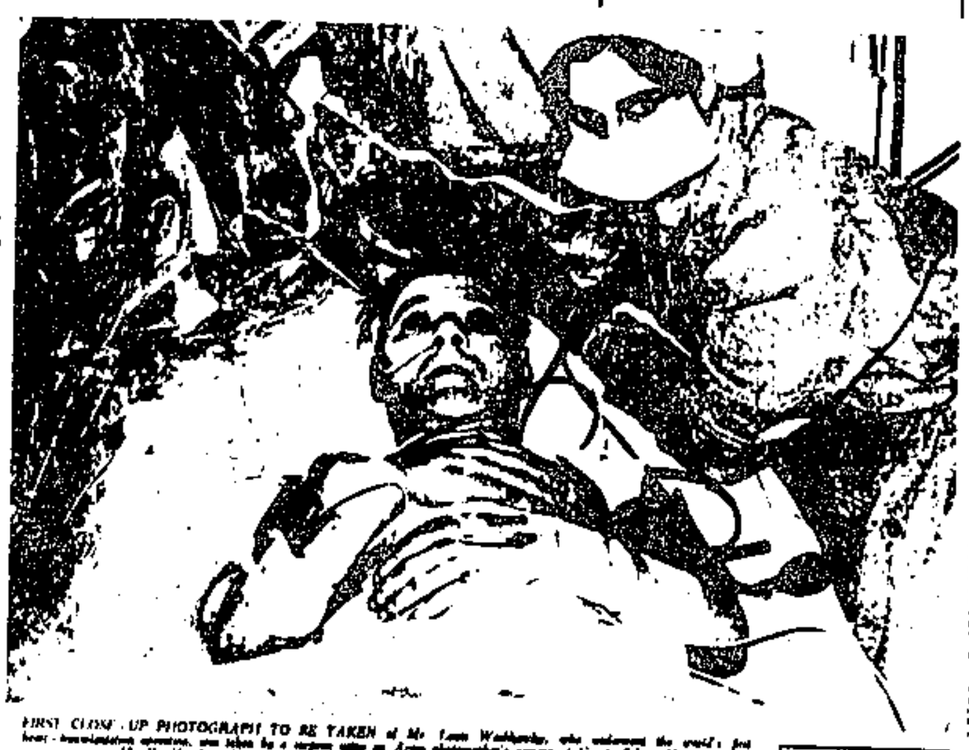
Crucial time

Round the clock

They will miss Denise...

DENISE ANN DARVALL, 23-year-old ledger machinist, was due to be promoted in about a month's time.

★ Beaufort West will be proud. Page 2.
★ More pictures. Page 3.
★ Chances of survival. Page 4.
★ The Argus medical correspondent. Page 6.
★ Leading article. Page 10.
★ Medical world thrilled.



FIRST CLOSE-UP PHOTOGRAPH TO BE TAKEN of Mr. Louis Washkansky, who underwent the world's first heart transplantation operation, was taken by a surgeon using an Argus photographer's camera at Groote Schuur Hospital today. Mr. Washkansky, whose condition was given as good, is being assisted to breathe by a respirator.

Woman had no chance of survival

MRS. Myrtle Ann Darvall, mother of the boy donor, was killed in the road accident which led to Mr Washkansky's part of a world milestone in medicine. Three members of the Darvall family survive — Mr. Edward George Darvall and his two sons, Kevin (14) and Stephen (11).

HEAD OF TEAM

By a Staff Reporter

MR. LOUIS WASHKANSKY, whose life expectancy was not longer than a few weeks because of a seriously diseased heart, is included in a special ward at the hospital and under minute-to-minute observation of his condition.

Her kidney helps a boy (10)

Partly cloudy

This month's 5 people have died on W.P. roads

DAVIS CUP: SPAIN WINS. REPORT Page 2

Other pages

LOOK MA! NO PINS...

Engineering sector hard hit

SHARON SOROUR
Labour Reporter

THE Western Cape engineering sector has been hard hit by the two-week nationwide strike by tens of thousands of workers, with strategically important companies being crippled by the industrial action.

According to National Union of Metalworkers of SA (Numsa) regional secretary Mr Adrian Sayers, about 2 000 regional workers have downed tools.

He said it was the first time the Western Cape engineering sector had been severely affected by a strike.

Mr Sayers said the last strike, in 1988, had barely had an effect, but this year companies in the docks were involved, as well as other "strategic engineering firms". Artisans were also on strike.

Workers were set to march to Seifsa's Foreshore offices this afternoon following a deadlock in talks with the employer body.

Seifsa spokesman Mr Hendrik van der Heever said the meeting had ended in deadlock.

Numsa was not prepared to withdraw its key demand for a moratorium on retrenchments, he added.

Seifsa would appeal against a Pretoria Supreme Court dismissal of its application for an interdict declaring the strike illegal.

Dispute over fired workers

Labour Reporter

CLOTHING union Sactwu has launched a campaign to secure the reinstatement of about 100 dismissed workers who were fired for joining a city centre protest march in June.

According to SA Clothing and Textile Workers' Union regional organiser Mr Ronald Bernickow, six Western Cape employers had refused to reinstate workers.

The companies, SA Cap, Teeny Tages, Alpa-Rose Manufacturing Co, Maxmore, HK Manufacturers and Shareen Knitwear, had also refused to enter into talks, he said.

Workers demonstrated outside the factories yesterday and handed a memorandum to the Cape Clothing Manufacturers' Association (CCMA).

● CCMA executive director Mr Peter Cragg was not available for comment.

Walmer Estate decision soon

Municipal Reporter

A CABINET decision on selling the seven ministerial residences in Walmer Estate is expected soon, a Department of Public Works spokesman said.

There had been a lot of interest from corporate potential buyers.

The department had drawn up a memorandum asking the Cabinet for guidelines for disposing of the property.

Responding to a proposal by the Woodstock/Walmer Estate/Salt River management committee that the houses be sold to the Saudi Arabian government, the director-general of public works said the future use of the houses had not been determined.

Professor's plea to keep transplant ops

ANDREA WEISS, Health Reporter

PROFESSOR John Odell, outgoing head of heart surgery at Groote Schuur Hospital, has made an impassioned plea for the survival of transplant surgery under a new dispensation.

Professor Odell was responding to ANC health secretary Dr Ralph Mgija's view that heart transplant surgery may well be scrapped to make way for broader health needs in the future.

Professor Odell

Speaking at a mayoral function to launch Organ Donor Week, Professor Odell said the ANC view was "rather shortsighted".

He said transplantation and organ donation had no racial barriers.

If transplantation was stopped it would set a precedent which would have a negative ripple effect on other related disciplines.

Transplantation was cost effective because the results were excellent and patients returned to active life.

It could also not be offered only in private practice because if only the affluent were to benefit from transplantation it would be impossible to approach the families of brain dead people to ask for their organs.

He said if transplantation was stopped, there would be impassioned pleas to raise money for transplants abroad. The money would leave the country and everybody would be reminded of the standard of medicine the country once practised.

Dr Mgija said the ANC's position was that basic health-care should be available to all. Once this had been budgeted for, the remaining money could be allocated to things like "heart transplants and other exotic operations".

Dr Mgija added that, given this background, it was highly likely that heart transplants would be scrapped.

Registration fees for doctors to be increased

The Argus Correspondent

JOHANNESBURG. — Registration fees for doctors will increase from R258,50 to R281 (including VAT) next year, according to the latest South African Medical Journal.

Meanwhile, doctors have called on the Medical Association of South Africa (Masa) to investigate the structure of the South African Medical and Dental Council (SAMDC) and look at alternative ways of funding for the organisation.

The SAMJ said the fees were payable to the SAMDC by all registered practitions on or before January 1 next year. Practitioners who failed to pay their fees might find themselves removed from the register.

"Although the percentage increase for 1993 is well below the inflation rate, the fact that these fees have risen steadily over the past few years has resulted in widespread criticism from among the ranks of the profession," said the journal. The fees have risen from R100 in 1987 to R235 plus VAT this year.

Govt, ANC tackle abortion in new SA

(85) (237) CT 20/8/92

Own Correspondent

DURBAN. — Abortion "on demand" in a new South Africa would not be "easily allowed" if the present government had anything to do with it, the director-general of the Department of National Health and Population Development said yesterday.

However, although official ANC policy had not been formulated, ANC Women's League chairwoman Dr Nkosazana Zuma indicated she was "pro-choice".

Dr Coenraad Slabber and Dr Zuma were tackling the topic of A Future Health System for SA at a forum organised by the Institute for a Democratic Alternative for South Africa (Idasa) here.

Dr Zuma said the number of fatalities from "backstreet" abortions — 14 out of 1 800 admissions at King Edward VIII Hospital last year alone — was enough to persuade her abortion should be legalised.

But both agreed that a future health system must promote the goal of free health for all, could not be based on ethnicity and must be decentralised to the greatest possible extent.

However, Dr Slabber said a "detailed blueprint" for a future health system would depend on the constitutional model adopted in the country, although it would be "folly to wait until finality is reached".

Therefore, the government had accepted five policy principles on which health services in South Africa should be built: equity, accessibility, affordability, efficiency and acceptability.

Granger Bay: Developer urges rethink

ARG 21/8/92

CLIVE SAWYER
Municipal Reporter

DEVELOPER Mr Harry Fuchs, up in arms about the way Cape Technikon has handled proposals to redevelop its Granger Bay campus, has asked for a chance to put in a proposal for the site.

He has questioned the Technikon's granting of power of attorney to a firm of architects to handle the rezoning application, and the fact that a Technikon council member is a partner in the firm.

Lawyers acting for Mr Fuchs's company, Seacore Investments, have asked Minister of Education and Culture in the House of Assembly Mr Piet Marais to ensure "free market principles" are applied.

Rezoning for offices, flats and a hotel on the old merchant academy site have so far got the go-ahead from the city council town planning and executive committees.

The rezoning application was made by architects Meiring, Van Der Lecq and partners, on behalf of the Technikon.

In correspondence with the Technikon and Mr Marais, copies of which were given to The Argus, Mr Fuchs objected to the proposal being processed without the Technikon calling publicly for proposals from developers.

The Technikons Act prevented it from giving away any rights, such as power of attorney, without ministerial permission, Mr Fuchs said.

He said one of the principals of the firm of architects, Mr Jack van der Lecq, was on the Technikon council.

A 1980s proposal for a R200 million development by Mr Fuchs's company was turned down by the Department of Trade because the only way to dispose of the site was by public tender.

Mr Fuchs said he had asked the Technikon to furnish plans of the site to enable his company to prepare a proposal.

In a July letter, the Technikon said it was autonomous, had not bound itself to any developer, but reserved the right to do so.

Lawyers for Seacore told Mr Marais that Cape Technikon seemed to be using a particular developer and firm of architects, to the exclusion of others from Cape Town and the rest of the country.

"The Granger Bay site, if indeed it is developable, is a unique development opportunity, the impact and benefit of which will be felt not only by the Technikon, but also the greater Cape Town and western Cape community,"

They asked Mr Marais to ensure, if he gave permission for the sale or swop of land, that the process be open and according to free market principles.

Technikon spokesman Dr Nick Kok said section three of the Technikons Act made it a body corporate, legally entitled to confer rights, while selling land would need ministerial permission.

ANC unsure about cost benefits of heart swops

ARG 21/8/92

ANDREA WEISS
Health Reporter

IT was an "embarrassment" that heart transplants had put South Africa on the medical map when the country had some of the worst infant mortality rates in the world mainly due to preventable diseases, the ANC has said.

The ANC was countering comments by Professor John Odell, head of cardiothoracic surgery at UCT, who has made a plea for the continuation of heart transplants in the "new" South Africa.

This year celebrates 25 years of heart transplants.

In a statement, ANC health secretary Dr Ralph Mgijima, said: "The fact of the matter is that health policy makers in South Africa including the ANC are unsure about the cost benefits of heart transplants.

"It has been argued for instance that if a heart transplant is done on a patient, it will decrease the costs which would be incurred were the patient instead be medicated and hospitalised repeatedly to sustain life."

Dr Mgijima said the ANC had no access to studies to prove this theory.

Even if heart transplant patients fared better, measures such as the promotion of health and provision of housing would have to be taken into account before transplants could have an established place in a future South Africa.

The prevailing view was that no country was justified in undertaking very expensive operations for preventable diseases if that country spent no resources on preventative measures.

Dr Mgijima said most health policy makers agreed on the need to maintain high standards in health within the primary health-care approach.

Dr Mgijima challenged Professor Odell to make concrete studies available to the ANC for comments or to allow a "third party" such as a community health department member of UCT to do such a study.

Govt plans new health policy

(85) CT 1/9/92

MMABATHO. — The government intended to introduce a new health policy as soon as possible, Deputy Health Minister Mr Fanus Schoeman said here yesterday.

Addressing a health conference in Bophuthatswana's capital, Mr Schoeman said the government had already succeeded in devolving primary health care to local authorities to a great extent.

● The prevalence of TB in certain areas of South Africa could be ascribed to the need for correct diagnosis, the stealthy nature of the disease and its tendency to take on different forms, Dr Johan Steenekamp of the Institute of Pathology, University of Pretoria and the H F Verwoerd Hospital said at the weekend.

He was addressing the National Conference of the Epidemiological Society of South Africa in Johannesburg.

Another speaker, Dr Krisela Steyn of the Tygerberg Hospital's Medical Research Council, said no smoking, a healthy diet and regular exercise will reduce the impact of chronic diseases on mortality in South Africa. — Sapa

Small rights . . . they may be little but they have big patients' rights.

What the South African Medical and Dental Council says:

The Council was established 80 years ago to protect patients' interests, says registrar Nico Prinsloo.

"This is done by ensuring the highest standards of training of doctors and other health personnel, and by laying down ethical norms with which practitioners have to comply.

"If any person is dissatified with the services of a doctor, he can lodge a complaint with the council. All complaints are investigated and, if there are grounds, the council will take disciplinary steps."

Mr Prinsloo says the council believes records made by doctors are done to assist that doctor in the treatment of the patient. "But a patient is entitled to a written report from his doctor if he requests one."

"Informed consent" means patients are being told the risks of treatment, Mr Prinsloo says; doctors are already required to inform patients "of the pros and cons".

While there is a rule regarding "supercession" in which a doctor may not take a patient from another doctor without a patient informing his own doctor, the patient can go to the practitioner of his choice.

"The patient has freedom of choice. All he has to do is tell his doctor he wants to go to another doctor," says Mr Prinsloo.

Medical professionals could form companies

KATHRYN STRACHAN

DOCTORS, dentists and other professionals registered with the SA Medical and Dental Council will soon be allowed to form group companies.

Council registrar Nico Prinsloo said last week that "group practices" could, for example, consist of a doctor, a dentist, a physiotherapist and a psychologist — all working for the commercial benefit of the shared company.

All parties of the company would have to be individual members of the SA Medical and Dental Council, which did not include nurses and pharmacists, who were registered with different councils.

Prinsloo said the Medical Act was amended in May, enabling Health Minister Rina Venter to make regulations to permit group practices.

The council's executive committee had made certain recommendations in connection with the new law, and these would be considered by the full council next month.

Prinsloo said there was a lot of support for the plan, and he expected it to be in place in November.

He said although professionals would share income under the trading company umbrella, professional conduct would be judged strictly on an individual basis.

Practitioners were expected to benefit financially from the scheme, because by sharing facilities and resources they would be able to run a cost-effective practice.

But Prinsloo said he did not anticipate that any savings would be passed on to the patient.

Medical costs would remain largely the same for patients, he said.

It was expected that the plan would offer certain communities a wider range of services, said Prinsloo.

He said it may not have been financially viable for professionals such as physiotherapists to open a private practice in some areas, but a company might enable them to do so.

The council had previously been opposed to group practices out of concern that the system could be abused.

Prinsloo said there had been fears that a patient could be unnecessarily referred by a general practitioner to a specialist because the GP stood to gain financially.

Although this possibility still existed, the council believed any abuse of the system would be reported to the council, and that medical aid schemes would be alert to the potential for unnecessary use of funds.

Cut-backs in health

ET 18/9/92

DRASTIC cut-backs in Cape Provincial hospitals are expected to be announced next week in an attempt to curb projected overspending of between R100 million and R200 million.

A Cape Provincial Administration (CPA) spokesman, Mr Krige Visser, said yesterday that the overspending would have to be "addressed" before the end of the current budget in March 1993.

Row over AWB driver

(85)

10/9/92

NO steps are being taken against a white ambulance driver who refused to work with a black colleague last weekend because he is a member of the AWB, a spokesman for municipal ambulance drivers claimed yesterday.

However, Cape Ambulance Rescue Service chief officer Mr Rod Douglas yesterday defended the service's non-racialism and said the incident had been probed and a disciplinary hearing arranged.

Mr Douglas said in response to the claim by the SA Municipal Workers' Union: "I would not allow anything like this to sit. The service has been colour-blind for years, and we're very proud of it."

Health workers aim to oust Venter

THE South African Health and Social Services Organisation (Sahsso) and the National Health, Education and Allied Workers' Union (Nehawu) were expected to lead a campaign of mass action yesterday. (85) (CPress 20/9/92

This follows an announcement made by the Natal Provincial Administration on its proposed cutbacks on health funding in Natal.

Demands made to the government include the resignation of Health Minister Rina Venter.

SA to have one health ministry

CT 29/9/92

(85)

Own Correspondent

PRETORIA. — South Africa is to get a single health department in a "drastic" rationalisation programme, National Health Minister Dr Rina Venter said yesterday.

The phasing out of own affairs health departments and their incorporation into general affairs of the national health departments was aimed at more efficient and cost effective service, she said.

The plan is part of an overall effort to rationalise own affairs administrations.

Dr Venter told the conference of role players and professional groups in the health field at a meeting yesterday that the necessary legislation would be finalised soon to make this possible.

She warned, however, that this move in itself would not solve the critical funding problems faced in the provision of health services.

She emphasised that the rationalisation plan was no cosmetic exercise. The Treasury was unable to provide additional funds because of the country's strained economic conditions.

The country could no longer afford big increases in the funding of health services. In the past, substantial additional allocations to health had been made. This was no longer possible.

Drastic steps had already been taken which resulted in big savings. These had not been taken without adverse consequences for health services.

Because of the current economic situation and its impact on health services, further savings were vital.

Primary health care would be devolved to local authorities. Academic hospitals would be granted maximum autonomy and their management model was being formalised.

The rationalisation of services would be investigated with the national committee co-ordinating.

Venter unveils health merger

B|D Any 29/9/92 85

PRETORIA — SA was to get a single health department in a "drastic" rationalisation programme, National Health Minister Rina Venter said yesterday.

The phasing out of own affairs health departments and their incorporation into general affairs was aimed at more efficient and cost-effective service, she said.

The plan was part of an overall effort to rationalise own affairs administrations.

Venter told role players and professional groups in the health field at a meeting yesterday that the necessary legislation would be finalised soon to make this possible.

She warned, however, this move in itself would not solve the critical funding problems faced in the provision of health services.

She emphasised the rationalisation plan was no cosmetic exercise. Treasury was unable to provide additional funds because of the country's strained economic conditions.

The responsibility not to overshoot budget limits rested on the shoulders of all in the health family.

The health dispensation, she said, was under severe financial pressure. It would be difficult, but no effort would be spared in bringing about further savings.

GERALD REILLY

The country could no longer afford big increases in the funding of health services. In the past substantial additional allocations to health had been made, but this was no longer possible.

During the past three years the provincial adminstrations had been confronted with services problems in staying within health budgets.

Drastic steps had already been taken which had resulted in big savings. These had not been taken, however, without adverse consequences.

Primary health care would be devolved to local authorities. Academic hospitals would be granted maximum autonomy.

Academic hospitals took about a third of total health budgets and they had an undeniable role in making health services more affordable.

Sapa reports that Venter said the rationalisation and devolution of all primary health care services to local authorities were intended to create a cost-effective service and to facilitate community participation.

Venter said the reconstruction of health services entailed the establishment of a national committee to initiate and co-ordinate an investigation into rationalising health services with input from regional committees.

SA'S HEALTH CARE SYSTEM IS BLEEDING TO DEATH

By FRED KHUMALO C/Pmen 27/9/92 (85)

SA's health care system is bleeding to death.

And tomorrow, when Health and Population Development Minister Dr Rina Venter makes a final nationwide address on the implementation of the controversial 5 percent cuts in the health budget, she could deliver a fatal blow to the already besieged sector.

The first casualty could be Natal, which this week saw Newcastle and Mpangeni hospitals up for sale as a result of the financial squeeze.

Privatisation will save Newcastle from certain closure, said MP for the area Adriaan Blaas.

Now at stake in the province is the possible withdrawal of benefits flowing from a R39-million grant given two years ago by the State President to Durban's hospitals. King Edward VIII got the lion's share of the grant, an attempt to bail the hospital out of its downward financial spiral.

Sick health system faces more cuts

Withdrawal of this grant will mean the sacking of 5 000 hospital staff, many of whom are at King Edward. The measures will also signal the closure of 2 400 beds and the turning away of 500 000 patients a year.

King Edward, one of the most overcrowded hospitals in the country, had a foretaste of worse things to come when 340 beds were cut from the hospitals allowance at the beginning of the financial year.

The measures are in keeping with the budget proposals of Finance Minister Derek Keys, whose aim is to slash government spending.

To Natalians, the cost-cutting measures also mean:

- The termination of the air and ambulance wing of the Ambulance and Emergency medical services; and
- Termination of subsidies to State-aided hospitals such as McCords Zulu Hospital and St Mary's in Marianhill.

The proposed cuts have roused an animated debate within medical and political circles.

Democratic Party MP Carole Charlewood said she was "absolutely appalled".

"Natal has always been shortchanged compared to other provinces when it comes to the health allocation, and to take a 5 percent budgetary cut such as this means our health system is going to haemorrhage," she said.

Head of King Edwad's paediatrics unit, Prof Jerry Coovadia, said: "For a province which boasts 25 percent of the country's population, we should have a far higher budget than other provinces."

Startling disclosures show that 90 percent of kidney failure patients referred to Durban's Addington Hospital renal unit are refused treatment for the life-threatening condition because of inadequate resources.

The hospital's renal unit services Natal and KwaZulu, which constitutes a population of six million people.

ANC health affairs Dr Nkosazana Zuma has hit hard at the proposed budget cuts and the privatisation of hospitals.

"While they (the government) say they want to negotiate the future of the country, they are at the same time unilaterally taking such drastic decisions as privatising hospitals. No consultation whatsoever was exercised by them with any of the interested parties," she said.

She said the ANC had appealed to the government to halt the privatisation of hospitals as it was diminishing the number of people who can afford medical care.

New name for body

THE National Cancer Association of South Africa will in future be known as the Cancer Association of South Africa.

The association will also have a new logo and corporate colour.

Making the announcement on Wednesday, Dr Tommie Liebenberg, executive director of the association, said the word "national" had been deleted from the association's name as it had become superfluous.

"The term 'South Africa' already indicates the association serves the total population of South Africa and underpins its mission to fight cancer with the help of the South African community," he said. - *Sapa*.

Note: The interim and full year results for 1991 have not been adjusted by the results of operations discontinued after the end of the year.

Masa rejects study 'leaked' to media

BI DAY 21/0/92

KATHRYN STRACHAN

THE Medical Association of SA (Masa) has dissociated itself from a study it commissioned which claimed that medical aid scheme fees were not justified by actual health costs.

Masa health policy director Reg Magennis said yesterday the study, covered in a report in Business Day on Monday, was one of several commissioned to assist Masa in its representations to government to make health services VAT-free.

But the study was discarded because it was found to be incomplete and to contain "inconsistencies, unsubstantiated conclusions and conjecture".

The economist who compiled the report had died.

Magennis said official Masa figures did not support the view that medical scheme membership fees were not justified by the increase in health costs.

He said the study had apparently been made available to Business Day by third parties without the knowledge or consent of Masa. Masa would not have granted permission for its publication.

Business Day was sent the report by a company that owns private clinics.

'Skin bleacher' probed

Staff Reporter (85) CT 2/10/92

AN investigation has been launched by the Medical Officer of Health into a cosmetic, "Essence of Ivory", alleged to be a skin lightener and sold to black women over the counter by at least one city pharmacy.

Skin lightening cosmetics have been banned in South Africa.

Dr N M Durcan, Deputy Medical Officer of Health, said yesterday a sample had been sent for examination, but the results were not yet available.

The Legal Resources Centre (LRC) had asked the City Health Department and the Department of National Health and Population Development to investigate the product.

The LRC had sought initially to launch Supreme Court proceedings to stop the manufacture and sale of the cosmetic, but it had been decided to refer the matter to the city council.

Mr Matthew Walton, an LRC attorney, said his organisation had been approached by Mr Dudley Martin, director of a recruitment company, to investigate the distributors.

The distributors had asked Mr Martin to recruit sales staff.

Mr Walton said there were grounds for investigating the distributors on a charge of manufacturing and/or selling a cosmetic that purported to be a "skin bleacher, skin lightener or skin whitener".

Lifestyles blamed for chronic diseases

NEARLY a quarter of all deaths in South Africa are due to diseases caused by an unhealthy lifestyle, according to a Medical Research Council (MRC) investigation.

OCT 3/10/92

The MRC said in a media release yesterday its researchers had found nearly half the South African population needed to improve its lifestyle to reduce the risk of chronic diseases.

"The unhealthy lifestyles that result in chronic diseases are smoking, unhealthy diet and a lack of exercise which in turn can cause risk factors such as tobacco addiction, hypertension, high blood cholesterol, obesity and diabetes to develop." — Sapa

SA lifestyle a grave fact

ANC 3/10/92

NEARLY a quarter of all deaths in South Africa are caused by unhealthy lifestyles.

This is the finding of a study by the Medical Research Council published in the latest issue of the SA Medical Journal.

Dr Krisela Steyn, Ms Jean Fourie and Dr Debbie Bradshaw attributed 25 percent of deaths in 1988 to chronic lifestyle diseases like strokes, heart disease and cancers.

Smoking, unhealthy diets and lack of exercise have been blamed.

Among the risks created by these behaviours are tobacco addiction, hypertension, high blood cholesterol, obesity and diabetes.

The researchers found that nearly half the South African population needed to improve their lifestyle to reduce the risk factors for chronic diseases.

The World Health Organisation estimates that if the rates of increase continue, chronic lifestyle diseases will account for a quarter of all deaths in developing countries — and the study shows that South Africa has already reached this mark.

The researchers found that 4,88 million South Africans smoked. Nearly five million South Africans had high cholesterol levels and an associated increased risk of ischaemic heart disease while 5,5 million South Africans had high blood pressure.

The highest smoking rate was among urban "coloured" men (57 percent), followed by Indian men (55 percent), black men (51 percent) and "coloured" women (40 percent).

Urban "coloured" populations had the highest prevalence of high blood pressure while high cholesterol levels were common among the "coloured", Indian and white groups.

The lowest rate of cholesterol was found in the urban black group in Cape Town while the rural black group in Qwa Qwa had remarkably higher prevalences. Dr Steyn described this finding as unusual.

She anticipated that, as availability of services improved in rural areas, there would be no discernable difference between urban and rural risk profiles.

Dr Steyn said there was no unified national programme to prevent or reduce the prevalence of lifestyle diseases which constituted a major health problem for South Africa.

"Lifestyles can be improved by directing intervention programmes at the whole population via the media, at the workplace, and from an early age within the educational system," she said.

"Adequate resources need to be allocated, and sound research must be conducted to implement effective prevention, diagnoses, management and rehabilitation for chronic diseases of lifestyle in South Africa."

■ South Africans are killing themselves with unhealthy lifestyles, a study in the latest issue of the SA Medical Journal has found. It is time the country's health services tackled the problem, says the research team.

ANDREA WEISS, Health Reporter

Doctors' orders: a health system that's free of profit

South
By Justin Pearce 3/10 - 7/10/92.

85

ONE SOLUTION — total revolution. That is the only way to create a health system that serves the needs of the people, say two Cuban doctors now visiting South Africa.

"The statistics speak for themselves," said Dr Carlos Zahala in his address to the first general meeting of the South African Health and Social Services Organisation (SAHSSO).

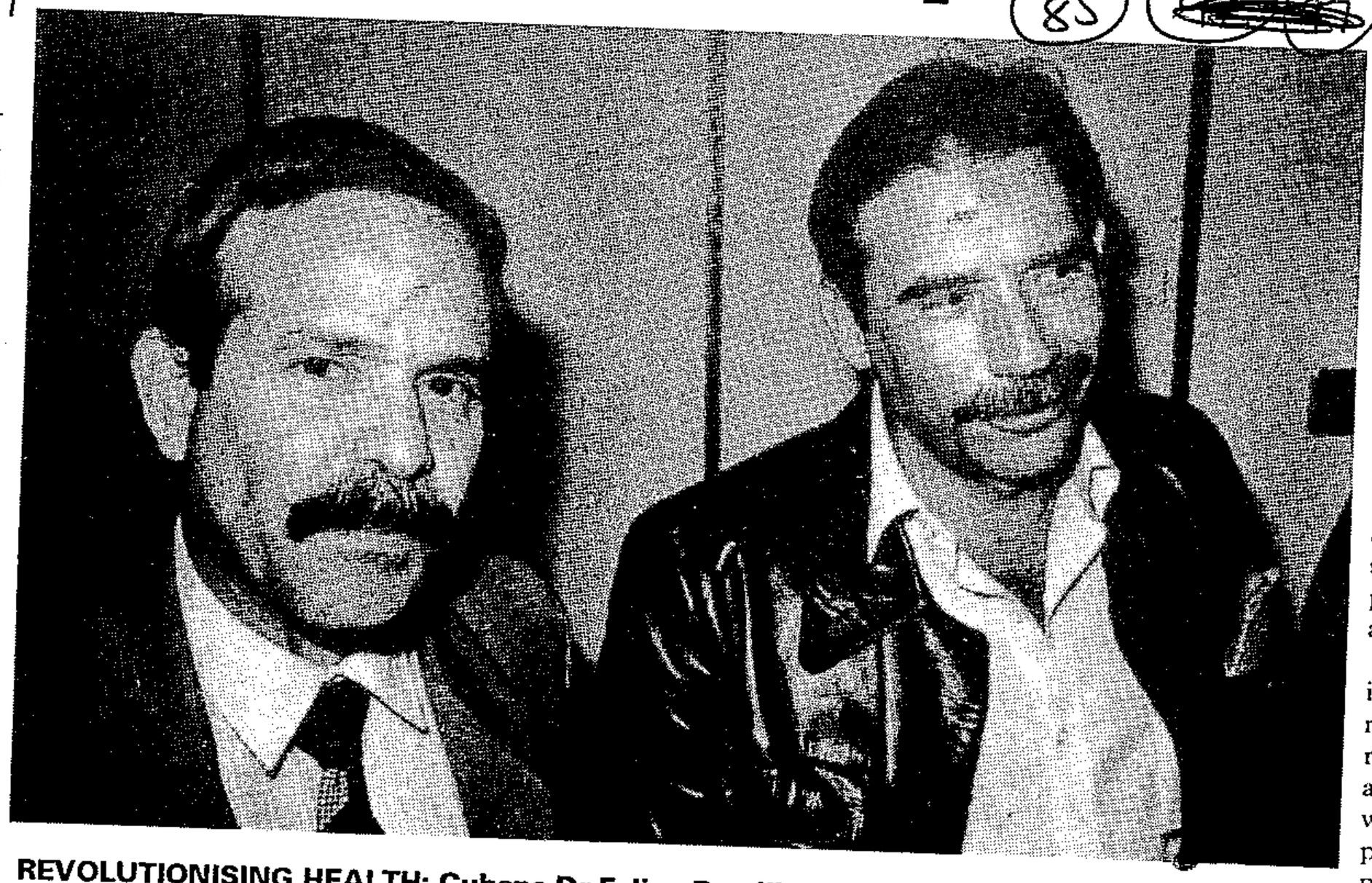
His colleague Dr Felipe Bustillo read a list of figures which document Cuba's remarkable record in the prevention and cure of disease.

Cubans have a life expectancy of about 76 years, the country has an infant mortality rate of barely one percent, and there is one doctor for every 250 people.

Other gains include the virtual eradication of tetanus, polio, diphtheria and German measles and the decline in cases of tuberculosis from 65 cases per 10 000 people in 1965, to 5,1 cases per 10 000 people in 1991.

Health care, whether it involves a headache or a heart transplant, is free. Even face-lifts have been provided by the state health system, though not without controversy.

The health system is partly financed by very heavy taxes on cigarettes and alcohol. Smokers pay the equivalent of R20 for a packet of cigarettes in Cuba — but the state won't charge you anything to treat your bronchitis or lung cancer.



REVOLUTIONISING HEALTH: Cubans Dr Felipe Bustillo (left) and Dr Carlos Zahala who are visiting South Africa

Also important, Zahala said, is that no profits are made from health care.

These developments have taken place in a country where before the 1959 revolution the services of a doctor were scarce and where half the doctors emigrated to the United States after the revolution.

Zahala maintained that such a record could not have been achieved without an integrated health system operated by the state, with the needs of society rather than profit as its priority.

He said an efficient disease prevention policy can help to eliminate 70 percent of diseases. Such a policy can never be implemented through a medical system that is privatised and profit-making.

"It is very difficult to sell lifestyle. How do you sell occupational or environmental health?"

Bustillo described the Cuban health system as a "doctor-based system".

In every community there is a state medical centre staffed by a resident doctor and nurse. As well as treating disease, the doctors are responsible for immunisation and the early detection of disease.

The nurse leads exercise programmes, conducts sex education, and teaches about aspects of healthy living, such as giving up smoking.

Integral to the health care system is a highly efficient hygiene and epidemiological surveillance system. Regional surveillance centres collate information from doctors, nurses, schools, workplaces and old age homes.

The team of health workers includes insecticide specialists who help to eliminate the insect-borne diseases that are common in a tropical country like Cuba.

HIV infection, which causes Aids, is handled with an efficiency that borders on the totalitarian. Testing is compulsory for "high risk" groups, including foreigners who spend more than three months in Cuba. This also includes Cubans who have spent more than three months abroad and "people near the harbours".

People found to be HIV positive are admitted to special "sanitoria" where they are isolated from society and educated about lifestyle. If they seem responsive to the education programme they are allowed home at specified intervals.

The result is an alleged HIV infection rate of 0,006 percent. The means used to achieve this startling result would probably horrify Aids activists in Western countries, where the emphasis has been on protecting the human rights of people with HIV and Aids.

Zahala also admitted that the Cuban approach to HIV infection would be impractical in Africa, where the virus is already widely prevalent.

Aids was already known in other countries before it reached Cuba, and the country's island position restricts the flow of people across its borders.

Cuba implemented a preventative strategy typical of the way its health system works, and a systematic HIV monitoring programme began even before Cuba's first HIV case had been discovered.

R50-m boost to health care

STAR 9/10/92

By Philip Zoio

The Department of National Health and Population Development yesterday unveiled a R50 million-a-year plan to improve primary health care (PHC) in South Africa.

The department's director-general, Dr Coen Slabber, told a press conference in Johannesburg that 151 clinics were being built around the country in a "concerted effort to expand our PHC services".

Although South Africa's hospital services were good, its health services were only average and significantly poorer than those of developed countries.

He said there was a marked difference in life expectancies and infant mortality rates between South Africa's population groups.

In the PHC programme, the department is to address the eight "critical" elements of PHC identified by the World Health Organisation.

These elements deal with nutrition, sanitation, disease control and family planning, and provision of information, medication and medical treatment.

Medics' 'union' gets new teeth

(85)

By EVE VOSLOO

FOR the first time in South Africa, doctors working at state hospitals will have their interests specifically represented in the formal process of collective bargaining.

In an insert distributed with the South African Medical Journal (SAMJ), the secretary general of the Medical Association of South Africa, Dr Hendrik Hanekom, says "this significant breakthrough has been achieved with the recognition of Masa as a staff association by the Commission for Administration". ST Times

"Masa now forms part of the negotiating forum within which each staff organisation has the opportunity of representing the unique and divergent interests of its members," he said.

The recognition of Masa as a staff association took place last month, a Masa spokeswoman said this week. [Cape Mail]

Enclosing a Masa membership application form with the SAMJ, Dr Hanekom appeals to all state-employed doctors to join "to add to Masa's strength when negotiating full-time practitioners' conditions of service and remuneration". 11/10/92.

Influence

"In an environment in which the quality of medicine is under siege, the influence of the profession depends on you and your membership of the medical association," Dr Hanekom says. "All future negotiations on behalf of doctors in full-time practice and the state will be governed by the Public Service Labour Relations Act."

He said Masa's recognition had already allowed the association to influence cetain provisions in the draft Public Service Labour Relations Act; gained acceptance that the needs of Masa members differed from those of other professional groups and also facilitated the setting up of additional channels for more efficient consultation between the state and the medical profession.

"The proposed Act will also create new machinery and procedures for the protection of state employees from unfair labour practices," Dr Hanekom says.

Masa to act as trade union for doctors

B1Days 13/10/92

THE 13 000-strong Medical Association of SA (Masa) is preparing itself to act as a trade union for doctors in both the public and private sectors.

Masa's secretary Hendrik Hanekom said Masa had recently been recognised as a staff association by the Commission for Administration and was now party to the negotiating forum with 11 other staff associations in the public sector.

He said Masa was investigating the role it could play in collective bargaining in other sectors as well.

Hanekom said Masa's new role gave it the opportunity to "responsibly represent the medical profession" in matters concerning salaries and wages.

He said that with the right to negotiate, came responsibilities Masa would uphold.

About 45% of Masa's members work as doctors in the public sector.

Masa was the first body to represent doctors in a collective bargaining capacity.

Although some doctors were members of the Cosatu-affiliated National Union of Health and Allied Workers' Union (Nehawu), the union had not yet tried to negotiate on their behalf.

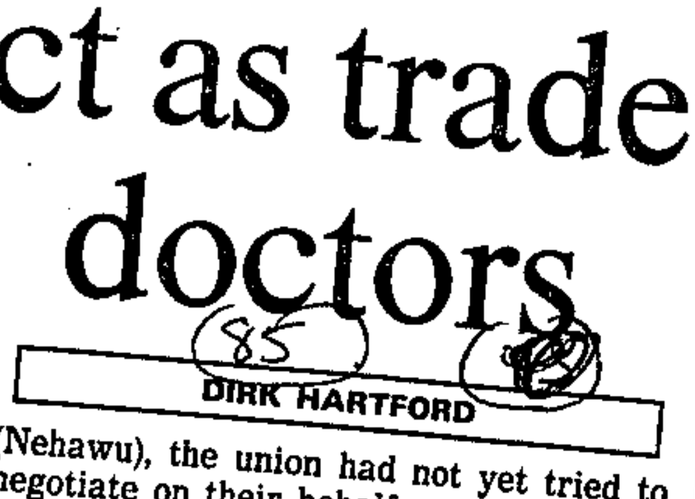
During the recent health workers strike, doctors who supported Nehawu threatened to take action — but this did not happen.

Masa had embarked on a recruitment drive among doctors in the public sector. Doctors have been urged to sign up and to recruit at least one other member so the medical profession can play a leadership role for health care in the public sector.

All negotiations on behalf of doctors working for the state would be governed by the proposed Public Service Labour Relations Act which was due to become law during this sitting of Parliament.

Cosatu and Nehawu have rejected the proposed new law which they believed had been pushed through the back door.

In addition, they said they had not been properly consulted on the law, although they had been the major organisations fighting for public sector workers to enjoy the same rights as workers covered by the Labour Relations Act.



DIRK HARTFORD

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Accused hoped 'to lure investors'

Thousands of marchers jammed Cape Town's streets yesterday to protest against the two-week special session of Parliament. Picture: AP

McBride cheered outside Parliament

B1 DAY 13/10/92

Political Staff

CAPE TOWN — Thousands of people marched through Cape Town's streets yesterday to protest against the reopening of the tricameral Parliament for a special session.

Outside the gates of Parliament the ANC welcomed new heroes through a booming public address system. The loudest cheer was reserved for Magoo's Bar bomber Robert McBride, one of the leaders of the march.

The ANC leadership, addressing thousands of supporters in the blazing sun in Roeland Street, insisted that the current government had to go.

ANC vice-president Walter Sisulu, Joe Slovo and Allan Boesak addressed the crowd gathered in Roeland Street — renamed "ANC Memorial Street" for the day.

Stalplein, next to Parliament, was renamed Luthuli Square in memory of former ANC president and Nobel peace laureate Albert Luthuli.

McBride and Mthetheleli Mncube, released from prison recently after both had spent time on Death Row after being found guilty of murder, were met with sustained applause when they were introduced to the crowd.

ANC leader Ronnie Kasrils rejected any comparison with those who had been killed in defence of apartheid, saying the linking of McBride with Strijdom Square mass murderer Barend Strydom was "utterly disgusting".

Sisulu, who replaced ANC secretary-general Cyril Ramaphosa as leader of the march, said this Parliament's last task was to rubber stamp agreements negotiated with "the legitimate representatives of the people".

Sapa reports six UN observers kept a high profile throughout the day, and were joined by six local monitors from the National Peace Secretariat and two representatives of the Goldstone commission.

Policemen in camouflage uniform watched the proceedings, while dozens of ANC marshalls in khaki controlled the demonstrators. A man was apprehended by marshalls for allegedly breaking a window in Plein Street.

Health bodies protest against restructuring

85

KATHRYN STRACHAN

HEALTH organisations yesterday staged a demonstration in Johannesburg in protest against government's plans to "unilaterally restructure health services" during the current session of Parliament.

The "Stop Rina Venter and Co" rally — which included supporters from the SA Health and Social Services Organisation, SA Dispensing Practitioners, ANC, Cosatu, SACP and Disabled People SA — was led by SACP general secretary Chris Hani.

B10DAY 13/10/92

A memorandum submitted to the health department's regional offices claimed that the session was intended to safeguard "the privileges of the ruling minority". It called for a moratorium on restructuring in the public sector which could lead to more than 50 000 retrenchments.

Private health plans slated

BIDAY 21/10/92

PLANS by the private health care community to introduce managed health care organisations have been condemned by the SA Dispensing Practitioners' Association.

Addressing the association's conference at the weekend, committee member Dr Rashid Saloojee said medical aid schemes, in collusion with clinic groups, planned to entrench "their dominance over all aspects of the private health care market".

Saloojee said while medical scheme administrators claimed managed health care organisations would do away with the abuse of medical aid schemes by patients and doctors, they would serve only vested interests and not the needs of the people.

The concept originated in the US and could not simply be transplanted into SA.

Account of Webster murder claim denied

BIDAY 21/10/92

SUSAN RUSSELL

A FORMER member of 32 Battalion, called to testify at the inquest into the murder of academic David Webster yesterday, denied former CCB freelance operative Ferdi Barnard had told him "we did Webster".

Kevin Treisman, who was subpoenaed to testify by lawyers acting for the Webster family, said he had never discussed the Webster murder with Barnard whom he described as an acquaintance.

When Treisman took the witness stand, counsel for the Webster family, E Bertelsmann SC, asked him if it was correct he had told instructing attorney Greg Nott earlier yesterday that he had been pressured and was not prepared to testify.

"I didn't say I was scared," Treisman said. "I said I had nothing to say."

He denied telling Nott yesterday that certain people and the police were all involved and/or a colonel from Bramley had said he should keep his mouth shut.

"Did you say you were prepared to spend 90 days in Diepkloof rather than answer questions," Bertelsmann asked him. "No sir," he replied.

He agreed that an explosive device thrown into his garden some months ago could be regarded as a threat.

"I would take it as a threat, but it could be for many things," Treisman said.

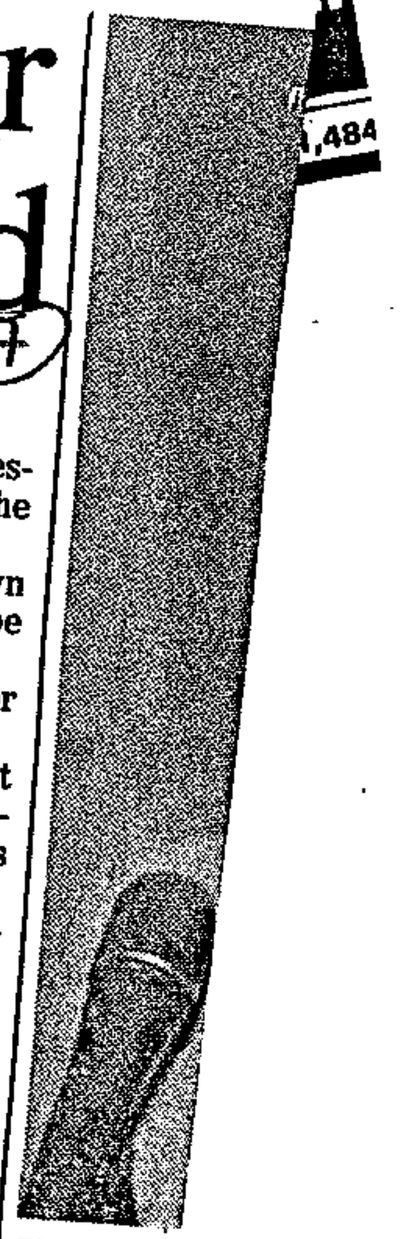
Questioned by Bertelsmann, he agreed that Nott and Weekly Mail journalists, Drew Forrest and Eddie Koch, had visited him at his Corlett drive home in May this year.

Treisman said he had not discussed his relationship with Ferdi Barnard with them.

He also denied telling them that he had discussed the Webster murder with Barnard or that Barnard had said "we did Webster".

He said when Nott called at his home in September he told him he had nothing to say.

Bertelsmann told Treisman that he would ask his instructing attorneys to arrange "that circumstances be created in which you may reconsider the evidence which you have given".



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Professor Hennie Snyman, principal of the Port Elizabeth Technikon.

METROPOLITAN DIGEST (Johannesburg)

(a) Vol 9 no 3 1991.

(b) Food Gardens Unlimited.

(c) People are encouraged to plant their own food.

(a) February and April 1992.

(b) South African Fashion Designers' Association.

(c) The organisation and its founder president: Ms Esther Mohlabi.

VISION (Durban)

(a) February 1992.

(b) ASSIST (Association Supporting Survivors of Incest and Sexual Trauma).

(c) The work that this organisation does.

(a) March 1992.

(b) Advice Desk for Abused Women.

(c) Where abused women can obtain advice.

KARET (Cape Town)

(a) 14 February.

(b) Women's Bureau.

(c) Report on seminar: 'Taking charge of your life'.

(a) 13 March.

(b) Kontak.

(c) Women must build on peaceful future.

(a) 13 March.

(b) Women for South Africa
Women's Bureau
National Council of African women
Orange Free State Women's Association.

(c) Group photograph.

(a) 1 September.

(b) Women for South Africa.

(c) Organisations co-operate to establish a training centre for women in Stellenbosch.

(a) 1 October.

(b) Women for South Africa.

(c) National president, Ms Jenny Malan, talks about human rights.

(a) 1 November.

(b) Kontak.

(c) Ms Pauline Mkalipe, chairperson, speaks about the aims and objectives of the organisation.

LIGHT/KHANYA (Pretoria)

(a) January 1992.

(b) Pretoria Friendship Forum.

(c) Function held by this organisation.

(a) April 1992.

(b) Tholuwazi Women's League.

(c) Activities of the group.

(a) May 1992.

(b) Tekset.

(c) Negotiation seminar held by this group.

(a) September 1992.

(b) Itsoseng Women's Club.

(c) Club receives financial aid from private sector.

LUX FEMINA, women's magazine, Pretoria Regional Office:

(a) December 1991.

(b) Atteridgeville Ladies' Club.

(c) Founding of the organisation.

(a) December 1991.

(b) SA Vroue Federasie.

(c) Interview with the president.

(a) March 1992.

(b) Kontak.

(c) Kontak emphasises nation-building.

(a) June 1992.

(b) Women's prayer day.

(c) A function in Mamelodi.

(a) June 1992.

(b) Tekset.

(c) Negotiation seminar for members of the organisation.

(a) September 1992.

(b) Sidingulwazi Women's League.

(c) The activities of the group.

PUISANO (Bloemfontein)

(a) October 1991.

(b) Women for South Africa.

(c) Profile of Dr Elsie de Beer.

(a) October 1992.

(b) Women for South Africa.

(c) Women in various communities must learn to understand one another.

4.4 RSA POLICY REVIEW/ RSA-BELEIDSOORSIG published the following:

(a) September 1991 p 56.

(b) The South African Nursing Association.

(c) Nursing Centenary: An interview with the president of the Association, Dr Anna-Marie Bruwer.

(a) September 1991 p 67.

(b) The sections: Vocational Matters and Community Health Care of the Department of National Health and Population Development, and the South African Nursing Council.

(c) Nursing geared for challenges: An article based on interviews with Ms Odelia Muller, Deputy Director: Vocational Matters, and Ms Iris Röscher, Director: Community Health Care of the department, and representatives of the South African Nursing Council.

(a) October 1992, p 94.

(b) Natal women's congress of the National Party.

(c) An announcement by the State President in Amanzimtoti (Natal) stating that the Government will sign international conventions relating to women and women's rights.

Forum on curtailment of cost of medicine

403. Mr M J ELLIS asked the Minister of National Health: 85

(1) Whether, with reference to her reply to Question No 348 on 19 June 1992, all interested parties have commented on the record of the proceedings of the forum held on 28 Feburary 1992; if not, when is it anticipated that this will be the case; if so, what parties;

(2) whether she is in a position to commission any investigations as recomended at this forum; if not, why not; if so, what are the relevant details;

(3) whether any such investigations have been commissioned to date; if not, why not; if so, (a) by whom and (b) on which recommendations;

(4) whether she will make a statement on the matter? B906E

The MINISTER OF NATIONAL HEALTH:

(1) Only 8 (eight) interested groups submitted comments on the report of the forum. The groups are:

The South African Pharmacy Council
The Medical Association of South Africa
The Pharmaceutical Manufacturers' Association of South Africa
National Association of Pharmaceutical Wholesalers
The South African Nursing Association
Noristan Group
Patients Rights Organisation of South Africa
Pfizer South Africa;

(2) yes, no investigation excepting those by the working groups have until now been commissioned;

(3) no, a working group has been appointed to investigate the recommendations of the forum and to report back;

(4) no.

Importation of parallel medicines

404. Mr M J ELLIS asked the Minister of National Health:

(1) Whether the Medicines Control Council has considered, is considering or intends considering regulations to allow the im-

cont-d.

portation of parallel medicines; if not, why not; if so, when;

(2) whether the proposed regulations have been or are to be (a) made known to and/or (b) discussed with interested parties; if not, why not; if so, what are the relevant particulars;

(3) whether she will make a statement on the matter? B907E

The MINISTER OF NATIONAL HEALTH:

(1) Yes, the Medicines Control Council is at present investigating the desirability of requesting the amendment of certain regulations made in terms of the Medicines and Related Substances Control Act, 1965 (Act 101 of 1965);

(2) yes, any proposed amendment of regulations must be published for comment unless the Minister is of the opinion that the public interest requires the regulation to be made without delay;

(3) no.

Discussions on health services

405. Mr M J ELLIS asked the Minister of National Health:

(1) Whether, subsequent to discussions held on 28 September 1992, a paper entitled "Announcement of a strategy to manage health services in the present economic climate" was published; if so, what are the names of the main participants and professional groups involved in these discussions;

(2) whether one of the aims discussed was to stimulate discussions on how health services could be made more affordable; if so, what items were discussed in this connection;

(3) whether the points debated at the forum held on 28 February1992 have been reviewed; if not, why not; if so, which points;

(4) whether any decisions have been taken on any of these points; if so, what decisions;

(5) whether she will make a statement on the matter? B908E

The MINISTER OF NATIONAL HEALTH:

(1) Following the discussion held on the 28 September 1992 with certain roleplayers on financial questions in the field of health I released a press statement entitled "Announcement of a strategy to manage health services in the present economic climate".

The main participants and professional groups involved in these discussions were:

Dr E H Venter MP
Minister of National Health and of Health Services: House of Assembly

Rev A A Julies MP
Minister of Health Services and Welfare: House of Representatives

Dr A S Jacobs
Department of Finance

Mr J W H Meiring
Administrator of the Cape of Good Hope

Mr D E T le Roux
Member of the Executive Committee: Cape

Mr J H A Beukes
Director-General: Provincial Administration of the Cape of Good Hope

Dr G S Watermeyer
CPA Branch: Hospital and Health Services

Mr C J van R Botha
Administrator of Natal

Mr P M Miller
Member of the Executive Committee: Natal

Dr N E Howes
Director-General: Provincial Administration of Natal

Dr L van der Watt
Administrator of the Orange Free State

Dr P J C Nel
Member of the Executive Committee: Orange Free State

Dr J H Kotzé
PAO Branch: Health Services

Mr S E S Ferreira
Member of the Executive Committee: Transvaal

Mr A Cornelissen
Director-General: Provincial Administration of the Transvaal

Dr H van Wyk
TPA Branch: Health Services

Mr P D McEnery
Director-General: Administration: House of Representatives

Dr L J Nel
Ministerial Representative

Mr R Dercksen
Ministerial Representative

Dr M H Veldman
Ministerial Representative

Mr H J Smith
Ministerial Representative

Mr R E Redinger
Ministerial Representative

Dr J H Kruger
Supervisory Board, Bloemfontein

Mr B B Humphris
Supervisory Board, Witwatersrand

Prof G Everingham
Supervisory Board, Cape Town

Prof J V Leatt
University of Natal

Prof J R van Dellen
University of Natal

Prof G J de Korte
Medunsa

Prof J Terblanche
University of Cape Town

Prof C W I Pistorius
University of Pretoria

Prof J V van der Merwe
University of Pretoria

Prof H P Wasserman
University of Stellenbosch

Prof C J C Nel
University of Orange Free State

Prof A D Rothberg
University of the Witwatersrand

Dr P S Maharaj
Administration: House of Delegates

Dr J E Pieterse
Administration: House of Assembly

Dr C F Slabber
Director-General: National Health and Population Development

Professional Groups:

Dr D A Green
Medical Association of South Africa

Mrs S J du Preez
Nursing Council of South Africa

Dr A M Bruwer
Nursing Council of South Africa

Prof M E Muller
Nursing Council of South Africa

P R de Kock
Environmental Health Officers Association of South Africa

R D Kennedy
Medunsa

Mrs L Munro
Society of Radiographers

Ms M Horak
Society of Radiographers

Ms A Hugo
Society of Radiographers

Dr M Adam
Society of Dispensing Family Practitioners

Cmdt H C Grobler
SA Association of Biochinetics

Mr M Tepper
Society of Medical Laboratory Technologists of South Africa

Prof B van Os
Dental Association of South Africa

Mr W Kriel
Pharmaceutical Society of South Africa

G N Lyne
Pharmaceutical Society of South Africa

E D Smith
South African Society of Physiotherapy

M W Cheyne
Orthotic and Prosthetic Association of South Africa

C M Smith

Orthotic and Prosthetic Association of South Africa

Dr G Kinmont Hicks

Psychological Society of South Africa

(2) yes, the aim was a discussion to make health services *within the public sector* more affordable and to have all within the public sector to participate in the establishing of priorities and possible identifying of saving precautions. No other items were discussed.

(3) no;

(4) no;

(5) no.

Own Affairs:

Model C schools: payment of school fees

74. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether his Department has laid down any guidelines concerning the measures that may be introduced by the governing body of a Model C school to recover compulsory school fees and other moneys owed by the parents; if not, what procedure is followed in this regard; if so, what measures may be introduced for this purpose;

(2) whether any steps will be taken in respect of any pupil whose parents do not pay compulsory school fees; if so, what steps;

(3) whether the governing body of a Model C school may refuse admission to any applicant pupil on the grounds that his parents have a history of non-payment of school fees? B895E

The MINISTER OF EDUCATION AND CULTURE:

(1) No, governing bodies determine their own measures regarding the recovery of compulsory fees and other moneys owed by the parents;

(2) no, legal action may be taken against the parent under specific circumstances but no steps will be taken against a pupil;

(3) no.

Educational properties: municipal rates

75. Mr D H M GIBSON asked the Minister of Education and Culture:

(1) Whether the Government will remain responsible for the payment of municipal rates levied by local authorities on Government-owned properties used for educational purposes; if not, (a) why not and (b) what is envisaged in this regard;

(2) whether the buildings housing Model C schools will remain Government-owned properties; if not, why not;

(3) whether it is the intention of the Government to pay rates levied on educational properties belonging to independent schools once such properties become rateable; if not, (a) why not and (b) what procedure will be followed in this regard? B905E

The MINISTER OF EDUCATION AND CULTURE:

(1) With reference to public schools for either public ordinary education or specialised education, which are state property, yes; with reference to state institutions as defined by the Rating of State Property Act, relating to universities and technikons, yes; with reference to state-aided schools for specialised education and technical colleges, yes; and with reference to state-aided schools for ordinary education yes, until such time as another arrangement, for example possible exemption, may be made by means of further negotiations,

(2) no, because the immovable property concerned is transferred to state aided schools in accordance with the provisions of article 31A(a) of Act 70 of 1988;

(3) no,

(a) in terms of a recent Cabinet decision private schools will not be expected to pay municipal rates until such time as another arrangement has been determined through negotiation.

(b) see answer 3(a).

School governing bodies: title deeds

76. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether it is the intention of the Government to make over title deeds to school governing bodies; if not, why not; if so, when;

(2) whether he will make a statement on the matter? B900E

The MINISTER OF EDUCATION AND CULTURE:

(1) No, because as from the date on which a public school is declared to be a state-aided school, the ownership of immovable property vested in the State, shall devolve upon the *state-aided school*. In order to record the transfer certain endorsements must be made on the title deed, and entries in the register of the Registrar of Deeds. The original title deeds remain in possession of the Registrar of Deeds, but after the endorsements and entries referred to, have been made, the state-aided school receives a copy of the title deed. The transfer is, however, subject to a reversionary clause endorsed on the title deed.

(2) no.

School fees: financial assistance

77. Mr R M BURROWS asked the Minister of Education and Culture:

(1) Whether any applications for financial assistance regarding the payment of school fees have been received from parents of children attending Model C schools; if so, how many such applications were (a) received and (b) approved;

(2) whether any funds have been allocated in respect of such assistance; if not, why not; if so, what total amount as at the latest specified date for which information is available? B901E

The MINISTER OF EDUCATION AND CULTURE:

(1) Yes,

(a) 53 304,

(b) 48 944;

(2) yes,

R38,89 million on 26 October 1992.

Parents of disabled march for new grants

CT 27/10/92 (85)

Staff Reporter

MORE THAN 100 mothers carried their disabled children on a march through the city yesterday and booed when the Cape Provincial Administration's director of community health, Dr Norman Kahlberg, picked up a child and said: "We love these children as much as you do."

The parents marched in the blazing sun to the CPA offices in Wale Street to demand full payment of state grants which they claim have been denied them since April.

A memorandum delivered to the CPA said that "despite the announced increase in single care grants in April 1992 from R150 to R278, quite a substantial number of parents still receive grants of less than R150 (per month)".

The memo also insisted that grants be equalised across racial lines.

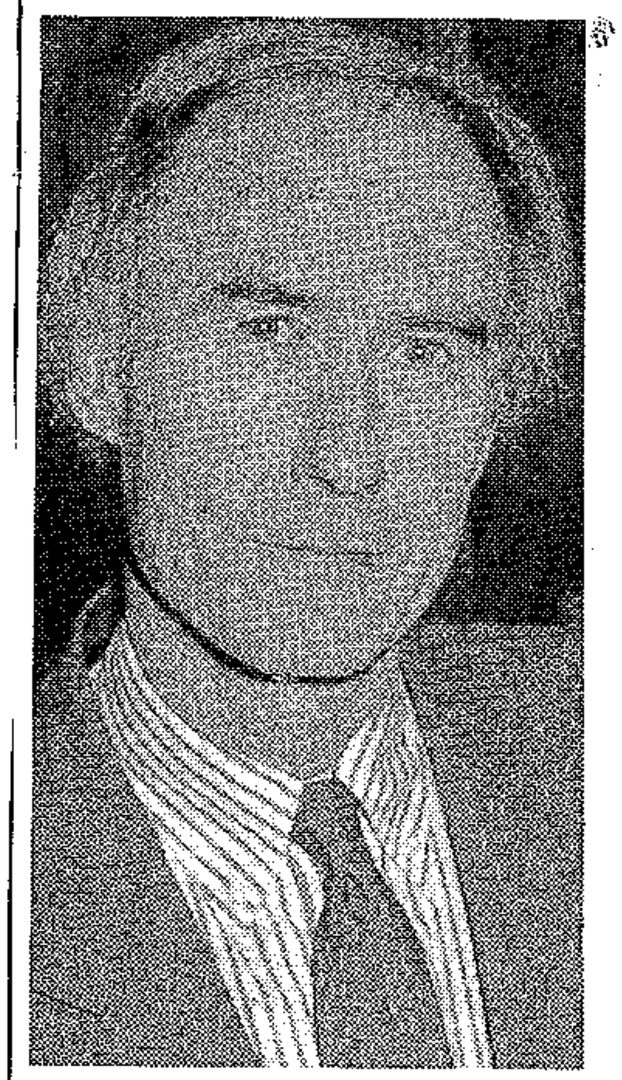
At present, coloured families with one mentally ill child receive R308 a month and white families R348, according to the deputy director of the Cape Mental Health Society, Ms Grace Matlhape.

Dr Kahlberg told the crowd: "Concerned parents, we hear your cry. We have sympathy for what you are asking. I can give you my assurance that everything humanly possible will be done ... this administration feels as strongly about their welfare as you do."

The parents' demands were supported by the Cape Mental Health Society, Disabled People of SA, the Black Sash and the SA National Civic Association.

Better health care planned for Cape Flats

ARG 28/10/92



Mr Herbert Beukes

TOS WENTZEL
Political Staff

THE provincial administration's battle with urbanisation and health problems has forced on it some imaginative adaptations and innovations, including plans to bring primary health care nearer to a huge population on the Cape Flats.

The director general of the Cape Provincial Administration, Mr Herbert Beukes, said the role of provincial administrations would change considerably under a new constitutional system.

All the main political groupings had agreed to a great degree of regionalism in a new constitutional system, he said in an interview.

At present provincial administrations were without a political base, playing the role of an extended central government, unlike the role of the provinces before the tricameral system.

On the other hand, provincial administrations were also service-oriented bodies, which brought them closer to their communities. They could therefore play a meaningful role in a new system of regionalisation because of their experience of interacting with local communities.

A great challenge for the Cape Provincial Administration was to manage rapid urbanisation, said Mr Beukes.

There was a growing demand for services by a rapidly growing urbanised community at the same time as financial resources were shrinking.

The Cape metropolitan area had to cope with ever-increasing numbers of people leaving Transkei and Ciskei to look for employment opportunities and social services.

Mr Beukes said the administration's biggest problem was health services.

The administration had a budget of R4 billion a year. The central government allocated some R3,5 billion and the administration generated the rest from sources such as hospital fees, taxes, and horse-racing and vehicle licences.

Half the total budget was being spent on health services. It was the administration's policy that no one was refused treatment at provincial facilities because they could not pay.

To make this expenditure more cost-effective, a strategic hospital plan was being phased in in the Peninsula, under which primary medical services through community health centres and day hospitals would be brought nearer to the people in areas such as the Cape Flats.

There were also plans to have bigger hospitals specialise in some forms of treatment to avoid under-use of facilities in some hospitals.

Many people did not require the more expensive and sophisticated services of the bigger hospitals, but the new plan did not suggest that people would not have access to more sophisticated health services.

Where necessary, expenditure on roads and school buildings could be adjusted to help to maintain health care. Cuts of this nature would have less serious immediate effects than cuts in health care.

Mr Beukes said among other problems the administration faced were those in local governmnent, especially black local government. The administration channelled central government money to black local bodies and there were tremendous problems in financial control and the fact that these authorities had no income base.

SA 'sliding towards third-rate medicine'

ST Times [Cape Metro] 1/11/92. (85)

IF academic medicine was not salvaged urgently "from its terminal illness", South Africa could face a future of not just Third World but also third-rate medicine.

By EVE VOSLOO

This was said by Professor John Terblanche, president of the South African College of Medicine, at the college's admission ceremony in Cape Town on Friday night.

Prof Terblanche said that in the private sector about 50 percent of the medical manpower provided care for about 20 percent of the population.

There were serious problems in this sector.

Inadequate

"Medical aid societies and insurance companies are spending more on medical services than they can afford or than can be construed as reasonable.

"There are more than 200 medical insurance companies. Clearly this has to change."

Prof Terblanche predicted that these would be reduced "to a very small number", which would promote the rational use of resources.

Private hospitals had an excess of beds and facilities, but many of these were being over-used "to the detriment of good patient care".

"Unless the medical profession controls these excesses, this or a future government will be forced to do so. I urge the medical profession and the medical association to take on this role as a matter of urgency."

In the public sector, 50 percent of available medical manpower provided care for 80 percent of the population "with inadequate resources and facilities", especially in the rural areas.

"Despite promises from the state, we remain with many of the serious legacies of the apartheid system, including 14 ministeries of health. Clearly this is ridiculous and needs to be rectified with great urgency."

Prof Terblanche believed the government had the political will to rectify this problem, but it "must ensure that the groundwork for a unitary health-care system is laid soundly at this time and that this is achieved on the basis of extensive consultation with all medical and political groups".

State plans included the provision of primary health care at the local level, secondary health care in nine proposed regions that would replace the provinces and tertiary care in the teaching hospitals, which would become autonomous academic complexes in April 1993.

"All this would sound fine and should be easy to implement were it not for South Africa's being in serious financial difficulties," Prof Terblanche said.

"Superimposed on these problems are an increasing demand for health-care services, a frightening increase in trauma load and the potential of Aids' aggravating the situation.

"Expenditure on health care is rising dramatically while the financial allocation for health is being cut back continually. In addition there is a gross maldistribution of human resources."

A "cure" required greater acknowledgement of the crisis by the state and alternative political groups.

"There has to be the political will to institute changes."

"Additional funds, which must be dedicated to health care, can be obtained by an immediate and significant raise in the tax on alcohol and tobacco."

However, this alone would not provide enough money.

"The only other method that can be instituted with minimal problems and which can generate major funds is a lottery."

Council to do HoR primary health care

ARG 85 | 11 | 92

(85)

■ The city council and the House of Representatives are to sign a contract concerning provision of primary health care.

Municipal Reporter

THE Cape Town City Council is to render primary health care services on an agency basis for the House of Representatives (HoR).

But, the actual transfer of existing staff and facilities will not take place because the SA Municipal Workers Union says this would be a "premature restructuring of health services".

The medical officer of health, town clerk and city treasurer will prepare an annual budget which will be given to the HoR for approval before the agreement starts.

In terms of a contract still to be signed, the HoR department of health services and welfare will compensate the city council in full for services.

The department will provide all medicines, which will be controlled by a pharmacist appointed by the council.

Mr Arthur Wienburg said he feared the takeover of services would mean a repeat of the financial crisis of the ambulance service, which is run by the city council on an agency basis for the provincial administration.

Dr John Sonnenberg said Mr Wienburg's fears were not well-founded.

However, changes were in the offing because the HoR itself was showing "signs of terminal decay".

■ The council voted 21 to three to give R1 000 towards a commemorative newsletter to mark the 25th anniversary of the first heart transplant at Groote Schuur Hospital.

Mr Wienburg slammed the spending as "emotional bunkum" and an "ego trip, throwing money away on a public relations exercise".

The money could have been used for housing or for feeding children, he said.

Mrs Eulalie Stott said the 1967 heart transplant had "put Cape Town on the map".

Restructuring plan for primary health

(85)
ANC 4/11/92

TOS WENTZEL
Political Staff

THE Cape provincial health service is pushing ahead with a major restructuring programme to bring primary health care closer to local communities.

At the same time the administration again is faced with substantial staff cuts as a result of envisaged cuts in state subsidies.

The provincial health budget is R2,2-billion, half of the administration's total budget.

The aim of the restructuring programme is to provide primary health care wherever possible to relieve the load on more sophisticated facilities and to make the system more cost-effective.

Administration sources emphasised this did not mean more sophisticated care would not be available to everyone, but that there would be a tighter system of referral while efforts were being made to make primary care more widely available in local communities.

Mr Dawie le Roux, MEC in charge of health and hospital services, said that while there was insufficient funding of health services, the administration faced the problems or population growth and rapid urbanisation.

Dr George Watermeyer, assistant director-general of health services, said the demography of some areas was changing so rapidly that in many cases it was impossible to obtain correct statistics.

Mr Le Roux said that, while the emphasis was on primary health care, this should not be seen in isolation as this type of care was linked with other levels.

In some cases, like Woodstock Hospital, some staff would be reassigned to areas where their services could be used better. Such a hospital had services which were needed in areas like the Cape Flats.

In such areas, optimal use would be made of available facilities, like expanding the hours of day hospitals in Khayelitsha and Blue Downs.

Huge extensions were in progress at the Khayelitsha 2 day hospital at a cost of about R5-million and a strategic plan to bring primary health care to as many areas as possible and to use existing facilities optimally would cost about R11 million.

In cases like the G F Jooste Hospital on the Cape Flats, aftercare facilities would be redeployed to change it into a trauma centre and a referral facility. This was needed to cope with the Cape Flats carnage.

At least 40% of the cases requiring treatment could be handled at primary care facilities and, with x-ray facilities, the case load would rise top 70%.

Mr Le Roux said that, due to financial problems, there would have to be substantial cuts in staff towards the end of the year.

The administration could take considerable credit for the way in which the strike of hospital workers was handled earlier this year.

The administration steered away from becoming involved in political disputes and did not use the "big stick" of dismissing people.

It had also recognised grievances like lack of permanency for some staff; had staggered deductions for time not worked after the strike; but the question of wages did not fall under it.

Private labour-relations consultants had been called in and good relations had been built up between the administration and the trade unions.

Horseracing in the province now also falls under Mr Le Roux.

He said the industry was going through a difficult time.

In the past 18 months, the share of the "gaming" or "recreational" rand which had been available for horse racing had been severely curtailed. This was as a result of scratch card competitions, private lotteries and casinos.

The administration had authorised an inquiry by the Cape Racing Board into possible restructuring.

● More CPA reports, page 8.

Police want to find

Critical shortage of blood

CT 7/11/90

Staff Reporter

A CRITICAL shortage of the 0-positive blood group is threatening the ability of the Western Province Blood Transfusion Service to meet needs over the festive season when the accident rate is expected to soar dramatically.

Dr Arthur Bird, medical director of the service, said yesterday it needed 600 pints of blood a day to meet the needs of patients in the Western Cape.

"Being the most commonly used blood group, a shortage of O-positive blood is of great concern to us, specially at a time when we are trying to build up stocks for the coming festive season," he said.

At one stage last year the service considered requesting hospitals to stop any planned surgery and only use the blood in stock for emergency treatment. He appealed to the public for donations.

The blood transfusion services share blood in times of need, but always meet their own local needs before supplying blood to other regions.

Dr Bird said the public were under the impression that it was dangerous to have blood transfusions, but the risk of getting Aids through a transfusion is one in 500 000.

Donor support is urgently needed during the festive season when stocks reach critically low levels. At this time of the year regular blood donor clinics and educational institutions, factories and other organisations are not operational and the blood intake decreases dramatically.

Dr Bird pointed out that blood and blood components have a short shelf-life and regular donations are needed to save lives during this time.

Dr Jane Pearce, deputy medical director of the service, revealed that of nearly a million people whose blood had been tested only 66 were found to be HIV positive. Of these 44 were new donors and 22 repeat donors.

A viral heat-treated plasma product is being made by the service for the treatment of haemophiliacs.

"Avert a crisis, donate blood" will be the theme during the national campaign from Monday and will culminate in a Blood Donor Week from January 10 to 16.

Natal protest on health cutbacks

DURBAN. — About 1 000 health workers marched through central Durban yesterday to protest proposed cutbacks in Natal's public health sector and to demand a moratorium on the proposals.

The march comes in the wake of an announcement by the Natal Provincial Administration in August that proposals were being considered to rationalise Natal's health sector.

The cutbacks include retrenchments of up to 5 000 people, according to the Health Crisis Committee. — Sapa

Barnard said he killed Webster — CCB officer

Blorm 20/11/92.

FORMER CCB agent Ferdi Barnard told his handler Lafras Luitingh he had killed David Webster to prove to the bureau's MD Col Joe Verster that he was of use, the Rand Supreme Court heard this week.

This was said by former CCB information officer Derrick Louw, an alias, at the judicial inquest into Webster's assassination.

On Monday Louw testified that Luitingh had told him shortly after the May 1 1989 attack that Barnard had confessed to the killing, in an attempt to show Verster that he was acceptable and of use to the bureau and should not be dismissed.

Louw's evidence was heard in camera on Monday but the transcript was made public yesterday afternoon.

He said following Barnard's dismissal from the CCB in 1989, Luitingh, a personal friend and former co-ordinator of Barnard, had approached him to use his contacts to try and get Barnard a job with special forces.

He had approached someone in special forces who required more background on Barnard — who had a criminal record and was a convicted murderer.

He had allowed the matter to rest there as he had not considered the matter a priority.

Luitingh had approached him a few days after Webster's death to tell him to inform special forces to rather "stay away" from Barnard.

He had told Louw he feared Verster would dismiss him too if he found out he was trying to get Barnard re-employed.

He admitted then that Barnard had confessed to him that he had killed Webster.

Louw said he found it strange that Barnard had chosen Webster as a target as he was unknown to the information branch of the CCB.

At no stage had the CCB targeted Webster as this would usually involve an intensive investigation of the person's activities, his routine, photographs of his house and aerial photographs.

"To my knowledge there was no indication of any sort that Webster was a priority of the CCB."

He had told former Military Intelligence chief Gen Witkop Badenhorst during his internal investigation into the Webster incident about the conversation with Luitingh. He was under the impression from later interviews with Verster that the information had been conveyed to him too.

Louw acknowledged during cross-examination by State Advocate Jannie van Vuuren that information had been gathered on activist Gavin Evans, but denied that it was the sort of information that would suggest that Evans had been targeted for assassination.

Van Vuuren put it to him that CCB chairman Gen Eddie Webb had told the inquest Verster had admitted in his presence that Evans had been targeted for murder.

He said he had no knowledge of this order nor did he have any knowledge about the collection of information regarding lawyer and activist Dullah Omar, who Webb also said was targeted.

Luitingh was called to give evidence yesterday as a consequence of Louw's evidence. His evidence was heard in camera.

Verster is expected to give evidence today. — Sapa.

Contraceptive put under the spotlight

85

Blorm 20/11/92

KATHRYN STRACHAN

THE controversial contraceptive injection Depo Provera came under the spotlight yesterday as leaders in the medical, political and labour spheres debated its use and abuse at a heated international symposium in Johannesburg.

Jan Peterse, CE of Upjohn Pharmaceuticals — which produces the drug — said his company had planned the symposium to provide a forum to review recent scientific evidence on the product.

Wits Centre for Health Policy researcher Barbara Klugman said the problem had not been with the product itself, but the way it was used.

Family planning in SA had historically been aimed at controlling and limiting the black population, she said, and it was in this context that Depo Provera had been prescribed.

Makhosazana Xaba, also at the centre, said it was now accepted internationally that Depo Provera was a medically safe and reliable drug, but the concern was that it was open to abuse.

It could be administered without women knowing what it was and uneducated black women were not always informed of its side effects and contra-indications. They were also not advised of alternative methods.

White women, on the other hand, were discouraged from using the drug.

The symposium focused on the need for more training, education and counselling to ensure that abuses of the drug came to an end.

Peterse said the recent approval of Depo Provera by the US Food and Drug Administration further proved the safety and effectiveness of the contraceptive injection.

Speakers at the symposium included a World Health Organisation advisory committee member, a World Bank representative and medical experts from Washington, Sweden and Australia.

'Barefoot doctors' are saying lives at vine-roots level

(85) ARG 24/11/92

ANDREA WEISS
Health Reporter

THEY'RE fast becoming the "barefoot doctors" of the winelands and they're paving the way for one of the most successful primary health-care projects in the country.

The project, which has already reaped rewards in the Transvaal and the Free State, is being run by the Rural Foundation and aims to make real inroads into the health problems that plague rural communities.

Since April, farm workers in the Hex River Valley, Worcester, Tulbagh, Wolseley and Stellenbosch areas have been in training to become "health-care workers" who will know enough to save lives and treat minor illnesses.

And according to those who are running the project, they are hungry for the knowledge which will enable them to improve the lot of those around them.

The project has its roots in the Transvaal where Rural Foundation employee Mrs Marina Clarke found herself on a farm near Middelburg where seven children had died in a month due to gastro enteritis.

She showed the workers how to make the oral rehydration fluid which could save the children's lives — and that was how the idea to start a project which would train a worker on each farm was born.

Initial results of the Transvaal project have shown that 88 percent of illnesses can now be treated on the farm by the farm healthworker — or the "Nompilo" as they have been named there. "Nompilo" is a name given to a woman "who brings love, care and health".

According to Miss Jenny Bader, who oversees the project in the Western Cape, one of the first things the workers wanted to know about was family planning — a surprise given the stigma usually attached to it.

But Miss Bader said the workers pointed out that they knew that family planning stopped one having children — but they didn't know how. They had numerous questions to ask (for instance, would sterilisation inhibit one sexually?) and for the first time somebody was prepared to answer them.

Mrs Juline Frieslaar, who is the local co-ordinator of the project in Worcester, said the health-workers had "blossomed" during their training.

Research chief hands over the reins of power

ARG 25/11/92

85

ANDREA WEISS
Health Reporter

DR Philip van Heerden, who has steered the Medical Research Council through a time of drastic change, is due to retire at the end of the year after four years as president.

Dr Van Heerden's presidency marked a major shift for the council, which has thrown its weight behind researching the key health problems affecting South Africa.

In his time at the helm, budget cuts forced a 20 percent reduction in staff, which Dr Van Heerden viewed as "a traumatic experience".

Dr Philip van Heerden

And in that period, major political changes saw the research institute re-enter the international arena both in the northern hemisphere and Africa.

Contact with France, the Scandinavian countries and more formal ties with the United States have been some of the spin-offs of an improved political climate.

There have also been wider contacts with Kenya, Zimbabwe and other African countries.

A graduate of Pretoria University's medical school, Dr Van Heerden specialised in internal medicine and nuclear medicine at the University of Stellenbosch before completing his post-doctoral research at the John Hopkins Medical Institutions in Baltimore, in the United States.

He served as vice-president for 10 years before taking over as president in January 1989.

Nuclear medicine remains his first love and he will be doing clinical work in that area at Tygerberg Hospital next year.

Dr van Heerden said that when he took over as president, his ideal was for research to be relevant to the country's pressing health problems.

His other objective was to continue building research capacity at medical schools around the country.

Consequently the council decided to target six main areas in need of urgent investigation: urbanisation and health, trauma, TB, Aids, nutrition and malaria.

Dr van Heerden said the shift was not intended to stifle research initiatives in other areas but to realign the council's priorities.

"The key word is quality," he said. "It is very important to keep our universities at a high level."

But budget cuts caused some of the council's previous areas of research to be gradually shut down — among them the research done on bilharzia.

"We felt that we had established what should be done to decrease bilharzia and it was up to the health authorities to do this. It had become too expensive and we decided to channel the money into areas of greater need."

The new "leaner and meaner" council is still under pressure to provide for researchers to study abroad, and for affirmative action among disadvantaged students.

In order to raise some money it has established a private company, Medtech. Its profits will be ploughed back into research.

"The good news is that we have managed to get collaboration with non-governmental organisations willing to invest in us," said Dr van Heerden.

And now with the World Health Organisation poised to get actively involved in South Africa, even more opportunities are presenting themselves.

But for Dr Van Heerden the most difficult part of his time as president was overseeing the staff cutbacks.

"I don't want to go through such an exercise again," he said.

But he believes it was swiftly achieved in a "one-off, quick, clean-cut" operation made essential by economic constraints.

He is also confident he will be leaving the council in good hands with Professor Walter Prozesky — "a very able man, a great scientist and a wonderful human being" — who takes over from him in January.

Call to support the disabled

PRETORIA. — National Health Minister Dr Rina Venter has appealed to all relevant organisations to support the International Day of Disabled Persons today.

The aim was to make the public aware of the role and potential of disabled people. This would help change community attitudes towards the disabled.

"The success of the day will depend upon close co-operation and effective co-ordination between the private and public sectors," Dr Venter said. — Sapa

Health care groups to discuss policy issues

STAR 3/12/92

Medical Reporter

Prompted by expectations that the health sector is facing a "fundamental transformation" within the next few years, primary health care groups will gather outside Johannesburg next week to discuss policy issues within the industry.

A joint South African Health and Social Services Organisation (Sahsso) and National Progressive Primary Health Care Network (NPPHCN) conference was announced at a press conference in Johannesburg yesterday.

Joint policy committee chairman Dr Max Price said the theme, "Transforming the Health Services", had been precipitated by the "realisation that within the next two to three years we expect to see a fundamental transformation of health services".

Price said pressure on the Government to reduce inequities in health care would be so great that it would have to respond immediately.

He added that transforming the present health bureaucracy — such as the attitudes and practices of health service managers who would probably continue to work in the future health services — would receive special attention at the two organisations' joint national policy conference next week.

Price said transformation would require the reallocation of financial resources and the establishment of facilities which were more accessible to previously oppressed communities. It would also require transforming the ideology, attitudes and practices of the current personnel in the health sector.

NEWS Msinga fights have cost 20 000 lives

Peace plan mooted

Sowetan 7/12/92

FACTION fights in Natal could be a thing of the past with the formation of Ubumbano Lwase Msinga, a formal structure for the unification of the different tribes in Msinga, outside Dundee.

A meeting of chiefs and residents of Msinga to "map out" plans and forge unity is scheduled for December 27 in Pomeroy, Dundee, said the organisation's chairman, Mr Derrick Mgaga.

Senior member Mr Ephraim Ximba said the idea of forming the organisation was conceived in 1987 in Msinga.

"We only managed to formally come out with the structure this year in Johannesburg."

"Wars in Msinga were such that you could not hold a meeting without being attacked," said Ximba.

According to Mgaga, the organisation has already managed to rally together all the different Msinga tribes on the Reef.

Ximba and Mgaga are among the many appointees of various tribal chiefs in Msinga.

Some of their duties are to see to the welfare of the Msinga people living in hostels.

■ Msinga men have a strategy to put an end to internecine killings:

Ximba and Mgaga expressed their fears of the faction fights which have been "exported" to places of work.

"People have had to abandon their jobs for fear of being attacked," they said.

In explaining the causes of these fights which have claimed "more than 20 000 lives since 1965", Ximba and Mgaga said:

"This is an age-old war when tribes were only fighting for land, stock-farming and supremacy. Only males would fight and the fighting took place outside on the battlefields.

"But now fights have taken a sinister turn. Tribes are fighting among themselves, homes are attacked and everyone - mother, father, granny, brother, even cats and dogs - are killed.

"That is not what the Zulu nation can be proud of."

In order to end the fights, the organisations will approach relevent authorities in the area with the aim of finding employment and more schools for local people.- *Sapa.*

Azapo looks at health care

By Mokgadi Pela

Sowetan 7/12/92

THE Azanian People's Organisation is to discuss the overhauling of the present health care system at its next national council.

Dr Nchaupe Mokoape, a former deputy president of Azapo, said the current health care system was designed to benefit the whites while blacks had been given a "rickety programme".

He said Azapo wanted to create a social and political environment which would be conducive to good physical and psychological health. Azapo yearned for a preventive health care system.

It also maintained that the responsibility of health care

■ Politicians will discuss system which caters largely for whites:

lay with the State. (85)

"Our health care system has been poorly financed and it has been worsened by recession, privatisation and overcrowding. It's in keeping with the philosophy of oppression," Mokoape said.

He said the long working hours and unacceptable working conditions of doctors were part and parcel of the system that denied blacks medical training.

Mokoape said whereas whites had five medical schools in the country, blacks had only two, namely Medunsa and Wentworth.

The medical world and Government have been preoccupied with the galloping increase of Aids in mothers, lung cancer, cervical cancer, TB, the use of steroids, the plight of the mentally handicapped, and muti poisoning, writes **Mokgadi Pela:**

Sowetan 11/12/92

85

AIDS HAS TOPPED THE LIST OF DISEASES that have received both media and health authorities' attention in South Africa this year.

What with the number of people with the virus having increased from the initial lone HIV carrier in 1982 to the present 200 000.

And according to the Department of National Health and Population Development, 400 South Africans acquire the virus daily. Recently, a leading obstetrician and gynaecologist at the Baragwanath Hospital told a multidisciplinary gathering in Kempton Park that two HIV-positive mothers delivered babies at the institution daily.

The figures for the Johannesburg Central Business District were even worse, with one in seven women carrying the virus. The figure was doubling every nine months.

Economists have predicted that this increase in HIV-positive people would adversely affect the sector. As the disease progresses towards full-blown Aids, workers are likely to take more time off for treatment.

The Government spends millions of rands on its educational campaign, as do various sectors of industry.

The increasing number of people with Aids has seen the advertisers of condoms taking up more space in the media. They have promised more aggressive marketing to influence the public into accepting condoms as the only protection against the virus.

Another disease that has received attention is lung cancer due to smoking. There is pending legislation against the habit. The bill will allow the prohibition, restriction or regulation of smoking in public places in order to ensure that:

A healthful environment is maintained; and

The health of non-smokers is not impaired by passive smoking.

In recent years, even the World Bank has started focusing on the economic costs of tobacco as an impediment to development. Some companies have said the overall consequences of having a smoker in the workplace were:

Smokers take 50 percent more leave and are more likely to be hospitalised;

Smokers are more than twice as likely to die during their work years (before age 65);

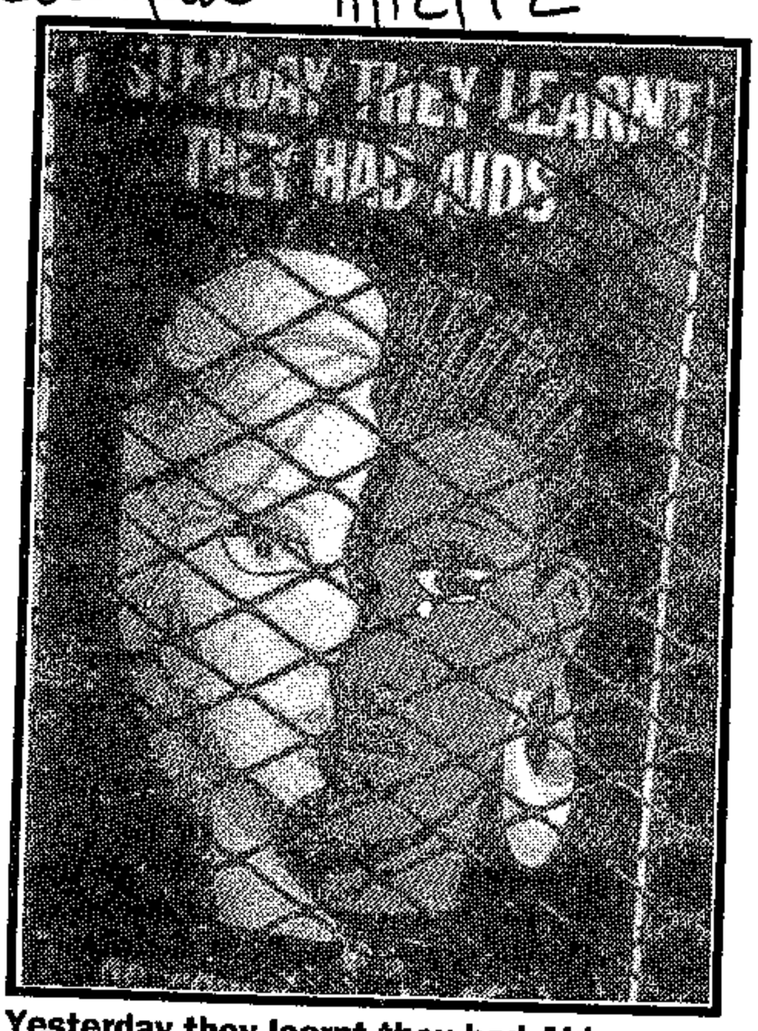
Smokers have twice as many on the job accidents;

Smokers waste 2 to 6 percent of their working time due to the smoking ritual;

Corporations incur increased cleaning, repair and maintenance costs due to smokers; and

There is significant irritation, discomfort and health risks to fellow workers caused by smoking.

A disease that continues to worry both the developed and developing world is cancer of the cervix. Mortality from cervical cancer in young



Yesterday they learnt they had Aids ... tomorrow it could be you.

women (under 35) appears to be increasing.

Data from the United Kingdom, New Zealand and Australia indicate a two to three-fold increase in deaths in young patients over the past two decades. There is a similar, though less pronounced trend in the USA.

A recent study conducted on 1 522 patients in the Groote Schuur Hospital concluded that the disease was common in young women, more often seen at an early stage and no different from the classic disease seen in older women.

The use of anabolic steroids by matric pupils has become another problem area. A study in the Western Cape concluded that it was confined to male sports participants.

The main reason for using steroids was improvement of endurance, strength and increased aggression. The researchers recommended a meaningful intervention programme for high schools to educate pupils on the effects of steroids.

The September issue of the *South African Medical Journal* showed that poisoning from traditional medicines accounted for the second biggest cause of hospital admissions, with a mortality of 15,2 percent.

In most cases the active ingredients of muti are not known and antidotal treatment is therefore out of the question. Management consists mainly of supportive procedures and treatment of symptoms. In some cases vomiting was induced in patients.

Clinicians have also noticed the rising incidence of coronary heart disease and other diseases of lifestyle. The diseases are likely to increase further as risk factor prevalence is altered by changes in lifestyle, westernisation and migration to urban or peri-urban areas.

The researchers have concluded that these diseases can still be prevented in the black population if preventive measures can be instituted rapidly.

In its 1992 campaign the South African National Tuberculosis Association disclosed that 36 people died daily in the country while 80 000 cases were reported annually.

The plight of mental health patients prompted the South African Federation for Mental Health to mount campaigns to raise awareness. The federation handed petitions to the Government demanding the inclusion of a Charter of Rights for Mentally Handicapped persons as an addendum to a general bill of rights in a new constitution.

Spokeswoman for the federation Mrs Thelma Mahlobo said three percent of the population which was mentally handicapped to varying degrees and was unable to exercise human rights to each individual's ability.

Able-bodied people refused to allow the mentally handicapped to make decisions, they were seldom consulted on matters concerning their lives and were often denied relationships of a sexual nature.

One would only hope that authorities would see the urgency of preventing these ailments with the seriousness they deserve. While the list is far from complete, more attention would go a long way towards achieving health for all by the year 2000.

National health policy proposed

BIDM 14/12/92.

KATHRYN STRACHAN

AFTER a week-long conference, major health organisations on Friday released their national health policy which is expected to hold far-reaching implications for future health provision in SA.

The policy document — which was formulated by the SA Health and Social Services Organisation and the National Progressive Primary Health Care Network — has first to be ratified at a regional level before it is formally adopted.

The document focused on the fragmentation of the present health service which has resulted in wasted resources and inequitable care to different sectors of the population.

The issue of labour relations in the public health sector was given prominence in the document. Poor labour relations had damaged and disrupted health care in SA and, by undermining the morale of workers, it had affected the quality of their care, it said.

The exclusion of civil servants from the Labour Relations Amendment Act of 1991 was the root cause of the strife. The conference called for the Act to be extended immediately to include all public servants and to guarantee their right to strike.

In order to avoid strike action workers, especially nurses, had to be guaranteed freedom of professional association, and acceptable dispute resolution mechanisms had to be adopted.

Many of the health sector's problems arose from the concentration of health personnel in urban white areas and in the private sector. To redress the imbalance, the document resolved to implement incentives such as higher pay or greater professional recognition for work to attract personnel to underserved rural areas or to the public sector.

The document also proposed a stronger emphasis on mental health. Several investigations in recent years had found that up to four in 10 people were suffering from some form of mental ill-health, which was often brought about by the violence in communities as well as within families and by alcohol and drug abuse.

Speaking at the conference Gerald Bloom, a developmental studies lecturer at Sussex University, said there was no simple solution to the problem of financing essential health services in a society as segmented as in SA, where there were many sophisticated hospitals for the rich and an under-developed primary health care service for the poor.

"It may be unrealistic to attempt to provide the entire population with the kinds of services which have been developed to serve the elite, or even those services which formal sector employees have come to regard as their right. The establishment of new institutions is costly and takes time to establish," said Bloom.

Johannesburg city health executive director Dr Nicky Padayachee proposed an option for health sector restructuring which could be rapidly implemented once an interim government was in place.

"There is obvious support for a unitary health system with decentralised implementation and the removal of fragmentation, duplication and racism. There is also wide support for equity and for a primary health care approach, including community accountability and participation."

Miss World 1992 Julia Kurotch
the Lost City. She is flanked
Gago, 19, who was named t

ANC slates TPA over hostels

RAY HARTLEY

THE ANC has called on the Transvaal Provincial Administration (TPA) to hand over the R326m set aside for upgrading of hostels to the National Housing Forum in order to improve community participation in the process. BIDM 14/12/92

ANC PWV spokesman Ronnie Mamoepa said the TPA was acting unilaterally and making false claims about having formally consulted hostel dwellers about the upgrading process.

"There have been instances where the TPA has talked to individuals. In reality the TPA has not consulted and, where there have been consultations, they have been undemocratic," he said.

The Hostel Residents' Association had informed the ANC that it had never been officially consulted by the TPA, he said.

The TPA said at the weekend it had reached consensus during consultations with the residents of 35 of the 92 hostels it administered.

"Negotiations among representative negotiation groups are in progress in respect of 42 other hostels," the TPA said, adding that it would proceed with the upgrading process despite recent ANC criticism.

A TPA statement said allegations that it was not following guidelines for upgrading agreed on in November by the National Discussion Forum on Hostels, were untrue.

"The TPA wishes to appeal to all role-players in this important aspect of housing to co-operate so that the whole issue may be addressed as speedily as possible.

"It must be stressed that the TPA regards proper and representative consultation of the utmost importance in achieving consensus regarding the upgrading or conversion of hostels in the Transvaal.

"This allegation is noted with concern as it appears that in some cases, ANC members at the grassroots level are not being informed on negotiations and progress regarding the upgrading and conversion of hostels by their organisation's representatives," the TPA said.

But Mamoepa said the ANC was "seriously concerned about the way the TPA goes about this kind of thing".

Tokoza hostel dwellers who had vacated their rooms when the TPA had begun renovations could not afford the higher fees charged after upgrading, he said.

The TPA said expectations of better living conditions had been created during the consultation process and the TPA wished to meet these by continuing upgrading.

SAP torture probe is on

(25) BIDM 14/12/92

STEPHANE BOTHMA

CLAIMS of widescale torture of suspects by Brixton murder and robbery unit detectives would be probed by Witwatersrand Regional Police Commissioner Maj-Gen Chris Serfontein, the SAP said at the weekend.

The announcement followed media reports alleging that policemen routinely extracted information from detainees by torturing them in a "truth room" at Brixton murder and robbery headquarters.

The Weekly Mail reported that electric shocks, hanging prisoners by their wrists and beatings appeared to be an everyday occurrence at Brixton.

The newspaper reportedly possessed a statement from a police source, backed by interviews with other policemen, former policemen, lawyers and former Brixton detainees to support the claims.

Witwatersrand police liaison officer Capt Eugene Opperman said the SAP had never tolerated misconduct by its members and called on those who alleged the torture to prove the claims so that the police force could be rid of "any unsavoury character".

An independent police board would soon investigate serious complaints, Opperman said.

Ingenious device for recycling own blood

ARG 14/12/92 (85)

ANDREA WEISS, Health Reporter

AIDS awareness has prompted city surgeons to make use of an ingenious device which is able to save a patient's blood during surgery to be given back to them if they need it.

The operations during which the device can be used are usually knee or hip replacements and vascular surgery.

The usè of the device spares the patients the risk of contracting either the Aids virus or hepatitis through a blood transfusion from donated blood.

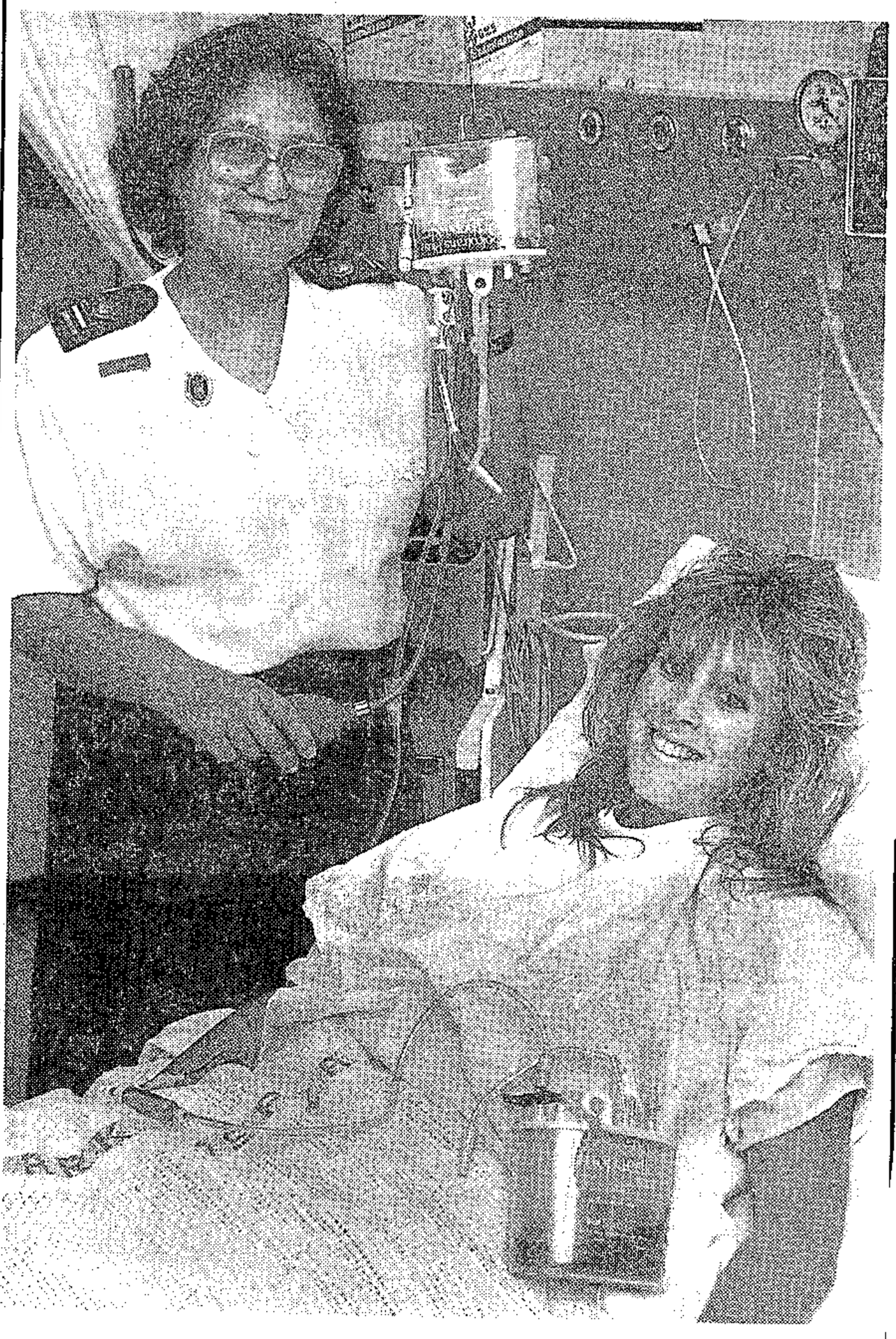
Although it is also possible to pre-donate your own blood for use in surgery, for medical reasons some patients are not able to do this and therefore rely on donated blood.

Now city orthopaedic and vascular surgeons are using the Solcotrans Plus which saves the patient's own blood by allowing it to drain into a disposable bag after knee or hip replacements, or by suctioning it into the bag during vascular surgery.

The same bag is then used to retransfuse the blood into the patient if necessary.

A city orthopaedic surgeon said that patients could lose up to two pints of blood after some surgical procedures and in the past this blood would have just gone to waste.

One of the first questions patients asked him when they needed surgery was whether they would have to have a transfusion. He said they felt a lot happier when they were told there were ways of avoiding using bloodbank blood.



Picture: BRENTON GEACH, The Argus

RECYCLING BLOOD: Sister Gadiah Fortune of City Park Hospital demonstrates to Miss Karen du Plessis a device that can save a patient's blood during certain operations for retransfusion if necessary.

NEWS Councils are in red for R104 million ● Conference highlights health care problems

Call to review health care plan

Sowetan 15/12/92

■ Lack of skilled personnel to implement system:

85

By Mokgadi Pela

THE GROSS maldistribution of personnel in the country should be reversed to suit the health care needs of the population, delegates resolved at the end of a five-day meeting on Friday.

The resolution emerged from a conference organised by the National Progressive Primary Health Care Network and the South African Health and Social Services Organisation in Broederstroom.

The delegates felt the problems with the present health care system include:

The concentration of health personnel in urban areas and the corresponding under-provision in the rural settings;

Concentration of health personnel in sophisticated, curative settings in the private sector with corresponding under-staffing of public health sector facilities; and

Complete lack of personnel with training and skills to implement specific programmes of a reformed system based on Primary Health Care (PHC).

The delegates further resolved to call on the Government to train new categories of health personnel in:

● Environmental health to tackle the need for small water supplies and household sanitation in poor communities; and

● Health promotion and advocacy to equip communities with skills to campaign for proper public policies.

The conference urged the Government to put a moratorium on the building of new training facilities in already well-served areas.

Cost-cutting sets an unhealthy precedent for 1993

STAR 31/12/92. (85)

While the world's eyes were focused on the Aids pandemic during 1992, further cracks began showing in SA's public health system, reports PAULA FRAY.

SOUTH Africa's cash-strapped public health system did not go untouched during the ongoing violence and political change in 1992 as Government embarked on a cost-cutting venture amid calls for more money to be poured into health.

As the Transvaal Provincial Administration (TPA) proceeds with cost-cutting plans in the public sector — in line with a Government call to cut staff by 5 percent — overworked doctors are concerned essential services will be first in the firing line.

Already, doctors at State hospitals are being offered substantial incentives if they leave the employment of the TPA.

Doctors are particularly concerned about what this will mean for rural health care where it is already difficult to retain good medical staff.

And Wits University Medical School is still discussing cost-cutting moves — to come into effect early next year — at TPA academic hospitals.

The lack of cash and even the shortage of medical staff was highlighted when concerned doctors at J G Strijdom Hospital warned that patients would die unless something was done urgently.

Although the TPA denied that any posts had been frozen, doctors there maintained that posts at consultancy and registrar level had not been filled.

The J G Strijdom crisis also highlighted the severe shortage of interns nationwide as high education costs and low pay in state hospitals discourage students from entering the medical field.

Many interns worked far longer than the maximum 80 hours a week laid down by the SA Medical and Dental Council. An investigation by the Department of National Health and Population Development found that all interns "work far too long hours as a result of the shortage of interns throughout the country".

Indicative of a health care system riddled with contradictions, it was also revealed that about R1 billion of medical payouts in the private sector each year — nearly 25 percent of all subscriptions — was wasted by continued fraud and over-utilisation of medical aid facilities.

It was a year in which South African medical expertise was used to separate Mauritian Siamese twins Ashlay and Ashil Fokeer. The weaker twin Ashil died in the operating theatre while Ashlay is preparing for the journey back home.

It was the year in which alcohol consumption by South Africans reached an all-time high. It is now conservatively estimated that there are at least 1 025 198 alcoholics in South Africa, nearly 30 percent of them women.

It was the year which saw the first fully representative medical congress. The National Aids Convention of South Africa (Nacosa) was labelled the "Medical Codesa" as it brought together a wide range of organisations dealing with the Aids dilemma.

In Amsterdam, the world's Aids authorities heard that one new person was infected with the Aids virus every 15 seconds, while between 10 million and 12 million adults — and one million children — already had HIV, according to the World Health Organisation (WHO). More than two million people have developed Aids.

The figures, released at the eighth International Conference on Aids, gave a chilling picture of the spread of the pandemic which is outrunning the modest progress of scientific efforts to combat it.

"One person is infected every 15-20 seconds," said Michael Merson, head of the WHO's global Aids programme.

In South Africa, the figures are as startling. At a multi-disciplinary conference in November, Dr James McIntyre of the Department of Gynaecology and Obstetrics at Baragwanath Hospital revealed that:

- At least two HIV-positive women give birth daily at Baragwanath.
- About 200 women had been identified as HIV-positive in the first eight months of this year.
- Figures indicated that about 20 000 Soweto women might be HIV-positive.

But it was also the year in which South Africa released a Charter of Rights on Aids and HIV which set out 12 basic non-discriminatory principles dealing with the fair and just treatment of those affected by the virus.

Activists believe the charter — signed by a wide range of political, medical, business and social groups — will play an important role in the fight against Aids.

However, it is at primary health level where medical experts believe South Africa should begin the fight for equal and adequate facilities for all.

Primary health care organisations believe the basic solution to ongoing problems in the public health sector is a reorganised and restructured public health service oriented towards primary health care, and not in privatisation or procurement by the State.

Achievement . . . Mauritian Siamese twins Ashlay and Ashil were separated in Cape Town, but the weaker twin Ashil died in the theatre.
Picture: Eric Miller

This month, health workers and members of the community, met to debate recommendations for the transformation of South Africa's primary health care system at a national conference outside Johannesburg.

Malnutrition was identified as a serious threat to the health of the nation, expecially children, at the joint health policy conference of the National Progressive Primary Health Care Network and the South African Health and Social Services Organisation. It recognised undernutrition as being caused by the economic inequalities reinforced by the apartheid system. □

HEALTH AND DISEASE – ~~ALCOHOLISM~~ GENERAL

1993

Health has claimed its share of headlines in 1993, and developments in this important social field have begun to show what the future will probably hold, reports Health Writer ***DAVID ROBBINS***

Important to correct imbalances now

Star 24/12/93 (85)

93 LOOKING BACK HEALTH

A glance at the statistics on notifiable diseases paints in some of the detail of South Africa's health crisis.

In the first nine months of 1993, 8 200 new cases of measles and 12 deaths were reported. The figures for Marburg fever were 9 901 new cases and 22 deaths; meningococcal infection, 323 and 44; and tuberculosis a chilling 55 346 and 1 439. That's 20 new TB cases and five deaths notified every day of this tumultuous year.

Aids is worth a special mention. Authoritative research has indicated that without significant interventions and behavioural change, roughly one in four Sowetans will be HIV positive by 2010. In 1990, one confirmed Aids case was reported in South Africa; in 1991, four cases were reported; 1992 brought a further 23; during the current year 488 cases have so far been reported, 54 of them in Venda, 57 in central Transvaal, 43 in Natal and 209 in KwaZulu. Our epidemic has begun.

Real depth

But the real depth of the health crisis is not recorded (or under-recorded) in neat statistics. How many children died of gastro-related diseases in 1993? How many have suffered irreparable damage from malnutrition? Nobody knows for sure, but the answers to both questions would need to be measured in hundreds of thousands.

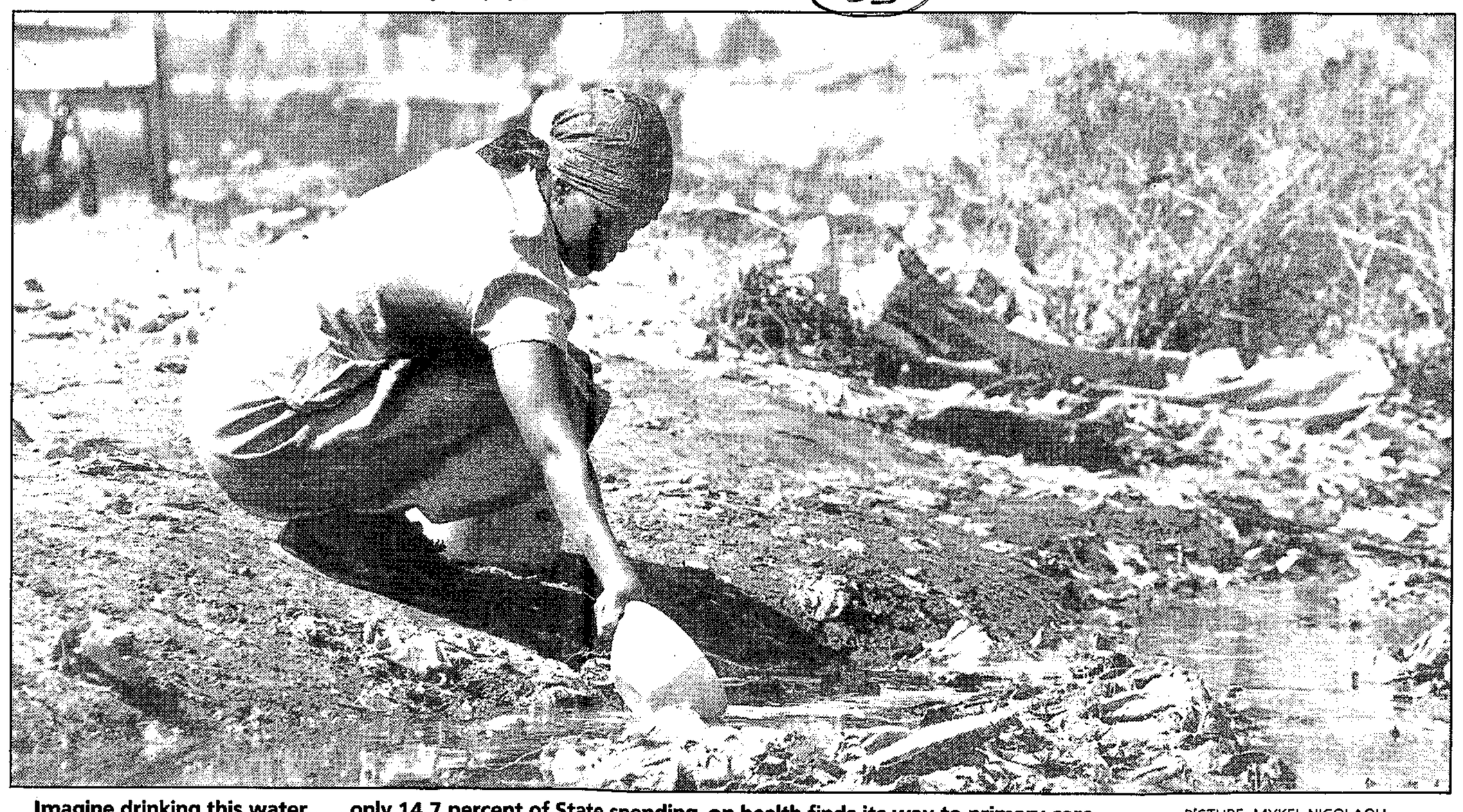
The State's R11 billion health budget is spent largely on hospital-based curative medicine. Only 14,7 percent finds its way to primary care where the accent is on preventive and promotive programmes.

Health experts are now advocating a major switch to primary health care built on a district model, with community participation and intersectoral co-operation. This makes good sense.

Work done during the past year by the Medical Research Council's Essential Health Research Group indicates that the provision of clean water and better education would do more to improve the health status of South Africans than the installation of a thousand cat-scan machines.

But the comparison highlights a central problem. Johannesburg has more cat-scans than the whole of Australia. And the private health sector spends about as much as the State, but it's spent on less than a quarter of the population. How is this imbalance to be righted?

The ANC believes that one solution could be the removal of the tax relief currently given on medical aid contributions. In theory, this would release a lot of money for direct State spending on health programmes. In practice, however, it might force thousands of people out of medical aid protection and on to the mercy of the State.



Imagine drinking this water . . . only 14,7 percent of State spending on health finds its way to primary care. PICTURE: MYKEL NICOLAOU

The central financial dilemmas remain. How can the total spending on health in South Africa be more equitably distributed without destroying the private sector and probably losing thousands of health professionals into the bargain? And, equally important, how can the State health budget be rearranged to favour primary care without committing hundreds of hospitals to outright ruin?

The hospital situation is exacerbated by public expectation. For too long the hospital and the doctor have been seen by all South Africans as the first port of call for everything from the common cold to serious illness.

The future is certain to be substantially different. Nurse-based health care is in store for millions of us. Hospital services will shrink, and resources will be poured into the hopelessly neglected rural areas. In Lebowa, for example, the doctor/population ratio is 1/33 000. In Johannesburg (including Soweto), it's less than 1/1 000.

April 1994 will see the most profound change experienced in the southern tip of Africa since Jan van Riebeeck landed here about 350 years ago. Yet some health experts are already expressing disillusion. The strength and autonomy given in the new Constitution to the regions could mean the perpetuation of the fractured health services under the current provincial and homeland system, they say.

Even more serious is the realisation that the existing bureaucracies will continue to administer health, with only the odd new face appearing at the top. And who knows, say the pessimists, what hidden agendas, whether blatantly racial or simply obstructive, will be played out in the middle and lower management of health?

My own view is more optimistic. It appears to me that everywhere, not least in health, there is an urgency to make things work better than they have in the past.

Imperative

The superintendent of a major hospital said to me recently: "We have a chance to make a new health system here. If we make a mess of it, we'll have to live with it for at least another generation. It's absolutely imperative that we make the right decisions now."

It's an imperative which extends into the political arena, too. The delivery of improved health services is possible. The key is the speed with which these improvements are felt on the ground. It's almost a truism these days that the biggest danger for South Africa in the next five years is the rot of disillusion. If it is allowed to take hold it will have the power to sweep away far more than good intentions and plans.

Circumcision rites: ANC wants change

ET 28/12/93 (88)

Own Correspondent

PORT ELIZABETH. — The Eastern Cape branch of the African National Congress Women's League has called for the immediate "modification" of the Xhosa initiation rite.

The circumcision rite, by which African boys traditionally become men, has been under close media scrutiny recently, following the deaths of at least 10 Xhosa initiates since November in the Border region.

ANC cultural desk co-ordinator Ms Bulelwa Sonjica said yesterday the league was concerned about the deaths and hospitalisation of Xhosa initiates (Abakhwetha).

She said the league was concerned because the problem had been exposed for a number of years "but nothing is being done, instead the numbers (of casualties) are growing".

The league has also called for the intervention of health workers to give "clear guidance and take a firm stand on the matter".

Circumcision clinics planned

Own Correspondent

EAST LONDON. — Ciskei health authorities have earmarked several centres to limit the ever increasing number of botched circumcisions and treat the victims.

Dr Philip Vogel, principal medical officer at Queenstown's Frontier Hospital, said yesterday he "wanted to cry" over the "devastation and mutilation" of human tissue he had seen this Christmas (85)

He said free assistance and training had been offered to those supervising and performing ritual Xhosa circumcisions, but to no avail. CT 30/12/85

Male nurses will be stationed at the centres.

Health train chugs off to help rural people

B1Day 20112193

TRANSNET's new primary health care train — the first in the world — embarks on a countrywide journey to 38 destinations next month to bring medical care to rural communities.

Named Phelophepa (good health), the 13-coach clinic on wheels boasts an eye unit, an education centre, a medical unit and a health unit for basic screening.

Transnet MD Anton Moolman said that by converting SA's first eye care train into a fully fledged primary health care train,

KATHRYN STRACHAN

Transnet aimed to focus its community involvement on primary health care.

Earlier this year the train travelled through rural SA and treated about 30 000 patients.

Transnet human environment manager Retha Ross said the most important feature of the train was its ability to reach isolated communities and provide a wide range of medical facilities.

"The success of the project will depend on the involvement of both the community and professional people in the areas visited by the train," she said. (85)

Moolman said the health train was a continuation of the company's community involvement drive.

This had already included the conversion of unused goods sheds and offices into community centres. Transnet had also donated old containers for use as spaza shops, as well as mobile containers for conversion into creches.

Traditional nurses slated

Own Correspondent

EAST LONDON. — A top local community health worker has lashed out at "negligent and inexperienced" traditional nurses after six Xhosa initiates died while in the "bush" during the November/December circumcision season.

Community health educator Mr Zweliphakamile Dweba said 41 Xhosa initiates were also admitted to Ciskei hospitals.

Many of the initiates' wounds turned septic. Others died of dehydration, as their liquid intake was restricted.

He said while monitoring the initiates' progress, he found "boys" being looked after by young men who lacked the skills and experience of professional nurses.

Some of the nurses were young men who had been circumcised six months earlier, he claimed.

Mr Dweba also blamed elderly people who, he said, failed to check on the initiates' progress and did not provide guidance to the "so-called" nurses.

In Umtata, doctors said yesterday that at least 25 initiates had been treated. CT 23/12/93

Focusing on health reform

Cl Press 21/11/93

Is the SA media paying enough attention to health problems? Is there a possibility that the media can focus more closely on health issues in post-apartheid SA? These and a legion of other questions were examined last weekend by a group of local and foreign journalists, health workers and prominent political players. Deputy editor ZB MOLEFE reports.

POPULAR TV and radio personality Tim Modise set the proverbial cat among the pigeons when he wanted to know what the role of traditional healers would be in a future health policy.

The question stung prominent community leader and medical doctor Nthato Motlana, who had been holding court in what had been billed "a conversation with Nthato Motlana: The Public, The Media and Politicians".

"I pray and hope that the day never dawns in my life when we are going to throw our health services into the hands of those people," retorted Motlana.

It was a free-for-all until Matla Trust executive director and SABC board member Billy Modise nailed his colours to the mast.

Modise challenged Motlana's stance against practitioners of traditional medicine by arguing that the Chinese had been successful in "marrying" their ancient medical science of acupuncture with modern medicine.

"Let us not forget that in the past Western medicine took a dim view of acupuncture. But now this very acupuncture is a big thing in the West.

"The rich are filling expensive clinics in the West to be treated by Chinese acupuncturists. Shouldn't we be looking at that route?"

Modise, in essence, was saying it was time Western-trained medical practitioners gave traditional medicine a break. It was time to make a scientific study of traditional medical practice to see if it could contribute to solving SA's crippling health problems.

The three-day health seminar, held at a northern Transvaal game reserve, was jointly-funded by SA's Health Systems Trust, the Open Society Foundation and the US-based Henry J Kaiser Family Foundation.

University of Durban-Westville vice-chancellor Jairam Reddy had said earlier: "Our health care politics are in a shambles and fail to meet the expectations of the majority of our people."

Reddy said the type of health system we should be putting up should be articulated by the media, along with the politicians who are entrusted with the task of mapping out SA's future.

ANC Education, Health and Welfare department director Cheryl Carolus said the question of health had always been misrepresented in SA.

Carolus promised that health would be a priority for a post-apartheid government.

"You can't address health problems in a vacuum," she said.

"Most deaths in SA are not the result of health problems, but of social problems. Access to health should be a basic human right.

"South Africans should hang their heads in shame when their country could produce 'slimkoppe' who could perform heart transplants, but allowed its babies to die from measles."

Former Philippines health minister Alfredo Bengzon told how his country's media became the searchlight and mirror of its society when it tackled health problems which stemmed from an inefficient Marcos administration.

"Your health sector is in a unique position to be a model in this time of transition. The question of expectations in the new SA is perhaps the most daunting," Bengzon said.

John Battersby, the SA correspondent for the US Science Christian Monitor, asked: "How do we (the media) make health a sexy story? Our challenge is to find out how we can do it."

George Strait of ABC TV, Paul Taylor of The Washington Post and Drew Altman of the Kaiser Family Foundation said health had become a crucial issue in the US.

Delegates travelled to Gazankulu's Bushbuck Ridge district where Stephen Tollman of the Wits Health Services Development Unit led an eye-opening discussion on health problems in the area.

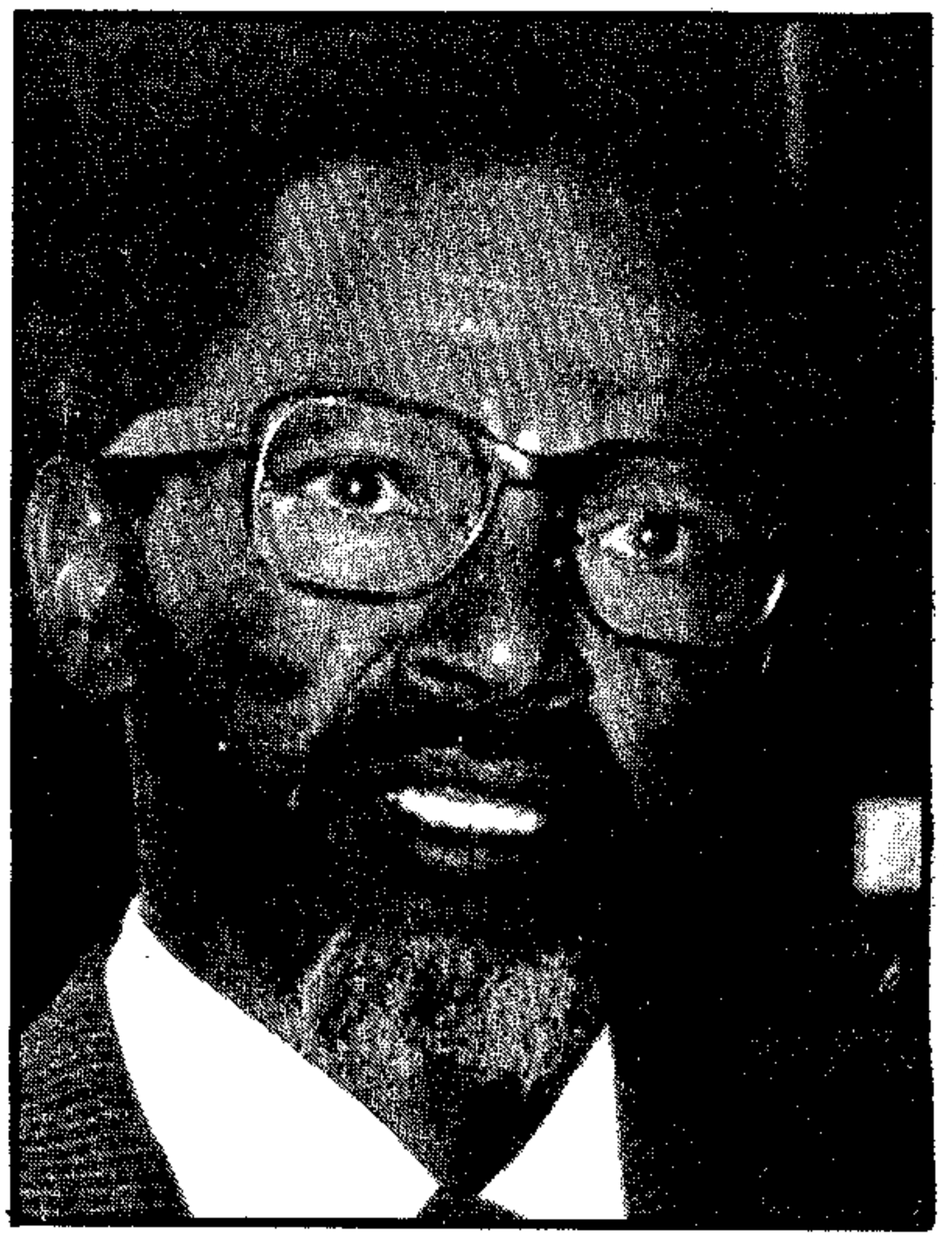
A snap tour of nearby clinics showed delegates just how rural health services groan under a combination of homeland politics and apartheid gone berserk.

The superintendent of the local Tshintswalo Hospital, Dr Jan Pienaar, said: "People are flocking to our side of the border (Gazankulu) for medicine. Since 1976 artificial political borders were created here.

"But people don't accept political borders when it comes to their health. The problems we experience here are not only health related, but the result of artificial separation of people."

Kaiser Family Foundation trustee June Osborne reminded participants of the responsibilities that lay ahead for the South African media.

Osborne said the grinding poverty and struggling health services in Gazankulu made for a sensational story, but warned that the temptation to superficial sensationalism had to be avoided in favour of a "responsible vocabulary".



MOTLANA ... Let's not throw health services into the hands of "those people".

Doctors 'thwart' chemists

CT 10/11/93

(85)

ANC for holistic approach to health

THABA'NCHU. — Long-term decisions on public and private health care should not be taken until a holistic assessment of the industry was completed in about four months time, ANC health policy development coordinator Dr Tim Wilson said yesterday.

He told delegates at the National Association of Pharmaceutical Wholesalers' conference here that the ANC is opposed to piecemeal adjustments to health care legislation.

This included changes to the Medical Schemes Act and the amendments to the Medicines and Related Substances Act.

He said the ANC was opposed to doctors trading in drugs, as "this was not what they were trained for", as well as to pharmacists taking over the prescribing function from doctors — although there were exceptions.

He added the future government of national unity would draw upon the expertise of all those presently involved in the health care system. — Sapa

Staff Reporter

THE Medical Association of South Africa (Masa) claims it has "thwarted" the campaign to allow pharmacists to render medical care to the public.

To allow them to do so would have been "legally intolerable and a public disservice", it says in the latest issue of its Medical Journal.

This refers to the Pharmacy Amendment Bill — an attempt to broaden the role of pharmacists in the health care system — which would have allowed chemists to diagnose and treat patients.

The bill was published in September for comment.

Masa states in the journal that it has "numerous examples of misdiagnoses and maltreatment by pharmacists that caused permanent damage and in some cases were fatal".

After making representations to the Parliamentary Joint Committee on Health, Masa had succeeded in convincing it to withdraw certain amendments to the bill that failed to delineate the role of pharmacists.

Masa also argued that allowing pharmacists to diagnose and treat people would not alleviate the burden on the state or make health care more accessible, as more than 80% of pharmacists were in the private sector and in 24% of magisterial districts there were no pharmacies.

The acting registrar of the Pharmacy Council, Mr Noel Pretorius, said from Pretoria yesterday he had had no official notification from the Department of Health that they had withdrawn certain amendments.

"As far as we know, the bill is with the minister who will decide whether to promulgate it or not, and in what form," Mr Pretorius said.

No response

He said he was unaware of any maltreatment by pharmacists that had, as Masa claimed, led to deaths. If there had been any cases, they should have gone through the normal channels and been reported to the council.

There has been no response from the Department of Health, which was approached for comment on Monday and yesterday.

When the Minister of Health was approached for comment, a spokesman for her office referred the Cape Times back to the Department of Health, saying they would know more about the matter.

Nearly 30 media people will go into the bush to think about health this week. The focus will be on a concept known as 'district health', new in South Africa, which could hold out real hope for millions of people. Health Writer ***David Robbins*** *reports*

District health – media have a role

Star 9/11/93

(85)

At the core of the health crisis in South Africa is ignorance. We're not talking here about the populace in general; we're talking more specifically about the health administrators.

There's ignorance of the extent of the problems, but, above all, there's the ignorance embedded in the assumption that more clinics, more nurses and doctors, more whatever, are what's needed to alleviate the situation.

In the most general terms, we know how bad the situation is — many thousands suffering from the effects of poor nutrition and lack of adequate water supplies; thousands more suffering from preventable diseases like tuberculosis and measles. But the closer we get to the ground, the more blurred becomes the detail.

This blurring is part of what the media people will see when they're invited into the bush this week by community groups and health experts.

They'll be going to the Bushbuckridge area of the eastern Transvaal lowveld, where Gazankulu and Lebowa health authorities, as well as the Transvaal Provincial Administration, try to administer to the health needs of half-a-million people.

More specifically, they'll see the incongruities of trying to run health services across an apartheid faultline.

They'll see clinics severely under-utilised on one side of the line while overcrowded on the other; they'll see a sophisticated health infrastructure which has never been adequately commissioned or staffed; and they'll see hospital cases of typhoid and other water-related diseases, but without being able to establish what the incidence of these diseases is in the community.

They also won't be able to find out what the precise infant mortality rate (the most basic health-status indicator) is for Bushbuckridge.

What is the solution to this frightening muddle of ignorance, coupled with the traditional and authoritarian (and often hopelessly inappropriate) provision of services from above? The answer lies in "district health" systems, an approach and a philosophy which has the potential to reverse current trends.

Perhaps the "district" concept can best be described as community-accountable, localised health management based on accurate information.

Take the information part of the equation first. There's a pilot programme going on in one corner of Bushbuckridge where field workers spent nearly two months actually mapping the area. It's never been done before or, if it has, no-one knows about or uses the information. Then they spent several more months taking a detailed census. Now they're repeating the whole house-to-house process again, but this time asking questions about birth and death to arrive at a detailed understanding of the health status of the targeted community.

"I don't believe there's a short cut," says Dr Steve Tollman, co-director of Wits University's Health Services Development Unit (HSDU), which is running the pilot programme.

"Without this detailed information, decision-making with regard to health interventions, their management, and the measuring of their effectiveness takes place in the dark."

Easy enough to see that the lack of this basic health information has led to some profoundly faulty — and expensive — decisions being made in the past. But how long will it take to gather the required information about every district in the country so that relevant interventions can be introduced?

Tollman: "Our pilot programme covers 60 000 people, but the data we collect could form the basis for designing health programmes for the whole of the Bushbuckridge area, and perhaps even beyond. It's crucial though that pilot programmes are set up in other parts of the country soon."

International thinking on district health systems indicates that districts should not usually exceed 250 000 people. This, according to Dr David Harrison of the Health Systems Trust, which is one of the organisations involved in bringing the media people to the bush, is large enough to achieve some economy of scale, yet small enough to render community involvement in health planning and administration a feasible proposition.

"It also breaks down the national crisis into segments which seem more manageable," he remarks.

Those with experience agree that community participation in the management of district health systems is essential. Community leaders, in Bushbuckridge at least, concur.

Sam Mkhabela, co-convenor of the area's district health systems initiative, is adamant that the people should be fully empowered.

"People want a fair slice of the national pie now, to make a difference to lives which always before have been little more than pawns in various ideological and power games."

"Communities, particularly rural communities, are so profoundly disillusioned with all official health systems and so they are more than ready to get involved," explains Sister Elizabeth Malomane of the HSDU and the local health service.

"But I think it's essential that this involvement should be tied in to district governance as a whole," adds Tollman. "Health care is a service — similar to the provision of water, education, and so on — and it should be seen in relation to the broad context of local development."

Indeed, the indications are that district health systems could provide a framework on which to construct workable local authority structures for numerous backwaters.

Although there are many problems to be overcome, and many questions still to be answered, one thing seems certain. The media people are about to help the experts, and numerous communities, to place the "district" idea firmly on the health and local authority maps. The idea may turn out to be a crucial building block in both spheres.

DP comes clean on health

Star 11/11/93

THE Democratic Party has released details of its thoughts on health care for South Africans. Everyone should have access to reasonable health services, and political ideologies should be kept out. Health Writer David Robbins reports

The Democratic Party believes that all South Africans should have access to reasonable health services and that health care policy should not be allowed to become subservient to any particular brand of political ideology.

The DP recognises that this is what has happened in the past.

"In South Africa," the party's health policy document says, "health services have been undermined by political policies, and a maldistribution of resources, the effect of which has been to deny health care facilities to those most in need, particularly of primary health care."

Some of the DP's main policy proposals are:

■ Both public and private health sectors, and all health workers, have an indispensable role and responsibility to provide quality yet affordable health care.

■ The valuable role of the country's doctors is recognised, but it should be acknowledged that the majority of South Africans cannot afford their services. Any health system needs to take account of the wide gaps in income.

■ There needs to be a shift away from public sector curative health care facilities towards a wide network of primary health care facilities with an emphasis on family planning, maternal and child care, immunisation programmes, health education, and appropriate treatment of common diseases and injuries. Special attention should be given to the training of primary health care personnel.

■ At the same time, secondary and tertiary hospitals should be maintained for curative and rehabilitative functions. No one should be further than two hours drive from one.

■ South Africans should be encouraged to minimise the demands on the health care system, and as many as possible should contribute to medical aid schemes to protect themselves and their families.

■ At the same time, public sector health spending should be increased from the current 3,2 percent of gross national product to 4,5 percent.

■ The best way of reducing disease is by eliminating poverty and the provision of adequate housing, potable water and sanitation.

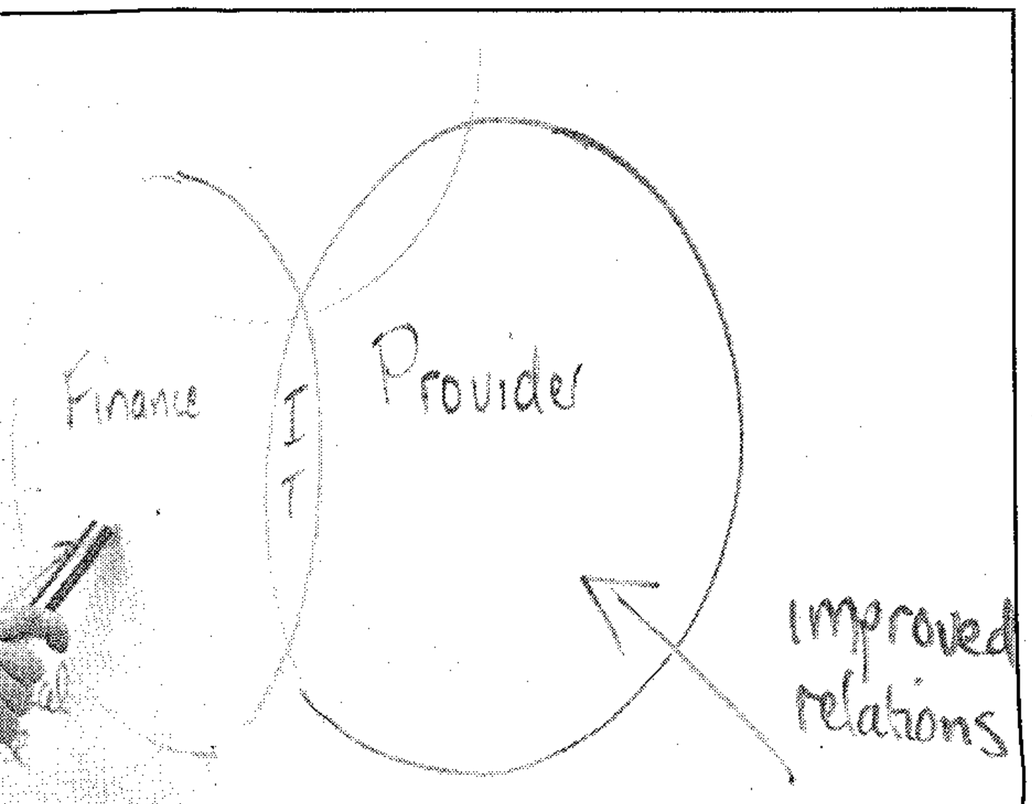
NO MORE BAND-AIDS: *Managed health care involving medical practitioners and efficient use of resources the only solution*

Past point of no return

Star 30/10/93 (85)

THE ailing medical aid industry was in the spotlight again this week when the Representative Association of Medical Schemes and the Medical Association of South Africa reached agreement in a deal intended to try to cut spiralling medical costs by offering incentives to doctors. Does this sound like a friendly deal intended to protect entrenched positions? Not according to Reg Magennis, new executive director of RAMS. Health Writer DAVID ROBBINS spoke to the man who intends to turn the industry around and make a major difference to health care delivery in South Africa.

DRAWING THE FUTURE: Representative Association of Medical Schemes executive director Reg Magennis says an integrated approach is the only way forward. He illustrates his ideas, saying there are two options for the private sector: "One is based on self-protection, the other on the idea of service." Either way, the road will be rocky.



REG Magennis has a habit of looking you directly in the eye. His own eyes are watchful, undeterred, friendly. He stands at a white board in his large office in Rosebank, Johannesburg, making diagrams to illustrate his ideas. "I have a triple mind," he says. "I see things in shapes and figures." He seems an unlikely figure to stand at the head of RAMS, the Representative Association of Medical Schemes. The industry is in disarray; indeed, it is in crisis, with escalating medical costs and premiums set against a background of decreasing cover, and a shrinking membership for the first time in 10 years.

But Magennis (35) radiates confidence. He has the air of a person who thrives on difficulties.

"When I took on the executive directorship here two months ago, I walked into an amazing set of opportunities. I am in the most stimulating situation of my career. But I see my role here as one of servant rather than as a power broker," he adds without affectation.

Yes, of course, the industry is in trouble. It's at a crossroads. The old days, when medical schemes collected money from members, held it for a while in the hope of earning some interest, then paid members' medical bills, are over forever. We've passed the point of no return."

In one area in particular Magennis has acted emptly to pave the way for an improved future — ntralised computer control. Sophisticated computer stems or speedy transactions between medical care oviders and medical aids, with a ility for information collection d processing, are needed urgently to improve the efficiency of edical aids and health care proion in general.

The ownership of such systems eans power, especially with re-d to the information collection ility. This could and should be ed in managed health care to onitor the cost-effectiveness of eatments and practitioners.

"Our approach has been to negote joint ownership of the new stems so that medical aids, docs and other stakeholders can are in the control and the bene-s," Magennis says.

A question: What is the future? here is the private health sector ing, whether equipped with soisticated systems or not?

Magennis draws a diagram: ree interlocking circles repreenting service management, fincial management, and custom-management.

THIS integrated approach is e only way forward for medical hemes, he says. "It's called maned health care. It's all about anagerial control and efficient e of resources. This will have a ajor impact on cost-effectiveness, ality of service and information th which to manage every aspect the enterpise."

He talks also of "threats" fragenting the industry. "Pulling it art," he comments, indicating in s diagram the negative effect of e insurance industry, independent actitioners' associations and ployers.

"Insurance companies are tendg to entice members away with w premiums, but largely the ung and fit; the independent actitioners' associations, fearful being swamped by managed alth care, are determined to opate outside our new computer tworks; and some employers are ing it alone with regard to health ver."

Yet, characteristically, Magennis es these threats as opportunities. he only way for the medical schemes to cope is to realise that their greatest strength will lie in consolidating the three elements of management — financial, service and customer — in the managed health care model, and also in forming partnerships with those offering the greatest threats."

Examples of such partnerships could be to use insurance brokers to market managed health care schemes and to work through employers to enhance service to members. To achieve co-operation on this scale, says Magennis, would be to place the private sector in a powerful position to enter "grand-scale contracting to the State.

"Our success will lie in making this paradigm shift from the protectionist preoccupations of some medical schemes and doctors towards a conscious understanding that the private sector can be of major service to South African society."

Another question: How would the private sector — in particular, the medical schemes — fare if the State, as has been mooted, decided to withdraw the tax subsidy on medical aid contributions?

MAGENNIS ponders the question for a moment. "The theory," he says, "is that this would release R2,5 billion for spending by the State. In practice, it wouldn't. Employers would immediately hide their share of contributions, probably in salaries, and the responsibility for health care would shift to the employee.

"Many employees wouldn't spend it on health, and far from being R2,5 million to the good, the State would find plenty of employees, hitherto protected by the medical schemes, thrown on its mercy when ill-health struck."

Magennis was born and educated in Johannesburg. He is a chartered accountant, holds B Com and B Acc degrees from Wits and a Master of Business Leadership from Unisa. He's an expert on health policy, having advised both the National Liaison Forum of Professional Associations and the Medical Association of South Africa before joining RAMS. As I glance at his CV, he tells me that a large painting had hung in the space now occupied by his white board.

"The board has been far more creative than the painting," he says. "But watch. I want to draw you the future. In fact, there are two distinct options for the private sector. The one is based on self-protection, the other on the idea of service."

He draws the two axes of a graph, the upright axis representing costs, the horizontal showing, from right to left, increasing degrees of computerisation, efficiency, co-operation and customer orientation. Then he places a solid-looking ball in the top right-hand corner.

'THAT'S where the private sector is at the moment. High cost, high technology. But we can't remain there. We've passed the point of no return. There are only two directions in which we can go. Either we move down towards the bottom left-hand corner by providing services and schemes to cater to larger and larger segments of the population, or we float off the graph to the right, getting smaller and smaller and more irrelevant to society — apart from the ultra-wealthy — as we go.'

His view is that either way, the road will be rocky. "There'll be bankruptcies, medical scheme mergers, upheavals, before we're through. But these will all form part of getting our house in order. Once that's been done — and the computer systems I spoke of earlier are central to this process — we will be perfectly positioned to talk to the State and take our place in the mainstream of health provision in this country."

Magennis taps the increasingly large circles as they descend to the bottom left-hand corner of his graph. "Mass provision of efficient health care; mass affordability. That's our place in the future."

Incentives for all to save

MANAGED health care is a relatively new concept in South Africa. An expert at a recent health-funding conference has defined it like this: "At the moment, all the medical aids are doing is getting accounts and sending out cheques. There's no control of costs or quality of service from health providers. Under a managed health care system, the medical aids will have to manage conglomerates of medical providers to ensure a cost-effective and quality service to clients."

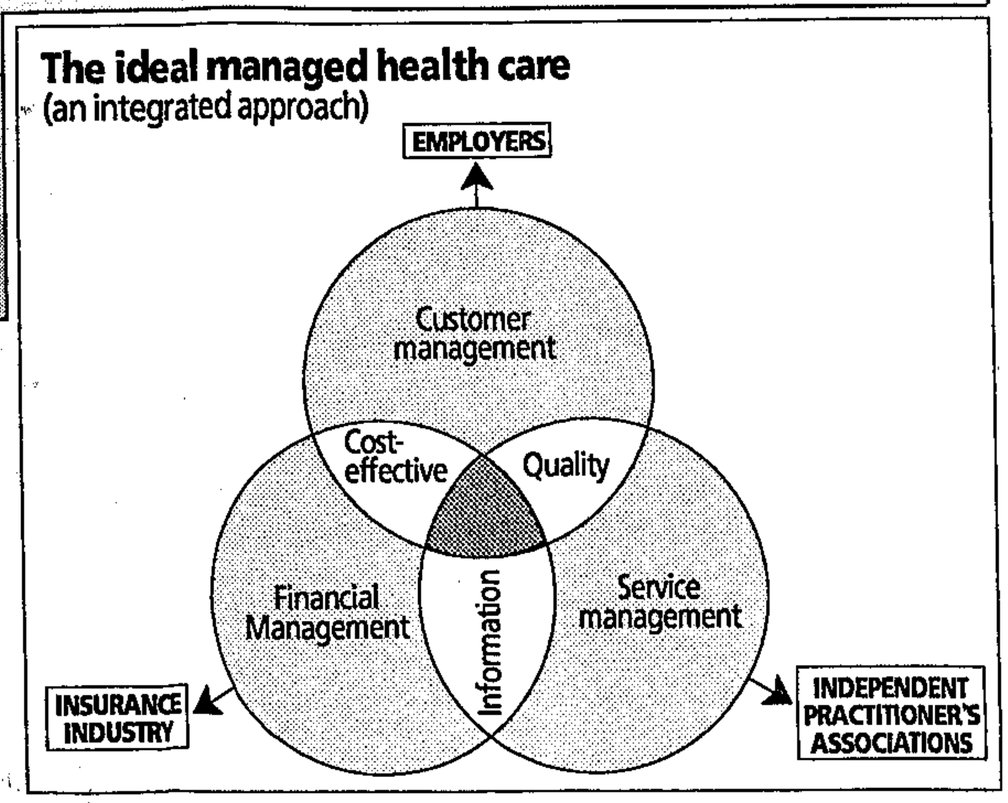
Managed health care conglomerates are well established in the US. The Blue Cross Blue Shield Association and the Kaiser Foundation Health Plan provide comprehensive health care to 20 million and nearly 7 million Americans respectively. The Kaiser Foundation employs more than 9 000 physicians and 75 000 other health and administrative workers. The organisation has its own hospitals and its own pharmaceutical formulary (list of medicines) from which its doctors are obliged to prescribe.

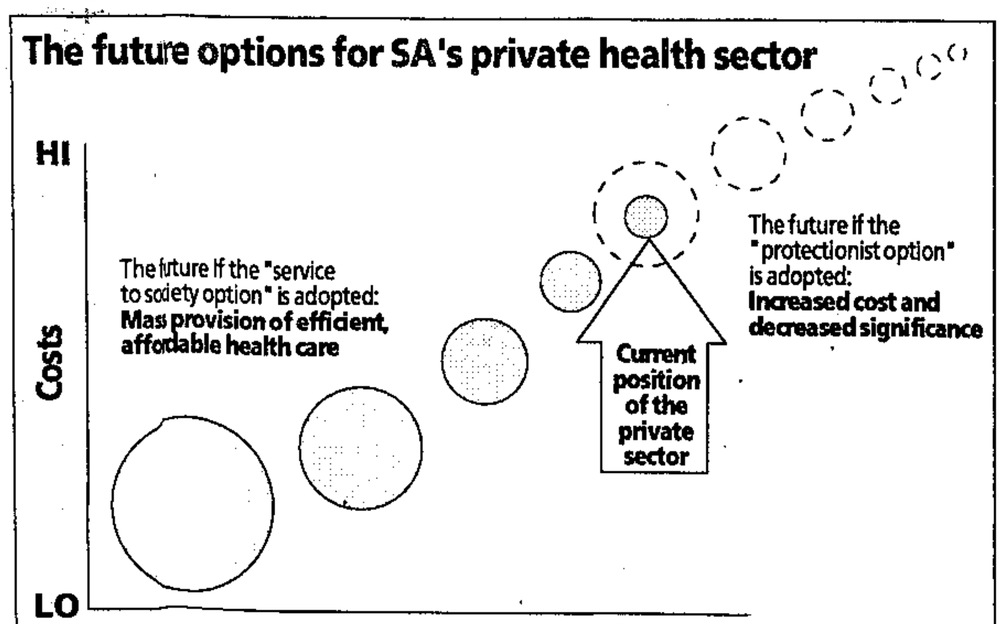
At the heart of managed health care lie sophisticated information systems and management techniques, incentives to members not to over-use medical services, and incentives to providers (doctors, nurses, and so on) not to oversupply. (85)

Checking expenses

This is what this week's agreement between RAMS and MASA boils down to: an increase in scale of benefit payments to doctors in exchange for savings worth R500 million in areas of overprovision, namely prescribing and hospital treatment.

Blue Cross Blue Shield research shows that its members paid nearly R3 billion less than the national average on health care between 1980 and 1988; from 1987 to 1991, while national medical expenses increased 56 percent, the increase for Blue Cross Blue Shield members was held to just less than 37 percent.





Rise in doctor benefits slated

CT 26/10/93 (85)

JOHANNESBURG. — The Patriotic Health Front — an umbrella group overseeing health care — rejected an announcement by the Representative Association of Medical Schemes (Rams) that the scale of benefits for doctors' services would be increased by 12% for the first half of 1994.

The announcement on the increase was made earlier yesterday by the Medical Association of South Africa (Masa) and Rams.

The national publicity secretary of the South African Health and Social Services Organisation, Dr Aslam Dasoo, said he did not believe the move would reduce the cost of health care but would increase the wealth of private practitioners.

Dr Dasoo said the increase would have no effect on most people in need of medical help.

He said the medical aid scheme structure had been investigated "but principally by those parties with vested interests in the medical aid industry, including Rams, Masa, pharmaceutical companies and other sectors of big business, together with the government".

Dr Dasoo said several parties in the health care sector were neither consulted nor party to any analyses carried out by these groups and "therefore all their findings we would regard as spurious and any consequent recommendations we would regard as highly suspect".

He said the "crisis" in the medical aid industry could only be solved once all parties accepted that the private health sector was inextricably linked to public health services.

Dr Dasoo said issues on tariffs and other aspects of the public and private health sectors should be tabled at the National Health Forum so that "all relevant parties will participate in the debate and the approach would be far more sensible".

Members of the Patriotic Health Front include the ANC, the PAC, the National Education, Health and Allied Workers' Union, Cosatu and the SACP, Dr Dasoo said. — Sapa

Health care body rejects fee increase

Bikay 26/10/93

THE Patriotic Health Front — an umbrella body involved in monitoring health care — yesterday rejected an announcement by the Representative Association of Medical Schemes (Rams) that the scale of benefits for doctors' services would be increased by 12% for the first half of 1994.

The announcement on the increase was made earlier yesterday jointly by the Medical Association of SA (Masa) and Rams.

SA Health and Social Services Organisation national publicity secretary Dr Aslam Dasoo said he did not believe the move would reduce the cost of health care but would instead serve to increase the personal wealth of private practitioners.

Dasoo claimed the increase in the scale of benefits would have no effect on most people in need of medical assistance.

He said the medical aid scheme structure had been the subject of review and analysis "but principally by those parties involved with vested interests in the medical aid industry, including Rams, Masa, pharmaceutical companies and other aspects of big business together with the government".

Dasoo said several parties in the health care sector were neither consulted nor party to any analyses carried out by these groupings and "therefore all of their findings we would regard as spurious and any consequent recommendations we would regard as highly suspect".

He said the "crisis" in the medical aid industry could be solved only once all parties accepted that the private health sector was inextricably linked to public health services and "any attempt to restructure the private health sector will always impact on the public health services".

Dasoo said tariffs and other issues affecting the public and private health sectors should be tabled at the National Health Forum so that all relevant parties could participate in the debate and the approach would "be far more holistic and sensible".

Members of the the Patriotic Health Front included, among others, the ANC, the PAC, the National Education, Health and Allied Workers' Union, Cosatu and the SACP, Dasoo said. — Sapa.

Thursday October 21 1993 SOWETAN

PEOPLE'S LIVES *Accessing basic health care like family planning is still a major obstacle*

Women's health education project

Sowetan 21/10/93

NATION-WIDE *Seminars will held regularly at branch offices:* (85)

By Pearl Majola

MRS IVY MOGANO SHUDDERS when she thinks what might happen if her two-month-old baby, Tshepo, were to be sick.

To get to the immunisation clinic from their squatter camp home, they have to take a taxi.

The clinic closes at five in the afternoon, so if anything happened at night, they would have to get to Baragwanath Hospital, which is more difficult without public transport.

For many women and mothers like Mogano, especially those in rural areas, the hope of health for all by the year 2000 as proposed by the World Health Organisation will remain an illusion unless they do something about it themselves.

Major obstacle

For them, accessing basic health care like family planning and immunisation for their children is still a major obstacle.

An attempt to change this situation and bring health to women through primary health care education is being made by the Women's Bureau and the Department of National Health and Population Development.

Through Women United in Health, as the project is called, regular information seminars are to be held, the first one starting in Johannesburg in November. The seminars are to be attended by delegates from various organisations who will in turn go back to their communities and impart the knowledge they have received.

The Women's Bureau branch offices nationally will be used for meetings where women from specific communities will decide what health issues they want to discuss and as venues for the seminars.

Exchange forum

A forum for the exchange of information and ideas between the communities will also be formed nationally.

"Women United in Health aims to provide women with necessary information to uplift and educate their communities to take individual responsibility for their health," says Mrs Natalie Stockton, the director of health promotion in the Health Department.

Stockton says mothers are neither ignorant nor unmotivated when their children's health is at stake.

But violence, poverty and other social, economic and political problems have forced women to move to cities as squatters under unhygienic and hazardous circumstances.

Ideal opportunity

"Women can play an important role in addressing health issues.

" These seminars will be an ideal opportunity for women to discuss their health needs, their role in promotive and preventative health as well as identify resources that can be used to improve the health status of all South Africans."

Emphasising education as an important element of health, Dr Nkosazana Zuma of the Medical Research Council says healthy mothers are crucial to producing healthy children and therefore a healthy nation.

"The country must invest in the health and education of women," Zuma says.

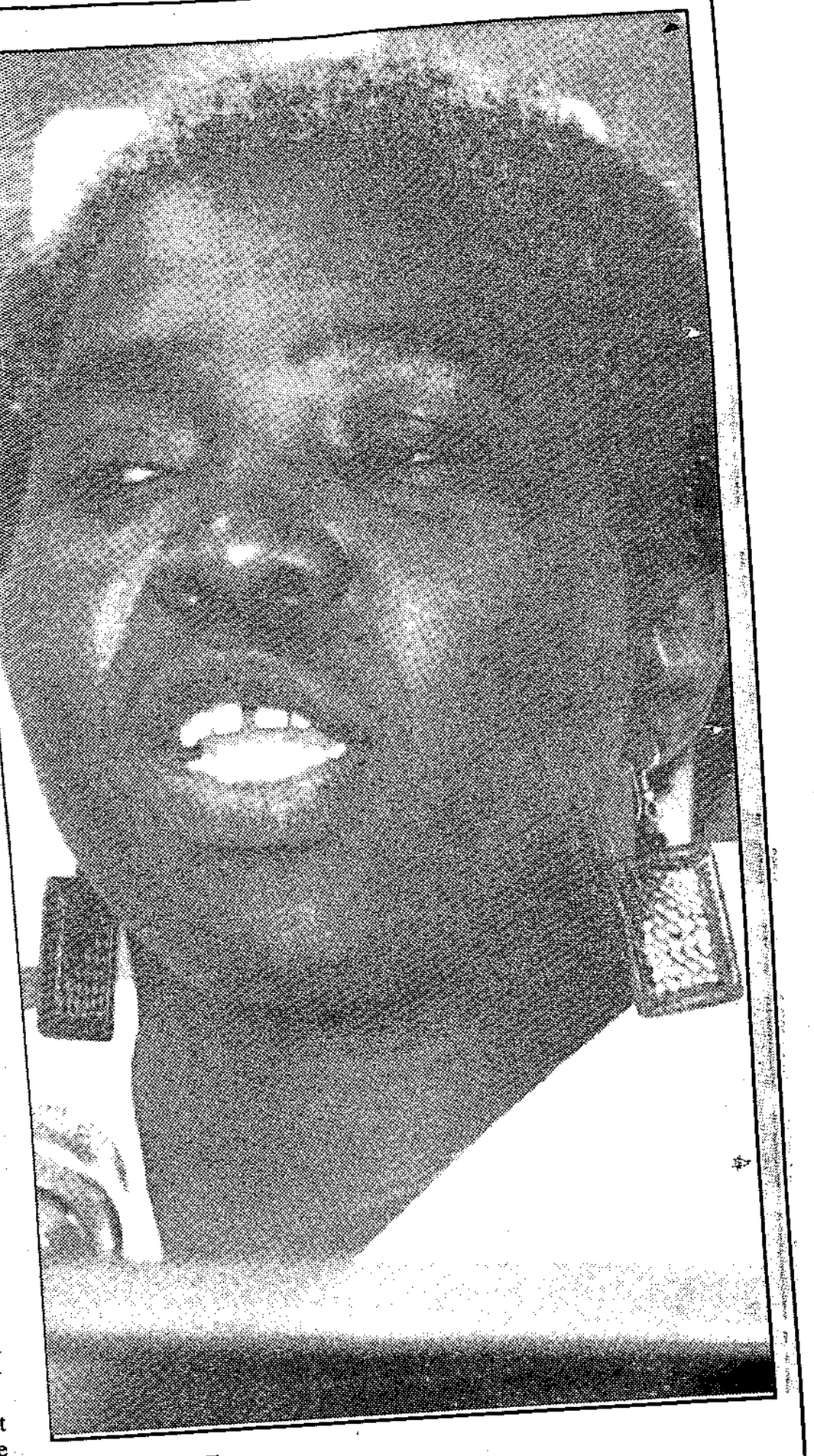
"Research shows that the education of women has a bearing on the health of their children — the mortality rate goes down and they have fewer children which means they can take good care of them."

Zuma says women needed empowerment through education to understand about their health and that of their families.

Women's Bureau executive director Mrs Margaret Lessing sums up the importance of the project by saying: "There can be no freedom, no free and fair elections and no democracy in any country that does not have a healthy population.

"Health is a matter of human rights and primary health care can be an insurance against disease and expensive hospitalisation later on.

"It is against this background that we are launching this campaign," she explains.



Dr Nkosazana Zuma

Health plan targets corporate market

CHARLOTTE MATHEWS

FIRST National Bank, Aegis Insurance and Fedlife Assurance are launching a health funding scheme for individuals which offers a savings element, medical insurance and long-term investment for post-retirement health costs. BIDay 13/10/93

"We believe that in Med Relief we have come up with a product that is comprehensive, simple and customer-friendly," Fedsure group CE Arnold Basserabie told a media conference yesterday. (384)(85)

The medical insurance element of the scheme is underwritten by Aegis.

It offers medical cover to a maximum of R150 000 for an individual and R300 000 for a family for premiums of up to R223,08 a month.

Emergency medical services and benefits through International SOS Assistance are included. The medical insurance scheme has a R5 500 excess, which may be covered by an optional hospital policy.

First National Bank offers a savings fund linked to a debit card which is intended to be presented to doctors and pharmacists to pay bills immediately.

The minimum monthly contribution to the fund is R100 but a credit balance earns preferential interest rates.

An optional endowment policy is available through Fedlife which is intended as a long-term investment for future medical costs.

According to Med Relief's brochure, 70% of all medical bills are incurred in the last three years of a person's normal lifetime but at that stage medical insurance can be expensive and difficult to secure.

The minimum contribution to the endowment policy is R100 a month and it has a waiver of premium benefit so that policy contributions are paid by Fedlife if the policyholder is permanently disabled.

The scheme will be targeted at the corporate market from 1994.

ther home to the United States

vehicles last month

SA: 'Lowest child deaths'

From CHRIS BATEMAN

LONDON. — South Africa's measles immunisation programme is expected to be ranked among the worst in Southern Africa when the United Nations Children's Fund (Unicef) release their annual Progress of Nations tables here today.

However, the country is believed to have emerged with the lowest child mortality and maternal death rates among its Southern African neighbours.

One of Unicef's most important indicators in assessing each country is by the number of children who die before the age of five (per 1 000 live births) and the maternal death rates.

CT 22/9/93

These gives vital clues to income and education levels of parents, prevalence of malnutrition and disease, availability of clean water and of the country's health services and the health of its women.

People — SA's big problem

JOHANNESBURG. — South Africans cannot expect to be better off in the future unless economic growth is complemented with a plan to combat the country's population crisis.

This was said yesterday at the World Trade Centre by the director-general of the SA Chamber of Business Mr Raymond Parsons.

His statement was backed up by National Parks Board public relations manager Mr Fanyana Shiburi, who said unless South Africa's population explosion was addressed soon all conservation efforts would be rendered futile.

At the same conference Peninsula Technicon rector Mr Franklin Sonn said apartheid induced black South Africans to flout population control measures.

Mr Sonn said the apartheid system had alienated blacks and diminished their sense of responsibility.

● Clerics who argue against family planning are highly irresponsible, Professor Len Hulley of the Department of Systematic Theology at the University of South Africa told the conference. — Sapa CT 22/9/93

theft, and one year for bribery. — aggravating ...

Evidence was that on Novem- Jotamo, on his own admission, same time it is seldom that one finds a murder where aggravat-

SA's health is first above all

Star 21/9/93

(85)

NEW research suggests that the state of health of South Africans will be critical to progress on the development front, reports Health Writer David Robbins

Establish a Cabinet-level committee on health on which all departments are represented. Put the State President in the chair. The committee's function will be to examine the long-term health implications of all development planning.

And educate our women.

These are some of the major suggestions which emerge from research conducted by Dr Derek Yach, who works in the Essential Health Research Group of the Medical Research Council, and Bruce Edwards, human resource development manager at the Development Bank of Southern Africa.

"It will require considerable courage to move in this direction," they say. "But it is becoming increasingly important to get beyond the entrenched views of both health and development. The truth is that health is a key determinant of development."

In other words: a nation in poor health (as South Africa undoubtedly is) will benefit little from development efforts unless these efforts are specifically designed to improve the life chances of those who stand to benefit from the development, be it in the field of housing, basic services, education or job creation.

This thinking is reinforced at an international level by the World Bank, one of the most powerful development agencies. For the first time, the bank has devoted its entire annual report to health, mainly in developing countries. The title of the report: "Invest in Health (for development)".

As long ago as 1890, health reformers in the United States were saying that public health should be viewed as "a paying investment giving higher returns than the stock market".

The lesson is still being learnt. Yach and Edwards point to data collected from 117 countries in the '80s which indicate that socio-economic factors are more closely linked to infant mortality rates (IMRs) than the size of the actual health budget or the quality of health resources.

"As the incomes of countries increase," write Yach and Edwards, "so does their life expectancy."

Seen from this perspective, it is small wonder that South Africa's health services are in crisis.

Quite apart from the blatant discrepencies in direct health spending between the different races and between rural and urban areas, the economy has been troubled for decades by declining growth rates and a rapidly increasing population.

This combination has meant that "while the percentage of the population living below the absolute living standard has decreased from 50 percent in 1980 to 42 percent in 1990, the absolute numbers of poor have increased from 14,7 million to 17,1 million, of whom 65 percent live in rural areas".

Coupled to this is the country's vast need for reasonable housing, a need exacerbated by high rates of urbanisation. Then there's unemployment (currently estimated at 46 percent), the looming spectre of Aids, and the continuing violence, all of which offer major threats to the health of the nation.

'Innovative ways'

Yach and Edwards say: "A future government will need to find innovative ways of stimulating economic growth to turn around the steady decline of the past decades.

"It is thus unlikely that we can expect any increase over the next three to five years in the proportion of the total budget being spent on health. Indeed, the real spending power on social investments is likely to decline if inflation stays above 10 percent."

It's a bleak picture.

The central thesis of Yach and Edwards is that economic and infrastructural development must be looked at from the health impact point of view, and developments which impact most surely, and widely, on the health of the nation must take priority.

Clean water before international airports. Rural development before sports stadiums. Good basic education, especially for girls, before grandiose tertiary institutions.

The mechanisms by which education leads to improved survival are complex, but the linkage between the education of mothers and the well-being of their children is well established.

It has been calculated, for example, that the under-five infant mortality rate among the children of mothers with no education is 80 percent higher than among those whose mothers have Std 8 or higher.

Various studies referred to by Yach and Edwards all show similar patterns: that weight and height for age and exposure to immunisation programmes improves the higher the education of the mother.

In addition, education is now widely recognised as a crucial element in the empowerment of women to make decisions on such issues as family size, and on the physical and intellectual quality of the country's future — its children.

It is also more and more accepted that strategies to improve the health of children (including the education and empowerment of women) are high priorities for the attainment of sustainable development in developing countries.

Especially in South Africa. A great deal of money and effort have been devoted here to curative health care, and especially the tertiary care of chronic and endstage diseases.

Outside the traditional health sector, the pair earmark:

- Providing sanitation and clean water for all, "prior to starting any new tertiary care facility for chronic diseases".
- Strengthening the education system and introducing a curriculum which promotes an awareness and understanding of health issues.

Within the health sector, Yach and Edwards pinpoint the crucial importance of the sustainability of immunisation and other child survival programmes.

There can be little doubt that vigorous attention (by health authorities, development agencies, and the proposed Cabinet-level committee) to these three factors will be crucial to the future health of all South Africans. Without such a foundation, the walls of whatever health care system we choose, be it public, private, or a combination of both, will not stand.

Visions of health care

Staff Reporter

PRIMARY health care for under-privileged youth is the aim of the Youth Care Foundation and National Youth Care programme Visions.

The programme was formed after research showed that 75% of young people living between Atlantis and Ocean View had no access to medical aid. CT 20/9/93

Mr Chris Mentor, the co-ordinating director, said the organisation would work with community and "progress orientated" organisations.

SA health system in funds crisis

By MELANIE GOSLING

HEALTH care in South Africa is on a downward spiral as hospitals battle to maintain standards in the face of drastic budget cuts, deteriorating equipment and escalating trauma to violence victims which costs the country R9,5 million a day.

At a press conference called by Groote Schuur's top academic and administrative executives yesterday, the dean of UCT's medical faculty, Professor J P van Niekerk, said there was deep concern about the slow attrition of standards at the Groote Schuur Hospital complex.

"All departments are deficient in equipment, waiting lists are getting longer, treatments are being cancelled or postponed and some treatments are simply no longer available," he said.

Chairman of the complex's supervisory board, Professor Geoff Everingham, said last year's budget was R128 million and expenditure R141 million.

"Somebody has to make the political decision to provide adequate funding or cut services. No one is keen to grasp that nettle," Prof Everingham said.

The deputy director of nursing, Mrs Anna-Marie van der Walt, said nurses at Groote Schuur were functioning at absolute minimum staffing levels.

"In the past we would deal mainly with panga or knife wounds. Now we have major trauma patients with AK-47 wounds which need increased expertise and medical supplies," Mrs Van der Walt said.

Prof Everingham said it was encumbent on the state to see that health care did not deteriorate further because of budget cuts.

Township violence hits health services

Health Reporter

VIOLENCE in Cape townships has had a "disastrous" effect on health care, according to Jocelyn Kane-Berman, chief medical superintendent of Groote Schuur Hospital.

At a press conference yesterday, Dr Kane-Berman said its maternity and obstetric units in Guguletu and Khayelitsha had been closed on several days, not because nursing staff weren't in, but because drivers were too frightened to deliver linen and supplies.

She praised the nursing staff who "worked through thick and thin".

Dr Kane-Berman said that the cost of treating victims of violence in South Africa was R9,5 million a day.

Nursing deputy director Anna-Marie van der Walt said that trauma cases being admitted to the hospital were coming in with increasingly serious wounds and were consequently more expensive to treat.

Groote Schuur admitted on average 120 gunshot wound patients a month, a figure matched by admissions at Mitchell's Plain day hospital.

Also, transport disruptions such as the taxi blockade in Mitchell's Plain had meant that many nurses had to walk "miles" to find transport to work.

eptember 17 to September 21 1993

Threats to health care in Africa

South 17/9-21/9/93

DETERIORATING hospitals and demoralised medical personnel are among the greatest threats to the standard of health care in Africa, according to World Health Organisation (WHO) Africa director, Mr Gotlieb Monekosso. (85)

"Because of a lack of finance, hospitals have become run down and health personnel are unhappy to the extent that they are not caring for people," Monekosso told a press conference at the end of a WHO regional meeting in Gaberone, Botswana, last week.

Infant mortality rates, which had been falling for the past three decades, had started rising again in some countries, possibly due to Aids, he said.

Health workers were at a standoff in the battle against malaria and were losing the fight against Aids, he added.

The 45 countries represented at the eight-day meeting agreed that health care must be decentralised to local structures and become more community-based.

"This is the first time that we have reached agreement that our efforts should be channelled through the local level to touch the people," Monekosso said. **— Sapa-AFP.**

health

Help for Phillipi workers

South 17/9-21/9/93

HEALTH is at hand for the impoverished farm worker community in Phillipi.

Medical staff and students from the University of Cape Town (UCT), keen to offer a health care service in the area, have received the necessary funding of R13 000 from a baby food company.

The Phillipi project has been initiated by the Nutrition and Dietetics Unit at UCT's Department of Medicine (85)

According to Mrs Joan Huskisson, head of the Nutrition and Dietetics Unit, the project will improve the nutritional status of the children by educating young mothers in the area.

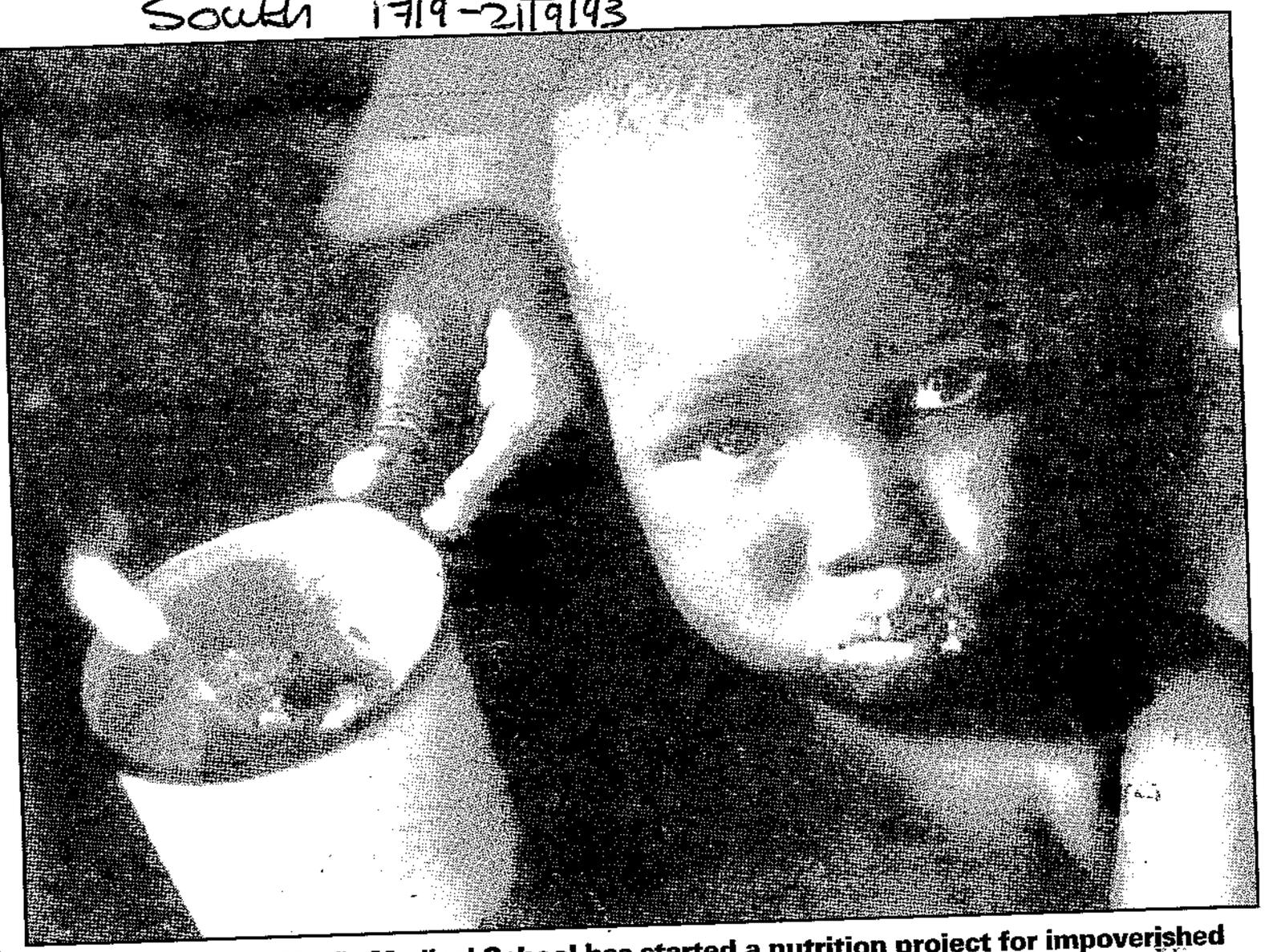
"Many of the farm labourers on the vegetable farms in the Phillipi area have long been regarded as a deprived, oppressed community with a high rate of illiteracy, few social amenities and an unacceptably high incidence of nutritional deficiency disease," Huskisson said.

A recent health report from the Diertrich Primary School, which is the only school in the area, found nearly 67 percent of the children are underweight, 46 percent are anaemic and nearly 87 percent suffer from various defects.

The local Trudy Thomas Creche currently cares for and feeds some 100 pre-school children.

The UCT Unit has assessed all the children at the creche as well as the Sub A children to determine the health status of young children in the area.

The unit will launch its community development programme later this month, which will initially be directed at the mothers of children at the Trudy Thomas creche to them basic skills and provide nutrition and health education.



FOOD IN PHILLIPI: UCT's Medical School has started a nutrition project for impoverished children on Phillipi's farms

"World-wide, one of the most relevant factors in improving nutritional status in similar circumstances is the education of women," says Huskisson.

"We have been given the use of a most suitable barn on the Welgevonden farm as a meeting place and the idea has been enthusiastically received by potential participants in the neighbourhood, who appear to have no social facilities besides alcohol at the weekends."

Post-graduate dietetics students and senior nursing students will initiate the presentations which will be continued on an ongoing basis by the local clinic sister and teachers.

"We plan to implement a weekly Saturday morning programme aimed primarily at improving the nutritional status of young children, but with a broader base to ensure ongoing interest," Huskisson said.

Topics to be addressed include breast-feeding, weaning practices, food budgeting, fuel saving and food preparation.

Health education will include basic first aid and address sanitation in particular.

There is currently only one toilet for the 40 people living in the immediate area.

After 25 weeks, the series will be re-evaluated and handed over to a local committee with ongoing monitoring and participation from the Nutrition and Dietetics Unit.

Early next year the children will be re-assessed to determine the effect of the development project.

QUENTIN WILSON

Victims of uneven health care? . . . 53 percent of South African children aged between two and five years suffered from stunting due to malnutrition diseases in the '80s. Alongside Gabon South Africa's health status is among the lowest in the world. With the new South Africa about to dawn, what should our future health policy look like and what will a future government have to do to ensure good health care all?

Looking healthy at election time

Star 16/9/93

(85)

POLITICALLY HEALTHY

Which health policy options will emerge after the election next year? And what, if anything, are the political parties saying about this crucial area of public life? **DAVID ROBBINS** reports.

A health administrator said recently: "We are one of very few countries which will have the opportunity of remodelling our entire health policy. The democratisation of South Africa will provide this opportunity. But if we miss the boat now, it's highly unlikely that we'll be able to change again for at least a generation."

As next April nears, there is a growing sense of the pivotal role health will play, not only in the election campaign itself, but in the months and years that follow. The possibility that the country might "miss the boat" again hovers like a nightmare in the minds of many health experts.

For we've missed the boat in the past, and we've missed it badly. According to the World Bank's latest development report, South Africa's health status relative to its income is placed in the worst category of countries in the world, alongside Gabon.

Look at a few facts: 53 percent of South African children aged two to five suffered from stunting due to malnutrition during the 1980s (the all-African average: 39 percent); our annual incidence of tuberculosis is around 250 cases per 100 000 (15 percent higher than the African average); and in 1990/91 only 63 percent of our children received immunisation against diphtheria and tetanus in their first year (in Zambia and Zimbabwe the comparable percentages were 79 and 89).

The seriousness of these figures is magnified by the growing realisation that radically improved health for all will be crucial to reconstruction and development in SA. In other words, what health policy ideas do the 26 political parties scrummaging at the World Trade Centre espouse?

This is where an organisation called the National Progressive Primary Health Care Network comes in. Quite simply, the network is going to ask the politicians for firm answers.

"There is a widespread use in SA of the least cost-effective health measures, and too great an emphasis on expensive tertiary care," says Dr Derek Yach, the Medical Research Council's group executive for essential health research. "In addition, most health interventions are unevenly applied, particularly with regard to race, religion and age. This has resulted in a wasteful health system.

"Correcting the balance would mean that we could buy substantially more health for our existing rands, but to shift resources requires strong political commitment to break what have become strong vested interests. Health for all is possible in SA, but it'll require, among other things, political commitment at all levels to ensure that healthy public policy is developed," he says.

The name of the game, then, is new ideas, but ones that will ensure we do not miss the boat once again.

Marginalise

"We're simply not going to allow the political parties to marginalise health, or to fob us off with stock replies," says Judi Fortuin, a national co-ordinator of the National Progressive Primary Health Care Network.

"What we are attempting to do is to establish the basic stance of each party."

All 26 parties will have been approached by the end of this month, and the network intends to publish the results and to rate each party's response to key health issues.

The network has identified five areas around which detailed questions will be designed. These are: women's health; community health workers; mother and child health; Aids and who pays for what, where and how.

The purpose of the network's "What are you saying about health?" campaign is to provide its own members with the best information on what political parties are planning with regard to health policy, especially as it relates to primary health care.

TOMORROW

Judi Moreo on why customer care is vital for South Africa's economy.

Forum for better health services

By BARRY STREEK
Political Staff

A MULTI-ORGANISATION Cape Metropolitan Health Care Forum had been established to promote improved health services in greater Cape Town.

The objectives of the forum were to identify health issues of the total population and to formulate, by consensus, appropriate plans.

An important function of the forum was the free flow of health information.

Chairman of the forum, Dr John Frankish, said many people in the Cape metropolitan area had inadequate access to good health services.

However, the health authorities were under financial pressure to reduce or restrict the expansion of health services.

"The establishment of the forum is an important step in attempting to resolve these conflicting demands," he said.

Organisations and institutions involved in the forum included the public health service authorities, non-government health organisations, political structures, academic and research bodies, the private sector, health sector unions and community organisations. CT 11/9/93

He said the public health authorities had undertaken not to restructure the present health services until agreement was reached with those affected.

Investing in a priceless treasure

(85) WM 10-16/9/93

PROFESSOR LEN KARLSSON: Director of Health and Rural Development.

HEALTH

DESPITE today's continuing advances in medical technology, most South Africans still have limited or no access to adequate health services, says Professor Len Karlsson, Director of the IDT's Health and Rural Development portfolio.

"Our interaction with communities all over the country has highlighted the magnitude of socio-economic and health deprivation."

He notes that tuberculosis and malnutrition are on the increase and that the impact of Aids on health services will be profound. Infant mortality rates are still at unacceptably high levels.

The IDT therefore continues to make primary health care a priority. The portfolio is attempting to tighten its focus and give special attention to rural areas.

In September 1992, R86 million was allocated to an IDT clinic building programme, after hundreds of applications for assistance had been received. A clinic building team is now actively engaged in implementing 212 primary health care facilities around the country.

The target is to complete 138 of these by June 1994.

All projects are endorsed by the health authorities who, in most cases, pay for running costs, staff and equipment. Land usually comes from local authorities.

The team has become the primary facilitator between communities and the structures that serve them. Wherever possible, it follows the principles of job creation and development of human resources in its delivery methods.

South 3/9 – 7/9/93

A question of health

South 3/9 – 7/9/93

85

HEALTH workers have launched a campaign to inform voters of the commitment to primary health care of the 26 negotiating parties at the World Trade Centre.

The campaign, launched exactly nine months before the April 27 elections by the National Progressive Primary Heaith Care Network (NPPHCN), is aimed at ensuring that all its constituents and South Africans interested in health and development know where political parties and organisations stand.

"This campaign will ensure that the debate around health will reflect the vision of primary health care," said campaign director Ms Judi Fortuin.

The campaign aims to provide NPPHCN members with the best information on health.

South Africans will also be provided with an opportunity to engage in the health debate by sending questions to the network to be relayed to the politicians for a response.

Public surveys will also be conducted to address community expectations and needs.

The 26 parties at the negotiations will be asked five questions to determine their positions on primary health care.

The questions will cover women's health, community health workers, mother and child health, community accountability and who will pay for health.

After the data is analysed, a report will be published and each party will be rated and their health profiles published.

...w "We are seeking ways all sub-Saharan Africa." [illegible] lost time.

HANDS-ON DOCTOR... Dr Ivan Toms takes on his Shawco portfolio Picture: AMBROSE PETERS

Hands-on Dr Toms new Shawco head

By PETA KROST

NEWLY-appointed Shawco head, former activist Dr Ivan Toms, says he will use his position to uplift local communities — but only with their co-operation. ST Times

Shawco (Students' Health and Welfare Centres Organisation), has over the years conducted a tireless campaign to provide care and support for thousands of disadvantaged people in the Cape Peninsula through health care, social work and education. CC (Metro)

But Shawco is no longer sending its vehicles into Khayelitsha because one of them was recently gutted. 29/8/93

"We plan to meet with the relevant organisations to check if they want us there because if they don't we will leave. The communities must stop passing the blame and take responsibility for their areas," he said. (85)

Hands-on person

This week Dr Toms, who spent nine months in jail as a conscientious objector, took up his position at the helm of Shawco, the largest student-initiated organisation in the world.

Dr Toms was involved with Shawco almost 20 years ago as a UCT medical student. He succeeds Dr Derrick Livesey who headed the organisation for 25 of its 50 years.

"I applied for this job because I'm a hands-on person and I want to be out there, finding the problems and dealing with them " he said.

"I bring with me the ethos of development and not just welfare. I'm talking about empowerment and passing on skills so people won't be dependent.

"So much of health has to do with sanitation and good roads and solid homes. Doctors and nurses play a role but clean water will improve matters more than they could."

Dr Toms was previously national co-ordinator of service development in the National Progressive Primary Health Care Network.

Warning by mayor on services

Municipal Reporter

MAYOR Frank van der Velde has warned of a complete breakdown of health services in townships unless leaders take strong initiatives for peace (85) ARG 26/8/93

He told the monthly council meeting today he had learnt with dismay of the tragic death of a young American student and the attack on a health worker in the past two days.

Mr Van der Velde said he had had repeated requests from many quarters to maintain the impetus of his peace initiatives in the wake of the St James massacre.

"I have thrown my support behind the National Peace Accord's 'Peace In Our Land' programme starting on September 2."

The programme will include a noon silence and requests to motorists to pull off the road or switch on headlights for the sake of peace.

Mr Van der Velde endorsed a call for people to share meals with members of other communities at weekends.

Care units to discuss safety

Health Reporter

PRIMARY health care organisations in Cape Town are meeting to discuss safety issues after an attack on an occupational therapist in Khayelitsha.

Seven-months pregnant Sacla worker Fiona Loubser was dragged from a van she was driving in Site B on Monday when youths stoned the vehicle. The van, bearing the organisation's logo, was burned.

She was later treated for injuries at Khayelitsha Day Hospital.

The organisations, which function under the umbrella of the Progressive Primary Health Care Network, called an urgent meeting following the attack, which has been condemned by Sacla (South African Christian Leadership Assembly) and others.

Sacla has provided health care in Peninsula townships since 1980.

Mob tries to steal rings on health worker's hand

ARG 24/5/90

ANDREA WEISS
Health Reporter

A HEALTH worker was attacked and her van, bearing the logo of the community organisation she works for, was burnt out in Site B, Khayelitsha.

A witness said that youths tried to steal rings off the fingers of occupational therapist Fiona Loubser after she was dragged from her van.

Bystanders said Mrs Loubser, who is reportedly pregnant, was rescued by some women who took her in a taxi to the Khayelitsha Day Hospital, where she was treated in the trauma unit for head injuries.

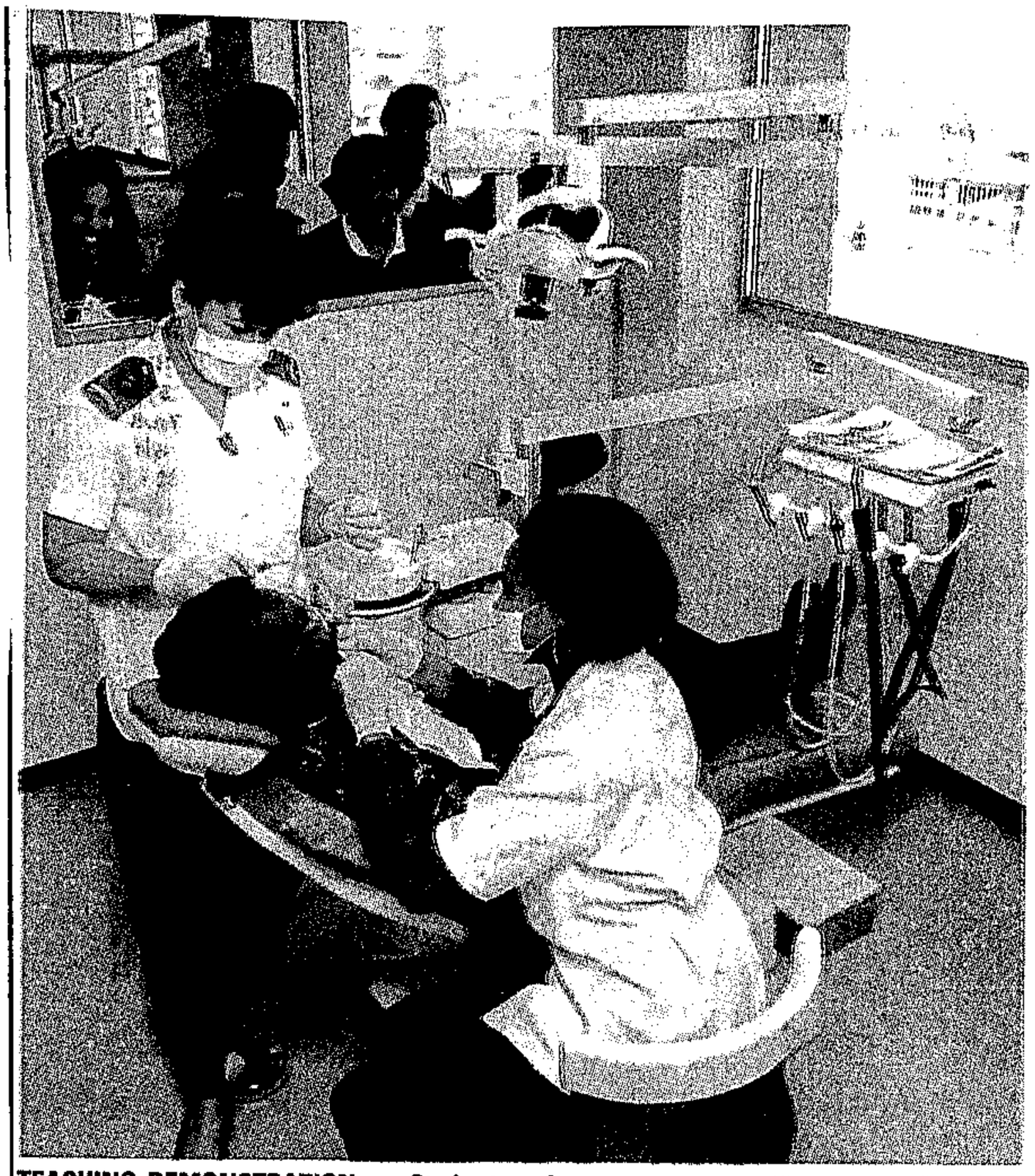
Mrs Loubser works for the South African Christian Leadership Assembly, which has provided health care to township communities in the Western Cape since 1980.

After she was taken to hospital, a group of mothers whose disabled children she assists arrived to rally to her support.

The attack has raised concern among other health organisations, particularly as Mrs Loubser's vehicle was clearly marked.

The Progressive Health Forum said that unless the violence stopped it would be impossible to continue providing community services.

"Essential referral and support systems will break down unless this violence stops," said a spokesman.



TEACHING DEMONSTRATION ... Students gain experience in different dental techniques
Picture: AMBROSE PETERS

New approach to health care

IN 1978 a new approach to health care was developed at a conference in the USSR.

This Primary Health Care approach brought together an understanding of the biological as well as socio-economic, political and cultural factors which cause ill-health.

PHC programmes involve communities in every stage of programme development and include strategies to promote health as well as treat disease.

The University of the Western Cape realised there was a strong need to educate and train public health personel who could work with communities to ensure the health sector met community needs and was fair, efficient and sustainable.

UWC has a well-developed health and welfare sector with a faculty of Community and Health Sciences which includes departments of nursing, physiotherapy, occupational therapy, human ecology and dietetics, psychology and social work; a faculty of dentistry and a School of Pharmacy within the Faculty of Science.

A distinctive feature of these departments is that their educational programmes include a significant amount of field practice where learning is combined with service to under-privileged local communities.

The establishment of an inter-disciplinary education service and research project which would bring together UWC, Peninsula Technikon, the communities of Mfuleni and Mitchells Plain and local health services is at present being investigated.

According to the Director of UWC's Public Health Programme, Professor D Saunders, the programme aims to consolidate the university's work and "develop further practise sites where education can take place in all aspects of community-based primary health care".

The PHP has already organised a number of successful Winter and Summer Schools where innovative, problem-orientated short courses in various area of public health and PHC have attracted wide attendance.

Efforts to create such a school are being co-ordinated by a committee which includes the three universities, two technikons as well as the Medical Research Council, the nursing colleges and the health service authorities.

Concerned group seeks to help in primary health care

By EVE VOSLOO

A LARGE group of practicing and unemployed health-care professionals and educators are so concerned about the medical needs of Cape Flats youth that they have formed a foundation to try to augment primary health care there.

"Several years of research have shown that about 75 percent of young people who live between Ocean View and Atlantis do not have access to medical aid," one of the people behind the project, Mr Chris Mentor, said this week.

He and Mr Craig Smith spent several years interviewing about 300 health-care professionals, including 30 doctors and dentists and optometrists and their research showed that there was an alarming incidence of sexually transmitted diseases among schoolchildren, some as young as 12, he said.

Encourgaging

Mr Mentor said the Visions! Youth Care Foundation was being set up to try to augment the work done in primary health care by the hard-pressed medical services.

"We would like to involve business and the private sector and work with all existing authorities, initiatives and institutions," he said.

Mr Mentor said response from business had so far been encouraging.

A meeting would be called before the end of the month to launch the project, he said.

Anyone interested should get in touch with Charlene Engel, Ebony Mathale or Renée van Breda at ☎ 511-5971.

An unnerving man

National health system in SA inevitable says outgoing SAMJ editor

■ Money and the right attitude could solve a multitude of South Africa's medical problems, says Dr Nic Lee, outgoing editor of the SA Medical Journal.

VIVIEN HORLER (85) Arg 21/8/93
Weekend Argus Reporter

SOME form of a national health service is inevitable in South Africa, says Dr Nic Lee, outgoing editor of the SA Medical Journal.

"This is not a popular argument," he says. "Money is cited as the problem. But accountants can afford what they're told to afford. What better thing to spend your money on than the health of the people of your country?

"Arms? Space races? They found the money to fight a war in Angola, didn't they? The problem with health services is that they're regarded by accountants as cost centres because you don't make a profit. What you get back, of course, cannot be quantifed — a population of happy, healthy, well-nourished people.

"Medicine should be doing good, not following up disasters afterwards. For example, South Africans are riddled with tuberculosis, yet this is a curable disease. And if its curable, why not cure it?"

Now 60, Dr Lee is about to retire, but he is not a retiring man. His editorials in the Medical Journal have been challenging and refreshingly outspoken.

The most memorable of these was an indictment in 1991 of the "indefensible" role of the medical profession in the death of black consciousness leader Steve Biko 14 years earlier.

Commenting on the rationalisation of state hospitals and reports that patients have been turned away because of lack of staff and time, Dr Lee is firm: "No patient should ever be turned away from a health facility. Historically a hospital is a place of refuge.

"The academic hospitals and their staff are demoralised because no one cares for them. And if no one cares for the carers, who will care for the patients?

"What a patient needs is a friendly and reassuring word. But the kind of attitude that tells someone brusquely to sit and wait, that's what kills medicine."

Dr Lee has enormous sympathy for many members of the medical profession who have been struggling under difficult circumstances.

"There are a large number of people doing what they believe is best for their patients, labouring under enormous difficulties. People in the public service have been given a terrible time.

"But I'm worried about the underpinning philosophy of the medical profession in South Africa today. We seem to be adopting the worst aspects of the US medical system. The Americans themselves agree that their system is unworkable, inefficient and expensive, yet we are looking to them as the saviour of what we are trying to do here.

"Doctors need to establish a common vision and decide why they are there. Are they doing what they are doing to help their fellows? Or to get rich? If money is their primary motivation, then they're in the wrong profession."

South Africa's big teaching hospitals gobble about 30 percent of the health budget, but the belief now is for primary health care. Health Writer ***David Robbins*** *reports*

Star 20/8/93

Health at crossroads

(85)

It was only in 1986 that South Africa's health authorities began to talk seriously about primary health care (PHC). Until then, the country's health system was concentrated in the cities, where the majority of whites lived, and it was largely hospital-based.

The move to PHC was motivated by belated commonsense.

Apartheid medicine had yielded a terrible harvest of disease and neglect in the homelands. PHC would afford an opportunity of redressing the imbalance.

This approach was certainly powerfully advocated by the World Health Organisation, the African National Congress, and numerous health organisations working in the rural areas.

By the turn of the decade, the State had drafted a comprehensive PHC strategy.

In 1991/2 spending on this strategy already stood at R393 million, or 5 percent of State health spending, while the PHC budget for the current year has been set at around R1 billion, nearly 15 percent of total spending.

A consequence is that hospital budgets are being squeezed; not least the country's seven academic hospitals.

Does this matter? And won't less money force hospitals to seek greater efficiency?

This has certainly happened at Groote Schuur, where, thanks to stringent controls, drugs spending is now only one-third of the amount being spent at its Transvaal equivalent, Johannesburg Hospital.

But how much can these expensive hospitals, which consumed a massive R2,5 billion last year, be bled before they stagger to their knees? And would it matter if they did end up on their knees?

The recent Steinmetz report, which offered recommendations for the rationalisation of South Africa's ailing health service, calculated that the difference between maintaining a bed at a specialist, hi-tech hospital and an academic hospital was R165 a day.

Basing calculations on this difference, and what it considered to be South Africa's annual need of 750 graduate doctors, the Steinmetz report suggested that the country's total number of academic beds could be reduced by 2 500, which would effect an annual saving of R150 million.

Desperate

In fact, the report argued that three of our seven academic hospitals were surplus to requirements.

Although the Ministry of National Health has rejected this argument, it does raise the whole question of the importance of these sophisticated teaching hospitals in a country in desperate need of basic health care programmes for many millions of its citizens.

Yet it is difficult to find a health expert who dismisses their pivotal role. Even the most ardant advocates of PHC agree that it cannot operate in isolation, and is part of a system which has tertiary/academic institutions at its centre.

The ANC recently objected strenuously to the Academic Health Centres Bill whose main objective is more administrative and financial autonomy for academic hospitals.

"We reject a Bill that opens the way for the complete autonomy of the most valuable part of our public health system," an ANC health spokesman said.

Valuable parts these hospitals most certainly are. Yet they are facing profound financial problems, with budgets growing at less than 5 percent in a climate where the inflation rate varies between 11,4 percent and 12,9 percent a year.

Listen to Groote Schuur's medical superintendent, Dr Jocelyne Kane-Berman: "South Africa's academic hospital complexes are the epicentres of medical training, research and patient care within the country, and indeed in the subcontinent. If current (financing) trends continue, a decline in standards is inevitable.

"If the academic foundations of health care in South Africa collapse, it will only be a matter of time before the country's entire health care structure suffers a similar fate."

The stresses and strains at Groote Schuur provide an example of what life is like at the centre of a health system in tumultuous transition.

The number of inpatients and outpatients has remained constant since 1989; nothing else has.

Take actual spending. In real money terms, using the 1990 rand as the constant, total expenditure has dropped steadily since 1989. Using the same constant, spending on consumables (drugs, etc) is less now than it was in the early '80s.

Capital expenditure, especially expenditure on vital equipment, presents a depressing picture. Apart from the late '80s when the new hospital at Groote Schuur was being commissioned, spending on capital equipment has been in decline since 1975.

"The value of equipment within the Groote Schuur Hospital region is approximately R374 million," says a recent report on the subject.

"If one assumes that the working life of medical equipment averages eight years, one would expect to have to replace one-eighth of the institution's total value of equipment each year, requiring an unrealistic capital equipment budget of R47 milion for replacement alone.

Uncertain

"At present budget levels, it is estimated that it will take 60 years to replace all ageing equipment once, a situation clearly leading to exponential deterioration."

But if the future of the equipment is uncertain, the future of personnel is more so. In 1989, the Groote Schuur group of hospitals was staffed by 9 077 staff of all levels. Although work loads have not decreased, increasing financial constraints had forced the staff complement down to 7 950 by April this year.

"You can ask people for just so much then their co-operation snaps," a weary medical worker at Groote Schuur told me.

"Decreasing pay in real terms, impossible work loads. How can standards be maintained when so many good people are getting out, moving into the private sector?"

What is to be done? The demand for primary health care, especially in the hopelessly neglected hinterlands, cannot be ignored. But neither can the demands of the academic hospitals, these "epicentres of training, research and patient care".

These conflicts lie at the core of the country's future health policy, and they will profoundly affect the lives of all South Africans in the years to come.

The time has passed when these conflicting claims on limited resources should be left to a largely unseen bureaucracy to resolve.

It is time that ordinary people begin to ask questions. Time for the politicians to provide some real answers.

Last word from Kane-Berman: "In the broad political context it is likely that considerable pressure will be exerted to establish a more extensive health service.

"Anticipating this future requires that the academic complexes should continue to provide high quality services.

"Erosion of standards caused by financial attrition at the centre will be calamitous for the health status of South Africans in the short, medium and long term, and will be politically indefensible."

13 workers hurt in fight at Star hospital

2018/93

At least 13 people were injured in a fight at Baragwanath Hospital yesterday.

Superintendent Dr Chris van der Heever said the fight started after an argument between two workers. It had nothing to do with labour matters (85)

But a worker said the fight followed a discussion over who would keep their jobs after the TPA's announcement that 2 000 workers who were employed during last year's strike would be retrenched. He said United Workers' Union of South Africa (Uwusa) members attacked other workers.

National Health, Education and Allied Workers' Union (Nehawu) spokesman Neal Thobejane confirmed the incident. Uwusa members, who were hired as "scabs", threatened to assault Nehawu members, he said. — Soweto Bureau.

Health workers face retrenchment deadline

B1Day 18/8/93

GAVIN DU VENAGE

MORE than 2 200 health workers have been given until this afternoon to voluntarily accept retrenchment packages by the Transvaal Provincial Administration, or risk being laid off with reduced benefits.

TPA director-general Len Dekker said yesterday extra staff were taken on last year during the health workers' strike. Part of the settlement was that a large number of discharged workers be re-employed. This had led to overstaffing and a bill of about R4m a month, Dekker said.

Dekker said an improved package had been put together to limit the need for forced retrenchments. It was targeted at all staff in specific occupational groups.

Staff already identified for forced retrenchment could also take the improved package and retrenchment proceedings against them would be withdrawn if they did so, he said.

The package included:

☐ Payment of salary from September 1 to December 31, with the end of August being the last working day;

☐ Payment of a pro rata service bonus and leave credit as at August 31;

☐ Pension and medical aid contributions will continue to the end of December;

☐ Pension benefits plus a supplement of up to five years will be paid;

☐ Home loan subsidies will continue for six months; and

☐ The package will be paid out at the end of August.

(250) (85)

Dekker said it would be possible to place some of the redundant staff in vacant posts. However, if there were not enough volunteers for the package, "the TPA would be forced to terminate the services of the remainder" at the end of this month.

He said everything possible had been done to limit the reduction programme.

A National Health and Allied Worker's Union spokesman said yesterday the union had rejected the offer. He said agreement had been reached in the National Economic Forum that no unilateral restructuring of state assets would take place. Retrenchments, he said, fell into this category, and he demanded that the TPA cease retrenchment procedures.

Health forum role outlined

BDay 16/8/93

ADRIAN HADLAND

PRETORIA — A national health plan and a critical review of public health sector senior posts are key goals of the newly formed National Health Forum, a National Health Department statement says.

The forum would be managed by a steering committee until its structure and membership were finalised at a meeting in September, the statement said at the weekend.

It would try to identify priority health development areas in communities which did not have health care facilities.

Health forum established (85)

PRETORIA. — The Department of National Health and Population Development announced yesterday that a National Health Forum (NHF) had been established. CT 14/8/93

The department said representatives of all government health departments and the Patriotic Health Front attended a meeting to establish the NHF.

NHF members would try to restructure the country's health system. — Sapa

Sheer 14/8/93

Forum to tackle health crisis

IN an urgent and far-reaching strategy to help solve the health crisis in South Africa, the Department of National Health, representatives of all the government departments of health and the Patriotic Health Front have established a National Health Forum. The forum will seek to find consensus in reconstructing the South African health system. The NHF will take special account of communities which have not had access to health care facilities. — Sapa.

Busloads of protesters to descend on hospital

ANDREA WEISS
Health Reporter ARG 12/8/93

SEVERAL busloads of protesters are expected to descend on Groote Schuur Hospital tomorrow in a campaign against the restructuring of the health-care system.

The programme, which has the support of the ANC, health unions and several primary health-care organisations, kicked off with a picket by patients and staff of the Guguletu Day Hospital yesterday.

Chief objections are against granting autonomy to academic health complexes such as Groote Schuur and Tygerberg hospitals and allowing doctors working at those hospitals to practise privately in a limited way.

These changes were made unilaterally and without consultation, organisers of the campaign said in a pamphlet.

The pamphlet claimed patients were being turned away from the academic hospitals while there were insufficient facilities at day hospitals to cope.

The amount of time doctors at day hospitals had to spend on patients was also severely restricted.

The law which gave academic hospitals autonomy would lead to a situation where they would not have to take into account the needs of the majority.

"These changes will take us further down the road towards fragmentation and privatisation of health care."

A further objection was that the changes would put workers in the academic complexes under a new set of conditions which could lead to retrenchments.

Seminal study of local teenagers reveals risky lifestyles

IN THE first study of its kind, startling findings about unhealthy teenage lifestyles in the Cape Peninsula came to light in research carried out by Dr A J Flisher, Dr C F Ziervogel, Dr D O Chalton, Mr P H Leger and Professor B A Robertson, all of the UCT Dept of Psychiatry and/or the Medical Research Council. BRIAN ROBERTSON reports.

A RECENT study carried out by the psychiatry department of the University of Cape Town and the Medical Research Council highlighted concern among parents and professionals over risk-taking by pupils in local high schools.

The July issue of the South African Medical Journal carries details of the study in which 7 340 pupils from 16 high schools in the Cape Peninsula completed a questionnaire asking for confidential information about their alcohol consumption, drug use, sexual activity and other behaviour linked to serious health consequences.

The impetus for the study came from the urgent need to do something about the increasing rate of teenage pregnancy, the rapid spread of HIV infection and the high number of deaths on the road and by violence in this age group. More than half the deaths among South Africans adolescents are accidental or could be prevented.

An important finding of the study was that alcohol and cigarettes posed a greater health hazard to our teenagers than illicit drugs such as cannabis (dagga) or cocaine. The percentage of schoolgoing teenagers who have tried drugs does not justify fears of an imminent drug epidemic and few persist with illict drug use.

The use of alcohol and cigarettes, however, is much more widespread. In the lower standards about one in 12 pupils admitted to smoking daily and to one or more episodes of binge-drinking (having five or more drinks on one occasion) in the past 14 days and the figure rose to one in four in the higher standards.

Cigarette smoking has been linked to lung cancer, heart disease and many other adverse health effects. The hazards associated with excessive alcohol use are numerous but one immediate consequence is an increased risk of death on the road. In the Cape Town municipal area alcohol has been implicated in more than 60% of deaths resulting from traffic accidents. One in 12 high-school pupils admitted having driven a car under the influence of alcohol during the previous year and this included those below the legal age for both driving and buying alcohol.

One in 10 male pupils carried a knife at school.

Suicide attempts were the only form of risk behaviour, which was more common in girls, and, all told, one in 12 high-school pupils reported having made a suicide attempt in the previous year. Although the researchers were not permitted to disclose the race of the pupils, home language was recorded. The rate of smoking, drinking and drug use was notably low among Xhosa girls, but they were the more sexually active than their counterparts. Afrikaans and Xhosa males used contraceptives less frequently and had a higher percentage of sexual partners whom they had not known for very long.

There was little variation between the language groups in the median age at first sexual intercourse — 14,9 years for boys and 15,6 years for girls. More Xhosa pupils were sexually active. On the occasion of their last sexual intercourse one in four high school pupils knew their partner for less than seven days and two out of five pupils had done nothing to prevent pregnancy. The use of condoms by Xhosa males was particularly low. These findings do not augur well for the containment of the "epidemic" of teenage pregnancies and of Aids.

Why is this study important? The answer is that it is the first time in South Africa that the behaviour of such a large multiracial group of high-school pupils has been studied and in such detail. For the first time speculation about the health-damaging activities can be replaced by first-hand information, without which no effective remedial action is possible.

The study has highlighted important differences between younger and older pupils, the sexes and pupils from different backgrounds. Knowledge of these differences is essential for planning interventions which will target the right teenagers. Also essential is knowledge about why pupils engage in risk behaviour, why some groups consistently expose themselves to more hazards, and what keeps others from following.

Only a small percentage of teenagers who engage in risk behaviour are suffering from a psychiatric disorder. For most, risk behaviour is a transient phenomenon, a typical adolescent experimentation. But the consequences may be tragic and it seems likely that such behaviour is increasing. Why? Although the cause is bound up with the very nature of adolescence, powerful influences may stem from the family, the school and the broader environment.

Quality care

It is likely that excessive wealth is as much implicated as poverty, deprivation, rapid unbanisation, widespread violence and the breakdown of social structures in the production of certain kinds of risk behaviour. Lifestyles emerge which are a reaction of the youth to their particular backgrounds. The lifestyle which is promoted by the local peer group, even when unhealthy or dangerous, appears often to be a stronger influence than that deriving from the parental home. The study reported here, for instance, suggests that for some high-school pupils, binge-drinking is part of the "in" lifestyle, while for other pupils, the "in" lifetyle means being sexually active.

What can parents do to keep risk behaviour in their adolescent children within safe limits? Children who have received quality care from birth are much more likely to behave responsibly in adolescence, so parents need to be responsible about marriage and parenthood. All couples contemplating marriage should embark on a marriage preparation course and there are courses on parenting. School adjustment is one of the foundations of mental health in childhood so parents need to be untiring in their efforts to ensure that school is a positive experience.

Parents need to become more active as a group to improve the environment for their children and to combat unhealthy teenage (and adult) lifestyles: this includes monitoring and taking action against misleading media influences with regard to sexuality, the use of alcohol, and violence. Communication with the adolescent must be kept open even when all else fails. Finally, parents must seek professional help before it is too late.

Health market battle looming

COMPETITION between "corporate" medicine and "grassroot" doctor organisations could bring the spiralling cost of private health care down to realistic levels — all to the benefit of the patient.

The Peninsula Independent Practioners Association (PIPA) launched in the city on Thursday night with a 450-doctor membership and R100-million combined annual income will form a powerful base to provide cheaper health care, chairman Dr Tony Berman said yesteday.

He said the timing of the "grassroots" initiative coincided with the expansion of Health Maintenance Organisations (HMOs) in South Africa.

Although Dr Berman denied their formation was a counter to HMOs, he said the patient would benefit from the initiatives. There was enough room in the market for both systems.

HMOs, of which 80% of Americans are expected to be members by the turn of the century, are set to burgeon in South Africa. An HMO is an arrangement between health fund administrators and providers of health care to deliver health services to an enrolled membership for a prepaid fee.

85 CT 24/7/93

Star 15/7/93

SA's health record 'worst'

South Africa's health status relative to income was one of the worst in the world, the World Bank said in its latest development report.

According to the report, 53 percent of South African children aged between two and five in the 1980s suffered from stunting as a result of malnutrition.

This compared with an average of 39 percent in the rest of Africa.

The annual incidence of tuberculosis in South Africa of 250 cases per 100 000 was nearly 15 percent above the African average and more than 10 times the rate of developed countries.

In 1990-91, 63 percent of children in South Africa younger than one received immunisation against diptheria, whooping cough and tetanus.

This compared with 89 percent of Zimbabwean children and 79 percent of Zambian children receiving the required shots.

Reacting to the report, Medical Research Council executive Dr Derek Yach said that while R22 billion was spent on health care in South Africa, of which about half was spent on private health care, the World Bank report suggested that this was not buying the level of health care the average person could expect. — Sapa.

Report has SA being rather ill

From SIMON BARBER

WASHINGTON. — Health statistics published in the World Bank's latest annual development report portray South Africa in a mixed light and in several key areas underperforming the rest of the continent.

According to the figures, 53% of children aged two to five suffered from stunting — low height for age — due to manultrition between 1980 and 1990, compared with a continent average of 39%.

The annual incidence of tuberculosis in South Africa — 250 cases per 100 000 in 1990 — is also nearly 15% above the African average of 220, and more than 10 times the rate in developed countries.

In the Republic, 63% of children under one received a complete course of DPT shots for tetanus in 1990-91, compared with 89% in Zimbabwe and 79% in Zambia. Twelve African countries had higher rates.

(85) CT 14/7/93

The South African fertility rate, at 4,3 in 1990, is well below the African average of 6,4. The global average is 3,4.

In 1990, half of South Africans could expect to die before they reached 41, whereas half of all sub-Saharan Africans don't make it beyond five. Globally, the median age at death is 55.

SA has 0,61 doctors and 4,1 hospital beds for every 1 000 people. For Africa, the figures are 0,12 and 1,4 respectively. The world average is 1,34 and 3,6.

Urban black allergy study

A MAJOR research project to study the increase in allergies and asthma in urban black communities has been initiated by two Cape Town paediatricians.

Professor Eugene Weinberg and Dr Matt Haus, of the Red Cross Children's Hospital, have been given a R100 000 research grant from a pharmaceutical company for the project.

"Allergies are relatively uncommon in traditional rural communities, yet our studies in urban squatter settlements show a high percentage of infants (53%) are sensitised to either milk, egg or house dust mite," Prof Weinberg said.

The researchers will try to identify factors in the urban environment which trigger off allergies and asthma.

Changes in traditional feeding methods, the abolition of prolonged breast feeding, the swing to refined foods and exposure to industrial and air pollution are all believed to be factors.

Prof Weinberg said a high level of exposure to allergens was difficult to avoid in urban black communities. — Sapa

(85) CT 13/7/93

Steps to ease delay at Industrial Court

BI Day

ERICA JANKOWITZ

MEASURES to address a serious backlog delaying the hearing of cases by up to nine months have been introduced in the Pretoria Industrial Court.

Writing in his first practice note since his appointment last month, Industrial Court president Adolph Landman said while the measures could inconvenience practitioners, the need to work off the backlog was "imperative and overriding". 14/7/93

One measure was the recent appointment of six additional members to preside in the Pretoria court. (165)

A motion court would be established as part of the Pretoria court from July 26 to expedite hearings which did not require the "presiding officer being seized with jurisdiction as regards the merits of the matter. (166)

"In the case of opposed applications for a determination in terms of Section 46(9) of the Labour Relations Act, parties will be required to hold a proper pre-trial meeting and to file a pre-trial minute with the court three weeks before the date of hearing."

Landman said this step had been taken as "many cases are withdrawn at the last minute because they only receive the earnest attention of the practitioners involved at a late stage".

He also proposed that the rules board function as a national advisory committee to enable better communication and feedback on the functioning of the court.

SA fares poorly in health survey

BI Day 14/7/93

(85)

SIMON BARBER

WASHINGTON — Health statistics published in the World Bank's latest annual development report portray SA in a decidely mixed light and in several key areas it fares the worst in Africa.

According to the figures, 53% of children aged two to five suffered from stunting — low height for age — due to malnutrition between 1980 and 1990, compared with a continent-wide average of 39%.

The annual incidence of tuberculosis in SA — 250 cases per 100 000 population in 1990 — is also nearly 15% above the African average of 220, and more than 10 times the rate in developed countries.

Many African countries also do a better job, though with considerable foreign assistance, of ensuring that infants are fully immunised against diphtheria, whooping cough and tetanus (DPT), and measles.

In SA, 63% of children younger than one received a complete course of DPT shots in 1990-91, compared with 89% in Zimbabwe and 79% in Zambia.

In all, 12 African countries had higher rates.

SA consumes more tobacco — 1,4kg per capita in 1990 — than other African countries for which there are statistics, but this may be a sign of relative affluence. Consumption in the developed world averages 2,4kg.

The SA fertility rate, at 4,3 in 1990, is well below the African average of 6,4, and roughly in India's league (4,0). The global average is 3,4.

In 1990 half of South Africans could expect to die before they reached 41, whereas half of all sub-Saharan Africans don't make it beyond five. Globally, the median age at death is 55.

Caring for the elderly is not a problem in Africa. Only 5% of the population is older than 60. In SA, the proportion is 6%; in the US, 22%.

In the developed world, 19% of the population is under 15, in SA 38%, in Africa generally 46%.

SA has 0,61 doctors for every 1 000 people — although the distribution is highly uneven — and 4,1 hospital beds.

For Africa as a whole, the figures are 0,12 and 1,4 respectively. The world average is 1,34 and 3,6.

Globally, the annual per capita expenditure on health care comes to an average of $323. In 1990, SA spent $158. The continental average was $23.

The average developed economy devoted 9,2% of if GDP to health care, SA 5,6%. This was well above the average in the developing world (4,7%).

Companies fight minimum wage

BI Day 14/7/93

UMTATA — A minimum wage regulation implemented by Transkei's government is being challenged in court by six industrial companies which fear they may be crippled by the new financial burden.

The minimum wage which was announced by Manpower Minister D D Mlindazwe, in terms of a government notice on May 7, was said to be substantially higher than wages negotiated with unions.

The Umtata Supreme Court was told that the wage determination could result in loss of jobs, retrenchments and closure of certain industries and relocation.

One of the companies said that the new wage determination would force it to increase its wages by more than R2,2m in 1994, and this after having suffered heavy financial losses from four weeks of industrial action this year. (164)

The applicants said they would not be able to afford to offer other benefits to employees such as 13th cheques, overtime and sick leave if they were obliged to grant the increments.

The applicants urged that the matter be dealt with as soon as possible as they would be committing a criminal offence if they did not comply with the determination, but would "suffer severe financial prejudice" if they did.

It was also feared that if the companies could not comply with the provisions it could result in widespread labour unrest.

The six industrial companies employ a total of more than 3 000 workers and all have wage agreements with unions.

Judge C White postponed the application for argument until July 30.

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Health budget cuts led to charges

CAPE TOWN — The introduction of tightened control measures, owing to a restricted health budget, has led to numerous charges of fraud, involving millions of rands, being laid against certainpart-time district surgeons in the western Cape.

A new computer programme was used to check reference numbers and patient names and thus detect suspected duplication. Previously, piles of claims submitted by doctors had been checked by hand, which had made it difficult to pick up irregularities.

Part-time district surgeons have their own practices, and are appointed on a contractual basis by the Cape Provincial Administration to treat country pensioners and indigent patients.

Each month, the part-time district surgeons claim for patients, certified indigent by a magistrate, they have treated.

Administration spokesman Krige Visser said the majority of doctors on contract adhered to medical ethical codes and formed "the lynchpins of primary health care on the platteland".

Yet the administration had become suspicious of certain doctors, who seemed to have

Own Correspondent

inflated their workload.

The computer traced enough irregularities for legal proceedings to be instituted against five part-time district surgeons in the western Cape.

They face over 40 000 individual fraud charges, amounting to millions of rands. The alleged offences are said to have taken place over several years.

And it was not only the administration which fell victim to the alleged frauds. Some patients were charged set fees, which they need not have paid at all, after which the doctors allegedly claimed again from the administration.

Some doctors allegedly received handling fees without dispensing the medicines to justify this.

Instead, they are said to have sold the medicines for their own gain to private patients.

Visser said yesterday that the western Cape planned to fully computerise claiming procedures as soon as possible.

SA health care: the absolute minimum

Star 6/7/93

(85)

How is South Africa's crisis-beset health care system to be restructured for the future? The Medical Association of South Africa (Masa), representing the powerful medical profession, has entered the debate by producing policy proposals which were ratified by the association's Federal Council last month. Health Writer DAVID ROBBINS looks at the main points.

AFFORDABLE, nonracial, comprehensive, effective — this is Masa's vision for health care in South Africa. More specifically, its new policy document, entitled "Towards a health policy agenda for the people of South Africa", concentrates on the provision of minimum levels, or core health services, to all, and how these are to be financed.

The policy document also stresses the importance of the private sector in the future health system, and insists on people's right to arrange private funding alternatives to cater for their health needs.

Although core services are not defined in detail, the principle that they should be available to all is well established.

The policy document indicates that they should operate at primary, secondary and tertiary levels, and that everyone, whether economically active or not, should have "reasonable access, on affordable terms and without unreasonable waiting times".

The core services, which will have to be identified through negotiation between all the health stakeholders, should also be seen as the "floor" of South Africa's health-care system and the "ceiling" on the State's obligation to assist people to gain access to the system.

Masa is more explicit with regard to how these core services, the necessary research to support them, and the training of the necessary health care workers, are to be administered and funded.

Guiding principles here include stressing the need for a single health ministry, and that funding be set up in such a way as to enable the State to provide greater assistance to those least able to provide for themselves.

"The State financing system can be successful," Masa says, "only if it is economically sustainable and secures the best use of available money and personnel.

"Because health care needs can be addressed only with available resources, we will be forced to prioritise care. This will mean that difficult choices must be made between costly therapy and palliative treatment."

It is inevitable, therefore, that certain medical procedures will fall outside the core services, and will require to be paid for either by private means or via medical aids and private insurance.

The administration of core health services, says Masa, should be the responsibility of a single ministry of health which would set funding objectives and action plans based on appropriate research and consultation with "relevant informed community and provider organisations".

The administrative and management information systems used by the State could be provided by existing private sector infrastructure (for example, the medical schemes), according to the Masa proposals. The State should also be encouraged to use certain core services already existing in the private sector.

All this is in line with Masa's belief that valuable medical systems and expertise which already exist should not be abandoned in the search for a more equitable health service for South Africa.

It also underlines Masa's insistence that "society should be free (and remain free under any future dispensation) to arrange alternative private funding for health care".

But how is the State's obligation to provide core services for all to be funded? The Masa document provides several firm suggestions.

- General tax revenues as at present.
- A compulsory premium-based social insurance system funded by employees and employers, especially to ensure that core services are available to the aged and chronically ill.
- Extra earmarked taxes on certain goods or activities which adversely affect health (cigarettes, alcohol, motor cars) could provide a further source of revenue for the State's core health services.

The Masa document specifically mentions other finance-raising methods which should be avoided, most notably the direct charging of patients for core health services.

Masa also makes recommendations with regard to reducing the costs of providing core-health services. These include:

- Eliminating the wastage associated with the fragmentation and duplication in our current system.
- Mobilising resources to support research into more efficient health delivery systems.
- Introducing evaluation techniques such as cost-benefit analysis.
- Increasing efficiencies by treating patients in the community rather than in hospitals, by introducing greater economies in the use of pharmaceuticals, and by delegating various medical tasks to less highly trained personnel.

The Masa document offers policy recommendations regarding a wide range of other health issues such as primary health care, academic hospitals, medical technology, managed health care delivery systems, and the funding of health research.

But it is the emphasis on core services for all and the suggestions on how to fund such services which will almost certainly bring the Masa document into the mainstream of the health policy debate. □

Doctors to focus on general health

(23) (85) CT 30/6/93

JOHANNESBURG. — Doctors will have to concentrate on providing services most likely to improve the general health of South Africans, says the Medical Association of South Africa.

Masa said in a statement yesterday that priorities should be the supply, mix and distribution of doctors to make health care equitable, accessible and acceptable. Focus should also be on the efficiency, appropriateness and effectiveness of doctors' services.

The profession should address:

- **The maldistribution of doctors between urban, peri-urban and rural areas.**
- **The distribution of doctors in the private and public sectors.**
- **The disproportionate training of doctors belonging to different population groups.**
- **The rising number of specialists compared to the number of family practitioners.**

Masa also proposed that academic health centres should take the lead in the appropriate training of doctors for the medical, social and economic realities of South Africa, and extending selection criteria for students to include qualities other than purely academic ability. — Sapa

B1Day 29/6/93

Health service ideas outlined

PRETORIA — Funds for core health services should come from general taxation supplemented by a premium-based social insurance system from wages and salaries, and a payroll tax on employers.

This suggestion was made at last week's annual meeting of the Medical Association of SA (Masa).

A Masa spokesman said funds could be further supplemented by earmarked taxes on certain goods or activities which could have adverse implications for health, including alcohol and tobacco (85)

GERALD REILLY

Delegates warned that unless health service priorities were set, limited funds and other priorities would overwhelm the system.

A first step should be the determination of minimum health care and the ceiling of state responsibility.

Masa believed core health services should be built on the premise they would provide greatest assistance to the poorest.

Meanwhile Masa federal council chairman Bernard Mandell said Masa again called for the urgent integration of a health care system into a broad multisectoral programme.

It was vital that health care be made more available, equitable and affordable, he said.

Difficult choices lay ahead between costly therapy and palliative treatment in fixing minimum levels of accessible care.

Mandell said discussion at the meeting centred on a fair allocation of resources to all levels of the health system and the extent to which co-operation between the public and private sectors should be encouraged. (24)

Send doctors to the rural areas — exile

South 2616 — 30/6/93

By Justin Pearce 85

A NATIONAL, state-funded health care system is the most effective way of ensuring equal access to health care, former exile Dr Raymond Hoffenberg said at a public lecture at University of Cape Town medical school.

"Owing to the vastness of a country like South Africa, it is going to be difficult to provide an equitable system — but it must be done."

He suggested that qualifying doctors be compelled to work for the state for a number of years, so that they could be assigned to rural areas which are at present critically lacking in medical services.

"Doctors may see this an infringement of their clinical freedom, but it is a useful way of addressing a need."

He criticised the erosion of Britain's once comprehensive National Health Service under the Conservative government. He is visiting South Africa for the first time in 25 years to receive an honorary doctorate from UCT.

He left the country in 1968, after being banned because of his work with political detainees. He reached the highest echelons of the medical profession in Britain, serving as president of the Royal College of Surgeons.

Hoffenberg, who was chairperson of the International Defence and Aid Fund, called on doctors to become involved in political issues.

"Medicine is a caring profession — if we care about patients we should care about humanity."

He referred to issues like third world poverty, environmental degradation, and money spent on nuclear armament which is many times greater than the sum needed to eliminate world hunger.

"These are issues of public health. Steve Biko realised this when he gave up his medical studies for a career in politics."

Hoffenberg frequently referred to Biko and to doctors who collaborated with the state in causing his death in detention. He emphasised that a doctor's responsibility was to patients rather than agents of the state, and they needed support from professional associations in this regard.

"Doctors must not be left alone to face reprisal. The medical profession was let down badly by the Medical Association of South Africa and the South African Medical and Dental Council," Hoffenberg said, referring to the failure of these organisations to support the doctors who made public the circumstances of Biko's death.

(2) *Department of Health and Welfare—QwaQwa*

(a) 641 and

(b) no change

Department of Health, Welfare and Pensions—KwaNdebele

(a) and (b) none

Department of Health and Welfare—KaNgwane

(a) 968 and

(b) no change

Department of Health and Social Welfare—GaZankulu

(a) 2 551 and

(b) 2 560 29 February 1993

Department of Health—KwaZulu

(a) 10 366 and

(b) no change

Department of Health and Social Welfare—Lebowa

(a) and (b) 5450 31 March 1992

Information contained in this reply has been furnished by the Department of National Health and Population Development, provincial administrations as well as the self-governing territories.

Old-age/war veterans' pensions for Blacks

402. Mr P G SOAL asked the Minister for National Health and Welfare:

How many (a) old-age and (b) war veterans' pensions paid to Black persons residing outside the self-governing territories were cancelled in each province in the 1992–93 financial year? B923E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(a) *Old Age Pensions:*

Provincial Administration of Transvaal	11 893
Provincial Administration of the Cape of Good Hope	6 268
Provincial Administration of the Orange Free State	4 140
Provincial Administration of Natal	1 458

(b) *War Veterans Pensions:*

Provincial Administration of Transvaal	93
Provincial Administration of the Cape of Good Hope	34
Provincial Administration of the Orange Free State	31
Provincial Administration of Natal	25

Health matters: total budgetary allocation

403. Mr M J ELLIS asked the Minister for National Health and Welfare:

(1) (a) What was the total budgetary allocation for health matters, including additional appropriations and amounts recovered from other Government Departments for agency work, for (i) each province, (ii) each of the own affairs administrations, (iii) the South African Development Trust and (iv) the Department of National Health and Population Development for the period 1 April 1991 to 31 March 1992 and (b) what are the actual or estimated figures in each case for the period 1 April 1992 to 31 March 1993;

(2) whether she will furnish the information requested in paragraph (1) of this Question in respect of the self-governing territories; if not, why not; if so, what are the corresponding particulars? B941E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) (i) *Provincial Administration of the Cape of Good Hope*

(a) R2 292 097 000 and

(b) R2 379 362 000

Provincial Administration of Natal

(a) R1 114 979 000 and

(b) R1 347 859 000

Provincial Administration of the Orange Free State

(a) R607 066 000 and

(b) R696 082 000

Provincial Administration of Transvaal

(a) R3 133 430 000 and

(b) R3 827 541 000

(ii) *Administration: House of Assembly*

(a) R1 044 890 000 and

(b) R1 215 650 000

Administration: House of Delegates

(a) R312 193 000 and

(b) R377 544 000

Administration: House of Representatives

(a) R165 352 000 and

(b) R195 952 000

(iii) (a) R55 294 000 and

(b) The funds for the South African Development Trust were devolved to other institutions as from 1 April 1992 and

(iv) (a) R700 314 946 and

(b) R921 774 690;

(2) *Department of Health, Welfare and Pensions—KwaNdebele*

(a) R25 214 000 and

(b) R31 123 000

Department of Health—KwaZulu

R641 105 400 (Not stated to which year this amount is applicable.)

Department of Health and Welfare—KaNgwane

(a) R82 191 699 and

(b) R96 153 574

Department of Health and Social Welfare—Gazankulu

(a) R140 953 568 and

(b) R178 123 620

Department of Health and Welfare—QwaQwa

(a) R63 890 000 and

(b) R67 335 000 (This figure does not include additional funds as calculations have not yet been completed.)

Department of Health and Welfare—Lebowa

(a) No information available and

(b) R341 041 429 (capital projects excluded)

Information contained in this reply has been furnished by the Department of National Health and Population Development, provincial administration, as well as the self-governing territories.

Question No 404—see col 2205.

***Ad valorem* excise duty paid on cosmetics/toiletries**

409. Mr M J ELLIS asked the Minister of Finance:

What amounts were paid in 1992 in *ad valorem* excise duty on (a) locally manufactured and (b) imported (i) cosmetics and (ii) toiletries? B973E

The MINISTER OF FINANCE:

(a) Locally manufactured cosmetics and toiletries: R210 290 087,89

(b) Imported cosmetics and toiletries: R19 389 699,85

Separate figures for cosmetics and toiletries are not available.

Written reply to questions set down for oral reply on Wednesday, 30 June 1993:

Ulundi airport: extensions

*1. Mr G C ENGEL asked the Minister of Transport:

Whether he will furnish information on whether any extensions to the airport at Ulundi are being planned; if not, why not; if so, (a) what are the reasons for these extensions and (b) what are the expected costs involved? B974E

The MINISTER OF TRANSPORT:

No. The Ulundi aerodrome is the property of the KwaZulu Government. The Department of Transport therefore has no control over any activities or the day to day management of the aerodrome.

Health budget

375. Mr M J ELLIS asked the Minister for National Health and Welfare:

(a) What total amount has been budgeted for health in South Africa in respect of the latest specified 12-month period for which figures are available and (b) how much of this amount has been earmarked for (i) primary health care, (ii) secondary health care, (iii) tertiary health care and (iv) any other specified division? B871E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(a) R12 117 130 927,00 and

(b) (i) R3 184 173 349,00,

(ii) R5 615 738 915,00,

(iii) R3 317 218 663,00 and

(iv) totals as per standard items

Personnel expenditure ..	R6 733 776 932,00
Administration expenditure	R246 981 198,00
Stores and livestock ...	R1 935 903 108,00
Equipment ..	R420 235 398,00
Land and buildings ..	R1 762 220,00
Professional and special services ...	R768 364 118,00
Transfer payments	R2 245 524 965,00
Miscellaneous expenditure	R94 873 633,00
Recoverable expenses ..	(R330 290 643,00)
Total	R12 117 130 927,00

Information contained in this reply have been furnished by the Department of National Health and Population Development, the provincial administrations as well as the self-governing territories.

Housing shortage for Blacks

388. Mr P G SOAL asked the Minister for National Housing:

(1) What is it estimated was the shortage of housing for Blacks in the Republic, excluding the self-governing territories, at the end of 1992;

(2) how many houses were provided in each province in 1992 for such Blacks by (a) the State, (b) local authorities and (c) the private sector;

(3) when is it estimated that this shortage will be eliminated? B890E

The MINISTER FOR NATIONAL HOUSING:

(1) The extent of the housing backlog for Blacks in the Republic of South Africa, is not readily available. However, the South African Housing Advisory Council stated in its report titled "Housing in South Africa: Proposals on a Policy and Strategy" which was released during May 1992, that the total backlog for all population groups including the TBVC States, amounted to 1,3 million housing units. However, it is estimated that the current total backlog is approximately 1,4 million housing units.

(2) Since 1983, the main form of housing assistance provided by the Government has been to provide sites with rudimentary services to households in the lower income group on a subsidised basis.

The backlog in housing in respect of the black community is, therefore, expressed as a backlog in serviced sites, which according to calculations amounted to 1 097 678 sites on 31 March 1993. The management information system of the Department of Local Government and National Housing is linked to the financial year. Therefore the rest of the information in this reply reflects the positions at the end of the 1992–93 financial year. The backlog in serviced sites in respect of the various provinces is as follows:

Province	*Sites*
Cape	211 079
Orange Fee State	144 307
Natal	180 000
Transvaal	562 292
	1 097 678

Transvaal

(a) 29 523 sites by the provincial administration

(b) 21 862 sites

(c) 38 976 houses

Cape Province

(a) 3 270 sites by the provincial administration

(b) 11 249 sites

(c) 2 313 houses

Natal

(a) 1 040 sites by the provincial administration

(b) 5 110 sites

(c) Information is not readily available.

Orange Free State

(a) 198 sites by the provincial administration

(b) 9 527 sites

(c) None

(3) The elimination of the backlog is dependent on the reaching of an agreement between the Government, the private sector and the community at large on a new comprehensive national housing policy and strategy. In such policy the affordability for the fiscus, maximum participation by the private sector and a firm commitment to responsible participation and meeting their obligations by the broad community will be of crucial importance. For purposes of such a policy, extensive negotiations are at present taking place with a broad spectrum of interest groups, including the National Housing Forum.

Resettlement of persons/communities

389. Mr P G SOAL asked the Minister for National Housing:

Whether any persons or communities have been resettled under section 5 (1) (b) of the Prevention of Illegal Squatting Act, 1951 (Act No 52 of 1951), since 1 January 1991; if so, (a) how many persons or communities, (b) (i) from and (ii) to which areas and (c) who applied for the resettlement in each case? B891E

The MINISTER FOR NATIONAL HOUSING:

Transvaal, Natal and Orange Free State

No persons or communities have been resettled under section 5 (1) (b) of the Prevention of Illegal Squatting Act, 1951 (Act No 52 of 1951), since 1 January 1991.

Cape Province

Yes, on a voluntary basis in consultation with the communities.

Northern Cape

(a) Three families.

(b) (i) From unserviced land.

(ii) To serviced sites within Mathlomola Town Council's area (Griekwastad).

(c) The Chief Executive Officer of the Mathlomola Town Council (Griekwastad).

Eastern Cape

(a) (i) 214 families

(ii) 3 000 people

(b) (i) (a) From the buffer zone in Sinakho.

(b) From Vale Farm, Gonubie.

(ii) (a) To serviced sites within Sinakho Town Council's area (Dordrecht).

(b) To serviced sites within Mzamomhle, Gonubie.

(c) (i) The Chief Executive Officer of Sinakho Town Council.

(ii) Gonubie Municipality.

Hostels: upgrading/conversion

392. Mr P G SOAL asked the Minister for National Housing:

(1) With reference to the reply to Question No 255 on 25 May 1992, (a) how many hostels (i) had been (aa) upgraded or (bb) converted, and (ii) remained to be (aa) upgraded or (bb) converted, as at the latest specified date for which infor-

Swing in health role forecast

(85)
ARG 22/6/93

KARIN SCHIMKE
Staff Reporter

CENTRAL government and large hospitals will play a smaller role in health care and local authorities a bigger role, Dr Derek Yach of the Essential Health Reserach Group of the Medical Research Council (MRC) told the MRC's *Building a healthy nation through research* conference.

He said yesterday national health policy was already emphasising the importance of initiatives by local authorities, but that finances had not moved appropriately from the provinces to make this policy work.

On the health status of the country as a whole, he said there was a high proportion of preventable deaths, disease and disability, which particularly affected children.

At the same time there was a "high occurrence" of behaviour that placed the population at long-term risk for an increasing incidence of chronic disease, trauma and Aids.

Dr Yach said the infant mortality rate was one of the most powerful indicators of the health status of a population.

"For comparison purposes, Japan has an infant mortality rate of around five, while for much of Sub-Saharan Africa, the figure is in the range of 80 to 120."

In Southern Africa two out of 25 children died before their first birthday.

Dr Yach

The most notable of the chronic diseases affecting South Africa was tuberculosis, with about 100 000 new cases of TB being reported every year.

Dr Johan van der Spuy, national programme leader of the MRC's Trauma Research Programme, said physical trauma was "disproportionately prevalent" in South Africa.

It was the second largest cause of death and by far the leading cause of loss of productive years of life. It was a major cause of temporary and permanent disability, he said.

Referring to the estimated 400 000 people infected by the Aids virus, Dr Yach said: "Aids will pose a major threat to the health services and to the economy by the end of this century, and well into the next century. The country's response has not matched the extent of the problem."

Current trends indicated that in the future there would be a continued fall in infectious diseases such as diarrhoea and pneumonia and a steady increase in diseases associated with the aggressive marketing of tobacco, increased consumption of high fat diets and the continued high level of air pollution.

It was also expected that there would be a rapid increase in Aids and TB. However, it was unclear whether homicide, traffic accidents and malaria would continue to claim as many lives as they were claiming now.

news in t

Sowetan 22/6/93

No money for MRC

DELAYS in reaching a political settlement in South Africa are hindering the work of the Medical Research Council, a health conference was told in Cape Town yesterday. 85

MRC president Professor Walter Prozesky said the recession and new health priorities had resulted in less money being made available for research. Money could be obtained from overseas but medical research would not benefit from it before political stability was achieved.

Haste on health Bill indecent, says ANC

Star 15/6/93

By David Robbins
Health Writer

85

The ANC has slammed the Government's unilateral action in health policy matters and has called for the establishment of a national health forum.

The ANC is also demanding the suspension of new legislation on academic hospitals.

The call for a forum follows recent State actions, including the tabling of the Academic Health Centres Bill, which had its second reading in Parliament on Friday.

"We reject the Bill," a spokesman for the ANC's health department said yesterday.

The Bill's main objective is to provide more administrative and financial autonomy for South Africa's seven academic hospitals. But the ANC warned that the most advanced hospitals could be privatised under the Bill.

Steamrollered

"The problem is that the most valuable part of our public health system, which trains our doctors and most other categories of health workers and which currently consumes 43 percent of the public health budget, can suddenly be made completely autonomous," the ANC spokesman said.

The ANC objected to the way the Bill was being "steamrollered through Parliament with no public debate".

The ANC had been assured by the Department of National Health on May 19 that the Bill would not be enacted this session, the spokesman added.

"What actually happened was that it was discussed only twice in committee (on June 2 and 9), given a second reading last Friday (on June 11) and is apparently now due for a final third reading on June 16."

The Bill could become law before month-end.

"Such indecent haste," the ANC declared, "stinks of ulterior motives and/or of very powerful vested interests."

Star 15/6/93

Venter to probe race bias

Political Staff

CAPE TOWN — National Health Minister Dr Rina Venter will examine the admissions policy of the University of Natal Medical School in Durban and remove any racial restrictions she finds.

Roger Burrows, DP spokesman on education, said in Parliament last week there was a "Government restriction that is still racially based" which controlled admission to the Medi cal School. The Conservative Party has started making noises about the blacks-only admission policy.

Venter admitted at a press conference she did not know if there was a bar on whites.

"I will look at this and make absolutely sure because it is not the intention of the Government that there should be."

Venter said this was the first time she had heard about it, "because all the universities are taking in all students of all racial groups".

"I will certainly follow up on this one. We will remove it, with the co-operation of the varsity complex itself."

DP health spokesman Mike Ellis was staggered Venter did not know there was a racial restriction on the Medical School: "It is something we have all known about for years. It is something we have all grown up with."

The Government is to build a teaching hospital at Cato Manor.

Ellis said this hospital had to be totally non-racial. Even before it opened, the medical school had to be non-racial and open to all students.

Govt health report 'omitted major players'

Star 14/6/93

Health Writer (85)

The Government's most senior health official has acknowledged that there were flaws in setting up the Steinmetz Committee which recently recommended rationalisation of the country's health services.

Dr Coen Slabber, director-general of National Health and Population Development, said last Thursday that it would be "difficult to sell the committee's report because the major health players were not involved".

According to the ANC, "a single businessman (Gerard Steinmetz of the Sage group of companies) and 15 civil servants together have a very narrow perspective".

Both the ANC and the Medical Association of SA have complained that the opinions of the majority of South Africans, especially health workers, were not solicited by the committee.

Slabber said National Health Minister Dr Rina Venter had already met health ministers of the six self-governing states.

The report had now been circulated to provincial and homeland health authorities, as well as to the ANC.

A meeting of the Government's Health Matters Committee has been set for June 24 when the recommendations will be examined.

Health services budget: amount spent

385. Mr M J ELLIS asked the Minister for National Health and Welfare: (85)

What actual or estimated amount of her Department's budget for health services was spent by (a) her Department itself and (b) other Government Departments as agents for her Department during the 1991–92 and 1992–93 financial years, respectively? B887E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(a)	1991–92	R635 589 438
	1992–93	R861 028 582
(b)	1991–92	R136 999 604
	1992–93	R137 995 798

Department's budget: amount spent

386. Mr M J ELLIS asked the Minister for National Health and Welfare: (85)

What actual or estimated amount of her Department's budget was spent by (a) her Department itself, (b) local authorities and (c) other agencies during the 1991–92 and 1992–93 financial years, respectively? B888E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(a)	1991–92	R700 314 946
	1992–93	R921 774 690
(b)	1991–92	R216 090 222
	1992–93	R226 738 957
(c)	1991–92	R139 804 200
	1992–93	R140 917 811

Looking for a healthy policy

Star 8/6/93

85

The Steinmetz report, given wide coverage in The Star recently, has made far-reaching recommendations designed to rationalise South Africa's ailing health services. Health Writer DAVID ROBBINS asked two major stakeholders and one expert observer to respond in detail to these recommendations.

THE creation of a single health department, new funding arrangements for hospitals, pharmaceutical and academic hospital reforms — these are among the most important Steinmetz recommendations.

But the composition of the committee which made them has already been questioned.

"A single businessman (Gerard Steinmetz) and 15 senior civil servants together have a very narrow perspective," says the ANC. "It seems incredible that a government ostensibly committed to negotiations could, in September 1992, set up a committee with such narrow experience. Once again, the views of the majority of South Africans, and even the views of most nurses, doctors and other health workers, were simply not solicited."

The Medical Association of South Africa (Masa) echoes this criticism, commenting that since a significant number of Masa's membership was employed in the public health sector, the association would have been ideally positioned to provide "appropriate input".

And Dr David Harrison, executive director of the Durban-based Trust for Health Systems Planning and Development, describes the Steinmetz report as "an attempt to accomplish too much with too little discussion".

But what of the recommendations themselves?

– Firstly, there's the restructuring of the health service into a "decentralised one-channel structure", which means a single health department with powerful regional authorities.

Harrison sees a commitment to a unitary health system, but reservations are expressed about leaving the private health sector out of the restructuring process.

"It's not clear whether the private sector will be further regulated, limited, or integrated into regional managements," Harrison says. "We're simply not told how Steinmetz sees this R8 billion-a-year industry."

The ANC sees other dangers. "The committee recommends that 14 health departments be brought into one central and nine regional health departments. This sounds better, but the proposed powers of these regional departments appear to be even greater than those of the present provincial health departments. One form of fragmentation could simply be replaced by another."

The ANC is also concerned that the central department will not have effective control over the regional authorities.

"Although it is right that the national department should not be responsible for the provision of health services, it cannot absolve itself, as the report suggests, of the responsibility for these services. It must ensure that service provision is in line with national policy by controlling the national budget."

Then there's the new method of funding. The recommendation here is that hospitals and other health institutions are no longer funded via a budget, but directly through the services rendered to individual patients.

This shift away from the funding of institutions on a historically established budget is welcomed by the ANC, but the proposed solution — the funding of the individual — is criticised as "the totally discredited 'fee for service, third party payment' system that is largely responible for the collapse of the private health care sector".

The ANC says: "It is also a system that actively promotes over-servicing and other forms of abuse."

Harrison calls the new fund ing recommendation a good budgeting idea, but questions its effectiveness.

Masa is even more forthright: "The conversion of health institutions and services into private enterprises, with powerful incentives to treat patients who are capable of paying for health care (private patients) is likely to deprive State-dependent patients, and force State-sector providers into an already over-serviced private sector, with potentially destructive effects to both sectors."

A more rational approach to funding, according to the ANC, "would be to allocate funds on the basis of the size of the community to be served and the standards of service to be provided".

Most controversial of the Steinmetz recommendations is the suggested closure of three of seven academic hospitals.

"There may well be good arguments for rationalising the medical schools," says the ANC. "However, the argument offered — that we are producing too many doctors because, despite the brain drain, the number of doctors registered with the SA Medical and Dental Council is not declining — is facile.

"Much more serious discussion is required concerning the numbers, types and training of all categories of health workers needed for South Africa.

"Doctors, and their training, are obviously important; but so are nurses, members of the allied medical professions, managers, and possible new categories of health workers."

The management and autonomy of academic hospitals concerns Dr Harrison: "I see a glaring deficiency in this report, according to which the ac ademic hospitals will fall under neither the national nor the regional authorities.

"Is there to be total management autonomy? We believe this to be impossible. Or is this a loose end which Steinmetz forgot to tie up?"

Other recommendations in the Steinmetz report concern the redistribution of doctors to service the many neglected rural areas; an overhaul of pharmaceutical policy, with the emphasis on generic medicines and a new stock-control system to reduce the current high levels of theft; and a system of reciprocity between the public and private sectors to enable health-care facilities to be better used and serviced.

Masa says of this last recommendation: "The report pays lip service to the relationship be tween the public and private sectors. We agree that a carefully designed, well-integrated relationship should evolve at both provider and funding levels.

"Medical schemes could administer and manage State funds, and private health service professionals and other service providers could deliver services to State patients. However, the public sector should be reluctant to enter into commerce with taxpayers' money (as the Steinmetz report suggests), or fund and deliver health services which are not part of their responsibility."

Responding to the recommendation that newly graduated doctors should be contractually obliged to serve for a set period in rural areas, Harrison remarks: "Relegating graduates to some far-flung rural settlement because there is no organised health service there may fail precisely because there is no organised health service there."

Harrison does maintain, however, that the report demonstrates a commitment to a unitary health service, that it makes a serious attempt to achieve appropriate budgeting and financial control mechanisms, and that it is serious about mobilising funds for primary health care.

The ANC, by contrast, finds that "the clear implication in the report is that the answer to balancing the public health budget is to cut services".

"Faced with the unpleasant and difficult tasks of rooting out theft and fraud, estimated by the committee at R500 million a year in stock losses alone, of cutting jobs in the bureaucracy, and of eliminating the duplication of services, this committee of civil servants has opted instead for the easy option (for them) of cutting services.

"It must not be allowed to happen," the ANC concludes. "Now is the time for better alternatives." □

left office in December 1991 ethnic groups." — Sapa-AP.

Africa warned of cholera epidemic

The Argus Foreign Service

LONDON. — Africa could face its biggest cholera epidemic within three years from a strain resistant to all known vaccines. ARG 31/5/93

The World Health Organisation reported that the new bacterium, discovered by Dr Balkrish Nair, a Calcutta toxicologist, could spread across Asia, the Middle East and Africa.

In 1992 more than 500 000 cases of cholera were reported worldwide. But this year the number is expected to double.

Calcutta, with its teeming slums, where open sewers and stagnant ponds are used for bathing and washing by millions, has been hardest hit. More than 22 000 cases were reported last month in one city hospital alone.

Provincial Administration of the Orange Free State

(a) 80 and

(b) Black—40; White—38; Coloured—2

Other Provincial Administrations

The Provincial Administration of Transvaal, Natal and the Cape of Good Hope do not keep statistics of causes of death.

Lung cancer: deaths

314. Mr M J ELLIS asked the Minister for National Health and Welfare:

How many persons (a) in total and (b) in each race group died of lung cancer in each province in 1992? B706E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

Provincial Administration of the Orange Free State:

(a) 80 and

(b) Blacks: 40 Whites: 38 Coloureds: 2

Other Provincial Administrations:

The Provincial Administration of the Transvaal, Natal and the Cape of Good Hope do not maintain statistics on causes of deaths.

***Per capita* allocation of health funds**

316. Mr M J ELLIS asked the Minister for National Health and Welfare:

(1) Whether her Department has made any calculations regarding the *per capita* allocation of health funds for 1991–92 in the four provinces of the Republic; if so, (a) which (i) census year's statistics and (ii) financial year's expenditure were used as the basis for these calculations, (b) what allowance was made for rapid urbanization, (c) how was the expenditure per province calculated and (d) what factors were taken into account in reallocating funds between provinces;

(2) whether the independent Black states (TBVC states) were included for the purpose of these calculations; if so, as part of which provinces; if not, what allowance was made for cross-border flows;

(3) whether the (a) self-governing territories and (b) various departments of health in the (i) Republic, (ii) self-governing territories and (iii) TBVC states were included for the purpose of these calculations; if not, why not; if so, in what way;

(4) whether provision was made in these calculations for (a) health facility planning, (b) construction expenditure, (c) expenditure on equipment and (d) extraordinary expenditure; if not, why not; if so, (i) what items of extraordinary expenditure were provided for and (ii) how did their inclusion affect the *per capita* allocations;

(5) whether the figures derived from these calculations are updated annually; if not, why not; if so, what are the most recent estimates? B708E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) Yes,

(a) (i) 1985, as adjusted and

(ii) 1991/92 budget allocations,

(b) none,

(c) the total budget allocations to the town affairs administrations, provincial administrations and the self-governing territories within each of the geographic regions of Transvaal, Cape Province, Natal and the Orange Free State respectively, are divided by the total populations in each of the mentioned geographic regions.

The budget allocation of the Department of National Health and Population Development is not included in the allocations mentioned above because the Department—

— has a national overall responsibility in respect of health services which can only with great difficulty be divided into regions; and

— has limited responsibility for the delivery of health services and

(d) the Department divides the national health budget on the basis of a financing formula which has been approved by the Cabinet. The relative need for health services in the different geographic regions is the principle on which the formula is founed. The need for health services is determined by the size of the population in a specific geographic region, as well as the health status of the population. The latter takes mortality rates, loss of potential years of life and utilisation rates of health care facilities into consideration;

(2) no, accurate figures are not available;

(3) (a) yes, as stated in paragraph 1 (c) and

(b) (i) yes, as stated in paragraph 1 (c),

(ii) yes, as stated in paragraph 1 (c) and

(iii) no,

the TBVC States are excluded because of the fact that the health services of these states are not funded from the national health budget. The Department of National Health and Population Development carries no responsibility for allocation of the budget for health services in these states.

Regarding the health departments which are included, refer to paragraph (1) (c);

(4) (a), (b), (c) and (d) yes,

(i) the total allocations to each of the health authorities are used in the calculations. Specific items are not referred to and

(ii) because specific items are not referred to in the calculations, the per capita effect of the allocations cannot be determined;

(5) yes,

1993/94 (provisional estimates)

	Rand *per capita*
Cape Province	401
Orange Free State	293
Transvaal	266
Natal	235

In an effort to establish the *per capita* allocation in the four geographical regions on a more comparable basis, steps have been taken to improve the backlog in the Natal region. The results are as follows:

Percentage disparity in the *per capita* allocation between the Cape Province (highest) and the Natal region (lowest)

1991/92	85,9%
1992/93	76,6%
1993/94	70,6% (provisional figure)

Political violence in Natal Midlands: inquests

324. Mr W U NEL asked the Minister of Justice:

(1) How many inquests pertaining to death resulting from political violence were conducted in each magisterial district in the Natal Midlands (a) in 1992 and (b) during the period 1 January 1993 up to the latest specified date for which information is available;

(2) in how many of these inquests (a) was death attributed to persons unknown and (b) were findings referred to the Attorney-General for his decision;

(3) in how many cases (a) did the Attorney-General decline to prosecute and (b) were prosecutions instituted? B748E

The MINISTER OF JUSTICE:

The required information is not readily available. In an effort to be of assistance to the hon member, a few magistrates of districts (Pietermaritzburg, Glencoe, Howick and Estcourt) in the Natal Midlands were requested to furnish information regarding inquests pertaining to deaths flowing from violence. The following information for the period 1 January 1992 to 31 December 1992 is available.

(1)	Pietermaritzburg	745
	Glencoe	39
	Howick	53
	Estcourt	74
(2) (a)	Pietermaritzburg	459
	Glencoe	37

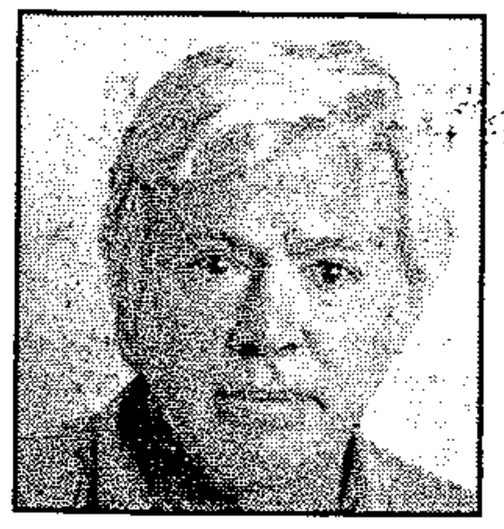
cont—d

Star 27/5/98

A healthy way forward

(85) (101) (98)

The Steinmetz recommendations, reported last week in The Star, could change the face of the health care system in South Africa, and save billions of rands. The recommendations will also stimulate much-needed debate on the health crisis, reports Health Writer DAVID ROBBINS.



A COMPLETE restructuring of health-care delivery systems and an important change in the method of health funding are among the major recommendations in the Department of National Health and Welfare's Steinmetz Report.

Last September, a national committee comprising representatives of South Africa's multiplicity of health authorities (but excluding the four independent homelands) was formed, headed by a private sector financial and managerial expert, Sage Group head Gerard Steinmetz.

The committee had to "formulate a strategy and proposals to enable government to render an effective health service within the financial resources available".

This the committee has done, and it has estimated that around R1 billion a year could be saved through rationalisations and improvements. That's a sizeable bite out of a total public sector health budget of R11 billion.

The Steinmetz committee took as its starting point the muddle of apartheid health care which still exists to a large extent in the country.

The Department of National Health, three "own affairs" departments (until April 1 this year), four provincial administrations and six self-governing homelands all contributed to a situation where the "fragmentation and duplication of the service became the order of the day".

In terms of the recommendations, a single health department replaces the current muddle with a three-tier system of administration.

The central or national department will control overall health policy, standards and norms, training and research and overseas liaison, but will have no direct service responsibility.

This responsibility will be vested in regional departments. The current suggestion is that the country's nine economic regions (or any future geographic regions as delineated by the Constitution) shall be the basis for the regional administration of health.

The district authorities within each region will be responsible for the actual running of the health services on the ground, from primary to tertiary health care.

This system is a far cry from today, when provision of actual health services is divided between the Department of National Health, the four provincial health administrations, the six self-governing states, and scores of city councils and other local authorities, resulting in considerable overlapping of services.

The Steinmetz Report estimates that these structural changes alone will set free around R400 million a year.

The report also has important recommendations for the funding of health institutions and services. The present situation is turned on its head.

The implications for hospitals are enormous, and some observers see a national health service coming in South Africa.

Hospitals should be funded from income derived from charging all patients at medical schemes rates (funded from the regional health budget where necessary), and from other sources such as laboratory and laundry services.

The Steinmetz Report says this system would encourage the efficient use of equipment and personnel and oblige hospital administrations to tighten their budgets.

The report calculates, however, that a 7 to 14 percent surplus should be possible in most institutions, a proportion of which would be used to improve facilities and to pay staff an incentive bonus.

The report looks closely at the interface between the public and the private health care sectors.

Main recommendations to emerge are that State hospital facilities should be made available to private practitioners, in return for services rendered to State-dependent patients; and that specialised services and equipment in the private sector should not be duplicated in the public sector, and vice versa.

The report also takes a look at the future of South Africa's seven academic hospitals.

"Is it not necessary to re-evaluate the role of these costly complexes? Should there not be some attempt at rationalisation of scarce academic manpower, expensive equipment and capital resources?"

Basing its calculations on a national requirement of 750 new doctors a year, and a ratio of 10 academic beds per final-year student, the Steinmetz committee recommends that three academic hospitals be converted to tertiary care. Although it is known that the Cabinet is not in favour of closing academic hospitals at this stage, this recommendation could save R150 million a year.

Further savings of R350 million could be achieved, says the report, if the buying and control of pharmaceuticals was rationalised. At the moment, pharmaceutical items covered in State contracts total 2 386, while the number of essential items proposed by the World Health Organisation is 260.

The Steinmetz Report recommends the South African figure be reduced to around 500 items, and that controls be placed on the number of items, and their individual quantities, per prescription.

The control of pharmaceuticals in hospitals is also examined.

"It is estimated," says the report, "that fraud, theft and trafficking in institutions managed by the State can amount to as much as R500 million per annum."

The recommendation here is in the form of a detailed proposal for a new stock control system for hospitals.

Finally, the Steinmetz committee examined the serious maldistribution of doctors. Although the current doctor/population ratio in South Africa is 1:978, the ratios in the self-governing states range from 1:10 000 in QwaQwa to 1:30 000 in Lebowa.

Among the recommendations to redress this imbalance are that contractual obligations such as serving in the rural areas should be attached to medical bursaries and loans; that one year's service in selected areas should be introduced prior to full registration with the Medical and Dental Council; and that the proposed funding of patients rather than institutions would encourage new private practices in underserved areas.

If the number of doctors serving in these areas should be doubled, the report says, and if increased benefits are paid, an additional R60 million would need to be spent. But the savings on patient travel and admittance to regional hospitals would amount to R150 million, thus effecting a net saving of R90 million a year. □

Health care system must heal itself or choke on greed

BDM 27/5/93 (85)

PETER BENINGFIELD

THE health care industry is in disgrace. We are widely perceived as unscrupulous, unethical and relentless in our exploitation of human suffering for commercial gain. Truly, if capitalism ever had an unacceptable face, this must be it.

Like the country as a whole, it is undergoing painful and profound changes which, if properly managed, could lead it onward and upward to a better future. But it is also bedevilled by the ruthless sectoral self-interest and the partisan bickering which characterises our political process.

The health care industry is a very broad association of bodies which range from manufacturers through pharmacists and doctors to the medical aids. This uneasy alliance somehow has to get to grips with the radical transformation required of SA's health care system.

The driving force behind this change is cost containment in the interests of providing affordable, accessible, high-quality health care for all SA's people by 2000 — only six years away.

It is interesting to note that US President Bill Clinton has appointed a high-powered task force, headed by his wife, to make sweeping changes to the US health care system. The task force's proposals might well contain such draconian measures as a government-imposed freeze on doctors' fees and medicine prices. Even at their mildest, they are still likely to give the US government a much more active role in controlling health care costs.

Why such a drastic departure from free-market principles in the world's foremost capitalist economy? This is how one US commentator explains it: "The health care free market has proved that it doesn't work, so only massive government intervention will."

This chilling verdict has ominous implications for us in SA.

We have to face the unpleasant truth that our health care system is ill — afflicted by soaring costs, cumbersome controls, overservicing in the private market and underfunding in the public sector, not to mention fraud and outright theft.

SA's private sector health care market spends about R10bn a year on itself. Public sector expenditure runs to a very similar amount — R11bn.

The problem is that the private market caters for a mere 20% of the population, while the public sector has to take care of the remaining 80%. And this is far from being the only or even the most glaring discrepancy in our delivery system.

Of our total expenditure, an almost negligible 4% goes to primary or preventative health care. About 69% is spent on secondary or curative care, and the balance on the tertiary level — heart by-pass operations and the like, regarded in some circles as elitist treatment to keep rich, old white people alive beyond their allotted spans.

Whether you share this view or not, it is indisputable that our priorities in the allocation of health care funds are badly disordered.

Our health care system was essentially designed to provide whites with a First World service, and is now belatedly being forced to adapt to meet the demands of a developing country in the Third World.

Government alone is not to blame. All participants in the health care industry have to bear some of the responsibility. If we are to survive as an industry, let alone prosper, we should accept that responsibility and deal with its consequences.

In doing so, let's agree first of all that there's nothing wrong with the profit motive. By all means, let us serve our own ends — but let us serve society at the same time.

The days of unfettered laissez-faire capitalism — when a company's sole duty was to its shareholders and its social responsibility consisted of paying its taxes — are long gone.

Business is now expected to conduct itself in a manner acceptable not just to its owners but also to the community in which it operates; in short, to behave like a useful and respectable corporate citizen.

If we don't succeed in getting our house in order, there is little doubt that some sort of order will be imposed upon us. That order is likely to be imposed by a new government which might be inherently suspicious of the profit motive in health care. Our survival depends on our ability to demonstrate to such a new government and its constituents that the health care system is capable of behaving responsibly in a free market.

We will require a real co-operative effort.

The participants are deeply divided by short-sighted self-interest. This has resulted in seemingly petty turf battles between the professions, brutally aggressive lobbying by special-interest groups and some highly dubious competitive practices.

Through public manifestations of our differences, we have consistently portrayed ourselves as a squabbling and greedy industry.

What we need now is a general realisation that we have to overcome these differences; that we have to concentrate on the crucial issues that unite us and set aside the lesser ones that divide us; and that we have to make common cause to restore our ailing industry to health.

What we need, in bottom-line terms, is to introduce self-regulation, and to do so soon.

I propose the establishment of a private health care forum to unite all the major players in the system and commit them to self-regulation.

Such a forum should not be a cosy circle of friends or a mutual admiration society. It should not advance the cause of nepotism, nor should it fight for narrow and self-serving sectoral interests. What it should do is agree on standards of conduct acceptable to the community in which we operate and enforce these impartially, vigorously, publicly and if need be, ruthlessly.

In other words, it should be an industry bulldog which is not only equipped with a full set of teeth but does not hesitate to use them.

To achieve this, it should be small — with probably no more than between eight and 12 members — and it should have real power. Its members should not be administrators or flunkies or time-servers but the true movers and shakers of the industry. Nothing less than the chief executives of the main players will do.

It isn't going to be easy. It is going to be a real labour of Hercules — the cleaning up of the Augean stables, to be precise. But it has to be done.

The issue which stands out most prominently is that of cost — and, in particular, the cost of medicines. When the cost of medicines soars from 18% to 30% of the total health care bill in the space of just 10 years, then something has gone very wrong with the pricing system.

Here again I believe there is a strong case for self-discipline to limit the need for controls. The industry has to return to the traditional trading practice of cost plus, rather than working downwards from a recommended retail price. Instead of being professional traders, we should return to being trading professionals.

Current changes and such strong indicators as the ANC's health policy all point to one thing: that SA's pharmaceutical market of the future will be characterised by larger volumes and smaller margins. Prudent businesses and professionals will understand and accept this, and adjust their strategies accordingly.

I would like to suggest that the local and multinational pharmaceutical companies set aside their differences to take the lead in determining and applying the therapy required for this recovery process.

☐ Beningfield is SA Druggists MD. This is an edited excerpt from his address to the Pharmaceuticals 1993 conference in Midrand yesterday.

focus on **black growth**

Entrepreneur and political activist Dr Nthato Motlana, the man who once regarded those serving in government structures as 'sellouts', explains to Mzimkulu Malunga why he has accepted a senior government post:

Sowetan 27/5/93

IT IS NOT TOO EARLY for blacks to accept appointments to senior civil service positions, argues the new chairman of the Population Development Council, Dr Nthato Motlana.

"If a young black is offered a position as superintendent of the Baragwanath Hospital and comes to me for advice, I will say take it," he says.

Ironically, these words come from a man who once regarded those serving in government structures as "sellouts".

The eloquent doctor scoffs at criticism that he has accepted a senior position from a regime he had energetically fought over the years.

Motlana firmly believes his comrades in the African National Congress are not angered by his decision to accept the post.

"What do you think all those groups at Kempton Park are doing? They are talking about power and bringing about changes and it is time black people start preparing themselves for the future."

SOME of the critics of Motlana's decision to serve on the PDC suggest he accepted an appointment from a person who once called black people "kaffirs". But, as usual, he refuses to be battered into submission. "Almost every white in this country called black people 'kaffirs' at one time or another."

Although most of the population programmes in this country have failed, Motlana believes he can put an end to this syndrome.

His strategy to bring about the changes will centre on thorough research accompanied by careful implementation.

"I first want to see what programmes are on the ground, which ones have succeeded and why. There must also be a reason why some were unsuccessful," he argues.

However, it appears as though the legitimacy of such population programmes remain a major problem.

As a first step in a quest to cultivate trustworthiness in population programmes, Motlana says he intends visiting the rural areas to spread the gospel of smaller families.

Population development activists are worried about the booming numbers of South African people in the midst of an ailing economy.

For years now the 68-year-old doctor has been engaged in what many believe are two irreconcilable activities — activism and business.

As a participant in the structures of a liberation movement dominated by people who regarded owning your own business and succeeding as selling out, Motlana admits it has not been easy.

But the realisation is steadily taking shape among a broad section of activists in the broad liberation movement that economic empowerment is necessary for political power to thrive.

Dr Nthato Motlana ... sits on many corporate boards.

"I get angry every time I see a skilled young black going to a white man for a job. For goodness' sake, why can't he create his own job?"

While some activists still believe it is shameful to be rich, these days even hardline communists like Chinese leader Den Xiaoping say: "It is glorious to be rich", argues Motlana.

To him, China has strengthened the arguments of the champions of black economic empowerment by combining their socialistic political approach with a wealth-creating economic formula.

"You have to create wealth before distributing it," says the man who believes in "capitalism with a human face".

Of course, some of those companies collapsed but Motlana never stopped trying as he saw such a strategy as the eventual salvation of black people in this country.

"What d'you think those groups at Kempton Park are doing? They are talking about power and bringing about changes and black people must start preparing themselves for the future"

His day begins in the early hours of the morning, ending deep into the heart of the night.

Motlana serves on the boards of more than a dozen institutions, with many others trying to lay their hands on him.

"I don't know how I manage. Sometimes I find meetings of these institutions clashing with one another," argues a figure who has engineered the formation of many black companies.

In such cases priority plays an decisive role. Meetings in which his presence is crucial get preference.

Two weeks ago, Motlana and five other activists-cum-businessmen made history when they acquired effective control of Metropolitan Life in a deal amounting to R137 million.

This move has been hailed as the second-biggest coup in black business history after National Sorghum Breweries landed in black hands.

As a result, the chairmanship of the board of Metropolitan Life is the latest to be added to Motlana's long list of responsibilities.

Though some people about love to hate him, one thing is certain with Motlana: he is a mover.

Education Sector	Per capita *State Expenditure (R)*	
	Capital expenditure included	*Capital expenditure excluded*
*Public Ordinary Schools	1 755	1 669
*Teacher Training Colleges	14 169	12 115
*Technical Colleges	5 287	4 825
Technikons	5 559	4 540
Universities	8 913	7 656

* Based on information in respect of actual expenditures of education departments as submitted to the DNE within the SANEP information system.

Dobsonville: payments to councillors

330. Mr P G SOAL asked the Minister of Local Government:

(1) Whether an investigation has been undertaken by the Director-General: Transvaal Provincial Administration in respect of certain payments made to councillors in Dobsonville; if not, why not; if so, (a) what did these payments relate to, (b) to whom were they made and (c) what amounts were involved in each case;

(2) whether he will make a statement on the matter? B770E

The MINISTER OF LOCAL GOVERNMENT:

(1) No.

The Director-General: Transvaal Provincial Administration has no knowledge of any payments, other than normal monthly allowances, made to councillors in Dobsonville.

(2) Falls away.

National Health and Population Development: top five post levels

346. Mr M J ELLIS asked the Minister for National Health and Welfare:

(a) How many persons from each race group occupy positions in the top five post levels of the Department of National Health and Population Development and (b) in respect of what date is this information furnished? B786E

The MINISTER FOR NATIONAL HEALTH AND WELFARE:

	White	*Black*	*Indian*	*Coloured*
(a) Director-general	1	—	—	—
Deputy Director-General	2	—	—	—
Chief Director	11	—	—	—
Director	30	1	2	—
Deputy Director	86	1	2	— and

This information does not include posts and incumbents that have been transferred from the House of Representatives to the Department of National Health and Population Development as a result of rationalisation with effect from 1 April 1993.

(b) 1 April 1993.

Schools in Departmental regions: number of teachers

351. Mr R M BURROWS asked the Minister of Education and Training:

(1) (a) How many teachers are employed at (i) primary and (ii) secondary schools under his control in each Departmental region and (b) in respect of what date is this information furnished;

(2) whether he will furnish the information requested in paragraph (1) in respect of each of the self-governing territories; if not, why not; if so, what are the corresponding particulars? B820E

The MINISTER OF EDUCATION AND TRAINING:

(1) (a)

	(i)	(ii)
Diamond Fields	4 055	1 477
Highveld	7 223	3 734
Johannesburg	4 378	3 040
Cape	6 957	3 051
Northern Transvaal	5 015	2 584
Natal	5 621	2 132
Orange-Vaal	6 288	2 816
Orange Free State	4 913	2 050
Total	44 450	20 884

(b) 3 March 1992.

(2) (a)

	(i)	(ii)
Gazankulu	6 031	2 979
KaNgwane	4 344	2 114
KwaNdebele	2 397	1 589
KwaZulu	23 768	10 859
Lebowa	15 701	10 403
QwaQwa	2 065	1 392
Total	54 306	29 336

(b) 3 March 1992.

A world health first for SA

Sowry 2015 - 2015 98

85

By Justin Pearce

MEDICAL technology is often demonised as an expensive solution to rare diseases. But in the past year researchers working under the auspices of the Medical Research Council (MRC) have come up with new electronic gadgets that will make the task of community health workers easier, and save money spent on primary health care.

One of the machines is the new "manz-imeter", a device that enables a health worker to identify dehydration, a consequence of diarrhoea in babies, before it becomes too severe.

The device works by passing a mild and harmless electric current through the child's body. The amount of electrical resistance accurately indicates how much water is present in the child's body, from which the health worker can determine whether the child needs rehydration therapy. The meter is a world first for South African medical technology.

Another machine is the spirometer, a portable device which measures the airflow from someone's lungs. You exhale all the air from your lungs into the meter. Electronic equipment records the capacity of your lungs and the pattern of the airflow, which gives a good indication of how well your lungs are functioning.

Data for 100 patients can be stored in the machine's memory, and then downloaded to a computer database for analysis.

The machine can be produced in South Africa for about R1000, a fraction of the price of the United States-manufactured machines that were used previously.

One advantage of the device is that it can be used to diagnose respiratory diseases quickly and easily without taking the patient to a hospital or clinic.

Dr Roger Stewart of the MRC's Technology Development and Transfer programme said devices like the spirometer and manz-imeter would quickly recoup their costs because they made accurate diagnoses possible without the expense of taking the patient to a hospital.

HEALTHTALK

HEALTH experts will answer readers' questions in our next Healthtalk column at the end of this month.

Send your questions to South Healthtalk, PO Box 13094, Sir Lowry Road, Cape Town, 7900.

Baby deaths, joblessness don't figure

NO overall figure for South Africa's infant mortality is available, according to the Minister of Health, Dr Rina Venter.

She said this in a written reply to a question from Mr Mike Ellis (DP), who had asked for the rate for black, white, coloured and Indian infants in 1991 and 1992.

"Since 1991, the Central Statistical Service does not publish information according to racial group," Dr Venter said. "A total infant mortality rate is not available."

In another written reply, the Minister of Home Affairs, Mr Danie Schutte, told Mr Andrew Gerber (CP Brits) that no projection had been made on what the country's unemplomoent figure would be by the end of 1993 as there was not sufficient information for a scientifically-sound forecast.

The most recent estimate, based on the last census, was that 2,1 million people, or 18,2 percent of the economically active population, were unemployed on March 7 1991. — Sapa

section 28 (2) of the Republic of South Africa Constitution Act, 1983 (Act No. 110 of 1983), amended with effect from 24 May 1993, Notice 1093 of 15 November 1991, as amended by Notice 915 of 16 October 1992, by the substitution in Schedule 1 of the said notice for the name **Rufus Dercksen** of the name **Martha Elisabet Olckers.**

(21 May 1993)

kragtens artikel 28 (2) van die Grondwet van die Republiek van Suid-Afrika, 1983 (Wet No. 110 van 1983), Kennisgewing 1093 van 15 November 1991, soos gewysig deur Kennisgewing 915 van 16 Oktober 1992, met ingang van 24 Mei 1993 gewysig het deur in Bylae 1 van gemelde kennisgewing die naam **Rufus Dercksen** deur die naam **Martha Elisabet Olckers** te vervang.

(21 Mei 1993)

BOARD NOTICES

BOARD NOTICE 52 OF 1993

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

NOTICE OF ELECTION: ELECTION OF MEMBERS OF THE PROFESSIONAL BOARD FOR PODIATRY

Notice is hereby given in terms of the provisions of the regulations relating to the election of members of the Council, read with section 15 (11) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 No. of 1974), that an election of five podiatrists as members of the Professional Board for Podiatry to serve during the period ending the 30th day of September 1998 is about to be held.

Nominations of eligible podiatrists are awaited. Every person so registered (a) who has not entered into a composition with the creditors of this estate, or whose estate has not been sequestrated, (b) who is not disqualified under the Act from practising his profession, is eligible for nomination.

Each candidate must be nominated on a separate nomination form, but any person entitled to vote in the election may sign the nomination forms of any number of candidates not exceeding the number to be elected.

Each nomination form must state the first names and the surname of the candidate nominated and must be signed by two registered podiatrists. The person nominated must also sign the form, confirming that he consents to his nomination. The registered address of each one so signing must be appended to his signature. If the person nomination is unable to sign the nomination form he may inform the returning officer by letter of telegram that he consents to his nomination.

Every nomination form must reach the undersigned (from whom nomination forms may be obtained on application) at the address given below not later than 29 June 1993 at 12:00.

A deposit of R34,20 must accompany the nomination.

RAADSKENNISGEWINGS

RAADSKENNISGEWING 52 VAN 1993

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

VERKIESINGSKENNISGEWING: VERKIESING VAN LEDE VAN DIE BEROEPSRAAD VIR VOETKUNDE

Hierby word ingevolge die bepalings van die regulasies betreffende die verkiesing van lede van die Raad, gelees met artikel 15 (11) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet No. 56 van 1974), kennis gegee dat 'n verkiesing gehou staan te word van vyf voetkundiges as lede van die Beroepsraad vir Voetkunde om te dien gedurende die tydperk wat op die 30ste dag van September 1998 verstryk.

Nominasies van verkiesbare voetkundiges word ingewag. Elke sodanige geregistreerde persoon (a) wat nie met sy skuldeisers 'n akkoord aangegaan het nie, of wie se boedel nie gesekwestreer is nie (b) wat nie kragtens die Wet onbevoeg is om sy beroep te beoefen nie, is nomineerbaar.

Elke kandidaat moet op 'n afsonderlike nominasievorm genomineer word maar elkeen wat by die verkiesing stemgeregtig is, kan die nominasievorms van enige aantal kandidate teken, dog nie meer as die getal wat verkies moet word nie.

Elke nominasievorm moet die voorname en die van van die genomineerde kandidaat aangee en moet geteken wees deur twee geregistreerde voetkundiges. Die genomineerde persoon moet ook die vorm onderteken ter bekragtiging van sy instemming tot sy nominasie. Die geregistreerde adres van elkeen wat aldus teken, moet by sy handtekening gevoeg word. As die genomineerde persoon nie in staat is om die nominasievorm te teken nie, kan hy die kiesbeampte per brief of telegram meedeel dat hy tot sy nominasie instem.

Elke nominasievorm moet die ondergetekende (van wie nominasievorms op aanvraag verkry kan word) voor of op 29 Junie 1993 om 12:00 by onderstaande adres bereik.

'n Deposito van R34,20 moet die nominasie vergesel.

Every nomination form in respect of which any of these provisions has not been complied with, or which is not received by the aforesaid date at the address given below, will be invalid.

N. M. PRINSLOO,
Returning Officer.

P.O. Box 205
PRETORIA
0001

or

SAMDC Building
553 Vermeulen Street,
Arcadia
PRETORIA
0002.

Elke nominasievorm ten opsigte waarvan een van hierdie bepalings nie nagekom is nie of wat nie teen voormelde datum by onderstaande adres ontvang is nie, is ongeldig.

N. M. PRINSLOO,
Kiesbeampte.

Posbus 205
PRETORIA
0001

of

SAGTR-gebou
Vermeulenstraat 553
Arcadia
PRETORIA
0002.

BOARD NOTICE 53 OF 1993

THE SOUTH AFRICAN NURSING COUNCIL

REMOVAL OF NAMES FROM REGISTERS AND ROLLS

Notice is hereby given that in terms of section 29 (1) (c) of the Nursing Act, 1978 (Act No. 50 of 1978), the name of Mr S. P. Olifant has been removed from the registers of nurses and midwives following on a disciplinary inquiry by the South African Nursing Council into his conduct on 2 March 1993. The sentence comes into operation on 17 May 1993.

F. GERMISHUIZEN,
Registrar.
14 May 1993.

RAADSKENNISGEWING 53 VAN 1993

DIE SUID-AFRIKAANSE RAAD OP VERPLEGING

SKRAPPING VAN NAME UIT REGISTERS EN ROLLE

Kennis word hiermee gegee dat, kragtens artikel 29 (1) (c) van die Wet op Verpleging, 1978 (Wet No. 50 van 1978), die naam van mnr. S. P. Olifant geskrap is uit die registers van verpleegkundiges en vroedvroue na aanleiding van 'n tugondersoek deur die Suid-Afrikaanse Raad op Verpleging op 2 Maart 1993. Die vonnis tree op 17 Mei 1993 in werking.

F. GERMISHUIZEN,
Registrateur.
14 Mei 1993.

Inoculation price rockets

ARG 20/5/73

The Argus Correspondent

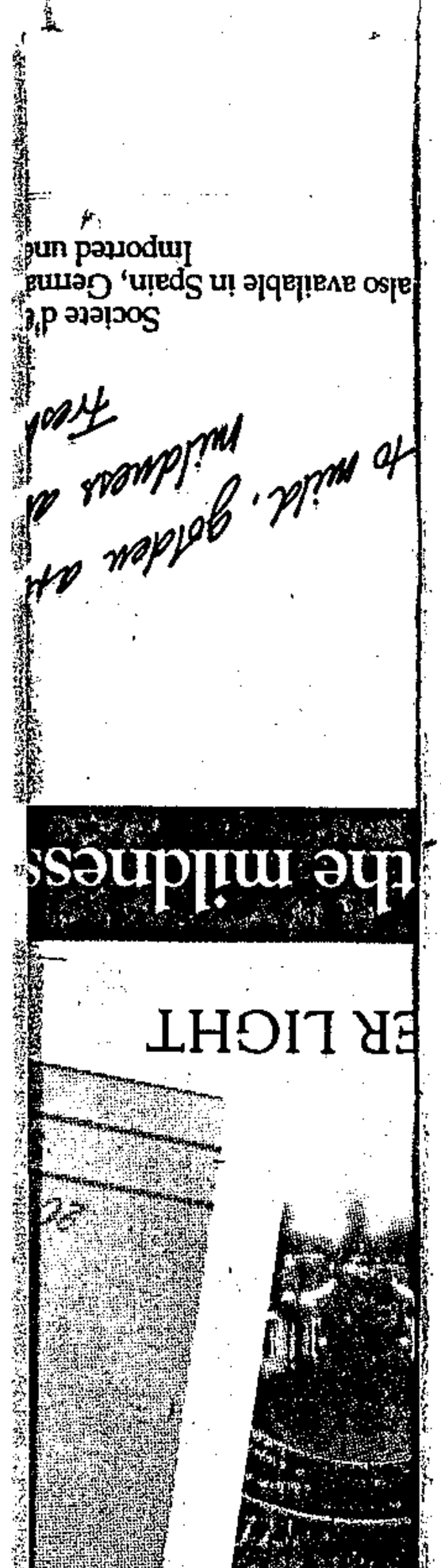
DURBAN. — The price of inoculations for overseas travellers has risen from R3 to R51 in a year.

Angry travel agents said that while they were fighting to keep air ticket prices down, authorities were adding to the burden.

Travel agent Mr Bobby Naidoo said that at the beginning of last year, an inoculation cost R3.

"Then at the beginning of this year it shot up to R14 and at the beginning of this month, it went up to R51," said Mr Naidoo.

A spokesman for the Department of Health Services said people now paid for the inoculation and the service.



Health plan could save SA billions

Star 19/5/93

By David Robbins
Health Writer

85

South Africa's crisis-ridden health care system stands to be transformed — saving billions of rands before the turn of the century — if recommendations from a high-powered national committee are accepted.

The recommendations, including major structural and funding changes in health, will be presented to the Minister of National Health and Population Development next week.

Meanwhile, recommendations concerning the future of the country's academic hospitals are being discussed by the Academic Policy Council today.

The national committee was chaired by Sage insurance and property empire head Gerard Steinmetz. Representatives of the Department of National Health, provincial health departments, the now defunct "own affairs" departments, and the six self-governing national states served on the committee. So-called independent homelands were not represented.

Savings from implementing all the Steinmetz Report recommendations could top the R1 billion mark each year.

Among the most far-reaching recommendations are those which concern the structure of the health services. The current multi-control system should be replaced by a single health department with a three-tiered system of control.

The central department would be responsible for overall health policy, planning and monitoring, international liaison, research and the allocation of the national health budget.

Nine regional authorities would take care of the delivery of the total health care package, from primary health care services to tertiary hospitals, through the agency of district health authorities within the various regions.

Other recommendations include:

- A system of reciprocity be established between the private and public health sectors.
- The present method of funding health care (by the subsidisation of institutions) be changed to a subsidy system directed at patients.

Although the current doctor/population ratio in South Africa was a respectable 1:978, the situation in the self-governing states was unacceptable, with ratios ranging from 1:10 000 in QwaQwa to 1:30 000 in Lebowa.

The Steinmetz Report seeks to redress this maldistribution through a number of recommendations, the most important of which include attaching contractual obligations to medical bursaries and loans and the introduction of one year's service in selected areas prior to full registration with the SA Medical and Dental Council.

The report also recommends that the number of academic hospitals be reduced from seven to four. However, a senior official of the Department of National Health said yesterday the Cabinet was not in favour of closing hospitals at this stage.

Star

Inoculation cost soars

Own Correspondent

DURBAN — The price of inoculations for overseas travellers has risen sharply — from R3 to R51 over the past year.

Angry travel agents said that while they were fighting to keep air ticket prices down, the authorities were adding to the burdens of a stricken industry.

Travel agent Bobby Naidoo said that last year an inoculation cost R3.

"Then at the beginning of this year it shot up to R14 and now from the beginning of this month, it has gone up to R51."

Naidoo said a traveller wishing to visit the United States had to pay R102 for two inoculations, one for yellow fever and the other for cholera.

A spokesman for the Department of Health Services in Maritzburg said that previously people paid only for the inoculation, but a decision had been taken to charge for the service.

"There are other things that go with an inoculation, like syringes and other expenses, and it has been decided that people should now pay for the entire service."

The spokesman said the cost of providing such services was high and the department could no longer carry the financial burden alone.

'Malaria threat to tourism'

GARNER THOMSON, Weekend Argus Foreign Service in London

85 ARG 15/5/93

THE advent of drug-resistant strains of malaria could affect the tourist industry in southern Africa adversely, a leading British political journal has warned.

Africa Analysis reports that the drug-resistant strain of often-lethal cerebral malaria is "sweeping" through Africa.

Already, cases in Zambia are said to have reached "epidemic" proportions, and in Zimbabwe Health Minister Mr Timothy Stamp has described the position as "extremely serious".

Zimbabwe's Health Ministry has reported 76 000 cases of malaria in the first quarter of this year.

Now, with a number of British and South African tourists having contracted cerebral malaria, the problem seems to be moving further south.

Africa Analysis blames severe economic cutbacks for the outbreak. "There has been virtually no spraying for more than a year in either Zambia or Zimbabwe," it points out.

The World Health Organisation says that northern Botswana and Namibia, Angola, Mozambique and parts of South Africa also are affected.

According to specialists in Luanda, the non-lethal, but recurrent, strains of malaria have apparently become resistant to anti-malaria drugs.

New Manzi Meter set to save babies' lives

(8C) ARG 15/5/93

■ Researchers at the University of Cape Town have invented an ingenious portable device which will help save the lives of babies with dehydration due to diarrhoeal disease. Weekend Argus Reporter **ANDREA WEISS** spoke to Professor Tony Bunn about the 'Manzi Meter'.

MEDICAL researchers in Cape Town have developed an ingenious, cheap device that could save the lives of hundreds of thousands of children.

It is estimated that a child dies every 10 seconds in the developing world from diarrhoeal disease and associated dehydration.

Now, the group of Cape Town researchers has produced a piece of equipment which could become standard apparatus in clinics throughout the developing world, likely to cost less than R1 000.

Called the Manzi Meter (amanzi is the Xhosa word for water), the device can be used to measure the level of hydration in infants under the age of two. It has an array of green, orange and red lights to indicate whether a child is dehydrated or not.

In the view of Professor Tony Bunn, who led the three-man research team, the device would probably pay for itself by saving just two unneccessary hospital referrals and admissions.

The portable Manzi Meter uses technology traditionally employed to measure fat and lean in the body.

Picture: BRENTON GEACH, Weekend Argus.

□ **ON THE METER:** Professor Tony Bunn demonstrates the benefits of the meter on five-month-old Tanya Luntonti of Nyanga East, who was admitted to the rehydration unit at Red Cross Children's Hospital.

The research team, from the University of Cape Town's Medical School's department of biomedical engineering, has modified this technology and applied it to the prevalent third-world problem of gastro enteritis and the dehydration with which it is associated.

The meter measures electrical resistance, which is related to the amount of water present in the body. As a result, the user can now tell accurately and quickly whether an infant is dehydrated or not.

After putting surface electrodes on an infant's right hand and foot, a harmless battery-generated current is passed through the body. If the infant is dehydrated, a light in the red band is displayed. As the child's hydration improves, the light will move into the orange and finally the green band.

Professor Bunn said that because dehydration was a life-threatening condition, staff working in primary healthcare clinics were inclined to err on the side of caution and refer even mild cases of dehydration to clinics and hospitals for drip therapy.

With the Manzi Meter, staff would be able to tell whether a baby needed to be put on a drip or if it could simply drink special fluids at a local clinic or at home. Besides major economic advantages, this also would spare the parents and child the trauma of going to hospital.

At Red Cross Children's Hospital, for instance, up to a 100 children a day were admitted during the summer when gastro enteritis was at its worst.

If the Manzi Meter were in use, this number would certainly decrease. The meter also could be used to monitor children admitted to the unit to see when they were rehydrated and could be discharged.

At present, monitoring involves three-hourly clinical checks by sisters and doctors. The children also were often weighed. Clinical assessment was subjective and based on clinical experience; so the Manzi Meter should prove a valuable aid.

Its major role, however, would be in screening infants in rural clinics to decide who should be treated on site or sent for more sophisticated drip therapy.

The device also had exciting international prospects and could become a standard tool throughout the developing world.

Professor Bunn and his colleagues, Dr Dave Moshal and electronics engineer Mr Alex Rawstorne, were funded by the Medical Research Council's technology development and transfer group which aimed to make easier the development of appropriate healthcare technology.

'Health for all' pledge

MORE than 200 delegates at the Pharmaceutical Society of SA conference in Durban signed a pledge yesterday to support the goal of health for all by the year 2000. Delegates recognised that primary health care was a priority and should be accessible to all.

REPORTS: Sapa, Business Day Reporters.

BOARD NOTICE 48 OF 1993

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

ELECTION OF ONE MEMBER OF THE PROFESSIONAL BOARD FOR SPEECH-LANGUAGE THERAPY AND AUDIOLOGY

It is hereby notified in terms of section 15 (5) of Act No. 56 of 1974, and regulation 8 (2) of the regulations for the election of members of the Council published under Government Notice No. R. 2279 of 3 December 1976, that the following persons have been validly nominated as candidates for election as a member of the Professional Board for Speech-Language Therapy and Audiology for the remainder of the five year period ending on 28 February 1996:

ROBERTS, Estelle.
STEENEKAMP, Anne-Marie.
TUOMI, Seppo Kalervo.

As the number of persons validly nominated exceeds the number of persons to be elected, I have appointed 21 June 1993 at 12:00, before which every person entitled to vote in the election may sign and transmit or deliver to me a voting paper described in the Third Annexure of the said regulations. A voting paper will be posted to the last registered address of every person entitled to vote in the election.

N. M. PRINSLOO,
Returning Officer.

SAMDC Building
553 Vermeulen Street
Arcadia
PRETORIA
0083;

or

P.O. Box 205
PRETORIA
0001.

(14 May 1993)

BOARD NOTICE 49 OF 1993

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

ELECTION OF MEMBERS OF THE PROFESSIONAL BOARD FOR HEALTH INSPECTORS

Notice is hereby given in terms of the provisions of the regulations relating to the election of members of the Council, read with section 15 (11) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), that an election of five health inspectors as members of the Professional Board for Health Inspectors to serve during the period ending 30 September 1998 is about to be held.

Nominations of eligible health inspectors are awaited. Every person so registered (a) who has not entered into a composition with the creditors of his estate, or whose estate has not been sequestrated, (b) who is not disqualified under the Act from practising his profession, is elibible for nomination.

RAADSKENNISGEWING 48 VAN 1993

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

VERKIESING VAN EEN LID VAN DIE BEROEPSRAAD VIR SPRAAK-TAALTERAPIE EN OUDIOLOGIE

Ingevolge artikel 15 (5) van Wet No. 56 van 1974, en regulasie 8 (2) van die regulasies vir die verkiesing van lede van die Raad afgekondig by Goewermentskennisgewing No. R. 2279 van 3 Desember 1976, word hierby bekendgemaak dat ondergenoemde persone geldig genomineer is as kandidate vir verkiesing tot lid van die Beroepsraad vir Spraak-Taalterapie en Oudiologie vir die oorblywende gedeelte van die vyfjaartydperk eindigende op 28 Februarie 1996:

ROBERTS, Estelle.
STEENEKAMP, Anne-Marie.
TUOMI, Seppo Kalervo.

Aangesien die getal genomineerde persone, die getal persone wat verkies moet word te bowe gaan, het ek 21 Junie 1993 om 12:00, vasgestel as die dag en tyd waarvoor elkeen wat geregtig is om by die verkiesing te stem 'n stembriefie in die Derde Aanhangsel van die gemelde regulasies beskryf, kan teken en aan my stuur of oorhandig. 'n Stembriefie sal gepos word na die laaste geregistreerde adres van elkeen wat vir die verkiesing stemgeregtig is.

N. M. PRINSLOO,
Kiesbeampte.

SAGTR-gebou
Vermeulenstraat 553
Arcadia
PRETORIA
0083;

of

Posbus 205
PRETORIA
0001.

(14 Mei 1993)

RAADSKENNISGEWING 49 VAN 1993

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

VERKIESING VAN LEDE VAN DIE BEROEPSRAAD VIR GESONDHEIDSINSPEKTEURS

Hierby word ingevolge die bepalings van die regulasies betreffende die verkiesing van lede van die Raad, gelees met artikel 15 (11) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974, (Wet No. 56 van 1974), kennis gegee dat 'n verkiesing gehou staan te word van vyf gesondheidsinspekteurs as lede van die Beroepsraad vir Gesondheidsinspekteurs om te dien gedurende die tydperk wat op die 30ste dag van September 1998 verstryk.

Nominasies van verkiesbare gesondheidsinspekteurs word ingewag. Elke sodanige geregistreerde persoon (a) wat nie met sy skuldeiser 'n akkoord aangegaan het nie, of wie se boedel nie gesekwestreer is nie (b) wat nie kragtens die Wet onbevoeg is om sy beroep te beoefen nie, is nomineerbaar.

Each candidate must be nominated on a separate nomination form, but any person entitled to vote in the election may sign the nomination forms of any number of candidates not exceeding the number to be elected.

Each nomination form must state the first name and the surname of the candidate nominated and must be signed by two registered health inspectors. The person nominated must also sign the form, confirming that he consents to his nomination. The registered address of each one so signing must be appended to his signature. If the person nominated is unable to sign the nomination form he may inform the returning officer by letter or telegram that he consents to his nomination.

Every nomination form must reach the undersigned (from whom nomination forms may be obtained on application) at the address given below not later than 21 June 1993 at 12:00.

A deposit of R34,20 must accompany the nomination.

Every nomination form in respect of which any of these provisions has not been complied with, or which is not received by the aforesaid date at the address given below, will be invalid.

N. M. PRINSLOO,
Returning Officer.

P.O. Box 205
PRETORIA
0001;

or

553 Vermeulen Street
Arcadia
PRETORIA
0083.

(14 May 1993)

Elke kandidaat moet op 'n afsonderlike nominasievorm genomineer word maar elkeen wat by die verkiesing stemgeregtig is, kan die nominasievorms van enige aantal kandidate teken, dog nie meer as die getal wat verkies moet word nie.

Elke nominasievorm moet die voorname en die van, van die genomineerde kandidaat aangee en moet geteken wees deur twee geregistreerde gesondheidsinspekteurs. Die genomineerde persoon moet ook die vorm onderteken ter bekragtiging van sy instemming tot sy nominasie. Die geregistreerde adres van elkeen wat aldus teken, moet by sy handtekening gevoeg wees. As die genomineerde persoon nie in staat is om die nominasievorm te teken nie, kan hy die kiesbeampte per brief of telegram meedeel dat hy tot sy nominasie instem.

Elke nominasievorm moet die ondergetekende (van wie nominasievorms op aanvraag verkry kan word) voor of op 21 Junie 1993 om 12:00 by onderstaande adres bereik.

'n Deposito van R34,20 moet die nominasie vergesel.

Elke nominasievorm ten opsigte waarvan een van hierdie bepalings nie nagekom is nie of wat nie teen voormelde datum by onderstaande adres ontvang is nie, is ongeldig.

N. M. PRINSLOO,
Kiesbeampte.

Posbus 205
PRETORIA
0001;

of

Vermeulenstraat 553
Arcadia
PRETORIA
0083.

(14 Mei 1993)

BOARD NOTICE 50 OF 1993

SECURITY OFFICERS' BOARD

In terms of section 10 (5) (b) of the Security Officers Act, 1987 (Act No. 92 of 1987) (as amended), the Security Officers' Board hereby gives notice that the Board intends to recommend to the Minister of Law and Order that the provisions of the Security Officers Act, 1987 (Act No. 92 of 1987) (as amended), shall apply to the categories of employees listed below who render a security service.

The Board invites interested parties to submit in writing to the Board within eight weeks from date of publication of this notice any objection to or representations concerning the inclusion of certain categories of practitioners who render a security service.

Comments or representations should be submitted in writing to the Registrar of the Security Officers' Board, Private Bag X817, Pretoria, 0001.

F. K. LUBBE,
Registrar: Security Officers' Board.

RAADSKENNISGEWING 50 VAN 1993

RAAD VIR SEKURITEITSBEAMPTES

Ingevolge artikel 10 (5) (b) van die Wet op Sekuriteitsbeamptes 1987 (Wet No. 92 van 1987) (soos gewysig), gee die Raad vir Sekuriteitsbeamptes hiermee kennis dat die Raad van voorneme is om aanbevelings by die Minister van Wet en Orde te doen dat die bepalings van die Wet op Sekuriteitsbeamptes, 1987 (Wet No. 92 van 1987) (soos gewysig), van toepassing sal wees op ondervermelde kategorieë van werknemers wat 'n sekuriteitsdiens lewer. Belanghebbendes word hierby uitgenooi om binne agt weke vanaf datum van publikasie van hierdie kennisgewing, besware teen of vertoë aangaande onderwerp skriftelik by die Raad in te dien.

Besware teen of vertoë moet by die Registrateur van die Raad vir Sekuriteitsbeamptes, Privaatsak X817, Pretoria, 0001, ingedien word.

F. K. LUBBE,
Registrateur: Raad vir Sekuriteitsbeamptes.

Medi-Clinic posts healthy earnings

MARC HASENFUSS
Business Staff

BETTER operating margins and a marked drop in the interest bill helped Medi-Clinic post a healthy 9,5 percent increase in attributable earnings to R26,3 million for the year to end March.

Directors deemed the results satisfactory in light of the poor economic conditions.

They attributed the results to the marked accent the group had placed on the provision of cost effective, quality services.

A final dividend of 4,4c a share was paid, increasing the total payout 10 percent to 6,6c.

Directors expect further earnings growth in the year ahead. "Continuous programmes to improve work processes and general efficiency are proceeding."

They stressed that the medical schemes scale of tariffs (effective from January next year) could have a significant influence on results.

■ Toy retailer **Redgwoods Holdings** lifted earnings 7 percent to R1,65 million in the year to end February — thanks to strong second half which included peak Christmas trade.

Operating margins, however, took a battering. Turnover increased almost 20 percent but operating profit increase was slightly down at R3,4 million.

A drop of nearly R150 000 in interest paid bolstered bottom line.

The dividend was held at 1,2c a share.

■ **African Cables** posted a 16 percent decline in bottom line to R7,5 million in the half year to end March as conditions in the power cable sector continued to wane.

The dividend was reduced 27 percent to 8c a share — reflecting bleak prospects for the full year.

During the year the group rationalised extensively, including closing down the Dundee factory.

■ **Shell** boosted capital expenditure by over R100 million to R270 million last year.

In its business report for 1992 Shell says the bulk of the investment programme was devoted to the R450 million upgrade of the Sapref refinery, a joint venture with BP, which is scheduled for completion later this year.

Chairman John Kilroe foresees further investments, "given a stable political and economic environment in South Africa".

'System cause of drug losses'

CT 11/5/93

Own Correspondent

DURBAN. — In one week alone, five wards at Baragwanath Hospital were unable to account for nearly R5 000 worth of injectable drugs because of outdated stock control systems.

Extrapolated over one year the loss would amount to R250 000, Mrs Sue Putter, president of the South African Association of Hospital and Institutional Pharmacists, told the Pharmaceutical Society of South Africa's annual congress here yesterday.

She said recommendations in the Du Toit report commissioned in 1990 by the Minister of Health, Dr Rina Venter, should be instituted and not sink into oblivion as other reports had.

The report highlighted severe shortcomings in the provision of cost-effective pharmaceutical services in the public sector.

Benefits

Mrs Putter attributed massive financial losses to inadequate stock control — based on the old ward-stock system. It was this particular problem that had led to a situation such as that at Baragwanath.

She pointed out that only 20% of all hospitals in South Africa made use of computerised stock control in spite of the proven benefits of such a system.

Greater use of computers by pharmacists, coupled with their involvement in hospital management, would enable them to institute cost-effective programmes which would result in huge savings.

"The overall picture of hospital pharmacy in the public sector mirrors the problems of the public health care sector in this country — with a maldistribution of pharmacists, fragmentation and duplication of services as well as wastage of manpower and resources," Mrs Putter said.

'Healthcare for all' is ANC policy

Own Correspondent

DURBAN. — The need for affordable and accessible healthcare for all people was central to ANC policy on pharmacy in a future health system, the organisation's drug policy commissioner said yesterday.

Dr Mano Chetty told the Pharmaceutical Society of South Africa's annual congress here that the ANC envisaged a strong public sector in the national health service.

CT 11/5/93

The price of drugs was "inordinately high" in South Africa, which might even be the third most expensive country in the world for drugs.

The ANC was looking at the possibility of including price controls as a function of the regulatory authority.

Govt wants cheaper medicines

DURBAN. — Pharmacies would have to sell medicines more cheaply if they wished to play a role in the future South Africa, the director-general of health, Dr Coen Slabber, said yesterday.

Dr Slabber told the annual congress of the Pharmaceutical Association that the government was under increasing pressure from medical aid schemes to let them dispense their own medicines.

The government would support this if it meant cheaper medicines.

The president of the Pharmaceutical Manufacturers Association, Dr Hugo Snyckers, said nearly 30% of benefits paid by medical aid schemes were on medicine. — Own Correspondent, Sapa

Development post for top Soweto man

Sowetan 10/5/93

■ **Dr Motlana rewarded for promoting small sized families:**

TOP Soweto medical practitioner Dr Nthato Motlana has been appointed chairman of the Council for Population Development.

The announcement was made on Friday by Population Development Minister Mr Jac Rabie in Pretoria.

According to the Department of Population Development, Motlana is an ardent advocate of the establishment of small families as a norm in South Africa to curb the rapid population growth and to improve the quality of family life.

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Lifesaving jabs too dear for poor kids

(85) ARG-8/5/93

■ A vaccination against a bacterial infection that causes meningitis and pneumonia in infants is soon to be released in South Africa, but despite its obvious benefits, the cost is prohibitive.

ANDREA WEISS
Weekend Argus Health Reporter

A VACCINE about to be released on to the South African market could prevent death and disability of infants under the age of two — the highest risk group — from Hib disease.

But public health authorities are unlikely to be able to prescribe the vaccine because of its cost.

Dr Greg Hussey, head of the paediatric infectious diseases unit at the University of Cape Town, has found that one in 250 city infants is at risk of getting Hib (Haemophilus influenzae type b bacteria).

Of those who do, one in 10 is likely to die.

Dr Hussey believes the odds are high enough to be a major public health concern and to rank Hib on a par with tuberculosis.

Among syndromes caused by Hib, meningitis and pneumonia rank as the most serious. Apart from death, complications from meningitis include permanent brain damage, epilepsy, behavioural disturbances and schooling problems. Children who have had pneumonia may develop chronic lung damage.

Although meningitis is also caused by other bacterial and viral infections, Hib is one of the leading causes.

In Cape Town, it was found the disease affected mainly infants, with 90 percent of cases occurring in children under two. Researchers estimate that given the under-diagnosis of the disease, it was probably as common among black children in the metropolis as TB.

While the disease has long been known, only recently have effective vaccines been developed for infants. Five years ago, the "second generation" vaccines, called "conjugated" vaccines were developed for this age-group.

A Hib vaccine would be extremely valuable in Cape Town where one of the prime risk factors for the disease — overcrowding — is an enormous socio-economic problem.

Dr Hussey said although nobody in public health would deny the importance of the vaccine, it was likely to be prohibitively expensive. In the United States the vaccine costs around R150 for three injections.

Although this group of vaccinations could easily slot into Cape Town's existing vaccination programme it would cost the city around R7 million a year to vaccinate 45 000 babies born here annually.

By comparison, the current series of three DPT injections, polio drops and a measles injection together cost about one tenth of what the Hib vaccine would cost.

Dr Hussey said: "The problem is a shrinking budget. The cake has to be sliced and there are other priorities. The question is can the state afford it?"

He added that the R7 million should be weighed against the enormous costs of the deaths and disability for which Hib was responsible.

The vaccine is part of the public health programmes of 15 developed countries. Finland has virtually eliminated Hib disease.

There is hope on the horizon. Vaccine for the Hepatitis B virus, an illness which can lead to liver cancer, initially cost around the same as the Hib vaccine — but is now available for around R10.

'Dignity for all' campaign launched

TOMORROW is World Red Cross Day and will be celebrated with the launch of the "dignity for all" campaign run by the South African Red Cross Society.

The "dignity for all" campaign has already been endorsed by leaders across the political spectrum in the country.

Resuscitation demonstrations, street collections and jumble sales have been organised countrywide.

African National Congress president Mr Nelson Mandela said in a statement of endorsement before leaving on an overseas his trip: "As president of the ANC, I fully endorse the Red Cross 'dignity for all' theme and campaign ."

National communications officer of

■ World Red Cross Day celebration endorsed:

the Red Cross Mr Derrick Thema said: "The Red Cross is the only organisation that can foster tolerance and dignity for all because of its history of impartiality and neutrality."

A statement by leaders, including *Sowetan* Editor Aggrey Klaaste, Mr Justice Richard Goldstone, Archbishop Desmond Tutu and Dr Zach de Beer, said: "At this crucial period in the history of our country we pay tribute to the Red Cross movement, whose humanitarian ideals embody the essence of what we want South Africa to be."

Sangomas 'set for State talks'

(85)

THE Traditional Healers Council was ready to negotiate with the Department of National Health and Population Development, National Health Minister Dr Rina Venter said. ARG 6/5/93

Replying to a question from Mr Mike Ellis (DP Durban North), she said she had been giving consideration to the inclusion of traditional healers in the restructuring of the health-care system. — Sapa.

Star 2/5/93

Arguing about health

(85)

Everyone knows that health in South Africa is in crisis, and that a new health policy must be adopted. How close to agreement are the major political players in terms of what that policy should be? And will health become politically significant in the country's first democratic elections? Health Writer DAVID ROBBINS reports.

SOUTH Africans are preoccupied with health matters. On the list of socio-economic priorities for millions of people, better health care is superseded only by the need for job creation, improved education and affordable housing.

It's a sad reflection on the current situation in health that even young people see improvements to health services as of crucial importance.

The current situation can be readily glimpsed by looking at the results of recent research undertaken by an organisation called the Health Systems Trust. After holding 10 workshops with health workers and community organisations throughout the country, the most critical areas for change in the country's health services were identified as:

- The fragmentation of existing health services.
- Poor community participation in planning and management.
- The inequity of services and resources provided to various sectors.
- And the inaccessibility of health care to many segments of the population.

To take these areas in turn, no one seriously believes in fragmentation any more. From a position where health care authorities were hamstrung by the fallacies of separate development and "own affairs", the need for a single department of national health is now widely accepted.

The ANC has long advocated a single health authority, while the Government's recent Steinmetz Commission has been looking at the reincorporation of the homeland health departments into a unified national arrangement.

On the issue of the level of regional power under a national department, however, there are some differences of opinion. The Government is leaning towards high regional autonomy, the ANC to a more integrated approach, with the accent on maximum community involvement.

TPA health planners have worked out a health delivery system based on autonomous regional hospitals, with other regional and community hospitals and clinics referring to it.

An example is the system centred on Bethal Hospital, to which the hospitals at Standerton, Ermelo and Piet Retief refer as other regional hospitals which, in turn, support such community hospitals as Amajuba-Gedenk at Volksrust and the Elsie Ballot at Amersfoort.

But this level of autonomy, based on and motivated by financial viability, is sometimes seen as a last-ditch attempt to preserve the political notion of a local option.

The need for strong national policy guidelines is always emphasised by the ANC and others.

And perhaps the most crucial difference between the ANC and Government here is the former's perception that health care should be seen as part of overall community development, rather than something which is provided from above.

The ANC says: "The provision of equitable health care should be guided by the aspirations of our people, and should be based on full community participation.

"There should be more community involvement," says a voice from the TPA, "far more than in the past. But sight should not be lost that the institution is not only for use by a specific community, but is part of a structured health chain."

Interesting differences here, as when one looks at the problem of the inequity of South African health care delivery. How is the imbalance to be corrected. Listen to the main players again.

The then Department of National Health and Population Development said in July last year that "the only way to provide an affordable health service ... is by means of a partnership between the State and the private sector ... with the emphasis on primary health care" as set out by the World Health Organisation (WHO).

The ANC also espouses the WHO-style Primary Health Care (PHC) approach.

"This approach," says the ANC in its health policy guidelines, "is essentially that of community development."

Closely allied to the inequalities in the present health care system is the issue of accessibility. On a geographical level, it is hoped that the PHC approach will so increase the network of clinics and other facilities that no one, in particular from among the millions of people living in rural areas, will be left without access to health care.

But financial accessibility is equally important, and it leads to the whole debate on how a new health policy is to be financed.

There are various methods used internationally for financing health care. The first is a national health service (NHS) financed by taxation, as in the United Kingdom, where 94 percent of all health spending is in the public sector. The second is via the private sector and medical aids, as in the United States, where millions are unprotected.

The third is a National Health Insurance Scheme where a fixed percentage for health insurance is deducted from individual salaries and wages. The scheme can be administered by government agencies as in Canada, or by private companies as in Germany.

The current reality in South Africa is a mixed bag of public and private health spending. The State spends R11 billion, while a further R8 billion is spent through the medical aids, and around R3 billion in direct over—the—counter payments.

Most, but not all, of the private sector spending is for the benefit of white urban dwellers while rural blacks, especially those in the homelands, have been seriously neglected.

Nowhere is the debate sharper and opinion more divided than over the financing of our future health policy.

The ANC wants to mobilise sufficient funds to ensure free and equal access to essential health care. What exactly "essential health care" is, is currently being debated, and the financial implications of various basic packages are being worked out.

There have been suggestions that the State subsidy, in the form of tax relief, on medical aids be withdrawn, in an effort to mobilise more funds for the public sector. Such suggestions are called irresponsible by the private sector.

On the other hand, the ANC does envisage "active co-operation between the two sectors". It could hardly do otherwise. Thanks, at least in part, to the efforts of black trade unions, more than a million black employees currently enjoy medical aid benefits.

How the health policy of the future is ultimately shaped will depend not only on the planners and the new breed of administrators waiting in the wings. Health will also become a major political issue as the country prepares for its first democratic elections.

Recall for a moment those priorities in the minds of millions of the electorate: better education, job creation, housing and health. Any future government is going to find itself under severe pressure to deliver on these issues — all of which will dominate the election campaign.

But only in the sphere of health care, say many observers, can rapid and visible improvements be made.

"We can't move to a new health system overnight," says a spokesman for the ANC health desk. "It'll take at least five years. But we can show real improvements in health care delivery in much less time than that."

This pressure from the electorate will encourage a pragmatic approach and should help quickly to refashion the country's health care system into one which more effectively serves the needs of all the elements of a diverse population. □

Not for the money: Volunteer workers explain why they do it

(85) ARG 1/5/93

A caring contribution

■ Next week is National Volunteer Week, when the contribution of hundreds of volunteer workers will be celebrated. Weekend Argus spoke to a few volunteers, to find out what motivates them.

LIBBY PEACOCK
Weekend Argus Reporter

THEY come from different corners of the Peninsula and different sections of society, but Quinton George, Shirley Epstein and Christina Booysens have one thing in common — they all do volunteer work.

Next week is National Volunteer Week, when the contribution of South Africans who volunteer their time and skills to welfare, health and community organisations will be celebrated.

Mrs Trish Sterling, co-ordinator of Cape Town's Volunteer Centre, said the contribution of volunteers probably ran into millions of rands every year.

Weekend Argus visited several to find out what drives them.

Mrs Christina Booysens is the convenor of a group of "home nurses" who do volunteer work for a community centre in Belhar, where about 117 senior citizens meet on Mondays, Wednesdays and Thursdays.

Activities include games, religious services and occupational therapy.

Volunteers also visit bedridden patients at their homes.

Mrs Booysens, mother of two and grandmother of four, has been a volunteer for twelve years.

She said: "I go out of my way where I can help an elderly person. I have no other job. I feel happy when I make others happy and I've never been disillusioned. Every day is a new challenge.

"It's a pleasure to serve my community."

Another volunteer is Mrs Shirley Epstein, who owns a garden nursery in Sea Point.

She spends many an evening teaching illiterate people — mostly domestic workers — to read and write.

Mrs Epstein became involved with the Maryland Literacy School, which has units all over the Peninsula, more than four years ago.

The students pay only R2 a term each. "We're not a money-making organisation," she said.

Cape Technikon student Quinton George listened to a sermon at the Vineyard Church one day and realised he had to become involved with volunteer work.

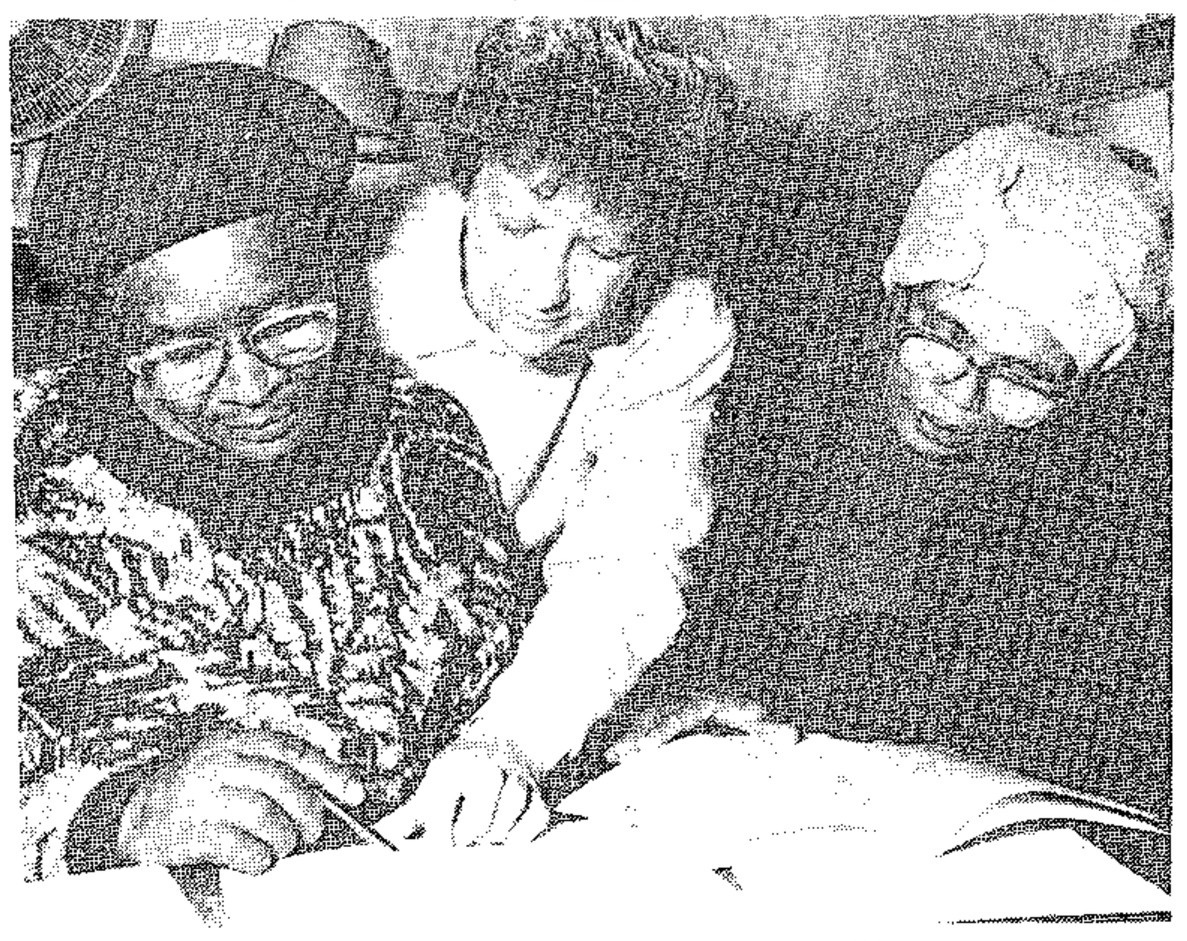
"I have always felt terrible about the masses of unemployed people in our country. I went to the Triple Trust Organisation (a non-profit organisation which trains people to become self-employed in the informal sector) and said I wanted to become involved."

He now works as a volunteer mentor to a widow from Khayelitsha, who has set up her own business as a seamstress.

"I am her link to the white collar sector. As a mentor even one's knowledge of how to use the telephone directory could help.

He said it was important for volunteers to realise that they were dealing with people's lives. "You just have to have the heart to do it, more than the ability. Then you'll be able to spend that extra time."

Volunteer Week activities include mayoral receptions in Cape Town and Bellville to honour volunteers, a tea at Zeekoevlei Yacht Club and a workshop for new volunteers.



Pictures: DOUG PITHEY and LEON MÜLLER, Weekend Argus.

☐ **HAPPY VOLUNTEERS:** Belhar community project convenor Mrs Christina Booysens, middle, front, in a happy mood with Mrs Janette Hendricks, left, front, and Mrs Rubena Barron. In the background are other volunteer "home nurses" and Belhar senior citizens.

☐ **EAGER READERS:** Volunteer literacy teacher, Mrs Shirley Epstein, with two "learners".

Prescription for healthy profits

(85) ARG 1/5/93

■ Carefully selected "bargain" acquisitions, keeping overheads at a minimum and an with anti-overdraft philosophy, play a key role in keeping Cape Town-based healthcare company Macmed on the path to sound profit growth.

MARC HASENFUSS
Business Staff

MACMED Healthcare remains well inoculated against the crippling recession virus and shareholders can expect another dose of above average profit growth in the year ahead.

In an interview this week chief executive Don McArthur predicted growth of between 35-40 percent in attributable profits in the year to end December 1993.

Cape Town-based Macmed distributes bandages, syringes, surgical gloves, braces, disinfectants and other medical supplies through five business units: Wound Care, Vascular Access, Infection Control, Operating Room and Speciality Products.

Mr McArthur emphasised that 1993 would be a year of well focused and calculated growth for the Cape Town medical suppliers. "Trading for the four months to end April has been good and the group is still on track to reach the expected growth target."

Carefully selected "bargain" acquisitions have played a key role in keeping Macmed on the growth path.

"In our acquisitions we go for value . . . especially those businesses that are struggling. Our recent acquisitions cost us feathers."

Mr McArthur said the size of the acquisitions meant the group always "adopted" a smallish staff, minimising group overhead costs.

"We have to take advantage of the current economic climate and maximise the benefit to the group by getting value in our acquisitions. We are constantly on the lookout for bargains."

Last month the group finalised the buyout of Procare for R180 000 cash. Mr McArthur said Procare was looking at a R5 million turnover this year. "The division could turn into a powerhouse given what we paid for it".

Mr McArthur said Procare had the technology to manufacture procedural trays for use in private hospitals. These trays contain a complete kit for all sterile usage in an operating theatre.

The procedural trays cut down on pilferage, reduce inventory and provide an accurate billing method for patients.

Last year the group gained a foothold in the Vascular Access market through the acquisition of Hygenico for R76 600. Macmed also strengthened its surgical glove business by buying out Rosstex for R1,7 million.

A rights issue of R4 million has been proposed to fund the strong organic growth prospects in the coming year and maintain the company's low gearing.

Mr McArthur points out that the philosophy of the group is anti overdraft — "we do not like to have any borrowings".

He said Macmed had set a 10 percent ceiling for gearing. "Ultimately we are aiming at no gearing whatsover".

The group has honed in on private hospital development and much of the group's future growth is expected to be generated in this sector.

Private healthcare business affords the group a good set of profit margins but also sets new parameters in higher service levels, improved quality and specific product requirements.

"So far we have been very successful in securing private hospital business and over 60 percent of our organic growth has come from this sector."

The group also distributes supplies to southern African countries on behalf of its principals. Macmed's market in Africa — in agreement with its principals — any country south of the 16th parallel.

The group already holds a number of contracts with Zimbabwe and also exports to Zambia and Botswana. Mr McArthur said the group planned to set its own offices up in Harare and Lagos, Nigeria in the next six months.

Exports to southeast Asia are also currently under consideration.

Although Macmed is keenly priced at around 75c, a considerable premium to its net asset value of 15,4c a share, investors will battle to obtain the tightly held stock.

Mr McArthur concedes that the share is too tightly held and that more paper in issue is needed to enhance tradeability.

However, he believes that the share will find its proper value after the rights issue is finalised.

5% pay offer 'a threat to health care'

The Argus Correspondent

PRETORIA. — The Medical Association of South Africa has warned that medical care could be severely jeopardised by the government's non-negotiable five percent salary increase.

Professor Ralph Kirsch, chairman of Masa's full time practice committee, said yesterday that the impasse between the government and the Public Service Caucus — which has declared a dispute — would be detrimental to health services.

"Every possible effort should be made to create a working enviroment which will retain health professionals," said Professor Kirsch.

"Masa is most perturbed by the government's rejection of the Public Service Caucus's demand that the five percent increase should be applicable to allowances as well as basic salaries.

"To ignore these perfectly reasonable demands is unfairly discriminatory against certain categories of employees," said Professor Kirsch.

As these allowances formed a significant part of doctor's salaries, they would receive an increase of between only 3,7 percent and 4,2 percent.

Professor Kirsch suggested that taxes on products which result in disease, such as tobacco and alcohol, should be increased and this income be dedicated to improving health care.

He said a state health lottery should be introduced urgently.

(3) whether he will make a statement on the matter? B689E

The MINISTER OF MINERAL AND ENERGY AFFAIRS:

(1) During 1992, 75% of all petrol sold in the Transvaal was manufactured by Sasol's synthetic plants. If Sasol's production through the Natref crude oil refinery (in which it has a 63,64% shareholding) is added, the volume of petrol manufactured by Sasol as a percentage of sales in the Transvaal increases to 90%. A portion of Sasol's fuel production from crude oil is also sold in the Free State, Northern Cape and Northern Natal.

(2) Sasol and Total, the latter having the balance of shareholding in the Natref refinery, who supply almost 100% of the fuel sold wholesale in the Transvaal, are responsible for the cost of distributing these fuel products by pipeline and other modes of transport from their plants in Secunda and Sasolburg to the various depots which constitute the total market.

(a) Detail regarding specific cost elements is company confidential information.

(b) Falls away.

(3) No.

Medicine: parallel importation

*6. Mr M J ELLIS asked the Minister for National Health and Welfare:

(1) Whether, with reference to a press conference held by her on or about 11 March 1993, she intends proceeding with allowing the parallel importation of medicine; if not, why not; if so, (a) for what reasons and (b) what does the parallel importation of medicine involve;

(2) whether the same registration requirements will apply to parallel imported medicine as are applicable to locally manufactured medicine; if not, why not;

(3) whether steps will be taken to combat the importation of counterfeit medicine; if not, why not; if so, what steps;

(4) whether the economic and legal implications of parallel imported medicine have been assessed or will be assessed before parallel importation is allowed; if not, why not; if so, what are the relevant particulars? B690E

†The MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) Yes,

(a) parallel importation is already possible as the Medicines and Related Substances Act, 1965 (Act 101 of 1965) does not prohibit this and

(b) a parallel imported medicine involves the registration of that medicine, which is the same medicine as that already registered by the original applicant for use in South Africa, by a different applicant. The parallel imported medicine should also originate from the same manufacturing facility as the previously registered medicine, or from manufacturing facilities belonging to, or falling under the control of the parent company;

(2) no, because parallel imported medicines are the same medicines as those which are known in South Africa; the data of which are already on file with the Registrar of Medicines. Regulation 15, which sets out the format of an application for registration, will have to be amended accordingly;

(3) no, no specific steps are necessary as the medicine registration process lends itself to the combating of the importation of counterfeit medicines;

(4) no, the legal implications have not been assessed as these are the responsibility of the applicant in each case. The economic implications are under discussion at the moment.

Air pollution

*7. Mr M J ELLIS asked the Minister for National Health and Welfare:

(1) Whether air pollution reached unacceptable levels (a) at any city centres and (b) in any regions in the Republic in 1992; if so, at which city centres and in which regions;

(2) whether any steps were taken in this regard; if not, why not; if so, what steps in each case? B691E

The DEPUTY MINISTER FOR NATIONAL HEALTH AND WELFARE:

(1) (a) and (b) Yes,

Cape Town, Vaal Triangle region, Edenvale, Kempton Park and Modderfontein region, as well as unelectrified urban areas;

(2) yes,

Cape Town:

The nitrogen oxide levels were exceeded a number of times. Monitoring of the pollutant concentrations and research into the occurrence thereof are being carried out. The pollutant mainly originates from motor vehicles. Control thereof by means of catalytic conversion will be considered when lead-free fuel becomes available.

Vaal Triangle region:

High levels of particulate pollution are experienced during the winter months. Research is carried out to identify the main sources. Improved control of industrial sources is being continued but smoke from domestic coal combustion can only be reduced by the use of alternative forms of energy such as electricity.

Edenvale, Kempton Park and Modderfontein region:

An excess of particulate pollution was experienced a number of times. Investigation into the sources causing the high levels is being carried out. Industries in the area are, however, still engaged in reducing their emissions.

Unelectrified urban areas:

No control can be exercised before alternative forms of energy such as electricity are in general use. Investigation into alternative fuels which will be less polluting are also being carried out.

Goldstone Commission: reports

*8. Mr L FUCHS asked the Minister of Justice:

(a) How many reports of the Commission of Inquiry regarding the Prevention of Public Violence and Intimidation (Goldstone Commission)* have been submitted to the State President to date and (b) what is the title of each of these reports? B692E

The MINISTER OF CORRECTIONAL SERVICES (for the Minister of Justice):

(Reply partially laid upon the Table with leave of House):

(a) Nineteen (19).

(b) 1. First Interim Report.

2. Interim Report on the Violence at Mooi River.

3. Report of the Second Committee appointed to inquire into the Violence at the President Steyn Gold Mine in Welkom.

4. Second Interim Report.

5. Report to the Commission of Inquiry regarding the Prevention of Public Violence and Intimidation from the Committee established to inquire into the involvement of 32 Battalion at Phola Park.

6. First Interim Report to the Commission by the Committee investigating Public Violence and Intimidation in the Taxi Industry.

7. Interim Report of the Committee appointed to inquire into Train Violence.

8. Second Interim Report to the Commission of Inquiry regarding the Prevention of Public Violence and Intimidation from the Committee established to inquire into the Taxi Industry.

9. Interim Report on the Violence in Hostels.

10. Report on the Bisho Incident.

11. Report on the Planning or Instigation of Acts of Violence by members of the South African Police in the Vaal Area.

12. Report on the Inquiry conducted by the Committee of Inquiry into the Violence at Tokoza.

Violence draining medical services

Star 22/4/93

By Paula Fray
Medical Reporter

SUN CITY — Violence is a major and unnecessary drain on South Africa's beleaguered public health sector, according to Pretoria University community health specialist Dr Lettie la Grange.

La Grange was speaking on "Medical excellence in Africa" at the 57th Medical Association of South Africa congress.

Assessing the impact of violence on health services in South Africa, she said victims of violence and assault constituted 49,23 percent of all trauma admissions.

In view of the fact that most trauma cases were seen in the public health sector, this cash-strapped arena was bearing the brunt of violence.

Over the past few years, acts of violence had become more serious, with the use of guns becoming more frequent.

Her view was endorsed by emeritus University of Natal Professor L W Baker, who said firearms were involved in 83 074 serious crimes last year.

A breakdown of crime statistics, Baker said, showed there were 77 murders, 68 rapes, 775 assaults, 219 robberies and 709 homes burgled each day last year.

Trauma-related cases cost South Africa R7,2 million a year. In addition, treating bullet wounds cost the public health sector R2,5 million a month.

Another trauma-related cost to South Africa was the continued high rate of road deaths and accidents. Baker said up to 75 percent of back seat passengers who died in road accidents would probably have survived if they had been wearing seatbelts.

A further cause for concern was the continued abuse of alcohol and drugs while driving.

In a recent survey 530 accident victims were tested for alcohol and marijuana. Of the 530, 289 (55 percent) were over the legal limit for alcohol; 186 (35 percent) tested positive for dagga and 99 (19 percent) for both.

Millions of world's children die needlessly

Star 22/4/93

TERRIBLE TOLL
Millions of children around the world die each year. Not from war, earthquakes or violence, reports **PAULA FRAY**, but from malnutrition, preventable diseases and inadequate basic health care.

MEETING the needs of all the world's children for adequate nutrition, clean water, basic health care and primary education would cost about R79 billion a year, according to the 1993 State of the World's Children report from the United Nations Children's Fund (Unicef).

And, reaching these goals would save the lives of more than 4 million children each year and help to lower birth rates.

Yet thousands of children die needlessly each day.

"The suffering of children in particular emergencies, whether in Afghanistan, Somalia or the former Yugoslavia, rightly occupies much of Unicef's attention at this time," says Unicef executive director James Grant.

"But it should never be forgotten that every day malnutrition and disease are tragedies on a far greater scale.

"No famine, no flood, no earthquake, no war, has ever claimed the lives of 250 000 children in a single week. Yet malnutrition and disease claim that number of child victims every week. And for every child who dies, many more live on with ill health, poor growth and illiteracy," says Grant.

There are some signs that the problems of the world's poorest children are beginning to be taken more seriously. In the 1980s, for example, immunisation levels have climbed from less than 20 percent to more than 80 percent — saving an estimated 3 million young lives each year and protecting many millions more from disease, malnutrition and disability.

"The immunisation achievement proves that it can be done," says Grant.

However, diseases that vaccines can prevent are still killing nearly 6 000 children every day in the developing world.

At present, almost 60 percent of the 13 million child deaths each year are caused by just three diseases: pneumonia, diarrhoea and measles — all of which can now be prevented or treated at very low cost.

Biggest killer

Pneumonia, with 3,5 million victims a year — is now the biggest killer of children in the modern world. In most cases, all that is needed is a course of antibiotics costing about R2,25.

Diarrhoeal disease kills 3 million children a year — a quarter of all childhood deaths. Life-saving oral rehydration therapy (ORT) is now used by one family in three and saves a million lives a year.

Vitamin A deficiency, which threatens up to 10 million of the world's children with blindness and early death could be controlled for about 90c per child per year.

Even traditionally more expensive propositions — adequate nutrition, clean water, safe sanitation and basic education — can be tackled at much lower cost because of new technologies and community-based strategies, says Unicef.

The R79 billion also includes making family planning services universally available — a service Unicef sees as vital for protecting the health of mothers and children as it is for slowing population growth.

The report argues that targeting particular problems, such as disease and illiteracy, is attacking causes as well as symptoms.

In South Africa, the battle has already begun. More than 15 000 cases of measles were reported throughout the country last year, according to the Department of National Health and Population Development.

Replying to questions on the state of South Africa's children, the department said a total of 15 056 cases of measles was reported for 1992. It said about 90 percent of the country's children have been immunised against the disease.

The department says South African children are vaccinated against polio, measles, tuberculosis, tetanus, diphtheria and whooping cough.

Research done in 1990 showed about 61 percent of South African children were immunised against tuberculosis, 81 percent against polio, 84 percent against diphtheria, tetanus and whooping cough and 90 percent against measles.

According to Unicef, high levels of routine polio vaccination and the absence of any reported polio cases in the western hemisphere during 1992 marked the first step towards the eradication of the crippling childhood disease.

However, while vaccines have cut the toll by 80 percent in the other half of the globe, polio still paralyses over 100 000 children each year.

According to the department, no cases of polio were reported in South Africa last year while only two cases were reported in 1991 and five in 1990. Since 1988, there have been 193 cases of polio in South Africa.

The Department of National Health has listed six priorities for taking care of South African children during 1993. These are:

- **To extend obstetric services so that more pregnant women can be attended to by health personnel during labour.**
- **To prevent tetanus neonatorum in children by immunising all pregnant women against tetanus.**
- **To promote the health of mothers by implementing a feeding programme and by placing more emphasis on family planning services.**
- **To promote the growth of children by placing more emphasis on breast-feeding.**
- **Continuing the life-saving oral rehydration therapy programme.**
- **Extension of primary health care services to disadvantaged communities through the establishment of clinic services.**

Worth the pain . . . nearly 6 000 children die each day from diseases that vaccines can prevent.

Govt 'busy deregulating health care'

Star 22/4/93

CAPE TOWN — The Government was busy deregulating the health care delivery system, and believed that any restrictive or protective measures which operated to the detriment of the consumer should be eliminated, Minister of National Health Dr Rina Venter said yesterday.

Speaking during an interpellation debate, Venter said the Government acknowledged its responsibility for the deregulation of the health care industry. — Sapa. (85)

Masa foot in Cama

Soweton 22/4/93.

■ African medical associations grace conference: (85)

THE 57th congress of the Medical Association of South Africa ended at Sun City, Bophuthatswana, yesterday with organisers claiming victory for having reached out to Africa.

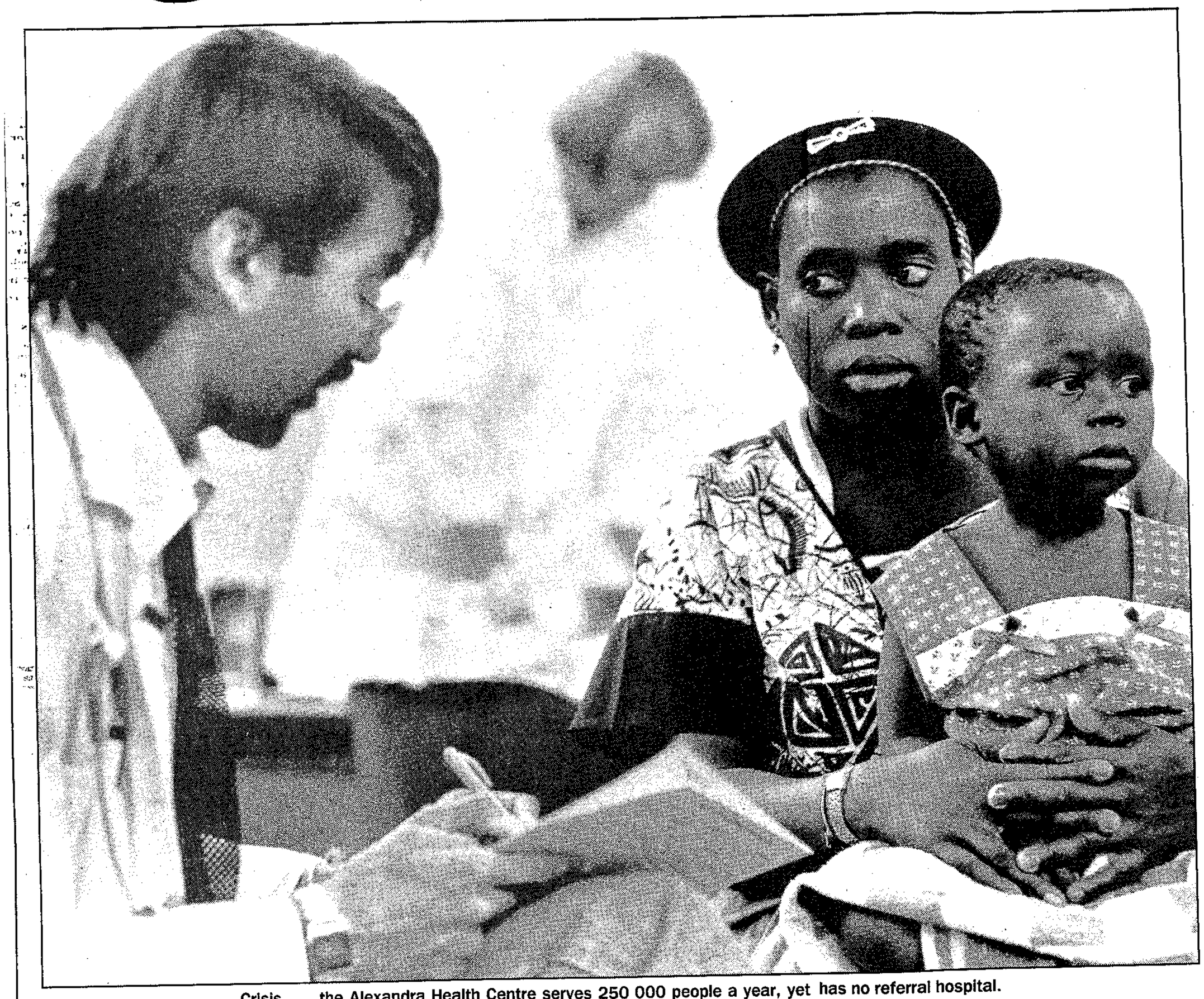
Representatives of other medical associations came from Nigeria, Tanzania, Kenya, Mauritius and Lesotho.

This sets the stage for SA to be accepted in the Confederation of African Medical Associations, which has banned South Africa from being a member.

Star 22/4/93

Fighting an unhealthy system

(85)



Crisis . . . the Alexandra Health Centre serves 250 000 people a year, yet has no referral hospital.

Amid the mourning and anger which overtook South Africa last week, one Witwatersrand community set out on a determined bid to secure improved medical facilities for all its members. The Star's Health Writer, DAVID ROBBINS, reports.

IN THEIR thousands, last Wednesday, they marched out of Alexandra town ship. They poured along Shakespeare Road in Lombardy East, then turned into Main and Wordsworth, and went singing down the hill to Edenvale.

The hospital gates were closed. The crowd assembled outside the perimeter fence. Then tear gas was in the air and grass by the roadside began to burn. But a petition had changed hands.

A man named Martin Mabiletsa said: "Yes, the petition has gone in. We want access to Edenvale Hospital. It's underutilised. Meanwhile, our people must die."

Mabiletsa is the chairman of the community board which controls Alexandra Health Centre and University Clinic.

"We lost a child the other day," he explained. "We couldn't find a hospital bed. An hour later an ambulance arrived to take the child to Tembisa. But by then it had died. Why can't we use Edenvale? It's nonsense."

Teeming

Alex Health Centre serves the primary health care needs of the quarter of a million people who live in teeming Alexandra. It's an efficient institution, but it's not a hospital.

Of the tens of thousands of patients it tends, about 5 000 a year need hospital treatment. And many of the 40 000 annual casualties also need hospital care. But which hospitals?

Alex Health Centre general manager David Robb talked about what he referred to as the "hospital referral crisis".

"We're supposed to be zoned to Tembisa, but the hospital there is 35 km away. That's a long ambulance ride. And, anyway, Tembisa is overcrowded. For at least two months now we've had literally nowhere to refer paediatric patients, especially those under two, and women with maternity complications.

"Yes, I can definitely confirm that there have been deaths relating directly to problems with referrals.

"Some hospitals are always very helpful, notably overcrowded Hillbrow and Baragwanath. But what is at fault here is the whole system."

"The current racial mix here," said Dr Mervyn Damelin, Edenvale's medical superintendent, "is 55 percent black, 45 percent white."

But only 108 beds are in use in a hospital which could hold 200, and of those in use the occupancy is normally around 80 percent. The hospital has five doctors and costs around R7 million a year to run.

"Its position, hardly 3 km from Alexandra, makes it ideal for conversion into a community hospital," said Robb. "These people marching today are certainly in need of it.

"So is the staff at Alex Health Centre. They waste hour after valuable hour on the telephone, trying to find a hospital to which to refer patients requiring special treatment."

But Damelin said that his staff also spent time on the telephone doing the same thing: "We simply don't have the facilities to become a full referral hospital for Alexandra, or anybody else."

But the Institute of Urban Primary Health Care, which is based at the Alex Health Centre, does not necessarily advocate primary health care at the expense of other levels of care.

A model for a health service structure, developed by the Institute, begins at the level of community health workers, environmental health services and clinics, which refer to community health centres (like the one at Alexandra), which in turn refer to community hospitals and to specialist hospitals beyond. Integration is the key.

And that is why the people of Alexandra marched. They want to see the under-utilised Edenvale Hospital integrated into the structure of health services available to them.

Perhaps they want it so badly that they are even prepared to endure the gas and smoke of open confrontation. Eight people were treated (at the Alex Health Centre) for gunshot wounds after the march on Edenvale.

What is the official response?

Direct

From Edenvale: "I have pointed out on many occasions that we are fully prepared to offer a more extensive service, provided that increased resources be made available to us," said Damelin.

And from the TPA health authorities who have this control: "Although the TPA managed Edenvale on an agency basis, it assumed direct control only on April 1 this year when the old 'own affairs' health departments were abolished.

"Our intention is to convert Edenvale into a regional hospital, one which serves the geographical area in which it is situated, including Alexandra. This will mean increased personnel and budget.

"We have now done a cost analysis, and our constraint is financial. Any assistance from the private sector in this regard would be greatly appreciated."

The TPA spokesman, Piet Wilken, explained that due to insufficient staff at the moment, it could happen that a patient with a private doctor and anaesthetist would be admitted while patients without these resources might be referred elsewhere. □

'Generous' TPA offers

Political Staff

DETAILS of the generous retrenchment packages offered to hospital workers in the Transvaal were disclosed in Parliament yesterday by Minister of National Health Dr Rina Venter.

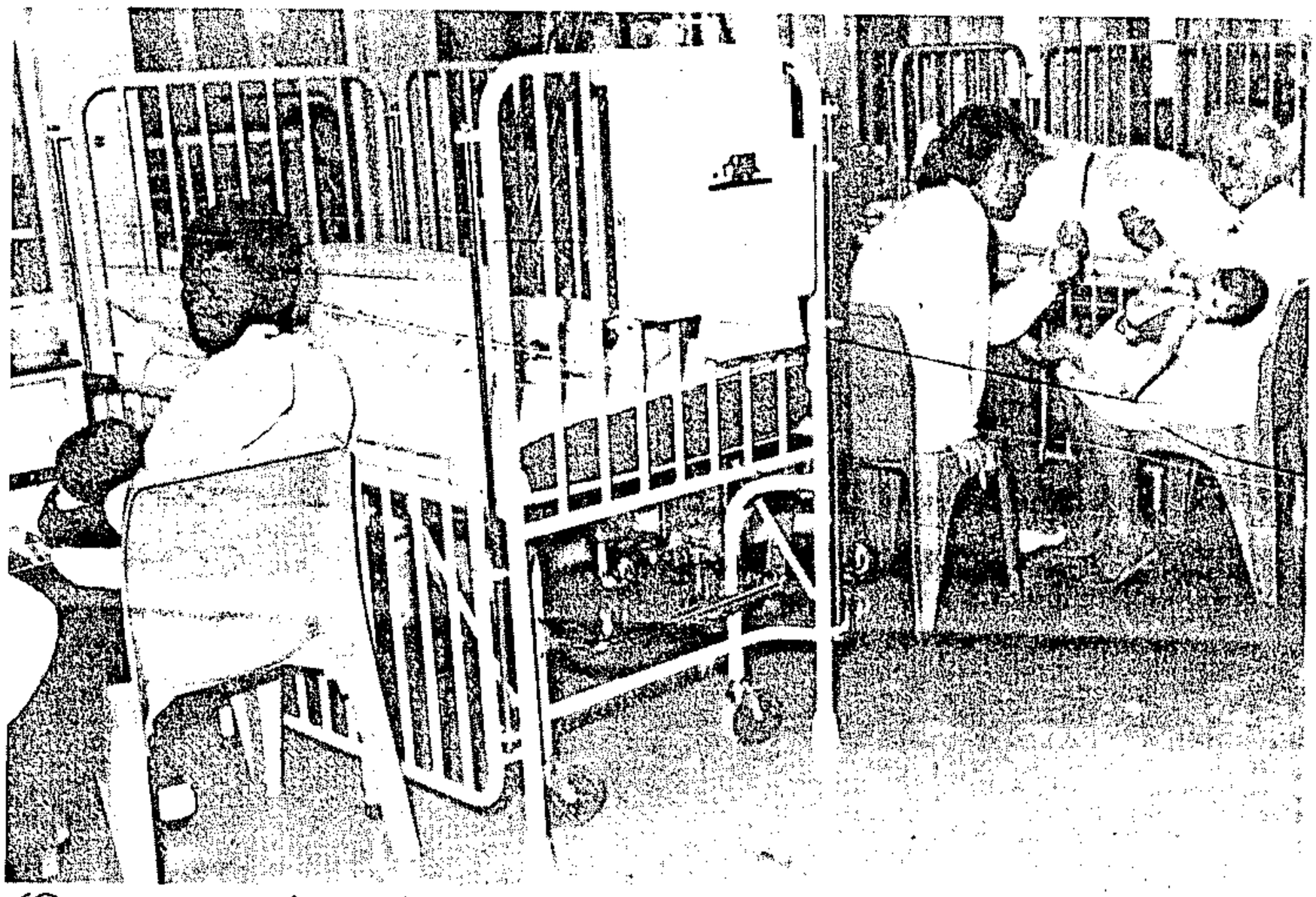
The packages included a cash amount equal to six times the monthly house owner's allowance.

However, Dr Venter said none of the 3 371 hospital workers' applications had been granted yet because in terms of the cabinet's directives, the entire Transvaal Provincial Administration should be reduced by five percent. The retrenchment of personnel in other branches of the TPA would be considered first.

CT 21/4/93

Not what the doctor ordered

The South African Health and Social Services Organisation (Sahsso) explains why it is opposed to the state's attempts to the restructure the health services:



FOR three decades, South Africa's health services have been fragmented because of the apartheid policies of the government, with disastrous consequences for health care in this country.

South Africa has had 14 "national health departments", a large provincial bureaucracy and multiple local authorities involved in providing health care, leading to enormous duplication and inefficiency.

There has been a bias towards curative services with, until recently, only five percent of state spending directed towards preventative health care.

Inequity has flourished under the present government's health policies, with 80 percent of the country's health expenditure going to the private sector which services only 20 percent of the population.

Rural and peri-urban health services have been neglected. For many years community participation has been a non-issue for central government which has been more concerned with providing resources for its electoral support base.

Recently, a number of significant changes have been taking place in the health sector. In the late eighties, the government committed itself to privatisation of health care.

It also introduced far-reaching, but flawed, legislation to rescue the ailing medical schemes industry. And teaching hospitals will soon become autonomous (from state control) and be forced to compete for their income.

At the same time, the quality of state health care has declined. Ordinary people are forced to use private health care which is largely beyond their means. The conditions and morale of public sector health workers has never been poorer, as a result of autocratic management.

The government has sought to absolve itself of responsibility for health care for the majority of South Africans. It has failed to develop a comprehensive approach for the provision of health care.

The health sector as structured cannot continue in its current crisis-ridden state. People's struggles for decent health care have forced the government to realise that it has to respond to the contradictions caused by its own policies.

We now see what we would never have expected years ago: the Department of National Health and Population Development is about to dissolve the tricameral health system.

'Secret committees have made recommendations on matters affecting the health care of all South Africans'

South 10/4 - 14/4/93.

It appears to be going to great lengths to initiate consultative forums on health care with a wide range of interest groups. In articulating the rhetoric of Primary Health Care (PHC), the government has indicated its intent to build clinics and to promote "community participation" in health care.

However, if we look more closely at the state's actions in this context, we identify many inconsistencies.

- It is clear that restructuring is not going to reincorporate the homelands health departments which carry the burden of illness in our country. A single health department in South Africa should be able to provide comprehensive and equitable health care to all South Africans at all levels. The recent health budget cut the allocation to homeland health departments.

Given the government's stated intention to reduce the wastage of multiple health departments, it is difficult to understand why the 1993 budget still includes the same allocation for staff salaries in the tricameral health departments.

- The process by which restructuring is to be effected illustrates the unaccountable style characteristic of government bureaucrats. There has been no consultation with any of the interested parties affected.

Secret committees have made recommendations on matters affecting the health care of all South Africans. The public has been denied the chance to contribute to or even scrutinise the process.

- The vision of real primary health care is comprehensive and seeks to empower people to achieve improved health status. The government is obviously out of touch with these principles.

"Community participation" has often meant that communities must pay for their health care, or must rubber-stamp the plans produced by the government.

The Department of National Health exhibits a handful of PHC projects for show, but resources for PHC remain scanty. It is also unacceptable that most South Africans still have no access to clean water and sanitation — basic requirements for health.

- Demands for the restructuring of the health services have been articulated by communities and progressive health organisations for many years, but the government remained indifferent.

Suddenly, the same government has expressed a need to restructure the health service. Why is this happening now?

It appears that this is part of an election strategy for the National Party, which has now appropriated many of the ideas emanating from groups opposed to apartheid health care.

Current moves to abolish racial and departmental fragmentation in health care are not sufficient to rectify the appalling state health services are in, particularly those in the public sector.

Viewed in the context of the government's arrogant commitment to restructuring, these moves were little more than a sop to the health care needs of our country.

To meet South Africa's health care needs, we require a fundamental reorientation in the process by which health policy is decided and implemented.

A future national health service must be founded on the PHC principles of equity and social justice and be structured to embrace meaningful consultation with communities and other parties over the nature of health care for South Africa.

Health care critically ill

ST Times 11/4/93

MIKE ELLIS says a new approach is needed if South Africa's ailing health-care system is to be rescued

(85)

HEALTH services in South Africa — public and private — are in a critical situation.

The fundamental facts are:

The public health system has been extraordinarily badly planned, is grossly under-funded and is in urgent need of restructuring.

The private system, which has developed alongside it, caters for the elite, is expensive and is regulated to the point of self-destruction.

The background is largely historical. The elite — originally the white population — had money and could afford its own health care through a system of medical schemes and health insurance.

Consequently, expensive private hospitals mushroomed during the apartheid years. Along with private pharmacies, and general and specialist practices, they catered for the elite 20 percent of South Africans who could afford them.

This system has now become severely strained. Many of the more than 200 medical-aid schemes in the country are in financial difficulties. They have stated that they expect to pay out more than R10-billion this year on claims, of which 25 percent will be fraudulent.

Add to this the problems of over-servicing and over-prescribing of expensive medicines by some professionals and the reasons for self-destruction become more apparent.

Measures of redress have been taken, but it is obvious that much more has to be done. The point is that health costs are spiralling in the private sector, pushing the service out of reach of a growing number of people.

But the real problems lie in the public sector, which caters for 80 percent of the population who cannot afford their own health care.

The lopsided provision of health care in this sector has its roots in history. By far the majority of people it serves are black, living in rural or peri-urban areas. Yet most state hospitals were built in predominantly white residential urban areas.

As a result, millions of black people have to travel hundreds of kilometres to receive medical treatment — whether for minor ailments or serious illness.

Another major flaw is that the system is based on cure rather than prevention. The rapid rise in the number of TB cases in recent months bears testimony. Curative health is expensive. It is doctor-based and relies heavily on costly medicines and hospital treatment. Add to this the cost of administering 14 departments of health and it becomes obvious that we have allowed the growth of a totally inadequate yet prohibitively expensive monster.

The problem does not end there. A system of unequal funding of the provincial health services has developed over the years to the extent that in 1992/93 the per capita allocation for each province was: Cape, R395; Free State R277; Transvaal, R250; Natal, R223.

This under-funding has left Natal in a parlous position. Major cuts have been made to the extent that hospital beds are being closed, 5 000 jobs are in jeopardy, vitally important AIDS services may have to be stopped — and that is just the tip of an already intolerable situation.

Last year, in spite of its greater per capita allocation, the Cape overspent its budget by R100-million while Natal balanced its books.

But the problems facing health care in South Africa are not insurmountable. The solutions do not lie in the short term in the development of a national health service. The country simply cannot afford it.

Spiralling costs in the private health sector must be controlled and the free-market system encouraged through greater deregulation.

But there is no doubt that public health needs the greater attention. It needs far more, and far more equitable, funding. A geographical per capita allowance patently does not work. Of even more importance is the need for restructuring, based on preventative health care.

There is a crying need to move away from the doctor-based hospital system as the first call for patients to a nurse-based, clinic system.

The proliferation of fixed and mobile clinics must be encouraged. Greater emphasis must be placed on health education.

In short, we need to take health care to the people. To make it available and accessible to everyone at a cost that the people and the country can afford.

□ *MIKE ELLIS is MP for Durban North and the Democratic Party spokesman on health.*

Expect 'big health cuts'

PROVINCIAL health services faced dramatic cutbacks unless enough money was made available, Cape Administrator Mr Kobus Meiring warned yesterday when presenting the province's R4,7 billion budget for 1993-4.

The total represented a 10,1 percent increase on the previous budgeted figure but was only 3,9 percent more than that year if the additional appropriation of R237 million was included.

He said the provincial system did not meet the challenges of the day because it did not represent the South African population.

PRIMARY HEALTH CARE

WORLD HEALTH DAY
7 APRIL 1993

SPECIAL SOWETAN FEATURE

Handle life with care
Prevent violence and negligence

R9774

Handle life with care

Sowetan 7/4/93 (85)

By Musa Zondi
Health Reporter

■ WORLD HEALTH DAY Preventing careless deaths through violence, negligence and lack of health facilities:

TODAY IS WORLD HEALTH DAY and the theme this year is *Handle life with care — prevent violence and negligence.*

An estimated 3,5 million people die each year throughout the world — with about one million deaths caused unintentionally, says the World Health Organisation.

"These deaths are not caused by disease but by injuries that are sustained through accidents and violence. These statistics do not include the many that are totally disabled and as many as ten times more partially disabled through loss of limb or eyesight," says the Department of National Health and Population Development.

In this country, the day comes against the backdrop of violence and turmoil. It comes against the backdrop of escalating crime which has claimed many lives. It also comes against the backdrop of an ailing health system where to be sick is a grave mistake.

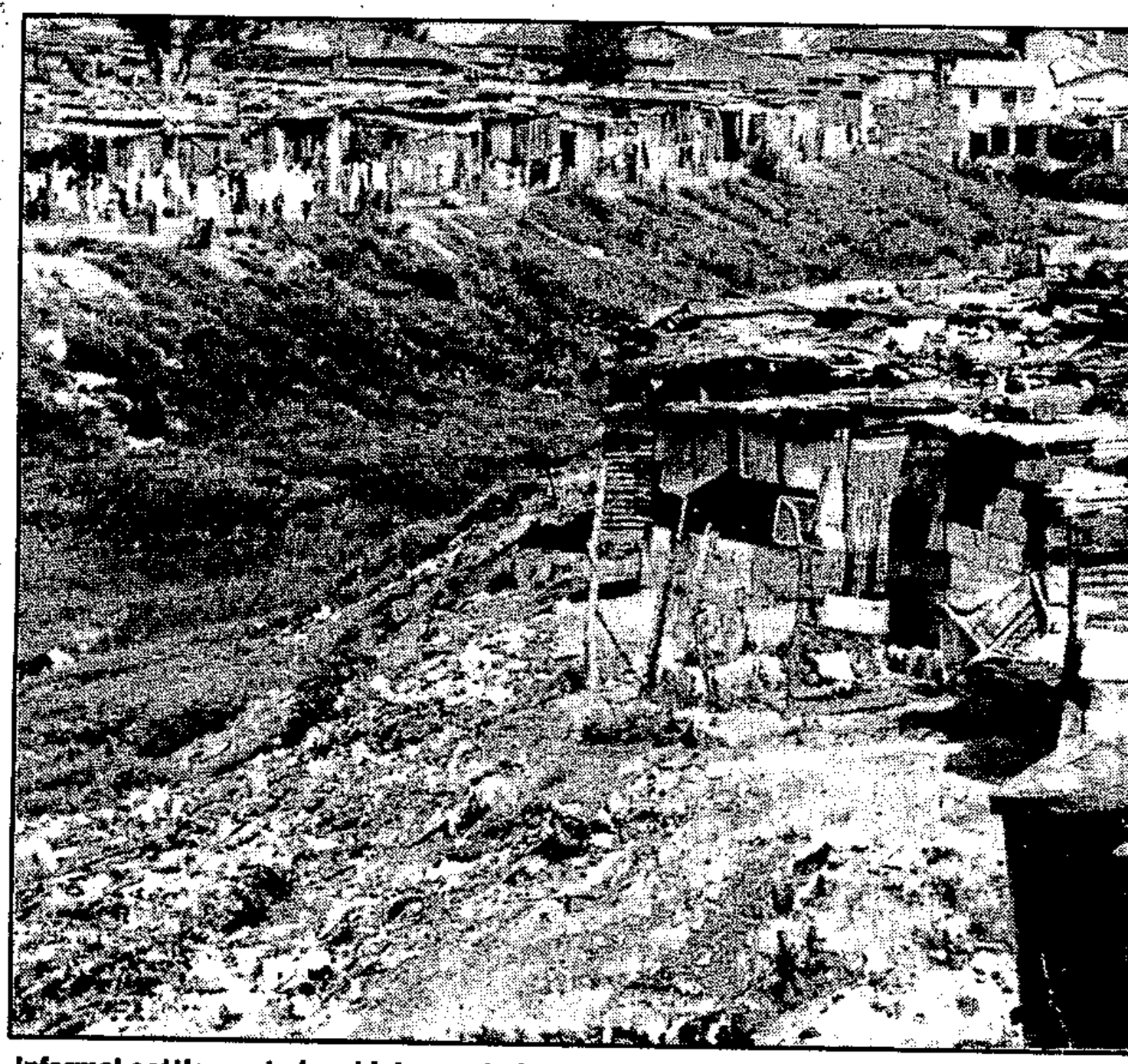
For many of our people in the rural areas, health care is still unattainable. This is no better for people who stay in the informal settlements, who have no jobs, no money or food. These people, who live in squalor and suffer from various diseases, do not have much hope in life.

According to the Central Statistics Service, "the total number of registered deaths in South Africa and self-governing territories for 1991 were 176 475. Nineteen percent of the total number of death registrations can be attributed to accidents, poisoning and violence," says the department.

"In this country, this day comes against the backdrop of violence and turmoil"

A lot still needs to be done to make health care more accessible to many South Africans. The posturing our politicians are engaged in at the moment will not help. We need to have a workable dispensation soon to address the imbalances, eradicate crime and the causes of ill-health. South Africans cannot wait.

Let us handle life with care.



Informal settlements in which people have to live is one of the greatest causes of ill these problems are tackled.

Trauma is one of main causes of death in SA

Health Reporter

SOUTH Africa has a disproportionate trauma problem.

This is the view of researchers funded by the Medical Research Council.

More than 16 percent of overall deaths occur as a result of injuries, compared with the World Health Organisation's comparable global figure of 5,2 percent.

In South Africa trauma is only superseded by circulatory diseases as a cause of death at all ages.

Vast after-hour services are needed to cater for the large numbers of trauma patients.

There are major service problems as more than 82 percent of patients are injured after office hours and more than half over weekends.

Researchers say that the trauma rate will also increase faster than the population.

● The first edition of a new publication providing facts and figures on the incidence of injuries in the Western Cape is being published today to coincide with World Health Day.

The new quarterly publication *Trauma Review* will be devoted to the prevention of accidents and injuries.

'Urgent bridging finance' needed to save health service

ANDREA WEISS
Health Reporter

URGENT bridging finance is needed to save the Cape health service from chaos and possible collapse, taking with it thousands of jobs in the health sector.

This is the grim picture painted by Mr Peter Marais, member of the executive committee of the Provincial Administration, in a dramatic appeal to parliament to provide "bridging finance" to stave off a projected shortfall of R402-million.

Unless further money is forthcoming, Cape health services are faced with hospital closures, abandoned projects, ageing ambulances, over-full wards, overworked personnel and an ever-increasing budget deficit.

Mr Marais said that a management plan drawn up by the province entailed "drastic steps" which might have to be instituted immediately. Among them:

- The immediate abandonment of 15 projects, including new services in Grahamstown, Khayelitsha 2 and East London;
- The closure of wards at Vredendal, Swellendam, Bredasdorp and Oudtshoorn hospitals, including the scrapping of the jobs of people who staff these wards;
- The closure of Tower Hospital in Fort Beaufort, where 600 people are employed, and the Sir Henry Elliot Hospital in Umtata;
- A delay in building extensions to hospitals at Beaufort West, Humansdorp, Knysna, Ladismith, Mossel Bay and Oudtshoorn;
- A R157-million cut in the budget to academic hospitals;
- The curtailment of services at Worcester, Paarl, George, Somerset West, Kimberley, East London and Port Elizabeth;
- The rationalisation of services at Worcester, Bredasdorp, Oudtshoorn, Riversdale, Beaufort West and Cape Town; and
- The loss of 149 vehicles in the province's fleet of 740 ambulances as these will have to be written off in the following book year.

He said the Cape had led the way by opening facilities to all South Africans and by introducing a strategic plan to bring primary health-care closer to the patients. Where other provinces had spent money on "beautiful roads and bridges", the Cape had built an efficient health service.

A strategic plan introduced in the Peninsula, which had included the closure of Woodstock Hospital's after-hour service, had made more jobs available in areas where they were needed. For instance, 24-hour services were introduced at Elsies River, Guguletu and Mitchell's Plain by making 86 additional posts available.

In Khayelitsha, an oral rehydration unit treated 780 sick babies who would previously have been sent to Red Cross Children's Hospital.

The strategic plan also envisaged the creation of a comprehensive Cape Flats service taking in areas such as Belhar No 1; Harare and Mayibuye in Khayelitsha, Brown's Farm in Philippi and providing a travelling health team for squatter communities.

The plan made services available at a lower level and closer to communities, preventing the academic hospitals from being flooded. However, the success of the plan rested on the development of regional hospitals such as Karl Bremer to act as buffers for the academic hospitals.

Health revamp

(BS) CT 7/4/93

Deep health cuts coming

By BARRY STREEK
Political Staff

DRAMATIC steps to take health to the people despite drastic cuts in government spending were revealed yesterday.

The MEC for health services, Mr Peter Marais, yesterday described the introducation last year of a plan for the Cape Peninsula, which included the closing of the Woodstock Hospital, as a turning point for expensive, hospital-based treatment.

Earlier the Administrator of the Cape, Mr Kobus Meiring, warned that although R2,27 billion of the province's R4,35 billion budget was allocated for health and hospital services, deep cuts in health spending were on the way.

Countrywide cuts in health budgets were announced by all four provinces yesterday.

Speaking in the Joint Committee on Provincial Affairs for the Cape, Mr Marais said the closure of Woodstock Hspital had enabled the authorities to start 24-hour medical services in Khayelitsha, Guguletu, Mitchells Plain and Elsie's River. The service in Khayelitsha could also be extended.

Mr Marais said the provincial administration was negotiating with the Western Cape Regional Services Council to provide joint services at Belhar, Harare and Mayibuye in Khayelitsha and Brown's Farm in Philippi as well as a travelling health team to serve the squatter communities of Philippi and Lansdowne.

However, his department's capital budget of R38 million had been halved.

Mr Marais said cuts in the health budget would result in the cancellation of 15 projects, extensions to various hospital postponed, wards closed and medical staff reduced.

The 15 projects included community health services at Khayelitsha 2.

Services at eight hospitals, including those at Somerset West, Worcester, Paarl and George, would be reduced.

The ambulance service was also threatened with a R7 million cut.

Last night, the professor of medicine at the University of Cape Town's Medical School, Professor Ralph Kirsch, said it was premature to cut the budgets of hospitals like Groote Schuur and Tygerberg before the primary health system was working properly.

● More reports — Page 5

GRIM EVIDENCE . . . Police Constable Quinton Roberts shows clothing and a ladder found at Bridgeville Primary School near the body of murdered Charlotte Hendricks, 16. The ladder may have been used to assault the girl. **INSET**: Charlotte Hendricks. Picture: ANNE LAING

City schoolgirl brutally murdered

By JACKIE CAMERON
Crime Reporter

THE naked, bloody body of a 16-year-old schoolgirl who had been stabbed at least 20 times was found in the grounds of a primary school near her Bridgetown home yesterday.

Charlotte Hendricks was found sprawled on her back by a boy, aged 12, police said. A metal ladder that may have been used in the attack was found nearby.

Police said there was a "strong possibility" Charlotte had been raped and sexually assaulted in the grounds of Bridgeville Primary School where her body was found around 10.30am.

A crumpled navy-and-white polka dot skirt, red blouse and jacket lay in a heap next to Charlotte's fragile body. She had been dead for at least 10 hours, a detective said.

Charlotte was last seen alive on Monday evening when four boys saw her crying among a group of men, aged around 20, on the steps of Bridgeville Primary School.

The frightened boys, all aged under 16, shouted at her to "run away", then ran from the school and reported the matter to a woman in a nearby house, a police spokesman said. He added that police were not contacted about this incident.

Charlotte's aunt, Mrs Maria Hendricks, said the family last saw Charlotte when she "waved goodbye happily" on Saturday before walking to her final confirmation class at a church in Silvertown.

When she had not returned by late Saturday night she was reported missing. No arrests have yet been made.

'Primary care must function'

cr 7/4/93 (85)

Staff Reporter

IT was premature to cut the budgets of hospitals like Groote Schuur and Tygerberg before the primary health system was working properly, the professor of medicine at UCT medical school, Professor Ralph Kirsch, said yesterday.

An enormous number of patients were still going to teaching or regional hospitals for primary care.

"I have no doubt that it is better to look after you close to where you live, but it's no good sending away the chap who has taken a taxi all the way from Khayelitsha. By the time he gets back, the day hospitals will be closed."

He was not convinced that there was no more money available for the authorities to spend on health. According to a South African Budget speech, levying an extra cent on every tobacco and alcohol transaction would generate R80 million.

An extra 20c or 30c on each packet of cigarettes or bottle of alcoholic beverage should generate enough money to fix up the health system, Prof Kirsch said.

"There is also the option of a lottery, on which they (the South African authorities) are dragging their feet."

To retain people who could train medical doctors, one had to have excellent training centres with diverse abilities and experience.

If doctors were not trained well, the health system could become terribly expensive because of mistakes and unnecessary tests.

It might be possible to argue that some overseas institutions concentrated too much on keeping elderly dying people alive for as long as possible with expensive medical equipment, "but here we don't even have enough artificial kidneys to go around for young, healthy people".

Groote Schuur budget 'pathetic'

Political Correspondent

GROOTE SCHUUR Hospital was being dragged down from the previous heights of excellence by a lack of proper equipment, the MP for Groote Schuur, Ms Dene Smuts, said yesterday.

"The pathetic sum of R7 million a year has been available to the hospital for equipment for the last few years. With the R450m replacement cost of the equipment, it would take 60 years to replace at current levels of funding," she said in the debate on the Cape Provincial budget.

Ms Smuts congratulated the CPA on improved hours and services at day hospitals and clinics at Khayelitsha, Guguletu and Mitchells Plain.

"It is shameful that Mitchells Plain, a city the size of Bloemfontein, was built without a hospital," she said.

Aids cuts a path through SA

Sowth 3/4-7/4 193.

By Wilson Carswell, WorldAids

AIDS in South Africa is set to follow the devastating path taken by the disease in the rest of the continent.

As in other parts of the world, the Aids pandemic is made up of several small epidemics. The first was as early as 1982 and affected white men who had sex with men. The number of reported Aids cases among gay men has now reached an all-time low, suggesting the number of new HIV infections is dropping, probably in response to community-generated Aids education.

But the heterosexually-acquired Aids epidemic is increasing.

There is little evidence that HIV was present among heterosexuals before 1987. Since then it has spread at a rate similar to that in other eastern and central African countries.

South Africa shares some of the conditions which have led to the explosive spread of Aids in the continent, such as a high prevalence of sexually-transmitted diseases (three million cases a year) which facilitate HIV transmission.

Because of the time lapse between HIV infection and Aids, the current number of Aids cases (1 295) only represents the epidemic's past.

The present is determined by extensive surveys from a number of groups — from blood donors to pregnant women — and the results are sobering. By the end of 1991, about 180 000 people were infected with HIV, increasing by about 400 people a day.

There are wide variations, depending on gender, ethnic group and geographical location.

In Natal, over 2,8 percent of young adults had HIV infection in 1991, while in the Cape Province the corresponding rate was under 0,4 percent.

Among women attending municipal clinics in Johannesburg, more than one in seven have HIV. One in eight newly-diagnosed female tuberculosis patients are HIV-infected.

Generally, as in other African countries, women are infected more readily and at an earlier age than men. Among prospective blood donors in 1991, 1,06 percent of black women had HIV against 0,71 percent of black men.

By contrast, only two out of 22 400 prospective white female blood donors had evidence of HIV infection. This ethnic disparity is also visible in the results of a 1991 survey of 17 000 pregnant women attending antenatal clinics. Overall HIV prevalence was 1,49 percent, but among African women the rate was 1,84 percent and among white women nil.

Short-term projections suggest that the number of HIV-infected people is doubling every 14 months: the figure of 250 000 will have risen to nearly 750 000 by mid-1994. After that, the rate of increase will depend on behaviour, chance and other interventions.

Initial scepticism was followed by a programme to monitor the epidemic and to ensure the safety of donated blood. Since 1985 over five million potential donors have been screened. But these early responses have had no significant effect on the pandemic.

People at all levels have difficulty accepting the enormity of the Aids pandemic hanging over the country.

Time is running out — the short time gap still available for effective interventions is shrinking. If it is ignored, the reality of the pandemic will eventually catch up with society. But by then it will be too late for the new generation of adults.

Health Day to focus on violence

85

Sowth 3/4-7/4193.

"HANDLE life with care — prevent violence and negligence" is the theme for World Health Day next Wednesday, April 7.

The World Health Organisation issued the slogan to raise public awareness of the impact accidents and violence have on health.

Throughout the world, health organisations will be looking at how people can make their lives healthier simply by taking more care.

Preventative health measures, such as immunisations, are part of the initiative. But lifestyles are equally important: Driving carefully, eating sensibly, and cutting down on smoking, drinking and drugs are contributions we can all make to our own well-being.

Health, Telkom staff protest govt cutbacks

CT 2/4/93 **Staff Reporter**

ABOUT 80 members of the SA Health and Social Services Organisation (SAHSSO) and dissatisfied Telkom employees protested peacefully outside Parliament yesterday against government plans for retrenchments, post-freezing and service cutbacks.

In a memorandum to the health ministry, SAHSSO said the government's deliberate policy of restructuring would severely limit the options of future governments and would benefit minority interests.

Star 21/4/93

Health now falls under one umbrella

Medical Reporter

Health yesterday became a "general affair" — reducing the 14 various health-related departments to 11 as three "own affairs" departments were integrated into the Department of National Health and Population Development.

The changes coincided with nationwide protests against the "unilateral" changes to the health system by a wide range of organisations.

The campaign was launched with low-key and peaceful protests at Johannesburg and Baragwanath hospitals as well as Parliament.

Organisations want a meeting with Health and Welfare Minister Dr Rina Venter.

According to the Department of Health, primary health care services, community psychiatric services, school health services, dental hospitals and the control of private hospitals were also integrated into the new consolidated health department.

The department said the rationalisation would contribute to "delivering more efficient and cost-effective health services by eliminating duplication and overlapping".

Health law protests today

JOHANNESBURG. — At least 13 organisations are planning to embark on a nationwide programme at noon today to disrupt the implementation of new health legislation announced by National Health Minister Dr Rina Venter.

The "Campaign for Peoples' Health and Social Services" said yesterday the demonstrations would also be aimed at halting the unilateral restucturing of health services. — Sapa

Health spending welcomed but...

By Justin Pearce

THE SOUTH African Health and Social Services Organisation (Sahsso) welcomed an 11 percent rise in health spending. But it is concerned much of the money will go into the wrong pockets.

"This government is spending more than the World Health Organisation recommendation for a country of our development level, yet health services are woefully inadequate for the majority of the population," said Sahsso national publicity secretary Dr Aslam Dasoo. "This could only mean incompetent administration."

Sahsso was concerned that health services were subject to VAT.

With health services due to be rationalised in line with the abolition of Own Affairs departments, Sahsso criticised the government's unilateral approach to restructuring.

"There has been no consultation with any of the extra-parliamentary organisations on how streamlining, which would affect the health costs and personnel, should be executed," Dasoo said. "Any action by the government, therefore, has no democratic legitimacy and would be rendered unworkable."

Earlier this parliamentary session, Minister of National Health and Population Development Dr Rina Venter announced new legislation to shift the financial burden of health services away from the state.

The draft Medical Schemes Amendment Bill would give medical aid schemes more freedom.

Venter recently announced legislation to check abuse of medical aid funds and shift the financial burden of health services from the state.

"The plan would definitely have a detrimental effect on public health," Dasoo said.

Central to the thinking behind the bill is Venter's assertion that it is "the responsibility of the individual to provide for his own and his family's health care and related costs".

Venter, Perlman clash

CT 27/3/93 (85)

JOHANNESBURG. — The government has requested a copy of a speech by the executive director of Operation Hunger, Mrs Ina Perlman, in which she criticised the government's feeding schemes.

Mrs Perlman claimed the schemes did not reach the needy.

National Health and Population Development Minister Dr Rina Venter said it appeared that Mrs Perlman wanted to politicise the government feeding schemes.

She said the allegations by Operation Hunger were not based on facts and Mrs Perlman did not understand the workings of the feeding development programme.

Concern at the alarming rate at which the number of people in need of relief aid is growing was expressed by regional directors of Operation Hunger throughout the country. — Sapa

CANCER CLINIC . . . Drum majorettes from the Zimasa Public Primary School in Langa escort the newly launched Philani Project's first fully-equipped mobile cancer clinic down the streets of Langa yesterday. The clinic will operate exclusively in townships with the intention of detecting early signs of cancer and educating and informing people. Picture: HAROLD KING

(85) CT 27/3/93

Mobile cancer clinic launched

Staff Reporter

IN an effort to combat cancer in the Western Cape, the first fully-equipped mobile clinic to operate in townships was launched at the Philani Cancer Centre in Langa yesterday.

The purpose of the mobile clinic is to detect early signs of cancer, offer information and educate the public, said Ms Amanda Botha, spokeswoman for the Western Cape regional office of the Cancer Association of South Africa.

The clinic will be manned by nursing personnel and medical staff, as well as a social worker.

"Cervical cancer is the most common malignant tumour affecting South African women and is reaching epidemic proportions, particularly among black women," she said.

There is at present no adequate screening policy for this cancer in South Africa and one of the main reasons given for the failure to provide this programme is that follow-up is inadequate.

This is particularly true in a number of areas where the population is mobile and only 20% of patients with abnormal cytological smears can be traced and treated, Ms Botha said.

The mobile clinic would address this need, she said.

Picture: ROY WIGLEY, Weekend Argus.

☐ **NEW DEAL:** Left: Sister Linda Gqiba of the cancer association is delighted to take charge of the first mobile cancer clinic for township women. Ms Jenny MacGregor, health project manager of the Independent Development Trust, main sponsors of the clinic, was there to hand over the keys.

Boost for Cape townships in the diagnosis of breast and cervical cancer

HENRIËTTE GELDENHUYS
Weekend Argus Reporter

FROM May 4, women in Cape Town townships will have access to early diagnosis and treatment for cervical and breast cancer, thanks to the Cancer Association of South Africa.

The Western Cape region of the association has launched a modern mobile clinic which will tour Khayelitsha, Langa, Guguletu and Nyanga from May 4, offering women results of cancer tests within two hours and offering immediate treatment where necessary.

If the cancer is already at an advanced stage, patients will be referred to Groote Schuur Hospital, which supervises the project.

Previously, women who were diagnosed did not return for their results and could not be traced either, Sister Linda Gqiba, of the Phelani branch of the cancer association, said.

The clinic will be manned by trained nurses, medical staff and a social worker.

Cancer association staff will hold educational workshops and spread information for a month in a township before the mobile clinic arrives there, she said.

Dr Eric Megevand of Groote Schuur's gynaecology department said thousands of lives would be saved by the clinic because cervical cancer diagnosed at an early stage was completely curable.

Cancer patient Ms Martha Myburgh of Guguletu said women in the townships needed the mobile clinic urgently because they "know something is wrong, but keep on guessing or wondering what it is, until it is too late".

Sangomas or traditional healers had agreed to be part of the medical team "for the first time", said Sister Gqiba.

Their support was crucial because it discredited the traditional belief that only blacks could cure cancer, she said.

Cervical cancer, the most common malignant tumour affecting South African women, was reaching epidemic proportions among black women, according to the cancer association.

But it is one of the few cancers where an ideal screening procedure is available.

prima facie involving or amounting to an offence on the part of any person: In the light of the fact that there was no direct evidence of how the wound under the chin of the deceased was sustained, the court was not in a position to make a finding as to who caused or administered it.

(iii) DAANTJIE BARENS, a 23 year old male.

(a) *Date of death:* 7 November 1991.

(b) *Cause or likely cause of death:* Internal and general loss of blood due to a penetrating projectile wound through the chest.

(c) *Whether the death was brought about by any act or omission prima facie involving or amounting to an offence on the part of any person:* On the available evidence it cannot be determined who was responsible for the death of the deceased when he was fired upon by armed persons, while he was assisting the South African Police as a tracker.

The findings of the inquest were brought to the attention of the Attorney-General, Kimberley, who indicated that no further steps were considered by him.

(2) A statement is not necessary, since this answer is itself too long in any case.

Navy: affirmative action

*5. Mr A S BEYERS asked the Minister of Defence:†

(1) Whether, with reference to certain statements allegedly made by a spokesman of the South African Navy on the radio programme Monitor on or about 4 March 1993, the Navy has decided to increase the percentage of Black employees in the Navy as against employees of other race groups; if not, what are the relevant details of the statements on Monitor; if so, (a) by what percentage and (b) as against what race groups;

(2) whether the Navy has accepted the principle of affirmative action; if not, why not; if so, what are the relevant details;

(3) whether the Navy recruits employees on a racial basis; if not, why not; if so, (a) for what reasons and (b) to what extent;

(4) whether the Navy intends to monitor the composition of its work force on a racial basis in future; if not, why not; if so, for what reasons? B431E

†The MINISTER OF DEFENCE:

(1) to (4)

Blacks only started to attest in the Permanent Force in the SA Navy in 1991 with the result that their numbers are very low in comparison to other population groups. In the Monitor radio programme the spokesman merely indicated that applications were at present being received from Blacks whose qualifications made them suitable for attestation and further training in the Permanent Force of the SA Navy. In so far as the term "affirmative action" means the replacement, without merit, of whites by blacks, the answer is no. All members with the necessary development potential receive purposeful and appropriate training to qualify them for successful careers in the Navy. Whereas in the past Indian males were specifically selected for voluntary services at SAS JALSENA, this practice has now ceased and this particular unit has been disbanded. The population composition of the SA Navy is not monitored. It is the result of selection on the grounds of candidates' abilities and qualifications and race plays no role.

†Dr W J SNYMAN: Mr Chairman, arising from the hon the Minister's reply, can we accept that he is saying, contrary to the former hon Minister, who mentioned on 17 June 1992 that provision would be made for affirmative action in respect of elements of the SA Defence Force, that this is now no longer the case?

†The MINISTER: Mr Chairman, every application is considered according to its specific merits. There is no question at all of there being discrimination against any population group. Merit is the only criterion that justifies an appointment. By that I mean that merely replacing White persons by persons of colour would be discriminatory, and this is certainly not the case.

†Dr W J SNYMAN: Mr Chairman, further arising from the hon the Minister's reply, I would like to know whether MK members who have for instance been trained elsewhere overseas, and who return and join the SA Defence Force, will be accommodated within the command structure of any section of the Defence Force by means of affirmative action.

†The MINISTER: Mr Chairman, there is no such policy. In most cases one would not even know whether such a man is an MK member or not.

I can tell the hon member that 11 new Black members have been recruited since 1991. According to tradition few Blacks were interested in the Navy before 1991. I accept that in the years to come more interest will probably be shown, and those cases will, like all other cases, be dealt with on merit.

MRC: buildings erected

*6. Dr F H PAUW asked the Minister of National Health:†

Whether the South African Medical Research Council at any time erected buildings, established an innovation fund and/or invested funds without complying with the required legal provisions or obtaining ministerial or Treasury approval for doing so; if so, (a) (i) when, and (ii) why, in each case and (b) what is the total amount involved? B432E

†The MINISTER OF NATIONAL HEALTH:

Yes,

(a) (i) and (ii) and (b).

Erection of buildings

In order to make provision for specific and motivated requirements, the MRC applied to the State to (a) erect a building in Pretoria to be used as a regional office and (b) to carry out certain extensions to the head office complex in Parow.

The regional office in Pretoria was completed in November 1988 at a cost of R9,1 million.

The extensions to the head office complex in Parow, which consisted of additional office space, computer accommodation and conference facilities, were completed in September 1991 at a total cost of R0,4 million.

Concerning both building projects, correspondence with the Department of National Health and Population Development commenced during 1983 and submissions and motivations were provided. On the grounds of these submissions and motivations, the Department of Finance gave financial backing to both these projects.

The Department of National Health and Population Development, as well as the Departments of Finance, State Expenditure and National Education, through the Committee of Heads of Scientific Councils, was at all times aware of the whole project. The only legal provision which was not complied with, was that formal ministerial approval for the project was not obtained. This omission has in the mean time been addressed and is in the process of being corrected.

Innovation fund

In terms of Framework Autonomy, it is expected from scientific councils to initiate own income supplementary to the basic financing provided by the State by means of commercialisation actions and initiatives.

In order to establish a management framework whereby requests for support with regard to these projects could be accommodated and managed, it was decided to earmark an amount of R1 million from the general reserves of the MRC for this purpose. The calculated interest on the R1 million can be utilised annually to support research projects with a market potential.

In the general and management documentation of the MRC this earmarked amount is referred to as the "Innovation Fund" merely to identify such fund. There is however no money or fund which is separately invested and it remains a part of the MRC's General Reserves.

As this "Innovation Fund" is purely a management aid establishing financial guidelines whereby awards can be made, the management of the MRC was of the opinion that it did not represent a "Fund" as intended by section 12 (5) (c) of the MRC Act, 1991 (Act 58 of 1991).

Cont.—n

This view was, however, not shared by the Auditor-General and the Joint Committee on Public Accounts. It was therefore decided to obtain formal ministerial approval for the Innovation Fund.

This process is currently under way and should shortly be completed.

Investment of reserve funds

During 1989 authorisation was granted for the MRC Personnel Expenditure Reserve Fund of R1 million to be initially invested with Volkskas Bank.

As this is a reserve fund with long-term objectives for, amongst other things, the payment of vacation gratuities and as the capital growth potential is significantly better in long-term policy investments, the short-term investment with Volkskas Bank was converted to a long-term policy investment with Sanlam.

Unfortunately, formal ministerial approval for this action was not obtained. Approval was, however, requested in 1991 but, owing to the fact that the report of the Tax Committee is still outstanding, the Department of State Expenditure cannot yet give approval. This matter has repeatedly been followed up and an answer is expected shortly.

Business interrupted in accordance with Rule 180C (3) of the Standing Rules of Parliament.

Investigation: prisoner transferred

*7. Mr D J DALLING asked the Minister of Correctional Services:

(1) Whether the allegations contained in a report in a certain Sunday newspaper of 7 March 1993, the name of which has been furnished to the Minister's Department for the purpose of his reply, have been investigated by his Department; if not, why not; if so,

(2) whether the investigation has been completed; if not, why not; if so, which of these allegations were found to be (a) true and (b) untrue;

(3) whether the prisoner concerned has been transferred from a minimum to a medium security prison; if so, why;

(4) whether any steps are being taken by his Department pursuant to this investigation; if not, why not; if so, what steps? B435E

The MINISTER OF CORRECTIONAL SERVICES:

(1) Yes.

(2) No, the investigation has not yet been completed as some of the witnesses have only recently been traced.

(3) Yes, the prisoner was relieved of his duties as a monitor and consequently could not be detained in the minimum security prison. On these grounds he was transferred to a medium security prison.

(4) No, as soon as the investigation has been completed, further action will be considered. Should it be found that the allegations against the member are well founded, we will not hesitate to hand the matter over to the South African Police for possible criminal prosecution.

DET: temporary teachers

*8. Mr J M BEYERS asked the Minister of Education and Training:†

(1) Whether, with reference to a press statement issued by him on or about 5 March 1993, he is at present negotiating with a certain teachers' union, the name of which has been furnished to the Minister's Department for the purpose of his reply, about the position of about 30 temporary teachers whose contracts with his Department have expired; if so, (a) what is the name of this union and (b) how many teachers are involved in it;

(2) whether these teachers are still receiving salaries; if so, (a) why, (b) what is the total amount that has been so paid in salaries to these teachers since the expiration of their contracts up to and including the latest specified date for which information is available and (c) what functions have they been performing at the schools concerned since the expiration of their contracts? B477E

The MINISTER OF EDUCATION AND TRAINING:

(1) The negotiations have been concluded.

(a) The South African Democratic Teachers' Union (SADTU).

(b) Thirty teachers.

(2) No.

(a) The 30 teachers have not been paid salaries since 1 January 1993 as their contracts lapsed at the end of December 1992.

(b) Falls away.

(c) Some of the teachers have, since the expiry of their contract periods, continued to perform the tasks of a teacher although they were not appointed or remunerated. After the negotiations between myself and a delegation of the Union on 5 March 1993, all of these teachers returned to their former schools and were given teaching tasks by the principals. In the meantime, the position of each teacher has been investigated and they will be remunerated for the periods that they have actually rendered service.

DET school in Pietermaritzburg: armed robbery

*9. Mr A GERBER asked the Minister of Education and Training:†

(1) Whether an armed robbery took place recently at a certain school near Pietermaritzburg, the name of which has been furnished to the Minister's Department for the purpose of his reply; if so, what are the relevant details;

(2) whether pupils were shot at in the school grounds during this robbery; if so,

(3) whether any pupils were (a) killed and (b) wounded in this shooting incident; if so, how many, in each case;

(4) whether security measures have been taken at this school since; if not, why not; if so, what measures? B481E

The MINISTER OF EDUCATION AND TRAINING:

(1) No, no case of armed robbery has been reported.

Questions (2), (3) and (4) fall away.

An incident occurred at KwaPhata Secondary School during which a pupil, Zondi Thamsanqa, was shot and killed by unknown gunmen before school started on 21 January 1993.

During the above incident, a female pupil, Ndwandwe Thokozile, was shot in the leg at the school gate while the unknown gunmen were leaving the premises.

The incident was reported to the South African Police (Case no 278/01/93). At a parents' meeting held on 31 January 1993, it was decided that parents themselves will take responsibility for the safety of pupils and staff members. The Department's offer to procure the services of a security firm was declined.

DET schools: student boycott

*10. Mr A GERBER asked the Minister of Education and Training:†

(1) Whether his Department has concluded an agreement with a certain student organization, the name of which has been furnished to the Minister's Department for the purpose of his reply, in terms of which discussions will be held before either of the parties concerned takes steps that may influence the school attendance of pupils; if so, what (a) is the name of this organization and (b) are the details of this agreement;

(2) whether the local committee of this organization in Soweto was involved in a call that pupils boycott classes in protest against the payment of examination fees; if so, what are the relevant details;

(3) whether any schools under the control of his Department have had to be closed since the commencement of this boycott; if so, how many;

(4) whether he will make a statement on the matter? B482E

The MINISTER OF EDUCATION AND TRAINING:

(1) No.

(2) Yes.

Persons claiming to be members of the Congress of South African Students (COSAS) visited certain primary and secondary schools in Soweto during Feb-

Prevention better than cure

(85) CT 23/3/93

Staff Reporter

IN the "War of Health for All" the major battle is against a nation of sceptics who resist the need to make preventative health services a priority rather than curative medicine.

Professor T Pretorius, University of the Western Cape's head of community and health sciences, stressed this at the first international conference held by UWC's nursing department. It ends on Wednesday.

Professor Pretorius said there needed to be a shift in resources towards preventative health measures, which would not neglect curative services but rather would redress the "deliberate skewness" in favour of them.

A major battle would be fought against the sceptics who believe that "preventative health measures will diminish the fiscal priority given to various curative services or treatment approaches," Professor Pretorius argued.

"Our nation's health system lies crushed under an evergrowing demand for cure. To those of us who accept the philosophy of preventative measures this is simply not a question of common sense — it is an ethical question."

Health: SA 'can learn from rest of Africa'

CT 22/3/93

SOUTH AFRICA had higher levels of wealth and health than other African countries, but the country could learn from them how to deal with health problems under the reality of scarcity.

This was said by Dr Derek Yach, co-ordinator of Essential Health for the Medical Research Council, at the first international conference of the University of the Western Cape's Department of Nursing, in Brackenfell last night.

Delegated from Kenya, Zimbabwe, Mozambique, the United States, Transkei, Ciskei, Botswana, Bophutatswana and Namibia attended.

Where blind are treated as outcasts

VUYO BAVUMA
Weekend Argus Reporter

WHEN Evelyn Siwa was jeered and scolded by taxi passengers for carrying a white walking stick, she felt her eyes were being removed for the second time.

Her "offence" was taking her long white cane into the taxi — and this irked the passengers who said the stick might hurt them.

Fortunately, the driver intervened and kept Evelyn's cane under his seat and the complaints died down.

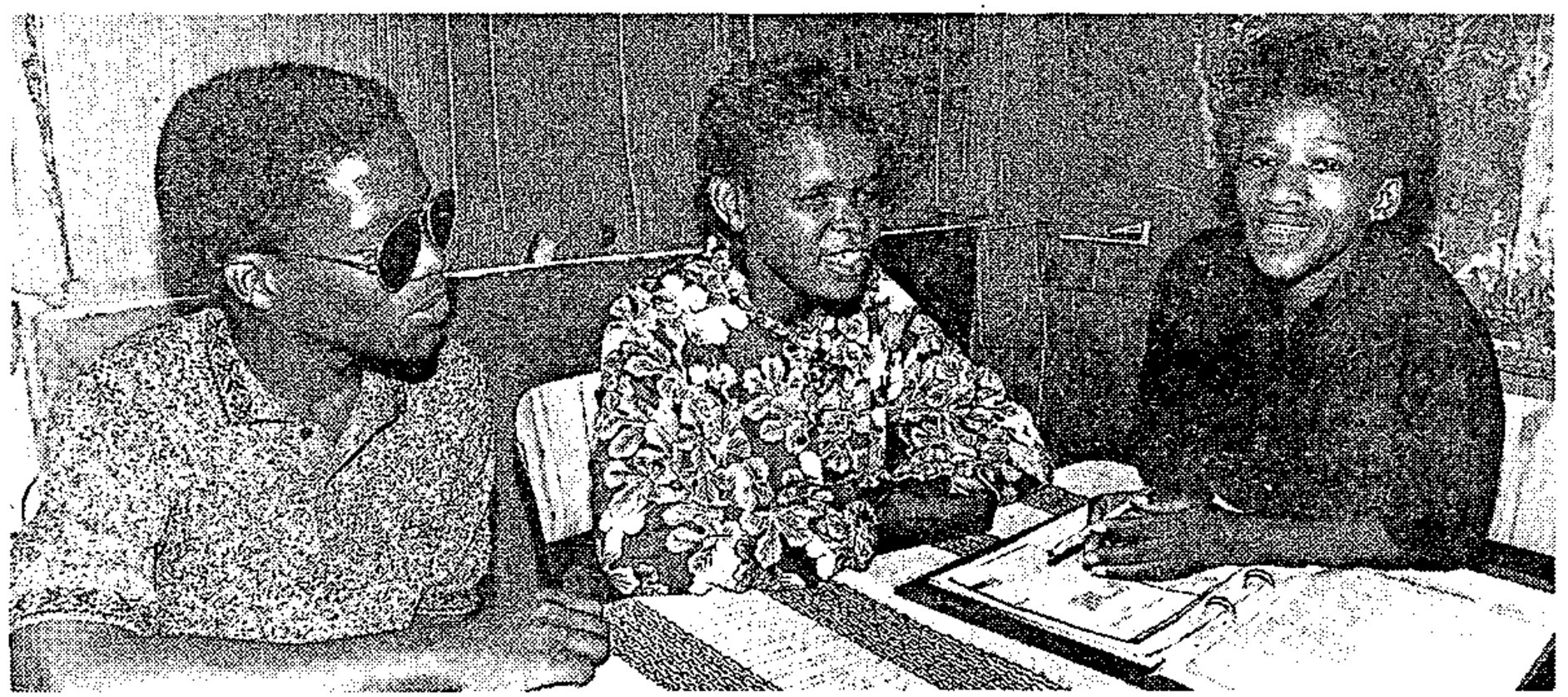
Evelyn felt desperately vulnerable being separated from her cane, but she dared not protest because it was better than being left at the Bellville taxi rank — and it was getting late.

Although Evelyn, 29, of Guguletu, was bitter about the incident, she knew it was part of the overwhelming discrimination against blind people.

To her, this showed that most township residents had not accepted the blind yet and such "distorted views should be urgently erased".

When using either bus or taxi, she experiences another type of discrimination — she is charged "double fare" for herself and the guide who is sometimes her sister.

She admits this is painful, but she has no option.



Picture: ANDREW INGRAM, Weekend Argus.

☐ **WE SHALL OVERCOME:** Evelyn Siwa, organiser and founder-member of the Western Cape Blind Association, with chairman Mr Malibongwe Mxobo and former Langa High pupil Nomzuzu Gqaleka inside their office.

(86) AHG 20/3/93

Like many blind township residents, Evelyn is reluctant to walk around the townships because there are no suitable roads or safe-crossings marked by robots.

Worse still, sometimes there are holes in the pavements because drains have been vandalised. Last year, Evelyn's friend was injured falling into an open drain.

But Evelyn, who became blind when she seven years old after an illness, is determined to fight on.

After passing one matric subject in 1990, Evelyn joined forces with her blind colleagues to set up an association to cater for their interests.

This week, Evelyn and the chairman of the association, Mr Malibongwe Maxobo, 24, of Guguletu, told Weekend Argus at their office — a one-roomed shack — about their plans to unite the blind and fight the discrimination.

As a first step in the struggle, the association registered as a welfare group and affiliated itself with the Rondebosch-based organisation, Disabled People of South Africa.

So far, the association has signed up more than 30 members.

High on its agenda are plans to raise funds and organise more workshops to teach the community that the blind are also people.

Evelyn said: "At workshops we've organised, we blindfolded people for about five minutes so that they ccould feel our life-long pain of being blind.

"We then organised activities to show that we could do most of what they could."

Another pressing problem is creating jobs for the blind so they can get decent wages.

Evelyn said finding jobs was one of the main problems.

Some of the association members did a course to become switchboard operators, but still were unable to get a job.

As part of its fund-raising campaign, the association will hold a "curry evening" at Uluntu Centre on Monday.

Plans also are afoot to organise a conference on bridging the gap between blindand seeing people.

"We will strike up relationships with many community organisations including taxi organisations. They don't seem to know that we exist," said Evelyn.

The association is planning to establish a home for blind people.

Mr Maxobo said: "We'll also work towards establishing a safe place for the blind people. Some of the blind people are being neglected by their families.

"Others live in squatter areas where they are sometimes caught up in violence that flares up there."

SA babies 'lighter, smaller'

JOHANNESBURG. — South African one-year-old children are smaller and lighter than their foreign counterparts, according to statistics released by a research study group yesterday.

The "Birth to Ten" study of children here and in Soweto was conducted by University of the Witwatersrand medical experts, the University of South Africa, the Medical Research Council and the health departments of Soweto, Diepmeadow and Johannesburg.

Study group chairman Prof Noel Cameron said in a statement the children studied were heavier than their American counterparts for the first six months, but by one year they were smaller. This was especially true of Sowetan children. ST 20/3/93

The study also showed the black community consumed on average a lower intake of macro-nutrients than other population groups. — Sapa

Council hires redundant staff

(85)
CT 1973/93

By GLYNNIS UNDERHILL

THE Medical Research Council (MRC) has taken on some staff from its bankrupt commercial subsidiary company.

MRC president Professor Walter Prozesky said staff from the provisionally liquidated Medical Technologies (Medtech) had been given temporary employment at the MRC.

Catering and conference division staff had resigned to take up temporary posts with the MRC, he said.

Medtech's liabilities apparently exceed its assets by almost R2 million. A hearing in May will investigate the company's financial management.

One liquidator, Mr Marius van den Berg, said meetings were being held today to discuss salaries and staff.

There were only about 10 Medtech staff who could not be placed at the MRC, he said.

Medtech was set up as a fund-raising venture to market the MRC's technology by developing some of its inventions. Professor Prozesky said the inventions had "not proved very successful".

It had been decided to end the venture which was threatening to jeopardise research at the MRC, he said.

Diet drink goes off market

(85) CT 19/3/93

Own Correspondent

DURBAN. — A popular diet preparation has been declared an "undesirable" product by the Medicines Control Council (MCC) and is being withdrawn from all its sale outlets.

This follows months of legal wrangling between the MCC and the distributors of the product, Belite Marketing.

According to Mr Ivan Coetzee, deputy director of MCC, the distributors had committed an offence by making several unproven medical claims.

"Belite was advertised as able to produce medical effects. However, this is illegal because it is not even a registered medicine," Mr Coetzee said.

The drink, according to the distributors, encouraged "rapid natural weight loss".

However, Belite Marketing did not register their drink as a medicine and according to managing director Mr Tony Hicks "the wording of some of our advertising was incorrectly done".

WINNERS

State gives health and education a R33 b slice

Political Correspondent

EDUCATION and health benefit by more than R33 billion with this year's Budget.

More than R22,7 billion is to be spent on education in 1993/'94 — 19,2 percent up on last year.

This does not include salary increases for teachers or TBVC countries.

A key element is the provision for the start of the long-term financing plan for a single education system under the Education Renewal Strategy.

Of the total allocation for education, R17-million has been earmarked for initial spending to get the strategy started.

● Health services are getting more than R11 billion in the Budget and more than R400 million is to be spent on feeding schemes. The health budget is up 11 percent on last year.

Furthermore, the government is to streamline health services to keep down delivery costs. A committee is expected to make recommendations soon.

The Budget Review says "the straitened economic circumstances necessitate a drastic improvement in the cost effectiveness in health care delivery on the part of all health authorities".

Legislation is to be introduced during this session of parliament to establish a new management model for academic hospitals to give them greater autonomy.

Poverty and the drought have increased the demand for food aid and the government is to spend R400 million this year on the National Nutrition and Social Development Programme.

This will be supplemented with any funds left from the R400 million allocated for nutrition schemes in last year's Budget.

The allocation to the Protein Energy Malnutrition Programme, also administered by the Department of National Health and Population Development, is to be raised to R40 million.

Other departments which will get more are:

● The R6,5-billion police budget for 1993/'94 is up 14,3 percent on last year's allocation. The recently-expanded air wing of the police will be funded from this amount. The Budget Review says greater police visibility is crucial;

● The allocation for prisons goes up 17,6 percent to R1,7-billion. In addition, the Department of Correctional Services is taking "various steps to counter rising costs ... including the further development of corrective supervision as an alternative service option and controlled early releases. Prison labour is to be used more effectively";

● The justice budget goes up 24,1 percent to R965,5 million — largely to fund structures arising from the National Peace Accord, various boards of inquiry, implementation of new legislation and a higher demand for legal assistance by the underprivileged; and

● The Rail Commuter Corporation is to receive R1,2 billion from the 1993/'94 Budget, with the Exchequer taking full responsibility for its operating deficit.

Transnet had not yet generated sufficient revenue for the commuter corporation's operating losses to be financed from direct payment of Transnet dividends.

The voted amount of R560 million for 1992/'93 had to be supplemented by R620 million — a total of R1,18 billion.

The Commuter Corporation's operating losses appeared to be on budget, while the accumulated debt would be merged in the public debt.

LOSERS

Defence spending slashed by 14%

Political Correspondent

DEFENCE spending has been slashed by more than 14 percent to R9,3 billion, taking inflation into account.

Nominally, the 1993/94 defence budget is 3,8 percent below last year's allocation, but the cut is 14,1 percent in real terms, according to the Defence Vote memorandum.

Most of the cut is expected to be absorbed by the Air Force.

A big cut — 15 percent in nomimal and 24 percent in real terms — is to be made in the Special Defence Account budget. Most of this covers weapons procurement, but also includes covert operations.

"The downsizing of the conventional fist of the Defence Force is regarded as quite acceptable on the present and projected reading of external threats to South Africa," according to the Budget review.

The explanatory memorandum says the cut in the Special Defence Account is due mainly to "the scaling down and cessation of conventional capabilities within the Army, Air Force and Navy as a result of the present perception of the threat and the reduced funds available.

"An attempt has nevertheless been made to maintain conventional operation capabilities at minimum acceptable levels."

The Defence Force will retain its medical capability "at this stage", to provide services to prisons and the police.

'Extra burden for private patients'

Star 18/8/93

85

Medical Reporter

The increase in VAT would burden private patients with an extra R350 million in health care costs this year, Representative Association of Medical Schemes (RAMS) executive director Rob Speedie warned yesterday.

Speedie said the VAT increase came at a time when health care was already under extreme pressure and people were suffering economically. "This could result in added pressure on public sector health care services."

RAMS would meet other concerned parties this month to discuss the VAT increase before a full meeting of RAMS on March 31 to discuss possible adjustments to the scales of benefits.

The Medical Association of South African (Masa) said it had hoped medical services and medicines would be zero-rated to provide more affordable health care.

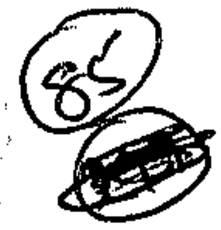
Masa also expressed concern that the VAT increase would mean that tax concessions on basic foodstuffs announced last week would not filter into households.

Masa federal council chairman Dr Bernard Mandell, however, welcomed the proposed 16,7 percent increase in spending on primary health care and the increase in the Protein Energy Malnutrition allocation from R400 000 to R40 million.

The Baragwanath Hospital Doctors' Association responded with "deep disappointment" at the way the Government "continues its policy of exploitation and neglect of State-employed" doctors. Association chairman Dr Ron Kemper said a mass exodus of doctors from State hospitals could be expected.

Rob Speedie . . . VAT to add extra R350 million.

Warning on private health care



CT 17/3/93

Own Correspondent

JOHANNESBURG. — Medical scheme costs have risen 33% faster than company salaries, and the national health minister warned that private health care was becoming increasingly unaffordable.

In her opening address at a Financial Mail Corporate Health conference here, Health Minister Dr Rina Venter stressed that there was an urgent need to restructure private health to enable the sector to function according to market-related principles.

"It is for this reason that tough decisions had to be taken to improve the health status of the population as a whole and to ensure that a cost-effective private health care system remains in place," she said.

Unemployment and high taxes have placed considerable pressure on the ability of individuals and companies to afford health care, Medical Association of SA (Masa) health policy director Mr Reg Magennis said yesterday.

Mr Magennis said that in recent years medical inflation was significantly higher than the CPI. Analyses of the years 1985 to 1990 showed that about R1,3 billion more was paid to medical schemes by companies and employees — which represented an increase of 34% in monthly premiums.

He added that the business sector was under pressure to alleviate social problems and it would be forced to prioritise health care if it was to survive in the prevailing harsh economic conditions. The Aids epidemic required immediate attention, he said.

Speaking at the same conference, Dr Izak Fourie of the Chamber of Mines said corporate health care costs were out of control and employee health benefits had become a major cost of doing business.

Govt restructuring prompts mass action

JOHANNESBURG. — A mass action campaign to oppose the government's restructuring of health services is to be launched next Saturday, the South African Health and Social Services Organisation (Sahsso) announced yesterday.

In a statement, Sahsso said the effects of restructuring were already being felt, with "massive retrenchments of health workers, cutbacks in services and the closure of hospitals at a time when people, especially the poor, need these services more than ever before".

"The actions by this government are, at best, heartless and cynical," the statement said.

As a result of the government's actions, "Sahsso and the South African National Civics Association are embarking on a mass action campaign to render all these proposed changes unworkable".

No details on what form the campaign, to begin on March 27, would take were available. — Sapa

CT 17/8/93

DP fury over health bill

85

Political Correspondent

THE Democratic Party has launched a blistering attack on Health Minister Dr Rina Venter for refusing to refer the Associated Health Professions Amendment Bill back to the parliamentary joint committee on health.

This follows a row in the committee in which all but National Party members walked out after its chairman Dr Johan Vilonel, refused to allow oral evidence from certain organisations.

The legislation governs the statutory recognition of allied health professions and during bitter debate on the bill in Parliament yesterday opposition members called on Dr Venter to refer the legislation back to the committee.

However she turned the request down, saying she believed the call arose from differences between committee members rather than the bill.

MRC faces parliament questions over audit

(35)

ART 16/3/93

MICHAEL MORRIS and PATRICK FARRELL
Staff Reporters

THE respected South African Medical Research Council is to be asked to answer audit queries on "disturbing" management deficiencies and lack of financial control by parliament's all-party public accounts committee.

Attention is expected to fall largely on the creation and management of a subsidiary research company, Medical Technologies (Pty) Ltd, which is bankrupt and was provisionally liquidated in the Supreme Court, Cape Town, yesterday.

The Parow-based company's liabilities exceed its assets by nearly R2 million and it is unable to pay staff their March salaries.

Questions are also likely to be asked about problems with the MRC's computer system after the 1991/92 auditor-general's report found the council wasted tens of thousands of rands on software which was never used and was replaced two years later with another package.

Auditor-General Mr Henri Kluever confirmed yesterday that "certain financial problems" in the MRC would be the subject of a public accounts committee hearing in May.

Medical Technologies (Pty) Ltd is a subsidiary of Medical Technologies Investments (Pty) Ltd, in which the MRC owns all the shares. It was set up in 1988 to develop medical technology and generate funds for the MRC.

The company holds between 49 percent and 75 percent of the shares in seven other companies, including Specialist Animal Feeds (Pty) Ltd and Swift Micro Laboratories (Pty) Ltd.

The auditor-general's report says the accumulated loss of Medical Technologies Investments (Pty) Ltd and Medical Technologies (Pty) Ltd rose from R104 089 in February 1990 to R412 995 a year later.

In papers before the Supreme Court yesterday, MRC president Professor Walter Prozesky said that by January 31 this year Medical Technologies' liabilities were R6,4 million and its assets R4.5 million.

Since 1990 it had been engaged on several projects, among them breeding experimental animals and the operation of a conference centre and restaurant at MRC headquarters in Parow.

Other projects included marketing a maths programme, selling equipment to diagnose TB, and administrative duties for other companies in which it held shares.

He said the MRC had given Medical Technologies R2,5 million from its own reserves and had signed surety for an overdraft of R2 million and hire purchase agreements for R1,8 million.

He said research projects had not materialised and the MRC no longer had funds to pump into Medical Technologies. The company was not in a position to continue its business or pay its debts.

It could not pay the Receiver of Revenue amounts owing for employees' tax, nor could it pay their pension and medical aid contributions. It would also not be able to pay their salaries on March 20.

It could pay February salaries only by using the proceeds of the sale of its interests in Swift Micro Laboratories and Specialist Animal Feeds.

In a May 1991 letter handed to the court, Medical Technologies' auditors, Coopers Theron Du Toit, said there was no control system for sales that they could rely on for an audit and there was no auditing process they could use to determine fully the income of the company.

Mr Justice Kühn granted a provisional liquidation order. The return date is April 14.

In the auditor-general's report, former Auditor-General Mr Peter Wronsley says: "In the light of the material interest of the MRC in the controlling company, this office is disturbed about deficiencies in the financial control systems of the companies and about the increase in accumulated losses ..."

The report says ministerial approval was not obtained in terms of legislation for a R2,8 million contingent liability to cover bank overdraft facilities and the purchase of assets by Medical Technologies.

A R1,5 million interest-free loan was also granted to Medical Technologies with no fixed repayment conditions and no loan agreement.

Mr Wronsley says: "There is some doubt ... whether the MRC is authorised to encumber its fixed properties with a view to rendering financial assistance to a wholly owned subsidiary of a company in which all the shares are held by the MRC.

"The MRC was therefore requested to obtain a legal opinion in this regard."

Problems relating to the MRC's computer system are also highlighted in the report.

A Chameleon package was bought for R41 350 to run the MRC's financial system, but the package was never implemented.

Medtech faces liquidation

(85)
CT 16/3/93

Staff Reporter

MEDICAL Technologies (Medtech), a subsidiary of the Medical Research Council, was provisionally liquidated in the Supreme Court yesterday, after the council applied for the order.

In papers, Professor Otto Walter Prozesky, chairman of the MRC, said Medtech's liabilities were R6,4 million and their total assets R4,524m.

Mr Justice G A Kuhn ordered the provisional liquidation.

New food laws welcomed

Staff Reporter

GREAT improvements in food regulations are about to be implemented, the Housewives' League said yesterday.

The new legislation would make basic training compulsory for all food handlers, set new standards for hygiene and improve food labelling, league national president Ms Jean Tatham told the annual Food Science Symposium in Somerset West yesterday.

She said it had been a source of concern for the league that no educational requirements had been laid down for owners of food establishments or for those who worked there.

New basic standard hygiene requirements for food premises were also to be set by the Environmental Health Officials' Association.

Premises that qualified under the regulations would be awarded a seal of approval "which will inspire consumer confidence", she said.

In addition, new labelling legislation would increase the minimum size of lettering on packaged food items from 1mm to 1,5mm.

However, Ms Tatham was disappointed the authorities were not prepared to insist on nutritional information being printed on all labels.

State aid for diseases

Health Reporter

THE government has set aside R2,3 million for the appointment of specialists to combat infectious diseases — with a strong emphasis on TB.

The new jobs provide for one specialist for each region as well as a new appointment in the head office of the Department of National Health and Population Development to focus on the TB problem.

There were 67 157 new TB cases last year.

CORPORATE HEALTH CARE CONFERENCE

85

FM 12/3/93.

Private-sector health care is set to undergo radical change with the recent passage of the Medical Schemes Amendment Act.

As the Act sweeps away guaranteed minimum payments and set tariffs for medical procedures, employers and employees will be swamped with health care cover options from the insurance industry, medical schemes, private hospitals, doctors and others — all bidding for business.

The *FM*'s one-day conference on Corporate Health Care next Tuesday at Johannesburg's Carlton Hotel will deal with the implications of the new legislation and highlight the benefits and pitfalls of the different policies on offer.

The keynote address will be delivered by Health Minister Rina Venter. Other speakers include Rob Speedie, executive director of the Representative Association of Medical Schemes; Reg Magennis of the Medical Association of SA; Alexander Forbes's Leon Lewis; and Izak Fourie of the SA Chamber of Mines.

About 400 delegates are expected to attend. For further information contact Global Conferences at (021) 683-3265 or fax (021) 683-4086.

Medical education council showing the way

ARG 10/3/93

ANDREA WEISS
Health Reporter

WHILE many firms battle to get to grips with "affirmative action", the Medical Research Council is showing the way with an innovative adult education programme for staff with an education gap.

The brain-child of Dr Sonia Wolfe-Coote, head of the MRC's experimental biology programme, the project is designed to train laboratory staff — from cleaners to receptionists — to do far more than just clean test tubes or answer telephones.

Mr Andrew Tomboer, a father of two who grew up in Ravensmead, is a case in point.

Mr Tomboer never completed matric and started his working life assembling diesel tractor engines on an assembly line in Atlantis. He joined the MRC in 1983 as a laboratory assistant and found himself washing glassware and keeping laboratories tidy.

Under the guidance of MRC staff, he gradually learned more intricate tasks usually done by medical technologists with technikon diplomas — and now he fulfills a combined managerial, technical and administrative role.

His title is chief laboratory assistant, but Dr Wolfe-Coote maintains this does not reflect fully his value to the laboratory which does, among other things, important research on heart disease and human reproduction.

Dr Wolfe-Coote said certain laboratory activities, such as processing tissue and section cutting, were repetitive but crucial to research.

By finding people with an aptitude and training them, she was freeing researchers to get on with their jobs.

The next step came when Dr Wolfe-Coote was put in charge of the experimental biology programme early last year and she had more direct say in how staff should be used.

"I was lying in bed one night and thought maybe we could use this example to train others," she said.

Her idea fell on fertile ground at a staff meeting.

And thus the adult education modules were born, offering a range of courses to train people in subjects such as laboratory safety, reagent and specimen preparation.

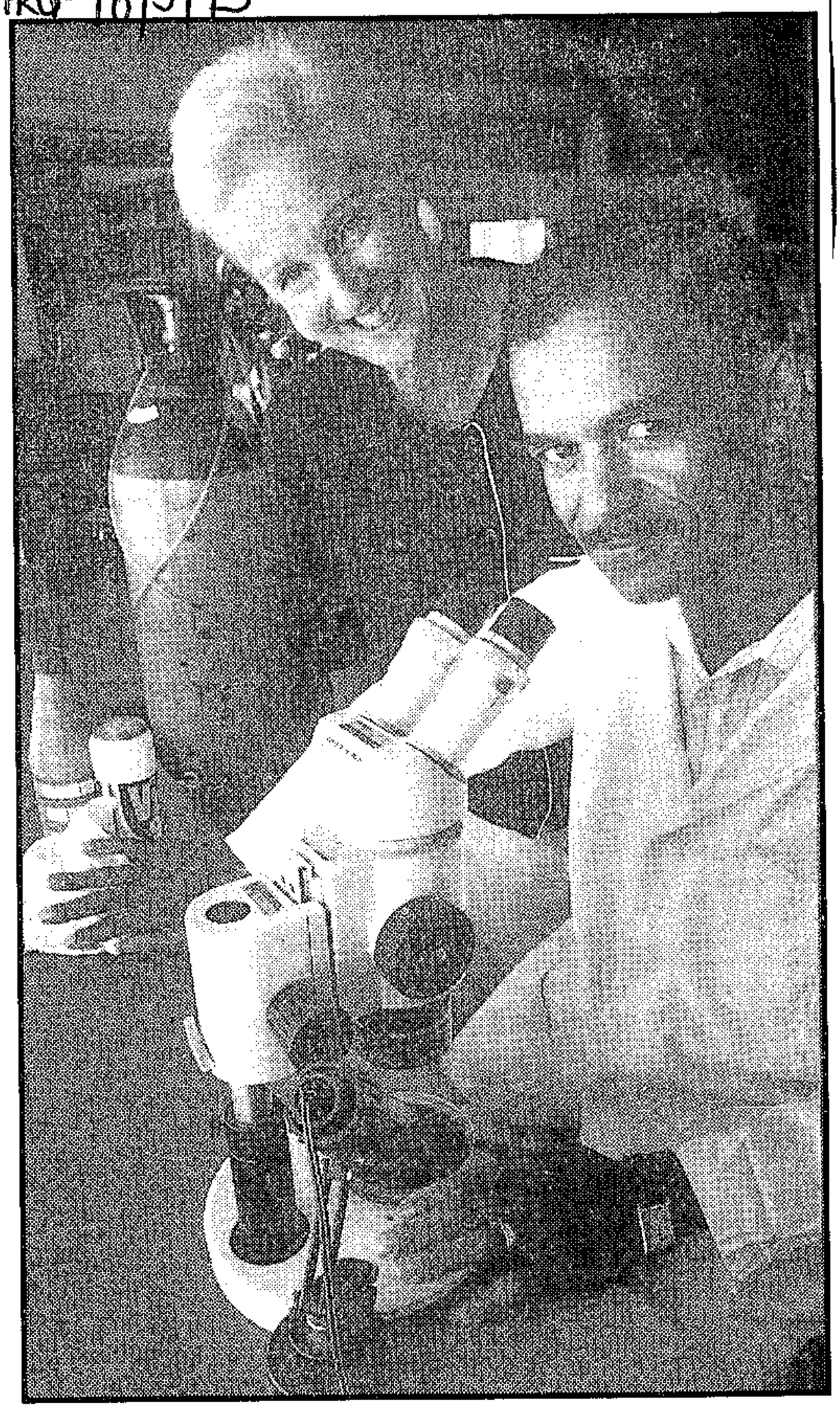
The courses are to be offered at a time both convenient to employers and their employees — and they have interested other adult-education orientated groups, notably the Congress of SA Trade Unions.

They have been designed to be accessible to people who are not entirely literate and include the use of cartoons as lecture notes.

While firms and even a doctor from the Eastern Transvaal are interested in sending their staff for training, African countries such as Kenya (which recently formalised links with the MRC) are also keen.

Dr Wolfe-Coote has also helped in getting medical technologists in her department to further their qualifications through universities — even though their initial diplomas are from technikons.

One such member of staff in her department is registered for a PhD, while several others are doing masters degrees.



GOING PLACES: Dr Sonia Wolfe-Coote of the Medical Research Council with chief laboratory assistant Mr Andrew Tomboer. The MRC is launching an adult education programme to develop the full potential of laboratory staff. Picture: ROY WIGLEY, The Argus.

Five parties in walkout

Political Staff

A MEETING of Parliament's Joint Committee on Health had to be adjourned this week after five opposition parties walked out in protest against the "autocratic actions" of its chairman, Dr Johannes Vilonel.

They said in a statement yesterday that the meeting of the committee was adjourned because there was no quorum after all parties except the National Party left in protest against Dr Vilonel's decisions.

Representatives from the Democratic Party, the Conservative Party, the Afrikaner Volksunie, Labour Party and Solidarity left the meeting after the NP had refused to hear evidence from interested parties that would be affected by the Associated Health Service Professions Amendment Bill.

The statement said they intended approaching The Speaker to discuss Dr Vilonel's "biased" actions.

CORPORATE HEALTH

FM 5/3/93.

Health Minister Rina Venter will deliver the keynote address at the Financial Mail Corporate Health Care conference in Johannesburg this month. (85) ([redacted])

The one-day conference, to be held at the Carlton Hotel on Tuesday, March 16, will deal extensively with the implications of the recently approved Medical Schemes Amendment Act.

In particular, speakers will discuss the various options available to corporate health care purchasers — medical aid schemes, managed health care and the insurance route — and offer delegates some valuable insights.

Speakers include Reg Magennis of the Medical Association of SA, Representative Association of Medical Schemes executive director Rob Speedie, Alexander Forbes's Leon Lewis and Izak Fourie of the SA Chamber of Mines. More than 300 delegates are expected to attend.

For further information contact (021) 683-3265 or fax (021) 683-4086.

Health reforms 'hampered'

(88) MRG 5/3/93

Municipal Reporter

THE Cape Metropolitan Health Forum could make much-needed restructuring of health services possible, says Medical Officer of Health Dr Michael Popkiss.

The forum, which includes formal health services and "progressive" organisations, was formed in October with Dr John Frankish as convenor.

Dr Popkiss said reforms to health services in the Cape Town metropole were hampered by shrinking money supplies, the fragmented structure caused by apartheid and a moratorium on unilateral restructuring.

"Progressive" organisations had urged that delegates be given full power to make decisions on behalf of their parent organisations.

"The impracticality of such a suggestion was pointed out by (Groote Schuur Senior Medical Superintendent) Dr Jocyelyn Kane-Berman and myself and accepted by the forum."

'Believe-it-or-nots' mark MoH's report

ANDREA WEISS (85) ARG 4/3/93
Health Reporter

DID you know that last year 1 100 seal carcasses washed up on the beach at Strandfontein?

This is just one of the more unusual facts in the 1991/92 annual report by Cape Town medical officer of health Dr Michael Popkiss.

The report notes that 325 000 tons of refuse were removed by the city council cleansing branch during the year — and that Cape Town people used 1 223 megalitres of water during the summer and 399 megalitres in winter.

Residents in Mitchell's Plain had cause for complaint when their drinking water was overchlorinated because of a malfunctioning problem at the Blackheath Reservoir.

Cape Flats residents also had to live with "bad tastes and smells" in their water from Theewaterskloof, caused by "harmless" seasonal algae in the supply dam.

Street sweeping frequency of Cape Town's 2 300 km of roads was "below standard" — and the council has decided to reinstate services to 1985 levels.

Cape Town citizens drank an average of 456 000 litres of milk a day and ice-cream outlets maintained "acceptable standards" although there was some cause for concern at the coliform counts in soft-serve, possibly because of dispensing machines not being properly cleaned.

Needy toddlers were given 61 024kg of skim-milk powder and 5 984 kg went to council creches and nursery schools.

Health inspectors took 1 151 food samples to test their chemical composition — and imposed fines of R8 360 for the 22,9 percent which did not comply with standards.

They also took 2 988 specimens of food and swabs from surfaces of food outlets — but they are not letting on what they found. Only six cases of suspected food poisoning involving 26 people were investigated.

Deregulation resulted in the council having to deal with an onion processor who "caused a stink in the neighbourhood" and an entrepreneur who sold sheep from his backyard.

Views are changing on the patient's right to die

STAR 3/3/93 (85) 847

As the Dutch parliament passed a law recently permitting mercy killing under strict guidelines, South African doctors were taking a closer look at patients' rights to refuse treatment . . . even if it leads to death, reports PAULA FRAY.

EUTHANASIA came back into focus in South Africa last year during the trial of a Cape nurse who administered a lethal injection of insulin to two elderly, infirm patients.

Then, later in the year, protracted legal proceedings eventually resulted in former Natal MEC Dr Fred Clarke being allowed to die in a Durban hospital. Dr Clarke, who had left a "living will" or advance directive, was in a persistent vegetative state from which there was "no prospect of any improvement in his condition, and no possibility of recovery".

According to Natal University dean of law Professor David McQuoid-Mason, the court did not decide on the legality of the living will, but appointed Clarke's wife as curatrix and gave her power to withhold agreement to treatment, including nasogastric treatment. If she did authorise the withholding of treatment, this would not be unlawful.

It has only been in recent years that our right to die has been debated.

In fact, the whole question of euthanasia has grown considerably more complex in the light of modern hi-tech medicine — particularly as the term is often used indiscriminately to describe both "active" euthanasia, which involves deliberate killing, and "passive" euthanasia, which implies the withholding of life-support systems or life-sustaining treatment, according to Dr S R Benatar, who wrote on the subject in the July edition of the South African Medical Journal.

"Medical progress, secularisation of life, growing acceptance of individual human rights (including the right to refuse medical treatment) and of shared decision-making in medicine have focused public attention on the ways in which life may, and perhaps even ought to, be allowed to end in our complex modern era," he writes. However, the concepts of assisted suicide and active euthanasia are generally still considered "unacceptable perversions" of medical practice, he adds.

Given medicine's ability to sustain life for prolonged periods, the unrealistic expectations of some medical personnel and the lay public, the severe constraints on health-care facilities, and the totally inadequate allocation of resources for highly effective medical treatments, the time was right to debate the limits of "striving officiously to keep alive", and on the distinction between "allowing to die" and "killing", he adds.

It is this debate which is taken further in the latest edition of "Continuing Medical Education" in which Dr Bruce Buchan and McQuoid-Mason present the medical and legal ethics of the living will.

Any patient has the right to refuse treatment, says Buchan, "but the moment the patient becomes unconscious, he amazingly loses all his rights", including the right to determine what is done with his own body.

"In order to overcome this problem — which is becoming more acute because of advancing technology — the living will/advance directive has come into being," he says. Common law in South Africa gives patients the right to refuse specific medical treatments: "A treatment given by a doctor or nurse against their wishes constitutes a common law assault."

McQuoid-Mason concurs: It is generally accepted in South African law that patients have the right to refuse treatment even if it may cause them injury or death.

"Furthermore, a physician may not treat a patient without his or her consent, except if there is a statutory duty to do so or there is an emergency, and then only if it is not done against the wishes of the patient," he adds.

In 1986, the American Medical Association's council on ethical and judicial affairs stated it was not unethical to discontinue life-prolonging treatment for patients in irreversible coma, reports Buchan.

In short, when a patient is in a persistent vegetative state, the stress on both the patient and the family must be taken into consideration.

Nasogastric feeding should be administered according to the patient's wishes; a hospital policy needs to be developed for the use of nasogatric tubes and other forms of alimentation.

When treating terminally ill patients, minimisation of pain is paramount, even if it has the potential to hasten death: "To allow a patient to experience unbearable pain or suffering is medically unethical," says Buchan.

Finally, he adds, medical training should emphasise the need for humanity, warmth and touch at the time of approaching death. □

PROVINCIAL ADMINISTRATION OF TRANSVAAL

(a) 1992/93 Financial year: R1 447 000,

(b)

	(c)	
Louw's Creek Clinic (Farmers Association)	R	146 400
Brondal Clinic (Farmers Association)	R	64 440
Boulders Clinic (Farmers Association)	R	68 160
Dirkiesdorp Clinic (Themba Trust)	R	21 000
Biesiesvlei Clinic (North-West Co-operation)	R	30 000
Alexandra Health Centre and University Clinic (University of the Witwatersrand)	R	1 117 000

ADMINISTRATION: HOUSE OF DELEGATES

(a) Nil,
(b) and (c) fall away

ADMINISTRATION: HOUSE OF REPRESENTATIVES

(a) Nil,
(b) and (c) fall away

ADMINISTRATION: HOUSE OF ASSEMBLY

(a) Nil,
(b) and (c) fall away

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

(a)

1992/93 Financial year: Transvaal	R	1 617 500
1992/93 Financial year: Cape Province	R	490 000
1992/93 Financial year: Natal	R	120 000
1992/93 Financial year: OFS	R	110 000

(b) TRANSVAAL

	(c)	
Agricultural Union of Komatipoort/Malelane	R	40 000
National Council for the Deaf:		
Ellisras project; and	R	25 000
Thabazimbi project	R	35 000
Institute of World Concern (Churches AIDS programme)	R	40 000
Lifeline SA	R	82 500
Medically acquired HIV Institute	R	40 000
National AIDS Convention of SA	R	250 000
Beplande Ouerskapvereniging	R	260 000
Boskop Training Centre	R	400 000
Rural Foundation	R	400 000
Assosiasie Vrywillige Sterilisasie	R	45 000
	R	1 617 500

CAPE PROVINCE

	(c)	
South African Christian Leadership Association (SACLA)	R	200 000
Medically acquired HIV Institute	R	30 000
Education Resources Network	R	60 000
Beplande Ouerskapvereniging	R	200 000
	R	490 000

NATAL

	(c)	
Medically Acquired HIV Institute	R	20 000
Beplande Ouerskapvereniging	R	100 000
	R	120 000

OFS

	(c)	
Medically Acquired HIV Institute	R	10 000
Rural Foundation	R	100 000
	R	110 000

Health budget

148. Mr M J ELLIS asked the Minister of National Health and Welfare:

What percentage of the health budget was allocated to primary health care in each of the four geographical regions of the Republic during the latest specified period of 12 months for which information is available?
B287E

The MINISTER OF NATIONAL HEALTH AND WELFARE:

PROVINCIAL ADMINISTRATION OF THE CAPE OF GOOD HOPE

1992/93 financial year: 9,5%

PROVINCIAL ADMINISTRATION OF THE OFS

1992/93 financial year: 6,8%

PROVINCIAL ADMINISTRATION OF NATAL

1992/93 financial year: 21,05%

PROVINCIAL ADMINISTRATION OF TRANSVAAL

1992/93 financial year: 6,32%

ADMINISTRATION: HOUSE OF DELEGATES

1992/93 financial year:

A total amount of R36 702 000 was allocated to primary health care. This amount was distributed to three geographical regions as follows:

Natal	R34 680 000 (95%)
Transvaal	R 1 612 000 (4%)
Cape Province	R 410 000 (1%)

ADMINISTRATION: HOUSE OF REPRESENTATIVES

1992/93 financial year: 14% for the whole Republic.

ADMINISTRATION: HOUSE OF ASSEMBLY

1992/93 financial year: 14,07% for the whole Republic.

cont—p

DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT

1992/93 financial year:

Cape Province	13,94%
OFS	4,18%
Natal	4,46%
Transvaal	14,57%

Port Elizabeth/Uitenhage: population numbers

209. Mr E W TRENT asked the Minister of Home Affairs:

How many (a) male and (b) female (i) Whites, (ii) Coloureds, (iii) Asians and (iv) Blacks were there in the magisterial districts of (aa) Port Elizabeth and (bb) Uitenhage or the Port Elizabeth/Uitenhage metropole as at the latest specified date for which information is available? B467E

The MINISTER OF HOME AFFAIRS:

(aa)	(a)	(b)
(i)	70 983	73 318
(ii)	76 963	82 415
(iii)	4 286	4 211
(iv)	182 517	175 960
(bb)	(a)	(b)
(i)	19 746	19 854
(ii)	21 937	23 189
(iii)	506	545
(iv)	48 614	48 160

1991 Population Census, 7 March 1991. Final data after having been adjusted for over- and undercount.

Mortality figure

215. Mr M J ELLIS asked the Minister of Home Affairs:

(a) What was the mortality figure in each province for the 1991 calendar year and (b) what percentage of the total population in each province does each such figure represent? B451E

The MINISTER OF HOME AFFAIRS:

	(a)*	(b)
Cape Province	50 610	0,8
Natal	26 330	1,1
Transvaal	62 958	0,7
Orange Free State	14 484	0,7

* Mortality figure not available. Figures represent death registrations.

Public telephones: cost of repairs

219. Mr P G SOAL asked the Minister of Posts and Telecommunications:

What was the estimated cost of repairing public telephones in the Republic during the latest specified 12-month period for which information is available? B465E

The MINISTER OF POSTS AND TELECOMMUNICATIONS:

The Managing Director of Telkom SA Limited replied as follows to the hon member's question:

The estimated cost of repairing public telephones in the Republic during the 12-month period ending 28 February 1993 is R35 245 000,00.

SAA cabin crew members: retrenchments/gratuities/lump sum payments

225. Mr R V CARLISLE asked the Minister for Public Enterprises:

(1) Whether the South African Airways are currently retrenching any cabin crew members: if so, (a) how many have been retrenched, (b) at what total cost and (c) in respect of what date is this information furnished;

(2) whether any (a) gratuity and/or (b) other lump sum payments were made to any of the crew members so retrenched; if so, (i) what was the total amount so paid, (ii) how many crew members were involved, (iii) how many such gratuity and/or other lump sum payments amounted to between (aa) R100 000 and R150 000 and (bb) R150 001 and R200 000 and (iv) in respect of how many years of service was each such payment made in each of the two categories referred to in subparagraph (iii) above? B495E

The MINISTER FOR PUBLIC ENTERPRISES:

The Managing Director of Transnet Limited has furnished the following reply to the hon member's question:

(1) No.

(2) Falls away.

Bophuthatswana: guarantees/sureties given by State

227. Mr K M ANDREW asked the Minister of Foreign Affairs:

(1) Whether any guarantees or sureties were given directly or indirectly by the Government or any Department or agency of the Government to any person or organization for (a) loans granted, (b) lines of credit granted and (c) other specified financial services rendered to (i) the Government of, (ii) any Government Department of, (iii) a development corporation in and (iv) any other specified person or organization in Bophuthatswana in the 1991–92 financial year; if so,

(2) (a) what amounts were involved in each case and (b) what was the total amount outstanding in terms of such guarantees or sureties as at the latest specified date for which information is available;

(3) whether foreign currencies are involved in any of these guarantees or sureties; if so, (a) what currencies, (b) how much is involved and (c) who is responsible for bearing the potential cost of exchange rate fluctuations? B515E

The MINISTER OF FOREIGN AFFAIRS:

(1) No.

(2) and (3) Fall away.

Transnet: office accommodation

232. Mr R V CARLISLE asked the Minister for Public Enterprises:

(a) What proportion of the office accommodation owned or leased by Transnet in certain buildings, particulars of which have been furnished to the Minister's Department for the purpose of his reply, is currently utilized by Transnet in respect of each such building and (b) in respect of what date is this information furnished? B528E

The MINISTER FOR PUBLIC ENTERPRISES:

The Managing Director of Transnet Limited has furnished the following reply to the hon member's question:

	Per cent
(a) Paul Kruger Building, Johannesburg	100
South Station Building, Johannesburg	100
Park Chambers Building, Johannesburg	100
Union Square Building, Johannesburg	61
NZASM Building, Pretoria	91
Station Building, Pretoria	100

(b) 23 March 1993.

Children in Port Elizabeth/Uitenhage

242. Mr E W TRENT asked the Minister of Home Affairs:

How many (a) White, (b) Coloured, (c) Asian and (d) Black children of school-going age in the (i) pre-school, (ii) primary school, (iii) secondary school and (iv) 18 to 22 years age categories were there in the Port Elizabeth/Uitenhage metropole as at the latest specified date for which statistics are available? B548E

The MINISTER OF HOME AFFAIRS:

	(a)	(b)	(c)	(d)
(i)	7 342	13 844	585	24 287
(ii)	18 776	32 564	1 391	62 000
(iii)	15 166	22 795	936	44 288
(iv)	16 973	23 691	867	50 661

Notes:
The age categories are compiled as follows:

(i) 3 to 5 years
(ii) 6 to 12 years
(iii) 13 to 17 years
(iv) 18 to 22 years

Cont'd.

City health service levels 'mustn't fall'

CT 26/2/93 (85)

Municipal Reporter

THE standard of services related to health — such as the provision of clean water and a proper sewerage system — could not be allowed to fall, town clerk Mr Donald Geyer said yesterday.

He was responding to remarks by Democratic Party spokesman on local government Mr Jasper Walsh, who said a whole range of municipal services are likely to be delivered at a lower standard in formerly white areas if amounts spent on council personnel are equalised with township spending.

Mr Geyer responded that the Cape Town City Council had always endeavoured to treat all areas within its boundaries on the same basis.

If spending cuts were to be made, the sort of thing that might be cut first would be the opening hours of libraries and of council cash receiving offices.

Eye train's tears of joy

The Argus Correspondent

DURBAN. — Tears of joy flowed from behind new reading glasses after optometry students doing their internship aboard a roving train "cured" poor vision among rural communities in the Natal Midlands.

The roving primary eye-care clinic, housed in train coaches, was the brainchild of Transnet, Lions International and Rand Afrikaans University (RAU).

It left the Transvaal in January destined to visit 65 towns across South Africa.

The project aims to provide an eye-care service to rural areas where people cannot travel to cities or afford eye tests.

Staffing the clinic are 11 final-year RAU optometry students with two supervisors.

At their second Natal stop, Howick, queues of men, women and children snaked through the train and emerged with their glasses, wearing smiles and shedding tears of joy.

St John 'should focus on community needs'

(85)

ARG 22/2/93

ANDREA WEISS
Health Reporter

VOLUNTARY organisations such as St John Ambulance have a vital role to play in improving health services in South Africa — but their focus must firmly be on the needs of communities.

This is the view of Peninsula Technikon vice-rector Mr Brian Figaji, who opened a historic meeting of African and Mediterranean representatives of St John Ambulance.

Delegates from 17 countries — including Nigeria, Tanzania and Mauritius — and some of St John's most senior members from Britain are meeting in Somerset West for a week to discuss a way forward for the region.

In his opening address Mr Figaji sketched some of the racial disparities still evident in South Africa.

"It is impossible to talk about redress without identifying racial groups," he said.

In health spending, only a third of the budget went towards primary health care and the black infant mortality rate was about 10 times higher than that of whites.

Almost 50 percent of money spent on health was in the private sector, which catered for 20 percent of the population.

Mr Figaji said major challenges faced South Africa and non-government organisations would play a significant role.

Health fees standardised

Own Correspondent

DURBAN. — A uniform nationwide price structure for all provincial health services, including ambulances and outpatients, will come into effect on May 1, Natal health MEC Mr Peter Miller announced yesterday after closed-door talks with his colleagues.

Mr Miller chaired the talks between the country's four provincial health chiefs.

(85) CT 20/2/93

He said the move "was the culmination of a three-year process".

"We've reached our objectives and from May 1 the provinces will introduce a tariff structure that, with minor exceptions, will be uniform thoughout South Africa," Mr Miller said.

"These tariffs apply to all medical services provided by provincial administrations, including ambulance and outpatient services."

Star 16/2/93

SA's scientific research a mess – international team

By Anita Allen
Science Writer

Scientific research in South Africa is in a mess, and the crisis goes to the highest levels of government, according to an international report released yesterday.

Institutions involved with science, technology, research and development are operating in a policy and leadership vacuum, it said.

The five-man team which produced the report, sponsored by the Canadian-based International Development Research Centre (IDRC) at the invitation of the ANC, Cosatu and the national civic body Sanco, said they found a highly fragmented group of institutions, trying to define a role for themselves in a "new" South Africa but not quite knowing how to do so. They existed in an overall system which was most frequently described by its own officials as "dysfunctional".

The strongest censure was directed at the Scientific Advisory Council (SAC), the 14-member body appointed by the Government to advise the Minister of National Education on policy and programmes. All research and development funding is channelled by various ministries to this Minister, whose department determines allocations.

The report said that, in practice, the SAC operated under a cloak of confidentiality and no public record was kept of its activities and advice.

Under its mandate, the IDRC mission paid particular attention to tertiary education and reserved some particularly harsh words for the Executive of the Committee of University Principals.

"The mission was dismayed to discover that that body had not ever considered discussing research policy as it affects their institutions. Our impression is that the body appears to devote its energies to the discussion of administrative matters which, though no doubt important, would in other countries be left to other less senior university officials to tackle."

The report said the universities saw themselves as divided between 11 historically white (HWUs) and 10 historically black universities (HBUs).

There was a deep sense of rivalry between and among the institutions and their staff.

There was no authoritative view of the volume of research funding, but according to Foundation for Research Development figures for 1989/90, support for natural sciences at HBUs was R23,6 million while at HWUs it was R306,6 million. In human sciences, HBUs received R15 million and HWUs R124,8 million.

Assessing affirmative action programmes, the report said the picture that emerged was of highly fragmented efforts. "We can only conclude that there is not in place at this time either programmes or policies to encourage affirmative action which are commensurate with the magnitude of the problems facing South Africa."

The report concluded that South Africa should embark on a process of participation of not only the scientific community, but of all sections of society.

MEC rejects ANC charges

ALLEGATIONS by the ANC that the country's health system was collapsing highlighted the organisation's inclination towards gross exaggeration to score minor political points, an MEC charged with Hospital and Health Services said yesterday. (65)

Mr Peter Marais said the standard of health care in the Cape Province was far better than any other service on the African continent but the ANC should be aware of economic restraints on state expenditure. — Sapa CT 13/2/93.

SA issues call on health

MICHAEL HARTNACK

HARARE — SA Health Department director-general Dr Coen Slabber yesterday urged southern African states to hasten an agreement on co-ordinating health services to make maximum use of their limited resources.

Slabber said in an interview at the end of a three-day visit, the first by an SA Health Ministry chief since Zimbabwe's 1980 independence, challenges posed by malaria, tuberculosis, cholera and the human immunodeficiency virus (HIV) knew no borders.

Resistant strains of infection were developing and spreading from one country to another, and a health co-operation agreement could eliminate wasteful and costly duplication if states shared the testing of imported drugs.

"If we can, let's get an agreement tomorrow," said Slabber. "You can try to control malaria here and we can try, but if Mozambique does nothing, we are in for problems, as all measures have broken down there. It seems to us that with the peace accord it will be for SA and Zimbabwe to help Mozambique with mosquito control and its malaria problem."

□ Sapa reports that the Medical Research Council of SA has signed a joint research agreement with its Kenyan counterpart, its first with an African institution. Malaria will be the most important of 19 areas of collaboration covered by the contract.

ECC opposes prosecutions

STEPHANE BOTHMA

THE SADF had begun renewed prosecutions of conscripts who failed to report for military camps, the End Conscription Campaign (ECC) said yesterday.

The ECC urged supporters to press for a moratorium on the prosecutions. "It appears that the SADF's tactic is to summon individuals . . . before a court martial with very little warning, in the hope that they will appear without proper legal representation and plead guilty," it said.

An SADF spokesman said investigations had started into failures to report for the January intake, but said the ECC claims were so vague that it was impossible to comment.

peak hours was conducive to acts of terror, for political reasons, he said.

Govt strategy for health care

B1DAM 5/2/93. (85) 247

KATHRYN STRACHAN

GOVERNMENT has enlisted the services of advertising agency Saatchi & Saatchi Worldwide to promote its new plan to revamp health care services.

The Health Department has stressed that the state cannot afford to spend a greater percentage of its GNP on health, and the only way it can hope to resuscitate the health system is by radically shifting its focus and resources from sophisticated curative care to primary preventative strategies.

Saatchi & Saatchi Klerck and Barrett director Kgomotso Modise said advertising in social marketing had proved itself capable of soliciting participation and response cost-effectively by focusing on a single-minded proposition.

It also provided a tangible benefit in solving a problem in a community, he said.

In his presentation at the launch, Modise said rapidly escalating costs and the growing need in providing health services to all had affected future plans for health care.

Health care had also been affected by economic and social pressures which had resulted in a tendency for people to be more concerned about their own interests than those of others, he said.

"There is an immediate need in SA today to restructure and launch a supportive community programme in order to redirect attitudes and perceptions regarding the health care system."

He said the primary health care programme hoped to strengthen health services particularly in rural and squatter areas, and the advertising campaign intended to focus on issues such as nutrition, hygiene and immunisation.

As well as educating people to take responsibility for their own health and advertising the services of clinics, one of the principal objectives of the campaign was to promote the concept of primary health care to the business sector and to gain business and community leaders' support for the new strategy.

To boost the strategy, a public relations campaign had been formulated with the aim of creating a partnership between government and the private sector.

cinema manager Pierre Joubert last year was yesterday sentenced in the Rand Supreme Court to life imprisonment.

Moses Dabula, 24, was also sentenced to 15 years' imprisonment for robbery with aggravating circumstances. His co-accused, David Makena, who was 17 at the time of the killing, was sentenced to 25 years' imprisonment for murder and robbery.

The pair, who were both employed at the cinema, attacked Joubert while he was cashing up. Joubert was stabbed 101 times.

A third man, Percy Tshabalala, who also took part in the robbery, escaped from the scene and did not stand trial.

Judge M J Stegmann, sitting with two assessors, found the fact that the robbery and murder were planned weeks prior to the incident was an aggravating feature of the crime.

Peace accord officer to look into Bopape case

B/DIM 5/2/93

DIRK HARTFORD

THE case of political detainee Stanza Bopape — who police allege escaped from custody in 1988 and who friends and family believe has been murdered — will be investigated by the newly appointed police reporting officer under the peace accord, Jan Munnik.

And Bopape's father Junius will today brief ANC leaders Nelson Mandela and Walter Sisulu on the circumstances surrounding his son's disappearance. Mandela has taken a personal interest in Bopape's case and is said to be determined to make sure the mystery of his disappearance is solved.

Munnik said yesterday he would be approaching the special police unit — set up in terms of the peace accord — to investigate Bopape's disappearance. He would then report back to Bopape's family who requested the investigation.

Bopape's family has also demanded a public inquiry.

Meanwhile, lawyers acting on behalf of the Bopape family claim to have established that two constables at John Vorster Square — Engelbrecht and Mostert — took Bopape out "for the purposes of investigation" on the day he allegedly escaped.

Mostert, together with a Maj van Niekerk, had interrogated Bopape in detention two days before he disappeared, said the lawyers.

They said yesterday it was not clear if these three policemen were the "major who was the authorised appointed investigating officer and two colleagues" said by Lt-Gen Johan van der Merwe to have been with Bopape when he disappeared.

The SAP and Law and Order Minister Adriaan Vlok have so far refused to name the men who were with Bopape when he allegedly escaped.

Health services to coalesce

B/Diary 3/2/93

CAPE TOWN — Own affairs and national health departments would amalgamate by April 1, reducing 14 departments to 11, National Health Minister Rina Venter said yesterday.

The new health department would have minimum executive functions, most of which would devolve to regional and local authorities.

Venter said rationalisation would not result in significant savings as only 8% of the total health budget was allocated to the three departments, "but it will enable us to address our problems more efficiently".

The move follows last week's announcement by President F W de Klerk that own affairs in health, education and agriculture would be phased out.

Venter said rationalisation of other public departments of health, including provincial administrations and self-governing territories and possibly some of the TBVC countries, would depend on progress made with the constitutional reform process.

Present co-ordinating structures and co-operation agreements should be used until a new political dispensation was established. Reconstructing the fragmented health services system was important.

SA's expensive hospital and curative-based model placed a greater strain on state coffers than the three own affairs departments. Good progress had been made with government's new approach to rendering health care and expanding primary community health care facilities.

The Academic Policy Council had accepted a draft Billwhich would be put before Cabinet and Parliament.

"This will enable academic complexes to manage their own affairs," she said.

Also to be introduced this session would be the Tobacco Bill, which aimed to protect the right of non-smokers to clean air.

She said tuberculosis and AIDS would be major priorities of the National Health Department — Sapa.

Boesak wants to return to the ministry

B/Diary 3/2/93.

LINDA ENSOR

CAPE TOWN — ANC western Cape regional chairman Allan Boesak yesterday indicated that he had a strong desire to return to the ministry with the Dutch Reformed Sendingkerk.

"Over the past few days the ANC, both at a national and regional level, have had a number of discussions with Dr Boesak regarding his future as the rules of the church state that no elected official of a political party will be eligible for the ministry," western Cape regional secretary Tony Yengeni said yesterday.

Boesak rejected speculation that he had been ousted by a militant western Cape faction, but he said there had been differences of opinion with the SACP and conservative factions.

Medical project to focus on plant power

ARG 1/2/93 (85)

ANDREA WEISS, Health Reporter

TRADITIONAL healers have long tapped into the secret power of plants but now an innovative Cape Town-based project aims to put this knowledge on a more scientific footing so that better use can be made of a unique resource.

The Traditional Medicines Programme for South Africa (Tramed) has been initiated by two people eminently qualified for the job. Dr Nigel Gericke is a medical doctor with an Honours degree in Botany and Mrs Gill Scott is a pharmacist with a Master's degree in Botany employed by the National Botanical Institute at Kirstenbosch.

The programme leader is Professor Peter Folb, head of pharmacology at UCT and chairman of the SA Medicines Control Council. The project has been approved by the World Health Organisation and by local traditional healers who are anxious to have formal recognition of their role in the health care of the country.

The WHO has for some time been recommending that more use be made of healing plants in primary health-care programmes because of their availability and acceptability to many people, and their potential for decreasing expenditure on costly imported pharmaceuticals.

According to Dr Gericke, it has been estimated that up to 70 percent of South African black people consult traditional healers and use the herbal remedies prescribed. In Europe, the use of healing plant materials has doubled in the last 10 years.

The first objective is to document at least 500 indigenous plants with healing properties so that they can be used by healers in a safe and effective way.

The possible spin-offs from the ambitious five-year plan are endless — from the establishment of nurseries to supply traditional healers with rare plant material, to the research of plant potential in fighting cancer, malaria and even Aids.

The project, which has a strong conservation thrust, also has the approval of both the African National Congress and the government's Department of National Health and Population Development.

Initial funds have been given by the Department of Environmental Affairs and international funders have also expressed a keen interest. But Mrs Scott and Dr Gericke are hoping to attract more local funds to give impetus to the Tramed project they believe holds "huge economic opportunities".

They also hope to draw together many people who have been working in the field of traditional medicines and to encourage country-wide collaboration between research, industry and the community.

Tramed will receive an invaluable leg-up in the form of 15 years of research by the pharmaceutical group Noristan which has spent several millions investigating indigenous medicinal plants. Noristan has agreed to release the information it has gathered to the Tramed database.

Dr Gericke said Tramed would also be inviting the public to contribute knowledge to the database. Sadly, only around 30 plants in the plant kingdom of the Western Cape are commonly used for traditional medicine because the indigenous people of the area have long disappeared.

Poor living conditions a health issue

Sowetan 30/1-3/2/93.

85

By Justin Pearce

BAD SANITATION, air pollution and similar unhealthy conditions must be addressed by health planners if a primary health programme is to be at all effective.

This was the conclusion drawn by Mr Chris Derry of the Cape Technikon at a conference on primary health care convened by the Medical Research Council.

In the past environmental considerations had been put outside of public health in South Africa, Derry said, and this was a problem that now had to be redressed.

"People in public health can no longer say issues like housing and air pollution are outside their portfolio."

Ms Angela Mathee, a researcher with the Johannesburg City Council, reported on conditions at the Imizamo Yethu squatter settlement in Hout Bay, which have been linked to incidents of diseases there.

Over a third of residents in the settlement cook in rooms in which they also sleep. Most cook over coal or wood fires in rooms without proper ventilation.

This means people breathe highly polluted air at night, a fact Mathee linked to the high incidence of respiratory problems in the settlement.

Gastro-intestinal problems are another common health hazard in the camp. This seems to be related to inadequate sanitation services.

Most surveyed complained of the large numbers of flies in the settlement, which contribute to spreading disease. Flies are encouraged by the use of pit latrines and a communal rubbish disposal system. Households dump refuse in open containers which often overflow.

Water storage also creates health risks. People in Imizamo Yethu collect their water from communal taps and store it in buckets or drums. In many cases these are left uncovered, leaving water open to contamination.

Derry reported a case in another squatter camp where a cholera epidemic broke out in spite of the presence of communal taps.

The epidemic had been traced to a water storage drum used by a number of households. A contaminated cup had been used to scoop up water and had consequently infected the whole supply.

Derry recommended that stored water be changed every day to prevent spreading diseases, even though this could be difficult for squatters who had to walk long distances to fetch water.

HEALTH HAZARD: Contamination is a danger in squatter areas when water has to be fetched and stored in buckets Photo: Yunus Mohamed

A "north European concept of water supply" had hindered the efforts of people trying to organise satisfactory water for South African squatter settlements, Derry said.

According to this European concept, chlorinated water necessarily meant good water. But for chlorine to be effective, one first needed a supply of clear water, which was unobtainable in many parts of South Africa. Amino acids and other substances present in the water could neutralise the sanitising properties of chlorine.

Bad lighting also contributed to food contamination and disease, Derry said.

"In bad light it is impossible to see what you're cooking or eating."

Unrest boosts spending

Political Staff

THE large increase in trauma cases because of violence and unrest had contributed significantly to the Cape's overspending on health services by R97,6 million, a joint committee of parliament has been told.

The former director-general of the CPA, Mr Barrie Van der Vyver, said the cost of treating unrest victims had been one of the reasons for the oversspending.

He said there had been a substantial increase in trauma cases from assaults as a result of unrest and the associated violence.

"Patients from the squatter areas are often so serious by the time they reach hospital that they require very expensive treatment."

The committee expressed its dissatisfaction with the unauthorised expenditure. Nevertheless, it recommended that it be approved.

WHO head re-elected despite opposition

Guardian/W in W/Mail 85

29/1-4/2/93

By John Parry in Geneva

HIROSHI NAKAJIMA of Japan has been elected to a second five-year term as head of the World Health Organization (WHO) despite a fierce US and European campaign to unseat him.

The WHO's executive board voted 18 to 13 to reconfirm Nakajima in his job over the American and European candidate, Algerian neurologist Mohammed Abdulmoumene. Abdulmoumene, 52, was Nakajima's deputy until last summer when he was fired, reportedly for declaring his interest in the top job.

The United States and its allies waged a long and public campaign against Nakajima. They claimed the 64-year-old chemist has mismanaged the UN agency, which has a budget of $850 million a year, engaged in nepotism and created a personality cult.

Japan, which fought to keep its man in office, countered by accusing Washington of mounting a disinformation campaign based on little more than animosity against Nakajima by some officials of the Department of Health and Human Services. Dr Jonathan Mann, the high-profile American who quit as head of WHO's Aids program in 1990 in a public fight with Nakajima, is accused privately by Japanese officials of being behind the U.S. position.

National pride is also believed to be involved on the Japanese side. Nakajima was the first Japanese elected — rather than appointed — to head a UN agency. His widely respected counterpart at the UN High Commissioner for Refugees, Sadako Ogata, is a political appointee.

The WHO battle developed last fall and turned what would have been a routine rolling over of the top job into a highly publicized dogfight. The United States and Japan, the two largest contributors to WHO's budget, both denied through their officials here that they would cut their share if their candidate lost.

HURST PESCHKES ... industrial councils are a vestige of apartheid

Forum for health market

REPRESENTATIVES of the fragmented health care market will meet in Johannesburg in March to discuss plans for a new national health policy.

Invitiations for the national Health Forum — to be held from March 24 to March 26 — are being sent out to all players in health services, confirms the Department of National Health and Population Development.

This follows a meeting earlier this month of a steering committee to draw the groundrules for the forum.

The meeting comes amid continued arguments about who is to blame for the high cost of health care and the massive abuse taking place in the private health care market.

Preliminary figures from the Registrar of Medical Schemes suggest that the high cost of medicines is one of the main reasons why medical inflation remains stubbornly above a rate of 30%.

By CHERILYN IRETON

His annual report to be released in April will show that medicine costs rose a rate of 40,4% in 1991 (the latest figures available), followed closely by a 40% increase in funds to specialists.

The increase in medicine costs follows a rise of 41,5% in 1990 and 29,5% in 1989. Other increases recorded by medical aids were:

- General practitioners: 25,6% (1990: 22,6%)
- Specialists: 39,9% (27,6%)
- Dentists: 29,8% (27,1%)
- Private hospitals: 21,7% (55%)
- Provincial hospitals: 16,8% (35,9%)
- Hospitalisation (total): 20,7% (50,4%)

The Registrar says 7,3-million South Africans enjoyed health care cover at the end of 1990.

Masa warns Govt on pay offer

Own Correspondent

DURBAN — The Medical Association of South Africa (Masa) has warned the Government that it would not tolerate actions that would harm patients — which would happen if State workers received only a 5 percent salary increase this year.

Professor Ralph Kirsch, chairman of the Fulltime Practice Committee of Masa, said medical care would be severely jeopardised by this offer, and the association was not prepared to indulge in any action which would see patient care compromised.

All levels of the health care team would be affected by the increase, from doctors to support staff such as cleaners, who previously expressed concern about low salaries by striking.

A 5 percent salary increase was very little, especially when faced with increased taxation, including VAT, which would hit the lower earners in particular.

If the increase was applied across the board for all public servants, categories such as doctors would receive effectively between 3,7 percent and 4,2 percent because their salaries included a non-pensionable allowance which would not be subject to the increase, Masa said.

Young doctors, often with debts totalling R30 000 to R40 000 by the time they graduated, would find it extremely difficult to pay them off if working in State services where earnings were not high enough. They would be reluctant to work in the public service.

This could result in a brain drain, where doctors would rather work overseas and earn more or enter the more lucrative private sector.

Many doctors and nursing staff would reconsider their positions in State facilities. The result would be an exodus of health workers from the public sector which would create a higher ratio of patients to doctors.

He said patient care would be affected and health professionals would be forced to compromise their standards.

State health services, which were not of an excellent quality anyway, catered for about 80 percent of the population. Health care would become even more inacessible to patients if professional posts were made unattractive, he said.

Nurses would also consider leaving State services because the private sector offered them higher salaries and better working conditions.

Conditions would worsen until the services collapsed totally, Kirsch predicted.

"We believe there are solutions to the problem. One is the fact that more money can be generated.

"One of our previous Ministers of Finance indicated that raising taxes on products which cause serious illnesses, such as tobacco and alcohol, would generate an enormous amount of money," he said.

An increase of 1 c on each purchase of cigarettes or alcohol would generate R80 million. An increase of 10 c would generate R800 million, and tobacco and alcohol would still be cheaper than in many other countries.

Taxes on these products in other countries were channelled into health and eduction, and if this money could be raised in South Africa and dedicated to the same fields, much could be done to solve the problems.

Poor water supply 'plays role in most baby deaths'

CT 22/11/93 (85)

Staff Reporter

South Africa was faced with high morbidity and mortality rates among children mainly through the poor availability and quality of water and sanitation, says Mr Bheki Nene of the Medical Research Council.

He was addressing a primary health care strategy conference at the Waterfront yesterday.

"Diseases related to inadequate water supply and waste disposal are contributing causes of the majority of deaths in infants," he said. Apartheid laws had dictated that specific races had been more seriously affected than others.

Train takes eye care to rural communities

(85) CT 14.11.93

JOHANNESBURG. — A mobile eye clinic on board a railway carriage converted by Transnet will go some way towards taking vision care to the estimated 28 million South Africans for whom it is inaccessible.

It is hoped the eye care train, which is the first of its kind in Africa, will be just the start of a wider mobile primary health care project.

Manned by RAU's optometry department, it started operations in the northern Transvaal on Monday to an overwhelming response.

The train will traverse the country this year to take vision care to rural communities.

Recent statistics indicate that there are at least 218 000 blind in these communities, whose blindness in most cases was preventable had it been diagnosed and treated at an early stage. — Sapa

Health care train has eye on future

(85) AMCG 14/1/93

The Argus Correspondent

JOHANNESBURG. — South Africa saw the dawn of a new era in primary health this week when a unique eye-care train — the first of its kind in Africa — undertook its inaugural journey to make vision care accessible to rural communities.

The project — made possible by, among others, Transnet and the South African Optometric Association — uses two converted and refurbished train coaches, which serve as mobile eye-care clinics travelling to the rural areas to help communities who need the care but cannot afford it.

The train eye-care project will visit 43 towns countrywide during the first half of this year.

The backbone of the project will be provided by students serving their internships at the Department of Optometry at the Rand Afrikaans University.

It also is intended to involve students from the University of Durban-Westville and the University of the North.

Dr Coen Slabber, the Department of National Health and Population Development director-general, has welcomed the project: "The unique model — where academics, interns, private optometrists, the private sector and the state's primary health-care services will co-operate to make available an important part of health care to the communities who have suffered a backlog in this regard — is a great step forward in the effort to improve the state of health of all members of the population.

"In my opinion, improved eye care will also have a positive influence on the effort to accomplish higher productivity, thus making a contribution to the economic upliftment of our respective communities," Dr Slabber said.

Home needs help

Disabled hope for race parity ruling from Cape administration

ARG 12/1/93

EDWARD MOLOINYANE
Staff Reporter

THE Langa Cheshire Home, in disarray because of a shortage of funds since it opened last April, hopes for a state subsidy to pay for improvements.

The chairman of Cheshire Homes in the Cape, Mr Vic Duggan, said parity in rates of subsidies, granted through the Cape Provincial Administration, would apply from April 1.

"We will be advised of the actual rates following the completion of forms in December," Mr Duggan said.

He said the subsidy "put Langa home on the same level as other population groups for subsidy purposes".

The home, a tiny building in sparse, overgrown grounds, accommodates five physically disabled men.

They each get a state disability grant of R290 and pay R156 a month for accommodation and other services.

All the men said life in the four-bedroomed home, which has two bathrooms, two toilets, a television room and a kitchen, was "fine".

Initially meant for 40 inmates but hit by financial difficulties from the planning stages in 1988, the building was made possible by a grant of R120 000 from the British Embassy. Cheshire Homes acquired the land.

A subsidy will come as a relief to Langa Home committee chairman Dr O Mbombo, who complained recently that two similar institutions for coloured and white people were run efficiently because the state lent a financial hand.

She said that although a nurse visited the home three times a week, there were no staff to run it properly and residents were left virtually alone.

"Because of lack of funds the home cannot function properly and it doesn't seem to serve the purpose for which it was was established," said Dr Mbombo.

Although a gardener is employed once a week, the grounds look awful, with overgrown vegetation and uncollected refuse scattered about.

But Mr Duggan stressed that a subsidy did not mean the end of the story.

"We are very anxious to proceed with extensions to the home to make it possible to increase the number of residents," he said.

The home was the first Cheshire Home for disabled black people in the Cape and the organisation is anxious to achieve the target of 40 residents.

Threat to health care

Staff Reporter

MEDICAL services could be jeopardised by the government's offer of a 5% salary increase, according to Professor Ralph Kirsch of the Medical Association of South Africa (MASA).

"The small increase in income, coupled with increased taxation, may result in a further loss of staff. This will aggravate the already intolerable workload of health service personnel, which recently has been compounded by the freezing and abolition of posts as part of the government's personnel reduction programmes," Professor Kirsch said.

Professor Kirsch urged the government to act swiftly to secure and strengthen the country's health services.

New betting board 'will help Transvaal'

CT 19/11/93 Own Correspondent 85

PRETORIA. — The creation of the Highveld Horseracing and Betting Board would generate additional funds for the provision of health services and pensions in the region, Transvaal Administrator Mr Danie Hough said yesterday.

Introducing the newly-appointed board, Mr Hough said the racing industry had contributed about R170 million to the province in the past financial year.

Cuba's way could transform our health

STAR 21/11/93.

(85)

CHANGE OF TACTICS

The fight for health for all in South Africa cannot be fought on the medical front alone . . . the battle needs to be taken into the community and its surroundings, say Cuban experts. PAULA FRAY reports.

WHEN Cuba emerged from its revolution more than three decades ago, it made health a right for all. Now, not only are medical services free, but the infrastructure has been improved to facilitate the move to better health.

"Today, that health service is one of the most important social achievements of the revolution in Cuba. Health, like education, is a priority," says Cuban epidemiologist Dr Felipe Delgado Bustillo.

Bustillo and Ministry of Health colleague Dr Carlos Mas Zabala have been in South Africa as guests of the African National Congress for the past six months — during which they visited 76 health institutions including 20 hospitals.

"The first task of our health service is prevention," says Zabala. "Then, we have an epidemiological approach to health problems. We see the disease in its context, its enviroment."

An example of this is TB: once someone has tested positive, the surrounding community is tested and the socio-economic conditions checked.

Bustillo emphasises that this is as important as prevention. To improve a community's health, it is important to look at nutrition, water supply education, social services, sanitation, recreation and employment.

"Health is not just the medicine, the nurse, the doctor ... health is also the socio-economic condition of the community," says Zabala. So, immunisation in Cuba went hand in hand with upgrading facilities.

In 1955, about 30 percent of the Cuban population had waste disposal; 30 years later this had increased to 80 percent. An excellent vaccination programme means that the last polio case was reported in 1962.

German measles, measles and mumps have been eliminated in five of the 14 provinces through immunisation — the country aims to eliminate it completely by 1995.

The island has 814 HIV cases — an incidence of 0,006 percent — and about 100 cases of full-blown Aids. Virtually everyone in the 10,8 million population has been tested — there have been more than 13 million tests.

A widespread education campaign has been well-received by the populution which has a 98 percent literacy rate and a high average education.

Cuba boasts 50 000 doctors and 80 000 qualified nurses — a ratio of one doctor for every 250 people and one nurse for every 150 people. A "Family Doctor Programme" — in which a doctor is placed to live within the community he or she serves — has helped cope with demand.

THESE doctors and health workers, says Bustillo, now concentrate on eliminating the chronic illnesses — such as hypertension and cancer — from the society by the year 2000.

"We were fifth place in Barcelona ... we are healthy people," he jokes.

But South Africa has a long way to go.

Reluctant to appear to be prescriptive, Zabala describes South African as two countries: "One in the First World and one in the Fifth World ... not even in the Third World. We think the deprivation — it's not a shortage — of health services to most of the people in a very big problem in South Africa. More than that, the majority of people have been deprived of life.

"It is very sad to see how many people are dying here every day ... in a very rich country ... of preventable diseases and malnourishment."

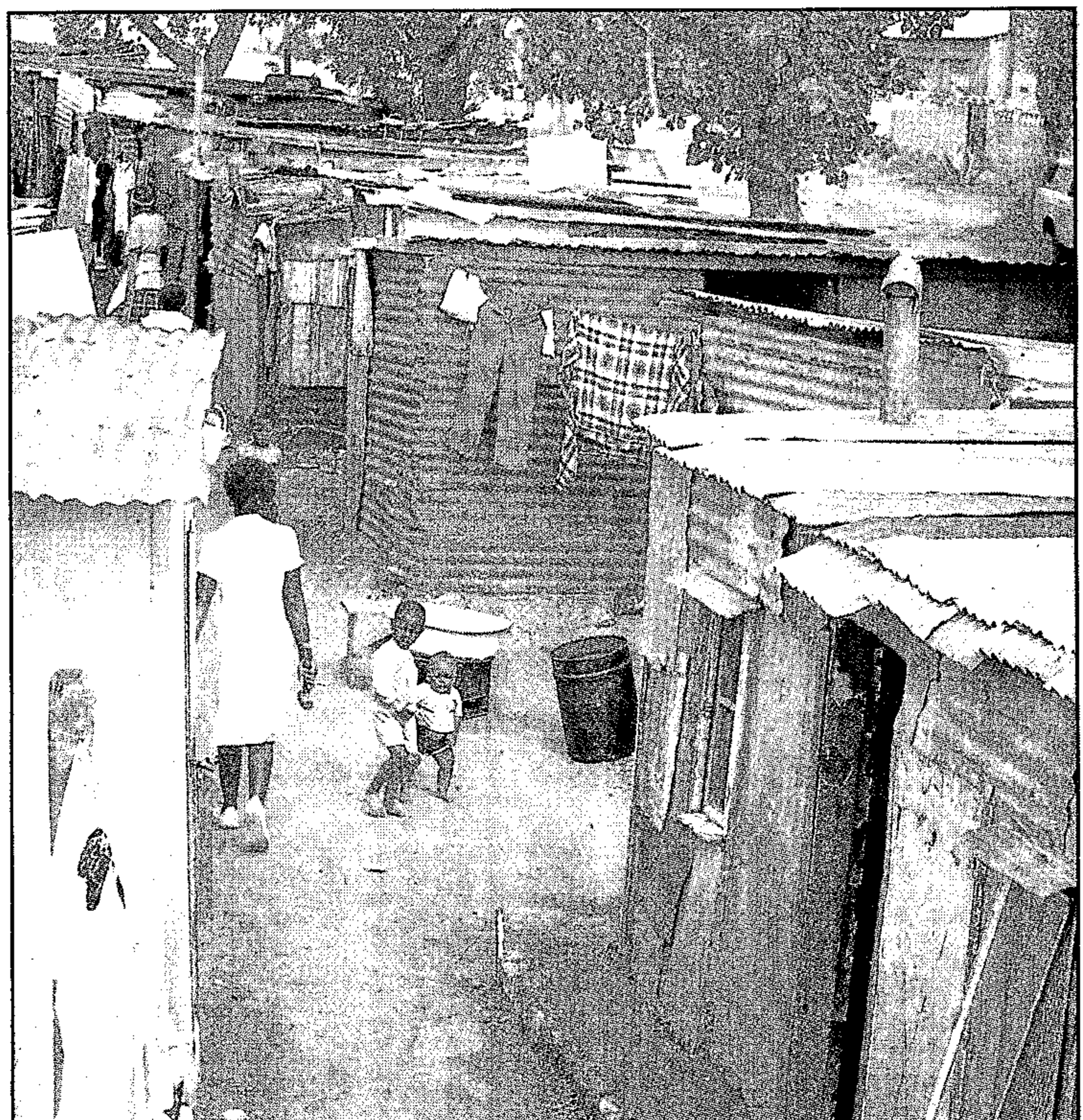
Primary health care (PHC), adds Zabala, is very weak for all races.

"There is a shortage of personnel, particularly in the rural areas. There is also an unequal distribution of facilities. For example, in the Transkei, 25 percent of the doctors are in Umtata. Hospitals don't have enough qualified personnel. And, because of the lack of PHC, hospitals' outpatients are crowded."

Bustillo sees several problems: fragmentation of services, a shortage of facilities and a real shortage of community, epidemiological and preventative approaches: "People here think mainly in a curative way."

Ironically, Zabala sees another major factor: "Wastage. There is a waste of resources. Some hospitals have expensive technology which is underused."

Cuba spends 8 percent of its budget on health; South Africa allocates 6 percent; "This is not a big difference. The problem is where you spend that 6 percent. If South Africa prioritises primary health care, prevention and some problem diseases, then the results will be evident in a few years."



In need of help . . . a squatter camp near Johannesburg. Visiting experts say health care here is so uneven that it divides between a First World and a Fifth World.

TOMORROW

Top Kenyan basketball player takes a turn on the silver screen.

Free health care 'not affordable'

IT IS unwise to raise expectations of free health care based on a national health system, said Adcock-Ingram chairman Rob Williams in the group's annual report.

Williams was referring to calls for "a greater or lesser degree of nationalisation of health care" which he considers simply not affordable.

Adcock-Ingram, in the Barlows stable, is engaged in the development, manufacture and marketing of health care, toiletry and retail self-medication products.

However Williams stressed there was an urgent need to redress the inequalities which exist in the health care system.

He said that cost-effectiveness of health care could be achieved without lowering standards based on self-regulation principles.

ST 5/1/93