

HEALTH AND DISEASE — HOSPITALS & CLINICS

1997

AUGUST — DEC.

## NEWS

# Better basic health care one step closer

ARG 7/8/97 (98)

## *New system in place next year*

JENNY VIALL  
HEALTH REPORTER

The district health system, which will provide one-stop primary care health centres and end fragmentation of services in the Western Cape, should be up and running by the middle of next year.

It will be the end result of a meeting of politicians and officials from local authorities and the province, who agreed yesterday to set up a task team to decide who should run health services in each of 25 districts in the Western Cape. It is a major step forward in setting up the district health service, which is seen as essential for effective primary health care.

The province had agreed to hand over the running of the district health system in areas where local authorities had the administrative and economic capacity to manage the service, said Health Minister Ebrahim Rasool.

Local Government Minister Pieter Marais said political preferences would not play a role in the decision on who should be the district health authority.

"What we have achieved is political co-operation to produce a high level of economic and administrative excellence."

Until now primary health care has been fragmented and people have had to go to different clinics for different services.

For example, in Elsies River the local authority clinic, which provides preventive services, is



BRENTON GEACH

Health team: Pieter Marais and Ebrahim Rasool yesterday

100m from the Elsies River Day Hospital (run by the province), which provides curative care. When you are sick you go to the day hospital, but if you have TB you go to the clinic. If you need family planning services you go to the clinic but if you are pregnant you go to the day hospital for antenatal care.

In each of the province's 25 districts, a team will be responsible for arranging comprehensive primary health care and district hospital services. This will mean better utilisation of staff and resources.

Bringing all primary health

services in an area under one authority will mean transferring staff, buildings and assets.

A major area of negotiation will be salaries as local authority nurses are paid more than provincial nurses. "I would like to reassure all staff that the process will be handled sensitively and in their best interests. They will be fully informed at all times," said Mr Rasool.

The task team, chaired by Faried Abdullah, head of health care in the Western Cape, will report back in November and submit a final report to the cabinet in December.



# Hospitals and services suffer during strike

(98) 

National Health and Allied Workers'

Union join national strike over

Government's 7,5% pay hike offer

Star 8/8/97  
STAFF REPORTERS

Services came to a standstill in at least one hospital and severe disruptions have been reported in others as National Health and Allied Workers' Union (Nehawu) members embarked on a 48-hour strike yesterday.

Nehawu joined other public service unions in a national strike over wages yesterday. The South African Democratic Teachers' Union (Sadtu) embarked on a two-day strike on Wednesday bringing education in some areas to a halt.

Police and Prisons Civil Rights Union (Popcru) and the South African Police Union (Sapu) have threatened to strike on Monday.

The unions want a pay hike of more than 9%, while the Government is offering 7,5%.

Last night workers at the Helen Joseph Hospital in Auckland Park allegedly forced other hospital personnel to leave their posts. Hospital superintendent Dr Arthur Manning said at one stage in the evening there had been no nurses on duty in the surgical wards because Nehawu supporters had intimi-

dated them into leaving their posts. No patients had lost their lives due to the strike action.

A woman who telephoned The Star at about 10pm last night and said her brother, due to undergo surgery at the hospital today, was left unattended while nursing staff were striking. She said she was concerned about leaving her brother because he needed an insulin injection and she was unsure if he would receive it.

Manning said that by 11pm last night enough sisters had been found to keep the hospital functioning.

Johannesburg hospital superintendent Dr Trevor Frankish said strike action had included most of the support staff and had affected the delivery of services. Operations have been delayed or cancelled due to the strike, said Frankish.

At Soweto's Chris Hani Baragwanath Hospital staff have been staging protests but Nehawu has ensured that emergency services continued throughout the duration of the strike. However, hospital management is concerned that clean linen supplies could run out by Monday.



Reminder ... a South African Police Union member sends his message loud and clear to police management and safety and security authorities following deadlocked wage negotiations.



# Hospitals affected as strike broadens

Reneé Grawitzky

ED 8/8/97 (98)

THE public service strike spread to hospitals around the country yesterday as thousands of health workers joined striking teachers to put pressure on the state to revise their offer of 7,5% plus rank promotions.

The start of the 48-hour strike by the National Education, Health and Allied Workers' Union was accompanied by reports of intimidation by other unions in the health sector and provincial health authorities reports of a number of sit-ins at hospitals.

Hospitals in Gauteng, Eastern Cape, Mpumalanga and North West were affected as thousands of general assistants heeded Nehawu's call, af-

fecting the provision of kitchen and laundry services.

Health department sources said the strike had not affected professional staff, such as nurses, badly.

The union and government negotiators continued meeting through the Commission for Conciliation, Mediation and Arbitration. Senior commissioner Sue Albertyn said the process was continuing and the parties were very optimistic.

A Gauteng health department spokesman said some disruptions had been experienced, but patient services were not affected.

A representative of the Hospital Personnel Trade Union of SA, not party to the strike, said disruptions had

been experienced at Coronation, JG Strydom, Johannesburg and Baragwanath as nonstrikers were intimidated by Nehawu members. He alleged that at Coronation Hospital Nehawu members forced the hospital secretary from the premises and workers were threatened.

An Eastern Cape health department representative said strikers occupied the administration offices at the Uitenhage provisional hospital.

The education department was unable to provide a clear picture of the effect of the teachers' strike, but reports from Mpumalanga said that the majority of schools were affected. The Western Cape reported a 23% stay-away by teachers.

# Crime pays for hospital work thieves

ARG 9/8/97

(98)

## *Right to sack wanted*

JILYAN PITMAN

**Crime is paying for hospital workers who steal from Western Cape hospitals, as bureaucratic tangles hold up disciplinary hearings for more than a year.**

During this time hospital thieves suspended from duty are on full pay and can do anything they want with their time - including earning more money somewhere else, giving them a double income.

Now hospital administrators want the power to kick them out on the spot.

They say they want to cut the long disciplinary process and to allow hospital heads to deal directly with punishment and suspension.

Edward Lotz, medical superintendent of Somerset Hospital in Green Point, said he looked forward to the day when hospital heads would get the go-ahead to take their own decisions.

"The whole suspension process needs to be decentralised. The paperwork is terrible and often documents get lost and then we have to start all over again," he said.

Dr Lotz said provincial hospitals had at least nine or 10 acts and codes to take into consideration before a thief was suspended. The ponderous Public Service Act of 1994 was one of them.

"Why can't we be like private hospitals, which have only the Labour

Relations Act and the Basic Conditions of Employment Act?" he asked.

He said that in other countries a criminal record was a shame, but: "Here it is not so. Criminals have the same rights as honest people."

He said statements, hearings, rights to appeal and different teams working on cases all added to the confusion.

"We sit with a lot of bad apples and there is no quick way to get rid of them."

The trebling of thefts since 1995 at Groote Schuur hospital cost the taxpayer more than R2-million a year.

A Groote Schuur spokesman said: "The hospital is not in a position to demand anything when it comes to the disciplinary process. The disciplinary procedure is a collective agreement and guided by the Public Service Act."

He added: "The period of between 12 and 13 months before a case is finalised is not ideal, but then one should keep in mind the factors that contribute to this situation - staff shortages, availability of funds, etc."

The spokesman said the final approval for suspensions rested with the Director General of Health.

"Suspension is taken very seriously because of the fundamental rights issue. Only in special cases will a staff member be suspended without remuneration," he said.



# Hospersa claims intimidation

FRANK NXUMALO

J (DR) 11/8/97 (98)

Johannesburg — The Hospital Personnel Trade Union of South Africa (Hospersa), handed a memorandum to Amos Masondo, Gauteng's MEC for health, at the weekend, in which it alleged intimidation of its members by people linked to the National Education, Health and Allied Workers' Union (Nehawu).

Mike Ryan, a spokesman for Hospersa, said its members and other government employees had been exposed to "horrendous acts of intimidation,

violence and victimisation" for the past three years.

"This has culminated in the events of the past weeks and, in particular, the forced removal of our members from their workplaces, to join Nehawu strike actions.

"Our members have received death threats and have been forcibly removed from hospital premises", Ryan said. He demanded action from Gauteng health authorities.

Nehawu officials could not be reached for comment on the claims.



# Home offers new lease on life for mentally ill

## Patients forced out of hospitals by budget cuts discover new freedom

(98) ART 11/8/97



BERTON GEMCK

Fashion follower: Maria Malherbe relaxes in Huis Sonop's makeshift hairdressing salon

LEWIS OWEN  
SARF REPORTER

A new initiative to house mentally ill patients discharged from psychiatric hospitals in group homes has been hailed as a major success by the project's organisers.

The organisation, called "Help your neighbour", looks after and runs such a home on the grounds of Stikland Hospital near Bellville. In an attempt to offer alternative accommodation to mentally ill people who are able to survive outside of the hospital.

These patients were released from Stikland, Alexandra, Lentegeur and Valkenberg hospitals after drastic budget cuts announced by the Government.

The provincial rationalisation plan was to have been carried out over five years but, because of the budget cuts, the process had to be speeded up.

The corridors and lounges of Huis Sonop are decorated with donated wall hangings, furniture and ornaments. In fact, even the curtains on the windows are secondhand.

But this building with its not-so-new accessories has given 46 mentally-ill people - who would otherwise have spent the rest of their days in an institution - a new lease on life.

The home opened in February. Llewellyn Snyman, the organisation's public relations officer, said some of the patients had lived in the hospitals for 30 or 40 years.

"Many of them were left there as children years ago and a lot of them have families," Mr Snyman said. "But some of their families

are too old to cope with them and some just can't go through the trauma of having to care for them."

He said Help your neighbour planned to open another group home by next year, but needed more donations from the public and private sector.

"We are totally dependent on donations," he said. William Zeeman, house-father at Huis Sonop, said he was confident the group home was a success.

"We are able to see to the patients' physical and social welfare," Mr Zeeman said.

Chief social worker Helma Gerritsen said the patients fitted in well in the new set-up. "This is a difficult project but so far it's been successful," she said.

"These people have been institutionalised for years and now they have to start their own little community. "But they are doing very well."

The home is overseen by a housefather, two house mothers and a part-time social worker.

A psychiatric nurse visits the home according to the patients' needs. All the patients have chores.

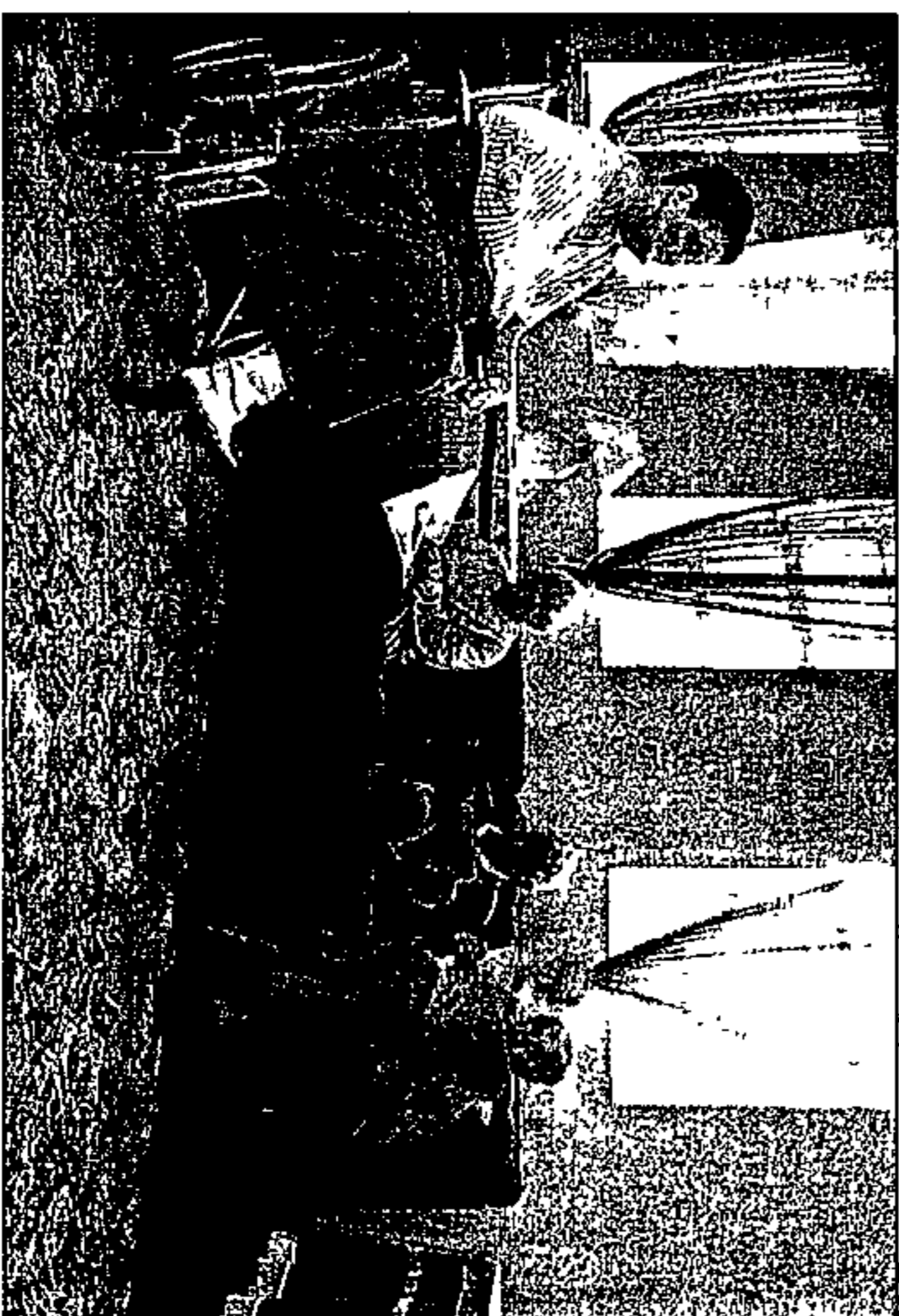
Mr Zeeman said it was vital for the well-being of the patients' minds and bodies that they were kept busy.

"It is important for them to know they are no longer patients, but lodgers," he said. All patients are allowed visitors and some visit their families for a week at a time. Many also go to daily work therapy sessions.

Besides a lounge with a TV and games, the home also boasts its own makeshift hairdressing salon. For more information, call Llewellyn Snyman at 25 2886.



Blanket effect: Henry Williams in the spacious men's dormitory. All the residents are required to do chores



Chair people: the residents' lounge. It is important for them to know they are no longer patients, but lodgers



# Psychiatric hospital in crisis

ART 11/8/97

(98)  
Grahamstown - The future of Fort England, one of the country's top psychiatric hospitals, may be bleak if financial aid is not forthcoming from Bisho.

So severe is the crisis that some doctors who spoke out on condition of anonymity feared that they would not get paid at the end of each month.

They said that Bisho had placed "severe financial restraints" on some psychiatric hospitals in order to prevent "indiscriminate expenditure".

"There is clearly a lack of funds within the provincial budget," said one doctor.

The hospital has been unable to pay many of its accounts and this is affecting the running of the facility.

"Certain services such as the

postal service were crippled for two weeks due to lack of funds.

"The situation was finally rectified yesterday," the doctor said.

An outlying psychiatric clinic belonging to Fort England has been threatened with eviction for falling into arrears on its rent in Stutterheim.

"The administration (of the hospital) is powerless at the moment," a doctor said. "There is no ink to type out letters and communication has come to a standstill. Staff are forced to buy their own stationery. Our budget has been cut so severely that we can't buy oxygen for the patients who need it."

The financial situation at the hospital is also affecting staff morale and doctors say that many of them get drunk at month end after being paid. "We have to

consult Bisho for everything, even to buy toilet paper. Our cars are not licensed."

The doctors claimed the hospital was also being plundered, with massive theft of everything from linen to curtain rails.

About 90 percent of the hospital's budget went on salaries.

The hospital's ills come at a time when the province's health department faces severe budget constraints. It was learnt earlier that Deputy President Thabo Mbeki had informed Premier Makhenkesi Stofile there was no more money for the province.

The department said that - far from being able to address the dire shortage of doctors in state hospitals - they would only be able to consider the "most crucial of the crucial" posts and only fill what it could afford - ECN



# East Rand hospital closes

(98)

Stow 15/8/97

MEDICAL CORRESPONDENT

Khayalami hospital is to close and Gauteng's health department will not attempt to keep it open, according to health MEC Amos Masondo.

Khayalami, previously called Kempton Park hospital, is one of the first institutions to be shut down in terms of the department's transformation plan.

The department had turned down a Khayalami Metropolitan Council (KMC) partnership proposal in June because it was out of line with basic principles for public health care.

Masondo said he had met several ANC councillors from the KMC in June and made it clear the closure would go ahead and the building would be sold.

"Whatever health ser-

vice may in future be run at the hospital by other organisations, the Gauteng health department will not be a partner," he said.

Given Khayalami's low utilisation and "inappropriate" location, the department judged that it had to follow other priorities, such as investing more in primary health care and under-resourced hospitals.

The closure of Khayalami was confirmed when the final announcement on the structural transformation plan was made in June this year. From July 1, people using the outpatient clinic were referred elsewhere, and the facility had closed by July 31.

Staff were busy moving to other jobs and others were carrying out tasks associated with closing a large institution.

Baragwanath to lose beds as it goes hi-tech

By JOVIAL RANTAO  
Political Correspondent

Chris Hani Baragwanath Hospital and Pretoria Academic Hospital are among 10 which the Government intends transforming into hi-tech medical centres.

Health Department officials have told Parliament's health committee that the 10 hospitals would be turned into smaller specialised units. They will be funded from the national budget.

The 10 hospitals' 13 000 beds are set to be drastically reduced, with beds being transferred to provincial and district hospitals.

Chris Hani Baragwanath's capacity is likely to be reduced from 1 200 to 800. "It's in the *Guinness Book of Records* as the biggest hospital in the world. We're not sure we want

to be regarded as a freak," said Dr Tim Wilson, the chief director of academic hospitals.

He said the plan was to turn the 10 hospitals into specialist units. For instance, Groote Schuur in Cape Town might specialise in heart transplants, Chris Hani Baragwanath in burns and kidney ailments, and Pretoria Academic in neurology.

Other hospitals earmarked for the hi-tech status include GaRankuwa Hospital in North West; Universitas Hospital in Bloemfontein; King Edward and Wentworth in KwaZulu Natal; and Groote Schuur, Red Cross and Tygerberg hospitals in the Western Cape.

A recent survey showed that 30% of SA's hospitals were in such a bad state of repair that they needed to be replaced at a cost of R8-billion.

Star 18/8/97 (98)

## Tuks blacks' 'apartheid' plea

(98) Star 15/8/97  
PRETORIA CORRESPONDENT

The SA Students' Congress, long a fighter for equality in education, is demanding the return of racially segregated hostels at the University of Pretoria.

Gauteng chairman Jacob Mamabolo made the call during a campus meeting, citing racial violence as the reason for the request.

This follows a number of alleged race-related incidents at campus hostels in which black students were apparently harassed.

These were isolated incidents in which black students were being beaten, harassed, or insulted by racist remarks, Mamabolo said.

"Initiation is also being imposed on black students. We have our own culture, so why the initiation?"

"And sometimes whites

call us 'kaffirs', spray us with fire extinguishers or throw food at us."

Mamabolo said Sasco considered it an option that hostels be segregated for two years and that hostels should also be mixed along gender lines.

He added that, at a meeting to be held within the next two weeks, Sasco intended to ask the university's management to segregate the hostels.

"We are not saying this is a correct decision because it defeats the objectives of nation-building."

University dean of student affairs Professor Flip van der Watt confirmed that isolated cases of racial incidents had occurred.

"There are incidents, but we're working on them."

Tuks spokesman Mike Smuts declined to comment.

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(98) Star 15/8/97  
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# Bara creaks into a crisis with its 'obsolete' equipment

(98)

Many of the diagnostic devices are out of date or don't work, so the backlog of patients keeps on growing

Alar 19/8/97

By PRISCILLA SINGH  
Health Reporter

The x-ray department at Chris Hani Baragwanath Hospital has been plunged into a crisis, with a backlog of at least 600 patients, because of the breakdown of outdated and old equipment.

Fed up with the ancient equipment the hospital has to work with, the head of the x-ray department, Dr Jack Mirwis, said staff were frustrated and angry and there had been numerous work stoppages due to the malfunctioning machines.

The present backlog for patients is about one to two days.

The department sees about 270 patients in the casualty and main x-ray sections each day, which excludes the booked cases for the scanner and special services, emergencies and night-duty x-rays.

Yesterday, only four of the nine equipped rooms in the main x-ray department were being used.

"Some of the equipment is so old that it has become obsolete and cannot be repaired, and we feel that the x-ray department at the hospital has been shamefully neglected in this regard," Mirwis said.

While a waiting list for patients existed, it was fortunate that nobody had died thus far because of the problems with the equipment, he added.

Another major concern is that the hospital did not have a dedicated paediatric x-ray unit.

Mirwis said it was a disgrace, for a hospital of Bara's size, not to have such a unit.

Chief superintendent Dr Chris van den Heever said new equipment costing about R2-million was in the process of being ordered and should be delivered next year.

Bara had been allocated R11-million by the Gauteng health department to buy new equipment. However, only R2-million had been allocated to the problematic x-ray division.

Long and protracted tendering processes had also been blamed for the delays.

A new Panalips Unit ordered during the previous financial year had yet to be delivered, although the long process for acquiring such an expensive unit was now nearing completion and with luck, it should be delivered within the next six months, Van

## Fortunately nobody has died thus far because of the problems

den Heever said.

Other reasons for the backlog could be the fact that budgets for academic hospitals rendering specialist services had been shrinking, and, therefore, had "less and less money" to buy new equipment or replace the old.

Gauteng health department spokesman Dr Eric Buch said they had inherited a multi-billion-rand capital backlog for maintenance and repairs of equipment in state hospitals, and a large proportion of the equipment had been bought as a result of bad decision-making.

The department was cur-



GARY BERNARD

Outdated ... one of the many x-ray units at Soweto's Chris Hani Baragwanath Hospital which are out of order because they are too old to be repaired.

rently doing an audit of all the hospitals and assessing what equipment was required in different institutions.

"We are also looking at transferring equipment from

hospitals which are being closed or converted, and Bara is one which will benefit with the x-ray equipment from Hillbrow Hospital," Buch said.

Hillbrow Hospital is being

downgraded to a community health clinic as part of the health department's structural transformation plan.

Buch said that, hopefully, Bara's problems in the x-ray

department would be sorted out during the course of the year, but for now the department was going to draw up a strategy to alleviate the bottleneck of patients in that

section. "Even if it means the unit staying open after hours and paying staff overtime, we will try to help the hospital as much as we can," Buch said.





OBED ZILWA

Helping hand: Red Cross patients with Dudley Cloete-Hopkins (left) of Syfrets and David Beatty

## R1,2-m for Red Cross Hospital

STAFF REPORTER

A much needed R1,2-million has been poured into the coffers of Red Cross Children's Hospital by a financial services group.

The donation will be made by Syfrets through the Nedcor Community Development Fund in instalments of R400 000.

The first instalment, handed over yesterday, will enable the hospital to begin building a new medical emergency unit.

"As the only specialist children's hospital in sub-Saharan Africa, its resources are in huge demand and an upgrade has

become critical, hence our decision to assist with funding," said Dudley Cloete-Hopkins, head of Syfrets' social responsibility division.

The new emergency unit will enable the hospital to act on its belief that the best place for a child is at home with the family.

According to David Beatty, chairman of the Red Cross Children's Hospital Trust and head of paediatric medicine at the University of Cape Town, the new unit will be used to deal with all non-surgical and non-traumatic emergencies. Construction will start as soon as an agreement between the hospital trust and the Cabinet is signed.

ARL 19/8/97

(98)





**FOOD MOUNTAIN:** The Federated Hospitality Association of SA donated four tons of food to the Salvation Army in Somerset West yesterday. At the handover were (back, left) Mr Ken Hine of the International Hotel and Restaurant Association, Major Robbie Mair of the Salvation Army and Mr Deon Viljoen of Fedhasa. Anticipating a taste of things to come were Pindiwe Mnyama, Stephanie de Koker, Chenay Carelse and Azandi Bidi. PICTURE: ALAN TAYLOR

## Fedhasa upset over tax plan

20/8/97

TOURISM WRITER

98

MOST owners and operators of rural tourism establishments did not know how the proposed land tax would affect them, the Federated Hospitality Association of South Africa (Fedhasa) said.

Fedhasa executive director Mr Deon Viljoen said only 10% of those who might be affected by the proposed tax were aware of the direct implications.

The idea of a land tax was to collect some form of taxation on any unused agricultural land.

It would be payable annually and would be calculated at 2% of the land value and any improvements on the property.

In the latest issue of *Hotelier & Caterer*, Viljoen said the proposed tax would apply to all land falling outside a municipality—except tribal and state-owned land.

“This means that any bed and breakfast, guest house, game lodge, camping area or resort falling outside the boundaries of a municipality will have to pay up.”

Viljoen said the tax could affect about 23% of the total workforce of the hospitality industry in rural areas.

Fedhasa viewed the proposal as “punitive” and had presented two submissions to the Tax Commission on behalf of the hospitality industry to renegotiate certain clauses that could be detrimental owners of game lodges, guest houses and bed and breakfast establishments which fell outside municipal areas.



4 766 JOBS IN JEOPARDY

# City hospitals face

**Closure**  
CT 20/8/97 (98)

**NEARLY 5 000** health workers will be made redundant, two hospitals will close and several others face stringent cuts if a planned health budget goes through. **CAROL CAMPBELL** reports.

**T**HE Western Cape Health Department has proposed that two public hospitals in Cape Town be closed and the size of three others be reduced to save a further R510 million on its already cash-strapped budget this year.

Labour organisations were told about the proposed cutbacks at a meeting with health department head Dr Tom Sutcliffe on Monday and have since written him a "strong" letter rejecting the plan.

The proposals will be considered by the provincial cabinet today. If the plan is approved another 4 766 staff working in public hospitals in the Western Cape will be made redundant.

The hospitals which face closure are the Lady Michaelis, an orthopaedic clinic in Plumstead, and a psychiatric hospital which is yet to be named.

The psychiatric hospital will be asked to discharge half its patients, with the remainder being transferred to other psychiatric hospitals. Half the staff will be transferred to other hospitals and the rest made redundant.

According to the proposals, the Lady Michaelis site would be used as a community health centre for primary health.

At Somerset Hospital, near the Waterfront, a wing would close and patients would be accommodated elsewhere in the hospital.

The tuberculosis hospital DP Marais in Westlake and the Westlake Hospital will be asked to reduce expenditure by 30%.

Between them Groote Schuur, Tygerberg and Red Cross Children's hospitals will have to lose another 988 beds, bringing the number of academic beds still open to 2 000. Already 560 beds have been closed because of budget cuts.

Since the change in government 5 400 health workers in the Western Cape have taken voluntary severance packages. For the health department to keep to its rationalisation schedule another 2 200 will have to leave by December.

The national health department will have to negotiate a retrenchment plan with trade unions first.

Mr Koos Kruger, provincial manager of the Public Servants' Association, said "excess" hospital staff would remain in their jobs and would continue to be paid by the provincial government — just not by the health department.

"That is why this plan is so ludicrous. All it does is give the health department a short-term saving but in the long term these extra people will still have to be paid until a retrenchment deal is negotiated at national level."

The cutbacks are part of the government's plan to redistribute resources out of "wealthy areas" to impoverished rural communities.

Health Minister Dr Nkosazana Zuma has succeeded in building more than 400 clinics in these communities in the past 18 months. Her gains in these areas are due to harsh budget cuts applied to

□ Turn to Page 3

## Hospitals set to close under new health cuts

(98) CT 20/8/97

□ From Page 1

hospitals in urban areas.

Yesterday Dr Norman Maharaj, general-secretary of the Health Workers' Union, said labour organisations representing health workers had unanimously rejected the budget plan.

"We believe if this plan goes through, the health system in the Western Cape will collapse."

Kruger said when retrenchment was "on the table" it had to be a realistic and negotiated process in which the state showed responsibility towards the people affected.

"This is what this exercise lacks," he said.

In an urgent press statement last night MEC for Health and Social Services Mr Ebrahim Rasool expressed his dismay at a breach of confidence by trade unions in releasing a document outlining the implications for the health services if the health budget for the financial year remained on its projected path.

The impact of the breach of confidence is to create unnecessary panic and apprehension among staff and the public about the future of the health system.

Rasool said he had held negotiations with Zuma and Dr Olive Shisana, director-general of health, and had "found enormous sympathy and understanding" for the situation in the Western Cape Health Services. It is far too early to push the panic button.

"While understanding legitimate anxieties among the unions, it is unfortunate that they have used information provided for them in good faith, to create unwarranted alarm in the health sector which can do without the added stress and strain," Rasool said.

# Cape's academic hospitals may get cash injections

8/15 (98)  
CAROL CAMPBELL

ET 21/8/97  
ACADEMIC hospitals can look forward to a cash injection from the national Health Department if Minister of Health Dr Nkosazana Zuma follows through with a plan to reorganise the way these hospitals are funded.

At the moment Cape Town's three academic hospitals, Grootte Schuur, Tygerberg and Red Cross Children's hospitals, are funded by the Western Cape Health Department, which means they are vulnerable to continuing budget cuts because of cash flow problems in the province.

Provincial health MEC Mr Ebrahim Rasool said yesterday that Zuma and the director-general of health, Dr Olive Shisana, had told him they did not want national assets (the academic hospitals) to be destroyed by provincial financial problems.

The Western Cape health budget was cut from R2,76 billion in 1996 to R2,47bn in 1997 — a consequence of a shift in government spending from wealthy urban centres to the impoverished rural provinces.

He said he was not sure when or if money would be forthcoming in the near future.

"The hospitals are national assets which provide specialised services to the whole country — like heart transplants," Rasool said.

To stop heart transplants because the Western Cape did not have the money to continue the service would not be in the long-term interest of the country, he said.

Deputy President Thabo Mbeki was also aware of the problem and visited Tygerberg Hospital two weeks ago to assess the difficulties facing these institutions, which have been cutting staff and closing beds as their budgets dwindle.

Rasool said the way the hospitals were managed was being reassessed and in future they would probably be run by one chief executive officer.

"This doesn't mean there will be no chief medical superintendent but rather that there will be joint planning and no duplication of services."

The provincial cabinet was also studying a plan to bring in more money to these institutions.

"We are going to improve the computer billing system and employ staff for better fee-collection. Already long outstanding debts have been handed over to private companies for collection."

The hospitals had to attract more private patients, especially those on medical aid, if they wanted a guaranteed source of income.

"Clinically we don't have to stand back for private hospitals. What we do have to do is spruce these places up, make sure they are clean and provide better meals to attract private patients."

Public hospitals charged fees lower than the medical aid rates and this meant patients need not use up their full medical aid allowance on only a few days in a private hospital.

The health department's controversial budget plan, suggesting more dramatic cuts in the province, was presented to the provincial cabinet yesterday but was a "what if" document and was not intended to cause panic, said Rasool.

Health labour organisations reacted with outrage earlier this week when they heard the province was proposing more cuts that would mean the loss of another 5 000 jobs.

The plan was intended to show the cabinet what the implications would be to health in the province if the health department was forced to finish the financial year within its existing budget, Rasool said.



## Land next to Rietfontein Hospital to be developed (98)

DD 26/8/97

Nomavenda Mathiane

A VIABLE commercial complex is to be developed on unused land adjacent to the Rietfontein Hospital in Edenvale on the East Rand to generate revenue for the hospital, which treats mainly infectious diseases.

Land Development Planning chief director Ralph Dauskardt said yesterday the health department owned the 200ha of land, 90% of which lay idle and would be developed for commercial, industrial and residential purposes.

The hospital occupies the remaining 10%.

He said the land would sell for R40m, but could fetch about R200m if it was developed.

There had been consultation between the province and a number of interest groups to gather information on the future of the area.

Phase one of this project — to assess and advise on the appropriate use and development mechanisms of the land — had been completed. A task team to work on the development framework of the project was to report back to the stakeholders within three months.

In the meantime, the health department is upgrading the hospital and has set aside R3m for improvement for 1996/97 and R1,5m for next year. The estimated overall budget for the hospital's upgrading is R20m.

Dauskardt said a medical team was looking into the implications of development around a hospital treating infectious diseases.

However, he said with modern medical technology there was no need for a buffer zone.

0029/8/99  
(98)

# Hospital group probes allegations

Reneé Grawitzky

NETWORK Healthcare Holdings (Netcare) is investigating allegations by the Hospital Personnel Trade Union of SA (Hospersa) that the group's St Augustine's hospital in Durban has overcharged patients.

Union sources said the investigation would look also into the activ-

ities of hospital management. The hospital manager had been "placed on leave" pending the outcome of the probe, the sources said.

Last month Hospersa accused St Augustine's former owner, Clinic Holdings, of overcharging patients.

The company denied these claims, saying they had been "cooked up" by

the union to discredit it in the region.

In a recent newsletter, the union said it had discovered the information by chance when representing some of its members in retrenchment negotiations.

A Hospersa shop steward reportedly told the union he had been receiving merit payments for inflating patient accounts.

He was subsequently suspended but, union sources said, he had been reinstated.

The newsletter said that since the Netcare consortium — which includes the Congress of SA Trade Union's investment arm Kopano ke Matla, and other union investment companies — had taken over Clinic Holdings, it had contacted Hospersa with the "stated intention of investigating matters".

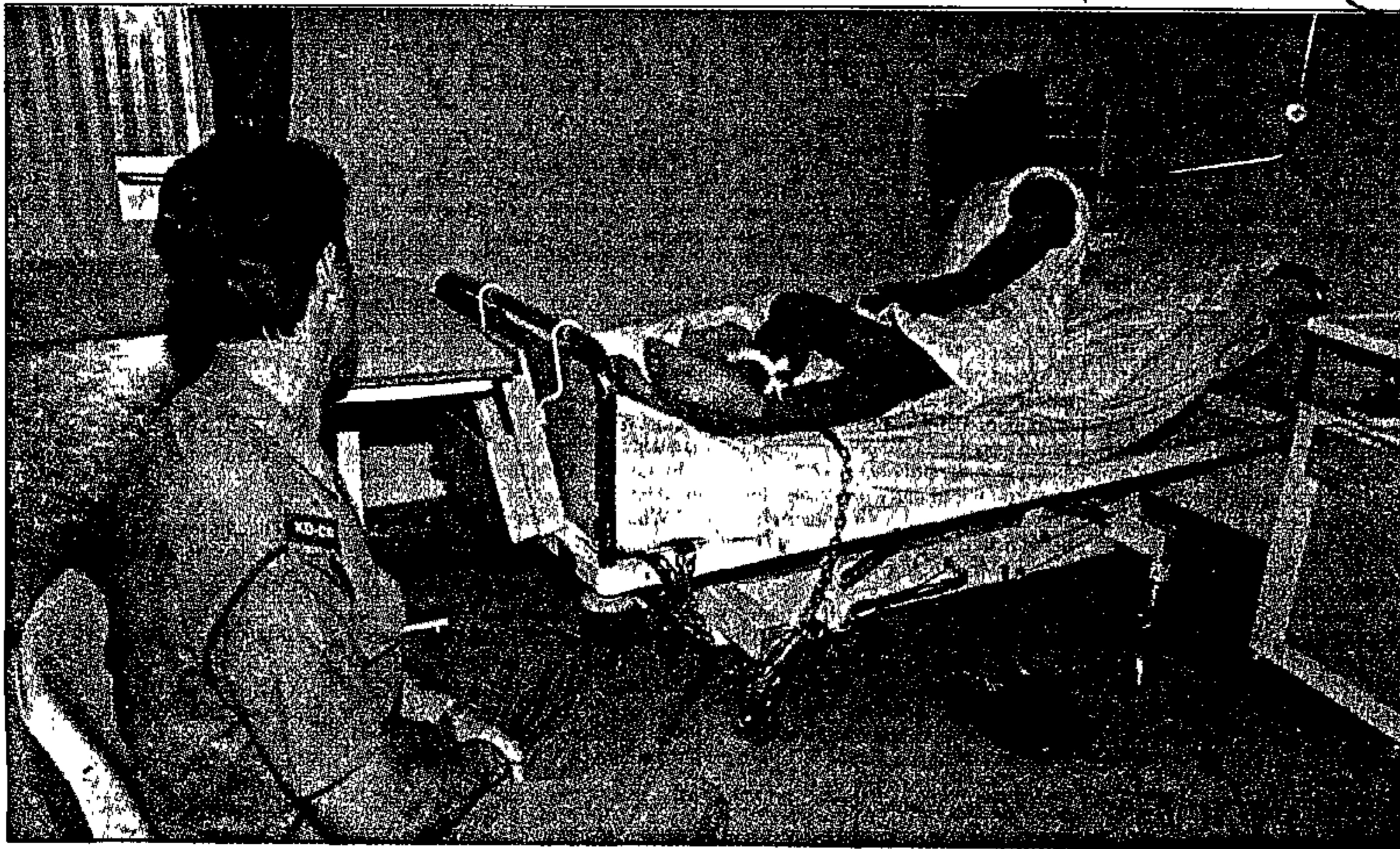
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# Top-class convi



**SIMPLY THE BEST . . .** A prisoner receives top-specialist care in a special ward at a private clinic in one of Johannesburg's suburbs... under the watchful eye of a prison warder.

■Pics: ANDRIES MCINEKA

## Prisoners a privately at citizens car

By JIMMY SEEPE

**SOUTH AFRICAN** prisoners get "Five Star" treatment once they fall ill - they are taken straight to private clinics at a cost beyond the reach of most ordinary citizens.

To date, taxpayers have already paid more than R150 million in medical fees for convicts since March last year.

The cost of prisoners' health care, which is expected to double this year because of increasing numbers in the prison population, could overtake last year's figure of R118 million - calculated from April 1996 to March 1997.

From April to July this year, taxpayers have worked out R45 million for the health care of South African prison inmates.

The department of correctional services' budget has now been stretched to the limit, and they are looking at ways to contain this expenditure.

Not only is the cost of prisoners' healthcare depleting the correctional services' budget, but it is draining a huge chunk of taxpayers' money which could have been used for other purposes.

The total health care cost includes the cost of hospitalising criminals at expensive private clinics in major cities around the country, rather than at over-crowded state hospitals such as the Chris Hani-Baragwanath Hospital in Soweto.

Private clinics charge the department the same rate they charge medical aid cardholders.

Correctional services director of communications, Barry Eksteen, said in choosing a hospital or clinic, prison authorities had to consider security issues to minimise escapes.

The R150 million does not include the cost of treating suspected criminals referred to hospitals for medical treatment before being sentenced by the courts. It is understood that the South African Police Services could be spending well over R200 million a year for the medical treatment of such persons.

In an effort to reduce medical expenditure, correctional services has been forced to release certain prisoners on medical grounds before their full prison term expires.

Since the start of the 1997, 21 prisoners have been released on medical grounds. Forty nine prisoners were released last year.

Correctional services is also looking at ways to ensure the cost-effective issuing and control of prescribed medicines given to prisoners. It is understood that expensive medicines prescribed for prisoners could also be causing the high cost.

## Crime victim is left without painkillers in busy state hospital

By BENISON MAKELE

**IMAGINE:** Thabani Zwane is a law-abiding citizen.

This week he fell victim to a crazed gunman who fired three bullets into his back.

Zwane, 34, of Msinga in Natal, lies in pain in the discomfort of the overcrowded Chris Hani-Baragwanath Hospital - because he cannot afford any better.

The gunman, if caught, is entitled to "five-star" treatment at a private hospital if he demands it.

This is the irony of South Africa where victims of serious crimes are likely to end up at overcrowded hospitals while criminals literally live it up at upmarket clinics - at the expense of taxpayers.

When City Press visited Zwane in hospital this week, he was writhing in pain after being transferred from the surgical admission ward (SAW) to Ward 2.

His appeal to the nurses for painkillers had fallen on deaf ears. It was then 4.05 pm.

Zwane said he had been admitted at around 8 pm the previous day and had still not received

any pain killing medication.

His assailant is on the run and, as far as he knew, had not yet been arrested.

Suppose the assailant got arrested after being wounded by the police . . .

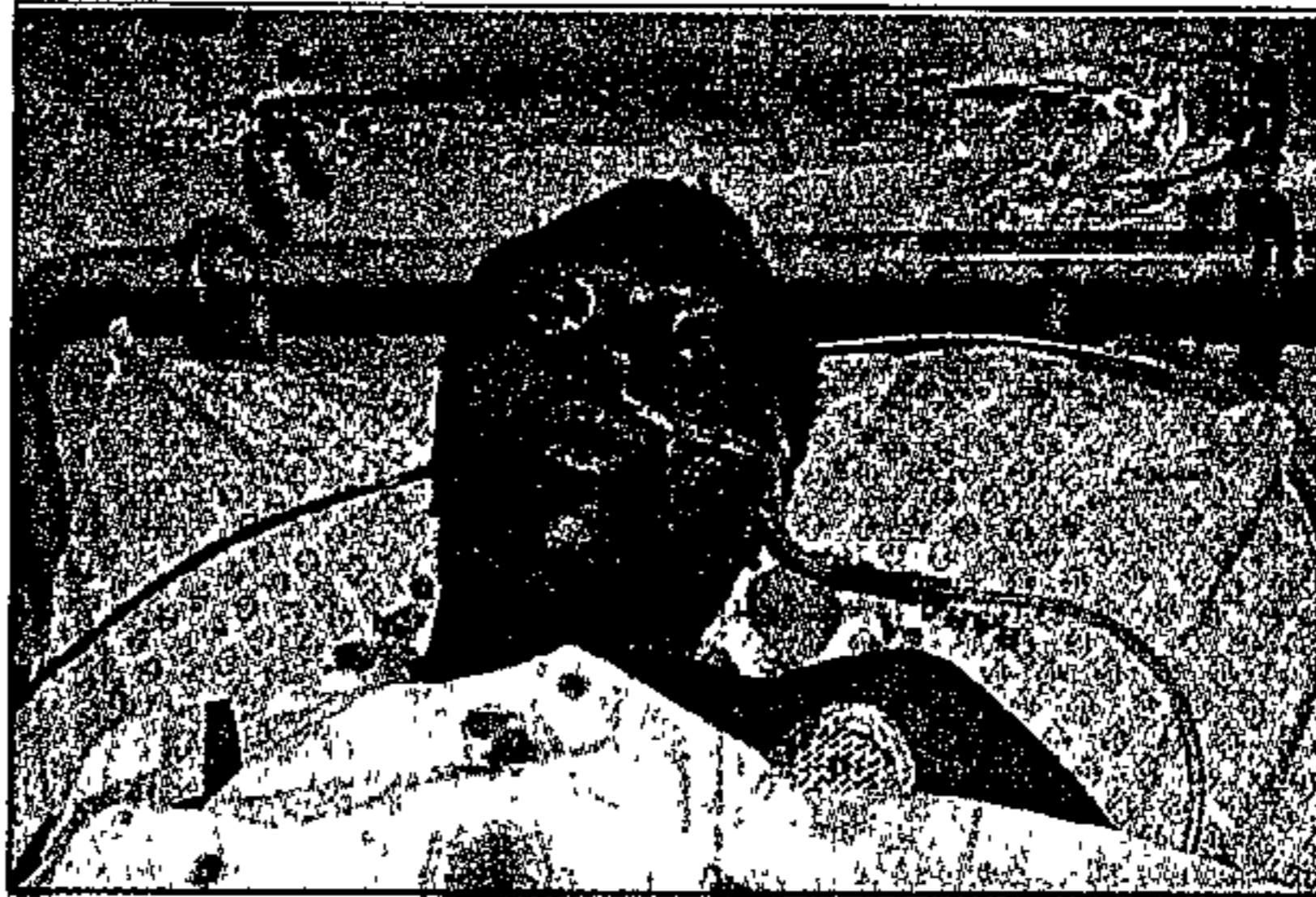
Instead of being taken to a state hospital ward the following day like Zwane, he would be whisked away to the comforting luxury of the Garden City clinic in suburban Brixton.

At the private clinic, he would be able to demand the best medical attention because of his testimonial value to the police as a suspect.

"We've had both victim and perpetrator lying next to each other but the latter would then be taken to Garden City as he would be under police guard while the former would remain confined to Bara," confirmed SAW sister-in-charge Nomaqhwa Mndebele.

Patients were not given medication either because of doctors' orders or because they were due to be X-rayed, or because their specimens had been sent for diagnosis, among other reasons, she said.

Beats the imagination.



**OPPOSITE CASE SCENARIO . . .** Crime victim, Thabani Zwani, 34, lies writhing in pain at the overcrowded Chris Hani-Baragwanath Hospital in Soweto.

## Five Star care for criminals

By JIMMY SEEPE

**IS THE** department of correctional services giving convicted murderers, car hijackers and rapists "first class" treatment, as opposed to their victims, by hospitalising them in private clinics at taxpayers' expense?

This is the question that most law-abiding citizens would ask if they were to visit private clinics treating convicts and awaiting-trial prisoners.

The clinics, dubbed "Five Star Hotels" by warders and prisoners alike, are being used more and more frequently by police and correctional services to hospitalise sick inmates and

suspects at huge tax payer's expense.

And these clinics are often inaccessible to crime victims.

In Johannesburg alone, three private clinics - including Garden City - are already equipped with a specially-designated section for convicted and suspected criminals.

But management at these hospitals deny that they provide "Five Star Hotel" treatment to suspected and convicted criminals.

A Garden City spokesperson said: "The patients do not receive the best food diet like private patients." But she added that the clinic did give patients the best available specialist care.



# ASS CONVICTS

Prisoners are treated privately at fees most citizens cannot afford

CP 31/8/97

By JIMMY SEEPE

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Correctional services director of communications, Barry Eksteen, said in choosing a hospital or clinic, prison authorities had to consider security issues to minimise escapes.

The R150 million does not include the cost of treating suspected criminals referred to hospitals for medical treatment before being sentenced by the courts. It is understood that the South African Police Services could be spending well over R200 million a year for the medical treatment of such persons.

In an effort to reduce medical expenditure, correctional services has been forced to release certain prisoners on medical grounds before their full prison term expires.

Since the start of the 1997, 21 prisoners have been released on medical grounds. Forty nine prisoners were released last year.

Correctional services is also looking at ways to ensure the cost-effective issuing and control of prescribed medicines given to prisoners. It is understood that expensive medicines prescribed for prisoners could also be causing the high cost.

Eksteen told City Press that the state was "responsible to foot the bill for the medical treatment of all prisoners".

He said an increase in the prison population, which is now over 132 000, is likely to contribute to the high medical costs.

Added to this is the cost of caring for elderly convicts within the prisons. There are currently 750 convicted people over the age of 60.

Eksteen said the department placed "a high premium on the medical treatment of all prisoners entrusted to its care".

He said although the department tried to utilise medical personnel already working within the prison system, they were sometimes faced with no choice but to refer prisoners to private hospitals on the instructions of district surgeons.

"The nursing personnel of the department of correctional services are guided by the district surgeon and his prescriptions and instructions have to be carried out meticulously," said Eksteen.

However, Eksteen was quick to point out that the figures quoted above include those of prison hospitals. He said the department was not forced to send convicted criminals outside the prison for medical treatment.

He said referral of prisoners to private hospitals was the prerogative of the district surgeon and specialist which the department does not interfere or have jurisdiction over.

Eksteen said the department had to exercise care in its choice of a clinic or hospital.

"It must be borne in mind that our patients are unique and that no service can be rendered to them without taking into consideration the aspect of safekeeping.

"The costs of medical services can therefore not only be determined on grounds of hospital and doctors' accounts, but must also be determined by the cost of guarding, transport service as well as the cost of minimising the risk of escape when taking the prisoner outside the walls of the prison," he said.

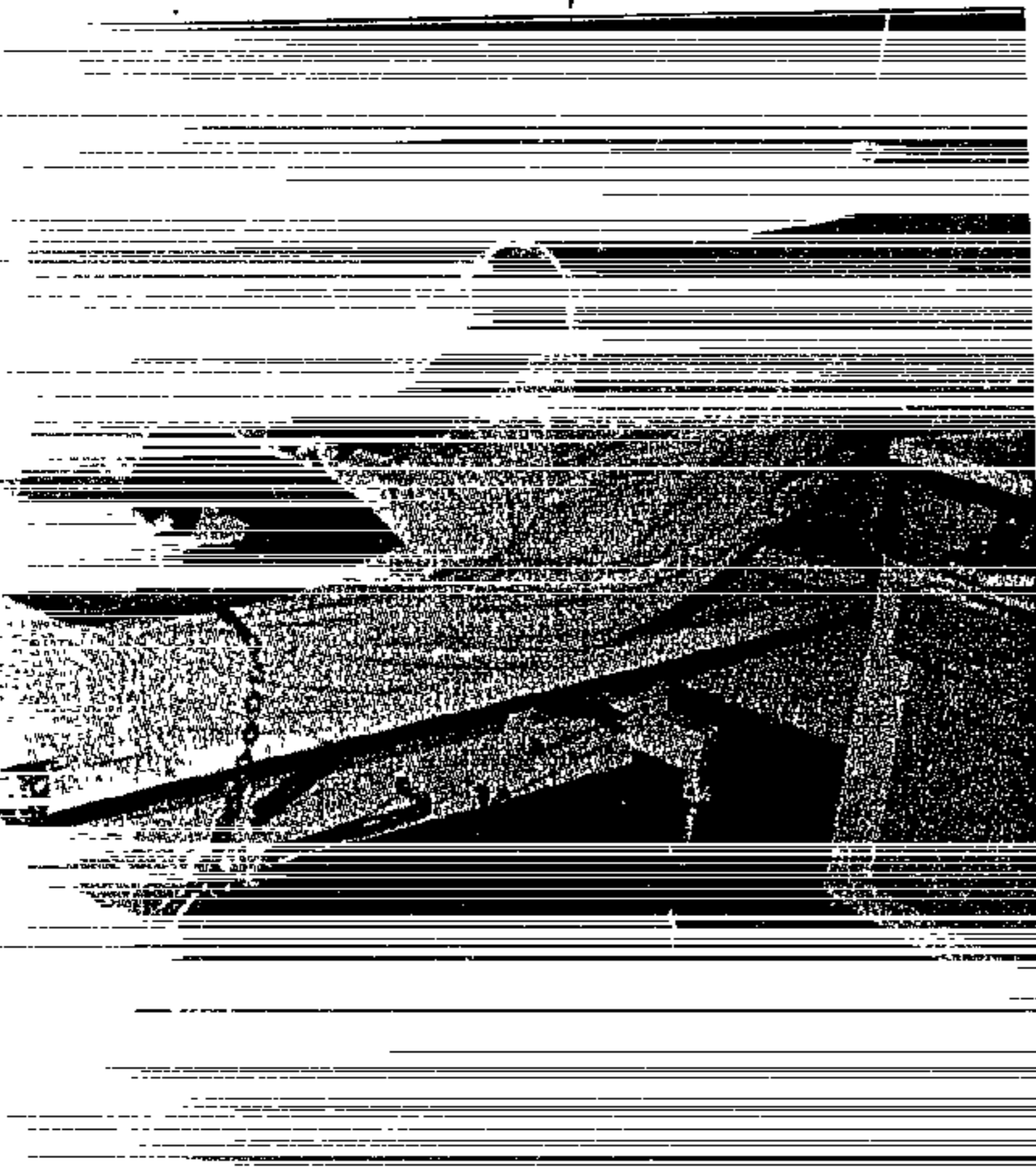
Eksteen said prisoners who qualified for release on medical grounds were usually first hospitalised before medical officers made a decision on whether or not to release them on parole.

In another effort to cut costs, the department is now looking at establishing provincial prison hospitals which will provide a 24-hour service.

The building of such hospitals is said to be currently hampered by budgetary constraints.

□ To Page 2

P.T.O.



Prisoner at a private clinic in one of Johannesburg's suburbs, under the watch of police. Pics: ANDRIES MCINEKA



OPPOSITE CASE SCENARIO... Crime victim, Thabani Zwanl, 34, lies writhing in pain at the overcrowded Chris Hani-Baragwanath Hospital in Soweto.

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D



## Convicts get treatment at private clinics

Continued from Page 1.

Meanwhile, correctional services this week requested Parliament to authorise R35,44 million that the department has already spent, without the necessary treasury approval, on clubs, canteens and messes.

Due to an "administrative error" the department had neglected to obtain permission to increase the number of these facilities, correctional services commissioner Khutekani Sithole said to queries from Parliament's public accounts

committee.

Sithole argued that only the money spent on the personnel who were managing and operating the facilities could be "technically" regarded as unauthorised.

The messes are non-profit institutions which provide food to personnel staying in single quarters who do not have facilities to prepare their own food.

The unauthorised expenditure showed up in the auditor-general's report on government's accounts for 1994/5.

Her Majesty's Government (HMG) on privatisation.

(c) Foreign investment in South Africa will contribute to the stimulation of economic growth and job creation while training will assist the parastatals. The experience of HMG in the privatisation process of the UK is instructive to the South African Government.

(d) I was overseas with the knowledge and consent of the Minister of Foreign Affairs who has acknowledged the value of such visits.

(5) Yes.

(a) Meetings were held with Senior Personnel at the HSBC headquarters and officials from the UK Treasury.

(b) The previous investment trip was on 23 and 24 October 1996 in Harare at the South African Trade and Investment Summit.

**Minister present/absent during Question Time**

\*10. Mr N J J VAN R KOORNHOF asked the Minister of Sport and Recreation: [Written Question No 870]

(1) Whether he was present in the House during Question Time on 4 June 1997; if not, (a) what was the reason for his absence, (b) who granted leave of absence to him and (c) what were his whereabouts at the time;

(2) whether any Minister or Deputy Minister was acting on his behalf during his absence; if so, who;

(3) whether the reasons for his absence were made available to the public; if not, why not; if so, what are the relevant details;

(4) whether he was on a visit abroad at the time; if so, (a) who did he meet, (b) what was the purpose of the visit, (c) how did such visit benefit South Africa and (d) what advice did he obtain from the Minister of Foreign Affairs concerning such visit;

(5) whether he met with any institutions and/or bodies during this visit; if not, what is the position in this regard; if so, (a) which institutions and/or bodies and (b) when was the last time a Minister visited each such institution and/or body?  
N1516E

**THE MINISTER OF SPORT AND RECREATION:**

(1) No

(a) Attending the Organisation of African Unity (OAU) summit in Harare, Zimbabwe

(b) The President

(c) Attending the OAU summit in Zimbabwe

(2) Yes - Minister J Radebe

(3) No - It was not necessary to make reasons available to the public

(4) Yes

(a) Delegates to the OAU summit

(b) South Africa is a member of the OAU and the Minister represented the country at the summit

(c) South Africa's membership to the OAU is certainly of benefit to the country

(d) the Minister did not need the advice of the Minister of Foreign Affairs

(5) No

(a) N.A.

(b) N.A.

\*11. Mr J S A MAVUSO - Transport. [Written question No 875] [Removed.]

**Vacant post of Chief State Law Adviser**

\*12. Mr P A MATTHEE asked the Minister of Justice: [Written Question No 890]

Whether any person has been appointed to the vacant post of Chief State Law Adviser; if not, (a) why not and (b) when is this post expected to be filled; if so, (i) who has been appointed to

this post and (ii) with effect from what date has this person been appointed to the post?  
N1536E

**THE MINISTER OF JUSTICE:**

No.

(a) The position was advertised but the Selection Committee failed to identify a suitable candidate.

(b) It is expected that a permanent appointment will be made within a year. In the meantime Mr Enver Daniels has been appointed on contract for one year to act as Chief State Law Adviser until the vacancy is filled.

*For written reply:*

**Doctors transported to patients by aeroplane**

262. Mr M J ELLIS asked the Minister of Health:

(1) Whether aeroplanes are being used in any provinces for transporting doctors to patients; if so, in each case, (a) why, (b) what is the make of the aeroplane and (c) what were the annual (i) running and (ii) maintenance costs in this regard during the latest specified period of twelve months for which information is available;

(2) whether any of these aeroplanes are being subsidised by any organisations; if so, in each case, (a) by what organisation, (b) what is the amount of the subsidy, (c) where is the aeroplane based and (d) what are the aeroplane's regular flight patterns?  
N410E

**THE MINISTER OF HEALTH:**

(1) Yes, in the Northern Cape Province.

(a) The Northern Cape Province has large areas which are inaccessible due to its topography and its population is widely spread in small settlements. Distances to the only secondary referral hospital (Kimberley) can be as far as 1050 km (Port Nolloth). The Province takes responsibility for the transportation of patients from the point that they enter the system to the point at which they can be treated.

During 1995, departmental vehicles travelled 3.5 million kilometres transporting these patients.

(b) Pilatus PC XII - 12 seater pressurised plane, capable of landing on short gravel landing strips.

(c) (i) R1 203 840 per annum

(ii) R1 915 200 per annum

(2) Yes.

(a) The South African Red Cross is a non profit making partner in the air service in the Northern Cape. Assistance is also given by Swiss Aviation, SA Express, Engen, Spilkin Optometrists and Airports Company amongst others. Local business in the Northern Cape has shown an interest in the air service by allowing the use of company airstrips and clinic facilities.

(b) Organisations involved mainly contribute in kind and not in cash.

The South African Red Cross contributes managerial capacity and volunteer pilots.

The estimated value of discounts and concessions received from other companies is approximately R350 000 per annum.

(c) The aeroplane is based at the Kimberley Airport, sharing a hangar with the South African Police Service.

(d) Flight patterns are set three months in advance, and are needs-based. On average, the air team provides a service at regional centres once or twice per day and at other clinics every four to twelve weeks as required.

*Source: Northern Cape Provincial Department of Health and Welfare, April 1997*

**Amounts paid to certain firm for services rendered**

566. Mr M J ELLIS asked the Minister of Health:

Whether any amounts were paid in 1996 to a



(a) How many cases of malaria were reported in South Africa in 1996 as compared to 1995 and (b) which areas had been declared as high risk malaria areas in South Africa as at the latest specified date for which information is available? N1649E

The MINISTER OF HEALTH:

(a) In 1996, 10 455 cases of malaria were reported in South Africa as 5 992 cases in 1995.

(b) The following areas have been declared as high risk malaria areas as on 1 August 1997:

KwaZulu/Natal

1. Hiabisa
2. Ingwavuma
3. Ubonho

Mpumalanga

1. Albertsnek
2. Block C
3. Fietree
4. Klipspruit
5. Mhangwane
6. Mbusuzi
7. Naas
8. Nelspruit town
9. Steenbok

Northern Province

High risk areas are North Eastern of the northern region and the eastern side of the Lowveld.

The specific districts are:

1. Dnazini,
2. Giyani,
3. Letaba,
4. Luikani,
5. Malamulele,
6. Mapulaneng,
7. Messina,
8. Mhala,
9. Mutale,
10. Namakgale,
13. Phalaborwa,
12. Thohoyandou,
13. Tshitale,
14. Vuwani.

Source: Provincial Departments of Health, August 1997

Private/public hospitals number of hospital beds

\*19. Dr S J GOUS asked the Minister of Health: [Written Question No 948]

What was the total number of hospital beds in (a) private and (b) public hospitals in each of the provinces in (i) 1995 and (ii) 1996? N1650E

The MINISTER OF HEALTH:

Province	Total number of beds in:			
	(a) Private Hospitals	(b) Public Hospitals	(i) 1995	(ii) 1996
1. 1 Military Hospital	0	0	386	386
2. 2 Military Hospital	0	0	236	236
3. 3 Military Hospital	0	0	180	183
4. Western Cape	4 857	4 857	14 762	14 402
5. Free State	2 152	2 216	7 267	7 183
6. KwaZulu-Natal	3 107	3 107	24 884	25 033
7. North West	*722	*722	7 905	7 905
8. Eastern Cape	1 199	1 199	17 416	17 416
9. Northern	196	196	10 299	10 430
10. Mpumalanga	1 353	1 353	4 427	4 427
11. Gauteng	14 594	14 594	19 967	19 733
12. Northern Cape	*449	*449	2 286	1 741
Total	28 629	28 693	109 935	109 045

\* Information from the National Department of Health and not the Province

Source: Provincial Health Departments, 1997

Dentists/pharmacists/specialists/general practitioners in practice

\*20. Dr W A ODENDAAL asked the Minister of Health: [Written Question No 964]

What percentage of (a) dentists, (b) pharmacists, (c) specialists and (d) general practitioners practised (i) in the private sector, (ii) full-time in the government sector, (iii) in the private sector, but rendering services in the government sector, and (iv) in the government sector, but also part-time in private practice, in (aa) 1995 and (bb) 1996? N1666E

The MINISTER OF HEALTH:

	(aa)					(bb)				
	(i)	(ii)	(iii)	(iv)*	(i)	(ii)	(iii)	(iv)*		
(a)	75.3%	17.0%	2.9%	3.0%	75.4%	17.3%	2.9%	3.7%		
(b)	73.3%	15.0%	0.75%	2.6%	75.3%	13.3%	0.75%	3.3%		
(c)	45.7%	38.0%	3.45%	2.5%	49.8%	37.8%	3.21%	2.0%		
(d)	42.7%	27.0%	15.7%	7.3%	45.7%	25.0%	13.8%	6.2%		

\*Only those for whom authority has been granted (Limited Private Practice or Remunerative work outside employment in the Public Service in accordance with PSSC Chapter Moonlighting cannot be determined in percentage.

Sources: Representative Association of Medical Schemes (RAMS), Personnel and Salary System (PERSAL), Department of Health (DOH), South African Medical Services (SAMS), Provincial Health Departments, Interim Medical and Dental Council of SA, Interim Pharmacy Council of SA.

*Harwood*

2417

MONDAY, 8 SEPTEMBER 1997

2418

QUESTIONS

†Indicates translated version.

*For written reply:*

**Public health institutions: shortages of staff/equipment** (98)

435. Mr M J ELLIS asked the Minister of Health:

- (1) Whether any public health institutions are currently experiencing shortages of (a) staff and/or (b) equipment; if so, what are the relevant details in each case;
- (2) whether any steps have been or are being taken to make up these shortages; if not, why not; if so, (a) what steps in each case and (b) when is it anticipated that these shortages will be made up? N715E

**THE MINISTER OF HEALTH:**

The hon member is advised to table this question in the Provincial Legislatures for a reliable answer.

**Deaths from breast cancer/prostate cancer**

476. Mr K M ANDREW asked the Minister of Health:

- (a) How many (i) women die from breast cancer and (ii) men die from prostate cancer in South Africa each year and (b) what amount is spent by the Government each year on research into (i) breast and (ii) prostate cancer? N814E

**THE MINISTER OF HEALTH:**

The most recent statistics available (published August 1997) with regard to the abovementioned cancer types are for 1992.

- (a) (i) 1 252 women died from breast cancer in 1992.
- (ii) 983 men died from prostate cancer in 1992.

*Source: Cancer in South Africa, 1992 (Published in 1997 by the National Cancer Registry).*

- (b) The Government partially funded the National Cancer Registry to the amount of approximately R260 000 (1996/97), and R266 000 (1997/98) for surveillance of all cancer types.

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An additional R100 000 was allocated to the Cancer Registry in July 1997 to overcome the backlog in data entry and enable the Registry to have more current data available by early 1998.

The amount spent by the Government specifically on prostate and breast cancers is not available.

**Most wanted criminals: court appearances/bail**

950. Mr A J LEON asked the Minister for Safety and Security:

- (1) (a) How many of the 10 000 most wanted criminals identified during the "Sword and Shield" campaign had appeared in court as at the latest specified date for which information is available and (b) how many of these persons have (i) been granted bail, (ii) failed to appear in court on the appointed date following their release on bail and (iii) been convicted.
- (2) whether his Department has communicated with the Department of Correctional Services in regard to special security measures for these persons; if not, why not; if so, what are the relevant details? N1652E

**THE MINISTER FOR SAFETY AND SECURITY:**

(1) (a) Unfortunately this information is not readily available. To obtain this specified information, faxes will have to be sent to all police stations countrywide, thereby placing an extra burden on limited manpower and financial resources. Members will in such a case have to be withdrawn from other essential duties and specially allocated to the time consuming and labour intensive process of perusing case dockets and registers.

(b) (i), (ii) and (iii) See (1) (a) above.

(2) Yes. On 1996-06-19 a directive was sent to all Provincial Commissioners whereby all Area Commissioners and Station Commissioners were instructed, as a matter of urgency, to take the necessary steps to liaise with the Department of Correctional Services in their respective areas of responsibility.



*Hansard*

**THE MINISTER OF HEALTH:**

Cabinet approved that the 47th Session of the WHO Regional Committee for Africa be held in South Africa. Tenders were invited by the Department of Health for the said conference and the tender was subsequently awarded to Sun International, trading as Sun City, as the lowest tenderer.

(a) The WHO Regional Committee for Africa is held at its head office in Brazzaville every other year which is budget year. That meeting tends to be longer. During the alternate years which are not budget years the meeting is hosted by one of the member states.

In 1994, it was held in Brazzaville, 1995 in Gabon, 1996 in Brazzaville, 1997 in RSA. In 1998 it will be held in Senegal (because of the war in Brazzaville), and in 1999 it will be held in Namibia.

(b)(i) as the meeting closed on 5 September 1997, the actual cost of proceedings, per item, is not yet available. The estimated expenses could amount to R2,9 million.

(ii) R125 000,00.

(c) Vote 15, Health, R268 000,00 was from sponsors

For written reply:

**Provincial hospitals: out-patients treated** 98  
684. Mr M J ELLIS asked the Minister of Health:

(a) How many (i) out-patients were treated at and (ii) persons were treated in the casualty section of each provincial hospital in (aa) 1995 and (bb) 1996 and (b) what amounts did the (i) out-patient and (ii) casualty section of each provincial hospital spend in (aa) 1995 and (bb) 1996? N1174E

**THE MINISTER OF HEALTH:**

The information requested is not readily available at the National Department of Health. Since this matter is administered by the Provincial Departments, it is advisable to refer the hon member to the Provincial Legislatures for a complete and

adequate reply.

**Teenage pregnancies in Western Cape**

995. Mrs P W CUPIDO asked the Minister of Health:

How many teenage pregnancies were recorded in the districts of (a) Paarl, (b) Worcester, (c) Ceres, (d) Stellenbosch, (e) Cape Town, (f) Calvinia, (g) Malmesbury, (h) Vredenburg, (i) Clanwilliam, (j) Vredendal, (k) Wellington, (l) Somerset West and (m) George (i) in (aa) 1994, (bb) 1995 and (cc) 1996 and (ii) during the period 1 January to 30 June 1997? N1702E

**THE MINISTER OF HEALTH:**

I would like to urge the hon member to table this question in the relevant Provincial Legislature

**Nursing colleges in SA**

1006. Mr T C NTSIZI asked the Minister of Health:

(a)(i) How many nursing colleges are there currently in South Africa, (ii) what is currently the cost of training each nurse and (iii) in respect of what date is this information furnished and (b) how many nurses were trained at each such college during the period 1 May 1994 up to the latest specified date for which information is available? N1713E

**THE MINISTER OF HEALTH:**

(a) (i) 27.

(ii) The cost of training a student nurse through a four-year course leading to registration as a nurse and midwife is more than R193 629. This excludes the costs of subsidized accommodation, ward's staff supervision, medical examinations, uniform and transport.

(See the attached Annexure as an example for how the costing was worked out)

(iii) 1 May 1994 to 30 May 1997.

(b) The table below reflects the situation in this regard:

College	Number of nurses trained (During 1 May 1994 - 30 May 1997)
Ann Lacks	100
Chris Ham Bergamoth	1 367
B G Alexandra	1 992
Bomlaseel	734
Bophuthatswana	319
Carnus	493
Caster	81
Coronation	407
Eastern Cape	784
Eldendale	314
Excelsus	664
Free State	1 701
Free State	300
Ga-Rankuna	624
Hemrita Stockdale	751
Kangwane	100
Lebone	535
Mangung	339
Matal	1 352
Ngelezana	243
Nico Malan	387
Northern Province	413
Otto du Plessis	719
Santh Dille	345
S G Lourens	1 361
South African Medical Services (SAMS)	280
Trankel	140
Total Number of Colleges: 27	Total number of nurses trained 17 989

**Luhewini locality: applications for clinic facilities**

1045. Mr J Z KATI asked the Minister of Health:

- (1) Whether she or her Department has received any applications for clinic facilities in the Luhewini locality in the Engcobo magisterial district; if so, (2) whether she or her Department has taken any action in response to such applications; if so, what action; if not, how does she or her Department intend assisting the community in the area in this regard;
- (3) whether she or her Department intends taking any steps to improve the situation in this regard in this area; if not, what is the position in this regard; if so, what steps:

(4) what health services are currently rendered in the above-mentioned area? N1756E

**THE MINISTER OF HEALTH:**

(1) Yes, the Regional Office in Umtata has received an application from Luhewini.

(2) The application is being investigated by the Regional Office in Umtata and once this has been completed it will be prioritised in consideration with all other applications received.

(3) This will depend on the Eastern Cape's overall assessment after the investigation is completed. This department remains fully committed to providing equitable access to comprehensive PHC services in the shortest possible time to all our citizens.

(4) The community consists of 8 schools and 4 locations with a total population of 11 258. At present a mobile clinic visits the area every fortnight. Statistics of the services provided by the mobile clinic are as follows -

January to August 1997

Minor ailments	685
Ante-natal	2
Child health	322
TB	10
Chronic ailments	25
Family planning	58
Psychiatry	67

**Immunisation**

Polio	1 year - 28	2 years - 26	3 years - 19
DPT	1 year - 30	2 years - 14	3 years - 19
HBV	1 year - 20	2 years - 12	3 years - 8
Measles	9		
BCG	4		
DT	2		



**Telkom's universal programme targets**

\*25. Mr A S BEYERS asked the Minister for Posts, Telecommunications and Broadcasting: [Written Question No 974]

Whether projected targets exist in respect of Telkom's universal programme; if so, (a) what do these targets entail, (b) what are the projected dates of implementation of these targets and (c) how will these targets be achieved?

The MINISTER FOR POSTS, TELECOM. MUNICATIONS AND BROADCASTING:

The Acting Managing Director and Chief Executive Office of Telkom has informed me as follows:

The targets for the Telkom roll-out exist and are specified in the licence agreement, as highlighted in the explanation below.

(a) The targets are thus a total of 2.8 million new lines at end of the financial year 2002. This includes 120 000 payphones and 1.6 million new lines in under-served areas.

(b) The new telephone lines will be rolled out in stages as outlined in the attached document, commencing with 340 000 lines by 31 March 1997 and finally 2 690 000 lines by 31 March 2002. The ultimate aim is to install 4.3 million new lines by 2004.

(c) In South Africa, the telephone penetration relative to the size of the economy is, on the average, in line with world norms. As in many other parts of the world, however, there are disparities between metropolitan urban areas compared to rural areas.

There are also differences in coverage between the disadvantaged rural communities of South Africa and the affluent citizens of our towns and cities. This is due to the higher costs of providing services in rural areas, as well as the fact that people in these areas tend to be poorer, and therefore less able to afford services, than those in the urban areas.

Telkom is committed to contributing to the country's economic development through the multiplier effect of telecommunications and by meeting the telecommunications needs of all

our citizens, communities and business customers. We are aware that our current network lacks adequate reach and quality, and Vision 2000 is our broad plan to build the network to world-class standards. Its primary goal is to make Telkom fit for global competition, while redressing disparities in service provision.

Vision 2000 is about delivery. This means extending the reach of telecommunications to areas not previously covered, modernising the network to world-class standards and providing the most advanced services to our customers.

The extent of the network roll-out of Vision 2000 will be driven by customer needs and affordability. Clearly, the roll-out requires the continuous balancing of more profitable services with less profitable ones. The pace of network roll-out will be monitored and the targets adjusted according to customer needs.

There are now just over four million main telephone services in operation in South Africa. Over the next five years, this number will probably have to grow by two or three million additional lines, depending on economic growth and Telkom's ability to improve efficiency. The higher the economic growth rate for instance, the greater the number of people who will be able to afford telephones. Similarly, the better Telkom's efficiencies, the lower its prices will be, so more people will be able to afford them.

Through lower prices, Telkom will also be able to use the money saved to roll-out more services. Projected roll-out is based on our current models. Of the three million additional lines for the high-growth case, an estimated two million will be aimed at increasing telephone penetration in under-served urban and rural areas, with the remaining one million lines catering for growth in developed areas.

Vision 2000 provides for easier telecommunications access for people who cannot afford individual services. This will be achieved through a dramatic increase in the provision of community phones and innovative methods for prepayment.

That all this is possible way aptly demonstrated by Telkom during the last financial year when the expansion programme resulted in more than 256 400 net new working lines 71% more than the previous year - being connected, including almost 25 000 new payphones which was double the number installed in 1995-96.

Telkom will be using various technologies to

achieve our targets with emphasis on wireless local loop as illustrated by the awarding of the large DECT contracts.

Listed below are Telkom's projected targets. Roll-out target and new line roll-out target part of the five year plan. The projects are each measured at the end of the relevant financial year

Category	97-8	98-9	2000-1	2001	2002	Total	Total line target
1 Total number of new access lines brought into service (000)	340	435	575	675	665	2 300	
2 Number of new access lines brought	265	318	359	357	378	1 676	Under-served
3 Number of new access lines for priority customer (000)	3 240	3 845	4 055	5 060	4 065	20 246	Priority customer
4 Number of villages served in under-served areas	510	610	610	800	644	3 204	Village target
5 Total number of public payphones	20	25	25	25	25	120	Public payphone target
6 Number of replacement lines (000)	20	13	65	591	603	1 252	Replacement line target

**Strikes at hospitals**

\*26. Dr R T RHODA asked the Minister of Health: [Written Question No 975]

(1) (a) How many strikes at hospitals occurred in South Africa in 1996 and (b) what were the reasons for or causes of these strikes;

(2) whether any steps have been or are to be taken to address the reasons for or causes of these strikes; if not, what is the position in this regard; if so, what steps?

The MINISTER OF HEALTH:

KwaZulu-Natal

1. (1) (a) 24 January 1996: King George V Hospital

(b) Complaint about filling of posts that were advertised in "Jobs For Africa"

(2) No work, no pay policy was applied. Power to advertise is now delegated to the Director-General and it is hoped that this problem with the Public Service Commission is now solved.

2. (1) (a) 13 February 1996: Clairwood Hospital

(b) Workers strike as a result of unrest because of the theft of 75 kg of chicken.

(2) Head Office faxed a letter to advise the striking workers to return to work. The Officer concerned has since been suspended and charged for misconduct.

3. (1) (a) 16 February 1996: Stanger Hospital

(b) Workers refused to work unless Staff Nurse Xhola is granted permission to attend a 32 day workshop with effect from 18 February 1996.

(2) Staff Nurse Xhola was eventually granted permission to attend a 32 day workshop. The problem was that another staff nurse was on leave and if she was granted permission, there would be nobody to tend the ward. However, in this case the staff nurse who was on leave was very kind to cancel her leave when she was approached. Nurse Xhola was advised by Management to apply in time for any congress if she would like to attend



4. (1) (a) 20 March 1996: Hillcrest Hospital  
 (b) General Assistants strike as a result of a staff member being shot in the neck and chest inside hospital premises.  
 (2) Increased security stepped up.
5. (1) (a) 26 April 1996: Midlands Hospital and Lower Umfolozi District War Memorial Hospital  
 (b) Personnel attended a COSATU March in Pietermaritzburg  
 (2) No work, no pay policy was applied. Personnel advised to apply for authority and leave prior to attending any marches in future.
6. (1) (a) 30 April 1996: Midlands Hospital  
 (b) Personnel attended a COSATU March in Pietermaritzburg  
 (2) No work, no pay policy was applied. Personnel advised to apply for authority and leave prior to attending any marches in future.
7. (1) (a) August 1996: Prince Mshiyeni Memorial Hospital  
 (b) Strike resulted (Group 8/96) NEHAWU alleged that there were certain irregularities with regard to the intake.  
 (2) A dispute was declared at the Provincial Bargaining Chamber and a task team was appointed to scrutinise applications and the selection process.
8. (1) (a) 2 October 1996: Ngwelezana Hospital  
 (b) Clerical staff dissatisfied about new grading system of clerical occupational class with effect from 1-7-96.  
 (2) The Director for Personnel addressed them and explained to the personnel the new Grading System. They were advised to approach the Personnel Division in the hospital in future if similar situations occur.
9. (1) (a) 3 October 1996: Ngwelezana Hospital  
 (b) Student nurses strike because of the one professional male nurse who raped the visitor of another nurse  
 (2) The professional nurse concerned was suspended and charged for misconduct.
10. (1) (a) 8 October 1996: Northdale Hospital  
 (b) Clerks demonstrated at the Provincial Bargaining Council  
 (2) They all signed for a day's leave. Advised to apply for authority and leave prior to such demonstrations in future.
11. (1) (a) 6 November 1996: Montebello Hospital  
 (b) Professional nurses were not happy with rank promotion salary adjustments  
 (2) The Management of the Hospital met with their delegates and sorted out the problem.

*Northern Province*  
 They had no hospital strikes in 1996.

*Western Province*  
 (1) (a) No strikes occurred at hospitals in the Western Cape during 1996. Mass protest marches took place to discuss socioeconomic issues and to hand over memorandums  
 (b) N/A

*North-West Province*  
 (2) The position in the Western Cape is currently handled in terms of the New Labour Relations Act (66 of 1996) through Collective negotiations

*Northern Cape Province*  
 They had no hospital strikes in 1996.  
 None of their Institutions was affected by the Strike Actions.

- Mpumalanga Province*  
 (1) (a) 7 strikes occurred at hospitals in the Mpumalanga Province.  
 (b) National Nursing : Conditions of Service Strike  
 NEHAWU Strike : Provincial and Local Grievances  
 Student Training  
 Lack of Understanding of Labour Action and Grievance Procedure
- (2) Contingency Plans Activated  
 Negotiations  
 Dissemination of Information  
 Labour Relations Training  
 Improvement of Working Conditions  
 Renegotiating Agreements with Unions  
 Application of no-work no-pay principle  
 Regular Meetings between Unions and Management
- Free State Province*  
 There were no strikes in 1996 in Free State Hospitals.  
*Eastern Cape Province*  
 1 (1) (a) Uitenhage Hospital (2 days) in January 1996  
 (b) Reason for strike was alleged racism by Hospital Administrator  
 (2) Case was resolved by negotiation.
2. (1) (a) Emptiveni Hospital (3 days) in March 1996  
 (b) Reason for strike was illegal occupation of Nursing Managers Office re duty allocation roster  
 (2) Case was resolved by negotiation
3. (1) (a) Frere Hospital, East London (2 days) in November 1996.  
 (b) All the posters demanding higher

salary scale than General Assistants.  
 (2) Case was resolved by negotiation and grievance sent to Central Bargaining Chamber.  
*Gauteng Province*  
 (1) (a) There were three strike actions  
 (b) The following are the reasons for the strikes:  
 - the national strike from COSATU regarding the proposed Labour Relations Act  
 - NEHAWU's action regarding the Nursing Council  
 - NEHAWU's action regarding employment procedures.  
 (2) With respect to the first two strike actions, the department had no jurisdiction and it was handled at national level. The strike by NEHAWU regarding the employment practices were referred back to the Central Bargaining Chamber who set up a task team to investigate the matter.

**Surveys of commuter attitudes**  
 \*27. Mr G M E CARELSE asked the Minister of Transport: [Written Question No 977]  
 (1) Whether any surveys of commuter attitudes were carried out in (a) 1995 and/or (b) 1996; if so, what were the results of such surveys;  
 (2) whether any significant improvements were noted in 1996 as compared to 1995; if so, what improvements? N1682E

**THE MINISTER OF TRANSPORT:**  
 (1) A survey of commuter attitudes was done during 1994-95. The purpose of the survey was to determine the perceptions of commuters of the Metrorail services.  
 The survey revealed complaints from commuters as follows:  
 - In general commuters complained about the lack of visible security on stations and

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*Hansard*

## QUESTIONS

+ Indicates translated version.

For written reply:

University: investigation into payment of consultants

3. Mr M F CASSIM asked the Minister of Education:

(1) Whether, with reference to his reply to Question No 4 on 21 August 1996, standing over from 19 June 1996, he or his Department has instituted an investigation into the matter; if not, why not; if so, (a) who was appointed to undertake the investigation and (b) what were the terms of reference;

(2) whether he will make a statement on the matter? N3E

The MINISTER OF EDUCATION:

(1) The Department did not institute an investigation into the matter because of severe financial implications. Furthermore, the council of that institution accepted responsibility for decisions taken during that period and stated that they were satisfied that the members of the special committee performed their task to the best of their abilities.

(2) No.

Academic hospitals: budget/bed occupancy rate

15. Dr W A ODENDAAL asked the Minister of Health:†

What was the (a) budget of and (b) bed occupancy rate at each academic hospital in each of the provinces in 1996? N24E

The MINISTER OF HEALTH:

Since these hospitals are run by the Provinces, the hon member should direct the question on bed occupancy to the Provinces. The budget however is as follows:

Academic Hospital	(a) Budget
Gauteng:	
Baragwanath Hospital	R 396 381 000
Coronation Hospital	R 57 408 000
Ga-Rankuwa Hospital	R 236 480 000
HF Verwoerd Hospital	R 272 631 000
Hillbrow Hospital	R 173 619 000
JG Strijdom Hospital	R 92 101 000
Johannesburg Hospital	R 365 057 000
Kalafong Hospital	R 137 152 000
KwaZulu-Natal:	
King Edward VIII Hospital	R 299 067 000
Wentworth Hospital	R 79 025 000
Western Cape:	
Groote Schuur Hospital	R 401 979 000
Red Cross War Memorial Children's Hospital	R 92 132 000
Tygerberg Hospital	R 378 455 000
Eastern Cape:	
Umatia General Hospital	R 93 063 168
Free State:	
Universitas Hospital	R 189 014 958

Source: Provincial Health Departments, April 1997

Tygerberg/Groote Schuur (98) hospitals: budget

77. Dr W A ODENDAAL asked the Minister of Health:†

What did the budget of the (a) Tygerberg and (b) Groote Schuur hospital amount to in (i) 1994, (ii) 1995 and (iii) 1996 and (c) which services were curtailed or expanded as a result of these budgets? N136E

The MINISTER OF HEALTH:

(a) and (b) The attached table reflects the budget situation.



*Hansard*

Academic Health Services	Budget		
	(i) 1994/95 R1 000	(ii) 1995/96 R1 000	(iii) 1996/97 R1 000
Groote Schuur	369,620	461,868	401,979
Tygerberg	353,578	423,331	378,455
Red Cross	82,401	107,248	92,132
<b>Total</b>	<b>805,599</b>	<b>992,447</b>	<b>672,566</b>

(c) Services have not been expanded. Beds have had to be closed at Tygerberg and Groote Schuur Hospitals as expenditure projections exceed budget. General in and outpatient services, as well as specialist services have been reduced as part of a structured reorganisation and redistribution exercise of the health services in the province, in an effort to contain the costs and implement the Primary Health Care policy. Administrative services and engineering services have been reduced for the same reasons.

Source: Western Cape Provincial Health Department, February 1997.

#### Students' fees charged/received

110. Mr M J ELLIS asked the Minister of Education:

- (1) What total amount was (a) charged in respect of students' fees, and (b) received in payment of these fees, by each specified university in the Republic in 1996;
- (2) whether results were withheld from any students as a result of their failure to pay fees; if so, (a) in how many cases and (b) at which universities;
- (3) whether the withholding of results resulted in the payment of fees in any cases; if so, (a) in how many cases; and (b) at which universities? N199E

#### Students' Fees 1996

University	1A Rand	1B Rand	2 Students	3 Students
Cape Town	144,000,000	133,790,000	not available	not available
Durban-Westville	58,861,606	47,572,589	4 370	2 900
Fair Hare	29,600,000	15,100,000	3 006	1 000

The MINISTER OF EDUCATION:

University	1A Rand	1B Rand	2 Students	3 Students
Medunsa	48,487,222	17,446,255	96	21
Natal	105,000,000	100,020,000	not available	not available
The North	149,218,270	126,138,236	not available	not available
Orange Free State	65,153,300	58,344,700	2 490	not available
Port Elizabeth	24,600,000	22,699,000	235	125
Potchefstroom	48,819,000	42,319,000	not available	not available
Pretona	160,400,000	149,100,000	not available	not available
Rand Afrikaans	80,131,000	74,100,000	0	0
Rhodes	50,075,000	49,148,000	860	599
Unisa	210,722,531	208,957,945	1 911	920
Stellenbosch	84,791,127	78,421,792	4 096	2 093
Western Cape	77,111,307	48,058,617	7 862	1 668
Witwatersrand	114,484,463	102,651,133	3 074	1 690
Zululand	68,400,000	42,100,000	4 000	n/a
Visia	60,785,000	41,662,000	5 664	2 364
North West	24,773,994	23,935,166	3 094	2 300
Venda	28,824,292	21,217,690	3 394	2 619
Transkei	No information available due to closure			

#### 98 Provincial hospitals: posts authorised/filled

111. Mr M J ELLIS asked the Minister of Health:

- (1) How many (a) doctors', (b) nursing, (c) support staff and (d) administrative posts had been (i) authorised and (ii) filled at provincial hospitals in each of the provinces as at 31 December 1996;
- (2) whether any posts have not been filled at any of these hospitals; if so, why in each case;
- (3) whether the failure to fill such posts has resulted in the deterioration of health care services at these hospitals; if so, to what extent;
- (4) whether it is envisaged that the vacant posts will be filled in the near future; if not, what is the position in this regard; if so, when is it envisaged that such posts will be filled? N200E

The MINISTER OF HEALTH:

In the interest of ensuring that she is supplied with the correct and complete information in this regard, the hon member is urged to table this question in the different Provincial Legislatures.

*Hansard*

#### AIDS budget

193. Ms M SMUTS asked the Minister of Health:

- (1) (a) What was the AIDS budget for the 1996-97 financial year and (b) what portion of this budget had been spent as at the latest specified date for which information is available;
- (2) whether any delays and/or blockages occurred which held up the rate at which AIDS projects were implemented by her Department; if so, (a) what was the nature of the delays and/or blockages which occurred, (b) what impact did this have on the success of the AIDS prevention programme and (c) what steps have been taken to ensure that these delays or blockages do not recur? N334E

The MINISTER OF HEALTH:

- (1) (a) The budget for 1996/97 was R80 million (R40 million departmental funds and R40 million RDP funds). R52 715 578 was available from the European Union National HIV/AIDS contract.

- (b) Expenditure as at 6/2/97 amounted to R61 470 051, which represents the total departmental allocation and half of the RDP allocation. Approval to access the RDP allocation was only received in October 1996 and for this reason, expenditure will continue into the new financial year. European Union funds spent amounted to R5 563 157 as at 6/2/97.

(2) Yes:

- (a) Staffing constraints at both the national and provincial level were the main constraining factor to implementation of the National AIDS Programme. In addition, HIV/AIDS is still perceived by some sectors to be a health issue and therefore the responsibility of the Department of Health.
- (b) Some targets set in the operational plans were not met as these had assumed a stable and fairly large staff complement.

Other objectives which relied on involvement by other sectors or departments were achieved only after protracted negotiations and consultation.

- (c) The staffing structure at national level has been finalised and permanent staff have been appointed, the last person will assume duty by May 1997. At the provincial level, most co-ordinators are now in permanent positions.

Specialist work in key areas will be undertaken by consultants in terms of the RDP business plan. It is anticipated that it will now be possible to meet the targets set for 1997/98.

On the issue of involvement by other sectors, much inter-sectoral work is planned with accompanying advocacy to recruit support by the leadership and membership of other sectors. This will generate an expanded response to the epidemic which involves a common vision of the Programme and joint ownership of its solution.

#### Skilled artisans: access to formal education

222. Mr M F CASSIM asked the Minister of Labour:

Whether the Government will consider taking any measures aimed at enabling skilled artisans lacking formal qualifications to obtain certificates or other forms of recognition on the basis of their performance in their work or their duration of service in order that such artisans will be able to gain access to formal education; if not, why not; if so, what measures? N363E

The MINISTER OF LABOUR:

At present we are applying Section 28 of the Manpower Training Act of 1981 which allows us to test persons who have three to four years of trade experience and who apply for testing at COTT. A large percentage of the applicants are from this category. These candidates will either get a fail, or a pass result. We hope to be able in the near future to allow for the part certification of persons who have certain skills but not the complete competence, as will be negotiated with the main stakeholders.



coupling of the different data bases-information sources with magisterial districts is in process.

(ii) According to the Property Management Information System (PMIS) of the Department of Public Works in the magisterial districts of Vredendal, Clanwilliam and Vanrhynsdorp collectively, there is, with the exception of certain unsurveyed and unregistered state land, approximately 26 500 ha of land in possession of the State. This represents about 1,3% of the combined surface area of the three magisterial districts mentioned.

(aa) State land in the magisterial district of Vredendal - refer to Table 1.

Magisterial District	Extent (ha)
Vredendal	74

Source: PMIS

(bb) State land in the magisterial district of Clanwilliam - refer to Table 2.

Magisterial District	Extent (ha)
Clanwilliam	12 191

Source: PMIS

(cc) State land in the magisterial district of Vanrhynsdorp - refer to Table 3.

Magisterial District	Extent (ha)
Vanrhynsdorp	14 257

Source: PMIS

(b)(i) The sizes of the properties for the Northern Cape per magisterial district are set out in Table 4. Tables 1 to 3 refer respectively to the total extent of the requested three magisterial districts of the Western Cape. The sizes do not include unsurveyed and certain unregistered State land.

(ii) The location of State property per magisterial district in the Northern Cape is set out in Table 4. Due to the comprehensiveness of this request it is not practically possible to supply a list of all property descriptions. Detailed information regarding property descriptions and sizes is available upon request from the relevant Deeds Offices, Surveyor General offices and the Directorate: Public Land Inventory of my Department. The Department of Land Affairs is also in the process of representing land information spatially on a Geographic Information System (GIS).

Distribution of State land in Northern Cape Province		
Magisterial District	Total Properties	Extent (ha)
Barkly West	85	23 286
Bristown	81	2 637
Calvinia	143	5 481
Carnarvon	49	18 325
Colesberg	104	24 757
De Aar	146	6 348
Fraserburg	33	22
Gordonia	654	148 983
Hanover	30	2 553
Hartswater	69	2 354
Hay	60	28 580
Herbert	59	108 756
Hopetown	43	2 332
Kenhardt	137	78 670
Kimberley	328	2 788
Kuruman	149	241 508
Namagatland	228	220 962
Noupoort	33	47
Phalpinstown	78	20 951
Postmasburg	541	11 512
Prieska	60	23 102
Richmond	28	26
Sutherland	19	17
Victoria West	80	61
Warrenton	26	6 341
Williston	26	20
<b>Total</b>	<b>3 289</b>	<b>872 179</b>

Note: Unsurveyed and Unregistered State Land are excluded.  
Source: Property Management Information System (PMIS), Department of Public Works.

**Applications for tax holidays received/approved**

825. Mr K M ANDREW asked the Minister of Trade and Industry:

Whether, with reference to his reply to Question No\*13 on 26 March 1997, any further applications for tax holidays in terms of the Revenue Laws Amendment Act, 1996, have been (a) received and (b) approved since the commencement of the scheme; if so, (i) how many (ii) what amount of new investment is involved and (iii) how many jobs will be created as a result?  
N1447E

**The MINISTER OF TRADE AND INDUSTRY:**

The following is a summary of (i) Number of tax holiday applications reported on 26 March 1997 and (ii) the number of tax holiday applications approved, applications still in process of evaluation and the total received as at 9 June 1997:

(i) State of Applications at 17 March 1997	Project received	Employment	Investment
	6	361	R52,0m
(ii) Status of total number of Applications at 9 March 1997			
• Project approved	8	812	R145,2m
• Project approved	13	1 654	R689,1m
<b>Total</b>	<b>21</b>	<b>2 466</b>	<b>R834,3m</b>

((i) included)  
**Rest facilities on N2 between Mount Frere/Kokstad**

828. Mr G Q M DOIDGE asked the Minister of Transport:

Whether he or his Department intends taking any steps towards providing rest facilities on the N2 between Mount Frere and Kokstad; if not, why not; if so, (a) what steps, (b) when and (c) where will such rest facilities be located?  
N1470E

**The MINISTER OF TRANSPORT:**

The Department does not build rest facilities on National roads. We, however, encourage the private sector to identify suitable locations and to make proposals to us for the development of rest areas at those locations. These applications are considered against our policies and design standards, and if they satisfy the requirements, we allow the private sector to finance and develop the rest areas.

In this manner the private sector is able, considering market forces, to identify where and when such facilities will be viable.

**Application for technical college**

829. Mr G Q M DOIDGE asked the Minister of Education:

- (1) Whether he or his Department has been informed of an application for a technical college, dated 18 August 1995, a copy of which has been furnished to his Department for the purpose of his reply, which was directed to the Deputy Permanent Secretary, Standard Education, in Bisho; if so,
- (2) whether he or his Department has taken or intends taking any steps in regard to this application; if not, why not; if so, what steps?  
N1471E

**The MINISTER OF EDUCATION:**

- (1) No.
- (2) No. The establishment of a technical college is a competence of the provincial education departments.

**Nigel Hospital: possible closure** (98)

830. Mr J A RABIE asked the Minister of Health:

- (1) Whether it is the intention to close the Nigel Hospital; if so, what (a) alternative facilities will be made available in this regard and (b) are the further relevant details; if not,
- (2) whether this hospital will be upgraded; if not, what is the position in this regard; if so, to what extent;



- (3) whether she will make a statement on the matter? N1472E

**The MINISTER OF HEALTH:**

- (1) No, it is the intention of the Gauteng Department of Health to convert Nigel Hospital to a Community Health Centre, and not to close it.
- (a) Falls away
- (b) Provisionally the Community Health Centre will render:
- (i) Limited Casualty Services: 07:00 - 22:00
- (ii) Midwife Obstetric Unit: 24 hours

Province	Units
Eastern Cape	24 359
Free State	15 505
Gauteng	71 276
KwaZulu-Natal	34 261
Mpumalanga	20 650
Northern Cape	7 758
Northern Province	21 240
North West	24 007
Western Cape	29 045
<b>Total</b>	<b>248 100</b>

- (2) No, the Hospital will be converted to a Community Health Centre.
- (3) No.

Source: Gauteng Department of Health, July 1997

**Details on houses built**

831. Mr J A RABIE asked the Minister of Housing:

With reference to her announcement during her budget speech that 200 000 houses have already been built or are being built, (a)(i) how many houses have been built and (ii) where were such houses built, (b)(i) how many houses are being built at present and (ii) where are such houses being built at present, (c) what type of houses have been built or are being built and (d) what does the cost in regard to each house amount to? N1473E

**The MINISTER OF HOUSING:**

(a)(i) and (b)(i) The information available at national level only provides for a consolidated figure on houses completed and those under construction. It is therefore not possible to differentiate between the number of houses completed and those which are still under construction. It may be mentioned that the figure of 200 000 houses completed or under construction I referred to in my budget speech, has until mid-June 1997 increased to 248 100 houses. The provincial breakdown is as follows:

was paid out in allowances and (c) in respect of what total amount of time spent in Cape Town were such allowances paid;

- (2) whether any non-sessional departmental officials received any allowances for time spent in Cape Town on governmental business during the above-mentioned period; if so, (a) how many such officials received such allowances, (b) what total amount was paid out in allowances and (c) in respect of what total amount of time spent in Cape Town were such allowances paid;

- (3) whether any of these officials did not stay in Cape Town for the full period for which they received allowances; if so, (a) how many such officials are involved, (b) what total amount of time did these persons actually spend in Cape Town and (c) what was the total amount in allowances paid to such officials for periods when they were not actually in Cape Town;

- (4) whether any action has been taken against any of these officials; if not, why not; if so, what action? N1474E

**The MINISTER FOR THE PUBLIC SERVICE AND ADMINISTRATION:**

- (1) (a) No.
- (b) No.
- (i) None
- (ii) Nil
- (c) N/A.

- (2) No. Non-sessional officials do not receive allowances. Such officials are however reimbursed for accommodation and incidental expenditure for the period spent in Cape Town in terms of PSSC D.III/1

- (3) No.
- (a) Not applicable.
- (b) Not applicable.
- (c) Not applicable.
- (4) Not applicable.

**Minister/Deputy Minister/staff: trips outside RSA**

834. Mr J A JORDAAN asked the Minister of Minerals and Energy:

- (1) (a) How many times in (i) 1996 and (ii) during the period 1 January 1997 up to the latest specified date for which information is available, did (aa) he, (bb) his Deputy Minister and/or (cc) staff members of his Ministry go on trips outside the borders of the Republic funded entirely or partially by the State and (b) what was the (i) purpose, (ii) cost to the State, (iii) destination and (iv) duration of each such trip:

- (2) whether any family members and/or other persons not employed by the State went on any of these trips; if so, in each case, (a) who and (b) at what cost to the State? N1476E

**The MINISTER OF MINERALS AND ENERGY:**

- (1) 1996 (i) Minister P M Maduna (aa) and staff members (cc)

(a)(b)(i) (ii)(iii) (iv)

Accompany Dep-Pres Mbeki to the USA/SA Binational Commission meeting \* USA 17-26/7/96

SADC Council of Ministers Meeting and accompany the President to the Heads of State Summit \* Lesotho 20-24/8/96

World Solar Summit on behalf of the President \* Harare 15-16/9/96

SA Joint Commission delegation led by Dep-Pres Mbeki and the Fifth International Energy Conference \* India 2-9/12/96

1997 (ii) Minister P M Maduna (aa) and staff members (cc)

(a)(b)(i) (ii)(iii) (iv)

Accompany President Mandela on official visit \* East Asia 27/2/97-9/3/97

Hanssa

**Land claims received**

186. Mr S D FISHER asked the Minister for Agriculture and Land Affairs:†

- (1) How many land claims did his Department receive in respect of each province (a) in 1995 and 1996, respectively, and (b) during the period 1 January 1997 to the latest specified date for which information is available;

- (2) whether any such claims have been referred to the Land Claims Court; if so, (a) how many and (b) when, in each case? C199E

**THE MINISTER FOR AGRICULTURE AND LAND AFFAIRS:**

(1)(a) and (b)

	1995	1996	1997 (up to 30/5/97)
Western Cape	627	2 144	1 233
Northern Cape	116	24	20
Free State	59	2	184
Eastern Cape	358	604	680
KwaZulu-Natal	2 035	2 833	1 056
Mpumalanga	278	53	4
Northern Province	362	103	Nil
Gauteng	1 068	2 028	220
North West	183	65	324

(2) Yes.

(a) 11 (eleven).

(b) Maclean town, Eastern Cape, June 1996

B F Liesenberg, Eastern Cape, June 1996

S & R Dulabh, Eastern Cape, June 1996

Elands kloof, Western Cape, September 1996

Cremm, KwaZulu-Natal, November 1996

Schmidtsdrit, Northern Cape, November 1996

Kono community, Northern Cape, December 1996

Hanssa

Groote Springfontein, Western Cape, January 1997

Dithakwaneng community, North West, April 1997

Western Education Trust, North West, April 1997

Tshivulana Royal Family, Northern Province, April 1997.

**Telephones installed in provinces**

187. Mr L J SWANEPOEL asked the Minister for Posts, Telecommunications and Broadcasting:†

How many (a) (i) private and (ii) public telephones and (b) business telephones were installed in each of the provinces (i) in 1995 and 1996, respectively, and (ii) in the period 1 January 1997 up to the latest specified date for which information is available? C200E

**THE MINISTER FOR POSTS, TELECOMMUNICATIONS AND BROADCASTING:**

The Acting Chief Executive Officer and Managing director of Telkom has informed me as follows:

A breakdown of the number of residential, public and business telephones that were installed (growth) in each of the six Telkom regions within the RSA is unfortunately not available for the 1994-95 financial year, but the total estimated number of telephones installed (growth) during the above-mentioned period was 115 492. The total growth in 1995-96 was 143 729 and in 1996-97 was 256 459.

A breakdown of the total estimated number of residential, public and business telephones installed (growth) in each of the six Telkom regions within the RSA during the 1995-96 and 1996-97 financial years are as follows:

Region	Residential 1995-96	Business 1995-96	Public 1995-96	Residential 1996-97	Business 1996-97	Public 1996-97
North Eastern (Former Transvaal excl. Witwatersrand)	8 329	17 816	1 747	53 708	44 091	8 173
Gauteng Central (Former Witwatersrand)	8 785	22 426	3 506	42 796	24 279	1 353
Eastern (KwaZulu-Natal)	1 410	16 655	1 602	21 948	16 912	5 205
Western (Western Cape)	5 923	21 338	1 628	13 541	21 185	6 200
Southern (Eastern Cape)	3 594	8 144	1 472	3 969	18 754	5 276
Central (Free State and Northern Cape)	12 140	6 662	552	19 843	3 222	2 100
Total	40 181	93 041	10 507	182 805	128 443	28 307

Please take note that the figures quoted for 1996-97 include 76 480 services which were taken over from the former TBVC countries as well as a correction of ISDB services (6616).

**Gauteng: operations at State hospitals**

189. Mr W F MINISI asked the Minister of Health:

- (a) How many (i) cancer (ii) heart bypass, (iii) hip replacement and (iv) cataract operations were performed at State hospitals in Gauteng during the latest specified period of three months for which information is available and (b) what was the average waiting time between diagnosis and the performance of the operation in each case? C202E

**THE MINISTER OF HEALTH:**

The information requested is not readily available from the National Department of Health. For the purposes of reliable statistics an accurate response, the non member is urged to table this question in the appropriate Provincial Legislature.

**Taxi violence: deaths/arrests**

190. Mr J SELPE asked the Minister of Transport:

- (a) How many deaths occurred as a result of taxi violence, (b) how many persons were (i) arrested, (ii) charged and (iii) convicted in connection with these deaths, and (c) how many firearms were confiscated following taxi violence in each of the provinces, in 1996? C203E

**THE MINISTER OF TRANSPORT:**

The statistics are based on that available from the South African Police Service.

	(b) (i)	(b) (ii)
Western Cape	98	76
Eastern Cape	105	104
Northern Cape	3	0
Free State	4	5
Mpumalanga	28	8
KwaZulu-Natal	47	43
North West	47	22
Northern Province	40	6
Gauteng	30	76
Total	81	340
Western Cape	57	98
Eastern Cape	8	104
Northern Cape	0	0
Free State	2	5
Mpumalanga	8	8
KwaZulu-Natal	1	43
North West	22	22
Northern Province	5	6



Province	Air Arrivals	%	Domestic Travel	%
Gauteng	931 000	66,5	2 400 000	15
Western Cape	721 000	51,5	1 920 000	12
KwaZulu-Natal	394 999	28,5	4 880 000	30
Mpumalanga	287 000	20,5	1 120 000	7
Eastern Cape	224 000	16,0	2 240 000	14
North West	105 000	7,5	1 440 000	9
Free State	70 000	5,0	960 000	6
Northern Cape	70 000	5,0	320 000	2
Northern Province	70 000	5,0	800 000	5
Gauteng	5			
Total	13			

(NB: Persons charged in 1996 are only now beginning to appear in court, due to the postponement of cases and the granting of bail.)

(c) Western Cape 46 plus 1 hand grenade made

Eastern Cape 62 plus 1 hand grenade made

Northern Cape 0

Free State 7

Mpumalanga 12

KwaZulu-Natal 26

North West 15

Northern Province 17

Gauteng 66

Total 251 plus 2 hand grenades

Provinces: tourism

193. Mr E K MOORCROFT asked the Minister of Environmental Affairs and Tourism:

What was the estimated (a) number of tourists who visited each of the provinces in 1996 and (b) income from tourism in that year? C206E

The MINISTER OF ENVIRONMENTAL AFFAIRS AND TOURISM:

(a) The estimated number of tourists who visited each province in 1996 was:

Province	Air Arrivals	%	Domestic Travel	%
Gauteng	931 000	66,5	2 400 000	15
Western Cape	721 000	51,5	1 920 000	12
KwaZulu-Natal	394 999	28,5	4 880 000	30
Mpumalanga	287 000	20,5	1 120 000	7
Eastern Cape	224 000	16,0	2 240 000	14
North West	105 000	7,5	1 440 000	9
Free State	70 000	5,0	960 000	6
Northern Cape	70 000	5,0	320 000	2
Northern Province	70 000	5,0	800 000	5

(b) The estimated tourism income generated by these figures was approximately R 31 billion for the year 1996 which is made up of:

International Market Revenue = R12 bn  
Domestic Market Revenue = R19 bn  
SANDF staff: absence

195. Mr J SELFE asked the Minister of Defence:

(1) (a) How many persons were employed by the South African National Defence Force as at the latest specified date for which information is available and (b)(i)(aa) what was the total number of man-days lost as a result of absenteeism during the latest specified period of 12 months for which information is available and (bb) what percentage of the total number of working days during this period does this figure constitute, (ii)(aa) to what causes was such absenteeism attributable and (bb) how many man-days were lost due to each of these causes and (iii) what was the average number of employees absent on each working day during the above-mentioned period;

(2) whether he or the SANDF has taken or intends taking any steps aimed at reducing the absenteeism rate in the SANDF; if not, why not; if so, what steps? C208E

The MINISTER OF DEFENCE:

(1) (a) As on 31 May 1997, there were 99 324 persons employed by the SANDF.

(b) (i) (aa) Total number of man-days lost to absenteeism - 324 931.

(bb) Percentage man-days lost out of the total man-days available - 1,63%.

(ii) (aa) Causes of absenteeism:

(i) Absent without leave (AWOL), [transport problems, imprisonment, financial problems, domestic problems, indiscipline, substance abuse, traditional ceremonies such as initiation].

(ii) Medical reasons.

(bb) Percentage man-days lost to:

(i) AWOL - 1,37%.

(ii) Medical - 0,26%.

(iii) Average number of employees absent each working day:

(aa) AWOL - 1 366.

(bb) Medical - 258.

(2) Yes. The SANDF is continuously taking steps aimed at reducing absenteeism. They include:

(a) Discharge of members who are AWOL for more than 183 days.

(b) Vigorous application of the Military Discipline Code (MDC).

(c) Command communication sessions to inform members of the procedures for obtaining official leave and the consequences of AWOL. A system for long weekends has also been created to accommodate transportation problems. Public or private transport has been arranged if a sufficient number of members travel in a specific direction.

(d) Consultations with commanders, welfare officers and chaplains is strongly recommended for professional support and to solve social and domestic problems.

(e) Appeals to medical officers to authorise sick-leave only when necessary.

(f) Demands for medical certificates for periods of absence due to illness.

#### Deportations

199. Dr G W KOORNHOF asked the Minister of Home Affairs:

(a) How many persons were deported from South Africa to their countries of origin in (i) 1996 and (ii) during the period 1 January 1997 up to the latest specified date for which information is available and (b) what are the (i) names of these persons and (ii) reasons for their deportation in each case? C212E

The MINISTER OF HOME AFFAIRS.

(Reply bound in Annexures of House - see M337/97.)

Foreign companies: business concerns established in SA

204. Mr A E VAN NIEKERK asked the Minister of Trade and Industry:

(a) How many foreign companies established business concerns in South Africa in (i) 1996 and (ii) the first four months of 1997, (b) what are the names of these companies, (c) under what industrial sectors do such companies fall and (d) what, according to the South African Reserve Bank, did the total net inflow of foreign investments amount to in each of the above-mentioned periods? C217E

The MINISTER OF TRADE AND INDUSTRY:

South Africa does not currently have a comprehensive investment tracking system that could record all of the information on the basis requested. For this reason Investment South Africa (ISA) has been mandated to establish such an investment tracking system. The Department of Trade and Industry obtained the following figures from the offices of the Registrar of Companies, the Board for Regional Industrial Development and the South African Reserve Bank. Their figures indicate that:

(a) The Registrar of Companies indicated that a total number of 225 foreign companies registered during 1996 and the first four months of 1997.

(b) Enclosed are the names of those companies registered during that period (Annexure A). [Partially illegible reply furnished by Department.]

(c) The Board for Regional Industrial Development indicated that investments by



## SECONDARY HOME LOAN MARKET

# A helping hand for the cities

Once the credit base is expanded many other things will become possible, including urban renewal

PM 19/12/98  
(123)

**S**ome ailing cities could get a leg up. The announcement a fortnight ago that the National Housing Finance Corp (NHFC) plans to launch a secondary home loan market in 1999 could significantly expand the housing credit base and open the doors for new investors, developers and banks.

The US secondary home loan market provides loans up to a maximum US\$200 000, primarily aimed at urban Hispanics and blacks. This market is mainly mortgage-bond based and run by Fannie Mae, a privately owned corporation with on- and off-balance sheet commitments of \$870bn.

With Fannie Mae's technical assistance, the public corporation NHFC is initially targeting non-mortgage home loans between R10 000 and R40 000 to supplement government housing subsidies. It says that new housing projects will receive attention first.

In time NHFC foresees the market growing to include conventional mortgage bonds in all income brackets and extending into urban upgrades in central business districts.

For potential institutional investors such as Sanlam and Old Mutual such a spin-off is a vital incentive, though predicated on a better functioning housing finance system.

They own underperforming commercial properties in cities like Johannesburg and Pretoria and see the new market as a way to sell old, empty office stock to a new generation of developers. These in turn could convert the property into rental or rent-to-buy sectional title flats.

The resulting urban renewal would improve returns on the revitalisation of better-grade commercial stock.

The institutions would not be compelled to invest directly in residential stock to carry out the necessary renewal.

The investment would be by their asset managers, utilising the new market instrument.

Sanlam Properties Gauteng manager Fanie Lategan says Sanlam will definitely

invest in a secondary home loan market.

For Sanlam Asset Management director Dries du Toit, apart from the demand that the bonds be tradeable and offer returns competitive with RSA or Eskom loan stock, risk will also have to be factored in.

This is not news to either NHFC CEO Johan de Ridder or senior GM David Porteous, who say initial discussions with investors and research carried out by ABT Associates show Du Toit's concerns and demands are common.



David Porteous, Johan de Ridder and Fanie Lategan . . . not the strangest of bedfellows

But in their talks with potential investors in coming months, keeping the risk premium as low as possible will be crucial. They will also have to deal with a number of expectations which could lead to investors demanding a government guarantee — something the NHFC is studiously avoiding.

To ensure tradeability, the size of the eventual market is important. Porteous thinks that could mean a market capitalisation running into many billions.

He estimates that it may even outgrow the R7bn SA banks have invested in mortgage loans in the past two years. These loans averaged R70 000. In the R40 000 and below market there are an estimated 2m needy households

The NHFC is still at the detailed planning stage. A funding adviser will soon be selected from a number now tendering for the job. NHFC plans a pilot issue of R500m in the second half of next year.

The NHFC is now gauging an area long overlooked — the size of the secondary home market in townships that will be needed to make the secondary bond market work. This will start next year once a researcher has been appointed.

It will initially conduct a household survey of township areas, compile deeds transfer figures, and interviews with black estate agents to "get a feel" for the market.

"We've been getting conflicting reports about activity in the secondary market. Black estate agents say they can't get finance, banks say they can," says Porteous. He adds that various potential roles are open to banks.

"First off is accreditation as primary market lenders, which will start in the new year.

"This will enable them to sell loans to us. They could also participate in funding ar-

rangements, given their access to large funding networks.

"For our part we still have to apply for a credit risk rating."

Council of SA Banks housing GM Lance Edmunds thinks banks will specialise in a secondary mortgage market by separating their functions as originators, servicers, risk managers and funders of the loans. "I'm not sure banks will want to do all these. Some will pick and choose and, not unlike the US, we will see special purpose vehicles formed and the entry of new players."

Quasi-equity funding may come from an international partner. Says Porteous: "Our biggest concern is to leverage our own investment as much as possible, an amount which has still to be determined." Alison Goldberg



# SANDF offers its hospitals

JERMAINE CRAIG  
STAFF REPORTER

(98)

ARG 3/9/97

**The defence force and provincial governments are negotiating to make military hospitals available to ease the load at public hospitals.**

South African Medical Services Surgeon-General W P van Niekerk said a multilateral agreement had been finalised that could open the way for more provincial patients to be treated at military hospitals.

The agreement has yet to go to the Treasury for final approval.

Military hospitals often have vacant wards and 2 Military Hospital in Wynberg could ease the pressure on the Western Cape's health service.

Colonel van Niekerk said although

this hospital was very busy, specifically in the outpatients department, facilities could be used to help the Western Cape Health Department. Details had yet to be negotiated.

The hospital, at present restricted to defence force members and their families, provides a comprehensive, multi-disciplinary service which includes outpatients, specialist, intensive care and casualty departments.

Colonel Van Niekerk said the hospital was "appropriately staffed" and had 236 beds.

Military hospitals treated provincial patients in certain cases and were as involved in inter-departmental disaster planning, often rendering medical support and facilities in disaster situations, he said.

# Overworked trauma staff abused daily

<sup>(98)</sup>  
*Relatives attack nurses*

ARG 3/9/97

**ASHLEY SMITH AND JENNY VIAL**  
STAFF REPORTERS

**Doctors and nurses at the Grootte Schuur Hospital trauma unit are being terrorised by violent relatives and friends of patients.**

At the same time all trauma services in Cape Town are under increasing pressure because of staff shortages, abuse and an increase in severe injuries, especially gunshot wounds.

Steve Lekhanya, a professional nurse who heads the Grootte Schuur trauma unit at night, said his staff feared for their safety as they were continually verbally and physically abused by members of the public.

The abuse was taking its toll on staff who often had to deal with violent attack at the same time as battling to save lives. Mr Lekhanya said the abuse happened daily and was usually because people were asked to leave the unit when they behaved badly.

He said the unit handled an aver-

age of 50 cases a day during the week and about 80 a day at weekends.

"The worst of these cases are normally stab and gunshot wounds, assaults and broken limbs. We are working under immense pressure and we have to concentrate on our work all the time as we cannot afford to make mistakes," Mr Lekhanya said.

Over some weekends up to 125 cases a night would be handled by the four registered nurses, two assistant nurses and two enrolled nurses. But their work was made even more difficult by the behaviour of hooligans who were making their lives hell.

He said he had been beaten and kicked by three men last year after asking them to wait outside the unit because they were making a noise.

Shafiek Howell, of the unit's administration section, said he had been threatened by gangsters on his first day. "They demanded that we attend first to their friend who had been stabbed," he said.



# 'Darkest blue Monday' for ambulance service

SHARKEY ISAACS AND JENNY VIALI  
STAFF REPORTERS

Cape Town's ambulance service, already short of staff and and vehicles, faced another crisis this week when they battled to find hospitals prepared to treat patients.

On Monday night, described by assistant ambulance chief Archie Flax as "darkest blue Monday", Groote Schuur and Tygerberg refused admissions because they

were full. Later the ban was extended to Conradie, Somerset and Victoria. Ambulance personnel were told to take serious patients to False Bay Hospital in Fish Hoek or G F Jooste Hospital in Manenberg.

It was the "darkest blue Monday" the service had yet encountered, Mr Flax said.

Peter Mitchell, chief medical superintendent of Groote Schuur, said services for major trauma cases were suspended for two four-hour periods on Monday. "In such instances Metro is informed and arrange-

ments for patient care are made with Tygerberg Hospital," he said.

But Tygerberg was also closed for four hours because waiting lists for non-critical patients got too long and Victoria closed its trauma unit as it had no vacant beds. Ambulances were told to take patients to G F Jooste and False Bay.

Ann Brand, director of support services in the Western Cape, said if both academic hospitals were flooded, they would take every alternate patient with multiple in-

juries. Trauma centres with no vacant beds or long waiting lists for theatre contacted Metro, which would divert ambulances to less busy units. Trauma units did not turn away critical patients.

Mr Flax said the ambulance service had conveyed 328 cases in 18 vehicles crewed by 36 staff on Monday. "Normally we work with an average of 20 to 21 ambulances, crewed by a staff of 42."

Overworked trauma staff abused, page 4

# Ambulances cannot cope

CT 3/9/97

**CAROL CAMPBELL AND  
FATIMA SCHROEDER**

PROVINCIAL ambulance staff are struggling to cope with a leap in referrals between hospitals required under the new district health system.

The growing demand for ambulances to take patients to the "right" hospital and at the same time respond to emergencies came to a head on Monday when 70 calls backed up.

Mr Archie Flax, the assistant chief director of the ambulance service, said of the 328 calls for help on Monday, 207 were for inter-hospital transfers.

"It could be that a patient at Khayelitsha Day Hospital needs to be taken to the GF Jooste secondary hospital, or to Grootte Schuur. Our ambulances have to transport them, putting pressure on the

staff," he said.

Dr Anne Brand, spokesman for the Western Cape Health Department, said: "There have always been inter-hospital transfers to get a patient to appropriate care. We are analysing figures to see if the number of these transfers have increased since the district health system was introduced."

To cope with Monday's workload, Flax called in off-duty paramedics, and sent them out in response cars to assess "emergencies" so that ambulances could rush to the most severe cases.

"If the patient was critical, we moved them higher on the waiting list. But the less critical patients had to wait for several hours."

Ambulance teams sometimes felt the workload was insurmountable and this demoralised and exhausted them, said Flax.

The ambulance backlog was

made worse when four major hospitals asked that patients be taken elsewhere, so that they in turn could catch up with their patient backlogs.

"It's a major problem because ambulances have to go out of their way to get patients to proper care," said Flax.

Brand said the public could ease the pressure on the ambulance service by being cautious on the roads, and not drinking and driving: "The traffic department and ambulance service expect to be very busy after the Olympic Party on Friday."

"Princess Diana was killed partly because the driver of the car she was travelling in had had too much to drink. Be careful."

On Friday over 30 ambulances will be on standby to cope with expected drunk-driving road accidents.

(98)



## Gauteng public hospitals in 77 malpractice suits

Pearl Sebolao

DD 4/9/97

(98)

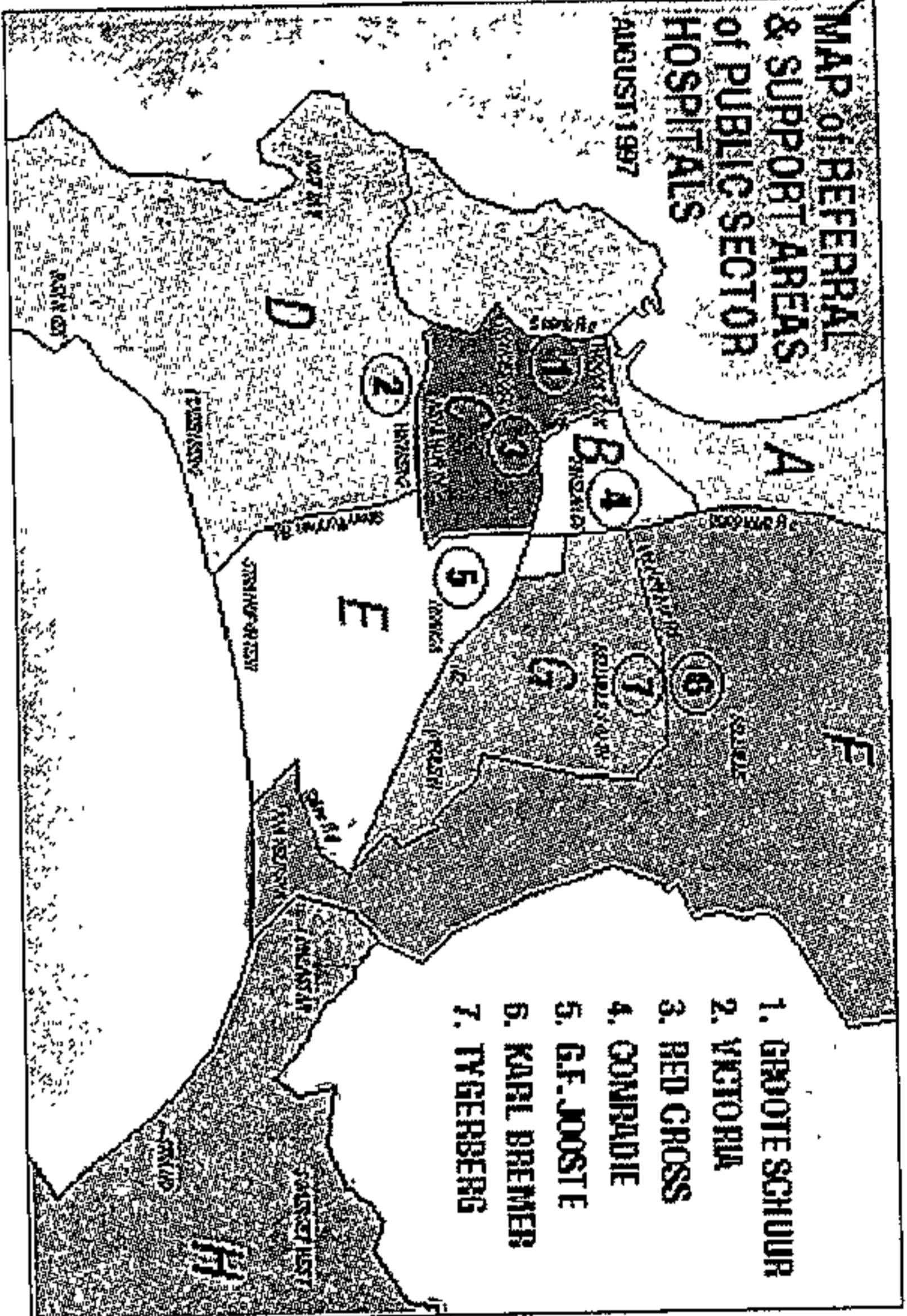
A TOTAL of 77 malpractice suits were launched against medical staff in Gauteng public health hospitals in the past three years, Gauteng Health MEC Amos Masondo said in reply to questions from the Democratic Party (DP) in the provincial legislature this week.

The total amount claimed in malpractice suits between 1993 and 1996 was R14,4m, of which only 11 cases had been settled at an amount of R413 000 — against original claims of R4,3m.

Masondo said most cases were still under investigation by the state attorney. He said each case was discussed with the hospital management, and where appropriate corrective measures like in-service training and disciplinary action were instituted.

Although malpractice suits were unacceptable, there were no discernible trends as each was different. They did not constitute a high percentage compared to more than 2,3-million admissions over that period, Masondo said.

DP MPL Jack Bloom said he was concerned that few of the cases had been finalised. He said it was also possible that the malpractice suits were just the tip of the iceberg.



**Streamlining:** a map of the referral areas feeding public sector hospitals.

**Key to secondary hospitals:**

- A - Somerset
  - B - Conradie
  - C - Grootte Schuur Hospital, Red Cross Children's hospital
  - D - Victoria hospital
  - E - GF Jooste
  - F - Karl Bremer
  - G - Tygerberg
  - H - Hottentots Holland
- Grootte Schuur is the tertiary hospital for adults and Red Cross the tertiary hospital for children in areas A to E, and Tygerberg is the tertiary hospital for both children and adults for F to H.

# Health service mapped out for you

**JENNY VALL**  
Health Reporter

Maps defining which hospitals people should be sent to from primary health care centres will be placed in all provincial clinics and ambulances in a bid to streamline health services.

The maps show nine areas and indicate the secondary or tertiary hospitals to which clinic staff should send patients.

There has been much confusion about where patients should

be sent as the province moves towards a primary health care system. This has led to frustration with people being sent from pillar to post. The goal of the Western Cape's health plan is for patients to be seen at the most appropriate health care institutions, closest to their homes.

Primary health centres are regarded as the backbone of the health system and have been upgraded.

People using the public health system must go to primary health centres (clinics and community

centres, formerly called day hospitals) first. Anyone going directly to a secondary or tertiary hospital will be turned away.

Clinic staff will write a letter of referral or make a telephone call if referral is necessary. If patients go to private doctors and find they cannot afford further private care, they must go to their local clinics before being referred to provincial hospitals.

The health department is planning a public awareness campaign to educate people how best to use the health service.

(98)



# Bitter pill for hospitals

(98) AFG 5-11/9/97

**Lack of stock controls in hospitals is costing the state millions, writes Aspasia Kararas**

**A** state-employed pharmacist in KwaZulu-Natal was almost killed last month by an armed gunman, in an attack that has been linked to the measures instituted by the provincial health department to curb the theft of pharmaceuticals from government stocks.

As 10% of the annual health budget, about R2 billion, is spent on purchasing medicines, this is the second largest recurrent cost after salaries. Various investigations have revealed that the estimated cost of theft to the government ranges anywhere from R50-million to R1-billion a year, says Bhada Pharasi, chief director of medicines registration, regulation and procurement, in the Health Department. "It is clear that this cannot be through pet-

ty pilferage by hospital workers. It's obviously syndicate related, and there is clearly collusion between people employed in pharmaceuticals companies and people working in the public sector."

Captain Daan Davis of the South African Police Services, who has been a key investigator into pharmaceuticals theft, explains that the ratio between private and public sector theft cannot be accurately determined.

"The problem is that no one can tell us the difference between private stock and government stock. It is not identifiable when it leaves the manufacturers and enters the market, so if it is stolen nobody can tell us where it was directed to. More critically, when you have parallel importing, and criminals buy medicine that has already expired, they simply replace the packaging and nobody can tell us where it came from."

Andrew Gray, a lecturer in the department of pharmacy at the University of Durban-Westville, is categorical: "It would be expected that such a large budget component would be subject to stringent controls, be well-managed and

accounted for. The mere fact that the losses cannot be pinpointed with more accuracy tells its own story. No figure claimed by any constituency can be challenged — the government simply does not know the scale of the problem and cannot find out."

Which is why since July last year the Minister of Health Dr Nkosasana Zuma has been trying to get the National Drug Policy off the ground and to pass related regulations through Parliament, a process that has drug manufacturers up in arms. One of their key objections focused on the proposals to adopt "Vericode", a multidimensional digital marking system that would track the approximately 18-billion packets and bottles of medicine made annually from manufacturer to dispenser. At a cost of 2c per unit, the system, which is used by NASA to identify and track space shuttle parts, would cost manufacturers R36-million per year — a high price for a very high-tech solution.

Pharasi explains that in response to the uproar, the Department of Health established a task team with the heads of the pharmaceutical industry to investigate less costly systems.

But, argues Gray, who has personal experience of state hospital dispensaries, "it does not help the situation when there are no accounting mechanisms in the hospitals themselves. Medicine handling in the state sector enjoys none of the technological support considered so essential to proper accounting in private sector settings." Gray explains that this lack of proper accounting is probably due to the manner in which previous health administrations ignored much of the law regarding medicine use. "The Medicines and Related Substances Control Act of 1965 prescribes the nature of the records that must be kept whenever a prescription is dispensed — but this section was blithely ignored in the state sector."

The Amendment Bill currently before Parliament expressly states that the Act will be applicable to the state, and provinces have started to implement monitoring mechanisms. State depot security is being tightened up; the Northern Province is now accounting for each pill and tablet, and almost each province is tending for computer systems that will go a long way to alleviate some of the problems.

Gray concludes: "It is to be hoped that the simple things will be done first; before turning to the high-tech, high-cost interventions, a system to document and hence account for medicines issued in state facilities is critical. The taxpayers deserve to know more than mere thumb-suck estimates of losses varying by hundreds of millions of rands."

Pharasi, although the department has written to more than 100 leading manufacturers about the different proposals, "not much feedback has been received".

Captain Davis explains that given the current system manufacturers are using, "of 1 008 packages they can only recover 70 packages. And prosecutors decline to prosecute, because there is no proof that these are stolen items."

Pharasi concurs: "The justice system presents a problem. According to what the police say, if someone is found in possession of medicines that are clearly in bulk and unaccounted for, the onus falls on the government to prove that the person stole the medicines, not on the person to show where the medicine came from. Round tripping is even more confusing, where dubious wholesalers sell stolen medicines to a second wholesaler, who then sells to a third. Without a tracking system it is very difficult to secure convictions."

Captain Davis says most of the medicines are stolen before they reach the government. Pharasi explains: "The theft of medicine happens fraudulently — the bulk happens before, which accounts for much more than is stolen in the hospitals and depots themselves. Provinces are trying to put measures in place, but clearly they are up against a very sophisticated and very lucrative operation."

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**Drug controls: Accounting systems are inadequate. PHOTO: DANNY HOFFMAN**

In December they produced a preliminary report outlining other possibilities, such as parcoding every individual packet.

The department is now going ahead with a pilot implementation project. Some companies, such as International Healthcare Distributors, are already using a batch tracking



# Top medic quits because

## of 'chaotic' trauma care

ARL 9/19/97

### Tygerberg Hospital in crisis, says doctor

(92)

JENNY WALL  
HEALTH REPORTER

The head of trauma at Tygerberg Hospital has resigned on the eve of the opening of the hospital's upgraded unit, saying people are dying unnecessarily because of chaotic trauma care in the province.

Elmien Steyn, who headed the unit for three years, denied any real upgrade of the Tygerberg unit, saying "politicians are trying to fool people".

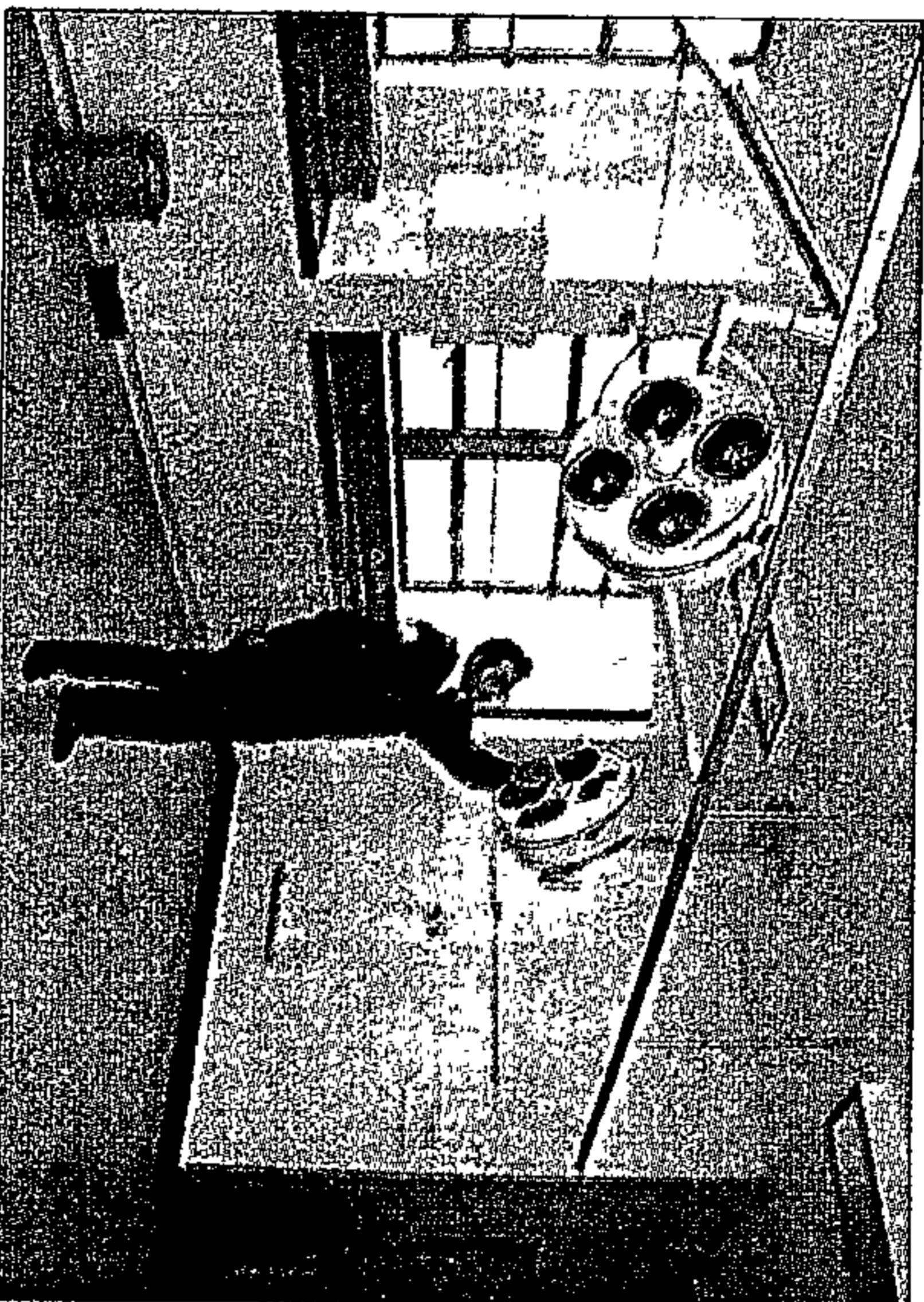
She said she could no longer take responsibility for the chaotic situation at the unit and had resigned because of "stupid and irresponsible" political games.

Dr Steyn has branded the upgrade as "window-dressing" and blames the health department for "ruining" staffing there.

"There's been no upgrade whatsoever. It is not a better facility. We have a shortage of equipment and the equipment we have is outdated. We have no overhead x-ray machine which a level-one trauma unit should have. We don't have enough staff.

"It did need a paint but that doesn't change the situation. Now it's slightly bigger and it's easier to manoeuvre trolleys."

Dr Steyn said trauma was out of control in the province: "People are



DOUG PITHEE

Upgraded: a security guard checks the lights at Tygerberg Hospital's trauma unit

dying all the time because of the overload of patients. They wait to see a doctor and then wait for a theatre. It's hard to put a finger on it but certain patients who died should not have.

"I can no longer take responsibility. Sometimes one doctor has to attend to 100 seriously injured people. That doctor can often only do too little too late. The politicians take the money away and the doctor takes the



I quit: trauma unit head Elmien Steyn

house you don't furnish it with everything at once. We have given her 10 staff, eight doctors in trauma and two sessional workers. She is damaging the hospital by saying such rubbish," Dr Rahmann said.

Dr Steyn countered that she had spent much time trying to staff the unit in recent months. "I have applicants from all parts of the world. I find people, then they abolish posts."



# Healthy boost for Brackenfell community

CITY REPORTER

August 10/9/97

(98)

(13)

The Cape Metropolitan Council has funded the building of a new R1-million community health centre for Brackenfell.

Opening the new centre in

Paradys Road recently, CMC mayor William Bantom told residents they had identified the need for an upgraded health facility to provide for the primary health care needs of about 27 000 people.

The new health centre would

have four full-time nursing sisters and a doctor would operate a tuberculosis clinic and be available for consultations. The facility would also have family planning, immunisation, pediatric care, a dispensary and a small casualty unit.

# Hospital is ready for more after tough year

## *25 000 treated at Manenberg unit*

**JERMAINE CRAIG**  
STAFF REPORTER

When the G F Jooste Hospital opened its doors a year ago in the heart of the Cape Flats as an emergencies-only trauma unit, the staff knew they were in for a rough ride.

And rough it has certainly been, with more than 25 000 people being treated at the Manenberg hospital in its first year.

Of these cases, two thirds were medical emergencies and the others trauma cases, including more than 500 people with gunshot wounds.

G F Jooste is the health department's flagship and in spite of its many problems, the tiny hospital can boast many successes.

The attitude of the staff is summed up by a young nurse quietly going about treating a stream of patients on a long night shift.

"It is hell working here. I am 23 years old and I don't have a social life, all I do is work and sleep. You are constantly harassed by rude patients - which makes it worse - and we are under-appreciated and underpaid."

But then, with a smile, she explains how she manages to carry on day after day trying to save lives.

"What makes it worthwhile is that my work is a calling, not just a job.

"A friend likens it to being pregnant. When you're pregnant you go into labour, but then you give birth to a life."

The fact that the hospital is the smallest secondary level unit in the Peninsula, with only two theatres and 184 beds, shows the enormity of the task of its staffers.

They serve a population of about a million people from Khayelitsha, Mitchell's Plain, Strandfontein, Nyanga, Manenberg, Philippi, Crossroads, Surrey Estate and surrounding areas.

G F Jooste has a staff of 431 - about 25 of whom are doctors and specialists - who provide a 24-hour service in the wards, theatres, emergency unit, x-ray, physiotherapy and social work departments, the kitchen, sterilising unit and maintenance divisions.



**People power:** Faldielah de Vries says the community should play a more active role in the hospital

Theirs is often a thankless job - with constant abuse from patients and the public, but head matron Julie Moses says the staffs' "commitment and passion" pulls them through under trying circumstances.

The hospital's senior medical superintendent, Norman Maharaj, said staff kept to a high standard in spite of staff shortages, inadequate resources and a heavy workload.

Looking at the history of some of the areas G F Jooste serves, the need for a trauma unit is immediately obvious.

Manenberg, with its estimated population of 85 000, is literally on the doorstep of G F Jooste. In the 1980s the leaders of the Hard Living Kids, Rashied and Rashaad Staggie, ruled supreme in the area.

Faldielah de Vries, of the Manenberg People's Centre, said that at the height of gang warfare there were four or five gang killings a week. All this changed when, in 1989, the community took to the streets in their thousands to condemn gangsterism. After this

major show of force from residents, gangs signed a peace pact - and relative calm has prevailed in the area for many years.

Although appreciative of G F Jooste, Ms De Vries said the community needed to feel a "sense of ownership" of the hospital which it did not. She also wanted communication between the hospital and residents to clear up exactly what kind of cases it treats as residents were often turned away when they needed treatment not deemed an emergency.

Commenting on the love-hate relationship between the hospital and the public, Dr Maharaj said he and his staff knew there would always be a need for a trauma unit and that they were up to the challenge. "We are proud of our achievements and - with the camaraderie, dedication and enthusiasm of the medical, nursing and general divisions of staff plus the support of the public - we are confident that the hospital will continue to fulfil its obligations," he said.





**One year on:** GF Jooste management team members Ahmed Kathree and Julie Moses. The hospital celebrates its first anniversary as a trauma unit this week

JACK LESTRADE

# Battle for ambulances as Cape hospitals fill up

**SHARKEY ISAACS**  
STAFF REPORTER

Cape Town's ambulance service was again in crisis this week when staff battled to find hospitals to treat patients.

From 1:30pm on Wednesday and throughout the night, Victoria, Wyn-

berg and False Bay hospitals refused patients because they were full.

Ambulance crews, already coping with their own problems of staff and vehicle shortages, were told to take only "extremely serious" patients to Groote Schuur Hospital and all others to Coronarie in Pinelands.

This resulted in longer and more

costly ambulance trips from areas like Simon's Town, Ocean View, Kommetjie, Fish Hoek, Cape Point and Muizenberg, said assistant ambulance chief Archie Flax.

"Our staff are trying to do their best under very difficult circumstances."

The situation improved slightly yesterday when False Bay hospital re-

opened at 8am but the admission ban at Victoria remained throughout the day and night.

Last week the ambulance service faced a major crisis when only two Peninsula hospital were open for admissions. Groote Schuur and Tygerberg trauma centres shut twice for four hours at a time on Monday last week.

ARC 12/9/97

(98)



# Council may act on 'referral incentives'

(98)  
BD 12/19/97  
Josey Ballenger

THE Interim National Medical and Dental Council of SA has decried the "escalation" of patient referrals to private hospitals which offer financial or other incentives when a better alternative existed, and is investigating taking disciplinary action against unethical health practitioners.

The council said in a written release yesterday it was "perturbed about the apparent escalation of unacceptable practices relating to perverse incentives," or kickbacks, offered by private hospitals to practitioners to "overutilise" services offered by these hospitals. Although the council had not received formal complaints, it said incentives were becoming increasingly prevalent "as many hospitals have become more aggressive in their attempts to recruit doctors and increase patient referrals".

All doctors, dentists and supplementary health practitioners in SA are required to be registered members of the council. The statutory body said it was also perturbed by the "apparent inability" of the medical profession to apply self-regulatory mechanisms to curb the acceptance of such schemes.

The council said it would establish a steering committee to investigate setting up a peer review committee consisting of representatives from the council, the Hospital Association of SA and organised professional bodies such as medical associations.

The peer review committee would develop guidelines on what constituted ethically acceptable arrangements between private hospitals and practitioners regarding incentives.

"Council must ... look at the issue of 'kickbacks' in terms of what it could mean for the public in general," council president Salomeni Kallichurum said.

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(98)  
DD 12/9/97

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the testimony of the security  
of the truth commission's  
was arrested and tortured

Picture: AP

# Cosatu optimistic about employment bill

Reneé Grawitzky

(98)  
DD 12/9/97

CONGRESS of SA Trade Unions (Cosatu) general secretary Sam Shilowa remained optimistic yesterday that a solution to breaking the log-jam on the Basic Conditions of Employment Bill could be found.

Addressing a media briefing yesterday, Shilowa said the bill should still go to Parliament this year. He was optimistic a solution could be found through the parliamentary committees and the alliance process. He did not expect a meeting with the African

National Congress until after the Cosatu congress next week.

It is understood that the timing of the passage of the bill through Parliament was to have been discussed by the relevant cabinet committee this week. The outcome of the discussion could not be confirmed.

A labour source said Labour Minister Tito Mboweni was consulting social partners. Meanwhile, Business SA has been waiting for a meeting with the labour department since Tuesday when it was advised to be "on standby" to discuss the bill, sources said.

# Mandela offers De Klerk role in nation-building

CAPE TOWN — President Nelson Mandela said yesterday he believed it would be in the interest of nation-build-

nessman Richard Branson at Tuynhuis.

Asked whether he envisaged De Klerk as a roving ambassador, the

given "something where he can use his talent, not as a leader of a political party, but as one of the most eminent South

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**WHEN** President Nelson Mandela opens his government's 350th new clinic on Saturday, he will put the Northern Province town of Nobody on the map.

Mandela's visit will make the opening an event that no one for miles around will want to miss — and eight cows will be slaughtered for the festivities.

But for the people of Nobody, a town whose greatest distinguishing feature is the ghost story that gave it its curious name, things began to change seven months ago when the clinic unofficially opened for business.

About 25 000 people, who are mostly unemployed, live in Nobody — a dusty collection of small houses along the road from Pietersburg to Morija.

Since February, instead of having to wait in the hot sun to take a taxi to Mankweng Hospital 10km away when they are sick, the villagers have been able to walk to the clinic.

Not only is the clinic close by, it's free and it doesn't have the long queues that line the corridors of the hospital.

Maria Mogale, one of Nobody's oldest residents, who is visiting the clinic with one of her 21 grandchildren, is one of its most enthusiastic patrons.

"We are very happy, especially because it is free," she says. "When we are sick, we get medicine here, we drink it and when we recover we are happy. Even if we get sick again, we are happy to come back."

In Mogale's eyes, the building of the clinic is the most significant development in the town since people defied the ghost which roamed the area and settled here about 50 years ago. Mogale, now 72, says: "A long time ago, nobody lived here except for one white farmer who lived near a small mountain close to the road. He died and was buried by people who came from town.

"The people who used to work for him would pass by from time to time and whenever they reached the small mountain they would hear a voice saying: 'Nobody must come and live here.'"

"So they wrote 'Nobody' on a boulder next to the road. But when people built the tar road, the stone was pushed aside and people started to settle here," Mogale says.

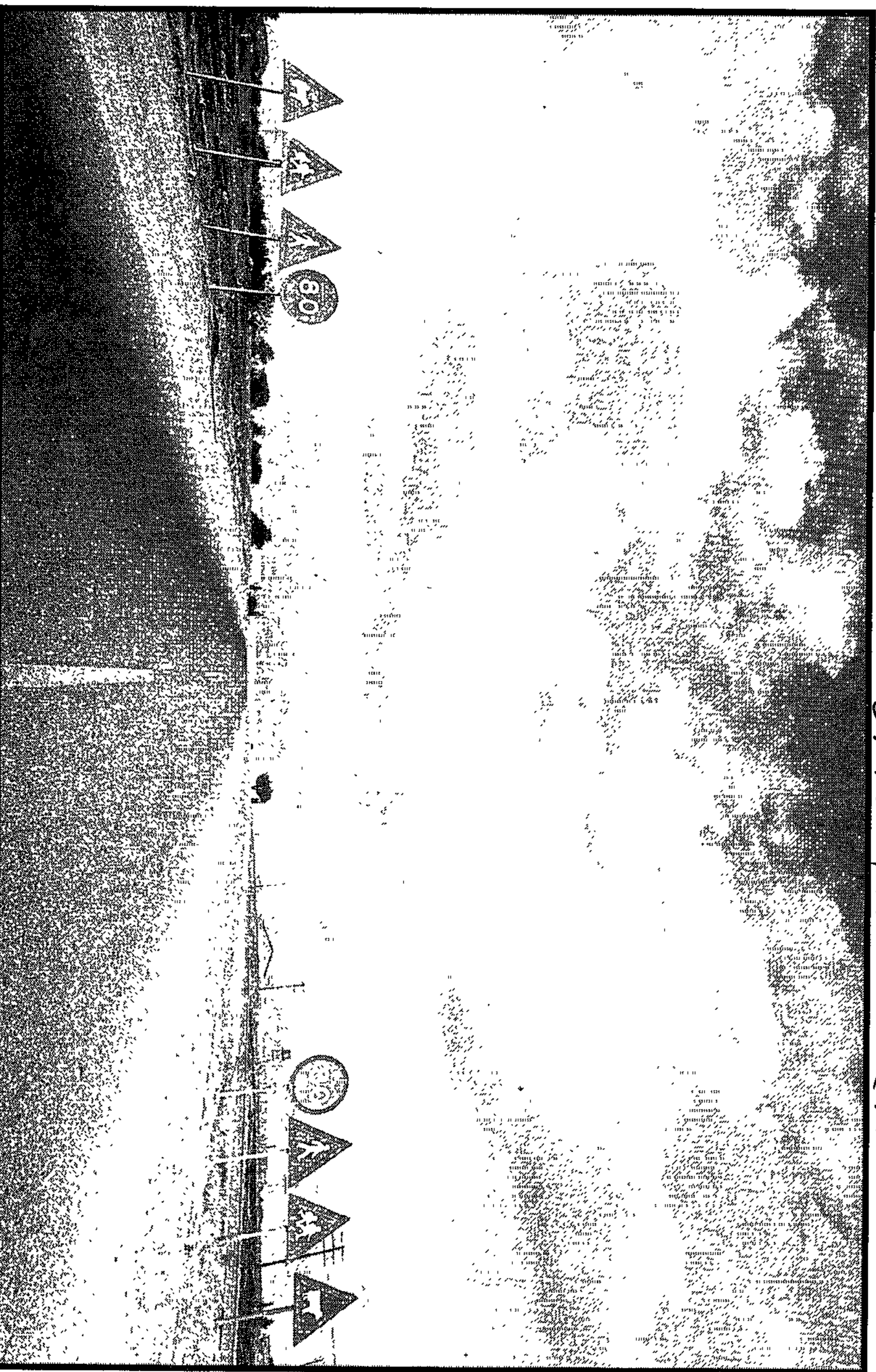
Sister Rahab Mamabolo is one of four nurses who run the Nobody clinic. They are backed by visits from doctors and refer serious illnesses or trauma to the Mankweng Hospital. Today, the ghost of Nobody is

# At last, somebody cares about a town called Nobody

*With preventive, primary health care as its goal, the government plans to ensure that there is a clinic within walking distance of every South African within the next 10 years, writes CAROL PATON*

ST 14/19/97

(98)



**ROAD TO NOWHERE:** These signs are the only hint that motorists are entering the district of Nobody

**Picture: RUVAN BOSHOFF**

not heard at all, she says. Mamabolo has worked in clinics since qualifying seven years ago, preferring them to hospitals because of the close contact with the community.

Mamabolo says she became a nurse "because I thought nurses were close to angels". She says she has discovered that that's not true and takes a practical approach to commu-

nity health matters such as contraception, AIDS and skin disorders caused by bad hygiene. "We call what we do here 'supermarket services,'" she says. The clinic "supermarket" here

provides everything from antenatal check-ups to child health, family planning and treatment of minor ailments. "We have found that people here come to the clinic first even

if their condition is serious because of the long queues at the hospital," Mamabolo says. And that is precisely the intention of the government, which hopes to draw people away from

overloaded hospital services to clinics which provide primary health care.

The first leg of the government's clinic-building programme aims to make up for a backlog of 1 000 clinics that should have been built by the previous government, says Vincent Hlongwane, a spokesman for the Minister of Health, Nkosazana Zuma.

"This backlog resulted in referral hospitals being overloaded by people who had a sore throat or a bout of flu. By 1999 we are hoping we will have made substantial strides in making up the backlog," says Hlongwane.

The second leg of the programme aims to provide a clinic in a 10km radius of every household within the next 10 years.

"Everyone will be in walking distance of a clinic," says Hlongwane.

However, the clinic-building programme has to be balanced with the government's ability to staff clinics and the budget to keep them running, he adds.

He estimates that the government has spent close to half a billion rand building clinics.

The superintendent general of health in the Northern Province, Dr Nicholas Crisp, says the Nobody clinic is a "critical and strategically placed clinic".

"It is one of several clinics being built in the area to unload Mankweng Hospital, which will become a tertiary service. Until now we have not had any tertiary hospitals in the province," he says.

The province has opened 35 new clinics in the past 18 months and has about another 40 to go. Crisp says 132 old clinics are also due to be refurbished.

A small clinic such as Nobody's costs about R1-million to build and set up and the recurrent expenditure is about R500 000 a year.

The biggest spin-off of the clinic-building programme will be the economic benefits of a healthier population, says Hlongwane.

"We are moving away from the curative approach to primary health care, which puts the emphasis on prevention. It is cheaper to prevent disease than to cure it. Clinics will be used as health centres where people can get information on a range of subjects and on lifestyle diseases and how to avoid them.

While the clinic at Nobody forms part of a grander plan, for the people of the village it sends out the simple message that the government regards each of them as somebody.



# Hospitals may publish guideline fees after medical aid scale rises 8%

Stephané Bothma

BENEFITS paid by medical aid schemes would increase by an average 8% next year, with recommended scales for doctors rising 10%, the Representative Association of Medical Schemes (Rams) said yesterday.

Benefits paid by Rams members this year are expected to exceed R20bn. The announcement of an 8% tariff increase for private hospitals was met with concern by the Hospital Association of SA, its executive director,

Anette van der Merwe, said the organisation might publish its own guideline fee. She said the health care inflation rate was 12%.

"In the past five years our members have consistently kept increases way below the hospital inflation rate and if we do not get a more realistic increase it will be difficult to survive," Van der Merwe said. Since 1993 private hospitals had received increases of less than half of the inflation rate. Rams said the 10% increase for doctors' services had evolved out of a new

co-operative agreement between it and the Medical Association of SA with the exception of cost containment and improved quality of care.

"Due to consideration of the Maintenance and Promotion of Competition Act, regrettably no consultation has taken place with the hospital industry," Rams executive director Declan Brennan said in a newspaper advertisement yesterday. He said his organisation again urged the hospital sector to address the spiralling costs of consumables,

medicines and disposables.

Van der Merwe said the hospital industry was vulnerable to labour cost increases and falls in the rand's value. "Our industry is very labour intensive and a large portion of our equipment and consumables is imported."

She said despite a significant hike in salaries last year combined with a sharp drop in the rand which "pushed hospital inflation through the roof", private hospitals fought back and managed to contain cost increases to 7%. "Now private hospitals alone can no

longer be expected to carry the burden of cost containment. The rest of the industry also has to play a role."

Van der Merwe said her organisation would decide whether to publish its own fee structure only after full consideration of all the implications of the tariff increase.

Other increases announced by Rams were 10% for psychology consultation and therapy, 5% for psychology, 8% for day clinics, 10% for basic dentistry and increases of between 6% and 10% for other health professionals.



## 'Kickbacks' to doctors investigated by council

By JANINE SIMON  
Medical Correspondent

(98)  
Star 16/9/97  
"Kickbacks" paid by growing numbers of private hospitals to doctors for patient referrals have drawn action from the Interim National Medical and Dental Council.

Council is to appoint a steering committee to set guidelines for acceptable arrangements between doctors and private hospitals.

It was perturbed at the apparent escalation of hospitals offering doctors "perverse incentives" to get them to refer patients and over-use facilities, and the profession's inability to stop doctors accepting.

It also warned that should complaints be received, disciplinary action would be considered against any practitioners cited for unethical behaviour regarding kickbacks.

Proof of kickbacks was first reported in the South African Medical Journal (SAMJ) in May.

The SAMJ said kickbacks had been fuelled by the oversupply of private hospital beds and increased competition.

But, it said, kickbacks had become embedded into medical practice in so many shapes and forms that it was increasingly difficult to distinguish between legal and illegal, ethical and unethical.

The council said incentive programmes could interfere with doctors' judgement of what was the most appropriate care for a patient.

It could also inflate costs by inducing a doctor to refer patients to a hospital providing financial incentives, rather than to a non-acute hospital which offered more appropriate care.

# Black woman takes over Verwoerd's hospital

Mail & Guardian 19-25/9/97

(98)

**Mukoni T Ratshtanga and  
Bongani Siqoko**

**A**partheid's architect, Dr Hendrik Verwoerd, would be turning in his grave. The hospital named after him is now headed by a black woman.

Dr Zola Njongwe is chief medical superintendent of Pretoria Academic Hospital — renamed in April after being HP Verwoerd Hospital since the death of the former prime minister. At 44, she speaks of an "era of romantics" when people went into medicine to help others. Today's medical students, she says, are acutely aware of other factors like financial rewards. "Things have changed and that may be a problem."

Her father was a doctor and her mother a nurse. She decided to follow in her father's footsteps and studied medicine at the University of Natal. Her two brothers — both de-

ceased — chose to abandon their studies at the University of Fort Hare to join the African National Congress in exile.

Her medical career started in 1977 when she took over her father's surgery at the KwaZulu-Natal village of Matatiele a year after he died. Four years later she went back to study for a career in community health. As a community health specialist, she does not feel misplaced leading a tertiary hospital. "Yes, there are specific areas that one is not experienced in. At the same time I have some management experience. But I'm on a learning curve," she said.

Njongwe speaks little of herself and her achievements. She often uses "we" instead of "I". In October, she intends gathering together political parties, clinics, the local government and communities to put together a referral system to streamline the way clinics refer patients.

The University of Pretoria is also being

brought in to help the hospital and four others — Kalafong, Witbank, Tembisa and Jubilee — in the creation of an academic complex to give students training and a research service. "This is a collective vision," she said.

Njongwe seems to be succeeding in bridging racial and gender problems. "We accepted we have a problem. There were constant accusations of racism. We started a process of meetings in every section of the hospital. Just talking has helped a lot. Now there are fewer complaints of racism."

And she has high praise for the gender-sensitive men with whom she works. "They treat her with respect" although there are times you have to shout because you realise a person is relating to you as a woman and not a colleague".

Patients and staff have been fully integrated, moving away from the old days when "white nurses treated white patients and black nurses treated black patients".



**Zola Njongwe: 'On a learning curve'**

Her aim is for the hospital to be able to streamline itself, so that primary health care functions and less sophisticated treatment are assigned elsewhere, and the Pretoria Academic Hospital remains a teaching hospital.



# Valkenberg hospital set to close

ST (CM) 21/9/97 (98)

YVETTE VAN BREDA

VALKENBERG hospital is set to close as part of a major cutback in psychiatric services.

The Western Cape's psychiatric institutions are only 60 per cent full and there is pressure to reduce psychiatric services at the Department of Health's five institutions by 1 000 beds.

The cut-back decision, which still needs to be ratified by the health ministry, comes after a

tortuous process of choosing between Lentegur, Valkenberg, Stikland, Alexandra and Grootte Schuur's G22 unit.

Valkenberg has 21 wards and serves 700 resident patients and about 1 000 outpatients a month.

The impending closure of the hospital is almost certain to provoke an outcry from environmental groups fighting to preserve one of Cape Town's last surviving greenbelts. The Liesbeeck and Black rivers run through the 44 ha site, which is

estimated to be worth R100-million on the open market.

Logan Wort, spokesman for Health and Welfare MEC, Ebrahim Rasool, said the process of cutting back psychiatric services started three years ago and was meant to take five years. But it eventually had to be pushed forward because of severe budget pressures.

Chairperson of the standing committee on Health and Welfare, Lynne Brown, said the department had no other choice but to close one of the hospitals

as psychiatric care was over-served.

Black River/Liesbeeck Confluence Alliance spokesman Ed Tilanus yesterday urged the city to draw up a policy plan for the area before any drastic decisions were taken.

"This is public land after all and the public should have a say before it goes to private use," he said.

The city had previously sold off stretches of Valkenberg land in the face of fierce criticism from environmental groups.

# All four psychiatric hospitals to stay

ARC 23 | 9 | 97

## *But land and beds must go*

**JENNY VIALI**  
HEALTH REPORTER

**All four psychiatric hospitals in the Western Cape will be scaled down and parts of the land on which they stand will be sold. But no hospital will be closed at this stage.**

Chief director of Supra-Regional Services Gilbert Lawrence said 50 to 100 more beds would have to go. Over the past 18 months 640 beds in Alexandra, Stikland, Valkenberg and Lentegour hospitals had been closed.

Vacant land at Valkenberg, Stikland and Lentegour, which was

becoming too costly to maintain, would be sold. The land belonged to the State so the provincial health department would not benefit.

The Pinelands section of Valkenberg would be sold but the future of the forensic unit had yet to be decided. The high-security forensic unit, the only place in the Western Cape where State President's patients were kept, could be retained, Dr Lawrence said.

Many staff had taken retrenchment packages over the past few years and staff at all four hospitals were stretched to the limit.

"We have reached the point of no return in terms of staff-patient

ratios," he said. "We need to consolidate the four hospitals."

They would have to be run with a combined management. "We will run one psychiatric service, not four institutions."

Psychiatric patients able to cope in the community or in group home situations had already been discharged from psychiatric hospitals.

"The next phase becomes more difficult. If we cannot operate within budget constraints, then yes, we will have to close a hospital.

"But it must be done slowly and in the context of building up regional and community psychiatric services," Dr Lawrence said.



OB LOSSES 'UNLIKELY'

# Valkenberg's services cut, land to be sold

**RE ALLOCATION** of funds to provinces that lack basic services means huge cuts for the Western Cape, but Valkenberg will stay open "for now", CAROL CAMPBELL reports.

ONLY a core psychiatric service to treat seriously mentally ill patients and the maximum security forensic unit will continue to operate at Valkenberg Hospital, because of government budget cuts.

Patients who are not critically ill will be referred to general hospitals, closer to their homes.

Western Cape health department head Dr Tom Sutcliffe said Valkenberg, like all psychiatric hospitals in the province, would have to shrink to accommodate the cuts. If budget cuts to the provincial health department continued, one psychiatric hospital in the city would be closed. A decision on which hospital this would be had been taken, he said.

In the meantime, land valued at 1 million on the Pinelands side of Valkenberg would be sold, he said. Vacant land at nearby Alexandra Hospital, Lenteguur in Mit-

chells Plain and Stikland would also be sold.

Sutcliffe said he would make every effort to retain the money raised from the sale for the health department, or at least keep the profits within the province.

Already the health department was running on a deficit of between R400 and R500m this year. The provincial health budget — like education — has been cut to free money for poorer provinces without basic services.

The Valkenberg land earmarked for sale houses a farm project aimed at creating work for psychiatric patients, several abandoned buildings and the maximum security and other forensic wards.

Sutcliffe said the forensic unit could not be closed because every province had to have somewhere to treat the criminally insane.

There are usually about 700 patients at Valkenberg, with 250 of

these in the forensic unit.

Professor Brian Robertson, head of psychiatry at the University of Cape Town, said he was not opposed to the decision to sell the land. He had been assured by Sutcliffe that a hospital housing the remaining Valkenberg patients and staff would continue to exist on the present site "for the time being".

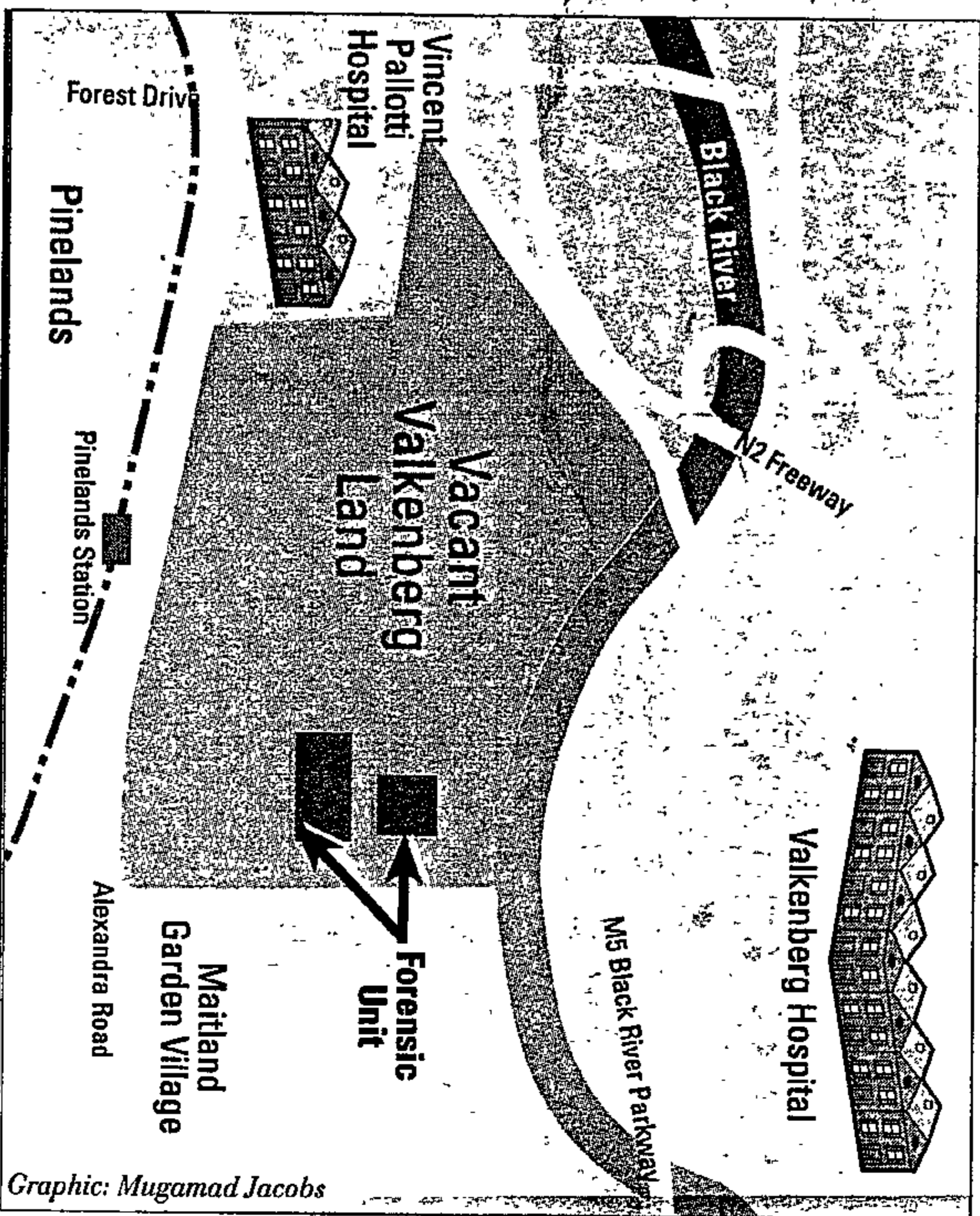
Hospitals like G P Jooste, Somerset, Conradie and Victoria are setting up psychiatric services to take pressure off the psychiatric hospitals, he said.

Staff at primary health care clinics had also been trained to deal with psychiatric patients.

Job losses are also unlikely because of the steady drain of trained staff who have been leaving hospitals to take voluntary service packages.

In the past 18 months, 640 beds in the province's psychiatric hospitals were closed.

"This still does not take the heat off psychiatric hospitals. I wish I could say it did, but more beds have to be closed," Sutcliffe said.



**UP FOR GRABS:** Valkenberg Hospital land to be sold off is depicted by the shaded area. The forensic unit will not be sold for the time being.

"If budget cuts continue we will have to close one hospital and consolidate staff and patients in the other three."

Robertson said psychiatric services in the southern suburbs centered on Valkenberg, which made it impossible to close it overnight.

"Besides the sheltered workshops and supervised group homes around the hospital, a number of old age homes need the hospital."

"To close the hospital means all these people will have to get to Lenteguur in Mitchells Plain and the province's public transport system does not make this a workable solution."

Similar constraints would apply to the rapid closure of any of the other hospitals.

Sutcliffe said he had been given an "indicative allocation" of R2,2 billion for health care in the

Western Cape for 1998. His budget for 1997 was R2,47bn which had already placed enormous strain on the public health service.

"We are hoping Dr Zuma will come in with more money for the academic hospitals, but this has not been confirmed," he said.

If R2,2bn was all the department was given in the final allocation, more cuts would have to be considered, he said.

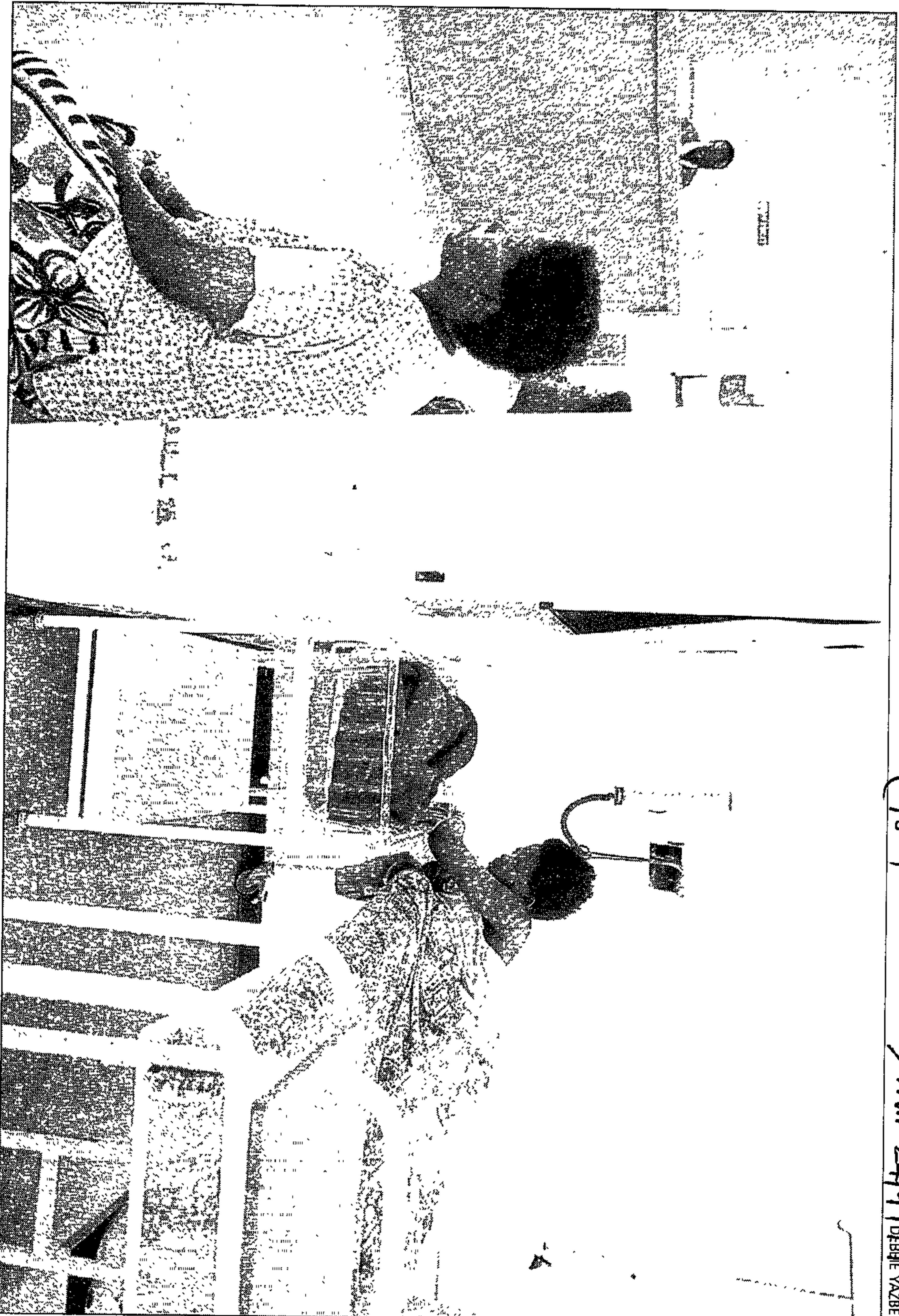
Graphic: Mugamad Jacobs



# New clinics are not all that is needed

Despite an enormous number of patients benefiting from more buildings, there are still problems of delivery

(98) Star 24/9/87  
GEBIE YAZBEK



Healthy mothers and babies ... teenaged mother Then iswa Jovra in bed



BY JANINE SIMON  
Medical Correspondent

It was no coincidence that the 350th clinic built since the 1994 election was opened at the weekend, after Health Minister Nkosazana Zuma had weathered a week of scathing public debate on her three new bills before Parliament.

However controversial the bills – and last week's attacks, particularly from the Medicines Control Council, have been stinging – the clinics are bricks and mortar evidence that the health system is delivering changes.

But, as the SA Health Review noted a year ago, new buildings can quickly fall into disrepair.

Or they may turn out to be badly located or designed, or cannot be opened because there is no money to employ staff or purchase supplies.

The health department says more than 8,5 million South Africans have benefited from the initiative to build new clinics and upgrade existing ones, and about 125 000 people per week can now rely on essential services.

But the questions now are whether the

clinics provide cost effective, quality care and whether they are sustainable.

"The nitty gritty of health reform is getting that new clinic to function effectively and efficiently. That's a far harder question that hasn't received enough attention," says Dr David Harrison, who heads the Health System's Trust Initiative for Sub-District Support.

He is heading projects in the Kalahari, amongst others, helping to build the in-clinic management skills that keep a service running smoothly.

Harrison says primary care is still considered the best way to respond to the broad health problems like tuberculosis which burden the poor with disease.

But the incidence of emerging chronic diseases like obesity, diabetes and hypertension is growing, and the only way to limit demand for hospital treatment of these problems is to provide prevention and control in communities.

Building clinics and giving free care was a starting point only, and now specific snarl-ups affecting quality of care in each district have to be tackled.

In many cases, simple systems of logistical and supply management are absent.

In one province, for example, managers at a regional meeting were bewailing the fact that they had no vehicles for TB control and drug distribution.

Ushering the entire meeting outside, the regional director pointed to the fact that there were plenty of government cars parked there, each driven by a single manager, Harrison recalls.

The task now is to create effective management teams, break down blocked "communication channels", give health workers easy access to health information and address the massive training needs.

"A number of nurses have told me that they 'treat patients through prayer', and they don't feel confident or supported to manage patients," he says.

The quality of services, staff qualifications and numbers and support systems like drugs and equipment vary immensely between provinces, and from clinic to clinic.

In Gauteng, there's no doubt that services are being used, says Dr Refik Bismilla, chief director, Gauteng District Health Services. Patient numbers at free health care clinics have more than doubled to 284 133 this year.

The Vaal's Empiliswini clinic opened for the first time on a Saturday six weeks ago, with two nurses and one doctor. It is now pushing through 500 patients on a Saturday, with six nurses and two doctors.

Yet one Johannesburg city GP says he's now seeing at least three patients a day willing to pay for his services, rather than return to a clinic.

"The repeated messages I get is that there was no medicine, or they were told to come back tomorrow, or they queued all day until the shutters came down," he said.

The province has taken some steps to smooth out these ground level problems, replies Bismilla.

At Mofolo Clinic in Soweto, patients were waiting an hour to get a card, another 30 minutes to have a temperature taken and then queueing for a doctor or nurse.

Province has cut the waiting time by 50% by allowing patients to keep their own medical records (patients don't misplace their own cards nearly as often as an institution), allocating routine temperature and urine tests more carefully, and seeing stable chronic patients less frequently.

Last year regional offices were reporting three to four thefts a month; this has

dropped off since fraud committees were set up in each region. Meetings with local police opened a line of communication, and burglar bars and perimeter fencing were set up.

The province is also hoping to free additional staff for clinics when the conversion of Hillbrow Hospital to a community health centre is complete.

Gauteng has also moved on the other national headache inhibiting service delivery: the integration of local authority and provincial clinics.

In theory, the process is being strangled by the Health Act and green paper on local government.

In practice the province has merged local authority and provincial clinics on the East Rand, so that 60 of the clinics which were former local authority clinics are now offering comprehensive care.

This was made possible because salaries of the two bodies were similar: anywhere closer to Johannesburg and local authority staff earn more than provincial bodies. Further away from town, the opposite applies.

Bismilla says Gauteng clinics are currently referring only 4% to hospitals, but

province has to work more carefully at making sure these patients actually get the treatment they need (See sidebar report).

Gauteng has increased its primary health care budget from R550-million to R739-million over the past three years by diverting funds from academic hospitals.

However, many argue that at the point when the shift to primary care began in earnest in 1995, the hospitals – to which primary clinics refer their patients – were already declining. The crucial need for hospital reform appears to have taken second place to primary care expansion, to the point where quality of care has suffered considerably.

What is not arguable is the effect of collapsing 20 years of health reform into three.

"What change is doing to our staff cannot be underestimated," says Joanne Collinge, Gauteng's head of communications.

"It places enormous demands on staff which can mean that services deteriorate because their efforts are being fragmented.

"It has been a hard process for staff and it has taken an enormous amount of courage to rise to the challenge," she says.



# Most private medical facilities will not be defined as essential

Reneé Grawitzky

SERVICES

BD 29/9/97

98

MOST private medical facilities, including clinics, which offer services also provided by the public sector will not be defined as essential services in terms of the Labour Relations Act, giving their employees the right to strike.

This has been determined by the essential services committee. Its chairman, Dhaya Pillay, said at the weekend heated debate had taken place on whether private emergency health services, nursing and private medical ser-

ices should be declared essential. The SA Blood Transfusion Services was an example of an essential private health service because it was the only provider of that service. A private sector health facility would be considered an essential service if it was the exclusive provider of services of a particular kind or in a defined geographical area.

The committee was established in October last year in terms of the Labour Relations Act, under the auspices of the Commission for Conciliation, Mediation and Arbitration, to de-

termine which services should be defined as essential and be subject to special labour relations procedures. The act states that workers in essential services cannot resort to industrial action. Disputes must instead go to compulsory arbitration.

Services previously defined as essential included passenger transport, parks and recreation maintenance to the production of tomato sauce. However, private health services had never been seen as essential.

Pillay said new areas declared essential — private and public — should be essential. Unions taking the opposing view included the National Education, Health and Allied Workers' Union (Nehawu) and the Hospital Personnel Trade Union of SA. Nehawu argued that not all public health services were essential. The union was prepared to negotiate collective agreements on minimum services at private hospitals.

Pillay said the national and regional health departments strongly supported private health-care facilities being defined as essential.

Pillay said the national and regional health departments strongly supported private health-care facilities being defined as essential.



# Valkenberg pressure group issues plea

## 'Treat sold-off land carefully'

ARL 29/9/97 (98)

**ANDREA WEISS**  
CITY EDITOR

**A call has gone out for a proper development plan to be drawn up before the land surrounding Valkenberg Hospital is sold off.**

The process should also follow the principles of "accountability, transparency and community participation", says a lobby group.

This follows news that health authorities are considering selling the land to help the cash-strapped health service.

The University of Cape Town, which also owns land in the area, is also considering selling its holdings.

Now, the Valkenberg Confluence Alliance, a broad-based umbrella organisation of interested groups, has appealed to the Cape Town municipality to safeguard the land

against irresponsible use.

The alliance has also written to provincial Health Minister Ebrahim Rasool to ask for a planning initiative to be started as soon as possible.

In recent months, several organisations have shown an interest in the Valkenberg land, among them His People Church, which wants to build a regional evangelical centre.

The Black-Liesbeek River confluence area lies within the boundaries of Alexandra Road in the east, Settler's Way in the south, Liesbeek Parkway in the west and Treaty Road in the north.

The area is associated with a series of wetlands incorporating the Raapenberg bird sanctuary, and is regarded by the alliance as valuable open space which could provide therapeutic areas for patients at Valkenberg and Alexandra hospitals.

But the area lacks a comprehensive policy plan. It was identified in the Observatory Policy Plan as regional recreational space.

"In the absence of a plan and in the light of current rationalisation within the Department of Health, this land is threatened by piecemeal development and change of ownership," the Confluence said.

Although UCT had promised to hold a participatory process before developing its land, it appeared the university planned to sell without consultation, the alliance said.

The alliance said it had tried many times to obtain existing plans for the area but had been unsuccessful. Calls to all levels of government and the municipality had gone unheeded. The alliance consists of a number of civic organisations and environmental groups.

# Private medical facilities ask not to be 'essential services' under act

Bonnie Ngqiyaza

(98)  
015 2019197

PRIVATE medical facilities said yesterday they had asked government not to declare them essential services in terms of the new Labour Relations Act, as they did not believe they needed protection from lawful strikes.

It was reported yesterday that most private facilities — including clinics — which offer services also provided by the public sector would not be defined as essential services, granting their employees the right to strike.

A Hospital Association of SA (Hasa) spokesman said yesterday the organisation had made approaches to the essential services commission with a view to having private hospitals declared nonessential services.

This was after careful analysis showed that in private hospitals most patients entered hospital on a booked basis, with only a few patients being admitted in an emergency or trauma condition.

"It therefore is not too difficult to plan a hospital's activities around a formal and legal

strike, if that should be necessary," he said.

The spokesman also said issues between management and employees in the private health care environment were very different from those in public health. Hasa was of the view that central bargaining councils in hospitals declared essential services would largely be dominated by the public sector, he said.

"It was therefore thought appropriate to distance ourselves from any central bargaining process that will largely be around issues of the public sector", the spokesman said.



## Bill on release of state patients is published

BO 110197  
KARE TOWN — Draft legislation to allow state patients detained on criminal charges in mental institutions to apply for their own release was published yesterday.

(93) (93)  
A memorandum on the Criminal Matters Amendment Bill says the provision seeks to get around the possibility of an attorney-general frustrating the release of a patient who is well enough for release.

At present, only an attorney-general can initiate a release application for people detained on violent charges, such as murder. Those held on lesser charges can be released by the hospital board.

The bill proposes to replace this system with a single procedure, allowing applications to be lodged with a judge in chambers by the patient, any other person or body on the patient's behalf, the superintendent of the institution, or an attorney-general.

The memorandum says a major objection to present law on mental illness and criminal responsibility is that it allows an accused who was mentally ill at the time of an offence and therefore "criminally incapable", but sane at the time of trial, to be detained as a state patient.

It also allows an accused who was criminally incapable at the time of trial to be detained as a state patient even though no offence has been proven.

The memorandum says the indefinite period of detention of state patients and the discharge procedure has also provoked much criticism.

The bill proposes to make it compulsory for the superintendent of an institution to report to the health director-general every six months on the condition of each patient. Present law requires a report every year for the first three years, then once every three years.

The bill proposes that accused be given access to state legal aid at hearings to decide whether they are fit to stand trial, or criminally responsible. — Sapa.

# Staff just can't take it any more - doctor

ARG 6/10/97

HEALTH REPORTER

(98)

A year ago staff at Retreat Maternity Hospital were unhappy. Six months ago they were desperate. Now they are not going to cope.

That is the opinion of Gregory Petro, a doctor responsible for community obstetrics at the Midwife Obstetric Units (MOUs), which fall under the Peninsula Maternal and Neonatal Service.

A "depressed" Sister-in-charge at Retreat, Menisia Barthus, says: "My staff tell me all the time they've had enough. The matrons are aware, the authorities are aware of our situation."

The nursing sisters want to give good care but they cannot do so with their workload, they say.

"We have no time to give women the time and respect they deserve," says a midwife. "We just do the essentials. Each is doing the work of three or four."

They're finished - mentally, physically and emotionally.

Helen de Pinho, acting medical superintendent in charge of the MOUs at Groote Schuur Hospital, said: "We try to identify staff from other MOUs to manage the situation. The staff are under tremendous pressure, they're at their wits end."

Voluntary severance packages have been one way for the Western Cape's health department to save money and many experienced nursing staff have been lost. The department faces further future cuts.

"Although the MOU budget has not been cut, our inability to replace staff makes it extremely difficult to manage," says Dr De Pinho. The MOUs are critical services ... we have to try to protect them. We keep making do, but soon we won't be able to."

MOUs - also located in Lotus River and Hout Bay - are one of the Western Cape's health success stories, reflected in its low perinatal mortality rates (deaths of babies just before and during birth).

Run by midwives, they offer a comprehensive service to poor pregnant women and are cost-efficient, all aims of the national policy for maternal and infant health care.

They offer reproductive health care from pregnancy diagnosis through to labour and delivery, early baby care and family planning.

Problems are picked up early and women are referred immediately to a hospital.

Started in 1980 by Groote Schuur Hospital's Gynaecology and Obstetrics department, the aim of MOUs was safe delivery of uncomplicated pregnancies at community level.

In 1985 all MOUs were gathered under the umbrella of the Peninsula Maternal and Neonatal Service, an international model for maternal and infant health.

About half of all deliveries in greater Cape Town take place in MOUs at a cost of R700 a normal delivery, as opposed to R2 500 at hospitals.



# Maternity unit 'cracking up'

## One nurse to attend to more than 60 women

(98)

ARG 6/10/97

JENNY VIALI  
HEALTH REPORTER

It is midday on Tuesday at the Retreat Maternity Unit. Heavily pregnant women who arrived at 7am sit quietly, reluctantly resigned to a wait of anything up to eight hours.

There is one nurse to attend to more than 60 women. Some nod off. They're fed up, they say. They're tired, sitting for hours is difficult, the service is going down. Something must be done.

Shanthol Fischer looks angry: "Three years ago it wasn't like this. It's impossible."

Patricia Lendis says more staff are needed: "We can't blame the nurses. They can't do the check-ups properly. We can't ask the questions we want to because we know there are others waiting."

Her baby is due next week. "It's so hard, I fall asleep. They try to make it easier. But you worry that when you come in in labour, there won't be enough sisters to help."

Woman after woman tells the same story.

Paulus Mbeteni has accompanied his wife Olga Kieghlaar. He says this morning two women came to Retreat from Khayelitsha because they were too full there. They were sent away and told to return the next day as new patients are booked in only between 6am and 7am.

Others leave because they are tired of waiting.

Gladys de Villiers has accompanied her daughter Carmen Coopoo: "What I saw this morning was chaos. The sister had to keep on running to find someone to help out. You can see on the mothers' faces that they're unhappy and tired."

They are not alone in their distress.

The nurses are at their wits end, exhausted, demoralised and not knowing where to turn. Their pleas for help have fallen on deaf ears, they say.



**Women in waiting:** pregnant women wait up to eight hours to be seen by midwives at the Retreat maternity centre, where there is little hope of relief for hard-pressed staff

The problem is a shortage of staff. Voluntary severance packages have left the unit understaffed and even though some have cancelled their leave to keep the unit running, they say they cannot keep up with the pressure anymore.

Even though maternal and child health have been identified as top priorities in the country's new health system, Midwife Obstetric Units (MOUs) are suffering as staff are lost to the health services.

The maternity unit reached cracking point this week.

Early in the morning 84 pregnant women arrive. About 20 of them coming for routine check-ups were turned away and told to come back the next day. But the staffing situation will be no better then, and the backlog will build up.

There is little hope of relief. More nurses are leaving. One left last week, another leaves this week. A third will leave in November.

When nurses leave their posts are frozen, with little chance of them being filled again.

Gregory Petro, consultant gynaecologist/obstetrician attached to the MOUs, says the unit is cracking up.

"Retreat has now passed the critical point of staff needed. The maternity unit is going to crack, it's going to implode. If we carry on like this staff aren't going to pitch up for work at the end of this week."

At times there are only two midwives on duty at Retreat. Two sisters are needed to resuscitate a baby or a mother.

"In this case there would be no one to attend to a woman in labour.

We cannot run the service like this. And there is no relief. If one person needs time off there is no cover."

"Mother and child care does not go away. If we cut numbers and people are sent away, they'll end up at Groote Schuur where they'll cost us more to treat."

Trevor Trout from the Greater Steenberg Civic Association has come to the hospital to assess the situation. He believes the community must speak out if anything is to change.

"When I came here this morning the nurses were running around like mad things. They can only do so much because they're only human. We believe they should stop the voluntary packages. If they continue, they should involve the community as to what the next step should be."

He said when the hospital was initially built it catered for far fewer people.

"They're cutting down on staff, but the number of people is increasing all the time. Someone is not doing their homework."

"We call on Ebrahim Rasool (health minister in the Western Cape) to come here and see. Community leaders must be consulted before packages are taken, we will give direction," he said.

Helen de Pinho, who heads the MOUs, says the community has a right to be angry. "The health budget is at a critical level. We're going to see more of this."

"It's just who the community directs its anger at. They must ask politicians what's happening to the health budget."



patients no longer had to lock their doors by

■ About 30 community organisations

■ Three sportsfields used by sports clubs

# Mental patients suffer in staff crisis

JENNY WALL  
Health Reporter

Mentally handicapped patients at Alexandra Hospital in Maitland are given coffee, bread, stew and whatever else is available for supper mixed together in a single cup.

Some are battered and bruised because they have fits and lash out at one another, with no one to stop them. So says the sister of an Alexandra resident.

"These are the very people who deserve the utmost pity and compassion," she said. "My brother has withdrawn into another dimension, sitting on a certain chair all day long with no hope of stimulation, change of environment or love from anyone. "They are all too busy and frustrated to worry about him."

The problems at Alexandra Hospital are those of institutionalised care and understaffing, and superintendent Linda Hering is the first to admit them.

In March, overcrowding reached crisis point as posts were frozen and more and more staff took severance packages or left.

Nearly 100 mentally handicapped people were identified as suitable for discharge and families were asked to take them home. Six months later, fewer than 10 families have done so.

Today, three group homes open to accommodate 13 people from Alexandra and 13 from Leithgaur Hospital. Another six houses are available for group housing - supervised care in a home setting.

"But we still sit with an enormous problem of overcrowded wards," said Dr Hering. "We have 30 fewer patients but we have lost more staff since March and are now down to 200 staff members."

The hospital has been given permission to fill 10 professional nursing posts in the next three months, and this will bring some relief. But at times there are two or three staff members caring for 40 patients.

"If one should be absent, there's a problem," she said. Ideally, there should be a nurse to every six patients.

"It is difficult to work out stimulating programmes under these conditions."

Dr Hering said there had been a rise in injuries... "and yes, there are a number of

incidents when nobody sees what has happened. If one staff member is at the dispenser and another is taking a patient to the toilet, there is no one to watch people."

She said the only way for three staff members to feed the number of patients in their care, many of whom had difficulty swallowing, was to mix their food together.

"We have to address the lack of individual care that happens in institutions. We encourage families to help."

In August, Dr Hering called a meeting of relatives to tell them once again that the hospital had reached breaking point and the nurses were exhausted.

"We said that even if they were not prepared to take relatives home, it would help if they took them home two days a week. We said it was not sufficient to bring them food, they should feed them as well. We asked the meeting of over 100 people to assist us practically. Six came forward."

"Hospitals cannot make it on their own, neither can the health department, NGOs or families. We need to all take ownership of the problem. It's no use rolling over and dying. We have to keep things going."



ST 12/10/97

# Doctors on the make had better watch out

(98)

CAS ST LEGER reports on the crackdown on profiteering in the health industry

**D**OCTORS who accept kickbacks — from cash to fax machines — for referring patients to private hospitals for tests or treatment had better beware.

The first meeting of a multi-professional peer review committee — representing doctors, nurses, pharmacists, private hospitals and other medical professionals — was held this week to ensure doctors toe the line.

The committee, an initiative of the Interim National Medical and Dental Council and the Medical Association of South Africa, says it will discipline doctors and oth-

er health professionals who accept kickbacks.

Rumours of crooked doctors receiving kickbacks have escalated recently and the committee was formed to thrash out ethical guidelines until new legislation can be introduced.

Professor Jan van der Merwe, chairman of the committee, says the body was established as it was "such an urgent matter".

He says policing of the medical profession has become necessary as times have changed.

The old-time doctor, Van der Merwe says, was known and honoured by his community. He was

reliable, trusted and was not motivated by money.

"Lately, basically because of cost spirals, the market-model doctor has come into existence."

Today, business practices are applied to the health care industry. If a doctor brings in business to a hospital, the hospital benefits. Hospitals, therefore, may be tempted to offer financial incentives to attract doctors.

Free market principles do not apply when it comes to the doctor and his patient.

"The doctor is both the buyer and the seller," Van der Merwe says. "The patient does not really

participate in the buying process."

If incentives are offered to the doctor by hospitals or other service providers, he can be influenced to recommend treatment that is not necessarily in the interests of his patient or the patient's medical aid.

"And there could be incentives to over-service," says Van der Merwe.

The immediate task of the committee is to draw up guidelines on ethical behaviour. It will then turn to the task of investigating allegations of kickbacks.

A Johannesburg gynaecologist says: "There will always be a few bad apples — but I do not know of any kickback cases personally and I have never been offered such a bribe."

Norman Weltman, an executive committee member of the Clinic Holdings private hospital group, says: "We most definitely do not do kickbacks."

"We choose to attract doctors by high technology and services rather than by kickbacks."

Weltman says his group offered the committee its support and cooperation.

One of the most outrageous claims to be investigated by the new committee concerns a Johannesburg doctor who has an interest in a men's outfitters.

The doctor allegedly sends patients to the shop to choose a new suit or shirt in return for signing blank forms — and the clothing bill goes onto a medical aid claim form under the guise of medicines or tests.

A more common allegation concerns aggressive marketing by private hospitals, creating incentives to attract doctors and encourage them to send more patients by offering reduced rentals or profit sharing.

The more patients the doctor sends to the hospital, the more cash flows back to the doctor.

In another case, a hospital group is alleged to have sent a doctor a handsome cheque in return for a batch of patients referred by him for kidney dialysis.

State doctors could also be involved.

A doctor needing a fax machine to receive laboratory results but with no budget for one could, for example, be provided with one by a laboratory which would be keen to have his business.

## Council slams kickbacks for doctors

25 14 10 197  
A COMMITTEE should be set up to probe unacceptable incentives or kickbacks being paid to doctors by private hospitals, the Interim National Medical and Dental Council of SA said yesterday.

The practice appeared to be escalating and could interfere with a doctor's judgment of what the most appropriate care for a patient was, council registrar Nico Prinsloo said. "(Hospitals) can inflate costs by causing doctors to overutilise inappropriately the services of a particular hospital," he said.

Prinsloo said a steering committee set up recently had had its first meeting and recommended a multiprofessional peer review committee be set up. This committee should consider all matters relating to "perverse incentives".

—It should also set up guidelines as to what constituted acceptable arrangements between private hospitals and practitioners as far as incentives were concerned. The statement said disciplinary action would be considered against any practitioner accused of accepting kickbacks.

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REPORTS: Business Day Reporters, Sapa



# Whistle blown on kickbacks to doctors

*Hospitals limited on incentives*

ARG 15/10/97

JENNY VIALL  
HEALTH REPORTER

**The practice of private hospitals giving kickbacks to doctors as incentives to use their services is to be stopped.**

Nico Prinsloo, registrar of the Interim Medical and Dental Council, said a multi-profession peer-review committee would be set up to establish guidelines for acceptable arrangements between doctors and private hospitals.

The committee would not limit investigations to the relationship between private hospitals and doctors. "The council is fully aware of the fact that the modern health care sys-

tem is extremely complicated, competitive and finance-related, while many outside factors impinge on the system, mostly commercially driven," a council statement said.

Incentive programmes could interfere with a doctor's judgment of the most appropriate care for a patient and inflate costs by causing doctors to over-utilise the services of a particular hospital, it said.

Disciplinary action would be considered against any medical practitioner cited for unethical behaviour as far as kickbacks were concerned.

The Medical Association of South Africa's board of trustees has said acceptable kickbacks are free meals, free parking and discounts on theatre

fees and drugs.

Unacceptable kickbacks are free shares in hospitals; direct payment or commission for referrals or treatment; educational policies for doctors' families; insurance policies for doctors; retirement annuities and car schemes.

Other incentives regarded acceptable, as long as they are not based on referrals or performance, are subsidised rentals, electricity and water and entertainment such as dinners.

Earlier this year the Cape Argus reported that a southern suburbs hospital was offering kickbacks to doctors in the form of shares in a trust scheme and 3% of fees billed to patients they referred to the hospital.



# Hospital holiday crisis

## Wards may close over hectic festive season

ARCT 16/10/97 (98)

JENNY WALL AND CAROL CAMPBELL  
STAFF REPORTERS

Hospitals in the Western Cape, facing a major staffing crisis over the festive season, will cut back on surgery, restrict leave – and could even be forced to close wards in a bid to cope.

The Western Cape Health Department plans to cancel all elective surgery during December and January to free staff to work in areas which need support.

Applications for leave will be critically assessed and key staff will not be granted leave, said Tom Sutcliffe, head of health in the Western Cape.

Dr Sutcliffe said some wards might have to be closed, but this was a last resort and the Health Department was looking at other measures. "If we have to close wards we will close medical rather than surgical wards. But we are not expecting any major closures, in spite of staff shortages," he said.

Hospitals which could face bed closures are Eben Donges in Worcester, Paarl, Red Cross, Victoria and Somerset.

Emergency services are also expected to be hard-pressed to cope and ambulance drivers and paramedics will work round the clock in anticipation of the annual carnage on South Africa's roads.

Wayne Smith, deputy director of Metro Rescue, said staffing of rescue services was "very tight" and the increase in accidents over the festive season pushed the handful of personnel to the limit, he said.

This year Operation Kamiedood, a high-profile team effort between traffic and rescue services, would again be in operation on the major routes through Lingsburg and extended to Maraisberg and Bredasdorp.

Hospitals, already struggling to cope as increasing numbers of staff take voluntary severance packages, expect a tough time over the festive period when there is a huge increase in the number of trauma cases.

The Western Cape health service continues to lose people as it tries to get within budget. Staff numbers have decreased from



ANDREW INGHAM

Season to be worried: head of health in the Western Cape, Tom Sutcliffe, centre, discusses staffing problems with David Beatty, paediatrics professor at Red Cross Children's Hospital, and nurse Kathy Simpson 31 769 in September last year to 28 168 this month. Dr Sutcliffe said another 700 people would be leaving soon.

Critical posts can only be filled with permission from the provincial treasury. "We are already in excess of our budget but we

have always had sympathetic support from the director-general (Niel Barnard)."

Dr Sutcliffe is to appeal to staff to swap workplaces for a short time and go to hospitals in outlying areas, where there is a sharp increase in accidents during the holidays.

He has also asked for volunteers to help.

Helise Schumann, medical superintendent at Eben Donges hospital in Worcester, said she had 40% fewer staff than had been approved for the hospital. "We've been coping up to now. We can't stretch any further.

We're having to seriously scale down our services."

Abul Rahmann, superintendent of Tygerberg hospital, said: "Our trauma unit is very stressed and understaffed. I don't know how we will cope – it will be a tremendous task."



# Sirens signal start of ambulance man's nightmare

*And he is the only person on duty*

ARC 18/10/97 (98)

Riviersonderend ambulance man Emmanuel Blom has a recurring nightmare.

Sitting at the ambulance station alone one night he gets a call saying that a bus heading for Umtata has overturned about 10km out of town and is on fire.

Mr Emmanuel gets into his ambulance, on his own, and races to the scene, sirens blaring. He has no idea what to expect.

How many people are dead? How many are injured? How will he be able to put out the fire with the single fire extinguisher he has with him? How will he, the only ambulance man on duty on the N2 at night between Caledon and Swellendam, be able to cope with the disaster?

For Mr Emmanuel, and hundreds of ambulance personnel in the rural areas of the Western Cape, this scenario is not just a nightmare.

It is a daily reality of working life.

With the staffing levels in the ambulance service at a critical low, the life of anyone needing an ambulance outside the Cape Town metropole – and that includes the thousands of motorists using the N1, N2 and N7 – are seriously at risk.

This is because most ambulances sent out in the rural areas are manned by only one person who is responsible for everything – driving, stretcher-bearing, medical care ... you name it.

Ambulance personnel even have to ask bystanders to help them carry stretchers.

"It is not the kind of care we've been taught to give our patients at the ambulance college," said one Hermanus ambulance man.

He and his colleagues have harrowing stories of their experiences.

Like Pieter Mentoor of Caledon, who was attacked by a psychiatric patient.

"A few years ago, I had to pick up a patient on a farm outside town. Everything seemed to be fine at first – I put him on a stretcher and started the 20km journey back to town."

But halfway to town, things went haywire.

"The next moment the patient stuck his arms through the little sliding window and tried to throttle me."

Mr Mentoor managed to pull the ambulance over to the side of the road and freed himself from his patient's grip. He calmed the patient and sped to the local police



Lone ranger: Julian April, senior ambulance man in control at Riviersonderend

PIETER  
MALAN



REPORT

ANDREW  
INGRAM



PICTURES

station where he asked for a police escort to accompany him.

Howard Brikkels, also from Caledon, was once called out to pick up a pregnant woman about to go into labour near Genadendal.

"I came there and found the woman in the back of an old bus where she and her husband were staying. It was late at night and pitch dark inside.

I soon established that she was in no state to be moved – the baby was on his way.

"The only problem was that I couldn't see a thing.

"So with a candle in one hand I tried to do what I could. But when the baby came I asked the husband to hold the candle for me.

"He was so under the weather that he couldn't hold the candle still.

"So with candle wax dripping on my arms and on the woman's legs, I brought the baby into the world."

But Mr Brikkel's problems had only just begun. He now had to get mother and baby onto a stretcher and out of the bus, with no help.

He eventually managed – after a heroic struggle – to get mother and baby out of the bus and to hospital.

And so the stories continue, whether it is Hermanus or Caledon, Riviersonderend or Swellendam.

Unfortunately not

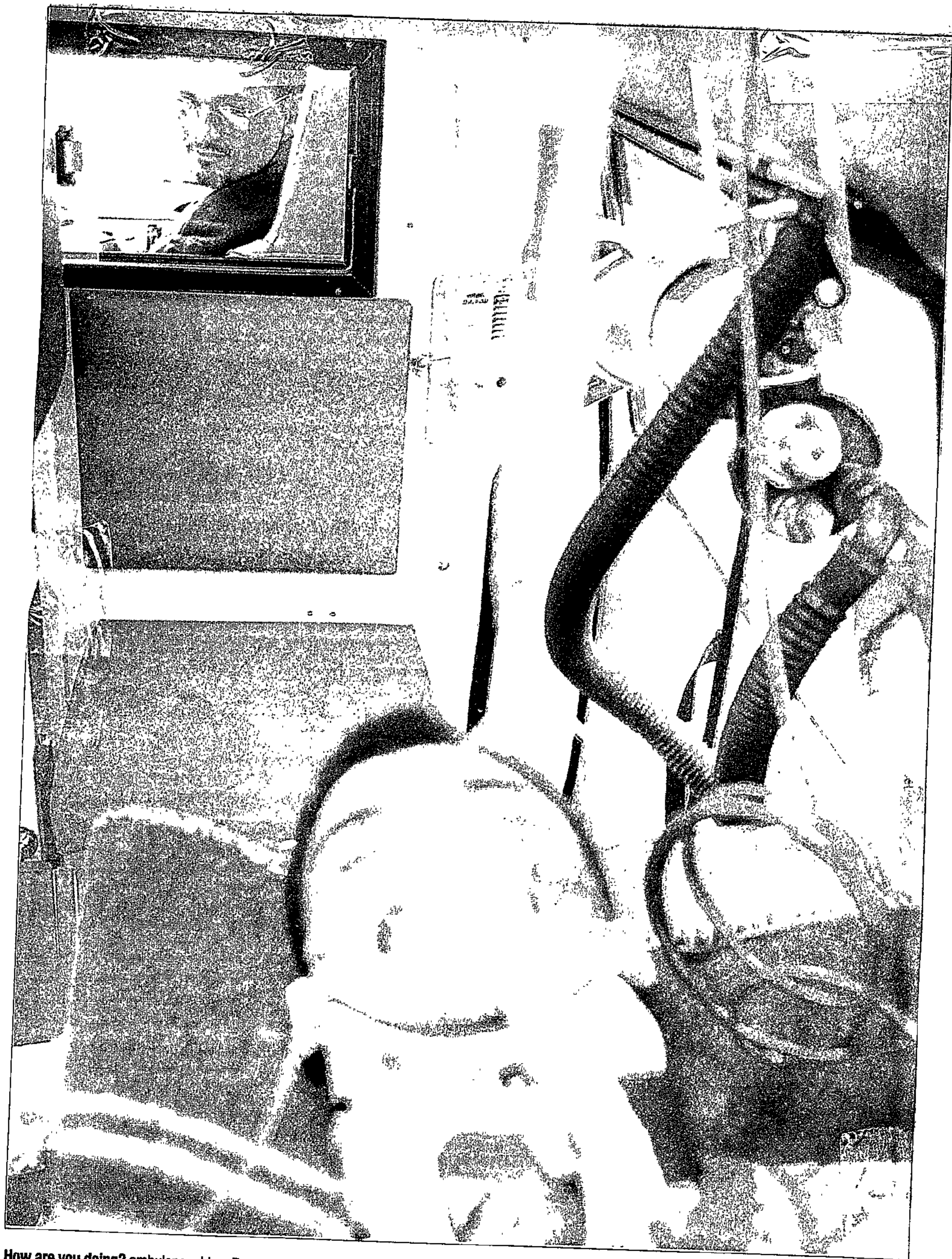
all have happy endings.

A premature baby died in Gerhard Louw's ambulance. He had to stop several times on his way to hospital to resuscitate the baby, and although he knew the child had very little chance, he tried his best. He said things would have been easier if he had had a colleague to help him.

"It makes things difficult being on the road on your own," he said. "It is a life you've got in your hands."

Critical, and the treatment's expensive – facing page

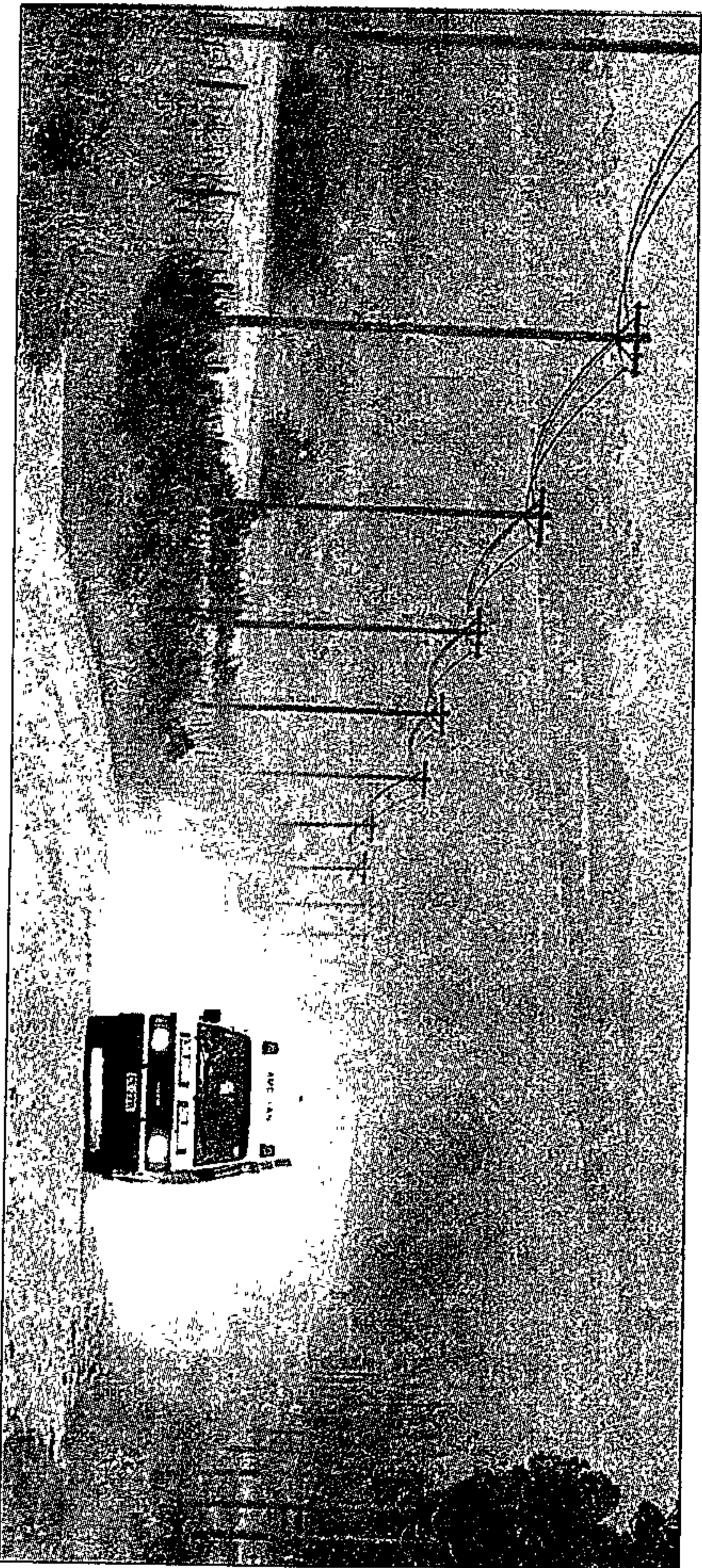




**How are you doing?** ambulance driver Emmanuel Blom demonstrates how he keeps an eye on his patients while on the road



*Quite often the only help comes from bystanders and other motorists – if there are any*



Dust storm: an ambulance on a dirt road near Riversoenderd



Patient's view: the only view that most rural patients will get of their emergency assistant

# Critical condition – and treatment is expensive

PIETER MALAN

Running an ambulance service with only one man is far from ideal – but with the money available to the service this is the only way out, says Western Cape emergency services director Anne Brand.

Far from ignoring the dire need of hundreds of men and women going out on a limb in dated vehicles – especially in the rural areas – she and deputy director Wayne Smith are working on an ambitious five-year plan to upgrade the ambulance service.

Their goal is to make every ambulance on the road a fully equipped life-support vehicle staffed with at least two basic ambulance assistants.

But between them and that aim stands an ever-shrinking health budget and a fleet of vehicles getting older and older each year, needing constant replacing just to maintain the existing service.

Dr Smith said that this year he needed to replace 81 vehicles out of a fleet of 341. Due to spending limit of R5-million, he was able to replace only 33.

This meant that next year he would have to replace 114, but with an allocated R5-million he would be able to replace only 29.

By 1999 he would therefore have to replace half his fleet if something was not done urgently to address the problem.

No wonder ambulance men, like Swellendam's Deon Greeff, throw up their hands in despair.

His only vehicle has travelled half a million kilometres on the Overberg's dusty roads – twice the distance believed viable for an ambulance.

Although the Western Cape service moved about 60 000 more patients last year than their colleagues in Gauteng – and even though Gauteng's territory is about a sixth of the size of the Western Cape – the local service's budget is R29-million less.

Faced with statistics like these, Dr Brand and Dr Smith would have every reason to be despondent.

But they choose to look at the bright side. This includes knowing that 70% of all ambulance personnel are advanced ambulance assistants – the second level of spe-

cialisation just before becoming a paramedic.

"While we don't condone one-man ambulances, at least we know that the people out there are the best possible," Dr Smith said.

And he said that with a province stretching over thousands of square kilometres, often it was impractical to maintain a full ambulance service with rescue ability in each town throughout the year.

"In areas like these we resort to multi-skilling where we train the police and traffic police and get them involved as well."

"And you only have to work with these guys – like I have done – to realise that it can work."

"They are the stars of the service (in the rural areas)."

"They have a love and enthusiasm for their job unequalled by many of their colleagues working in the city."

Swellendam's Mr Greeff said: "The situation is chaotic."

While there are two people on duty during the day in Swellendam, at night there is only one.

Rescue equipment in Swellendam, like in many other small towns, is loaded on a rescue trailer equipped with lights and includes the jaws of life.

When Mr Greeff or a colleague is called to an accident he has to hook the trailer, go to the scene, unhook it again, turn the ambulance and start extricating the patients from the wreck.

Often he is the only one there trained for the specialised work.

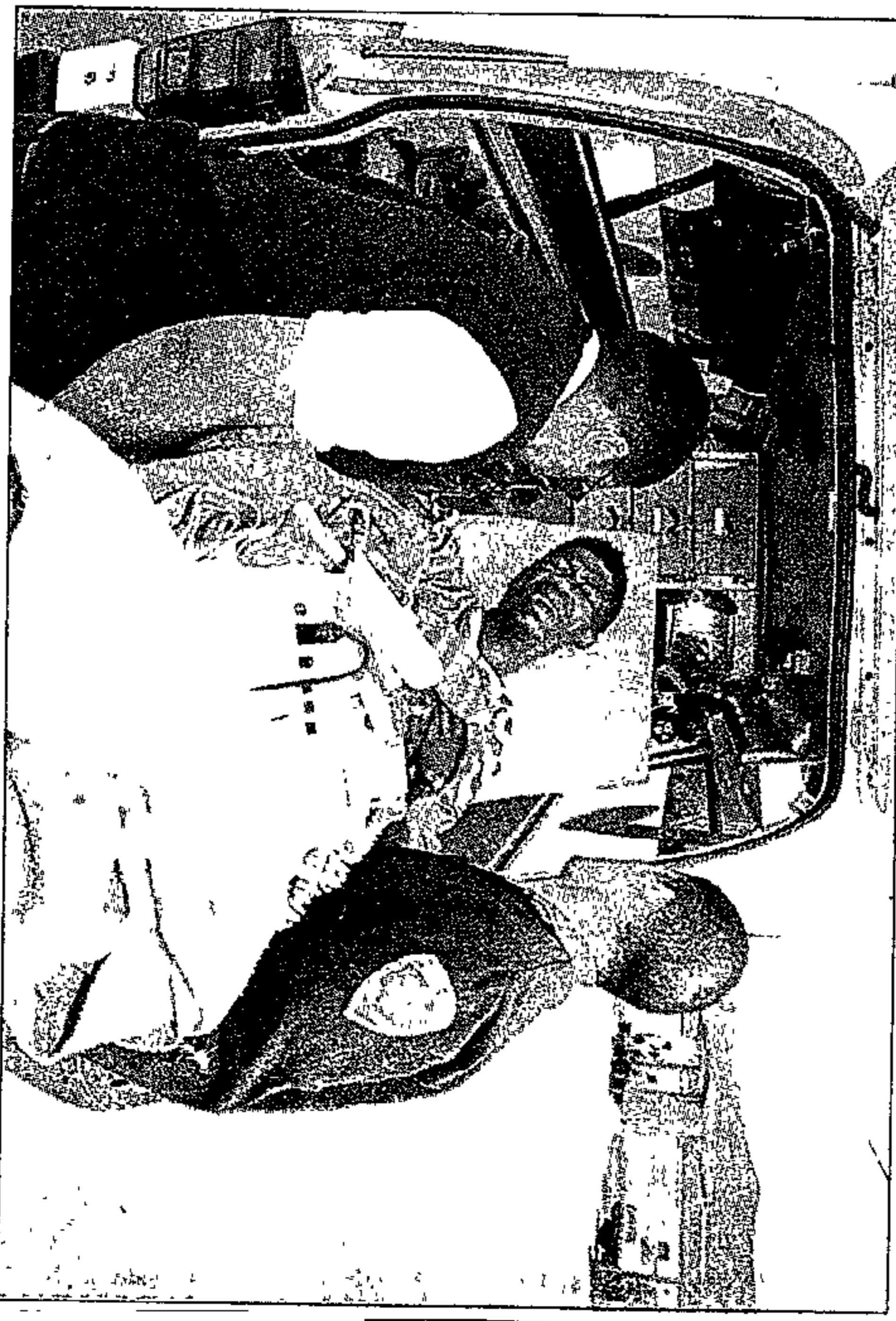
Help comes from bystanders and other motorists – if there are any.

But Mr Smith said that with Cape Town serving as the province's specialised rescue centre, help for the single ambulance man on the ground was never far off.

"With the excellent back-up we get from the Air Force, we can get specialised equipment and care to a patient in distress anywhere in the province within 60 to 90 minutes," Dr Smith said.

By the time the helicopter landed the ambulance man who had arrived first would have been joined by ambulances and more personnel from neighbouring towns.

(98)  
ARC 18/10/97



In pain: Hermanus ambulance men Parnell Jansen and Samuel Manuel load a patient in Zweelstse, Hermanus



# R1,5-m shot in arm for Baragwanath Hospital

ART 18/10/97 (98)

Johannesburg - The Chris Hani Baragwanath Hospital has been given R1,5-million to upgrade facilities in its medical admissions ward and for building a new emergency laboratory, Gauteng health MEC Amos Masendo has announced.

ble by the Merck Foundation, a wing of Merck Sharp and Dohme (MSD) South Africa.

Dr Masendo said yesterday the collaboration between the hospital and MSD was in line with the department's strategy to promote co-operation between the medical and business sectors.

The Chris Hani-Baragwanath Hospital is one of the busiest in the southern hemisphere.

The upgrade of facilities will allow for more effective patient care.

It also will provide quicker services and help improve efficiency at the hospital. - Sapa

The donation was made possi-



## Overspending at Gauteng hospitals amounts to R461m

BUDGETARY overspending at some Gauteng hospitals had amounted to R461m last year, or 35% over budget, the Democratic Party said yesterday.

There was little prospect of controlling runaway spending, Gauteng legislature health spokesman Jack Bloom (DP) said after receiving written replies to his questions from health MEC Amos Masondo.

About R421m was spent at the

Johannesburg, Chris Hani Baragwanath, Pretoria Academic and Helen Joseph hospitals for the previous budgetary year.

According to Bloom's analysis, 60% of the budget for the first three hospitals had already been spent this year, and 46% at Helen Joseph, which indicated further overspending this year.

"I am concerned the final adjusted budget is still not available as this indicates appalling bud-

getary practice." Bloom called for realistic budgets which would be strictly adhered to.

Masondo's said the reasons for the overspending were budgeting allocations less than the actual need, not keeping up with inflation and services being delivered to other provinces with minimum interprovincial funding.

Steps to remedy the overspending included the closing of three hospitals. — Sapa.



# R1,5-m donation a boost for Bara

Star 20/10/97 (98)

STAFF REPORTER

The more than 100 emergency patients who enter Chris Hani Baragwanath Hospital daily could soon be booked into the right wards faster, thanks to a R1,5-million donation from an American company this weekend.

The SA arm of Merck Sharp and Dohme donated the money to upgrade facilities at the admission

ward and build a new emergency laboratory for critically ill patients.

The equipment to be upgraded includes x-ray facilities and resuscitating machines.

According to Gauteng Health Department spokesman Popo Maja, the hospital had been using old equipment.

Professor Ken Huddle, co-ordinator of the project, said the upgrading would promote more effective patient care.

Currently, of the 3 500 laboratory tests carried out at the hospital daily, about 1 400 are done at the emergency laboratory.

The new laboratory is located next to the emergency ward and will feature automated equipment to help doctors access the information needed to treat critically ill patients.

The hospital also plans to improve conditions in the ward for doctors and nurses.



L. G. W.

# Johannesburg Hospital buckles under influx of patients

Star 20/10/97

(98)

By **STUART KELLY**

Burgeoning queues at Johannesburg Hospital have compelled many patients to wait for weeks to see a doctor.

Doctors and other hospital staff are struggling to cope with the number of patients coming from outside Johannesburg who are bypassing medical facilities in their own areas because they are under the impression they will receive better care in Johannesburg.

Because of the workload, some patients arriving at the emergency ward have been turned away with little more than painkillers and appointments scheduled for weeks ahead.

Johannesburg Hospital superintendent Dr Trevor Frankish said: "Doctors, nurses and administrative staff are work-

ing under tremendous pressure. The queues are getting longer and, as a result, one can expect the hospital's ability to deal with the number of cases to be stretched."

More than one patient has complained to The Star about the waiting lists in the past week. Mugging victim Spencer Atkin (31) of Rosettenville is still in pain and unable to eat solids after doctors at the emergency ward of Johannesburg Hospital failed to do anything about his broken jaw last Sunday.

Atkin, who was kicked in the face several times by a gang of muggers while walking home from a bar at about 2am, said he was discharged from the hospital with a few pain-killers, mouthwash and an instruction to phone the hospital the next day to make an appointment



**Broken jaw ... Spencer Atkin is still unattended to after week.**

with a doctor. He was also told he faced a wait of up to two months before his jaw would be wired up. When Atkin phoned the hos-

pital the following day, he was told to come in today, by which time more than a week will have passed since the mugging. "I'm not even sure if they will wire my jaw then. They only said a doctor would see me."

In the meantime, Atkin has been living off soft foods such as icecream, because he is unable to chew. Although his swelling had gone down by the weekend, he said he still experienced severe pain.

Ilana de Vries of Turffontein said she was told her 4-year-old daughter would have to wait more than two months before a doctor could see her about her recurring tonsillitis.

"I went to the hospital about a month ago, and after waiting around for several hours and being banded from one department to the next, she still didn't get to see a doctor. They then

said my daughter had been booked to see a doctor on December 4. I am unemployed and unable to pay the R4 000 a private clinic would charge to remove her tonsils," she added.

Frankish said: "While it is true that patients are now having to wait extremely long periods to see a doctor, critical patients are still receiving immediate care."

Commenting on De Vries' complaints, Frankish said tonsillitis was not regarded as a critical case in light of more serious cases that doctors at the hospital were required to attend to first. As a result, she had been moved to near the back of the queue.

He confirmed that Atkin had been told to return to the hospital to see a doctor today because the injury was not an emergency.

# Hospital short of (98) ICU beds

*Sewetan 21/10/97*

THERE was a severe shortage of post-operative and surgical intensive care beds at Johannesburg Hospital, Gauteng MEC for health Mr Amos Masondo said yesterday.

Masondo was responding to questions in the Gauteng legislature by Democratic Party MPL Jack Bloom in a statement released yesterday.

Masondo said there were between 14 and 16 such beds, depending on available nursing staff, and that up to 12 additional beds could be used, depending on surgical policy and practice.

The shortage led to 79 patients being referred to five clinics at a cost of R2,7 million or R34 000 per patient in the 16 months until July this year.

He said it was not possible to determine the number of emergency patients transferred to other state hospitals without further research into this matter.

Bloom said in yesterday's statement: "I know of many hair-raising incidents where desperate measures are resorted to between various hospitals to find ICU beds for critically injured patients."

Masondo also said in his response that it was not possible to measure the extent to which patients requiring post-operative intensive care facilities were placed in general wards.

However, he said: "Patients requiring post-operative intensive care, if placed in general wards, either have special nurses or are kept in the recovery area in theatre until they are ready to go to the wards."

If an additional 12 beds were made available, about 48 extra intensive care staff would be required. "The main problem is the high demand in the private sector for intensive care staff. There is extensive head-hunting."

Bloom said the erosion of conditions at state hospitals was so severe that there was little chance of attracting these nurses back.

"Lives of emergency patients are at stake, as well as the interests of other state patients who suffer from long waiting periods for operations because of the shortage of state ICU facilities," Bloom said. - Sapa.



# Costs cut, so state hospital patients starve (98)

Star 26/10/97  
By TWEET  
GAINSBOROUGH-WARING

Patients are starving in state hospitals throughout South Africa, top medical professionals have revealed.

Severe budget cuts mean as little as R6 a day can be spent on feeding patients. The experts also blame lack of nutritional knowledge by hospital staff.

Recent surveys show that as many as 60% of state hospital patients are malnourished. One in five of these are severely malnourished.

By saving money on food, hospital authorities are having to spend more on medicines because starving patients take longer to recover.

Professor Demetre Labadarios, head of human nutrition at Stellenbosch University, said nutrition was the most neglected aspect of patient care in hospitals.

"Malnourished patients are a nursing nightmare. They are far more difficult to treat as they are more susceptible to infection, and post-operative wounds take longer to heal."

Death came more quickly to a patient suffering from malnutrition because they had less resistance to disease and infection, Labadarios said.

Staggering statistics showed the hospital stay of a patient suffering from malnutrition was on average 10 days longer than it needed to be. At a cost of R600 a day to the state, this amounted to R6 000 for each malnourished patient. In the case of a patient in intensive care, the cost was R3 000 a day.

He said that in the Western Cape, the high rate of alcoholism, tuberculosis and trauma increased the number of malnourished patients admitted to hospitals.

Inadequate funding was part of the problem, with less than R6 a day spent on food for each patient.

Malnutrition was compounded by the effects of the disease and by the patient missing meals while spending time out of the ward undergoing tests.

Labadarios said patients admitted to emergency units were a high-risk group because they might spend days on a drip with inadequate food. These patients might also have injuries requiring special foods or diets, which were often overlooked. As a result, patients were sometimes left to fend for themselves.

He said doctors were well trained in coping with heart attacks, bullet wounds and accident cases because there were specific treatment routines to follow. "But they do not look at a patient's state of nutrition on admission."

Surveys in state hospitals showed that less than 10% of patients had their body weights recorded and less than 5% had any information on their nutritional state on record.

TO PAGE 2

## State hospital cost cutting: now patients are said to be starving (98)

they were completely recovered. They went back to their homes, where they did not have access to good nutritional advice.

There was no doubt that undernourished people were targets for infection.

TB, one of the most prevalent diseases in South Africa, reinforced the patient's already poor state of nutrition, he said.

**FROM PAGE 1**  
Labadarios said there were no proper systems in place to cope with the admittance of malnourished patients. "Quite often they get worse while hospitalised."

Hospital budgetary cuts had led to a decrease in the number of beds, which meant patients were often discharged before

Aref Haffjee, duty head of surgery at King Edward VIII Hospital in Durban, said the incidence of malnourished patients in the medical wards was as high as 80%.  
"There needs to be greater awareness among hospital staff as to the importance of nutrition, and more emphasis should be put on nutrition in the curriculum of medical students," Haffjee said.

The University of Stellenbosch launched a nutrition information centre this month, with health professionals offering a food advice hotline to the public.  
Free advice on diet and nutrition are available, with specialist testing done at medical aid society rates. Telephone (021) 933-1408.

R19 000 MONTHLY FOR NO WORK

# Authorities slammed over suspended doctor

**AS HOSPITALS** lose legitimate staff through budget cuts, a doctor suspended over a year ago pending a hearing, has been drawing full pay. **CLAUDIA CAVANAGH** reports.

**A** FORMER head of Tygerberg Hospital's trauma unit, who was found guilty of disgraceful conduct by the Interim National Medical and Dental Council last week, has been off work on full benefits for over a year.

Dr Richard Muller, a principal specialist earning around R19 000 a month, was reported to the council by the provincial health department for allegedly not keeping "required patient records" and "prescribing excessive dosages of pethidine on a regular basis to a patient".

Pethidine is a schedule seven narcotic pain-killer related to opiate drugs. It is potentially addictive if administered incorrectly.

Muller was suspended — with full benefits, including pension and a car — in June last year pending the outcome of an inquiry.

This delay could have cost the taxpayer about R350 000.

"Although a principal specialist earns no overtime pay, the benefits are substantial," said Dr Gilbert Lawrence, chief director of Supra Regional Services for the provincial health department.

Angry staff at the unit, where services were drastically reduced earlier this year because of government budget cuts, criticised the system for taking so long to resolve the issue.

"On one hand we're told the province doesn't have any money, and on the other we see the department taking ages to rectify this situation," said one staff member.

Last month, the head of trauma at Tygerberg, Dr Elmien Steyn, resigned on the eve of the opening of the hospital's upgraded unit.

She said she could no longer take responsibility for the "chaotic situation" at the unit and branded the upgrade as "window dressing".

She blamed the health department for "ruining staffing here" saying she'd spent much time trying to staff the unit but that as soon as she found suitable applicants, the posts were abolished.

At the time, the chief medical superintendent at Tygerberg, Dr Abul Rahman, labelled her accusations as "rubbish".

"People must not forget we are in South Africa. When you build a house you don't furnish it with everything at once. We have given her 10 staff — eight doctors in trauma and two sessional workers."

Yesterday, Lawrence blamed the process which had to be followed for delaying the Muller issue.

It would have been illegal to suspend Muller without benefits until the outcome of the investigation was finalised.

(98) CT 27/10/97  
But even now the committee has made a final recommendation, the situation will not be immediately resolved.

"We will have to wait for the finding and carefully study the conditions imposed on him before we can decide what to do about the situation," said Lawrence.

According to information released to the Cape Times, the medical council findings follow an internal investigation alleging that Muller had "neglected to adhere to his official working hours" and a police matter involving his alleged failure to report the loss of a prescription pad subsequently found in a patient's possession.

In keeping with a preliminary committee's recommendation, the council found Dr Muller guilty of disgraceful conduct. However, the council suspended for five years the original recommendation that he be "erased from the register" on several conditions.

These include that he only practise at a hospital approved by the council and under the supervision of a medical superintendent, that he receives treatment from an approved psychiatrist and that he does not "purchase, acquire, keep, use, administer, supply or possess" any schedule five, six or seven substances.

This would include most injectable strong pain-killers, anti-depressants, tranquillisers and hypnotics, drugs that diminish appetite, short-acting barbiturates and therapeutic narcotics.



# Valkenberg (98) stares closure in the face (28)

CAROL CAMPBELL AND ANDREA WEISS

STAFF REPORTERS

ARG 28/10/97

The death knell has sounded for one of Cape Town's oldest hospitals.

After months of speculation, Valkenberg psychiatric hospital has been officially identified as the institution to close in a bid to rescue the Western Cape health department, which is in dire financial straits.

The provincial health department said it believed the Western Cape needed only three psychiatric hospitals and "the most appropriate to close would be Valkenberg".

Stakeholders and citizens have been given until Monday to say why they do not agree with this decision.

The announcement has been greeted with shock and dismay by hospital staff, patients and numerous support organisations, including old age homes, sheltered workshops and group homes.

Dr Tom Sutcliffe, head of the provincial

To page 2

## Valkenberg to be closed

ARG 28/10/97

(98) (28)

From page 1

health department, says the final decision has not been taken. Provincial health minister Ebrahim Rasool is expected to make an announcement in about a week.

Lisa Wolter, director of the Abri Foundation which houses 27 schizophrenic and manic depressive patients, said the decision would be "catastrophic" for the foundation. She said the residents, able to cope in a stress-free environment, were in a state of panic about the closure.

Brian Robertson, head of psychiatry at the University of Cape Town, said patients and their families were

not being considered. "Many people struggle to get to Valkenberg hospital, especially people from informal settlements in places like Hout Bay and Noordhoek. The extra distance to Mitchell's Plain would make it very difficult for them."

Dr Sutcliffe has been told he should expect a health budget of R2,2-billion next year. His budget this year was R2,47-billion which placed enormous strain on the health service.

"The health department proposes that the most appropriate hospital to close would be Valkenberg but we are nowhere near a final decision yet. This is not an easy decision to make," he said.

# Developers clamour for hospital land

ANDREA WEISS AND CAROL CAMPBELL  
STAFF REPORTERS

**Developers are clamouring to get their hands on the scores of hectares surrounding Valkenberg hospital.**

But local lobby groups are insisting that there should be an open public process before any decisions are made about the land, which the Observatory Policy Plan describes as "regional recreational space".

Speculation is that Valkenberg has been identified for closure because of the value of the surrounding land, a portion of which on the Pinelands side is valued at R30-million.

Provincial Health Minister Ebrahim Rasool's office has reportedly been inundated with queries.

Ward councillor Owen Kinahan has warned that the hospital land could fall into the hands of the public works department, "with all the sinister and maladministrative results that are associated with it".

He appealed to the Health Department to "at least entertain suggestions that would manage the estate in such a manner that it would not simply be regarded as a financial drain".

Among the groups which have indicated an interest in the land are:

■ His People, an evangelical church which wants to build a region-

al centre on the Pinelands side.

■ Friend of Alexandra, with plans for a farm to house and provide work for handicapped people.

■ The Tree Oxygen organisation, which has been growing organic vegetables around the historic Oude Molen farm house and wants to expand this project.

■ The Strategic Development Agency, which also has plans for a farm, but with an office park too.

■ The River Club is rumoured to want to expand to include a hotel, possibly on to Valkenberg land.

A public meeting is to be held on Thursday at 6pm at the Environmental Centre at Valkenberg.

(98) ARG 28/10/97



# Avalanche of children hits hospital

## Demand on paediatric facilities has soared since child health care became free

By Mike Masipa

**J**ohannesburg Hospital's paediatric ward intake has increased four-fold and it has been forced to turn away patients because of the shortage of beds and lack of staff.

Since the introduction in 1994 of free health care for children under 6, the hospital has been bursting at the seams and has seen the patient intake in paediatrics grow from 2 000 in 1990 to 8 000 last year.

Speaking to The Star yesterday, paediatrics head Professor Peter Cooper said the fact that the hospital was the only one in Greater Johannesburg offering specialised paediatric care

meant there was an even bigger influx because all major areas in the metropole were sending patients there. "But our main problem is

### One bed

### can cost

### R320 000

### a year

### to provide

the shortage of nursing staff. We have had to limit the number of patients we take in because of the shortages.

"But we also try to send incoming patients elsewhere

such as the Chris Hani-Barragwanath, Coronation and Edenvale hospitals, depending on their condition. "Some of the wards have been standing empty because of the same problem," Cooper said.

He added that Johannesburg Hospital was allocated the same number of nurses as before the institution began admitting patients of all races in the late 1980s.

"We have had several meetings with the Gauteng Department of Health in an attempt to have the situation improved but we were always told there was not enough money."

He said that his department currently utilised seven wards with 28 beds each at a cost of

R900 a bed per day. A single bed would therefore cost more than R320 000 a year to run.

A nursing sister, who did not want to be identified, said the situation was worsened by the exodus of experienced nurses to the private sector.

"The trend has been going on since long-serving nurses took severance packages a few years ago. These, especially those with specialised units, were never adequately replaced as those who came in after them left for the private hospitals soon after gaining marketable experience," she said.

She added that bureaucratic red tape also ensured that those who left were not always replaced quickly.

Star 29/10/97

98

# Valkenberg closure may put dangerous patients on street,

ANDREA WESS  
CITY EDITOR

Increasing numbers of psychiatric patients could find themselves on the streets of Cape Town, - some a danger to themselves or to others - unless they get the help they need.

This is the dire prediction of psychiatrists who are fighting the impending closure of Valkenberg Hospital, which they say will deal a "disastrous" blow to psychiatric care in the Western Cape.

At a press conference at Valkenberg yesterday, principal psychiatrist Francois Daubenton said psychiatric care in the province was already desperately under-funded.

He argued that psychiatric hospitals were the "soft underbelly" of the health service: "It is easy to close psychiatric hospitals because the patients are not vocal. There is a stigma attached to their illness and they do not wish to identify themselves."

Only 8% of the provincial budget (half the international standard) is dedicated to mental health, and the cracks have already begun to show. In the past three months, Valkenberg and its counterparts at Lentegour and Stikland, have had to refuse new admissions several times.

Admissions to long-stay beds have been closed for the last four months, even though there is a dearth of facilities within the community for chronically disabled psychiatric patients.

These are the people most at risk of ending up on the streets, a phenomenon which accounts for more than half the homeless in cities like London and New York.

The fact that 60% of the admissions to Valkenberg Hospital are re-admissions is indicative of the lack of care within the community.

Michelle de Benedictis of Cape Mental Health said it was "shocking that people most sensitive to change" were being subjected to this uncertainty. She said psychiatric patients responded best in a situation of routine, constancy and security.

People on the streets who were chronically ill had very little ability to protect themselves.

Graham Louw of Comcare in

Observatory said the five homes and 10 flats it provided for more than 40 people were closely bound up with Valkenberg. "We take patients ready for discharge who have no family or no appropriate home to go to and the majority of our residents attend Valkenberg outpatients, particularly now that the clinics in the southern suburbs have collapsed."

Dr Daubenton said that closing a psychiatric hospital, without having psychiatric services in local clinics and regional hospitals, was effectively a case of "putting the cart before the horse".

In a letter, he and seven other consultant psychiatrists at Valkenberg have appealed to the public to speak out against the proposed closure of the hospital, because ultimately it would be "the community at large left to deal with this problem due to the deficit of resources".

MLT 29/10/94

psychiatrists warn



Shisana says  
61 clinics (98)  
stand empty

Star 30/10/97  
STAFF REPORTER

Only 11 clinics built in the fast tracking programme stood open for longer than six months after completion, says director-general for health Dr Olive Shisana.

Shisana yesterday told the standing committee on public accounts that 61 of the 227 clinics built in the health department's fast tracking programme since 1994 were not yet operational.

This was because the business plan was approved for the construction and not operation of the clinics.

Chairman of the standing committee Andrew Feinstein criticised the department as irresponsible, saying each empty clinic cost up to R500 000 a year.

She said in a later statement that up to July 19 this year, R710-million would have been spent to provide 460 new clinics, 210 upgrades, and 807 staff houses in providing access to primary health care for 8 million people.

R186-million had been saved on design, construction and escalation. This was sufficient to fund 155 clinics.

# Quarter of new clinics not operational

Linda Ensor

CAPE TOWN — Sixty-one of the 227 clinics completed by the health department in a "fast-track" exercise which circumvented normal tender board procedures were not operational at end-August because there were no funds for operational expenses, Parliament's standing committee on public accounts heard yesterday.

"The business plan which was approved was only for the construction and not for the operation of the clinics," health director-general Olive Shisana said. The problem would be exacerbated because the provinces had no funds to employ staff for the clinics.

Two-thirds of the clinics built in the Eastern Cape had not been operational for 10 months or more.

African National Congress (ANC) committee member Andrew Feinstein

ARG 30/10/97  
criticised the department for having embarked on a rapid clinic-building programme in rural areas without making allowances for operational expenditure.

"It is extremely irresponsible to plan capital spending when it is not clear that the operational expenditure is going to be available," he said.

About R500 000 was being lost every year that a clinic was not functional in terms of the capital cost, he said.

Shisana said the health department had no control over how provincial resources were allocated. When the provinces submitted their business plans for the clinics they were asked to assure the department they had sufficient operational funds. They had also undertaken the construction.

"Clinics take many months to complete and although assurances may be given in good faith, the financial po-

sition of a provincial health department may change in the meantime."

Committee member Barbara Hogan (ANC) said the problem stemmed from the lack of co-ordination between national and provincial government expenditure.

Shisana cited a number of reasons why the clinics had not become operational, one being the time it took to get staffing establishments approved by provincial public service commissions.

Since 1994, 393 clinics had been built with government and nongovernment resources and 2 298 clinics had been repaired.

The department incurred a final unauthorised expenditure of R34m in the 1995/96 fiscal year. Of this a substantial amount was paid to consultants for the clinic-building programme without complying with tender board directives.



# Cost of running clinics 'not known'

Josey Ballenger

THE health department could not say how much it would cost to operate 61 clinics standing unused since construction, but was assessing how provinces could alleviate the problem, director-general Olive Shisana said yesterday.

"We are discussing the provinces' overexpenditure and how they could gain some savings," Shisana said during a break from a meeting with the director-general of state expenditure and provincial health department heads and their budget leaders.

She said the provinces would have to account for "why they don't have the money when they

indicated they did in their budgets", and said they would have to "rearrange" their spending.

Shisana informed the parliamentary public accounts committee on Wednesday that 61 of 227 clinics built under a "fast-track" programme outside normal tender procedures were not operational at the end of August.

Despite previous assurances by the provincial governments that they would have adequate operational funds, Shisana said that this did not seem to be the case.

KwaZulu-Natal has the most unopened clinics (20), followed by Northern Province (15), North West (12) and Eastern Cape (9).

The department had spent

R710m on "improved access to health care" and built a total of 504 clinics by September, of which 393 were in underserved areas.

In addition, 210 clinics were repaired and 807 staff houses built, providing access to primary health care for about 8-million people. Repairs to 2 298 clinics had cost a further R26m.

Shisana said another problem facing government was health professionals' reluctance to work in remote areas.

She said that new legislation binding post-intern doctors to one year of community service would only partially solve the problem and that it was not known when that was going to come into effect.

ED 31/10/97 (98)

# Valkenberg allies press for indaba

ARG 31/10/97

(98) (8)

JENNY VIAL  
HEALTH REPORTER

**Opposition is growing to the proposed closure of the Valkenberg psychiatric hospital in Observatory and a public meeting has called for a planning process for the land before any further steps are taken.**

At a meeting called by the Valkenberg Confluence Alliance, a group of civic and environmental organisations, it was decided that a comprehensive policy plan for the area was needed before a decision could be taken about the future of the hospital and the land on which Valkenberg is situated.

The hospital is on public land and

any plans to develop it should be done with full consultation of all interested individuals and organisations, an alliance official said. As state land it belonged to everyone and everyone should have a say in how it was developed.

The provincial Health Department has said it will consider all submissions on its plans to rationalise psychiatric services which include closing the hospital.

The meeting of Observatory residents and other interested groups opposed any plan to close Valkenberg and said alternatives should be explored. There is at present no policy plan for the Black and Liesbeek rivers confluence area.

In the absence of such a plan and

in the light of rationalisation of health services, this land is now threatened by piecemeal development and change of ownership, says Kate Snaddon, a spokeswoman for the alliance.

Meanwhile Gilbert Lawrence, chief director of supra-regional services, has said the prime objectives of the rationalisation process has always been to improve the quality of service delivery and ensure equitable distribution of services.

Dr Lawrence said stakeholders had until November 10 to comment on the proposals, and a decision would be made public on November 18 after a final evaluation.

See letter, page 11



# Transplant patients being sent home to die

## Over 1 000 people a year cannot get a second chance on life



insplamt op: but more than 30% of all people waiting for a new heart die before one arrives available

### OWN CORRESPONDENT

At least 35 people are sent home to die each week from Government hospitals because there is a dire shortage of donated organs.

From Groote Schuur alone, up to 15 people with kidney failure are sent home a week, rather than being put on a dialysis programme until a kidney is donated. Between 15 and 20 are being sent home weekly from the Johannesburg Hospital.

Up to 30 percent of all patients waiting for a heart or liver transplant die before an organ is available, according to Groote Schuur transplant co-ordinator Fiona McCurdie.

While adult patients in need of a kidney transplant could survive many years on dialysis, they are being turned away because there are insufficient "dialysis slots". "It's not so much a lack of machines, but a lack of staff to monitor the patients on the machines."

While there are an average of 350 transplants of vital organs a year, there are over 1 000 people who will not get a second chance on life.

Across South Africa there are between 80 and 100 people desperate for a new heart, 40 to 50 on the waiting list for a liver and well over 1 500 awaiting kidneys.

Because of insufficient organ donations, only about 350 transplants are performed each year. More than 30 percent of all people waiting for a heart transplant die before a heart

becomes available. More than 1 500 people a year needing a kidney transplant die waiting for a transplant.

Far too few people are willing to donate vital parts of their loved ones to help others so that hundreds die waiting for a vital organ transplant.

As transplant co-ordinator Lyn Botha explained, doctors and nurses often get in the way of saving people's lives because of their own personal beliefs and agendas. "They are often our biggest problem as they sometimes dissuade potential donors. They sometimes keep us away as they feel we would be traumatising the family when, in fact, donating substantially helps the grieving process because people feel their loved one's death has helped others to live."

Not understanding the legalities, doctors also are afraid of being sued if they suggest organ donation to families.

Most potential donors around South Africa die as a result of car accidents. In Gauteng, the second most common cause of death for donors is suicide. Most of these people are aged between 14 and 30.

In KwaZulu Natal, most non-accident-related donors die in hijackings and robberies. In a recent trend, many donors are people from Gauteng involved in car accidents while travelling in KwaZulu Natal.

Many donors who commit suicide are policemen.

In the Western Cape, most of the donors are pedestrians. Ninety-five percent of children who die in acci-

(98) ARG 11/11/97

idents are pedestrians. Apart from accidents, assaults and murder are high on the list of donors' deaths.

Kidney transplants, the most prevalent of organ donor operations, are done in Government and private hospitals around South Africa. The only Government hospital doing heart transplants is Groote Schuur.

The problem with this is that Groote Schuur's medical team expect awaiting-heart patients to live in the region so they do not have to be flown to Cape Town when a heart is available. This means many people have to relocate.

"This is a problem as we are talking about desperately ill people who are depending on their spouses for their livelihood and constant physical support," said transplant co-ordinator Margie Seyffert. This was often impossible because spouses had to give up work to be with the patient in another city and then had insufficient funds to live there.

Because of this, heart patients who did not have medical aid often had no choice but to wait to die at home or in hospital in their own province.

Chris Foster, who is awaiting a heart transplant, said, "It's not easy finding a heart to fit me. It's like going into a shoe shop - you have to get the right size."

Ms Seyffert said that doctors had to ensure "weight for weight" with heart transplants. "You cannot put a child's heart in a huge man because it would not cope." Time is crucial because the person

can be a donor of vital organs only if these are still functioning. Once a person is brain-stem dead, it is a matter of a few hours before the vital organs stop working.

Once the next-of-kin have agreed to their loved one being a donor, the doctors have to ascertain whether the person is brain-stem dead. This requires two doctors, one with at least five years' experience.

In all unnatural deaths, doctors need a state pathologist's permission to ensure that taking the organs will not get in the way of the postmortem.

"So, often we struggle to identify the potential donor, making it impossible to get permission from the next-of-kin in time," said Ms Botha.

In South Africa, most black, Muslim and Jewish people refuse to be donors because of their religious and cultural beliefs. Most donor families are white, coloured or Hindu.

"Many black people do not agree with donating because they see it as desecrating the body," she said. "There is a perception that body parts are ripped to pieces and cut up rather than being removed in a surgical procedure. There is also a terrible fear of body parts being removed and not put into people's bodies, but being sold for muthi."

Ms Botha said the laws pertaining to donors and recipients were far too stringent for any of these things to take place.

KwaZulu Natal transplant co-ordinator Nickie Crookes said that in the past 15 months there had been one

black donor in her area and that was only because a family member was an ambulance worker and understood the need.

"The idea is that one has to meet one's ancestors intact, which is similar to the Muslim and Jewish belief of being buried whole," she said.

However, a majority of recipients, especially of kidneys, were black. "I only wish that these recipients would explain to other black people just how important being a donor really is," said Ms Crookes.

"The truth is that, for most of us, unless we come face-to-face with the desperate need for donors, it is not something we even consider."

Racism did not enter the mind of a recipient, according to the transplant co-ordinators.

"They are so desperate to live, it does not matter whose heart they get," said one.

The co-ordinators are forbidden by law to inform either donor or recipient families of the other's identity. "This law is important as it ensures privacy and protects the families from any undue stress."

However, nothing stops either side from finding out for themselves. "It is quite uncanny how many people have done this only to find that, somehow, they know the other family," said Ms Seyffert.

Invariably, the recipient sends a letter via the co-ordinators to the donor family, thanking them for the biggest gift they have ever received - the gift of life.



# Gauteng hospitals owed R152-m in patient fees

## STAFF REPORTER

Slack administrative practices have resulted in R152-million in outstanding patient fees being owed to Gauteng's state hospitals, the Democratic Party said yesterday.

Democratic Party MPL Jack Bloom said that according to statistics released by health MEC Amos Masondo, Johannesburg hospital was owed R46,4-million, Pretoria Academic hospital was owed R35-million and GaRankuwa hospital, near Pretoria, was owed R15,6-million.

More than R27-million in outstanding fees had already been written off.

"The truly astonishing figure is that about R27-million of outstanding fees is owed by patients who are on medical aid, and therefore payment should be guaranteed, provided there is proper administration," Bloom said.

"These figures reveal the abysmal state of financial

administration in state hospitals, which is confirmed by the admission by Masondo that vacant administration posts in hospitals vary from 10% to as much as 55%," Bloom added.

The Democratic Party legislator called for the aggressive use of private collection agencies, as well as an effort to improve hospital admini-

**More than  
R27-million  
already**

**written off**

stration.  
*Stan 3/11/97*

"It is very disappointing that the much-promised managerial autonomy for hospitals has still not materialised, as it is simply not possible to attract high-calibre administrative personnel at civil service salaries," Bloom added.



# Patients plead for their place of love <sup>(98)</sup>

## *Walkenberg man: 'Please don't shift us, please don't shift us'*

ENNY WALL  
LEATH REPORTER

Walkenberg patients have made an impassioned plea to health authorities to not close their hospital which they say is their anchor, offering them support when they need it.

The threat of closure has left many patients unsettled, say staff. Many long-term patients have spent a large part of their lives at the hospital while short-term patients rely on it heavily.

"We are very depressed," said patient Monica Mtwecu who lives in Guguletu. "We are asking the community to speak up for us to the government. The outside world doesn't understand us. It is only here we are treated as humans with respect and dignity. So please, whoever can help us, do so."

Mrs Mtwecu, who is spearheading a petition to keep Walkenberg open, has already appealed to TRC chairman Desmond Tutu for help. Patients and staff will march to Parliament

today to highlight their plight. "Please, tell them money isn't everything, feelings are more important than anything else," said one patient.

Walkenberg is special, patients say. For some it is the quality of care, for others it is the healing environment. "Here I've learnt to be a person again. Walkenberg is about love and care."

"Ask (MEC for Health Ebrahim) Rasool and (Health Minister Nkosazana) Zuma if they've ever been depressed," said another patient. "We are a cross section of people here, we all have mental illnesses. There is a great need for Walkenberg. I live in horror as to where I will go if it closes."

The main concern for patients is that the two other psychiatric hospitals, Lentegour and Stikland, are far away from where they live. They are also familiar with staff here.

"Do you know that one in eight people will be touched by mental illness in one way or another?" one



JACK LESTRADE

What next? Staff members Nuruh Titoti, Sharon Ndude, Lindiwe Marepuia, Sharon Michaels and Benita Felar discuss the proposed closure of Walkenberg hospital

patient asked.

Another said that because of the stigma of mental illness "they don't care about us".

"If Red Cross was closing, people

would be so upset and would stand against it."

Jeremy King, a member of This Ability, a support group for people affected by mental illness, said his

group wanted Walkenberg to stay open, perhaps in a consolidated form. "A lot of stress is involved with major change. I've built up relationships with a number of staff over the years. They know how my illness works and how to control it quickly. If Walkenberg goes, that would be lost."

A huge infrastructure has been built up in Observatory around Walkenberg, which is not duplicated around Stikland and Lentegour. Places like Fountain House, Cape Mental Health and group homes offer shelter and support for people, an integral part of rehabilitation.

"If you close Walkenberg it's going to cause a lot of hardship to a lot of people," said Mr King.

Social worker Nuruh Titoti said that without these support structures there would be a high relapse rate.

"I'm about to be discharged," a patient said, "but this has been a little bit of a setback. If anything should go wrong I know I can come back. If Walkenberg is not here..."

Asked whether they could instead

go to Lentegour or Stikland, patients said it would be impractical. Those hospitals were already overcrowded, far from the communities people lived in and off transport routes.

"I live in Guguletu, how am I going to get out there?" asked Mrs Mtwecu.

Staff are also concerned about patients' wellbeing should they be discharged. Community psychiatric services are not equipped to deal with people who are mentally ill, they said.

Already, hard-pressed community clinic staff do not have time for home visits or to check that people keep up their clinic visits. A patient said: "A lot of people would end up on the streets. Mentally ill people would slip through the cracks."

In a long-term ward, an old man sums up patients' feelings: "Please don't shift us, please don't shift us."

A website has been set up for those who want to send comments on the proposed closure of Walkenberg to head of health Tom Sutcliffe. It is at <http://freedom.co.za/walkenberg/webboard.html>.

# Province's hospitals are owed R152m (98)

Business Day Reporter

BD 3/11/97  
GAUTENG state hospitals were owed R152m in outstanding patient fees, Gauteng Health MEC Amos Masondo said last week in response to questions put by Democratic Party MP Jack Bloom.

Johannesburg Hospital is owed the most at R46,4m, followed by Pretoria Academic Hospital at R35m and GaRankuwa Hospital at R15,6m.

An amount of R27m of outstanding fees was owed by medical aid patients, where payment "should have been guaranteed provided there was proper administration", Bloom said in a statement which was released yesterday.

Bloom suggested the figure of R27m was an underestimate as several hospitals, including Johannesburg Hospital, were unable to provide figures on their medical aid patients.

"These figures reveal the abysmal state of financial administration in state hospitals, which is confirmed by Masondo's admission that vacant administration posts in hospitals vary from 10% to as much as 55%," said Bloom.

There was a "serious need" for the health department to improve hospital administration as well as upgrading facilities.



# Valkenberg must keep faith with its patients

ARLT 6/11/97 (98)

## Closing hospital would not save much

### INSIDE STORY

There are many reasons why Valkenberg psychiatric hospital should not close. In fact, there are good reasons not to close any of the three psychiatric hospitals. François Daubenton, principal psychiatrist at Valkenberg, spoke to Health Reporter **JENNY VIAL**



The proposal to close Valkenberg Hospital will do little to bring financial relief to the Western Cape health department, nor will it improve access to psychiatric services for the thousands of people affected by mental illness.

In fact, says Dr Daubenton, closing the hospital will mean a deterioration of psychiatric services and ultimately patients will suffer. "The best reason not to close Valkenberg Hospital has to be the consumers of psychiatric services, the patients and their families.

"Patients' well-being depends on stability. They are among the most vulnerable members of society and change affects them to a greater degree than change in physical health services.

"It's important to remember that a large majority are stabilised and controlled with treatment rather than cured, and they get to know us over long periods of time."

This, says Dr Daubenton, is the strongest argument for maintaining all three hospitals, albeit in a downsized capacity. "The counter argument is that people should be seen in the primary health care system. The reality is that effective community psychiatric services don't exist."

For example, Wynberg's community clinic did not provide psychiatric services for two months because of staffing problems, says Dr Daubenton. "And we (at Valkenberg) had difficulty getting access to their folders so we could treat them. It was unbelievable."

The result was a large number of patients had to be readmitted.

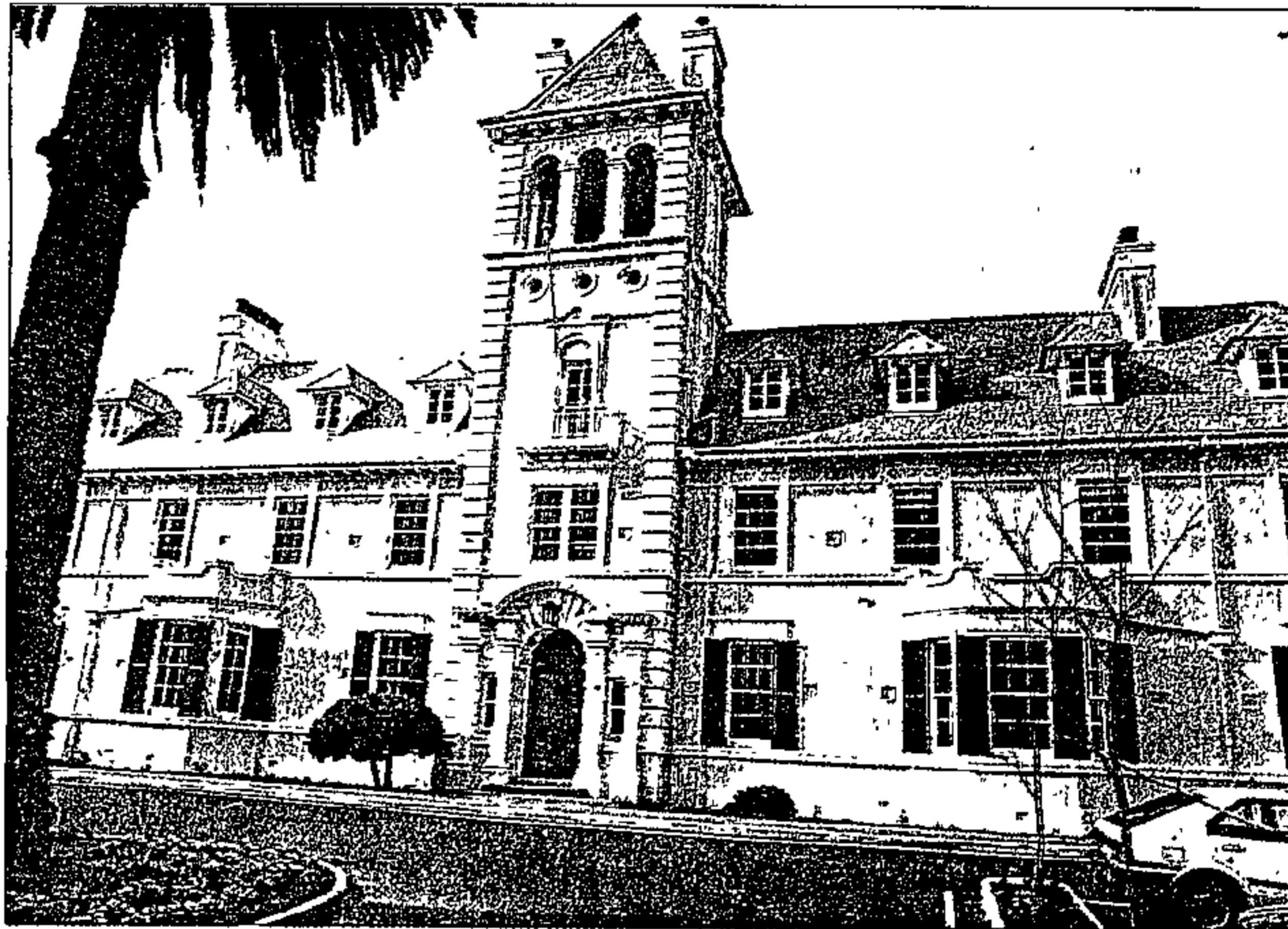
Valkenberg is the busiest, the best-staffed (except for nurses) and the most accessible psychiatric hospital in the Western Cape. It has also a lot of NGO support. Why then has it been chosen for closure?

The reasons are essentially three-fold, believes Dr Daubenton.

■ A report by Health Minister Nkosazana Zuma on South Africa's psychiatric services found it difficult to evaluate Valkenberg Hospital as half the wards were excellent and half were in a terrible state of disrepair. These ought to be closed by the rationalisation process. "Unfortunately I think the bad of Valkenberg was emphasised and that remains in the minds of individuals. But we already have funding support to refurbish wards on the Observatory side."

■ There continues to exist a prejudice around psychiatric patients and units, he says. "Placing psychiatric services on the periphery of cities has always been the norm."

■ The property is valuable, being centrally situated. "A high proportion of our patient base comes from the less affluent sector of society, who rely on



Bastion of mental health care: closing Valkenberg Hospital would save only between R5-million and R7-million a year, says Dr Daubenton



Protagonist: Dr François Daubenton

public transport. Fifty percent of our admissions are coloured, 30% black and 20% white. It's difficult enough for a patient from Hout Bay to reach this hospital. If you close it, how will patients get to Stikland (in Bellville) and Lentegour (in Mitchell's Plain)?"

Dr Daubenton says closing down Valkenberg would save the province only R5- to R7-million a year.

"That's very little considering the R400-million present budget deficit," he says. "If the argument is that we need to close the hospital because of financial problems, the reality is that there is no significant saving. Of the R175 million spent on psychiatric services (out of the Western Cape's R2.47-billion health budget), 85% goes on personnel costs."

Although Valkenberg is on a valuable piece of land, that land belongs to the state, not the province. "The notion that selling state property is going to directly benefit health services is a possibility, but there are a number of steps to take before we get there.

"Psychiatric hospitals occupy immense tracts of land which are very valuable. There is no doubt that portions of land at all hospitals could be alienated. But it's a complex legal process to transfer the land to the province, with no guarantees it will be successful. And, once transferred, there is no guarantee funds will come to health

"With privatisation of state assets, there is a strong lobby which says the money raised should be shared among all provinces," says Dr Daubenton.

Over the past eight years there have been three investigations into psychiatric services.

"All recognised the underdeveloped nature of psychiatric services and the need for them to be integrated into general health care services.

"When the strategic management team (SMT) looked at rationalisation, we from the psychiatric services supported the principles of ensuring services became more accessible, affordable and appropriate."

The mental health task team report, accepted by the SMT, indicated that no psychiatric hospitals should be closed, but all should be downsized.

That report also said there was a potential for a significant reduction in the number of beds to a point where it might be possible to close a hospital over a 10-year period provided the following were adhered to:

■ Psychiatric beds were opened in regional hospitals.

■ Efficiently staffed community psychiatry services were developed.

■ Primary health care nurses and doctors were actively involved with the delivery of psychiatric services

■ In co-operation with the private sector and NGOs, alternative accommodation structures for long-stay patients were developed.

"However, without any of these being complied with, a proposal has

been made to close Valkenberg Hospital. We can downscale. But closing will result in a deterioration of services.

"In the last three months, all three psychiatric hospitals have had to close their male or female admission beds for variable times because capacity had been reached. There is no way we can consider a reduction of acute beds. We could reduce long-stay beds by 80 (out of 227) in a fairly short space of time

"The other cohort of patients for whom we're responsible are the criminally insane, the fastest growing population of psychiatric patients. The closure of Valkenberg would mean building another maximum security unit.

"I find it rather bizarre that they're seriously contemplating moving the unit in a socio-economic climate where there is no money."

Does he hold out any hope that health authorities will not close Valkenberg?

Dr Daubenton replies cautiously: "In my heart of hearts I believe sincerely that if the hospital is not closed it will be as a result of the community voice being heard on this issue.

"The people of the Western Cape will ultimately receive services dependant on their response to this proposal."

Psychiatric staff have been negotiating with decision-makers for eight years on how to best provide psychiatric services. "This proposal indicates we have been unsuccessful in convincing them.

"The health department is saying the proposal is for debate and they will make a decision after November 18. The way they put this proposal to the psychiatric sector is a mechanism utilised at the end stage of a decision-making process."

If the health department decides to close Valkenberg, the provincial cabinet has to approve the decision "hopefully according to the wishes of the population it serves".

***'I believe that if the hospital is not closed, it will be as a result of the community voice being heard'***



# Ex-pats from war-torn African countries find warm haven in hospital under threat

ARG 8/11/97

(98)

ADELE BALETA

Micky, a young Tanzanian, has made his mark in the male admissions section at Cape Town's Valkenberg Psychiatric Hospital.

His brightly-painted mural of an African sunset with a grazing giraffe and a palm beach lights up an otherwise grim sitting-room. For Micky it holds the promise of a better, healthier life in his East African country. Opposite the sunset he has painted a mural of Table Mountain silhouetted against the night sky.

The young man who has been treated for schizophrenia found his way to Cape Town from Tanzania, as have a number of patients from other African countries. He is one of an increasing number of foreign patients to be treated at the hospital, which is under threat of closure by the Western Cape Health Department.

Patients and staff are vociferously opposed to closing the hos-

pital, a move they say is unethical and would violate patients' basic human rights. It would be like "kicking a dog when he is down. It is marginalising the marginalised," says consultant psychiatrist David Kibel.

He and other staff members feel that closure of the hospital would not save the department money, but result in a dramatic decrease in accessibility of mental health services and a severe decline in standards of care. Dr Kibel said foreign patients from war-torn countries in Africa, where there is a complete breakdown in services, were referred to the hospital by police and the Trauma Centre.

These patients place an extra burden on already stretched services. Psychiatric consultant

Sean Baumann had recently treated patients from Mozambique, Angola, Zaire and Burundi. They had psychotic disorders and most were infected with HIV.

"There has been an increasing frequency in the number of people admitted with mental ill-

ness from across the border as far north as Burundi. These people come from countries where there have been extremely

stressful and traumatic events.

"They mostly suffer from psychotic disorders and drift down to Cape Town because there is a complete breakdown in services in their own countries," he said.

Dr Baumann said the greatest problem was the language barrier and the fact that there were few aftercare services to offer.

***Closing Valkenberg Hospital would be like 'kicking a dog when he is down'***

"They are at risk because there is often no family to support them."

He said treating these patients had to be seen against a broader context, which was the potential dangerous situation that would arise if psychiatric services in the Western Cape were under threat. Dr Kibel said that foreign patients were alienated from their families, they suffered economic hardship, cultural alienation and were the victims of xenophobia.

Attempts were made to send people home once they had been treated and stabilised.

The male admissions ward also witnessed a steady stream of black students from the University of Cape Town.

"These students, many of whom are disadvantaged, are under extreme pressure to perform, especially during exam time. They suffer from stress and paranoid illnesses," he said.

Dr Kibel says Micky is doing well and sometimes comes to outpatients.



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AR 8/11/97

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## Closing Valkenberg Hospital would be like 'kicking a dog when he is down'

These patients place an extra burden on already stretched services. Psychiatric consultant

Sean Baumann had recently treated patients from Mozambique, Angola, Zaire and Burundi. They had psychotic disorders and most were infected with HIV. "There has been an increasing frequency in the number of people admitted with mental illness from across the border as far north as Burundi. These people come from countries where there have been extremely stressful and traumatic events.

"They mostly suffer from psychotic disorders and drift down to Cape Town because there is a complete breakdown in services in their own countries," he said. Dr Baumann said the greatest problem was the language barrier and the fact that there were few aftercare services to offer.

"They are at risk because there is often no family to support them."

He said treating these patients had to be seen against a broader context, which was the potential dangerous situation that would arise if psychiatric services in the Western Cape were under threat. Dr Kibel said that foreign patients were alienated from their families, they suffered economic hardship, cultural alienation and were the victims of xenophobia. Attempts were made to send people home once they had been treated and stabilised.

The male admissions ward also witnessed a steady stream of black students from the University of Cape Town. "These students, many of whom are disadvantaged, are under extreme pressure to perform, especially during exam time. They suffer from stress and paranoid illnesses," he said. Dr Kibel says Micky is doing well and sometimes comes to outpatients.





ANDREW INGRAM

Valkenberg patient: Peter enjoys being outside in the hospital gardens. Valkenberg Hospital patients, their families and staff are planning a protest

# Valkenberg objectors plan street protest

*Patients and staff vow to march*

ARG 8/11/97

ADELE BALETA

Hundreds of Valkenberg Psychiatric Hospital patients, their families and staff are planning to take to the streets of Cape Town to protest against proposals to shut down the hospital.

The Friends of Valkenberg, set up to raise funds to upgrade the hospital, is planning the march to the Wale Street offices of the Department of Health.

Members of the National Education Health and Allied Workers Union will be calling on all their members to join in the protest on November 17.

Chairperson of the Friends of Valkenberg, Francois Robertson, said: "The idea of the march is to give the patients a chance to express themselves. They want everyone to know what the closure of Valkenberg Hospital would mean for them and their families."

The Department of Health has proposed the closure of Valkenberg as part of the rationalisation of health services in the province and to increase the accessibility and affordability of the service for all.

The plan includes resettling the mentally ill patients at Lenteguur or Stikland Hospitals.

But the department's rationale for the closure has been criticised by medical staff, non-governmental organisations, patients and their families.

They believe that accessibility to services for the mentally ill will decrease and more and more patients will be left with-



Valkenberg Sunset: consultant psychiatrist David Kibel

out anyone to care for them. They have warned of the potentially dangerous risks involved for the patients and the public.

This week a Matroosfontein grandmother, Petronella Kleinhans, 82, was fatally stabbed by her grandson who was dis-

charged from Stikland Hospital. Despite appeals from his family, the hospital refused to readmit him.

Patients and staff have said that Lenteguur and Stikland hospitals are not an option for many patients who have to survive on a monthly R480 disability grant, and are not able to trav-

el the distance to these hospitals. Taxis and buses did not adequately service the route.

Valkenberg sister Theresa Gogela who lives in Guguletu said it was "unsafe" for her to travel to Lenteguur Hospital.

In a report this week, principal psychiatrist of Valkenberg, Francois Daubenton, said that closing the institution would not mean a great financial saving.

The Friends of Valkenberg have embarked on an innovative advertising campaign to challenge the department's plans to close Valkenberg

In the cleverly-worded adver-

tisement in editions of this week's Cape Argus, members of the public who are concerned about the fate of the hospital are encouraged to contact health department head Tom Sutcliffe directly. A fax and phone number is supplied.

Since then, the department has been bombarded with petitions from organisations and individuals.

Mrs Robertson said that organisations linked to the hospital, such as the Ark and Adam's Farm, will not be able to take on mentally ill patients without the support of Valkenberg.

She said the Friends of Valkenberg, started two years ago, had recently lined up two major sponsors but they pulled out with the department's announcement that the hospital should close.

Mrs Robertson said that Lenteguur and Stikland hospitals would not be able to accommodate the extra patients that Valkenberg admits, especially patients with acute problems.

Valkenberg's consultants say the proposed closure of any psychiatric hospital in the province, without first addressing the deficits in clinics and regional hospitals, would result in the inability of the public sector to give psychiatric services, as guaranteed in the constitution.

The result would be individuals not getting the help they need, and could thus pose a danger to themselves and, perhaps, to others.

***'The patients want them to know what the closure will mean for their families'***



# Health workers allergic to gloves

AYESHA ISMAIL (98)

31/11/97

HEALTH workers at Groote Schuur Hospital have become allergic to latex items such as surgical gloves.

Cheap, poor quality latex products bought because of budget cuts have been blamed for the allergy outbreak, which has affected more than 80 workers.

Paul Potter, associate professor of UCT's Allergology Unit, warned that allergic reactions to latex could be severe and even fatal.

Potter fears that health personnel across the country could be in

danger and has called on other hospitals to act swiftly if staff become allergic.

He has warned that unless latex exposure in hospitals is limited, an increase in allergy from the present 10 percent of staff to about 25 percent could be expected.

Groote Schuur authorities have moved allergic staff to latex-free areas. But this is not easy as latex goods, such as gloves, tubing and containers, are found extensively in the hospital.

The hospital has formed a special committee to deal with the allergies and has started a latex clinic where staff are treated.

The hospital authorities are also developing a policy on latex which includes a wider use of powder-free gloves and a latex-free operating theatre.

Latex allergy symptoms include itchy eyes, coughing, wheezing, asthma and anaphylaxis (when victims enter a state of shock).

Potter said: "Increased glove usage over the past eight years and cheap quality gloves appear to have caused an increase in latex allergy. Because of budget cuts, cash-strapped hospitals have been forced to buy the cheap gloves."

He called for the use of better quality, powder-free gloves.

# Many not paid for extra load

By **BARRY WEST**  
City Reporter

(98) Stan 10/11/97  
~~SP~~

More than 200 Gauteng hospital and health employees, from porters to assistant directors, are doing more senior jobs without being paid for their increased responsibilities.

According to Health MEC Amos Masondo, 221 staff members, including 12 from his own office, are performing their duties only in acting capacities.

Masondo released the figures in response to a question by the DP's Jack Bloom on conditions in Gauteng's health sector.

Bloom said the two worst cases seemed to be that of an R Nugent from Nigel Hospital and Dr I van der Werke of Kala-fong Hospital. He said Nugent has been an acting administrative clerk since June 1980, and Van der Werke, a senior radiologist, has been acting chief specialist since January 1982.

Neither could be contacted for comment last night.

Masondo said there had been "some delay" in making permanent appointments, mainly because of a moratorium placed on filling posts. He said a task team had been convened to streamline the procedure.



# Patients to pay price of closing Valkenberg

**CYNTHIA VONGAI**

MS BELINDA CONRADIE is 27 years old, a mentally ill patient and she lives alone.

Conradie is a manic depressive and is currently a patient at Valkenberg Hospital after a "manic" attack. She, unlike other mentally ill people, is lucky enough to have a support structure once she is released.

Her parents are divorced. Her father lives in Pretoria and supports her financially, her mother lives in Kenilworth and visits her regularly.

Besides her family support, Conradie belongs to a mental support group, "This Ability", which meets once a week to help patients who have been reintegrated into society. She has also been admitted to a rehabilitation programme run by the Fountain House, an Observatory non-governmental organisation.

"I have been here five weeks but I have also been in and out of the hospital many times. When I came to Valkenberg a few weeks ago they could not admit me (because the hospital was full), so I was referred to Lenteguur, which turned out to be an acute lock-up.

"I know one thing for sure: If Valkenberg closed and I became severely depressed I would not return to Lenteguur. I would rather kill myself and I probably would, especially when I am in that state.

"People do not realise that when you are treated with respect, you heal. When you are locked up and treated like a child with no choice on your healing process, you become worse.

"I asked whether I would be locked up at Lenteguur and I was told no. When I arrived there, I was, and my medication was changed. I would never go back there," she said.

Unlike Conradie, Ms Monica Mtwecu, 23, does not have a good support structure once she leaves Valkenberg.

She lives in Guguletu with her parents, who, because of the stigma associated with mental illness, leave her to deal with her depression alone or send her to Valkenberg.

When she is well she stays at home and her problems are not discussed. There is no support structure for her except for a visit to the local day hospital or clinic.

"I am Xhosa. In my home I cannot sit down with my mother and tell her about my depression or illness," Mtwecu said. "My parents think I am acting like a child. They do not understand that I am ill and that I need help to cope.

"At Valkenberg I have group therapy and I can talk about my problems. If this place is closed, they will take away my right to live in a normal society.

"Lenteguur — I do not think I would go there — it is too far for me and I cannot start explaining and talking about my feelings all over again. I will probably stay at home. I do not know what will happen."

(98) (98) CT 11/7/97

# Valkenberg may be saved if province heeds call for team

EMMY WALL  
HEALTH REPORTER

Valkenberg Hospital may not lose, at least in the immediate future, if the provincial cabinet agrees to appoint a team to

investigate the future of psychiatric services in the Western Cape.

Health Department management has recommended that a task team be set up to investigate the implications and potential benefits of various

options of rationalisation, including the closure of Valkenberg, and to recommend cost-effective solutions.

If the team is appointed, the decision about Valkenberg's future will be postponed until it completes its work.

Further recommendations are that Stikland, Lentegour, Valkenberg and Alexandra hospitals be managed jointly.

The province will hold public hearings on Monday on the future of psychiatric services.

Head of health Tom Sutcliffe said his department had noted with great interest the response and debate on proposals for psychiatric services contained in a draft report issued on October 20.

No further decisions on rationali-

sation would be taken until the major interested parties had been consulted on the task team's recommendations.

Dr Sutcliffe said his department appreciated the input from the public, non-government organisations and health professionals on the clo-

sure of Valkenberg Hospital

"The issue at stake goes well beyond the closure of a psychiatric hospital and must encompass a vision for total future mental health services. Change is being forced on us by a number of issues," he said.

**to probe options**  
(98) PRG 12/11/97



## Doctors fear breakdown at hospital

Star 14/11/97 (98)  
By PRISCILLA SINGH

Doctors at the Helen Joseph Hospital, formerly JG Strijdom, fear there will be a breakdown in services unless a dispute between management and a union is resolved.

Staff at the hospital, in Johannesburg's western suburbs, is being called a "rudderless ship" because of the recent resignations by superintendent Dr Blumeris Niewoudt and his deputy Dr Frikkus van der Merwe.

Niewoudt resigned for the second time in six weeks at the end of last month, allegedly over disagreements with the National Education, Health and Allied Workers' Union (Nehawu). Van der Merwe left last week.

Dr Martin Smith, chairman of the medical advisory board, said yesterday there was a collapse of management at the hospital and if this situation was not rectified it would affect service delivery and ultimately the patients.

The two superintendents were needed to order medical supplies and sign for the goods, and no one else had the authority to do so.

The Gauteng Department of Health has appointed the superintendent of Coronation Hospital to act in the same capacity at Helen Joseph, while

looking after his own institution as well, but Smith said as far as he was aware this move had not yet been implemented.

"The conflict right now precipitated the crisis which has been brewing at the hospital for a long time," said Smith.

He said the concern also was that there had not been adequate handling of the labour issues, which, while he could not be specific, were varied and numerous.

Smith said the doctors were not taking any sides in the disputes and their main concern was for the patients.

In an attempt to mediate between the different parties, the medical advisory board would meet Nehawu today, he said.

However, Paul Pudi, chief shop steward for Nehawu, yesterday denied there was any crisis or problem between the union and management.

He also expressed surprise at the doctors' request for a meeting: "I really don't know the purpose of the meeting. We (Nehawu) have always had a good relationship with the present management." Pudi said this included Niewoudt and Van der Merwe.

The Gauteng Health Department has also been drawn into the crisis. It was asked to intervene a few months ago and is investigating claims made by management and Nehawu.

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# Seeking sane solutions for mental health care dilemma

REG 14/11/97

(98)

The debate on mental health services needs to be brought back on track, says Gilbert Lawrence, with the focus on a vision of how to provide services to all the people of the Western Cape.

Two weeks ago Dr Lawrence tabled his report "Mental Health into the 21st Century" on rationalising mental health services and asked for comment on it. And comment he got.

The department was inundated with a flood of submissions, many initiated by the campaign to save Valkenberg Hospital.

Dr Lawrence said he was disappointed that while he asked for comment on the plan as a whole, the proposed closure of Valkenberg stole the limelight.

"I think the criticism has not been so much criticism of the plan as such but perceptions of pace and scale of change, for instance how great down-scaling should be and what should be the sequence," says Dr Lawrence.

"Those are useful and we need to be addressing them. But at no stage did anybody say that Valkenberg is closing by such and such a time."

For mental health services to be effective, everyone needs to work together, he says. An adversarial situation is counter-productive.

Unfortunately the Save Valkenberg campaign has been "excessive" in trying to prevent the closure of the hospi-

The storm unleashed by the proposal to close Valkenberg

Hospital has obscured the bigger picture of

mental health provision in the Western Cape, says Gilbert Lawrence, head of Supra-Regional Hospitals in the province.

JENNY WALL spoke to him



tal, he says, while few inputs have been received on how to work together and look to the future.

The future for the health department is one in which budget cuts are getting worse and worse.

"We are faced with two issues," says Dr Lawrence. "We have to address budget constraints but we also have to have a vision for the future."

"If we just look at our shoes and try to save money then we will become totally ineffective and demoralised."

Why has a task team been appointed to further investigate mental health when there has already been years of discussion and consultation?

The debate has gone off track, says Dr Lawrence. There have been asper-

sions cast on Lentegour hospital, voiced publicly, saying it should close, and now there is a Save Lentegour campaign.

"So we have decided to suspend the issue and have a task team look at the inputs. Hopefully this will bring it back on track," he says.

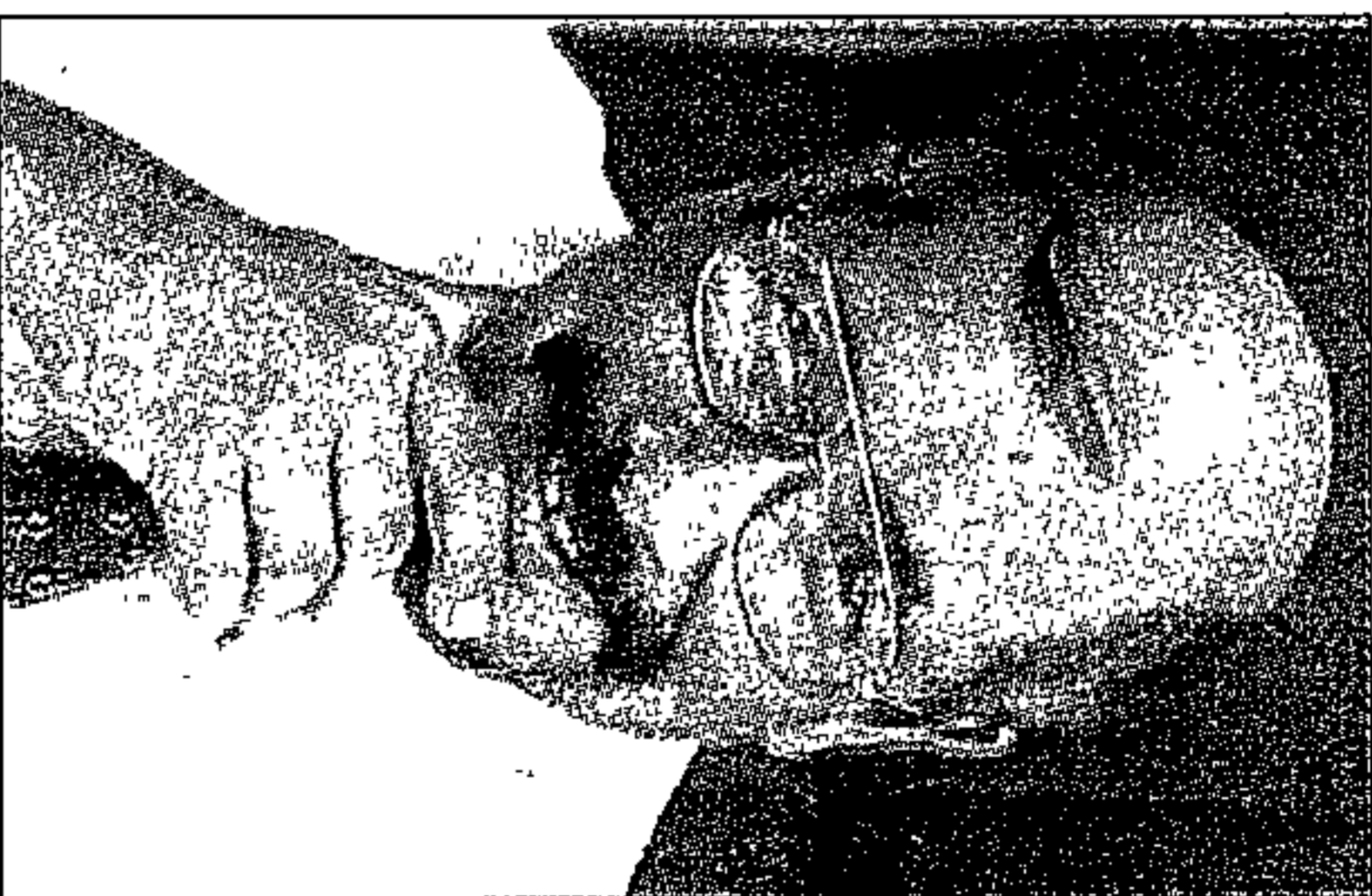
The task team, to be appointed soon, will investigate various options of rationalisation and recommend appropriate cost-effective solutions. Its lifespan will be weeks rather than months, says Dr Lawrence, and then decisions will be taken.

"However, given budgetary constraints, and they've actually become worse since we issued that plan, I personally see no other way but to close one of the aggregated hospital sites," he says.

Financial constraints in the Western Cape have had a dramatic effect on health services. Staff numbers in April 1995 were 33 295; they are now 27 900, a decrease of 5 395. To meet the budget over the next three years another 7 000 posts will have to be shed.

Within this framework the health department has to provide more accessible health services to those who have historically not had access.

"We have to have a vision and redress some of the problems we are facing in spite of budget constraints," says Dr Lawrence.



Inundated: Gilbert Lawrence got response

"People say you cannot have services in other places because they are far, because they are gang-infested, there is no infrastructure. Well, that is a chicken and an egg situation.

"The arguments are that there are problems around travelling and safety. That's true, but remember our staff are working in those areas, there are people who have to travel the distance. So the problem is not the issue, how we

address it is.

"We now have four institutions, the majority filled with chronically ill patients. We have to address the issue that there are more patients outside the hospitals who need services and we do not have the capacity to provide relief for those who need it.

"People say that closing a hospital means patients will be dumped on the streets. That's not so. Those patients, instead of being spread over four hospitals, will be in three hospitals. There must be economies in scale."

The health department will also make the vast sites more manageable by alienating some of the land.

"What we are addressing is basic principles of human rights. Now you can ask: is it only the right of that individual in a Valkenberg ward to have care or is it the right of a patient in Khayelitsha or Constantia who also has a mental health problem?"

"We have to look at the bigger picture as well as the smaller picture."

Budget constraints may force a rapid acceleration of the province's plans for mental health, he said.

"We would like to ensure that we have facilities in place in communities, beds in regional hospitals to deal with psychiatric patients and we would like to have a referral network.

"But we are struggling to do that. So we have put a plan on the table. Cer-

tain things can be implemented rapidly. And there are longer time frames which will be constrained by other issues like the lack of resources.

"For example the current situation is that we may not be able to appoint a single staff member between now and the end of the financial year. That will have dire consequences for the health service, not just mental health services. Lentegour and, to a lesser extent, Alexandra hospitals, which don't have direct links to universities, also need to be assisted.

"People have said 'Why do you want to lose one of four hospitals, don't you need more hospitals?' And the answer is, not really, if you have this plan in place, if you have group homes set up and if you have regional beds. The debate is where do the 'ifs' come in. The crisis is facing us across the board and what I think has been very positive has been the way all NGOs have responded to the Save Valkenberg campaign.

"They are saying they are supportive of our programme. They've given all the reasons why it works, transport, accessibility, safety, consistency of interaction. Is it not selfish to say it works here, leave it alone?"

"The question is how do we share those resources with other areas? It will be wonderful to get an indaba of NGOs to take up that challenge."

## Lives risked with speeding up of plan for Gauteng hospitals

BY JAMIE SIMON

Lives may be at risk because ambitious plans to equalise the Witwatersrand's public hospital services are being speeded up to meet budget pressures.

Hillbrow Hospital will be downgraded to a community health centre on December 24.

In its place, new specialist services will be set up for hospitals in the areas from which many Hillbrow patients come.

*Star 17/11/97*  
The new services will be provided by a pool of doctors, according to a series of hard-won agreements between provincial health authorities and academic departments at Johannesburg Hospital.

Doctors fear Hillbrow patients will go straight to Johannesburg - the nearest and most overloaded tertiary hospital - ignoring improvements at Edenvale (near Alexandra), South Rand (The Hill), Tambo

*(98)*  
Memorial (East Rand) and Leratong (West Rand).

Morale has hit rock-bottom at Johannesburg, which intermittently closes its casualty section for up to 12 hours when beds are full. Hillbrow doctors warned that further overcrowding at Johannesburg could increase the chances of patients dying before getting attention.

► Hospital revamped

Page 3



## Revamp and expansion give hospital a big boost

(98) Star 17/11/97

By PRISCILLA SINGH  
Health Reporter

Edenvale Hospital on Modderfontein Road on the East Rand has a new lease of life.

About three years ago it was widely rumoured that the 108-bed community hospital was earmarked for closure. Instead the Gauteng Health Department has upgraded it into a small regional hospital with about 220 beds.

Superintendent Dr Mervyn Damelin is thrilled about the alterations and expansion and says the institution is nearly ready to cope with the expected influx of patients from nearby Alexandra; former patients of Hillbrow Hospital, which closes next month; and Kempton

Park Hospital, which closed its doors a few months ago.

The grand changes at Edenvale Hospital form part of the health department's restructuring plan, which aims to adjust inequalities, staffing and facilities in the health sector.

So far, a new 28-bed obstetrics and gynaecological ward and a 28-bed paediatric unit have been completed. Only equipment and staff are needed. A five-bed high-care paediatric section has also been built.

"We will be getting equipment and staff for the obstetric ward from Hillbrow Hospital when it closes. I expect this to be about the middle of December. The new paediatric unit is already half full," Damelin said.





Down with management ... workers belonging to the National Education, Health and Allied Workers' Union at Helen Joseph Hospital toyi-toyed in the foyer yesterday during protests against alleged racial inequalities at the hospital. The angry group of women threatened and jostled The Star's photographer.

# Crisis deepens in hospital labour clash

Pandemonium reigns and officials are attacked in battle over black advancement

By PRISCILLA SINGH  
Health Reporter

Management officials at Helen Joseph Hospital in Auckland Park have refused to report for duty from today for fear of their lives.

In another move which also threatens to cripple the hospital, about 700 members of the National Education, Health and Allied Workers' Union (Nehawu) were due to embark on a strike today.

Police were called yesterday after six administrative staff members were evicted from their offices and others were slapped in the face by union members.

The Gauteng Health Department will hold an emergency meeting with the hospital's acting management and represen-

tatives of Nehawu today in a bid to prevent further disruptions and find a way to resolve the crisis.

The workers include cleaners and laundry and kitchen staff. Ambulance drivers have not only refused to drive their vehicles but have also refused to hand the keys to the hospital, according to acting superintendent Dr Arthur Manning.

The hospital was in a state of pandemonium yesterday when six management officials were attacked and physically removed from their offices, apparently by Nehawu workers.

Management called the police to intervene, but Nehawu shop steward Paul Pudi said workers persuaded the police not to arrest any of their comrades.

Tensions have been simmer-

ing between Nehawu and hospital management for a long time and have resulted in the resignation of superintendent Blumeris Niewoudt and his deputy Frikkus van der Merwe.

Niewoudt resigned from his post for the second time in six weeks at the end of last month, and Van der Merwe left last week, both apparently as a result of the conflict with the union.

A group of about 70 Nehawu members from various departments chanted slogans and sang union songs in the foyer of the administration building yesterday while Nehawu held discussions with doctors.

"The reality at Helen Joseph is that whites within the hospital are rejecting the changes which were supposed to take place in the new South

Africa," Pudi said. There were no blacks in senior administrative posts despite Nehawu approaching management to talk about these inequalities.

"There is nothing we can do now. The workers are angry and are not prepared to sit for negotiations, it is too late. It is now up to the Department of Health," Pudi added.

He denied there had been any incidents of violence or intimidation on management, but claimed instead that management had authorised a traffic policeman to assault him on Friday.

"The workers have decided that enough is enough, and they cannot allow me to be attacked through authorisation by management," Pudi said.

Manning said yesterday that the problem was caused by

Nehawu wanting to see immediate promotion of blacks into senior positions and the union's unwillingness to wait for posts to become vacant before this could happen.

"Nehawu wants to see more black people in senior posts and wants this to be done immediately.

"Since last week, Nehawu members have been invading administration offices and preventing people from working," said Manning.

Gauteng Health Department chief director of human resources Dawn Joseph condemned any "acts of violence and coercion".

"It is intolerable for health personnel to reduce a public hospital to chaos and to prejudice patient care in pursuit of their own interests."

(98)  
Star 18/11/97



# Steady erosion of staff, standards, teaching



Warning: Professor SR Benatar

Recent trends in macroeconomic policies and national budgeting processes in South Africa have resulted in major reductions in State allocation of funding to the Western Cape Province.

There has also been a shift in emphasis away from hospital medicine towards primary and community based health care in response to the apartheid legacy of maldistributed health care services.

The overall reduction in funding to the province and the shift in distribution of resources are having radical short term effects on the delivery of health care and will have profound long term implications for medical education and health services.

The public at large is beginning to perceive these trends but has not been adequately informed. It is in their interest to be made more aware of the changes and their significance.

The extent to which health care services have been curtailed in recent years is illustrated by the following data.

By March 1998, personnel employed in the health services in the Western Cape will have been reduced to 27 500 from 33 295 in April 1995. But this has not met the stringent target of 21 000 personnel for which the 1998 budget makes allowance!

Hospital beds have been reduced from 14 709 in March 1995 to 12 128 in June 1997, and further reductions are planned.

By October 1997 as many as 4 047 health care staff had taken the voluntary retirement package. Of these 17,7% were administrative staff, 36,8% were nurses (mostly senior and highly trained), 1,3% were medical staff, 10,8% technical staff (also the most highly trained and least dispensable), and 33,7% general and general assistant categories of staff.

Many more medical staff have been lost through retirement and transfers to the private sector or academic positions elsewhere – and these posts have since been frozen.

The totally random way in which attrition of staff has been allowed from some of the most vulnerable areas of health care provision has had an even greater detrimental impact than if carefully planned reductions in person-power had been implemented as a cost-containing measure.

Remaining professional and technical staff are thus working under increasingly difficult conditions trying to provide quality services to an expanding population.

The adverse effects being experienced resemble those which have now been well documented in other countries following the imposition of notorious structural adjustment programmes by the International Monetary Fund and the World Bank.

These include an overall reduction in health services for the poor within less efficient and less effective public health care systems, the growth of private medical care at increasing and unsustainable cost, and erosion of capacity to educate future generations of health care professionals.

The reduced scale of efficiency in public institutions has severely undermined the infrastructure required to maintain equipment in good condition, to provide food and clean linen, to maintain cleanliness, to

## INSIDE STORY

The rush to achieve much-needed change in the country's health services has brought with it errors of judgment which have serious implications for the future, writes Professor **S R BENATAR** head of the University of Cape Town's Department of Medicine and Chief Physician at Groote Schuur Hospital

transport patients safely and promptly to x-ray facilities and operating theatres, and to provide the personal care, compassion and attention required by sick patients.

Escalating theft of drugs and materials, and the pressures from unions to increase salaries have further reduced work output relative to expenditure.

As productivity and quality of work have never been considered when allocating budgets (available objective data is ignored by those who provide the funds for health care), there is little appreciation of the extent to which these changes have resulted in less value being obtained for money spent on health care – a form of erosion that is difficult to document objectively.

But deterioration in the quality of overall care delivered is apparent to many.

The training of doctors, nurses, and other health professionals is also being undermined. Sadly, sophisticated skills built up with dedication over many decades are being devalued and future generations of health educators are being driven away from public institutions.

The ability to sustain modern medical care in a teaching hospital in the public sector is becoming even more patchy and less sustainable without the back-up of viable academic institutions – which function as the dynamos for education and practice.

The aspirations of universities and those of the provincial health services – previously integrated into a seamless web of clinical services, teaching and research – are thus now being roughly torn apart. While the province is shifting resources away from academic hospital complexes, universities wish to increase student numbers and to intensify teaching and academic functions.

It does not take much imagination to appreciate how such poorly planned changes will adversely affect medical practice – initially in the public sector but inevitably and very soon in the private sector as well.

There are at least two explanations for what is happening. First, the dangers described are not being recognised, or at the

very least are being underplayed.

In the rush to achieve much needed change insufficient attention is being paid to more innovative pathways to change that could optimally utilise existing strengths to fashion a transformed but also very strong public health service.

Second, and more ominous, the process could be deliberate with the intention of gradually restructuring our medical schools into centres for training only primary care practitioners to meet the needs of neglected rural populations. This will enable future ministers of health to allocate graduates to any part of the country with impunity, as they will have no where else to go.

Academic institutions will either have to accept this as their changing role in the new South Africa, or will have to take on the responsibility of generating their own resources for teaching and other academic pursuits. As academic functions are undervalued by the State the latter course will be inevitable if universities wish to retain highly skilled and highly motivated professionals capable of providing sophisticated services for the poor in the public service and undertaking research.

At best, further training for a select few may be retained in the future in public/private liaisons which will survive for a little longer than purely public academic centres in this milieu – and this education will be available predominantly to the rich.

The need to restructure health care services and medical education inherited from the apartheid era is quite clear. The undisputed goals are to achieve more equitable access to affordable and appropriate health care at primary, secondary and tertiary levels with an effective and efficient referral chain.

The rationale for such change and the means of achieving it, intensely debated in the 1980s, seem to have been forgotten.

The burning question of how these goals can be achieved remains. It is necessary to ask whether the current ideological approach with all its errors of judgement and deficiency of consultation can be converted into the desired democratic dialogue – characterised by due process, at least some rationality, and accountability.

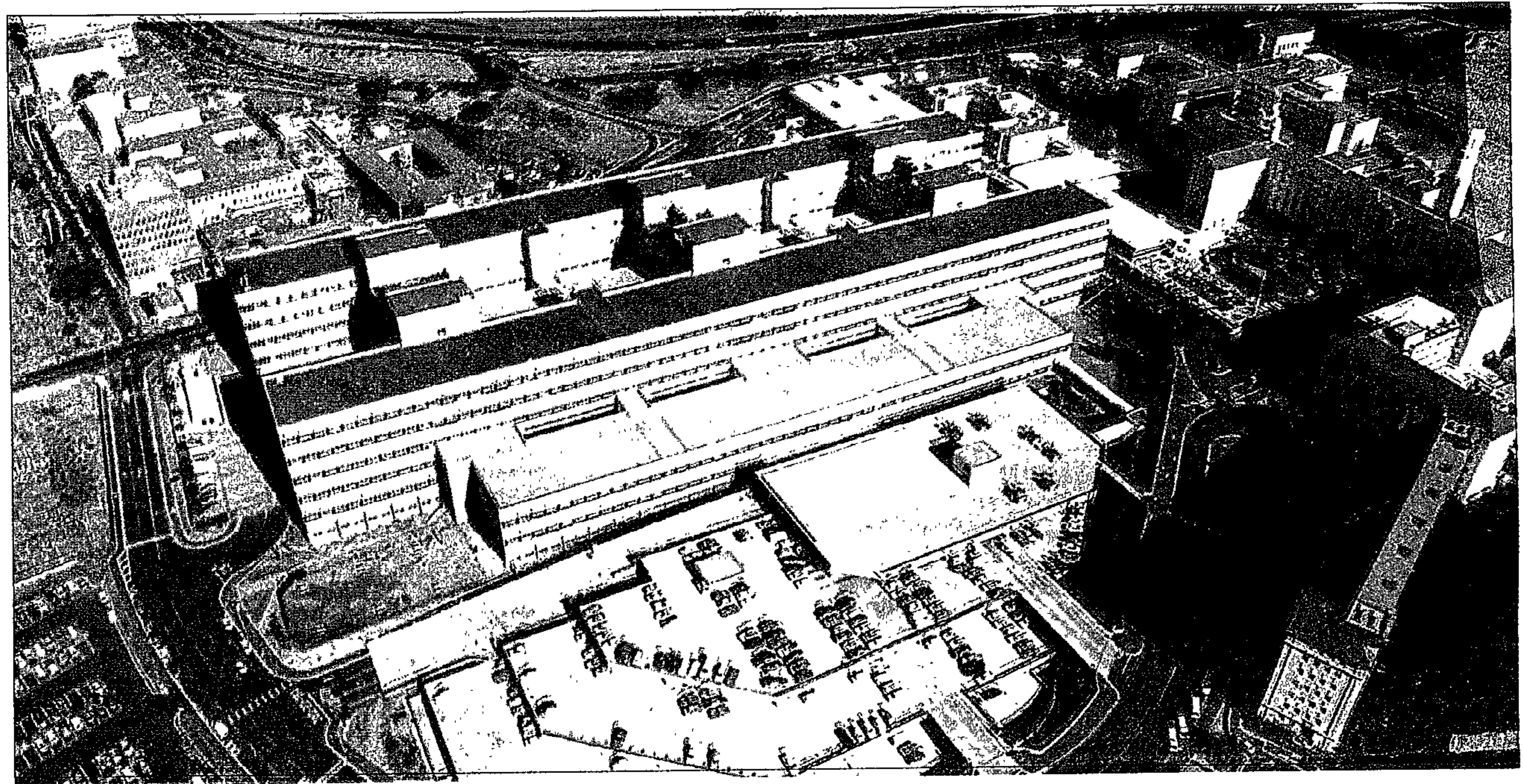
As medical education and health care vary greatly in our eight medical schools and nine provinces, reform processes will have to be contextually appropriate.

Acknowledging this and carefully considering the implications of different starting points for reform could facilitate the construction of a mosaic of training facilities and health care delivery activities that will be more effective and more sustainable than the simplistic and impoverished vision of a stereotypic primary care service in isolation.

The beauty, unity and utility of such a mosaic can best be appreciated by viewing it from a broad and imaginative perspective that incorporates an understanding of the complex requirements for economic growth in the future.

***'The ability to sustain modern medical care in a teaching hospital is becoming even less sustainable'***





**Future uncertain:** increasingly stringent budget cuts are affecting the ability of hospitals like Groote Schuur to deliver the quality of care they would like to provide to patients

# **'Quick-fix' solutions are damning medical care**

*ARG 18/11/97*

*(98)*





# Union-management clash hits hospital

Vuyo Mvoko  
and Josey Ballenger

CHAOS erupted yesterday at the Helen Joseph Hospital in Rossmore, Johannesburg, when members of the National Education, Health and Allied Workers' Union (Nehawu) "forcibly" removed the hospital's acting superintendent from his office.

A shaken Roelof van der Berg, who was whisked away by police, said workers had accused him of being "racist" — a charge he denied. Fifty to 60 workers had dragged him and two clerks out of their offices and "trapped" staff in the reception area.

Van der Berg said "lots of trouble" had been brewing for months between

BD 18/11/97  
the union, which consists of black support staff, and the mostly white management. "It's a black and white thing; they say they want us out of here."

Gauteng health department human resources chief director Dawn Joseph said senior managers and the department's labour relations unit would hold an "emergency" meeting with the union and hospital management today "to put additional controls in place to prevent any party at the institution resorting to physical force".

Joseph said: "Without prejudging the validity of various allegations and counter allegations in this matter, the department wishes to make it clear that coercion and violence will not be condoned as means of settling dis-

(98)  
putes. It is intolerable for health personnel to reduce a public hospital to chaos and to prejudice patient care in pursuit of their own interests."

Nehawu officials refused to comment, saying they would wait for a briefing from their shop stewards.

National Party Gauteng MPL and health spokesman Nana Masango said pointers to yesterday's incident — such as alleged assaults by union members on a radiographer and a nurse on Friday — had been reported to the department and could have been prevented. She accused Gauteng health MEC Amos Masondo and the Congress of SA Trade Unions of "turning a blind eye".

Picture: Page 2

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## Hospital services on track amid dispute

(98) Star 19/11/97

Services at Helen Joseph Hospital in Auckland Park were not disrupted yesterday, despite fears that the hospital would be crippled by a planned strike by members of the National Education, Health and Allied Workers' Union (Nehawu).

Union members engaged in "sporadic toyi-toying" but the protests did not disrupt hospital services or affect patients, said acting chief superintendent Dr Arthur Manning.

Nehawu's 700 members are protesting against what they see as management's failure to appoint blacks to senior posts.

Gauteng Health Department officials held talks with Nehawu and the hospital's management yesterday in a bid to resolve the conflict. An independent inquiry is expected to begin investigating the causes of the conflict at the 740-bed hospital today. The parties had agreed on who should conduct the inquiry, but these people had by last night still not confirmed their availability.

Hospital spokesman Dawn Joseph said all parties had undertaken to "refrain from any disruptive action with immediate effect". - Health Reporter

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# Long-awaited Red Cross revamp under way

## But R16-m still needed to finish outpatient, emergency services upgrade

ARGUS 19/11/97

(98)

LENORE OLIVER  
STAFF REPORTER

After more than two years of intensive fundraising, redevelopment of the R36-million specialist outpatients and emergency services at Red Cross Children's hospital has finally begun - to the delight of staff, parents and patients.

The well-known hospital is the only dedicated, specialist children's hospital in southern Africa and treats all referred children as well as emergency cases.

In a remarkable show of unity, the public, business sector, schools and hospital staff came together with the Red Cross Children's Hospital Trust more than two years ago to start raising funds for the hospital - a vital national institution in dire financial straits.

All the effort paid off and in just two years, R20-million was raised - enabling bulldozers and workmen to turn the first sod at the beginning of the month.

But R16-million is still needed to

complete the hospital makeover, scheduled to be complete by 2000.

Medical sisters and chief hospital redevelopment planners Fleur Key and Toni Whithair are excited that building is finally about to start.

They were on the first committee to moot the idea of redeveloping the hospital 11 years ago.

"It's wonderful to see an idea which started so many years ago come to fruition," they said.

The project is a redevelopment and upgrade of existing facilities currently housed in prefabricated buildings.

David Beatty, chairman of the Trust, said the current specialist outpatient and emergency services was housed in 30-year-old prefabricated buildings which leaked during winter and baked in summer.

"If we want to remain able to treat the sickest of southern Africa's children, we need to ensure adequate facilities in which doctors can do this," he said.

One of the main features of the redevelopment is a parents' accommodation centre to house parents of

children who are being treated at the hospital.

Medical superintendent Saheed Hassim said the aim of the parents' accommodation centre was to maintain contact between the children and their families.

"This is in line with the international trend where doctors don't want children to feel lost, and at the same time parents are taught how to cope with, and treat, their children when they return home," said Dr Hassim.

Other new departments include surgical and medical consultation specialist clinics, night observation rooms and emergency services.

Dr Hassim said that the redevelopment would put the hospital on track to deliver what it was supposed to deliver.

"We can now fulfil the role we're meant to, and that is to provide a comprehensive service to children in the Western Cape and the whole of southern Africa."

The new building will enable patients to visit the hospital as outpatients instead of being admitted - and this has financial implications.

"Our new facilities will mean we will be able to treat patients more cost-effectively."

Dr Hassim said the new facilities would also enable them to treat more children than previously.

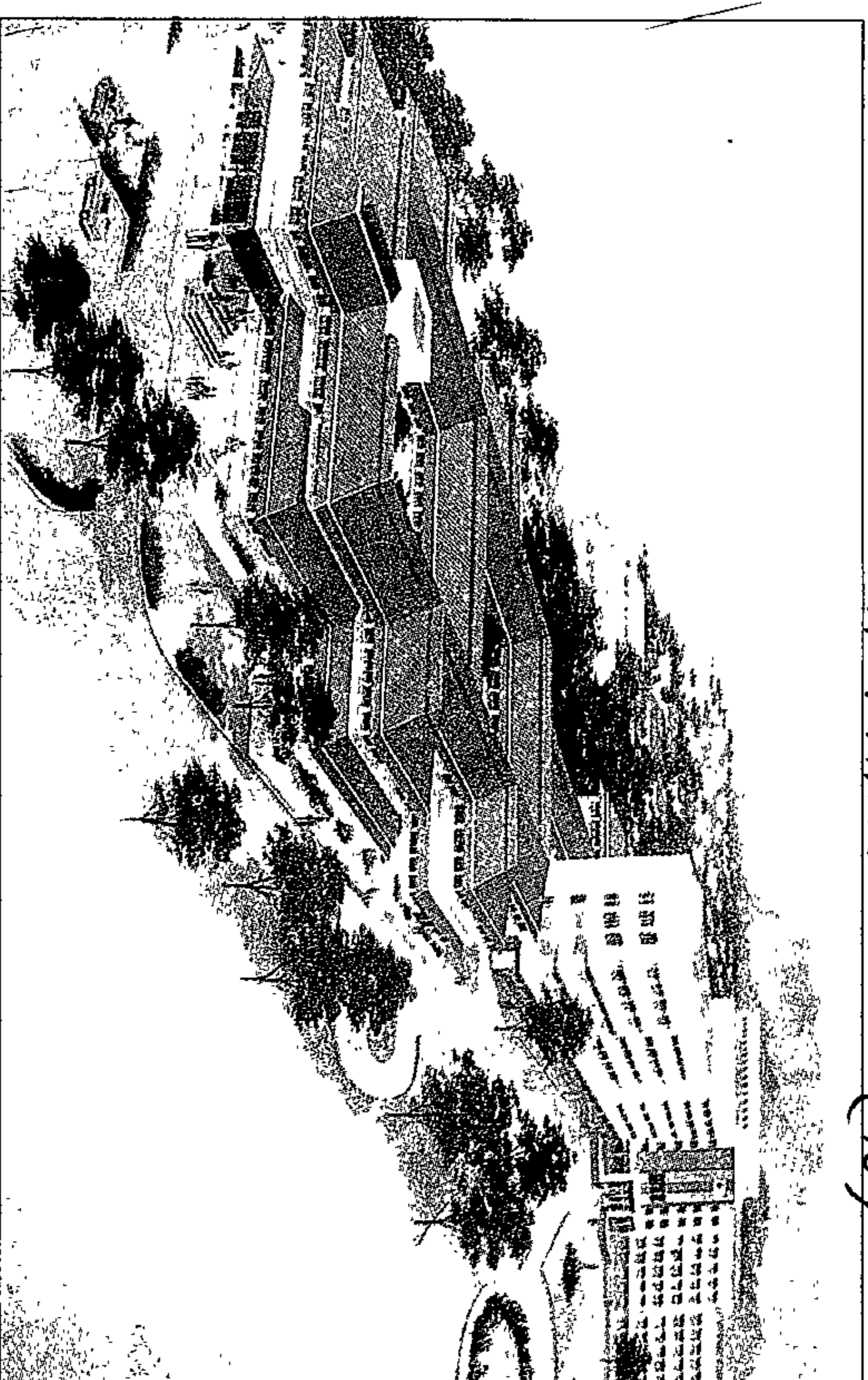
The hospital currently treats an average of 685 children a day, a third of them from outside the Western Cape.

Dr Hassim said the hospital was a national asset - proved by the fact that eight children from outside the Western Cape were currently waiting for liver transplants at Red Cross.

A total 75% of all referrals were from other provinces and in the cardiology department 40% of the children requiring open heart surgery were from other provinces.

Parents of children cured of severe illnesses at the hospital are delighted over the plans to revamp Red Cross.

Said Anthony Africa, father of Wilmot, the youngest kidney and liver transplant recipient in South Africa: "The hospital is the best - I was told my son had only three weeks left to live. Because of this hospital he is alive today."



Finished product: an artist's impression of the completed revamp of part of Red Cross Children's hospital



# Committee to probe hospital conflict<sup>(98)</sup>

Josey Ballenger

BD 19/11/97

THE National Education, Health and Allied Workers' Union (Nehawu), Helen Joseph Hospital management and the Gauteng health department agreed at an emergency meeting yesterday to set up a committee to investigate recent unrest at the hospital and to refrain from further disruptive action.

Acting chief superintendent Dr Arthur Manning denied that a patient had died as a result of Friday's conflict, as the National Party alleged.

"It is quite clear that the patient's death was not connected in any way to the strife at the hospital," said Dawn Joseph, the department's chief director of human resource management. Manning could not be reached for confirmation.

In general, Joseph said the talks were "constructive and restrained. But it was evident that there are deep differences between Nehawu and the administrative unit which must be explored and resolved in order to create lasting stability at this hospital."

The meeting, called by the health department, followed union demonstrations at the hospital on Friday and Monday which culminated in the physical removal of acting superintendent Roelof van der Berg and two clerks from their offices.

Joseph said an independent inquiry would begin as early as today.

Joseph also said ground rules would be put in place to reinforce, but not replace, existing labour codes and legal provisions. All participants would be able to amend or add to a draft submitted by the department before it would become binding.

Nehawu media officer Joe Lekola said at issue was the "broken transformation" of putting more blacks into management positions.

The Democratic Party (DP) said the department had been "remiss in not having prevented the latest outbreak despite signs of trouble that have been building up for months".

"Charges must definitely be laid against workers involved ... and Nehawu held to account for the desperate compromise in patient care at the hospital," DP health spokesman Jack Bloom said.



INCREASED PATRONAGE NEEDED

# Model clinic may have to close (98)

**PATIENTS AND STAFF** are devastated at the prospect of a Montague Gardens clinic having to shut down through lack of support. Political writer **KARIN SCHIMKE** reports.

**A**t a time when hospital services are shrinking under financial strain and the queues at government primary health care clinics are burgeoning, one small primary health care centre offering cheap and personal care is facing possible closure because of a lack of patients.

The Multicare Community Health Centre in Montague Gardens has mere days to prove that its existence is financially justifiable. Its staff and patients are devastated and now only increased patronage will save it from what must surely be an unnecessary fate.

Run by experienced nursing Sister Hilary Truter and two other clinically trained nurses, the clinic; the picture of ideal health services. Its clean, apricot-coloured

interior, its friendly staff, its outstanding education programmes and modern equipment are only one side of the bargain.

The other side is that, as it is a privately subsidised clinic run by the Amalgamated Chemists' Association (ACA), the services are provided at low rates.

Two patients, Ms Veronique Thameria and Ms Joan Hollywood, appear to have little in common on the face of it. But financial strain and a desire for excellent health care are what led them to the Multicare centre.

As a resident of Marconi Beam squatter camp Thameria pays for her visits to Multicare, despite being unemployed. "I come here because the people are friendly and the medicine is part of the price,"

Thameria said. "The sisters always explain very nicely what is wrong with me. At other clinics you have to wait in a queue all day."

Hollywood is foster mother to eight children, several with disabilities. Since her husband's company went into liquidation she has sometimes had to put off taking her ill children to the doctor because she can't afford it. Nor does she have the time or back-up to spend an entire day at a clinic when only one child is ill and the others need her attention.

"A doctor's consultation costs R60 at a reduced rate, without the medicines. Here I pay R35, I know exactly what the problem is and the medicine is included. I would be devastated if this had to close down," said Hollywood.

"Where else can people who can't afford doctors go and leave with their human dignity intact?" The clinic offers family planning and contraception for R5.

Consultations and primary medication cost R35. It also offers pap smears, eye-testing, weight management, TB screening and education, diabetes, hepatitis and asthma education, doctor's consultations and trauma facilities.

Mr Julian Isaacs, a patient of the clinic since it opened earlier this year, said he was sceptical at first.

"I'm used to doctors and I was under the impression sisters were just there to help the doctor."

But he is sold on the idea now, especially since the burden on his medical aid has lightened.

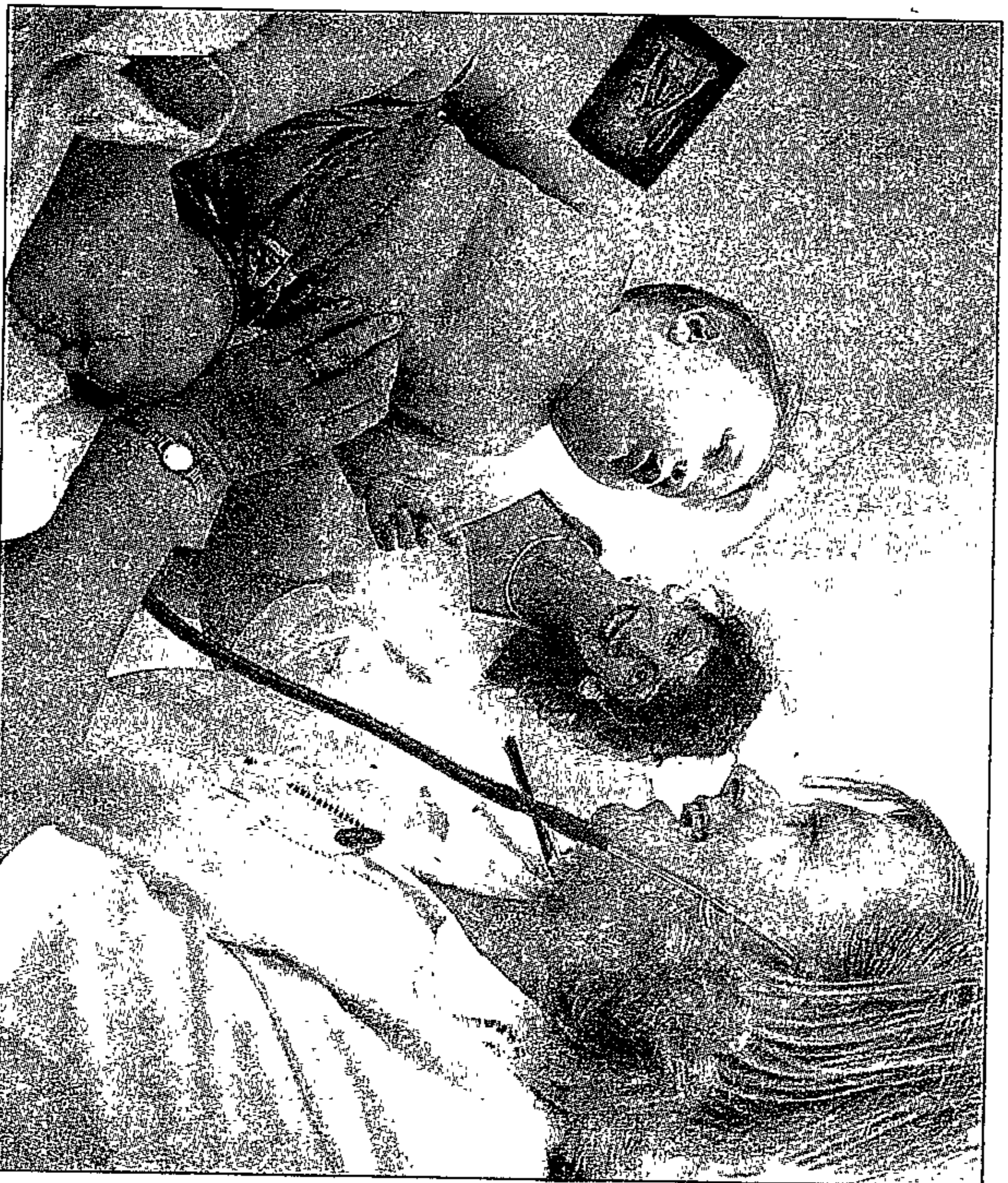
Truter is at the end of her tether about what to do next. She has foot-slogged all over Montague Gardens to "sell" the clinic and the initial response to a viability study proved promising. She has also posted pamphlets in Marconi Beam, Milneron, Edgemead, Bothasig, Summer Greens, Phoenix, Joe Slovo Park and Sandrift.

"There are 16 000 people working in Montague Gardens and that's not counting the people who live around these areas. I've tried every avenue. I don't know what to do any more."

The response from authorities has been dismal despite government calls for the private sector to get involved in primary health care.

So far only the African Christian Democratic Party's national executive chairman, Mr Michael Louis, has shown an interest. "Here is a business that has been initiated and subsidised by the private sector. It needs to be congratulated, not punished," he says.

Provincial Health and Welfare MEC Mr Ebrahim Rasool was distraught at hearing of Multicare's difficulties. He said he would brief the departmental chief director who would contact the clinic to offer support. But financial assistance was ruled out because of fiscal restraints on health in the province.



**TENDER LOVING CARE:** Sister Hilary Truter (right) of the Multicare Community Health Centre in Montague Gardens, treats Gareth Rhys while his mother, Alison, looks on. They have been patients since the clinic opened eight months ago and Alison says she wouldn't know where to go if it was closed.

PICTURE: KIM LUDBRACK



GOOD NEWS FOR HOSPITALS

(98)

# Long-term funding plan can bring relief

ET 19/11/97

**ANDRÉ KOOPMAN** and **JOVIAL RANTAO** of the Parliamentary Bureau report on a new budgeting system introduced by the government.

**G**ROOTE Schuur Hospital and other cash-strapped academic hospitals could receive more funds from conditional government grants in terms of the state's new three-year budgeting system.

The conditional grants, which will be funded separately from provincial budgets, will be available to the health sector and tertiary hospitals in particular. RDP programmes, infrastructure at local government level and for improvement of conditions of service at provincial level.

In a special briefing yesterday Finance Minister Mr Trevor Manuel said government departments would establish conditions which should be met before provinces could access the grants. The grants would remove some of the confusion which existed where, for example, the Western Cape had to bill other provinces for patients treated at Groote Schuur Hospital. Manuel gave as an example

an instance of a province needing funds to build classrooms.

To ensure optimal use of the money the department of finance, under the new system, "could hold the money back as a conditional grant and when they are ready to build schools we will release the money".

The Medium Term Expenditure Framework (MTEF) aims to provide for expenditure over three years but not revenue.

Manuel said he wanted to get to "the situation where if we put a rand into education you know what it is worth when the chalk touches the board".

The government wanted to determine: "Are administration costs too high? How do you measure the quality of your output? Those are all the things we think the budget should be about."

Manuel said the current single-year budget cycle limited the opportunity to set priorities, created an uncertain planning environment, distorted the incen-

tives for efficient delivery and lacked political input and commitment.

The MTEF would enhance the credibility of fiscal strategy, provide a framework for assessing priorities and promote predictable medium-term planning, Manuel said.

"The MTEF will help the government to meet its developmental objectives. It creates common ownership and political control of the budget.

"The budget will reflect the development objectives and priorities of the government."

Manuel said a Borrowing Council would be established to determine the borrowing powers of provinces.

"The questions we are asking in the MTEF is what kind of education system for how many people? Where do you devote resources for education and how do you weigh this up in relative terms? Bear in mind that the budget is not something that we dream up in finance it is a synthesis of all government.

"So you are constructing a policy direction that cuts across, certainly in respect of education,



**MEDICAL AID:** Trevor Manuel yesterday. **PICTURE:** THEMINKOSI DWAYISA

national and provincial government.  
"But you recognise at the same time that provinces are not bound by that.  
"We are trying to provide

something that sets a number of trend lines for development in a way that recognises that the responsibility and power to take decisions doesn't always reside in one place," he said.



R16M STILL NEEDED

# Red Cross Hospital's R36m revamp starts

**NOT CONTENT** to sit back and merely complain about a dire lack of government funding, staff initiated a multi-million and fundraising campaign, reports **CYNTHIA VONGAI.**

**CHILDREN** have reason to smile broadly today. After an 11-year battle, the community has come together to raise 120 million of the R36m needed for extensions to the Red Cross Children's Hospital.

"The support received from the community and the Red Cross Hospital staff demonstrates the commitment to care for the child," said Dr Saheed Hassim, Red Cross medical superintendent. "Everyone is prepared to go the extra mile."

The changes to the hospital will include a specialist outpatients section and emergency services.

A delighted Professor David Beatty, chairperson of the Children's Hospital Trust, said specialist outpatients were housed in "a rab-



**THANK YOU:** Red Cross Appeal sent out a congratulatory card depicting this fetus with the words: "A message from our future patients, well done!"

bit warren of 30-year-old prefabricated buildings" — that leaked in winter and baked in summer.

"If we want to remain able to

treat the sickest of southern Africa's children, we need to ensure we have the facilities to do so. And we will, once the redevelopment is completed," he said.

Although the trust has to raise a further R16m, fundraisers expect to do this over two years.

"This hospital was built by the community ... the Red Cross Society and ex-servicemen, and it is important that this legacy is continued," Beatty said.

"We raised the R20m over the past three years and although we started out with no fundraising experience we had a clear vision of what we wanted to achieve and we learnt as we went along.

"The money was raised from individual contributions and business. The government gave us R5m from the RDP. The redevelopment will mean that we will have a children's hospital with specialist clinic facilities."

Although the Health Depart-



**REASON TO SMILE:** Red Cross Children's Hospital staff celebrate the generosity of Capetonians yesterday after R20m was raised for much-needed renovations to the hospital's outpatients and emergency sections.

ment funds daily running costs, they could not fund renovations to the hospital because of the government's focus on setting up primary health care facilities.

Realising this, the Children's Hospital Trust was established in 1994. The trust began to raise money through active fundraising, rather than waiting for more

money from the state. Changes to the hospital will ensure that the more than 250 000 children treated at the hospital each year will be provided with

world-class medical expertise. Phase one of the development, which began this month, will comprise parent's accommodation, education and training areas. A

pharmacy is scheduled to be completed in August 1998. The entire project, in three phases, is scheduled for completion in 2000.

**PICTURE: THEMINKOSI DWAYISA**



# Rasool begs for cash to save health service

JENNY WALL  
HEALTH REPORTER

Western Cape Health Minister Ebrahim Rasool has asked central government for bridging finance to bail out the ailing health service, and says the scale and pace of change required is unmanageable and unachievable.

He said key areas of the health system would be threatened if there was no financial relief soon for increasingly understaffed services.

Academic hospitals had been hit hard by budget and staff cuts, and primary

health-care centres had also been affected.

"Any user or practitioner in our health services feels the impact of diminishing resources, of our drastically reduced staff numbers, of the diminishing quality of care in the wake of bed closures and the inevitable consequences this must have on medical education," Mr Rasool said.

This was the result of successive and unsustainable budgets for health. They set targets that were unachievable.

Responding to an article in Tuesday's



Ebrahim Rasool

budget by the end of the financial year. This would mean staff numbers would have to be reduced from 27 500 to 21 000. Voluntary severance packages had already

resulted in all areas of the health services being understaffed.

The department had been told by provincial management that it would not be able to fill any posts until the end of the financial year. Budgets for next year had not yet been set, but the Western Cape's health budget was expected to be cut further.

He said the debate about a "conditional grant" to academic hospitals announced this week could offer some relief, in recognition of academic hospitals being national rather than provincial facilities.

Provinces told to sink or swim, page 2  
Rasool responds to Benatar, page 14

AR 21/11/97

98



# Second best health care for rural areas

JENNY VIALI  
HEALTH REPORTER

ARG 26/11/97  
Rural areas and poorer provinces get second best in terms of health care and the move towards more equitable services is becoming increasingly uncertain now that funding is at the discretion of provincial cabinets.

So says the Health Systems Trust in its latest South African Health Review, a recognised barometer of the progress of reform in the health service, which assesses health successes and failures. It includes a survey of the realities in clinics in every province.

Past reviews have focused on the development of new policies as part of restructuring in the health sector.

This one concentrates on trying to assess the extent to which new policies have been translated into real improvements in the quality of life of South Africans.

The review found that in spite of the commitment to providing primary health care for everyone, there was continuing disparity between service provision in rural and urban areas with rural people and poorer provinces still losing out.

The survey showed only 41% of

(98) (98)  
rural clinics had ambulances on their doorsteps within an hour of emergency calls compared with 74% in urban clinics.

The move towards more equitable provision had become even more uncertain now that provincial cabinets got block grants from the national treasury and made allocations to health at their discretion.

The review found that in spite of legislation allowing for termination of pregnancy which came into effect in February, service provision had been "patchy at best" with a number of provinces doing far less than their proportional share of terminations.

The clinic survey revealed that only just more than 60% of rural clinics and about 85% of urban clinics offered family planning services on a daily basis. The review found it was difficult to measure what had really changed for a poor person in need of health care.

More reliable up-to-date information was needed to assess, evaluate, plan, prioritise and improve in every part of the health system.

The review is funded by the Department for International Development in the United Kingdom and the Kaiser Family Foundation in the United States.

# Dept responds to private issue

By Khangale Makhado

THE Gauteng health department said yesterday that it had not privatised its ambulance service *in toto*, but only the section responsible for the maintenance of vehicles. This was done with a view to improve the service.

This follows accusations that the department had privatised the facility and that the move would lead to job losses.

Spokesman for the department Mr Popo Maja said yesterday that all they had done was to opt for leasing; in that the private sector would lease the ambulances to the department. The ambulances would be manned by government staff, but maintained by the private sector.

"In the past we had a situation where ambulances were owned and maintained by the state and this resulted in the government encountering huge problems whereby broken down vehicles took longer to repair, causing

the public to suffer.

"The delay in making available the vehicles endangered lives of people and, in a bid to address the imbalances of the past in the health service delivery, we had to ensure that we opted for the most efficient, reliable and effective way that would ensure the availability of ambulances when they are needed," Maja said.

## Fierce opposition

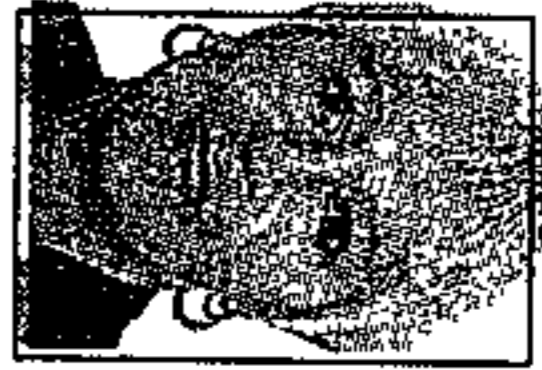
He said there was fierce opposition to the new arrangement, launched in February this year, with fears that if the department was to privatise the service workers would lose their jobs.

"The new arrangement will ensure that there is a definite number of vehicles on the road or ready to be there at any given point in time when needed. And if a vehicle breaks down it would be replaced within an hour," said Maja, adding that they were saving a great deal on costs, time and the lives of people.



# Health cuts set

# TO SHUT DOWN THOUSANDS OF HOSPITALS



**HEALTH** care services in the Western Cape face catastrophic cuts next year when thousands of hospital jobs and beds will be lost and there will be "massive changes" in hospital services. **DIANE CASSERE** reports.

**A** R300-million reduction in health funds faces the Western Cape, translating into a loss of 6 000 more jobs and 2 500 hospital beds.

This is over and above staff losses of around 2 300, and the closure of around 2 000 beds since March this year.

"This will be catastrophic," head of the Western Cape Health Department Dr Tom Sutcliffe said yesterday.

The worst casualties will be training and tertiary care — like intensive care and transplants of, for instance, corneas.

High-cost care will be virtually unavailable to the person in the street who does not have medical aid or insurance.

Planned new health care clinics in outlying areas are also in question.

Sutcliffe emphasised that the budget allocations would only be confirmed next month, but added that he was not optimistic that the situation would improve.

This is in response to a meeting on Monday with a government task team touring the provinces to discuss budgets.

It had been hoped that the allocation to health in the Western Cape would be improved, said Sutcliffe, but this had not been the case: "All provinces are experiencing the cuts. Global budgets, especially in the public sector, have been reduced in keeping with the national financial discipline for fiscal discipline."

From March 1 this year, the Western

Cape's health department staff complement had been reduced from 30 202 to 27 900, resulting in the closure of just over 2 000 beds, Sutcliffe said.

"There will be no additional money or additional help in the next few financial years," he said.

Sutcliffe said it had not yet been decided where the closures would be.

"There will be a process of consultation involving all the role-players, the universities, medical schools, local organisations, non-government organisations,

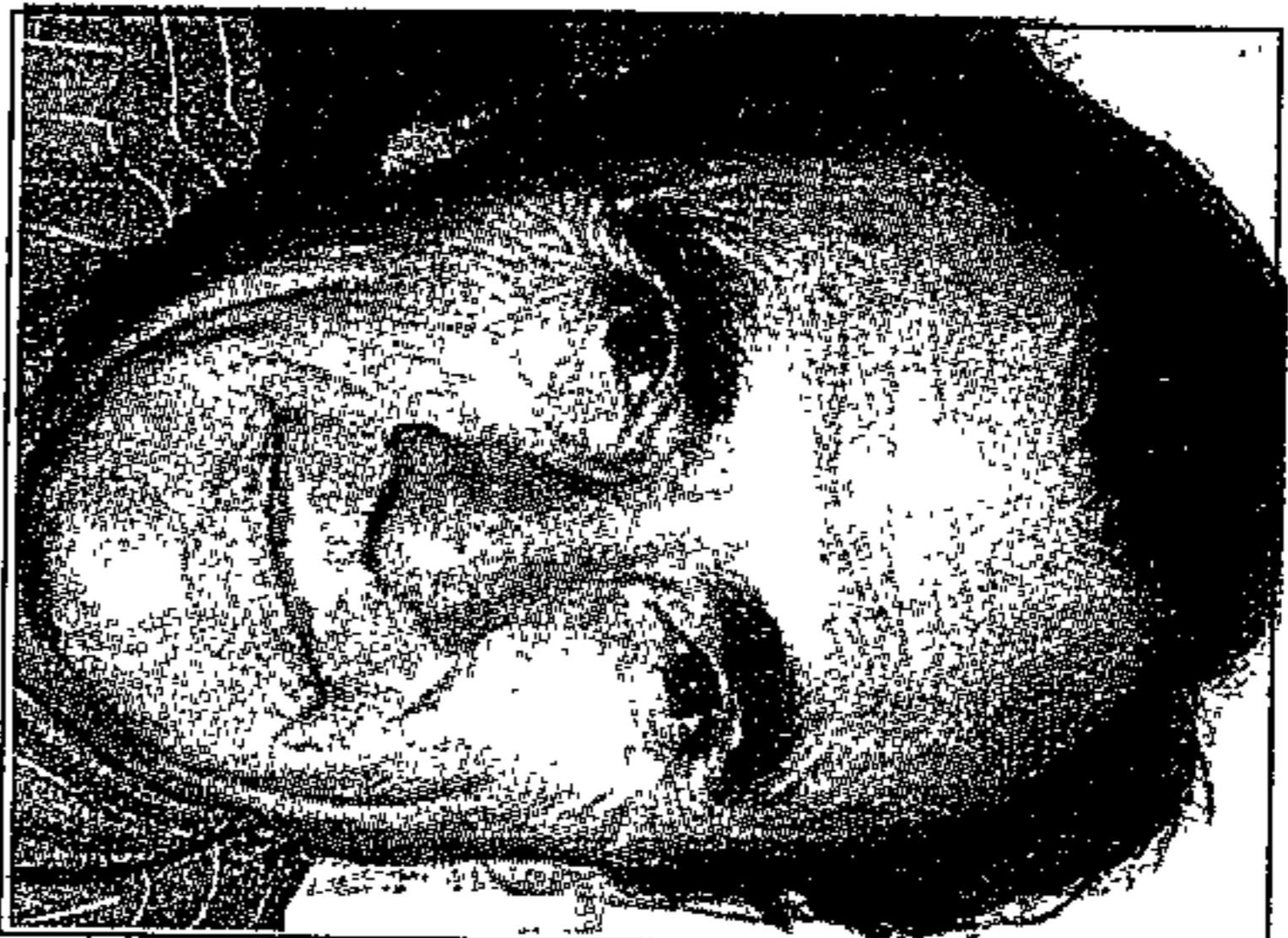
tions, the national Department of Health and other provincial departments of health.

"The best the public can expect from us is to be fully informed. We will use every facility available to us to make the most rational use of the services we have left over to, insofar as it is possible, remain within the framework of the provincial health plan," said Sutcliffe.

"Generally speaking, the effect will be most major in high-cost beds, the tertiary beds."

Sutcliffe said that "primary beds" dealt with low-cost care like the stitching of wounds. Secondary beds were those used for procedures such as fractures and appendectomies. Level three was for high-cost care, such as intensive care and transplants.

Referring to reported assistance for the central academic hospitals such as Groote Schuur, Red Cross Children's Hospital and Tygerberg, he said that "in effect that relief has not been converted into actual money."



**DIRE WARNING:** Provincial health chief Tom Sutcliffe calls for enterprise.

Sutcliffe described it as a "technical exercise which would give a slight benefit to the province over five years".

While the effect of the cuts will be felt throughout the health service it was particularly "bad news" for training and tertiary services.

New clinics planned for areas such as Kraaifontein, Macassar, Delft and Ceres might be in question.

Sutcliffe said that while the budget cuts were "horrific for health", many of the public services were cash-strapped and the situation was no less "bleak" for education.

(98) CT 27/11/97

"This province has done its level best to advocate the folly of this step (budget cuts) and to appeal for more funds."

"There is a national drive to equity and we subscribe to that. What we are challenging is the pace and scale of the change."

Sutcliffe said that the Western Cape had enjoyed a more sophisticated health care system than some other provinces.

"But now, while other provinces are creating and building, we are dismantling as best we can."

"This province has done its best to fairly allocate the money. What is at fault is the magnitude of the reduction in allocation. The equity formula which decides how much a province gets is based on the population with a proxy for poverty."

"The poorer your population, the more money you are given. But this is flawed, in that there is no proxy for development."

Sutcliffe said that public expectations were based on what people were used to, "but we cannot do business as usual".

"Massive changes" in hospitals would include outsourcing non-core services such as catering, laundry and grounds, giving hospital managements greater responsibility and authority, and developing partnerships with the private sector.

Sutcliffe said he had already opened discussions with the private sector to lease available space and equipment in provincial hospitals to create revenue for the overburdened health service.

"If we are going to survive this budget we will have to be much more enterprising," he said.

THOUSANDS OF JOBS, BEDS TO GO



# Planet of delusions, hospital of hope

MtG 28/11-4/12/97

(98) (88)

*Closing Valkenberg hospital would involve a sacrifice by the people least able to bear it,*  
writes **Lin Sampson**

**V**alkenberg: one alights rather than arrives on its pulsating terrain, as if on another planet. It is an eccentric place, a hovering satellite of hope and despair, dishevelled in part, but with pretty gardens that stretch down to the river, known by patients as "the waterfront".

At 9.30am in Dr Baumann's office the place seems sane, but there is the knowledge that all around are lives in disarray. Indeed, a cursory look from the window reveals a head clutched despairingly in a pair of hands. It turns out to be a worker taking a break from building. That has always been the problem in these places: telling the patients from the staff.

Baumann is clearly practised in the art of disguised firmness, and it does not escape notice that he gets his way by a charming slight of hand. However, the proposed closing down of Valkenberg has brought his firmness to the fore.

"One major cause of our outrage is that the closing of this hospital represents to us a massive step back, an alienation of people suffering from mental illness. Also Valkenberg must be seen in the broader context of health services in the Western Cape. The closure of the busiest and most accessible of hospitals will do irreparable harm to the non-governmental organisations in the area which form such vital links with the hospital."

The plan is to tour the hospital and talk to patients and visiting ex-patients. Here is Marc Vervitsiotis who brings his blue eyes close to mine and whispers: "Have you ever had the torments?"

He is of Greek descent, a vivid character who suffers from severe mood swings. He trained as a hairdresser, but has spent 16 years of his 37 years in and out of Valkenberg.

For nine years Vervitsiotis never left the place. He has now been living in a Salvation Army hostel for a year and has come in specially to talk to me. He is well-built and carries a haversack bulging with books on Jesus, one of which he gives me as a parting present, signing it with a flourish.

He tells me that over the years he has tried to obliterate himself in every way known to man. Once he hurled himself at a car on the N2. He has cut his wrists and set his bed on fire.

However, today he seems very much alive. When I ask him how old he is, he says: "Thirteen snails. A snail lives for three years, so I am thirteen snails. You are probably 14 snails," he guesses.

Vervitsiotis thinks his illness might have started when he got involved with some occultists. (I was to discover that most people pinned the onset of their illness to a specific event.) The occultists took him to the beachfront in Hermanus where he watched the full moon come up.

"It got bigger and bigger in my head and all the planets started moving at tremendous speed and I imagined everything was on top of me. It was mind-blowing," says Vervitsiotis. It sounds like the sort of experience a few people I know would



Protest: Patients and staff from Valkenberg march through Cape Town's streets. PHOTO: RODGER BOSCH

## Shutting another door on the mentally ill

**F**or many months there have been rumblings involving the proposed closure of Valkenberg hospital in Cape Town.

In May 1997, Western Cape Department of Health head Dr Tom Sutcliffe said Valkenberg, like all psychiatric hospitals in the province, would have to shrink.

Only a core psychiatric service, to treat seriously mentally ill patients, and the maximum security forensic unit would continue to operate at Valkenberg hospital because of government budget cuts.

However, already the department was running on a deficit of between

R400-million and R500-million a year, and in the last few months closure of the entire hospital was deemed necessary.

Out of all the hospitals earmarked for the chop — Stickland, Lentegour, Alexandra, Valkenberg — it was Valkenberg, lying on valuable land at the Black-Liesheek river confluence, that attracted developers.

Several organisations showed an interest in buying it. A cry went up, petitions were handed around. Patients themselves began to agitate.

Consultant psychiatrists at Valkenberg, who seemed particularly slow on the draw, signed a let-

ter with the ominous wording: "We believe that the closure of any psychiatric hospital in the Western Cape, without first addressing the deficits in the clinics and the regional hospitals, will result in the inability of the public sector to provide the psychiatric services guaranteed in terms of the Constitution."

Everyone connected with Valkenberg realises that rationalisation is needed, plus better and more efficient accommodation and services.

But most also know that closing Valkenberg for a fistful of cash will only exacerbate the crisis of treating mental illness in the Western Cape.

spend a couple of bob to have.

He believes Valkenberg hospital saved his life. "I feel I have spent 16 years fighting for my sanity. You know when you're ill, everywhere is awful, but I knew I had to be here. If I wasn't here I would have killed myself."

He says he is now able to cope with life in a better way and has even thought about getting a girl friend. "I was married for three-and-a-half years and I never spoke once. I just wept. I didn't know what I was weeping about but the tears were just streaming down, for the brokenness of it. Ah, and my wife didn't know what to do, a girl with big cheeks. She really loved me that girl."

It is 2pm at Ward 14, acute male admissions, Baumann's special turf. It is as strange a place as you might ever connect with, the rumbling engine room of mental illness. By the end of the day there will be 25 admissions, many of them re-admissions in what Sister Edith Smith, who has worked at Valkenberg for 16 years, calls "the revolving door" of mental illness.

There is a mural of Table Mountain on the wall and the curtains have been donated by Biggie Best. But, without wishing to be unduly cynical, the patients in Ward 14 seem a little beyond interior decorating.

A lot of people are lying on the floor like the wrangled remains of a car accident. "Hi doc," one pipes up. A male nurse puts on Duran Duran, enough to drive anyone bats, and narcosis hovers in the air.

**O**utside in the garden people sleep. "I think if people are to get well it is important to be in a nice place," Baumann says.

Strangely, Ward 14 is not a frightening place. The atmosphere is casual, almost homely. Smith says most of these people will get better — at least for a time. As I leave a man puts his arms around me and says: "Bye Di."

Princess Diana, Prince Charles, Jesus and Nelson Mandela often feature at this hospital. At one time there were three Nelson Mandelas in one ward. But if a statue were to be erected it would probably be to Peter Stuyvesant. Smoking is an art form here.

As we move through wards, the most noticeable thing is the thesaurus of gaits — people click, slouch, clomp, scuttle along.

In the neuro-clinic Belinda Conradie (27) and Monica Mtweu (23), both of whom have been in and out of Valkenberg for years, have arisen, out of depression to launch their own amazingly vociferous resistance to

the closing down of Valkenberg.

Conradie, who declares herself to be Bi-polar Two (a type of manic depression), says: "I think mental illness makes you vulnerable and open to abuse. I have decided I do not want to be a victim. I feel that as patients we have to say that this is enough. We do not want this hospital to close."

"When I came to Valkenberg a few weeks ago they could not admit me [the hospital was full], so I was referred to Lentegour in Mitchell's Plain, which turned out to be an acute lock-up. I know one thing for sure: if Valkenberg closed and I became severely depressed, I would not return to Lentegour. I would rather kill myself." This is not a threat to be taken lightly.

Mtweu says she does not like the idea of Lentegour. "It is too far away. My family do not like to go there. We know this place."

In Ward 8, Marilyn recalls the days of living in Hollywood Hotel, Port Elizabeth, with Prince Charles — a union, if I am getting the gist of the conversation, that produced not one, but two sets of sextuplets.

Her friend Jacoba nudges me: "Don't listen to a word she says."

In a way these delusions are easiest to hear, way beyond repair, and in-

cluding something many of us see women on the outside lack your own man banged up right next to you

Jacoba has Lionel with whom has been going steady for 30 years

Marilyn's Ian is trundled in as she whispers urgently: "I am terribly love with him." Ian seems to be smoking in such a serious way that even the thought of love is secondary.

As we leave Jacoba tugs me in sleeve: "Please lady don't close the hospital. It is my home."

**A**t the end of the day I feel overwhelmed by this tide of human intricacy. Valkenberg exists in our midst as a hospital and a symbol. "You'll end up in Valkenberg" has ricocheted across the Western Cape for decades.

And, in fact, I did end up there for a hallucinatory few weeks with anxiety. Of course, I witnessed tragedies. There was a girl who received messages via the wall plugs and was always standing beside a three-pronged plug.

Perhaps I was lucky, they all survived. The girl who talked to plugs became a land surveyor.

Valkenberg is a place that is shining light for many — like Garth Davies (35), a paranoid schizophrenic who now lives in Abri, a community-care house in Observatory.

If Davies's medication goes awry life can be hazardous. Only the week before he threw a dumb-bell through a TV screen. "In the beginning it was quite scary to go to a mental hospital. Now Valkenberg just over the way seems like a light I can see from here."

At the top of the main Valkenberg building is a room where brown paper files allotted to each patient have piled up, each representing some unique set of circumstances.

Here psychosis, neurosis, murderous intent and broken-heartedness, together with splendid names of medication, the padded cell, the *grill* of shock treatment, all blend to form an intimate narrative.

There is much courage in the world, most of it never seen. However, more than anywhere else, the history of a mental institution represents the history of a place.

Valkenberg, like many good hospitals, is part of a heritage many of us would like to keep in good running order — just in case.

A cousin of mine, reading for a masters in mathematics, was recently jolted from the smoothness of suburbia into an acute psychotic phase that entailed a three month's hospital stay, way beyond the income of his divorced mother.

On two visits to Professor Frances Ames in 1991 at Out Patients, I saw Trevor Manuel, now finance minister, sitting between two policemen, probably getting a break from prison. But still.

Although the uniqueness of the hospital has been preserved in articles and documentaries, its blend of success is as fugitive as the sudden onset of madness.

Valkenberg has doctors of a calibre you might spend your life trying to find in the national health system in Britain, and nurses — sadly many recently took a retrenchment package — who retain a sense of vocation.

Whatever is wrong with Valkenberg — and I suggest there might be quite a lot — it is certainly not a hospital without hope.

*Patients who are certified, or have been in the hospital for a long time, are not allowed to have their surnames used.*



# Ambulance staff in strike threat

Emergency services may grind to halt

BOBBY JORDAN

**M**UNICIPAL ambulance staff have threatened strike action in the wake of a council decision to transfer the cash-strapped ambulance service over to provincial administration.

The strike could lead to an ambulance standstill — involving about 90 ambulances and 500 personnel — with potentially fatal consequences for critically ill patients.

Staff say strike action might be the only way to reverse the council's decision and to secure their jobs with the local council.

Although wholly subsidised by provincial government, the service is currently administered by both the Cape Town City Council and the Cape Metropolitan Council.

In terms of recent moves to streamline public administration, the CMC had been earmarked to take over full control of the service. However, the CMC turned down the service, claiming insufficient funds.

"We've got such a lot of functions and pressure on our own resources — why should we take on more services?" asked CMC executive council chairman Pierre Uys.

"In terms of the new Constitution ambulances are a provincial service.

"We've been helping render the service on their behalf, but now with budget cuts and everything they're not making it possible for us to do that," Uys said.

But union bosses say ambulance staff are suffering while administrators squabble over resources.

"Nobody seems to want us because we're not a big earner like bulk water or electricity," said Aboubaker Kippie, spokesman for the South African Municipal Workers Union.

"We feel extremely unhappy that our futures are being threatened. The provincial administration has a bad record as an employer and, because of financial constraints, has laid off staff," Kippie said.

The CMC's rejection of the service appeared to be politically motivated, he added, and the two ambulance unions would demand that

the matter be reconsidered.

He said it was "strange" how the CMC could plead poverty yet still consider spending R200-million on a new head office.

Transfer to province would "almost certainly" result in salary cuts and retrenchments, Kippie added.

Cape Town ambulance service director Greg Pillay said a strike was an unlikely option because of the unit's "essential service" status and also because the matter was likely to be resolved through negotiation.

"So far our personnel have always acted responsibly and I would like to call on them now to act in that same frame of mind."

"I'm hopeful a strike will not happen and that the whole matter will be resolved early in the new year."

"The sooner this is resolved the better because uncertainty leads to demotivation and there's no reason why the man in the street should suffer," Pillay said.

The service was currently suffering from a R12-million budget cut and was unable to keep up with population growth.

# SAVE OUR HOSPITALS

## Western Cape in cash plea as cuts crisis

BY WALL  
ALTH REPORTER

The Western Cape Health Department is fighting for increased funding from central and provincial government in a last-ditch attempt to avert a crisis that could spell the collapse of all three Western Cape academic hospitals and the loss of 6 000 jobs.

Provincial Health Minister Ebrahim Rasool today announced a three-pronged plan to press the central and provincial gov-

ernments to step up funding for health in the Western Cape, as both share the responsibility for increasing budget allocations.

The national and provincial cabinets meet on Wednesday to discuss budgets for next year. The provisional health budget allocation for next year is R2,08-billion, R800-million short of the R2,9-billion needed to fully sustain health services.

"In real terms this represents a massive 27,5% downscaling of all services which, if implemented, will lead to the collapse of all three academic hospitals and the closure of a

large number of community health centres and regional and district hospitals," said Faeed Abdullah, director of health services in the Western Cape.

The accepted international maximum for cutting health services in one year is 2,5%.

Mr Rasool said the first line of pressure was to get the Western Cape to place a higher priority on health. "We agree with Finance Minister Trevor Manuel that between R300-million and R500-million could be found by the province for health if there was the political will to do so and the desire to

prioritise health in the Western Cape. We will push for this," he said.

Second, the Health Department would continue to push for central government's conditional grant of R264-million for academic hospitals to be added to the budget allocation and not taken from money allocated to primary health care.

The conditional grant is in recognition of such academic health centres as Groote Schuur and Tygerberg hospitals as national assets.

Dr Abdullah said: "This is an area of the

greatest disagreement between us and central government."

Third, Mr Rasool said, he would ask that the R400-million deficit from this year's budget be spread over three years. At this stage he would not be announcing any "excisions, cuts or amputations" to health services, in the hope that they could be avoided.

Six provinces face health cuts during the next three years, but the Western Cape faces the most severe cuts. Mr Rasool said a health indaba last week had highlighted tremendous resistance to "catastrophic" cuts.

LOOMS  
(98)ARG 11/12/97



# Health budget cut a crisis in the Cape

B02/12/97  
Linda Ensor

CAPE TOWN — Next year's budgetary allocation earmarked by the Western Cape treasury for the provincial health department was about R800m short of requirements and would require a drastic 27,5% downscaling of services, health services chief director Faried Abdullah said yesterday.

He warned that a massive "health crisis" was looming in the province.

Already the Western Cape faced a budget deficit of over R400m this year on a projected expenditure of R2,9bn. The department rejected next year's allocation of R2,1bn as the "last straw", Abdullah told a news briefing.

Abdullah said that if the Western Cape budget was slashed in this way, the three academic hospitals would collapse, a large number of community health centres and regional and district hospitals would have to close, 6 000 jobs would have to be cut, the closure of a further 2 500 hospital beds would be necessary and the number of hospital admissions would have to fall by 80 000 annually.

Expenditure on nursing colleges, dental schools and capital investment would have to be reduced by about 50% or more. This would be over and above the staff reduction of 5 000 since 1995 and the closure of 2 500 beds.

"It is significant that the accepted international maximum for the downscaling of health services over one year is 2,5%," Abdullah said. "The health department believes it would be irresponsible and virtually impossible to deliver satisfactory health services on such a reduced budget. It will be making an urgent plea for review by the national and provincial treasuries."

(253) (98)  
Abdullah complained that the province's attempts to cut expenses were constantly being undermined by decisions at national level. For instance, in the present fiscal year, conditions of service increases of R442m had been approved, while the overall health budget was reduced by R372m.

He laid some of the blame for the pending crisis on the fact that national government used budgets as a baseline instead of expenditures; allowed large conditions of service increases and other personnel increases while implementing the growth, employment and redistribution strategy; allocated too little to the provinces for basic services; and introduced changes too rapidly.

Last week 160 health officials, non-governmental organisations, community health representatives and other health sector workers met to discuss the situation.

The department will lobby the provincial legislature's standing committee on health today to recommend that next year's allocation be reviewed. The committee is to receive submissions on the crisis from trade unions, nongovernmental organisations, academics and health service officials.

National and provincial cabinets meet tomorrow to discuss the medium-term expenditure framework and budgets for next year. The Western Cape is to appeal for greater funding for health and for the repayment of this year's deficit to be spread over three years.

Health and Welfare Services Minister Ebrahim Rasool said he had also written to Finance Minister Trevor Manuel for him to "reconfigure" the R264m for academic hospitals, arguing this it should be added to, rather than be part of the provincial allocation.

# Satisfactory health care 'impossible' after cuts

ET 2/12/97

DIANE CASSERE

THE Western Cape Department of Health believes it would be "irresponsible and virtually impossible" to deliver satisfactory health services on the reduced budget for 1998/99.

Dr Faried Abdullah, chief director of health services, said the department would meet this morning to discuss a strategy to appeal for more funds. The meeting would also seek ways to protect the already hard-hit health services from further "catastrophic" cuts.

The provisional budget allocation is R2 083 million — R800m short of the R2,9 billion needed to sustain health services in 1998/99. This represents a 27,5% cut in all services, which, if implemented, will lead to the collapse of all three academic hospitals (Groote Schuur, Red Cross Children's and Tygerberg).

It will also mean the closure of many community health centres and regional and district hospitals, the loss of 6 000 staff members and the closure of 2 500 hospital beds.

"It is significant that the accepted international maximum for the downscaling of health services over one year is 2,5%," says Abdullah.

The department will make a presentation to the Western

Cape Standing Committee on Health. The committee will also receive submissions from many other sectors, such as trade unions, NGOs, academics and health service officials. Interested members of the health sector and the public are also urged to attend the meeting.

"The Department of Health is confident that the standing committee will make substantive recommendations to have the allocation reviewed," said Abdullah.

"We believe it would be irresponsible and indeed virtually impossible to deliver satisfactory health services on such a reduced budget and will be making an urgent pleas for review by the National and Provincial Treasuries."

The budget cuts have been made despite the fact that:

- 5 000 staff have been lost since 1995.
- 2 500 beds have already been lost.
- There were 400 000 more outpatient visits in the past year.
- Free primary health care has been implemented.
- Termination of pregnancies has been implemented.

The crisis in health care has been caused by the need to bring

equity between provinces and the scale of existing inequities, as well as reduced social spending; insufficient recognition for services and training rendered to other provinces; and the failure to prioritise health care.

The cuts mean there will be longer queues at health services and some patients may be turned away. There will also be

closures of casualty services, ward closures at some hospitals, longer waiting times for ambulances, some non-emergency operations will be curtailed and there will be increased stress

and demoralisation among staff.

"The Department of Health's management position is that the budget cut of R800m cannot be implemented," says Abdullah.

"The department asks the public from all sectors to attend this hearing and take whatever action they think necessary to lobby for a realistic budget.

"It is imperative that the health sector and all other affected persons unite to sustain a workable health system in the Western Cape."

● The meeting takes place this morning at 9 in the auditorium, Western Cape Legislature Building, Wale Street.

**'The planned budget cut of R800m cannot be implemented.'**



# Groote Schuur's transplant unit may close

Star 3/12/97

From next year the unit will have less than 25% of the skilled staff needed to function properly

By JAMINE SIMON

The heart transplant unit at Groote Schuur Hospital may be forced to stop performing transplants as the country's entire transplant programme struggles to find donors.

Groote Schuur cardiac transplant unit head Dr Johan Brink says he is still reeling from the announcement last week that he has only four staff members to run his unit next year as no posts in academic hospitals can be unfrozen.

This is because the Western Cape's treasury has again cut the provincial health budget, leaving it R800-million short of its required funding for 1998 and forcing a drastic 27,5% downscaling of services.

"It's too soon to take a firm decision on our future," says Brink. "I'm committed to staying on to care for the 180 patients who have already had transplants, and those waiting for new hearts.

"But if I take on new transplant cases, I could compromise the care of existing patients."

The transplant unit should run on its approved staff complement of 20 but is down to only four full-time and one part time staffer.

It is the only state facility allowed to conduct heart transplants in South Africa, according to a 1995 decision by Health Minister Dr Nkosazana Zuma.

Zuma made the ruling after a furore erupted over attempts by Dr Fanus Serfontein to conduct heart transplants in Gauteng state hospitals.

At the time, she and senior health department officials promised the unit would be considered a national resource and would receive its entire R9-million budget and finance to transport patients from other parts of the country, says Brink. But nothing has



(98) THE CAPE ARGUS

Pioneer ... Louis Washkansky, the world's first recipient of a new heart.

been forthcoming.

The minister is also dragging her heels on setting up a committee to formulate a national policy on organ transplantation, he said. Guidelines were published 18 months ago.

stabilised. Some relief should be announced in the Minister of Finance's budget speech next year.

The guidelines on transplantation had provided a useful outline for the policy on chronic renal dialysis and making organ transplants available to non-South Africans.

But Wilson said the delay in setting up a ministerial advisory committee meant that the issue of promoting organ donation was not addressed.

"The transplant unit is an important unit, and should be kept going, but chronic renal dialysis and maternal deaths are also important, and we are trying to address as many as we can," he said.

Brink warned that if transplant surgery was only available to patients on medical aid, non-medical aid patients would stop donating organs.

This could be "big trouble" for the national transplant programme, which already faces serious difficulties, says Lynn Botha, national transplant co-ordinator of the Clinic Holdings/Netcare Group. Gauteng aimed to perform 120 transplants this year, but managed only 84, because of donor shortages and the lack of resources to follow referrals.

Only a third of the 1 500 South Africans awaiting kidney, heart or liver transplants will get a donor organ, says the Organ Donor Foundation.

Lack of donors lie behind the highly publicised case of Thiagraj Soobramoney who died after losing his Constitutional Court appeal for access to kidney dialysis at Addington Hospital.

Every week, more than 10 patients suffering end-stage renal failure are sent home to die because patients waiting for a transplant are taking up the dialysis machines.

For information on organ donation contact 0800 22 65 11.



MANY CITY TRADERS WHO OPERATE ON THE NARROW

# Cuts will rip heart out of health, say hospital chiefs

JOSEPH ARANES

STAFF REPORTER

ARG 3/12/97 (98)

Top Groote Schuur Hospital academics warned today that drastic health budget cuts would result in severe curtailment of services offered by all provincial hospitals in the Western Cape.

At Groote Schuur, emergency treatment for victims of road accidents, domestic and criminal violence and heart attacks is likely to be affected and several specialist services may have to be stopped as a consequence of belt-tightening.

The warning - in an open letter on page 12 of today's Cape Argus - comes on the 30th anniversary of the first human heart transplant operation, which was carried out at Groote Schuur.

Chief medical superintendent Peter Mitchell said that while heart transplantation was just one of the many specialised services provided to patients over many decades, the hospital was committed to pro-

viding the highest possible quality of patient care, research and health care teaching.

"But we are gravely concerned at the current and future threats to the province's health services as drastic budget restrictions have already been imposed over the past few years and even greater cuts are on the cards for next year," he said.

"For Groote Schuur it will mean the possible closure of many highly specialised services, marked delays in or non-availability of operative procedures and a possible collapse of services for the management of cancer patients."

The chairman of the hospital's teaching board, Abdul Barday, said the inevitable result of the proposed budget cuts would be a further deterioration in the quality of clinical care.

"Emergency services like caring for motor vehicle accident injuries, domestic and criminal violence victims and patients with heart attacks or other serious conditions will be directly affected."



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# GROOTE SCHUUR HOSPITAL



## OPEN LETTER TO THE PEOPLE OF THE WESTERN CAPE

Dear Friends,

OT 3/12/97 (98)

Today, 30 years ago, the world's first human heart transplant was performed at Groote Schuur Hospital. The hospital looks back with pride at this historic milestone, which earned the hospital and South Africa's health services international recognition. The heart transplantation service is, however, only one of many highly specialised services which have been provided over many decades, to our patients in the Western Cape and beyond.

On this occasion, we wish to rededicate ourselves to the service of you, the people. We are deeply committed to continuing our tradition of the highest possible quality of patient care, research and the teaching of health care workers.

### BUT:

We regard it as our duty to inform you of our grave concern over the current and future threats to the Western Cape health services in general, and to Groote Schuur Hospital in particular. Drastic health budget restrictions have already been imposed over the last years. Even greater budget cuts are being proposed for 1998.

For Groote Schuur Hospital this could mean:

- severe curtailment or even closure of many highly specialised services
- marked delays in, or non-availability of, operative procedures or outpatient appointments
- collapse of services for the management of cancer patients
- lack of emergency care for patients with heart attacks, motor vehicle accident injuries, gunshot wounds or other serious conditions
- inability to provide specialised care to pregnant mothers and newborn babies.

The inevitable result will be a further significant deterioration in the quality of clinical care due to shortages of staff, equipment, drugs and other resources. As Groote Schuur functions as a tertiary referral centre both locally and nationally, the implications for referring hospitals and their patients are equally serious.

We call upon you, as the community we serve, to join us in voicing our deep concern over, and registering protest against, the proposed health budget cuts in the Western Cape.

- Support the hospital
- Contact your MP
- Inform others of the health service crisis
- ACT NOW!

Dr AW Barday  
Chairperson, Teaching Hospital Board

Dr PJ Mitchell  
Chief Medical Superintendent

Groote Schuur Hospital Region.

*This notice paid for independently by the Groote Schuur Teaching Hospital Board.*

# Budget cuts will cost lives, experts tell

CT 3/12/97 (98)

## health crisis meeting

DIANE CASSERE

THE auditorium at the provincial administration buildings in Wale Street had never been so crowded. Members of the public, academics, politicians, unionists, health care workers and others poured in to voice their opinion at the crisis meeting on health budget cuts.

Some 50 health care workers from Tygerberg Hospital arrived together: they had organised a bus so that they could be at the meeting. There were nurses, doctors, ambulance personnel, administration staff, professors and teachers, some in uniform, some not.

They were there to hear submissions to the Western Cape Standing Committee on Health from all the key role players and other sectors such as trade unions, NGOs, academics and health service officials. Members of the public were also given time to ask questions.

What they heard from more than one health department head was that lives could be lost — perhaps were already being lost — if additional money was not found for essential health services.

They also heard that if Groote Schuur and its complex was closed for a year, a saving of R500 million could be achieved — but with disastrous results to health care.

The Western Cape Department of Health believes it would be "irresponsible and virtually impossible" to deliver satisfactory health services on the reduced budget for 1998/99. Yesterday's meeting was to call for a review by the national and provincial treasuries.

The provisional budget allocation stands at R2,083 billion, R800 million short of the R2,9 billion required to sustain health services in 1998/99. This represents a massive 27,5% downscaling of all services, which, if implemented, will lead to the collapse of all three academic hospitals in the province (Groote Schuur, Red Cross and Tygerberg).

It will also mean the closure of a large number of community health centres and regional and district hospitals, the loss of 6 000 staff members and the closure of 2 500 hospital beds.

The budget cuts have been made despite the fact that 5 000 staff have been lost since 1995, 2 500 beds have been closed to date, there were 400 000 more outpatient visits in the past year, free primary health care has been implemented and the termination of pregnancy policy has been implemented.

In his presentation, Dr Tom Sutcliffe, head of the provincial department of health, said while he backed the government policy of equity, health and training were non-negotiable.

There had been cuts in the health budgets in all provinces, from 8% (Mpumalanga) to 27% in the Western Cape.

Sutcliffe said that to survive, the public health sector would have to make itself more marketable and introduce a private/public mix. However any money generated by the province would go to the national budget.

Professor Solly Benatar of UCT said he did not believe proposed ways to counteract the budget cuts would make a difference in time to prevent the collapse of the system: "If we closed Groote Schuur Hospital complex for a whole year, we could save R500 million, but we would have to fire everyone with no provision for a severance package to achieve this."

Benatar said the "short-term approach" of budget cuts discounted the ability to train people for the future.

Dr Edmond Michaels, head of primary health services for the Western Cape, said it was "false economy" to focus only on reducing the budget deficit: "With the Aids epidemic and the reduction in health care, there may be nobody left to worry about our debt."

At present, patients faced a four to six-hour waiting period in casualty, three days on a trolley or chair waiting for a bed, five days for surgery

for a broken jaw and six to ten weeks for an appointment with a doctor.

"There will be many more deaths of young children — and from violence. I want to say cynically to the politicians, those people are voters and the children are children of voters," said Michaels.

Professor A G van Wyk, rector and vice-chancellor of the University of Stellenbosch, pointed out that the three training hospitals in the Western Cape produced one-third of South Africa's medical graduates: "I deplore the insufficient allocation of funds by national government for the academic hospitals. Groote Schuur, Tygerberg and Red Cross are pillars far beyond the borders of the Western Cape."

A statement from Nehawu (National Education Health and Allied Workers' Union) and Pawusa (Public and Allied Workers' Union of SA), which represent 80% of health department employees, denounced working conditions for health care workers and said the unions would not condone unfair labour practice, excess overtime and poor pay. The unions called on the department to address the present staffing and related crisis.

At tea time, members of the audience voiced their own opinions on strategy to increase funding for provincial health care: "We should have a lottery to benefit Western Cape health," suggested one woman.

"Great idea, we could call it Zuma Zuma," quipped her companion.



*'Maybe we should have a lottery for the health services and call it Zuma Zuma.'*  
— Delegate



# Budget cuts will cost lives, experts tell

CT 3/12/97 (98)

## health crisis meeting

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What they heard from more than one health department head was that lives could be lost — perhaps were already being lost — if additional money was not found for essential health services.

They also heard that if Groote Schuur and its complex was closed for a year, a saving of R500 million could be achieved — but with disastrous results to health care.

The Western Cape Department of Health believes it would be "irresponsible and virtually impossible" to deliver satisfactory health services on the reduced budget for 1998/99. Yesterday's meeting was to call for a review by the national and provincial treasuries.

The provisional budget allocation stands at R2,083 billion, R800 million short of the R2,9 billion required to sustain health services in 1998/99. This represents a massive 27,5% downscaling of all services, which, if implemented, will lead to the collapse of all three academic hospitals in the province (Groote Schuur, Red Cross and Tygerberg).

It will also mean the closure of a large number of community health centres and regional and district hospitals, the loss of 6 000 staff members and the closure of 2 500 hospital beds.

The budget cuts have been made despite the fact that 5 000 staff have been lost since 1995, 2 500 beds have been closed to date, there were 400 000 more outpatient visits in the past year, free primary health care has been implemented and the termination of pregnancy policy has been implemented.

In his presentation, Dr Tom Sutcliffe, head of the provincial department of health, said while he backed the government policy of equity, health and training were non-negotiable.

There had been cuts in the health budgets in all provinces, from 8% (Mpumalanga) to 27% in the Western Cape.

Sutcliffe said that to survive, the public health sector would have to make itself more marketable and introduce a private/public mix. However any money generated by the province would go to the national budget.

Professor Solly Benatar of UCT said he did not believe proposed ways to counteract the budget cuts would make a difference in time to prevent the collapse of the system: "If we closed Groote Schuur Hospital complex for a whole year, we could save R500 million, but we would have to fire everyone with no provision for a severance package to achieve this."

Benatar said the "short-term approach" of budget cuts discounted the ability to train people for the future.

Dr Edmond Michaels, head of primary health services for the Western Cape, said it was "false economy" to focus only on reducing the budget deficit: "With the Aids epidemic and the reduction in health care, there may be nobody left to worry about our debt."

At present, patients faced a four to six-hour waiting period in casualty, three days on a trolley or chair waiting for a bed, five days for surgery for a broken jaw and six to ten weeks for an appointment with a doctor.

"There will be many more deaths of young children — and from violence. I want to say cynically to the politicians, those people are voters and the children are children of voters," said Michaels.

Professor A G van Wyk, rector and vice-chancellor of the University of Stellenbosch, pointed out that the three training hospitals in the Western Cape produced one-third of South Africa's medical graduates: "I deplore the insufficient allocation of funds by national government for the academic hospitals. Groote Schuur, Tygerberg and Red Cross are pillars far beyond the borders of the Western Cape."

A statement from Nehawu (National Education Health and Allied Workers' Union) and Pawusa (Public and Allied Workers' Union of SA), which represent 80% of health department employees, denounced working conditions for health care workers and said the unions would not condone unfair labour practice, excess overtime and poor pay. The unions called on the department to address the present staffing and related crisis.

At tea time, members of the audience voiced their own opinions on strategy to increase funding for provincial health care: "We should have a lottery to benefit Western Cape health," suggested one woman.

"Great idea, we could call it Zuma Zuma," quipped her companion.



*'Maybe we should have a lottery for the health services and call it Zuma Zuma.'*  
— Delegate

# Key hospitals saved by health cash boost

*But others may pay the price*

ARG 4/12/97  
(98)

**JENNY VIAL**  
HEALTH REPORTER

**Western Cape academic hospitals have been rescued from impending collapse by the province increasing its health budget for next year by R603-million to almost R2,7-billion.**

But secondary and district hospitals may suffer as a result unless the central government gives the province an additional R264-million conditional grant.

Announcing the decision by the provincial cabinet to increase its allocation to health, Health Minister Ebrahim Rasool said it would pull health care "from the abyss" and avert the disastrous consequences of cuts which would have resulted in the loss of 6 000 jobs and 2 500 bed closures.

The R2,686-billion approved by the provincial cabinet is still well under the R2,9-billion the Health Department says it needs to fund health services for 1998/99.

The department is pinning its hopes on the central government's promise of a R264-million conditional grant, to be spent on academic health centres in recognition of their status as national assets

for training and health.

Central government has said this must be spent on academic health centres, but where the money is to come from is in contention.

The Government says it must come from the provincial health budget and the Health Department says it should be an additional payment from the central Treasury.

"We must continue the debate on the conditional grant vigorously with the Department of Finance," said Mr Rasool.

If the money is taken from the provincial health budget, the Health Department will have to close four to six secondary and district hospitals, 905 chronic-care beds (800 of them psychiatric) and 531 acute-care beds, and reduce staff by about 2 500.

These changes would take place over three years under the new three-year budgeting system.

Head of health in the Western Cape Tom Sutcliffe said his department had drawn up a "compromise plan", approved by cabinet, to tide things over until there was clarity on the conditional grant.

"This plan doesn't provide enough room for appropriate expansion in primary health-care services," he said.

Nursing training, primary health care and ambulance services would not have their budgets cut, but since there was no provision for inflation "we can expect a slow decline in these services".

"It is a compromise plan and it is not without pain and difficulties. If we get additional money we would make the plan more realistic and sustainable."

The department will also get some relief in that it is being allowed to absorb its R392-million budget deficit over the three years.

The chief superintendent of Tygerberg Hospital, Abul Rahman, said he was thankful the province had identified health as a priority.

"However there is still a significant shortfall and we will still have to rationalise services and cut costs in such a way as to take care of top-priority specialities and patients," he said.

Academic health centres also served primary and secondary services. "We will have to make sure all three services get a fair share of the money. We can't look only at tertiary care, otherwise the others will suffer and we will end up with more people at tertiary level, where they are more expensive to treat."



# Health dept thrown R600m lifeline

LISA TEMPLETON

THE cash-strapped Western Cape Health Department has been granted a R600-million lifeline by the provincial treasury.

This was announced yesterday by the provincial Health MEC Mr Ebrahim Rasool.

He also said the government had agreed to spread the health department's R400m deficit this year over three years, instead of recalling the debt by March next year, which would cripple the health system.

But last night a spokesperson for Finance Minister Mr Trevor Manuel denied this.

Until yesterday the Western Cape

Health Department was faced with a massive 27% budget cut, which would have led to the loss of 6 000 staff, 2 500 hospital beds and the collapse of all three of the province's academic hospitals (Grote Schuur Hospital, Red Cross Children's Hospital and Tygerberg Hospital).

But, faced with a provisional budget of R2,083 billion, Rasool said yesterday's R2,686bn budget allocation made up for the R600m shortfall and "pulled us from the abyss".

However, it was still short of the R2,9bn needed to fully sustain health services in the province.

An additional R264m conditional grant by the government was under debate to

save the three academic hospitals and a decision would be made before the national budget is put to bed in March next year.

At the standing committee on health hearing — when more than 250 health providers, trade unionists, non-government organisations and health department members crowded into the provincial administration buildings to discuss the crisis facing the health service — the common call was that budget cuts would lead to unnecessary loss of lives and something needed to be done.

Since Rasool took office in 1994 the provincial health system has already been slimmed down by more than 1 000 staff.

Rasool said he would continue to fight

the national treasury for the conditional grant of R264m. Failing this, cuts would be made over the next three years, including:

- The closure of nearly 1 500 beds (including 800 at a psychiatric level).

- The cutting of some 2 500 staff in the health department.

- The closure of four to six hospitals in the province.

In terms of this the deficit would be factored out by 200.

Dr Tom Sutcliffe, head of Health, said the R600m boost was "important because it came at a time when the situation was becoming unmanageable," but so much more rested on the grant by central government.

'PUBLIC HAS RIGHT TO KNOW'

# Budget cuts forcing doctors to 'play God'

IF HEALTH care cuts are implemented, the Western Cape's academic hospitals could face collapse, warns a Grooteschuur doctor. **MELANIE GOSLING** reports.

THE head of Grooteschuur's cardiac unit has called on the government to explain to the public how doctors are going to be forced to play God in choosing who gets medical treatment at academic hospitals.

Professor Ulrich von Oppell, head of UCT's Department of Cardiothoracic Surgery, said the government's drastic budget cuts to academic hospitals meant that secondary and tertiary medical treatment to poor people would soon have to be rationed.

"The question is how? The public has a right to know," he said.

Speaking at Grooteschuur's 30th anniversary celebrations on Wednesday of the world's first heart transplant, Von Oppell referred to the case of Mr Thiagraj Soobramoney, who died last week after being denied dialysis treatment at a public hospital.

Von Oppell said that press headlines — such as "Too poor to live!" — raised the question of how medical care for 80% of the South African population would in future be rationed.

Doctors were being expected to select "the most deserving patient", yet their medical ethics demanded that they seek the best medical care for each patient. They were being forced, through budget cuts, to play the dual role of rationing medical care and being the patients' advocate.

"With reduced funding to Grooteschuur and Red Cross, it is inevitable that secondary and tertiary health care to patients who cannot afford private health care,

will have to be rationed.

"Will it be rationed by default, by the non-existence of certain services like heart transplantation in the public sector?"

"Will it be rationed by ever increasing queues for services, or by forcing the majority of the population to pay for medical care in the expensive private sector?"

Von Oppell said Grooteschuur's heart transplant unit, famous throughout the world for its excellence and for its pioneering work, was likely to shut next year because of lack of money.

Once it closed, it was extremely unlikely that a heart transplant unit would ever again function in the public sector.

"Whether Grooteschuur will continue with an active heart and lung transplant programme must now be decided by the public through their elected politicians.

"The collapse of Western Cape academic hospitals is something South Africa cannot afford to risk."

About 83% of South Africans are dependent on academic hospitals for high-tech tertiary medical care, and it was this group who would be affected by the government's drastic cut-backs, he said. His department had been forced to decrease their clinical service at Grooteschuur and Red Cross by

30%, despite an increase in patient referrals.

While the unit was considered to be an international leader in some fields, this excellence was being seriously eroded. Budget cuts, retrenchments and the freezing of posts had already driven many doctors, nurses and technologists into the private sector or overseas.

"Transplantation has been singled out as a costly intervention and yet, in terms of life-years saved, heart transplantation is more cost-effective than the pharmacological treatment of mild-to-moderate high blood pressure," he said.

The trauma units were overloaded with drunk patients who repeatedly expected free medical treatment, although their condition was often the result of their irresponsible behaviour.

Von Oppell said academic hospitals needed to become autonomous and retain generated income, provided a management system based on business principles was established.

"The government should allocate the national health budget by defining what level of primary health care can be provided free, and the amount of subsidisation it can afford for higher levels of care.

"Common business sense needs to be applied to the allocation of scarce funds. The current structure of fee tariffs, where a patient will pay R37 irrespective of whether he is admitted for an enema or a heart transplant, is clearly ludicrous," Von Oppell said.

WHEN THEY  
FIRST CUT OUT  
A LIVE  
PERSON'S  
HEART

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CT 5/12/97



# Babies

With limited resources, doctors play God and decide who lives

Star 6/12/97 (98)

By JACKIE CAMERON

More than 20 premature babies die in Gauteng state hospitals each month because doctors are forced to play God and decide which children to treat - and which ones will be left to fight, alone, for their lives.

Their dilemma is caused by severely limited resources.

And not only our children face such arbitrary choices: people awaiting organ transplants also face death penalties in government hospitals - at least 40 adults are sent home to die from Gauteng hospitals each month because there are not enough experienced staff to man the sophisticated machines for chronic renal dialysis.

Professor Peter Cooper, head of Johannesburg Hospital's paediatric unit, says: "It's a very heartbreaking situation. We spend hours debating who to save. It's very emotionally draining."

"We only have 75% of the ventilators we should have, and that's assuming we only ventilate babies from the (policy guideline) cut-off weight of 1 000g."

Dr Larry Margolius, a consultant at Johannesburg Hospital's kidney transplant unit, described his daily dilemma as "nightmarish".

"It's terrible. You try and shut it out. You see women with children in desperate situations, and young people who still have to live life. Who do you choose?"

Among the shock revelations that emerged this week from hospital officials are:

- At least 40 people die each month because there are not enough qualified nursing staff to man dialysis machines 24 hours a day. These machines are switched off at night.

- There are not enough kidneys

- donated to state hospitals because there are not enough organ donation co-ordinators in the country - and also because organ donation goes against many religious beliefs.

- The numbers of people being sent home to die because they cannot have access to renal dialysis is expected to grow, as those currently on the programme wait for too few donors.

- Many donations are lost because organs are not removed timeously from brain-dead people in hospitals.

- Illegal immigrants and residents of neighbouring provinces are draining resources at several hospitals. Pretoria Academic Hospital has warned that more than half of its resources are being used by people from neighbouring states.

- Gauteng residents are also abusing the medical system; many people do not disclose that they are on a medical scheme when they go to state hospitals for cheap medicine and care.

- Private medical care for prisoners, nationwide, has cost taxpayers more than R27-million since April.

- Two prisoners are currently receiving chronic renal dialysis at a private clinic while awaiting kidney transplants, according to the Department of Correctional Services.

- Netcare CHL organ donations co-ordinator Sister Lynne Botha says medical staff at private hospitals refuse to supply organs to prisoners. She has also identified

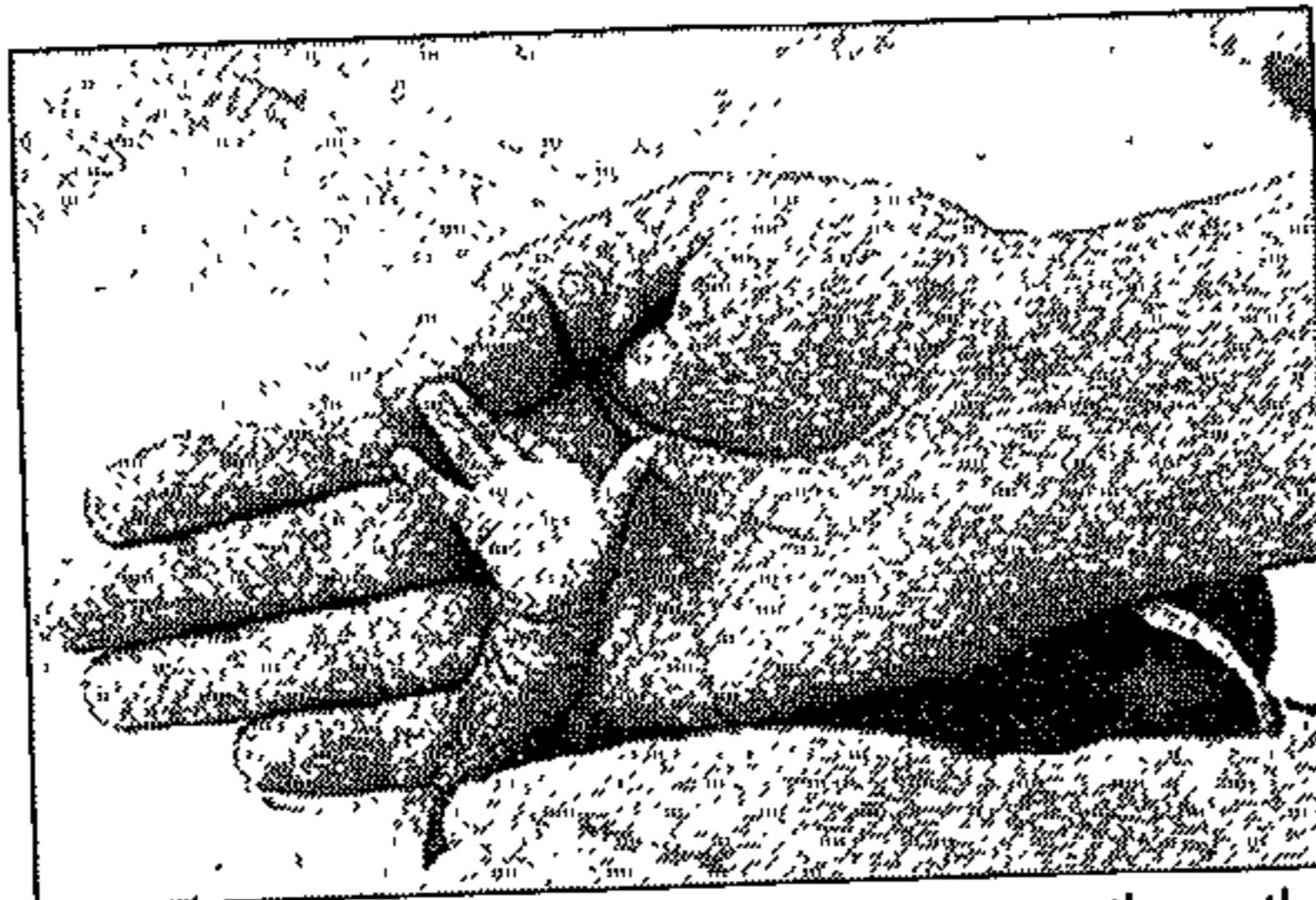
a trend of donors stipulating in their wills that they do not want criminals as the beneficiaries.

- A total of 33 prisoners escaped from custody while receiving treatment at hospitals between January and September.

Margolius said: "Anyone over the age of 60 or with severe or other associated disease will not get a transplant or dialysis. The great tragedy is that we are turning away people who meet the criteria. These people are transplantable."

"The estimate is that about 3 200 people in Gauteng alone get this condition every year. This is a poor man's disease. It's not like coronary heart failure, which is often seen among people with affluent lifestyles."

TO PAGE 2



**BRIEF LIVES:** The methods are there to save them, the wherewithal is not  
PHOTOGRAPH: DEBBIE YAZBEK

- Health officials have a policy to give preferential treatment to premature babies born above the weight of 1 000g because bigger babies have a better chance of survival and can be processed

**CRIMINALS WILL BE REFUSED DONATED ORGANS SEE PAGE 3**

through life-saving systems more swiftly.

- Doctors admit that about five babies each week would probably live with assistance from a ventilator. There aren't enough ventilators to save lives.

- Donated blood goes to waste because doctors order too much at once and it cannot be used after it has been out of refrigeration for more than 30 minutes.

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REPORT

P.T.O.



# Doctors choose which babies live, die

STW 6/12/97 (98)

FROM PAGE 1

"If you are poor and have chronic renal failure, there is only a 5% chance that you will receive treatment. We reject 95% of people who come here."

It costs about R60 000 a year to have one person on dialysis.

These people must stay on dialysis for the rest of their lives. A transplant is the cheaper option in the long term.

Margolius said many kidney patients arrived at the hospital when their medical aid allocation ran out, and that these people "join the queue like everyone else".

Cooper said: "Other provinces, like North West and Northern Province, have bigger problems when trying to care for babies. Their facilities are even worse equipped than ours."

"It's not just a matter of money. You need properly trained staff. You could do more harm than good if you don't know what you're doing. For example, you could end up with a child who is brain-damaged."

"This is, unfortunately, a reality of life at the moment. Even in the best parts of the world, doctors still have to make choices like this. The only difference is in the numbers. This country can't afford to treat all the people who need treatment."

Tragically, many adults being turned away from Johannesburg Hospital would survive and lead normal lives with a donated kidney or dialysis. Instead, these people are sent home

and usually die within a month.

Because the drugs are too costly, patients with HIV are also not provided with life-prolonging medication.

The message is clear - your right to life is dictated by your finances. If you can afford a medical aid, you'll get care until your personal limit runs out.

If you are poor, it's pot luck, and a doctor's decision, whether you have access to the state medical treatment you need to survive.

Minister of Health Dr Nkosazana Zuma's spokesman Vincent Hlongwane said the health budget "is not expected to expand dramatically" because "Government doesn't have a bottomless pit of funds".

Gauteng's deputy director-general of health care, Dr Eric Buch, said: "We are working on redistributing resources. We have analysed the workload per doctor, per discipline. Certain hospitals have more doctors than required, and others fewer. We have shed 5 000 staff members."

Buch said his department was working on eliminating wastage, including the large quantity of blood was left too long out of blood banks, and excessive drug prescriptions.

Department heads would have to approve expensive drugs, and doctors would be expected to recommend tests selectively "based on clinical judgments" rather than ordering "batteries of tests for academic reasons".

"Doctors won't be able to spend quite as long explaining all the

niceties. We won't be able to provide every possible care to every patient.

"We have delays in chronic surgery. There are delays in areas like cataract and hip-replacement operations. We feel it would be nice if we could help people see well in their old age. These areas are troubling us."

Buch warned that the effects of the province's inability to provide triple drug therapy to HIV-positive patients - a treatment which greatly reduces the transmission of HIV from pregnant women to their foetuses - would be felt only in about 10 years.

Security sections to handle prisoners, thus eradicating the need for them to be treated in private hospitals, were expected to be completed by end 1998. On the premature babies, he said: "It's quite impossible to say that every baby born will get intensive care. It's highly expensive."

Buch said wards could be fully equipped with ventilators, but only at the cost of diverting scarce resources from other equally needy areas, such as the transplant unit.

Children born at a weight of 1 000g have a 30% chance of surviving. This chance increases with ventilation, and decreases with the weight of a baby.

"It's a very complex situation. A social health insurance, with a card system, would help reduce the load, particularly from the illegal immigrants and those on medical aid. We also feel that other provinces should pay for services," Buch added.



# Farmworkers, who must come early to avoid losing money, get treatment they've never had before

The Mogale Clinic in Magaliesberg is a simple brick building in what feels like the middle of nowhere. Surrounded by farmlands, the experts will tell you the clinic serves a community of 70 000, but you will not see any homes or large settlements.

The people who visit the clinic are labourers from farms in the region. The community chose the site for the clinic, but many people still travel long distances to reach Sister Elizabeth Mahmare and her small team.

Two small houses next to the clinic are home to Mahmare and the clinic's visiting Cuban doctor, Dr Leonardo Cruz.

The clinic, which is in a sub-district of Krugersdorp, attends to about 180 patients a week.

The hospital closest to the clinic is Paardekraal, about 40km away. Leratong Hospital, frequently used by the staff for emergencies, is 70km away.

When we arrived for our visit on a Wednesday afternoon, the clinic was quiet, with not a single patient in sight. Mahmare said one of the main reasons for the afternoon lull was poor labour relations on many of the surrounding farms.

## Neat and clean

"Farmers take money out of the pay of the workers if they take time off to come to the clinic, so most try and come very early in the morning, before the day starts, to avoid that," she said.

The exceptionally neat and clean clinic offers treatment for all chronic illnesses, family planning, immunisation, dental care and emergencies.

With Cruz and Mahmare on the property, the people of the area don't have to go very far if they need urgent medical care, and late-night

knocks on both their front doors are not uncommon.

The people of Magaliesberg place so much confidence in the clinic that women occasionally choose to have their babies there.

Although they are meant to travel to one of the nearby hospitals for the birth, some women avoid hospital costs by arriving at the clinic fully dilated.

"We warn women not to come here, but they often arrive when there is no time left to get them to a hospital, so we just have to deliver here," Mahmare said.

Although the job gets lonely at times, both Cruz and Mahmare believe they are achieving something in the town.

"Here we make a difference, we are giving these people a service they have never had before: the right to basic health," Cruz said.



# Era of the clinic on the corner

Star 6/12/97 (98)



Primary health care programmes have been quietly accomplishing 'mini-miracles' across Gauteng this year.

**JACQUI REEVES** investigates how the comprehensive clinic system could help to relieve chronic congestion at state hospitals

As the scramble for free caps, book-marks and condoms ensued, one could not help but wonder whether those attending the recent launch of the "Health-Promotion with a Vision" campaign at the Gauteng legislature were paying any attention to what the stall promoters were frantically trying to tell them.

With masses of information on hand about everything from family planning to chronic illnesses, and environmental pollution, the health representatives were eager to speak about what their clinics could offer. But in this instance the public seemed a little too pre-occupied to listen to how primary health care programmes have been quietly accomplishing "mini-miracles" across Gauteng this year.

Dr Rabrik Bismilla, Gauteng's chief director of district health services, speaks passionately about primary health care in the province and the massive challenges the service faces.

People would, and still do, go to a large hospital and wait for many hours for a simple rash.

At the top of Bismilla's "must do" list is changing the way the public views health care.

Previously, access to primary health care facilities such as clinics was limited, especially in rural areas. For their health care, the bulk of South Africa's population became accustomed to visiting state hospitals, where they would spend many hours just waiting for a consultation.

The result was the creation of what Bismilla calls a "hospital-centric" society - where the public believes the only place to receive quality service is at a large hospital.

"People would, and in fact still do, go to a large hospital and wait for many hours with something as simple as a rash. Our clinics and community health centres (CHCs) are equipped to deal with a wide variety of problems, yet people still think the only way to get better is through a hospital," Bismilla says.

Clinics and CHCs are two different types of services within the primary health care model. Clinics are the most localised institution for basic



Gauteng Health Department aims to get us out of hospitals, waiting for hours to cure small ailments, and into clinics and community health centres, of which 40 new ones have been built in the past year

**LIGHT AT THE END OF THE TUNNEL:** New clinics have provided access, or greatly improved the service on offer, to more than 2 million of Gauteng's people. Among the personnel on the frontline is Sister Elizabeth Mahmare of Mogale Clinic in Magaliesberg

health care and are generally small, fixed facilities. They serve a population of up to 50 000 and are open at least from Monday to Friday. The full-time staff are professional nurses, but clinics also often have the services of doctors and other specialised staff on a visiting basis.

The core services of a clinic are the preventive and curative care of newborn babies, treatment for chronic illnesses such as diabetes or asthma, reproductive health care, as well as oral and mental-health services.

A CHC is a larger facility than a clinic and serves between 100 000 and 300 000 people. It is a referral centre for surrounding clinics, and although preventive and promotive functions remain essential, curative and rehabilitative functions are offered.

CHCs have the full-time services of community health workers, a professional nursing staff as well as dentists, social workers, mental health specialists and pharmacists.

In the past year, the Gauteng Department of Health has built 40 new clinics. Recent surveys estimate that the new clinics have provided access to, or have greatly improved the service on offer to, more than 2 million of the province's inhabitants.

Another key aspect of the department's successes has been the "activation" of clinics run by local authorities.

A decision to devolve health care to a community level has created a need to further develop clinics run by local authorities that have, in the past, offered only limited services.

Bismilla's plan has seen these local authority institutions gain staff and equipment as well as more curative facilities.

"We have to make as many services available to as many people as possible. To do this we have taken health care right down to a direct community level," Bismilla says.

In the past, a woman would take her baby to be weighed at a clinic, but would have been referred to hospital for a hypertension check. With the new system, this duplication is avoided, creating something of a "one-stop health shop".

Activating local authority clinics has, however, also meant that the gaps created by the divided system had to be filled. Years of locally and provincially run clinics created a system where nurses and doctors employed

at local clinics were paid substantially more than their provincial counterparts.

This division had to be bridged in order to create an integrated health care system for the province.

"One of the great challenges facing us next year will be to create this integrated system where division was once the norm. Only once we have secured this integration will we be able to build really strong districts," Bismilla says.

The annual health service barometer, the Health Systems Trust, of which the third one was recently released by the *South African Health Review*, says many of the Gauteng Health Department's programmes appear to have borne fruit already.

Close on 80% of Gauteng's clinics were visited by a doctor in the month of the survey, while the province rates a 100% availability of emergency communication. This indicates that the public has regular access to doctors and a stable source of aid in an emergency.

The province also rated comparatively well against the rest of the country on issues such as infrastructure, nurse supervision, and regularity of family-planning and immunisation services.

One problem the department is still grappling with is patients' lengthy wait at many clinics and CHCs. The free health service to mothers and their children has placed a huge burden on clinics, and waiting in a queue for up to two hours is not unusual.

Bismilla says that while the number of patients has skyrocketed, his staff complement has remained fairly static.

The introduction of "patient retention" cards, where patients no longer have to

To educate our people is the only way to ensure that all have an equal chance at good health.

queue for their medical history cards, has been one step towards solving the problem.

Another is what Bismilla calls the efficient approach to patient care. Cutting out, for example, temperature checks and weigh-ins where it is not essential can save valuable minutes for nursing staff.

"Another option is when you have a chronic patient like an epileptic who has consistently kept the condition under control with medication for a reasonable period. That person should not be required to make monthly visits, but could possibly be given medication for longer periods," he says.

Gauteng's clinics are increasing in number and are improving the range of services on offer, but Bismilla believes these advances will amount to little unless the public becomes better educated about them.

"We need to aggressively educate our population on issues of primary health care. It is not something we will achieve overnight, but it is the only way to ensure that all South Africans have an equal chance at good health."

PHOTOGRAPHS: CHRIS ADLAM



# Many more patients at health centre but staff complement stays the same

**A**t 7am, every day, there is already a queue outside the Chiawelo community health centre when the staff arrive for work.

The staff have to hit the ground running to cope with the immediate demand for everything from chronic illnesses to advice on breastfeeding and urgent pharmaceutical requirements.

The 14-year-old centre serves an average of 800 people a day and offers the advanced health care facilities of antenatal and postnatal care, midwifery, physiotherapy, abortions and psychological services.

Chief nurse Sister Agatha Zwane says that since the introduction of free health care to mothers and children, the clinic's case load has increased dramatically.

"We are seeing so many more people, but the staff has not increased, so it can become very

frustrating and chaotic at times."

That frustration is also felt by the patients. Two- or three-hour-long waits are commonplace.

Patients often take their frustrations out on the staff, which creates a difficult working environment.

Despite this, one is struck by the terminology used by the staff when they refer to the patients.

They talk about their "clients", and how best to serve them - a far cry from the impersonal sausage-machine mentality of the past.

## Abused

However, Zwane points out, the clinic is being abused by some sectors of the public.

For instance, people claiming to need medication "stock up" at the clinic by regularly visiting the place without their medical history cards.

Pulling an envelope from her

drawer, Zwane holds up examples of cards that have simply been torn up and thrown down on the clinic's grounds, wiping away the patient's record.

"We can't distinguish immigrants from locals, so the visitors often try and stock up on medicines to take back to their homes, where they cannot get decent medical services," Zwane says.

Because the clinic serves a working community, limited services are available until 7pm.

"The initial plan was just to use the late night service for emergencies, but more and more people are coming for other services which we have to try and supply, so it is a busy time for us as well," Zwane says.

And with more than 100 births at her clinic each month, and a constant queue of "clients", it doesn't look as if Sister Zwane's workload is about to decline.

## READY AND WAITING:

Afternoons at Mogale Clinic are quiet for Sister Elizabeth Mahmare and her staff. But mornings are hectic as patients queue to be examined before they start working







**JUST ANOTHER**

**DAY:** Since women and children became entitled to free health care, the waiting rooms at the Chiawelo Community Health Centre in Soweto fill up as soon as the doors open – leaving chief nurse Sister Agatha Zwane with her hands full.



# Patients urged to gripe as private hospitals propose own tariff rises

Star 9/12/97 (98)  
 BY JANINE SIMON AND  
 MELANIE-ANN FERIS

Unhappy with an 8% tariff increase proposed by the Representative Association of Medical Schemes (Rams), private hospitals are proposing their own tariff increases - which could be as high as 25%.

The tariff increases in private hospital care, expected to be between 15 and 25%, are likely to hit consumers early in the new year.

Hospitals say consumers should complain to their medical aids about the rise.

The Hospital Association of South Africa (Hasa) is in the process of finalising its new guideline tariffs and is expected to announce them before March, said executive director Annette van der Merwe.

The new recommended tariff would mean that patients would have to make a co-payment for every day spent in a private hospital, in addition to the fees paid by the medical aid, she said.

Rams policy director Dr Aslam Dasoo, however, said the increase would have to keep pace with inflation.

Service provision within private health care, he added, had shown an escalation in costs way in excess of inflation.

"Our tariff structure is a recommended guideline. Every (medical) scheme is at liberty to negotiate above or below the benchmark," he said.

But Rams had yet to be convinced that increases of between 15 and 25% for private hospitals were justified.

"With wage increases between 8 and 10% and increases in medical aid contributions between 15 and 20%, employee organisations and trade unions have asked that increases in medical aid contributions should be in proportion to salary increases.

"We believe this is fair, reasonable and justifiable," Dasoo said.

Van der Merwe said, however, that Hasa felt a single

Rams fee was inappropriate to the industry because costs differed in different locations.

The tariff system should be deregulated to allow medical aid schemes to negotiate fees directly with hospitals, she said.

But, said Dasoo, the medical aid industry needed a benchmark pricing or faced tremendous cost increases driven by unregulated private health care providers.

"We have no confidence in the provider industry to contain costs by themselves - they have failed miserably in the past. It is in the consumers' interests that we provide annual increase benchmarks," he said.

Van der Merwe said the Rams tariffs were only recommended fees and it was up to consumers to become far more proactive about their medical costs.

Medical aid members were required to pay their contributions upfront, but the medical aid refused to do the same for their medical bills, she said.



ANC leaders have proposed a change to the conference rules that would require documented support from at least a third of all voting delegates.

## Hospital in crisis

(98) ARG 9/12/97

Queenstown - Unpaid bills have forced the Elliot municipality in the Eastern Cape to cut electricity to the town's 60-bed provincial hospital which has had to send seriously ill patients to other hospitals and discharge others, a spokesman said.

The hospital has a stand-by generator but the health department has not paid its diesel account and the local supplier is refusing to supply more diesel to the hospital.

A butchery, which also supplied milk, had cut off supplies to the hospital because bills had not been paid for months, said acting matron Enid Kakaza. - Sapa



# DP calls for probe of hospital complaints

Mboneni Mulaudzi

THE Public Service Commission should launch an investigation into management, and professionalism of certain staff members, at Ntalspruit hospital on the East Rand, Gauteng Democratic Party health spokesman Jack Bloom said yesterday.

Bloom said he was calling for this after making a "personal investigation of persistent complaints into the decline in the quality of care" at the hospital. He wanted the commission to investigate, as the reports he was

getting from sources inside the hospital were not consistent with the answers provided by Gauteng health MEC Amos Masondo when he posed questions concerning the allegations, which related to managerial and surgical decisions made by senior medical staff.

Bloom said the commission should also investigate procedures followed in appointing senior medical staff and claims that many senior specialists spent "little time" at the hospital, and more time at their private practices.

Bloom said Masondo was given wrong information about the state

of affairs at the hospital, as a cover-up by those involved.

Ntalspruit hospital acting superintendent Muvuli Simba said to his knowledge the MEC had the correct information.

A spokesman for Masondo, Joanne Collinge, said the MEC had asked acting health department director-general Eric Buch to launch an informal investigation into the allegations. The investigation is scheduled to start today. She said a decision on whether to institute a formal inquiry would be made after this initial investigation.

# Amnesty launches campaign in SA

Pearl Sebela

HUMAN rights organisation Amnesty International today launches its most ambitious global campaign in order to mark the 50th anniversary of the Universal Declaration of Human Rights.

Amnesty had chosen to launch its "Get Up, Sign Up" campaign in SA because of its status as a beacon of hope, not only in Africa but throughout the world, Amnesty International SA chairman Noel van Breda said yesterday.

It would also lend support to the establishment of a human rights culture in the country as well as pay tribute to the SA people who had suffered human rights violations since 1948, Van Breda said.

During the year-long campaign, Amnesty would collect signatures from world leaders, leading personalities and ordinary people in about 100 countries, pledging to do everything in their power to ensure that the rights in the Universal Declaration of Human Rights became a reality throughout the world.

Amnesty International secretary-general Pierre Sane said the organisation would present the signatures collected to United Nations (UN) Secretary-General Kofi Annan on December 10 next year. He said governments had signed the declaration, proclaimed as a response to the atrocities of the Second World War, promising to work toward a world without cruelty and injustice. "Yet almost 50 years later, the record of many is one of broken promises."

The aim of the campaign was not to point fingers, but to show that people would not stand by for another 50 years of broken promises, Sane said. The first person to sign the pledge was human rights campaigner Daw Aung San Suu Kyi, a Nobel laureate and leader of the opposition in Burma. Mary Robinson, the UN High Commissioner for Human Rights and Graca Machel, a leading defender of children's rights, were also among the first signatories. Van Breda said that they aimed to collect 50 000 signatures in SA. He said that because there was no awareness of the culture of human rights in SA, the country was a challenge to Amnesty. A pilot project had already been launched to promote respect for human rights in the SA Police Service and they were also looking at lobbying the national education department to have the school curriculum rewritten with a special focus on human rights.

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# Hospitals to

(98) 27/10/12/97

# Shut out thousands

UNIVERSITY OF CAPE TOWN  
SALDRU LIBRARY

**INCREASED DEATH** and disease will be some of the effects when the health budget is further reduced. **CHRIS BATEMAN** and **CLAUDIA CAVANAGH** report.

**T**ENS of thousands of people will be turned away from provincial hospitals next year, and pre-primary and remedial education will be crippled as the Western Cape government battles to manage a rapidly shrinking annual budget.

Further downgrading of nursing care and services in academic and tertiary hospitals is inevitable.

The Western Cape has shed 10 000 civil servants — mostly education and health workers — over the last 18 months, placing enormous pressure on remaining staffers labouring under a mounting workload.

Painting a gloomy picture to Cape Metropolitan Council executive members — a scenario described by Western Cape health chief Dr Tom Sutcliffe as “pretty accurate” — Dr Mike Tatley, head of the CMC’s health services, said the crisis could result in increased death and disease.

“Not all of those who need care will get it — they will die in the communities which we as local authorities have a responsibility to serve,” Tatley said.

In real terms, over the next year, the province will have to come to terms with a health budget deficit of R692 million.

“This can only cause a slow and irreversible collapse of health care in our region,” he said.

Tatley, working on the original R2,1-billion health budget, said the department would have to:

- Turn away 80 000 people from hospital admissions.
- “Lose” 6 000 more staff members by April next year, bringing the total since 1995 to 11 000.
- Close up to 2 500 more beds by April, bringing the total here to 5 000.

The public can brace itself for even longer queues at outpatient units and clinics, ambulances taking longer to arrive, being increasingly turned away from hospitals and the closure of more wards and casualty units.

The situation was aggravated by 400 000 more outpatient visits in the past year and the implementa-

## Health

- Budget deficit by end of 1998 expected to reach R692 million.
- Labour Relations Act prevents retrenchment of staff.
- Voluntary severance package counter-productive as a “downsizing tool” (huge skills loss).
- High staff vacancies (20%) leading to overworked existing staff.
- Disproportionate downscaling of academic hospitals to maintain funding levels at secondary hospitals and primary health clinics.

## Education

- 2 200 idle-but-paid teachers awaiting redeployment (conservatively estimated to be costing R66 million over six months). Protracted court action by teachers to halt redeployment has drawn out resolution — costing millions not budgeted for.
- Creation of new posts at disadvantaged schools filled with temporary teachers until a permanent teacher can be redeployed.
- Both the above resulted in the Western Cape Education Department spending 106% of its budget on salaries alone.

tion of abortion services.

“Services will be below all minimal acceptable norms,” Tatley said.

Sutcliffe said Tatley’s scenario was “probably pretty accurate”, but emphasised that it pre-dated the Western Cape exco voting an extra R600 million to health last week.

“Thankfully we’ve moved away from that (R2,1bn) budget. While we are by no means out of the woods, we do not predict a picture quite as gloomy as that,” he said.

Sutcliffe said his health managers had tried to achieve a reduction at a pace and scale that was “actually not manageable or realistic”.

The drastic measures have been forced upon the province by the Finance and Fiscal Commission’s

equity formula, which tries on a per-capita basis to balance funding between the provinces over a rapid five-year period, and by the central government’s bid to rectify apartheid imbalances.

Dr Jocelyne Kane-Berman, chief director of administration for the Western Cape Health department, said they now hoped to keep the main academic hospitals open.

Reducing nursing care while maintaining existing bed numbers was one of the best options for the city’s three academic hospitals.

She would not rule out closing “one or two” under-used district hospitals.

“We’re looking across the board — our main aim is to come up with a plan that is least damaging to service delivery,” she said.

Kane-Berman emphasised that service and staff level reductions were inevitable.

She said a health crisis bosbe-raad, being held at the Medical Research Council building near Tygerberg Hospital until tomorrow, hoped to spread spending over three years to avoid a major crisis.

Economists at the Institute for a Democratic South Africa (Idasa) said health and education service delivery was aggravated by the legal inability to retrench staff (the Labour Relations Act) and the unsuitability of the voluntary severance package (VSP) as a retrenching tool.

The VSP crippled managers’ ability to control the flight of vital needed skills.

Idasa said “disproportionate” downscaling of academic hospitals was unavoidable if district health and other hospital services were to be maintained at current funding levels.

Without maintaining and expanding district health services there would be no “safety net” for patients turned away from academic hospitals, they emphasised.

Staff vacancies (over 20% in the health field) were also destroying morale.

The only way to reduce the risk of totally collapsing “essential elements” in the health service was to co-ordinate closures of operating theatres and other services between hospitals, Idasa reported.

Among the options the health

□ Turn to Page 11

P.T.O.



# Business plans for vacated hospital space 'advanced'

(98)  
ET 10/12/97

□ from Page 1

bosberaad will be deciding on will be the "outsourcing" of laundry and catering services and custodial care, consolidating the province's four "virtually independent" pathology services and the currently separate trauma services.

Business plans to use vacated space in Groote Schuur and Tygerberg hospitals for private health providers were at an "advanced stage" and had been submitted for treasury approval.

Sections of hospitals — such as parts of Valkenberg and Stikland hospitals — not needed for future expansion would be sold and the money used for capital projects.

Idasa economist Ms Shirley Robinson said that with teacher salaries forming 90% of the education budget, the redeployment of teachers had meant effectively "double-funding" teacher posts as an interim measure.

Surplus teachers awaiting redeployment were classified as "supernumeraries" — earning salaries but not actually teaching. On the other hand, at disadvantaged schools new posts were being created and filled with temporary teachers until these posts could be filled by a relocated "incumbent".

Conservative estimates showed that with 2 200 idle-but-paid teachers awaiting redeployment, earning an average of R60 000 a year over six months, the cost of duplication came to R66m.

Education's failure to release teachers earlier (because of protracted centralised union bargaining) had meant that the Western Cape had higher teacher/pupil ratios than other provinces.

This had sounded the death knell for

marginal education such as reform schools, adult basic education, early childhood education and farm schools.

Western Cape bursaries and subsidies to pupils had declined by about half (to R50 million).

A 61% decrease in financial aid to public school pupils and a major reduction in special education (physically and mentally handicapped pupils) funding meant that "the most vulnerable and disadvantaged segments of society were being put at risk".

No new school buildings were planned this year and school transport schemes had been cut by 50% from last year's levels.

"This means the province is withdrawing transport to urban learners," Idasa said.

Funding for independent schools had declined by 15%.

Idasa said R24m was spent this year on employing state pre-primary teachers in mainly white and former House of Representative (coloured) areas. The money could not be redirected to disadvantaged areas in the short term because of labour complications.

Idasa said the education department estimated that there were 1 140 000 adults with "inadequate" education in the province, yet only 28 000 would obtain some kind of certificate. This meant the department would reach less than three percent of its target market this year.

Dr J C Stegmann, head of finance in the Western Cape, said severance packages and natural attrition over the past 18 months had reduced overall staff numbers in the Western Cape from 80 000 to 65 000.

This meant a reduction in health workers from 33 000 to about 27 700 and teachers from 47 000 to 45 000.

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Home Comment

## Charter to protect patients' rights

For too many South Africans, a painful, day-long wait in clinic queues results in a rushed consultation with a surly doctor.

According to the National Progressive Primary Health Care Network (NPPHCN), a non-governmental organisation, this sad state of affairs is partly due to patients being ignorant of their rights and to the health department's inability to motivate its employees to provide a more caring service.

This week the NPPHCN launched its health charter, which it hopes will improve the quality of services by informing patients of their rights.

NPPHCN spokesman Judi Fortuin said most doctors entered their profession for the money and were not prepared to engage in "meaningful dialogue" with their patients. She said the doctor or nurse often assumed a "demagogue" status when dealing with patients.

Members of the public who are interested in learning about their health rights should telephone the toll-free number: 0800-114-010. - Staff Reporter

# Private hospital fee increases 'undecided'

(98) Star 11/12/97

Rumours of 15%-25% said to be unfounded

### STAFF REPORTER

Private hospitals have not yet announced tariff increases for 1998 and it was incorrect to say that price hikes would be between 15% and 25%, the Hospital Association of South Africa (Hasa) said this week.

The association was responding to a statement by a Representative Association of Medical Schemes (RAMS) policy director Dr Aslam Dasoo that there was every indication that an increase in the region of 15% to 25% was being considered by private hospitals.

Dasoo added that hospitals said they had a year-to-year cost increase of this amount, but RAMS had yet to be convinced this was so.

Hasa said there would be new guideline tariffs next year, but these were still being finalised. Neither executive director Dr Annette van der Merwe, nor any Hasa board member had ever quoted figures of 15% to 25%.

RAMS has posted an 8% across-the-board tariff increase for next year and this will affect doctors, dentists and hospitals. Hasa said the 8% increase was not the only reason why it was considering asking patients to make an additional co-payment over and above what medical aids would pay for every day spent in a private clinic.

The other factors were:

- The health care inflation rate was 10,9%, well above the 8% increase proposed by RAMS;
- The falling rand had affected the costs of imported equipment and consumables;
- There had been sharp increases in nurses' salaries and labour costs;
- Private hospitals had consistently received increases less than half of the inflation rate and were no longer able to absorb the costs, and
- They also faced immense problems with delayed payments and short payments by medical schemes' accounts.



# Patients' rights incorporated into health bill

Josey Ballenger

BD 11/12/97

A CHARTER of rights and responsibilities regarding health care would be incorporated into the national health amendment bill to be tabled early next year, the charter's developer said last night.

The charter outlines 24 patient "rights", including access to care, confidentiality, treatment, choice and information; 18 "responsibilities", such as being constructive in complaints and providing accurate information to health providers; and ways in which the charter could be implemented.

The charter was developed by one of SA's largest nongovernmental health care organisations, the National Progressive Primary Health Care Network, following two years of consultation with community groups nationwide.

Network advocacy manager Judi Fortuin said at the charter's Johannesburg launch that the constitution and the National Health Act were the charter's legal framework and that health director-general Olive Shisana had committed the department to

adopting at least some of the charter's recommendations into the national health amendment bill to be tabled in Parliament's first session next year.

"Access to these basic rights is still beyond the reach of a large proportion of the population and ignorance of their health rights has left many people at the mercy of health workers who do not always have their welfare at heart," Fortuin said.

"In fact, those most vulnerable to ill health have the greatest difficulty in accessing health services and are treated shabbily when they do go for care.

"An example of this is waiting for the whole day at a health centre without being seen and then being told to come back the next day."

Fortuin said the network would also lobby government to implement mechanisms to address health rights "violations", as the present avenues — the courts, the Interim Medical and Dental Council, provincial health officials and facility administrators — were "inadequate, cumbersome, not user friendly and not accessible to everyone".

She said there was an urgent need for such a mechanisms, as evidenced by the network's toll-free number for health-rights inquiries and complaints, which had so far received 1 850 calls.

Fortuin also said the organisation needed funding to print and distribute more charters in at least three other languages. At present, they were available only in English.

The present copies had been funded by the Kaiser Family Foundation in the US.

# Netcare takes Western Cape govt to court over hospital sale

00 11/12/97

(98)

Ingrid Salgado

THE Western Cape government is facing court action over a decision to sell the Volks Hospital to pharmaceutical group Medi-Clinic.

Rival business Network Healthcare Holdings (Netcare) served papers on the provincial administration this week and is asking the high court to set aside the sale so that fresh tenders can be called.

Netcare chief operations officer Richard Friedland alleged yesterday that the tender process for the sale was riddled with irregularities. Chief among the group's claims were:

That the National Party-dominated provincial cabinet opted to award a new private hospital licence to the successful bidder for the hospital — without communicating this decision to the industry. Netcare submitted that it would have tendered a "substantially higher" bid than R12,5m had it known a new licence would be issued in conjunction with the sale of the hospital;

That the Rembrandt-controlled Medi-Clinic group appeared to be aware a new licence would be issued;

That the provincial tender board did not examine the tender. This was confirmed in a letter from the state attorney in November. Instead, the decision was left to a subcommittee in the public works department, and was later ratified by the provincial cabinet; and

That for a year the provincial government stonewalled queries from Netcare to ascertain the basis on which the tender was granted.

The Volks Hospital, established in 1928 and situated in Oranjezicht in Cape Town's densely populated city bowl, passed hands from the Dutch Reformed Church to the state in the early 1980s. It was closed in 1994 due to lack of government funds and a decision was taken to sell the facility.

Netcare, which saw its bid lose out to Medi-Clinic's offer of R15m, claimed the decision to award the licence flew in the face of national government's moratorium on the issuing of new private hospital licences. Cape Town's city bowl was an overbedded area, while the licence granted to Medi-Clinic increased the number of beds permitted by 150 and made allowance for five theatres.

Friedland said the provincial government would have netted much more from the sale of Volks Hospital had the private hospital industry been aware that a new licence was to be granted to the successful tenderer. The tender document made no reference to a new licence and inferred that a licence would not automatically be granted, he said.

The Western Cape administration indicated yesterday it would oppose the Netcare challenge. Health and social services MEC Ebrahim Rasool confirmed that the issue whether to grant a licence had been discussed in the cabinet but declined to comment further, saying the matter was subjudice.

Medi-Clinic said it was taking legal advice. Company secretary Pierre du Plessis said the group was not aware that the tender board had to be involved and the company had no reason to believe anything had been wrong with the process.

He said the hospital would reopen towards the middle of next year. In addition to the purchase price, Medi-Clinic would spend millions of rands upgrading the premises and buying new equipment.



(98)

# Hillbrow Hospital to stop admitting patients

*Sowetan 12/12/97*  
**By Sello Seripe**

HILLBROW hospital will stop admitting new patients from Monday.

This was announced by the Gauteng health department in Johannesburg yesterday.

The move is in line with the intention to convert some hospitals into community health centres.

In a statement, the department said this was part of a broader plan to achieve a more rational, equitable and cost-efficient health service, with greater emphasis on primary health care.

The department called on ambu-

lances to stop ferrying patients to the hospital from Monday.

"Over the next 10 days, the number of in-patients will decline as they are discharged. Specific wards will be relocated as other hospitals become ready to accommodate them."

The statement added that over the same period, an appropriate number of staff would be seconded to each of the hospitals to which Hillbrow's workload had been apportioned.

However, the polyclinic and some specialist out-patient units will continue and will form the core of the Hillbrow Community Health Centre. The casualty service will continue.

**Jacqui Pile**

LACK of money has prevented a sophisticated R4,5m forensic unit, designed to accommodate mentally ill offenders, from being opened at Fort England Hospital in Grahamstown. The ward was built 20 months ago, but has stood vacant since its completion.

## Lack of money means new R4,5m ward stands empty

The unit can accommodate 49 mentally ill criminals under maximum security.

Eastern Cape MEC Dr Trudy Thomas said the problem of staffing the unit was mainly a fi-

98  
nancial one. An audit had been done on hospitals in the Eastern Cape to assess how best to deploy staff.

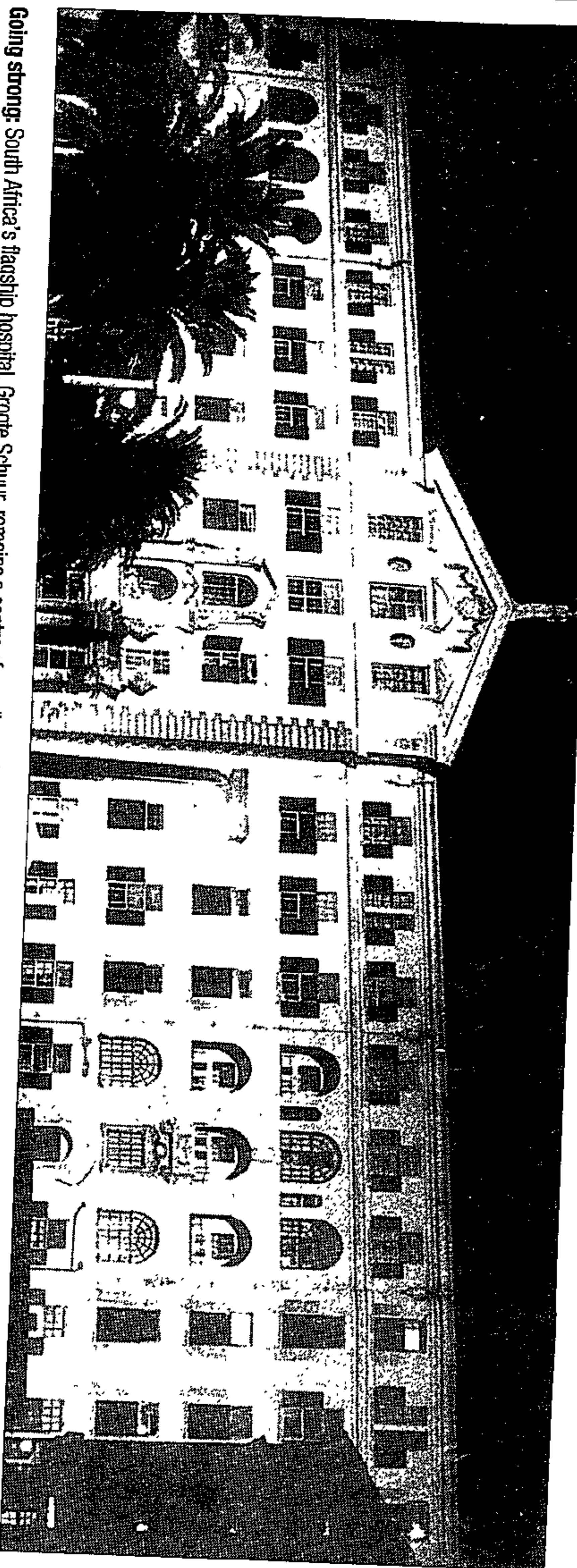
A Fort England staff member said the decision to build the unit was

taken before this government came to power and although the project was questioned by the new authorities, tenders had already been awarded and would have incurred a penalty had the project been shelved.

Fort England had forwarded a business plan to Bisho, where it was under consideration.

ED 12/12/97





Going strong: South Africa's flagship hospital, Groote Schuur, remains a centre of excellence in health care in spite of the steady erosion of resources, including staff

# Groote Schuur still excels

*ARK 13/14/88 (1/14/88)*

## But resources are being steadily eroded

ADELE BALETA

South Africa's flagship hospital, Groote Schuur, remains a centre of excellence in health care in spite of the steady erosion of resources, including staff.

Budget cuts, the rush on voluntary leave packages by staff and the freezing of posts have taken a heavy toll in the ability of the hospital to deliver adequate health care to people in the Western Cape.

Head of Surgery at the University of Cape Town, John Terblanche, said that although the hospital was under threat,

it boasted dedicated people in most departments - many of whom were leaders in their field of medicine. An example of this excellence was in the surgical departments whose senior staff were nationally and internationally respected.

"We have remarkable people, many of whom are the best in South Africa and in Africa. They handle referrals both locally, nationally and beyond our borders at the highest level."

He said that these surgical department and unit heads were frequently offered lucrative jobs overseas, but were committed to staying.

As heads of academic departments, the staff had four major responsibilities. They were expected to give the best patient care, teach undergraduate doctors, specialists and support staff, carry out research and evaluate research in other countries with a view to applying it to health care in South Africa, and they were expected to fulfil administrative responsibilities.

The problem was that with staff cuts, "outdated" and even "dangerous" equipment and decreased funding for items such as heart valves, the senior staff were finding it increasingly difficult to care properly for patients.

Professor Terblanche has warned that if bridging finance is not found to unfreeze vacant posts urgently, more valuable staff will be lost.

"Without money for posts and people to fill those that become available, these excellent surgeons will not be able to care for people needing specialist care."

"We are determined to fulfil this obligation. The current freeze on all posts that become vacant, and the cut back on consumables, is going to destroy our health care system before the beginning of the next financial year," he said.

### CARDIOTHORACIC SURGERY

Ulrich van Oppell and his team run South Africa's leading academic cardiothoracic (heart surgery) unit. There is no other comparable unit in South Africa or in Africa. The group are internationally recognised for their Heart Transplant Programme headed by Dr Johan Brink.

Professor Mark de Groot heads the Thoracic Surgical Unit (chest surgery) and is the only full-time academic thoracic surgeon in South Africa. The department has a unique, internationally recognised and well-funded Cardiac Surgical Research Unit under the direction of Peter Zilla, who has developed a cheaper heart valve for use in South Africa and elsewhere. The department is regarded as an important provincial, regional and national asset.

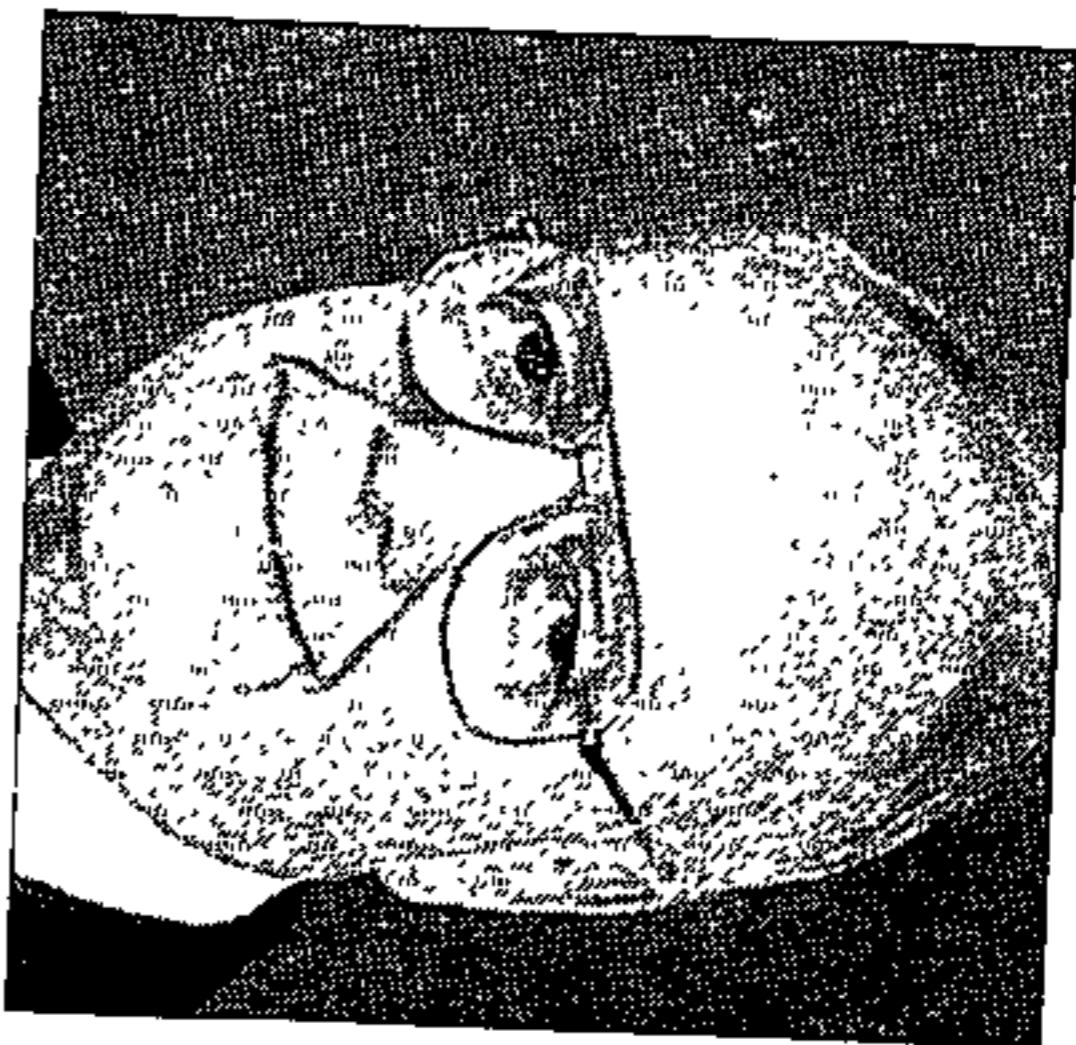
### EAR NOSE AND THROAT SURGERY

Department head Sean Sellers is nationally and internationally recognised as a leading ear nose and throat surgeon. Other provinces frequently refer patients to him because of his expertise which includes head and neck cancer surgery. In spite of limited staff, the group remain the leading academic ENT department in South Africa. Chris Prescott, who is based at the Red Cross Children's Hospital, is a nationally and internationally recognised paediatric ENT surgeon.

### GENERAL SURGERY

The department is headed by John Terblanche, who is internationally recognised for pioneering work in liver and bile duct diseases over the past 30 years. The department is similar to major international units, but is unique in South Africa and on the African continent, in that it is divided into separate specialist units headed by nationally or internationally recognised experts in each field. Several of these specialist units are important national and tertiary resources. Unfortunately, many of the units have only one permanent senior staff member which puts the survival of the units at risk.

### Pioneering work: John Terblanche



Important inter-provincial services which include the only fully established Congenital Hand Defect Clinic in South Africa.

### NEUROSURGERY

Jonathan Peter, supported by an excellent team, is an internationally recognised paediatric neurosurgeon with expertise in surgery for cerebral palsy patients. As such, he is unique in South Africa and is one of a small international group. Together with the epilepsy group at Groote Schuur's Neurology Department, he is the only academic surgeon in South Africa who does specific brain surgery for these conditions.

### The Specialty Units are:

■ Liver, Biliary and Upper Gastrointestinal Unit. Headed by Philip Bomman, the unit still does clinical work there. The deputy head is Jake Krige and all three are internationally recognised authorities in this field. The unit takes national referrals for complex liver, biliary and pancreatic disease patients.

■ Oncology (Cancer) and Endocrine (hormonal) Unit. Department head David Dent has a national and international reputation. His breast clinic at Groote Schuur is a unique outpatient facility both in South Africa and Africa. Patients are seen, diagnosed, counselled and, if a malignant lesion is confirmed, they are booked for the required surgery on the same day that they first attend the clinic. The only delay is for in-patient operating time for surgery which is due to operating staff shortages.

■ Vascular Surgery Unit. Edward Immanuel heads the unit, which is one of only three fully functional academic vascular units in South Africa at present. The unit, which conducts surgery involving blood vessels, accepts referrals from other provinces. Staff shortages are threatening the survival of the unit.



Highly productive: Tony Murray



Recognised: Johan Naude

Cont



Tony Murray runs a highly productive Academic Ophthalmology Department. Despite staff shortages they maintain an impressive academic output. The department's eye tumour clinic is unique, both in South and on the African continent. Staff handle the most complex eye movement disorders. Very little cataract surgery for poor people is undertaken outside teaching hospitals and there is a long waiting list. If any operating list is cancelled, as is currently happening, blind patients have to wait at least a year before they can re-enter the programme for an operation that would restore their sight. Current financial and staff cutbacks will further aggravate the situation. There is a national move to establish cataract surgery outside teaching hospitals but this will be impossible if staff shortages persist or get worse.

#### **ORTHOPAEDIC SURGERY**

Department head Johan Walters is a nationally recognised expert in knee injuries and in joint replacements. He is the overall head of orthopaedic surgery performed at Groote Schuur, Red Cross and at Princess Alice Orthopaedic Hospitals. Princess Alice admits patients countrywide. The multidisciplinary Arthritis Unit at Princess Alice, which is under threat of closure, is unmatched in Africa. The Paediatric Surgical Service under Teddy Hoffman at Red Cross is the premier academic paediatric unit in South Africa. The hand unit at Groote Schuur is the only one of its kind in South Africa, and has been for the past three decades.

Department head Johan Naude is internationally recognised for the development of several novel urological procedures, and for his expertise in urological conditions relevant to Africa. Urology at Red Cross is headed by Larry Jee, who forms part of small group of international paediatric urologists.

#### **PAEDIATRIC SURGERY**

The department is based at Red Cross Children's Hospital and is one of the most highly respected in the southern hemisphere and the world. However, the freezing of posts has had a devastating effect. Last December there were four senior paediatric surgeons and now there are only two. The vacant posts have been cut. Head of department Heinz Rode is internationally and nationally known for his work on burn patient care amongst other research. Alistair Millar is in charge of the paediatric liver transplant programmes in association with Del Kahn (of the Transplantation Unit at Groote Schuur Hospital). This is a unique resource for which central funding has been promised by the National Department of Health, but which is still not forthcoming.

#### **PLASTIC SURGERY**

From May 1998 the department will have only one specialist, Don Hudson. The present head, Cecil Bloch, will retire in May and his post will be frozen. This will make the department, which services five hospitals, non-viable. The department provides a number of

Goldberg who is nationally recognised. He is the only full-time surgeon in this field in South Africa. His special interests include inflammatory bowel disease and inherited colon cancers. The unit is supported by the internationally acclaimed South African stomatherapy unit, headed by Prilly Stevens.

#### **Transplantation Unit.**

Unit head Del Kahn has a national and international reputation and is the only full-time transplant surgeon in South Africa. He runs the only viable liver and kidney transplant programme in the country. The liver programme has been earmarked by central government for funding as a national resource but nothing has been received to date. Dr Kahn is also in charge of the only internationally recognised and fully functional general surgical laboratory in South Africa.

#### **Trauma Unit.**

Head of the unit Peter Bautz is supported by temporary junior specialist staff. He has a national and international reputation in trauma management. The unit urgently needs another senior trauma surgeon. The unit staff resuscitate all trauma patients before referring them to the specialist units.

#### **Surgical Intensive Care Unit.**

Lance Mitchell is head of the unit and is assisted by two temporary specialists. He is a specialist in critical care medicine and heads one of the most successful Intensive care units in South Africa. The unit runs the only fully functional critical care technologist course in the country but the unit's existence is seriously threatened by staff shortages.



# Hillbrow Hospital poised for rebirth

(98) Star 15/12/97

By PRISCILLA SINGH  
Health Reporter

Hillbrow Hospital will cease to be a regional hospital on Christmas Eve, when it begins its rebirth as a "super" community health centre.

From today, no new inpatients will be admitted to the hospital. Over the next 10 days the number of patients is expected to decline as most will be discharged, and the functions fulfilled by specific wards will be taken over by other hospitals, according to Gauteng director of health Dr Eric Buch.

Some staff will be seconded to other hospitals. All patients still in Hillbrow Hospital on December 24 will be moved by ambulance to other institutions.

"There is going to be a greater emphasis on primary health care, with two big additions in child health and a com-

bined gynaecology and obstetric unit, which Hillbrow did not have before," Buch said.

To start with, the Hillbrow community health centre will continue to offer services which were part of the polyclinic, including treatment for diabetes, hypertension and other common illnesses, minor procedures and dressings.

A 24-hour "walk-in" casualty will take care of minor accident injuries, cuts, simple fractures and medical emergencies such as asthma or pneumonia. If patients arrive at Hillbrow Hospital with serious injuries or medical conditions, they will be stabilised and sent by ambulance to the appropriate hospital, Buch said.

Other services include oral health, optometry and minor surgery. Specialist services will cover HIV/Aids; dermatology; and gynaecology, including

termination of pregnancies.

The radiation/oncology unit will continue to operate at Hillbrow for the next two-and-a-half years. It will eventually be transferred to Johannesburg Hospital.

The department intends "blitzing" communities with pamphlets and using community newspapers and radio stations to inform them of the proposed changes.

Johannesburg Hospital and the Helen Joseph/Coronation complex will take on the tertiary-level care Hillbrow used to offer. The secondary-level care is being shared among Edenvale, South Rand, Tambo Memorial and Leratong hospitals.

Buch said former Hillbrow Hospital patients could transfer to Chris Hani Baragwanath Hospital, which was conveniently located for them and "far from being fully utilised".

# Hospital starts <sup>(98)</sup> *September 16/12/97* moving staffers

**By Sello Seripe**

MANAGEMENT at Hillbrow Hospital in Johannesburg yesterday started relocating staff and certain units to other hospitals in preparation for converting the institution into a community health centre.

Gauteng Department of Health (GDH) spokeswoman Ms Jo-Ann Collinge said yesterday the trauma unit was among those relocated elsewhere. The unit and its staff have been relocated to Helen Joseph Hospital and Johannesburg Hospital.

Hillbrow Hospital has 610 beds and by late yesterday afternoon only 103 patients remained.

## **Seeking medical attention**

Collinge said although notices were sent out in advance to the public around the hospital informing them that it would stop admitting patients as from yesterday, people seeking medical attention were still arriving at the hospital in taxis and private cars. Ambulances no longer ferried patients to the hospital.

"However, not a single patient was turned away. Those in need of immediate attention were attended to before doctors could make a decision on whether to transfer them to other hospitals around Johannesburg," she said.

Collinge said: "The security staff has also been briefed that they should not turn away patients because doctors have to see them before a decision is made on whether they are in a position to reach the nearest medical institution."

She said staff already relocated to other hospitals would be there on a temporary basis until early next year when formal permanent placements would be made.

"However, the GDH would prefer that staff members with long service chose which hospitals they wanted to be transferred to."



# Calls for probe into death of patients

Sowetan 17/12/97

(98)

(98)

By Mokgadi Pela

THE Citizens Commission on Human Rights (CCHR) has reiterated its call for an inquiry into the deaths of patients in psychiatric institutions during the apartheid era.

In an interview with *Sowetan* yesterday, CCHR president Ms Colleen Wiltshire said the Truth and Reconciliation Commission should unequivocally condemn the psychiatric abuses committed against South Africans in psychiatric facilities. We urge them to condemn those professional bodies, health authorities and practitioners who were party to them.

Wiltshire said by adopting this attitude, the TRC "will make it broadly and publicly known these abuses, especially the state-funded private institutions do fall within the TRC's mandate."

She asked that the:

● TRC call on all psychiatrists and psychologists who committed patient

abuses, in violation of the Hippocratic Oath and other ethical codes, to take the amnesty offered by the body;

● System of accountability is established for professional bodies allegedly involved in creating, covering up or denying the abuses of blacks in such institutions; and

● Investigation be carried out into the drug practices within these facilities and any causal link to any death.

The TRC should also establish who were the medical officers responsible for investigating and reporting on each death.

Who did they report to and what annual reports exist on these deaths.

Wiltshire said the TRC should determine which deaths should be reported to the police for criminal investigation.

"The TRC should initiate appropriate criminal proceedings against any mental health practitioner for whom there is evidence of murder or assault in accordance with the law," she said.

# Decision to cut services will hurt patients

Sowetan 17/12/1997

By Khangale Makhado

THE Gauteng Health Department's decision to curtail certain operations at the Chris Hani Baragwanath Hospital aimed at making up for the budgetary shortfall will impact badly on patient care.

This was said by specialist physician and cardiologist at the hospital Dr Mashudu Nethononda in response to a recent decision by the department whereby the hospital had to cut its spending by R37,8 million until the end of the year.

The cuts are an attempt by the department to be within the budget with a projected overspending of about R840 million by the end of the year.

Some of the ways to be used include the reduction of staff by 30 percent, no more overtime for professional staff and no more operations except in emergency cases.

The latest move by hospital management to curtail all elective opera-

tions and other so-called non-life saving procedures is to make up for the expected provincial budgetary shortfall.

It was unfair, Nethononda said, to punish ordinary people because administrators have failed to do their work.

"What this hospital and others in the province need to save costs are good managers and decentralised management systems. It should also be mandatory for the institutions to have hospital forums comprising all stakeholders so that we can have accountability," he said.

The problem has been worsened by the closure of the Hillbrow Hospital and if Bara started referring patients to other hospitals such as Leratong and Johannesburg, these are likely to be overcrowded.

Bara Hospital spokeswoman Mrs Esther Hlongwane was yesterday quoted in a Johannesburg daily newspaper as saying that the hospital's budget outlook for the next three years was bleak due to financial constraints.

98



# Campaign slams hospital closure

By Sello Seripe

THE Ceasefire Campaign (CC) has criticised the Gauteng department of health after a decision to close down the Hillbrow Hospital in Johannesburg.

Regardless of the fact that the hospital will be converted into a community health centre, CC spokesperson Nan Cross said yesterday that the closure of the hospital would leave one of the most densely populated and violent areas without close access to health and emergency services.

Cross said the move "is just one

terrible harsh example in a number of service reductions".

"The recent denial of access to dialysis treatment to kidney patients such as Thiagraj Soombramoney is another example."

She said while the GDH was determined to go ahead to realise their plan for the Hillbrow Hospital, a "shopping list" for new weapons worth R14 billion was being suggested by the South African National Defence Force and Armscor.

"The CC wants to draw the attention of the public to the inter-relatedness of the two processes: the amounts

currently spent on the SA National Defence Force are an exorbitant drain both on government resources and on the economy as a whole.

"As long as the disparities between the poor and the rich are not addressed, and as long as the poor majority have insufficient access to healthcare and other vital services, the priority of government spending must certainly not be on unproductive equipment such as submarines and tanks," she said.

She appealed to members of parliament to think carefully about priorities for expenditure next year.

*Sowetan 17/12/97*



(98)

## No cover for hospital fee hike

FM 19/12/97

Patients will be hit with a whopping 17% average increase in private hospital fees in the new year — the bulk of which nearly all medical aids will not pay.

Because of a discrepancy between what medical aids are prepared to pay and what hospitals say is a true reflection of their costs, patients will not be able to rely on medical schemes to cover 100% of all hospital costs

From January 1 the private hospital industry will introduce a surcharge — an additional 9% on top of the average hospital bill — which patients will have to pay out of their own pockets directly to the hospital.

Most medical aids will not reimburse the surcharge as it is above the 8% across-the-board tariff increase the Representative Association of Medical Schemes (Rams) has recommended that medical schemes pay for hospital expenditure in 1998.

At present private hospitals— irrespective of whether they are one- or five-star establishments — charge the uniform Rams hospital tariffs which most medical aids pay in full.

The Hospital Association of SA (Hasa), which represents 97% of all private hospitals, has obtained permission from the Competition Board to publish its own guideline tariffs

It will do so from January 1. They are 9% higher on average than Rams' hospital tariffs for 1998.

In total, patients can expect a 17% average increase in private hospitalisation fees in the new year. Medical aids, on the other hand, are likely to cover only 8%.

"A 17% increase year on year is inexcusable and unjustifiable, given the generally healthy state of the private hospital industry," says Rams policy director Aslam Dasoo.

The average hospital bill is R1 000 a day. This means that the average surcharge of 9% recommended by Hasa will cost patients an extra R90 per day.

The surcharge is as high as 15% for some procedures like cardiothoracic surgery and childbirth. However, no surcharge has been levied on pharmaceuticals and surgical disposables used in hospitals.

As the usual hospital stay is between two and a half and three days, patients will be hit for an additional R225-R270 on average. Patients will have to decide whether they are prepared to pay the extra amount to secure the quality of service they

are accustomed to receiving from private hospitals.

Hasa says it has been forced to publish its own tariffs partly because of Rams' persistent refusal to grant the hospital industry realistic tariff increases. Over the past five years these have been way below the hospital inflation rate.

Hasa executive director Dr Anette van der Merwe says other compounding factors such as the rising cost of equipment because of currency devaluation, increasing nursing salaries, rates and taxes as well as problems with delayed payments and short-payments of medical scheme accounts have resulted in

"unmanageable cost increases to private hospitals."

She says it is impossible to predict how many hospitals will adopt the new Hasa-recommended tariffs

Industry players expect a whole range of fees to emerge between the Rams and Hasa parameters as hospitals position themselves in the market according to their differing cost structures and locations.

Claire Bisseker



Russell Roberts

Hasa's Dr Anette van der Merwe ... can't say how many hospitals will hike tariffs



# Baragwanath will not turn away emergencies

BD 18/12/97

(98)

Josey Ballenger

SOWETO's Chris Hani Baragwanath Hospital would continue to admit hundreds of emergency patients a day and would not see staff cutbacks, despite the recently implemented spending constraints, senior superintendent Bokkie Rabinowitz said yesterday.

About 70% of the world's largest hospital's cases were considered to be emergencies, ranging from patients suffering from minor illnesses needing immediate attention to serious health problems such as heart attacks and trauma. The only services being temporarily eliminated were procedures which were not life-threatening, such as general physical examinations and minor operations, Rabinowitz said.

Baragwanath decided this week to handle only emergency cases in an effort to trim the hospital's projected R152m overspending this financial year by R37,8m, or R12m a month, following central government's instructions to the province's health department and public clinics and hospitals to take budget-cutting measures.

Gauteng health department communications director Jo-Anne Collinge said yesterday the provincial health services' anticipated total deficit of

R840m would be partially offset by a special allocation from central government of between R200m and R220m to cover across-the-board salary increases effective from last July. Baragwanath's deputy director of finance Pieter Nortje said salaries were the hospital's biggest expense, comprising 84% of the R495,5m budget or 65% of the projected R647,5m expenditure.

Rabinowitz and Nortje said the public health financial "crisis" had worsened in recent years due to inefficiencies, such as some doctors not working all the overtime hours for which they were paid. Other factors were theft, escalating costs, staff attrition, labour problems, free treatment for children under six, and government's inability to bail out of its overexpenditure. In addition, the hospital was owed R10m by patients, but didn't have the administration to collect.

The National Party said yesterday that the health department's budget deficit could be attributed to bad management of funds and an "undisputed subservience to trade unions".

Despite governmental undertakings, the necessary administration systems to record, control and collect debts from provinces referring patients to Gauteng were still not in place.



Patients queue for treatment at Chris Hani Baragwanath Hospital in Soweto, which has eliminated about 30% of its patient load by treating only emergency cases.

Picture: TREVOR SAMSON

MEDICAL COSTS

# No cover for hospital fee hike

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FM 19/12/1987  
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Claire Bissek



Russell Roberts

**Hasa's Dr Anette van der Merwe** . . can't say how many hospitals will hike tariffs





Dr Chris Barnard . . . on a recent visit to the heart transplant unit where he made his name

## HEALTH CARE

# Golden era ends

FM 12/12/97 (98)

SA's showcase medical institutions crumble as pressures mount on authorities to expand primary health services for the poor

**G**roote Schuur Hospital's heart transplant unit faces imminent closure — 30 years after Dr Chris Barnard stunned the world by performing the first heart transplant there

Its demise symbolises the broader battle being fought to maintain the country's First-World academic hospital infrastructure, given government's commitment to provide basic health care to the majority of the population.

Groote Schuur is the only public hospital performing heart transplants in SA and its head, Dr Johan Brink, says he knows of no other unit in the world which can perform heart transplants as cost-effectively.

Brink says that Health Minister Nkosazana Zuma has failed to honour a commitment she gave to him two years ago that a specific budget for heart transplants would be made available

Since then his top class team has slowly disintegrated, as with many other academic health units where the best staff have taken voluntary retrenchment packages and the freezing of posts has prevented their replacement. The unit is down to five staff and a further two key people may be leaving soon. By international standards it

should have a staff of 18

Unless the R9m budget Brink is appealing for materialises in the new financial year so that he can hire more staff, the world-renowned unit will be forced to close its doors to new patients. Last year it performed 31 transplants and cared for 200 national heart transplant patients with an "inadequate" R6m from Groote Schuur's budget.

Brink expects several of SA's hi-tech units in academic institutions — such as cardiac surgery, dialysis facilities and cancer therapy — to fold in the coming years as funds dry up. The remaining handful will probably be concentrated in one or two national centres.

Dr Tim Wilson, the national health department's chief director of hospitals and academic complexes, denies that government is destroying this heritage.

"We would like the heart transplant unit to continue and believe it is a valuable service and one we can afford if we can learn to use our resources more cost-effectively."

But, he says, SA has been spending more than it should treating people inappropriately at expensive institutions, resulting in

the "gross underdevelopment" of primary care and regional hospitals

"It is incorrect to say that central hospitals are not our priority — they are vitally important. Our priority is to achieve the appropriate balance between the different levels of the health system"

Brink agrees that primary health services need to be expanded for the poor, but argues that if SA tears down existing First-World institutions it will never be able to afford to rebuild them

The wealthy will pay a high premium for private care — a heart transplant at Groote Schuur costs about R60 000 compared to about R140 000 in the private sector — while the poor will just get sicker. Some will die, like kidney patient Thiagraj Soobramoney who was denied free dialysis treatment after the Constitutional Court ruled that the State's obligation to provide health care is not absolute. These are the real losers who until now have been able to obtain hi-tech treatment almost for free at academic hospitals

At the time of Barnard's pioneering surgery in 1967, Groote Schuur attracted world class doctors. "Now we are seen as a Third-World hospital for the indigent," says Brink

Barnard himself is despondent. "Groote Schuur would definitely not have been the site of the world's first heart transplant had the conditions which prevail now been in place 30 years ago," he says

"Now specialised medicine is not encouraged at all, most major research is privately funded and there is too much bureaucracy. I didn't even have permission to do the first heart transplant. Now it would have to go through a whole lot of committees and each one would have a reason why we shouldn't do it"

Groote Schuur is deteriorating fast. It cannot afford to carry out proper maintenance and will eventually go the way of the older hospitals like Tygerberg and Pretoria Academic Hospital whose infrastructure is crumbling.

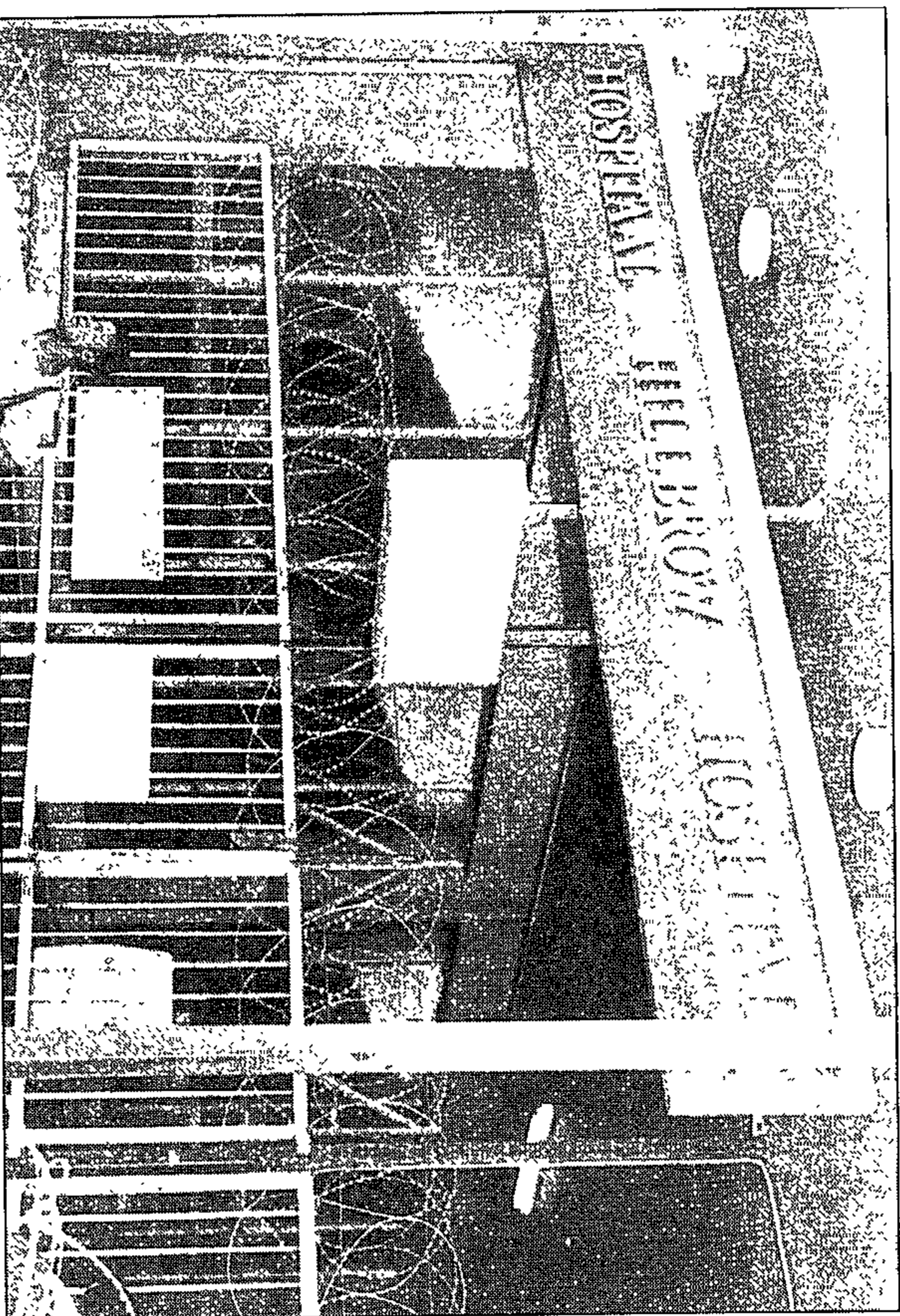
These are the hospitals where, 10 years ago, today's private doctors were trained. As they lose top academics and conditions deteriorate, so too will the quality of doctors they produce. Brink fears that unless the state of academic medicine is addressed, South Africans may ultimately have to go overseas to obtain hi-tech medical treatment

As the home of three academic hospital complexes, the Western Cape has been particularly hard hit by government's plan to divert resources towards primary health care while systematically reducing the province's share of national revenue. This

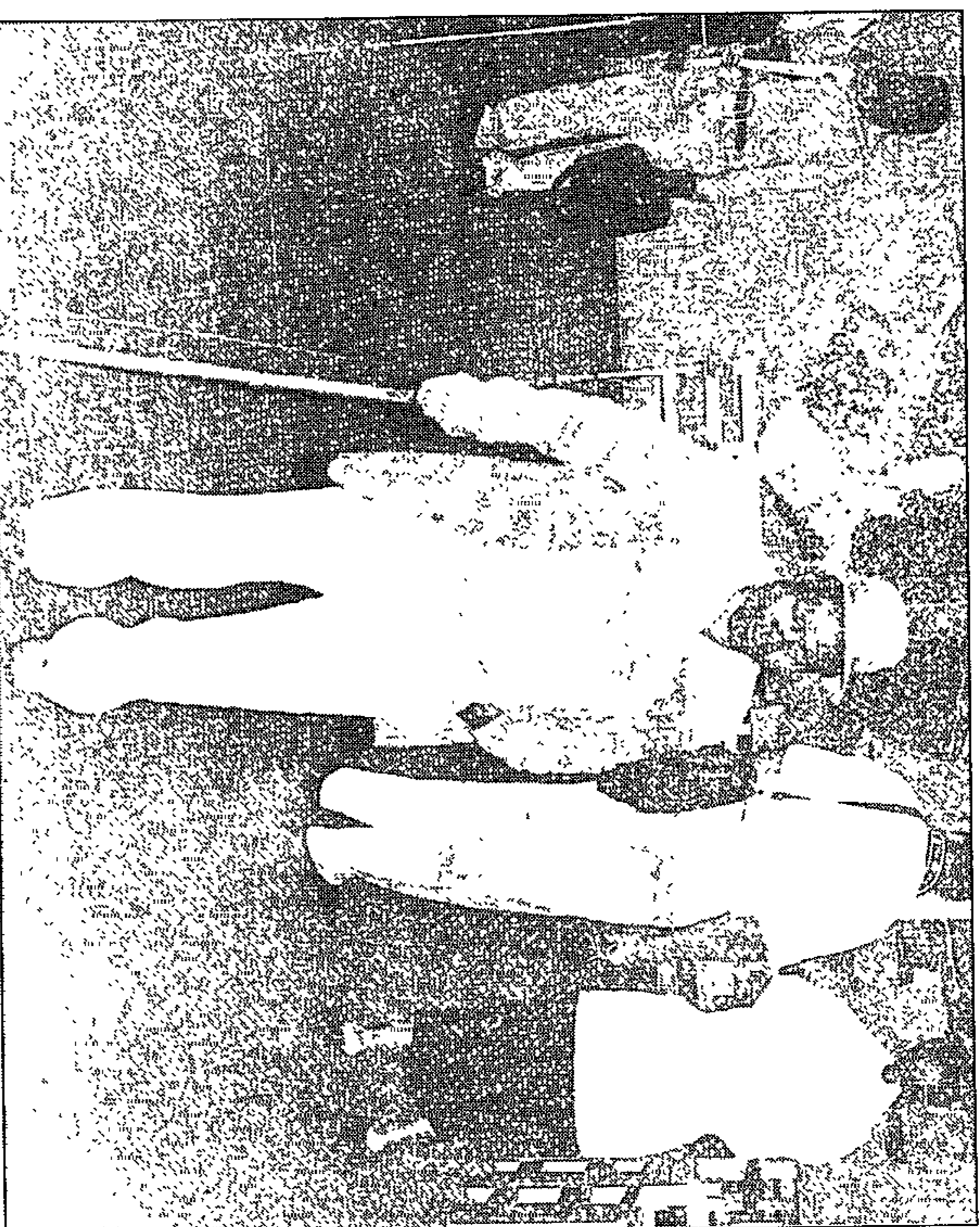


# Hospital dies for lack of money

## Gauteng Health comes under fire for creating severe problems at the hospitals



**BARRICADED ENTRANCE** ... The name of the Hillbrow hospital will be taken down on Wednesday. The hospital is being downgraded to a community health service - leaving the densely populated Hillbrow without a hospital.



**UNABLE TO HELP** ... Disgruntled Shadrack Nkosi leaves the Hillbrow hospital in tears - after nurses told him there was nothing they could do about the leg cast causing him agony. **■ PICS: SOLLY MOELLA**

**S**HADRACK Nkosi (71) of Swaziland shook his head in disgust on Thursday afternoon as a nurse at Hillbrow hospital explained to him that there was no doctor available to remove the irritating plaster of Paris cast from his swollen left leg.

"Yanguhlala lento (this thing is killing me)", he protested.

Nkosi had slept at the Johannesburg station after arriving on a train the previous night. He is one of thousands of out-patients who flock to Hillbrow hospital daily and face uncertainty.

On Wednesday the hospital is to be downgraded to a community health centre - and all the doctors have taken leave ahead of their transfers to other hospitals. Nkosi left the hospital in tears after nurses told him there was nothing they could do to help him.

Many people have expressed outrage at the Gauteng Health Department, accusing it of creating unacceptable conditions in the health sector.

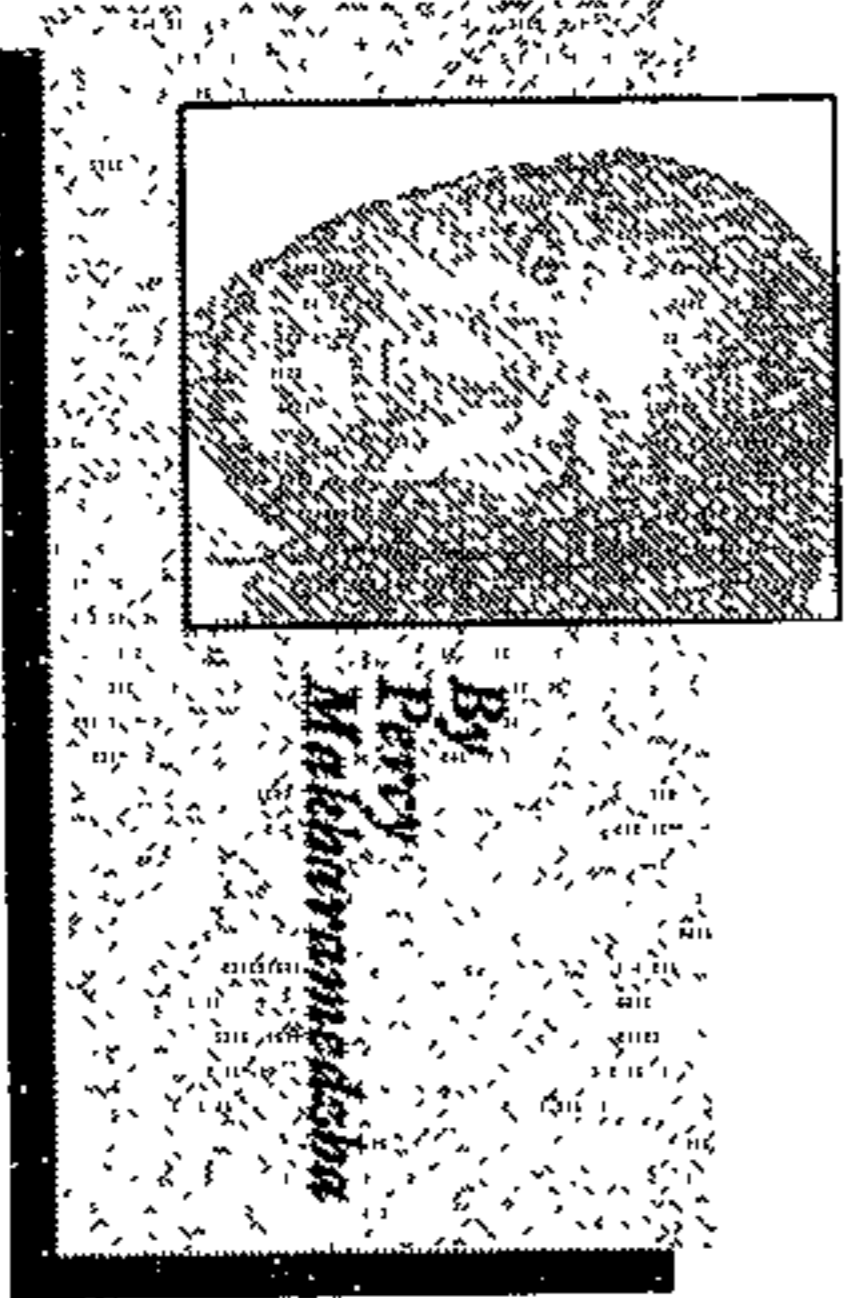
The community-initiated Ceasefire Campaign lambasted the department for closing the hospital and appealed to government to carefully reprioritise the health budget next year.

Ceasefire co-ordinator Helke Spielberg said the closure of the hospital was a harsh example of serious service reductions. "This will leave one of the most densely populated and violent areas in SA without close access to hospital and emergency facilities," he said.

The superintendent of the Hillbrow hospital, Dr Emma Bondarenko, told City Press: "Between Christmas and June 8 next year, the hospital will be transformed into a community health centre." The hospital is left with only 50 patients after more than 500 were transferred to other hospitals or discharged. It stopped admitting patients on November 15.

Dr Bondarenko said the 18-year-old hospital was being closed as part of a structural transformation plan in which six other hospitals have been downgraded and three more completely closed. Westfort, a psychiatric hospital in Pretoria, Andrew McCohn in Pretoria and Khayalami, better known as Kempton Park Hospital, on the East Rand have been closed.

Nigel on the East Rand, Lenasia, Discovery, Hillbrow, Laudium in Pretoria and Johan Heyns in the Vaal.



By Perry Makhovane

**AS part of a cost-effective plan, the 18-year-old Hillbrow hospital is being downgraded to a community health centre...**

have been downgraded. Dr Bondarenko said that about 2 000 Hillbrow employees were affected by the plan, introduced six months ago to cut down on unnecessary spending. She emphasised that no employee would be retrenched: "Nurses have been given choices either to move to other hospitals or remain with the community health centre, which will be able to employ about 200 workers."

Hillbrow surgeons have been transferred to the Johannesburg hospital and the centre would now boast specialist services, said the superintendent. "It will have short-stay wards that will accommodate patients for a maximum of three days and it will act as a respite and referral institution for clinics and hospitals," she said. The Hillbrow centre would offer promotive, preventative and curative services in: mother and child health,

including immunisation; reproductive health; treatment and care for infectious diseases, including HIV and AIDS. "It will also offer facilities for the management of chronic conditions like hypertension, diabetes and asthma; geriatric services; community-based rehabilitation services; mental and oral health services; and medico-legal services," she said.

Sister Lydia Gxwala, of the chemotherapy department, said: "Our transfers have not yet affected us." Our department is for out-patients, so maybe they have decided to begin with the in-patient wards. "The situation is traumatic because we have been given short notice. We were told to be ready to leave Hillbrow hospital as it was going to lose the department," she said.

patients come back to me complaining that they have been turned away from Johannesburg hospital. "Patients are suffering. Those who are supposed to be operated on are forced to wait - with serious complications - for the other hospitals to finish the list they they already had," said Mhlauti. If a patient needed emergency service, Mhlauti said, the nurses had to summon a doctor from his home by phone. "We send most patients to other hospitals. Some obviously don't have

Gxwala added that she was definitely going to be transferred to the Johannesburg hospital because, on the East Rand, there was no hospital that has chemotherapy wards. For nurse Vhah Mhlauti of the eurology department, the changes in the hospital have brought confusion. "Some

money to travel up and down. But we have to force them - otherwise they could get worse," said Mhlauti. Senior Medical Superintendent of the Central Witwatersrand Health Region, Dr Mohamed Darod, a specialist in primary health care, said Hillbrow hospital staff would be transferred to Helen Joseph, Johannesburg, Edenburg, Leratong, South Rand or the Tambo memorial hospital in Boksburg. He said in-patients would be transferred to these hospitals free of charge. According to Dr Darod, Hillbrow hospital has been converted because many people admitted to the hospital were not from Hillbrow. He said: "We opted to set up new specialist services in hospitals in the areas from which many Hillbrow patients come. The new services will be provided by a pool of rotating doctors, according to a series of hard-won agreements between provincial health authorities and academic departments at the Johannesburg hospital. "Bed occupation at the Hillbrow hospital is not cost-effective. Only 56 percent of the beds are used. The department is paying excessively to maintain unused beds. "Ninety-five percent of the sick people who go to Hillbrow hospital are in need of primary health care," said Dr Darod. "With unused beds at other hospitals in Johannesburg, we'll be able to accommodate the five percent of in-

patients come back to me complaining that they have been turned away from Johannesburg hospital. "Patients are suffering. Those who are supposed to be operated on are forced to wait - with serious complications - for the other hospitals to finish the list they they already had," said Mhlauti. If a patient needed emergency service, Mhlauti said, the nurses had to summon a doctor from his home by phone. "We send most patients to other hospitals. Some obviously don't have



# SICK SCUM

## Christmas thieves prey on children in cancer ward on way to chemotherapy

CAS ST LEGER

ST 21/12/97 (98)

the Sunday Times president in Broome, who said he himself with Ji es saw the c lent crimes h se the familie ffect. We s come to as terrent. Yet

**H**EARTLESS thieves are preying on children being treated for cancer.

They have stripped the children's wards at Johannesburg Hospital of toys, clothes, a TV, video machine and microwave oven — and this week even walked off with the Christmas decorations.

"How low must a person be to steal from sick children," asked cancer charity worker Jane Bruss.

Health department figures indicate that theft from state hospitals has trebled. The most recent figures show equipment worth R2,08-million was stolen last year, up from the R708 000 two years before that.

But the targeting of critically-ill young patients is a sickening new trend.

Among the crooks is a bogus doctor on the prowl at Johannesburg Hospital.

In the latest incident, a blanket and coat were snatched from a 20-month-old toddler about to undergo chemotherapy on Friday. Thieves had already stolen her favourite toys, a pink elephant and a blue bear.

Other thefts in the weeks before Christmas include:

- A Dracula toy from an eight-year-old boy;
- A TV and video machine used to show cartoons to children undergoing chemotherapy;
- A microwave oven;
- A hand-held computer game;

● Meals en route from the kitchen, leaving the youngsters nothing to eat but bread; and

● Parents' belongings, including a purse and cellphone from a mother attending to her sick child. Locks on most of the cupboards provided for parents have been smashed and cars have disappeared from hospital grounds.

The only likely culprit spotted so far has been a man posing as a doctor, complete with a green theatre gown.

Robin Bruss, chairman of the Parents' Association of Children's Haematology Oncology Clinics, or Choc, said the man's movements coincided with the disappearance of appliances.

"Someone must have let this man in via a fire escape late at night when the wards were dark," said Jane Bruss, a Choc committee member.

The man — or men — has been spotted by two small girls who claimed he "flashed" at them.

Sam, a 12-year-old patient, said a man pretending to be a doctor had told him to go to the lift to meet his father. The boy said he knew the man was bogus because a real doctor would not have told him to get out of bed while on a chemotherapy drip. He said as much to the intruder, who then left.

Nadia Greyvenstein, aged 20 months, was so upset after her favourite blanket was snatched that she had to be sedated before undergoing chemotherapy on Friday.

Her mother, Jacqui Greyvenstein, said she stepped into a crowded lift at the hospital with Nadia at 7am.

"Nadia's favourite blue blanket and a jacket were on top of my bag. Nadia cried out: 'Mummy, coat, coat,' but I couldn't see what was going on. When we got out of the lift, I discovered that what had upset my daughter was the theft of her 'blankie' and jacket."

A few days before, the girl's favourite toys went missing.

Twelve-year-old orphan Glen Mofokeng's favourite toy, a hand-held computer game donated by Choc, was stolen this week. Now he and his fellow patients can do little more than wish for another for Christmas.

Leonard Cruywagen, 8, was given a Dracula doll to give him courage for his coming bone marrow test. When he returned from theatre after 15 minutes, it had disappeared.

"Maybe another boy was made happy," he said.

A shocked Health Ministry spokesman, Vincent Hlongwane, appealed to hospitals to beef up security to stop thefts, particularly those affecting children, and "to the whole community to make such behaviour socially unacceptable".

He said Health Minister Dr Nkosazana Zuma's particular concern was the well-being of children.

"We appeal to people with any information to pass it on to the relevant officials," he said.

In Gauteng state hospitals alone, equipment, linen and drugs worth R12-million were stolen in the three years to 1996. Johannesburg Hospital accounted for R1,2-million of that figure.

Robin Bruss said he and Choc would do whatever it took to ensure children with cancer received the best possible treatment in the best surroundings.

"You can't compromise a child with a disease as serious as cancer," he said.

Choc's eight committee members had done everything from buying linen when hospital supplies ran out to arranging

the cleaning of wards.

His wife said that every couple of months ward staff called her to say there was nothing but bread for the children's meals.

Johannesburg Hospital superintendent Dr Trevor Frankish denied as unsubstantiated the allegation about the lack of food.

"We are aware of intermittent thefts

from various parts of the hospital," he said. "We are not aware of the allegations about a bogus doctor."

Cancer Association of SA spokesman Jill Nay said they had written to the superintendent about the thefts.

● The SundayTimes will donate a TV set to Choc for the young patients.

**Choc**

We are ladies and gentlemen of the world. Our perfume is fragrant. Work with us.

Joining includes training. If you advance, you have opportunities for growing.

Barbara

Taking care of you.

NA



# Johannesburg Hospital on critical list

Extra patients strain medical resources already overburdened by festive season casualties

BY DEREK ROONEY

Johannesburg Hospital, regarded as one of the country's premier state hospitals, is buckling under a patient load which has increased at the same time as the festive season onslaught.

The conversion of Hillbrow Hospital to a community health centre has resulted in a massive overflow of patients to the already overburdened Johannesburg Hospital.

The hospital as a whole is bursting at the seams, with a 130% bed occupancy. Emergency admissions often have to lie on the floor as staff battle to find places for patients, while the trauma unit is operating at 200% capacity.

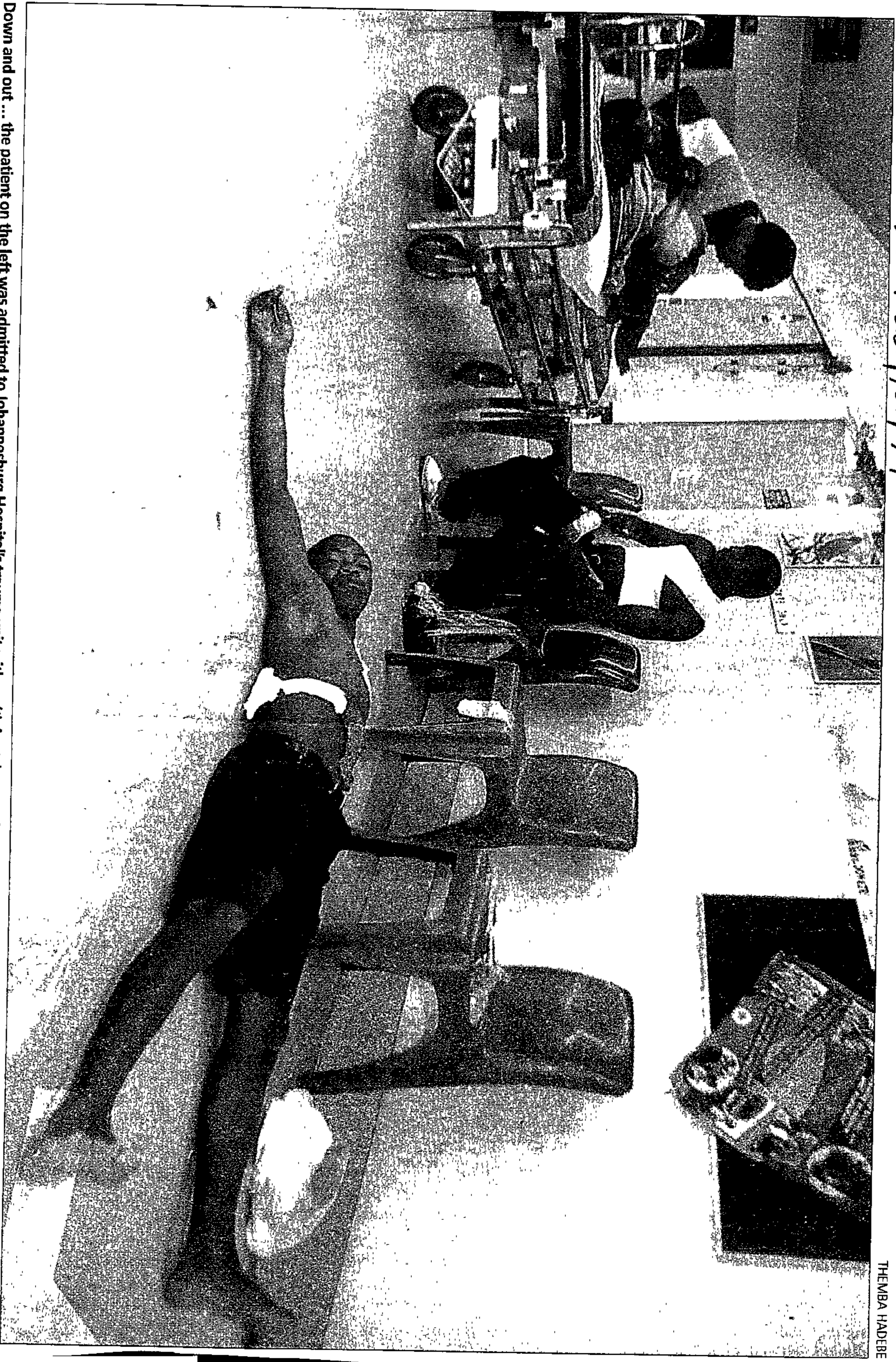
The Star has learnt from senior doctors at the hospital that several deaths might indirectly have resulted from Hillbrow Hospital's conversion last month, but this is disputed by Johannesburg Hospital's chief medical superintendent, Dr Trevor Frankish, as unsubstantiated.

Before its conversion, Hillbrow dealt with about 170 emergency cases a month. According to medical staff most of these cases have spilt over to Johannesburg's trauma unit.

When The Star visited the unit at the weekend, admittance records revealed that between 95 and 110 patients a day were treated on weekends and public holidays, while between 60 and 80 were admitted on weekdays.

But besides the emergency cases seen by the trauma unit, up to 600 walk-in patients a month are expected to now go to Johannesburg Hospital. Dealing with them at a hospital which at any given time already receives about half of the overflow from other busy state hospitals, is a recipe for disaster, say a number of doctors interviewed by The Star. "They could not have closed

Star 22/12/97



THEMBA HADEBE

Down and out ... the patient on the left was admitted to Johannesburg Hospital's trauma unit with multiple stab wounds to his back and shoulder. While waiting for treatment, his options were the row of chairs or the floor.

Hillbrow Hospital at a worse time of year, a month before the festive season," said Dr Harry Berzen, a former orthopaedic surgeon at Hillbrow Hospital.

A trauma unit is being put in place at Edenvale Hospital to

deal with some of the influx but, according to Berzen, this unit will not be fully functional until March. Most of Berzen's team has been transferred to Edenvale and Boksburg/Beroni hospitals.

Johannesburg trauma unit head Dr Kenneth Boffard said his unit was stretched beyond its limits to cope with the overload and had received no extra staff, beds or equipment.

The situation at Johannes-

burg Hospital is compounded by the fact that orthopaedic operations have been cut back until early next year to make way for emergency operations, resulting in a backlog of up to a week for patients needing

surgery for serious fractures. These patients often clog up the trauma unit as there is nowhere else in the hospital to put them.

The trauma chaos is further exacerbated by the fact that one

of the three duty doctors is permanently, using duty in the hospital's emergency helicopter, which is working overtime during the festive season. The remaining two doctors are assisted by four nurses.



# 'You are not going to die, now please wait outside'

BY DEREK ROBNEY

Johannesburg Hospital has been experiencing a number of "bad" nights since the conversion of Hillbrow Hospital into a community-health centre, and this past weekend was no exception.

"You are not going to die, now please wait outside until we can see to you," were the words given to a patient bleeding from multiple stab wounds. The speaker was a harassed doctor who, after giving the man a quick check, returned to attend to other serious patients admitted to the casualty unit on Saturday evening.

When The Star visited the unit between 10pm and 2am, it

was cluttered with between 18 and 20 people who, because the available trolleys were occupied, were scattered on chairs or simply lay on the floor.

Visibly exhausted staff attended to the flood of patients, several of whom had gunshot and stab wounds, before calling in less seriously injured or walk-in patients from the crowded waiting area.

Treated patients often have to wait several hours in the casualty unit as duty nurses and doctors attempt to find beds for the more serious cases.

"It's a zoo in here over weekends and public holidays, and we constantly have to play musical chairs with new arrivals as we don't have the

beds or facilities to deal with them," one nurse said.

In some instances, doctors were forced to treat patients as they lay on the floor. In one case, a girl who had a broken wrist had to wait for more than four hours before she could be treated by an orthopaedic surgeon.

"We do a quick check as they come in. If it is not life-threatening, we tell them to wait outside until we can call them in. It's not the way medicine is meant to be practised, but with the limited staff and equipment we have, there is no alternative," a trauma doctor said.

One nurse answers the telephone (as ward clerks work

only certain shifts); a second nurse threads stitches; a third does resuscitations; and the fourth controls the walk-in patients.

Unit head Dr Kenneth Boffard is under no illusions about the difficulties.

"One doctor does stitches while the second doctor links up with a nurse for resuscitations," he said.

The hospital averages about 14 resuscitations a day.

Boffard expects the nightmare in the casualty unit to become worse.

"We don't have the staff, beds or equipment to cope with the situation, let alone offer proper trauma care for people who need it most," he said.



# Bleak job outlook for new cancer workers

## Budget cuts to force unit's closure

JENNY VALL  
HEALTH REPORTER

Five newly-qualified oncology radiographers have no jobs next year in spite of the fact that Groote Schuur Hospital's cancer unit will have to close one of its units because there are no staff to run it.

Posts have dwindled from 44 to 29 during the past four years, says Liz Greeff, assistant director of radiation oncology at the hospital.

Cuts in the Western Cape Health Department budget have meant that when posts become vacant they are frozen.

Five staff - all with many years of experience who will be hard to replace - have taken voluntary severance packages.

Others have resigned. In June this year, eight vacant posts were abolished.

"One in four people get cancer and every year we register between 2 500 and 3 000 new patients. Two thirds of new patients need irradiation. And we also treat those whose cancer recurs," said Mrs Greeff.

"We now have five qualified students who need jobs. Cancer treatment is carefully planned and administered and we need adequately trained staff, which these young people are. But we cannot employ them."

Dudley Werner, head of oncology at Groote Schuur Hospital, said although his department's equipment needed upgrading, patients still received excellent treatment.

However, with too few staff to run the machines, one of the major cobalt units was running only half time and would have to be closed in the new year.

The hospital has four major treatment units and two subsidiary units.

"We can't use the machines optimally because we don't have the staff. People have to go on a waiting list, but with malignancies you don't want to wait because it's detrimental to the treatment," he said.

Waiting lists for radiotherapy for cancer patients at the hospital now run to four weeks.

Lack of adequate staff is placing many of the curative treatment programmes in jeopardy.

"The radiographers are a wonder-

ful, dedicated group who, of their own volition, have decided to work shifts to assist in reducing the waiting list and are doing this without financial reward," Professor Werner said.

The five students say there are no jobs available in the Western Cape.

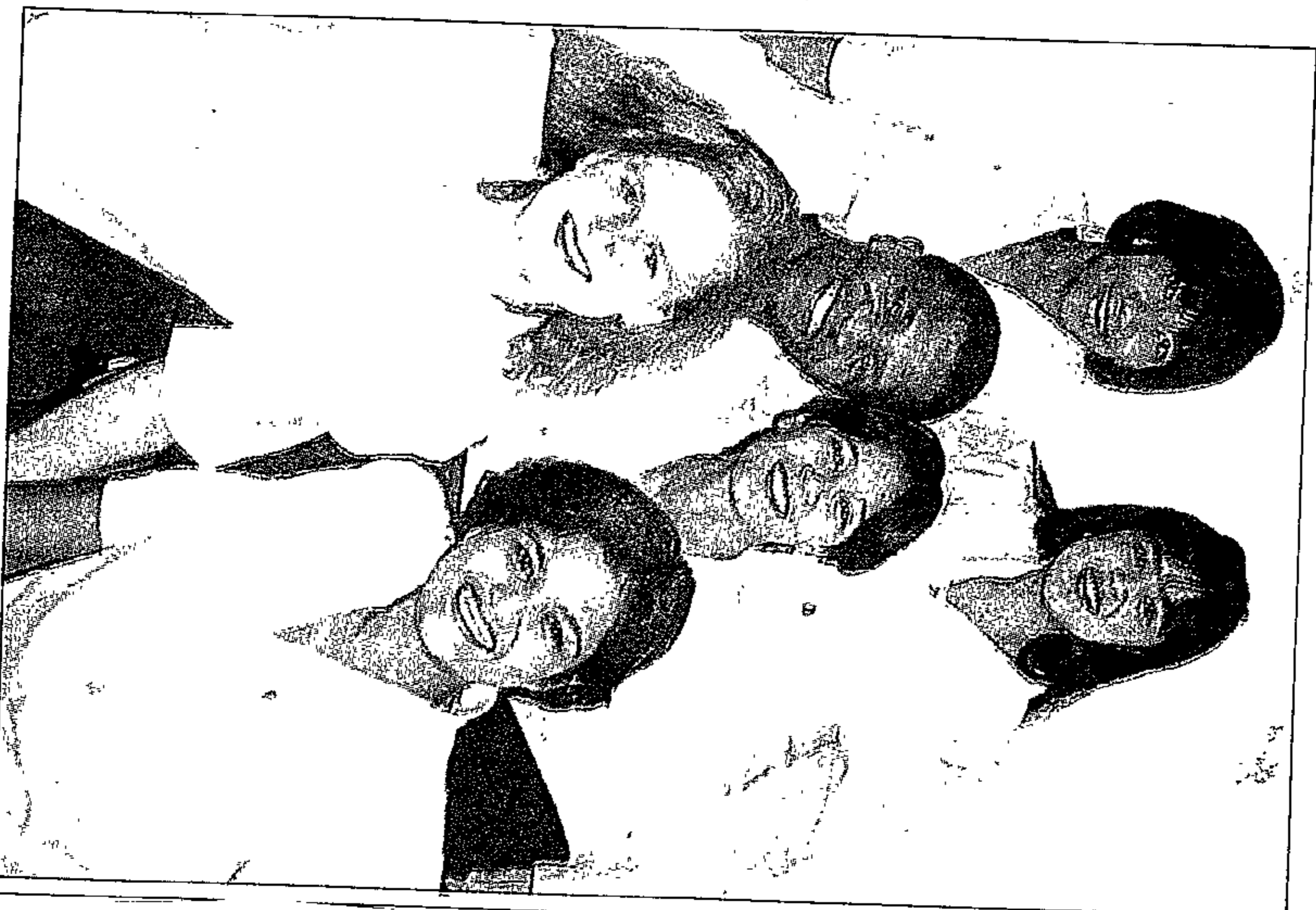
"It's a very specialised course and the private sector is full," said Zaidah Hoosain, one of the students.

"While other countries are willing to employ oncology radiographers from South Africa, they want a few years' post-graduate experience. We don't want to leave, we want jobs here."

Only one student, Enoch Gutywa, who did an advanced course in radiotherapy, has found a job in East London.

Six years ago the Cape Argus started a campaign for the oncology department and successfully raised R5,5-million to buy new equipment. The present budget would preclude the maintenance and upgrading of the machines, Professor Werner said.

He said 83% of patients referred for cancer therapy did not have medical aid or health insurance. "What is to become of these people?" he asked.



**No jobs:** Five women who recently qualified as oncology radiographers, clockwise from left top, Liza Spangenberg, Shafieka Darries, Zaidah Hoosain, Gadija Hendricks and Teresa van der Byl, with Enoch Gutywa, who did an advanced course in radiotherapy



# State hospital battling under seasonal load

(98)  
OWN CORRESPONDENT

07 20/12/97

JOHANNESBURG: Johannesburg Hospital, one of the leading state hospitals in the country, is buckling under its patient load as the festive season peaks.

The closure of Hillbrow Hospital last month has resulted in a massive overflow of patients at Johannesburg Hospital, which now has 130% of its normal patient capacity.

Emergency patients often have to lie on the floor while staff battle to find places for them.

The trauma unit is operating at 200% of capacity.

Before it was closed, Hillbrow Hospital dealt with about 170 emergency cases a month. According to doctors, most of these have spilled over to Johannesburg's trauma unit.

But dealing with up to 600 extra walk-in patients a month at a hospital which at any given time receives about half of the overflow from other state hospitals is a certain recipe for disaster, say doctors.

"They could not have closed the Hillbrow Hospital at a worse time of year, a month before the festive season," Dr Harry Berzen, former Hillbrow orthopaedic surgeon, said.

Johannesburg Chief Medical Superintendent Dr Trevor Frankish said: "There are usually enough doctors. Less-injured patients will be referred to Hillbrow Casualty (which will continue to function) and more seriously injured patients will be referred to other hospitals, which may have some spare capacity, if necessary."



# Health workers defy stayaway

(98)

Sowetan 23/12/97

## Organisers blame hospital authorities

By Khathu Mamalla

**H**OSPITALS in the former Venda homeland have been operating as usual despite calls by Daba-lo-rivhuwa Pension Crisis Forum that health workers should join a stayaway which started about two weeks ago.

Chairman of the forum Mr Tshifhiwa Makhale said last week that workers had resolved that the stayaway aimed at forcing the government to surrender the pension fund to its beneficiaries should affect all civil servants, including those rendering essential services.

Makhale had said health workers would be briefed about the decision and added that critically ill patients could be transferred to other hospitals outside the former homeland.

However, *Sowetan* has discovered that hospitals in the area were working as usual.

Makhale confirmed yesterday that

things were normal at hospitals.

He said there had been a problem of communication as the department's senior officials had refused forum leaders access to the hospitals.

"Our plan to move from one health institution to another was frustrated by the officials who did not allow us to address the workers.

### Support action

"The workers do not attend our meetings and it is difficult for them to support our action.

"We will continue to search for ways of informing them about our action. The stayaway has been effective, although there are a few people in other departments who are working," said Makhale.

He said the stayaway would continue until the government had responded to the workers' demands.

The government has repeatedly said that workers would not get their pensions as long as they were still employed.

The workers are demanding that they be paid the money that remained in the pension fund when the scheme was privatised in 1992.

Meanwhile, Makhale, who has refused to be transferred from Thohoyandou to Pietersburg, has been served with a letter informing him of his dismissal.

According to Makhale, if he failed to report in Pietersburg on December 15 he would be seen as having absconded.

Makhale did not report in Pietersburg on the day. He argued that the transfer was aimed at weakening the forum. He said he had already briefed his lawyer to challenge the government on the matter.



# Urgent meeting over hospital crisis

Star 23/12/97 (98)

By DEREK RODNEY

An emergency meeting of hospital managers has been scheduled for today to discuss the "disproportionate" flood of trauma patients to Johannesburg Hospital, due largely to the conversion of nearby Hillbrow Hospital to a community health centre.

Following an article in The Star yesterday, in which conditions at the congested unit were highlighted, the Gauteng Health Department conceded yesterday that the conversion had caused a substantial overload of trauma patients at Johannesburg Hospital.

A weekend visit to the trauma unit revealed how patients waited for hours, sometimes lying on the floor because of a lack of stretchers or beds, before receiving treatment for injuries.

Staff and equipment are stretched to the limit to deal with the steady stream of pa-

tients over the festive season.

The managers are expected to discuss issues affecting conditions at other Johannesburg hospitals and the possibility of redistributing vital equipment and personnel from less stressed hospitals to the hard-hit hospitals.

Department spokesman Jo-Anne Collinge said large num-

## Trauma patients flood in

bers of trauma patients were being accommodated in wards which were not usually used for these purposes.

"In addition, there has been insufficient nursing and administrative support for the unexpectedly heavy demand on the casualty section, as well as a shortage of equipment (such as trolleys and wheelchairs)."

Collinge said various steps were being taken to strengthen Johannesburg Hospital's capacity to cope with this large trauma load. They included the secondment of additional staff from Hillbrow and the transfer of more equipment.

Collinge reminded inner-city residents that there was still a casualty service, around the clock, at Hillbrow Hospital, which, although not equipped to deal with the most severe cases, could still cope with sewing up cuts and stab wounds, setting broken bones, and dealing with ordinary burns and household injuries. The casualty section at Hillbrow Hospital can be accessed at any time through the main entrance.

"Service users should not be put off by the fact that secondary entrances have been closed off for security reasons now that many sections of the hospital are not in use," Collinge added.



# 'Health services are deteriorating fast'

Pearl Sebolao

THE United Democratic Movement called on Health Minister Nkosazana Zuma yesterday to appoint an inquiry to investigate the theft of equipment and supplies worth more than R12m from Johannesburg General Hospital.

Party spokesman Paulo Andrade said the theft underlined an unhealthy state of affairs in the department, especially in Gauteng, where health services seemed to be deteriorating fast. He urged Zuma to put in place measures to ensure state assets were not abused.

Johannesburg Hospital's medical resources could barely cope with the increasing patient load over the festive season

and the conversion of Hillbrow Hospital into a community health centre had led to a massive overflow of patients.

The party's call followed the announcement by Soweto's Chris Hani Baragwanath Hospital of strict spending constraints in an effort to cut its projected R152m overspending this financial year.

Andrade said Zuma "must be held accountable personally for this state of affairs. Failure to deal with the problem expeditiously will once again reflect on the total inefficiency of a health department."

Andrade said it was evident that medical services in government-controlled hospitals were in a state of crisis.

"We are asking her if she is capable of controlling the situation. If she can't then

she must reconsider her position" and allow a capable person to take over, he said.

The National Party (NP) blamed what it called the tripartite alliance's dogma-driven policies and administrative bungling for the chaos in the Gauteng health system.

With Johannesburg Hospital buckling under pressure, Chris Hani Baragwanath delivering only emergency treatment, the conversion of Hillbrow, and Helen Joseph and Coronation paralysed by labour disruptions, "it can justly be stated that public health services in Gauteng have become nonexistent", the NP said.

Blaming the situation on apartheid would no longer disguise incompetence. It said it would demand that Gauteng

ED 23/12/97

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premier-elect Moshkega took urgent steps to restore acceptable health services to the people of Gauteng.

Meanwhile, the provincial health department denied there were disruptions at the Helen Joseph and Coronation hospitals. A conflict which had affected services in November had been resolved by an independent investigation, spokesman Jo-Anne Collinge said.

She said it was untrue that Chris Hani Baragwanath was delivering only "emergency treatment". It would perform only urgent and emergency surgery for the next few months to reduce its overspending.

Steps were being taken to strengthen Johannesburg's capacity to cope with the large trauma load, Collinge said.

# Johannesburg hospital in dire straits

*Jo Sowell 24/12/97 (98)*

By Sello Seripe

THE heavy inflow of patients at Johannesburg Hospital as a result of the closure of Hillbrow Hospital could soon land the hospital in a financial crisis.

Sowetan has learned that even before patients were diverted to Johannesburg Hospital, the institution had already overspent its budget by R160 million. The state allocation to the hospital was R480 million in 1996/97.

Johannesburg Hospital's chief medical superintendent Dr Trevor Frankish yesterday agreed that the hospital faced a financial problem and "must make extra efforts to reduce its over-expenditure." The next budget allocation is in March 1998.

Head of the trauma unit at the hospital, Dr Kenneth Boffard, suggested that the allocation made out to Hillbrow Hospital for 1996/97 should

be transferred to Johannesburg Hospital to alleviate the burden now faced by that hospital.

Dr Boffard, who is also a senior lecturer in the surgery department at the University of Witwatersrand, said it cost between R7 000 and R10 000 a day to treat a single trauma patient, especially victims of road accidents.

He said patients living around Johannesburg preferred to come to Johannesburg Hospital because it was the nearest since the closure of Hillbrow Hospital.

"This has resulted in double workloads for the nursing staff. For example, the trauma unit can only accommodate 28 patients, but due to the current influx, 56 patients are presently admitted to the unit.

"On the other hand, nurses and doctors cannot do overtime work because there is no money to pay for extra work performed," he said.

Department of Health

(GDH) spokesperson Jo-Ann Collinge said most of the hospitals overspent while under the now defunct Transvaal Provincial Administration and the GDH inherited the deficit.

Collinge said nurses and doctors could still perform paid overtime work if the need arose.

## Last few patients

She also pointed out that staff, seconded to other hospitals would remain on the payroll of Hillbrow Hospital until permanent appointments were made.

Meanwhile, only 15 patients still remained at Hillbrow Hospital yesterday while preparations were being made for their transfer.

The hospital's superintendent, Dr Emma Bondarenko, said the hospital's 747 beds would be given to other needy hospitals.

Dr Bondarenko said a multi-union team representing workers and management were involved in a process to

ensure that staffers were seconded to hospitals of their choice.

Hillbrow Hospital, which is being converted into a community health centre, has seen a rapid decline of number of patients since it stopped admitting on December 15.

Sister-in-charge of casualty said since December 15, only 324 patients were treated and either discharged or transferred to other institutions.

Units that have been relocated from Hillbrow Hospital to Johannesburg Hospital include ophthalmology, urology, the in-patient and radiation therapy for various cancers.

Meanwhile, the National Party has accused the ANC government of lack of financial and managerial skills regarding health services.

The party said it would demand that Gauteng premier-elect, Mathole Motshekga, who assumes office in mid-January, takes emergency steps to restore "acceptable health services".



# Disciplinary (98) *seweta* 24/12/97 action suggested

A TEAM of investigators into last month's violent conflict between members of the National Education, Health and Allied Workers Union (Nehawu) and the administrative staff at the Helen Joseph Hospital has recommended that disciplinary action be taken regarding the incident, the Gauteng health department said yesterday.

It said the recommendations were contained in a report by the investigating team headed by labour relations director of corporate services in the Gauteng health department Mr Adrian Oelofse, assisted by assistant directors in his office Mr Vincent Dladla and Mr Stanley Rakgantso.

The team recommended that disciplinary hearings should be instituted in relation to:

- The "roughing up" of a Nehawu shop steward, allegedly by a traffic officer called in by his mother who works in the administration unit, on November 14;
- The forced removal of administrative staff allegedly by Nehawu members on November 17; and
- The alleged assault of a member

of the administrative staff by a leading Nehawu member on November 17.

The statement said charges would be drawn up relating to all these incidents and disciplinary hearings would be instituted in January.

The health department also accepted the investigation team's view that disciplinary hearings relating to industrial action in August should be expedited.

It said immediate steps should be taken to fill senior vacancies at Helen Joseph Hospital.

The report stated that the hospital was in "dire need of effective leadership". It highlighted the fact that with the exception of the head of nursing, all top management posts were currently vacant.

"Head of nursing Matron Jane Ramaboa is mentioned as having the skills, experience and leadership qualities needed to tackle some of these tricky labour relations questions and is recommended as acting superintendent," the statement said.

"However, national legislation still stipulates that the superintendent must be a medical doctor."

In the light of this the department had decided that:

- Dr Arthur Manning, superintendent of Coronation Hospital, would continue to "double" as acting superintendent of Helen Joseph Hospital. The post would be advertised in January;

- Dr Hans Rothschild would be transferred from Tara Hospital to assist Manning;

- Boitumelo Matsose, an assistant director at head office with experience in a number of hospitals, would be seconded as acting hospital secretary; and

- Various unattended grievances, lodged both by Nehawu and management, be investigated as soon as possible and resolved.

The statement said a process had been agreed for Helen Joseph Hospital's new executive team (Manning, Ramaboa, and Matsose) to review the grievances and ensure action in relation to matters which were pending. Acceptable deadlines had been set.

Additional findings included:

- The death of a man at the X-ray department was not linked to the problems between Nehawu and the administrative unit. *Sapa*

# The blood still flows at Bara

By Pearl Rantsekeng

**A** HUGE SIGN greets you as you enter the Chris Hani Baragwanath Hospital in Soweto. It reads: "Only

urgent cases and those referred by private doctors will be seen. Non-urgent cases from Soweto are requested to attend the Soweto Community Health Centres."

It's a Sunday night, a few minutes after nine, and yet the movement outside the hospital's casualty ward belies the time. It's as if it is daytime with private cars and ambulances coming and going as if at a taxi rank. Hardly five minutes after the arrival of the *Sowetan* team, four serious cases had poured in.

All the injured people were males, one had a gaping stab wound in his left arm, a broken bottle protruded from his chest. He screams that it should be taken out.

"*Hey mina angina niks*. I am not injured, please just take out this bottle from my chest so that I can go home," says the drunk youth as he

**Five minutes after we got there, three men with stab wounds arrived**

fiddles with the wound on his arm.

Everyone in the ward just turned away in shock, not wanting to look at the wound. Except for the nurses on duty who continued with their work, seemingly unperturbed by the youth.

After all it is nothing new to them. Actually they have seen worse.

The other three patients were in a similar condition. Their injuries send shivers down one's spine.

One of the men had a bandage on his head that had changed colour to red. The man appeared to have been hacked with a panga.

As one of the nurses removed the bandage to attend to him, blood just oozed out of his head like water com-

ing out of a tap.

The other man appeared to have been either shot in the leg or was involved in an accident. Still clad in pants, his left leg was soaked in blood with no apparent injuries to his upper body.

The last victim was wheeled in on a stretcher by paramedics, with a neck brace on. He was knocked down by a car. Throughout the

razzmatazz in the casualty department, only four nurses are seen working tirelessly, admitting all the patients flocking in.

The nurses, mostly young, seem genuinely committed to their work and have the patience needed for their stressful job (unless they were acting after seeing this reporter taking down

notes) as they went about helping the families and friends of the injured while admitting them.

What was apparent was that most of the injured, if not all of them, were drunk.

A factor which the nurses had to contend with was some of the patients started throwing tantrums while another just decided to throw up on the floor where he was seating.

What was amazing about the whole evening was the speed with which the nurses and about 10 clerks, worked to get everyone registered and ready for the doctor.

Only one doctor, a middle-aged black man, was visible throughout. His task appeared to have been made easier by the nurses, who seemed to be keeping the situation under control.

Some patients with minor wounds did not even have to see the doctor. The nurses attended to their injuries and in no time they were on their way out.

What puzzled me was that none came out with any form of medica-

(98)

*Sowetan 24/12/97*

tion - not even pain tablets or ointment - after their wounds were cleaned.

One man with less serious wounds was just wrapped in plaster and then his entire hand bandaged to hold it up.

By the time the *Sowetan* team left at about 11pm, the hospital had a lull with some of the nurses relaxing outside in the cool breeze.

But knowing Baragwanath, it would only be a matter of minutes before the nurses were back on their feet running around like crazy.

Public relations officer Ms Esther Hlongwane said nothing had changed at the hospital.

"There have been no cuts in costs, but we have introduced some saving measures within the hospital," said Hlongwane.

She said no one was turned away but only urgent cases were attended to. "The doctor normally sees the patients and all those cases that aren't urgent are sent back and given a date to return for the operation," said Hlongwane.

**I am not injured, please just take this bottle out my chest so I can go**



# Boost for trauma unit at Jo'burg Hospital

(98)

Extra staff and equipment provided after

arrangement with Hillbrow worked out *SPW 24/12/97*

**By PRISCILLA SMITH**  
Health Reporter

**T**he Gauteng Health Department (GHD) took measures yesterday to bolster the embattled Johannesburg Hospital's trauma unit.

Extra staff and equipment have been brought in to cope with the influx of patients since the conversion of Hillbrow Hospital to a clinic this month.

Management teams from hospitals around Johannesburg met GHD officials yesterday to discuss ways to alleviate the flood of patients streaming to Johannesburg Hospital's trauma unit, which experienced a 30% increase of patients since Hillbrow's conversion to a community health centre.

This followed a report in The Star on Monday in which conditions at Johannesburg Hospital's trauma unit were highlighted.

GHD acting superintendent-general Dr Eric Buch said the department had expected "some

rough patches along the road" with the conversion of Hillbrow Hospital to a community health centre. He conceded, however, that the impact on Johannesburg Hospital had been larger than expected.

Buch spent several hours at Johannesburg and Hillbrow hospitals last night to get a first-hand impression of the problems, and said he was confident the new arrangements for emergency care at Johannesburg were appropriate and would ensure satisfactory patient care.

It was agreed yesterday that a shuttle service would be operated to transfer patients from Johannesburg to Hillbrow in cases where the injury or illness was not so severe as to require trauma care.

"The Hillbrow casualty is well equipped and staffed, and could cope with hundreds of patients daily, but is currently seeing only 30 to 40 a day," he said.

The Hillbrow casualty section is not equipped to deal with serious trauma cases.

Johannesburg Hospital yesterday received additional equipment for its casualty department from Hillbrow, ranging from basic items such as trolleys to sophisticated instruments used in resuscitation.

"This will enable the hospital to cope far more effectively, particularly during peak periods," Buch said.

Signs had been erected at Hillbrow Hospital to counteract the perception that Hillbrow had "closed". Possible miscommunication by personnel, including security workers and emergency services, had been checked and pamphlets were being distributed in the area, Buch said.

"Staff from Hillbrow, such as porters and clerks, will be seconded temporarily to Johannesburg and this will free the nursing staff to do more appropriate work. Some nursing staff will also be seconded and every effort is being made to ensure that staff are in place by the Christmas long weekend," he said.



# A little bit of joy for cancer kids

ST 28/12/97

(98)

CAS SI LEGER

WARM-hearted Sunday Times readers have showered the children of Johannesburg Hospital's cancer wards with gifts and cash donations.

There has been such an avalanche of toys that five boxes full of teddy bears, dolls and other playthings were delivered to the delighted small cancer patients at Chris Hani Baragwanath Hospital on Christmas Eve.

The Sunday Times reported last week that callous thieves had stripped Christmas decorations and stolen the children's microwave, TV and video sets, toys and other personal possessions.

"We have received such an overwhelming response from the public. We are very grateful," said an overjoyed sister-in-charge Sadie Cutland.

Bongani Keswa, Sunday Times assistant editor (management), gave the young patients a colour TV on Tuesday. Cutland was forced to lock up the new TV until some way of preventing it from being stolen could be found — and the next day Sunday Times reader Gareth Ladeira donated a lock-up TV "cage".

Since last Sunday, a steady stream of families, children and pensioners has visited the hospital with offerings.

Youngsters have even handed over loved but much-used favourite teddies.

One of the most touching gifts with everything from food to toys came from Brother Giovanni — himself suffering from cancer — and his Johannesburg Destitute Feeding Scheme. Brother Giovanni also gave R500 towards a new microwave oven.

Robin Bruss, chairman of the children's cancer charity Parents' Association of Children's Haematology Oncology Clinics (Choc), said: "One of our main

projects is to provide a house where parents of children from outlying areas can stay while their children are receiving treatment. You can't take a sick child home by taxi or train after therapy, so the parents desperately need somewhere to stay near hospital.

"We have been spending our funds on replacing stolen items and were unable to save much towards the Choc home. Now public generosity has meant we have hope," Bruss said.

By the weekend, Choc had been given or pledged several cash donations by individuals who gave anything from a few rands to R1 000 — the total is not yet known. One company, Midas, donated a TV set. Others have promised another TV and video.

Patrick Lewis of Choc received the welcome of his life from the children when he took five boxes of toys to the hospital.

Christmas meals were taken care of by Woolworths at Eastgate, which gave the children anything perishable left on their shelves or in refrigerators on Christmas Eve.

Radio Highveld and Radio Today both took up the children's cause, with phone-in programmes this week that resulted in an avalanche of pledges. Through Radio Highveld, Choc was promised R10 000 by Boswell Wilkie's Circus from a special performance at 3 pm on December 30.

Thanks to the generosity of a Johannesburg couple, who asked to remain anonymous, 12-year-old orphan Glen Mofokeng

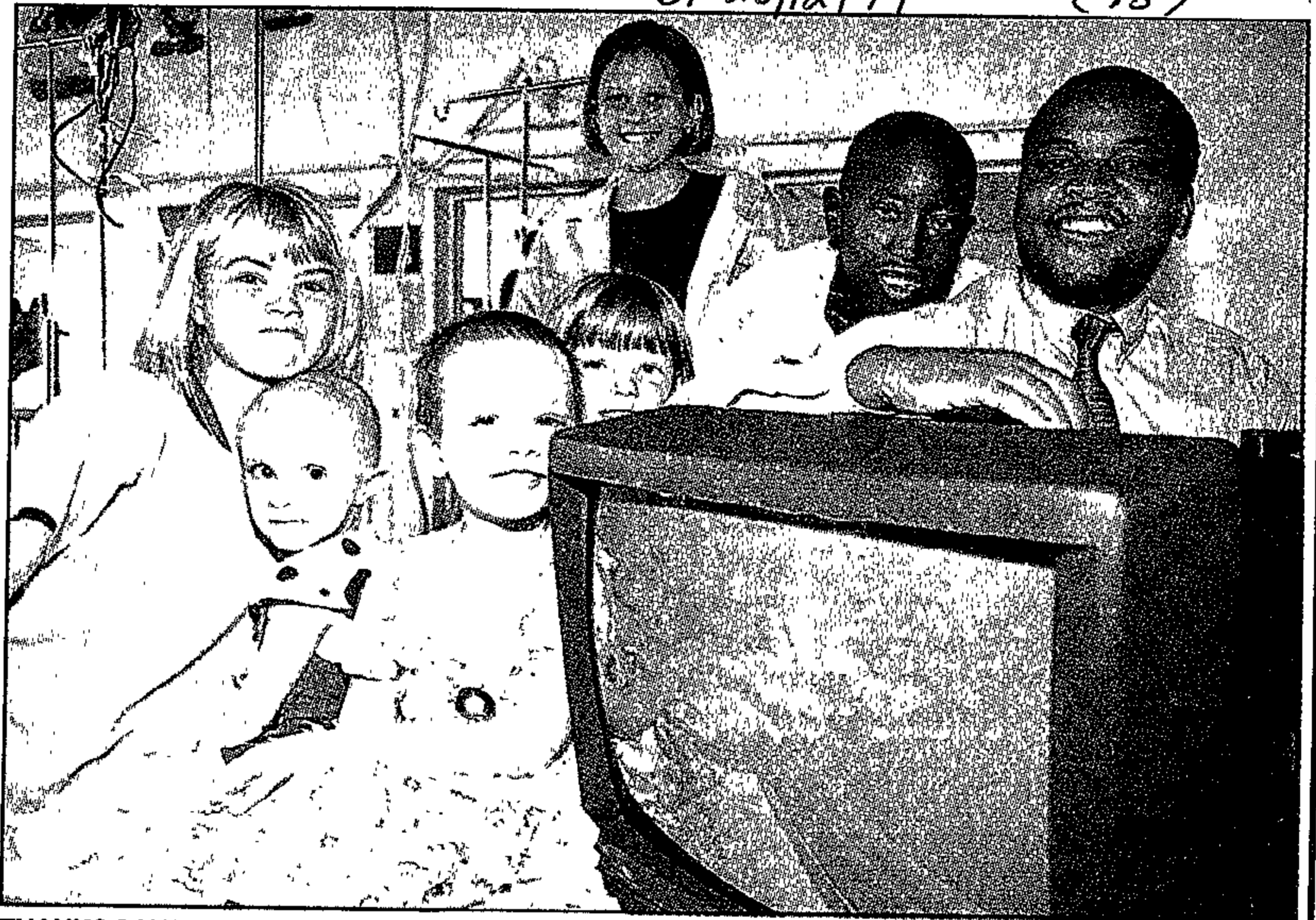
was able to go home to his aunt for Christmas. The couple gave him a gas-operated refrigerator.

"My doctor said I could go home if there was a refrigerator to keep my medicine in," said Glen, who needs daily treatment. "But my auntie moved into an RDP house in January and there is no electricity," he said.

Also among those who promised help were Game Stores, which offered to replace every item stolen.

On Tuesday, Santa Claus was sent to the hospital by the Randburg Waterfront. Santa handed out Christmas presents to children in the two cancer wards.

Choc presented the doctors and nurses with gift vouchers and it has arranged with the hospital to pay for the use of outside cleaners to keep wards pristine.



**THANKS SANTA:** Sunday Times assistant editor Bongani Keswa (right) hands over a new TV to (from left): Chané Vos, 12, Monica Zamarian, 3, Nastassja Kean, 6, Felicity Hunt, 7, Barbi Andersson, 13, and Bongani Mathe, 16, at Jo'burg Hospital's children's cancer ward  
Picture: JULANI VAN DER WESTHUIZEN



# Hillbrow Hospital now to function as a day clinic

Taryn Lamberti

ALTHOUGH the Hillbrow Hospital in Johannesburg was closed last week and all its patients were transferred to other hospitals, it will continue to function as a community health care centre and patients from other hospitals will be taken there daily for radiation treatment.

The last of the hospital's patients were transferred to other centres on Tuesday last week, after the Gauteng health department's controversial decision to downscale the hospital to a day clinic.

Hillbrow Hospital staff were clearing furniture yesterday and the hospital superintendent was sifting through a pile of applications from other hospitals in urgent need of its medical equipment.

Superintendent Dr Emma Bondarenko said she was still deciding where to transfer certain of the hospital's equipment and staff members.

Hillbrow's eight intensive care unit beds were in high demand, while four beds would go to Edenvale Hospital and a decision was still needed on the rest, Bondarenko said.

BD 30/12/97 (98)

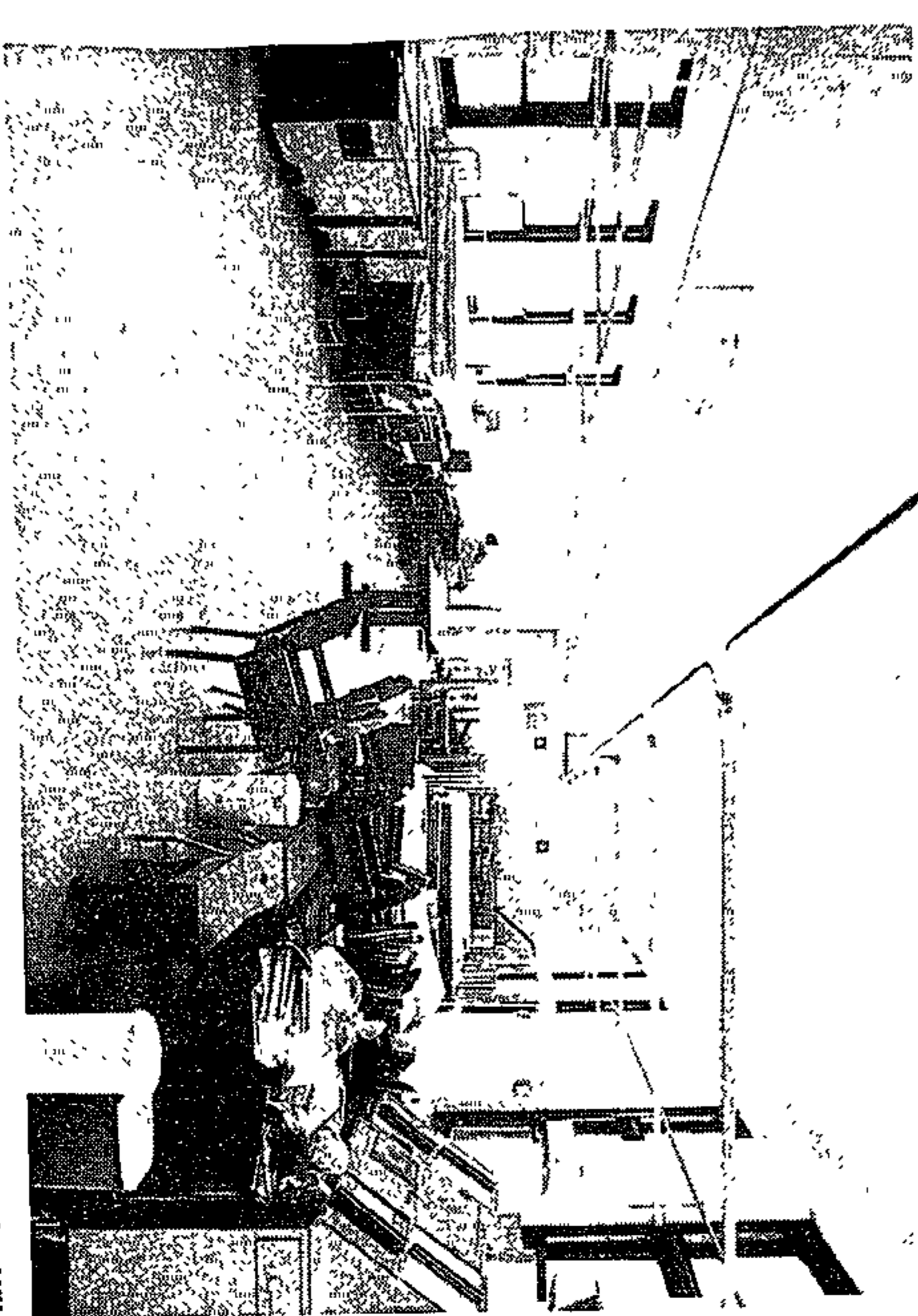
Her priority was to transfer the equipment to other primary health care centres in the Gauteng district and then to pass on what was left to other hospitals which were in urgent need of the facilities.

The Hillbrow Hospital would now function as a community health centre treating patients with minor ailments, while more serious or specialised cases would be transferred to other hospitals including the Johannesburg Hospital and the Edenvale Hospital.

Hillbrow Hospital's radiation and oncology department — one of a few in the country — would be transferred to the Johannesburg Hospital, but the transfer could take up to two years to complete.

Bondarenko said Hillbrow Hospital's maternity and paediatrics departments would be expanded to accommodate primary health care needs.

The Gauteng health department will hold a news conference today to release details of an increase in resources at the Johannesburg Hospital to cope with the influx of patients.



Patients queue for treatment at the Johannesburg Hospital, top, yesterday while the Hillbrow Hospital, bottom, stands empty after it was downsized to a primary health care centre last week and its patients transferred to other centres.

Pictures: TREVOR SAMSON



# 'All under control' at Gauteng hospitals

BY GILL GIFFORD

Hospitals in Gauteng are prepared for the anticipated flood of patients over the New Year's season and dismissed suggestions they would collapse under the heavy workload.

Gauteng Health Department acting head Dr Eric Buch said the situation at provincial hospitals was "manageable" although a few teething problems still had to be addressed.

"We experienced a bad Christmas at Johannesburg Hospital, as well as the weekend before. This was about the time of the closure of Hillbrow hospital, and insufficient

*Star 31/12/97*  
equipment and staff had been transferred from the one hospital to the other. This has, however, been completed for New Year," Buch said.

He attributed most of the problems experienced on Christmas night at Johannesburg Hospital to a communication break down.

The Star last week reported that the hospital's trauma unit was unable to cope with a flood of incoming patients, with bleeding and injured people lying on the floor.

"Unfortunately no-one called on the back-up surgical team at Hillbrow that was available to help," said Buch. A

backlog of orthopaedic patients had contributed to the Christmas chaos, but had been cleared in anticipation of the New Year rush.

"We are satisfied that more than adequate measures have been taken," he said, describing Hillbrow hospital's transformation into a health centre as a smooth conversion.

Buch said there were about 20000 beds available in provincial hospitals, with recorded figures indicating that only about 10000 patients were treated in hospital during the festive season, meaning there was no shortage of beds.

"We believe the Gauteng

*(98)*  
health department is in good shape and we are functioning below our capacity to provide good care," he said.

Concerning the situation at Chris Hani-Baragwanath hospital, Buch said the hospital always had the busiest casualty ward, but was coping well during the holiday period.

Gauteng's Health MEC Amos Masondo said rumours that health services were "about to collapse" were unfounded, and doing a disservice to dedicated medical practitioners and health workers.

"There's no need to panic, everything is under control," he said.



# Hospitals face problems after restructuring process

Taryn Lamberti

BA 31/12/97

(98)

JOHANNESBURG hospitals were experiencing teething problems after some of the changes which had been instituted as part of a restructuring scheme, Gauteng health department acting head Dr Eric Buch told a news briefing yesterday.

Buch said problems had surfaced at the Johannesburg Hospital after the department's controversial decision to downsize Hillbrow Hospital to a primary health care centre.

The last of the Hillbrow Hospital's patients were transferred to other hospitals on Tuesday last week, with many of the patients being taken to Johannesburg Hospital, causing a patient overload on Christmas night.

"There were a couple of bad nights around the closure of Hillbrow Hospital and sufficient capacity had not been transferred from Hillbrow to Johannesburg," Buch said.

The conditions were aggravated on Christmas night because a surgical team was on duty at Hillbrow Hospital when it should have been assisting with the delays in patient care and surgery at Johannesburg Hospital.

"It would have taken one phone call.

It was a communication lapse," Buch said.

Additional theatre nurses have since been transferred from Hillbrow to Johannesburg Hospital. Buch was confident that "more than adequate" measures had been taken to rectify the situation.

There was concern over the fact that the day clinic at Hillbrow Hospital had not been receiving patients.

The hospital was closed last week but the casualty department was open for patients with minor ailments. More serious cases would be transferred to the Johannesburg Hospital.

Buch said he believed patients had been "put off" by the barbed wire fencing that had been wrapped around the hospital for security purposes.

"The public needs to know that the clinic is a 24-hour service," he said.

Johannesburg Hospital acting superintendent Dr Warrick Sive would not comment on the transfer of resources from Hillbrow Hospital to his hospital.

Buch was unable to say what had been transferred to the Johannesburg Hospital in preparation for the expected New Year's eve rush which was usually experienced by hospitals.

HEALTH & DISEASE - HOSPITALS & CLINICS

1998



# 'Inhuman' city midwives beat women during labour

## Researchers unveil abuse at obstetric unit

JENNY VIALI  
HEALTH REPORTER

**Women attending a Cape Town midwife obstetric unit say they were beaten, slapped and scolded by midwives during pregnancy and labour.**

Mothers interviewed for a research study at the unit said midwives spoke to patients as if talking to children and many reported that "nobody showed any kindness".

They described midwives as "inhuman", "not caring", "silly", "rude", "ridiculous", and "not kind".

The report of the study, published in the Urbanisation and Health Newsletter, said the patients' accounts were of great concern.

One woman said she was slapped in the face when she was found squatting next to a bed because she could not climb up. Another said she was repeatedly beaten on the thighs during delivery.

A woman who delivered her baby on the

ARG 2/21/98  
floor was beaten, scolded and told to clean up the mess herself and the midwife refused to pick up the baby, the report said.

The research by Rachel Jewkes, Zodumo Mvo and Naeema Abrahams of the Medical Research Council's women's health division found midwives felt justified in scolding patients who were seen as "morally deviant", such as pregnant teenagers.

Hitting was part of the routine management of women who panicked during delivery and closed their legs, said staff. But cases of women being beaten for sitting or delivering their babies on the floor were clearly cases of violence being used as punishment, said the report.

There was also evidence that some staff regarded their patients as "stupid" or "like children" who were not worth the time and effort of proper explanations.

Most pregnant women indicated they had expected problems at the unit, in particular being shouted at, beaten or neglected. These

(98) (95)  
expectations were largely based on personal previous experience or that of friends.

All but one of the 17 women interviewed reported shouting, scolding, rudeness or sarcasm in some form which they found unpleasant or hurtful.

Some women resisted the treatment, leading to arguments. Others avoided the unit as long as possible or tried to book elsewhere. Others tried to find help from other patients or cleaners.

The study findings suggested that part of the problem might lie in communication skills of staff and deficiencies in training about information sharing and support for patients, said the report.

Health managers and the Nursing Council needed to take a firmer line on what constituted unprofessional, unethical and unacceptable behaviour from nurses and seek evidence and use disciplinary action to ensure violence against patients was stopped.





# 170% fees increase short-changes consumers

BD 9/1/98

(98)

The Hospital Association of SA is to publish its own set of 'guideline' tariffs after a ruling from the Competition Board allowing it to do so. They are likely to be higher than medical schemes will pay. Alex van den Heever examines the association's reasons for doing this

THE Hospital Association of South Africa (Hasa) has responded to permission by the Competition Board to publish a set of guideline tariffs by setting hospital fees 17% higher for 1998 than they were in 1997.

Aside from the fairly self-serving rationalisations for such a high tariff increase, various interesting and problematic issues arise concerning the nature in which "competition" works in the private health industry and the implications for members of medical schemes.

The publication of a set of hospital fees guidelines arises out of a conflict between the Representative Association of Medical Schemes (Rams) and Hasa. Rams has, until now, been allowed to publish guidelines for hospital fees, provided they are not directly or indirectly enforced, while Hasa could not because this was considered price collusion.

However, not all providers are excluded from setting guidelines. Representative associations of professions can do so: the Medical

Association of South Africa (Masa) sets fee guidelines for doctors, for example.

A distinction, however, needs to be made between the amount that a medical scheme chooses as its price for a medical service, and the fee charged by the provider.

Where a difference occurs between the scheme price and the provider price, balance billing can occur. In other words, the patient is billed for the difference.

In the health care market, prices are determined to a large extent by the existence of health insurance — medical schemes.

Because the patient is actually paying either nothing or very little at the point of service, they tend to be indifferent to prices generally, and apathetic about which provider (in this case hospital) to select. This means there is no real competitive market for hospitals within the insurance-funded fee-for-service setting. In addition to price indifference is the power of the provider to determine the level of

services needed by a patient.

In hospitals, where detailed telephone-book type itemised bills result, overbilling can be, and has become, a serious problem. This has left the consumer of private health care disempowered. They can neither negotiate prices nor moderate the volume of services provided.

Within this context, per capita medical cost increases faced by medical schemes have gone up by an astounding 7,6% a year in real terms (after inflation has been accounted for) since 1982. Hospital per capita costs have outperformed all others, except for notorious pharmaceuticals (10% a year, after inflation), by going up by 9,6% a year, again in real terms. All this in a period when the SA economy grew at less than 1% a year in real terms and achieved negative per capita growth.

Furthermore, during this period, private hospitals dependant on the fee-for-service environment introduced no efficiency improve-

ments, information systems to assess efficient outcomes or improvements in management.

Allowing hospitals to effectively collude in the setting of prices through Hasa, puts individual consumers of health care at a substantial disadvantage.

The balance billing does not apply to medical schemes. If the recommended fees were to be used as reference prices for negotiations between schemes and providers in setting the reimbursement rates, this would be less of a problem.

However, the moment these are used to determine a "surcharge" over and above medical scheme rates, this must be considered anticompetitive. This is because there is one Hasa and 7-million individual consumers of health care — who cannot shop around for a better deal if

all providers have the same price.

Some of the reasons for Hasa's actions need examination. Normally in competitive health care markets an all-inclusive fee is created which increases, at most, at the inflation rate.

To include input costs in the argument is much like saying the gold price should be \$500 an ounce because of gold mining input costs.

Demand should determine price and quantity, except where demand is subject to manipulation and price exclusively determined by the supplier.

The reasons given for the "unmanageable" cost increases to hospitals include items like nursing salaries and the rising cost of equipment due to currency devaluation.

Salaries are a negotiation between hospitals and staff for which both parties should accept the risk of any decision made, otherwise private hospitals would have unlimited potential to pass on cost inefficiencies and poor bargaining arrangements to patients.

Currency devaluation has been given as an excuse but it can only have an impact on the capital depreciation portion of hospital costs in any year where costs depend on foreign imports and where purchases cannot be delayed. As it happens the producer price index shows only a 2% change for medical equipment for domestic consumption between December 1995 and October 1997.

There is clearly much to think about within the private health system. The 8% across-the-board increase in tariffs suggested by Rams is, in many senses, generous as it is above the inflation rate. If they gave higher, one would have to question their legitimacy in representing members in fee negotiations. Over the next few years medical schemes are going to push much harder to contain costs.

What appears to be clear is that consumers are being short-changed and that the Competition Board needs to think again.

□ Van den Heever is a senior researcher at the centre for health policy at the University of the Witwatersrand.

# Health officials firm on overtime

BY PRISCILLA SINGH  
Health Reporter

Star 13/1/98

The Gauteng Health Department will not budge on its decision to change the system of overtime schedules and has taken strong exception to doctors at Johannesburg Hospital threatening to quit public service.

Following a report in The Star yesterday, the department issued a statement in an effort to clear any misunderstandings doctors had on how the new "commuted overtime scheme", which will be implemented on February 1, will work.

The department traced the history of overtime payments to the days of the non-pensionable allowance (NPA), where doctors received a fixed sum for overtime. The result of the NPA system was that some doctors did a great deal of overtime work, and others very little, yet all received the same remuneration.

From July 1996, the new commuted overtime policy was implemented and revised twice.

The department said it "was absolutely clear from the national policy framework that commuted overtime was not part of the basic salary package", and should be paid for additional clinical work performed.

Documents were circulated from August last year inviting comments from doctors on the new overtime schedules, and they were modified and improved from the input received, according to the department.

Hospitals were given a "logic-based allocation" of medical staff for any one overtime shift, and management will decide on the split and mix of doctors.

At hospitals such as Tambo Memorial, Thembisa, South Rand or Edenvale, there are insufficient doctors to treat patients after hours and these duties are being offered to doctors not able to access all their overtime at their base hospital.

"This means that all doctors willing to take part in the scheme will be accommodated at an appropriate facility, based on their skills and qualifications, within reasonable proximity to their place of residence," the department said.



# Gauteng moves after-hours doctors to district hospitals

BD 13/11/98  
Josey Ballenger

SOME doctors at central Gauteng public hospitals would be asked to work overtime at understaffed regional or district hospitals from next month in an effort to distribute after-hours staff equitably, the provincial health department announced yesterday.

The province was not planning to cut overtime payments in the medium term. This had been "misunderstood" in media reports, the department said.

"We are not cutting overtime. Any doctor willing to utilise overtime at a hospital within a reasonable geographical distance (of their home or "base" hospital) will be able to do so," said Dr Norman Kernes, Gauteng director of hospital management.

Department spokesman Popo Maja said many hospitals did not have enough doctors to run an effective after-hours service. "On the other side of the spectrum, some hospitals have more staff on their establishments, due to the range of services run during normal hours, than are required to staff their after-hours needs."

The system will mean some doctors will not be able to work all their overtime at their "base" hospital, but could spend some or all of it at other hospitals. Specialists in short supply, such as neurosurgeons, will stay at central

hospitals and will be paid more than 16 hours overtime if need be.

Kernes said these were the latest in a string of measures to "refine" the public health sector's "commuted overtime" scheme introduced in July 1996 to improve efficiency. It was in line with government's policy to build its regional and district hospitals' capacities and to "decrease (the) load of inappropriate patients flooding the central hospitals".

The plan, as outlined in a document called "Overtime equivalents" which was modified following public comment from August to November last year, asserts that individual hospitals will be given a "logic-based" allocation of medical staff for overtime duty. The institution will then decide on the mix of doctors that best suits its patients.

Hospitals have been asked to indicate their needs and excesses by the fifth of each month to their regional director, who will co-ordinate the next month's placements by the 20th. Kernes said he would not be able to estimate how many centrally located doctors would be asked to work some of their overtime hours in other hospitals until later this month.

He said that in the long term, the department hoped to reduce its overtime bill. It has spent about R200m a year on overtime payments.

# Only one province has paid health dues to Gauteng

## Masondo

PD 14/1/38

TTLE progress had been made in getting her provinces to pay for medical services undered by his department to non-Gauteng students, Gauteng health MEC Amos Masondo said yesterday.

Sapa reports he said: "Only one of the eight provinces has made an attempt to pay its debt." These outstanding monies made up a substantial amount of the Gauteng health department's budget shortfall, he said in Johannesburg.

Northern Province had paid about R31m of its debt, but other provinces had not made any payments. The department's

budget shortfall was estimated at R450m.

Masondo said other provinces had agreed in principle that they should pay what they owed, but no monies had been forthcoming. His department would increase efforts to recover monies owed for services rendered.

Meanwhile, Josey Ballenger reports the Medical Association of SA (Masa) has put doctors overtime pay on the agenda of the January 22 provincial bargaining council meeting following "unilateral" decisions by the Gauteng health department to modify the overtime system from next month.

Masa industrial relations head Peter Brewer said the organisation was raising the issue on the grounds of "a unilateral decision on a matter of mutual interest" which legally required negotiation in the provincial bargaining council.

The council, which replaces the former bargaining "chamber" under the new Labour Relations Act, aims to settle disputes between public servants and their employers.

The health department announced on Monday that it would ask doctors at central hospitals who were willing to put in over-

time hours, from February 1, to spend some or all of those hours at regional or district hospitals which were "geographically convenient". This is intended to distribute resources equitably between central and out-lying areas.

Specialists in short supply, such as neurosurgeons, would remain in urban centres and would be paid for more than 16 hours overtime if necessary.

Brewer said that Masa, which represented 14 000 doctors, two-thirds of the profession in SA, had not been consulted. He said government was required to ne-

gotiate with Masa and other unions such as the National Education, Health and Allied Workers' Union and the Hospital Personnel Association of SA in the bargaining council before implementing changes.

Brewer said Masa objected not only to the alleged breach of procedure, but also to the proposed policy. "If you were working at Johannesburg Hospital and you were told to make the same amount of money by going to another hospital 30km away, I'm sure you'd be concerned about it," he said.

The was also lack of clarity on the extent of proposed changes. Some hospital admin-

istrators sent letters to their staff, apparently in response to a government instruction, that after-hours duty would have to be reduced by as much as 50%.

Despite government's assurances on Monday that it was not proposing cutting overtime compensation in the near future, Brewer said: "We are waiting to hear more at the provincial bargaining council. There is so much speculation."

National health department spokesman Vincent Hlongwane said Gauteng was the only province to have proposed significant changes to its overtime system.

Dairv nices set to rise



# Pension: Hospersa lays into Govt

By Abdul Milazi

**T**HE HOSPITAL Personnel of South Africa (Hospersa), yesterday accused the Government of trying to shift economic risks to workers, in its plans to change the public service pension fund into a provident fund.

The announcement made by Deputy Finance Minister Gill Marcus on Tuesday has angered Hospersa, while the National Education, Health and Allied Workers Union (Nehawu) remained indifferent to the issue.

Nehawu president Vusi Nhlapo said there were more serious issues to be negotiated than arguing over what form the pension fund should take.

"It is immaterial whether the Government calls the fund a defined

*Sametaw 15/1/98*  
Union feels that disparities between black and white is a serious issue

contribution or a defined benefit."

Nhlapo said the Government needed to address the disparities between black and white workers.

"Black workers had been denied membership of the pension fund until the late 1970s, which is why one finds a worker with 20 years of service, only having ten years of contribution with the fund.

"Whites, however, get hundreds of thousands of rands when they retire," he said.

Hospersa assistant general secretary Albert Wocke said there were a number of trade unions involved in

the negotiations for the planned restructuring and it was not certain that they would vote in favour of the move.

"A defined contribution pension fund (provident fund) is not necessarily cheaper than a defined benefit pension fund (a normal pension fund), as the employer may not make contribution holidays in order to redirect funds elsewhere in the budget," said Wocke.

Under a normal pension fund, employees are entitled to a percentage payout plus a monthly payment till death, while a provident fund only offers a once-off payment.



# Minister's R3-m parting gift to emergency units

HEALTH REPORTER  
AKG 15/11/98 (98)

Emergency medical services are to get an extra R3-million in the next financial year and ambulance services will be run by the province by mid-year.

Announcing this at his last press conference as Health Minister in the Western Cape yesterday, Ebrahim Rasool said emergency service staff and volunteers had been the heroes of the festive season.

"We have had our best festive season for a long time, thanks to the combined efforts of all the staff and volunteers involved. Their personal efforts are appreciated. They work while others enjoy themselves," said Mr Rasool.

Wayne Smith, head of emergency medical services, said all incidents were dealt with promptly and efficiently. More than 30 000 patients were transported by ambulances in the Western Cape between December 5 and January

5, about 16 000 of them in the Cape Town metropolitan area.

Extensive restructuring of ambulance services will be completed by mid-year, when all 14 services run by local authorities are united and managed by the province.

The R3-million will bring the budget for emergency medical services to R91-million.

Emergency medical services formed part of the Arrive Alive road safety campaign over the holiday season.

About 150 volunteers helped emergency staff over the season. Metro Rescue medics and paramedics had volunteered to be on standby on their days off for Operation Kannedood, on the 300km "death stretch" of the N1 between Beaufort West and Pous River, Dr Smith said.

Other volunteers had helped in such areas as Lingsburg where meals and refreshments had been sponsored by communities.

# Health goes to grassroots: Task team calls for local responsibility

AKG 15/11/98

All primary health care in the Western Cape should be provided by local authorities.

This is the key recommendation in an interim report on the management of a district health system for the province.

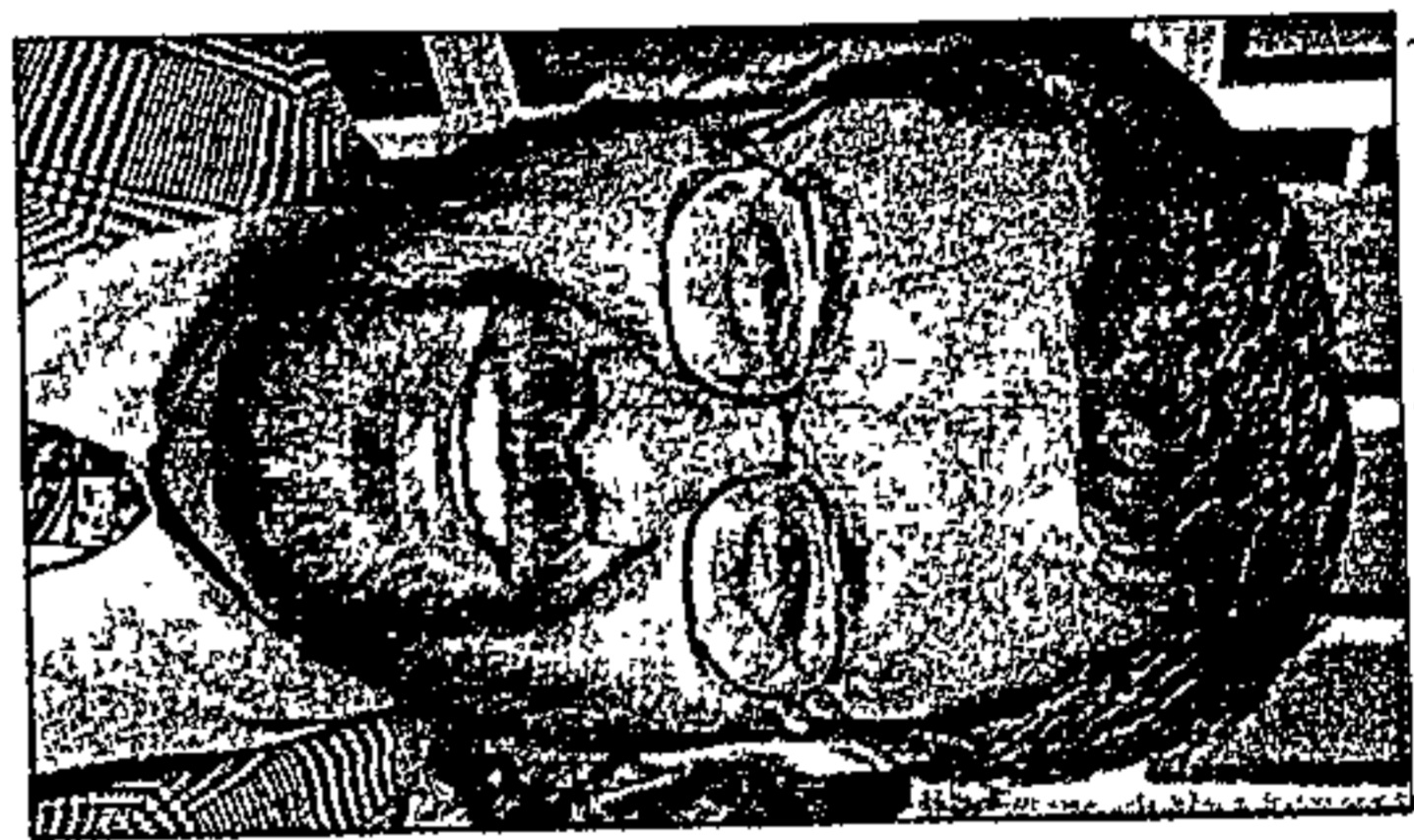
The report, drawn up by a ministerial task team, also recommended that the provincial Health Department be responsible for the co-ordination and monitoring of primary health care.

This brings the district health system, a cornerstone of the provincial and national health plans, a step closer.

The ministerial task team was set up in August by provincial Health Minister Ebrahim Rasool to review health care at primary care level.

The team found that primary health care was "sub-optimal" and improvements could be made by restructuring.

The team members found an "astounding" duplication of facilities



Parting shots: Ebrahim Rasool

## SPECIAL REPORT



JENNY WALL

between the local authorities and the province, with many facilities next door to each other.

Because they were run by different authorities, and staff had different conditions of employment, there was no sharing of resources, particularly in the rural areas.

The task team recommends that responsibility for primary health in greater Cape Town be delegated to the six municipalities.

Who will render services in rural areas can be decided only when new local government boundaries are announced later this year. The transfer of primary health care from

provincial to local authorities is due on July 1 next year.

The ability of local authorities to provide health care will be evaluated in the meantime and the transfer of staff negotiated.

The 60-member task team (including 18 trade union representatives) under the chairmanship of Fareed Abdullah, head of health care, has met four times.

Dr Abdullah said the report on the management of district health was the last "key to be turned" before the province's five-year health plan could be implemented.

"All major policy reform initiatives undertaken at the end of 1994 have now been concluded," he said.

The interim report would be sent to all local authorities in the Western Cape for consideration. A final report would be completed by June.

Provincial staff would be given the option of transferring to the relevant local authority.

# R48-m grant 'a sign of EU confidence in SA's future'

A R48-million grant for community health in the Western Cape shows the European Union has confidence in the future of South Africa, says outgoing provincial Health Minister Ebrahim Rasool.

The EU made the grant to the Community-Based Primary Health Care Programme, a consortium of five non-government organisations. It is the largest single grant to South African primary health organisations.

At the hand-over ceremony yesterday, Mr Rasool said the NGOs had shown their relevance and credibility and survived difficult times.

EU ambassador Erwan Foureé said the union was anxious to support

the vital role of community health-care organisations. The donation was an indication of the EU's commitment to reconciliation and reconstruction in South Africa.

The five NGOs in the consortium are the South African Christian Leadership Assembly Health Project, the Health Care Trust, the National Progressive Primary Health Care Network (Western Cape), the Zibonele Community Health Worker Project and the National Progressive Primary Health Care Training Centre.

A substantial proportion of the money would pay the salaries of community health workers, said Elise Levendal, chairwoman of the consortium.

# Heideveld 'supermarket' shows way

(98) AKA 15/11/98

The Heideveld community health centre, run by the provincial Health Department, is one door away from the Heideveld clinic, run by Cape Town municipality.

To all intents and purposes the clinics work as one facility, offering a comprehensive package of health services.

This "supermarket" concept of a primary health service is the ultimate aim of the district health system, which will offer curative, preventive and rehabilitative primary health-care services under one roof, run by one authority.

Not all of the Western Cape is as fortunate or as advanced in the amalgamation process.

Historically, preventive health clinics have been run by local author-

ities, whereas curative services (such as hospitals) have been run by the province, leading to a fragmented health services.

In some areas two clinics across the road from each other provided different services so that people had to go from one clinic to the other according to what they needed. Sick people would go to the provincial day hospital, but TB, family planning and baby clinics were at the council clinics.

To overcome fragmentation, the ministerial task team on district health management, which has just released its interim report, decided that the key to improving the system was to place all of an area's primary health-care services under the control of a single authority.

It noted that:

Local authorities run most of the clinics (400 of 450) providing preventive care.

The 50 community health centres providing curative care are run by the province, some offering 24-hour services.

Curative primary health care in rural areas is provided by the province through the part-time district surgeon service and hospital outpatient departments.

About 3 000 primary health-care personnel are employed by the province and about 2 000 by local authorities.

Most local authority clinics provide care for TB and sexually transmitted diseases and run well-baby clinics, which provide immunisation and growth monitoring, health

education, nutrition education and family planning services.

These clinics are not always available every day of the week at the same place. Some of them are dedicated to treatment of a particular area of health care, such as sexually transmitted diseases.

Most primary curative work is done at 50 community health centres in the province, which treat 3 million outpatients a year. Five are in the rural areas and the rest located in the city.

In Heideveld, the two health providers are amalgamating their services.

From next year it is planned that the clinics will come under the control of one authority and staff will work for a single employer.



EU SPENDS ON BASICS

# R48m tonic for primary health care in W Cape

**PREVENTING DISEASE** and providing treatment before it becomes chronic is the most efficient way of spending money on the country's wellbeing. Health Writer **JUDITH SOAL** reports.

**I**N three years, R48 million could fund 160 heart transplants, 40 beds at Groote Schuur Hospital or primary health care to one million people.

Given these figures, it's not hard to understand why a primary health care programme was chosen as the recipient of a R48m European Union (EU) grant announced yesterday.

Ms Elise Levendal, the chairperson of the coalition, Community Based Primary Health Care Programme, says primary health care — in which community health workers treat people in the places where they live and work, focusing on preventing diseases or treating them in the early stages — has been shown to be a lot cheaper than hospital-based care.

"We did an economic evaluation of our project last year and found that the cost of a community health worker's visit to a home is between R11 and R35. But a patient's visit to the outpatient unit of a hospital costs R55.

"Also, because we can detect and prevent diseases earlier, treatment is much cheaper.

"For example, it costs between R36 and R171 for a community health worker to teach a family about oral rehydration (treating diarrhoea), but to treat a dehydrated child in hospital

costs about R450 — so you can see there is a big saving."

The announcement of the grant to the coalition — the largest single donation to primary health care in the Western Cape — was made by the EU ambassador Mr Erwan Fouéré at a press conference called by outgoing Western Cape Health MEC Mr Ebrahim Rasool.

The coalition consists of the South African Christian Leadership Assembly (Sacla), the Health Care Trust, the National Progressive Primary Health Care Network (NPPHC) — Western Cape, Zibonele Community Health Worker Project and the NPPHC Training Centre. Together, these five organisations reach a million people in the Western Cape.

The grant will be used to fund the work of community health workers like Mr Pumelele Notshe of the Zibonele project in Khayelitsha. Notshe explains how Zibonele operates:

"There are 15 community health workers, and we each have 300 houses under our care.

"We keep a record of all the people in the house and visit each house regularly. The 'at risk' houses — where someone is sick — we visit about twice a week."

Notshe says that health workers

are trained to treat minor illnesses such as skin problems, colds and flu, diarrhoea and headaches, and to provide information and advice on health-related problems.

"If something is more serious then we refer people to the day hospitals."

Zibonele also runs a women's health project with community health workers who hold clinics and visit homes, giving advice on contraception and sexually transmitted diseases and providing both ante-natal and post-natal care.

Mrs Liziwe Mpe, a community health co-ordinator at the Health Care Trust, says primary health care has an important role to play in preventing tuberculosis — one of the most serious health problems in the Western Cape.

"If people don't take their tablets, then TB becomes resistant to the medication, so we tell them how important it is, and check that they take them."

Community health workers also keep records of children's immunisation details and are able to ensure that they receive the vaccinations they need to prevent future diseases.

Mpe says that a community health worker is never off duty: "They come to our houses all the time, during the night, at the weekend, when the day hospitals are closed.

"They come with stab wounds and we dress them.

"They say they would rather come to us than to the hospital."

ET 15/1/98

(98)

# Everybody gets a say on health care

## *New bill to replace hospital boards*

ART 17/1/98

(98)

ADELE BALETA

Everybody in the Western Cape soon will have a say in the running of hospitals in their areas, instead of merely complaining to authorities as they now do.

Communities will be given this say on hospitals and on the delivery of health services when the proposed Western Cape Health Facility Boards Bill is passed.

The draft bill replaces the existing hospital boards, established under a 1946 ordinance, which are perceived to have inadequate powers and community involvement.

Western Cape Health Department legal expert Steven Harrison said the draft bill was written in response to increasing pressure from the community to review the existing hospital boards, which were in a state of crisis.

The new boards, which can be applied potentially to clinics and community health centres, will be given real powers and functions that will affect decisions with medium- and long-term implications for patients and communities, without interfering in the day-to-day management of health facilities.

The new boards will have about 50% community representation, along with technical experts, health facility management, facility staff and academic staff.

Community representation would allow patients, their families and local communities an effective say in the delivery of health services that affected

them, said Mr Harrison.

Complaints about long queues, inadequate treatment and dilapidated and outdated facilities could be taken up by the new boards.

The bill also gives communities a chance to give valuable

input on improving their health facilities. The bill was gazetted yesterday for public comment and is likely to be tabled in the

provincial legislature early this year.

It is the first bill to be tabled by the provincial health department since 1994 and is "an indication of the department's commitment to community participation as a central principle in the delivery of health services,"

said Mr Harrison.

The draft bill, which received provincial cabinet approval in principle in December, was selected by the department to initiate a legislative programme to emphasise the commitment of the health ministry to community participation in the delivery of health services.

Several other health laws are planned for the Western Cape this year.

Outgoing Health Minister Ebrahim Rasool of the African National Congress, who has been replaced by Peter Marais of the National Party, said he was sorry he would not be able to see his legislative agenda through to its conclusion.

"In the interests of the health of the people of the Western Cape," said Mr Rasool, "I can only hope my successor vigorously pursues this legislative programme to fruition."

***'I can only hope my successor pursues this legislative programme'***



Wednesday January 20 1998

# 'Hospital supplies discarded'

Jan 20 11 1998

By PRISCILLA SINGH  
Health Reporter

The Gauteng Health Department yesterday expressed shock about unused and unopened medical supplies which were apparently being tossed out with the rubbish at the former Hillbrow Hospital.

Beeld reported yesterday that usable medical supplies and equipment such as drips, oxygen masks, catheters and surgical masks, as well as linen and blankets, were found in rubbish disposal containers.

Spokesman Popo Maja said yesterday the department did not expect such things to happen and deplored the actions of those who might be responsible: "We cannot understand how new surgical gloves or syringes can be thrown away."

He said he went to Hillbrow, now a 24-hour community health centre, yesterday but did not find any signs of waste.

Hillbrow superintendent Dr Emma Bondorinko said she knew nothing about medical supplies being thrown out and did not know where Beeld got its information. Beeld's report included a photograph.

Maja said the department would investigate.

# Home's staff boot out director

BY STUART KELLY

(98) (98)

Star 20/1/98

Striking workers at the Takalani home for the mentally handicapped in Soweto threw their director out on to the street yesterday to protest against what they claim is his poor management of the home.

About 50 workers waving placards demonstrated outside the home for much of the day after warning the director, Dr Jacob Semela, not to come back until he was prepared to deal with the problems faced by the 105 staff members and 600 child residents.

They also took away his car keys and locked them up inside the premises.

Spokesman for the workers, Elizabeth Mokone, said nurses and other employees were finding it increasingly difficult to carry out their duties.

"There is plenty of food coming in, but for some reason Semela keeps it locked in storage until it is no longer good for eating. No maintenance is being done at all. Children cannot be looked after well because the money Semela receives from donors does not reach us on the ground," Mokone claimed.

She stressed that, although the nurses and other staff were on strike, they would ensure that the children were cared for.

A small police contingent kept vigil outside the home last night. Semela was believed to have been taken home by the police earlier in the day and could not be reached for comment.

When The Star visited the home last night, exposed electrical wires were evident on many broken heaters, mattresses and blankets were shabby, and a number of the geysers were not working.



## Cutbacks on new clinics

NELSPRUIT — The Mpumalanga health and welfare department would not build any hospitals or clinics this year because of financial constraints, director Dr Gulam Karim said yesterday.

But the department was hoping there would be a surplus on the budget, which would allow the building of a psychiatric ward at Nelspruit's Rob Ferreira Hospital, African Eye News Service said.

Karim said the department would spend R1,5m this year to complete the construction of three hospitals and two clinics in the province which were started in 1996.

"Tonga, Ermelo and Witbank hospitals, and the Emjindini and Daggakraal clinics, will be completed this year," he said. Sapa.

98 BD 20/1/98

# R300 000 debt for coal threatens hospital crisis

ARC 20/1/98 (98)

East London - Coal supplies for Cecilia Makiwane Hospital at Mdantsane here were to end today unless the provincial government came up with an outstanding payment of R300 000.

Chief medical superintendent Patrick Sendyose admitted the hospital was in a crisis because a company said it would have to stop supplying coal from today.

Dr Sendyose said the hospital had done all it could to get the provincial government to pay the outstanding account.

He was not certain how much fuel was in stock but the hospital would not be able to function if it ran out of coal. It was understood, however, that the hospital had enough fuel on hand

to keep it running for another four days.

East London and Border Coal Distributors' managing director Kevin Lodge said they had been most patient in trying to secure payment of the R300 000, which had been outstanding for some time.

"We have been most reluctant to take this step but in the end we had to give the hospital and financial authorities seven days' notice of our intention to stop supplying coal by Tuesday."

He added: "We have had no response whatsoever."

Cecilia Makiwane is the main hospital for the big township of Mdantsane, which is now part of East London. - Sapa



# Clouds gather as patients lose place in sun

ET 21/1/98

(98)

JUDITH SOAL AND  
PATRICK BURNETT

THE sun shines brightly on the patients at the New Kings complex in Kalk Bay — a tightly knit community who are looked after by dedicated staff. On good days, they can lounge on the lawn, watching the sea.

Severe disability seems manageable in this world.

But now departmental budget cuts have intruded. The complex is to be closed and patients are worried what will happen to them.

Among them is former speech therapist Ms Beverley Greenwood. An undiagnosed virus contracted 10 years ago left her with brain damage and she needs constant care. She is worried about her future as the Department of Social Services prepares to close the frail-care facility that is her home. She says she will miss her most treasured companion — the sea.

Greenwood is one of more than 200 mentally and physically disabled patients at New Kings whose lives are about to be thrown into turmoil by the department's attempts to save money.

"It will be sad. I am upset about the whole thing closing down and worried that I won't go to church and won't be with my friends," Greenwood says.

"Before I became ill I used to surf and windsurf. I used to love being at the sea and will miss it so much when they take me to a different place."

It is not clear where Greenwood and the others will be taken.

The department says they will be transferred to other frail-care centres, but a retired district surgeon who used to work at New Kings doubts if there are other centres equipped to care for them.

"New Kings has been the end of the line for most people," said Dr Rob Hawke.

"They have all been through other facilities and ended up here. They've been through a lot of trauma before they got to New Kings.

"They have found a community here. From the nursing staff to the floor cleaners and the kitchen staff, everyone goes out of their way to make this a home. It truly is a remarkable place and it will be shattering to these people to leave. I know because I know them well.

"New Kings has all types of cases, from burnt-out schizophrenics to people who are severely brain-damaged. Many are wholly disabled and require tube-feeding.

"The department wants to reintegrate these people into the communities, but the communities can't cope."

Most of the patients didn't have families. Those who did could not be cared for by their families.

"Many are from poor areas and even if they have families, there

aren't facilities to look after them," Hawke said.

"Even upper-middle class people would struggle because caring for them is a full-time job. They need to be fed, washed, lifted out of bed, they are probably incontinent and they can easily get infections — it's a lot of work."

Mr John Haycox has a daughter who has muscular dystrophy and is at New Kings. He is worried that he will not be able to care for her.

"I don't know where this leaves us. We are not equipped to look after her as I have to go to work and she needs constant surveillance.

"These are the things the new government said it would look after."

Greenwood's mother, Mrs Yvonne Greenwood, shares his concern.

"Beverley is in a wheelchair and can do little for herself. From a financial point of view, we can't afford the costs of a private institution or private nurse. Many people in New Kings are worse off. Beverley is not the only one in this predicament. They all are."

There is also concern that potentially violent patients may be released into the community without support.

In November, the Cape Times reported that an 82-year-old woman had been murdered, allegedly by her grandson who had been released from the Stikland Psychiatric Unit. The young man's family had believed him to be

unstable and violent and had pleaded, to no avail, with the hospital to readmit him. When his grandmother was murdered, doctors warned that this sort of killing could happen again because

of the absence of support systems for released psychiatric patients.

A source close to New Kings, who asked not to be named, said 30 patients would be released into the community — an apparent metaphor for being sent home, even if the patient did not have one to go to — by the end of this month. Another 110 are expected to be released by the end of June. The remaining 60 — who are the most severely disabled or potentially violent patients — are to be transferred to other centres.

The head of the Western Cape Department of Social Services, Mrs Sharon Follentine, denies that New Kings residents will be dumped.

"It is possible to accommodate the residents in existing vacancies in subsidised frail-care facilities," she said. "Adequate vacancies are available."

Residents would be given the option of moving to Beaconvale in Mitchells Plain, Zerilda Steyn in Pinelands or KSE Home in Kraaifontein.

The patients would receive the same care as they had been given at

*Many are from poor areas and even if they have families, there aren't facilities to look after them.'*



**FRIGHTENED:** Beverley Greenwood used to surf before her illness, now she takes comfort from living next to the sea. She is not sure what will happen when the New Kings frail care centre closes. **PICTURE: GARTH STEYN**

New Kings, Follentine said.

About 60 residents could not be cared for at these centres as they had special needs. The department was negotiating a contract with Life Care, the company that ran New Kings, to make provision for these patients, Follentine said.

Provincial budget cuts had made the closure of New Kings necessary. "All departments are obliged to effect savings to address shortfalls in the provincial budget. New Kings has been identified as a situation where the department could effect a saving.

"We had to take a tough decision on the future of the contract (with Life Care) when we determined our 1998/1999 budget."

## State contract to be phased out

THE New Kings Complex is managed by Life Care Special Health Services, a private company, under a contract with the Department of Social Services that is to be phased out by the end of June. Most residents are eligible for social security, but do not receive state pensions, as the government pays the full tariff of the contract. About 16% make contributions according to their income.

A frail care facility is defined as a registered home for aged persons

and people with severe disabilities and provides 24-hour care.

There are 144 registered state subsidised frail care facilities and 38 registered private facilities in the Western Cape that take care of people with conditions similar to those at New Kings.

Life Care managing director Dr Louis Moolman said: "We understand it is a rationalisation process and the department has to scale down and make use of other under-utilised facilities."

— Staff Writer



# It's sink or swim for provincial hospitals after belt-

(98) SAN 22/1

By PRISCILLA SINGH  
Health Reporter

The past three months have been a case of sink or swim for provincial hospitals throughout the country after superintendents were forced to implement drastic cost-saving measures to reduce overspending.

The new system of block grants to provinces, introduced last year, leaves health financing to the discretion of provincial governments, including allocation of budgets.

The Government will no longer bail provincial health departments out of financial crises, as in the past. The total budget allocated to provincial health departments was R18,9-billion for the 1997/1998 financial year, an increase equivalent to 4,25%.

There has been huge overspending by hospitals whose budgets must cater for increased demand from the public and for renovations and upgrading of hospital services.

So serious is the financial crisis that the ability of the public health system to achieve its objective of a just, fair and equitable health system may be compromised.

The Gauteng Health Department (GHD) has looked at reducing the overspending of hospitals by stopping certain expenditures and considering savings from the health facilities development and maintenance fund.

Dr Kamy Chetty, deputy director-general of health administration in the health department, said his department looked at what projects were ur-

gent and what could be delayed or phased in at a later stage. The same was done for equipment and repairs.

The GHD is looking at an overall R840-million deficit in its budget for the current financial year, but it is also trying to reduce it by at least R200-million through cost-saving measures.

Hospitals have been advised to stop sending people to local symposiums and seminars, to reduce expenditure on transport, to reduce telephone costs, and to examine the purchases of stores, wastage of food supplies and drugs, and duplicate tests at laboratories.

"This does not decrease patient care. We are continuing with service delivery while maximising resources," Chetty said.

Other areas in which hospitals can save, especially the "big four" - Johannesburg, Chris Hani Baragwanath, Gankuwa and Pretoria Academic, who are well over their budgets - are on stationery, hospital services and through surgical thriftiness.

Chetty said the department was looking at a leasing system for ambulances and a reduction in the use of nurse agencies.

"The impression given that there is a crisis at hospitals is not true. We have spoken to academics and physicians and there is a constant review of whether this is the best use of public money," Chetty said.

Johannesburg Hospital received R480-million and has overspent by R151-million. The department hopes to reduce this to R106-million.

Chris Hani Baragwanath received R490-million and at the end of March will be overspent by R152-million. The department will try to reduce this amount to R115-million.

Doctors who are members of the Hospital Personnel Trade Union (Hospersa) discussed the possibility of industrial action at a meeting this week in protest at the GHD's unilateral decision to cut doctors' overtime pay by as much as 50%.

This "would demoralise the already overworked and underpaid doctors" and "severely hamper the after-hours emergency services".

Last week the GHD defended its decision to rationalise overtime for doctors from February 1 and said it took exception to any threat by medical practitioners to walk

out on the service. Under the new system many doctors working at major hospitals will have overtime restricted and will have to work at some of the province's smaller, regional hospitals to supplement their monthly pay packages.

In practice this means that Johannesburg Hospital, where 409 doctors were being paid a total of 6 296 hours a week overtime, will be reduced to having a maximum of 196 doctors being allowed a maximum of 16 hours a week overtime.

Doctors at the King Edward VIII Hospital in KwaZulu Natal have also threatened to leave because of the new overtime constraints, and to explore overseas options or, the Government's worst fear - private practice.

# Lightening steps

A practising haematologist at the hospital, who has one year left before writing his exams for specialisation, said he would walk away from the hospital if nothing is done about the cutting of overtime allowances.

The renowned Groote Schuur heart transplant unit is also in dire straits because the Western Cape health department is in a similar, if not worse, financial state as other provinces.

It is functioning with at least five staff members, including part-time nurses, when it should have a complement of about 20.

Another reason for the overspending of budgets is that thousands of people from neighbouring provinces seek treatment at Gauteng provin-

cial hospitals. The other provinces have been slow in paying up what was owed and Gauteng health MEC Amos Masondo said not much progress had been made in getting other provinces to pay.

The Northern Province had paid about R31-million of its debt, but other provinces had not made any payments.

Gauteng Democratic Party health spokesman Jack Bloom said the financial crisis was "utterly predictable" and blamed it on the GHD's lack of creativity to devise money-making incentives.

"The latest move by the department to cut doctors' overtime is definitely going to have negative consequences on patients and hospitals, and unfortunately it's too late to turn back the clock," Bloom said.



# Councils plan to create 911 service

(98)

## Slow response, attitude of ambulance workers leads to public outcry

Star 22/1/98

By VIDA LI SIK

Vagrant Selina Mokgalema was lying on a Selby, Johannesburg, pavement convulsing and foaming at the mouth for nearly five hours this week, waiting for an ambulance to take her to hospital.

Workers from nearby offices called the emergency ambulance number, but after several fruitless attempts, discovered that if they had called the ambulance dispatchers directly they would have been able to get help quicker.

A worker at the Ambulance Control Centre said callers for non-emergency situations, like Mokgalema's, can wait for up to an hour before an ambulance is sent out. He said because the 999 is a tollfree number, they often have a problem with children playing on the phone, and people who try that number could often find it engaged.

The staff at Elpar Distribu-

GET HELP



**USEFUL NUMBERS**

**Gauteng ambulance 999**  
Emergency tollfree

**National 10177**  
Tollfree  
(This call will be routed to the nearest service)

**Ambulance Dispatchers (011) 484-1611/6**  
For services in the north and south of Johannesburg

**Cell phones 112**  
Emergency  
Vodacom: free MTN: 68c

tors called from 7.30am but it was not until shortly after mid-day that an ambulance arrived to assist a very dehydrated

Mokgalema who had had a fit and was taken to Johannesburg General Hospital where she is in a stable condition.

"My colleague tried the 999 number without much success. The woman who answered was very rude and told him that because it was not an emergency we just had to wait until an ambulance became available. I phoned the police emergency number and they gave me the direct number for the ambulance dispatchers," said Theresa Aban.

Aban was told an ambulance had been sent out from Turffontein, but the vehicle was involved in an accident on the way to the scene and that they'd have to wait a bit longer.

"The slow response the public who call 999 get create problems because the people at the Ambulance Control Centre are often not trained on how to deal with members of the public," said an ambulanceman

sent from Roosevelt. He added that they only received the call after 12 noon.

Deputy Chief of Operations for the Johannesburg ambulance and fire services, Brian Hogan, said staff shortages and mechanical problems to about 30-40% of the emergency vehicles used, make a quicker response difficult, and that the accident to the ambulance sent out to Selby compounded the problem.

He said emergency staff are trained to exercise tact when dealing with the public, but that complaints should be lodged in writing before any disciplinary action could be taken.

The Johannesburg metropolitan council are currently co-ordinating preliminary plans to amalgamate the disaster management services of the 11 different councils into a "911" type service within the next few years.



# Marrais has shopping list for hospitals

## Will ask for private sponsors

JENNY WALL

In a bold attempt to end the Western Cape's hospital crisis, provincial Health Minister Peter Marrais is to ask private companies to sponsor the maintenance of wards at state hospitals.

The move is aimed at upgrading health services and winning paying patients back to state hospitals in the Western Cape.

Mr Marrais spent yesterday visiting hospitals and clinics to assess health services first-hand and asked staff to draw up "shopping lists" for him.

Mr Marrais's vision is to "commercialise" health in the Western Cape by approaching companies with a list of what he needed. In return, they will have wards named after them.

His second big drive will be to get communities involved at hospitals and clinics on a voluntary basis.

"Already the Lions and Rotary clubs have volunteered to help us in fixing up hospitals," he said.

"Churches sell compassion, the churches must now show they live compassion. I also want women's groups to give us their spare time.

"We have to decrease the burden on nurses. We must get people to help them. People have plenty of spare time to sit in bars and watch sport. We need a new work ethic. I'm going to test the compassion of the people of the Western Cape. I'm going to ask them to help me for a year, until we can restructure our budget allocation."

He said cosmetic changes at the hospitals he visited were necessary because the visual impact of hospitals was just as important as the level of the qualifications obtained by nurses and doctors.

"We cannot afford to lose all our patients to private hospitals. We have excellent nursing staff, dedicated doc-

tors. We must win medical aid patients back. We must start marketing ourselves. We must now see ourselves as in the health business.

"We can't wait for Dr Zuma (the national health minister) to find the money. There is no money."

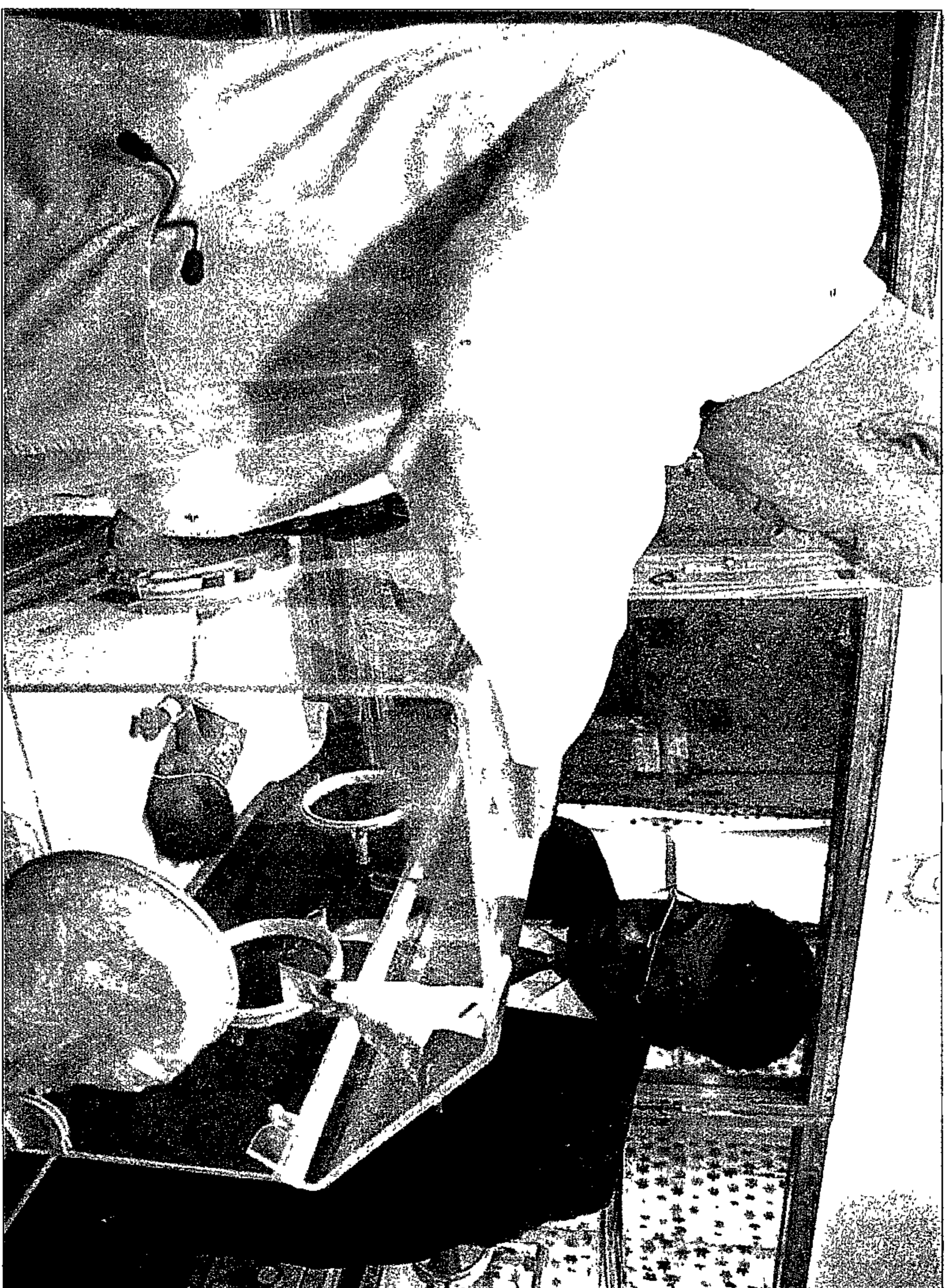
Mr Marrais said he wasn't planning to make radical changes to primary care.

"But we must get a better balance between primary and secondary services."

He said he could not change the policy of free care for pregnant women and children under six as Dr Zuma determined policy.

"But who must pay? We are losing millions of rands, not only for free health care, but for people from other provinces flocking here for better health services. These monies aren't paid back. So, there are big problems.

"I want Dr Zuma to be more supportive of health care than of staying within Trevor Manuel's budget."



The man from the ministry: Peter Marrais, the new provincial health minister, and Jan Wiggelinkhuizen of Conradie Hospital's neo-natal unit inspect a tiny patient

ANDREW INGRAM



# R4-m upgrading to hospital shortly before its shutdown

Star 26/11/98

PRETORIA CORRESPONDENT

The auditor-general is investigating why the Gauteng Health Department requested upgrades worth more than R4-million to Andrew McColm Hospital shortly before it was shut down.

Upgradings included a new R3,8-million boiler room, renovations worth more than R120 000 to the kitchen, and a new telephone system installation worth an unconfirmed amount of R130 000.

While academic and regional hospitals in Pretoria battle to ward off a financial crisis and looming budget cuts for the next financial year, placing added pressure on crisis care, the newly built boiler room at Andrew McColm stands moth-

balled until the fate of the empty, 169-bed hospital has been decided.

The Pretoria News was informed that the office of the auditor-general had been summoned to investigate particular aspects of Andrew McColm's closure and repairs during a routine performance audit at the Gauteng Department of Transport and Public Works, which acted on instructions from the Gauteng Health Department.

The Pretoria News was told by an official source, who preferred to remain anonymous, that once the information was gathered from last week's audit, officials from the Gauteng Health Department would be confronted if it were deemed necessary.

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# R4m spent on state hospital before closure <sup>(98)</sup>

OWN CORRESPONDENT

CT 26/1/98

PRETORIA: The Auditor General is investigating why the Gauteng Health Department requested upgradings worth more than R4 million to the Andrew McColm Hospital shortly before it was shut down.

Upgradings included a new R3,8m boiler room, renovations worth more than R120 000 to the kitchen, and a new telephone system installation worth an unconfirmed amount of R130 000.

While academic and regional hospitals in the city battle to ward off a financial crisis, the newly built boiler room at Andrew McColm stands mothballed until the fate of the empty 169-bed hospital has been decided.

The Cape Times was informed that the Office of the Auditor General had been summoned to investigate particular aspects of Andrew McColm's closure and repairs during a routine performance audit at the Gauteng Department of Transport and Public Works, who acted on instructions from the Health Department.

The information comes from an official who preferred to remain anonymous.

In October 1996 Health MEC Mr Amos Masondo announced that the hospital would be closed. His decision followed recommendations of the department's structural transformation process aimed at redistributing health services.

Construction on the new boiler room started in January 1995.

The Public Works Department, responsible for overseeing the upgradings, said they were never informed of any considerations to close the hospital.

Public Works officials, none of whom wanted to be named, said they learnt through the media that the hospital was to close. They were only later informed in a meeting where it was decided to go ahead with the construction. Cancelling the contract would have been more costly.

Ex-hospital staff, who also did not want to be named, said finishing touches to the boiler room were not completed until July 1997 when the last few patients at the hospital were still being discharged.

Health Department officials, ex-hospital staff and Public Works officials blamed poor forward planning and a lack of co-ordination.

One of the previous staff members said: "In retrospect it was bad planning to close the hospital ... it seems illogical, but Public Works cannot be blamed for a political decision made by Health."

She said the boiler had cost the department R3,8m and that it had added to the market value of the unused premises.

The Gauteng Department of Health is expected to overspend its budget by R450m this financial year, ending in March.



# Fate of New Kings patients in balance

## *Kalk Bay aims at restoration*

PETER GOOSEN  
METRO REPORTER

The decision to close the New Kings frail-care facility and residence in Kalk Bay, home to about 200 disabled people, has come as a shock to residents who know no other home.

The New Kings, which is run on behalf of the Western Cape Department of Social Services by private contractors, Johannesburg-based Life Care Special Health Services, is to be phased out by the end of June, a casualty of provincial budget cuts.

The New Kings and the next-door Majestic house 200 mentally and physically disabled residents, who, says Social Services, will be transferred to other frail-care centres where there are vacancies.

The department has said it can no longer afford the New Kings contract and believes that it could rehouse residents satisfactorily.

However, an alternative will

have to be found for at least 60 patients, those with the most severe disabilities.

The closure of the New Kings will mean that a large area of the False Bay seafront is likely to be available for restoration.

"The fact that these people are to be moved is tragic, but at the same time it's a tremendous opportunity to take another look at this area, which needs upgrading," said chairman of the Kalk Bay Development Steering Committee Neville Riley.

"The buildings are basically sound and they could be restored to their former glory."

Both the New Kings and Majestic, built on Main Road, Kalk Bay, early this century, were formerly hotels. The Majestic, in its heyday, was considered the coastal alternative to the Mount Nelson.

Although a number of schemes to redevelop the New Kings and the surrounding area had been put forward over the past few years,

there never had been a formal application, said Mr Riley, who is also chairman of the South Peninsula's urban and environmental planning committee.

Louis Moolman, managing director of Life Care, which owns the New Kings, said the company's only concern at present was the welfare of its patients.

The New Kings was home to about 200 people and by the end of May only 60 would remain. It was up to the department to arrange frail-care accommodation for the remaining patients, but Life Care still might be given responsibility for them, somewhere else.

It would be uneconomic to keep New Kings open for only 60 patients.

Dr Moolman said he had had a number of approaches from developers, but until satisfactory arrangements had been made for all the patients at New Kings, the company would not consider any other use for the buildings.

(98)  
ARG 27/1/98







# Health dept to make changes at Helen Joseph <sup>Southern 28/1/98</sup> (98)

Investigation finds hospital in 'dire need of leadership'

By Abdul Milazi

**T**HE Gauteng department of health is to implement wide-sweeping changes at the Helen Joseph Hospital in Hurst Hill, Johannesburg, to address the conflict between management and workers over the restructuring of the hospital.

This follows the completion of an investigation by the department of corporate services (DCS) into the conflict. The findings confirmed workers' concern that hospital management was not changing with the times.

The DCS found that "there was a notable lack of a managed programme of change driven by the head office at the institution". It also found that there was an absence of a shared organisational culture at the hospital.

The report said the Helen Joseph

Hospital was "in dire need of effective leadership" and that with the exception of the head of nursing, all top positions were vacant.

In a statement director of health promotion and communications Ms Jo-Ann Collinge said the report also found the present allocation of responsibility for the various levels of management was "too centrally managed".

The investigation team recommended an alternative role for the head office; that of building capacity in labour relations management at institutional level.

"It is also recommended that - as soon as the required level of competency was obtained in the institution - the head of the health department delegates the authority to initiate, conduct and authorise the disciplinary process to the heads of the respective institutions," said Collinge

In the meantime Coronation Hospital superintendent Dr Arthur Manning will also act as superintendent at Helen Joseph, while department of health assistant director Boitumelo Matsose has been appointed the hospital's new secretary.

Members of the National Education, Health and Allied Workers Union (Nehawu) will face disciplinary action for allegedly forcibly removing administrative staff during a strike on November 17 last year.

An administrative staff member will also face disciplinary action for calling her son who works as a traffic officer to "rough up" Nehawu members on the same day.

The health department will also discipline a senior Nehawu member who allegedly assaulted a member of the hospital administrative staff.

Workers who took part in the strike also face disciplinary action.

# Hospital set to take knife to surgery list as cash crisis bites

## *Ops at Grootte Schuur delayed*

ARG 28/1/98 (98)

JENNY VIAL  
HEALTH REPORTER

**Cash-strapped Grootte Schuur Hospital is to delay all non-urgent procedures and operations until April in a bid to manage its financial crisis.**

Chief medical superintendent Peter Mitchell said the hospital had to reduce spending by R10-million to R15-million to meet its budget for this financial year.

But Tygerberg Hospital is not facing a similar crisis, says chief superintendent Abul Rahmann.

"We are not in the same position as Grootte Schuur. They did not plan properly and carried on as though it was business as usual."

Dr Mitchell said Grootte Schuur hospital was allocated R560-million for the 1997/98 financial year, but in November was told spending had been capped at R545-million.

"The hospital has been forced to take stringent and urgent action to

manage the financial crisis - and management is working closely with the clinical staff to try to minimise the impact of any measures on our patients," he said.

The hospital also plans to consolidate hospital beds into fewer wards to make the best use of diminished staff, and to refer patients to regional hospitals and community clinics.

"We ask that our patients and the public understand the problems facing us and other hospitals.

"We are undergoing major changes in funding and organisation. We regret that our measures are going to affect many individuals, and we ask for patience."

Non-urgent procedures like hernias and heart valve replacements could safely wait a few months, said Dr Mitchell. Tests leading to such procedures were also costly and the hospital could save money on items such as blood, valves, x-ray film and syringes. "To meet the needs of all our patients we are projected to over-

spend in these areas and have been informed that no extra funds will be available to us. We're also intensifying efforts to reduce other expenses such as telephone calls, water and electricity. Vigorous action will be taken to combat theft, losses and wastage."

Funds for the next financial year had not been finalised yet, so it was not possible to say whether the situation would improve, Dr Mitchell said.

At Tygerberg, Dr Rahmann said spending had been carefully planned.

"We have put controls on expenditure and planned consistently. So while we have reduced the number of 'cold case' procedures we do over the year, we are not in the same position as Grootte Schuur."

Red Cross Children's Hospital was operating as usual, said a spokesman.

All provincial hospitals are experiencing staff shortages because of reduced funding, the abolition and freezing of posts and the number of staff taking severance packages.





Overcrowded ... patients in the Johannesburg Hospital's admissions ward are at times forced to lie on the floor while waiting for attention from overworked and overwhelmed doctors and nurses.

# Hospital overcrowding may cause irreversible damage

(98) 29/11/98

Frustrated doctor shows The Star around ward where eight beds are crammed into a space for four and some must sleep in chairs

BY MATTHEW BURBIDGE

**C**rowded patients on makeshift beds may not be a new sight at the Johannesburg Hospital, but if the trend continues, damage to the over-taxed hospitals systems may be irreversible, disillusioned doctors have warned.

Frustration finally drove Dr David Brittain, a senior registrar in the medical admissions ward, to telephone The Star this week.

"We're absolutely swamped," he says, walking us through the ward where up to eight people were crammed into an area meant for four beds.

"If we don't have the beds we can't examine people, and you can't get an accurate diagnosis by examining someone who is sitting upright.

"And in addition, how can you tell a 70-year-old man and his anxious family members that he is going to have to spend the

night in a chair?" asked Brittain.

Because the beds, and sometimes stretchers, were placed just wherever there was space, the overhead curtains became redundant and it was almost impossible to examine a patient in privacy.

A person who had had a heart attack earlier in the day was in one of the ward's few high-care beds - although Brittain felt she would probably have received better treatment in the intensive care unit, because it had a better staff-patient ratio and nurses who were more qualified.

After the doctors left for the night - if they left - there would be one qualified nursing sister and two nursing assistants on duty. If a patient needed to be resuscitated all three staffers would be needed to revive him or her, which meant the ward came to a halt.

Brittain explained that, in a perfect world, the ward should be filled with a new set of sick people

every day: it had not been built to handle them on an in-patient basis. The hospital only had one functioning CAT-scan machine - which forced patients to wait and caused a bottleneck in the system.

"We often let patients go home early and, while they are not 100%, they can always come back to the out-patient clinic.

"It's the best and the safest thing we can do to make space for people who really need the beds.

"And these, our constant friends," says Brittain pointing to the cockroaches scurrying about the doctor's resting area.

Hospital superintendent Dr Trevor Frankish refused to comment about the situation other than to say he felt the cockroaches comment was frivolous considering the seriousness of the hospital's predicament.

"Overcrowding - and the consequent less-than-satisfactory patient care - should not be trivialised," Frankish said.



# Patients at private hospitals may be forced to pay more

JOHANNESBURG: Patients could be forced to pay extra for treatment in some private hospitals after these institutions take up the option to charge from next week 9% more than the tariff recommended by medical aids.

The Hospital Association of South Africa (Hasa), which represents more than 90% of all private hospitals, yesterday disputed the accuracy of the 8% Representative Association of Medical Schemes (Rams) increase, which takes effect on February 1.

Hasa director Mr Dick Williamson said the 8% increase announced by Rams was a 2,3% decrease, if the reduction on other services was taken into account.

Dr Anette van der Merwe, executive director of Hasa said: "The Rams tariff adjustment has been totally inadequate for the last five years and our members are no longer able to absorb the increasing costs. The change to day tariffs, drug mark-ups and maternity and psychiatric ward reductions, will result in a significant decline in real income to Hasa members."

Williamson also pointed out that the recommended Hasa tariff was a guideline to its members and completely voluntary.

"We received permission from the Com-

petition Board to publish our own medical tariffs, something the Medical Association as well as the Dental Association, among others, have done for many years."

Van der Merwe said she believed the Hasa tariff accurately reflected the increases in costs and rising inflation and would ensure that private hospitals were able to provide quality care and specialised service.

Hasa director Mr Rob Speedie said the future of private health care would rely on split billing. The larger portion would be payable by the scheme and the balance by the patient.

Speedie said most hospitals were expected to stick to the Rams increase of 8%, but hospitals and clinics in affluent suburbs would charge more to "enable the hospitals to provide the frills".

A Competition Board ruling bars Rams and Hasa from negotiating the tariff issue as it would be construed as collusion.

Rams represents over six million beneficiaries, with Rams-affiliated schemes paying about 90% of hospital payments.

Hasa last month denied a Rams prediction that price hikes at private clinics and hospitals would be between 15% and 25%.

— Own Correspondent



# Claims of racism in Brits' emergency service verified

BY MIKE MASIPA

The SA Human Rights Commission has sought a meeting with the North West department of health and welfare after finding this week that allegations of racism at the Brits fire and ambulance service were true.

Commissioners Pansy Tlakula, Jody Kollapen and Nalini Bagrath paid a surprise visit to the Brits fire and ambulance service on Wednesday after black ambulance and fire brigade workers had complained to the SAHRC late last year about working conditions and racism.

Tlakula said black workers told her that they had to use separate facilities from those used by their white counterparts.

"The service is divided into two groups, one made of the ambulance and firemen and the other made exclusively of ambulancemen. The former is made of 24 white men and only one black, while the ambulancemen are all black," Tlakula said.

Black workers alleged they were not given the opportunity to attend training courses.

Tlakula said there were even separate signals sent out to

different emergency workers to attend to an emergency.

"While we were touring the fire services premises with two management officials, a Mr Booyjens and a Mr Van der Walt, a bell went off three times and Booyjens said "That must be for a black patient'," Tlakula added.

She said she had established from representatives of the South African Medical Workers' Union (Samwu) that when the bell rang twice it was for white ambulance workers to attend, and meant the patient was white as well.

Tlakula said the head of the fire and ambulance service in Brits, Gert Malan, denied the allegations and said the different bell tones were to distinguish emergency calls from non-emergency ones.

Samwu said they had been trying to resolve the issue with the Brits Town Council for the past three years, but to no avail.

"We intend having discussions with the Brits Town Council and the North West department of health and social welfare within the next two weeks with a view to charting a way ahead that would see these problems being effectively addressed," Tlakula said.

Star 30/11/98 (98)

## Hospital staff hit by payment bungles

PORT ELIZABETH — Port Elizabeth medical interns and other newly appointed hospital staff were the latest victims of Bisho payment bungles when the Eastern Cape health department failed to pay their salaries this month.

The 60 junior doctors, pharmacists and medical officers — most of them from Livingstone Hospital — will now be paid only on Friday.

This is the third big payment crisis to hit the Eastern Cape government this month, and comes days after the

Welfare and Education MECs were sacked because of poor performance.

The regional health department said there was a delay in new staff receiving their SA Medical and Dental Council registration forms. This resulted in their names being omitted from the January payroll.

Officials stressed that the problem was an administrative one and not due to lack of funds.

Doctors and pharmacists were not happy but accepted the explanation, a spokesman said. — Sapa.

BD 2/2/98



# Health chiefs blame each other

JUDITH SOAL

WHO was to blame for Alfred Thomas' death? The *Cape Times* asked the national and provincial health departments this question and found itself in the middle of an argument about responsibilities and budgets.

Health MEC Mr Peter Marais laid the blame for Alfred's death firmly on the shoulders of the central government, because of the cuts in the Western Cape health budget.

"There are more and more people needing trauma care at hospitals, but they don't have the resources to cope. There aren't resources to run enough operating theatres, particularly over weekends, but we are under pressure from (Health Minister Dr Nkosazana) Zuma to cut their budgets further," he said.

But Zuma's spokesperson Mr Vincent Hlongwane disagreed, saying it was premature to blame budget cuts without a proper investigation into Thomas' death.

"Even if it was because of a



NOT US: Peter Marais

shortage of resources in the hospital, it is not the national ministry's fault. Provincial MECs are in charge of running their hospitals. They need to make sure that the proper equipment is in place."

Marais argued that he could not equip hospitals properly because of cuts in the budget allocation from the central government.

"It's no good giving a man R300 when his rent is R500, then when he tells you he can't pay his



NOT US: Nkosazana Zuma

rent you tell him he is allocating his money wrongly. That's ludicrous."

Hlongwane stressed that the limitations on the Western Cape health budget were necessary to ensure that all provinces could provide equal care to their citizens.

"The budget for the Western Cape used to be abnormally high. You have services here that people in the Eastern Cape couldn't dream about. That isn't fair. We need to

provide health care to people who have never had it before."

But Marais insisted that the method of allocating the money was wrong.

"The Western Cape trains a third of the country's doctors, two-thirds of the specialists and 25% of the nurses. We see patients from all over the country, but we only get a budget for the people that live here. Anyway, the provinces that don't have facilities can't use the money they are given. It's like taking Baby Jake (Mallala) and (Evannder) Holyfield and saying they must both eat exactly the same. The one will die from starvation and the other from over-eating."

Hlongwane would not entertain this argument. "He is a new MEC. He hasn't even been introduced to the minister yet, so he doesn't understand how we do things here."

"Those other provinces need the money to build the services. Anyway, the minister doesn't decide how much money will go to health, that's decided by (Finance Minister Mr Trevor) Manuel."

CT 5/2/98

98

I WILL UNFREEZE KEY HOSPITAL POSTS — MARAIS

# Death prompts promises

CT 5/2/98

(98)

**WESTERN CAPE** Health MEC Peter Marais is to order an inquiry into the death of Alfred Thomas and says he will unfreeze key posts to help embattled hospitals. Health Writer **JUDITH SOAL** reports.

## How Alf Thomas was left to die

ALFRED THOMAS WAITED more than 11 hours for an operation after a car crash, but there was no operating theatre available. Doctors aren't sure if the operation could have saved his life, but they are sure that he wasn't given a decent chance. Health Writer **JUDITH SOAL** reports.



It was a Friday night when Alfred Thomas made up his mind to go to Groote Schuur hospital for a car crash. He had a headache and a sore throat, but he didn't think anything was wrong. He was driving home from a friend's house when he was involved in a head-on collision with a truck. The truck was carrying a load of bricks and it was completely out of control. Alfred's car was crushed and he was thrown out of the window. He was lying on the road for hours before an ambulance arrived. The ambulance took him to Groote Schuur hospital, but there was no operating theatre available. He was left in a ward for 11 hours before a surgeon was finally able to operate on him. The operation was a success, but Alfred died a few days later. His family is still in mourning.

**A FAMILY IN MOURNING**  
— PAGE 9



**WESTERN CAPE** Alfred Thomas was left to die after a car crash. His family is still in mourning.

**T**HE death of Alfred Thomas has captured the hearts of Cape Times readers and prompted politicians to act to save our ailing health care system. On Friday the Cape Times told the story of how Thomas, a born-and-bred Cape Flats resident, died without receiving treatment, 11 hours after a car crash.

Although an ambulance was at the scene almost immediately, it took four hours for Thomas to get to Groote Schuur — the only hospital that could treat his head injuries — because of policies governing the transport of patients in ambulances.

Once Thomas arrived at Groote Schuur, he did not receive the relatively simple procedure that could have saved his life because there was no operating theatre available. His family feel the health system failed him.

The extent of the problems in the health care system was highlighted by the many phone calls to the Cape Times from people who had experienced similar situations, as well as calls from doctors expressing their frustration at not being able to do their jobs properly. They told of increasing patient

**TRAGIC TALE:** Last Friday the Cape Times featured a report about the death of Alfred Thomas, after a wait of more than 11 hours for an operation. Groote Schuur said that there were no operating theatres available.

loads, broken equipment, staff cuts and declining morale. One doctor from a large provincial hospital, who asked not to be named, said there were more stories that could be told of patients who had died or suffered unnecessarily.

New Western Cape Health MEC Mr Peter Marais said he was "greatly disturbed" by Thomas' death, and would do everything in his power to make sure this sort of tragedy did not happen again.

He said he would ensure there was a full investigation into the circumstances of Thomas' death, and announced that he would unfreeze key hospital posts to provide immediate relief to hospitals affected by budget cuts in the province.

"There is a light at the end of the tunnel for health care in the Western Cape. We have decided to work out the budget over three years, which means we can spread the R250-million shortfall over that time. This is where we will get the money to unfreeze hospital posts."

Marais could not say how many or which posts would be unfrozen, saying this would be decided in consultation with the hospitals.

He promised to review all health policies — like those governing ambulance services that delayed Thomas' arrival at Groote Schuur.

Since taking over as Health MEC a few weeks ago, Marais has been canvassing the private sector for donations to help the health

service. He said he would soon announce the donation of "quite a few million rand" to be used to upgrade hospital equipment.

Marais' predecessor, Mr Ebrahim Rasool, now ANC spokesperson on health in the provincial legislature, agreed that the provincial health service was well positioned to improve.

He said that as Health MEC he had "led the fight for a better budget for health in the Western Cape".

"My successor, as a result, has the best budget (R2,7bn) that this province has ever had for health. Alfie Thomas will not be brought back to life, but the system can save other victims."



HEALTH CARE

(918) PM 6/10/98

# Privatisation creeps up on public hospitals

Wits and UCT medical schools go shopping for private patients

**W**its and UCT medical schools are in the market to buy private hospitals which they want to convert into academic teaching centres funded by private patients, not the State.

The move is a desperate attempt to save academic medicine in SA which has been bled dry in recent years by severe budget cuts, a mass exodus of top specialists and a steady decline in private fee-paying patients (see graph).

It is also part of a larger market-driven push for co-operation between private and public hospitals.

Plans are advanced for Wits Medical School to add a private hospital to the five public hospitals in the Wits academic circuit. Wits medical staff and students will rotate through all six hospitals, except that patients attending the new private hospital will pay higher fees.

This will enable Wits to practice sophisticated medicine in a model teaching environment and raise revenue for the academic hospital sector.

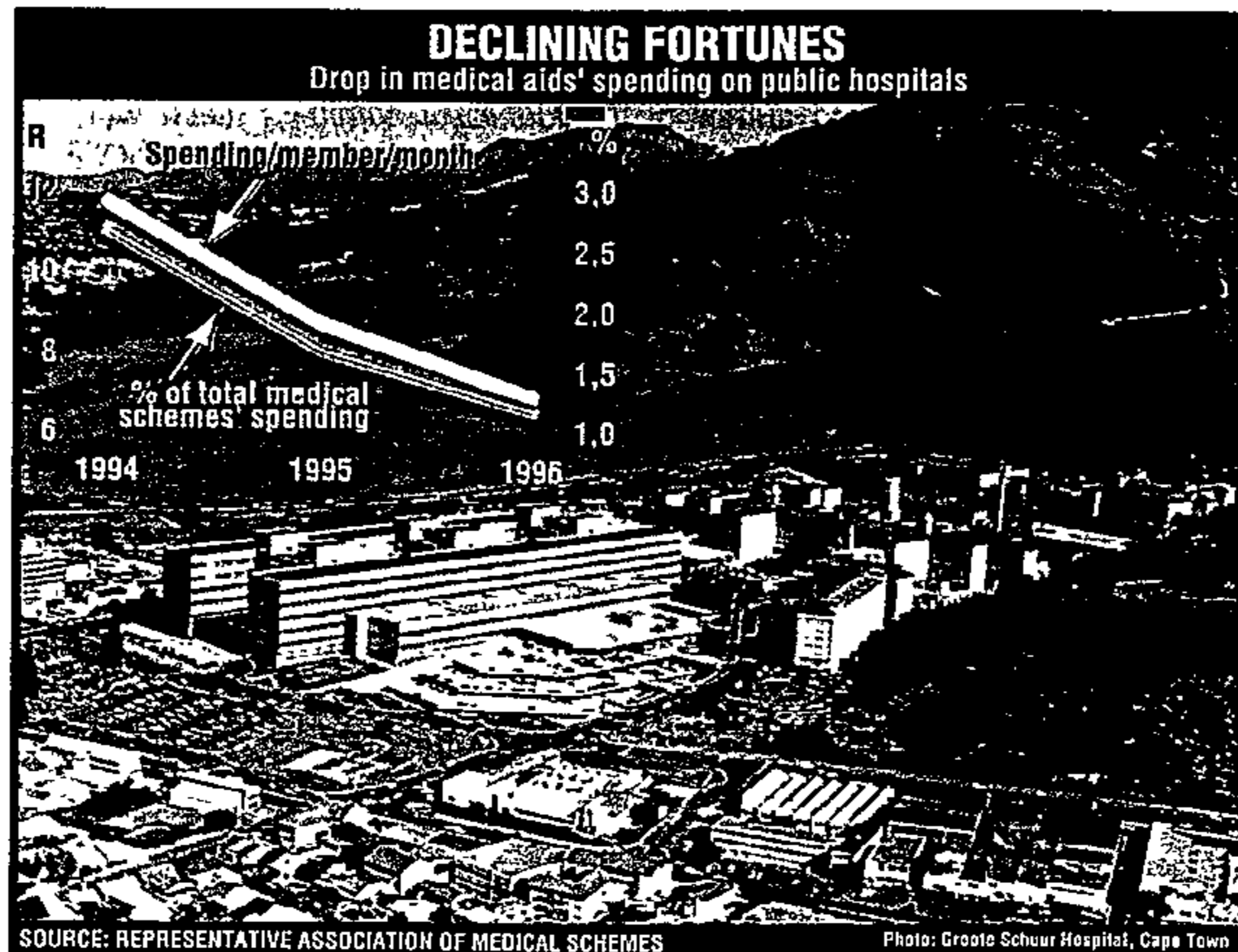
"We've lost quite a number of senior academic hospital staff recently because of the uncompetitive public-sector salaries and because they are disillusioned about the future of academic medicine in SA," says Wits Medical School dean Prof Max Price. "If we can show them that we are creating a satisfactory environment for teaching and research, I think they'll stay."

UCT Medical School is also searching for ways to protect its valuable teaching and research base "We are pursuing a wide range of options with a view to forming significant partnerships which could include the provision of a private hospital or the rental of unoccupied facilities in Groote

Schuur," says UCT Medical School dean, Prof J P van Niekerk.

He would not be drawn on the possibility of Groote Schuur being sold to a national private hospital group to be sectionalised into private and public wards, but did confirm that exploratory talks had occurred.

Wits will receive submissions from six private hospital groups soon and has formed a private company, the Wits Health Consortium, to handle commercial transactions arising from the tender.



It may buy one or even two private hospitals and contract a private hospital group to manage it, or it may enter into a joint venture with a private hospital group to convert one of their existing hospitals into an academic hospital.

Price hopes to have the new hospital operational by the end of the year. He says Wits has not sought permission from government because it is an autonomous institution, but stresses that the scheme will not disadvantage the public hospital sector or cost the State money. "In fact, the State

will gain from the retention of expertise that is flooding out of the system."

The Health Department was unable to comment at the time of going to press.

The hospital will not compete with luxury private hospitals but will target the 6.9m blue collar workers, including their beneficiaries, who don't have medical aid but would be able to afford basic hospital cover if hospital fees were undercut.

Health Department, medical insurers and private hospital groups are working feverishly to develop low-cost hospital insurance products to cater for this huge untapped market (*Current Affairs* October 31 1997).

But to make it work they need cheaper, no-frills hospitals. Hence the move by private doctor groups in conjunction with large low-income medical aids to lease empty wings of public hospitals where overheads are minimal.

At the very least, Wits, UCT and Stellenbosch medical schools are all seeking to lease and upgrade empty wards in their respective academic hospitals for private patients.

It will be hard for government to refuse their requests, given the concept's success at Uitenhage Provincial Hospital where it netted R2m for the province in its first year.

The patients are mostly Volkswagen factory workers who pay 30% more than the standard fee, which is still less than that charged by private hospitals.

Three provincial delegations are due to visit Uitenhage this year to see how to implement the project and private doctor groups are imitating it in Port Elizabeth, Nelspruit, Kempton Park and Mafikeng.

At last the tightly regulated public hospital environment is loosening up,

public hospitals are being given greater management autonomy and more services are being contracted out.

Industry players say private hospitals will ultimately run public hospitals on management contracts.

"We are breaking new ground and old mindsets are changing," says Netcare National Hospital Network CEO Dr Peter Botha. "I expect big changes in the next three to four years. Private hospitals will start to assist in managing public hospitals to improve their efficiency." Claire Bisseker



**Cold comfort:** It takes patience to be a patient at King Edward hospital in Durban. PHOTO: JEEVA RAJGOPAUL

## Cause of death: staff shortages

(98) M+G b-12/2/98

Wonder Hlongwa

**T**handeka Shabalala (16) lies on a stretcher at King Edward VIII Hospital in Durban, with a heavy brown blanket thrown over her body despite the heat.

She has travelled all the way from Pietermaritzburg. She is one of hundreds of patients who come for treatment at King Edward and instead either sleep on stretchers for a couple of nights or leave untreated.

The hospital has severe shortages of nursing staff, general assistants and messengers. But it has to cope with an influx of thousands of patients from different corners of the country's most populated province.

Over the past two years at least 10 people have died at King Edward because of staff shortages.

Senior nurses complain they have only half the staff they need to perform their duties effectively. They are ignoring a call by the government to volunteer an extra two hours a day in an attempt to treat all the people who come seeking help.

Nurses say they already "slave" the entire working day because of the overwhelmingly high nurse-patient ratio.

"Our workers' forum wrote a number of letters to the chief medical superintendent asking for a

change in the admission system. We even sent them statistics on daily basis, detailing patients who have spent more than one night but who have not received treatment, and those who died on the stretchers," said a nursing sister.

The outpatients department is the most crowded at King Edward, with more than 500 patients on daily basis. The dispensary has no seats for patients waiting for their medicines. Some lean against the wall, while others wait in passages nearby.

The overcrowding is not only caused by patients with serious ailments who require treatment at a central hospital like King Edward. Hundreds come from the surrounding townships with minor ailments that can be treated in a local clinic. They have their reasons for shunning the clinics.

"My child can't eat, he's got diarrhoea and sores next to his penis. I'm from Umlazi township, we have a clinic nearby but it doesn't have medication," said Pretty-Girl Zulu, mother of seven-month-old Memory.

Because of a shortage of hospital porters, patients have to be carried into the hospital by their relatives. And because of the shortage of stretchers and wheelchairs, a patient was seen being brought into the hospital in a supermarket trolley.



*Will take plenty of time and money for the government's health care vision*

# Cash is the only

(98) MHG 6-12/2/98

**Ann Eveleth**

**F**roro stories of South African public hospitals abound, but perhaps none more poignantly than recent claims by paediatric staff at Durban's King Edward Hospital that "children have died because of insufficient staff being available".

The hospital's paediatric department has battled "for years" to convince provincial health authorities to give it more nurses, but documents in possession of the *Mail & Guardian* suggest they are losing the battle. Fourteen senior paediatrics professionals at King Edward signed a letter last month to hospital management threatening to reduce admissions if last year's 30% to 40% staff cuts are not reversed by March 1.

But provincial health authorities say the hospital is "sufficiently staffed with a nurse:bed ratio of 1,32:1". Not so for paediatrics, says department head Professor Jerry Coovadia.

Coovadia says his department has suffered staff shortages "for years, but I am sorry to say things are

worse now than before the new government".

So whatever happened to Minister of Health Nkosazana Zuma's bold new vision of universal basic health care for all?

National Department of Health Director General Olive Shisana is adamant the vision remains the guiding force of government policy. But, she says: "A policy can only be real if you have enough money to implement it." Shisana estimates the R20-billion annual health budget needs a "R4-billion to R5-billion" top-up to ensure universal health care.

In the meantime, her department has had to respond to "real budgetary cuts" in recent years by shifting resources from apartheid's hospital-centred approach to primary health care clinics in underserved areas.

Coovadia, a veteran African National Congress health care activist, says he supports this policy, but argues that its impact on some hospitals is "phenomenally negative".

"In theory it sounds great, but you can't consider all tertiary hospitals the same. We were not all born equal under apartheid. King Edward was

underfunded by apartheid as a black hospital. It is the final referral centre for the whole of KwaZulu-Natal's eight million population," he says.

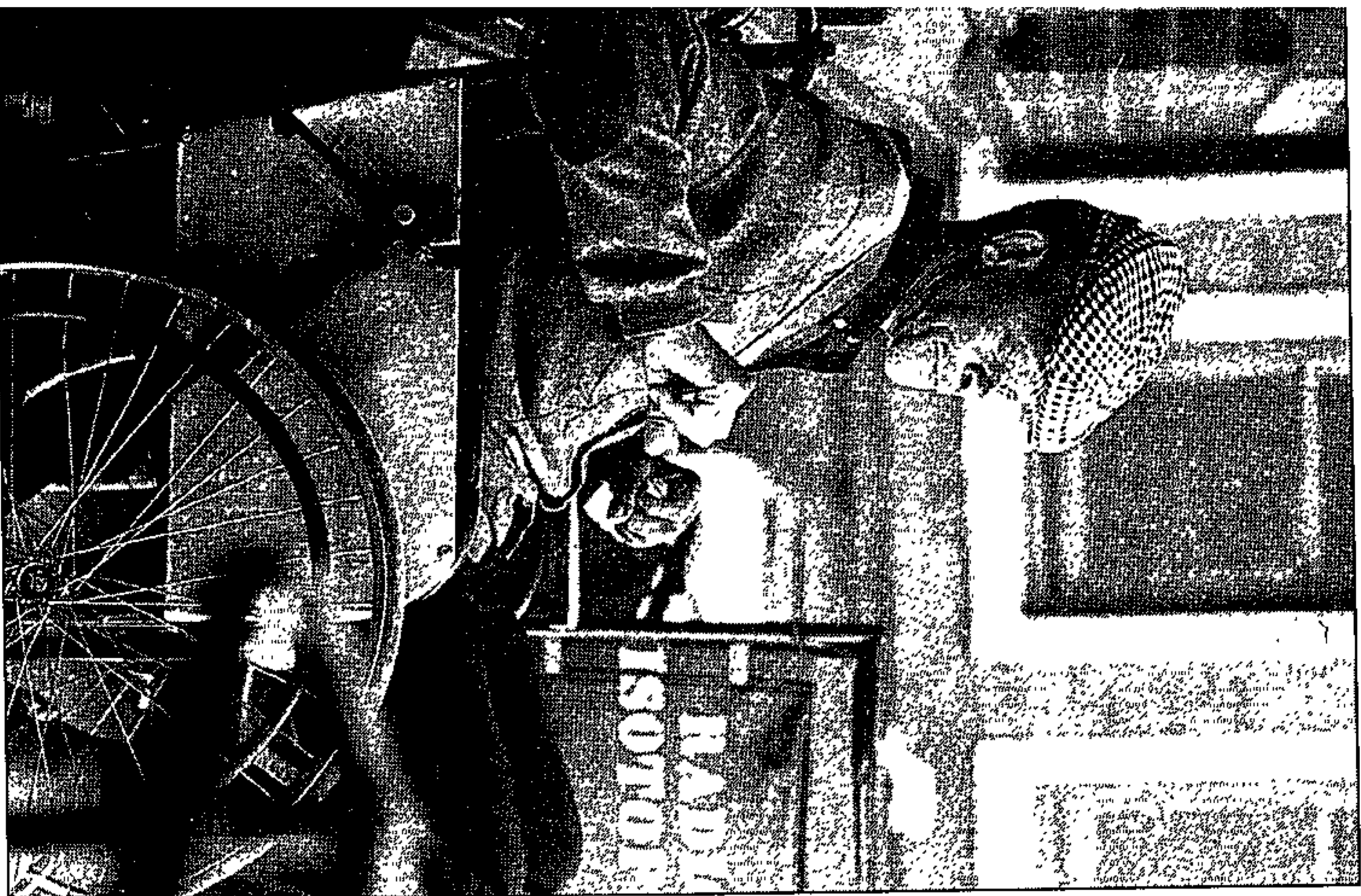
The numerical pressures on central and district hospitals are reinforced by the now common sight of hundreds of patients queuing for hours for treatment. But Shisana interprets these scenes differently.

"If you are coming from an area that had no health care in the past, getting care after waiting in a queue is better than no care at all," she says.

Progressive Primary Health Care Network general manager Khathato Mokoetle says the recent Gauteng hospital closures must be seen in this context, but adds that a lack of public education about the new referral system is adding to hospital bottlenecks.

"People go to Johannesburg [General Hospital] directly, without knowing they can still go to Hillbrow's community health centre for many things. People aren't used to going to clinics for minor ailments," she says.

In terms of the new national health care system, patients with minor ailments are expected to attend local clinics or 24-hour community



**heelchair wait: An old man waits for treatment. PHOTO: NADINE HUTTON**



*to be realised — and in the meantime people are dying*

# Cure for ailing hospitals

health centres first. Nursing staff at these institutions will then refer seriously ill patients to district, regional or central hospitals, depending on the type and level of care they require.

That is the vision, but again reality falls short. The government has nearly halved its estimated national clinic shortfall of 1 000 with the construction of 493 new clinics since 1994. But at least 117 of these are not yet operational, due mainly to financial, equipment and staff shortages.

Shisana says rural clinics have been the most difficult to staff, due to a preference among health professionals to work in urban centres. South Africa's doctor:patient ratio ranges from 1:500 in some urban areas to 1:30 000 in some rural districts. Some provinces are worse than others. Of the 113 new clinics built in KwaZulu-Natal since 1994, for example, only 46 are open for business.

Even where clinics are up and running, they may not have the necessary medicine and equipment to treat their patients. Shisana says real medicine shortages are "rare" and are usually due to anomalies in the pharmaceutical industry, a lack of ca-

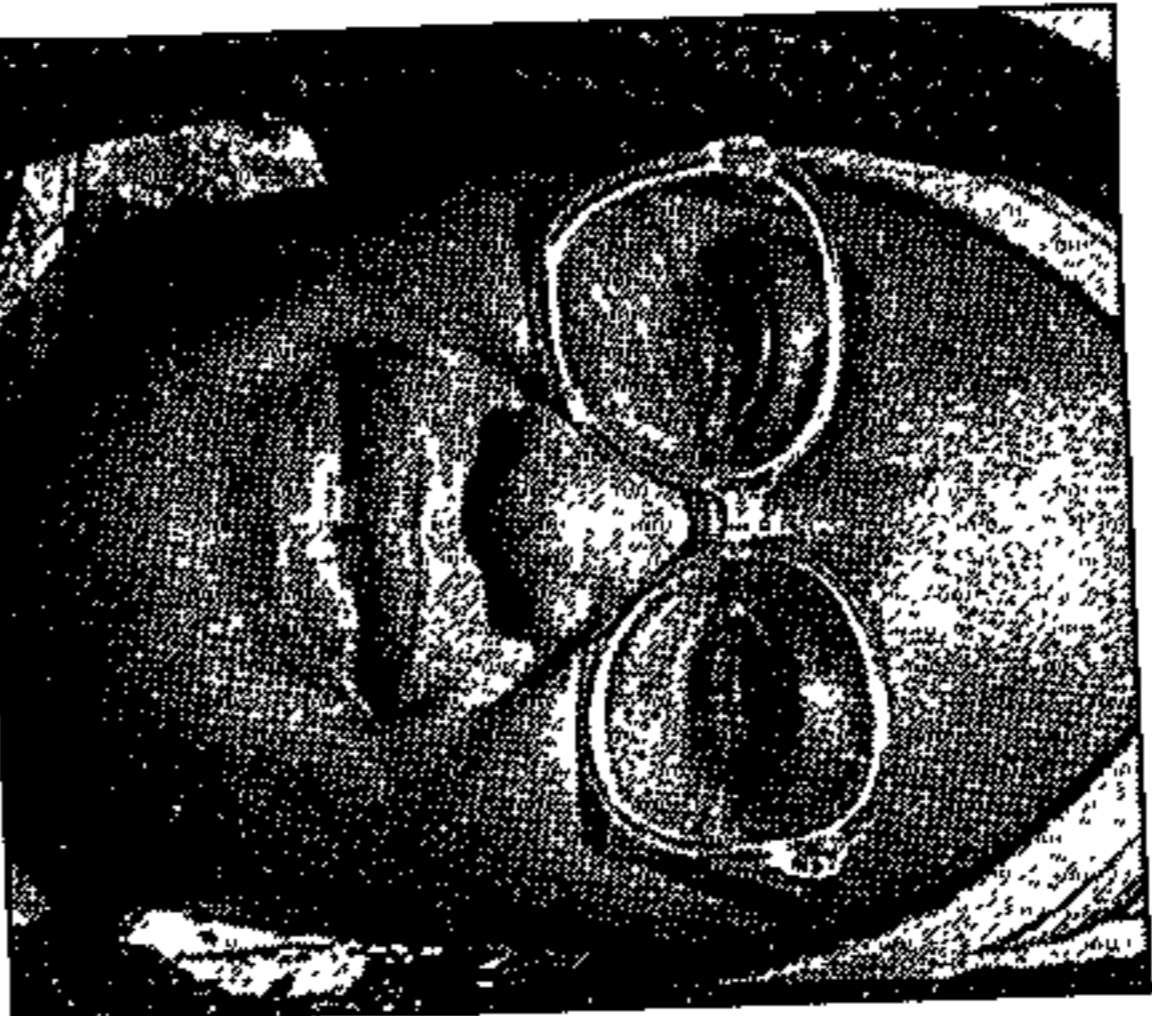
capacity among those ordering supplies, or patient preferences for brandname drugs over generic drugs.

But she admits nurses are often not empowered to dispense the medicines their patients need. Moves to allow wider dispensing registration are afoot, but until then the primary health care vision's main providers are unable to dispense everything on the primary essential-drugs list.

Shisana says provinces are expected to reduce hospital over-use by charging a "bypass fee" for patients who jump the referral queue in non-emergency cases. But the public education needed to jump-start this system will only begin later this year, when district and clinic health committees are formed.

Doctors like Coovadia dismiss this explanation for overcrowding as "total rubbish. They must show me one patient in my department who shouldn't be there."

Coovadia's department is the tertiary-level supplier of the government's three-year-old policy of free health care to children under six. Demand for health care has apparently simply outstripped supply.



**Shisana: 'Getting care after waiting in a queue is better than getting no care at all'**

Shisana is quick to concede serious national staff shortages, with provinces reporting a total 2 426 vacant health posts by December 1997, a gap she says prompted the new compulsory community service requirement for doctors beginning July 1. While 1 706 of these vacant posts are approved for funding, many have not been filled simply because nobody wants them. An estimated 1 000 new

interns are expected to help close the gap when they begin their service. Shisana also hopes to include nursing, pharmacy and physiotherapy students in the programme.

But many interns have been dragged kicking and screaming into their service. When voluntary service came into effect on January 1, only 62 interns joining the public system declared their voluntary status.

Coovadia says the underlying problem is low morale. "Vacillation on salaries and overtime for doctors has brought morale plummeting. That professional ethos we had which made us work five or six days without worrying about better pay is gone. It doesn't exist among the new crop of interns. It may be gone for ever."

The government has spent more than R2 billion in health care salary increases in recent years, but Coovadia says public salaries still compare poorly with those in the private sector who often earn three times as much. "The dominance of the private sector has serious effects on the ability of the public sector to operate effectively."

Shisana agrees the dual public-private

health care system remains skewed. Sixty-four percent of health professionals are ensconced in the private sector, to which barely seven million medical aid beneficiaries have easy access, leaving only 36% to treat the remaining 30-million South Africans with a per capita health allocation of less than R600 a year.

Shisana says the only option is to integrate the two more effectively. Getting private doctors to do essential work in the public sector, sharing expensive medical equipment and sending public patients to private hospitals for an agreed fee are some of the plans under discussion.

But Coovadia says King Edward's problems could be solved simply by greater consultation and better management at the hospital and provincial government level.

Shisana says this, too, is understood by the national government. "We are looking at ways to reduce waste, improve planning information and the hospital managers to performance contracts."

"The problems we know, the solutions we know. The problem is money," she adds.



# Marais calls for Conradie facelift

HEALTH WRITER

CT 6/2/98 (98)  
MAKE Conradie Hospital your valentine on February 14, says Health MEC Mr Peter Marais.

Marais has made upgrading the appearances of hospitals one of his primary concerns since taking over his new portfolio.

"It's terrible to be sick when the place is falling apart. How are people supposed to get better when it's dirty and dingy?" he asked.

"On Saturday, February 14, we will work together to make Conradie a better place."

Marais appealed to the public to go to the hospital to help his team cut the lawns, clean up the grounds, paint six of the wards and start building extensions.

Marais said he had had a fantastic response to appeals to the private sector for donations in return for publicity.

"We have been given paint, building equipment, tiling, all sorts of things. And it won't cost the health department a cent."

● Anyone who wants to help should phone 483-3158.

# Hospital needs resources - DP

*Sowetan 9/2/98*  
EDENVALE Hospital, east of Johannesburg, was being crippled by renovations and understaffing, the Democratic Party said yesterday.

"This hospital has experienced dramatically increased patient loads, rising from 100 patients a day in 1996, to 200 in 1997 and 300 in January this year - a 200 percent increase in two years," Gauteng DP spokesman Mr Jack Bloom said. (98)

He attributed the increase at Edenvale Hospital to the closure of Kempton Park and Hillbrow hospitals.

Bloom accused the Gauteng health department of handling the closure of Hillbrow Hospital poorly as it had failed to ensure that alternative facilities for Hillbrow patients were arranged in good time.

"Furthermore, the transfer of the promised personnel and equipment from Hillbrow to Edenvale has been extremely slow. The Hillbrow nurses that were promised have yet to arrive," he said.

Bloom said there were only six doctors at Edenvale Hospital who had to cope with a vastly increased patient load, which resulted in long queues and exhausting working hours. - Sapa.



# Dust-up over cheap vaccine

M+G 9-15/1998 (98) (10/11)

**Marion Edmunds**

**T**he government is considering taking disciplinary action against an Eastern Cape public health specialist who last year suspended the use of a cheap Korean hepatitis B vaccine in 14 East London clinics because he doubted its efficacy.

The head of the department of public health at Cecilia Makiwane Hospital, Dr Costa Gazi, said he believed Heppacine B was ineffective and ordered that it no longer be used in 14 clinics under his supervision after a field trial conducted there by the National Institute of Virology in 1996 showed it was ineffective.

The study's results showed a 44% seroconversion rate, which is alarmingly low for a vaccine. (Seroconversion describes the build-up of antibodies in the blood stream, activated by a vaccine.)

"I felt I had to take action because I was in charge of the clinics," said Gazi. "I follow the national immunisation list, but not blindly. I look forward to defending myself from charges if they are laid."

Hepatitis B is transmitted through sexual contact and blood-products, and can be transmitted by pregnant mothers to unborn children. Toddlers can also transmit it to each other. The younger the age at infection, the higher the probability of the infected child becoming a carrier — thus the need for a vaccine for infants younger than one year.

Heppacine B, a generic plasma-derived drug, is favoured by the government because it is considerably cheaper than a competing genetically engineered vaccine, Engerix-B. However, the supply of vaccines is lucrative business, and the 1995 Heppacine B consignment is said to have cost the government R12-million.

Gazi believes a cheaper vaccine is a waste of resources if it is not effective, and says his stand against the department is on ethical grounds.

The provincial health department sent out letters last month to the 14 clinics, overriding Gazi's instructions. The department also threatened Gazi with disciplinary action.

The department's acting permanent secretary, Dr Peter Milligan, said Gazi lacked the authority to act as he did: "It is not appropriate for an individual to suspend the activity of the vaccine. Gazi never drew the department's attention to the issues, nor said let's take this up with the national department." Gazi said he had informed the department of his actions.

Despite strong support for Heppacine B by the South African health authorities, doubts over the vaccine's effectiveness persist, partly because it is administered in an extremely small dose of 1,5 micrograms.

Published research from a study done in the Solomon Islands in 1995, by a New Zealand expert, Professor Alex Milne, showed that Heppacine B failed dismally there as a vaccine against hepatitis B.

However, World Health Organisation representatives have urged the international community to ignore the Milne study and not to question the use or dosage of the Korean drug, because of its success in countries such as South Africa, Gambia and the Philippines.

The health department referred the *Mail & Guardian* to a 1995 study by Professor Sunette Aspinall, which showed a 93% success rate in the use of the vaccine on infants in Shoshanguve and North West province.

Professor Barry Shoub, the director of the National Institute of Virology, this week cited the Aspinall success story, and cast doubt on his institute's own 1996 research, saying the results were probably misleading and the researchers who compiled them "inexperienced".

Controversy over the 1996 results has led to further, more rigorous research, whose results are to be published later this year.

## Hospital deliveries stopped after suppliers' bills unpaid

(98) 50 9/2/98

PORT ELIZABETH — A shortage of government funds, in the wake of the Eastern Cape pension crisis, had affected health services in the province, Health MEC Trudie Thomas said.

Thomas called on government to transfer funds to her department before a crisis set in. She said deliveries to some Eastern Cape hospitals had been stopped because central government had not released money to pay their bills.

Several hospitals in the province have been without food, basic groceries, equipment and services because suppliers' bills have not been paid by the provincial government in Bisho.

She said the shortage of funds meant her department was unable to pay some of its hospital suppliers, and some suppliers had stopped deliveries until they received payment.

Thomas said that mainly small-town hospitals were affected.

The delivery of bread and basic groceries to the Steynsburg hospital stopped at the beginning of the week. There were also shortages of medical supplies.

Fort Beaufort hospitals lacked x-ray plates and other supplies, while several hospitals had complained of a shortage of staff because new personnel could not be paid.

Thomas said most hospitals had needs that could not be met at one time or another, but the department was trying to "fill the gaps" where the need was greatest.

"We identify the greatest problems and then try to pay those bills first, but obviously we can not do much at the moment. The transfer of money from central government to our province will be a great relief," she said. — Sapa.



# Partnership between doctors, hospitals may become a reality

(98) (98) DD 11/2/98  
Josey Ballenger

PUBLIC and private partnerships which could help bale out underfunded public hospitals and encourage doctors to practise "ubuntu" — humaneness — could become a national reality if one Eastern Cape hospital sets a trend.

Tim Wilson, the national health department's chief director of facility planning and hospital management, said the department was looking into the possibility of private practition-

ers using unused wards in public hospitals in exchange for making capital improvements.

Public and private sector health experts said the arrangement would inject cash into embattled public health services and, at the same time, allow private doctors to tap into public facilities' infrastructure, equipment and client base.

The model was the Uitenhage Provincial Hospital, where a group of general practitioners had formed the Uiten-

hage Independent Practitioners' Association.

About 50 doctors consult and treat patients for general ailments off hospital premises, but use a ward when hospitalisation is necessary.

Siva Pillay, association founder and chairman, said the association's doctors did not reap big profits compared with those running a nearby private clinic, but that their sense of ubuntu had led them into the venture.

The doctors do not pay rent to government, nor do they pay for capital improvements or hold shares in the association. Instead, the venture helps the hospital generate income by charging 30% more than the "ridiculously low" public tariff — but still only two thirds what the private sector charges — and putting the difference into a reconstruction and development fund to upgrade district health facilities.

Pillay said about R1m had been used so far to upgrade the hospital and nearby clinics and implement health education programmes such as AIDS awareness.

Eastern Cape health MEC Trudy Thomas said: "It is a model we are exploring which seems to be useful for both sides. In some of our areas, we do have extra space, and we are looking at expanding (this arrangement) into other, bigger hospitals".

# Children's hospital on road to recovery

## R1,5-million raised after province runs out of money (98)

JENNY WALL  
HEALTH REPORTER

The Red Cross Children's Hospital is on the road to recovery with the donation of a new CT scanner to replace an old machine forever breaking down - permanently last month - and which the provincial health department could not afford to replace.

The new, R1,5-million CT scanner, ordered, delivered and installed in a record 24 days, was handed over yesterday, saving future patients a trip to Groote Schuur hospital or 2 Military Hospital in Wynberg.

A fund to raise money for a new scanner was set up in 1996, and although the Muslim Association of the Red Cross Children's Hospital and the radiodiagnostic department raised R257 000, it was not enough.

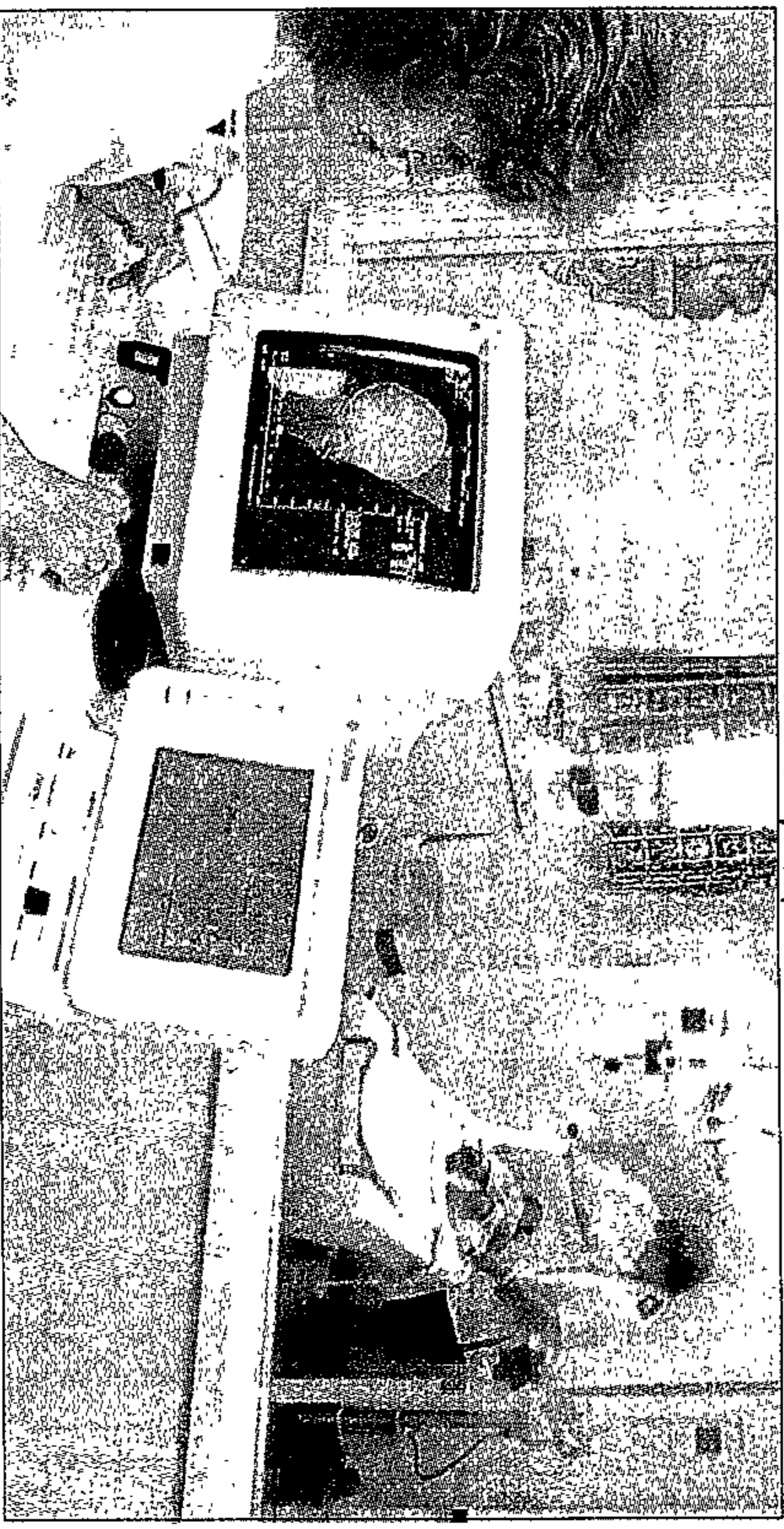
Fortunes changed when Wendy Ackerman, wife of Pick 'n Pay chair-

man Raymond Ackerman, gave R250 000, the value of a wedding anniversary gift her husband was to give her. This was followed by a R700 000 donation from the hospital board and a bequest from a deceased estate, and the Children's Hospital Trust lent the shortfall of about R500 000, which the D G Murray Trust began repaying with a donation of R350 000.

A deal was made with General Electric to supply the machine at a discounted price and airfreight it from Paris, and the scanner was up and running in 24 days.

Chief medical superintendent Saheed Hassim said it was an exciting day for the hospital, and: "The dedication of the staff concerned cannot be emphasised enough.

"Now we have to raise money to repay the trust, and we must raise a further R1,5-million to upgrade the basic unit."



Life support nurse Barbara Dumlhiet prepares 'patient' Laura Skippers for a CT-scan. Chief radiographer Gill Stark is at the computer

BRENTON GEACH



# Wits medical students move to private care

Public hospital teaching stays, but can't cover all needs anymore, says dean

*Star 16/2/98 (A2) (98)*

BY JANINE SIMON  
Medical Correspondent

**W**its medical school plans to end uncertainty and guarantee staff their future in academic medicine by opening up academic beds in private hospitals before the end of this year, breaking a tradition of teaching only at public hospitals.

University staff and students will remain based in the five academic hospitals in the city, but will also spend a limited amount of time working with private patients in one or more outside academic units.

Teaching currently happens at Johannesburg Hospital, Chris Hani Baragwanath, Helen Joseph, Coronation Hospital and Tara.

The move, which has been under discussion for some time, is likely to ease the remuneration uncertainty among doctors working in academic hospitals.

But, says the dean, Professor Max Price, it should benefit all parties.

The private facilities will be used for the teaching of specialist and sub-specialist staff and will make up between 10

## 'Changes will benefit all'

and 15% of the university's total 4 500 teaching beds.

Price said the plan is seen as a means for the health faculty to take control of its own destiny and hedge its bets against the continuing uncertainties and overcrowding in the state sector.

elective surgery now under pressure in the state sector; state patients will benefit because top academics will remain in the system; and private patients will now also be able to access their expertise at a fair rate.

Gauteng Health Department director of policy and planning Dr Ahmed Valli said Wits had been discussing the concept of accessing paying private patients by opening a private ward in Johannesburg Hospital for the past two years.

Its proposal is being adjudicated and a decision should be made by the end of March.

Wits started new discussions with private hospital groups over a plan to open one or more units in the private sector in December last year.

They were precipitated by a string of problems within the public health system, Price said.

The Government had been vacillating for two years over the issues of overtime pay, limited private practice for academic staff and downsizing of tertiary hospitals, and there was a real need to end the uncertainty.

Overtime pay made up 30% of staff income, and many academics would desert the state if they could no longer work in an acceptable overtime system.

Doctors were allowed to earn extra income by spending 11 hours a week doing limited private practice, but while this kept them in the system, it diverted their energies away from teaching, Price said.

He stressed that the move was also a way for the university to create a teaching environment in which it could control overcrowding and patient mix.

The university hopes to have a proposal regarding private academic beds on the table by April.

A decision should be taken by the faculty board at its meeting in May, Price said.

It is not yet clear whether the plan would involve individual wards in several private hospitals, private wards in state hospitals, or even an entire quasi-public hospital, where profits generated would be ploughed back into the university.

State hospitals were being overwhelmed by trauma cases, and there was not enough elective surgery, such as gall bladder surgery, for postgraduate students to be trained in those procedures.

Students were already being sent to the private sector for training in general practice, magnetic resonance imaging scans and some orthopaedics.

According to Price, medical staff will be guaranteed equitable incomes, and students will be able to access training on specialised equipment and



# Budget crisis leaves

## male docs in dresses

ARG 19/2/98

(98)

CAROL CAMPBELL  
SPECIAL WRITER

Money is so tight at Groote Schuur Hospital that male surgeons are having to wear women's overalls in theatre and some equipment is so dated it should have been discarded years ago.

But a hospital spokesman says all the old stockpiled items being used to cut costs, such as artificial blood vessels, are being "meticulously" checked and are completely safe.

Hospitals and schools in the Western Cape are struggling to offer a quality public service because of rigorous budget cuts, yet the Western Cape government has refused money from Finance Minister Trevor Manuel to bail out the province.

Apparently the provincial government fears that if it takes the money this will give the national government the right to intervene in the running of the Western Cape.

Provinces which take bail-out money have to submit to plans to bring spending in line with national resources.

Groote Schuur, which will have no additional funds until the beginning of the new financial year on April 1, is expected to overspend its capped allowance of R545-million by R12-million this year. Its original budget for the year was R375-million.

In a letter to the Cape Argus, a doctor at Groote Schuur said there were "cupboards-full" of unused equipment bought by the old Cape provincial administration.

"We have been instructed to use it up in spite of the fact that much of the stuff is obsolete. I only hope this does not affect the patients we operate on daily."

He said that for the past year male surgeons had been forced to wear women nurses' overalls in theatre, which was causing them "much distress".

"This seems to be of little concern to the hospital management, but we find it degrading and insulting. It is also very difficult to operate in a size 36 dress."

A doctor said some specialists were operating in their own T-shirts, which



The real thing: the usual male doctor's theatre outfit

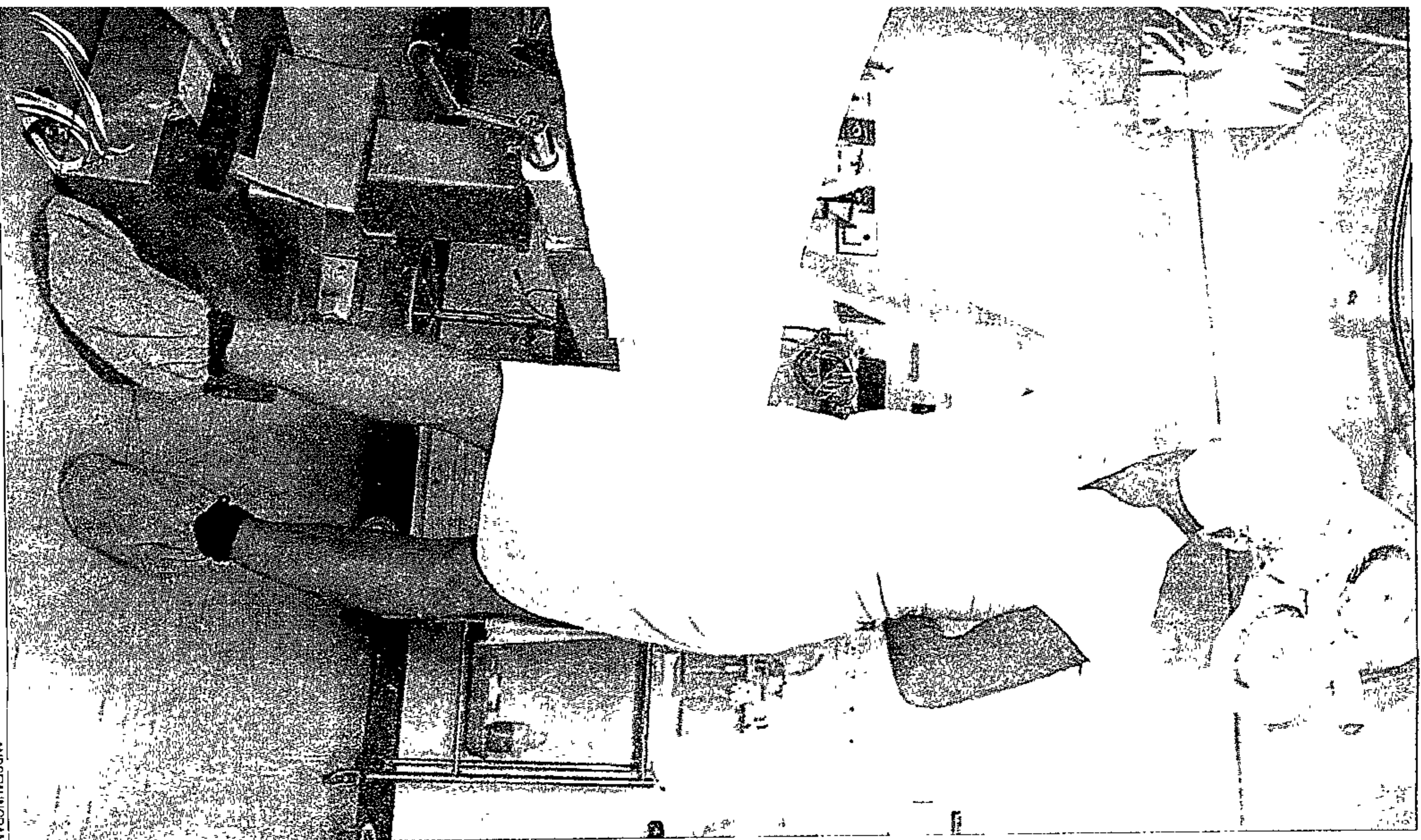
meant they had to take the blood-stained garments home for washing.

"Surely it is possible to find some money in the budget somewhere to buy some theatre shirts for the surgeons in our tertiary care hospital?" the letter writer said.

The hospital spokesman said the administration had, on a number of occasions, bought large quantities of theatre shirts, which were soon stolen or "went missing".

"The administration has at this stage not implemented an efficient control system in the hospital," said the spokesman.

There was just no money to replace missing theatre shirts and staff had to make do with what was available. "Funding to national teaching hospitals is dwindling. We have to work harder and smarter so that we do not compromise patient care."



ANDREW INGRAM

ght fit: a Groote Schuur doctor models the nurses outfit which male doctors are being forced to wear



# Food shortage hits schools and hospitals

Sowetan 20/2/98

Non-payment discourages food suppliers and some schools go without toilet paper

## Special Investigation By Khathu Mamaila

**S**TATE hospitals and colleges in Northern Province are facing severe food shortages because suppliers have not been paid.

And at some schools the situation is so serious that there are not enough funds to supply toilet paper.

Sowetan has learnt that at hospitals things are so critical that nurses have told patients' families that they should bring food for their relatives in hospitals.

Colleges and schools with boarding facilities are also facing critical shortages of food throughout the province. Most suppliers have suspended supplying food and other material such as toilet paper because they had not been paid for several months.

Education spokesman Mr Bernard Matsane confirmed that the department owed suppliers R1.9 million.

Hospitals affected by the shortage of food include Groothoek, St Ritas, Maphutha Malatji, Letaba, Siloam, Thilidzini and Donald Frazer.

Health and welfare department spokesman Mr Tshepo Moshima confirmed that some of the hospitals, especially those in rural areas, were experiencing food shortages. He said the problem was particularly serious between December last year and January this year. He said the matter was receiving attention and in most areas it had been resolved.

A worker at Maphutha Malatji in Namakgale, near Phalaborwa, said yesterday that the supply of bread had been suspended more than three months ago.

He said the last delivery of milk was more than six months ago. He said fruit had become a luxury that could not be afforded for patients.

A patient at Groothoek said patients were offered soft porridge without sugar. He said

sometimes they were offered bread as the main meal because there was no mealie meal.

A patient at Siloam said about two weeks ago he was given porridge and an apple as there was no meat.

A shop steward of the National Education Health and Allied Workers Union (Nehawu) at Siloam Hospital, Mr Mbulaheni Mukhathedzwa, said that the hospital was experiencing food shortages because of poor management.

"I do not think that money is the root of the problem. The problem lies with the officials who are loyal to the old order and their agenda is to see the present Government fail.

"We have discovered cases where a supplier was paid R90 for a chicken and R76 000 for 16 carcasses of beef.

"The hospital is paying R56 000 for four small van loads of vegetables," said Mukhathedzwa.

## Peanut butter and margarine

An official at Donald Frazer said the hospital had had to change the suppliers who stopped supplying food because they were not being paid.

She said the supply of peanut butter and margarine had been stopped. Since last month patients were forced to eat bread without peanut butter or margarine.

Moshima urged those who had information about corruption to come forward.

Meanwhile, Democratic Party health spokeswoman Ms Ann Kirkpatric said yesterday that her organisation had received a damning report about the services in state hospitals in the province.

She said there was widespread theft and mismanagement. Kirkpatric said in many cases suppliers had stopped supplying food because they had not been paid.

She also said there was a shortage of linen. Some of the hospitals could be closed because of lack of funding.

# Alarm as deadly dysentery strikes nursing homes (98)

MICHAEL SCHMIDT

ST 22/2/98

MEDICAL authorities in Kwazulu Natal are on the alert after an outbreak of a virulent strain of dysentery killed 11 elderly people at two nursing homes recently.

Environmental health officers have not yet determined how the disease entered the Sunnyside Park Home in Maritzburg, where nine people died, but believe it may have been carried from an outlying rural area by an employee who fell ill on February 5, suffering from diarrhoea and vomiting.

He survived, but four days later an elderly resident was admitted to the casualty department of Grey's Hospital. She died shortly afterwards.

Two elderly people also died from dysentery recently at an unidentified Durban nursing home.

Sunnyside Park Home matron Hillary Mumford said the outbreak had initially appeared to be diarrhoea. But when several patients died last weekend, she called in Maritzburg's medical health officer, Dr Julie Dyer.

Dyer said environmental health officers tested the kitchens, water supply, drains and perimeter of the institution, but could not identify the source.

"Although it can be waterborne, dysentery is usually transmitted by the

fecal-oral route, from hand to mouth."

Provincial laboratories have so far returned only four results: "One sample showed shigella dysenteriae type 1, the more virulent strain, another two showed the less lethal flexneri strain, and the fourth strain has not yet been identified," Dyer said.

On Friday, four employees at the Sunnyside Park Home fell ill with what is believed to be shigella. And eight elderly patients are being treated in isolation by nursing staff wearing protective gear.

Shigella was first identified in Durban in 1994, the year the shigella 1 strain killed thousands of people in Zimbabwe and Mozambique.

The epidemic was believed to have erupted during the Rwandan holocaust and brought south by fleeing refugees.

An outbreak occurred at the Aryan Benevolent Home in Durban last year, but no deaths occurred.

Unless it is treated with antibiotics within 72 hours, the shigella pathogen produces a toxin which may enter the bloodstream, causing disorientation, kidney failure and inflammation of the heart or pancreas. Old people, children and the frail are most susceptible to the disease.

Provincial health spokesman Dave McGlew said the authorities recognised that shigella was "a huge problem", but controlling it was difficult because of poor sanitation and hygiene.



# Hospitals ban ops after cash runs out

ARG 25/2/98 (98)

**DI CAELERS**  
SPECIAL WRITER

**State patients needing hip replacement surgery can expect to wait, often bedridden, for as long as six months.**

If patients need cataracts removed, the waiting list is about a year, and if they need hernias repaired Groote Schuur Hospital says they could wait forever.

This is the reality of severe budget cuts that have forced Western Cape academic hospitals to suspend all "elective" surgery – operations not regarded as "emergencies" or "urgent" – until the start of the new financial year on April 1.

Groote Schuur stopped elective surgery at the beginning of the month and Tygerberg Hospital on Monday.

But with waiting lists for these opera-

tions already extending up to a year or even indefinitely, surgeons have made it clear that come April 1, their problems will be far from over.

John Terblanche, head of surgery at Groote Schuur, said a patient with a fractured jaw might well have to wait – while being given medication for the pain – for up to a week for surgery. Someone admitted on a Saturday with a compound fractured femur might have to wait until the Tuesday for an operation.

The financial situation was so bad that Groote Schuur had considered doing only "life-or-death" operations, but had resisted as it would be "ethically unjustified", Professor Terblanche said.

Japie du Toit, senior medical superintendent at Tygerberg, said there were waiting lists in all theatre-related areas.

Even though cancer-related surgery was regarded as elective, operations were still being done when a patient could be at risk.

There were waiting lists of up to six months for hip replacement surgery and ophthalmology.

"Our only intention is to save money and this way we're saving on consumables like drugs, equipment, food, medicines and linen every time we can put off an operation until the new financial year," said Dr Du Toit.

Both institutions are awaiting possible relief in the form of central government funding for academic hospitals, in recognition of their status as national assets, but Vincent Hlongwane, spokesman for Health Minister Nkosazana Zuma, said this week the matter was still under discussion.

They hoped to have clarity by the end of next month.



Eastern Cape health MEC Dr Trudy Thomas (centre) at the opening of the Canzibe Hospital last week. PICS: DAN FUPHE



# Hospital gives district a new lease of life <sup>(98)</sup>

*Sowetan 27/2/98*

By Dan Fuphe

WHEN Eastern Cape health MEC Dr Trudy Thomas officially opened the R3,1 million Canzibe Hospital recently in the district of Ngqeleni, outside Umtata, she was in a way giving the local community a new lease of life.

"This day is a double celebration," she told the ululating crowd "We are also the proud recipients of a new mobile clinic." The 4x4 mobile clinic, worth R160,000, was donated by Absa.

Guests at the opening of the hospital included government officials, chiefs from the surrounding areas, doctors, teachers, healthcare personnel and excited pupils from nearby schools, accompanied by their parents.

Thomas paid tribute to President Nelson Mandela and the Government and was given a rapturous standing ovation when she declared: "Mandela delivers."

She also stressed the need for closer working partnerships between big business, non-governmental organisations and provincial governments.

Community leader Mr Mzinto Bungani told *Sowetan* that the original Canzibe Hospital was founded in 1961 and was initially housed in four separate mud-built rondavels.

"This part of the province was for many years neglected by the former apartheid government," he said. "It is only now during the new dispensation that things are beginning to happen in Ngqeleni."

"In the past even cattle used to graze within the then so-called hospital premises. It is the first time that Ngqeleni has attracted so much attention from the government."

Canzibe Hospital spokesman Dr PAG Schrooders painted a bleak picture of the hospital during apartheid.

"The outpatients section was outdated - patients sat outside, even on rainy days. We had a pre-fab building which was also inadequate and uncomfortable to work in," he said.

Other medical staffers said certain diseases, such as tuberculosis and malnutrition, which were normally easy to control, were very common because they were not detected in time and therefore became rampant.

"A need was expressed for a mobile clinic which could take healthcare to the people," said Absa's head of group communications in Eastern Cape, Mr Andy de la Mare.

"What we have achieved is proof that the private and public sectors can work together. Absa can provide the funds but without the staff and expertise of the public sector this project would not have taken off."

Canziba Hospital is staffed by four doctors: principal medical officer Dr MA Kabir (from Bangladesh), Dr N Bustamante and Dr R Brito (from Cuba) and Dr F Henning.

## Massive burden

Kabir decried what he termed the massive burden caused by occupational lung diseases, such as pneumoconiosis or phthisis, among former mineworkers and other migrant workers.

"These people are retrenched from the mines and return home without any access to medical services.

"This happens regularly despite the fact that the Labour Relations Act stipulates that any kind of damage resulting from any kind of work must be compensated."

Kabir said it was painful to see these people being ignored by their former employers.

Nursing sister Mrs Nōzipō Pantshwa confirmed that their records reflected an average of about 71 tuberculosis patients a month. Of this 34 were males with serious respiratory problems.



Patients waiting to be treated at the outpatients section of the new Canzibe Hospital.



## Closed hospital 'has R75m (98) equipment'

THE Democratic Party (DP) yesterday expressed concern following the disclosure that medical equipment worth R75m was still left at the Hillbrow Hospital two months after its official closure.

DP MPL Jack Bloom said the disclosure was made by health MEC Amos Masondo following a question in the legislature this week.

Bloom said in the case of larger items, the delay was caused in certain instances by the need to obtain Tender Board approval, but other options were being considered with regard to the destination of other items.

"I am appalled at the lack of planning that has led to this situation, whereby such a large amount of equipment still remains at Hillbrow Hospital when it is desperately needed elsewhere." It was inexcusable that the Gauteng health department did not plan well ahead of the closure of the hospital, he said. — Sapa.

BU 27/2/98

MAKING A BUSINESS OUT OF ILL HEALTH

# How private hospitals doctor your accounts

**PRIVATE HOSPITALS** and medical supply companies are colluding to add substantial amounts to your medical bills. Health Writer **JUDITH SOAL** reports.

**S**ECRET agreements between private hospitals and medical equipment suppliers cost patients millions every year. The *Cape Times* has evidence of large discounts — or mark-ups — which are hidden from medical aids and patients, who are billed for the full amount.

In one example, a hospital charged over R7 000 more than it paid for three components of a top-of-the-range knee prosthesis. Medical aids are prepared to pay hospitals a 10% handling fee for medical equipment, but price lists in the *Cape Times*' possession show mark-ups of 20% that are added before VAT or the 10% allowed mark-up. Patients are charged about 30% more than hospitals pay.

Rather than being fraudulent, these mark-ups form part of business practices labelled by those on the receiving end as "unethical, dubious and purposely wasteful".

The private medical industry was thought to be worth about R25bn in 1997 and estimates of the cost to consumers of this kind of "manipulative" business practice, over-use and fraud is about 20% of this — R5bn. Medical aids and the Representative Association of Medical Societies (Rams) say they are investigating the practices.

Mr Gary Taylor, director of medical aid administrators Medscheme, said confidential discounts were common practice. "These arrangements are unethical but not unlawful, and all the big supply companies do it.

"The medical aids set a price that they are prepared to pay and hospitals put pressure on suppliers to give them a discount on this price. They consider this to be part of smart business practice. This stretches from prostheses to gloves and plasters and bandages — just about everything.

"It says a lot for their commitment to affordable health care," Taylor said.

The *Cape Times* has a letter from Smith & Nephew, one of the largest medical supplies companies in South Africa, in which medical director Mr Kelvin Johnson admonishes sales staff for telling a surgeon about the confidential discounts, so costing the hospital "a substantial amount of money" because the surgeon informed the medical aid of the discount, who then refused to pay the full price.

Johnson told the *Cape Times* that this was business as usual. "Hospitals are entitled to charge whatever they like for goods, and trading terms are confidential in all businesses, so there is nothing underhand."

He said hospitals received further yearly rebates if they purchased more than a specified quantity from a company in one year.

But Professor John Walters, head of orthopaedic surgery at Groote Schuur Hospital, questioned whether these practices were justifiable.

"Is it reasonable for a hospital to add a mark-up of 40-50% or more to the product without adding any

value, running any risk or incurring any costs?" he asked.

Walters said this mark-up applied to all items sold or purchased through private hospitals and constituted a "significant portion of their income".

Orthopaedic surgeons at private hospitals, who asked not to be named, said that the only people who benefited from this system were the large hospital groups.

"The patient loses, the medical aid loses, the supplier loses because they have to take a lower price, the

surgeon certainly doesn't get anything except blame for high costs, the profit goes to (the large private medical groups)," said one.

"It's all about the middle men. They get richer while the medical doctors and the patients get poorer," said a Rams spokesperson.

Dr Edwin Hertzog, chairperson of the Medi-Clinic Corporation, defended the private hospitals' right to make a profit. "If it is wrong to make a business out of ill health, what about companies selling food to hungry people, fluids to

## HOW IT WORKS

- Medical Aids are prepared to pay hospitals a mark-up of 10% on all equipment sold to patients.
- Hospitals receive discounts from medical supply companies, but don't tell the medical aids about these discounts and add the 10% mark-up on to the higher price that they have not actually paid.
- In this example, for the top-of-the-range replacement knee, the hospital makes a R7 464,15 profit on selling the knee to the patient
- Medical Aids allow surgeons R1 600 for performing the operation.
- Hospitals receive this profit although the sales representative of the medical supply company takes the prosthesis right to the theatre and gives it to the surgeon.
- Hospitals are billed only after the operation, they do not buy prosthesis in advance, they do not store them, they do not handle them. They take no risks and add no value.
- These profits apply to all equipment used in hospitals, from bandages to gloves to wheelchairs.

## Example

(Taken from actual price lists):

Prosthesis (paid by hospital): (porous femur, tibia and patella): R 17 460 ('Net price')
14% VAT: R2 444.40
TOTAL: R19 904.40
Prosthesis (billed to patient): (porous femur, tibia and patella): R 21 825 ('wholesale price')
10% mark-up for hospital: R 2 182.50
14% VAT: R3 361.05
TOTAL: R27 368.55

**Smith & Nephew Limited**  
11 Gales Road, Parklands, 2092  
P.O. Box 100, P.O. Box 97, Parklands, 2092  
Republic of South Africa  
Telephone: Durban (031) 7101111  
Toll-free (011) 7101111

From: Kelvin Johnson  
Subject: Confidentiality of Trading Terms

I have just received an irate phone call from a Hospital Administrator complaining that someone at S&N Head Office (in Surgical) disclosed to a Surgeon, the discount we allowed on a Knee prosthesis, to the Hospital. Armed with this information, he educated the Medical Aid who deducted the mark up between list and discount price and in so doing cost the Hospital a substantial amount of money!

Please remember that Trading Terms remain confidential between customers and S&N and should be disclosed to no one - not even the Doctor.

Many thanks,  
*Kelvin Johnson*  
KELVIN

**SECRET LETTER EXPOSED**

(98) CT 3/3/98



# Alarms ring for emergency services

Star 3/3/98

## Patient dies after ambulance takes an hour to arrive, and firefighters don't have vehicles

By Anna Cox

Emergency services in Greater Johannesburg are in crisis again, with 320 positions vacant and several stations on the brink of closing.

The services are battling to respond to day-to-day emergencies, and last week at least one person died as a result of an ambulance taking almost an hour to arrive.

Staff have described the conditions under which they are working as disastrous, and say the services would not cope if there were a major emergency in Greater Johannesburg.

As a result of the metro council's financial problems, all overtime pay for staff has been cancelled, and emergency officers reported last week that three fire stations, Rosebank, Berea and Roosevelt Park - did not have

any staff or vehicles.

Many vehicles are out of commission because there is no money to repair them, and where there are vehicles, there is no staff to use them. Crews attending emergencies are severely understaffed when compared with international regulations.

### No money, low morale, and staff shortages

This is causing great unhappiness and demoralisation among staff, who say that in addition to members of the public being at risk, they too risk their lives every time they attend an accident or fire without enough officers.

Metro emergency services

head Alan Cloete admitted that staffing had reached crisis proportions, but said they were managing.

He confirmed that a woman suffering from asthma died last week after the ambulance took almost an hour to get to her, but said 13 priority calls had come in at the same time. This was not unusual, he said.

"There is a moratorium placed on hiring staff, and although the situation is critical we are managing to service emergency calls. The technical task team is looking at the second phase of restructuring and by April we should know what is happening," Cloete said.

In the Sandton/Alexandra emergency cluster, only 46% of vehicles are operational. On an average shift where there should be nine vehicles, there are three, said councillor Craig Stephens.

"Eight highway patrol vehicles should be in operation, but at present we have only one working. In the period February 1 to 13, a total of 76 collisions were attended to. A collision occurred at a school patrol crossing in Alexandra, resulting in the deaths of two children.

### Plea for return of control to local level

"The officer who usually controlled the crossing had been unable to be there because he has been without transport for over two months. His presence could have averted the tragedy," he said. The department had also been without summons books for a period of four

weeks this year, depriving the council of income, Stephens added. Emergency services used to be run by local councils, but were centralised under the Greater Johannesburg Metro Council about three years ago.

"Since then, things have gone from bad to worse. Sandton used to have one of the best and most efficient emergency services in South Africa - all funded by the community. We have to get control of these services back under the Eastern Council for them to operate properly," he said.

Last week the Democratic Party, with the support of independent councillors and the National Party, proposed a motion at the council meeting for emergency services to be returned to councils, but the motion was defeated by the ANC.

# Hospitals' cash crisis strangles wards of despair

Doctors decide who may live a little while longer

MICHAEL SCHMIDT

**T**HE soft cries of a woman in pain echo down the white ward at Durban's sprawling King Edward VIII Hospital.

This is a place where people suffering from terminal diseases expect to be able die in peace, their agony eased by drugs.

But this is no serene hospice. Instead, it is the front line in the medical profession's losing battle against disease and bankruptcy.

Soon, at least five patients a week will be turned away from the hospital, denied the minor dignity of dying under sheets stamped with

the logo of Kwazulu Natal's cash-strapped health service.

The department is busy drafting new guidelines to help doctors decide who lives and who dies — to save the province money.

First on the list are AIDS patients suffering from secondary diseases like cryptococcal meningitis, followed by others with incurable diseases like terminal cancer.

The guidelines, which are not yet complete, may also cover heart transplants, certain head injuries, and newborn babies.

The proposal was submitted to Kwazulu Natal's health portfolio committee by the provincial health secretary, Professor Ronald Green-Thompson, in Umtata this week.

It was immediately greeted with outrage by AIDS activists, who warned they might take the matter to the Human Rights Commission.

Green-Thompson said this week that the province's R800-million health overspend meant patients with fatal diseases like cryptococcal meningitis would have to go.

The disease, a fungal infection of the brain tissues, accounts for up to eight percent of secondary infections in patients with HIV. The treatment, which gives most patients up to nine more months to live, costs R11 432.

Dr Das Pillay, a member of the ad hoc team drawing up the protocol, said some hospitals were refusing to treat HIV-patients and those with



**END OF THE LINE:** One in five of these patients at Durban's King Edward VIII Hospital has full-blown AIDS and soon five of them a week will be sent home to die

Picture: MICHAEL WALKER

cryptococcal meningitis.

Green-Thompson said: "I accept it will become an emotional issue, but it would be irresponsible to try to do everything for everybody when you know you can't."

"We're using all the experts in the province to draw up the protocol, and will then circulate it among anybody who can give input."

He said the health service was "very concerned" about the cost of treating AIDS patients, who were often responsible for their condition because of unsafe sex.

But the provincial co-ordinator of the AIDS Legal Network, Ncumisa Nongogo, said: "The attitude is: it is a waste of time to treat people who are HIV-positive because they are

going to die anyway.

"This is a widespread practice in almost every institution which is in complete opposition to the Hippocratic oath."

"We don't accept resources are the problem here. It is a strong case for referral to the Human Rights Commission. We are working on a submission."



# Private care soon off limits to prisoners

By Sunday Woodgate  
10/3/98

The controversial practice of treating prisoners in private hospitals will be phased out from June 30, when people in the custody of the Correctional Services Department will be sent to state hospitals.

The only exceptions will be when public facilities are unavailable or inadequate, according to the Department of Correctional Services.

The limited private service was in line with the constitution, which states: "Everyone who is detained, including every sentenced prisoner, has the right to conditions of detention that are consistent with human dignity, including ... medical treatment."

Although this meant that private services were allowed in certain circumstances, a loophole was being exploited "to an unacceptable degree", the department said.

In Gauteng, the continued use of private institutions was an area of grave concern.

The situation was being addressed by establishing secured wards in provincial hospitals, the department said.

The primary healthcare sys-

## Loophole exploited to unacceptable degree, says department

tem would also be used.

In January this year, 666 prisoners were admitted to hospital - 308 to private institutions and 358 to provincial ones.

The ratio of private to public was especially high in three provinces: Gauteng sent 213 prisoners to private hospitals and only 46 to state ones; Mpumalanga sent 33 to private clinics and only 13 to provincial hospitals; and North West had 32 prisoners treated privately and 28 in public institutions.

Correctional services deputy director (medical support services) Maria Mabena said that in some instances it was cheaper to use private hospitals, for instance in the case of open heart surgery, which could mean up to a month in a public hospital but only four or five days in a private clinic.

Clinic Holdings spokesman Amelda Swartz said her organisation had received no official notification that its contract had been terminated.

Approached by the Government to provide a private facility for prisoners, the group had provided a 36-bed, high-security underground ward with a very high occupancy rate, she said.

Swartz said it was excellent news from a public relations point of view because no one wanted to go to a hospital that housed prisoners.

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# Grants to provinces will boost hospitals

ARL 11/3/98

(98)

Health is a government priority, receiving R5,3-billion in 1998/99, rising to R6,1-billion over the next three years, with a new conditional grant mechanism to support professional training, research and central hospitals.

The grants will be transferred to provinces on certain conditions and include sums for the redistribution of specialised health services and allocations for primary school nutrition programmes. R200-million will go to build the Durban Academic Hospital and there will be another allocation for the construction of the Umtata Regional Hospital.

Hospitals will undergo a rehabilitation programme over the next three years, with an allocation rising to R600-million in 2000/01 from R100-million in 1998/99. Planning for the rehabilitation of hospitals will be done jointly by provincial and national public works departments.

Provincial health spending is projected to increase by around 5% a year over the next three years.

The clinic-building programme has raised 504 new clinics since 1994, serving an additional 5-million.

Since abortion was legalised in

## HEALTH

February last year, 15 545 women have terminated pregnancies, compared with 2 599 legal terminations under previous law in 1996.

"This service, together with an expanded reproductive health service, reduces the risk of unnecessary illness and death in women," Mr Manuel said in the Budget review.

A National Health Bill tabled last year provided a legislative mandate for the creation of a national health system that integrates the public, private, non-governmental organisations and community health systems.

It would also lay the foundation for co-ordinated national health research and information systems to inform the development of health policy and programmes.

Policy strategies addressed include nutrition, maternal and child health, HIV/AIDS and sexually transmitted diseases.

The Budget also provides R76,4-million for the Medical Research Council in 1998/99, increasing to R83,4-million over the next three years.



# Hillbrow Hospital empties its wards

Star 12/3/98

(98)

Some delays in transfer of equipment due to expense and size of some of the machinery

**By ANSO THOM**  
Health Reporter

**T**he transfer of equipment from Hillbrow Hospital to other medical institutions will be completed within the next three months.

Gauteng health department spokesman Popo Maja said yesterday the delays had been caused by the "immense size" of some of the machinery.

Hillbrow Hospital is one of the institutions which the department down-scaled to a community health centre as part of the rationalisation process.

Delays in the transfer of the maxilla facial unit to Helen Joseph Hospital in Auckland Park has led to a waiting list of between four and six weeks. Some patients with broken jaws have been forced to wait as surgeons accommodate emergency cases first.

Maja added that the equipment, which was portable and could be transferred easily, was being taken to Helen Joseph. Arrangements were being made with the company that installed this equipment to move the x-ray unit. "We expect the unit to be installed and functional shortly."

Some operations, which would have been performed at Hillbrow, were being carried out at the Oral and Dental Hospital in Braamfontein and some at Johannesburg Hospital.

Other equipment, left at Hillbrow Hospital after its closure on December 24, would be moved within the next six months as would the 148 staff

members still working there.

Maja said equipment worth between R10-million and R15-million would remain at the Hillbrow Hospital site to equip and furnish the health centre.

He said the size of the cancer radiation equipment meant it would remain at Hillbrow for at least two years.

"Although the units belong more appropriately at Johannesburg Hospital, it is uneconomical to move these sections at present. The radiation unit is being fully utilised."

Maja said all remaining equipment would be transferred, once needs had been identified at other hospitals, and the most poorly equipped institutions would get preference.

The specialised units have moved to the following institutions: radiotherapy, urology, ear-nose-throat to Johannesburg Hospital; internal medicine has been split between Edenvale, South Rand, Helen Joseph and Johannesburg; surgery has been split between Edenvale, South Rand, Helen Joseph, Johannesburg, Oliver Tambo Memorial and Leratong; orthopaedics has gone to Oliver Tambo Memorial and Edenvale; and psychiatry has moved to Helen Joseph, and the maxilla facial unit will be moved there.

A total of 2 352 staff members were seconded out of Hillbrow and the hospital operates on a skeleton staff.

Of those who had been redeployed, 265 had been seconded to the community health centre on the same premises as the hospital.





When one of South Africa's leading doctors, Professor John Milne, who has given his life to hospital and academic medicine, decides at the age of 57 he's had enough, it is surely cause for concern.  
**David Robbins reports**

# Disillusioned medical chief throws in the towel

Star 12/3/98  
(98)

**A**t only 57, one of South Africa's most respected figures in academic medicine has decided to take early retirement. The reason is that Professor John Milne, dean of Wits University's medical faculty in 1990/1 and currently head of the faculty's department of medicine, is a disillusioned man.

He says: "When people ask if I would be prepared to be admitted into most of the Johannesburg Hospital wards for which I am responsible, I am forced to answer, 'no'. Standards have deteriorated alarmingly. Yes, I'm afraid I am talking about the period since 1994."

Milne admits immediately that he cannot fault the post-1994 health policies now more or less in place throughout the country. The idea of the redistribution of resources from the hospital-based centre to the under-served periphery is perfectly acceptable to him. The move from hospital-

deteriorating services.

"We have been recommending for years that Johannesburg Hospital becomes a referral tertiary hospital. This would mean admission only by referral from regional hospitals."

"Instead, one of the country's premier teaching institutions is having to cope with a flood of admissions through the casualty department every day, the majority not in need of expensive tertiary care at all."

Milne highlights another area of concern when he talks of the problems which academic doctors and specialist trainees are experiencing with the mooted changes to the overtime system.

The health authorities are asking that overtime now be recorded, and that some overtime be worked at hospitals other than those on the tertiary level.

"I think this is unrealistic," Milne says. "The profession is being trivialised. It's tantamount to asking our specialists and sub-



RIAN HORN

Professor John Milne ... finds conditions at the Johannesburg Hospital much worse than five years ago and puts blame on a health department focused on policy rather than excellence.



"At the same time, though, I don't believe that anyone would wish the tertiary level of the medical service to collapse, or even to become run down," he adds.

"Good primary care is dependent on good tertiary medicine simply because good care at the clinics identifies many more patients in need of higher levels of care. A second reason for maintaining high standards at tertiary and academic institutions is simply that these training centres ultimately dictate the quality of clinical expertise at every other level, including the clinics and the sophisticated private sector.

"Yet the reality now at Johannesburg Hospital is that standards of patient care have slipped and academic medicine itself is threatened because of a vacillating and often ineffective provincial health department."

Forthright words from a man who has spent his entire life, apart from a year at a mission hospital, working in the public health sector.

Milne was born in Johannesburg, but elected to study at the University of Cape Town. He was soon back in his home town, doing his internship here, and then working at various times in all five academic hospitals to which the Wits Medical School has traditionally been attached.

But what is the detail behind Milne's sombre contentions?

To begin with, he points out that patients in the general medical admissions ward now regularly exceed the number of beds, and the situation has worsened since the closure of Hillbrow last year.

Several meetings with high-level Gauteng health authorities in the past eight weeks have yielded no concrete results.

"Of course we've been promised additional beds and nursing staff from Hillbrow, but there's no sign of them yet. Meanwhile, overcrowding breeds all the other problems related to declining services: deteriorating physical infrastructure and cleanliness, problems with linen and food and increasingly patchy standards of nursing care.

"This is essentially why I'm leaving," Milne admits.

"As the person in charge, I can no longer control the situation. There are still pockets of real excellence here, but generally conditions are much worse than they were five years ago. This was a well-run and efficient hospital then."

Milne is aware that by comparison with most hospitals in the countryside, Johannesburg Hospital is still a palace, but the point he stresses is that tertiary care cannot flourish in an institution characterised by overcrowding and

duction of 50% in overtime worked here at the centre will leave too many jobs undone, accelerating the drop in standards.

"Rather than going this unpopular and profoundly unsettling route, why don't the health authorities help us to formalise our outreach programmes which have already been happening for years from certain departments.

"The same redistribution goals will be achieved, but without unsettling doctors and tempting them into abandoning the working of any overtime at all.

"Where would Johannesburg Hospital be then?"

Milne's twin concerns of declining standards and indecisive or ill-advised policy application by the health authorities is perhaps best illustrated by the fact that they are still considering the opening of private beds in Johannesburg

Hospital.

For several years such a course has been suggested, the idea being to derive income for public institutions from the private sector, including the mooted national health insurance (NHI) scheme for all formally employed people. But NHI has failed to materialise, and no private beds have appeared.

"And now it's too late," Milne declares. "Suitable wards for this use have recently been filled by the dental faculty and by radio therapy patients from Hillbrow. Worse still, the public perception of Johannesburg Hospital is such that it will no longer be considered a realistic alternative to the private hospitals in town.

"The opportunity for this approach regrettably has been lost."

Milne will be leaving the public health sector at the end of June. He is not the first high-ranking medical professional to go, neither will he be the last. Should South Africa let these people go with a shrug?

Or should South Africans take steps to prevent a drain of expertise which will most assuredly have detrimental effects on the quality of health care at all levels?

But what steps can be taken to encourage them to stay? At least a part of the answer to this important question lies in Milne's final comment.

"The new health authorities are much better than the previous ones, and their overall policies are good. They're even prepared to negotiate.

"But they negotiate without really listening. For them, policy is everything. For us, the practitioners, quality of service is everything. And too often these days synthesis seems impossible."



# Fair allocations policy not just 'a nice idea'

By Dr Pieter van den Berg

For the Gauteng Health Department, the policy of equity in allocating resources to hospitals and clinics is not "a nice idea", divorced from the reality of service provision. It is a constant and practical guide to moving away from past discrimination in service standards, making the most urgent service gaps and filling the trade-offs required to manage health care on a finite budget.

With 48 000 workers, in diverse occupations, we have mounted an enormous planning effort to effect restructuring for equity. The process has extended over many months and has caused other important activities to be held back.

No doubt this has contributed to the feeling of powerlessness that Professor John Milne expresses.

In addition, redistribution, by definition, has an uneven impact on those involved. Since the pool of resources is not increasing in real terms, some institutions will gain overall, while others will make sacrifices. Understandable fears arise about how this will settle out - including how it will impact on standards of tertiary level care.

Certainly, Johannesburg Hospital will

never be restored to the state of extraordinary privilege it enjoyed as a "white" institution. The staff-patient ratios, which existed then, the bed occupancy rates - those standards are indefensible and unaffordable. But this does not mean the department has abandoned tertiary care.

For the past 18 months, we have had a team working fulltime to design new staff structures for every hospital and clinic.

In this process, we have specifically sought to protect tertiary care by allocating the highest staff complements equally to all those hospitals which focus on this level of service - Johannesburg, GaRankuwa, Pretoria Academic and Chris Hani Baragwanath.

It is true that economic realities have forced us to settle for fewer nursing posts than ideal. But we do envisage retaining specialists across the full spectrum of tertiary care, and we will renew equipment as necessary for this sophisticated level of practice.

Far from ignoring the proposal that Johannesburg Hospital should become a referral-only institution, the department sees this as an outcome of its restructuring programme.

But there is a logical - if frustrating - sequence to the change process. We can-

not close the doors to patients who present themselves at Johannesburg's casualty department before we have improved the quality of care at regional hospitals.

The upgrading of regional hospitals depends largely on relocating staff, many of them from three hospitals which we closed and six which have converted into primary health care centres. The conversion of the Hillbrow Hospital, with more than 2 000 staff, has been the most significant.

The obvious snag is that closures and conversions do not only free up staff - they create added demand on remaining hospitals. With its drawing power, Johannesburg Hospital has borne the brunt of this. And it cannot be denied that there have been hitches in managing the process.

Nonetheless, Johannesburg has gained at least 128 seconded staff members to help it over this difficult period. Some of these have more relevant skills and experience than others. However, since seconded staff have a choice of placement, the supply cannot be matched exactly to demand.

When the new staff structures are ap-

plied later this year, the placements will be rationalised.

The Hillbrow conversion has also given impetus to the outreach programme by academic hospitals. We now have specialists working every day in a range of outlying hospitals (like Edenvale and Tambo Memorial) and these institutions, too, are reporting a surge in patient numbers.

When it comes to the new system of overtime, there has never been a question of "clocking in". Doctors and specialists are merely required to fulfil specified duties for a set rate of pay - unlike the old system where some doctors got overtime pay simply for being "available" to work.

The new overtime system justly places medical practitioners on a footing comparable to their nursing colleagues.

The resignation of a respected teacher and practitioner like Milne has not been shrugged off.

Although he could not be persuaded to stay, we hope he will not sever all ties with the public health sector where many dedicated professionals are striving to ensure that the benefits of change clearly begin to outweigh its tribulations.

Dr Pieter van den Berg is the Chief Director of Provincial Health Services in the Gauteng Department of Health.



# Band-aid for hospitals as more revenue is voted

Tax increase on medical aid will affect only high-income earners

By Anso Thom

Health-policy experts and non-governmental organisations have applauded the Government for the R500-million allocation over the next three years to rehabilitate South Africa's hospitals, which are falling into disrepair.

However, they have criticised it for not representing any "real increase in the overall budget".

Finance Minister Trevor Manuel said in his budget address on Wednesday that health, as one of the Government's priorities, would receive R22,7-billion this year (14% of non-interest spending), R24,5-billion during the 1999/2000 financial year and R26-billion in 2000/1.

An economist at the University of the Witwatersrand's health policy studies unit, Alex van der Heever, said there had been a slight decrease in real terms, and this would put the health sector under some stress.

Van der Heever said it was disturbing that social services had to make sacrifices.

Bupendra Makan, a researcher at the University of Cape Town's health economics unit, said it did not represent a major increase in real terms, when inflation was taken into consideration.

He welcomed the substantial increase for hospital rehabilitation, but questioned how Manuel was planning to address equity at a provincial level.

Makan said he was also concerned about whether Manuel had budgeted to improve the conditions of service of health workers.

"What we are asking is what has the minister included in the 14% increase."

Irwin Friedman, national director of the National Progressive Primary Healthcare Network, said he was respectful of the fact that government had approached the budget in an honest way.

But he said the Government had made a major strategic mistake in terms of maintaining fiscal discipline.

"Government has the desire to be popular with the international community rather than face up to the problems locally," Friedman said.

He said the country faced extreme poverty and that more had to be allocated to poverty relief.

However, he said the Government's commitment to rehabilitate hospitals was wise and sensible, and applauded Manuel for his continued commitment to tax tobacco and alcohol.

Manuel also announced that if the employer's contribution to a medical aid scheme on behalf of an employee exceeded two-thirds of the total contribution, that excess would be taxed as an employee fringe benefit from April 1.

"We have become aware that, increasingly, contributions to medical fund schemes are being used to structure salary packages in a way that was never intended by the Income Tax Act," he said in his budget address.

The proposed tax would help boost state coffers in the 1998/99 financial year by an extra R700-million.

John Pugsley, director: finance and administration at the Representative Association of Medical Aids, said it would have a greater impact on people in higher income brackets. A high earner contributing R1 000 towards the medical aid could end up being

taxed R150.

He said that many people in the lower income tax brackets would not even notice this tax increase.

Pugsley said it would have levelled the playing fields if employees had been allowed to deduct medical aid contributions.

"It's a pity there is no relief for the self-employed as this would have encouraged people to leave the state system and join a medical aid," Pugsley added.

Focusing on medical practitioners and dentists, Manuel said they would no longer be entitled to a special tax deduction for costs incurred while attending courses or congresses outside South Africa.

He said that various other professions had submitted proposals for the extension of this provision to their profession.

In terms of Section 16A of the Income Tax Act, only medical practitioners and dentists registered in terms of the Medical, Dental and Supplementary Health Service Professions Act were entitled to such a deduction.

The provision discriminated against other professions and was possibly unconstitutional, Manuel said. The tax advisory committee had considered the matter and recommended that the section be deleted.

The deductibility of expenditure of this nature would have to be dealt with in terms of the ordinary provisions of the Income Tax Act, he said.

Assistant registrar at the Interim National Medical and Dental Council, Daan Naude, said the council accepted the proposals in principle, but said doctors fell in a different category to businessman.

Star 13/7/98

(98)



# Patient buys implants from supplier; saves over R1 000

(98)

ET 17/3/98

**JUDITH SOAL**  
HEALTH WRITER

ARRANGING to buy dental implants from the supplier rather than the hospital saved a patient over R1 000 — just one example of the large mark-ups hospitals put on medical supplies.

The *Cape Times* recently exposed the practice of "confidential discounts" given to hospitals by suppliers, which mean that patients can pay 30 to 60% more for equipment than hospitals do, and received an overwhelming response to the report from readers.

There are many stories that illustrate this practice, but one of the most glaring examples came from Mr Roy Andrew in Ronde-

bosch.

Andrew showed the *Cape Times* copies of invoices proving that a private clinic had added more than 50% to the price of equipment that it hadn't even touched.

Four years ago Andrew needed extensive dental surgery.

His dental surgeon arranged for him to buy the expensive implants that he needed directly from the importer to help him keep the costs of the operation down.

Andrew was charged R1 841,10 (including VAT) for two implants.

After the operation, Andrew was billed for the implants by the Shirnel Clinic as if he had received them in the normal way.

"That wasn't a problem.

"I pointed it out and they deducted the amount immediately," said Andrew yesterday.

"What did shock me was how much they were going to charge."

The clinic had billed Andrew R2 925,68 (including VAT) for the same two implants.

"They were going to make R1 084 profit.

"That's a 59% mark-up and they didn't even touch the things," he said.

Sister Julie Coleman of Shirnel Clinic denied that it was the clinic's policy to add large mark-ups to equipment.

"We would never add that much, we add on 10% or so, but I don't know how that happened.

"It must have been a mistake," she said.

# No blame accepted for higher health bills

ET 17/3/98

(99) (98)

**WHY ARE OUR** medical bills so high? Health Writer **JUDITH SOAL** asked hospitals, doctors, medical aids and policy-makers who was to blame for escalating health costs.

**T**HE cost of private health care in South Africa is increasing by about 25% a year — way above the inflation rate — and experts agree that the industry's pricing structure is in disarray.

The *Cape Times* recently exposed the practice of "confidential discounts" whereby private hospitals can make profits of between 30 and 60% on all equipment — from bandages and cotton wool to prostheses and pacemakers — used in the hospitals, although they often do not handle the equipment or add value to it.

But hospitals have defended this practice, saying they have to make money in some areas — such as equipment and drugs — to cross-subsidise the losses they make on other areas — such as ward fees.

"Hospitals are on thin ice if you look at our profit margins," said Dr Anette van der Merwe, the executive director of the Hospital Association of South Africa, which represents private hospitals. "You can't just look at the mark-up in isolation unless you examine the whole pricing structure."

Predictably, hospitals, medical aids and doctors can't agree on who is to blame for escalating

costs, but they do agree that the cost structure of private health care is "a mess".

"The problem is that the health care industry doesn't operate like a normal business," said Dr Jocelyne Kane-Berman, chief director of health administration in the Western Cape. "The normal principles of supply and demand don't apply because it is the provider who decides what should be purchased."

"Patients don't know whether or not they need an operation, or expensive tests, or how long they have to be in hospital. They have to rely on the doctors and hospitals, and there are 'perverse incentives' for over-use of medical services."

"Also, unlike other businesses,

the prices aren't set by market forces or even the provider, they are set by an outside body, the Representative Association of Medical Schemes (Rams)."

A factor that seems to complicate an already convoluted price structure is the oversupply of private health services in Cape Town.

"There is no doubt about it, the city bowl and southern suburbs are over-bedded," said Dr Richard Friedland, the chief operating officer of hospital group Netcare, which owns City Park, among other hospitals.

Hospital occupancy rates are confidential, but insiders suggest that private hospitals are only just maintaining the 60 to 65% occupancy they need to remain in business. Treatment costs are based on 65% occupancy, so patients are already subsidising empty beds.

The same applies to operating theatres.

Ten years ago there were 17 private operating theatres in Cape Town. Now there are almost 50, with more planned to open soon.

"It can cost millions to equip a theatre and consulting rooms," said Van der Merwe. "Just a microscope can cost about R8 000."

Hospitals have spent a lot of money equipping theatres that aren't being fully used, and those costs are being passed on to patients and medical aids.

Because of the structure of medical aid tariffs, certain procedures are more profitable to hospitals than others, so some services are provided at the expense of others.

This is particularly noticeable in the field of mental health, which does not receive much compensation from medical aids, so few private psychiatric hospital services are available.

Surgery, on the other hand, can be very profitable, hence the surfeit of theatres. But this can also be

costly as hospitals fight for operations.

"If you have so many beds and theatres but only five orthopaedic surgeons, they will be wooed and given incentives by all the hospitals. There are many ways that it is done, but in the end it increases the price of health care," said Van der Merwe.

Because of this excess capacity, there are rumours that at least one private hospital in Cape Town will close in the next year or two, although this has been strongly denied by the hospitals.

Whatever happens, it is clear that all is not well in the health sector. Sixty-two percent of all the money spent on health care is spent in the private sector, which services only 20% of the population.

The other 80% of South Africa's people receive less than 40% of health care funds. Paradoxically, as the costs of private health care rise, less people are able to afford it, forcing more people to rely on over-burdened state services and further increasing the costs of private health care.



**UNHEALTHY DISTRIBUTION:** State hospitals such as Red Cross Children's they need to remain in business.

## They all vow to keep costs down

### PRIVATE HOSPITALS:

- Say private health care costs are not too high when compared with other countries.
- Point out it costs "millions" to equip hospitals with the latest equipment.
- Claim medical aids waste money on administration costs.
- Stress that contributions to medical aids have consistently gone up at a higher rate than medical aid tariffs.
- Say the medical aid tariff structure is "obscenely" skewed and forces them to make large profits in some areas to recoup losses in others.
- Point out that the share prices of most hospital groups are dropping on the JSE.
- Stress the costs of theft, breakages and bad debts.
- Vow they are doing everything possible to keep costs down.

### DOCTORS:

- Feel they are being exploited by hospitals, who often make more out of an operation than the surgeon does.
- Say medical aid rates are far too low and point out that a specialist who has trained for 14 years will be paid less per hour than a plumber.
- Emphasise that no ethical doctor would purposely "over-serve" patients to make money.
- Say there are too many medical aids and managed health care schemes, which add to administration costs.
- Point out that many doctors are leaving the country because of low earning potential.
- Claim some patients are guilty of seeking health care unnecessarily because they are paying medical aid subscriptions.
- Vow they are doing everything possible to keep costs down.

### MEDICAL AIDS:

- Say they are paying more to hospitals than ever before.
- Stress medical aids are non-profit organisations, with administration costs fixed at five percent of contributions, and the rest paid to settle claims.
- Claim hospitals provide doctors with incentives to use their wards and equipment, which can lead to over-servicing.
- Say doctors can inflate bills by "bumping" patients up to intensive care units without reason, performing unnecessary procedures or carrying out expensive, non-essential tests.
- Cite cases where hospitals have billed for procedures that haven't been performed and selling re-used equipment as new.
- Ask why "mistakes" on patients' bills favour hospitals.
- Vow they are doing everything possible to keep costs down.







# Budget boosts schools - but hospitals face job axe

ARG 18/3/98  
CHENÉ BIGNAUT  
STAFF REPORTER

There was good news for teachers, but warnings of further job cuts in hospitals in Western Cape Finance Minister Lampie Fick's budget speech today.

Unveiling a tight budget for 1998/99, Mr Fick announced a better deal for the cash-strapped education department in the province, but no extra funds for health.

The lion's share of the budget will again be spent on education, with R3,6-billion - 36% of the province's total expenditure.

This is considerably more than last year's allocation of R3,3-billion, which should lead to fewer job cut-backs than originally planned, and restore some stability.

But it falls short of the R3,8-billion called for by the African National Congress to alleviate the education crisis in the province.

(98)  
The allocation for health for 1998/99 is more or less the same as last year at R2,9-billion, which spells further rationalisation and more job losses in hospitals this year.

More than 6 000 provincial health services staff have already been axed in an attempt to cut costs over the past three-and-a-half years.

"Further hospital bed closures and a reduction in the availability of health services in some areas will become a reality," said Mr Fick.

Academic hospitals would be the hardest hit by rationalisation, because spending on them remained "unaffordably high".

Key district hospitals in the province could also be consolidated to ensure optimum use and improve levels of service.

The province's total income for 1998/99 is

To page 7

# Budget boost for Cape schools, but hospitals face more job cuts

From page 1

R10,1-billion, which is about R59-million more than last year.

The main source of income is the R9,5-billion grant from central government, which is about R220-million higher than last year, mainly because the province has more residents than was earlier estimated.

Locally generated sources of revenue for the province include R244-million from motor licence fees, R152-million from casino licence fees, R95-million in hospital fees and R134-million from a number of smaller sources.

The sale of state assets, however, will not bring in more money for the province this year.

Although the province has a marginally higher income than it did last year, it is not really better off.

This is mainly because Mr Fick has, over the next two years, to repay a R627-million deficit incurred in the 1997/98 financial year.

Mr Fick also was not allowed to budget for a deficit for 1998/99 in terms of the constitution and because he wanted to avoid the danger of having the province placed under

judicial management by the central government.

In line with guidelines issued by the national budget council, the province is spending almost R9-billion on education, health and welfare - 86% of its total expenditure.

This includes R2,2-billion to be spent on social services.

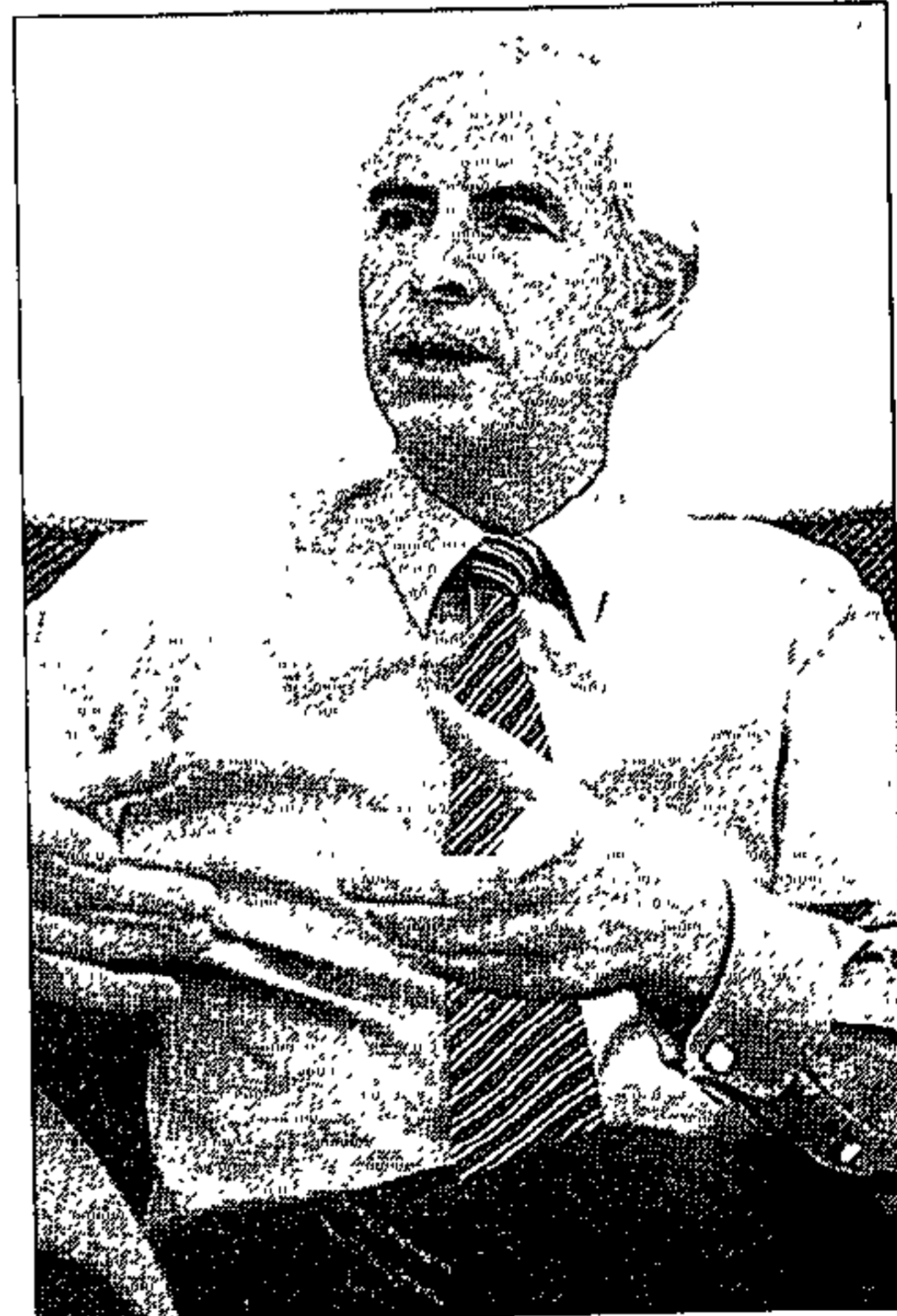
Indicating the Western Cape government's commitment to help realise the province's potential as a world-class tourist destination, Mr Fick announced a R2,7-billion increase in the amount spent on tourism, which will go to the Western Cape Tourism Board.

Wesgro, the province's main marketing agent, got a bigger share at R3,5-million.

Agriculture, which along with tourism is one of the two main contributors to the provincial economy, gets R1-million more this year.

This year's budget, for the first time, provides for a contingency reserve fund of R115-million to pay the interest on government debts.

Tackling the problem of crime, Mr Fick announced an increase of R2-million for community security.



Lampie Fick: more hospital bed closures

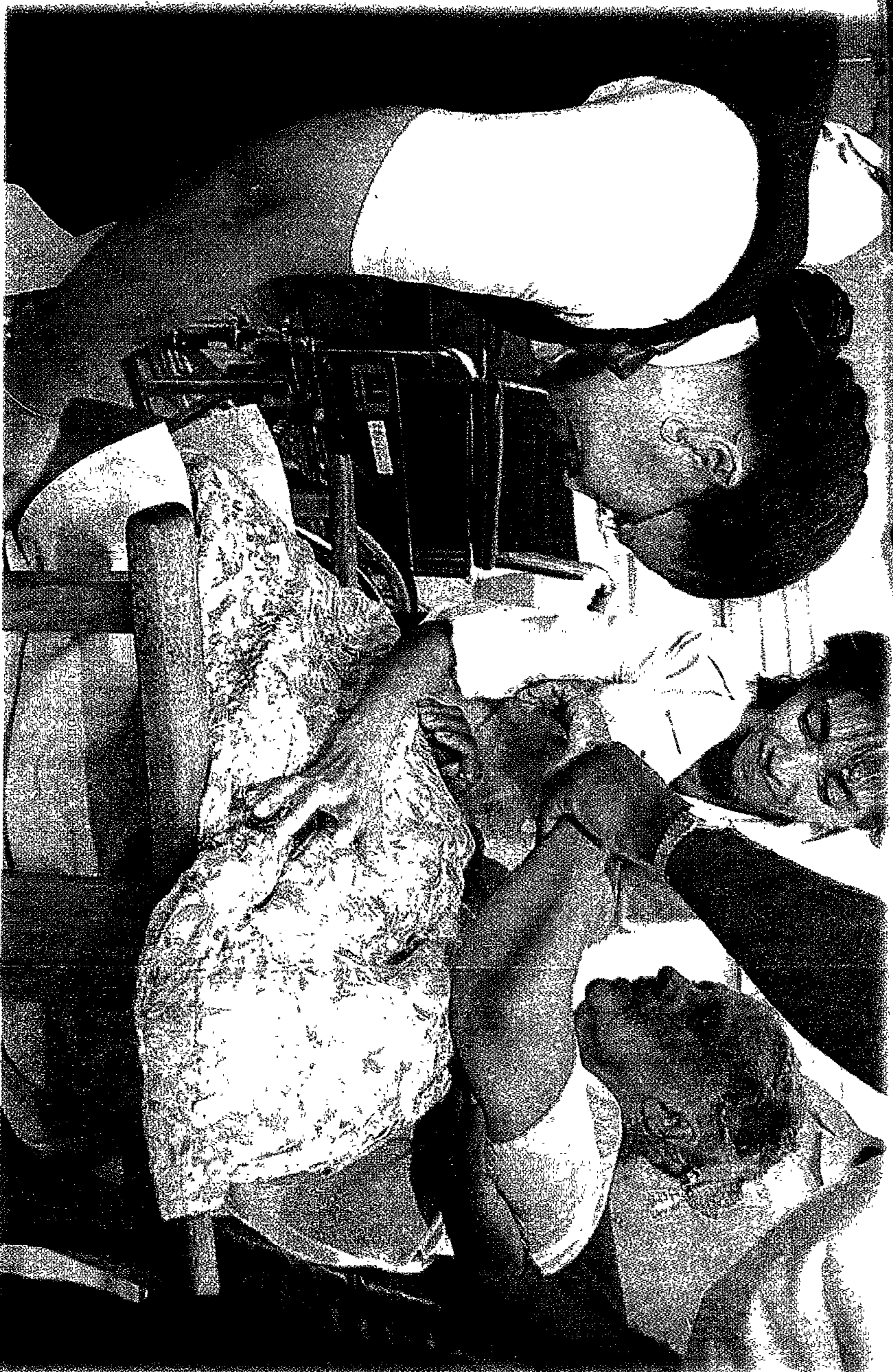


# THE PEOPLE'S HOSPITAL

SECTION EDITOR: DON LILFORD  
TELEPHONE: (021) 488 4508

# Can Groote Schuur pull through? may as well close down Cape Town

BUT THE CARING ENDURES



need specialist care they are referred to Groote Schuur. In some cases this has reduced the patient load on the hospital, while in other areas like maternity numbers are much the same.

Some departments are seeing more patients. As the focus of health

the services they provide are essential. As one doctor puts it: "The buck stops here. If we can't handle problems others can't, it will lead to enormous suffering."

The new section of the hospital itself is huge, built to accommodate over 1 700 beds. Just 1 163 beds are in

become apparent.

The hospital faces serious challenges if it is to survive turbulent economic times. It may not be crumbling, but it is shrinking. Ward F17 has a large chain and padlock on its doors. It was the plastic surgery ward, but in January it was closed and plastic

Overnight pay for doctors for February will only be paid in April and every part of the hospital has been told to save money.

"We can't just order what people want anymore," says Nigel Dearden, head of the Direct Issue Store. "Orders" go to a waiting committee.

seem minor, they can be the last straw for staff whose morale is low after years of steady pressure.

Topping the list of serious concerns is shortage of staff. Whoever you speak to, from storemen to professors, the refrain is the same. Since May 1996, when voluntary severance

is reinstated is a tedious, frustrating and often hopeless process, say managers.

In many cases those who took packages were experienced, highly skilled people whose expertise has now been lost to the hospital. For those who stay, the workload gets heavier. Some areas like the maternity unit have reached crisis levels.

Says head of nursing at maternity Winifred Thomas: "We need a minimum of 175 staff. We're down to 164."

Hospital management had no say over the introduction of the severance packages, which were the result of agreements reached at central government level.

Another major area of concern is the lack of equipment. For many years the equipment budget has been woefully inadequate.

A hospital should spend 5% of its budget on equipment. Groote Schuur spends 0.5%. Ageing machines cannot be replaced and it is costly to fix them. The hospital cannot even replace nuts and bolts equipment such as x-ray tables. Theft, or "shrinkage" as it is euphemistically called, is regarded as a significant problem.

Shrinking budgets for Groote Schuur Hospital are a worry. Expenditure for this financial year is R545-million, while next year's budget (1998/99) is R486-million. The budget for consumables, which include medicines, bandages, blood, x-ray plates, water and electricity has decreased from R110-million in 1996 to R105-million this year in spite of inflation.

Paul Ciaparelli, senior medical superintendent, says the hospital is still a major asset to the city, the province and the country. "We offer a range of highly specialised services, some of which are unique to the Western Cape and some unique in the country. We also offer a broad range of general tertiary services."

The challenges may seem insurmountable, but in spite of everything there is a steady determination among the staff that Groote Schuur will survive the hard times.

Those who stay don't do it because it's lucrative. It's not. But time and time a fair staff like O... ..

ists and nurses for the whole country, including private hospitals.

Academics speak of a critical mass for the hospital in terms of patient numbers and staff, beyond which it will implode.

How close the hospital is to this point is uncertain. Even a minor shift now could have a major effect.

Freezing one post can mean a unit is no longer viable.

Take the plastic surgery department. Its head, Cecil Bloch, retires in May, leaving only one consultant in the unit responsible for serving Groote Schuur Hospital and four other centres. Without teachers, there will be no more plastic surgeons.

Some may argue that plastic surgery is a luxury, but we're not talking facelifts and tummy tucks. South Africa has many children born with congenital hand deformities, for example, and plastic surgeons are needed to treat burn victims.

"How do you prioritise?" asks Professor Bloch. "Do you give a heart bypass operation to an older man or operate to release the clawed hands of 25-year-old burn victim who can then lead a productive life?"

It's questions like these doctors now have to answer. Each department has developed strict protocols for prioritising patients, based on clinical, ethical and resource considerations, but doctors are still faced with difficult decisions.

While academic medicine is expensive, and everyone agrees that resources must go to building up primary health care, this should not be at the expense of tertiary care.

"This hospital could be a resource for Africa," says Solly Benatar, head of medicine at Groote Schuur and UCT's Medical School. Patients are referred to Groote Schuur from many countries in Africa. UCT's medical school trains doctors from Africa and provides intellectual and practical assistance to countries in Africa as well as doing research on diseases of particular relevance to Africa.

"Now a complex organisation is threatened by indiscriminate damage to some of its crucial components."



because of staff shortages. There's a quiet buzz down Hospital Street, the name of the main corridor, as nurses, physiotherapists, students and cleaners go about their daily tasks. To the casual visitor, the hospital looks like any other modern hospital. But probe a little deeper, talk to the staff and the problems

another ward. The same happened to G26 surgical paediatrics. Complaints from staff are legion. Doctors sometimes have to wait for an intensive care bed to become available before they can operate. That doesn't mean that patients' needs are fewer, just that waiting lists will get longer.

# In surgery, shortages

## take their toll on care

By *RAF 19/3/98* (987)

The surgeon picks up a small, greenish, balloon-like structure with forceps. He's working through a camera inserted in a small hole in the abdomen, watching a screen above the patient to see what he's doing. The greenish balloon is a gall bladder and it is being removed.

It's like watching television. The steady hands of the surgeon guide the instruments through two other tiny incisions - and on the screen you see the tips of the instruments probing and tearing connective tissue.

This is laparoscopic surgery and its advantage over open surgery is that the patient recovers far more quickly.

It's Wednesday morning in surgery at Groote Schuur Hospital. It's a slow day, with few operations because the hospital is only doing emergency operations until the next financial year.

Anthony Jackson is a registrar, a surgeon in training. At 29 he's spent a lot of time at Groote Schuur Hospital, having studied at UCT and done his internship here. After a short stint overseas he returned to general practice and decided to specialise.

"It would be nice to have some positive sentiment about funding," he says. "This hospital has an excellent name all over the world. We are desperate to maintain high academic standards. Practising good medicine in the 1990s has become a problem. Financial problems set the tone for the whole hospital. We all support primary care, but the change shouldn't be as drastic as this."

Dr Jackson has been training for four years and he's got one year to go. His training has been excellent, he says.

But morale is low. Specialist doctors feel they are not valued for what they do. "We're unhappy about the support we get from the top," says John Marr, a junior consultant.

They say that while it's necessary for the country to provide services at

the orders. We used to keep three months supply of everything, now we have one-month supply."

Because of a shortage of porters, doctors and nurses sometimes have to wheel patients around themselves. Fresh milk has been replaced with powdered milk because it is cheaper. While some of these economies may

returning. "Why? The concept of the new South Africa was irresistible. I wanted to work at Groote Schuur but they couldn't fit me in in the area of my speciality. The obvious difference at this hospital is that you don't have the quality of hotel treatment you do at private hospitals. But here you have a team. The joy of working here is training young surgeons.

"I'm optimistic about Groote Schuur. All over the world health care is in crisis. I still find it easier to get a cancer patient into a bed in hospital here than I did in England or Australia.

"The future of health care depends on the reconciliation of the private and public sector. We need that vision."

Tea break is over. It's time for the next operation.

Bob Baigrie is a surgeon in private

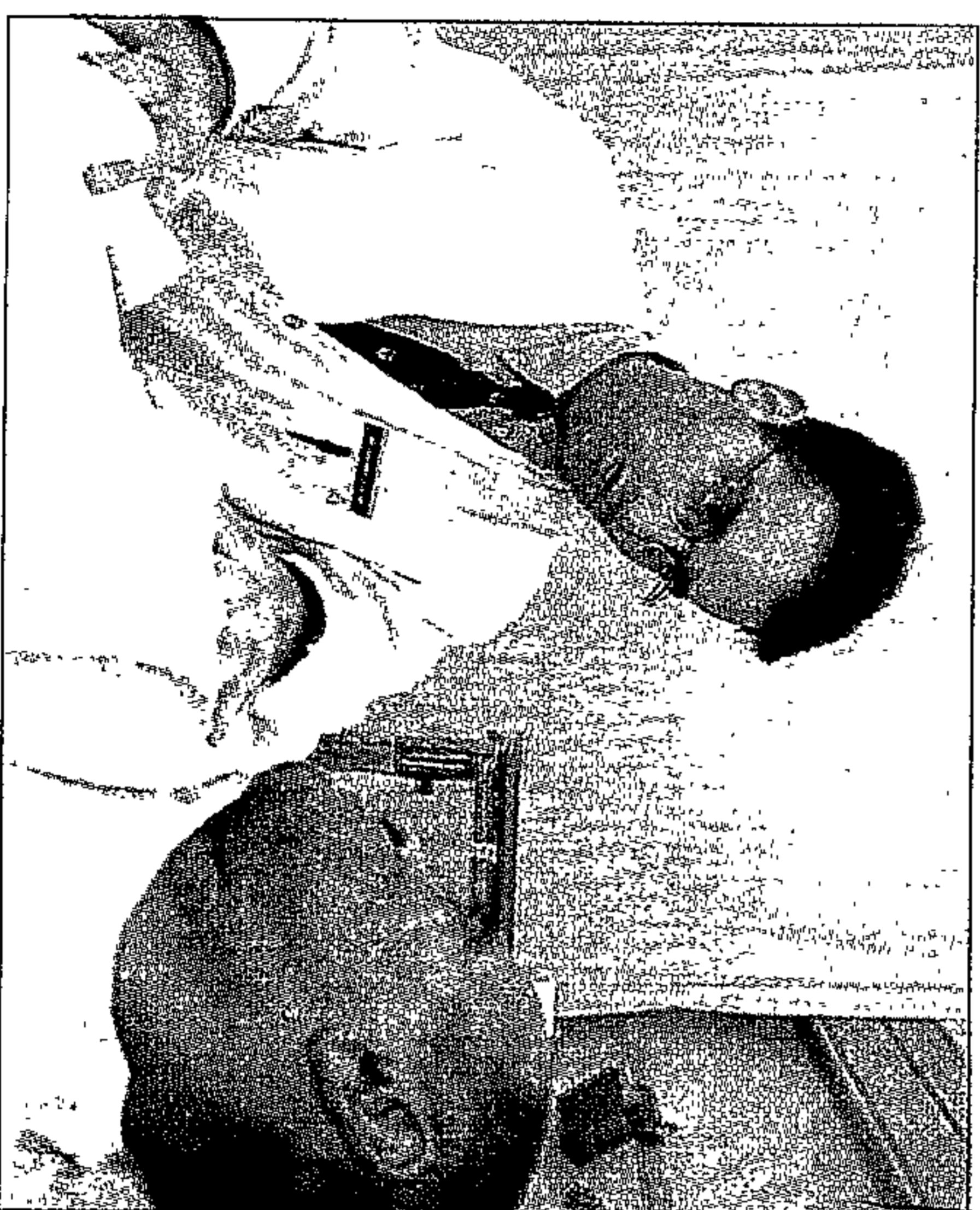
practice who does part-time work at the hospital. He worked in Britain and Australia for 13 years before returning.

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In training: surgeon Anthony Jackson on a ward round at Groote Schuur

# Doctor on

## frontline of Cape's civil war

By *RAF 19/3/98* (987)

Peter Bantz can't sit still. He fiddles with his scissors while he talks to me. Dr Bantz is head of Groote Schuur's trauma unit, a level-one high-trauma unit that's one of the best in the country.

He's a remarkable man in his dedication to what has to be one of the most highly stressed jobs in the hospital. He's the man who heads the team which patches up the seriously wounded victims of the low-grade civil war in Cape Town. And those who have been in motor accidents.

"They call us adrenaline junkies," he says.

"When a guy flies through the door here, bleeding from everywhere, he can't tell you what's wrong, he's about to die, it's highly stressful. You never relax. It takes its toll."

Why does he do it? "I'm stupid," he laughs. "No, it's exciting, it's for a good cause. I enjoyed trauma when I was a student and when I specialised. I didn't realise at that stage what effect it has on your life though."

He's been at Groote Schuur since 1991, one of just five trauma surgeons in the country.

How does he cope? "I take refuge in computers, it's my cave man retreat," he says. "And I have an understanding wife, who is also in medicine."

He calls up the Website he's created for trauma, complete with dripping blood. It's worth a visit.

A graph of trauma load shows clearly how it increases at weekends, largely as a result of increased alcohol consumption.

"When the troops were in Mannenberg for 10 days recently, the number of trauma cases dropped," he says.

to keeping it going. How long can the hospital keep up the standards needed for it to continue as a teaching hospital?

The combination of teaching, research and patient care gives the hospital its unique character. One of Groote Schuur's important functions is teaching medical students, special-

lems. "More is being lost than can be justified by the savings made. This country must retain one or two medical centres capable of sustaining meaningful links with the best of medicine worldwide. As we learnt from the Titanic, a mighty ship can sink as a result of a strategically placed hole."

Visible policing is what is needed. That, and a campaign to reduce the amount of alcohol consumed."

Groote Schuur is the headquarters of advanced trauma life support in Cape Town.

It treats about 15 000 patients a year, and about 100 gunshot victims a month. Although the unit's patient load has halved in the past three years, this is because the hospital now only admits patients from certain areas and the serious cases which cannot be handled at hospitals like G F Jooste.

"The lesser half of our severe cases has gone. But those are patients who stressed our system and shouldn't have been here. What we're getting now is appropriate."

The resources needed for trauma patients are very expensive. This year trauma cost the hospital R95-million of its total R545-million budget.

More than half of the trauma patients are victims of assault, and 18% have been in car accidents. The number of people coming in with gunshot wounds has increased. "Gunshots tend to cause twice as many injuries, patients stay twice as long and the cost of treating them is at



Adrenalin junkie: trauma surgeon Peter Bantz, right, heads the team attending a patient with a stab wound in the neck

least double that of stab wounds. These days half of gunshot wounds are single, half are multiple.

Trauma is the biggest surgical problem in the country today, says Dr Bantz. If you work in a provincial hospital, 60% of your work is trauma, and that's way above world figures.

The Groote Schuur unit is an excellent training centre because of its workload and the kind of injuries seen. People come from all over the world to train here.

"We're a paradise for a traumatologist," says Dr Bantz. He is alternately upbeat and downhearted about the unit. It is still a world class unit, unrivalled in Cape Town.

"At the moment we have been unscathed in our ability to help patients. Emergency services take priority. You can turn away a hernia patient, but not the guy who has been shot."

"But our equipment needs to be replaced and there's been no money for the past two years. We need more nurses, and the need for radiographers (who do x-rays) is critical.

"If they want world class services, and I don't know what their commitment is to that, they must pay."

"I might have to close 10 beds in the next couple of weeks because of staff shortages. It's an increasing headache to run a trauma service like this."

Apart from working at the coal-face, Dr Bantz does all the administrative work for the unit, daily ward rounds and directs the training programme. He could walk into a job overseas. Will he stay?

"I don't know. At the moment the Government doesn't do much of a job trying to keep people here. I have shown my commitment to trauma but that commitment is sorely tried these days."

If he leaves there's no replacement for him, he says. "We're a dying breed, there's not enough support, no reward."

Understandably, it's not a popular field. "When I'm not on, I'm on call. Sixty percent of your work is after hours. You take your work and your problems home. It burns you out gradually."

In Dr Bantz's secretary's office there's a saying pinned on the board: "Blessed are the cracked, they let the light through."

The trauma website address is: <http://www.uct.ac.za/depts/trauma>



# THE PEOPLE'S HOSPITAL

CAPE ARGUS, THURSDAY, MARCH 19, 1998

## Cape Argus The heartbeat of Grootte Schuur

THERE HAVE BEEN HUGE BUDGET CUTBACKS AT STATE HOSPITALS LIKE GROOTE SCHUUR, WHICH HAVE LED TO CONCERN ABOUT THEIR LONG-TERM VIABILITY

There is a popular belief that state hospitals are decaying, that staff no longer care for patients and that they are institutions to avoid if one has the choice. But a week-long Cape Argus investigation of the services provided at Grootte Schuur hospital - full reports of which appear today on this page and the page opposite - show that this perception is neither accurate nor fair.

We found that the hospital's staff, whether directly involved in patient care or not, are dedicated professionals who are doing their best to cope with the many challenges and difficult choices they face.

Nevertheless, Grootte Schuur, like all teaching hospitals in South Africa, is going through difficult times as the emphasis of the country's health care system changes from large academic hospitals to primary health care facilities close to where the majority of the population lives.

The change is logical, given South Africa's circumstances, and it is widely supported by staff at Grootte Schuur, but it has meant enormous budget cutbacks at academic hospitals and has exposed the danger, inherent in such an exercise, of overlooking the value of tertiary institutions where teaching, research and excellent patient care are provided to everyone irrespective of their ability to pay.

South Africa must maintain a balance between providing clinic-based health care and providing specialised hospital care. It has taken decades to build up the expertise at Grootte Schuur and this "people's hospital" has emerged as the undisputed flagship of academic health centres in Africa. It would be tragic if the country were to lose all this through neglect or a lack of balance in managing the transformation of health care policy.

# In a critical condition -

## INSIDE STORY

It is Cape Town's world-renowned centre of health care - and yet Grootte Schuur Hospital faces an uncertain future. Health writer JENNY VALL reports. Pictures by Andrew Ingram, graphics by Bob Grierson and layout by Melissa Stocks



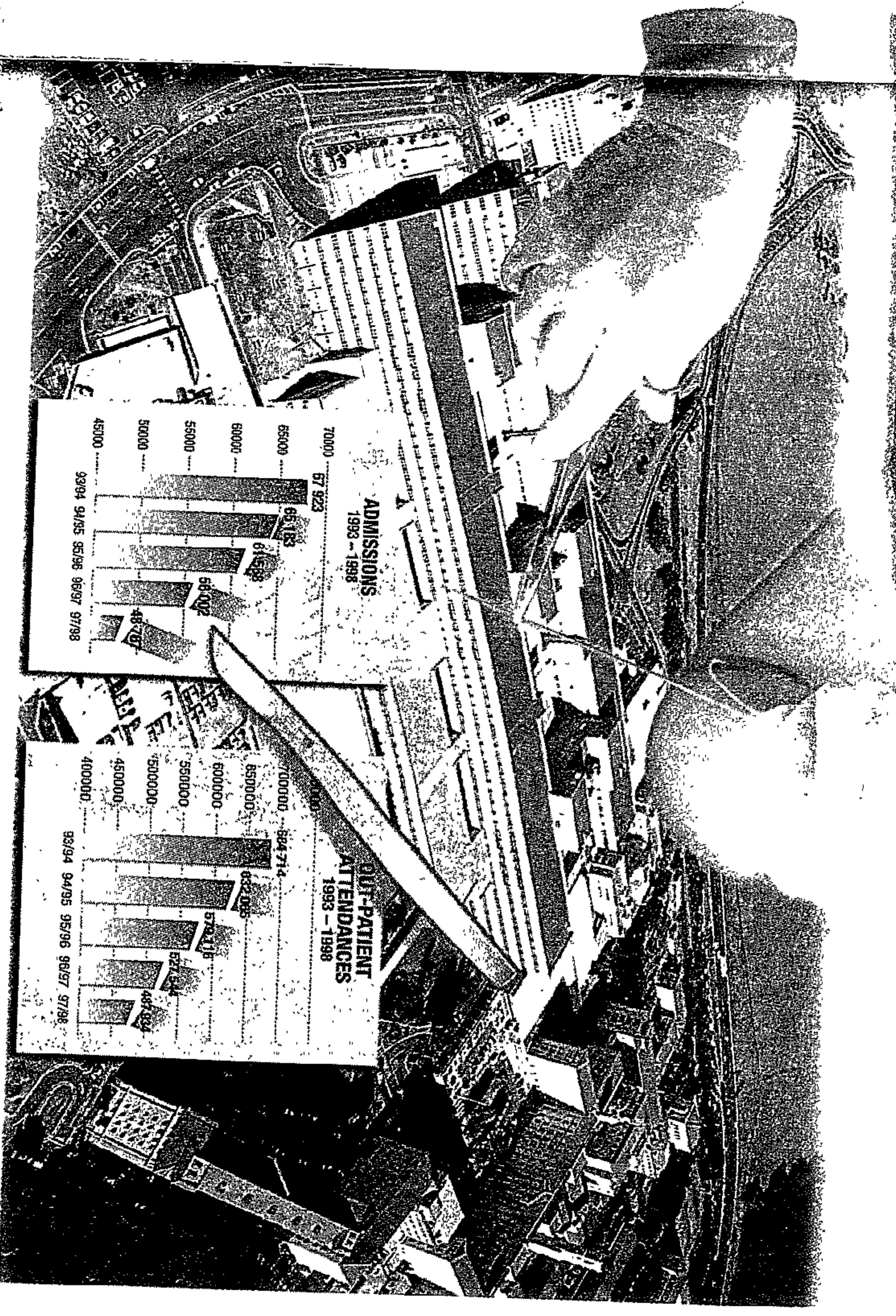
"Resusc!" shouts a nurse, and the trauma team drops everything and comes to the aid of a young man from Langa. He lies unconscious on the resuscitation table, a bullet in his head. There's a pipe down his throat to ventilate him, and a nurse drains bloody fluid through his mouth. The team works urgently to save his life.

Occasionally he gasps and thrashes out with his left arm and leg, narrowly missing the nurse. His right side is still. It's midnight on a Friday at Grootte Schuur's trauma unit, and the casualties are coming in thick and fast. This is ER - live. There's a 15-year-old boy from Guguletu, shot through both legs, and three assault victims, two with wounds to their heads. A nurse stitches on part of an ear. The man with a bullet in his head may or may not survive. If he does, it will be thanks to the excellent care the trauma unit is still able to provide to the seriously injured.

The trauma unit is the most dramatic interface between specialist medicine and the people of Cape Town, but it is just one of the vital services this world-renowned hospital provides. Grootte Schuur has been in the news lately as the squeeze on academic hospitals tightens. In January 1998,

# This (hospital) closes down, you

GROOTE SCHUUR UNDER THE KNIFE (98) ART 19/3/98



the next few months as part of efforts to save 25 million to meet the 1997 target.

Many believe Grootte Schuur is no longer a place you would go to. The truth is that the hospital is being referred to the world-class care from top medical and nursing staff. "If this closes down you own Cape Town," said Oregon.

often no toilet paper in the public toilets intended for visitors. But Grootte Schuur, no matter what its problems, is still the people's hospital, serving everyone from Bonteheuwel to Bishopscourt and in many cases patients from beyond the borders of the Western Cape. Here health is a right, not a commodity for those who can afford to pay. This shows, says patients, in the

Hospital represents a complex combination of patient care, teaching and research, intricately linked to the University of Cape Town's medical school. On the mountain below Devil's Peak, the hospital, which turns 60 this year, is watched over by a statue of the goddess of health, Hygieia. Over decades the hospital and medical school have built up a worldwide reputation for excellence. here that top medical specialists - in many cases leaders in their fields - still work. Until recently Grootte Schuur was all things to all people and anyone with anything from an infected toe to a gall bladder problem could be seen here. Now provincial health policy stipulates that people must go to their local clinics first. From there they are referred to specialist hos-





Food for thought: Groote Schuur food services manager Pierre Cloete

### 3 meals a day, but some are fed up

ARR 19/3/98 (98)

The proof of the pudding, it is said, is in the eating. Pierre Cloete, chief food services manager, and I are eating the hospital kitchen's lunch. It's a cabbage bredie served with rice and gem squash.

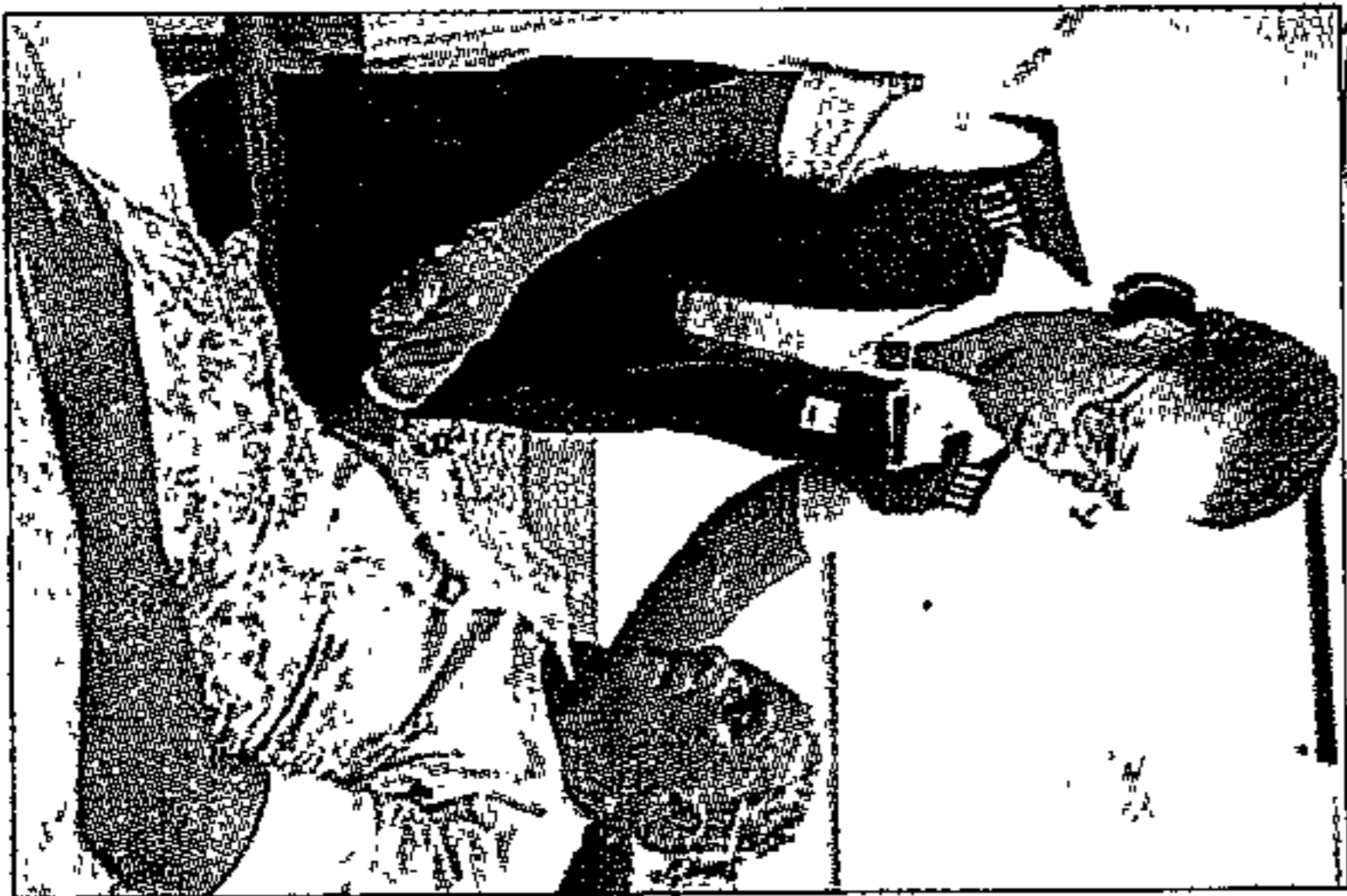
I've been told the hospital's food is bad, disgusting, atrocious. Maybe I've hit a good day, but it's not bad at all.

Mr. Cloete and his team at Groote Schuur's catering department supply 4 500 meals a day. That's a lot of food, and it takes a lot of planning.

His measure of the food is how much is sent back every day. It's not much. The hospital's kitchen, which is halal (there is also a small kosher kitchen), is on the ground floor of the hospital.

The hospital prepares food using a cook-chill system, which means that meals for the next day are cooked, then chilled to just above freezing point in blast chillers.

The next day the food is dished up and sent up to the wards where it is reheated. Patients get three meals and six bev-



Caring: assistant director of nursing Maureen Ross talks to a stroke patient

Maureen Ross is not going anywhere. "Groote Schuur Hospital is the old lady on the hill and I will nurse her until they kick me out. I will be the last to leave and I will switch off the lights here," she says, laughing.

Mrs. Ross is assistant director of nursing, medicine and typical of Groote Schuur's dedicated staff. After close on 30 years of nursing, most of them at Groote Schuur, she's committed to seeing that the hospital survives the hard times.

"I'm here because I love the place. I came here as a naive 17-year-old, shocked when I was exposed to a man's naked body. You either sink or swim, and I swam."

Mrs. Ross was closely involved with the racial integration of the hospital in the late 70s.

### 'I will be the last to leave and I will switch off the lights'

ARR 19/3/98 (98)

While white wards were less than half-full, they had to bring camp beds into the coloured wards to accommodate the patients. Coloured nurses could work only in coloured wards, although white nurses worked in both. Integration began slowly.

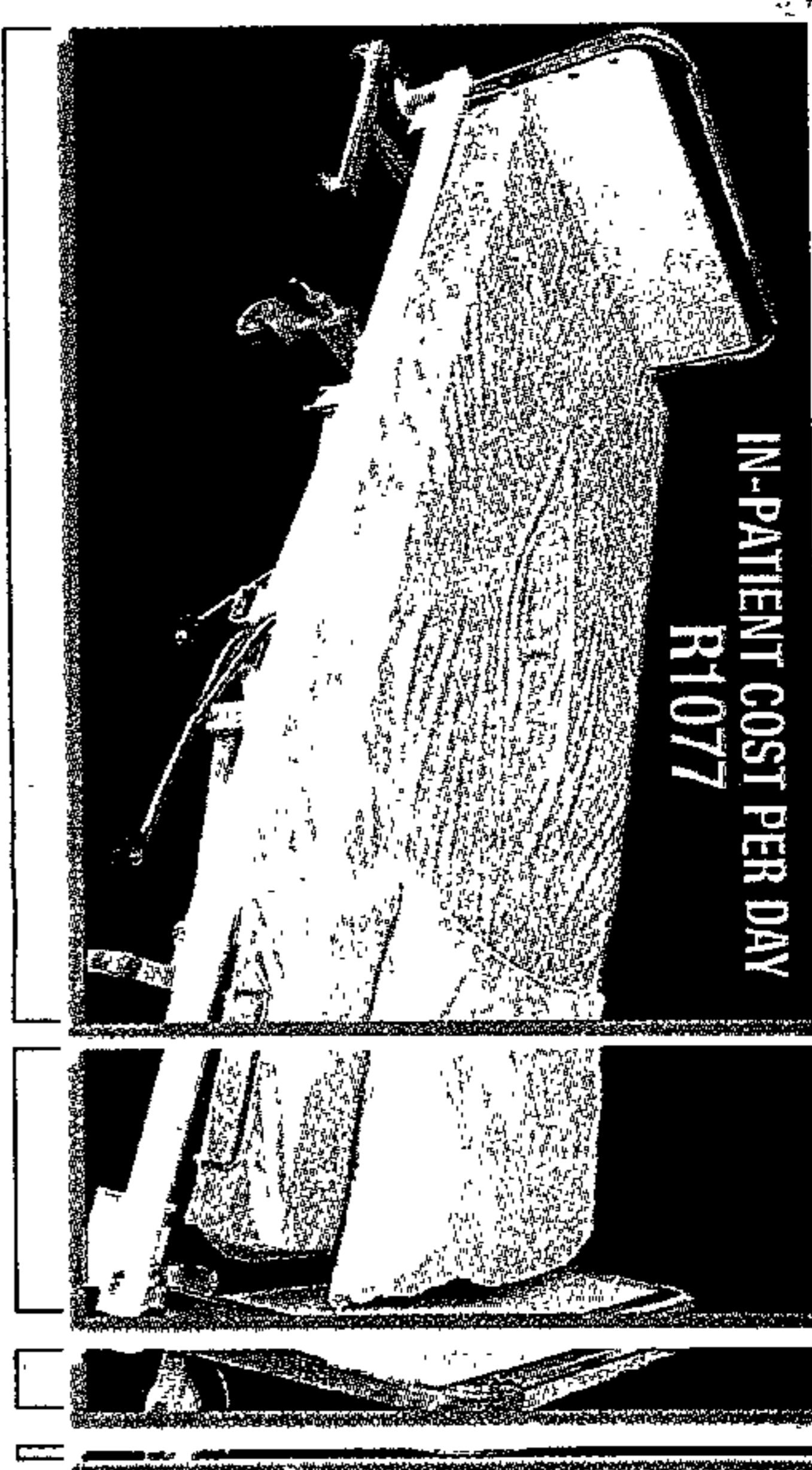
"We used to choose the very clean, quiet coloured patients to put in the white wards. It's ridiculous when you think about it now!"

It didn't always go smoothly, and there can still be problems today. "We have to deal with it. We're not yet tolerant of each other," she says.

Mrs. Ross is in charge of all nursing at the hospital. "The feeling among nurses at the moment is definitely one of uncertainty."

Morale is shaky. Nurses constantly ask her when more money will be

operations would be performed for you won't find carpets and there is looks after them. Groote Schuur p and was performed. n. 2001, 1. 8 more health...



**75% STAFF SALARIES**  
80% patient-related eg: medicines, blood, x-ray plates, medical and surgical requisitions etc.  
20% water, electricity, fuel, paper, batteries, bedding, uniforms etc.

**20% CONSUMABLES**

**4.5% PROFESSIONAL AND SPECIAL SERVICES**  
Machine maintenance, transport, waste removal etc.

**0.5% EQUIPMENT**

### Unit that saves dignity: 'It's a myth our hospitals aren't good'

ARR 19/3/98 (98)

No one likes going to hospital. You're away from home, among strangers, frightened, in pain and worried.

Robert Nel, however, thanks God for Groote Schuur Hospital. "In January, the priest was reading me the last rites. Now look at me, this place has saved me."

Mr. Nel, 52, lives in Port Elizabeth. For 22 years he's had Crohn's disease, a form of cancer. "I've had parts of my intestines taken out, and operation after operation in private and state hospitals.

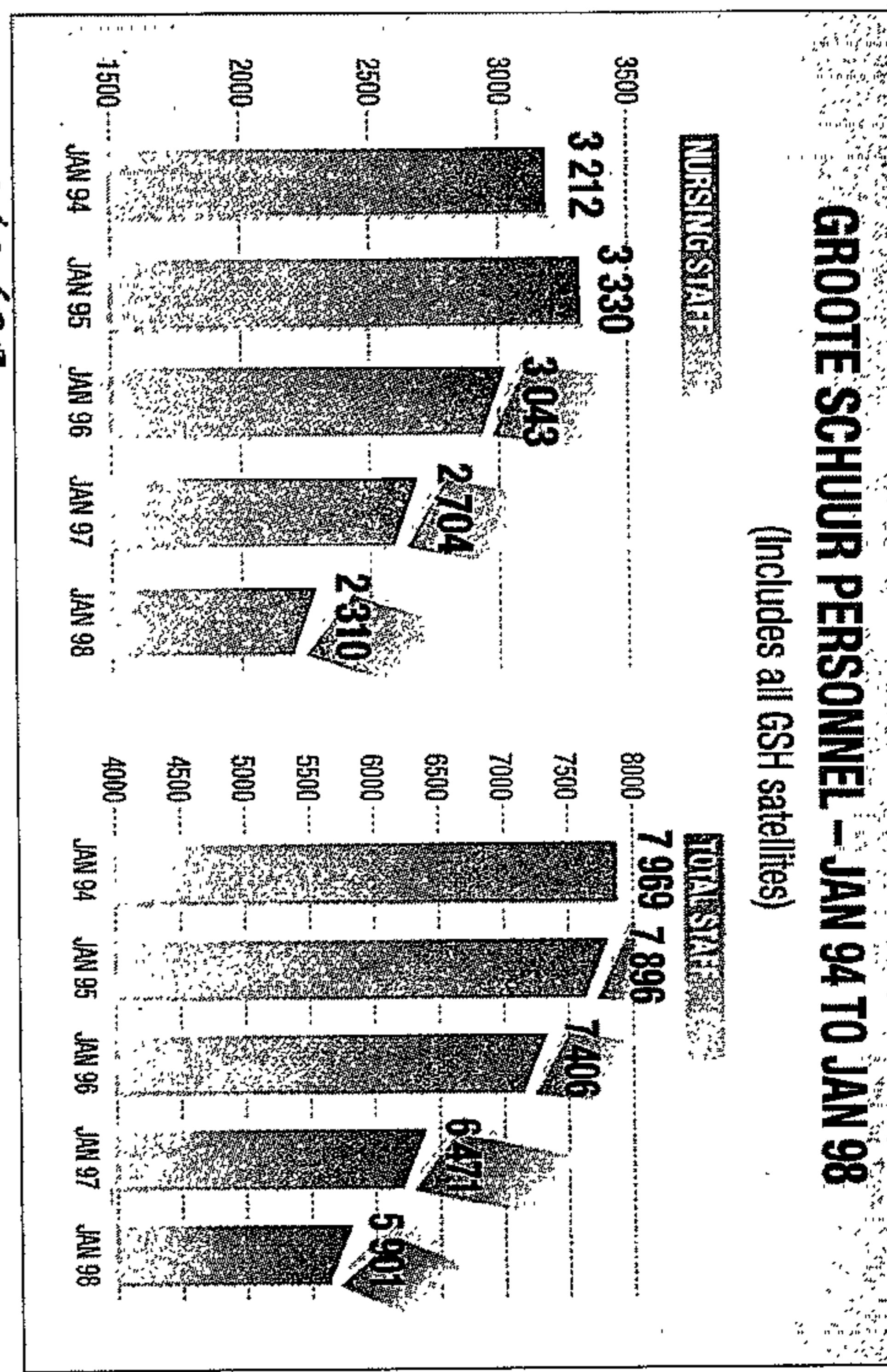
This will be my 15th operation. "Before I came here, my doctor said: 'I can't help you anymore'. Now I'm a different person."

For many people like Mr. Nel, Groote Schuur is a safety net into which they fall when all other avenues have been exhausted.

Part of his treatment is at the stomatherapy clinic, run by Prilli Stevens. It's like a home from home. Thousands of people have ostomies, literally a hole in their body. They have to wear a pouch, she explains, to contain faeces and

urine. Wearing the wrong pouch can mean the patient ends up with an ulcer or bleeding. "You've got to have the right bag. And it's important that we know our patients," she says.

Her clinic sees people from all walks of life with all kinds of problems, caused by anything from cancer to gunshot wounds. It's a core department, serving all the hospital's units. "The unit does not save lives, but it saves dignity."



"Without this unit, people would just have to live with a nasty disease and discomfort," says Mrs. Stevens. A patient who doesn't want to be named has just seen Mrs. Stevens. He's a large man and tells me he never cries. But he's close to tears now.

When he heard he had cancer, he went to a private doctor. "People said: 'Don't go to the state hospitals, you know the situation here.' So, I went private," he says.

"Eventually, I had to sell my house to pay the bills and I'll have to carry on paying for the rest of my life. "I was terrified of coming here. But the treatment I got outside does not come near to what I'm getting here."

"The attitude of the people here is fantastic. People here care. "It's a myth that our hospitals are not good. I've spent the whole day here waiting at various places, but I don't mind. "They've done things for me which have made my life more bearable and comfortable."

### 'I will be the last to leave and I will switch off the lights'

ARR 19/3/98 (98)

For Mrs. Ross, it's a case of confidence, will units close and will voluntary severance packages be offered indefinitely. She can't answer them. "We need more information from the province," she says.

The stress of managing nurses under these conditions takes its toll. The main problems are the moratorium on filling posts since 1986, and the voluntary severance packages which resulted in the departure of experienced, skilled people.

"That was quite a debate, to stay or to go. But we couldn't offer nurses anything to stay," she says. Filling critical posts is a tedious exercise. "And the frustration remains while you wait. When posts are granted, you get maybe a quarter of the number you asked for. You accept under duress."

But having complained about these things, I have to say it's also these things which keep me here," she says. "I love the challenge and the diversity. I stay because I believe that I can give a better service here than anywhere else."



Patient Robert Nel: see 'Unit that saves dignity'

TAVERN OF THE SEAS APPEARS ON PAGE 2 TODAY. CAP POINTS WILL RETURN TOMORROW



# Groote Schuur faces lean year

ARG 19/3/98 (98)

JENNY VIAL  
HEALTH REPORTER

**Groote Schuur Hospital has a tough year ahead if it is to stay within a budget which is 13% less than it spent in the last financial year.**

The Western Cape's three academic hospitals, Groote Schuur, Tygerberg and Red Cross, have had their budgets reduced by R135-million for the 1998/99 financial year.

The budget for academic health services, which include dentistry, is R1,072-billion.

The overall allocation for health services is R2,9-billion, with a projected deficit of R284-million.

Primary health care services will get R834-million, an increase on last year, and secondary hospitals R720-million.

The provincial health depart-

ment has drawn up a business plan which sets out ways to reduce the number of staff and services. This will be discussed with hospitals and trade unions over the next three weeks and details will finalised after April 6.

Groote Schuur Hospital has been allocated R486-million. In the 1997/98 financial year, it spent R545-million and has carryover payments of R10-R15-million, which include doctors' overtime pay. These must be paid from its new allocation.

This means the hospital will have about R74-million less to spend in 1998/99.

Senior medical superintendent Paul Ciaparelli said the hospital had no option but to spend less. "Our approach is that this is what we have been given, so we have to come within that budget. The provincial Health Department is

under massive pressure not to overspend.

"That pressure just gets passed down to institutions. There's likely to be zero tolerance on overspending this year."

The hospital does not determine how its budget is spent. Most of the money - 76% - will go on salaries.

The hospital cannot retrench and has to rely on staff resigning, retiring or taking voluntary severance packages.

Peter Mitchell, chief medical superintendent of Groote Schuur, said: "We're going to organise a finance summit with our senior management and clinical staff to look at the options of operating with this size budget. We will have to reduce staff numbers in the least damaging ways."

Special report, pages 10 and 11

# W Cape health budget ~~(87)~~ (98) likely to put squeeze on jobs

**JUDITH SOAL**  
HEALTH WRITER

HEALTH services were the Western Cape's greatest achievements as well as its most difficult cut-backs, the provincial government said yesterday.

In an apparent pat on the back to former health MEC Mr Ebrahim Rasool, Finance MEC Mr Lampie Fick's budget mentions that a million more people receive primary health care now than three years ago.

"This must stand out as this province's greatest single achievement," Fick said.

But the move to primary health care under Rasool's leadership has had its price. The province's proud tradition of excellent tertiary care and academic training has born the brunt of the shift in funding priorities, and hospitals are facing the threat of closure and further job losses.

Fick's budget, announced yesterday, will not alleviate their fears. Fick allocated R2,9 billion towards health care, which is slightly up on last year but does not include an increase to match inflation. Of this, R834m will go to primary health care, R1,072bn to academic centres and the rest to district and regional hospitals.

Current Health MEC Mr Peter Marais made it clear that job losses were to be expected. "If 70% of the running costs in a department go to personnel, then it is obvious personnel will be affected," he said.

CT 19/3/98

"If we want to stay within the budget, voluntary severance packages are going to be an important part of the solution."

He also mentioned the possible closure of hospitals. "It is surely better to have seven hospitals functioning at 75% capacity than 12 hospitals at 45%."

But details of Marais' plan to stay within budget will not be released until trade unions have been consulted.

"We have worked out a plan with people in the department, now we have to negotiate with those who will be affected. We will announce the details in April," Marais' spokesperson Mr Johan Smit said.

It is the details that the opposition ANC fears. "The devil could be in the details," said ANC finance spokesperson Ms Tasneem Essop.

She said the health budget was the biggest it had been in four years and should be sufficient to extend primary services as well as maintain academic hospitals.

"With the additional funds that the central government has earmarked for the academic hospitals, there should be enough to ensure that the excellent care they provide continues," said ANC provincial spokesperson Mr Cameron Dugmore.

"What is important is that the general direction of Mr Rasool's health plan is maintained. It would be a tragedy if the overall policy of providing services at a primary level was lost."



# Four city hospitals to close doors

AKG 20/7/98 (98)

**JENNY VIAL**  
HEALTH REPORTER

**Four hospitals in Cape Town, including Somerset and Valkenberg, are to be shut, 300 beds at academic hospitals are to be closed and staff numbers are to be reduced by 3 816.**

These decisions are part of the Western Cape Health Department's business plan approved by the provincial cabinet earlier this month and intended to bring the department within its budget.

Health Minister Peter Marais said the plan was "not cast in stone and if someone can tell us of a better way to save money, we will do it".

The department's projected deficit for 1998/99 is R284-million and the plan is to bring about savings by July.

Other hospitals to be closed are Westlake near Lakeside and the D P Marais TB Hospi-



**Peter Marais**

tal at Westlake.

Somerset will be closed and its staff declared supernumerary and offered voluntary severance packages. Proposals for the site will be called for.

Valkenberg is to be closed and its patients and staff accommodated in other hospitals.

The decision to close Valkenberg was taken because it was "the most logical psychiatric hospital to close" according to the business plan. This is expected to reduce staff by 100 and save R4,7-million, and reduce infrastructure expenditure by R4-million.

Groote Schuur, Red Cross and Tygerberg hospitals will lose 300 beds between them.

The business plan is to be discussed with institutions and unions and changes will be finalised by April 6.

Mr Marais said the savings effected this year would mean there would be no further cuts in the next two years.

# pe hospitals to close

(98) ARG 21/7/98

JENNY VIALI

It's finally happened: ominous warnings that Western Cape hospitals will be forced to shut up shop because of drastic budget cuts, have become reality. The province will close five hospitals in the next three months, by July 1.

Wielding the battle axe rather than the scalpel, health authorities will cut 8 816 health jobs and close hundreds of hospital beds.

The greatest shock is the closure of Cape Town's oldest hospital, Somerset, overlooking the V&A Waterfront. Somerset is the only state hospital serving the densely-populated city bowl and Atlantic suburbs.

Its patients traditionally have come from afar to attend its specialised services including the vital AIDS clinic which is being closed just as the rate of HIV infection in the Western Cape rockets.

The other hospitals to be closed are:

- Valkenberg psychiatric hospital in Observatory which has played a major role in Cape Town's mental health for many years.
- The DP Marais TB hospital at Westlake.
- The nearby Westlake convalescent hospital.
- Nelspoort, a tuberculosis and psychiatric hospital near Beaufort West.

The closure of the TB hospitals is especially serious as the Western Cape has one of the highest rates of TB infection in the world.



Farewell: Gadlja Henkeman, assistant director of nursing at Somerset Hospital

These four hospitals had been earmarked beforehand for closure.

But the sudden announcement of the closure of Somerset Hospital has come as a complete shock.

Medical superintendent Edward Lotz said, "It's as though there's been a death in the family. There's almost a deathly silence around."

"The first indication we had of the closure was two days ago. We, the staff... had no input in the plans."

Dr Lotz said he would be submitting an alternative plan for the hospital now that he had been invited to comment.

The facade of the old building, renovated in 1991 at a cost of R90-million, is a national monument.

The provincial health department has said it needs to reduce staff by a further 3 816 and close hospital beds to make up its projected deficit of

R284-million before July 1.

Somerset Hospital has been told that it will be closed and its 260 beds "absorbed" into Groote Schuur, Karl Bremer, Mowbray Maternity and GF Jooste hospitals.

Its 791 staff will be declared redundant and offered voluntary severance packages.

Dr Lotz said it would not be practically possible for staff to leave before July 1.

Somerset Hospital runs a HIV clinic considered a vital research and treatment centre for AIDS in Africa.

It also has 76 maternity beds and as many babies are delivered here as at Mowbray Maternity Hospital.

The Inter-Hospital Co-ordinating Committee, a grouping of hospital superintendents, has stated it is extremely concerned about the closure of hospital beds, but it under-

stands the severe constraints under which the provincial Department of Health functions.

Provincial Health Minister Peter Marais said yesterday that closing Somerset was "negotiable if someone can tell us how to save R47-million".

He said the move to primary health care meant services had to be cut at secondary and tertiary levels.

"If the ANC and the unions are in favour of primary health care, they should take full responsibility for the consequences of the plan," he said.

"I've told the unions that if they have different ideas about how I can deliver services within the budgetary constraints, I am open to persuasion - as long as it's a workable plan."

■ Ebrahim Rasool of the African National Congress who was replaced by Mr Marais of the National Party as provincial health minister in January, said: "With the best health budget the Western Cape has ever had, of R2,9-billion, Mr Marais will have a very difficult task to explain to the public why such catastrophic measures are being imposed."

"The Western Cape was on the path of orderly rationalisation and one would have expected Mr Marais to have stuck to this instead of closing hospitals."

"In addition, the communities of Delft and Kraaifontein have a right to be angry. They won't see the opening of community health centres which have been negotiated for over two years and, in fact, have been built."

"This makes nonsense of Mr Marais' promise of 'every patient is a VIP'."

## 'Ag, that can't be true...'

PIETER MALAN

Tears well up in the eyes of Gadlja Henkeman when she talks about Somerset Hospital.

The hospital's assistant nursing director, Matron Henkeman, started her nursing career 30 years ago at the venerable institution.

"When I got this post a few years ago, I thought it would be nice to retire here - at the same hospital where I started my nursing career. But I didn't expect it would end like this."

On Thursday, medical superintendent Edward Lotz dropped the bombshell to the nearly 800 staff members: Somerset Hospital is set to close by July 1. Yesterday, Western Cape Health Minister Peter Marais publicly announced the news.

Less than a month ago, an "Important Notice to All Staff" still on the hospital's notice boards and signed by Dr Lotz read: "Please attach no value to the rumour

(about the future of Somerset Hospital) which is circulating. It includes no factual information ..."

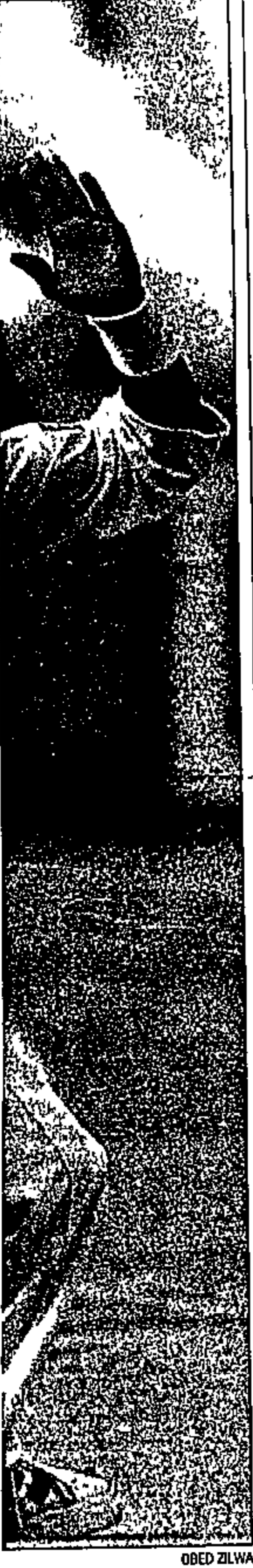
"Please note that ... before any decisions are made, all stakeholders will be consulted well in advance."

After Thursday's announcement, someone scribbled across the notice "Who's fooling who?"

Senior administration official John Fortuin echoed the feeling of many when he said it had come as a complete shock. "Luckily I'm only six years to retirement anyway, but I feel sorry for the young people who have got families and other commitments."

A trauma doctor, who did not want to be named, was more blunt about his patients' prospects: "I don't know what will happen to them - die I suppose."

Male nurse Keith da Silva was still reeling from shock: "When I first heard it ... my first reaction was to say: 'Ag, that can't be true - they're talking nonsense.'"



OBEID ZILWA



HOSPITALS THROWN LIFELINE

# Wage hikes 'forcing closure'

CAPE HOSPITALS facing closure have one last chance to avert their fate — think of other ways of saving the money themselves. **CLAUDIA CAVANAGH** reports.

SALARY hikes for public servants are largely to blame for a R284 million provincial department of health deficit which could see the closure of five Cape hospitals by July 1, says health chief Dr Tom Sutcliff.

Last week, superintendents and unions at the hospitals — including the historic 260-bed Somerset Hospital in Green Point and Valkenberg Psychiatric Hospital in Observatory — were given just under three weeks to come up with alternative ways to save the money or close their doors forever.

Other affected hospitals are the DP Marais TB Hospital in Westlake, the Westlake Convalescent Hospital and the Nelspoort Psychiatric and TB Hospital near Beaufort West.

"Unfortunately, recent signifi-

cant salary increases and other benefits for public servants have offset the savings which were anticipated from the loss of more than 3 000 staff members last year," Sutcliff said yesterday.

In July last year, he said, staff were given an across-the-board seven percent increase which in turn pushed up the overtime and housing allowance bill. Structural changes to the way some grades were paid also guzzled funds.

"All this had a huge effect on potential savings for the year, without which we wouldn't have had to downscale," said Sutcliff.

In the meantime, hospital heads, initially floored by the proposals, have come back fighting.

"The Inter-Hospital Co-ordinating Committee will generate alter-

CT 24/3 1998  
native proposals as a group," said Dr Edward Lotz, Somerset Hospital medical superintendent.

"We do not believe that a single bed needs to be closed and, taking the budget constraints into consideration, are working towards a plan for increased efficiency," he said.

The proposed closure of his hospital came "like a bolt out of the blue" last Wednesday.

"We're all very unhappy about the whole thing and wish we had been asked before or given more time to respond," said Lotz.

Staff at the hospital are still said to be "reeling from shock" but an inside source says they "won't take it lying down".

"They will mobilise efficiently and make their mark on the process," he said.

Valkenberg's superintendent Dr Jan Schoombie said consultations with staff would begin immediately. "We will definitely try and develop alternative proposals. We

(98)  
have been asked to respond and have a responsibility to do so."

Unlike Somerset Hospital, Valkenberg has been threatened with closure since October last year.

"It's all been extremely stressful. Staff morale is at an all-time low. They need finality on the matter."

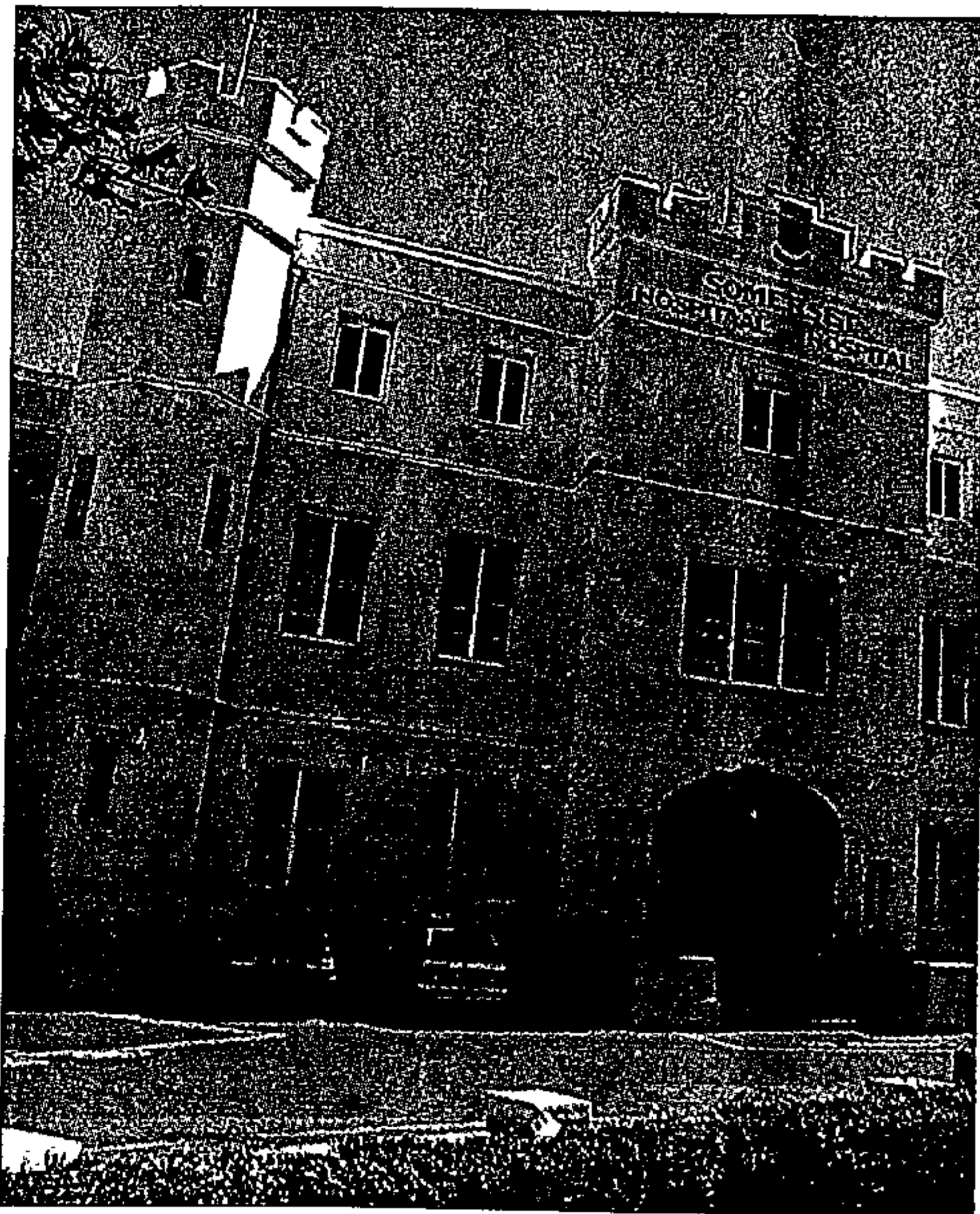
And that is what they will have pretty soon.

A spokesperson for MEC for health Mr Peter Marais said final decisions on the hospitals' future had to be made by the end of April so changes could be made in May and June.

All in all, 3 816 staff members stand to lose their jobs in a massive "voluntary severance" programme which "in the absence of a retrenchment tool is the only way to reduce staff".

"But more than that number have already applied for voluntary severance packages, so we do not anticipate any problems there," said the spokesperson.





**DEATH KNELL?:** The historic Somerset Hospital in Green Point — one of five Cape hospitals facing closure. **FILE PICTURE**

## Why these hospitals could be closed down

(98) 48/ CT 24/3/98

BY closing Somerset Hospital, R37,2 million will be saved in staff costs and infrastructural expenditure will be reduced by R9m a year.

The hospital was targeted because it:

- Has a high patient-day cost of R535.
- Is not well served by public transport.
- Is associated with Groote Schuur and so patients who need sophisticated treatment can go there.
- Is facing increasing pressure as a result of development in the area and occupies an increasingly valuable site. The building could be leased for millions of rands a year and proposals have already been called for.

By closing Valkenberg, R4,7m will be saved in staff costs and another R4m in infrastructural expenses. It was earmarked because:

- Many of its buildings and facilities are unacceptable for patient accommodation, while

facilities at Stikland and Lentegour are newer and more modern.

- Community support structures have been built up in Observatory, so the area will be able to sustain patient care services on an outpatient basis.

● The relocation of patients to Stikland and Lentegour will allow poorer communities easier access to facilities.

● Closure of the Nelspoort Hospital will save R5,8m in staff cuts and reduce infrastructural expenditure by R1,5m. It was chosen because:

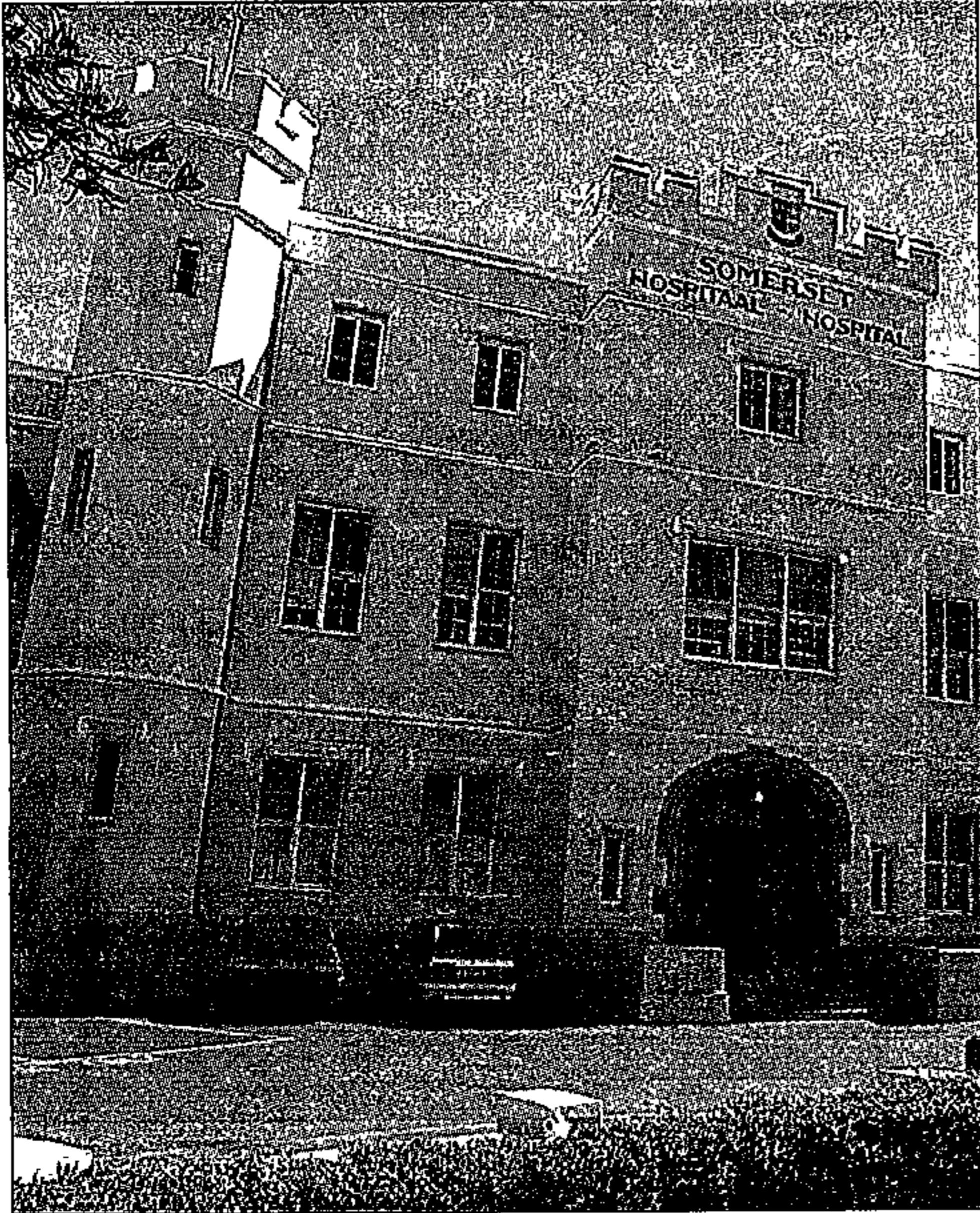
- Its borehole water is unfit for human consumption and its alternative water supply is dependent on regular rains.

● Its sewage works is overloaded and needs upgrading, as does its electrical reticulation.

- The patients can conveniently be relocated to other hospitals.

By closing Princess Alice Hospital, R2,8m will be saved in staff costs and infrastructural expenditure decreased by R3m.





**DEATH KNELL?:** The historic Somerset Hospital in Green Point — one of five Cape hospitals facing closure.

**FILE PICTURE**

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# Row over emergency services

Politicians blamed for moratorium on hiring of personnel

(98)  
Star 24/3/98

By ANSO THOM  
AND LEE-ANN ALFREDS

Johannesburg council officials are blaming politicians for the personnel shortage in the Greater Johannesburg emergency services, which are facing collapse unless a moratorium on recruitment of personnel is lifted.

Critically injured victims of Sunday's horror crash near Lonehill, Sandton, in which five people were killed and 31 injured, waited for up to two hours for ambulances to transport them to hospitals while Johannesburg emergency personnel struggled to cope with treating the injured.

Ambulances were called in from Roodepoort, Krugersdorp and Midrand to assist.

Brian Hogan, deputy chief of operations in Greater Johannesburg, said the question

as to whether the 330 vacancies would be filled should be directed at the politicians.

He said about 100 vacancies were for office personnel, which included operators. The rest were emergency personnel, including firefighters and paramedics.

Committee of Ten chairman Kenny Fihla said officials had not informed politicians of the problem.

He said according to policy laid down by the committee, established to reverse Johannesburg's bad financial situation, line managers had to submit reports on employee complements and motivate if they needed more staff.

"We haven't received a single report at the level of the committee from emergency services. It is inexcusable for people who are employed to manage to expect politicians to do

their (the manager's) job," Fihla said. The committee would investigate.

Emergency services strategic executive Hillow Maeko said councillors had been informed that the situation was critical.

He said recommendations to fill critical vacancies had been forwarded to the Greater Johannesburg metro executive committee to consider.

Maeko also denied that emergency services had been slow in responding to the Sandton pile-up, saying the first vehicle was on the scene 13 minutes after receiving the report.

The accident was cleared two hours and 13 minutes later, he said.

Paramedics who spoke to The Star last week said they were struggling to cope.

They claimed that if a bomb were to explode in Johannes-

burg, injuring many people, the city's emergency services would be unable to cope.

"An incident would have to occur for this to be proved," Hogan said.

One paramedic said it was not strange to, at times, work 72 hours non-stop.

In response, Hogan pointed out that overtime was voluntary and "no one is forced to work overtime".

He admitted that if no overtime was allocated, even fewer emergency vehicles would be available daily.

Jo-Anne Collinge, communications director in the Gauteng Health Department, said the department was aware of the many emergency-services posts that were vacant.

"This may be partly due to the complexities of local government restructuring," she said.



# Boss taken hostage in health row

ART 25/3/98 (98)

## 'Save hospital'

JENNY VIAL AND LINDSAY BARNES  
STAFF REPORTERS

A Western Cape Health Department official was taken hostage at Nelspoort Hospital near Beaufort West by workers demanding a moratorium on the hospital's closure.

Mike Hendricks, director of health care for the Southern Cape-Karoo region, went to Nelspoort yesterday to discuss the proposal to close the hospital as part of the department's plan to save money.

The hospital is on a farm and 140 families stand to lose their homes if it is closed. Dr Hendricks was taken hostage about 2.30pm by workers who sent a list of demands to provincial Health Minister Peter Marais.

Police spokesman Louis Nortje said the staff were "unruly" but it did not appear that they used weapons.

Late last night, the hospital received a fax from Mr Marais's office saying representatives would visit the hospital on Monday. Dr Hendricks was then released.

Johan Smit, spokesman for Mr Marais, said no decision had been made yet on the future of the hospital. "It's only a proposal documented in our business plan. The staff are welcome through their unions to make alternative proposals by April 5," he said.

Hospital superintendent Olaff van der Westhuizen said staff demanded that Mr Marais and the heads of the provincial departments of education, agriculture and housing visit the hospital.

The hospital was built on 7 000 hectares and the grounds were farmed. A primary school and hostel for 370 pupils were also under threat.

The department says it wants to close the hospital because the water supply is a problem and the buildings, sewerage and electrical works need renovating.



# What is to become of needy patients? With hospitals closing, the province's impaired will be the biggest losers

(98) ART 25/3/98

## INSIDE STORY

The announced closure of hospitals in the Cape Town area has shocked professionals and patients alike.

Apart from many losing their jobs and reductions in student training opportunities, the primary question is what is to become of the patients? With the recent closure of Lady Michaelis Rehabilitation Hospital, inpatient rehabilitation facilities were reduced to Westlake and Conradie hospitals.

These two are invaluable in the rehabilitation of stroke and head-injury patients.

With the increase in violence, motor vehicle accidents and strokes, there has been a reciprocal increase in the number of patients who have physical, communicative and/or swallowing difficulties due to neurological damage.

These disorders all need long-term therapy. Despite drastic staff cuts at Groote Schuur, these types of patients receive high quality in-patient and out-patient care from speech therapy, physiotherapy and occupational therapy (OT).

What happens post-discharge? A majority of these patients are referred to Westlake and Conradie for further in-patient treatment so that they can return to as close to normal function as possible and thus once again contribute to their community.

Closure of Westlake will place a tremendous burden on Conradie, which also is trying to stay afloat with present staffing restrictions, and I can foresee many patients being turned away or placed on waiting lists.

This will place increased pressure on caregivers, as many patients have communicative, feeding and physical limitations and need close supervision and assistance.

There are limited facilities in the outlying communities to attend to the rehabilitation needs of the larger community.

The issue was raised that tertiary care was being reduced to increase primary and secondary care.

The writer of this article, a speech therapist at Groote Schuur Hospital, says she felt compelled to air her frustrations at the news that more public hospitals in Cape Town are facing closure. She has asked that her identity be kept confidential for professional reasons

I have yet to see this happen.

At Groote Schuur Hospital, we have lost a number of speech-therapy posts in recent years and, if one of us were to resign, the post would be frozen because of budget cuts.

We are limited in the number of positions that specialise in the treatment of neurological disorders.

If one of us were to leave, we would be severely pushed to provide the high-quality in-patient care to swallowing and communicatively disordered patients that we do at present.

The position regarding physiotherapy and occupational therapy posts is the same.

There are no speech therapy posts at Conradie, Westlake, Jooste, Somerset or at any of the day hospitals and clinics.

To increase our services to the community, we send qualified therapists, together with students, to Westlake and Conradie one afternoon a week during student term time.

During the vacation, we get an increase in referrals from these hospitals.

Patients with swallowing disorders are given priority treatment because of the health risks posed, but those with communication difficulties are placed on a growing waiting list.

Patients can be on this list for three to six months, as communica-



Road strasar in the aftermath of a severe accident like this one, patients often need prolonged rehabilitative therapy. With fewer resources, they will be left without care

tion disorders can take months or years to remedy. With limited staff and even with student therapy, the waiting list moves slowly.

How are we expected to tell patients and their caregivers that they will not be able to receive therapy for a length of time?

Communication and feeding or swallowing are integral to our identity and its essential to social integration and function in the workplace. Caregivers report that their loved ones end up sitting at home watching

soap operas all day where once they had been active and served their communities and families well.

Now many of them can't mobilise themselves, can't work and can't communicate. All of these things lead to depression and increased frustration levels.

Where is the quality of life? We have stroke patients coming in as young as 28 with an alarming increase in the number of "younger" strokes in their 30s and 40s. They still have a good 20-30 years in which to

work, but they won't be able to return to the workforce if their rehabilitation needs aren't met.

Good rehabilitation facilities are provided at Groote Schuur for speech therapy, physiotherapy and OT, but we are being pushed to our limits.

The patients travel in from afar for therapy and, at times, have to pay high taxi fares to commute. Many ask for therapy at day hospitals closer to home, but we have to tell them that there are no services provided.

As a result, many can't afford to continue therapy and remain communicatively impaired.

There are some physiotherapy and OT posts in the community, but I have heard that they are just as overworked.

This great plan on increasing services to the community has yet to happen. So now we just shut down vital inpatient rehabilitation facilities so that we can send more "impaired" patients home to sit for the next 20-40

years and live off a minimal disability grant.

It's all right for those with a medical aid, but what about the large majority who don't have it?

What hope can we give our patients when they sit in our offices crying that nobody can help? All they want to do is be functional in their families and communities once again!

Members of government will probably never have these problems as I am sure they can seek private intervention if God forbid, they ever have any neurological damage.

Maybe things will change only when they experience at first hand what they are doing to the public by closing these hospitals down.

The medical and rehabilitation staff at Groote Schuur Hospital are good and the hospital itself is one of the best in the country.

We are doing the best we can in the given situation, but we cannot work alone!

I understand that the province has financial difficulties, but are we going to be sitting with a province of disabled people?

No matter their race, socio-economic status or impairment they all have the right to comprehensive rehabilitation and it is the Government's responsibility to provide it.

There are so many therapists unemployed and willing to do the work, but no positions for them to fill. Those who do have jobs are fortunate, but are also on the verge of burn-out with the large patient-to-therapist ratios.

With the closure of Westlake, and no provisions for the community, the pressure on Groote Schuur's rehabilitation staff is bound to increase and we will be pushed to continue with our high standards.

What is to become of this province's disabled? The contents of this letter are based on my personal opinion and may not reflect the opinions of others working at Groote Schuur Hospital.



# City should have 10 times more ambulances

Star 25/3/98 (98)

Greater Johannesburg has only six vehicles serving the area, while many firefighters cool their heels awaiting calls

**By ANSO THOM**  
Health Reporter

**G**reater Johannesburg should be serviced by between 50 and 60 ambulances and response cars instead of the six currently serving the city, deputy director-general in the Gauteng health department Eric Buch said yesterday.

He was speaking after Gauteng health officials and Johannesburg emergency services management held an urgent meeting after The Star revealed widespread concerns of paramedics regarding the dire emergency-services situation in Johannesburg.

The top-level meeting is set to continue today.

Buch said that, according to a formula which took into account that Gauteng subsidised 40% of ambulance and para-

medic staff members' salaries, there should be at least 50 response and ambulance vehicles on the road during peak times.

"The meeting was called to establish why they (Greater Johannesburg emergency services) aren't maintaining these levels," said Buch.

He said another core issue which arose at the meeting was the fact that there was a large number of fire personnel waiting for fire calls at emergency stations although fire emergencies were much more infrequent than ambulance calls.

"These people (firefighters), who have been trained to fulfil a dual role, should be out on the road in ambulances, but be available to attend to a fire scene if necessary. It boils down to the balance currently maintained between personnel who stay behind and those out in ambulances," Buch said,

adding it was also unnecessary to have 26 fire stations in one metropolitan area.

He said Gauteng was currently subsidising 800 ambulance and paramedic staff members. Firefighters were being funded at council level.

At present, Greater Johannesburg has about 330 vacancies within its emergency services department.

A senior paramedic, who asked to remain anonymous, said most emergency stations were being managed by former fire chiefs who did not have the interests of the ambulance and paramedic staff at heart.

ANC councillor and chairperson of the public safety committee, Nkele Ntingane, said service levels had dropped because emergency stations were now forced to serve areas such as Alexandra which were previously ignored.





**SAVE OUR HOSPITALS:** A crowd of angry health workers toyi-toyed outside the administration building of the Valkenberg psychiatric hospital yesterday while unions met with department representatives inside.

PICTURE: THEMBINKOSI DWAYISA

## NOT CONSULTED ON HOSPITAL CLOSURE

# Health unions talk of 'war'

(98) CT 26/3/98

**LOSING THEIR JOBS** would force health workers to turn to crime, they say, adding that the Health Department faces a 'war', which it will lose. **FATIMA SCHROEDER** reports.

**F**IVE health trade unions have threatened to take drastic action against the Department of Health for failing to inform them about the closure of five Cape hospitals.

This was decided at a heated meeting between union and department representatives yesterday.

Last week hospital superintendents and unions were given a deadline of under three weeks to find ways to save thousands of rand or close their doors forever.

Health authorities also announced that 3 816 health jobs would be cut and hundreds of hospital beds closed.

National Health and Allied Worker's Union (Nehawu) representative Mr Theo Twala described the situation as a "war" and said the department was on the losing side.

The first round of the "war" took place yesterday when a crowd of angry health workers protested and toyi-toyed outside the administration building at Valkenberg psychiatric hospital.

The protesters demanded that

the government deal with what they said might become an ugly situation, saying that drugs, gangsterism and crime could be the only alternative for jobless workers and miserable patients.

"If the place (hospital) is closing down where must we go to? People won't have jobs

"Patients will be miserable with nowhere to go. Everyone will turn to crime," Twala said.

While workers demonstrated outside, union representatives were discussing their plans inside the building.

The department was accused of dealing with the closure of the hospitals unprofessionally and unions challenged them to apologise in public for "failing to consult" them.

The unions involved in the meeting yesterday included the Health Workers' Union, the Medical Association of South Africa, the National Health and Allied Workers' Union, the Hospital Personnel

Trade Union of South Africa and the Public and Allied Workers' Union of South Africa.

Each union will hold separate meetings to discuss the action to be taken against the department.

The closure of Cape Town's oldest hospital, Somerset, has shocked several hundred workers there.

Somerset offered services and research that would be lost not only to greater Cape Town but also to the African continent if the hospital was closed, the hospital board said in a statement yesterday.

"The authorities are trying to bamboozle us with words when what they are doing will be to allow a major loss of life through reducing facilities — and of course, thousands of workers and their families will be impoverished," said Somerset Hospital Forum spokesperson Mr Haroun Esau.

"We plan to fight this with every tool we have and insist that the authorities consult us every step of the way."

The services at Somerset include an HIV clinic, which is considered a vital research and

treatment centre for Aids in Africa, a medical education centre which offers a bridging course for enrolled nurses and has a close involvement with the University of Cape Town's medical school and the only casualty department for patients from coastal areas.

The board said Somerset had been targeted for closure because it had a high patient-day cost of R535.

The inter-hospital co-ordinating committee was working to develop a plan to reduce costs and increase service efficiency to prevent the closure.

Other hospitals to be closed are:

- Valkenberg, which has served mentally ill patients in Cape Town for over a century.

- The DP Marais TB hospital at Westlake.

- The nearby Westlake convalescent hospital.

- Nelspoort — a tuberculosis and psychiatric hospital near Beaufort West.

Other hospitals which faced closure but managed to escape include Victoria Hospital in Wynberg, Conradie Hospital in Pinelands and the Karl Bremmer Hospital in Tygerberg.

Nehawu will hold a meeting at 2pm today to formulate its plan of action against the department, Twala said.

*'We plan to fight with every tool we have and insist that the authorities consult us.'*



# Politics wrecks possible plan to save Somerset

**KARIN SCHIMKE**  
POLITICAL WRITER

(98) CT. 27/3/98

A POSSIBLE plan to save Somerset Hospital foundered on the rocks of party politics in the second reading debate on the Western Cape budget yesterday.

Speakers continually referred to the fate of Somerset Hospital — one of five provincial hospitals to be closed to save money.

But though all parties expressed concern and sadness at the pending closure, they were disunited on how to avoid what many see as a disaster.

Yet only two days ago the legislature's standing committee on finance drafted a report censuring Health MEC Peter Marais.

In the draft the committee expressed concern about the closures and the way the business plan to close the hospitals had been announced. It recommended that Somerset Hospital not be sold, because it served a "vital geographic area".

But when the final report was tabled in the legislature yesterday, there was no trace of the strong disapproval of Marais' plan — only a somewhat watered-down recommendation that the standing committee be "updated on the plan on an ongoing basis".

The ANC said the encouraging signals of co-operation between the parties had

been destroyed, implying that the NP members of the standing committee had been "whipped into line" by the cabinet.

When Marais addressed the house yesterday, he emphasised that the business plans were not final, and added that the top department officials who had drawn up the plan had been appointed by his predecessor, Mr Ebrahim Rasool of the ANC, who had himself approved the plans.

He said: "The grand old lady (Somerset Hospital) has served many people well for many years. On 9 May 1965 my wife gave birth to my first son there ... (The Somerset) is a member of my family and I pray for wisdom to keep her from closure."

Mr Daniel Silke of the Democratic Party said that with rationalisation and specialisation, the province could keep hospitals open. He called the closure plan "ill-conceived" and "dangerous".

"However, it was also incumbent upon the previous health MEC, Mr Rasool, to plan ahead in the face of the threat of budget cuts. The DP believes that adequate leadership from the current and previous minister has been and is sorely lacking and that a financial management strategy, including the appointment of a senior financial manager, (should) be expeditiously completed."



# Accident victims left waiting, says report

More than half priority cases were not reacted to within specified response times, Johannesburg Metro council told

By ANSO THOM AND  
THEMBA SEPOTHEKE

Less than 50% of Johannesburg's Priority One (life threatening) calls are reacted to by emergency vehicles within specified response times, says a confidential report submitted to the Greater Johannesburg Metro council late last year.

In addition, some patients waited for more than an hour for ambulances to arrive and take them to hospital, the council's executive committee was told.

The report was compiled by the Support Services Division of the council.

With Johannesburg's emergency services reportedly facing collapse, it was revealed yesterday that Soweto's more than 2 million residents were being serviced only by Jabulani emergency station.

In addition, the station was reported to have only two fire engines, a water tank, a disaster bus, a subsidiary vehicle, five ambulances and one

response car.

Paramedics in Soweto, who spoke on condition of anonymity, said the level of service delivery had collapsed during the apartheid era and this was worsened by the amalgamation of the emergency services.

They said staffers who had left had not been replaced. The station had 95 staffers and needed another 300.

They said Soweto was at times serviced by only three ambulances.

Brian Hogan, deputy chief of operations in Greater Johannesburg, said Jabulani could be assisted by the Rietfontein training academy which had three ambulances but no response cars or fire engines.

Alexandra, which was serviced previously by Sandton, had one ambulance, one fire engine and no response car, Hogan said.

But he said that there were plans to build fire stations in Ennerdale, Dobsonville, Ruimsig, Lenasia South, Orlando

East, Diepsloot and Orange Farm, where a temporary fire station was erected because of the high risk of shack fires.

But he warned the possibility was small with the capital budget slashed.

Hogan agreed to an extent with Dr Eric Buch, Deputy Director of Health in Gauteng, that Greater Johannesburg should be serviced by 50 to 60 ambulances and response cars instead of the 26 currently serving the city.

Hogan said Johannesburg had 58 ambulances with 14 down for repairs.

"A total of 34 are operational, but there is not enough staff to man them," Hogan said. Johannesburg's emergency services had 790 staff instead of the 1 200 needed, he added.

The Star reported on Wednesday that only six emergency vehicles were operational in Greater Johannesburg. There are, according to the Gauteng department of health, 26 emergency vehicles in operation. The Star regrets the error.

*Star 27/3/98 (98)*





# Last bid to save Somerset Hospital

**SOMERSET HOSPITAL** staff believe the motivation for closure is not the cost of its services but the value of the land it occupies. **CLAUDIA CAVANAGH** and **KARIN SCHIMKE** report.

CT 30/3/98 (98)

**T**HE ANC has plans to save Somerset Hospital from closure — but party politics could torpedo efforts to keep the country's oldest hospital running.

Ten days ago, Health MEC Peter Marais released a business plan detailing a R284-million deficit for the year. Somerset Hospital, which dates back to 1818, would have to go, as would Valkenberg psychiatric hospital, he said.

Other hospitals affected by the cuts include the DP Marais TB Hospital at Westlake, the Westlake Convalescent Hospital and the Nelspoor Psychiatric and TB Hospital near Beaufort West.



Although old, a R19m refurbishment a few years ago equipped Somerset for the 21st century. Since then, it has provided maternity care for 400 babies a month, a top HIV clinic and the only casualty department at a state hospital for the coastal areas, from Atlantis, round Table Bay, through the city bowl to the Atlantic suburbs.

Marais gave the hospitals three weeks to come up with alternative ways of saving the money, and staff members and the unions set to work immediately.

"We've organised a public lunchtime meeting in the City Hall on Wednesday and invited the heads of health and the minister to be there," said Somerset Hospital's superintendent Dr Edward Lotz.

"The hospital does not belong to politicians but to its staff and the people it serves. The powers that be must explain why these people were not consulted before the decision to close the hospital was made."

Staff interviewed by the *Cape*

*Times* believe the value of the Somerset Hospital site near the Waterfront — not the service it provides — explains why it was singled out.

"We're next to what we call the Vatican," said a senior staff member pointing towards the Waterfront. "That's the only reason they want us out."

ANC members of the provincial legislature said last week that savings in the Western Cape budget could be made to save at least Somerset Hospital. But their plans — for which they got "significant endorsement" from NP members of the standing committee on finance on Wednesday — were brushed on Thursday.

In a marathon meeting of the committee to discuss the budget on Wednesday, the ANC had proposed ways of saving R200m on this year's budget. The plan had been for these savings to be pumped into education.

But then they found they could save more than R250m. As Somerset Hospital was said to need R47m to avoid closure, the extra savings could be used by the provincial health department, the ANC said. At Wednesday's committee meeting, the NP endorsed some of the plans.

All parties also agreed that Somerset Hospital should not be closed and by late Wednesday the committee had drafted a report censuring Health MEC Peter Marais.

The draft report stated that the committee wanted to express concern at the way in which the business plan to close the various hospitals had been announced, as well as the implications of the closures. It recommended, among other things, that Somerset Hospital not be sold, because of the "vital geo-



**REACHING OUT FOR LIFE:** This tiny hand belongs to a premature baby being nursed in the high care department at Somerset Hospital's full neo-natal unit. "I'm just not emotionally prepared for losing my job," said Sister Wilhemina Petersen as she tenderly handled the 900gsm infant.

graphic area" it served.

But when the final report was tabled in the legislature on Thursday, no trace was left of the strong disapproval of Marais' plan, only a somewhat watered-down recommendation that the standing committee be "updated on the plan on an ongoing basis".

According to the province, Somerset Hospital was earmarked for closure because it has a "relatively high cost per patient day of R535" and Somerset patients who need sophisticated care could get it at Groote Schuur. But, according to the hospital board, the corresponding cost is R1 067 at Groote Schuur

and R499 at Karl Bremer. The hospital board says the hospital offers services and research that would be lost to the African continent if closed. It is also a good hospital for medical students doing their internship, because of the wide range of disciplines practised there.

These include:

- The maternity service at the hospital deals with 400 babies delivered there every month. They cannot be absorbed at Mowbray Maternity Hospital without extra beds and personnel, says the board.
- A neo-natal ward provides high care for 22 babies and intensive care for nine. When the *Cape Times* visited the hospital on Friday, this ward was overflowing with premature and sick infants.
- Professor Greg Hussey, a specialist in paediatric infectious diseases, heads the only infectious disease unit in the city.
- The hospital's HIV clinic is considered a vital research and treatment centre for Aids in Africa.
- The casualty department
- Facilities for intensive and high care for adults as well as a renal programme.
- A bridging course for enrolled nurses.

● See Page 9

## How R250m can be saved

AFTER doing their sums, ANC members of the provincial legislature, who at first said they could save R200 million, found they could save over R250m.

Since it was said Somerset Hospital needed to find R47m to save itself from closure, the extra savings could be used by the Health department, the ANC said.

The savings were divided as follows:

- R5m from the premier's vote, which would be used to establish cultural councils and other commissions set out in the Western Cape constitution.
- R2,3m set aside for the new ministries in the province.
- R67m from savings made in the welfare department.
- R50m saved by staggering the filling of funded but unfilled posts in the administration.
- R3m taken from the cultural affairs and environment portfolios.
- R57m savings from reduction in contingency reserve projected for 1998/99.
- R30m saving from establishment of district offices in the education department.
- R40m saving on rationalisation fund for capital works. These add up to R254,3m.

PICTURE: KIM LUDBRONK



# Partnership to bring new life to emergency system

Josey Ballenger

A PUBLIC-private partnership would breathe new life next month into Greater Johannesburg's ailing emergency management system with the arrival of 12 more response vehicles and 32 paramedics, private hospital group Netcare and its proposed partners said yesterday.

The greater Johannesburg metropolitan council, Netcare, private emergency service insurance division EuroAssist, cellular telephone provider Vodac and an anonymous automobile distribution company agreed yesterday to establish a not-for-profit section 1 company that would guarantee service to patients on an equal basis.

This would mean that people without medical insurance or the means to pay would not be discriminated against, said Richard Friedland, Netcare's chief operations officer.

However, the proposal would first have to be approved by the Gauteng health department, the council's section 60 committee on public safety and emergency services and stakeholders, including labour.

The new service would combine forces with the municipality's system in terms of advanced life support, training and control room operations. Paramedics would be dispatched from hospitals, rather than fire stations.

Friedland said the partners hoped to get a petrol company on board to annually contribute petrol worth about 300 000, and were open to other pri-

vate companies joining, provided they complied with certain "conditions".

Monitoring of the joint venture's response records had not yet been worked out but would be "transparent and open to public scrutiny".

He said the proposed hire of 32 paramedics would "not denude" the public service, as half would come from other private emergency management system companies, one quarter from Netcare or its partners, and the remainder would be returning to the industry. If the project did not work out after a three- to six-month period, the paramedics would remain government employees.

Hilow Maeko, strategic executive for the municipality's public safety and emergency services, said the moratorium on filling the 300 other paramedic vacancies was still intact as the municipality had "no finances to support" additional capacity, which had stymied emergency response time.

The goal was to bring response time down to a respectable 12 minutes or less, as opposed to the current record of up to one hour. Paramedics in response vehicles, rather than ambulances, are usually the first to arrive on an accident scene and are responsible for stabilising patients, the most critical factor in their survival.

Maeko said that if the partnership worked, the municipality would hope to get additional staff for its ambulances. The local authority has only 36 to 40 operating on most days due to lack of funds.



Netcare chief operations officer Richard Friedland, left, speaks to journalists in Sandton yesterday about a proposed public-private emergency management service. In the background is the Greater Johannesburg metropolitan council's Hilow Maeko, strategic executive of public safety and emergency services. Tumelo Matsisi, top right, the CEO of labour federation Cosatu's investment arm, Kopano Ke Matla, and Adriaan Jacobsz, bottom right, CEO of Netcare's trauma division, are also to be involved in the joint venture.

Pictures: ROBERT BOTHA



# Somerset staff vow to stay

## Province closure plan illegal, says union

ARG 31/3/98

(98)

GLYNNIS UNDERHILL  
SPECIAL WRITER

Hundreds of staff at Somerset Hospital are refusing to take voluntary severance packages and say they will continue to turn up for work on full pay if the hospital is closed.

"This proposal stinks. Last year some staff applied to take voluntary severance packages, but were turned down by province. Now all of a sudden they want to declare us supernumerary and for us to take packages. They will have to keep paying our salaries. We won't go," said Reggie Daniels, chairman of the Hospital, Personnel Trade Union of South Africa (Hospersa).

The Western Cape Health Department had failed to consult or adhere to the Labour Relations Act before threatening to close five leading hospitals by July 1, he claimed.

The department has presented the five hospitals, Valkenberg, Somerset, Nelspoort, D P Marais and Westlake - with a business plan outlining its attempts to make up a R284-million shortfall in the health budget.

Edward Lotz, superintendent of Somerset, said he was not consulted by the department before the business plan was drawn up.

None of his 800 staff had applied for voluntary severance packages after the release of the plan.

"Province cannot dismiss staff. There is no retrenchment package negotiated with the organised labour unions. If you declare staff supernumerary you have to have vacant positions for them, but the Health Department intends decreasing staff by 3 800. There are no vacant posts.

"It has got itself into a tremendous pickle, because its plan is not

implementable," Dr Lotz said.

However, health authorities were anxious to emphasise yesterday that the plan was "not carved in stone".

Johan Smit, spokesman for provincial Health Minister Peter Marais, said the business plan was part of the consultation process.

"We are still waiting for proposals from all roleplayers. The process is going on until the second week in April.

"What nobody understands is that we had to prove to (Finance Minister) Trevor Manuel that the finances of this province are not beyond redemption. This is a business plan put together in a short time and the final plan will be the result of the input of all players in health."

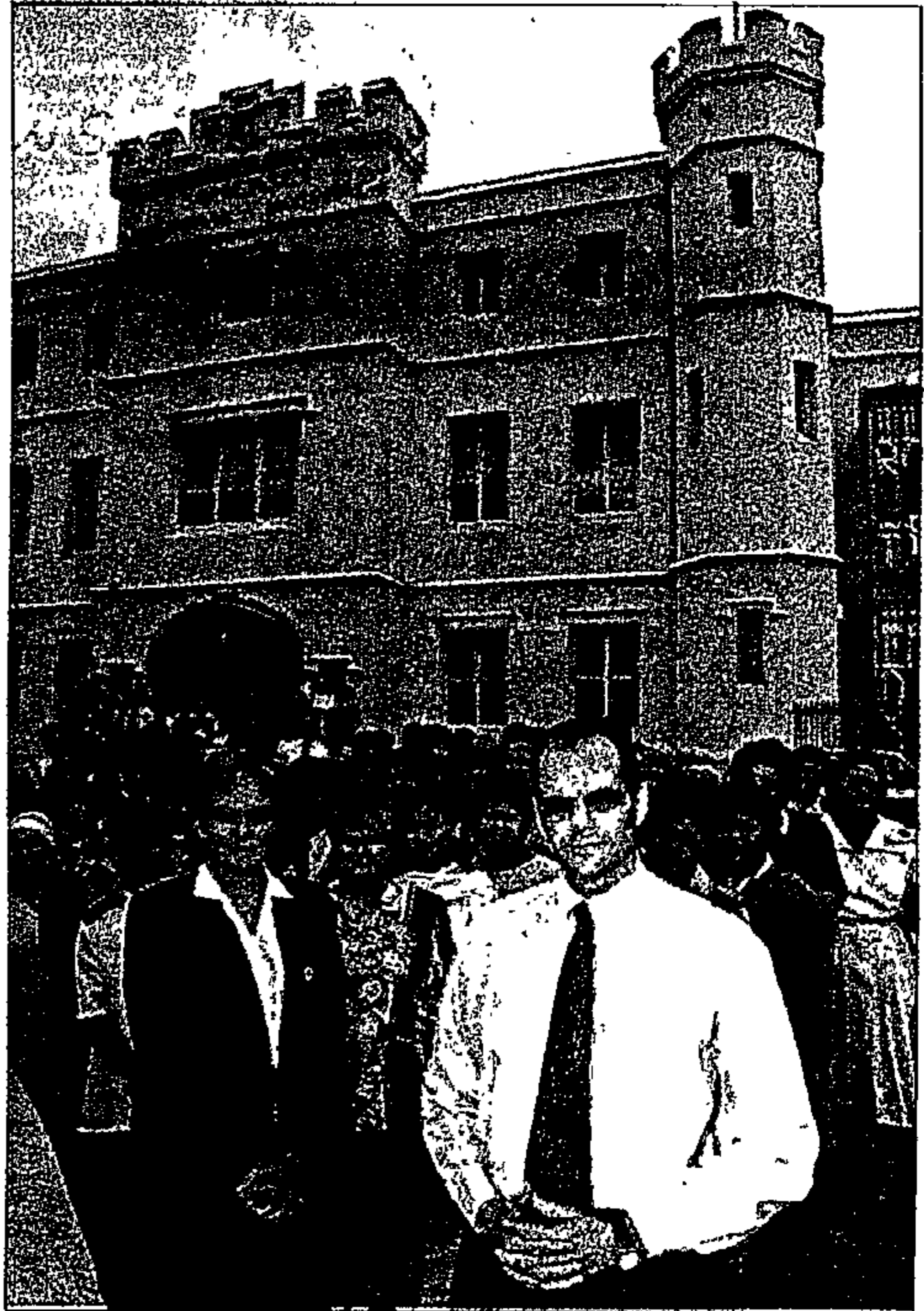
Mr Smit insisted no HIV or any other patient would be left in the lurch. The plan had been compiled in a rush as the department had only three days to react to the budget.

The hospital superintendents were part of the consultation process as they had been handed the business plan and had two weeks to come up with suggestions, he said.

"These are clever people. They don't need months to consult. They are so intensely involved with the hospitals. They know where to save money," Mr Smit said.

Meanwhile Dr Lotz is desperately trying to come up with a plan in a week to prevent closure of his hospital.

"As head of this institution, I still haven't been officially invited to make any other alternatives to this proposal. All that I am going to do is make them aware of the unimplementability of this plan and the absolute devastating and crippling effect it will have on health services," Dr Lotz said.



ROY WIGLEY

No deal: Edward Lotz and staff at Somerset Hospital who won't take packages



## Fick throws cold water on ANC's savings proposals

KARIN SCHIMKE  
POLITICAL WRITER

CT 31/3/98

(98)

THERE is no extra money to be squeezed out anywhere in the Western Cape budget to help save Somerset Hospital, despite the African National Congress' suggestions, Finance and Agriculture MEC Lampie Fick said yesterday.

He was responding to the ANC's plans touted last week during a committee meeting to review the budget for the coming year.

The ANC suggested that over R250 million could be siphoned off other budget allocations to give a R200m boost to education and a R50m boost to health.

But Fick said: "None of the ANC's plans are practical.

"We welcome any suggestions and plans on how to save Somerset and Mr (Peter) Marais has made it clear that the plans have not been finalised. But there can be no overspending on the budget this year. That is final, final, final."

The ANC had suggested that a R67m saving made in the welfare department be used for education and health, but Fick said this money came from the child allowances and was cancelled out by the increase in the old-age pension budget.

As for suggestions that unfilled posts in the administration be filled in stages to make savings of around R50m, Fick said the filling of the posts was already being staggered as far as possible.

There were 1 300 unfilled posts, but if these were left vacant for the rest of the year it would be "no new income-generating systems, no maintenance of roads, schools, hospitals and clinics".

The ANC also said last week that R57m of the R115m contingency reserve could be skimmed off for savings, but Fick said this was impossible.

The contingency reserve was to be used to repay the province's deficit.

If the province failed to repay R100m of this, the budget would not be certified by the national government and the province would lose out on a R270m bonus.

The R40m the ANC suggested could be saved on rationalisation of office accommodation would also be senseless, said Fick, since it was being used to move staff into government offices in an attempt to cut down on the almost R50m paid out in rent every year.

"There are almost no chances of any savings in this year's budget," he said.

## EXPERTS WORRIED

# Disease unit may be lost for ever

(98)

IF SOMERSET HOSPITAL goes, then it's infectious disease unit goes — and therein may lie a danger, warn experts. Metro Editor **CLAUDIA CAVANAGH** reports.

CT 31/3/98

SOMERSET HOSPITAL'S world renowned children's infectious disease unit has felt the squeeze since the beginning of the year — but if the hospital closes it will cease to exist altogether, say experts.

This follows the release of provincial Health Minister Mr Peter Marais' business plan two weeks ago, suggesting the closure of Somerset and Valkenberg Psychiatric hospitals to offset a R284-million deficit for the year.

And while the province has stressed that all services affected will be absorbed by other hospitals and clinics if a way to save Somerset is not found, this won't be an easy task.

"It will be extremely difficult to absorb the infectious diseases unit into another hospital because of the constraints on beds all round," said head of department Professor Greg Hussey.

Somerset Hospital has the only paediatric isolation unit in the region.

"If Somerset closes, there will simply be no infectious disease facility in the Western Cape."

Hussey, a consultant to the World Health Organisation on the management of communicable paediatric diseases, says that besides caring for sick children, the unit provides an important research and teaching component.

"We do a lot of very relevant work on the effect of nutrition on disease.

"This is borne out by the fact that I've been invited to present papers on a variety of subjects all over the world."

Undergraduate and postgraduate doctors are trained through the facility, as are provincial primary health care sisters.

"The unit has developed a sound reputa-

tion both nationally and internationally — we take at least one call a day from health care professionals in other areas wanting advice on an infectious disease."

In the past, the community referred all cases requiring isolation to Somerset.

Because of financial constraints though, this service was closed to other hospitals from the beginning of the year.

"So now a sick child will be kept at its base hospital — whether there are adequate isolation facilities there or not.

"This obviously carries a risk of transmitting the infection to other children in the hospital," said Hussey.

Although improved living conditions and immunisation coverage have led to a decline in the prevalence of children with infectious diseases over the years, cases of typhoid, meningitis, hepatitis, measles, dysentery, TB and chicken pox still occur.

"As people stream into the Western Cape from other areas where immunisation coverage is not as high, chances are that the incidence could increase.

"And because we've improved measles immunisation coverage doesn't mean we won't have an outbreak in the next few months. If this occurs and we have no Somerset Hospital, where will these children be cared for?"

● A delegation from Somerset Hospital will meet provincial authorities today to present their plans for saving the hospital.

"This is a continuous process of negotiation and whatever happens we'll make sure that services affected — like Somerset's HIV clinic — are still delivered," said a department spokesperson yesterday.





# Private-sector plan to boost Jo'burg's emergency services

BY LEE-ANN ALFREDS  
City Desk

A private-sector proposal heralded as the solution to Greater Johannesburg's emergency services crisis is months away from being implemented, with the approval of the trade unions and other stakeholders still in the balance.

A private consortium headed by Netcare proposed yesterday that the Greater Johannesburg Metro Council combine resources with the private sector and set up a not-for-profit company to boost the region's paramedic and ambulance service.

In terms of the proposal, the consortium – which includes Europassist, Vodac, a vehicle company and a petroleum company – will inject money into the project to supplement the municipalities' staff, vehicles and equipment.

The money from the consortium will be used to appoint 32 paramedics and more vehicles.

The consortium's offer follows warnings that Greater Johannesburg's emergency services are on the verge of collapse because of a moratorium on the recruitment of medical personnel. Only half of the city's 25 ambulances and 11 response cars in working order

can be manned because 330 posts have not been filled.

Netcare trauma division chief executive officer Adriaan Jacobsz said the proposal would cover all residents – even those who were indigent.

Netcare has predicted that the venture could receive the go-ahead for implementation in about three weeks, but Greater Johannesburg public safety and emergency services head Hilow Maeko has indicated it could take much longer.

Maeko said he would be meeting the Gauteng health department on Friday or Monday to get approval for the proposal. If approved, the proposal would

be submitted to the council's Section 60 and executive committees on April 20 and 21.

After this, the council would still have to consult the trade unions and other "stakeholders", Maeko said.

Independent Municipal and Allied Trade Unions spokesman Ben Kotzë expressed concern about the proposal. He said while it was difficult to comment without having been consulted, the union would want several assurances before they approved of the proposal.

The South African Municipal Workers Union was not available for comment last night.



# Court told of unfair advantage

**RONALD MORRIS**  
JUSTICE WRITER

PUBLIC interest demands that a proper tendering process be followed in deciding who should operate a private hospital at the now defunct Volks Hospital, the High Court was told yesterday.

This was said by Mr Marius Scholtz, SC, counsel for Clinic Holdings Limited, and Gauteng businessman Mr Barney Hurwitz, in an application to review and set aside a decision by the Western Cape government to accept a tender of R15 million by the rival Medi-Clinic Limited for the Volks Hospital complex.

Clinic Holdings, who

offered R12,5m, complained in papers that the tendering process for Volks Hospital was neither fair nor competitive and that prospective tenderers were not informed that a private hospital licence had been approved in principle before tenders were called for.

Had prospective tenderers been informed that an additional private hospital licence would be allocated to the successful tenderer, much wider participation in the tendering process would have resulted and much higher tender amounts would have been offered, the court was told.

Evidence is that last September the province invited tenders for the sale of Volks. Clos-

ing date was September 27.

A special condition was that tenderers must assure themselves that they can obtain a licence to operate a private hospital and that Provincial Administration is not bound to accept the highest offer.

These conditions and the restrictive condition that Volks be used as a hospital for 15 years is of special significance because of the moratorium on the issuing of private hospital licences which existed at the time Clinic Holdings submitted its tender, the court was told.

Hurwitz said in papers that the tenders were not opened simultaneously and no explanation was given. When the province's Tendering Commit-

tee met last November 12 to consider the tender, the only issue which appears to have concerned it was the price for which Volks should be sold.

The fact that Medi-Clinic appears to have been aware that an additional private hospital licence was to be made available, gave it an unfair advantage in the tendering process, the court was told.

Scholtz, with Mr Colin Kahmovitz, instructed by Mallinicks Inc, appeared for Clinic Holdings. Mr Peter Hodes SC and Mr Rudy van Rooyen, instructed by the state attorney, appeared for the Western Province government. Mr Willie Burger, SC, and Mr John Dickerson, instructed by Hofmeyr Herbsteins Gihwala and Cluver Inc, appeared for Medi-Clinic Holdings.

# Somerset interns could take legal action

**CLAUDIA CAVANAGH**

DOCTORS doing their internship at Somerset Hospital will take legal action against the province if the hospital is closed and their contract breached.

This follows the recent release of plans to close the historic hospital, as well as Valkenberg Psychiatric Hospital, in an attempt to offset a R248-million provincial health deficit.

But besides the obvious loss to the community should the hospital go, 14 interns' lives, and their training, will be severely disrupted.

One of them, Dr Leigh Gor-

don, explains: "Our contract with the Western Cape Department of Health says that in the event of rationalisation, we may be rotated through, or transferred to, other hospitals, specifically in the Metropolitan area.

"But at present, we know that there are no available intern posts at any of the hospitals in this area. Thus in closing Somerset, there will be a direct breach of contract."

Somerset Hospital, she said, was particularly sought after by interns.

"It's a secondary hospital so

one can be sure of getting more hands-on experience and doing a lot more surgery than at Groote Schuur, for instance.

"All the disciplines are available here too. We get to do all our medicine, surgery and paediatrics right here, with an option of doing obstetrics and gynaecology afterwards as Senior House Officers."

She also pointed out that this year's fifth-year medical students had to submit their applications for internship by last Friday.

"If they've put down Somerset and it closes, they'll have

nowhere to go. But on the other hand, if no one chose Somerset because they're afraid it's going to close, then the hospital will have no interns next year if it is saved."

Gordon has appealed to the Medical Association of South Africa for help and Mr Peter Brewer of Masa's legal department is addressing the issue.

● A public meeting regarding the proposed closure of Somerset Hospital will be held in the City Hall today at 1pm. Provincial health department heads and the MEC for health Mr Peter Marais have been asked to attend to answer questions from staff and members of the public.





# Nelspoort fights for life

## End of road for hospital town

(98) AR4 2/4 198

The wooden floor of the Nelspoort community hall rocks with dancing and hundreds of people sing freedom songs and toyi-toyi. The mood is passionate, sad and angry at the same time.

It could have been a scene in South Africa 10 years ago, only today the struggle is a different one.

The community of Nelspoort is fighting for its survival.

Nelspoort is a small Karoo hospital town 52km past Beaufort West on the way to Three Sisters.

### COMMUNITY WALL



#### SPECIAL REPORT

For 74 years, it's been a place of healing, a hospital and rehabilitation centre, first for TB patients and now also for psychiatric patients.



OBEID ZILWA

Save our town: Nelspoort's people in full swing at a public meeting



OBEID ZILWA

Past its best: Pastor Jim Dick at the disused dairy on the once-thriving farm. The community says the farm must be part of their plans

Two weeks ago, the community heard the hospital was earmarked for closure by July 1.

The hospital is the only employer of people in the town of about 1 000 people and, without the hospital, the town's future is uncertain.

It was not the first time people had heard the hospital was to close, but the three-month deadline was a shock.

Last year, former health MEC Ebrahim Rasool visited the town and broke the news to them. But he'd agreed to phase the closure over three years to allow the townspeople to set up alternative employment.

Then followed a delegation of provincial ministers and a Cabinet committee was set up to look at ways to save the town.

The first step would be to make Nelspoort a town with its own council. Nelspoort and the houses in which people live are owned by the Department of Health. Until the town has its own council, no one can own land or set up businesses.

Peter Marais, former minister for local government and now provincial health minister, said he would report back to the people of Nelspoort on the matter in January.

In the meantime, the community formed an accredited RDP (Reconstruction and Development Programme) forum with representatives from the school, the civic association, the hospital, police, political parties and pastoral committees.

They waited for the cabinet committee to report back. Nothing happened. Then they heard the hospital would close in three months' time.

People are angry, they feel betrayed. Hands outstretched to the provincial delegation at the community hall meeting, they sing "Senzinina, what have we done? Help Nelspoort, make a plan."

Nelspoort needs a plan. It's a close-knit community where people are warm and welcoming to strangers, political differences are tolerated and people live in peace. This closure affects us all, I'm told,

this is not about ANCO/NP. While it has its share of unemployment, people do not want to leave.

"We'll stand firm. We won't leave," says Klaas Jonas. "Where must we go? Here we treat each other humanely, not like in Cape Town. Our parents and grandparents are buried here."

This is a largely religious community of about "10 or 12" denominations which share the (formerly Dutch Reformed) church building for weddings and funerals.

People sleep with their doors open, it's a safe community. The local policeman confirms this.

Three years ago, the run-down school was upgraded, and a 200-bed hostel was built for the children of the surrounding farm areas.

Now the blue, green and beige buildings stand out in the dusty town, a facility of which many other communities would be proud.

School teacher and RDP forum chair Juliet Jonas says she came to Nelspoort eight years ago because it was the only one of eight posts she was offered that she wanted.

"It is the safest and healthiest community I've ever lived in," she says. "We are very sad about this. They've said they'll give us houses, but what's the use of houses if you can't feed your kids?"

The RDP forum has plans for the town. They want to build a business centre and a bakery, and get the farm, which was originally part of the hospital working again. But first, the town must have its own council.

The farm is an important feature of the town, and many talk of the golden days when it supplied the hospital with milk, meat, vegetables and fruit. Patients and townspeople worked there and the farm flourished.

Then the Department of Agriculture took over its management and said it was not viable to run. Livestock was sold off and today all that remains of the farm are empty buildings and a flock of sheep, which is also due to be auctioned off.

Jim Dick, now 60, was born on the



OBEID ZILWA

Hospital stalwart: Matron Cathy Sprinkle, "ma" to many of the psychiatric patients

farm. He remembers the days of a dairy, an apple orchard, vineyards. Water comes from a strong spring in the nearby mountain and he says the water made the vegetables sweet.

He and others are adamant that the farm is part of the town, and

should be included in future plans.

The community of Nelspoort is not sitting back. The hospital is an integral part of their life, and closing it is like removing a pillar of a building without first shoring it up with another support.

They have decided to fight against the decision to close the hospital in July and are determined they will succeed.

There must be hope, they say. This is not about saving a hospital, but about saving a community.



# Shocked staff ask who will care for their patients now

ARLT 2/4/98 (98)

JENNY VIALI

Nelspoort Hospital is a large, sprawling one built as a TB sanatorium in the 1920s, in the days when the "mountain magic" cure of clear, dry air and rest was the most that could be offered to patients with what was then called "consumption".

Much has changed over the intervening 70 years, and while there are still 28 tuberculosis patients at Nelspoort, it is now largely a haven for chronic psychiatric patients.

Cathy Sprinkle is matron at the hospital and "ma" to most of the 118 psychiatric patients, many of them older than she is. The trend in psychiatric care is for people to live in the community, but 74 of these people have no contactable family members.

"Anyway, we don't expect families to care for these people, they're institutionalised and couldn't survive out there. There's one man who's been here for 35 years," she said. The community is closely connected with the hospital, and when a patient dies, the community buries them. "We are their family."

At present, there are 28 TB patients at the hospital from all over the country. Three of them are children. Their stay here is anything from four months to a year, and mostly they have drug-resistant TB or are HIV-positive.

The proposed closure of the hospital by July 1 has come as a shock to staff. "This is an autocratic decision from the top," said Ms Sprinkle. "We're in the dark about what will happen to patients and staff."

The hospital employs 143 people, most of whom live in Nelspoort. The health department business plan proposes that staff will be "reduced" by 126

and the rest will be transferred to nearby Beaufort West.

"There's a lot of tension among staff," said Ms Sprinkle.

"A lot have gone onto anti-depressants. I lie awake at night, worrying about what will happen," she said.

Ms Sprinkle has not been told where patients will be moved if the hospital closes, but Lentegour in Mitchell's Plain and Stikland in Bellville are the likely options for psychiatric patients.

Gideon Rittels, who works as stores manager at the hospital, said the news shocked him. "I was born in Nelspoort and worked at the hospital for 24 years. When I heard, it was as though someone held a revolver to my head, as though someone wanted to shoot me, my wife and children."

"Close the hospital and the community will be crippled. People will leave to look for jobs, the school will run empty," he said. Nurses say they face a dilemma: they don't want to ask for transfers, because that will make it easier for authorities to close the hospital.

"On the other hand, we have to think about ourselves, plan our futures. Other staff don't have the choices we have. If we go, it makes it bad for others," said one nurse.

Afrika Spogter has spent 20 years in the work therapy department at Nelspoort hospital. He's taught thousands of patients the potting skills he's perfected, and he's seen people support themselves with these skills once they've left the hospital. His main concern is what will happen to patients.

"These are our children. Their own people don't care about them, we do."

Staff at the hospital realise the hospital will be closed at some stage. All they want is some certainty about their future.



4 000 COULD FACE THE CHOP

# Delays may mean loss of salaries

CT 2/4/98

(98)

A MEETING is told that the department of health may not be able to pay salaries unless a controversial plan is implemented. Metro Editor **CLAUDIA CAVANAGH** reports.

ELAVS in implementing the provincial health department's controversial business plan could mean "that we won't be able to pay salaries later in the year", the department's Dr Gilbert Lawrence warned health workers yesterday.

Nearly 4 000 people will lose their jobs and Somerset and Valkenberg hospitals will close if the plan goes ahead unchanged.

Both hospitals now have only one week left to come up with alternative proposals or face the chop in July.

Addressing a City Hall packed with angry workers, doctors, nurses and members of the public protesting against the proposed closure of Somerset Hospital, Lawrence pointed out that the health department faced a R284 million budget deficit from yesterday, April 1.

"The longer we take to address the problem, the worse it will become," he said.

Numerous speakers said they believed Somerset was targeted not because it was expensive to run, but because the property was extremely valuable.

"I urge you all to reflect any Waterfront proposals to develop Somerset," said Mr Ismael Achmat of the Bo-Kaap Residents' Association, to rousing applause.

Dr Elaine Clarke, chairperson of the Dispensing Family Practitioners Association, said the develop-

ment of District Six would bring thousands of people into the Somerset catchment area.

"As a community activist I know that there is some sort of vested interest in the proposals. The ground is extremely valuable and I question the motives of the province in trying to sell it. We will see to it that no development of that land ever benefits the rich. The hospital will always remain the property of the people," she said.

Clarke, a doctor in the area, says Somerset is the only hospital in the City Bowl which meets the needs of the poor. She did most of her training there and had two babies and a number of operations at the hospital. "Somerset taught us as students that patients are people not just numbers," she said.

Lawrence said his department was "most unhappy" with the fact that its "good three-year health plan" had been "cut through" by budget constraints.

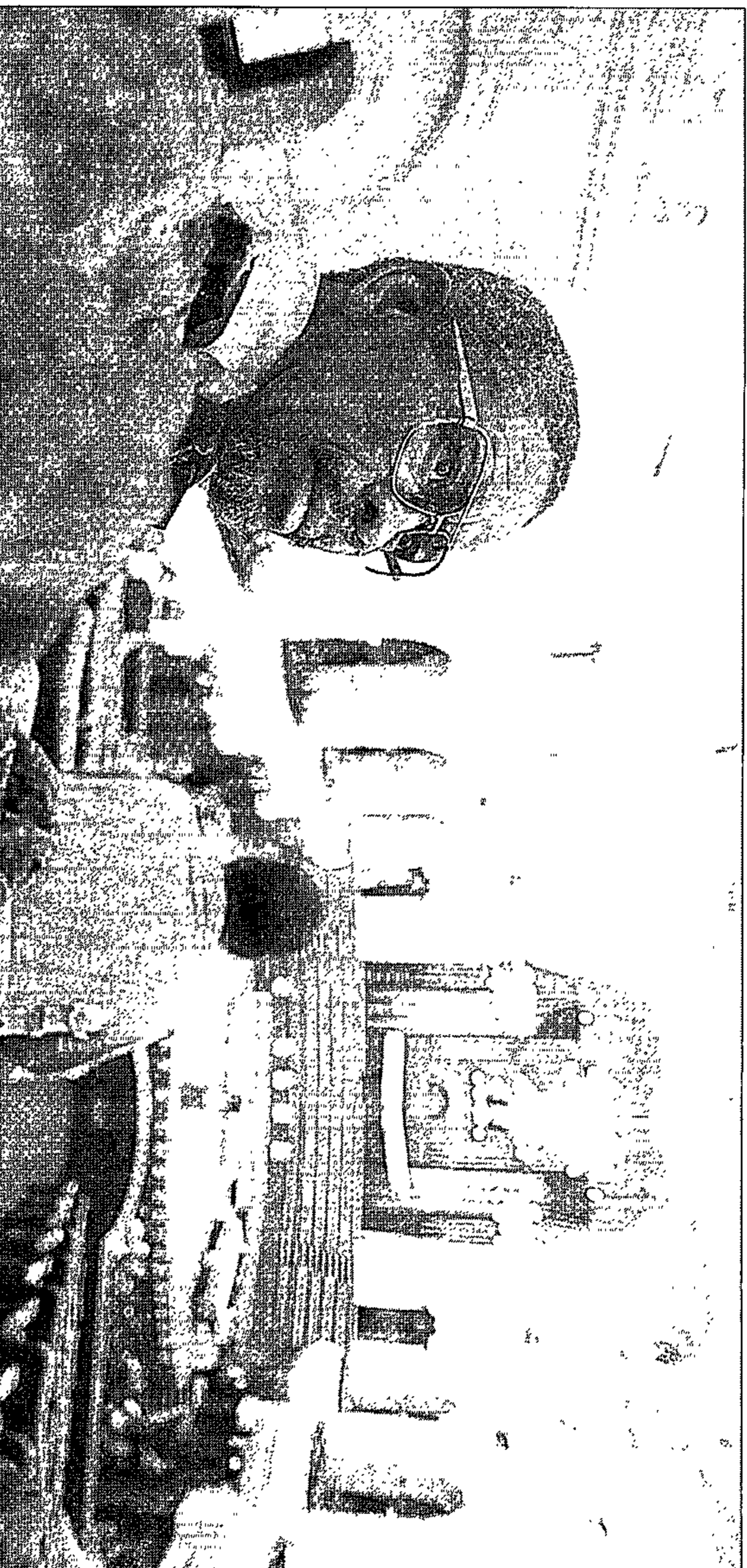
"The irony of the matter is that we believe we'll actually be in a better situation in year two and three. The tragedy is that the dip this year and the implementation of the proposals (to close hospitals) will damage our health services," he said.

"If that's the case, why suggest closing Somerset Hospital in year one?" Democratic Party provincial spokesman on health Mr Daniel

Sluke asked. "In year two or three you'll have more money but no Somerset Hospital for the people of the Cape Peninsula."

Lawrence said that if "the worst came to the worst" and the hospital closes, certain services like maternity and the neonatal unit will be relocated to other hospitals.

"It would certainly be more difficult for people to benefit from the health services. None of us like that but that's the inevitability."



**WHERE TO NOW?** Danny Mashabe is homeless and makes his living selling copies of the Big Issue. He and his wife have been treated at Somerset Hospital several times since 1968 when they came to Cape Town from Bloemfontein. "It will be just terrible if it closes, for the whole Peninsula, for the whole country," he told yesterday's public meeting at the City Hall.

PICTURES: GARYN STEAD

## Support grows against Somerset closure

CT 2/4/98

(98)

THE following groups have pledged support to the newly formed Community Against Hospital Closure:

- The District Six Civic Association: "These facilities are sorely needed now and in the future, especially when thousands are returning to the city centre. We believe the decision is motivated by greed rather than need."
- The ANC: "We cannot follow a real estate approach and rush to sell off the crown jewels. Is the real

reason for the imminent closure of Somerset that a developer has already persuaded the province to sell?"

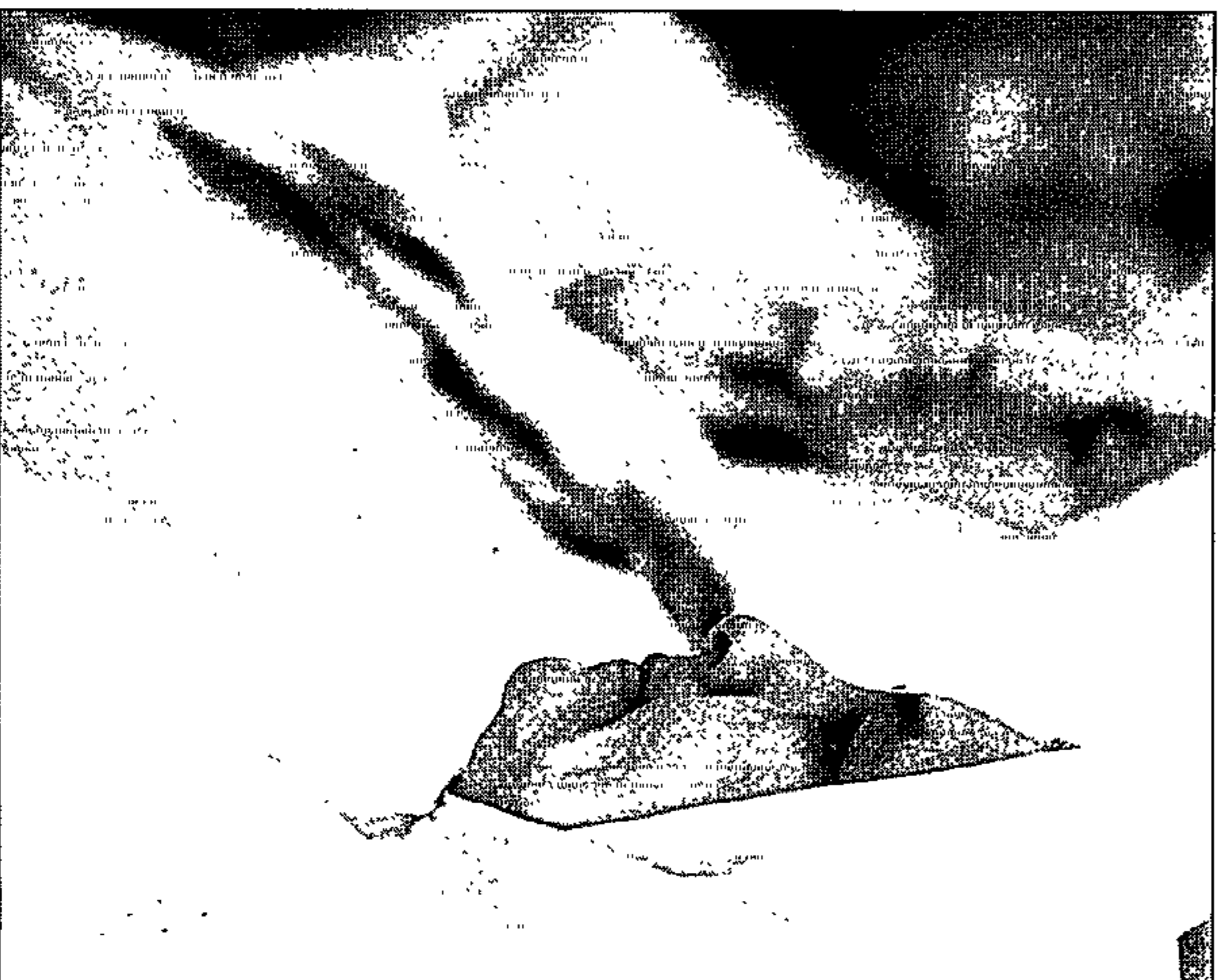
- The Medical Association of South Africa and the Full Time Medical Staff Association: "... support the campaign against the closure of Somerset Hospital."
- The Democratic Party: "The proposed closure will not only be a severe blow to health care for tens of thousands of residents of the Atlantic seaboard who cannot

afford private health facilities, but will also affect many patients from less advantaged areas who make regular use of the hospital."

- The Dispensing Family Practitioners' Association: "Somerset has always served the less privileged communities of Cape Town. The authorities should consult them before making decisions which will adversely affect them."
- The South African Academy of Family Practice/Primary Care: "We feel this will compromise the

provision of health care to the poor and under-served."

- The National Medical and Dental Forum: "There should be a proper process of consultation with local community leaders with regard to any change or reduction in the delivery of health services to our communities."
- The Democratic Nursing Organisation of South Africa: "Denosa will consider legal action if the employer proceeds unilaterally in this matter."



**BEEN THERE BEFORE:** Sharifa Dawids, a former resident of District Six, has lived through one forced removal and has pledged her support to Somerset Hospital's fight for survival.



# Hundreds join hospital fight

## *'Closure of Somerset a ploy to get money'*

(98) ARG 2/4/98

JENNY VIAL  
HEALTH REPORTER



Medic alert: doctor and community leader Elaine Clark addresses the City Hall meeting

Hundreds of people attending a spirited public meeting added their voices to protests at the proposed closure of hospitals in the Western Cape with a call to keep Somerset Hospital open.

Elaine Clark, chairwoman of the Dispensing Family Practitioners Association, told a packed City Hall that Somerset was the only hospital in the city bowl area serving people who did not have medical aid. It would not be allowed to close.

She said the closure was part of the structural adjustment programme imposed on South Africa by the World Bank and International Monetary Fund which told governments of poor countries to cut spending on health, welfare and education.

"We say to Mr (Peter) Marais (MEC for health), the National Party and the ANC, we will not easily lie down and see you close Somerset Hospital. We will see to it that no development takes place there that will benefit the rich."

Gilbert Lawrence, director of supra-regional hospitals in the provincial Department of Health, told the meeting

the department had been told by the national and provincial finance departments that they had to keep within budget this year and the R284-million deficit could not be extended over three years.

He said the department's highest costs were staff and it had to reduce the staff bill and beds by July 1.

"We are most unhappy about the impact this will have on health services."

John Frankish, the department's head of health for the Cape Town metropolitan area, said if Somerset were to close certain services would have to be replaced.

"We would have to have a 24-hour primary care clinic in the area. Maternity would have to be replaced at Grooté Schuur and Mowbray maternity hospitals. There are plenty of empty beds, the problem is staff."

People at the meeting suggested that the proposed closure of Somerset was an excuse to sell and make money out of prime land opposite the Waterfront.

They called on Mr Marais to maintain the hospital as a much-needed facility for the poor people living on the Atlantic seaboard, in the city bowl and along the West Coast up to Atlantis.



Mass backing: a spirited crowd turned up in support of the drive to save Somerset Hospital



# Somerset weighs private venture

ARG 3/4/98

(98)

**JENNY WALL**  
HEALTH REPORTER

**Health officials and hospital superintendent Edward Lotz are checking proposals to make Somerset hospital a facility catering for both private and public patients.**

Dr Lotz said Somerset hospital could not stay unchanged. A facility was needed in the area, there was a shortage of funds and the Somerset site was valuable.

"I foresee a public/private venture," said Dr Lotz, but could not elaborate on proposals

put forward by private health care companies.

The public/private venture would probably mean a private company would buy or lease the hospital and would be required to provide a certain amount of beds to the public who could not afford private care. "I definitely see the hospital changing," he said.

This would mean the services and site would have to be consolidated and its teaching function would have to be shared with other regional hospitals. Cheap accommodation for 200 staff at the hospital would no longer be provided. He said the hospital

needed about half the present site to run the hospital and the other half would probably be leased or sold.

"I would suggest the north block stays. In 1981 R90-million was spent on renovating that section for use as a hospital for the 21st century.

"Also, there's the historical aspect. Somerset was the first teaching hospital in Cape Town and I think it needs to remain part of health care."

Dr Lotz said the outpatients section would move to a community health clinic already planned for Sea Point.



# Western fight against Cosatu strike looms over teachers, SA

THABO MABASO  
BUSINESS REPORTER

Thousands of workers are ready to down tools on April 21 when the Western Cape branch of the Congress of SA Trade Unions stages a 24-hour strike over the province's plans to axe teachers and hospital staff.

Cosatu provincial secretary Tony Ehrenreich said today the decision at a meeting last night would be reversed only if the province put its cutback plans on hold.

Cosatu affiliate unions in the Western Cape claim more than 300 000 members.

Mr Ehrenreich said if the Western Cape government was prepared to rethink its budget strategy, Cosatu would also be prepared to make an extra effort.

"If we see a commitment from the provincial government to redress the disparities between black and white education, for instance, we will discuss with our members the possibility of working on a public holiday," he said.

"But the government would have to see to

it that our taxpayers' money was being directed towards addressing these backlogs in education."

Cosatu wants Premier Herinus Kriel's government to budget more money for education and health care.

The federation's ire was raised in February when the provincial government refused to take up an offer by Finance Minister Trevor Manuel of a grant to cash-strapped provinces provided they opened up their books for scrutiny and undertook to manage their finances better in future.

PRG 314/98

Mr Manuel set aside R1,5-billion for conditional grants to struggling provinces.

The Western Cape government decided not to apply for any of this money, arguing that this would put the province under "judicial management".

Finance Minister Lampie Fick has also said the money was intended as a loan, not a grant, and would have had to be paid back.

Three of Cosatu's largest affiliates in the province, the Southern African Clothing and Textile Workers' Union, the National Union of Metal Workers of SA and the

National Education, Health and Allied Workers' Union, have already given their backing to the April 21 strike.

Mr Ehrenreich did not rule out the possibility of other trade union federations joining the protest action.

The decision comes after the failure of talks in the National Economic Development and Labour Council.

Under labour legislation, Cosatu members may only strike if all attempts to resolve the dispute with the province have been exhausted.

hospitals (98)



# R95m Somerset (98) tender in waiting CT 3/4/98

DAN SIMON

ONE of South Africa's richest property companies, Seeff Holdings, has prepared a R95-million tender for when the Western Cape government decides on the future of Somerset Hospital.

And contrary to rumours, the Western Cape government yesterday said it was not prepared to sell off the hospital or any other buildings or vacant portions of the approximately 68 000 square metres of prime land, on which the hospital is situated near the V&A Waterfront.

Instead, the provincial government would favour a lease agreement as the land was simply too valuable to sell, an MEC said.

How valuable? According to a

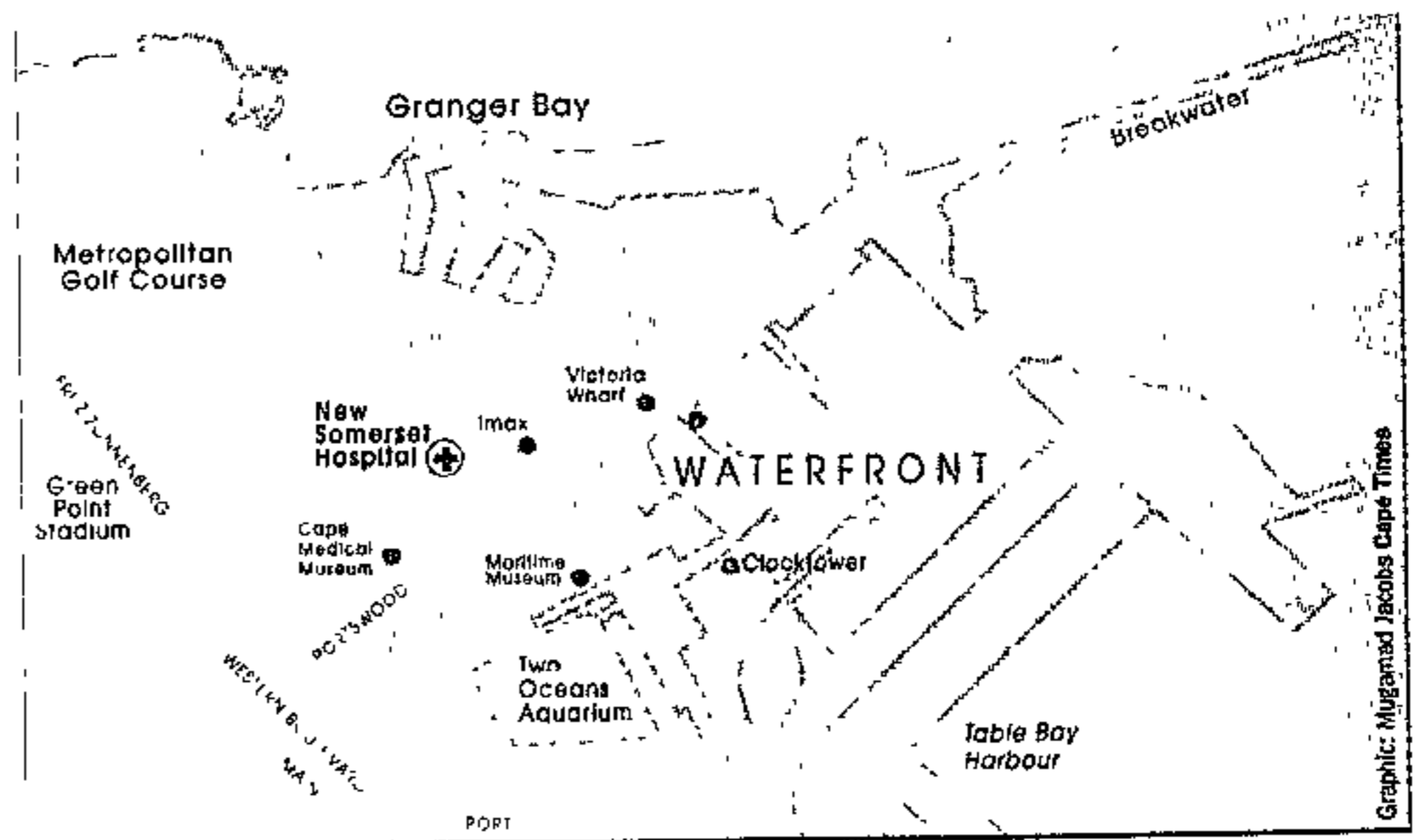
property valuator it would "take days" to determine.

One would have to look at "comparable sales" and then determine a price at which each square metre would sell if the land was used for residential or commercial purposes.

Estimates ranged between R4 000 to R7 000 a square metre.

But Western Cape MEC for Asset Management Michael Louis said if the government made a decision, it would prefer to negotiate a lease agreement and utilise a portion of the money tendered for the land to build a hospital in a needy area.

"The Land Administration Bill makes provision for a capital account to be utilised for infrastructure," said Louis. "I wouldn't



mind getting R100m (from a tender) and use R50m to build a hospital in say Athlone and place R50m in the capital account."

Dr Alan Louis, managing director of Seeff Commercial Properties, said his company was "seriously looking" at tendering for 43 000 square metres and had updated a two-year-old tender proposal should the government make a decision on its future.

Louis said it was the most

sought-after piece of land in Cape Town.

"We know that the government has been looking for alternatives for two years as the hospital is costing it a lot of money. We prepared a tender two years ago and just updated it. What makes it expensive is that it is raised land," he said.

But the future of the hospital is far from decided. The medical

□ Turn to Page 3

# R95 million (98) tender in CT 3/4/98 the waiting

□ From Page 1

superintendent of Somerset Hospital, Dr Eduard Lotz, this week submitted a proposal to Western Cape health MEC Pieter Marais to ensure the hospital remained open through consolidation of services.

Apart from Somerset Hospital, four other hospitals on the Cape Peninsula have been earmarked for closure because of budget cuts.

The proposal was submitted ahead of a deadline proposed by Marais for submission of alternative plans to save the hospital and "was favourably received," Lotz said yesterday. The proposal dealt with two concepts, service consolidation and site consolidation.

Service consolidation entailed outsourcing certain services, including teaching, which should be shared more equitably with other regional hospitals.

As for site consolidation, Lotz said: "We don't need 68 000 square metres to run a hospital. There is a lot of land with buildings which are not used here."

"Implementation of our proposals will result in both considerable savings and in generation of substantial income.

"The net effect is that we will be able to continue to provide health care services to those sectors of the community where they are most needed."



# Let's get Doti about health drive

# UCT will fight closings of hospitals

CLAUDIA CAVANAGH

MS Doti Mukwa's health problems are about to become a matter of public scrutiny — and it's a good thing, too.

For Doti is the star of a series of three illustrated pamphlets and three 15-minute radio "documentaries" in a campaign with the slogan "Move-it-for-a healthy future!", which will try to explain the intricacies of the Western Cape health department's District Health System (DHS), a new plan to bring more effective and equitable health care to the province.

The DHS is based on the tenets of Primary Health Care, which is designed to provide better health care generally, take pressure off hospitals and contain costs by having patients regard clinics or community health centres as their first stop when they need treatment.

Some 450 000 pamphlets, will be distributed from April 9 through hospitals, clinics and community health centres. The docu-dramas, as well as five radio spots, will run on regional and community radio stations from April 9 until the end of the month. — Staff Writer

THE University of Cape Town is set to clash head-on with the provincial department of health over plans to close Somerset and Valkenberg hospitals.

The proposals — aimed at off-setting the department's R284-million budget deficit — are "illegal", will destabilise and seriously undermine the university's world-class teaching and research base, and will be "very strongly resisted", said Vice Chancellor Dr Mamphele Ramphele yesterday.

"We must retain our world-class medical school and will use every means at our disposal to do so.

"These are national assets serving the city, the province, the country and the continent. We are committed to defend these precious and irreplaceable resources."

And, according to Ramphele, the

university has good reason to be angry. "We have held several high-level meetings with the province and other tertiary institutions where we have agreed on a set of core principles as the basis for rationalisation. The latest proposals violate these principles," said Ramphele.

In addition to closing Valkenberg and Somerset, the health department's business plan outlined a further downscaling of Groote Schuur and Red Cross Children's hospitals.

UCT would not accept the plan because it would also destabilise and seriously undermine the academic teaching and research base in the health services, and further seriously erode health services to the poor.

"There is no indication of how the remaining hospitals will accommodate

the thousands of people currently served by the institutions under threat," said Ramphele.

She said the university had clear principles for achieving "significant rationalisation" while keeping and even building quality in the health care system.

Late yesterday, the recently retired vice-chancellor of the UCT, Professor Stuart Saunders, added his stern warning to the authorities over the proposed closure of Valkenberg, in particular.

"Patients will die if the province implements its proposed cut-backs," he said. "There is a great risk that the needs of psychologically ill patients will be perceived as less critical than other patients. Acute psychological illnesses are also life-threatening. We must ensure that Valkenberg hos-



pital is not sacrificed by a poorly thought-through plan."

The former professor of medicine at Groote Schuur and current chairperson of The Friends of Valkenberg Trust, said he felt sure the officials involved knew that the goals of the proposed savings would be impossible to meet and "that patients would die as a result".

Saunders suggested alternative ways of tackling the problem.

"By the health department's own admission, the plan to close Valkenberg in its entirety would save only R8,7m, while disrupting and permanently damaging the system of psychiatric care built in this area over decades," he said.

The solution, he said, would be for the hospital to use only the new wards built in the 1980s. Most patients in need of acute care would be admitted. Most of Valkenberg's grounds could be sold or leased.



# Man dies after four days in waiting room

*Doctors at Johannesburg General hospital allegedly refused to examine a dying paraplegic patient, writes*  
**Angella Johnson**

**A** wheelchair-bound teenager died after he was found sitting in his excrement in the emergency waiting room at Johannesburg General hospital.

He had spent four days there waiting to be examined for abdominal and chest pains.

Petrus Ndlovu (19) arrived at the hospital last Wednesday in considerable distress. He was treated for bed sores and then discharged.

He got as far as the waiting room, where he was discovered by friends on Sunday, doubled over in his wheelchair. An hour later, after a doctor allegedly refused to examine him, Ndlovu was dead.

Kevin Daly, who runs a Christian street ministry in Hillbrow, is accusing the hospital and its staff of neglect and gross negligence. He says he found Ndlovu sitting in his own faeces.

"The smell was so overpowering that there was no one else in the waiting room. It was obvious to even the untrained eye that the groaning figure was ill and weak.

"He could not sit up straight in his wheelchair, so we took [him] to ward 165, where a doctor assured us he had already been treated for bed sores and discharged."

After a lengthy discussion, the doctor admitted Ndlovu had not had an abdominal examination and agreed to re-admit him.

No further assistance was offered, so Daly and a colleague wheeled Ndlovu into an examining room, removed his soiled clothing and lifted him on to the bed.

Within 20 minutes a doctor entered the



**Petrus Ndlovu: Doctors ignored his pleas for assistance**

room, asked a few questions and without once touching Ndlovu, discharged him.

Daly pleaded with another doctor to conduct a proper examination and was told that would place her colleague's professional integrity in question. But she eventually agreed.

When Daly went to give the good news to Ndlovu, he found him dead.

"I was flooded with emotion," he recalls. "Those doctors and nurses knew that a young man — a paraplegic — had been there for several days because they had phoned around to get someone to fetch him. Yet they did nothing to help him."

Dr Pascal Ngakane, the hospital superintendent in charge of casualty, says he received a letter of complaint about the incident and is looking into it. He has asked the head of the emergency ward to collect statements from all the people concerned.

"These are very serious allegations. I'm most surprised to hear this.

"Someone should have spotted him long before, but I cannot make any further

comment until I have collected all the facts."

Daly is demanding to see the results of an autopsy being carried out and has asked the Medical and Dental Council to investigate.

"I don't think this is an isolated case," he insists. "Most of the people who get treated this way are poor, displaced and voiceless — people with no one to stand up for them; people for whom no one would look twice if they disappeared."

Ndlovu was no saint. Typical of Southern Africa's lost generation — the old regime offered him no real education and the new regime appeared to offer him no real opportunities — he ran away from his home in Zimbabwe about six years ago and turned to crime, until he was stopped by a police bullet in the spine.

Alone and still wanted by the authorities, he lived in squalid conditions in a Hillbrow block of flats frequented by drug dealers — always fearing arrest.

Ironically, on Sunday his father, Ronnie Ndlovu, who works for a family in Randjiesfontein, drove to Johannesburg to look for him.

Ronnie Ndlovu, who had not seen his son since January, said: "Petrus has been in several hospitals, including Baragwanath, since the shooting.

"I thought he had gone back home to his mother, then out of the blue someone called to say he was sick again."

He went to identify the body at the hospital mortuary this week and doctors explained that his son had suffered a cardiac arrest.

Lawyers for Human Rights believe Ronnie Ndlovu may have grounds to sue the hospital or health authorities for negligence.

"According to the scenario you have put to me, this appears to be a very serious case of a failure to exercise duty of care," explained Corlett Letlojane.

"By not examining a sick patient, it could be considered that a doctor behaved unethically and dangerously."



179  
107

# Proposed closures of Somerset and Valkenberg hospitals 'illegal'

CAPE TOWN — The proposed closure of Somerset and Valkenberg hospitals was illegal, University of Cape Town vice-chancellor Mamphela Ramphele said yesterday.

The proposals — aimed at offsetting the Western Cape health department's R284m budget deficit — would destabilise and seriously undermine the university's world-class teaching and research base and would be very strongly resisted, she said.

"These are national assets serving the city, the province, the country and the continent. We are committed to defend these precious and irreplaceable resources." Ramphele said the university had good reason to be angry.

"We have held several high-level meetings with the province and other tertiary institutions where we have agreed on a set of core principles as the

ED 314198  
basis for rationalisation. The latest proposals violate these principles."

The Western Cape health department's business plan also outlined a further downscaling of Groote Schuur and Red Cross Children's hospitals.

She said the university would not accept the plan because it was a breach of the joint agreements between the university and the province affecting teaching hospitals; would destabilise and seriously undermine the academic teaching and research base in health services and would seriously erode health services offered to the poor.

Retired UCT vice-chancellor Stuart Saunders warned that patients would die if the cutbacks were implemented. There was a great risk that the needs of psychologically ill patients would be perceived as less critical than other patients, he said. — Sapa.



# Hospital closure a threat to future birth care

(98) ART 2/4/98

ADELE BAILEY

Women with difficult pregnancies may find themselves with nowhere to go to deliver their babies if Somerset Hospital is closed, health professionals warned yesterday.

The proposed closure of Somerset Hospital has put a question mark over the care of women and their newborn babies in the province, where resources are already under severe pressure.

"You cannot tell a pregnant woman to wait until the next financial year to have her baby," said Professor Zephne van der Spuy, University of Cape Town's head of obstetrics and gynaecology based at Groote Schuur Hospital.

She said pregnant women who needed to be in hospital had to go somewhere.

She pointed out that the government had prioritised maternal and child health by providing healthcare free of charge to pregnant mothers and children under the age of six.

Dr Van der Spuy said the closure of Somerset would upset the successful synergy between tertiary, secondary and maternal units in the community.

**'You can't tell a pregnant woman to wait until the next financial year to have her baby'**

Women without pregnancy complications were seen by midwives at the six maternal units in the community.

Problematic pregnancies were referred to the secondary level at Somerset and Mowbray hospitals.

If emergency procedures were required the women were sent to Groote Schuur Hospital.

Each hospital had a neonatal service.

She said statistics showed that only one of 200 pregnant women admitted to Groote Schuur Hospital with serious high blood pressure would die. In peripheral hospitals the number of deaths for the same problem was around 40 in 100.

With severe cuts to Groote Schuur Hospital's budget, the hospital would not be able to accommodate Somerset's patients.

Somerset had 66 maternal beds. Groote Schuur and Mowbray had 33 beds available, but these had been withdrawn because of budget cuts.

However, even if these beds were available, that would still not be enough. She said 30 beds for newborns would also have to be found if Somerset closed.

Dr Keith Gunston, the head of obstetrics and gynaecology at Somerset Hospital, said he believed the closure of the unit would cripple maternity care in the Western Cape.

He said Victoria and Conradie hospitals did not have maternity sections. If Somerset closed, about 4 000 women a year would not be able to deliver their babies in a hospital.

## Pregnant with nowhere



To go

ANDREW INGRAM

**Mother's love:** Antruh Grove and baby El-Shane at Somerset Hospital's high-care unit for newborns. Doctors are not sure whether hospitals will be able to cope with the overflow if Somerset is closed

Of these women, at least 1 000 needed Caesarean sections.

He said Somerset Hospital delivered 350 babies a month.

The proposed plan for Somerset Hospital is that patients from the maternal and neonatal units be absorbed by other hospitals.

But Dr Sue Fawkes, head of obstetrics at Mowbray Maternity Hospital, said the hospital had very little room and even fewer

staff to handle more than their current load.

"We don't feel that we can take on the women who deliver at Somerset Hospital at the moment."

Like Somerset, Mowbray was a secondary level hospital handling complicated pregnancies referred by midwives at maternal units in the community, including Guguletu, Mitchell's Plain and Khayelitsha, she said.

Mowbray delivered about 460 babies a

month, a third of whom were delivered by Caesarean section.

"Our budget has been cut, we have lost 18 beds and our nursing staff levels are below the optimum," Dr Fawkes said.

She said a grave concern was that if Somerset closed, the midwives who picked up complications at the maternal units in the community would be saddled with problems that should be managed in secondary and tertiary hospitals.

Mowbray's neonatal (newborn babies with complications) section was also working to full capacity and had a serious shortage of nursing staff. Dr Fawkes said the news of impending closure of the obstetric and neonatal units came at a time when the Government was looking to reduce the high number of maternal deaths.

In Sweden four women die of every 100 000 that give birth. In South Africa, estimates are around 80 deaths per 100 000.



# No room at city hospitals for sick children of Somerset

*Red Cross says it's too full to help*

(98) ARG 4/4/98

**ADELE BALETA**

The Red Cross Children's Hospital will not be able to take on the children treated at Somerset Hospital if the Green Point hospital is closed, Dr Joe Ireland, a consultant at Red Cross, said yesterday.

He said Red Cross was already overloaded with sick children and had a shortage of nursing staff. Unless the hospital was able to employ more staff, it wouldn't be able to cope with more children.

Last weekend was unusually busy, according to sources. The intensive-care unit was filled to capacity and couldn't accommodate all the children requiring assisted breathing.

A two-month-old baby with severe pneumonia died before a space in the

unit became available. The child was on full treatment at the time.

Dr Ireland, who was on call at the hospital last weekend, said: "We were filled to capacity with 10 children on ventilators and limited staff to run the intensive care unit."

Ideally, there should be one nurse for every child on a ventilator, he said.

On Sunday, only six nurses and two sisters were on duty in the ICU because of the number of ill children in the general hospital at the time.

Dr Ireland said it would be impossible to take over Somerset Hospital's six ICU beds and the 32 ordinary paediatric beds without the transfer of additional staff.

It has been proposed that Somerset's paediatric beds be absorbed by other hospitals, but bed numbers

have already been cut at the Red Cross, Conradie, Victoria, Tygerberg and Karl Bremmer hospitals,

The secondary level hospital GF Jooste, which serves Khayelitsha and the central Cape Flats, doesn't even have a paediatric service.

Three wards have already been closed down at the Red Cross Children's Hospital.

Dr Ireland said many nurses had accepted voluntary severance packages, leading to a loss of experienced staff.

"When staff numbers drop you reach a critical mass and then the stress experienced by the remaining staff is so great they find it difficult to cope.

"You can have an excess of doctors but, without nurses, children cannot be cared for optimally. The nurse is

the fulcrum around which all care revolves," he said.

Nurses were needed to change nappies, feed children, administer intravenous fluids and give antibiotics.

"Every aspect of childcare requires good nursing and this is especially the case in ICU."

Dr Ireland said he had written to Dr Faheed Hassim, the hospital superintendent, explaining the staff situation.

Dr Tom Sutcliffe, the Western Province's head of health, held a staff meeting at the hospital on Thursday. Dr Sutcliffe said applications for more voluntary severance packages had not been approved. In addition, more nursing posts were being given to key institutions like the Red Cross Children's Hospital.



## Property outfits hover over ailing hospital

TOM HOOD (98)

ST(CM) 5/4/98

PROPERTY developers are hovering over cash-strapped Somerset Hospital in the hope of buying the valuable site overlooking Cape Town's Waterfront.

The Western Cape government wants to close the hospital because of heavy losses, and developers believe the site is ideal for an upmarket shopping centre, expensive townhouses or a cluster village, office park, corporate headquarters or conference centre.

Seeff Commercial Properties has disclosed that it is prepared to pay R95-million for half of the 68 000 m<sup>2</sup> site.

This would work out at R2 790/m<sup>2</sup> — far below the area record of R4 330/m<sup>2</sup> paid two years ago when Golding manager Denise Dogon sold a vacant, 3 000 m<sup>2</sup> Mouille Point site to a German buyer for R13-million.

Nearby, at Granger Bay, apartments were selling for between R15 000/m<sup>2</sup> and R20 000/m<sup>2</sup>, the top prices in Cape Town, said Steven Nelson, Atlantic manager for the Rawson property group.

"There should be some way to keep the hospital going and make it a multi-use property," he said. He calculated that the 34 000 m<sup>2</sup> site could be worth from R340-million to R510-million.

Developer Des Kruis, MD of Richprop property organisation, feels overseas investors with cheap rands would outbid local companies if the hospital land came on the market. This had happened twice with other beachfront sites.



# Waiting for rain and a flood of patients

## Other side of the health crisis: two nurses for ten villages

### SPECIAL REPORT

The closure of Western Cape hospitals

because of budget cuts is hard to swallow — but in Northern

Province two nurses at Masisi clinic near Mutale

treat people from ten villages and the nearest doctor is over two hours drive away. Special

Writer **CAROL CAMPBELL** investigates



"If there is an emergency then I phone for an ambulance and after about four hours it comes to take the patient to hospital."

The nearest public hospital is the Donald Fraser Hospital at Thohoyandou, a two-and-a-half hour drive from the clinic.

The Masisi clinic is a simple brick building, built by the former Vanda government.

It has two consulting rooms and a wide verandah in the front where waiting patients shelter from the sun — or rain.

At the back is a room with a few beds where mothers and their newborn babies can recover after the birth.

Sister Masilinge says she delivers about 12 babies a month.

"Most of the babies in the area are born at home.

"There is nowhere for the other patients to sleep so even if they are sick they must go home when we have helped them," says Sister Masilinge.

At the beginning of the month there are enough medicines in the two-door metal cupboard in the sister's office to satisfy the needs of the stream of people looking for help.

After two weeks the supplies are finished and then all the nurses can dispense is advice.

"We need so much chloroquine because of the malaria here," says Sister Masilinge.

There are many people with sexually transmitted diseases but only about one new AIDS case a month.

At the Tshikonolani coal mine a few kilometres away, some AIDS cases have been reported.

The people who come to Masisi clinic come for a medicine to take away their blinding headaches, aching muscles and raging fevers — the symptoms of malaria.

The old man sitting on the wooden bench outside the clinic doesn't move.

There is still chloroquine in the sister's cupboard — a woman who went in ahead of him told him she saw the pills.

Today there will be enough for everybody.

The rain splattering into the red dust around the Masisi Clinic in the Northern Province brings a shout of joy from an old man waiting on a wooden bench under the shelter of the verandah.

"It's good, it must rain, rain, rain," he says in Venda.

It means his milies will grow, there will soon be grazing for the cattle and the Mutale River will swell with water to drink and wash.

But for Nancy Masilinge, sister-in-charge of the clinic, the down-pour means the arrival of mosquitoes and malaria.

Sister Masilinge (one of only two qualified nurses at the clinic) says 90% of the patients she treats have the disease.

"They come by donkey cart or on foot from their villages which are far away," Sister Masilinge says.

Northern Province malaria coordinator Philip Kruger says the Mutale district — a stone's throw from the Pafuri Gate, the Kruger National Park's most northern entrance — is the worst "malaria zone" in the province.

"We have got the malaria figures down over the last year by spraying buildings and training clinic staff to accurately diagnose their patients," Mr Kruger says.

Between July 1996 and 1997 there were 6 262 reported malaria cases in Northern Province and, from July 1997 until now there have been 2 000 reported cases.

The area's tropical climate — along with the movement of local people to and from Mozambique, and immigrants arriving from other African countries where malaria is out of control — makes the job of health authorities difficult.

"The borders between countries are artificial.

"Many of these people have family living in Mozambique and move back and forth all the time," Mr Kruger said.

The problem is that Mozambique has no malaria control programme in place, which seriously affects the control efforts of South

African health authorities.

There had to be a regional approach to the control of malaria, he said.

"Malaria is passed on by people, the mosquito is just the carrier. It's very difficult to control when there are many people in an environment who have the disease."

For thousands of people in the Masisi area, the clinic and the nearby malaria field centre (both state funded) are the only accessible medical facilities.

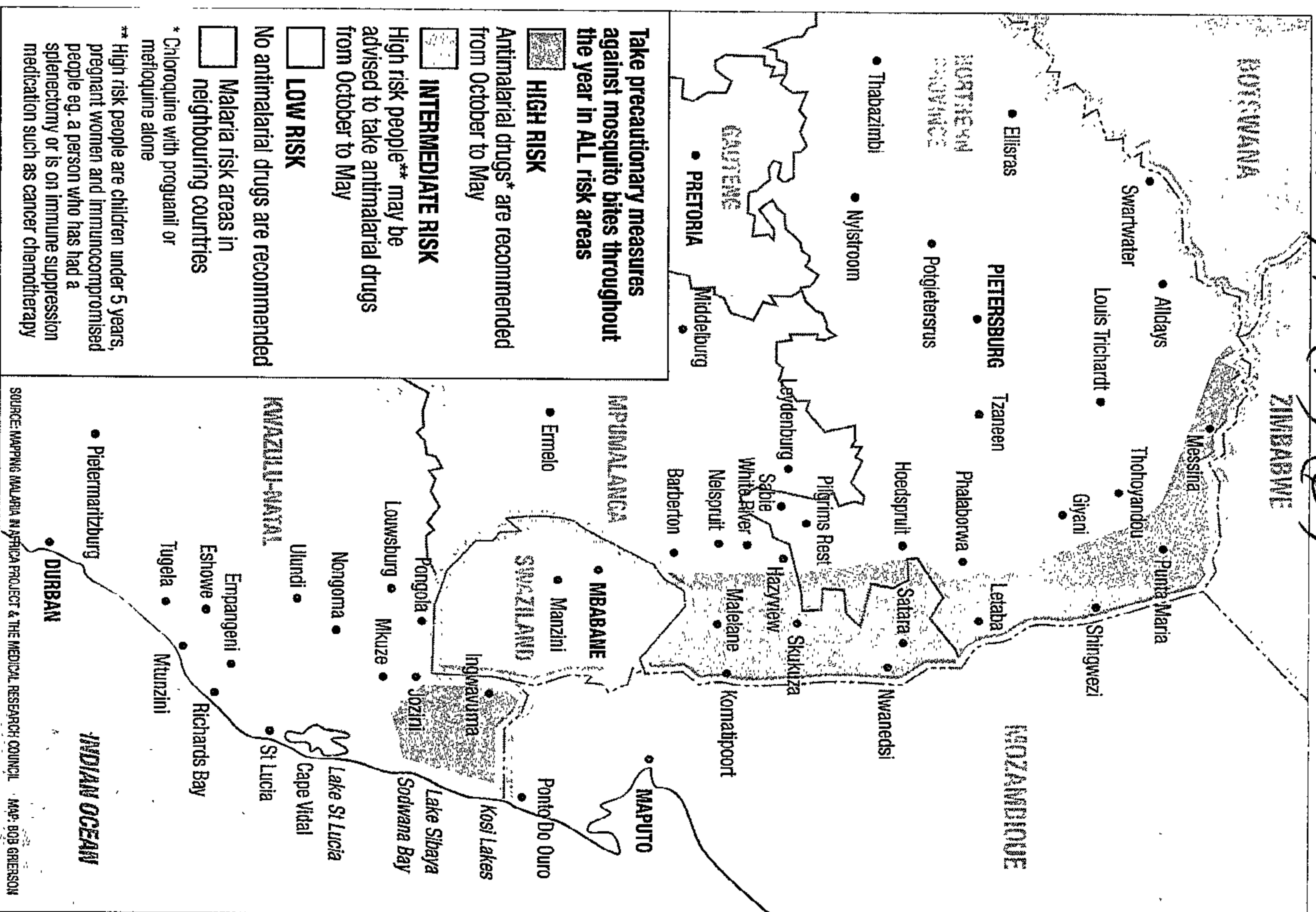
It is in communities like Mutale that Health Minister Nkosazana Zuma wants to improve health services by building more clinics, providing doctors and ensuring their is always a ready supply of medicine.

Dr Zuma has been praised by health workers in the area for being committed to stamping out malaria and giving them enough money to run effective control programmes.

Costs are being cut in other areas of the country, like Cape Town, where hospitals are being closed so the health budget can be directed to providing basic health care to everyone.

"We have no doctor here," says Sister Masilinge.

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# 'This is how to save Valkenberg'

## *Sell land and build new hospital, says UCT chief*

(98)

ARG 7/4/98

JENNY VALL  
HEALTH REPORTER

The land on the Observatory side of Valkenberg hospital should be sold or leased to a developer in return for building a new hospital on the Pinelands side and making annual payments to the health department.

This is one of the proposals for the future of Valkenberg hospital, which has been earmarked for closure in the provincial health department's business plan. Already a developer has indicated willingness to buy or lease the land.

The proposal, by Brian Robertson, head of psychiatry at the University of Cape Town, is supported by staff and organisations which serve Valkenberg's patients and their families, and UCT's faculty of health sciences and psychiatry department.

In his proposal, Professor Robertson says the southern suburbs needs a 280-bed public psychiatric hospital with 130 acute beds, 60 beds for respite care and clinic patients and 90 forensic beds.

There are 650 patients at Valkenberg, which has the Western Cape's only forensic psychiatry unit.

Professor Robertson's plan, which he has submitted to provincial health minister Peter Marais, would require the transfer of 370 chronic psychiatric and forensic patients to Stikland and Lentegeur.

The plan would free all the land on the Observatory side and about half the land on the Pinelands side. Professor Robertson said closing Valkenberg entirely would be opposed by UCT, unions, patients and families, NGOs, civic associations and political parties.

Western Cape director of health Tom Sutcliffe said his department



ROY WIGLEY

**Hospital march:** hundreds of people yesterday marched to the provincial building in Wale Street yesterday to protest against hospital closures. The march was organised by Labour and Communities Against Hospital Closures. A memorandum was handed to health officials asking the health department to discuss their budget allocation with unions who say no consultation had taken place with workers before the closures were announced

would examine all proposals submitted in response to the business plan "At the end of the day it is in our interests to do what is best for our patients," he said.

"Valkenberg remains the institu-

tion that we as a department believe should close and there is a lot of rationale in consolidating four psychiatric hospitals into three."

He said the forensic unit would have to stay where it was in the inter-

im. "The building is in a shocking condition and we must urgently find some solutions in consultation with the department of correctional services."

He said that should Valkenberg close, a community-based psychiatric

service for outpatients could possibly be opened at Alexandra hospital, which is nearby. The acute psychiatric wards at Groote Schuur Hospital and Tygerberg could also increase their capacities.



# Hospital shutdown ... suffer little children

CT 7/4/98  
USING ALREADY watered down criteria, a study established that the metropole was short of beds, but province says there is a surplus. **CLAUDIA CAVANAGH** reports.

If Somerset Hospital is closed and its beds are not replaced elsewhere, sick children throughout the metropole will suffer and possibly die, Professor David Power of the University of Cape Town's department of paediatrics said yesterday.

Power revealed this and the results of an in-depth study he completed last year which refutes province's claims that Somerset can be closed because of a surplus of 2 000 beds in the metropole — there is in fact a shortage of 1 018 beds, he says.

"Because a large proportion of the sick children who come to Red Cross for admission cannot be accommodated and are referred to Somerset and other hospitals in the region, the closure of Somerset will impact enormously on Red Cross and will spell disaster for child health in the metropole generally.

"We're already feeling very pinched for beds and every day fight to admit children who desperately need hospitalisation. The plan, geared at off-setting a R284 million deficit in the provincial health budget, effectively cuts 12% of paediatric beds currently available in the metropole.

"Overall, 124 children's beds will be lost through the cuts," said Power.

And he should know since he was appointed by the provincial health department to review the bed situation in hospitals across the metropole last year. His findings differ remarkably from those used to motivate the closure of Somerset in the province's plan.

It all started two years ago with the Hospital Strategy Project — internationally funded research commissioned by the National

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ed a shortage of over 1 500 beds will exist.

"And if we count the number of regional beds that are actually in regional hospitals like Somerset, there are only half the number we really need.

"The rest have to be provided in teaching hospitals like Groote Schuur and Tygerberg."

Power says that of all the regional hospitals in the metropole, Somerset is the most developed — offering a full range of services.

"Some, like the J F Jooste, for instance, have no paediatrics department. Others, like Victoria and Conradie, have no maternity section.

"And some services, including maternity, cannot really be closed. You can go on to a waiting list for a transplant, but not if you need a delivery."

Yet if the proposals are implemented, gynaecology and obstetrics departments across the metropole will lose 16% of their beds.

## Closure of Somerset Hospital would overload the medical system

DAN SIMON

MORE than 300 expectant mothers will have to find alternative hospitals to deliver their babies from July if the Western Cape government goes ahead with its plans to close Somerset Hospital.

And most of the expectant mothers can forget about being absorbed into Groote Schuur Hospital or Mowbray Maternity Hospital unless the provincial authorities re-open closed beds and provide additional staff and funding quickly.

Failure to provide alternative arrangements could jeopardise the lives of pregnant women and their unborn infants, warned a senior

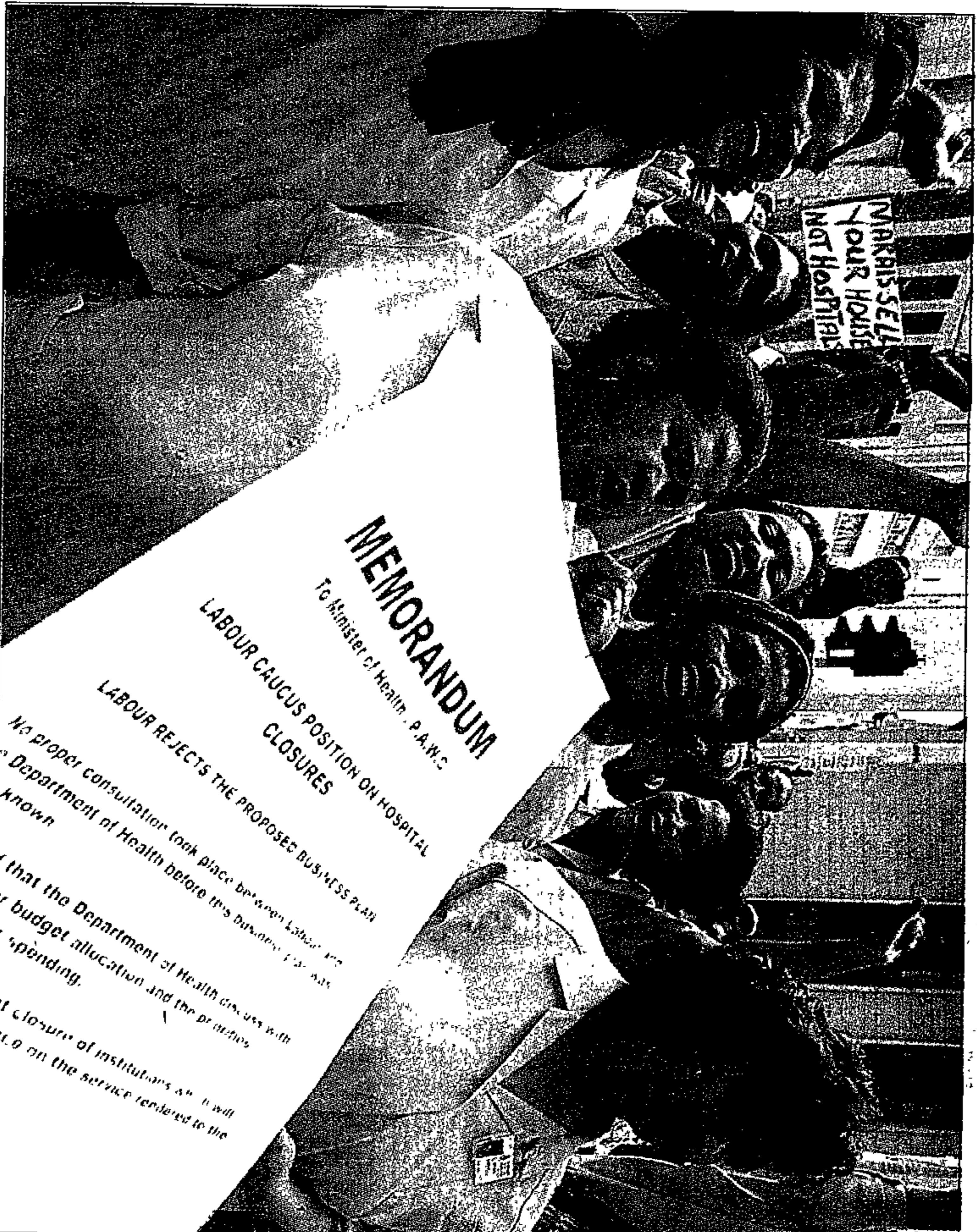
(98)

hospital department head.

Although the provincial government has made no final decision on the future of the hospital, it has indicated that should it close the facility, it would be keen to lease the valuable land and use a portion of the money tendered for it to build a hospital in a needy area.

But the medical superintendent of Somerset Hospital, Dr Eduard Lotz, last week submitted a proposal to Western Cape Health MEC Peter Marais to ensure the hospital remained open through consolidation of services. The proposals are still being considered by Marais.

Apart from Somerset Hospital, four other hospitals in the Western



**VIVA SOMERSET:** Somerset Hospital workers marched to the provincial legislature yesterday to hand a memorandum to Health MEC Peter Marais protesting against the business plan that will lead to the closure of community hospitals, including Somerset. Marais was not available to receive the memorandum.

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Cape — Valkenberg, DP Marais, Westlake Convalescent and Nelsonspoint — have been earmarked for closure. But with the uncertainty growing daily, senior medical personnel are now starting to speak their minds.

Yesterday both the head and the medical superintendent of Groote Schuur Hospital's obstetrics and gynaecology service condemned the provincial government's decision, saying it was extremely short-sighted and would have a dramatic impact on health care.

"You cannot announce in March that you are going to close a facility by the first of July.

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hospitals should have been consulted," said the head of obstetrics and gynaecology, Professor Zephane van der Spuy.

Van der Spuy said Somerset Hospital delivered about 4 200 babies a year.

"This means about 350 women a month give birth there and these women, who are secondary patients (meaning they cannot give birth in a primary clinic for medical reasons) will now have to have their babies delivered elsewhere. They have 66 beds at Somerset, that's for the entire maternity service. We have 33 beds between Mowbray and Groote Schuur that are closed and that we could open.

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half the work or, if they expanded our facility, take all the work provided they give us staff at every level, meaning nursing staff and medical staff."

Groote Schuur medical superintendent Dr Tracy Eastman said an elaborate referral system existed in the provincial health system of which Somerset formed an integral part.

"The 350 patients at Somerset have already been referred through the system, so they can't go back down the system. They would have to be picked up either at Mowbray or Groote Schuur."

Van der Spuy said medical and nursing staff numbers had decreased alarmingly over the past

few years.

"We've lost 50% of our medical staff compared to what we had in 1990. The staff are actually starting to crack because they keep saying they cannot work like this.

"So we've lost medical staff and we are below the norm with our nursing staff. Our total budget has been cut by R74 million and we are still expected to absorb 350 deliveries a month into our system without any additional funding or staff or beds because nobody has proposed we re-open the closed beds.

"We have (the beds) available but the proposal is not that we re-open them. We simply have to absorb them into our present system."

## Workers

### hand memo to MEC

CT 7/4/98  
ERIC NABAZALLA

MORE than 100 Somerset Hospital workers marched to the provincial legislature yesterday to hand a memorandum to Health MEC Peter Marais.

The memorandum was handed to Health Department official Dr Gilbert Lawrence by Nehawu provincial chairperson Mr Michael Makwayiba.

"Today's march is just a tip of the iceberg and the department should brace itself for bigger things to come," Makwayiba said.

"The unions and the communities involved in opposition to the closing down of community hospitals will not take the closures lying down.

"Our politicians are not concerned about the health and welfare of the communities. They are only concerned with their political power. Health does not belong to politicians; it belongs to the communities and the staff at the hospitals."

Lawrence said the health department did not want to close down the hospitals, but the government had insisted that the province reduce its deficit and operate within the budget this year.

If there had been other ways to achieve this, the planned closures would have been avoided, he said.

The union said in the memorandum that there had not been proper consultation between labour and the Health Department before the business plan was made known. Labour demanded that the department discuss its budget allocations and priorities.

It was up to the department, not the unions or the public, to find the resources to keep hospitals open.

After discussions with Cosatu and other unions, it had been decided that a dispute would be declared and that the unions would down tools in protest.

Nehawu would confer with other unions in the health sector to mobilise them for the planned April 21 strike.

PICTURE ALAN TAYLOR



KEY SERVICES TO BE MAINTAINED

# Somerset gets a temporary reprieve

(98)

CT 8/4/98

**A DOCTOR WARNS THAT** closing the largest HIV clinic in the Western Cape would have a dramatic impact on HIV health care throughout the country. **DAN SIMON** reports.

**I**N-DEPTH research at Somerset Hospital has shown that there is a tremendous interaction between tuberculosis and HIV in the Western Cape.

But with the threat of closure hanging over Somerset Hospital as a result of the Western Cape government's proposed cost-cutting plan, this vital research could grind to a halt.

Closing the hospital and terminating vital services, including the Western Cape's main HIV clinic, would be disastrous given the budgetary constraints on health and the latest statistics on the increased prevalence of HIV in the province.

But indications are that the provincial government is toning down its talk of an across-the-board closure and is now reassuring some key services at the hospital that they will be "maintained in some form or other"

Yesterday, Western Cape health MEC Peter Marais also extended the deadline for alternative proposals to save Somerset Hospital by another two weeks. The deadline for alternative proposals was origi-

nally due to expire today.

Head of the HIV unit at Somerset, Dr Robin Wood, said yesterday: "Of late there have been some reassurances from the minister (Marais) that the patients will be looked after and that the HIV clinic will be maintained in some form.

"We don't know what that really means, but I think we should hold the minister to these reassur-

ances and make sure they are not political jargon or platitudes."

Wood said any move to close the biggest HIV clinic in the province would have a major impact on HIV care and research in the province and coun-

try as a whole.

"The clinic has consistently been the busiest clinic in the Western Cape and there has always been a balance between patient care and research activities."

The clinic has seen more than 2 500 HIV patients since it opened in 1983 and at present serves about 500 patients.

Included are about 150 HIV patients who partake in running clinical trials utilising modern HIV therapies. The trials make use of

recognised drugs which are licensed in many parts of the world.

Woods said this type of therapy was "unique" in a state service.

"Obviously a large number of our in-patients are also HIV positive, especially the TB patients. So we have done a lot of work on that. We're trying to develop cost effective ways of making a diagnosis on patients. We believe we are saving money because the majority of our TB cases are HIV positive.

"It is difficult to diagnose TB. So we are working specifically on trying to get a cost-effective way of making these diagnoses so as to best use the resources available."

Wood said that should the unit be closed and staff retrenched, patients would have to find treatment at other hospitals.

"Unfortunately all the other hospitals are very stretched and have cuts of their own. So it will have a serious impact on their management."

And regarding HIV, Wood said this was on the rise.

"About 6% of ante-natal women in the Western Cape are HIV positive. There are about three million with HIV in South Africa as a whole. This is about the fastest growing epidemic in the world. A tenth of the world's HIV affected patients now live in South Africa."

Wood added that the Western Cape had the lowest prevalence of HIV in the country — yet the fastest growth rate.

*We believe we are saving money because the majority of our TB cases are HIV positive*



**NAPPY HAPPY:** Somerset Hospital voluntary worker Val Goebel watches a baby model one of R15 000 worth of nappies bought by the hospital from money donated by the Nelson Mandela's Children's Fund. The nappies will only last until the end of this month.

PICTURE: GARTH STEAD



MORE GOOD NEWS POSSIBLE

# Key health posts unfrozen

(98) CT 16/4/98

**THE JURY IS** still out on the fate of Somerset Hospital, but there was some good news for the health services yesterday — and hints that the city's stalwart might be saved. Health Writer **JUDITH SOAL** reports.

**FIFTY-THREE** key hospital posts are to be unfrozen, the provincial administration confirmed yesterday, providing some relief for the Western Cape's beleaguered health services.

Details of all the posts are not yet available, but health chief Dr Tom Sutcliffe confirmed that 13 of these would be at Red Cross Children's Hospital. Six are for professional nurses, six for nursing assistants and one for a radiographer. Posts will also be unfrozen at Grootte Schuur Hospital.

"We called the provincial health personnel together and asked them which posts were of critical importance," Sutcliffe said. "We obviously can't meet all their requirements but we have been able to fill the most important

ones, despite the business plan."

This "business plan" is the one that proposes closing five hospitals — Somerset, Valkenberg, D P Marais, Westlake and Nelspoort — cutting 3 816 jobs and closing hospital beds to make up a provincial budget deficit of R284 million by July 1. "We are scaling-down in areas where we feel we can but we still have to look at the integrity of the services," Sutcliffe said. "That's why we are unfreezing the posts."

The move follows recent reports that nurses at Red Cross were having to decide which

babies to treat because of staff and equipment shortages. The hospital's chief matron, Ms Daphne Hoogenhout, said the new nurses would be invaluable to relieve the pressure in intensive care units and theatres.

"We have already started interviewing applicants and hope that we can make appointments by the beginning of the month," she said.

On Somerset Hospital, Sutcliffe hinted that a compromise might be reached to save the hospital from total closure. "We have alternative proposals in front of us — at the one end we

could keep it going as is, at the other we could close it completely. Then there is a point somewhere between.

"Some functions — like obstetrics, the neo-natal unit and paedi-

atrics — are in short supply throughout the province and we have to address that."

He said other departments — like the infectious diseases unit — were general functions that could be provided elsewhere.

Health MEC Mr Peter Marais' spokesperson Mr Johan Smit seemed to agree. "The business plan was always the worst-case scenario. Any decision after that is an improvement."

But this decision hasn't yet been made. The deadline for proposals to save the Somerset is Monday, April 20, and Sutcliffe said his department had received many "interesting ideas" so far. "We are discussing them but what isn't negotiable is the budget. If we retain Somerset then we will have to cut somewhere else."

The final business plan will be announced next week, but Sutcliffe's comments suggest there could be some more good news — along with some bad.

*Nurses at Red Cross were having to decide which babies to treat because of staff shortages*



## Hospital named in honour of Tambo

PRESIDENT Nelson Mandela honoured the name of former African National Congress leader Oliver Reginald Tambo yesterday by officiating at the opening of the Tambo Memorial Hospital, formerly the Boksburg-Benoni Hospital.

Mandela said it gave him the greatest joy to rename the hospital after one of his greatest friends and colleagues.

"It seems entirely appropriate that Comrade OR (Oliver Reginald) should be associated not with some international airport, nor even with a fine university — but with a public hospital near the town he called home, where the daily business is to serve those who are ill (or) in distress," Mandela said.

Mandela said Tambo was not only the longest-serving ANC president,

but also a national leader whose historical importance transcended party boundaries. "As Mahatma Gandhi was to India, so Oliver Tambo is to SA." dT

Mandela said Tambo's greatest achievement lay in his ability to sustain a liberation movement thousands of miles from home; to devise ways to keep it alive in the hearts of most South Africans and to build a corps of leaders committed to working for peace even while waging an armed struggle. He said qualities such as those Tambo possessed had particular relevance for health workers who struggled to bring essential health services to all people.

Tambo is to have a tombstone unveiled in his memory in his hometown of Wattville, near Benoni, on Sunday. — Sapa.

(98) 80 17/4/98



'I WAS LEFT OUTSIDE ON THE FLOOR'

# Patients' shocking tales

## of treatment at clinics

(98)

**AS THE HEALTH SERVICES** brace themselves for decisions about hospital closures this week, chilling details of the care being dispensed at community clinics have emerged. Health Writer **JUDITH SOAL** reports.

**I**f Capetonians need evidence that our health services aren't coping, it came at the Easter weekend. After a car accident last Saturday night, three seriously-injured passengers were placed in the hands of the public health system.

But one woman was left lying on the cement floor outside the Mitchells Plain Day Hospital the next morning, covered in blood and whimpering with pain; a second woman's relative was sent home from G F Jooste Hospital after being told she had died — when she was in the ward all the time; and a man, whose ribs had been broken, had to walk to the train station because the hospital refused to help him.

These stories are not unique. The *Cape Times* has heard many harrowing tales of overworked doctors and nurses at community hospitals who are unable to care for even the dignity of their charges.

Yet these same hospitals and clinics are at the centre of the health authority's vision for the future. The province recently announced its "business plan" to make up a R284 million budget deficit — a plan that entails the possible closure of Somerset Hospital and four others and the loss of 3 816 jobs. The hospitals should hear of their fates this week, but even if Somerset is saved there is no doubt there will be further cuts.

Authorities say the effects of these cuts will be managed by passing responsibility for less-specialised health services from academic hospitals to the community services — a laudable and sensible plan — but the recent incidents question whether this is possible.

"I will never forget what I saw there for as long as I live," said Mr John Nelani, who found his daughter Ms Judith Nelani lying outside the Mitchells Plain Day Hospital.

"When I got to the hospital on Saturday night they said they were going to discharge her, but she had a big cut on her face and her leg was messed up from her hip to her knee. She was in terrible pain. I said 'How can you discharge a person like this? She can hardly move'.

"Then they said she could stay but I must fetch her in the morning. But by the time I had organised a bakkie and got there they had put her in a wheelchair, taken her outside and just dumped her."

Nelani took his daughter to G F Jooste Hospital in Manenberg.

"When we loaded her into the bakkie she was screaming so much from the pain. They hadn't even treated her, she was still covered in blood."

But the hospital's Sister Florence Evert said Nelani had been treated.

"It is written in the folder that the patient was given medication and ointment was put on her wounds," she said. "Maybe there wasn't time to clean her properly."

She denied that Nelani had been "dumped" outside. "The patient probably asked to be taken outside."

Ms Anna Manuel (not her real name) was taken straight to G F Jooste. She complains that she waited hours for attention and wasn't given anything to quell the pain in her broken arm, but the worst treatment was meted out to her sister-in-law who came to visit her after hearing of the accident.

"She went to ask for me but they told her I was dead. They didn't take her aside or tell her to sit down or anything, they just told her straight. She said that couldn't be true, but they told her three times that I was dead. Her boss phoned early in the morning and then they told him I had left the hospital — but I was in the ward all the time."

A sister at Manenberg Hospital, who

ET 20/4/98  
asked not to be named, was puzzled by the incident.

"That is a horrible thing to do, I don't know how it happened. We are frantically busy here and sometimes people may make mistakes."

Another accident victim, Mr Samuel Stefans, was sent away from G F Jooste early in the morning after X-rays showed he had broken ribs.

"I was in pain and I asked for a transfer to Conradie or Somerset, but they ignored me."

Stefans had lost his shoes in the accident and had to hobble barefoot to the train station, racked by the pain in his chest.

A few days later he went to Mitchells Plain Day Hospital because he wasn't feeling any better.

"A doctor there gave me an injection and some pills, then said if it didn't get better I must go to a private doctor."

Stefans is struggling to afford the high cost of private treatment, and feels let down by the public health services.

The Chief Medical Officer of Mitchells Plain, Dr Rob Marrell, agreed that all was not well at the community hospitals.

"In principle I support the plan to pass responsibility to our hospitals, but the problem is that resources aren't being passed down. Last year they effectively closed the Red Cross Children's Hospital outpatients unit, so we had thousands of extra children, but they didn't give us more staff or more money. We are stretched to our absolute limit and there aren't the resources to deal with things like patient dignity."

But Mr Johann Smit, spokesperson for Health MEC Mr Peter Marais, disagreed. "They can't always blame resources, the infrastructure is in place for everyone to receive access to care. G F Jooste is running at 40% bed occupancy, so they have no reason to turn people away."

Smit said Marais was enraged by the incidents. He promised a full and immediate investigation.



**NEGLECTED:** Judith Nelani was left lying outside Mitchells Plain Day Hospital last week. **PICTURE: GARTH STEAD**



# D-Day for cash-strapped Somerset Hospital

JENNY WALL  
HEALTH REPORTER

Today is D-Day for cash-strapped Somerset Hospital to come up with a plan to save it from closure.

The provincial Health Department said in a business plan released last month that, if it was to keep within budget, 3 800 people would have to leave the health service, 300 academic hospital beds would be lost and Somerset Hospital would have to close.

The plan caused a public outcry and Health Minister Peter Marais set today as

the deadline for alternatives to the plan. Gilbert Lawrence, head of supra-regional hospitals, leads the team of top officials who will evaluate the proposals.

Plans will be discussed by unions and the department will come up with a final business plan at the end of the month. The department has to shed more than 3 800 jobs this year, but will be able to re-employ people in the next financial year.

This anomaly - spending money to reduce staff this year only to employ more people next year - was the result of cash flow problems, said Johan Jooste, head of

finance in the department.

About 70% of the health budget was spent on salaries and this was where most savings could be made, he said.

"We have to get into budget this year. At the end of the month we must have a business plan and it must be enforced. Every day we wait the situation gets worse," said Mr Jooste.

The provincial and national governments have stipulated that there will be no overspending this year. Provinces that do

To page 3

## D-Day for Somerset Hospital

From page 1

not keep within their budget lay themselves open to management by central government, a situation untenable to most provinces but especially so to the Western Cape, which is National Party controlled.

The department has a R284-million projected deficit for this financial year and will have to cut staff and services to keep within its R2,9-billion budget. Almost R90-million of the budget has been set aside for voluntary severance packages and about R47-million more will be needed.

But in the next two financial years, R164-million and R222-million have been set aside for "restructuring" the health service.

This money will be spent on correcting the "Swiss cheese" (full of holes) effect caused by staff taking voluntary severance packages.

The packages have resulted in a loss of staff in key areas, creating holes that have been difficult to fill because posts are frozen when people leave. Restructuring the service will include employing or re-employing people.

"We are being called on to come within budget this year, which is creating a situation where our projected expenditure next year will be under our allocation and we could find ourselves in the position where we re-employ people," said head of health Tom Sutcliffe.

"We are doubly concerned about it, because the acceptance of a voluntary severance package is on condition that a person cannot be re-employed.

"We wonder if there isn't an opportunity to alter this and allow people to be re-employed at the discretion of administration," Dr Sutcliffe said.

"It is an anomaly we have brought to the attention of the provincial department of finance and to our minister (Peter Marais). We have to take a dip in staff numbers now, but we don't want it to be quite as acute as it is at the moment."



# Somerset saved, but 1 988 jobs will go <sup>(98)</sup>

## ANC wants to see clinics opened

ART 23/4/98

STAFF REPORTER

The closure of Somerset Hospital was never "cast in stone" and would have happened only if no other solution to the health service cash crisis had been found, said Western Cape ministry of health spokesman Johan Smit today.

Western Cape Minister of Health Peter Marais announced last night that cuts in other areas would be made to keep the hospital open.

African National Congress spokesman Cameron Dugmore said he hoped projects initiated by Mr Marais's predecessor, Ebrahim Rasool, would not be stopped to

appease the demands of one section of the community and so score points in Mr Marais's bid to become premier.

Mr Rasool, now chairman of the ANC in the Western Cape, was behind the Delft and Kraaifontein 24-hour clinics, which have yet to open.

There were also additional wards and an operating theatre at Wesfleur Hospital in Atlantis which had to be staffed, said Mr Dugmore.

He said Mr Rasool was concerned these projects would not go ahead if Mr Marais's business plan was implemented.

Mr Smit said the provincial cabinet and medical unions had yet to approve Mr Marais's plan.

It includes cutting 1 988 jobs and not 3 816 as previously proposed, freezing new appointments from August, stopping capital expenditure, selling some of the Somerset Hospital's land, closing 57 beds in the hospital's north block and reducing its services.

Mr Marais also talked of implementing "other elements" of the plan to cover the shortfall of R284-million in the health budget. The new plan means a R69-million shortfall will be carried over to next year.

Mr Smit said people had to understand that "there is no money", but Mr Marais's plan would ease the cash crisis.

# New population policy focus is on human development

ART 23/4/98

CLIVE SAWYER

POLITICAL CORRESPONDENT

Welfare Minister Geraldine Fraser-Moleketi today unveiled a new population policy signalling a radical departure from the past.

In a white paper tabled in Parliament, she said the central theme of the new population policy would be sustainable human development.

Hallmarks of past policies were the provision of contraception "often through coercive means" and restricting the movement and settlement of Africans.

Addressing a media briefing, Ms Fraser-Moleketi said South Africans,

especially women and young people, should be empowered to take control over their own lives. Families should be able to provide for their needs to meet their potential.

The country's natural resources should be used in a sustainable way to meet the needs of the current generation.

The white paper sets out 24 strategies, covering areas including poverty reduction, health, mortality and fertility, gender, women, young people and children, education, employment, migration and urbanisation.

Ms Fraser-Moleketi said the thrust of the new population policy was not on controlling the population growth rate but on providing for the

socio-economic needs which affected population growth.

The white paper calls on all policy makers to take population factors into account when developing policies and programmes. By taking population into account, policy-makers would be able to plan more accurately to meet the needs of the population and of future generations.

Her ministry was awaiting the latest census results to enable a detailed analysis of population concerns.

A national population policy unit will be responsible for implementing the policy. Its priorities included helping government departments interpret the population policy as it affected their areas of responsibility.



MARAIS' NEW PLAN

# SOMERSET HOSPITAL

# saved

ET 23/4/98 (98)

**ON THE EVE** of the election of the Western Cape National Party leader, one of the top contenders for the job, Pieter Marais, announces that he will save Somerset Hospital. Health Writer **JUDITH SOAL** reports.

**S**OMERSET HOSPITAL will not close, although some services will be cut. This is definite, although not yet official, Health MEC Mr Pieter Marais said yesterday. The health department has outlined a plan to keep the hospital open, which includes:

- Cutting 1 988 jobs, not the 3 816 as originally intended
- Freezing all new appointments from August
- Stopping all capital equipment expenditure on health in the Western Cape
- Closing 57 beds at the north block of the hospital and possibly selling this land
- Reducing the "scope and scale" of services at the hospital
- Implementing the "other elements" of the business plan.

These "other elements" relate to the plan announced by Marais' department in March, and include the closure — or relocation — of Valkenberg, D P Marais, Westlake and Nelspoort hospitals, to make up the R284 million health budget shortfall. The new plan means that a R69m budget shortfall will be carried through to next year.

"I am delighted to be able to announce that Somerset will stay open," Marais said last night.

He said his department had taken heed of the opposition to the closure. "Somerset was District Six's hospital, that is why these people still come there. This link must be respected."

It seems that the hospital's land could not have been sold as prime property as had been predicted when the closure was mooted.

"A review of the title deeds shows that the land can't be used for anything but hospitals," Marais said. He hinted that Somerset's north block would be privatised, but that it would have to be used for medical purposes.

Some commentators were sceptical of Marais' announcement, coming as it does on the eve of the election of a new National Party leader in the Western Cape. Marais, along with Community Safety MEC Mr Gerald Morkel, is a top contender for the job.

"It looks like he is trying to gather some votes," said Somerset doctor Professor Greg Hussey. "The health services are again being used as a political football."

ANC provincial leader Mr Ebrahim Rasool called

□ Turn to Page 3

## Hospital saved

□ From Page 1

ET 23/4/98 (98)  
the announcement a capitulation. "We are glad that Peter Marais has backed down and bowed to the enormous pressure applied by the staff, the patients and the community. But we can't help wondering if this is based on a genuine concern for the hospital and patients, or whether it represents an election trick."

Dr Elaine Clark, who heads a group called Labour and Communities against Hospital Closure, said Marais had not gone far enough. "What about the services that will be cut? What about Valkenberg, where are those patients going to? We want assurances that services will be open and that they will stay open."

But Marais said Valkenberg and the other services would not be closed "as such", but that they would be relocated to other hospitals.

The head of health in the province, Dr Tom Sutcliffe, was more circumspect than his political boss: "We cannot presume anything until it has been cleared by the cabinet and the unions. To save the hospital we need to make cuts elsewhere, most notably in capital expenditure. Also, some services will have to be scaled down."

Although it is unclear which services will be curtailed, Marais said the neo-natal and paediatric units would remain at the site, as would the casualty department and outpatients unit. It was possible that the Aids unit would be moved, although it would not close.

On the need for cabinet approval, he said he had spoken to Finance MEC Lampie Fick — "a reasonable man" — and was confident it would be approved. On the unions, however, he was less complimentary: "If the unions leave me alone, I will do my job, why don't they just stay away and let me do my job," he said in a television interview. "If the unions really want to contribute they will accept the new plan, but if they are politically driven then there is no way we can find a solution," Marais told the *Cape Times* later.



# Marais denies election ploy in health plan

*DP queries timing*  
(98) ARG 24/4/98

JENNY VIALI  
HEALTH REPORTER

**Health Minister Peter Marais may have announced Somerset Hospital would be saved in a desperate but vain bid to secure the premiership of the Western Cape, say opponents and political observers.**

Not so, says the feisty Nat, who took over the health portfolio earlier this year from the Ebrahim Rasool, the new ANC Provincial leader.

"I am not that kind of person," he protested yesterday.

While the move to save the historic Waterfront hospital is being welcomed, there are concerns that it could be at a cost to health services elsewhere.

ANC MP Willie Hofmeyr commented: "This is typical of the way Peter Marais does things. He tends to decide first, and look at the details later."

Closing Somerset Hospital was just an aspect of a health department business plan to save money.

After a storm of protest, unions and hospital management were asked to submit alternative plans. The report on a possible rescue plan is expected only in the first week of May. So the about-turn announcement by Mr Marais on the eve of the election of the NP regional leader, one of the frontrunners, came as a surprise.

Mr Marais's political opponents were as one in their scepticism about the timing of the announcement.

Democratic Party health spokesman Daniel Silke noted: "The timing of his latest announcement was remarkably close to the election of a new NP leader."

But Mr Marais said: "My whole hospital plan is being jeopardised by sentiment around Somerset. This is why I thought I had to address the issue."

He acknowledged his new plan was not final and said while he could go ahead without union approval, he wanted to talk to them and convince them his plan was "reasonable".

"The main thing is that I will not close Somerset," Mr Marais said.

He would achieve this by "privatising half and the income will allow me to pay for the other half".

Gilbert Lawrence, head of supra-regional hospitals, has been charged with drawing up a rescue plan for health in the province.

He said while "certain undertakings by the minister may be final, until we have the total plan I cannot speculate on how services (elsewhere) will be affected".

The team was looking at the department's deficit and how to stay within the budget.

## Protest meeting is on

A protest meeting at Somerset Hospital planned for tomorrow will go ahead in spite of the announcement by provincial Health Minister Peter Marais that the hospital will not close.

Elaine Clarke, spokeswoman for Labour and Communities Against Hospital Closure, which is organising the meeting, said the closing of hospitals would

reduce people's access to quality health care.

Other hospitals earmarked for closure in the health department's business plan are Valkenberg, Westlake, Princess Alice and Nelspoort.

"Instead of offering better health care to people, health care is being diminished and taken away," she said.





HANNES THIART

Joy: patient Neville Boysen and staff share their delight at the news

## Somerset's staff want it in writing

APR 24/4/98 (98)  
BLACKMAN NGORO  
STAFF REPORTER

Staff at Somerset Hospital are elated – but confused – by the decision not to close the hospital after weeks of lobbying by unions, workers and the community.

The decision was announced by provincial Health Minister Peter Marais on the eve of last night's election of a new National Party Western Cape leader.

By late yesterday the hospital had not formally been told of Mr Marais's decision. Staff have asked for written confirmation.

"We want to believe the news because we want to save our hospital. But we also want official notification," said matron Gigi Henkerman.

Linde Moore, staff support unit member, said some staff had applied for jobs at other hospitals and been accepted. Now they did not know what to do.

Somerset Hospital workplace forum spokesman Haroun Esau



'Permanent solution': Haroun Esau

said: "We want assurances that come 1999, the whole nightmare isn't going to start all over again. We want a permanent solution."

He said workers wanted to see an official notice stating exactly what Mr Marais had in mind for the hospital.



# Hotspot clinic stays shut as Manenberg recovers

ARG 24/4/98

98

**JERMAINE CRAIG**  
CITY REPORTER

**The main clinic in Manenberg is still closed after the upsurge of gang violence, although residents say the situation has "returned to normal in an abnormal society".**

The Cape Town municipality suspended all its services in Manenberg, including the library, clinic, rent office and crèche, after gang violence claimed several lives.

All services have since reopened, except for the main clinic in Manenberg Avenue.

Chief medical officer of health Michael Popkiss said the clinic was in a "real hotspot" on the border of rival gang territories.

This meant that when gangsters were treated there, there was a distinct possibility that rivals would enter the clinic.

Staff and other patients were in danger of being caught in the

crossfire, he said.

The clinic service had been moved to a smaller facility on the safer northern boundary of Manenberg.

He said that because of concerns for the safety of staff, the municipality had also moved the dental and mental health services to Hanover Park and Kewtown.

Dr Popkiss said the municipality was considering posting three security guards at the Manenberg clinic and altering the building to make it safer for staff and patients.

"We don't have a date for the re-opening of the clinic - all we have is a desire to do so.

"When the clinic re-opens we hope we will have a calm atmosphere and the security measures we put in place will ensure the safety of the staff and our patients."

He said the intention was to restore normal services as soon as possible - next month at the latest.

But there was still the fear that sporadic gang warfare could erupt at any time.

Faldiela de Vries, Manenberg community worker and African National Congress councillor, said the situation had stabilised substantially and it would be possible to restore services.

"The shootings have substantially abated - the situation is what is normal in an abnormal society.

"All the facilities can function as they did before the closure," said Ms de Vries.

She had recently written to city manager Andrew Boraine saying the council was rendering a service which was "legally flawed".

She was also not happy that people now had to travel outside their area for services they were accustomed to getting in Manenberg.

She said this was not in accordance with the Government's approach to primary health care.



# R40-m Flats hospital deal

LLEWELLYN JONES (98)

BUSINESS REPORTER

ARG 24/4/98  
Melomed, the company which owns the Mitchell's Plain and Gatesville medical centres, is to raise R40-million to buy another hospital in Cape Town.

Ebrahim Bhorat, who founded electronics chain Melotronics

and is the major shareholder in Melomed, said the company was planning to buy a hospital in Gatesville, Rylands, Mitchell's Plain or Athlone.

Mr Bhorat said the company would fund the acquisition with the R40-million it was expected to raise through its listing on the Johannesburg Stock Exchange in August.



# City may link with private firms on emergency services

Partnership proposed by consortium to help boost flagging service

By Anso Thom  
Health Reporter

Greater Johannesburg could enter into a public private partnership within the next two months in an effort to boost the city's emergency services which is facing severe staff shortages.

A private consortium headed by Netcare proposed last month that the Greater Johannesburg Metro Council combine resources with the private sector and set up a not-for-profit company to boost paramedic and ambulance services.

Deputy director in the Gauteng health department Dr Eric Buch said province was keen and supportive, but there had to be an open and fair opportunity for other roleplayers to

forward proposals as well.

He said that, in the interests of transparent and fair government, the process should follow several steps. These included deciding whether they (council) were keen to look at private public partnerships, deciding what kind of private public partnership would be feasible, drawing up the principles that would govern this partnership and, lastly, calling for proposals, through advertisements in newspapers.

Consortiums or interested parties would then be invited to forward proposals.

Buch said province was keen to see the process begin as soon as possible, possibly within two months, even though it normally took much longer.

Star 28/4/98  
He emphasised that the province was very interested and keen on developing public private partnerships, but that government rules had to be followed to avoid nepotism, corruption or kickback charges.

"My sense is that Netcare has entered the process in good faith, but the nature of government determines that you have got to offer all players an open and fair opportunity to put in a proposal," Buch said.

Emergency services strategic executive Hillow Maeko said council would be meeting with province today as some questions needed clarification.

"I don't know which way the process is going to go and we are waiting for clarity from province," he added.

Chief operating officer at

Netcare Dr Richard Friedland said they remained committed to a strong public and private sector. He said the Section 21 joint venture proposed by Netcare was an ideal template as it took the monopoly motive out of the venture.

"We have no objection to other company's tendering," Friedland added.

In terms of Netcare's proposal, the consortium - which includes Europassist, Vodac, a vehicle company and a petroleum company - will inject money into the project to supplement the municipalities' staff, vehicles and equipment.

Buch said the process offered positive potential for the service, expressing the hope that staff in the services would see the positive benefits.



# Goods, equipment worth R210 000 stolen from Jo'burg Hospital

(98) Star 28/4/98

## STAFF REPORTER

Equipment and goods valued at about R210 000 were stolen from Johannesburg Hospital in 1996 and last year, former Gauteng health MEC Amos Masondo has revealed.

Replying to questions

from the Democratic Party, Masondo said items amounting to R91 931,55 were stolen last year.

Goods worth R118 890 were stolen in 1996.

The stolen goods included a diagnostic set and ECG machine worth R14 230, two public address systems

valued at R34 085, a computer worth R5 000, a trolley valued at R1 449 and a lawnmower worth R2 200.

None of the items were recovered.

Masondo said that while more guards and better equipment was needed to combat theft, financial con-

straints meant the health department was not able to do everything necessary to deal with the problem.

DP spokesman Jack Bloom said the failure by the department to install security was "short-sighted as the safety equipment would easily pay for itself in

the prevention of thefts".

The health department's Popo Maja said security at hospitals was an ongoing challenge: "We have limited resources which must be used sparingly and effectively in our commitment to provide basic healthcare to the public."



# Health authorities look ahead to public/private partnership

Star 29/4/98 (98) (98)

By ANSO THOM

A public/private partnership appears to be on the cards to boost Greater Johannesburg's emergency services following a meeting yesterday between the council and the Gauteng health department.

The city's emergency services face severe staff shortages, especially among para-

medic and ambulance staff.

A private consortium proposed last month that the Greater Johannesburg Metro Council combine resources with the private sector and set up a not-for-profit company to boost paramedic and ambulance services.

Since then, the province has suggested several steps. These included deciding what kind of

public partnership would be feasible, drawing up the principles that would govern it, and calling for proposals through advertisements in newspapers.

Deputy director in the Gauteng health department Dr Eric Buch said emergency services strategic executive Hillow Maeko would take the proposal to a committee, which would make a decision.

If there was agreement, a proposal regarding public/private partnerships would be tabled.

Maeko said the meeting had been convened so that the province could approve a change to the agreement under which Greater Johannesburg's municipalities administered the emergency services on behalf of the health department.



## 'You just let our baby die'

Staff held hostage as angry protesters condemn clinic that turned away seriously ill six-week-old girl while they celebrated

(98) Star 29/4/98

CHRISTINE NESBITT

By Anso Thom  
Health Reporter

A six-week-old girl died when staff at Kliptown Clinic in Eldorado Park, south of Johannesburg, allegedly refused to treat her because the clinic was closed for a ceremony.

Last night, enraged residents were holding clinic staff hostage in protest.

A commission of inquiry will be held into the death of six-week-old Raygene Dixon on Friday.

Monica Pietersen, Raygene's aunt, said the child's mother, Cordella, had gone to the Ascot Road clinic early on Friday because the baby was struggling to breathe.

"Cordella was turned away at the clinic gate and was told the clinic was closed because Mandela was coming to open it later in the day," said Pietersen.

(The recently renovated clinic was in fact officially opened by newly elected Health MEC Mondli Gungubele on Friday.)

"She left and phoned an ambulance. She went back to the clinic. By this time the child was blue in the face. The ambulance arrived and, all of a sudden, the clinic staff stormed outside to try to help. They pushed the baby into the ambulance and one of the sisters went with, but the baby was dead when they arrived at (Chris Han) Baragwanath (Hospital)," an angry Pietersen said.

Popo Maja, spokesman for outgoing Health MEC Amos Masondo, said there had been no instruction from head office that the clinic should be closed for the opening of the clinic. He said the clinic was open from 8am to 4pm. He said the angry protesters who held clinic staff hostage yesterday.

About 50 women, mostly representing the South-Western Joint Civic Association



Bereft ... Henry Dixon, father of six-week-old Raygene, who died after allegedly being refused treatment at Kliptown Clinic in Eldorado Park, is comforted outside the clinic by South-Western Joint Civic Association secretary Bernadette Klein.

(Sowjoca), stopped staff, including nurses and medical staff from leaving the clinic. They demanded to see Masondo. He was in Sweden. At the time of going to press, the clinic had added two directors from the Gauteng health

department - who had been sent to resolve the issue - to their bar of hostages. Residents claimed medical staff preferred to watch soap operas rather than work, and refused to treat more than a certain number of patients each day. They said long queues were

caused by inefficient service, and that patients arriving at the clinic as early as 5.30am found at least 60 patients already waiting in line. "The clinic is always short of medication, with staff dispensing Panado syrup for any paediatric ailment," said one mother.

Sowjoca spokesman Lola Wolmink said demands being made included extended clinic hours with the clinic operating on a 24-hour basis, a full-time medical doctor on duty, emergency transport on standby, a well-stocked pharmacy and the election of a representative

community/clinic committee. Kliptown Clinic staff referred all queries to the Coronationville Clinic superintendent. However, the matron, Sister Ruth Budhal, said: "We phoned for an ambulance, and one of our nurses went with the paramedic to try to assist."



# Clinic opens late as staff fear community's wrath

Star 5/5/98

(98)

By Anso Thom  
Health Reporter

Kliptown Clinic in Eldorado Park opened more than four hours late yesterday after most of the nursing staff failed to report for duty for fear of their lives. Three doctors and a few nurses managed to keep the clinic running after it opened at about 11.45am instead of 7.30am.

The clinic was in the spotlight last week when 6-month-old Raygene Dixon died after clinic staff allegedly refused to treat the baby. The clinic had been closed for an opening ceremony at the time.

Members of the community and the South Western Joint Civic Association's (Sovejoca) women's brigade staged a protest outside the clinic last week, holding clinic staff hostage for more than 18 hours. A joint committee was formed last week to investigate the circumstances surrounding the death. "We didn't come to fight, we came to see why the clinic hadn't opened," said brigade chairman Lola Wolmink.

She said she could not understand how the nurses could be scared of five Sovejoca members. "If I wanted to hit them, I would have hit Dr (Arthur) Manning," Wolmink said. Manning is superintendent of Coronationville and Helen Joseph hospitals, where Kliptown patients are referred to.

Communications director in the Gauteng Health Depart-

## Uproar over baby's death scares nurses in Eldorado

ment Jo-Anne Collinge said nurses were concerned about their safety. "The situation will have to be assessed on a daily basis and it is impossible to say whether the clinic will open on time or when the nurses will return to work," Collinge said.

She said doctors had been sent to the clinic to attend to patients and to prescribe medication because no primary health care nurses had gone to work.



# Long wait as Kliptown Clinic staff stay away

By Charity Bhengu

SCORES of sick people had to wait a long time at the controversial Kliptown Clinic in Soweto yesterday because doctors and the nursing staff had not reported for work.

Babies, pregnant women and elderly people were unattended until about 10am. The administration offices and dispensary were locked. Some of the people at the clinic claimed they were at the gate from as early as 5am.

The head of the clinic, Dr Arthur Manning, arrived shortly after 10am. He told *Sowetan* that staff members were afraid to come to work.

This follows the death of six-week-

old Raygene Dixon after allegedly being turned away by the clinic's security and staff members last week.

The clinic's services were suspended for that day in preparation for the official opening of the clinic. The baby allegedly died shortly after being turned away.

Manning said yesterday, "We have about 12 staff members and they did not come to the clinic because they are afraid of being victimised. I am hoping that by coming to work, I am able to prove that no one wants to harm them."

The only staff at the clinic yesterday morning were Manning and two nurses. They could not cope and a bus was provided to take some of the

patients to Coronation Hospital. They were later joined by two doctors.

The Gauteng health department said the clinic had been operating yesterday, but under extremely difficult circumstances.

The clinic opened late because of the need for a prior meeting with clinic staff, most of whom were returning to work for the first time since last week's hostage-taking by the Sowejoca Women's Brigade in response to the death of baby Raygene Dixon," the department.

Last week members of the South Western Joint Associations (Sowejoca) Women's Brigade held staff hostage for several hours.

(98)  
*Sowetan* 5/5/98



## Health savings plan held back

98  
JENNY VIAL

HEALTH REPORTER

ARC 6/5/98  
Western Cape Health Minister Peter Marais presents his budget to the provincial legislature today, but final details of his business plan to save money will be announced only at the end of the month.

A preliminary business plan announced in March proposed closing Somerset, Valkenberg and Nelspoort hospitals and shedding 3 816 staff from the department through voluntary severance packages.

The plan was opposed by unions, community organisations and others and the deadline for alternative proposals was extended by two weeks to enable everyone to have a say.

Two weeks ago Mr Marais announced that Somerset Hospital would not close, but said other details were still being worked out and he would announce a final plan in his budget speech. But unions have yet to be consulted.

The Health Department's projected deficit for 1998-99 is R284-million and the provincial and national treasuries have said no overspending will be allowed this year.



# Rasool call on sale of Somerset Hospital

ARG 7/5/98

(98)

JENNY VIALL  
HEALTH REPORTER

**An independent body should handle the sale or lease of the Somerset Hospital and proceeds of the sale of the north block should be used for a hospital to serve Khayelitsha, Philippi and Mitchell's Plain, says Ebrahim Rasool.**

The leader of the African National Congress in the Western Cape and former health minister was replying to Health Minister Peter Marais's budget speech in the provincial legislature yesterday.

Mr Rasool said this move would ensure integrity in the handling of provincial assets.

Mr Marais confirmed yesterday that the north block of the hospital would be closed and said Minister of Asset Management and Works Michael Louis had been asked to "alienate" it at the best

value to the health department.

The western block, which has 260 beds, will be retained. Health services in the Western Cape faced another tough year with budget allocations down in most areas, said Mr Marais.

Although final details of his business plan for health services would be available only at the end of the month, Mr Marais announced that clinics at Kraaifontein and Delft would be commissioned fully this year.

This was essential to create a safety net for reduced capacity at hospitals.

Mr Marais said some hospitals in rural areas would close, but more beds would be opened at Ceres Hospital.

Planned upgrading at regional hospitals would not take place this year because of a lack of funds.

The allocation to academic hospitals (Groote Schuur, Red Cross and Tygerberg) had been cut by R135-million, an 11% cut.



# Tax incentives could boost efficiency

Josey Ballenger

THE days of poor waste management and inefficient industrial practices may be limited if tax incentives are introduced — an idea that may be incorporated into government's waste management strategy, a consultant to government said this week.

"We cannot just use sticks. We need some carrots," said Dave Baldwin, technical director of consultancy Bohlweki Environmental, in reference to measures being considered by an interdepartmen-

tal committee to encourage waste generators to engage in better practices.

Government's national waste management strategy process, which began last August, is a joint effort between the environmental affairs and water affairs departments, various SA consultants and Danish consultancy Ramboll. The two-year project is primarily funded by Danish aid agency Danced's R8,2m contribution, with the SA government kicking in R700 000.

Baldwin said the strategy fo-

cus on four major areas: hazardous and related wastes, including mining and radioactive materials; nonhazardous waste; waste minimisation; and compiling a national database.

The project's first phase — a baseline analysis of SA's waste output and minimisation efforts — is due for completion at the end of the month.

The second phase will be to develop a strategy within six months, and the final phase will see the creation of "action plans" by next May.

## Baragwanath upgrading 'allows for better care'

Josey Ballenger

THE recent R2,3m upgrading of what has become the world's largest hospital — Soweto's Chris Hani Baragwanath — puts the community institution in a better position to cope with the 30 000 patients it sees every year.

Baragwanath's revamped medical admissions ward 20, which was opened this week by greater Johannesburg mayor Netta Mogase, includes a medical high-care unit and a better equipped laboratory six times the size of its predecessor.

"About 3-million people live in Soweto and most of them will come to this hospital for medical care. The ward gives patients more privacy and dignity and access to improved quality of care," said Donald de Korte, CE of pharmaceutical company Merck Sharp & Dohme (MSD).

Between 70 and 100 patients — with ailments ranging from tuberculosis to heart disease and strokes — are admitted daily, while only R8m of the hospital's R500m annual funding needs is collected from its primarily poor patient base.

The hospital also functions as a referral centre for SA's 40 provincial hospitals and medical facilities in neighbouring countries and is the largest teaching hospital for medical students from Wits University.

The upgrade was a public-private partnership between MSD, which contributed R1,5m, the Gauteng health department, which paid R500 000, and the SA Institute for Medical Research, a statutory body which contributed R300 000.

The upgrade resulted from a 1996 survey of staff members which painted a "disturbing" picture, the hospital said. In the survey 96% of the respondents felt the quality of care was poor and equipment inadequate, while 57% said emergency care facilities were insufficient.

The new ward is divided into five sections, each staffed by two nurses, two doctors, a registrar and an intern. This "dramatically improves the quality of care", said project co-ordinator Dr Ivor Katz.

## JUDGMENT IN BRIEF

A recent court judgment of interest to business

NBS Boland Bank Bpk v One Berg River Drive CC, Witwatersrand Local Division, 8 April 1998, B Southwood

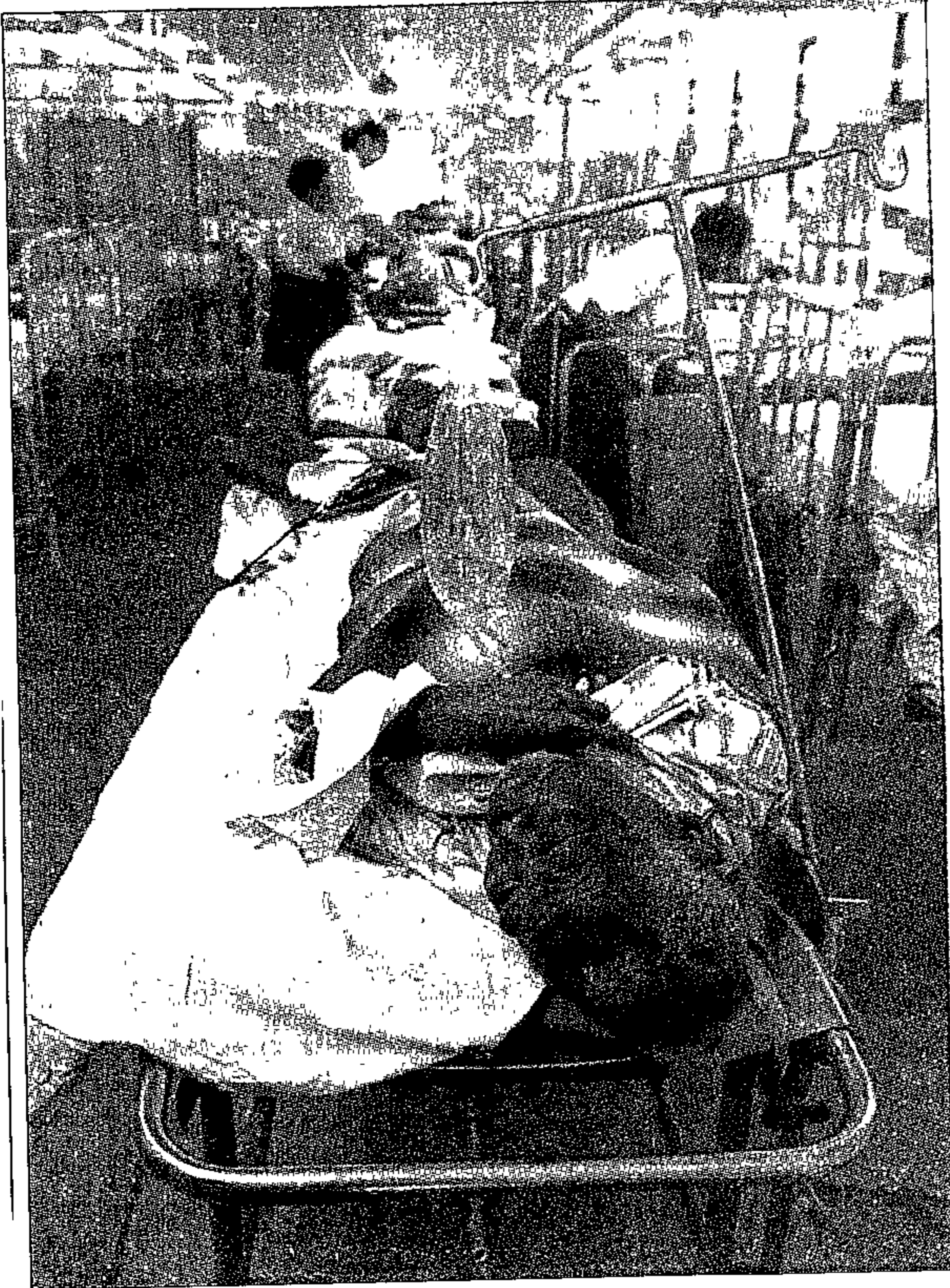
MORTGAGE bonds passed by One Berg River Drive in favour of NBS Boland Bank provided that specified interest rates would be payable on the loan advanced, or such rates as the NBS might determine from time to time. Clause 14 of the bond provided that the NBS could vary the rate of interest and could increase the monthly repayments so as to ensure ultimate payment of the whole bond within the period of the bond.

The NBS brought an action against Berg River, claiming amounts outstanding in terms of the bonds. The parties agreed that the point of difference between them was the legality and enforceability of clause 14. Berg River argued that clause 14 was void because it was vague, having left the determination of the interest rate completely within the discretion of one party, the NBS. The NBS argued that in interpreting the provision, enforceability rather than unenforceability should be sought; furthermore, that the NBS's discretion was to be exercised reasonably.

The judge said that it was a principle of our law that when a term of a contract depends entirely on the will of one of the parties to determine the extent of performance of either party, the contract is void. While it was true that a contractual term should be interpreted so as to be enforceable, rather than unenforceable, the provisions of clause 14 gave the NBS an unfettered discretion to vary the interest rate. The discretion did not have to be exercised reasonably. Clause 14 was therefore unenforceable.

□ Advocate Mark Stranex's feature appears every Friday. Full transcripts are obtainable from e-mail [lawpub@global.co.za](mailto:lawpub@global.co.za) or fax 011-337-6634 or <http://www.lawpublisher.co.za>.





◀ The old ... overcrowding and insufficient beds.

▲ The new ... reflecting a social conscience.

## No need for fear in new Bara ward

*Nov 8/5/98 (98)*

**BY ANSO THOM**  
Health Reporter

Years of shocking conditions at the Chris Hani Baragwanath Hospital's (CHB) medical admissions ward ended yesterday with the opening of a new wing sponsored by government and the private sector.

"It was not hard for us to sell the project once a potential donor came to see the ward, because the inhumane and disgusting conditions that existed spoke for themselves," said project co-ordinator Dr Ivor Katz.

Between 80 and 130 patients, suffering from diseases such as tuberculosis, Aids-related illnesses, diabetes, strokes and psychiatric disorders pass through Ward 20 every day.

After a survey conducted two years ago to assess the needs of the patients and staff, a management committee was set up.

The survey found the ward was not efficiently run, quality of patient care was poor and the equipment inadequate.

"Doctors and nurses used to run around looking for patients and this led to poor teamwork," said matron-in-charge Joyce Pooe.

The project teamed up with the SA Institute for Medical Research (SAIMR) to build a new

emergency laboratory adjacent to the ward. "The new lab is six times the size of the old lab," said SAIMR head at CHB Dr Martin Hale.

Merck Sharp and Dome agreed to sponsor the project with assistance from the SAIMR and Gauteng Department of Health.

Yesterday The Star saw patients lying on the benches in the passage or lined up on trolleys or in wheelchairs waiting to be transferred from the old overcrowded ward.

Doctors performed medical procedures in the presence of the patient's families as there was no waiting room.

Chief of medicine at CHB Professor Ken Huddle said the new ward reflected the social conscience of the hospital.

The new high care unit, with eight beds, would have more oxygen points than the old ward. And a fully fitted kitchen, resting areas for staff, curtains around the beds and a store room for medication have also been built.

"I came in yesterday and already I have seen two corpses which is really upsetting," said cardiac patient Veronica Nota (54), who was yesterday still being treated in the old ward.

"I just want to go home, I'm afraid here," she said.





HANNES THIART

**Helping hands:** Christine Brathwaite, John Sonnenberg and Sharifa Fredericks join hands at the opening of the new St Luke's Hospice at Somerset Hospital

## New hospice under threat

STAFF REPORTER

ARG 12/5/98

A new St Luke's Hospice has been set up in a vacant ward at Somerset Hospital - but it may be forced to move soon if part of the hospital is sold in terms of a provincial government plan to save money.

At the opening of the Milner Ward hospice yesterday, St Luke's chairman John Sonnenberg said the organisation had to get on with its work and could not wait for the provincial health department to decide the future of the hospital.

The sale of part of Somerset has been mooted as a way to help the department keep

(98)  
within its budget and avoid closing the whole hospital. Dr Sonnenberg said he hoped it would be a couple of years before the property was sold.

St Luke's cares for terminally ill patients, the majority of whom have cancer or AIDS. The Somerset hospice is able to serve 40 people from an area stretching from Woodstock to Sea Point. Previously, patients had to travel to the hospice in Kenilworth for treatment ranging from physiotherapy to group discussion on the trauma of dealing with life-threatening disease.

The hospice will also offer support to Somerset Hospital AIDS patients, who cannot be helped by the diminished staff.



## Call for Discoverers to go back to being a hospital

(98) Star 13/5/98

By ANSO THOM  
Health Reporter

Discoverers Hospital on the West Rand was surrounded by angry picketers yesterday.

They demanded that the institution, which has been converted by the Gauteng health department into a community healthcare centre, be reopened as a hospital.

Communications director for the Gauteng health department, Jo-Anne Collinge, said the decision to convert the hospital into a community health centre was taken as part of a plan to achieve a more rational, equitable and cost-efficient health service, with greater emphasis on primary healthcare.

"Most important for the community to know is that Discoverers is not closed or not about to close. And the change is not as dramatic as some people allege," she said.

Collinge said the community could still gain access to a wide range of healthcare services including a number of free primary healthcare services, a day-time casualty service, a 24-hour midwife obstetric unit, short-stay beds, dental care, an x-ray unit, a pharmacy and social work services.

In March, 5 688 outpatients were treated compared to 3 924 during the same time last year.

"Although some staff have been lost as a result of the drawn-out process of conversion, there are plans to address the situation, with the number of doctors increased to provide for more complex clinical services planned for the centre. This would enable the clinic to extend casualty hours," Collinge added.

In the second half of this year, additional primary healthcare services – including family planning, a well-baby clinic, immunisation and the management of tuberculosis – would be added.

The petition contained more than 20 000 signatures as well as 500 letters.

Rae Baur, chairman of the Democratic Party's Roodepoort branch, said it was unacceptable that a modern, five-storey hospital serving a community of 107 000 people could be closed and a small portion transformed into a healthcare centre. She said Discoverers had been the only hospital capable of serving Roodepoort and Dobsonville.

A misunderstanding led to picketers failing to hand over a memorandum and petition to the department yesterday. A government official waited for the picketers inside the clinic while they waited for her outside the gates.



residents of the hostel, which was extensively damaged, escaped.

His body was found in the afternoon. - Sapa

Delay: Allan Boesak and his wife

# 100 docs face axe in W Cape hospitals

## Budget may cut 2 148 staff

(98)  
ARL 13/5/98

JENNY VIAL  
HEALTH REPORTER

The Western Cape Health Department will have to shed 2 148 staff, most of them by September, if it is to keep within budget.

This is set out in the department's revised business plan, which was discussed with labour organisations last week. It has yet to be approved by the provincial cabinet.

Although staff cuts will affect all employees, doctors will be hit particularly hard by the proposals on how many employees in each category should leave.

More than 100 doctors at Somerset, Princess Alice, Grootte Schuur, Red Cross and Tygerberg hospitals

have been described as "supernumerary", which means they will not be needed.

This number includes 58 registrars (doctors training to be specialists) and more than 30 specialists.

But doctors also will be affected by plans to defer their overtime pay from March 1998 to April 1999, and reduce the overtime worked.

About a third of doctors' pay is overtime pay, and this will save money in this financial year. Payments to district surgeons also will be limited.

Employees declared supernumerary will be given the option of taking voluntary severance packages or of being deployed in other posts.

The draft business plan released in March required 3 800 staff to leave the service. Of the 2 148 required to

leave in the revised plan, 1 200 are expected to leave through natural attrition (resignation, death, ill-health).

The rest will be encouraged to take voluntary severance packages.

The department says it can save R22-million on personnel and R90-million in other areas.

But Michael Makwayiba, of the National Education, Health and Allied Workers' Union, which represents about a third of health workers in the province, said the department could not afford to lose more staff.

He said: "It does not make sense to say we want to retrench more staff when there is a shortage of staff. We will not support a loss of jobs or a plan based on rands rather than the health needs of people."



# X-ray crisis hits Leratong Hospital

By Noxolo Nxusani

**H**UNDREDS of desperate patients are believed to have been turned away from the Leratong Hospital on the West Rand because X-ray machines have broken down.

Those with serious injuries have, however, been admitted and told to wait until the machines have been fixed.

Leratong Hospital public relations officer Mrs Francina Ratsaka confirmed that one of the two functioning X-ray machines broke down on Friday. She said only patients with minor injuries were sent home.

"Since Friday we have fortunately not received any urgent cases," Ratsaka said. "However, from yesterday we have an arrangement with the Paardekraal Hospital, about 10 kilometres away, to take our patients there for X-rays."

She was unable to confirm how many patients had been turned away.

Ratsaka said initially the hospital had five X-ray machines. Three broke down a month ago.

"Since then we have been using only two machines and another one broke down last week," she said.

Mr Popo Maja, a spokesman for Gauteng's MEC for health, said his department was not aware of the problems at the hospital.

Maja said: "The normal procedure is that the department has to be notified of anything that hinders the provision of services to the public. In this particular case, we have not been informed at all."

Maja promised to investigate the matter further.

Sources told *Sowetan* that about 120 patients are treated at the hospital on Saturdays and Sundays.

The source said some patients had asked to be referred to other hospitals after they were turned away.

## Accident victim

One of the patients – an accident victim who who did not want to be named – was told to go home and come back the following day when staff members intervened.

"She was forced to wait in the casualty room for several hours for transport to take her to the Tshepo Themba Private Clinic in Soweto," the source said.

When *Sowetan* visited the hospital yesterday there were two empty rooms that were supposed to contain X-ray machines. Staff members at the orthopaedic department, which deals with bone disorders, were sending patients away.

Several other ward patients were waiting anxiously for their turn to be taken to the Paardekraal Hospital.

(98)  
*Sowetan*  
20/5/98



# An early start (98)

## in Guguletu

JUDITH SOAL

ET 21/5/98

IT'S 6.30am. Nomsamo Matebi is squashed onto a rickety bench at Guguletu Day Hospital, one of about 250 people sitting patiently in rows, waiting for treatment. And that's just inside. Outside the queue is growing steadily.

Matebi woke up at 3.30am and arrived at the hospital just after 4am. She comes here once a month for treatment for her high blood pressure and has learnt that it pays to be early.

"We sit here first, waiting for our files. After this we go to the scale to be weighed, then the sister checks our blood pressure, then we must queue again for the doctor, then we go to the dispensary for drugs. It is afternoon before we get out of here."

Near her sits Leonard Gcobo. Gcobo has beads of sweat on his face and is coughing weakly. He arrived at the hospital at 4.30am and hopes to be home before lunchtime. He really should be in bed. It will be over an hour before the first doctor arrives and even longer before Gcobo will get any attention.

But Matebi and Gcobo are among the lucky ones. The people outside arrived after 6am and have to stand in the dark, between outbreaks of rain, hoping that they will be able to see a doctor at all.

Gertrude Nzwane was here last week but went home without get-

ting treatment for her three-year-old daughter Wendy.

"She is vomiting. She hasn't eaten properly for two weeks. I brought her last week but by 12.30 I was still in the queue and they told me there wasn't a doctor.

"So I left and went to the chemist for some pills but it didn't help. I came earlier this time. I got here at 6.30am, but I am still outside. I am worried because she is very weak."

The sister inside the hospital assures the *Cape Times* that no one is ever sent away without treatment, but a security guard says that it can happen.

"The doctors come at 8am and leave at 4pm. So people might be sent away, but it isn't usual."

The hospital is open 24 hours a day and runs a trauma department.

"You should see it here on a Saturday night," says Laurence Gillmanne, the guard. "You should take your pictures then."

One group tell us about the woman who died in the queue at a different hospital, they're not sure where. None of them were there, but they have heard about it. Rumours spread quickly when the circumstances are right.

Thelma Depa says she has to walk for 45 minutes to get to the hospital every month.

"I am a granny and I must do this! I left home at 5am today but that is late. It is better to leave at 4am but what about the skollies?"



**IDLE:** Msimasi Pasile waits hours for mom.



**ENOUGH:** It is wrong that they have to wait like that, says Elsie Mgwell, 76. Specially the people that are old like herself. She visits monthly to keep her high blood pressure in check.

We are not safe on the street.

"Sometimes we come here and wait and they say 'we don't have your medicine today. You must come back tomorrow'."

Despite the wasted hours, the

crowd do not show their frustration. The mood is one of co-operation as the sickest people are sent to the front and every one helps with childcare. There isn't much conversation though, just quiet

resignation and bored stares. By the time the *Cape Times* team leaves just before 8am the queue has stretched around the building and out the gate. The doctors are starting to arrive for work.

## The business plan: How to save R147m

Non-personnel savings: R90,486m

- Close Princess Alice Hospital, saving R1,5m
- Close Valkenberg, saving R2m
- Cut Somerset Hospital down to 260 beds, saving R2m
- 'Rationalise' the dental hospitals, saving R2,5m
- Cut support to Nelspoort Hospital, saving R3m
- Cut projections for inflation to three percent, saving (on paper) R20m
- Limit payments to district surgeons, saving R3m
- Replace steam heating systems with electric ones, saving R3,5m
- Spend R20m less on equipment, and hope nothing breaks down
- Raise an extra R10,986m by charging more people more for services
- Cut R22m on the maintenance budget, and hope nothing breaks down

Personnel savings: R22m

- Cut staff overtime payments by 18% to save R18,3m
- Do away with 2 148 jobs, which, after paying out severance packages, will save R3,7m this year, but a good deal more next year
- Defer payments: R35m
- Pay next March's overtime expenses in April, passing the bill on to the next financial year, saving R8m
- Defer transfer payments to local authorities and payments on capital and maintenance projects to the next financial year, saving R27m

## The staff plan

Academic hospitals (Red Cross, Groote Schuur and Tygerberg) — 870 jobs to go

Princess Alice Hospital — 60

Somerset Hospital — 146

Voluntary severance packages already approved — 310

Voluntary severance packages turned down, to be reconsidered — 100

New voluntary severance package applications — 183

Estimated normal staff losses through illness, death etc — 1 200

721 outstanding 'key' post will be filled — perhaps with people losing their jobs as described above — so the net loss in jobs is 2 148



health services have been severely wounded by budget cuts

# seven victims (98)

M+G 22-28/5/98 (98)

Valkenberg all but froze the release process late last year, as the killings mounted. Kaliski estimates that discharged patients have now killed at least 11 people over the past three years. Many of them have since been returned to the institution.

"Either we've got to watch them closely, or someone else must, but we have great difficulty keeping an eye on everyone," Kaliski adds. "The only way we can keep control of them is to keep them in our walls."

He says the unit is unable to gauge what sort of treatment, if any, other discharged former patients are receiving.

Adequate community care will be vital in preventing the government's drive toward releasing state patients ending in a smash. The government's main motive is to modernise its approach to mental and psychiatric health care, away from often grotesque past practices such as simply locking patients away.

But similar experiments overseas have left many former state patients on the streets or in jail. Such results prompted the United Kingdom recently to reverse its

care-in-the-community policy.

The Western Cape based its rationalisation plans partially on a task-team report finalised earlier this year.

The report warned that community care for psychiatric and mental patients, already hampered by staff shortages, had been further hurt by voluntary severances. It recommended that posts vacated under the pay-off programme be retained and filled.

But the department responded that it could not "guarantee" the posts would be retained. "Cognisance must be taken of the need to rationalise the total health department to set budget limits," the department noted.

Freeman says community care in the Western Cape "has not collapsed. However, there is little doubt that these services could be improved."

Lawrence adds that the province will only release patients into the community "at a rate that can be received". At the moment, such patients are being moved into halfway houses.

SA Health in need of treatment, PAGE 24



On the street: Where will Valkenberg patients go if the institution closes? PHOTOGRAPH: JUSTIN SCHOLK

# Subtle signs of relapse hard to detect

(98) (98)

Andy Duffy M+G 22-28/5/98

Staff at the Valkenberg forensic security unit are busy retracing their steps to see what, if anything, could have been done to prevent the killing of seven people by former state psychiatric patients.

There are common threads. Each patient, despite their usually violent history, seemed to have responded well to rehabilitation treatment at the unit, each responded well to outside treatment at clinics, and then, one by one, each fell from the state's radar screen ... re-emerging only once they had killed.

Names and specific dates remain under wraps, often for legal reasons, often because Valkenberg fears for the safety of the patient. One Cape Flats community is still looking for the man who knifed to death one of its highest-profile women — the aunt who had taken him in when his family in the Eastern Cape refused.

One case, however, seems to sum up what's gone wrong. Valkenberg had held one violent patient for years, finally deciding early in the 1990s that he could be released.

"He did very well," says unit head Sean Kaliski. "He found a job, he got married, he was coming to a clinic. And then he stopped coming."

So nobody picked up the growing friction between the man and his stepdaughter. He wanted her to treat him like a father; she laughed at him for being a former psychiatric patient.

One afternoon, in the family's lounge, in front of her laughing friends, the girl pushed the ridicule too far. The man fled to his room, and returned with an axe that he swung high and sank deep into her chest.

The ex-patient was initially held at Pollsmoor, apparently because he did not appear sufficiently insane to warrant a place at Valkenberg. In a matter of months he had totally relapsed and was back at Valkenberg.

"We still don't know what went wrong," Kaliski says. "The early signs of relapse can be very subtle and you must see these people quite a lot. They should be seen at least once a month." But when they don't appear at the clinics little effort is made to find them. "We just don't have the resources to do that anymore."

The unit is still chasing details from the Free State police about the abduction, rape and killing of two small girls by one of its ex-patients, early last year. The patient's case history shows that he too had been a very violent character, but after he had spent years in Valkenberg, staff "felt obliged to start the rehabilitation process".

He too disappeared after a few clinic visits, only to resurface in the hands of the Bloemfontein police. "We had no way of tracking him down," Kaliski says. The other cases include a patient stabbing his wife, and a patient who stabbed his mother.

One former patient, who had married and had a daughter, slipped when he was walking down the street, stabbing to death a man he remains convinced was a top gang leader.

Valkenberg has its successes. Kaliski has one patient who was held at the maximum security unit for 16 years after killing three people. The man is still a state patient, but he holds down a job in the city. Kaliski sees him regularly.

"It's only a very small section of those who become ill that are violent and they need extra care," Kaliski says. "But when budgets are cut we're cutting very important and very sensitive services."



Overcrowded: There are only four beds for children in the Alexandra clinic. photographs: nadine hutton

# Just three hours to rest after giving birth

Bongani Siquoko

The road to Alexandra clinic is lined with filthy industrial buildings. But the large, brightly painted clinic looks cared for and cheerful. Many visitors mistake it for a creche.

Inside, however, it looks like any other state-funded health institution. Very long queues, busy nurses, crying children and wheelchairs fill the waiting room.

The clinic will be forced to close down if it does not get more funding from the government, staffers say. This follows a budget cut of R9-million by the Department of Health. "We were getting R21-million a year, but now we only get R12-million. What can you do with R12-million these days?" asks a senior nurse at the clinic.

Director Catherine Mvelase says although the clinic is expecting another R1,2-million from the Eastern Metropolitan Local Council,

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it still won't be enough. The clinic, which has been operating for 68 years, treats more than 1 000 patients a day from Alexandra township — which has a population of about 500 000 squeezed into 2,5km<sup>2</sup>.

It is also struggling to pay the R5-million it owes the Gauteng provincial administration for drugs. "We are trying to pay what we can," says Mvelase. Every month the clinic has been buying R210 000 worth of drugs, but since the Hillbrow hospital closed down it has been forced to double that amount.

"We are getting more people from Yeoville, Hillbrow, Alex, Midrand and Berea who have been referred to us by Hillbrow hospital," says Sister Legora Marumo. As a result the clinic's pharmacy has run out of some essential drugs. "For weeks we have been telling people to come back later for these drugs," she says.

If the clinic shuts down, sick children and

pregnant women will suffer. Although it has limited resources, the clinic still treats hundreds of children with diarrhoea, flu, pneumonia and asthma.

The children's observation area has only four beds. It is overcrowded and sometimes four children have to share one bed.

The adult observation areas are the same. Three women share one bed, and the women are sometimes housed with male patients. Only two professional nurses, a porter and an assistant nurse are on duty at any given time for all three wards.

The situation is even worse in the maternity ward. There are only two midwives to look after women who are about to deliver or who have just given birth. Women are given only three hours to rest after giving birth. "We cannot do otherwise, there are other women queuing up for the beds," says Marumo.



*From the monitoring of released mental patients to the provision of ambulances,*

# 'Rehabilitated' patients claim

Andy Duffy

**P**sychediatric patients treated and released by Western Cape health authorities have killed seven people over the past 18 months, including two children, amid an apparent collapse in the system set up to monitor them.

The former patients, all from the high-security forensic unit at Cape Town's Valkenberg hospital, represent a small proportion of the mostly harmless population of state mental and psychiatric institutions.

But the killings could fuel fears about the government's drive to release thousands of patients into the care of their family and friends. Health officials say community care has been hit by staff shortages and cost-cutting measures such as voluntary severance packages.

The deaths could also leave state health open to huge legal and civil action from the victims' families.

Valkenberg forensic unit head Sean Kaliski says the six patients who turned killers were all judged to be rehabilitated and low risk pri-

or to their release. The unit treats patients who are deemed unfit to stand trial for crimes such as murder, rape and assault.

But he adds that an exodus of state psychiatric nurses and social workers holed the safety net designed to catch the relapses among discharged patients. Valkenberg only discovered the homicidal activities of its former patients from police inquiries throughout last year.

Their victims were mainly family members. One man buried a hatchet in his stepdaughter's chest, another stabbed his mother. The children — two small girls abducted, raped and killed in the Free State — are believed to have been random victims of one former patient. All have been caught.

Kaliski adds that the unit also releases dozens of other patients for a month at a time because the hospital lacks the staff to control them.

"We just hope to God they don't hurt someone while they're out," Kaliski says.

The killings caught national and provincial health officials off guard. The Department of Health had to check with Valkenberg before issuing a written response.

"Patients released from forensic units of mental institutions sometimes do commit crimes of varying seriousness," department director for mental health and substance abuse, Melvyn Freeman, says. "This is, however, the exception rather than the rule."

Other institutions report that less than 5% of their released patients commit crime.

Freeman adds the department would have to consult its legal advisers to check whether it can be held liable in criminal or civil law for the deaths.

The Western Cape health chief director of supraregional hospitals, Gilbert Lawrence, says the killings are a "wake-up call" about the weakness of current community care.

"Doctors [at Valkenberg] face the dilemma about releasing patients into a structure that is adequate or not adequate. At the end of the day it's a question of resources. It's happening across the country."

Around 735 staff at the province's four psychiatric and mental institutions have taken pay-offs since June 1996, close to one-quarter of their total staff. More than 420 have taken the

package in the past six weeks.

The staff losses form part of an overall health rationalisation and cost-cutting programme. The province also plans to close Valkenberg, transferring its services and staff to three surviving state institutions.

Kaliski and Dr Brian Robertson, head of the psychiatric department at the University of Cape Town, believe the closure could further weaken the care given forensic unit patients. Valkenberg is one of UCT's teaching hospitals. "I've no doubt it will increase the risk," Robertson adds.

Lawrence says that is just an opinion; he expects the rationalisation will improve care.

Valkenberg treats 280 forensic unit patients — 65 of them in a maximum-security unit — from the Western, Eastern and Northern Cape. The unit discharged 33 patients between 1996 and 1997, following lengthy, gradual rehabilitation.

The discharge application is approved by the attorney general — in Valkenberg's case, Frank Kahn — following consultation with a judge.

## Don't get sick after midnight

Swapna Prabhakaran

**T**he KwaZulu-Natal Department of Health announced an "inadequate" health budget for 1998/99 this week, sparking an outcry from hospital staff who predict it will have dire consequences for health services.

Drastic cutbacks in services and staff have already been implemented at some provincial hospitals in preparation for the budget, which is R621-million short of the expected expenditure for the year. Several vital health-care services will either be completely suspended, or run at partial capacity.

In his budget speech, MEC for Health Dr Zweli Mkhize said while cuts are unavoidable, they have been planned to have "the lowest possible impact on the population as a whole".

He did admit, however, that some of the measures "will have negative medical, or even life-threatening consequences". One of these is that no government ambulance services will be available to patients in KwaZulu-Natal between midnight and 6am.

This measure, which the department labels as "cutting down on ambulance response time by 30%", may be a blanket measure, regard-

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less of how ill the patient is. Alternatively, ambulances may respond selectively, attending to only the most dire emergencies during those hours.

Earlier in the month Mkhize warned that the balancing act of budgeting health meant making some tough choices. "The truth is, there is very little fat to trim in KwaZulu-Natal and any cuts go straight into flesh and bone," he said.

And now those cuts are beginning to bleed. Some hospitals have been forced to close down specialised wards — two wards have already

**'The scenario we face is that on any night in Durban, about 500 ill and dying people will be desperately trying to get into a hospital, any hospital'**

been closed at Addington hospital in Durban, and the closure of nine other wards seems likely — while smaller hospitals have to close down entire sections.

King Edward VIII hospital has to cut down 50% of all non-emergency operations, while Wentworth hospital faces a 50% cutback on cardiac surgery procedures.

St Mary's hospital in Marianhill has already cut back on a large number of patients' beds and is considering closing the doors of its casualty ward after hours and on weekends — patients who become ill on a Saturday night will have to find another hospital, or wait until Monday morning.

In a statement jointly released by doctors and nurses at some of the province's biggest hospitals, one angry doctor warned of the dreadful consequences of the cutbacks.

"The scenario we face is that on any night in Durban, about 500 ill and dying people will be desperately trying to get into a hospital, any hospital. Hospital gates will be closed, with little tent cities of desperate, sick people waiting outside, praying for hospital beds," the doctor said.

Mkhize denied the need for such pessimism. "What we have to do above all else is focus on the R4,7-billion we have got, and not only on the R621-million that



Hurt by the cuts: Budget cuts to hospitals and clinics mean less care for the sick

we do not have," he said in his budget speech.

Over the past few weeks, the Department of Health has drawn up a list of some of the money-saving devices planned for the near future. Much of it is administrative detail — increasing efficiency, cutting out waste of resources, shortening the length of stay at hospitals.

But also on the list are some items marked as "negative medical implications". These include: "reduce treatment to terminal cases"; "closure of 9 000 out of 28 000 beds [available at hospitals]"; and "cut highest levels of surgery".

One particularly carefully worded item — "introduce stricter protocols" — effectively means victims of strokes, heart attacks and other major debilitating diseases may be refused beds in hospitals if they don't meet the strict criteria of entrance.

Doctors predict these are most likely to affect "the weakest in our communities — the elderly, children, pregnant women and their unborn babies, and those with chronic diseases and Aids".

The sad irony is that the cuts come at a time when the province's health-care service is experiencing a boom.

More people than ever before have had access to health care and child mortality rates have dropped by nearly half.

Much of this is thanks to the province's network of clinics, and the department has committed itself to improving this network of services and staff. However, clinics are not able to replace all the services hospitals provide.

The superintendent of St Mary's hospital, Dr Douglas Ross, says the state-subsidised hospitals are among the worst hit by the cuts.

He says large-scale retrenchments seem inevitable at his hospital — its subsidy has been cut by R10-million and it seems likely this will mean the hospital will scale down to become a community health centre.

"It's terrible, shocking, almost ridiculous," Ross said this week. "I'm faced with the position of retrenching doctors at a time when the government is importing Cuban doctors."

**Golf Course**  
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From the monitoring of released mental patients to the provision of ambulances,

# 'Rehabilitated' patients claim

Andy Duffy

**P**sychoiatric patients treated and released by Western Cape health authorities have killed seven people over the past 18 months, including two children, amid an apparent collapse in the system set up to monitor them.

The former patients, all from the high-security forensic unit at Cape Town's Valkenberg hospital, represent a small proportion of the mostly harmless population of state mental and psychiatric institutions.

But the killings could fuel fears about the government's drive to release thousands of patients into the care of their family and friends. Health officials say community care has been hit by staff shortages and cost-cutting measures such as voluntary severance packages.

The deaths could also leave state health open to huge legal and civil action from the victims' families.

Valkenberg forensic unit head Sean Kaliski says the six patients who turned killers were all judged to be rehabilitated and low risk pri-

or to their release. The unit treats patients who are deemed unfit to stand trial for crimes such as murder, rape and assault.

But he adds that an exodus of state psychiatric nurses and social workers holed the safety net designed to catch the relapses among discharged patients. Valkenberg only discovered the homicidal activities of its former patients from police inquiries throughout last year.

Their victims were mainly family members. One man buried a hatchet in his stepdaughter's chest, another stabbed his mother. The children — two small girls abducted, raped and killed in the Free State — are believed to have been random victims of one former patient. All have been caught.

Kaliski adds that the unit also releases dozens of other patients for a month at a time because the hospital lacks the staff to control them.

"We just hope to God they don't hurt someone while they're out," Kaliski says.

The killings caught national and provincial health officials off guard. The Department of Health had to check with Valkenberg before issuing a written response.

"Patients released from forensic units of mental institutions sometimes do commit crimes of varying seriousness," department director for mental health and substance abuse, Melvyn Freeman, says. "This is, however, the exception rather than the rule."

Other institutions report that less than 5% of their released patients commit crime.

Freeman adds the department would have to consult its legal advisers to check whether it can be held liable in criminal or civil law for the deaths.

The Western Cape health chief director of supraregional hospitals, Gilbert Lawrence, says the killings are a "wake-up call" about the weakness of current community care.

"Doctors [at Valkenberg] face the dilemma about releasing patients into a structure that is adequate or not adequate. At the end of the day it's a question of resources. It's happening across the country."

Around 735 staff at the province's four psychiatric and mental institutions have taken pay-offs since June 1996, close to one-quarter of their total staff. More than 420 have taken the

package in the past six weeks.

The staff losses form part of an overall health rationalisation and cost-cutting programme. The province also plans to close Valkenberg, transferring its services and staff to three surviving state institutions.

Kaliski and Dr Brian Robertson, head of the psychiatric department at the University of Cape Town, believe the closure could further weaken the care given forensic unit patients. Valkenberg is one of UCT's teaching hospitals. "I've no doubt it will increase the risk," Robertson adds.

Lawrence says that is just an opinion; he expects the rationalisation will improve care.

Valkenberg treats 280 forensic unit patients — 65 of them in a maximum-security unit — from the Western, Eastern and Northern Cape. The unit discharged 33 patients between 1996 and 1997, following lengthy, gradual rehabilitation.

The discharge application is approved by the attorney general — in Valkenberg's case, Frank Kahn — following consultation with a judge.

## Don't get sick after midnight

Swapna Prabhakaran

**T**he KwaZulu-Natal Department of Health announced an "inadequate" health budget for 1998/99 this week, sparking an outcry from hospital staff who predict it will have dire consequences for health services.

Drastic cutbacks in services and staff have already been implemented at some provincial hospitals in preparation for the budget, which is R621-million short of the expected expenditure for the year. Several vital health-care services will either be completely suspended, or run at partial capacity.

In his budget speech, MEC for Health Dr Zweli Mkhize said while cuts are unavoidable, they have been planned to have "the lowest possible impact on the population as a whole".

He did admit, however, that some of the measures "will have negative medical, or even life-threatening consequences". One of these is that no government ambulance services will be available to patients in KwaZulu-Natal between midnight and 6am.

This measure, which the department labels as "cutting down on ambulance response time by 30%", may be a blanket measure, regard-

less of how ill the patient is. Alternatively, ambulances may respond selectively, attending to only the most dire emergencies during those hours.

Earlier in the month Mkhize warned that the balancing act of budgeting health meant making some tough choices. "The truth is, there is very little fat to trim in KwaZulu-Natal and any cuts go straight into flesh and bone," he said.

And now those cuts are beginning to bleed. Some hospitals have been forced to close down specialised wards — two wards have already

**The scenario we face is that on any night in Durban, about 500 ill and dying people will be desperately trying to get into a hospital, any hospital'**

been closed at Addington hospital in Durban, and the closure of nine other wards seems likely — while smaller hospitals have to close down entire sections.

King Edward VIII hospital has to cut down 50% of all non-emergency operations, while Wentworth hospital faces a 50% cutback on cardiac surgery procedures.

St Mary's hospital in Marianhill has already cut back on a large number of patients' beds and is considering closing the doors of its casualty ward after hours and on weekends — patients who become ill on a Saturday night will have to find another hospital, or wait until Monday morning.

In a statement jointly released by doctors and nurses at some of the province's biggest hospitals, one angry doctor warned of the dreadful consequences of the cutbacks.

"The scenario we face is that on any night in Durban, about 500 ill and dying people will be desperately trying to get into a hospital, any hospital. Hospital gates will be closed, with little tent cities of desperate, sick people waiting outside, praying for hospital beds," the doctor said.

Mkhize denied the need for such pessimism. "What we have to do above all else is focus on the R4,7-billion we have got, and not only on the R621-million that



Hurt by the cuts: Budget cuts to hospitals and clinics mean less care for the sick

we do not have," he said in his budget speech.

Over the past few weeks, the Department of Health has drawn up a list of some of the money-saving devices planned for the near future. Much of it is administrative detail — increasing efficiency, cutting out waste of resources, shortening the length of stay at hospitals.

But also on the list are some items marked as "negative medical implications". These include: "reduce treatment to terminal cases"; "closure of 9 000 out of 28 000 beds [available at hospitals]"; and "cut highest levels of surgery".

One particularly carefully worded item — "introduce stricter protocols" — effectively means victims of strokes, heart attacks and other major debilitating diseases may be refused beds in hospitals if they don't meet the strict criteria of entrance.

Doctors predict these are most likely to affect "the weakest in our communities — the elderly, children, pregnant women and their unborn babies, and those with chronic diseases and Aids".

The sad irony is that the cuts come at a time when the province's health-care service is experiencing a boom.

More people than ever before have had access to health care and child mortality rates have dropped by nearly half.

Much of this is thanks to the province's network of clinics, and the department has committed itself to improving this network of services and staff. However, clinics are not able to replace all the services hospitals provide.

The superintendent of St Mary's hospital, Dr Douglas Ross, says the state-subsidised hospitals are among the worst hit by the cuts.

He says large-scale retrenchments seem inevitable at his hospital — its subsidy has been cut by R10-million and it seems likely this will mean the hospital will scale down to become a community health centre.

"It's terrible, shocking, almost ridiculous," Ross said this week. "I'm faced with the position of retrenching doctors at a time when the government is importing Cuban doctors."

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## 'Calculated risk' when criminally insane freed

STAFF REPORTER

ARG 22/5/98  
(98) ~~98~~  
Psychiatrists working with criminally insane patients "take a calculated risk when they release them back into society, and there is always a chance the decision will backfire".

This is the view of Gilbert Lawrence, chief director of supra-regional hospitals for the Western Cape Health Department.

He was responding to allegations that the Health Department was irresponsibly cutting resources to psychiatric hospitals like Valkenberg.

In an article in the Mail & Guardian today, Valkenberg's forensic unit head Sean Kaliski said seven people had been murdered by released patients in the past 18 months. He said there were not enough staff members in the unit to safely care for patients or to follow up once patients were released.

Most of the victims were family members of the killers - and included two children.

Dr Lawrence said the responsibility for releasing a patient rested with the doctor who recommended to the authorities that a patient be released.

"In any dealing with a patient a doctor has to use his best clinical judgment. Even in the most well-resourced society there are failures. Many patients who go out are successfully rehabilitated."

But Dr Kaliski said the exodus of psychiatric nurses and social workers from the public service meant there were not enough qualified staff available to check up on patients once they were back in society.

He said many patients were being released for a month at a time because the hospital did not have the staff to control them. "We just hope to God they don't hurt anyone," he said.

Dr Lawrence said: "Obviously if we had more resources there could be better programmes inside and outside - but at the end of the day the doctor still has to make the final decision."



# Where patients get a bed with a view

## Reborn - city hospital that treated presidents and princes

(98)

ARL 28/5/98

JENNY WALL  
HEALTH REPORTER

President Mandela was treated there. So were D F Malan, Hans Strydom, Danie Craven and Betsy Verwoerd. Princess Labia and an unnamed Indian prince also spent time at the Volks Hospital, as did thousands of Capetonians until it closed in 1994.

Now the Volks Hospital is to open again as a revamped 150-bed private hospital. It's been given a new name, the Cape Town Medi-Clinic, but the old star-shaped building remains, renovated from top to bottom.

### City Bowl

The circular wooden staircase with its brass handrail, which runs from the ground to the top floor, has been retained, as have all the teak and meranti door and window frames.

It's a magnificent hospital, and every room has a view of the harbour, Table Mountain, Devil's Peak or Lion's Head. New additions are 200 parking bays and new consulting rooms for 18 doctors.

The cost of the hospital, including the R15-million purchase price and refurbishment, will be R61-million.

In its 63 years as a hospital the Volks has seen many of Cape Town's people pass through it, either as patients or as staff. Thelma Triem is one of them.

For 23 years she worked at the hospital as a general assistant, leaving when the hospital closed its doors in 1994. "It was a sad day, we all cried when they closed the doors," she said.

Now she's back, and busy cleaning up after construction workers.

She remembers well the time Mr Mandela, then still a prisoner, was a patient. "We weren't allowed into his

room. I had to take his food to the door - all I saw were members of his family," she said.

When she started work at Die Volks, she was paid R16 a month. "But then bus fare was a ticky, and things were cheaper."

"And board and lodging was provided for me."

The hospital's beginnings go back to 1919, when the Dutch Reformed Church identified a need for a hospital for the *volk*, where nurses could be trained to speak Afrikaans and Afrikaans people would be sym-

pathetically received and treated in the spirit of Christ-

ianity. Funds to build the hospital were raised through donations and fundraising events, the first of which was a fete held in October 1919 in the Cape Town City Hall.

The hospital cost R87 800 then to build and equip and was opened in February 1930 by Princess Alice.

The hospital was owned by the NGK until 1981, when it was bought by the Cape Provincial Administration for R1,75-million.

In October 1994 the province closed it because of a glut of beds in central Cape Town. The land was sold to Medi-Clinic and a year ago work started on site.

It's been an architect's nightmare to renovate because the original building plans were destroyed by a fire.

The hospital is due to open in a month and the first patient has already been booked in, for a Caesarian section.

The maternity section has a specially designed delivery bath for women in labour, the most up-to-date version in Cape Town.



Welcome back: Thelma Triem has returned to her old workplace, the Volks Hospital, which is being revamped into a private hospital

HANNES THART



# Valkenberg patients step into unknown

AR 28/5/98 (98)

## Shutdown part of plan to reshape mental health in W Cape

JERRY WALL

Abel was making good progress at Valkenberg hospital and was close to being discharged.

Then the first announcement was made that the hospital would close and he suffered a relapse. He recovered from that, but then the second announcement came and he's had another setback.

Abel is a chronic psychiatric patient and just one of the many people at Valkenberg who have had relapses in the past months due to anxiety about the hospital's future, say staff.

Psychiatric patients are different from other patients, you can't just move them to another hospital, they say.

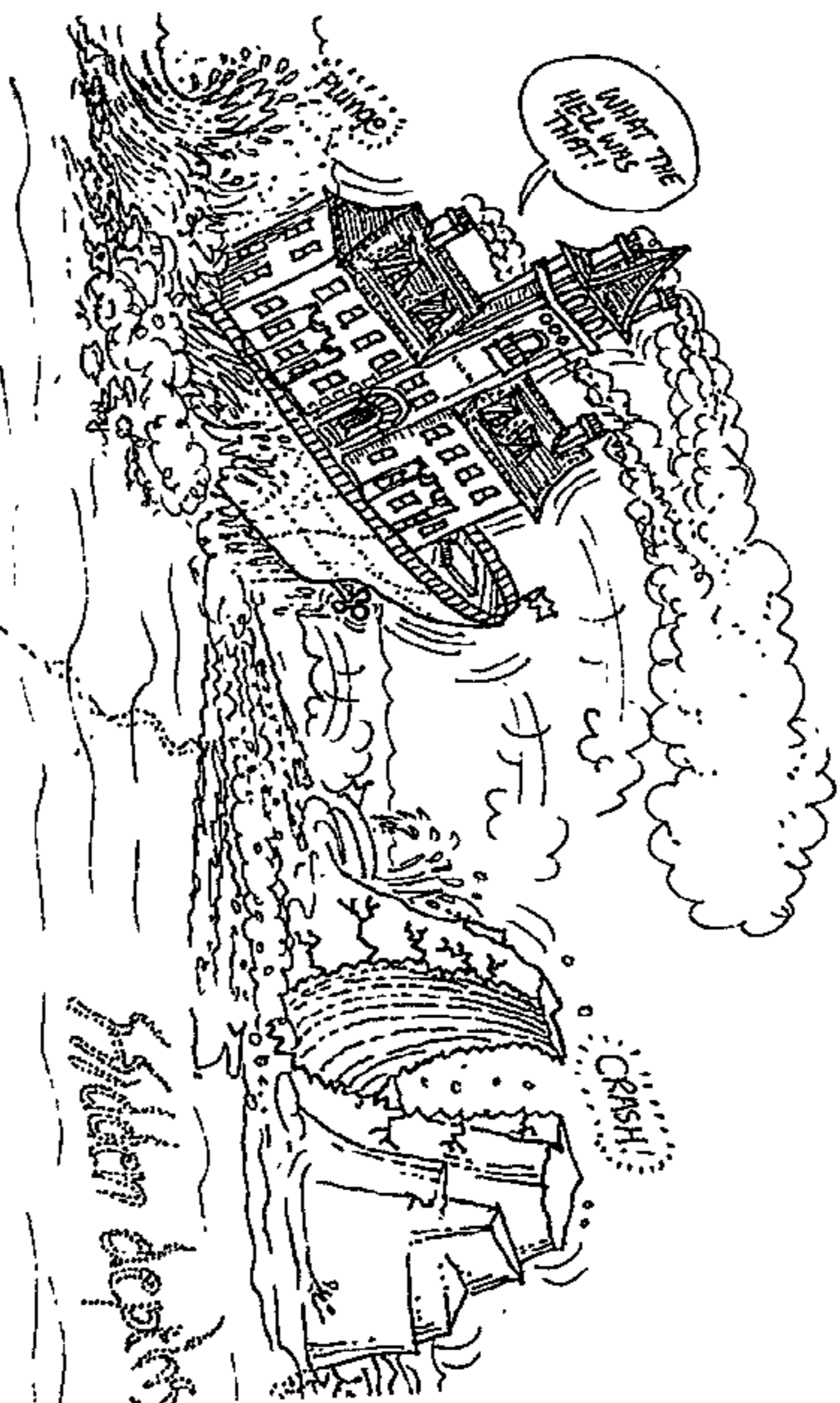
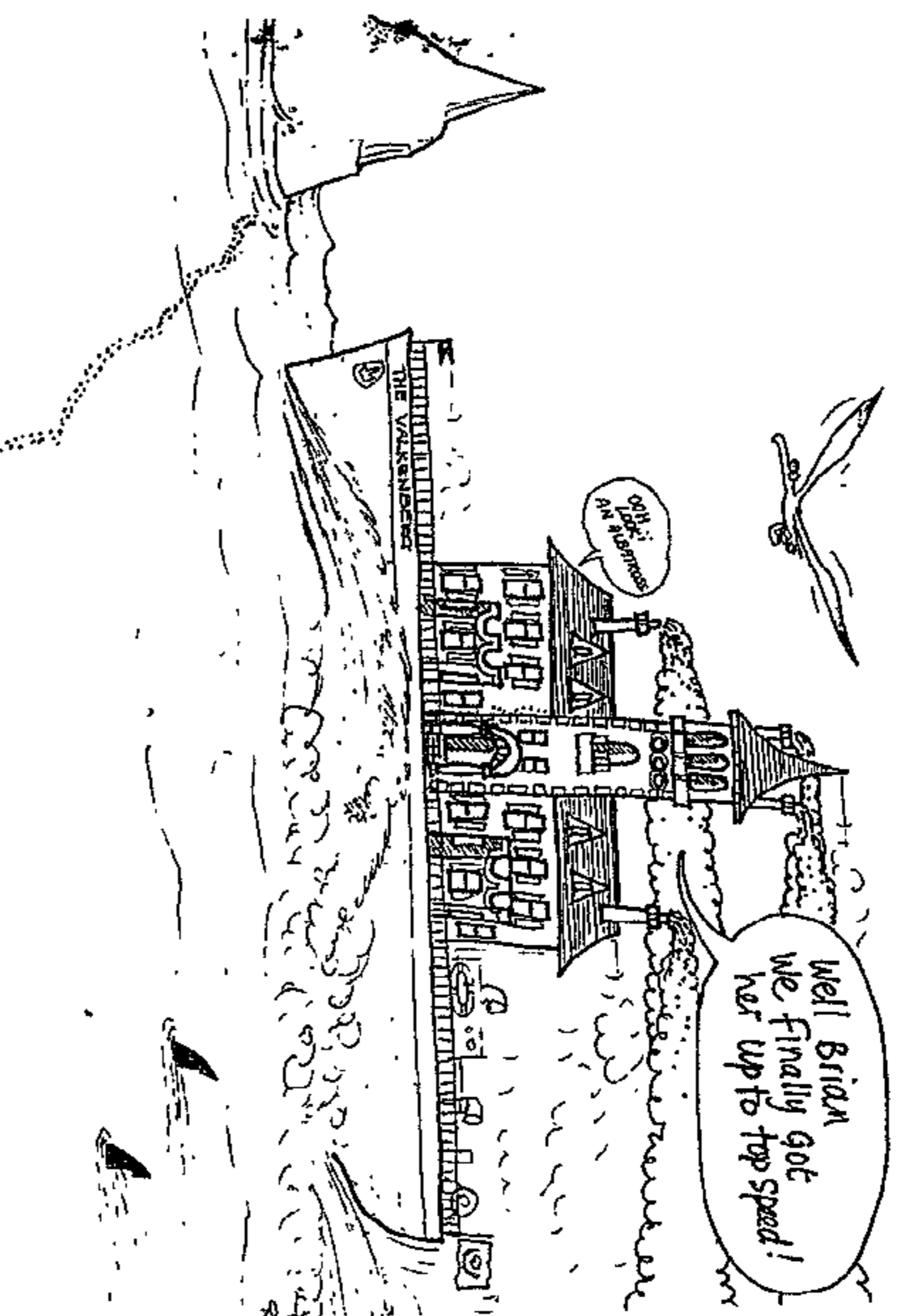
Sue Blyth, a psychologist at Valkenberg, says psychiatric patients need stability and the knowledge there is a safe place for them to come to when they need it. When their security is threatened, they relapse.

"There's an enormous amount of anxiety," she says.

Despite assurances that there will still be services at Lentegeur and Stikland hospitals, and outpatient clinics for them, there remains concern for the patients.

The nature of mental illness means that the majority of psychiatric patients relapse and need to be readmitted to hospital. Easy access to a hospital and a steady relationship with staff is essential.

"My experience is that it can take anything up to two years to build up enough trust to get patients to work with us," says Ms Blyth. Sean Baumann, a psychiatrist at the hospital, says fragmenting mental health services will create havoc and the relapse rate will increase, placing a heavy burden on families, patients and hospitals.



**Sinking ship:** patient Roy Foster's impression of the plan to close Valkenberg Hospital. "Some people do adjust, but some will get lost along the way"

"Some people do adjust, but some will get lost along the way," he predicts.

Valkenberg hospital's future has been uncertain for many months. Now the health department has decided to close it, a decision which still has to be ratified by the provincial cabinet.

Patients and staff will be reassigned to Lentegeur and Stikland psychiatric hospitals and an out-patients unit will be established either at Alexandra or at Groote Schuur. This means there will be no loss of services, says the department. Staff at Valkenberg say it's not that simple.

About 50% of staff have indicated they won't move to the other hospitals. This is mostly for personal reasons such as travel-

ling distances or lack of confidence in the future of health services.

What it means is that there will be fewer services for psychiatric patients at a time when more are needed. The head of psychiatry at the University of Cape Town, Brian Robertson, says the inevitable loss of services is serious. Patients for acute patients, many of them wards for acute patients, many of them psychotic, at all three psychiatric hospitals are frequently closed to new admissions because they're full. Hospitals help each other out, but there have been times when all three have had no space. Staff question why a well-functioning, well-resourced hospital is being closed, when all it will save the health department is

about R8-million this year?

The head of supra-regional hospitals in the Western Cape, Gilbert Lawrence, says Valkenberg will close for one reason only - it is part of the plan to reorganise mental health services in the Western Cape, to rescue a service which has been affected by staff taking voluntary severance packages over the past four years.

It is not about saving R8-million, nor is it about losing services. "We've had no say over the packages, that's why we need to rationalise. Otherwise we'll end up with only chronic mental hospitals. We have to protect our acute beds.

"I have to look at the bigger picture of mental health services. We either need

more resources, which we don't have, or we must consolidate."

Staff at Valkenberg say they are not opposed to restructuring. Academics, staff, non-governmental organisations and friends of Valkenberg have put forward alternative proposals. Professor Robertson says there has to be at the very least a 100-bed unit in the area to cope with patient demand.

"But we've been told we won't even get this at Groote Schuur Hospital."

But it's not yet the end of the Valkenberg story, says Fran Robertson, of Friends of Valkenberg.

"We are exploring legal avenues to stop the hospital from closing."



# No one is fighting for us, say psychiatric staff

CAROL CAMPBELL  
SPECIAL WRITER

(98) (98)

Three of the four psychiatric hospitals in Cape Town have no medical superintendents and staff fear no-one is fighting on their behalf to stop the reduction of psychiatric services in

the Western Cape.

Worst hit is Valkenberg which is threatened with closure because of a shortage of cash in the Western Cape health budget.

Valkenberg medical superintendent Deon Schoombie left at the end of April. He emigrated to Australia.

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At Alexandra Hospital, medical superintendent Linda Hering has been promoted, leaving her old post vacant, and Miles Bowker, medical superintendent of Stikland hospital, is on long-term sick leave.

"I want to know who is making the decisions for Valkenberg, who is

fighting for us," said Sean Kaliski, head of the Valkenberg forensic unit.

The provincial cabinet was supposed to make a final decision on the future of Valkenberg yesterday but it was postponed for another week.

See page 11



# 'You'll find a lot of bodies in these two rivers when

Change is difficult, not only for patients, but for hospital staff who have to move to a new workplace.

Kate Josiah, a senior nurse working in the forensic rehabilitation ward at Valkenberg, said she has decided to leave the health service.

"I must go now; I can see the difference already at the hospital. We are going down," she said.

Mrs Josiah, who will take the voluntary severance package, has 11 years' experience in psychiatric nursing. She's a valuable member of the team and her leaving is a loss to

## JENNY VIAL



HEALTH REPORTER

health services. "A few years ago I considered it but I thought maybe we'll come right with a new budget. But as time went by I saw the reality.

"I have no other option but to go. The staff-patient ratio is so bad, we are down to the bone.

"I have to do admin, stores, deal with the public. After a while you find your frustration affecting your patients, and that's not good," Mrs Josiah said.

The prospect of moving to another psychiatric hospital has no appeal for her. "I don't want to go through the emotional upheaval of moving to a new place, where you have to fit in to another structure."

"When they amalgamated the Pinelands and Observatory side of

Valkenberg, the vibes were difficult, there were strong feelings of not being welcome, of people seeing you as a threat. I don't want that again."

She applied for the package on April 7 and heard on May 11 her application had been approved. "It was so quick," she said.

Mrs Josiah believes that closing Valkenberg will be a problem for her patients, many of whom are outpatients for three weeks of the month and return for a week to be assessed.

"They need stability. They get used to this hospital, the same staff. I'm afraid you'll find a lot of bodies in

(98) (98) ARG 28/5/98 these two rivers when the hospital closes.

"Patients will default on their treatment and relapse. The route to the other hospitals is complicated, they won't go there.

"Here they know the staff, they need the same face, or a voice on the telephone they know. It's already a battle for them to get here from places like Ocean View - how will they manage to Lentegour?"

"Already patients are getting anxious - they're saying rather discharge me than move me.

"People will be on the streets. I feel

sorry for them." Dennis, a patient with schizophrenia, echoes this sentiment.

He's been in Valkenberg 10 times. "It's nice to have doctors you know. I know Dr Baumann will help me," he said repeatedly.

"People on disability grants can't afford to go to Lentegour, and anyway, they'll get lost.

"Why don't they just keep this part open?"

■ There will be a meeting of patients and their parents and relatives on Saturday at 2pm at Valkenberg's Education Centre.



JACK LESTRADE

Leaving: sister Kate Josiah is getting out

It closes



# Equipped to face our madness?

*Uneven standards of community care mean the state's new policy of releasing mental patients could be a bad plan, writes Andy Duffy*

**T**he deaths of seven people at the hands of former state psychiatric patients in the Western Cape have exposed a raw nerve in state health circles.

The Department of Health this week slammed a *Mail & Guardian* report on the killings, claiming it had sensationalised the incident, leading to "panic and unnecessary paranoia"

## Home is where the health is

Angella Johnson

**W**hen Bafana Cele saw the car parked outside his Soweto home he ran and hid in the veld opposite. "He thought you had come to take him to Sterkfontein [mental hospital]," said his grandmother.

Martha Cele smiled toothlessly as she explained that the threat to institutionalise her 19-year-old grandson was the most effective remedy she used whenever he refused to take the medication that keeps him stable.

There has never been any doubt in her mind that he would always be cared for at home. "He's family and we will look after him. Just because someone is sick you don't just throw them away," she said.

It took Martha Cele (64) more than a year to realise that Bafana, who she has cared for since he was abandoned by his mother as a baby, suffered from a mental illness.

Doctors at the Chris Hani Baragwanath hospital in Soweto diagnosed him schizophrenic after he was admitted. They decided his condition could remain stabilised with monthly injections and a course of tablets.

So Bafana joined the ranks of patients who rely on a network of small outreach clinics for medication and other support, while being cared for in the community.

A shabby looking Bafana is eventually persuaded to vacate his hiding place, his bloodstained eyes darting wildly around as he shuffles into the cramped room the family use to entertain.

"I just feel sick," he mutters. "Sometimes I feel scared and want to go away. I think that my head hurts ... it's like a fever ... I feel so cold and shivery ... People laugh at me and sometimes I fight with them."

Martha Cele stares fondly at her grandson. "He's much better since the injections. Oh, but he used to go berserk, tear off his clothes and jump over the fence to run away. Then when he comes back he's wearing rags."

Bafana was a normal child; thoughtful, helpful and attentive at school, until about three years ago when he was beaten within an inch of his life by a gang of local vigilantes who claimed he had stolen someone's gun.

"I was away at the time. When I came back and saw him in intensive care at Baragwanath it seemed as if he would die," says his grandmother. Bafana survived

about mental and psychiatric patients.

But state psychiatrists and NGOs across the country say the deaths are merely an extreme symptom of the lack of funds and staff that hamper the system.

Valkenberg, the Cape Town hospital that treated and released the six patients who killed, says the report was fair.

The *M&G* reported last week that six patients released from Valkenberg's high security forensic unit had killed seven people in the past 18 months, including two children.

Forensic unit head Sean Kalski blamed weak community care structures. A recent provincial health department report also found that staff shortages had weakened community care.

The Western Cape provincial Cabinet was due to decide this week whether to approve a health department proposal to close Valkenberg,

as part of a rationalisation of health services.

Other state institutions approached this week said the standard of community care for discharged state patients is often patchy, and in many poor and rural areas is non-existent.

The health department also concedes that, with its "limited sources" community treatment and monitoring of discharged patients "is not always as regular or comprehensive as we would like".

Three of four major state institutions have cases on their books of discharged patients committing new crimes, of varying seriousness.

The largest institution, Pretoria's Weskoppies, released a patient who last year killed a child in Mpumalanga.

The Free State's Oranje hospital, has taken 13 years to establish a community care

network that ensures relapses among discharged patients are caught quickly.

State forensic patients, held because they are judged unfit to stand trial for a crime, represent a small minority of the thousands of harmless state psychiatric and mental health patients.

But effective community care is central to the government's attempts to release thousands of such patients into the community — a project led by health department director for mental health and substance abuse, Melvyn Freeman.

Freeman refused to respond to further questions this week. Instead, he issued a lengthy condemnation of the *M&G* report. "This article dramatises the situation and spreads false fears to the public regarding people with mental disorders," Freeman says.

"The result is public panic and unnecessary paranoia of people with mental disorders."

Freeman says the report also "undermines" the government's deinstitutionalisation programme — "an approach to care which is more humane and rights-oriented than the current system of largely custodial care".

But the South African Federation for Mental Health, which represents NGOs across South Africa, says Valkenberg fairly reflects the general problems facing state psychiatric and mental health.

The federation also has concerns about the government's deinstitutionalisation drive. "The health system just isn't equipped to look after these people," says federation director Lage Vitus.

"It is a major problem that we don't have the funds for community service. The [department] has left it for NGOs to pick up, and we're not really equipped for it either."

Weskoppies senior medical superintendent Leandre Gauche says two of its discharged patients have killed in the past six years. In the most recent case which took place in Mpumalanga last year, the patient had originally been held at Weskoppies for killing another child.

**T**he 300-bed unit treats patients from across Gauteng, Mpumalanga and the Northern Province. "When [relapses] have occurred we suspect it's because of inadequate care," Gauche says. "We find the relapse rate is higher among people coming from these [rural, poorer] areas."

Dean Stevenson, forensic unit head at Sterkfontein, says the unit knows of one of the 20 patients it has discharged who committed a crime. "We may not always get to hear of it," he adds. "Where we do have a concern is the patients that are discharged to other [under-resourced] provinces."

John Dunn, principal psychiatrist at Fort Napier in KwaZulu-Natal, says the hospital does not regard its relapse rate as a major cause for concern. But he adds that half of its 180 patients come from far-flung rural areas, where community services are often thin.

Susan Otto, senior executive officer at Oranje hospital, says discharges can only go ahead with a sound community structure in place.

The Free State pioneered the programme, in 1985, that the national department wants other provinces to follow. "We don't struggle like other provinces do," she adds.

Around 500 patients were admitted to state forensic units last year. Freeman says the department would rather discharge those deemed rehabilitated than build new institutional facilities. Discharge conditions are stringent.

"The reality is that despite the fact that patients are assessed to the best of our abilities and that community facilities are provided (with resource limitations), there are, at times, awful consequences," Freeman says.

"However, the freedom of hundreds of people with psychiatric illness cannot be forgone because of unfortunate, and we agree, tragic exceptions."



Always cared for Martha Cele with her grandson, Bafana. PHOTOGRAPH: RUTH MOTAU

but his mind was no longer the same.

He became restless and complained of seeing things. He stopped going to school, refused to wash and took to walking the streets, disappearing sometimes for days.

At home his two teenaged cousins became targets for bouts of violence. "We lived in fear that he would do something like burn down the house or hurt himself," says Martha Cele.

"Of course he was going mad, but we didn't really know what to do then." Now, thanks to medication from Chiawelo clinic the family is able to live a fairly normal life.

Caroline Siguba is the sister in charge of the clinic, one of nine in the township linked to Baragwanath, which treats some 700 patients monthly. Mainly males aged 19 to 60, they suffer from a range of disorders — including epilepsy with psychosis, paranoia and schizophrenia.

Siguba believes most people suffering from mental illnesses (she claims the numbers are increasing) need not be institution-

alised. "As long as they have been stabilised in a hospital first, we can usually help them live useful lives (some of her patients hold down steady jobs) in a family environment.

Siguba cites Baragwanath as one of the country's success stories in psychiatry. "We used to get patients released too early who could be dangerous. They came here agitated and aggressive, but we sent them back and that doesn't happen any more."

While the hospital was grateful for the approval rating, it admitted that a vast majority of its discharged patients never make it to a clinic for outpatient treatment. Dr Graham Behr, a senior consultant at the psychiatric unit, believes most just revolve through the doors.

Behr said one way to free more beds was for the government to provide halfway houses for the mentally ill. This would allow supervised care and some sort of rehabilitation process, for patients who have no family support base to help them cope on the outside.



## PUBLIC HOSPITALS

# STEERING CLEAR OF CAPITAL

Gauteng Health Department reneges in fear of privatisation

(98) AM 5/6/98

**D**espite having publicly called on the private sector to inject fresh blood into its ailing public hospitals service, the Gauteng Health Department has spurned an offer from SA's largest private hospital group, Netcare, to run the province's academic hospitals.

Though the department has initiated five pilot projects in partnership with the private sector — most of which aim to attract private patients back to public hospitals — it has shrunk from giving hospitals the full managerial and financial autonomy they need to slash costs and improve delivery.

The department received about 30 proposals from the private sector in response to media advertisements it placed late last year.

Half of the respondents were invited to make presentations to the department. One of them was Netcare. It is not clear who the other 14 groups that made presentation are.

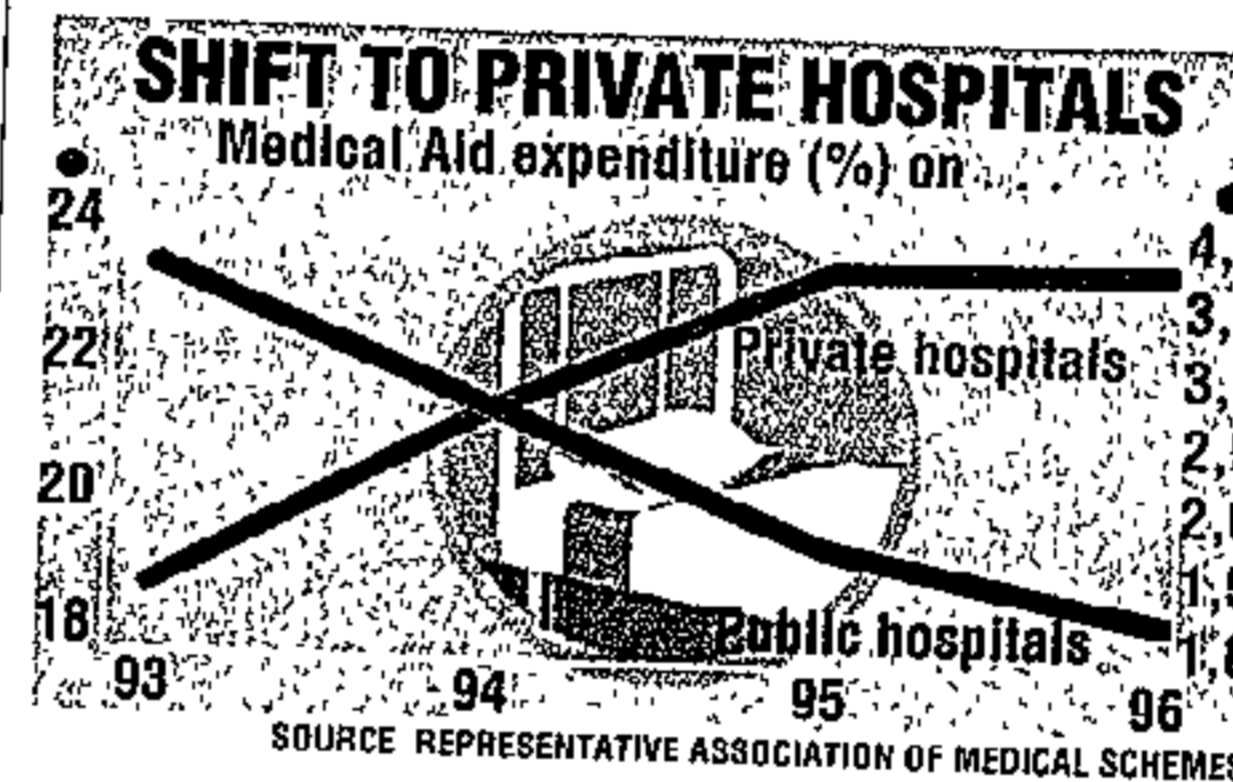
Netcare has confirmed that it was among the 15 and claims that, given a chance, it can cut about R555m or 15% off the department's R3,7bn hospital budget. This, it says, can be done through better cost controls, working capital management, economies of scale, standardising operations, raising productivity and streamlining the administration.

Netcare ran its 35 hospitals with 5 600 beds at a cost of R1,3bn last year whereas Gauteng spent R1,2bn on the Johannesburg and Chris Hani Baragwanath hospitals alone. They have 4 102 beds.

In its presentation to the department, Netcare revealed that by using similar management strategies it had shaved about R100m (on an annualised basis) off the operating costs of Clinic Holdings since purchasing the private hospital

group in November 1997.

"We are happy to invest capital, expertise and time but they are suspicious of the private sector, they see outsourcing as a sign of failure and are in a state of denial that the public sector needs help urgently," says Netcare CEO Jack Shevel. "Government sees health care as its responsibility but it can't seem to divorce responsibility



Jack Shevel

from delivery."

Wits University's dean of health sciences, Prof Max Price, pleads for an experiment in which a few academic hospitals are given financial and managerial autonomy so that they are free to hire staff at competitive rates, outsource services and draw on private hospital managers. "Only in this way will academic hospitals become more efficient and more attractive to private patients again."

Figures from the Representative Association of Medical Schemes show that medical aid payments to public hospitals declined

25% — a shift of R400m from public to private hospitals — between 1994 and 1995 (see graph)

"Only if hospitals are allowed to use the revenue generated from private patients to improve the local hospital environment and provide appropriate incentives to staff will we be able to retain the outstanding

academics and improve the quality of care in academic centres," says Price.

The Gauteng Health Department's chief director, strategic management, Laetitia Rispel, admits that the hospitals are experiencing problems but says: "We believe in a strong public sector. We are not going to hand over management of public hospitals to the private sector, we prefer joint management and partnerships."

Despite Gauteng's inability to grasp the nettle, its five pilot projects are a step in the right direction.

One involves leasing empty public hospital wards to doctors to treat medical aid patients.

The hospital receives revenue from these patients who would otherwise have attended more costly private hospitals or, in all likelihood, paid a nominal charge along with the indigent. This is because public hospitals have inadequate billing systems.

Government estimates that public hospitals lose R1bn in fees from medical aid patients each year, either because the patients fail to disclose that they have medical aid or because the hospital is unable to bill them accordingly.

The concept was pioneered by the Uitenhage Independent Practitioners' Association (Udipa) which leased and upgraded an empty ward in the Uitenhage Provincial Hospital for private patients in April 1996. It netted almost R2m for the hospital in the first 12 months.

Two years later, the Gauteng health department is allowing GPs to lease empty beds in Sebokeng and Kaponong hospitals for private patients.

In another pilot project, the 9 000 members of Transmed's State hospital plan in Gauteng will be billed slightly more than the standard public hospital fee which they have been charged until now.

The department has also invited private-sector proposals on ways to overhaul its emergency services, antiquated hospital IT systems and underperforming renal service. It may also outsource hospital laundry services.

Claire Bisseker

**"We're not handing over public hospitals to the private sector"**



# Crisis looms for Wynberg hospital

*Service cuts as doctors axed*

(98)  
AR 5/6/98

Doctors at Victoria Hospital in Wynberg have warned that the quality of service there will deteriorate further when the hospital loses five doctors' posts in the next three months.

Long queues and appointment delays will worsen – and it will be impossible to maintain the present standard of service.

The medical committee of the hospital said last night the hospital had steadily lost its ability to serve the area because of staff cuts over the years. Doctors and nurses were often the targets of disgruntled patients who found the delays and conditions hard to accept.

Victoria hospital is a referral hospital for the southern suburbs serving a population of between 300 000

JENNY  
VIAL



HEALTH REPORTER

and 400 000.

Alan Tooke, head of medicine at the hospital, said two doctors' posts had already been frozen and at least three more would be frozen – which would reduce the number of doctors from 21 to 16. In 1995 a crisis in the number of nurses had forced a reduction in the number of beds able to be staffed from 172 to 140.

In spite of few staff there had been a 50% rise in the number of admis-

sions to the hospital for acute illness.

Because of a shortage of beds, patients were often discharged while they were still sick to make place for the next patient.

Freezing doctors posts would reduce the hospital's ability to offer specialised services. Already neurosurgery and thoracic surgery were not available at the hospital and from August neurology and ophthalmology services would not be available after hours. All patients needing these services would have to be referred to Groote Schuur Hospital – with its own staff and budgetary constraints.

The medical committee said it was aware of the financial situation in the Western Cape but that people had to know that the hospital was cutting its service.



BY ANSO THOM  
Health Reporter

## Auditor-general details losses of R65-m at Gauteng hospitals

Maladministration, poor security and lack of controls at three Gauteng hospitals have led to losses of about R65-million, according to a performance audit released by the Gauteng auditor-general yesterday.

The report focused mainly on aspects of administration of academic health centres at Chris Hani Baragwanath (CHB), Pretoria and Kalafong hospitals. Performance audits were completed from January last year to

February this year.

Shortcomings highlighted in the report include inadequate funds for the replacement of equipment older than 10 years, long outstanding debt of R5,5-million at CHB and accumulative debt of R34-million at Pretoria, R8,1-million outstanding debts for treating patients from other hospitals at the three hospitals, and linen losses amounting to R3,5-million.

Furthermore, 62 abandoned

children were accommodated for a total of 4 290 days at CHB at a cost of R2,4-million between 1993 and April 1997. The problem had since been addressed by the Department of Welfare and the children transferred to places of safety.

Three cases of alleged malpractice by medical personnel, in particular junior doctors at CHB, were not followed up.

When a patient underwent an operation on November 1

1996, a gas mixture without oxygen was administered (according to a summary compiled by an anaesthetist), causing severe brain damage. In addition (according to a memorandum compiled by the chief of the department of anaesthesia), owing to a technical problem with the tracheotomy during a follow-up operation on November 26, the patient died.

According to a letter by the senior superintendent on No-

vember 4 1996, a cervical fracture that had not been diagnosed had probably contributed to a patient's quadriplegia and death on October 20 1996.

Another letter by the senior superintendent on November 5 1996 revealed that the condition of a patient was not monitored after he had been admitted as a result of an accident, and he died on October 21.

CHB was also criticised for failing to timeously institute

disciplinary procedures in all instances of misconduct. One case included a personnel member who had been jailed for six years following a charge of rape. He was not charged with misconduct, but granted a voluntary severance package of R74 000.

The report also highlighted the theft of medical stock. At CHB, stock to the value of R99 135 was stolen between May and December 1996, while stock amounting to R14 771 was stolen at Pretoria. Kalafong wrote off medicine worth R135 138 between 1995 and 1997.

(98)

Star 11/6/98



## PLAN FOR REDUCED SERVICES

# Campaigners to save Valkenberg take heart

ET 15/6/98

**THERE HAS** been a late surge of hope in the campaign to save Valkenberg Hospital, and the provincial health department is considering a proposal to keep a reduced service operating. Health Writer **JUDITH SOAL** reports.

**W**HEN the proposal to close Valkenberg Hospital was first mooted, the public responded with a resounding "No way". But then the greater evil of closing Somerset Hospital raised its head and was firmly squashed, and the campaigners for Valkenberg began to lose steam.

It seemed certain that the hospital would close, except for the unit housing forensic patients — those accused of violent crimes and considered unfit to stand trial — which would remain open "in the short term". But there has been a late surge of resistance.

Brian Robertson, head of clinical services at Valkenberg, met the province's health chief Tom Sutcliffe recently and outlined his proposal to save the hospital without exceeding the health budget.

Robertson's proposal would allow the department to sell most of the Valkenberg land and reduce the services on the site, but to stop short of closure. He asks for 100 acute psychiatric beds to remain at Valkenberg alongside the forensic unit.

"It was the first time we'd been given an opportunity to discuss this proposal with the department," said Robertson. "They haven't accepted it, but at least they have listened."

Sutcliffe had this to say: "It's a very interesting proposal. We will go over it before the next cabinet meeting on Wednesday."

Campaigners for Valkenberg have taken heart.

There may finally be some *toenadering* — however tentative. The issues at stake are those that dog all

the health services: How to change from a system that focused almost entirely on treating really ill people in hospital (until recently the entire mental health budget for the province was spent on psychiatric institutions) to a system that tries to help more people before they get that sick. How do you do this without destroying the services that exist, when there just isn't enough money to go around?

"They keep delaying the decision and changing their minds, we just don't know where we stand," said Jonathon Burns, a registrar at Valkenberg. He believes uncertainty has almost destroyed the hospital.

"There have been continual threats; then at the same time they offer voluntary severance packages, so of course people are taking them, rather than waiting to hear that they will be transferred somewhere they don't want to go."

Over 25% of the nursing staff have left the hospital in the last year. Twenty left at the end of May, and 32 are leaving this month. Two of the eight psychiatrists have left, more are expected to go soon, and all have said they will leave if the hospital is closed. Many of the registrars say the same.

Once these people leave the public health service, they will not be able to return because of a clause in the voluntary severance agreement. As with the teachers, it is often the most experienced who go.

The health department — under pressure from the provincial government to stay within budget — does not have an enviable task. Although closing Valkenberg

won't save much money this year, it hopes that running three psychiatric hospitals instead of four will free money for community services in the long run.

But mental health activists say this isn't good enough.

"Mental health is underserved already, why cut where you are already short?" asks social worker Michelle De Benedictis.

"You know, Robben Island used to be a psychiatric institution before it housed the political prisoners. Now the political prisoners have been released and the country has changed, but very little has changed for the psychiatric patients. They are still the soft targets, the ones who always have to suffer when it comes to cuts."

## Where to get help:

- The MRC's Anxiety and Stress Unit is offering free assessment and treatment to anyone who thinks they may have an anxiety disorder. These include post-traumatic stress disorder, social phobia, obsessive compulsive disorder and panic disorders. The unit can be contacted on 0800-600-411.

- The unit also runs a youth clinic at the University of the Western Cape, known as Bathuthuzele, for children who have experienced trauma.

- The Cape Support Group for Mental Health provides support to families and friends of people with schizophrenia. They can be contacted at 448-0760.

- The Depression and Anxiety Support group can be contacted on 0800-119283 or 0800-118392.



# Patients upset by closure, officials blame protesters

CT 15/6/98

(98) (88)

GILLIAN EDWARDS spent a month in a locked ward at Valkenberg in 1987 and hasn't been back, except as an outpatient. She lives in Observatory and visits Valkenberg every three months.

"It's not pleasant being in a locked ward for psychotics, but Valkenberg got me right.

"All I need to stay right is five minutes with a doctor who knows me, every three months. Now they are proposing that we see a different psychiatrist every six months, and a sister in between at the day hospitals. That's not a service, I can't see how I will cope on that."

Noël Bates has been going to Valkenberg since he was 23. He is now 49. He has been an inpatient for the past four years, but has recovered enough to face the outside world.

"I'm leaving soon, but would like Valkenberg still to be there as a safety net, in case I need it again.

"I've had a lot of help, that's why I'm ready to leave. I really

wish they wouldn't close it down."

Elaine Tshuka has been in and out of Valkenberg seven times.

"I go back every month for medication, I don't know how I'll get to the other places. It's easier for people in the townships to go there than to go to Lentegour or Stikland, where there is no transport."

Edwards, Tshuka and Bates are part of the community that has grown around Valkenberg Hospital in Observatory. It's a community that has little resemblance to the stereotyped image of dangerous "mental" patients ready to kill anyone who crosses their paths. These people are unlikely to hurt anyone other than themselves.

They are friendly, interesting, sometimes slightly shy and often a little eccentric. They are also in crisis. The proposed closure of Valkenberg Hospital has shaken their already fragile worlds.

"People with mental health problems are particularly vulnerable, and all the uncertainty is very

damaging for them," said social worker Michelle De Benedictis of the rehabilitation centre Fountain House.

"We have seen so many people become unwell recently."

But the health department believes that the campaign to save Valkenberg has to take some responsibility for this disturbance.

"If patients were being reassured that services would continue rather than being taken out on protests, there would be less confusion and panic," said Greg McCarthy, head of the Western Cape mental health programme.

"These people are very insecure anyway; it's easy to use that insecurity to promote your own cause."

McCarthy's department knows that people who rely on Valkenberg will be hard-hit by the closure. "We are trying to minimise the damage by opening services at Groote Schuur. Although we know the short-term view is bad, we have to plan for the future."



## *Groote Schuur treatment tops*

(98) Arcs 16/10/98

It has become the norm to knock the country's most famous hospital. Therefore when we heard that our daughter had been admitted to the respiratory intensive care unit at Groote Schuur after a tour bus accident we were very apprehensive.

She was in the unit for a week during which time she received absolutely top-class treatment.

The care and concern shown by the doctors and nursing staff could not have been surpassed anywhere and our only regret was that when her condition improved she had to be moved from the unit.

We would like to publicly express our most sincere and heartfelt thanks to the Staff of C27. God bless you all.

**The Stoner Family.  
Milnerton**





**COMBINED PROTEST:** Fountain House worker Elma Badenhorst (fifth from left) was joined by Valkenberg outpatients (from left) Gillian Edwards, Elaine Tshuka, Richard Greyvenstein, Noel Bates, Desiree de Jongh and Roderick de Kock in a protest last week against the closure of the hospital.

PICTURE: THEM BINKOSI DWA

# Mental illness the pauper of health budgets

MORE hospital beds in South Africa are filled by people with schizophrenia than any other illness — including heart disease, cancer and diabetes put together — although new treatments for the disease mean that long-term hospitalisation could often be avoided. Professionals say that although mental illness is costly to treat, it is more costly not to treat it.

"Research has shown that 20 to 40% of people attending community clinics have some sort of undiagnosed mental illness. Often this presents itself as a physical illness, because people have no other way of expressing their distress," said Liz Dartnell of the Wits Centre for Health Policy.

ET 15/6/98

The World Health Organisation names depression as the leading cause of disability and includes five mental illnesses in the top 10 disabling disorders. In the United States, every third dollar spent on health is spent on anxiety disorders.

In South Africa, the mental health burden is thought to be even greater, although — as is typically the case in this Cinderella of medical fields — very little local research into mental illness exists. To rectify this, the Medical Research Council and the University of Stellenbosch have launched a research unit to focus on anxiety and stress disorders.

"Studies have shown that stress

and anxiety disorders are the most common psychiatric disorders, yet there has been very little research in South Africa," said Dan Stein, the head of the new unit.

"Failure to diagnose and treat these disorders at a primary level contributes to enormous costs."

Professionals say that South Africa has a high incidence of disorders like post-traumatic stress disorder because of our violent history. We also have a strong culture of substance abuse, with levels of risky drinking reaching 30% in some areas.

"We know that 25% of the population is affected by a mental illness at some point in their lives, and in South Africa this is probably

higher," said Lage Vitus, director of the SA Federation for Mental Health.

"If this is not treated, the number of people who need hospitalisation will escalate."

The World Health Organisation recommends that 10% of a country's health budget be spent on mental health, yet South Africa spends less than half that. In some provinces it is as low as one percent.

The Western Cape has one of the better budgets, spending about eight percent on mental health, but most of this goes on psychiatric institutions which care for people once they have reached a crisis.

Robin Emsley, the head of psychiatry at the University of Stellenbosch, believes that many of the crises could be avoided.

"In the last few years the treatment of psychiatric diseases has changed dramatically. There are some very promising new drugs that offer sufferers a good chance of recovery.

"All the research shows that the most important factor in this recovery is early diagnosis and treatment."

Unfortunately this isn't happening. More than half of schizophrenics relapse in the first year. "Most of the patients come to us too late for effective treatment," said Emsley.



# Privately funded hospice will ease plight of ailing Sowetans

Josey Ballenger

60716/98  
A HOSPICE funded by the private sector with help from foreign governments was opened by Archbishop Desmond Tutu in Soweto this week.

The opening of the hospice, housed in 11 shipping containers refurbished and reconfigured at a cost of about R1m, marked 10 years of hard work by Soweto residents in their efforts to provide accessible health care for the terminally ill. The Gauteng health department will provide medicines for poor patients.

Tutu said that, in the light of disclosures to the truth commission in the past week about apartheid-era chemical and biological warfare programmes aimed at killing black people and making them ill, the hospice showed that "people are not all like that, there is compassion and caring".

The hospice, which is situated at the Mofolo primary health clinic, employs two registered nurses to provide home care, day care for patients who are fit enough to leave home and counselling for patients and their families. Within

(98)  
a year, the hospice plans to hire an additional community nurse, a social worker and a 24-hour service in a nine-bed, in-patient unit.

Prof JP van Niekerk, chairman of the Hospice Association of SA, said more than 50 hospices in the country served 6,000 people a year, the majority of whom lived in disadvantaged areas. He said the number of patients was rising.

The biggest increase was coming from AIDS victims.

Nigel Unwin, chairman of the hospice association's board of governors, said one in four Sowetans over the age of 60 was terminally ill with cancer. Many more were estimated to be HIV-positive or had full-blown AIDS.

Peter Buckland, director of the Hospice Association of the Witwatersrand, said the Corporate Outreach Trust contributed the R450 000 shipping containers, while McCarthy Motor Holdings donated two vehicles for staff use. The US and Japanese embassies and other donors contributed the balance for salaries, equipment, drugs and infrastructure.

Founded 1966



# SA officials 'bribed to let in chemical warfare ingredients'

Nyndham Hartley

**CAPE TOWN** — Tens of thousands of dollars were used to bribe officials in various parts of the world so that ingredients for SA's chemical weapons programme could be smuggled to his country, the truth commission heard yesterday.

Still more money was paid to Vouter Basson, the head of the chemical and biological warfare programme, and apparently never accounted for. This emerged during a day of

testimony from the former surgeon-general of the SA Defence Force, Niel Knobel.

Croatian military officials, officials in Switzerland and customs officials at an airport in Chad were paid as part of the operation to obtain the active ingredient of Mandrax and smuggle it back to SA, he said.

He also said that a problem with money paid over in Croatia had resulted in a special trip to that country by Basson in an attempt to retrieve the money. The attempt failed and Basson

was himself detained in Switzerland.

This occurred after Basson was summarily put on early retirement by the then president, FW de Klerk, late in 1992 after an investigation into alleged illegal activities by the defence establishment.

Knobel told the commission that he had no operational control over Basson in spite of being the head of the defence force's medical services under which the chemical and biological warfare was placed.

Basson, who allegedly developed poisons and gadgets to inject people, was under the operational control of special forces, he said.

Knobel told the commission that he had approved in early 1993 the dumping into the ocean off the southern Cape of hundreds of kilograms of chemical agents which could incapacitate enemies.

He said the drugs, which included Mandrax, were "deactivated" and dumped from an SA Air Force training flight about

150 sea miles off the coast in a position beyond the Agulhas plateau. About 20 plastic drums were involved and Basson was on the flight, Knobel said.

The hearing was adjourned until a date to be determined next month. Knobel will again give evidence and Basson could also be called if his application to the high court is unsuccessful. Basson has asked the court to review the commission request for him to testify on the basis that it would prejudice his criminal trial.

losey Ballenger

**THE Red Cross Children's Hospital** in Cape Town, the only medical children's hospital in Africa south of Cairo, needed a R36m capital injection if it was to continue being one of the world's most renowned paediatric institutions, trustees and supporters said yesterday.

The hospital, which is the only SA public hospital to have its own trust fund, aims to build a

## Children's hospital in need of R36m

new education centre for various health disciplines; a new pharmacy; a mothers' accommodation unit and a new wing to house outpatient services, short-term surgery and beds, and an accident/emergency management service.

The hospital cares for more than 250 000 children annual-

ly, many of whom were referred from other institutions throughout southern Africa.

Prof David Beatty, University of Cape Town's acting medical school dean and the trust's chairman, said the hospital's facilities were "still the same as 42 years ago," when the hospital opened, although equipment

had been upgraded.

The main building had 242 beds, but the overflow from 350 patients was put into pre-fabricated units, he said.

Speaking at a fund-raising event in Johannesburg, Beatty said the trust provided the hospital's capital budget, as the hospital received only R110m

from government for its operating costs and recovered less than 4% in patient fees. Like many hospitals battling with dwindling budget allocations, the Red Cross Children's Hospital wanted "autonomy to manage (its) funds, including collection."

Beatty said the redevelopment campaign had raised R20,9m so far and needed the private sector and individuals to kick in the remaining R15m.



*TOBACCO Rothmans International a strong performer, says Rupert*

# Tobacco helps Richemont lift profit

ST (Par) 19/6/98

(1989)

MARC HASENFUSS

CAPE EDITOR

Cape Town — Richemont, the Swiss-based conglomerate, boosted attributable profit 27 percent to £386 million in the year to March, thanks to solid showings by tobacco and luxury goods, and reduced losses from pay-television interests, Johann Rupert, the chief executive, said yesterday.

Rupert said exchange rate effects masked a strong underlying performance from Rothmans International during the year.

A breakdown of the tobacco division's performance showed that if figures were translated at constant currencies, net sales revenue increased 10.2 percent to £3.6 billion, while operating profit rose 15.9 percent to £938.4 million. However, translated at actual rates, net sales revenue declined 3.9 percent and operating profit growth was restricted to 1.3 percent.

Rupert said Rothmans' performance reflected growth in most regions, with particular improvements in France, Malaysia and the UK.

He said the continued success of the Winfield brand in France and price increases more than offset an increased investment in marketing in central and eastern Europe.

Richemont's results also reflected a 12-month contribution from Burrus, the Swiss tobacco subsidiary. Rupert said Vendome,

Richemont's luxury goods arm, managed to increase net sales 19.3 percent to SF3.6 billion (R13 billion) and operating profit by 15.2 percent to SF577.5 million, despite economic woes in the Far East, its second biggest market.

He said the Japanese market continued to show growth, although economic developments in Hong Kong and in southeast Asian countries had led to a slowdown of demand.

"The countries most affected by these events, such as Indonesia, Malaysia and Thailand, represent a small percentage of our sales. Hong Kong, in contrast, is a much more important market, and developments there will continue to be carefully monitored."

Rupert said net sales increased 27 percent in Europe, 8.7 percent in the Far East and by 25 percent in the Americas.

"The increase in jewellery sales and gold and jewelled watches has been primarily achieved through increased retail sales at Cartier. Sales of other watches showed increases in all the group's watch brands following the success of new products and the successful introduction of a new watch range."

Turning to Richemont's 15 percent stake in Canal-Plus of France, a leading pay television operator in Europe, Rupert said the company's share of exceptional items (largely the gain realised on the Premiere disposal) came to almost £35 million.



**HIDDEN LIGHT** Johann Rupert says exchange rate effects masked a strong underlying performance from Rothmans International during the year

PHOTO: JOHN WOODROOF



(98) pm 26/6/98

# STEMMING THE TIDE OF ACADEMICS' FLIGHT

But Nkosazana Zuma will take some convincing

The University of Cape Town has formed a partnership with SA's largest private hospital group, Netcare, and the listed German hospital group, Rhön-Klinikum, to build a R250m university hospital near Groote Schuur Hospital.

The 600-bed facility will focus on the provision of specialised care to ensure that such services — which are no longer adequately funded by the State — are not lost to the country.

The Oude Molen University Hospital, as it has provisionally been named, will be fully funded, equipped and managed by Netcare and Rhön-Klinikum. UCT will provide about 150 clinical personnel and share in the profits of the joint venture. Cosatu's investment arm Kopano Ke Matla — through its association with Netcare — will also be involved.

UCT hopes the new hospital will stem the flight of academics to the private sector by creating a First-World teaching and research platform — something Groote Schuur Hospital is unable to provide.

For the same reasons, Wits University is also seeking gain access to private tertiary

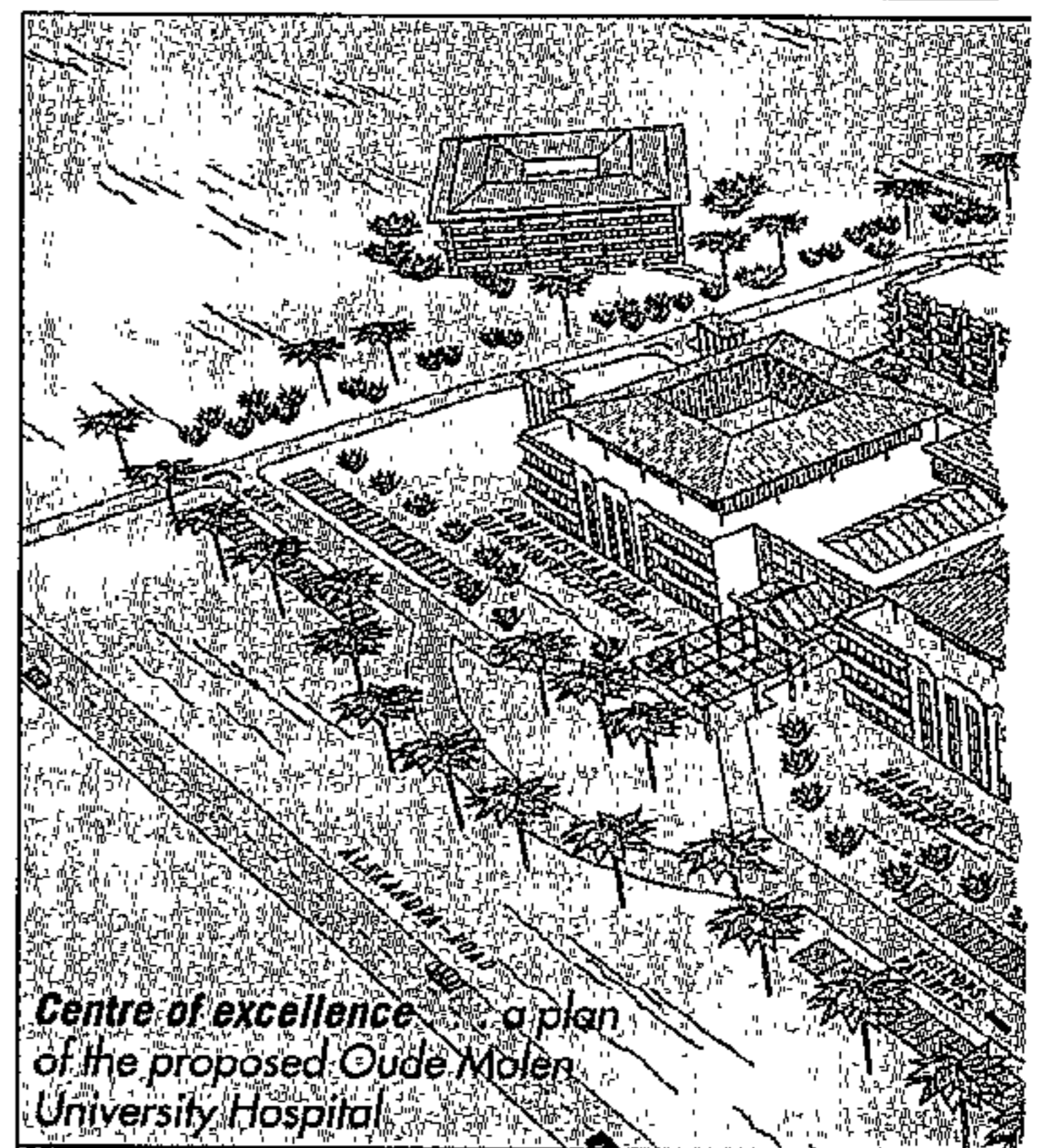
hospital services. Both universities realise that if they are to continue to produce top notch medical graduates, it will have to be in partnership with the private sector.

SA's academic hospitals have lost highly trained staff and private patients as a result of large and sustained budget cuts. They are swamped with trauma and communicable disease cases while some specialised services, academic programmes and wards are closing and research output is falling.

Groote Schuur Hospital has 1 734 beds but is only using 1 163 because of budget cuts. Of these, about 950 beds are devoted to tertiary care but the number is set to be slashed to 450.

UCT medical school Dean Emeritus, Prof J P van Niekerk, says the new hospital will complement rather than replace Groote Schuur Hospital. It is not intended to strip out the best staff, hi-tech equipment and tertiary services from Groote Schuur and to relocate them in a private facility free from State interference.

Health Minister Nkosazana Zuma will take some convincing, though Zuma, who

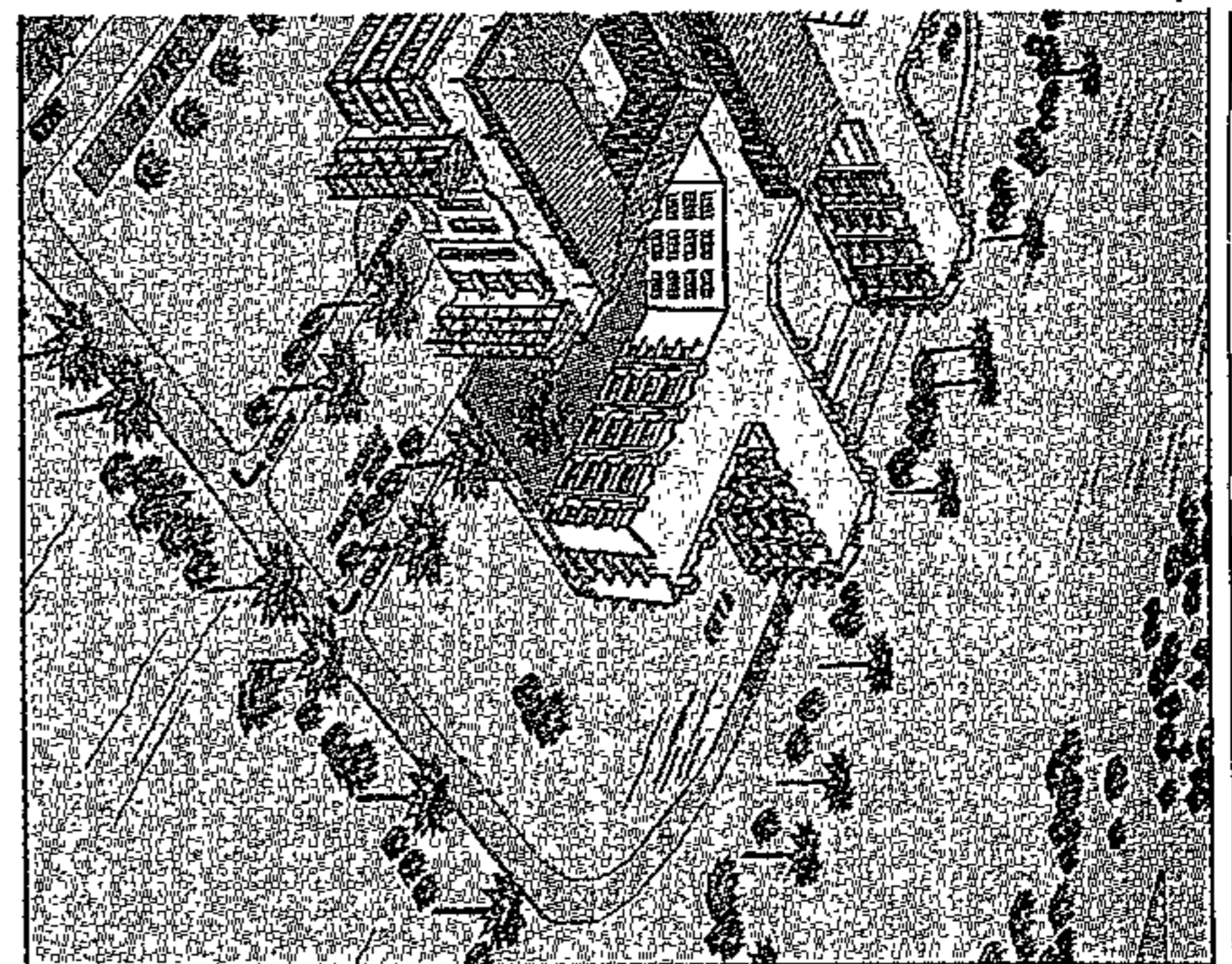


Centre of excellence — a plan of the proposed Oude Molen University Hospital

has yet to be informed of the plan, placed a moratorium on the issuing of private hospital licences more than two years ago in the belief that government should decide the location of new private hospitals according to society's needs — a policy designed to discourage the flow of patients away from the public sector.

Van Niekerk says though the new hospital's emphasis will be on tertiary medicine, 450 beds will provide general care aimed at a large sector of the market not adequately catered for at present — those with jobs but no medical aid.

The hospital expects to charge fees below that of State hospitals — which av-



average R628/day in Gauteng — by importing the unique design, efficient management structure and administrative expertise of Rhön-Klinikum hospitals. Rhön-Klinikum owns 13 hospitals in Germany and operates a university hospital in Leipzig. Its hospitals are one-third cheaper than most State and private hospitals in Germany.

Costs will be cut by running the Oude Molen Hospital on a staff-model whereby doctors are paid a monthly salary rather than a fee per consultation. They have to conform with agreed clinical guidelines for the most cost-effective treatment and subject their clinical decisions to peer review

The staff shares in any savings achieved through the payment of bonuses.

"This proposal presents a unique opportunity to embark on a co-operative venture with the private sector in developing facilities as a means of providing improved health care to a large sector of the population, while achieving benefits for the State," says Van Niekerk. "It is an opportunity that if rejected, is unlikely to come again since the private sector fully intends to proceed along these lines and will do so without partnerships of State and university to the detriment of both."

As a step towards the planned commissioning of the new hospital in 2002, the UCT/Netcare/Rhön-Klinikum partnership wants to lease six empty wards in Groote Schuur Hospital. These would be consolidated into a private 120-bed hospital — containing theatres, Intensive Care Unit and outpatient facilities — to be operational by late this year.

The site earmarked for the Oude Molen Hospital is on the vacant Pinelands portion of the Valkenberg Hospital grounds, near Groote Schuur, which is owned by the province. UCT has met Western Cape Health Minister Peter Marais and has the province to lease land to UCT and to supply it with hospital licences.

Marais' representative, Johan Smit, says the Minister supports the concept in principle as he is an enthusiastic proponent of public/private-sector partnerships. Smit says the province has the authority to issue new hospital licences without the concurrence of central government.

Claire Bissaker



FEWER SERVICES BUT ...

# Valkenberg Hospital will be kept open

(98)  
CT 26/6/98



**VALKENBERG** outpatients are delighted their support system is not to disappear, reports Health Writer **JUDITH SOAL**.

**V**ALKENBERG HOSPITAL will not close, and that's definite. The provincial authorities have bowed to public pressure to save the hospital.

They announced yesterday it would stay open with fewer services.

"We haven't worked out all the details yet, but we intend to keep an outpatients unit and acute beds (for emergency patients) open on

the Observatory side of Valkenberg," said Linda Hering, the acting chief medical superintendent of psychiatric hospitals in the Western Cape.

"The other services will be transferred to other hospitals, which will mean that the land on the Pinelands side and most of the Observatory side will be available."

The to-ing and fro-ing over Valkenberg has continued for

years, with the department announcing it would close, then allowing a reprieve, then threatening closure again.

Hering said the latest announcement was not just another interim step.

"Valkenberg will go on into the next millennium," she said. "We are relieved that a decision has finally been reached, the indecision has been destructive for everyone."

Former patients who rely on Valkenberg's services were delighted by the news.

"My first reaction was such relief," said Gill Edwards, a Valkenberg outpatient.

"You can't go out into the world as a mentally ill person without proper medical back-up. I haven't had problems as a schizophrenic, people treat me as an equal, but it's on one condition: If I don't feel well, I will go and seek help.

"They were threatening to destroy all that, but now I feel confident that my backup is safe."

Brian Robertson, the head of clinical services at Valkenberg, was also relieved.

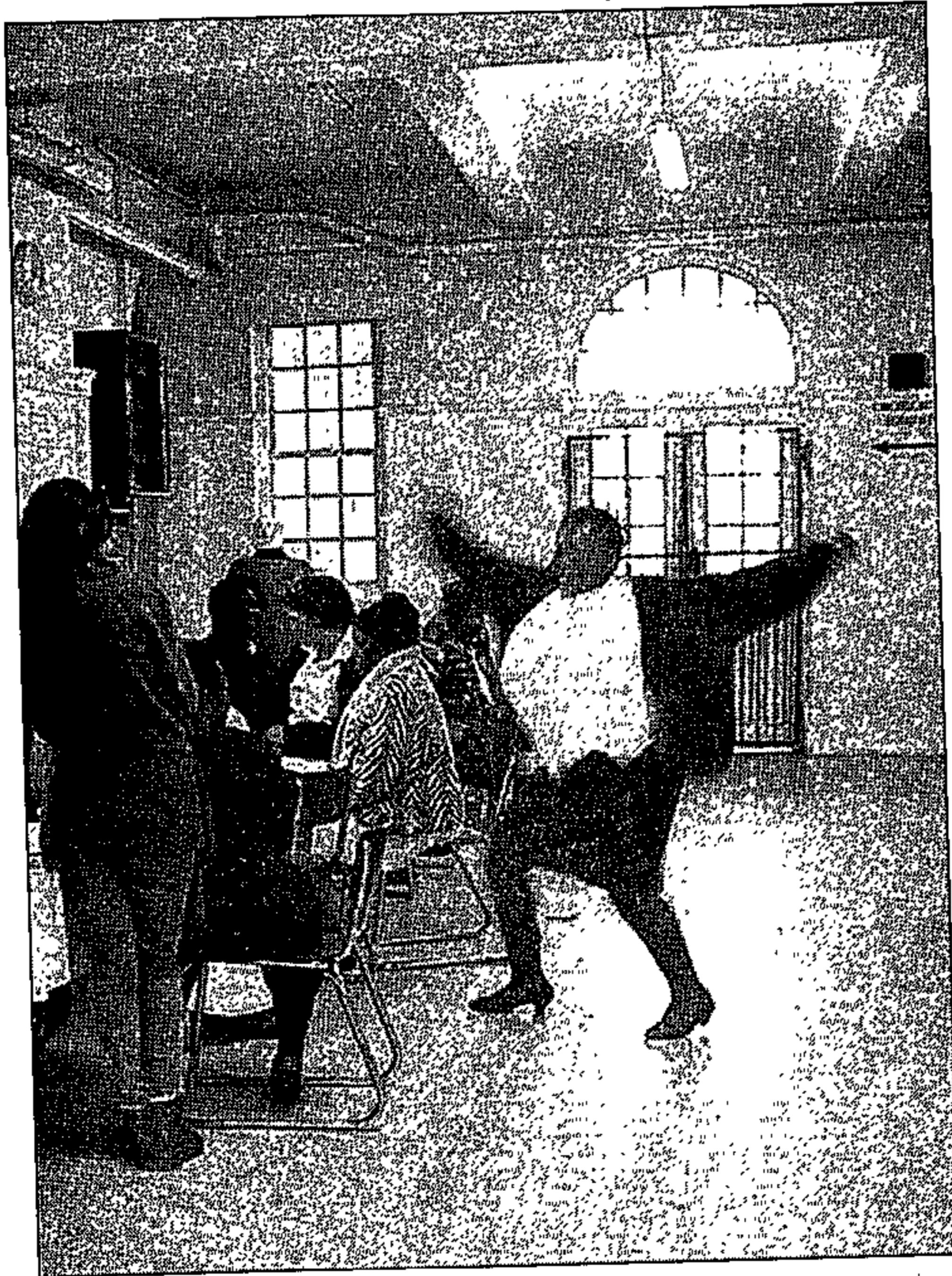
"At last the department is being sensible. We have always agreed it would be best to get rid of most of the land, but that it's crucial to keep some services for those who depend on them.

"The other hospitals would never have been able to absorb all the patients from Valkenberg, and they seem to have realised that at last," he said.

Money raised through the sale or leasing of the Valkenberg land will go into the general provincial revenue fund and will not be earmarked for health.

But the Western Cape's health chief, Tom Sutcliffe, said his department was hoping to gain some benefits.

"We have recommended to the Works Department that the land on the Pinelands side of the site be alienated in return for the relocation and building of another forensic unit, probably at Lentegeur."



**SAVED:** Valkenberg patients can now jump for joy.

**FILE PICTURE**



# Valkenberg to stay open, 2 000 health staff to lose jobs

AR 26/6/98

JENNY VALL  
HEALTH REPORTER

Valkenberg Hospital will not be closed after all, but more than 2 000 Western Cape health service staff are set to lose their jobs.

This is in terms of the final plan for health services in the Western

Cape which has been announced after months of uncertainty about staff losses and hospital closures.

Only the north block of Somerset Hospital will close and the provincial Department of Asset Management will look at options for its use. A total of 2 148 staff will have to leave - 1 600 at the three academic hospitals, Red

Cross, Groote Schuur and Tygerberg, and 146 at Somerset.

Provincial Minister of Finance Lampie Fick said budget cuts were severe enough that there would have to be staff cuts at clinics and secondary hospitals as well as the academic hospitals. The final plan for health will ensure the department

stays within budget this year, he said.

"It is recognised by Cabinet and my department that this will be an extremely difficult year for the health department."

It was "wonderful" that Valkenberg would stay open, said Brian Robertson, its head of psychiatry.

"My major joy is for the 20 000

patients and families we serve. We are so relieved, the staff are so drained after all the uncertainty."

The Pinelands side of Valkenberg hospital will be sold or leased and the department has asked that the developer rebuilds the forensic unit, possibly at Lentegeur, said Head of Health Tom Sutcliffe.



# Marais 'fuelled insecurity in health service'

ARC 27/6/98

Staff reduced but Valkenberg stays open (98)

JENNY VIALI

**W**estern Cape Health Minister Peter Marais has fuelled insecurity in health services in his few months as minister by announcing hospitals will close and then changing his decisions, says Ebrahim Rasool, leader of the ANC in the province.

Valkenberg hospital, originally planned for closure, is now to stay open, provincial finance minister Lampie Fick announced yesterday. To keep within budget 2 148 staff will have to leave the health services through voluntary severance packages, retirement and resignations.

Since March, when the first business proposals were announced, there has been uncertainty about the closure of both Somerset and Valkenberg hospitals.

Following widespread criticism over the possible closure of Somerset hospital Mr Marais announced last month that the hospital would stay open. At the time a revised business plan still proposed that Valkenberg be closed.

Both hospitals will now stay open

but be reduced in size. Land at both sites will be sold or leased by the Department of Asset Management.

"It is unacceptable for a minister to make announcements before final decisions are made and then in the face of public pressure to make a U-turn," said Mr Rasool.

"Mr Marais gives the signal that if you protest enough, he'll change his mind. He has put the province in a permanent state of instability because he cannot rationally think through decisions and then reach a calm decision, which the fragile health department needs."

He said a task team appointed to investigate mental health services had recommended that Valkenberg stay open.

"I don't think he even read the task team report," said Mr Rasool. Mr Rasool, who was minister of health before Mr Marais, said he welcomed the announcement that Delft and Kraaifontein community health centres and a ward in Ceres hospital would be commissioned.

"However, I am worried that the final plan does not mention Delft clinic becoming a 24-hour clinic," said Mr Rasool. It is needed as such

and was intended as such in the original health plan.

"I'm also worried about the further erosion of staff numbers. It was my consistent contention and my fight in the cabinet that staff numbers should never be allowed to go below 27 500.

"This plan brings numbers to around 25 000. This is an enormous erosion of staff and I do not think the health system will be able to absorb it. It can only result in longer queues and more overworked staff at every facility."

Mr Rasool said the announcement of the final health plan by Mr Fick, rather than Mr Marais, was clearly because the National Party government in the province had decided to keep sensitive matters away from Mr Marais and prevent further embarrassment and damage caused by his "shooting from the hip" about matters like Valkenberg and Somerset hospitals.

Armand le Roux, Mr Fick's secretary, denied this, saying the announcement was drafted by both ministers. Mr Fick as finance minister was responsible for ensuring the plan would stay in budget.



# Health officials question plans for R250m private hospital

**Josey Ballenger**

A PROPOSAL to build a private hospital near Groote Schuur Hospital, intended to "complement" the public hospital and reverse the trend of doctors leaving, has caused officials and health experts to question the University of Cape Town's (UCT's) commitment to improving the public sector.

Groote Schuur, known as an "academic" hospital because of its teaching and research relationship with UCT's medical school, is regarded as one of SA's finest medical institutions.

However, it has suffered budget cutbacks and staff losses in recent years, prompting the UCT faculty to look at solutions to retain health professionals and tertiary care (98)

UCT has joined SA's largest private hospital network, Netcare, and German hospital group Rhön-Klinikum, in discussions to build a R250m hospital to focus on specialised care. JP van Niekerk, the school's dean emeritus, said the 600-bed facility would charge lower fees than either the public or private sector.

Prof Max Price, Wits Univer-  
BD 2/7/98

sity medical school dean, said SA would see "a number of different models of private academic hospitals" which would be better funded due to their use by private patients.

The Wits faculty is looking at leasing ward space in Johannesburg Hospital to absorb people from the public sector. "We believe this would relieve the state of a burden," Price said.



# '40 die' in hands of poor surgeons

Mar 17/98

Allegations that numbers of patients have died at Chris Hani Baragwanath Hospital in Soweto since 1996 due to lack of supervision during surgery will be investigated, Gauteng health department spokesman Popo Maja said yesterday.

A former principal surgeon and senior superintendent at the hospital, Dr Bokkie Rabinowitz, has claimed that since the end of 1996 more than 40 patients have died at the hospital during surgery that was performed by inexperienced surgeons without the proper supervision.

"I saw a number of deaths that should never have happened. It is a total abscence that needs to be

opened," he said.

The incidents of negligence he allegedly unearthed include:

■ The death of a young girl after a breathing tube to her stomach instead of her lungs.

■ The death of an elderly woman who allegedly died after surgeons turned her away on two separate occasions, without detecting a hip fracture.

■ A case involving a man who left the hospital a paraplegic after doctors allegedly manhandled him as they bandaged his fractured jaw.

On a number of occasions, Rabinowitz tried to persuade management at the hospital and

Gauteng health department officials to probe the deaths, but his efforts were met with fear and hostility.

He also claimed this cost him his position at the hospital. He worked at the hospital's surgical department for 30 years and was a surgical superintendent before he was appointed senior superintendent in the administration department in 1993.

According to the department, Rabinowitz (68) was appointed on a two-year contract after reaching the retirement age of 65 in terms of public service regulations. At the end of last year his contract was renewed for another six months and had now expired.

Rabinowitz conceded this, but could not understand why other employees older than himself were still allowed to work at the hospital while he was not.

Maja admitted there had been delays in starting the investigation, which he said would begin on Monday next week.

Professor Taole Mokoena, head of surgery at Kalafong Hospital, would head the panel that would hear evidence on Monday and Tuesday. Johannesburg Hospital trauma unit head Dr Ken Boffard and acting academic head of surgery at the Wits Medical School, Professor Mike Davis, would be the other members, Maja said. — Sapa and Staff Reporter



# 'Doctors at Bara couldn't give a damn'

(98)

Forty deaths to come under the spotlight at inquiry into former superintendent's claims

BY ANSO THOM  
Health Reporter

Shaw 6/7/98

Former superintendent of Chris Hani Baragwanath Hospital, Dr Bernard "Bokkie" Rabinowitz, has accused his colleagues of "not giving a damn" about people dying at the hands of junior doctors performing surgery without supervision.

Rabinowitz, who worked at the hospital for more than 25 years, went public last week with claims that at least 40 patients had died at the hands of surgical staff at the hospital.

"I was driven to this (going public). It had become intolerable," said Rabinowitz, who will appear at a hastily convened special inquiry today and tomorrow.

Rabinowitz claimed that more than 40 patients died during surgery performed by inexperienced surgeons without the proper supervision.

"Those doctors at the hospital who are involved, or those who knew, don't give a damn. I constantly notified (chief superintendent Chris) Van der Heever and (Dr Pieter) Van der Berg (director of hospital services at the Gauteng department of health), but they gave it no time and expressed no concern.

"Van der Heever tried to protect the surgeons," he said.

Rabinowitz said the inquiry

was a damage control exercise, adding that he had insisted that Professor Taole Mokoena, head of surgery at Kalafong Hospital, head the panel.

Rabinowitz accused Van der Heever of removing him from his position as superintendent of surgery to protect the surgeons and to limit his access to data.

Van der Heever was not available for comment yesterday. Hospital spokesman Hester Vorster referred all queries to the department of health.

Rabinowitz said he would like to see the guilty surgeons disciplined and forced to resign.

"Disciplinary action must also be instituted against the administration, who are now literally being dragged to an inquiry, kicking and screaming," he said.

Rabinowitz said it was essential that senior people be present during surgery.

The hospital had about 70 surgeons at one time, with junior doctors "coming and going" while practising surgery unsupervised.

Cases of negligence Rabinowitz allegedly found included the death of a young girl after doctors allegedly directed a breathing tube to her stomach instead of into her lungs, and the death of an elderly woman who died after surgeons allegedly turned her away without detecting a hip fracture.



# Probe into surgical negligence will finish today

Bonile Ngqiyaza

(98)  
DD 7/7/98

A PROBE into allegations that negligence and indifference among Chris Hani-Baragwanath Hospital's surgical staff resulted in about 40 deaths at the hospital got under way yesterday.

This came after the hospital's former superintendent, Dr Bernard Rabinowitz, accused his colleagues last week of an uncaring

attitude, claiming that at least 40 patients had died as a result of junior doctors performing surgery without supervision.

Gauteng health spokesman Popo Maja said yesterday the probe, led by Taole Mokoena, surgery head at Kalafong Hospital, would be completed today.

Maja said the probe's brief would be to establish the facts and to find out whether there was sub-

stance to the claims.

A decision on whether to appoint a commission of inquiry would be taken after Mokoena had tendered his report.

Opposition parties expressed concern at the news yesterday, saying the claims could be just the tip of the iceberg because the hospital was, unlike rural hospitals, well placed and constantly under a spotlight.



# Bara deaths: worry that doctors will close ranks

By ANSO THOM  
Health Reporter

Dr Bernard "Bokkie" Rabinowitz, former superintendent of Chris Hani Baragwanath Hospital, has expressed concern that "doctors will help doctors" while testifying at a panel looking into the deaths of patients, allegedly at the hands of inexperienced surgeons.

Rabinowitz has claimed that at least 40 patients died at the hospital, where he worked for more than 25 years, after being operated on by inexperienced young surgeons without proper supervision.

"The meeting was not quite what I had expected," Rabinowitz said yesterday, shortly after being questioned by the panel.

"I was asked to list the cases and my concerns, and then I left. The surgeons who have been implicated were then called in to defend themselves.

"I didn't like it. I would have preferred a state inquiry, but this is how they have decided to do it," Rabinowitz said, adding he understood that an inquiry was still possible depending on the findings of the panel.

"I am concerned because doctors like to help doctors, but I guess that is the way it should be," he added.

The panel is chaired by Dr



**Dr Bernard Rabinowitz**

Taole Mokoena, head of surgery at Kalafong Hospital.

A senior physician at the hospital, who asked to remain anonymous, agreed with Rabinowitz's claims that many deaths at Chris Hani Baragwanath were related to negligence.

"A bad attitude does exist at the hospital. I think it's a case of racist attitudes die hard. There doesn't seem to be the same urgency with black patients as there would be at other hospitals. It's almost as if some surgeons rate black people's lives as cheaper than other races."

He added that young registrars, specialising in surgery, were merely using the hospital to gain practical experience before leaving for the more lucrative private hospitals.



# Negligence alleged at other state hospitals (98)

8/7/98

**Bonile Ngqiyaza**

THE problem of patient deaths at surgical wards due to alleged indifference and negligence could develop into a full-blown crisis after medical personnel in the Northern and Mpumalanga provinces complained yesterday of similar occurrences.

A three-man team of doctors led by Kalafong hospital surgery head Taole Mokoena on Monday started probing claims that at least 40 patients had died at the Chris Hani-Baragwanath hospital recently.

This came after the hospital's former superintendent, Dr Bernard Rabinowitz, went public last week with claims accusing senior personnel of an uncaring attitude, including allowing junior doctors in the hospital to perform surgery without supervision.

The Hospital Personnel Trade Union (Hospersa) yesterday handed over a memorandum to the provincial department of health, expressing concern that some of the files in the Chris Hani-Baragwanath case had disappeared. However, Mokoena said yesterday his team had received all 20 files that were "specifically" brought to the surgeon's attention and a report would be handed over to the department within the next three weeks.

He said members of the team had conducted interviews with the heads of the surgery, anaesthetic and nursing departments.

Hospersa expressed concern that the team's findings might not be acted on and requested that Gauteng premier Mathole Motshekga give the issue his personal attention.

The union also asked that all interested parties be updated continuously on the probe's progress and the team's findings.

Union spokesman Elize Richards said senior union officials would meet to discuss the possibility of approaching national government as the impression was that the provinces did not want to co-operate with the union.

She said the union had given the Gauteng health authorities until Friday to respond to the memorandum, hinting at mass mobilisation of the union's members if a resolution was not reached by then.

Richards said there was a general impression that the department was dragging its feet, as correspondence to the premier and health MEC Amos Masondo since September 1996 had not been addressed.

She said that the union had also approached Public Protector Selby Baqwa.



# Bara deaths spark an outcry

Star 9/7/98 (98)

## Public health service comes under the political scalpel

**A**llegations of irregular deaths at Chris Hani-Baragwanath Hospital in Soweto have sparked an outcry about the state of the public health service.

Baragwanath was better equipped and supervised and was less overcrowded and overstressed than most other hospitals, Gauteng Democratic Party health spokesman Jack Bloom said yesterday.

"There is no reason why Baragwanath should be the worst."

What was happening at the hospital, the country's largest, was symptomatic of problems throughout the public health service, said Inkatha Freedom Party health spokesman Dr Ruth Rabinowitz.

Her husband and a former superintendent at Chris Hani Baragwanath, Dr Bokkie Rabinowitz, recently went public with his allegations that more than 40 patients had died there

since 1996 because of lack of supervision during surgery by inexperienced doctors.

This week, a three-person commission investigated his claims to establish whether a commission of inquiry should be set up.

Hospital Personnel Trade Union of SA spokeswoman Elize Richards said various doctors from Northern Province and Mpumalanga had approached the union for help to uncover malpractices at state institutions.

Both Bloom and Ruth Rabinowitz were convinced that patients of hospitals in more rural areas were far worse off, not only because of poor medical care, but also because of a lack of staff and equipment.

Bloom said he had received numerous complaints with horrific stories emanating from Natalspruit, Oliver Tambo Memorial, Leratong and Far East Rand hospitals.

A report by the Gauteng provincial service commission about alleged bad management at Natalspruit Hospital is due to be completed within the next few weeks. The commission also investigated claims that a gynaecologist at Natalspruit cut the urethras of women on whom he performed hysterectomies.

In one case, a woman with thrombosis in her leg had to wait for treatment in a queue at Helen Joseph Hospital from 7pm on a Monday until 4am the following day. In another case, it was alleged that a patient's tongue was mistakenly cut out at a Gauteng hospital.

An 81-year-old woman died recently after she reportedly fell from her bed at Bethal Hospital in Mpumalanga and was left on the floor for about seven hours.

Relatives of an 84-year-old woman are considering legal steps because of her death last

week after having been refused admittance at one Gauteng state hospital, and allegedly receiving little and poor treatment at two others.

Bloom said aggrieved state hospital patients or their relatives rarely had the money to pursue matters further. Furthermore, grievance procedures were very cumbersome and inaccessible.

However, not every complaint indicated negligence. In many cases, hospitals were under such strain that they did not take the time to explain a patient's death to grieving relatives, Bloom said.

Conservative Party health spokesman Dr Willie Snyman said reports about negligence and malpractice were so serious that the appointment of a judicial commission of inquiry was warranted.

The national health department would comment later, a spokesman said. - Sapa



# Surgery allegations 'are not a vendetta'

Nomavenda Mathiane

FORMER Chris Hani-Baragwanath Hospital superintendent Dr Bernard "Bokkie" Rabinowitz said yesterday allegations that he had gone public about the deteriorating situation at the hospital because he had been passed over for promotion were "rubbish".

Rabinowitz, who alleged that more than 40 patients had died at the hospital due to lack of supervision during surgery, said his detractors were failing to deal with the problem and instead chose to get "personal".

He said for as long as he was chief surgeon at the hospital, there was only one case of negligence and the doctors concerned were disciplined.

"In my time, we built Baragwanath to be the best hospital in the southern hemisphere," Rabinowitz said. Since 1994, standards at Baragwanath had deteriorated and his attempts to get the chief superintendent Dr Chris van der Heever to act upon such matters had fallen on deaf ears.

Commenting later, Rabinowitz's wife, Inkatha health spokesman Dr Ruth Rabinowitz, said her husband was too narrowly focused on Baragwanath. The entire state health system was in a shambles.

"The allegations and investigation at Baragwanath hospital should not be viewed in isolation. They are symptomatic of problems throughout the public health service," she said.

(98) BD 10/7/98  
Democratic Party health spokesman Jack Bloom echoed her sentiments, saying Baragwanath was better equipped than most hospitals and that there was no reason why it should be the worst hospital.

Baragwanath spokesman Hester Vorster said she could not comment on whether Rabinowitz had informed the hospital superintendent about the problems at the hospital, saying the matter was now in the hands of the Gauteng health department.

Departmental spokesman Jo-Anne Collinge said the fact-finding mission into the hospital allegations, which is led by Professor Paoloe Mokoena, was expected to produce its report by the end of the month.

## Women politicians will gather in Cape Town

Wyndham Hartley

CAPE TOWN — Twenty-three of the world's most successful and powerful women politicians will gather in Cape Town next week to debate ways of making parliaments across the world more gender sensitive institutions.

Nine of the 23, including the speaker of the National Assembly, Frene Ginwala, are presiding officers in their national parliaments. The remaining 14 are deputy presiding officers.

They include the president of

the Bundestag in Germany, Rita Sussmuth; Swedish parliament speaker Birgitta Dahl; and Stortinget president Kirsti Gron-dahl of Norway.

Ginwala, said yesterday that the fifth international conference of women presiding over national parliaments would have as its main theme the transformation of the institutions and what measures could be taken to ensure women were not disadvantaged in political careers.

She said the issue went beyond simply electing quotas of women

and that a handbook entitled Beyond Numbers would be launched during the conference.

The book, to which both she and former ANC MP Mavivi Mayakayaka-Manzini have contributed, has been produced by the Institute for Democracy and Electoral Assistance in Stockholm. It is designed to be a practical guide for women parliamentarians.

Invited to the conference as observers are President Nelson Mandela's companion Graca Machel, and Zanele Mbeki, wife of Deputy President Thabo Mbeki.

Workshop



# Surgery allegations 'are not a vendetta'

(98) BD 10/7/98

**Nomavenda Mathiane**

FORMER Chris Hani-Baragwanath Hospital superintendent Dr Bernard "Bokkie" Rabinowitz said yesterday allegations that he had gone public about the deteriorating situation at the hospital because he had been passed over for promotion were "rubbish".

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# NEWS

# INSIDE OUR DYING HOSPITALS

(98)  
ST 12/7/98

■ *Man bleeds to death outside theatre*  
 ■ *Students scrub up to operate*  
 ■ *Hospital can't buy surgical gloves*  
 ■ *Patients wait 40 hours for surgery*



THE ROT SETS IN: Patients await treatment at one of South Africa's state hospitals, where people are dying unnecessarily, say medical staff      Picture: HERBERT MABUZA



LAURICE TAITZ, DINA SEEGER  
and ROWAN PHILP

**A** MAN bled to death in the country's largest hospital as he waited for an operation in front of the doors of a theatre.

In the same hospital, another man waited a whole day for an operation on a gangrenous bowel. He had the surgery, but the length of time he waited caused complications that finally killed him.

This is the face of the country's major state hospitals that was revealed after a former superintendent at Chris Hani Baragwanath Hospital, Dr Bernard "Bokkie" Rabinowitz, prompted an inquiry into 21 "preventable deaths" at the hospital.

Specialists, surgeons and doctors say patients in hospitals around South Africa are dying unnecessarily. And they say others are not receiving treatment to which they are entitled.

They blame a lack of funds and the soaring crime rate, which has left many of them dealing with numerous victims of violence.

At Addington Hospital in KwaZulu-Natal, a girl who was involved in a car accident last week was unable to move her arms or her legs but could not have a scan to check for spinal injury as "the state cannot afford it", a doctor claimed.

Professor Roger Saadia, the chief of surgery at Chris Hani-Baragwanath Hospital, said on Thursday that operating theatres at the hospital were grossly insufficient. "In my own ward I have had two fatalities in the past two months that can be directly attributed to this."

These were conditions at the hospitals this week:

● At Chris Hani-Baragwanath Hospital, six surgeons deliver service for 320 beds. In the past two years, more than 160 nursing sisters have left the hospital, spurred by generous retrenchment packages and better working conditions in the private sector or overseas.

The most visible effects have been: fewer intensive-care beds available; fewer functioning operating theatres (with longer queues for patients in need of urgent and non-urgent operations); and poorer monitoring of critically ill patients in general surgical wards (with incidents of undetected complications and deaths).

● In the same hospital, doctors say they have access to five intensive care beds at a time, for 300 patients, and resuscitation equipment is antiquated.

● At Tygerberg Hospital in Western Cape, patients can wait up to 40 hours for surgery and those with breast cancer are being turned away because the radiotherapy machinery has broken down.

● At King Edward VIII Hospital in KwaZulu-Natal, there is often not enough staff to run two theatres.

● At Addington Hospital, students scrub for major cases because the hospital has lost six highly trained sisters in its surgical ward this year.

● At Edendale Hospital in Maritzburg there were no surgical gloves used in the theatre this week because the hospital could not afford them. Equipment that had been broken for more than three weeks could not be repaired or replaced.

In response to the number of deaths at Chris Hani-Baragwanath Hospital, Saadia said: "The inquiry should find the allegations are misplaced. Those people could have been saved — by a better health

system. Even a figure of 10 preventable deaths a year for a 320-bed surgical department is minute, and I can state confidently that a greater number of preventable trauma deaths occur in my department out of the thousands of surgical operations performed each year. I am unable to give exact figures as we cannot afford the services of a full-time computer-literate doctor solely devoted to the collection and analysis of data."

Saadia said: "The unavailability of an ICU bed for a trauma victim who needs it means almost certain death. Three of the patients mentioned in Rabinowitz's report required ventilation; they were denied ICU access, and they died."

"One figure alone can illustrate

the magnitude of the emergency surgical load: over the past three years we have treated 2 500 victims of gunshots a year. This excludes victims of stabbing, assaults, road accidents and non-traumatic surgical emergencies. This is where we end up devoting our resources. And we're not having a civil war."

"We are hamstrung by finances," said Saadia. "In 1981 the people of Soweto were getting much better health care than they are now."

A surgeon at Tambo Memorial Hospital in Boksburg said: "It's easy to exhaust Bara's facilities because we at the peripheral hospital refer our priority trauma cases to Bara. Lack of facilities does play a big part. Our first-level trauma cases get refused at Johannesburg Hos-

pital when it cannot cope, and Bara ends up with them."

Professor John Robs, the head of surgery at the University of Natal, said the number of preventable deaths had increased as trained medical staff were emigrating or defecting to the private sector.

"Too many people are dying. Our nurses are superb, but there's been a massive defection to the private sector and to countries like the United Arab Emirates and the US," he said.

Robs said King Edward VIII Hospital in Durban had excellent trauma facilities, but there was a shortage of trained staff to operate them. "I can't complain about the equipment at King Edward, but you can't put a bus driver in a Ferrari."

At Edendale Hospital, which caters for all emergency cases in the KwaZulu-Natal Midlands, a surgeon said: "The medical service here is going down so rapidly, I just don't know what will happen."

Elize Richards, of the Hospital Personnel Trade Union of SA, which represents about 60 000 health care practitioners in the public and private sectors, said: "The standard of health care is down and the lives of patients are being compromised."

She said doctors in Northern Province and Mpumalanga had come forward with the same problems since the Bara inquiry.

"The national department should establish better monitoring procedures in provinces.

"Only by having those can we safeguard patients' lives.

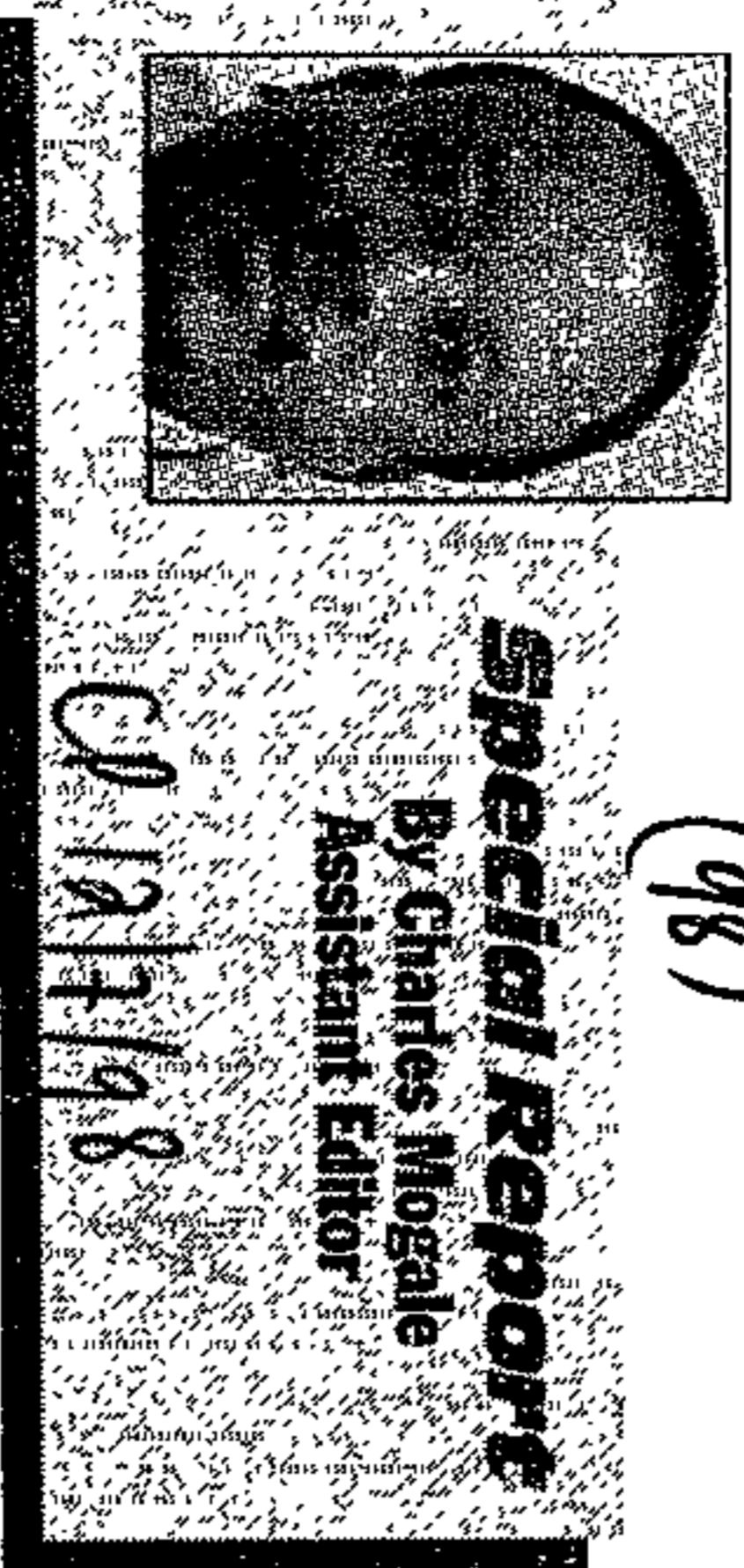
"When free health care and abortion were introduced the necessary research was not done to see whether the system could cope. And patients have flooded the hospitals. These are wonderful concepts, but they need assessment and consultation. We do not have the necessary statistics to see who we are serving, and foreigners are flooding our health care system.

"The allegations made by Dr Rabinowitz and our calls for an investigation into conditions at the hospital are only the tip of the iceberg. These conditions prevail throughout Gauteng, and we have received similar information from other provinces," said Richards.



# Bara file of death

And it isn't just at Bara, say doctors in other provinces (98)



THE HORROR of "avoidable deaths" that has rocked the Chris Hani Baragwanath Hospital in Soweto could spread to other provinces - following a meeting of senior doctors in Pretoria this week.

Doctors from Mpumalanga and the Northern Province met at the offices of the Hospital Personnel Union of South Africa (Hospersa) on Friday to submit evidence of possible negligence in their respective provinces.

The meeting followed a harrowing disclosure by former Chris Hani Baragwanath superintendent surgeon, Dr "Bokkie" Rabinowitz, that at least 40 people had died at the hands of negligent or inexperienced medical staff.

Hospersa has announced its plan to enlist the help of civic organisations and the public in pressuring the government to undertake a full-scale independent inquiry into the state of public health in the country.

"The public is at risk. We have a responsibility not only to our employees, who have to work with ridiculous patient-doctor ratios, but also to the public," spokesperson Elize Richards said. Although Hospersa would not reveal the contents of the doctors' submissions, provincial secretary Manfred Rothballe said it was clear there was "some negligence".

Rabinowitz this week showed City Press a thick dossier of correspondence he had sent to the hospital's superintendent, Dr Chris van der Heever, and to the provincial ministry of health - however, Gauteng's media liaison officer for health, Popo Maja, denied that Rabinowitz had been ignored. Maja said the process to establish the facts was underway.

"It is not true that the inquiry was hastily put together after Rabinowitz decided to make his allegations public," Maja said. He said Rabinowitz was informed as early as October 1, 1997 about the inquiry. On subsequent occasions he was asked to furnish relevant information to back up his allegations, but failed

DEAD



ESTHER MATHOLE

to do so, Maja said. However, Rabinowitz was adamant that he was not taken seriously.

"They did not bother to do anything about it. There was not one inquiry," Rabinowitz said.

"I have proof of this. One wonders how many more have died that I am not aware of?"

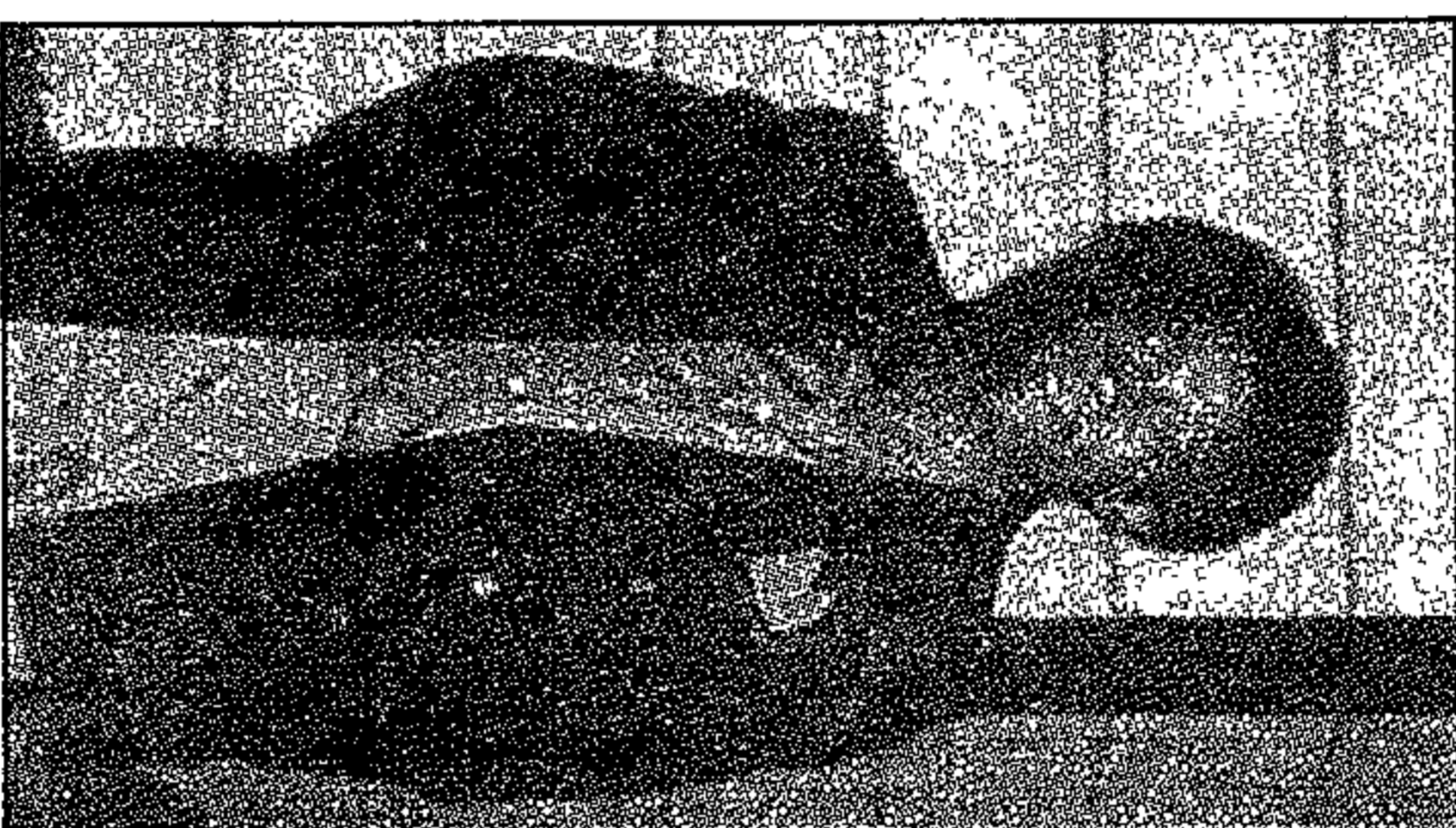
"This is about the ones who died... but what about those who had wrong operations done to them but lived? It makes me mad," Rabinowitz said.

Speaking from his home in Sandton, Rabinowitz related a sombre tale of his lone two-year battle with the authorities to step in and investigate deaths.

Rabinowitz worked as a principal surgeon at Bara for 27 years, before retiring in 1993. He then applied for the position of superintendent surgeon, which he got.

"During the interview for the post they asked me what I thought of the hospital. I asked them if they wanted a nice answer or the truth. I never-

DEAD



CECIL RINGANE

theless gave them the truth... that people were dying who should not be dying," he said.

After his appointment to the position, he says he came down hard "on sloppy surgeons".

He told of incidents where:

□ A 70-year-old woman was admitted with a gash on her neck. "A blood vessel in her neck should have been tied up to stop the bleeding. It was not, and the old lady was left to bleed to death on her bed. What inquiry was held after that? Whose head rolled? Nothing was done."

□ A 70-year-old was admitted with a fractured pelvis. The patient was seen by junior doctors and sent home although she could not sit or stand because of the pain. The following day she was brought back to the hospital, and died. "The doctors had missed the fracture - but even a layman could have seen the crack from the X-rays."

□ A man was shot in the face and suffered a broken jaw. His whole face was wrapped up in bandages but the doctors "did not check his spine".

"In facial injuries, it is standard procedure to

DEAD



SIPHO MAKHOBENI

check that the spine, at the neck, is not injured, because any small movement could break it. They did not, and as a result of moving the head up and down while bandaging him, they broke his neck. He died."

□ Fifteen hours after her admission there was nothing more written in her bed letter. A tube was inserted into her lung, which was the right thing to do. Only, the tube was not in her lung - it was in her stomach. She died.

"The doctors complained to the superintendent that I was harassing them and he told me to leave the surgeons alone.

"Eventually I was forced to retire at age 66, because of old age. But I can tell you that there are people who are working at Bara who are 80 years old!"

"They now say I am speaking out because of sour grapes.

"Sour grapes don't kill people, it is negligence that kills people," Rabinowitz said.

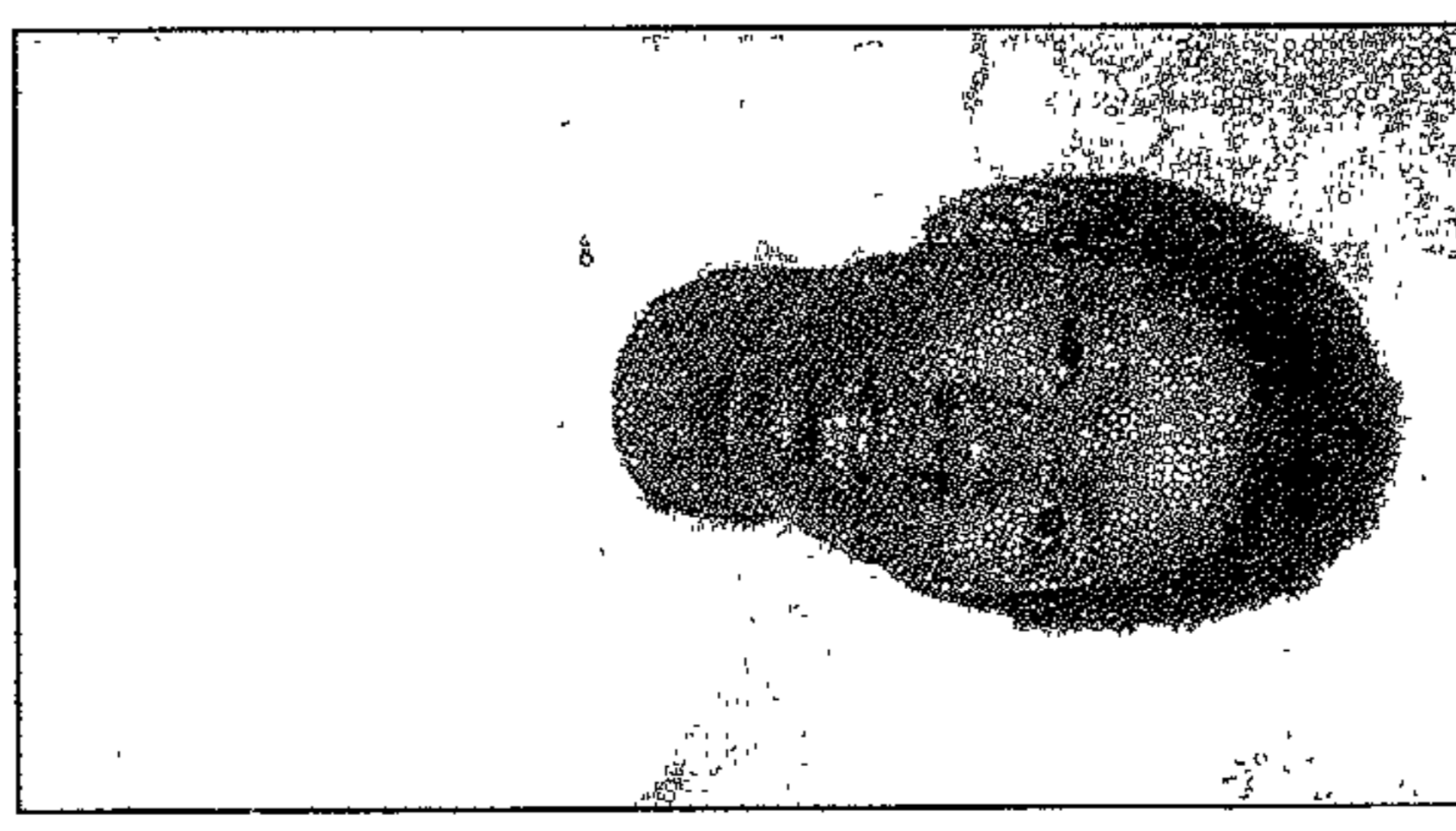
DEAD



THABITHA NDLOVU

MADODA NDLOVU

DEAD



Follow the stories of shattered families who are voicing their grief after needlessly losing their loved ones - on



# Families angry at Bara deaths

(98) CP 12/7/98

## They are rallying their support behind Dr Rabinowitz

**T**HE FAMILIES of people who died "unnecessarily" because of alleged negligence or inexperience at the Chris Hani Baragwanath hospital in Soweto are angry.

City Press this week spoke to relatives who said they believed the claims that "people are dying who should not be dying" are not without substance.

They pledged their support for rabble-rousing Dr Bokkie Rabinowitz, who made startling claims that at least 40 people died whose lives could have been saved by medical staff at the hospital.

Johanna Ndlovu of Mofolo Central said her mother-in-law, Thabitha Ndlovu, slipped and fell on a dressing table in October 1997, cutting her neck in the process.

She was rushed to the hospital where her neck was stitched up. "She was then taken back to the ward where she looked quite normal. She spoke to visitors and nurses and all thought she was on her way to full recovery."

"I was shocked the following day when I went to visit her and was told she was dead. Although I am not a doctor, it does not make sense that she died like that."

"It makes one angry that a human life gets lost just like that," Ndlovu said. The death certificate indicated she had died of "unnatural causes".

By Rabinowitz's account, she bled to death because the doctors failed to tie up a bleeding blood vessel.

The circumstances surrounding Cecil Ringane's (31) death last year have led his family to believe that there might be substance in the allegations made by Rabinowitz against his former colleagues.

The Ringane family said they could not believe it when they were told Cecil had died.

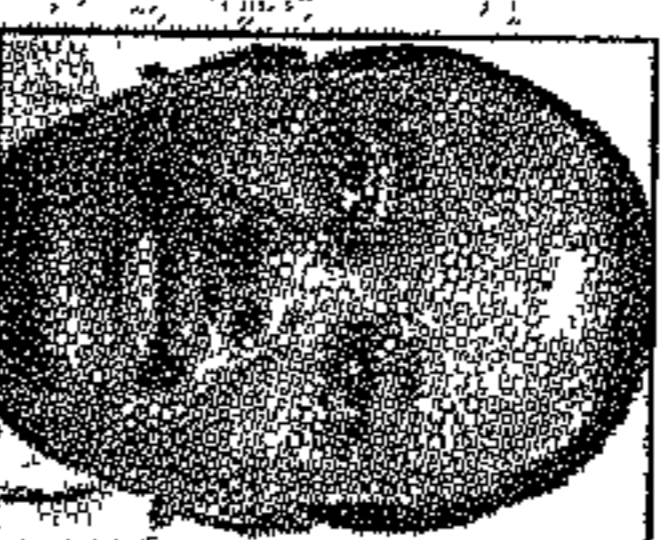
Ringane was admitted to the hospital after he was shot in the abdomen by an unknown gunman at Klipspruit.

"When we went to see him he was not even in an operating theatre. He was not critical at all. My wife and I talked to him and he said he was fine and only complained that it was cold in the ward. We promised to bring him a blanket the following day."

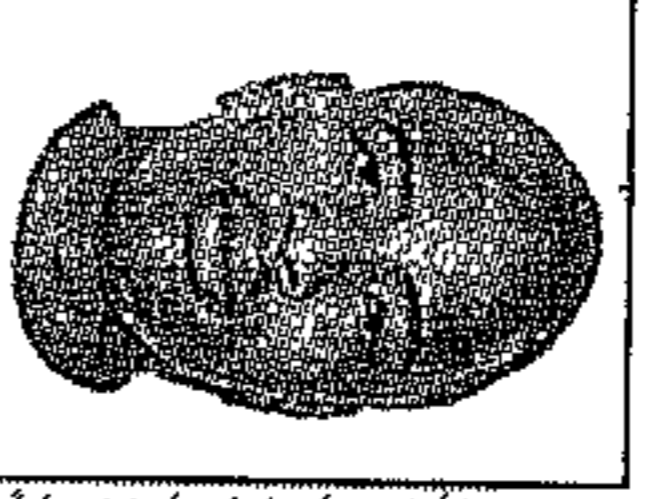
Alfred Longwe, Cecil's brother-in-law told City Press.

The following morning Longwe was called and told that Cecil had died. Longwe says Cecil's death was not even explained to them.

"I have to say we were shocked because just a day before, he looked



By Charles Mogahe



with Zolile Ngoyi



**HELL-RAISER...** Dr Bokkie Rabinowitz (right) denies he is bitter. (Pic: Tladi Khuele) while Mmadiphoko Manguogape (above) says ambulance staff refused to help her stabbed boyfriend (Pic: Andries Meineke).

fine to us. When we asked the trainee doctors about his condition and progress we were told to leave the surgical ward," Longwe said.

Ringane was the sole breadwinner in the family. His parents are both pensioners.

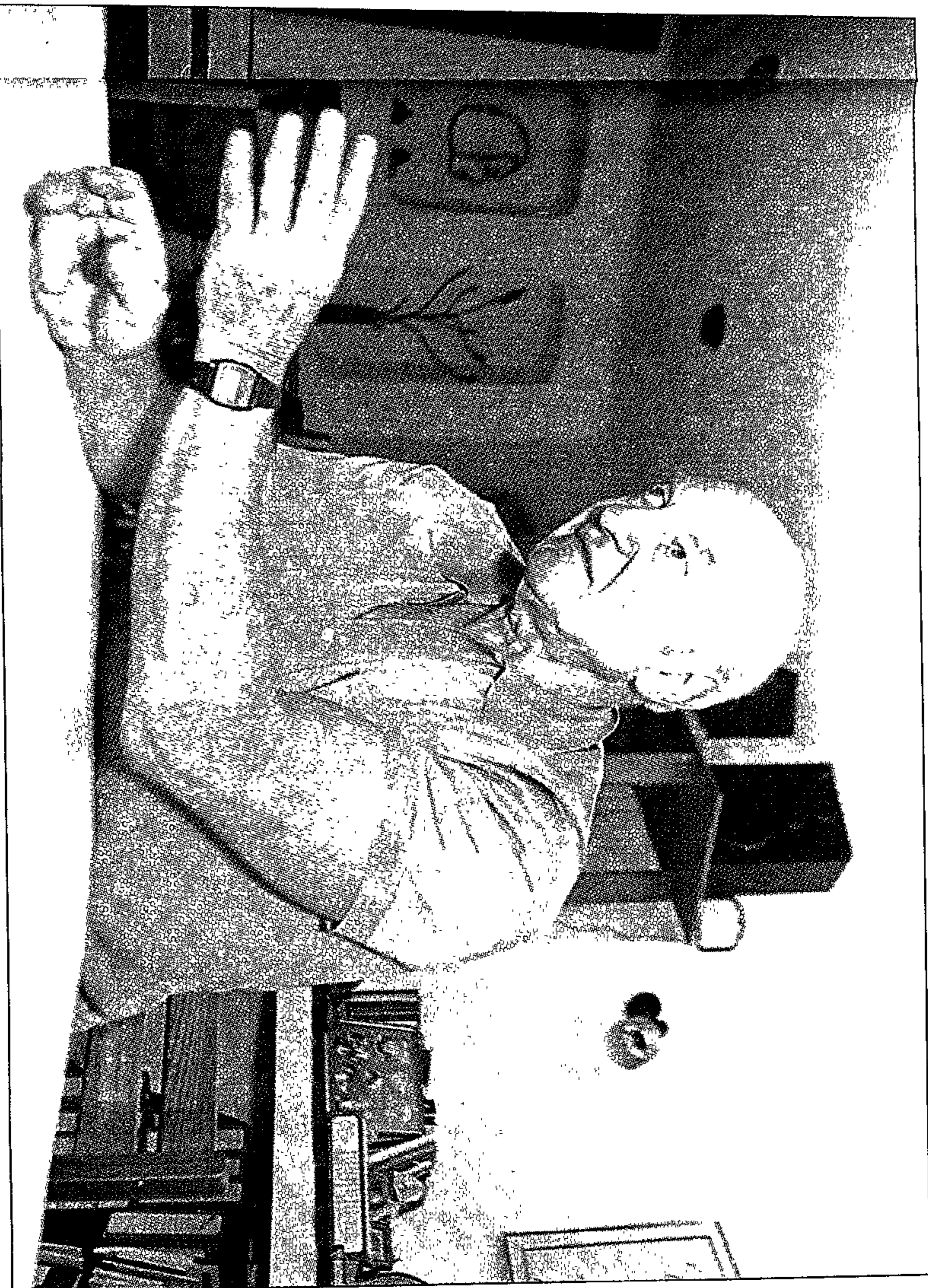
"It has been an uphill battle without Cecil. It has been particularly difficult to pay rent and electricity bills. This has been heartbreaking for all

of us," said Hlanganani Ringani, Cecil's brother.

Simon Malaka (37) of Dobsonville was stabbed once in the neck on July 5, 1996. His girlfriend, Madipeko Manguogape, called an ambulance. When it arrived,

the paramedics refused to carry him into the vehicle, saying it was not their job.

"He was a little weak at the time, but he continued to talk all the way to Bara. I went



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**BARRED FROM DEATHBED**... Jackie Simelani waited at Bara gate while her brother died.

**Johanna Ndlovu**

**On the death of her mother-in-law**

“She was then taken back to the ward where she looked quite normal. She spoke to visitors and nurses and all thought she was on her way to full recovery. “I was shocked the following day when I went to visit her and was told she was dead. Although I am not a doctor, it does not make sense that she died like that.”



**DISTRAUGHT MOTHER**... Annah Makhobeni was not told why her son died. **Pics: ANDRIES MCINENKA**

“We did not get any other explanation.”

Jackie Simelani rues the day when the police shot her younger brother Madoda Ndlovu (30) and took him to Bara while he had a medical aid card in his pocket. Madoda was shot two doors away from his chain-style home in Zola. The policeman who shot him later told an inquest court that he had opened fire because Madoda was “running away.”

Jackie only learnt the following morning that his brother had been shot the previous night, on the eve of his trip to KwaZulu-Natal to visit his parents. “I asked for time off from work to visit him at Bara. The security guards at the gate would not allow me in. I waited at the gate from 11 am until visiting hours started at 3 pm. When I got to the ward they told me he had died at 2 pm. I will never forgive those people for barring me from my brother’s death-bed. I am even angrier since it is said he could have been saved,” she said.

There were allegedly no explanations, and the death certificate indicated he had died of “unnatural causes.”

On March 30 last year, Sipho Makhobeni (17) was involved in a car crash near his home in Meadowlands.

The standard nine pupil was taken to Baragwanath hospital, but his family does not know what caused his death.

“If he could be saved, why was he not? He was my youngest son,” his mother Anna said, choking with emotion.

Esther Mathole (19) also died after she had sustained serious gun wounds to her head. Fer grandmother, Maud Sekgapano, with whom Esther lived at the time, was told “by young doctors” that although Esther could live, she was brain damaged.

Esther was shot while she was driving in a car with her boyfriend and friends in Senaone in Soweto in May 1997. The bullet entered her skull through the back and exited around her nose. The family feels that though they were assured by junior surgeons she would be fine, they do not hold the hospital accountable for her death.

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# R400 000 scandal hits ANC offices

SEVERAL individuals hired by the African National Congress in the North West to run constituency offices have allegedly defrauded the organisation of about R400 000 of taxpayers' money.

The money, allocated to the provincial organisation by the national government to run constituency offices, was allegedly misappropriated during the past months.

The ANC has formed a task team consisting of provincial MECs and members of the Provincial Executive Committee to probe the missing funds. It is suspected that the



By Jimmy Seabe

## High-powered tax team investigating

personal accounts using several banks. It is understood that the North West investigation will also probe the possibility that the individuals may have colluded with certain members of the ANC.

It is understood that the ANC was alerted to the missing funds after one of the suspected individuals decided to resign from his position without giving notice of his intention.

The provincial ANC caucus is said to have met to discuss the

matter and to have established a task team to investigate the missing funds with the possibility of referring the matter to police for further probing.

The task team is composed of provincial executive members of the ANC including the organisation's treasurer general, Maureen Modiselle, and MECs - Saitsh Rooga, MEC for City and Security and Martin Kus, MEC for Finance and Administration.

The organisation is said to have hired a forensic company help

with the investigation.

Task team member Kuscus told City Press the investigation was continuing and the team was waiting for a forensic audit report.

Kuscus said the task team was looking at the system and procedures used in the allocation and handling of constituency funds.

He said once the investigation was complete, a report would be tabled to the ANC caucus which would then decide what to do following its outcome. Meanwhile, the ANC in

Mpumalanga took a tough stance against legislature deputy speaker, Cynthia Maropeng - saying she should be fired from the legislature and criminal charges should be laid against her.

In its comment on the Ngobeni Commission's report on allegations of financial impropriety in the Mpumalanga legislature, the provincial executive also recommended that provincial speaker Elias Ginhadza be demoted to an ordinary member of the provincial legislature.

# 'I can't remember whether I killed one or one hundred'

SECURITY forces - policemen and soldiers - just stood and watched as he and his accomplices shot, butchered and murdered the people of Boipatong, a 29-year-old convicted murderer and member of the Inkatha Freedom Party testified this week.

Victor Mthandeni Mthembu, serving a 226-year prison term, was giving testimony in his application for amnesty at the Sebokeng College of Education this week.

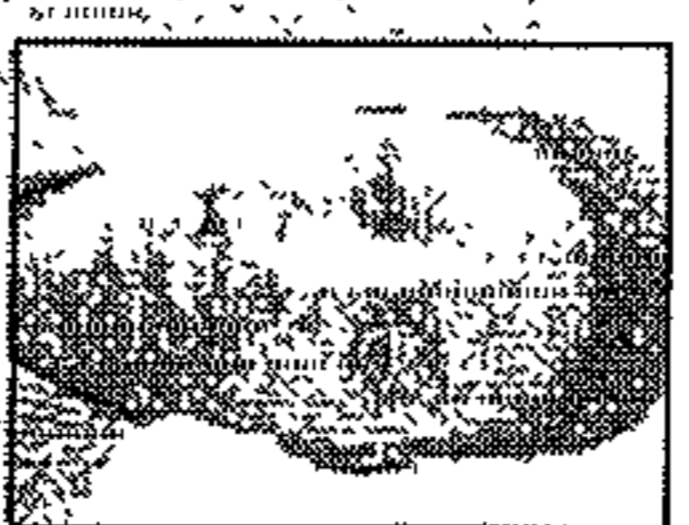
Mthembu is one of the 16 applicants who want amnesty for the Boipatong massacre on June 17, 1992, in which 45 people were killed by IFP members.

About 108 Boipatong residents survived the attack but some are now confined to wheelchairs. Among those killed were 11 children, some as young as six.

Mthembu said he was not sure how many people he had killed that night. "I cannot say whether I killed one or 100 people, I did not count them. It was a war situation," he said.

Mthembu who lived at the KwaMadala Hostel at the time, later contradicted himself by saying he did not kill but only weakened the victims so that his 300 accomplices - armed with firearms, spears and pangas - could finish them off.

He said he stabbed a man who tried to hide behind a car, only once in the back with a spear. "I did not have to finish him because I knew I had company who would do their part," Mthembu said.



By Steve Dlamini

ANC's self protection unit responsible for torching and killing IFP members.

Mthembu said he had experienced "difficulties" at the first house entered in Boipatong when he saw two young girls who seemed to be twins.

"As a parent, I felt sorry for them. I hid them under a bed and made sure no one else entered the house. But Daniel Berger, one of the legal representatives of the victims, said the children had hid themselves under the bed without Mthembu's help.

The argument between Berger and Mthembu continued on Friday as Berger tried to point out discrepancies in the applicant's testimony. Another discrepancy in Mthembu's testimony was that on Thursday he said he did not know who the provincial leader of the IFP was, but on Friday admitted he knew it was Phisoana Molele.

The committee was also told of

and families of the victims knew who their attackers were, and the overwhelming feeling among them was the 16 should not be granted amnesty. Johannes Mbatha, the husband of Poulinah, who is in a wheelchair because of the attack, said at times he found it difficult to help his wife because he was no longer a "healthy" man.

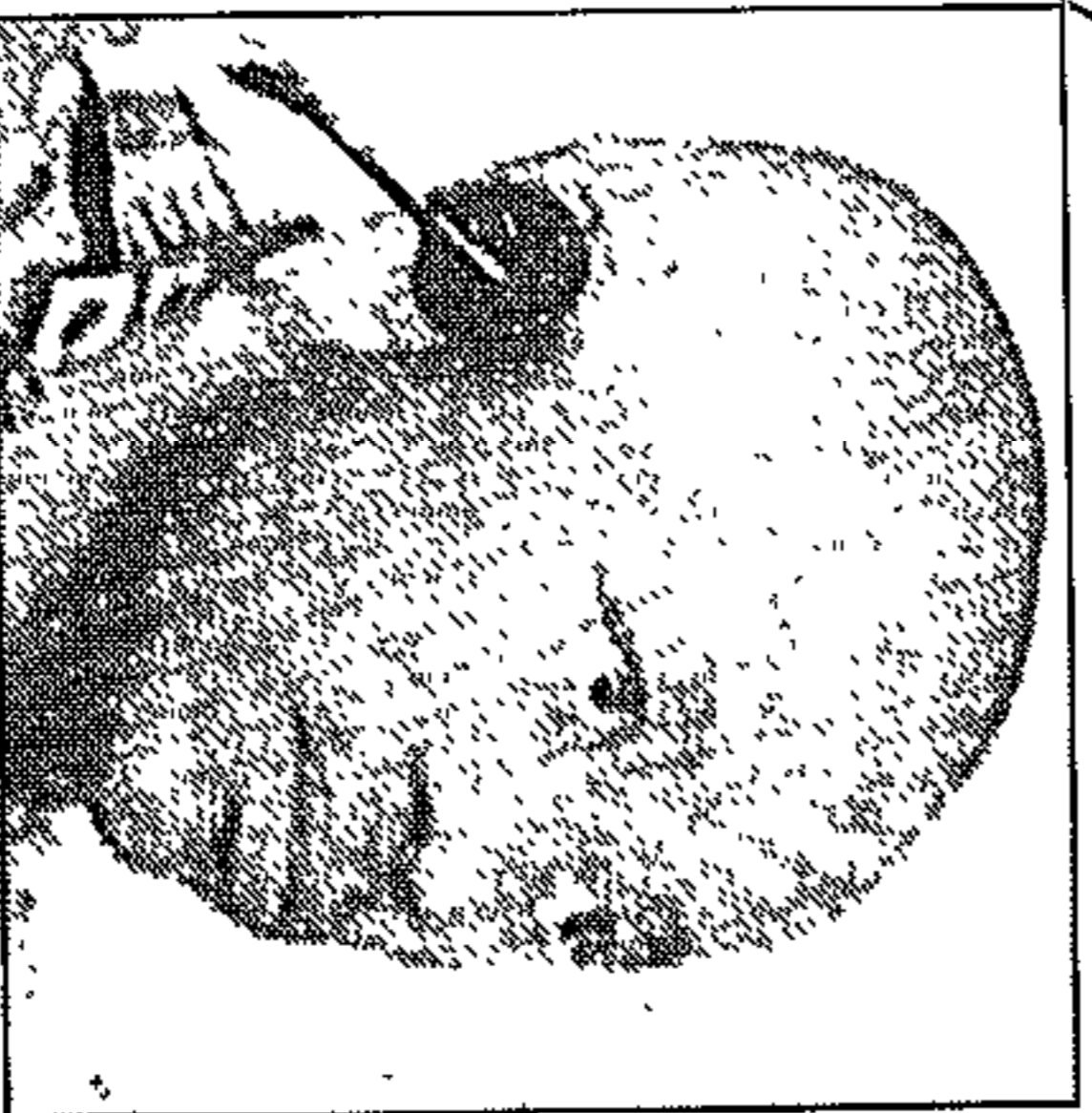
"I can't see the reason why this man (Mthembu) applied for amnesty because everyone can see that what he tells is not true. He is not an honest man. This man is dangerous, you can't trust him," Mbatha said.

His wife Poulinah said: "I can hardly walk because of them. I'm permanently confined to a wheelchair."

Paulinah's sentiments were echoed by Maleseng Mirriam Molele, who was stabbed with a spear just below the eye. Molele's three-year-old daughter, Mita, was struck with a panga in the head. Molele said she still could not believe her only daughter had survived the gruesome attack.

Describing the night's events, she said just after 10 pm they had heard windows shattering. "My daughter was sleeping and her father was listening to the news. I was naked in the bath at the time," Molele said.

"I peeked through a window to see what was happening. I saw a group of men in white and red colours. Some of them were white people. I rushed to the bedroom where my daughter and I were. I heard the windows shattering and I saw the



MASS KILLING ... Victor Mthandeni Mthembu wants amnesty.

stabbed and her daughter was attacked with a panga.

"I fell down pretending I was dying. They left with my husband, whom they killed later that night. We ran out of the squatter camp to an open area where we asked for help."

She said she was rushed to the Sebokeng hospital in an ambulance protruding from her head. Mita, a grade four pupil at Thembehle middle school, is now confined to a wheelchair. Mita said she could not recall how the incident had happened as she was only three at the time. She is now nine. "All I can say is that they (the applicants), should not be given amnesty."

The 16 applicants are

## Four more die in taxi violence

BY STEVE DLAMINI

THE ongoing taxi violence in Pretoria has claimed four more lives and left 17 people wounded in 13 separate drive-by shooting incidents yesterday.

Pretoria police spokesman Inspector Gideon Thesener said 10 of these incidents occurred in the Soshanguve area while the other three happened at Pretoria North.

Thesener said the incidents in Soshanguve happened at about 6.30 am while the Pretoria North incidents took place at about 7 am.

"Ak47 guns, R5 rifles and 9mm pistols were used. Police recovered empty bullet cartridges on the scenes," Inspector Thesener said.

He said the wounded victims were rushed to a Soshanguve Clinic and Ga-Rankuwa Hospital. Inspector Derek de Jager, spokesman for the Taxi Violence Unit in Pretoria, said:

"We recovered more than 11 R5 empty cartridges and nine 9mm cartridges. No arrests have been made but we expect a break through soon," he said.

According to police only nine people were wounded, but the Ga-Rankuwa Hospital's spokesperson, Babe Mosuwe, confirmed that 17 people were admitted to the hospital's casualty unit. Of these, two were "critically" wounded.

"The critical patients were admitted to the hospital's ICU with bullet wounds in the back and on the arm," Mosuwe said.

"A kidney of the patient shot in the back has been damaged possibly because of the wound. The patient shot in the arm suffered a fractured bone," she said.

Mosuwe said among the patients was a nurse from the hospital had been on her way to work from Soshanguve.

Thesener said that among the injured people were three taxi operators belonging to South African Local and Long Distance Taxi Association (Sallata).

He added that police suspected that the attack might have been launched by members of the Federated Local and Long Distance Taxi Association (Feldata).



M.L.H. ... ORROR ... when she was hacked in the head with a pangla. She is now permanently confined to a wheelchair.

massacre, the hostel dwellers had been looking for members of the

the ammunition at the hostel. Years passed before the survivors

word and headed for a door. She said it was then that she was

uiko, Jack Mbele and on Mkwanzu.

CP 1a/2/98

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## A gathering of the vibes to salute Madiba

By VUKILE POKWANA

SOUTH Africans can brace themselves for a mega birthday bash when ten top international artists and a variety of local artists take to the stage to celebrate Mandela's 80th birthday at the Johannesburg Stadium on July 25.

The super line-up which encompasses R&B, hip hop, kwato and reggae, will include LL Cool J, Dru Hill, TKZee, Tshapo & Sankomota, Salif Keita, Bongo Mafin, Aza Shante and Lyra, Ishmael Lo, Najee, Skeem and E'Smile, Just Jinger, Kenny Lattimore, James Ingram, Shakar and Lucky Dube.

The concert - dubbed "The Gift To The Nation" - will kick off at the Kingsmead Cricket Stadium



DOING THE MUSICAL HONOURS ... Famed musician Salif Keita (left) and seasoned entertainer L.L. Cool J.

in Durban on July 24. And on July 19, a day after Madiba's birthday, 2 000 invited guests, including family and friends, dignitaries, celebrities and the corporate world from near and far, will converge at Gallagher Estate in Midrand at a special dinner

to wish the President a happy birthday.

Part of the festivities at this special party, which is also a fundraiser for the Nelson Mandela Millennium Fund, will be a 45-minute all-South African musical tribute. Children will lead in special song and there will be a special birthday cake. Tickets priced between R50 and R75 will be available at Computicket outlets nationwide.



SHINING EXAMPLES ... Born in a gangster-ridden area of the Cape Flats, Batana Batana youngsters, Quinton Fortune and Benni McCarthy, continue to set the pace among their peers. Fortune (21) recently bought his family a house in the affluent Cape Town suburb of Pinelands worth half a million Rands. He is pictured here with his mother, Hilda, at their previous home, a council flat in Kentonville, Athlone. McCarthy moved his family to Diep River last year.

## Company will bury fallen bridge victims

By HANGWANI MULAUDZI

ACCUSATIONS that inferior materials led to the collapse of a 300-metre long bridge still under construction outside Bushbuckridge were dismissed this week by Concur Construction managing director John Laverly. Fourteen people died in the accident.

Laverly said allegations that the cement used was not approved by the South African Bureau of Standards were unfounded.

Northern Province public works spokesman Simon Matome said a top level investigation team had been assembled to probe the disaster. Matome said all the evidence gathered would be put before an official inquiry.

He added that all work on the bridge would cease pending the outcome of the inquiry.

The suspension would also delay the building of the Injaka Dam. Matome said: "An investigation is necessary to determine the cause of the accident and to ascertain whether all health and safety procedures were followed."

The bridge, being built across the Marhe River about 14km outside Bushbuckridge, collapsed on Monday.

Several workers fell 90 metres to their deaths, while others were crushed by gigantic concrete slabs. Fourteen people died and 13 others were injured.

Laverly said his company and the involved engineering firm were co-operating fully with the investigators.

"We are committed to finding the cause of the tragedy, the first we have had in the building of more than 200 bridges in South Africa.

"At this stage we would appeal to all affected parties not to speculate on the circumstances that may have caused the accident until the official inquiry has been concluded," he said.

Laverly said Concor and Van Niekerk, Kleyn and Edwards (VKE) - the consulting engineers on the project - were mystified as to what had caused the accident.

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CP 6

## SABTACO\* CONFERENCE/WORKSHOP

CSIR CONFERENCE CENTER, PRETORIA

DATE: 20 - 21 JULY 1998 (08H00 - 16H30)

THEME: Empowerment in a Free market Economy - The Role of the State and the Private Sector

GUEST SPEAKER: Prof. Kader Asmal, Minister of Dept. of Water Affairs and Forestry

SPEAKERS FROM: TRANSNET, NAIL, AIRPORTS COMPANY SOUTH AFRICA, SAPDA, SABTACO, COROBRICK, GOVERNMENT, DANIDA, ETC.

GALA DINNER: The conference will culminate in a Gala dinner to be addressed by MR JEFF RADEBE, Minister of Dept. of Public Works

DAY 2 IS A WORKSHOP FOR SABTACO, DWAF AND DANIDA

FOR MORE INFORMATION CONTACT: MOTHOB I MOTHOB I (0140) 841-229 OR J NGBENI (011) 403-9501

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CP000610



# UCT plans private teaching hospital

*A THIRD ROAD for health care, somewhere between expensive private services and the overstretched public services, has been proposed by the University of Cape Town. Health Writer JUDITH SOAL reports.*

THE University of Cape Town plans to build a R250 million private teaching hospital on the old Valkenberg Hospital site in Pinelands, in partnership with the German private hospital group Rhön-Klinikum. It also hopes to run private wards in Grootte Schuur Hospital by the end of the year.

The plans have not yet received formal approval, but the partners have encountered "sufficient support to persevere", said UCT's dean emeritus, J P Van Niekerk.

South Africa's largest private health care group, Netcare, has also discussed joining the venture.

The new services would be directed at low-income earners who do not have medical aid cover at the moment, but who would qualify for insurance under the government's social health insurance scheme, which will be tabled in Parliament this year.

"This is a completely different concept in health care," said Netcare's Ian Kadish. "It will not compete with existing private hospitals or the state. It will target the so-

called emerging market."

The venture is divided into two phases. The first, the "immediate solution", involves taking over about five wards at Grootte Schuur Hospital, to be known as the UCT Medical Clinic. It would consist of 100 beds, 20 intensive care beds, four theatres and consulting rooms for specialists.

The UCT clinic would not simply move into vacant wards at Grootte Schuur. "We need to structure our clinic efficiently, so Grootte Schuur would need to be restructured, which is happening anyway because of changes in the health system," said Van Niekerk.

The second phase "comprehensive solution" would be the Oude Molen University Hospital in Pinelands, datemarkeid 2002.

The services would be run according to a model developed by Rhön-Klinikum, which is said to be much cheaper than either state or private health care in Germany.

"These people have examined the business of hospital care in minute detail and made some

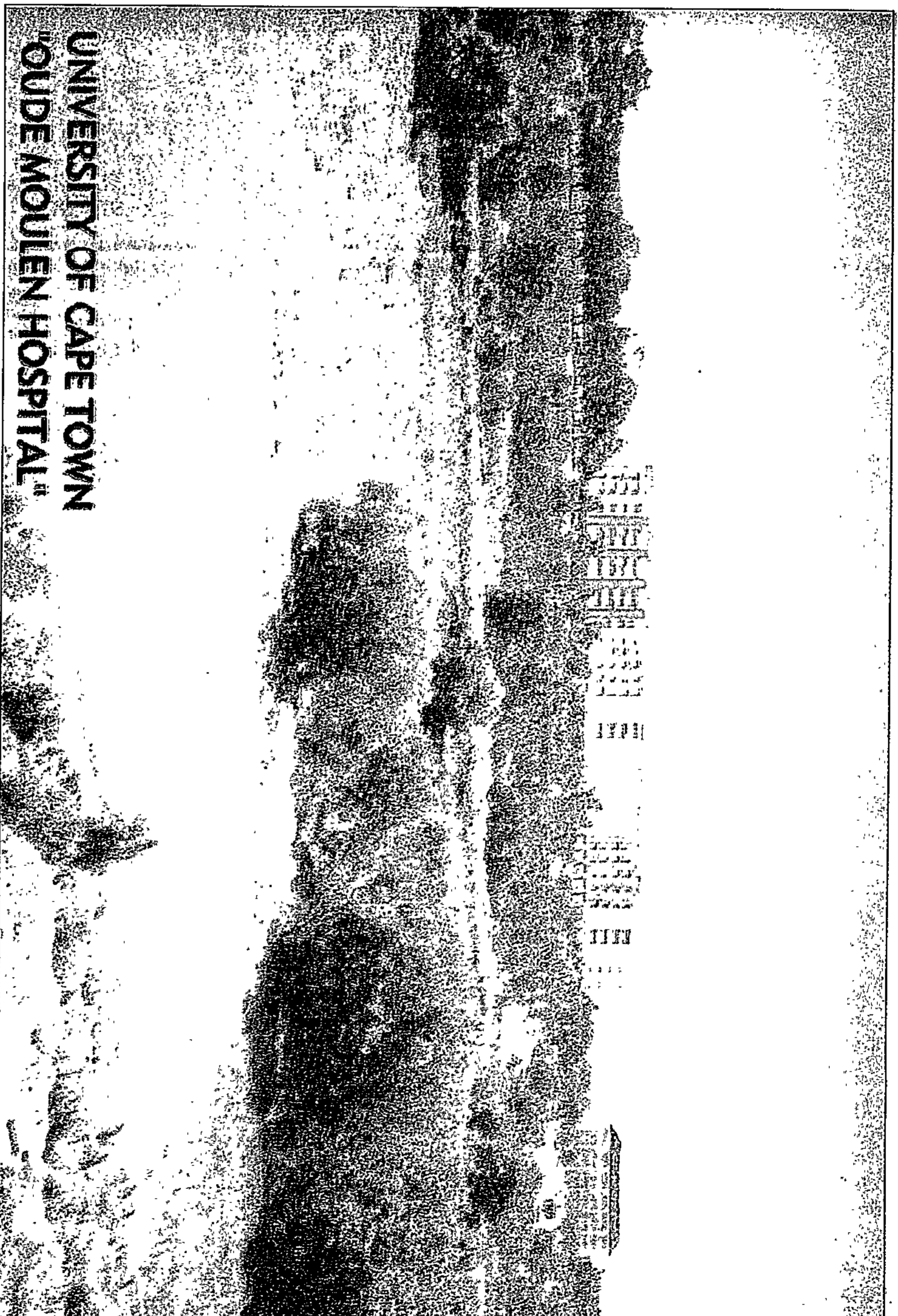
comprehensive changes," said Van Niekerk. "We can gain from all this expertise. We will also gain on foreign investment."

Rhön-Klinikum has already spent "hundreds of thousands of Rands" on the South African plans.

UCT's vision is not unique. Teaching hospitals around the country — including Tygerberg — are looking to the private sector for ways to provide specialist training to their students and maintain their academic and research interests in the face of budget cuts and an increased emphasis on primary health care. Wits and Pretoria University are discussing similar schemes in Gauteng.

Although everyone — from Health Minister Nkosazana Zuma to provincial Health MEC Peter Marais — says they support the "public-private mix" (the current buzz-phrase in health care), there is already opposition to the plans.

Grootte Schuur Hospital medical superintendent Peter Mitchell says the hospital supports "in principle" the plan to rent available



**UNIVERSITY OF CAPE TOWN  
"OUDE MOULEN HOSPITAL"**

**LAND MARKED:** An artist's impression of the new Oude Molen Hospital, superimposed on the intended site of the hospital, near the Vincent Pallotti Hospital in Pinelands. J P Van Niekerk of the University of Cape Town says the partnership is committed to preserving the ecologically sensitive surrounds.

space to the UCT clinic, but insiders say senior staff are divided on the issue. "Some people are deeply against it," said one doctor.

There are also fears that state services will suffer further staff and income losses. "They could end up taking resources out of the state services. The state could lose experienced people who are attracted to

the better salaries and more specialised services, and the patients who are able to pay for health care," said David McCoy of Health Systems Trust.

The health department had intended that funds from the social health insurance system be used to boost state health services, not the private sector. By taking this rev-

enue away, they leave a poorer service for the poor.

Getting permission to build a new private hospital will not be simple, as Cape Town already has too many private hospital beds.

Zuma has put a moratorium on the issuing of private hospital licences, saying the state should decide where these services are most

needed. It is unlikely she would agree to another licence here.

But Health MEC Peter Marais' office says the province, not the national government, has the authority to issue licences. Marais is in Australia but met the UCT group to discuss the plan before he left. His spokesperson, Johan Smit, says Marais supports the idea in principle.

"What is not up to us though," said Smit, "is the land at Valkenberg. That belongs to the Asset Management portfolio."

Asset management MEC Michael Louis said the province had not yet called for tenders for the land. "There has been a lot of interest in that land, it's impossible to say right now what will happen."



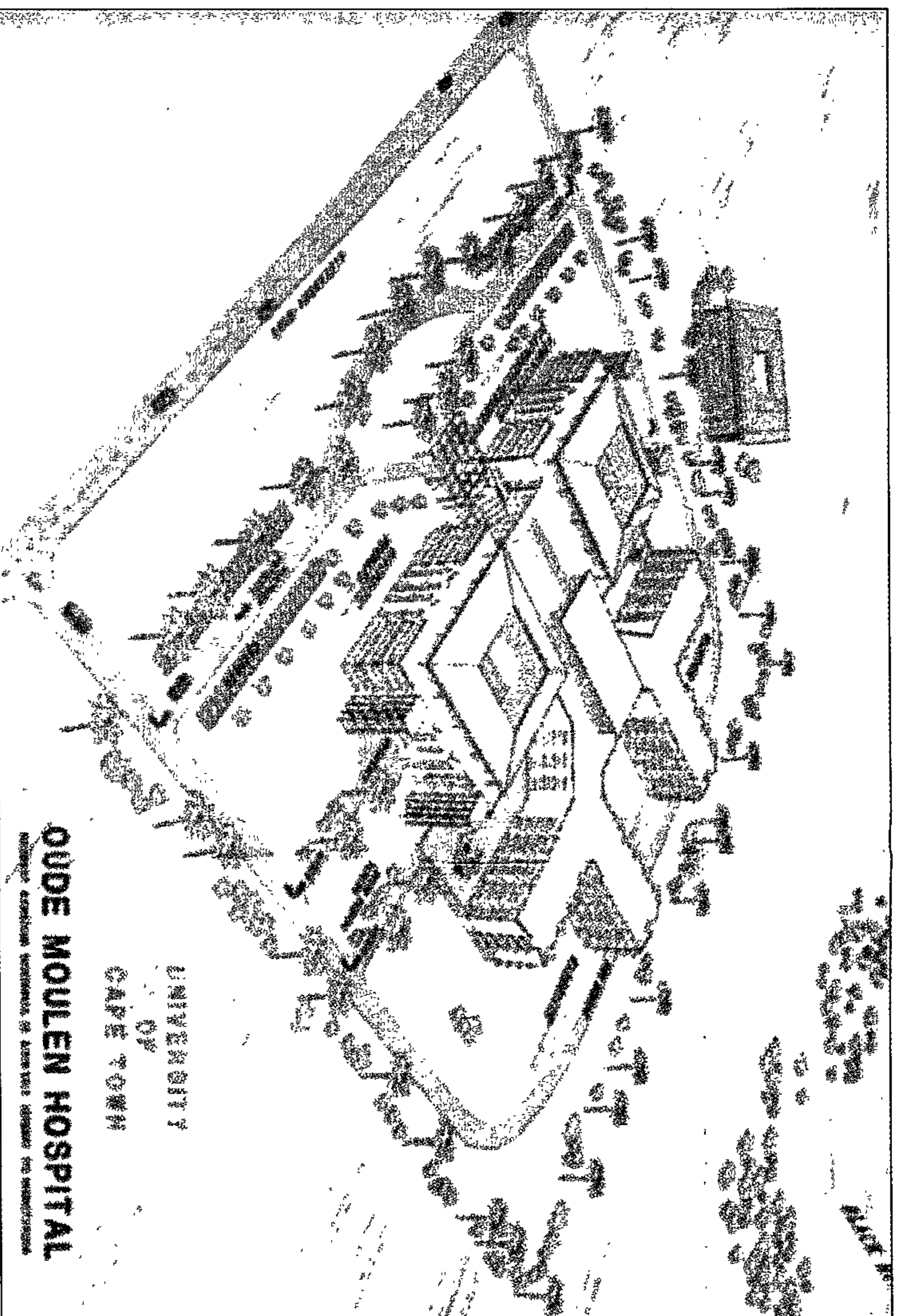
## The case for and against

### Arguments for:

- Cheaper health care would be available to more people.
- Fewer people would rely on state services, allowing the state to provide better care for those who cannot afford the new scheme.
- Medical students would have access to specialised training, which is being squeezed in state hospitals by budget cuts.
- Doctors and other health workers who are leaving state services could work at the new hospital, keeping their experience in the country and making it accessible to more people than it would be in private services.

### Arguments against:

- There would be a loss of revenue to state services when workers who could afford to pay sought treatment from the new venture.
- Experts would be taken out of the public service, leaving fewer — and less experienced — people to care for those who could not afford to pay.
- Cape Town already has too many private hospital beds.
- The plan is motivated by an interest in training and research, rather than patient care.
- A new tier in health services would lead to more fragmentation.



**OUDE MOULEN HOSPITAL**  
Architectural rendering of the new hospital building, designed by the Rhön-Klinikum medical group.

**TRUE TO PROTOTYPE:** German architects have designed the Oude Molen Hospital in line with the model used by the Rhön-Klinikum medical group. Rhön-Klinikum hospitals are said to provide considerably cheaper services, partly because of their streamlined layout.

## 'No frills' model has focus on health care

THE German group Rhön-Klinikum claims to provide cheaper services than the state or other private health care groups, but how do they do it?

● Rather than paying doctors and specialists according to the amount of work they do, the German model pays its staff a monthly salary, like in the public services, but at a higher rate.

"Staff would probably earn something between what they would in state hospitals and private hospitals," said UCT's dean emeritus, J P Van Niekerk.

Monthly rates remove the so-called "perverse incentives" for doctors to over-service their patients that are blamed for much of the high cost in private care.

● The new model hopes to increase the number of patients by entering into contracts with employers, medical aids or the state to provide particular services.

These contracts would offer reduced rates to medical aids in return for them sending their members to the new clinic. There could also be a fixed rate to cover a group of people.

"We might enter a contract to, say, care for garment workers at a fixed rate. Then no matter what services we provide, we will get the same money. This removes the incentive for the hospital to over-treat patients," said Van Niekerk.

● Rhön-Klinikum has studied "the ill-

ness event" and come up with a business plan to optimise hospital care. They have increased services available immediately after an operation, but reduced staffing and equipment in the wards during convalescence when patients don't need much attention.

"There are beds in the wards but patients sit around at tables with minimal nursing. This speeds up convalescence and makes a big difference organisationally," said Van Niekerk.

Another change has been to stagger the starting time of operations, so that there isn't a bottle-neck (with subsequent costs and wastage) at 8am.

● A lot of attention is paid to the physical planning of the hospital. For example, at Oude Molen, the theatres would be built next to wards, meaning that doctors or nurses could wheel the patient a few metres before and after the operation, cutting down on staff.

"In general hospitals have a staffing bill of 75% of their budgets. Rhön-Klinikum has reduced this to about 50%," said Van Niekerk.

● The group eliminates many of the private sector frills and focuses purely on health care.

"It's like the difference between shopping at Woolworths or Pick & Pay," said a private health care worker.



NAASHON ZALK



Close scrutiny ... Gauteng Health MEC Mondli Gungubele during a tour of Chris Hani Baragwanath Hospital yesterday.

## MEC pronounces Bara healthy after quick tour

By ANSO THOM  
Health Reporter

(98) Star 15/7/98

at least 40 patients had died at the hands of junior doctors.

Gungubele said he was satisfied with a preliminary investigation but added that a commission of inquiry would be appointed if necessary.

He said the majority of professionals were doing their best to make the hospital work, and added that media reports were causing the staff to be harassed by patients and the public.

The MEC also admitted that the department had received Rabinowitz's allegations in 1996, but that he had failed to elaborate.

He also pointed to recent trends and various problems at the hospital and commended the staff for coping with a difficult situation.

Gauteng Health MEC Mondli Gungubele whizzed through Chris Hani Baragwanath Hospital yesterday and, at the end of his 30-minute tour, pronounced the hospital healthier than it had been in the past.

After going through the casualty and surgical admissions wards, he praised the staff for working under immense pressure.

Gungubele met with hospital management before going through the hospital, where he spoke briefly to supervisors, nurses and patients.

He declined to comment in detail on claims by a former superintendent at the hospital, Dr Bernard Rabinowitz, that



# Future of hospital site in your hands

*Park plan proves popular*

ART 16/7/98

(98)

JENNY VIAL  
HEALTH REPORTER

It's the place where two rivers meet with a wetland rich in bird life, wide open spaces and a magnificent view of Devil's Peak.

It's home to one of the few urban farms in the city and a haven for the mentally ill and disabled. It's rich in history, is environmentally important as a "green lung" for the city and has remained largely undeveloped since the first settlers began farming the land in the 17th Century.

Now the people of Cape Town must decide what its future will be.

Most know the area as Valkenberg, but it is much bigger than just the hospital. The City of Cape Town, which has begun a public process to determine future use, is calling it the Black River Regional Park.

It's an enormous tract of land, about 250ha in extent, and most of it is public land, either state or council-owned. Transnet owns a large portion on which the River Club is situated, the University of Cape Town has just sold most of its holding to developers LTA Construction, a small portion was swapped with the Chinese Association for its Mowbray building and part is owned by Nashua and by the Vincent Palotti Hospital.

For years the land has been the centre of environmental studies, council reports and policy plans. There's a wealth of information on the area, but no clear plan for it.

## Neighbours



Send your neighbourhood news and notices to Peter Goosen at 488 4311, fax 488 4075 or e-mail rhood@ctn.independent.co.za

There are also a lot of people with an interest in the land, from developers who would like to see office parks, to those who would prefer there to be no further building.

Most of the land is zoned for community facilities, or public open space. His People Christian Missionaries would like to build a centre there and UCT has come up with a plan for a private teaching hospital.

A working farm village where mentally ill and disabled people can live and work has also been suggested.

Now that Valkenberg's future as a smaller psychiatric hospital has been decided, state land has come under the control of the province's Department of Asset Management.

While it seems that the city would

like the land to be a park, what form that park takes and how to finance it have to be decided. It's valuable land, close to the city. It's also home to one of the city's few remaining nature reserves, the Raapenberg Bird Sanctuary. The Vincent Palotti wetlands are there, and more than 100 different species of birds, 60% of them terrestrial, nest there.

It's rich in history: Zulu king Cetshwayo was imprisoned on the Oude Molen farm, where the first brick mill was completed in 1718, and there are four national monuments in the area, one of which is the original Valkenberg Manor House.

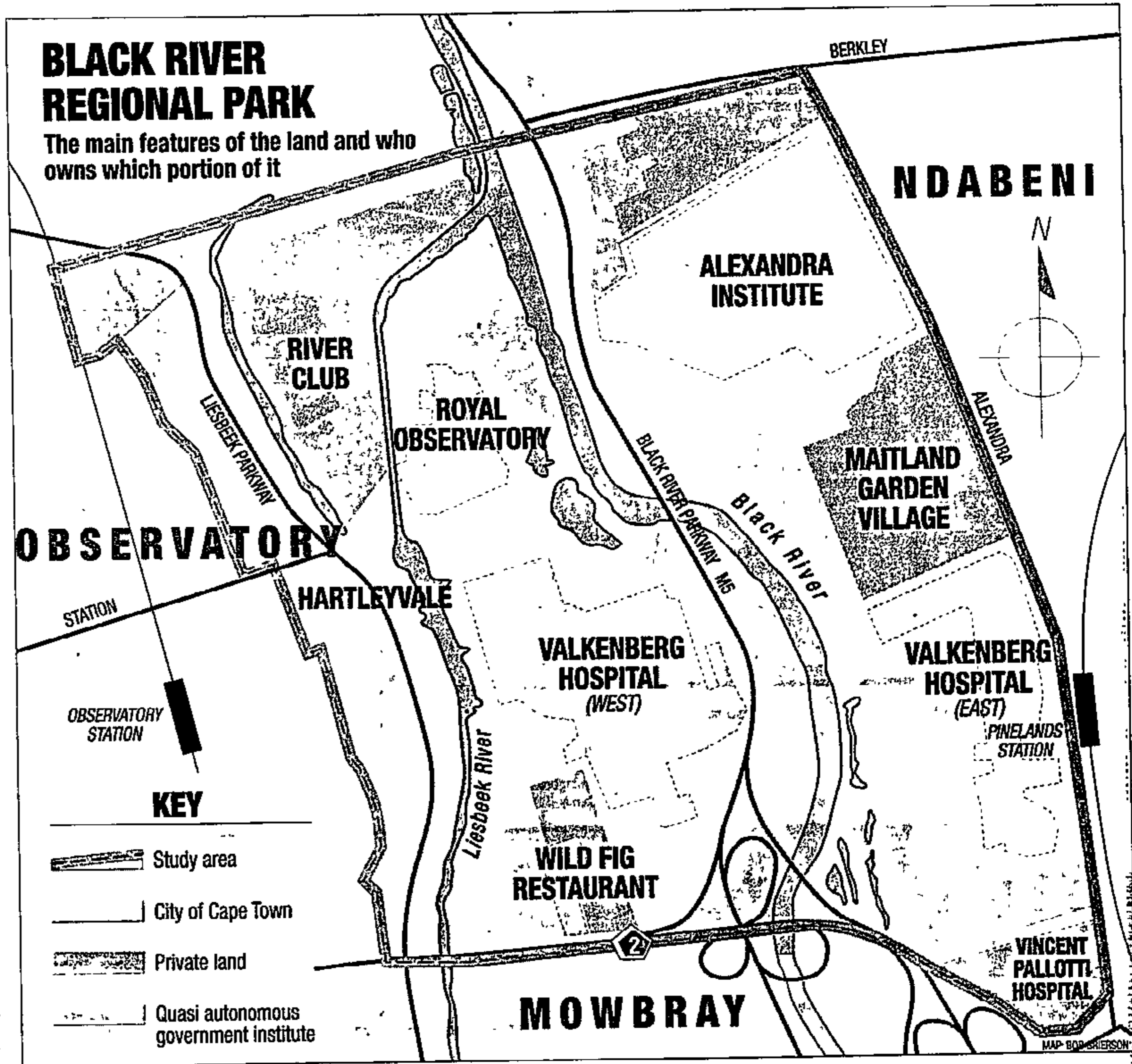
Cape Town has no large outdoor recreational area and needs open areas as suburbs get more built up. The Valkenberg Confluence Alliance would like to see a therapeutic centre for the people of Cape Town, and an open place for people to jog and walk.

The challenge is to come up with a plan that takes into account conflicting interests, and the City of Cape Town has now begun a public participation process to determine what should be done with the land.

Desiree Shepherd, who is co-ordinating the process, has asked any organisation or individual with particular knowledge of the site to register with her as a stakeholder.

She can be telephoned at 400 2399, or faxed at 419 8536, or e-mailed at dsheper@ctcc.gov.za

A public meeting on the issue will be held later this month.





# Doctors battle to cope with flood of ailing and bleeding

Star 17/7/98 (98)

As the spotlight focused on Chris Hani Baragwanath hospital this week, Health Reporter Anso Thom spent time at the recently re-vamped medical admissions ward.

Tuesday, 9pm: The hospital should be in a mid-week lull, but the medical admissions ward is already resembling a train station and the number of patients waiting to be attended to continues to swell despite the efforts of doctors and nurses.

Sannah (17) starts shaking uncontrollably as Dr Sherwyn Roman approaches her. "Mammie, mammie," she calls, trying to attract the nurse's attention.

"It's okay," says Roman in a soft voice. "I just want to have a look."

Sannah's frail body is covered in bruises and scars. An old operation scar cuts through her chest. "She's very sick," says Roman as he leans over her, listening to her heartbeat.

On Tuesday, Sannah was one of more than 100 patients who passed through the medical admissions ward.

The red circle next to her name on the admittance list alerted Roman, a registrar and doctor at CHB for the past five years, that she needed to be treated urgently.

The others have to wait. Hours on end as three registrars and five interns battle to stay ahead while patients on trolleys continue to stream through the double doors of Ward 20, which was recently rebuilt with the assistance of a pharmaceutical company.

Nurses guide the trollies like skilled drivers, parking patients between beds and in open spaces. But for the doctors it's just another day at CHB.

Roman, like his colleagues, starts his day at 8am when he sees his patients from the previous night, who have since been transferred to wards.

By 10am he's at the admissions ward. If he wants to finish by midnight, he has to maintain a hectic pace while trying to spend enough time

## Awesome facts and figures

Number of approved beds	3 240
Total staff establishment	6 760
Employed nurses	3 362 posts (of which 1 227 are vacant)
Number of operations last year	48 107
Approved budget for 98/99	R555 569-million
In patients treated last year	116 861
Out patients treated last year	429 444
Casualties last year	107 409
Deaths at the hospital last year	5 795
Meals	About 10 000 prepared every day
Latex gloves	9 200 pairs used every day
Deliveries (1997)	10 986

Gunshot wounds treated	
1987.....1 044	1993.....2 431
1988.....988	1994.....2 249
1989.....1 446	1995.....2 155
1990.....2 213	1996.....2 367
1991.....2 170	1997.....2 904
1992.....2 539	1998 (first 6 months) - 1 374

with a patient to make an accurate diagnosis. Mostly his diagnosis is purely clinical. X-rays are mostly non-existent.

But among all this chaos, much good prevails. Staff clearly treat patients in a sensitive manner and there is no obvious shortage of medication or equipment despite the

## Staff have to maintain hectic pace

huge demands.

"It is unfair to the patients and doctors that Bara has an open door policy. Hundreds arrive at casualty and are routed to us," says Roman.

The medical admissions ward deals with psychiatric cases and other medical problems such as tuberculosis, HIV/Aids, hypertension, cardiology and most cases where the casualty department struggles to make snap diagnoses.

By 4pm, 60 patients had arrived, by 5pm the list had grown to 80 and so it continued until after 7pm when the list grew to more than 100.

"You try to check the list every hour and kind of calculate how much time you can

spend with a patient. This open door policy is not good for the patient/doctor relationship,"

Roman reiterates. "The pressure expands all the time. I really think universities should set guidelines on how many patients a doctor should see."

By 9pm traces of exhaustion start to appear. Roman meets a colleague in the passage.

"Have you caught up yet?" he asks. His colleague shakes his head. "We're losing the battle man," he smiles.

A registrar and intern take over all cases arriving at 10.30pm to allow those already on duty to try and finish by midnight.

"Sometimes I only finish at 3am," says an intern.

"Pilots are compelled to rest. But not us. We have to battle on," says a registrar.

An intern smokes outside the ward. "The way I feel now, I want to become a secretary.

"It helps that Bara is well equipped. I'm worried about community service in poorly equipped clinics next year. I can work under any circumstances or pressure as long as I have the proper resources."

As an intern leaves after a 16-hour shift, a colleague calls:

"Close the gates as you leave." But still the patients arrive.



# Bara managing to cope despite crisis

Experts believe more money and more doctors and nurses is the only way conditions at the world's biggest hospital can be improved upon

NEIL SPENCE

By Anso Thom  
Health Reporter

Soweto's Chris Hani Baragwanath (CHB) hospital is ill, say doctors in the know. But the prognosis is not terminal although the symptoms are long working hours, huge patient loads and staff shortages. Their prescription is more nurses, more doctors and, ultimately, more money.

Now listed in the Guinness Book of Records as the world's biggest hospital, it was originally built by the British in 1941 as a convalescent facility for wounded Allied troops during the World War 2 and to cater for soldiers of the Middle East Command.

After the war the South African government bought the "Imperial Military Hospital" from Britain for the princely sum of £1-million, converting it to serve the rapidly growing population of Soweto.

Now the hospital is bursting at its seams, its open-door policy leading to patients flocking to the hospital from as far afield as Botswana, Zimbabwe and Mozambique.

In the past 50 years the hospital has grown in size and status, and now also serves as a referral hospital for many clinics in this country and surrounding African states.

In essence, the CHB is a microcosm of the greater South Africa, reflecting the stresses of the broad social, economic and political changes.

During times of political violence, CHB's trauma unit became an accurate barometer of the situation.

Nowadays, it has become a barometer of the escalating crime, with more than 50% of surgical cases being trauma-related. Last year 2 904 patients were treated for gunshot wounds alone.

In an effort to provide healthcare for even the most impoverished, patients pay for their treatment according to their income. But the needs of the community are great - only



The long wait ... a weary patient waits for a bed to become vacant before a doctor can examine him at Chris Hani Baragwanath hospital's medical admissions Ward on Tuesday.

12% belong to medical aid schemes and are therefore restricted to outpatient facilities.

As the hospital struggles to cover its costs, patients pay only a small percentage of what is needed: in 1994/5, patients paid only R8-million of the R324-million required to keep the hospital afloat at the time.

This year the hospital is operating on an approved budget of more than R557-million.

But, amid allegations that junior doctors are performing

unsupervised surgery, leading to the deaths of at least 40 patients, there are renewed calls for more financial support.

Most doctors at the hospital agree that there are many cases of malpractice, but instead of blaming the hospital, they blame the system which has created the inequitable doctor/patient ratio.

"We work like dogs. It never stops: work, work, work. It's quite possible to make a judgment error if you start working

at 8am and you're still at it by midnight," said a doctor.

In the wake of allegations of incompetence, Mondli Gungubele, Gauteng Health MEC, met hospital management this week before touring the institution.

He declined to comment in detail on allegations by a former superintendent, Dr Bernard Rabinowitz, that at least 40 patients had died at the hands of junior doctors since the end of 1996.

"At face value I can say that I am not disappointed by the general attitude of the staff, but I want to remind the media that we are investigating the allegations and that we will not hesitate to appoint a legal commission of inquiry," said Gungubele.

"I have been reminded that the hospital used to have patients sleeping under beds," said Gungubele, adding that there had been an alarming increase in trauma cases at the hospital. More than 50% of surgery cases were trauma-related.

"The staffing is not satisfactory, but we are interacting with clinicians to establish appropriate staffing ratios," he said. "I am proud of what the little staff are doing at this hospital with the capacity they have."

The hospital's successes are rooted in the Government's new primary health care system, which has already alleviated the patient load. Last year the hospital delivered 10 986 babies in comparison to previous years when more than 30 000 women gave birth at the hospital in one year.

"The clinics have taken many maternity cases away and we only deal with referrals," said hospital spokesman Hester Vorster.

In the hospital's yearbook, Dr Chris van den Heever, chief superintendent, recalled that a visit in July 1996 by President Mandela to an old friend at CHB had had positive results.

Van den Heever pointed out that, since Mandela's visit, work had begun on improving the antiquated sewage and water reticulation system and plans were approved for a new kitchen. Planning is also going ahead for a major upgrading of the main theatre block, a new outpatient block and an emergency medical centre.

"With the restructuring nearing its end, we look forward to doing what we do best: treat patients," Van den Heever concluded.



*Availability of drugs could be retarded*

# New cartel 'could kill pharmacies'

ET (MR) 20/7/98 (96)

**ADELE SHEVEL**

Johannesburg — Pharmacare, the healthcare company, and five top multinational pharmaceutical companies were poised to cause a realignment of the pharmaceutical industry with a deal aimed at bypassing wholesalers, they revealed last week.

News of the deal, called Project Nasa, caused concern among pharmacists, who were worried that the removal of wholesalers from the drugs distribution loop could prove to be lethal for retail pharmacists. It could also retard the availability of drugs to the consumer, they said.

But an analyst said Project Nasa could save distribution channels which were verging on bankruptcy because of cut-throat competition among distributors. He also said it would decrease competition in drugs distribution, leading to a slight increase in costs which would probably be passed on to the consumer.

John Bartlett, the project's spokesman, said pressure from managed healthcare and the government to contain costs had spurred the formation of the company. International management consultants are already working on Project Nasa.

It would be the second such deal in the industry, following on the heels of International Healthcare Distributors (IHD), which distributes goods directly to end-dispensers and is jointly owned by nine international pharmaceutical manufacturers.

Nasa's multinational partners include Glaxo Wellcome, Janssen-Cilag, Pfizer, SmithKline

Beecham, Warner Lambert and Pharmacare, which is part of the SA Druggists group. No formal agreement has been reached.

Val Beaumont, the chairman of Southern Gauteng Pharmaceutical Society, voiced concern about the implications of the deal: "If you kill the wholesaler, the retail pharmacist will be close behind."

"Experience has shown through IHD that margins for pharmacists fell dramatically. We already give medical aids a rebate. We cannot afford any further cost-cutting exercises."

Nasa said it was formed in response to uncertainty within the traditional South African distribution channels to streamline distribution; limit fraud and grey market transactions; and meet government demands for transparency in distribution costs.

Grey market trading of pharmaceuticals in South Africa was believed to be in excess of R500 million last year.

"It looks like we will have about 25 percent of market share," said Bartlett, referring to the combined market penetration of the companies. Bartlett estimated the total amount of pharmaceutical goods traded a year to be about R4 billion.

Products to be distributed through the company include prescription medicines, generic medicines, over-the-counter and consumer products.

"The time of the wholesaler is basically over," said an analyst. Adcock Ingram, for example, had closed down its distribution division, which had been operating at a loss, the analyst said.



# Phelophepa, train of hope

CT(MA) 22/7/98 (98)

WENDY LOPATIN

*The world's first health train and eye clinic is a godsend to rural people*

**E**VERY weekday for nine months of the year, Lillian Cingo — nurse, midwife, psychologist, earth mother and manager of Phelophepa, the world's first health train — awakens her staff at 6am with her special morning call in many languages.

The train delivers an affordable, accessible, mobile primary health care service, to supplement and support existing facilities in the rural communities of South Africa.

Phelophepa, "good clean health" in Tswana and Sotho, originated in 1993 as a joint Transnet/Rand Afrikaans University two-coach mobile eye clinic, the brainchild of Professor Jannie Ferreira, nurtured by Lynette Coetzee of Transnet, now senior manager of the project.

Now the 16-coach train has a multi-professional, multicultural staff of 10 professionals, and 40 final-year and post-graduate students from colleges and universities throughout South Africa, working on two-week rotation. There is great competition for student placements and some have returned after qualifying to join the full-time staff.

The train visits isolated and impoverished areas where there are either no health clinics or a critical lack of facilities. It supports existing services through referral to local clinics, hospitals and doctors and facilitates the establishment of permanent clinics in towns visited — such as Verulam, KwaZulu-Natal.

There is co-operation with the Health Department and last year Nkosazana Zuma, Minister of Health, visited the train at Malmesbury and voiced her enthusiasm and support for the programme.

South Africa's vast rail infrastructure helps Phelophepa's mission. Some 15 000 km of railway track is covered annually — about 37 stops in 8½ months. Since 1994, 166 360 patients have been treated, 86 000 children screened and 1 220 community volunteers educated in the train's education clinic.

Transnet has invested R14-million to fund Phelophepa. The "train of hope" spends five weekdays at each stop, travelling to its next destination at weekends. One third of expenses is recovered through patient income — R5 for prescriptions and basic spectacle charges — plus donations. Transnet makes up the deficit. A drug company supplies all generic medicines, another provides educational materials and some of the professional posts are sponsored.

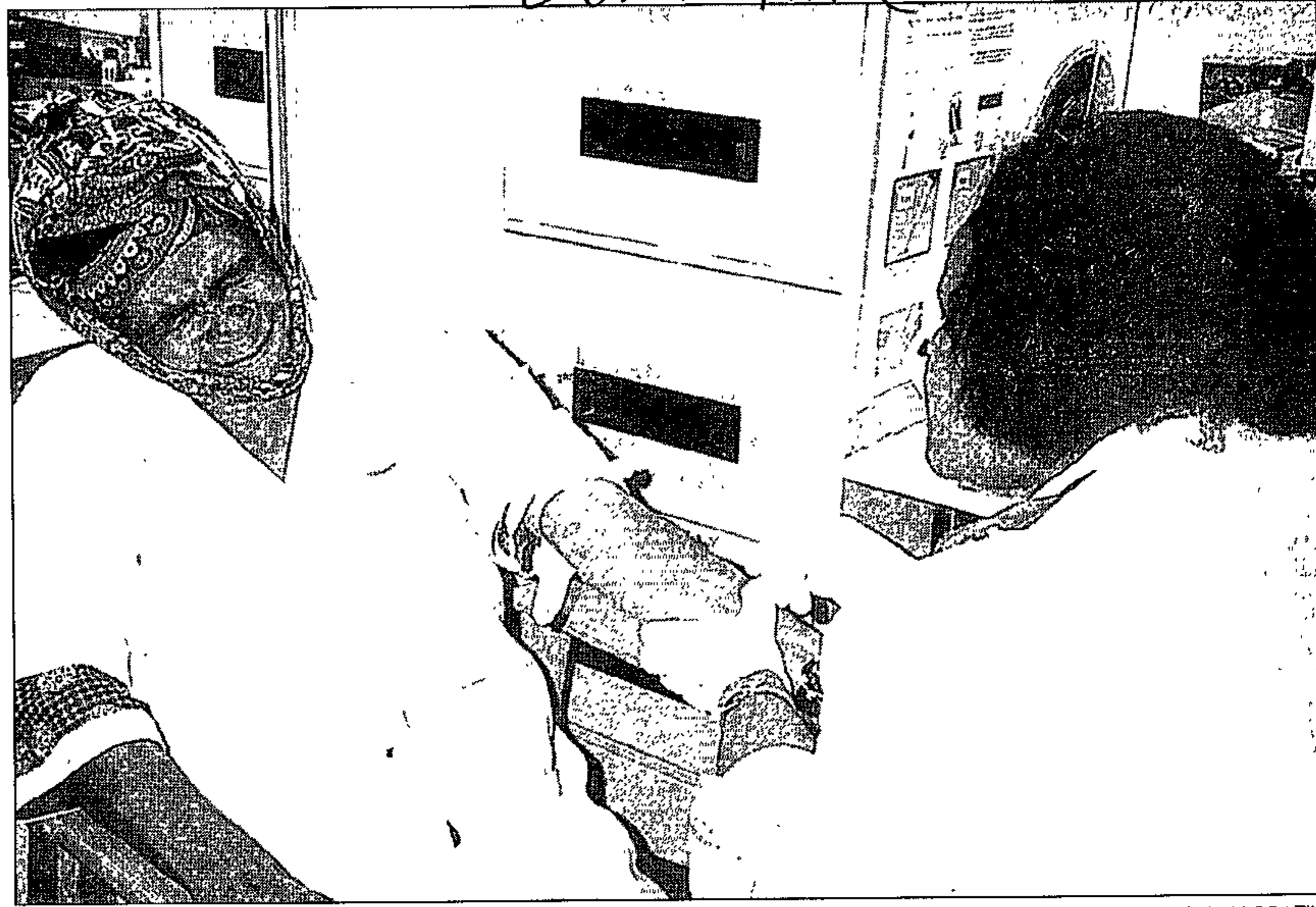
Speaking to me of her multicultural staff, Lillian Cingo said: "They can learn from each other, working as a team and capitalising on differences."

She calls them her "little rainbow nation". Because of the cramped accommodation, long hours worked and encounters with so many traumatic situations, Cingo supports her staff by facilitating regular sensitivity meetings.

This warm and competent person of great energy studied nursing in South Africa before moving to Britain in 1966, specialising in neurosurgical nursing and later gaining her master's degree in counselling psychology.

She returned to South Africa in 1994 to manage Phelophepa.

"I am especially moved by the plight of rural people," she told me. "Whatever



PICTURE: BRIAN LOPATIN

Maggie Ntikanca, a community health nurse on the Pelophepa health train, takes blood from a patient during a stop in a rural area.

Phelophepa, the "train of hope", is the world's first health train, having started in 1993 as a joint Transnet/Rand Afrikaans University initiative. Staffed by doctors and medical students, it dispenses eye and dental treatment and other medical services to people in remote rural areas.

government is in power, the rural people will always be the most in need. They ask for basics with such dignity."

In February, Ferreira joined other distinguished guests — Leah Tutu, Joyce Seroke of the Truth and Reconciliation Commission and Nombita Stofile, wife of the Eastern Cape premier — and Phelophepa supporters at Stutterheim.

"The train carries the message of hope," the professor told me, "giving back not only sight, but also quality of life. Prevention through lifestyle education is so important, making local communities more aware."

Leah Tutu and Stofile recognised the great need for more rural health care and additional health-care trains. Seroke highlighted the potential for counselling work with trauma victims of vio-

lence in areas such as KwaZulu-Natal.

A mobile infoshop visits towns before the train arrives, liaising with local health authorities, hospitals, magistrates, clinics, police and shopkeepers. News is spread to the local population.

Often health department co-ordinators liaise with Phelophepa. School outreach programmes are organised, concentrating on dental health. Local labour is recruited such as cleaners, interpreters and cashiers. In some towns recreational facilities such as braais are laid on for train staff.

I spent three days visiting the train, and also accompanied staff to local rural schools. I was moved by their passion and dedication which has helped to change the lives of so many people. Some have received medical care for the first time. The resident dentist, Emile Prince, spoke passionately, saying the three most important aspects of his work were "education, education, education".

He trains his students never to extract a tooth unless they can teach the patient how to save the next one.

Patients, hundreds of them unemployed and from areas of great poverty, walk distances of more than 30 km to the train. Some sleep out in the open to ensure they will be there when the clinics open. Sometimes farmers transport their workers and families in trucks.

The train has eye, dental, health and education clinics, accommodation for 50 staff, a laundry, a power-generating coach and communications network and a pharmacy. The dental clinic, with six surgeries, is equipped to perform cleaning, extractions, restorative work and X-rays.

The highly sophisticated and well-equipped eye clinic also has a workshop that prepares spectacles for long and short-sightedness. An elderly woman, who had just been given her first pair of spectacles, told me through an interpreter of her great joy on being able to see her grandchildren for the first time.

Colin Boucher manages the catering department, serving 180 meals a day. He

is married but, like other married staff, sees his wife only twice a month.

His dedication is illustrated by his comment that if the Blue Train pulled up alongside and offered him twice the pay for his skills, he would choose to stay on Phelophepa.

The focus of the health clinic, managed by community nurse Maggie Ntikanca, is education, giving special attention to mother and baby care, nutrition guidance and economical use of water.

Patients are supplied with seeds and taught seed cultivation. Nurses screen all patients. Some common ailments are respiratory such as TB and bronchitis, skin problems, bilharzia, sexually transmitted diseases and urinary infections. Chronic ailments such as blood pressure and diabetes are referred to local clinics for follow-ups. Aids is widespread in rural South Africa and rapid HIV tests are carried out, but there is no repeat assessment because of shortage of time.

The psychology clinic, which conducts workshops in the local communities and schools, forms support groups and puts local people in touch with the closest professional help. Recent workshops concentrated on conflict resolution, HIV and Aids, sexuality, parenting skills and stress management — these services being free. The education clinic offers structured five-day courses for 21 community volunteers, covering environmental and personal hygiene, diseases, nutrition, family health and first aid, and promotes empowerment of their communities.

One of the most moving comments I heard was from a Transnet security guard who drives the kombis and escorts staff and students to the outlying schools.

"I'm not just a security guard, but part of a family, helping to do something really worthwhile for the new South Africa."

■ Wendy Lopatin, formerly chief librarian of the Cape Times, is head of information at EMAP Healthcare, a large UK publishing company



# Women beat cancer crisis once – R5-m can make it happen again

(98)

ARG 24/7/98

DI CAELERS  
SPECIAL WRITER

Dee Krauss, Funeka Xamlashe and Zahrah Damonse have Groote Schuur hospital's cancer unit to thank for their lives. Now, unless Cape Town rises to the challenge of ensuring the unit's future, other women may not be so lucky.

In 1990 women made it happen when they raised R1-million in just three weeks for hi-tech equipment for the unit.

Today the Cape Argus resuscitates its Women Can Make It Happen campaign, this time with a target of R5-million in three months.

The money will buy Groote Schuur a replacement for a cancer treatment machine – a linear accelerator, or Linac – that is the oldest still operating anywhere in the world.

In spite of its age, the machine is used to treat between 30 and 35 people a day, five days a week.

If it were to finally break down, thousands of lives would be compromised, particularly since 83% of Peninsula residents have no medical aid and do not have the choice of shopping around for treatment.

And these will not be the lives of some unknown people somewhere out there; the cancer unit at Groote Schuur is everyone's business. Latest statistics from the Cancer Association of South Africa are that one in four people will suffer from cancer in some form, and that one in five women will get some form of cancer.

Women like Dee Krauss, Funeka Xamlashe and Zahrah Damonse know what it is like to be a statistic. But they also know all about the high standards of treatment, concern and even friendship they got at Groote Schuur's cancer unit, all of which they say combined to ensure the quality of life they enjoy today.

All three women suffered breast cancer, but thanks to treatment on the ageing Linac, all avoided mastectomies that would have disfigured them. They have all been clear of cancer for several years.

Ms Krauss – a former top model as Dee Gardiner in the 1960s and 1970s and now a property consultant in Plumstead – was living alone and had no medical aid when she found a lump in her breast in January 1995.

A former nurse, she noticed a puckering in her breast and knew immediately something was wrong.

When a private doctor drew fluid off the lump and said it was not cancerous, she told him she had no medical aid and could not afford to have an operation to remove the lump. That was when she was referred to Groote Schuur.

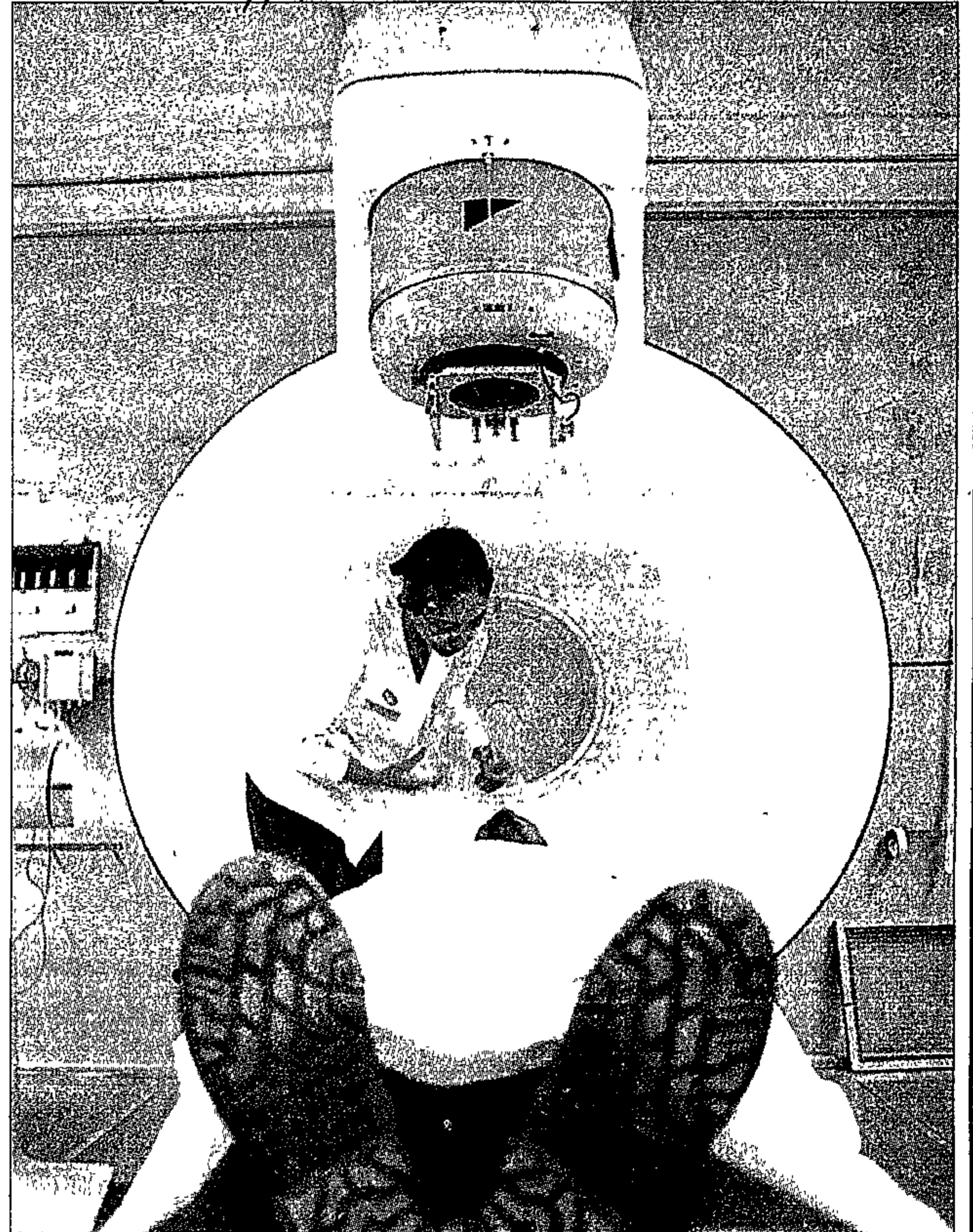
And at the hospital a needle biopsy to test the tissue found the lump was indeed cancerous.

"A week later I went in for the operation to remove the lump. Then followed chemotherapy, during which I lost all my hair, and a series of radiation treatments on the Linac."

She said staff at the unit were "just the most amazing people in the world".

"It wasn't just with me – they are absolutely wonderful with every single patient."

Mrs Krauss said that although it was really a matter of life and death and that



OBED ZILWA

Will you help to foot the bill? we need R5-million to replace Groote Schuur's linear accelerator



Survivors: Zahrah Damonse, top, Funeka Xamlashe, left, and Dee Krauss have new leases on life

CAPE ARGUS  
**WOMEN CAN MAKE IT HAPPEN**  
GROOTE SCHUUR CANCER UNIT APPEAL  
in association with Pick 'n Pay

**R570 000**

That's what you can win in the Weekend Argus Charity Jackpot this weekend. Get Saturday Argus and Sunday Argus to find out how you can help the Women Can Make It Happen Appeal just by sending in your jackpot entry



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**Fresh A-Grade**  
**R99,99**

(B)

# R5-m will head off cancer crisis

(98) ARG 24/7/98

From page 1

she would have been happy to lose a breast if it meant saving her life, "it was absolutely wonderful that I had the choice" to avoid a mastectomy thanks to the Linac.

Zahrah Damonse, 50, of Hanover Park, has been clear of cancer for seven years. With no previous family history of cancer, this mother-of-three found a lump in her breast when she slid some money into her bra.

"The doctor sat on one side of me at Grootse Schuur and a nurse-aid on the other, and they told me I had stage one cancer. I felt like someone had poured a jug of cold water over me." She told the doctor she was putting her life in his hands.

"I had so much support from the people in my courts (she lives in Walvis Court). I knew I had to fight it, for my own sake and for my family's sake."

Mrs Damonse had 30 treatments on the Linac machine, 25 on her breast and five under her arm. She

now has check-ups once a year.

"Although I am on my husband's medical aid, we could never have afforded the treatment privately. But my doctor had advised me to go to Grootse Schuur anyway, because he said they were the best.

"The people at the unit were so important to my recovery. I still speak to them and keep in touch with them." And, said Mrs Damonse, "I still thank God for those people."

Single parent Funeka Xamlashe, 36, was referred to Grootse Schuur's cancer unit after having an operation to remove a cancerous lump from her breast, done privately in 1990.

"The treatment was very expensive even though I am on a medical aid, and my doctor referred me to Grootse Schuur for my follow-up radiation." She had treatments on the Linac for nearly a year, first three times a week and then once a week.

Ms Xamlashe, who lives in Mandelaysburg, found a lump in her breast when she was searching for R2 she had misplaced. In spite of her mother, De Villier Xamlashe, dying from

breast cancer at 34, Ms Xamlashe had not checked her breasts regularly.

"I got a lot of family support from my father, Silas, and five brothers, and my son, Xolani, who was nine at the time. They were afraid for me because of what had happened to my mother. But the staff at Grootse Schuur were very, very nice. I felt very confident because they took care of me so well."

Today, eight years later, she was "fit as a fiddle", said Ms Xamlashe.

The positive pictures painted by all these women could look very different for others who will follow them if Grootse Schuur loses its 20-year-old Linac machine. The "shelf life" of these machines is just 10 years, so Grootse Schuur's one is already 10 years overdue for replacement.

Without the people of Cape Town rising to the challenge of raising the necessary funding, there is no chance that the Linac will be replaced.

Dudley Werner, head of radiation oncology at Grootse Schuur, said the hospital's entire equipment budget for 1998/99 was only R2-million.

## Calling all women - make it happen again!

It's over to you - the wives, mothers, daughters and sisters who in 1990 never once believed they would not raise the necessary money to upgrade equipment at Grootse Schuur's embattled cancer unit.

In three weeks, R1-million was raised and to date the total raised by that campaign is close to R6-million.

The new campaign's target is R5-million in three months.

The Cape Argus is appealing to its readers in the belief that "women can make it happen".

If each of the Cape Argus' 160 000 women readers alone decided to raise R10 each, there would already be R1,6-million rand in the bank account.

Women can ask 10 friends to donate R1 each. Lift club members can ask for a R1 donation for each child in their scheme.

Receptionists can ask their colleagues for a donation. Parents can

ask each family member to donate R1. Readers should feel free to organise charity events to raise funds for the cancer fund. Their events will be publicised in the Cape Argus.

Donations can be mailed to: Cape Argus Cancer Appeal, Box 15465, Vlaeberg, 8018. Money can also be deposited directly into the Cape Argus Cancer Appeal account, number 9057225931. The account is at Trust Bank in Claremont, branch code 632005.

Money can also be dropped at the Cape Argus Promotions Department, Newspaper House. Fax your deposit slips to 404 2002 to get a mention in our list of donors that will published regularly.

For more information or to secure publicity for your fundraising event, call Di Caelers at 488 4045, Beryl Eichenberger at 488 4025 or Di Joffe at 488 4029, Monday to Friday office hours only.

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COMPILED BY:



# Cover-up feared in health probe

By ZOLILE NQAYI

(98) CP 26/7/98  
**F**EARS of a cover-up have surfaced around the probe into alleged malpractice at public hospitals after files were removed from the home of a doctor involved in the exposé.

The doctor, based in the Northern Province, was confronted by the police in his home and told to hand over the files - which he intended to make public.

The files contain information regarding an investigation into culpable homicide which resulted from alleged malpractice at a public health institute.

The Hospital Personnel Union of South Africa (Hospersa), which is backing the probe into malpractice, this week refused to identify the doctor - but disclosed that he had been transferred from Gauteng to Mpumalanga and then to the Northern Province after exposing malpractices in each province.

When he spoke out in the Northern Province he was dismissed from his job.

According to Hospersa organiser Elize Richards, the files were taken back from

the police because they had failed to make any progress in investigating the culpable homicide charge. Hospersa took the files to supply proof of claims that medical services were collapsing in almost all provinces.

□ Former senior superintendent of the Chris Hani Baragwanath Hospital in Soweto, Dr Barney Rabinowitz, has added fuel to cover-up claims with his dismissal of the recently launched commission of inquiry investigating his allegations concerning the hospital.

Rabinowitz fired the first salvo against the medical authorities three weeks ago when he made shocking allegations that at least 40 people had died "unnecessarily" at the hospital because of either negligence or inexperience.

The commission's report is to be released this week.

Rabinowitz said the investigations would not come up with anything credible as it was only aimed at covering up for the Gauteng Health Department.

He told City Press a commission could only work if it was completely independent. All the commissioners

investigating his allegations could not be expected to be impartial as they were all in the employ of the Gauteng Health Department, he said.

Rabinowitz said he was ousted from Baragwanath because he had rocked the boat and not because he was too old (the official reason for terminating his employment). He showed City Press a list of at least 200 surgeons who are 60 or older and are still employed at the hospital. Some are well into their 70s.

"I asked questions which were too uncomfortable to some people in authority. Some say I am a bitter old man. Yes, I am bitter - not because my employment was terminated, but because of what is happening at this hospital," he said.

"I started asking questions about the deaths while I was still a senior superintendent at the hospital. I went to the media when I realised there was a major cover-up of what was happening at Baragwanath. I am bitter because people are getting away with murder and those in authority are trying to conceal that which is indefensible."



# Audit of all senior Gauteng hospital posts to be conducted

(98) / Nov 27/9/98

Irregularities at Natalspruit lead to wider investigation by commission

By ANSO THOM  
Health Reporter

An audit will be conducted of all senior appointments at Gauteng hospitals after the Gauteng Provincial Service Commission (GPSC) established that none of the senior medical posts at Natalspruit Hospital, except the post of superintendent, had been advertised and no formal interviews had been conducted.

An investigation by the commission was instituted last year after Jack Bloom, Democratic Party leader in the Gauteng legislature, made certain allegations concerning the hospital, in Thokoza on the East Rand.

Bloom claimed that senior medical appointments had not taken place in accordance with national norms and standards; that a surgeon had been grossly negligent on five occasions while performing operations - a charge that the department and the commission have denied; and that senior consul-

tants were not productive.

"In each case there was one applicant who was automatically appointed. The head of gynaecology, Dr Atkin Pitsoe, was appointed at the age of 33 years with two years' private practice experience," Bloom said. He added that other applicants were sidelined, threatened and discouraged in favour of lesser-qualified favourites of an "inner clique".

Mondli Gungubele, MEC for Health in Gauteng, said the non-clinical posts of assistant director and higher had to be approved by the GPSC, but entry-level specialist posts were exempt from this procedure because of the need to fill them rapidly in order to sustain services.

The report said: "It was found the procedures followed by the hospital were in terms of policy set out by the department, but did not comply with the national norms and standards as well as delegations from the GPSC."

## Applicants were sidelined and discouraged

It said the senior posts were not advertised because a notice from the health department said posts could be filled by way of a direct appointment if "the advertising of the post will unduly delay the filling of the post, rendering in a breakdown in service-rendering".

It was also policy that entry-level posts could be filled and approved by the hospital's chief superintendent. Bloom went on to say the heads of the medical, surgery and gynaecological depart-

ments, Drs Andrew Ratsela, Fred Luvuno and Pitsoe, spent long hours at their private practices at Botshelong Clinic instead of the hospital.

Gungubele said it should be noted that the commission had found that although doctors at Natalspruit were not working regular hours, the time they put in after hours ensured they worked the normal complement.

Regarding the negligence allegations, Bloom claimed that a doctor and "other witnesses" had told him of a surgeon who had cut the urethra of at least five patients during hysterectomy operations.

Gungubele said no evidence could be found to support Bloom's allegations by either the department or the commission. He said the investigating team had found that the "dossier of information" to which Bloom referred did not exist and that Bloom had acknowledged this. "He has therefore misled the public on this count," the MEC said.

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# Vital health centre is out on a limb

## Disabled patients wait as embattled staff struggle to cope

ENNY WALL  
HEALTH REPORTER

The machines are quiet in the well-equipped machine room at the Pinelands orthotic and prosthetic centre.

There's little activity in the large unmy rooms where artificial legs, plints and spine braces are made.

The stillness, however, is not because there's nothing to do. There's a backlog of 6 000 hours work to catch up on and orders are piling up. That's enough work to last until February next year.

Meanwhile the demand for plints, artificial limbs, special boots continues. Each club foot needs a plint, each spinal injury needs a brace.

There is just not enough staff to do the work. A sign on the door states that from August the centre will be closed until further notice.

"It's going to be chaos," says Feith Stoffberg, control manager at the centre. He shows me a thick pile of papers from people waiting to be

seen for first appointments.

This is in addition to the clinics held in country areas of the Western Cape, as well as the hospital clinics for clubfeet and amputations. The spinal unit staff go to hospitals twice a week to consult with surgeons about spinal injuries, either caused by accidents or TB, and to fit neck braces and corsets.

Marie Croydon, who works in administration, says: "It just boils down to staff. We want posts to be opened. If we lose one more person we will have to close our clinics."

Medical orthotists and prosthetists design devices which will make people more mobile. That could mean anything from a special shoe to an artificial limb.

After a child has an operation to correct a club foot, it needs a splint as soon as possible to prevent the foot growing crooked. Now splints are often made too late and another operation has to be done.

Making limbs and splints is a highly skilled job, demanding medical knowledge and technical skills.

The centre, with its tongue-twisting name, is tucked away behind Conradie Hospital in Pinelands. It's the place which disabled people depend on for their artificial limbs, special shoes, spine braces and splints for their mobility.

Staff cannot cope with the workload. Since 1995 staff numbers have dropped from 35 to 11 in the orthotics and prosthetics department. Many people have taken voluntary severance packages or have resigned.

As they go, their posts are frozen and those who stay behind have to work harder. In December another person leaves.

Staff call it the forgotten centre, a place few have heard of. Yet for the disabled and those recovering from injury, it's a vital support service.

When you have a spinal injury, for instance, you need a spinal brace to get up and become mobile. The longer you lie down, the weaker you get, the longer it takes to recover.

But as the backlog of work increases, so does the time it takes to get a brace.

One woman has spent four months waiting in Conradie for her brace. Until she gets it she cannot go home. And she's not the only one, there are hundreds like her, waiting.

At a cost of R350 a day for hospitalisation, it's expensive, apart from the personal anguish.

For those who cannot pay, it's a financial drain on an already overloaded health system.

From August, the spinal unit at the centre will close so that staff can work in the orthotic and prosthetic departments. That means no spinal braces for the Western Cape, unless you can afford to buy one privately.

The only room buzzing with activity at the centre is the boot and leather section which is managing to stay afloat.

The staff are at their wits end - they cannot keep up with the work, their patients are suffering and they bear the brunt of disenfranchised doctors who complain they cannot get the service they need. Patients who could be mobile and productive are having to wait an unacceptably long

time, delaying their rehabilitation.

The Pinelands centre has a reputation as the best orthotic and prosthetic centre in southern Africa. It is also the only training facility for this work and the only one in the Western Cape.

When it comes to filling staff places, it's forgotten, say staff, because as a profession it falls between medicine and engineering. The centre is managed under the health department's "engineering: technical support services", so when posts are allocated they are given to engineering services.

"We've written letters, we've asked for help," says Mr Stoffberg. None has been forthcoming.

The centre has been told that the filling of posts is dependent on the successful implementation of the health department's business plan, which itself depends on a loss of jobs in the health sector.

"People depend on us to get out of hospital," says Johan Swanepoel, an orthotist. "You're not mobile until you get that brace."





**Special boots:** Manuel Rodrigues, originally from Madeira, is one of the master craftsmen in the center's boot-making section



**Limb support:** Cobus Venter works on an artificial leg at the Pinelands orthotics centre

BRENTON GEACH





Boxing junior flyweight champion Sydney Elerine during the official weigh-in, on Monday. Elerine's fight is set to take place at the Mxgopong creche and sports centre. PIC CLEMENT LEKANYANE

# Train strike off after agreement

*Sowetan 30/7/98*

By Mzwakhe Hlangani

**A** POTENTIALLY crippling nationwide strike planned for tomorrow was averted last night when six trade unions representing about 10 000 workers and management of Metrorail reached a last-minute agreement over wage increases.

Only one union, the SA Footplate Association (Safsa) with a membership of only 1 700, including train drivers, technical workers and train guards, rejected Metrorail's final offer.

Safsa spokesman Mr Chris de Vos said the union's demands were not met and it would report back to its members for a new mandate.

The deal followed lengthy talks in Johannesburg yesterday between the SA Railways and Harbours Workers Union, the Black Allied Workers Union and the Technical Allied Workers Union (Tatu) in a bid to resolve the wage dispute.

The signatories said social commitment was the major criterion for reaching consensus among all the parties

since the strike would affect the poor communities more than it would Metrorail's management.

Metrorail executive human resources director Mr Mark Ganstein-Bein pointed out that the deadlocked negotiations were reopened after chief executive officer Mr Z Jakavula and Sashwu general secretary Mr Derrick Smoko had started informal talks with the aim of "putting out the flames that could be caused by the strike".

He said the doors would be left open for Safsa to join the fold as it had reneged in the final minutes.

If the union decided to go on with the strike, minimal disruption could be expected as buses had been hired in anticipation of the strike by some train drivers.

The terms of agreement include a 7,5 percent increase backdated to March 16 1998 and 3,5 percent to be effective from November 16 1998. There would be a further 5 percent from March 16 next year.

Both parties agreed to negotiate a deal on profit-sharing among the workers.

# Hospital sets quotas

*(98) Sowetan 30/7/98*

By McKeed Kotlolo

A CRISIS is gripping the Pretoria Academic Hospital, one of the capital's busiest hospitals, following an acute shortage of pharmacists caused by resignations.

As a result, hospital management has introduced a temporary quota system with a maximum of 150 outpatients accepted each day.

Dr Julius Kunzmann, the Pretoria hospital's director, said yesterday such situations occurred from time to time when pharmacists left to join the private sector which offers lucrative salaries.

Although the Pretoria Academic

hospital has managed to cope with the situation in the past, the recent departure of four pharmacists in a short period had dealt the institution a serious blow, he said.

Kunzmann said the issue of improving hospital salaries was out of their control since it was negotiated at the national level.

The hospital's chief medical superintendent, Dr Zola Njongwe, said the new quota system came into effect on Monday in an attempt to ease the pharmacy's load.

She said the hospital had 32 approved pharmacist posts, but only nine were filled. "Of the remaining nine, three have resigned their posts

and would be leaving us at the end of the month," Njongwe added.

The departure on maternity leave at the end of this week of one of the remaining six pharmacists would worsen the situation.

She appealed to residents, in particular those from the eastern and central suburbs of Pretoria, to take note of the limited number of patients to be admitted a day at the general outpatients clinic.

Njongwe appealed to qualified pharmacists "who are able and willing to assist us on a full-time or sessional basis (with remuneration)" to urgently contact Mrs A Engelbrecht on telephone number (012) 354-2235.



## Underqualified staff 'a time bomb' at hospitals

Josey Ballenger

(98) 80 11/8/98  
 A "LOOMING time bomb" is developing, with 800 staff members in Gauteng hospitals doing work beyond their qualifications or job descriptions, the Democratic Party (DP) said last week.

The DP said it was important to highlight the difficulties hospitals faced with the moratorium on hiring staff.

Answering a DP question in the Gauteng legislature, health MEC Mondli Gungubele said a departmental survey revealed about 800 cases of "misappropriation" — defined as people carrying out functions not applicable to their posts.

The results revealed that Chris Hani Baragwanath had 179 staffers who were wrongly placed, Johannesburg Hospital had 52, Tembisa 48, South Rand 37, Natalspruit 30 and Pretoria Academic Hospital 28.

Gungubele acknowledged that this "might lead to labour unrest ... cases of unfair labour practice being instituted against the department, (or create) a legitimate expectation of inappropriate personnel being absorbed into higher posts".

DP health spokesman Jack Bloom said "messengers earning R25 255 a year are acting unofficially as grade one administrative clerks — a post with a R29 618 salary. If the moratorium is lifted the appointments will have to be regularised, which means advertising and possibly finding the messenger unqualified. This could lead to a dispute."

Gungubele said the primary problem was the moratorium on filling vacancies imposed by the Cabinet in 1994, and the lack of funds for exceptions.

"The department is trying to stamp out misappropriations, but I cannot blame the hospitals because they couldn't function otherwise," Bloom said.

Gungubele's spokesman, Popo Maja, said unions officials were involved to "try to rectify" the situation.





# Crime cripples clinic for mums

## Doctors stay away as attacks put Guguletu unit's staff at risk

JANET HEARD (98)

ST (CM) 16/8/98

**T**HE maternity clinic in Guguletu has become a no-go area for doctors and medical students because of crime.

The medical faculty at the University of Cape Town suspended its services and teaching activities at the maternity obstetrics unit more than two weeks ago because the safety of doctors and students could no longer be guaranteed.

In the past month, students travelling to the clinic in Guguletu have been held up at gunpoint, but have managed to get away unharmed.

The driver of a Grootte Schuur van was hijacked.

In June, a man driving his pregnant wife to the clinic had been stabbed at the front gate and a cellphone had been stolen from another on the premises, said supervising matron Olga Lenga.

This week, the 42 staff members at the clinic held a crisis meeting at which they called on the community to help put an end to the alarming rise in crime and take steps to make it safer for doctors, students, staff and patients.

"The clinic won't be able to function longer than a couple of weeks without the medical back-up of paediatricians, gynaecologists and students," said Lenga.

The sister in charge of the clinic, Mary-Ann

Mamatsiare, said antenatal care was at greatest risk.

Doctors were vitally needed to check on high-risk pregnancies. If there was any sign of danger to a woman's health, they referred her to a hospital, Mamatsiare said.

The 24-hour clinic delivers up to 12 babies a day and serves a wide area that includes Brown's Farm, Langa and Old and New Crossroads.

Negotiations are under way to resolve the crisis and the Guguletu policing forum has offered to escort doctors and students.

At the meeting, Dr Ruth Rabinowitz, the Inkatha Freedom Party's spokesman on health, said doctors had lost confidence in the police's ability to deal with crime. "We have a clinic with dedicated staff, but it cannot function properly because of the breakdown in law and order."

Dr Greg Petro, a gynaecologist who supervises medical staff and students at the clinic, emphasised the potential repercussions of the suspension of services.

"The clinic can operate for a few weeks, but not much longer, without medical personnel."

An effect was that more mothers and newborn babies were being referred to Grootte Schuur and Mowbray hospitals, overloading staff at these hospitals.

Petro paid tribute to the dedicated midwives at the Guguletu clinic and said that he hoped conditions would be made safer for doctors and students "as soon as possible" so UCT could reverse its decision.

**RYING FOR HELP: For Mary-Ann Mamatsiare, sister in charge at Guguletu's only maternity clinic, crime turned baby care an uphill battle**

Picture: RICHARD SHOREY



# Marais' bold plan to overhaul hospitals

AYESHA ISMAIL

ST (Cm) 16/8/98

(98)

WESTERN Cape MEC for Health Peter Marais is planning a radical overhaul that will see the public and private health sector functioning in partnership, sharing equipment, premises and staff.

He is also looking at ways of optimising the use of state hospitals by letting, leasing or swapping vacant beds with the private sector to generate income.

Letting vacant space to commercial enterprises — such as grocery stores, as is being done in Australia — is also a possibility, he says.

Marais bases his proposals on a study of the Australian health system.

"Ever since I took over this portfolio I have had to cut costs to stay within my budget," he said.

"We have been drowning and the only thing other politicians have done is to describe the water to us.

"This has driven me to think of creative ways to run an effective health system on a limited budget."

Marais said he had been impressed with the way the Australians had devised a model based on partnership between the public and private sectors.

"I was surprised to see grocery and clothing stores sharing a building with state hospitals. This is something we could introduce here, given our underused space and buildings."

It was an effective way for hospitals to generate income, Marais said.

In Australia, private pharmacists dispensed medicines in state hospitals.

If this system was introduced in

South Africa, it would help to reduce the long queues and hours of waiting that patients had to endure at state hospitals.

However, state hospitals had the benefit of buying medicines in bulk and at a discount.

"I do realise that in Australia they have a social security system, which we do not have here," Marais said.

Once a private-public partnership had been set up here, the health department could call for tenders to take over and stock hospital dispensaries.

"The pharmacists would then charge us for medicines dispensed," Marais said, adding that he wanted to see the optimum use of hospital facilities.

"If we do not have the need for certain buildings and space, we will rent it out, lease it or swap it."

Groote Schuur and Tygerberg hospitals had about 900 unused beds between them.

As state hospitals did not have the money for the latest technology, their patients were sent to private hospitals for expensive high-tech examinations, Marais said.

"If we get the private hospitals to buy equipment that we can't afford but desperately need, we could, for instance, rent space to them — and private and state patients alike would benefit."

It would be more cost-effective for private and state hospitals to share equipment and resources, Marais said.

"Whatever I do will be in the interests of state patients and not to their disadvantage."

His proposals would be structured to ensure that all patients, and not only the rich, would benefit from a good and efficient health system,

Marais said.

However, he acknowledged that the private sector was already involved in projects aimed at making health care more accessible to the disadvantaged.

Ultimately, said Marais, he would like to maintain and improve the high standard of service at the province's teaching and academic hospitals.

"We cannot afford to lose good doctors to the private sector through poor working conditions and the lack of facilities.

"A public-private partnership is the only mechanism to maintain a high standard of service and to keep good staff."

Marais is to call for proposals from the private sector soon.

He said aid from overseas countries had increased. In the rural town of Haarlem, R5-million worth of medical equipment had been supplied by the French, German and Belgium governments, while the Japanese government had fitted out the entire trauma unit at the George hospital.

China had donated 1 000 wheelchairs, which would arrive in Cape Town soon.

ANC provincial spokesman Cameron Dugmore said his organisation would support a working relationship between the public and private health sectors.

He claimed former Health MEC Ebrahim Rasool had "pioneered" the use of public hospital beds for private paying patients.

"The key must be to ensure the provision of affordable and accessible health-care for all," Dugmore said.

He was confident that the national health insurance scheme proposed by Minister of Health Dr Nkosazana Zuma would be a boon to the health sector.



DOCTORING SERVICES: MEC for Health Peter Marais says he is determined to provide good health care to people at all levels  
Picture: AMBROSE PETERS



BABIES' LIVES ENDANGERED

# Red Cross Hospital runs out of oxygen

(98) CT 18/8/98

A TINY baby may die and many other lives were endangered after Red Cross Children's Hospital ran out of oxygen last week — apparently because the person responsible for checking supplies has left. Health Writer **JUDITH SOAL** reports.

OXYGEN is as vital to the running of a hospital as is blood — perhaps more so because it is needed by more people. Last Thursday, Red Cross Children's hospital ran out of oxygen and now a two-week old baby is struggling for its life while the health of at least two other children has deteriorated.

Operations scheduled for Friday were cancelled. An emergency delivery restored supplies within about six hours, but as the hospital was investigating how the tank of liquid oxygen had been allowed to run dry, another oxygen scare yesterday had staff switching off all but essential supplies. Operations were again cancelled.

Doctors have no doubt that last week's crisis endangered children's lives.

Registrar Liesl Hendricks said the children who were too young or unable to speak had suffered the most. "They just lay there. They knew something was wrong, but they couldn't tell anyone."

Paediatric specialist Louis Reynolds said it was a "miracle" that no one had died. "It's like an earthquake. You rely on the earth to be there and then suddenly it's not. It's the same with oxygen. It's crucial to what we do and then suddenly it's not available," said Reynolds, one of the consultants in charge of the intensive care unit (ICU).

He said that on Thursday at 3am a doctor had noticed that two children who rely on ventilators were not getting enough air.

"At first he didn't realise what was going on. There is no indicator or warning on the ventilator that oxygen isn't coming through, it keeps on working as if normal."

Once they realised the source of the problem, staff connected the patients to oxygen cylinders in the wards.

"The children were scared stiff," said Reynolds. "Not to be able to breathe is one of the most frightening things."

One tiny baby in the surgical ICU went without the necessary levels of oxygen for two to three hours. His kidneys stopped working.

The baby's doctor, cardiologist John Lorensen, said he may not survive. "He had a very serious cardiac operation and the hours just after that are critical. It's absolutely essential that everything is kept stable. His condition was deteriorating, but no one realised the ventilator wasn't supplying him with oxygen."

"When they ventilated him by hand his condition improved remarkably, so the deterioration could have been related to the oxygen problems."

The baby, who has not been named, did not respond to his first dialysis treatment.

"He will have more dialysis tomorrow but if he doesn't respond, he will die. He's not doing well," Lorensen said.

Hendricks said several children had suffered serious consequences. "There was one child with critical pneumonia and another with renal (kidney) failure whose conditions

have worsened. There are lots of children whose health has suffered. Although we can't say it is directly related to the oxygen, it certainly appears so."

The hospital cancelled operations again yesterday after a problem with the oxygen supply.

"We had a warning that we were running out of oxygen," said Hendricks. "Apparently there is something wrong with the pipes, but no one seems to know."

"We have been running around making sure there are enough cylinders and switching off oxygen where it is not absolutely necessary."

Hospital authorities were reluctant to comment on the incident.

"We are still busy investigating," said hospital secretary Lennie du Preez. "We are not sure if it was a technical problem from the firm's side or on the hospital's side."

He denied that there had been another oxygen crisis yesterday.

"It was nothing major and everything has been sorted out satisfactorily," he said. "It wasn't actually necessary to cancel theatre."

Red Cross staff say the person who was supposed to check the level of oxygen in the tank had accepted a voluntary severance package and no one had been given responsibility for this task. Du Preez could not confirm this.

Alan MacMahon, chief executive officer of the three academic hospitals, Red Cross, Tygerberg and Groote Schuur, said the crisis was not related to budget cuts.

"Obviously we would rather break the budget than run out of oxygen. This is not a budget problem, but a managerial one."

Red Cross medical superintendent Shahid Hassim was unavailable for comment.



# Bara hospital report damns doctors, nurses

By Anso Thom  
Health Reporter

A commission of inquiry has been appointed after a task team investigating alleged irregular deaths at Chris Hani-Baragwanath Hospital found there was a lack of supervision and a breakdown in nursing at the hospital.

The task team was established about two months ago, after Dr Bernard Rabinowitz, a former medical superintendent at the Soweto hospital, claimed that at least 40 patients had died at the hands of junior doctors performing surgery without supervision since 1996.

Professor Taole Mokoena, head of the three-man commission, said yesterday the overall impression was that the majority of the 21 deaths brought before the commission by Rabinowitz would have occurred anywhere else and under any type of care.

Mokoena added that two cases had died "unexpectedly and inexplicably", and that it had not been possible to obtain postmortem results. He did not elaborate on these two cases.

Mokoena said the allegation by Rabinowitz that senior supervision had been less than adequate was legitimate.

"Close supervision by senior consultants was not always robust enough nor well structured. This allowed 'junior' doctors to make and execute decisions which ought to be referred to 'seniors'," he said.

One of the most damning findings in the report was a breakdown of effective nursing with no effective communication between doctors and nurses. This was blamed partly on a severe shortage of nurses, but it was also pointed out that "the degree of lack of nursing is out of proportion to the nursing personnel shortage".

Mokoena said there were

(98)  
insufficient beds in the intensive care units, with post-operative care carried out in the general wards without adequate nursing or equipment.

It appeared that management either did not take that seriously enough or did not push hard enough with the Health Department to have the problems rectified, or the department did not heed the complaints, Mokoena said.

He added that besides Rabinowitz, senior administrative and nursing staff members had submitted representations regarding the various problems to management.

Rabinowitz described the statement that the majority of deaths were unavoidable as "absolute rubbish".

Gauteng Health MEC Mondli Gungubele said the follow-up investigation would focus specifically on how the system failed desperately ill patients.

Star 18/8/98



# Bara findings 'drivel', says Rabinowitz

**A** FORMER Chris Hani Baragwanath Hospital superintendent Dr Bokkie Rabinowitz said yesterday that some of the findings of a commission investigating his claims of irregular deaths at the hospital were "absolute drivel".

"People do not die because of bad management, they die because of bad doctoring," Rabinowitz said.

The investigation stemmed from Rabinowitz's claims last month that more than 40 patients had died at the hospital since 1996 because of insufficient supervision during surgery by junior doctors.

A commission was then instituted to investigate 21 patient deaths at the hospital.

The chairman of the three-man commission, Professor Taole Mokoena, told a press conference yesterday that the majority of 21 patients investigated would have died in any institution under any type of care.

However, Mokoena pointed out serious problems at the hospital, including a breakdown in nursing and a lack of communication between health professionals.

"It appears that senior professional staff and hospital administrators failed to press the case for provision of adequate facilities with the provincial authorities, or their pleas went unheeded. They allowed morale and professional diligence to deteriorate among junior staff, especially nurses."

The commission found close supervision by senior consultants was not always robust enough, nor well structured. "This allowed junior doctors, mainly because of inexperience, to make and execute decisions which they ought to have deferred to seniors."

The commission also found that procedures

for post-operative care and the handover of critically ill patients among doctors was not sufficiently structured or enforced.

"In some cases that could have led to the death of patients," Mokoena said.

The panel also found that the physical facilities for the management of critically ill surgical patients, such as intensive care monitoring facilities, were inadequate.

"Post-operative care of critically ill patients was carried out in the general ward or in the anaesthetic recovery room without adequate medical oversight or nursing procedures."

Mokoena said there was no evidence that any particular doctor needed to be referred to the South African Health Professionals Council for possible disciplinary action.

## Disciplinary action

Gauteng health MEC Mr Mondli Gungubele said the commission's report would be submitted to the relevant medical and nursing councils to decide whether any disciplinary action was necessary.

A follow-up investigation would be instituted to focus on how the system had failed desperately ill surgery patients.

Gungubele said the hospital performed an almost heroic task daily. Yet it was clear from the report that there were failures in basic healthcare practice at the hospital.

Asked whether similar investigations would be instituted at other Gauteng hospitals about which complaints had been received, Gungubele said the Chris Hani Baragwanath Hospital was the first priority.

If similar conditions prevailed at other hospitals, they would also warrant investigation. — Sapa.



# Forests bill 'puts R300m and 23 000 jobs at risk'

Wyndham Hartley

CAPE TOWN — Almost R300m in turnover and 23 000 jobs would be at risk if the National Forests Bill was implemented in its present form, Eastern Cape sawmillers told a parliamentary committee yesterday.

In a tough rejection of the changes to conditions of contract contained in the bill, sawmills from across the country said if the contract period was reduced to three years from the present five, confidence in the industry would diminish and further investment in the rural areas would be discouraged.

The sawmills hold contracts to purchase the harvest from state forests and the bill proposes to change the terms of these contracts.

The parliamentary agriculture, water affairs and forestry committee was also told that if state-owned forestry operations were privatised it would be important to prohibit the buyers from exporting the logs as this could be disastrous for the timber industry.

Christopher Rance, representing Rance Timber and four other companies, warned that the depreciation of the rand had made the export price of logs high in rand terms, making it more affordable to export logs than to process them locally.

Rance said if the licence period was reduced to three years the successful bidder for a state forest could cancel all contracts, wait three years and then export all the timber.

Rance said: "The state might get a

BD 18/8/98  
higher initial sale price but the economy and the job market will lose much more."

He said there was nothing in the new legislation that prevented this from happening.

Nthato Motlana, executive director of Madiba Mills in Mpumalanga, called for the clause reducing the licence period to three years to be scrapped.

"What we as new entrants to the industry need most is opportunity and the confidence of the providers of capital. Section 28, if it ever became law in this form, will hurt confidence in the industry and in us. Without security of tenure it will become too risky to support sawmillers financially or to rely on them for stable supplies," he said.

Motlana said the intended privatisation of the SA Forests Company and other state forests was a way to give formerly disadvantaged newcomers to the industry a start.

Solly Tucker, from York Timber, said section 28 of the bill empowered the minister to deprive people of their contractual rights without compensation and that this violated the constitution. He said the clause also offended "the spirit if not the letter of the bill of rights".

The legislation seeks to rectify the discriminatory allocation of forest resources of the past either for recreation or for commercial exploitation.

It also seeks to resolve the anomaly that, at the moment, makes the state a participant and regulator of the industry at the same time.

## DP critical of discipline at hospitals

Josey Ballenger

BD 18/8/98 (98)  
THERE was an alarming breakdown in discipline in Gauteng hospitals, with a low incidence of action taken against guilty parties, Democratic Party MPL Jack Bloom said yesterday.

Health MEC Mondli Gungubele told the Gauteng legislature that 214 disciplinary cases were handled last year and 58 formal charges laid

against officials.

Forty-one of these officials were found guilty on various charges, including 22 cases of fraud and theft.

But Bloom said the figures were "extremely low in view of the widespread theft in hospitals and public complaints of indiscipline". Disciplinary procedures were "so slow" that six employees were still employed despite being convicted in court.



# Semi-private state hospitals proposed

BP 20/8/98 (98)  
Josey Ballenger

PUBLIC-private partnerships at state hospitals could become more mainstream and make the institutions more alluring to private patients once a national framework was ironed out, Tom Sutcliffe, head of the Western Cape's health department, said this week.

Sutcliffe said provincial department heads were considering a framework drafted by the Western Cape earlier this month to develop guidelines for partially "privatising" public hospitals.

Sutcliffe said the need for the guidelines arose after proposals were tabled at Tygerburg Hospital in the Western Cape and Uitenhage in the Eastern Cape to lease unused wards to private practitioners. The argument for the guidelines was that professionals would not be easily tempted to move from one hospital to another, in search of better working conditions, if a national framework was adopted and the practice became widespread.

Sutcliffe said calls for public-private partnerships posed some "interesting pros and cons". One positive aspect was that the public sector would receive revenue from private beds and a more varied patient profile and spectrum of disease, which would be useful for teaching purposes.

The ultimate aim was for public hospitals to compete for private patients. "Right now the perception (of public facilities) is not good and that must be changed. We have a high level of skilled resources — as good as, if not better than, the private sector — plus resources that are nonexistent (in the latter)."

Provincial departments' heads are due to report back on the draft framework and consolidate a position at a meeting next month. The framework would ultimately have to be approved by Health Minister Nkosazana Zuma and provincial MECs.

Sutcliffe said he had "reason to believe they are open-minded," but authorities had to be assured there would be "checks and balances" and that "indigent patients' care would not be sacrificed or compromised."



# 'Home of shame' investigated

(98)  
LAURICE TAITZ

ST 27/8/98

POLICE are investigating complaints of assault and neglect at South Africa's largest state home for the mentally handicapped.

The complaints came to light after a nurse was charged with assaulting two minor patients, aged 15 and 17, at the 1100 bed Witrand Hospital in Potchefstroom in the North West.

Some of the accusations levelled against the hospital are that:

- On one visit parents found their 15-year-old son tied to a chair in the TV room;

- A mother of a 41-year-old woman found her wearing no underwear and weighing 39kg. She took her home, yet a month later received a letter from the hospital saying her daughter was making good progress; and

- The parents of one patient said they found her body covered in bruises.

The parents of one of the boys who was allegedly assaulted on July 4 — a 15-year-old who has a mental age of three — further charged that their son's assault was covered up.

They said they were only alerted to the fact that something was wrong one week after the incident when their son ran away.

The boy was found 14 hours later.

The mother was told he had climbed through a window and over a razor-wire fence into the neighbouring army base. He was found in an army truck, naked and bleeding.

"The man who found him followed a trail of blood. My son's clothes were still stuck in the razor wire," she said.

The teenager received 62 stitches for his injuries.

Soon after the incident, the parents met

with hospital management to discuss their son's condition and a programme of activities for him.

"They never mentioned the assault during the meeting. I heard about it the following day," said the mother.

"My son is a lovable, beautiful kid. In the past I have seen marks on his body that I have not been happy about. But I was told he got into fights with other kids. I worry that he may have been assaulted before."

Although provincial policy is that relatives must be informed of any injury to a patient at the hospital, Michael Siebert, the hospital secretary, said the assault case was a police matter and it was not the hospital's duty to inform the parents.

Witrand has been described by doctors as "the last stop". It "gets patients other people cannot manage".

George Sekoele, 35, the nurse charged with the assault, appeared in the Potchefstroom magistrate's court last month. He was released on bail of R400 and is due to appear again on August 31.

This week, Captain Louis Jacobs, the Potchefstroom police media liaison officer, said the hospital had been unco-operative in the investigation and had not complied with a request to transfer Sekoele to another institution.

Responding to the other allegations, Siebert and Annetjie de Bruin, the nursing head matron at the hospital, said many of the problems at Witrand were the result of staff opposition to transformation — the institution's attempt to bring the hospital in line with government policies.

"The impact on staff has been severe and we have experienced a lot of turbulence during this process," Siebert said.



# Goodbye, Princess Alice

## End of an era for orthopaedic hospital

ANNY WALL  
HEALTH REPORTER

The last operation has been performed at Princess Alice Hospital.

The few remaining patients have been moved to Groote Schuur Hospital and the wards are empty except for a few boxes still waiting to be taken away.

Equipment and hospital beds are being packed and loaded into a large removal van. Princess Alice Hospital is moving.

There's a sombre mood at the hospital in Main Road, Retreat.

Staff are sad to be saying goodbye to the spacious hospital which has been a place of recovery for thousands of people in its 35 years as an orthopaedic hospital. It's a long history to leave behind.

A few outpatients are making their last visit to the clinic.

A nurse patiently explains to a patient over the phone that the unit will now be at Groote Schuur Hospital and that it's no use coming to Retreat any more.

Opened in February 1933 by Princess Alice, Countess of Athlone, the hospital was

used as a recovery unit for children suffering from complaints involving disease or injury of bones. In the 1950s it was converted to a fully-fledged orthopaedic hospital.

When it first became known that the provincial authorities wanted to close the hospital, 10 000 signatures were collected in opposition to the move.

Princess Alice holds a special place in the hearts of the patients who have stayed there and their families.

Many people with chronic illnesses such as arthritis have visited the hospital on a regular basis, sometimes for years, for therapy and monitoring.

They've become used to the easy access to the hospital from Main Road, and the proximity of the train station. Getting to Groote Schuur is going to be more difficult for many.

Ray Arendse, assistant director of nursing at the unit, says: "We will monitor the situation and help where needed."

Mrs Arendse says the orthopaedic unit as a whole will be relocated to Groote Schuur Hospital, including the school for children who spend many months in hospital.

All services will be housed together, so that people don't have to travel Groote Schuur's long corridors to go for X-rays, for instance.

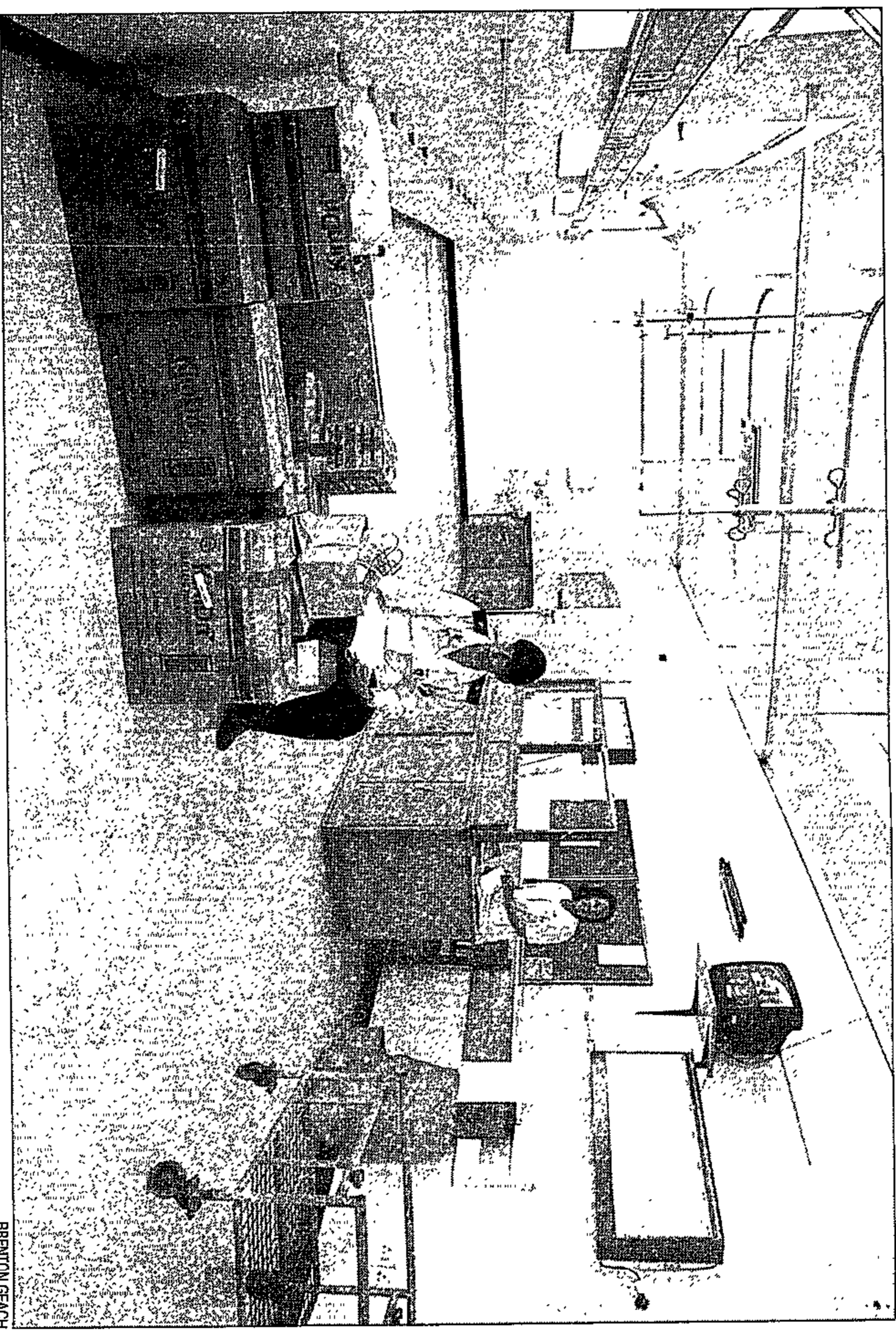
For the next month, there will be no hip replacement, knee replacement or joint replacement operations as hospital staff set up the new unit, which will be known as the Princess Alice Orthopaedic unit.

Johan Walters, head of orthopaedic surgery at the University of Cape Town's medical school, says an emergency facility will be set up for existing Princess Alice patients who may need it. Outpatients will be seen again from mid-September.

Many of the 158 staff at Princess Alice will not be making the move. They've decided to take the voluntary severance package or have left for other jobs. Only 98 of the staff remain.

The Princess Alice Hospital will now house patients from the D P Marais TB hospital in Westlake.

Princess Alice Hospital patients who need emergency consultation can ring (021) 404 5124 until August 31 or (021) 404 5134 thereafter.



Empty shell: Alison Marshall and Inshaaf Elicker pack up the final pieces of the intensive care unit at the Princess Alice Hospital in Retreat

BRENTON GEACH



# Hospitals owed R42-m

(98)

*Sowetan 27/8/98*

**By Joshua Raboroko**

PATIENTS still owed three Gauteng hospitals R42 million despite legal action to recover the money, an audited report tabled in the Gauteng provincial legislature said.

The auditor-general's report on the performance audit at the Gauteng hospitals administration said that Pretoria Academic Hospital was owed R34 million while Chris Hani Baragwanath Hospital was owed R5,5 million at the end of January last year.

The report said although 76,8 percent of the debtors' account at Chris Hani Baragwanath Hospital, which amounted to R5,5 million in January 1997, had been outstanding for a long time, no legal action had been taken for its recovery.

The accumulative debt of R34 million in October 1996 had not been effectively retrieved by Pretoria since 1991, the report said.

Kalafong Hospital was owed R3,2 million. Money has also not been recovered from patients from other countries. Nobody may be refused treatment but in most cases addresses cannot be verified.

Treatment of patients from other provinces had cost the Chris Hani Baragwanath Hospital R87 230 between October 1996 and January 1997.

The cost to Pretoria Academic Hospital between April and October 1996 had been R1 million and to Kalafong Hospital R7 million.

A total of 62 children had been accommodated for 4 290 days at a cost of R2,4 million from the 1993-94 financial year to last year. Abandoned children requiring no medical attention had been accommodated at Chris Hani Baragwanath Hospital and had not been transferred to places of safety.

Community's needs at the outpatient section of Mamelodi had not been optimally addressed. From April 7 to 17 a daily average of 85 patients had been turned away.



By **Gershwin Chuenyane**

# Hospitals move to ease workload

IN AN effort to ease the outpatient workload, Gauteng provincial hospitals are going to give preference to patients referred from clinics designated by each hospital.

"This was aimed," according to a statement by Pretoria Academic Hospital senior superintendent Dr AP van der Walt, "at ensuring a more cost-

effective utilisation of the public health facilities (clinics, community health centres and hospitals) and to ensure equal distribution of the outpatient workload among the various provincial hospitals of Gauteng.

"Hospitals outpatient departments should give preference to patients properly referred from clinics designated to each specific hospital," Van der Walt said.

"During the introductory period, which started on Tuesday, a degree of leniency will still be allowed towards patients without referral letters, and patients from areas outside the referral route of the hospital, depending on the workload at the outpatient department at that specific time."

He stressed that referrals should preferably be arranged by means of direct communication between the referring doctor and the specialist of the clinic concerned.

for further treatment," he said. Van der Walt added that outpatients at present attending or referred to specialist clinics of the Pretoria Academic Hospital were not affected.

7



ANDRÉ JURGENS

# Where gangsters call the shots

## Budget cuts paralyse security at hospital

(R) ST 20/9/98

**A** NARCHY reigns at the Dora Nginza Hospital, where terror-stricken staff have been forced to treat gangsters at gunpoint, nurses live in fear of being robbed or raped by knife-wielding vagrants, and new-born babies are at risk of being snatched as they sleep.

Security at the hospital — a huge complex on an industrial estate near Zwide, about 10km outside Port Elizabeth — has been crippled, with the number of guards slashed from 14 to 5.

Sections of the 850-bed hospital have had to be shut down for financial reasons, providing a haven of hiding places for criminals, vagrants and drunkards.

"The security situation here is totally unacceptable," said medical superintendent Dr Gabriel Sserwanga. "No doctor can work under these conditions."

The following incidents have occurred at the hospital in recent weeks:

- An armed gang, hurling abuse at nurses, dragged a 19-year-old gangster into a ward on a Saturday evening and forced staff to attend to the man, who had been stabbed in a fight.
- A nurse was robbed at knife-point of her jewellery;

- Holes have been cut in the fences surrounding the 35ha property, giving unlimited access to strangers;

- Burglars have stolen bed linen from the laundry and patients' food from the kitchens on a few occasions; and

- Cars belonging to staff and patients have been stripped of parts and broken into.

"When people rush into a hospital with guns, swearing at staff, there is a good chance of someone getting killed," said Sserwanga.

Widespread theft and vandalism at other Eastern Cape hospitals will be exposed in a damning report by the provincial legislature's standing committee on health next month.

The report is expected to highlight poor security at hospitals, staff shortages, medicine short-

ages and a partial collapse in the delivery of health services.

A senior nurse, who did not want to be named for fear of reprisals, said she was the supervisor on duty at the Dora Nginza Hospital on the night the armed gang forced nurses in the casualty ward to attend to their injured companion.

"I was phoned by the security guard in the ward. He was on his own and could do nothing.

"He said the gang were waving knives and guns around."

The nurse summoned the lone guard from the maternity wing and went to the rescue of the nurses.

The gangsters stopped threatening the nurses with guns and knives only once their stabbed friend had been admitted to a ward.

When the Sunday Times visited the hospital on Wednesday,

a fragile-looking student nurse was the only person "guarding" babies in the maternity ward.

Three years ago a female clerk was raped on the hospital grounds, a memory that still haunts nurses on night shift.

Provincial health committee chairman Sally Ngodi said staff at the hospital worked under "pathetic" security conditions.

The chief medical superintendent of state hospitals in the Port Elizabeth region, Dr Frederick Rank, said crime was becoming "unmanageable", even in clinics.

"There is widespread theft of laundry, food and equipment, and staff often work under dangerous circumstances," he said.

"We are looking at high-tech ways of beefing up security but it is unclear whether the provincial health department will be able to pay for this equipment."



# The babies who are born to die

South Africa's cash-strapped hospitals can no longer afford to keep premature infants alive

ADELE BALTA

ARL 26/9/98 (98)

**H**er fragile foot is the size of my thumb. Her weak wail haunts the room as the nurse gently places her tiny body in a warm, soft glass container.

Born too soon and weighing only 700g - about the same as a tub of margarine - the tiny baby has no access to the expensive equipment that could increase her chances of survival. She does not qualify for the treatment.

"We make sure that babies who do not qualify to be put on a breathing machine and who are about to die are given a dignified death," says a Groote Schuur nurse.

Some babies under 1kg manage to survive on their own with minor medical intervention, but many others don't make it.

And with the dwindling health resources, drastic cuts in the number of hospital beds, the loss of irreplaceable nursing staff and the high cost of equipment, state hospitals have been forced to introduce a tough general ruling that babies under 1kg cannot be put on a ventilator.

In some provincial hospitals in the Northern Province and the Eastern Cape, babies under 2kg are not put on ventilators because resources here are at a premium. Babies born in rural areas have an even smaller chance of access to the life-saving equipment.

Parents fortunate enough to have medical aid can get their children on to a ventilator at a private hospital, but at a cost of R6 000 a day, the option is not available to most people.

This week, overburdened doctors and nurses in neonatal units at Peninsula hospitals spoke of the trauma of having to make life-and-death decisions about tiny babies.

They believe they are being asked to make an extremely difficult ethical choice, one that could be very difficult to defend in court. They are particularly distressed at "miscarceptions" that they are callously abandoning babies under 1kg.

Many say they need counselling. Groote Schuur specialist Dr Mary Hann told Saturday Argus: "It's



**IRRAWING:** Eunice Ploedies and her son, Alura, who was born after 26 weeks and weighed only 900g. He qualified for ventilation at Groote Schuur Hospital.

hard to see a tiny child struggling. We do what we can. "It's hard to see them getting tired and slipping away."

Weight is not the only criterion on which the decision is based. The baby's gestation period - the time it spent in the mother's womb - can be an important factor. In many cases, a lighter infant with a longer gestation period has a better chance of survival.

Groote Schuur's Professor David Woods says when he asked an ethics specialist for advice on how to decide who should live and who should die, he was told: "The only way to be really fair is to spin a coin."

But he said in reality the mother's rights came first.

"We make a team decision, very often based on the mother and not the baby. An older mother who has had three miscarriages is likely to be given the thumbs-up over a younger mother who has an unwanted pregnancy and who

wants to go back to school. We just cannot look after both of them."

The availability of beds, ventilators and staff play an important role. But Professor Woods said the decision "is really determined by funding and not by what is best for

the patient, which is an appalling situation for doctors."

There is another side to the issue. Between 20 to 40% of children born below 1kg will have some form of neuro-developmental problem if they survive. These range from mild hyperactivity to severe cerebral palsy.

And many babies from disadvantaged homes face bleak conditions when returning home.

Professor Woods says: "I say this with great sensitivity and reservation, but we have to ask ourselves sometimes whether it is worth going the whole way for some children."

Professor Lucy Linley, a specialist at Mowbray maternity hospital, said the biggest crisis affecting intensive-care units countrywide was the drastic nurse shortage.

"There are not enough nurses to look after premature babies. Staff are being asked to do more and more with less and less."

She believes that good antenatal care would mean fewer children would have to be given assisted breathing.

Somerset Hospital's Dr Geoff Moller said the 1kg cut-off was "not cast in stone. It is time to balance the resources with patients."

According to Dr Johan Smith of Tygerberg Hospital, the tragedy was that previously disadvantaged people were still being discriminated against.

"The truth of the matter is that the right to life is being determined by whether the parents are on medical aid."

He believes the Department of Health, not doctors, should be making the decisions and taking responsibility for the premature babies.

Dr Smith said to put an average of 10 000 underweight babies born annually on ventilators cost about R166-million. The annual health budget for the 1997 and 1998 financial year is R22,7-billion.

He said the budget was "negligible."

It did not take into account the building costs of new ICUs to accommodate these babies, but he said that once the units had been built, they were a valuable resource.

Picture: ANDREWINGRAM



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# Mamelodi Hospital bursting at the seams

EP 27/9/98 (98)  
By STEVE DLAMINI

**C**ALLS to upgrade Mamelodi Hospital in Pretoria to a regional hospital seem to have fallen on deaf ears.

Donny Makola, secretary of Mamelodi Civic Organisations, claimed an agreement to improve the hospital and its working facilities was reached with the Gauteng Department of Health and the hospital's senior staff.

But the hospital's matron Stella Sebati said it would probably take longer than seven years to convert the hospital into a regional hospital because of budget constraints.

The health department could not be reached for comment, but it recently made plans for the hospital to be converted into a regional hospital, without specifying when.

The hospital needs to be upgraded to supply a more effective health service for the community it serves and to eliminate the queues in which patients have to wait for hours to receive attention.

Even though the casualty unit will

be upgraded next month and 10 extra consulting rooms will be built, the community fears this will not sufficiently improve the facilities.

"The position will largely be the same. The hospital is too small to serve the entire Mamelodi community with a population of more than 800 000," Makola said, adding that the hospital also catered for people as far away as the Cullinan and Mpumalanga areas.

The hospital's acting superintendent, Dr Julia Blitz, confirmed the hospital was experiencing a number of problems but said the matter was receiving the department's attention.

The hospital, with a staff of 131 nurses and 18 doctors, has two wards totalling 90 beds, and has to attend to more than 600 outpatients a day.

"The beds are used for people hospitalised for five days or less. Patients who sustain serious gun and knife wounds are transferred to Kalafong Hospital in Atteridgeville or the Pretoria Academic Hospital," Dr Blitz said.

The hospital also did not have facilities to test blood, she said.

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# Air ambulance to die tonight

Anger as Gauteng's aerial rescue service - which transports 1 500 patients a year - is to be axed due to a shortage of funds

Star 30/9/98

(98)

CAROLINE SUZMAN

By Aniso Thoma  
Health Reporter

Gauteng's air-ambulance service, Flight for Life, will be axed at midnight tonight, increasing the burden on the province's already stretched emergency services. Gauteng's department of health has recommended the service be terminated when the contract with Europ Assistance expires, according to sources within the health services.

According to reports, no tender will be awarded by the Gauteng Tender Board (GTB), when it meets tomorrow, for the operation of the helicopter service from the Johannesburg and Pretoria academic hospitals.

Europ Assistance has been operating the service for the province, transporting more than a thousand patients each year. The service has operated uninterrupted since 1978.

Indigent patients in rural areas are expected to be hit hardest when the only 24-hour air-ambulance service in Africa is axed.

A senior source in emergency services said the final blow to the helicopter service came when Johannesburg Hospital's intensive-care unit, which treated most of the patients transported by the air ambulance, overran its budget. "The hospital was told that the helicopter service was placing a burden on the ICU service, which costs them money," a source said.

A Pretoria High Court judge in May last year granted an interdict stopping the GTB from granting a R14.8-million air-ambulance contract to Ndabizani Aviation Services.

Europ's managing director, Mr. Cornish said in an affidavit at the court that the fact that their R7.8-million tender was the lowest (and also within the budget set by the health department), the board awarded the tender to Ndabizani, who wanted



Grounded ... paramedics attend an accident victim on a Gauteng highway yesterday. The air ambulance service, Flight for Life, is to end tonight.

to charge R7-million more.

"We have had no indication from province that they want to extend the tender," Cornish said yesterday.

"I am horrified to hear that the service is going to be axed. This service saves lives and it is going to be another blow to health care."

A department of health report stated that the province could not afford the annual

R5-million needed to keep the two helicopters in the air for the benefit of state patients.

Head of trauma at Johannesburg Hospital, Dr. Ken Boffard, confirmed that the flight for life service at Johannesburg had handled 1 004 emergency calls last year, with most patients being taken to Johannesburg hospitals.

Chris Hani Baragwanath and Boffard said the helicopters

had a two-fold purpose - transporting critically injured patients, as well as assisting paramedics when they did not have adequate resources at accident scenes.

Peak-time traffic on roads caused a delay of ambulances of up to an hour before a patient reached a hospital.

Dr. Eric Buch, deputy director-general at the department of health, declined to comment.

Sapa reports that the Democratic Party yesterday said the termination of the service would be a virtual death sentence for critically-injured people in inaccessible areas.

Spokesperson, Jack Bloom said clarity was urgently needed on the future of the service. "It is deeply disturbing that a new tender for an air-ambulance service was awarded some months ago, but appears

to have been put on ice until a decision on Thursday." The National Party said the department should recover money owed to it when it treated patients from other provinces, before depriving seriously injured people of the service.

Gauteng health spokesperson Jo-Ann Collinge said she did not want to comment until the tender board's decision was known.

## Paramedics handicapped in race to save lives

Most patients with internal injuries or gunshot wounds have little chance of surviving unless they reach a hospital within an hour.

Urban emergency services are finding it increasingly difficult to get critically injured patients to well-equipped hospitals within 60 minutes - a period referred to by paramedics as "the golden hour".

The obstacles to meeting this deadline are many. One is that major cities such as Johannesburg experience huge traffic jams during peak times. Others are that emergency services are understaffed, that there is a shortage of qualified emergency personnel, and that there is a shortage of well-equipped regional hospitals.

Dr. Kim Panovka, medical director at Europ Assistance, said it was a well-known fact that the sooner patients reached a hospital, the less time they spent in the institution.

"If the person has an internal injury a brain injury or a gunshot wound, he has to get to the hospital within less than an hour," Panovka said. "Most internal injuries need to be operated on. In cases like this, time is of the essence."

Panovka said a person could live for nine minutes without oxygen.

"If the patient reaches a hospital within a short space of time, the damage is also more reversible," Panovka added. - Health Reporter



# Lifeline thrown to air-ambulance service

BY ANSO THOM  
Health Reporter

At least four major businesses have offered to help keep Gauteng's 24-hour Flight for Life service alive by footing the R5-million needed to keep the two helicopters in the air.

The province's air-ambulance service was axed at midnight last night by the department of health - but Europ Assistance is to keep the lifeline open by using a small helicopter during the day. Other companies have also offered assistance.

Popo Maja, spokesperson for Gauteng Health MEC Mondli Gungubele, confirmed yesterday that the province would not be in a position to renew the contract. "We don't have the

funds to do that."

Ian Cornish, the managing director of Europ Assistance, which has been operating the service from the Johannesburg and Pretoria Academic Hospitals since 1993, confirmed that at least three big businesses had approached the company with offers to help meet costs.

Cornish said that, although they had received no directive from the department of health as to what should happen by the time the extension expired, they had taken a decision to keep a small helicopter in the air during the day.

Cornish also disclosed that Europ Assistance had approached the Government with a proposal to become a co-sponsor. "I sent a proposal yesterday to sponsor the service with a

fixed amount of R2,5-million a year, which would allow us to continue servicing non-paying patients. We guaranteed that we would find the sponsors to make up the rest."

He would not reveal who the interested sponsors were, but indications were that the SABC and Telkom had or were planning to approach the company.

He said Netcare, John Rolfe and Europ Assistance would foot the bill for the next few days until a solution had been found. "We won't be able to run a 24-hour service anymore," he confirmed.

Dr Pieter van den Berg, director at the Gauteng department of health, said the department was willing to negotiate with Europ Assistance on the co-sponsor proposal.

11/10/98 (98)



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## Lack of planning led hospitals' problems

(98) BD 1/10/98

CAPE TOWN — Inadequate financial management and lack of planning affecting two KwaZulu-Natal hospitals — King Edward and Wentworth — were cited by the auditor-general's office in a report tabled in Parliament yesterday.

It said an amount of R321m had been allocated by the provincial administration to King Edward during the 1997/98 financial year, about 14% lower than the expenditure of R372m for the 1996/97 financial year.

However, the budget had already been overspent by nearly R26m by January 31 this year. An amount of R92m had been allocated to Wentworth for 1997/98 financial year, about 3% lower than the expenditure of R95m for the 1996/97 financial year. However, the budget was already overspent by nearly R11m by January 31 this year.

The report said although every effort was made to confine the budgeting process to the actual needs of hospitals, allocations were not made accordingly.

Although a strategic plan was developed and documented by the provincial health department during June last year, its contents were not adequately communicated to and monitored by relevant role players.

The need for additional staff was not addressed on time, the report said. This had contributed to staff not being used according to their qualifications and skills, as well as a loss of potential income.

Monthly service accounts were not always paid on time, and as a result at least R39 476 interest on overdue telephone, water and electricity accounts was incurred. The collection of outstanding patient fees at Wentworth was not adequately addressed. This had led to revenue being forfeited. — Sapa.

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MTG 2-8/10/98

# Threat of cuts to medical services

(98)

Stuart Hess

unable to provide specific figures indicating its spending this year.

Gauteng deputy director general for health administration, Kanny Chetty, said no further funds can be made available to the hospitals this financial year. "The department does not get any extra money, and it is up to the hospitals to maximise the use of the available resources," she said.

**P**atient care in Gauteng could be curtailed as state hospitals run out of funds because of overspending of this year's budgets. Government health officials said no additional financial assistance will be made available until the start of the next financial year in April 1999.

The chief superintendent at Ga-Rankuwa hospital, Reg Broekmann, said his hospital would also be requesting further funding from the provincial administration after spending more than R107-million on medicines, blood, equipment and transport. This represents an over-expenditure of more than R24-million.

Salaries, which make up more than 65% of the hospital's total budget, incurred a R3-million over-expenditure.

The health, welfare and education departments take up more than 90% of the current Gauteng budget. More than 60% of the R5,2-billion budget for health in the province is spent on salaries for nurses, doctors and administrators. Chris Hani Baragwanath receives the largest allocation among Gauteng hospitals. This year its budget is R565-million, an increase of R78-million from last year.

However, major institutions such as Chris Hani Baragwanath hospital in Soweto and Ga-Rankuwa hospital near Pretoria will still be requesting supplemental funding from the Gauteng Department of Health.

"The money is necessary for the work we do," Broekmann said. "We are trying hard to work in a cost-effective manner. We will probably have to request extra funds from the provincial administration sometime in October."

Chetty said hospital administrators and doctors need to show more discretion regarding the use of equipment, drugs and blood. The department is currently looking into the redeployment of staff to correct the imbalances faced by previously disadvantaged institutions.

Baragwanath hospital superintendent Claude Manzanga said the hospital urgently needs more money for pharmaceuticals, equipment and salaries. "We might request more money from the provincial department in November," said Manzanga.

Broekmann said the hospital may need to terminate some services or decrease its size to stay within future financial boundaries.

Provincial health representative Popo Maja said hospitals did not get the "ideal" budgets, but funding for hospitals is "sufficient to provide basic, efficient care for the people".

However, the budgetary difficulties would not lead to the closure of any departments for the foreseeable future, but if the hospital does not receive more money, medical services will be cut back, Manzanga said. The hospital was

This week the emergency helicopter service in Gauteng was shut down as the provincial department was no longer able to provide the R5-million annual fee needed to continue the operation.

He said the department was unable to provide further funding for hospitals: "[The hospitals] are asking for money that's not there."



# First traditional hospital opens in Mpumalanga

By Saint P Molakeng

SOUTH Africa made medical history yesterday when the first traditional hospital was opened in Mpumalanga.

Samuel Traditional Hospital, near Kwamhlanga in Bronkhorstspuit, has a staff of five different traditional doctors.

The practitioners would be able to cure "notorious" diseases that have been incurable for Western medicine,

the traditional doctors claimed at a media briefing. These conditions include Aids, asthma, diabetes and epilepsy.

"It is impossible for orthodox medicine to cure all diseases - just as it is impossible for any indigenous medicine," said traditional healer Mr Ephraim Mabena.

Therefore, the hospital would boost comprehensive medicine that is both orthodox and indigenous. "If we can

unite against crime, why not against diseases?" Mabena asked.

The hospital is named after its founder, Mr Samuel Kwadi, who has been a traditional doctor for many years.

## Intensive treatment

The institution is situated at 115 military base, which was previously occupied by the former South African defence force. It has been leased to the

hospital for 10 years.

The hospital has two wards with 24 beds each. Kwadi said admission and treatment charges would not be the same as at government hospitals.

A patient would pay R180 a day for admission. Treatment for Aids would be R500 monthly.

The doctors said that for chronic diseases patients would need two months intensive treatment to improve and possibly cure the condition.

The Medical Aid Association of South Africa is said to be in the process of extending recognition to the hospital. A medical practice number has been awarded.

Local mayor Mr Speed Mashilo, whose office helped the healers in preparing the ground for the establishment of the hospital, praised Health Minister, Dr Nkosazana Zuma for having recognised traditional medicine.

*Source: Mm 6/10/98*



# Doctors must decide which babies will die'

**PRISCILLA SINGH**

AN urgent appeal for public donations has been made by the Groote Schuur Newborn Medicine Unit, which loses two to three babies a week because of a critical cash shortfall.

At times, painful decisions like taking babies off ventilators and allowing them to die are part of the normal duties in the unit. A lack of resources and money has forced this situation, coupled with the fact that equipment in the unit is more than 30 years old and broken and obsolete machines are not replaced, doctors say.

The plight of the babies has been highlighted by three senior doctors who are forced to deal with the unfair reality of making life and death decisions every day.

Dave Woods, who heads the unit, said yesterday that they were "totally strangled as far as resources are concerned".

"Care is determined by budget and not by need. We sometimes

(98) ET 8/10/98  
put two babies at a time in an incubator and then we have to make the difficult decision to take very underweight babies off ventilators because it is too expensive."

A three-month survey at the unit indicated that 482 infants were cared for; of these 33 weighed less than 1kg at birth while the remaining 449 weighed 1kg or more. Survival rates in the two groups were 60% and 98,4% respectively.

The 33 low-weight infants accounted for 31,2% of the total expenditure. The financial cost to the state per survivor was 10 times higher for this group compared to the heavier babies.

Very small infants therefore, have a reduced rate of survival and take up a large slice of the funding available and also need a lot of nursing time.

Over the past two years the nursing staff has been cut by more

than half and specialists from six to two. The unit was equipped to accommodate 60 low-weight babies, but a room with 10 incubators now stands empty because of the staff and finance crunch.

One of the strategies that have been implemented is the "Kangaroo Mother Care" facility, where mothers act as incubators, keeping the babies close to their bosoms at all times to ensure warmth.

Woods said the most difficult fact to deal with was that babies under 1kg will not be ventilated unless under very extreme circumstances.

"The way our budget is structured, it is a lot cheaper if we had to let babies die. It sounds harsh and inhumane, but unfortunately this is the reality," Woods said.

To pledge donations, call Dave Woods on (021) 404-6022 or (021) 488-4728.

**LIFE OR DEATH  
DECISIONS**  
— PAGE 13





AL CONSTRAINTS: One of the low-weight babies at Groote Schuur's neo-natal unit, whose life hangs in the balance because of serious budget limitations. PICTURE: KIM LUDBROOK

# Doctors must decide which babies will die

PRISCILLA SINGH

(98) 27 8/10/98

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**LIFE OR DEATH DECISIONS**

—PAGE 13



## Gauteng 'dragging heels on health partnerships'

(98)  
Primarashni Pillay

20 16/10/98  
THE Democratic Party (DP) yesterday criticised the Gauteng health department for "dragging its heels" on private/public partnerships in health institutions and attributed this to "ideological reasons and administrative incapacity".

DP Gauteng health spokesman Jack Bloom said private/public partnerships would bring in badly needed income to sustain Johannesburg Hospital. He was concerned Wits University's proposal for the private use of 200 beds at Johannesburg Hospital had been stalled for years.

"It is vital that we have faster movement in this area, as it is an opportunity to generate income desperately needed to halt the alarming decline in medical standards at Johannesburg Hospital," said Bloom.

In a written response to questions by the DP, Gauteng health MEC Mondli Gungubele said the department was conducting a detailed audit of underused space in all Gauteng's hospitals. Spare capacity at public hospitals could be used for partnerships either in specific clinical departments or in a hospital as a whole.

"The department is exploring various options including partnerships with the universities," Gungubele said.

Before entering any partnership, the department needed to give full consideration to the impact of the proposal on equity, efficiency, quality of care and whether it addressed the need for services. The department also had to consult staff and unions at the institutions to ensure partnerships did not have a negative impact on the public sector.



# Foreign doctors get the needle

(97) (98) 8/17/10/98  
They're doing a great job but get little recognition or reward

BY CHARLENE SMITH

**W**hen is a South African not a full South African? When he or she is a doctor who qualified abroad, emigrated to this country and became a citizen.

While their SA-born counterparts leave the country in droves for hospitals or private practices overseas, foreign-born and trained doctors who live in South Africa, even if they are citizens, are forced to work the rest of their lives in under-resourced, poorly paid, overloaded government hospitals.

At Germiston Hospital (formerly known as Willem Cruywagen Hospital), all the doctors are foreign. The superintendent is a Bulgarian, and all the remaining staff are foreign trained (although most have taken out South African citizenship). A single South African paediatrics consultant comes in two to three times a week to help an over-staffed woman doctor who is in charge of the paediatrics, gynaecological and obstetrics wards.

## No unions

A look at her case load gives an idea of what foreign doctors do for this country. She is a Bulgarian who qualified in 1990. She came to SA in 1992, sat South African exams and completed a year of internship here (despite having already done all that in Bulgaria).

In her typical 8am to 4pm working day she cares for an average of 15 patients in the paediatrics ward, 30 antenatal patients and 10 patients in the gynaecological ward, monitors about 10 women in labour, delivers at least 10 babies and performs two to five caesareans.

A doctor like her earns, after tax, around R4 000 a month. Senior doctors in South African hospitals gross R6 000 a month. Nearly all work overtime to increase their earnings, and earn around R30 an hour for overtime work.

There is probably not a union in the country that would accept such rates, but doctors are not allowed to be unionised.

There is a furore in medical circles at present because foreign doctors, the Department of Home Affairs, the SA

Interim Medical and Dental Council, and even, initially, Dr Nkosazana Zuma's own Health Department claimed she had instructed Home Affairs not to renew the work and residence permits of about 1 300 foreign doctors. However, after persistent *Saturday Star* inquiries, Zuma denied this.

If foreign doctors leave, in their place will be community service doctors - who have just qualified or are about to qualify. But even with those doctors, SA's understaffed, under-resourced hospital system cannot cope, as Mpumalanga Premier Mathews Phosa found after being involved in a car accident.

Phosa said that when he arrived at a government hospital after the accident, "There was not even a stretcher to carry me. Many hospitals don't have enough staff or medical equipment."

But while the system may be inadequate, the doctors are not. Mark Joubert, who was shot in his lower back, was taken to Germiston Hospital. Dr Valentin Iordanov, the hospital's acting superintendent, and who was a specialist general and thoracic surgeon in Bulgaria, operated on him. Joubert believes he would have died if not for the help of Iordanov and his team.

Iordanov wrote to President Nelson Mandela in July this year querying legislation that would not allow him full registration (which would put him on a higher-paying specialist scale at his hospital). His letter was referred to the minister of health who referred it to her director-general, who wrote back a letter headed Application for Employment, essentially saying his failure to adopt a new regulation to write a South African exam for final year medical students excluded him from full registration.

However, Dr Vesselin Milkov, who was a specialist nephrologist in Bulgaria with 22 years' experience, has applied to

write the exam. He is one of two qualified nephrologists at Chris Hani Baragwanath Hospital; the other is Cypriot. But with a month to go, Medunsa has failed to send him details of the exam.

The situation is rendered ridiculous because Milkov, an SA citizen, trains South African students and registrars. Many of those he has trained have left the country. But present regulations mean he cannot legally write prescriptions, he has to ask SA-born junior doctors to do that for him. "I love South Africa and this hospital, but because I am foreign trained, I will never rise higher, I can never be a specialist and get the pay benefits of that."

Dr Marietjie du Plooy, a registrar at Chris Hani Baragwanath, and a South African-born doctor, says: "In South Africa we come from a background of discrimination and yet we are continuing that with foreign-trained doctors. Health services have dropped. There are two to four sisters per ward caring for 60 patients. The more patients you deal with, the more likely it is that mistakes will be made."

## Solution

But Milkov, who was part of a delegation of foreign doctors to the Human Rights Commission last year with their plea for equality, has a possible solution. "If doctors come to this country there is no reason why they should not work in government hospitals for two or three years. But, if they make a commitment to this country and become citizens, they should have the rights of citizens. There is no reason why the government should not have categories of doctors who are only contract workers and who may have contracts for no more than, say, four years, with an option to extend for two or three years."

Members of the SA Foreign Qualified Doctors Association are so incensed that they have established a "fighting fund" to pay for their legal battles against the minister of health. They plan to meet next weekend to discuss strategies.

One doctor said: "I am getting tired of this humiliation. Maybe I should do what the South African-born doctors do and just leave the country too."



PHOSA: Had first-hand experience of SA's ailing health system



# Valkenberg 'abuses' probed

BOBBY JORDAN

(98)

ST (cm) 18/10/98

THE Human Rights Commission is investigating reports of improper conduct by staff at Valkenberg psychiatric Hospital.

This follows the death of a 39-year-old patient — admitted to nearby Conradie Hospital with a chest infection — and the alleged sexual abuse of a male patient.

The commission's legal officer, Faranaaz Veriava, said it was waiting for a response from the Cape Town hospital before deciding on the next step.

According to a report, many inmates raised concerns about the sudden death

of Joseph Damon on August 18.

"From the evidence there could have been some negligence on the part of those responsible for treating Damon," the report said. The hospital is also investigating an allegation that one of its staff assaulted and sexually abused a patient earlier this year.

Valkenberg medical superintendent Dr Garvin MacKay this week confirmed that the hospital had launched an internal investigation into the sexual abuse case and had reported the matter to the police. He said the hospital had to deal with many allegations against staff members but most had proved to be false.

"There will also be a thorough internal investigation," MacKay said.



# Ambulance crisis as 50 quit service

**SHARKEY ISAACS**  
STAFF REPORTER

Cape Town's emergency rescue service has been plunged into a crisis after the shock resignation of 50 ambulance staff members, including a top executive and the first black person to be appointed to a senior officer's post.

Uncertainty over who will run the ambulance service in future, as well as a change to the rules of the Cape Town municipality's pension fund appear to have prompted the resignations.

The exodus of about 17% of the city's 291 ambulance staff members comes after months of uncertainty for the service which is funded by provincial government but run on an agency basis by the Cape Town municipality.

Cape Town has signalled that the service should be taken over by provincial government, and staff are uncertain what the implications are for their pay scales and other benefits should this happen. The pension fund change has allowed staff to take out lump sums.

Some personnel left at the end of last month, others at the end of this month and a



OBED ZILWA

**Time to go:** John Bester, 51, the 'first senior officer of colour' of the Cape Ambulance and Rescue Service, has quit

number indicated they were planning to go at the end of November.

Among them was ambulance station control room officer John Bester, 51, who has opted for early retirement after directing emergency personnel and emergency vehicles for 29 years in his 31-year career at the city council.

Mr Bester was a legend in his time at the helm of the control room.

(98) ARG 2/11/98  
He was on duty during major emergencies such as massacres at Kenilworth's St James Church and Observatory's Tavern Heidelberg and the recent Waterfront Planet Hollywood bombing.

Mr Bester's appointment as the first black officer of the city's central ambulance station made labour history.

Mr Bester said he believed the ambulance service transfer was jeopardising the entire emergency and rescue network because it had created fears of uncertainty with the spectre of privatisation looming.

Cape Town director of protection services Alan Dolby said changes in personnel pension funds from a defined benefit to a defined contribution scheme had prompted a spate of up to 50 resignations from the beginning of September.

Ambulance chief Greg Pillay said he had decided to apply for for the post of disaster manager in the city council. He will take up his new appointment at the beginning of next month in a step which will leave his post vacant. His assistant chief officer Cyril Leeuwendaal resigned and opted for early retirement from the end of October.

Mr Dolby said both executive posts would have to advertised and filled soon.



# Delft's sick livid over hardly-used new clinic

98

ARL 22/10/98

The building smells new. Wooden benches line the waiting area in a light and airy room.

But the admission hatches are closed, except for one.

Very few patients wait in what should be a busy 24-hour community health centre in Delft.

The problem, says Shaheeda Samaai, is that there are not enough staff.

Ms Samaai is a member of the crisis committee formed two weeks ago to put pressure on authorities to staff the clinic as a 24-hour service, as was originally intended.

She has been involved with the clinic since the province, the city of Tygerberg and the community planned it for the estimated 50 000 people living in the area.

Delft residents were employed in its construction and it was completed a year ago.

Since then the community has waited in vain for the service it was



HEALTH REPORTER

promised.

The clinic is not yet open officially, although it offers a limited service.

The staff of 38, three of them doctors, see the patients they can.

The rest are turned away. There is no emergency service or maternity unit.

Theatres stand empty save for a few boxes.

The rehydration unit for babies is stacked full of plastic chairs, x-ray viewing boxes and drip stands.

The x-ray unit is in the process of

## LATEST

Staff at Delft community health centre were today prevented from entering the premises by the crisis committee. Committee member Gadjia Francis said the community wanted authorities to come to the clinic and talk to them.

being equipped.

A staff of more than 100 is needed to run the centre as it was intended.

Last month the clinic was given the go-ahead to interview staff to begin work on October 1.

Those hired were then told they could not begin on that date. "We've been kept in the dark from the start," said Ms Samaai.

"No one knows what's going on."

Faxes have been sent to the provincial authorities and Health

Minister Peter Marais, but they are unanswered.

Residents have now had enough. A meeting was called yesterday and outside the clinic hundreds of people listened to speeches by community leaders who asked why the 40 posts had not been approved, and why their new clinic was understaffed.

"We desperately need the 24-hour centre," said Ms Samaai.

"Without it people have to travel to Elsies River or Mitchell's Plain, which costs about R50 by taxi."

Rachma Goodall lives in Delft and does voluntary work at the clinic with senior citizens.

She hears their complaints of being turned away, of not having access to emergency services.

Johan Smit, Mr Marais's spokesman, said the 40 posts for the clinic had been approved and would be filled in line with the Health Department's business plan, probably before the end of the year.



Gathering dust: Shaheeda Samaai in the emergency clinic at Delft, empty because there are no people to staff it

ROY WISLEY



# As Atlantis convulses, hospital

**WESFLEUR HOSPITAL** is reeling — and not only from budget cuts. Situated in the crippled, National Party-created town of Atlantis, whose industry is evaporating, it also faces the fallout from large-scale and growing unemployment. But a helping hand from the Lions service organisation is making a difference. Senior Writer **YAZEED FAKIER** reports.

**C**HRISTMAS 1997 at the Wesfleur Hospital in the apartheid-created town of Atlantis on the West Coast. The staff had been holding a Christmas Eve party at the end of another long year serving the people of the town and its surrounds in Mamre, Pella and the informal settlement of Witsands nearby.

"We started the evening so well," recalls Des Stumpf, the doctor in charge of the ailing hospital's outpatient section.

"We had a sound system, we were singing carols, dancing in dressing gowns ... then all hell broke loose."

By the end of his shift, Stumpf and his handful of dedicated staff had treated more than 100 stabbing cases. One involved a young woman who had stabbed her father to death in a domestic squabble.

The usually good-humoured doctor drove home in tears. "God, please help Atlantis," he prayed.

Depending on who is being interviewed, the unemployment rate in the town is put at 40%-50%.

The ranks of the unemployed will be swelled by nearly 700 by the end of the year due to job cuts at the Atlantis Diesel Engines company, situated in the area's industrial hub.

Everyone agrees that the jobless fig-

ure is frighteningly high for a town with a population of 100 000.

Tales of desperate struggles for survival abound.

Sylvia Brand, a community worker and assistant chairperson of the Wesfleur Hospital Board, tells of children scrounging for breadcrumbs at the bread-slicing machine of a local supermarket; or the family driven to drawing water from their rusted geyser for domestic consumption.

Many of Atlantis' inhabitants have been forced to turn to alternative ways of securing an income, such as travelling to Cape Town and other centres for work, or establishing informal businesses, including wholesale shebeening, in the town itself. An average of eight Atlantis residents are dependent on the salary of one working person.

Forty percent of Atlantis' working residents are employed outside the town. They have to wake as early as 4am for the daily journey that will cost them an average of R300 per month — a huge chunk considering that most earn about R1 000 a month for menial jobs in factories and as domestic servants.

With both parents at work, there is little or no adult supervision in the home to ensure children attend school.

Often parents learn only much later that their children have been absent for several months, having instead fallen prey to gangsterism and drug abuse.

The Wesfleur Hospital, surrounded by sturdy metal security fencing to ward off marauding gangsters, has been struggling to cope under the weight of the need for its services.

Staff and budgetary cuts have further shaved its capability down to the bone.

Speculation is rife that the needs of Atlantis are deliberately being ignored because its inhabitants voted for the National Party in the 1994 elections. "Not white enough and now not black

enough," is a saying often heard when residents struggle to make sense of the new dispensation.

The prospect of the hospital acquiring urgently needed equipment and additional staff is bleak.

In its 1997 annual report, the hospital says that it presently provides a busy outpatient service which is divided into general and chronic sections, 24-hour

*"There's a disaster here in this town; it's an explosion just waiting to happen."*

casualty and 24-hour maternity services.

It notes that in terms of the principles of primary health care adopted by the new government, there has over the last two years been a net reduction in staff by 15% and a loss of service in terms of the hospital's 25-bed ward and theatre, both of which are not operating due to staff shortages and despite a net increase in the patient workload of 40%.

The voluntary service package has removed a number of experienced staff in all departments. In many instances they have not been replaced.

"Where they have, relatively inexperienced staff have joined," says the report.

"These have not been adequately inducted due to service pressures and so have required extra supervision, creating increased work and decreased morale."

Many nurses perform duties beyond their scope of practice. Four staff members were medically boarded during the year and another awaits medical boarding by the end of the year. A few simply resigned.

When the *Cape Times* visited the hospital, staff said they were discouraged from taking the retrenchment package; management on the other hand point to the scarcity of staff and ask from where they are to recruit additional staff if the haemorrhaging continues at the present rate.

"In every instance management has made strenuous efforts to fill the vacated posts," the report notes. "The rules and procedures for filling posts changed frequently through the year, thwarting these efforts."

This culminated in the "Friday 13 June" cancellation of all vacant posts, in which posts which had been hard fought for but not yet filled were abolished.

Equipment is also sorely needed. It is this desperate scenario that drove Stumpf to contact the Lions service organisation to help lift the hospital out of its quandary.

With its motto "We serve", the objective of Lions internationally is to promote good government and good citizenship, encouraging service-minded people to serve their community.

Stumpf first came into contact with the Lions Club of Groote Schuur when they were involved in Operation Bright Sight, which facilitated eye tests and provided spectacles for needy residents, providing a R30 subsidy towards the R50 cost, R20 of which is provided by the patient.

"Through that contact I asked them if they could please have a look at the hospital," said Stumpf.

Outgoing Lions Groote Schuur president Alan van Wulven and fellow Lion Ingrid de Klerk travelled to the hospital one night to experience its predicament first-hand.

"I got a phone call from Des (Stumpf)," says Van Wulven. "It was really an appeal, saying 'Help, our hospital is in trouble, can you people do anything?'"

"When we got there, we found him to be the only doctor working in this massive hospital. One thing led to another.

"We saw an opportunity where we could possibly help."



**PUTTING DEED TO THE WORD:** Lions Club members Richard Hayman (second from left) and outgoing Lions Club Groote Schuur president Alan van Wulven (third from left) help to load a crate of tomatoes into a bakkie headed for Rainbow Educare Centre in Guguletu. With them are (from left) driver Solani Femela, Pieter van Heerden, Mwonke Mkoko and Bazoya Mtini, 13. The Lions food project has been operating for approximately 27 years and is currently annually providing foodstuffs to over 1,7 million people. It operates in the southern suburbs and northern suburbs. Recipients include creches, schools, church groups, soup kitchens, homes and institutions serving underprivileged and needy communities.

PICTURE: GARTH STEAD

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"These have not been adequately inducted due to service pressures and so have required extra supervision, creating increased work and decreased morale."

Many nurses perform duties beyond their scope of practice. Four staff members were medically boarded during the year and another awaits medical boarding by the end of the year. A few simply resigned.

When the *Cape Times* visited the hospital, staff said they were discouraged from taking the retrenchment package; management on the other hand point to the scarcity of staff and ask from where they are to recruit additional staff if the haemorrhaging continues at the present rate.

"In every instance management has made strenuous efforts to fill the vacated posts," the report notes. "The rules and procedures for filling posts changed frequently through the year, thwarting these efforts."

This culminated in the "Friday 13 June" cancellation of all vacant posts, in which posts which had been hard fought for but not yet filled were abolished.

Equipment is also sorely needed. It is this desperate scenario that drove Stumpf to contact the Lions service organisation to help lift the hospital out of its quandary.

With its motto "We serve", the objective of Lions International is to promote good government and good citizenship, encouraging service-minded people to serve their community.

Stumpf first came into contact with the Lions Club of Groote Schuur when they were involved in Operation Bright Sight, which facilitated eye tests and provided spectacles for needy residents, providing a R30 subsidy towards the R50 cost, R20 of which is provided by the patient.

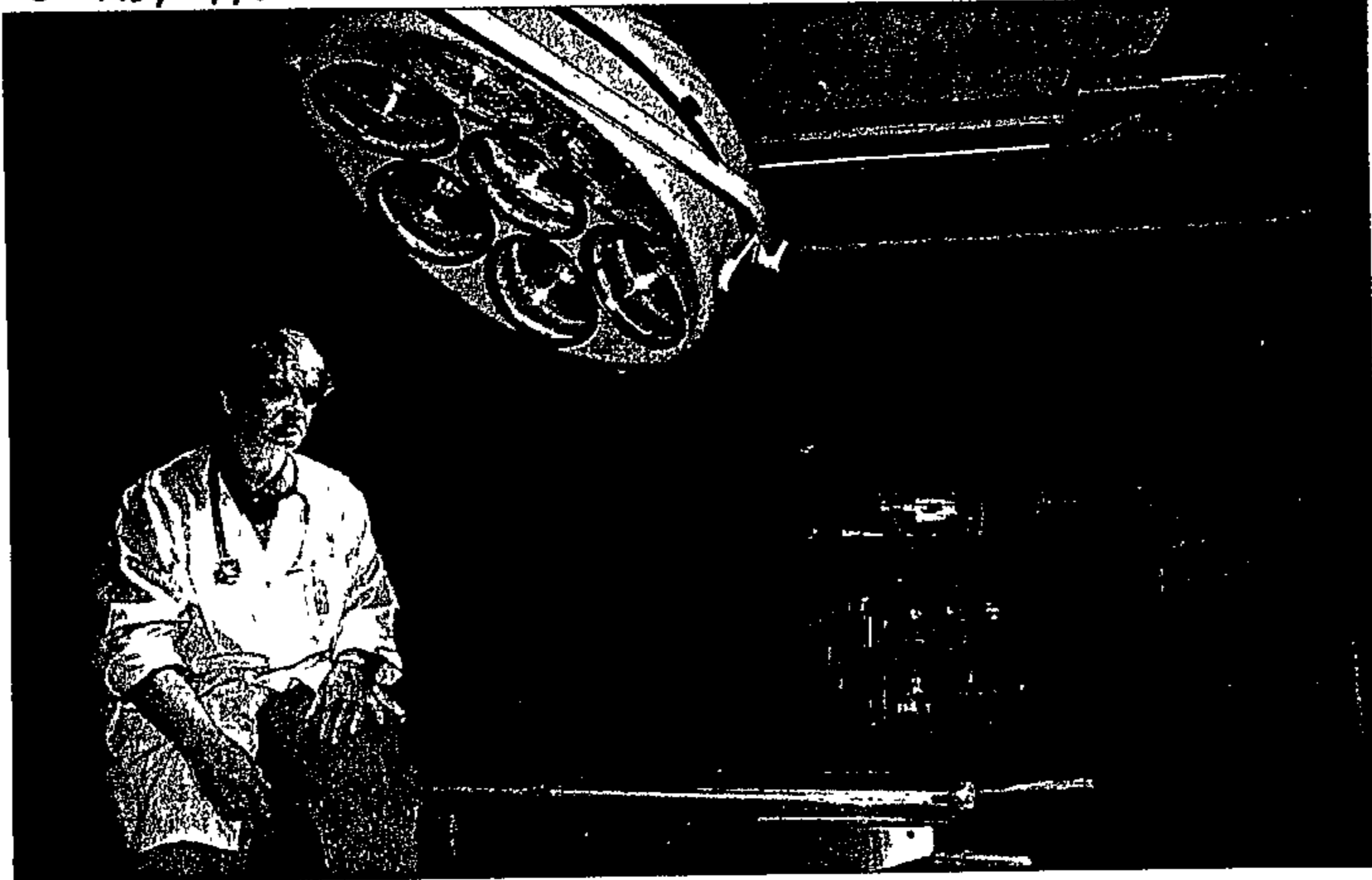
"Through that contact I asked them if they could please have a look at the hospital," said Stumpf.

Outgoing Lions Groote Schuur president Alan van Wulven and fellow Lion Ingrid de Klerk travelled to the hospital one night to experience its predicament first-hand.

"I got a phone call from Des (Stumpf)," says Van Wulven. "It was really an appeal, saying 'Help, our hospital is in trouble, can you people do anything?'"

"When we got there, we found him to be the only doctor working in this massive hospital. One thing led to another.

"We saw an opportunity where we could possibly help."



**FORLORN:** The expression on the face of duty doctor Kris Georgieva mirrors the dire conditions at the crumbling Wesfleur Hospital in Atlantis. The operating theatre has been closed for two years.

PICTURE: KIM LUDBROOK

Only limited assistance has so far been possible, such as trying to bring the services of the Lions' Medic Alert campaign to the hospital as well as providing blankets, but says Van Wulven, the hospital's needs are "far bigger than just what our club can manage".

"My feeling is that even if all Lions put their money into the hospital it will never fill the gap. It is a massive project, so if we can do just a little bit to help, well, we're there."

Committees are being set up to tackle the project and fund-raising is being planned for the near future.

Stumpf has also been asked to draw up a wish list so that the organisation can get cracking on the hospital's immediate needs

Said Van Wulven: "Your health is your most important asset, so many of the Lions projects revolve around the principle of providing service that will help practically."

His colleague and Goodwood Lions president Clive Fox has been doing international fund-raising and promotion projects for 10 years with Lions organisations all over the world.

Through his effort, the wish list has been included in an aid application and sent overseas.

Fox hopes that he will be able to persuade two American relief agencies to repeat the success they scored last year in supplying medical equipment to the Border Institute of Health in East London.

"It was of considerable value and two Lions clubs picked up the cost of bringing in the equipment. It went primarily to clinics in the Border area; tens of thou-

sands of people have been assisted by that equipment."

Both relief organisations have now been asked if they would be willing to supply the equipment necessary to meet Wesfleur's needs.

In both cases, some funding will be required locally and free clearance and shipping costs will have to be arranged.

The success of the project, however, depends on the availability of equipment.

"We are just one of many applications they get and they must now determine whether they are in a position to help us. But we will have to come up with some kind of sponsorship contribution ourselves

anyway."

Fox said the advantage of involving an organisation like Lions is that it is an international association with many contacts worldwide.

"The point is that as an individual there's a limit to what I can do, but once I belong to an association where its members cover every conceivable form of employment you can think of, I can become all-powerful because the team can work wonders."

Jeannie van Wulven, spokesperson for the Lions' 64-chapter Cape Town district, which reaches as far Windhoek, says that with the Wesfleur appeal it was realised that "we have to do something about the hospital service in general".

"The point is that the government doesn't have the funds, so that's why we as a service organisation are taking a more serious interest in Wesfleur. We want to develop a long-term involvement with the hospital."

For his part Stumpf and his dedicated

staff, immensely grateful for the Lions efforts, are trying to organise a fund-raising event, with a government dignitary as guest, at which memorabilia of sporting greats will be auctioned.

"My appeal is that we obviously need the funds. When you ask for manpower, the manner in which you get it is not sustainable.

"People from their altruistic motivations say 'yes we'll help' but we can't work out something where they can be permanently engaged all the time.

"And, what's more — the community of Atlantis is traumatised.

"It's enough for them just trying to survive on their own. They've got no money for things like fund-raising, so it's like a losing battle you fight in the end.

"With the funds we can at least get the equipment that we require."

The most immediate priority, however, is to ensure the 25-bed ward, closed for a long while now, is opened. Stumpf and his staff are confident they will be able to demonstrate to the authorities that they are able to run it economically by reducing the unnecessary R600 000-R700 000 a year it costs to ferry patients by ambulance to Somerset Hospital.

Asked what he most wanted other Capetonians to know about Atlantis, Stumpf said without hesitation: "That there's a disaster here in this town; it's an explosion just waiting to happen."

He said the fortunes of the town are directly related to the state of its industry. "And if it's shrinking at the rate that it is, how are these people going to live?"

● Those wanting to help boost the Wesfleur Hospital relief effort should contact:

Alan van Wulven on (021) 930-4046 (a/h); Jeannie van Wulven on (083) 305-0424; or Clive Fox on (021) 559-1440 (home and business).

*"Once I belong to an association ... I can become all-powerful because the team can work wonders."*



# Hospital union in conflict after walkout

Reneé Grawitzky

(98) (48)

THE Hospital Personnel Trade Union of SA faces a possible split after five of nine regions walked out of its national congress on the weekend amid claims of racism and a leadership battle.

Union sources said the congress was disrupted after a vote of no confidence was taken against the current union leadership. The leadership disputed this and said the congress was disrupted by four, mainly black, regions which had lost a vote by a wide margin.

"This minority faction originates from the Lebowa Action Committee

and favours radicalism."

The sources said tensions had been building up ahead of the congress after the union's former vice-president David Tsheola was forced to resign. He had gained support from the four, mainly black regions.

The union said the four regions had tried to create the erroneous impression the leadership was still white.

The union said the congress was forced to close after the five regions walked out as the constitution required that a quorum include six regions. The union will have to reconvene a congress within eight weeks.

BD 28/10/98



# Ambulances: red lights flash

(98)  
*Last day for chief, No 2*

SHARKEY ISAACS  
STAFF REPORTER

## The crisis in Cape Town's ambulance service has deepened.

Yesterday its chief, Greg Pillay, and his deputy, Cyril Leeuwendaal, left the service, but staff learnt with dismay that no one had been appointed to replace them.

Mr Pillay is to become the City of Cape Town's disaster manager on Monday and Mr Leeuwendaal has opted for early retirement, along with about 50 colleagues.

Uncertainty over who will run the service in future and a change in the rules of the Cape Town municipal pension fund appear to have prompted the resignations.

But last night, director of the city's uniformed services Alan Dolby announced that Mr Pillay had been asked to carry on at the helm of the ambulance service until a replacement was found.

"Obviously Mr Pillay will not be entirely withdrawn from the service and will be working closely with staff in his new portfolio," said Mr Dolby.

Yesterday Mr Pillay told a farewell reception for 30 staff that the exodus would leave a void that would be difficult to fill.

"Emergency medical services is a distinct discipline with specialist training and development. Experience and expertise cannot be attained overnight. We are worried that so many trained personnel are leaving at once.

"Notwithstanding these circumstances, I wish to thank all these people for their many faithful years of dedicated service and devotion in caring for

and transporting the sick and injured, the core function of this organisation."

He handed long-service certificates to staff and plaques to personnel with more than 20 years' service.

Staff said they were concerned about the simultaneous departure of both senior executives. One said: "It's like a ship at sea losing its captain and first mate in a storm."

Embattled staff say Cape Town is heading for a crisis in the busy summer season.

The ambulance service in greater Cape Town was already stretched because of insufficient staff.

Already the service was being run on shifts and overtime and the system suffered when staff declined to work extra time or were off sick.

On some days the standard 24 vehicle fleet was reduced to 20, 16 or even 10 ambulances to serve the entire city.

Answering questions, Mr Pillay told staff that 53 members had resigned and 41 new people appointed, 15 of whom had not had any emergency service training.

He emphasised that ambulance and rescue personnel were resigning to take advantage of the new pension deal.

He confirmed the section hardest hit by resignations was the ambulance service.

Metro emergency services founder and former chief Allan MacMahon said he believed the city's metropolitan ambulance division was the best in the country.

He believed that a privatised ambulance service would not work because profit would be a priority and many people could not afford to pay for ambulances.

ARG 30/10/98



# Health dept 'will recover money'

(98) Sowetan 4/12/98

By Charity Bhengu

**T**HE Gauteng health department, which is owed R4,25 million by foreign governments for the treatment of their patients in state hospitals, said yesterday the debt would be recovered within the next month.

Department chief director Dr Trevor Frankish said contrary to the impression created by the media, the matter of the outstanding amount did not constitute a crisis.

"No cognisance seems to have been taken of the millions of rands already paid by these foreign governments for services rendered over many years," Frankish said.

Over two years about 871 foreign patients were treated at Chris Hani Baragwanath, Johannesburg, Garankuwa and Pretoria Academic hospi-

tals by arrangement with foreign governments at a total of R9,6 million.

Kenya still owes R746 000 and Botswana R1,5 million. Mozambique, Zambia and Angola owe about R475 000 each.

Swaziland owes R310 000 and the Democratic Republic of Congo owes R277 000.

Democratic Party Gauteng health spokesman Mr Jack Bloom said every effort should be made to recover the outstanding amounts.

"There is no reason why such patients should not be treated in the private sector," Bloom said.

Gauteng health spokesman Mr Popo Maja said the DP was not interested in the humanitarian aspect of health but only in profit making.

"It is in extreme bad taste for the DP to suggest that foreign patients should be sent to private hospitals

when they lack necessary resources and expertise," Maja said.

He said that a policy that stipulates that costs be paid in full by foreign governments before patients were admitted "would be enforced on non-emergency cases only".

"The policy had always been there but for humanitarian reasons we could not turn people away because they had no money," he said.

Pan Africanist Congress spokesman Mr Ngila Muendane said human life was more important than money.

"It is a Western mentality to turn people away because they have no money," Muendane said.

African National Congress spokesman Mr Thabo Masebe said: "Even if the hospitals were crowded, it would be insensitive to turn foreign patients away."



## List drawn up to ensure public hospitals stock basic drugs

Star 4/12/98

(98)

A list of cheaper, alternative drugs that all public hospitals and clinics are obliged to keep in stock was launched by Health Minister Nkosazana Zuma in Pretoria yesterday.

"The list was drawn up with a view to ensuring the availability of medicines to the majority of South Africans at affordable prices," she said in Pretoria.

"Drugs that are on the list will always have to be in public clinics and hospitals, but drugs that have not been listed will not be banned from the country," Zuma said.

The Essential Drug List (EDL) names 693 medicines which can be used to treat most

of South Africa's common health problems, according to EDL committee chairperson Patrick Mokhobo.

A statement released at the launch said the list was drawn up based on World Health Organisation guidelines.

Drugs included on the list were those found to be the cheapest, the best researched, and those produced by the most reliable local manufacturer.

Mokhobo said the list would be updated regularly in response to new diseases. Zuma said there was a huge market for South African-made drugs because they were cheaper but still of a high quality. - Sapa



# Equipment 'could endanger patients'

Pearl Sebolao *BD 4/12/98 (98)*

AN ARRAY of condemned and defective hospital equipment that could pose a danger to patients and staff was still in use in Gauteng hospitals, the provincial health department has admitted.

It would cost the province an estimated R24m to replace the condemned equipment — which includes ventilators, dialysis machines, x-ray systems and monitors which are an electrical hazard, the department said in response to questions from the Democratic Party (DP) in the legislature.

The Pretoria Academic Hospital was the worst affected, with 11 pieces of defective equipment that needed to be replaced at a total cost of R9m. Kalafong and Garankuwa hospitals need R8m and R6m respectively for new equipment.

Other affected hospitals were Johannesburg and Yusuf Dadoo, near Krugersdorp.

DP health spokesman Jack Bloom said the use of some of the substandard equipment could lead to patient fatalities. "It is absolutely shocking that condemned equipment that is a danger to staff and patients is still in use," Bloom said.

He called on the provincial health department to institute urgent steps to rectify the situation. He suggested this be done through leasing arrangements or partnerships with the private sector.

Gauteng health spokesman Popo Maja said the department could not readily replace the worn-out equipment as it was subject to financial constraints.

Maja said that funds that had been earmarked for capital expenditure had been frozen and redirected to other projects, such as services. However, the department had already instituted "a thorough situational analysis as far as equipment is concerned and critical areas will be attended to as the situation develops".

He said the department would concentrate on the replacement of equipment which was crucial to the running of the hospitals.



# Bara probe reveals (98) poor management

By Charity Bhengu

GAUTENG health MEC Mr Mondli Gungubele conceded at the weekend that there were problems at the Chris Hani Baragwanath Hospital regarding the supervision of junior staff.

This follows claims by former senior superintendent Dr Bokkie Rabinowitz that 21 patients may have died because junior doctors were unsupervised during surgery.

"To a certain degree there is a basis for concern about the problem of consultation with and supervision of junior staff," Gungubele said. "But we are careful about how this may have contributed to the death of each patient. We would prefer the relevant medical councils to decide on that."

The matter has been referred to the Medical and Dental Council for inde-

pendent scrutiny.

"It is my intention that all necessary actions be taken, be it against the institution or against individuals."

In July, *Sowetan* reported on claims by Rabinowitz about deaths due to negligence at the hospital.

## Investigated the claims

A committee under the chairmanship of Professor Taole Mokoena investigated the claims. The findings have not yet been made public.

Gungubele spent two days last week investigating the hospital's administration and management systems.

Addressing a press briefing on Friday he said: "The hospital's management leaves much to be desired."

Gungubele said there was serious cause for concern about sub-standard

medical care and the failure and absence of senior surgical supervision.

Gauteng health spokesman Mr Popo Maja said only 25 percent of Rabinowitz' claims were true. The rest were unfounded.

"In as far as the breakdown of communication between doctors and nurses is concerned there was a case. But this was not disclosed by Dr Rabinowitz anyway."

Regarding poor administration and management of patients, Gungubele believed Rabinowitz had a case.

Gungubele said the disclosure had made them realise that the hospital's management needed to be revolutionised.

"I am not opposed to whistleblowing but I will not allow people to talk about untested things," he said.



Gauteng health MEC Mondli Gungubele feels the province's hospitals leave much to be desired.

PIC: CLEMENT LEKANYANE



# Bara's state of management 'is shocking' <sup>Sowetan 9/12/98</sup> (98)

By Charity Bhengu

TOURING Chris Hani Baragwanath Hospital in Soweto last week was like running a marathon, said Gauteng health MEC Mr Mondli Gungubele at a media briefing afterwards.

Before addressing the media, Gungubele slumped into a chair and said media reports about people dying at the hospital prompted him to "get into the works of this hospital"

He spent time at Bara and Johannesburg hospitals after reading a report in a weekend newspaper about two infants who allegedly died because of negligence.

He was also perturbed by *Sowetan's* report that 21 people allegedly died because junior doctors were not supervised during surgery at Bara.

"Yet this is not only about Bara; but about the overall management of our entire health system," Gungubele said.

Before he visited Bara, he also went to Natalspruit and the Far East Rand hospitals. "All the hospitals I visited leave much to be desired when it comes to management," he said.

## 'Disappointed'

Gungubele said the main purpose of visiting Bara — a 3 400-bed hospital which admits about 275 000 people a year — was to check the systems, regulations and controls in place at the hospital.

Accompanied by a task team Gungubele interviewed the staff, nurses, doctors, staff in allied professions, trade union officials and members of management for two days.

"I was disappointed by obvious problems such as chaos in the laundry department and bad management. There is no system for laundry in this hospital and this impacts badly on the dignity of patients."

Patients who did not bring their own bed linen to the hospital were reduced to sleeping on plastic mattress covers, he said.

"I will send the acting deputy director-general in charge of administration, Ms Letitia Rispel, to check on the laundry."

He said that he expected a report in a week's time on "why this has been allowed to happen and what will be done to turn it around".

But, despite the negative aspects of the hospital, Gungubele pointed out that there was a significant number of dedicated staff at Bara. "Without them,

the worst could happen. The danger is that good doctors, nurses and technicians will lose morale because of poor management."

Once he receives the findings of the report on Bara, Gungubele plans to invoke Section 17 of the Public Services Act to determine whether some staff members were incapable of carrying out their duties.

In terms of Section 10 of the Act, if officials were found to be unfit or incapable of doing their work efficiently, they could face being transferred, discharged or reduced in salary.

"We are not talking only of inefficient systems; we are talking about individuals as well. I have found that some officials in management have been negligent."

## Common complaints

Linked to the management system, one of the most common complaints of staff was their workload. This was a legitimate concern, Gungubele said, with two nurses sometimes attending to 50 to 60 patients in a shift.

"The problem is probably magnified by bad management and should be addressed in conjunction with an effort to improve their workload." However, he did admit the huge impact of staff cuts on the hospital.

Another problem he found at Bara was a lack of communication between nurses and doctors.

"It is a deep-seated problem clouded by the legacy of apartheid, which granted white doctors supremacy over black nurses."

He argued that the minimum safety of patients could only be guaranteed if nurses and doctors applied a multi-disciplinary approach, which respected each other's professional autonomy.

"For us to consciously allow the breakdown of doctor-nurse communication is criminal. Only a complementary principle will succeed."

He announced that plans would be developed to manage hospitals. Among these would be an amendment to the province's hiring procedures.

Hospital superintendents under the new plans would no longer require a primary background in medicine but would be selected for their management skills.

"We cannot allow Bara to control an annual budget of R500 million without conventional management structures."

Gungubele will visit Tembisa Hospital next week.



# Strikes at Netcare likely to 'escalate'

(98) (P) CT (OR) 11/12/98  
**ADELE SHEVEL**

Johannesburg — Strikes at Netcare, South Africa's largest private hospital group, would "escalate next week when we continue the pressure", Albert Wöcke, the assistant general secretary at the Hospital Personnel Union of South Africa (Hospersa), said yesterday.

But discrepancies abounded as Peter Warrener, Netcare's human resources director, said what was touted as a national strike ended up being "isolated events", with only 13 administrative staff taking an active role.

The dispute revolved around yearly wage increases. Netcare had put forward an increase of 8,5 percent, while union members were demanding a 9,5 percent rise.

"We believe the offer is good given the economic climate," Warrener said.

Wöcke said the action had been boiling for the past three years. Yesterday, it ranged from a series of short work stoppages such as "grasshopper strikes" to go-slows to general disobedience.

Wöcke said the union had to build confidence of members, some of whom had been intimidated.

Warrener said the dispute could not extend to other hospitals because the union represent-

ed administrative staff of only seven of the 35 hospitals within the group.

The union claimed they had been "recruiting like mad", and sympathy had been expressed from the nursing staff in one of the hospitals.

Wöcke said 300 union members had been involved nationally through six hospitals in four provinces.

"The irony is that the union negotiated with us recently over the same increase with regard to the nursing staff, which they settled," Warrener said.

Wöcke said the increases in this regard included an adjustment in the nurses' minimum salaries.

"This was not the case with regard to the administrative staff, who have been given a raw deal," Wöcke said.

"The effect has been minimal, and there has been no negative effect on any of the hospitals," Warrener said.

Although Wöcke said replacement labour had been taken on board, this was refuted by Netcare.

Hospersa is the biggest union in Netcare, with about 3 000 members. It represents about 76 000 hospital staff, mainly within the public services sector.

Netcare closed up 1c at 72c on the JSE yesterday.



DAVID MARCUS GORE, a British doctor, describes the horror of work:

# Descending into the

(98)

**C**hris Hani Baragwanath Hospital is the biggest in the world, with 3 200 beds. Even in South Africa it is infamous for being a rough place to work.

In the white northern suburbs of Johannesburg the beleaguered citizens are fixated by stories of Bara and violence in Soweto. It's like their worst nightmare - the barbarians at the gate.

Black people tend to be more reflective. Soweto still has a central role in the black South African psyche as the epicentre of the Struggle, the anvil on which the nation was forged. Thus tales of my job at the hospital would provoke much speculation about problems facing the new South Africa: crime, violence, ignorance, alcoholism and unemployment.

The main surgical action in Bara is in the "pit", the surgical casualty department. Structurally it is falling apart at the seams and when busy it's a special circle of hell. Interns and registrars mill around, tending to the great unwashed. Gunshot wounds and other assaults are the stock-in-trade.

The wounded are brought in by ambulance, minibus taxi or private cars and laid on ancient red trolleys. If they are badly injured a red "urgent" sticker is slapped on their foreheads lest we forget about them. If they are really bad they are wheeled at speed into the resuscitation room en route to the theatre or the mortuary. "Resus" can get very excited on a Saturday night or any day near the end of the month, when salaries are paid and liquor flows freely in the townships. It's not a place for the faint-hearted.

I suppose many people's images of trauma in hospital are shaped by the American television series *ER*. The surgical pit at Bara has all the excitement of *ER* but beats it hands down when it comes to numbers and grossness. Moreover, the recurring theme of *ER* is one of care and commitment. The recurring theme in the Bara pit is one of weariness, cynicism and indifference. Compassion is absent.

I had been told about the horrific injuries but I was unprepared for this. The black community here may be good at looking after their young and old, but they demonstrate precious little concern about each other's physical suffering.

At first I was amazed at how the patients can suffer: rarely do they groan and they never complain. They would be unwise to try for sympathy. The nursing staff, wholly black, does not tolerate whingers. These are tough people.

Privacy and dignity are in short supply. Patients are examined where they lie. Communication skills, now fashionable in medical schools, take on a new meaning



**CIRCLE OF HELL:** gunshot victims receive treatment at Chris Hani Baragwanath. Advice given to patients is blunt: 'If you don't want an operation...

when you are faced with patients who are uncomfortable speaking anything other than Zulu or Sotho and who associate interrogation by a white official with the police. Inevitably the finer points of the doctor-patient relationship are lost. "Yebo baba! Is it paining? Kubunhlungu kuphi? My friend, we must put you to sleep and cut you, from here to here."

The patient is too spaced out to sign a consent form, but their inked thumb is applied to the sheet of paper anyway.

Advice given to a reluctant patient is blunt: "Baba, without the operation you die. Understand? If you don't want the operation you

hamba kaya (go, home) right now."

Sometimes it all gets too much and tempers fray. For example, Easter Sunday was bedlam: three patients had died on the operating table by six o'clock that evening. One of my senior colleagues would lay into the gunshot victims as they were wheeled in: "Did you get that going to church, baba? Did you have a nice Easter, my friend?"

The most abject cases are those shot in the head. The patients are brought in comatose; we intubate them with a tube in their airway and leave them to die. There's nothing to be done. The neurosurgeons don't even bother coming to see them.

Gunshot wounds to neck, chest or abdomen are often much more challenging. There's nothing quite like a badly injured patient to concentrate the mind. Patients with stab wounds to the heart occasionally need to have their chests opened by a surgeon there and then in a ghoulish orgy of blood and chaos. Alas, stab wounds are old hat in Soweto: any self-respecting tsotsi carries a gun nowadays.

The "blunt" trauma of road-traffic accidents is much in evidence as well. People continually wander into the path of the ubiquitous minibus taxis. Perhaps it's because there aren't many footpaths in the townships, just dirt roads.

I came to hate these wretches with their faces and limbs as they hours spent on them to out, splinting limbs, cross blood, placing chest-drain ing X-rays from surly and arranging brain-scans

Gunshot abdomens were comparison: you wouldn't the victim to theatre, gas always a him), open him. look. With 15% of the HIV positive, one has to where one puts one's scalpels.

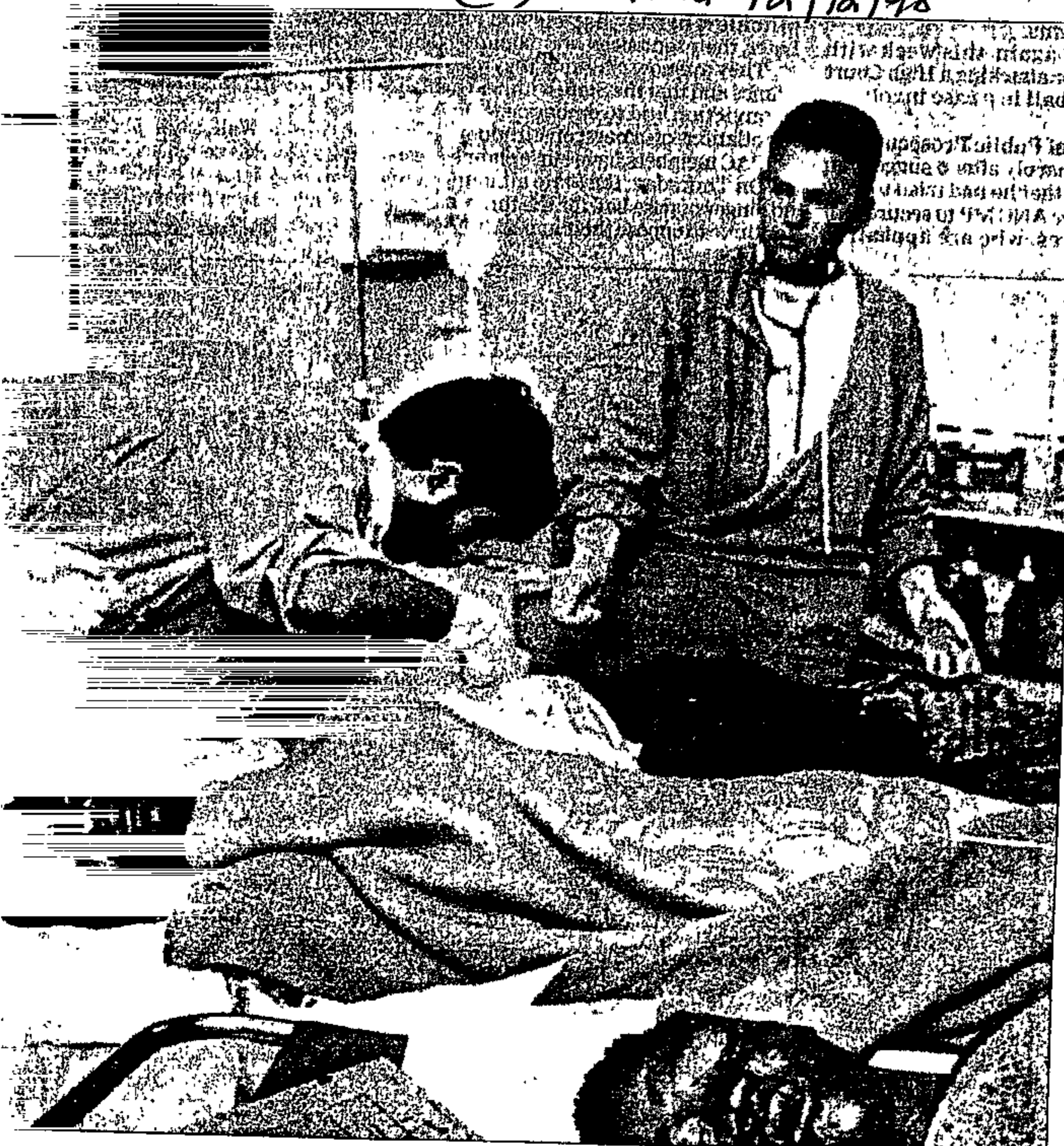
The smell of liquor on the ambient aroma when pumping. These black h



lor, describes the horror of working in the world's largest hospital

# g into the Bara pit

(98) ARG 12/12/98



strained or non-existent. The surgical registrars generally hail from countries whose public health services are even rougher than that of South Africa.

Nearly all my colleagues imagined the British National Health Service to be a scriptural promised land. About one-third of the surgeons come from Bangladesh and Pakistan, one-third from the rest of Africa and the rest from here and there, including quite a few from eastern Europe and a small number of voyeurs, like myself, from western Europe.

On the other hand, the anaesthetic department is wholly white and wholly South African. These white supremacists viewed us as the flotsam and jetsam of the world of surgery, and despite the colour of my skin I was tarred with that same brush.

Anaesthetists and surgeons have differences of opinion the world over, but here the appalling rapport was truly a wonder to experience. It was as if we worked in different dimensions: we would get through a three-hour operation without the slightest social pleasantries.

I found working with the nursing staff in the pit and on the wards quite difficult at first because a lot of them don't work very hard. It is a paradox of the hospital that one can get a state-of-the-art cat scan, but patients can quietly expire for want of basic nursing observation at night-time.

There's a favourite northern suburbs joke to which tourists are subjected: what's the difference between a tourist and a racist? The answer, inevitably, is two weeks.

Twisted as this might sound, as I worked with some black nurses who ignored me and manifestly couldn't care less about their charges, and as I dealt with a sullen, mute and violent clientele, I wasn't far off illustrating that cliché myself. It was only through meeting some splendid doctors from the rest of Africa, working with the odd diamond of a nurse and seeing through to the basic humanity of the patients that I escaped that fate (I think).

It is said that life is cheap in Africa. As a generalisation this is untrue, but there's no doubt that life isn't at a premium in Soweto.

Did I become brutalised by the carnage? A little. Did I enjoy my spell at Bara? Yes, I did, but it wasn't all plain sailing. Would I recommend it to another? Yes, but not blithely.

Certainly it was the most memorable year of practice I have ever had. Hospitals come and go, but it will be a long time before I forget the smell of the Bara pit on a Saturday night.

■ This article was published in the British magazine the Spectator

gwanath. Advice given to patients is blunt: 'if you don't want an operation, go home now.'

Gunshot wounds to neck, chest or abdomen are often much more challenging. There's nothing quite like a badly injured patient to concentrate the mind. Patients with stab wounds to the heart occasionally need to have their chests opened by a surgeon there and then in a ghoulish orgy of blood and chaos. Alas, stab wounds are old hat in Soweto: any self-respecting tsotsi carries a gun nowadays.

The "blunt" trauma of road-traffic accidents is much in evidence as well. People continually wander into the path of the ubiquitous minibus taxis. Perhaps it's because there aren't many footpaths in the townships, just dirt roads.

I came to hate these hapless wretches with their smashed-up faces and limbs as they would need hours spent on them to sort them out, splinting limbs, cross-matching blood, placing chest-drains, requesting X-rays from surly radiographers and arranging brain-scans.

Gunshot abdomens were easy by comparison: you would simply take the victim to theatre, gas him (it's always a him), open him and have a look. With 15% of the patients being HIV positive, one has to be careful where one puts one's needles and scalpels.

The smell of liquor on breath is the ambient aroma when the pit is pumping. These black blokes can

certainly drink and fight - I thought the Irish were good at it until I came here. All sorts of misery has alcohol at its root. Imprinted on my mind is the sight of the drunk who fell asleep on a railway line and had both legs severed at the knee. When the ambulance fetched him he still had his bottle of Klipdrift brandy in his hand. He made it, but what a nightmarish hangover he had.

It took me two months until I really started to get a grip on what Bara was really all about and what people's expectations actually were. Never have I worked in such a hostile and unpleasant atmosphere. Relationships with medical colleagues from other specialities are



# Law will allow for hospitals overhaul

Pearl Sebolao

(98)

BD 17/12/98

NEW legislation aimed at revamping the management systems in Gauteng hospitals would be tabled in the provincial legislature early next year, Gauteng health MEC Mondli Gungubele said this week.

According to the proposed legislation, hospital superintendents would no longer be required to have a primary background in medicine, but would be selected for their management skills.

"Medical background has little to do with the running of hospitals. It is about the economics of the hospital — the management of human and financial resources," Gungubele said.

He said the need to develop management capacity remained a serious challenge for the department.

The department employed 48 000 people and had a budget of more than R5bn.

Gungubele, who recently toured Gauteng hospitals to assess management practices and standards of care, said that management at most of the hospitals "left a lot to be desired".

He threatened to invoke section 18 of the Public Service Act which made provision for officials to be transferred or even discharged from the public service if they were found to be unfit or incapable of carrying out their duties efficiently.

Asked whether the new law would mean large-scale replacements of superintendents, Gungubele said the health department could have created "a new post of CEO over and above the ones we have now". Alternatively, CEOs would be appointed as positions became vacant. He did not, however, rule out the possibility of replacements.

The department also planned to prioritise the creation of new hospital boards during the next six months to ensure accountability to the communities they served. Two hundred new board members would be confirmed by the end of January.

The department also wanted to fast-track the creation of the district health system and to consolidate the promotion of HIV/AIDS awareness. It would hold breakfast meetings to get support from sports clubs, artists, and nightclub and brothel owners.



# Zuma gets taste of her own

## Minister of Health sees the effects of her cutbacks when her brother

(98)

XOLISA VAPI

Senior medical staff at Durban's Addington Hospital are outraged by the actions of Health Minister Nkosazana Zuma, who charged past the security guards into the casualty section and allegedly demanded preferential treatment for her brother.

Incensed by what they called Dr Zuma's "excessive reaction" to the delayed and inadequate treatment she alleged was accorded her brother, staff are annoyed by the minis-

ter's complaints about the standard of staffing, considering her hefty budget cuts in health services.

Fears are rife that heads may roll following the ordering of a special inquiry into the incident by Kwazulu Natal's health department.

Dr Zuma's brother, Malusi Dlamini, was brought to the hospital by ambulance about 9.30pm on December 5 after having an hour-long epileptic fit. Because of staff and bed shortages, and the fact that there were other patients who had come before him, Mr Dlamini was put in a

stretcher bay while awaiting the attention of the casualty officer.

About 45 minutes after Mr Dlamini's arrival, Dr Zuma allegedly "stormed" the casualty section after gaining access through the patient entrance. A scuffle broke out between her and a security guard at the entrance point after she allegedly refused to be subjected to hospital regulations which prohibit non-accident and ambulance personnel from entering through the back door.

Dr Zuma also took exception to a "white female doctor" who was

allegedly berating "two Indian male persons in an unacceptable fashion".

However, a committee of hospital specialists reported that the argument was between a nurse and two presumed relatives of a patient "who had been discovered stealing considerable quantities of provincial medical goods".

In a written account of the event, medical duty officer Dr K Moodley said she was busy with a patient who needed resuscitation when she was informed that Dr Zuma wanted to

speak to her about her brother.

In her response, Dr Moodley said: "I was the only doctor on duty. The patients were prioritised by the sister on duty. I would probably see him within the hour if no further emergencies arrived. Dr Zuma then asked me what would happen if Mr Dlamini had a fit in the interim. I replied that the two nurses were constantly observing all the bays and that should he have a fit, we would all respond immediately to abate another seizure. Dr Zuma then left the department."

## is admitted to hospital

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The Addington Hospital committee also expressed its displeasure that Dr Zuma was passed information about her brother's condition, saying it constituted a breach of patient confidentiality. The leaked information regarded "diagnostic consideration... given to the small possibility that alcohol had contributed to the patient's seizures".

Dr Zuma is said to have been "perturbed" after learning of the alcohol test from Kwazulu Natal health secretary Professor Green Thompson a day after it was conducted.

However, the committee defended the alcohol test, saying not to have done so would have been clinically negligent. It maintained that "there were good and sound clinical reasons to at least consider the possibility that alcohol had played a part in the genesis of the patient's seizure".

Provincial health communications director David McGlew said the inquiry would decide whether Dr Zuma qualified as Mr Dlamini's next-of-kin and was therefore entitled to be informed about Mr Dlamini's health status.

# Medicine



# Soweto club cleans up Bara eyesore (98)

'The last time the floors shined was 10 years ago'

SHALO MBATHA

The casualty and surgical departments at the Chris Hani Baragwanath Hospital in Soweto have been given a much-needed facelift.

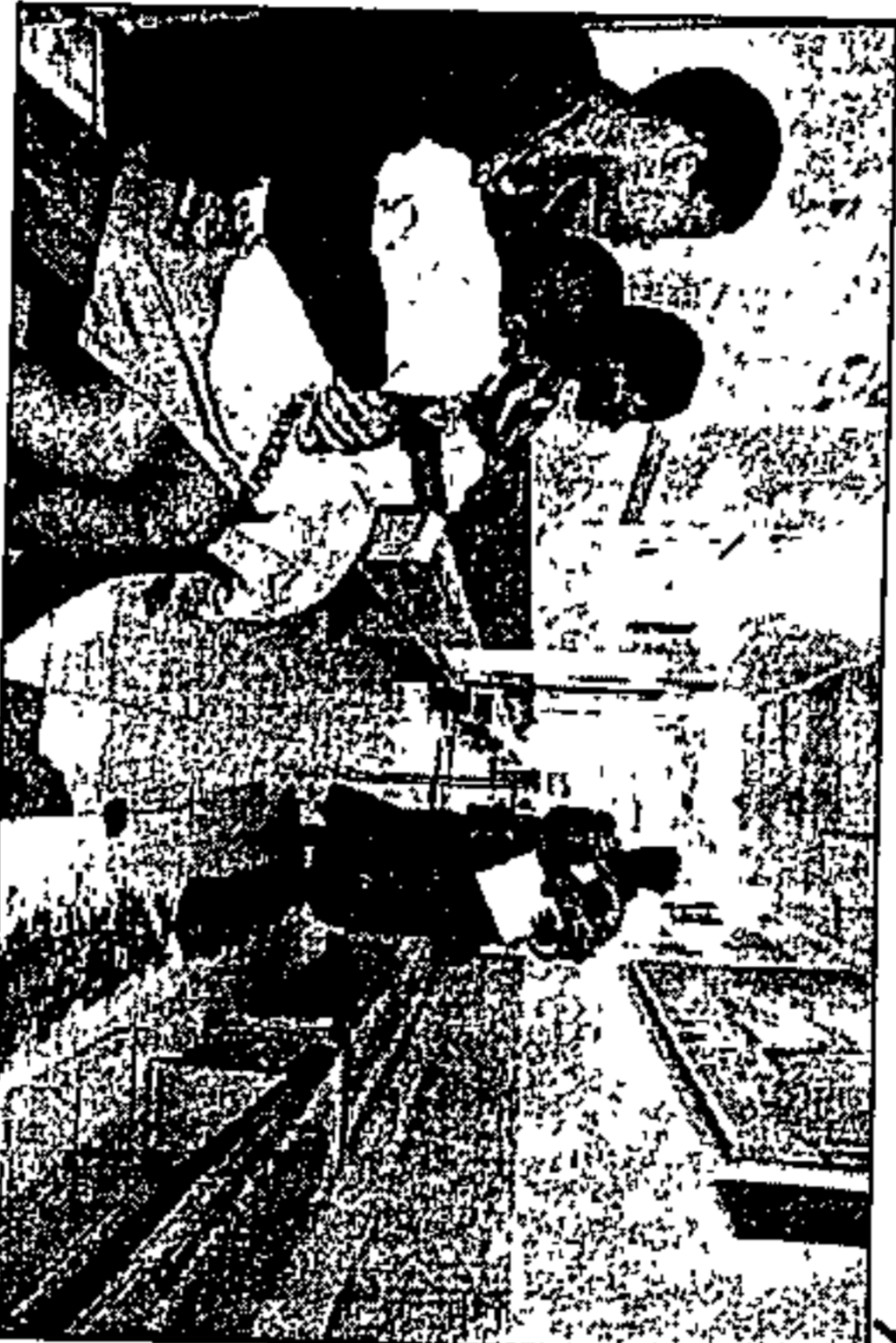
The revamp came courtesy not of the Health Department or the hospital authorities, but a concerned group of Soweto residents, who decided enough was enough and that their hospital was becoming a filthy eyesore.

Way Forward, a social club in Dube, approached sponsors to pay for the paint and cleaning materials, and then got stuck in at the hospital last weekend.

Tsidi Maisele, the sister in charge at Bara's casualty section, said she was stunned by the transformation. She said that in the 20 years she had been working at the casualty department, no one had ever volunteered to clean and paint the section.

She said she hoped other community organisations would follow suit. "Sadly, I cannot even remember when last casualty was painted, but the last time the floors shined like this was 10 years ago."

Why the community should have found it necessary to step in and paint the hospital is understandable, given the current squeeze on provincial and national health budgets. But why volunteers should have to carry out basic cleaning operations is not clear, especially since Bara has a large staff of cleaners and auxiliary workers, most of them members of the National Health and Education Allied Workers' Unions (Nehawu).



ANNOUS: ANNOUS mothers wait for their children to be discharged

Nursing staff, who spoke on condition of anonymity, said some nurses and doctors wear home to use the toilets because the hospital ablation facilities were filthy.

Joe Lekola, of Nehawu, said Bara was dirty because of shortage of staff.

"Bara is a very busy hospital. You can't expect it to be 100% clean all the time. The Government is also to blame because they claim not to have money to pay for cleaning materials. Our members cannot be held responsible for anything."

Members of Way Forward said they were struck by the degradation of a once-proud health institution and had bent over backwards to get the huge job done.

The social club, which started 10 years ago, includes bankers, mer-

chants, tavern owners, teachers, consultants, managers, accountants and artisans.

Sipho Moetsama, the club chairman, said: "We started off as a drinking club but over time we realised that there was more to life than that. We decided to do something positive for our own community as black people for a change."

"We chose the health theme because everybody is into housing and crime busting. However, no sick society progresses."

"We also realised that the health sector has the worst publicity and big business is not interested in donating into it because of Minister Nkomo's radical health policies and forthright character. But we love Bara and we are going to continue cleaning and painting

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other places that need attention."

The major sponsor of the clean-up was Soweto's Tshelo-Themba Private Hospital. Managing director, Peter Maisele said: "We are very proud to be associated with Way Forward because they took the initiative to paint and clean Bara."

"We are a private hospital situated in Soweto and are aware of the community needs in the health sector. I worked here for five years and I want to ensure that people who cannot afford private hospitals can be cared for in a healthy environment. I hope the Government appreciates the community effort."

Universal Cleaning Services, another sponsor, supplied the cleaning materials. Director Chris Billings said: "I've never seen such filth in all the history of this company. But we shall always lend a hand where necessary to keep our society healthy."

Sister Maisele said: "I'm sure the floors will shine for some time. My staff and I have decided to wear our white uniform for the next few days to complement these shiny floors."

Popo Mafa, of Gauteng's provincial health department said, Mofokeng Gungubele, the provincial health minister, appreciated the community's efforts.

"We hope other private hospitals will follow the standard set by Tshelo-Themba and meet the public health needs in a similar way."

He added: "As for the dirty toilets and filth in the hospital, those responsible will face the full force of labour law that will make them deliver services they are paid for."



DESPAIR: staff at Bara say working in the dirty conditions is difficult



**T**HE Chris Hani Baragwanath Hospital, situated at the edge of Soweto, is the biggest in the world, with 3 200 beds. Even within South Africa it is infamous for being a rough place to work. In the white northern suburbs of Jo'burg the beleaguered citizens are fixated by stories of Bara and violence in Soweto. It's like their worst nightmare — the barbarians at the gate.

Black people tend to be more reflective. Soweto still has a central role in the black South African psyche as the epicentre of the Struggle, the anvil upon which the nation was forged.

The main surgical action in Bara is in the "pit", the surgical casualty department. Structurally it is falling apart at the seams and when busy it's a special circle of hell. Interns and registrars mill around, tending to the great unwashed. Gunshot wounds and other assaults are the stock in trade.

The wounded are brought in by ambulance, minibus taxi or private cars and laid on ancient red trolleys. If they are badly injured they have a red "urgent" sticker slapped across their foreheads lest we forget about them. If they are really bad they are wheeled at speed into the resuscitation room en route to the theatre or the mortuary. "Resus" can get very exciting on a Saturday night or any day near the end of the month, when salaries are paid and liquor flows freely in the townships. It's not a place for the faint-hearted.

I suppose many people's images of trauma in hospital are shaped by the US television series *ER*. The surgical pit at Bara has all the excitement of *ER* but beats it hands down when it comes to numbers and grossness. Moreover, the recurring theme of *ER* is one of care and commitment. The recurring theme in the Bara pit is one of weariness, cynicism and indifference. Compassion is absent.

I had been told about the horrific injuries but I was unprepared for this. The black community here may be good at looking after their young and old, but they demonstrate precious little concern about each other's physical suffering.

At first I was amazed at how the patients can suffer: they rarely groan and never complain. They would be unwise to try for sympathy. The nursing staff, wholly black, does not tolerate whingers. These are tough people. Privacy and dignity are in short supply. Patients are examined where they lie.

Communication skills, now fashionable in medical schools, take on a new meaning when faced with dealing with patients who are uncomfortable speaking any thing other than Zulu or Sotho and who associate interrogation by a white official with the police. Inevitably the finer points of the doctor-patient relationship are lost. "Yebo babal is it paining? Kubunhlungu kuphi? My friend, we must put you to sleep and cut you, from here to here." The quality of informed consent given by the patient prior to surgery is variable. If a patient is too spaced out to sign a consent form, their inked thumb is applied to the sheet of paper anyway. Advice given to a reluctant patient is

# Guts and loathing in the pit of agony

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*DAVID MARCUS GORE, a surgeon who returned home to Belfast, Northern Ireland, recently after a stint at Baragwanath, describes the horror of working in the world's largest hospital*

blunt: "Baba, without the operation you die. Understand? If you don't want the operation you hamba kaya [go home] right now."

Sometimes it all gets too much and tempers fray. Easter Sunday was bedlam: three patients had died on the operating table by 6pm. One of my senior colleagues would lay into the gunshot victims as they were wheeled in. "Did you get that going to church, baba? Did you have a nice Easter, my friend?"

The most abject cases are those who've been shot in the head. The patients are brought in comatose; we insert a tube in the their airways and leave them to die. There's nothing to be done; the neurosurgeons don't even bother coming to see them.

Gunshot wounds to the neck, chest or abdomen are often much more challenging. There's nothing quite like a badly injured patient to concentrate the mind. Patients with stab wounds to the heart occasionally need to have their

chest opened by a surgeon there and then in a ghoulish orgy of blood and chaos. Alas, stab wounds are old hat in Soweto: any self-respecting *tsot-si* carries a gun nowadays.

The "blunt" trauma of road accidents is much in evidence as well. I doubt there was ever a Green Cross Code here; people continually wander into the paths of the ubiquitous minibus taxis. Perhaps it's because there aren't many footpaths in the townships.

*The most abject cases are those who've been shot in the head... the neurosurgeons don't even bother coming to see them'*

I came to hate these hapless wretches with their smashed-up faces and limbs as they would need hours spent on them to sort them out, splinting limbs, cross-matching blood, placing chest drains, requesting x-rays from surly radiographers and arranging brain scans.

Gunshot abdomens are easy in comparison: you would simply take the victim to theatre, gas him (it's always a him), open him up and have a look. With 15 percent of the patients being HIV positive, one has to

be careful where one puts one's needles and scalpels.

The smell of liquor on breath is the ambient aroma when the pit is pumping. These black blokes can certainly drink and fight — I thought the Irish were good at it until I came here. All sorts of misery has alcohol at its root. Imprinted on my mind is the sight of the drunk who fell asleep on a railway line and had both legs severed at the knee. When the ambulance fetched him he still had his bottle of Klipdrift brandy in his hand. He made it, but what a nightmarish hangover he had.

It took me two months until I started to get a grip on what Bara was really all about and what people's expectations actually were. Never have I worked in such a hostile and unpleasant atmosphere. Relationships with medical colleagues from other specialities are strained or non-existent. The surgical registrars generally hail from countries whose public health services are even rougher than that of South Africa. Nearly all my colleagues imagine the British National Health Service to be a scriptural promised land. About one third of the surgeons come from Bangladesh and Pakistan, one third from the rest of Africa and

the rest from here including quite a few from eastern Europe and a few of voyeurs, like western Europe.

On the other hand the plastics department is white and wholly different. These white surgeons viewed us as the jetsam of the world and despite the fact that my skin I was tarred with a brush. Anaesthetists are different on the world over, but the appalling rapport



**A SPECIAL CIRCLE OF HELL:** The casualty section





• The casualty section at the Chris Hani Baragwanath Hospital — 'not a place for the faint-hearted', especially on a Saturday night

the rest from here and there, including quite a few from Eastern Europe and a small number of voyeurs, like myself, from western Europe.

On the other hand, the anaesthetics department is wholly white and wholly South African. These white supremacists viewed us as the flotsam and jetsam of the world of surgery, and despite the colour of my skin I was tarred with that same brush. Anaesthetists and surgeons have differences of opinion the world over, but here the appalling rapport was truly a

wonder to experience. It was as if we worked in different dimensions: we would get through a three-hour operation without the slightest social pleasantries.

I found working with the nursing staff in the pit and in the wards quite difficult at first because a lot of them don't work very hard. It is a paradox of the hospital that one can get a state-of-the-art CT scan but patients can quietly expire for want of basic nursing observation at night-time.

There's a favourite northern suburbs joke to which tourists

are subjected: what's the difference between a tourist and a racist? The answer, inevitably, is two weeks.

Twisted as this might sound, as I worked with some black nurses who ignored me and manifestly couldn't care less about their charges, and as I dealt with a sullen, mute and violent clientele, I wasn't far off illustrating that cliché myself. It was only through meeting some splendid doctors from the rest of Africa, working with the odd diamond of a nurse and seeing through to the basic humanity

of the patients that I escaped that fate (I think).

It is said that life is cheap in Africa. As a generalisation this is untrue, but there's no doubt that life isn't at a premium in Soweto. Did I enjoy my spell at Bara? Yes, I did, but it wasn't all plain sailing. Would I recommend it to another? Yes, but not blithely. Certainly it was the most memorable year of practice I have ever had. Hospitals come and go but it will be a long time before I forget the smell of the Bara pit on a Saturday night.

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# Zuma visit sparks hospitals probe

**Durban - All major hospitals in KwaZulu Natal would be investigated to ensure service was delivered properly, provincial health superintendent-general Ronald Green Thompson said here.**

He was speaking at a press conference yesterday after a complaint by Health Minister Nkosazana Zuma about the delay of treatment of patients at Addington Hospital in Durban.

Dr Zuma discovered the discrepancy when her younger brother, Malusi Dlamini, was admitted to the hospital two weeks ago after an epileptic fit.

Dr Zuma claimed there were

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many patients at the casualty section on the evening when her brother was admitted and that there was only one doctor to attend to them.

"There was only one doctor on that night.

"I want to know why a major hospital in Durban has one doctor on duty at the casualty section at a weekend," she said.

She alleged that some patients told her they had waited for long hours to get treatment.

She added that a meeting with Dr Green-Thompson and hospital management was held to discuss the matter and that an investigation into problems was launched.

Dr Green-Thompson said the

investigations would assist in identifying problems in the hospitals and if there was a delay of treatment as a result of shortage of doctors alternative arrangements would be made.

Dr Zuma denied weekend reports that she abused her position by demanding preferential treatment for her brother.

"As a minister I have a right to ask if our people are not receiving proper treatment.

"I want to make it clear that I did not abuse my position and I did not demand preferential treatment for my brother," she said.

Dr Zuma said she would take legal action against newspapers and anyone who alleged otherwise. - Sapa