HEALTH AND DISEASE - GENERAL

1994

A joint pioneering drive by South African companies to bring primary health care to the rural areas is to be repeated next week. Science Writer ***Anita Allen*** *reports on a Spoornet train with a difference*

Phelophepa brings message of hope

Star 4/1/94

(85)

DATES	
1	Arlington ..... 10 - 12 Jan
2	Theunissen ..... 17 - 21 Jan
3	Thaba 'Nchu ..... 24 - 28 Jan
4	Zastron ..... 31 Jan - 4 Feb
5	Aliwal North ..... 7 - 11 Feb
6	Noupoort ..... 14 - 18 Feb
7	De Aar ..... 21 - 25 Feb
8	Kakamas ..... 28 Feb - 4 Mar
9	Laingsburg ..... 7 - 11 Mar
10	Wolseley ..... 14 - 18 Mar
11	Bitterfontein ..... 21 - 25 Mar
12	Vredendal ..... 28 Mar - 1 Apr
13	Piketberg ..... 4 - 8 Apr
14	Saldanha ..... 11 - 15 Apr
15	Grahamstown ... 18 - 22 Apr
16	Somerset East ... 25 - 29 Apr
17	Maclear ..... 2 - 6 May
18	Volksrust ..... 9 - 13 May
19	Dundee ..... 16 - 20 May
20	Bergville ..... 23 - 27 May
21	Mooi River ..... 30 May - 3 Jun
22	Dalton ..... 6 - 10 Jun
23	Verulam ..... 13 - 17 Jun
24	Gingindlovu ..... 20 - 24 Jun
25	Mtubatuba ..... 27 Jun - 1 Jul
26	Ulundi ..... 4 - 8 Jul
27	Piet Retief ..... 1 - 15 Jul
28	Roossenekal ..... 18 - 22 Jul
29	Belfast ..... 25 - 29 Jul
30	Barberton ..... 1 - 5 Aug
31	Duiwelskloof ..... 8 - 12 Aug
32	Messina ..... 15 - 19 Aug
33	Zebediela ..... 22 - 26 Aug
34	Naboomspruit ..... 29 Aug - 2 Sep
35	Vaalwater ..... 5 - 9 Sep
36	Coligny ..... 5 - 9 Sep
37	Sishen ..... 19 - 23 Sep
38	Mafikeng ..... 26 - 30 Sep

When Transnet's Health Care train pulls out of Johannesburg station on January 10, a new era in primary health care in South Africa will begin.

By converting its eye care train, which travelled through rural South Africa last year and drew 30 000 patients, into a fully fledged mobile clinic, Transnet has focused its community involvement drive on primary health care, and has boosted that market, says Lynette Coetzee, manager: community involvement and manager of the train project.

Named Phelophepa — good health — the train will be stopping at 38 destinations countrywide until September. It comprises 13 coaches, which have been custom-made at Transwerk workshops in Salt River and Bloemfontein. These include two eye clinic coaches, a medi-clinic and pharmacy, a health clinic for basic screening, and coaches for storage, laundry, dining and a kitchen, as well as three accommodation coaches and a power car equipped with generators and diesel tanks for the supply of electricity.

A special feature of the train is its edu-clinic, which can accommodate up to 50 people, and is equipped with two TV and video recording sets supplied by Teljoy.

"The idea is to complement information from education videos with personal information sessions, while also training people informally," says Coetzee.

She emphasises that the project is not a public relations exercise. It is an honest attempt to reach people who do not have primary health care, and to preempt needless suffering.

Transnet has invested R5 million in the project, and for the time being is not looking for outside sponsors, Coetzee says. However, operating costs and the costs of transporting staff back and forth as they rotate will be high and the company may have to look for partners.

"The primary health care train is a learning process," says Coetzee. "As the needs of the community come to light, adjustments will be made. Our main aim is to co-operate with communities in providing a comprehensive primary health care service for people in rural areas, in order to enhance their quality of life."

The eye care team will consist of 16 final-year students who will alternate every five weeks, and work under local opticians and an optometrist.

Professor Jannie Ferreira, head of the department of optometry at RAU, who was the driving force behind the initial eye care train, says there is no problem getting students to do duty on the train.

"The initial list was filled within half an hour. When we circulated the list for 1994, I had a problem. I had to call a meeting to sort out the wrestling among enthusiastic students."

Another RAU lecturer, Elna Gross, acts as co-ordinator of nursing services. Eight third and fourth-year student nurses will be managed by a full-time community nurse, whose salary is sponsored by the pharmaceutical company Roche.

The processing of information in case files and accounting of services needed and delivered, is being done by Transnet's computer company, Datavia.

Another of Transnet's companies, Transtel, which has a share in one of the cellular telephone licences, is looking into providing a continuous service via satellite.

Community involvement at Transnet is promoted through selected employees at depots countrywide who are known as human environment champions. Two weeks before the train arrives at a destination, local role players, such as civics, clinics, municipalities, hospitals and the police will be informed. After the train has left the champions will be responsible for follow-up and feedback to ascertain the effectiveness of the project.

"The main objective is to make a difference in primary health care," says Coetzee. "My job is to make sure that we do just that and take hands with everyone in the system."

Gross says the project is the launch of an idea whose time has come.

"People think nursing is all about making sick people well, but it is also about keeping healthy people healthy. Health services in the past have focused on curative medicine. We (the nursing fraternity) no longer want to even talk about preventing illnessess, instead we want to promote, maintain and rebuild health. The emphasis must therefore be on health, instead of disease and illness."

Ferreira points out that news of the project has extended to overseas media, professional people and governments.

For Coetzee, the essence of Phelophepa is its message of hope: "We started it and we hope it will expand into something big. Our dream is four trains running through southern Africa, and then to the rest of Africa," she says. "Transnet can't make a difference on its own, but if potential sponsors and the communities believe and see that this train can make a difference, then it will never stop."

It's been called the best good luck story of 1993. Who knows, maybe Transnet will do what Cecil John Rhodes could only dream about and get to Cairo.

WHO may take SA back

JOHANNESBURG. — Professor Gottlieb Monekosso, World Health Organisation (WHO) regional director for Africa; is to urge the forum to reactivate South Africa's full membership when it gathers in Geneva on May 2.

This emerged after a meeting between the WHO representative and ANC president Mr Nelson Mandela yesterday.

The South African government's voting rights were suspended in 1964.

At the meeting, Mr Mandela provided Professor Monekosso with the ANC's latest policy document entitled "A National Health Plan".

A joint statement said that the WHO would mobilise technical and material support for a new government, and would help to train health service managers.

The ANC's policy on health and medicare will be released next week. — Sapa

(85) CT 11/1/94

Rina Venter ready to retire

PRETORIA. — National Health and Welfare Minister Dr Rina Venter announced yesterday she would not be available as a candidate for the April 27 election.

CT 12/11/94

According to a statement issued by the Government Communication Service, Dr Venter planned to retire from politics after the election and make herself available for community development. — Sapa

Health care 'appalling'

CT 13/1/94 (8S)

Staff Reporter

WESTERN CAPE ANC chief Dr Allan Boesak yesterday met the World Health Organisation's regional director for Africa, Dr Gottlieb Monekosso, to discuss "appalling" health care in the Western Cape.

Dr Boesak and other ANC officials, including regional secretary the Rev Chris Nissen and regional health department head Professor Peter Owen, took Dr Monekosso and his entourage on a tour of city townships before the group had lunch at the Waterfront.

"We talked about the health situation in the Western Cape," Dr Boesak said afterwards. "I think it is appalling."

By that, Dr Boesak said, he particularly meant the state of primary health care in the Western Cape.

Dr Monekosso, who is in South Africa at the invitation of ANC president Mr Nelson Mandela, is the first WHO official to travel to the country in more than 30 years.

Mr Mandela presented him with the second draft of the ANC's national health plan, which was produced with the technical assistance of the WHO and Unicef.

Prof Owen said yesterday the draft would be released publicly on January 19, and a final document to the government of national unity at the end of next month.

Boesak favourite for top spot

THE ANC is to announce its candidate for prime minister of the Western Cape — almost certainly its regional chairman, Dr Allan Boesak — at a public meeting on Sunday afternoon.

A "premier conference" of the ANC alliance will be held at the Peninsula Technikon on Sunday morning to formally choose its candidate.

The alliance's election co-ordinator in the Western Cape, Mr Ebrahim Rasool, said the regional premier conference would take place the day after the national list conference in the Transvaal at which the 200 candidates for the National Assembly would be decided on.

Mr Rasool said the meeting on Sunday afternoon at the Education Hall at the Peninsula Technikon at which the candicate for premier would be announced would be open to the press, the diplomatic corps, other organisations and members of the public.

The ANC's draft National Health Plan, published yesterday, outlines major administration changes, new financing arrangements, and real hope of improved health care for millions of South Africans. Health Writer ***David Robbins*** *looks at some of the details*

Star 20/1/94

Levelling the playing field in health

(85)

Although the role and position of the private sector is almost certain to change, the ANC's health proposals are perhaps intentionally vague about how this will be achieved. What is absolutely clear, however, is the determination of the plan to arrive at an equitable distribution of resources over the entire population.

It's hardly necessary to reiterate the existing racial and geographical disparities, and the hopelessly fragmented and wasteful nature of the old apartheid-driven health services. But the days of the existing equation, which shows the private sector accounting for 50 percent of total health spending for only about 20 percent of the population, are clearly numbered.

"The gross inequalities in the health status of different groups" will be eradicated by the creation of a single government structure "accountable to the people of South Africa through democratic structures".

Forthright stuff. But the key questions are how will this be achieved, and in what sort of time-frame?

For a start, the proposal is that all existing public sector health departments — including national, provincial, local authority, homeland, military and prisons — will be integrated with the private sector into a single National Health System (NHS), which will be established by July. By then, the necessary legislation will have been enacted and existing legislation repealed or amended to fit with the aims of the national plan.

Financing from general tax will remain at the same level, but will be added to by substantial increases on tobacco and alcohol, substantial increases for insured patients (medical aid members) attending state hospitals, and by savings effected in the rationalisation of existing (often overlapping) health bureaucracies.

Free health care is envisaged for certain groups: children under six, pregnant and nursing mothers, the elderly, the disabled and the chronically ill.

Certain services will also be free, including immunisation and some screening procedures, school health services, contraceptives, ante-natal and delivery services, nutrition support, and curative care for public health problems such as tuberculosis and sexually transmitted diseases.

The plan does not mention how much all this will cost, but it has set some encouraging deadlines which will help lift the health status of the majority of South Africans from the bottom of the all-Africa league table.

Here are some of the priorities set in the plan:

- Ante-natal care and delivery: The aim is to ensure that at least 50 percent of South African babies are born under hygienic conditions by the end of 1995, this figure growing to 90 percent by the turn of the century. At the same time, more than 90 percent of pregnant women must be attending clinics at least once by the end of 1995.
- Immunisation: Here the aim is to provide full immunisation (polio, neonatal tetanus, measles, etc) for 80 percent of all children under two by the end of 1995, and 90 percent by the end of 1997.
- Free health for children under six: Available at all existing health facilities by June this year, and 100 percent coverage by 1995.
- Nutrition: By means of price controls, subsidies and educational support, to reduce moderate malnutrition by 20 percent and severe malnutrition by 40 percent by the end of 1995, and by 50 percent and 75 percent respectively by 1999.
- Communicable diseases: Stringent preventive programmes are planned here. An example is tuberculosis where the aim is to achieve a national immunisation of 80 percent of children under two by 1995 and 95 percent by 1999. Hepatitis B also comes under scrutiny, and a major immunisation campaign is planned for 1995.
- Clinics and community health centres: By June of this year to establish the number of new facilities needed, including future forecasts, and have them all built by the turn of the century. Furthermore, ensure that at least 75 percent of the population lives within reach of a primary health care (PHC) facility by the end of 1995.
- Training of personnel: Aim to train or retrain 25 percent of district health workers in the PHC approach by the end of 1995, and 50 percent by 1997. By the end of 1995, a long-term programme to cover the total personnel needs of the NHS must also be prepared, and changes to existing curricula at medical training institutions should be in place by the end of 1996.

Targets are also set for health (especially sex education) programmes in all schools (by January 1996); new legislation which protects women and children from all forms of violence (by the end of this year); the establishment of an essential drugs list (end of this year); issues pertaining to environmental health and the protection of the environment; and the setting up of comprehensive health information systems.

Since the 1994/5 health budget has already been established, the plan sets a deadline for the end of next year (1995) to achieve a redistribution of the budget which will provide 50 percent for community and district spending, 30 percent for the provincial level, and 20 percent for the centre.

A commission of inquiry into the future of South Africa's more than 100 medical aids will be established by August, and increased excise duty on tobacco and alcohol should be in place before Christmas.

The thrust of the draft health plan is based on the recognition of the need for a "total transformation of the health sector in South Africa". No longer must health be more concerned with ideological correctness and political control than service, and no longer must it be "biased towards domination by doctors, by men, by curative care and by the private sector".

These intentions are abundantly clear in the detail of the plan and should come as a relief to those acquainted with some of the hardship and suffering caused by the present health system.

"This draft plan is presented for debate, discussion and amendment," says the ANC. "Thereafter a final draft will be available for presentation to the government of national unity."

ANC plan for medicine sales is 'monopolistic'

CT 21/1/94 (85)

Political Staff

IT would be socialistic and monopolistic for the pharmaceutical industry to sell medicines to the state alone in a new South Africa, said the chief executive of one of South Africa's largest pharmaceutical companies.

Dr Tobias Kiechle, of Roche SA, was responding to the ANC's draft national health plan — released in Johannesburg on Wednesday — which suggested that the pharmaceutical industry sell its products largely, if not exclusively, to the state.

Spokesmen for Norristan, Reckitt & Colman and the Pharmacy Council said they had not yet studied the draft plan.

Meanwhile the Minister of National Health, Dr Rina Venter, said the ANC's draft largely corresponded with the government's approach — but she reserved judgment on its plans for private medicine which the Democratic Party criticised.

The DP's deputy health spokesperson, Ms Carole Charlewood, said the ANC plan had distinct tones of socialism in its intention to restrict the practice of private medicine.

The DP welcomed provisions for the disadvantaged sector of the community, but "it must be made clear that unless the wheels of free enterprise continue to spin, there will be no money from taxes to fund such welfare proposals".

"The DP welcomes the proposal for increased taxes on alcohol and tobacco, both of which are long overdue thanks to the National Party's protectionism towards its supporters in the tobacco and liquor industries," Ms Charlewood said.

The ANC's draft National Health Plan, published yesterday, outlines major administration changes, new financing arrangements, and real hope of improved health care for millions of South Africans. Argus Correspondent DAVID ROBBINS looks at the details.

(85) ARG 20/1/94

ALTHOUGH the role and position of the private sector is almost certain to change, the ANC's health proposals are perhaps intentionally vague about how this will be achieved.

What is absolutely clear, however, is the determination of the plan to arrive at an equitable distribution of resources over the entire population.

It is hardly necessary to reiterate the existing racial and geographical disparities, and the hopelessly fragmented and wasteful nature of the old apartheid-driven health services. But the days of the existing equation, which shows the private sector accounting for 50 percent of total health spending for only about 20 percent of the population, are clearly numbered.

"The gross inequalities in the health status of different groups" will be eradicated by the creation of a single government structure "accountable to the people of South Africa through democratic structures".

Forthright stuff. But the key questions are how will this be achieved, and in what time-frame?

For a start, the proposal is that all public sector health departments — including national, provincial, local authority, homeland, military and prisons — will be integrated with the private sector into a single National Health System (NHS) which will be established by July.

By that time, the necessary legislation will have been enacted and existing legislation repealed or amended to fit in with the aims of the national plan.

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Free health care is envisaged for certain groups: children under six, pregnant and nursing mothers, the elderly, the disabled and chronically ill.

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The plan does not mention how much all this will cost, but it has set some encouraging deadlines which will help to lift the health status of the majority of South Africans away from the bottom of the all-Africa league table.

Here are some of the priorities set in the plan:

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● Training of personnel: the aim is to train or retrain 25 percent of district health workers in the PHC approach by the end of 1995, and 50 percent by 1997. By the end of 1995, a long-term programme to cover the total personnel needs of the NHS must also be prepared, and changes to existing curricula at medical training institutions should be in place by the end of 1996.

Targets are also set for health (especially sex education) programmes in all schools (by January 1996); new legislation which protects women and children from all forms of violence (by the end of this year); the establishment of an essential drugs list (end of this year); issues pertaining to environmental health and the protection of the environment; and the setting up of comprehensive health information systems.

The determination to right the inequities of the past are no more clearly evidenced than in the proposed speed with which the new financial arrangements should be installed.

Since the 1994/5 health budget has already been established, the plan sets a deadline for the end of next year to achieve a redistribution of the budget which will provide 50 percent for community and district spending, 30 percent for the provincial level, and 20 percent for the centre.

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No longer must health be more concerned with ideological correctness and political control than service, and no longer must it be "biased towards domination by doctors, by men, by curative care and by the private sector".

These intentions are abundantly clear in the detail of the plan and should come as a relief to those acquainted with some of the hardship and suffering caused by the present health system. There is, however, still room for manoeuvre by interested parties.

"This draft plan is presented for debate, discussion and amendment," says the ANC. "Thereafter a final draft will be available for presentation to the government of national unity."

Private sector growth discouraged

ANC unveils sweeping health plan

BIDay 20/11/94

(85)

KATHRYN STRACHAN
and JACQUIE GOLDING

THE ANC's plan for a new health care system includes a strong emphasis on building up the public health service and discouraging expansion of the private sector.

The ANC's draft plan, announced yesterday at a Johannesburg news conference by national executive committee member Cheryl Carolus, set out a five-year programme to create a national health system based on effective primary health care and funded through existing taxation levels.

The ANC said it hoped the draft would spark rigorous debate and, with amendments if needed, be considered as a national health programme.

One of the most controversial aspects of the plan is likely to be the ANC's stance on abortion. A clause proposes that all women be given the choice of having abortions, and medical practitioners be given the choice of performing the operations.

Carolus said she did not believe this position conflicted with the Bill of Rights, which affirms the right to life.

The ANC believes SA's existing health budget of 6,5% of GDP is adequate to provide high quality care for all, but says a lack of co-ordinated planning, mismanagement of resources and inefficiencies in the public and private sectors have resulted in an "appallingly" inefficient system when compared with other countries.

In addition to general taxation, the ANC proposed health care be funded by national health insurance, based on employer and employee contributions, and increased taxes on alcohol and tobacco.

Carolus said the national health system would include public and private practitioners. Most health care would be provided by the public sector, with the private sector playing a complementary role. Private practitioners would be encouraged to work in public clinics, health centres and hospitals on a regular, rotational basis.

She conceded the public sector would be unable to compete with private sector salaries, but incentives such as better working conditions would be offered to encourage practitioners to return to the public sector. The state would not subsidise expansion of the private health sector, which would be discouraged. Privately owned services run on a fee-for-service basis would play a lesser role in future.

The private sector could play an important role in achieving health for all if profit was not the major incentive of practitioners, Carolus said.

The licensing of private sector facilities would be more tightly regulated. To avoid conflicts of interest, health workers would not be permitted to hold shares or have other financial interests in private clinics.

The pharmaceutical industry and suppliers of medication and equipment would be encouraged to sell their products largely, if not exclusively, to the state.

The system's targets were free maternity care within five years, full immunisation by 1998 of 90% of children younger than two, and eradication of polio and neonatal tetanus in 1995. The plan also pro-

☐ To Page 2

Health plan

BIDay 20/11/94

☐ From Page 1

vided for mass education and counselling to combat AIDS and greatly improve services for the disadvantaged.

(85)

The draft also acknowledged the role of traditional healers and said their registration within the system would have to be investigated.

The Medical Association of SA (Masa), which represents doctors and dentists, said strengthening the public sector was to be welcomed, but expressed reservations about the plan to discourage growth in the private sector.

Masa welcomed the ANC's intention to introduce incentives to attract practitioners to the public service, adding that the staffing of primary health care facilities and improved service conditions were two important aspects of the plan.

Wits University centre for health policy director Max Price said the draft plan was an "excellent start". It was the first time a political party had detailed its plan for health, and it was to the ANC's credit that it placed health so high on the agenda. The clear timetable and objectives indicated that the ANC was committed to the plan, and was not making vague promises.

However, he was concerned that the plan was ambitious and not linked to the resources available. The cost of upgrading had not been carefully calculated, and the ANC could well find that the necessary resources were not available and priorities would have to be identified.

● Picture: Page 3

THE WEEKLY MAIL & GUARDIAN
January 21 to 27 1994

Health professionals scurry abroad

WM 21-27/1/94 (23b) (85)

Vuyo Mvoko

POLITICAL instability and low pay are driving highly skilled South African health professionals into exile.

Physiotherapists, occupational therapists and professional nurses with a degree are the special target of overseas employers, says recruiting agent Ron Seymour, who processes 100 foreign job applications a year.

The main destinations are Canada and America, which need 20 000 of these health workers.

"A brain drain has already happened," says Lo-an Roux, editor of the South African Society of Physiotherapy's journal, *Physio Forum*. Roux believes that "a lot of people do not want to be involved in the upsets of the revolution".

Some professionals later return to South Africa, but there are fears that, influenced by South Africa's political upheavals, more may settle abroad.

Advertising consultant Rory Macnamara says overseas employers are prepared to spend huge sums on advertising because of the overwhelming and immediate response. Advertising has become more aggressive, and includes full-page ads in professional magazines.

In contrast to what one occupational therapist called "pretty shocking" local salaries — R2 286 a month for physiotherapists with four-year university degrees — packages in the US include a salary of at least $36 000 (R122 000) a year, a fully insured company car or down payment on a new car, free air tickets and relocation expenses, free accommodation of up to a year, and health and professional liability insurance.

Additional benefits may include help in acquiring drivers' licences, permanent housing and bursaries for further education.

Recruitment agencies are doing a roaring trade. On average, they charge 12 percent of each recruit's annual salary for their services. Fly-by-night recruitment agencies are also said to be mushrooming.

For physios and occupational therapists, the application process takes between three and four months. Recruits write an "acceptance test" in their adoptive country, which most South Africans are said to pass with flying colours.

Local physio Joanne Enslin did her postgraduate studies in America and spent two years practising in a general hospital. She goes back to the US to work each year, earning $40 (R136) an hour.

Enslin said America offered unique opportunities for skills upgrading on new therapeutic techniques and advanced technology.

Commenting on the exodus, Professor Muriel Goodman, head of physiotherapy at both Wits University and Johannesburg Hospital, said: "There is worldwide shortage of physiotherapists. It makes no sense that cleaners at South African Breweries want a minimum wage of R1 800 a month, when our graduates get R2 286 after four years of BSc training."

WM 21-27/1/94 (267) (85)

ANC controversy over abortion plan

The ANC's draft plan on health care backs abortion on demand, report **Pat Sidley and Reg Rumney**

THE ANC's tentative backing for abortion on demand in its draft health policy has already drawn criticism from pro-lifers. It is one of several highly contentious suggestions in the ANC's draft plan for a national health policy plan released this week, which emphasises public sector health at the expense of the private sector.

The support for women's choice on abortion is hedged with a note that "the issues around abortion remain contentious and need to be discussed and debated further".

The move to support abortion is also likely to stir up feelings within the ANC itself, where the issue of abortion is by no means settled. Another issue likely to cause controversy is the suggestion that medical graduates be forced to work for the state for a period — or repay state loans.

The reaction of the Medical Association of South Africa to the plan has been muted, with the association saying it is "encouraged" by the policy proposals in general. Masa merely notes that "to discourage growth in the private sector is debatable". It also says ambitious time schedules could create unrealistic expectations.

Centre for Health Policy Studies' Max Price comments that there is a contradiction in the document which later talks about contracting the private sector to provide services for the public sector, which would entail growth.

Price believes that overall the document offers health care workers a rosy future, albeit in a regulated environment. The move to bar doctors dispensing medicines they themselves have prescribed will cause unhappiness among some members of Masa itself.

It is also unclear how the bar on medical practitioners buying shares in private clinics is to work. Dr Gordon Cohen of Clinic Holdings notes the move could not be done retrospectively and he doubts its feasibility. "Our doctors are free to buy Clinic Holdings shares on the JSE."

The plan proposes free basic medical care. Some proposals are also likely to send shivers up the spine of the pharmaceutical industry.

The ANC plan, which runs to 100 pages and was presented this week in Johannesburg by health and welfare supremo Cheryl Carolus, calls for a strengthening of the public health sector and the availability of basic medical care to the whole population. Free health care would be available to children under six, pregnant and nursing mothers, the elderly, disabled and chronically ill.

Cheryl Carolus ... radical new plan

Free medical services would include immunisation, regular screening procedures to detect cancer, ante-natal care and child delivery, contraceptives, feeding support and treatment for TB.

The national health service would be financed through current income tax levels, claims the ANC. Extra revenue would come from steep increases in the prices of tobacco and alcohol. Patients with health insurance or medical aids will face steep charges at public hospitals.

In an attempt to redirect resources towards the public sector, the plan would regulate private health care, which it says currently channels resources disproportionately to wealthier, healthier people.

Single national system proposed

ANC plans big switch 'on health

Star 20/11/94

85

EMPHASIS on primary care will boost services in rural areas, while hospitals will get less

■ **BY DAVID ROBBINS**
HEALTH WRITER

A single national health system which promises major changes for the powerful private sector — including medical aid schemes, doctors and hospitals — has been proposed by the ANC.

Details are contained in the ANC's national health plan which was made public at a press conference yesterday.

The emphasis is placed on primary health care, which will be bolstered by a major redistribution of the health budget.

The ANC proposes that a single central structure replace the present fragmented health authorities.

Decision-making and control of funds should be "decentralised to the lowest level possible that is compatible with rational planning and the maintenance of quality care".

In the current health budget, most money is spent on hospitals, with only 15 percent going directly to health care.

The ANC says 50 percent of the budget should be spent at district level, including primary health care and community hospitals, and only 30 percent at regional/provincial level.

Funding

This shift will improve services in the neglected rural areas but could have a negative impact on hospitals already strapped for cash.

In terms of the plan, health funding will continue to be drawn from general tax revenue and will remain at about 12 percent of the national budget. Additional funds will be found through "substantial increases" in excise on tobacco and alcohol products.

Fees for medical aid patients using public hospitals will be "significantly increased to levels which are nearer cost recovery" than they are at present.

This will place an increased burden on the country's hard-pressed medical aid schemes.

The plan says the advisability of continuing public subsidies to the private sector, especially tax concessions for medical aid contributions, will be examined by a commission to be established by August.

The role of the private sector will "continue to be acknowledged and regulated".

However, expansion of this sector will be discouraged. Incentives will be created for private sector health workers to return to the public sector.

▶ **See Page 15**

R200-m trust to help rural communities

Star

■ BY ABDUL MILAZI

The Independent Development Trust (IDT) has allocated R200 million for the upliftment and development of South Africa's rural communities. 21/11/94

Addressing a press conference in Johannesburg yesterday, IDT director of communications Jolyon Nuttall said the development of rural communities, which was vital to the prosperity of a new South Africa, was neglected by most development initiatives.

Nuttall said the R200 million, R31 million of which came from the National Economic Forum, would be used to build roads, schools and support self-help projects in rural areas.

Since its inception a year ago, the IDT's Relief Development Programme (RDP) has supported 717 community projects with a combined budget of R85 million, 60 percent of which has been disbursed.

The RDP began as a drought relief programme and facilitated the construction of dams, schools, roads and community gardens in drought-stricken areas.

About 68 000 temporary jobs were created, Nuttall said.

"Employment is a major problem in rural areas and this is where the RDP will concentrate its efforts in future projects."

The purpose of the RDP's emphasis on employment creation this year was to channel most of the project funds into direct labour income.

Masa 'encouraged', DP critical

Reaction to ANC health plan mixed

Star 21/11/94

85

■ BY DAVID ROBBINS
HEALTH WRITER

Mixed response has greeted the ANC's national health plan, which makes provision for a single health ministry and attempts to redress the gross imbalances which have traditionally afflicted health care in apartheid South Africa.

The Medical Association of South Africa (Masa) said it was "encouraged by the proposals", which were philosophically sound.

The Democratic Party, on the other hand, complained that the new health plan "has distinct overtones of socialism".

The ANC plan, released on Wednesday, pays special attention to the role of the powerful private sector, which accounts for about 50 percent of the country's health spending, although only servicing 20 percent of the population.

Among the proposals designed to correct this inequity are various controls, price pegging and prohibitions aimed directly at the private sector, the growth of which would be discouraged.

Carole Charlewood, the DP's deputy health spokesman, said: "While the DP welcomes the provisions for the disadvantaged sector of the community, it must be made clear that unless the wheels of free enterprise continue to spin, there will be no money from taxes to fund such welfare proposals."

Although praising the general principles of equity in the report, Masa chairman Dr Bernard Mandell said that to discourage the growth of the private sector was "debatable".

"We believe that ways should rather be explored to optimise the role of the private sector in the rendering of services to people who are the responsibility of the State," he said.

Mandell also said the concept of managed health care, a system of cost containment being considered by many South African medical aids, had not even been mentioned by the ANC.

The ANC has indicated that a commission of inquiry into the future of medical aids would be established by August.

Representative Association of Medical Schemes executive director Reg Magennis said he would welcome "any structured initiative" of this kind.

Health care group to monitor promises

B1Day 2/1/94

KATHRYN STRACHAN

THE National Progressive Primary Health Care Network last night launched its campaign to ensure health care would be an important issue during the elections.

The campaign will press political parties to put their health policies and plans on the line — and will monitor progress after the elections to assess whether the promises were kept or not. (85)

Spokesman Judi Fortuin said: "The elections provide all South Africans with an opportunity to elect the parties that promise to ensure their health care needs will be met, and to hold those parties accountable in the future."

Political parties will be challenged by the public to discuss and defend their positions on health issues at forums throughout SA. The network will also publish an analysis of parties' positions on health, as well as the results of a public opinion poll measuring people's concerns about health.

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Health train helping to put communities back on track

ST Times 23/11/94

THE old woman lifted the simple black frames to her eyes. (85)

Behind the lenses her eyes widened and her face creased in wonder. Turning to Rand Afrikaans University optometry professor Jannie Ferreira, she said: "God has sent you."

Professor Ferreira is part of Transnet's unique community health project, a train that chugged into its first stop this week at Arlington in the Free State.

The company has invested R5-million into equipping Phelophepa, meaning good health, and sending her around the country to bring basic health care, an eye clinic and a pharmacy to the doorstep of people who don't have easy access to clinics.

Project manager Lynette Coetzee is delighted to see the train on track. "This train belongs to the community. We will need a lot of money to keep going but we feel very relaxed about it because it is going so well," she says.

The first few days in Arlington were slow but as word got around, numbers swelled. On Wednesday, more than 500 people turned up for glasses, pills and treatment for minor ailments.

The service is not free. Eye tests cost R10, glasses are R30 and there is a flat fee of R5 for any prescription.

THEATRICAL TEACHER: A nurse entertains patients with a puppet Picture: MARTIN POPE

By GILLIAN BESTER

One man says he does not have the money for his glasses but promises to come back in the afternoon with the cash. They let him have his new glasses, and that afternoon he does indeed return, clutching a fistful of notes.

A farmer pulls up with 25 labourers in a truck. He has a quiet word with the cashier and leaves him a blank cheque to cover the cost of checking his staff.

For many of the rural people the train has already begun to take on a mystical quality. A childless 50-year-old woman solemnly tells a student nurse: "The train is going to give me a baby."

Johannes Safatsa, a labourer, has arrived with his whole family for treatment.

"This train is very good. It will help us a lot, especially the people with bad eyes. We don't get doctors for eyes here, only very far from us."

By midday more than 200 people are waiting patiently, including a handful of whites.

Arthur and Helene Strey, an elderly couple from Steynsrus, say they received a letter in their postbox that morning about Phelophepa.

"This train really is fantastic. There is no optician in town and the fact is that glasses here are very cheap," says Helene.

A community nurse moves along the rows with a puppet on her hand, talking to the children. Many of them have never seen a puppet before and are not sure whether to laugh or cry.

The puppet steals a hat off the head of an elderly gentleman and places it on its own. This draws a positive reaction: the crowd giggles and begins to pay attention.

"How many times a day do you brush your teeth?" the puppet asks the nearest child. "You must brush your teeth every day, or your teeth will go *vrot* and fall out."

The train has 13 coaches and is staffed with 18 optometry students, their lecturer, a qualified optometrist, eight student nurses, their lecturer and a qualified sister, as well as Transnet security, a manager, chef and pharmacist.

But what does the future hold for Phelophepa?

Lynette hopes that education will be a major part. "We have to teach them to be healthy, to sterilise the water, basic hygiene and good eating. You can't just give out a tablet for a pain because when we are gone they have to carry on."

Professor Ferreira, who first dreamt up the idea of a health train, envisages 101 little Phelophepas pulling into every corner of rural Africa.

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How the ANC plans to turn you into a healthy teetotaller

By CAS St LEGER

THE new South African will be stress-free, breast-fed, vaccinated, a non-smoker and teetotal — if the ANC's plans for health care succeed.

In the event of medical problems, he or she will also have access to a primary health clinic, and — should the ailment prove serious — be flown to a hospital in an SA Air Force helicopter.

According to the ANC's draft health plan, prepared with the help of the World Health Organisation and the United Nations Children's Fund, health care will be financed not by tax hikes, but by significantly bumping up the levies on alcohol and cigarettes to discourage "destructive lifestyles".

"The additional revenue raised from this source will be specifically dedicated to public health services," according to the plan, released this week.

The ANC has calculated that the R550 that South Africa spends per person per year on health care — 6,5 percent of GDP — is sufficient for future needs.

This amount is 10 times the World Bank's basic health care estimates, and the ANC maintains it is only mismanagement that has resulted in South Africans getting "so little value for their money".

Free health care will be provided to children under six, pregnant and nursing mothers, the elderly, the disabled and the chronically ill.

Also free will be immunisation, certain screening, school health services, antenatal and delivery services, contraceptive services, nutrition support and curative care for public health problems like tuberculosis and sexually transmitted diseases.

Free, community-based care for AIDS patients is also proposed.

The emphasis falls on primary health care, and the plan recommends that all emergency patients must have transport to hospital, whether or not they are able to pay for it.

Emergency-response vehicles could range from taxis to helicopters, to be provided by the SAAF "at the request of the health control centre".

Traditional healers and herbs will form an integral part of the new National Health Service, and a committee will investigate the incorporation of traditional drugs into the health-care system.

Healthy lifestyles will be encouraged. While there will be a focus on the eradication of major diseases such as AIDS and tuberculosis, attention will also be given to education on sexuality, family planning and substance abuse.

Dentistry will receive special attention, with priority being given to a reduction of "community exposure to oral disease".

This will be achieved by the introduction of a policy enabling the "effective delivery of fluoride to the whole community", and a food policy which limits the frequency and quantity of sugar consumption.

The pharmaceutical industry will be encouraged to sell its products largely, "if not exclusively", to the state.

Drug prices will be fixed and a registration process introduced for the initial pricing of drugs to ensure cost-effectiveness. Wider use of generic drugs will be encouraged.

While a footnote cautions that abortion remains a contentious issue, the section on women's health suggests there could be recognition of the right of women to control the reproductive functions of their bodies, including abortion.

AIDS-infected women who fall pregnant should be offered easy access to abortion, the plan recommends.

The new minister of health will have special responsibilities to the hitherto largely overlooked rural areas. He or she will play an "advocacy role" in ensuring that attention is given to the provision of water, sanitation and other infrastructures.

The country will be divided into 100 health districts, each containing between 200 000 and 750 000 people.

Each district will be allocated a budget, and a team to manage it, and doctors in private practice will be integrated into the national health system, with encouragement to work in primary health-care centres on a rotational basis.

R1,8 m boost for health

(85) ARG 24/11/94

Health Reporter

FIVE South African projects focusing on maternal and child health have been given a R1,8 million boost by the Medical Research Council and Independent Development Trust.

The projects in Soweto, Natal, Eastern Trasnvaal, BophuthaTswana and King William's Town were selected from over 60 which applied for the funding.

Each of the five was deemed to be directly addressing health problems of women and children.

They will be carefully monitored by the MRC and IDT over the next three years.

Parties to state position on health

(85) ARG 24/1/94

Health Reporter

THE major players in the April election are to be called on to spell out their positions on health at public meetings to be held around South Africa.

Eight meetings are being organised by the National Progressive Primary Health Care Network, which has elicited written responses from the major political parties on 29 health-related questions.

The network will publish an analysis of the various positions, focusing on primary health care, the health of women and children, sexual health and Aids, community involvement and financing.

The objective is to put health on the political agenda.

Network national co-ordinator Judi Fortuin said: "The elections provide all South Africans with a chance to elect the parties that promise to assure that their health care needs are met and to hold these parties accountable in the future."

The Cape Town meeting date must still to be announced.

Cautious welcome for health policy

JOHANNESBURG. — The Pharmaceutical Society of South Africa yesterday welcomed the broad principles of the ANCs' health policy but questioned its possible tendencies towards nationalisation.

Executive director Mr Boet van der Merwe said the planned encouragement of the pharmaceutical industry to sell most of its production to the state smacked of nationalisation.

"Health care should remain a dual system between the private and public sectors provided there is an aggressive drive to root out inefficiencies.

"That the growth of private health care services is to be discouraged is a matter of concern."

The society also supported the integration of aspects of traditional healers' practices within the health care framework. — Sapa

Guarded support for ANC health plan

B/Day 25/11/94

THE Pharmaceutical Society of SA yesterday welcomed the broad principles of the ANC's health policy but questioned its possible tendencies toward nationalisation.

Executive director Boet van der Merwe said the planned encouragement of the pharmaceutical industry to sell most of its production to the state smacked of nationalisation.

"Health care should remain a dual system between the private and public sectors provided there is an aggressive drive to root out inefficiencies," said Van der Merwe.

"That the growth of private health care services is to be discouraged is a matter of concern.

"While the plan proposes to raise funds through increased taxing of alcohol and tobacco, the state will remain hard-pressed for health care funds."

He said it was desirable rather to minimise state involvement and expenditure by encouraging the private sector to serve those who could afford it.

Stimulation of the private sector to develop health care services and systems to serve lower income groups equitably and cost-effectively was the more attractive option, he said.

"Although it is envisaged that national health insurance is to be funded by employees and employers, more details are required.

"The private sector already funds a form of medical insurance for part of the population, through shared funding of medical schemes and 'top-up' health insurance," he said.

"Being privately administered, of which the medical scheme portion is non-profit making, the state and private sector could co-operate in extending such in-place expertise and facilities."

Van der Merwe added that where the ANC document referred to "private practitioners", the society needed assurance that this was a generic term for all healthcare professionals, including pharmacists.

"The society applauds moves towards formalising patients' rights," he said, adding that it was encouraging to see private practitioners and private hospitals would play an important role in the national health system.

"Likewise, that health personnel will be multi-disciplinary."

The Pharmaceutical Society supported this concept, as it did that of integrating aspects of traditional healers' practices within the healthcare framework.

Van der Merwe said his society also welcomed the ANC's recognition of the need to retain statutory bodies in a more co-ordinated manner. — Sapa.

Agriculture buys 5% more diesel

MUNGO SOGGOT

WHOLESALE diesel sales to agriculture in the first 10 months of 1993 were 5% up from the same period the year before, according to a survey released by the Central Statistical Service (CSS) yesterday.

Econometrix economist Tony Twine attributed the increase to better summer rainfall crops — in particular the maize crop which weighed in at 8-million tons in 1993, compared with 3-million tons the year before.

Twine said more diesel would have been used to harvest the crops, and to transport the produce afterwards.

In December last year the SA Agricultural Machinery Association said total tractor sales in 1993 had risen 41,6% from the year before.

"The growth of the agricultural sector's contribution to GDP in the second and third quarters of 1993 was phenomenal," Twine said. Contribution to GDP in the second quarter was 35% larger than in the first, and in the third quarter it was 31% up on the second.

However, the CSS survey showed that diesel sales in October 1993 dropped 17,3% from September.

Twine said this fluctuation followed a similar pattern in wholesale petrol sales caused by supply distortions that surrounded September's fuel price increases. The price of diesel went up 6c on September 15.

He said the fall in sales in October could be explained by "pre-emptive stocking before the September price increase".

ANC health plan 'idealistic'

CT 27/1/94 (85)

PRETORIA. — National Health and Welfare Minister Dr Rina Venter has labelled as "idealistic" the ANC's national health plan, saying it will be "difficult if not impossible" to implement in its entirety.

Time schedules for the implementation of the objectives were unrealistic as were the expectations it would create, she said.

Dr Venter criticised what she considered to be the ANC's vagueness on the management mechanisms by which the plan would be implemented and the "superficial viewpoints" put forward on the financing of the system.

She said the ANC's envisaged price control of medicine could create major problems for pharmaceutical firms. — Sapa

NP wants private sector to do more for health care

JACQUIE GOLDING

THE thrust of the NP's health policy was to encourage co-operation between the private and public sectors, as there was no room for duplication of services, Health Minister Rina Venter said yesterday.

Detailing the NP's health policy in Pretoria, she said it would like to see the private sector caring for more than its 20% to 25% of patients. B/Day

She said government would follow a policy of encouragement for expansion wherever it could cost-effectively be introduced.

The policy, however, stipulated the need for central control over the private sector to ensure the "public is not exploited" and that the aim of "improved health for all" remained the driving force behind services rendered.

She said the escalating cost of medicines was "far in excess of inflation".

Generic substitution, the Medical Association of SA and medical schemes' incentives to doctors and revision of government tender practices were cited as ways of cutting costs.

General taxation would be the primary revenue base for the NP's health policy. The minimum package of services would be financed through the health budget while other sources would include income tax, company tax, VAT and customs duties. 27/11/94

Venter said the training of manpower for actual needs regarding primary health care received special attention. (85)

She said the access to health care was accepted by the NP as being a basic human right but the "voice of sanity" said it could never be unlimited.

Fin 28/11/94 (85)

subsidies. For instance, if a company pays 100% of an employee's R800/month premium, the employee would have to pay up to R320/month in extra tax.

Says Representative Association of Medical Schemes executive director Reg Magennis: "With no tax advantage, many people, particularly the young and healthy, would opt out. When they needed health care, they would have to rely on the State and that would be counter-productive."

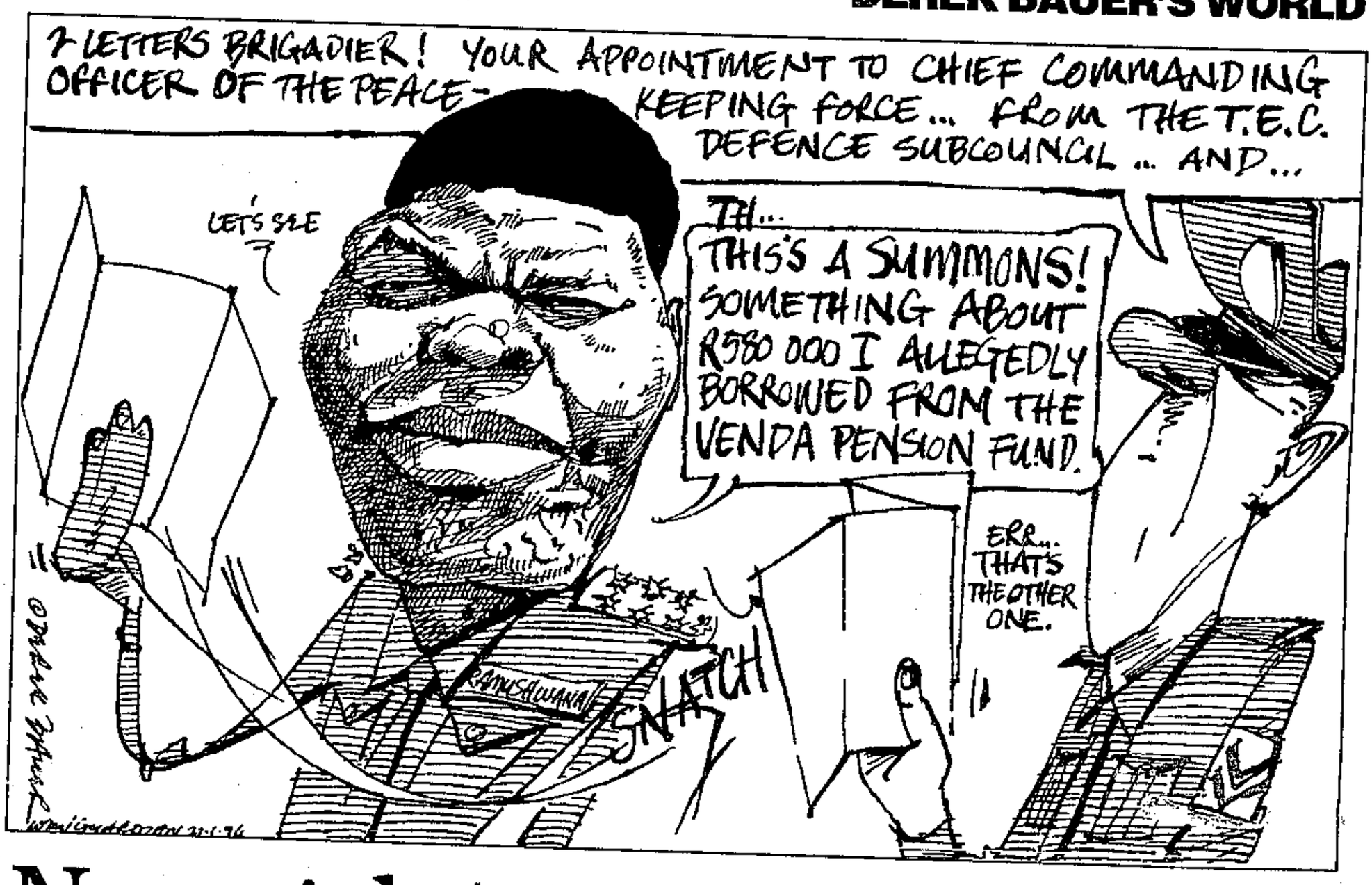
Up go the taxes

His preliminary estimates are that even with the tax subsidies, the health-care industry funnels 10%-15% annually — between R1,2bn and R1,8bn — in taxes back to the State. He also believes that withdrawing the subsidies could destroy part of the private health-care infrastructure, which could be used by public sector patients. "If you pull the plug on tax subsidies, the State is going to lose a lot more money than it gains."

The question remains: why is the ANC insisting on a discredited socialist system — Wilson cites Cuba among various models — at a time when nationalised health care is in retreat worldwide?

"If 25% of the population is prepared to self-fund its health care, why shouldn't the State accept that?" says Archer, who is a consultant to Standard Bank Medicard. "The socialist point of view is to give everyone the same coverage. But the private sector reduces the responsibility for the State. And there are a tremendous number of other things that the State has to address."

Maureen Sullivan



No quick treatment for SA's ailing health care system

WM 28/1-3/2/94 (85)

The ANC's draft national health care plan has received a mixed reception. The Mail & Guardian invited Dr Anthony Zwi, a South African who lectures at the London School of Hygiene and Tropical Medicine, to comment on the plan

THE ANC faces a number of dilemmas in the health field. It is under pressure to deliver substantial services quickly to the vast majority of the population who suffer ill-health and from the current inequitable distribution of health care.

Improvements will have to be achieved without additional resources, because it is unlikely that any significant addition to the public purse will be available to the health sector.

But this sounds like a bigger problem than it need be. Current spending in the public and private systems together is probably sufficient to meet the health care needs of the population; the key issue is the allocation of such resources more equitably and efficiently.

Health care expenditure in South Africa is currently highly skewed towards the minority, those who use the private sector, to the urban areas, to those who are insured, and to the large public and numerous private hospitals.

The challenge of how to finance a more equitable health system is not yet resolved, although debate around some form of national health insurance has already taken place.

The ANC plans to set up a high level commission to consider this issue, to be established in August 1994 and report within a year.

Too late, perhaps. The work of this group should receive priority — the proposed members of the commission should be identified now, it should start work on April 28th and be given a shorter timetable in which to report.

There can be little doubt that the private medical sector is here to stay within the context of a mixed economy.

But there is a need for incentives for more appropriate medical facilities and for regulating its less desirable attributes. Incentives to work in under-served areas could be readily instituted.

The ANC proposals to decentralise decision-making give regions and districts greater flexibility in determining local priorities and targets.

This would allow local health management structures to take account of the specific needs of an area, the resources available, the needs of other sectors, and the preferences and concerns of local government and community organisations.

Commitments to large sections of the population "being within the reach of a primary care service" needs more explicit definition if areas previously neglected are to be specifically identified.

The promotion of community health workers may be appropriate in those areas which have experience with and trust in such personnel. It may be an error, however, to generalise from this to promoting such personnel on a national basis.

The ANC is sensibly not rushing into the construction of new facilities. This strategy created more problems than it solved in other countries because recurrent costs associated with running the system were ignored and little attention was paid to how the system functioned.

The ANC proposes to construct primary care facilities according to national standards and norms, yet to be developed. But besides facilities, they will have to give greater attention to personnel. Nurses basically run the health service today. Improvements to the terms and conditions of their work will have to be a high priority

Policies which have proved themselves elsewhere are likely to be easily enforceable, such as targeting medicine expenditure on cheap and effective brands, regulation of advertising and sponsorship by the alcohol and tobacco industries, better immunisation, and obstetric services.

But better access to health care alone will not be enough. Redistributing the other essentials which influence health — housing, employment, water and sanitation, food nutrition and peace — may take longer to achieve.

Some of the ANC's proposals are over-ambitious, despite being worthwhile. Establishing rehabilitation services in half of all community health centres by the end of next year is not a realistic goal.

Key issues like population policy and the needs of women, not simply as bearers of children, are discussed in the proposals but deserve greater priority.

Establishing intersectoral activities is important, but caution about measuring achievement by the number of committees established is warranted.

Some of the ANC's priorities seem inappropriate. Officially notifying cases of malnutrition is unlikely to be an effective means of promoting improved nutrition within the population. Increasing penalties for those convicted of dealing in drugs may do little to limit the spread of narcotics.

Reducing sugar consumption by 10 percent per year is unlikely to be achievable.

The challenge will be to improve health care for every South African while keeping control of health policy at a time when international donors whose funds South Africa cannot do without are more aggressive than ever before in imposing their plans for the health sector.

Their vision tends to include the promotion of the private sector, a more limited role for the state, promoting competition, wider adoption of user fees and other cost-sharing mechanisms, and giving priority to a limited range of health care packages.

Offers of foreign assistance, often directed at buildings as visible symbols of achievement, will need to be carefully scrutinised by the new government to ensure their coherence with policy objectives.

> "Nurses basically run the health service today. Improvements to their working conditions will have to be a high priority"

More criticism for health plan

Star 31/11/94

(85)

■ **BY DAVID ROBBINS**
HEALTH WRITER

The ANC's recently released national health plan continues to draw criticism from influential quarters, being most recently described as a "wish-list" which will be "difficult if not impossible" to implement.

The ANC's plan advocates a single health structure, with a refocus on primary health care, decentralisation and increased spending at a local (and especially rural) level.

The plan includes an ambitious timetable for the implementation of a variety of improvements, ranging from immunisation to the training of health personnel.

National Health and Welfare Minister Dr Rina Venter has called the plan idealistic, adding that it would be "difficult if not impossible" to implement in its entirety.

"Time schedules for the implementation of the various policy objectives are unrealistic, as are the expectations the plan will create," she said.

Dr David Harrison, executive director of the influential Health Systems Trust, described the ANC plan as "in parts, a wish-list oozing the influence of the World Health Organisation. However, perhaps we should laud this for it implies a commitment to ideals which are universally promoted.

"Still more promising is that it seeks to address the fundamental flaw in the structure of our existing system by creating a single health authority. And that's more than many of the plan's detractors have been able to do."

Venter said the plan made no provision for the present dispensing doctor system, which could have a negative effect in underserved areas where doctors were the only source of medicine.

Pharmaceutical Society of South Africa executive director Boet van der Merwe said the planned encouragement of the pharmaceutical industry to sell most of its production to the State smacked of nationalisation.

Violence and health

Sowetan 31/1/94

By Mokgadi Pela

INNOVATIVE violence-prevention projects in the area of public health should be encouraged, a medical scientist has urged his colleagues in South Africa.

Dr Anthony Zwi, of the health policy unit at the London School of Hygiene and Tropical Medicine, said public health practitioners should help co-ordinate efforts of the health sector to respond to violence.

"Public health practitioners should assist in developing interventions, designing them in such a way that they can be tested for effectiveness and efficiency," Zwi said.

Zwi appealed to public health practitioners to use their skills to place violence high on their list of priorities as this was one of the major public health problems facing South Africa. He said public health practitioners should help the sector maximise its input to resolve social problems. (85)

"The agenda must include further research, not as a way of delaying making decisions and developing interventions, but in order to refine our understanding and improve our ability to respond.

Data may be useful in influencing change, heightening perceptions of the problem and stimulating debate. Women-only police stations in Brazil, for example, have been shown to greatly increase the reporting of gender-based violence," Zwi added.

Inkatha's health secretary Derek Arbuckle and ANC health director Ralph Mgijima at the conference. Picture: ROBERT BOTHA

Venter warns against unrealistic health promises

B/Star 11/2/94

IT WAS irresponsible to make unrealistic promises to an expectant electorate, Health Minister Rina Venter said yesterday. (85)

She told a Midrand conference on financing a new health care structure that the NP would attempt to be a "voice of sanity" in a field where expectations were running high and where there was a temptation to propose unrealistic solutions.

KATHRYN STRACHAN

To be sustainable, health care had to be affordable, which entailed primary health care focused on the community and devolved to the lowest levels of government structures.

ANC health spokesman Ralph Mgijima said the option of a national health insurance scheme — proposed in the ANC's draft health policy document — should be given urgent attention. National health insurance would largely affect those who fell within the sphere of the private sector.

However, the financing of the national health system would not be dependent on this model.

The ANC could realistically meet its goals through other sources of financing, including revenue from higher tobacco and alcohol taxes.

Nurses pitch in to help clean up dirty hospital

B/Star 11/2/94

JACQUIE GOLDING

JOHANNESBURG Hospital nurses and superintendents began cleaning up the hospital yesterday after a go-slow affected hospital services.

"Things were getting out of hand and patients deserved better," said one nurse who declined to be named.

It was reported in the Sunday Times that patients were facing infection from grime as a go-slow by general assistants to protest against the Transvaal Provincial Administration's decision to award a R500 bonus to Baragwanath Hospital workers entered its fifth week.

Independent arbitration on the strike has been postponed until Friday. (86)

A Johannesburg Hospital spokesman said the Sunday Times report had been an exaggeration but admitted the hospital had been in a "bad state" last week.

The situation at all Transvaal hospitals was quiet but tense, a TPA spokesman said. Workers at nine Transvaal hospitals had returned to work this week.

However, a skeleton staff attended to patients at Hillbrow Hospital yesterday and the Far North Hospital in Pietersburg was overcrowded because of striking workers at Lebowa hositals.

At Leratong Hospital, which was closed temporarily last week, the TPA held talks yesterday with unions and employee associations.

Sapa reports the SA Nursing Association yesterday said health employees who left patients without care should be dismissed.

The association was reacting to ANC spokesman Carl Niehaus's alleged statement that he could see no reason why health services should be declared an essential service.

"It will be a tragic day when defenceless patients are consigned to a system where human lives are used as the only mechanism for solving disputes," said association president Marie Muller.

Trends in health industry criticised as irrational

BDay 2/2/94

(85)

TRENDS in important areas of the health industry were contrary to a rational development policy, Development Bank health director Mike Muller said yesterday.

He told delegates at a Midrand conference on financing a new health care system that unless concerted efforts were made, the next few years would see growing conflict between the rational policy ideals of a development-minded state and the short-term self-interest of the private health industry.

Raising primary health care expenditure without an increase in total health spending left few policy options.

With little scope for reduction in spending elsewhere in the public sector, an alternative was to shift the balance between the public and private health sectors. One possibility was to shift more of the burden to the private sector, he said.

This would run counter to trends in the insurance industry, which aimed to reduce demand for services by focusing on lower-risk patients, and in medical schemes, whose failure to pay full costs for expensive procedures reduced their members' options.

The other alternative was to shift resources from the private to the public sector by removing the tax subsidies from the private sector.

Muller said private health care would increasingly become a luxury rather than a necessity.

KATHRYN STRACHAN

"It would be sound economic and development policy to end current subsidies for the rich, although the potential for undesirable outcomes should not be ignored," he said.

The removal of subsidies might force large numbers of marginal private sector users into the public sector, thereby increasing its costs. Without improvements in efficiency in the public sector, the cost of providing the same levels of service might be greater.

Muller said a likely compromise was, as a first step, for subsidies to be removed from all schemes that rated individual risk and which rejected cost containment policies, such as the use of generic medicines.

□ International condom experts have converged on Cape Town for a meeting on safety and efficiency problems.

At the meeting, hosted by the SA Bureau of Standards, a technical committee of the International Organisation for Standardisation will set global standards for condoms and other contraceptives. Methods for testing standards will also be discussed at the meeting, which ends today.

Experts from Europe, Japan and Thailand, as well as representatives of the World Health Organisation and the US Programme for Appropriate Technology in Health, are attending the meeting.

THE WEEKLY MAIL & GUARDIAN
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WHO slams SA polio vaccine

Local production of the life-saving polio vaccine has been stopped following a WHO report criticising the Institute for Virology's facilities. Pat Sidley reports

(85) WM4-10/2/94

THE World Health Organisation has severely criticised South Africa's only polio vaccine-making facility and recommended that it cease production of the vaccine until a new facility is built.

All polio vaccine currently being dispensed in South Africa is imported, and local production will only begin when new facilities match the standards set by the WHO.

No polio vaccine produced in this country has been subjected to quality testing outside of the production facility, as no such testing facility exists here. But it is likely that as a result of the WHO visit, South Africa may become a test case in how to develop adequate testing facilities. And it is possible the country will become a major supplier of several vaccines regionally in Africa.

The criticism of the facility followed a visit to the country by the WHO in September last year at the invitation of the Medicines Control Council (MCC) and the Department of National Health. The move was prompted by a routine inspection by the MCC at the National Institute for Virology, near Johannesburg, which produces the vaccine.

According to Dr Julie Milstien of the WHO in Geneva, the mission was undertaken to see what improvements could be made to South African production; she says the WHO regards it "as a real success story with a high level of co-operation from every level."

According to Professor Peter Folb, the chairman of the MCC, the report of the WHO was critical of the way in which polio vaccine is produced, and made a number of recommendations which will all be adopted.

"They advised us to upgrade the local production of the polio vaccine," said Folb and the result was that production was stopped. Folb said the MCC required evidence from the Institute for Virology that WHO standards had been met before the material could be used.

However, independent quality testing of the vaccines could not be conducted locally. Milstien confirmed the WHO had offered to assist with the testing. Although it had no facilities of its own, it contracted the testing out.

According to Professor Barry Schoub, director of the virology institute, the facility, built in the 1950s, requires modernisation, which he had requested previously. A new building would be built soon which would conform to all the requirements set by the WHO. His institute, he said, had not produced vaccine for two years — but had stored five years' worth of the vaccine.

The WHO had also advised that the way in which the vaccine was dispensed needed changing, and changes had been implemented.

Later this month, Schoub said, local vaccine would be dispensed. According to Folb, this vaccine will be tested and any problems will mean continued importing of vaccine.

Fin 4/2/94

Changing the emphasis

But the private sector still has much to offer

(85)

Unless the ANC's health policy document is mere election rhetoric, private-sector health care could be under threat.

Promises to discourage growth in the private sector, which self-funds 25% of the population (*Business* January 28), are particularly disheartening at a time when some countries round the world — with stronger economies than ours — are looking at ways of strengthening private-sector health to lessen the burden on State resources.

The near-6,8% of GDP which SA spends on health is more than we can afford. The World Health Organisation's target for SA — as a developing country — by the year 2000 is only 5%. Put differently, 11,7% of total State income is spent on health, close to the average 12,6% by developed countries.

The ANC clearly believes that a smaller private sector will somehow boost the public sector, which it envisages will supply "most health care." The plan, however, offers scant details on just how this expanded sector — which for example will guarantee free maternity benefits and treatment to children under five — will be financed, except to allude to greater direct taxes. Health Minister Rina Venter says the full spectrum of possible financing needs to be investigated.

Certainly, the ANC has a point when it accuses the private sector of inefficiency. Abuse has seen member contributions spiral in recent years. But recent deregulation — in particular the Medical Schemes Amendment Act (which took effect last month) — has set the framework for increased competition and efficiency.

So it's surprising the ANC has chosen to attack the backbone of the medical schemes movement by threatening to end tax concessions for contributions by employers. "Perhaps the ANC knows this is the Achilles heel of the private sector," says Presmed joint MD Rob Speedie.

These deductions encourage employers to enlist employees to take medical aid cover. Speedie suggests if they are ended, employers might pay the equivalent as wages, passing the tax burden on to the employee, who might not take cover, ultimately falling back on the State. This could undermine the cross-subsidisation principle which still underpins how schemes work: in a nutshell, the young and healthy subsidise the aged and ill but benefit when they themselves later put in heavy claims.

Venter

The ANC also appears to have overlooked the Vat charge that all private-sector services carry. Coupled with other taxes, the State pulls in as much as R1,8bn annually from the sector. The Representative Association of Medical Schemes (Rams) this week announced a plan that could see schemes offer a basic health care package to all employees.

Rams executive director Reg Magennis envisages that this should be included

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in every medical aid package. To succeed, he concedes it would probably have to be funded through a compulsory payment into a fund which would be used as a common risk pool to ensure sound cross-subsidisation. He stresses that this basic package would not exclude other benefits.

Clearly, Magennis hopes the ANC will see merit in the plan. "We would hope to extend this service later to State-subsidised persons on an agent basis." The ANC will be loath to hand over public funds for administration by the sector it seems so suspicious of.

But the schemes may not have to wait for a miracle cure. The Medical Schemes Amendment Act allows them to offer a diversity of products. Innovative operators already offer full spectrum of options from as little as R250 a month.

An alarming trend, however, has seen some schemes merely slash benefits, which Speedie suggests is a crude option. "The legislation envisaged a deregulated environment in which schemes could bargain with health care providers to secure the best deal. This often means creating differentiated or tailor-made packages — not always easy or convenient for the administrator."

Magennis

The limits of the funding of private-sector health care will probably be detailed by the Melamet Commission, due to report next month. So it's surprising the ANC already states an intention to set up a similar commission, particularly since an ANC person is already on Melamet's team.

The most unexplored option is managed health care. Industry observers believe unfettered choice of practitioner and health institution remains a priority for private-sector patients. But managed health care would do well to target the worker for whom traditional scheme benefits are out of reach.

Where managed health care has been implemented, the trend seems to be for health financiers to acquire an interest in hospitals and clinics. Owners like Clinic Holdings, Afrox and the Rembrandt Group are also beginning to market managed health care packages. In a nutshell, they operate by restricting members to specific doctors and clinics or hospitals. Costs are contained by either paying doctors a set fee for a number of patients or a capitation fee as opposed to the traditional fee-for-service fee.

Doctors are encouraged not to overuse facilities and keep down costs, often in return for high patient turnovers. Thus, for example, a basic managed health care package covering GP visits, medicines and stays at State hospitals only is available to a single member for as little as R114 a month. Another plan covers stays at some private hospitals and the full range of diagnostic procedures for about R140 for a single person.

The ANC's intention to apply tighter regulations to the licensing of private facilities amounts to a rejection of the widely acclaimed Strauss report, released in December. Unisa law professor S A S "Sas" Strauss concluded that the current system of issuing licences for private institutions on the basis of apparent "need" is open to bureaucratic and political abuse and that there should be free entry to the hospital business.

Speedie

Drug manufacturers and pharmacists can't be happy about ANC proposals to limit drugs, apply price controls, encourage a single wholesale price, and preferential drug prices for the State. None of these has elsewhere kept down the costs of what now constitutes around 37% of the total health care bill. The reason — they are simply too difficult to enforce without the large multinationals pulling out. The Pharmacy Council would have done better under Venter's proposed deregulation, which would just have subjected the sector to a bit of competition.

Schemes and administrators are under increasing pressure to eliminate waste before it is incurred. John Cowlin, medical doctor and former scheme administrator, has set up a computer-aided medicine peer-review system in Cape Town thatmanages the drug bill for the chronically ill, who use expensive and long-term drugs, that saves up to 25% on drug costs — which amount to 30% of the total private-sector health bill. His management methods include giving advice on the use and cost of medicine and scanning the market for possible generics, though he stresses generics are not an automatic option.

Another cost-saver likely to be increasingly explored is the use of cheaper day clinics as opposed to fully fledged hospitals.

All that is needed is innovation and an awareness of the costs, cost-effectiveness and appropriateness of certain procedures to keep a private-sector health system viable. "The private sector will always have the advantage of greater flexibility over any public sector," says Fincorp medical director Rhys Edwards.

Given the far-reaching inroads into the private sector proposed by the ANC, Edwards suggests the challenge for private health care must be to achieve the best system in Africa. "There is no reason why health care can't generate income from the rest of Africa. Curbing the private sector won't automatically result in a more effective public sector."

Edwards

Reducing the national health bill does require that sound principles govern the public sector. (85)

The ANC's emphasis on primary care and apparent decentralisation are meritworthy, and almost mirror many of Venter's reforms in the public sector, but many of their technical applications are impractical. Take the proposal that 50% of the health budget be allocated immediately to primary health care. Says Venter: "This is not feasible because one will always have to keep a substantial secondary and tertiary capacity — the broader the primary health care base the more the referrals to the top levels."

Venter has allocated 15% for primary health care, which has translated into the construction of over 200 new community health clinics. Government also secured an additional R2bn for social development.

But the rewards of her sound planning will be reaped only long after she's left her post. While she banned racial discrimination at State facilities in her first year in office and set about eradicating duplication of services under the myriad of different departments, it has taken longer to turn round a budget allocation which historically almost ignored primary and secondary health care in favour of tertiary care (the most expensive level) and academic hospitals. Today the allocation of 15% to primary health care, 58% to secondary and 27% to tertiary health care is a balanced model.

One of her greatest achievements has been to give the academic institutions management autonomy to bring about a balance between service to the community, training and research, and force them to operate under the constraints of an own budget (which they can now help augment). The ANC, however, is keen to restore these institutions to the public sector.

Both in the private and public sectors, Venter has premised her work on independence and efficiency of service, together with affordability and appropriateness. These principles at some point will always boil down to rationing and priority setting — that is, making tough choices about how most equitably to allocate scarce resources.

The ANC sees an all-powerful public system as the answer. Venter says the two sectors are inextricably linked and must form a joint task group to find solutions to the financing of health care.

Politicians cannot have the answers because they are bound by party ideologies, she says. They must therefore merely facilitate the development of workable solutions by technicians and experts. ■

P.T.O.

Flats health centre to step up aid for victims of sex, drugs

(85) ARG 5/2/94

DI CAELERS
Weekend Argus Reporter

■ Medical help for the poor of the Cape Flats, especially among hard up younger people, is the aim of a new health care foundation.

A MEDICAL care foundation to tackle the needs of Cape Flats youth, initiated last year and due to be launched officially next month, will take on health issues like sexually transmitted diseases, tuberculosis, drug abuse and other "life-threatening social phenomena".

The foundation, comprising practising and unemployed health-care professionals and educators, is designed to augment primary-health care in the area.

Spokesman Chris Mentor said one clinic alone treated 20 people a day for sexually transmitted diseases.

"They're not all youths, but those kind of figures show how vitally important it is to tackle these issues among the youth before they get to be adult problems.

"And, people must realise that while we're talking about lower-income areas, people do mix freely in all levels of society and, at the end of the day, these problems will affect everyone, even the upper echelons."

The foundation is to be named Visions! Youth Care Foundation.

It will be launched with a fun walk /run for health on March 30 starting at 6.30 pm from the Sea Point Pavilion. The route is along the promenade to the V & A Waterfront.

The foundation is appealing not only for entrants but for donations, sponsored prizes, promotional input and voluntary help, as well as for people to sponsor particular children to enter.

For more information, call Cedric Newton at 402-1911.

Mr Mentor said the idea for the foundation followed research that showed about 75 percent of young people living between Ocean View and Atlantis had no access to medical aid.

The high incidence of tuberculosis and Aids-related illnesses, balanced against the state's inadequate and ailing health budget, made the new association vital.

"Mass counselling is one of our priorities, so we expect to do a lot of work in the schools, promoting and providing professional general health awareness — counselling, as well as treatment.

"Where specialised medical care is required, patients will be referred to practitioners on the foundation's panel on a rotation basis.

"Our particular emphasis will be on sexually-related diseases, Aids and other social phenomena like drug abuse, unplanned pregnancies and malnutrition," said Mr Mentor.

Finance is expected to come from subscriptions, sponsorship, grants and fund-raising activities.

SA infant mortality rate drops

CT 9/2/94

By BARRY STREEK
Political Staff

(85)

THE infant mortality rate in South Africa has dropped over the past 30 years from 126 to 70 per 1 000 births, the United Nations Children's Fund (Unicef) says in its report The State of the World's Children 1994.

This places the country 61st out of 145 countries, with Niger heading the log with 320 deaths per 1 000 births. Japan and Ireland are lowest with six per 1 000 births.

Unicef says four African countries have lower infant mortality rates than South Africa — Morocco (61 per 1 000 births), Botswana (58 per 1 000), Egypt (55 per 1 000) and Tunisia (38 per 1 000).

Namibia, Kenya and Algeria have 79, 74 and 72 deaths per 1 000 births respectively, but Lesotho — 31st on the list — has a rate of 156 deaths per 1 000 births.

Pneumonia

Unicef says 88 000 children younger than five died in South Africa in 1992. There were 1 253 000 births during that year.

South Africa has 16,1 million children under the age of 16 and 5,5 million under the age of five, but the growth rate has dropped from 2,7% to 2,5%.

Unicef says that pneumonia is now the biggest single killer of children and progress was too slow in reducing the number of deaths attributed to the disease — 3,1 million in 1992.

Diarrhoeal disease is still killing almost three million children a year.

Measles killed more children annually than all the world's wars and famines together — 1,1m in 1992 compared to 2,5m in 1983.

Many developing countries are progressing towards the easy access of clean water by the year 2000. In India, the percentage of rural people with access to safe water has risen from just over 30% to over 80% in 1992, Unicef says.

ARG 9/2/94 (85)

Rights key in medical council's code of ethics

JOHN VILJOEN, Staff Reporter

A COMPREHENSIVE guide to the ethics of medical research which deals with issues such as animal experiments, research using prisoners and test tube fertilisation, has been released.

The SA Medical Research Council's guidelines reflect growing support for individual human rights.

A prominent academic said ordinary South Africans would now be better protected against abuse.

The comprehensive ethical guide runs to more than 100 pages and is to be distributed to hundreds of researchers countrywide.

Any researcher operating with MRC funding is legally obliged to follow the guidelines. But the guidelines are also likely to have a major influence on ethical decisions outside MRC-backed studies.

The guidelines, compiled by a committee of 11, are a revised version of a 1987 document and borrow extensively from reports by the Royal College of Physicians in London.

They bring South Africa up to date with ethics issues overseas, according to MRC president Walter Prozesky.

H e said the new guidelines reflected the growing support for individual human rights, and ordinary South Africans would now be better protected against abuse.

Among the points made in the guidelines are:

- Reproductive biology research is essential but should not cause moral dilemmas or be harmful to patients.
- There is no moral problem with the use of in vitro fertilisation, where the male and female germ cell from the husband and wife are used.
- There are potential psychological problems with regard to artificial insemination by a donor, as well as the risk of transmitting serious genetic disorders and diseases such as Aids.. The MRC recommends that research into artificial insemination be limited to the essential, with consent from all parties. The use of donor eggs is controversial but acceptable to the MRC provided the donor is not paid.
- The MRC regards research into extending child-bearing beyond menopause as usually ethically unacceptable.
- Maintaining embryos in vitro beyond a gestational age of two weeks is ethically unacceptable.
- Many new methods of fertility control are being investigated.
- Research into selecting the sex of a foetus is unethical.
- The approach to research using animals is that this has made a large contribution to the welfare of humans as well as animals and it is necessary for future progress.
- All institutions using animals in experimentation must establish an ethics committee. No animal experiment may be carried out before the MRC's research committee and the institution's ethics committee have approved it. All attempts have to be made to keep the use of animals to a minimum and researchers have to choose their animal models carefully.
- Therapeutic research is allowed on child volunteers provided legal consent has been obtained. Non-therapeutic research on children is justifiable if it will benefit other children. Research which could be done equally well on adults should never be done on children. Similar conditions apply to mentally handicapped people.
- Student volunteers should be allowed to withdraw from research without this counting against them. Similar conditions apply to mentally handicapped people.

CROSSTALK

Two weeks ago the ANC released its health policy document, evoking a wide range of responses, from the critically dismissive to the enthusiastically admiring. SOUTH spoke to some of the national players to see what they had to say about the document.

WHAT DO YOU SAY?
SOUTH readers are encouraged to respond to any of the viewpoints presented on this page.
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The ANC's health policy — an illness or a cure?

South 11/2 - 15/2/94

(85)

Dr SAADIQ Karriem, general secretary for the ANCs Western Cape Health department, explains some of the general principals of the health policy document.

"In terms of the health vision we see the key to all South Africans' upliftment being secured through socio-economic improvement.

"The health system will be an integrated and comprehensive one under the control of a single government structure. Under the current system this would include the local, homeland, military and prison health services.

"In the future the provision of health care must be co-ordinated among the local, district, provincial and national authorities.

The underlying philosophy is on how primary health care can be improved.

"What the policy aims to do is redress the inequalities in health care experienced in the rural areas and other deprived sections of the community.

"We also hope to redress the existing inequalities in the situation as it exists now, where the whole system is controlled by doctors, men and the private sector.

"We want to implement a bill of patient rights. We see the whole process as a fluid and dynamic one and believe that individuals and interest groups should be given the opportunity to participate in the formation of the ANC health policy.

"On the question of abortion the health policy guidelines have been established. Abortion will be legalised and women will have the right to choose whether or not they want to have one. No woman will ever be forced into having an abortion.

"A general practitioner will have the right to give consent for an abortion to go ahead. Currently what happens is that both a psychiatrist and a gynaecologist have to approve an abortion — we hope to change this.

"We recognise that the private sector plays an important role, but our emphasis is going to be to strengthen the public sector, to make it more accountable to the communities it serves.

"We hope to give incentives which will induce those who have chosen the private sector to return to the public sector.

"There will be a de-emphasis on the private sector, for example there might be cuts on subsidies in the form of tax concessions and similar things.

"On the issue of the pharmaceutical companies we want to encourage them to sell their products largely, if not exclusively, to the state.

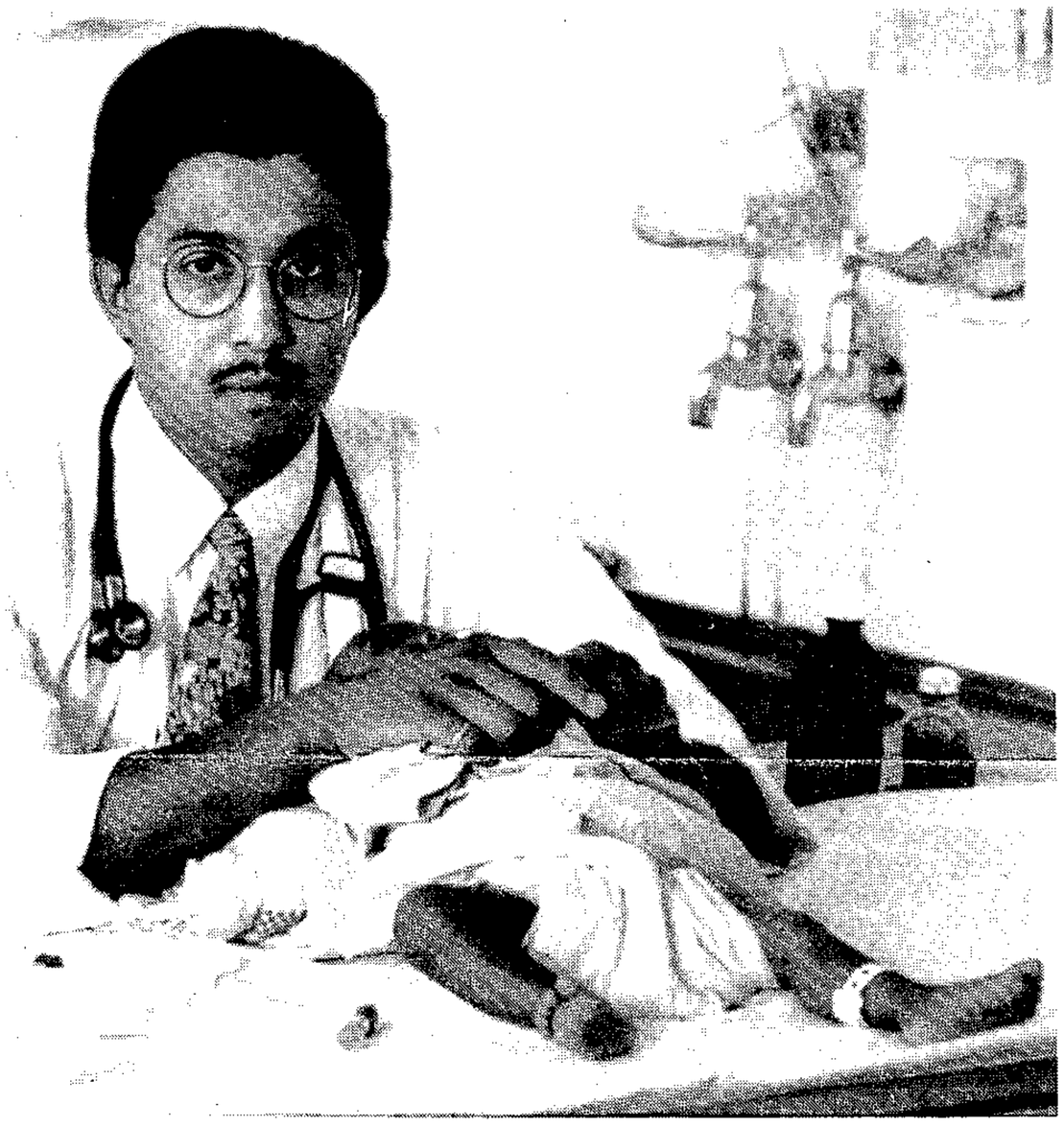
"The state will control drug lists and the equipment being brought into the country.

"In terms of financing for the health service, this will come largely from tax revenue as it does now. We recognise that there are other social issues that need to be addressed — like education and housing — and health won't take more than the 12 percent it currently gets.

"Additional funding will come from special excise duties that are to be put on tobacco and alcohol. We can generate billions of rands through this. This additional money will be dedicated to public health services.

"We want to abolish user fees — the obligatory fee paid at any hospital or clinic — in certain categories. That is, for children under six, pregnant and nursing mothers, the elderly, the disabled and the chronically ill.

"This will include school health, antenatal and delivery services, contraception, nutrition support and curative health, for example TB and sexually-transmitted diseases, including HIV."



NEW HEALTH: Dr Saadiq Karriem eaxamines a baby at the Red Cross Childrens Hospital Photo Yunus Mohomed

Dr MIKE ELLIS, spokesperson on health for the Democratic Party, expressed some concern on the ANC's newly-released health policy document.

"The ANC draft health plan released last week has distinct undertones of socialism as contained in its plans to restrict the practice of private medicine in this country.

"While the DP welcomes the provisions for the disadvantaged sector of the community, it must be made clear that unless the wheels of free enterprise continue to spin, there will be no money from taxes to fund such welfare proposals.

"The market, not regulations, should determine fee structures and people should be encouraged to take out health insurance and join medical aid schemes, which have now been deregulated to provide a wide range of affordable cover.

"The placing of ceilings on private health service fees and the removal of tax concessions for medical contributions can only lead to a reduction in the quality of service and a further flight of medical expertise from the country.

"Fees can be negotiated between doctor and patient, and between the medical aid societies and the practitioners to the satisfaction of both.

"State intervention such as the ANC proposes is both dangerous and non-productive.

"The DP welcomes the proposals that there should be increased taxes on alcohol and tobacco both of which are long overdue, thanks to the NP's protectionism towards its supporters in the tobacco and liquor industries."

Dr IVAN TOMS, director of Shawco, was positive about the ANC's health policy.

IVAN TOMS

"To me the most positive thing in this document is the clear move in health service delivery — the emphasis is on primary health care which is taking house services to the people rather than expecting them to trek up to expensive hospitals.

"This is picking up on a whole range of issues that have previously been ignored, for example there is strong concern about HIV and cervical cancer.

"What is exciting about the document is that it promises free care for children under six years and vulnerable groups such as pregnant women.

"I feel it's a health policy that is trying to grapple with real issues — up to now health care has never really been accessible to the poor.

"The big question that remains is whether there is the political will to implement this policy.

"This is going to cost a fortune and there is going to be a need to prioritise. The essential question remains, though: Is there the commitment to implement this policy?"

Ms Khosi Xaba, researcher at the Centre for Health Policy at Wits University, expressed reservations about certain sections of the health policy document.

"Broadly speaking it's okay because it's addressing very broad questions, but it doesn't go on to say how all of this will be done.

"The policy values address issues that people want to talk about, but I have a major problem with the way it talks about women and children.

"There are four paragraphs in this section and only one of them talks about women. Women's health needs particular focus, this section really only talks about the health of children.

"On the issue of abortion, again it doesn't say how it is going to be facilitated, how it's going to make conditions favourable for women who want to have abortions.

"Cancer of the cervix is the greatest killer of all the cancers in South Africa. It should be under the section of women's health. It is very simple to cure if detected at an early stage, what we need are people committed to curing it.

"The issue of occupational health for women is not mentioned. That is, there are large numbers of women working in industry, where there are health hazards particular to women.

"This needs a lot of focus.

"The issue of women's health has to be addressed in the social context of women's lives.

"Women often need to get permission before they can go and get medical attention. Many have no money for bus and train fare. There are many more variables for the issue of women's health than there are for men.

"The focus on primary health recognises the lack in this area. But again my question is, how do you do it?

"The policy addresses the issue of reversing the inequalities of apartheid."

P TO 7

DEBATE:
Boesak vs Kriel

Dr ALLAN BOESAK and Mr HERNUS KRIEL are both premiers-elect for the Western Cape. They are clearly not too fond of each other as **QUENTIN WILSON** found out when he asked them to interview each other.

Questions to Kriel

BOESAK: Through its group areas and forced removals policies, your party is responsible for the widespread destabilisation of communities which, it is widely accepted, is responsible for one of the highest crime rates in the world. It is clear that a law and order approach is inappropriate and ineffective, yet the NP obviously does not enjoy the confidence of the communities which have been a victim of these policies. What is your plan for the gangs and other criminal elements in our city?

KRIEL: The ANC/SACP looks everywhere for a scapegoat instead of in the right place — itself. Of course apartheid was responsible for many injustices and imbalances — that is why the NP had the moral courage to reject it. But the NP is now a new NP while the ANC/SACP is still the old, intolerant and intimidatory ANC/SACP whose violence is eating up the future of our children.

Tragically, there still are forced removals — but this time they are the terrified refugees who are forced to flee their homes in the townships because of the ANC/SACP's war for political domination.

Apartheid was evil, but is it still really necessary for ANC/SACP supporters to burn down schools, organise teachers' strikes just before matric exams and to disrupt health services at the expense of the sick?

Crime and violence rocketed after the ANC/SACP was unbanned in 1990. This was no coincidence but the direct result of the violence, intimidation and intolerance of ANC/SACP supporters and the failure of their leaders to control them.

The ANC's drive for total political domination has sparked off waves of violence which the SAP has to deal with. Up to 30 percent of the police force has to be deployed to combat these symptoms of ANC/SACP intolerance and intimidation.

ALLAN BOESAK

The result is that crime — including gang crime in the Western Cape has increased dramatically because so many policemen are standing by to police ANC/SACP-generated political violence, strikes, boycotts and other forms of intimidatory mass action.

ANC/SACP self-defence units are on the rampage all over the country, including the Western Cape. They are killing political opponents, policemen, members of the public and even ANC/SACP members.

The lesson is quite clear — political violence leads to increased crime and destabilisation of the community and if the ANC/SACP were to rein in their supporters and cease their intimidatory and intolerant political tactics, more policemen would be available to combat crime and the public would be safer.

BOESAK: The NP claims that it has brought an end to apartheid. Yet apartheid is an NP creation which has caused untold suffering in our country. What action do you plan to take to atone for the suffering of the people in this region under apartheid?

KRIEL: Apartheid most certainly did lead to suffering in our country — but, as I have said before, the NP had the moral courage to reject it. But ANC/SACP violence and intimidation after their unbanning in 1990 and after the rejection of apartheid have brought far more misery, death and destruction to the victims of apartheid than apartheid ever did.

It is the height of irony that after the tyrannical system of apartheid was removed in order to create democracy, that the ANC/SACP openly imposed the Stalinist tyranny of violence, intolerance and intimidation of millions of our people.

The ANC/SACP cannot hide behind apartheid forever — this only shows that they are still caught in the time-warp of the past. They are the new "Total Onslaught" against the people. Instead of looking forward, they are and have been using "dog in the manger" tactics with regard to redressing the socio-economic backlogs of apartheid, because, through political posturing, they want to deny the NP credit for building more schools, more houses and more hospitals.

Instead of allowing the government to implement programmes for housing, education and health care, they have chosen to destroy and disrupt what the people already did have.

Apartheid was evil, but why destroy the material basis on which we can redress the imbalances of the past and improve the lot of the people? Surely even a school building built during the apartheid era is better than no school at all, and surely it is far better than the heaps of ashes which ANC/SACP supporters have created? The emphasis must now be on reconstruction and reconciliation, not ANC/SACP destruction and alienation.

BOESAK: The NP has three African people on its regional list, including two men who are well-known for their criminal activities — Mali Hoza and Johnson Ngxobongwana. The latter, particularly, is associated with the activities of the "Witdoeke", who were responsible for massive bloodshed and destabilisation in Crossroads. What made you choose these men who are held in terror by the communities in which they live for your list?

KRIEL: The violence referred to in this question is itself the product of the long tradition of violence, intimidation and intolerance of the ANC/SACP who, through its front organisations such as the UDF and others, ignited large scale violence throughout the country. To the best of my knowledge, none of the NP candidates mentioned has a criminal record linked to the Crossroads violence.

But the ANC/SACP has at least one high-profile candidate with a criminal record — namely Mrs Winnie Mandela, who was found guilty of kidnapping a young boy who was subsequently murdered by ANC/SACP supporters.

The residents of Crossroads were victims of the ANC/SACP's policy of ungovernability, "No education before liberation" (and by liberation they mean not democracy but ANC/SACP dictatorship), and the ruthless elimination of all political opposition. We see this violence once again reflected in the ethnic cleansing and the establishment of political no-go areas by ANC/SACP self-defence units in East Rand townships and elsewhere.

Questions to Boesak

KRIEL: Dr Boesak claims to be a man of God, yet he directly supports atheist communists whose discredited ideology has denied the existence of God, persecuted Christians and Moslems for their faith and murdered more people than even Hitler. Now, using the ANC, they seek to impose their disastrous policies on South Africa. Who will really govern if Dr Boesak is elected as the puppet of the SACP?

BOESAK: The ANC alliance includes both the SACP and Cosatu, a detail often omitted by those who seek to use cheap "rooi gevaar" tactics to discredit the ANC. For the purpose of elections, that Alliance has been further broadened by the inclusion of Patriotic Front and MDM structures.

The aim, as it has always been, is to build a common front for democracy in South Africa — an alliance against a common enemy, apartheid. One of the major strengths of the ANC is its ability tc include and involve a wide range of people and opinions. We are a broad church and, as much as we include communists in our ranks, we include Muslims, Jews and Christians. Indeed it might interest Mr Kriel to know that many members of the SACP are devout Christians. It might interest him further to learn that 10 percent of the people on our list are Muslims.

HERNUS KRIEL

To suggest, as Mr Kriel does, that the SACP will use the ANC to impose its policies on South Africa is another piece of nonsense. The SACP has been intimately and fully involved in the process of drawing up ANC policy and that process has been both transparent and democratic. Why should any person or organisation attempt to hijack a programme they themselves have played a major role in developing?

KRIEL: Violence and crime have rocketed in South Africa since the unbanning of the ANC in 1990 because, instead of working for democracy, it decided to eliminate all political opposition. The ANC/SACP has done nothing, except blame everybody else, to stem the killing. Why has the ANC/SACP always opposed every attempt to remove AK-47's — the biggest violence multiplier in the country — from circulation? Why have they not disciplined a single supporter in public for involvement in the violence?

BOESAK: Mr Kriel puts a lot of energy into trying to pin the violence on the ANC. Yet, as Mr Kriel must know, the ANC has played a central role in all the major peace initiatives since its unbanning.

It was the ANC that called, as early as July 1990, for an international presence during this transitional period. It was the NP that resisted the idea of an international peace-keeping force and has fought consistently to keep the numbers of international monitors to a minimum — despite advice from the international community. If the ANC had anything to hide, surely we would not have opened ourselves to public scrutiny in this way.

In the Western Cape itself, the ANC has played a major role in bringing peace to a war-torn taxi industry and in squatter areas. But, beyond our role as resolvers and mediators of conflict, we have appealed continually for understanding that violence is caused by poverty, by vulnerability and by deprivation.

It is no accident that it is in areas where people experience the daily humiliation of back-breaking poverty that crime rates are highest. Nor is it any accident that these are the very areas the "third force" elements exploit for their own ends.

None of these problems has the NP or Mr Kriel attempted to address. But neither, it seems, do they have the capacity to perform tasks which fall in their area of responsibility.

In Manenberg, people complain continually of police collusion with the gangs which terrorise the area, yet nothing is done to address the problem. In Mitchells Plain, a dangerously sick man haunts the community for eight years and Mr Kriel's police force does not only fail to capture the perpetrator, but they cannot even find the bodies of children buried in shallow graves on a nearby field.

KRIEL: Why has Dr Boesak, as a self-professed Christian, and other churchmen aligned with the ANC/SACP, not unambiguously and categorically condemned the mass slaughter of policemen, 260 of whom were murdered combating crime and violence last year? Is it because the SAP stands between the SACP/ANC and the elimination of their political opponents?

BOESAK: The ANC has consistently condemned the killing of policemen. We are still waiting, however, for Mr Kriel to utter one word of condemnation of the bombings of eight of our offices over the past month. Selective morality is not becoming in a man who wishes to stand as a candidate for premier in the Western Cape.

Mr Kriel is fond of challenging my role as a Christian leader. Christians need to ask for forgiveness. Is Mr Kriel planning to apologise to the people of the Western Cape for apartheid? Is he prepared to go down on his knees to our communities to beg forgiveness for the crimes he and his police force and his party have committed? If he does, he will surely be forgiven. But when will he say: "I am sorry. We were wrong. You were right"?

'Don't politicise health'

(85) CT 11/2/94

BLOEMFONTEIN. — President F W de Klerk yesterday warned it was essential that health care was not politicised under a new government.

Speaking at the opening of a new hospital in Thabong, near Welkom, on his election campaign trail through the Free State, Mr De Klerk said health care should not be subjected to ideological experimentation.

"It is disturbing that some parties are now making revolutionary and alarming proposals concerning future health care policy," Mr De Klerk said.

A system whereby doctors would be forced to devote part, or all, of their time to public service at a fixed remuneration would accelerate the emigration of South Africa's most skilled medical practitioners.

He said this was an example of an authoritarian approach.

"The question must once again be asked whether those involved have learned anything at all from the catastrophic experience of other societies which have arbitarily interfered in the provision of health services." — Sapa

HEALTH CONFERENCE FM 18/2/94 (85)

New-look private sector

The ANC's representative at last week's *FM* health care conference, Ralph Mgijima, said the private sector still had to convince the ANC it had a role to play in making health care generally affordable and accessible.

FM 18/2/94 (85)

"Tighter regulations will be applied to the licensing of facilities, practices and equipment," he warned. "In addition, the private sector will no longer be subsidised by the State — the ANC is evaluating the implications of removing tax concessions for medical aid contributions."

The past year has, in fact, seen various cost-saving innovations as a result of extensive deregulation. For example, the Medical Schemes Amendment Act, which took effect last month, ended minimum benefits and guaranteed payments by schemes to doctors and members on receipt of a claim. The result — medical aid schemes, doctors and patients are now able to negotiate more affordable packages.

Representative Association of Medical Schemes executive director Reg Magennis says the private sector is also investigating ways to make private health care more accessible. "Schemes are looking at implementing a low-cost, basic-cover package for all formal sector employees."

Industry players have also been working on practical solutions. Hospital group Presmed joint-MD Carl Grillenberger told the conference that day clinics offered cheaper theatre and ward rates for a number of procedures regularly performed at fully fledged and more expensive hospitals. "A comparison between day clinic and hospital theatre and ward costs, based on 30-minute theatre time and a half-day ward fee, shows that hospital fees are some 58% more than in a day clinic," he said.

Managed health care, though not yet widely practised or even explored in SA, has effected huge savings for some. Gencor spokesman Dirk van der Merwe says his company has managed to arrest the cost spiral by negotiating rates with Independent Practitioner Associations (IPAs — groups of doctors willing to supply health care on a managed, negotiated and evaluated basis). He stresses the need for the employer to become more involved in supplying or managing health care.

The newly deregulated sector has, of course, resulted in a proliferation of products that confuse many. Choices have been further complicated with the recent financial collapse of several schemes.

To help choose a medical aid scheme, medical schemes administrator Sally Velzeboer suggests, would-be members should ask basic questions.

They include:

- ☐ Is doctor choice restricted?
- ☐ Are medicines limited to a short list and is there flexibility for a patient who is already on nonsubstitutable chronic medication? and
- ☐ Do managed health-care plans comply with requirements of fund solvency and offer a deceased's dependants cover?

Health consultant Stephen Toovey offers another crisp question for employers to ask: is the scheme efficiently administered? Are staff happy with the way their claims are handled? ■

A beacon of hope for the sick and poor

South Easter Suppl to South

BY SABATA NGCAI (85)

The South African Christian Organisation Leadership Assembly (Sacla) is a beacon of hope for sick and poor people.

Sacla is a community-based health organisation which works to improve the health conditions of poor black communities, mainly in squatter areas.

It operates by training local people as community health workers who are elected at community meetings.

Each community of not more than 250 houses has one community health care worker who is there whenever needed.

Doctors help support and educate health care workers.

Sacla operates in areas like Brown's Farm, New Crossroads, KTC, Site B in Khayelitsha, Montague and Ashton.

The organisation runs clinics, a rehabilitation project for the disabled and a special clinic looking after people suffering from chronic illnesses such as diabetes and hypertension.

Patients pay R1 for treatment.

"If someone doesn't have money we don't chase him away, we give treatment," said Sacla co-ordinator Mrs Anna Genu.

There were times when health workers discovered medicines did not work because patients were living in poor conditions.

"When you go to squatter areas you find a leaking shack and a patient sleeping in those conditions," said Genu.

"Whatever we try to cure that person doesn't work."

Genu said the health workers had problems when people with tuberculosis had nothing to eat at home.

"If they have to take tablets, they must eat, and so if they have no food what can they do?"

Despite these problems, Genu said Sacla has achieved something.

"The fact that the demand for Sacla clinics is growing, shows that the community is in need of our services," she said.

National strike on the cards as tension mounts

ST Times 20/2/94

By RAY HARTLEY: Political Reporter

THE simmering tension between health workers and provincial administrations could boil over into a national wage strike in April — the month of South Africa's first democratic election.

National Education, Health and Allied Workers' Union official Neal Thobejane warned this week that politicians would have to make "strategic political decisions" to avert the impending strike.

He said his union was already mobilising its members around the country to protest against the disparity between the 3,4 percent pay increase for public sector workers and the 20 percent hike offered to senior civil servants. (85)

Public sector wage increases are scheduled to take effect on April 1.

The Transitional Executive Council's sub-council on finance has been dealing with the projected public sector pay hike since January, but has failed to reach a resolution.

The new strike threat comes after several strikes, involving nearly 20 000 workers in the volatile health sector, recently ended.

The strikes were mainly over a R500 bonus paid to Baragwanath Hospital workers and administrative failures regarding wages and promotions in the homelands.

Mr Thobejane said 21 shop stewards and a union official from Nehawu's Eastern Cape region had been suspended pending investigations into intimidation and failure to use correct union procedures.

A strike involving "renegade" members of the union, who called themselves the Action Committee was continuing in Lebowa, but the union was actively trying to defuse this, he said.

There have already been at least eleven wage strikes this year, according to statistics compiled by labour monitors for IR Network.

These have included work stoppages at companies as diverse as Amalgamated Beverage Industries, Carlton Paper, Unilever and Sappi.

IR Network's Wendy Dobson said the strikes appeared to be concentrated in high-paying industries which had not centralised their wage bargaining.

Most seemed to have been triggered by workers who believed signs of an improvement in the economy should translate into higher increases than those paid over the last two years, she said.

High-paying companies were now trying to reduce their wage bills to cope with increased international competition as the economy opened up to foreign competition, she added.

ANC health plan top-rated

KATHRYN STRACHAN

THE ANC has come top in an analysis of the national health care policies of six political parties carried out by the National Progressive Primary Health Care Network.

According to the report, released on Friday, there had been remarkable consensus that primary health care was a policy priority. However, the ANC's plans were the most detailed and far-reaching.

None of the parties had laid out an explicit financing plan to provide for basic health needs.

The report said the NP had identified primary health care as a priority but its campaign statement had not been as far-reaching as some of the policies gazetted by government in recent years.

Inkatha had supported the principle of primary health but had sought regional solutions to a national crisis.

The DP, while acknowledging the importance of primary health, had made few commitments.

The CP had supported universal access to primary health care but had distinguished between citizens and non-citizens in a new Afrikaner state.

The PAC had been committed to a system based on primary health principles but had not elaborated.

The analysis was partly aimed at gaining a commitment from parties which would have to be upheld after the elections.

Health Minister looks at laws to protect patients

BDay 21-2-94

ERICA JANKOWITZ

HEALTH Minister Rina Venter said yesterday she was investigating taking legislative steps to protect patients from the effects of industrial action at hospitals, which has led to evacuations, overcrowding and some deaths.

But National Education, Health and Allied Workers' Union official Neal Thobajane said this would escalate the dispute. He said it was essential for health authorities to redress disparities between proposed salary increases of 3,4% for lower-paid workers and 20% for the top ranks.

He said about 150 000 Nehawu members in the public service would embark on a national strike in early April if their demands were not met by March 18. "It is important for us to achieve our goals before the election, as afterwards we will be concentrating on reconstruction."

Reacting to this threat, Venter said patients were suffering the most from industrial action.

"I am evaluating existing dispute resolution mechanisms whilst trying to balance the interests of patients, workers and employers. My priority now is to take steps, within my legal limits, to protect patients. If I must get tough, I am prepared to do so."

Venter said local forums had been established at all affected hospitals to investigate worker grievances.

The forums, representing all parties, were established in agreement with Nehawu.

Venter maintained health authorities and Nehawu were in constant contact, both at these forums and over any specific issues tabled by the union. However, she felt the union was not in control of its membership as return-to-work agreements signed by Nehawu officials had not been adhered to by hospital staff.

Also, grievances were frequently raised after negotiations had been concluded.

(85)

Last week, Nehawu tabled new proposals to the Transvaal Provincial Administration requesting renegotiation of issues, but Venter would not disclose the content as she would consider the request this week.

Another case in point was Nehawu's rejection of the 3,4% wage increase agreed at a Commission for Administration chamber meeting last year. Venter said Nehawu was one of the many employee bodies represented at the chamber and consensus had been reached and an agreement signed. "We cannot reopen negotiations now without calling in all parties to the chamber."

Thobajane said Nehawu had not signed the wage agreement, but was bound by it according to legislation. "We will fight it," he said.

Venter felt Nehawu had "a political motivation", as the dispute would have been resolved had it had been strictly labour-related. Venter said arbitration over the selective R500 bonuses paid to nurses would begin in a few weeks.

Public sick of poor health care

(85) CT 24/2/94

JOHANNESBURG. — Dissatisfaction with health professionals is growing and civil claims are rising, National Health and Population Development director-general Dr Coen Slabber said yesterday.

Addressing the second National Medico-legal Conference in Sandton, Dr Slabber cited a Medical Defence Union circular which said the number of medico-legal problems reported to the union had risen sharply in 1991.

The circular continued: "Complaints by dissatisfied patients to the South African Medical and Dental Council have risen by nearly 50%.

"Civil claims have also shown an increase, both in number and in the size of settlements."

Dr Slabber said there were many deficiencies in the health care system and he foresaw major changes. One would be a move toward the "health team" — a team of professionals supplementing and supporting each other.

"The rules forbidding partnerships between doctors, pharmacists and nurses are outdated and certainly not in the interest of the public," he said.

"As long as we train medical students, nurses and pharmacists in isolation they are not professionals supporting and supplementing each other, but professionals competing with each other." — Sapa

Business scores from afterbirth

Sowetan 25/2/94

■PLACENTAE SALE

Rare products retrieved:

By Sizakele Kooma

ABOUT 70 hospitals are involved in a business deal that sees 120 000 afterbirth products leave South Africa each year for a medical institute in France. (85)

In an agreement concluded between the Department of National Health and Welfare and Mr Steve Mendelsohn of Bockneck Organic Materials in 1992, an undisclosed sum of money has been generated from shipments of placentae "donated" by private and provincial hospitals in Cape Town and Natal.

Mendelsohn would not reveal how much money his Greenside, Johannesburg, company makes from the sale of the products to Merieux Institute of Lyons, apparently the only institute in the world that processes placentae for pharmaceutical purposes.

"We are a private company and details of our profits are privileged information," Mendelsohn said.

He said there were massive costs involved in the business. The placentae for instance, had to be retained and shipped frozen.

The hospitals apparently do not receive any compensation for the products although some have been given donations — microwaves, clock watches or trolleys.

Mendelsohn said his company did not have to pay: "We provide a valuable service in terms of waste disposal. They are saving the cost of burning the material."

Bockneck Organic Materials was given permission by the Minister of National Health and Welfare to enter into negotiations with the Cape hospitals in 1992. Permission for Transvaal hospitals was granted in 1993.

The minister's office said its conditions to Bockneck were that it use the placentae only for medical purposes and that every patient should be informed and grant permission before her placenta was donated.

Placentae from women of the Islamic or any related faith, are not part of the agreement.

Pharmaceutical products made from the afterbirth are used in intensive care units for burn victims. It is also used in Guachers disease, caused by a problem in breaking down sugar. The enzyme found in placentae is the only one that can cure the disease.

It has been rumoured that the placentae are used in cosmetic creams to retard the ageing process.

Dr Rina Venter — gave permission for placentae to be donated by provincial hospitals.

NEWS 'Health continues to be a privilege' Monday February 28 1994 SOWETAN

Looking beyond the elections

■ FUTURE SYSTEM DETAILS *Health care network is watching the promises made by politicians:*

'Health continues to be a privilege'

Health services like this have been out of reach for millions of people and have been the privilege of those who could afford it and those on medical aid. The future government is expected to provide basic health care to all of South Africa's people.

By Russel Molefe

HEALTH crises continue to plague South Africa despite the coming elections which will usher in a new dispensation.

Politicians say National Progressive Primary Health Care Network (NPPHCN) co-ordinator Mrs Thangry Chikala did not seem bothered about the health care situation in the country reaching boiling point last month when services at more than 15 hospitals were halted.

Chikala says that health matters are among the issues that can make or break a party. For instance, President Bill Clinton of America came into power by promising better health services to those who could not afford them.

Chikala said During the elections in Britain in 1991 the ruling Conservative Party and the opposition Labour Party gave health a lot of attention.

Cuba remained the most envied country when it came to health services despite the constant criticism by Western countries of its communist system. Even the poorest of the poor had easy access to health facilities, Chikala said.

According to Chikala, millions of people — mostly blacks — have been out of reach of health services for many years.

Privilege for the rich

Health care also continues to be a privilege for the rich and for those who were on medical aid, she said.

"The politicians are not giving much attention to those whose votes they are seeking in the April elections. They do not explain what the future health care system will be like," Chikala said.

"The NPPHCN is looking beyond the elections to the time when it will be able to work with a parliament in which all parties, even opposition parties, will be on record as committed to improving primary health care.

"The NPPHCN is committed to working with South Africa's next government to ensure that basic services are universally available," Chikala said.

To bind the parties and make sure they will meet the public's health care needs, the NPPHCN challenged political parties to outline their policies on the following:

- Primary health care;
- Women's and children's health;
- Aids prevention;
- Community involvement; and
- Financing of health care.

According to an analysis of health policies of six parties released by the NPPHCN, all — the African National Congress, Pan Africanist Congress, Democratic Party, National Party, Conservative Party and Inkatha Freedom Party — agreed that basic health services should be available to all citizens.

Although all the parties agreed on the availability of health services to all, there were differences which could have a profound effect on the lives of people.

Financing plan

Although the NPPHCN found that none of the parties had worked out a clear and adequate financing plan for providing for basic health needs, its basic findings were that:

- The plans for reform put forward by the ANC were the most detailed of all the parties although not complete in their identification of funding sources;
- The PAC was committed to fully implementing a system based on primary health care principles but does not elaborate on its implementation plans;
- The DP, while acknowledging the important role of primary health care, has made few actual commitments to improve services;
- The NP states a priority for primary health care but its campaign statements, in many cases, were not as far reaching as some of those proposed by the Government in recent years;
- The CP expressed support for universal access to primary health care but distinguishes between citizens and non-citizens in a new Afrikaner state; and
- The IFP states emphatic support for most primary health care principles but seeks regional solutions to what is a national health crisis.

Chikala said that the coming elections provided all South Africans with an opportunity to elect the parties that promise to assure that their health care needs will be met and to hold those parties accountable in the future.

ANC calls indaba on health crisis

PIETERSBURG — The ANC has called for a forum tomorrow to discuss the health services crisis in the northern Transvaal.

The health and social welfare department of the ANC's northern Transvaal branch said yesterday strikes by public servants were responsible for "the near total collapse of health and other essential services in the region".

"The purpose of the forum will be to address those genuine grievances of the public servants and to jointly explore ways of securing a speedy end to the crisis."

All affected parties have been invited to attend the forum, starting at 9am at the Nirvana Civic Centre.

Hospitals in Lebowa were back to normal after striking nurses and labourers at 13 hospitals resumed their duties on Sunday.

The strike was called off after the Lebowa Health Department apparently agreed to meet all the strikers' demands.

Action committee chairman David Tsheola said good progress had been made on the processing of promotions, the adjustment of salaries and the payment of overtime and night duty allowances.

Health services in the homeland have been disrupted by a series of strikes over the past two months.

☐ More than 60 000 Lebowa public servants did not receive salary payments yesterday as promised.

SA task group head P Mathee said the money would be paid out only today because of administrative delays caused by a three-week public servants' strike. The salaries had been due on February 22. — Sapa.

Millions lack basic facilities and care

BDay 7/3/94

85

KATHRYN STRACHAN

MILLIONS of people in SA were living without toilets, clean drinking water or access to basic health care, according to the results of a national survey released at the weekend by the National Progressive Primary Healthcare Network.

The survey, conducted by the Community Agency for Social Enquiry, is one of the most comprehensive assessments ever of basic health conditions in SA.

It found that 31% of South Africans had been unable to afford to feed their children under the age of five.

Among blacks, 12% (2,1-million) in rural areas and 7% (1,5-million) in informal settlements had no toilets at all — neither pit latrines nor bucket toilets. Only 10% of blacks had a flush toilet inside their homes.

About 33% of blacks had regular refuse removal, and 44% had to fetch water for daily use outside their yard.

Cost of treatment was found to be a major obstacle to the rendering of health care. This applied particularly to blacks (22%) and to the retired and disabled (28%).

The survey also found that only 11% of blacks had medical aid coverage as opposed to 83% of whites. This meant that 28-million blacks had no medical cover.

The success of public education campaigns was reflected in relatively high rates of immunisation; 77% of respondents could produce official cards showing the immunisation status of children under five.

Political violence had prevented 11% of blacks from receiving health care when they needed it. About 12% of blacks reported that someone in their a family had been killed or injured in the violence.

According to the survey, South Africans view health as a key political issue, with 86% of respondents saying health should be high on the agenda in the election and 77% saying they wanted to know more about the health policies of political parties.

Network spokesman Judi Fortuin said that while the minority enjoyed first-rate health care, most people lacked the basics.

As the gulf in the provision of health care would continue long after the election and the establishment of a new government, health would continue to be a central concern in the future, she said.

"The poll documents widespread devastation. The findings point to the fact that the approach to bringing primary health care to SA must be an intersectoral strategy combining public works, nutrition programmes, job programmes and health services," said Fortuin.

Independent Electoral Commission head Judge Johann Kriegler and commission electoral administration chief director Piet Colyn conduct the draw to determine the party at the top of the ballot paper. Picture: ROBERT BOTHA

BDay

Draw gives PAC top place on ballot

7/3/94

THE PAC heads the list of political parties on the April 26-28 election ballot paper.

This resulted from a draw to determine the order of parties on the ballot paper. The draw was broadcast live on television on Saturday.

Independent Electoral Commission head Judge Johann Kriegler and IEC chief director of electoral administration Piet Colyn supervised the draw. Kriegler said other parties had until Monday night to object to the draw.

Second on the list was the Sports Organisation for Collective Contributions and Equal Rights, followed by the Keep it Straight and Simple Party. The Vryheidsfront/Freedom Front — registered provisionally by the Afrikaner Volksfront — is fourth.

The IEC also released the order of political parties appearing on the ballots for the nine regions. — Sapa.

Report by N Lewis, Sapa, 141 Commissioner St, Jhb.

Shocking picture of South Africans' poor quality of life

85 ARG 9/3/94

☐ Survey exposes low level of health care for blacks

JOHN VILJOEN
Staff Reporter

A SHOCKING picture of the poor quality of life of millions of South Africans has emerged in an independent survey.

Millions are living in unsanitary conditions without a toilet, without clean drinking water, without access to basic health care and under a constant threat of violence.

The disturbing information is contained in a nationwide poll conducted last month by the Community Agency for Social Inquiry at the request of the National Progressive Primary Health Care Network.

The network, an independent non-governmental organisation, said the poll was one of the most significant assessments yet of basic health conditions among South Africans.

The poll findings are based on 800 face-to-face interviews.

Thirty-one percent of those polled said there had been times when they could not afford to feed a child aged five or younger.

The poll showed unemployment among Africans to be 61 percent of those available for work.

Among Africans, 12 percent, or 2,1 million people in rural areas and 7 percent, or 1,5 million in informal settlements, have no toilets at all — no flush toilets, pit latrines or even bucket systems.

Only 10 percent of Africans, compared to 75 percent of coloureds, 97 percent of Indians and 99 percent of whites, have a flush toilet inside their dwellings.

Only a third of Africans have regular refuse removal, compared to all whites.

Fifty-four percent of Africans and 5 percent of coloureds — but no Indians or whites — have to fetch water for daily use from a source outside their home or yard.

The survey shows that some South Africans are refused medical treatment on financial grounds.

Almost one in five respondents said they had been refused treatment because they could not afford to pay. This had happened to 22 percent of Africans — and 36 percent of those living in traditional huts — and to 28 percent of retired and disabled people.

Almost one in five poll respondents do not buy prescription medicines because they are too expensive.

The poll shows that worry over the cost of health care crosses colour lines.

Two-thirds of whites said they were worried about the cost of treatment — 83 percent of whites have medical aid coverage compared to just 11 percent of Africans.

Twenty-eight million Africans have no medical aid coverage.

Relatively high rates of immunisation reflected the success of public education campaigns.

Three-quarters of the respondents with a child under five years old have a record of their child's immunisation.

Political violence has prevented 11 percent of Africans from reaching health care, but others are not affected.

Twelve percent of Africans reported that someone in their family had been killed or injured in violence.

South Africans view health as a key political issue, with 86 percent of respondents saying it should be an important election issue — 77 percent believe parties should be talking more about health policies.

A minority of South Africans enjoy state-of-the-art health care, but the majority live out their lives without the most basic elements of health, according to Elise Appel, the network's regional co-ordinator.

treatment ● Judge refuses to recuse himself

Health care crisis

Sowetan 11/3/94

■ HUNGER MONSTER Thirty-one percent cannot feed their children

By Russel Molefe

POLITICAL VIOLENCE gripping most of the black townships has prevented more than 2 million people from receiving health care.

A further 2,1 million people — especially in rural areas and in informal settlements — were living in extremely poor and unsanitary conditions without access to clean water, toilets and regular refuse removal.

Major findings

These are some of the major findings of a nationwide survey commissioned by the National Progressive Primary Health Care Network as part of its campaign aimed at enabling the public to scrutinise political parties' health policies before April 27 elections and committing those parties to be accountable in the future.

The survey, described by NPPHCN as the most recent and significant assessment ever conducted on the basic health conditions, also documented hunger as a "monster" with which many people had to live. (85)

About 31 percent of the population could not afford to feed their children aged five years and younger, the survey has found. The survey revealed that while the minority in the country enjoyed a state-of-the-art health care system, the majority — blacks in particular — lived without the most basic elements of health.

The survey further revealed that 83 percent of the white population had medical aid coverage while 45 percent of blacks avoided going for treatment because they could not afford to pay.

Also, 19 percent of blacks were refused medical treatment because they did not have money.

NPPHCN co-ordinator Mrs Thangry Chikala said health of the people must be a central issue and political parties satisfactorily explain to the would-be voters about their health policies.

Health issues

"Health may continue to be in a terrible state even after the elections if political parties are not pressurised to give much attention to health issues," Chikala said.

The NPPHCN will also sponsor eight forums throughout the country where political parties would be challenged by the public to discuss and defend their positions on health.

Pictures: DOUG PITHEY, Weekend Argus.

☐ **CRAFT TABLE:** There's plenty of activity to keep busy the mentally and physically disabled members of the Mamre community who proudly show off some of their craft creations at a special tea party.

AMG 12/3/94 (85)

Pilot health-care project points the way to the future

■ The success of an experimental health-care project in Mamre could be good news for the future of primary health care in South Africa's rural and semi-rural areas.

DI CAELERS
Weekend Argus Reporter

GOOD living is top of the list of priorities in the small West Coast town of Mamre where a unique pilot health-care project is seeing residents quit smoking, lose weight, seek psychological counselling and generally upgrade their lifestyles.

A joint effort between the 6 000 strong local community, the Medical Research Council and the University of Cape Town's community health department, the programme is run in association with the Progressive Primary Health Care Network.

And while it will be another year before any accurate statistics are available, community health workers are elated at the enthusiastic response from residents previously isolated in the semi-rural town.

Apart from the obvious health benefits of the programme, the community is winning in other ways including the sharing of professional skills, empowerment of residents, and the establishment of an extensive support network in respect of the elderly, the disabled and the youth.

Original surveys in Mamre, according to project co-ordinator Mercia Arendse, turned up hypertension as a major source of concern with nearly half the total population of women over 65 affected — about three times as many as their male counterparts.

"Lifestyle modification is the only answer to that and we immediately set up a blood pressure clinic, introduced smoking cessation classes as well as weight reduction classes."

But quitting smoking and losing weight are much easier instituted, she said, than dealing with the stress factor which, in the town which has an extremely high unemployment rate, manifests itself in almost half the entire population experiencing some form of psychological distress.

A UCT psychologist involved in the project, who may not be named for professional reasons, told Weekend Argus child sexual abuse cases and adolescent suicide attempts were alarmingly high in Mamre.

Intern psychologists who spend four months each gaining practical experience in the town relieve some of the pressure, but she said essentially the answer was a major departure from one-on-one counselling.

"The aim is to transfer or spread skills and we are working with and training both health professionals here as well as lay people.

"The psychological distress we encounter is not neurotic distress but rather is linked very closely to socio-economic hardships. People lack self-esteem and self-worth and we work by empowering them and not by creating jobs."

UCT social work and occupational therapy students also spend practical time in Mamre.

Project developer and UCT staffer Ronelle Carolissen explained that community health workers had been appointed in the fields of home nursing and care of the elderly, disabled and the chronically ill, as well as to deal with youth issues such as substance abuse and sexuality education.

☐ **FREE WHEELING:** The multi-disciplinary approach of Mamre's community health project includes a disabled awareness campaign and assistance for residents like Maggie and Adam September. Both Adam's legs were amputated recently.

☐ **CHECK-UP:** Community health worker Gavin Collins, who runs Mamre's blood pressure station, checks that all's well with Western Cape Regional Services Council inspector Oswald Johannes. Looking on is Mercia Arendse, co-ordinator of the town's health-care project.

Parents of disabled children 'left alone'

Cape townships sick of empty promises

■ Parents of disabled children in Guguletu, tired of being fobbed off by authorities, have set up their own initiative to gather statistics, gauge attitudes and, they hope, come up with solutions.

DI CAELERS
Weekend Argus Reporter

A UNIQUE research initiative by parents of disabled children, in association with the University of Cape Town's psychology department, is expected to turn up some of the first "real" data in the crisis of South Africa's "forgotten kids".

Experts have hailed the programme as an important step forward for embattled parents and a move away from traditional research around disabled children registered with formal institutions only.

Shanaaz Majiet, national advocacy manager of the Disabled Children's Action Group (Dicag), said: "This project has the potential of bringing out those children that are still locked away and of compiling a true reflection, via data and statistics, of what's really out there."

Weekend Argus revealed last month that thousands of physically and mentally handicapped children in Cape Town's black townships were experiencing appalling hardship. Many were locked alone in shacks all day while their parents worked, because of hopelessly inadequate facilities.

Discussing details of the Guguletu-based parents' initiative, research co-ordinator Thozi Mciki told Weekend Argus this week that frustrated and angry parents in Guguletu and Brown's Farm had formed the Siyazama Parents' Society for Disabled Children about two years ago.

Funded by the Department of National Health, the aim was to scientifically identify problems, needs and attitudes of affected parents.

UCT psychology department lecturer Ken Roper described the project as a fully participative one run by the parents for the parents. Workshops had been conducted, interviews done and some skills passed on and the first data is to be analysed within the next few months.

"We have avoided trying to count numbers at this early stage and rather have gone along with international figures that suggest about four severely mentally handicapped children per 1 000 — although in areas of severe deprivation that figure could be as high as five.

"We've instead gone into a limited number of homes to conduct in-depth interviews with parents to find out how they cope with existing resources, their needs and their thoughts around the issue generally."

The next step, he said, was to take a "survey approach", broadening the original project and going into as many homes as possible to achieve a "meaningful data base".

"Then, we go into implementation and whatever action we take would be in line with the broader objectives of Siyazama which include counselling, training of parents and teachers, establishment of day-care centres as well as the question of children's rights."

Abigail Sibali, one of the parents who conducted interviews for Siyazama, said parents finally had decided to "go it alone" after becoming extremely bitter at promises from authorities which never came to anything.

"We have been three times to the Cape Provincial Administration and were involved in a steering committee for parents of disabled children. The parents are promised all sorts of things — but, it ends there, there's never any follow-up.

"At the end of last year on International Day of the Disabled we marched through the city and handed over a petition for health minister Rina Venter. We've heard nothing."

■ Anyone wanting to help Siyazama can leave a message at 638-7291.

Traditional healers meet

(85)

2/13/94

GIYANI. — Traditional healers are to fight for representation at all levels of government.

At a conference in Gazankulu yesterday, five organisations of Northern Transvaal traditional healers also vowed to seek formal recognition for their trade.

Gazankulu chief minister Mr Samuel Nxumalo told delegates the government had robbed traditional healers of dignity and power, which they could only reclaim by voting for the ANC. — Sapa

Women work towards a brighter future

☐ Disadvantaged trained for caring

(85) ARGT 25/3/94

SHARON SOROUR
Labour Reporter

FOR Cecile Kotzé and Myrel Ginsberg, retirement has not translated into a time of rest, but a time of work.

The two inspiring women, both Stellenbosch residents for decades, are at the hub of the Bergzicht Training Centre in the town, which uplifts and trains disadvantaged members of surrounding communities in home management, frail care, educare and the hospitality industry.

The brainchild of director Mrs Kotzé, a retired Stellenbosch University home economics lecturer and Western Cape chairwoman of Women for South Africa (WSA), the centre opened in 1992.

Mrs Kotzé said the idea started at WSA, "a movement which aims to bring people together". When the Bergzicht farm complex became available, it was rented from the municipality and "the rest is history".

"At first we planned to give courses in frail care, educare and hospitality, but as a home economist I knew it was impossible to train people to look after the elderly or children in the home without knowing how to cope with home management," Mrs Kotzé said.

ority — one Mrs Ginsberg, head of the in-house employment bureau, takes to heart.

A no-nonsense practical women who has been living in Stellenbosch for about 45 years, Mrs Ginsberg said her position at Bergzicht was her "retirement job".

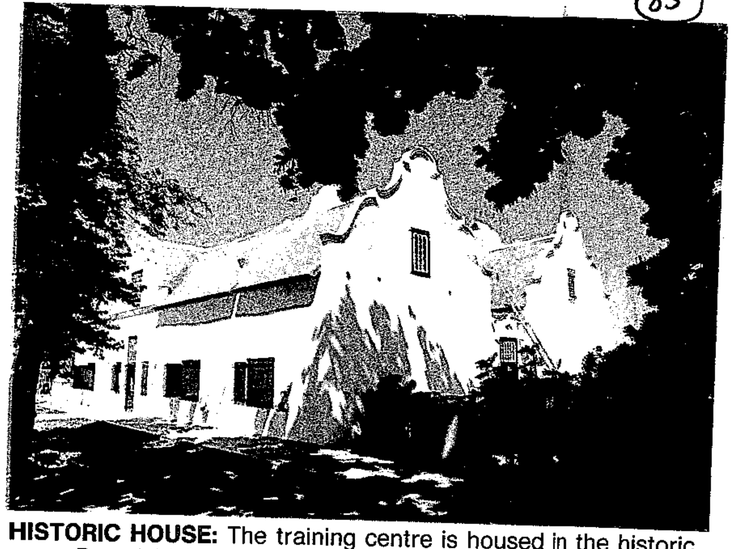
"We don't believe in training without finding people jobs, and we place 90 percent of our students mostly in Stellenbosch, Cape Town, Somerset West and Paarl," said Mrs Kotzé.

The niche it has created for itself in the community is demonstrated by the large number of applicants it receives for its courses.

"We get 100 to 120 people applying every month, from whom we choose 28 because we can only cater for two classes of 14 students each — it's impossible to give personal attention to larger classes," Mrs Kotzé said.

And the employment bureau, which used to advertise, now places people by relying on "word of mouth".

Potential employers are provided with a four-day induction to ease both the domestic worker and the employer into the new relationship, and the centre has a contract of employment and code of conduct to facilitate the process



HISTORIC HOUSE: The training centre is housed in the historic Bergzicht farm complex which dates back to 1796.

welfare organisation and as a non-profit making company under the Companies Act.

Its sponsors include the Department of Manpower, the Hanns Seidel Foundation of the German government, the Viva trust and the Joint Education Trust.

Lectures are given in English and Afrikaans, but a class of Transkei Xhosa-speakers will be trained in May with the help of an interpreter.

Mrs Kotzé said her staff, which included six lecturers, was very committed and students were taught to handle conflict

SHOW TIME: Centre students show director Cecile Kotzé their work.

"We then started with a month-long home management course, to uplift the job as well as the person carrying it out."

On completion of the course, students then have an opportunity to graduate and find a job, or "specialise" in frail care (looking after the elderly), educare (looking after children) or hospitality training (working in restaurants, hotels or guest houses).

Finding jobs for students is a priSince opening, the centre has trained about 500 people.

All applicants above the age of 18 are interviewed, and they have to pay R10 (R2 for registration and R8 for a medical certificate).

Although Mrs Kotzé conceded that the selection process was not "waterproof", the centre's successes outnumbered its failures.

Housed in the outbuildings of the historic farm complex which dates back to 1796, the centre is registered with the Department of Finance as a

Pictures: ROY WIGLEY, The Argus.

SECRETS OF SUCCESS: Bergzicht Training Centre employment bureau chief Myrel Ginsberg shows student Nora Jaza a pamphlet with pictures of past students who have successfully secured good jobs.

ANC changes medicine plan

CT 25/3/94

Own Correspondent

JOHANNESBURG. — The proposal that pharmaceutical manufacturers sell medication and equipment "directly if not exclusively to the state" had been dropped from the ANC's health plan, ANC health secretary Mr Ralph Mgijima said yesterday.

The final draft of the plan will be published next month, he said.

ANC drops health plan proposal

THE proposal that pharmaceutical manufacturers sell medication and equipment "directly if not exclusively to the state" had been dropped from the ANC's health plan, ANC health secretary Ralph Mgijima said yesterday. B Day 26/3/94

He said the proposal for state control of medicine distribution did not "fit in with other principles in the health plan". The final draft would be published next month.

The motivation behind the proposal had been to keep medication costs down, but there were other ways this could be achieved. The ANC and manufacturers would have to "look together to see where costs can be cut", he said. (85)

Pharmaceutical manufacturers welcomed the move. The Pharmaceutical Manufacturers' Association and the ANC would discuss proposals from manufacturers next Tuesday. The association would not disclose the proposals, but it had been lobbying for an extension to medicine patents to allow recovery of losses incurred in research and development.

BEATRIX PAYNE

Mgijima said the ANC would examine the amount invested in the development of a drug and consider the benefits of extending the patent. He was concerned that multinational manufacturers would be discouraged from investing in research and development if patents were shortened.

He said the cost spiral in health care was unacceptable. Prices could be cut by factories, wholesalers and distributors, and pharmacists or dispensing doctors.

Many manufacturers imported cheaper medicines but sold them at higher local prices, Mgijima said. State-controlled parallel importing could prevent this.

Report by B Payne, TML, 11 Diagonal St, Jhb.

Phasing out of apartheid health

ST Times
3/4/94

By CAS St LEGER

DRASTIC measures will restructure the fragmented and unwieldy Department of National Health and Welfare.

After the announcement of the three-phase amalgamation on Friday, officials said this would not, however, result in any budget savings or staff cuts.

In the first phase, the three "own affairs" administration departments as well as welfare components in the four provincial administrations were combined on Friday.

Health spokesman Andre Loubser said 9 500 workers would be affected in the first phase — but they would merely be shifting offices within the existing provinces.

In phase two, with the amalgamation of welfare departments in the self-governing territories and TBVC states, the total number of staff will swell to 12 496. (85)

These moves will take plaee after changes to the territories' constitutions.

Phase three involves rationalisation and "organisational refinement" of all social welfare functions in the government sector within the framework envisaged by the transitional constitution. As soon as the new constitution is in force, the authority of welfare administrators will be carried over to the premiers of the new provinces.

Third world health conflict

PIETER MALAN
Staff Reporter

PRIMARY health-care services should not be to the detriment of specialist and sophisticated treatment, says S N Amadhila, health secretary of the Namibian ministry of Health and Social services.

Dr Amadhila addressed delegates from 24 countries — including 16 African states — at an international congress for paediatric oncology (cancer) at the University of Stellenbosch.

He said third world countries were prone to spend more money on primary health care than on sophisticated treatment like that needed for malignant diseases.

The reasons were that no data on malignant diseases was available for sub-Saharan Africa and health authorities had no idea how many deaths were caused by them.

In most third world countries, cost efficiency and effectiveness had become integral components of the health planning process, said Dr Amadhila.

Immunisation programmes were inevitably more cost effective because they would protect all the children in a community, while investing the same amount of money in an oncology service would save relatively few children with less assured results.

Malignant diseases thus failed to attract the attention of budget planners.

Dr Amadhila said the importance of treating malignant diseases would grow as third world countries successfully controlled common infectious diseases and nutritutional disorders.

health

April 8 to April 12 1994

(85) South 8/4 - 12/4/94

Visions of healthy youth

A HEALTH programme aimed at preventing the spread of tuberculosis (TB), sexually transmitted diseases (STDs) and drug abuse among the youth was officially launched last week with a fun-run/walk in Sea Point.

Visions! Youth Care Foundation is a national youth care plan initiated by a large group of health care professionals to supplement the present health care system.

Mr Chris Mentor, co-ordinating director of Visions!, said doctors were concerned at the high numbers of people with STDs visiting clinics.

He said between 20 and 30 adults with STDs visited local clinics every day, and they started asking where the children were.

Mentor said the figures were high not because people were overtly promiscuous, but because they were unaware of how their bodies work.

"Some schoolchildren become sexually active at a young age while they are unaware of their own personal health," said Mentor.

"A girl may have an abnormal discharge, and she may see it as normal or it could worry her, but she may have no-one to confide in.

"We will have a different approach to counselling. Counsellors will be young so that the youth can relate to them.

"They will go into schools to educate children and will use music, dance and other methods to make counselling more lively."

According to Mentor, Mitchells Plain and Khayelitsha will be pilot areas for the programme.

Health centres will be opened in these communities and they will be run by counsellors from other communities so that young people won't have to confide in people from their own communities.

Visions! has been researching the health problems of youth for more than two years during which they spoke to more than 400 medical and education professionals.

"We feel that it is important to target the youth because they are the future," said Mentor.

Independent medical practitioners and voluntary staff will also help in the running of medical centres. Later a toll-free line will be introduced for counselling.

Visions will be funded by members' subscriptions, sponsorships, grants and joint fund-raising with schools.

BARBARA-ANN BOSWELL

Expert: Health care 'sick'

Staff Reporter

THE physical infrastructure of sub-Saharan Africa's health care is in a pathetic state, Dr Andre Issakov, from the World Health Organisation in Geneva, said at the opening address of a massive meeting on healthcare technology in Cape Town yesterday.

The meeting, being hosted by the Medical Research Council, marks South Africa's return to the sub-Saharan region.

The meeting of 200 delegates from over 27 countries will discuss a number of issues with regard to regional collaboration around health facilities and clinical engineering, conference organiser Mr Peter Heimann said.

Dr Issakov said health sectors in the African countries have little to spend on medical equipment.

"It is very gratifying that new political realities made it possible to convene this workshop," he said.

(85) CT 12/4/94

Star 14/4/94

Train of hope in sight

FUTURE VISION

The man behind South Africa's "Phelophepa" health train dreams of seeing it in action all over Africa, especially countries with rundown medical infrastructures.

DUNCAN GUY reports.

Not much has happened in Wolseley in the western Cape since the 1969 earthquake put the Boland dorp squarely on the map.

The current fruit season, which generates temporary employment on surrounding farms, is the most important time of the year for locals to earn cash.

And with elections coming up, Wolseley's predominantly Afrikaans-speaking population, divided by apartheid, struggles to agree how to establish a transitional local authority.

Election posters are ubiquitous, and perhaps more visible this week to 340 more residents than they were a few weeks ago — since the arrival of Transnet's eye and primary health care clinic-on-rails.

It rolled into Wolseley after beginning the year in the Orange Free State town of Arlington and completing nine week-long medical stops en route, at stations like Kakamas and Laingsburg, with 28 more to visit until it winds up the year's schedule at Mafikeng.

People need R40 for an eye test and spectacles from Rand Afrikaans University and University of the North final year optometry students who man the eye unit of the train, called the Phelophepa (Good Health).

With seasonal work on the go, Phelophepa's first couple of days at Wolseley saw only a trickle of patients.

But then numbers picked up, perhaps following the example of people such as Rachel Prins who sacrificed a precious work day.

She walked from a farm in the district, clutching R40, and emerged delighted from the train's eye clinic with her first-ever pair of spectacles.

Kortbroek medics

(85)

"It was those small letters I couldn't read — my Bible, the hymn book in church, newspapers — and feeding cotton through the eye of a needle," said the farm labourer, who was born in Wolseley and educated at a farm school until Std 4.

"I could never afford glasses in the past. I could always go to the clinic for medical treatment, but not for glasses."

After speaking to the "kortbroek" train medics, she learned why she had struggled to see.

"As a child I used to show other children how I could look into the sun. They told me the back of my eyes have now burned out."

Sister Eunice van den Berg and other nurses in the train's primary health care unit — the only charge is R5 for medicines — also emphasise preventative measures.

"There was lots of high blood pressure among adults here and I told them about the problems associated with too much salt in their diet," says Van den Berg.

"Patients also watch preventative health care videos in our 'educlinic' while waiting for consultations."

Other nurses noted the incidence of tuberculosis and commented on the high level of alcoholism. Part payment in wine and brandy at certain farms around Wolseley is not yet buried in history.

The medics issue letters to patients in need of follow-up treatment.

"It's the patient's responsibility to go there and also that of the local nurse to consult the person in the community," says Van den Berg.

For the optometry students, the experience brings more "eye-to-eye contact" than they experience at varsity.

"We are seeing a lot of pathological cases that could have been prevented had they been identified earlier," says RAU student Morne Botha.

Colleague Bernhard Nel says he enjoys doing community work.

Asked if most eye patients he was treating had been disadvantaged by apartheid, he says: "I would be lying if I said that was not the case."

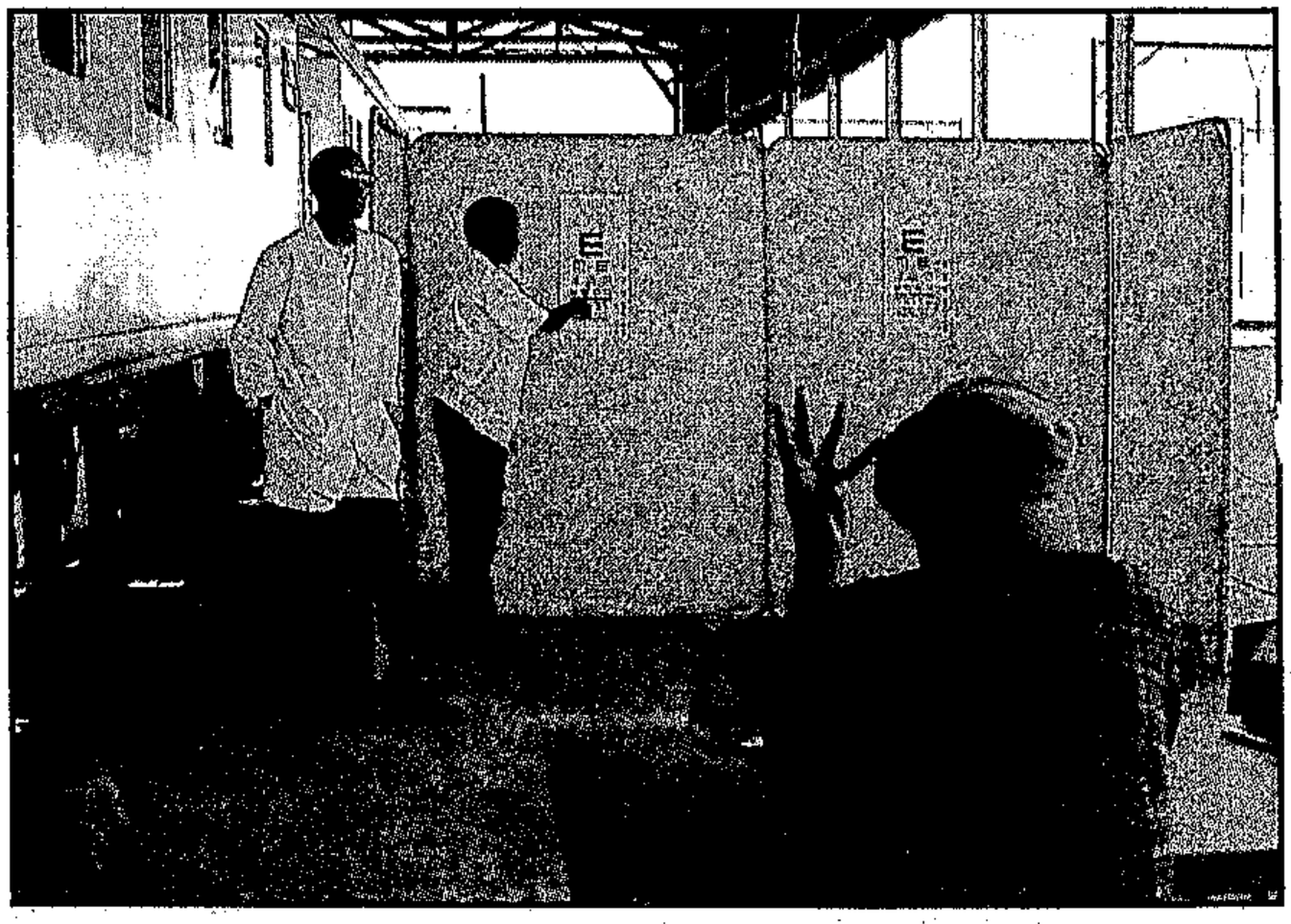
University of the North student Sandy Netshitumi hoped to see the train one day include a dental facility, even an operating theatre.

And the man behind the whole idea, RAU Professor Jannie Ferreira, says he dreams of the Phelophepa in action all over Africa, especially countries with run-down medical infrastructures.

"We are hoping, with international funding, to bring students down from African countries to study optometry at RAU, then return home and work on the train as part of their bursary conditions," he said.

"It would solve a lot of problems as far as culture and language are concerned."

So, one day, the Phelophepa could be at places such as Kasama in Zambia, served by the Chinese-built Taxara railway to Tanzania.



Eyes right . . . the Philophepa health train tracks good eyesight.

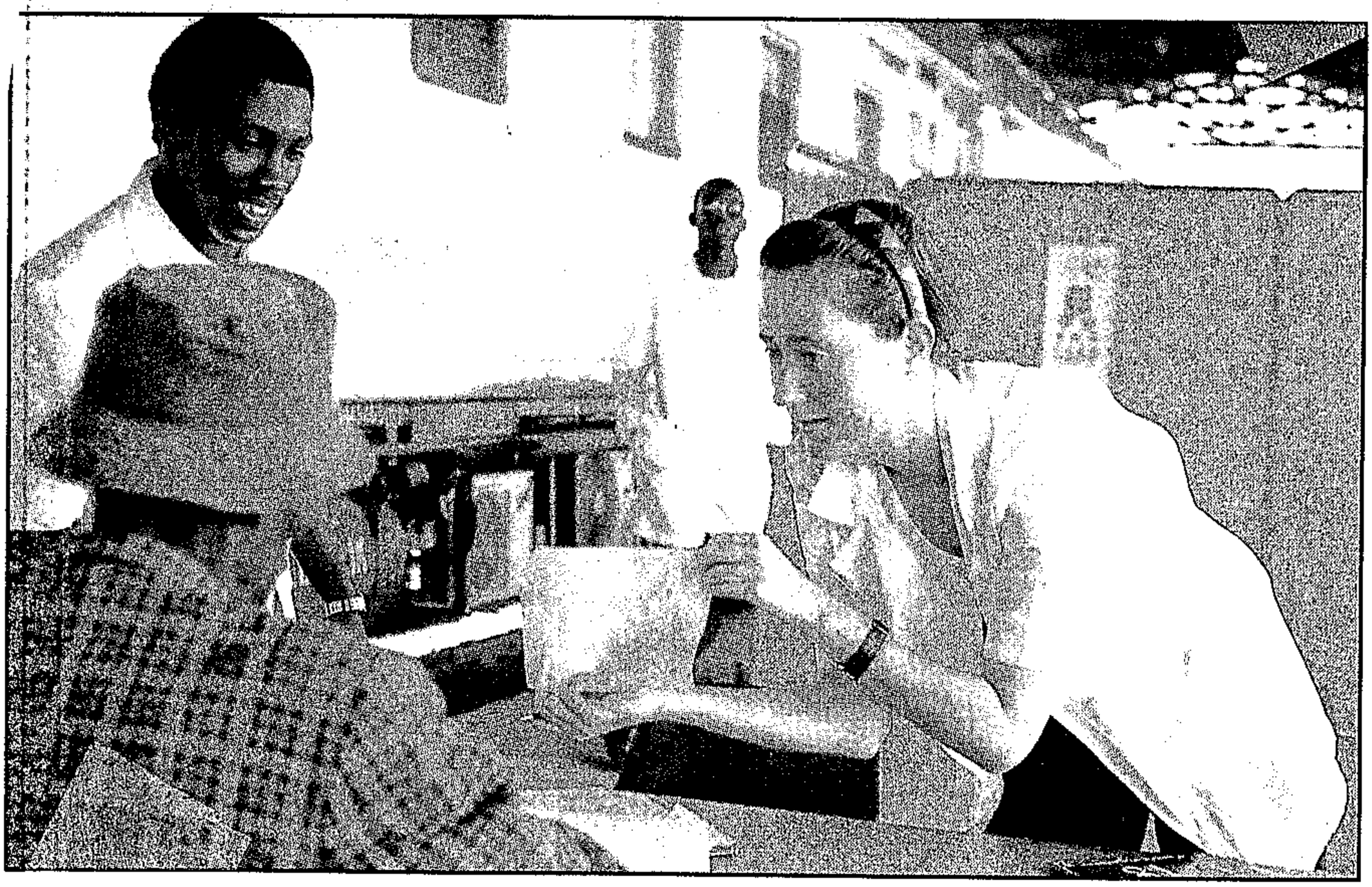
PICTURES: DUNCAN GUY

TOMORROW

A black South African living in England fine-tunes the precious classical pianos of music maestros abroad.

TRENDS

Edited by Marika Sboros



A primary health care worker from the Philophepa health train instructs a patient on good health care.

Council plan to enforce safe disposal of medical waste

CLIVE SAWYER, Municipal Reporter

HEALTH regulations should be changed to enforce safe disposal of hazardous medical waste, says the City Council amenities and health committee.

85 ARG 19/4/94

Surveys had shown disposal of hazardous medical waste was unsatisfactory. It was often thrown away with ordinary office waste.

Concern about hazardous medical waste, including "sharps" such as needles or scalpels, was growing because of blood-borne diseases like Aids.

Appeals by the city health department to generators of medical waste "have not been entirely successful", a council report said.

Regulations should be amended to specifically make it an offence to dispose of hazardous medical waste, the committee said.

● Cleansing director Kendal Kaveney told the utilities and works committee that some organisations had been reluctant to pay for the council's "pink bag" medical waste refuse collection system.

Millions in SA lack safe water

JOHANNESBURG. — About 10 million South Africans do not have access to safe drinking water and nearly 18 million lacked adequate sanitation, according to a Water Reseach Commission statement released yesterday.

CT 21/4/94

The commission opened a two-day workshop in Pretoria yesterday in a bid to co-ordinate research efforts and attempts by more than 100 organisations to provide safe water and sanitation to those in need.

WRC research manager Mr Charles Chapman said representatives from government, local and regional authoritites as well as communities, researchers and engineers had been invited to attend the workshop.

A co-ordination committee would be set up to manage research.

Mr Chapman said the commmittee would be an important mechanism to distribute guidelines and decide on project funding. — Sapa

Primary health gets a a boost

ES ARG 23/4/94

Weekend Argus Reporter

PLANS are afoot to launch an organisation representing various provincial, non-government and academic institutions working with primary health care institutions to help co-ordinate health care in the Cape.

The organisation will be known as the Cape School of Public Health and will be modelled on a similar organisation operating in the Transvaal, according to Dr Jarl Chabot, of Amsterdam's Royal Tropical Institute (RTI).

Dr Chabot and a team of Europe-based health experts were in South Africa at the invitation of the Transvaal School of Public Health to help local health workers formulate a strategy to improve primary health care. The other specialists were Dr John Martin, the World Health Organisation's deputy director of its international co-operation division and the RTI's Dr Gustaaf Wolvaardt.

The RTI has a long history of involvement in Africa and Dr Chabot has extensive experience in community-based health care development in West and Central Africa.

He participated in a training course for health workers in Cape Town this week which was aimed at equipping them with first-rate skills and a working knowledge of available resources. Dr Chabot said prospects for improved primary health care in South Africa were good.

Health care to get major shot in arm

By PETA KROST

SWEEPING changes have been instituted to make health care more accessible to people living in the Cape metropolitan area.

In an all-out effort by the Cape Metropolitan Health Care Forum to ensure future medical accessiblity for all, four new 24-hour clinics will be established and a major revamping of regional hospitals will take place.

The 24-hour clinics will be set up in Delft, Kraaifontein, Retreat and Crossroads. The two in Retreat and Crossroads will be ready within the next six months, according to the forum's chairman Dr John Frankish.

The forum represents over 100 organisations — including existing state health authorities, non-governmental bodies and political parties from the extreme left to the far right of the political spectrum.

While all four clinics have been approved by the forum and the community leaders, one stumbling block is the Transitional Executive Council's blanket ban on changes to civil service staff.

"But we are confident that after the elections the TEC will fall away and we can get on with it," said Dr Frankish.

The Retreat 24-hour clinic will be at the site of the present day hospital and an extra wing is to be added.

Dr Frankish said CPA had already drawn up plans and made funds available for a 24-hour clinic with X-ray facilities at the present Crossroads day clinic.

Both will be up and running within four to six months.

In Delft four tiny houses offer the only medical facilities while none are available in Kraaifontein.

Both these clinics will be "built from scratch. They will include large community health centres and obstetrics clinics."

Although these clinics will cost R7-million, only R3-million has so far been allocated for them. The forum has appealed to government bodies for funds and "requests have been sent to Pretoria".

"The earliest these two will be ready is in 1995," Dr Frankish said.

Victoria Hospital is at present supposed to serve the southern suburbs; Karl Bremer the northern areas, and Somerset Hospital the City Bowl. An urgent need for regional hospitals serving the Cape Flats has not been addressed.

The "contentious option" of selling the north block of the Somerset Hospital in Moullie Point to finance a new regional hospital in the middle of the Cape Flats, "where there is a dire need for a regional medical services" is also being "seriously considered".

The forum work group believes the west block of the Green Point Hospital and the City Hospital would be sufficient to serve the City Bowl area.

Wynberg's Victoria Hospital may be moved to the site presently occupied by the Princess Alice Orthopaedic Hospital in Retreat because it is not easily accessible to all the southern suburbs communities it serves.

The G F Jooste Hospital in Mannenberg is being upgraded to serve as an emergency hospital and will be "up and running" in January 1995.

Health system 'must be changed'

BDay 24/2/94

ADRIAN HADLAND

PRETORIA — The health care system, with its bias towards catering for the affluent urban population, would have to be changed, Health Department director-general Coen Slabber said yesterday.

Speaking at the second medico-legal conference, in Sandton, Slabber said that while locally trained doctors had an excellent international reputation and parts of SA's health system were comparable to those in Western countries, serious flaws existed.

These were best illustrated by the 77 306 cases of tuberculosis recorded in SA in 1992, the 7 159 cases of measles reported in the first eight months of 1993 and the serious typhoid outbreak last year.

Slabber warned the conference that public dissatisfaction with health professionals was growing and civil claims were rising, Sapa reports.

The number of complaints to the SA Medical and Dental Council had risen 50% in 1991 while civil claims had increased both in number and size of settlement, he said.

To achieve a more effective health care system in SA, the industry needed to be deregulated and a new emphasis needed to be placed on preventative primary health care.

Health teams in which medical doctors, pharmacists and nurses formed a single unit in private practice should be implemented, Slabber said.

"The rules of forbidding partnerships between doctors, pharmacists and nurses are outdated and certainly not in the interests of the public." (85)

Co-operation between medical practitioners and associated health professionals such as chiropractors and homeopaths, which is currently not allowed, should also be looked at in a bid to deregulate the industry, he said.

"We must start training health professionals to function in a team.

"As long as we train medical students, nurses and pharmacists in isolation they are not professionals supporting and supplementing each other, but professionals competing with each other."

The present emphasis on curative services rendered by doctors in hospitals would certainly change, Slabber said.

"In a new system, equal importance will be given to promotive, preventive and rehabilitative services."

Report by A Hadland, TML, 216 Vermeulen St, Pta.

Revamp planned for national health system

B Day 31/5/94

KATHRYN STRACHAN

A MAJOR revamp is planned for the national health system under an ANC-led government — based on building up a strong public health service and discouraging expansion in the private sector. (85)

The draft plan for health, released in January, sets out a five-year programme to create a national health system based on effective primary health care and funded through existing taxation levels.

The ANC believes SA's existing health budget of 6,5% of GDP is adequate to provide high quality care for all, though a lack of co-ordinated planning, mismanagement and inefficiencies in the public and private sectors have led to a lot of wastage.

In addition to general taxation, the ANC proposes that health care be funded by a national health insurance scheme, based on employee and employer contributions, and increased taxes on tobacco and alcohol.

The national health system envisaged would include public and private practitioners. Most health care would be provided by the public sector, with the private sector playing a complementary role. Private practitioners would be encouraged to work in public clinics, health centres and hospitals on a regular basis.

The ANC said at the announcement of the draft plan that the public sector would be unable to compete with private sector salaries, but incentives such as better working conditions would be offered. The state would not subsidise the expansion of the private sector and the licensing of private sector facilities would be more tightly regulated.

The plan targets free maternity care within five years, full immunisation by 1998 of 90% of children under two, and eradication of polio and tetanus in 1995. It also provides for mass education and counselling to combat AIDS and greatly improve services for the disadvantaged.

The draft acknowledges the role of traditional healers and proposes that their registration within the system be investigated.

Another break with tradition is contained in a clause which proposes that all women be given the choice of having abortions, and medical practitioners be given the choice of performing the operations.

Plan to study health care needs

BDay 25/4/94

KATHRYN STRACHAN

ONE of the largest private foundations in the US dedicated to health, the Kaiser Family Foundation, and the Johannesburg-based Community Agency for Social Enquiry (Case), have announced a major nationwide survey of SA's health care needs.

More than 4 000 households across the country will be interviewed on access to health services, the type of services most used, satisfaction with the quality of available health care and the outcome of treatment.

Additional questions will focus on public attitudes to a range of critical public health issues, such as childhood immunisation and AIDS.

Foundation president Drew Altman said the survey was "the first attempt to establish scientifically reliable baseline data on the country's health care needs".

He expected the information would provide a substantial basis for planning improvements in health services and from which to monitor progress in coming years.

He said the initiative was part of the foundation's commitment to help SA establish a more equitable national health system.

Over the past four years the foundation had committed more than $20m to improving the health of South Africans. (85)

Kaiser vice-president and director of the foundation's SA programmes Michael Sinclair said the lack of a national health information system and the historic manipulation of health data to disguise racial disparities had created a serious dearth of reliable health information.

The foundation was making substantial investments to ensure the availability of reliable and comprehensive health information on which to plan the reorganisation of the national health system. The system would be designed and co-ordinated by Case with assistance from an international advisory committee.

Case director Mark Orkin said that in a recent poll 86% of those questioned indicated that health care was of critical concern to them.

This survey would for the first time provide comprehensive data collected nationwide on factors affecting public utilisation of health services.

The results would provide strong guidelines for the new government to set priorities on health resources, he said.

No doctor? Classic book re-designed for Africa

(85) ART 7/5/94

GARNER THOMSON
Weekend Argus Foreign Service

LONDON. — When are herbs better to use than modern antibiotics? How should an injection be given by an untrained worker? Why should mealies be soaked in lime before cooking?

These are just some of the questions addressed by a new edition of a classic handbook for "barefoot doctors", re-designed especially for healthcare workers in rural Africa.

Where There Is No Doctor: A Village Healthcare Handbook For Africa, commissioned by Teaching Aids At Low Cost (Talc) is published by Macmillan Press in a bid to bring up-to-date medical aid to areas without hospitals, clinics or trained doctors.

Selling at a subsidised price of £6 (R32) — but, available from Talc at a lower cost to especially impoverished communities — the handbook is based on the original publication, *Donde No Hay Doctor*, aimed at South American healthcare workers.

Especially revised for African conditions, it is colour-coded, with sections on common illnesses, drug dosages, risks and precautions, emergency action, and preventive health in families and communities as a whole.

Authors David Werner and Felicity Cary illustrate *Where There Is No Doctor* with simple, but detailed, line drawings to supplement the text.

The handbook aims to spread sound medical knowledge and preventive care with the suggestion that "almost everyone" in a rural community can and and should be a health worker.

The Africa edition of *Where There Is No Doctor* has new information on nutritional diseases such as kwashiorkor, as well as up-to-date guidelines on the prevention and management of Aids.

Talc, a registered charity which also produces material on surgery, anaesthetics, nutrition and other topics at district hospital level, developed out of the work of child-care specialist Professor David Morely of London University, who began by preparing slide shows for overseas students to take back for use in their home countries.

The organisation is now advised by staff from the Centre for International Child Health, the Appropriate Health Resources Technology Action Group and the Child-to-child programme, as well as by a large panel of experts in a wide range of medical and healthcare specialisations.

A spokesman for Talc said this week that the charity was hoping the book would be of interest and use in South Africa where president-elect Nelson Mandela has repeatedly spoken of the need for increased health care throughout the country.

For further information contact: Talc, Box 49, St Albans, Herts, AL1 4AX.

PEOPLE'S LIVES *Violence, sex education, teenage pregnancies and abortion to get priority*

Women meet to formulate policy

By Pearl Majola

HEALTH ISSUES *Proposals to be made to the new Government:*

THE WOMEN'S HEALTH PROJECT is to host the first conference on health which will involve all women in formulating policy proposals for the government.

The conference is to be held in Johannesburg in December and preparations are already under way.

A national conference organising committee has been formed involving, among others, the Planned Parenthood Association, the Rural Women's Movement, Disabled People of South Africa, the National Progressive Primary Health Care Network and the South African Health and Social Services Organisation.

"It became clear to the WHP that there were women's issues that needed urgent policy not formulated by academics but by South African women from all walks of life," explained WHP's Ms Marion Stevens.

After discussions with interested parties, four urgent policy issues have been identified: violence, sex education in schools, teenage pregnancy and abortion.

Regional preparatory meetings are to start soon to get women from the various areas to start off the policy proposals.

A section of the conference is to be devoted to a topic on women in the media.

This area will be about the portrayal of women in the media as well as the participation of women journalists.

"Women's health and women's issues in general are not covered enough by the media," charged Stevens. "When they are, they are sensationalised or placed on the back pages where nobody sees them."

She conceded, however, that some of the women's issues were too sensitive and difficult to present in an effective way.

She suggested that part of the solution was to formulate a data base of interested journalists for the women's organisations to refer to.

"We are bringing in the Tanzanian Media Women's Association to share their experiences with us.

"They are an organised and a very effective group of journalists.

"They publish a magazine called *Sauti ya Siti*, which covers a wide variety of women's health issues," Stevens explained.

For further information on the conference, the WHP can be contacted at 725-0511 extension 2119.

FACTFILE

- **The WHP was started in 1991 and is based at the Centre for Health Policy and the Community Health Department at the University of Witwatersrand.**
- **WHP was set up because of lack of information about and involvement of women in the process of developing health policy in South Africa.**
- **Among other things, the WHP aims to:**
- **Create a network of people interested in women's health issues and maintain a resource centre;**
- **Carry out policy research;**
- **Produce a health handbook.**

"Women's health and women's issues in general are not covered enough by the media. When they are, they are sensationalised or placed on the back pages where nobody sees them"

Area not provided with primary health care

Sowetan 9/5/94 (85)

By Russel Molefe

THE Bushbuckridge area, which encompasses the poor territories of Gazankulu and Lebowa, is an area where primary health care is non-existent. Death from untreated poverty-induced diseases is rife in Mhala in Gazankulu and Mapulaneng in Lebowa.

The National Progressive Primary Health Care Network, together with the South African Health and Social Services Organisation, carried out a health situation analysis which revealed that ill-health in the area was largely related to poverty.

The Durban region in Natal, informal settlements of Botshabelo in the Orange Free State and Mzimhlope and Diepkloof squatter camps in Soweto are also areas where health conditions were found to be pathetic.

The findings also negate the notion that "rural homelands" allow for successful subsistence farming. In fact, high population densities and low annual rainfall allow no more than a vegetable garden, according to NPPHCN findings.

The health situation analysis was described as an important component to gain information on perceptions of communities and health workers on issues that affect them.

The analysis was also to challenge the assumption that only highly specialised people and academics can undertake policy formulation and aimed at:

● Identifying the most serious backlogs in essential health services which a new democratic government would be expected to address within five years;

● Strengthening the capacity of members of health organisations to evaluate health services and to participate in health policy debates; and

"Other sources of division include the gap between literates and illiterates, employed and unemployed, and migrant and permanent residents. This is complicated by between 30 000 and 60 000 Mozambican refugees"

● Discussing with some community members and organisations their perceptions and attitudes to current health services and priorities.

Environmental degradation and socio-economic conditions in the Bushbuckridge area were aggravated by the administrative and political illogicality of the South African situation and the resultant geographic and administrative fragmentation.

Although no recent population figures were available, the 1991 census showed there were more than 181 000 people in Mhala and approximately 224 000 in Mapulaneng.

In many places people have been resettled, pushing them together from different backgrounds and leading to disputes — at times bloody ones — over resource allocation.

Other sources of division include the gap between literates and illiterates, employed and unemployed, and migrant and permanent residents. This is further complicated by the presence of between 30 000 and 60 000 Mozambican refugees.

These problems make it difficult for health services to provide equal access to all, leading to the development of a parallel structure to meet the needs of the community, the NPPHCN and SAHSSO said.

The main structures involved in the provision of health services are the tribal authorities, civic associations, political parties, churches and various community-based projects.

However, it was found that the pathetic health conditions in the area were aggravated by the major groupings which are played off against each other for political purposes, a process which has been institutionalised in the tangled web of bureaucratic structures.

Different structures

NPPHCN and SAHSSO found that due to division in the community, it was difficult to provide services when nobody can say exactly who has authority and power at local level, or when authority resides with different structures within a relatively small geographic area.

Health services have been provided by the Lebowa government in Mapulaneng and the Gazankulu government in Mhala.

Although there are 14 clinics and a state hospital in Mhala district and 10 clinics and a hospital in Mapulaneng district, services exist in theory only with diarrhoea and malnutrition in children a common feature.

(85)

ARG 12/5/94

Primary health care is new minister Dr Zuma's speciality

Staff Reporter

DR Nkosazana Zuma, with her "intimate knowledge of primary health care at ground level and her solid background in research", promises to be an excellent Minister of Health, says the Medical Research Council.

A council spokesman said Dr Zuma's appointment augured well for a "completely revised and improved chapter in the realm of health and biomedicine in South Africa".

Dr Zuma joined the MRC's Natal office in May 1991. Her projects focused especially on Aids and maternal and child health.

Her Aids project tackled the role of women in the prevention and transmission of the disease.

She also initiated a collaborative project on abortion, looking at, among other things, the current management and attitudes towards South African laws on abortion.

She worked on the development of a national Aids strategy document for the National Aids Committee of Southern Africa.

Dr Zuma also investigated the limitations of family planning programmes in South Africa.

She spent many years in exile, during which she obtained her MBChB at Bristol University and a diploma in tropical child health at the School of Tropical Medicine, University of Liverpool.

She returned to Southern Africa in 1980 and worked at the Mbabane Government Hospital in Swaziland until 1985.

During 1989 and 1990 she was director of the Health and Refugee Trust in the ANC Health Department in Lusaka.

THE STAR / THURSDAY MAY 12 1994

Facing up to enormity of health reform

From school days in Natal's hinterland to the most powerful position in public health — that's the path taken by Africa's new Minister of Health and Welfare. David Robbins spoke to her.

Edited by Mike Siluma

Star 12/5/94 (85)

"Yes, I am excited," Nkosazana Zuma says in her quiet way. "But I am also anxious, because I am aware of the enormity of the task."

It is hardly necessary to detail this enormity: the high incidence of preventable diseases, the massive inequities between urban and rural health care, between services for white and black, the plight of millions of children. The question is clear: now that apartheid is finally dead and gone, where to start?

Zuma has definite ideas. "It must be with discussion. We in the ANC have a national health plan; that plan will give us guidelines; within them we will talk to everyone concerned with health. I believe that the creation of a good health service is a collective responsibility."

We chat around some of the issues facing the new ministry: how to redistribute resources (finances and expertise) from the curative-based centre to the impoverished rural periphery; and how to incorporate the powerful private sector into a national effort to bring quality and equitable health care to all.

Change

"Don't ask me to commit myself on the detail too soon," she says. "But let me say this: change is absolutely necessary. I think that everyone working in health, whether in the private or public sectors, is aware of this. That is why I stress the need for discussion, so that the changes can be made collectively and in the right direction."

What if people resist change or refuse to enter the discussions? Zuma is undeterred by the question. She smiles easily, but her eyes reveal a manifestation of strength.

"Everybody will be invited to participate. If they refuse, that can't be helped."

Yet she is quick to add her appreciation to "the many people who have been willing to work hard for health".

"There is expertise in large quantities, and the commitment is wonderful. It's one of the really exciting things about the challenge and responsibility I've been given."

Zuma (45) was born in Maritzburg and spent the first years of her life in rural Zululand, at Pholela, a name made famous by pioneering work done there in the early 1940s in the field of primary care and district health systems.

"Of course, Pholela is better known internationally than it is in South Africa," Zuma comments. "The doctors who initiated the work there, Sydney Kark and his wife, finally left the country after the Nationalists came to power in 1948. Yes, absolutely, primary health care based on the district model will form the basis of South Africa's new health care system."

Anxious . . . Nkosazana Zuma wants equitable health care for all.

It was in junior high school at Pholela that the young Zuma's political awareness began.

"I was an inquisitive child, and it didn't take long to see and question some of the things that happened under apartheid. Also we had good teachers. Our history teacher told us: this is what you need to know for the examinations; and this is what you must know about the country in which you live."

Zoology

Zuma matriculated from Adam's Mission outside Amanzimtoti in 1967. She had taken an extra year to master mathematics and science because already her sights were set on becoming a doctor. After obtaining a BSc in zoology and botany at the University of Zululand, she began her medical studies at Durban's medical school.

"It was while studying that my interest in public health developed," Zuma explains. "My experience of malnutrition, and how the same children would keep returning for treatment, made me realise that more than hospitals were needed to cope with this scourge. It was a matter of looking at a whole range of socio-economic conditions."

By 1976, Zuma was an active member of the ANC and in frequent trouble with the police. She therefore made the decision to leave the country, finally completing her medical degree at Bristol University in England. She has worked at several British hospitals, as well as serving both medicine and the ANC in Swaziland and Zambia.

But Zuma is now more interested in talking about future health policy.

"Clinics and referral hospitals are important, of course. But the health ministry will have to become a powerful advocate for jobs and housing, water and sanitation, as well. Without the development of these things, good health is impossible, and children get off to a bad start from which often they cannot recover."

Special

In fact, children will almost certainly get "special attention" so long as Zuma holds the ministerial reins. She is a mother of four (plus one stepchild), and she also holds a post-graduate diploma in tropical child health from the School of Tropical Medicine in Liverpool.

"I feel strongly that child health is critical, especially from conception to around five years old. Most brain growth in humans occurs during the first two years, and many skills are acquired during that time which are indispensable in later life. It is therefore imperative for the future of any nation that its children are looked after. Children are a crucial investment in that future."

How had her own children taken the news of her appointment as Minister?

"Of course, they were excited," Zuma replies. "But they were also concerned that I will not often be at home, because I will be spending a lot of my time in Cape Town and Pretoria."

But Zuma has no plans to take the family with her. Her husband, Jacob Zuma, is to lead the ANC in the provincial parliament of Natal/KwaZulu, and in any case the children are settled in schools in the Durban area.

"To begin with, the children will stay with Jacob," says Zuma, but not without regret. "We'll see how it goes."

What the Zuma children sacrifice could be a major gain to millions of their counterparts throughout South Africa: a woman and a politician who will wield considerable power, and also one who is not afraid to care.

Jo'burg revamps health services

BEATRIX PAYNE

SUN CITY — The Johannesburg City Council had restructured and decentralised its health department into a district health service at no cost to the city, Health, Housing and Urbanisation executive director Dr Eric Buch said at Sun City yesterday.

Speaking at a conference organised by the Pharmaceutical Society of SA and SA Association of Community Pharmacists, Buch said the council had been restructuring the department over the past two years. This had been in line with international trends towards decentralisation.

Although the district health care system resembled proposals made by the ANC in its health plan, Buch said, "we didn't restructure along ANC lines".

Most district health care managers were now at clinics "in the field". "Previously we had seven based at the civic centre; now we have only two".

He said the council had expanded its health care responsibilities beyond "the traditional narrow preventative only services of local authorities".

The creation of a single primary health care system from various Home Affairs and provincial departments would eliminate waste, Buch said. The racial fragmentation of services would be tackled by the Central Witwatersrand Metropolitan Chamber.

He said the private sector would still have an important role to play, particularly if more black employees were covered by medical aid.

Macmed's turnover up 79%

SELLO MOTLHABAKWE

HEALTH care company Macmed's turnover rose 79% on an annualised basis for the year to March due to increased demand and the benefits from last year's acquisition of Hospital Products.

Figures have been annualised to reflect a change in year-end from December to March.

A 60% rise in attributable earnings to R3,5m, or R2,8m (R1,8m) annualised, was diluted by additional shares in issue, and earnings were 7,5c or 7% higher at 6c (5,6c) a share on an annualised basis.

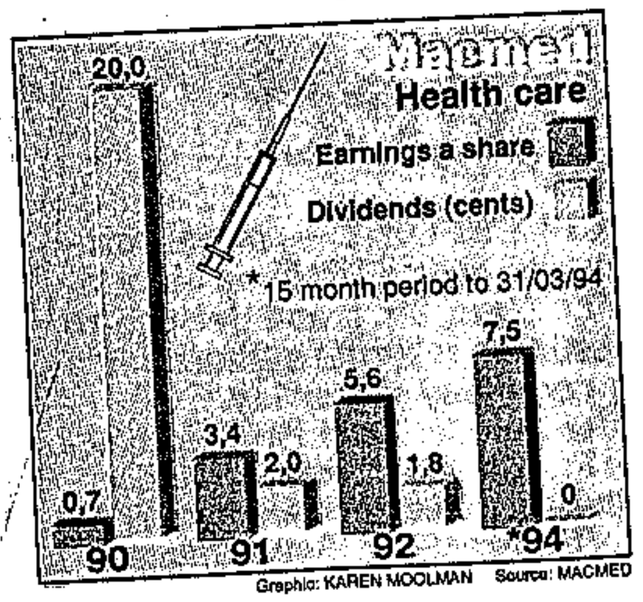
No final dividend has been declared but a capitalisation award of 1,25c a share was. The award would be made through the issue of new ordinary shares on the basis of one share for every 68 held.

The company acquired the entire share issue of Hospital Products in September last year and raised additional capital by way of a rights issue. The acquisition effectively bonded the company with the Rembrandt-controlled Medi-Clinic.

Macmed further improved its market share this year when it bought Ross Import Export company for R232 100. The acquisition was settled in full this month by a cash payment.

Net operating income was R4,4m, or an annualised R3,6m (R2,9m), while pre-tax profit dropped to R3,4m, or R2,7m (R2,8m) annualised. But the bottom-line increase was boosted as no tax was payable due to substantial accumulated losses.

The group anticipated strong future growth prospects and continued demand for its products despite increased competition.



Needle exchange plan coming

JOHANNESBURG. — The implementation of a needle exchange programme for drug addicts was well advanced, Mr Gary Kohn, president of the Pharmaceutical Society of South Africa (PSSA), said yesterday.

Speaking at the PSSA's national conference at Sun City, Mr Kohn said the aim was to limit the spread of Aids within a high-risk group. CT 18/5/94

Also yesterday, Mr Kohn said the PSSA was pressing for changes to the Medicines Control Act in the interests of better health for all in South Africa.

Mr Kohn said while access to higher schedules was still pending, the PSSA was encouraging its members to equip themselves to obtain section 21 permits allowing access to certain schedule three and four medicines for specified ailments. Fifty-one of these permits had been granted.

He reported the society had been instrumental in training pharmacists to obtain family planning permits, 2 200 of which had been issued (85) (92)

Dispensing doctors remained a major issue and high level discussions were being held to break the impasse. — Sapa

Health plan provides for R2-bn jump in state spending

(85) ARG 19/5/94

☐ ANC moots huge tax on tobacco, alcohol to foot the bill

The Argus Correspondent

JOHANNESBURG. — The final draft of the African National Congress's health plan for the nation provides for an increase in state health spending of about R2 billion — financed largely by huge excise increases on tobacco and possibly alcohol.

Maternal and child health, nutrition, the control of communicable diseases, and measures to combat the effects of violence have been highlighted as areas of greatest need and priority in the draft, which was unveiled yesterday.

The plan was presented to the Minister of Health, Nkosazana Zuma, for approval yesterday.

A recommendation to the cabinet that health care for children under six be provided free is expected next month, and the enabling legislation is to be enacted by 1995.

Significant targets relating to child health contained in the plan include 50 percent of births to be supervised and carried out under hygienic conditions, and at least 70 percent of children to be breast fed until the age of six months.

Special attention will be given to increased measles immunisation, and programmes to decrease dehydration problems and respiratory infections in the very young.

Priority has also been given to nutrition, where the aim is to reduce by 40 percent the prevalence of severe malnutrition, a major scourge in South Africa, by the end of 1997. More basic foods are likely to become exempt from VAT in the near future, and the question of price controls and subsidies is to be considered soon.

Immunisation programmes and other strategies will be established to help curb the major threat to public health in South Africa by tuberculosis, hepatitis B, and sexually transmitted diseases, including Aids.

The health plan, prepared over several years with the technical support of the World Health Organisation and the United Nations Children's Fund, has gone through several drafts and wide exposure to public opinion.

"We are pleased with the responses received to the various drafts," an ANC spokesman said.

"All the comments and ideas have been taken seriously, and have been used to improve the document. The plan now includes, for example, sections on care of the elderly and terminally ill, and represents wide consensus on most issues."

'Patients can see sangomas'

JOHANNESBURG. — Traditional healers, known as sangomas, may be brought into South Africa's mainstream health system.

The ANC's national health plan, drawn up by the ANC health department, says: "Traditional healing will become an integral and recognised part of health care in South Africa.

"Consumers will be allowed to chose whom to consult for their health care and legislation will be changed to facilitate controlled use of traditional practitioners.

"Traditional practitioners will be controlled by a recognised and accepted body so that harmful practices can be eliminated and the profession promoted."

Health Minister Nkosazana Zuma will decide in consultation with her cabinet colleagues which parts of the plan should become policy.

Many black South Africans consult traditional healers for physical and psychic problems. — Sapa-Reuter.

100% cigarette, alcohol tax mooted

ANC plans R12bn health care shake-up

BDay 19/5/94

320 85

JACQUIE GOLDING

THE ANC plans to increase the health budget from 3,4% of GDP to 4%, raising government expenditure on health care to more than R12bn.

The hike, proposed in the ANC's national health plan presented in Johannesburg yesterday, represents a shift from 11,5% to at least 13% of last year's Budget.

ANC health department head Dr Ralph Mgijima said the plan set out a five-year programme to create a single, integrated national health system based on effective primary health care and funded through existing taxation.

"A single government structure will coordinate all aspects of both the public and private health care delivery and all existing departments will be integrated."

In addition to general taxation, ANC health advisers recommended increased excise on tobacco and alcohol of up to 100%. They added that reduced expenditure by other government departments such as defence could see extra funds being diverted to health.

"Additional expenditure can be immediately derived by increasing taxes on tobacco which will have an added effect of reducing consumption," Mgijima said.

The plan, which includes a strong emphasis on building up the public health service and discouraging expansion of the private sector, was presented to Health Minister Nkosazana Zuma yesterday and was likely to become official health policy.

The comprehensive plan, which also recommended the zero-rating of basic foodstuffs, would be "thoroughly discussed" with the Finance Department, said Mgijima, adding that the ANC strongly supported moves to extend VAT exemption to medicines and medical services.

As a means of achieving an equitable health care system, the report urges the Health Minister to recommend next month that, among other things, free medical services be provided to children under the age of six, the elderly, the disabled and pregnant and nursing mothers.

It also called on government to urgently appoint a commission of inquiry to examine the crisis in the medical aid sector and to consider alternatives such as a compulsory national health insurance system.

It proposed that, in addition to general taxation, health care be funded by an insurance system based on employer and employee contributions.

The proposed commission of inquiry is expected to investigate the economic feasibility of such an insurance scheme and undertake planning if there is sufficient consensus on the option.

The investigation into an insurance system would be based on whether current

To Page 2

Health plan

BDay 19/5/94

From Page 1

medical schemes could form its basis and whether existing schemes met specified statutory conditions governing the health insurance system.

85 320

The ANC's health plan suggests that membership be compulsory for all formal sector employees and their dependants and that the health coverage provided by the scheme be statutorily defined.

Existing health insurance companies and medical schemes would be free to offer "top-up" cover for services not covered in the insurance package, said Mgijima, adding that the long-term goal would be for all citizens, including the unemployed, to be covered under the system.

An Econometrix senior economist said the zero-rating of more basic foodstuffs was better than government food subsidies, and said government could make up for the lost revenue by increasing taxes on "luxuries" such as tobacco and alcohol.

ANC unveils health plan

Smokers, drinkers may help finance R2-bn rise in State spending

Star 19/5/94

CHILD health and control of communicable diseases are among priorities

■ BY DAVID ROBBINS
HEALTH WRITER

The final draft of the ANC's health plan for the nation, unveiled yesterday, provides for an increase in State health spending of about R2 billion — financed in part by massive excise increases on tobacco and possibly alcohol.

Maternal and child health, nutrition, the control of communicable diseases, and measures to combat the effects of violence have been highlighted as areas of greatest need and priority in the draft.

The plan was presented to the Minister of Health, Dr Nkosazana Zuma, for approval yesterday.

A recommendation that health care for children under six be provided free is expected next month, and the enabling legislation is to be enacted by 1995.

Significant targets relating to child health contained in the plan include: 50 percent of births to be supervised and carried out under hygienic conditions, and at least 70 percent of children to be breast fed at six months, both by the end of 1995.

Special attention will be given to increased measles immunisation, and programmes to decrease dehydration problems and respiratory infections in the very young.

Priority has also been given to nutrition, where the aim is to reduce by 40 percent the prevalence of severe malnutrition, a major scourge in South Africa, by the end of 1997. More basic foods are likely to become exempt from VAT in the near future, and the question of price controls and subsidies is to be considered soon.

Immunisation programmes and other strategies will be established to help curb the major threat to public health in South Africa by tuberculosis, hepatitis B, and sexually transmitted diseases including Aids.

The health plan, prepared over several years with the technical support of the World Health Organisation and the United Nations Children's Fund, has gone through several drafts and wide exposure to public opinion.

"We are pleased with the responses received to the various drafts," a spokesman from the ANC department of health said. "All the comments and ideas have been taken seriously, and have been used to improve the document. The plan now includes, for example, important sections on care of the elderly and terminally ill, and represents wide consensus on most issues."

The complete health plan can be obtained from the ANC, and will also soon be available from CNA outlets.

▶ **Rationalisation the key – Page 19**

Plan's points

- Equitable health care for all, regardless of race or geographical position.
- Primary health care approach, with emphasis on preventive and promotive care.
- Basic health care package, including curative services, to be defined by statute.
- Single national health system to regulate public and private health care.
- Decentralised health authorities with emphasis on community involvement.
- Intersectoral collaboration with other developmental initiatives such as education, housing, water and sanitation, job creation.
- Financing through general tax at 13 percent of government expenditure (current levels vary between 11 and 12 percent).
- Additional financing through new taxes on tobacco (also aimed at reducing consumption); and savings on efficiency as old apartheid structures are dismantled.
- Commission to examine medical aids and possible establishment of a national health insurance system.
- Priorities (headed by maternal and child health) set over a wide field and, in some instances, planned to run until the end of the century.

Larger role for sangomas likely

The Government proposed yesterday that traditional healers be brought into the country's mainstream health system.

"Traditional healing will become an integral and recognised part of health care in South Africa," said a national health plan drawn up by the ANC health department and presented at a news conference.

Health Minister Nkosazana Zuma will decide in consultation with her Cabinet colleagues what parts of the plan become policy.

"Consumers will be allowed to choose whom to consult for their health care, and legislation will be changed to facilitate controlled use of traditional practitioners," the plan said.

"Traditional practitioners will be controlled by a recognised and accepted body so that harmful practices can be eliminated and the profession promoted," it added.

Many black South Africans consult traditional healers, known as sangomas, for physical and psychic problems.

Sangomas are often asked for potions — sometimes made from human body parts — to ward off evil spirits. — Sapa-Reuter.

Star 19/5/94

Rationalisation is the key

85

HEALTH Writer David Robbins discusses the challenges of integrating South Africa's health services with the Director-General of National Health, Dr Coenraad Slabber

"Our health services require large-scale rationalisation. This must be our first move. And it's not going to be easy. In fact, it's going to be a very difficult and complex operation in many parts of the country."

This is the view of Dr Coenraad Slabber — and he should know. He's been Director-General of National Health since 1988, and is now widely expected to stay on at least until his present contract expires in November.

"In some parts of the country, the necessary reorganisation will be easier than in others," Slabber points out, "but there'll be problems everywhere as our present fragmented services are taken apart and put together in more rational ways."

From the virtual autonomy of the health departments of 10 independent and self-governing homelands and four provinces, South Africa has itself rationalised into nine provinces which, in turn, will devolve authority to district and community structures.

As Slabber explains: "In a province like the Western Cape, rationalisation will mean, at least to start with, simply calculating which portion of the old Cape provincial administrative staff and budget should be allocated to the new province. But at the other extreme, think of the problems confronting the Northern Transvaal."

Within the boundaries of South Africa's most northerly province are situated the former homelands of Venda, Gazankulu and Lebowa, each with its own health department. To this must be added the Transvaal Provincial Administration health authority, as well as the functions previously undertaken by National Health.

"Out of all this we will have to create a single health department. This is going to be extremely difficult."

Slabber pinpoints people as the most important consideration. While doctors and nurses will go on working, more or less as and where they did before, the administrative staff which supports these front-line workers will face considerable change.

"In the northern Transvaal for example, people will be moving to the new headquarters in Pietersburg. They'll be coming from Thohoyandou in Venda, Giyani in Gazankulu, Lebowakgoma in Lebowa, and also from Pretoria. A new administration, including a new hierarchy, will need to be established."

Other rationalisation difficulties will revolve around the differing pay scales and conditions of service existing across the old health departments, and also the different methods of data collection and storage used.

Will it be possible to combine crucial health infomation stored at Giyani, for example, with those records kept for the "white" far North at Pretoria?

"And the problems don't stop at integration," says Slabber. "In some places, there is a serious lack of basic information. When Lebowa collapsed, for example, our people couldn't establish what had actually been spent on health. People knew what the health budget was, but nobody knew whether it had been over or underspent."

To rectify all this will take time. New administrations will need to be assembled, new systems installed. Budgets will have to be taken to pieces and reassembled.

Health services must be maintained. Will there be immediate improvements at the interface between these health services and those people most in need of them? The realistic answer is probably not.

"People will need to be patient," Slabber says. "We're not going to see results immediately. Rationalisation must come first. The obvious question here is: can rationalisation be done in six months? I believe we must try.

"Yes, I believe that the ANC's health policies are sound. It's the implementation which is crucial. In the past, our health policies have been good, but our implementation was pathetic because of the way the country — and health — had been carved up on ethnic lines.

"Now there is a real chance of improving implementation. But we'll need to get good people at the top and we'll need to be serious about rationalisation."

Health plan

(85) CT 19/5/94

Tax on cigarettes, alcohol may double

DANCING MASTER ... Ballroom dancer Graham Solomons, 21, dances with mayor Mrs Patricia Kreiner. She had presented him with a R2 000 donation towards a trip to compete in British dancing championships. Picture: ALAN TAYLOR

THE African National Congress wants the government to increase the tax on cigarettes and alcohol by up to 100% to pay for an ambitious new national health plan based on primary health care.

The plan outlined by ANC health department chief Dr Ralph Mgijima at a press conference in Johannesburg yesterday was earlier presented to Health Minister Dr Nkosazana Zuma.

It is likely to become official health policy.

'TRADITIONAL HEALING WILL BE RECOGNISED'

As a method of achieving an equitable health care system, the report urges Dr Zuma of the ANC to recommend, among others, to the cabinet next month that:

● Free medical services be provided to children under the age of six, the elderly, the disabled, and pregnant and nursing mothers.

● Traditional healing will become an integral and recognised part of health care in South Africa.

● Traditional practitioners will be controlled by a recognised and accepted body so that harmful practices can be eliminated and the profession promoted.

● Consumers will be allowed to choose whom to consult for their health care and legislation will be changed to facilitate controlled use of traditional practitioners.

● The zero-rating of basic foodstuffs will be "thoroughly discussed" with the Finance Department.

● The ANC strongly supported moves towards extending VAT exemption to medicines and medical services.

● In addition to general taxation, health care should be funded by an insurance system based on employer and employee contributions.

● Membership of a national health insurance scheme should be compulsory for all formal sector employees and their dependents and the health coverage provided by the scheme should be statutorily defined.

The plan includes a strong emphasis on building up the public health service and discouraging expansion of the private sector.

Dr Zuma will decide in consultation with her cabinet colleagues which parts of the plan will become policy.

Dr Mgijima said yesterday the plan set out a five-year programme to create a single, integrated national health system based on effective primary health care and funded through existing taxation.

In addition to general taxation, ANC health advisers recommended doubling the price of tobacco and alcohol to fund the plan.

Dr Mgijima said cutting down on tobacco consumption would have an added benefit on reducing health risks.

Dr Mgijima said: "Additional expenditure can be immediately derived by increasing taxes on tobacco which will have an added effect of reducing consumption."

An official at the conference, Dr Kami Chetty, said details had not been worked out, but the price of cigarettes could double.

ANC officials added that reduced expenditure by other government departments such as defence could see extra funds being diverted to the health department.

The ANC also recommended yesterday that the government of national unity urgently appoint a commission of inquiry to examine the crisis in the medical aid sector and to consider alternatives such as a compulsory national health insurance system.

The proposed commission of inquiry is expected to investigate the economic feasibility of an insurance scheme and undertake planning if there is sufficient consensus on this option.

The investigation into an insurance system would be based on whether current medical schemes could form its basis and whether existing schemes met specified statutory conditions governing the health insurance system.

Existing health insurance companies and medical schemes would be free to offer "top up" cover for services not covered in the insurance package, said Dr Mgijima.

He added that the long term goal would be for all citizens, including the unemployed, to be covered under the system.

An Econometrix senior economist yesterday said the zero-rating of more basic foodstuffs was better than government food subsidies, but that the ANC would make up for it by increasing taxes on "luxuries" such as tobacco and alcohol.

'PRIVATE SECTOR EXPANSION DISCOURAGED'

The ANC plan would increase the health budget from 3,4% of GDP to 4%, raising government expenditure on health care to more than R12 billion.

The hike represents a shift from 11,5% to at least 13% of last year's budget.

Current prices are relatively low in a heavy-smoking country. Locally-made brands retail for R2,60, while American-made cigarettes cost around R4,30.

● **Mandela to launch back-to-school plan — page 2**

Better health for all the aim

Sowetan 19/5/94

THE Pharmaceutical Society of South Africa is pressing for changes to the Medicines Control Act in the interests of better health for all in South Africa, the society's president, Mr Gary Kohn, said on Tuesday.

He delivered a report at the PSSA's annual national conference at Sun City.

Kohn said while access to higher schedules was still pending, the PSSA was encouraging its members to equip themselves to obtain Section 21 permits allowing access to certain Schedule 3 and Schedule 4 medicines for specified ailments.

Kohn reported the society had been instrumental in training pharmacists to obtain family planning permits, 2 200 of which had been issued so far. A further 380 pharmacists were awaiting permits after passing their November 1993 examinations.

Turning to the extended role proposed for pharmacists, Kohn said there appeared to be areas of contradiction between the Pharmacy Act 101 of 1965, and the Medical and Dental Act 56 of 1974.

He drew pharmacists' attention to section 36 (3) of the Medical and Dental Act which, he said, determined that a registered pharmacist might perform certain duties, even though they were defined by the Medical and Dental Act as ones that could be performed only by a doctor.

He said this led to the question whether it was the Act's intention for pharmacists to diagnose a condition and prescribe medicine, or were they allowed only to dispense medicines upon request or on prescription?

Dispensing doctors remained a major issue and high level discussions were being held to break the impasse.

Kohn reminded delegates that pharmacists could supply medicines upon the written or oral prescription of a nurse. It had been established that the nurse would, under certain conditions, become a prescriber and provider of medicines. The list of medicines would be limited. —*Sapa*.

ANC unveils health plan

Emphasis on public service

(85)
CT 20/1/94

Own Correspondent

JOHANNESBURG. — The ANC unveiled its plans for a new health system yesterday that includes the right to abortion.

The ANC's vision for a new health care system includes a strong emphasis on building up the public health service and discouraging expansion of the private sector.

Presenting the plan, ANC spokeswoman on health Ms Cheryl Carolus said lack of co-ordinated planning, mismanagement of resources and inefficiency in the public and private sectors had resulted in an "appallingly" inefficient health system.

The draft plan sets out a five-year programme of priorities aimed at correcting past racial and geographical imbalances in the provision of health care through more efficient management of resources.

The organisation believes the existing health budget (6,5% of GDP) is adequate to provide quality care for all.

Some highlights are:

- Health care be funded through national health insurance based on employer and employee contributions and increased taxes on alcohol and tobacco in addition to general taxation.
- The state would not subsidise expansion of the private health sector.
- Private practitioners would be encouraged to work in public health centres on a rotational basis.

Targets for the next five years include:

- Free antenatal, delivery and post-natal care.
- Full immunisation of 90% of all children under the age of two by the end of 1997 and free health care for children under six.
- Health centres and clinics in all rural areas by 1999.

The Medical Association of SA (Masa), which represents doctors and dentists, said strengthening the public sector was to be welcomed, but expressed reservations about the plan to discourage growth in the private sector.

Wits University centre for health policy director Mr Max Price said the draft plan was an "excellent start".

It was the first time a political party had detailed its vision for health. The clear timetable and objectives indicated the ANC was committed to the plan.

Access to clean water, safe sanitation for all

Own Correspondent

PRETORIA. — All South Africans will have access to clean drinking water and safe sanitation within the next three years, Water Affairs and Forestry Minister Dr Kader Asmal said yesterday.

(85) (8)

The move was a response to genuine needs and during the ANC's earlier People's Forums access to water had emerged as the most urgent demand over the need for housing and jobs, he said.

CT 20/5/94

Announcing new initiatives and policy adaptations in the department in line with government's Reconstruction and Development Programme (RDP), Dr Asmal said more than 12 million people in the country currently did not have access to water and 21 million did not have adequate sanitation and refuse removal.

"This appalling situation is unjustifiable and unacceptable and it will henceforth be the policy of the department to treat water security as a basic human right," he said.

He said the immediate aim was to establish a national water and sanitation programme which would assist households to secure a clean, safe water supply of 20 to 30 litres per capita per day within a 200m reach and adequate sanitation facilities.

Dr Asmal said a "minimum programme" could be in place within the next three years.

Liquor, tobacco tax threat outcry

CT 20/5/94 8S

By IVOR CREWS

MEMBERS of the liquor and tobacco industry yesterday hit out at the ANC proposal that the government double the tax on cigarettes and alcohol to pay for its new national health plan.

Mr Andre Steyn, director for administration at Stellenbosch Farmers' Winery said increased taxes on alcohol would be counter-productive, causing sales to drop and causing the government to lose money.

He said increasing taxes on alcohol would drive the liquor industry underground. However, a decrease in drinking would contribute to health.

A spokesman for KWV said excise duties could lead to unemployment in the Western Cape.

He said higher taxes had not curtailed alcohol abuse anywhere in the world.

The Tobacco Institute of South Africa, representing the industry, said a large increase in price would lead to a decrease in tobacco consumption and a loss of jobs.

The Tobacco Action Group, representing the Heart Foundation, the Cancer Association and the National Council Against Smoking, said a R1 increase in the price of a packet of 20 cigarettes would raise about R1 billion annually.

Professor Solly Benatar, head of the department of medicine at UCT, said he supported an increased tax on alcohol and tobacco which would generate funds for primary health care as well as the public sector.

Prof Benatar said he supported many of the principles outlined in the ANC plan.

Bid to stop backstreet operations

Abortion on demand if health plan is approved

Star 20/5/94

(85)

ILLEGAL abortionists "have neither the inclination nor the training to provide counselling and contraceptive advice"

■ BY MARIKA SBOROS

South African women will in effect have access to abortion on demand if the final draft of the ANC's health plan is approved by the Minister of Health.

But ANC spokesmen were quick to point out that draft proposals are aimed at reducing the huge number of illegal abortions in this country, and the deaths and complications that arise from them.

The proposals recognise that every woman has a right to choose "early termination of pregnancy", and equally that health workers have a right to refuse to participate in such terminations, a spokesman said.

The current estimate is that every year 300 000 women have abortions in South Africa, of which less than 1 000 are legal. Around 80 percent of legal abortions are performed on white women.

The majority of women who are treated at Baragwanath Hospital for complications following backstreet abortions were not irresponsible teenagers, but women in their 30s, who already had children, said a hospital spokesman.

"We need to provide quality of care and ensure the safety of women who choose to terminate a pregnancy.

"After all, backstreet abortionists have neither the inclination nor the training to provide counselling and contraceptive advice to ensure that the woman doesn't get pregnant again."

Legislative changes will have to be made if the proposals are accepted.

The law at present allows for legal abortion under such circumscribed conditions that only middle and upper-class women have benefited.

The law requires that three doctors, one a State-registered psychiatrist, be involved in a legal abortion. Poor, rural women do not have access to such resources.

Just what the doctor ordered

ANC plan gets to the heart of the matter

Star 21/5/94

THE ANC's national health plan, released in its final form this week, provides a comprehensive overview of the shape of things to come. But what are the implications for ordinary South Africans? Health Writer DAVID ROBBINS attempts some answers.

(85)

THE ANC's health plan, which will almost certainly become the national health plan for the next five years, has a decidedly solid feel about it.

There can be no argument with the main intentions of the plan:

1. To correct the often scandalous inequities created by apartheid.
2. To shift the emphasis from hospital-based curative care to primary care.
3. To concentrate, as a priority, on the health of mothers and their children.

It has been proposed that health spending should increase by up to R2 billion. But who will bear these additional costs? The short answer is that probably smokers and drinkers will. But it's worth looking in a little more detail at how the new Government is likely to do its sums.

State spending on health at the moment stands at around R11 billion a year, or just more than 11 percent of total State spending, or around 3,4 percent of the country's gross domestic product. The World Health Organisation recommends that 5 percent of GDP be spent on health.

The ANC is now recommending that our spending increase to around R13 billion, or 13 percent of total State spending, or 4 percent of GDP. The extra funds, they say, can be raised by excise increases on tobacco and alcohol.

■ See Editorial Page 8

But this still doesn't bring our health spending in line with the WHO recommendation — until private sector spending is taken into account.

At the moment, another R11 billion is spent largely by people who enjoy medical aid benefits. This brings our current total health spending to around 6 percent of GDP, a figure likely to rise to about 7 percent soon. But concealed within these globular figures is the essence of South Africa's inequality in health expenditure.

The great divide is simply between people (largely white, urban dwellers) in the private sector, and those who are dependent on public sector health care.

Let's express the inequality in arithmetic terms: 20 percent of the population is, with a great deal of overservicing, waste and downright abuse, consuming half of total health spending while the other half goes to the remaining 80 percent of the population, the majority of them black, many of them unemployed and living in underserviced rural areas or informal settlements.

It's because of these hopelessly skewed realities that the ANC — and the new Government — are committed to achieving equity.

The extra R2 billion, if the Finance Ministry can be persuaded to raise it, will be a start, because all of it will go to improving State health services at the primary level.

In fact, spending at this level could be increased by as much as 100 percent, a possibility which will bring a real chance for improved health to millions living in South Africa's hitherto underserviced periphery.

But this proposed injection of new finance will not be enough to achieve the desired equity. Other strategies are needed.

Most importantly, the overservicing of 20 percent of the population will give way to a more efficient spread of health care. At the same time, a system of public sector self-sufficiency will draw increasing financial resources towards the hitherto underserviced 80 percent.

Central to the new arrangements is the principle of cost recovery that is to be put in place in the public health sector. Hitherto, what little revenue was generated at public hospitals and clinics didn't go into Health Department coffers, but disappeared into the central revenue fund.

This procedure is set to change. Public sector hospitals will retain their own revenues, and will thereby be able to use cost-efficiency techniques as a management tool. Furthermore, these public sector institutions will be able to charge patients covered by medical aids at a level equal to "full cost recovery".

All sorts of differentiated fee structures are being mooted, but perhaps the bottom line is that public hospitals will at last be managed as income-earning business centres, thus reducing the responsibility of the State from its current crippling commitment of around 75 percent of total health expenditure — and more importantly placing State hospitals in direct competition with those operating purely in the private sector.

The implications for the private sector, and especially for medical aids, are considerable. Even if, as seems likely, the medical aid industry will be used to establish a national health insurance system for people employed in the formal sector, the main challenge will be to contain costs even more rigorously than in the past.

Some of the more practical ways in which this can be done will include the use of generic drugs where possible; the introduction of managed care, an arrangement where medical financers negotiate prices with a set group of providers; special deals with specialist practitioners and hospitals which would limit user choice; and a possible reduction of benefits to a more basic "core services" level, with the individual option of buying top-up cover for more sophisticated treatments.

A national commission of inquiry is almost certain to examine what the ANC's health plan calls "the crisis in the medical aid sector" and to "advise on the most appropriate system for financing the health sector". Without preempting the commission, it is possible to sum up the situation as folows.

If you're part of the underserviced 80 percent, the news is almost all good, except that the pace of improvement might not be quite what you'd expected.

If you're part of the overserviced 20 percent, you could end up paying slightly more for your health cover (depending on your position on the economic ladder), you might lose your tax rebate on medical aid contributions (the commission will probably decide) and your basic benefits will possibly shrink. But on the plus side, the quality of the health care you experience will improve, forced to do so by the increasing competitiveness in both the public and private sectors.

● FACE-TO-FACE WI

Health boss Dr Zuma is pro-choice in abortion controversy

S1 Times
22/5/94

NKOSAZANA ZUMA

By CAS St LEGER

NEW Health Minister Dr Nkosazana Zuma backs freedom of choice on issues ranging from abortion to patients preferring private hospitals.

She was party to the ANC National Health Plan released this week, which promotes the liberalisation of abortion laws. (85)

However, Dr Zuma says: "Any law should respect the right of people not to have a termination of pregnancy if they do not believe in it.

"Health workers should not be made to perform that termination if it is against their morals and religious beliefs.

"People feel it may be un-Christian. As a Christian, I find it difficult to be judgmental of women wanting a termination.

"That is something they have to sort out with their God. It is not for me, as a doctor, to judge them."

Dr Zuma moved into her slightly shabby ministerial suite high in the Civitas Building in Pretoria on Monday.

Brightening the meagre decorations were the South African flag and a bouquet of flowers sent by the dean of the University of Pretoria.

Already immersed in a formidable schedule and en route to Cape Town for the opening of Parliament, Dr Zuma paused for a second to wonder about the fate of the flowers.

"I was touched," she said.

Dr Zuma's first task will be to guide the National Health System, which will unify South Africa's fragmented health services, through Parliament.

She intends retaining and supporting the valuable parts of the old health service — like research and academic hospitals — and rebuild the entire health edifice around primary health care.

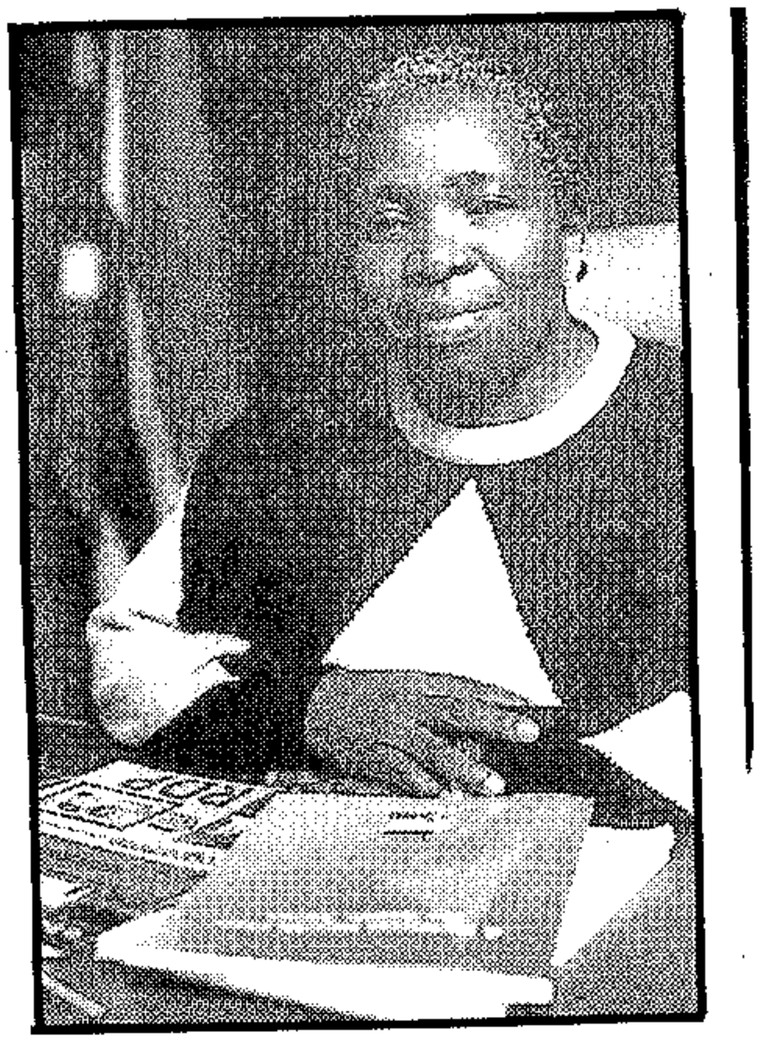
"I don't want the impression created that once we go the primary health care way, academic medicine and research goes out of the window," said Dr Zuma.

"I see both primary health care and academic medicine as essential to the health service."

While there would have to be "some rationalisation", Dr Zuma said she believed anxieties that academics would become poor relations in the new health service were unfounded.

Dr Zuma's priority will be the well-being of South Africa's children.

Everything else — from streamlining inefficient provincial hospitals, to nudging the private sector to co-operate, to setting up free medical care for those who need it and establishing a primary health care network — will follow.



AT WORK ... Dr Zuma has a heavy schedule Picture: JON HRUSA

She intends the changes — at least in child care, with free medical services for under-sixes — to be visible by the end of this year, depending on legislation.

"Children are the first priority. If you have a nation of stunted, malnourished individuals, children whose brains have not grown to their full potential, then you can't hope to have a nation that will be properous and able to compete with the rest of the world ..."

If this mother and professional woman has one pang about her new post, it is that she has had to leave her four children and one step-child, aged between five and 12, behind in Durban.

She is confident the money for restructuring health services — about R2-billion or 14 percent of the Budget — will be found.

"Unless we're saying that the changes taking place should only be meaningful for me as a minister and not for anybody else, then we have to find the money. The restructuring has to happen."

Maritzburg-born Dr Zuma, 45, was raised at Pholela in Zululand. She matriculated from Adam's Mission in Amanzimtoti and went on to study at Durban's medical school.

In exile with her husband, ANC deputy secretary-general Jacob Zuma, she completed her MB ChB degree at Bristol University and received a diploma in tropical child health from the University of Liverpool.

She then worked at the Mbabane Government Hospital in Swaziland and at the ANC health department in Lusaka before joining the Medical Research Council in Natal in 1991 to research AIDS and maternal and child health.

Academic hospitals — now called academic complexes to include their teaching function — are regarded as national resources. They will fall directly under the NHS, rather than under provinces.

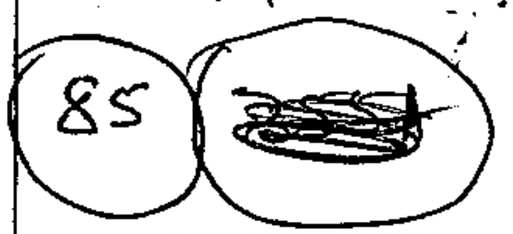
"They should be seen as national assets shared across provinces," Dr Zuma said.

One possible way of streamling services would be for specialised operations like heart transplants to take place in one centre.

Health packs aim to keep women well

23/6/94

Star 23/6/94



AN AFFORDABLE NEW PACKAGE

It's long been recognised that women play a pivotal role in the health of their communities. This makes it even more important that women themselves remain healthy. **DAVID ROBBINS** reports on a new and affordable health workshop package aimed specifically at women.

Women are a particularly vulnerable section of the population. Not only must they face the normal health risks associated with high-stress living, but they have some unique risks.

One of the most prevalent and dangerous types of cancer is that of the cervix.

And a glance at the statistics reveals that, in the Aids epidemic now taking serious hold in South Africa, women are more at risk than men. Indeed, the gender ratio among people currently testing HIV positive is 1:0,7 in favour of men.

It takes little imagination to realise that both these health problems — cancer of the cervix and HIV positivity — are sexually related. Couple this with the lower economic status of women (which often forces sexual encounters on them) and all the hype about the mysteriousness of women's bodies, and you end up with a health problem of considerable proportions.

Knowledge is the key to its solution. This is certainly the view of the Women's Health Project, a small organisation based at the Wits Centre for Health Policy, which has recently launched three health packages designed specifically for women.

According to the introductory material, the purpose is "to help women learn more about health ... by giving information about a woman's body and how it works ... and by giving information about diseases that can make a woman's body sick".

The material is for use in a workshop situation and it should come as no surprise that the three packages deal in turn with the woman's body, Aids and cancer of the cervix.

Each package includes a manual, with useful and practical notes for facilitators, and five instruction posters (one is coloured in on this page) with clear line drawings and captions.

The cost of all three packages, plus a manual on how to set up a workshop and how to use the material to best effect, is R30.

The workshop on the woman's body is in two sections, the first dealing with the inner parts of the body, where they are and what their functions are.

The second section concentrates on the reproductive functions: sexual intercourse, the monthly period, getting pregnant. A useful glossary lists everything from anus to vulva, and provides concise, easy-to-follow definitions.

The workshop on Aids packs a great deal into its estimated two-hour duration: what the disease is, who gets it, how it is spread, how HIV ultimately affects the body, how protection can be achieved.

Special sections also explain the Aids test, counselling, and safer sexual practices.

The Aids workshop closes with the question regarding who should have control over women's bodies.

Although the answer should be obvious to most of us, the workshop does not shirk the reality that in many situations, especially those where the economic independence and status of women are in question, other forces are constantly challenging this fundamental human right.

Cancer of the cervix, say, the workshop notes, is a very serious disease:

"If found early in a woman's body, it can be easily treated. However, if the cancer is allowed to stay, it can make a woman very sick. She can even die. In this workshop it is important to discuss how a woman can help protect herself by asking a doctor or a nurse for a pap smear."

The workshop talks (in great and reassuring detail) about pap smears, and how women can ask for one.

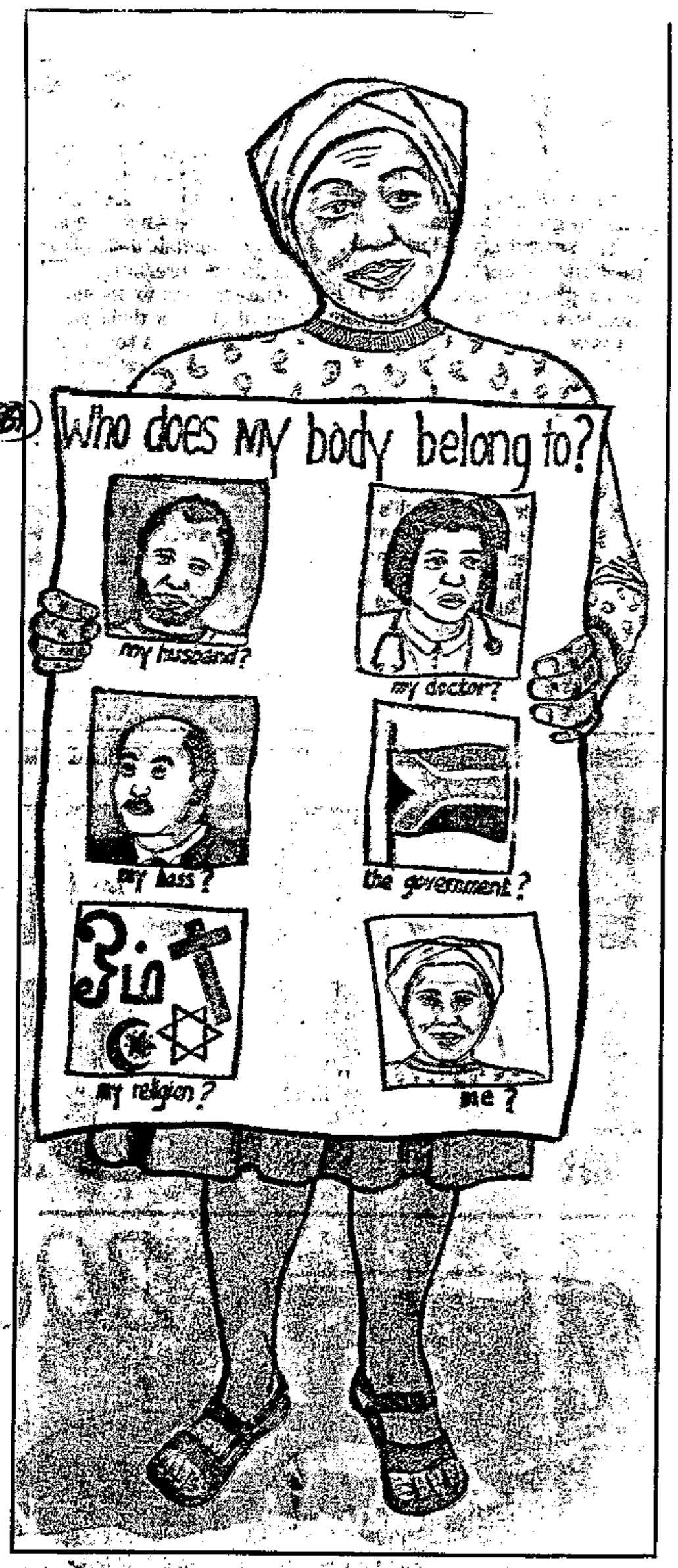
Taken generally, these workshop packages constitute essential learning material for millions of South African women. If you doubt this, listen to just two recent (1990) research findings.

Although more than 85 percent of 659 women interviewed in formal and informal housing in the western Cape had heard of Aids, ferwer than 5 percent linked the disease to sexual activity.

And again, fewer than half these women had heard of cervical cancer or the possibility of having pap smears.

It has been to combat such chilling levels of neglect and ignorance that the Women's Health Project has designed these packages.

■ For more information, contact Marion Stevens on (011) 725-0511, extension 2150 or 2119.



Ready to bind nation's wounds

Sowetan 23/5/94

■ NEW ERA SA Medical Services contribute to the healing process:

By Lulama Luti
Political Staff

AS THE COUNTRY ENTERS a new era, the South African National Defence Force's Medical Services stand by, ready to help bind the nation's wounds.

And according to South African Medical Services surgeon-general Lieutenant General Niel Knoebel, binding the wounds of the nation is going to be tops on the SAMS 'sagenda.

While they will continue to provide medical services for the country's defence force, they will also play a major role in reconciliation efforts.

"We've got the best rehabilitation programme in the country and through this programme we can contribute quite a lot to the healing process," said Knoebel.

The SAMS also trains medical orderlies and doctors to be able to give the necessary medical support to the army, navy and air force. Knoebel sees the SAMS as a national asset.

"Our other function is as a collateral utility. For example, in various disaster situations, it was mainly the army and the medics that were involved in the saving of lives.

"During the sinking of the Oceanos, the outbreak of typhoid in Delmas and more recently the strike in Bophuthatswana where the entire staff of a home for the disabled walked off the job, we walked in and helped the kids," he said.

(85)

When the Union Defence Force was constituted in 1912 under the Defence Act, the Medical and Nursing Services formed part of the force.

And today, the SAMS comprises a staff complement of 7 000 people and this includes nurses and doctors.

While the SAMS do have the capacity to help in disaster situations, Knoebel said, there was strength in working together with other medical services in the country. "The other area where we could play a big role is in the primary health care sphere and in the training of primary health orderlies so that they could go back to their communities and apply those skills," Knoebel said.

The most important of the SAMS's facilities are the three military hospitals: the No 1 Military Hospital in Pretoria, No 2 Military in Cape Town and No 3 Military in Bloemfontein.

And as integration of the various armies begins, these facilities will be increased.

Knoebel said while a difficult task lay ahead for the SAMS, they were more than prepared for the challenge.

National Health Forum could be restructured

BEATRIX PAYNE

THE National Health Forum has been put on ice as the ANC and the National Health Department consider restructuring it, forum co-chairman and National Health Department director-general Dr Coen Slabber said yesterday.

"The forum was initially formed to stop the unilateral restructuring of the health care sector, but that role is no longer applicable," he said.

Sources in the industry said the planned restructuring could have been triggered by a lack of funding for the forum.

But forum co-chairman and ANC health secretary Dr Ralph Mgijima said: "The life of the forum was up as soon as the government of national unity was in place. We didn't budget for it to go on for ever."

The forum could become a statutory body and "part and parcel of the government of national unity".

Slabber said he thought it was unlikely the forum would be made a statutory body this year as government had other priorities. "But inputs will be taken seriously whether it is a statutory body or not."

He said the restructuring of the forum had been discussed with Health Minister Dr Nkosazana Zuma, who was concerned that the forum was not inclusive.

Slabber said that so far few university medical faculties, private clinics and day clinics had been represented in the forum.

"It is just impossible to include all these people without it becoming a circus but we must consider more representation from the communities," Slabber said.

"At best the forum can become an advisory body."

Feeding scheme for needy children

ARG 24/5/94 (85) (287)

A FEEDING scheme will be established in needy primary schools and children under six and pregnant women will get free medical care in state hospitals and clinics within the next 100 days, says President Mandela.

Addressing parliament today, he said these were some of the projects that should be seen as signals of serious intent to address the desperate needs of society.

The goverment would take steps to provide clean water for all and to introduce proper sanitation sensitive to the protection of the environment.

Mr Mandela said the government was determined to address the housing shortage vigorously in collaboration with the private sector and needy communities.

It would also address the needs of the aged and disabled, upliftment of disadvantaged sectors such as women and the young and improve the conditions of rural communities and informal settlements.

There should be substantial investment in education and training and the government would try to meet its commitment to introduce free and compulsory education for at least 10 years.

"We must combat such pathologies as widespread poverty, the breakdown of family life, crime, alcohol and drug abuse, the abuse of children, women and the elderly and the pitiful reality of streetchildren.

Social needs tackled with feeding, work schemes, free medical care

B Day 2515194

TIM COHEN

CAPE TOWN — Children younger than six and pregnant mothers would receive free medical care, while a primary school feeding scheme and a public works programme would be launched within 100 days, President Nelson Mandela announced yesterday.

Outlining government's policy on a host of questions in his opening of Parliament speech, Mandela announced the new measures as a signal of how serious government was about meeting social needs.

Within the next 100 days, government would implement various projects under the direct supervision of the President.

Children under the age of six and pregnant mothers would receive free medical care in every state hospital where such need existed, he said. (85)

A nutritional feeding scheme would be implemented in every primary school where such a need was established. A process of consultation between major stakeholders would be organised immediately.

The public works programme would involve every level of government and all efforts would be made to involve the private sector, organised labour, the civics and other community organisations.

Mandela said a programme was already being implemented to electrify 350 000 homes during the current financial year.

Addressing broader policy issues, Mandela said government welcomed recent developments that would provide for the creation of community banks.

Government would also encourage the greater participation of established financial institutions in black economic empowerment and support for the development of small and medium-sized businesses.

He expressed support for consumer protection and said government would have to pay increased attention to tourism.

His government would take steps to ensure the provision of clean water, address the dire housing shortage in a vigorous manner, and address the needs of the aged and the disabled.

Substantial amounts would be invested in education and training in order to meet government's commitment to introducing free and compulsory education for a period of 10 years.

Government was determined to confront the scourge of unemployment, not by way of handouts but by the creation of work opportunities.

Government would deal "sensitively" with the issue of population movements into the country to protect SA workers, to guard against the exploitation of vulnerable workers and to ensure friendly relations with all other countries.

Drug trafficking would be dealt with firmly, while racism in the workplace, in particular, had to end, he said.

Basic health care starts on a cold winter's morning

(85) ARG 25/5/94

□ Dedicated employees attend monthly lectures

LIBBY PEACOCK
Staff Reporter

IT is a cold winter's morning in the Western Cape's apple-producing Grabouw area.

In a small building on a farm a group of dedicated employees from different farms in the area are attentively listening to Rural Foundation local health care co-ordinator Angela Joorst.

The day's lecture is about hygiene.

The student health workers have been attending monthly classes for the past year.

Having been chosen for their roles by their own communities, it is their responsibility to convey what they have learnt about preventative care and basic health to their fellow farm workers once a month.

They are also available to diagnose and treat minor ailments and dispense basic medicines on the farms, while being adequately trained to know when a patient needs to see a doctor.

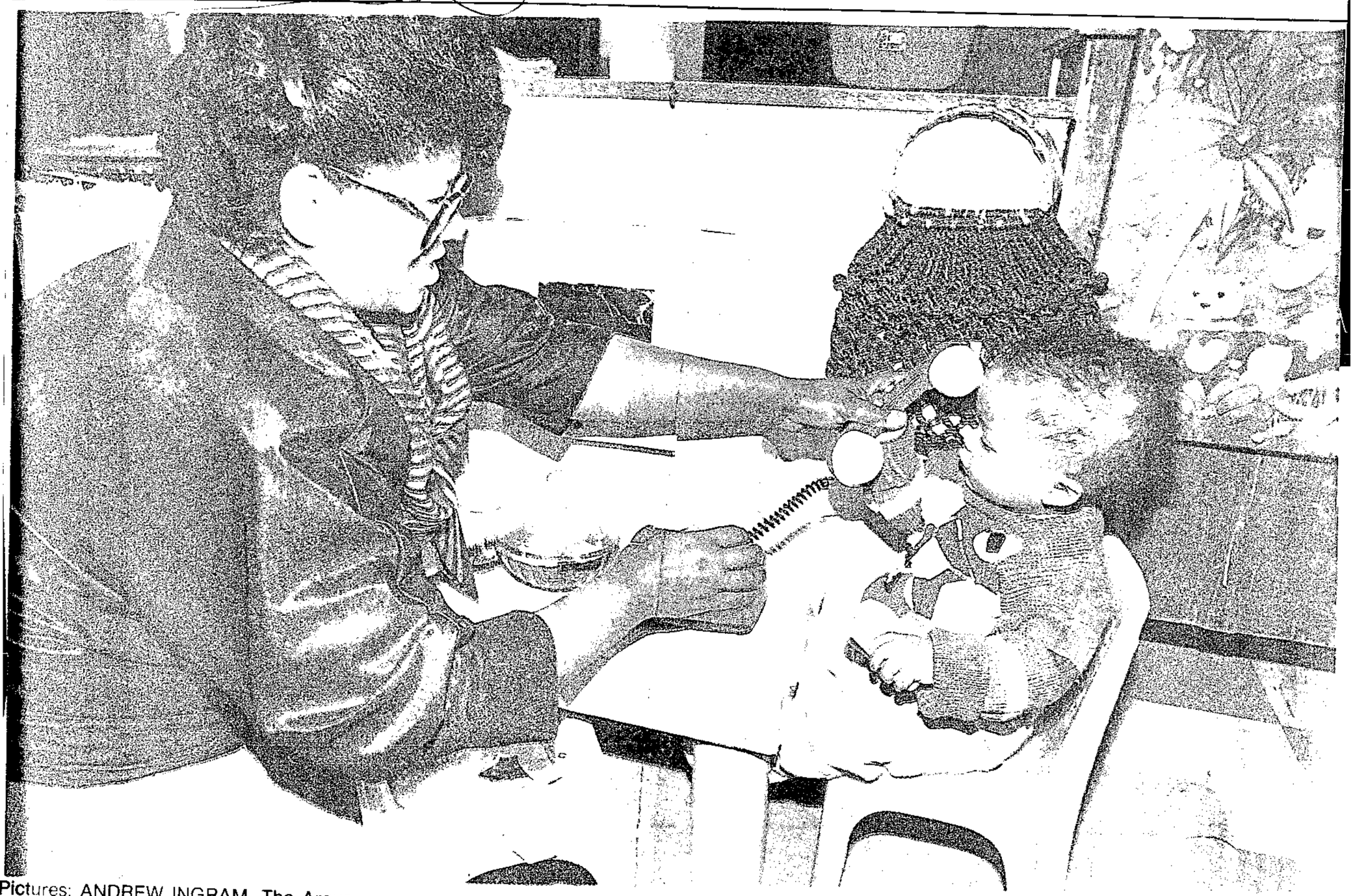
The farmers participating in the Foundation's health care project pay R50 a month, bear responsibility for the medication and administration costs and pay the health care worker's salary — but find that they are able to cut previous costs for doctors and transport to doctors in this way.

The Argus team spoke to irrigation supervisor Gabriel Katiso, who decided to become a health care worker because he cared about people.

"It is very expensive to go to the doctor for small things. Now I can treat them for those things," he said.

Mr Katiso is one of two health workers on the farms where he is employed. He works only with the men, who "prefer to tell another man about their problems", while a female worker looks after the women and children's health needs.

Paulina van Wyk speaks Afrikaans and Xhosa and was chosen as health worker by her farm community.



Pictures: ANDREW INGRAM, The Argus.

BABY CARE: Health care worker Anna Willemse, trained by the Rural Foundation, plays with one of the employees' babies in day-care on Twaalffontein Farm near Grabouw.

TREATING A WOUND: Health care worker Anna Willemse treats a wound on truck driver and community leader Petrus Mars' arm in the clinic established on Twaalffontein Farm near Grabouw. Trainee health care worker Ellen Jacobs looks on.

COMMUNITY CONSCIOUS: A group of farm employees, on their way to become primary health care workers, discuss an aspect of their course during a Rural Foundation training session.

Rural Foundation's health care course saves childrens' lives, cuts farm medical costs by half

Staff Reporter

PAULINA van Wyk works in a kitchen on a Grabouw farm; Gabriel Katiso is a farm irrigation supervisor in the same area.

Apart from being farm employees, both are close to the end of an 18-month basic health care course offered by the Rural Foundation.

Said the non-profit organisation's Western Cape regional health co-ordinator Jenny Bader: "Our main aims are to make people more aware of their own needs and help them gain independence."

Other goals are making basic health care accessible, acceptable and affordable and addressing and evaluating primary health.

In the Western Cape only about five percent of the trainee health care workers are illiterate, but in some areas of the country, mainly in the north and KwaZulu-Natal, about 80 percent cannot read or write.

For this reason the 18-month programme is extended to three years in those areas and teaching there is based on drawings, memory and reinforcement of information.

And traditional healers in some parts of the country also have a role to play.

"We've got some sangomas who are health care workers as well."

Ms Bader said farmers who belonged to the Rural Foundation were "forward-thinking" and welcomed the programme.

According to the Occupational Health and Safety Act there now had to be one health worker for every 50 employees on farms.

The programme, initiated in 1987, has had much success so far and basic knowledge, such as how to treat babies and young children suffering from gastro, has led to a decrease in the child mortality rate.

"The joy of the programme is that intervention is so simple. Farmers say to us in general they've dropped medical costs by half."

Free medical care coming

ET 5/5/94 (85)

FREE medical care for children younger than six and pregnant women would be implemented from next Wednesday if this was possible, Health Minister Dr Nkosazana Zuma said yesterday.

The latest date on which the scheme would be implemented was July 1, she said in Parliament during the debate on President Nelson Mandela's State of the Nation address.

She also said she would announce a five-year health care plan during the debate on her budget vote.

Dr Zuma said unfortunately there were large areas of the country where the free medical scheme would have little effect as there were no facilities.

"This can be attributed to disparities in the allocation of funds. During the 1993/94 financial year the average per capita allocation to the provincial administrations was R255. In the self-governing territories this was only R94.

"It is obvious the rural areas are underserved. To ensure our

Pregnant women, toddlers to benefit

services are accessible we will have to launch a major programme to increase the number of clinics.

"Eventually, clinics used after hours for community activities, for example literacy classes, is thought to be the answer," she said.

The major problem facing the ministry was the rationalisation of the fragmented system. It was crucial the provincial health departments be established as soon as possible, she said.

Dr Zuma is expected to announce soon regulations stipulating stronger health warnings on cigarette advertisements.

Under the new regulations, the tobacco industry would have to include explicit information in its advertisements on the hazardous effects of smoking. Various hard-hitting slogans to be displayed on the advertisements are being drawn up to replace the vague references to the effects of smoking.

National Council Against Smoking executive director Dr Yussuf Saloojee said Dr Zuma had made an encouraging start by announcing plans to increase tobacco taxes and to ban smoking in public places.

However, the tobacco industry spent R205 million on promoting smoking in South Africa, compared to the state's current budget of R25m for health education on all issues.

The UN's World Health Organisation (WHO) said in the run-up to World No-Tobacco Day on Monday the tobacco industry was increasingly targeting developing countries in its marketing campaigns to make up for the decline in smoking in First World countries. — Political Staff, Own Correspondent

Syringe trade takes aim at import duties

THE Department of Health and the Board on Tariffs and Trade have been asked to lower "punitive" import duties on syringes and so reduce health-care costs.

Import duties were increased from 25% to 30% in December 1992. The formula duty was was also raised, effectively increasing imposts to as much as 170%, says Don McArthur, managing director of JSE-listed Macmed Health Care.

Macmed is one of South Africa's largest syringe importers..

Higher duties were imposed after an application by Promex, then the only SA manufacturer of syringes. It complained that syringes were being dumped. The higher duties were imposed after an 18-month investigation.

A group consisting of Macmed, RM Salters, Vitamed and General Medical opposed the increase.

Promex has a major share of the R30-million syringe market and is by far the largest supplier to state hospitals. Syringe imports have grown since sanctions were lifted in October 1992.

Syringes worth R9-million were imported last year, all paying higher duties and adding to health-care costs, says Mr McArthur.

By DON ROBERTSON

"We could sell an imported 2ml syringe for 15c compared with the Promex price of 26c, or a 5ml syringe for 24c compared with 33c," says Mr McArthur.

"High duties make the cost of importing safety syringes prohibitive. They are vital in combating blood-related diseases, such as AIDS and hepatitis. Other necessary products, such as the Solo Shot syringe recommended by the World Health Organisation, are also severely affected by the duty structure.

"These products self-destruct, prohibiting their re-use by drug addicts and unscrupulous general practitioners," says Mr McArthur.

The two-piece syringe is inexpensive to make and ideal for Third World countries, but also falls under the new duty structure and the cost of importing it is excessive. It is not made in SA. Imports at a lower price would reduce health-care costs, says Mr McArthur.

Mr McArthur accuses Promex of selling a 2ml syringe for 15c in Zimbabwe compared with 26c in SA.

Macmed's principal, Becton Dickinson, the world's largest manufacturer of syringes, would build a manufacturing plant in SA if it could first establish a presence in the market through imports.

Promex marketing director Rob Millar says the higher import and formula duties were imposed solely to prevent dumping, mainly from eastern European countries. They are based on the landed fob price.

"If the fob price is low, suggesting dumping, the formula duty is high. If the fob price is based on normal Western prices, the duty is low."

Mr Millar says duties will have to fall as SA complies with the General Agreement on Tariffs and Trade. Promex is gearing itself for this.

He expects the first cut in duties to come into effect in January. Duties should be reduced gradually over five years, allowing increased imports.

It is hoped that even with Gatt requirements in place, provision will be made for dumping duties.

Defending the price of syringes sold in Zimbabwe, Mr Millar says Promex is merely trying to establish an export market by accepting small margins and using incentives.

He says that if Macmed is able to sell an imported 2ml syringe for 15c, it is admitting to dumping because this product sells for two to three times this amount in Britain and the US.

MAKING A POINT . . . Macmed's Don McArthur, who says health services need cheaper syringes

Picture: AMBROSE PETERS

TPA counts cost of free medical care

Star 3/15/94

■ BY DUNCAN GUY

The Government's plan to supply free medical care to children under six and pregnant women is expected to cost the TPA R32 million a year.

Spokesman Lenette Roeleveld said yesterday the under-six-year-olds at TPA hospitals would cost around R18 million a year and the pregnant women R14 million.

Health Minister Dr Nkosazana Zuma told Parliament she planned to meet provincial health Ministers to ensure the scheme could be operative by tomorrow.

If not, it would definitely be in place by July 1.

She said the scheme would have little impact in many areas as facilities were unavailable.

85

Professor calls for health district system 'as priority'

ARGT 26/5/94 (85)

□ Primary care must stop children dying of ordinary conditions'

LIBBY PEACOCK
Staff Reporter

THE establishment of health districts with trained maternal and child officers, and the involvement of universities in community health, must enjoy high priorities in the new South African health system.

This is the opinion of Red Cross Children's Hospital head of Ambulatory Paediatrics David Power.

Most of the problems that South African children were suffering and dying from were "very familiar ordinary conditions", which did not need high-powered research, Professor Power said in an interview. Existing knowledge could be used and it was now "a matter of organisation and management".

Praising the African National Congress's recently unveiled health plan, Professor Power said: "We don't need to get more specialised or build more large hospitals; we need more basic health services."

The accepted world norm for hospital beds was 3,5 beds for 1 000 people. In this country there were about 4,4 beds for 1 000 people.

Also, the world norm for clinics was one for 10 000 people. In South Africa, the national average was 0,61 clinics for 10 000 people.

So, what was needed was not necessarily more hospital beds, but more clinics — about 1 300 of them.

"If we've got money to spend, there's where it must go."

Professor Power urged the establishment of a district-based health service.

Each district (of which there would be about 100 to 120 in the country) would have a single health authority — as opposed to the situation now, where there were, for example, three health authorities in Khayelitsha: the Regional Services Council, the Cape Provincial Administation and Groote Schuur Hospital's maternity services.

In the district health system, the flagship of each district would be one or more community health centres and there should be a proper range of services in each district.

In the Western Cape the "bones" of such a structure already existed, but in some places in the country it was non-existent.

An integral part of the health districts would be trained maternal and child health officers.

Professor Power said universities also had a big part to play in the future health system.

Undergraduates had to be given the basic tools for understanding the primary health care approach and students had to work in a whole range of health set-ups.

South Africa has very good hospitals, specialists and super-specialists and these were still necessary, but "the other side" — primary health care — had to be pushed now.

● South Africa's infant mortality rate is about 12 deaths in 1 000 live births a year in the white sector, while it is about 50 in 1 000 in the black sector.

Figures show that in a district population of 250 000 people, there would be an average of 450 children with mental disability, 226 with cerebral palsy, 390 with epilepsy and 3 900 with asthma.

● Professor Power was the head of the Department of Paediatrics at Cecilia Makiwane Hospital in the Ciskei from 1980 to 1992 and was a consultant on maternal and child health to the Northern Johannesburg Joint Negotiating Forum based at Alexandra Health Centre from 1992 to 1993.

He has written several studies, and chapters in books, on child health.

Pictures: ANDREW INGRAM, The Argus.

BETTER FUTURE: Professor Power believes that a proper primary health care system would be to the benefit of all — including these children and their parents queuing at the out-patients section at Red Cross Children's Hospital.

Free health care introduced

School food scheme likely to cost R600m

B1 Day 21/6/94

85

TIM COHEN

GOVERNMENT's planned scheme to feed schoolchildren is likely to cost about R600m this year.

The programme was proposed by President Nelson Mandela in his opening address to Parliament last month. Estimates are being discussed by the Health Department.

Sources said yesterday the scheme would provide for 30% of schoolchildren — about 7,8-million in total — each of whom would be subsidised at the rate of about R1 a school day. This would be sufficient to supply each child with a slice of bread and peanut butter and a cup of soup every day.

Specific schools would be targeted and all children in those schools would receive assistance.

The amount spent on the scheme would be considerably higher than the R40m currently spent on school feeding schemes and the R400m spent on the national nutrition scheme.

The school feeding scheme was one of four projects announced by Mandela. The others were a public works project, free health care for needy children and pregnant women and an electrification scheme — all of which he said would be operational within 100 days of his announcement.

Sapa reports Health Department director-general Coen Slabber said a R50m health plan giving children under the age of six and pregnant women free medical care came into effect yesterday. The plan applies only at state hospitals and for people not covered by medical aid schemes.

A spokesman for government's reconstruction and development effort declined to confirm what the four projects would cost, saying only that a process of ascertaining the costs was under way.

The results of these investigations, undertaken in conjunction with government departments, would be announced within weeks. However, sources close to the Health Department confirmed that R600m was likely to be spent on the school feeding scheme in the 1994/95 financial year.

Mandela's proposal has sparked a debate about whether the scheme would sufficiently address nutritional problems, with experts saying that nutritional assistance was most effective between the ages of six months to two years.

They claim the scheme would have little nutritional effect and that it would also be difficult, politically, to halt the project.

But, they said, it was comparatively easy to implement and would boost the extent to which children would be responsive to education.

Health Department officials are nevertheless concerned that the school feeding scheme should not be a substitute for the nutritional scheme.

Health care can pay dividends

BIDay 2/6/94

DEREK YACH

PRESIDENT Nelson Mandela's statement that "health is fundamental to building a humane society" echoes recent World Bank reports encouraging investment in health to achieve sustainable development. This represents a profound shift from seeing health spending as consumption.

The focus on the health of children and electrification will have important long-term implications for populations. Proper nutrition in infancy means fewer premature deaths and improved intellectual development. School feeding programmes will improve scholastic performance and boost the morale of teachers, parents and pupils. (85)

Accelerated electrification will reduce deaths from pneumonia, paraffin poisoning and burns.

The priority for the first 100 days, which will support the major thrust of the ANC's health plan, is a properly planned shift in resources to deprived communities.

Effective intervention by targeting the poor appropriately needs urgent consideration. The opportunity exists to significantly reduce several mineral, vitamin and protein deficiencies in children through feeding programmes.

The agricultural sector and food industry must develop products that meet internationally accepted nutritional standards.

Targeting those most in need will be problematic because there is still no National Nutrition Surveillance Programme — despite pleas for its establishment during the last drought. If programmes are not targeted, scarce funds for the poor are wasted through subsidisation of those who can afford food. A rapid assessment of the nutritional and economic status of communities is needed. This should aim to identify whole provinces that need programmes and significant parts of provinces and definable peri-urban communities at risk. Targeting at individual clinics or schools will not be cost effective.

In addition to nutritional interventions, the announcement of free health care for children in their first six years, taken with the provisions of the Bill of Rights, creates the opportunity to implement programmes nationally that have shown their impact globally. These would include a strengthened immunisation programme; an acute respiratory infection focus and diarrhoeal disease control programme. While it is unlikely that these can be implemented in 100 days, they are short term interventions that will show results and allow time for water, sanitation and housing projects to be introduced.

With adequate planning, the focus on child health could in the short term re-establish community confidence in the ability of the public service to deliver perceptible improvements to the lives of the poor.

☐ **Yach is Medical Research Council group executive: community health research.**

Nats ended a pioneering concept

Ideology killed a healthy scheme

Star 2/6/94

■ OWN CORRESPONDENT

Durban — Several decades ago, South Africa had the opportunity to lead the world in developing primary health care, the cornerstone of the new government's health policy.

But the National Party government derailed plans to implement a community-based health system 35 years ago because they were being conducted along multiracial lines.

South Africa lost valuable expertise which benefited several countries throughout the world.

At the forefront of the primary health care initiative launched in South Africa in the '40s was Sydney Kark, then a young doctor in Durban.

APARTHEID in its early days killed off a primary health care plan which would have benefited millions of South Africans

Instrumental

He left South Africa in 1959, after the Nationalists refused to fund an institute which had begun to train doctors in community medicine, and became instrumental in developing primary health care systems throughout the world.

Dr Kark and his wife, Emily, now live in Israel. Speaking from his Jerusalem home, he described how the early days of apartheid led to his departure from South Africa.

He had helped establish the Polela Health Centre in rural Natal in 1940 and the Institute of Family and Community Health in Durban in 1945.

"Community health care combined curative and preventive practice with health promotion, emphasising the involvement of the community to promote its own health through social activities," said Dr Kark.

"Between 1940 and 1948 our progress was smooth and development went ahead well.

"The government's National Health Commission visited Polela and they were very excited by what they saw.

"They said Polela could become a model for the future health service."

In 1948 the National Party came to power.

"That was the beginnings of our troubles," said Dr Kark.

"There was serious political disagreement with our policies. People of all races were involved."

By 1959, more than 40 health centres were already in place and about 360 more were planned.

Officials of the University of Natal's medical school had secured funding from the Rockefeller Institute in the United States for the Department of Preventive and Social Medicine to train doctors for the centres.

The five-year funding programme came to an end in 1959.

The Government refused to provide finance and primary health care collapsed.

A group of four doctors he had trained had already left to start primary health care clinics in Uganda, transplanting South African expertise into Africa.

"We also decided to leave South Africa." (85)

Dr Kark took up a post at an American university.

The following year, the World Health Organisation invited Dr Kark and his wife to establish a primary health care project in Israel.

"Our international health division at the University of Jerusalem eventually trained 400 people from Africa, Asia, Latin America and some developed countries."

Grown

Members of staff visited several countries to run workshops on developing community health centres.

Workshops in Spain led to the formation of a system of family and community doctors, which has grown into a major southern European health scheme.

The most recent development to emerge from Dr Kark's work was a programme to train British doctors in community-oriented medicine with a grant from the Kings Foundation.

Dr Kark was pleased that South Africa has now decided to return to primary health care.

Biko influence lives on

By Mokgadi Pela

THE life and death of Steve Biko played an important role in the changes that are taking place in South Africa, a medical expert says in the latest issue of the *South African Medical Journal*.

Sir Raymond Hoffenberg, who has chaired world-acclaimed bodies like the International Physicians for the Prevention of Nuclear War and the Medical Foundation for the Care of Victims of Torture, told a Biko Memorial Lecture at the University of Cape Town that it was tragic that "Biko was not here to play his part".

Biko died in police custody on September 12 1977. This was after the June 1976 uprisings initiated by organisations of the Black Consciousness Movement.

Hoffenberg, who was banned in 1968 and left for Britain to practice medicine, urges doctors to follow Biko's footsteps in seeing poverty and lack of education as medical issues.

"Biko saw this quite clearly when he gave up his medical studies. As Lindy Wilson says: 'The choice he made was one that thousands of black students would come to face: the choice of either becoming a political activist or taking the time to gain some sort of qualification towards a professional life.'"

On the dilemma facing doctors employed by the State, Hoffenberg says it is hard to ignore their role in a memorial lecture to Biko.

A number of recent publications have examined the involvement of doctors in torture — from Amnesty International, the British Medical Association and the Institute for Medical Ethics.

The spectrum of medical involvement ranges from certifying a subject fit for torture to reviving a person who has been maltreated.

Hoffenberg says the proper response is to condemn all such abuses of detainees.

He asks where the professional or personal consciences of Dr Ivor Lang and Dr Benjamin Tucker were when they collaborated with the police during Biko's detention.

Lang and Tucker treated Biko while he was in police custody in Port Elizabeth for 26 days prior to his horrible death.

"One can't help wondering how many deaths, how much suffering might have been avoided had Lang or Tucker spoken out when they encountered such brutality," Hoffenberg says.

He pays tribute to Dr Wendy Orr for blowing the whistle when she discovered the police torture of detainees.

While praising the brave stance taken by late pathologist Dr Jonathan Gluckman for speaking out against police torture of prisoners, he feels Gluckman could have done so much earlier to prevent further abuses.

Hoffenberg also blasts the Medical Association of South Africa and the South African Medical and Dental Council for failing to speak out against such abuses.

"Nothing could have done more damage to the cause of South African medicine in the eyes of the world than the deplorable lack of principle shown by these bodies.

"It is worth noting that years after Masa and the SAMDC failed to support Orr, the SAMDC wasted no time in taking disciplinary action against Dr Nchaupe Mokoape when he came out of prison after serving a sentence for political activities," Hoffenberg adds.

Hoffenberg says while he never knew Biko personally, the manner of his death shocked the world and his name has become a symbol of oppression.

"It brought into lurid relief the brutality and inhumanity of the security police and the system they represented," Hoffenberg adds.

Steve Biko ... doctors condemned for what they did during his detention.

Hospitals not yet told of free health care

Star

■ BY DUNCAN GUY

It was "payment as usual" for pregnant women and children under six at hospitals yesterday, in spite of hopes that the new policy allowing those communities free medical treatment at State hospitals would have been implemented. 21/6/94

In the thick of urban South Africa, cashiers at Hillbrow Hospital said they had not yet received any circulars informing them of new policies. (85)

And in the deeply rural former homeland of KaNgwane, Embuleni Hospital superintendent Dr Roan Chundu said the information had not yet been received.

"It will take a bit of time at this end of the world," he said.

Back in Johannesburg, a spokesman for J G Strijdom and Coronation hospitals said there had not even been demand from the public for free health care.

"The news will probably have to spread to the public first."

Up to now, State patients unable to afford medical bills have received treatment anyway, said Hillbrow Hospital medical superintendent Dr Emma Bondarenko. "We never turn patients away. Sometimes we send people several accounts and eventually scrap them."

Meanwhile, Health Minister Dr Nkosazana Zuma, who has said she hopes to have the new system in place by the beginning of next month if it was not possible by yesterday, is about to set off on a two-week tour to investigate health needs throughout the country.

Development role for ANC

WHEN ANC provincial leader Jacob Zuma took the oath of office as Minister of Economic Affairs and Tourism this week, it meant more than simply resolving the provincial cabinet crisis.

It also gave his party the key role in overseeing the reconstruction and development programme in the region, and it was the third portfolio offered to Mr Zuma. Previously, he had been offered the welfare portfolio and then public works.

The ANC now has three provincial cabinet portfolios: economic affairs and tourism, health, and roads and traffic control.

The Inkatha-ANC deal also involves IFP backing for a provincial request that central government approve deputy cabinet ministers in portfolios where necessary.

At present the constitution does not make provision for provincial deputy ministers, nor does it specifically outlaw them. Central government has undertaken to consider the request and a further meeting on the issue is likely in about 10 days.

The deal between the ANC and Inkatha focuses on the police portfolio in particular. According to sources close to the talks, the IFP agreed that if Pretoria approved deputy ministers, the ANC would take the deputy police post.

It is likely that the ANC will also put up a strong case for the deputy education position.

Rush to get free health-care plan under way

S1 Times 5/6/94

By CAS St LEGER

THE NEW government's health plan is being introduced at break-neck speed.

And, only days after free health care for pregnant women and children under six was launched at a cost of R77-million to taxpayers, the government is also considering free medical treatment for pensioners.

The scheme is restricted to patients without medical aid. (85)

The introduction this week of free medical care for children and pregnant women caught many hospital administrations by surprise.

"Administrations were asked to implement the project by June 1," said the Department of Health's deputy director-general, Dr Hans Steyn.

But, said Dr Steyn, such short notice meant that not all hospital superintendents were fully aware of the project, and some hospitals continued to charge patients who would otherwise have qualified for free treatment.

Dr Steyn said the total loss of income to the old provinces would be about R77-million — about one percent of their budgets.

He said private hospitals have indicated they would like to join the free health-care scheme on a contractual basis.

No decision taken on Thor Chemicals

THE Minister of Environment Affairs has not yet decided on what course of action to take regarding evidence of alleged malpractice by British multinational Thor Chemicals.

Minister Dawie de Villiers confirmed he was studying ANC proposals for a commission of inquiry, but added the issue was "very complex" and had to be thoroughly studied before any decisions could be taken. He also pointed out other ministries and departments were involved in the laws which had allegedly been transgressed.

TOUGH NEW RULES ON TOBACCO ADVERTISING

S1 Times 5/6/94

THE first salvo in the anti-cigarette war was launched this week with the gazetting of stringent regulations governing the labelling and advertising of tobacco products.

The new rules, under the Tobacco Products Control Act, would require tobacco companies to include explicit health warnings on cigarette packets and in radio and print advertisements.

The proposals have been called draconian by the Tobacco Institute of Southern Africa.

By CAS St LEGER

There are 11 new warnings. They include messages like:

- Danger: smoking can kill you;
- Danger: smoking causes cancer;
- Pregnant? Breast-feeding? Your smoking can harm your baby.

A longer second warning must also be included. This would explain how smoking increases health risks, emphasise the benefits of quitting and give a phone number where smokers can get more information.

Similar warnings must be included in cinema advertisements. (145)

The Tobacco Action Group said it considered the new initiative to be a crucial part of informed comment reflecting a serious government commitment to reducing tobacco use in South Africa.

Mr Joppie Graham, chairman of the Tobacco Institute, said: "First impressions of the envisaged regulations concerning warnings on advertisements are that they are draconian and restrictive in nature."

If the regulations were adopted it would be impossible for the tobacco industry to continue promoting trademarks by way of advertising.

"In the light of various representations for an advertising ban by anti-smoking groups, it appears that the strategy is to compel the tobacco industry to cease advertising."

This held serious implications for consumers' rights to take informed decisions and would threaten thousands of jobs in advertising and media.

R27,8 m ambulance budget turned down

SHARON SOROUR
Municipal Reporter

CAPE Town City Council has rejected a R27,8 million ambulance budget and is to seek an urgent meeting with the regional health minister to thrash out problems concerning the allocation of health care funds.

Councillors at a health and amenities meeting yesterday said the budget for the 1994/95 financial year was not feasible to maintain standards.

Assistant city administrator Alan Dolby said council had proposed a R30,5 million budget, but this was turned down by the directorate of emergency medical services.

Mr Dolby said even the proposed R30,5 million budget was not enough to operate the ambulance service effectively.

Committee vice-chairman John Sonnenberg said the council worked hard last year to implement a 37-point plan to improve the ambulance service.

This had been put in place and could not be repeated.

Dr Sonnenberg rejected the allocated budget as "totally unacceptable".

"The amount allocated for fuel consumption does not allow for fuel increases ... who is supposed to pick up the bill for this? The ratepayers?

"We need an urgent interview with the regional health minister. They must go back to the drawing board," he said.

Committee member Leon Markowitz said the committee should approach a meeting with regional government "with a positive frame of mind" in an attempt to secure more money.

"If we come back with a flea in our ear, we can then adopt a different approach," he said.

Dr Sonnenberg said the regional government would have to change the way it worked out budgets, as the Transitional Metropolitan Council, which would inherit the ambulance budget, was a "completely different ball game".

He said the council also expected the new regional government to underwrite unexpected overruns in the budget as the provincial administration had done.

"Access to health care is a basic right ... if they want us to render the service, which we are perfectly willing and able to do, we must have this assurance," he said.

He said R30,5 million would not provide Cape Town with a better ambulance service.

In a report, emergency medical services director J M Kotzé said the "critical financial situation" had forced the hospital and health services branch to allocate "only R113 million" to the directorate for the ambulance services in the Cape.

"The requirements of the service exceed the funds available and this office has had to implement conservative norms to aid budget allocations," Dr Kotzé said.

Health care in container loads for townships

Souky 817 - 12/7/94

A UNIQUE township health care project was recently launched by the South African Association for Relief of Medical Ailments (Saafroma) in Khayelitsha, with the opening of five primary health centres.

The organisation hopes to establish another six centres in the townships by July and a total of 50 by the end of the year.

The medical centres are a first for South Africa. Saafroma trains people to run the centres in basic first aid, community health, emergency childbirth, product knowledge and business skills.

The centres are linked to the formal health care sector and provide a meeting point for mobile clinics on certain days to advise the community on nutrition, sexually transmitted disease and also to weigh babies and provide inoculations.

The centres are double-storey structures made from refurbished Safmarine containers.

Upstairs is used to provide accommodation — complete with hot and cold running water, a shower and furniture — for the person running the centre.

Downstairs has a first-aid station with hot and cold running water, an examination table and a shop which sells medicines, toiletries and food.

Saafroma installs electricty and telephones to the centres wherever possible. (85)

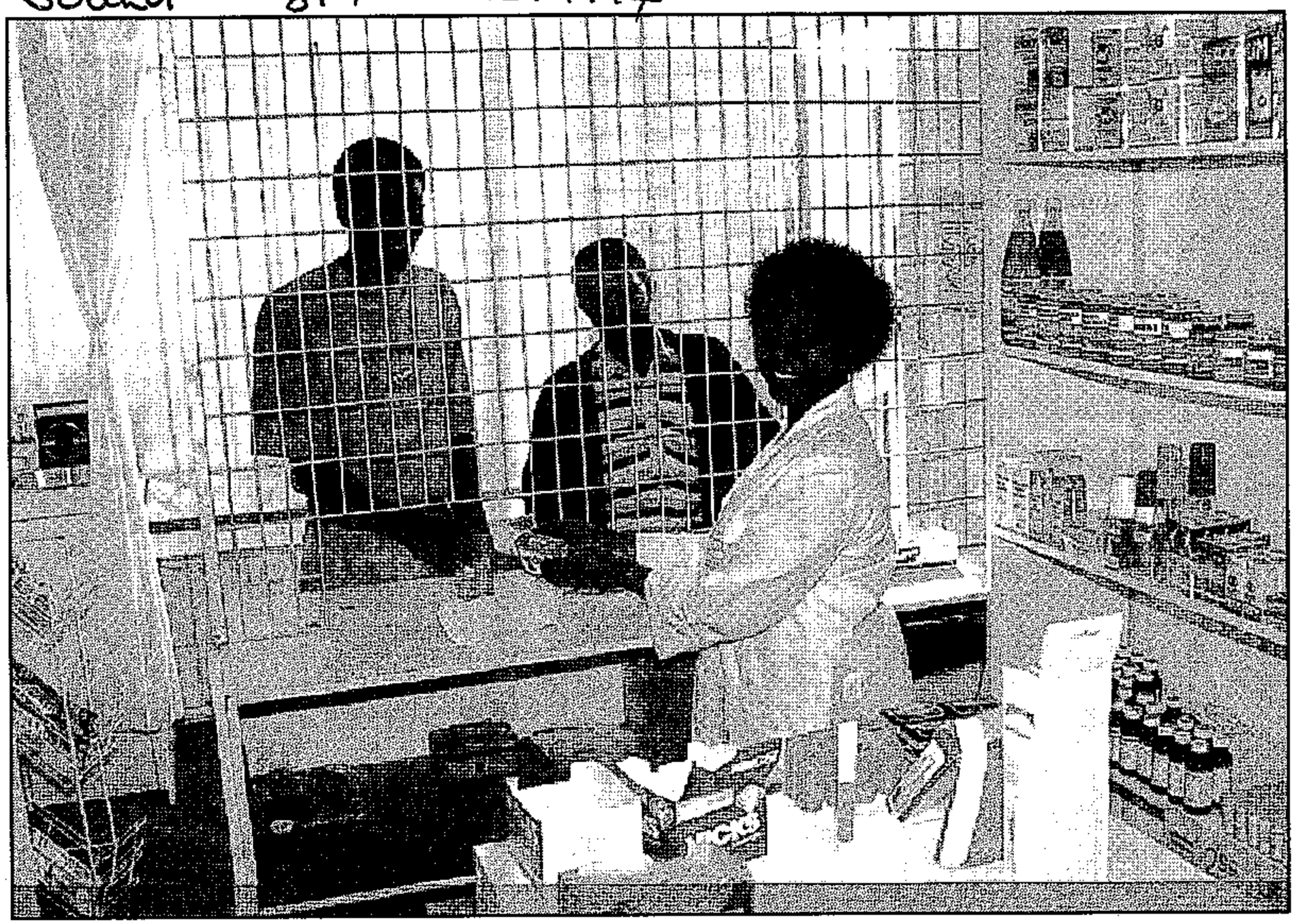
The centres address three vital economic reconstruction issues. It provide people with skills and work, as medical practitioners. And it provides accommodation for the practitioners and their families.

With accommodation at the centres, staff are available 24 hours a day to give emergency after-hours treatment.

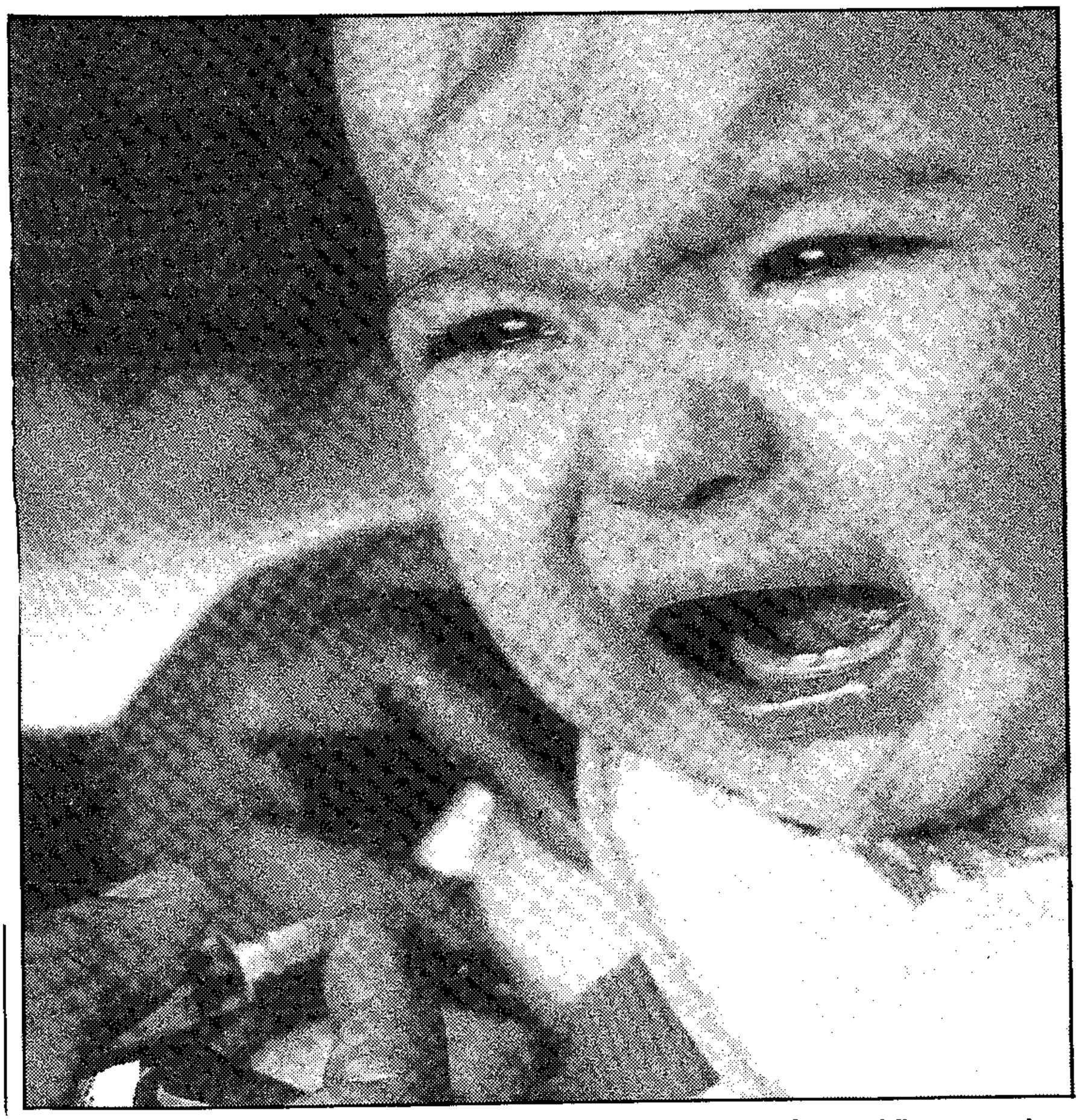
Saafroma has the support and active involvement of medical doctors, nursing sisters, community nurses, pharmacists, accountants and lawyers, providing the centres with a competent and reliable infrastructure.

To speed up the provision of the centres, Saafroma is asking other organisations and interested parties to either provide funds or advertising on the centres. For details contact Mr Derek Marks at 448-6280.

BY SHANNON NEILL



HEALTH FOR ALL: The container shops and clinics are convenient and cheap



Tears after the jab . . . nine-month-old Chane Human was the first toddler to receive Jo'burg City Council's piggy-back Hib vaccination yesterday. PICTURE: RUVAN BOSHOFF

City offers 'piggy-back' vaccination

Star 9/6/94

■ BY SHIRLEY WOODGATE

Johannesburg City Council scored an innovative first with the launch of a "piggy-back" immunisation scheme yesterday, whereby certain costly vaccinations for underprivileged children will be cross-subsidised by medical aid patients attending any of the 50 municipal clinics.

This means that each medical aid-funded child that is immunised by the council against Haemophilus influenza type b (Hib) enables a poor child to be immunised as well. Hib disease, which affects one in 250 children under age five, causing meningitis, pneumonia, septicaemia and acute arthritis, is highly contagious and can be spread in the same way as the common cold.

The chairman of the city's health and housing committee, Marietta Marx, said although the State had introduced free medical care for children under six, the private sector had become involved in the Hib scheme as the vaccine was too expensive to be included in the national health offer.

Professor Alan Rothberg of the Representative Association of Medical Schemes said his organisaton had negotiated with several medical schemes and the council to make the offer viable.

International company picks up blood contract

ARG 10/6/94

Staff Reporter

A LARGE international medical diagnostic products company, International Murex Technologies Corporation, has announced its signing of a product contract with the South African Blood Transfusion Service for about 1,5 million virology tests a year.

Murex researches, manufactures and markets products for the detection, monitoring and screening of infectious diseases. It is involved with more than 600 products world-wide.

The company said in a press release that the South African Blood Transfusion Service was one of the largest services of its kind in the world and processed about 550 000 blood donations a year.

All the donations were screened for HIV, hepatitis B and hepatitis C infections.

President and chief executive officer of Murex, David Tholen, said: "This is a very important contract for Murex. It significantly expands our business in South Africa where infectious diseases have spread rapidly and where high-quality blood screening tests are essential.

"Initial product shipments have commenced to the South African Blood Transfusion Service to meet its immediate needs."

Professor A Du P Heyns, medical director of the blood transfusion service, said: "It is vital for us to provide high-quality safe blood for medical use.

"In this respect we are pleased to work with Murex to ensure effective viral screening of all blood released."

Women encouraged to lead the way to a healthier lifestyle

ARG 10/6/94 (85)

☐ 'Most illnesses are avoidable or preventable'

LIBBY PEACOCK
Staff Reporter

WOMEN should play an active role in educating their communities about primary health care.

And even the simplest preventive measures are the grassroots building stones of a healthy society.

These were some of the messages conveyed at a seminar hosted by Women United in Health — an organisation formed last October by the Department of National Health and Population Development and the Women's Bureau of South Africa to create communication channels and disseminate health care messages at community level.

The difference between Women United in Health and many other health care organisations is that the target group consists of ordinary women and mothers and not specifically health care workers.

Addressing the seminar, Fransie Prinsloo, acting chief of the Department of Community Health in the Faculty of Medicine at the University of Stellenbosch, said: "Women have the natural ability to assist their fellow human beings and customarily do most of the caring for their families."

The cliché "prevention is better than cure" was still true and primary health care was the most affordable and best form of health care, Dr Prinsloo said.

"Most illnesses are avoidable or preventable if we take care of our lifestyle and stick to the basic health principles, for example proper nutrition and hygiene."

National Health and Development nursing services manager Tryfina Lethoba emphasised the element of team work in primary health care. It was a personal issue and the receiver of the health care was a member of the team.

Women United in Health aims to keep in contact with all members and monitor what is being achieved at grassroots level.

Its main objective is eventually to extend to all women's organisations in the country, with special emphasis placed on disadvantaged communities.

People wanting to attend one of the seminars and become members should contact Women United in Health at ☎ (011) 726-5161, or P O Box 4383, Johannesburg, 2 000.

New jobs for 'needy'

(476) (85) CT 11/6/94

MOST of the new appointments at the Medical Research Council will be drawn from "disadvantaged people", including black, coloured and disabled people and women as the MRC board applies its new policy of affirmative action.

A report in the newsletter MRC News said no employees at the council will be retrenched or forced to leave in order to achieve this goal.

The MRC has accepted a policy document concerning a 10-year plan for affirmative action within the council and the development of potential at black universities.

The goal is to enable disadvantaged groups to participate in the activities of the MRC to the extent that they will truly represent their respective population distribution.

This will be achieved over the next five years by active recruiting, training and development.

Single health plan for province

DURBAN — National Health Minister Nkosazana Zuma said after a visit to KwaZulu/Natal yesterday that she hoped there would be a single health administration in the province within six months.

Zuma and MEC for health Zweli Mkhize met local health leaders, the Natal Provincial Administration and the National Health Department.

She said: "I estimate six months.... We should have one provincial authority," adding that regular meetings to discuss integration were being held between the various administrations.

During talks with local administrators, Zuma focused on how well the state's plan to offer free medical health to children under six and pregnant woman was being put into place.

Complaints from medical staff ranged from "unrest in the workplace" to a lack of "affirmative action in terms of gender", she said.

Other worrying features were a shortage of medical facilities in rural areas and the need for better nutrition for children.

Zuma said the province had received 19% of the national health budget, and with nine provinces rather than four, was not the most underfunded region in terms of health care.

She said the high incidence of HIV infection in the province was "worrying", and government departments were to blame for not promoting education about the disease.

Meanwhile, the Inkatha Freedom Party has threatened mass action if the state of emergency in KwaZulu/Natal was not lifted.

IFP MP Themba Khoza said there were also other provinces affected by violence, but it was the only one where emergency regulations were in effect. The IFP, however, had no problem with the deployment of the army in the province, he said.

The Black Sash yesterday also said the continued retention of the emergency in the region flew in the face of the democratic order of the newly elected government.

The Black Sash said it had called on President Nelson Mandela nearly four weeks ago to lift the emergency.

□ A tripartite alliance in the KwaZulu/Natal Midlands at the weekend called on ANC MPs and MECs to boycott any meetings of the provincial legislature at Ulundi.

Blade Nzimande, spokesman for the ANC/Cosatu/SACP alliance, yesterday said a weekend congress had voted for Maritzburg as the provincial capital.

The province's executive council holds its weekly meeting at Ulundi today. If the three ANC MECs attend it will be their first official visit to the former homeland capital. — Sapa.

Free medical care plan in operation

Star 15/6/94

MANY hospitals have already implemented Government's health programme for the poor, survey finds

Several State hospitals in the PWV are already giving free treatment to children under the age of six and pregnant women who cannot afford medical care.

This emerged from a survey yesterday.

Free treatment for these categories was announced by President Mandela when he opened Parliament on May 25.

Hospital superintendents said patients qualified only if they were not beneficiaries of a medical fund.

Most hospitals reported an increase in the number of patients but said they were coping.

Dr Renier Greyling, senior medical superintendent of the Far East Rand and Pholosong hospitals, said there was uncertainty about certain fees.

"For example, there is no clarity on who is accountable for ambulance fees if a pregnant woman has to be transported from one hospital to another. This could be as much as R200."

He added: "We fully implemented the programme soon after Mr Mandela's announcement. The same goes for our satellite hospitals at Delmas and Heidelberg."

A circular from the Department of Health notifying hospitals about free treatment had reached hospitals only about a week ago, the hospitals said.

Trudie Schutte, Johannesburg Hospital's spokesman, said: "We started only about a week ago. the number of patients, but nothing dramatic."

The same applied to H F Verwoerd Hospital in Pretoria, spokesman Neville Botes said.

At Paardekraal and Leratong hospitals on the West Rand the programme was fully operational on June 1. Superintendent Dr Pauline van Heerden said there had been a marked increase in the number of patients (85)

The Vereeniging and Sebokeng hospitals started free treatment "virtually a day after Mr Mandela's announcement", said chief superintendent Dr Norman Kerns. The increase in patient numbers had been significant, especially at Sebokeng Hospital.

Willem Cruywagen Hospital in Germiston and Hendrik Vanderbijl Hospital in Vanderbijlpark started the programme early this month. — Sapa.

Rasool holds healthy record for the job

South 1716 - 21161194

By Shannon Neill

SOME might think that at 31 Regional Minister of Health and Social Services, Mr Ebrahim Rasool, is too young to take on the massive task of trying to sort out the mess in the social services left by the apartheid regime.

However, the demanding positions he filled in various organisations have proven his ability to get things done even under the most difficult conditions.

Rasool is taking his new job seriously. He has already been out to observe the difficulties people face in pension queues and is considering a number of possible changes to the system to alleviate problems.

He described how he became involved in the struggle for democracy which eventually led to his ministry.

"I was born in District Six in 1963 and attended Livingstone High School where most of the teachers belonged to the Unity Movement.

"You could say my initial political education was through the Unity Movement," he said.

After matric he went to the University of Cape Town (UCT) where he obtained a BA degree and was an active member the Azanian Student's Organisation (Azaso) and the Muslim Student's Association.

In 1983 when the United Democratic Front was launched he was elected to the regional executive and served on the committee until 1988. He was regional secretary from 1985 to 1987 and then treasurer until 1988.

Rasool was involved in the launching of the Call if Islam in 1984.

"I was detained in October 1985 for the first time and released in January 1986. When I was released I was restricted," he said.

In 1987 he was arrested again and detained for 13 months. After his release he remained a "banned" person until the unbanning of the ANC and SACP in 1990.

Rasool got married during his banning in December 1988.

"It was weird. We had to ask for permission to have more than 10 people present and get permission to have it out of the magisterial district I was restricted to," he said, laughing at the absurdities that ruled people's lives under the state of emergency.

Elected ANC regional treasurer in 1991, Rasool held the position until his appointment as minister.

Speaking about his ministry, he said: "I've not wanted to come in and take control immediately, I've wanted to understand what's going on and get to know the people I'm working with."

He wants his policies to relate to the Reconstruction and Development Programme which he would use to develop a "people centred approach" to health and welfare.

HEALTH *Region accounts for 25 percent of South Africa's total population*

Health services under-funded

By Praveen Naidoo

SHORTFALL *KwaZulu-Natal will receive only 19 percent of health budget:*

PRELIMINARY details of the national Budget indicate that health services in KwaZulu-Natal may continue to be under-funded.

Speaking at a Press conference in Durban yesterday, Minister of Health Dr Nkosazana Zuma disclosed that about R2 424 million would be spent on health services in the region during the next financial year.

The Natal Provincial Administration would provide R1 600 million, the KwaZulu administration would allocate R700 million and R120 million would come from the Department of National Health and Population Development.

Asked if the money would be adequate for the region, Zuma replied: "I don't think so. Discussions indicate there may be a shortfall."

The allocation means that KwaZulu-Natal, which accounts for 25 percent of South Africa's population, will receive only 19 percent of national health funds. Zuma said that KwaZulu-Natal's health budget was still ahead of "some other regions" when compared with the population of the regions. In an interview soon after her appointment as minister last month, Zuma said a new formula would have to be applied to supply adequate health funds for all the provinces. This would ensure KwaZulu-Natal would no longer be under-funded. It was not known how much influence Zuma had on allocations in this year's Budget. Many details had been finalised before she took office.

A health administration source said funding for KwaZulu-Natal was equivalent to last year's Budget which was widely accepted as too little for the region's population.

A gradual increase in the budget for KwaZulu-Natal was envisaged over the next five years so that other provinces would not suffer from a lack of essential services, said the source.

Zuma was in Durban to meet staff from the various health departments as part of a national tour. She said integrating the three health administrations now serving KwaZulu-Natal was proving to be "a major problem".

Each department had separate offices, staff and budgets. Integration had already begun at leadership level.

All departments were expected to be integrated into one working unit within six months, said Zuma.

Zuma chastised government departments for not doing enough about the "worrying" incidence of Aids in the region.

"In many government buildings you will still find three-dimensional posters showing bombs and guns. But you will be lucky to find one poster about Aids."

An apple a day

FM 17/6/94

Articulate Health Minister Dr Nkosazana Zuma has wasted little time in delivering her party's general election promises.

Zuma (45) this month released stringent draft regulations for tobacco advertising as part of the ANC's plan to discourage substance abuse. She's also made free health care a reality for children under six and pregnant women provided they use State facilities and don't have medical aid.

Right now she's grappling with the mechanics of implementing a primary school feeding scheme at an annual cost of about R600m. Few would argue with the merits of curbing malnutrition in the crucial formative years but many would question the economic wisdom of government intervention in a thriving industry. Certainly, there's a contradiction between Zuma's proposed curbs on tobacco advertising and the ANC's promise — in its health plan — to increase taxes on tobacco in an attempt to raise additional revenue for health expenditure. Sceptics would also argue that free health care has always been available to the needy at State institutions.

Zuma says she helped to draft the ANC's latest health policy document, a statement that's very vague on the future of private-sector health care. The document promises greater controls over private hospitals and facilities, as well as licensing requirements for doctors to encourage them to serve rural areas. But Zuma says she will respect a patient's freedom of choice to use private-sector facilities.

It's not clear whether she will be prepared to further the reforms her predecessor Rina Venter implemented in her attempts to make the private sector more efficient, economically viable and more accessible. Venter's changes were premised on extensive deregulation — less government intervention and protection for doctors and vested interest — and certainly didn't make her popular.

Zuma, a doctor, could find the medical lobby too overbearing.

She was born in Maritzburg and matriculated at Adam's Mission in Amanzimtoti. She then studied at the medical faculty at Natal University's Durban campus.

While in exile with her husband, ANC deputy secretary-general Jacob Zuma, she completed her degree at Bristol University, later specialising in tropical diseases and child health at the University of Liverpool. She worked at Swaziland's Mbabane Government Hospital and the ANC health department in Lusaka before joining the Medical Research Council in Natal in 1991.

Zuma ... *squaring up to the medical lobby*

Her current research includes illegal abortion, Aids and opinion leaders and primary health care models in SA. She has five children. (85)

Her political achievements are also impressive. She chaired the ANC Women's League (Southern Transvaal Region) in 1991-1993 and served on the ANC executive committee of that region. ■

Spotlight on air quality

LIBBY PEACOCK
Weekend Argus Reporter

CONSENSUS has been reached by various parties on a comprehensive proposal to study the air quality — and its impact on health — in Milnerton and surrounds.

At a meeting in Milnerton this week residents, representatives from various town councils and ratepayers' associations, environmentalist organisations, action groups and other parties unanimously agreed that an improved monitoring system to provide adequate data to determine the impact of emission levels on health should be instituted.

This followed recommendations by the Medical Research Council, which was commissioned by Caltex in 1993 to undertake an impartial needs-assessment of the possible implications of emissions from the refinery on the health of the people in the community.

The report, published in March, concluded that, due to lack of continuous, representative data on human exposure to pollutants it was difficult to judge the potential impact or to recommend a particular line of short-term health research.

But, it did recommend an improved monitoring system and it was suggested that an integrated approach, going well beyond dealing with emissions from a single industry, be followed.

The report was accepted by Caltex, which commissioned Petro Terblanche — manager of the Environmental Health and Safety Management Services division of the CSIR — to prepare detailed proposals.

Dr Terblanche submitted a situation-analysis and her proposals included the installation of two monitoring stations located in line with the prevailing winds that crossed the path of the main factory areas. She also recommended the use of the Goodwood monitoring station.

It was proposed that a wide variety of pollutants be monitored, including sulphur dioxide, oxides of nitrogen, respirable particulates and airborne-toxics such as lead and sulphates.

Former Cape Town City Council chief air pollution control officer Derek Oxley was elected as chairman of the project commitee.

The project, estimated to cost more than R1 million in the first year, will be funded mainly by the industry.

A public meeting to present the proposals will be convened shortly.

Acting chairman Dave Brook said public involvement was an essential part of the project.

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Health services in jeopardy

ST Times [CC/Metro]

19/6/94

By PETA KROST

THE vital role played by community health workers in disadvantaged areas hangs in the balance as a result of key changes in the government's national health plan.

More than 400 community health workers supplement medical and social services in disadvantaged communities by dealing with minor medical and social problems, taking the pressure off over-burdened hospitals.

People with more serious problems are referred to doctors, hospitals, or the social welfare authorities.

This service has become more essential because of continued cutbacks in state-run medical and social services.

However, providers of this much-needed service are totally dependent on foreign funding channelled to them through non-governmental agencies.

Continue

Now with a democratically elected government in place, their funds are fast drying up and by next month most of these organisations will no longer be able to continue their operations.

"I don't know what we will do because there doesn't seem to be any money coming our way and we still have to support ourselves," said Anna Genu, a co-ordinator of the New Crossroads Community Health Workers.

The health workers expected the new government's health plan to keep them afloat so they could continue the essential role they play.

In the run-up to the April elections, the ANC assured them of their continued role.

At a Cape Town public meeting in March the local ANC leadership assured health workers that they need not worry because their work formed the basis of the organisation's health policy.

In the minutes of the meeting an ANC representative was quoted as saying "without them there would be absolutely nothing" and spoke of plans to expand the programme for health workers, also bringing in community involvement by training people.

The NPPHCN were originally consulted over the ANC health plan and were satisfied with the first two drafts which spoke of their being "paid, like other workers, according to their level of training and skill by the community or government".

But when the final health plan was made public, the NPPHCN and health workers were "shocked" to find how the "ANC's promises were not kept", said Dr Louis Reynolds of the NPPHCN.

(85)

Although the plan speaks of the important role that community health workers could play, the issue of payment and that of their work being recognised by the introduction of career structures and pathways to promotion was omitted.

One of the points that was also omitted from the National Health Plan was the importance of "guarding against the misconception that community health workers offer a cheap health-care option".

Negative

There is a serious lack of understanding concerning the service these health workers provide and the medical fraternity also generally has a negative view of their work, according to NPPHCN regional coordinator Elize Appel.

These workers fill the essential role between the medical fraternity and the disadvantaged communities.

Former domestic worker and mother-of-four, Anna Genu was elected eight years ago by the New Crossroad community to the position of health worker.

She has since become a co-ordinator and through the years has become one of the most respected people in the area.

"With just two months training we are not doctors, but we are taught to check for certain obvious things, like tuberculosis, and deal with minor ailments," Mrs Genu said.

People with more serious medical problems are referred to the doctors who hold twice-weekly clinics in the township.

"We don't just look for medical problems. We sit and hear all their problems. Very often, it turns out their ailments are related to social problems. Then we refer them to social workers."

They also check up on people who default on ongoing treatment, like tuberculosis sufferers.

Medication

"It is essential that they keep taking their medication. Sometimes they do not have food to take with their medication, so they don't take it. We ensure they take the tablets, sometimes we even feed them first," she said.

"We cannot replace doctors or nurses. But we can help them with their load by working with them," she said.

"The government should support us because we are doing the work it should be doing."

Cape Metro was unable to obtain comment from the government in spite of several calls and a questions faxed to the Department of Health.

A spokesperson for Minister of Health Nkosazana Dlamini Zuma, said: "The minister would personally like to respond, but she does not have time at the moment."

Health systems: the way ahead

Star 20/6/94

A DYNAMIC partnership in the OFS could soon change SA's whole approach to primary health care (PHC). David Robbins reports

They call it, with characteristic brevity, the PHC/Info project. It's currently the main preoccupation at the Centre for Health Systems Research, established in January last year on the campus of the University of the Orange Free State.

With equal brevity, the centre's director, Professor Dingie van Rensburg, says: "The project is about information and management." It's something of an understatement.

It looks more like an administrative revolution. By the time the project is complete, the delivery of primary health care throughout the OFS will be radically improved. And the new system, currently under development here, shows signs of being transferable to other parts of the country.

To understand the significance of what is happening in the OFS, we need to start at the beginning of the PHC/Info project story.

Enter a young doctor from Wits, Ronald Chapman, who found himself doing his national service in Bloemfontein in 1986.

He enrolled at the local university to specialise in community medicine and developed a special interest in epidemiology and biostatistics.

"During my post-graduate studies I became involved with the provincial administration," Chapman recalls, "and I witnessed at first hand the frustrations generated by trying to manage health services without reliable information.

"The chief director of professional services, Dr A G S Gous, challenged me to do something about it. So in 1989 I did a community-based study, attempting to record the actual health status and existing PHC coverage for the whole province."

He trained 250 nurses to do random selection and interviewing of households, and with the aid of a single secretary, fed the information from the questionnaires into a computer.

Some important results emerged. First, that the standard monthly returns completed by PHC nurses in the field were inaccurate and incomplete. Second, that health managers didn't know how optimally to use the more reliable and extensive information provided by Chapman's own survey.

Chapman made recommendations. These were noted but not acted on.

But the wheel soon turned full circle. After completing his post-graduate studies, Chapman accepted the post of director of community health services with the Free State Provincial Administration — and found his own recommendations staring at him from the middle of his new desk.

"I knew that what I had to do was change the whole information culture: what was collected and how it was used," he said. "That was the bottom line. I decided that I needed a specialised group to design and drive a special project."

Van Rensburg recalls how Chapman asked for the participation of the Centre for Health Systems Research. "At first I couldn't understand what he was driving at. But when he drew a diagram on a table napkin in a Pretoria restaurant, everything fell into place. We succeeded in getting a grant from the Health Systems Trust in Durban (R350 000 for the first year) and the work is now forging ahead."

The task includes changing a rigid and inappropriate system of information-gathering to one which more accurately reflects conditions; and then using this information in a way which makes health management, including budgeting and planning, more precise.

The obvious question is: how on earth has the system worked before? Listen to Annalize Fourie, PHC/Info project co-ordinator.

"PHC nurses spend a large portion of their time filling out statistical returns which aren't used as management tools. The returns are inappropriate, often inaccurate, and generally inaccessible.

"Managing health up until now has been a bit like trying to plan for a dinner party without knowing how many guests are coming, what their preferences are, and which couples are bringing their children. As a result, PHC planning has been rather haphazard: in other words, what was spent last year, plus a bit extra to cope with population increases and inflation."

Says Van Rensburg: "The aim of the project is to establish a need-related, community-based information system which reflects the real situation on the ground. This is not an academic exercise: it must work for, and be comprehensible to, everyone in the administration and the communities the administration serves."

Fourie says the project had been divided into four phases. The first, already completed, established the administrative, planning and evaluating infrastructure.

Phase II involves the setting up of eight task groups to address specific areas within the overall project. Each task group will establish strategies and write detailed instruction manuals by the end of the year.

In 1995 (Phase III) pilot programmes will be launched to test and modify these strategies and manuals. One urban and one rural area in each of the four hospital regions of the OFS will be included in these studies.

Phase IV will be a two-year implementation programmme throughout the province.

Among the aspects to be examined by the task groups are: routine statistics; community-based research; community involvement; management information; general health and health-related information; financial resources management; and information about traditional healers.

A special recently established task group is examining the crucial question of computerising the entire information system. In this regard, Chapman has already persuaded a major private company to become involved at the design stage.

Med council 'needs vision'

JOHANNESBURG. — The Medical Research Council has said without long-term vision it will be doomed to mediocrity and become vulnerable to scientific and colonial exploitation.

MRC president Prof Walter Prozesky said yesterday the council found itself "awash in a sea of challenges and opportunities" created largely by bewildering changes within and outside the country.

The health of people should be developed, as well as the skills required to provide and foster that health. There should be a clear focus on the development of research skills and capacity, particularly among disadvantaged people. (85)

The MRC's research strategy would be based on the government's Reconstruction and Development Programme and the ANC's health plan. — Sapa CT 22/6/94

BUDGET '94

Zuma disappointed with Budget

New health plan suffers hard blow

Star 23/2/94

MINISTER says her department was never consulted and academic accuses tobacco industry of wooing Government

■ **BY DAVID ROBBINS**
HEALTH WRITER

Health spending in South Africa has not been increased — in spite of an announced 7 percent increase over last year's budget — and a disappointed Minister of Health has said that plans to extend services would now not be possible.

Dr Nkosazana Zuma was reacting to the health allocation of R14 billion — or just over 10 percent of the total Budget.

In addition, a university health expert has voiced harsh criticism over the low tax increases on tobacco products and has accused the tobacco industry of putting pressure on the Government.

Zuma said: "Two factors need to be taken into account. First, last year's budget did not include spending in the TBVC states, whereas this year's does. Second, inflation in health is substantially higher than inflation generally. Taken together, these factors mean a decrease in real money terms. It's a major disappointment."

Zuma, who stressed that her ministry had not been involved in the preparation of the Budget, also expressed disappointment in the low tax increases on tobacco products. "But at least the Minister of Finance did recognise that tobacco needed to be taxed differently" (85)

A spokesman for the ANC's health department doubted that the "minimal" tax increases would deter youths from smoking — as the ANC envisaged.

But the phased approach was dismissed as "misguided" by Professor Max Price, director of the Wits-based Centre for Health Policy.

"A phased approach is nonsense from a public health point of view. All it does is get people used to the price increases."

He said South Africa's tobacco taxes were among the lowest in industrialised countries.

Increase in allocation to health 'not sufficient'

CAPE TOWN — Primary health care services had been allocated R3,5bn — a quarter of the total health budget, Finance Minister Derek Keys said yesterday.

Sapa reports he said the allocation for primary health was a substantial increase on 1993/94 spending, and this was accommodated by restricting growth on secondary and tertiary health care. The total 1994/95 health budget was about R14bn and included provision for TBVC budgets. It represented an increase of about 7% on 1993/94.

"Progress has been made in implementing the primary health care approach in many regions of the country. The National Health Department undertakes primary health care projects in conjunction with local communities, thereby also contributing to job creation, skills development and local capacity-building."

KATHRYN STRACHAN reports that Wits University's centre for health policy said the 7% increase in the health budget was insufficient — and making way for the primary

health sector by restricting growth at secondary and tertiary levels could lead to the closure of hospital wards.

The centre's researcher Alex van den Heever said there was little space for constraining spending in the secondary and tertiary levels.

Given the 10% inflation rate, the 7% hike represented a decrease in real terms, he said.

This was exacerbated by the fact that medical costs increased at a rate higher than the CPI.

Yesterday's Budget allocated R3,5bn to primary health care services, a quarter of the total 1994/95 health budget of R14bn.

The Centre believed a 14% increase, which represented an increase of R2bn on last year's budget, was necessary to bring health spending to an acceptable level.

National Progressive Primary Health Care Network director Erwin Friedman said the 7% increase was not sufficient to address the inequities in health. However, he supported the increase in spending in primary health care.

Friedman said the Budget as a whole did not address the needs of the poor. In particular the R292m set aside for job creation fell far short of being able to provide jobs for the millions of unemployed.

The Medical Association of SA said the Budget had not gone far enough in indicating government's commitment to health. Major issues of disappointment were the failure to remove VAT from medical services and from basic foods.

The association also expressed doubt about government's ability to determine the ideal balance between primary health care and secondary and tertiary health care.

HEALTH CARE

Booster

Primary health care will enjoy a generous 25% of the R14bn allocated for health services. This is a big increase on last year's national target of 15%.

It's an allocation made possible by new funds and strict financial disciplines during the past four years. Former Health Minister Dr Rina Venter's policy of rationing fragmented services and restricting growth in secondary and tertiary health care — the most expensive levels — also contributed.

The 7% increase for health compares favourably with allocations for other departments but Health Director Coen Slabber says it is less than the projected inflation rate. He explains: "Medical inflation is usually 3% higher than the normal inflation rate because of high pharmaceutical prices and the cost of imported equipment." He adds that the cutback will be offset by a greater rationing of services but this might show results only by the next financial year.

Finance Minister Derek Keys's claim that the total allocation for health care represents a 7% increase on last year's allocation could also be misleading. Representative Association of Medical Schemes executive director Reg Magennis points out that Keys is comparing the current health budget allocation with last year's — which, he claims, was overspent.

"This means the increase is only 2,4%, a health budget growth well below Keys's projected national inflation rate of 7%-8%."

This, of course, implies a real decline of 5%-6% — a small allocation considering the ANC's elaborate plans to extend health care to the broad population. Slabber, however, denies that his department overspent. "We will be closing our books only at the end of this month and most regions, except for the PWV and Cape, appear to have kept within their budgets."

This year's allocation to health care represents 10,2%, down by 1,4 percentage points on last year's projection, of total government spending.

Vat on health care hasn't been dropped, something the Katz Commission might reconsider if the facility is to appear to be more accessible to all. ■

Health fund inadequate

Sowetan 24/6/94

THE slightly increased expenditure allocated in the Budget to the health sector is welcome, but regrettably insufficient to address the inequities in the health care system, the National Progressive Primary Health Care Network said yesterday.

The increased proportion of the Budget spent on primary health care is also an important step in ensuring accessible services are made available to the most needy.

The increased tax on cigarettes, other tobacco products and alcohol is also welcome, but the increase was much too moderate to decrease use of products that impose enormous social costs on society, the NPPHCN said in a statement.

"We welcome the R2,5 million allocated to the Reconstruction and Development Programme and R292 million to employment creation as a useful step forward, but note that both these amounts fall far short of what is required to tackle an anti-poverty programme on a meaningful scale."

"The increased expenditure on primary health care is important step in making services available to the most needy"

Following pre-election promises of jobs, it was not unreasonable for the 18 million people living below the poverty datum line of R750 a month to expect a far greater proportion of the planned deficit to be allocated to assist the unemployed find jobs in widely distributed labour-intensive public works programmes. (85)

"The current allocation will not permit more than a few hundred thousand people to obtain even the most meagre job. This is far below the need for several million jobs now.

"Since household income is a most critical determinant of health and well-being, the implications of continued high unemployment are of grave concern," the NPPHCN said. — *Sapa.*

Masa recognises 'Living will'

(85) ARG 25/6/94

LIBBY PEACOCK
Weekend Argus Reporter

EVERYBODY has the right to refuse medical treatment or insist on not being kept alive artificially.

New Medical Assocation of South Africa (Masa) guidelines clarifying doctors' obligations when presented with "living wills" are based on this principle.

According to Masa a "living will" is "a declaration or an advance directive which will represent a patient's wish to refuse any medical treatment and attention in the form of being kept alive by artificial means when the patient may no longer be able to competently express a view."

The comprehensive guidelines, compiled because there is no legislation in South Africa to validate "living wills", were produced at Masa's federal council meeting in Pretoria this week.

According to Masa, "every person may refuse medical treatment even if such refusal will result in death, unless such treatment is sanctioned by law.

"To be able to make a declaration such as the 'living will', a person must be over the age of medical consent and *compos mentis*. The declaration will remain valid even if the declarant later on becomes *non compos mentis*."

Guidelines include:

- **A doctor should offer to treat and to relieve suffering and should generally act in the best interests of his patients;**
- **All patients have a right to refuse treatment, which should be respected. This, however, does not imply or justify abandonment of the patient;**
- **A written advance directive, in the absence of contrary evidence, must be regarded as representing the patient's expressed wish;**
- **If an advance directive is specific to a particular set of circumstances it will have no force when these circumstances do not exist;**
- **It is patients' responsibility to ensure that the existance of advance directives are known to their families and those who may be asked to comply;**
- **It is strongly recommended that patients review their "living wills" at regular intervals.**

Health services to be restructured

85

Municipal Reporter

ARG 11/2/94

PRIMARY health services may be provided by individual municipalities when local government is restructured — if negotiating parties agree.

This recommendation was one of seven accepted by the city council's amenities and health committee on restructuring health services in the Cape metropolitan area.

The committee also accepted:

- That health services be excluded from the functions of the Transitional Metropolitan Council (TMC) to avoid further fragmentation and duplication.
- The National Health Forum management committee recommendations on allocating health functions to central, provincial and local government.
- Hospital services, currently administered by provincial authorities, should also not be administered by the TMC.
- Primary health services to be rendered by primary local authorities include facilities currently operated by other authorities, such as day hospitals.

Hospitals groan with the load

CPress 3/7/94

85

By ZANELE VUTELA and SIPHO ZUNGU

THE clearly exhausted nursing sister looked through her thick-framed spectacles and admitted with resignation: "It is true, children in Soweto hardly go beyond the age of six nowadays."

This statement underlines the present health crisis in the township since the announcement by President Nelson Mandela that all children under the age of six and pregnant mothers would receive free medical treatment from June 1.

Joyce Nxumalo, a Soweto resident, told City Press that people were taking unfair advantage of free medical health for the under-sixes. "They have taken to lying about the ages of the children they bring into the clinics."

The crisis is generated by the fact that health facilities that were already at pathetic levels are just about collapsing with the strain brought about by the sudden increase in the number of clinic attendances.

According to Dr Soomati Natha, acting superintendent of Soweto's 12 clinics, the declaration of free medical services, while welcome, "found us unprepared and is way beyond what we can cope with".

The number of children under six years old being brought into the clinics has increased dramatically and there are fewer older children. With Soweto's characteristic speed, this problem has in less than a month embedded itself into the health services.

This has led to Natha to the conclusion that if it came to the push, the clinics would have to insist that the children bring their "road to health certificates" to provide proof of age.

There have also been reports that in abusing the system, people tend to bring the "not-so-sick", who in the past would not have taken the trouble to go to a doctor for the same ailments.

A notice issued by Health Minister Dr Nkosazana Zuma stipulating guidelines for rendering free medical services was published in the Government Gazette on Friday. The notice stipulates that free medical care must be provided to:

- Pregnant women from the day the pregnancy starts until 42 days after the pregnancy has been terminated, for whatever reason. If a complication arises because of the pregnancy, the patient is to remain under free medical care until she is well.
- Health care will be rendered to pregnant women for ailments not related to pregnancy.
- Children under the age of six.
- Non-citizens of South Africa who are in the above categories who incidentally get sick while they are in the country.

According to the notice, free medical care is to be provided by the following institutions and people:

- State-care facilities, including hospitals, community health centres, clinics, mobile clinics and satellite clinics.
- State-aided clinics whose budget is subsidised by more than 50 percent by the government.
- By district surgeons.

The following are not eligible for free health care:

- People and their dependants who are on a medical aid scheme.
- Non-citizens of South Africa who visit South Africa for the purpose of obtaining free medical care.

The notice does not say anything about how the health services will be revamped to face up to their task. As it is, Baragwanath Hospital is on the verge of curtailing its services. On Monday the hospital's superintendent, Dr Chris van der Heever, told the media that Bara would have to close some wards unless additional funding is found.

ıier ● Hospitals may have to close wards

Free health plan faces cash crisis

By Mokgadi Pela

■ FINANCIAL CONSTRAINTS

Hospital budgets overstretched:

RECENT reports about the cash crisis afflicting hospitals do not augur well for the much-publicised primary health care (PHC) programme adopted by the Government of national unity.

In fact, according to the African National Congress's health plan, PHC "requires political will on the part of the Government".

That political will must of necessity include financing health care to achieve this objective.

Already we are being told that the defunct Transvaal Provincial Administration has instructed all hospitals to scale down their services in order to stay within the limits of their budgets.

This crisis can obviously break the optimism of anyone still chanting "health for all by the year 2000".

In an interview with the chief director of TPA health services, Dr Jan Nagtegaal, it became clear that it was not far-fetched to foresee the closure of several wards at hospitals like Baragwanath. Nagtegaal could not, however, confirm this view.

He attributed the cash crisis to the large amount of PHC being offered at hospitals and clinics. Nagtegaal cited two main items of overspending at hospitals — salaries and expenditure on usable items such as drugs.

> **"This crisis can break the optimism of anyone still chanting 'health for all by the year 2000'"**

Nagtegaal said whereas it cost R237 39 per patient per day in 1992-93, it now cost R436 95.

Difficulties

Last week, Baragwanath Hospital superintendent Dr Chris van der Heever said the hospital was in financial difficulties.

"The population of Soweto is growing at a rate of three percent annually, which means it has doubled itself in the last 15 years.

"There is also a tendency at the hospital to overspend the budget the Government has approved for Bara."

Van der Heever said given the financial position of South Africa, Government spending had to be curbed.

"The problem facing Bara is to remain within the financial constraints of a budget which leaves very little manoevring space. As in any household, when your expenditure exceeds your income, you either have to increase your income or drop your standards."

He said Bara's future depended on political and administrative rethinking. The impact of the Government's new "free services" policy towards children and pregnant women could strain the hospital's financial position even further.

There is no doubt that with all hospitals in the country facing problems similar to Bara's, hope seems to lie in the Government investing in the development of a proper PHC system to achieve results.

Council sl slams heath minister for ignoring ambulance crisis

Municipal Reporter

THE city council has criticised regional health and welfare minister Ebrahim Rasool for failing to respond to a call for an urgent meeting to resolve the city's ambulance service crisis.

At an amenities and health committee meeting yesterday, councillors berated Mr Rasool for not replying to a letter calling for an urgent meeting.

The minister had since met the SA Municipal Union.

"If he can meet the union, why can't he meet the agents of the service?" councillor Arthur Wienburg asked.

Mr Wienburg said the ambulance service had too many "frills", and that there should be one control room instead of two.

He objected to the Cape's ambulance training college being funded through the Peninsula's ambulance budget.

Deputy city administrator Alan Dolby said special provincial services could be "handed back" to the provincial authorities, "but that will not mean we will get a bigger slice of the cake". ARG 5/7/94

Mr Wienburg said resources were needed to run an efficient service. (85) (42)

● Ambulance services were disrupted yesterday when ambulance workers refused to go on duty with beach constables — assigned to other duties during the winter months.

The beach constables had just finished a three-week training course.

Ambulance workers said they had not been consulted. They were also unhappy that constables were getting a five percent increase.

Civic amenities director Jack Kloppers said this week about 38 constables had been assigned to the ambulance service.

Another 60 would patrol central business districts in Camp's Bay and Sea Point where they would enforce municipal regulations.

Demo plan by health workers

PRETORIA. — Members of the SA Health and Public Service Workers Union will protest in Cape Town, Pretoria and Bloemfontein on July 15 demanding, among other things, increased wages, it was announced today.

Union general secretary Silas Baloyi told a news conference in Pretoria that the 45 000-strong union would demand a minimum salary of R1 500 per month, an across-the-board increase of 17,5 percent and that March 21 and June 16 be paid public holidays.

"These demands have been presented to the Commission for Administration, but the commission is hiding behind procedure not to meet these demands or alternatively continue to exploit these workers," he said. ARG 5/7/94

Mr Baloyi said the same demands had also been presented to President Nelson Mandela, whose administrative secretary had responded by saying the matter had been forwarded to the Minister of Labour as it fell under that department.

The protesters in Pretoria will march to the Union Buildings, those in Bloemfontein to the Supreme Court and those in Cape Town will go to parliament to present memorandums to government officials. — Sapa.

Water supply 'crucial in struggle to stop disease'

(85) ARG 9/7/94

JOHN VILJOEN
Education Reporter

THE supply of clean water to communities was a crucial aspect of the government's fight against preventable disease, said water affairs and forestry minister Kader Asmal.

He told the graduation ceremony of the University of the Western Cape's first water and sanitation course that more than 12 million South Africans did not have access to clean drinking water and 21 million did not have adequate sanitation.

Water had a crucial role to play in the fight against disease, he said.

Typhoid, cholera, diarrhoeal diseases, parasitic infections and infectious communicable diseases were directly related to the inadequate provision of basic water and sanitation.

It was the job of his department, as a major priority under the reconstruction and development programme, to give all South Africans access to basic water services.

South Africa had an impressive record when it came to water resource management, but the delivery of basic services to communities had been neglected.

Many diseases among the poor and disadvantaged were preventable.

His department had also turned "major" attention towards the provision of water in rural areas and had set up a special section devoted to community water supply and sanitation.

A top-level meeting would be held in Johannesburg late in July to address this issue.

Bank's policies a 'health scourge'

BDay 11/7/92

KATHRYN STRACHAN

THE World Bank's economic policy for Africa, with its stringent structural adjustment policies, has contributed to rising rates of disease and mortality, says a visiting expert.

Zimbawean epidemiologist Rene Loewenson said last week the twin health scourges in Africa were AIDS and structural adjustment. While the policy was supported in banking and finance circles, it was seen by the poor as a source of decline and hardship.

Infant and child health, an indicator of social development, had shown a marked decline since structural adjustment policies were applied in the early 1980s. The infant mortality rate, which had begun to decline in many African countries, rose by up to 54% in the structural adjustment policy periods in seven African countries studied by the UN Children's Fund.

These countries included Ethiopia, Mali, Madagascar, Uganda, Tanzania, Somalia and Kenya.

Increases of up to 91% in mortality rates of children under five were also observed in these countries in the same period. Diseases that had reportedly been eliminated also reappeared.

At the same time, health sector expenditure was dramatically cut in nearly all countries and health policies were replaced by health sector measures designed to accommodate the structural adjustment policies.

(85)

With rising political and economic tensions, developing countries had been encouraged to adjust their economies to increase their external funds for debt repayments, mainly through domestic expenditure cuts and exports increases.

As a result most developing countries had experienced falling incomes, higher costs of living and reduced government expenditures on social services since the early 1980s.

In sub-Saharan Africa per capita incomes fell more than 25% in the 1980s and unemployment rose.

Although the new policies intended to raise producer prices of export crops to stimulate production, poor rural households had not benefited from these measures. Producer price increases had been offset by increases in costs of inputs to production.

6m helped by health plan

(85)

PRETORIA. — More than six million people were helped by the Department of Health's nutrition and social development programme in the past financial year, the department said yesterday. CT 12/7/94

About 5 000 programmes and 11 000 projects had been funded from a budget of R400m.

The scheme focused on the poorest two percent of the population.

"The aim is to enable communities to achieve self-reliance in food and nutrition. Emphasis is mainly on young children and pregnant and lactating women.

"Direct food aid by on-site feeding such as soup kitchens and food parcels is making way for more development-orientated programmes with household food security as the main aim," the department said. — Sapa

among refugees.

Picture: ALLEN VAN DER LINDE

22 murdered in continuing KwaZulu/Natal violence

ADRIAN HADLAND

TWENTY-two people were murdered in KwaZulu/Natal at the weekend as political and criminal violence continued.

More than half the deaths were linked to political disputes, while robberies and other criminal activities accounted for the rest, a police spokesman said.

In the south coast region 11 people had been killed in the past seven days.Continuing fighting between Inkatha Freedom Party and ANC supporters was blamed.

The province also reported six attempted murders, a petrol bombing and four arson attacks. BIDay

An Inkatha monitor said rumours, suspicions, revenge and poverty had contributed to the atmosphere. 12/7/94

Inkatha supporters felt attacks on party members had not been sufficiently followed up by police or the Goldstone commission.

Reports suggesting factional disputes within ANC structures, that self defence units had switched to criminal activities and alleging that police had armed Inkatha had exacerbated the situtation, he said.

SA Communist Party Southern Natal deputy secretary Nhlanhla Buthelezi said violence and intimidation was rife in the Eshowe district.

He had written to Public Safety and Security Minister Sidney Mufamadi asking for an investigation of the recent arrest of six people who had allegedly been caught with AK-47s, revolvers and ammunition.

Regional police spokesman Maj Bala Naidoo said he could find no evidence of the arrests.

Naidoo said the number of incidents of political violence had plunged since the elections.

Joint ANC/Inkatha peace initiatives and rallies had helped, he said.

Health department project assists millions

PRETORIA — More than 6-million people were helped by the Health Department's nutrition and social development programme in the past financial year, the department said yesterday. BIDay

About 5 000 programmes and 11 000 projects had been funded from a budget of R400m. The scheme focused on the poorest 2% of the population.

"The aim is to enable communities to achieve and sustain self-reliance in food and nutrition. Emphasis is on young children and pregnant and lactating women," the department said. 12/7/94

"Direct food assistance is, however, making way for more development-oriented programmes with household food security as the main aim." (85)

The department said it was actively involved in the primary school nutrition scheme announced by the President in his state of the nation address. — Sapa.

Health crisis intensifies

Star 13/7/94

◀ From Page 1

hospital sources said.

Understaffed and overworked hospitals were having to cope with more frequent ante-natal visits by pregnant women. (85)

At Johannesburg Hospital, paediatric casualty patients have increased by about 150 percent from 50 or 80 to up to 180 a day. Attendances at the ante-natal clinic have increased by 20 percent since the introduction of the new policy.

A statement from the hospital said the sudden influx had put "a considerable additional workload on medical, nursing and administrative personnel". The situation had been compounded by the recent loss of several paediatricians.

Coronation and J G Strijdom hospitals also report a "tremendous stress on services". A spokesman said health care personnel were having to work longer hours.

Baragwanath Hospital, because it has referral facilities only, is not as badly affected, although it has had to attend to the overflow of patients from clinics after they close.

"We are getting double the number of patients at night," said Dr Karin Simmank, head of the outpatients department.

Health care officials and workers agree, however, that the new policy is not entirely to blame.

"The new policy has merely led to an exacerbation of the problems rather than being the primary cause or even a cause of the problem," said Dr David Green, director of health care policy at the Medical Association of South Africa.

The historic lack of primary health care facilities in many areas, which could relieve overloaded hospitals, has been cited by experts as a major contributory factor.

Piet Wilken, director of communications for the PWV provincial administration, said there was a R316 million financial shortfall for services in the Transvaal this year, and that hospital services would have to adapt to the new Government's health policy guidelines "as far as possible".

LACK OF primary health care facilities cited by experts as a major cause of the current problem

■ BY HELEN GRANGE and CHRISTINA STUCKY

Provincial hospitals and clinics in the PWV — particularly in Soweto — are creaking under the strain of the massive influx of patients qualifying for free medical care in terms of the Government's health care initiative.

The situation is critical at clinics in Soweto, where the number of qualified medical practitioners is continuing to drop, Dr Soomati Natha, acting superintendent of Soweto's 12 clinics, said yesterday.

Frequent depletion of drug supplies, massive overcrowding, and screening of patients with illnesses not requiring urgent attention has resulted.

Hospital authorities on the Reef said yesterday that the unusually cold weather and the resulting increase in flu complaints had exacerbated the problem.

The Government's new health plan, which allows all children under the age of six and pregnant women free medical treatment, has prompted many parents to bring their children into medical centres even for very minor illnesses,

▶ To Page 3

New health plan leads to massive influx of patients

Free care fuels hospital crisis

Star 13/7/94

(85)

NEWS

Patient flood expected to ease

Hospital crisis 'is being addressed'

Star 15/7/94

■ BY HELEN GRANGE

HEALTH MEC assures public that steps are being taken to ease medical staff and drug shortages at PWV hospitals and clinics

PWV MEC for health Amos Masondo has given the assurance that steps are being taken to remedy the shortage of medical staff and drugs at PWV hospitals and clinics battling to cope with increased patient loads.

Masondo said in a statement he was aware of the problems being experienced in many provincial health-care institutions, but said the initial flood of patients qualifying for free medical treatment was expected to ease off and reach a point of equilibrium.

Struggling

Hospitals and clinics, particularly those operating in Soweto, are struggling to cope with the massive increase in patient numbers due to the Government's new health policy, which affords pregnant women and children under six free medical treatment.

Masondo pointed out that the introduction of the new policy had coincided with an influenza epidemic and the beginning of a particularly severe winter with its concomitant illnesses.

He added that problems surrounding the supply of drugs, "which are, by nature, short term", were being addressed at present.

"Shortage of staff, particularly doctors, is not so easily solved in the short term, but increasing use is being made of appropriately trained primary health-care nurses at facilities such as the Soweto community health centres."

Masondo added that the problems, while understandably frustrating to patients and staff alike, should be seen in the context of the National Health Plan, which was intended to benefit the broad populace on the basis of need.

Frustrating (85)

The National Party has accused the Government of not making the necessary preparations for the sudden increase in the number of patients, and has called on Health Minister Nkosazana Zuma to take immediate steps towards solving the "crisis".

"The announcement on free medical care was apparently made without making preparations to cope with the expected influx," the NP said.

Zuma has been unavailable for comment this week.

Financially strapped Red Cross needs first aid

BIDay 18/7/94

MICHAEL ACOTT

THE SA Red Cross is in need of more than first aid. While officials at its Johannesburg headquarters hope the Red Cross will not close down here, there are real fears that many of its activities will cease.

Ambulance services in violence-racked Natal have already closed; in other regions assets are being sold off to keep services going.

It is not the sort of problem South Africans associate with an organisation with international backing, which has just raised nearly R700 000 for Cape flood victims, produced 3 000 volunteers over the election period, takes food and clothing to needy townships, gets government subsidies and maintains an expensive air ambulance service.

The fact is that each of these activities is separately funded; money donated for flood and violence victims goes nowhere else and government funds are specifically for the organisation's old-age homes. The ICRC contributes to specific local projects, while the air ambulance is staffed by volunteers and costs the Red Cross nothing.

Behind it all, the Red Cross is broke, its coffers depleted by the demands of a particularly violent year. It has been driven to the verge of bankruptcy by the costs involved in maintaining its regular services and often burdened by the expense of getting donated food and blankets to the people who need them.

The problem, besetting many charities during an economic downturn, is a drop in donations, and particularly the lack of an assured income. Unlike countries where businesses and governments provide regular funds on which the Red Cross can bank and budget, the SA branch has been dependent on collections and donations. Its future, after nearly 100 years, will be determined by the success of a major fundraising drive and by some innovative ideas for securing a regular income.

The situation is bleak. The current projection is that by the end of the financial year next March, the Red Cross will be R2,5m in the red.

"If that happens, there is a real possibility we will have to close down," says director-general Keith Gower. He does not want to believe it might happen, but warns the reality might be a Red Cross reduced to "book sales on a Saturday morning".

That, he says, would be a disaster for the country, not just the local Red Cross. The organisation has built up credibility with foreign governments and local communities and is a channel for international donations to SA organisations. (85)

"Some countries do not like donations to go to other governments, but look for someone like us to act as implementation agent and watchdog. This could happen with some contributions to the reconstruction and development programme."

Gower has overseen a restructuring of the local operation, from largely autonomous regions to more centralised administrative and budgetary control. There have been retrenchments, and a reordering of priorities, but a deteriorating financial situation has worsened in a year of violence and natural disaster.

The organisation has also been burdened by a debt of nearly R3m incurred by the southern Transvaal region before the restructuring. Some investments are being liquidated, with Gower and accountant Ian Gould aware of the desperation involved in using capital assets to fund current expenditure.

"Natal is out of money and the situation in the Eastern Cape is critical," Gower says. "We are considering selling our buildings in both regions, and after that there is nothing more to sell."

The Red Cross has chosen not to be among the charity beneficiaries of the Ithuba and Viva scratch cards, and its own card, Scratchit, is losing out to these operations, which have the major distribution points.

The rescue operation being planned includes local and international fundraising drives, although foreign donors tend to regard SA as a rich country which should be able to keep its own Red Cross branch going.

Gower is hoping to persuade 10 foreign corporations each to put R1m into a trust fund, with the annual interest going to the Red Cross.

The low profile of the SA operation will end with a nationwide drive to get individual and corporate donors. Apart from the companies which contribute food, clothing, transport services and sizeable amounts of cash for Red Cross operations, there are hopes of a regular income from two foreign companies in particular.

An international beverage company is planning to donate a cent a can sold in each country to the national Red Cross or Red Crescent society. And negotiations are under way with McDonald's, when it opens in SA, to give a donation for each hamburger sold here.

Other business partnerships are being explored, including municipal donations of a few cents for each rates account where Red Cross ambulances helped during recent violent periods.

"In Germany, all customs fines go to the Red Cross. In Finland, the organisation gets 10c a packet of cigarettes sold. This is money you can bank on; we have to try to budget for donations," Gower says.

BOOKS

Counting the cost of meeting SA's basic health needs

Bl Day 18/7/94

MAX PRICE

85

THE reconstruction and development programme is committed to meeting basic needs as a primary development strategy. Improving health care is clearly part of a basic needs approach.

The health and nutrition chapters of the RDP, and the ANC's final national health plan, identified several priority programmes, projects and extensions to services that are the most likely to have capital and recurrent cost implications.

The total additional cost of these programmes, outlined below, is R990m, excluding the nutritional supplementation programme, and R2,82bn including it. In many cases services already exist and proposed targets do not take account of them. Where possible I have indicated the total costs (at 1994 prices) for programmes as well as estimates of the cost of closing the gap between the present level and the 1999 target.

☐ Extending child health services would involve treating all children under six (not covered by medical aid) for free at all public sector facilities. Extending the services to children who do not yet have access would cost an extra R205m;

☐ Maternal health care would entail pre- and post-natal care and delivery free of charge by 1997 and coverage extended to 80% by 1999. The total recurrent costs at a target level of 80% coverage are R347m (R38m more than at present), at 90% they are R391m (R82m more) and at 100% they are R434m (R125m more);

☐ Providing nutrition supplementation to vulnerable groups would cost R1,83bn a year. This is based on an estimated group of 2,5-million needy people in 1993, at an average cost of R2 a person a day;

☐ Expanding access to basic clinic services requires, in the medium term, at least another 150 clinics. Assuming 50 large and 100 small clinics, the capital and recurrent costs would be R176m and R70m respectively. The annual costs of this programme are about R85m;

☐ According to the ANC, all health districts should have at least one 24-hour facility by the end of 1995. To provide emergency care we estimate an extra annual recurrent expenditure of R206m;

☐ An immunising programme against Hepatitis B has been estimated by the ANC health department to cost R25m annually;

☐ The National AIDS Congress of SA developed a comprehensive AIDS strategy which will cost about R100m in 1994/95 and will involve the Health and Education Department budgets. Health would be responsible for funding R50m to R60m, of which around R45m would come from the existing AIDS budget. The gap is therefore R15m in the health sector;

☐ A mental health programme for the victims of violence involves the training, supervision and support of primary care workers, teachers and volunteers to identify and treat psychological problems, especially those related to exposure to violence. The set-up costs for the first year are estimated at R10m;

☐ It is not possible to cost the net effect of improving health services in rural areas. But one intervention proposed is to increase salaries as an incentive to attract staff. A crude estimate of the additional costs is R290m; and

☐ Improving and strengthening existing health services imply a general increase in maintenance spending and improvements in conditions of service. This could absorb as much money as was available and therefore cannot really be costed.

It should probably be managed through a planned, real increase in health expenditure derived largely out of efficiency improvements by managers, who should be allowed to retain saving made for facility and service improvement.

It is not, strictly speaking, the concern of the health sector how the additional R2bn is generated. Since state financing and expenditure are usually separate processes, the sector should not get involved in taxation of deficit funding policy.

However, three sets of health policies have been motivated primarily for their health and health service management consequences, and have revenue implications which might be useful in providing funding for the sector too.

The first is increased taxes — either excise, or higher VAT rates — on tobacco products and alcohol. The possibility of using this revenue for the health sector can be defended on the principle that those who generate additional costs to the health services should foot the bill for those services. This does not require earmarking the revenue to go to health, but an increase in the health budget to match increased revenue from these taxes.

The second cluster of policies relates to the need to change management incentives within the public sector by allowing facilities to retain a portion of the revenue they generate from paying (insured) patients.

At present, all revenue generated from fees is returned to the central revenue fund. This creates incentives for hospital managers to turn away any patient who can afford to go elsewhere, since these patients generate costs which are not recovered from their fees. The hospital simply goes further over budget. If paying patients do come, there is no incentive to collect their bills since this also costs the health service money which it does not recover. Hence the revenue to the central revenue fund is also reduced.

If facilities were allowed to retain revenue generated, and if managers were given the autonomy to adjust staffing levels according to need and to spend the revenue they generate, they would attempt to attract paying patients, would improve the quality of care and perhaps also be able to improve the conditions of employment of their staff.

It is mainly hospitals that would be able to attract insured patients. This revenue could cross-subsidise the non-paying patients, thus allowing the health authorities to divert some of the funding from hospital services to primary care.

The third set of policies relates to the development of a national health insurance system. Of relevance is the principle that anyone able to afford health care should have to pay for it. Membership of a medical aid that is part of a national health insurance system would become mandatory. The public sector would reduce the number of people for whom it is responsible, perhaps by several million, and per capita expenditure would increase proportionately even if public spending on those services remained fixed.

One can criticise the RDP health plan priorities for having selected these programmes rather than others which some would argue are more urgent. The more comprehensive ANC national health plan will be criticised for setting goals which resemble a naive wish list, far longer than the priority programmes described here — and obviously less affordable. But the fact that the programmes are described and costed almost as vertical independent activities is largely a result of the RDP's principle role as an instrument for advocacy. Demanding R2bn for a general expansion of the primary health care system just does not sound as sexy.

Yet in reality, there cannot be a singular expansion of child health services without expanding access for adults, treating sexually transmitted diseases, detecting tuberculosis and the whole gamut of health care provision. This in turn will generate referrals to hospitals for higher level care. Thus the programmatic definition of the RDP health plan belies the practical implementation, and to a large extent, makes a mockery of the attempts to cost it.

In my view, the priority programmes address such basic needs — needs many would almost consider rights fundamental to a society which respects human diginity — that they are uncontroversial. From a politician's perceptive, they are highly visible, generally achievable within five-year period and would have long-term benefits. They will probably never have a better chance of being funded. Perhaps that applies to all the other sectors too.

☐ Price is director of Wits University's Centre for Health Policy. This is an edited version of an article in the latest Indicator.

Old Mutual warns of future medical costs

EDWARD WEST

CAPE TOWN — Nearly two-thirds of SA companies had failed to take into account future contributions towards pensioners' medical costs, representing a serious hidden liability, Old Mutual warned at the weekend.

Actuary Heather McLeod said recent studies by the University of Pretoria indicated that health benefit schemes' total assets amounted to about R1bn while future commitments towards pensioners amounted to about R15bn.

The liability was "enormously underfunded" because company medical benefits were not subject to actuarial valuation and because medical benefit schemes operated on a "pay as you go" basis, with young healthy contributors cross-subsidising the medical costs of pensioners.

One industry said the problem was being compounded by an average 20%-25% annual rise in medical costs, growing questions among young members about the cost of their benefits, and a steadily aging population.

McLeod said few companies were building up sufficient reserves for future medical costs through investing funds in long-term growth assets, which was the way the life benefit industry provided for its future requirements.

In the US companies were required to include medical benefit liabilities on their balance sheet, but there were no such provisions in SA, which could give analysts a better understanding of future liabilities of companies.

The recently concluded Melamet commission of inquiry into health care benefits found the "pay as you go" concept untenable and more sophisticated financial management, such as actuarial valuation, was suggested.

Red Cross faces closure

Sowetan 25/7/94

(85)

By Russel Molefe

THE SOUTH AFRICAN RED CROSS Society faces possible bankruptcy and may be forced to halt its services.

The Red Cross, whose income depends on donations, spent about R26 million last year on humanitarian services, relief supplies and paying off debts.

Red Cross spokeswoman Miss Ann Gordon yesterday said there was no Government support for the Red Cross in South Africa and it was totally dependent on public funding, which was fast becoming non-existent.

"Getting food to starving children or medical aid to wounded civilians caught in the crossfire is expected of the Red Cross.

"How it is done is of no concern. Volunteers are so busy doing the work but where the resources come from is seldom mentioned," Gordon said.

Gordon also outlined the sterling services the Red Cross offered in disasters such as the internecine violence that has gripped most of the townships, the Merriespruit disaster and the Cape floods.

She said the Red Cross desperately needed an injection of R2,5 million to continue its services. Failure to raise this amount might force the Red Cross to stop its services, she said.

Terminating these services could adversely affect violence-riddled areas, especially in Natal and East Rand townships.

Gordon made an impassioned plea to the public to donate for "the Red Cross to continue saving lives because one day they could save yours.

"Given the wide variety of services considered charitable acts, charity should fund them. After five years of recession there is no funding, all charities are suffering. Nevertheless famine, floods and other disasters continue unabated.

"Victims cannot donate, circumstances have reduced them to penury," Gordon said.

Private doctors 'must aid poor'

LIBBY PEACOCK
Staff Reporter

ADEQUATE medical care can be provided to the disadvantaged only with the assistance and co-operation of doctors in the private sector, according to Ivan McCusker, Medical Association of South Africa (Masa) health policy committee chairman.

Dr McCusker said the implementation of free health care for pregnant mothers and children under the age of six, who were not covered by medical aid, could "overwhelm" a system which was "already overburdened and inadequately staffed".

But Masa shared the government's conviction that a large disadvantaged sector of the population was entitled to adequate health care.

And in an attempt to relieve the burden on state facilities, Masa commissioned experts in health care management to develop practical proposals for services to be provided by private doctors as well.

The association plans to present its recommendations to Minister of Health Nkosazana Zuma next month.

The proposal for private sector involvement, which Masa believes should be voluntary and affordable to the government, is being discussed widely within the medical profession.

An outline of the draft plan to involve the private sector in providing free health care to children under six and pregnant women include:

- Private practitioners, working from their consulting rooms, form the basis of the plan.
- A combination of payment mechanisms is recommended. Both the mechanism and level of payment must be seen as the medical profession's *pro Deo* contribution to the Reconstruction and Development Programme.

Health duties 'punitive'

HEALTH care products group Macmed had a broad portfolio of products that would allow it to survive the move towards low-cost health care, chairman Kobus Visser said in his annual review. BD Sday

The group provided imported and locally manufactured health care products to SA hospitals.

Visser said that focusing on locally manufactured bandages and dressings would allow the group to provide cost-effective products to the primary health care sector. But duties and surcharges on imported products would need to be assessed. (85)

BEATRIX PAYNE

"Punitive import duties make the cost of importing syringes prohibitive and we have requested the Department of Health and the Board on Tariffs and Trade to lower them." 27/7/94

The group intended to achieve an annual growth in earnings of 20%.

The group reported a 7% rise in earnings a share to 7,5c for the 15 months to March on a rise in operating income to R4,4m or an annualised R3,6m (R2,9m).

The group had not declared a dividend to maintain its low-gearing objectives.

Young SA drug 'guinea pigs'

CT 27/1/94

(98) (85)

By GLYNNIS UNDERHILL

YOUNG healthy South Africans were volunteering to be paid as guinea pigs for drug tests undertaken by local academic institutions conducting research for pharmaceutical companies.

Volunteers participating in these "clinical trials" can earn from R200 a day to up to R2 000 for a six-month trial.

Professor Otto Müller, head of the pharmacology department at the University of the Orange Free State, said most of the volunteers were students aged between 18 and 25.

"There is tremendous control over these clinical trials in South Africa," said Prof Müller.

The chairman of the Medicines Control Council, Professor Peter Folb, said yesterday that it was part of the code of conduct that clinic trials should not be seen to be providing "undue financial incentive".

R200 a day for 'trials'

All the big academic institutions in South Africa, including Groote Schuur and Tygerberg hospitals, were involved in clinical trials, Prof Folb said.

Prof Müller said the volunteers were paid as compensation for "inconvenience" but not for risk.

He was not aware of any healthy volunteer in South Africa who had died or been hospitalised as a result of a drug test.

Volunteers reactions had occasionally included fainting, a slight skin reaction, or in rare cases, vomiting.

LINDA ENSOR reports from London that hundreds of young South Africans travelling abroad were making easy money as guinea pigs for drugs tests at the city's Guy's Hospital.

They can earn £250 (R1 425) for a two night admission and £1 400 (R7 980) for a two-week stint.

A hospital spokesman estimated that about 1 500 people were admitted for drugs testing each year, most of them South Africans and Australians. She estimated that South Africans made up 40% of the volunteers.

Most were between 18 and 35 and were travellers in need of money.

Deterioration

Director of clinical research, Dr Dipti Amin, emphatically denied that the health of the young people was at risk.

She said that in all the years in which Guy's had undertaken this work, there had never been any legal action against it and no reports of a deterioration in health after the tests.

State cannot shirk primary health care

ARG 28/7/94

(85)

☐ Ideas must be swopped with communities

Staff Reporter

COMMUNITIES should be responsible for many of their own health care decisions, but this should never relieve the government of the responsibility of providing primary health care.

This is the opinion of Coen Slabber, director-general of health, who was speaking at the annual meeting of the Western Cape region of the Cancer Association of South Africa yesterday.

All too often the gap between the formal health sector and communities was the result of social or cultural "distance", he said. Communication and the exchange of ideas were important.

Dr Slabber said the association and the Department of National Health should prepare for "the new approach" and move closer as partners.

Cancer was one of the three biggest causes of adult death in South Africa, but cancer programmes had many flaws, including poor co-ordination between role players, the fact that programmes were inaccessible to a large part of population, ignorance in communities and limited community participation.

One of the six basic principles of the reconstruction and development plan was that it was a "people-driven process".

In the past in South Africa the theme of community action in health had met with a mixed response.

And the government had maintained that health and health care were best handled at a central level.

It had felt health care was a public service which could be delivered to people only by professionally trained staff, but this philosophy had limited opportunity for community action.

Conflict arose if a community believed initiatives were being generated from outside and were not consistent with their own feelings about what was needed.

● National Cancer Week, in which all six regional offices and 31 area offices of the association will participate, starts on Saturday.

The aim of Cancer Week, with the theme "Yes, Families can beat Cancer", is to heighten awareness of the association and its services.

The association said the role of the family in beating cancer was multi-faceted, starting with the creation of a healthy, smoke-free home environment.

Cancer Week activities will include:

● Exhibitions at various venues, including Milnerton Library, Hyperama N1 City, Montana Shopping Centre, Westgate Mall and Cavendish Square;

● The broadcast of programmes dealing with lifestyles, cancer and the family and emotional aspects of cancer on Radio Xhosa; and

● A terminal cancer workshop involving medical and auxiliary personnel.

For more information, contact the Cancer Association at ☎ 689-5347.

An Inkatha Freedom Party supporter in traditional Zulu dress prepares to photograph fellow protesters after marching on the SABC's headquarters on Saturday. Inkatha was calling for the SABC to cancel the screening of mini-series The Line, which Inkatha said portrayed its members in an unfavourable light. However, the series was screened. Picture: AP

Community health workers fear redundancy

B1Day

KATHRYN STRACHAN

THERE is growing concern among community health workers that with government's new focus on primary health care, their role will be subsumed by state employees.

This fear was fuelled when community health workers were dealt with in a single sentence in the ANC's health policy document.

Director of Alexandra Health Centre's urban primary health care unit Kim Goodman said the role of community health workers had not been fully explored, though they were often regarded as a panacea for all ills.

While they were trained to play a mobilising role in communities, they were usually treated as "one more pair of hands" in clinics, she said.

Community workers were usually trained by non-governmental organisations to make people more aware of health issues, and to ensure community needs filtered through to the health services. 118194

Goodman said community health workers had to be better utilised while more concrete career paths and remuneration packages had to be formulated for them.

They were an essential part of any primary health care programme, but this did not translate into support in practice. "Traditional health workers will not be able to take over their role," she said. "Community health workers will have to fight for that place; it is not automatic."

Health Department deputy director-general Hans Steyn said he believed community health workers should operate outside the state structure (85)

Omar outlines his plan for 'the truth'

CAPE TOWN — Detailed proposals for an eight- to 10-member truth and reconciliation commission were released by Justice Minister Dullah Omar at the weekend.

Speaking at an Institute for a Democratic Alternative in SA (Idasa) conference on truth and reconciliation, he said a major task of the commission would be to establish as complete a picture as possible of gross human rights violations between March 1 1960 and December 5 1993.

"The object of the exercise is not to conduct a witch-hunt or to haul violators of human rights before court.

"It is a necessary exercise to enable South Africans to come to terms with their past on a morally acceptable basis and to advance the cause of reconciliation."

Omar said he had considered representations to the Department of Justice, and media comments.

The proposal would be submitted to Cabinet. It suggested the commissioners, who should be impartial and not have a high political profile, be appointed by the President on recommendation of a parliamentary joint committee. B1Day 11/8/94

Three committees would operate under the commission, one dealing with amnesty and indemnity, one with human rights violations and one with reparations.

Omar said the deadline for offences for which applications for amnesty could be made was December 5 1993.

A precondition for indemnity or amnesty was full disclosure. Anyone given full, conditional or temporary indemnity, amnesty or immunity under the 1990 and 1992 Indemnity Acts would be deemed to have indemnity under the proposed new Act. (352)

The human rights violations committee would be expected to make recommendations to the President on a policy for reparations, restoring the dignity and honour of victims and for the rehabilitation of victims.

Omar said the commission would not have powers of prosecution or judicial functions. It would, however, have investigative powers, the power to subpoena witnesses and powers of search and access to documents.

Answers were sought on a number of issues, including whether hearings should be open, how extensive powers of the commission should be and whether perpetrators should be allowed to hold public office.

Omar said SA's approach was "more generous" than suggested by Amnesty International, which believed pardons could be granted only after conviction. — Sapa.

Call to revise health budgets

CT 2/8/94 (85)

Staff Reporter

A MAJOR revamp of Western Cape hospital spending has been proposed to make use of the limited funds available.

Hospital and health services assistent director-general Dr E A le Roux,said yesterday there should be a move away from expensive hospital-based services to primary health care programmes.

He said the province's health services were underfunded, and they were set to overspend their budget despite severe cutbacks. These included scaling down on spending and rationalising services wherever possible.

"What is needed is a complete revision of current expenditure

Prevention should be the focus

patterns, which are largely focused on curative, hospital-based services, and a realignment to more affordable, comprehensive primary care programmes which also serve the broad requirements of the Reconstruction and Development Programme," Dr Le Roux said.

Senior medical superintendent at Groote Schuur Dr D J Adams said yesterday budget allocations were well below what was required to maintain hospital services at their previous level.

'In terms of drugs available to treat patients, the hospital has no choice other than to restrict the use of certain expensive items," he said.

At the hospital's Lipid clinic, for example, there was a supply of medicines available each month to patients with inherited lipid disorder.

"Once the budget is exhausted each month any patients who need treatment have to be given the standard items available orhave to purchase the more expensive drugs themselves," Dr Adams said.

Health plan already running into problems

CT 3/8/94 (85)

JOHANESBURG. — PWV Health Minister Mr Amos Masondo admitted yesterday the plan to provide free health care to pregnant women and children under six has already run into problems.

Mr Masondo also acknowledged the provincial government had been caught unawares by the May 24 announcement by President Neslon Mandela, but said once the plan was public the ministry had moved immediately to implement it.

He said an increased patient load after the announcement had placed undue presssure on medical staff and auxiliary services and had caused a shortage of drug supplies and confusion amongst staff responsible for administering the programme.

The system had also been burdened by children over six presenting themselves for treatment.

Hillbrow yesterday. The children gathered at the centre for a lunch laid on by the provincial government. Picture: NICKY DE BLOIS

consequences.

PWV medical services 'swamped by patients'

BIDay 3/8/94

NOMAVENDA MATHIANE

PWV clinics and hospitals had been inundated with patients since President Nelson Mandela's promise on May 24 of free medical services to children under six years and pregnant women, PWV health minister Amos Masondo said yesterday.

Immediately after the policy was introduced there had been problems with the sudden increase in the patient load, up to 300% in some areas, which resulted in added pressure on staff and services.

While the situation had stabilised, the strain on the health system had been exacerbated by the beginning of a particularly severe winter flu epidemic.

But the numbers of pregnant women and children under the age of six taking advantage of the policy had almost returned to normal levels.

In Soweto's Zola township, 5 294 children had been treated in June compared with 1 839 in July. In Stretford at Orange Farm 1 752 patients were attended to in June which decreased to 868 in July.

Masondo said until the statistics had been analysed it was impossible to indicate the financial implications of the project.

"There is obviously the cost of lost revenue which would have accrued to the health services."

Drug costs had increased only marginally as very ill children would have received treatment in any case. The policy would also save costs in the long term by encouraging the early detection of pregnancy abnormalities or diseases.

The problems around the supply of drugs and staff shortages would be addressed through the envisaged rationalisation and restructuring of the health services.

In spite of the problems, Masondo said the PWV health ministry had been encouraged by the response to the new service.

Masondo said the primary school feeding scheme, also announced earlier this year, would be ready for implementation in the PWV by January 1995. (85)

The business community and other stakeholders were expected to help in the delivery of the scheme, he said.

Sapa reports that Dr Ralph Mgijima, a member of the strategic management team advising the provincial health ministry, said: "The institutions and resources needed for the plan do have problems but in the long term very concrete solutions should be found.

"These include a greater emphasis on primary health care."

Masondo said the programme should be seen in the context of the reconstruction and development programme designed to address poverty, under-development and disparities in society.

King calls for peace in KwaZulu/Natal

ZULU King Goodwill Zwelithini yesterday appealed to people in KwaZulu/Natal to stop killing and to start protecting each other. BIDay 3/8/94

He said he was concerned about a surge in violence in the province which was hampering reconstruction. Investors would avoid KwaZulu/Natal unless they were assured their money was safe.

KwaZulu/Natal premier Frank Mdlalose appealed to business in the province to help create an environment which would curtail violence.

Addressing business people in Durban, Mdlalose said the top structures of all political parties in the region were determined to counter violence. (276)

"Rogue policemen, hit squads, people's courts, banditry, revenge killings and any form of taking the law into one's own hands has no political support in this region.

"Anyone, no matter how high an office he or she holds, or in what estimation they are held by their supporters, who takes the law into their own hands can expect the full wrath of the authorities."

But crime and violence could not be eliminated while the region was beset with "ignorance, poverty and deprivation".

He appealed to the business community to develop an economy that would offer the necessary business opportunities, jobs, schooling, health care and housing.

With the "magnificent" resources and potential KwaZulu/Natal possessed, "all we need is the elimination of the scourge of violence to ensure an economic miracle", he said. — Sapa.

Holomisa seeks leadership, resources for environment

Political Staff

LAUNCHING SA's first Tidy Town project yesterday, Deputy Environment Minister Bantu Holomisa called on the non-governmental sector to provide leadership and resources in environmental protection.

The former military ruler of Transkei said that littering was a greater social evil than most people realised.

Holomisa, who was appointed a patron of the Keep SA Beautiful campaign,said conservation was a low priority in SA.

"I anticipate the present government will also be subjected to powerful pres-

few years with the greater influx of people into urban areas.

"Other reasons such as the lack of environmental awareness and education programmes, complexity of the socio-economic situation in our country and fragmentation of existing control measures have complicated the problem."

Holomisa said yesterday that the provisions of the Basel Convention governing the trans-boundary movement of hazard-

6-18

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Feeding scheme final report

By Mokgadi Pela

THE Provincial Technical Task Team charged with investigating the implementation of the feeding scheme for pupils will table its final report to the PWV ministry of health on Saturday.

Announcing this, MEC for health Mr Amos Masondo said his ministry would urge the business sector to provide funds to ensure the success of the project.

He said the scheme would contribute to improved learning capacity among children; encourage better school attendance; and lead to improved nutritional status among school children and communities through linkages to development.

Masondo said further consultation would take place to ensure that schools and communities would take over delivery of services in January 1995.

The programme would target farm schools. Those serving disadvantaged communities would be phased out, he added. On the extension of free health services to pregnant mothers and children under six, Masondo said the ministry was encouraged by recent extensive use of these facilities by "people who were previously denied access to such basic items".

"Any costs of policy must be weighed against the medium to long term benefits to society. Early detection of abnormalities saves the cost of more severe diseases later on," Masondo said.

Health sector non-governmental organisations' representatives Frank Sibeko and Judy Fortuin discuss the role of these bodies in the reconstruction and development programme, at a conference in Johannesburg yesterday. Picture: ROBERT BOTHA

Health groups lobby for more influence on RDP

NOMAVENDA MATHIANE

HEALTH sector non-governmental organisations agreed yesterday to lobby government for a more important role in the reconstruction and development programme.

At a meeting of 45 organisations in Johannesburg yesterday, delegates said they were concerned that their contributions to the RDP, as well as access to funding, would be overlooked as as result of competition from the public and private sectors.

National Progressive Primary Health Care Network representative Judy Fortuin said non-governmental organisations were better suited to the implementation of the RDP than the public sector as they were more in touch with grassroots organisations and conditions and could better represent disadvantaged communities.

"If the RDP is about the alleviation of poverty, which would solve our health problems, the bottom line is to make sure that the end receiver is best represented."

An interim committee was nominated at yesterday's meeting to represent health sector non-governmental organisations at a RDP summit later this month. It was mandated to investigate the organisations' role in the RDP.

Through the committee, these organisations would provide government with their vision of the implementation, priorities and issues of the RDP.

Government would also be presented with a non-governmental organisations policy framework concerning their niche and role within the RDP and their relationship with the state and civil society.

(85)

Government is leading to hospital crisis

Shortcomings in health care exposed

By Mokgadi Pela

HEALTH Minister Dr Nkosazana Zuma feels the extension of free health care to pregnant women and children under six has helped expose the inadequacies in the country's health care system.

"This move has shown that we have too few clinics or none at all in many places, that some clinics close too early and that health care costs have been prohibitive to many people."

Zuma, in an interview with *Sowetan*, said she felt most health workers welcomed State President Nelson Mandela's call for the extension of free health care to pregnant mothers and children under six.

She acknowledged, however, that health workers could be working much harder since the announcement was made on June 1.

Zuma said the budget allocated to health prevented them from meeting some of the expectations. She said the Government was taking all the concerns seriously and would act on them.

"I am confident that in the long run we will reap the results as people visit clinics early. We will then ensure prevention of diseases with immunisation," Zuma added.

R6 m health project has heart and Soul

(85) ARGS 8/94

Health Reporter

A R6-million multi-media community health project — the first of its kind in the world — reaches fruition in The Argus on Monday with the publication of a primary health care series.

The eye-catching colour graphic series, which will appear daily on the front page of The Argus Classified section, is linked to the CCV television programme *Soul City* and a radio drama series of the same name.

It is aimed at communities which have been deprived of basic health education, but the series will be informative to a wide spectrum of people in need of health care information.

The Argus has joined the venture as part of its newspaper-in-education commitment and in the interests of community welfare.

SOUL CITY
COMMUNITY HEALTH PROJECT

The project kicked off this week with the screening of the first episode of the innovative squatter camp soap opera *Soul City*, which has been received with acclaim. The first episode — which will be repeated on CCV tomorrow at 1pm — portrays a young mother's personal story, and it tackles two of South Africa's most serious child health issues: the high infant mortality rate and diarrhoea.

These issues — and how to solve them — will feature next week in The Argus' daily serialised *Soul City* material. Other issues to be dealt with in the weeks ahead include child abuse, accidents, immunisation, breastfeeding and nutrition.

The Argus' *Soul City* pages will be ideal for collecting, cutting out and posting on workplace notice boards, or passing on to friends or employees who may benefit from the information.

'Intervention needed in health sector'

KATHRYN STRACHAN

INCREASED state intervention is needed in the inefficient private health sector to improve its service to the community, says Johannesburg City Council health executive director Eric Buch.

He said that although the private health sector would continue to grow, it had to become more a part of the public health sector.

The private sector was extremely inefficient, he said, and state intervention was necessary as the expensive technology and procedures in private hospitals contributed to an overall escalation of health costs.

Intervention was necessary because in health care the service provider decided what the consumer needed. This did not happen in any other industry.

Buch believed this state intervention would be supported by companies. There was a new interest from corporations in health care costs as workers' demands for medical cover began to affect the total wage bill. As organised labour campaigned for medical benefits, companies' wage bills were being pushed up by the medical component, and companies were calling for greater efficiency.

The rate at which the private health sector grew would depend on the strength of trade unions and whether the inclusion of medical aid cover in pay packages was extended to the black community said Buch.

However, medical aid administrators had begun to target organised labour. Buch believed this could result in a trend of more people entering the private health sector, and of improved efficiency in this sector.

Buch said this trend would also affect the pharmaceutical industry, which would have to increase its cost-effectiveness and come up with a more concrete contribution towards achieving a more efficient health care system.

PWV health minister Amos Masondo, right, addressing a health conference at the Johannesburg Hospital yesterday. Listening intently were delegates Dawn Joseph and Malcolm Brown.

Pictures: ROBERT BOTHA

PWV parties discuss future health service

Bibby

11/8/94

NOMAVENDA MATHIANE

PWV politicians, doctors, health workers and members of the public met in Johannesburg yesterday to devise a programme for restructuring health services in the province.

Opening the conference, PWV health minister Amos Masondo said the most urgent task for his department was the establishment of a new administration which would determine priorities for the delivery of health services to all the inhabitants of the province.

Dr Ralph Mgijima said there was "too much duplication" in health services and this created confusion.

In the PWV region there were three bodies doing the same work — the Transvaal Provincial Administration, the National Health Department and local authorities.

(85)

Mgijima said current legislation would have to be studied with a view to determining which functions were to be performed by which tier of government.

Legislation needed to elaborate on the functions of departments. "For instance, we would need to know if environmental health issues are to be dealt with at national or regional level."

Among the strategies to improve health awareness among people was to promote community participation in the form of outreach programmes and health forums.

There would also be "right to health" programmes aimed at educating the public on its right to health services.

"The people-driven approach to health care means members of the community will take charge of their lives and decide what (facilities and services) they need, and where."

Members of a community would be asked to decide where clinics should be built and whether they ought to concentrate on primary care.

health

Healthy state of affairs

South 12/8 – 16/8/94 85

FREE HEALTH care is available at all state hospitals and clinics to all children under six and all pregnant women who are not on medical aid, no matter what they earn.

This follows the implementation of the ANC's health plan on June 7 for children and on July 1 for pregnant women.

The plan for children allows for most kids under two to be weighed regularly to progressively reduce the number of children who are under-weight for their ages.

It is hoped that by 1997, 90% of all children will be immunised against measles which is still one of the biggest child-killers in the country.

And polio and neo-natal tetanus is expected to be eradicated by 1999.

By the end of 1995, 50% of all babies will be delivered under hygienic conditions and under the supervision of trained medical personnel.

An awareness campaign is under way, aimed at encouraging breastfeeding for at least the first six weeks after birth.

By the end of 1997 at least 70% of mothers, it is projected, will be breastfeeding their babies.

SHANNON NEILL

Health services link-up urged

Star 12/18/94

Delegates to a conference on PWV health services yesterday called for the immediate amalgamation of various health services in the province and the restructuring of management.

The two-day conference was held at Johannesburg Hospital under the auspices of the PWV Health Department's strategic management team.

The delegates included doctors and representatives of health institutions, community organisations and unions.

They also recommended that urgent attention be given to the AIDS epidemic.

Strategic management committee chairman Dr Ralph Mgijima said AIDS education would begin at schools within eight weeks, and condoms would be issued to the public.

"The building of clinics as well as feeding schemes will also be given urgent attention in all regions," he said.

Funding will come from central Government and other bodies, as part of the Government's Reconstruction and Development Programme. — Sapa.

(85)

R3,2bn to cut health backlogs

(85) CT 15/8/94

JOHANNESBURG. — It would cost South Africa R3,2 billion over the next five years and R875 million in capital spending to redress inequalities in health facilities, Health Ministry adviser Dr Olive Shisana said.

Addressing an annual general meeting here yesterday of the South African Medical and Dental Practitioners on their role in implementing the RDP, Dr Shisana said this spending excluded the R14bn spent annually to provide health services in the private and public sectors.

She said the provision of health care was in a crisis and health services were so fragmented they failed to meet the basic needs of the population.

She said the health department had started integrating the fragmented health services in the nine provinces and hoped to merge them into one health department by the end of the year.

Earlier, Health Minister Dr Nkosazana Zuma told delegates a large number of practitioners were leaving the country and that the health authorities were addressing this. — Sapa

Health care to benefit from pharmacy grant

(85) CT 16/8/94

THE private sector should make a significant contribution to university funding to maintain adequate training facilities, particularly for health care.

This was said by Don Bodley, group chief executive of Adcock Ingram, during a function at the University of the Western Cape where Adcock Ingram and its sister company Logos Pharmaceuticals committed R1,2-million to the development of a pharmacy laboratory at the university.

The School of Pharmacy at UWC is the only pharmacy training facility in the Western Cape.

The laboratory, which can accommodate 60 students a week, includes a dispensing practice monitoring area with five cubicles for post-graduate students and a simulated pharmacy laboratory with a patient counselling area.

Mr Bodley said pharmacy was not only the custodian of medicine but had a key role to play in the provision of primary health care.

"Unfortunately pharmacists have traditionally established themselves in urban areas. This means that their badly needed services have been largely inaccessible to rural and disadvantaged urban communities.

Responsibility

"UWC's pharmacy school is proactively addressing this problem and is setting an example through its community partnership programme with impoverished communities throughout the Western Cape.

"At the same time the university is instilling a strong sense of community responsibility among its graduates."

The grant should help to strengthen this approach, as well as the pharmacy school's commitment to national health research and the development of a drugs policy, he said.

The head of the pharmacy school, Professor Peter Eagles, told people at the function that the grant would benefit pharmacists and ultimately the community, leading to a balanced and improved health care service for all.

"We are looking for greater synergy with the private sector and need to draw the pharmaceutical industry into the education process to fully use its expertise.

Innovators

"Instead of merely going around cap in hand, we would like to offer academic guidance and provide, where possible, the necessary human and physical resources.

"We see pharmaceutical companies as constant and dynamic innovators. It is therefore important for us to be part of this technology transfer process."

Prof Eagles added that there was an urgent need for the pharmaceutical industry and all tertiary educational institutions jointly to examine the contribution they could make to primary health care.

"The pharmacy school of UWC is intent on improving the scope of skills of pharmacists to the benefit of the disadvantaged communities of the Western Cape," he said.

"It is vital that the communities see a transfer of our skills to where they are most needed. We are therefore researching their needs so that we can adapt our training programmes where necessary."

Rising costs will shape future medical services

KATHRYN STRACHAN

THE future of SA's private health sector in its present form was limited unless it succeeded in keeping costs down, Health Department director-general Dr Coen Slabber said last week.

Resistance by employers to ever-rising health care costs could force the department to adopt a more rigid system in which the major players would be big business and not the medical profession.

He said private hospitals were one of the fastest growing expenditure items, mainly because only "five-star" hospitals were being built. Last year 18% of all benefits were paid for hospitalisation, but if hospitals were built at a cost of R300 000 a bed it was inevitable that high fees would be charged. However, "three-star" hospitals should also be available to those who wanted a less expensive service.

Slabber added he had severe reservations about the ethics in many of the country's private hospitals. By providing cheap or even free consulting rooms, private hospitals had a hold on medical practitioners that could only be to the detriment of the patient.

The private hospital associations had to ensure that market-related rents were charged and that doctors could not lose their rooms because they were unable to provide enough patients for a particular hospital, he said.

The escalating costs in the private sector could also be attributed to over-servicing in private hospitals. An all-inclusive tariff was needed in hospitals as the present system of charging per item led to unnecessary items being added to inflate accounts.

The pharmaceutical sector also came under fire for failing to co-operate in keeping down prices. Slabber said it was still possible to buy some medicines manufactured in SA cheaper in neighbouring countries.

Another factor was the constant undermining of the general practitioner. Over the past decade, benefits paid out by medical schemes to GPs had dropped from 17,2% to 11,5%, he said.

Laws 'exacerbating health sector failure'

Bidey 17/8/94

KATHRYN STRACHAN

PROBLEMS caused by the failure of the health market were made far worse by government regulation, Prof Duncan Reekie, dean of Wits University's faculty of commerce, said in a presentation of the Melamet report.

Reekie, a member of the commission, said the Melamet commission into providing for medical expenses gave the health industry a chance to break from monopoly distortions.

The proposals of the report had been successfully applied in other countries, he said.

Reekie cited examples of monopoly distortions in SA which had resulted in stifling of innovation and a reduced search for lower cost or higher quality alternatives.

The first was that the pharmacy profession insisted, with legal backing, that manufacturers have a pharmacist as MD, that retailers not have their equity owned by non-pharmacists and that only pharmacists dispense medicines.

The advent of CEOs above the MD in the manufacturing sector, an excess of small, low-turnover retailers with mark-ups over 50%, the absence of corporate-owned multiple chains in pharmacy and an explosive growth of dispensing doctors attempting to undercut mark-ups epitomised distorting effects of monopoly.

It illustrated that moves to stamp out competition resulted in its reappearance — not necessarily in the desirable form — elsewhere.

The ability of doctors to preserve legislation which prevented pharmacists from dispensing medicines without prescription also illustrated regulation-protected monopoly.

The Melamet report proposed those able to contribute towards their health be compelled to, at least with respect to minimum care.

Other proposals were that the system be structured so that perverse incentives to reduce quality and increase costs of care were eliminated.

The report also said that there should be as little disruption as possible to the system when reforming it, and it should be both affordable in the short-term and sustainable over the longer term.

85

Crackdown on medicine costs

ET 18/8/94

(85)

'Drastic' steps in the offing

THE government yesterday vowed to take "drastic steps" to crack down on the rocketing cost of medicines — including installing price control to stamp out profiteering.

Health Minister Dr Nkosazana Zuma told Parliament that she was alarmed that the costs of medicines had soared by 37,2% from 1990 to 1991 and by a further 39,1% from 1991 to 1992.

Speaking during a mini-debate amid calls from parties across the spectrum for drastic action to curb costs, the minister said that in the public sector — where buying was done in bulk and on tender and mostly generics were used — the cost of medicines was 9,9% of total health spending.

But in the private sector 31,8% of benefits paid by medical aid schemes was for medicines.

Dr Zuma said a departmental committee had been established to look into this "serious problem" and develop a new pharmaceutical policy that would include cost-cutting measures for the price of medicines.

Earlier official probes had recommended that pharmacists and dispensing doctors should be paid dispensing fees rather than by the mark-up system which served as an incentive to use more expensive medicines.

The committee could look into this and consider reintroducing price control.

Its brief included developing a pricing plan, an essential medicines list for the public sector, increased use of generics and improved medicine distribution in rural areas.

"I hope this house will support me when we have to take very drastic steps, because we can't solve this problem unless very drastic steps are taken," Dr Zuma said.

Mr Farouk Cassim (IFP) said the costs of medicines were "moving into orbit", with prices about 600% higher than in India. Cheaper medicine could be bought in Swaziland.

Mr Mike Ellis (DP) said medicine wholesalers put a 21,3% mark-up on prices paid to manufacturers, and retail pharmacists added another 50%, often adding a dispensing fee and a 10% broken bulk fee as well. — Political Staff, Sapa

Pledge to curb soaring costs

Zuma warns of medicine price control

Star 18/8/94

■ **BY CHRIS WHITFIELD**
POLITICAL CORRESPONDENT

Cape Town — Health Minister Dr Nkosazana Zuma has warned of "drastic steps" to curb soaring costs of medicine — including possible price controls and changes to the "monopoly of pharmacies". (95) (85)

The Minister signalled in a mini-debate in Parliament yesterday that she intended tackling the issue vigorously.

Zuma was responding to MPs' charges that some pharmacists were engaged in profiteering and that prices in South Africa were vastly more expensive than those around the world.

She revealed that her department had set up a committee which would thrash out a pharmaceutical policy.

One of its briefs would be to develop a "one price" medicine scheme for both the private and public sectors.

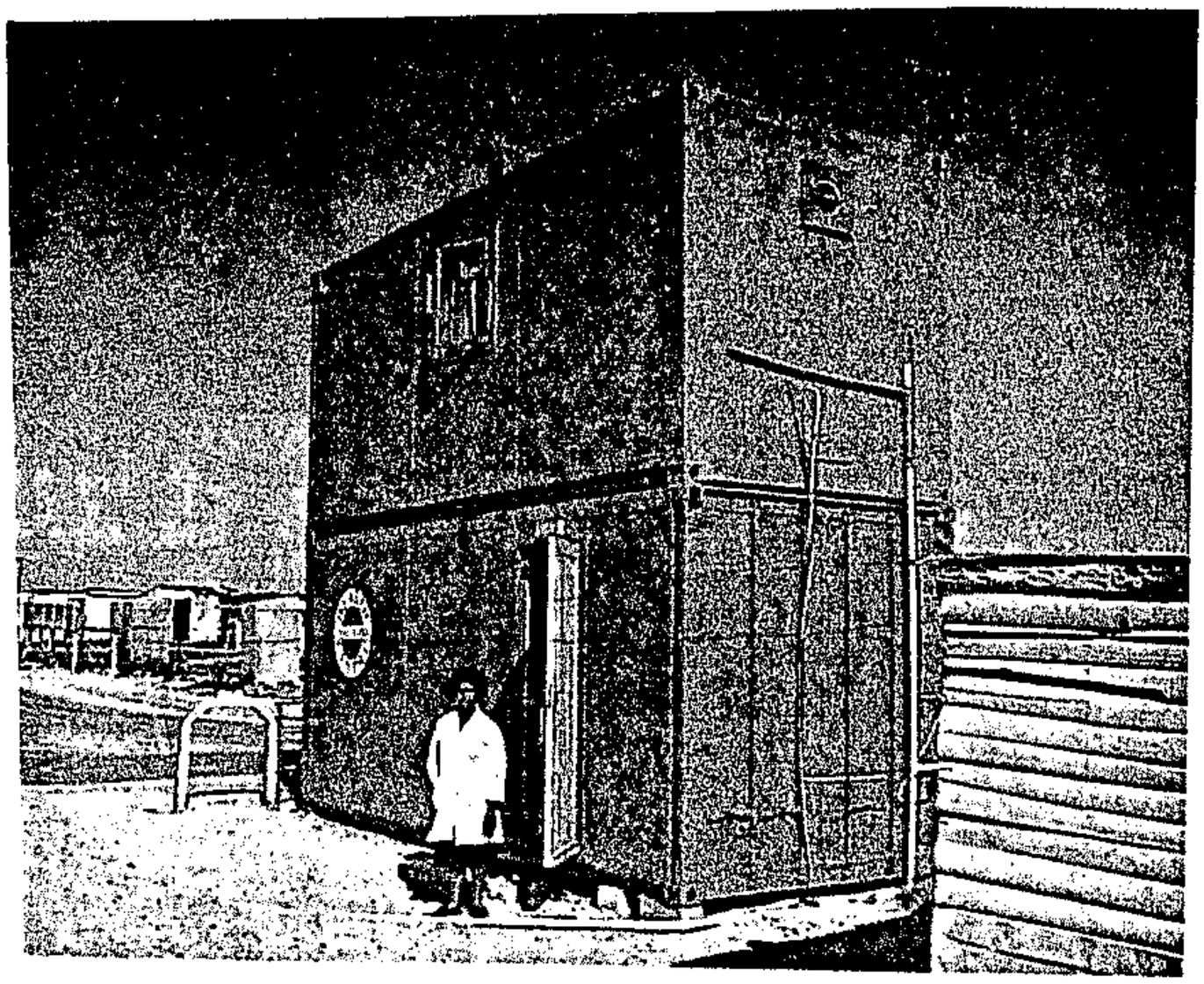
Other tasks of the committee would include compiling an essential-medicines list for the public sector and considering strategies to increase the use of generic medicines.

"We may have to look at reintroducing price control," the Minister said.

IFP MP Dr Dennis Madide said: "The problem is purely and simply profiteering."

Fellow IFP MP Farouk Cassim said medicines in South Africa were 120 percent more expensive than in the US and 600 percent more than in India.

Democratic Party MP Mike Ellis said wholesalers put a 21,3 percent mark-up on medicines and then retail pharmacies added a 50 percent mark-up.



NTAINER CLINIC ... A township health centre in a "double-decker" shipping container

Containers keep people ship-shape

ST Times Kimetro
28/8/94

By FRED ROFFEY

A MOWBRAY-based organisation, has launched a primary health care operation with the establishment of 11 franchised health centres in Khayelitsha.

Saafroma (South African Association for Relief of Medical Ailments), has plans to establish 50 health centres in Cape townships and another 50 nationwide by the end of the year — many developing into new township billboards as company advertisements appear on the container-built structures to help pay for the costs.

The aim is to franchise health centres in underprivileged areas and staff them with local residents who have been trained as primary health care practitioners. (85)

They will also be taught basic business skills such as product knowledge and stock control.

The centres will be linked to the formal health care sector and provide a meeting point for mobile health clinics.

Saafroma is building the centres from refurbished Safmarine containers, with one container stacked on top of another to form a double-storey unit.

The upper is used for living accommodation, while the downstairs container consists of a first aid station complete with hot and cold water, examination plinth, curtain for privacy and a retail section for the sale of toiletry items and nutritional foods.

The new outdoor advertising opportunities are expected to attract strong demand, as Saafroma has received many serious enquiries from outside the Cape and plans 250 centres by the end of 1995, with a total of 500 by the end of 1996.

Primary health system for 1995

(88)

Own Correspondent

JOHANNESBURG. — A national primary health care system would be in place early next year, creating at least 10 000 jobs by October 1995 at a cost of R540 million, Health Ministers said on Friday.

Western Cape Health Minister Mr Ebrahim Rasool told a European Union-organised foreign donors' workshop in Pretoria that 600 clinics and health centres would be built.

Mr Rasool criticised the "hierarchical structure" of existing health care, saying the people most in need of primary health care were those most alienated by the current system.

Addressing the same workshop, Health Minister Dr Nkosazana Zuma appealed to foreign aid agencies to provide bridging loans to finance the primary health care infrastructure. CT 29/8/94

The R14 billion budgetary allowance for health would not cover the capital costs of new infrastructure unless funds were diverted from hospitals.

Savings gained from professional management of hospitals, which were currently run by administrators with medical rather than business training, would not make up the balance, she said.

Primary health is ...

(85) WM 29/7-4/8/94

A clear, blue vision of the future

A blue train is slowly chugging around South Africa but Phelophepa is no ordinary train, reports **Mapula Sibanda**. It brings primary health-care to thousands of rural people

AFTER the spectacles were placed on her face, the old woman blinked, then beamed with joy. Earlier she could not even see the letters on the board used to test her eyes.

"Now that I have my eyes back, I can start weaving my mats again," said Sophia Leshega (70). A farm labourer from Roossenekal, Eastern Transvaal, she is one of thousands of mostly rural people who have benefited from a unique initiative, *Phelophepa*, the world's only primary health-care train.

***Phelophepa* — which translates into "clean health" — started tracking across the country last January. Custom-built by Transnet as part of its social responsibility programme, *Phelophepa* began life as three coaches devoted to providing eye-care. Some 30 000 people, mostly elderly with cataract problems, received treatment between January and June. Now, more coaches have been added to offer a range of health services.**

When *Phelophepa* pulled into the Eastern Transvaal town of Roossenekal last week, it looked just like an ordinary train — except for its bright blue paintwork. But a tour of its 13 coaches revealed a hospital on wheels.

There are two eye-care coaches and a pharmacy coach, which has specially fitted cabinets to store medicine safely while the train is moving. Two other coaches, their walls plastered with posters, serve as clinics. Others provide storage, space for staff to eat, sleep and do administrative work, a laundry, a kitchen and power for electricity.

"I can light up the whole of Johannesburg with these generators and the two diesel tanks that you see in this power car," said train manager, Ginger Terblanche, with pride.

Apart from Terblanche, the train is home to about 30 people, including 10 trainee community nurses, 17 final-year optometry students from the universities of the North, Durban-Westville and RAU, a lecturer and a full-time community nurse. All are looked after by eight Transnet employees, including a cook who used to work on the Blue Train.

Outside, shaded from the winter sun by a blue tent, a handful of patients sat waiting to be seen to. "This is the poorest attendance since the train began its trail," said community nurse Marietjie Bester. "At all the other stations there were about 200 people a day."

But for the people of the area, *Phelophepa* was answering a much-felt need for health facilities. Most of those who visited the train on Friday had walked from farms as far as 20km away. Usually, residents of the district are forced to travel up to 50km to Middleburg for medical attention.

Sophia Leshega paid R40 to have her eyes tested and the price included the cost of the spectacles she was given to correct her vision. Immunisation, health education and basic tests are carried out for free, while medication is dispensed at a flat rate of R5. Serious cases are referred to the nearest hospital.

While *Phelophepa* has touched the lives of people living in remote rural areas, it has also touched the hearts of those working on it.

RAU final-year optometry student Karen Vorster (22), told how she joined the train's team because she thought it would be an adventure; she also had to do a compulsory practical to finish her degree. "It was only after being on the train that I realised the need for health care facilities in rural areas," she said. "The appreciation that people display after you put the spectacles on their faces is quite amazing. I have seen old people get down on their knees with gratitude and was deeply touched by the gesture.

"*Phelophepa* has touched the lives of so many people, including myself. "My attitude towards black people warmed when I learned from them the beauty of appreciating the small things in life."

Brighter future ... Sophia Leshega will now be able to weave her mats again

PHOTO: RUTH MOTAU

During her days working on the train she's also seen something of the countryside — and eye diseases she'd only learned about in theory. "Many are caused by the pollution (from fires and dusty conditions) in rural areas," she said.

After stopping at more than 24 stations across the country, testing an estimated 23 000 patients and issuing 11 721 pairs of spectacles, *Phelophepa* is still to visit 10 more areas. Journey's end will come in September, when the train will be sent to Transnet's engineering wing in Bloemfontein for renovations and refitting in preparation for its next journey, planned for 1995.

***Phelophepa* provides more than basic health-care for people in far-flung rural areas. For people like Sophia Leshega, who can now see to weave the mats she sells, it brings a new vision of the future.**

'Health system for all is not possible'

BDay 7/9/94

KATHRYN STRACHAN

WITH SA's level of development it was impossible to consider a health system that could cover the entire population, said Wits Centre for Health Policy researcher Alex van den Heever.

He said the challenge facing health systems was to find a mechanism for ensuring extensive and equitable coverage for the entire population, while avoiding potential negative factors.

Funds for general development were thinly spread and consequently the funds were not available for universal coverage to be a serious option.

However, within existing constraints, much could be done to ensure that, at least, every person had access to basic minimum care within the public and private sectors.

He said the fundamental principles a future health system should comply with to be consistent with this goal were that people unable to pay towards their care in terms of the minimum level of care should be funded by the state.

And all who were able to contribute towards their health care should be compelled to do so — at least to a minimum level.

Van den Heever said the system should be structured so that perverse incentives that served to reduce the quality and increase the costs of care were eliminated, and that there should be as little disruption as possible to the system when it was being reformed.

Endemic cost increases in the private health sector had to be contained to the extent that they at least converged towards those of the rest of the economy.

Private health expenditure had increased by 121%, the public sector by 3%, and health expenditure as a whole by 31% over the past decade.

Van den Heever estimated that per capita spending would more than double by the year 2003 if trends continued. Overall health expenditure expressed as a percentage of GDP would increase to 9,39% by 2003, exclusively as a result of increased private health expenditure. Health services, however, would not change much.

It was clear that this situation was unsustainable in the long term, he said. Such cost increases would result in fewer and fewer people being able to afford private health care, and the burden of caring for these people would fall on the state.

The first groups to fall out of the private sector would be high-risk categories, such as the old and chronically ill. This would place a significant additional burden on the state.

Van den Heever said government intervention was required to prevent this from happening. This would entail integrating aspects of the private sector service with the public sector, and integrating and reforming funding mechanisms to ensure adequate risk-sharing and cost containment.

In discussing the possible extension of the private sectors, he said too few people were employed in the formal sector for any form of medical insurance to cover the entire population.

On the other hand, extending the public sector to the extent of nationalising the private sector would be catastrophic, and would miss the opportunities for redirecting the private sector towards more socially desirable objectives.

Consequently, both sectors had their place. It was just a matter of restructuring relationships and incentives.

Hospitals strike threat

BDay 7/9/94

KATHRYN STRACHAN

THE Hospital Personnel Trade Union of SA (Hospersa) yesterday threatened "serious action", which could include strikes, if government did not respond to its demand for next year's wage increases.

The union, which represents 180 000 public servants, as well as other public sector unions, walked out of negotiations last week after the state showed "bad faith" in trying to discuss rationalisation of the public service instead of following the agreed agenda of wage increases.

Hospersa director Nita Ceronio said the union had lowered its demands to a general salary adjustment of 15%, and an increase of the minimum wage to R1 500 a month. This represented a total drop in the union's demand from R16,1bn to about R8bn.

However, the union also objected to the fact that the state appeared to be giving higher priority to rationalisation than to wage negotiations and stability.

Ceronio said that in integrating the homeland public services into a national structure, parity in terms and conditions of service had to be established.

Unless the state responded to these demands by the next session of negotiations, beginning on September 19, employee organisation would consider far-reaching action, she said.

Independents set radio broadcast deadline

BDay 7/9/94

AMANDA VERMEULEN

INDEPENDENT radio broadcasters have vowed to take to the airwaves on October 1 if attempts to end the deadlock with the Independent Broadcasting Association (IBA) over commercial licences is not resolved on September 12.

Station manager of independent radio station Solid Gold, Cal Kennedy, said yesterday the Independent Broadcasters' Committee would meet the IBA next Monday in a final effort to resolve the problem.

"If no common ground is achieved, committee members will probably begin broadcasting on October 1."

He said the author of the Broadcasting Act, attorney David Dyson, had admitted it was a mistake, therefore Parliament should intervene to "save what has become a farce".

Committee members would invoke their constitutional rights to freedom of the media as the situation was now beyond a joke, he added.

"In every country in the world where an IBA has dragged its heels, broadcasters were forced into piracy. We will not pirate but will be forced to resort to invoking our constitutional rights."

Meanwhile committee chairman Tony Sanderson has launched another scathing attack on the IBA, criticising its "disregard" for the expertise that local broadcasters had made available to them by importing foreign consultants to advise them.

He called on the IBA to consult the committee on technical matters in order to avoid further delays in the granting of licences.

"This issue is of vital importance to the broadcasting industry and cannot be dealt with by an IBA with limited experience," he said.

Hardware that keeps you healthy

Star 8/9/94

NETWORKED NURSING

Computers are being put to use in the Free State to enable primary health-care nurses to better manage and involve the communities under their care. Health Writer **DAVID ROBBINS** reports.

The setting is a flat landscape in the rural Free State. A minibus stands in the middle of a collection of houses occupied by farm workers and their families.

Inside the minibus is a wash basin, a blood pressure machine, a cupboard of basic medicines, and a highly qualified professional nurse.

There's nothing unusual about this small primary health-care (PHC) service unit: there are well over a hundred of them in the Free State alone.

But look again. What is new is the cigarette lighter socket installed in the rear of the vehicle. It's not that the nurse, Helene Palmer, smokes (she doesn't); it's simply the most convenient way of powering the small computer which is rapidly becoming part of her basic equipment.

Palmer is part of the pilot PHC/Info Project — jointly launched by the Free State health authorities and academics at Free State University's Centre for Health Systems Research — which could soon result in the transformation of the management of health services throughout the country.

Data base

The capabilities built into Palmer's notebook computer are impressive. Experts from the private sector are designing software which will give Palmer, her head office in Bloemfontein, and ultimately a national data base, the sort of information required for effective management.

Palmer's working week consists in moving from point to point in scattered farming communities, keeping a detailed record of health and environmental factors such as availability of water and sanitation, and also of providing basic health care.

Instead of transporting armfuls of files around on every trip, the tiny computer is capable of holding all this and more. At the flutter of an electronic mouse, individual patient records appear, as do medicine dispensing and stock records, community profiles at all the stopping points on Palmer's complex routes, as well as immunisation and notifiable diseases records.

Mobile medicine . . . Sister Helene Palmer attends to patient Anna Kikera while the mobile clinic is parked at the cattle post Rooisteen, in the Dealesville district. PICTURE: CHARLES CORBETT

"The trouble in the past," says Joan McKenzie, senior nursing manager in charge of PHC information services in the Free State, "has been that our data collection has tended to be time-consuming and also irrelevant, based more on directives from Pretoria than on local needs.

"Often these directives were based on funding purposes, having nothing to do with local management concerns."

The direct benefits to Palmer in the new system are obvious. Time is saved by using the computer to collate information which nurses themselves have helped to compile.

But these benefits are vastly amplified when looked at from the point of view of Palmer's head office in Bloemfontein. Once information from scores of clinics is safely in a central data base (**see companion article**), the regional pictures, and finally the provincial picture, will become much clearer.

In the words of Dalene Grobler, nursing services manager for the southern Free State region: "I suppose we've always had the information in some file or other, but the problem has been accessibility, and also to get at it in time to influence our managerial decisions."

Nor is the provincial picture the whole story. In common with many developing countries, South Africa has no clear and accurate picture of even its basic health status indicators.

Elements such as infant mortality and life expectancy rates are educated estimates, but there has been no way of knowing how this or that intervention would impact on such rates.

Given the financial constraints on health spending already evidenced in the current budget, accurate information is going to be crucial if the health elements in the RDP are to be properly monitored.

For example, what impact will potable water for all have on gastro-related diseases? Another example: what are our immunisation levels, and at what rate are we improving them?

A national task group will be set up in the next month to establish the set of minimum data necessary to monitor the progress of the RDP.

Health data will obviously be an important component of this data set, and it is clear that the information system currently being pioneered in the Free State will feature prominently in the task group's deliberations.

So the core of the system's usefulness is threefold: it can link in to a national data base for the accurate monitoring of countrywide initiatives; it will be a vital tool in clinic-level health management, including the provision of information necessary for community participation; and, if coupled with improved financial reporting, it could revolutionise health financial management at the provincial level.

Henk Vernhout, a Bloemfontein accountant and consultant for the PHC/Info Project, sums up the initiative so far:

"We found that senior staff were spending around one-third of their time on paper work, trying to extract necessary financial information from various sources. We have worked to reduce this effort, and to keep the system as simple as possible. There's a long way to go, but I believe we're laying a solid foundation."

Health services in crisis

CT 9/9/94

By CLAUDIA CAVANAGH

HEALTH SERVICES in the Western Cape are crumbling with patient numbers rocketing due to new government policy, stringent budget cuts and untenable staff problems.

A Cape Times investigation has revealed that:

- Next year's budget for the region has been cut to R1,6 billion — 13,6% less than the projected expenditure for the current year.
- New government policy on free care for children under six and pregnant women has led to overcrowding, long waits and angry patients.
- Staff morale in hospitals and clinics is at an all-time low.
- Many skilled people are leaving for the private sector.
- Western Cape hospitals and clinics are understaffed by 12,3%.
- Twenty-six medical officers' posts at day hospitals in city townships are vacant due to lack of applicants.
- A plan to address the crisis has been put in motion by the province.

Red Cross Children's Hospital medical superintendant Dr Rod Marshall said the number of patients seen at the trauma unit each month had increased 60%.

He said staff could not cope.

Western Cape Health and Social Services Minister Mr Ebrahim Rasool said yesterday the problem was exacerbated by bureaucratic procedures that slowed down the filling of posts.

Mr Rasool said an appeal will be made to the national Minister of Health, Dr Nkosazana Zuma, to maintain previous funding levels.

Rationalisation between hospitals will be implemented to use facilities better.

Specialists will visit clinics regularly to lessen strain on hospitals.

Community health centres are to be established in as many areas as possible.

Dr Tom Sutcliffe, the Deputy Director-General for Health Services in the Western Cape, said he was deeply concerned about low staff morale.

VERBURDENED . . . A 60% increase in patients at the Red Cross outpatient unit as put staff under pressure. Here four-month-old Leon Esau is seen to by Nurse illian Ada as his mother, Mrs Susan Esau (centre) looks on. Picture: ANNE LAING

NEWS Doctors' degrees 'may not be recognised'

Med schools face chop

Sowetan 22/9/94

■ THREATENED CLOSURE Lack of finance may close medical schools:

UNDERFUNDING and lack of bridging finance for the Department of Health could result in the closure of some medical schools, Health Minister Dr Nkosazana Zuma said yesterday.

The budgets of academic hospitals had been cut by five percent to provide more funding for primary health care, she told the National Assembly's select committee on health. "Because of budget constraints we may have to reduce the number of medical schools from eight to six.

"Instead of running eight underfunded and mediocre medical schools, it is better to have six excellent schools."

Facilities at King Edward Hospital are in a bad state and unless they are upgraded there is the danger that the hospital's medical degree may not be recognised internationally.

The General Medical Council in Britain, which evaluates the quality of training and facilities at medical schools, could stop recognising the degrees. Facilities at the Medical University of Southern Africa in Pretoria are also inadequate. (85)

The two universities — which train a majority of black doctors — could find their graduates' degrees not being recognised, unless money was found to upgrade their facilities.

Zuma said she was misquoted in media reports stating that she was looking for money to retrench white civil servants.

"I am not in the business of retrenching. I am not an employer. The Public Service Commission is in charge of employment."

Zuma also said South Africa had one of the worst primary health-care services, with people having to travel up to 50km to reach a clinic, while the accepted distance for countries at South Africa's level of development was between 5 and 8km.

Govt may close medical schools to redirect funds

CAPE TOWN — Government intended slashing funding for SA's teaching hospitals next year and would consider closing two or three of the country's medical schools, Health Minister Dr Nkosazana Zuma said yesterday.

A committee was already examining the matter, she told a parliamentary select committee on health.

Government wanted to reduce substantially the 30% of the health budget spent on academic hospitals.

Zuma said she met university vice-chancellors and deans of medical schools on Tuesday and asked them to divert 5% of their budgets to primary health care.

She said the withdrawal of 5% of funding from medical schools on an indefinite basis would mean that standards in academic hospitals would fall.

"If we rather reduce this to five or six institutions, these could continue to be schools of academic excellence. Instead of running eight underfunded and mediocre medical schools, it may be better to cut them to six."

Zuma said a departmental committee had been appointed to consider the option of closing some teaching facilities, possibly including one of the two in the Western Cape and one of the three in the PWV area.

Political Staff

Funds released by the closure of some schools could be redirected to build a primary care service based on a network of clinics, ensuring that no one was more than 10km from a health care facility. Government would have to build about 1 200 new clinics to meet this goal.

Zuma said government was wary of undermining the country's academic hospital services, which were among the best in the world. But with no bridging finance available for restructuring health services, a portion of the funds allocated to medical schools would have to be be redirected, she said.

UCT acting principal Prof Davids Woods and a spokesman for Stellenbosch University said the possible closure of academic hospitals was not discussed at Tuesday's meeting.

Woods warned that it was easy to close down a medical school. However, if the UCT medical school disappeared the people of the Cape Flats would suffer, he said.

Stellenbosch University rector Prof Andreas van Wyk said it would be a pity if Zuma's statements were to create the impression that a decision on the closure of two or three academic hospitals was a foregone conclusion.

"The health needs of the country are such that more medically trained personnel are urgently needed, not less. This can best be obtained by optimal use and management of the existing medical and dental schools within a framework of close regional co-operation, and not by reducing the number of training institutions," Van Wyk said.

DP health spokesman Mike Ellis said the cuts would be regrettable. "It is essential that this decision is changed and government actively seeks overseas funding for primary health care programmes."

Reuter reports that Health director-general Dr Coen Slabber said 5% would probably be cut from the 1994/95 budget level and this would result in an effective cut of up to 14% for academic hospitals.

"Everybody is going to to have a bad year next year." Slabber said indications were that the Health Department's budget for the 1995/96 financial year would remain nominally unchanged at about R14bn.

"If the budget is R10 now, it will be R10 next year, not R10 plus inflation. That will mean an effective cut of 8% or 9% for the primary health care service, which is what we are trying to protect," Slabber said.

POLITICS

Medical schools at risk

Star 22/9/94

Cape Town — Underfunding and lack of bridging finance for the Department of Health could result in the closure of some medical schools, Health Minister Dr Nkosazana Zuma said yesterday.

The academic hospitals' budget had been cut by 5 percent to provide more funding for primary health care, she told the National Assembly's select committee on health.

"Because of budget constraints we may have to reduce the medical schools from eight to six. Instead of running eight underfunded and mediocre medical schools, it may be better to cut them to six schools of excellence."

Facilities at King Edward Hospital were in a bad state and unless they were upgraded the hospital faced the danger of having its medical doctors' degree not recognised internationally.

The General Medical Council in Britain, which evaluated the quality of training and facilities of medicals schools, could stop recognising the degrees.

Facilities at the Medical University of Southern Africa, Pretoria, were also inadequate.

Thus two universities training the majority of black doctors could find their graduates' degrees not being recognised, unless money was found to upgrade their facilities.

South Africa's health service was not a real health service, but rather a hospital service.

The country had excellent tertiary and academic hospitals, but no primary health care infrastructure. (85)

Zuma said South Africa had one of the worst primary health care services, where people had to travel up to 50 km to reach a clinic, while the accepted distance for comparable countries was between 5 and 8 km.

She said 1 200 clinics would have to be built, but some areas would still have to rely on mobile clinics. — Sapa.

No plans to co-opt media – Mbeki

Cape Town — Deputy President Thabo Mbeki has dismissed any suggestion that the ANC has plans to co-opt the media or to restrict press freedom.

His comments in a mini-debate in the National Assembly yesterday came after the NP's Marthinus van Schalkwyk suggested that recent comments by Mbeki appeared to indicate he was in favour of "development journalism" — where there was no room for dissent.

The NP MP also warned against subsidising newspapers, saying this could effectively lead to Government control. Mbeki asked what could be done about those in rural communities who had no access to newspapers. — Political Correspondent.

Cape Times

Carfinder Inside

Cape Town 2004

FOUNDED 1876 ★ ☎ 488 4911 THURSDAY, SEPTEMBER 22 1994 R1,00 (Country R1,20) Prices include VAT

Govt may axe Cape medical school

By BARRY STREEK
Political Staff

ONE of the two local teaching hospitals — either the medical school at Groote Schuur or Tygerberg — might be closed down to save money, Minister of Health Dr Nkosazana Zuma warned yesterday.

But the possible closing of either school was rejected yesterday by representatives of both institutions.

Dr Zuma said the government intended slashing funding for teaching hospitals next year.

It would also consider closing two or three of the country's medical schools — and said a departmental committee was already examining the matter.

At present, 30% of the national health budget is spent on academic hospitals but the government wants to reduce this substantially.

Dr Zuma met university vice-chancellors and deans of medical schools on Tuesday and asked them to divert five percent of their budgets to primary health care.

Acting Principal of UCT Professor David Woods and a spokesman for Stellenbosch yesterday said the possible closure of academic hospitals was not even discussed at Tuesday's meeting.

However, Dr Zuma said she informed the deans of the eight medical schools and the six dental schools on Tuesday that the cuts would be implemented in the 1995/6 financial year.

Prof Woods warned: "It takes many years to develop a medical school — and it is very easy to destroy it overnight."

Rector of Stellenbosch University Prof Andreas van Wyk said it would be a pity if Dr Zuma's statements were to create the impression that a decision on the closure of two or three academic hospitals was a foregone conclusion.

"The health needs of the country are such that more medically trained personnel are urgently needed, not less."

The university recognised the need for a shift in emphasis in the training and services provided by medical and dental faculties to a greater emphasis on primary health care, he added.

The Democratic Party's health spokesman, Mr Mike Ellis, said any cut in the budget of academic hospitals would be regrettable.

"It is essential this decision is changed and the government actively seeks overseas funding for the implementation of primary healthcare programmes."

The director-general of health, Dr Coen Slabber, said five percent would probably be cut from the 1994/5 budget.

Dr Zuma said the withdrawal of the five percent of funding on an indefinite basis would mean that standards in academic hospitals would fall.

"If we rather reduce the number to five or six institutions, these could continue to be schools of academic excellence."

Dr Zuma said the savings would be directed towards the restructuring of the health service around a network of clinics.

The aim was to build a primary care service based on a network of clinics ensuring that no one was more than 10km from a healthcare facility.

Some people lived more than 80km from a clinic and the government would have to build about 1 200 new clinics to meet her goal.

Plea for teaching hospitals

Staff Reporter

THE diversion of funds from teaching hospitals could have dire consequences for health care, the Medical Association of SA said yesterday.

Reacting to reports that the government may axe some teaching hospitals, Masa said rationalisation of facilities was a step which could be taken only after careful study and negotiation. CT 23/9/94

"The economic recession and poor planning, which has resulted in inadequate primary and secondary care, has increased the demand for care at teaching hospitals. 85

"Highly skilled health care workers are working long hours simply to cope with immediate patient demands and then have to find time to do research — which is vital if medical care is to be improved."

Fin 27/5/94

What will come under closer scrutinty will be the relationship between the Ministry of Health and the tobacco industry. The ministry has now shown its hand, as it were: swingeing increase in duty (good for the reconstruction & development programme) may be followed by — US-style — curtailing smoking in public places and a complete shutdown of cigarette advertising. (85)

Analysts say advertising and marketing account for about 20c on every packet of cigarettes above the line so, curiously, a blanket ban of that kind would actually enhance earnings short-term.

Up in smoke

While the prime target is tobacco producers, the liquor industry shouldn't be forgotten. No-one has yet put a quantifiable number on the likely increase in excise duties on wines, malts and spirits. A mitigating factor may be National Sorghum Breweries and its fledgling Vivo brewery, whose clear lager has just hit the taverns. NSB's presence as a major player raises the possibility that the attack on this industry may be muted.

This is a classic case of taking care of special constituencies. The ANC doesn't exactly owe anything to wine farmers or, for that matter, to Anton Rupert. Governments look after interests to which they have some obligation: tobacco doesn't qualify, though liquor may just scrape over the welcome mat.

David Gleason

HEALTH POLICY

Fin 27/5/94

Not so healthy for some

Who would have thought new Minister of Health Nkosazana Zuma would raise blood pressures in the business and financial communities quite so quickly? (85)

That's what she achieved by releasing the ANC's proposed health policy. This delineates clearly the ANC's approach to some basic problems — notably tobacco and alcohol abuse. It sent investors scurrying to reduce their exposures in these areas. One result is that companies in the Rupert group, especially Remgro and Rembeheer, recorded large declines over a short period.

The health plan was first revealed on May 18; a day later Remgro's share price fell nearly 6% to R30 — it has now shed nearly 13% since the beginning of the month. If anything, Rembeheer reacted even more sharply: it fell 17% in one day (May 19) and has seesawed since then.

The issue isn't that the ANC is threatening to double the price of a tot or a fag — it is not; it is that excise duties may be doubled in the Budget and that could increase the price to consumers by up to 30%.

It is clear the new government has adamantly set its face against what is sees to be tobacco and alcohol abuse, both of which threaten the health of the nation. Analysts believe the overall effect of a 30% consumer price hike could be to drop volumes by perhaps as much as 20%, though much depends on price elasticities.

Zuma calls for regional health departments

ARG 27/5/94

VUYO BAVUMA, Political Staff

PROVINCIAL health departments should be set up immediately to replace the present fragmented system, Health Minister Nkosazana Zuma said.

Regional health departments would increase efficiency of the health-care system as well as accessibility, she said.

Speaking during the debate in parliament on President Mandela's state-of-the-nation speech, Dr Zuma said the implementation of government plans depended on the effectiveness of these departments.

The department of health planned to undertake a survey to determine the nutritional status of pre-school children. The results are expected by the end of October.

She said the feeding scheme was an important programme because no child could concentrate in schools if his or her stomach was empty.

The department would also liaise with education bodies to develop education programmes to fight alcohol and drug abuse in schools.

Dr Zuma said each community should have its own committee responsible for the clinic or hospital.

New health system kicks off

Star 11/6/94

■ STAFF REPORTER

The Government's promise of free medical health care for children under six and pregnant women is due to come into effect today.

According to reports, if Health Minister Dr Nkosazana Zuma finds this impractical, the arrangement will definitely come into effect from the first day of next month.

The Transvaal Provincial Administration told The Star that, at its hospitals alone, the new policy would add R32 million to its budget.

Spokesman Lenette Roeleveld said that free health care for under six-year-olds at TPA hospitals would cost the administration a further R18 million a year and pregnant women around R14 million.

In reports, Zuma has cautioned that there are large areas of South Africa in which the scheme would have little impact because facilities are not available. (85)

She also said she intended to travel around the country for two weeks.

During her travels she will be able to to see what facilities were needed.

H

Free medical care 'more economical'

CT 2/6/95 (85)

By BARRY STREEK
Political Staff

THE R50 million plan to give free medical care to children under the age of six and to pregnant women came into effect yesterday.

Although the estimated cost of the programme was about R50 million, it would result in considerable savings in the long-term, director-general of health Dr Coen Slabber said yesterday.

Through this programme, it would be possible to treat children and mothers at an early stage, rather than at a later stage when matters become very complicated and very expensive.

Dr Slabber said the plan only applied to state hospitals and for people without a medical aid scheme or people who had used up their medical aid benefits.

However, the free medical scheme for children and mothers applied to state hospitals throughout the country, although its application in the rural areas was "a major problem".

"It is very difficult to provide these where facilities are not available at present. It is very troubling," Dr Slabber said.

The scheme means that, provided they can get to a state hospital, no child or mother will denied access to health facilities for financial reasons.

HEALTH

Fm 24/6/94

Strengthen the backbone

The private sector is vital to the success of overall policy

Health Minister Dr Nkosazana Zuma hasn't yet spelt out her plans for the private sector. We must hope that the delay is a result of caution and wise consideration. Private health is not entirely well —- but the remedy is not simple.

The shock collapse this month of the 20 000-member Midland Medical Plan, based in Port Elizabeth, and the ailing finances of a number of other large medical aid schemes point to a growing crisis in the schemes movement.

Registrar for Medical Schemes Danie Kolver confirms that a number of schemes once again showed a loss during the past year and many operated on very thin reserves, around 6% of income, as opposed to the recommended 25% margin. He's also investigating the soundness of a few major players.

Of course, medical aid schemes make up the backbone of private health care. They pay for the care of about 25% of the population and deliver about R1,8bn in taxes annually. So it's no exaggeration to say that the financial strength of this sector is a pretty accurate indicator of the soundness of the private health sector.

Sharply rising medical bills have forced schemes to raise premiums by about 25% annually for the past 10 years — yet they have still fallen short of their budgets.

Former Health Minister Dr Rina Venter isolated over-use, abuse and fraud as major contributors to the cost spiral. Accordingly, she initiated legislation — the Medical Schemes Amendment Act, which took effect in January — that gives schemes greater powers to keep costs in check.

They are empowered to end guaranteed payments to doctors and health-care providers, as well as minimum benefits to members. This means schemes now have greater powers to bargain on behalf of members. The Act also enables schemes to provide health services themselves — for instance, by managing hospitals and employing medical staff. The potential saving, by undercutting the traditional fee-for-service system used by private practitioners, is estimated at up to 40%.

Sadly, while most schemes have hiked premiums and cut benefits drastically in the past year, few have used their newly won powers to negotiate substantial discounts from health-care providers. Nor have they implemented managed health-care structures or principles in any meaningful way.

Schemes, it seems, still unduly fear the powerful doctors' lobby which, they believe, could put them out of business by refusing to recognise them. They are also wary of investing in additional and educated manpower, new computer technology and sophisticated management techniques that include peer review, treatment guidelines and a variety of benefits.

Zuma

The Representative Association of Medical Schemes (Rams), the sector's spokesman, late last year concluded an agreement with the doctors' lobby — the Medical Association of SA (Masa). The agreement effectively retains favourable direct payments to doctors if they manage to keep down volumes of servicing — a practice that could prove difficult to monitor and prove detrimental to members. But Rams executive director Reg Magennis says the agreement provides an incentive for doctors to reverse the growing cost spiral.

He says: "This innovative step is geared to encourage schemes and doctors to co-operate in eliminating unnecessary services. It's also meant to overcome the tremendous past hostility between doctors and schemes. An intense period of negotiations between Rams and the medical profession is imminent. This may offer a crucial opportunity for finding effective solutions by agreement and without State intervention."

How long will schemes be able to limp along under the old dispensation? They have been underwriting losses for at least the past seven years.

Danger signals are coming from the report of the Melamet Commission into the financing of medical schemes, released last month. Chaired by Judge David Melamet, the three-man commission is scathing in its criticism of schemes and their administrators. In particular, the report accuses schemes of abdicating their responsibilities to administrators who owe members no legal obligations.

There's also a clear inference of incompetence in the report — Melamet calls for stricter controls, greater transparency and increased input in the management of funds by actuaries, legal and accounting professionals, and people experienced in hospital and business administration and insurance.

Of course, these findings aren't reassuring for the employer who's trying to secure adequate cover for his employees. But Melamet's recommendations are sound since they emphasise the need for greater business, financial and administrative efficacy.

Kolver says he will table the report with the Council for Medical Schemes, which will then consider it along with any objections and recommendations from the public, before passing it on to Minister Zuma.

The ANC, it its latest health policy document — released last month — has already said it would appoint its own commission to investigate the schemes movement. But it's unlikely the new government will reject out of hand the findings of Melamet's report. An ANC nominee participated in the commission's inquiries and the latest ANC health policy document does suggest greater recognition of the role of private-sector health care. The ANC's first policy document bluntly promised that "growth in the private sector would be discouraged."

Melamet recommends the direct supervision of schemes by the Financial Services Board — not out of place for a sector that holds in trust large amounts of public money. There's also talk of a single Private Health Finance Act, to regulate all types of medical cover, and an ombudsman to deal with complaints from the public. More important, however, Melamet wants schemes to submit financial reports bi-annually to the Council for Medical Schemes Registrar — the sector's controlling authority — to avoid sudden bankruptcies and report on any unusual

Rand values of income and claims

1982 - 1991

Year	Member's contribution	Total claims cost	Administrative costs	Underwriting surplus (loss) as % of contribution	
1982	R838m	R815m	R60m	(R37m)	(4)
1983	R1 078m	R1 033m	R74m	(R29m)	(3)
1984	R1 387m	R1 319m	R91m	(R23m)	(2)
1985	R1 658m	R1 600m	R105m	(R47m)	(3)
1986	R2 095m	R2 050m	R128m	(R83m)	(4)
1987	R2 691m	R2 435m	R158m	(R98m)	4
1988	R3 440m	R3 696m	R203m	(R486m)	(14)
1989	R4 264m	R3 885m	R250m	R129m	3
1990	R5 529m	R5 319m	R323m	(R113m)	(2)
1991	R7 365m	R6 892m	R421m	R52m	1

Source: REPORT OF THE REGISTRAR

financial changes as they occur.

He wants scheme auditors to meet the same stringent obligations imposed on bank auditors by the Registrar of Banks. The report also recommends greater powers for the Registrar of Medical Schemes to enable easier access to information. It says: "There are more than 230 schemes reporting to the registrar, with an annual contribution from employers and members of R7bn."

From 1994, the report continues, the Registrar will be called on to supervise more and more hybrid and innovative schemes, with different criteria for reserves and funding. Melamet highlights a controversy in the schemes' sector when he recommends that they should no longer be legally obliged to provide for retired members. In essence, Melamet is criticising a system which legally forces schemes to retain retired members but, in practice, allows them to abandon the aged simply by hiking premiums to unaffordable levels. Put into practice, such a recommendation would oblige schemes and employers to specify at the outset their policies on pensioners.

Speedie

Hospital Group Presmed joint-MD Rob Speedie, however, warns that this recommendation needs further investigation to avoid a situation where the aged are merely dumped on the overburdened State system.

Ironically, while the schemes movement tries to weather the storm, Rams, its representative body, is trying to convince the new government that the existing schemes movement should be used to finance and implement a national health insurance system. Rams CE Reg Magennis explains that such a system would offer a package of basic cover to all employed people, perhaps extending this to the unemployed later, as a agent of the State. The system would be funded through compulsory payments to a common fund. He stresses that schemes should be free, however, to offer cover over and above this system.

It's an issue the ANC commission of inquiry will investigate. Another is the desirability of retaining tax concessions on employer contributions to medical aids. In an earlier document released in January, the ANC threatened to end these concessions, arguing that the practice amounted to a State subsidy to the private sector. Of course such a move would threaten the lifeblood of the schemes movement.

Says Speedie: "Employers would merely pay employees more and this would be taxable in the hands of employees. Employees — particularly the young and healthy — could choose not to take medical cover, thus weakening the principle of cross-subsidisation that underpins the financing of the schemes movement." He explains that unions could also pressure employers to carry the additional tax burden.

But while the ANC's recent document still talks of ending State subsidies to the private sector, it concedes that some sort of tax concession will be retained. On this score Melamet suggests that employer contributions could be taxed as a fringe benefit to discourage abuse by employees.

Perhaps the ANC has finally realised that it's the private patient who subsidises the public-sector medicine bill through the State's drug tender system.

This enables the State to buy its medicines from manufacturers for as little as 10% of the price paid by the private patient at a pharmacy — simply because manufacturers are able to recoup these huge discounts to the State from the private patient.

The latest ANC policy document suggests greater recognition of the role of the private sector but the thinking that underpins the entire document is that stringent controls of the sector are somehow necessary and desirable. The document, however, is vague on how these controls will be exercised.

Take, for instance, the promise to introduce a system of registration for all private practices. This, claims the document, will be used to encourage practitioners to serve rural areas. If government implements this policy by refusing doctors permission to work in urban areas, a strong case could be argued that the individual's constitutional rights to economic freedom are contravened. Under such a system, an exit of highly skilled professionals is inevitable. It might be more sensible to encourage doctors to work in rural areas by offering them tax concessions or housing subsidies.

The threat to regulate private hospitals and facilities is still apparently a feature of ANC policy.

But it's clear the authors paid no attention to the Strauss report, which concluded that stringent licensing of private facilities would lead to administrative abuse. The ANC document stresses the importance of encouraging private patients to return to State facilities, even though those facilities are already stretched. Speedie warns that such a policy can work only if the State facilities are competitive.

The ANC document, however, stresses that the full cost of services will be recouped from private patients attending State facilities — but how will costs be determined?

Certainly, the State facilities benefit from cheaper medicines and from fixed doctors' salaries. As State institutions the physicians are also able to borrow at substantially lower interest rates so they already have a competitive edge.

Dealing with drug policy, the ANC document states that health-care providers should not benefit from dispensing drugs, presumably to take away any incentive to overprescribe (by dispensing doctors) or to prescribe expensive drugs. It's a proposal that seems to tie in nicely with a recent decision by pharmacists to charge a professional fee, rather than operate only on mark-ups. For pharmacists, of course, this is good news, particularly since the ANC has promised to make greater use of cheaper generics — the pharmacist won't lose out on big mark-ups on expensive products.

"But will this mean cheaper prices for the consumer?" asks Speedie. He suggests that a cheap drug or small amount of medicine could well end up costing the patient more with the professional fee than under the current mark-up system.

Of course there's no talk of opening up the ownership of retail pharmacies to nonpharmacists, a move that would attract large retail stores to the business of selling drugs to the public.

The public would certainly benefit from such economies of scale — as shown by Boots in the UK.

But it's a change pharmacists continue to oppose fiercely. They argue that about 2 900 independent pharmacists would lose their livelihoods. This isn't completely true: nobody advocating deregulation would suggest that nonpharmacists must be involved with dispensing.

Melamet suggests that a new government needs to consider whether a small professional group, by holding on to their legal and inefficient monopoly, should be entitled to hold the rest of the country to ransom — particularly since medicines make up 29% of private sector health expenditure.

Price controls

The ANC document still talks of implementing limited drug lists that would restrict the number of available drugs, though the threat of price controls on drugs is less blunt. Limiting goods always holds the danger of making a line commercially unviable.

Wits economics professor Duncan Reekie points out that in Canada and Australia the adoption of limited drug lists led to several multinationals withdrawing — a move SA could ill afford.

Underpinning the ANC's document is still the belief that a regulated private sector will somehow boost the public sector.

Says Magennis: "Every reference to strengthening the public sector is made with the suggestion that this must somehow take place at the expense of the private sector — a deduction which is cause for concern."

Just how strong the public sector can remain — while it promises free care that includes unlimited crisis control, mental health services, rehabilitation and abortion — is debatable.

Like her counterparts around the world, Zuma will soon find that there are physical limitations to State spending, particularly in emotional portfolio like health. Sooner or later she will have to make some unpleasant choices. A robust, efficient and independent private sector will ease her burden. ■

Managing health on the ground

(85) Star 14/7/94

(85)

CARING FOR COMMUNITY

How will South Africa's new health-care system be managed at the clinic and district level? **DAVID ROBBINS** gets some answers from a training programme convener.

There's an experimental course that is teaching health workers how to be managers.

Course convener Dawn Joseph says: "The old assumption is that managers are at the top, with the workers in layers underneath. This training shifts people's thinking away from the hierarchical model to one that says the workers themselves need to manage."

The course, the primary health-care (PHC) service management programme, is being held at the Wits Graduate School of Public and Development Management in Johannesburg.

Joseph, a nurse and health activist with degrees from Unisa and Leeds University in England, says students for the first PHC management course were drawn largely from working environments. The majority are nurses who have come to lectures on the block-release system. In this way, they have been exposed to about 200 hours of lecture time.

But it hasn't all been taken up with listening. Experiential and participatory learning processes are stressed, which in themselves persuade the students away from the old bureaucratic approach to health administration.

Joseph says: "We are teaching them that the process of transformation and of managing the attendant change is in their hands, and we are giving them the tools to cope with this challenge."

The course was first mooted at a workshop held at the Alexandra Health Centre two years ago. Prominent organisations involved were the Medical Research Council and the Alexandra-based Institute of Urban Primary Health Care.

Problems

"The workshop explored the problems being experienced at the delivery point of PHC," says Joseph. "It then made recommendations regarding the development and management of this aspect of health care. A key recommendation concerned the special training of PHC service managers. This is what we're doing here; and our first graduation ceremony will be at the end of July."

It's not difficult to imagine the radical changes which will be necessary at community or district level to cater for the new emphasis on PHC.

Vastly increased community involvement in health-care systems and decision making is just one change for which health workers/managers will have to be equipped. The shift from curative care to the idea of maintaining wellness, a cornerstone of the PHC approach, is another.

The curriculum of the PHC management course, which is broken into four main modules, is worth examining in some detail.

The first module deals with the background issues in health service management. An overview of health and health care in South Africa is provided, as is a resume of the basic principles of the PHC approach. Students look at the question of community development and the democratisation of health care. Legal and ethical questions, including the avoidance of corruption in development organisations, are also scrutinised.

An introduction to general management techniques forms the second module. The identification of problems, finding appropriate solutions, managing change, setting priorities, establishing and using control systems, and time management are a few of the topics covered. Basic office practices, including report writing and the drawing up of duty rosters, are also learnt.

Module three is devoted to the management of human recources. The theory and practice of successful motivation of staff, communication, conflict resolution, leadership, grievance handling and job design are among the many aspects dealt with through the various teaching methods employed on the course.

The techniques of managing resources forms the fourth and final module. Students are taken through the entire process of planning a health centre or clinic, and of the managerial implications of commissioning and running it in conjunction with the necessary support services, such as stock control and transport. Financial and information management and computer skills are also learned.

Internships for successful students are currently in the planning stage, says Joseph. "What we're looking at is sending them for a month to work in African countries which have well-established PHC/district health systems. This experience would be invaluable for them as they help to transform South Africa's health-care system from the bottom up."

What of the future? The initial course has been run as an experiment, thanks to funding from the American-based Kellogg Foundation, the Standard Bank and the French Embassy. Support has also been received from British Aid and Interfund.

"There has already been a request to repeat the course in September," Joseph concludes. "But this will depend on evaluation and further funding. As course convener I feel a great sense of achievement, and I am optimistic because I believe we are responding to a deeply felt need within the overall framework of health reform."

New horizons . . . Dawn Joseph turns health workers into managers. PICTURE: RUVAN BOSHOFF

TOMORROW

Move over, Pavarotti. A young local singer is taking opera to the people.

Medical aid free for many

85

ET 1/7/94

PRETORIA. — Minister of Health Dr Nkosazana Zuma released a notice yesterday on free medical services, which come into effect today.

The notice will be published in today's Government Gazette.

It says free health services must be provided to pregnant women until 42 days after the baby's birth or, if complications set in, until the patient is cured or stabilised.

Free health services must be provided to children under the age of six.

Free treatment must also be given to pregnant women or children under six who are non-citizens and develop health problems while in the country.

Free treatment must be provided only by state facilities, hospitals with state subsidies for more than half their expenditure and district surgeons.

Free services will not be provided to people and their dependants who belong to medical aid schemes, nor to non-citizens visiting the country specifically for medical care. — Sapa

Govt focus is now on prevention

Sowetan 21/7/94

85

By Mokgadi Pela

THE OLD ADAGE *prevention is better than cure* explains appropriately what the concept Primary Health Care means.

With PHC the Government is looking at preventive health care.

This includes vaccination for measles, hepatitis B and other diseases, treatment of minor illness like flu, control of hypertension, educating people about diseases of lifestyle and the need for exercise to stay healthy.

"We need a system where people can be screened early and have access to health care," says Dr Jan Nagtegaal, chief director of the Transvaal Provincial Administrations' health services. "By so doing, we will prevent many people going to the hospital. This is clearly a cost-effective method of administering health."

According to the Department of National Health and Population Development, PHC should be generally accessible to all individuals and their families. PHC is a system which requires a healthy attitude towards health care and provided the leaders in society are prepared to get involved, it is a system that can work.

Its aims are:

- To promote the provision of food and correct nutrition;
- To ensure the provision of an adequate supply of safe water and basic sanitation;
- To ensure the rendering of mother and child services and family planning; and
- To provide essential medication.

Nagtegaal said South Africa needs to amalgamate its health services to curb unnecessary duplication.

Rush to get free health-care plan under way

ST Times 15/8/94

By CAS St LEGER

THE NEW government's health plan is being introduced at break-neck speed.

And, only days after free health care for pregnant women and children under six was launched at a cost of R77-million to taxpayers, the government is also considering free medical treatment for pensioners.

The scheme is restricted to patients without medical aid. (85)

The introduction this week of free medical care for children and pregnant women caught many hospital administrations by surprise.

"Administrations were asked to implement the project by June 1," said the Department of Health's deputy director-general, Dr Hans Steyn.

But, said Dr Steyn, such short notice meant that not all hospital superintendents were fully aware of the project, and some hospitals continued to charge patients who would otherwise have qualified for free treatment.

Dr Steyn said the total loss of income to the old provinces would be about R77-million — about one percent of their budgets.

He said private hospitals have indicated they would like to join the free health-care scheme on a contractual basis.

Ilpa convention

Private health systems can no longer keep pace

BIDay 8/6/94

Reports by
CHARLOTTE MATTHEWS

RUNAWAY medical inflation, massive unfunded liabilities, inequalities and AIDS' needs had made the present private health system unsustainable, National Health Forum steering committee member Dr Isak Fourie told a medical/-health assurance workshop at the Ilpa convention.

The cost of health care benefits as a percentage of employees' salaries had risen as few lower income people were members of medical schemes because of the cost.

Employees health benefits had to become a fixed contribution benefit. It was critical that employers' liabilities towards pensioners' medical benefits should cease when the employees were retired and there had to be a-mechanism to prefund pensioner benefits.

Pretoria University insurance and actuarials science Prof George Marx said R150 000 to R250 000 was needed at retirement to fund a couple's health care costs, which was an employer's liability of about R1m for every 10 pensioners.

Funding that liability in advance would cost R300 to R4 500 a month per employee. In addition, to cover the death and disability risk, R90 to R150 per employee a month in insurance was needed.

There was an opportunity to talk to employers and make them aware of the problem.

"Solutions are costly, but if nothing is done now the liability will explode more and more."

Representative Association of Medical Schemes executive director Reg Magennis said medical schemes would have to build positive relationships with a number of players to remain a force in health care funding, with suppliers and providers of health care services, with public health authorities, life assurers and actuaries.

ANC health plans indicated strong thinking in the direction of a partnership between the public and private sectors. Deregulation was likely to bring health care costs down while adjustments legislation could create a partnership between life assurance type products and those offered by health schemes.

Momentum Health MD Adrian Gore said the ANC's health policy was rational, based on equity and moving away from world care towards primary health care. It included proposals to look at a national health scheme.

Although in SA 6% of GDP was spent on health care, similar to the UK, SA's infant mortality rate was 54 out of 1 000 compared with the UK's seven out of 1 000 and life expectancy in SA was 62 years against the UK's 76 years.

However, a national health scheme would not meet the needs of everyone, since SA was a poor country and its resources would be spread very wide.

The consequences would be a shift towards the private sector and emphasis on pensioner health care.

NEWS FEATURE *Impetuous top down approach by*

Free health woes

By Mokgadi Pela

■ PREMATURE CARE *Hospitals cannot cope with influx of patients:*

PROBLEMS BESETTING hospitals due to the extension of free health care to pregnant mothers and children under six make one wonder whether the Government will admit that the step was premature.

From Leratong Hospital on the West Rand to Nobel Hospital in the Far Northern Transvaal, the story is the same — a top-down approach does not work.

To borrow prominent writer Dr Gomolemo Mokae's words: "Although the Government meant well, it failed to act well."

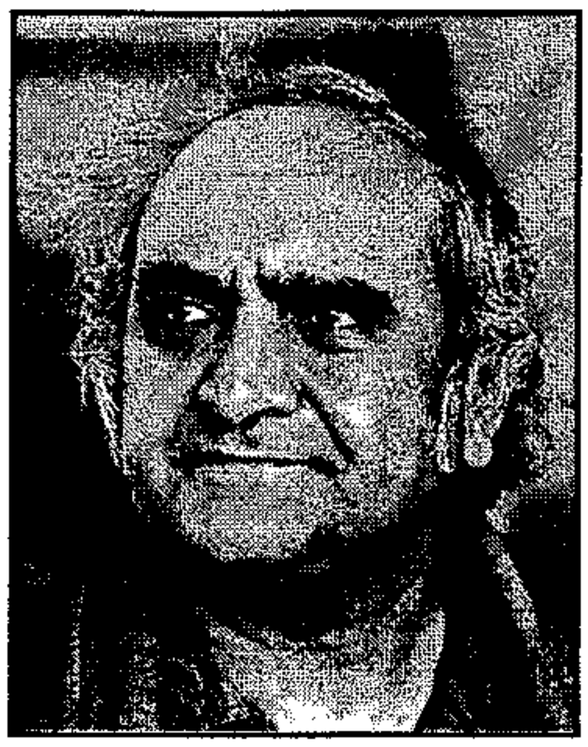
First to blow the whistle was chief superintendent of Baragwanath Hospital Dr Chris van den Heever when he said it was not far-fetched to foresee the closure of several wards at the hospital. Van den Heever said Bara faced the problem of remaining within limits of a budget which left very little chance to manoeuvre.

This view was reinforced by the chief director of Transvaal Provincial Administration's health services, Dr Jan Nagtegaal. He said all hospitals had been instructed to scale down services due to budgetary constraints.

Some of the complaints raised by hospital staffers include:

● A rapid increase in the number of patients with insufficient personnel;

● Lack of resources, especially drugs;



Dr Mayet of the Wattville Clinic.

●Lack of consultation by authorities;

●No remuneration for sacrifice in handling greater numbers; and

●Lack of supportive primary health care clinics in the area of the hospital.

One clinic in the East Rand township of Wattville epitomises the situation very well.

This clinic has one part-time doctor, one primary health care nursing sister, one staff nurse, one clerk and two general assistants (both do urine and blood sugar tests on patients). They earn R800 a month and have not had a salary increase in six years.

It opens for two hours a day and during that period treats an average of 60 patients. Whereas this clinic used to treat about 30 children a month, it now handles more than 300 in the same period.

For two months, this clinic did not have medication for scabies. The clinic still does not have medication for fungal infections. (83 85)

What should doctors do? Write a prescription for people who can hardly afford the R8 fee?

According to Dr Abram Mayet, this sort of situation leads to bad blood between the community and hospital personnel. Patients think health workers are reluctant to help them, unaware of the dilemma they find themselves in.

"They don't blame Zuma, Mandela or the TPA. They blame health workers. We are in the firing line of the patients due to politicians making decisions from their ivory towers."

"Not a single person from the Government has come down to hospitals to see what the situation is like on the ground," Abram said. If the situation is like this in urban areas, how is it in Magoebaskloof or Cofimvaba?

focus on health

Sowetan 13/6/94

Former Minister of Health Dr Rina Venter looks back on her five years in office and chats to **Sizakele Kooma** about the changes she made to the health system of South Africa:

AFTER FIVE HECTIC years in Parliament, Dr Rina Venter is back at her home in the exclusive suburb of Verwoerdburg, outside Pretoria.

The former minister of health and population development is recovering from a position that brought her more media attention than any other minister in FW de Klerk's government.

This, not because she was the only woman Cabinet minister, but because of the controversy that dogged her department.

Most remember her for her anti-abortion stance.

Some blame her for the strikes that brought most provincial hospitals to a virtual standstill and others for the disease and hunger that ravaged parts of the Northern Transvaal and the Orange Free State.

Teaching freely

Rina Venter is still as ready to defend her policies as when she was in office.

Looking taller, younger and smiling more often, Venter has dropped her guard and is talking freely about her years as a minister.

She never wanted to be a politician, she says. "I am a trained social worker. My strength is in social development. Politics is for people who want to stay popular."

Nevertheless, history books will record her as a politician.

She says she is proud of the contributions she made to the public welfare, even though they might not be aware of any.

She maintains her brief to create a coherent health system for a fragmented society was most demanding.

"It was the most difficult thing trying to change a country's health system, working within the constraints of the old constitution.

"Most of the efforts of the department were concentrated on establishing a national framework.

" This meant that a lot of time was spent doing research to analyse the needs of respective communities and creating a basis for change.

17 health bodies

"I was working with 17 autonomous health bodies and had no authority to legislate.

" I also had no legal right over the independent states. When I got into office there was not an item called 'health' on the budget.

" We had to bring some order to the budget by allocating funds to specific health and welfare programmes and not have money going into a general item," she explained.

Despite the difficulties, Venter says she had a definite plan and specific objectives.

The benefits of some of the things she initiated, she says, will unfortunately be seen long after she has left.

Her administration introduced a regional health coordinating committee to bring all facilities of the four provinces under the control of one central body.

Former minister of health and population development Dr Rina Venter.

The committee's function was to address the problems of fragmented departments, among them duplication of services.

They also developed a health reconstruction plan based on five principles — to increase access, affordability, efficiency, acceptability and making the health service equitable.

Venter reckons she deserves credit for the improvements she made in primary health care.

"A lot of money, about 43 percent of the health budget, was spent on curative medicine and only five percent was given to preventative medicine.

" We committed ourselves to changing the focus from tertiary care to primary health care and we succeeded in most areas.

"We were fortunate to get funds from the oil reserves and that enabled us to build 143 clinics," she says.

Her department initiated several campaigns, including the measles, tuberculosis and dehydration campaigns.

"The Aids programme was also accommodated in primary health care. When I became minister there was no programme for the disease. We put R19 million on the programme which looked at creating awareness and providing education," she says.

Venter says she is not bitter that she has had to leave office before her plan had taken effect."We built a good foundation for the incoming minister.

" Many countries tend to have women as health ministers. A woman has a lot of personal experience to put into the job and she knows the needs of the family and the community "

"I was looking forward to the day I would retire from politics. Politics divides. If I were to come back I would put emphasis on development."

She has no qualms about her successor being a woman. Many countries, she says, tend to have women as health ministers.

Needs of family

A woman has a lot of personal experience to put into the job and she knows the needs of the family and the community.

As for herself, she is already planning her way back to social work.

"When the former State President approached me I was running a big welfare project for the Vrouefederasie and controlled a budget of R7 million in 1982.

" I was responsible for 34 old age homes, 54 nursery schools, 26 aftercare centres and 16 crèches, among others," she says.

She is planning to get involved in social development projects, working specifically with black women's organisations because "that is where the need is".

She cannot give a definite date but it will have to wait until she comes back from holiday in July.

"I had a wonderful experience working with women in both rural and urban areas. A most satisfying aspect of my work was seeing the light shine in the eyes of people who had previously been bogged down by problems.

"To develop people you have to let them do things for themselves and only act as facilitator," she says.

Govt plans to eradicate polio

Star 24/9/94

ESTHER WAUGH
POLITICAL CORRESPONDENT

CAPE TOWN — The Government has adopted a comprehensive immunisation plan which should see 90 percent of children vaccinated by the year 2000.

Describing the plan yesterday, Health Minister Nkosazana Zuma said the strategy was the result of a review of the existing immunisation programme in South Africa by experts, including the World Health Organisation and UNICEF.

Although no cases of polio have been reported during the past few years, the Government aimed to eradicate the disease within five years. It will also aim to ensure that fewer than 4 000 cases of measles be reported for a five-year period starting in 1996 (85)

The plan would further involve the reduction of neonatal tetanus to fewer than one case for every 100 000 births by 1997.

Zuma said money for the programme would be found within the Department of Health's Budget but additional funds would be found from international donor agencies and the private sector. The minister said she had started discussions with the SANDF's medical services to explore ways of assistance with the programme.

'90 percent of children vaccinated by year 2000'

(85)

Weekend Argus Political Staff

THE government has adopted a comprehensive immunisation plan which will see 90 percent of children vaccinated by the year 2000.

Unveiling the plan yesterday, Health Minister Nkozasana Zuma said the strategy was the result of a review of the existing immunisation programme in South Africa by experts, including the World Health Organisation and Unicef.

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The plan would further involve the reduction of neonatal tetanus to fewer than one case for every 100 000 births by 1997.

A review of the present immunisation programme said the so-called "cold chain" — the process whereby vaccinations were kept cold from production to reaching clinics — needed attention.

It was also found that the administrative process involved in the programme needed to be simplified. At present, a baby's weight is noted on nine different forms.

The review further revealed that many opportunities were being missed. It found that it was rare for vaccination to be done at state hospitals' outpatient departments.

A telephone survey of approximately 300 private doctors showed that only two percent of them did any vaccinations.

ARG 24/9/94

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The minister said she had started discussions with the South African National Defence Force's medical services to explore ways of possible assistance with the programme.

Transplants to continue

(85) CT 28/9/94

Primary care 'first priority'

Staff Reporter

LEVELS of excellence in highly specialised fields of medicine such as transplants will not be scrapped, but primary health care facilities must be extended to all sectors of the population as a first priority.

Western Cape Minister of Health and Social Services Mr Ebrahim Rasool said this in a statement yesterday when he met Groote Schuur Hospital transplant unit chief Professor Del Kahn to discuss the future of transplants in South Africa.

Prof Kahn said he had invited Mr Rasool to the hospital for a tour of the unit following criticism that specialised transplant operations were very costly and beneficial to relatively few people.

Mr Rasool said transplants would not be "sacrificed at the altar of the new order".

However, he added, most public sector hospital transplants in South Africa were performed in the Western Cape, and the provincial legislature — with a massive budgetary deficit of R213 million — could not afford to carry the cost of these procedures.

Mr Rasool said that because the operations were beneficial to people from all provinces, new ways of funding specialised medical procedures were being discussed at central government level.

One such option was a special national health budget, said the minister.

Prof Kahn voiced concern that Groote Schuur's famous transplant unit would go the way of that at Johannesburg General Hospital, where rationalisation had impacted on the infrastructure of its main transplant centre.

Most kidney transplants which would previously have been done at Johannesburg General were now being done at private hospitals, he said.

Prof Kahn added that heart transplants were also being performed at private hospitals, but he said this was taking place on a smaller scale.

Shock findings in rural injury study

ARG 28/9/94 (85)

LIBBY PEACOCK, Health Reporter

INTERPERSONAL violence is the major cause of injury in Western Cape rural areas, and accounts for more than half of all hospital cases.

And more than 49 percent of rural hospital cases are alcohol-related.

These are some of the shock findings published in a new Rural Injury Surveillance Study guide launched yesterday by the Medical Research Council (MRC).

Western Cape Health Minister Ebrahim Rasool, who attended the launch, congratulated the MRC on "yet another fine piece of work that is practically orientated".

He said it came at a time when Western Cape and national health authorities had to draw on the work and experience of the MRC.

Mr Rasool said if one looked at the number of pedestrians involved in accidents and the number of alcohol-related accidents, "we might have to look at legislation with regard to that".

The study was conducted at 15 rural Western Cape hospitals serving about 900 000 people and the guide is useful for health workers in determining important features of rural injuries throughout South Africa and other African countries.

It followed the success of the Cape Metropolitan Study, which gave a detailed picture of trauma in the metropolis and was the most comprehensive study of its type in Africa.

The Rural Injury Surveillance Study found that the rural *per capita* trauma rate was even higher than that in the metropolitan area.

The respective annual hospital attendance rates per 100 000 population were 6 180 patients rurally and 5 392 in the city.

Time to deregulate

Fin 30/9/94

Bureaucratic red tape is throttling health care and wasting taxpayers' money. Public health authorities will probably overrun the R14bn national budget by a record R1bn this year. And while we spend 10 times more than the World Bank says we should on basic health services, the quality and scope of our care is in decline.

Take Baragwanath Hospital. The southern hemisphere's largest medical complex is seriously short of doctors, especially in casualty and paediatrics, and needs at least another 100 cleaners. "The hospital is filthy; it's very demoralising," says superintendent Dr Grant Rex, a health care management specialist and former ANC nominee for the PWV legislature.

But the staff shortages could take up to 18 months to set right, he says, given the government's tardiness in approving postings. Every hospital appointment must first be cleared at provincial level and then by the Treasury and Public Service Commission (PSC). The process usually takes so long that circumstances are often changed by the time appointments are made.

Responsibility for this rests with the central government's Personnel Administration System (PAS), which allows the PSC a steely grip on the public service. The PAS consists of four large rule books that were designed to maintain strong central government control. No-one knows how much of its power will eventually devolve to the provinces, though the constitution does say that the provinces must set up their own PSC with similar powers to the central body.

The ANC seems merely to have embraced the old system. The central body, meanwhile, seems hardly in touch with regional needs. For example, half of SA's graduate doctors routinely move into private medicine, for better pay and working conditions, where they serve the 20%-30% of the population with medical aid. Many of the others emigrate. One reason is salaries. A government intern will earn about R25 000 a year, a junior doctor around R60 000 and a chief superintendent only R110 000. Health officials are bound by this.

As a result, most doctors moving into public health are foreigners. But even they are now finding it hard to get hired, observes Rex, as government is holding back foreign appointments to keep jobs open for South Africans, preferably blacks. It does not seem to matter that there simply are not enough SA doctors available and of those who are, few relish working in rural areas where they are needed mos(85)

Then there is the cost-cutting sham. To reduce public health spending, government has simply reduced the health budget. In the past four years, health's share of the national budget has fallen from 11% to 10,2% in real terms. With the overall budget already cut, the actual decline is worse.

Spending, meanwhile, has climbed because inflation in the import-dependent health sector is far higher than domestic inflation; salaries have risen commensurately and patient volumes have increased. PWV hospitals, for instance, overspent their 1993 budget by R93m, their 1994 budget by R121m and this year will overshoot by at least R318m, says PWV health chief Amos Masondo.

Zuma

"It's a ridiculous approach to management," says Rex. He projects a 20%-30% overspend at Baragwanath this year, "despite belt-tightening for so long we've got no fat left." Hospitals are clearly crying out for decentralisation and deregulation: "Give us the R300m-R400m it takes to run Bara," says Dr Rex. "We'll come in under budget, provide full medical services and computerise the system in a year. All we ask is that the authorities leave us alone, except for audits."

Government is searching for ways to decentralise. The most likely programme is known as cost-effective decentralisation of administration, which emphasises local autonomy and seems to have impressed health authorities: "It is a superb programme in principle and we are very much in favour of implementing it," says Deputy Director-General of Health Harm Pretorius, adding that it will require extensive training of health care managers.

This would help but the problem is lack of money. Government is committed to moving from hospital-bound health care to focusing on primary facilities such as clinics in neglected areas. To fund them, it will pare funds from the country's 16 academic hospitals, including Baragwanath. Health Minister Nkosazana Zuma said two or three medical schools may have to be closed. Meanwhile, she has asked the heads of medical schools to divert 5% of their budgets to primary health care.

The academic hospitals consume about 43% of total health funding but serve a relatively small portion of the population. They focus largely on training, research and hi-tech medicine such as organ transplants and cancer treatment. The remaining 57% of the budget must then be spread around about 700 secondary-care hospitals and over 2 000 clinics serving 70%-80% of the population, largely sufferers of TB, malnutrition and trauma.

The ANC has begun to implement some of the health objectives outlined in the RDP such as free health care for pregnant women and children under six. But there are many programmes, mostly geared towards the poor and upliftment of previously neglected areas.

To this end, it has the support of some of the finest medical administrative minds in the country. The trouble is that health priorities of the RDP could cost up to R3,6bn, according to Wits economist Alex van den Heever. This would overwhelm the RDP funding. Clearly, if the new government is to implement all its health care promises, it will have to draw from the national health budget which, as we have seen, is already under pressure.

The question is whether cost-cutting can finance the upliftment programme without injuring excellence. Far more might be achieved by slashing the centralised bureaucracy that has been stifling health care and driving up costs for years.

Tobacco tax proposed to improve health care

BDay 5/10/94

KATHRYN STRACHAN

ADDITIONAL resources were needed if government was to meet the enormous challenge of achieving greater equity in access to health care, a health analyst said yesterday.

Di McIntyre, researcher at the University of Cape Town's health economics unit, said there would be pressure for health services to receive a higher proportion of general tax revenue than at present.

If there was no increase in health spending, there would be no significant effect on the health status of the disadvantaged in the short to medium term.

There was a growing call for substantial increases in excise on tobacco (and possibly alcohol) products, motivated largely on public health grounds.

International research showed that the most effective policy for reducing consumption, and therefore improving the health of the population, was through significant price increases.

Another source of revenue was that of patient fees — a source that was relatively untapped at present as public hospitals discouraged medical scheme members.

McIntyre said with certain quality improvements, it was likely public hospitals would more actively compete with the private sector for patients in future.

However, mechanisms would be required to ensure that access by patients entirely reliant on state services was not jeopardised. In this way, "private sector" financial resources could be harnessed to help meet reconstruction and development programme (RDP) and other public health sector priorities. (85)

There were also likely to be changes in the way patients' fees were collected to provide incentives to hospitals to maximise their revenue.

At present, all fee revenue was returned to the central treasury. This meant there was no benefit for the hospital collecting these fees or to health services in general, and therefore no incentive.

McIntyre suggested that institutions be allowed to retain at least a proportion of the revenue generated by them, to be used for improving the quality of service and conditions of service for staff. The remainder of the fee revenue could then be submitted to the Health Ministry for redistribution to areas of need.

Plan to upgrade hospitals

ST Times Ed (Metro)

By NAZEEM HOWA

STATE-RUN hospitals in the Western Cape may soon undergo a major upgrade so they can challenge the region's private hospitals for the lucrative medical aid patient business.

This is part of a comprehensive plan being developed by regional Health Minister Ebrahim Rasool to reduce his department's budgetary deficit which has been projected at R213-million for this year. 9/10/94

Mr Rasool plans to increase income by upgrading peripheral services at state hospitals so that they can challenge private hospitals for business.

"At present there's little difference in the quality of medical treatment offered by the two. Where we fall down, however, is in the area of providing peripheral services such as quality meals, conducive environment and privacy. I expect these questions to be addressed when we start restructuring our hospital services," he said.

Interviewed this week, he said the projected over-expenditure for this year was not unusual.

"In previous years the health budget has always been exceeded. However, what has changed is that from now on it will not be possible to fund that deficit from other budgetary components. That is why there is so much pressure on us to cut costs," he said.

Staff cutbacks, according to Mr Rasool, will be a last resort. Instead a creative plan was presently being developed to ensure better use of the department's R1,2-billion annual budget.

Although the department is looking at containing expenditure in several areas, Mr Rasool said he expected to spend more on providing health care in rural and disadvantaged areas through a public health programme.

Mr Rasool said the two academic hospitals in the region were using a significant proportion of the R1,2-billion budget. 85

"To make matter worse, running costs at Tygerberg and Groote Schuur are making treatment of patients there more expensive than within their own communities," he said.

"Both do not have to specialise in heart surgery, for instance. I've also suggested that the medical schools at UCT and Stellenbosch consider a co-operation agreement to limit duplication in teaching. Ending such duplication could easily save us a substantial amount of money," he said.

As a cost-cutting measure, the department was now considering establishing a 24-hour casualty unit at the Vredenburg Hospital and upgrading the G F Jooste hospital in Manenberg so that maternity and casualty patients can be handled there.

Cape gets biggest bite of health cake — study

BDay 12/10/94

KATHRYN STRACHAN

THE disparities in the allocation of public health care resources between the provinces is emerging as one of the major areas to be addressed in achieving a more equitable health system, a health analyst said last week.

University of Cape Town health economics unit researcher Di McIntyre, who has completed a study of the distribution of public health care expenditure in terms of the new provincial boundaries, said annual per capita spending in the Western Cape was almost four times as much as in the Eastern Transvaal.

With the exception of KwaZulu/Natal, those provinces which had academic hospitals — Western Cape, PWV and Free State — also had the highest per capita expenditures, McIntyre said. (85)

However, it was necessary to make regional comparisons after excluding expenditure on academic hospitals as these institutions often provided specialist services for a wider population than residents of the province in which they were based.

In addition, these hospitals trained health professionals who, once qualified, often worked in other provinces.

Excluding academic hospitals from the geographical analysis reduced the gap in spending and affected the ranking of provinces — but glaring disparities were still obvious, said McIntyre.

The highest spending was in the Western Cape, which had an annual per capita spending of R303, and the lowest in the Eastern Transvaal, with a per capita spending of R142,75.

Following the Western Cape on the list were Northern Cape, PWV, Eastern Cape, Natal/KwaZulu, OFS, Northwest, Northern Transvaal and Eastern Transvaal.

McIntyre said government was faced with the challenge of meeting calls for a more equitable distribution while at the same time ensuring this process occurred at a pace which did not jeopardise the existing health infrastructure. Issues such as differential population densities and migration patterns also needed to be taken into consideration, as well as the allocation of private health resources.

R300m for SA health, literacy

CT 14/10/94

From LINDA ENSOR

LONDON. — Over R300 million is to be committed for development projects in South Africa by the European Commission (EC) over the next few months.

Commitment of the funds — which form the bulk of the European Union's 110m European Currency Unit (about R529m) allocation for South Africa — is crucial if allocation is to be increased by 25% next year.

Development committee official Mr David Lowe said yesterday there had been fears the funds would not be committed in time because EC officials had been unaware of the progress made.

Sympathetic

About R100m was likely to be committed to health projects and over R100m to education, particularly literacy, and the rest to rural and community development projects.

Most of the money would be channelled through provincial legislatures.

The EC was sympathetic about the causes of the delay, especially as they arose from a determination on the part of the SA government to establish proper procedures which were effective, transparent and efficient.

Funds dry up on health workers

By AYESHA ISMAIL

COMMUNITY health worker projects in the Western Cape region are on the brink of collapse as a result of lack of funds from traditional foreign donors who have changed their funding priorities.

Community health workers provide primary health care in informal settlements in the greater Cape Town area as well as in several rural towns.

In a bid to save a project begun at Brown's Farm Squatter Camp in 1989, the Health Care Trust wrote to President Nelson Mandela this week asking him to put pressure on the European Union to expedite the payment of funds owed to them. They have also asked him to provide interim financial assistance to allow them to continue their work.

Also facing collapse is the South African Christian Leadership Assembly Health Project (Sacla) which was established in 1980. Sacla is engaged in several projects involving community health and rehabilitation workers.

Sacla spokesperson Di Hewitson said non-governmental organisations (NGOs) could no longer rely on overseas funding. There was an urgent need for the government to recognise community health and rehabilitation workers and to pay their salaries.

"Funders have told us that South Africa is no longer a special case, we are part of Africa and must now compete for funding," Ms Hewitson said.

"We have approached the government on national and provincial level for funding, but structures have not yet been put in place for them to process funding applications," Ms Hewitson said.

"Our project received bridging funds for six months. We do not know how we will survive beyond that," Ms Hewitson said.

Sacla Health Project is a non-profit NGO and at present is almost entirely dependent on donations and fund-raising to run the project and pay the salaries of its employees.

The Health Care Trust's Brown's Farm Health Worker Project, which trains community workers in primary health care, is at present unable to implement its programmes due to a delay in receiving funds owed to them by the European Union.

According to the projects primary health care nurse, Bridget Lloyd, they have not yet received their full budget for 1993, despite a contract between her organisation and the Kagiso Trust, which acts as a conduit for the European Union.

As a result of lack of funds, community health workers had run out of medicine stocks and clinics had to be suspended, she said.

Poor health service 'due to inequity'

CT 18/10/94 (85)

Staff Reporter

THE poor performance of South Africa's health care system was due to the gross inequity in the distribution of resources where more than 50% of the health budget was spent on 20% of the population, Groote Schuur's chief director, Dr J Kane-Berman, said yesterday.

Speaking at the Conference of the International Federation of Hospital Engineering in the city, Dr Kane-Berman said South Africa spent more than six percent of its GNP on health care — more than the WHO target of five percent for developing countries.

"Yet South Africa's health status indicators such as longevity, infant mortality and immunisation coverage are poor compared with some less developed countries, even in Africa. It seems that some health care systems are carefully designed to waste resources," she said.

She said the public sector would have to carry the major responsibility for the government's programmes to achieve equity and access to health care for all.

Dr Kane-Berman said the government had cut the budgets of academic hospitals by five percent for 1995 and would impose further cuts over the next four years.

"The minister has been advised of the extremely damaging effect this will have on health services," she said.

Patients queue for hours for medicine

Staff Reporter

A LABOUR dispute in the pharmacy department at Groote Schuur Hospital is causing long queues and shortened dispensing hours.

Patients from clinics, out-patients and in-patients at the hospital have been queuing for hours to receive medicines, a hospital source told the Cape Times.

The pharmacy department is normally open until 5pm but now closes each day at 3pm to deal with the backlog of work.

A hospital spokeswoman said yesterday that shortages of pharmaceutical staff and the dispute over some job functions in the department had led to delays in dispensing medication.

Hospital backup vital, says doctor

KATHRYN STRACHAN

UNLESS hospital backup could be provided for life threatening situations, primary health care was being reduced to little more than a cynical political ploy, Baragwanath Hospital superintendent Dr Grant Rex told a recent conference.

He said that taken in isolation, primary health care was a form of second-rate care to people who could not afford private health services.

Unless it was backed up by sophisticated, high technology secondary and tertiary levels of care, primary health care was reduced to a public relations exercise which offered little more to people than if they were left to their own devices.

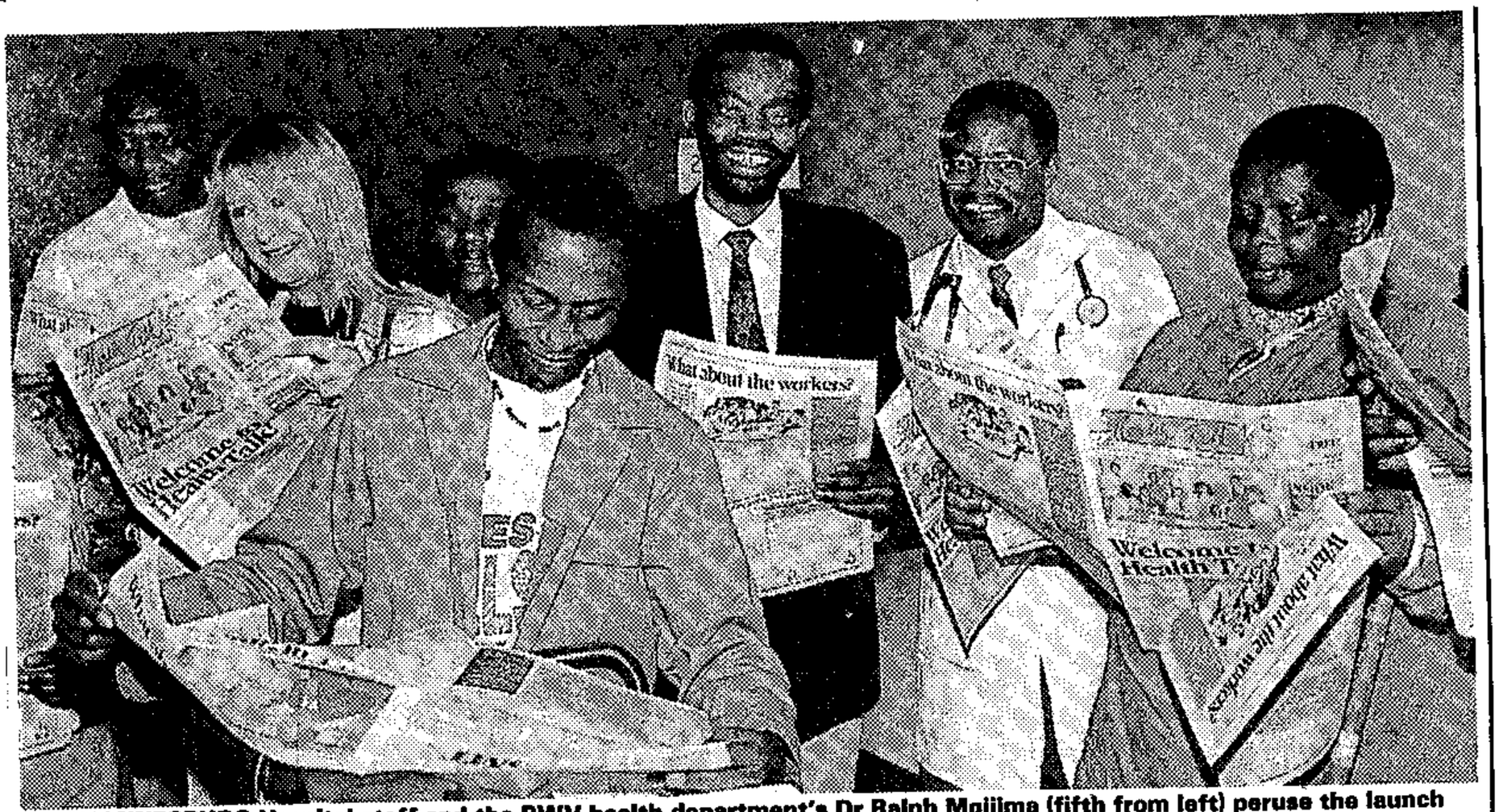
It was only in the context of accessible and effective hospital service backup that primary care could be justified as a development which offered any improvement to those most in need.

He said the shift in policy towards primary care was brought about mainly because of the unequal access which different population groups had to hospital services. B/Day 15/10/94

In a 15-year survey from 1976 to 1990, it had been shown that the annual rate of admission to hospitals had been significantly less for blacks than for whites.

The same discriminatory pattern was seen when looking at the outpatient consultation rate at the hospitals — despite the fact that the black mortality rate was higher than whites'. (85)

The survey also showed blacks were generally far sicker than whites when they were eventually admitted.



JOHANNESBURG Hospital staff and the PWV health department's Dr Ralph Mgijima (fifth from left) peruse the launch copies of Health Talk, a PWV health department newspaper, at the hospital yesterday. Picture: ROBERT BOTHA

B Daily 13/10/94

Free newspaper launched for health workers

NOMAVENDA MATHIANE

THE PWV health department yesterday launched a free newspaper aimed at health workers.

The four-page tabloid, called Health Talk, is the first of a string of initiatives by a health strategic management team aimed at informing health workers in hospitals and clinics about developments in their profession. Although most of the articles are in English, major stories appear in Zulu, Sesotho and Afrikaans.

Team spokesman Dr Ralph Mgijima said the newspaper was a way of getting in touch with the community and improving labour relations within the health sector.

He said as services were being restructered, workers needed to be informed of the changes. They hoped to alter the bad impressions workers had of the TPA.

"We will appeal to companies to buy space. We hope readers will inform us of their needs," he said.

Mgijima said the newspaper would be followed by a series of video programmes that would focus on health issues. (85)

The newspaper will be distributed at health centres every six weeks.

Clean hands 'can save money'

(123) (85) CT 9/10/94

By MELANIE GOSLING

IF all South Africans washed their hands at the appropriate time, primary infections would be reduced by 15%, Mr G A Muhl said at the International Federation of Hospital Engineering conference in the city yesterday.

"Poor sanitation is a major health hazard. The number of diseases directly related to inadequate sanitation acounts for about 54% of all hospital admissions.

"The simple act of washing hands could decrease primary infections by 15%, which at R150 per patient a day, could generate enormous savings," he said.

The provision of water and sanitation was a basic need, but even in some urban areas, people found it difficult to pay for such services.

"Services will have to subsidised to a certain extent (but) in the long-term, services must be paid for by the user. The ideal approach should be that each user pays for what he uses," Mr Muhl said.

"Education must include basic health education and communities must be taught that water and sanitation services affect their health positively," he said.

Crisis conditions at hospitals may worsen

BIDay 20/10/94

KATHRYN STRACHAN

CONDITIONS at crisis-ridden state hospitals could worsen with the proposed academic hospital budget cut next year, unless services at clinics were upgraded so they could relieve the pressure on hospitals, hospital managers said yesterday.

Responding to a flood of complaints from the public about the squalor and poor services at many state hospitals, Health Department director-general Coen Slabber said the lack of funding lay at the centre of the problems.

There was a shortfall of R800m on the 1993/94 health budget, and a greater shortfall could be expected this year. He said there was no increase expected in the health budget next year.

JG Strijdom superintendent Annemarie Richter said a few clinics were beginning to move into the area of curative care, in addition to their preventative immunisation and maternal care services.

These upgraded clinics would go a long way to easing the load at overburdened hospitals, but the process of transforming their services was too slow.

If these primary health care services could be immediately set up they could lessen the impact of Health Minister Nkosazana Zuma's proposed 5% cut on existing academic hospital budgets, said Richter.

JG Strijdom experienced many problems as a result of a shortage of nurses, she said, and a committee had been set up to investigate ways of improving nursing services through a rationalisation programme with Coronation Hospital.

Baragwanath Hospital superintendent Grant Rex said powers needed to be decentralised to give hospital managements the space to make changes and improve services.

Slabber said that once control was devolved to the provinces and to a single health authority in each district, there would be an improvement.

He added that labour relations played a major role in conditions at hospitals, and it was often not the hospitals which were the most under-resourced, but those with the poorest labour relations which experienced the greatest problems.

Slabber said that all medical school deans and hospital superintendents had been asked to submit their ideas on how to improve management, especially financial management of hospitals.

Health services hamstrung by financial restrictions – Zuma

■ BY CHRIS WHITFIELD
POLITICAL CORRESPONDENT

Cape Town — Health Minister Dr Nkosazana Zuma has fleshed out plans to transform South Africa's health services towards primary care driven at district level.

But in her budget vote address to the National Assembly yesterday she stressed that her plans were being hamstrung by financial restrictions and said bridging funds would be needed to address disparities.

"The cornerstone on which the future health care system will be built is the district health system," she said.

A functional, integrated system in which health districts were developed was crucial to the success of transformation.

"It is at district level that people's basic health needs are met, that the community can participate in the planning and provision of services, and intersectoral co-operation and co-ordination becomes a reality.

"The goal we must strive for is the development of an integrated comprehensive primary health care service rendered by a single authority at the district level."

She did not directly address the controversial issue of academic hospitals, only pointing out that the deans of all medical schools had agreed that their expenditure would be reduced by 5 percent next year.

Mortality

Zuma listed priorities as:

■ Childhood survival. The mortality rate for under five-year-olds in South Africa was 70 per 1 000 live births. Immunisation and nutrition programmes were being developed.

■ Safe motherhood. The maternal mortality rate for Africans in the country was 58 per 100 000 live births, while the comparative figure for whites was only eight. Improved access to health services and family planning services would be sought.

Other areas of concern included AIDS and sexually transmitted diseases, hypertension and diabetes, emergency health services, mental health care, the disabled, the elderly, and the fact that the public and private sectors were not working together in a "collaborative manner".

Zuma painted a bleak picture of the financial difficulties facing the country's health services, pointing out that 81 percent of the population had no medical aid.

"The R14 billion we allocated for 1994/95 is clearly not sufficient to meet the challenges in 1995/96. Bridging funds in the short to medium term are necessary."

Health care to target districts

(85) ARG 21/10/94

Political Staff

HEALTH Minister Nkosazana Zuma has fleshed out plans to transform South Africa's health services into a primary-care driven service at district level.

But in her budget vote address to the national assembly yesterday, she emphasised that her plans were being hamstrung by financial restrictions and said bridging funds would be needed to address disparities.

"The cornerstone on which the future health-care system will be built is the district health system," she said.

Dr Zuma said a functional, integrated system in which health districts were developed was crucial to the success of transformation.

"It is at district level that people's basic health needs are met, that the community can take part in the planning and provision of services, and where intersectoral co-operation and co-ordination becomes a reality."

The ideal was that the political and administrative boundaries of local government and health districts should correspond.

"The goal we must strive for is the development of an integrated comprehensive primary health care service rendered by a single authority at the district level."

She did not directly address the controversial issue of a reduction in the size or number of academic hsopitals, only pointing out that the deans of all medical schools had agreed that their expenditure would be reduced by five percent next year.

"This is a significant loss to them, but when it is divided among the nine provinces it is not very significant."

After her budget vote address, Dr Zuma said she was involved in discussions with the deans — "looking precisely at academic medicine".

Dr Zuma said the new health department had to seriously address the issues of childhood survival, safe motherhood and healthy workers.

Health budget gets thumbs-up

ET 22/10/94

JOHANNESBURG. — The health policy committee of the Medical Association of South Africa yesterday reacted favourably to this week's budget speech by Minister of Health Dr Nkosazana Dlamini Zuma. (85)

Committee chairman Dr Ivan McCusker congratulated Dr Zuma for correct priorities of improving access to health care and the emphasis on women's and children's health. — Sapa

Kriel warns thousands may lose jobs

CT 24/10/94

By BARRY STREEK
Political Staff

THOUSANDS of people in the health and education sectors in the Western Cape would lose their jobs if government guidelines for next year's budget were implemented, Premier Mr Hernus Kriel warned at the weekend.

The government decided because the province has the best health and school facilities in South Africa, it would get less money, he said at the NP's Western Cape congress in Somerset West.

"If you cut back in the health service, standards will drop," Mr Kriel said.

However, health services in the Western Cape were already stretched.

Despite the severe backlogs in former black areas, the government was adopting the same approach in education as in health and thousands of people would have to be retrenched.

"If these cuts are made, we will tell people the reductions were made because the ANC does not want to give us the money.

NP TO BUILD NEW IMAGE
See PAGE 2

"What happened to the ANC's promises in the election campaign that there would be better health services and better education in the Western Cape?"

Provincial Education Minister Mrs Martha Olckers told the congress if the provincial budget was so poor, "we are going to have to retrench teachers, not 20 or so but thousands".

She also said the Western Cape needed R65 million to address backlogs in education, but had only received R6,9 million.

Thousands of children could not attend school in Khayelitsha.

At Brown's Farm, there were only two primary schools for an estimated 12 000 children.

The Western Cape Minister of Finance, Mr Kobus Meiring, said the province had submitted 2 492 projects, which cost about R3,07 billion, to the RDP office, but it had been told it would only receive R15m.

Alex health programmes suspended

Star 26/10/94

■ BY ANNA COX

Increased crimes against nurses and health workers have forced the Alexandra Health Care Centre to suspend three vital community outreach programmes.

During the past nine months three clinic vehicles have been hijacked, nurses have been held at gunpoint and robbed in a children's health outreach caravan, health workers have been threatened by criminals during house visits and handbags have been stolen from clinic premises.

Last week, a bakkie was stolen at gunpoint from the clinic. The driver, Ben Mashigo, was warming the engine when two armed men attacked him and threw him out of the vehicle.

The suspended outreach programmes involved nurses going into the township and providing health care and rehabilitation programmes for children, the aged and invalids.

Nursing staff members are now afraid and are refusing to go into Alex. (85)

Institute of Urban Primary Health Care community liaison officer Willy Lekoloane said: "The situation is out of control. The community itself must put a stop to these criminal acts against us. In the past, during all the violence in Alexandra, we were left alone to do our work. We were able to go anywhere, irrespective of political delineations, and would be given free passage because people realised we were there working for their benefit. Now common criminals are preventing us from rendering badly needed health services."

On Tuesday next week clinic staff, including doctors and nurses, plan to march to the Alex police station to hand a memorandum to the police.

Combining old and new to heal and relieve

(85 ARG 27/10/94

☐ 'Recognise traditional medicine'

JENNY VIALL
Staff Reporter

TRADITIONAL healing and high-tech medicine should be combined to optimise care and therapy for cancer patients.

This was the message from several speakers at a seminar on co-operation between traditional healers and western health professionals.

Philip Kubukeli, president of the Western Cape Traditional Doctors and Herbalists Association, said it was essential for traditional healers and western practitioners to share skills in treating cancer and other illnesses.

He said traditional healers had to be recognised by the government and needed to be sponsored to upgrade their skills and set standards for the profession.

"Western people don't understand healing and herbalism: there is a great need for collaboration to increase understanding.

"Health is a complete state of physical, social and mental well-being. Western medical doctors treat disease; traditional doctors treat the person, who happens to be ill."

Dr Carl Albrecht, chairman of the Cancer Association, said it was important to look at the totality of the experience of the cancer patient.

He said the war against cancer continued, with one in two cancer patients likely to die "in the best of situations".

Dr Nandi Mbawu, a medical officer for the Cape Town city council, told the seminar the role of traditional healers should not be underestimated in the fight against cancer and they should be encouraged to come forward with their knowledge.

Traditional healers had a lot to offer in the spiritual healing of cancer and in alleviating their suffering.

Many cancer patients consulted both traditional and medical doctors, but were ashamed to admit it and did not tell their doctor, she said.

"We need to tell people that belief in ancestors is not stupid or superstitious. Let the traditional healers come forward and let the medicines be researched properly. We need co-operation so that the left hand knows what the right hand is doing."

Linda Gqiba, Philani Cancer Centre area manager, said the patient stood to lose if traditional healers and western doctors undermined each other.

The Philani office in Langa drew together traditional healers and medical practitioners into a holistic team to treat cancer patients in a unique project, she told the seminar.

Speaking from an indigenous healer's perspective, Hillary Shannon, a specialist in Flower Essence therapy, said cancer was often about coming to terms with aloneness, learning to forgive and learning to express love.

Cancer isolated people by forcing then to confront death.

People with cancer were also forced to look at the "bigger picture".

"You can't just operate on cancer and say it's cured — you have to look deeper."

Eighty percent of traditional medicines already tested had been found to be safe and effective, said Dr Nigel Gericke of the UCT Pharmacology department.

"About nine percent of these plants showed some toxicity."

His department was drawing up a traditional medicine database.

Isaac Mayeng of the same department said a partnership between traditional healer and scientist was a daunting, challenging venture requiring understanding, trust and mutual respect.

HEALING HANDS: Traditional and western medical practitioners came together in Langa to discuss co-operation between the two in treating patients. From left, traditional healers Rita Ncivata and Christabel Luzipo dance with nursing sister Linda Gqiba, traditional healers Caroline Ntilashe and Ester Dube, and Cancer Association hospice worker Carol Jacobs.

Picture: OBED ZILWA, The Argus.

Rural poor at risk of disease

Sowetan 27/10/94

By Mokgadi Pela

LARGE sections of South Africa's population, particularly black rural communities, could be at risk of conditions like Down syndrome and albinism, a study undertaken in the Northern Transvaal has revealed. (85)

The study done at Mankweng Hospital, 30km east of Pietersburg, showed that five to eight percent of infants born in rural areas could be affected by a genetic anomaly by the age of five.

Genetic anomalies

"This has serious consequences for mortality and morbidity of children in rural areas. The economic repercussions of such an ongoing epidemic cannot be ignored," says Dr AL Christianson, of the Department of Human Genetics at the University of Pretoria's Faculty of Medicine.

Socio-economic factors that predispose mothers to having an infant with a congenital anomaly include poverty and poor diet. The incidence is also known to vary with geographical location and ethnicity.

"The silent ongoing epidemic of genetic anomalies documented in the Northern Transvaal is possibly endemic in many rural areas of the country.

"This has highlighted the fact that the ravages of poverty and malnutrition are not confined to the living, but are also imparted to the unborn," says Christianson.

A genetics outreach programme, called Genetics for Africa, is being undertaken by the Department of Human Genetics to address these problems.

The combined incidence of neural tube defects and Down Syndrome in the Northern Transvaal study was one in 177 live births.

This incidence could to a great extent be reduced by simple inexpensive means through an effective primary health care system.

NEWS Hospital finance: Baragwanath to get less per bed than Johannesburg

Uneven health fund allocations

Sowetan 27/10/94

By Ismail Lagardien
Political Correspondent

BARAGWANATH Hospital has received considerably less money per bed for the current financial year than the Johannesburg Hospital, according to the Ministry of Health.

In answer to questions in the National Assembly, Health Minister Dr Nkosazana Zuma said Baragwanath, with 3 205 beds, had been allocated R321 million while Johannesburg Hospital, with 897 beds, had been allocated nearly R368 million.

According to the Defence Ministry, One Military Hospital in Pretoria, with 485 beds, had been allocated R108 million. The total bill for military hospitals countrywide was R181 million, compared with R3,104 billion for civilian hospitals.

Unacceptable

The Democratic Party's Mike Ellis said this was unacceptable as "there is no war". He suggested that the military hospitals carry the overflow of patients from the government civilian hospitals.

Under the terms of the interim constitution, military hospitals will continue to provide medical care for ex-members and retired members of the old South African Defence Force. (85)

Civilian hospitals

Ellis referred in particular to emergency cases where some civilian hospitals had more patients than beds.

In answer, the Defence Ministry said military and civilian hospitals could not be compared statistically as defence medical personnel were deployed in various areas and for extended periods.

A sample breakdown of the "per-bed" allocation is as follows: Johannesburg Hospital — R410 176; One Military Hospital — R223 287; Baragwanath — R100 223; Hillbrow — R166 395; Garankuwa — R121 246; and, Coronationville — R158 892.

A sample breakdown of the hospitals' "bed-occupancy" rate is as follows: One Military Hospital — 50,8 percent; Baragwanath — 53,4 percent; Coronationville — 62,8 percent; Garankuwa — 82,7 percent; Hillbrow — 69,5 percent; and, Johannesburg — 97,6.

Tygerberg workers return

By Vicky Stark

Sowetan 28/10 - 1/11/94

STRIKING health care workers at Tygerberg Hospital returned to work this week.

Mr Wilfred Alcock of the National Education Health and Allied Workers Union (Nehawu) said workers were drafting an agreement which they will present to the authorities this week.

"The agreement will specify time frames for an inquiry into appointments, promotions and disciplinary measures at the hospital," Mr Alcock said.

Spokesperson for the hospital said for the first time since the strike was initiated on October 4, all services were running smoothly. (85)

"Patient services are back to normal," she said.

Health workers send out SOS for funds

By Shannon Neill

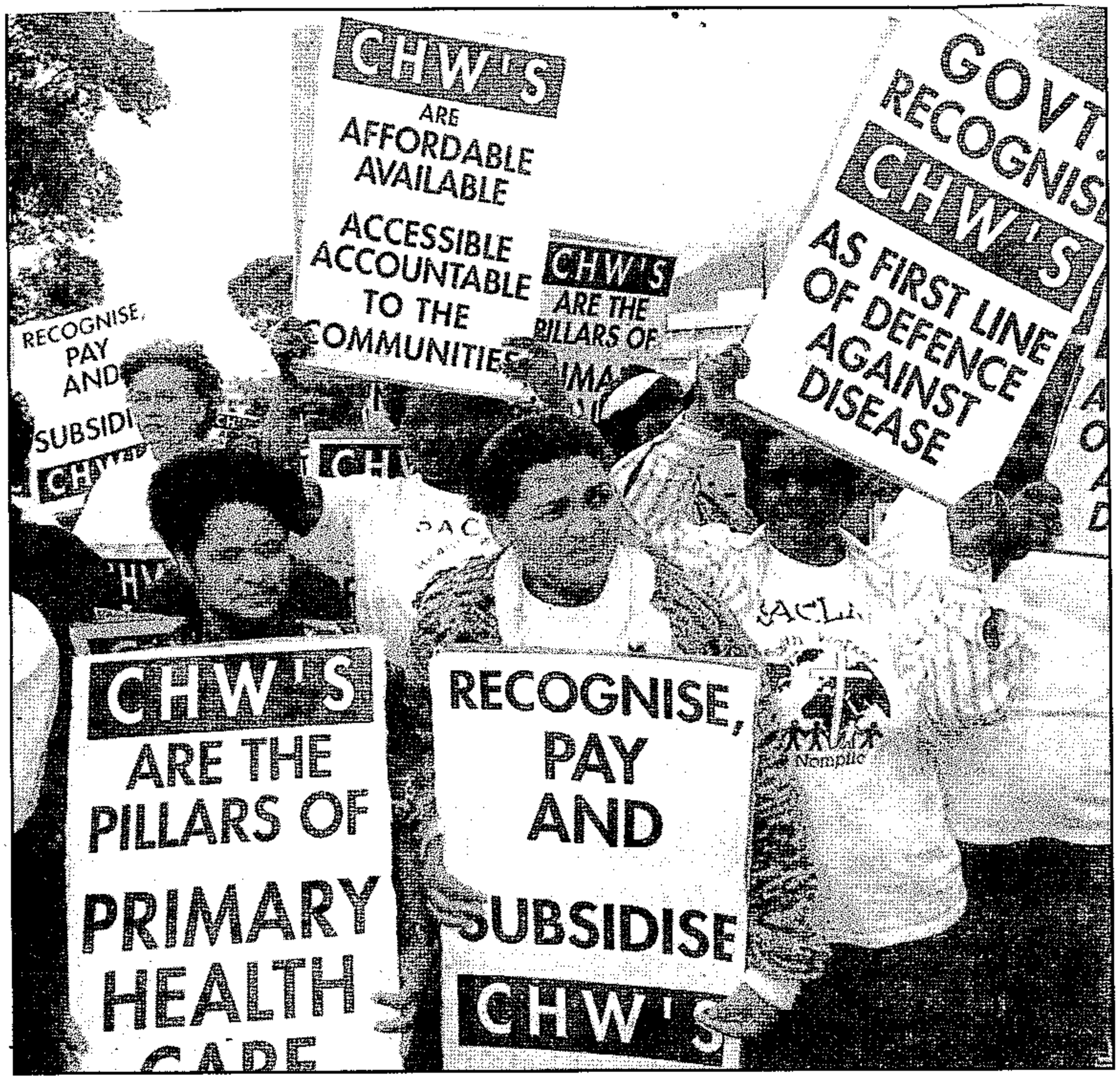
A DESPERATE lack of funds has driven the National Progressive Primary Health Care Network (NPPHCN) to make an urgent appeal for assistance to the Minister of Health, Dr Nkosazana Zuma.

About 300 community health workers (CHWs) marched to parliament to present a memorandum to the minister requesting her help in getting foreign donor agencies to honour their pledges for aid.

The delegation was met by regional minister of health and welfare, Mr Ebrahim Rasool.

He said he would arrange a meeting with the NPPHCN to "discuss the memorandum and other issues". He did not specify what these other issues were.

Chairperson for the CHW Development Group, Mr Whitey Jacobs, said that prior to the election most political parties, the ANC included, had expressed a willingness to support CHWs.



RUNNING ON EMPTY: Health workers seek more funds **Photo: Yunus Mohamed**

Jacobs said: "Our main concern is that the ANC isn't doing anything now and if the CHWs collapse the country will be deprived.

"Because we're on the ground we can treat diseases while they're still curable. Anything we can't treat we immediately refer to a hospital or clinic.

"These workers are community based and can deliver a service that the people trust."

A CHW who did not want to be named said the disabled would suffer most if the CHWs were unable to continue their work.

She said the state would rather move the disabled into institutions than provide them and their families with support at a grassroots level.

"We get them involved in making decisions about their future in the community. If they go to an institute they become completely dependant on others," she said.

The minister will respond to the NPPHCN's memorandum at a later date.

FW: Govt committed to health

(85)

CT 29/10/94

JOHANNESBURG. — Deputy President F W de Klerk reiterated the government's commitment to restructuring health services while opening a polyclinic at Sebokeng Hospital, in the Vaal Triangle yesterday.

He said available funds had to be spent more efficiently, adding the Department of National Health was currently discussing its needs with the treasury.

It was possible that more money could be given to health.

"South Africa's spending pattern on health is not in step with comparable countries."

An important step would be upgrading the referral system to remove unnecessary pressure on hospitals, especially academic hospitals.

Mr De Klerk said too much was being done at hospital level and too little at entrances which referred patients for treatment.

During his five years in office, a blueprint for new health care had been developed, including what he called the five pillars of health care — accessibility, efficacy, affordability, equity and acceptability.

He warned not to expect too much too soon. "We only have so much money," he said. — Sapa

No speed limit for NP chief

JOHANNESBURG. — A national blitz on speed limit breakers was of little concern to Deputy President F W de Klerk as he raced from Johannesburg to open a polyclinic at Sebokeng in the Vaal Triangle yesterday.

His entourage reached speeds up to 180km/h, which according to Johannesburg traffic spokesman Mr Eric Hill would have earned a motorist "a heavy fine" and possibly a court appearance. — Sapa

Trauma shown to be SA's second biggest killer

(85) ARG 29/10/94

■ Future trauma services and intervention strategies in the Western Cape should lead the field in South Africa if planners heed the results of a unique study by the Medical Research Council concerning the issue of what's needed, where facilities should be and when they should be open.

DI CAELERS

Weekend Argus Reporter

THE Western Cape has the advantage when it comes to pinpointing future health needs in the province.

It's armed with unique data that leaves planners with no excuse for not being spot-on with future location of services, deployment of staff and operating times of emergency facilities.

The ambitious Cape Metropolitan Study, and the subsequent rural injuries surveillance study for surrounding regions, are unique in Africa and have come up with the first verifiable regional data concerning the country's second biggest killer — trauma.

The studies — projects of the Medical Research Council — have provided data regarding some 3,4 million residents of the Western Cape.

Apart from being vital for future design of health services, the studies are just as important for pointing out particular phenomena that should be addressed by means of direct intervention.

Johan van der Spuy

Johan van der Spuy, head of the MRC's national trauma research programme, puts the study in perspective:

"In South Africa trauma is the second biggest cause of death as opposed to the United States where it is fourth.

"Globally, trauma accounts for 5,2 percent of all deaths, but in South Africa that figure spirals to 16 percent."

Dr Van der Spuy said changes were being made in accordance with findings, most noticeably changes to operating times of day hospitals and clinics following evidence of a "geographic mismatch of what is needed for trauma services and what is open (to the public) when trauma occurs".

"We found that a lot of trauma was minor and could be managed by nurses. But, it came through into the main hospitals because they were the only ones open."

The study found that 74 percent of trauma occurs after office hours and 52 percent over weekends. On Saturday nights the load exceeded the total 24-hour load of any other day.

"So we end up with the teaching hospitals — which are designed to treat severe trauma — being bogged down to the point where they are forced to close down for some hours because of the multitude of relatively minor trauma coming through."

At Groote Schuur, he said, only 4,4 percent of the people treated there in one year actually required the facilities of such a hospital.

Day hospitals and clinics could have taken care of 73,4 percent of the trauma.

"Because of this unnecessary load on tertiary hospitals, we have people waiting up to 10 to 12 hours to get into theatre for urgent abdominal injuries."

The following observations were made:

■ That interpersonal violence accounted for 34 percent of trauma.

■ That alcohol accounted for (very conservatively estimated) 28 percent of all trauma in the Cape Peninsula. But 67 percent of all trauma deaths were alcohol related. Alcohol was not involved in only one third of trauma deaths.

■ That one third of people who get injured were pedestrians, but two thirds of people who died were pedestrians. And, of adult pedestrians who were killed, three quarters were alcohol positive and 58 percent had extremely high blood-alcohol levels — more than two and a half times the legal limit for driving.

■ Almost half the incidence of spinal cord paralysis was due to interpersonal violence — 30 percent as a result of stabbings, seven percent from gunshots, and six percent from blunt-force attacks.

The study also found that one in 10 people each year needed medical attention for a "fresh injury" and that the highest incidence of trauma occurred in the age group 15 to 29 years, with twice as many men as women being injured.

The treatment load was also extremely heavy on the State sector with only 24,2 percent of injured people being treated in private facilities and the remaining 75,8 percent being treated by the State.

Sutcliffe slams critical report on CPA 'fraud'

(85) CT 2/11/94

By CHRIS BATEMAN

UNDER-funding of hospital and health services in the former Cape Province was directly responsible for the R108 million of "unauthorised expenditure" — without which services would have collapsed and staff retrenched.

This was said yesterday by Dr Tom Sutcliffe, deputy director-general of Hospital and Health Services in the Western Cape, in response to the auditor-general's critical 1992-93 report on the CPA tabled in Parliament on Monday.

The document painted a picture of corruption, theft, fraud and financial mismanagement — but press reports had ignored "pertinent explanations", given by his branch to questions raised by the auditor-general, Dr Sutcliffe said.

He said the past few years had been "desperately difficult times" in which to manage health services with rising crime, violence and rapid informal urbanisation set against diminished health funding.

A sum of R14,6m attributed by the auditor-general to theft and losses was neither lost nor stolen and referrred to unrecovered fees, written off to the satisfaction of the auditor-general. These fees had been charged to the poorest patients.

The sum of R502m for equipment used by the Peninsula Technikon but belonging to the Peninsula's academic hospitals was fully covered by a legal agreement which the auditor general's staff "regrettably overlooked". This had since been corrected, Dr Sutcliffe said.

Of major concern were cases of fraud by "certain part-time district surgeons", which brought the whole district service into question, he said.

Zuma seeks aid boost

(85) CT 4/11/94

From LINDA ENSOR

LONDON. — The Department of Health needed at least R2 billion extra next year to finance its health programme, Health Minister Dr Nkosazana Zuma said in an interview yesterday.

This year the health budget amounted to R14bn, and any future increase would have to come from international aid raised through the government, through a reallocation of the existing budget and from Reconstruction and Development Programme funds.

Dr Zuma was in transit from Washington where she addressed a public health conference.

She noted that the budgetary shortfall was largely due to the amount spent on tertiary care.

In her speech in Washington the minister attributed the high rate of violence to the way people were brought up.

"The only way to reduce violence is to improve the material conditions in which people live ... If our young people do not have a stake, they have nothing to protect and will become destructive," she said.

Private hospital fees set to rocket

(85) CT 10/11/94

JOHANNESBURG. — The private hospital industry proposes 1995 tariff increases of 60-90% for high-care and major surgery to offset price reductions at the lower end of the market and in pharmaceuticals, a spokesman said.

Although the proposal had not yet been accepted, medical scheme administrators had indicated approval despite opposition from smaller "cost-conscious" hospitals, said Carl Grillenberg, joint MD of President Medical Investments.

Addressing analysts, he also said that government was not in a position to run an efficient national health insurance scheme. It said recently it was considering such a scheme.

Grillenberger said the health care industry was paying "lip service" to the curtailment of health care costs, and new current global incentives to practioners would not work.

Only direct incentives would motivate practioners to cut costs and reduce fraud, over-servicing and abuse of medical aid schemes, he said.

Immediate incentives should be to promote the use of day clinics and encourage the use of generic substitution, he said.

Forum opts for primary health care

CT IS 1/11/94

THE Cape Metropolitan Health Care Forum (CMHCF) adopted the primary health care principle at the weekend as the way to approach health care in the Western Cape.

Chairman Mr Michael O'Brien said yesterday the plenary CMDCF meeting had also decided to adopt a district system.

The restructuring would use the boundaries of 10 districts proposed by the Western Cape Negotiating Forum. (85)

"Much of health care has to do with the provision of housing, sanitation and water. If the health care boundaries are the same as the political boundaries, health care would be facilitated," Mr O'Brien said.

● The CMHCF is open to all organisations able to contribute towards better health services.

R7m network of centres to serve needy

CT 16/11/94

(85)

By CHRIS BATEMAN

A NETWORK of five multi-purpose community centres, costing nearly R7 million, serving needs as varied as street children and the frail and aged, was announced by Western Cape Health and Social Services Minister Mr Ebrahim Rasool yesterday.

Two are to be built between George and the nearby Tembalethu township and in the Worcester area between Zwelethemba and Riverview townships at a cost of R2,5m each. Another three existing buildings will be upgraded in Atlantis, Bonteheuwel and Guguletu at a cost of R626 000 each.

Construction of the new centres will use 70% of local labour.

Mr Rasool said negotiations with the City Council to take over a building in Bonteheuwel were far advanced and a site was being sought in Guguletu that would best serve the wider community.

"In urban areas the centres will serve as shelters for the growing number of street children because they will be located where the kids come from."

He revealed that the German consulate had donated R50 000 for containers and equipment for use as crèches at the Lusaka Camp in Nyanga. Existing creches would also be upgraded in Khayelitsha and Old Crossroads.

'Crisis not caused by free health care programme'

Hospitals overspend – Zuma

Star 17/11/94

■ **BY DAVID ROBBINS**
HEALTH WRITER

Overspending by provincial hospital authorities, and not the introduction of free health care for children and nursing mothers, is one of the major causes of the crisis in South Africa's health care delivery system, accoring to Health Minister Dr Nkosazana Zuma.

This overspending is seen as part of an historical pattern which has regularly included mid-year supplements to most hospital budgets. This year, the total mid-year supplement amounts to a massive R2 billion.

Zuma said in an exclusive interview that some provincial health authorities were "overspending with impunity" in spite of appeals for constraint.

"Then there is a tendency to run to the press, saying hospitals will have to close unless additional funds are found to cope with the demands of the free health programme," Zuma said.

Children

The programme, which provides free health care for children under five and pregnant and nursing mothers, was initiated by President Mandela earlier this year. (85)

Zuma said the introduction of the free health programme had been discussed with provincial authorities who had shown varying degrees of co-operation, but it had been generally agreed that the cost of its application would not be exorbitant.

Initial estimates suggested a figure of about R70 million, although it seems likely that the final cost could be more than R100 million.

"The need to introduce free health care for the young is underlined by South Africa's under-five mortality rate, which stands at 70 per 1 000, compared to the 32 per 1 000 average for other countries in our income group," she said.

Zuma also pointed out that the free health programme had highlighted "the terrible inadequacies" in the existing health care delivery system where hospitals consumed 75 percent (R10,5 billion) of the public health budget, leaving only R3,5 billion for peripheral services.

Distribution

"The point I have tried to put across is that the amount we spend on health is probably enough. The problem has been in its distribution. We simply have to move more of our resources from hospitals to the periphery, thus relieving hospitals of the burden of patients who should properly be treated at peripheral clinics," Zuma said.

▶ S Africa shoulders health burden – Page 23

The words "health" and "crisis" have for a long time been synonymous in South Africa. Before April 27, the health crisis was always discussed in terms of apartheid-based iniquities. ***DAVID ROBBINS*** *asked Health Minister Nkosazana Zuma to help define the new state of affairs.*

S Africa shoulders health burden

In need of surgery ... the rationalisation of hospitals and emphasis on primary health care lies at the heart of the envisaged health plan.

It must be taken as absolute that the new health crisis has not replaced the old, but has added to it. The disastrous iniquities of apartheid persist, and the new problems relate to the nature of the transformation necessary to correct the earlier imbalances.

It is worth recapping briefly on these imbalances. Blatant racial differentiation in terms of infant mortality rates and life expectancy, and an equally blatant bias in favour of urban-based curative care, have left millions of black South Africans out in the cold.

Conviction

Into this morass, in mid-1994, marches a new Minister of Health, Dr Nkosazana Zuma, armed with an ANC-inspired health plan.

At the heart of the new plan lies the conviction that peripheral health services — in the form of community-participative district health models — should become the basis of the nation's new package.

Primary health care, with its emphasis on preventive and promotive programmes, should hold centre stage, while the curative institutions should be rationalised — and protected from patients in need of lower levels of care — to more cost-effectively perform their vital supportive and referral roles for the peripheral services.

That's the theory. What of the practice?

"It's like a minefield," says Zuma. "There are so many vested interests in health."

The mechanics of introducing the new health policy are described by Zuma as "inverting the expenditure pyramid".

The current situation, inherited from the past and still existing in the shape of the R14 billion 1994/5 budget which was set before the new era began, is that more than three-quarters of the public health budget is spent on hospitals, while the peripheral services subsist on the balance.

"This needs to be reversed," says Zuma. "The bulk of our budget should be going to the periphery if the new health plan is to succeed. But the problems of shifting financial resources in this way are enormous."

Central to these problems, at least from a logistical point of view, is that hospitals are overloaded simply because the peripheral services are so weak.

"Most of South Africa's academic hospitals, for example, spend large proportions of their budgets on dealing with patients who should be attending at clinics which very often don't exist because resources are so concentrated in the hospitals. It's a vicious circle.

"What I have tried to argue is that the gradual release of resources from the hospitals for use at the periphery is not sufficient," Zuma explains.

"We cannot wait for this to take effect. For this reason, I have asked for bridging finance which we will spend at the periphery.

"This will have the effect of taking some of the pressure off the hospitals and facilitating a reduction of their budgets."

Zuma has already approached the Ministry of Finance, which has agreed to provide this bridging finance on condition that a plan is prepared to show how resources will be shifted from the hospitals to the periphery in the long term.

Nkosazana Zuma ... trying to divert resources from the centre of the health service to the periphery.

"Of course, we're already working on this plan. An important element concerns the country's seven academic hospital centres.

"The hospitals themselves are looking at the possibility of reducing their number of academic beds, and also at the need to spread these national assets more evenly over the nine provinces.

"In fact, they've already agreed on a 5 percent budget cut for 1995/6.

"Another element of the plan concerns managerial reform in all hospitals. Our belief is that if hospitals were better managed, costs could be reduced."

Logistical considerations aside, there emerges an even deeper malaise which is beginning to colour the new health crisis. Diverting resources from hospitals to the periphery is difficult enough, but not impossible. What might prove to be so is coping with the enormous powers and vested interests residing in the hospital structure itself, a structure which controls and consumes more than 75 percent of the health care budget.

Zuma deflects the suggestion. She talks instead of the high levels of co-operation she is receiving from the academic hospitals and from the majority of those engaged in public health.

She also says: "I believe we should be extremely careful not to alienate hospital superintendants and their managerial staff.

"We need to provide them with assistance, rather than destructively criticise."

Yet the thorns of the new health crisis are everywhere apparent. I remind Zuma of one of the recurring themes — hospitals overloaded and collapsing under the pressure of the recently introduced free health for childen and nursing mothers, a situation (if some press reports are to be believed) which has forced the provinces to call for a supplementary vote of more than R2 billion to bolster the country's hospitals over the remaining months of the current financial year.

Zuma's reply is suddenly unequivocal. "The hospitals are not collapsing. Nor are supplementary votes anything new. They're as old as the budgeting system we've inherited. And let's remind ourselves that this R2 billion shortfall in the budget was established before any impact of free health care for children could possibly have been felt."

Zuma says that when she first began to hear reports of overstrained hospitals, she called for random figures from the provincial health authorities. That was six weeks ago. So far, only the Free State has responded.

"The Free State figures show clearly that bed occupancy rates are, if anything, lower than in previous years. The crisis is in the outpatients' departments and the clinics," she says.

"In fact, the impact of the free health programme has highlighted the inadequacies of the present system and the need for precisely the sort of health care reconstruction which our health plan advocates. (BS)

"I would like to stress that the free health programme has not brought our system close to collapse, nowhere near it.

"But there are some who would blame everything on this programme while, at the same time, disregarding budgets and overspending with impunity, and then running to the press and saying they'll have to close unless more money can be found."

Represent

Who were these people prepared to lay the blame in this way? Do they represent those vested interests in hospitals anxious to ward off the reforms which would diminish the power of the hospital structure?

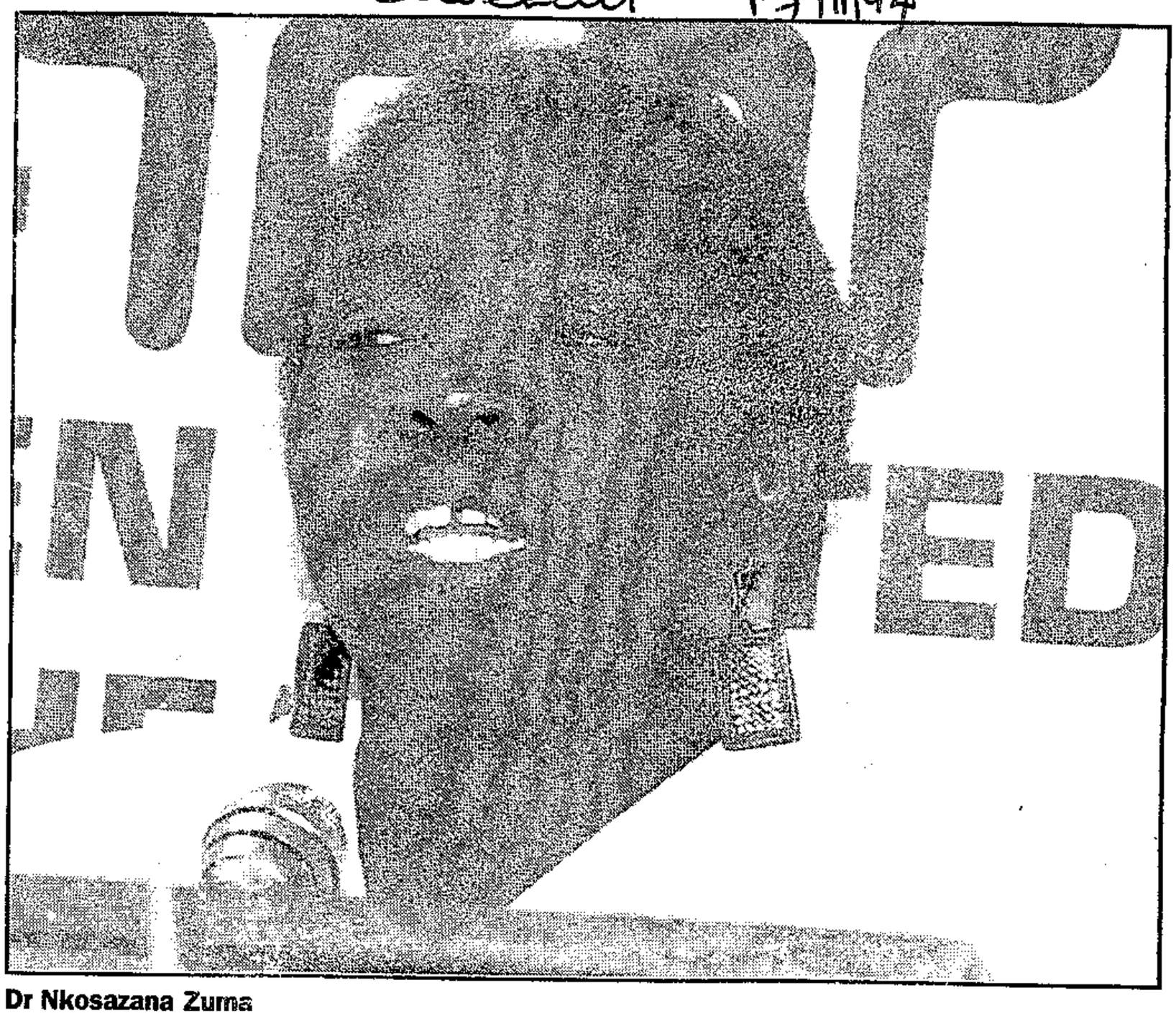
Or are they people, even within the ANC itself, who feel they have been ignored in the apportionment of plum jobs within the health department?

Of course, Zuma wasn't saying. What she did say, however, was: "It would be naive to believe that I have the support of everyone. Some have not been honest, confidences have been broken. But this is to be expected when we're dealing with fundamental transformations.

"I believe, though, that within the department there is a critical mass of people who want to see the new plan succeed."

Minister of Health Dr Nkosazana Zuma remains determined to live up to the ANC's promise of health care for all. **Glenn McKenzie** talks to her about the problems facing her in one of South Africa's toughest jobs:

Sowetan 17/11/94



Dr Nkosazana Zuma

SIX MONTHS AFTER taking office, Minister of Health Dr Nkosazana Zuma often wonders if she has the most difficult job in South Africa.

"I used to think education was the biggest problem in this country. But with health, there are so many questions ... we have many complicated issues," she says with a sigh.

A mother of four girls and one of three wives to KwaZulu MEC Jacob Zuma, she jokes that she has grown a few grey hairs and lost many hours of sleep since the April 27 elections.

Public health care is still aimed at a relative minority of the country's population. Budgets still favour traditionally "white" hospitals and provinces like the Western Cape and PWV.

But Zuma, a small woman whose appearance belies her powerful position, remains determined to live up to the ANC's promise of available, accessible health care for all.

"It is a difficult responsibility you would never ask for. But once it is given, you have to do your best," she says.

One challenge facing Zuma is to get more blacks and women into senior administrative posts. This week, she began interviewing applicants for the position of national Aids coordinator. Other key positions will be advertised in the next few months. Many of these new posts will probably be filled by people from "outside" the Health Department, says Zuma.

"We can't have a rainbow nation without rainbow departments," she says with a chuckle.

Another problem for her is an empty pocketbook. South Africa already spends ten times what the World Bank estimates it should cost to provide basic public health services. The Government is unlikely to spend more, so cuts will have to be made.

In April of next year, budgets will be "gradually" cut to pay for new primary health care plans, says Zuma.

"The health care sector to some extent is like an elephant," she says in her patient, careful voice. "It moves very slowly and takes time to change direction. We have to make it move like a cheetah."

Despite good intentions, Zuma has been criticised for divulging few details about her health plan.

Special interest groups

Part of the problem stems from Zuma's expressed desire to "depoliticise health" and prevent alienating special interest groups.

The tobacco and liquor industries are already unhappy with the prospect of increased taxes to pay for health programmes.

Zuma would like to prevent making more enemies before Government plans have been finalised.

At the same time, she says she is not intimidated by interest groups that are opposed to change.

"If you come in when people are expecting change and you don't change anything, then you let people get back to their interests, and everything crystalises again. When you try again later, you meet conflict," says Zuma.

Two of Zuma's personal interests are in promoting health and preventing disease. Children from primary school level upwards need to be educated about health issues, she says.

"What we (the Department of Health) are is a service for the sick. We are not necessarily a health department.

That has to change," she says.

Another priority for the minister is to change the way hospitals are managed. Waste and bad management cost the Government millions of rands every year.

Labour disputes and drug thefts are problems that hospital superintendents are not trained to handle.

"Part of the problem is that in our training as medical doctors, we don't get trained in management. But somehow it is expected that suddenly a doctor can be made a superintendent of a hospital and become an excellent manager."

85

Still, Zuma gets strength from meeting dedicated health workers who are also struggling.

"We shouldn't give the impression that hospitals are just a den of thieves. I think the majority of hospital staffs are dedicated people who want to be of service to their communities," she emphasises.

"You know, what makes it all worthwhile is when you meet someone in the street and they say, 'We support you, you're doing a good job. Carry on.'"

Will she still be as optimistic by the time elections roll around again in 1999?

"I may have lost all my hair by then, but yes," she says with a laugh.

Medicine crisis

Hospitals running out of drugs as free patients pour in

CT 19/11/94

By MELANIE GOSLING

PROVINCIAL hospitals are running out of drugs fast as the number of outpatients continues to rocket after the government decision to give free medical treatment to pregnant women and children under six.

It is reported that some hospitals in rural areas have less than a week's medicines left and no money to buy more.

Provincial hospital spokesman Ms Eleanor Valentine said yesterday the health service had already spent its entire annual medicine budget to meet the demand as people crammed outpatient departments for free treatment — many with minor ailments.

Patient numbers had increased from 20% to 80% at some hospitals.

"In the past people did not bring their children to hospital with minor ailments because they were charged R4. Some hospitals can barely cope with seeing so many patients.

"Children with runny noses which parents would have treated at home are now sent to hospital because it is free. We are running a bankrupt company," Ms Valentine said.

● Health Minister Dr Nkosazana Zuma

She said the health service had established that some parents had taken their children under six off medical aid so they could capitalise on the government's new policy.

"These people are not poor," she said.

Dr David Webster, executive chairman of a drug company that is the biggest supplier of medicines to the state, said yesterday the company was working overtime to supply the state backlog.

"We are working unbelievably hard. We are flying in raw materials from overseas and have put on extra staff shifts, which is not reflected in our prices," Dr Webster said.

He said the state demand was 50% higher than it was six months ago for drugs right across the spectrum.

Backlog

The backlog would get worse, as factories would close between December 15 and January 4, he said.

An added complication was the continuing go-slow strike at the provincial hospital medicine depot in Cape Town.

A spokesman for Groote Schuur Hospital said yesterday the go-slow had forced them to get their drug supplies direct from the manufacturers.

"Fortunately they are giving the medicines to us at the tender price, so we are not losing financially yet," the spokesman said.

Health Minister Dr Nkosazana Zuma announced in June this year that there would be free medical treatment for pregnant women and children under six from July 1.

Hospitals set for big changes with plans to shift staff and equipment

See PAGE 2

New health awareness project

(85)

CT 21/11/94

Staff Reporter

A BLACK CONSCIOUSNESS-aligned Community Health Awareness Project (Chap) was launched in the Western Cape on Saturday at the Uluntu Centre in Guguletu.

Mr Selema Mashiane, who is on the steering committee that has now been set up, said yesterday the outreach programme was started by the late Dr Abubaker Asvat, who was murdered in his Soweto surgery on January 27, 1989.

The Community Health Awareness Project is working well in the Northern Transvaal, where it operates from clinics.

Dr Asvat was a widely respected doctor in Soweto.

Mr Mashiane said the project would uphold the black-consciousness principles of self-reliance and self-assertiveness.

The project will network with existing community structures, and seek not to compete with them.

Research will be a large part of its role, although it will also provide a community service.

"We try to understand underlying community dynamics," Mr Mashiane said.

Others on the steering committee are Mrs Nombulelo Mkefa, Mr Danile Landingwe, Dr Nosisa Matsiliza, Mr Welile Dlwengu, Mr Simon Dyakala, and coordinator Mr Dumile Baqwa.

Call to create paraffin law

A LAW should be made compelling traders to dispense paraffin in re-usable child-proof containers, according to a report in the latest South African Medical Journal.

It says paraffin is the most common poison affecting children. A 1992 survey of poisoned children in GaRankuwa Hospital showed 78% were victims of paraffin.

Another survey, in the Western Cape, showed the cost of treating victims would fund child-proof containers for 95% of households in high-risk areas. (85)

The GaRankuwa survey found children most at risk were two years old on average.

Most victims mistook paraffin for cold-drink or water and most accidents happened during summer. CT 22/11/94

The Cape survey found that most victims were aged between 12 and 36 months. Some 62% were male.

The cost of treating the children in the Cape survey was R111 673.

"This amount would have been sufficient to provide 95% of households in the eight identified high-risk areas with child-resistant paraffin containers," the survey concluded. — Sapa

Brown's Farms gets new clinic

By YVETTE VAN BREDA

HEALTH care had to be brought to the people in disadvantaged communities instead of their having to queue at state hospitals, local health minister Mr Ebrahim Rasool said at the opening of a new health care centre at Brown's Farm yesterday. (85)

Mr Rasool said that for too long the government had not satisfied people's needs and had not provided facilities in squatter communities or rural areas. CT24/11/94

The opening of the clinic proved that when the government, the business community and bodies like the Health Care Trust and the community co-operated, the community benefited.

"The community must be taken on as a partner in the provision of health care," Mr Rasool said.

He said that although South Africa was renowned for heart and other organ transplants, these could not "combat the march of tuberculosis, diarrhoea or measles".

HEALTH Fri 25/11/94

Primary switch

In her reasonable quest for a revamped national health system, based on primary care to cater more effectively for the whole population, Health Minister Nkosazana Zuma says her attitude from the outset has been to get party politics out of health.

In this she has achieved some — but not complete — progress. For example she says that the parliamentary debate on health was not polarised. (85)

Many obstacles remain, however — despite the beginnings of attempts to place more emphasis on primary health under former Minister Rina Venter. "Changing the system of health care in post-apartheid SA is a difficult and complicated business," Zuma acknowledged when she spoke at the start of a recent travelling seminar on health and the role of the media, organised by the Washington-based Kaiser Family Foundation. Kaiser, a private philanthropic trust dedicated to improving the health and life chances of the poor, has spent more than US$20m in SA over the past six years. The tour of poverty-stricken informal settlements like Groutville, which lack running water or sanitation, and malaria and bilharzia-infested areas further north in Natal, certainly underscored the widespread need for the kind of community-based approach to health being implemented by Zuma.

A formidable member of her team is Dr Olive Shisana, who seems a strong candidate to be the new director-general of health. Shisana's address to the seminar kicked off with a quote from Machiavelli: "There is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new system, for the initiator has the enmity of all who profit by the preservation of the old institutions, and merely lukewarm defenders in those who would gain by the new ones."

Spelling out this theme, Zuma charged that aside from historical difficulties associated with race, class, sex and geography, "there are also a lot of vested interests which make change very difficult." For example, the "attitude and skills of health workers" will be important in the shift being effected. While it was "natural for them to resist change," and acknowledging that SA doctors are praised internationally, Zuma nevertheless asks: "But are they being trained for the US and UK or for our needs and priorities?" The Minister does not believe local training institutions are effective in meeting these needs and priorities. Some would disagree and point out that hospitals such as Baragwanath do provide effective primary care.

Fri 25/11/94

Zuma includes among the vested interests she is up against the pharmaceutical companies. While they may well be legitimate targets in some respects, Zuma betrays an ignorance of elementary economics when she asks: "How do we get them to try to help us meet our needs without making such a big profit?" She wants to see the private and public sectors "complementing" each other — but she appears too suspicious of the former. There are also "interdepartmental problems", because health straddles all portfolios, notably water and housing. (*see page 50*)

Zuma

Among her difficulties, says Zuma, is that "the constituency that I as an ANC Minister represent often feels my approach is not revolutionary." But she says she is determined to be nonpartisan. (85)

Because health care has tended to be seen as a "bottomless pit," part of Zuma's battle has been to convince government that it is "an investment worth making for long-term gain." She eloquently explains why a healthy population is a vital part of increased productivity in the workplace.

Investment in health needs to be made "very early on — in pregnant women and in children (since) trying to invest later on means the loss of a great deal of potential," says Zuma, pointing to the importance of the first five years of a child's growth.

She strongly doubts, however, that cost-effective investment can be made under the present health service, because it focuses more on curative than preventative care. (The current health budget is about R14bn, of which only 25% is allocated to primary health.)

"Therefore, we need to invest in the community," says Zuma, who spent a large part of her first seven months in office putting together consensus on the new approach. It now remains to tackle the mechanics of funding and delivery, which, it seems, has to await local government elections since a district health system will be the foundation of delivery.

Zuma concluded with a plea for a new "culture of caring" that goes beyond merely treating the clinical problem at hand.

Health staff transfer plan

Municipal Reporter

ALL health personnel employed by local authorities should transfer to the new provincial health departments as soon as possible, according to a report to be submitted to the national Minister of Health.

The report was prepared by Dr Tim Wilson, a Johannesburg-based health expert.

The paper's main recommendation is that all district-level health staff should be employed by provincial health departments.

Reacting, Dr Michael Popkiss, Cape Town's Medical Officer of Health, said it was ludicrous to transfer staff to provinces and then later transfer large numbers back again.

30/11/94

(85)

Youths' health 'is neglected'

CT 6/12/94 (85)

Conference spotlights inequalities

Staff Reporter

ADOLESCENTS make up a third of the world's population and 80% of them live in developing countries — yet they are neglected by their countries' health services, a conference on promoting adolescent health has been told.

The week-long conference, organised by the Commonwealth Medical Association (CMA), Unicef and the World Health Organisation (WHO), has brought together government officials, medical professionals and young people from seven African countries to discuss adolescent health problems and find possible solutions.

Apart from health service problems, the lifestyles and habits of the 10- to 24-year-old age group is also to come under the spotlight this week.

CMA secretary Dr John Havard said yesterday that, in contrast with developed countries, the number of adolescents in developing countries was increasing markedly and at the same time their life expectancy was decreasing.

This he ascribed to accidents "of all kinds", suicide, substance abuse and the high incidence of sexually transmitted disease, particularly HIV/Aids.

Health services also placed little emphasis on adolescents, concentrating on infants and mothers instead, and adolescents on their part failed to use health services.

He said the conference's aim was to identify the reasons for these problems, and come up with workable solutions.

However, a change of attitude by all those involved was essential, hence the involvement of young people in the conference.

"It's desperately important that something gets done about it," Dr Havard said, adding that the health problems of youths directly affected their adult health and their ability to be good parents.

Teens' health under threat

UNSAFE sex, smoking and drug abuse are among the major avoidable threats to teenage health being discussed at an international medical conference in Cape Town this week.

The conference is being hosted by the Medical Association of South Africa. CT 7/12/94

Secretary of the Commonwealth Medical Association Dr John Havard said yesterday a third of the world's population was aged between 10 and 24, and 80% of these lived in developing countries.

In some countries adolescent life expectancy was falling though many deaths were avoidable.

The lives of young people were being affected by changes in traditional family structures, rural-urban migration, early marriage and early childbearing, unemployment, sexually transmitted diseases, alcohol and drug abuse. — Sapa

'Health care plan an opportunity'

(85) ARG 7/12/94

Staff Reporter

THE government's primary health care plan is a challenge and an opportunity for health professionals to develop new values, attitudes and behaviour.

This was the view of Groote Schuur Hospital regional chief director Jos Kane-Berman, who was speaking at the University of Cape Town medical and musical graduation ceremony last night.

She said the health plan stressed the need for community-based education of all health professionals, the need for multi-disciplinary teams of health workers and a comprehensive approach to the patient, who would be seen against their social contexts.

"Health professionals can help patients and communities to develop as persons, educating and involving them in making informed decisions about their own health, their families' health and their communities' health."

She said this required doctors and other health care professionals to have a radical rethink of attitudes, roles and behaviour.

"I believe it is an opportunity which must be seized with enthusiasm.

"Primary health care should not be regarded as being antagonistic to the so-called biodmedical model but as complementary to it."

Dr Kane-Berman said academic medicine and hospitals also had to adapt to these concepts.

Medical school curricula, student selection and undergraduate training were being critically reviewed by all the faculties, and significant changes would be introduced soon, she said.

Japanese aid to build clinics

JOHANNES NGCOBO

ABOUT R13m in Japanese aid would be passed on to the Eastern Transvaal provincial government for the construction of seven clinics, provincial Health Minister Kwati Mashego said yesterday.

Mashego said building of the clinics in the province would begin immediately. Central government, which was holding the funds donated by the Japanese government, had already been approached to arrange transfer of the R13m.

A task team to oversee construction and consult with relevant stakeholders had been established. BD 8/12/94

Mashego said the main aim of the clinics project was to promote the health and welfare of all people in the province by developing and supporting a caring, efficient and accountable district health service through a primary care approach.

"Primary health care has many interpretations. Many people understand it as first-contact care with a general practioner, a nursing sister or a traditional healer," Mashego said.

He said the Eastern Transvaal had 179 clinics and 27 hospitals.

Meanwhile, the province's education minister, David Mabuza, said yesterday his ministry would request business, community, church organisations and parents to make a donation for pupils who could not afford to pay school fees.

Mabuza said his office could only provide free education to grade one students.

"Contributions by parents, the community and business will be made to a school development fund to ensure that all schools are provided with the basic infrastructure and facilities," said Mabuza.

He said his ministry would recommend that empty buildings be utilised as schools.

"In addition, we will begin a classroom-building programme as we have a shortage of at least 5 391 classrooms," he said.

'Desperate' Transkei needs help

(85)

EAST LONDON. — The Eastern Cape provincial legislature yesterday heard impassioned pleas for urgent improvements to province's ailing health system, specially in the Transkei.

Health MEC Dr Trudy Thomas described the rural and underfunded Transkei as "the sickest patient that apartheid made".

ARG 8/12/94

Dr Thomas said children were suffering from the nutritional disease kwashiorkor, others were wasted like children in Biafra and there were often three to a bed.

Patients with typhoid, measles, hepatitis and meningitis shared the same wards.

*Health Writer **DAVID ROBBINS** travelled to the Northern Cape to see how South Africa's new clinic-building programme is faring*

Clinics to suit the community

Star 9/12/94

Dr Modise Matlaopane, the Northern Cape's MEC for health and welfare, cut short an interview last Friday to travel to Warrenton to listen to the views of local people on the exact siting of one of the new clinics to be built under the new programme.

"We have to engage the communities," he says, "and so far we are very pleased with this process. Our target for detailed information to Pretoria was mid-December, but in fact it will now only be early next year."

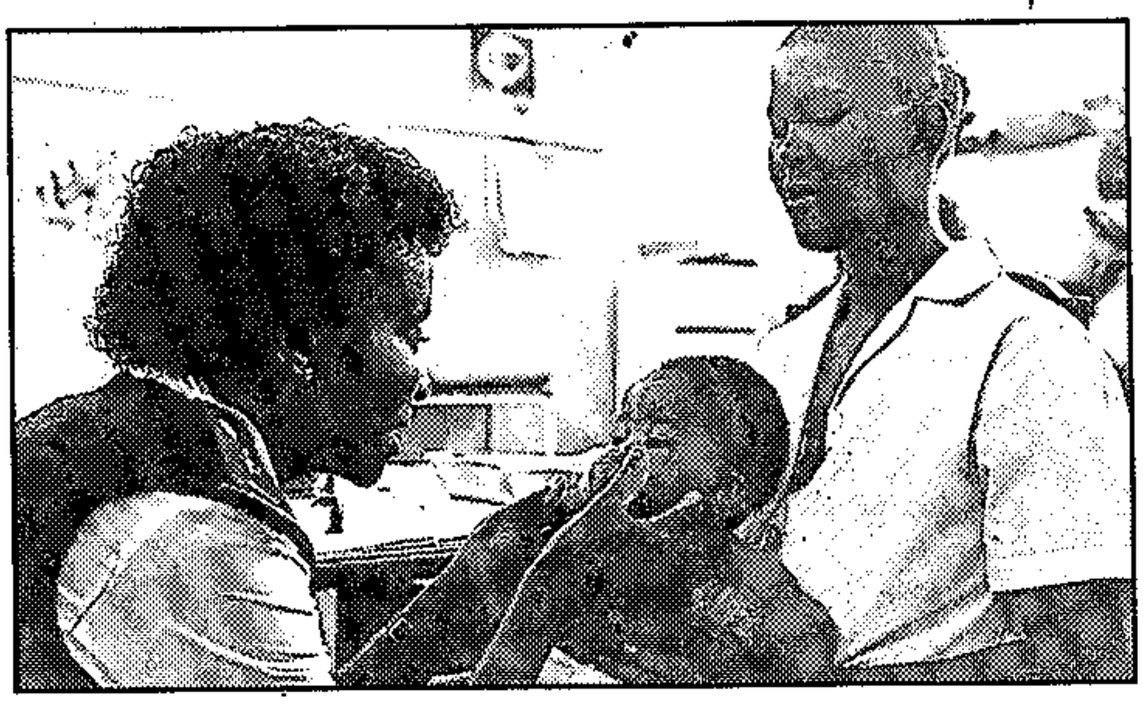
The impatience in Pretoria is understandable. Money has been promised from the RDP for capital expenditure, and national Health Minister Nkosazana Zuma has persuaded tertiary (academic) hospitals to sacrifice 5 percent of their collective expenditure next year to cover the cost of running the new clinics.

But complicated budgets have to be set, and the provinces' delay in giving detailed information will almost certainly mean that some of the provincial allocations will be guesstimates.

Apart from the desire of newly elected politicians to consult their constituencies, delays are also being caused by the multiplicity of agencies involved in clinic development before the elections, and the need to test the appropriateness of the plans which these agencies had developed. Above all, however, a new unified health administration must be established which can assume responsibility for driving the new clinics programme.

Northern Cape Director-General Martin van Zyl says: "The political agenda should not be allowed to pressure the administrative delivery system. If this system is pushed, especially now while it is in the process of being developed, we are doomed to fail."

After the April election, a strategic management committee (SMT) was established to develop an organogram for top health management in the Northern Cape, and to introduce the policy of district health on the ground,



The home front ... district health means not only enabling people to plan their own futures, but also making real improvements in health care delivery.

85

out of a hotch-potch of services previously provided by local authorities, regional services councils, and the old Cape Provincial Administration (CPA).

"Being a relatively under-resourced province, with most of the old CPA expertise staying in the Western Cape, our health SMT found itself quite heavily involved in line management functions and in securing finance," said Dr Philip Erasmus, a member of the Northern Cape's health SMT. "Nevertheless, we have completed the management organogram based on the guidelines laid down by the national Public Service Commission."

This organogram, according to Van Zyl, will be examined by the Northern Cape's own brand new Public Service Commission which will decide on the final structure to administer health care and welfare in the province. Meanwhile, the SMT, due to disband at the end of this year, will continue to the end of March, and an acting chief director of health will be appointed.

Erasmus defines district health as "providing maximum devolution of power and community participation". To this end, it has been proposed to divide the Northern Cape into six districts according to the old regional services councils delimitations, with the upper Karoo district centred on De Aar serving as the pilot.

"The district has 16 towns," says Dr Des Theron, director of health in the upper Karoo. "We have established democratically elected health committees in each town, and representatives from these committees sit on the district health forum."

Theron explains that the forum has been operating in the upper Karoo since July last year. Some improvements already instituted are: a district laboratory in De Aar, rather than being dependent on Kimberley; the appointment of a district pharmacist; the improvement of ambulance services, and the acquisition of new vehicles more economical than fully-equipped ambulances for transporting non-emergency patients to Kimberley.

In addition, the rationalisation of clinics run by various authorities in three upper Karoo towns has resulted in an immediate saving of R300 000, which can be used to equalise the conditions of service for staff from the different authorities operating in the past.

But how will the clinic building programme affect this system?

"The needs of the little towns and scattered communities are definitely coming through," Theron said. "For example, Hopetown, population around 10 000, has one of the highest incidences of resistant TB. Now look at the health facilities: a single sister operating out of a converted house. Obviously, the clinic programme will make a major impact in Hopetown."

As it will all over the Northern Cape. Matlaopane estimates that about 30 extra clinics are needed, but "I must still go into the field to engage the communities, to find out exactly where they should be situated".

Matlaopane says that detailed plans for about six new facilities will be in Pretoria soon, and he envisages that they will be operational by May.

"We are very optimistic," says Theron. "District health — and the clinic programme will bolster this process — is not only enabling people to plan for their own futures, but is also making real improvements in health care delivery."

Sight should not be lost of the overall rationale of the new health policy: spend money and develop systems at community level and the pressure on the centre will ease. Theron, who doubles as the superintendent of De Aar hospital, says developments in the peripheral services are "making a major impact on hospital loads", to an extent that it may ultimately be possible to reduce hospital budgets.

In the light of all that is happening in the Northern Cape, the tension between political demand and administrative reality is not necessarily a bad thing. The national health department has found the money for the clinic programme; and the provinces must build systems capable of efficient delivery of value for this money.

Delays are inevitable; yet at the same time it is essential that the basic health problems which beset so many South African communities are not obscured in the inevitable stresses of transformation.

HEALTH POLICY

Fin 9/12/94

Faulty diagnosis expected

But a good start would be to devolve responsibility, not centralise further

(85)

Baragwanath Hospital is badly overspent, Pretoria's HF Verwoerd Hospital has just closed its neurological department and the Department of Health is appealing to the public not to use State health facilities unless they must.

Is public health in crisis?

Director-General Coen Slabber says his department is trying to calculate the shortfall on its R14bn budget and estimates it at R1bn. The problem isn't new. Last year, all the health departments jointly overspent by R800m, though Slabber stresses that — in real terms — the health-care budget has been cut back in recent years, increasing at a rate well below the inflation rate.

In international terms, however, the budget crisis for health care that SA faces isn't unique. Few countries have managed to keep within their budgets for health expenditure. But SA already spends 10,2% of total government expenditure on health care — a figure dangerously close to the average 12% spent by developed countries.

Clearly, the emphasis for public health must be on the better management of resources and facilities, coupled to a degree of fiscal discipline. It's a philosophy that underpinned former Health Minister Rina Venter's policy and one that translated — in the State sector — into an emphasis on developing primary health care.

The benefits of a strong primary health structure are obvious. Preventative measures are dispensed at community clinics — including immunisation, screening, health education, nutrition and sanitation, prevention and control of local and endemic disease and the treatment of common disease and injury. This is more effective and cheaper than the curative medicine delivered at the secondary (provincial or regional hospitals) and tertiary levels (academic hospitals).

The ANC and Health Minister Nkosazana Zuma have clearly opted to strengthen the primary health-care structure further — 25% of this year's R14bn has been allocated to primary health care, 10% up on last year's allocation.

The extra allocation to primary care has been made possible by a 5% cut from the allocation for academic hospitals. But Slabber points out that additional funds and bridging finance are still needed: "You can't take more money from existing facilities to finance new clinics, especially when the institutions are still charged with providing primary services."

It will be some time before the new clinics are up and running.

Slabber says the RDP fund has allocated an additional R155m over the next two years for building and upgrading clinics. He adds that statistics pinpoint the national shortfall of clinics at about 1 400. The average clinic costs about R500 000 to establish, which means the RDP allocation for the next two years will be able to fund the building of only about 300 clinics. These amounts, of course, exclude running costs. An average clinic operating from 8 am-5 pm costs around R600 000 a year to run, while a 24-hour facility offering, for example, maternity facilities costs about R1,2m a year.

Zuma ... *emphasising primary health care*

Positioning these clinics correctly and ending the duplication and fragmentation of services they offer could help provide the solution to the shortfall. Slabber says Zuma's plans are to build 780 clinics within the next three years, placing about 90% of these in the rural areas (at squatter or informal settlements). Plans for the urban areas still need some attention.

One suggestion could be to link a separate primary health-care facility to the well-known and heavily frequented academic and provincial hospitals, rather than letting these cases overburden secondary and tertiary institutions. The benefits of such proximity would allow for quick cross-referrals, introducing greater efficiency in basic screening.

Venter — now a health-care and community development consultant — suggests the system is probably still swimming in bureaucratic fat. She explains that she inherited a clinic system that differentiated between preventative and curative services, and often duplicated efforts simply because some fell under the domain of the local authorities, while across the road, others were funded and run by provinces.

These services were often duplicated for blacks and whites, giving rise to the situation where four primary health clinics — along with their separate facilities and staff — could be located in a radius of only a few kilometres. This duplication permeated virtually every level of health care. But while Venter managed to eradicate the racial duplication in the early part of her term, she largely failed to end the duplication of services between local government and the provinces, which enjoyed autonomy and were opposed to losing any part of their power base or resources. Also hindering her efforts was a constitution that allowed 17 different health authorities — and ANC pre-election efforts to undermine the NP government did not help. But Venter did manage to complete research detailing precisely which services and funds around the country were being duplicated and under-utilised, specifying recommendations to end this fragmentation. So Zuma has a sound blueprint to work from.

Slabber says consolidating the numerous former health authorities into a single head office will make huge cost savings. But the latest ANC health document and speeches from Zuma's adviser, Olive Shisano, talk of establishing additional district health authorities to administer primary health care. Why, one may well ask, is another national bureaucratic structure needed to implement health at the community level, when the constitution accepts that local government (in a form still to be finalised) will continue and is best suited to this task?

The ANC paper also details extensive powers for the health department at central government but appears to duplicate — without sound justification — many of these at regional level.

On this score, the ANC's commitment to a strong central system of health care could be entrenching the cumbersome bureaucracy in a public health system that was already groaning under the weight of racial discrimination.

The practical implications of keeping extensive powers at central government level are enormous.

Take, for example, the case of Baragwanath. Superintendent Dr Grant Rex points out that he needs approval from central government and the province before he can make any staff appointments or acquire any equipment. Getting this approval takes about 18 months though the new constitution alludes to the decentralising of certain powers. Then there's the

Minister of Health has no easy path to tread

Tough call for Dr Zuma

A WEEK after restrictions on tobacco advertising were made public, Health Minister Dr Nkosazana Zuma was awarded Woman of the Year award by the Union of Jewish Women. She spoke to MAUREEN ISAACSON recently.

AN OCCASIONAL smile wraps the Minister of Health in light. Then it withdraws quietly with a composure and calm that will surprise anyone who expects her to be a jumped-up Rina Venter poised to whack the tobacco industry and all who consume its fumes.

Somewhere out there, after last week's Government Gazette announcement, cigarette ads are waging battle for space with health warnings. Everywhere, new primary health care structures are on the way.

Inside her inherited Civitas office in Pretoria, viewless and unadorned except for the new South African flag, Dr Nkosazana Zuma (45) sits in a floral chair. Her earrings and blouse are green, her skirt exposing a fraction of calf.

HOME — where husband Jacob Zuma, ANC deputy secretary-general and KwaZulu/Natal ANC chairman, four daughters aged six to 13 and an adopted 16-year-old son live — is 600 km away in Durban. But the Minister's maternal instincts do not lie fallow.

It's just as well she is in fine fettle. A healthy woman is what is needed to heal a sick country — a country, according to Zuma, that is ill with the side-effects of apartheid.

But for nine-year-old Gugu's asthma, Zuma's children and husband share her good health. Her refusal to divulge infor-

A WOMAN OF OUR TIMES: Implementing existing laws and taking health reform to the limit with primary health care structures and a "culture of caring" are the chief concerns of Minister of Health Dr Nkosazana Zuma. *PHOTOGRAPH: TJ LEMON*

She is still firmly holding the cudgels for SA women

nation about her marriage, insisting that she needs to keep "some private things" to herself, sets the tone for the interview.

Zuma's words are carefully considered and guarded, honoured that the Woman of the Year award is "an acknowledgement of women's contribution". She trots out the line about the meeting of women of all creeds, colours, etcetera.

WHERE is the stamina and the energy that drives this trailblazer? She sits so still, almost inanimate. Her gestures are few.

The proof of her potency is in the implementation of the feeding scheme that since September has given heart and incentive to pupils at 5 000 primary schools countrywide. It is in the urgent appeals to overseas funders to bridge the gap that next year's 5 percent tax reduction on academic hospitals and the disappointingly low increase in health spending will create.

Already there are results. Already the pregnant moms and under-six-year-olds who receive free State health care could be toasting Dr Zuma's health. And her appointment to the Cabinet might well have been a turning point for those benefiting from the R256 million National AIDS Plan.

And nobody — except the pharmaceutical companies — seems to be complaining, because the problems of soaring medicine costs are being addressed.

Zuma's entry into this office has been the highlight

> *'It's just as well she is in fine fettle. A healthy woman is what is needed to heal a sick country.'*

of her life, she says. "It is the beginning of trying to address things I have fought for all my life. It enables me to be able to participate directly in people's lives."

Her daunting CV lists illegal abortion among her research interests. A discrepancy between "ministerial and personal opinion" prevents her from making a statement on abortion, despite the fact that it has repeatedly been reported that she is pro-choice. "It is common knowledge what I think," she says.

Also on the research list are primary health care models based on Natal's Pholela Health Care Centre, the district model providing the basis of the country's new health care system.

Pholela is where she grew up, the eldest of eight, daughter of a schoolteacher and housewife. Amamzimtoti is where she matriculated. In 1976, five years into her medical studies at Natal's University of Durban, Zuma went into exile, graduating from Bristol University and later specialising in tropical diseases and child health care at the University of Liverpool.

Zuma's post meant goodbye to chairing the ANC Women's League, southern Natal region, but no way have the cudgels for the sisterhood been dropped.

"Are we making progress as far as feminism is concerned? What do you think?" she inquires.

THEN she answers: "In general, people realise South Africa is made of men and women — but we cannot relax, there is still a lot to be done."

> *'One should look at patients beyond the broken leg and care for the person as a whole.'*

High on her agenda is what she calls a "culture of caring".

This will be an integral part of the service provided by the one-stop health centres with efficient referral systems, which is what she means by primary health care.

Zuma would like to see health workers "look at patients beyond the broken leg and care for the person as a whole".

Despite glaringly obvious health problems, the country's prognosis is not fatal.

While neither the private sector and traditional healers are to be co-opted into the formal structures of the department, they can rest easy.

"The private sector is here to stay, it is not about to be nationalised," says Zuma, that million-dollar smile breaking through. She is keen to encourage the private sector to co-operate and work closely with her department.

Time forces us to take Zuma at her word when she says she is religious "in the sense of liking justice and wanting everyone to have a fair chance in this world".

"I'm a fairly relaxed person. I'm firm but soft, if that makes sense to you."

TELL that to her critics, who see her approach to tobacco advertising as just another version of *baasskap*.

Zuma says these reforms were passed by the previous government in 1993. She says she is "now simply implementing them".

"It will be controversial anyway, whatever I do they will not like."

Alternative medicine 'in from cold'

CT 12/12/94

(85)

Own Correspondent

EAST LONDON. — Practitioners of alternative medicine have been let in from the cold, following the recommendation of a historic amendment to the South African Medical and Dental Council (SAMDC).

SAMDC confirmed yesterday it had recommended to the Minister of Health, Dr Nkosazana Zuma, the scrapping of Ethical Rule 9(2), which prohibits doctors from "consulting, assisting or supporting" among others, chiropractors and homeopaths.

Under the existing ethical rules, medical practitioners were also barred from undertaking any investigations, clinical, radiological or pathological, on request by alternative practitioners.

The imminent scrapping of the rule, said to be merely a formality, will allow the inter-referral of patients, and will give patients in both private and public patients access to "alternative" treatment.

While SAMDC denied yesterday this about-turn was the result of continued pressure from lobby-groups, its decision comes in the wake of new representation from the Medical Association of South Africa (Masa).

Masa's director of medical ethics and legal affairs, Mr Braam Volschenk, said Masa had notified the SAMDC in September this year that patients who consulted practitioners of both conventional and alternative medicine would probably be better served if the prohibition on co-operation was lifted.

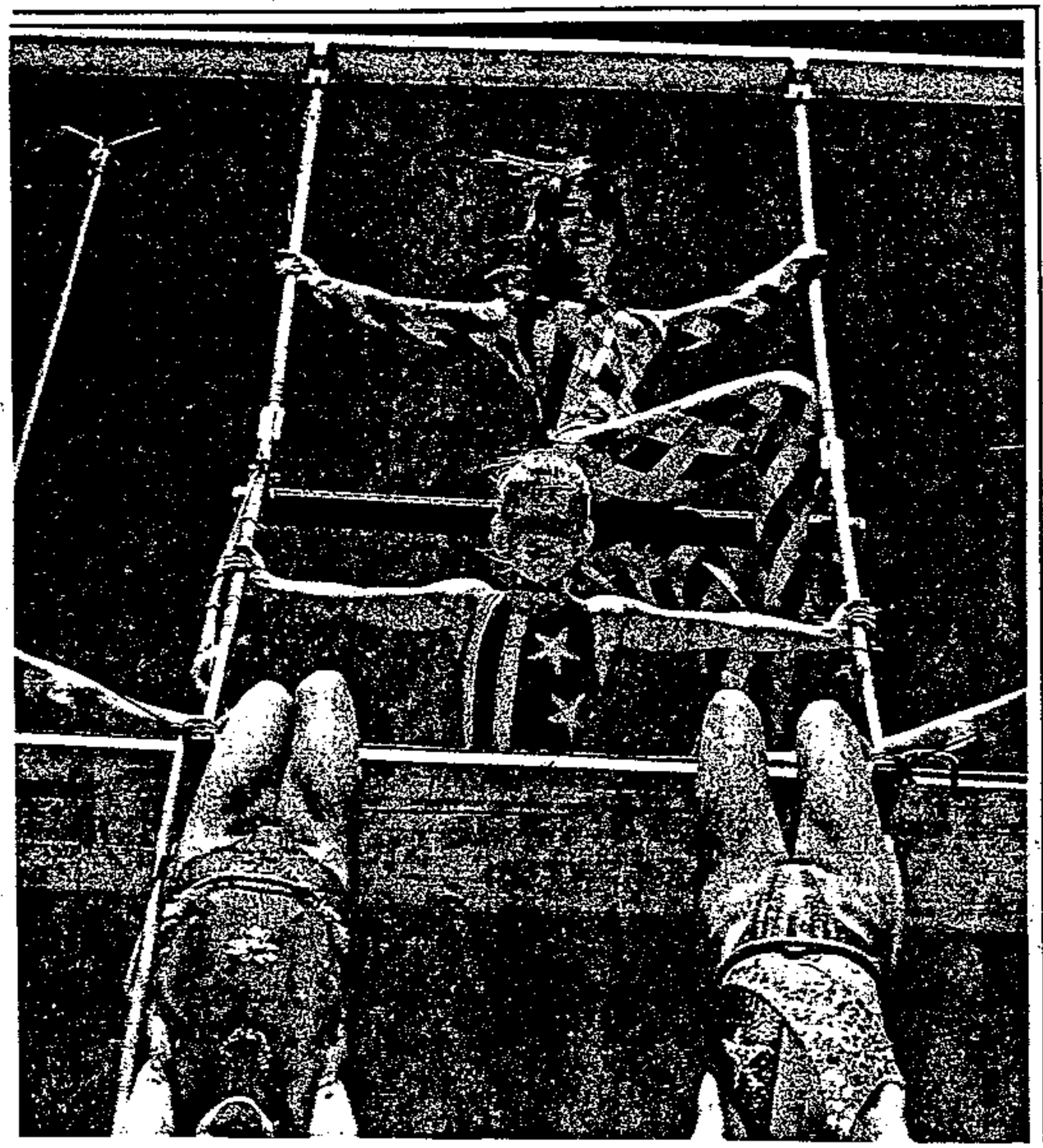
The scrapping of the rule 9(2) would be in the best interests of patients, particularly those intent on consulting alternative practitioners, who will do so, despite advice to the contrary.

The Chiropractic Association of South Africa has welcomed the recommendation signalling it "a major breakthrough, not only for the chiropractic profession, but for the general public".

Masa, who will be responsible for the drafting of guidelines on future relations between the two groups, said it would meet early in January to start compiling guidelines for profession interaction.

Ambulance chaos

(85) CT 14/12/94



By CHRIS BATEMAN

A SHOCK report on the ambulance service of the Western Cape has revealed that one of the region's most crucial services is in chaos.

A community-based task force which investigated the service disclosed in a 146-page appraisal, released yesterday, that:

● In at least one region the clinical ability of staff is "sub standard".

'Go-slow'

● "Bad attitudes" exist in the Cape Metropole between management and the radio control room, with communities reporting ambulances "floating around aimlessly for hours on end without disembarking patients".

This "form of go-slow" included dallying at hospitals after delivering patients or "hiding" in unobtrusive areas to avoid being given further work.

● Rural ambulance services were "fragmented, isolated and not run according to acceptable norms and standards", resulting in frustrated and demotivated staff.

● Rural staff were expected to transport patients hundreds of kilometres without help in blazing heat or bitter cold, only to find no overnight bed or facilities.

The report suggested that:

Report slams service in W Cape

Local Health Minister Mr Ebrahim Rasool

● Drastic changes are needed to ensure the Western Cape's ambulance services reduce non-emergency work.

● Callers should be treated more considerately and response times improved.

The task force was led by Ms Elize Appel, regional chairwoman of the National Progressive Primary Health Care Network appointed four months ago by local Health Minister Mr Ebrahim Rasool.

Its report said control room staff constantly complained about not having enough ambulances to dispatch.

Cape Town had a 42-hour work week while virtually all other emergency services in the Western Cape worked a 56-hour week, resulting in a third more crews being available. It noted that trade union agreements made change difficult.

Present response times in the Cape Metropolitan area had 20% of ambulances arriving within eight minutes of a call, 40% within 14 minutes and 60% within 20 minutes. This was 10, 20 and 30% respectively below the norms the service had set itself, the task team revealed. George, which runs a combined fire/ambulance service, was singled out for forcing ambulancemen to play second fiddle to an "elitist" fire service, which was "not in the interests of the patient".

The report found the clinical ability of staff here to be "sub standard".

The appraisal tried to refocus resources without incurring extra costs.

Stakeholders would respond to the recommendations by February to enable an action plan by mid-March, Mr Rasool said.

Successfully carrying it out would depend on how much closer hospitals were brought to people on the ground and on the implementation of the RDP, he said.

Reducing non-emergency work would require co-ordination and control of out-patient transport and inter-hospital transfers (including possible private contractors), more careful means assessment of callers, and enlisting police help in transporting obviously dead people.

Help-line

Death certification by private doctors should be encouraged where victims died of natural causes, and police could also transport these bodies and those at crime scenes to the state morgue.

A public educational and marketing campaign, highlighting the effects of abusing the 10177 number and establishing a complaints help-line were other recommendations.

The public were "particularly critical" of how they were treated when calling control rooms, the task force found.

Plans for revolutionary health care ...

W/Mail 15-22/12/94 (85)

A new health scheme favoured by the government is likely to prove hugely popular. Pat Sidley reports

THE government is actively investigating a national health insurance plan which would, if implemented, revolutionise the country's health system and provide the funds for basic health care to all citizens.

Three options are under consideration. The *Weekly Mail & Guardian* has been given a copy of a summary of the option most favoured by the Department of National Health, which is the most contentious of the three.

This plan, if implemented, is likely to be hugely popular with the majority of South Africans; resisted by those already paying large amounts of income tax; alienate many doctors; and, at the very least, set off widespread debate about its merits.

It would, if implemented:

- Be funded by a payroll tax of three percent of annual income to be shared equally by the employer and employee. Self-employed people would pay two percent of their income. This tax, which would be levied in addition to normal taxes, would raise about R5-billion a year, to which the state would add a further R1-billion.
- Provide basic care at the level of general practioner (and nurse) throughout the country, with no exceptions. Included would be certain basic medicines identified on a drug list.
- Private practices, clinics or community health centres would be accredited as national health practices and would be funded upfront with a global payment to run the practice. General practitioners could not charge on a "fee for service" basis, as they do now.
- Patients would not necessarily be treated by doctors. At least half to a third of complaints would be attended to by a nurse or other health professional.
- All primary or general practice care would be removed from existing medical aid and insurance packages. These institutions would accordingly lower the premiums they charge their members.
- It is envisaged that most of the basic care and medicines would be offered free of charge, although there is the possibility of a nominal charge for visits. Some procedures, such as immunisations, would attract a small charge; the plan suggests R10. However, pregnant women and children under six would continue to receive free health care.

The department is in the process of setting up an "implementation committee" to review all three options and

Health Minister Nkosazana Zuma

is unlikely to have a plan in place until the 1996/97 budget. The introduction of any such major change is likely to undergo a great deal of debate, including a separate debate in parliament.

The plan the department currently favours was put forward by Australian health economist Dr Jonathan Deeble, who has visited the country on two occasions. In 1992 he came at the request of the ANC health support group, bringing with him the experience of Australia's own relatively recent introduction of a national health system. He returned this year, spending two weeks investigating options for the introduction locally of a national health insurance scheme.

According to a summary of Deeble's proposals in the hands of the *WM&G*, patients would be covered for three visits a year to primary care centres — a substantial drop in the coverage they are getting from medical aids. The number of visits is currently an area of widespread abuse by both doctors and patients.

Deeble recognises in his summary that it would be "unrealistic" to expect medical aid members to "reduce their GP use immediately".

Some people whose salaries are low and who are either not on medical aids, or who pay very little into their medical aid schemes, would probably have to pay more for their health care through the insurance scheme than they pay now.

Indigent citizens would still be able to get most of their basic health care needs met through state facilities.

Somebody earning R50 000 a year (around R4 000 a month) would pay about R1 500 a year on the proposed national health insurance scheme. People receiving higher salaries would also effectively pay more than they have been paying for general practice care. This would have the effect, according to Deeble's paper, of redistributing wealth for health care.

After his 1992 visit, he produced a report which compared the South African and Australian systems, from which it emerged that South African doctors charge fees similar to those charged by their Australian counterparts. However, he noted that the care costs South Africans relatively more, because their incomes, even among whites, are much lower than Australia's average income.

He remarked in 1992: "The problem is not just one of affordability, however. Insurance-supported fees now yield private doctors in South Africa, particularly GPs, relative incomes very much greater than their Australian counterparts, which makes their incorporation into any financially viable public system very difficult indeed."

The proposals by Deeble form one of the three options which have been offered as alternatives. Among the points of departure are the nature of payment to doctors, whether they should be paid on a fee-for-service basis or by "capitation" (whereby they would be paid upfront to run the practice).

Other options include providing primary care through state facilities only — leaving private doctors out of that system.

Health fund proposed

85
ET 16/12/94

PRETORIA — A committee set up by Minister of Health Dr Nkosazana Zuma has agreed in principle that a national health fund should be established, her ministry said yesterday.

The committee recommended Dr Zuma appoint another committee, comprising government officials and local and overseas experts, to investigate implementation of a national health scheme.

Speaking yesterday on her return from a visit to the European Union, Dr Zuma said that funds allocated by the EU were earmarked for Aids projects, restructuring the health system, and for the provision of expertise.

An agreement between her department and the EU would lay the foundation for collaboration in research and fighting drug abuse, cancer and infectious diseases, she said. — Sapa

Health services proposal slammed

(85)

CT 16/12/94

By CLAIRE BISSEKER

MOVES to take over the city council's health department by province were condemned by the council yesterday as "power mongering" that should be vigorously resisted.

At the council's monthly meeting, councillors slammed the takeover proposals contained in a report of the Districts Health Systems Committee prepared for Health Minister Dr Nkosazana Zuma.

The report recommended that local government health staff in every province be transfered to the provincial authority until such time at the local government was sufficiently established to take their staff back.

City medical officer of health, Dr Michael Popkiss, denounced the takeover plan as "arrogant, centrist, wasteful and inefficient".

He said the proposal was a "complete about-turn" on the principles of the RDP which saw local government as the best vehicle for the delivery of primary health care.

He conceded that in parts of the country where there were no viable local authorities province had no alternative but to take on the responsibility themselves, but it was absurd to apply this thinking to the Cape Town City Council.

The council offered a "particularly effective and very efficient" health service through 25 major clinics and 25 satellite clinics and the takeover of a traditional function of local government was of grave concern, said Mr John Muir.

Mr John Sonnenberg said the proposals were "mad and irresponsible and should be rejected with all the contempt they deserve".

Mr Frank van der Velde and Ms Ruth Ortlepp claimed the takeover was an attempt at empire building by province which was hardly able to handle its present obligations in the hospital and ambulance services.

Mr Van der Velde said the success of Cape Town's primary health care service was evident in the fact that the city's infant mortality rate was 16,5 for every thousand births compared to 49 for the remainder of the country.

● **Hands off the city's health! — Page 6**

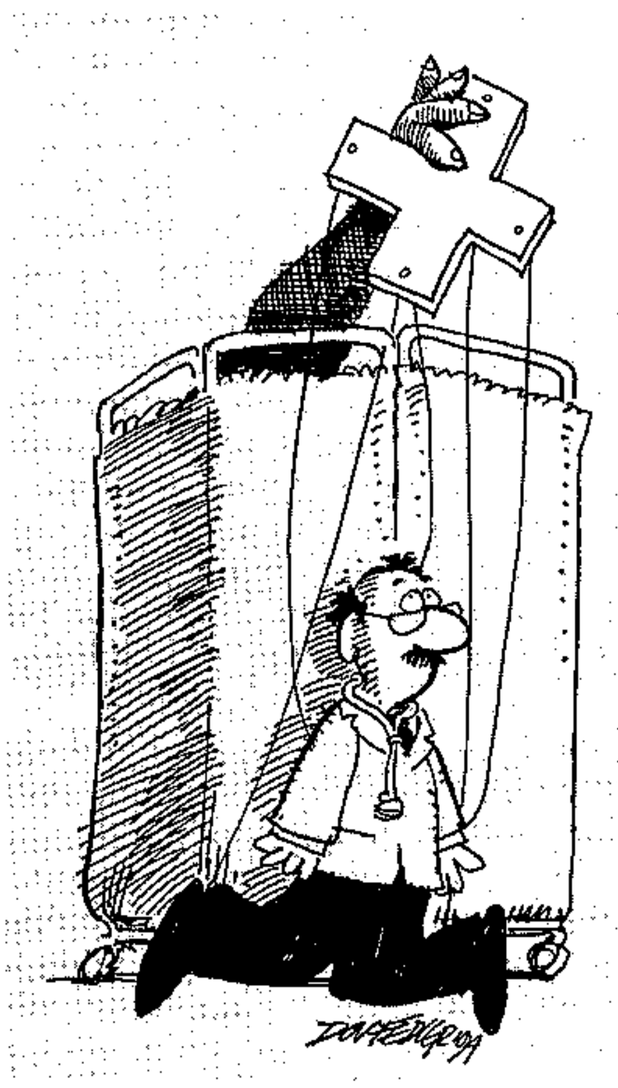
HEALTH CARE

Nationalisation by stealth

Fin 16/12/94

Government appears to have taken the first tentative steps towards nationalising private sector health care. Its proposed Social Health Insurance — if implemented — will mean private-sector medical schemes and insurers will no longer be able to fund many services usually provided by general practitioners.

The proposal to move a "primary package" of services, believed to include preventative, promotive, first and follow-up treatment of chronic conditions, away from private-sector funders is in the report of the Health Financing Committee.



Just how it will be implemented is not clear. The committee, headed by Olive Shisano, completed its work last week but its findings have not been made public. Committee members have been barred from speaking to the press. Regrettably, members' credentials and their brief were also not made public. Nor was the public given an opportunity to make submissions — in stark contrast to the transparent manner in which the Melamet Commission of Inquiry into private health funding was conducted earlier this year.

Highly placed sources told the *FM* the proposal could be funded by a compulsory tax on all wage earners deducted directly from the payroll and boosted by an equal (tax-deductible) contribution from employers. Self-employed or independent taxpayers, pensioners and investors will pay the health levy with their taxes.

The proposal specifically prohibits medical schemes and private insurers from covering this primary package of services. The scope and extent of the package has apparently not yet been finalised. Medical schemes and insurers will, however, be allowed to continue offering cover for secondary and tertiary care (no definitions have been supplied though traditionally these include hospitalisation and curative care for acute conditions) but employer contributions for such cover will no longer be tax-deductible.

This threatens the financial soundness of medical schemes. Says hospital group Presmed joint-MD Rob Speedie: "The additional compulsory payment will see many medical aid members cancel or lower their medical aid cover which will put increased pressure on medical schemes — the backbone of private health care."

Removing cover for primary services from the private sector will undermine the cross-subsidisation between the treatment for serious, infrequent illnesses and the common and less serious treatments, ultimately weakening the resources a Social Health Insurance system needs to cross-subsidise the unemployed.

Doctors too, are under threat. The package of health care is to be provided by contracted private practitioners, paid on a fixed fee per head basis, and State-run health centres. Just how much the State can afford to pay these practitioners and the amount of time doctors will be able to allocate to this service, given the wide definition of primary care, is uncertain. "Will doctors ultimately be forced into working exclusively for the State?" one doctor asks. The Medical Association of SA (Masa), representing doctors, says it is investigating the practicalities of providing a package of core services and will complete its findings only next year.

Free Market Foundation director Eustace Davie says the proposal contains an element of compulsion: "The idea is to move private-sector patients to State facilities to cross-subsidise the unemployed. Anyone who pays for this insurance policy will be paying more than the cost of treatment to create this cross-subsidy. But determining actual cost in a State bureaucracy is difficult since the State seldom takes account of capital expenditure and interest payments." Another danger, he says is over-utilisation leading to cost escalation, queuing and ultimately rationing.

Who will administer this new bureaucracy is not certain. The Representative Association of Medical Schemes (Rams) has been lobbying Zuma for the job. Whether the sector, battling to adapt to deregulation, is ready to take on additional responsibilities of such magnitude is questionable. Rams executive director Reg Magennis, who sat on Shisano's committee, says he can't comment because it would compromise his standing.

Certainly, creating a new bureaucracy to administer the system would eat up much of the money available for health care. Policing it would also be a bureaucratic nightmare.

Says Davie: "How will thousands of State-contracted providers be effectively monitored?"

Speedie suggests it's unlikely State control of primary services can guarantee basic care for all employed let alone unemployed. "The proposal should be seen for what it is — another tax with little intention of providing real service." (85)

The proposal is geared to strengthening the public sector at the expense of the private but undermining private health care could threaten the estimated R2bn it pays in taxes each year — something the committee hasn't fully considered. ■

AGRICULTURE

The drought returns

The spectre of drought is once again stalking SA as the summer rainfall planting season draws to a close. Some of the principal grain-growing regions have had only half their normal summer rainfall and late frosts on the Highveld and in southern

WINNING WAYS

Medical aid premiums and the quality of service they buy remain an ongoing problem for employers.

The *FM*'s third annual Corporate Health Care conference, which will take place at Gallagher Estate, Midrand, on February 7, will provide valuable tips on how to maximise returns on this essential investment. Topics include government health-care policy and feedback from the Melamet Report into the financing of private health care.

Speakers include Dave King, who will talk on rating medical schemes, Peter Benningfield on the benefits of managed health care and Health Minister Nkosazana Zuma.

Contact Crystal at Global Conferences on (021) 762 8600 or fax (021) 762 8606.

ARG 17-18/12/94.

Zuma spells out SA plan to ensure child health

DAVID ROBBINS
Weekend Argus Correspondent

JOHANNESBURG. — More than two million children worldwide are being saved from certain death each year by basic health interventions introduced in the developing world over the past five years.

This emerges from a new United Nations Children's Fund (Unicef) report, "The State of the World's Children 1995".

The situation in South Africa, however, is far from satisfactory, according to Health Minister Nkosazana Zuma, due to our years of isolation from international influences.

In the developing world generally, infant mortality rates and life expectancy are improving, and Unicef executive director James Grant says the improvements since 1990 "are as much as was achieved in all previous history".

"The 20th century will be remembered not so much as an age of political conflicts, but as one in which human society dared to think of the welfare of the whole human race as a practical objective," says Mr Grant.

Targets for the basic health interventions were set at the 1990 World Summit for Children. Goals for the year 2000 included the cutting of child deaths by one-third, and malnutrition by a half. Major childhood diseases like measles and diarrhoea were to be brought under control; polio was to be eradicated; and, at least 80 percent of children were to complete primary school.

"Almost 60 nations are on track to achieve these goals, and another 32 could do so with a big effort over the next 12 months," states the Unicef report.

At the South African launch of the report in Durban this week, Dr Zuma said: "Our years of isolation had a negative impact on all spheres of South African life, not least on our health-care services. In consequence, many of our programmes are inappropriate for a developing country and the situation facing children and families in South Africa is cause for alarm."

She said it was for this reason that free health for young children and pregnant woman, as well as the primary school feeding programme, had been introduced as a top priority.

She also announced South Africa's own child-health goals, which included:

- 90 percent coverage for each vaccine in the primary childhood series (diphtheria, whooping cough, tetanus, tuberculosis, polio and, sometimes, German measles and mumps) by 2000;
- Polio eradication by 1998;
- Fewer than 4 000 measles cases a year for a period of five years beginning in 1996; and
- Reduction of neonatal tetanus to fewer than 1/1 000 by 1997.

Dr Zuma said: "For years, South Africa has neglected these tasks. In future, we will succeed, but only if we can forge a partnership between family, community, non-governmental organisations and government."

The Unicef report also devoted considerable space to the problems of global over-population, but argued that "the world will not solve its fundamental long-term problems until it learns to do a better job of protecting and investing in the physical, mental and emotional development of its children".

■ See page 21

SA health wins EU funding

KATHRYN STRACHAN

HEALTH Minister Nkosazana Zuma said on her return from a visit to Brussels that a significant amount of funding had been allocated by the European Union to improve SA's health system. BD 19/2/94

Zuma said the funds were earmarked for health restructuring, developing a district health system, and AIDS projects. Aid had also been allocated for non-governmental organisations, he said. (85)

A separate allocation was made by the EU's science division for research and intervention in drug abuse, cancer, AIDS and sexually transmitted diseases. The Flemish government was to fund programmes on rehabilitation for the disabled.

The figure allocated by the EU would only be announced with the signing of the contract in January, but Zuma said the figure had exceeded her expectations.

However, another R1,5bn was still needed to implement the initial steps of the new health plan.

Zuma added that a ministerial committee had agreed in principle that a national health fund be established.

The committee recommended Zuma appoint a technical group, made up of Finance and Health Department officials and local and foreign experts, to investigate implementation of a national health scheme and ways of collecting the funds.

The Health Ministry was still in the process of restructuring its budget to address the new health priorities and the problems of those disadvantaged in the past.

The Health Department was also looking at ways to encourage doctors to serve in public health and rural facilities. To create incentives, service in rural and peripheral areas would have to be academically recognised. At present service in these facilities was not accredited for specialist training.

Support and supervision from senior staff would also have to be offered.

Most blacks see traditional healers

ED 21/12/94

PRETORIA — There are 200 000 traditional healers in SA and they are consulted by 80% of the black population, according to a study commissioned by the Medical Association of SA.

Masa yesterday released the results of a comprehensive study on the role of traditional healers, conducted for it by the Medical Research Council.

Masa science and education committee chairman Edoo Barker said the study was commissioned to give doctors "as deep an insight as possible into the world in which large numbers of their patients live".

There was one traditional healer for every 200-300 in the population served.

In some rural areas up to 80% of all babies were delivered by traditional birth attendants.

"The traditional healer shares with the patient a view of the world and the way it works which is completely alien to the non-African, Western-orientated health care worker, in particular the view which the patient shares with the healer with regard to the nature and causation of disease," Barker said.

"This view is totally different from that held by biomedical workers and this makes it difficult, if not impossible, for Western doctors or nurses to understand all those aspects of the patient which are essential to really effective medical care."

He said recommendations on traditional healers' potential role in the health care system included a nationally legislated policy accepting them as health care workers. — Sapa.

Ritual: Xhosa teens admitted

(8 5)

22/12/94

EAST LONDON. — About 30 Xhosa youths who have undergone circumcision as part of their initiation are in Eastern Cape hospitals for treatment of septic wounds.

Sixteen-year-old Thandila Sophila, of Mdantsane, died of hunger and dehydration undergoing initiation last week.

Another youth will have his penis amputated because it was nearly severed in the ritual performed by a "traditional" surgeon. — Sapa

Getting health system in shape

ARG 24/12/94 (85)

■ The way to resolve the Western Cape's healthcare crisis lies not in crisis management, but in restructuring the health system. And plans are already afoot for a five-year-plan to bring the province's health budget in line with the national average.

DI CAELERS
Weekend Argus Reporter

FAR-REACHING plans to save the Western Cape's ailing health system include new secondary hospitals to take the pressure off the teaching hospitals, the rationalisation of Groote Schuur and Tygerberg hospitals, as well as national compensation for training and research.

So says regional health minister Ebrahim Rasool who revealed that a preliminary report from his Academic Priorities Group showed that R50 million a year could be saved through internal rationalisation at Tygerberg and Groote Schuur, along with a suggestion to reduce the number of tertiary beds available at the hospitals.

Early next year, he said, new secondary hospitals would open in the form of the upgraded G F Jooste in Manenberg and Karl Bremer in Bellville, with plans afoot also to upgrade to the same status Eben Dönges Hospital in Worcester and the George Hospital.

Further relief would come if professors were paid from national level via the education department, and he anticipated further special income from national level for research and services.

This would mean unique services like transplants would not become the burden of the Western Cape's tenuous health budget, but rather get national compensation.

But three issues were imperative to a positive future for the province's health services:

■ A change in teaching orientation so that standards set in high-tech tertiary institutions did not become the accepted norm,

■ A change in the over-reliance of patients on the three tertiary institutions, Red Cross, Tygerberg and Groote Schuur hospitals, and

■ The investment of resources in building good emergency services in the rural areas.

Mr Rasool said the Western Cape got R1,65 million a year now, but used R1,8 million. It would be "suicidal" to absorb a sudden cut to get to national equity.

"We are willing to embrace change in the health system, and a move away from the three big tertiary hospitals, but what is required is bridging finance for a five-year plan for national equity.

EBRAHIM RASOOL: 'We need to see the whole picture ... the solution is not just to send in crisis staff and make crisis improvements.'

"That way we must still cut down but we have five years in which to do it."

Mr Rasool said there was no intention of retrenching staff nor closing hospitals. He expected the health budget to remain the same next year but with health inflation running at about 18 percent, it translated to a cut in the budget of almost five percent.

Commenting on specific existing problem areas in health services, Mr Rasool said the answer was not to "tinker with the system": "We don't need crisis measures if the little bits we do only tinker with the system, providing their own usefulness, but delaying at the end of the day the real solution.

"We need to see the whole picture, not just the little bits, and like that we see the solution is not just to send in crisis staff and make crisis improvements."

Red Cross Children's Hospital was by its nature unique and there province had already unfrozen posts, appointed people and invested money in the structure of the building.

"We have also offered to get in voluntary doctors and volunteers from the Red Cross Society, so they have that too."

But Mr Rasool said they would never allow the children's hospital "to go under": "Within the constraints of a strained budget we will try to prioritise Red Cross. Unfortunately, the bottom line is that the only way to eliminate the queues there is to eliminate free health."

Discussing the beginnings of the existing healthcare crisis, Mr Rasool explained that the previous Cape province had always operated on an inflated health budget, but had not used that extra to develop services in other areas of the province.

The previous administration had centred on the three teaching hospitals instead of building a system allocated across the geographic spread.

"That's how the misconception of associating quality with these three hospitals was conceived. Now people don't want to use the clinics so they go to these three with primary healthcare problems and get expensive tertiary treatment.

"The pressure from the public is in line with the notion that standards of tertiary institutions are normal standards and the only ones acceptable to them."

The answers, he said, definitely lay with a whole new system rather than with crisis management that would maintain existing expectations.

hursday, December 29 1994 ★

Drastic health cuts 'inevitable'

CT 29/12/94

(85)

By CHRIS BATEMAN

DRASTIC cuts and redistribution of health care resources locally are inevitable as the national formula for health funding reduces the Western Cape budget to benefit poorer provinces.

This was said yesterday by the director-general of health for the Western Cape, Dr Tom Sutcliffe, who confirmed some 800 tertiary health care beds in Groote Schuur and Tygerberg hospitals could be re-allocated for secondary health care.

He said the re-allocation would occur within each hospital.

Because secondary health care needed less intensive nursing, large numbers of staff would be posted to rural hospitals where their services were needed.

These postings would save the province some R40 million.

Poorer provinces to benefit

"Health services countrywide are seriously underfunded. Locally our funding per person is far higher than elsewhere.

"We have two academic hospitals and some other provinces none," Dr Sutcliffe said.

He said the new funding formula involved a "head count" in each province, but with an "income factor per person" added.

This "reduces our local population by half," he said.

The reverse applied in the poverty-stricken Northern Cape.

With local expenditure about R1,99 billion and funding at R1,66bn, contingency plans were needed to meet the national allocation — expected soon.

Dr Sutcliffe confirmed the upgrading of Manenberg's G F Jooste Hospital and rural hospitals in Paarl, Worcester and George to regional hospital status offering secondary care.

Regarding criticism of national Health Minister Dr Nkosazana Zuma by the Cape Town Medical Officer of Health, Dr Michael Popkiss, about the probable incorporation of the city's health care service into the province, Dr Sutcliffe said: "It's time we stopped thinking in terms of cloistered interests.

"Whether he works for us or the council, his job is health care provision — not politics."

Verbal battle over city's health dept

ET 30/12/94 (85)

By CHRIS BATEMAN

A WAR of words has erupted between Cape Town's Medical Officer of Health Dr Mike Popkiss and the convenor of the provincial Strategic Management Team, Dr Fareed Abdullah, over the proposed take-over of the city's health department.

A prelimary report by a top medical adviser to national health minister Dr Nkosazana Zuma insists that Cape Town's health department, widely regarded as one of the country's best, be handed over to the Western Cape government.

The motivation is to facilitate a single integrated provincial health service.

Replying to Dr Abdullah's claim that he was trying to "whip up emotions" in a "non-constructive manner", Dr Popkiss said yesterday Dr Abdullah was not averse to "throwing a few stones at me".

In a letter to the Cape Times Dr Popkiss wrote: "Fareed, (Dr Abdullah), you are too young to have been around for many of the 24 years I have been active in primary health care in Cape Town."

He added that Dr Abdullah was not on the management committee of the National Health Forum last year which required that he (Dr Popkiss) make frequent trips to Pretoria and Johannesburg where he "ceaselessly argued the local authority option for primary health care".

A "clear consensus" had emerged from the Cape Metropolitan Health Care Forum (with the exception of provincial officials) that primary health care was best vested at the level of democratic government "closest to the people".

The first public salvo was fired by Dr Popkiss in mid-December when he slammed the recommended takeover as "arrogant, centrist, non-consultative, wasteful, inefficient and traumatic".

Dr Abdullah replied that fundamental to the government's restructuring proposals was the establishment of a district health system in which single health authorities would be responsible for providing comprehensive, integrated community and district level health services.