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DRUGS

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Thanks:
Bada Pharasi, Helene Moller, Beverly Summers, Glenda Grey, Cathy Tyacke, Ms van der Merwe and the pharmacists of Johannesburg General Hospital, and the pharmacists who agreed to be interviewed.

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Editorial

"The sad fact of the matter is that the health care industry is in disgrace. We are widely perceived as unscrupulous and unethical, motivated purely by greed, and relentless in our exploitation of human suffering for commercial gain. Truly, if capitalism ever had an unacceptable face, this must be it."

So said Peter Beningfield, the chief executive of SA Druggists, at a pharmaceuticals industry conference earlier this year. He went on to specify the cost of medicines as the most prominent issue which needs to be addressed. However, the progressive health sector has been far less outspoken in its criticism. At the same conference, the ANC representative somewhat timidly asked the question, "Are the medicine prices too high in this country?" Progressive health workers have had extensive debates on the crisis in the private sector, yet, when it comes to the cost of drugs, we have been relatively slow to assess the reasons and reluctant to put pressure on the big drug companies.

Meanwhile, both multinational and local drug manufacturers have continued to increase prices as well as profits. In 1992, a quarter of the world's largest 500 companies lost money, but all 25 pharmaceutical companies in the top 500 were profitable. Despite the current recession, SA Druggists, Adcock Ingram and Premier Pharmaceuticals have also filled their pockets. During 1992, the Pharmaceutical and Medical sector was easily the strongest performer on the Johannesburg Stock Exchange. The majority of South African private sector retailers are controlled by the big three and they continue to mark up the ever increasing producer prices by a further 50%.

The state sector is also beset with problems. Despite the severe shortage of hospital pharmacists, the government is insistent on making further cutbacks on state services. As a result, patients are suffering. This picture is compounded by corruption and theft of state drug supplies.

In this edition, Critical Health examines some of these issues and explores options to ensure affordable, accessible and appropriate drug use within a primary health care context.

We start with an article by Muller, author of a study on the negative effects of multinational pharmaceutical companies on health in developing countries. He now argues that we should no longer focus our energy on the multinationals because they cannot influence and dictate prices in the way they did before.

Several babies and adults died of infections related to intravenous drips produced by Sabax. Soller argues that the company was able to deny responsibility for the deaths largely because of the way in which the government health structures and the Medicines Control Council responded.

Many drug manufacturers also fail to provide adequate safety measures for workers in the factories. Colvin describes how workers at a pharmaceutical production plant, owned by a German multinational, have been poisoned by chromate compounds. The employers retrenched affected employees without compensation.

Jeebhay and Mbuli suggest that most pharmaceutical companies in this country have inadequate safety programmes. South African legislation is too lenient and poorly enforced. This allows companies, which are compelled to adhere to strict policies in their home countries, to ignore these in South Africa.

The second section focuses on pharmacy in the state sector. Critical Health interviewed a number of pharmacists who complained of staff shortages and poor remuneration. This leads to overwork and stress, and consequent neglect of counselling of patients in the use of medication.

Moller and Summers highlight the severe shortage of staff in the rural and 'homeland' hospitals. They suggest improving conditions of service to attract graduates into the state sector and training additional black pharmacists to overcome staffing backlogs.

Summers argues that the high proportion of women pharmacists in the state sector is due to the poor conditions of service and salaries which men are less prepared to endure. Women are discriminated against in terms of promotion to management levels.

We include a number of articles suggesting ways in which the pharmacy sector needs to change. There is a need for a drug policy which ensures that essential drugs of acceptable quality and efficiency are made accessible to the majority of the population. Pharasi stresses that such a policy must be integrated into a comprehensive primary health care approach.

Eagles outlines the ANC's views on drug policy. The ANC is considering price control, an essential drugs list and a policy on generics, within the context of a strong national health service.

The demand for drugs in a new South Africa should determine the nature of pharmaceutical production, according to Crompton. He suggests the need for appropriate state intervention in production to facilitate our research and development capacity, increase pharmaceutical exports and keep prices down.

Hodgkin, speaking from international experience, argues that the availability of essential drugs is not sufficient to prevent irrational drug usage. Companies which promote such bad practices must be opposed and people must be educated about drugs to empower them to challenge these practices.

Pharasi argues that pharmacists should not be paid on a fee for service basis as this encourages them to focus on the sale of medicines. They should use all their skills in collaboration with general practitioners in health teams.

Modern and traditional medicine must be integrated, argues Jacobs. However, traditional medicine must remain under the ownership and control of people within black communities. Health personnel in the modern sector and traditional healers need training to facilitate integration.

The progressive health sector has only recently started to critically analyse pharmacy in South Africa and develop ideas on policy. We have a lot to learn from international experience. For this reason Critical Health includes a resource list of publications available from WHO and international pressure groups HAI and BUKO. We also provide a review of an article on Zimbabwe's post independence experience, which highlights the successes and failures of an interactive approach between the state and the market oriented pharmaceutical industry.

In the first contribution in the general section, Le Roux argues that many mothers cannot breast feed. Their children need infant formulas and milk, but, for many, these products are unaffordable. She suggests the need for research as to the reasons for the high price of milk and possible ways of lowering it.

Masobe and Price argue that the Medical Schemes Amendment Act allows for the development of managed health care options such as health maintenance organisations. However, it will also result in medical aid becoming unaffordable to the aged and ill, who will be forced to rely totally on a weak public sector.

Responding to an article on SAHSSO's emergency services group in a previous edition, Wildschut argues that SAHSSO's Victims of Violence, Torture and Rehabilitation Programme is well established. She describes aspects of the work this programme is involved in.

Next Edition - HIV/AIDS in South Africa

The HIV virus is spreading at an ever increasing rate. Hundreds of people are being infected every day. All sections of society are at risk, but it is spreading fastest among the oppressed. HIV/AIDS will further accentuate the poverty of the majority, throwing people into a cycle of greater risk to infection. Is the government committed to fighting the spread of HIV, and providing care for those who become ill with AIDS? How effective are NGOs, para-statal and community groups in their prevention and care work? What have we learnt from experience? How can we develop effective approaches to the social impact of the epidemic? Critical Health investigates these issues in the next edition.

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The Drug Manufacturing Industry

The multinationals, their local subsidiaries and South African companies have a track record of being motivated purely by financial gain. How does this affect drug prices, patterns of drug use and working conditions in the factories?

Medicine and the Multinationals
Time for a Fresh Look?

Mike Muller

Just over a decade ago, Mike Muller wrote a book, "The Health of Nations", an investigation of multinational pharmaceutical corporations in the Third World. He set himself the task of assessing their impact and "whether their positive contributions are outweighed by, and incidental to, the damage they do and the bad health care they promote".

He referred to the example of a person in Mozambique who was getting headaches and took a popular over-the-counter painkiller, Cibalgin. She developed a sore throat and a fever. Her condition got progressively worse. She suffered from cold sores, degenerating gums, a swollen face and painful infections in her veins. She then developed abscesses in her lungs, her lips decayed, her teeth became loose and her jaw bone was exposed.

It had already been known for 58 years that the active ingredient of Cibalgin, Amidopyrine, causes agranulocytosis. In developed countries, the drug was either only available on prescription or banned altogether. Ironically, the drug was freely available in a developing country which has a lack of facilities to diagnose drug induced illness. The Cibalgin package merely noted that the drug can cause drowsiness. The only warning of the dangers associated with the drug was phrased in technical language, in the small print of the package insert.

He then showed that this is not an isolated case and that the use of unsafe and inefficient drugs in the Third World is a widespread phenomenon. This misuse is actively promoted by the multinationals, who typically spend at least 20% of their sales revenue on promotion. They provide minimal information on proven dangers and make exaggerated claims on the usefulness of their drugs. Muller provided a number of examples, including the aggressive marketing of chloramphenicol, which can cause aplastic anaemia, and the deceitful marketing of lomotil, which stops diarrhoea by slowing down the gut, but does not counteract dehydration. The drug can be life threatening to young children in relatively low doses.

His evidence provides ample support for the Director General of the World Health Organisation (WHO), Halfdan Mahler, who said, "Drugs not authorised for sale in the country of origin, or withdrawn from the market for

reasons of lack of safety or lack of efficacy, are sometimes exported and marketed in developing countries; other drugs are promoted and advertised in these countries for indications that are not approved by the regulatory agencies of the countries of origin. Products not meeting the quality requirements of the exporting country, including products beyond their expiry date, may be exported to developing countries that are not in a position to carry out quality control measures. While these practices may conform to legal requirements, they are unethical and detrimental to health."

Muller argued that multinationals engage in research and development of new products with the aim of getting the best possible financial return. He highlighted the bias towards developing non-essential drugs and variants of existing products which can be marketed profitably in the developed world, rather than drugs to control serious diseases in the Third World. In addition, new drugs are developed and actively promoted to displace older drugs, irrespective of whether they are better, merely because they can be sold at far higher prices.

He then looked at the market power of the multinationals. The international pharmaceutical industry is dominated by a few dozen big companies. Moreover, these companies specialise in particular types of drugs and monopolise the market for their drugs. Companies take out patents for the drugs they discover in order to obtain a complete monopoly of the market. This allows them to dictate prices. Each company varies its prices from country to country by as much as 400%.

Multinationals maintain strict control of raw materials and technical know-how to obstruct Third World countries from developing their own manufacturing capacity. They also transfer wealth from the developing to the developed world by setting up subsidiary companies in developing countries and charging them exorbitant prices for raw materials. Payments are made to the parent companies in the developed world.

Muller argued that the method of operation of the multinationals leads to irrational drug use. Misuse of drugs leads to drug resistance and drug induced diseases. Moreover, scarce resources are squandered. He took us back to Beira, Mozambique, with 60 doctors and 20 salespersons, where the high summer temperatures and humidity contribute to headaches. His colleague went to the local health centre and was given a five item prescription, namely [illegible]rine, diazepam, mebendazole, amoxicillin and promethazine. His headache did not get better, so he went to another practitioner, who prescribed six [illegible]s, more diazepam, co-trimoxazole, furosemide, potassium chloride, aspirin and vitamin B12. His headaches eventually disappeared when the rainy season started. At

the same time, the entire province had run out of essential anti-tuberculosis drugs.

In the following article, Muller argues that the way in which multinationals operate is less important than it used to be.

The medicine multinationals became a particular target for anger in the sixties and seventies because they controlled access to life saving drugs. They did this principally through the patent system. This allowed the company which discovered a drug to make large profits since it had a complete monopoly and could control all sales. A large number of new medicines were developed over this period by big international companies, but sick people were affected by their high prices.

Why Do We Need to Take a Fresh Look?

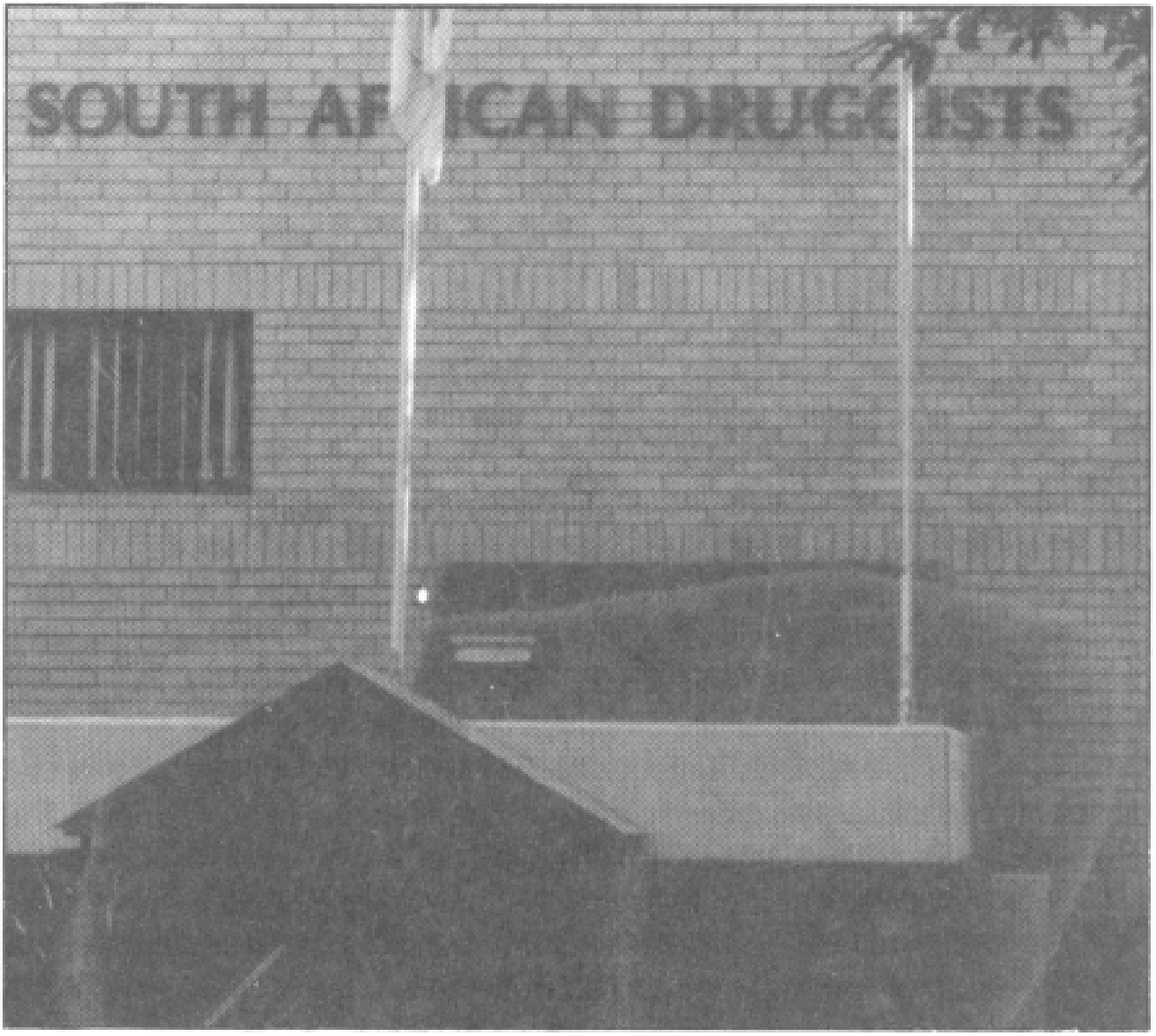
Patent protection for new medicines does not last forever. Typically, a patent is given for 15 to 20 years. This starts when the medicine is first discovered, which may be five or ten years before it can be tested and sold.

Many medicines, including common antibiotics, important tranquillisers and products for hypertension and ulcers, are now no longer protected by patents. This means that any company can make and sell them. As soon as this happens, the price falls, often to as little as a quarter or a tenth of what it used to be. Because many good medicines are now available without patents, not as many sick people are dependent on patented medicine as their only chance of a cure. This is one reason why we need to reconsider whether it is the big multinationals which get all our interest or whether there are other areas which need attention.

The other reason is that many of the medicines we need to provide a basic health service are now supplied by other companies which specialise in 'generic' drugs - drugs made and produced to the same chemical formula but not sold with the brand name of the multinationals.

Do We Need to Worry About Medicines?

If multinationals are no longer controlling access to medicines, why do we need to pay attention to medicine policy? There are three reasons. First, new medicines are still being produced. Since these are patented, the companies with the patent will promote their use to make as much profit as possible. We need to ensure that we do not waste public money on buying medicines which are not



Do we really need to focus on the monopolies? ***Photo: Ismail Vawda***

much better than existing products. Also, medicines used in private practice set an example which often affects how medicines are used in the public sector.

Secondly, many people believe that medicines are one of the most important parts of health care. If we are to help and encourage people to understand how to improve their own health, we must try to ensure that medicines are used for their correct purpose.

Lastly, in private practice, a large proportion of the cost of health care is accounted for by the cost of medicines. (The proportion is less in public health care systems). If private health costs are to be controlled, an important part of the process will be controlling the costs of medicine. This may mean that more people will be able to use the private sector and thus leave more money in the public sector to help those who cannot pay for their care.

Using Medicine Effectively and Efficiently

The fact that many highly effective medicines are now more freely available is important for any national health care system. One result, however, is that the medicine makers are less concerned with advertising and promoting their products. Instead of complaining about the amount of medicine promotion, we may soon find that, in many areas of health care, there will not be enough information available about how best to use medicines.

The health services will save money through cheaper medicine, but some of that will have to be used to provide information to health workers to help them choose the right medicine for their patients' needs. Managing the quality of medicine use will become important, but it is difficult because health workers are often reluctant to change their ideas once they think they know best.

A well organised health service can introduce management systems to ensure that medicines are well used, but only if all health workers are prepared to make the systems work. The same systems should also ensure that money spent on medical equipment and buildings is appropriately spent.

In the private sector, different rules are needed. If people want to spend money on unnecessarily expensive medicine, they should be free to do so. But they should not be encouraged or subsidised. In this respect, the COSATU policy of exempting all medicines from VAT may be misguided. It will have the effect of subsidising the rich to waste their money on expensive medicines. A more sensible policy would be to exempt from VAT only a list of recommended generic medicines to encourage their use wherever possible.

What about the South African Companies?

South Africa is fortunate in that it has a few companies which are able to make a wide range of generic medicines. Adcock Ingrams, SA Druggists and Twins are just some of the better known names, although different names sometimes conceal the fact that companies have the same owner.

Because the number of companies is relatively small, there is the risk that they can use their virtual monopoly to keep the price of medicines higher than it ought to be. One way to prevent this would be to encourage all medicines to be imported. This might reduce prices in the short term but it would also put many people out of work and mean that South Africa will be dependent on other countries for its basic medicine supplies. Price control of medicine is difficult, because there are many reasons for prices to fluctuate, particularly when the raw materials to make them are imported.

The problem is to find a way to ensure that the local medicine companies are encouraged to carry on producing without being able to take unfair advantage of their home market.

Need for Strong Health Authorities

To promote the policies advocated in this article, there is an urgent need for strong health authorities committed to making sure that the industry is serving the needs of the nation. Their tasks will be to provide the information, implement management systems and impose controls where needed. At a time when deregulation and privatisation are being pushed hard in many circles, and with government budgets always under pressure, it may be hard to achieve this.

To conclude, the misbehaviour of the multinationals is less important than it used to be. We still need to pay attention to medicine policy. We also need to provide health workers with the right information about medicines, establish management systems to control medicine use and ensure that the South African monopolies don't exploit consumers. We will only achieve effective and efficient use of medicine if we have strong health authorities.

In addition to "The Health of Nations", Mike Muller has also written "The Baby Killer" and "Tobacco and the Third World: Tomorrow's Epidemic", about the role of multinational business in promoting bottle feeding and cigarettes. Mike Muller works for the Development Bank Southern Africa.

The Finality of Death by Intravenous Infusion

Peter Soller

At the beginning of 1993, state president F W De Klerk wrote to the author, saying "I wish to inform you that I share with deepest sympathy your concern with the loss and grievances suffered by the parents and families involved in the tragic events ... I regret that I can be of no 'further' assistance to you."

For all practical purposes, this callous response represented a tragic ending to the equally tragic start of a chain of events which took place between 1990 and 1992. It is believed that, during this period, scores of babies and adults died after receiving an intravenous infusion contaminated with bacteria of the Klebsiella group.

Contaminated SABAX Infusions

The tragedy started in about February 1990, when neonates and adults, who were being treated with intravenous potassium cocktail and non-potassium cocktail infusions, began dying in greater than usual numbers from septicaemia associated with the Klebsiella group. The intravenous infusions which were linked to the chain of deaths were prepared in the sterile unit of SABAX laboratories in Johannesburg. To this day, SABAX denies that their intravenous infusions were, in any way, a contributory factor to the deaths, despite the fact that in some instances it was shown beyond doubt that patients received infusions contaminated with traces of bacteria of the Klebsiella group.

At the same time, deaths were occurring from similar causes at the Ga-Rankuwa Hospital, where medical workers who were on strike were being blamed for the deaths of approximately 35 babies. The clinical symptoms preceding death were identical at all the affected hospitals. In most cases, the intravenous infusions were put up as a precautionary measure in premature babies and ill patients, so that, if necessary, drugs could be administered intravenously. Within a few hours of infusion, patients showed severe clinical signs of septicaemia which, despite aggressive antibiotic therapy, progressed until death.

According to the official stance, apparently none of the health workers involved saw that there was a causal link between all these unaccounted for

deaths. However, evidence was given at the inquest into a few of the deaths that SABAX were warned of the possibility of their drips being the cause of some deaths in or about March 1990. It is also recorded that SABAX disputed the ability of the Clinic Holdings Group of Hospitals to prove their assertion in a court of law.

More Deaths, No Justice

Although neonatal intensive care units closed, they re-opened after assurances were given by the manufacturer that the entire process was found to be acceptable. After the units in Johannesburg private hospitals were re-opened, more deaths occurred, in what can only be described as a "mini-epidemic".

Scientific investigations revealed a number of serious flaws in the manufacturing process of the potassium cocktail and non-potassium cocktail infusions. It was also found that these products were never terminally heat sterilised before administration.

An Inquest Court found that there was no causal link between the contamination of the intravenous infusion and the deaths of the babies. These findings were challenged, but it proved impossible, without the active assistance of the state, to successfully challenge these findings in a superior court. The vast resources of SABAX made it overwhelmingly impossible to ensure that an effective, full or proper inquest took place.

It remains a proven fact that the intravenous infusions manufactured by SABAX were contaminated and that patients who received these infusions and who ought to have survived their illnesses did not so survive. It should be emphasised that these patients did not only include babies, but included adults who died from overwhelming Klebsiella infection during the same period and at the same institutions where the infusions in question were being supplied.

The doors of justice have now been closed to many families who know why their dear ones died. These same doors remained closed to so many of the less privileged members of society, reliant on the public sector, who were denied the basic right of being properly informed of the circumstances surrounding the unexpected complications and untimely deaths of their loved ones.

Missing Letters

Why was this medical catastrophe allowed to occur in the first place, and then permitted to remain clouded in mystique? How could a society which pretends to invoke advanced standards of medicine allow characteristically backward

circumstances to occur in its health services?

The root causes allowing those responsible for the deaths to escape from justice include the tardy supervision and administration of health services by government at its highest level, a gross failure in the proper administration of justice in the lower courts and the grossly inadequate performance by the statutory body, the Medical Control Council (MCC), appointed to control the supply, manufacture and distribution of medicines in South Africa.

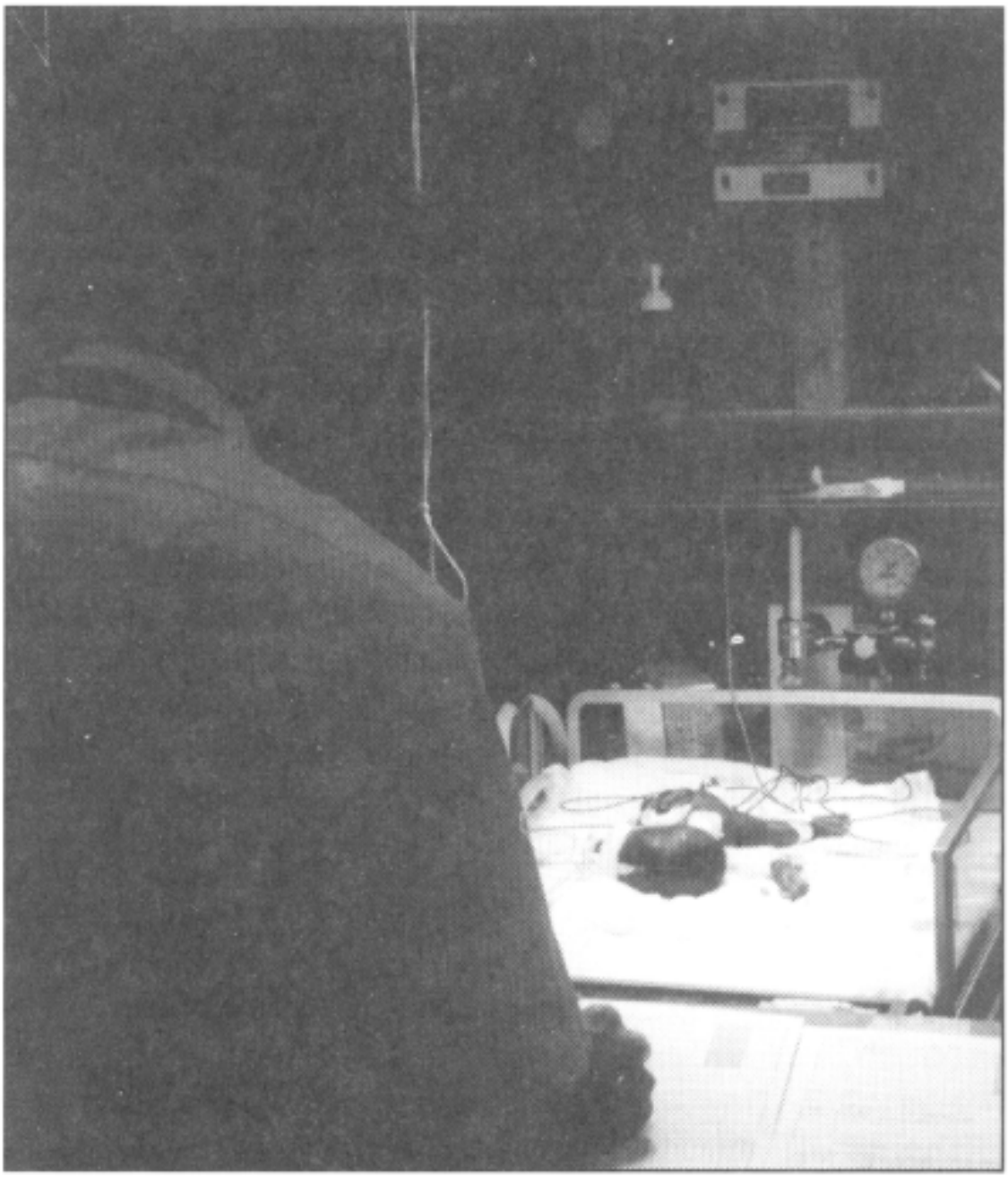
Can the state honestly deny that the premature deaths in 1990 of the babies at Ga-Rankuwa were cynically used for political propaganda against the nursing strike which took place that year? The state knew, and was told in no uncertain terms by the staff of Microbiology and Paediatries, that the deaths of each baby could be linked by genetic coding, not to the strike, but to identical intravenous infusions that were simultaneously terminating the lives of babies at sophisticated obstetric units in central Johannesburg and its environs. Letters written by the academic staff to the provincial health authorities and the manufactures of the infusions, mysteriously disappeared when they were required for official purposes. To this day these letters remain 'missing'.

Another State, Foreign Deaths

Academic staff of Medunsa who offered to testify at the inquest were 'reminded' that they were contractually not entitled to make statements in public, except through a spokesperson of the Transvaal Provincial Administration. Yet, the South African inquest court found that, even with its wide powers to subpoena, it did not have the legal powers to subpoena the medical staff at Ga-Rankuwa or Medunsa as these staff were employed and lived in another state. With the invocation of this novel bit of international law, vital scientific evidence was conveniently withheld from the 'official' South African inquest into the deaths of the children from the region of southern Africa. It is strange but true that a 'foreign' professor at Medunsa was actually asked to be an assessor at the inquest.

Inept and Inactive

To add insult to injury, the MCC has failed to publicly proclaim that the law relating to supply and distribution of scheduled drugs was disregarded. This council was both inept and recklessly inactive. It chose to adopt such a low profile that even an acknowledgement of correspondence proved to be an impossible objective. It blatantly ignored the need to adhere to basic principles of prescribing, control of batch numbers and supervision of drugs with a limited



Is this baby secure from IV contamination? *Photo: Ismail Vawda*

shelf life.

The council clearly refuses to see itself as a public body answerable to society. The failure of the MCC was yet another 'nail in the coffin' of those intent on exposing the truth. It has been shown that there is a need in every society to maintain an independent and reliable body to monitor every facet affecting the general interests of society. In South Africa, facing a total breakdown of its health services, it should be clear that the MCC, as it now functions, cannot be expected to play an effective role. With the inevitable political change in this country, there must be a total reassessment of the functions of all structures related to the adequate provision of medical services.

The juridical factors affecting the unfortunate outcome of this tragic event

also require comment. Access to our courts is, in many instances, restricted to the very rich or the very poor. This is not acceptable. Justice must become accessible to all, regardless of race, colour or creed. With erudite and costly legal advice, those answerable to society for the drip deaths were successful in defying the truth.

An unsatisfactory medical malpractice investigatory procedure continues to thrive. It is questionable whether justice in medical matters can, at present, be achieved in courts other than the Supreme Court.

No Consolation

The families who escaped the effects of the tragic drip deaths, should take no consolation on that account. They should keep in mind the oft used phrase which says "There but for the grace of God go I". Medical professionals need to stand up and be counted every time they come across any medical injustice. Without the application of such integrity, tragedies of this sort will inevitably happen again. Lastly, no minister of health or government official in a future South Africa should ever be given the unfettered privilege of writing a letter similar to that quoted at the beginning of this article, thereby closing the doors of justice.

Peter Soller is an attorney practising in Johannesburg

Occupational Diseases at Chrome Chemicals

Mark Colvin

The Chrome Chemicals factory is situated in Merebank about 20km south of Durban. For the last 30 years, employees at this plant have been breathing dangerous levels of toxic chromate dust. This article is about the suffering experienced by workers and explains why the situation was allowed to occur.

The factory is owned by Bayer, a German multinational that has huge investments in the health sector. The main complaint of the workers and their union, the Chemical Workers' Industrial Union (CWIU), is that workers' health was largely ignored by management, factory inspectorate and health authorities. It is only through the union taking up the issue that it can become a public concern.

Can Workers Avoid the Risk?

Appropriate technology has been developed to keep workers' exposure to the dust to below internationally set standards. By using machines that do not leak dust and the installation of other engineering devices, workers may manufacture chromate compounds with minimum risk to their health. The Bayer chromate factory in Germany is virtually free of any dust and there have been no cases of nasal septum perforation there for over 20 years. When a senior CWIU shop steward went to Germany in 1991, he was astounded at the contrast between conditions workers' faced there and conditions at the Bayer factory here.

Associated Health Hazards

The most serious long term effect of exposure to chromate compounds is the development of lung cancer. Other effects of exposure includes asthma and dermatitis (a skin rash). If workers are exposed long enough to high concentrations of chromates, they may also develop nose ulcers and complete perforation of the nasal septum.

Bayer factory, Durban. ***Photo: Ismail Vawda***

In April 1991, 215 workers were retrenched when a part of the firm was closed down. The Industrial Health Unit was approached by CWIU to examine these workers. A hundred and twenty six medical records were studied. Thirty four percent had complete nasal septum perforations. Symptoms also included chronic sinusitis, nasal bleeding and rhinorrhoea ("runny nose"). Only one of these workers received specialist treatment at company expense, many were referred to a company nurse or paid their own medical costs. Up to 1989, at least three workers contracted lung cancer. All had their services terminated and died shortly thereafter, without having been considered for compensation.

What led to this disastrous situation?

Although primary blame lies with local and foreign management of Chrome Chemicals, almost none of the parties involved is free of responsibility. Each of the parties involved are considered below, including the Department of Manpower, local health authorities and factory health services.

The Department of Manpower

Legislation dealing with the occupational environment is weak, with pathetically low fines against offenders. There is no legislation for the provision and effective running of factory based health services. There is no state occupational health services in the province nor any such facilities at the major hospitals.

The ill equipped and understaffed factory inspectorate, who are responsible for monitoring working conditions, did not use their extensive powers to make the company comply with acceptable standards. In 1976, a government commission, the Erasmus Commision, into occupational health matters in South Africa as whole, showed the state's awareness of the situation at Chrome, yet did very little to rectify the situation.

Local Health Authorities

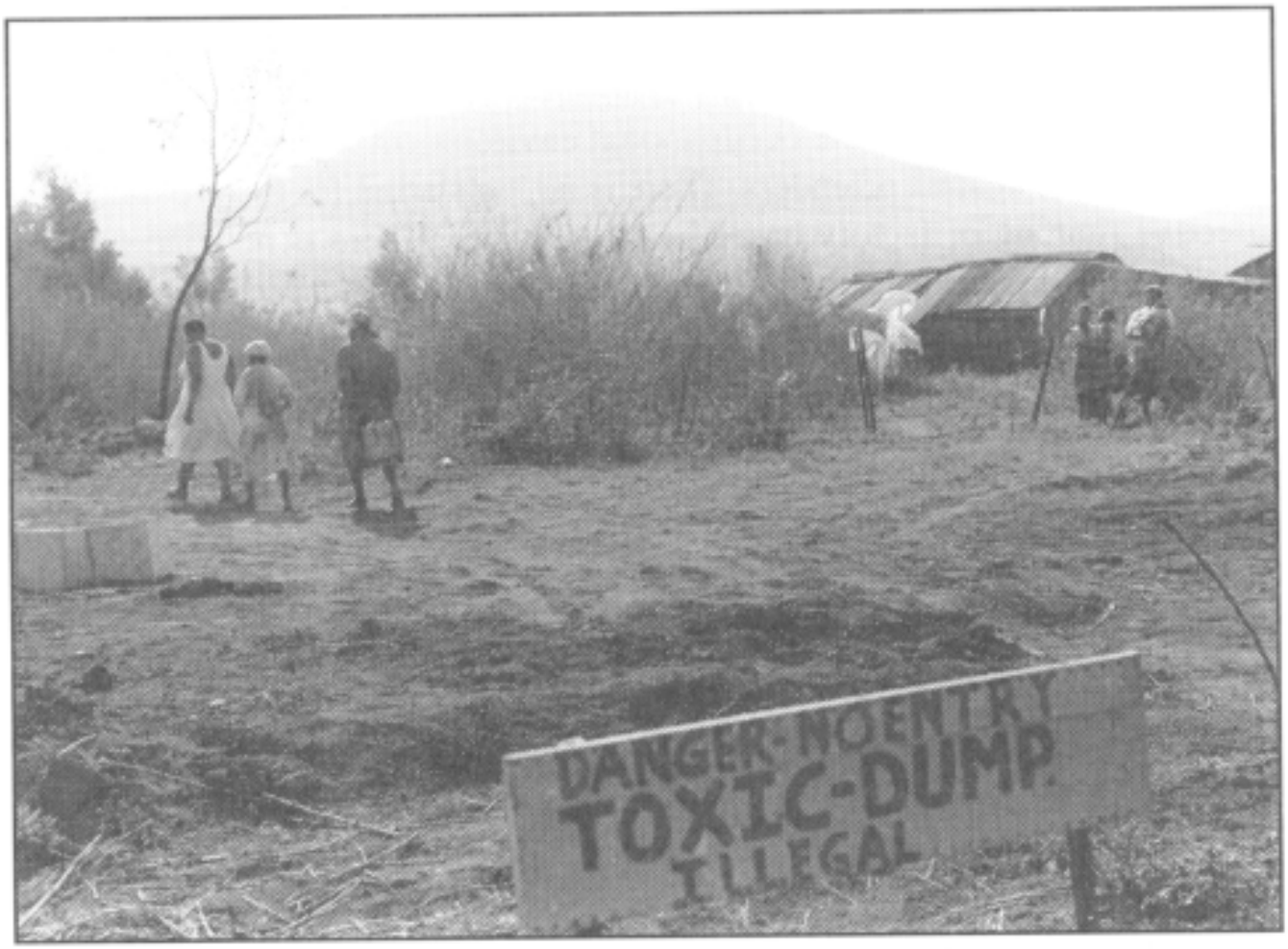
Chrome Chemicals was obliged to obtain from the Durban medical officer of health (MOH) a "scheduled trade permit" on an annual basis. Part of the conditions of the permit was that the company had to furnish the city health authorities with relevant health related information. Although local authorities have little jurisdiction over industry, the MOH should have done more to draw attention to the health disaster that they knew was occurring.

The Factory Health Services

It was the responsibility of the company doctor to detect workers' health problems early on and to initiate steps to rectify the situation. However, this did not occur. The company doctor diagnosed chrome related health problems, but took no action. Medical records kept by the clinic reveal that the staff simply documented workers' declining health, but did nothing to prevent this deterioration. Communication with workers was very poor. Many workers interviewed, said that the company health services had not informed them of their nasal problems.

The Role of The Union

As early as 1973, the secretary of CWIU in a local newspaper, was quoted saying workers were suffering from chrome related illnesses and receiving no compensation. At a time when black trade unions were still illegal, the new



The tragedy at Chrome Chemicals is not isolated to factories only.
Photo: Cedric Nunn

union could do little to improve conditions for its members. The issue reappeared in 1989, when a senior shop steward became concerned about members becoming ill and having their services terminated.

The union was alerted to the situation and started negotiating health and safety with the company. Management's response was unco-operative. Management refused to allow the union's health and safety advisors to do an investigation, and would not reveal data on the levels of chromate dust in the workplace. When the issue became publicised in the local press, only then did management make minor concessions. This included an agreement to pay for annual medical examinations on all former employees with more than five years of service.

The union also raised the issue at the international level by trying to get their corresponding union in Germany to assist them. A CWIU shop steward and the union organiser went to Germany and met with union officials and Bayer management but with no outcome. Since then, German NGOs have publicised the problem and have highlighted the different standards Bayer was applying in Germany and South Africa.

What of Compensation?

The Industrial Health Unit applied for compensation for all the affected workers. Most have received compensation which, unfortunately, is far too little. Payments are a lump sum of between R200 and R400, which hardly pays for two months of medical expenses. All workers with nasal septum perforations were inappropriately assessed as being 3% disabled, while the amount of compensation was calculated on their wage at the time of diagnosis, which in the early 1970s, is 10% of wage levels today.

Objections were made to the Compensation Commissioner. So far only one case has been heard. The commissioner decided to raise the degree of disability from 3% to 15% but would not change the date of diagnosis. The Legal Resources Centre at UND is considering taking this matter to the Supreme Court.

The tragedy at Chrome Chemicals was not an isolated incident (another example is the poisoning at Thor Chemicals), and it should not be a surprise that it happened. The reason for this is that in South Africa we do not have the laws, monitoring authorities or public pressure to prevent such occurrences. The public and workers in South Africa have not traditionally challenged industry on issues of environmental pollution, whether in the workplace or externally. This allows industry to do as it wishes with workers' health.

Added to this, South Africa has an inadequate social security system. The country is in the grips of an economic recession and rising unemployment. Unemployment insurance only pays 45% of a workers previous wage for a maximum of six months. Most retrenched Chrome Chemicals workers, therefore, have no source of income and pay for their own medical costs. These workers also have great difficulty in finding employment. Many companies do not want to employ ex-Chrome Chemicals workers because they are aware that many of them have industrial diseases. The families of workers who died of lung cancer have lost their breadwinners without sufficient compensation.

Under current circumstances, and until there is a national strategy to deal with occupational health, workers will have to depend heavily on their unions to take up these issues. This creates a heavy responsibility on the unions to commit more resources to attending to health and safety.

Mark Colvin , at the time of writing, was a researcher at the University of Natal's Industrial Health Unit. He now works for the Medical Research Council in Durban

Health Hazards in the Pharmaceutical Industry

Mohamed Jeebhay & Simphiwe Mbuli

"Indeed, if we questioned closely those who work ... in the shops of apothecaries ... as to whether they have at any time contracted some ailment while compounding remedies that would restore others to health, they would admit that they have very often been seriously affected."(B Ramazzini, 1713)

It has been suspected for centuries that the manufacture and handling of therapeutic drugs is potentially hazardous to health, yet this remains a neglected area of occupational health research. There have, for example, been very few studies which evaluate the effects of exposure to drugs poisonous to the bone marrow on workers in the pharmaceutical industry. There are, however, numerous clinical studies on patients who have received the drugs azathioprine and chloramphenicol for therapeutic purposes, which highlight the toxic effects of these drugs on the bone marrow. Both these drugs are also known to cause cancer when used in therapeutic settings.

These findings can not necessarily be extrapolated to workers involved in the production of these drugs. Therapeutic doses of a drug are intended to produce an appreciable effect on the human body. Furthermore, the body's handling of a drug administered therapeutically is different from inhaling a drug in an occupational setting. Finally, occupational exposure usually occurs over a length of time and, therefore, allergic sensitisation, cancer and reproductive problems become more likely.

CWIU Workers Affected

The authors, with Peter Lewis of the Industrial Health Research Group investigated the effects of azathioprine and chloramphenicol on workers in a Cape Town plant. The project was requested by the Chemical Workers Industrial Union (CWIU) after a group of workers at this plant were found to have abnormalities in their blood tests, indicating bone marrow dysfunction. Workers refused to continue working with these drugs until a comprehensive health hazard evaluation of exposure to these two drugs had been conducted.

The study showed that, while none of these substances could be detected

in body fluids, changes in peripheral blood counts were suggestive of exposure. Furthermore, environmental monitoring measurements demonstrated contamination of the air inside airhoods, a form of protective equipment worn by the workers.

The project highlighted various deficiencies in the health and safety programmes of the pharmaceutical industry in this country in general and at this plant in particular. These deficiencies will be highlighted in the ensuing discussion.

Unsafe Workplaces and Inadequate Training

In order to cut costs, employers rely on personal protective equipment rather than a safer work environment. At the plant under study, a significant reduction in dust levels was achieved through the use of airhoods, but they were not entirely effective in preventing exposure. The limitations of personal protective equipment were only made worse by the use of inappropriate or poorly maintained equipment and the lack of emphasis on training the workers. This is clearly an unsatisfactory approach. More attention needs to be paid to the work

Personal protective equipment makes work safer - but is it enough?
Photo: IHRG

environment, including ventilation systems and isolation of dusty processes.

Most workers are either not informed of the hazards of the substances they work with or the information provided to them is technical and poorly understood. Furthermore, the health and safety training provided for workers is inadequate in that it does not provide them with the necessary skills to monitor employers' compliance with health and safety measures.

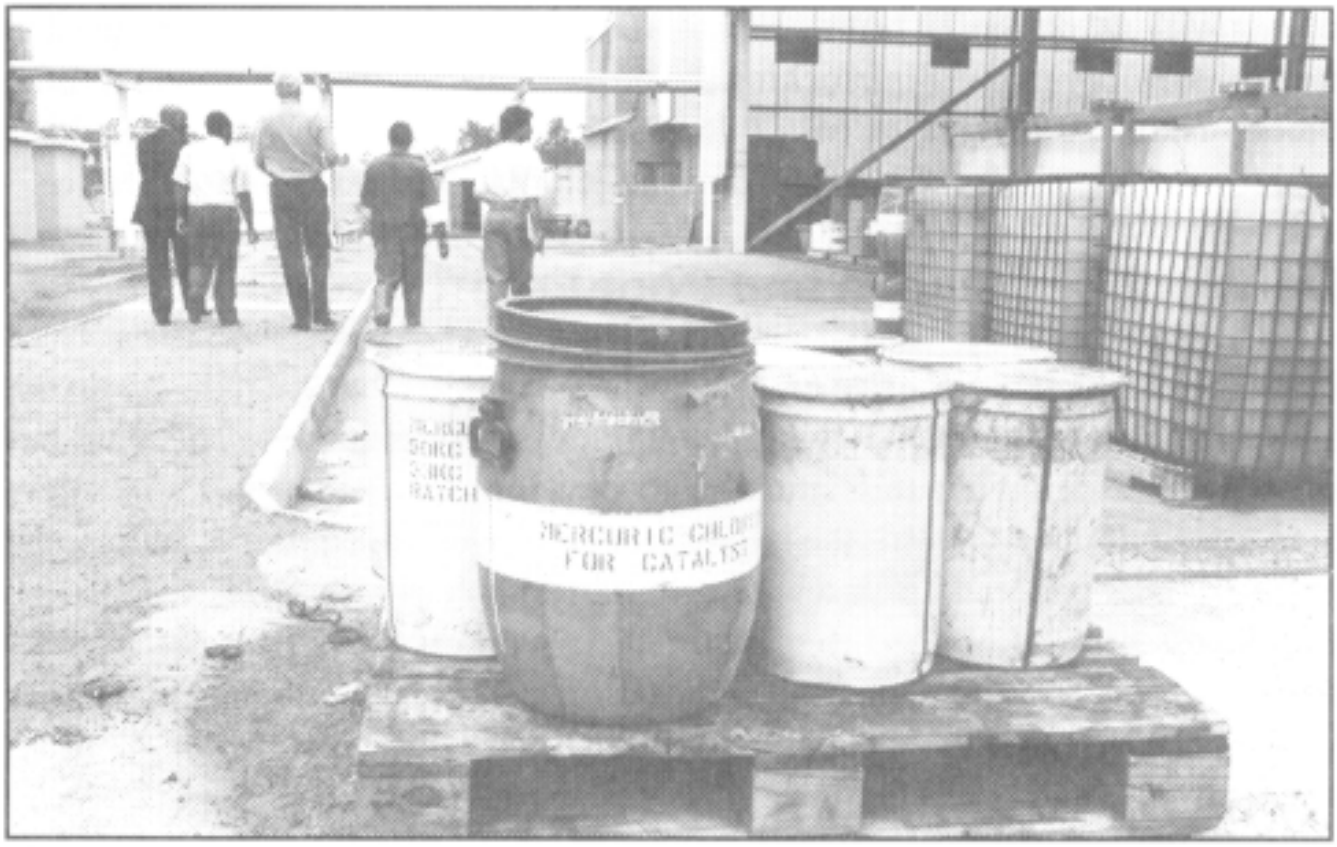
Employers usually use the issue of trade secrets as an excuse for not providing information. They only divulge such information if trade unions apply pressure and when crises develop. Trade unions argue that the right to know, the right to refuse dangerous work, and the right to appropriate health and safety training are some of the basic tenets of any health and safety programme at the workplace.

Poor Medical Surveillance

The lack of appropriate medical surveillance programmes for workers involved in the production of toxic drugs is in stark contrast with the emphasis placed on monitoring the effects of these drugs on patients in clinical settings. In view of the fact that both chloramphenicol and azathioprine are toxic to the bone marrow and have the potential to cause cancer, there is a need for an ongoing surveillance programme at the Cape Town and similar plants. This should include monitoring workers as well as the work environment. Recommendations and protocols to this effect were submitted to the company upon completion of the study. It will, however, be necessary to evaluate whether the company is implementing effective preventive measures at a later date.

The lack of appropriate surveillance is compounded by the absence of reliable methods of monitoring exposure to drugs in the factory setting. The assessment of exposure is fraught with difficulties. Workers each have different exposure times to hazardous drugs at their workplaces, they may or may not have absorbed biologically active amounts of the drugs, they may also be exposed to other industrial pollutants and may be taking other drugs for therapeutic purposes.

More sensitive analytical methods need to be developed to evaluate workers' absorption of chemicals toxic to the bone marrow. Reliable data are essential to data collection. Accumulation of exposure data and adverse health effects over a lengthy period of time may provide opportunities for more detailed analysis of the risks associated with chronic exposure to these substances.



Exposure to corrosion on floors at a mercury acetate plant - how is saftey ensured? ***Photo: Rafs Mayet***

No Standards, Double Standards and Unethical Practice

There are no workplace exposure standards for most pharmacologically active substances, including chloramphenicol and azathioprine. There is an urgent need to develop standard occupational exposure limits for the pharmaceutical industry worldwide. Many multinational companies have their own in-house standards in their factories in Europe or the United States, but they fail to apply the same standards in South Africa and other developing countries. In-house standards are themselves limited. While having a role in regulating exposure of workers to toxic substances, they are based on economic considerations and technical feasibility, rather than the prevention of adverse effects in healthy workers.

Medical surveillance programmes can encounter serious problems if occupational health personnel are insensitive to ethical issues in the workplace, such as obtaining informed consent prior to testing workers. Confidentiality is also of utmost importance, as it is not unusual for workers to be discriminated against on the basis of ill health. In the Cape Town workplace, confidential medical results were made available to the management by the company

doctor without obtaining prior consent from workers. The results were used in a discriminatory manner in blocking the promotion of workers with suboptimal blood results. Arguably, the only information employers are entitled to relates to the capacity of a worker to perform the job that he/she was employed for.

Deficient Legislation and Poor Enforcement

From the above, it is clear that employers in the pharmaceutical industry do not adhere to acceptable occupational health and safety practices. The state has been party to allowing this situation to develop. Current health and safety legislation is biased towards the interests of employers and does not address the issue of occupational diseases resulting from pharmaceutical production. Employers are not obliged to monitor their workers for illnesses they may develop from exposure to pharmaceutical drugs. There are no sound guidelines for workers affected by occupational diseases on issues such as job security, compensation and rehabilitation.

In the current legislation there is a great reliance on self-regulation in occupational health and safety on employers. Furthermore, there is a lack of an efficient inspectorate responsible for enforcement of the legislation, and fines charged to employers contravening the law are very small. The lack of trade union participation in drawing up the current legislation is also evident.

In conclusion, for successful implementation of any health and safety programme at the workplace, the participation of all parties is essential. Employers need to provide a comprehensive service, appropriate to controlling the various hazards encountered in the pharmaceutical industry. The state needs to pass appropriate legislation, and to enforce acceptable workplace conditions more vigorously. Workers and their trade unions must push for internationally acceptable standards which are safe, monitor employers' adherence to laws intended to ensure the health and safety of all workers and challenging unsafe conditions wherever they may arise.

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State Dispensing Services

Pharmacists are a key to rational drug use in hospitals, but they are in short supply as a result of government cutbacks in state services. How does this situation affect patient care?

Hospital Pharmacy: The Staff Shortage Crisis

Critical Health

Overcrowded wards and outpatient areas, staff shortages and inadequate facilities: this scenario depicts the state of South Africa's public sector hospitals. Critical Health spoke to a number of senior hospital and provincial pharmacists countrywide. They all expressed that hospital pharmacy is very much part of this scenario. There is a serious, escalating shortage of pharmacists, they are overworked and receive poor salaries. Many of those interviewed expressed frustration at the authorities, including central government, which is largely responsible for these problems.

The pharmacists interviewed concurred that work pressure did not allow for adequate counselling of patients on the medication they receive. Most were concerned about the possibility of patients becoming ill as a result of incorrect usage of prescribed drugs, and some gave examples of situations in which patients did get ill. These views were substantiated by several doctors who work at state hospitals.

Some of the pharmacists approached were cautious about publicising their frustrations. In one case, a pharmacist sought permission from his superintendent and was blocked from speaking about the situation at his hospital. All interviews are, therefore, treated in confidence.

Staff Shortages, Black Patients and Rural Areas

Almost all state hospitals, including previously white tertiary hospitals, are facing shortages of pharmacists. Just over 10% of all pharmacists in South Africa work in the public sector, yet they handle almost 70% of all medicines. Moreover, according to a senior Transvaal pharmacist, a large proportion of public sector pharmacists are over 65 years of age and work mornings only. They are employed because most younger pharmacists prefer the private sector. The older pharmacists do not necessarily have a detailed knowledge of recent developments in pharmacology. However, they need to have an updated knowledge of the explosion in the range drugs developed in the last 30 years if they are to make a meaningful contribution to patient care.

Staff shortages tend to have a greater effect on black patients because of

the legacy of inequitable distribution between hospitals in black and white designated areas. For example, Baragwanath Hospital is far more poorly staffed than Johannesburg Hospital. It has one pharmacist for every 88 beds. In comparison, Johannesburg Hospital has a ratio of one pharmacist to 20 beds. In Pretoria, Kalafong Hospital has a ratio of one to 57, versus H F Verwoerd, one to 26.

There are very few pharmacists in the rural areas. For example, there are no pharmacists in the hospitals in the rural areas of KwaZulu. According to a senior Natal pharmacist, in these rural hospitals, "the people working in the pharmacies are pharmacy assistants for whom the minimum educational requirement is a standard eight certificate. These workers are given in-service training for which there is no widely recognised certification at all."

Slashing Essential Services

The shortages are exacerbated by the government's policy of cutting back on state expenditure and pruning the size of the civil service. Under the Minister of Finance, Mr Derek Keys, this process has intensified. He publicly stated his intention to trim the civil service by 5% (about 30 000 members of staff), during the course of this year.

It may be acceptable to eliminate bureaucrats whose only function was to bolster apartheid, but it becomes a serious problem when cutbacks affect the availability of essential civil servants like school teachers or hospital pharmacists. A senior Transvaal provincial pharmacist argued, "The government has taken a hard attitude toward the civil service in general. Derek Keys' attitude is that the civil service is too large. This may be true, but the health service suffers a shortage of essential clinical staff. A bloated bureaucracy exists more in the overall administration of the civil service".

Stress, Poor Pay and Demoralisation

Cutbacks place remaining staff under great stress as they are compelled to do additional work. Pharmacists have to cope with long queues of out-patients waiting for their medication. They don't have the time to do tasks for which they have been trained, for example, attend ward rounds with doctors, check on the use of particular drugs and advise medical staff on side effects of particular drugs. Many pharmacists become demoralised in this environment. According to one of the pharmacists interviewed, "The expectations of most young pharmacists are not met. They do an extremely long course, yet in the state

service there is a lot of pharmacology they don't apply. Many feel that all they do is hand out medicine, that their job is rote work."

Pharmacists in the public sector also face the problem of low levels of remuneration. Pharmacists, for example, earn less than administrative staff. Many pharmacy graduates avoid seeking employment at state hospitals because of poor remuneration. Salaries are far too low to attract pharmacists into rural areas. This adds to hospital pharmacy staff shortages. All these factors lead to a high staff turnover among state hospital pharmacists and, when vacancies occur, the authorities are reluctant to replace lost staff.

Staff Cutbacks Undermine Patient Services

A hospital in the western Cape has been considering referring many of its out-patients to outlying primary health care services to reduce the overload of patients on its staff. This, a pharmacist said, is likely to reproduce the problem at understaffed primary health care services. Frere Hospital in Port Elizabeth is, in fact, considering withdrawing from its outlying clinics at a black township, Duncan Village, because of a shortage of pharmacy and other staff.

Pharmacists have limited or no time at all to counsel patients on their prescriptions, thereby unavoidably acting in contravention of Pharmacy Council regulations. In the past, all aspects of dispensing were carried out by the pharmacist, but now the tasks are divided. Typically, the pharmacist writes up the folder, another staff member does the labelling and a further person counsels the patient. The supporting staff have become indispensable, but hospitals are now starting to experience shortages of assistants too.

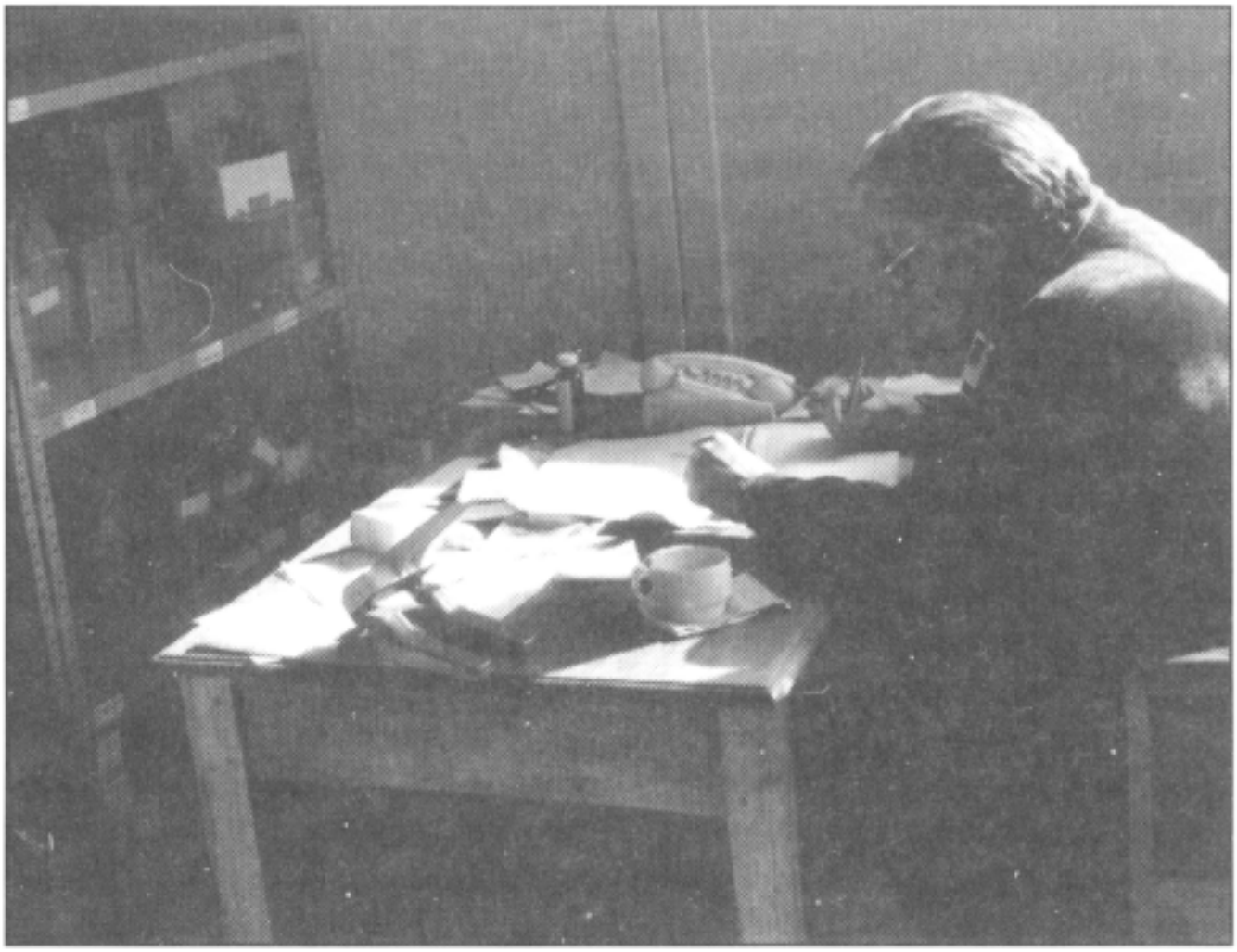
Counselling patients is often further complicated by language differences. Most pharmacists in South Africa are white people who cannot speak any African languages. They, therefore, rely on a clerical category, specialised auxiliaries, to interpret. In some cases, hospitals arbitrarily use hospital general staff to do translations. As a result of this communication gap, pharmacists often have no way of assuring that patients receive the correct information.

What Happens to Patients?

Pharmacists probably make some mistakes in dispensing due to work pressure. The pharmacists interviewed also acknowledged that inadequate counselling can lead to incorrect usage of prescriptions and that adverse drug effects are a potential threat. Patients have, for example, been known to use suppositories

incorrectly due to a lack of understanding or confusion on receiving their medication. Patients often fail to comply with their medication as result of a lack of counselling. For instance, a patient given a 5 day course of anti-bioties will take this course for 2 days, feel better and stop taking the medication. As a result, sometimes the symptoms of the illness return or even worsen. Asthma patients are given asthma pumps containing a drug which can cause ulcers if taken in excess. Patients are often not counselled adequately on how to prevent over-dosage. In serious cases, patients have been admitted to hospitals as a result of adverse drug effects and, in one or two instances, pharmacists have known of patients who have died.

According to a doctor at Baragwanath, a diabetic patient who had not been taught how to use her prescription was swallowing her insulin instead of injecting it. Diabetic children who inject themselves often give themselves too much. These examples indicate another shortfall in the public sector, a lack of district home nurses to oversee the administration of medicine at home.



Many hospital pharmacists have passed retirement age. *Photo: Ismail Vawda*

Pharmacists and Ward Rounds

The Pharmacy Council also requires pharmacists to give advisory services to health workers. Years ago, when there were adequate levels of staffing, pharmacists were involved throughout the process of medication. They accompanied medical staff on ward rounds, advising them on the side effects of drugs, the effects of drugs in combination with other drugs and other possible options for therapy. They also checked that drugs were being used correctly.

Lately, pharmacists only do ward rounds at intensive care units. Furthermore, other medical staff such as nurses are also overstretched. In this situation, mistakes can occur in the delivery of medication. For example, a nurse may administer too large a quantity, fail to give enough doses each day or continue providing medication well beyond the duration of the course. A child with meningitis who gets therapy twice a day instead of four times a day may die as a result.

One of the pharmacists interviewed indicated that pharmacists also have an important role to play in advising medical staff in ongoing out-patient therapy. For example, a patient who is given a prescription of drugs may feel dizzy and return to the hospital to have this treated. The doctor may not realise that one of the drugs in the prescription could be the cause and, therefore, give the patient an additional drug to stop the dizziness. Early intervention by a pharmacist could detect this as a problem and prevent a second inappropriate prescription.

A Complicated Mechanism to Say No

The shortage of pharmacists in most hospitals is reaching serious proportions. Working conditions for existing staff are exceptionally difficult and patients are suffering. In theory, hospitals with a shortage can apply for more staff. However, in the western Cape, a pharmacist said the provincial administration's response is, "supportive but cautious, providing relief only within the financial constraints of their hospitals."

In the Transvaal, the process consists of a number of stages and is time consuming. As a rule, the finance department responds by rejecting requests for staff on the grounds that additional staff have not been budgeted for. A senior pharmacist expressed the frustration of getting an unfavourable response through this convoluted bureaucracy: "I go out to a hospital, say, in Sebokeng, which is understaffed. My department does a new post establishment calculation, and confirms reported staff shortages at the particular hospital. At head

office, we make recommendations to the work study officer, who goes out to check our calculations. From his visit, work study suggests, say, eight more posts. Their recommendation goes to the personnel department and then to the finance department. Finance then says there is no more money in terms of the budget. Too often, I have to return to the hospital which made the staff request, and tell them I cannot help. I lose credibility. The person in finance has no idea of what goes on in the workplace. He simply imposes the line from cabinet."

The response of the provincial administration to a request for staff is, in fact, not dependent on actual budgetary constraints, but rather on "the political climate and what the government wants to achieve. A year ago a business management style was introduced at one hospital. Because the government wanted the project to work at this hospital, we did get the staffing levels required." That hospital is a rare exception in a situation in which the government intends to choke the health services.

Understaffing Wastes Money

These bureaucratic decisions are made within the framework of the government's overall drive to lower state expenditure. However, this is actually a short-sighted approach. The lack of an adequate number of pharmacists contributes to an inability to control stock. Overstocking is common, drugs expire and have to be destroyed. The Transvaal Provincial Administration spends R150 million a year on drugs, and significant quantities have to be destroyed. 'Shrinkage', or loss due to theft, is another major problem. According to a recent newspaper report, the market for stolen medical supplies is over R6 million a year, a large portion of which is stolen from state hospitals.

In attempting to cut state expenditure, the government is deepening the crisis in hospital pharmacies and, at the same time, it is actually failing to meet its objective of saving money.

This article was written by Joe Kelly.

Pharmacists

A Key Factor in Health Care

Helene Moller & Beverly Summers

In South Africa, in both public and private sectors, approximately 25% of the health budget is spent on drugs. Eighty percent of the country's drugs are used in the public sector.

Pharmacists - A Cost Saving Investment

Pharmacists are the country's experts in the care, storage, action and use of drugs. They are university trained to do these tasks for four years, plus a further year of internship, before they register. Yet the public sector, with its consumption of 80% of the country's drugs, employs around 10% of the country's pharmacists. Drugs in the health service constitute a massive investment. The TPA alone spends over R150m on drugs a year. Pharmacists are able to advise on safer and more economical methods of drug use. In Canada, it has been calculated that for every $1 spent on pharmacists' pay, a saving of $20 can be made on drug costs (and this with no decrease in the quality of patient care).

Studies in southern African hospitals have shown massive savings through better use of pharmacists in wards and in patient care areas. They assist doctors and nurses alike on drug use. At one Cape teaching hospital, pharmacist audit of the emergency drug cupboard has been projected to save R60 000 to R70 000 a year. In another study in a Transvaal teaching hospital, involvement of one pharmacist in intravenous feeding is calculated to save over R100 000 a year. At the clinic level, pharmacists' advice on the distribution, care, control and use of medication promotes better and more cost effective patient care and helps to reduce medicine wastage. Simple arithmetic shows that in the Transvaal alone a 1% reduction in the drug bill would result in a saving of R1,5m.

Staffing: Supply and Demand

If pharmacists can make such savings and improvements in patient care, why are more of them not employed by the state?

The majority of pharmacists work in the private sector as community retail pharmacists, where they can earn a living which is appropriate to their qualification - and there are still plenty of jobs in retail pharmacy. Hospital pharmacists have poor conditions of service by comparison. The majority of hospital pharmacists do "after hours" work in retail pharmacies to supplement their income.

In recent years the number of pharmacy schools has been cut in an attempt to rationalise training. Although this move was aimed at more effective use of resources, it has not been properly implemented and has resulted in a fall in the number of pharmacists qualifying. In 1985, 497 new pharmacists registered, and there was a net increase of 468 to the register. By 1992, the number of new pharmacists had fallen to 350, and the net increase to the register was a mere 180. The reduction in pharmacist numbers is further complicated by the fact that over 80% of pharmacy graduates are women. Women make excellent pharmacists, but on average a woman pharmacist works for 56% of her potential working life, compared with 85% for a man.

Staff Vacancies and Turnover

Vacancies and staff turnover place a further constraint on the public sector. In 1991, in the eastern Cape and border region there were 23% vacancies, and 33 out of 88 pharmacists left the services that year. In the Transvaal, there were approximately 10% vacancies, with a staff turnover of about 20%. Some hospitals in the Transvaal have vacancy rates of up to 75%. In the self-governing and independent states, conditions are much worse, to mention only a few examples:

Percentage of Vacancies (1991)

Bophuthatswana	53%
Gazankulu	68%
Kangwane	67%

The overall vacancy rate for the self governing and independent states was 56%.

In 1993, the government decided to freeze all posts that had been vacant for more than a year. This has grave implications for an already overburdened profession. Services which were cut temporarily until the posts were filled, are to be shelved indefinitely.

Geographical Maldistribution of Pharmacy Staff

A factor which adds to the problem of supply of hospital pharmacists is their geographical maldistribution. As with doctors, pharmacists are concentrated in urban areas. Hospitals in rural areas struggle to obtain pharmacists. There is also the question of ethnic maldistribution. In 1989, there were 2,9 pharmacists per 10 000 people in southern Africa. This figure compares well with the 3,1 per 10 000 people in the United Kingdom. Yet in southern Africa the ratio was 15,3% for the white population and 0,06% for the black population. This shows a tremendous imbalance due to the educational disadvantage of black people.

As a result of the shortage of pharmacists in rural areas, many pharmaceutical services rely heavily on the use of assistants. The appropriate use of trained assistants is a tremendous benefit to hospital pharmacy worldwide. In the UK and USA, pharmacy technicians are employed in all hospital pharmacies in a ratio of approximately one assistant or technician to one pharmacist. Appropriate training and an adequate career structure for assistants is essential. In 1986, the South African Pharmacy Council introduced a new training and registration system for pharmacists' assistants. The process involves registration and a 2 year course with examinations. There is no mechanism in the public sector for official help with funding of registration and examination costs, nor is there any financial benefit to be gained once the trainee assistant qualifies. What then is the training incentive for these much needed members of the pharmacy team?

Determining Needs

One way of measuring the need for pharmacists is to calculate how many hospitals beds are served by one pharmacist. In a recent survey to investigate pharmacy labour power requirements, an overall figure for the average pharmacist to bed ratio was 111 beds per pharmacist. Figures per region are:

Cape province	72 beds
Transvaal	85 beds
Natal	90 beds
Orange Free State	135 beds
KwaZulu	275 beds
Ciskei and Transkei	475 beds
Bophuthatswana	484 beds
Venda and Lebowa	542 beds

The greatest need exists in Lebowa and Venda, where there is a ratio of 542 beds per pharmacist.

The problems associated with both pharmacists' and their assistants' conditions of service have been brought to the attention of successive ministers of health and the Commission for Administration over the past few years with little result, despite active campaigning on the part of the South African Association of Hospital and Institutional Pharmacists (SAAHIP). In the meantime hospital pharmacy services crumble, patients suffer and vast quantities of money are wasted through the inappropriate storage, handling and use of drugs, as well as theft.

It is clear that more pharmacists are needed in hospital and primary health care services, where there are currently no pharmacy services. In particular, there is a great need for pharmacists in poorly serviced rural areas. Greater numbers of trained assistants are needed as part of a vital support system. Concerted action is necessary on several fronts:

- conditions of service must be improved for pharmacy staff, with appropriate career structures for pharmacists and assistants;
- conditions of service for part-time staff must be addressed;
- there must be equal opportunities for all, regardless of race, gender or creed;
- more assistants must be trained and supported in their training;
- more black pharmacists must be trained;
- posts in rural areas must be made more attractive through area allowances;
- efficient medicine distribution systems must ensure a continuous supply of medication to those who need it; and
- a national drug policy must be established.

Through action on these points, a better, more cost effective health service would be provided to a population which has been considerably deprived.

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Women In Pharmacy

Beverly Summers

There is an increase in the number of women in pharmacy worldwide. In Europe, the proportion of women in pharmacy ranges from 40% to 70%. In the USA it is still only 28%, but 60% of pharmacy graduates in 1989 were women. Denmark has the highest proportion of women pharmacy graduates in Europe. In 1989 over 80% of pharmacy graduates were women.

How Many Women Pharmacists Are There?

South Africa has one of the fastest growing population of women pharmacists in the world. In 40 years the proportion of women pharmacists has risen from 10% to 44%. With 84% of current pharmacy graduates being women, the proportion can only rise, even more rapidly than it has in the past.

Overall the proportion of women pharmacists who work in South Africa is approximately the same as that of men (around 90%). However, 85% of men work full-time, compared with only 56% of women. Comparative figures for the UK and the USA are shown in Table 1.

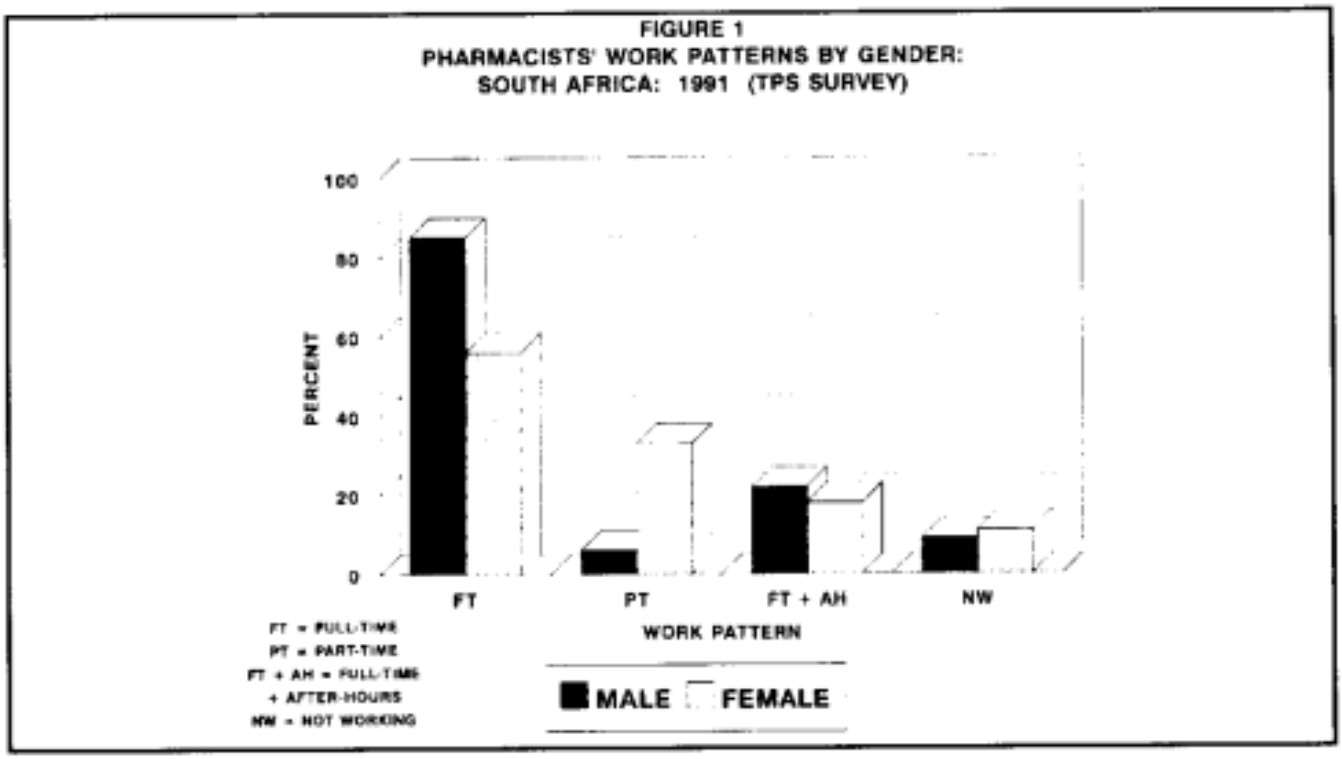

Figure 1: Pharmacists' work patterns by gender - South Africa 1991 (TPS Survey)

Work Patterns among Men and Women

The overall work patterns of male and female pharmacists in southern Africa were examined in a recent postal survey (see Figure 1). Although only 56% of women work full time, compared with 85% of men, the proportion of men and women who do not work at all are very similar (9% and 11% respectively). A larger proportion of women (33%) work part-time than men (6%), and almost as many women (18%) as men (22%) have after hours jobs in addition to their full-time work.

Country	RSA	USA	UK
Year	1991	1988	1990
% women	56	63	54
% men	85	74	73

Table 1: Percentage of pharmacists who work full-time, by gender: RSA, USA and UK

Hospital pharmacy services could not function without women pharmacists. In 1989, 70% of all hospital pharmacists were women under 40. Many women work part-time. These part-timers are classified as temporary staff. This classification means that they are not eligible for promotion or for housing subsidies. The pension scheme for which they are eligible requires smaller contributions, but with smaller benefits too. In addition, as is the case with temporary staff, they can be dismissed at 24 hours notice.

Incentives for Women

Elsewhere in the world (the United Kingdom and the USA) women pharmacists are encouraged to return to work after having children. Special courses are provided and "job sharing" is encouraged ie women who want to work part-time are encouraged to share full-time posts. The UK National Health Service (NHS) is one of the largest employers of women in Europe. In 1991, the NHS joined the "Opportunities 2000" campaign to actively promote employment opportunities for women.

Lack of Promotion

In South Africa, women have been in the majority in hospital pharmacy for many years. Yet only in 1993 have we seen the first appointments of two women as a chief pharmacists in hospitals, at Baragwanath Hospital (Johannesburg) and Tygerberg Hospital (Cape Town).

Although pharmacy in South Africa has one of the highest proportions of women in the world, it has a very poor representation of women at the managerial and professional leadership level, as can be seen from Table 2.

Organisation	No. of members	No. of women members	% Women members
SA Pharmacy Council	16	1*	6
Pharmaceutical Soc. of SA	15	1	7
Pharmaceutical Soc Fellows	151	3**	2
SA Assoc. of Retail Pharmacists	22	2	9
SA Assoc of Hospital Pharmacists Exec. Committee	14	6	43

Note: * Ex officio: member of Nursing Council
** Of which 1 is honorary

Table 2: Women in Pharmaceutical Organisations in South Africa (1991)

Some the of the reasons for lack of women in key posts include:

- the tendency among women (especially young women) to take career breaks in order to bear and raise children;
- lack of domiciliary mobility which hinders promotion;
- lower career drive and higher tolerance levels among women than men;
- entrenched attitudes in southern Africa that women are less able than men to hold positions of responsibility; and
- prejudice against women within male dominated managerial structures.

What underlies discrimination against women pharmacists?

There is a rise in the number of women entering many of the professions. There is an increasing number of women doctors, lawyers and accountants, but when there is an increase in females to the extent that is occurring in pharmacy, the question must be asked "why are so many women choosing pharmacy as a career?", or conversely "why are so few men entering the profession?". The answers lie partly in the poor conditions of service in the public sector and partly in the reduction in the number of pharmacies in the private sector. Salary scales are of course identical for both men and women in government pharmaceutical services. Public sector pharmaceutical salaries have, however, failed to keep pace with inflation in recent years. In addition, other important groups of professional health workers, such as doctors and nurses, have had significant improvements in conditions of service. Pharmacists representations to government on their conditions of service have tended to be ignored. These gradually eroding conditions of service have resulted in a steady flow of pharmacists out of the public sector into the private sector, where the trend is towards fewer but larger pharmacies. It has been demonstrated that women generally are more prepared to occupy a subordinate role than men. The net result of the deterioration in job prospects over the past years has been a reduction in the number of males entering the profession. This, it can be argued, creates a downward spiral in terms of conditions of service as employers expect to pay women less than men, and women are less likely to voice their dissatisfaction.

Good pharmaceutical services are vital. The World Health Organisation recognises that "efficient medicine can be practised only where there is efficient drug management". It is totally false economy to allow public sector pharmaceutical services to collapse through neglect of proper working conditions.

The Need for Change

The large number of women in pharmacy means that changes must be made to existing structures and conditions in order to use the workforce to its full potential. This group is likely to need part-time employment at some stage. Part-time workers are often better motivated and harder working than full-time workers, given the same incentives. This valuable sector of the workforce must be encouraged to work, particularly in the public sector in order to reduce staff shortages. Women pharmacists must be encouraged to work. This can be done

through action in

a) the practice setting where:

- job sharing should be simplified and encouraged;
- part-time employees should not be classified as temporary staff or penalised through being declared ineligible for promotion and other employment opportunities;
- promotion must be on ability and merit, not on length of service; and
- there must be a "no penalty" return to work policy for women after child bearing.

b) academia where:

- an increase in pharmacy student numbers is required to compensate for the increased proportion of women graduates;
- post-graduate qualifications must be encouraged and recognised; and
- "return to work" courses for new mothers should be made available.

Women in certain sectors of South African society are socially conditioned to accept a passive role. Women pharmacists should, however, realise that they have the same potential as their male counterparts to succeed in management. They must strive for equal opportunity and equal rewards in our patriarchal society. They must be more assertive and prepared to take leadership roles. Their confidence must be enhanced, and their political awareness and involvement must increase. With the increase in the number of women in key positions, it may be that a more caring, enlightened, honest and objective profession would result.

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Managing Drugs - Policy Options

What role should drugs play in primary health care? What policies do we need to develop to ensure rational drug use? How do we compel the drug industry to respond to the country's health needs? What can we learn from international struggles?

National Drug Policy as Part of Comprehensive Health Care

Bada Pharasi

South Africa is experiencing a crisis in its health care services, which is, in large part, due to the high cost of private sector services, particularly the cost of drugs. Presently, medical aids are unable to absorb further costs without increasing members' contributions beyond affordable levels. In finding solutions, debate has focussed on descheduling, calls for increased self-medication, dispensing by doctors, generic substitution and new regulations for the medical aids. These mostly concern the private sector and primarily reflect conflict amongst vested interests in that sector contesting their respective share of the market.

These debates obscure the need for an all encompassing review of health services, particularly the health care needs of the majority of South Africans who cannot afford private health care and rely on the inefficient public sector. The failings of the health service as a whole are also reflected in the public sector distribution of drugs. Drugs are often not available to the poorest, personnel responsible for drug management at the periphery are often inadequately trained and support services are sadly lacking.

The Need for a National Drug Policy

A policy is needed to address both drug availability in the public sector and the rational and cost-effective use of drugs in the private sector. There have been various calls in the past for a national drug policy. This is by no means a new concept for South Africa. Drugs alone, however, cannot be relied on to solve the health care problems of the nation. A drug policy can only be successfully implemented if it forms an integral part of an approach based on the primary health care concept. However, the application of a national drug policy to the private sector need not involve nationalisation nor lead to disinvestment of multinational pharmaceutical manufacturers from the country.

A national drug policy aims to make essential drugs of acceptable quality and efficacy, accessible to the majority of people at affordable cost. It lays the basis for the achievement of greater efficiency in the pharmaceutical supply system, co-ordination of its different components and training and deployment of appropriate pharmaceutical personnel at every level.

The starting point of a national drug policy is an essential drugs list
Photo: Ismail Vawda

A national drug policy is also intended to ensure the rational use of drugs, for both economic and therapeutic reasons. The components of a developed drug policy include drug legislation and regulatory control, product selection, quality assurance, local production, procurement, distribution, pricing, research and development, training of health workers in the proper use of drugs and utilisation of locally available natural resources. It is also important to evaluate the use of traditional medicines and rationalise these remedies, with a view to incorporating their use in the health system.

Essential Drugs List

The first step towards establishing an effective drug policy is the compilation of an essential drugs list, whereby drugs are categorised to indicate the level of the health system at which each drug may be used. Essential drugs are drugs that meet the needs of the majority of the population. They must have proven therapeutic effectivity and be acceptably safe.

The number of drugs necessary for treating the large majority of diseases both in developed and developing countries is relatively small. It is estimated that diseases accounting for up to 90% of illness and death amongst the poor in the developing world, fall into 2 main groups, nutritional deficiencies and communicable diseases. Yet, according to World Health Organisation (WHO) research concerning the ten years from 1977 to 1987, leading products on the world market were mainly for the treatment of ulcers, anxiety and hypertension. In developing countries, scarce resources have been used for non-essential drugs, mostly consumed by a small segment of the population.

WHO recommends that a list of essential drugs should be drawn up by every developing country as a first step towards achieving cost effectiveness in the supply of drugs. It is then necessary to ensure that the country's drug requirements are purchased and distributed through the most efficient and cost effective system. WHO surveys show that access to essential drugs is highest in those countries with well developed procurement and distribution systems. A centralised procurement agency is important for bulk purchasing of raw materials or finished products on the world market.

It is estimated that an effective policy based on a national selection of drugs linked to bulk purchase could reduce costs by 40%. The use of generic names, domestic production and a public system of distribution could account for a further 20% reduction.

Drugs and Comprehensive Health Care

In South Africa, a central agency is responsible for the bulk purchasing of drugs on tender for the public sector. It is successful in terms of cost-effectiveness. Discounts of up to 80% have been achieved in some instances. However, it is not linked to a comprehensive drug policy to ensure that these drugs are widely available and accessible to the greater majority.

Drugs are undoubtedly important to improving the health of nations, but their role in sustaining good health tends to be exaggerated. Preventive public health which emphasises adequate sanitation, housing, nutrition and primary health care facilities, represents the most efficient long-term strategy to the control and eventual eradication of a wide range of infectious and parasitic diseases. Many developing nations have, however, relied on pharmaceuticals as their first line of defence against disease. United Nations estimates show that drugs constitute approximately 40 to 50% of the health budget in many developing countries, compared to 10 to 20% in developed countries.

The availability of drugs is meaningless if health promotion and preventive programmes are not developed simultaneously, on a scale dictated by the primary health care principles. A researcher on the impact of drugs on health in developing countries says he is "struck by the grand paradox of the existence of an assertive drug industry with its powerful armoury of products, alongside this sanitary chaos with its almost total absence of the physical and economic structures essential for 'health'. Just how relevant to health could the products of the research based pharmaceutical industry be in a community in which the supply of enough food to meet even minimum energy needs cannot yet be assured?"

Thus, comprehensive health care strategies, together with the political will of governments, are critical to ensuring that drug policies yield the desired results. This is well illustrated by the case of Bangladesh. Although Bangladesh has a well-defined national drug policy, it's population is among those with least access to essential drugs. In 1982 Bangladesh adopted an essential drug policy, resulting in the elimination of non-essential and harmful drugs. By 1984, 80% of drug requirements were locally produced. Medicines were soon available at lower prices countrywide. However, years later most people were still without access to basic essential drugs.

Widespread coverage cannot be achieved without a comprehensive health policy and integration of a national drug policy into an approach based on primary health care. Pharmaceutical services have to be an integral part of, and subject to, the broader health care strategy. Does this imply unwarranted

controls over the private health care sector or even nationalisation of that sector?

The private retail sector

The private sector, with 84% of the country's pharmacy personnel and responsible for 80% of the country's total medicines expenditure, is a major player. A democratic government that seeks to provide health care to all will be unable to provide facilities over-night and will have to rely, in the interim, on existing private sector services.

Countries with a strong private sector have found it politically expedient to confine drug policy to rationalising supply in the public sector, leaving drug use in the private sector largely uncontrolled. However, the availability of essential drugs has a limited benefit if drugs are not used correctly. As the private sector is often guilty of promoting irrational drug use, it must be included in the national drug policy. The medical aid third party payment system has been largely responsible for irrational drug use in the private sector by making it attractive for providers to over provide and over prescribe.

The relationship between the public and private sectors has to be defined in such a way as to promote national health care goals, but in a way that will minimally affect the independence of the private sector. Ironically, it is the much criticised Medical Schemes Amendment Act which could facilitate cost effective restructuring of the private sector.

The Act could result in the creation of group practices, with pharmacists participating in multi-disciplinary health care teams. Such teams could be contracted to the public health care authorities to provide care to the state's dependents. It would be possible for the state, as the main buyer of health care, to insist on certain drug policy guidelines being followed when public sector patients are seen. Such guidelines would be the subject of negotiation between the state and independent contractors.

Multinational Corporations

Multinational pharmaceutical corporations are averse to the concept of a national drug policy because it implies the adoption of limited drug lists and policies of generic substitution which could affect the sales of branded products. Warnings have been sounded that such a policy would lead to the withdrawal of multinational pharmaceutical manufacturers from the country, and large scale private investment in the industry would dry up. The consequence would be the loss of vital technology and the loss of thousands of jobs. This scenario is not

supported by events in a number of developing countries, such as Mexico and Zimbabwe, where the tightening of drug legislation did not precipitate large scale disinvestment.

In the case of South Africa, certain factors mitigate against the possibility of the "technology flight". The adoption of a drug policy might limit the number of drug formulations on the market and affect profits generated by the sale of certain drug brands. However, increased health care coverage under a new government is likely to lead to increased sales of the fewer drugs remaining on the market.

Recent changes to legislation will provide an extra incentive for the multinationals to stay. The formation of group practices, unless they adopt generic purchasing as a cost minimalisation measure, presents the possibility of a 'new' market. Allowing pharmacists to prescribe medicines in higher schedules and non-pharmacists to own pharmacies will also lead to an expansion in the market for branded products.

South Africa has the potential of becoming a regional centre of supply to the rest of southern Africa. With the imminent removal of sanctions, the vast trade opportunities awaiting it cannot be lost on the pharmaceutical industry. The potential threat of losing innovative capital can be discounted. No multinationals are involved in any real basic research here, despite South Africa having some well established clinical research centres.

A new government, while requiring the industry to comply with industrial and health promotion policies, will probably be mindful of the industry's contribution to the industrial development of the country. It will most likely consult with representatives of the pharmaceutical industry before embarking on any new policies that affect it.

The multinational pharmaceutical industry needs to base its strategies on producing and promoting products which address the real therapeutic needs of the population. Its future in the country is assured if it participates actively in the economic and social development of South Africa.

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The Drug Policy
of the African National Congress

Peter Eagles

The lack of a cohesive drug policy in South Africa, has been identified as a major contributor to the country's health dilemma. A drug policy consists of many aspects. Some of these exist already, but in forms which are detrimental to patients.

The African National Congress (ANC) is committed to the principle of a written drug policy for SA which is legislated and appropriately regulated. The major components of the drug policy will include legislation and regulations, choice of drugs, supply of drugs, quality assurance of drugs, and human resources within the health care system.

These components have to be informed by analysing and assessing the qualitative and quantitative aspects of health resources (human, financial and physical) in the country and their comparison with international data.

The accurate collection and correct interpretation of data needed for developing a rational drug policy must be a priority, especially if one considers the dearth of accurate information in the country and its dire consequences which we experience today.

The ANC's drug policy is being developed against the backdrop of a health care system made up of a public and a private sector. The National Health System (NHS) of an ANC government will have a strong public sector, which will provide care to all, and a private sector which will care for those persons who can afford it or who are referred from the public sector.

The central tenets of the ANC's drug policy will be:

- the registration of drugs with special emphasis on their approval and pricing;
- continued and wider use of generics;
- an essential drugs list;
- the procurement of drugs for the country's public and private sector;
- distribution and accessibility of drugs, and the rational use of drugs and their implications for the drug products, the patients and the professionals;
- the promotion of local industry.

The drug policy document, which is being developed, will incorporate a strategy for the effective application of drugs within the framework of the NHS. The NHS will be based on primary health care, emphasising more the preventive and rehabilitative aspects rather than curative ones as the tradition in this country has been.

Many areas are being fleshed out in the process of policy development. Some of these are presented here.

1. The Choice of Drugs

Drug choice is influenced by many factors and considerations including:

a. Approved drugs

Only drugs proven to be safe and of acceptable quality and efficacy will be marketed. When drugs are registered, their prices will be decided on after adequate consideration by the registering body of the country. The present Medicines Control Council which registers drugs in the country has controlled the standards of medicines on the market adequately. It has set a good example, but certain aspects like the structure, scope of activities and the composition of the council will have to be improved.

b. Rational use of drugs

For optimum benefit to patients, the rational use of drugs will be recommended. The main principles are well known and include:

- the effectivity of a drug, and its prescription only when it is essential - at the right time and in the correct quantity; and
- the availability of an essential drug countrywide, including the remotest of rural areas.

c. Essential drug list of South Africa (EDLISSA)

This includes a list of the most needed drugs to fit the disease profile of the country. It has , to a certain extent, already been applied in the public sector. Wider use and regulation of the list will take place, thereby allowing for flexibility in the inclusions and exclusions of drugs. The number of permutations of a drug will be limited on the advice of expert committees established for this purpose.

d. Generics Policy

Generics are well used in both the public and the private sectors (medical aids use the maximum medical aid pricing system).

The use of generics of acceptable quality will be encouraged. Compliance of the generic drug with the principle of therapeutic equivalence, as assessed by the registering body of the country, will be used to decide on the suitability of a generic for use in the country, after adequate investigation of international experiences. Expert committees which would liaise with subcommittees made up of academics, clinicians and representation from professional bodies, pharmaceutical manufacturers, consumer and patient organisations will be involved, in an advisory capacity, in the process of selection. This will ensure that the generics policy has the approval of the providers and consumers of health care. Health education directed at all the participants in the health care system will include, amongst other issues, the one of generic medicines and education around the rational use of drugs and the health care system itself.

e. Therapeutic protocols

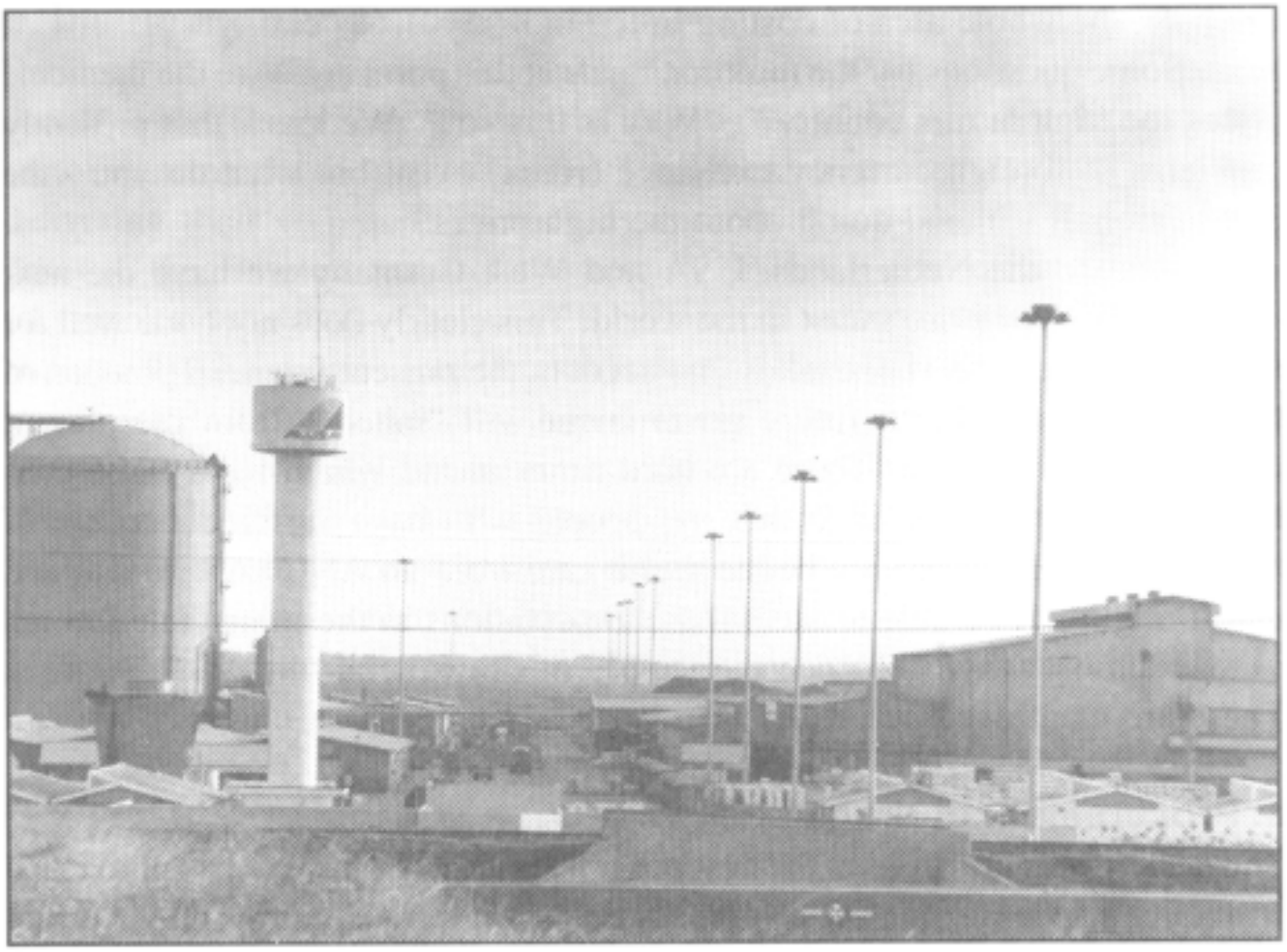
These are lists of specific protocols to be followed in the treatment of designated diseases. They are used in conjunction with considerations on choices of essential drugs which will include generics.

f. Traditional drugs

These drugs are extensively used. They will be incorporated into the health care system in a way which ensures their quality, efficacy, acceptability and safety are in line with other drugs in use. Traditional drugs will be thoroughly investigated by a special committee of the ANC due to the multi-factorial nature of this aspect of health care. Culture, health care (somatic and psychosomatic applications) and the economy of our country are all intimately linked through and by the use of these traditional medicines.

2. The Supply of Drugs

The annual pharmaceuticals or drugs bill accounts for 45-50% of health care expenditure, that is, R8 to R10bn. Yet not everyone receives adequate drug therapy. There are many reasons for this. But a central point about drugs is that the supply of drugs will always be important even in the new health care system where preventive care will be emphasised. It is widely recognised that patients regard the receipt of a drug as the end of their interaction with the system and it heralds the beginning of "the cure". While education can correct the misconception that there is a drug for every disease, it will be an aim of policy to ensure adequate drugs are available. Some will be imported and others



There is a sprinkling of local pharmaceutical industry in South Africa.
Photo: William Matlala

produced locally.

There is a sprinkling of local industry in South Africa, and the ANC has committed itself to the promotion of a local drug industry. The multinational pharmaceutical companies make up 170 out of 250 manufacturing concerns. Their influence is far reaching, not only in health but also in the economy where vast revenues are generated for the country's coffers. The Economics Department of the ANC has stated that the country will function with a mixed economy composed of a public and a private sector. This has opened up the debate as to how the health care system engages this powerful force for the purposes of mutual benefit.

The ANC will strive towards a symbiosis of state, communities and the multinationals. The multinationals will be given the chance to contribute to the health care system in many ways, including social awareness programmes, improved employment policies, education on drug usage and essential national health research. They would also be involved in matters of drug policy including working towards creating more transparency in the industry. For

example, the whole area of costing in the industry needs clarity.

Some questions for the multinationals at this point are "Are the medicine prices too high in this country?", "Why is this so?" We know that presently problems of foreign currency exchange (forex) exist, but what do you - the multinationals - intend doing about the high prices?

Next to the Netherlands, USA and West Germany we have the next highest consumer price index in the world. This clearly does not bode well for the future, especially if one takes into account the present financial position of the country and what a future government will "inherit" from the present nationalist government. There are hard times ahead which have to be confronted with the knowledge that the people who have suffered because of apartheid will be expecting better health care from an ANC government and that it might not be able to meet these expectations in the immediate future.

Factors which influence the supply of drugs need further elaboration. These are mentioned here.

a. Procurement of drugs

The need to procure drugs at the best possible prices will have to be approached with circumspection and the awareness that short term solutions must be well thought through if our long term solutions and expectations are to be realised. The central procurement of all drugs by the government was a route taken by some countries in the developing world. In that system the public and private sectors would purchase drugs from the government which would be the sole procurer in the country. Other options to be investigated could be:

- the state as sole procurer of essential drugs for either both the public and private sector or only the public sector with the private sector following its own wishes;
- the present system ie. the tendering system used by the public sector, with the private sector acting independently but within the laws of the country; and
- the state and other countries in the region jointly tendering at the international level for essential drugs only.

Thorough research of all possible advantages and disadvantages will be done before deciding on one or more of these options for drug procurement. Market forces will be closely monitored. Any emerging information which might inform other aspects of the drug policy, particularly the promotion of local industry, also needs to be noted.

b. Distribution and storage

Rational use of drugs can only take place if drugs are accessible to people countrywide. This will be achieved by making use of the infrastructure of public sector systems and the private sector. The latter, never seems to have problems delivering their commodities such as cool drinks, medicinal and industrial gases to the remotest areas of the country. Better use of private community pharmacies would also help. In fact, partial incorporation of the private community pharmacies into the public sector/ national health service will be investigated. If this is suitable, then it would go a long way to making drugs accessible and available at all times. This is especially necessary when the clinics and other government suppliers are closed. Good stock control would have to be put in place to ensure cost-effectiveness of drug use, unlike the present situation in which the "district" pharmacist is being supplied from a central provincial store in an inefficient way. Storage, either centrally or regionally, would also have to be investigated for suitability.

c. Local production

A strong local industry is desirable and comprehensive research would be needed to assess its real value to the country. We will need to foster a strong local chemical industry to produce and supply the raw materials needed for pharmaceutical manufacturing. Presently, most of these materials are imported at great cost to the country. An interesting fact is that just about all the multinationals have set up generic producing companies which might, if moved into the country, help to provide the expertise and infrastructure to aid in the research of raw materials.

3. Human Resources

Human resources, including new categories of personnel, appropriately trained, to run and organise the different elements of drug policy will be a priority. The establishment of training schemes which would serve South Africa and countries in southern Africa, will be established.

Aspects of the drug policy of the ANC have been discussed above. The final policy will be evaluated regularly to ensure that it serves its purpose of effective drug management. It has to be beneficial to patients and to the country as a whole. Where the evaluation shows a need to change, the policy will be adapted accordingly.

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Some Thoughts on Strategy Options for the South African Pharmaceutical Industry

Rod Crompton

Pharmaceutical production in a less developed country like South Africa should primarily be determined by demand. The demand for drugs is shaped by a wide range of factors, including, the size and role of the public and private sectors, and drug policy with regard to generics and essential drugs.

It is, therefore, almost impossible to set out a development strategy for pharmaceutical production when the demand pattern that is likely to prevail in a new South Africa has not yet been crystallised and stabilised. The state needs to set the direction of development for health care first. Hopefully, a new government will do so. Thereafter, a production strategy can more easily be identified. Consequently, what follows is more an identification of problem areas and possibilities than a set of solutions.

Research and Development

The international pharmaceutical industry is a small but important part of the chemical industry. It is characterised by high levels of profit. Although the volumes of material handled are comparatively small, manufacture often involves many, up to 14, processing stages.

The engine driving the international pharmaceutical industry is Research and Development (R&D). Typically, the leading multinational companies (MNC's) spend 15% of sales on R&D. They are mainly in pursuit of new active ingredients with which to make a new 'blockbuster' drug which, when globally patented and marketed, will generate the high profits to fund the next round of R&D.

The USA, western Europe and Japan, with only 20% of the world's population, account for about 70% of the world market for drugs, so the MNC's have tended to focus on the most profitable ailments in these rich countries. These MNC's have huge numbers of researchers and sales people. Merck & Co., for example, employ 6 300 researchers and 6300 sales people, excluding

The engine driving the pharmaceutical industy is research and development.
Photo courtesy of SALB

production workers. Together, this represents more than the total South African pharmaceutical industry workforce, including production workers.

Part of the reason for the small workforce in the local industry is the very limited expenditure by pharmaceutical companies in South Africa on R&D. The more active firms typically spend only about 4% of sales on R&D. Clearly, South Africa is not in a position to compete against the major MNCs.

Over the last decade, R&D spending by MNCs in the developed countries has been increasing, partly because of wage gains made by researchers. This also has to do with the fact that most of the 'easy' drugs have been discovered and the remaining health problems require more 'difficult' and costly solutions. The MNCs are therefore looking for ways of conducting R&D more cheaply.

Putting Our R&D Capacity to Use

This presents South Africa with an opportunity. Our historically skewed emphasis on providing health care for rich whites and establishing relatively

good 'white' universities has led to the development of an R&D capacity. South Africa may, therefore, be able to make an impact on the global pharmaceutical industry which is larger than our meagre local demand for pharmaceuticals. Although much attention is rightly being devoted to correcting historical discrimination, this resource base need not be wasted. Indeed it is beginning to be exploited where some existing infrastructure already exists. In certain research areas, South African firms and universities have been able to take on contract research for MNC clients. This capacity is enhanced by the weak exchange rate and, by international standards, comparatively low wage costs of researchers, especially those with technikon type training.

There are a number of reasons why an active state policy encouraging this type of contract research would be useful. Apart from generating skilled jobs, there can be a wide range of feedback into the scientific community. It could also be a learning conduit which may, over time, connect South Africa to wider and larger international developments. Moreover, there are also prospects that this first world R&D capability could be used to help solve some of South Africa's third world health problems.

An active state policy promoting R&D would have to be complemented by matching policies in the fields of science and technology and education and industrial policy.

Trade Imbalance

One of the general problems facing the South African economy concerns the balance of payments. The pharmaceutical industry contributes to these problems. Imports are greater than exports. In the late 1970s and early 1980s, imports of pharmaceuticals increased significantly, from 10% of domestic demand to about 30%. Exports over the 1980 to 1990 period declined from about 10% of production to about 6%, despite the fact that export incentives make exports more lucrative than sales on the domestic market.

It may be that the import of brand name finished goods is boosting imports. Imports could be reduced by an essential drug list and a central buying organisation such as we have for crude oil. The low level of exports may be increased by the usual incentives, such as access to duty free intermediate inputs, soft credit and tax write offs for marketing expenditure. The contract research discussed above is also an export product which can help to address the trade imbalance.

However, the larger problem is likely to be the preponderance of MNCs in South Africa. They account for 70% of the pharmaceutical industry within

the country and are reluctant exporters. For years they have had a cosy time selling into our protected market. The De Villiers investigation established that the prices of ethical drugs produced by MNCs rose at a much faster rate than those produced by local firms.

Countering the Negative Effects of the MNCs

The high level of penetration of the local industry by foreign MNC's allowed by the apartheid regime is a difficult problem which will take some undoing. Nationalisation would be one simple solution, but the political price that SA would have to pay in terms of a drop in international 'confidence' may not make it worth the trouble.

A different package of policies could achieve a similar result. For example, the UK, even after years of right wing government, still expropriates surplus profits made by pharmaceutical corporations. Even that cornerstone of free market ideology, the USA, is considering a price freeze on drugs.

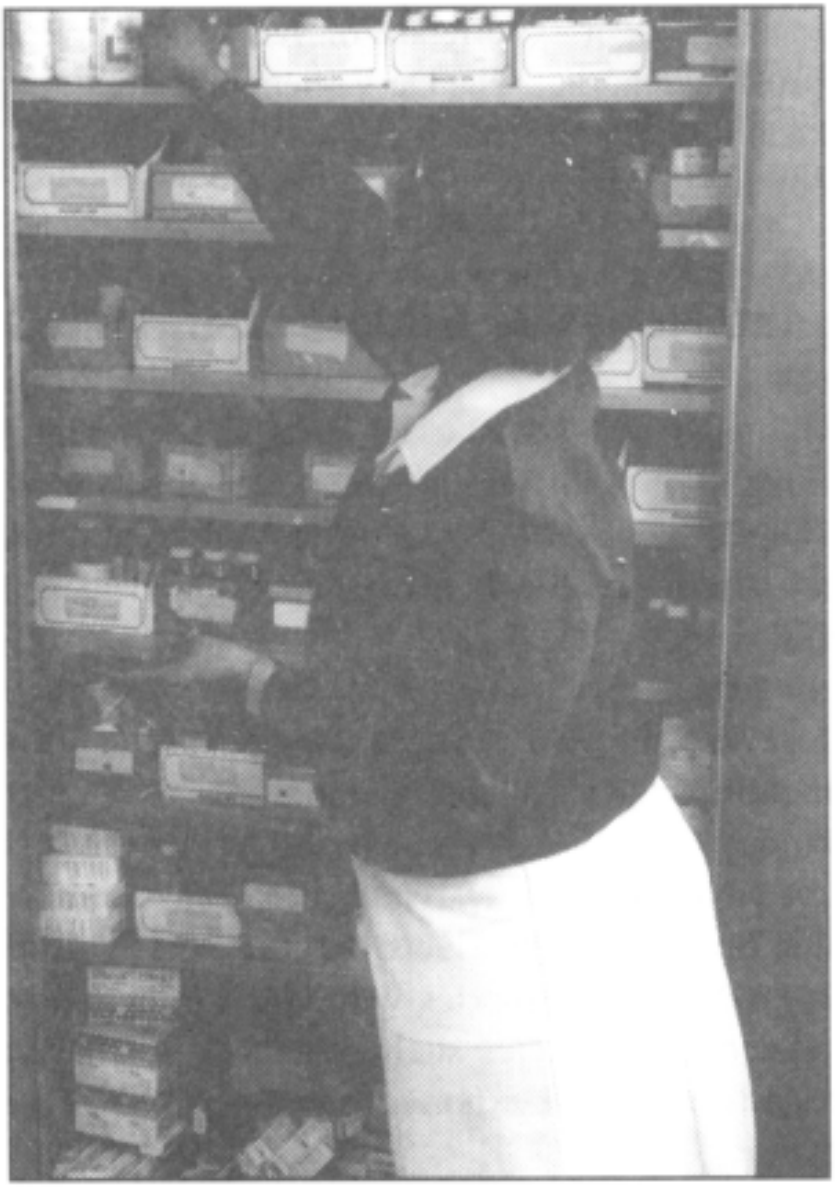
The foreign MNC's active locally are chiefly involved in the production of more profitable brand name products. Accordingly, a drugs policy which gives far greater emphasis to generics will squeeze their market and should reduce imports. Secondly, policies such as a state purchasing policy which gives preference to firms which exported, say, over 30% of sales, would also force firms to export.

Proper state licensing and investment policies will be crucial, with access only for those which make significant exports and which enter into joint ventures with local or state owned firms. The strategy should be to force MNC's into joint ventures with an export orientation.

Lack of Training and Inflated Prices

It is quite probable that local production efficiency levels are well below internationally competitive levels. For example, whilst capital has been quick to invest in hi-tech computerised warehouses, they have neglected the basics such as worker training. The only real solution for continuing improvements in production efficiencies lies in the fruits of industry level collective bargaining. This is because of the particular political, cultural and racial heritage which inform current shop floor attitudes and perceptions.

Another important feature of the local industry is the very high cost delivery chain, from production to wholesaling to retailing. This is despite the



The demand for drugs is shaped by a wide range of factors. ***Photo: Ismail Vawda***

fact that there is a high level of vertical integration in the ownership of the pharmaceutical chain. In other words, the major local producers are also the major local wholesalers and also dominate the retail pharmacy industry. Three firms dominate the local industry and some 70% of retail pharmacies are bonded to these manufacturers. Vertical integration is usually a strategy adopted by firms to keep final prices down in the face of competition. In South Africa, it seems to be a mechanism for market control and excessive profits.

Oligopolies do tend to inflate prices if they are given the opportunity and stricter measures are needed to prevent this. An active competition board with some backbone and a judicious use of tariffs will help to keep prices down. A plethora of detailed regulations contribute to this high cost chain and they will need to be substituted with regulations and schemes which deliver lower prices rather than protection for some interest group or other.

State with Resolve or Forum with Worker Participation

All of these measures require a good deal of state intervention. Internationally, the pharmaceutical industry is one of the most highly regulated industries, so this should not draw undue attention from the detractors of post apartheid reconstruction. Nevertheless, the morass of existing problems will require a state with firm resolve, capable of some rapid political footwork to deal with the squabbling interest groups. It will also require a co-ordinated strategy which draws in education policy, science and technology policy, trade policy and industrial policy around that most important ingredient, a clear state health care policy.

In order to address the pharmaceutical production issues raised here, it will be necessary to develop a research capacity to identify far more precisely the nature of the problems and then to develop a detailed strategy for the industry. Ideally, we will need a state committed to and able to implement a proper strategy for health care and the pharmaceutical industry. However, the prospects of these requirements being met is, at best, uncertain.

Recently, a representative of one of the major local firms called for the establishment of a forum of "the real movers and shakers in the industry" to address the cost of medicines and other issues and thereby "get their house in order". Squabbling interest groups within the forum will fight to promote their particular interests. Nevertheless, this might have been an important initiative if the representative in question had not excluded organised labour, the real producers. Clearly, it is an invitation to organised labour to do some "moving and shaking" in the industry so that they too may be regarded as eligible to attend.

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Ensuring Rational Drug Use in the Context of Primary Health Care

Catherine Hodgkin

This article is a shortened version of a paper presented at a conference, "Primary Health Care and Drugs: Global Action Towards Rational Use", in Bielefeld, Germany, 1990, organised by BUKO and Health Action International. For more information on these organisations, see the Resources pages

The provision of essential drugs is only one element of a comprehensive primary health care (PHC) system. Although Health Action International (HAI) works mostly on drug related problems, it does not believe that the provision of drugs is the most important element of PHC. In fact, any mention of the rational use of essential drugs is remarkably absent from the 1978 Alma Ata Declaration on PHC, the issue is only dealt with in Point 14 of the detailed recommendations.

Declarations of this sort tend to become set in stone. It is not normally possible to add amendments after the benefit of experience. One of the most important lessons of the last ten years is that we cannot assume that essential drugs, once available, will automatically be used rationally, and that inessential drugs will then magically fade from the scene. The provision of essential drugs has to be accompanied by measures, at all levels of the health care system, to encourage and promote the rational use of drugs and to discourage irrational use.

Drugs for Profit

Steps to encourage rational drug use are frequently countered by established irrational patterns of drug use and misleading drug advertising. These have adversely influenced health and undermined attempts to change health policy. Of all the elements of PHC, the provision of drugs is most clearly determined by commercial concerns and the drive for large profits.

If health considerations were of prime importance to the pharmaceutical industry, we would not face a situation in which hundreds of anti-diarrhoeals are sold on the world market. If the industry was in the hands of those who had sworn to abide by the Hippocratic Oath, we would not have a situation in which children in developing countries have a degree of resistance to antibiotics. A recent survey of antibiotic resistance in developing countries found that all but one of 41 children screened in Caracas and all but two of 53 in Qin Pu (China) carried resistant strains of E coli.

The Need to Encouraging Rational Use

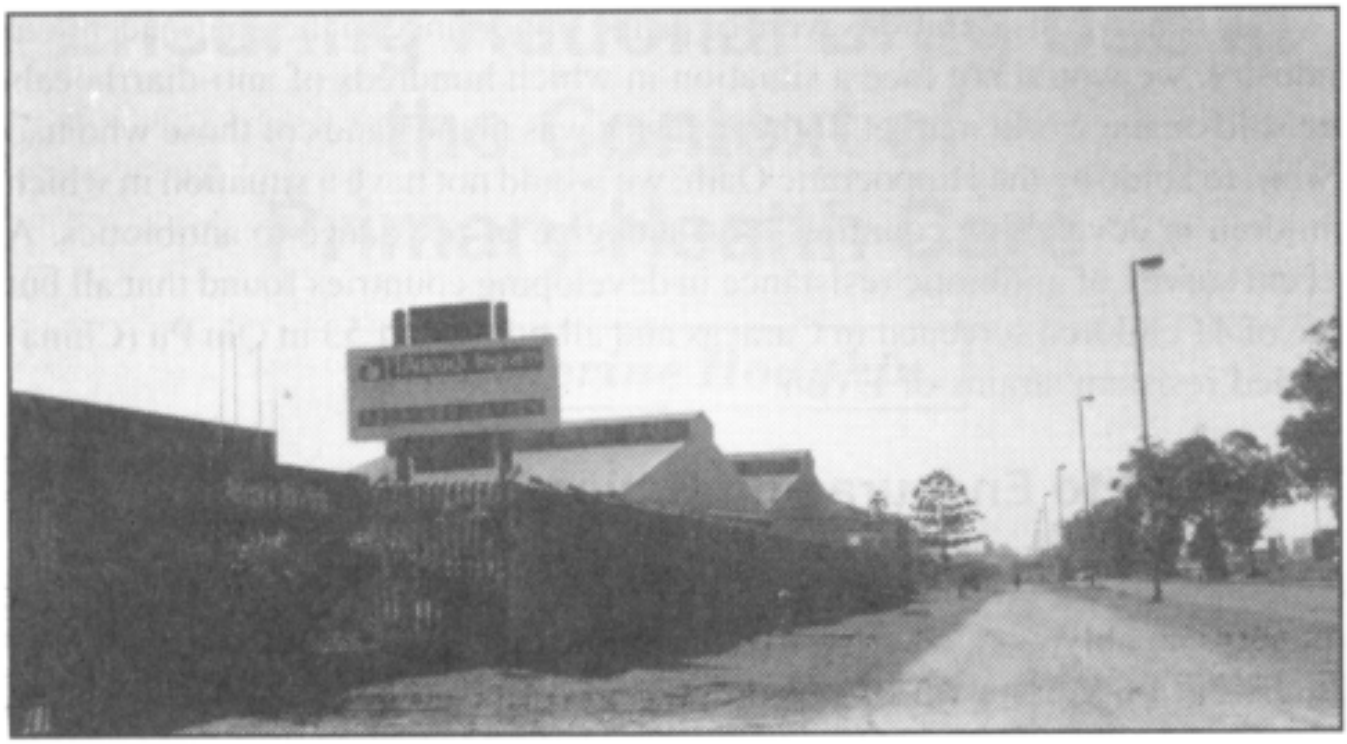
HAI supports the global essential drug strategy developed by WHO. But this strategy can only work if activities concentrate, not only on providing essential drugs, but on getting rid of inappropriate and ineffective drugs in both the private and public sectors. Once these steps have been taken, it is important to ensure that the remaining essential drugs are used rationally.

This has turned out to be a more difficult task than first anticipated. For example, although the drug policy of Bangladesh has set an example for the world, a recent survey of prescribing practices for children in Bangladesh showed that more than 70% of prescriptions contained antibiotics. Sri Lanka has also had some success in rationalising its drug market, yet a survey found that 85% of prescriptions were for three or more drugs.

Rational drug policies and rational drug use are an important part of primary health care in both developing and industrialised countries, but the consequences of irrational drug use are much more serious in situations of extreme scarcity. Unfortunately, the number of countries affected by extreme scarcity has increased in the past decade. The number of Least Developed Countries (LDCs), defined as countries with per capita incomes under US$ 240, increased from 28 countries at the beginning of the 1980s to 42 at the end of the decade. WHO estimates a per capita health expenditure of $5 per year for LDCs, compared with expenditures of up to $2000 per capita for industrialised countries.

The Problem: A Case History

A case history illustrates both the problem and provides some ideas about the possible ways for HAI and other organisations to assist the move forward from irrational to rational drug use. A mother in India took her one year old child, suffering from severe diarrhoea, to hospital. The paediatrician gave the mother



The Provision of drugs is most clearly determined by the drive for profits.
Photo: Ismail Vawda

a prescription including eight drugs. Two of the drugs contain a form of opium and another contains a pethidine substitute. The prescribed dosage of a further drug could be a risk to the health of a sick one year old.

The story, at first sight, is a simple horror story, another of those frightful but far too common examples of extremely inappropriate prescribing practices. Enormous amounts of money have gone into conveying the simple message that children with diarrhoea need fluids and salts, not drugs. Yet, governments, the pharmaceutical industry, the medical education system and health care consumers still fail to ensure the rational use of drugs. Children will continue to die, not because of a lack of expensive medical care, but because they receive inappropriate medical care.

Fortunately, the mother consulted another paediatrician. the child was given oral rehydration and made an 'uneventful' recovery. This ending provides room for optimism and points to several ways to move forward from irrational to rational drug use.

An Educated Population

The first reason for optimism relates to the mother's critical appraisal of the prescription. However, she must have been a rather exceptional woman. It takes considerable guts to question a specialist's advice when the health of your

baby is at stake. Therefore, it is important to have adequate quality controls and regulations to ensure that only effective drugs of a guaranteed standard are on the market.

Good regulations, although necessary, are not sufficient by themselves. It is also vital that the consumer is well educated and capable of recognising a clearly unsatisfactory prescription. Regulations alone will not lead to rational drug use if people are convinced that the quality of a prescription can be measured by the number of drugs prescribed and preferably given through an injection. The rational use of drugs will not be achieved unless people develop a good understanding of health and what drugs can and cannot do.

HAI groups can help to promote rational drug use by working in their own communities to challenge people's attitudes. This can be done by producing simple printed materials, working with the media, organising discussions at the community level or working, as BUKO does, through street theatre. One of the Indian HAI groups publicises rational health issues through people's science marches, which use dance, mime and puppet theatre. These initiatives are important and most successful when they are developed and followed through at the community level.

Changing Prescribing Practices

The next reason for optimism is that the second paediatrician referred the case to the prescription audit group in the hospital. The first doctor was, in some sense, brought to account and the chance of a similar prescription occurring again was reduced.

Both developing and industrialised countries are taking measures to promote rational prescribing. Formularies, therapeutic guidelines or limited drug lists are used to influence prescribing in advance and monitoring and auditing of prescriptions are used to evaluate, in retrospect, prescribing practices. The provision of independent sources of both written and oral information on drugs to doctors can also have a significant effect on prescribing.

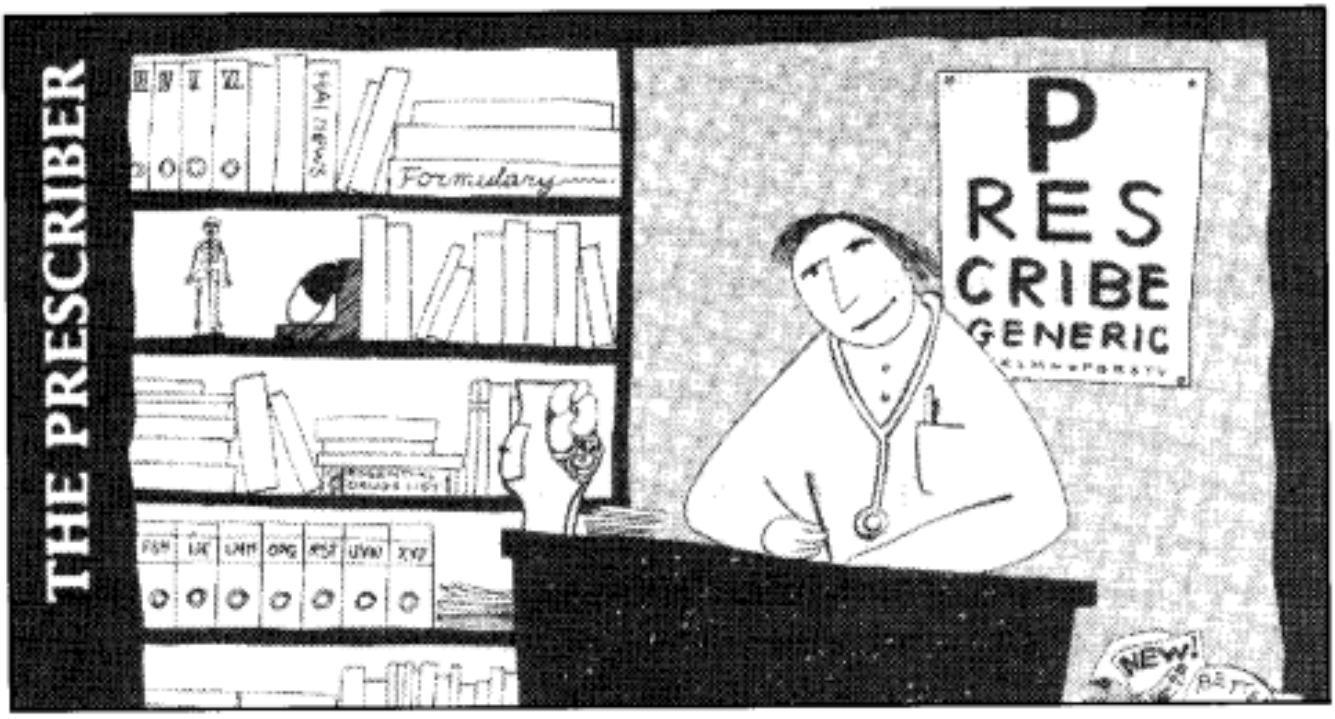
Controlled trials have shown that the most effective way to influence a doctor's prescribing pattern is the one to one technique employed by pharmaceutical sales representatives. We are learning, belatedly, to use this technique to counter the promotional activities of the pharmaceutical industry. HAI groups in all regions of the world are involved in initiatives such as these to promote rational prescribing practices and in helping to spread information on how to set up and make these initiatives work.

Withdrawing Inappropriate Drugs

The third reason for optimism is that some of the drugs listed in the paediatrician's prescription, and other drugs of doubtful value, are disappearing from the market as a result of pressure by consumer health groups. In June of 1990, Johnson and Johnson announced that it was withdrawing paediatric formulations of imodium. In 1989, Wellcome announced the withdrawal of its popular anti-diarrhoeal ADM, a best seller in Africa. These drugs were not withdrawn because the companies suddenly realised that they were medically inappropriate, but because the publicity their products were attracting was, quite simply, bad for business.

HAI members in Asia, Africa, Latin America and Europe were important participants in the campaigns which led to the withdrawal of these drugs. HAI as a whole, and HAI groups operating nationally, have played an important role in monitoring the pharmaceutical industry, in drawing attention to examples of poor practice, and in conducting international campaigns about categories of drugs which are common problems, such as anti-diarrhoeals. As a result, some companies have been forced to think critically about their own policies. The pharmaceutical industry also presents less of a united front than it did ten years ago.

HAI welcomes dialogue with companies that are serious about change and will continue to monitor and expose bad practice. We will also strive for a situation in which the WHO Ethical Criteria for Medicinal Drug Promotion are more than a widely ignored set of guidelines, but taken seriously and used by governments as a baseline for the control of drug advertising.



The Struggle for Control

In the late 1980s, it looked as if the rational drug debate was being won on the policy level. There have been some real successes, but several factors force us to be anything but complacent. Recent signals from WHO indicate that its days of pioneering advocacy for rational drug use may be over, although it will continue to play an important role in providing technical support on drug policies. Donors to the Drug Action Programme are openly expressing concern about this shift in WHO policy.

New policies often favour community financing programmes which focus on covering health care costs from the sale of drugs. These programmes can all too easily fall into the trap of emphasising the provision of drugs and under-estimating the importance of training in rational drug use and monitoring.

In the present situation, in which up to half of the world's population has no regular access to drugs, and given the stark realities faced by many developing countries, the choices are limited and the outlook isn't very bright. It is important to keep the need for rational drug policies and a more equitable distribution of medicines between developed and developing countries firmly on the agenda of international organisations such as WHO, the IMF and donor agencies. We also have to continue to press for export controls to guarantee that developing countries do not get the leftovers of the industrialised world.

The current inequities in health can only be addressed by a massive and integrated international effort. Though rational drug use is only one part of good health care, it is nonetheless an important part because it involves gaining control of a section of the health care system which is out of control and ensuring that drug policy and use unambiguously serve real health needs. To gain control of drug use requires creativity, commitment and a broad perspective. We have to convince both national and international policy makers, drug regulators, medical professionals, drug manufacturers, those who dispense and sell drugs and those who use drugs.

Catherine Hodgkin is Co-ordinator of Health Action International, Amsterdam, The Netherlands

Transforming Retail Pharmacy:
The Challenge of Group Practice

Bada Pharasi

New legislation is to be enacted which will bring about fundamental changes in the way retail pharmacists operate. The Medical Schemes Amendment Act will make it possible for health maintenance organisations (HMOs) and medical schemes to employ various health professionals. It also opens up the possibility for teams of health professionals to come together and provide primary care in multidisciplinary health centres.

At the same time, the Pharmacy Amendment Bill, also expected to be passed this year, will make amendments to the Pharmacy Act to make it possible for pharmacists to participate in group practices. At present, only pharmacists registered with the Pharmacy Council may own or share ownership of pharmacies. The bill makes provision for the Pharmacy Council to exempt non-pharmacists from provisions in the act which do not allow them to own or jointly own pharmacies.

This article focuses on the implications of the proposed legislation for the future of pharmacy, and the options available to retail pharmacists to respond to the changed circumstances. Now, more than any time in their history, pharmacists will have to re-examine their role and look at ways of re-shaping it so as to remain relevant to patient care. Already, proposals have been tabled for an 'extended' role for the pharmacist. The next section looks briefly at factors which have influenced the nature of retail pharmacy, followed by a critical examination of the proposed extended role. Its appropriateness is examined in relation to the pharmacist's traditional role in drug therapy, and the involvement of the pharmacist in the health team for comprehensive patient care.

Retail Pharmacy and Profit

Pharmacy is a specialised health profession in which pharmacists derive satisfaction from applying unique skills in drug therapy to achieve patient care. Its practice is regulated by ethics to ensure that services are in the best interest of the patient. However, private sector retail is also a business which relies heavily on the profit motive. Retail pharmacists receive their income from the

sale of medicines. They, therefore, have an incentive to sell large amounts of expensive medicines, potentially in violation of ethical codes.
There is little or no financial reward for patient oriented services, such as drug education, consulting with prescribers and monitoring excessive drug use, abuse and patient compliance. Very little attention is paid to such tasks. This results in pharmacists not utilising their training and skills to ensure optimum drug therapy.

Traditionally, the retail pharmacist was the sole private sector provider of prescribed medicines and held a near monopoly in the market. Before the revolution in the pharmaceutical industry that led to the production of patient ready medicine packages, a considerable amount of prescriptions were filled through small '63 scale preparation in the pharmacy. The great majority of people using private health care services were on medical aid, and the cost of private medical care, including that of drugs, was hardly an issue. So lucrative was the market for drugs, mainly in "white" metropolitan areas, that little thought was given to the provision of pharmaceutical services in the rural and black urban areas. This was fulfilled mostly by dispensing doctors.

Growing Competition

More recently, retail pharmacists have had to face increasing competition from grocery stores for the retailing of over-the-counter drugs, as well as from general practitioners, about 50% of whom are now licensed to dispense drugs. The role of pharmacists as trading professionals in the private sector is under severe threat from the growing competition. The restructuring now made possible by the Medical Schemes Amendment Act will see most patients eventually belonging to some form of managed care scheme, which attempts to control medicine costs by integrating the dispensary into the scheme. This will reduce the number of patients covered by a traditional medical aid which reimburses patients or independent pharmacies for all prescribed medicines.

The Pharmacy Amendment Bill aims principally to make it possible for non-pharmacists to open pharmacies in remote areas in order to improve access to medicines. However, the bill has already been interpreted as clearing the way for supermarkets and other enterprises to operate pharmacies and employ pharmacists. It has been argued that large retailers would be able to sell drugs more cheaply. To a degree, this is true, but the level of optimism is misplaced. It is based on the assumption that the retail mark up of medicines is solely responsible for their high cost in the private sector. It is, nevertheless, clear, that large retailers would make further inroads into retail pharmacists' profits.

What becomes of retail pharmacy under a NDP? *Photo:Ismail Vawda*

In addition to the possibility that big business enterprises could soon be allowed to operate pharmacies, a new government may decide to get involved in the retail market. This would be one way of ensuring that essential drugs were made more accessible and affordable to the population. State pharmacies would have the advantage of selling cheaper generic medicines bought on tender.

These developments will also lower the status of retail pharmacists in comparison to other professionals within health teams providing primary care to the community. Increasingly, there will be no meaningful role for independent pharmacies in their present form. The response to this changing reality by organised retail pharmacy might also be unrealistic and inadequate.

An Extended Role

The Pharmaceutical Society of South Africa calls for new functions for the pharmacist to be identified, developed and legalised. This includes training pharmacists to carry out functions currently performed by nurses at clinics. This would involve the pharmacist administering injections, providing preventive care services and caring for the chronically ill, including diabetics, hypertensives and cancer patients. The present functional layout of pharmacies would be changed to include a consultation room in which pharmacists could practise, and another room for injections and screening tests.

The Pharmacy Council has agreed to allow pharmacists to deschedule certain Schedule 3 and 4 medicines, thereby giving them greater discretion in treating certain minor ailments. This means that pharmacists, under given circumstances, will be able to dispense medicines in these schedules without a doctor's prescription. The extension of the pharmacist's role is to be given legal status by the Pharmacy Amendment Act which also aims "to enable pharmacists, for instance, not only to sell medicine but to administer it and to design and implement therapeutic plans".

Both Prescriber and Dispenser

If these plans come to fruition, pharmacists would no longer constitute the independent interface between patients and prescribers as they would be both prescribers and dispensers. This effectively removes the final check traditionally provided by pharmacists to detect any errors made during prescribing. Furthermore, the pharmacist as prescriber would have an economic interest in the dispensing. This would distort the pharmacist's clinical decision making, as the tendency would be to prescribe medicines which bring profit. There would be little incentive to refer patients to doctors unless they obviously required hospitalisation. The pharmacy would become a type of day hospital where the functions of doctor and nurse are provided by the pharmacist.

Clearly, therefore, the proposed extended role of the pharmacist will have the effect of presenting the pharmacist as an alternative to the GP. This type of practice might be acceptable in areas without GPs. Some could even see it as healthy competition in areas where GPs do exist. In the latter case the quality and the cost of the service would eventually determine whether the public can confidently forsake the traditional doctor's 'surgery' and turn to the pharmacist for most primary care. Medical aids would only contract such a service if it were shown to be a more cost effective alternative to GPs.

The Pharmacist's Role

However, it must be questioned whether it is appropriate for pharmacists to take on additional tasks, currently performed by other health professionals, given that they have not carried out their full role as pharmacists in ensuring optimum drug therapy.

The pharmacist's role as a professional with special skills in drug therapy includes product and patient oriented tasks. The pharmacist should monitor drug therapy, including drug interactions, adverse effects, multiple prescribing, excessive use and abuse, compliance and effectiveness of therapy. Such a role excludes prescribing, except for minor cases of self-medication. It includes collaboration with the medical practitioner in deciding on the most appropriate treatment, provided the pharmacist does not have a financial interest in the dispensing of the drugs.

Integration into Health Teams

Two conditions would have to be satisfied for pharmacists' potential to be realised. Firstly, pharmacists would need to work more closely with medical practitioners and encourage practitioners to consult on drug related matters. Pharmacists would have to maintain patient medication profiles and have access to patients' diagnoses and records. The participation of pharmacists in multidisciplinary health teams providing primary care would ensure they play leading roles in drug therapy.

Secondly, to enable pharmacists to pay due attention to patient oriented tasks, their professional incomes must cease to be linked to the sale of drugs. Financial reward for all pharmaceutical tasks, irrespective of whether drugs are dispensed or not, would enable pharmacists to provide more comprehensive services. An integrated group practice using the capitation system (that is, payment by the number of patients seen at or registered with the practice, as opposed to a fee for each service rendered) would remove the financial incentive to over provide certain services.

Retail pharmacy as we know it is under threat. Organised pharmacists seem determined to find a way forward in isolation of other health professionals. However, pharmacists have a positive role to play in multidisciplinary health care teams. Rather than resisting integration, pharmacists should start working now to secure their place in the health team.

Bada Pharasi works for the Centre for Health Policy.

The Role of Traditional Medicine in a Changing South Africa

Marisa Jacobs

If there is to be any improvement in the health of the under-served populations of the world there will have to be full utilisation of all available resources both human and material. This fundamental to the primary health care (PHC) approach. Traditional practitioners constitute the most abundant and, in many cases, valuable resources present in the community and traditional medicine, like orthodox medicine, aims at healing or preventing disease. In many developing countries experience has been accumulated in the use of locally available drugs of natural origin, mainly medicinal plants, and some of them have been used effectively.

These drugs, however, are not necessarily safe because they are natural. Some have caused serious adverse reactions and some contain chemicals that may produce long term side-effects such as carcinography and hepatoxicity. A number of traditional drugs could, however, be safely used in organised health care. Symptomatic treatment is frequently required in PHC and in these cases the use of traditional drugs may be included in national drug policies.

In South Africa, the provision of medical care (especially of drugs) is scarce, and traditional beliefs and practice of medicine are still deep rooted in black communities. A traditional medicine programme for South Africa (TRAMED) has been proposed for 1993, and is the product of collaboration between the Department of Pharmacology (UCT) and the National Botanical Institute (Kirstenbosch). Recently, the University of Western Cape was also drawn in. Noteworthy is the absence of civic representation. South African National Civic Association (SANCO), non-government organisation's (NGO's) such as the South African Health and Social Services Organisation (SAHSSO), National Progressive Primary Health Care Network (NPPHCN) and other traditional healer and medicine associations of whom only the Traditional Healers and Herbalist Association and the African Healers Association have been consulted. Absent is also the TBVC states.

Some concerns of NGOs who were not consulted are that:
traditional medicine should become part of organised health care in South Africa; traditional medicine should be researched and developed, and development should include informed indigent choices of South African communities;

the research could be undertaken by national and multi-national pharmaceutical companies as long as legislative guidelines and contracts around patents are developed in consultation with traditional healers and the communities they work in; legislation around patents should exist and be enforced so that multi-national pharmaceutical companies do not have the right to market the traditional medicine in their home country without the necessary consultations; clear definitions of traditional medicine, herbs/plants, remedies, therapeutic protocols and regimens; development of traditional medicine should always be on the basis of accountability to communities; broad consultation is an important component for development of traditional medicine (for example, consultation with community and the civic leadership as well as all interested parties); issues around traditional medicine should reflect political will; and control over traditional medicines should remain with the indigent communities, and decisions should be made in collaboration with leadership structures of these communities, such tribal authorities or civics.

Another incentive for ensuring that decisions about traditional medicine be made in collaboration with community leadership is the fact, especially in peri-urban and urban areas, that when a new-comer to a community sets up shop as a traditional practitioner, people are often attracted to the service without assuring that the person was genuine. This has allowed opportunists to set up as 'sangomas' and sell scheduled medicines on the pretence that these are traditional remedies. Standardising traditional remedies and setting guidelines for evaluating practices would assist in ensuring that illegal and dangerous practices, such as these, are contained.

Training

All health staff need to be made aware of the place of traditional medicine in their culture, its strengths and weaknesses and the use that may be made of it. Similarly, traditional practitioners need to be approached with understanding and recognition of their skills. This should encourage them to share their knowledge and play a part in the national health service, usually after a period of special training.

Evaluation

Evaluation is the most difficult and yet the most needed field of endeavour. It can be said that traditional medicine has the support of the population, whereas the health profession opposes it. One of the aims of the evaluation component

is to put traditional medicine on a scientific basis, which involves statements and claims about the therapeutic value of particular traditional remedies which could be proven by means of controlled experiments and tests. This is achieved by critical examination of traditional material and practices; accurate identification of the plants and other natural products; identification of useful remedies and practices and suppression of those that are ineffective or unsafe; and promotion of further research and exchange of information.

What is to be done?

In the process of incorporating traditional medicine into a national health policy, we need to engage in situational analyses of the potential role of traditional practices and practitioners in national primary health care programmes; development of policies and legislation for the incorporation of traditional medicine into health systems; support to multi-disciplinary investigations and surveys of local traditional medicine practices and the use of plants of medicinal value; collection, analysis and dissemination of information from countries and regions on successful activities, projects and programmes on traditional medicine.

This process will take many years. In the meantime, we have to move towards the integration of traditional medicine into the national health care systems, incorporating only those aspects which have been proven to beneficial and desirable. Traditional practitioners should be involved in the evaluation of their own practices so as to facilitate the ready acceptance by their peers of suggestions for change, including the assumption of new responsibilities, for example, in the field of health education.

There is no single approach to the problem of how to involve traditional practitioners in national health systems, especially at the primary health care level. Dedicated and sincere action on the part of all concerned will be required to foster a collective effort to generate and implement policies best suited to South Africa. Most of the present legislation in this field is outdated or irrelevant and thus needs to be reviewed to conform with the new policies adopted. Reasonable and enforceable legislation would greatly enhance the implementation of traditional medicine activities.

National Drug Policy and Traditional Remedies

Importing drugs is always very costly and consumes scarce foreign currency. Developing traditional remedies of proven efficacy and quality will not only

promote economic self reliance but will have a ripple effect and encourage researchers to investigate other traditional remedies more carefully.

At present, research policies in South Africa do not reflect the role of traditional medicines in health services. New research and development policies could greatly assist institutions in addressing the critical problems now being faced.

The first step should be the establishment of a National Council for Traditional Medicine which could be charged with the responsibility for preparing a national strategy and laying down a broad plan of action to be followed by government. TRAMED is an attempt at this, but has omitted to ensure that as a body it adopts a multi-disciplinary and multi-sectoral approach, with appropriate representation of the different type of traditional practitioners involved. Major policy issues need to be identified, priorities determined and mechanisms established to propose the various options and courses of action open to government with ad-hoc groups being formed to tackle issues.

Adequate finances should be made available in the national budget for the support and promotion of traditional medicine. External finances should only be considered as a complement to government initiative. It will also be necessary to undertake a survey of the national situation with respect to practitioners, population preferences and needs, available resources, and an investigation of specific problems.This should provide a basis on which a sound national health plan, reflecting the role traditional medicines, may be formulated.

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RESOURCES

[A] World Health Organisation

The World Health Organisation (WHO) publications on pharmaceuticals are an outgrowth of the organisation's efforts to unite governments, prescribers, dispensers, consumers and the pharmaceutical industry in a search for ways to ensure that safe, effective and affordable drugs are available - and widely used. Books are grouped in the following categories: essential drugs, drug policies, drug regulation, international pharmacopoeia, generic names, quality control, ethical guidelines, safety assessment, drug research and development, biological standardisation, drug prescribing, clinical pharmacology, drugs for relief operations, nutrient deficiencies, supplements, blindness prevention, contraceptives, traditional medicine, AIDS, psychotropic drugs, substance abuse, travel medicine.

Books on Essential Drugs, Drug Policy and Drug Regulation

Essential Drug Requirements: A Practical Manual (1988)

A task oriented manual covering the full range of decisions, proceedures and calculations needed to formulate accurate estimates of drug requirements at national or regional levels.
Swiss Francs (Sw.fr.) 15.00 Developing countries Sw.fr.10.50

The Use of Essential Drugs: Model List of Essential Drugs (seventh list) (1992)

Presents and explains the seventh model list of essential drugs issued by WHO. Provides updated information on several components of national drug policy necessary to assure essential drugs correspond to health needs. Presents guiding principles for a system of legislative and administrative procedures that ensure quality, efficacy and safety.
Sw.fr. 10 Developing countries Sw.fr. 7.00

The World Drug Situation (1989)

A comprehensive review of the many factors influencing the current availability, consumption and effectivity of pharmaceuticals throughout the world. It analyses global trends in the consumption, production, trade and sales of pharmaceuticals, and profiles the drug situation in individual countries.
SW.fr 20.00 Developing countries Sw.fr. 14.00

Guidelines for Developing National Drug Policies (1988)

A detailed guide to the development of a national policy aimed at ensuring the availability, quality, safety and efficacy of drugs and vaccines. Addressed to policy makers and administrators, the book explains the complex factors that must be considered when planning and implementing a national drug policy.
Sw.fr. 11.00 Developing countries Sw.fr. 7.70

The Rational Use of Drugs (1987)

Summarises the numerous issues identified and discussed during an international conference in Nairobi on the rational use of drugs, including issues related to rational practices and policies in the manufacturing, marketing, distribution, prescribing, quality control and regulation of pharmaceuticals.
Sw.fr.52 Developing countries Sw.fr. 36.40

Sw.fr.52 Developing countries Sw.fr. 36.40

Regulation of Pharmaceuticals in Developing Countries (1985)

Explains laws and legal frameworks necessary to ensure that safe, effective and inexpensive drugs of good quality reach consumers in developing countries. Addressed to policy makers, the book provides the basis for a sound understanding of each step involved in the formulation and implementation of an effective national drug policy.

SW.fr.14 Developing countries Sw.fr. 9.80

Publications and Further Details from:

World Health Organisation
Distribution and Sales
1211 Geneva 27
Switzerland
Tel: +41 22 791 2476
Fax: +41 22 788 0401

[B] Health Action International

Health Action International (HAI) is an informal network of some 150 consumer, health, development action and other public interest groups involved in health and pharmaceutical issues in 60 countries around the world. HAI has active participants in Africa, Asia, Europe, Latin America, North America and the Pacific region. HAI believes that all drugs marketed should meet real medical need; have therapeutic advantages; be acceptably safe; and offer value for money.

In 1988, WHO calculated that of the 5 billion people in the world, between 1,3 and 2,5 billion have little or no regular access to essential drugs. At the same time, it is estimated that as many 70°₀ of the drugs on the global market are inessential and/or undesirable products. HAI supports the essential drug policy of WHO which concentrates on the supply and use of some 250 drugs considered to be the most essential. HAI also believes that the problem of the enormous numbers of inappropriate and ineffective products must be tackled.

HAI recognises that access to appropriate medicines is only one element of health care and that a significant improvement in world health will be achieved only if the problems of poverty, inadequate sanitation and malnutrition are addressed.

HAI has achieved successes at both international and national level. HAI's contribution has been important in areas such as:

- achieving a gradual improvement in the advertising standards of many of the major multinational pharmaceutical companies;
- promoting the essential drugs concept and winning both political acceptance and public understanding of rational drug use;
- establishing an international network which has become accepted as the group protecting the interests of users of medicines;
- campaigns leading to regulatory action in various countries to ban harmful antidiarrhoeals, stop the inappropriate use of high dose hormonal drugs, end the use anabolic steroids as growth stimulants for children.

Publications which may be obtained from HAI include:

Problem Drugs • Chetley & Gilbert (1986)
Information pack on various categories of problem drugs
Dutch Guilders (DG) 20.00*

Antibiotics: The Wrong Treatment for Diarrhoea • Chetley (1987)
Reports on the widespread use of inappropriate antidiarrhoeals containing antibiotics
DG 20.00*

Dipyrone: A Drug No-one Needs (1989)
Critical review of dipyrone including annotated bibliography and list of brand name products containing dipyrone
DG 20.00*

Peddling Placebos • Chetley (1989)
Report on the inappropriate marketing of ineffective cough and cold remedies
DG 20.00*

Drugs and World Health • Medawar & Social Audit (1984)
Highlights the problems of inequitable distribution and inappropriate marketing
DG 10.00

Women and Pharmaceuticals Bulletin • HAI Europe/ WEMOS (1990)
Critical review of new contraceptive and reproductive technologies
DG 10.00

Marketing Fertility • WEMOS (1989)
Critical examination of promotion and use of high dose oestrogen-progestin combination drugs
DG 17.50

Fewer Drugs Better Therapy • BUKO (1988)
Proceedings of an international conference on the essential drug concept
DG 20.00

German and Swiss Drug Supplies to the Third World • Hartog & Schulte-Sasse (1990)
A Critical analysis of drug exports
DG 30.00

A Healthy Business • Chetley (1990)
Traces the campaign for more rational use of drugs and examines the response of the industry to its crisis
DG 35.00*

The Provision and Use of Drugs in Developing Countries • Hardon (1991)
Annotated bibliography of studies on drug use. Includes a review of policy implications DG 32.50*

Guidelines for the distribution and use of fertility Regulating Methods • WEMOS/HAI Europe (1991)
1 free 10 copies DG 5.00

A Question of Control • WEMOS/HAI-Europe (1992)
Women's perspective on the development and use of contraceptive technologies. Report of an international conference held in 1991
DG 20.00*

Promoting Health or Pushing Drugs? HAI Europe (1992)
A critical examination of marketing pharmaceuticals
DG 15.00*

Med-Sense • HAI-Europe (1992)
A new HAI promoting critical attitudes towards medicines and encouraging the rational use of drugs. Comes in the form of a pill box.
DG 5.00 5 boxes 20.00 10 boxes 25.00

Primary Health Care and Drugs - Global Action Toward Rational Drug Use • BUKO/ HAI-Europe (1991)
A detailed examination of the implementation of primary health care in the framework of social and economic issues facing developing countries. Based on proceedings of an international conference in Bielefeld, Germany September 1990
DG 30.00*

Exposed Deadly Exports • van der Velde (1991)
The story of European Community exports of banned or withdrawn drugs to the Third World
DG 20.00

Power and Dependence • Medawar (1992)
Discusses safety of medicines from a consumer perspective with special reference to benzodiazepine tranquillisers
DG 37.50

* Handling charge 10% of total. Minimum 5.00 Reduced rates available for groups in developing countries and for members of HAI-Europe. Please write for details.

Publications may obtained from:

HAI-Europe
Jacob v. Lennepkade 334 T
1053 NJ Amsterdam
The Netherlands
Tel: +31 (0) 20 683 36 84
Fax: +31 (0) 20 685 50 02

[C] BUKO Pharma - Kampagne

BUKO Pharma-Kampagne is a non-profit organisation dealing mainly with German pharmaceutical enterprises and their drug exports and marketing in Third World countries. It is a campaign of BUKO, the German Federal Congress of Third World solidarity and development action groups, an umbrella organisation with about 300 member groups. BUKO works towards structural changes in the economy and politics within Germany to stop the continuous exploitation of countries in the south.

German pharmaceutical industry is the world largest drug exporter, yet 60% of drugs exported into Third World countries are either obsolete, irrationally combined, of doubtful efficacy or even detrimental to one's health. Marketing practices of companies often prevent rational drug use and sometimes give wrong information. Many countries of the south have only very limited health budgets and it is therefore very important not to waste money on useless drugs. BUKO Pharma-Kampagne supports the essential drugs concept of the World Health Organisation. We monitor German pharmaceutical companies drug exports and marketing practices. We try to raise public awareness and pressure for the withdrawal of certain drugs from the market.

BUKO also considers it important to deal with rational drug use in Germany itself. We are developing an information leaflet for patients and a general information package on several drugs. We also want to pay more attention to the development, marketing, the use and abuse of modern contraceptives. We are publishing a follow-up study on German drug exports in the Third World and a study on benzodiazephine marketing and use in six countries of the south.

This is a list of some BUKO publications in English:

Vaccination against Pregnancy - Miracle or Menace? Richter (1993)
German Marks DM 15.00

Disturbing tranquillisers - Dependency through obsolete barbiturate combination • Hartog (1993)
DM 8.00 (16.00 for institutions)

Dipyrone: a drug no one needs • BUKO Pharma-Campaign, Health Action International (1993)
DM 8.00 (16.00 for institutions)

German and Swiss Drug Supplies to the Third World • Hartog & Schlulte-Sasse (1990)
DM 28.00

Primary Health Care • BUKO Pharma-Campaign
Conference Proceedings, Bielefeld (1991)
DM 28.00

Fewer Drugs, Better Therapy - Learning from the Third World?
Conference Proceedings, Bielefeld (1987)
DM 14.00

Hoechst - A cause of illness? BUKO Pharma-Campaign (1986)
DM 14.00

Publications can be bought from:
BUKO Pharma-Kampagne
August-Bebel-Str.62
D-33602 Bielefeld, Federal Republic of Germany

[D] The Zimbabwe Experience

A Question of Priorities: Pharmaceuticals for the Privileged or Essential Drugs for All? The Zimbabwe Experience
Hanif Nazerali

Herewith a summary of some of the issues raised and debated in the article with particular relevance to the South African situation.

Hanif Nazerali writes on the Zimbabwean post independence experience of trying to make drugs available to all. He notes that Zimbabwe was fortunate to inherit a sizeable local pharmaceutical industry. However, as a result of providing improved levels of health care to the majority, Zimbabwe soon experienced a shortage of essential drugs. The Ministry of Health set up the Zimbabwe Essential Drugs Action Programme (ZEDAP) to ensure a regular supply of low cost, good quality drugs in the government and non-profit health service, and to ensure optimal and rational use of drugs.

Nazerali points out that the first phase of the programme, from 1987 to 1992, is widely perceived to have been a success, in large part due to the participatory methods of developing policies and plans, involving public and private sector interests. He then questions this perception and argues that success finally depends on a "sufficient alignment of the interests of parties concerned to common goals, and not the methodology itself." He then looks at `common and conflicting interests' encountered in the first phase of ZEDAP.

In 1987, a wide range of parties involved in the manufacture, distribution and utilisation of drugs reached consensus on a national drug policy. A key feature of the policy was the commitment to the promotion of generic drug use. By 1989, the generics policy had been reasonably well implemented in the public sector. At the primary care level, prescribing by generic name reached 90%. However, far less success was achieved in the private sector. Regulations on labelling only came into effect in 1991 and still allow brand names on labels. The principal member of the legal sub-committee for drafting regulations for generics came from a legal practice which handled patent applications by pharmaceutical companies.

During the first half of the 1980s, the Essential Drug List of Zimbabwe (EDLIZ) was developed. It contained 375 drugs relevant to the country's health needs. From 1988 onwards, some expensive drugs in demand in the private sector were added to the list in order to woo the private sector. This has important implications. Zimbabwe and other developing countries share the problem of having very limited amounts of foreign exchange (forex). The Reserve Bank, when allocating forex for imports, gives priority to desperately needed imports, including EDLIZ drugs. The expensive drugs now on the list are also eligible for favourable treatment. This moves Nazerali to comment that "Zimbabwe's mixed economy necessitates a precarious balance between central planning goals and the interests of a pharmaceutical supply system dependent on private enterprise".

Forex used to be allocated in an ad-hoc way and this was associated with drug shortages. In 1988, the Government Medical Stores was given access to a special reserve of forex. This contributed to making EDLIZ drugs widely available. More than 80% of essential drugs were available at all levels of the public sector. However, by 1991 there was a forex crisis which led to major drug shortages. The government provided the Prescription Import facility to allow for imports in exceptional cases of need. Multinational companies were quick to abuse this facility and it became the major channel for private sector imports. Non-EDLIZ drugs, unregistered drugs, inappropriate and expensive brand name drugs and non-essentials such as vitamins and tonics were imported in large quantities, for use by a small minority.

ZEDAP is now entering its second phase, at a time when the World Bank is imposing an Economic Structural Adjustment Programme (ESAP) on Zimbabwe. Nazerali suggests that liberalisation of exchange controls and relaxation of import regulations will improve the availability of drugs in Zimbabwe. However, he expresses concern that these changes can have a negative impact on the accessibility, affordability and rational use of drugs, and that the drug needs of the majority may not be met.

Hanif Nazerali is an independent consultant based in Harare. He previously worked in the Zimbabwe Essential Drugs Action Programme (ZEDAP). His article also includes discussion on problems of inefficiency in the Ministry of Health and the Government Medical Stores, as well as some detailed information on the private sector, including local pharmaceutical manufacturers and importers and wholesalers. He highlights conflicts of interest within the private sector, for example, between local industry, which fights for a protected market for its products, and importers and multinational companies, which try to bring identical products into the country.

Copies of the article are available from Critical Health.

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General Section

Why are infant formulas and ordinary milk so expensive, and how does this affect infant and child nutrition? What are the advantages and drawbacks of the Medical Schemes Amendment Act? What is SAHSSO doing to assist the victims of violence and torture?

The Prohibitive Cost of Milk

Ingrid le Roux

Breast milk is the ideal food for babies. It should be a national health and nutrition priority to encourage mothers to breast feed. Nevertheless, there is still an important role for breast milk substitutes, namely feeding babies less than six months of age where there is no alternative.

Breast Feeding Not Always Possible

The reality in many poverty stricken areas in South Africa is that many infants are not being breast fed. For example, 25% of children admitted to Philani Nutrition Centres and 12% of children in Site B Township in Khayelitsha have never been breast fed, according to a survey done in 1988. There are many social and economic reasons for this. For instance, mothers have to go back to work, or children are admitted to hospital and are separated from their mothers. Mothers themselves might be hungry and may even be starving and, as a result, do not produce breast milk. In these circumstances, infant formulas may be their only option, yet their children are often denied access to adequate breast milk substitutes by prohibitive cost.

Over the age of six months, children are no longer dependent on the more expensive specially processed infant formulas, but can drink ordinary milk, fresh or powdered. However, many children are denied access to ordinary milk as well, again due to its high cost.

Milk or Cereals and Ground Nuts

Few people deny the value of milk as a nutritious, well balanced component of a child's diet. There are, however, different opinions in the international literature about the suitability of milk as part of nutrition intervention programmes. Many fear that the availability of milk will interfere with breast feeding practices. These concerns are indeed valid. Nutrition experts suggest that cereal based products or ground nuts with oil and peanut butter are more cost effective alternatives for intervention programmes. It is important to realise, however, that any nutrition intervention programme which offers a product which the receiver feels is of low quality, second rate or only for the poor, is bound to fail. The product distributed must be of excellent quality and must be perceived as

such.

In summary, milk products do have an important role to play in child nutrition. For many infants and children, infant formulas and ordinary milk are essential components of their diet. It is, therefore, crucial that formulas and ordinary milk should be available to those needing them at an affordable price.

Milk for Profit

Today, more than enough milk is produced in this country. Its quality is acceptable and it is distributed by means of a far reaching network. It is, however, priced out of reach of the majority of South African families.

Prices are maintained at unacceptably high levels by removing surpluses from the market. Milk powder and butter surpluses were exported at a loss of R108 million during the 1991/92 financial year. Offers from companies within South Africa to purchase these surpluses for sale at a lower price inside the country were refused. The press reported that hundreds of tons of milk have been dumped in the sea.

Decisions on what to do with surpluses were taken by the Dairy Board. The majority of positions on the board were occupied by representatives of the four largest milk producers, Dairy Belle, NCD, Bonnita and Nestle. The

Workiing mothers can't be expected to breastfeed. *Photo: Afrapix*

government subsidised the dairy industry to the amount of R288 million in 1991. In the same year, the government only made R220 million available for the state food aid programme. It is clear that the size of the subsidy to the dairy industry and the way in which this subsidy is used serves vested interests at the expense of the poor.

The Dairy Board has been stripped of its powers, but the largest milk producers continue to dominate the industry. Today, surpluses are still removed from the market and artificially high prices are maintained. There can be no justification for this in a country in which at least 30% of children under the age of five show marked signs of nutritional deficiency.

The Progressive Health Sector Must Act

It is unfortunate that we do not have a sufficient base of knowledge to make appropriate policies with regard to the distribution of milk. The progressive health sector should commission research to clarify in more detail how milk and other agricultural products are produced and priced in this country. Food aid programmes by the state and nutrition programmes supported by milk manufacturers are token gestures without credibility and it is important that the progressive health sector challenges the current status quo.

Ingrid le Roux works for the Philani Nutrition Centre, Cape Town

The Medical Schemes Amendment Act

An Appropriate Response to the Crisis?

Patrick Masobe & Max Price

The Medical Schemes Amendment Bill, tabled before parliament this year, proposed radical changes to the current medical aid system. Medical schemes are currently required to guarantee payment to providers of care who agree to charge patients within a tariff of fees that has been determined by the Representative Association of Medical Schemes (RAMS). The new law will abolish such guarantee of direct payment by medical schemes to providers.

At present, medical schemes are bound by law to offer members a minimum package of benefits which is, in fact, quite comprehensive. The schemes have to pay, within certain limits, for doctors' fees, hospital costs and medicines. The amendments will do away with these prescribed benefits. The status of RAMS as a statutory body will be repealed and its scale of benefits will thus be reduced to guidelines.

At the same time the new act will have the effect of facilitating the development of managed health care options such as health maintenance organisations (HMOs) and preferred provider organisations (PPOs).

Why the Changes?

The private health sector has been in crisis for some time now. Central to this has been the escalating costs of private care, which have risen on average by 26% each year. On the one hand, the rising costs make private care increasingly unaffordable for members of medical schemes and their employers. On the other, these escalations in costs place tight constraints on medical schemes' ability to attract new members. Faced with impending collapse, the medical aid industry put tremendous pressure on the government to come up with this 'rescue package' in the form of the Medical Schemes Amendment Act.

The bill has engendered an acrimonious and, at times, misplaced debate between its supporters and its opponents. It has garnered ardent support from the private medical aid sector, which has argued that it will allow medical

schemes to negotiate payments with providers in return for concessions that they might demand, and will provide incentives for containment of costs.

Is Loss of Provider Choice the Key Issue?

A number of general practitioners and their organisations are very much against these changes and have argued that the new amendments will result in patients losing their choice of providers. Medical aid schemes will require members to go to those providers who offer discounted fees or are employed by HMOs. This lobby has also argued that the repeal of a guarantee of payment will increase providers' exposure to bad debts. The costs of administration will also escalate as schemes enter into separate contracts with a large number of providers.

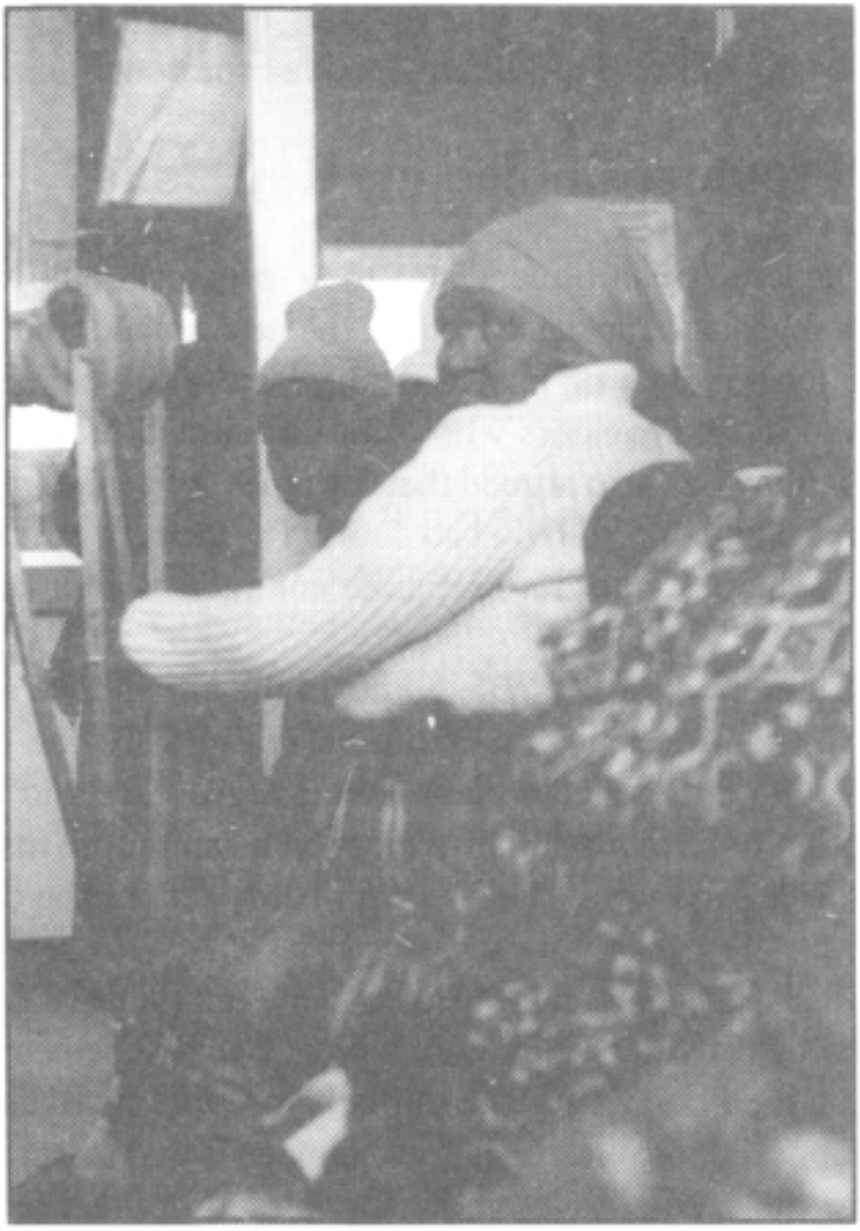
There are a number of laudable points in the bill and we should not lose sight of these in the process of assessing its failings. To the extent that the amendments facilitate the development of managed care and allow medical schemes the option of reimbursing providers on a capitation, instead of fee for service basis, it is a good thing. This will probably reduce the costs of private care.

We would also argue that opposition to the bill on the basis that patients will lose choice of providers is unconvincing. Most schemes have member representation on their boards and are unlikely to effect changes that members are vigorously opposed to. What is likely to happen is that members will be free to choose either more cost effective managed care options or to pay higher premiums for traditional medical aid cover with greater freedom of choice.

Will the Bill Benefit the Public Sector?

The argument by supporters of the bill that it will benefit the public sector also runs hollow. The repeal of the requirement for a minimum package of benefits will result in the introduction of variable packages which allow schemes to rate members on the basis of risk presented. The consequence will be a loss of cross subsidisation as the young and healthy choose cheaper packages and the old and infirm are confronted with the more expensive ones. Many people in the latter group are unlikely to afford such packages and will be forced to drop out of the system.

Thus, from the public sector point of view, the fundamental criticism of the bill is that the advent of variable packages will erode cross subsidisation in the medical aid system and will push a lot more elderly and sickly people into



How do patients benefit from the Medical Schemes Amendment Act?
Photo: Ismail Vawda

the public sector. The people most in need of health care will be least able to afford medical cover and the higher medical costs of these patients will be borne by the public sector. This will further increase the imbalances between the two sectors.

The minimum package requirement has had other profoundly positive effects which would be lost if it were abolished. Millions of patients were able to obtain much of their health free from the majority of general practitioners and specialists who were 'contracted in'. These patients are not always able to pay 'the first rand' when they need care. The new act will mean that many patients may, for the first time, be faced with significant out of pocket expenses at a time when they need essential care the most. Once again, such patients are likely to be off loaded onto an already overstretched public sector.

Forward Funding

One solution to this problem would be for legislation requiring medical schemes to forward fund, that is to hold in reserve funds for the future care of present contributors. This will prevent the proliferation of 'fly by night' schemes offering cheaper packages to the young and healthy, and forcing the elderly and sickly into the public sector as a result of the more costly packages they are confronted with. The representation made by the Medical Association in this regard ought to be supported.

Though the advent of managed care should go some way towards putting a lid on escalating costs, there may be other reasons why costs of health insurance may remain high. If medical schemes were required to forward fund, then it is unlikely that the cost of health insurance would drop substantially. In fact, cost may even go up. If contributions reflected their true costs to medical schemes and insurance, private care would remain relatively expensive.

The Amendment Act or an NHI?

The proposed changes will leave large numbers of medical scheme members without the ability to meet the substantial out of pocket expenses they will face, and thus without adequate cover. The introduction of flexible packages will fracture the cross subsidisation that is a feature of the current system. Those people faced with expensive packages, the old and sick, are unlikely to afford them. Such patients will inevitably have to be cared for by a public sector already struggling to provide adequate care to almost 80% of the population.

Though few people would dispute the dire need for radical reform to the private health sector in South Africa, and though this bill makes a contribution by facilitating the development of managed care options, it nevertheless fails to extend private sector care to a larger proportion of the population. It falls well short of providing health care to all South Africans. We have argued elsewhere for a National Health Insurance (NHI) system that will incorporate the private sector and will ensure the equitable provision of cost effective care to all South Africans. Such an NHI system should be the result of a process of negotiations among all those concerned with health for all South Africans.

Patrick Masobe and Max Price work for the Centre for Health Policy at the University of the Witwatersrand

SAHSSO's Victims of Violence, Torture and Rehabilitation Programme:
a response

Glenda Wildschut

The 'Violence and Health' edition of *Critical Health* included an article on SAHSSO's emergency services groups (ESGs), established as a response to appeals at our launch, from ANC leaders that health workers begin to set up structures to prevent violence or to deal with the effects of violence on individuals and communities.

The ESGs, however, are only a small aspect of our work. SAHSSO has taken up the challenge in the holistic way emphasised by Barbara Hogan. Our work on violence and related issues includes the problems of captivity and torture, urban and rural violence and returning exiles.

Urban Violence: Counselling and Care

We have established a programme which provides counselling and medical care to victims of violence and also social relief and assistance in rehabilitation. We are also involved in assisting people traumatised by imprisonment and torture. This includes support to returning exiles previously held in camps outside the country or captured by enemy forces.

So far, our programme, the Victims of Violence, Torture and Rehabilitation Programme, has been well established in the western Cape, although we do have branches in Natal and the southern Transvaal. People in our border and northern Transvaal regions are working at establishing related projects, but it is difficult to get things going due a lack of human and financial resources.

In Cape Town, we have a centre called the Western Cape Trauma Centre. At this centre, we provide a combination of individual and group counselling. Individual counselling involves psychotherapy around issues which clients might wish to keep confidential, whereas group counselling emphasises the principle of 'survivor helping survivor'. We involve group participants in collectively working out strategies of coping. Group counselling is a suppor-

tive approach in which people feel less isolated.

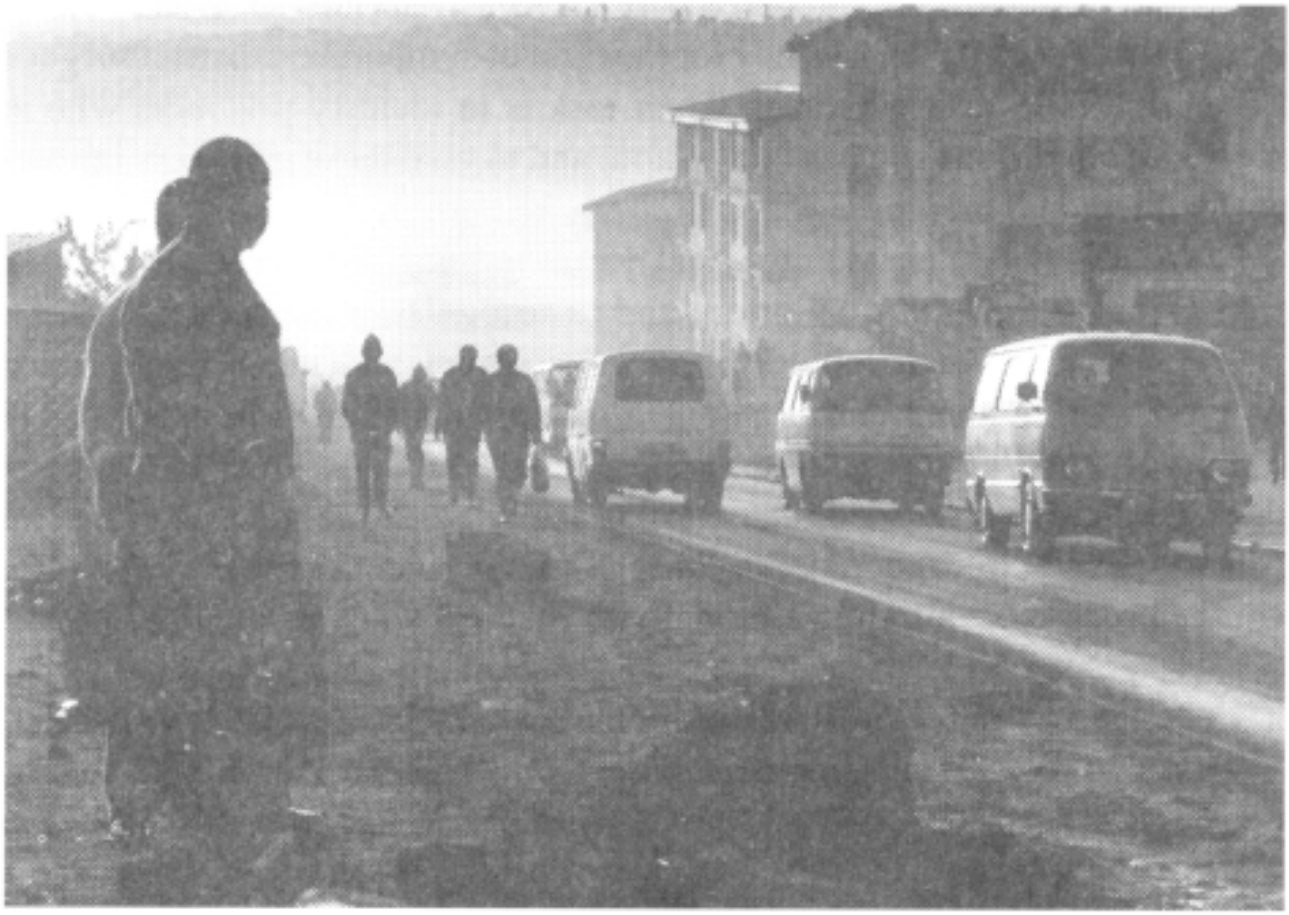
The level of political violence has escalated in Crossroads. This is, however, not widely covered by the media. Here we provide a medical service to injured people. To perform this task, we have a wide network of medical practitioners and other health workers who volunteer their services. Their services are performed at the trauma centre or we refer our patients to them.

At Crossroads, we have a satellite station which is involved in liaising with community organisations and identifying potential areas of risk. We help avoid conflict, by assisting in mediation between people. For instance, we encourage older refugees to accept newcomers in already overcrowded areas.

We also provide a link between affected communities and various social relief agencies like Operation Hunger and the Black Sash. The government has a fund for victims of violence to which we do not have direct access, so we refer people to agencies such as Quaker Peace, St John's Ambulance or the Red Cross which have access to this fund.

Rural Violence: Starting Up

SAHSSO is trying to set up a rural aspect to the programme. At the moment, our focus is on violence in rural Natal and on farm workers who are abused by



Below the mist - an atmosphere of tension and trauma ***Photo: Photo Workshop***

their employers. This programme is not well developed as yet. It has been difficult to encourage health workers to work in these areas. The programme has only one full-time worker and we will be employing four senior counsellors in each of the areas we are involved in. We have also advertised a field workers' post. The role of the field worker would be to liaise with affected communities.

Returnees: From Exile and Captivity to Reintegration

Our work with returning exiles involves, not only assisting them in coping with psychological problems associated with torture and captivity, we also assist in reintegrating them into South African society. For instance, we liaise with the city council of Cape Town to make housing available for returning exiles, and we also refer returnees to organisations involved in education and training or to organisations which could assist them with study bursaries. NCCR has a centre, the Moira Henderson Centre, which is used as a half-way house for returning exiles. While they live at the centre, we engage them in our group therapy sessions and also provide them with individual psychotherapy.

Detainees

The extent of our work on the effects of all forms of violence is indeed vast. SAHSSO has been trying to lobby for the right of sympathetic district surgeons or counsellors to visit detainees. Their task is to identify prisoners who are faced with conditions such as depression, and to give these prisoners immediate treatment and therapy.

We find that in nurse or medical doctor training, little provision is made for courses on the ethics of torture and in recognising the consequences of torture. We have been lobbying the government and other organisations involved, as individuals and as an organisation, to include these aspects in the training of health workers. At a nursing college in Cape Town, a course on ethics related to torture and detention is included in the general ethics and professional practice module. Similarly, a doctor, who is a SAHSSO member is in the process of initiating a module for medical students at UCT.

Glenda Wildschut is the coordintor of SAHSSO's National Organising Committee of SAHSSOs Victims of Violence, Torture and Rehabilitation Programme

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